

**In the matter of a prosecution  
of the Victorian and Australian Governments  
— in relation to their ongoing crimes against  
humanity since end-March 2020 arising from  
reckless and disproportionate public health measures**

**COMMUNIQUÉ TO THE PROSECUTOR  
AT THE INTERNATIONAL CRIMINAL COURT**

This communiqué requests the Prosecutor to utilise its *proprio motu* investigative powers under Article 15 of the *Rome Statute of the International Criminal Court*.

**FIRST INFORMATION REPORT SUBMITTED TO  
The Information and Evidence Unit**

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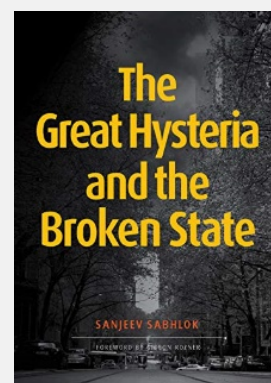
**BY**

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- **Resigned as Victorian Government economist** in September 2020 to protest **Police brutality and harmful policies**.
- Former senior civil servant in the Indian Government.
- **Author:** *The Great Hysteria and The Broken State* – which describes the collapse of governance during this pandemic.

**& the supporters listed in this communique**



13 November 2020

# Contents

INTRODUCTION TO THE SUBMISSION .....	8
<b>1. OUTLINE OF THE COMPLAINT .....</b>	<b>9</b>
1.1 THE RELEVANCE OF THIS SUBMISSION FOR HUMANITY, NOT JUST FOR VICTORIANS .....	10
1.2 THE ICC WAS NOT MY FIRST PORT OF CALL, BUT ALL OTHER ATTEMPTS AT JUSTICE HAVE FAILED .....	10
1.2.1 <i>Outright rejection of human rights by Daniel Andrews and his government</i> .....	11
1.2.2 <i>Reign of terror: The Police State and abolition of innumerable human rights</i> .....	12
1.2.3 <i>Sabotage of Democracy: Censoring People’s submissions to the Parliament</i> .....	13
1.2.4 <i>Both sides of politics are hands-in-glove about locking up Australia till 2022</i> .....	13
1.2.5 <i>The failure of the courts in Australia</i> .....	14
1.3 ALLEGATION: ARTICLE 7 OF THE <i>ROME STATUTE OF THE INTERNATIONAL CRIMINAL COURT</i> HAS BEEN CONTRAVENED ..	15
1.3.1 <i>It is not necessary to prove malicious intent</i> .....	15
1.3.2 <i>The judgement of national authorities on derogation of human rights is not conclusive</i> .....	15
1.4 THE TWO PARTIES ACCUSED IN THIS COMPLAINT .....	16
1.4.1 <i>Accused Group 1: Victorian Administering Authorities</i> .....	16
1.4.2 <i>Accused Group 2: Australian Administering Authorities</i> .....	17
1.5 THE SUMMARY OF THE ARGUMENT IN THIS COMPLAINT .....	17
1.6 WHAT I SEEK FROM THE ICC’S PROSECUTOR .....	21
1.7 ACKNOWLEDGEMENT OF SUPPORT RECEIVED IN PREPARING THIS SUBMISSION .....	22
1.8 LIST OF SUPPORTING COMPLAINANTS .....	22
<b>2. DISTINGUISHING PUBLIC HEALTH FROM PUBLIC HEALTH TERRORISM.....</b>	<b>24</b>
2.1 PUBLIC HEALTH CAN DO A LOT OF GOOD BUT ALSO HAS A LONG HISTORY OF CAUSING HARMS.....	24
2.1.1 <i>Horrifying abuse of civil liberties</i> .....	24
2.1.2 <i>Creating hysterias and ignoring other aspects of health</i> .....	24
2.1.3 <i>W.H.O.’s acknowledgement of these endless public health hysterias</i> .....	25
2.2 MODELS, ALWAYS UNRELIABLE AND DISCREDITED, ARE THE BASIS OF THESE HYSTERIAS.....	25
2.2.1 <i>Chronic failure of modelers to understand the basics of the immune system</i> .....	26
2.3 DANIEL ANDREWS WAS AWARE EVEN IN 2008 THAT PUBLIC HEALTH MEASURES CAN DISRUPT HUMAN RIGHTS .....	27
2.4 THRESHOLD QUESTION: CAN A GOVERNMENT KILL ITS CITIZENS OR SHORTEN THEIR LIFE? .....	28
2.4.1 <i>Can public health measures kill (or shorten people’s life)? No.</i> .....	28
2.5 CONDITIONS FOR JUSTIFIED COMPULSION IN PUBLIC HEALTH.....	29
2.6 PUBLIC HEALTH MEASURES IN 2020 HAVE CROSSED ALL BOUNDARIES OF LAW AND ETHICS .....	32
2.7 VOICES AGAINST THE PUBLIC HEALTH TERRORISM ARE GETTING SHRILLER.....	33
2.8 THE MAGNITUDE OF THE CORONAVIRUS PANDEMIC IS IRRELEVANT TO THE COMPLAINT .....	35
<b>3. THE STRUCTURE OF THIS COMPLAINT .....</b>	<b>37</b>
3.1 PART 1: THE REASONABLE AND PROPORTIONATE WAY TO PRACTICE PUBLIC HEALTH .....	37
3.2 PART II: THE ACCUSED KNOW THAT THEIR ACTIONS BREACH THE SCIENCE AND THE LAWS .....	37
3.3 PART III: THE CATASTROPHIC HARMS CAUSED BY THE ACCUSED.....	38
3.4 PART IV: EXPLORING THE INTENTIONS OF THE ACCUSED .....	38
3.5 PART V: SUMMARY OF MY ARGUMENTS AND A PRELIMINARY LIST OF WITNESSES .....	39
<b>PART 1: THE REASONABLE AND PROPORTIONATE WAY TO PRACTICE PUBLIC HEALTH ...</b>	<b>40</b>
<b>4. SWEDEN AS A ROLE MODEL OF GOOD PUBLIC HEALTH PRACTICE .....</b>	<b>41</b>
4.1 THE WORLD HEALTH ORGANISATION’S 2019 GUIDELINES FOR FLU-LIKE PANDEMICS .....	41
4.2 SWEDEN’S ACTIONS ARE THE TEXTBOOK IMPLEMENTATION OF W.H.O.’S GUIDELINES .....	43
4.2.1 <i>No border closure, mass-scale workplace shutdown or stay-at-home orders</i> .....	44
4.2.2 <i>Risk-based and proportionate interventions</i> .....	44
4.2.3 <i>Honest and clear goal of flattening the curve – no secret focus on eradication</i> .....	44
4.2.4 <i>Sweden’s results are superlative but that is not relevant to this complaint</i> .....	45
<b>5. ETHICAL CONSIDERATIONS IN DESIGNING PUBLIC HEALTH POLICY.....</b>	<b>47</b>

5.1	THE CRUCIAL SIGNIFICANCE OF ETHICAL FRAMEWORKS IN PUBLIC HEALTH POLICY .....	47
5.2	CONSIDERATION OF UNINTENDED HARMS BY THE PUBLIC HEALTH LITERATURE.....	49
5.2.1	<i>Compensatory policy for economic harms from restrictive measures .....</i>	<i>50</i>
5.2.2	<i>Mental harms from quarantines must be minimised.....</i>	<i>51</i>
5.3	THE ETHICAL REASON WHY COST-BENEFIT TESTS CANNOT BE USED TO ASSESS LOCKDOWNS.....	52
<b>6.</b>	<b>INTERNATIONAL HUMAN RIGHTS COVENANTS THAT PROTECT AUSTRALIANS .....</b>	<b>54</b>
6.1	UNIVERSAL DECLARATION OF HUMAN RIGHTS .....	54
6.2	INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS.....	54
6.2.1	<i>Permissible limitation of human rights to advance public health .....</i>	<i>55</i>
6.2.2	<i>The Siracusa Principles .....</i>	<i>55</i>
6.3	THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS.....	58
6.3.1	<i>General Comment No. 14 (2000) - Economic and Social Council of the United Nations by the Human Rights Committee .....</i>	<i>58</i>
6.4	NUREMBERG CODE.....	59
6.4.1	<i>Lockdowns are an unethical human experiment in breach of the Nuremberg Code .....</i>	<i>59</i>
6.5	UNIVERSAL DECLARATION ON BIOETHICS AND HUMAN RIGHTS .....	60
6.6	W.H.O.'S INTERNATIONAL HEALTH REGULATIONS 2005.....	60
<b>7.</b>	<b>THE AUSTRALIAN AND VICTORIAN HUMAN RIGHTS FRAMEWORK.....</b>	<b>61</b>
7.1	COMMON LAW FRAMEWORK IN AUSTRALIA.....	61
7.2	THE COMMONWEALTH'S BIOSECURITY ACT 2015 .....	61
7.3	VICTORIA'S HUMAN RIGHTS FRAMEWORK .....	62
7.3.1	<i>Fundamental human rights in Victoria.....</i>	<i>62</i>
7.3.2	<i>The element of proportionality .....</i>	<i>63</i>
7.3.3	<i>Protections in the Public Health and Wellbeing Act 2008 against arbitrary orders.....</i>	<i>63</i>
7.3.4	<i>Victoria's Public Health law does not authorise government to kill X to save Y .....</i>	<i>64</i>
7.3.5	<i>Emergency public health powers in Victoria .....</i>	<i>64</i>
<b>8.</b>	<b>VICTORIA'S 10 MARCH 2020 PANDEMIC PLAN WAS SOUND .....</b>	<b>66</b>
8.1	VICTORIA'S 10 MARCH 2020 PANDEMIC PLAN WAS REASONABLE AND PROPORTIONATE .....	66
8.1.1	<i>Risk assessment.....</i>	<i>66</i>
8.1.2	<i>Proportionality .....</i>	<i>67</i>
8.1.3	<i>Flattening the curve .....</i>	<i>67</i>
8.1.4	<i>No authorization to kill X in order to save Y.....</i>	<i>68</i>
8.2	AUSTRALIAN HEALTH SECTOR EMERGENCY RESPONSE PLAN FOR NOVEL CORONAVIRUS (COVID-19).....	68
8.2.1	<i>No lockdowns .....</i>	<i>68</i>
8.2.2	<i>No strategy of eradicating the virus while waiting for a vaccine.....</i>	<i>68</i>
8.2.3	<i>No sealing of Australia's international borders indefinitely.....</i>	<i>69</i>
8.2.4	<i>Proportionality .....</i>	<i>69</i>
8.3	OTHER JURISDICTIONAL PLANS .....	70
8.3.1	<i>European CDC pandemic guidelines did not mention lockdowns either .....</i>	<i>70</i>
8.3.2	<i>US Government's pandemic plan .....</i>	<i>70</i>
8.3.3	<i>The CDC's pandemic guidelines.....</i>	<i>71</i>
	<b>PART II: THE ACCUSED KNOW THAT THEIR ACTIONS BREACH THE SCIENCE AND THE LAWS.....</b>	<b>73</b>
<b>9.</b>	<b>LOCKDOWNS ARE REJECTED BY SCIENCE AND W.H.O. FOR A FLU-LIKE PANDEMIC..</b>	<b>74</b>
9.1	LOCKDOWNS HAVE LIKELY INCREASED COVID-19 DEATHS IN MANY COUNTRIES.....	74
9.2	LOCKDOWNS FOR FLU-LIKE VIRUS HAVE NEVER BEEN PART OF PUBLIC HEALTH PRACTICE .....	75
9.2.1	<i>The history of lockdowns (cordon sanitaires).....</i>	<i>75</i>
9.2.2	<i>But even with Ebola, community-wide lockdowns have been ineffective.....</i>	<i>76</i>
9.2.3	<i>Consideration of community-wide quarantine as a public health tool .....</i>	<i>76</i>
9.2.4	<i>Lockdowns are not taught anywhere as a remedy for flu-like viruses .....</i>	<i>78</i>
9.2.5	<i>Lockdowns are a "new invention" - Professor Martin Kulldorff, 2020 .....</i>	<i>78</i>
9.3	LOCKDOWNS ARE REJECTED OUTRIGHT BY THE SCIENCE FOR FLU-LIKE PANDEMICS.....	78
9.3.1	<i>W.H.O.'s 2019 guidelines .....</i>	<i>78</i>
9.3.2	<i>A 2006 paper, 'Disease Mitigation Measures in the Control of Pandemic Influenza' .....</i>	<i>79</i>
9.3.3	<i>The 2007 Scottish framework for influenza pandemic rejected lockdowns .....</i>	<i>79</i>
9.3.4	<i>The Great Barrington Declaration rejects lockdowns .....</i>	<i>80</i>

9.4	UNSCIENTIFIC CLAIMS .....	80
9.4.1	<i>Unscientific claim 1: That there is a duration for which lockdowns are ‘beneficial’</i> .....	80
9.4.2	<i>Unscientific claim 2: That lockdowns work</i> .....	81
9.5	LEGALLY, LOCKDOWNS ARE NOT QUARANTINE BUT A FORM OF IMPRISONMENT .....	83
<b>10.</b>	<b>ABANDONMENT OF THE PLAN AND VICTORIA LAWS – AND STEALTHY ADOPTION OF VIRUS ERADICATION .....</b>	<b>84</b>
10.1	NO BASIS FOR EMERGENCY DECLARATIONS.....	84
10.1.1	<i>Nothing had changed in five days</i> .....	84
10.1.2	<i>Objective assessment not provided</i> .....	85
10.1.3	<i>Chief Health Officer’s 15 March 2020 memo was deranged and alarmist</i> .....	85
10.1.4	<i>Claim of flattening the curve but the hidden reality of eradication</i> .....	86
10.1.5	<i>Chief Health Officer’s 11 September 2020 memo - reckless and alarmist</i> .....	86
10.2	MODELLING IS DISCREDITED GLOBALLY; MODELERS WITH NO INFECTIOUS DISEASE BACKGROUND .....	87
10.3	REPRESSIVE AND ARBITRARY “PUBLIC HEALTH” MEASURES.....	88
10.3.1	<i>Disproportionate, arbitrary public health measures not targeted to the risk</i> .....	88
10.3.2	<i>Human experimentation without consent: lockdowns, curfews, mandatory masks</i> .....	88
10.3.3	<i>No inputs asked or accepted from the people of Victoria</i> .....	89
10.4	THE SCANDALOUS 2020 AMENDMENT TO THE PUBLIC HEALTH ACT 2008.....	90
10.5	REFUSAL BY VICTORIAN ADMINISTERING AUTHORITIES TO ASSESS LOCKDOWN HARMS.....	90
10.5.1	<i>Victoria’s Treasurer has admitted to “devastating” economic harms from lockdowns</i> .....	91
10.5.2	<i>Victorian Administering Authorities have admitted to significant mental harms</i> .....	91
10.5.3	<i>Victorian Administering Authorities have tangentially acknowledged harms to life</i> .....	92
<b>11.</b>	<b>FEAR MONGERING AND POLICE BRUTALITY.....</b>	<b>93</b>
11.1	A POLICE STATE TO CREATE FEAR PSYCHOSIS .....	93
11.1.1	<i>Brutally enforcing mandatory mask orders on people with insignificant COVID risk</i> .....	93
11.1.2	<i>Suppressing lockdown protests while “taking the knee” for BLM protestors</i> .....	94
11.2	FEAR MONGERING THROUGH MISLEADING AND CHARGED MESSAGES TO CREATE TERROR .....	94
11.2.1	<i>Comparing the pandemic to Spanish flu</i> .....	95
11.2.2	<i>Deliberately inflating estimates of potential deaths through models</i> .....	95
11.2.3	<i>Scaring people by talking about an even harsher restriction: Stage 5</i> .....	95
11.2.4	<i>Hysterical claims that this virus will “crush” the people of Victoria</i> .....	95
11.2.5	<i>False and misleading advertising</i> .....	95
11.2.6	<i>Mass-scale data deception including the conflation of flu and misuse of PCR tests</i> .....	96
11.2.7	<i>Large fines to terrorise the people into compliance</i> .....	96
11.3	ILLUSTRATIVE CONTRAVENTIONS OF THE CHARTER OF HUMAN RIGHTS BY ACCUSED GROUP 1 .....	96
11.4	INCONSISTENCIES IN PUBLIC HEALTH ORDERS AND INCONSISTENCIES IN ENFORCEMENT.....	97
<b>12.</b>	<b>THE MOST HARMFUL OF THE COERCIVE “PUBLIC HEALTH” MEASURES .....</b>	<b>98</b>
12.1	MASS IMPRISONMENT (LOCKDOWNS).....	98
12.1.1	<i>Mass imprisonment of the people of Melbourne</i> .....	98
12.1.2	<i>Curfew</i> .....	99
12.1.3	<i>Locking down residents of nine public housing towers</i> .....	100
12.2	THE MANDATORY MASK POLICY .....	101
12.2.1	<i>Dr Brett Sutton’s own study contradicts the mandatory mask mandate</i> .....	101
12.2.2	<i>Arbitrary, illogical, complex and self-defeating mask rules</i> .....	101
12.2.3	<i>Masks do not work and can be harmful</i> .....	102
12.2.4	<i>Masks are particularly harmful for children</i> .....	103
12.2.5	<i>The list of other harms from masks</i> .....	103
12.2.6	<i>Reports on mask harms from Victorians</i> .....	106
12.2.7	<i>Doctors harassed if they issue mask exemptions</i> .....	106
12.2.8	<i>Huge inconsistency in mask requirements within Australia</i> .....	107
12.2.9	<i>Other documents and videos on masks</i> .....	107
<b>13.</b>	<b>BREACH OF ETHICS AND THE LAWS BY THE AUSTRALIAN ADMINISTERING AUTHORITIES.....</b>	<b>108</b>
13.1	AUSTRALIAN PUBLIC HEALTH TERRORISM .....	108
13.1.1	<i>Australians banned from leaving Australia</i> .....	108
13.1.2	<i>Eradicating the virus within Australia contravenes the Biosecurity Act</i> .....	109

13.1.3	<i>Coercing Australians to be vaccinated.....</i>	109
13.2	IT IS ATROCIOUS – AND ILLEGAL – TO LOCK UP AN ENTIRE NATION TILL A VACCINE IS FOUND.....	109
13.2.1	<i>Even if a vaccine is found such a strategy would be unethical and illegal.....</i>	110
<b>PART III: THE CATASTROPHIC HARM CAUSED BY THE ACCUSED .....</b>		<b>111</b>
<b>14.</b>	<b>THE CARNAGE IN VICTORIA.....</b>	<b>112</b>
14.1	LOCKDOWNS CAUSE GREAT HARM.....	112
14.1.1	<i>The need to exclude “business-as-usual” harms.....</i>	113
14.1.2	<i>Harms of commission: short-term and longer term .....</i>	114
14.1.3	<i>A summary of “collateral” harms by the Covid Doctors Network.....</i>	114
14.1.4	<i>Lockdowns seek to shift life from the young to the old .....</i>	115
14.2	THE HARMS CAUSED BY THE ACCUSED ARE NOT PROTECTED BY ARTICLE 7(2)(E) .....	115
14.3	(A) HARMS OF OMISSION: DEATHS OF THE ELDERLY THAT THE VICTORIAN GOVERNMENT FAILED TO PREVENT .....	115
14.4	(B-1) HARMS OF COMMISSION: MENTAL HARMS CAUSED BY VICTORIAN LOCKDOWNS.....	116
14.4.1	<i>Massive spike in suicide prevention and mental health calls.....</i>	117
14.4.2	<i>Dramatic increase in online child sex abuse .....</i>	118
14.4.3	<i>Increase in family violence.....</i>	119
14.4.4	<i>Significant increase in substance abuse.....</i>	119
14.4.5	<i>Elderly gave up their desire to live.....</i>	119
14.4.6	<i>Andrews is throwing money at mental health but that can never work .....</i>	119
14.5	(B-2) HARMS OF COMMISSION: PHYSICAL HARMS CAUSED BY VICTORIAN LOCKDOWNS.....	120
14.5.1	<i>Significant disruption to health care for the chronically ill .....</i>	120
14.5.2	<i>Loss of mobility among the elderly, leading to reduced lifespan.....</i>	120
14.5.3	<i>Critical tests not happening .....</i>	120
14.5.4	<i>Additional undetected cancer and heart disease.....</i>	121
14.5.5	<i>Significant increase in self-harm by adults and children.....</i>	122
14.5.6	<i>Four newborns effectively killed by the lockdowns.....</i>	122
14.5.7	<i>Long-term damage to children’s health.....</i>	122
14.5.8	<i>Significant increase in deaths from cardiac arrest.....</i>	122
14.5.9	<i>Indirect health effects from economic harms .....</i>	123
14.6	PROFESSOR GIGI FOSTER’S COST BENEFIT ANALYSIS OF VICTORIA’S LOCKDOWNS .....	124
14.6.1	<i>Cost benefit analysis .....</i>	124
14.6.2	<i>Testimony to Victoria’s Parliament.....</i>	124
14.6.3	<i>Some articles and talks by Profs. Foster and Fritjers .....</i>	124
<b>15.</b>	<b>THE GLOBAL CARNAGE: HUNDREDS OF MILLIONS OF LIVES SHORTENED .....</b>	<b>125</b>
15.1	WEBSITES THAT ARE COMPILING LOCKDOWN HARMS .....	125
15.2	SOME ESTIMATES OF OVERALL HARM.....	125
15.2.1	<i>UK Government: Loss of life years from lockdowns is greater than life years saved.....</i>	125
15.2.2	<i>Estimate: Lockdowns will kill at least as many as they potentially save (they don’t).....</i>	126
15.2.3	<i>Study: Lockdowns could be 10 times more deadly than the virus .....</i>	126
15.2.4	<i>Study: At least 12 times more will be killed by lockdowns.....</i>	126
15.2.5	<i>Study: A tsunami of excess non-COVID deaths .....</i>	126
15.2.6	<i>Study in the USA: around 100,000 lockdown deaths.....</i>	127
15.3	MENTAL HARMS.....	127
15.3.1	<i>Significant increase in substance abuse.....</i>	128
15.4	PHYSICAL HARMS.....	128
15.4.1	<i>Referrals from primary clinics are radically down due to lockdowns .....</i>	128
15.4.2	<i>Ongoing tests and treatment abandoned .....</i>	129
15.4.3	<i>Domestic abuse murders .....</i>	129
15.4.4	<i>Babies killed or harmed because of lockdowns .....</i>	129
15.4.5	<i>Increase in child trafficking in India .....</i>	129
15.4.6	<i>Suicides .....</i>	129
15.4.7	<i>Cancer deaths .....</i>	130
15.4.8	<i>100+ millions pushed into extreme poverty – which reduces lifespan.....</i>	131
15.4.9	<i>Lower childhood vaccination rates .....</i>	131
15.4.10	<i>Stillbirths.....</i>	132
15.4.11	<i>Children not born because of the lockdowns.....</i>	132
<b>PART IV: EXPLORING THE INTENTIONS OF THE ACCUSED .....</b>		<b>133</b>

<b>16.</b>	<b>QUESTIONABLE INTENTIONS: LIES, FEAR MONGERING, DECEPTIVE DATA .....</b>	<b>134</b>
16.1	TAXPAYER FUNDED ADVICE ON PROPAGANDA TECHNIQUES THAT ANDREWS REFUSES TO PUBLISH .....	134
16.2	QUESTIONABLE INTENTIONS: GROSSLY EXAGGERATING THE VIRUS THREAT .....	135
16.2.1	<i>Exaggerating the magnitude of the threat .....</i>	<i>135</i>
16.2.2	<i>Lying about the risk distribution of the virus.....</i>	<i>135</i>
16.2.3	<i>Exaggerating the “long-term” COVID problem .....</i>	<i>136</i>
16.3	QUESTIONABLE INTENTIONS: LYING ABOUT THE REAL STRATEGY – OF ERADICATION.....	137
16.4	QUESTIONABLE INTENTIONS: DECEPTIVE DATA ABOUT COVID DEATHS .....	137
16.4.1	<i>Very few deaths are “from covid”, most are “with covid” .....</i>	<i>137</i>
16.4.2	<i>Financial incentives to report cases and deaths as COVID.....</i>	<i>140</i>
16.4.3	<i>Flu deaths are almost certainly being counted as COVID-19 deaths .....</i>	<i>140</i>
16.5	QUESTIONABLE INTENTIONS: DECEPTIVE COVID “CASES” BASED ON WORTHLESS PCR TESTS .....	142
16.5.1	<i>Long history of being unreliable and supporting hysterias .....</i>	<i>142</i>
16.5.2	<i>No proof that PCR tests are testing SARS-CoV-2 .....</i>	<i>143</i>
16.5.3	<i>The Australian Government doesn’t consider these tests to be reliable.....</i>	<i>144</i>
16.5.4	<i>Powerful reasons why PCR tests are not necessarily detecting COVID .....</i>	<i>144</i>
16.6	QUESTIONABLE INTENTIONS: IMPOSING RESTRICTIONS THAT ARE NOT PROVEN BY SCIENCE .....	145
16.7	QUESTIONABLE INTENTIONS: RESTRICTING POTENTIALLY HEALTH TREATMENTS (E.G. HCQ).....	145
16.8	QUESTIONABLE INTENTIONS: VACCINE COMPANIES BEING PROTECTED FROM PRODUCT LIABILITY CLAIMS.....	146
<b>PART V: SUMMARY OF MY ARGUMENTS AND A PRELIMINARY LIST OF WITNESSES .....</b>		<b>147</b>
<b>17.</b>	<b>CONCLUDING CHAPTER.....</b>	<b>148</b>
17.1	SUMMARY OF MY ARGUMENTS.....	148
17.2	SUMMARY OF THE OFFENCES COMMITTED BY THE ACCUSED .....	152
17.3	WITNESSES.....	152

# TORTURE

FRYDENBERG VS ANDREWS

## End lockdown 'torture': rage against regime

Josh Frydenberg, the most senior Victorian federal minister, sparked a bitter row when he accused Premier Dan Andrews of 'callous indifference'

By JOE KELLY, REMY VARGA

# AND CARNAGE

(This headline is from the UK but applies equally to Victoria)

Page 6 Daily Mail, Sunday, October 25, 2020 Page 7

## LOCKDOWN'S LETHAL TOLL LAID BARE

**FOUR-PAGE SPECIAL REPORT**

by David Rose

**A SHATTERING picture of the impact of the lockdown on the nation's health and wellbeing is today revealed in an evidence dossier that brings together more than 100 studies.**

The study, published in *Lancet*, is the most comprehensive to date on the impact of the lockdown on the nation's health and wellbeing. It shows that the lockdown has led to a massive increase in mental health problems, a sharp decline in physical health, and a significant increase in deaths.

<b>Surgery postponed for 50,000 children in England</b>	<b>Cancer patients set to suffer for years</b>
<b>March-May ++ Stroke treatments down 45% ++</b>	<b>87,902 heart ultrasounds in England in April and May, down from 274,235</b>
<b>++ Endoscopy procedures dropped to just 12% of pre-Covid levels in UK ++</b>	<b>Depression hits one in five in June in UK, up from one in ten</b>
<b>++ A&amp;E visits down 52% in April</b>	<b>Chemo admissions down by up to 66% in April in England</b>

### SNAPSHOT OF EVIDENCE IN INTO IMPACT

The study shows that the lockdown has led to a massive increase in mental health problems, a sharp decline in physical health, and a significant increase in deaths. It also shows that the lockdown has led to a massive increase in hospital admissions, with a significant increase in deaths.

### THE DAMNING EXPERTS' REPORTS OF COVID RULES

The study also shows that the lockdown has led to a massive increase in mental health problems, a sharp decline in physical health, and a significant increase in deaths. It also shows that the lockdown has led to a massive increase in hospital admissions, with a significant increase in deaths.

## Introduction to the submission



## 1. Outline of the complaint

### Dr Gauden Galea

On 24 January 2020, Dr Gauden Galea, the World Health Organisation's representative in China stated that: "trying to contain a city of 11 million people is new to science. **The lockdown of 11 million people is unprecedented in public health history, so it is certainly not a recommendation the WHO has made**".<sup>1</sup>

### Dr Anders Tegnell

On 24 June 2020 Sweden's State Epidemiologist Anders Tegnell exclaimed in astonishment at the policies being implemented worldwide: "**It was as if the world had gone mad, and everything we had discussed was forgotten**".<sup>2</sup>

### Ramesh Thakur, PhD

Professor Ramesh Thakur of the Australian National University wrote on 24 October 2020 about the "**crimes against humanity resulting from the brutal perverse consequences of the stringent measures**"<sup>3</sup> (lockdowns).

Australia signed the *Rome Statute of the International Criminal Court* on 9 December 1998 and deposited its instrument of ratification on 1 July 2002.

Pursuant to this ratification and the access to the International Criminal Court (ICC) that this gives me as a citizen of Australia, I, Sanjeev Sabhlok, resident of the city of Melbourne in Victoria, Australia – along with the supporters listed in this chapter – wish to lodge this complaint with the Prosecutor of International Criminal Court as a first information report about what I believe are significant breaches of **Article 7 of the Rome Statute** occurring in the State of Victoria but also in Australia more broadly, since late March 2020, in the guise of "public health" policy. This complaint should be read in conjunction with Article 22, *Nullum crimen sine lege*.

I wish to emphasize at the outset that I do not lightly accuse any government of committing crimes against humanity and that in this particular case I have firm reasons to believe that innumerable laws, human rights and principles of ethics have been contravened through Victoria's coercive lockdowns, curfews and the mandatory masks policy, and through Australia's indefinite and already seven-months-old closure of international borders. These measures, together, have led to catastrophic mental and physical harms including the shortening of lives of millions and permanent harm to the brain of innumerable children.

As a lifelong public servant (in two countries) and a professional economist with extensive experience in regulatory policy, I specialise in assessing the unintended consequences of public policy. In this case the governments involved have aggressively refused to provide any justifications for their actions, and they have refused to even acknowledge, let alone assess, the harms they are causing. The threshold policy question that is pivotal to this complaint is whether a public health measure is able to kill a person X (or shorten his or her life) in order to save some other person Y. This is not an academic but a critically

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<sup>1</sup> Senger, Michael P., 'China's Global Lockdown Propaganda Campaign', *Tablet*, 16 September 2020. Short URL: <https://bit.ly/2RXS0RA>.

<sup>2</sup> Rolander, Niclas, 'Sweden's Covid Expert Says 'World Went Mad' With Lockdowns', *Bloomberg Quint*, 24 June 2020. Short URL: <https://bit.ly/3kQhGvZ>.

<sup>3</sup> <https://www.spectator.com.au/2020/10/hippocrates-cancelled/>

important question the position of the ICC on which can help save the lives of millions across the world today and in the future.

Suffice it to note that not only are the harms from lockdowns and such policies cumulative, there is an ever present risk that the Victorian Government will re-impose its harshest possible restrictions at any time without providing any justification, as it has done in the past, thus further exacerbating the harms.

***Editorial aside:** Since I have written this submission in around 20 days, being driven by a sense of great urgency, I trust the Prosecutor will bear with its many rough edges including typos or unclear expression. A remark about style: throughout this document I will emphasise important portions of text.*

## 1.1 **The relevance of this submission for humanity, not just for Victorians**

Human rights are not a gift of any government but entitlements intrinsic to all of us at birth (and some would argue, even before birth). On 10 December 1948 the Universal Declaration of Human Rights (UDHR) assured us through its Preamble of ‘the inherent dignity and of the equal and **inalienable rights of all members of the human family**’.

The UDHR also reminded us how ‘disregard and contempt for human rights have resulted in barbarous **acts which have outraged the conscience of mankind**’. Unfortunately, acts which outrage the conscience of mankind are occurring once again – **in the guise of a public health emergency**.

This Communiqué outlines what I believe are large-scale contraventions of human rights that are taking place all over the world, but specifically in Victoria and Australia, that have led to catastrophic harms. The discipline of public “health” has entered the killing fields. It is no longer a caring sub-discipline of medical science focused on protecting people’s health and well-being. It has become a reckless enterprise endangering the lives of billions of people and cancelling all human rights in its psychotic obsession with a single virus: and that, too, with a virus that is nowhere as lethal as was once thought.

Medical practitioners like Dr Brett Sutton (who runs the public health system of Victoria) have failed to comply with their basic duty of care as doctors and have issued “public health” directives that are harming millions of people. The lifespan of 6.5 million Victorians has been shortened and the brain of thousands of Victorian children permanently harmed (I will elaborate this alarming issue latter) through lockdowns and mandatory mask directives.

It is crucial that the ICC accord this matter the greatest priority as it is probably the single most pressing matter in the world today, and provide an **urgent ruling that declares such policies a “crime against humanity”** and compels all nations on Earth to **draw a sharp line between public health and public health terrorism**.

We must end this ongoing massacre of human rights and lives immediately and, as soon as possible, leash our public health practitioners and keep them for ever under a leash from which they must never stray. Public health practice has taken the shape today of a mad dog that is devouring the people it was charged to protect.

The ICC remains the only hope of mankind today to stop this global carnage of both the living and the unborn.

## 1.2 **The ICC was not my first port of call, but all other attempts at justice have failed**

I am aware that the ICC is founded on complementarity, that is, it should complement its member states’ domestic judicial jurisdiction. In its November 2013 *Policy Paper on Preliminary Examinations*, the Prosecutor stated:

In accordance with the Rome Statute, the Office of the Prosecutor (“OTP”) of the International Criminal Court (“ICC”) is responsible for determining whether there is a reasonable basis to proceed with an investigation into a situation pursuant to the criteria established by the Rome Statute, subject to judicial authorisation as appropriate. As reflected in the principle of

complementarity, **national jurisdictions have the primary responsibility to end impunity for the crimes listed under the Rome Statute**, namely genocide, crimes against humanity, and war crimes. However, **in the absence of genuine national proceedings, the OTP will seek to ensure that justice is delivered for crimes within the jurisdiction of the Court.**<sup>4</sup>

Unfortunately, while it is true that a few courts across the world have started handing out harsh judgments against lockdowns (for instance, on 14 September 2020, the judgement in the case of “United States District Court for the Western District Of Pennsylvania, Civil Action No. 2:20-cv-677” declared lockdowns unconstitutional<sup>5</sup>), these are not enough and have had no impact, even in the USA.

### ***1.2.1 Outright rejection of human rights by Daniel Andrews and his government***

Mr Daniel Andrews, the Premier of Victoria, has publicly rejected the idea that human rights are even a relevant consideration during a public health ‘emergency’. On 10 September 2020 he **defended the curfew** in Melbourne (something which never formed part of any approved pandemic plan or public health policy and is in clear breach of all the laws of Australia and its international covenants), arguing that it is **‘not about human rights. It is about human life’**<sup>6</sup>. Despite having been a Health Minister as well in the past Mr Andrews has no understanding of his legal obligation to ensure that he does not derogate the human rights of Victorians unless doing so is absolutely necessary – and he should know that the tests for proving this are very stringent.

He has also supported the compulsory vaccination of every Victorian. On 4 July 2020 he said:

At that point we will not be returning to normal because there will be no vaccine in the weeks ahead, some argue even in the months ahead. It is a long way off. And **unless and until that vaccine is developed, and then administered to every single Victorian**, we will have to live with and embrace a COVID normal.<sup>7</sup>

These actions (and there is a litany of them) sabotage the very concept of ethical medical practice. Today ‘public health’ has become an excuse, a tool, to breach all laws, all liberties and to attack the life itself of millions of people. Dr Eamonn Mathieson of Melbourne has expressed great alarm: **‘This is now how medicine is done. We don’t terrorise our patients. We give them real information, and in perspective’**<sup>8</sup>. And he told Channel 9’s Today show on 8 September 2020 that ‘[t]his attempt for viral elimination is irrational and unachievable. Simply it is madness and it needs to stop’<sup>9</sup>.

For many months since March 2020, while I worked as an economist in the Government of Victoria (a role I held for almost 15 years), I raised the alarm regarding the disproportionate policies being implemented in Victoria. I have sought copies of my emails from the Department of Treasury and Finance (DTF) that confirm that I raised such an alarm. But on 9 September 2020 I was asked by DTF to remove my social media posts that criticised the government’s pandemic policy and the Police State that Victoria had become. I decided to resign rather than stop speaking the truth about the tragedy unfolding before my

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<sup>4</sup> [https://www.icc-cpi.int/iccdocs/otp/OTP-Policy\\_Paper\\_Preliminary\\_Examinations\\_2013-ENG.pdf](https://www.icc-cpi.int/iccdocs/otp/OTP-Policy_Paper_Preliminary_Examinations_2013-ENG.pdf)

<sup>5</sup> <https://sanjeev.sabhlokcivcity.com/Misc/Cnty.%20of%20Butler%20v.%20Wolf.pdf>

<sup>6</sup> McGowan, Michael, ‘Daniel Andrews dismisses human rights complaint over Melbourne Covid curfew’, *The Guardian*, 11 September 2020. Short URL: <https://bit.ly/2G1MEIM>.

<sup>7</sup> *The New Daily*, ‘Victoria’s COVID crisis grows: Two more postcodes locked down, 108 fresh cases’, 4 July 2020. Short URL: <https://bit.ly/3ixgeg9>. The video of Daniel Andrews’s statement is found in a Tweet by @YellowCube7 on 3 October 2020. Short URL: <https://bit.ly/3cWdmbD>. Also at: <https://www.facebook.com/sabhlok/posts/10159024532863767>

<sup>8</sup> <https://www.sabhlokcivcity.com/2020/09/public-health-terrorism-additional-suicides-self-harm-cancer-and-heart-deaths-from-lockdowns/>

<sup>9</sup> Oliveri, Natalie, ‘It is madness’: Doctors plead with Daniel Andrews to rethink virus response’, *Today* show, Nine Now, 8 September 2020. Short URL: <https://bit.ly/2HseUOV>.

eyes.<sup>10</sup> On 13 September 2020 I wrote to the Treasurer of Victoria to give me an opportunity to explain why I had to resign. He never bothered to respond.

My resignation was widely reported in the media. Mr Daniel Andrews was asked by the media about my resignation but he shrugged it off, saying it was merely my personal opinion. He did not care to ask me to explain my concerns to him. Nevertheless, within days of my resignation I wrote a book, *The Great Hysteria and The Broken State*<sup>11</sup>, to explain the breaches of the laws and policy principles by the Andrews Government. I then sent information about the book to all of Victoria's elected representatives, including to Mr Andrews. I also appeared on a number of TV and other media programs to ask politicians to must stop their reign of terror, but they did not change their policies.

In addition, there have been innumerable attempts by hundreds, if not thousands of people to communicate to the Victorian Government that they are doing the wrong thing but the Government simply does not care. For instance, a group of over 500 Victorian doctors has written an Open Letter to Daniel Andrews about how the health of Victorians is being compromised by the directives that have been issued by Dr Sutton:

The Victorian government's response to the SARS-CoV-2 virus is now doing more harm than good. These measures will cause more deaths and result in far more negative health effects than the virus itself. Left unchecked, **the Victorian government risks creating the state's worst ever public health crisis.**

Many Australian doctors and other health professionals consider the lockdown measures to be **disproportionate, unscientific, excessively authoritarian** and the cause of **widespread suffering for many Victorians.**

Thereby, we Australian Doctors and Health Professionals, in solidarity with thousands of international doctors, call for the cessation of all disproportionate measures that contravene the International Siracusa Principles.

The Victorian government's measures are 'anti-health' and deny the principles of good medical practice. They constitute a disproportionate approach which relies on a fear-based media narrative as well as inadequate and misleading information. This must cease as soon as possible.<sup>12</sup>

The Andrews government has refused to respond to this letter. Dr Brett Sutton, Victorian Chief Health Officer not only has never responded to any of my questions, he has now **blocked my access to all communication on his Twitter account.**<sup>13</sup> The Twitter account @VictorianCHO is not the personal account of Dr Sutton but a Victorian Government account managed by taxpayer-funded DHHS. Blocking a citizen from accessing official information constitutes is a brazen attempt to blank out those who ask inconvenient questions; it is effectively another example of "public health" terrorism.

### ***1.2.2 Reign of terror: The Police State and abolition of innumerable human rights***

Victoria today is a Police State. There is no rule of law (since all the key laws have been breached, and whimsy, capriciousness, prevails) and the government systematically targets and blocks political speech and dissent.

There are innumerable examples across social media of brutalities meted out by the Police to the people of Victoria for months on end now. A video that was shared with me about an event that took place on 31 October 2020 noted the following, and perhaps says it best<sup>14</sup>:

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<sup>10</sup> Sabhlok, Sanjeev, "Why I quit rather than be silenced: Vic Treasury insider", *Australian Financial Review*, 16 September 2020. <https://www.afr.com/policy/economy/victoria-has-locked-itself-into-a-lockdown-blunder-20200916-p55w1z>

<sup>11</sup> <https://www.amazon.com.au/Great-Hysteria-Broken-State-ebook/dp/B08L26W2WY/>

<sup>12</sup> <https://liberatevictoria.org/covid-medical-network/>

<sup>13</sup> <https://twitter.com/sabhlok/status/1323768302628347904>

<sup>14</sup> <https://youtu.be/V7sq--ToUrw>

A number of public went to Treasury Gardens to hear people speak. A journalist and organiser had been arrested by police but were later arrested. Most of the people had already left, **most of who were intimidated by the police presence**, but some arrived later. After the release of journalist and organiser, the few people who still remained and were standing around with media and police were **given permission to gather and listen to the speakers** as long as everyone socially distanced.

Immediately after walking down a path to stand in park **police started forming a large circle and moving in on the people**. At first people weren't sure what was happening, but then it became apparent. **Police had lied to the people, and were conducting a militarized police exercise** and were intent from the beginning on either arresting or fining people there.

Not only had the police lied, **they entrapped the people with intimidation and fear tactics**. The shock and surprise not to mention fear, left some young women in tears, as they were terrified. Most everyone though was also angry, and lost what remaining respect they had for VicPol and the Victorian government in the process. Is this the future for Australia?

A person sent me an email on 11 November, extracted below, about the “war on the people” that is going on in Victoria. Such language is not an exaggeration of the situation that prevails on the ground:

I was held hostage and against my will for approx 4 hours at the cup day protest 3rd Nov 2020. I was and still am traumatised, as I asked to leave just after the pepper spray incident, as **I was helping a man, who copped it in his eyes and could not see**. When all of a sudden the robo cops came charging in to grab a protestor out of the crowd, that had just been doused in pepper spray, **I was thrown by force, which stunned and shocked me**.

No word as to what was going on or what we are being held for and the psychological operation and trauma continues for 3 more hours, to them get arrested, line up for 200 metres to be processed and fined.

This is not my home town anymore and will never trust police or government again. **This is a war on the people and nothing to do with health, wellbeing or human rights**.

### ***1.2.3 Sabotage of Democracy: Censoring People's submissions to the Parliament***

The Andrews Government has comprehensively failed to consult with the People of Victoria about the coercive public health policies it is imposing. It is acting like a Star Chamber. But it is not just about lack of ordinary consultation, even Parliamentary processes have been mangled.

A Victorian MP, Ms Beverley McArthur told me a few weeks ago that 13,000 submissions were received from the People of Victoria<sup>15</sup> by the Scrutiny of Acts and Regulations Committee (SARC) of the Parliament while it was examining legislation to extend the emergency for another six months. SARC is responsible for advising Parliament if legislation unduly trespasses on Victorians' rights and freedoms. The people of Victoria obviously had something to say. 13,000 submissions is unheard of, one would imagine.

It is standard practice in a functioning democracy to publish the People's submissions on the Parliament's website. But in this case the Labor-led committee **blocked the publication of these 13,000 submissions**. Such censorship is reminiscent of totalitarian states. Democracy is clearly dead.

When the views of 13,000 people – who put in the hard work to make a submission to their elected representatives in Parliament – can be **blanked out from history**, what prospect is there for an ordinary citizen like me getting heard in this State?

### ***1.2.4 Both sides of politics are hands-in-glove about locking up Australia till 2022***

This breach of laws has occurred from both sides of politics in Australia – the Labor Party at the State level in Victoria and the Liberal Party at the national level.

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<sup>15</sup> <https://www.bevmcarthur.com/victorians-thrown-under-the-omnibus>

The incentives of politicians to follow the crowd (who are at present completely hysterical and terrorised) will not allow them to do the right thing. They are the ones who have failed us in the first place – how can they possibly protect us?

This collusion between both sides of politics has made it impossible to protect basic human rights in Australia without appealing directly to the International Criminal Court. I have extensively engaged with members from both the Labor and Liberal parties over the past two months and do not believe even the good ones can make a difference, given the decisions taken at the highest level in both parties.

### 1.2.5 *The failure of the courts in Australia*

#### **The High Court of Australia**

On 6 November 2020, the High Court of Australia ruled<sup>16</sup> that **border closures within Australia** by the West Australian Government are valid – despite the WHO’s October 2019 guidelines<sup>17</sup> that clearly prohibit long-term border closures and Australia’s own pandemic plan<sup>18</sup> which did not have any such provision – even for the worst-case respiratory pandemic, which this is not. The High Court has failed to recognize the enormous harm that “public health” measures are causing. I will send a copy of this complaint to the High Court but as I note later, even if the High Court of Australia wakes up, that would not detract from the essential role the ICC should consider playing in this situation.

#### **Supreme Court of Victoria**

The Supreme Court of Victoria has recently pronounced on the question of whether **curfews** are legal. Despite there being not the slightest shred of science behind the curfews and knowing clearly that these are grossly disproportionate and cause enormous harm, the Supreme Court accepted the “models” and other futile arguments provided by the Victorian Government and declared the curfews legal.<sup>19</sup> It is impossible to expect justice if Victoria’s courts do not even ask for proofs (such as published scientific journal articles) that curfews are a legitimate public health measure for a flu-like virus. This absurd decision should show the ICC that there is no hope of justice within Victoria.

#### **Magistrates Court**

I do not have direct evidence about this, but there is chatter on social media that Victoria’s Magistrates Courts have not been hearing appeals against the COVID fines being imposed by the Victorian Administrative Authorities. Apparently, such appeals have been adjourned till well into 2021. If this is true, it also violates Siracusa principles:

60. The ordinary courts shall maintain their jurisdiction, even in a time of public emergency, to adjudicate any complaint that a non-derogable right has been violated.

\* \* \*

I am also forced to knock on the ICC’s door since I have no financial capacity to go to the High Court of Australia with a complaint like this to seek redress. I will, nevertheless, send this complaint to the High Court of Australia should they wish to progress *suo moto* the matters I have raised. But even if the High Court of Australia acts on this complaint, I believe the ICC should act on the matters I have raised independently anyway since these matters are **critically important for all of humanity and for all times to come**. If these grossly disproportionate, even evil, “public health” actions are not nipped in the bud in 2020, they will become a template for the future – a truly dystopian future.

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<sup>16</sup> <https://www.abc.net.au/news/2020-11-06/clive-palmer-loses-high-court-challenge-against-wa-border-close/12855286>

<sup>17</sup> [https://www.who.int/influenza/publications/public\\_health\\_measures/publication/en/](https://www.who.int/influenza/publications/public_health_measures/publication/en/)

<sup>18</sup> [https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/\\$File/w-AHMPPI-2019.PDF](https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/$File/w-AHMPPI-2019.PDF)

<sup>19</sup> <https://www.abc.net.au/news/2020-11-02/challenge-to-melbourne-coronavirus-curfew-dismissed/12709788>

Having provided the reasons why I am obliged to bring my complaint directly to the ICC, I will now commence my complaint.

### 1.3 Allegation: Article 7 of the *Rome Statute of the International Criminal Court* has been contravened

I consider that the following sub-sections of Article 7 have been contravened by the Accused whom I will presently identify. The key breaches of Article 7 are bolded in the box below – mainly the offence of causing ‘**serious injury to mental or physical health**’ to millions of Victorians and Australians by imposing callous and reckless public health measures, measures that were enforced without any regard to proportionality or to the harms (that were readily foreseeable) that they would cause.

#### Article 7 - Crimes against humanity

- For the purpose of this Statute, ‘crime against humanity’ means any of the following acts when committed as part of a **widespread or systematic attack directed against any civilian population, with knowledge of the attack**:
  - k. **Other inhumane acts** of a similar character **intentionally causing great suffering, or serious injury to body or to mental or physical health.**
- For the purpose of paragraph 1:
  - a. ‘Attack directed against any civilian population’ means a course of conduct involving the multiple commission of acts referred to in paragraph 1 against any civilian population, pursuant to or **in furtherance of a State or organizational policy to commit such attack**;
  - b. ‘Torture’ means the **intentional infliction of severe pain or suffering**, whether physical or mental, upon a person in the custody or under the control of the accused; except that torture shall not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions.

#### 1.3.1 *It is not necessary to prove malicious intent*

I understand that unlike the definition under the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, the ICC does not require a purposive reason for the pain and torture. The acts of pain and torture are sufficient in themselves to constitute a crime. Despite that, I will adduce evidence in this submission about the **questionable intentions** of the Accused who have chosen to contravene, despite being warned by innumerable commentators against doing so, the laws of the State and nation of Australia and all relevant international laws, leading them to perpetrate (and to continue to do so) the enormous harms that I will detail in this submission. At a minimum, I believe the Accused have been **callous and reckless** in their chosen actions.

#### 1.3.2 *The judgement of national authorities on derogation of human rights is not conclusive*

Section 57 of the Siracusa Principles states that:

In determining whether derogation measures are strictly required by the exigencies of the situation **the judgment of the national authorities cannot be accepted as conclusive.**

I do not believe that the two Australian court judgements that I have cited are conclusive in any way regarding the derogation of human rights that were involved, since these judgements did not consider the fundamental breaches of the laws and principles of ethics by these allegedly “public health” measures.

The only judgement that does make sense to date is that of Pennsylvania<sup>20</sup> but that judgement does not apply directly to Victoria, although Victorian law does permit international judgements to be cited as evidence.

Given the global ramifications of this matter, I believe the International Criminal Court should independently review any claims that the Victorian and Australian governments might make in response to this complaint, illustratively that the situation arising from this (rather modest) coronavirus pandemic called for extreme and coercive derogations of human rights that and that the harms caused to the People of Victoria were necessary. Any such arguments would be futile and should be rejected out of hand by the ICC based on the evidence I will furnish in this submission.

Any claimed “determinations” by Australian authorities on the justification for derogation of human rights to support public health are not conclusive given the government’s determination, repeatedly expressed, to lock up the people of Australia until a vaccine can be injected into every one of us. These people are not subject to any reasoning any more: they have entered a different realm where laws and human rights no longer apply.

#### 1.4 The two parties accused in this complaint

I am accusing the following two groups of persons for the alleged offence of crimes against humanity.

##### 1.4.1 *Accused Group 1: Victorian Administering Authorities*

This submission claims that the main perpetrator of the alleged offence of crimes against humanity in the State of Victoria is the group of persons led by the elected Premier of Victoria, an office held by Mr **Daniel Andrews** during the commission of the crimes alleged in this submission. His Crisis Council of Cabinet and senior executives are his accomplices since they are responsible for restraining him from actions that exceed the remit of the laws but have failed to do so. A few of these additional offenders include:

- Victoria’s Chief Health Officer, an office held by Dr Brett Sutton who has signed on many disproportionate and harmful public health orders.
- Minister for the Coordination of Education and Training, an office held by Mr James Merlino.
- Minister for the Coordination of Treasury and Finance, an office held by Mr Tim Pallas.
- Minister for the Coordination of Transport, an office held by Ms Jacinta Allan.
- Minister for the Coordination of Health and Human Services, an office initially held by Ms Jenny Mikakos, later substituted by Mr Martin Foley.
- Minister for the Coordination of Justice and Community Safety, and office held by Ms Jill Hennessy.
- Minister for the Coordination of Jobs, Precincts and Regions, an office held by Mr Martin Pakula.
- Minister for the Coordination of Environment, Land, Water and Planning, an office held by Ms Lisa Neville.

Executives in the rank of Executive Director and above in the following departments and other relevant agencies (such as Emergency Management Victoria) should also form part of the list of accused:

- Departments of Premier & Cabinet (DPC)
- Treasury & Finance (DTF)
- Health & Human Services (DHHS)
- Chief Commissioner, Victoria Police

In this submission I will refer to this group of persons as ‘Victorian Administering Authorities’ and will specify the actions of this group of persons either individually or as a group.

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<sup>20</sup> <https://sanjeev.sabhlोकcity.com/Misc/Cnty.%20of%20Butler%20v.%20Wolf.pdf>



#### 1.4.2 *Accused Group 2: Australian Administering Authorities*

In addition, this submission claims that the **secondary perpetrator or accomplice** of the alleged offence of crimes against humanity in the State of Victoria and in Australia more broadly is the group of persons led by the elected Prime Minister of Australia, a role currently held by **Mr Scott Morrison**. All his Cabinet Ministers and senior executives who have advised him on his policies to lock up Australia till everyone can be vaccinated, are implicated.

Mr Morrison has been personally supportive of Mr Daniel Andrew's policies from day 1. On 23 March 2020 he is reported to have said this, expressing support for the lockdown in Victoria:

"If Australians choose not to self-isolate, if Australians choose to not observe the medical advice of keeping the distance that we've recommended then, **we'd obviously be forced to take very draconian measures in shutting down**," Mr Morrison said in an ABC interview on Sunday night. "If Australians don't play their part, they can't then believe that the system won't come under greater stress. And this is why we're trying to be so clear about this."<sup>21</sup>

There was never any basis for Mr Morrison to have made these heinous allegations – about Australians not being trustworthy. This entirely unwarranted slur on the proud people of Australia was made even as Mr Morrison himself attended a rugby match during the initial COVID outbreak in mid-March 2020 but then aggressively defended his attendance.<sup>22</sup> Mr Morrison speaks for himself when he thinks Australians are untrustworthy.

Just like the Swedes have been trusted by their government to take their own precautions, there was never any reason to ill-treat Australians the way Mr Morrison has done. No opportunity was given to Australians: the official pandemic plans were binned right away and all the laws breached.

In this submission I will refer to this group of persons as 'Australian Administering Authorities' and will specify the actions of this group of persons either individually or as a group.

#### 1.5 **The summary of the argument in this complaint**

I begin by summarising the argument in this complaint and will end the complaint by repeating this summary.

##### **The basic framework of human rights and ethics that underpins public health**

1. Nature is not always our friend. From time to time, it springs an unpleasant surprise, like this novel coronavirus. Public health interventions do the right thing when they minimise the loss of life from such natural causes (Acts of Nature) without causing additional mental or physical harms (Act of Man).
2. While humanity can accept unavoidable deaths from a natural cause, we cannot accept government mandates that end up killing even one additional person. That is because while any economic harms can be compensated, we can never compensate anyone for any mental harms or the loss (or shortening) of life from such measures.
3. The public health literature is keenly aware that its actions must not cause harm. For instance, there is requirement in the literature to compensate for even minor economic harms caused by public health measures.
4. This threshold underpins all valid government policy: That the policy must not *directly* harm anyone. Governments do not have the power to kill person X (or shorten his life) while trying to save person Y. No government is authorised by the laws, for instance, to burn down additional homes and kill unaffected people in order to save those who might be at risk of being engulfed in a bushfire.

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<sup>21</sup> <https://www.heraldsun.com.au/news/victoria/latest-coronavirus-news-young-people-urged-to-follow-social-distancing-advice/news-story/16a404629f2bf975f4f3a539804b6f2f>

<sup>22</sup> <https://www.theguardian.com/australia-news/video/2020/mar/13/scott-morrison-defends-decision-to-attend-rugby-league-game-during-coronavirus-outbreak-video>

5. In relation to this ongoing pandemic, if killing X (through additional suicides, cancer or heart disease not identified in time because of terror caused by government, and from increased poverty) in order to save Y (generally an elderly person well beyond average life expectancy) from COVID-19 was such a good idea, then this strategy would have formed part of the laws and pandemic plans across the world.
6. This threshold question distinguishes genuine public health from public health terrorism. Public health interventions that cause widespread additional mental and physical harms and shorten the lifespan of hundreds of millions, even billions, can only be classified as public health terrorism.
7. There is a long and well-understood history of human rights abuses, hysterias and exaggerated claims made by public health practitioners (e.g. “culture of fear” and “exaggerated claims ... from disease advocacy by influenza experts”, noted in the *Bulletin of the World Health Organization* 2011<sup>23</sup>).
8. International and national laws are designed to prevent public health excesses.

