A submission by **CO**VERSE on the *Australian Centre for Disease Control Bill 2025 and a related bill*[1]

About **CO**VERSE

We are the national peak body representing Australians who have been adversely impacted by the COVID-19 vaccines. Our science-led organisation is 100% controlled and operated by COVID-19 vaccine-injured Australians and is a charity registered with the Australian Charities and Not-for-profits Commission.[2] Full details of our organisation and activities can be found on our website at ***coverse.org.au***.

We have no conflicts of interests and have not accepted any funds from government, political parties or candidates, medical groups, or pharmaceutical corporations.

Commendations for the Bill

We commend the government for drafting legislation that pays attention to some of the key recommendations raised from its own COVID-19 Response Inquiry.[3] Especially with regards to transparency and full disclosure of all materials relied upon in formulating public health advice and materials.

While we understand the desire, and practical need, for an Australian Centre for Disease Control (CDC), we have several concerns around the *Australian Centre for Disease Control Bill 2025* as presented.

We make several recommendations that we feel could help strengthen trust and legitimacy for the CDC and hopefully avoid the kinds of real iatrogenic, social, political and mental health harms that we have experienced and been subject to by our public health actors.

Context of our contribution

Many Australians continue to suffer physically, financially and socially from medically-confirmed reactions to COVID-19 vaccines. We have extensively detailed these impacts in previous submissions to Parliament and Government, which can all be found via our website at *coverse.org.au/submissions*.

Australians who have experienced a serious COVID-19 vaccine adverse reaction have intimate informed structural experience of ‘disease management’, to bring to policy development in this area, which must be taken into account. While adverse iatrogenic events are life-changing on their

[1] *www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/DiseaseControlBill2025*
[2] *www.acnc.gov.au/charity/charities/ef2b7613-c6d1-ed11-a7c7-00224893b304*
[3] *www.pmc.gov.au/domestic-policy/commonwealth-government-covid-19-response-inquiry*

own, our experience as COVID-19 vaccine-injured citizens on the receiving end of neglectful, often harmful, and wholly inappropriate treatment (or lack thereof) by Australia's public health bodies and infrastructures following our reactions since 2021, has been just as, if not more, devastating than our physical injuries. Most Australians are still unaware that if they have a serious adverse reaction to a COVID-19 booster today, there is *no infrastructure to help them*.

Statistics are relevant to frame the gravity of our submission. According to the Government's own data, only some 10% of the 4,962 Australians who have medical documentation of a serious COVID-19 vaccine injury and have applied to the Government for compensation have been approved for compensation. A far larger number of seriously ill and/or permanently disabled people were *ineligible* to apply for the narrow scheme (noting that the Government reported that 10,000 Australians expressed initial interest in the scheme, and our own insights suggests a far greater volume of impacted Australians do not appear in these statistics).[4]

On the serious matter of appropriate vaccine safety communication, despite the official Australian public health narrative that serious adverse reactions to COVID-19 vaccines are 'mild and short-lived' and affect predominantly 'young males' or senior citizens with comorbidities, **CO**VERSE data shows that two thirds of our members are women whose average age is 53; and the majority of the people we represent have not recovered from their new medical conditions. In 2025, many MPs are not aware that there are still no national medical guidelines for doctors about how to recognise or treat COVID-19 vaccine reactions. Despite this, Australians continue to be diagnosed with COVID-19 vaccine injuries, and affected people find our support groups devastated to discover a community of Australians abandoned for over 4.5 years.

It is in this context, and mobilising our own experience of failed pandemic management, that we wish to remind the MPs working on this Bill that COVID-19 vaccine-injured people respectfully submitted to Australia's public health policies for the sake of the broader Australian disease response, and out of care for our communities. This sense of responsibility is also what we bring to our engagement now, as injured people, to the Bill for an Australian CDC.

COVID-19 vaccine-injured people evidence the challenges of population-level disease communication, whole-of community and vulnerable community vaccine guidance, and transparency in pandemic surveillance and vaccine safety surveillance. Our devastatingly 'inconvenient' experiences must inform discussions on a future Centre for Disease Control in order to make this future institution perform best.

We urge all MPs who work to develop this Bill to consider that any and all attempts at 'success' in disease management must take account of actual and potential harms and collateral damage in public health policy, past and future, and work towards addressing and mitigating such.

Finally, we want to highlight to the MPs contributing to this Bill that for 3+ years **CO**VERSE and its constituents have written to MPs for help to address their institutional concerns (and not just their injuries), and they have been met only with the advice to write to the Federal Health Minister.

We have never received an appropriate response from the Federal Health Minister to our situation, let alone been able to have a discussion with any Health Minister about the following pandemic management failures of the COVID-19 era:

[4] *www.news.com.au/finance/work/at-work/more-than-10000-aussies-plan-to-claim-for-covid-injuries-under-the-governments-nofault-indemnity-scheme/news-story/4d4e8a1ff7489b6f0728766ebee5c8b2*

- The failure of the TGA to address significant safety signals for COVID-19 vaccines, noting that COVID-19 vaccine adverse event reports make up **¼ of *all* medicine reaction reports** in government databases since 1971.[5]

- The failure of the government to apologise for unprecedented rates of harm from public health policy.

