I am writing this letter to strongly oppose the pending 'NO JAB NO PLAY' legislation that is currently being considered by the Queensland Government.

I want to begin by stating that; Informed consent is written into the Australian government's vaccine handbook and clearly states "For consent to be legally valid, the following elements must be present: "**It must be given voluntarily, in the absence of undue pressure, coercion or manipulation."**

The proposed legislation infringes on our right to bodily integrity (your right to choose how you care for your own body) that is currently protected in criminal law in Australia.

Unfortunately what this kind of legislation is doing, is condemning families and turning decent, loving and responsible parents and their children into social outcasts but condoning the social stigma that this kind of blatant discrimination supports. As it is we already have a situation where non-vaccinators are vilified and labelled abusers by the ill-informed public, so why would we want to further exacerbate the situation? By legislating segregation, no matter what the issue, we are making outcasts of a sector of the community. This is undoubtedly discrimination in its most callous form.

My concern is that there is a growing belief that vaccines are a one size fits all solution. This has never been the case and could not be further from the truth. Vaccination is NOT simply black or white. There is a very big grey area that the media, the medical profession, and politics refuses to address. There are hundreds of potential side-affects which are listed on the product insert for all to see which can be as mild as a temperature or as severe as death! Let's not forget the many toxic ingredients which are not tested thoroughly for their safety, carcinogenic or mutagenic potentials, or long term affects. These ingredients include formaldehyde, aluminum, thimerosal (mercury), aborted fetal dna, animal dna and polysorbate 80 (a surfectant). Many of these ingredients are well known for their toxicity in the human body. For these very reasons alone, vaccination should remain a CHOICE and parents should be able to choose freely as to whether they want their child to undergo this potentially life threatening medical procedure.

WHERE THERE IS POTENTIAL HARM, THERE MUST BE CHOICE!

I believe, this drive to boost vaccination rates is based on the flawed concept of Herd Immunity, which was a term originally referring to naturally acquired immunity and then adopted by pharmaceutical companies in relation to vaccine induced immunity. To bully and coerce parents into vaccinating their children based on a theory is unethical and unjust. The scientific evidence for vaccine induced herd immunity DOES NOT exist, yet this THEORY is the underpinning of the aggressive nature of vaccine policy in this country. We should be focusing on all aspects of disease prevention and not one aspect in it's entirety. Stripping individuals of their human right to refuse a medical procedure is nothing short of extremist and dictatorial.

Through my 8 years of research I have discovered that there is a sliding scale to who will produce an anti-body response to a vaccine and who will produce very little. Not to mention the fact that an anti-body response DOES NOT guarantee IMMUNITY!

Like most mothers I began my journey into motherhood by following the status quo and believing that vaccines were good and safe. In hindsight my daughter was slow to develop, but being my first I was unaware and living in parental bliss up until she was around 9 months which is when she had her first re-action to vaccines, a violent temperature, which we are told is normal. In the days following her

12month vaccines she became very ill with vomiting and temperatures, and came down with a chest infection that took almost a year to clear up. It was during this time that we observed her doing some strange things which we came to know later as behavior associated with Autism. When she was 18months old we contacted our local GP who then referred us to a Paediatrician. By 2 years of age she was having hundreds of seizures a day. At 3 she was diagnosed with Rett Syndrome. A diagnoses of Rett Syndrome is said to be like having Autism, Epilepsy, Cerebral Palsy, Developmental Delay and Parkinson's disease all in one. As you can imagine our world came crashing down.

The condition of Rett Syndrome is identified by a genetic mutation of the MECP2 gene. What triggers a child to regress into Rett Syndrome typically between the ages of 9 months and 2 years of age is unknown, although I have my suspicions. What I do know for sure through DNA sequencing and Blood and Urine tests (at my own expense) is that Mia suffers from chronic inflammation (oxidative stress) and has an inability to detoxify normally on a cellular level. Vaccines injected into a child with this type of genetic make-up is like playing Russian roulette with their health. Of course once the damage is done there is no turning back.