### **Unimpeachable proof that flu-like pandemics can be managed without committing crimes**

9. It is not only ethically and legally valid, but perfectly feasible to implement well-balanced and non-criminal public health policies even in the face of severe pandemics and great uncertainty.
10. As noted at the outset, Gauden Galea, the World Health Organisation (WHO)’s representative in China said on 24 January 2020 regarding Wuhan’s lockdown, that: “**The lockdown of 11 million people is unprecedented in public health history**”.<sup>24</sup>
11. Never in the past during any flu-like virus pandemic – which were often much worse than the current one – have the kinds of inhumane and reckless policies that we are seeing this time around been considered, let alone implemented.
12. Even this time, we have unimpeachable proof that sensible policies can be implemented during pandemics. **Sweden**, led by perhaps the world’s most experienced epidemiologist, Dr Anders Tegnell, has demonstrated that it is quite possible – mainly through voluntary guidelines and light-handed closure of targeted events or workplaces – to deal with the ongoing respiratory virus pandemic without causing additional harms to people’s mental or physical health.
13. Policy applied by Sweden this year is not unique to that nation. Such policy is embedded in all the laws of the world, all ethical principles, and was part of all approved pandemic plans across the world – including in Victoria and Australia: plans that were designed and thus capable of managing respiratory virus pandemics far worse than what we are experiencing from this novel coronavirus.
14. While the size of the pandemic is irrelevant to the arguments, the Australian authorities seem to be behaving like exorcists fighting an imaginary spook. They decided in March 2020 that this virus is “deadly” and that they must exorcise Australia from it, regardless of the fact since April 2020 we know that it is nowhere as deadly even as the Asian and Hong Kong flu. And if the data deceptions and confusions (about PCR tests, conflation of COVID and flu, assuming COVID deaths) are taken into account, it is hard to say that this pandemic is far worse than a bad flu. Data from Sweden suggests that it might be somewhat hard at the end of 2020 to distinguish this year’s total deaths in that country from the average of the past five years.

### **Lockdowns, curfews, mass-testing and other mandates for flu-like viruses are contrary to science**

15. Respiratory viruses like flu and the common cold (of which this novel coronavirus is one) have characteristics which lead to certain types of public health policies and rule out others.
16. SARS-CoV2 has strong similarities with the flu in both transmission and lethality (as well as symptoms). Its first cousin, SARS, was far more lethal and did not transmit asymptotically. As a result, targeted quarantines were able to not only isolate SARS, they were able to eradicate it: SARS disappeared without a trace after 2004, perhaps because the virus found nowhere else to go after it killed its hosts who had already been isolated.
17. The WHO, through its October 2019 guidelines<sup>25</sup> laid down the **state of knowledge** on how we should deal with flu-like viruses. For instance, the WHO’s guidelines state that quarantines, mass-scale

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<sup>23</sup> <https://www.who.int/bulletin/volumes/89/7/11-089086/en/>

<sup>24</sup> Senger, Michael P., ‘China’s Global Lockdown Propaganda Campaign’, *Tablet*, 16 September 2020. Short URL: <https://bit.ly/2RXSORA>.

testing and contact tracing are not appropriate in this case, and lockdowns are not even a possible consideration.

18. Community-wide cordons (lockdowns) were last used for Ebola (a virus which kills up to 90% of those infected) in 2014 in Africa. An evaluation of these lockdowns found that even for such a virus, only “very small-scale cordons” – similar to quarantine – were effective; not large-scale lockdowns.
19. When large-scale lockdowns are unscientific and unethical even for a lethal virus like Ebola, the concept of lockdowns being applied for a flu-like virus simply does not exist.
20. Lockdowns, being untargeted, cannot eradicate SARS-Cov2 from the Earth. They merely slow down the development of immunity among younger people who could then have acted as barriers to the spread of disease. Further, there are innumerable voluntary and better ways to “flatten the curve” should the health system ever come under pressure. (There was no pressure, ever, on Victoria’s health system.)
21. “Scientists” who claim that lockdowns “work” neither know the science nor understand the meaning of “work”. The existence of a “flat-earthers” who have been trying to go against the well-established science of flu-like pandemics during 2020 does not make them right.
22. Masks have been shown in the scientific literature to be potentially helpful in limited medical settings but have never been proven through randomized controlled trials (RCT) to be helpful for use by the general population, let alone on a mandatory basis; and can cause great harms, instead.

### **Imposing such unscientific measures is an unethical human experiment forbidden by the laws**

23. To impose coercive lockdowns, curfews, mass-scale testing and mandatory masks for the general population for a flu-like virus – “measures” that have been specifically ruled out by the science – amounts to the conduct of a human experiment that has never been approved by any ethics process and which breaches an extensive range of laws – including many international laws.
24. Such measures cannot be justified by the “precautionary principle” either, since it is not a precaution in the face of incomplete knowledge to administer a well-known poison (lockdowns). Further, any claim of incomplete knowledge might have been valid on 15 March 2020 but was not tenable by 15 April 2020, by which time abundant knowledge about the nature and risk of this virus had become available.
25. Most “public health” measures used by the Accused (such as lockdowns, curfews and mandatory mask mandates) are grossly disproportionate as well as ill-targeted to the nature and risk presented by the virus, and thus contravene public health laws and international covenants. Moreover, since the pandemic never managed to apply even a Scenario 1 level of pressure upon the health system in Australia (as identified in Australia’s pandemic plan), there can be nothing more disproportionate than these “public health” measures.
26. To ensure compliance with their illegal “public health” measures it was necessary for the Victorian Administering Authorities to not only create a Police State (with extreme brutality meted out on numerous occasions), but to also create mass hysteria so the people remain in a state of terror. As a result of State-created terror, many Victorians did not get themselves checked for essential health conditions including mental and physical, thus leading to enormous human harms from these policies. Many have died unattended at home. The lives of millions of others have been shortened.

### **The mental model of the Accused: to shift life from the young to the old**

27. The Accused know very well that the people – particularly the youth – are paying a very high price for their virus eradication goals.
28. But the Accused have a mental model according to which it is OK to “sacrifice” the young in order to save even one elderly person from COVID death: “Even one loss of life from COVID is too many” has been their motto. The Accused have been actively trying to “shift” life from the young to the old.
29. After one year of this virus, 17 out of 100,000 persons on Earth have died *from* or *with* this virus. Most of these 17 were the extreme elderly, aged well beyond the average life expectancy for their country. It is these elderly people whom the governments are attempting to give a few more months of life – at

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<sup>25</sup> [https://www.who.int/influenza/publications/public\\_health\\_measures/publication/en/](https://www.who.int/influenza/publications/public_health_measures/publication/en/)

the cost (that they are aware of) of many months, even years, taken out from the life of those whom the virus would never have even mildly impacted.

30. Further, because most of the young whose life has been shortened don't die immediately, the Accused are able to claim that they have been successful in "saving" lives by citing discredited "models".

### **The 2020 lockdowns have increased *even* COVID-19 deaths**

31. Many studies are showing that the 2020 lockdowns have not saved **any** elderly lives from COVID. Instead, a comparative analysis of deaths per million in the US, UK and Sweden over the past year shows that lockdowns have **increased** COVID deaths.
32. This seemingly counter-intuitive result is plausible because lockdowns:
- dissipate scarce resources by trying to prevent the spread of the virus to low risk groups and not focusing sufficiently on cocooning the elderly; and
  - stop the development of immunity among the young who could then have acted as barriers to the spread of disease. Herd immunity is a law of nature for all infectious disease. Respiratory viruses peak fairly quickly, with those who've recovered becoming immune, which then makes it hard for the virus to infect others. Lockdowns do not allow herd immunity to develop which means the virus continues to spread – and wreak havoc on the elderly.
33. Another reason why deaths of the elderly have not been averted is that Australian government authorities have literally burnt hundreds of billions of dollars on futile activities (first stopping the young from going to work and then paying them through vast borrowing) but did not even provide health workers with N95 masks, which led to 3,500 of them getting infected by the virus and transmitting to the elderly in hospitals and aged care centres.

### **The Accused have continued their actions despite concerns being repeatedly raised**

34. The Victorian Administering Authorities had comprehensive knowledge of the harms that lockdowns and their hysteria-rousing policies can cause – for these are well-documented in the scientific and ethical literature, apart from being impossible to arrive at through any risk-based policy making process – but they have refused to acknowledge and formally assess these harms.
35. The Victorian Premier Daniel Andrews has publicly brushed aside my views as just my "opinion". The Chief Health Officer of Victoria has not only refused to answer any questions but has blocked me on his taxpayer-funded Twitter account. They are driving Victoria into a ditch blindfolded. They do not want any discussion of the harms.
36. The Victorian Administering Authorities recklessly and arbitrarily continue to ride roughshod over proportionality requirements and human rights embedded in the laws in their belief that every Victorian needs to stay locked down till a vaccine is punched into all of us. This belief, which is at loggerheads with international and domestic Australian laws, is not amenable to any reasoning.
37. Mr Morrison and Mr Andrews do not trust the people of Australia. Had they followed their original pandemic plans, they would have implemented mainly voluntary measures and educated the community. Instead, they chose to stand "over and above" the People and use force.
38. It is not just the Victorian and Australian Administering Authorities that are responsible for these crimes against humanity. Political parties in Australia from both sides of the spectrum are hands-in-glove about the breaches of the laws. Further, the High Court of Australia and the Supreme Court of Victoria have provided their stamp of approval respectively on border closures within Australia and the curfew that was till recently in place in Melbourne.

### **The enormous cost to health and life of these illegal public health measures**

39. The harms arising from public "health" measures such as lockdowns, in terms of lost life-years, have been estimated to be many orders of magnitude greater than any lives the lockdowns could possibly have saved (they do not save lives, as noted above).
40. But even making such a comparison is incorrect since a virus is an Act of Nature while lockdown deaths are an Act of Man – hence must be treated as a crime. Each additional mental harm caused and each additional life-year reduced by the policies of the Victorian and Australian Administering Authorities adds up to cause what is best described as a crime against humanity.
41. I have estimated that lockdowns across the world have **shortened the lives of hundreds of millions of people, including people like me** who have been forced into an extremely unhealthy condition

for many months, a situation from which the harm done to the body (or mind in many cases) can never fully recover.

42. These harms are not protected by Article 7(2)(e) of the Rome Statute. These harms were not “inherent in or incidental to, lawful sanctions” because the actions were themselves unlawful, having breached all considerations of proportionality and scientific proof. Any authorization to kill (or shorten the life of) person X in order to protect person Y necessarily had to be obtained in advance from the People of Victoria through the Parliament, through legislation. No such legislation exists.
43. Should the Accused deny causing the harms – which are real and which I document in this complaint – then the burden of proof must be placed on them to prove that these harms have **not** been caused by **their** policies. There is no way that so many harms would have been caused by voluntary measures aimed at flattening the curve, instead of the coercive measures used as part of the strategy of aggressive suppression or eradication.
44. Sweden’s results in terms of deaths per million from the COVID disease are superlative in comparison to many nations that imposed coercive lockdowns, thus demonstrating that it is possible to minimise harms from the virus to the elderly without causing additional “collateral” damage while trying to save people from what is basically a natural disaster. But even if Sweden’s results were not that great, it would not change the argument in this complaint since the core issue is that Sweden did not cause additional harms, while Victoria did.
45. It also doesn’t matter if a vaccine is ultimately found and some lives are then saved in Australia. Those who wish to wait for a vaccine have always been free to do so, voluntarily. But the idea that a Government can forcibly lock up an entire nation for months, even years – as if the People are the private farm animals of the Government – and then coercively jab these People (most of whom would never have been adversely affected by the coronavirus anyway) is nothing short of criminal. The People are not the private Animal Farm of Australia’s politicians.
46. There have been many supplementary offences committed by the Accused to support their government-created hysteria and terror, such as the use of PCR tests which are formally acknowledged by the Australian government to be unreliable. There are also very serious data integrity issues regarding the reported COVID deaths.

### **The International Criminal Court’s role in stopping these crimes**

47. When institutions of redress in Australia have failed, and almost the entire leadership of society is intent on committing (or supporting) mass-scale crimes, the only resort left to humanity is the International Criminal Court.
48. There is little point in having so many laws to protect human rights and policies and plans based on science and ethics if, when a minor pandemic comes upon us, all these are tossed out of the window. Today, many of Australia’s politicians, business leaders, media and perhaps even the courts, are supporters of tribalism and fear.
49. The battle today is effectively the biggest fight for liberty and human rights since slavery and colonialism. The ICC must play its role, perhaps the most important role it will play in this generation, by drawing a sharp line between what is acceptable as a public health measure and what is public health terrorism.
50. Without this sorry episode being declared a crime against humanity and the genie of public health terrorism being locked up inside its bottle forever, such extremism will happen again, and yet again.

### **1.6 What I seek from the ICC’s Prosecutor**

I request from the Prosecutor a **preliminary examination** of this complaint followed by a comprehensive **investigation** of the ongoing attacks by the Victorian Administering Authorities on the people of Victoria and the supportive actions of the Australian Administering Authorities in this regard.

I would hope that the investigation would lead to formal charges being drawn up for the consideration of the International Criminal Court. I would hope that would lead to a **ruling**, a **declaration** by the ICC that the actions of the Accused are a crime against humanity. Such a declaration, once made, will become a landmark in the history of public health and one of the most important rulings in the history of mankind.

Any follow-up actions that might follow such a ruling (such as punishments of the Accused, whether by the ICC or by the High Court of Australia) are not the focus of my complaint. I am entirely focused on getting the ICC to consider and make a sharp distinction between public health and public health

terrorism, to clarify which public health measures are legal and consistent with human rights and which are not. I would then hope that as a result of the ICC's ruling, the relevant laws and systems across the world will change forever for the better.

I have proposed some suggestions for legal and governance reforms in my book, *The Great Hysteria and The Broken State*<sup>26</sup>, but I trust the ICC will provide its authoritative stamp on a range of recommendations and remedies for all nations to then implement through their domestic democratic systems.

### 1.7 Acknowledgement of support received in preparing this submission

A number of people have shared valuable information about relevant matters with me on social media and via email for possible inclusion in this submission. I have also used content from public documents such as AdvocateMe's Open Letter<sup>27</sup> and Alexander Cooney's Open Letter<sup>28</sup>. In addition, I would like to specifically acknowledge the following individuals for the information they have provided:

- **Julia Slayo** and **Mishka Hudson** for their views on the scientific literature on the use of masks.
- **Danielle Burnie** for providing me with a copy of her letter to the Therapeutic Goods Administration of Australia which provides information on the pitfalls of PCR tests.

### 1.8 List of supporting complainants

I had placed drafts of this complaint for public comment on my personal blog and also invited any supporters. The following Victorians (listed in no particular order) have asked me via email or Facebook messenger for their names be included in this complaint as its supporters.

Name	Postcode	Name	Postcode	Name	Postcode
Chunlei Li	3000	Nadia Zekaria	3181	Melanie Lamoureux	3198
Alex Deans & Dorothy Deans	3777	Jayne Fenton and Ross Quick	3146	Jen Dodsworth	3757
A. Freeland	3104	Ahmad Hoblos	3046	Marina Stojcevska	Marina 3076
Sin-Li Tan	3125	Suncica Hoblos	3046	Melissa Zagami	3754
Anthony Cincotta	3351	Renee Flood	3015	Dana Janjic	3174
Kylie McIndoe	3555	Elisey Agarev	3181	Deanna Hewett and Ian Hewett	3820
Franck Verez	3192	Louise Hicks	3761	Joanna Adams	3217
Matt Lawson	3187	Cynthia Macdonald	3977	Aldo, Silvia, Daniel & Andrew Marinucci	3088
Gina Collins	3142	Susan, Neil, Leigh, Brent, Hannah Roach	3028	Meryem Binici	3048
Ken and Gladys Muir	3216	Neta Janev	3752	Ellena Tsatsos	3197
Brenton Murray	3977	Kevin Spencer	3810	Kyle and Melissa Sherwood	3754
Lara Campana	3936	Bill and Dimitra Haralambakis	3166	Clint Facey	3182

<sup>26</sup> <https://www.amazon.com.au/Great-Hysteria-Broken-State-ebook/dp/B08L26W2WY/>

<sup>27</sup> [https://832894cb-902f-415c-ba0e-f312627aa319.filesusr.com/ugd/e12357\\_2bda687b44b34d4bb607594b9a02aa3f.pdf](https://832894cb-902f-415c-ba0e-f312627aa319.filesusr.com/ugd/e12357_2bda687b44b34d4bb607594b9a02aa3f.pdf)

<sup>28</sup> [https://12224e9c-a5fa-4daf-962b-f9379e0c0efa.filesusr.com/ugd/e12357\\_d13aa26d9fe84d809d3aebf2481ac274.pdf](https://12224e9c-a5fa-4daf-962b-f9379e0c0efa.filesusr.com/ugd/e12357_d13aa26d9fe84d809d3aebf2481ac274.pdf)

<b>Name</b>	<b>Postcode</b>	<b>Name</b>	<b>Postcode</b>	<b>Name</b>	<b>Postcode</b>
<b>Beverley Easton</b>	3156	<b>Louis Andreou</b>	3942	<b>Vanessa Mangion</b>	3335
<b>Sean Hutchinson</b>	3280	<b>Bianca Lagalla</b>	3434	<b>Robert Jones</b>	3199
<b>Ryan Morgan-Brooker</b>	3006	<b>Linda Chisholm</b>	3139	<b>Simon Mullin and Penny Mullin</b>	3116
<b>Rocco Marinelli</b>	3930	<b>Simone Cordell and Dean Lonza</b>	3517	<b>Jesse Lotito</b>	3038
<b>Donella Storey</b>	3131	<b>Peter Stellas</b>	3082	<b>Nicholas Mancuso</b>	3064
<b>Ursula McAllister</b>	3095	<b>Maria Zakou</b>	3029	<b>Silvia Russo</b>	3918
<b>Beverley Stammers</b>	3084	<b>Rita Choueiri</b>	3105	<b>Jackie Hrkac</b>	3217
<b>Bonnie Radoja</b>	3153	<b>Brenton Sherwell</b>	3201	<b>Francis Ruggiero</b>	3008
<b>Judith Bartalis</b>	3032	<b>Elizabeth Eaton</b>	3006	<b>Janet Devlin</b>	3198
<b>Gillian Burridge</b>	3808	<b>Rosemary Cooper</b>	3199	<b>Belinda Holland</b>	3977
<b>Rania Seoud</b>	3072	<b>Jodie S</b>	3105	<b>David Kirkpatrick</b>	3796
<b>Deborah Parfitt</b>	3044	<b>Alex Deans</b>	3777	<b>Irene</b>	3150
<b>Nikolai Sokolov</b>	3150	<b>Chrissie Neill</b>	3156	<b>Kelly Clements</b>	3150
<b>Kerryn McLeod</b>	3136	<b>Giovanna Mercuri</b>	3195	<b>Rosanna Mercuri</b>	3195
<b>David Bernard</b>	3029	<b>Gloria Soto</b>	3073	<b>Alexandra Chapman</b>	3440
<b>Joanna Benhamou</b>	3162	<b>Susan Waghorn</b>	3820	<b>Pare Tutu</b>	3030
<b>Angelo Di Ciero</b>	3114	<b>Trevor Nimmo</b>	3496	<b>Caitlin Doyle</b>	3496
<b>Sharon Douglass</b>	3500	<b>Anita Binnington</b>	3065	<b>Cheryl Garland</b>	3076
<b>Jenny Matthews</b>	3140	<b>Dawud Selek</b>	3048	<b>Marcelle Quinn</b>	3936
<b>Ihsani</b>	3108	<b>Adam Hoehn</b>	3182	<b>Irina Sovan</b>	3802
<b>Amanda Ferguson</b>	3040	<b>Koby Martin</b>	3121	<b>Mathew Estrada</b>	3754
<i>Via Facebook Messenger:</i>		<b>Eddie Kaplan</b>	3121	<b>Susanne Burrage</b>	3804

## 2. Distinguishing public health from public health terrorism

I will attempt in this chapter to make a distinction between valid and invalid public health measures, this being the core threshold issue for this complaint.

### 2.1 Public health can do a lot of good but also has a long history of causing harms

For the past 170 or so years the discipline of public health has been critical to improving the human condition and extending the human lifespan. In the ordinary course of its work, this discipline implements measures that benefit everyone while harming no one.

But just like with any other health measure, when ill-targeted public health approaches are adopted, catastrophic harms can occur. In public health, such harms get magnified greatly since vast numbers of people are potentially impacted. What is happening in Victoria today is an extreme example of what can happen when public health goes astray.

#### 2.1.1 *Horrible abuse of civil liberties*

This is not the first time that the practice of public health has abused its powers. In 2009, Wendy Parmet, the Director of the Northeastern University's Program on Health Policy and Law said:

**The history of public-health responses and the abuse of civil liberties is horrifying.**

Abuses occur even though in every era, public-health officials always believe they're doing the right thing and acting in good faith.<sup>29</sup>

In March 2020, David J Carter wrote about the **abuses of public health in Australia** after conducting extensive research across the country:

The powers available to the state in the name of advancing or protecting the public's health are extensive and **highly elastic**. The research reported here reveals some serious concerns about the use of these powers. This includes evidence of the **indefinite detention of multiple individuals** by public health authorities, including those **detained until their death**, and **public health orders made without time limits and never rescinded**.<sup>30</sup>

#### 2.1.2 *Creating hysterias and ignoring other aspects of health*

There is considerable literature about the tendency of public health practitioners to grossly exaggerate risks and foster tunnel-visioned hysterias that ignore all other health issues. In a 2007 book, *How the Medical Industry Continually Invents Epidemics, Making Billion-Dollar Profits At Our Expense*, Torsten Engelbrecht and Claus Kohnlein showed us the risks to humanity when public health is misused:

**We are not witnessing viral epidemics; we are witnessing epidemics of fear.** And both the media and the pharmaceutical industry carry most of the responsibility for amplifying fears, fears that happen, incidentally, to always ignite fantastically profitable business. **Research hypotheses covering these areas of virus research are practically never scientifically verified with appropriate controls.** Instead, they are established by "consensus." This is then rapidly reshaped into a dogma, efficiently **perpetuated in a quasi-religious manner by the media**, including ensuring that research funding is restricted to projects supporting the dogma, excluding research into alternative hypotheses. An important tool to keep dissenting voices out

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<sup>29</sup> Efrati, Amir, 'Public Safety v. Civil Liberties: Health Crisis Leads to New Case', *The Wall Street Journal*, 7 May 2009. Short URL: <https://on.wsj.com/36ncFag>.

<sup>30</sup> Carter, D 2020, "The Use of coercive Public Health and Human Biosecurity Law in Australia: An Empirical Analysis", *University of New South Wales Law Journal*, vol. 43, no. 1. <http://www.unswlawjournal.unsw.edu.au/wp-content/uploads/2020/03/04-Carter.pdf>



of the debate is censorship at various levels ranging from the popular media to scientific publications.<sup>31</sup>

During the Swine Flu as well, the behaviour of public health practitioners was extremely questionable, to say the least – as reported in many documents including by the Council of Europe,<sup>32</sup> the continent’s leading human rights organisation.

### 2.1.3 *W.H.O.’s acknowledgement of these endless public health hysterias*

In an article published in 2011 in the *Bulletin of the World Health Organization*, Luc Bonneux and Wim Van Damme wrote<sup>33</sup>:

The **repeated pandemic health scares** caused by an avian H5N1 and a new A(H1N1) human influenza virus are part of the culture of fear. **Worst-case thinking** replaced balanced risk assessment. Worst-case thinking is motivated by the belief that the danger we face is so overwhelmingly catastrophic that we must act immediately. ... The **pandemic policy was never informed by evidence**, but by fear of worst-case scenarios.

In both pandemics of fear, **the exaggerated claims** of a severe public health threat **stemmed primarily from disease advocacy by influenza experts**. ... There is no reason for expecting any upcoming pandemic to be worse than the mild ones of 1957 or 1968,<sup>7</sup> no reason for striking pre-emptively, **no reason for believing that a proportional and balanced response would risk lives**.

**Resources are scarce and need to be allocated to many competing priorities**. Scientific advice on resource allocation is best handled by generalists with a comprehensive view on health. **Disease experts wish to capture public attention and sway resource allocation decisions in favour of the disease of their interest**.

These learnings from past hysterias and the lack of evidence-based claims by “experts” did go into well-structured and well-designed pandemic plans and the WHO’s October 2019 guidelines for flu-like pandemics.<sup>34</sup> But in 2020, it appears that the same vested interests and infectious disease “experts” came out of the woodworks, creating the biggest hysteria seen to date in human history and causing **health harms** on a scale in comparison to which harms caused by any other hysteria in the past appear insignificant.

## 2.2 **Models, always unreliable and discredited, are the basis of these hysterias**

Public health has a sub-discipline called epidemiology which does not necessarily require any medical training. Anyone with elementary mathematical skills can set themselves up as an “epidemiologist”. They do not need any training in (and are probably disinterested in) the ethics of medicine or the laws of public health. Such “experts” have been the bane of mankind for a long time but this time around they have caused unimaginable devastation.

Epidemiological models are notoriously unreliable. There is no basis in science to use them for any public policy. They are a form of guess work but shrouded as “expertise”, with simple mathematics being put out as an apocalyptic prophesy for all of mankind to “believe”. But mathematics is not science; at best it is a tool of science. Given my strong mathematics and modelling background, I wish to assure the Prosecutor that any claims that models are a part of science are a figment of the imagination. Mathematical models can be made out of anything that a person imagines, but as we all know, imagination is not science.

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<sup>31</sup> <https://bit.ly/3p1Ynmh>

<sup>32</sup> <https://www.youtube.com/watch?v=i5PyUrkAvwY&feature=youtu.be>

<sup>33</sup> Bonneux, Luc and Van Damme, Wim, “Health is more than influenza”, in *Bulletin of the World Health Organization* 2011; 89:539-540. <https://www.who.int/bulletin/volumes/89/7/11-089086/en/>

<sup>34</sup> [https://www.who.int/influenza/publications/public\\_health\\_measures/publication/en/](https://www.who.int/influenza/publications/public_health_measures/publication/en/)

It is very problematic that modelers seem to have taken over the discipline of public health (except for a few wholistic practitioners like Anders Tegnell).

I have written elsewhere about the innumerable problems with these models, such as in my 30 May 2020 blog post on my *Times of India* blog<sup>35</sup>:

One reason we can't use these models is that **their most basic concept, R0, is not just difficult to calculate, it can be misleading**. The shakiness of this concept is known among the epidemiologists.

For instance, a 2007 paper, "Theory versus Data: How to Calculate R0?" by Breban et. al. warned us that "obtaining R0 from empirical contact tracing data collected by epidemiologists and using this R0 as a threshold parameter for a population-level model could produce extremely misleading estimates".

And a 2011 paper entitled, "The Failure of R0" by Jing Li et. al. said: "If R0 is to be used, it must be accompanied by caveats about the method of calculation, underlying model assumptions and evidence that it is actually a threshold. Otherwise, the concept is meaningless".

I have also elaborated this issue in my book, *The Great Hysteria and The Broken State*<sup>36</sup>. In this (ongoing) pandemic, modelling by the Imperial College in the UK and the Peter Doherty Institute in Australia indicated that the hospital system would not cope and up to 150,000 Australians would die. But their modelling has been entirely discredited, as usual with all such models.

If needed by the Prosecutor, I can provide a fuller list of such examples and extensive proofs (including from peer reviewed journals) to confirm that epidemiological models have no credibility and must never be allowed to play a primary role in determining public health policy.

Unfortunately, the Victorian Government has continued to use a range of discredited "experts" and ignored anyone who wishes to bring reason, risk assessment, proportionality and **ethics** to the table.

There is perhaps no greater evil mind today in the world than that of these "modellers" who are literally playing with our lives on their computer screen, with no accountability whatsoever.

### 2.2.1 *Chronic failure of modelers to understand the basics of the immune system*

One of the basic problems with most modelers is that they are not biologists but mathematicians and do not understand immunology.

In a paper on 17 September 2020 in the *British Medical Journal*, entitled, "Covid-19: Do many people have pre-existing immunity?"<sup>37</sup>, Peter Doshi showed that key policy makers have forgotten key biological lessons learnt from the swine flu pandemic:

In late 2009, months after the World Health Organization declared the H1N1 "swine flu" virus to be a global pandemic, Alessandro Sette was part of a team working to explain why the so called "novel" virus did not seem to be causing more severe infections than seasonal flu.

Their answer was pre-existing immunological responses in the adult population: B cells and, in particular, T cells, which "are known to blunt disease severity." Other studies came to the same conclusion: people with pre-existing reactive T cells had less severe H1N1 disease. In addition, a study carried out during the 2009 outbreak by the US Centers for Disease Control and Prevention reported that 33% of people over 60 years old had cross reactive antibodies to the 2009 H1N1 virus, leading the CDC to conclude that "some degree of pre-existing immunity" to the new H1N1 strains existed, especially among adults over age 60.

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<sup>35</sup> <https://timesofindia.indiatimes.com/blogs/seeing-the-invisible/why-less-than-25-of-the-worlds-population-is-likely-to-get-covid-19/>

<sup>36</sup> <https://www.amazon.com.au/Great-Hysteria-Broken-State-ebook/dp/B08L26W2WY/>

<sup>37</sup> Doshi, Peter, "Covid-19: Do many people have pre-existing immunity?", *BMJ*, 17 September 2020. Short URL: <https://bit.ly/33TO8GE>.

The data forced a change in views at WHO and CDC, from an assumption before 2009 that most people “will have no immunity to the pandemic virus” to one that acknowledged that “the vulnerability of a population to a pandemic virus is related in part to the level of pre-existing immunity to the virus.” But by 2020 it seems that lesson had been forgotten.

In my book, *The Great Hysteria and The Broken State*<sup>38</sup> I have discussed the nature of the human immune system in some detail – the Prosecutor may wish to examine it. The main lesson of biology that I outline in my book is that humans have a strong immune system that develops immunity to a range of viruses over a lifetime. We have significant cross-reactivity to this novel coronavirus. I have discussed this at some length in my *Times of India* blog posts of 24 May 2020<sup>39</sup> and 27 July 2020<sup>40</sup>, as well as in my book.

Models do not even remotely the complexity of biological science into their equations, leave alone the complexity of risk assessment and proportionality. They are children’s toys and must be kept out of any discussion of public health policy.

### 2.3 Daniel Andrews was aware even in 2008 that public health measures can disrupt human rights

Daniel Andrews knew about the huge dangers posed by public health measures. He was Victoria’s Health Minister when the *Public Health and Wellbeing Act 2008* was enacted. He tabled a statement<sup>41</sup> in the Parliament in accordance with Charter of Human Rights and Responsibilities Act which recognised that the Public Health Act **will limit at least 14 out of the 20 human rights** that the Charter protects. It was clear then that this legislation is potentially one the most intrusive of human rights in Victoria.

1. Section 8 — right to recognition and equality before the law
2. Section 10(1)(c) — right not to be subjected to medical treatment without his or her full, free and informed consent
3. Section 11 — freedom from forced work
4. Section 12 — freedom of movement
5. Section 13 — privacy and reputation
6. Section 14 — freedom of thought, conscience, religion and belief
7. Section 15 — freedom of expression
8. Section 16 — peaceful assembly and freedom of association
9. Section 17 — protection of families and children
10. Section 19 — cultural rights
11. Section 20 — property rights
12. Section 21 — right to liberty and security of person
13. Section 24 — fair hearing
14. Section 25 — rights in criminal proceedings

But he then assured the Victorian Parliament that these rights limitations would be constrained by the provision in the Bill that **‘the least restrictive measure that would be effective in minimising the risk to public health should be preferred’**.

Illustratively, he said: ‘a public health order should therefore only limit a person’s freedom of movement to the degree necessary to protect public health’. Also, Victoria’s public health law expressly prohibits the exercise of arbitrary power in the name of public health: ‘actions ... should be proportionate to the public health risk sought to be prevented, minimised or controlled; and should not be made or taken in an arbitrary manner’<sup>42</sup>.

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<sup>38</sup> <https://www.amazon.com.au/Great-Hysteria-Broken-State-ebook/dp/B08L26W2WY/>

<sup>39</sup> <https://timesofindia.indiatimes.com/blogs/seeing-the-invisible/the-effect-of-innate-immunity-cross-reactivity-trained-immunity-and-vitamin-d-on-covid-19/>

<sup>40</sup> <https://timesofindia.indiatimes.com/blogs/seeing-the-invisible/explaining-indias-extraordinarily-low-death-rate-from-covid-19/>

<sup>41</sup> <https://bit.ly/3kKq7cE>

<sup>42</sup> <https://www.legislation.vic.gov.au/in-force/acts/public-health-and-wellbeing-act-2008/043>.

But when the time came, in 2020, to enforce these limitations that are found in the laws on the use of coercive “public health” measures, Mr Andrews tossed aside the concepts of proportionality and human rights.

## 2.4 Threshold question: Can a government kill its citizens or shorten their life?

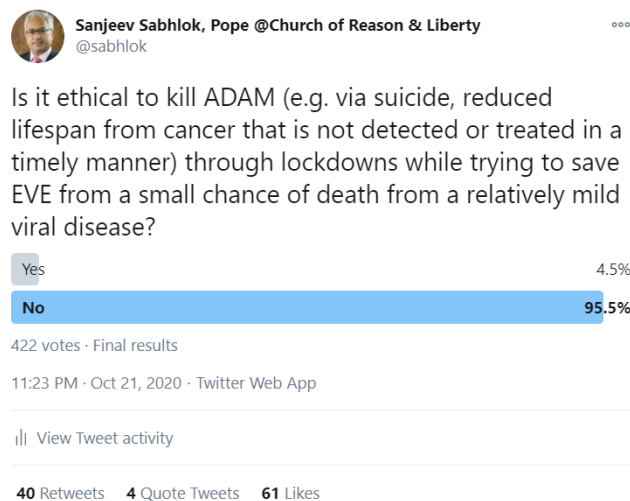
No government is authorised by the laws in any country to burn down additional homes and kill unaffected people in order to save those who might be at risk of being engulfed in a bushfire.

In this regard I wish to provide the ICC with results from my personal research into this question.

I held a Twitter poll<sup>43</sup> on 21 October 2020 that asked:

Is it ethical to kill ADAM (e.g. via suicide, reduced lifespan from cancer that is not detected or treated in a timely manner) through lockdowns while trying to save EVE from a small chance of death from a relatively mild viral disease?

The response was overwhelmingly **against the right of anyone to kill additional people** in order to prevent the loss of someone’s life. There were a few people who accidentally voted ‘Yes’, but basically it is very clear that mankind is not willing to authorise governments to kill (or shorten the life of) X in order to protect Y.



This is a core ethical principle on which there is unanimous agreement across the world. It is also a basic concept of morality – that we cannot harm others or treat them as a means to our ends.

### 2.4.1 Can public health measures kill (or shorten people’s life)? No.

Public health is a sub-discipline of the health sciences. In general, only **medical practitioners** (not economists like me, for instance) are made the Chief Health Officer in Victoria.

The boundary condition for the practice of medicine is the dictum, *primum non nocere* – i.e. *first do no harm*, being a part of the Hippocratic Oath. The boundary condition for all public health practice is necessarily the same.

Two types of public health measures exist: advisory and mandatory. When public health is practiced through voluntary measures and educating the community, there is obviously no prospect of the public health profession harming anyone.

Mandatory public health measures can, however, cause harms.

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<sup>43</sup> <https://twitter.com/sabhlok/status/1318890560363573256>

The public health discipline has considered at length the kinds of harms that might arise from coercive interventions and has identified remedies for them. I will discuss them in a separate chapter. But never has the discipline considered harms on the scale we are seeing today from lockdowns and curfews. No one who teaches public health imagined a situation in which **people will be harmed or even killed (or lifespan shortened) on such a mass scale** as a result of public health measures.

I believe that the ICC must rule clearly that public health policy is not exempt from the rule that applies to all other government policy: that government policy must not *cause* severe harms to mental health or to life while attempting to save lives.

## 2.5 Conditions for justified compulsion in public health

Ethical considerations are particularly important to public health practice. If a public health measure is not proportionate and risk-based, it has the potential to become unethical and therefore criminal.

Public health theorists have been long concerned about even minor public health measures such as time-limited quarantine that might cause harms. There is significant literature about the need to minimise mental health harms from quarantines and the need also for compensatory mechanisms (reciprocity) for any economic harms caused.

Marcel<sup>44</sup> has analysed the conditions for justified compulsion in public health in a 2011 paper. The following extract confirms that any public health measure that has a negative effect on human well-being necessarily requires a strong ethical justification.

Compulsory screening for dangerous infectious diseases, contact tracing, case reporting, isolation and quarantine, vaccination or treatment – all these measures can deeply interfere with people’s well-being and freedom, and they **require a strong moral justification**. There should be sufficient evidence that a coercive measure is necessary to prevent significant harm to others. Paradoxically, **the more this measure and its justification is endorsed by the public, the less force and compulsion may be required to protect public health**.

Overall, voluntarism is clearly to be preferred: it is the gold standard of public health policy.

In order to ensure that coercive public health measures do not end up harming people, a number of analytical steps need to be undertaken first, such as:

- a careful assessment of the level of risk;
- scientific proofs about the effectiveness of any proposed measure;
- the proportionality of the measure in relation to the risk (in comparison also with all other risks to health and more generally as well); and
- ethical (including human rights) considerations.

Marcel has identified many factors including the following that public health practitioners must take into account while considering a compulsory public health measure:

Quarantining healthy persons in order to reduce the risk of contagion, or mandatory screening at borders, or compulsory tests for pregnant women, all involve situations where it is less clear whether the persons compelled are indeed causing harm to others – or even imposing risk on others. ... Just the fact that a certain compulsory intervention may prevent harm is not enough to consider the intervention morally right.

### **Magnitude of harm**

A first issue that will be relevant in any justification of compulsory measures is that **the harm or risk to be averted should be significant** and realistic. Chicken pox and the common cold are contagious, but, apart from special circumstances, do not create clear risks to individuals or the population. The magnitude of the harms that can be prevented does not only depend on how

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<sup>44</sup> Verweij, Marcel, “Infectious disease control”, in Dawson, Angus (ed.) *Public Health Ethics: Key Concepts and Issues in Policy and Practice*, Cambridge University Press, 2011.

[https://www.researchgate.net/publication/289008303\\_Infectious\\_disease\\_control](https://www.researchgate.net/publication/289008303_Infectious_disease_control)

severe a disease is for a patient, but also on the mode and speed of transmission. Infections that lead to severe disease but that also spread rapidly within a population pose a serious threat to the public health at large. Such a disease, if not averted, will affect many individuals, and the ravages will not only be visible in each patient, but also on a population level.

### **Effectiveness and evidence**

A necessary condition for any compulsory public health measure to be justified is that it should be **effective** in preventing infection and reducing the risks of disease. ... Randomized trials of policies like surveillance, isolation, or border control are rare if not impossible. Moreover, evaluation of effectiveness should not just focus on theoretical effects in ideal circumstances, but also on the **feasibility** of measures in times of crisis. Especially where measures are compulsory, people may try to find ways to avoid them. If persons who are tested positive for disease are isolated from their families, they may decide not to see a doctor if they have symptoms. Finally, judgments of effectiveness of planned interventions against future diseases, such as pandemic influenza, are complicated by many uncertainties about the characteristics of the virus and its effects (infection rate, transmissibility, mortality, risk groups, etc.).

### **Proportionality and the least restrictive alternative**

A further requirement for controlling measures is that their impact on the liberties and well-being of individuals should be in the right proportion to the magnitude of harm that can be prevented. **Major threats to public health – for example, a bioterrorist attack with smallpox – may require interventions like compulsory isolation and vaccination**, yet such measures may be effective but not reasonable in order to contain an outbreak of less severe diseases, like rubella or measles.

**Reasonable** approaches to protect public health will also endorse the principle of the least restrictive alternative: measures may sometimes justifiably impose constraints on civil liberties, but such constraints should not be greater than strictly necessary. ... One interpretation of the principle is that compulsory interventions should only be imposed

where less restrictive measures have been tried, and have failed (Annas, 2002).

### **Infectious disease control and public trust**

[I]t is essential for effective infectious disease control that the public trust public health authorities and [has] confidence in the interventions that those authorities impose. If there is a lack of trust in public health authorities, even compulsory policies will be futile. Conversely, if public health professionals and authorities **can and do publicly justify regulations that are deemed necessary** – especially those regulations that are compulsory in nature – they provide reasons for the public to trust such interventions.

Public trust may be further strengthened if adverse effects of controlling public health measures are countervailed where possible and if persons can expect reasonable compensation for economic losses.

The World Health Organisation's approach in its October 2019 report: *Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza*<sup>45</sup> includes consideration not just of six analytical factors but also detailed consideration of ethics. A scan of the relevant section from the report is provided below:

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<sup>45</sup> [https://www.who.int/influenza/publications/public\\_health\\_measures/publication/en/](https://www.who.int/influenza/publications/public_health_measures/publication/en/)

### Development of recommendations

A technical consultation meeting for the development of this guidance was held in Hong Kong Special Administrative Region (SAR), China, on 26–28 March 2019. The systematic review team presented the outcomes of the systematic review. Recommendations were formulated by the guideline development group to determine the direction and strength of a recommendation by six indicators according to the WHO handbook for guideline development (38); the indicators are quality of the evidence, values and preferences, balance of benefits and harms, resource implications, acceptability and feasibility. In addition, ethical issues were taken into consideration. The strength of recommendations expressed the confidence of the guideline development group members in balancing desirable and undesirable consequences, which were classified as:

- “recommended” – the group is confident that the desirable effects outweigh the undesirable results;
- “conditionally recommended” – the group believes that the balance between benefits and harms is uncertain, and some conditions should apply when implementing the recommendation; or
- “not recommended” – the group is confident that the disadvantages outweigh the advantages.

Likewise, Gostin’s 2007 paper<sup>46</sup> discusses the principles that might underpin a coercive public health intervention:

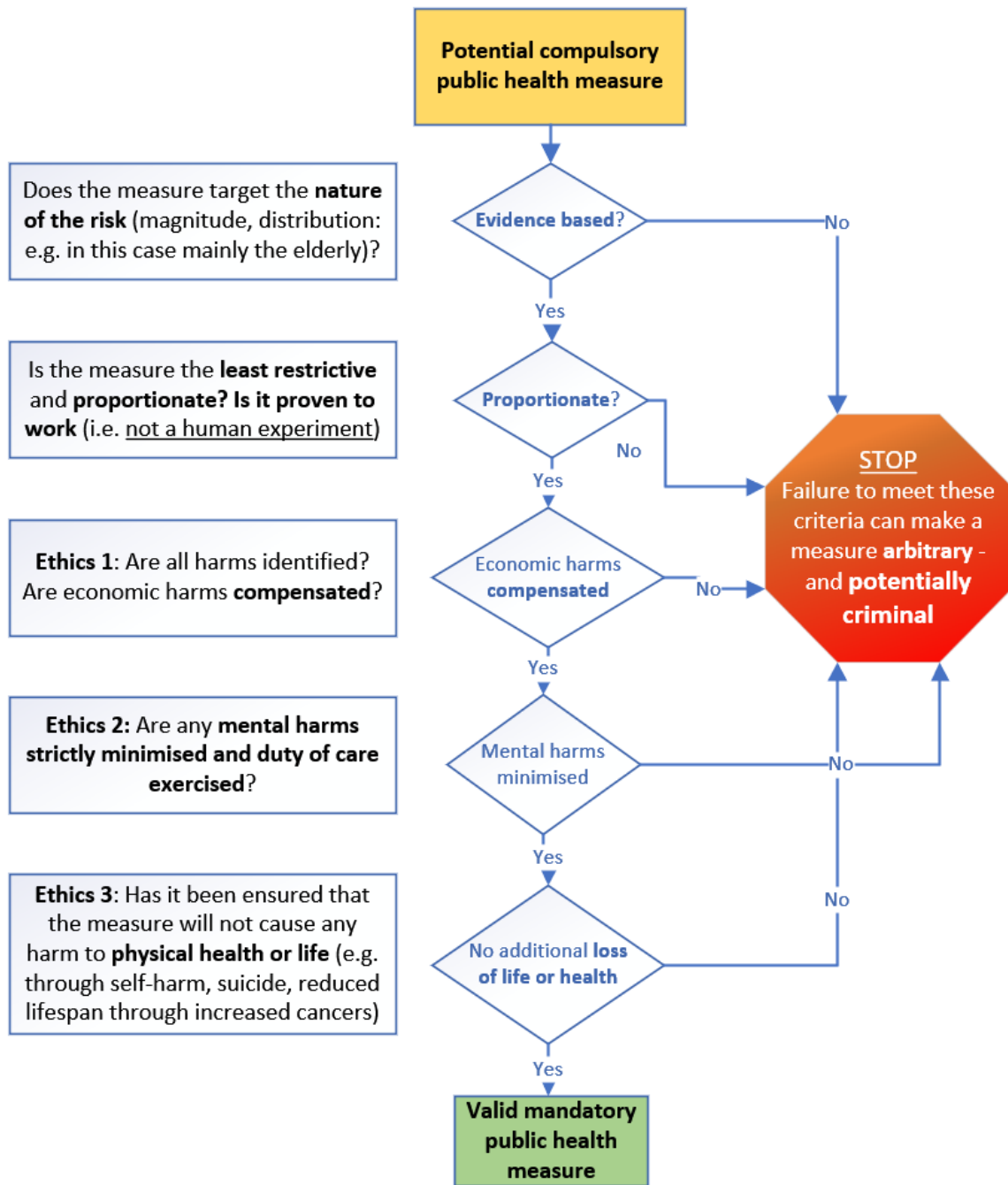
- Public health officials must be able to prove that they had ‘a good faith belief, for which they can give supportable reasons, that a coercive approach is necessary’.
- The standard of public health necessity requires, at a minimum, that **the subject of the compulsory intervention must actually pose a threat to the community.**
- There must be a reasonable relationship between the public health intervention and the achievement of a legitimate public health objective.
- A policy that entails personal burdens and economic costs is only justified if the government can demonstrate that there is a reasonable chance of protecting the public health.
- **The government has the burden of proof** and has to engage in ongoing evaluation of the public health intervention and its effectiveness
- Evaluation of effectiveness is important not only from a public health perspective, but also from an **ethical perspective**. To the extent that interventions impose costs and burdens on individuals or the population, they are ethically warranted only to the extent that they are effective and **proportionate** in terms of benefits and burdens.
- **If the intervention is gratuitously onerous or unfair, it may overstep ethical boundaries.**

Based on my review of this and other public health literature, and also based on my decades-long experience in designing good public policy, I have prepared a preliminary flowchart, below, that can help the ICC distinguish reasonable and proportionate public health measures from acts of public health terrorism.

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<sup>46</sup> Gostin L, Berkman B. ‘Pandemic influenza: Ethics, law, and the public’s health’, *Admin. L. Rev.*, 2007; 59:12

**Voluntary public health measures are always preferable. Where necessary, a mandatory public health measure can be adopted but it must not be arbitrary**



**2.6 Public health measures in 2020 have crossed all boundaries of law and ethics**

The leash of proportionality that is embedded in the laws exists in order to sift out bad public health policy from good. But despite his claiming in 2008 that Victoria’s public health legislation in Victoria would protect us from arbitrary actions, Mr Daniel Andrews threw out the principles of proportionality



and the requirement in the law to identify ‘the least restrictive measure that would be effective in minimising the risk to public health’ during this pandemic.

He abandoned also Victoria’s officially approved 10 March 2020 Victorian Pandemic Plan<sup>47</sup> which would never have implemented the lockdowns and curfews that we have seen. All legal restrictions designed specifically to stop extreme public health measures during challenging public health situations have been brazenly contravened. By disregarding due process, transparency, proportionality and ethical considerations, public health in Victoria has degenerated into **public health terrorism**.

The Victorian Administering Authorities have been playing God with the lives of 6.7 million humans as if we, the People, are their private chattel. They have taken arbitrary actions that involve a widespread and systematic derogation of human rights, such as on the freedom of movement, ability to work, religious belief, and association – *and* on top of that they are directly causing grievous mental and physical harm.

The crippling financial, psychological, social and health distress that has been caused to the Victorian people as a result of the actions taken by the Victorian Administering Authorities cannot even begin to be quantified. Any excesses committed by public health practitioners in the past pale in comparison to the brutalities we have witnessed during this pandemic.

Many of the harms could have been readily averted by recommending and not mandating, measures that might have otherwise been disproportionate. By leaving it to the judgement of the People of Victoria to adopt measures that would improve their own health, the burden of compulsion would have been removed and community trust and self-respect enhanced. As noted above, voluntarism is the gold standard of public health policy. But that was not even tried. It is this disrespect for citizens as humans and of their right to agency and self-determination that is at the core of the offences committed by the Victorian Administering Authorities.

## 2.7 Voices against the public health terrorism are getting shriller

I have written against lockdowns since late February 2020 but that was not public (in emails to my former bosses in the Department of Treasury and Finance).

But I have expressed my strong opposition to lockdowns from 6 March 2020 onward in my public article, “Age-based risk management of coronavirus”<sup>48</sup> on my *Times of India* blog. On 25 March 2020 I wrote an article entirely against lockdowns: “Lockdowns won’t defeat the virus but will definitely destroy us all”<sup>49</sup>.

But there are many other voices against lockdowns. An illustrative list of eminent persons who have objected to lockdowns and other extreme “public health” measures across the world include:

### **Professor Sunetra Gupta**

Dr Sunetra Gupta, professor of theoretical epidemiology at the University of Oxford, wrote on 31 October 2020:

[M]ass lockdowns cause enormous damage. We are already seeing how current lockdown policies are producing **devastating effects on short and long-term public health**. The results — to name just a few — include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health’.<sup>50</sup>

### **Professor Ramesh Thakur**

Professor Ramesh Thakur of the Australian National University wrote on 24 October 2020:

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<sup>47</sup> <https://www2.health.vic.gov.au/about/publications/researchandreports/covid-19-pandemic-plan-for-vic>

<sup>48</sup> <https://timesofindia.indiatimes.com/blogs/seeing-the-invisible/age-based-risk-management-of-coronavirus/>

<sup>49</sup> <https://timesofindia.indiatimes.com/blogs/seeing-the-invisible/lockdowns-wont-defeat-the-virus-but-will-definitely-destroy-us-all/>

<sup>50</sup> <https://www.dailymail.co.uk/debate/article-8899277/Professor-Sunetra-Gupta-reveals-crisis-ruthlessly-weaponised.html>

Dr Matt Strauss of Queen's University in Canada has written: 'If lockdowns were a prescription drug for Covid-19 treatment, the FDA would never have approved it'. Hence his conclusion as a medic with clinical practice: 'mandatory government lockdowns amount to a medical recommendation of no proven benefit, of **extraordinary potential harm**, that do not take personal values and individual consent into account'.<sup>51</sup>

In this article, Professor Thakur also called out the “**crimes against humanity** resulting from the brutal perverse consequences of the stringent measures”.

### **President of Australia's Human Rights Commission**

On 22 October 2020, Professor Rosalind Croucher, President of Australia's Human Rights Commission is reported to have criticised Australia's extreme public health measures<sup>52</sup>:

Australians are being exposed to “potentially unnecessary” infringements on their basic human rights during the lockdown because of a lack of scrutiny and accountability, says Australian Human Rights Commission president Rosalind Croucher. Professor Croucher said any measures to combat COVID-19 that curtailed human rights needed to be necessary to protect public health and proportionate to meet that goal, with the least restrictive measures imposed to do so, to comply with international human rights obligations.

“I am concerned at the **lack of transparency in explaining the continued justification for some emergency measures**, and even for identifying precisely which level of government is responsible for some of them”. “Australians have been, and continue to be, exposed to potentially unnecessary restrictions of their rights and freedoms, because of the lack of transparency and accountability,” she told Senate estimates.

She said any **decisions needed to be subject to regular, ongoing scrutiny**. “What was appropriate in the circumstances of three months ago, may not be so justified in the circumstances of today,” she said.

### **Editorial in Australia's major medical journal**

On 27 October 2020 the *Internal Medicine Journal*, published by RACP, an organisation that represents 25,000 medical specialists and trainee specialists in Australia, said in an Editorial:

**Public health agencies have a responsibility to consider how to achieve overall public health goals with the least restrictive or burdensome strategies**, and to weigh each intervention on its merits'. ‘the justifications for restrictive interventions, and the long-term all-things-considered goals of public health policy. Six months on, it is no longer acceptable that this responsibility be deferred on the basis of emergency.’<sup>53</sup>

### **Editorial in *The Australian* newspaper**

Australia's premier newspaper, *The Australian*, wrote in an editorial on 27 October 2020 that: ‘the disproportionate financial and **human costs of lockdown and poorly thought-through border closures** are becoming more obvious by the day’.<sup>54</sup>

### **William Barr**

The US Attorney General William Barr said that “other than slavery, which was a different kind of restraint, coronavirus **lockdowns were the ‘greatest intrusion on civil liberties in American history’**”<sup>55</sup>.

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<sup>51</sup> <https://www.spectator.com.au/2020/10/hippocrates-cancelled/>

<sup>52</sup> <https://www.theaustralian.com.au/nation/coronavirus-australians-exposed-to-potentially-unnecessary-infringements-human-rights-chief-says/news-story/ebe0281f29e61bbb8afdaf8ea20d01b5>

<sup>53</sup> <https://onlinelibrary.wiley.com/doi/10.1111/imj.15038>

<sup>54</sup> <https://twitter.com/sabhlok/status/1320888071861071872>

<sup>55</sup> <https://www.newsbreak.com/news/2063436089181/ag-william-barr-coronavirus-lockdowns-greatest-intrusion-on-civil-liberties-since-slavery>

## Dr Scott Atlas

Dr Scott Atlas of the Hoover Institution has said that it may be legitimate to call lockdowns a crime against humanity.<sup>56</sup>

## Simon Dolan

Lawyers for Mr Dolan of London are “arguing in a judicial review that the UK’s lockdown rules were among ‘the **most onerous restrictions to personal liberty’ in almost four centuries**”<sup>57</sup>.

## 2.8 The magnitude of the coronavirus pandemic is irrelevant to the complaint

I wish to emphasise that the magnitude of the novel coronavirus pandemic is irrelevant to the complaint. For viruses like flu or coronavirus, coercive lockdowns can never be a remedy.

Policies for any flu-like respiratory virus would therefore be basically the same, even for a pandemic the size of the Spanish flu. Implementing policies of the kind we are seeing in Victoria and Australia would be unethical no matter how big such a pandemic.

It is worth noting, however, that the magnitude of this pandemic is **modest in historical context**. The Spanish flu killed at least 50 million people worldwide in 1918 when the global population was 1.8 billion<sup>58</sup>. Proportionately, to be as lethal as the Spanish flu, today a virus would need to kill at least 210 million people. But to date around 1.25 million have died from (mostly *with*) COVID-19. When we compare this also with the 60 million who ordinarily die each year from all causes worldwide, we find that we have had *just over a week* (1.1 week) of additional deaths this year from COVID-19: that barely registers when compared with many previous pandemics.

After more than a year, this pandemic has not yet reached the lethality (globally) of the 1969 Hong Kong flu which would have killed 2.1 million people this year, or the 1957 Asian flu which would kill 4.6 million people this year.

In Australia approximately 160,000 people die each year, around 440 every day during an average year. More than 1250 people died of the flu last year. 4300 people usually die of pneumonia every year. As at 27 September 2020, 870 people had died in Australia from or with COVID-19. Even assuming that all reported COVID-19 have been genuinely caused by this virus, that would amount to just under two days of annual additional deaths in Australia, to date. Nobody under the age of 40 has died in Australia from this disease by 2 October 2020 (the last time I checked).