- Advice to vaccinate higher risk populations despite the initial absence of robust scientific data relevant to these groups (the clinical trials excluded these populations, namely older, disabled, or pregnant people).

- The censorship of doctors by AHPRA (Australian Health Practitioner Regulation Agency), which impacted the investigation, diagnoses, reporting of, and possible treatment pathways for the COVID-19 vaccine injured.[6]

- The relationship of the U.S. CDC to Silicon Valley, and the Australian Government's own information policies, which censored global social media on real community concerns, censored peer reviewed science, and shut down online mutual aid responses to medical abandonment and genuine injury.[7]

These failures have been furthermore mirrored in the performance of governments globally. In January 2025, as part of the Covid Vaccine Injury Alliance, **CO**VERSE co-released a 'Public statement regarding global public health abandonment of those injured and bereaved by COVID-19 vaccination'.[8] This public, non-partisan, statement by and on behalf of COVID-19 vaccine-injured organisations around the world, aimed to draw attention to the fact that public health agencies and ministries around the world have:

- Failed to adequately and transparently assess the safety profiles of the COVID-19 vaccines,

- Failed to undertake scientific studies of those individuals harmed by the COVID-19 vaccines,

- Failed to provide adequate support and compensation for people injured or bereaved by the COVID-19 vaccines, and

- Engaged in significant campaigns that censored the voices of the vaccine-injured and bereaved and minimised discussion of COVID-19 vaccine harms.

Read the full statement here: *www.covidvaccineinjuryalliance.org*.

COVERSE would like to ask how an Australian Centre for Disease Control will avoid transnational vaccine safety surveillance failures. We are invested in a high-functioning Centre for Disease Control in Australia, not least so that our fellow Australians in future might avoid the experience of structural injustice, censorship and abandonment from their commitment to public health policies.

While we would like to believe a future Centre for Disease Control may serve that purpose better in future - we don't see how the Bill will address the existing COVID-19 vaccine injured community, or

[5] *x.com/radofaletic/status/1721812818423582745*
[6] *www.ahpra.gov.au/Resources/COVID-19/Vaccination-immunisation-information.aspx*
[7] *nclalegal.org/press_release/ncla-suit-demands-end-to-govt-censorship-of-support-groups-for-victims-of-covid-vaccine-injuries*
[8] *www.covidvaccineinjuryalliance.org/documents/CVIA 2025-01 public statement.pdf*

reverse the political damage and lack of trust in government resulting from the abandonment of these citizens. This is despite our community repeatedly being told by MPs that this future institution could benefit us. We have continued this point in the final pages.

Comments on the *Australian Centre for Disease Control Bill 2025*

Extraordinary discretion around transparency

One major aspect in the design of the new CDC is that the Director-General (DG) has extraordinary discretion as to what topics they choose to investigate and what material they choose to publish. Conversely, the DG can avoid weighing in on important, and perhaps unpopular, public health topics if they have not been asked to do so, by merely choosing to not investigate or report on them.

If, to use a real world example from during the COVID-19 pandemic, a State decides to initiate vaccine mandates for large sections of the workforce and introduce vaccine passports to limit the freedoms of unvaccinated citizens, on the premise that doing so would stop the spread of a pathogen, the DG is not compelled to provide advice or to investigate the situation or public health claims made by that State, or to produce independent advice or reports about those public health actions. In the real world example, vaccine mandates ***assumed*** that the COVID-19 vaccines were sterilizing, while it was later revealed that these vaccines were not even tested for their capacity to stop transmission.

While the proposed legislation does include impressive transparency safeguards and obligations, they are of no value if the DG simply **chooses not to address** a significant public health issue, or if they frame the topic in a way that avoids the need to challenge or contradict assertions made by a Health Minister or Chief Medical Officer.

We feel there should be obligations built into the legislation for the DG to initiate investigations of major public health decisions (such as vaccine mandates, decisions to censor doctors, non-disclosures of pharmacovigilance matters, alongside civil liberty curtailments like lockdowns and border closures, during the COVID-19 pandemic), irrespective of being asked to do so.

Furthermore, these obligations must come with responsibilities to ensure that where little or no compelling evidence exists to support a particular policy or action, the DG cannot be allowed to offer affirmative advice in support of the measures, and must conclude that the CDC cannot provide evidence to support them. Recent reflective comments by the former Chief Health Office of Victoria admitted that on some occasions the evidence used to justify COVID-19 public health measures were no more than a ‘best guess’.[9]

Recommendation 1

The DG must be obligated to produce timely and independent advice on any and all major public health decisions across Australia, including disclosing when it cannot find compelling evidence to support those decisions.