We will never know what Mia's potential could have been had she not been vaccinated. I didn't know any different then. However, with the knowledge I have gained after these events, I know wholeheartedly that I would never vaccinate any further children of mine. My 5yo son is unvaccinated and thriving. He has never had any major childhood illnesses and I have learned how to keep his immune system healthy so that his immune system can do its job as nature intended.

All I ask is that you look at this issue and consider the many implications in a humane and compassionate manner. Fear mongering aside, thinking with a rational and open mind. Is this the kind of society we want to live in? A society that discriminates, condemns, coerces, vilifies and enforces medical procedures?

Some of my concerns are:

Discriminating against families and children/Illegal and contrary to Bio-Ethics and Human Rights laws

Vaccines are unavoidably unsafe, therefore there MUST be choice.

Inciting fear and hatred towards families who choose not to vaccinate/Breeding contempt in the community.

Forced medical procedures, this is only the beginning.

No vaccine injury compensation scheme. (The U.S.A have paid out billions in dollars for vaccine injury under their vaccine injury compensation scheme)

No vaccine injury diagnostic criteria.

Placing extreme emphasis on one small sector of healthcare instead of focusing on the bigger issues like the Autism, Obesity, Diabetes, Allergies, Asthma, Autoimmune Disease and many more epidemics that we are now facing.

NO scientific evidence stating that unvaccinated children pose a threat to vaccinated children or that vaccines actually prevent disease.

Corruption in pharmaceuticals and politics.

I have included some resources below which is available to the public should you wish to look in to this issue further.

Documentaries - YouTube

The Greater Good or Bought

Silent Epidemic: The Untold Story of Vaccines by Gary Null PhD

How Vaccines Harm Child Brain Development by Dr Russell Blaylock MD

Vaccine Nation

Autism: Made in the U.S.A

Vaccination: The Hidden Truth (Australian Documentary)

Dr Andrew Wakefield tells his side of the story in the MMR Vaccine causes Autism debate (YouTube)

Books

Vaccines & Autoimmunity

Callous Disregard by Dr Andrew Wakefield

Vaccine Illusion by Immunologist Dr Tetyana Obukhanych

Dissolving Illusions by Dr Suzanne Humphries MD

Vaccine Epidemic How Corporate Greed, Biased Science, and Coercive Government Threaten Our Human Rights, Our Health, and Our Children by Louise Kuo Habakus and Mary Holland

Vaccine Information Websites

National Vaccine Information Center http://www.nvic.org/

International Medical Council on Vaccination http://www.vaccinationcouncil.org/

Other Resources

http://www.hrsa.gov/vaccinecompensation/index.html

Hayley Rikihana

[redacted]

[redacted]

NSU NOVA SOUTHEASTERN UNIVERSITY
College of Pharmacy

May 2, 2015

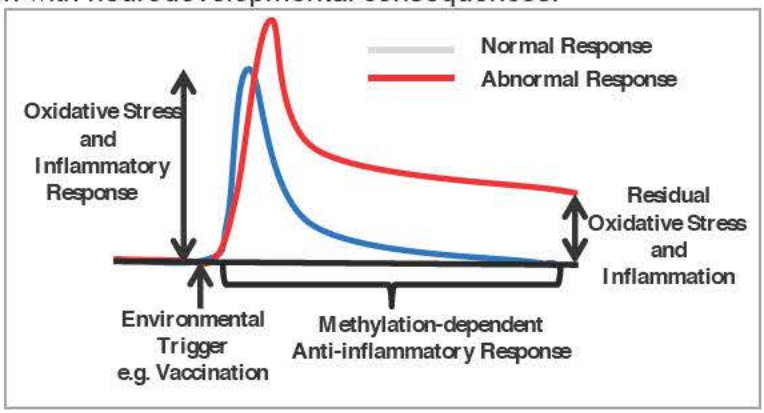
To Whom It May Concern:

As a researcher with expertise in the molecular origins of neurodevelopmental disorders as well as the adverse effects of vaccines, I would like to provide my perspective on the issue of individual genetic vulnerability, as it relates to the current debate over mandatory vaccination.