Of the 6.359 million Victorians, about 40,000 people die each year of all causes. That’s about 110 a day, with a substantial proportion of these deaths taking place within the nursing homes. As at 27 September 2020, only five people below the age of 50 had died in Victoria out of 782 reported COVID-19 deaths. And even within the 50-plus age group, the risk has been disproportionately high for those over 70 (729 of the 782 deaths were in this age group). The elderly needed to have been protected – but were not.

I have tried to place this pandemic in context below in chart that I found in the CDC’s *Community Mitigation Guidelines to Prevent Pandemic Influenza – United States, 2017*<sup>59</sup>.

Moreover, as I show later in this document, if the great confusion (some could say deception) that is going on regarding both PCR tests and the way COVID deaths are counted is factored in, then the magnitude of this pandemic becomes even smaller.

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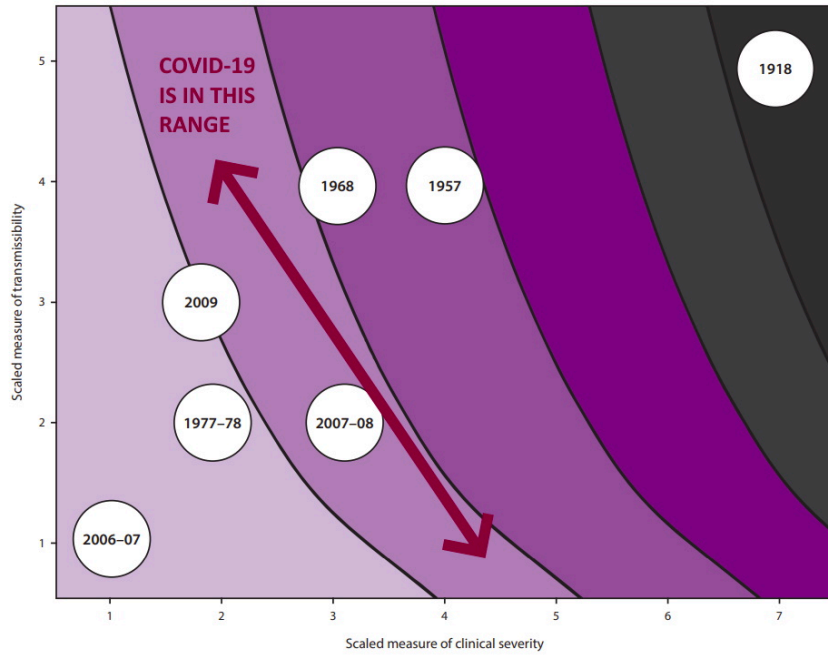
<sup>56</sup> <https://www.youtube.com/watch?v=5aMV8NSQ7is&feature=youtu.be>

<sup>57</sup> <https://www.thetimes.co.uk/article/simon-dolan-coronavirus-lockdown-restrictions-were-unlawful-entrepreneur-tells-judges-f3zl8sfjr>

<sup>58</sup> Centers for Disease Control and Prevention, “1918 Pandemic (H1N1 virus)”, website as at 2 October 2020. Short URL: <https://bit.ly/2S7GraC>.

<sup>59</sup> <https://www.cdc.gov/mmwr/volumes/66/rr/pdfs/rr6601.pdf>

FIGURE 4. Pandemic Severity Assessment Framework using surveillance indicators for the refined assessment\* of an influenza pandemic on the basis of past pandemics and influenza seasons



### 3. The structure of this complaint

The rest of this complaint is structured into the five parts outlined below.

#### 3.1 Part 1: The reasonable and proportionate way to practice public health

In part I of the complaint I outline the legal human rights available to Victorians and Australians. I then show that these were appropriately taken into account while planning for pandemics.

Pandemics can be, and are, fully anticipated. It is possible to contemplate all pandemic scenarios and prepare for them in advance. Legally and ethically valid plans were prepared across most parts of the world. Victoria, too, had its plan, called the *COVID-19 Pandemic plan for the Victorian Health Sector*<sup>60</sup>, which was published on 10 March 2020. It stated (correctly) that “COVID-19 is assessed as being of moderate clinical severity”. The plan did not limit itself only to a pandemic of moderate severity. It stated that “we are preparing so that we are ready to respond if a larger, or more severe outbreak occurs”.

According to all such approved pandemic plans, the legally valid public health response to the coronavirus pandemic would be driven by known science and proportionality. It would therefore not include:

- An attempt to lock down an entire country to make everyone wait for a vaccine
- A scare campaign to terrorise the people
- Shutting down of international borders, or shutting down only for a brief period
- Shutting down of domestic borders within the nation, or shutting down only for a brief period
- Mass-scale workplace shut downs (lockdowns)
- Coercive stay-at-home orders for the people (lockdowns) for 23 hours a day, within a ring of 5 kilometres (lockdowns)
- Curfew from 8 pm to 5 am
- Mandatory requirements for the use of masks, even outdoors
- Contact tracing after the initial stage of surveillance
- Mass testing without a person being hospitalized
- Inventing ‘new’ science and conducting mass-scale human experiments without ethics approval
- Deceptive or distorted data about cases and deaths.

For obvious reasons, none of these “public health” measures were included in these plans – but each of these were implemented during the pandemic, in complete breach of the plan as well as the laws.

I will also establish in this part that **it is perfectly possible to deal with all kinds of pandemics without committing mass-scale crimes against humanity**. I will do so mainly by discussing Sweden’s response to the coronavirus pandemic which was in accordance with its original plans, and therefore consistent also with all the other pandemic plans that were in place across the world.

The principles that Sweden used in implementing its policies were the same as those found in Victoria’s pandemic plan. None of these involved coercive actions by the police. As a result, Sweden did not commit any crimes against humanity.

#### 3.2 Part II: The Accused know that their actions breach the science and the laws

A pandemic is not time for experimentation. Only scientific conclusions that have been strongly established and agreed by public health and policy professionals in advance of a pandemic can be

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<sup>60</sup> <https://www2.health.vic.gov.au/about/publications/researchandreports/covid-19-pandemic-plan-for-vic>

legitimately applied during a pandemic. **Any deviation would constitute an experiment**, and depending on the nature of the experiment (such as if it were applied to humans), it would need to go through an ethics approval process – or at least (with most public health policy formal approvals through ethics processes are not generally progressed, which is a matter of concern in itself) a **detailed analysis of ethical implications**.

In this Second Part of the complaint I will show that Accused Group 1 knew that by discarding Victoria's Pandemic Plan and enforcing an entirely new, **experimental regime** on the people of Victoria they were in breach both of the science and the laws.

The Accused cannot claim to the Prosecutor of the ICC that they needed to “invent” these coercive experiments because the coronavirus pandemic was unexpectedly bad, because:

- The 10 March 2020 Pandemic Plan of Victoria<sup>61</sup> clearly stated that it was intended for all levels of pandemic. It was capable of handling the worst pandemic without imposing a Police State.
- The Plan had correctly noted that COVID-19 is a moderate pandemic. Since mid-April 2020 it has been clear as day that this is a relatively mild and manageable pandemic (without stretching hospital capacity) compared with many previous pandemics – even if we accept the reported data on COVID-19 deaths at face value.
- Trying to create new science during the chaos of a pandemic is simply not acceptable as way to design public policy, particularly a policy that is known in advance, in fact guaranteed, to harm people.

### 3.3 Part III: The catastrophic harms caused by the Accused

In Part III I will summarise the harms, including to the health of Victorians, to the social fabric and trust within Victoria, and to Victoria's economy, caused by the actions of the Accused. I will also outline similar harms reported from across the world which are surely happening in Victoria even if we may not yet have sufficient data for each of them.

There are mainly two types of harms that I will report to the ICC:

- **Harms of omission.** These include, for instance, the deaths of hundreds of elderly persons in Victoria caused directly by the fact that the Victorian Administering Authorities did not focus on the protection of high-risk groups such as the elderly and, instead, spent most of their energy on aggressively restraining those who were at minimal risk from the virus; and
- **Harms of commission:** These include mental and physical health harms to millions of Victorians, including short-and longer-term harms.

Even though precise estimates for the magnitude of these crimes are not available at present, a lot of information has become available. It can be said, without fear of contradiction, that the sum total of these thousands of ‘small’ crimes constitutes a **‘widespread or systematic attack directed against any civilian population’** that has caused **‘great suffering, or serious injury to body or to mental or physical health’**.

### 3.4 Part IV: Exploring the intentions of the Accused

It is my understanding from reading Article 7 of the Rome Statute that all that I am expected to prove is that the Accused committed ‘widespread or systematic attack directed against any civilian population’ ‘with knowledge of the attack’. That is something I prove in Part II of the complaint.

In addition, I am required by Article 7 to show that the attack was ‘pursuant to or in furtherance of a State or organizational policy to commit such attack’. There is overwhelming proof that these harms are a direct consequence of well-publicised State ‘public health’ policies which were novel, un-approved, unplanned,

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<sup>61</sup> <https://www2.health.vic.gov.au/about/publications/researchandreports/covid-19-pandemic-plan-for-vic>

and coercively implemented to the extent that one Victorian had to be sent into induced coma from Police brutalities<sup>62</sup> directed by Accused Group 1.

As noted earlier, Article 7 of the Rome Statute does not require the demonstration of criminal intent. That is perhaps because once harms on such a large scale are proven, it should not matter whether the perpetrator had ‘good’ or ‘bad’ intentions. The Accused may well claim ‘good’ intentions and they may well believe that they followed the laws, but that does not absolve them of responsibility for the harms.

In general, **good intentions are never enough to arrive at good public policy**. Good policy must consider all benefits and all costs. In this case the Accused focused entirely on ‘saving lives from COVID-19’ to the complete exclusion of all other considerations and ways in which humans can lose their lives. They have actively refused at each stage of the pandemic to recognize these other costs. In doing so they have displayed **callous and reckless disregard for these harms** despite these concerns bring brought to their notice by innumerable commentators (including by me, such as through my book).

I will prove that the Accused had knowledge of the harms they were causing and that, despite many warnings not to undertake such actions, they went ahead. They have displayed callous and reckless disregard for the loss of wellbeing of millions of Australians.

Further, the way the laws have been allegedly “followed” breaches the principles and the spirit of these laws. For example, just making a claim of the reasonability of an action does not meet the requirements of the law for transparency, full disclosure of information, analysis of less intrusive options and engagement with the community. The **pretense of compliance** with the laws does not make the initiatives lawful.

There is also preliminary evidence now about **the *potentially* criminal intent** of the Accused. While I will outline some such evidence, the evidence I have to date on this does not meet the standard of “beyond reasonable doubt” – therefore, I cite it more in the context of questionable intentions that have driven data distortions, scare-mongering, and propaganda.

### 3.5 Part V: Summary of my arguments and a preliminary list of witnesses

In the last part of the submission I will repeat the summary the arguments that I made in the first chapter and will outline a preliminary list of witnesses whose views the Prosecutor of the ICC might wish to ascertain.

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<sup>62</sup> <https://www.abc.net.au/news/2020-09-14/arrest-to-be-examined-by-victoria-police-professional-standards/12661334>

## Part 1: The reasonable and proportionate way to practice public health



## 4. Sweden as a role model of good public health practice

Except for Sweden and perhaps a few others, most nations have responded in 2020 to the coronavirus pandemic with public health policies that have caused severe harm to the mental and physical health of their people. While panicked responses were seen during the 2009 Swine flu pandemic, what we are witnessing this time around is in an entirely different league.

In a normal setting, public health depends on three pillars to deal with a pandemic:

- a strong understanding among public health practitioners of the laws and human rights;
- a strong understanding among public health practitioners of ethics; and
- honest implementation of the laws which necessarily requires risk-targeted, proportionate actions.

These pillars generally come together in the design of pandemic plans of jurisdictions.

In this chapter I outline key aspects of the approach taken by Sweden, which is the only nation that has acted in a textbook manner – fully compliant with the laws, human rights and ethics through risk-targeted, proportionate actions. It has not indulged in any scare-mongering or public health terrorism. It has actively defused hysteria and supported the mental well-being of its people in every possible way during this challenging time.

As a result, no additional harms have been caused to the mental and physical health of the Swedish people by government action (i.e. any harms over and above any harms naturally caused).

**The Swedish response forms the control case of this complaint.** Anyone who argues to the ICC that they ‘had’ to take strong and potentially criminal actions against the people because of the ‘magnitude’ of this pandemic, will have to prove how Sweden was able to deal with the pandemic without any panic or hysteria and without indulging in mass-scale crimes.

### 4.1 The World Health Organisation’s 2019 guidelines for flu-like pandemics

Not all viruses, even from the same group, have exactly the same characteristics. But in general, respiratory viruses like flu and coronavirus (the latter being a form of common cold) have characteristics which lead to certain types of public health policies and rule out others. The science behind such viruses has been extensively researched in the literature and within weeks of its advent it was clear that the coronavirus was behaving like the flu, albeit like a really bad flu. Although there is no specific “coronavirus plan” in any government, the standard “pandemic plan” is sufficient to deal with all such viruses.

The World Health Organisation is responsible for setting out the **state of knowledge** about how such pandemics are to be dealt with. This it did for flu-like pandemics through its October 2019 report, *Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza*<sup>63</sup>. In this complaint I consider the recommendations in these WHO guidelines to be **authoritative** for the state of knowledge that was known, or should have been known, to public health practitioners across the world. The document is literally a ‘textbook’ or Bible for public health practitioners.

The process of developing these WHO guidelines was comprehensive:

The guideline development process included the formation of four main groups: a World Health Organization (WHO) guideline steering group, a systematic review team from the University of Hong Kong, a guideline development group and an external review group. A technical consultation meeting for the development of this guidance was held in Hong Kong Special Administrative Region (SAR), China, on 26–28 March 2019. The systematic review

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<sup>63</sup> World Health Organisation, ‘Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza’, October 2019. Short URL: <https://bit.ly/3mPsmg0>.

team presented the outcomes of the systematic review. The quality of evidence was ranked as high, moderate, low or very low, based on each study’s risk of bias (including publication bias), consistency, directness and precision of results. Two reviewers independently assessed the risk of bias and the quality of evidence. Disagreements were resolved by a third reviewer if consensus could not be reached.

The guidelines carefully (and transparently) reviewed the quality of scientific evidence for a range of non-pharmaceutical public health interventions. Most importantly, in conducting its analysis, the WHO carefully considered the **ethical implications of each intervention**.

I bring to the ICC’s attention the following extract from Table 1 in the report:

**Table 1. Recommendations on the use of NPIs by severity level**

SEVERITY	PANDEMIC*
Not recommended in any circumstances	UV light Modifying humidity <u>Contact tracing</u> <u>Quarantine of exposed individuals</u> Entry and exit screening Border closure

NPI: non-pharmaceutical intervention; UV: ultraviolet.

In this figure, above, I have underlined two key aspects: that contact tracing and quarantine of exposed individuals are ‘not recommended in any circumstances’. But also worth noting is that border closures are not recommended in any circumstances. This table frames my analysis in this complaint.

As I will show elsewhere, quarantines are completely different to lockdowns. Quarantines could well be appropriate for use in certain types of pathogens but the WHO’s guidelines do not recommend them in any circumstances for flu-like viruses. This recommendation might sound counter-intuitive but it is based on through analysis of the evidence and ethics of the situation.

Thus, at page 16 of its report the WHO guideline states: “Home quarantine of exposed individuals to reduce transmission is not recommended because there is no obvious rationale for this measure, and there would be considerable difficulties in implementing it”.

The following is its ethical analysis of quarantines for flu-like pandemics:

As with isolation, the main ethical concern of quarantine is freedom of movement of individuals. However, such concern is more significant for quarantine, because **current evidence on the effectiveness of quarantine varies**, and the measure involves restriction of movement of asymptomatic and mostly uninfected individuals. **Mandatory quarantine increases such ethical concern considerably compared with voluntary quarantine**. In addition, **household quarantine can increase the risks of household members becoming infected**.

But stay-at-home orders (lockdowns) are not even quarantines, because they are imposed on everyone regardless of whether someone has been exposed to a pathogen. Lockdowns are mass-imprisonment of the entire population regardless of an individual’s infection status.

Since the very idea of quarantines has been rejected after rigorous analysis, the possibility of stay-at-home orders (lockdowns) was never even considered in the WHO’s guidelines.

It should come as no surprise, therefore, that Gauden Galea, the WHO’s representative in China made it very clear on 24 January 2020 when China imposed lockdowns in Wuhan that: ‘trying to contain a city of 11 million people is **new to science**. The lockdown of 11 million people is unprecedented in public health history, so it is certainly **not a recommendation** the WHO has made.’<sup>64</sup>

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<sup>64</sup> Senger, Michael P., ‘China’s Global Lockdown Propaganda Campaign’, *Tablet*, 16 September 2020. Short URL: <https://bit.ly/2RXS0RA>.

Nothing “new” to science can be implemented during a pandemic, particularly a policy that has been found to be unsuitable even for Ebola. But the key point made by the WHO was that lockdowns are “not a recommendation” of the WHO.

To recap, a good public health response for a flu-like virus would **not** include lockdowns, border closures or contact tracing (after an initial stage to assess the nature of the virus).

I wish to note again that this WHO’s report’s recommendations apply *only* to flu-like viruses, not to viruses with entirely different characteristics, such as Ebola, which is enormously lethal.

Ebola emerged in 1976 in Zaire. In the West African outbreak, which began in December 2013, more than 27,000 people have been infected and more than 11,000 have died, according to the WHO. Over the years, mortality rates have ranged from 25% to 90%.

According to the CDC,

Ebola is spread by direct contact with the body fluids of a person who is sick with or has died from Ebola, or from objects contaminated with body fluids of a person sick with Ebola or who has died of Ebola. Flu-like viruses, however, can spread from droplets and aerosols during a cough, sneezing or even talking. People with flu can spread the virus both before and during their illness<sup>65</sup>

Basically, flu-like viruses transmit even in the early stages of the disease when an infected person might not be experiencing any symptoms. Second, Ebola is very lethal. Therefore, lockdowns have actually been attempted while trying to control Ebola.<sup>66</sup> (But as I show later, even for Ebola, it was the **targeted small-scale cordons that proved effective**, not large-scale community-wide lockdowns.)

Nevertheless, this approach is not even remotely applicable to the novel coronavirus. That is the key point to note.

But not just lockdowns, the Victorian Administering Authorities have applied massive pressure upon Victoria’s population to get tested. Mass testing has been considered suitable even though it is not recommended in any circumstances by the WHO. Threats of mandatory testing in workplaces have been made, as well – in violation of the WHO’s guidelines.

It is not just in Victoria that governments are have dumped all the science and all the laws. There are reports from the USA of some states trying to coercively test even school children. The USA’s CDC has, however, come down heavily on 10 October 2020 against such attempts<sup>67</sup>:

The CDC is condemning mandatory coronavirus testing in K-12 schools, updating guidance after New York City began random testing this week on thousands of students and educators. In revamped advice published this week, the Centers for Disease Control and Prevention endorses voluntary “surveillance” testing in schools but decries any mandates. **“It is unethical and illegal to test someone who does not want to be tested**, including students whose parents or guardians do not want them to be tested,” the CDC said.<sup>68</sup>

Had this “textbook” of the WHO’s guidelines been followed in Victoria, this complaint to the ICC would not exist.

## 4.2 Sweden’s actions are the textbook implementation of W.H.O.’s guidelines

As noted earlier, Sweden has been managing this pandemic without the slightest panic – and therefore without brutalising its people.

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<sup>65</sup> [https://www.cdc.gov/vhf/ebola/pdf/is-it-flu-or-ebola.pdf?\\_cid=cs\\_021](https://www.cdc.gov/vhf/ebola/pdf/is-it-flu-or-ebola.pdf?_cid=cs_021)

<sup>66</sup> <http://www.nytimes.com/2014/08/13/science/using-a-tactic-unseen-in-a-century-countries-cordon-off-ebola-racked-areas.html>

<sup>67</sup> <https://www.politico.com/news/2020/10/15/cdc-mandatory-school-testing-429667>

<sup>68</sup> <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-testing.html>

Sweden's response to the pandemic has been entirely in accordance with the WHO's guidelines, consistent with the science, with human rights and ethics. The Swedes were provided with relevant information about risks and asked to take responsibility for their own health, including through voluntary hand hygiene and social distancing recommendations. They then chose their own preventative actions voluntarily. No police was set upon them to beat them up and send them into induced coma<sup>69</sup>. No fines were issued, no rings of steel established to surround everyone with guns.

It may come as a great surprise to many Victorians who have been indoctrinated into thinking that such brutality is the only way to deal with pandemics, that instead of being terrorized by their government at every step and in every possible way during the pandemic, the Swedes were offered reassurance, comfort, hope and faith that things will work out well. They were given honest information and not lies at every step. That is how a decent society, a free society that respects individuals for who they are, operates.

The Swedish people are blessed that they are not treated by politicians as their private chattel. That is not how Australian politicians think about Australians. (It also appears, based on the support in the polls for Mr Andrews during this period, that a good proportion of Australians see themselves as private property of politicians and are content to be muzzled by the Police – although this might be an aberration due to the fear psychosis engendered by Mr Andrews.)

#### ***4.2.1 No border closure, mass-scale workplace shutdown or stay-at-home orders***

As noted above, the most important aspects of Sweden's policy response are what it did not do.

- It did not shut down its international borders to make everyone wait for a vaccine (any vaccine remains entirely voluntary in Sweden). Its citizens remain free to leave and return at any time.
- It did not shut down domestic borders or create a 'ring of steel' outside its cities.
- It did not enforce the mass-scale shut down of workplaces.
- It did not issue coercive stay-at-home orders (lockdowns) with a 5 km boundary, one hour permission to go outside, and curfews.
- It did not engage in a scare campaign to terrorise the people.
- It did not force people to wear a mask even outdoors and get the Police to beat them up brutally if they did not do so.
- It did not engage in mass-scale contact tracing. It mainly tested only those who need to be hospitalised. Only 0.09% of its population had been tested by the end of April 2020, by which time the main phase of its pandemic was over.
- It did not shut down its primary schools since this novel coronavirus has virtually no effect on children. In fact, children getting infected and becoming immune remains a main line of scientific defence against the spread of virus to the elderly.

#### ***4.2.2 Risk-based and proportionate interventions***

The Swedish government put most of its effort on protecting the elderly and those with serious pre-conditions. Once the elderly were safely cocooned, the remaining people were able to operate at a level of normalcy. This normalcy was, of course, different from regular normalcy and included working from home where possible.

#### ***4.2.3 Honest and clear goal of flattening the curve – no secret focus on eradication***

Sweden's goal was to 'flatten the curve' of hospital admissions by protecting the elderly and vulnerable. This is also what the Victorian Pandemic plan had said. This being a relatively mild virus, there was never any pressure on the ICUs in Sweden. **According to Andres Tegnell, at the pandemic's peak in March-April, there was over 20 per cent spare capacity in Sweden's ICUs.**<sup>70</sup>

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<sup>69</sup> <https://www.abc.net.au/news/2020-09-14/arrest-to-be-examined-by-victoria-police-professional-standards/12661334>

<sup>70</sup> <https://www.youtube.com/watch?v=eyZtuzOIY7M>

And this, despite having 1 in 5 persons over the age of 65 compared with only 1 in 7 persons in Australia. There was no way that Australia – with an extremely young population and high levels of Vitamin D, being soaked in sunlight – could possibly have had any problems with hospital capacity had they followed the pandemic plan’s goal to flatten the curve.

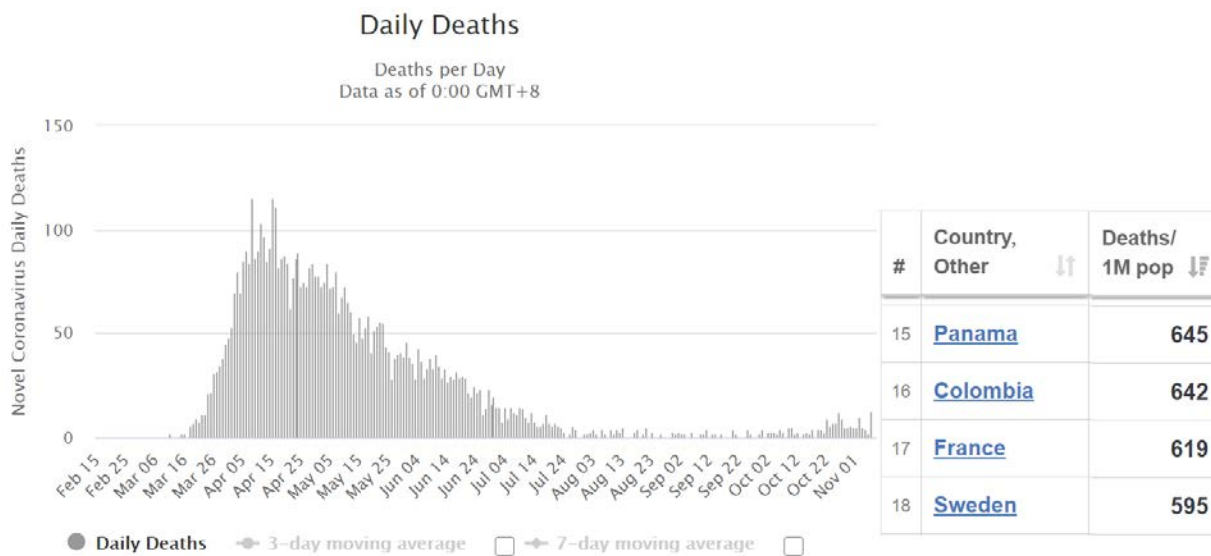
Most importantly, Sweden did not lie to its citizens by claiming it was flattening the curve while in actual practice implementing an eradication strategy, like the lying politicians of Australia have done.

#### 4.2.4 *Sweden’s results are superlative but that is not relevant to this complaint*

Sweden made some mistakes initially, such as insufficient protection in its privately managed nursing homes. Despite that, and despite having an extraordinarily high population of the elderly its overall “performance” in terms of relatively low deaths rates per million is nothing short of amazing.

As at 9 November 2020, Sweden’s death rate per million was the 18<sup>th</sup> in the world. Seventeen countries, most of which imposed extremely coercive lockdowns, had higher death rates – which is further proof that, as expected, lockdowns not only do not work, they increase virus deaths. That is because unless we allow the young to acquire immunity the virus will continue to spread and kill the maximum number of the elderly and vulnerable. Even the worst flu-like pandemic does not normally infect more than around 25-33% of the population of a nation<sup>71</sup>, but if artificial brakes are applied to its rapid spread (and rapid immunity by the population which is least vulnerable, in this case the young) then it can linger on for longer, infecting more than this proportion. That is what has happened in most nations with lockdowns.

Sweden’s daily deaths chart, below (from Worldometers), is a **textbook example of flattening of the curve**. The virus tapered off in summer and is now returning in the form of seasonal common cold.



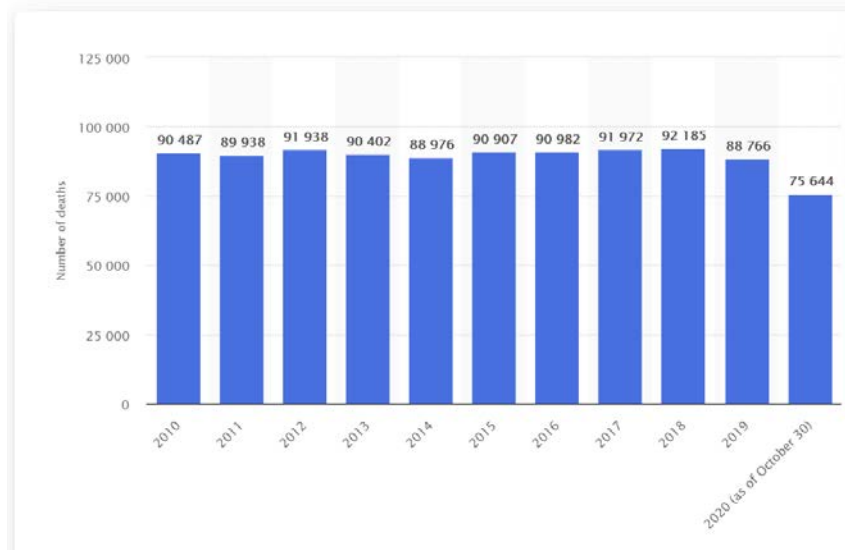
Sweden is also on track to have **virtually no extra deaths over the whole year in 2020 or just a small additionality** that could easily form part of normal variation.

The following chart, taken from Statista<sup>72</sup>, suggests that Sweden is likely to end up the year 2020 with around 90,000 deaths plus or minus a couple of thousand, virtually the same as the average number of deaths per year over the past 10 years. It will be hard in retrospect, looking at the total deaths in Sweden this year, to detect this pandemic. A key reason for this is that deaths have plummeted after the peak in mid-April 2020. The COVID pandemic shortened the life by a few months of many of the elderly in the nursing homes who were already extremely sick and **would have died in 2020 anyway**.

<sup>71</sup> <https://timesofindia.indiatimes.com/blogs/seeing-the-invisible/why-less-than-25-of-the-worlds-population-is-likely-to-get-covid-19/>

<sup>72</sup> <https://www.statista.com/statistics/525353/sweden-number-of-deaths/>

## Number of deaths in Sweden from 2010 to 2020



But for the purposes of this complaint it would not matter even if Sweden did not get a close-to-perfect score in terms of public health outcomes for its citizens. That is because **it did not cause any additional deaths** from coercive lockdowns.

Sweden's example also proves conclusively that it is *entirely* possible to deal with flu-like pandemics without committing mass-scale crimes against humanity. All that is needed is that the laws of the nation be followed.

As I will show in the next three chapters, the laws of Australia and Victoria fully protect human rights and mandates a sensible, ethical approach towards public health. But in Australia and Victoria political leaders from both sides of the spectrum have united during 2020 to **break the laws of the land** on a scale unprecedented – and continue to do so.

## 5. Ethical considerations in designing public health policy

If it was ethical to kill some people or to reduce their lifespan under certain circumstances as part of public health practice in order to save others, then one would expect extensive discussions about this novel approach in the public health literature, and considerable debate about it in the philosophy departments of the world's universities. Presumably, public health ethics and the laws would then authorise such action after detailed consideration.

But while there is robust public health literature on various ethical aspects of public health policy, there is no literature that even considers the possibility of killing someone or reducing their lifespan – let alone the carnage currently being caused by lockdowns – in order to presumably save someone's life.

That is because the very possibility of such an intervention was never imagined, it being entirely out of the bounds of ethical consideration.

Instead, the public health literature does consider a range of small harms that might arise from relatively minor coercive public health measures and has aggressively and actively sought to minimise or compensate for such harms.

### 5.1 The crucial significance of ethical frameworks in public health policy

Plato and Aristotle wrote about the concept of *phronesis* – the wisdom, judgement and ethics that leads to the common good. For a field of knowledge like public health whose practitioners can, during times like this coronavirus pandemic, gain extraordinary powers over the people's lives, there is a crucial need to develop such wisdom.

Public health educators are aware of this and have long recognised the need for such training:

The Association of Schools of Public Health has identified professionalism—an **ability to demonstrate ethical choices, values, and practices in decision-making** and to commit to the practice of personal and professional values—as one of the cross-cutting or interdisciplinary competencies necessary for graduate education in public health.<sup>73</sup>

Likewise, in 2002, Upshur wrote:

Surveys done by Coughlin and others have pointed out the **relative lack of systematic instruction in ethics in both public health and epidemiology**. Thus, there is a **need for ethics instruction in both epidemiology and in schools of public health**.<sup>74</sup>

Work at least since the early 2000s has attempted to embed ethical frameworks and thinking into public health practice. For instance:

- In 2002, a document issued by the Public Health Leadership Society laid out 12 *Principles of the Ethical Practice of Public Health*<sup>75</sup> (see box below).
- In 2005, the University of Toronto issued, *Ethical considerations in preparedness planning for pandemic influenza - A report of the University of Toronto Joint Centre for Bioethics Pandemic Influenza Working Group*<sup>76</sup>.

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<sup>73</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2431097/>

<sup>74</sup> R E G Upshur, 'Principles for the justification of public health intervention', *Canadian Journal of Public Health* 93/2 (2002), pp. 101-103. <http://www.jcb.utoronto.ca/people/publications/cjph2002.pdf>

<sup>75</sup> [https://www.apha.org/-/media/files/pdf/membersgroups/ethics/ethics\\_brochure.ashx](https://www.apha.org/-/media/files/pdf/membersgroups/ethics/ethics_brochure.ashx)

<sup>76</sup> [http://www.jcb.utoronto.ca/people/documents/upshur\\_stand\\_guard.pdf](http://www.jcb.utoronto.ca/people/documents/upshur_stand_guard.pdf)

- In 2007 the report of a workshop held on September 19-20, 2006 in Washington, DC by the Institute of Medicine's Forum on Microbial Threats was released as book, *Ethical and Legal Considerations in Mitigating Pandemic Disease: Workshop Summary*<sup>77</sup>.

**Box**

**12 Principles of the Ethical Practice of Public Health**

(by the Public Health Leadership Society)

1. Public health should address principally the fundamental causes of disease and requirements for health, **aiming to prevent adverse health outcomes.**
2. Public health should achieve community health in a way that **respects the rights of individuals** in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an **opportunity for input from community members.**
4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.
5. Public health should seek the information needed to implement effective policies and programs that **protect and promote health.**
6. Public health institutions should **provide communities with the information they have** that is needed for decisions on policies or programs and should **obtain the community's consent** for their implementation.
7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.
8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.
9. Public health programs and policies should be implemented in a manner that **most enhances the physical and social environment.**
10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
11. Public health institutions should ensure the professional competence of their employees.
12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

If Victoria's Chief Health Officer had abided by the 12 principles outlined above he would have done the following:

*Principle 1.* He would have identified ways to increase immunity in the community, such as by getting Victorians to get some sun and boost their level of Vitamin D. Instead, he locked them up indoors for 23 hours a day for months on end.

*Principle 2.* He would not have terrorised, fear-mongered, or otherwise created panic among Victorians. Instead, he terrorised them with false and grossly exaggerated claims.

*Principle 3.* He would have sought inputs from the community on his proposed policies. Instead, he has issued innumerable arbitrary directives that fail the most basic test of scientific proof and common sense – and blocked me on Twitter on asking for proof.

*Principle 6.* He would have provided detailed and truthful information to Victorians about all aspects of the pandemic. Instead, he has provided data much of which is deceptive (I will explain this later). He also does not respond to questions – and uses obscure 'models' that have absolutely nothing to do with science.

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<sup>77</sup> [https://www.ncbi.nlm.nih.gov/books/NBK54167/pdf/Bookshelf\\_NBK54167.pdf](https://www.ncbi.nlm.nih.gov/books/NBK54167/pdf/Bookshelf_NBK54167.pdf)



One demonstration that ethical ways of thinking are starting to have a real effect on the profession is the process of development of WHO's 2019 guidelines. Its recommendations about public health interventions are based on careful consideration of ethics. It not only considers the evidence, risk and proportionality but then carefully examines the ethics of each option before providing a verdict.

Of course, if we only consider the actions of Australia's public health practitioners like Dr Sutton of Victoria, we would not know that any discussion of ethics has ever taken place in the public health portals.

## 5.2 Consideration of unintended harms by the public health literature

A number of papers over recent years in the public health literature have considered the harms that might arise from coercive public health interventions. Such papers include:

- 2004: "Balancing benefits and harms in public health prevention programmes mandated by governments"<sup>78</sup>;
- 2014: "Adverse effects of public health interventions: a conceptual framework"<sup>79</sup>;
- 2018: "Modeling Health Benefits and Harms of Public Policy Responses to the US Opioid Epidemic"<sup>80</sup>; and
- 2019: "Understanding the unintended consequences of public health policies: the views of policymakers and evaluators"<sup>81</sup>.

The 2014 paper cited above comes closest to acknowledging that public health policy can cause grievous harm, but paper does not then develop the idea further to consider the possibility that public health policy might actually kill people. All it does is to call for the need to recognise all such harms:

Whether intended or unintended, direct or indirect, interventions of any kind are **likely to have wider effects than usually acknowledged by evaluators**. For ethical and methodological reasons, it is imperative that the harmful effects of interventions are considered, collected and if possible alleviated by evaluators and designers of interventions.<sup>82</sup>

Further, it notes:

[U]nintended adverse effects may also frequently result from well-intentioned interventions, but are rarely addressed in the literature. ... [I]n many areas of public health research, the picture is highly unclear: most systematic reviews do not extract data on adverse effects, and those that do often find little or no evidence. In this respect, public health contrasts markedly with clinical medicine, where there is a substantial literature on adverse events and **patient safety, and the Hippocratic injunction to 'do no harm' is arguably more salient**.

This is stinging criticism, that even in 2014 the profession had not started following even the basic ethical practice of the Hippocratic Oath.

The 2019 paper cited above notes:

[I]n fields such as public health ... [l]ess attention has been paid to the unintended consequences (UCs) of interventions, that is, the ways in which interventions may have impacts – either positive 'spillover' effects or negative harms – not planned by those implementing them. ... [U]nintended consequences may fall most heavily on the most disenfranchised.

Adverse effects have always been a part of clinical research. Understanding the side effects of drugs and procedures is as important as their clinical effectiveness, when deciding whether to

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<sup>78</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC443455/>

<sup>79</sup> <https://jech.bmj.com/content/jech/68/3/288.full.pdf>

<sup>80</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6137764/>

<sup>81</sup> Oliver, K., Lorenc, T., Tinkler, J. et al. Understanding the unintended consequences of public health policies: the views of policymakers and evaluators. *BMC Public Health* 19, 1057 (2019). <https://doi.org/10.1186/s12889-019-7389-6>

<sup>82</sup> Lorenc T, Oliver K, 'Adverse effects of public health interventions: a conceptual framework', *J Epidemiol Community Health* 2014; 68:288-290. <https://jech.bmj.com/content/68/3/288.full>

use them in treatment. Clinical researchers are required to report and monitor adverse effects, interventions go through multiple rounds of testing to explore possible effects, and the modes of action of clinical interventions are usually well-articulated. **In public health, however, it is harder to connect changes in social outcomes to specific interventions, and even harder to articulate mechanisms underpinning these changes.**

[O]ur current understanding of how policies are made suggests that there is limited testing of [public health] policies.

It was accepted [by public health practitioners who were surveyed by the study] that **policy-makers knew that sometimes not all policies worked for all, even harming some. Politically, this means that discussion of UCs, let alone evaluation of them, was challenging.**

Most participants felt that UCs were very common.

Policy-makers are trained to develop policy using rational-actor models, which participants felt were not always, perhaps never, appropriate. **Policy silos meant underlying assumptions were not challenged.** It was widely acknowledged that blunt policy tools have multiple effects, and thus it is not always easy to carry out a ‘surgical strike’ to change one outcome – yet silos tended to reinforce this linear way of thinking about outcomes, populations and contexts which are in reality complex.

Unlike clinical trials, social policies do not undergo several rounds of testing and refinement.

[P]olicy actors **may have to emphasise a narrow subset of their aims for reasons of acceptability or political strategy.**

[O]nce a policy has been put in place, especially if it is costly or high-profile, it can be very hard to change, leading to negative effects.

Politicians prefer narratives of success, and are under pressure not to admit to ‘U-turns’. **Admitting UCs is equivalent to admitting failure** and this can only be done with political support. **Public opinion and scrutiny of politicians can lead to positive spin rather than reflective practice.**

At times, policy-makers may find it easier to respond to evidence of UCs if they are not particularly wedded to a policy. At other times, they may react with denial / anger – it is hard to admit something doesn’t work, especially if it is a core ideological belief held by the proponent.

**[W]hile it may not always fit the political discourse to admit it,** if are made aware of UCs, they may address them behind the scenes, by running parallel policy development processes, for instance.

[Practitioners] **should list the consequences,** considering the **whole life-cycle of the policy.**

Accepting that trade-offs need to be made, and communicating these is essential to a transparent system.

[T]he identification of policies and goals is itself always political in nature, and implicitly prioritises the interests of certain actors or groups over others.

[W]hile all participants accepted the idea that policies and interventions may have unexpected effects, this is rarely taken into account by research or evaluation funding.

This (the 2019) paper also, like the 2014 paper, recommended the “importance of identifying unintended consequences for public health in particular, which can affect entire populations”.

Unfortunately, public health professionals do not currently identify harms – at least we know that Dr Sutton of Victoria has actively **refused** to do so, and if he is challenged, he blocks them from a Twitter account that is managed by taxpayer funded resources. Not quite ethical, the Victorian public health practitioners.

### 5.2.1 *Compensatory policy for economic harms from restrictive measures*

The public health literature dwells quite a bit on any economic harms that might arise from restrictive measures:

An important part of infectious disease control is to prevent further spread of disease during an outbreak. This is especially true for respiratory infections like influenza, where coughing, sneezing or talking are important means of transmission, as it makes sense to limit the number of contacts between healthy people, and to avoid large group meetings or other risk situations. In an outbreak, public health authorities may decide to cancel fairs, football matches, to close schools, crèches, companies or shops. Again this will be a clear – but sometimes necessary – restriction of liberties for many people, but moreover, these measures will have significant impact on their daily life, as well as on their financial resources or their property. For example, the closing of factories, offices and shops and cancelling of mass-events will involve financial burdens for companies and citizens. Employees may run the risk of losing their job if their place of work is closed for a long time. Such burdens will be faced particularly severely by vulnerable groups who are social-economically worse-off, for example employees with temporary jobs or no contracts at all. **If certain groups of people run risks and bear significant extra costs due to public health measures, the question arises whether they would have a justified claim to receiving compensation for their losses. Government-based compensation schemes can be considered as an expression of solidarity:** if there is a public health threat then all citizens should be willing to share in the costs of protective measures – after all, if such measures are effective then everyone will benefit.<sup>83</sup>

This is also discussed in papers such as:

- S. Holm, ‘Should persons detained during public health crises receive compensation?’, *Journal of Bioethical Inquiry* 6/2 (2009), pp. 197–205.
- A. M. Viens, C. M. Bensimon, and R. E. G. Upshur, ‘Your liberty or your life: Reciprocity in the use of restrictive measures in contexts of contagion,’ *Journal of Bioethical Inquiry* 6/2 (2009), 207–217.

This literature suggests that the society should compensate for such financial harms. That makes sense, but obviously we cannot compensate anyone for shortening their life. So this principle does not apply to physical and mental harms.

### 5.2.2 *Mental harms from quarantines must be minimised*

Quarantines are a coercive policy that can cause not just economic but mental harms. There is robust public health literature about the need to assess, understand and minimise such harms.

As noted in the book, *Public health: ethical issues* by the Nuffield Council on Bioethics (2007)<sup>84</sup>:

Liberty-infringing measures to control disease, such as **compulsory quarantine and isolation, rank towards the top of the intervention ladder.** The ethical justification for such measures involves weighing the classical harm principle on the one hand, and individual consent and the importance of avoiding intrusive interventions on the other.

A 26 February 2020 paper (“The psychological impact of quarantine and how to reduce it: rapid review of the evidence” by Samantha Brooks et. al. in *The Lancet*<sup>85</sup>) notes that:

Most reviewed studies reported negative psychological effects including **post-traumatic stress** symptoms, confusion, and anger. Stressors included longer quarantine duration, infection fears, frustration, boredom, inadequate supplies, inadequate information, financial loss, and stigma. Some researchers have suggested **long-lasting effects.** In situations where quarantine is deemed necessary, officials should **quarantine individuals for no longer than required, provide clear rationale for quarantine.**

Other discussions of harms from quarantine include the following – by Marcel Verweij:

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<sup>83</sup> Verweij, Marcel, “Infectious disease control”, in Dawson, Angus (ed.) *Public Health Ethics: Key Concepts and Issues in Policy and Practice*, Cambridge University Press, 2011.

<sup>84</sup> <https://www.nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf>

<sup>85</sup> [https://www.thelancet.com/article/S0140-6736\(20\)30460-8/fulltext](https://www.thelancet.com/article/S0140-6736(20)30460-8/fulltext)

From an ethical point of view, **the most appalling public health measures are quarantine and isolation of persons.** Both concepts are used for the same sort of measures, but it makes sense to distinguish them in a way that is morally relevant.

Gostin defines **isolation** as the physical separation and confinement of an individual or group of individuals who are known to be infected with a contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals (Gostin, 2000: 210). **Quarantine** also involves separation, but this applies to *healthy* individuals or groups who may have been exposed to a contagious or possibly contagious disease.

Both isolation and quarantine measures can be applied to large groups. As was illustrated in the historical examples given above, extreme forms of isolation or quarantine may be similar to putting individuals in jail, excluding them from public life completely – possibly for the rest of their lives. Even if the means of separations are less severe, the impact on personal life may be overwhelming, as it **combines most of the adverse events that arise in all other public health measures.**

Isolation and quarantine effectively make it impossible for individuals to continue their lives as planned, to fulfil their jobs and responsibilities, to earn their living, to see and care for their loved ones.

The separation of persons also has an important symbolic dimension. Individuals or groups are labelled as dangerous, which could undermine their sense of being part of a community. Being separated from the community, there is a risk that isolated and quarantined groups will not have sufficient access to such basic needs as food or health care. In short, all quarantined and isolated individuals are deprived of at least some essential sources for well-being.

Moreover, quarantine measures may mean that all suspected persons are held together: this includes persons who are in fact exposed to the disease and may get ill in the short term, as well as those who are only believed to be exposed but are in fact not infected. **The non-infected persons may be detained with people who may infect them.**

In this way, **quarantine procedures, while intended to reduce the risks of contagion within the larger population, may actually increase the risk for (at least part of) the quarantined population.**

It is clear that isolation and quarantine procedures can have extremely adverse implications for individuals and that procedures **should be applied with due care.**

In the last few decades, much work has been done to develop procedures and regulations in such a way that risks for quarantined persons are minimized, and that they at least have rights to due process that protect citizens from arbitrary detention. However, even if these measures are applied with due care, they remain morally problematic and require a strong moral justification.<sup>86</sup>

It is clear that given the huge mental harms caused, coercive measures such as quarantines can only be justified for extremely lethal infectious diseases. Such quarantines are not recommended for flu-like viruses in the October 2019 WHO guidelines.

The Victorian Administering Authorities have brazenly violated this scientific and ethical position by implementing a policy that is far worse than quarantines (lockdowns and curfews), while refusing to even identify the harms.

### 5.3 The ethical reason why cost-benefit tests cannot be used to assess lockdowns

A robust literature has arisen in recent times on the application of cost-benefit analysis to lockdowns. I believe that while such analysis is technically feasible, it faces a fundamental ethical problem.

Unfortunately, most economists have lost sight of the fact that theirs is a branch of moral philosophy. They have forgotten the classical tradition which considered moral sentiments first and foremost, while setting markets and government action in the broad framework of ethics. They have failed to morally

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<sup>86</sup> Verweij, Marcel, "Infectious disease control", in Dawson, Angus (ed.) *Public Health Ethics: Key Concepts and Issues in Policy and Practice*, Cambridge University Press, 2011.

distinguish the analytical issues that arise while considering the consequences of the impacts of government expenditure on a health policy from a policy of mass-scale imprisonment which actively harms people.

In normal public health policy, we may impose a financial cost on the business community (say, shutting down a restaurant which has cockroaches) in order to *save* some lives that would have been otherwise lost due to what economists call ‘market failure’. But lockdowns don’t save lives that would be lost due to market failure (in this case “natural causes”) – they actually kill or shorten the lives of unspecified persons (e.g. a young person who may commit suicide) in order to purportedly save the lives from COVID-19 of other unspecified persons.

The implications of coercive lockdowns are therefore best considered like we might think about a Trolley Problem and not the way we might think about a Benthamite comparison of utilities. How can anyone possibly calculate the ‘total’ happiness generated (‘the greatest good of the greatest number’) by a government policy that ends up killing thousands, possibly millions across the world? Can we even try to value the ‘benefit’ to society from a crime committed in the name of public health?

One remedy for this ethical conundrum is to conduct the usual cost-benefit analysis (CBA) as a first test of a lockdown policy. Then, even if the CBA proves that lockdowns are ‘justified’ (in actual fact, no CBA does that) we could add a note that lockdowns are fundamentally immoral and that we have also prepared an associated Crimes Register to list the number of people the government is willing to kill or whose life it is willing to shorten in order, purportedly, to save some other people from COVID-19.

Basically, we cannot compare lives taken by Nature with lives taken by Man (government). That is why the ‘human cost’ side of lockdowns is inevitably a list of crimes.

This suggests to me that that economists might also need to get back to the basics and get some training in ethics in order to distinguish the impacts of a spending policy or a policy that saves lives, from a policy that kills.

## 6. International human rights covenants that protect Australians

The principles of due process and proportionality that have been discussed so far are embedded into number of international covenants that shelter human rights across the world, including during public health emergencies. I show in this complaint that the Victorian and Australian Governments have contravened all these covenants.

### 6.1 Universal Declaration of Human Rights

Post WWII, fifty-one nations, including Australia, founded the United Nations (UN) to maintain international peace and security and promote social progress and rights. Australia was a founding member of the UN and one of only eight nations involved in the drafting of the Universal Declaration on Human Rights (UDHR)<sup>87</sup> – a set of rights for all people and all nations, adopted on 10 December 1948.

Although not a legally binding treaty, the UDHR establishes an internationally recognised set of standards applicable to all persons without qualification. It is unique in that it represents a worldwide charter of rights, proclaiming universal and fundamental freedoms which transcend national, religious, cultural and ideological factors. In this respect, it remains the most fundamental expression of international human rights standards.

The UDHR provided the foundation for the *International Covenant on Civil and Political Rights* (ICCPR) and the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), as well as the subsequent development of other international human rights standards.<sup>88</sup>

Article 3 of the Universal Declaration of Human Rights provides that ‘Everyone has the right to life, liberty and security of person’. Article 29(2) of the Universal Declaration of Human Rights sets out the ultimate purpose of law:

In the exercise of his rights and freedoms, everyone shall be **subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others** and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

A number of treaties followed from the UDHR. Australia is signatory to seven major human rights treaties and numerous conventions. I will focus mainly on two covenants which interact the most with the impacts of public health on human rights.

### 6.2 International Covenant on Civil and Political Rights

A number of key human rights are protected in the ICCPR such as through articles 12, 19, 21, and 22.

Article 12: The right to movement and to leave a country

Article 19: The right to freedom of expression

Article 21: The right to peaceful assembly

Article 22: The right to freedom of association.

Australia’s ongoing, seven-month long but indefinite ban on outbound travel of its citizens contravenes Article 12:

*Article 12*

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<sup>87</sup> <https://www.un.org/en/universal-declaration-human-rights/>

<sup>88</sup> <https://www.dfat.gov.au/sites/default/files/human-rights-manual-fourth-edition.pdf>

1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.
2. Everyone shall be free to leave any country, including his own.
3. The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order (ordre public), **public health** or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant.
4. No one shall be arbitrarily deprived of the right to enter his own country.

Even if we allow the right of Australia to close its borders temporarily in a great crisis (a commitment to close borders for two years is not temporary – that too, for a pandemic which is nowhere in the league of Asian or Hong Kong flu, leave alone Spanish flu), **Australia cannot restrict its residents from leaving Australia** under Article 12(3) since someone who leaves Australia may present a public health risk to the country to which he depart: but such public health risk is not Australia's business.

Moreover, thousands of Australian citizens have not been allowed to return home.

I will discuss this further, separately.

### 6.2.1 *Permissible limitation of human rights to advance public health*

The rights in the ICCPR and other covenants can be limited (or “derogated”) in the interest of ‘public health’, among other possible reasons. But these limitations do not overthrow the right. As Australia’s official document on this matter states:

[I]t is accepted that limitations should have a clear legal basis, pursue a legitimate objective and **should not destroy** or impose improper limitations on the enjoyment of **these rights**.<sup>89</sup>

In this regard:

Guidance on when these rights can be restricted is commonly found in two sources: **first**, in the **Siracusa Principles**, a non-binding document developed by non-governmental organizations and adopted by the United Nations Economic and Social Council in 1984; and **second**, in the **authoritative interpretations of the United Nations Human Rights Committee**, the body charged with overseeing state implementation of the ICCPR.<sup>90</sup>

### 6.2.2 *The Siracusa Principles*

The Siracusa Principles<sup>91</sup> on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights were arrived at during a Conference held at Siracusa (Italy) from 30 April to 4 May 1984. The following extract from a journal article<sup>92</sup> outlines their role:

The Siracusa Principles state that restrictions on human rights under the ICCPR must meet standards of legality, **evidence-based necessity, proportionality, and gradualism**. Specifically, limitations on rights must be, among other provisions, **‘strictly necessary’**, meaning that the limitations respond to a pressing public or social need and proportionately pursue a legitimate aim, and are the least restrictive means required for achieving the purpose of the limitation. Additional protections include that the restriction is provided for and carried out in accordance with the law, that it is **neither arbitrary** nor discriminatory, and that the **burden of justifying a limitation upon a right lies with the state** seeking to impose the limitation. Specific to limitations on the

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<sup>89</sup> <https://www.dfat.gov.au/sites/default/files/human-rights-manual-fourth-edition.pdf>

<sup>90</sup> Todrys, et. al., ‘Failing Siracusa: governments’ obligations to find the least restrictive options for tuberculosis control’, *Public Health Action*, 2013 Mar 21; 3(1): 7–10. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4463097/>

<sup>91</sup> <https://www.refworld.org/docid/4672bc122.html>

<sup>92</sup> Todrys, et. al., ‘Failing Siracusa: governments’ obligations to find the least restrictive options for tuberculosis control’, *Public Health Action*, 2013 Mar 21; 3(1): 7–10. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4463097/>

basis of ‘public health’, the Siracusa Principles note that public health can be used as a ground for limiting certain rights if the state needs to take measures ‘aimed at preventing disease or injury or providing care for the sick and injured’.

The Siracusa Principles place the **justificatory burden of rights limitations on the State** (Article 12):

12. The burden of justifying a limitation upon a right guaranteed under the Covenant lies with the state.<sup>93</sup>

But the Victorian Administering Authorities have never justified **any** of their actions except by declaring that these are reasonable, without in any way subjecting these claims to discussion or being validated by the community. They have also never responded to questions that seek proofs for their innumerable absurd and arbitrary claims and “interventions”.

### **Provisions for emergencies**

Victoria has resorted to emergency provisions during this pandemic. These powers are problematic. For instance, it has been observed by the American Association for the International Commission of Jurists that one of the main instruments employed by governments to repress and deny the fundamental rights and freedoms of peoples has been the **illegal and unwarranted declaration of Martial Law or a State of Emergency**. Very often these measures are taken under the pretext of the existence of a ‘public emergency which threatens the life of the nation’<sup>94</sup>.

The World Justice Project notes that:

emergency powers should be in accordance with the law, including international obligations; based on a legitimate objective; time bound; strictly necessary in a democratic society; **the least restrictive and intrusive means available; and not arbitrary, unreasonable, or discriminatory**<sup>95</sup>.

We have seen none of this judicious action in Victoria in 2020. Instead, the Victorian Administering Authorities **have used the most restrictive measures possible**.

The relevant Siracusa Principles that restrain the government during a public health emergency are outlined in the Box below:

## **II. DEROGATIONS IN A PUBLIC EMERGENCY**

### **A. ‘Public Emergency which Threatens the Life of the Nation’**

39. A state party may take measures derogating from its obligations under the International Covenant on Civil and Political Rights pursuant to Article 4 (hereinafter called ‘derogation measures’) only when faced with a situation **of exceptional** and actual or imminent danger which threatens the life of the nation. A threat to the life of the nation is one that:

- (a) affects the whole of the population and either the whole or part of the territory of the State, **and**
- (b) threatens the physical integrity of the population, the political independence or the territorial integrity of the State or the existence or basic functioning of institutions indispensable to ensure and project the rights recognized in the Covenant.

