SUPPLEMENTARY FORMAL STATEMENT OF ROBERT KEITH RHODES SCRAGG

INTRODUCTION

1. My full name is Robert Keith Rhodes Scragg.

2. This is the second formal statement I have given in relation to this matter.

3. My previous formal statement was dated 12 November 2024.

4. I am an Honorary Academic at the University of Auckland, having retired from my position as Professor of Epidemiology (which I held at the time of my previous formal statement) since the date of that statement.

5. I live in Auckland, New Zealand.

6. I have been asked to act as an expert witness by the Crown in this prosecution.

CODE OF CONDUCT FOR EXPERT WITNESSES

7. I confirm again that I:

   7.1. have received from the prosecutor a copy of schedule 4 to the High Court Rules 2016 (the Code of Conduct for Expert Witnesses), and a copy of paragraphs [169]-[171] of the judgment of the Court of Appeal in *R v Hutton* [2008] NZCA 126 where the Court sets out a statement of principles outlining the obligations of expert witnesses in criminal cases;

   7.2. have read and understood these documents; and

   7.3. agree to abide by the requirements for expert witnesses outlined in the Code of Conduct and *R v Hutton* at all times in giving evidence in relation to this matter.

RELEVANT QUALIFICATIONS AND EXPERIENCE

8. My qualifications relevant to my instruction in this matter are set out in my earlier formal statement.

SCOPE OF THIS SUPPLEMENTARY FORMAL STATEMENT

9. I have been asked to consider the materials listed at **Appendix B** to this statement by the prosecutor, which I am instructed are the documents filed by Mr Young with the Court, and the correspondence he has sent to the Court, since the date of my earlier statement relevant to the matters in my statement.

SUMMARY OF COVID-19 INFECTION, VACCINATION & MORTALITY IN NEW ZEALAND

10. Before commenting on the specific contents of the above two documents, there is a need to summarise the New Zealand situation from the start of the COVID-19 epidemic in early 2020 with regard to excess mortality, COVID-19 vaccination and the incidence of COVID-19 since

both of Mr Young's documents create the false impression that there was excess mortality in New Zealand arising from the COVID-19 vaccination campaign.

Covid-19 infection

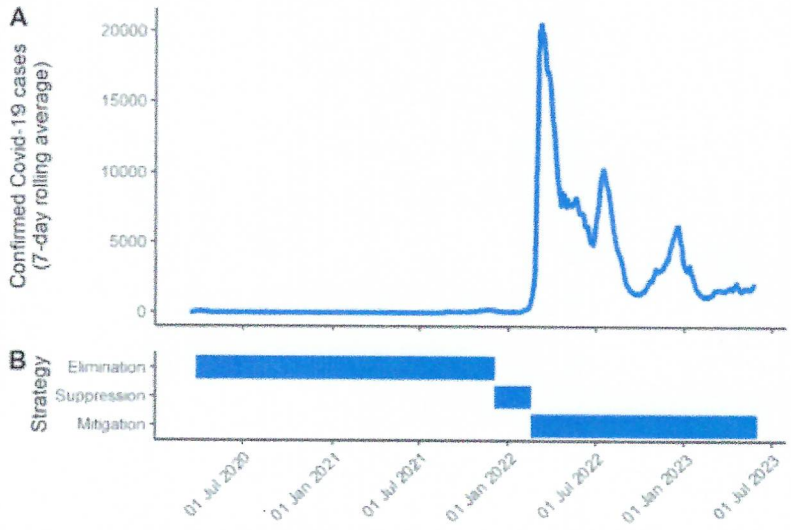
11. The figures below come from: Baker MG, et al. Continued mitigation needed to minimise the high health burden from COVID-19 in Aotearoa New Zealand. *New Zealand Medical Journal* 2023 (Oct 6); 136 (1583): 67-91.

12. The figure (numbered 1) shows the number of COVID-19 cases in New Zealand from the start of the epidemic in March 2020 to July 2023, and the three strategies used to control the epidemic:

    12.1. elimination which aimed to reduce transmission of the disease to zero (from 23 March 2020)
    12.2. suppression which aimed to reduce the transmission of the disease after it had entered the NZ population (from December 2021)
    12.3. mitigation which aimed to prevent the NZ health system from being overwhelmed after COVID-19 started to spread through the NZ population (from January 2022).