[9] *www.dailymail.co.uk/news/article-15124287/Covid-health-boss-makes-shock-admission-Dan-Andrews-draconian-restrictions-Never-necessary.html*

Following are our comments and recommendations on specific sections of the proposed *Australian Centre for Disease Control Bill 2025* (which we hereafter refer to as either the *Bill* or the *CDC Bill*):[10]

Section 5 Definitions

Several of the definitions listed in Section 5 appear to leave open the possibility for abuse by public officials in the withholding of important information, in contradiction to the transparency requirements that are enshrined elsewhere in the Bill.

- **exempt material** (a) (viii) documents disclosing trade secrets or commercially valuable information)
- **protected information** (b) is information (including commercially sensitive information) the disclosure of which could reasonably be expected to found an action by an entity (other than the Commonwealth) for breach of a duty of confidence

These two specific exemption items raise serious concerns. By way of a real-world example, we refer to various Parliamentary and FOI efforts to obtain access to information submitted to the Australian Government from COVID-19 vaccine suppliers that formed part of the regulatory approvals processes for these products. Many efforts to access those documents for independent scientific and public policy scrutiny were denied (or completely redacted),[11] often on the basis of being 'commercially sensitive information'.[12] In these instances, not only was the public denied the opportunity to scrutinise this information (upon which significant public health measures were enacted during the COVID-19 pandemic, such as vaccine mandates and passports), but the redacting of much of this information served to instil significant distrust in the Government and its institutions.

While, on the topic of public health, the public has no great need to inspect incidental commercial information, it does have great interest in any and all commercial information that will be used (in whole or in part) for public health advice, policy, and programs that affect their own individual and their community's health decisions and economic futures. Carving out exemptions for information, such as described above regarding the COVID-19 vaccines, only serves to increase distrust in the honesty and integrity of government processes.

Recommendation 2

Remove exemptions and protections for commercial information that is used (in part or in whole) for the substantive purposes of the CDC.

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[10] *parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22legislation%2Fbills%2Fr7369_first-reps%2F0000%22;rec=0*

[11] For example, FOI 4558, 4 October 2023, "Batch testing for the Pfizer/BioNTech vaccine", *www.tga.gov.au/sites/default/files/2023-10/FOI 4558_0.pdf*

[12] For a narrative description of how the FOI rules have been perverted to obstruct access to information upon which critical public health decisions were made, see *news.rebekahbarnett.com.au/p/behind-the-scenes-how-freedom-of*

- **exempt material** (b) there is a risk that publishing the document or material could cause: (i) physical harm, or threats of physical harm; (ii) social stigma; (iii) bullying; (iv) vilification; or (v) other harm

It is a sad fact that Australians who have experienced harms from the COVID-19 vaccines have, in large part, experienced these harms as a result of public health actors failing to disclose all risks, including emerging safety issues, associated with these products. As the science of harms and risks accumulated however (there are now 4,300+ peer reviewed articles on COVID-19 vaccine harms, outside of post-marketing reports),[13] public health authorities have argued that public confidence in the COVID-19 vaccination program was of far greater importance than the disclosure of all information relevant to changing understandings of safety, efficacy, pharmacovigilance, mechanisms of action and so on. Much relevant information was not routinely disclosed through the media channels via which most of the public were getting their information.

The withholding or downplaying of relevant research and public health information, on the basis of concern that such factual information might undermine public health program goals, and hence lead to potential harm in the community, itself led to significant harms. A prime example of this phenomenon is when Premiers, Health Ministers, and Chief Medical Officers continued heavy promotion of the COVID-19 vaccines for *everyone* even after highly concerning safety issues had been identified for specified sub-populations. As a result, many people made personal health decisions to get vaccinated and subsequently suffered a serious injury. Had the public messaging been more transparent and up to date about the risks, many of those individuals would have made different decisions at the time, and hence would have avoided those harms.[14]

Under the guise of ‘authority’ that leaned often towards moralism rather than a critical scientific approach, many public health actors (including officials and Ministers) actively used highly stigmatising and vilifying language against Australians who either disagreed with public health decisions (such as vaccine mandates for novel products with no long-term safety data) or who chose to not follow public health advice (e.g. to get vaccinated).[15] Terms such as ‘anti-vaxxers’, ‘cookers’, and ‘extremists’ were deliberately used by our public health actors to target these people and to encourage the broader Australian community to vilify them as negatively impacting the official pandemic response (taking pressure off governments’ own policy decisions and regulatory and safety responsibilities, which we would argue is an approach that continues to this day).

So, while exempting certain material because of perceived social risks, our public health actors have already seen fit to deploy, and further encouraged, social stigma, social bullying and vilification tactics, under the misguided belief that doing so was in the best interests of public health. Not only was it unscientific, but it also didn’t work, and we believe there is no reason to continue such an approach in future, given the social impacts that continue to affect COVID-19 vaccine-injured and bereaved citizens, as well as trust in future Australian governments.