### **C. ‘Strictly Required by the Exigencies of the Situation’**

51. The severity, duration, and geographic scope of any derogation measure shall be such only as are **strictly necessary** to deal with the threat to the life of the nation **and are proportionate** to its nature and extent.

52. The competent national authorities shall be under a **duty to assess individually the necessity of any derogation measure** taken or proposed to deal with the specific dangers posed by the emergency.

53. A measure is not strictly required by the exigencies of the situation where ordinary measures permissible

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<sup>93</sup> <http://hrlibrary.umn.edu/instree/siracusaprinciples.html>

<sup>94</sup> <https://www.icj.org/siracusa-principles-on-the-limitation-and-derogation-provisions-in-the-international-covenant-on-civil-and-political-rights/>

<sup>95</sup> <https://worldjusticeproject.org/world-justice-challenge-2021/accountable-governance>



under the specific limitations clauses of the Covenant would be adequate to deal with the threat to the life of the nation.

54. The principle of strict necessity shall be applied in an objective manner. Each measure shall be directed to an **actual, clear, present, or imminent danger** and may not be imposed merely because of an apprehension of potential danger.

**56. Effective remedies shall be available to persons claiming that derogation measures affecting them are not strictly required by the exigencies of the situation.**

57. In determining whether derogation measures are strictly required by the exigencies of the situation **the judgment of the national authorities cannot be accepted as conclusive.**

#### **D. Non-Derogable Rights**

58. No state party shall, even in time of emergency threatening the life of the nation, derogate from the Covenant's guarantees of the right to life; freedom from torture, cruel, inhuman or degrading treatment or punishment, and from **medical or scientific experimentation without free consent**; freedom from slavery or involuntary servitude; the right not to be imprisoned for contractual debt; the right not to be convicted or sentenced to a heavier penalty by virtue of retroactive criminal legislation; the right to recognition as a person before the law; and freedom of thought, conscience and religion. These rights are not derogable under any conditions even for the asserted purpose of preserving the life of the nation.

60. **The ordinary courts shall maintain their jurisdiction**, even in a time of public emergency, to adjudicate any complaint that a non-derogable right has been violated.

#### **E. Some General Principles on the Introduction and Application of a Public Emergency and Consequent Derogation Measures**

61. Derogation from rights recognized under international law in order to respond to a threat to the life of the nation is not exercised in a legal vacuum. It is authorized by law and as such it is subject to several legal principles of general application.

62. A proclamation of a public emergency shall be made in good faith based upon **an objective assessment of the situation in order to determine to what extent, if any, it poses a threat to the life of the nation. A proclamation of a public emergency, and consequent derogations from Covenant obligations, that are not made in good faith are violations of international law.**

63. The provisions of the Covenant allowing for certain derogations in a public emergency are to be interpreted restrictively.

64. In a public emergency the rule of law shall still prevail. Derogation is an authorized and limited prerogative in order to respond adequately to a threat to the life of the nation. **The derogating state shall burden of justifying its actions under law.**

65. The Covenant subordinates all procedures to the basic objectives of human rights. Article 5(1) of the Covenant sets definite limits to actions taken under the Covenant:

Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms recognized herein or at their limitation to a greater extent than is provided for in the present Covenant.

Article 29(2) of the Universal Declaration of Human Rights sets out the ultimate purpose of law:

In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

These provisions apply with full force to claims that a situation constitutes a threat to the life of a nation and hence enables authorities to derogate.

66. A bona fide proclamation of the public emergency permits derogation from specified obligations in the Covenant, but **does not authorize a general departure from international obligations.** The Covenant in Article 4(1) and 5(2) expressly prohibits derogations which are inconsistent with other obligations under international law. In this regard, particular note should be taken of international obligations which apply in a public emergency under the Geneva and I.L.O. Conventions.

69. No state, including those that are not parties to the Covenant, may suspend or violate, even in times of public emergency:

- (a) the right to life;

(b) **freedom from** torture or cruel, inhuman or degrading treatment or punishment and **from medical or scientific experimentation**;

(c) the right not to be held in slavery or involuntary servitude; and,

(d) the right not to be subjected to retroactive criminal penalties as defined in the Covenant.

Customary international law prohibits in all circumstances the denial of such fundamental rights.

**None** of these principles were followed by the Victorian Administering Authorities during this pandemic.

### 6.3 The International Covenant on Economic, Social and Cultural Rights

Australia has been a signatory, ratified in 1976, to this Covenant. Article 4 outlines the principles that apply even during a public health emergency:

**Article 4:** The States Parties to the present Covenant recognize that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law **only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare** in a democratic society.

#### 6.3.1 *General Comment No. 14 (2000) - Economic and Social Council of the United Nations by the Human Rights Committee*

The concepts of **necessity and proportionality** that are found in the Siracusa Principles were elaborated and adopted by the twenty-second Session of the Committee on Economic, Social and Cultural Rights (CESCR), on 11 August 2000, and published as the *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)* by the Office of the High Commissioner for Human Rights<sup>96, 97</sup>.

A key element involves the principles that apply to limitations on movement:

[The] General Comment related to freedom of movement ... includes an analysis of the criteria for **justifiable limitations on movement, including for public health reasons**. The General Comment, like the Siracusa Principles, stresses the need for restrictions to be provided for by law, demonstrably necessary, consistent with other rights in the ICCPR, and non-discriminatory. In particular, the Committee dwells on the requirement of necessity for a proposed restriction.<sup>98</sup>

Paragraphs 28 and 29 of the General Comment are particularly relevant – see the Box below.

#### SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

##### Limitations

28. Issues of public health are sometimes used by States as grounds for limiting the exercise of other fundamental rights. The Committee wishes to emphasize that **the Covenant's limitation clause, article 4, is primarily intended to protect the rights of individuals rather than to permit the imposition of limitations by States.**

Consequently a State party which, for example, restricts the movement of, or incarcerates, persons with transmissible diseases such as HIV/AIDS, refuses to allow doctors to treat persons believed to be opposed to a government, or fails to provide immunization against the community's major infectious diseases, on grounds such as national security or the preservation of public order, **has the burden of justifying such serious measures in relation to each of the elements identified in article 4.**

<sup>96</sup> <https://www.refworld.org/pdfid/4538838d0.pdf>

<sup>97</sup> <https://digitallibrary.un.org/record/425041?ln=en#record-files-collapse-header>

<sup>98</sup> Todrys, et. al., 'Failing Siracusa: governments' obligations to find the least restrictive options for tuberculosis control', *Public Health Action*, 2013 Mar 21; 3(1): 7–10. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4463097/>

Such restrictions must be in accordance with the law, including international human rights standards, compatible with the nature of the rights protected by the Covenant, in the interest of legitimate aims pursued, and strictly necessary for the promotion of the general welfare in a democratic society.

29. In line with article 5.1, **such limitations must be proportional, i.e. the least restrictive alternative must be adopted** where several types of limitations are available. Even where such limitations on grounds of protecting public health are basically permitted, **they should be of limited duration and subject to review.**

**None** of these principles were followed by the Victorian Administering Authorities during this pandemic.

## 6.4 Nuremberg Code

On 19 August 1947, the judges of the American military tribunal in the case of the USA vs. Karl Brandt et al. delivered their verdict. Dr. Alexander submitted a memorandum to the United States Counsel for War Crimes on 17 April 1947, outlining six points defining legitimate research. The verdict of 19 August reiterated almost all of these points in a section entitled **“Permissible Medical Experiments”** and revised the original six points into ten.

Subsequently, the ten points became known as the “Nuremberg Code”<sup>99</sup> and form the basis for ethical considerations regarding any human experiment (as summarised below):

- 1) Voluntary consent is essential.
- 2) The results of any experiment must be for the greater good of society.
- 3) Human experiments should be based on previous animal experimentation.
- 4) Experiments should be conducted by avoiding physical/mental suffering and injury.
- 5) No experiments should be conducted if it is believed to cause death/disability.
- 6) The risks should never exceed the benefits.
- 7) Adequate facilities should be used to protect subjects.
- 8) Experiments should be conducted only by qualified scientists.
- 9) Subjects should be able to end their participation at any time.
- 10) The scientist in charge must be prepared to terminate the experiment when injury, disability, or death is likely to occur.

**None** of these principles were followed by the Victorian Administering Authorities during this pandemic.

### 6.4.1 *Lockdowns are an unethical human experiment in breach of the Nuremberg Code*

Lockdowns breach all known science and the WHO’s 2019 guidelines. Science rejects lockdowns as a potential preventative or therapeutic intervention. That is why they have never formed part of any approved pandemic plan of any government. They do not work, they are not reasonable, they are not proportionate. The only time they might possibly be used is for a virus with entirely different characteristics, such as Ebola<sup>100</sup> - but as I will show, even here only small-scale cordons similar to quarantine are effective and justified.

Since they are not approved and agreed by the published, peer-reviewed science, they are at best a human experiment, a **human science experiment** (although it is strange to call them even an experiment since science has rejected them as an option after due consideration). Worse, the concept of curfews, 23-hour 5-kilometre movement limits and other such constraints in Victoria are entirely experimental, with not the slightest scientific (evidentiary, not modelling) basis in peer-reviewed literature. All these actions comprehensively violate the Nuremberg Code<sup>101</sup> and therefore had any such experiment been proposed to

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<sup>99</sup> <https://www.usmmm.org/information/exhibitions/online-exhibitions/special-focus/doctors-trial/nuremberg-code>

<sup>100</sup> <http://www.nytimes.com/2014/08/13/science/using-a-tactic-unseen-in-a-century-countries-cordon-off-ebola-racked-areas.html>

<sup>101</sup> Jarmusik, Natalie, ‘The Nuremberg Code and its impact on clinical research’, IMARC Research, 9 April 2019. Short URL: <https://bit.ly/2HxBd5Y>.

some university for funding, it would have never received ethics approval. They are a crime against humanity.

Further, as noted earlier, even during an emergency, a government is not permitted to experiment with its population (Siracusa Principles). But that's what's been going on in Victoria with the curfews, lockdowns and mandatory mask mandates - which have all been rejected outright by the science. I repeat clause 58 of the Siracusa Principles below:

58. No state party shall, **even in time of emergency threatening the life of the nation**, derogate from the Covenant's guarantees of the right to life; freedom from torture, cruel, inhuman or degrading treatment or punishment, and **from medical or scientific experimentation without free consent**; freedom from slavery or involuntary servitude; the right not to be imprisoned for contractual debt; the right not to be convicted or sentenced to a heavier penalty by virtue of retroactive criminal legislation; the right to recognition as a person before the law; and freedom of thought, conscience and religion. These rights are not derogable under any conditions even for the asserted purpose of preserving the life of the nation.<sup>102</sup>

## 6.5 Universal Declaration on Bioethics and Human Rights

Article 6 of the Universal Declaration on Bioethics and Human Rights<sup>103</sup> states:

Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the **prior, free and informed consent** of the person concerned, based on adequate information. The consent should, where appropriate, be expressed and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.

Lockdowns are presumably implemented as a "preventative health" intervention but in that case they would require prior informed consent from *each individual*. That was never taken. Once again, Victorian Administering Authorities have contravened these covenants. There are surely many other breaches of the Bioethics and other such Declarations.

## 6.6 W.H.O.'s International Health Regulations 2005

Australia is a signatory of the International Health Regulations 2005 which specify that "a health measure does not include law enforcement or security measures"<sup>104</sup>.

To me this suggests (or at least the spirit of the regulation suggests) that police must not be used to enforce public health measures. But the Victorian Administering Authorities have actively – and indiscriminately – used Victoria's Police to brutally suppress the people of Victoria (particularly those with low to no risk from coronavirus) – allegedly to protect someone else's health.

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<sup>102</sup> <http://hrlibrary.umn.edu/instree/siracusaprinciples.html>

<sup>103</sup> [http://portal.unesco.org/en/ev.php-URL\\_ID=31058&URL\\_DO=DO\\_TOPIC&URL\\_SECTION=201.html](http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html)

<sup>104</sup> <https://www.who.int/publications/i/item/9789241580496>

## 7. The Australian and Victorian Human Rights Framework

The human rights commitments made by Australia under various international laws have been incorporated into Australia's, including Victoria's, laws. In addition, section 32(2) of Victoria's *Human Rights and Responsibilities Act 2006* states: "International law and the judgments of domestic, foreign and international courts and tribunals relevant to a human right may be considered in interpreting a statutory provision". Likewise, Victoria's *Public Health and Wellbeing Act 2008* incorporates the principles outlined in the previous chapter through the requirements of proportionality and a prohibition on arbitrary directives.

I will outline the Australian and Victorian human rights framework in some detail in this chapter, to set the scene for analysing the offences of the Accused. The issue in this complaint is not so much that the laws in Victoria or Australia are in any way contrary to human rights but that **all** key legal requirements – and **all** principles of ethics that are incorporated into these laws – have been comprehensively breached. It is as if these laws simply do not exist.

### 7.1 Common law framework in Australia

Although the Australian Constitution does not have much to say about human rights, it can't be claimed that the rights of the people of Australia are any less than the rights that people have in other parts of the world, like in Sweden or in the USA.

As a Western nation with a common law tradition, Australia relies not so much on its Constitution to protect rights but on well-functioning institutions. As Timothy Jones has noted:

Australia and Britain have remarkably few constitutional guarantees of fundamental rights. This is not to say, of course, that the two countries are without any such protections. The *Magna Carta* of 1215 ('that great confirmatory instrument ... which is the ground work of all our Constitutions') and the Bill of Rights of 1689 ('the product of an alliance between parliamentarians and common lawyers') remain, but they have a limited field of operation and are inadequate as modern statements of fundamental rights.<sup>13</sup> And as subsequent discussion will demonstrate, the Australian Constitution does have something to say on the subject. It is nevertheless the case that the Anglo-Australian tradition has been to place faith in the common law, supplemented by legislation in specific areas, together with responsible and representative Parliamentary government, as the best means by which fundamental rights can be protected. As Sir Ninian Stephen has noted: 'The 'founding fathers' of our Constitution took it for granted that individual rights were secure under the common law.'<sup>105</sup>

And while Australia is a common law driven nation, it has an ancestry that goes back to the Magna Carta and the right to *habeas corpus*. People have spilled blood in the past for the liberty that is the birthright of all humans, including Australians.

(I discuss the history of freedom in my manuscript, *The Discovery of Freedom*, which is available at: <https://sanjeev.sabhlokcitiy.com/book2/discovery.pdf>; however, the ICC is fully aware of the long battles for freedom over many centuries, for mankind to have been able to reach this point.)

### 7.2 The Commonwealth's Biosecurity Act 2015

I will outline elsewhere the restriction in *Australia's Biosecurity Act 2015* against attempting the eradication of a virus. Here I wish to show that human rights impacts were carefully considered in the design of this legislation.

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<sup>105</sup> Jones, Timothy H., 'Legal Protection for Fundamental Rights and Freedoms: European Lessons for Australia?', *Federal Law Review*, Vol 22, Issue 1, 1994. <http://classic.austlii.edu.au/au/journals/FedLawRw/1994/3.pdf>

The Parliamentary Joint Committee on Human Rights (the Human Rights Committee)<sup>106</sup> on the Biosecurity Bill reported to the Parliament of Australia on the human rights impacts of the Bill in February 2015.

It acknowledged that the Bill engaged the following human rights:

- right to life
- right to freedom from torture and cruel, inhuman or degrading treatment
- right to liberty and freedom from arbitrary detention
- right to freedom of movement
- right to a fair trial and fair hearing rights
- right to privacy
- right to freedom of association
- rights of the child
- right to an adequate standard of living
- right to health
- right to enjoy and benefit from culture and
- rights of persons with disabilities.

After careful consideration, though, the Human Rights Committee stated that **“the Bills have been drafted in a manner which is consistent with Australia’s human rights obligations and that limitations on rights have been well considered with appropriate safeguards”**.

[The] Committee ... was satisfied that the relevant provisions of this Bill ‘have been appropriately and sufficiently justified in the statement of compatibility for the Bill’. That being the case, **whilst the “Bills limit multiple rights, the limitation on rights imposed by the Bills are justified and compatible with Australia’s human rights obligations”**.

There have, unfortunately, been (and continue to be) significant breaches in the application of the principles of proportionality under this Act<sup>107</sup>. However, none of these breaches has been on the scale that we are seeing this time around, with the Australian Administering Authorities determined to eradicate coronavirus from Australia – which is in complete violation of **all** key aspects of this Act.

### 7.3 Victoria’s Human Rights Framework

Unlike Australia which does not have a “Bill of Rights”, Victoria does. The rights included in Victoria’s *Charter of Human Rights and Responsibilities Act 2006* (‘the Charter’) are adapted from international human rights instruments including the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights.

#### 7.3.1 *Fundamental human rights in Victoria*

The Charter protects twenty fundamental human rights:

1. Right to recognition and equality before the law (section 8, Article 6)
2. Right to life (section 9, Article 3)
3. Right to protection from torture and cruel, inhuman or degrading treatment (section 10, Article 5)

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<sup>106</sup> [https://www.aph.gov.au/Parliamentary\\_Business/Bills\\_Legislation/bd/bd1415a/15bd093](https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/bd/bd1415a/15bd093)

<sup>107</sup> Carter, D 2020, “The Use of coercive Public Health and Human Biosecurity Law in Australia: An Empirical Analysis”, *University of New South Wales Law Journal*, vol. 43, no. 1 <http://www.unswlawjournal.unsw.edu.au/wp-content/uploads/2020/03/04-Carter.pdf>

4. Right to freedom from forced work (section 11, Article 4)
5. Right to freedom of movement (section 12)
6. Right to privacy and reputation (section 13)
7. Right to freedom of thought, conscience, religion and belief (section 14)
8. Right to freedom of expression (section 15)
9. Right to peaceful assembly and freedom of association (section 16)
10. Right to protection of families and children (section 17)
11. Right to taking part in public life (section 18)
12. Cultural rights (section 19)
13. Property rights (section 20)
14. Right to liberty and security of person (section 21)
15. Right to humane treatment when deprived of liberty (section 22)
16. Rights of children in the criminal process (section 23)
17. Right to a fair hearing (section 24, Article 10)
18. Rights in criminal proceedings (section 25)
19. Right not to be tried or punished more than once (section 26)
20. Retrospective criminal laws (section 27)

Any Bill introduced into the Victorian Parliament must be accompanied by a statement that explains any impacted human rights and why any limitations on rights are reasonable and justified.

### 7.3.2 *The element of proportionality*

Section 7(2) provides that Charter rights: “may be subject under law only to such **reasonable limits** as can be **demonstrably justified** in a free and democratic society based on human dignity, equality and freedom, taking into account all relevant factors including:

- (a) the nature of the right; and
- (b) the importance of the purpose of the limitation; and
- (c) the nature and extent of the limitation; and
- (d) the relationship between the limitation and its purpose; and
- (e) **any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve”.**

The requirement here – which filters through into all Victorian legislation – is to **demonstrably** justify any derogation of rights.

The Andrews government has not demonstrated any of its “justifications”, just waved its arms around and made the arbitrary claim that it *has* justified them. In imposing its illegal restrictions (lockdowns) that are prohibited by the science and WHO’s 2019 guidelines it has used models which cannot be even remotely considered scientific, leave alone a scientific proof of a policy. The lockdowns can never be justified on the basis of real science, proportionality and ethics. Victoria’s actions are a travesty and complete refutation of the principles and spirit of the laws and of the Charter. Its **pretence of compliance** is intended to throw wool over the eyes of the people.

### 7.3.3 *Protections in the Public Health and Wellbeing Act 2008 against arbitrary orders*

The *Public Health and Wellbeing Act 2008* took effect on 1 January 2010. There are exceptionally tight restrictions on the health officer’s powers in the Act (summarised in the Box, below).

**Box: Key provisions of the *Public Health and Wellbeing Act 2008***  
**Principle of least restrictive public health measures**

Section 111 lays out principles that apply to the management and control of infectious diseases, including: (a) the spread of an infectious disease should be prevented or minimised with the minimum restriction on the rights of any person;

Section 112 further emphasises that “If in giving effect to this Division alternative measures are available which are equally effective in minimising the risk that a person poses to public health, the measure which is the least restrictive of the rights of the person should be chosen”.

Section 190 of the Victorian *Public Health and Wellbeing Act 2008* gives the Chief Health Officer significant powers but none of these are intended to be exercised arbitrarily.

#### **Evidence needed**

The Act states that public health measures must be based on evidence (Section 5: ‘decisions should be based on evidence available in the circumstances that is relevant and reliable’).

#### **People must be given full information**

Section 8 requires that those who impose public health measures must provide full information and allow the public to participate: ‘Members of the public should be given access to reliable information in appropriate forms to facilitate a good understanding of public health issues’ as well as ‘opportunities to participate in policy and program development’.

#### **Proportionality. Not arbitrary.**

Section 9 of the Act prohibits arbitrary action: ‘decisions made and actions taken in the administration of this Act should be proportionate to the public health risk sought to be prevented, minimised or controlled; and should not be made or taken in an arbitrary manner’.

#### **Infectious disease prevention with minimum restrictions on rights**

Section 111 of the Act requires that ‘the spread of an infectious disease should be prevented or minimised with the minimum restriction on the rights of any person’.

#### **A 12-hour limit**

190(6) of the Act states that ‘A direction under subsection (1)(b) to remain at any particular premises may be extended as many times as is reasonably necessary for the purpose of investigating, eliminating or reducing the risk to public health but so as not to exceed a continuous period of 12 hours’.

### ***7.3.4 Victoria’s Public Health law does not authorise government to kill X to save Y***

It goes without saying that when considering the least restrictive measure, the prospect of killing someone as a result of the measure cannot possibly arise. For how can something that is the least restrictive kill anyone?

It is crucial for the purposes of this complaint to re-emphasise the obvious fact that the Public Health Act does not empower the Victorian Administering Authorities to kill or other harm Victorians on a mass-scale to purportedly save some other (mainly the extremely old in this case) Victorians from COVID-19.

There is a provision in Victoria’s public health law to allow actions to be taken as part of a “precautionary principle” – which requires a lower level of analysis (I have written strongly against the existence of such a principle in my book, *The Great Hysteria and The Broken State*) – but actions justified by the precautionary principle cannot kill some people in order to save others, either. Further, all such actions must still be consistent with the spirit of the law and with all international covenants to which Australia is a signatory.

Finally, initiatives that are specifically prohibited by the science and internationally accepted guidelines (WHO guidelines) cannot possibly be imposed as a “precaution”. It is never acceptable to administer poison as a “precaution”.

### ***7.3.5 Emergency public health powers in Victoria***

Division 3, sections 198-204 of Victoria’s Public Health Act provides for *slightly* broader powers during an “emergency”. In the main it allows the broadening of the geographical area in which “any person or group of persons” might be restricted (called the **emergency area**) but only “**for the period reasonably necessary** to eliminate or reduce a serious risk to public health”.



Note that the word “eliminate” in this Act **cannot, ever,** over-ride the restriction imposed by the *Biosecurity Act 2015* against eradication of a pathogen, nor can the period of such restriction be indefinite (as has always been the case in Melbourne with its lockdowns).

Further, all constraints of proportionality, justification and transparency found in the Act continue to apply even during an emergency. Just making a pretend claim that the restrictions imposed are “reasonable” but not proving them comprehensively and unambiguously contravenes the restrictions on arbitrary action in the laws.

It goes without saying that these emergency powers also do not empower the Victorian government to kill X (or shorten the lifespan of X) in order to save Y. Even during an emergency, a government cannot experiment with its population (Siracusa Principles<sup>108</sup>).

Sadly, the Victorian Administering Authorities have entirely trashed the State’s laws. It is as if the law was merely a worthless piece of paper, not the distilled wisdom of hundreds of years of human action.

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<sup>108</sup> <http://hrlibrary.umn.edu/instate/siracusaprinciples.html>

## 8. Victoria’s 10 March 2020 Pandemic Plan was sound

Initially, the Victorian Administering Authorities were committed to following sound policy and the laws. That would have dealt with the pandemic without crushing human rights or causing additional harm.

### 8.1 Victoria’s 10 March 2020 Pandemic plan was reasonable and proportionate

DHHS released Victoria’s *COVID-19 Pandemic Plan for the Victorian Health Sector*<sup>109</sup> (“Pandemic Plan”) on 10 March 2020. The Victorian Plan was consistent with the Federal Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)<sup>110</sup>.

The Plan noted that DHHS is the control agency for this Class 2 public health emergency (as per the State Health Emergency Response Plan – Emergency Management Victoria) and will take urgent action under legislation including the *Public Health and Wellbeing Act 2008*, *Emergency Management Act 2013* and *Commonwealth Biosecurity Act 2015* to safeguard the health and wellbeing of all Victorians.

The plan had a section on page 4 that stated:

#### Important principles

Our response is guided by the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* and the pandemic response plans of other jurisdictions.

These principles guide us to ensure our response is:

- Flexible and **proportionate**, and can be scaled up or down as required
- Reliant on existing health systems and health system governance where possible
- Inclusive of all Victorians and acts to reduce any form of xenophobia in the response
- **Focused on protecting vulnerable Victorians, including with underlying health conditions**, compromised immune systems, the elderly, Aboriginal and Torres Strait Islanders, and those from culturally and linguistically diverse communities
- Integrated with the efforts of the Commonwealth, other states and territories and relevant public agencies and sectors to make best use of common systems, plans and processes.

The design and principles underpinning Victoria’s officially approved 10 March 2020 Pandemic Plan are consistent with human rights and the principles of good policy making. Had this plan been followed, Victoria would have seen policy similar to Sweden’s and there would have been no additional physical and mental harms (crimes).

#### 8.1.1 Risk assessment

##### Magnitude of the risk

The Plan stated (correctly) that ‘COVID-19 is assessed as being of moderate clinical severity’. The plan did not limit itself only to a pandemic of moderate severity. It stated that ‘we are preparing so that we are ready to respond if a larger, or more severe outbreak occurs’.

No one knew the magnitude of the risk posed by this novel coronavirus in February 2020 but by mid-April 2020, anyone with rudimentary arithmetic skills would have found that the pandemic was tracking far below initial estimates.

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<sup>109</sup> <https://www2.health.vic.gov.au/about/publications/researchandreports/covid-19-pandemic-plan-for-vic>

<sup>110</sup> <https://www.health.gov.au/resources/publications/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19>

For example, initial models (such as those based on the work of Neil Ferguson from the Imperial College) had suggested that Sweden would experience over 95,000 deaths from COVID-19 without lockdowns, with a bulk of these deaths occurring in April 2020. As at 10 November 2020, 6,022 have reportedly died in Sweden from (or with) COVID-19. And, as Sweden's State Epidemiologist Anders Tegnell regrettably admits, many, if not most of these deaths could have been averted had Sweden deployed more resources into its aged-care homes in the early days of the pandemic.

More than a year after the virus mutated from an unknown mammal to humans (it started in October 2019 in Wuhan), we can say (anyone can check for themselves) that this novel coronavirus pandemic is likely to be at least 50 if not a hundred times less lethal overall, globally, than the Spanish flu was.

For example, the world's population today is 7.594 billion of which approximately 1.27 million have died to date from (or with) COVID-19. That means 1.27 person has died out of 7594, or 0.17 out of every 1000. In other words, 999.83 people out of every 1000 have so far escaped death from COVID-19.

After one year, this pandemic has not yet reached the lethality (globally) of the 1969 Hong Kong flu which would have killed 2.1 million people this year, or the 1957 Asian flu which would have killed 4.6 million.

Had the plan been followed, all these pieces of information would have been taken into account as new data came in. But that is not what Victorian Administering Authorities have done. They remain as hysterical as they were on the first day when they abandoned all the laws and plans of Victoria.

### ***Distribution of the risk***

Victoria's 10 March 2020 pandemic plan took a risk-based approach and "focused on protecting vulnerable Victorians".

It was widely known from mid-February 2020 that the risk of dying from COVID-19 is skewed towards the elderly, especially those – amongst them – whose immune system is compromised by other illness. Therefore, Victoria's pandemic plan stated that "older Victorians and people with chronic diseases are known to be at greater risk of COVID-19 infection". And said that it would "ramp up risk reduction activity [for] at-risk groups".

It is a different matter that the moment things started heating up, Daniel Andrews abandoned the plan and **inverted the planned approach**: he started implementing society-wide lockdowns that focus mainly on the *low-risk* population instead of on the *high-risk* groups. He put 99 per cent of his effort in controlling the 99% of the Victorian population that would never have been affected adversely by the coronavirus, and put 1 per cent of his effort on the 1% of the population (the elderly) that faced an enormous risk.

### **8.1.2 Proportionality**

Section 9 of Victoria's *Public Health and Wellbeing Act 2008* states: "decisions made and actions taken in the administration of this Act should be **proportionate** to the public health risk sought to be prevented, minimised or controlled; and should not be made or taken in an arbitrary manner".

The 10 March 2020 Victorian pandemic plan included this most important principle of all – of proportionality: to "ensure a **proportionate** and equitable response". It wanted things to be "flexible and proportionate".

Lockdowns would never have been possible under this plan. It goes without saying that Victoria's pandemic plan did not say that Melbourne would be converted into a city-wide prison (that too with a ring of steel) all for the sake of a moderate pandemic while everyone is forced to sit at home waiting for a vaccine to get invented, tested, approved, mass-produced and punched into every Victorian.

### **8.1.3 Flattening the curve**

The Plan wanted to "**reduce** [not eliminate] the morbidity and mortality associated with COVID-19". It is clear that on 10 March 2020 the Victorian Administering Authorities were planning to 'flatten the curve',

illustratively through education of the community and some social distancing, to reduce pressure on the hospital system.

When the declaration of emergency was made on 16 March 2020 the press release issued by the Victorian Government confirmed this. It said that the emergency would “**assist with measures designed to ‘flatten the curve’ of COVID-19** and give our health system the best chance of managing the virus”<sup>111</sup>

Likewise, on 4 August 2020, in response to a Parliamentary Question,<sup>112</sup> the Victorian Health Minister stated: “The Victorian Government is **focused on the immediate issue of flattening the curve**, reducing cases and driving down rates of unknown community transmission”. This was, however, a complete lie since the policy had shifted long ago – from end-March – towards eradication of the virus from Victoria.

As expected, there was no mention in the 10 March 2020 Pandemic Plan to undertake extreme suppression bordering on elimination since such an action is specifically forbidden by Australia’s biosecurity laws.

Had the Victorian government followed its 10 March 2020 plan, this complaint to the ICC would not have existed nor would I have needed to resign from my economist role in the Andrews government in order to protest these policies.

#### ***8.1.4 No authorization to kill X in order to save Y***

And again – even at the risk of appearing over-zealous and belabouring the point – I wish to note that there was no authorisation in Victoria’s Pandemic Plan for the Accused Group 1 to kill X (or to shorten their life) in order to save Y.

In sum, the 10 March 2020 Victorian plan was a well-balanced response to what was always going to be a difficult problem. Following it religiously would have averted the excesses of “public health” that we are witnessing.

## **8.2 Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)**

Australia’s national pandemic plan was also quite good. Published on 18 February 2020 and updated on 23 April 2020, the Plan is available on the Australian government website<sup>113</sup>.

### ***8.2.1 No lockdowns***

One would imagine that if lockdowns were so good, this plan would have emphasized them as a first step during pandemics, particularly given Mr Morrison’s strong statement in support of lockdowns on 23 March 2020. But there is no mention of “lockdowns” or “stay-at-home” orders in Australia’s pandemic plan.

### ***8.2.2 No strategy of eradicating the virus while waiting for a vaccine***

Since Mr Morrison is obsessively focused on keeping Australia sealed off till a vaccine is punched into every Australian, this strategy would presumably have been mentioned at the top and in great detail in Australia’s pandemic plan. But the Plan does not say that anything about such a policy. Instead, it notes that **a vaccine is not guaranteed:**

Currently, there is no specific treatment (no vaccine and no antiviral) against the new virus.  
Availability of a customised novel coronavirus vaccine would be the greatest tool in reducing the

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<sup>111</sup> <https://www.premier.vic.gov.au/state-emergency-declared-victoria-over-covid-19>

<sup>112</sup> [https://www.parliament.vic.gov.au/images/Hayes\\_040820\\_.pdf](https://www.parliament.vic.gov.au/images/Hayes_040820_.pdf)

<sup>113</sup> <https://www.health.gov.au/resources/publications/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19>

impact. It is not known if or when this might be available. There is still no vaccine available for the other major coronaviruses SARS and MERS.

The Australian Government will fast-track assessment and approval of a customised vaccine, should this become available; procure vaccines; develop a national novel coronavirus vaccination policy and a national novel coronavirus immunisation program; and communicate immunisation information on the program to the general public and health professionals.

This is a reasonable position to take, which does not also contravene the *Biosecurity Act 2015*.

### 8.2.3 *No sealing of Australia’s international borders indefinitely*

On international borders, the Plan’s position is consistent with the 2019 WHO guidelines. There is no mention of sealing Australia till a vaccine is found.

#### **Border measures**

<b>Border measures</b>	<ul style="list-style-type: none"> <li>• Implement enhanced border measures, such as enhanced entry screening, non-automatic pratique, preventative biosecurity measures</li> </ul>
<b>Communications</b>	<ul style="list-style-type: none"> <li>• Provide information to travellers through               <ul style="list-style-type: none"> <li>○ in-flight and on-arrival announcements</li> <li>○ fact sheets (incoming travellers, border workers, airlines, cruise industry)</li> <li>○ communication materials (e.g. printed and electronic media) at the border; and</li> <li>○ social media.</li> </ul> </li> <li>• Provide guidance for border workers, the airline and maritime industry on:               <ul style="list-style-type: none"> <li>○ the disease and personal risk</li> <li>○ respiratory hygiene and hand-washing</li> <li>○ appropriate use of PPE while assessing ill travelers; and</li> <li>○ where to find more information.</li> </ul> </li> </ul>
<b>Traveller clearances</b>	<ul style="list-style-type: none"> <li>• Maintain requirements for customs, immigration and biosecurity clearances (including for Australian Defence Force Personnel);</li> <li>• Enhance for travellers identified as potentially higher risk.</li> </ul>

The sealed borders we have today in Australia (expected to continue till 2022) are, as expected, in complete contravention of Australia’s Pandemic Plan.

### 8.2.4 *Proportionality*

Australia’s plan had a well-graded system to assess proportionality of responses. The **lowest** level of clinical severity was “Scenario one”, in which:

The majority of cases are likely to experience mild to moderate clinical features. People in at-risk groups and those with comorbidities may experience more severe illness. Strategies to support at-risk groups, once they are identified, may be required (e.g. people with underlying illness, people with immunocompromised conditions, aged care, infants, Aboriginal and Torres Strait Islander peoples, remote communities). **At the peak of the outbreak, and increasingly when transmissibility is higher, primary care and hospital services may become stretched in areas associated with respiratory illness and acute care.**

There has never been a situation anywhere in Australia in 2020 during this pandemic in which its health services were “stretched” in any way. **The severity of this pandemic has never exceeded Scenario one**, and given the global experience, it will not do so anytime in the future.

But the actions *actually* taken by the Accused Groups 1 and 2 are hysterical and disproportionate in every possible way.

All relevant legislation and pandemic plans in Australia have been aimed at the effective management of a virus (i.e. “living with it”) – not its eradication. But the Accused don’t care for any laws, so these plans are just worthless pieces of paper to them.

## 8.3 Other jurisdictional plans

### 8.3.1 *European CDC pandemic guidelines did not mention lockdowns either*

#### February 2020 guidelines

The February 2020<sup>114</sup> European CDC (ECDC) guidelines for COVID-19 did not mention, nor therefore recommend lockdowns. That was, once again, because science prohibits lockdowns for flu-like viruses.

#### September 2020 update

The ECDC's September 2020 update<sup>115</sup> of its February 2020 guidelines mentions that some countries have imposed lockdowns but notes that **there is no evidence of their effectiveness**.

In this manner, the **ECDC is effectively telling us that lockdowns are bad a mass-scale human experiment** because:

- it is telling us that these measures were never imposed before; and
- now that these have been implemented without prior agreement and discussion, the ECDC has evaluated them like it would evaluate any other experiment and found they do **not** reduce the spread of disease but, instead, have significant negative impacts.

It is important to mention here that ECDC's current view (in its September 2020 update) that stay-at-home orders during the first phase of the outbreak could "*probably*" help reduce virus transmission must be treated as a truly bad scientific hypothesis since not only does the ECDC cite papers to prove show that lockdowns have no effect, but the very idea of lockdowns and been rejected in the past. It is completely inappropriate for the ECDC to publish a speculative hypothesis in its guidelines. Such is the state of even scientists today: they imagine that by using the word "probably" (which effectively means nothing) they can justify the most harmful policies ever seen in public health history.

More problematically, the ECDC has acted inappropriately in its September 2020 report by ignoring Sweden's superlative experience. Sweden did not need any lockdown to achieve good results for its population. The ECDC should at least have had a full chapter on the Swedish experience, but during this pandemic even so-called "scientists" have forgotten everything they learnt and stood for.

### 8.3.2 *US Government's pandemic plan*

The 2017 US Department of Health's pandemic plan (*Pandemic Influenza Plan 2017 UPDATE*)<sup>116</sup> has absolutely no mention of lockdowns, either. It says:

NPIs that all people should practice at all times are particularly important during a pandemic. These everyday preventive actions include **staying home when sick**, covering coughs and sneezes, frequent and appropriate hand-washing, and routine cleaning of frequently touched surfaces. Community-level interventions can be added during pandemics and implemented in a graded fashion depending on the severity of the pandemic; these include **measures aimed to reduce social contacts between people in schools, workplaces, and other community settings**.

This extract above is not about coercive lockdowns but about the voluntary measures that we have seen being implemented in Sweden.

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<sup>114</sup> [https://ecdc.europa.eu/sites/default/files/documents/novel-coronavirus-guidelines-non-pharmaceutical-measures\\_0.pdf](https://ecdc.europa.eu/sites/default/files/documents/novel-coronavirus-guidelines-non-pharmaceutical-measures_0.pdf)

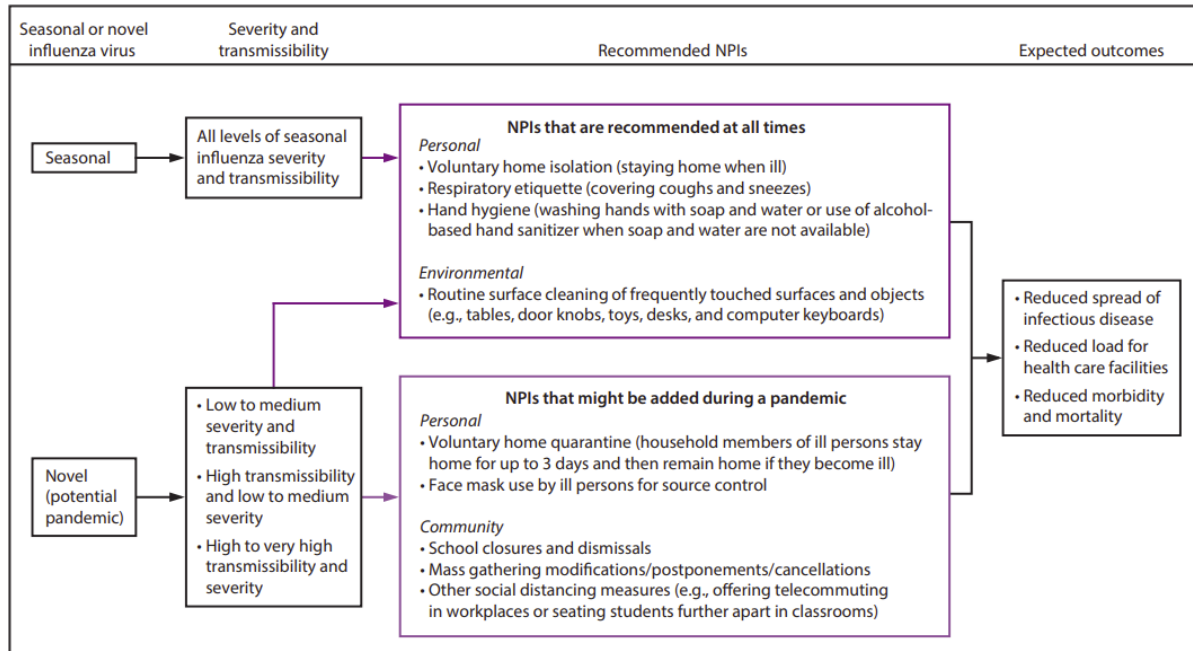
<sup>115</sup> <https://www.ecdc.europa.eu/sites/default/files/documents/covid-19-guidelines-non-pharmaceutical-interventions-september-2020.pdf>

<sup>116</sup> <https://cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf>

### 8.3.3 The CDC's pandemic guidelines

The following figure from the CDC's *Community Mitigation Guidelines to Prevent Pandemic Influenza – United States, 2017*<sup>117</sup> shows that CDC did not recommend society-wide lockdowns and curfews, either – even for the worst-case pandemic (and COVID-19 is only a modest pandemic).

FIGURE 5. Phased addition of nonpharmaceutical interventions to prevent the spread of pandemic influenza in communities



Abbreviation: NPI = nonpharmaceutical intervention.

These 2017 CDC guidelines are the epitome of reasonability. They talk about (at page 27) not creating “intervention fatigue” and making sure that the **unintended costs of interventions** are fully understood (“estimated”) and minimized (“minimization of social and economic costs during a pandemic”). I have extracted the relevant section from a key table in the report, below.

Balancing public health benefits and social costs	<ul style="list-style-type: none"> <li>Maximization of NPI public health benefits and minimization of social and economic costs during a pandemic</li> </ul>	<ul style="list-style-type: none"> <li>Estimating economic and social costs of NPIs and their secondary (unintended or unwanted) consequences</li> <li>Balancing those costs against public health benefits, with reference to different prepandemic planning scenarios</li> <li>Identifying strategies for reducing the cost of NPI implementation</li> </ul>
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Further, the following extract from a table in CDC's 2017 guidelines (page 32) is even clearer – that even if this were the Spanish flu, coercive lockdowns would never be acceptable (“does not recommend **voluntary** home quarantine of exposed household members” – exactly what the WHO's guidelines state).

<sup>117</sup> <https://www.cdc.gov/mmwr/volumes/66/rr/pdfs/rr6601.pdf>

TABLE 10. Recommended nonpharmaceutical interventions for influenza pandemics, by setting and pandemic severity\*

Setting	Pandemic severity		
	Low to moderate severity (mild to moderate pandemic)	High severity (severe pandemic)	Very high severity (very severe to extreme pandemic <sup>†</sup> )
All	CDC recommends voluntary home isolation of ill persons, respiratory etiquette, hand hygiene, and routine cleaning of frequently touched surfaces and objects. <sup>5</sup>	CDC recommends voluntary home isolation of ill persons, respiratory etiquette, hand hygiene, and routine cleaning of frequently touched surfaces and objects.	CDC recommends voluntary home isolation of ill persons, respiratory etiquette, hand hygiene, and routine cleaning of frequently touched surfaces and objects.
Residences	CDC generally does not recommend voluntary home quarantine of exposed household members.  CDC generally does not recommend use of face masks by ill persons.	CDC might recommend voluntary home quarantine of exposed household members in areas where novel influenza virus circulates.  CDC might recommend use of face masks by ill persons when crowded community settings cannot be avoided.	CDC might recommend voluntary home quarantine of exposed household members in areas where novel influenza virus circulates.  CDC might recommend use of face masks by ill persons when crowded community settings cannot be avoided.



Part II: The Accused know that their actions breach the science and the laws

## 9. Lockdowns are rejected by science and W.H.O. for a flu-like pandemic

I will explain in this chapter how lockdowns are not supported by science and do not qualify even remotely as a quarantine measure. They are ambiguously a **human experiment** – an experiment that violates the Nuremberg Code.

Since this knowledge was widely available, there is no basis for the Victorian Administering Authorities (or the Australian Administering Authorities) to ever claim in the future when challenged by the ICC, that they did not know this. The Victorian Administering Authorities must have known there is not a single peer-reviewed paper before 2020 that recommends lockdowns. Instead, the literature regards lockdowns to be effectively a public menace (since community-wide lockdowns are not effective even for Ebola).

Moreover, **if lockdowns were such a good idea**, they would necessarily have formed part of pandemic plans all across the world. But as I have shown, there is no plan in the world that even remotely recommends mandatory stay-at-home orders, curfews, and 5- or 25- kilometre boundaries.

Had the Victorian Administering Authorities actually ‘followed the science’ (instead of “following” speculative and ridiculous models), lockdowns would never have happened. Had they even conducted a simple 10-minute tabulation on a blackboard of the costs they are imposing on society they would have realised that they were necessarily going to kill many Victorians (and shortening the lives of millions). In that case, too, lockdowns would never have happened.

But the Accused did not exercise any due diligence either in March or now. They threw out the plans, laws, and principles of good policy and ethics.

### 9.1 Lockdowns have likely increased COVID-19 deaths in many countries

Before going into the science, I wish to note some papers that have studied the impacts of the 2020 lockdowns.

- 21 July 2020: “Chaudhry, Rabail et. al., “A country level analysis measuring the impact of government actions, country preparedness and socioeconomic factors on COVID-19 mortality and related health outcomes”<sup>118</sup>
- 12 August 2020: Liu, Yang, et. al., “The impact of non-pharmaceutical interventions on SARS-CoV-2 transmission across 130 countries and territories”<sup>119</sup>
- 14 October 2020: Brauner, Jan M. et. al., “The effectiveness of eight nonpharmaceutical interventions against COVID-19 in 41 countries”<sup>120</sup>

The key conclusions from these studies are outlined below.

- The July 2020 cross-country study showed that **‘full lockdowns, border closures, and high rate of COVID-19 testing were not associated with reduced number of critical cases or overall mortality’**.
- The 12 August 2020 study concluded that “there was **limited added value to introducing stay-at-home orders** as an addition to other physical distancing measures”.

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<sup>118</sup> Chaudhry, Rabail et. al., ‘A country level analysis measuring the impact of government actions, country preparedness and socioeconomic factors on COVID-19 mortality and related health outcomes’, *EClinical Medicine*, 21 July 2020. Short URL: <https://bit.ly/3j2gMF7>.

<sup>119</sup> <https://www.medrxiv.org/content/10.1101/2020.08.11.20172643v1>

<sup>120</sup> <https://www.medrxiv.org/content/10.1101/2020.05.28.20116129v4>

- The 14 October 2020 study concluded that “closing schools and universities was highly effective; that banning gatherings and closing high-risk businesses was effective, but closing most other businesses had limited further benefit; and that **many countries may have been able to reduce R below 1 without issuing a stay-at-home order**”.

It is clear that, as expected, lockdowns do not reduce deaths. But as noted earlier, data now suggests that lockdowns **may increase COVID deaths**.

A comparative analysis of deaths/million in the US, UK and Sweden is shown in the table below:

#	Country, Other	Deaths/ 1M pop
10	<a href="#">USA</a>	736
12	<a href="#">UK</a>	724
18	<a href="#">Sweden</a>	595

(Data from Worldometers on 10 November 2020)

**Many lockdown countries have ended up with a higher COVID-19 death rate than Sweden** even though Sweden has an exceptionally high elderly population.

I believe this outcome is expected and supported by robust logic. Lockdown nations focus their energy on trying to prevent low-risk people (such as the young) from contracting the virus. This inverted focus on the low-risk population has two effects:

- First, it leaves fewer resources for the government to deploy to cocoon and care for the elderly who are most at risk. As a result, *more* of the elderly die in these nations; and
- Second, it stops the development of immunity among the younger people who therefore cannot act as barriers to the spread of disease. I have shown in my book, *The Great Hysteria and The Broken State*, that herd immunity is a law of nature for all infectious disease. Respiratory viruses peak fairly quickly, with those who’ve recovered becoming immune, which then makes it hard for the virus to infect others.

In summary, I now begin the analysis of the science by noting this finding (which was always known) that lockdowns for flu-like viruses **do not save lives but might actually cost more lives from the virus itself** (apart from their other catastrophic harms).

## 9.2 Lockdowns for flu-like virus have never been part of public health practice

### 9.2.1 *The history of lockdowns (cordon sanitaires)*

A 2015 paper has outlined the history of lockdowns:

**First developed during the Black Death** of the Middle Ages, cordons sanitaires have since been used to quarantine inhabitants of Georgia, Texas, and Florida during the 1880s to combat the spread of **yellow fever**; Honolulu’s Chinatown during a **bubonic plague** outbreak in 1900; and Poland during a typhus outbreak after World War I; along with historical examples that include infected communities voluntarily cordoning themselves. These cordons achieved varying levels of medical success; at their worst, cordons sanitaires, including most American examples of the practice, have been examples of callousness and racism that unnecessarily victimized minority communities. However, **an EVD outbreak in 1995 in Kikwit, Zaire was reportedly contained by “heartless but effective” cordons sanitaires**.<sup>121</sup> [EVD = Ebola virus disease]

<sup>121</sup> <https://www.clinicalcorrelations.org/2015/02/19/ethical-considerations-in-the-use-of-cordons-sanitaires/>

We note that lockdowns were never used in the past for flu-like viruses. A pathogen has to be extremely lethal with certain characteristics of transmission before this option can even be considered.

### 9.2.2 *But even with Ebola, community-wide lockdowns have been ineffective*

Lockdowns were reportedly used in 1995 for Ebola. In 2014, lockdowns were again used to try to control Ebola in Africa.<sup>122</sup> It was noted in the *New York Times* article which reported this, that lockdowns created significant logistical and other challenges and impacted human rights.

These 2014 Ebola lockdowns were reviewed by Rachel Kaplan Hoffmann and Keith Hoffmann in a paper “Ethical Considerations in the Use of Cordons Sanitaires”, in 2015 (the same paper cited above regarding the history of lockdowns).<sup>123</sup>

The Hoffmans evaluated these cordons sanitaires according to four fundamental ethical principles of autonomy, beneficence, non-maleficence and justice. Apart from the logistical issues and mismanagement, which is not so relevant to Australia, their main conclusions are very significant:

[T]hese cordons have had variable effectiveness. Clinically, **very small-scale cordons**—quarantining individual patients and those with whom EVD patients have come into direct contact—**have demonstrated effectiveness, while medium- and large-scale cordons** around neighborhoods, regions, and nations **have proven ethically troubling, largely ineffective**, and difficult to enforce.

**[P]ublic health officials should focus on the containment of EVD by zeroing in on those already infected and containing its spread through small-scale cordons sanitaires**—like those that have been successful in Nigeria and Senegal—conducted in the most ethical manner possible. Fortunately this type of effort has demonstrated effectiveness; in their most recent report, the WHO states that on a national level, Guinea, Liberia, and Sierra Leone have achieved the capacity to isolate and treat all reported EVD cases and to bury all EVD-related deaths safely and with dignity.

**Even while strictly enforcing small-scale cordons, public health officials should be vigilant to prevent unnecessarily harsh or capricious cordons as inappropriate quarantines raise ethical issues, may create public health panic, and waste resources.**

In summary, there is no scope to apply community-wide lockdowns even for Ebola-type virus. Even for Ebola, “very small-scale cordons” – a little bigger than the regular quarantine – are effective. When large-scale lockdowns even for a lethal virus like Ebola are unscientific and unethical, the concept of these measures being used for a flu-like virus simply does not exist.

In relation to Ebola issues, another article for reference:

- Diego S. Silva, Maxwell J. Smith, “Commentary: Limiting Rights and Freedoms in the Context of Ebola and Other Public Health Emergencies: How the Principle of Reciprocity Can Enrich the Application of the Siracusa Principles”, *Health and Human Rights* 17/1, 11 June 2015.<sup>124</sup>

### 9.2.3 *Consideration of community-wide quarantine as a public health tool*

The only time I have been able to locate something that might resemble lockdowns for a flu-like pandemic is in a paper, “Public health and ethical considerations in planning for quarantine” by Martin Cetron and Julius Landwirth presented in a 2006 workshop and included in the 2007 book, *Ethical and Legal*

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<sup>122</sup> D.G. McNeil Jr., ‘Using a tactic unseen in a century, countries cordon off Ebola-racked areas,’ *New York Times*, August 12, 2014, <http://www.nytimes.com/2014/08/13/science/using-a-tactic-unseen-in-a-century-countries-cordon-off-ebola-racked-areas.html>

<sup>123</sup> <https://www.clinicalcorrelations.org/2015/02/19/ethical-considerations-in-the-use-of-cordons-sanitaires/>

<sup>124</sup> <https://www.hhrjournal.org/2015/06/commentary-limiting-rights-and-freedoms-in-the-context-of-ebola-and-other-public-health-emergencies-how-the-principle-of-reciprocity-can-enrich-the-application-of-the-siracusa-principles/>

*Considerations in Mitigating Pandemic Disease: Workshop Summary*<sup>125</sup>. The paper is available in HTML form on the NIH website as well.<sup>126</sup>

The paper defined ‘**Community-wide quarantine**’ as the ‘closing of community borders or the erection of a real or virtual barrier around a geographic area (cordon sanitaire)’. I provide the relevant extracts below in order to make key deductions.

Note that it begins by stating:

Principles of modern quarantine and social distancing **limit their use to situations involving highly dangerous and contagious diseases** and when resources are reliably available to implement and maintain the measures. It encompasses a wide range of **strategies to reduce transmission** that may be implemented along a continuum based on phase and intensity of an outbreak.

This point above is important – that even for highly dangerous pathogens, the purpose of quarantine is never to eradicate but to reduce the transmission of a virus (“flatten the curve”).

It further notes:

For example, at a stage when transmission of a novel influenza virus is still limited, either abroad or in the area, and local cases are either imported or have clear epidemiological links to other cases, individual quarantine of close contacts may be effective. At a more advanced phase of the pandemic, however, when virus transmission in the area is sustained and epidemiological links to other known cases is unclear, limiting quarantine to exposed individuals may be ineffective, and the strategy may need to expand to include community-based interventions that increase social distance. These include school closings, cancellation of public gatherings, encouraging non-essential workers to stay home, and reduced holiday transportation schedules. If these measures are believed to be ineffective, community-wide quarantine may need to be implemented.

Here we note that the idea of a cordon sanitaire has been **casually thrown into the mix** – but no thought was given to develop this offhand suggestion unlike in the papers that I will cite later which more carefully consider this question and reject it outright.

We know that the October 2019 WHO guidelines are authoritative and have considered the entire literature. The WHO **rejects the idea of quarantine even for exposed individuals** after an early stage of surveillance and information gathering for a flu-like pandemic. The mere thoughtless mention of the possible use of cordon sanitaire in a 2007 paper does not make it an acceptable scientific strategy in any way or excuse for the Accused to justify their crimes.

Moreover, by reading the next sections of the 2007 paper, we can deduce that a cordon sanitaire for a flu-like virus would never have passed muster even at that stage:

The HHS guidelines cite two important principles designed to help ensure that those in quarantine are not placed at increased risk. First, quarantined individuals will be **closely monitored, with daily visits as needed**, in order to detect earliest onset of symptoms and separation from those who are well. Second, persons in isolation will be among the first to receive any disease-prevention interventions. In addition, the HHS plan recommends that they should be provided with all needed support services, including psychological support, food and water, and household and medical supplies.

Home quarantine is the preferred method of separation, whenever possible. Designated quarantine facilities may have to be identified for potentially affected persons who do not have access to an appropriate home environment, such as persons living in dormitories, travelers, the homeless, or if the configuration of the home is not suitable for the protection of the potentially infected person and other occupants.

**Voluntary quarantine is the preferred first option before resorting to mandatory orders** or surveillance devices. In this connection, it is noteworthy that quarantine does not require 100

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<sup>125</sup> [https://www.ncbi.nlm.nih.gov/books/NBK54167/pdf/Bookshelf\\_NBK54167.pdf](https://www.ncbi.nlm.nih.gov/books/NBK54167/pdf/Bookshelf_NBK54167.pdf)

<sup>126</sup> <https://www.ncbi.nlm.nih.gov/books/NBK54163/#ch3.s1>

percent compliance to be effective. Toronto Public Health officials reported only 22 orders for mandatory detainment among the approximately 30,000 persons who were quarantined (Upshur, 2003).