13. COVID-19 cases did not occur in significant numbers until February 2022 when the Omicron variant started to spread through the population.

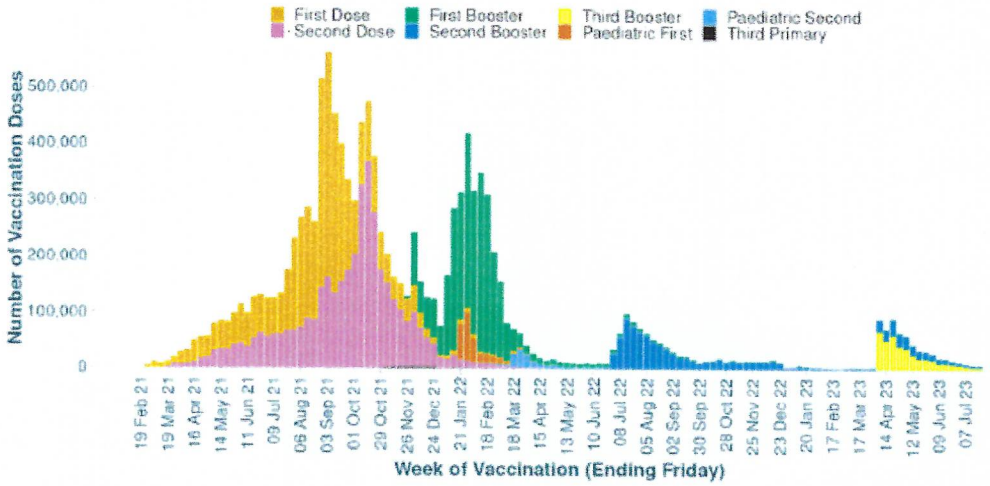
Figure 1: Reported COVID-19 cases in New Zealand (A) and changing COVID-19 pandemic responses strategies (B) during the pandemic. Data source: Ministry of Health (MoH).[4] The key dates for these strategies are described in Appendix 2.



Covid-19 vaccination

14. The figure below (numbered 8) shows the number of vaccinations administered to the NZ population from February 2021 to July 2023. Vaccination initially was prioritised to the elderly and those with comorbidities (eg. diabetes). By January 2022, 90% of people aged over 12 years had received two doses of the Pfizer vaccine.

Figure 8: Count of vaccinations administered by week from the COVID-19 Immunisation Register. Source: MoH.[98]



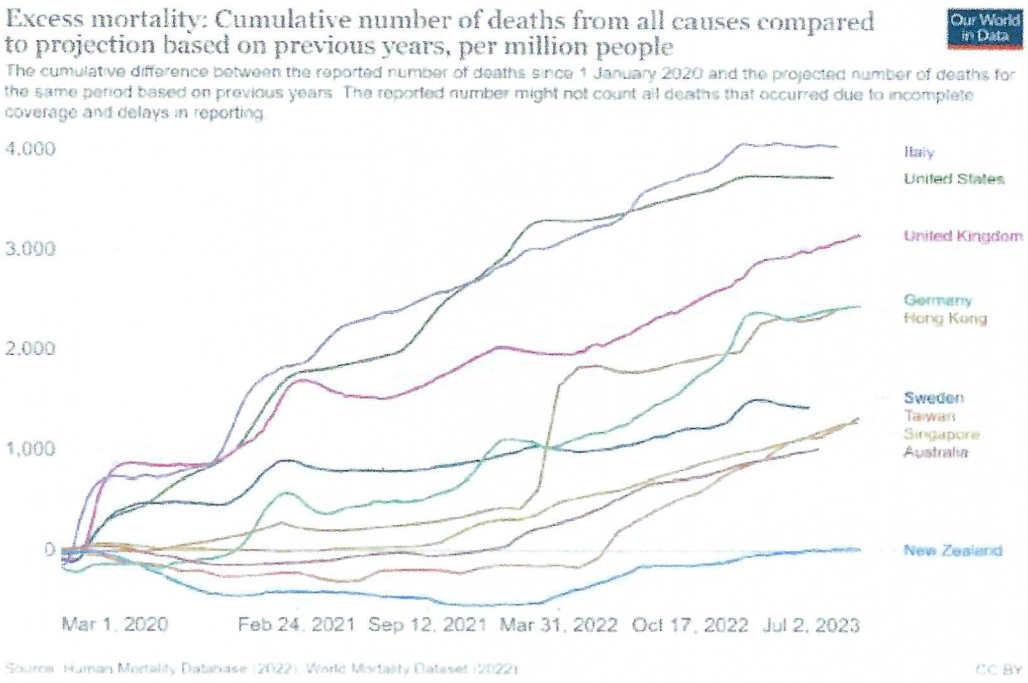
15. The Pfizer vaccine was originally developed to prevent infection from the Alpha variant of COVID-19, against which it was extremely effective (preventing 95% of infections, much higher than the 50% prevented by influenza vaccination), while also being safe (Polack FP et al. Safety and efficacy of the BNT162b2 mRNA Covid-19 vaccine. *New England Journal of Medicine* 2020; 383: 2603-15). As the COVID-19 virus continued to mutate, the effectiveness of the Pfizer (and other) vaccines against infection from COVID-19 waned, which allowed the Omicron variant to spread throughout the NZ population, but the vaccine continued to protect against death and hospitalisation both in New Zealand and overseas (eg. Lin D-Y et al, Association of primary and booster vaccination and prior infection with SARS-CoV-2 infection and severe COVID-19 outcomes. *Journal of American Medical Association* 2022; 328: 1415-26; Mbinta JF, et al. Effectiveness of COVID-19 vaccines against hospitalisation, death and infection over time in Aotearoa New Zealand: a retrospective cohort study. *NZ Medical Journal* 2024 (Sep 6); 137 (1602): 65-86).