Recommendation 3

Remove exemptions for the release of material, where the release of that material might be considered to cause harm.

[13] *www.lens.org/lens/search/scholar/list?collectionId=232079*
[14] *www.news.com.au/lifestyle/health/health-problems/katie-did-not-need-the-vaccine-astrazeneca-victim-was-doing-her-bit-to-end-lockdown/news-story/78b2ea5ffe93473d1ada4827b8bc3202*
[15] *www.abc.net.au/news/2021-11-22/nt-covid-vaccine-mandate-opponents-anti-vaxxers-michael-gunner/100640656*

Furthermore, add additional obligations for the Director-General and all CDC staff to refrain from using language that provokes social stigma, bullying and the vilification of members of the public.

Division 2 The Australian Centre for Disease Control

Establishing the CDC as a statutory agency is an important feature of the Bill and ensures a level of independence from the Department of Health.

However, we retain concerns that the Bill may not contain adequate safeguards to ensure that conflicting priorities between functions of the CDC can be adequately carried out independent of each other and without conflicts of interest favouring one over the other.

By way of an example, we refer to the TGA (Therapeutic Goods Administration). Although not a statutory agency, the public at large have been led to believe that the TGA is an independent agency; a belief that is encouraged by officials of the Department of Health and government Ministers. Its function within the Department of Health has given rise to critical conflicts of interest within the Department, which has been responsible for:

1. Regulatory approvals of the COVID-19 vaccines
2. Receiving payment from manufactures of the COVID-19 vaccine for those approvals
3. Purchasing the COVID-19 vaccines
4. Indemnifying the manufacturers of the COVID-19 vaccines
5. Promoting and marketing the COVID-19 vaccines
6. Recommendations of who should get COVID-19 vaccination
7. Safety monitoring of the COVID-19 vaccines
8. Developing compensation policies for the COVID-19 vaccines
9. Deciding who should be compensated for harms experienced from COVID-19 vaccines

All of these tasks conflict with one another. We strongly suspect that these conflicts have played a key role in the Government's lack of acknowledgment, scientific investigation, and compensation of the many thousands of Australians who have been seriously harmed by these products, while simultaneously downplaying all other political and economic criticisms and scrutiny of the entire COVID-19 vaccination program.

How can the Australian public trust that, when faced with another major public health emergency, advice from the CDC will remain independent of political, ideological, commercial, and reputational interests?

The experiences of our COVID-19 vaccine injured colleagues in the U.S.A. suggests that the U.S. Centres of Disease Control (along with the U.S. Food and Drug Administration) ignored or downplayed a significant number of safety signals regarding the COVID-19 vaccines.[16] It is suspected that the reason for this is that the U.S. agency was also tasked with vaccine recommendations, maintaining public confidence in these vaccines, and in running public health campaigns to encourage the uptake of these products - tasks that are at odds with thoroughly investigating and uncovering safety issues with the same products. This is in addition to murky

[16] *researchrebel.substack.com/p/cdc-finally-released-its-vaers-safety*

financial relationships with vaccine manufacturers that skirt rules meant to ensure independence from private interests.[17]

Given this recent history, had the Australian CDC existed, as proposed in these Bills, during the COVID-19 pandemic, we remain unconvinced that it would have operated truly independently and in a manner that would have represented the Australian public's best interests. A body of the form proposed would not have addressed the interests or needs of Australians who have suffered harms from the COVID-19 vaccines.

Our further comments below are aimed at addressing this very real concern.

Section 11 Functions of the Director-General

- The Director-General has the following functions:
  - (i) developing, publishing and promoting
    - (ii) guidelines and statements on public health matters
    - (iii) public communications and advice on public health matters
    - (iv) reports, information and papers on public health matters
  - (j) conducting, promoting, and supporting community awareness initiatives and educational campaigns on public health matters

Our experience during the pandemic is that official communication from public health authorities was inadequate to fulfil obligations of providing members of the public with enough information about the risks (as well as benefits) of the COVID-19 vaccines, in order to make adequately informed decisions regarding consent to be vaccinated.

All public communications were skewed in such a way as to portray that the risks (to healthy people) posed by the SARS-CoV-2 virus were *greater* than they truly were, and conversely that the risks (again, to healthy people) posed by the COVID-19 vaccines were *less* than they truly were. This was done to fulfil a singular public health goal of getting as many people vaccinated as possible as quickly as possible.[18] Importantly, too, 'high risk' and vulnerable populations were encouraged to go first for their vaccinations, but the clinical trials for the vaccine products did not test the products on those groups. The proposed CDC's publications and public communication efforts must place paramount importance on the need to be *sensibly and accurately balanced* (rather than skewed in the interests of public health policy priorities), and the need to ensure that all CDC information available to members of the public enables them to make informed decisions based on the truth (the aggregated best-available science, including conflicting evidence), rather than them being led to make personal health decisions through the kinds of non-medical, generic and psychological nudge tactics that were deployed against us during the pandemic. These non-scientific 'pandemic management' tactics actively overrode doctor-patient discussions regarding individuals' particular health situations, including comorbidities and risks. Members of our groups who have never recovered from injuries are very angry that public health communications downplayed deliberations regarding risks to individuals' health from a non-sterilising vaccine that didn't stop transmission or infection (but which was initially incorrectly advertised as sterilising and highly effective in stopping transmission).