My personal background includes a B.S. degree in Pharmacy from the State University of New York at Buffalo (1970) and a Ph.D. degree from the University of Miami (1975), followed by 38 years as Professor of Pharmacology at Northeastern University, before taking my current position at Nova Southeastern University (2014). Throughout this time I have conducted laboratory-based research into various aspects of neuroscience and development, and I have authored over 100 peer-reviewed research papers as well as a book entitled "Molecular Origins of Human Attention: The Dopamine-Folate Connection". I have also served as an expert witness in a number of vaccination-related court cases.

For the past 10-15 years my lab has focused on the metabolic and molecular origins of autism. Much of our effort has been directed toward understanding the factors which regulate gene expression during neurodevelopment and their sensitivity to various environmental exposures. This includes the relatively recent recognition of **epigenetic regulation**, which involves turning genes on or off by the reversible addition of carbon atoms (methyl groups) to DNA. This process of **DNA methylation** is fundamental to neural development but is also involved in ongoing brain functions, including the capacity for memory formation. Our work, as well as that of many other scientists, shows that DNA methylation and the epigenetic regulation it provides is highly sensitive to environmental exposures, and, not surprisingly, it is particularly sensitive to **neurodevelopmental toxins**. Underlying this extreme sensitivity is the ability of these toxins to promote oxidative stress and since autistic children have about one-third less antioxidant than normal, they are most likely to develop oxidative stress.

Vaccination provokes inflammation and causes oxidative stress. Indeed, these responses are integral to successful vaccination. As such, vaccination represents an "environmental" challenge, both to antioxidant capacity and to DNA methylation-dependent epigenetic regulation. Individuals with sufficient antioxidant and methylation capacity can withstand this challenge with little or no interruption in epigenetic regulation and can restore their systems to normal after vaccination. However, as illustrated below, individuals with only limited antioxidant capacity or limited methylation capacity are less able to restore normal status after vaccination, placing them at higher risk of sustained oxidative stress and impaired methylation, which can lead to disruption of epigenetic regulation with neurodevelopmental consequences.



Naturally occurring genetic variations play a significant role in determining who will be more likely to have problems with vaccination-induced oxidative and impaired methylation. In a very common example, the gene known as MTHFR (methylenetetrahydrofolate reductase) has several different variants which differ in their activity and people carrying the lower activity forms are at greater risk of impaired methylation. A higher incidence of adverse reactions to vaccination has been linked to MTHFR status[1] and a number of studies have reported an association between autism and MTHFR variants[2-4], as well as other genes affecting antioxidant and methylation capacity[4].

The bottom line is that the risk of adverse responses to vaccination is significantly greater for certain individuals and medical science is beginning to identify genetic factors which place people at greater risk. Personalized medicine based upon our genetic vulnerabilities is becoming a reality and it is foolhardy to compel such vulnerable individuals to place themselves or their children at extraordinary risk by enacting mandatory vaccination legislation. This is especially true when vaccines are given so early in life prior to assessment of genetic risk factors. Moreover, in my view, enacting such laws will place states in the position of assuming liability for the health consequences of vaccinating high risk populations, with significant legal and financial implications.

While vaccination provides a substantial benefit to society, this benefit is not without cost. Until the necessary research into vaccine safety is completed and sources of individual vulnerability are better defined, we need to maintain caution and maintain accommodation for individual exemptions. This is a circumstance where the guidance of *"First do no harm"* makes both scientific sense and common sense.

I hope you find this perspective of value and I would be happy to provide further details as needed.

Sincerely,

Richard C. Deth, PhD
Professor of Pharmacology
Nova Southeastern University
3600 S. University Drive
Fort Lauderdale, Florida 33328

Email: rdeth@nova.edu
Phone: 954-262-1332 FAX: 954-262-2278

[1]Reif DM *et al.* Genetic basis for adverse events after smallpox vaccination. J Infect Dis. 2008;198(1):16-22.
[2]Park J *et al.* MTHFR 1298A/C is a risk factor for autism spectrum disorder in the Korean population. Psychiatry Res. 2014;215(1):258-9.
[3]Mohammad NS *et al.* Aberrations in folate metabolic pathway and altered susceptibility to autism. Psychiatr Genet. 2009;19(4):171-6.
[4]James SJ *et al.* Metabolic endophenotype and related genotypes are associated with oxidative stress in children with autism. Am J Med Genet B Neuropsychiatr Genet. 2006;141B(8):947-56.