The above paragraphs effectively rule out the possibility of cordon sanitaires being adopted by any government as a strategy. There are very good reasons why this reckless “thought bubble” of 2007 did not go any further. We know that since no government plan preceding this pandemic even remotely suggested lockdowns.

#### 9.2.4 *Lockdowns are not taught anywhere as a remedy for flu-like viruses*

Stefan Baral, MD, Associate Professor and Infectious Disease Epidemiologist at John Hopkins School of Public Health tweeted on 16 August 2020: ‘I spent a decade in public health training and **do not remember the lockdown lecture**. At best, they drive inequities across socioeconomic lines. At worst, the same but no PH [public health] impact’. He has cited four journal articles to prove his case.<sup>127</sup>

#### 9.2.5 *Lockdowns are a “new invention” - Professor Martin Kulldorff, 2020*

Professor Martin Kulldorff of Harvard Medical School said on 2 October 2020 that ‘Lockdown is a **new invention** of 2020. Every European country had prepared pandemic plans. We knew one was going to come along. Except for Sweden, all the countries threw it out of the window when Covid-19 arrived’.<sup>128</sup>

The key word here is that lockdowns are a ‘**new**’ invention (for flu-like viruses). There was never any contemplation, approval or use of such an inhumane policy in the past for flu-like viruses.

### 9.3 **Lockdowns are rejected outright by the science for flu-like pandemics**

Now I discuss the scientific consensus regarding lockdowns.

#### 9.3.1 *W.H.O.’s 2019 guidelines*

The WHO’s October 2019 report, *Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza*<sup>129</sup> that I have cited earlier recommends (and only where appropriate) face masks and some (targeted) internal travel restrictions for major flu-like respiratory pandemics but prohibits lockdowns.

As mentioned earlier, Page 3 it of the report notes that contact tracing and quarantine of exposed individuals is ‘**not recommended in any circumstances**’. We also know that Gauden Galea, the WHO’s representative in China made it very clear on 24 January 2020: ‘trying to contain a city of 11 million people is new to science. The lockdown of 11 million people is unprecedented in public health history, so it is certainly **not a recommendation** the WHO has made.’<sup>130</sup>

Why are lockdowns not recommended by the WHO? The annexure to this 2019 WHO report (‘Annex: Report of systematic literature reviews’ (chapter 3. Social distancing measures)) cites, among other documents, a 2004 paper, ‘Factors That Make an Infectious Disease Outbreak Controllable’<sup>131</sup>, by C. Fraser et. al. that states:

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<sup>127</sup> Baral, Stefan. Tweet, 16 August 2020. Short URL: <https://bit.ly/33XKHin>.

<sup>128</sup> <https://reaction.life/we-are-throwing-the-working-class-under-the-bus-an-interview-with-professor-martin-kulldorff/>

<sup>129</sup> World Health Organisation, ‘Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza’, October 2019. Short URL: <https://bit.ly/3mPsmg0>.

<sup>130</sup> Senger, Michael P., ‘China’s Global Lockdown Propaganda Campaign’, *Tablet*, 16 September 2020. Short URL: <https://bit.ly/2RXS0RA>.

<sup>131</sup> Fraser, Christophe et.al., ‘Factors that make an infectious disease outbreak controllable’, *PNAS*, 20 April 2004. Short URL: <https://bit.ly/341gRcF>.

for SARS, our analysis indicates that effective **isolation of symptomatic patients** is sufficient to control an outbreak. Influenza, on the other hand, is predicted to be **very difficult to control even with 90% quarantining and contact tracing** because of the high level of presymptomatic transmission.

Even for SARS large scale community lockdowns were not recommended, despite SARS being much more lethal than SARS-CoV2. Further, perhaps due to its very lethality and ability to be controlled with strong quarantine of infected persons it is possible that SARS found nowhere to go after it killed its hosts. Therefore, perhaps, it has disappeared long ago.

SARS, a coronavirus also known as Severe Acute Respiratory Syndrome, first appeared in 2002 and was identified in 2003. SARS infected nearly 8,100 people, **killing about 10%**, according to the WHO. **It disappeared after 2004, for reasons that scientists don't totally understand.**<sup>132</sup>

The novel coronavirus of 2019, on the other hand, has much in common with the flu virus in both its transmission mechanism and lethality: therefore the guidance of the WHO about flu applies to it.

### 9.3.2 *A 2006 paper, 'Disease Mitigation Measures in the Control of Pandemic Influenza'*

This 2006 paper, which considered flu-like viruses, rejected '**large-scale quarantine**' (lockdowns) which it said '**should be eliminated from serious consideration**' as a public health measure.

There are no historical observations or scientific studies that support the confinement by quarantine of groups of possibly infected people for extended periods to slow the spread of influenza. A World Health Organization Writing Group, after reviewing the literature and considering contemporary international experience, concluded **that 'forced isolation and quarantine are ineffective and impractical.'** Despite this recommendation by experts, mandatory large-scale quarantine continues to be considered as an option by some authorities and government officials.

The interest in quarantine reflects the views and conditions prevalent more than 50 years ago, when much less was known about the epidemiology of infectious diseases and when there was far less international and domestic travel in a less densely populated world. **It is difficult to identify circumstances in the past half-century when large-scale quarantine has been effectively used in the control of any disease. The negative consequences of large-scale quarantine are so extreme** (forced confinement of sick people with the well; complete restriction of movement of large populations; difficulty in getting critical supplies, medicines, and food to people inside the quarantine zone) **that this mitigation measure should be eliminated from serious consideration.**<sup>133</sup>

### 9.3.3 *The 2007 Scottish framework for influenza pandemic rejected lockdowns*

The 2007 *Scottish framework for responding to an influenza pandemic* considered and rejected the ideas both of contact tracing and lockdowns:

Whilst it might be possible to isolate initial cases and quarantine their immediate contacts, such an approach will become unsustainable after the first few hundred or so cases. **Geographic quarantining measures** ('cordons sanitaires') have been used in an attempt to isolate affected communities in the past, but are **unlikely to be effective against pandemic influenza** in the UK as infection is expected to affect all major population centres within one to two weeks of initial cases being identified.<sup>134</sup>

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<sup>132</sup> <https://www.usatoday.com/story/news/2015/06/03/mers-south-korea-quarantine/28406489/>

<sup>133</sup> Inglesby, Thomas V., et. al., 'Disease Mitigation Measures in the Control of Pandemic Influenza', *Biosecurity and Bioterrorism*. Volume 4, Number 4, 2006. Short URL: <https://bit.ly/3mTUrCN>.

<sup>134</sup> <https://bit.ly/37EBxLd>

We can unambiguously confirm that no official publication or plan has ever recommended lockdowns. That is because lockdowns cannot eradicate a flu-like virus which is able to transmit even when it is asymptomatic or mildly symptomatic.

### 9.3.4 *The Great Barrington Declaration rejects lockdowns*

The Great Barrington Declaration, created by some of the world's best epidemiologists, has an FAQ which states:

Basic epidemiological theory indicates **that lockdowns do not reduce the total number of cases in the long run and have never in history led to the eradication of a disease**. At best, lockdowns delay the increase of cases for a finite period and at great cost<sup>135</sup>.

Harvard Medical School Professor Martin Kulldorff has summarised the science of lockdowns by stating: “By increasing other types of morbidity during lockdowns, we end up with much higher mortality in the long-term with lockdowns”.<sup>136</sup>

We can summarise the science by noting that lockdowns do not eradicate coronavirus from planet Earth. They merely stop the development of immunity among those who could then have acted as barriers to the spread of disease. Further, there are innumerable voluntary and better ways to “flatten the curve” should the health system ever come under pressure.

## 9.4 Unscientific claims

### 9.4.1 *Unscientific claim 1: That there is a duration for which lockdowns are 'beneficial'*

Some people have suggested that lockdowns might be helpful for a short duration during a crisis.

For instance, WHO envoy Dr. David Nabarro has said that: “The only time we believe a lockdown is justified is to buy you time to reorganize, regroup, rebalance your resources, protect your health workers who are exhausted, but by and large, we'd rather not do it”.<sup>137</sup>

Likewise, Professor Emanuel Ornelas suggested on 28 March 2020 that there might be a duration for which lockdowns might reduce overall costs<sup>138</sup>. And Boris Johnson's pandemic adviser Graham Medley said on 4 April 2020<sup>139</sup> that, “for all countries at some point, prolonged lockdowns risk causing more suffering than the killer virus itself”. This suggests Medley thinks there might be a duration when lockdowns do not cause this additional suffering.

But such views are wrong in *many* ways.

There is simply no reason to resort to draconian measures to “reorganize, regroup, and rebalance resources”.

- First, flu-like pandemics are entirely predictable and all nations have their plans. The situation should not arise in a Western nation to even consider locking down everything just to get its act together. We know from Sweden's example that pandemic management can work without a glitch if planned well.
- Second, a vast suite of voluntary and targeted measures exist to deal with that issue if it ever does arise. There are innumerable non-criminal voluntary ways to slow down the spread of a flu-like virus to “flatten the curve” without resorting to draconian measures that have significant harmful effects.

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<sup>135</sup> <https://gbdeclaration.org/frequently-asked-questions/>

<sup>136</sup> Kulldorff, Martin, Tweet, 29 August 2020. Short URL: <https://bit.ly/2RUc0oe>.

<sup>137</sup> <https://nypost.com/2020/10/11/who-warns-against-covid-19-lockdowns-due-to-economic-damage/>

<sup>138</sup> Ornelas, Emanuel, “Managing economic lockdowns in an epidemic”, VOX-EU, 28 March 2020. Short URL: <https://bit.ly/30ellKV>.

<sup>139</sup> Dettmer, Jamie, “Officials Face Hard Questions in Weighing COVID Lockdown Exit Strategies”, VOA News, 4 April 2020. Short URL: <https://bit.ly/3idnhuF>.



- Third, had such views had any validity, they should have formed part of WHO’s October 2019 guidelines along with a detailed discussion of the evidence (and the ethics) for such claims. There is no such evidence.
- Fourth, hospital capacity is regularly exceeded all over the world for short durations during the flu season but no one has ever suggested shutting down the entire society because a short-term capacity constraint. In this case, though, there have been few instances of a capacity constraint. Sweden had 20% spare capacity even at its peak, despite having one of the world’s oldest populations. South Dakota in the USA never reached even close to capacity.

As WHO envoy Dr Nabarro is not authorised to make on-the-spur-of-the-moment statements that go outside the scope of proven science and WHO’s own 2019 guidelines, as well as the WHO’s 2011 News Bulletin which strongly criticised hysteria and fear driven policies during pandemics.

Even a short duration lockdown on a society-wide basis will cause significant collateral health harms (crimes) and therefore would not pass any ethical test.

Such scientists also seem not to be aware of the science of pandemics, that flu-like pandemics spread very quickly once they are established in a community. They do not seem to be aware that the 2007 *Scottish framework for responding to an influenza pandemic* stated that “infection is expected to affect all major population centres within one to two weeks of initial cases being identified”<sup>140</sup>. There is strong evidence that this is what happened in 2020 in most European countries. This means that **all preparation must be done in advance**. Locking down society after a virus has entered cannot help in the preparation.

That is why Professor Martin Kulldorff is correct to argue that no duration of lockdowns is justifiable, since by increasing other types of morbidity during lockdowns, we always end up with higher mortality in the long-term.

But even, for the sake of argument – if the Victorian Administering Authorities argue to the ICC that they became hysterical and lost their sense in the initial weeks of March 2020 – that can’t explain why they have remained hysterical for over seven months. No public health emergency gives a government *carte blanche* to disregard human rights for as long as a health problem persists. The emergency measures taken by the Accused were promulgated a long time ago: in March 2020. What were initially billed as temporary measures necessary to ‘flatten the curve’ and protect hospital capacity soon converted into open-ended and ongoing restrictions aimed at a very different end – eradication.

There is no duration for which lockdowns are justified. Any such justification would necessarily have to be pre-determined through extensive scientific, legal, and ethical analysis.

#### 9.4.2 *Unscientific claim 2: That lockdowns work*

The Accused might present to the ICC some “scientists” who have actively supported, even canvassed for lockdowns in 2020. Such claims cannot be sustained for innumerable reasons, some of which include:

1. These scientists cannot deny any of the facts I have presented. They cannot present any peer-reviewed evaluation of lockdowns which supports them for a flu-like pandemic. They cannot present any WHO or CDC guideline prior to 2020 supporting lockdowns even remotely. They cannot present any pandemic plan for flu-like viruses from anywhere in the world to support their claims.
2. Second, most such scientists have no credibility of their own. For instance,

**A) Professor Neil Ferguson** has repeatedly put out exaggerated estimates not just for this but for many prior pandemics. He has no credibility in the scientific profession. Johan Giesecke, the former chief scientist for the European Centre for Disease Control and Prevention, has opposed Ferguson’s calamitous estimates. On 28 March 2020 he said that Ferguson’s model is “one of the

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<sup>140</sup> <https://bit.ly/37EBxLd>

most wrong” papers ever published<sup>141</sup>. Later, Anders Tegnell of Sweden got the model investigated by his team and has repeatedly stated in the media that he does not agree with Ferguson’s findings.

To get a sense of how wrong Ferguson’s upper end estimate was, here’s what a 29 July 2020 article reported<sup>142</sup>:

On May 10, Dagens Nyheter – Sweden’s biggest daily newspaper – analysed a pair of models inspired by the Imperial College of London study, which predicted as many as 40 million people could die if the coronavirus was left unchecked. The models predicted that Sweden’s ICUs (intensive care units) would expire before May and nearly 100,000 people would die from COVID-19 by July.

“Our model predicts that, using median infection-fatality-rate estimates, at least 96,000 deaths would occur by 1 July without mitigation,” the authors wrote.

Total COVID-19 deaths in Sweden stand at 5,700, nearly 90,000 less than modellers predicted. Hospitals were never overrun. Daily deaths in Sweden have slowed to a crawl. The health agency reports no new ICU admissions.

Recently, the scientist Mike Yeadon has said that “no serious scientist gives any validity” to Ferguson’s model<sup>143</sup>. “It’s important that you know most scientists don’t accept that it [Ferguson’s model] was even faintly right...but the government is still wedded to the model”.

**B)** Likewise, there is **Dr Anthony Fauci**. Governor Kristi Noem of South Dakota said<sup>144</sup> on 15 October 2020 that Fauci had told her that she would need 10,000 beds at a time without lockdowns. But she refused to implement any lockdown and the maximum beds she needed at any point in time were just 200. Fauci is just the typical scare-monger of the type cited in the World Health Organisation’s 2011 Bulletin.<sup>145</sup>

Such scientists may have relevant qualifications and even have some relevant experience but their support for lockdowns is baseless.

3. As I have shown above, the claims from some scientists that lockdowns *might* work in the short-run are hypotheses that fly in the face of science. Such views are not based on peer-reviewed, well-accepted scientific and ethical analysis.

4. By now we know conclusively that the 2020 lockdowns have not “worked” (as discussed earlier). Instead, there are strong reasons to suggest that **lockdowns may be causing additional COVID (i.e. virus) deaths** – even ignoring the additional carnage they cause.

Science is sure to come down very harshly on the 2020 human experiment of lockdowns. Any scientist today who tries today to justify lockdowns, even for a short duration, is both wrong and (in my view) guilty of being an accomplice to crimes against humanity.

We must not forget that many “scientists” supported Hitler. Just being a scientist does not mean that someone is doing science. Science is a transparent and open process of evidentiary proof that everyone on Earth can get involved with. Science has to be open, replicable, transparent and available for scrutiny.

Lockdowns do not work even for Ebola-like viruses. That is what the science states today. There is no reason to expect that science will change its mind in the future, regardless of any wishful thinking from

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<sup>141</sup> Rushton, Katherine, and Foggo, Daniel, “Neil Ferguson, the scientist who convinced Boris Johnson of UK coronavirus lockdown, criticised in past for flawed research”, *The Telegraph*, 28 March 2020. Short URL: <https://bit.ly/33mkpXV>

<sup>142</sup> Miltimore, Jon, “Sweden’s Actual COVID-19 Results Compared to What Modelers Predicted in April”, Foundation for Economic Freedom, 28 July 2020. Short URL: <https://bit.ly/3inEJMK>.

<sup>143</sup> Lopez, Ralph, “Former Chief Science Officer for Pfizer Says ‘Second Wave’ Faked on False-Positive COVID Tests, ‘Pandemic is Over’”, HubPages, 1 October 2020. Short URL: <https://bit.ly/2RZZV0F>.

<sup>144</sup> <https://www.youtube.com/watch?v=R6HQM3ZzyhM>

<sup>145</sup> <https://www.who.int/bulletin/volumes/89/7/11-089086/en/>

alleged “scientists”. “Scientists” who claim that lockdowns “work” (or could work for a short duration) neither know the science nor understand the meaning of “work”.

The existence of a few “flat-earthers” who have been trying to go against the well-established science of flu-like pandemics during 2020 does not make them right. Just because a “scientist” says that the sun rises from the West does not make it so. We know very well that the public health field is full of scare-mongers<sup>146</sup> and we need to be on guard against them.

In addition, there are innumerable other reasons, not just scientific, to reject lockdowns. Lockdowns have been declared unconstitutional in Pennsylvania in the USA since they are grossly disproportionate. The human rights and ethical issues raised by lockdowns and the collateral harms caused will never allow lockdowns to be justified for a flu-like virus.

## 9.5 Legally, lockdowns are not quarantine but a form of imprisonment

The lockdowns imposed in Victoria fall well outside the scope of Australia’s **quarantine** laws. I use the example of USA here but similar principles apply to Australia.

On 14 September 2020 Judge William Stickman struck down the lockdown orders of the Governor of Pennsylvania. Basically, we quarantine sick people but lock down prisoners. He cited the *Pennsylvania Disease Prevention and Control Law of 1955 which defines quarantine in this manner*:

**Quarantine.** The limitation of freedom of movement of persons or animals who have been exposed to a communicable disease for a period of time equal to the longest usual incubation period of the disease in such manner as to prevent effective contact with those not so exposed. Quarantine may be complete, or, as defined below, it may be modified, or it may consist merely of surveillance or segregation.

Judge William Stickman then determined that lockdowns are not a form of quarantine:

A quarantine requires, as **a threshold matter, that the person subject to the ‘limitation of freedom of movement’ be ‘exposed to a communicable disease.’** Moreover, critically, the duration of a quarantine is statutorily limited to ‘a period of time equal to the longest usual incubation period of the disease’.

The [Pennsylvania] lockdown plainly exceeded that period. Indeed, Defendant’s witnesses, particularly Ms. Boateng, conceded upon examination that the **lockdown cannot be considered a quarantine.**<sup>147</sup>

In Australia the legal term “quarantine” seems to have been replaced from 16 June 2016 by a ‘human biosecurity control order’. However, it is not possible to have changed the medical principles that determine such matters. The principle of time limited duration would still apply.

While the ICC’s Prosecutor may need to examine this issue further (I have not had time to fully study the nature of Australia’s quarantine laws), in my view, lockdowns will be proven unambiguously even in Australia to be a form of mass imprisonment. Calling them an ‘emergency area’ restriction (as they do in Victoria) cannot take away from this underlying legal implication.

Effectively, Accused Group 1 has imprisoned Victorians for months on end without individual charges. A more comprehensive breach of liberty and human rights cannot be imagined in what is allegedly a Western democracy.

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<sup>146</sup> <https://www.who.int/bulletin/volumes/89/7/11-089086/en/>

<sup>147</sup> <https://www.sabhlokcity.com/2020/10/the-full-text-of-the-judgement-striking-down-the-pennsylvania-lockdowns/>

## 10. Abandonment of the plan and Victoria laws – and stealthy adoption of virus eradication

In this chapter I summarise the major failures of decision-making and even law-making in Victoria during this pandemic – how the laws were breached, how arbitrary orders were issued, how scandalous and atrocious new amendments were made to the legislation, how false and alarmist pretexts were provided for declaring the emergency, how there was complete lack of transparency or demonstrable justification, and how the people of Victoria were subject to human experimentation.

Somewhere between **mid- to late-March 2020**, the Victorian Administering Authorities abandoned the approved Victorian Pandemic Plan.

This did not happen in an open, transparent and well-documented manner but by stealth.

Initially the Victorian Chief Health Officer of Victoria wrote a memo<sup>148</sup> to Health Minister Mikakos on 15 March 2020, based on which the Minister signed a State of Emergency on 16 March 2020 (with effect from 19 March 2020).

As a result of the State of Emergency being declared, the CHO issued a Direction on the same date and placed a number of restrictions on Victorians in terms of gatherings and the quarantining of people from overseas for 14 days. However, this initial Direction does not seem to have significantly breached the 10 March 2020 Victorian Pandemic Plan, even though the reasons provided in the Memo that led to the declaration of emergency were extraordinarily hysterical and unbalanced.

Lockdowns only came in from 23 March 2020<sup>149</sup>, and curfews later. By that time it was clear that the Plan had been dumped. It was never referred to again. Also, from that point on, only lip-service was paid to the concept of “flattening the curve”. The real focus since then has been on the eradication of the virus within Australia. Mr Scott Morrison has been fully behind Mr Andrews all the way.

In this chapter I will first compare and contrast the hysterical memos issued by the Chief Health Officer against the well-balanced views in the 10 March 2020 Pandemic Plan before detailing other breaches of the laws and good policy process.

### 10.1 No basis for emergency declarations

#### 10.1.1 *Nothing had changed in five days*

Victoria had a published pandemic plan on 10 March 2020 that stated (correctly) that **‘COVID-19 is assessed as being of moderate clinical severity’**. Further, the plan did not limit itself only to a pandemic of moderate severity. It stated that ‘we are preparing so that **we are ready to respond if a larger, or more severe outbreak occurs’**.

By 15 March 2020, within five days, no reason had emerged from anywhere for the government to change its mind (In my book, I suggest it might have been the hysterical 16 March 2020 modeling of Neil Ferguson that might have precipitated hysteria in Victoria). Further, existing powers under public health legislation had not been exhausted. Most powers under the Public Health Act, such as detaining people, restricting movement, preventing entry to premises **do not require emergency powers**.

Yet, on 15 March 2020 the CHO wrote his infamous memo which led to the declaration of emergency. In retrospect, it is clear that the only reason for this emergency declaration was to scare the people of

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<sup>148</sup> <https://sanjeev.sabhllokcocity.com/Misc/CHO%20letter%20to%20HM%20Mikakos%2015%20March%202020.pdf>

<sup>149</sup> <https://www.heraldsun.com.au/news/victoria/latest-coronavirus-news-young-people-urged-to-follow-social-distancing-advice/news-story/16a404629f2bf975f4f3a539804b6f2f>

Victoria, to prime them for harsh lockdowns that would form part of the eradication strategy that was implicit in this shift from sanity to insanity.

### *10.1.2 Objective assessment not provided*

Emergency powers are not intended to be used without a very strong reason. Section 62 of the Siracusa Principles makes clear that any proclamation of emergency shall be on the basis of “objective assessment”, which means empirically valid analysis that any rational person can understand.

62. A proclamation of a public emergency shall be made in good faith based upon an **objective assessment of the situation** in order to determine to what extent, if any, it poses a threat to the life of the nation. A proclamation of a public emergency, and consequent derogations from Covenant obligations, that are not made in good faith are violations of international law.<sup>150</sup>

Victoria’s declaration of emergency was **not even remotely based on any “objective assessment”**. Instead, models – that are merely the wild imagination of alleged “scientists” – were used. The memos from the Chief Health Officer that underpin these emergency proclamations do not even tangentially meet the standard of objective assessment. I should know. I have spent decades in public service across India and Australia, and 15 years in Victoria looking into justifications for a wide range of policies. These memos are a travesty.

### *10.1.3 Chief Health Officer’s 15 March 2020 memo was deranged and alarmist*

On 15 March 2020 the Victorian Chief Health Officer of Victoria wrote a memo<sup>151</sup> to Health Minister Mikakos, based on which the Minister signed a State of Emergency on 16 March 2020. (These memos to justify emergency powers are in the public domain since they need to be tabled in the Parliament.)

The 15 March 2020 memo is deranged, with no relationship to reality, no semblance of reasoning. It is a litany of claims of panic and hysteria that are not justified or proportionate in any way.

Sadly, it is through such bogus “analysis” that the well-balanced assessment in the 10 March 2020 plan was overturned within just five days. This is an example of **pretend compliance** at its worst: a tick-a-box approach while missing the substance.

#### **Extreme alarmism**

The CHO does not mention the advice in Victoria’s Pandemic plan of 10 March 2020 which had clearly said that “COVID-19 is assessed as being of **moderate clinical severity**”. He does not mention that all was under control just five days ago. He does not explain what has changed in five days.

He starts out as if Victoria had no preparedness, no advance thinking or planning, and that everything was now dependent solely on the genius of just this one person: the CHO.

He starts in the memo by saying the complete opposite of what is in the 10 March 2020 plan:

The morbidity and mortality projections for Victoria are a **serious threat** to the population, create serious risks particularly for the elderly, chronically ill and vulnerable, and a significant burden will be placed on the Victorian health system to respond at a scale that has little precedent.

I have bolded and underlined this last phrase: “scale that has little precedent”. This phrase set the tone for hysteria-making that has not stopped even today. And note that he is talking about “projections”, and – as expected – he refers immediately thereafter to (entirely discredited) mathematical models.

The current best available international evidence and **modelling** indicates that throughout Victoria, in a severe scenario, if the mitigating steps are not taken, in the next four months 54,939

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<sup>150</sup> <http://hrlibrary.umn.edu/instreet/siracusaprinciples.html>

<sup>151</sup> <https://sanjeev.sabhlokciv.com/Misc/CHO%20letter%20to%20HM%20Mikakos%2015%20March%202020.pdf>

people will require hospitalisation across the epidemic, with 12,552 in hospital at peak and 1,556 daily hospital admissions at the peak.

But there was no such “best available international evidence”. He did not take into account Sweden’s approach, which is also part of “international evidence”. Sweden had not shifted its approach one inch nor declared any emergency.

He was cooking up wild statements and also liberally using words like “evidence-base” and “proportionality” without the use of these words bearing any resemblance to their meaning. As if to cover all bases, he also threw in the infamous “precautionary principle”.

The memo is a hodgepodge of panic and chaos.

For something to be proportional, context has to be provided. But only tunnel-vision and hysteria is evident in the memo – a singular focus on the virus, and no context about anything else in the world.

We know that around 110,000 people die annually of all causes in Victoria. According to the memo, the pandemic could kill 6,808 Victorians in a “severe unmitigated scenario” and 3,192 in a “moderate scenario”. **In context, even these “worst case” figures may seem bad but not alarming enough to declare an emergency.** In the more reasonable “moderate” scenario, the projected 3,192 deaths would not be particularly different from a bad flu season. Definitely no reason for an “emergency”, no reason to shut down Victoria from 23 March 2020.

#### **No mention of any review process or consultation on the findings**

The memo did not provide any opportunity for public input or discussion about the “justifications” that were being offered. The memo did not lay out any review process for evidence, data and modelling. No such review occurred, so when the next memo was issued six months later to justify the extension of the emergency, it continued in the same alarmist vein.

But from mid-April 2020 it was very clear that this pandemic is nowhere as severe as had been originally envisaged. By then **all** epidemiological models had, once again, as usual, completely failed.

#### ***10.1.4 Claim of flattening the curve but the hidden reality of eradication***

It was said that the declaration of emergency would “begin on Monday, 16 March at midday and be in force for the next four weeks to assist with measures designed to **flatten the curve**’ of COVID-19 and give our health system the best chance of managing the virus”<sup>152</sup>

But we know this claim was a big lie, for within days (23 March 2020), Andrews started enforcing draconian restrictions with a single goal: to **eradicate** the virus from Victoria. This lie has never stopped.

#### ***10.1.5 Chief Health Officer’s 11 September 2020 memo - reckless and alarmist***

The CHO’s 11 September 2020 memo<sup>153</sup> that was tabled in the Parliament continued on a hysterical and alarmist note.

As noted above, from mid-April 2020 all model forecasts had failed but instead of admitting that, the CHO declared on 11 September 2020:

Pursuant to section 198(1) of the Act, the Minister may declare an extension to a state of emergency arising out of any circumstances that **continue to present a serious risk to public health.**

He also filled the memo with even more patently false information:

Avoiding the risk of a rebound in case numbers is necessary in order to avoid another lockdown and **cases overwhelming the hospital system**, or a higher fatality rate.

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<sup>152</sup> <https://www.premier.vic.gov.au/state-emergency-declared-victoria-over-covid-19>

<sup>153</sup> <https://sanjeev.sabhlokciv.com/Misc/CHO%20memo%2011%20September%202020.pdf>

The morbidity and mortality projections in the event of control not being maintained for Victoria are a **serious threat to the population**; create serious risks particularly for the elderly, chronically ill and vulnerable; and a **significant burden will be placed on the Victorian health system to respond at a scale that has little precedent**.

This is a huge lie. There was never the remotest pressure on Victoria's health system nor any prospect of that happening. The claim by the Premier on 15 March 2020 that Victoria was going to flatten the curve is disproven by such claims in the CHO's memo. There was never any intent to flatten the curve but to eradicate the virus, but they could not put that down in writing since that would be a direct breach of the Biosecurity Act.

Perhaps the biggest proof of this memo being part of an orchestrated plan to create terror is the claim in the memo that the young can also die. The numbers or proportions were not mentioned. It was implied, therefore, that anyone and everyone could die:

However, while some demographic profiles are at greater risk of severe illness and death, all Victorians are potentially vulnerable to infection, and it is not possible to determine with confidence who will have mild self-limiting illness and who will have a poor outcome. As we have seen in Victoria, **young people can also succumb to severe illness and the severity of illness cannot always be predicted by age or comorbidities alone**.

This memo is clearly focused, through its suite of deception and lies, on creating hysteria.

## 10.2 Modelling is discredited globally; Modelers with no infectious disease background

I have discussed this earlier but wish to emphasise that models can never form the basis of any public policy, particularly for a pandemic in which tens of thousands of factors come into play which no model can *possibly* accommodate. At best, models can support the policy process.

But the main data for policy making should include things like the actual gap in the capacity of the health care system. Such data was never presented because there was always huge spare capacity.

But Victoria also seems to have had particularly bad modellers. Aaron Patrick wrote in the *Australian Financial Review* on 16 September 2020 that:

One of the mysteries behind Victoria's plan out of one of the most extreme pandemic lockdowns anywhere is: why did the government select a team of highly opinionated non-specialists to advise when normal life would be safe to begin again. **The lead researchers who built the model used for Daniel Andrews COVID-19 "road map" aren't infectious diseases scientists**. The team does include epidemiologists such as New Zealander Tony Blakely. But his career has spanned computer science, economics, smoking and cancer.<sup>154</sup>

Not to be outdone, some of the modelers themselves objected to the misuse of their models. On 12 September 2020, it was reported in the newspapers that:

**World-leading scientists linked to the modelling** Daniel Andrews has used to lock down Melbourne say **the research has been misrepresented** and have urged the Premier to rethink the restrictions as his virus -suppression targets are impossible to meet.<sup>155</sup>

This would have been a comedy of errors if only it did not have such disastrous consequences for millions of people.

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<sup>154</sup> Patrick, Aaron, "Did Daniel Andrews cherry-pick his modellers?", *Australian Financial Review*, 16 September 2020. <https://www.afr.com/policy/health-and-education/did-daniel-andrews-cherry-pick-his-modellers-20200914-p55vjz>

<sup>155</sup> "Professors' message for Daniel Andrews: redo the coronavirus modelling", *The Australian*, 12 September 2020, <https://www.theaustralian.com.au/nation/politics/professors-message-for-daniel-andrews-redo-the-coronavirus-modelling/news-story/5cf65533b11cce3ef23f3cfedd247143>

### 10.3 Repressive and arbitrary “public health” measures

Underpinning the radical change in policy within five days was the hidden strategy of **extreme suppression of the virus** within Australia while waiting for a vaccine. We now about this only from verbal statements of Daniel Andrews, who said on 4 July 2020:

At that point we will not be returning to normal because there will be no vaccine in the weeks ahead, some argue even in the months ahead. It is a long way off. And unless and until that vaccine is developed, and then *administered to every single Victorian*, we will have to live with and embrace a COVID normal.<sup>156</sup>

In order to achieve extreme suppression, Accused Group 1 had to introduce extraordinarily repressive experimental measures like lockdowns and mandatory masks outdoors that had been rejected by the science.

As doctors from the Covid Medical Network have said, “the ambition for ‘viral elimination’ and the intent of achieving zero cases for a period of time, is both **irrational and unachievable**, according to the best local and international evidence”.<sup>157</sup>

#### 10.3.1 *Disproportionate, arbitrary public health measures not targeted to the risk*

It is evident that since around mid- to late-March 2020, **all** mandatory ‘public health’ measures (lockdowns, curfews, mandatory masks) imposed by the Victorian Administering Authorities are **unlawful, unethical and arbitrary** – therefore potentially **crimes**, particularly those that directly caused serious mental and physical harm. The sum total of these millions of small crimes is the Article 7 crime against humanity.

These “public health” directions do not provide any analysis of the reasons, have no ethical assessment and no assessment of the harms they might cause: only a claim that these are somehow reasonable. The Victorian Administering Authorities rejected an evidence-based approach that was part of the 10 March 2020 pandemic plan. They **did not focus on the high-risk segment** of the population. Instead, they have **focused on the low-risk segment** of Victoria’s population. And in doing so they have brutally attacked this low risk segment through the Police, including through obtrusive surveillance (drones).

This lack of focus on the high-risk segment has led to around 800 avoidable deaths mainly in aged care.

#### 10.3.2 *Human experimentation without consent: lockdowns, curfews, mandatory masks*

As noted earlier, the Victorian Administering Authorities have effectively been conducting a wide range of human experiments on Victoria’s population – experiments that are prohibited by the law.

Illustratively, the Victorian Administering Authorities imposed a mandatory mask requirement on millions of Victorians even **outdoors**. The science on masks is very controversial<sup>158</sup> but there are no benefits, *only* harms, when masks are worn outdoors. This mandate, too, was brutally enforced through the police.

Further, thousands of school children over the age of 12 have been forced to wear a mask at school when they are at virtually no risk from the virus<sup>159</sup> - thus permanently damaging their brain development.

I will repeat Sections 58 and section 69 of the Siracusa Principles here as context:

58. No state party shall, **even in time of emergency** threatening the life of the nation, derogate from the Covenant’s guarantees of the right to life; freedom from torture, cruel,

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<sup>156</sup> *The New Daily*, ‘Victoria’s COVID crisis grows: Two more postcodes locked down, 108 fresh cases’, 4 July 2020. Short URL: <https://bit.ly/3ixgeg9>. The video of Daniel Andrews’s statement is found in a Tweet by @YellowCube7 on 3 October 2020. Short URL: <https://bit.ly/3cWdmbD>. Also at: <https://www.facebook.com/sabhlok/posts/10159024532863767>

<sup>157</sup> <https://covidmedicalnetwork.com/about-covid-medical-network/declaration-statement.aspx>; PDF at: <http://sanjeev.sabhlokcity.com/Misc/CMN Statement Final Version 5-10 signatories.pdf>.

<sup>158</sup> <https://twitter.com/ManualMethod/status/1319539258110087169>.

<sup>159</sup> <https://twitter.com/sabhlok/status/1315015492289982464>



inhuman or degrading treatment or punishment, and from **medical or scientific experimentation without free consent**; freedom from slavery or involuntary servitude; the right not to be imprisoned for contractual debt; the right not to be convicted or sentenced to a heavier penalty by virtue of retroactive criminal legislation; the right to recognition as a person before the law; and freedom of thought, conscience and religion. These rights are not derogable under any conditions even for the asserted purpose of preserving the life of the nation.

69. No state, including those that are not parties to the Covenant, may suspend or violate, even in times of public emergency:

(b) **freedom from** torture or cruel, inhuman or degrading treatment or punishment and from **medical or scientific experimentation**.<sup>160</sup>

These experiments also contravene the Nuremberg Code.

If the Andrews experiment was a clinical trial it would have never received ethics approval. Even one death in a clinical trial is reason to pause and review the trial's future. Instead, the most bizarre types of human experiments have been conducted (and continue to be conducted) upon the people of Victoria without any consent from any one of us – even as it was abundantly clear from mid-April 2020 that the models used to justify the lockdowns were hopelessly inaccurate.

Andrews and his team have kept tinkering with the settings of their 'human experiment' – things like curfews, 5 km, 25 km rules; 2, 5 and 10 people gatherings; facemasks everywhere, even outdoors, and so on.

### ***10.3.3 No inputs asked or accepted from the people of Victoria***

The Victorian Administering Authorities have never published the detailed reasoning, scientific proofs and analysis of the ethical and human rights implications of their totalitarian "public health" measures.

During the 15 years I worked in the Treasury, I was not used to bad policies being implemented in this State. Economists like me help various departments design policies by identifying the nature of the problem (including associated risks) that they are trying to address, then recommending an option to the government that deals with the problem in a targeted manner – more like a surgeon's scalpel than an axe: an option which also strikes the right balance between the competing objectives of the government.

**All such policy has traditionally been developed in Victoria consultatively and transparently, with a lot of community engagement.** We have a web portal called *Engage Victoria*<sup>161</sup> for such consultation. We are (or were) a deliberative democracy.

But this time around there has been a black box around the policy-making process, a Star Chamber of "leaders" where no information is shared with anyone. The Accused have refused to subject themselves in any way to public scrutiny.

No matter how many commentators (and, later, from mid-September 2020, my *Australian Financial Review* article<sup>162</sup>, presentations on the media and a book – *The Great Hysteria and The Broken State*<sup>163</sup>) have tried to warn Daniel Andrews against his actions, he has not changed his stance. A journalist asked Andrews in a press conference about my resignation from the Treasury but he said it was just my opinion. He should have known that I have been advising different governments in Victoria on a wide range of public policies. My opinion is not just any opinion, it is a deeply informed opinion.

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<sup>160</sup> <http://hrlibrary.umn.edu/instreet/siracusaprinciples.html>

<sup>161</sup> <https://engage.vic.gov.au/>

<sup>162</sup> <https://www.afr.com/policy/economy/victoria-has-locked-itself-into-a-lockdown-blunder-20200916-p55w1z>

<sup>163</sup> <https://liberatevictoria.org/the-great-hysteria-and-the-broken-state/>

Further, as mentioned earlier, over 500 Victorian doctors wrote to Daniel Andrews on 5 October 2020 to caution him about the extraordinary harms from his “public health” measures but he has not cared to respond to them.

#### 10.4 The scandalous 2020 amendment to the Public Health Act 2008

The *Public Health and Wellbeing Amendment (State of Emergency Extension and Other Matters) Act 2020*<sup>164</sup> is a direct attack on all principles of proportionality, basically empowering the CHO to impose whatever restrictions he can dream of. Just because something is in legislation does not make it right.

Basically, the amended Act now asserts that there is a “material risk to the health of human beings” even **when there are no cases of COVID-19 in Victoria “for a period of time”**. **Even if there is no evidence of any COVID-19 disease, Victorians can be deprived of all their human rights.**

The idea that something can pose a risk to health when it doesn’t exist is so absurd, like the belief in ghosts, that this amendment effectively **eliminates** the concept of risk-assessment, evidence-base for a policy and proportionality.

### Part 2—Amendment of the Public Health and Wellbeing Act 2008

#### 3 Definitions

(2) After section 3(3) of the **Public Health and Wellbeing Act 2008** insert—

"(4) Without limiting the definition of *serious risk to public health* in subsection (1), for the purposes of Division 3 of Part 10 COVID-19 may pose a material risk of substantial injury or prejudice to the health of human beings even when the rate of community transmission of COVID-19 in Victoria is low or there have been no cases of COVID-19 in Victoria for a period of time."

I trust the ICC’s Prosecutor can see through this totalitarian regime’s intentional attack on the life and liberty of Victorians. They have tried to build a fence around themselves by legislating away all human rights, all international covenants and all laws. But this ring-fence is imaginary: they are ultimately accountable to humanity. A “law” absolving them of the need to take into account reality is not good enough to defend them against the International Criminal Court.

#### 10.5 Refusal by Victorian Administering Authorities to assess lockdown harms

I will provide more details about key “public health” measures of the Victorian government subsequently, but it is worth noting at this point that the Victorian Government has repeatedly refused to even identify, let alone assess, the harms from its policies.

This is not just happening in Australia. As Dr Simon Thornley of New Zealand has noted regarding New Zealand’s policies (similar in many ways to Australia’s) the Government’s elimination and lockdown policy was based on hope because little analysis of the downsides of the policy has been carried out.

**If you base your rationale on discredited models and you don’t count impacts**, this is not a policy based on evidence. “This is a policy based on an assumption that the low Covid-19 impact is the result of the lockdown policy. There is no proof of that, and international studies indicate it is unlikely.”<sup>165</sup>

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<sup>164</sup> <https://www.legislation.vic.gov.au/as-made/acts/public-health-and-wellbeing-amendment-state-emergency-extension-and-other-matters-act>

<sup>165</sup> <https://www.covidplanb.co.nz/epidemiology/call-for-data-on-covid-19-health-impacts/>

A crucial part of a good public policy process to consider potential negative impacts, but none of that was done in this case.

I have no doubt that members of the Accused Group 1 are fully aware of the harms they are causing but they have studiously avoided looking into this systematically. For instance:

- In one of Mr Daniel Andrews’s early press conferences he was asked about these costs and said words to the effect that ‘we will work that out later’.
- A question was asked on 4 August 2020 in the Victorian Parliament whether “the Minister and the Government done a breakdown of the health costs of the strategy of elimination and compared it with the health costs of the strategy of suppression, which is currently being pursued and, if so, will she make the results public”<sup>166</sup>. The Minister refused to answer the question, instead, stating: “The Victorian Government is focused on the immediate issue of flattening the curve, reducing cases and driving down rates of unknown community transmission”.

But – as I note below – the Accused have actually, albeit tangentially, admitted to a wide range of harms their policies have caused. The ICC’s Prosecutor could ask the Accused to provide proofs that they anticipated and therefore prevented the harms that were certain to arise from the suppression of the virus.

### *10.5.1 Victoria’s Treasurer has admitted to “devastating” economic harms from lockdowns*

Victoria’s Treasurer Tim Pallas admitted on 10 September 2020 that “These restrictions are keeping us all safe but they come at a **devastating** economic cost”<sup>167</sup>.

### *10.5.2 Victorian Administering Authorities have admitted to significant mental harms*

On 10 August 2020 it was reported that: “In response to the increasing number of people having a hard time coping with the pandemic, the Victorian government yesterday announced **an additional A\$59.7 million in funding for mental health services**”<sup>168</sup>. This is a clear indication that the Victorian government had become aware of the enormous harms its lockdowns were causing.

On 11 September 2020 the Chief Health Officer of Victoria<sup>169</sup> admitted to “significant impact on the well-being of Victorians” from “the measures” (lockdowns) to “**slow the spread of coronavirus**” but did not quantify or assess these harms in any meaningful way (of course, the claim that the CHO was in any way trying to “slow down” the spread of the virus (flatten the curve) is a blatant lie: there was never any capacity issue in the health system. He has been without doubt trying to eradicate the virus):

81. I acknowledge the measures taken to **slow the spread** of coronavirus will have a **significant impact on the wellbeing of Victorians, especially those who are living or parenting alone, as well as those who have mental health conditions or other complex needs.**

82. While there has been evidence of the strong resilience of the Victorian community during the state of emergency (for example, a Coroner’s Court of Victoria report on 27 August 2020 found that the number of suicide fatalities remained consistent at 466 this year compared to 468 from last year), there is **significant evidence of the community’s distress due to the significant limits on social movement and interaction** (such as a 40% increase in calls to Lifeline when restrictions were strengthened in August 2020).

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<sup>166</sup> [https://www.parliament.vic.gov.au/images/Hayes\\_040820\\_.pdf](https://www.parliament.vic.gov.au/images/Hayes_040820_.pdf)

<sup>167</sup> <https://twitter.com/timpallas/status/1303907008920211457>

<sup>168</sup> <https://theconversation.com/the-victorian-government-has-allocated-60-million-to-mental-health-but-who-gets-the-money-144188>

<sup>169</sup> <http://sanjeev.sabhlokcity.com/Misc/CHO%20memo%2011%20September%202020.pdf> - extracted from a Parliamentary document.

### *10.5.3 Victorian Administering Authorities have tangentially acknowledged harms to life*

It was reported on 11 September 2020 in ABC News<sup>170</sup> that:

Hospitals are reporting a ‘concerning’ decline in the number of Victorians seeking treatment for heart attacks and strokes, as well as essential cancer screening, during the state’s coronavirus second wave. Health Minister Jenny Mikakos said the number of people presenting to emergency departments with strokes was down 24 per cent on the same time last year. For heart attacks, the number of ED presentations was down 18 per cent. “This does suggest that **people are putting off seeking urgent and important medical care that could make that critical difference to their life.**” Ms Mikakos said.

The report also noted that: “Victoria has seen a 30 per cent drop in reports for the five most common cancers”.

But to date the Victorian Administering Authorities have not formally identified these additional physical harms (and shortening of lives) caused their coercive lockdowns.

I will elaborate these harms in a subsequent chapter.

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<sup>170</sup> <https://www.abc.net.au/news/2020-09-11/victoria-coronavirus-drop-in-stroke-heart-attack-cancer-screens/12654588>

## 11. Fear mongering and Police brutality

The coercive “public health” measures (attack measures) against the people of Victoria that have been described in this complaint should be considered as a whole. I have split elements of these measures into separate chapters for ease of presentation.

### 11.1 A Police State to create fear psychosis

The WHO’s International Health Regulations 2005 specify that “a health measure does not include law enforcement or security measures”. This suggests that police must not be used to enforce public health measures or only minimally, when necessary. But the active use of Police has been a major part of the coercive approach of Victoria.

The Police have been empowered through emergency powers. They are allowed to enter homes without a warrant: “The state of disaster declaration will empower the police minister, Lisa Neville, to appoint police as authorised officers. This means when doing spot checks on people’s homes, if the residents did not give permission for them to enter, police will be authorised to enter without a warrant”<sup>171</sup>. The Police has been ordered to do things that are unjustified, disproportionate and without any proven science benefits.

#### 11.1.1 *Brutally enforcing mandatory mask orders on people with insignificant COVID risk*

The Police have in one case smashed a person’s head with a boot and sent him into induced coma for not wearing a mask outdoors.<sup>172</sup> But the Police has meted out many other brutal punishments to innumerable otherwise law-abiding citizens, creating a full-blown Police State.

Instead of focusing on protecting the elderly and vulnerable, Police were seen seemingly strangling a young woman outdoors without a mask (a woman who faced virtually no risk of death from COVID-19), putting handcuffs on a pregnant woman in her own home (as if she was going to flee in her pyjamas) and snatching the phone of an elderly lady sitting on a bench. People’s car windows have been smashed if they decline to provide details about their travel or identification. Further, the police has not been waiving fines on appeal despite legitimate reasons.<sup>173</sup>

The social media is full of images and videos of police brutality and excesses.

#### Illustrative videos

- Police brutality on 23 October 2020:  
<https://www.facebook.com/therealrukshan/videos/785907141970980/>
- Police arrested a journalist who was documenting protests:  
<https://www.facebook.com/457673070969056/videos/443006480196325>
- Police behaviour on 3 November 2020:  
<https://www.facebook.com/457673070969056/videos/3351745941546735>  
and  
<https://www.facebook.com/reignitedemocracyaustralia/posts/160098632459676>

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<sup>171</sup> <https://www.theguardian.com/australia-news/2020/aug/02/victoria-premier-daniel-andrews-stage-four-coronavirus-lockdown-restrictions-melbourne-covid-19>

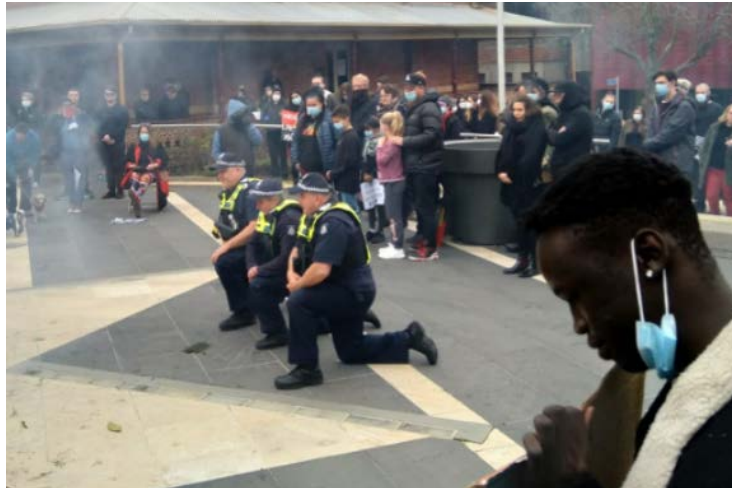
<sup>172</sup> <https://www.abc.net.au/news/2020-09-14/arrest-to-be-examined-by-victoria-police-professional-standards/12661334>

<sup>173</sup> Clayton, Rachel, “Victorian coronavirus fines not being reviewed properly, Melbourne community legal centres say”, ABC News, 30 September 2020. Short URL: <https://ab.co/2EIPVWz>.

### 11.1.2 *Suppressing lockdown protests while “taking the knee” for BLM protestors*

The Victorian Administering Authorities have effectively prohibited, for many months, political liberty by coming down hard against protests against lockdowns. Daniel Andrews has called the protests against lockdowns “unlawful” and “shameful”<sup>174</sup>.

At the same time, the Daniel Andrews has allowed the Black Lives Movement (BLM) protest. Over 10,000 BLM protestors were allowed. Not just that, the Victorian Police, which ruthlessly beats up or arrests anyone who protests the lockdowns, “took the knee” for them (picture below).



On 4 November 2020, David Limbrick, a Member of Victoria’s Parliament issued a press release about atrocities by the Police and its double standards<sup>175</sup>:

David Limbrick says the Chief Health Officer and the Premier have questions to answer after police forced hundreds of protesters to stand shoulder to shoulder for four hours on Tuesday. **Mr Limbrick says there was a stark contrast between police handling of yesterday’s protest and the BLM protest he attended in June.**

“Yesterday, police herded people together, forcing them to mingle at close proximity for four hours or more, and then essentially charged them for failing to socially distance,” Mr Limbrick said. “COVID escaped hotel quarantine because of a lack of planning. This was almost worse, because they created a high risk situation despite planning it carefully.”

“I saw young women having panic attacks and an old man who asked to go to the toilet grabbed by the head and dragged away. When we asked for water, they found a bucket and dipped cups in it and handed them out”.

It is becoming hard to distinguish the Police in Victoria today from Mussolini’s Brownshirts.

## 11.2 **Fear mongering through misleading and charged messages to create terror**

The Victorian Administering Authorities have been putting out alarmist and hysterical messages every day for over seven months, scaring the Victorians the vast majority of whom now genuinely believe that the virus is so deadly they will all definitely die if they get it. There are many examples where a person infected by COVID-19 did not infect anyone in the family but such cases are never mentioned. Gross exaggeration of selective pieces of information is the propaganda technique being used.

Without such fear mongering, the Victorian Administering Authorities could never have “effectively” implemented their harsh lockdowns. We know that by mid-April 2020 only utterly incompetent persons

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<sup>174</sup> <https://www.facebook.com/therealrukshan/videos/785907141970980/>

<sup>175</sup> <https://www.facebook.com/davidlimbrickldp/posts/2537950656502781>

could have thought of comparing this pandemic with the Spanish flu but the Accused have kept the pedal on the hysteria.

### *11.2.1 Comparing the pandemic to Spanish flu*

Dr Brett Sutton, Victorian Chief Health Officer has been constantly fear mongering. He is reported to have said in July 2020 that he considers this pandemic to be the **“greatest public health challenge since the Spanish flu”**<sup>176</sup>. He has used similar language in his March and September Memos which are an illustration of panic and hysteria, not sensible thinking by a person who is allegedly trained in science but has no rational bone in his body.

### *11.2.2 Deliberately inflating estimates of potential deaths through models*

The act of fear-mongering has included **deliberately inflating estimates of potential deaths** in Victoria – estimates that have never been corrected even after it became clear in mid-April 2020 that SARS-CoV-2 is a moderately lethal pandemic in comparison to the Spanish flu<sup>177</sup>.

Further, as mentioned earlier, a mathematical model is necessarily the wild imagination or speculation of a modeller. **All epidemiological models have comprehensively failed – always**, in the written historical record and are unfit for purpose. At a minimum, they have no business being used as the primary tool in public health decisions which should be informed by a knowledge biology, immunity, laws, human rights and ethics.

### *11.2.3 Scaring people by talking about an even harsher restriction: Stage 5*

Mr Andrews has talked about potential ‘Stage 5’ restrictions in order to further terrorise the population. As soon as Stage 4 was announced, Andrews started talking about Stage 5 in which citizens would only be allowed to shop once a week and would not be able to go outside at all. All this for a virus that has not even reached the basic Scenario 1 level as identified in Australia’s Pandemic Plan<sup>178</sup>.

### *11.2.4 Hysterical claims that this virus will “crush” the people of Victoria*

On 3 November 2020, Dr Brett Sutton wrote on Twitter: “Why is getting to very low/no cases and keeping them there so important? The graph below is of Switzerland. Three cases on June 3 and now 10,000 per day and rising exponentially. **If you don’t crush this virus, it could crush you**”.<sup>179</sup>

It turns out that in making his claim the CHO was not only fear-mongering but he was misrepresenting the way seasonal deaths occur in Switzerland<sup>180</sup>. He is like a surgeon who tells his tonsillitis patients that they will all die.

### *11.2.5 False and misleading advertising*

The disinformation and propaganda campaign using taxpayer funds by the Victorian Administering Authorities includes **advertisements to create hysteria**. The campaign has terrorised thousands of patients who have been made too scared to visit their GP or specialist. Innumerable people have ended up with anxiety disorders or worse.

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<sup>176</sup> Carey, Adam, and Webb, Carolyn, ‘Remote-learning move not enough to quell teachers’ virus fears’, *The Age*, 12 July 2020. Short URL: <https://bit.ly/309l4tX>.

<sup>177</sup> Modelling released by Dr Brett Sutton claimed that if COVID-19 had spread out of control, more than 58,000 Victorians could have contracted the virus every day, 10,000 patients could have needed intensive care and 7000 could have required ventilators. This was an entirely bogus claim. <https://twitter.com/sabhlok/status/1319510248659374080>

<sup>178</sup> [https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19\\_2.pdf](https://www.health.gov.au/sites/default/files/documents/2020/02/australian-health-sector-emergency-response-plan-for-novel-coronavirus-covid-19_2.pdf)

<sup>179</sup> <https://twitter.com/VictorianCHO/status/1323465023579058177>

<sup>180</sup> <https://twitter.com/Pratistha25/status/1323514160622137344>

### *11.2.6 Mass-scale data deception including the conflation of flu and misuse of PCR tests*

The Victorian Administering Authorities have committed mass-scale **data deception** by using PCR tests on a mass scale (mass-scale testing is forbidden for such pandemics according to the 2019 WHO guidelines). These tests have been declared to be unreliable by the Australian government and are otherwise known to be unfit for purpose.

Thus, as at 7 November 2020, the Australian Government, Department of Health, Therapeutics Goods Administration (TGA) website notes (the information was updated on 1 October 2020):

**The reliability of COVID-19 tests is uncertain** due to the limited evidence base.<sup>181</sup>

From my preliminary analysis of information available to date (I will discuss this in more detail later) there also seems to be significant data deception going on about COVID death counts.