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[17] *doi:10.1136/bmj.j5104 & doi:10.1136/bmj.h2362*
[18] *www.health.gov.au/resources/publications/op-covid-shield-national-covid-vaccine-campaign-plan*

Recommendation 4

Section 11 on the Functions of the Director-General should conclude with a subsection codifying how the functions of the DG should be delivered in a manner that ensures independence from and impartiality towards government public health policy priorities, and all public information and advice produced by the CDC be a truthful as well as faithful portrayal of the relevant facts.

(We appreciate that such sentiments may indeed be codified elsewhere in legislation governing the conduct of public servants and public bodies, however we urge the government to codify specific requirements in the CDC Bill in order to further engender trust in this new institution and to protect members of the public from the kinds of 'official misinformation' we experienced during the pandemic.)

Section 15 Remuneration and conditions of appointment

- (6) The Director-General must not engage in paid work outside the duties of the Director-General's office without the Minister's written approval.

We fail to see why this incredibly important and consequential public health role should allow the office holder to undertake any other paid work at all. While the Bill does give the Minister the obligation to approve or deny such engagement, we feel it would send a far stronger message to the public about the DG's independence and sole commitment to public health matters regarding the citizens of Australia if the individual were banned from taking on any other paid work (or, indeed, any kind of remuneration, gift or gratuity aside from remuneration for their role as DG).

Recommendation 5

Revise the conditions of appointment of the DG to prohibit any and all work (paid or rewarded in any other way) outside of their role as DG.

We note that the CDC Bill does not impose any restriction on what the DG can do after their appointment has ended. Sadly, we have come to learn that the previous head of the Therapeutic Good Administration (TGA) has entered into roles that see them advising the very same companies whose products the TGA was tasked with approving and regulating. Moreover, that former official has advocated, alongside a former state chief health officer and a representative of a pharmaceutical company, for reduced regulatory requirements for certain pharmaceutical products - regulatory changes that that company stands to benefit greatly from.[19] One wonders whether these former public officials began formulating such corporate-friendly regulatory positions while in public office, and whether their interactions with those companies while they were in office led to such close relationships as to subsequently further the interests of those private corporations. The 'revolving door' problem affecting the lax regulation of other Australian industries is no different in the pharmaceutical industry (there is just less mainstream media attention to the problem).

[19] *doi:10.3390/vaccines12050528*

This kind of post-appointment activity should be prohibited by law for a period of no less than 3 years, if for no other reason than to ensure that the public maintains absolute trust that key officeholders have *only* the interests of the Australian public in their mind, and that there is no possibility they can be parachuted into post-appointment roles that enrich either themselves or private interests on the back of their insights and relationships from their public roles.

Recommendation 6

Add an additional clause to Section 15 stipulating restrictions regarding the DG's post-appointment activities that might have any connection with their role as DG - either real or perceived. Enact similar restrictions for other senior officials of the CDC.

Section 30 Appointment of Advisory Council members

Subsection (4) lists fields of expertise, qualifications or experience that make an individual eligible for appointment to the Advisory Council.

While this list does appear to be encompassing, we suggest that two additional areas be explicitly added to this list, to ensure that people are not excluded from consideration if their background does not neatly fit into any of the proposed fields.

We suggest that fields of 'consumer health interests' and 'adverse public health outcomes' be added to the list to ensure that the valuable experience of people who have been impacted by public health advice and decisions can assist the CDC in achieving wiser and more inclusive public health outcomes.

The necessity to include such people on the Advisory Council can be demonstrated by considering the development of the government's COVID-19 Vaccine Claims Scheme - a now-defunct no-fault compensation scheme that was supposed to compensate any Australian who had suffered a serious outcome from the COVID-19 vaccines. The Department of Health has ***never*** consulted with affected patients or their representative groups in the design (or much-needed reform) of this scheme, even after it was acknowledged by MPs from multiple political parties that the scheme was entirely inadequate for the task of compensating citizens with life-changing injuries. Industry and medical groups were consulted,[20] but relevant patients and patient groups were not.[21] The result of this incredibly condescending exercise is now obvious - the Claims Scheme has utterly failed to live up to the promise of being a 'quick and easy access' to compensation to any Australian harmed by the COVID-19 vaccines. We estimate, based on our engagement with the COVID-19 vaccine-injured community, and the **CO**VERSE member surveys we have conducted, that up to 99% of such Australians have been rendered ineligible for compensation, either via deliberate design or apparent negligence on the part of the Government.[22]

[20] *www.medicinesaustralia.com.au/media-release/covid-19-vaccine-claims-scheme*
[21] *www.abc.net.au/news/2025-09-24/covid-compensation-scheme-labelled-"complex-and/105813992*
[22] *media.coverse.org.au/documents/vaccine-indemnity-bill/060 COVERSE.pdf*

Recommendation 7

Add 'consumer health interests' *and* 'adverse public health outcomes' (or similar) to the list of fields of expertise for eligibility to be appointed to the Advisory Council.