RE: SB 277 (Elimination of Personal Belief Vaccine Exemptions)

March 16, 2015

Dear Legislator:

I earned my PhD in Immunology from The Rockefeller University, New York, and did my postdoctoral research training at Stanford University, California. My professional background compels me to bring to your attention some key vaccination research relevant to SB 277. This bill would affect all children in California and therefore merits your careful consideration.

SB 277 would eliminate non-medical exemptions for all children in California, including those in private home schools. It would also require that children be vaccinated per the CDC-recommended schedule, without any delays. You may have been led to believe that such a drastic measure is justified, despite violating parental rights and leaving many parents no choice but to submit their children to involuntary vaccination or leave California, because it could make public spaces safer. However, this viewpoint is not borne out scientifically.

I hereby submit my analysis of the vaccinations currently mandated for daycare and school-age children in California: Polio, Tetanus, Diphtheria, Pertussis (whooping cough), Hib, Hepatitis B, Measles, Mumps, Rubella, and Varicella (chickenpox).

Polio

IPV (inactivated poliovirus vaccine) cannot prevent transmission of poliovirus.

IPV, now in use in the USA, replaced OPV (oral poliovirus vaccine) at a time when wild poliovirus was no longer present in North and South America. The Cuban IPV experiment demonstrated that while IPV can induce antibody production in the serum, it cannot prevent infection and excretion of live attenuated poliovirus after an oral viral challenge.[1] Because wild poliovirus is significantly more virulent than the attenuated poliovirus used in the Cuban experiment, vaccination with IPV cannot be expected to prevent infection and transmission of wild poliovirus, after failing to achieve this outcome even for the weaker attenuated poliovirus.

Wild poliovirus has been non-existent in California for at least two decades. Even if wild poliovirus were to be re-imported by travel, vaccinating for polio with IPV cannot be expected to alter the safety of public spaces.

Tetanus

Tetanus is not a contagious disease, but rather acquired from deep-puncture wounds contaminated with *C. tetani* spores. Vaccinating for tetanus cannot alter the safety of public spaces.

Diphtheria

While intended to prevent the disease-causing effects of the diphtheria toxin, **the diphtheria toxoid vaccine is not designed to prevent colonization and transmission of *C. diphtheriae*.** Vaccinating for diphtheria cannot alter the safety of public spaces.

Pertussis (whooping cough)

The acellular pertussis (aP) vaccine, now in use in the USA, replaced the whole cell pertussis vaccine in the 1990s, which was followed by an unprecedented resurgence of whooping cough. An experiment with deliberate pertussis infection in primates revealed that **the aP vaccine is not capable of preventing colonization and transmission of *B. pertussis***.[2]

Furthermore, the 2013 meeting of the Board of Scientific Counselors at the CDC revealed alarming data that **pertussis variants (PRN-negative strains) currently circulating in the USA acquired a selective advantage to infect those who are up-to-date for their DTaP boosters**.[3]

Therefore, vaccinating for pertussis with the aP vaccine is in fact undermining rather than securing the safety of public spaces, now that whooping cough is caused predominantly by strains that have evolved under the aP vaccine-induced selection pressure to infect the vaccinated.

Hib (*H. influenzae* type B)

Among numerous types of *H. influenzae*, the Hib vaccine covers only type b.

Despite its sole intention to reduce symptomatic and asymptomatic (disease-less) Hib carriage, **the introduction of the Hib vaccine has inadvertently shifted strain dominance towards other types of *H. influenzae* (types a through f).** These types have been causing invasive disease of high severity and increasing incidence in adults in the era of Hib vaccination of children.[4]

Hib vaccination of children has not only failed to make public spaces safer from overall risks of invasive bacterial disease in the general population, but has instead contributed to the increase of invasive disease caused by other virulent strains that have replaced Hib.