### *11.2.7 Large fines to terrorise the people into compliance*

Fines have been in the order of \$1650 or greater, and it has been rumoured that if these are challenged, the Court will impose \$10,000. I am aware of at least one person (who has sent me an email) who has been fined \$10,000 and is trying to appeal the fine, without any luck to date.

## **11.3 Illustrative contraventions of the Charter of Human Rights by Accused Group 1**

I have earlier outlined some of the Victorian Charter of Human Rights that have been breached by the Accused Group 1. Some more detail:

### **Freedom to protest**

Sections 15 and 16 have been breached, with the Police “taking the knee” for BLM protestors but brutally suppressing any other protest.

### **Human experiment on Victorians**

Section 10: People must not be tortured or treated or punished in a cruel, inhuman or degrading way. This includes protection from treatment that humiliates a person. **People must not be subjected to medical treatment or experiments** without their full and informed consent.

### **Unreasonable and disproportionate restrictions on movement**

Section 12: People can stay in or leave Victoria whenever they want to as long as they are here lawfully. They can move around freely within Victoria and choose where they live.

### **Mass scale invasion of privacy**

Section 13: Everyone has the right to keep their lives private. Your family, home or personal information cannot be interfered with, unless the law allows it, and it is based on reasonable grounds. The right to privacy also includes personal autonomy.

The Victorian Administering Authorities have also committed mass-scale **invasion of privacy**<sup>182</sup> through:

- mass-testing for COVID (thereby breaching the WHO’s October 2019 guidelines and ethical analysis of such policies); and
- **surveillance** of citizens through ‘apps’ and drones that follow people around<sup>183</sup>; cameras. Daniel Andrews has justified the use of drones that follow people around; and
- the police have also used their unlimited powers of entry to terrorise the people.

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<sup>181</sup> <https://www.tga.gov.au/covid-19-testing-australia-information-health-professionals>

<sup>182</sup> <https://twitter.com/sabhlok/status/1319096993185034246>

<sup>183</sup> <https://twitter.com/sabhlok/status/1319096993185034246>



#### 11.4 Inconsistencies in public health orders and inconsistencies in enforcement

Being entirely arbitrary, the “public health” mandates issued in Victoria contradict themselves repeatedly. The lockdown orders also physically look similar to orders that a communist central planner might issue – with enormous detail and micro-management. Some businesses are magnanimously “allowed” to remain open because some central planner thinks they are “essential”; other businesses, not so fortunate, have seen their operations shut down either entirely or partially, or asked told to comply with absurd rules that have no justification. Detailed reasons are never provided.

The list of inconsistent orders is endless. A few examples:

- Mandatory masks, after earlier saying for months that masks were useless and even harmful (which was the scientifically correct position)
- There is the example of Jim’s Mowing which was not allowed to even mow lawns for months.
- Hairdressers allowed to open (19 October 2020) but not beauty salons or other retail shops irrespective of COVID plans and number limits.
- A report in the newspaper: “Take the Portsea Hotel (on the Mornington Peninsula). We can get 2400 people there inside and outside but with just 70 people allowed (outside) it would be crazy,’ he says. ‘You can have 20 inside, but at Portsea even with people 4m apart you can still have 400 people. So we would lose so much money if we open up. The 25km limit (on people leaving their homes) stuffs it up a bit too”.<sup>184</sup> (Alan Jones has ridiculed many other such rules in his TV program.)
- New Zealand travellers have been allowed into Victoria but a ring of steel for Melbournians.
- Neither Andrews or his CHO wear a mask during press briefings. Apparently, an exemption is provided for media briefings because the hearing-impaired need to read lips. But how does the virus know?

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<sup>184</sup> <https://www.theaustralian.com.au/business/wealth/victoria-restrictions-too-onerous-to-reopen-pubs-chris-morris/news-story/c0efb4a38ac143ba4f82078e8da8f696>

## 12. The most harmful of the coercive “public health” measures

The list of arbitrary “public health” orders by Victoria’s government is in the hundreds, possibly thousands – if we account for different types of businesses and the innumerable times these have changed – making it impossible to keep track of them. A full list of the directives is perhaps available on the DHHS website, but it is doubtful that anyone could ever compile the full list which would literally fill thousands of pages.

A few of the more egregious “public health” measures that have **directly harmed millions of Victorians** are outlined in this chapter.

### 12.1 Mass imprisonment (lockdowns)

As noted earlier, the Victoria’s 10 March 2020 pandemic plan did not say that Melbourne will be converted into a city-wide prison (with a ring of steel) while its residents wait for a vaccine to get invented, tested, approved, mass-produced and punched into every Victorian. The following illegal measures were not listed in the Plan:

- To imprison Victorians 23 hours a day within a radius of 5 kilometres: of these 23 hours, no one must step out even one metre from their home for 9 hours (from 8 pm to 5 am);
- To force people to wear a mask outdoors; and
- To shut down hundreds of thousands of businesses.

Since 23 March 2020, lockdowns have been the main tool for the **widespread, systematic and planned attack by the Victorian Administering Authorities against the civilian population** of Victoria. Lockdowns have involved freezing Victoria’s population (mainly Melbournians) in place (stay at home) for months a time and stopping all human interaction – whether social, spiritual or any mundane and insignificant human endeavour till the virus is eliminated from Victoria *and* till a vaccine is found, produced and administered to all Victorians.

#### 12.1.1 *Mass imprisonment of the people of Melbourne*

Even though quarantines are banned by the WHO for flu-like pandemics, one can potentially understand (and maybe even forgive) temporarily quarantining the sick in the initial stages of a flu-like pandemic.

But Victorians have been **imprisoned** at home in various ways since end-March 2020. Particularly harsh requirements were imposed on Melbourne from 2 August 2020 (“Stage 4” restrictions) in order to eliminate the virus even though the health system was not facing even the mildest capacity problem.

From 6 pm on Sunday 2 August 2020 you are not allowed to travel more than 5km from your home for shopping or exercise. You can travel further than 5km from your home for work, medical care and caregiving. For some people the nearest essential goods and services (including shopping) will be more than 5km away.

Approximately 4.9 million Melbournians, who had been already reeling under months of severe restrictions, mental anguish, anxiety and terror, were now imprisoned within a 5 km boundary. Country areas were blocked off, with Police checkpoints. If people travelled more than 5km from home they copped a \$1650 fine. People were only allowed outside their homes for 1 hour of exercise a day, like in a prison. Conditions have included:

- Only 1 hour a day exercise allowed (with mask) – later increased to 2 hours; now temporarily lifted
- Only 1 person may go shopping from a house.
- Visitors not allowed in the house – this rule has constantly changed, rarely for the better.

- Cannot meet friends or relatives; cannot attend funerals of loved ones.
- Need to carrying work permits to go to work<sup>185</sup>.

Months later now minor temporary changes have been made but the threat remains: to lockdown Victorians like they are the personal chicken of Daniel Andrews till he can punch all of us with a vaccine. Andrews can go feral any time. Stage 5 is not ruled out. The policy remains unchanged.

It is hard to even begin to describe the crushing sense of foreboding and misery caused by these cruel and inhuman “public health” orders. These lockdowns are undoubtedly some of the most **inhumane tortures imposed on mankind** in human history.

### 12.1.2 *Curfew*

The curfew was even more draconian. Melbournians were placed under **curfew** from 8pm to 5am with full scale Police enforcement without any justification given for the curfew. No published scientific paper has been provided to prove that curfews eradicate coronaviruses from Earth. Daniel Andrews even defended the curfew, arguing that it is “not about human rights. It is about human life”<sup>186</sup>.

Some pictures of the curfew: <https://www.facebook.com/DanielAndrewsMP/posts/3300972753300571>

I found the following chart on the internet<sup>187</sup> – it is not up-to-date and I have not verified it but it gives sense of what has happened in Victoira.

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<sup>185</sup> <https://www.abc.net.au/news/2020-08-04/coronavirus-worker-permit-victoria-stage-4-lockdown-explained/12521368>

<sup>186</sup> McGowan, Michael, ‘Daniel Andrews dismisses human rights complaint over Melbourne Covid curfew’, *The Guardian*, 11 September 2020. Short URL: <https://bit.ly/2G1MEIM>.

<sup>187</sup> [https://www.reddit.com/r/CoronavirusDownunder/comments/inmjso/melbourne\\_lockdown\\_timeline/](https://www.reddit.com/r/CoronavirusDownunder/comments/inmjso/melbourne_lockdown_timeline/)

Beginning	Ending	# Days	Outdoor Gatherings	Home Gatherings	Restaurants, Bars, Cafes	Exercise	Shopping	Curfew	Distance
March 26	March 30	4	10	Kept to minimum	Open	Yes	Yes	No	No
March 31	May 11	41	2	0	Takeout	Yes	Yes - essentials only	No	No
May 12	May 31	19	10	5	Takeout	Yes	Yes - essentials only	No	No
June 1	June 19	18	20	20	Open w/ restrictions	Yes	Yes - essentials only	No	No
June 20	July 8	18	10	5	Open w/ restrictions	Yes	Yes - essentials only	No	No
July 8	August 1	24	2	0	Takeout	Yes	Yes - essentials only	No	Within reasonable distance
August 2	September 13	42	2	0	Takeout	1 hour/day	1x per day per house - groceries/essentials only (incl. takeout, post office, coffee, wine)	8pm-5am	<5km of home
September 14	September 29	15	2	0 (1 w/ single social bubble)	Takeout	2 hours/day	1x per day per house - groceries/essentials only (incl. takeout, post office, coffee, wine)	9pm-5am	<5km of home
September 29	October 26	27	5 from 2 households	0 (1 w/ single social bubble)	Takeout	2 hours/day	1x per day per house - groceries/essentials only (incl. takeout, post office, coffee, wine)	9pm-5am	<5km of home
October 27	November 23	27	10	5 from 1 nominated household bubble	Predominantly outdoors w/ 10 person group limit	Yes	Yes with restrictions	No	No
Total Projected		235 days	33.6 weeks						
Total Projected Stay at Home		168 days	24.0 weeks						
Total as of Sept 6		164 days	23.4 weeks						
Total Stay at Home as of Sept 6		124 days	17.7 weeks						

### 12.1.3 Locking down residents of nine public housing towers

On 5 July 2020 Daniel Andrews **completely locked down around 3,000 residents** of nine public housing towers in Flemington and North Melbourne<sup>188</sup>, which he admitted was the first time such a thing has ever been done (namely, it was a human experiment).

These 3,000 residents were **imprisoned** only on the basis of an assumption that some of them had a virus. They were locked down suddenly and without any warning. Nobody was allowed to leave for many days. The Police blocked off the towers and did not allow protestors. There is footage of them trying to arrest some protestors.

The tower blocks had many refugees, indigenous people and people from a lower economic standing. The residents were not allowed to shop for food and were not provided with food appropriate for their cultural needs.

They were also forced to get tested. A separate makeshift hospital was made at Flemington Racecourse even though the Royal Children's and Royal Melbourne Hospitals are only a kilometre or so away from the towers. These people were then forcibly herded into the new makeshift hospital instead of taking them to the actual hospital which had sufficient capacity.

<sup>188</sup> <https://theconversation.com/nine-melbourne-tower-blocks-put-into-hard-lockdown-what-does-it-mean-and-will-it-work-142033>

## 12.2 The mandatory mask policy

Since late February 2020 I have been wearing a N95 mask, disposable gloves and a face shield in crowded settings. But I also know that masks are unnecessary outdoors. I asked the Chief Health Officer via Twitter for his evidence for requiring masks outdoors. He never responded. Later, he blocked my Twitter account.

Andrews does not like any questions, either. On 29 September 2020 it was reported that: ‘Asked why he would require Victorians to wear masks when there is no health purpose, Mr Andrews dismissed the question. “That’s an esoteric debate, isn’t it? Maybe there will be a time when we have the luxury of having those debates”’.<sup>189</sup>

Victorians are required to wear masks even in extreme summer. School children aged over 12 must wear masks as well. This is dangerous.

### 12.2.1 *Dr Brett Sutton’s own study contradicts the mandatory mask mandate*

Dr Brett Sutton, Victoria’s current Chief Health Officer, published a meta-analysis in 2001 in which he found that there is little evidence to suggest that wearing surgical face masks by staff in the operating theatre decreases postoperative wound infections (Skinner & Sutton, 2001<sup>190</sup>). In fact, evidence indicates a significant reduction in postoperative wound infections when theatre staff were unmasked.

And yet, Dr Sutton is insisting on the mask mandate even though it directly contradicts his own research, and despite the lack of any rigorous research to justify his change of mind.

### 12.2.2 *Arbitrary, illogical, complex and self-defeating mask rules*

The masks mandate in Victoria is arbitrary without **any** scientific backing. Moreover, the rules are confusing as well.

#### **Constantly changing rules**

The rules keep changing.

- The first time Victoria “achieved” zero cases was without any mandatory masks policy. This time around, **even with zero cases** (as at 10 November 2020), masks are mandated.
- Perhaps the biggest give-away that the masks mandate in Victoria has nothing to do with the virus is that **any type** of mask can be used. At one time any face covering was considered OK. Then certain types were banned (such as face shields). But as Anaesthetist Dr Babak Amin said on Sky News on 29 October 2020<sup>191</sup>:

[T]he Andrews governments’ mask mandate is another **‘dreamt up’ draconian measure** because it **does not refer exclusively to surgical masks** but rather masks with no universal standard of manufacture. ‘We’re talking about cloth masks, **non-medical masks with no universal standards for their manufacture**,’ Dr Amin told Sky News host Alan Jones. ‘We’re talking about masks that – when you look through the medical literature – play no role in stopping the spread of respiratory illnesses. ‘There is a significant body of evidence from years gone by, looking at the role of these cloth masks in community settings with previous pandemics.

‘There is a raft of high-quality data, what we call meta-analyses, studies that compile multiple other studies together, and these studies have found that **non-medical masks in community settings play no role in protecting the wearer from infection.**’

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<sup>189</sup> Creighton, Adam, Tweet, 29 September, 2020. Short URL: <https://bit.ly/2G7suHg>.

<sup>190</sup> Skinner, M. W., & Sutton, B. A. (2001), “Do anaesthetists need to wear surgical masks in the operating theatre? A literature review with evidence-based recommendations”, *Anaesthesia and Intensive Care*, 29(4), 331-338.  
[https://www.researchgate.net/publication/11832106\\_Do\\_Anaesthetists\\_Need\\_to\\_Wear\\_Surgical\\_Masks\\_in\\_the\\_Operating\\_Theatre\\_A\\_Literature\\_Review\\_with\\_Evidence-Based\\_Recommendations](https://www.researchgate.net/publication/11832106_Do_Anaesthetists_Need_to_Wear_Surgical_Masks_in_the_Operating_Theatre_A_Literature_Review_with_Evidence-Based_Recommendations)

<sup>191</sup> [https://www.skynews.com.au/details/\\_6205476904001](https://www.skynews.com.au/details/_6205476904001)

‘We are dealing with the administration who dreamt up... three draconian unforgivable measures with no basis in scientific evidence whatsoever,’ Dr Amin said. ‘And now they’re trying to do it again with this mask mandate.’

In this context, Dr Babak Amin should be made aware that **there is no evidence that even surgical masks do any good in high-transmission settings**, with 3,500 healthcare workers having contracted the virus despite using surgical masks. On 11 November 2020 a news report stated:

Austin Hospital radiographer Bruno Treglia is one of more than 3,500 Victorian healthcare workers who contracted coronavirus during the state’s second wave. He believes he caught the virus because of the type of mask he was wearing at work. After initially being given a high-protection N95 respirator mask, Mr Treglia says he was later told to use a surgical mask instead. About half of Victoria’s infected healthcare workers were in aged care, nearly 1,100 in hospitals, with the remainder in community healthcare.<sup>192</sup>

This last issue (about surgical vs N95 masks) is important for another reason. It shows the comprehensive failure of the “public health” policies of the Accused who have burnt hundreds of billions of dollars of taxpayer funds in first stopping the young from going to work and then paying them through vast borrowing, but failing to buy health workers N95 masks – which has then led to 3,500 of them getting infected by the virus and transmitting it to the elderly in hospitals and aged care centres.

### Constant touching of masks is encouraged

The mask rules remain obscure and leave many questions unanswered.<sup>193</sup> The rules are also self-defeating. For instance, the government’s guidance states that:

You must carry a face mask with you when leaving home, even if you don’t need to wear it while undertaking your current activity. For example, you can take your face mask off to eat or while you are running, but you must carry it with you and put it back on when you finish.

But carrying a mask and constantly putting it on and taking it off, putting it one’s pocket, and so on, defeats the point of masks (assuming there is any) – with people constantly touching them.

### Does anyone wash their mask or replace their disposable mask?

It is unclear whether anyone washes their masks made from washable material or disposes their disposable masks appropriately. I would hazard a guess that most Victorians have not bought more than a couple of masks each during 2020: after all, masks do not come free. We will only know about the actual use of masks once sales data come. That means most masks are absolutely filthy: a collection centre for all the world’s pathogens.

### 12.2.3 *Masks do not work and can be harmful*

The following table is extracted from a meta-analysis published by the CDC in May 2020. The article studied the effect of masks on flu and found they don’t work<sup>194</sup>. The coronavirus is broadly similar in size to the flu virus, so **masks can’t work for coronavirus, either**.

Types of interventions	No. studies identified	Study designs included†	Main findings
Face masks	10	RCT	The evidence from RCTs suggested that the use of face masks either by infected persons or by uninfected persons does not have a substantial effect on influenza transmission.

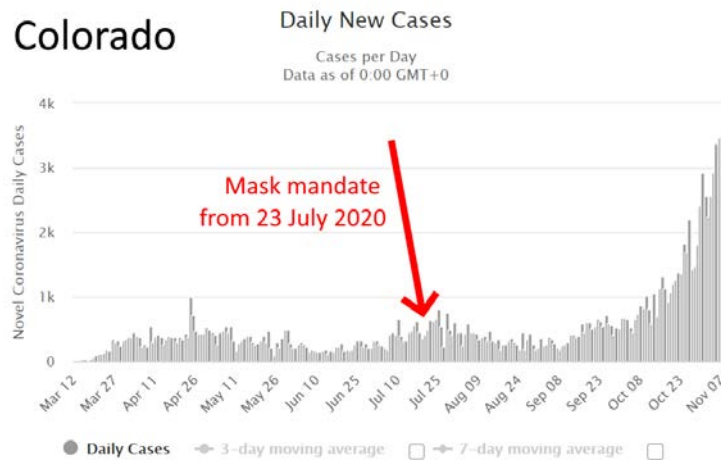
Dr Jim Meehan’s analysis shows that: “Masks worn properly are well documented to cause harm to their wearers. **Masks worn improperly, re-used, or contaminated are dangerous**”<sup>195</sup>.

<sup>192</sup> <https://www.abc.net.au/news/2020-11-11/why-did-so-many-healthcare-workers-in-victoria-catch-covid-19/12869008>

<sup>193</sup> <https://www.dhhs.vic.gov.au/face-masks-vic-covid-19>

<sup>194</sup> [https://wwwnc.cdc.gov/eid/article/26/5/19-0994\\_article](https://wwwnc.cdc.gov/eid/article/26/5/19-0994_article)

There is more data about effectiveness of masks available today and many new analyses will surely emerge. Being a data person I decided to look at the performance of masks in the State of Colorado in the USA. Colorado State’s mask mandate started from 23 July 2020. The chart below suggest to me that masks have had no influence on the transmission of the virus in Colorado and possibly increased it (many factors come into play, so this is not conclusive, but masks definitely don’t eliminate the virus).



#### 12.2.4 *Masks are particularly harmful for children*

It is mandatory for children over 12 in Victoria to wear masks. It is hard to imagine a more ill-targeted and harmful recommendation for an age group that has not even been slightly impacted by the virus *anywhere in the world*.

Dr. Margarite Griesz-Brisson (a Consultant Neurologist and Neurophysiologist) has warned against significant harms from masks, particularly for children.<sup>196</sup> Likewise, Dr Sucharit Bhakdi has warned against masks use in children<sup>197</sup>.

Masks cause oxygen deprivation which can lead to fainting and even seizures. There is evidence that breathing in one’s own CO<sub>2</sub> can exacerbate bacterial infections and respiratory disorders. All this is over and beyond the fact that wearing masks can cause significant stress and anxiety in the wearer, particularly if these are coercively imposed. For children of growing age, though, wearing a mask is **positively harmful**.

#### 12.2.5 *The list of other harms from masks*

In the box below, I present some peer-reviewed evidence that I have been sent (see the acknowledgements section), that questions the use of masks and concludes that **face masks are insufficient at protecting the wearer and others from SARS-CoV-2 and are even harmful in many ways**.

**BOX: Summary of some peer-reviewed literature on masks**

It was formerly presumed that the benefits of surgical face masks outweighed the harm. However, it has also been suggested that they do more harm than good (Lipp, 2003<sup>198</sup>).

**Brett Sutton’s 2001 study**

- Sutton and Skinner summated Duguid, (1948) and stated; “The numbers of airborne bacteria expelled

<sup>195</sup> <https://www.meehanmd.com/blog/2020-10-10-an-evidence-based-scientific-analysis-of-why-masks-are-ineffective-unnecessary-and-harmful/>

<sup>196</sup> <https://www.sott.net/article/442455-German-Neurologist-Warns-Against-Wearing-Facemasks-Oxygen-Deprivation-Causes-Permanent-Neurological-Damage>

<sup>197</sup> <https://www.bitchute.com/video/UkzVcsPlladv/>

<sup>198</sup> Lipp, A. (2003), “The effectiveness of surgical face masks: What the literature shows”, *Nursing Times*, 99(39), 22.

from the nose and mouth are insignificant when compared with the substantial numbers shed from the skin’.

- Table 3 in Sutton and Skinner’s (2001) study illustrates that the diameters of viral and bacterial particles are usually much smaller (0.1-0.8 microns), in relation to the filtration properties of high filtration surgical masks, (0.60 microns). This echoed Weber’s (1993) work which concluded that surgical masks offer insufficient protection against potentially hazardous aerosols.
- Sutton and Skinner (2001) reported that Mitchell (1991) found there was no need for theatre staff, away from the immediate vicinity of the surgical site, to wear masks, as zero colony forming airborne microbial dispersal under laminar air flow conditions was detected.
- According to Sutton and Skinner’s meta-analysis: ‘The evidence for discontinuing the use of surgical face masks would appear to be stronger than the evidence available to support their continued use. In this climate of economic justification it would appear prudent to say that the use of surgical face masks by non-scrub operating theatre staff cannot be scientifically justified’.
- Further, ‘There is little evidence to suggest that the wearing of surgical face masks by staff in the operating theatre decreases postoperative wound infections. Published evidence indicates that postoperative wound infection rates are not significantly different in unmasked versus masked theatre staff. However, there is evidence indicating a significant reduction in postoperative wound infection rates when theatre staff are unmasked. Currently there is no evidence that removing masks presents any additional hazard to the patient’.

#### **Datta’s study**

- Datta (2010)<sup>199</sup> found that surgical face masks are associated with increased surgical site infections as a result of raising operating theatre germ concentration.

#### **ISSUES WITH MASKS**

##### **Venting/tenting**

- Surgical facemasks do not filter all particles from inhaled and exhaled air as much of the air exhaled escapes from where there is least resistance, usually around the sides of the facemask, permitting nonfiltered air from escaping and entering the face mask allowing the dispersion of microbes (Lipp, 2003 - *ibid*).
- Surgical face masks are loose fitting, especially when the strings are tied incorrectly or with insufficient tension (Nicolette, 2011<sup>200</sup>; Roberge, Kim & Coca, 2012<sup>201</sup>; Skinner & Sutton, 2001- *ibid*).

##### **Wicking**

- There is a problem of wicking: capillary action of liquid (i.e. sweat/moisture of expired air) from the inside to the outside of the surgical face mask.

##### **Wiggling**

- There is a problem of wiggling: Of the surgical facemask causes dead skin cells and bacteria from beards to shed and disseminate due to friction (Lipp, 2003 - *ibid*; Skinner & Sutton, 2001 - *ibid*). In fact, Skinner and Sutton (2001) stated that the numbers of airborne bacteria expelled from the nose and mouth are insignificant in comparison to the substantial numbers shed from the skin. Few, if any, nasal bacteria are expelled into the air during quiet breathing despite a high number of colonisation (Skinner & Sutton, 2001).
- Even the most effective filter face mask can be useless if worn incorrectly and even dangerous if handled improperly (Nicolette, 2011 - *ibid*). Surgical face mask wear is recommended to last no longer than 4 hours as they become less effective over time (Datta, 2010 - *ibid*). A fresh surgical face mask almost completely prevented contamination of an agar plate 30 cm away from the mouth, but after 15 minutes there was a measurable increase in the level of contamination (Datta, 2010). This time is even

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<sup>199</sup> Datta, R. (2010), “Use of surgical facemasks in the operation theatre: Effective or habit?”, *Medical Journal, Armed Forces India*, 66(2), 163. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4920922/>

<sup>200</sup> Nicolette, L.H. (2011), “Infection prevention and control in the perioperative setting”, in J.C. Rothrock (Eds.), *Alexander’s Care of the Patient in Surgery* (14th ed., pp. 48-110). Elsevier Mosby.

<sup>201</sup> Roberge, R. J., Kim, J. H., & Coca, A. (2012), “Protective facemask impact on human thermoregulation: An overview”, *Annals of Occupational Hygiene*, 56(1), 102-112. <https://pubmed.ncbi.nlm.nih.gov/21917820/>



further reduced when they are poorly fitted, placed below the nose or are wet (Datta, 2020).

- The filtration efficiency and protective ability of a wet face mask is compromised (Datta, 2010; Lipp, 2003 - *ibid*).
- Face masks should never be allowed to hang around the neck nor be folded and placed in a pocket for later use as this causes dry bacteria that has been filtered by the face mask airborne (Datta, 2010; Nicolette, 2010 - *ibid*). However, this is exactly what we are seeing the public do as people remove their face masks before they eat, drink and smoke. We are also seeing people handling their face masks by its faceplate, thereby contaminating the wearer's hands with droplet nuclei which he/she most likely is unaware of and consequently touches their face or surroundings (Datta, 2010).
- Contaminated disposable facemasks should be disposed of immediately into infectious waste bins however they are either ending up in landfill or in our oceans killing sea creatures and birds (Lipp, 2003; Nicolette, 2011 - *ibid*).
- The facial heat created by wearing a face mask causes skin reactions, increased temperature of breathing air, elevated core body temperature and psychophysiological effects (Roberge, Kim & Coca, 2012 - *ibid*). Roberge, Kim and Coca (2012) further demonstrate that mask-associated changes in body temperature are created by:

#### **Respiratory heat exchange mechanisms**

- Body heat is lost through the skin via radiation, convection and evaporation which can only occur optimally if the skin is exposed to the ambient environment. This ability is impeded by the barrier effect of face masks.

#### **The impact of breathing through one's mouth versus their nose**

- Most face mask wearers switch to mouth breathing which bypasses the nose's role in retaining heat and humidity, therefore air exhaled via the mouth is hotter and contains more moisture.

#### **Ambient climate heat and humidity/moisture content**

- At ambient temperatures of 18.9-25.5 degrees Celsius and 49-63% humidity, the skin temperature of the tip of the nose and chin rose by 4.7-7.3 and 2.6-3.6 degrees Celsius respectively, during sedentary activity while wearing a surgical face mask for only 15 minutes.

#### **Microclimate (space between one's face and face mask which becomes the wearer's breathing environment) heat and humidity/moisture content**

- In hot conditions, especially combined with physical activity, when temperatures approach or exceed body temperature, evaporative cooling through sweating becomes the main source of heat loss. The high heat and humidity of the expired air in the breathing environment can cause moisture to condense in the outside of the mask, impairing air permeability (creating breathing resistance), increasing venting and increasing exposure of the wearer to infectious microbes via wicking. The World Health Organisation (2020) also advises against wearing face masks while exercising as sweat can make breathing difficult and promotes the growth of microorganisms. Not to mention the discomfort of facial heat for the wearer.

#### **Psychophysiological heat responses**

- Anxiety disorders (e.g. panic attacks) send a false suffocation alarm to the person's central nervous system and high levels of carbon dioxide in the body can trigger a panic attack. The body's response during a panic attack involves releasing adrenaline which in turn increases metabolic rate and initiates the fight or flight response (increased blood pressure, heart rate and respiratory rate). The flushing of the skin and increase breathing effort in those with anxiety disorders are exacerbated by the effects of mask-wearing (i.e. perceptions of mask-related breathing resistance and increased sweating in the microenvironment). Together, these lead to an intolerable warm sensation in individuals with anxiety disorder.
- Surgical face masks can limit emission of large droplet sprays and aerosol droplets larger than 5  $\mu\text{m}$  (Milton, Fabian, Cowling, Grantham & McDevitt, 2013<sup>202</sup>). However, it is well known that they provide insufficient protection from potentially dangerous sub-micron sized particles including viruses (Lipp,

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<sup>202</sup> Milton, D. K., Fabian, M. P., Cowling, B. J., Grantham, M. L., & McDevitt, J. J. (2013), "Influenza virus aerosols in human exhaled breath: Particle size, culturability, and effect of surgical masks", *PLoS Pathog*, 9(3), e1003205.

2003; Milton et al, 2013). Furthermore, the majority of virus in the exhaled aerosol appear to be too small to be contained by surgical face masks (Milton et al, 2013). A study conducted in Hong Kong in 2003 found that surgical face masks did not provide sufficient protection from SARS (Ho et al, as cited in Lipp, 2003). Surgical face masks also do not form a complete seal around the wearer's face (Lipp, 2003). It is for these reasons that they are not classified as personal protective equipment (Lipp, 2003).

- Studies on this matter during 2020 are not reliable since they have been done in a hurry without proper controls.
- In sum, there is good evidence that **face masks are insufficient at protecting the wearer and others from SARS-CoV-2 and are even harmful in many ways.**

### 12.2.6 *Reports on mask harms from Victorians*

As part of her research, a well-known Victorian doctor, Dr Suzanne Humphries asked a question<sup>203</sup> on Facebook:

Has wearing a mask caused you an injury or illness? Please tell your story here. Use pictures of injuries if possible. One of my good friends' 14 year old son passed out today wearing a face mask. Cloth. He smashed his face and his knee. He's healthy at baseline.

She received many responses that document a range of harms. Some of these below:

- 1) My 18 year old niece has debilitating asthma. She works at a pizza restaurant with mask on all day. At the end of her shift she bought a pizza to take home and passed out in their parking lot. She ended up with 11 stitches in her forehead and ... she was told she was a customer so she can risk being fired to file an accident claim.
- 2) Early in COVID i went into a tachycardia ( svt) from mask usage while at work. I am in the medical field so after doing a carotid massage. I had to revert to medication. I wear a cloth mask at work now not an N95. The headaches and recurrent aphthous stomatitis( canker sore) r ridiculous. I have had no less than 5 outbreaks since march.
- 3) After wearing my mask at work for several hours I have experienced extreme fatigue and crushing chest pain afterwards.

A person reported this on Twitter:

Older people are tripping over steps because they cannot see them because of the mask bad rashes because of mask people cannot understand people speaking because of mask we do lip read half the time.<sup>204</sup>

In a Tweet, a person reported to me:

Just had to call an ambulance for an old man in my local park who became dizzy and fainted because of wearing a mask.<sup>205</sup>

### 12.2.7 *Doctors harassed if they issue mask exemptions*

There have been reports that doctors in Victoria are being harassed by the Andrews government if they give exemptions to their patients from wearing masks<sup>206</sup>. But people are also reporting that the Police (and many shops like IGA and Bunnings) do not trust those who claim an exemption without presenting a medical certificate<sup>207</sup> - which they can't get. This situation is absolutely inhuman and will cause major health harms to thousands of Victorians, apart from destroying trust in the community.

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<sup>203</sup> <https://www.facebook.com/drsuzanne/posts/2673270776264280>

<sup>204</sup> <https://twitter.com/tyrelle123/status/1322057334948950016>

<sup>205</sup> <https://twitter.com/patambur/status/1322013617106026496>

<sup>206</sup> <https://twitter.com/sabhlok/status/1322308598165250048>

<sup>207</sup> <https://twitter.com/sabhlok/status/1322326739456909312/photo/1>

### 12.2.8 *Huge inconsistency in mask requirements within Australia*

The *Australian Health Management Plan for Pandemic Influenza*<sup>208</sup>, published in August 2019 said that “**Mask wearing [should only be] by symptomatic individuals in the community**” (page 115).

It was not a recommendation or mandate in that plan that an entire population wear a mask. This position was consistent with WHO’s October 2019 guidelines.

However, on 6 November 2020 the Australian Government website<sup>209</sup> states:

Where there is low community transmission of COVID-19, wearing a mask in the community when you are well is not generally recommended.

However, where there is significant community transmission (as determined by jurisdictional public health authorities), you may choose, or be required to, wear a mask. If physical distancing is difficult to maintain, for example on public transport, covering your face with a mask can provide some extra protection.

While this says that “Where there is low community transmission of COVID-19, wearing a mask in the community when you are well is not generally recommended”, there is a today **mandatory mask requirement in Victoria despite zero community transmission** as at 10 November 2020.

Moreover, the Australian Government has provided no evidence for why it changed its August 2019 position regarding masks. This seems political, not scientific. Science must never be done in a rush, particularly on a matter as complex as masks. It is entirely inappropriate to overturn well-established science in the middle of a pandemic.

Even within Australia there is no consistency about the use masks. Masks are only mandatory in Victoria. The fact that different jurisdictions within the same country are able to decide their own recommendations shows that this mandate is not based on **any** science. Science leads to clear and uniform recommendations across the world: it does not vary by state jurisdiction.

### 12.2.9 *Other documents and videos on masks*

I invite the ICC Prosecutor to consider the following documents and videos:

#### **Documents**

- Four potential consequences of wearing face masks we need to be wary of
- Masks Don’t Work: A Review of Science Relevant to COVID-19 Social Policy

#### **Videos**

- <https://thehighwire.com/videos/mask-whistleblowers-tell-all/>
- [https://brandnewtube.com/watch/2020-laboratory-testing-data-for-face-masks\\_fvpnVmsgjmu6Ge.html](https://brandnewtube.com/watch/2020-laboratory-testing-data-for-face-masks_fvpnVmsgjmu6Ge.html)

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<sup>208</sup> [https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/\\$File/w-AHMPPI-2019.PDF](https://www1.health.gov.au/internet/main/publishing.nsf/Content/519F9392797E2DDCCA257D47001B9948/$File/w-AHMPPI-2019.PDF)

<sup>209</sup> <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/how-to-protect-yourself-and-others-from-coronavirus-covid-19/masks>

## 13. Breach of ethics and the laws by the Australian Administering Authorities

Australia has behaved like an ostrich with its head buried in sand, with febrile dreams about vaccines and treatments. Morrison and Andrews want to keep their society in suspended animation while attempting to reduce the loss of life from the virus.

While the most cruel “public health” measures are the lockdowns imposed by Accused Group 1, Accused Group 2 has actively supported Accused Group 1’s key argument – of shutting down Victoria till a vaccine is found and punched into each Victorian. Had Morrison called out the illegality of this strategy, Daniel Andrews would have been long brought to heel.

In doing so, both the Accused have refused to admit and analyse the torture and carnage (mental health cost and shortened lifespans) they are causing. Most of these costs – particularly the loss of life years – can never be compensated. Being harms to the human body and mind, these are crimes.

While it may not be easy to attribute the harms (detailed in a subsequent chapter) directly to Accused 2, the Australian Administering Authorities have – at a minimum – contravened the *Biosecurity Act 2015* and the fundamentals of ethics. They have also closed Australia’s borders unlawfully. In doing so, they have supported Accused Group 1 in perpetrating the torture and carnage we are seeing.

### 13.1 Australian public health terrorism

Despite raising a few minor concerns from time to time, the Australian Administering Authorities have been instrumental in supporting the hysteria about the pandemic, which has provided cover for the egregious attacks on the People by the Victorian Administering Authorities.

We know that Mr Morrison has been personally supportive of Mr Daniel Andrew’s policies from day 1. On 23 March 2020 he expressed strong support for Victoria’s lockdowns:

“If Australians choose not to self-isolate, if Australians choose to not observe the medical advice of keeping the distance that we’ve recommended then, **we’d obviously be forced to take very draconian measures in shutting down,**” Mr Morrison said in an ABC interview on Sunday night. “If Australians don’t play their part, they can’t then believe that the system won’t come under greater stress. And this is why we’re trying to be so clear about this.”<sup>210</sup>

This was at a time when there was some (imaginary) prospect of hospital systems being overwhelmed but from mid-April 2020 such language had to be toned down. Mr Morrison did not change his tune, however, and like Mr Andrews, has kept up the hysteria.

The Australian Administering Authorities have contravened a wide range of human rights and covenants, thereby providing shelter to the Victorian government in its inhuman enterprise.

#### 13.1.1 *Australians banned from leaving Australia*

For over seven months now Mr Scott Morrison, Prime Minister, has indefinitely banned Australia’s residents from leaving or entering the country<sup>211</sup>. A screenshot from the Government website is provided below.

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<sup>210</sup> <https://www.heraldsun.com.au/news/victoria/latest-coronavirus-news-young-people-urged-to-follow-social-distancing-advice/news-story/16a404629f2bf975f4f3a539804b6f2f>

<sup>211</sup> <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-restrictions/coronavirus-covid-19-advice-for-international-travellers#travel-out-of-australia>. The screenshot of the web page above is available at: <https://bit.ly/34Lh3hP>

## Travel out of Australia

There is a ban on all overseas travel, unless granted an exemption.

Apparently only 3 countries in the world prohibit their own citizens today from leaving the country without permission: North Korea, Cuba and Australia.

In addition, Mr. Morrison has indicated that he will continue the ban till **at least** till end-2021 by which time he intends to compel every Australian to get the vaccine before they are allowed to leave Australia. The Reserve Bank of Australia on 7 November 2020 has gone further. It has recently said that the border might remain closed “until at least mid-2022”<sup>212</sup>.

This ban is not just a breach of the WHO’s October 2019 guidelines on borders but **one of the most egregious violations of human rights in Australia’s history**. It also contravenes Article 12 of the International Covenant on Civil and Political Rights to which Australia is a signatory.

It is almost as if Mr Morrison thinks that Australian residents are his private fish pond, that we Australians are his personal property. Even Australians abroad are not allowed in without extensive prior discussion and at great cost.

This is nothing short of public health terrorism.

### ***13.1.2 Eradicating the virus within Australia contravenes the Biosecurity Act***

As noted earlier, Mr Morrison has been insistent on freezing the virus at a level of zero within Australia till he can punch everyone with a vaccine, but the policy to eradicate the virus within Australia is prohibited by section 5 of the *Biosecurity Act 2015* which specifies that the:

Appropriate Level of Protection (ALOP) for Australia against biosecurity risks’ is ‘a high level of sanitary and phytosanitary protection aimed at reducing biosecurity risks to a very low level, **but not to zero**.

### ***13.1.3 Coercing Australians to be vaccinated***

Mr Scott Morrison has personally committed that a vaccine for coronavirus will be “as mandatory as you can possibly make it”<sup>213</sup> – further breaching a range of human rights and international covenants.

## **13.2 It is atrocious – and illegal – to lock up an entire nation till a vaccine is found**

No public health law in the world says that an entire nation can be kept in isolation and hibernation from the rest of the world until a virus is eliminated or until a vaccine is found: even more so for what has turned out to be a modest pandemic. Further, the overwhelming majority of humans have natural immunity to this virus and can readily defeat it.

There was nothing in the pandemic plan in Victoria (or in the Australian pandemic plan) about eradicating the coronavirus while waiting for a vaccine. That strategy would never have been approved if someone had proposed it in advance because it is unethical and comprehensively illegal.

As we have seen, this “strategy” is prohibited by section 5 of the Australian *Biosecurity Act 2015*. And yet, the memorandums of the Victorian Chief Health Officer of 15 March 2020 and 11 September 2020 have

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<sup>212</sup> <https://www.rba.gov.au/publications/smp/2020/nov/economic-outlook.html>

<sup>213</sup> <https://www.sbs.com.au/news/scott-morrison-says-a-coronavirus-vaccine-would-be-as-mandatory-as-you-can-possibly-make-it>

**hidden this illegal intent** and do not mention officially that Victoria's draconian restrictions will be indefinitely in place till a vaccine is punched by force into every Victorian.

### ***13.2.1 Even if a vaccine is found such a strategy would be unethical and illegal***

Four coronaviruses commonly infect humans: OC43 and 229E (discovered in the 1990s) and HKU1 and NL63 (discovered a decade ago). These are part of a group of 200 odd (and distinct) viruses that cause the 'common cold' for which, as we all know, there is no vaccine.

In addition, two other coronaviruses can infect us: SARS and MERS. For these, as well, there is no vaccine despite scientists working on it for years. Instead, we know that "Early efforts to develop a SARS vaccine in animal trials were plagued by a phenomenon known as vaccine-induced enhancement, in which recipients exhibit worse symptoms after being injected"<sup>214</sup>. Basically, **a bad vaccine can kill far more of us than the virus itself**. At a minimum it can kill those whom the virus would have not harmed. Therefore, any attempt to administer such a vaccine would violate the Hippocratic Oath.

Jane Halton, who chairs the Bill Gates-backed Coalition for Epidemic Preparedness Innovation "has warned that there is **no guarantee of success**"<sup>215</sup> of a vaccine. Australian National University academic Peter Collignon has confirmed to me that: "I don't think we can assume with any certainty we will get a safe and effective vaccine for all. We haven't for a number of other infections eg HIV, Hep C, Dengue, RSV despite trying very hard"<sup>216</sup>.

Thus, virtually everyone who knows about coronaviruses knows that a **vaccine is a moonshot**. Anders Tegnell, who is leading the Swedish fight against this virus is clear that "the vaccine is so far off"<sup>217</sup>.

On 2 April 2020, Scott Morrison said, regarding development of a vaccine, that "experts predict could take six months"<sup>218</sup>. But well after the six-month mark, on 25 October 2020, Greg Hunt, Australia's Health Minister has said that "Australia is on track for first quarter commencement of that roll-out"<sup>219</sup>. That means **another six months after the first six**, since the "first quarter" commencement could easily mean 31 March 2021. But that, too, is rather optimistic. As I have noted above, the Reserve Bank of Australia is now talking about 2022. This whole thing is a moving goal post (that too a goal that is surreptitious, hidden, illegal and unethical).

However, it doesn't matter if a vaccine is ultimately found and some lives (mainly of the extreme elderly) are then saved in Australia. **Those who want the vaccine have always been free to wait voluntarily for it – like in any other normal civilised society**. The idea that a government can lock up an entire nation for months, even years, and then coercively jab millions of people – of whom the overwhelming majority would **never** have been adversely affected by the coronavirus anyway – is nothing short of criminal.

I believe the case against Accused Group 2 being an accomplice to the crimes against humanity of Accused Group 1 is clear as day.

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<sup>214</sup> <https://www.nbcnews.com/health/health-care/scientists-were-close-coronavirus-vaccine-years-ago-then-money-dried-n1150091>

<sup>215</sup> <https://www.theaustralian.com.au/science/coronavirus-plan-b-needed-says-australian-vaccine-hunter-jane-halton/news-story/3c2956ae01a2cdd5b6b1d59da94b8c63>

<sup>216</sup> <https://twitter.com/CollignonPeter/status/1248767934211584000>

<sup>217</sup> <https://www.youtube.com/watch?v=UuBJSfNUmw>

<sup>218</sup> <https://www.theaustralian.com.au/nation/politics/scott-morrison-wary-on-setting-reopening-target/news-story/72986f50365199f5f263e588b5e0b2a2>

<sup>219</sup> <https://au.news.yahoo.com/eyes-vic-again-hopes-easing-163038431--spt.html>

### Part III: The catastrophic harm caused by the Accused

## 14. The carnage in Victoria

“The government’s anti-COVID-19 measures are **grotesque, absurd and very dangerous**. The **life expectancy of millions is being shortened**. The horrifying impact on the world economy threatens the existence of countless people. All this will impact profoundly on our whole society. All these measures are leading to **self-destruction and collective suicide** based on nothing but a spook”.<sup>220</sup>

*Dr. Sucharit Bhakdi, Head of the Institute for Medical Microbiology and Hygiene, Germany*

Summary of lockdowns’ collateral harm: “lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – **leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden**”.<sup>221</sup>

*The Great Barrington Declaration, authored by world-leading scientists Jay Bhattacharya of Stanford, Sunetra Gupta of Oxford and Martin Kulldorff of Harvard*

In this alleged ‘war against COVID’, the people of Victoria have been collateral damage. As shown earlier, mandatory lockdowns – large-scale mass-imprisonment – are human experiments with no proven benefit, imposed without consent and with known harms that were clearly anticipated in previous scientific papers. The concept of lockdowns is so bizarre it was rejected outright in the literature and never investigated in any detail.

This chapter outlines **a few of the mass-scale harms to the human mind and body** caused by the Victorian Administering Authorities. The data on harms from Victoria’s coercive public health policies is incomplete. It will take months, if not years, to fully understand the magnitude of the harms, but we have sufficient information today – as I will show – for the International Criminal Court to commence its investigations.

As noted at the outset, this complaint is not just about Victoria and Australia. I will therefore report harms from other jurisdictions across the world in the next chapter to provide the ICC with a better sense of the magnitude and range of harms, many of which will almost certainly be soon reflected also in Victorian data.

### 14.1 Lockdowns cause great harm

There have been mainly two types of harms caused by the lockdown policies of the Victorian Administering Authorities:

**a) Harms of omission:** These are deaths that were not averted because the risk-based approach was inverted (with a focus on low-risk instead of on the high-risk groups). An example of this inversion and misdirection of effort is the failure of Victorian authorities to provide N95 masks in high-risk settings<sup>222</sup> but burning tens of billions of dollars in low-risk settings.

**b) Harms of commission:** These are of two sub-types:

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<sup>220</sup> <https://europost.eu/en/a/view/necessary-measures-or-mass-panic-27724>

<sup>221</sup> <https://www.spectator.com.au/2020/10/hippocrates-cancelled/>

<sup>222</sup> <https://www.abc.net.au/news/2020-11-11/why-did-so-many-healthcare-workers-in-victoria-catch-covid-19/12869008>



- **additional mental harms**, including torture (the Australian Treasurer, Josh Frydenberg, himself made an appeal to Daniel Andrews to ‘**end lockdown torture**’ on 20 October 2020<sup>223</sup>; a letter from a Melbourne person to his friend in USA shows how badly the minds of people were pressured; and there has already been a resulting increase in self-harm by children); and
- **additional physical harms**, such as reduction in the lifespan of millions of Victorians because fear and terror was created in their minds which led to a steep decline in timely health check-ups and treatment; as well as compulsion to stay indoors which lead to a sedentary lifestyle for months on end: that would surely increase chronic disease.

Further, the Victorian economy has been decimated. It will take decades to recover. This loss of economic capacity will have serious long-term health effects: unemployment and poverty cause major health harms and shorten lifespans.

Australia’s premier newspaper, *The Australian*, is finally waking up after seven months. On 27 October 2020 it wrote in an editorial that: ‘the disproportionate financial and **human costs** of lockdown and poorly thought-through border closures are becoming more obvious by the day’.<sup>224</sup> The “human cost” is a polite name for crimes.

The same point has been made in *Newsweek* on 30 October 2020 by Professors Martin Kulldorff, Sunetra Gupta and Jay Bhattacharya who wrote about the effect of lockdowns across the world:

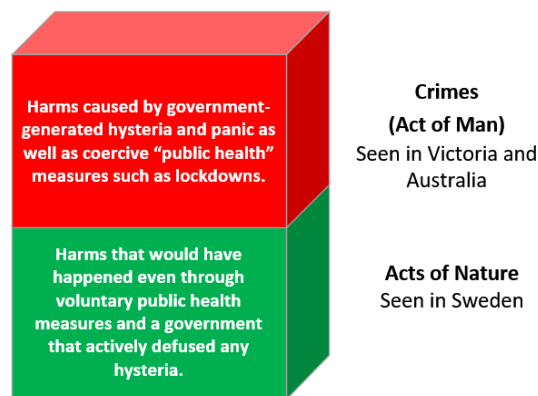
Lockdown strategies have led to many avoidable deaths among those at high risk from COVID-19 infections, while creating enormous collateral non-COVID health damage on everyone else.<sup>225</sup>

This statement captures the two types of harms outlined above.

#### 14.1.1 *The need to exclude “business-as-usual” harms*

In identifying the harms attributable to the policies implemented by Accused Group 1 (Acts of Man), we will need to exclude any harms that might have occurred in a “business-as-usual” situation, i.e. a situation in which public health policies are not disproportionate and unlawful (such as those adopted in Sweden). Such “business-as-usual” harms can be attributed to Nature. A level of mental pressure would have been experienced within the community even if Victoria had adopted voluntary social distancing.

In the diagram (below) I illustrate the need to distinguish between natural harms and harms attributable to the Accused because of their coercive measures and fear-mongering.



The distinction between the two is not self-evident in the data and will require statistical analysis. Two methods (among others) could be considered:

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<sup>223</sup> <https://twitter.com/sabhlok/status/1318237019823239168>

<sup>224</sup> <https://twitter.com/sabhlok/status/1320888071861071872>

<sup>225</sup> <https://www.newsweek.com/we-should-focus-protecting-vulnerable-covid-infection-opinion-1543225>

- comparing the harms in Victoria with countries like Sweden which did not apply coercive policies; and
- comparing the harms in Victoria in 2020 with harms experienced in Victoria in previous pandemics when coercive measures were not used (and controlling for the magnitude of the respiratory infection).

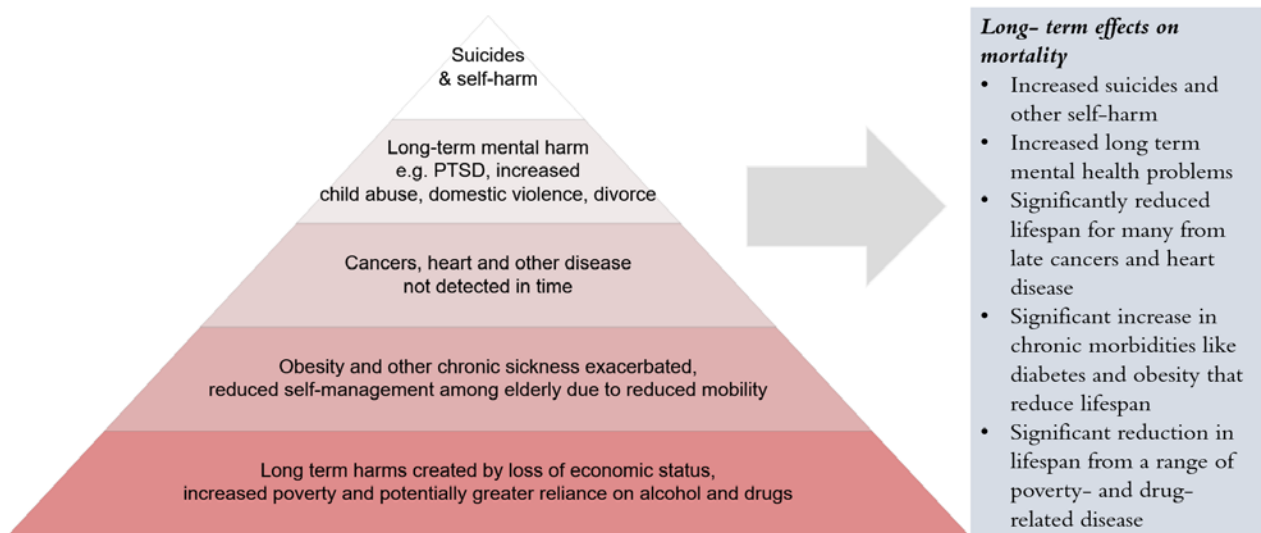
Although conducting such an analysis will require further work and might need to wait for fuller data, I believe there is sufficient indicative data and circumstantial evidence today for the ICC to draw a firm conclusion that the **lockdowns have indeed caused very significant additional harms**.

#### 14.1.2 *Harms of commission: short-term and longer term*

The harms of commission, being the direct harms caused by the actions of the Accused, are basically of two types: short-term and longer term.

I have made a diagram below to summarise the nature of these harms.

**Harms of commission: Short and longer term mental and physical health impacts of extended lockdowns**



In this diagram (above) I have tried to show that in the short-term we might only see a few additional harms such as additional self-harm and possibly some additional suicides, but there is a massive build-up of harms caused by the lockdowns which is certain to show up in medium to longer-term harms and shorten the lives of millions. We must be very careful not to discount the medium- and longer-term harms just because they are not entirely visible today.

#### 14.1.3 *A summary of “collateral” harms by the Covid Doctors Network*

This letter, issued on 5 October 2020 to the Premier of Victoria (he has never responded) contains a summary of harms caused by the “public health” policies in Victoria:<sup>226</sup>

**Children and adolescents** are suffering and being needlessly harmed by the denial of normal social interactions such as play, schooling and relationships with family and friends, particularly as the virus poses an almost negligible risk. These effects on child and adolescent health will impact their future wellbeing for many years to come.

These **policies seriously compromise the health of individuals and the wider community** by imposing curfews, local travel restrictions, reduced exercise and outdoor activities, imposed isolation and the quarantining of the healthy, enforced mask wearing in open spaces, the denial of children’s play, the denial of socialisation and education with friends and peers and the

<sup>226</sup> <https://covidmedicalnetwork.com/about-covid-medical-network/declaration-statement.aspx>; PDF at: <http://sanjeev.sabhlokcity.com/Misc/CMN Statement Final Version 5-10 signatories.pdf>

disruption of family relationships. ... [T]he **arbitrary application of laws** enforcing these policies has created unnecessary disquiet in our community and a growing loss of confidence in those responsible for such decisions.

The **fear and societal anxiety** caused by these policies **has delayed presentations of many serious medical conditions, including cancers and heart disease**. The interruptions to both public and private health-care systems has adversely impacted access to health services. The imposition of isolation on the elderly and the vulnerable has caused a **dramatic increase in mental health problems**. The interruption and closure of businesses has created significant financial and relationship strain for many families and further impacted the **mental stress and negative health impacts** we are witnessing.

It is incumbent on all of us to examine the bigger picture and assess the **significant harms being inflicted on our society in the pursuit of a very narrow concept of 'health'**.

[W]e implore the governments of Australia, state and federal, to be ever mindful of the balance between loss of freedoms and basic rights and the promotion of public health, never losing sight of the **potential for collateral harms to exceed the effects of the disease being managed**.

#### ***14.1.4 Lockdowns seek to shift life from the young to the old***

The objective of the human experiment being conducted by the Victorian Government seems to be to shift 'life' from one group of individuals (the young) to another (the old).

The UK Department of Health and Social Care, Office for National Statistics, Government Actuary's Department and Home Office on 15 July 2020 published a report that says "when morbidity is taken into account, the estimates for the **health impacts from a lockdown and lockdown induced recession** are greater in terms of QALYs than the direct COVID-19 deaths"<sup>227</sup>, where QALY stands for Quality Adjusted Life Years. This is based on the analysis of this "shift" in life between two groups of people.

The Victorian Administering Authorities have known this, that they are **shortening the life of millions of young in order to purportedly save a few elderly**. (The word purportedly is being used since there is no proof that lockdowns save *any* life in the longer term; instead, and by focusing on beating up the young, the government is unable to focus its attention on the elderly more of whom then die.)

#### **14.2 The harms caused by the Accused are not protected by Article 7(2)(e)**

The additional harms caused by the Accused are **not protected by Article 7(2)(e)** because these were not "inherent in or incidental to, **lawful sanctions**". That is because the actions of the Accused were themselves **unlawful**, having breached the legal requirements for the consideration of proportionality and scientific proof. Further, there is no provision in Victorian law for the Government to kill a person X (or to shorten his or her life) while protecting a person Y (and such a provision can never exist). Therefore the harmful consequences from the unlawful actions of the Accused are not protected under the Rome Statute.