Furthermore, we strongly urge the government to disallow any individual from membership of the Advisory Council if they hold financial interests in private organisations that stand to profit from the public health advice and activities of the CDC. For example, any executive or expert employed by, holds direct financial interests in, or who has received substantial funding from a pharmaceutical corporation whose products are either on or in consideration for recommendation by the CDC or other areas of the Government (e.g. National Immunisation Program vaccines). Having such individuals on the Advisory Council, even if they disclose their interests and remove themselves from discussions involving those interests, undermines public trust in the Council and the entire CDC.

Recommendation 8

Exclude from Advisory Council membership any individuals who have direct and/or substantial ties to entities that stand to benefit from advice, decisions and activities of the CDC.

Section 38 Meetings of the Advisory Council

- **Publication of summary** (7) As soon as practicable after a meeting, the Director-General must cause to be published on the Centre's website a summary of any advice, or recommendations, relating to public health matters that the Advisory Council adopted during the meeting.

The language used here does not allow for the full discourse and discussion of the Advisory Council meetings to be published. If there were dissenting views or recommendations, or discussion of underacknowledged risks, this subsection would allow those to be kept from public record.

The illusion of consensus during the COVID-19 pandemic was manufactured by the hiding and silencing of dissenting views. This served only to build distrust in our public health institutions, as the public learned about the real concerns motivating dissenters. Indeed, a number of the concerns of the so-called dissenters turned out to be wholly factually correct. For example, the concern that vaccinating young people might cause more harm than the virus that the vaccines were meant to protect again, has now been validated by ATAGI.[23]

We appreciate that robust discussion in a body such as the Advisory Council can only be possible if members know that their back-and-forth debates and disagreements will not be aired in public. However, there is most definitely a need for summaries of Advisory Council meetings to disclose dissenting opinions where those dissenters wish their views to be captured on record, precisely to benefit the public.

[23] *immunisationhandbook.health.gov.au/recommendations/healthy-infants-children-and-adolescents-aged*

Recommendation 9

Adjust the language governing the publications of Advisory Council meeting summaries to require that dissenting and alternate views and recommendations be included in the summaries.

Part 4 Information

- 45 (5) The Director-General must not give a direction under subsection (1) to any of the following…

Section 45 details how the DG can go about issuing a directive to compel another person or organisation to provide certain information. However, government organisations and personnel cannot be issued a directive. While we are not across any other government legislation that may provide other routes for the CDC to compel government entities to comply with such directives, we feel that the exclusion of these entities can only harm public trust in the CDC and allow other government policy priorities to take precedent (by withholding data from the CDC) over the need for the CDC to be independent and transparent on critical public health matters.

Recommendation 10

Allow the DG to compel government entities to provide relevant information.

- 71 **Unauthorised use or disclosure of protected information**, Subsection (5): Subsections (1) to (4) do not apply if the person uses or discloses the information in good faith

Unfortunately, acting in “good faith” has allowed public officials to downplay very real safety concerns, and to issue advice based on missing information. For example, early in the rollout of the COVID-19 vaccines people with significant disabilities were eligible for, and encouraged to be first in line to receive, a COVID-19 vaccine. Whilst this advice was given “in good faith”, it was nevertheless given without any clinical trial or other robust data on safety and efficacy being available for these cohorts. Similarly with the Government’s initial recommendation for pregnant women to also get vaccinated against COVID-19.

To protect the public from public health policy “wishes” and “beliefs” that have little or no compelling supportive data, and to ensure that the CDC’s activities and advice are trusted by the public, we urge the government to require the DG and CDC staff to be held to a higher standard than “in good faith”.

Recommendation 11

Protections from prosecution for officials if they acted in good faith should be narrowed to “reasonable care and good faith” (or similar).

(This should be reflected not only in the CDC Bill, but also in any other legislation that empowers the DG and/or CDC, such as the *Biosecurity Act*.)

A major shortcoming of the Therapeutic Goods Administration's pharmacovigilance efforts is that it never follows up AEFI (adverse event following immunisation) reports with the reporter (beyond confirming the report is a legitimate submission from a real person), and never conducts scientific (as opposed to statistical) investigations into any of the affected patients, short term or long term. The same is true of the vast majority of pharmacovigilance agencies around the world (including the U.S. CDC). This oversight (whether deliberate or negligent) has meant there is significant under-acknowledgement of the serious harms inflicted by the COVID-19 vaccines, despite the volume of evidence available in the community.