Excess mortality

16. Excess mortality from March 2020 (the start of the COVID-19 epidemic) to July 2023 in New Zealand and several other countries is shown in the figure below (Figure 7 in Baker et al), as the cumulative number of excess deaths per 1 million people when compared with mortality during 2015-19. Excess mortality was lowest in NZ compared to all other countries. The decline in excess mortality during 2020 and 2021 is due to the elimination strategy in those years. As well as preventing COVID-19 infection, the elimination strategy also prevented influenza infection, which contributes to several hundred deaths each winter in NZ.

17. Of particular significance, given the efforts by Mr Young in his court documents to link excess mortality to COVID-19 vaccination, mortality remained lower than expected throughout 2021, by the end of which (as stated above) 90% of adults had received two doses of the Pfizer vaccine. If COVID-19 vaccination was causing excess mortality, it should have started to occur in 2021, but the latter remained low and actually declined during 2021. The trend for the increase in excess mortality starting in March 2022, back up to the mortality seen during 2015-19 by July 2023, is consistent with the spread of COVID-19 infection starting in 2022, and not

with increased rates of vaccination (which mostly occurred in 2021). It has been estimated that COVID-19 vaccination saved 6650 lives in New Zealand between January 2022 and June 2023 (Datta S, et al. The impact of Covid-19 vaccination in Aotearoa New Zealand: a modelling study. *Vaccine* 2024; 42: 1383-91).



SAFETY OF THE COVID-19 VACCINE

18. The table below comes from the main initial report of the COVID-19 vaccine, which randomised over 21,600 people to each treatment arm – vaccine or placebo – and who were then followed for a median period of 2 months (Polack FP, et al. Safety and efficacy of the BNT162b mRNA Covid-19 vaccine. *New England J Medicine* 2020; 383: 2603-15). The specific vaccine used in the study is the same vaccine that was mainly used in New Zealand.

19. Adverse events were more likely to be reported by people in the vaccine group. Most of these were short-term, and included pain at the injection site, fever, fatigue, headache, chills, muscle pain and joint pain. These symptoms are expected to occur in vaccine trials as they confirm that the vaccine is inducing an immune response, which manifests as inflammatory symptoms.

20. Importantly, there was no statistical difference in the frequency of serious adverse events or death between the vaccine and placebo groups. The similar number of deaths in the vaccine arm (n=2) and placebo arm (n=4) challenges Mr Young's claim that the vaccine increased mortality during follow-up — which extended up to 4 months in this study.

21. The frequency of adverse events reported by people in the placebo arm (12.2%) is relevant to reports on adverse events submitted to the Court by Mr Young (see my comments below), as it shows that many of the reports submitted to Medsafe and the ACC are likely not due to the Pfizer vaccine.