Likewise, it wouldn't help the defence of the Accused if a vaccine is found and saves thousands of elderly Australians from dying from an Act of Nature (COVID-19). The fact that millions of (mostly young) Australians have been harmed by the Accused (an Act of Man) was entirely unlawful and therefore a crime against humanity. There are no mitigating circumstances to the actions of the Accused.

#### **14.3 (A) Harms of omission: Deaths of the elderly that the Victorian Government failed to prevent**

As noted earlier, Victoria's pandemic plan took a risk-based approach and 'focused on protecting vulnerable Victorians'. It explained that 'older Victorians and people with chronic diseases are known to

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<sup>227</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/907616/s0650-direct-indirect-impacts-covid-19-excess-deaths-morbidity-sage-48.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907616/s0650-direct-indirect-impacts-covid-19-excess-deaths-morbidity-sage-48.pdf)

be at greater risk of COVID-19 infection'. And it said that it would 'ramp up risk reduction activity [for] at-risk groups'.

However, instead of focusing on the elderly, the Victorian Administering Authorities **reversed the plan**. They spent most of their effort (possibly 95%) in policing the young (who were at low risk) during their society-wide untargeted lockdowns.

Most of the 800-odd deaths in Victoria to date reportedly from COVID ("with" and "from") happened in aged-care homes. Many of these deaths could have been averted if the original pandemic plan had been followed. But we know that many aged care workers were provided with surgical masks, not N95 masks, which led to the spread of the virus in the centres. Further, many aged care patients were transferred to hospitals and lumped together because of under-resourcing the care of the aged. That, too, increased COVID deaths of the elderly:

[O]ne of the lessons from the second wave was that **aged care patients transferred to hospitals and held together in groups** increased the risk of virus transmission through "aerosol-generating behaviours" such as wandering around, calling out and coughing.<sup>228</sup>

#### 14.4 (B-1) Harms of commission: Mental harms caused by Victorian lockdowns

Lockdowns, being a form of mass imprisonment, cause severe mental anguish. When we imprison criminals, we give them food but exclude them from something vital: a normal life. During Victoria's lockdowns only one person per home was permitted to go out to buy food.

But people do not live only to eat.

Our species is not built, whether by God or by Nature, for such terror. The people who have spiritual faith were deprived of basic spiritual solace from visits to their place of worship for over seven months. About forty per cent of Victorians live in one-person households. These people were subject virtually to solitary confinement for many months during which they were also not able to see another human face due to the mandatory masks requirement.

This extract from Judith Lewis Herman's book, *Trauma and Recovery* (1992)<sup>229</sup>, which reflects the experience of all kinds of victims, aptly describes the mental condition of the average Melbournian during the lockdowns. In this narrative, below, the average Melbournian can be imagined as the victim and the perpetrator, Daniel Andrews, who has been omnipresent on the TV in Victoria, talking entirely about a single issue, COVID-19, for over seven months.

Captivity, which brings the victim into prolonged contact with the perpetrator, creates a special type of relationship, one of coercive control. This is equally true whether the victim is taken captive entirely by force, as in the case of prisoners and hostages, or by a combination of force, intimidation, and enticement, as in the case of religious cult members, battered women, and abused children. The psychological impact of subordination to coercive control may have many common features, whether that subordination occurs within the public sphere of politics or within the private sphere of sexual and domestic relations.

In situations of captivity, the perpetrator becomes the most powerful person in the life of the victim, and the psychology of the victim is shaped by the actions and beliefs of the perpetrator. Little is known about the mind of the perpetrator. Since he is contemptuous of those who seek to understand him, he does not volunteer to be studied. Since he does not perceive that anything is wrong with him, he does not seek help -- unless he is in trouble with the law. His most consistent feature, in both the testimony of victims and the observations of psychologists, is his apparent normality. Ordinary concepts of psychopathology fail to define or comprehend him.

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<sup>228</sup> <https://www.abc.net.au/news/2020-11-11/why-did-so-many-healthcare-workers-in-victoria-catch-covid-19/12869008>

<sup>229</sup> <https://sites.google.com/site/lspironello2/home/captivity>

More specifically, this is how a Melbourne person described his mental condition from the endless lockdowns<sup>230</sup>:

It's been three months since I saw another human face besides [my partner's]. Seven months since [my partner] and I had a little break together in the form of going and having a coffee down the street. Sitting staring at the wall for two hours, again, unable to move. **Despair.** Horrible negative emotions virtually all day. Awake and tired nights, **distress.** This **doesn't feel human.** I don't smile. I don't laugh.

Recently, Ben Mitchell wrote on Twitter: "The people of Melbourne/Victoria are victims of trauma. Months of isolation from family & friends, unable to work, deprived of basic freedoms & living under constant threat of fines/police intimidation took a toll. **We may seem OK but we are in collective shock.** We need justice".<sup>231</sup>

A mother wrote me an email on 28 October 2020: "I have two **teenage daughters** who will never be the same now **suffering with ongoing anxiety.** One of my girls is having **panic attacks daily** and this is affecting her return to school immensely as she no longer wants to even go".

An elderly lady wrote on my blog on 11 November 2020: "As a 77 year old **my health suffered greatly due to Dan's lengthy lockdown** requiring me to spend time with relatives as I live alone and didn't cope with the loneliness. A daughter has disowned me as her opinion differs from mine. Mask wearing caused panic attacks so I no longer wear them".<sup>232</sup>

#### 14.4.1 *Massive spike in suicide prevention and mental health calls*

On 10 July 2020, it was reported that:

More and **more Victorians in crisis are reaching out to Lifeline Australia's suicide prevention** and crisis support services. In the past week alone, Lifeline Australia has noted a 22 per cent spike in calls originating from Victoria.<sup>233</sup>

Total suicides in Victoria have fortunately not increased (as at 30 September 2020)<sup>234</sup>. Other parts of the world including India have not been so fortunate. But there is at least one case in which the wife of a builder who committed suicide in Melbourne on 16 October 2020 thinks that the harsh lockdown restrictions contributed to his death.<sup>235</sup>

Further, on 14 October 2020, *The Australian* reported that:

More than a million Australians have sought mental health treatment during the COVID-19 pandemic, while ongoing lockdowns in Victoria have sparked a social crisis, with a 30 per cent rise in cases in the past four weeks.

The first official data revealing the depth of the mental health disaster in Victoria since the second wave outbreak reveals access to **some crisis services has risen by up to 67 per cent in the space of four weeks.**

Demand for **children's mental health** has also skyrocketed in Victoria, with access to services jumping more than 30 per cent since September.

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<sup>230</sup> <https://www.zerohedge.com/medical/isnt-human-unseen-perils-covid-faceless-number-melbourne>

<sup>231</sup> <https://twitter.com/BenMitchellSong/status/1324227461953933312>

<sup>232</sup> <https://www.sabhlokcity.com/2020/10/for-public-comment-my-draft-complaint-to-the-international-criminal-court-against-daniel-andrews/#comment-1005393>

<sup>233</sup> <https://www.bendigoadvertiser.com.au/story/6828084/lifeline-reports-surge-of-victorian-callers-in-the-past-week/>

<sup>234</sup> <https://www.coronerscourt.vic.gov.au/sites/default/files/2020-10/Coroners%20Court%20Suicide%20Data%20Report%20-%20Report%202%20-%20005102020.pdf>

<sup>235</sup> <https://www.news.com.au/lifestyle/real-life/news-life/hero-dad-dies-after-struggling-in-melbourne-coronavirus-lockdown/news-story/7d9396d4a7944edd67fc5c36618dfb39>

[I]n September and October, 350,884 Victorians sought access to Medicare-funded GPs, psychiatrists, psychologists and counselling treatments. This was a **31 per cent increase** on the same period last year and three times higher than the national average.

According to the data, there were 3702 calls to the Kids Helpline by Victorians, a 61 per cent increase in just four weeks.

Access to **Beyond Blue services in Victoria was 77 per cent higher** than the rest of the country. The total number of contacts to the mental health organisation was 6472 over the same four weeks — a **67 per cent increase on the same time last year** — compared with a 27 per cent increase in NSW and 8 per cent nationally.

Victorian use of Lifeline services was 16 per cent higher than the rest of the country and Kids Helpline 24 per cent higher. Victoria's own data showed a 33 per cent spike in "child and youth contacts in community mental health services for eating disorders".<sup>236</sup>

It is also worth mentioning again that on 11 September 2020 the Chief Health Officer of Victoria<sup>237</sup> admitted to the significant impact on the well-being of Victorians from "the measures" (lockdowns) to "slow the spread of coronavirus" – but did not care to quantify or assess the harms, or commit to a process to do so:

81. I acknowledge the measures taken to slow the spread of coronavirus will have a **significant impact on the wellbeing of Victorians, especially those who are living or parenting alone, as well as those who have mental health conditions or other complex needs.**

82. While there has been evidence of the strong resilience of the Victorian community during the state of emergency (for example, a Coroner's Court of Victoria report on 27 August 2020 found that the number of suicide fatalities remained consistent at 466 this year compared to 468 from last year), there is **significant evidence of the community's distress due to the significant limits on social movement and interaction** (such as a 40% increase in calls to Lifeline when restrictions were strengthened in August 2020).

While the impact of these mental harms can take different forms and we may need to wait for more data, it is clear from the above that **the lockdowns in Victoria have been form of mass torture** and therefore qualify as a crime under Article 7.

#### ***14.4.2 Dramatic increase in online child sex abuse***

Additional mental health harms include increased online child sex abuse. *The Australian* newspaper reported on 12 October 2020<sup>238</sup> that:

Authorities are becoming increasingly concerned at the surge in child sex abuse, with the number of arrests and charges since the start of the coronavirus pandemic almost double that of the same period last year. "These type of offenders are **using the lockdown restrictions to take advantage of vulnerable children** who may be spending an increased amount of time online during this period," Mr Dutton said.

[T]here has been a 129 per cent increase in the number of reports of online child sex abuse material to the commissioner from March to August compared to the 2019 monthly average.

There is also a 31 August 2020 video on the Facebook page<sup>239</sup> of Craig Kelly, MP, who is seen asking the Police about this matter. It seems that the police have been too busy targeting young people who may be breaking the mask rules to worry about paedophiles and real criminals.

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<sup>236</sup> <https://www.theaustralian.com.au/nation/politics/mental-health-crisis-one-million-lost-in-coronavirus-lockdown/news-story/fc8c1da341ca392166fce6aba9ca4f69>

<sup>237</sup> <http://sanjeev.sabhlokcity.com/Misc/CHO%20memo%2011%20September%202020.pdf> - extracted from a Parliamentary document.

<sup>238</sup> <https://www.theaustralian.com.au/nation/politics/child-sex-predators-rampant-as-covid-forces-kids-online/news-story/c936092b74022fb91f5c6fb9c0d26e20>

<sup>239</sup> <https://www.facebook.com/watch/?v=2736575970002566>

#### 14.4.3 *Increase in family violence*

A report to the Victorian Parliament by a Parliamentary Committee in July 2020 noted anecdotal reports about the increase in family violence:

In the early stages of the COVID-19 pandemic, the Victorian Government responded to a concern about a spike in family violence by **providing funding** to the sector and initiating a pro-active policing campaign, Operation Ribbon. However, data is not yet available to determine whether these activities were successful in limiting family violence. During the hearings **stakeholders provided anecdotal evidence to suggest that the rate and type of violence used during the pandemic had changed and possibly escalated.** In addition, the COVID-19 pandemic created real and perceived barriers to service access for victim survivors, while there have been notable gendered impacts of the pandemic.<sup>240</sup>

#### 14.4.4 *Significant increase in substance abuse*

The Australia National University is reported to have found that 20% of respondents have been drinking more alcohol since the start of lockdowns.<sup>241</sup>

#### 14.4.5 *Elderly gave up their desire to live*

It was reported on 16 September 2020 that

Nurses sent in to help Melbourne’s coronavirus-ravaged aged care facilities say they are gravely concerned for residents — even those without COVID-19 infections — who have been **stuck in “solitary confinement” for months. One resident has even refused to eat and drink because she can’t see her family or leave her room.**<sup>242</sup>

#### 14.4.6 *Andrews is throwing money at mental health but that can never work*

The Victorian Administering Authorities don’t seem to understand how important normal social relationships and engagement with Nature are, for humans. They think that throwing money at mental health is the answer. Thus, on 10 August 2020 it was reported that: “In response to the increasing number of people having a hard time coping with the pandemic, the Victorian government yesterday announced **an additional A\$59.7 million in funding for mental health services**”<sup>243</sup>.

But throwing money can’t work since the system was never designed for such an enormous increase in mental health harms. There is anecdotal evidence that severe mental health illnesses are not being diagnosed today as people are not going to their doctor, having been terrorised by the Government.

On 23 October 2020 a person wrote to me with a personal example:

I presented to my GP the day after level 4 lockdowns were announced after suffering from a mental breakdown. I was referred to a local mental health clinic. They called me back, and said that **they are not taking on any new patients.**

They also mentioned that all their consultations are done over the phone and **if any of their patients are suicidal, they will not continue with treatment** as they said it was too dangerous to do such counselling over the phone. **It took over a month before I managed to talk to a psychologist.**

It was also [another] month before I talked with a Psychiatrist who wanted to put me straight on medication, which I refused as I am weary of side effects and long term harms.

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<sup>240</sup> PAEC, *Inquiry into the Victorian Government’s response to the COVID-19 pandemic - Interim report*, July 2020. Short URL: <https://bit.ly/3oB8Zbl>

<sup>241</sup> <https://endlockdowns.org/substance-use/>

<sup>242</sup> <https://www.abc.net.au/news/2020-09-16/covid-19-isolation-sees-some-aged-care-residents-giving-up/12655642>

<sup>243</sup> <https://theconversation.com/the-victorian-government-has-allocated-60-million-to-mental-health-but-who-gets-the-money-144188>

**In my experience, there is inadequate mental care in Victoria.** It is all good and well to say they have doubled the Medicare mental health plan from 10 to 20, but **if you can't see anyone due to lack of doctors, then it makes no difference.** They could offer 1000 Medicare consultations, but if they are not taking on new patients it means nothing.

#### 14.5 (B-2) Harms of commission: Physical harms caused by Victorian lockdowns

People are dying at home because they do not want to attend the hospital or emergency department after listening and buying into months of propaganda and fear mongering until their situation is too late.

##### 14.5.1 *Significant disruption to health care for the chronically ill*

Here is an extract from an email I received on 11 November 2020:

I'm a sole parent and Carer of a child with severe Cystic Fibrosis related chronic illness, Lockdown and isolation makes it extremely hard to care for her illness. The nonsensical Victorian COVID-19 response rules are so blindly directed towards SARS-Cov-2, **other illness are being ignored.** Many parts of our health care systems are being crippled, and **quality of life for chronically ill people has been severely degraded.**

##### 14.5.2 *Loss of mobility among the elderly, leading to reduced lifespan*

A nurse has reported to me that as the elderly are forced to stay at home they lose their mobility and become more reliant on health and social services. This is not just about additional health needs. The loss of muscle mass surely contributes directly to reduced longevity.

A person reported to me on Twitter: "My 92 year old grandmother who lives with me said 'I feel I have aged 10 years since this started'. All she wants to do is go to church and return to her volunteer work at the local Catholic shop".<sup>244</sup> The loss of quality of life of millions of people is surely part of public health terrorism. But the issue here is how badly our elderly have suffered both mentally and physically during the lockdowns (which are still ongoing but in a less restrictive way in Melbourne) because the Accused refused to let the young become immune so they can shield the elderly from the virus and allow normalcy to return in six to eight weeks, which is typical during such respiratory pandemics.

I have turned 61 today. I am a "seniors card" holder. I have myself suffered from significant loss of mobility over the past seven months. The mandatory masks policy makes it entirely unviable for me to take exercise in the open. And tennis courts have been closed since February. I am certain that my lifespan has been significantly truncated by Mr Daniel Andrews's brilliant actions. I have no doubt that without the mandatory masks policy I would have engaged in much more compensatory exercise (such as walking in the hills) that would have minimised the enormous harms to my health. But I was not allowed to take care of my own health by Mr. Andrews. He wants to protect me only from COVID but I could also die from large number of other diseases that require constant care of the body. He is a mad man and I hope the ICC will bring him to account.

##### 14.5.3 *Critical tests not happening*

Despite significant spare capacity in the hospital system, the government has issued restrictions on a number of critical tests. A person wrote to me recently that despite a referral for a particular test he needed urgently the pathology lab has refused to conduct it, saying that the test is unavailable due to the COVID-19 pandemic: that, too, at a time when there were are few COVID-19 cases in Victoria.

I am providing below a redacted image of the email this person received. Full details can be provided to the ICC upon request.

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<sup>244</sup> [https://twitter.com/\\_Ricky89\\_/status/1321576817350778880](https://twitter.com/_Ricky89_/status/1321576817350778880)



**From:** [REDACTED]  
**Sent:** Friday, 30 October 2020 2:05 PM  
**To:** [REDACTED]  
**Subject:**

[REDACTED]

Your Reference: Lab Reference:  
Laboratory: [REDACTED]  
Addressee: [REDACTED] Referred by: [REDACTED]  
Name of Test: FAECAL MULTIPLEX PCR  
Requested: 22/10/2020 Collected: 28/10/2020 Reported: 28/10/2020 15:03

#### FAECAL MULTIPLEX PCR

Parasites  
Entamoeba histolytica DNA Not Performed  
Giardia species DNA Not Performed  
Dientamoeba species DNA Not Performed  
Cryptosporidium species DNA Not Performed  
Blastocystis species DNA Not Performed  
  
Bacteria  
Yersinia enterocolitica DNA Not Performed  
Campylobacter species DNA Not Performed  
Shigella species DNA Not Performed  
Salmonella species DNA Not Performed  
Aeromonas species DNA Not Performed

Due to the COVID-19 pandemic, we regret that faecal multiplex PCR is temporarily unavailable.

Requested Tests : FZ\*, FPC

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This email is sent from an account we use for sending messages only. Please contact us directly at [REDACTED] to book an appointment if you have any questions for our doctors.

Also, as noted earlier in this submission, it was reported on 11 September 2020 in ABC News<sup>245</sup> that Victorian:

Hospitals are reporting a ‘concerning’ decline in the number of Victorians seeking treatment for heart attacks and strokes, as well as essential cancer screening, during the state’s coronavirus second wave. Health Minister Jenny Mikakos said the number of people presenting to emergency departments with strokes was down 24 per cent on the same time last year. For heart attacks, the number of ED presentations was down 18 per cent. “This does suggest that **people are putting off seeking urgent and important medical care that could make that critical difference to their life**,” Ms Mikakos said.

The report noted that: “Victoria has seen a 30 per cent drop in reports for the five most common cancers”. People are not even turning up for treatment, let alone tests.

#### ***14.5.4 Additional undetected cancer and heart disease***

Cancer screening, heart disease and stroke presentations have been down in Victoria during coronavirus pandemic<sup>246</sup>. This would suggest a significant reduction in the lifespan of many people due to the coercive lockdowns.

Australia is already reporting additional cancer deaths.<sup>247</sup> This report also notes that ‘Pandemic shutdown ‘means thousands more bowel cancer deaths’ in Australia.

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<sup>245</sup> <https://www.abc.net.au/news/2020-09-11/victoria-coronavirus-drop-in-stroke-heart-attack-cancer-screens/12654588>

<sup>246</sup> <https://www.abc.net.au/news/2020-09-11/victoria-coronavirus-drop-in-stroke-heart-attack-cancer-screens/12654588>

#### 14.5.5 *Significant increase in self-harm by adults and children*

According to Victoria's Department of Health and Human Services, the number of people presenting to emergency departments for treatment for self-harm and suicidal ideation has increased 5.7 per cent compared with the same period last year. **For young people aged 17 and under, the rate has risen 31.3 per cent**, as of September 25, when compared with last year.<sup>248</sup>

It was reported in ABC News on 8 August 2020 that: 'Department of Health and Human Services data shows Victoria has recorded a **33 per cent rise in children presenting to hospital with self-harm injuries** over the past six weeks, compared to a year earlier'<sup>249</sup>.

#### 14.5.6 *Four newborns effectively killed by the lockdowns*

It was reported on 18 October 2020 that four newborns in Adelaide have died after being denied lifesaving heart surgery because it wasn't available in Adelaide, and they couldn't be transferred interstate because of travel restrictions<sup>250</sup>. This was confirmed in *The Australian* newspaper on 21 October 2020 that "Victoria's stage-four lockdown prevented four sick newborn babies – who subsequently died – from being flown from Adelaide to Melbourne to receive lifesaving cardiac surgery"<sup>251</sup>.

Regardless of any other statistical analysis to prove crimes against humanity, this is at least a **direct proof of deaths caused by the lockdowns**.

#### 14.5.7 *Long-term damage to children's health*

An August 2020 news report entitled, "Hidden pandemic trauma harming children" said that "While children are unlikely to suffer physical harm as a direct result of COVID-19, its **impact could still have health ramifications for years to come**"<sup>252</sup>. It also reported that research conducted by the Royal Children's Hospital in Melbourne has "found children are having their healthcare impacted due to parental concerns related to contracting the virus. One in three unwell or injured children captured by the survey has had their **treatment delayed** due to COVID-19, while one in five children under the age of five has had a routine **vaccination delayed** during the pandemic".

#### 14.5.8 *Significant increase in deaths from cardiac arrest*

As noted earlier, patients are dying at home because, out of the sheer terror created by the government, they are not seeking urgent care. According to a 26 September 2020 news report:

**Cardiac-arrest survival rates halved** in Victoria during the first wave of the coronavirus pandemic. The spike in deaths has been linked to a sharp decline in bystanders performing CPR on the street and a lack of access to the state's more than 6500 public defibrillators which are stored in shuttered schools, offices, sporting clubs and shopping centres. "We have seen fluctuations of 1, 2 or 3 per cent, but we are talking about a fluctuation of around 50 per cent".

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<sup>247</sup>Scholefield, Antony, 'Pandemic shutdown 'means thousands more bowel cancer deaths'', AusDoc, 21 September 2020. Short URL: <https://bit.ly/342v2OP>.

<sup>248</sup> <https://www.theaustralian.com.au/nation/coronavirus-number-of-suicide-attempts-surges-during-lockdown/news-story/fc71cb1b275d80d30ca202fe93985804>

<sup>249</sup> Clayton, Rachel, 'Statistics show increase in children presenting to hospitals after self-harming', ABC News, 8 August 2020. Short URL: <https://ab.co/349vjzy>.

<sup>250</sup> <https://twitter.com/simondolan/status/1318830554020708352>

<sup>251</sup> <https://www.theaustralian.com.au/nation/coronavirus-why-were-these-four-newborns-left-to-die/news-story/f9059bdfbdc33e368167f6b340c9586f>

<sup>252</sup> <https://www1.racgp.org.au/newsgp/clinical/hidden-pandemic-trauma-harming-children>

If this trend continues, researchers estimate an **extra 186 preventable cardiac arrest deaths** will occur this year.<sup>253</sup>

Someone reported to me on LinkedIn that “Sanjeev, my best friend from primary school is married with two children aged 8 and 10. He died suddenly from an aneurysm age 51 on the 15th. He had pains but postponed going to the doctor for weeks because of covid”. The lockdowns and hysteria created by the government have surely been a contributor.

#### ***14.5.9 Indirect health effects from economic harms***

##### **Financial cost to society**

There has been an enormous financial cost of lockdowns. On 29 September 2020 the Institute of Public Affairs found the “**cost of trying to eliminate the coronavirus from Australia is more than annual government spending on defence, education, health and social security combined**”. “From June this year to the middle of 2022, the “elimination strategy” being pursued by state and federal governments will cost \$319bn, equivalent to 23 per cent of GDP, according to the report, *Medical Capacity: An Alternative to Lockdowns*”<sup>254</sup>.

##### *Consequences for the poor*

With huge fiscal deficits and a vast amount of borrowing, the health of the poor will be severely impacted in the coming years as taxes skyrocket and the job market dries up. Thousands of government jobs will need to be slashed. Many young persons will be dumped into the welfare system which tends to push families into intergenerational disadvantage and chronic, long term poverty and poor health.

Many Victorian schools remained closed for much of the lockdown so similar effects are likely to be experienced to those reported in a recent paper that “shows that students learn significantly less during lockdown compared to prior years. Disadvantaged students suffer most”<sup>255</sup>. Many children of the poor are likely to experience lifelong harms from these entirely unnecessary measures.

##### *Health consequences for the long-term unemployed*

While Sweden also experienced a significant increase in unemployment during the pandemic (even with voluntary measures), statistical analysis will be able to distinguish the additional unemployment that has been caused by Victoria’s lockdowns.

Long-term unemployment can precipitate a vast number of mental health, family stability and health issues – including morbidity and mortality. There is a proven statistical link between unemployment and health outcomes.

According to one study a 1 percent increase in the unemployment rate will be associated with 37,000 deaths [including 20,000 heart attacks], 920 suicides, 650 homicides, 4,000 state mental hospital admissions and 3,300 state prison admissions<sup>256</sup>.

##### **Increased crime**

There have been reports that crimes have increased in Australia during this period since the Police have been diverted to unnecessary “public health” functions.

I heard there has been a burglary boom in Brisbane. Police have told a mate that with all their attention on closing the QLD border, looking for burglars is a low priority<sup>257</sup>.

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<sup>253</sup> <https://www.smh.com.au/national/i-couldn-t-let-a-mate-die-study-shows-hidden-spike-in-cardiac-deaths-20200924-p55ysx.html>

<sup>254</sup> Creighton, Adam, “Coronavirus: Elimination strategy ‘will cost us \$319bn’”, *The Australian*, 29 September 2020. Short URL: <https://bit.ly/2ELCrcP>.

<sup>255</sup> <https://twitter.com/ArunFrey/status/1321796975013044224>

<sup>256</sup> <https://nypost.com/2020/04/20/explaining-the-link-between-unemployment-deaths-amid-coronavirus/>

<sup>257</sup> <https://twitter.com/sabhlok/status/1320542471386886146>

## 14.6 Professor Gigi Foster's cost benefit analysis of Victoria's lockdowns

Professor Gigi Foster of the School of Economics at the University of New South has done substantial analysis of the costs of Victoria's lockdowns.

### 14.6.1 *Cost benefit analysis*

The cost benefit analysis conducted by Professors Gigi Foster and Paul Frijters (of the London School of Economics) is available at: <https://clubtroppo.com.au/2020/08/20/professor-fosters-cost-benefit-analysis-for-the-victorian-parliament/>

### 14.6.2 *Testimony to Victoria's Parliament*

The transcript of Professor Foster's testimony and the ancillary material she submitted to Victoria's Parliament is found at <https://parliament.vic.gov.au/paec/inquiries/article/4554> (scroll to Wednesday 12 August to locate the transcript and the "Tabled Documents" listed against Professor Foster's name).

### 14.6.3 *Some articles and talks by Profs. Foster and Fritjers*

Some of the articles below can throw further light on the issue discussed in this chapter and complaint:

<https://theconversation.com/open-letter-from-265-australian-economists-dont-sacrifice-health-for-the-economy-136686>

<https://clubtroppo.com.au/2020/05/18/the-corona-cost-benefit-analyses-of-richard-holden-bruce-preston-and-neil-bailey-ooops/>

<https://clubtroppo.com.au/2020/03/26/6-post-corona-institutional-questions/>

<https://clubtroppo.com.au/2020/09/10/the-descent-into-darkness-of-the-uk-and-victoria-quo-vadis/>

<https://www.abc.net.au/radionational/programs/the-economists/>

Paul Fritjer of the London School of Economics made a presentation about the human costs of lockdowns, with a focus on how WELLBY can be used in the required calculations. I have linked it here:

[http://sanjeev.sabhlokcity.com/Misc/Presentation CBA Covid July 2020\\_LSE\\_V2\\_Frijters.pptx](http://sanjeev.sabhlokcity.com/Misc/Presentation CBA Covid July 2020_LSE_V2_Frijters.pptx)

A vast amount of additional material is available, some of which I discuss in the next chapter. I might provide a more comprehensive compilation as part of a supplementary submission **once the Prosecutor confirms that a formal investigation has commenced.**

## 15. The global carnage: Hundreds of millions of lives shortened

Epic fail of gov't public health, US & UK "State **scientists tragically overlook collateral deaths** that will result from tunnel-vision strategy...**yrs from now we'll fully undrstnd the true extent of lockdown's damage**, history will not be kind.

*Dr Scott Atlas on Twitter<sup>258</sup>, 30 October 2020*

Data on health harms from lockdowns is starting to flow in from across the world and will soon become an unstoppable flood. It is quite likely that, globally, the reported 1.27 million deaths from (mainly "with") COVID-19 to date will be left far, far behind in their wake by long-term deaths caused by lockdowns.

If we are worried about preserving three months of life of a 90-year old by preventing him from contracting a COVID-19 infection, we should be equally (or more) worried about reducing far more than three months of life from the lifespan of younger persons (or even a person aged 61 like me) through the lockdowns – most of us with nothing to fear from COVID-19.

I estimate in this chapter that lockdowns across the world have likely already **shortened the lives of hundreds of millions of people**, including people like me.

### 15.1 Websites that are compiling lockdown harms

The following websites are among the many that are compiling information about lockdown harms:

<https://collateralglobal.org/physical-health>

<http://thepriceofpanic.com/>

<https://tomwoods.com/death-by-lockdown/>

### 15.2 Some estimates of overall harm

As I have pointed out earlier, lockdowns do not save any lives and very likely even increase the loss of life from SARS-CoV2. Despite that, there is an impression among some analysts that they do save lives. While disagreeing entirely with their projections about any "saved lives" from lockdowns, I am noting below their estimates of non-COVID deaths caused by lockdowns, which are likely to be more reliable.

These estimates of non-COVID deaths from lockdowns can be roughly extrapolated to fall between around 2 to 15 million additional deaths across the world. But I consider the harm from lockdowns in countries like India to be far more severe. Lockdowns have dumped hundreds of millions into poverty across the world, many into deep poverty. Given my experience of working at the grassroots in India and how poverty drastically curtails lifespans, I believe that these global lockdowns **have shortened the lives of 100s of millions of people**.

#### 15.2.1 UK Government: *Loss of life years from lockdowns is greater than life years saved*

The UK Department of Health and Social Care, Office for National Statistics, Government Actuary's Department and Home Office on 15 July 2020 published a report that says:

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<sup>258</sup> <https://twitter.com/SWAtlasHoover/status/1322148245435523072>

when morbidity is taken into account, **the estimates for the health impacts from a lockdown and lockdown induced recession are greater in terms of QALYs than the direct COVID-19 deaths**<sup>259</sup>

(where QALY is Quality Adjusted Life Years).

### 15.2.2 *Estimate: Lockdowns will kill at least as many as they potentially save (they don't)*

As reported on 29 October 2020:

‘Almost two and a half million people missed out on cancer screening, referrals or treatment at the height of lockdown—even though the NHS was never overwhelmed.’ They had the honesty in the UK to say that. ‘Experts now fear the number of people dying as a result of delays triggered by the treatment of coronavirus patients **could even end up being responsible for as many deaths as the pandemic itself.**’ Now, we won’t see that kind of effect right away. It’s not like a huge number of cancer patients are going to die immediately in 2020, but it does mean that people who might have lived an extra fifteen to twenty years, may live just another three or four, and we’ll see those numbers in the coming years.<sup>260</sup>

### 15.2.3 *Study: Lockdowns could be 10 times more deadly than the virus*

This is an extract from a news report about a study:

A groundbreaking new study commissioned by Revolver News concludes that COVID-19 lockdowns are ten times more deadly than the actual COVID-19 virus in terms of years of life lost by American citizens.<sup>261</sup>

### 15.2.4 *Study: At least 12 times more will be killed by lockdowns*

Prof John Gibson of New Zealand of the University of Waikato<sup>262</sup> reviewed the following three papers and concluded that 12 times as many years of life will likely be lost by lockdowns compared with any people saved from COVID deaths. For Indonesia the estimate is 10,000 times.<sup>263</sup>

- “Hard, not early: Putting the New Zealand Covid-19 response in context”, *New Zealand Economic Papers*, (2020, forthcoming).<sup>264</sup>
- “Government mandated lockdowns do not reduce Covid-19 deaths: Implications for evaluating the stringent New Zealand response”, *New Zealand Economic Papers*, (2020, conditionally accepted).<sup>265</sup>
- “Direct and indirect effects of Covid-19 on life expectancy and poverty in Indonesia”, *Bulletin of Indonesian Economic Studies*, (2020, forthcoming).

### 15.2.5 *Study: A tsunami of excess non-COVID deaths*

*The Lancet* has published a paper<sup>266</sup> on 10 August 2020, “Coronial autopsies identify the indirect effects of COVID-19” by Robert Pell et. al. which shows that there is already a **pandemic of excess deaths** from non-COVID causes.

**Indirect increases in morbidity and mortality resulting from movement restrictions** imposed during the COVID-19 pandemic have been identified as a public health concern.

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<sup>259</sup> [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/907616/s0650-direct-indirect-impacts-covid-19-excess-deaths-morbidity-sage-48.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907616/s0650-direct-indirect-impacts-covid-19-excess-deaths-morbidity-sage-48.pdf)

<sup>260</sup> <https://www.zerohedge.com/medical/isnt-human-unseen-perils-covid-faceless-number-melbourne>

<sup>261</sup> <https://www.revolver.news/2020/08/study-covid-19-lockdowns-deadlier-than-pandemic-itself/>

<sup>262</sup> <https://www.waikato.ac.nz/staff-profiles/people/jkgibson>

<sup>263</sup> [https://www.youtube.com/watch?v=O2JOg4ki\\_so](https://www.youtube.com/watch?v=O2JOg4ki_so)

<sup>264</sup> <https://ideas.repec.org/p/wai/econwp/20-08.html>

<sup>265</sup> <https://ideas.repec.org/p/wai/econwp/20-06.html>

<sup>266</sup> [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(20\)30180-8/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30180-8/fulltext)

Deaths registered in England and Wales exceeded the 5-year average by almost 50 000 during the first 2 months of lockdown.

Professor Ramesh Thakur of the Australian National University wrote on 24 October 2020:

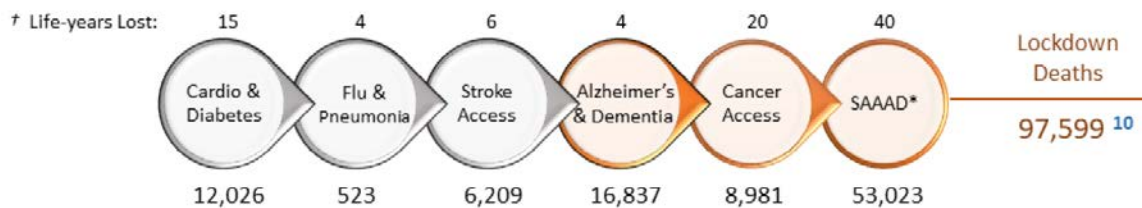
The US Centres for Disease Control estimates **93,814 non-Covid excess American deaths**. In the **UK, 'up to 150,000' could suffer non-Covid-19 premature deaths**, the Financial Times reported.<sup>267</sup>

A 26 September 2020 paper published by the Boston University School of Public Health along with other experts, "Assessing the Impact of the Covid-19 Pandemic on US Mortality: A County-Level Analysis", noted:

26.3% of excess deaths between February 1 and September 23, 2020 were ascribed to causes of death other than Covid-19 itself. **Excess deaths not assigned to Covid-19 were even higher than predicted by our model** in counties with high income inequality, low homeownership, and high percentages of Black residents, showing a pattern related to socioeconomic disadvantage and structural racism.<sup>268</sup>

### 15.2.6 Study in the USA: around 100,000 lockdown deaths

An estimate has been made in the USA based on official statistics, that lockdowns will lead to around 100,000 additional deaths in the USA.<sup>269</sup>



### 15.3 Mental harms

In the UK domestic-abuse hotline calls were up over 60%. Drug abuse and alcoholism are up.<sup>270</sup>

An article on 25 October 2020 described the devastating effects of lockdowns on mental health in Argentina.<sup>271</sup>

Three out of four people, or **seventy-five percent, now have sleep problems in Buenos Aires**, while one in two have decided to stop daily activities. Residents have spoke about the numbing effect of social isolation.

"Having more than 200 days without pleasant stimuli, such as social meetings, trips or outings affected my motivation...even more so knowing that the economic situation in my context is terrifying," said Azul Weimann, who is in the third year of studying to be a nutritionist and now has **sleeping problems and an eating disorder**.

Another resident, a woman named Julieta who works nine hours a day from home, said she has had **anxiety attacks** and is now undergoing therapy.

A website has reported that:

<sup>267</sup> <https://spectator.com.au/2020/10/hippocrates-cancelled/>

<sup>268</sup> <https://www.medrxiv.org/content/10.1101/2020.08.31.20184036v3#p-5>

<sup>269</sup> <https://twitter.com/EthicalSkeptic/status/1319731033009520640>

<sup>270</sup> Carter, Michael P., "Counting the Cost of U.K., U.S. Lockdowns", Letters, *Wall Street Journal*, 30 August 2020. Short URL: <https://on.wsj.com/3kQexvT>.

<sup>271</sup> <https://samadim.com/psychological-trauma-mounting-in-argentina-lockdowns-do-not-discriminate/>

The psychological harms of social isolation often manifest themselves as depression. Many studies have captured a sharp rise in depression and anxiety since lockdowns began. According to one study, a third of Americans are now displaying clinical-level depression. A Greek study discovered a major increase in mental health issues among university students: 42.5% for anxiety, 74.3% for depression, and a 63.3% increase in suicidal thoughts. A common finding across lockdown mental health surveys around the world is that approximately 25% of people are now experiencing severe mental distress.<sup>272</sup>

This is nothing short of **torture on a global scale**<sup>273</sup>.

### 15.3.1 *Significant increase in substance abuse*

A survey by UK's Office for National Statistics found that 20% of people that drink alcohol daily have increased their consumption.

The Canadian Centre of Substance Abuse and Addiction discovered that 25% of people aged 35 to 54 have been drinking more.<sup>274</sup>

A website<sup>275</sup> states:

New research from the University of Bristol has found that loneliness has multiple effects on smoking — it leads to the commencement of smoking, an increase in the number of cigarettes smoked per day in existing smokers, and makes it less likely to quit smoking. These effects are greater in longer periods of social isolation according to the research team. Probably the most surprising finding of the study was that being socially isolated results in many people taking up smoking for the first time, flying in the face of the traditional view that people only start smoking due to peer pressure.

## 15.4 Physical harms

### 15.4.1 *Referrals from primary clinics are radically down due to lockdowns*

A group of health, economics and law experts in New Zealand have published their concerns about the costs of lockdowns in that country. They note, however, the paucity of studies at this stage.

The only known study of lockdown health impacts in New Zealand was of a Dunedin primary health clinic, where **referrals and tests had dropped 100% and 99% respectively**. Anecdotal evidence provided to the Covid Plan B group is that referrals and tests may be down across the country by two thirds.<sup>276</sup>

On 29 October 2020 a news report entitled, “Cancer crisis: The hidden victims of COVID – 50,000 people missing a diagnosis”, noted that:

“As the pandemic escalated, we know there was a significant drop in people visiting their GP with symptoms and being referred for cancer tests. This has meant a ‘colossal’ **50,000 people in the UK are now missing a cancer diagnosis** because of the disruptions caused by COVID-19 – a number that could double by this time next year.”<sup>277</sup>

Professor Ramesh Thakur of the Australian National University wrote on 24 October 2020:

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<sup>272</sup> <https://endlockdowns.org/isolation/>

<sup>273</sup> <https://www.thestar.com/news/gta/2020/10/24/ontario-shut-down-non-urgent-health-services-in-the-spring-now-ontario-hospitals-are-seeing-many-more-patients-with-advanced-cancers.html>

<sup>274</sup> <https://endlockdowns.org/substance-use/>

<sup>275</sup> <https://endlockdowns.org/smoking/>

<sup>276</sup> <https://www.covidplanb.co.nz/>

<sup>277</sup> <https://www.express.co.uk/news/uk/1353562/cancer-crisis-coronavirus-latest-missing-diasgnosis-treatment>



‘Hundreds of thousands of cancer screenings were deferred after worries about Covid-19 shut down much of the US health-care system this spring’, the Wall Street Journal reported on 15 October. ‘There’s really almost no way that doesn’t turn into increased mortality’.<sup>278</sup>

A news report from Canada reported on 24 October 2020<sup>279</sup>:

Between March 15 and May 31, **screenings for all three cancers plunged** compared to the same period in 2019. According to data shared by Ontario Health, there was a 97 per cent decrease in screening mammograms (4,065 from 158,967), an 88 per cent decrease in Pap tests (26,269 from 219,079) and a 73 per cent decrease in fecal tests (38,000 from 141,251) in provincial programs.

#### 15.4.2 *Ongoing tests and treatment abandoned*

Governments seem to be deliberately shutting down essential treatments and prioritising COVID even though hospitals have sufficient capacity. Even cancer treatment has been pushed back – this is nothing short of criminal.

For instance, the UK Health Secretary Matt Hancock said on 6 October **that cancer treatment would have to wait until coronavirus was ‘under control’**.<sup>280</sup>

#### 15.4.3 *Domestic abuse murders*

These have possibly doubled: “According to Dame Vera Baird, victims’ commissioner in the U.K., domestic-abuse murders of women increased significantly, possibly doubled, during lockdown”<sup>281</sup>.

#### 15.4.4 *Babies killed or harmed because of lockdowns*

The BBC reported on 7 November 2020 that:

There was an alarming 20% rise in babies being killed or harmed during the first lockdown, Ofsted’s chief inspector Amanda Spielman has revealed. Sixty four babies were deliberately harmed in England - eight of whom died. Some 40% of the 300 incidents reported involved infants, up a fifth on 2019. Ms Spielman believes a **“toxic mix” of isolation, poverty and mental illness** caused the March to October spike. Health staff and social workers were hampered by Covid restrictions. And many regular visits could not take place, while others were carried out remotely, using the telephone or video links.<sup>282</sup>

#### 15.4.5 *Increase in child trafficking in India*

Professor Ramesh Thakur of the Australian National University wrote on 24 October 2020:

I ask the question ‘triggered’ by a report in the *Indian Express* (12 October). There’s been a **sharp surge in child trafficking in India following lockdowns**. Westerners have forgotten what ‘hand to mouth’ existence means, when the sole breadwinner must earn daily wages to buy food for the family, including elderly parents. With lockdown for months without end, children are inevitably at risk of being trafficked into labour bondage, street begging or sexual slavery.

#### 15.4.6 *Suicides*

It has been reported that:

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<sup>278</sup> <https://spectator.com.au/2020/10/hippocrates-cancelled/>

<sup>279</sup> <https://www.thestar.com/news/gta/2020/10/24/ontario-shut-down-non-urgent-health-services-in-the-spring-now-ontario-hospitals-are-seeing-many-more-patients-with-advanced-cancers.html>

<sup>280</sup> <https://www.spectator.com.au/2020/10/hippocrates-cancelled/>

<sup>281</sup> Grierson, Jamie, “Domestic abuse killings ‘more than double’ amid Covid-19 lockdown”, *The Guardian*, 14 April 2020. Short URL: <https://bit.ly/3ionpat>.

<sup>282</sup> <https://www.bbc.com/news/education-54827702>

Since lockdowns began, numerous studies have already captured a surge in the number of people moving towards suicide. In a survey of university students in Greece, suicidal thoughts had increased 8-fold compared to pre-lockdown. According to the CEO of the Canadian Mental Health Association, calls to its hotlines have increased 50-60%. A hospital trust in the UK reported seeing as many suicide attempts in the first few weeks of lockdown as it saw in all of 2019.<sup>283</sup>

There are around 230,000 suicides each year in India. Based on limited data (for the district of Noida) I have estimated that India could end up with an up to additional 50,000 suicides due to lockdowns.<sup>284</sup> This is very tentative and more information is needed. An Indian website is attempting to track the non-COVID impacts of lockdowns but it is a small effort.<sup>285</sup> It has recorded a number of lockdown-motivated suicides.

#### 15.4.7 *Cancer deaths*

- A report from Canada on 24 October 2020: “Anecdotally, we are **seeing more advanced cancers as patients** finally present to their surgical specialist,” he said, noting that usually means patients will require a bigger operation and longer hospital stay and are more likely to need radiation and chemotherapy and other multidisciplinary care. “So the impact to the entire system is significant”.<sup>286</sup>
- “Patients **dying at home from causes other than Covid-19** are fuelling excess deaths across the UK. The data from the Office for National Statistics shows more than 6,700 extra deaths in homes across the UK in the past two months”<sup>287</sup>.
- In the UK, a report has stated: “The Health Data Research Hub for Cancer, who used health data to predict that there could potentially be an additional 18,000 additional deaths in people with cancer, as a result of the pandemic”<sup>288</sup>.
- Richard Sullivan, professor of cancer and global health at King’s College London, director of its Institute for Cancer Policy, saying “**The number of deaths due to the disruption of cancer services is likely to outweigh the number of deaths from the coronavirus itself.** The cessation and delay of cancer care will cause considerable avoidable suffering. Cancer screening services have stopped, which means we will miss our chance to catch many cancers when they are treatable and curable, such as cervical, bowel and breast. When we do restart normal service delivery after the lockdown is lifted, the backlog of cases will be a huge challenge to the healthcare system”.<sup>289</sup>
- Cancer Research UK has reported that 27 million GP appointments have been lost due to the scare during the lockdowns. 350,000 people who should have been urgently referred to specialists weren’t. The report predicts that **35,000 avoidable cancer deaths might result.**<sup>290</sup>
- Dr Scott Atlas has reported that 46% of the cancers have not been diagnosed due to lockdowns, 50% of chemotherapy appointments have been missed, 50% immunizations have been missed and 25% of young people have considered suicide.<sup>291</sup>

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<sup>283</sup> <https://endlockdowns.org/suicide/>

<sup>284</sup> Sabhlok, Sanjeev, Tweet of 8 September 2020. Short URL: <https://bit.ly/3mXuVg0>.

<sup>285</sup> <https://thejeshgn.com/projects/covid19-india/non-virus-deaths/#Table>

<sup>286</sup> <https://www.thestar.com/news/gta/2020/10/24/ontario-shut-down-non-urgent-health-services-in-the-spring-now-ontario-hospitals-are-seeing-many-more-patients-with-advanced-cancers.html>

<sup>287</sup> Donnelly, Laura, “Non-virus deaths at home behind surge in excess fatalities, figures show”, *The Telegraph*, 2 September 2020. Short URL: <https://bit.ly/3l92J8t>.

<sup>288</sup> Health Data Research UK, “The Big C isn’t COVID-19 - it’s cancer”, 25 August 2020. Short URL: <https://bit.ly/3kSs8mxw>.

<sup>289</sup> <https://www.zerohedge.com/medical/isnt-human-unseen-perils-covid-faceless-number-melbourne>

<sup>290</sup> <https://twitter.com/sabhlok/status/1317387329997131776>

<sup>291</sup> [https://twitter.com/justin\\_hart/status/1316381998345146369](https://twitter.com/justin_hart/status/1316381998345146369)

#### 15.4.8 *100+ millions pushed into extreme poverty – which reduces lifespan*

On 26 September 2020, the *Economist* magazine reported the World Bank's research that due to the lockdowns the number of extremely poor people (those who earn less than \$1.90 a day) will rise by **70 to 100 million this year**<sup>292</sup>.

Given the reports I have been getting from India I have reasons to consider this to be an under-estimate. It is not unreasonable to expect that the lives of these (at least) 100-odd million people will be significantly shortened because of the extreme poverty into which they have been thrown. In addition, hundreds of millions live in India just above poverty. They will face severe financial hardship in accessing health care in the coming years.

India's lockdowns were entirely unnecessary. I have written 17 articles about pandemic policies for India on my *Times of India* blog which are listed at: <https://swarnabharat.in/pandemic>. Despite extensive communication with Rajiv Gauba, India's Cabinet Secretary and my batchmate from the Indian Administrative Service, Mr Modi, India's Prime Minister chose the worst possible strategy for India. The harms caused to the poor of India as a result simply boggle the mind.

Professor Ramesh Thakur of the Australian National University wrote on 24 October 2020:

Of course, the biggest tragedy will be across the developing world over the next decade, with over 100 million more people pushed into extreme poverty, **tens of millions of additional dead from increased infant and maternal mortality, hunger and starvation** with more poverty and disrupted crop production and food distribution networks, sharp cutbacks in immunisation and schooling, and destruction of the informal sectors of the economy in which daily wage earners earn a pitiful living. Most countries will also need to prepare for potential spikes in mental health problems and suicides from the fear generated by exaggerated alarmism as well as the loneliness, isolation, financial ruin and despair caused by the lockdowns.<sup>293</sup>

The following article confirms this situation: "The new urban poor in Mumbai: Salaries gone, pawning gold to pay school fees, NGO meals, rents unpaid".<sup>294</sup>

Based on analysis by his organisation, the German Minister of Economic Cooperation and Development, Gerd Muller said on 25 September 2020<sup>295</sup> that lockdowns have resulted in "one of the biggest" hunger and poverty crises in history. He believes that "an additional 400,000 deaths from malaria and HIV" will occur this year "on the African continent alone". Further, "half a million more will die from tuberculosis". This is largely attributable to the breakdown of food and medication supplies and lack of funding of the West's aid programs.

#### 15.4.9 *Lower childhood vaccination rates*

There have been many reports of a significant drop-off in childhood vaccinations in developing countries.<sup>296</sup> Some of this disruption might have occurred anyway due to the pandemic but there is a strong link between lockdowns and such a drop-off. This could dramatically increase child mortality in developing countries.

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<sup>292</sup> *The Economist*, "Covid-19 has reversed years of gains in the war on poverty", 26 September 2020. Short URL: <https://econ.st/3kSij84>.

<sup>293</sup> <https://spectator.com.au/2020/10/hippocrates-cancelled/>

<sup>294</sup> <https://indianexpress.com/article/india/the-new-urban-poor-salaries-gone-pawning-gold-to-pay-school-fees-ngo-meals-rents-unpaid-6889887/>

<sup>295</sup> Durden, Tyler, "German Minister Admits Lockdown Will Kill More Than COVID-19 Does", Zerohedge.com website, 26 September 2020. Short URL: <https://bit.ly/2FXcgk2>.

<sup>296</sup> <https://www.who.int/news/item/15-07-2020-who-and-unicef-warn-of-a-decline-in-vaccinations-during-covid-19>

#### 15.4.10 *Stillbirths*

The UNICEF has warned that disruptions arising from lockdowns could result in potentially devastating increases in maternal and child deaths.<sup>297</sup>

On 3 November 2020, it was reported that in the UK, “Stillbirths doubled during first wave of Covid-19 pandemic amid fears that mothers were delayed from seeking NHS care”<sup>298</sup>. Although the number is not large (40 stillbirths between April and June compared to 24 in same period in 2019), this is almost certainly yet another loss of life caused by coercive lockdowns and the scare campaign of the government.

And a *Lancet* study has reported a 50% increase in stillbirths during lockdowns in developing countries because of insufficient medical care.<sup>299</sup>

#### 15.4.11 *Children not born because of the lockdowns*

There are also innumerable lives that were never even conceived because of the loss of economic stability and poverty arising from lockdowns. As a result of the financial pressures so generated, millions of poor parents across the world would have put off having children. Innumerable marriages across the world would have got pushed back by months, if not years. This will lead to lower fertility than we might have otherwise seen without lockdowns. How can we even begin to value the loss of a life the very conception of which we have disallowed?

While the ICC cannot obviously count these lives that were not even conceived as a crime, the actions of governments worldwide that have led to this inhumane situation will remain **a blot on mankind for all times to come**.

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In sum, there is ongoing **carriage**. The issue of public health terrorism needs to be taken head on and stopped, before similar harms are caused by public health professionals and policy makers in the future.

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<sup>297</sup> UNICEF Press Release, 12 May 2020. Short URL: <https://uni.cf/2GwOpHE>.

<sup>298</sup> <https://www.dailymail.co.uk/news/article-8905643/Stillbirths-DOUBLED-wave-Covid-19-pandemic.html>

<sup>299</sup> Watson, Clare, “Stillbirth rate rises dramatically during pandemic”, *Nature*, 15 September 2020. Short URL: <https://on.wsj.com/3kQexvT>.

## Part IV: Exploring the intentions of the Accused

## 16. Questionable intentions: Lies, fear mongering, deceptive data

I will focus in this chapter on trying to understand the intentions of the Accused.

One would always prefer to assume good intentions among our elected political leaders and public health practitioners – particularly in an advanced Western democracy like Australia.

I have worked for 15 years in Victoria's Treasury advising various governments and would not have done so had I doubted their intentions. But this time it does not seem that this is about erroneous policy by otherwise good people.

Even good people make mistakes. The proof of someone's good intentions that they take feedback and correct their mistake as soon as possible. They apologise and make amends. But the Accused have rejected all advice and insist on making things worse. They have put a blindfold on their eyes to prevent them from seeing the **carnage** they are causing.

The Accused had no reasons to make these policy blunders. They had all possible knowledge through the laws and approved pandemic plans to follow a proportionate and least interventionist path. But they rejected this path despite being reminded about it by well-wishers.

The give-away about their bad intentions is when these leaders attack Sweden's sound approach (which was a replica of Australia's own pandemic plans), instead of praising its well-balanced strategy.

I am now sadly coming to the view that the Accused have **deliberately** chosen this path. They have deliberately engaged in fear mongering and deliberately misled the people. This fear mongering was needed to make the people of Victoria accept their arbitrary directives. As a result of the fear mongering, many government-trusting Victorian parents even put **masks on their toddler's face**, blotting the development of their own children's brain.

This nightmare will be written about for generations to come.

That is why I no longer continue to think of the Accused as good people.

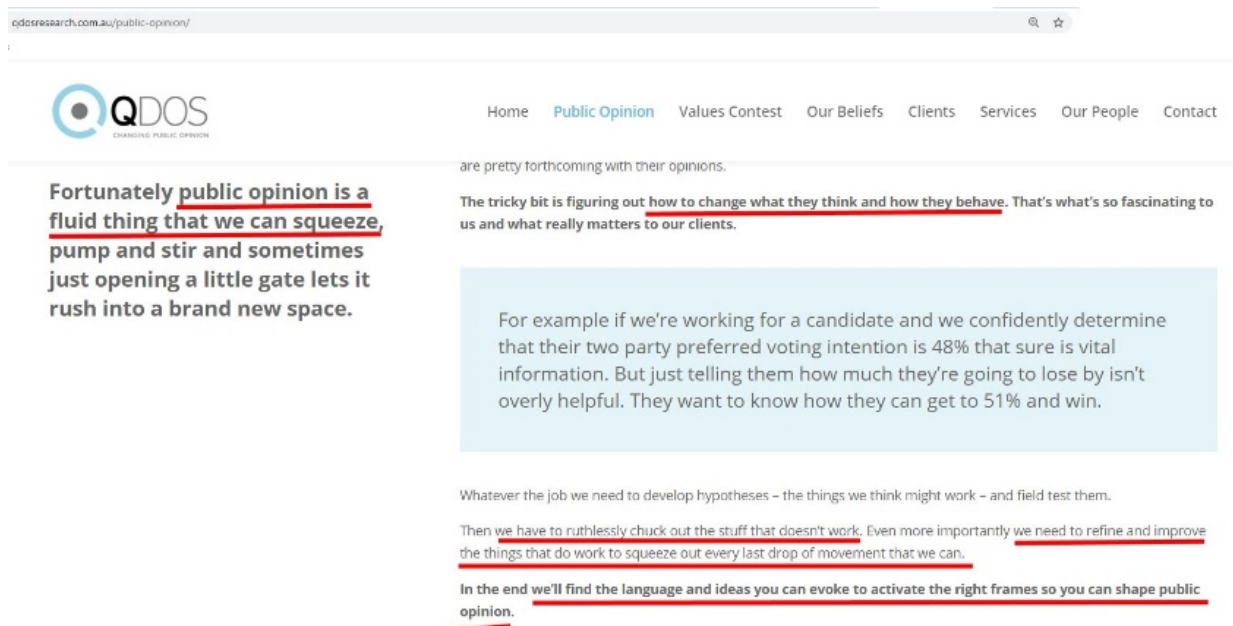
### 16.1 Taxpayer funded advice on propaganda techniques that Andrews refuses to publish

On 29 October 2020 *The Australian* published a news report, "\$2m taxpayer bill for Labor's secret program to monitor Victorians"<sup>300</sup>. This was about a contract that Victoria's Premier Daniel Andrews has signed with a company called QDOS which specialises in changing public opinion.