While the TGA claims it simply does not have the resources to undertake such activities and studies, the fact remains that patients' medical teams often do not have the skills or facilities to be able to undertake necessary scientific investigations, especially for novel or emergency approved products. Hence it ought to be the responsibility of pharmacovigilance agencies to initiate such studies (either by their own means or via referral to appropriate scientific bodies).

While the proposed CDC's information gathering powers *do* allow it to engage directly with patients, there is nothing in the Bill to ensure that the CDC will actually do so, nor are there any mechanisms for it to initiate scientific investigations of individual patients or cohorts of patients. If, for example, the CDC were to assume responsibilities for studying any adverse side-effects of vaccinations (or other public health interventions), it must not only have the ability to follow-up with patients and initiate scientific studies with them, but also it must be *compelled* to do so transparently. Otherwise, the outcomes of CDC information gathering activities will lead to similarly dismissive and inadequate responses from the agency, no different to what has been experienced by citizens dealing with COVID-19 vaccine adverse events.

Such has been our stark experience of the COVID-19 vaccine rollout - pharmacovigilance was not actively undertaken, no short term or long term scientific studies of the COVID-19 vaccine-injured have been pursued by any publicly funded research organisation in Australia (with the exception of the 5-year QoVAX-SET study that was disbanded after 8 months).[24] Confirmed reactions were not actually tracked or updated in the system beyond the initial moment of registration, which means the government's pharmacovigilance data excludes later medical diagnoses, and any knowledge of conditions worsening. Claims that authorities proactively assessed product safety is absolutely inaccurate, because proactive and responsive scientific investigations have never occurred.

Recommendation 12

When conducting studies involving patients and/or identified patient data, the CDC should be compelled to make reasonable efforts to follow-up with those patients to verify their data and to track their health trajectory, biomarkers and diagnoses over years.

Where patient safety is concerned (including with vaccines and other drugs), the CDC should be compelled to initiate scientific studies involving affected patients and not merely rely on statistical summaries, e-health records, or patient medical reports from treating physicians.

[24] *canberradaily.com.au/queensland-government-to-destroy-globally-significant-covid-vaccine-study-biobank*

Financial independence

We do not see any provisions in any of the proposed Bills to ensure that the CDC retains financial independence.

It is incredibly important - for both public trust as well as institutional independence - that the CDC not be allowed to receive funds from vested interests (particularly private entities who may stand to profit from CDC activities), nor to fund activities that also receive support from vested interests (for example, a vaccination campaign run by a non-profit that receives funds from vaccine manufacturers or trade groups).

Recommendation 13

Ensure the CDC remains financially independent of non-government funding, and that the CDC does not co-fund activities with external organisations that have vested interests in the activity.

Aboriginal and Torres Strait Islander aspects

While we are not an organisation that has a special focus on Aboriginal and Torres Strait Islander (ATSI) issues, we are, nevertheless, aware of some of the unique challenges and aspects faced by ATSI peoples. In particular, the structural experiences of Australia's medical system by ATSI people - in the past as well as the present - continue to display paternalistic tendencies towards disease management (including vaccination).

While it would be logical (if the COVID-19 vaccines were as safe and effective as advertised) that the pre-pandemic prevalence of comorbidities in ATSI communities could justify strong messaging on the need for COVID-19 vaccination, it remains undeniable the government *should* have known that COVID-19 vaccines were never tested on high-risk, comorbid, or otherwise vulnerable populations, including ATSI peoples. From a scientific perspective, the extremely reductive and wholly positive information supplied by immunisation bodies to ATSI health workers - about how the COVID-19 vaccines worked, and how negligible the side effects - was inaccurate, or even missing altogether. Informed consent did not occur.

Our deepest concern regarding ATSI health in relation to COVID-19 vaccines and future pandemic planning, is that over the last four years little or no data has been shared between pharmacovigilance bodies, MPs, and the public on vaccine adverse events experienced in ATSI communities. **CO**VERSE's direct experience of the barriers faced by anyone attempting to have a serious adverse event recognised in the current Australian medical system, let alone correctly diagnosed after years of multiple medical consultations, makes us confident that adverse events in Indigenous communities will have been severely undercounted and underestimated.[25]

Without transparent and rich depoliticised data on Indigenous communities' actual experience of COVID-19 vaccines (as opposed to the usual focus on uptake rates and perceptions of safety) there is no possibility of improving vaccine safety or pharmacovigilance for ATSI peoples. **CO**VERSE is aware of entire Indigenous families affected by COVID-19 vaccine injuries who, over four years, have never once been contacted by government agencies or received any support.[26]

[25] *doi:10.33321/cdi.2024.48.2*
[26] *dailydeclaration.org.au/2024/05/31/covid-submissions-censored*

The transparency issues we raise in Recommendation 1 go directly towards our key concern here. It is not only necessary to actively collect AEFI data reflecting vaccine-related safety issues amongst Indigenous peoples, it is also important to transparently release that data in order to improve political awareness of, and policy responses to, inequalities amongst vaccine-injured citizens.