	BNT162b2 (30 µg) (N[a]=21621)	Placebo (N[a]=21631)
Adverse Event	n[b] (%)	n[b] (%)
Any event	5770 (26.7)	2638 (12.2)
Related[c]	4484 (20.7)	1095 (5.1)
Severe	240 (1.1)	139 (0.6)
Life-threatening	21 (0.1)	24 (0.1)
Any serious adverse event	126 (0.6)	111 (0.5)
Related[c]	4 (0.0)	0
Severe	71 (0.3)	68 (0.3)
Life-threatening	21 (0.1)	23 (0.1)
Any adverse event leading to withdrawal	37 (0.2)	30 (0.1)
Related[c]	16 (0.1)	9 (0.0)
Severe	13 (0.1)	9 (0.0)
Life-threatening	3 (0.0)	6 (0.0)
Death	2 (0.0)	4 (0.0)

Table S3 | Participants Reporting at Least 1 Adverse Event from Dose 1 (All Enrolled Participants). The 'all enrolled' population included all participants who received at least 1 dose of vaccine irrespective of follow-up time. a. N = number of participants in the specified group. This value is the denominator for the percentage calculations. b. n = Number of participants reporting at least 1 occurrence of the specified event category. For 'any event', n = the number of participants reporting at least 1 occurrence of any event. c. Assessed by the investigator as related to investigational product.

RESPONSE TO MR YOUNG'S AFFIDAVIT DATED 23 MAY 2025

Paragraph 2(a)

22. Mr Young is certainly an expert in data *management*, for which he was employed by the Ministry of Health. But this is not the same as being an expert in data *analysis*.

23. The latter requires epidemiological and/or statistical expertise which, as stated in my previous affidavit, is not shown by the methods he (and his co-authors) used to analyse the data he extracted from the Ministry of Health, as described in the PDF file called 'Paper'.

24. Mr Young states that he has the expertise 'to find inconsistencies and anomalies' in databases, and to identify 'odd patterns' and 'clusters of death'. He states he has used probability analyses to determine whether these could have arisen by chance. However, in his 'Paper' he did not used the appropriate statistical methods to determine if the results remain statistically significant after:

    24.1. comparison with a control (unvaccinated) group;
    24.2. correction for differing follow-up periods after vaccination;
    24.3. and adjustment for confounding variables (age, gender, ethnicity and comorbidity).

25. Analyses that do not meet the three above requirements cannot determine whether vaccination increases mortality.

26. In his affidavit, Mr Young does attempt to address some (but not all) the criticisms in my affidavit of the data analytical methods used in his 'Paper', which I discuss below.

Paragraph 5(a)

27. The aim of this paragraph is to show that COVID-19 vaccination increases mortality.

28. The text in this paragraph is about Exhibits H and J.

29. The first part of Exhibit H is a graph of all-cause mortality for New Zealand from July 2019 to about 2-3 months after July 2023. From the weblink above the graph I have been able to trace the source of the graph to a post on X by 'Ben@USMortality'. The green area represents unvaccinated people and the red vaccinated, with the latter starting around Feb-March 2021 at the same time as the beginning of the rollout of the COVID-19 vaccination programme.

30. The graph is misleading. It implies that all the deaths in the red area after the Feb-March 2021 date are due to COVID-19 vaccination; but all it likely shows is the cumulative proportion of the NZ population that was vaccinated, as the programme progressed, applied to the number of deaths in NZ during this period. From my search of the freedom-of-information website (https://fyi.org.nz/) I cannot find evidence that Te Whatu Ora (Ministry of Health) has released data on both COVID-19 vaccination and mortality that allows the two variables to be combined at the individual level. Thus, this graph cannot be used to determine whether COVID-19 vaccination at the individual level increases mortality.

31. The graph does show a small increase in the mortality in the winter of 2022, but this is unlikely due to COVID-19 vaccinations since only a small number were given at that time period (see above, Figure numbered 8). The increase is more likely due to increasing deaths from COVID-19 in 2022 when the virus started to spread through the country, as discussed in my original affidavit (paragraph 78).