Hepatitis B

Hepatitis B is a blood-borne virus. It does not spread in a community setting, especially not among children, who are unlikely to be engaged in high-risk behaviors, such as needle sharing. Vaccinating children for Hepatitis B cannot significantly alter the safety of public spaces.

MMR, Varicella

Viral childhood diseases, such as measles, mumps, rubella, and varicella (chickenpox) are life-threatening in vulnerable groups comprised of the immuno-compromised, pregnant women without prior immunity, and infants born to women without prior immunity. **These groups are eligible to receive immunoglobulin, a life-saving measure that supplies antibodies directed against the virus to prevent disease upon exposure**.[5] Although avoidance of exposure is best for vulnerable groups, their lives are not threatened by these viruses when immunoglobulin is properly administered.

Vaccinating others for the sake of the immuno-compromised is a redundant measure, even if it could guarantee complete lack of exposure, which it does not. Studies of measles outbreaks in Quebec, Canada, and China attest that **outbreaks of measles still happen, even when vaccination compliance is in the highest bracket (95-97% or 99%).**[6-7]

Although it is often stated that vaccination rarely leads to serious adverse events, a recent study done in Ontario, Canada, established that **vaccination actually leads to an emergency room visit for one in 168 children following their 12-month vaccination appointment and for one in 730 children following their 18-month vaccination appointment**.[8]

By coercing parents to follow the CDC-recommended immunization schedule without delays, SB 277 can be expected to increase the number of babies who will end up in the emergency room after their vaccination appointment. The pursuit of safety of public spaces from communicable viral infections—realistically unachievable even with extremely high vaccination rates and redundant due to the availability of immunoglobulin for vulnerable groups—is not a reasonable justification for the increased suffering of babies and increased burden on medical care in emergency rooms.

In conclusion, my objection to SB 277 is based on several key points.

First, this bill cannot improve the safety of public spaces from non-viral and toxin-mediated diseases. Nor can it guarantee public spaces to be free from viral exposure, based on the experience to the contrary in regions where nearly complete vaccination compliance has already been achieved.

Moreover, therapeutic measures of protection (immunoglobulin) exist, which can effectively protect immuno-compromised individuals from imminent viral infections.

Finally, SB 277 would eliminate the right to informed consent to a medical procedure that carries the risk of a serious adverse event or, in some cases, death. This is unacceptable from the standpoint of medical ethics.

It is my strong conviction that vaccination must remain a personal choice in California.
SB 277 must be defeated on scientific, ethical, and Constitutional grounds.

Sincerely Yours,

Tetyana Obukhanych, PhD

(See supporting scientific sources on the next page)

Sources

1. The Cuba IPV Study collaborative group. (2007) **Randomized controlled trial of inactivated poliovirus vaccine in Cuba**. *N Engl J Med* 356:1536-44

http://www.ncbi.nlm.nih.gov/pubmed/17429085

The table below from the Cuban IPV study documents that 91% of children receiving no IPV (control group B) were colonized with live attenuated poliovirus upon deliberate experimental inoculation. Children who were vaccinated with IPV (groups A and C) were similarly colonized at the rate of 94-97%. High counts of live virus were recovered from the stool of children in all groups. These results make it clear that IPV cannot be relied upon for the control of polioviruses.

Table 3. Isolation of Poliovirus in Stool Samples 1 Week after Oral Poliovirus Vaccine Challenge According to Study Group and Poliovirus Type.*

Group†	No. of Infants	Type 1		Type 2		Type 3		Any Type of Poliovirus		
		No.	% (95% CI)	No.	% (95% CI)	No.	% (95% CI)	No.	% (95% CI)	Mean Log_{10} Titer in Fecal Sample (95% CI)‡
A	52	10	19 (10–33)	45	87 (74–94)	5	10 (3–21)	49	94 (84–99)	3.46 (3.17–3.75)
B	54	9	17 (8–29)	48	89 (77–96)	3	6 (1–15)	49	91 (80–97)	3.89 (3.64–4.14)
C	72	13	18 (10–29)	67	93 (85–98)	10	14 (7–24)	70	97 (90–100)	3.37 (3.14–3.60)