Further, ATSI people with lived experience of adverse reactions, as well as ATSI researchers specialising in immunology, infectious disease, and the cultural politics of structural racism in health, must be meaningfully included in the Australian CDC beyond the single reserved spot on the Advisory Council.

Recommendation 14

Consider additional provisions in the legislation to ensure adequate representation of ATSI experts (in fields such as immunology, infectious disease, and the cultural politics of structural racism in health) in consequential roles within the Australian CDC. This should include representatives from urban, regional and remote communities, which face very different public health experiences.

Final remark

It has been suggested, by the Minister's office, Departmental officials, and Government responses to inquiries, that the issue of a no-fault compensation program for Australians who suffer harms from public immunisation programs will be examined by the new CDC.[27] We note that none of these communications make any commitment to implementing such a scheme.

The vast majority of Australians who have suffered harms from the COVID-19 vaccines remain without compensation (many with over 4½ years of continued and now permanent disabilities and impairments), while the Government and Parliament defer this matter to the CDC (which does not yet exist) for potential consideration at some undisclosed time in the future. This is absolutely unacceptable, as the impacted Australians are suffering right now, and have been suffering for years.

On 21 March 2024, former Senator Gerrard Rennick introduced a motion into the Senate seeking a Senate inquiry in the government's COVID-19 Vaccine Claim Scheme.[28] During debate, spokesperson for the Government, Senator Katy Gallagher, rejected the motion, declaring that there was no need for such an inquiry as the Government has already been recommended (via the Senate inquiry in the Vaccine Indemnity Bill)[29] to conduct an inquiry into the scheme. However, to date no such inquiry has taken place, and those impacted by the COVID-19 vaccines remain disabled and wholly abandoned by their Government and by Parliament.

In fact, no less than six governmental and parliamentary inquiries have delivered recommendations to support (including, but not only, via a no-fault compensation scheme) Australians who have been harmed by the COVID-19 vaccines. These include:

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[27] *www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ExcessMortality47/Government_Response*
[28] *www.aph.gov.au/News_and_Events/Watch_Read_Listen/ParlView/video/2291095?startTime=10020*
[29] *www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/VaccineIndemnity47*

- Senate inquiry into COVID-19 Royal Commission[30]
- Senate inquiry into Excess Mortality[31]
- Senate inquiry in Vaccine Indemnity Bill[32]
- Commonwealth Government COVID-19 Response Inquiry[33]
- House of Reps inquiry into Long Covid[34]
- Review of WA's COVID-19 management and response[35]

Yet, still, the Government and Parliament have done nothing.

Back in 2021, Australians injured by the COVID-19 vaccines predicted that vaccination rates for routine vaccines (including childhood vaccinations) would decline, due to the disdain, derision, and abandonment they have suffered. Our families, friends, and the community at large have seen how we have been treated by our government and by most of our politicians, and they have taken notice.

Through the appalling way we have been treated, the message to Australian citizens has been loud and clear: if you get vaccinated and are injured (or worse), you are on your own. The very institutions that promoted the COVID-19 vaccines *without exceptions*, on the basis of providing indiscriminate (generic) protection for the entire community, have turned their backs on the people most affected by their own commitment to these public health policies. Is this the message our Parliament truly wishes to be conveying to the citizens of Australia?

Legislation and the operation of a national no-fault compensation scheme should be informed by the experiences and needs of those who have been harmed by vaccines. This group of people are the prime stakeholders, and to enact legislation without being led by them, or to consider the views of other groups over the needs of vaccine-injured and bereaved citizens, would be a betrayal, and would only lead to further inadequate and disastrous programs, as has already been amply demonstrated by the failure of the COVID-19 Vaccine Claims Scheme.

The time to act is now. We urge Parliament to immediately introduce legislation that will establish a national no-fault compensation scheme for Australians who have already been harmed by their commitment to community vaccination programs.

Not next year.

Not "sometime in the future", when the CDC *might* get around to considering looking at the issue, and the Government *might* subsequently think about acting on it.

Now!

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[30] *www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/COVID19RC47/Report*

[31] *www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ExcessMortality47/Report*

[32] *www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/VaccineIndemnity47/Report*

[33] *www.pmc.gov.au/resources/covid-19-response-inquiry-report*

[34] *www.aph.gov.au/Parliamentary_Business/Committees/House/Former_Committees/Health_Aged_Care_and_Sport/LongandrepeatedCOVID/Report*

[35] *www.wa.gov.au/organisation/department-of-the-premier-and-cabinet/review-of-was-covid-19-management-and-response*