This, below (next page), is what its website states at: <https://www.qdosresearch.com.au/public-opinion/>.

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<sup>300</sup> <https://www.theaustralian.com.au/nation/2m-taxpayer-bill-for-labors-secret-program-to-monitor-victorians/news-story/e07988aa1755943c347096c2271a35d0>



(Screenshot of QDOS website with some of the more alarming content highlighted in red)

The language used by QDOS on their website is beyond the pale, being reminiscent of propaganda techniques we thought the world had left far behind. It is obnoxious in the extreme that Victorian taxpayers are paying big money to such a company that treats people with such disdain.

The fact that the Andrews Government has refused to publish the advice it has received from QDOS in relation to the COVID pandemic tells us that there is a hugely compromised mindset somewhere in this process.

Victorians have **paid** for this advice. They must see it. **Mr Andrews is surely hiding something that he believes will expose the truth about his intentions.** I believe the ICC should summon the advice that QDOS has provided to Mr Andrews. It may provide a direct window into the mind of Accused Group 1.

## 16.2 Questionable intentions: Grossly exaggerating the virus threat

### 16.2.1 *Exaggerating the magnitude of the threat*

As mentioned earlier, the Victorian Chief Health Officer said in July 2020 that he considers this pandemic to be the 'greatest public health challenge since the Spanish flu'<sup>301</sup>. Such a statement might have been potentially reasonable to make in mid-March 2020 when so much was still uncertain (but even then it is completely wrong for a public health practitioner to create hysteria), from mid-April 2020 scientists and policymakers of even the most basic calibre could have readily deduced that this was no Spanish flu.

I deduce that the CHO has extremely questionable intentions. Why is he continuing to stoke hysteria?

This approach is not like the rational, balanced and calm behaviour we have seen in his Swedish counterpart, Anders Tegnell

### 16.2.2 *Lying about the risk distribution of the virus*

The Victorian Administering Authorities have been falsely claiming that the virus does not discriminate among people. On 30 July 2020 Daniel Andrews issued a press release in which he said:

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<sup>301</sup> Carey, Adam, and Webb, Carolyn, 'Remote-learning move not enough to quell teachers' virus fears', *The Age*, 12 July 2020. Short URL: <https://bit.ly/30914tX>.

Today is not a good day. And as the numbers show, **this virus does not discriminate**. It rips through workplaces, sweeps through aged care settings, cuts through communities – and tragically, takes lives with it as it goes.<sup>302</sup>

Likewise, on 11 September 2020 the Chief Health Officer wrote:

As we have seen in Victoria, **young people can also succumb to severe illness and the severity of illness cannot always be predicted by age or comorbidities alone**.

It seems that the Victorian Administering Authorities have been using all opportunities to mislead and terrorise Victorians. In this case they are implying that all Victorians *could* die from this virus. But they know very well – and the data are clearly available even on government websites – that this coronavirus is fatal mainly to the elderly, a fact that has been widely known since mid-February 2020 and was explicitly mentioned in Victoria’s 10 March 2020 Pandemic Plan.

Talking death non-stop for seven months is extremely abnormal. Every other task and function of society was suspended and ignored. If people hear about death all the time on the TV from their leaders, is it any surprise that they have shut down their mind in total terror and fear? This is mass psychosis created by public health terrorists.

### 16.2.3 *Exaggerating the “long-term” COVID problem*

On 10 August 2020 Daniel Andrews’s website issued a statement: “Victorians are being reminded that coronavirus does not discriminate – and that even those who recover from the virus **are** left with long-term consequences, both physical and psychological”<sup>303</sup>.

The statement implies that *all* of those who recover will have long-term consequences. This is a **huge lie**, specifically designed to create hysteria.

We know that millions of people including major sports stars have fully recovered from the novel coronavirus and are doing perfectly fine. News reports suggest that some of the recovered major sports stars are back to their sport with full vigour.

Data that is emerging also tells us that “long term” harms of COVID are comparable with long term harms that we normally see with other respiratory viruses. Mike Yeadon<sup>304</sup> has noted that “although COVID can have serious after-effects, so can flu or any respiratory illness”. SARS, another coronavirus, also had cases with long term effects.

A British study with 200 long COVID patients found mild myocarditis in about 10% of them. This value is significantly lower than originally assumed and **comparable to influenza virus infections**.<sup>305</sup>

The results from a UK study suggest that “Extrapolating out to the general UK population, which has a different age and gender makeup compared with the COVID Symptom Study app users, the team estimated that around one in seven (14.5%) of people with symptomatic COVID-19 would be ill for at least 4 weeks, one in 20 (5.1%) for 8 weeks and **one in 45 (2.2%) for 12 weeks or more**”<sup>306</sup>.

The fact that only 2.2% of those who experienced symptoms (many who are infected do not even experience symptoms so were not counted) are being impacted for more than 12 weeks is further confirmation that long-term COVID cases are comparable in magnitude with other respiratory viruses.

But even if these effects were actually much worse, they are an Act of Nature. We must accept Nature for what it is. The harms of Nature cannot be used as an excuse to impose coercive lockdowns (an Act of

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<sup>302</sup> <https://www.dhhs.vic.gov.au/updates/coronavirus-covid-19/statement-premier-30-july-2020>

<sup>303</sup> <https://www.premier.vic.gov.au/stories-coronavirus-survivors>

<sup>304</sup> Lopez, Ralph, “Former Chief Science Officer for Pfizer Says ‘Second Wave’ Faked on False-Positive COVID Tests, ‘Pandemic is Over’”, HubPages, 1 October 2020. Short URL: <https://bit.ly/2RZZV0F>.

<sup>305</sup> <https://swprs.org/post-acute-covid-long-covid/>

<sup>306</sup> <https://covid.joinzoe.com/post/long-covid>



Man) that then cause real mental or physical harm to those who will not experience any such effects. Collateral damage of other humans from any government policy is *always* a crime.

The remedy is for everyone to take voluntary precautions. No matter how small or how large such harms, there is no excuse to create *additional* harms. But Andrews has been taking all opportunity to drum up hysteria to bring Victorians to their knees. This reflects badly on the intentions of Accused Group 1.

### 16.3 Questionable intentions: Lying about the real strategy – of eradication

As I have shown earlier, the Andrews government is **not** flattening the curve: it is eradicating the virus, **by stealth**.

Even with zero cases (as at 10 November 2020) Andrews is insisting on coercive restrictions and mandatory masks – even outdoors with no one around for a mile.

Yet he and his Ministers keep misleading us all by chanting that mantra about “flattening the curve”.

On 4 August 2020 the Minister for Health of Victoria advised the Parliament that “The Victorian Government is focused on the immediate issue of flattening the curve”<sup>307</sup>. That was a lie. There was never a single day or week in 2020 when Victoria’s hospital system came under stress. Illustratively, on 4 September 2020, there were only 20 COVID-19 patients in ICU<sup>308</sup>. Victoria has “695 intensive care beds and the capacity to rapidly expand that number if cases surge, according to state Health Minister Jenny Mikakos”<sup>309</sup>.

We know from his public statements that Andrews is in reality committed to the **eradication strategy** and wants to force a vaccine into every Victorian. On 4 July 2020 he said:

At that point we will not be returning to normal because there will be no vaccine in the weeks ahead, some argue even in the months ahead. It is a long way off. And **unless and until that vaccine is developed, and then administered to every single Victorian**, we will have to live with and embrace a COVID normal.<sup>310</sup>

This statement also displays a mindset that disregards other human beings as autonomous people, and also disregards all laws and ethics. It is impossible for anyone who has made such a statement to keep lying in Parliamentary documents about “flattening the curve”. But these people have truly bad indentations and lying comes naturally to them.

### 16.4 Questionable intentions: Deceptive data about COVID deaths

I have recently identified a major problem with data on COVID deaths – and this is not just about the Andrews Government. It is a global issue.

#### 16.4.1 *Very few deaths are “from covid”, most are “with covid”*

There is a genuine problem in classifying a death: “It’s not always easy to tell if someone has died because of the effects of the SARS-CoV-2 virus, or whether they’ve passed away from pre-existing medical conditions but with the virus in their system”.<sup>311</sup>

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<sup>307</sup> [https://www.parliament.vic.gov.au/images/Hayes\\_040820\\_.pdf](https://www.parliament.vic.gov.au/images/Hayes_040820_.pdf)

<sup>308</sup> Victorian Government, ‘Coronavirus update for Victoria - 04 September 2020’, DHHS website. Short URL: <https://bit.ly/34hD117>.

<sup>309</sup> Mannix, Liam et.al., ‘What is Victoria’s ICU capacity, and could we exceed it?’, *The Age*, 17 July 2020. Short URL: <https://bit.ly/3mTWsyR>.

<sup>310</sup> *The New Daily*, ‘Victoria’s COVID crisis grows: Two more postcodes locked down, 108 fresh cases’, 4 July 2020. Short URL: <https://bit.ly/3ixgeg9>. The video of Daniel Andrews’s statement is found in a Tweet by @YellowCube7 on 3 October 2020. Short URL: <https://bit.ly/3cWdmbD>. Also at: <https://www.facebook.com/sabhlok/posts/10159024532863767>

<sup>311</sup> <https://theconversation.com/died-from-or-died-with-covid-19-we-need-a-transparent-approach-to-counting-coronavirus-deaths-145438>

But the data collection methodology for COVID seems to be **hugely biased towards inflating COVID death figures**. Just having coronavirus in the body at the time of death is no proof that it caused the death. The virus must actually *cause* the death, but today we can't be sure of that.

I outline below some of the information I have gathered to date. The public has also begun to get anxious about this issue.

On 5 October 2020, a Melbourne newspaper, *The Herald Sun* reported that: "The accuracy of Victoria's coronavirus death toll is being brought into question following allegations government officials attributed deaths to COVID-19 even when doctors were unable to verify a cause"<sup>312</sup>.

On 9 September 2020 Marc Trabsky, the Director of the Centre for Health, Law and Society, La Trobe University and Courtney Hempton of Deakin University (both in Melbourne) noted:

There's been confusion, however, over whether reported death statistics reflect those who've died **from** COVID-19, or those who've died **with** the virus. Often it's hard for medical practitioners to determine which of these categories a death falls into. But the COVID-19 death toll publicised daily on Australian state and territory government websites and reported to the press **does not differentiate between the two**. Clarifying what's being counted as a COVID-19 death is necessary for understanding the impact of the virus, and for informing public health and clinical responses to the pandemic.<sup>313</sup>

In the USA, we know that CDC has reported that:

For 6% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19, on average, there were 2.6 additional conditions or causes per death"<sup>314</sup>.

This means that only 6 per cent of the reported COVID deaths in USA can be genuinely considered to be entirely caused by COVID. For the remainder, the real cause remains unclear. In general, it seems that most "COVID-19 deaths" in the world have not occurred '**from**' COVID-19 but '**with**' COVID-19.

I have tried to look into this in some detail, below:

### **Case 1: When a person dies with the virus**

*The Age* reported on 10 September 2020<sup>315</sup> that "under federal Health Department guidelines, a death is defined for surveillance purposes as COVID-19-**related** if the person dies **with** the virus and there is no clear alternative cause of death, such as trauma. Those guidelines also stipulate that when a coroner's report finds a different cause of death, those findings take precedence".

But the mere fact that someone died **with a virus** in his or her body is no proof that the virus actually killed the person. Dr Ngozi Ezike Director of Public Health, Illinois, said this clearly on TV in April 2020.

I just want to be clear in terms of the definition of people dying of covid. So the case definition is very simplistic. It means at the time of death it was a COVID positive diagnosis. So that means that if you were in hospice and had already been given – you know a few weeks to live – and then you also were found to have covid, that would be counted as a COVID death. It means that if **technically even if you died of a clear alternate cause but you had COVID at the same time, it is still listed as a COVID death**. So everyone who's listed as a COVID death **doesn't mean that that was the cause of the death** but they had COVID at the time of death. I hope that's helpful.<sup>316</sup>

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<sup>312</sup> <https://www.heraldsun.com.au/lifestyle/health/doubts-raised-over-accuracy-of-victorias-coronavirus-death-toll/news-story/6e4c77fb8c0425ea854f8445845db264>

<sup>313</sup> <https://theconversation.com/died-from-or-died-with-covid-19-we-need-a-transparent-approach-to-counting-coronavirus-deaths-145438>

<sup>314</sup> [https://www.cdc.gov/nchs/nvss/vsrr/covid\\_weekly/index.htm#Comorbidities](https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm#Comorbidities)

<sup>315</sup> Baker, Richard, "Youngest COVID-19 victim may have died of another cause", *The Age*, 10 September 2020. Short URL: <https://bit.ly/346a8yc>.

<sup>316</sup> <https://www.youtube.com/watch?feature=youtu.be&v=zYUEXbc1ijU>

When autopsies are actually done, it seems that the death reports can change completely. Hamburg in Germany decided to conduct autopsies and found that **none** of the deaths were actually **caused** by covid:

According to Dr Klaus Püschel in this interview on 21 April, out of the over 100 COVID-19 deaths he autopsied, all of them died with significant pre-existing conditions, and so had a weakened immune system when they contracted COVID-19.<sup>317</sup>

It is not clear whether any such validation of COVID deaths is taking place through autopsies in Victoria.

### **Case 2: When a person who dies had the virus in the past month**

I am not sure whether this applies to Australia but in the UK “deaths within 28 days of a positive Covid-19 test” are counted as a COVID death.<sup>318</sup> This approach is even more problematic, in that a person need not even have an active COVID infection at the time of death.

As Roger Helmer, former Member of the European Parliament has remarked about such cases:

Anyone who dies within 30 days of a +ve C19 test is being counted as a Covid death. **It’s like saying that someone dying of a heart attack, who also had a cold, has died of the cold.** And the bitter irony is that many of those C19 infections will have been acquired in hospital.<sup>319</sup>

### **Case 3: When a person who dies did not even test COVID-positive**

On 25 March 2020, the Australian Bureau of Statistics wrote that it is quite valid to even make an *assumption* about a death being from COVID – effectively without regard to the existence of the virus in the body:

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.**<sup>320</sup>

The Coroners Court in Western Australia has the following guidance on counting COVID deaths:

Where a person is known to have **suffered typical symptoms of COVID-19**, such as fevers, cough, or breathing difficulties, during a COVID-19 pandemic, but has **not been formally tested** or diagnosed, then it is reasonable to **“assume”** the death was related to COVID-19 and should be recorded on the death certificate.<sup>321</sup>

The University of Melbourne (CRVS technical guide: Correctly certifying deaths due to COVID–19: guidance for physicians<sup>322</sup>) has issued guidance which states that “there are two distinct ICD-10 codes used for coding COVID-19 deaths - U07.1 (COVID-19, virus identified) and U07.2 (COVID-19, **virus not identified**)”. It then notes that “Evaluation studies have shown that **medical certificates of cause of death are often of poor quality**, even when the cause of death has been certified by a physician”.

It seems highly questionable to have a code for COVID deaths (U07.2) when the virus **was not even identified on the person.**

It appears that deaths from respiratory illness (or even other causes) can be simply assumed to be COVID deaths. But given the strong overlap in symptoms between COVID and flu, how can we say that we are not classifying flu as covid? Indeed, that is what is certainly happening. (I’ll discuss this separately, below).

In addition, financial incentives seem bias the reporting.

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<sup>317</sup> <http://www.jorgprobst.com/en/covid-19-inflating-the-numbers/>

<sup>318</sup> <https://www.spectator.co.uk/article/The-ten-worst-Covid-data-failures>

<sup>319</sup> <https://twitter.com/RogerHelmerMEP/status/1320998352813776896>

<sup>320</sup> <https://www.abs.gov.au/ausstats/abs@.nsf/mf/1205.0.55.001>

<sup>321</sup> [https://www.coronerscourt.wa.gov.au/\\_files/COVID\\_Medical\\_Certificate\\_Cause\\_Death\\_Guide.pdf](https://www.coronerscourt.wa.gov.au/_files/COVID_Medical_Certificate_Cause_Death_Guide.pdf)

<sup>322</sup> <https://crvsgateway.info/file/17062/3922>

#### ***16.4.2 Financial incentives to report cases and deaths as COVID***

The following financial incentives are likely at play:

##### **a) Payments to residential care for COVID cases**

We know for certain that the NDIS system pays residential care facilities between \$1200-\$1800 per patient per day for COVID-19 positive patients.<sup>323</sup> This could easily set up corrupt incentives for data reporting.

##### **b) Payments to hospitals for COVID cases**

In the USA hospitals are provided financial incentives for COVID cases:

U.S. Centers for Disease Control and Prevention Director Robert Redfield acknowledged during a House hearing Friday that COVID-19 data could be inflated because hospitals receive a monetary gain by reporting COVID-19 cases.<sup>324</sup>

Some evidence has emerged in a letter issued by a few Melbourne lawyers on 6 November 2020<sup>325</sup> that suggests that something on these lines (of the US experience) might be also happening in Victoria. The letter provides as evidence a statement from an anonymous former Health Information Manager & Clinical Coder, in whose opinion:

[T]he coding rules for Covid (coded information is the baseline data for reporting the total number of state cases). Under a 'mandated screening by authority test' or a 'self-presenting non-mandated test' (where there has been NO exposure and NO symptoms), the reporting guidelines state 'for clinically diagnosed or **probable cases where testing is inconclusive, unavailable or not specified**', Australian hospitals (including emergency and non-admitted care) are to assign;

Principal Diagnosis - B34.2 - "Coronavirus infection, unspecified site"

Additional diagnoses - U07.2 "Emergency use of U07.2, **Coronavirus NOT identified**"

(I have discussed the U07.2 code earlier)

It is suggested in this letter by these Melbourne lawyers that the use of this COVID code for inconclusive cases could provide Australian hospitals with more money than attributing the case to some other cause. Obviously, once such coding – no matter how erroneous – gets into the system, the code is likely to continue till the death of the patient. (I am not certain about this matter, though, and it will need further investigation.)

##### **c) Payments to relatives to declare non-COVID deaths as COVID.**

Finally, in relation to financial incentives, there are unverified reports circulating on social media about payments being made to the relatives of those who have died from a non-COVID cause, to motivate them to agree to the (fraudulent) declaration of that death as a COVID death. These social media reports are entirely unverified and need investigation.

Regardless, there is sufficient reason overall to believe that data on COVID deaths is unclear if not biased towards over-reporting.

#### ***16.4.3 Flu deaths are almost certainly being counted as COVID-19 deaths***

As if this confusion wasn't enough, it is almost certain that flu deaths are being counted as COVID deaths.

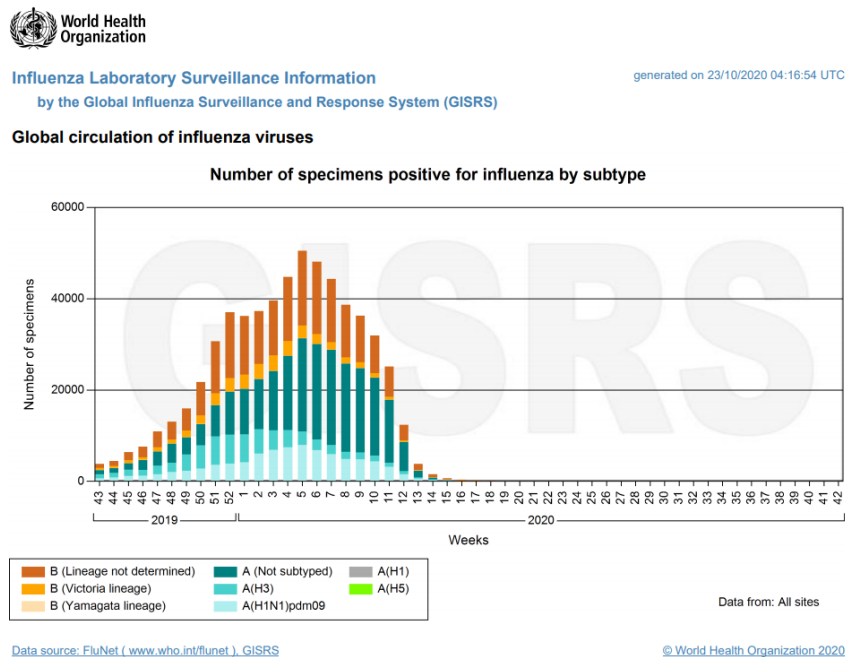
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<sup>323</sup> <https://twitter.com/sabhlok/status/1315577610508750848>

<sup>324</sup> <https://www.christianpost.com/news/cdc-director-agrees-that-hospitals-have-monetary-incentive-to-inflate-covid-19-data.html>

<sup>325</sup> <https://concernedlawyersnetwork.net/wp-content/uploads/2020/10/6.11.20-CLN-TO-GOVTS-LETTER.pdf>

It is shocking to realise that the overall prevalence of flu during 2020 has dropped off a cliff, even as COVID has spread like wildfire across the world. The World Health Organization website has the following chart on 8 November 2020<sup>326</sup>:



This chart mainly reflects the performance of flu in the Southern Hemisphere, but the virus seems to have gone dormant even in the Northern Hemisphere. Charts that compare flu cases of 2020 with previous years show that the situation is even more stark.<sup>327</sup>

In relation to the Southern Hemisphere:

In Australia, just 14 positive flu cases were recorded in April, compared with 367 during the same month in 2019 – a 96 per cent drop. By June, usually the peak of its flu season, there were none. In fact, Australia has not reported a positive case to the WHO since July.

**In Chile, just 12 cases of flu were detected between April and October.** There were nearly 7,000 during the same period in 2019.<sup>328</sup>

The idea that flu virus can disappear makes no sense. Claims by some academics that social distancing measures are causing this cannot be believed.

To rebut such claims we simply need to look at Chile's data. How is it possible to have 518,390 coronavirus cases in Chile during this period and only 12 cases of flu? Chile has also reported 14,450 COVID deaths. If one virus can transmit in Chile, why can't the other?

The only explanation that makes sense is that **deaths from flu-like symptoms are being counted as COVID deaths.** (We have seen above how this is feasible, with COVID deaths often just being "assumed".)

If this interpretation is correct then we have further serious reasons to doubt the COVID case and death counts. Since flu kills up to 650,000 people each year, if it is proven that flu is being counted as COVID, then COVID would turn out to be an even milder pandemic than currently thought.

As if this data confusion was not enough, we find that PCR tests for COVID can't rule out flu.

<sup>326</sup> [https://www.who.int/influenza/gisrs\\_laboratory/updates/summaryreport/en/](https://www.who.int/influenza/gisrs_laboratory/updates/summaryreport/en/)

<sup>327</sup> [https://twitter.com/MLevitt\\_NP2013/status/1323416055507677184](https://twitter.com/MLevitt_NP2013/status/1323416055507677184)

<sup>328</sup> <https://www.dailymail.co.uk/health/article-8875201/Has-Covid-killed-flu.html>

The CDC says on its website that “This test cannot rule out diseases caused by other bacterial or viral pathogens”<sup>329</sup>.

Further, it appears that only on 4 September 2020 has the first PCR test which can allegedly distinguish between the flu and Covid-19 been approved<sup>330</sup>. This suggests that prior to 4 September 2020 the PCR tests that were available were perhaps unable to distinguish between COVID-19 and the flu. And we don’t really know whether the 4 September 2020 test actually works since it was given emergency approval, therefore its validity has not been confirmed.

There is perhaps yet another proof that flu and COVID are being conflated. A 16 October 2020 study reported that: “we found that SARS-CoV-2 infection was less common among Dutch hospital employees who had received influenza vaccination during the 2019/2020 winter season”<sup>331</sup>. One hypothesis is that this is about “trained immunity” imparted by the flu vaccine. But the more direct link is far more plausible – namely, that the flu vaccine is actually preventing the flu virus but because the PCR test can’t distinguish between flu and COVID, these hospital employees are testing negative for COVID. This is how immunising against flu might be creating immunity against “so-called” COVID.

In conclusion, an overlap between flu and COVID is almost certainly happening on a rather large scale.

This is not directly related to the intentions of the Accused since it is probably a global issue. But I believe that honesty is the first requirement in any government and to date the Victorian Government has not discussed these matters truthfully with the people.

## 16.5 Questionable intentions: Deceptive COVID “cases” based on worthless PCR tests

In relation to the COVID cases there are two major problems: a) financial incentive to report COVID “cases” (already touched upon above) and b) the unreliability of PCR tests. A review of the literature on PCR tests by Dr Sebastian Rushworth on 6 November 2020 states:

**PCR positive cases are a very poor indicator of how prevalent COVID is in the population, and why we should instead be basing decisions on the rates of hospitalization, ICU admission, and death.**<sup>332</sup>

How far is this claim valid?

### 16.5.1 Long history of being unreliable and supporting hysterias

Polymerase Chain Reaction (PCR) tests have a long history of being wildly inaccurate. For instance, in 2007 a major blunder was made and a pandemic declared based on the PCR tests. Its story is described in Gina Kolata’s 2007 *New York Times* article “Faith in Quick Test Leads to Epidemic That Wasn’t”<sup>333</sup>.

Extracts:

At Dartmouth the decision was to use a test, P.C.R., for polymerase chain reaction. It is a molecular test that, until recently, was confined to molecular biology laboratories.

At Dartmouth, when the first suspect pertussis cases emerged and the P.C.R. test showed pertussis, doctors believed it. The results seem completely consistent with the patients’ symptoms. “That’s how the whole thing got started,”

[But after eight months] “It was going on for months,” Dr. Kirkland said. But in the end, the conclusion was clear: There was no pertussis epidemic.

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<sup>329</sup> <https://www.fda.gov/media/134922/download>

<sup>330</sup> <https://www.roche.com/media/releases/med-cor-2020-09-04.htm>

<sup>331</sup> <https://www.medrxiv.org/content/10.1101/2020.10.14.20212498v1>

<sup>332</sup> <https://sebastianrushworth.com/2020/11/06/how-accurate-are-the-covid-tests/>

<sup>333</sup> <https://www.nytimes.com/2007/01/22/health/22whoop.html>

“The big message is that every lab is vulnerable to having false positives,” Dr. Petti said. **“No single test result is absolute and that is even more important with a test result based on P.C.R.”**

According to Torsten Engelbrecht and Konstantin Demeter, the inventor of the PCR technology, Kary Mullis, considered the PCR test to be inappropriate for the purposes of detecting a viral infection. PCR is apparently intended to be a manufacturing technique, being able to replicate DNA sequences millions and billions of times, and is not a diagnostic tool to detect viruses.<sup>334</sup>

### ***16.5.2 No proof that PCR tests are testing SARS-CoV-2***

It is understood that the: “PCR is extremely sensitive, which means it can detect even the smallest pieces of DNA or RNA – but it cannot determine where these particles came from. That has to be determined beforehand”<sup>335</sup>.

Torsten Engelbrecht and Konstantin Demeter point out that the PCR tests used to identify so-called COVID-19 patients do not have a **valid gold standard** to compare the results with.<sup>336</sup> According to them, tests need to be evaluated to determine their preciseness by comparison with a “gold standard” – meaning the most accurate method available. As an example, for a pregnancy test the gold standard is the pregnancy itself.

But there is a “lack of such a clear-cut ‘gold-standard’ for COVID-19 testing”. It seems obvious that only the virus concentrated through isolation and purification can be considered a gold standard. **But in the case of PCR tests the pure form of the SARS-CoV-2 virus does not exist.**

A 20 August 2020 FOI request to Public Health England confirmed that the virus has not been isolated<sup>337</sup>. The CDC has also confirmed this (as at 13 July 2020):

The analytical sensitivity of the rRT-PCR assays contained in the CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel were determined in Limit of Detection studies. Since **no quantified virus isolates of the 2019-nCoV are currently available**, assays designed for detection of the 2019-nCoV RNA were tested with characterized stocks of in vitro transcribed full length RNA (N gene; GenBank accession: MN908947.2) of known titer (RNA copies/μL) spiked into a diluent consisting of a suspension of human A549 cells and viral transport medium (VTM) to mimic clinical specimen.<sup>338</sup>

PCR tests are therefore currently calibrated for certain gene sequences (RNA sequences because SARS-CoV-2 is **believed – not proven** – to be a RNA virus). However, there is no proof that the RNA being used by these PCR tests is specifically from the SARS-CoV-2 virus.

If there is no virus concentrate, what is being used? Apparently **“virologists at the Charité are sure that they are testing for the virus.** RNA was extracted from clinical samples with the MagNA Pure 96 system (Roche, Penzberg, Germany) and from cell culture supernatants with the viral RNA mini kit (QIAGEN, Hilden, Germany)”. But according to Torsten Engelbrecht and Konstantin Demeter this only “means **they just assumed the RNA was viral**”.

It is shocking to discover that mass-testing is being done using a “test” that has not been calibrated with the real virus, nor was ever designed by its inventor for such things. And has been used in the past to create fake pandemics.

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<sup>334</sup> <https://off-guardian.org/2020/06/27/covid19-pcr-tests-are-scientifically-meaningless/>

<sup>335</sup> <https://bpa-pathology.com/covid19-pcr-tests-are-scientifically-meaningless/>

<sup>336</sup> <https://off-guardian.org/2020/06/27/covid19-pcr-tests-are-scientifically-meaningless/>

<sup>337</sup>

<https://www.whatdotheyknow.com/request/679566/response/1625332/attach/html/2/872%20FOI%20All%20records%20describing%20isolation%20of%20SARS%20CoV%202.pdf.html>

<sup>338</sup> <https://www.fda.gov/media/134922/download>

If this is true (and there is no reason that I know to suggest that this information is not true), it strikes at the very root of the usability of PCR tests.

It is obligatory for the Accused to be honest and forthright about these limitations and not make panicky claims based on something which is clearly very unreliable. (In addition to the fact that mass testing is simply not acceptable for such a virus, as per the WHO's October 2019 guidelines).

### ***16.5.3 The Australian Government doesn't consider these tests to be reliable***

As at 7 November 2020, the Australian Government, Department of Health, Therapeutics Goods Administration (TGA) website notes (the information was updated on 1 October 2020):

**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. COVID-19 is an emerging viral infectious disease. There is **limited evidence available to assess the accuracy and clinical utility of available COVID-19 tests**. Due to the urgent nature of the COVID-19 pandemic, a number of SARS-CoV-2 tests have undergone an expedited assessment by the TGA to enable their legal supply in Australia. These expedited assessments are based on the limited clinical and performance data currently available. All SARS-CoV-2 tests currently approved for supply are required to provide updated evidence to support the ongoing safety and performance of the tests to the TGA.<sup>339</sup>

A 22 May 2020 version of the above website is available on archive.org.<sup>340</sup>

### ***16.5.4 Powerful reasons why PCR tests are not necessarily detecting COVID***

There seem to be a few other reasons why PCR tests don't (or can't) do what they say they do:

#### **1. Cannot distinguish whether RNA is from COVID or some other pathogen**

This is what the CDC says:

Detection of viral RNA may not indicate the presence of infectious virus or that 2019-nCoV is the causative agent for clinical symptoms. The performance of this test has not been established for monitoring treatment of 2019-nCoV infection. **This test cannot rule out diseases caused by other bacterial or viral pathogens.** Positive results are indicative of active infection with 2019-nCoV but do not rule out bacterial infection or **co-infection with other viruses.** The agent detected may not be the definite cause of disease. Laboratories within the United States and its territories are required to report all positive results to the appropriate public health authorities.<sup>341</sup>

This, in my view, is a huge problem. As discussed earlier, this may be why flu and COVID are getting conflated on a mammoth scale across the world.

#### **2. Cannot distinguish between live and dead RNA**

Guidance issued by the Department of Health of the Australian Government states: "it should be noted that **PCR tests cannot distinguish between "live" virus and noninfective RNA**"<sup>342</sup>.

So, this means just having a positive test doesn't mean one is infectious. Therefore, the test serves no real purpose medically or (therefore) for public health purposes.

#### **3. Can give a positive result even if there is no RNA in the sample**

The worst issue, as reported by Lab Tests Online, is that: "You could tweak the test to find lower levels of virus RNA but in doing so you will increase the likelihood of the test giving a positive result even if there

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<sup>339</sup> <https://www.tga.gov.au/covid-19-testing-australia-information-health-professionals>

<sup>340</sup> <https://web.archive.org/web/20200607060454/www.tga.gov.au/covid-19-testing-australia-information-health-professionals>

<sup>341</sup> <https://www.fda.gov/media/134922/download>

<sup>342</sup> <https://www.health.gov.au/sites/default/files/documents/2020/03/coronavirus-covid-19-information-for-clinicians.pdf>



was no RNA in the sample”.<sup>343</sup> This has something to do with the “cycles” of refinement during the testing process.

As far as I can see, the whole thing about COVID “cases” is very suspicious, indeed.

Reference: There is more information about PCR tests in a complaint made 23 October 2020 by Danielle Burnie to the Therapeutic Goods Administration.<sup>344</sup>

## 16.6 Questionable intentions: Imposing restrictions that are not proven by science

I have detailed this earlier but I’m making a note again (as part of the analysis of the intentions of the Accused) that it is highly questionable for the Accused to not have accept any feedback on their “public health” mandates which are not arbitrary, disproportionate and harmful. Why does the Andrews government refuse to consider any alternative opinion? Why have all the regular consultative processes for good policy making been disbanded?

## 16.7 Questionable intentions: Restricting potentially health treatments (e.g. HCQ)

If the Accused were genuinely interested in saving lives from COVID-19, they would have promoted the use of Vitamins D and C but also possibly HCQ and Ivermectin (among others).

Instead, Victoria’s Health Minister Jenny Mikakos signed orders to ban Hydrochloroquine until late October 2020. This will deprive Victorians of a potential treatment that many have argued is effective. This ban remains in place. As at 10 November 2020, the DHHS website<sup>345</sup> continues to state that “There is no clinical evidence that hydroxychloroquine is effective as prophylaxis against coronavirus (COVID-19)”.

### Can hydroxychloroquine be used for prophylaxis?

- There is no clinical evidence that hydroxychloroquine is effective as prophylaxis against coronavirus (COVID-19).
- Hydroxychloroquine is in short supply and should be prioritised for use in recognised indications including autoimmune conditions and Q-fever endocarditis.
- The Pharmaceutical Society of Australia (PSA) have advised pharmacists to refuse the dispensing of hydroxychloroquine unless it is for a recognised indication.

This claim of the Victorian government does not stack up. Apparently, “over 121 peer reviewed scientific studies have shown it to be effective in treating and preventing the disease”<sup>346</sup>. Further, this medicine is said to have saved tens of thousands of lives in India.

Regardless of the truth about the effectiveness of this drug, the issue is that trained doctors are not being allowed to exercise their judgement. If the opponents of the government’s position are right (and there are many of them), then the idea of banning a drug that could potentially have saved the lives of many of the elderly who died in Victoria from COVID-19 becomes even more of a crime.

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<sup>343</sup> <https://www.labtestsonline.org.au/learning/index-of-conditions/covid-19/how-accurate-are-covid-19-tests>

<sup>344</sup> <https://sanjeev.sabhlokcitiy.com/Misc/Letter-complaint-TGA.docx.pdf>

<sup>345</sup> <https://www.dhhs.vic.gov.au/vaccines-and-medications-patients-coronavirus-covid-19>

<sup>346</sup> [https://12224e9c-a5fa-4daf-962b-f9379e0c0efa.filesusr.com/ugd/e12357\\_d13aa26d9fe84d809d3aebf2481ac274.pdf](https://12224e9c-a5fa-4daf-962b-f9379e0c0efa.filesusr.com/ugd/e12357_d13aa26d9fe84d809d3aebf2481ac274.pdf)

## 16.8 Questionable intentions: Vaccine companies being protected from product liability claims

The vaccine issue is extremely perplexing. While there is no problem in principle with a government engaging with private companies to discuss, even support research in an area of urgent public interest, the way it has been done has raised significant questions – particularly about why such companies have been given blanket indemnity from product liability claims for a COVID vaccine, if and when such a vaccine is approved.

As an illustration, it has been reported that:

AstraZeneca has been found guilty of offences relating to off-label or unapproved promotion of medical products, making false claims, kickbacks and bribery, consumer protection violation, healthcare offences, government-contracting violations and more. Since 2000 they have been fined over US\$1.1 billion dollars for these offences and violations. Still, **they have been granted protection from future product liability claims relating to its COVID-19 vaccine.**<sup>347</sup>

Further:

[T]he federal government has done a vaccine deal with AstraZeneca and Australians told we cannot expect to go back to normal until a vaccine arrives (*ibid*).

The ICC's Prosecutor should examine whether there is more here than meets the eye.

Locking down Australia and trying to eradicate the virus is entirely illegal (in contravention of Biosecurity laws). But there is a problem with the Australian government doing deals with a company of questionable integrity and giving it **blanket indemnity** – even as it locks down all Australians so it can punch them forcibly with that vaccine.

The Prosecutor might wish to investigate whether the Liberal or the Labor Party in Australia (and Victoria) have received donations from vaccine companies. Also, whether any of the Accused hold shares in such vaccine companies. If these financial links are established, then we could more clearly and definitely make a comment about the motivation of these people. As an economist I know that there is often a money trail behind the actions of people. We must “follow the money” even in this case to determine what motivates these people to break the laws and destroy human rights on such a large scale.

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<sup>347</sup> [https://12224e9c-a5fa-4daf-962b-f9379e0c0efa.filesusr.com/ugd/e12357\\_d13aa26d9fe84d809d3aebf2481ac274.pdf](https://12224e9c-a5fa-4daf-962b-f9379e0c0efa.filesusr.com/ugd/e12357_d13aa26d9fe84d809d3aebf2481ac274.pdf)

Part V: Summary of my arguments and a preliminary list of witnesses

## 17. Concluding chapter

I sum up this **first information report** to the Prosecutor in this chapter by repeating the summary of my arguments, by providing a summary of (what I believe are) the key offenses committed by the Accused, and by suggesting names of some possible witnesses.

### 17.1 Summary of my arguments

#### The basic framework of human rights and ethics that underpins public health

1. Nature is not always our friend. From time to time, it springs an unpleasant surprise, like this novel coronavirus. Public health interventions do the right thing when they minimise the loss of life from such natural causes (Acts of Nature) without causing additional mental or physical harms (Act of Man).
2. While humanity can accept unavoidable deaths from a natural cause, we cannot accept government mandates that end up killing even one additional person. That is because while any economic harms can be compensated, we can never compensate anyone for any mental harms or the loss (or shortening) of life from such measures.
3. The public health literature is keenly aware that its actions must not cause harm. For instance, there is requirement in the literature to compensate for even minor economic harms caused by public health measures.
4. This threshold underpins all valid government policy: That the policy must not *directly* harm anyone. Governments do not have the power to kill person X (or shorten his life) while trying to save person Y. No government is authorised by the laws, for instance, to burn down additional homes and kill unaffected people in order to save those who might be at risk of being engulfed in a bushfire.
5. In relation to this ongoing pandemic, if killing X (through additional suicides, cancer or heart disease not identified in time because of terror caused by government, and from increased poverty) in order to save Y (generally an elderly person well beyond average life expectancy) from COVID-19 was such a good idea, then this strategy would have formed part of the laws and pandemic plans across the world.
6. This threshold question distinguishes genuine public health from public health terrorism. Public health interventions that cause widespread additional mental and physical harms and shorten the lifespan of hundreds of millions, even billions, can only be classified as public health terrorism.
7. There is a long and well-understood history of human rights abuses, hysterias and exaggerated claims made by public health practitioners (e.g. “culture of fear” and “exaggerated claims ... from disease advocacy by influenza experts”, noted in the *Bulletin of the World Health Organization* 2011<sup>348</sup>).
8. International and national laws are designed to prevent public health excesses.

#### Unimpeachable proof that flu-like pandemics can be managed without committing crimes

9. It is not only ethically and legally valid, but perfectly feasible to implement well-balanced and non-criminal public health policies even in the face of severe pandemics and great uncertainty.
10. As noted at the outset, Gauden Galea, the World Health Organisation (WHO)’s representative in China said on 24 January 2020 regarding Wuhan’s lockdown, that: “**The lockdown of 11 million people is unprecedented in public health history**”.<sup>349</sup>
11. Never in the past during any flu-like virus pandemic – which were often much worse than the current one – have the kinds of inhumane and reckless policies that we are seeing this time around been considered, let alone implemented.

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<sup>348</sup> <https://www.who.int/bulletin/volumes/89/7/11-089086/en/>

<sup>349</sup> Senger, Michael P., ‘China’s Global Lockdown Propaganda Campaign’, *Tablet*, 16 September 2020. Short URL: <https://bit.ly/2RXS0RA>.

12. Even this time, we have unimpeachable proof that sensible policies can be implemented during pandemics. **Sweden**, led by perhaps the world's most experienced epidemiologist, Dr Anders Tegnell, has demonstrated that it is quite possible – mainly through voluntary guidelines and light-handed closure of targeted events or workplaces – to deal with the ongoing respiratory virus pandemic without causing additional harms to people's mental or physical health.
13. Policy applied by Sweden this year is not unique to that nation. Such policy is embedded in all the laws of the world, all ethical principles, and was part of all approved pandemic plans across the world – including in Victoria and Australia: plans that were designed and thus capable of managing respiratory virus pandemics far worse than what we are experiencing from this novel coronavirus.
14. While the size of the pandemic is irrelevant to the arguments, the Australian authorities seem to be behaving like exorcists fighting an imaginary spook. They decided in March 2020 that this virus is “deadly” and that they must exorcise Australia from it, regardless of the fact since April 2020 we know that it is nowhere as deadly even as the Asian and Hong Kong flu. And if the data deceptions and confusions (about PCR tests, conflation of COVID and flu, assuming COVID deaths) are taken into account, it is hard to say that this pandemic is far worse than a bad flu. Data from Sweden suggests that it might be somewhat hard at the end of 2020 to distinguish this year's total deaths in that country from the average of the past five years.

### **Lockdowns, curfews, mass-testing and other mandates for flu-like viruses are contrary to science**

15. Respiratory viruses like flu and the common cold (of which this novel coronavirus is one) have characteristics which lead to certain types of public health policies and rule out others.
16. SARS-CoV2 has strong similarities with the flu in both transmission and lethality (as well as symptoms). Its first cousin, SARS, was far more lethal and did not transmit asymptotically. As a result, targeted quarantines were able to not only isolate SARS, they were able to eradicate it: SARS disappeared without a trace after 2004, perhaps because the virus found nowhere else to go after it killed its hosts who had already been isolated.
17. The WHO, through its October 2019 guidelines<sup>350</sup> laid down the **state of knowledge** on how we should deal with flu-like viruses. For instance, the WHO's guidelines state that quarantines, mass-scale testing and contact tracing are not appropriate in this case, and lockdowns are not even a possible consideration.
18. Community-wide cordons (lockdowns) were last used for Ebola (a virus which kills up to 90% of those infected) in 2014 in Africa. An evaluation of these lockdowns found that even for such a virus, only “very small-scale cordons” – similar to quarantine – were effective; not large-scale lockdowns.
19. When large-scale lockdowns are unscientific and unethical even for a lethal virus like Ebola, the concept of lockdowns being applied for a flu-like virus simply does not exist.
20. Lockdowns, being untargeted, cannot eradicate SARS-Cov2 from the Earth. They merely slow down the development of immunity among younger people who could then have acted as barriers to the spread of disease. Further, there are innumerable voluntary and better ways to “flatten the curve” should the health system ever come under pressure. (There was no pressure, ever, on Victoria's health system.)
21. “Scientists” who claim that lockdowns “work” neither know the science nor understand the meaning of “work”. The existence of a “flat-earthers” who have been trying to go against the well-established science of flu-like pandemics during 2020 does not make them right.
22. Masks have been shown in the scientific literature to be potentially helpful in limited medical settings but have never been proven through randomized controlled trials (RCT) to be helpful for use by the general population, let alone on a mandatory basis; and can cause great harms, instead.

### **Imposing such unscientific measures is an unethical human experiment forbidden by the laws**

23. To impose coercive lockdowns, curfews, mass-scale testing and mandatory masks for the general population for a flu-like virus – “measures” that have been specifically ruled out by the science –

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<sup>350</sup> [https://www.who.int/influenza/publications/public\\_health\\_measures/publication/en/](https://www.who.int/influenza/publications/public_health_measures/publication/en/)

amounts to the conduct of a human experiment that has never been approved by any ethics process and which breaches an extensive range of laws – including many international laws.

24. Such measures cannot be justified by the “precautionary principle” either, since it is not a precaution in the face of incomplete knowledge to administer a well-known poison (lockdowns). Further, any claim of incomplete knowledge might have been valid on 15 March 2020 but was not tenable by 15 April 2020, by which time abundant knowledge about the nature and risk of this virus had become available.
25. Most “public health” measures used by the Accused (such as lockdowns, curfews and mandatory mask mandates) are grossly disproportionate as well as ill-targeted to the nature and risk presented by the virus, and thus contravene public health laws and international covenants. Moreover, since the pandemic never managed to apply even a Scenario 1 level of pressure upon the health system in Australia (as identified in Australia’s pandemic plan), there can be nothing more disproportionate than these “public health” measures.
26. To ensure compliance with their illegal “public health” measures it was necessary for the Victorian Administering Authorities to not only create a Police State (with extreme brutality meted out on numerous occasions), but to also create mass hysteria so the people remain in a state of terror. As a result of State-created terror, many Victorians did not get themselves checked for essential health conditions including mental and physical, thus leading to enormous human harms from these policies. Many have died unattended at home. The lives of millions of others have been shortened.

#### **The mental model of the Accused: to shift life from the young to the old**

27. The Accused know very well that the people – particularly the youth – are paying a very high price for their virus eradication goals.
28. But the Accused have a mental model according to which it is OK to “sacrifice” the young in order to save even one elderly person from COVID death: “Even one loss of life from COVID is too many” has been their motto. The Accused have been actively trying to “shift” life from the young to the old.
29. After one year of this virus, 17 out of 100,000 persons on Earth have died *from* or *with* this virus. Most of these 17 were the extreme elderly, aged well beyond the average life expectancy for their country. It is these elderly people whom the governments are attempting to give a few more months of life – at the cost (that they are aware of) of many months, even years, taken out from the life of those whom the virus would never have even mildly impacted.
30. Further, because most of the young whose life has been shortened don’t die immediately, the Accused are able to claim that they have been successful in “saving” lives by citing discredited “models”.

#### **The 2020 lockdowns have increased *even* COVID-19 deaths**

31. Many studies are showing that the 2020 lockdowns have not saved **any** elderly lives from COVID. Instead, a comparative analysis of deaths per million in the US, UK and Sweden over the past year shows that lockdowns have **increased** COVID deaths.
32. This seemingly counter-intuitive result is plausible because lockdowns:
  - dissipate scarce resources by trying to prevent the spread of the virus to low risk groups and not focusing sufficiently on cocooning the elderly; and
  - stop the development of immunity among the young who could then have acted as barriers to the spread of disease. Herd immunity is a law of nature for all infectious disease. Respiratory viruses peak fairly quickly, with those who’ve recovered becoming immune, which then makes it hard for the virus to infect others. Lockdowns do not allow herd immunity to develop which means the virus continues to spread – and wreak havoc on the elderly.
33. Another reason why deaths of the elderly have not been averted is that Australian government authorities have literally burnt hundreds of billions of dollars on futile activities (first stopping the young from going to work and then paying them through vast borrowing) but did not even provide health workers with N95 masks, which led to 3,500 of them getting infected by the virus and transmitting to the elderly in hospitals and aged care centres.

#### **The Accused have continued their actions despite concerns being repeatedly raised**

34. The Victorian Administering Authorities had comprehensive knowledge of the harms that lockdowns and their hysteria-rousing policies can cause – for these are well-documented in the scientific and

ethical literature, apart from being impossible to arrive at through any risk-based policy making process – but they have refused to acknowledge and formally assess these harms.

35. The Victorian Premier Daniel Andrews has publicly brushed aside my views as just my “opinion”. The Chief Health Officer of Victoria has not only refused to answer any questions but has blocked me on his taxpayer-funded Twitter account. They are driving Victoria into a ditch blindfolded. They do not want any discussion of the harms.
36. The Victorian Administering Authorities recklessly and arbitrarily continue to ride roughshod over proportionality requirements and human rights embedded in the laws in their belief that every Victorian needs to stay locked down till a vaccine is punched into all of us. This belief, which is at loggerheads with international and domestic Australian laws, is not amenable to any reasoning.
37. Mr Morrison and Mr Andrews do not trust the people of Australia. Had they followed their original pandemic plans, they would have implemented mainly voluntary measures and educated the community. Instead, they chose to stand “over and above” the People and use force.
38. It is not just the Victorian and Australian Administering Authorities that are responsible for these crimes against humanity. Political parties in Australia from both sides of the spectrum are hands-in-glove about the breaches of the laws. Further, the High Court of Australia and the Supreme Court of Victoria have provided their stamp of approval respectively on border closures within Australia and the curfew that was till recently in place in Melbourne.

### **The enormous cost to health and life of these illegal public health measures**

39. The harms arising from public “health” measures such as lockdowns, in terms of lost life-years, have been estimated to be many orders of magnitude greater than any lives the lockdowns could possibly have saved (they do not save lives, as noted above).
40. But even making such a comparison is incorrect since a virus is an Act of Nature while lockdown deaths are an Act of Man – hence must be treated as a crime. Each additional mental harm caused and each additional life-year reduced by the policies of the Victorian and Australian Administering Authorities adds up to cause what is best described as a crime against humanity.
41. I have estimated that lockdowns across the world have **shortened the lives of hundreds of millions of people, including people like me** who have been forced into an extremely unhealthy condition for many months, a situation from which the harm done to the body (or mind in many cases) can never fully recover.
42. These harms are not protected by Article 7(2)(e) of the Rome Statute. These harms were not “inherent in or incidental to, lawful sanctions” because the actions were themselves unlawful, having breached all considerations of proportionality and scientific proof. Any authorization to kill (or shorten the life of) person X in order to protect person Y necessarily had to be obtained in advance from the People of Victoria through the Parliament, though legislation. No such legislation exists.
43. Should the Accused deny causing the harms – which are real and which I document in this complaint – then the burden of proof must be placed on them to prove that these harms have **not** been caused by **their** policies. There is no way that so many harms would have been caused by voluntary measures aimed at flattening the curve, instead of the coercive measures used as part of the strategy of aggressive suppression or eradication.
44. Sweden’s results in terms of deaths per million from the COVID disease are superlative in comparison to many nations that imposed coercive lockdowns, thus demonstrating that it is possible to minimise harms from the virus to the elderly without causing additional “collateral” damage while trying to save people from what is basically a natural disaster. But even if Sweden’s results were not that great, it would not change the argument in this complaint since the core issue is that Sweden did not cause additional harms, while Victoria did.
45. It also doesn’t matter if a vaccine is ultimately found and some lives are then saved in Australia. Those who wish to wait for a vaccine have always been free to do so, voluntarily. But the idea that a Government can forcibly lock up an entire nation for months, even years – as if the People are the private farm animals of the Government – and then coercively jab these People (most of whom would never have been adversely affected by the coronavirus anyway) is nothing short of criminal. The People are not the private Animal Farm of Australia’s politicians.
46. There have been many supplementary offences committed by the Accused to support their government-created hysteria and terror, such as the use of PCR tests which are formally acknowledged

by the Australian government to be unreliable. There are also very serious data integrity issues regarding the reported COVID deaths.

### **The International Criminal Court's role in stopping these crimes**

47. When institutions of redress in Australia have failed, and almost the entire leadership of society is intent on committing (or supporting) mass-scale crimes, the only resort left to humanity is the International Criminal Court.
48. There is little point in having so many laws to protect human rights and policies and plans based on science and ethics if, when a minor pandemic comes upon us, all these are tossed out of the window. Today, many of Australia's politicians, business leaders, media and perhaps even the courts, are supporters of tribalism and fear.
49. The battle today is effectively the biggest fight for liberty and human rights since slavery and colonialism. The ICC must play its role, perhaps the most important role it will play in this generation, by drawing a sharp line between what is acceptable as a public health measure and what is public health terrorism.
50. Without this sorry episode being declared a crime against humanity and the genie of public health terrorism being locked up inside its bottle forever, such extremism will happen again, and yet again.

## **17.2 Summary of the offences committed by the Accused**

### **Accused Group 1**

I believe that Accused Group 1's main prosecutable offence is the direct health harms caused to Victorians – including harms of omission and commission. These amount to are “a widespread or systematic attack directed against any civilian population, with knowledge of the attack”. There is simply no way that Accused group 1 can claim they were not aware of the extraordinary harms they have caused.

I believe the actions of Accused Group 1 fully satisfy the requirements of Article 7 of the Rome Statute.

### **Accused Group 2**

I believe that Accused Group 2's main prosecutable offence is of being an **active accomplice** of Accused 1 by supporting the Victorian government's strategy of eradication of the virus through lockdowns. In this regard, its main action has been an act of omission: to not implement the Biosecurity Act and stop the actions of Accused 1.

However, Accused Group 2 has an act of commission, as well. It has actively locked up Australia indefinitely, caused inhuman torture potentially millions of people in Australia and outside who are thus unable to engage in normal human interactions. Thousands have been separated from their families across different continents.

I believe the actions of Accused Group 1 also fully satisfy the requirements of Article 7 of the Rome Statute.

## **17.3 Witnesses**

I believe I have proved most of my claims through my arguments, detailed content and the footnotes and references, such as published peer-reviewed journal articles or reports of the Government or other reliable news and other reports.

However, the Prosecutor of the ICC could also consider inviting expert witnesses to confirm my claims, particularly regarding the science of flu-like pandemics and impacts of lockdowns. Some of the following experts could be considered in this regard:

- **Dr Martin Kulldorff**, Professor at the Harvard Business School (He has been supportive of my approach to pandemic policy for many months).
- **Dr Anders Tegnell**, State Epidemiologist of Sweden.
- **Dr. Sunetra Gupta**, Professor of theoretical epidemiology at the Department of Zoology, University of Oxford.
- **Dr Jay Bhattacharya**, Professor of Medicine at Stanford University.
- **Dr Scott Atlas**, President Trump's medical adviser.



- **Dr Reiner Fuellmich**, who has been preparing a case against the WHO for crimes against humanity.
- **Professor Ramesh Thakur**, of Australian National University who has called out the ‘crimes against humanity resulting from the brutal perverse consequences of the stringent measures’<sup>351</sup>.
- **Gigi Foster**, Associate Professor in the School of Economics at the University of New South Wales in Sydney, Australia.
- **Dr Eamonn Mathieson**, MBBS (Hons), FANZCA, Melbourne.

\* \* \*

I hope that document provides the Prosecutor with enough information to commence an investigation. I will continue working on this project and might lodge a supplementary submission in due course as more information becomes available.

I am happy to provide any clarifications upon request to the Prosecutor, including through Zoom or other video calls. In this regard, I note that some information probably lies within the Cabinet system of the Andrews and Morrison governments and may need to be summoned by the Prosecutor.

Putting the genie of public health terrorism back into its bottle is one of the biggest challenges for our generation. The time has come to draw a clear boundary between public health and public health terrorism, to force public health practitioners to identify and disclose all harms from their interventions, and for the laws to punish the perpetrators of such harms just like one would punish any other crime.

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<sup>351</sup> <https://www.spectator.com.au/2020/10/hippocrates-cancelled/>