* All stool samples taken from study participants just before the challenge dose were negative for poliovirus. Exact confidence intervals (CIs) are based on the binomial distribution.
† Group A received a combination of diphtheria–pertussis–tetanus vaccine, *Haemophilus influenzae* type b vaccine, and inactivated poliovirus vaccine (DPT-Hib-IPV) at 6, 10, and 14 weeks of age. Group B, the control group, received a combination of DPT vaccine and Hib vaccine at 6, 10, and 14 weeks. Group C received the DPT-Hib-IPV combination at 8 and 16 weeks.
‡ Mean values are given for excretors of poliovirus.

2. Warfel *et al.* (2014) **Acellular pertussis vaccines protect against disease but fail to prevent infection and transmission in a nonhuman primate model.** *Proc Natl Acad Sci USA* 111:787-92

http://www.ncbi.nlm.nih.gov/pubmed/24277828

"Baboons vaccinated with aP were protected from severe pertussis-associated symptoms but not from colonization, did not clear the infection faster than naïve [unvaccinated] animals, and readily transmitted B. pertussis to unvaccinated contacts. By comparison, previously infected [naturally-immune] animals were not colonized upon secondary infection."

3. Meeting of the Board of Scientific Counselors, Office of Infectious Diseases, Centers for Disease Control and Prevention, Tom Harkins Global Communication Center, Atlanta, Georgia, December 11-12, 2013

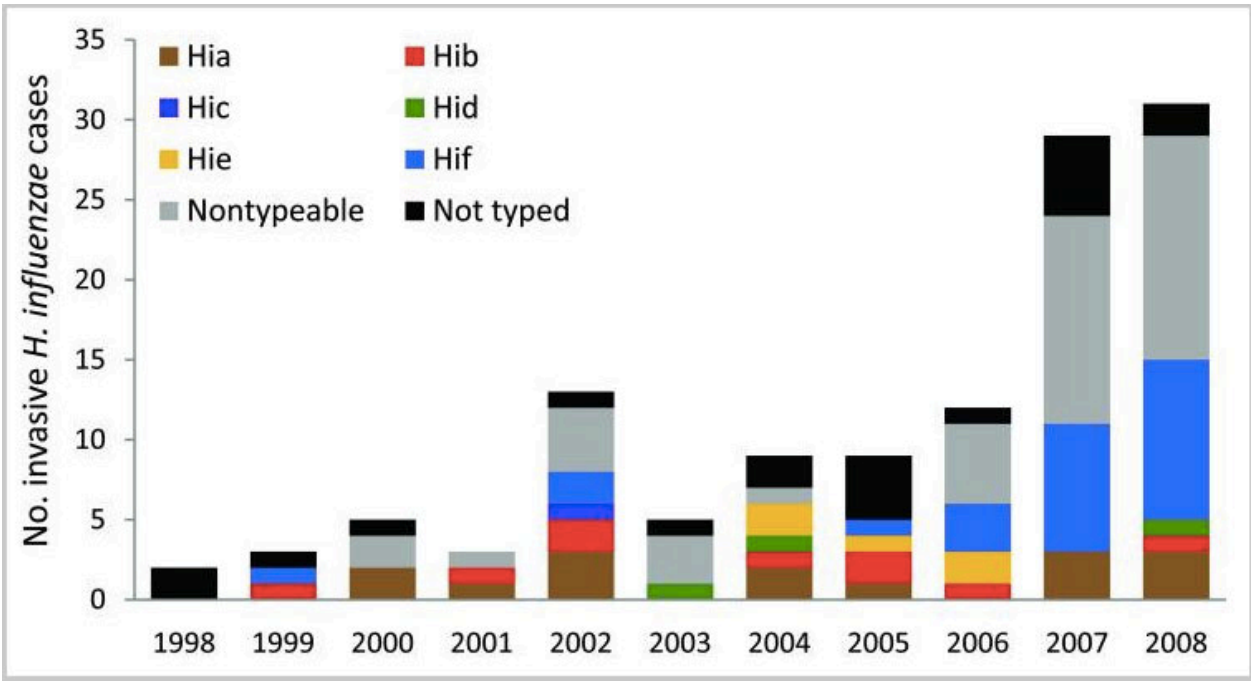
http://www.cdc.gov/maso/facm/pdfs/BSCOID/2013121112_BSCOID_Minutes.pdf

Resurgence of Pertussis (p.6)
"Findings indicated that 85% of the isolates [from six Enhanced Pertussis Surveillance Sites and from epidemics in Washington and Vermont in 2012] were PRN-deficient and vaccinated patients had significantly higher odds than unvaccinated patients of being infected with PRN-deficient strains. Moreover, when patients with up-to-date DTaP vaccinations were compared to unvaccinated patients, the odds of being infected with PRN-deficient strains increased, suggesting that PRN-bacteria may have a selective advantage in infecting DTaP-vaccinated persons."

4. Rubach *et al.* (2011) **Increasing incidence of invasive *Haemophilus influenzae* disease in adults, Utah, USA.** *Emerg Infect Dis* 17:1645-50

http://www.ncbi.nlm.nih.gov/pubmed/21888789

The chart below from Rubach *et al*. shows the number of invasive cases of *H. influenzae* (all types) in Utah in the decade of childhood vaccination for Hib.



5. Immunoglobulin Handbook, Health Protection Agency

http://webarchive.nationalarchives.gov.uk/20140714084352/http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1242198450982

HUMAN NORMAL IMMUNOGLOBULIN (HNIG):
Indications
1. To prevent or attenuate an attack in immuno-compromised contacts
2. To prevent or attenuate an attack in pregnant women
3. To prevent or attenuate an attack in infants under the age of 9 months

6. De Serres *et al*. (2013) **Largest measles epidemic in North America in a decade--Quebec, Canada, 2011: contribution of susceptibility, serendipity, and superspreading events.** *J Infect Dis* 207:990-98

http://www.ncbi.nlm.nih.gov/pubmed/23264672

"The largest measles epidemic in North America in the last decade occurred in 2011 in Quebec, Canada."

"A super-spreading event triggered by 1 importation resulted in sustained transmission and 678 cases."

"The index case patient was a 30-39-year old adult, after returning to Canada from the Caribbean. The index case patient received measles vaccine in childhood."

"Provincial [Quebec] vaccine coverage surveys conducted in 2006, 2008, and 2010 consistently showed that by 24 months of age, approximately 96% of children had received 1 dose and approximately 85% had received 2 doses of measles vaccine, increasing to 97% and 90%, respectively, by 28 months of age. With additional first and second doses administered between 28 and 59 months of age, population measles vaccine coverage is even higher by school entry."

"Among adolescents, 22% [of measles cases] had received 2 vaccine doses. Outbreak investigation showed this proportion to have been an underestimate; active case finding identified 130% more cases among 2-dose recipients."

7. Wang *et al*. (2014) **Difficulties in eliminating measles and controlling rubella and mumps: a cross-sectional study of a first measles and rubella vaccination and a second measles, mumps, and rubella vaccination.** *PLoS One* 9:e89361

http://www.ncbi.nlm.nih.gov/pubmed/24586717

"The reported coverage of the measles-mumps-rubella (MMR) vaccine is greater than 99.0% in Zhejiang province. However, the incidence of measles, mumps, and rubella remains high."

8. Wilson *et al.* (2011) **Adverse events following 12 and 18 month vaccinations: a population-based, self-controlled case series analysis.** *PLoS One* 6:e27897

http://www.ncbi.nlm.nih.gov/pubmed/22174753

"Four to 12 days post 12 month vaccination, children had a 1.33 (1.29-1.38) increased relative incidence of the combined endpoint compared to the control period, or at least one event during the risk interval for every 168 children vaccinated. Ten to 12 days post 18 month vaccination, the relative incidence was 1.25 (95%, 1.17-1.33) which represented at least one excess event for every 730 children vaccinated. The primary reason for increased events was statistically significant elevations in emergency room visits following all vaccinations."