32. I do not see how Mr Young could have removed the number of COVID-19 deaths from this graph because cause-specific mortality data for 2022 only became available in January 2025 (https://tewhatuora.shinyapps.io/mortality-web-tool/), well after the date of the post by 'Ben@USMortality' on 26 February 2024, and Mr Young did not have access to cause-of-death information in the data he extracted from the Ministry of Health. It takes up to 2 years for the cause-of-death to be determined, whereas information on the event of death is processed very quickly after death and reported in the following year as total (all-cause) mortality.

33. The second part of Exhibit H is a table showing age-specific death rates (from all-causes combined) annually during the period 2020-2023, compared with the baseline (average) during 2015-2019, as a control period before the COVID-19 epidemic started. The table purports to show an increase in mortality during 2021 for age-groups 50-54 years and above, and in all age-groups during 2022 and 2023, compared with the baseline period.

34. I am unable to verify the accuracy of these calculations based on the mortality and population data publicly released by Stats New Zealand (www.stats.govt.nz/infoshare). My calculations (in **Appendix A, Table 1**) are different to those shown by Mr Young in Exhibit H and do not

show a pattern of a consistent increase during 2021-2023 compared with the baseline period. Mr Young should provide the source of his data so that other people can check his calculations.

35. Mr Young also makes a comment in this paragraph 'Age Standardised Mortality Rates' which suggests that he does not fully understand this concept. Age-standardisation is used to weight age-specific rates from different groups or time periods, by a common set of weights (or proportions), so that the age-specific data can be combined into a single age-standardised value. It is not logical to say that age-standardisation was used 'accross [sic] each age group' and then report them separately. Exhibit H does not contain any age-standardised rates.

36. I have rechecked the Excel data files created by Mr Young that were originally sent to me by the prosecutor, and the PDF file called 'Paper', and I cannot find any mention or evidence in them of the calculation of age-standardised mortality rates (ASMR).

37. The first part of Exhibit J shows vaccination date and date of death (if it occurred) for individuals at separate vaccination centres. These data cannot be meaningfully interpreted when examined like this. The data from vaccination centres need to be aggregated and compared to a separate standard (control) to see if the rates are elevated.

38. Mr Young does this in the second part of Exhibit J, which shows calculations using data from two vaccination centres comparing observed deaths with the expected number of deaths based on the age-distribution of the people at each vaccination centre. The calculations shown at the end of this exhibit (under the heading '3. Effect Size and Relative Risk') are correct. However, Mr Young has not stated the source of his data for the control/comparison group that he used to calculate the expected number of deaths. If it is the total New Zealand population, he will have underestimated the number of expected deaths because he has not adjusted for gender, ethnicity and comorbidity (as discussed in my original affidavit (paragraph 40). Nor has he indicated whether he used person-time in his calculation to calculate the expected number of deaths. Only a p-value from analyses that further adjusted for these variables and correcting for person-time would be meaningful. In my opinion, it is highly likely that Mr Young has gone through his data and selected batches with high standardised mortality ratios (**SMRs**), which is the ratio of observed over expected deaths, to support his views about the harm caused by COVID-19 vaccination. Given the fact there was no excess mortality in New Zealand during the COVID-19 vaccination period (see graph above), the SMRs from the different vaccination batches will vary from being below 1.0 (the comparison value) to above it. Mr Young has chosen to emphasise the latter and has ignored the former.

Paragraph 5(b)

39. Based on the content of Mr Young's affidavit, he has demonstrated some expertise in analysing epidemiological data. But the question must be asked – why didn't he use these methods in his original PDF called 'Paper' If he had the appropriate training and experience in these methods, he would have used them in his original analysis of the data he extracted from the Ministry of Health.

40. In addition, I do have some reservations about the accuracy of Mr Young's calculations, given the differences between the mortality rates shown in the table in Exhibit H and my calculations

shown below (**Appendix A, Table 1**). Mine are similar to (although not exactly the same as) those reported by Stats NZ (**Appendix A, Table 2**, which shows rates per 1000); while Mr Young's are substantially different, particularly in the older age-groups which have the greatest influence on the value of an age-standardised mortality rate. My calculations of the rate difference in Table 1 are also consistent with the excess mortality calculations shown above.

RESPONSE TO MR YOUNG'S (UNDATED) MEMORANDUM RESPONDING TO MY REPORT

Paragraph 10

41. This paragraph is addressed by my summary of the COVID19 situation in New Zealand at the beginning of this document. It shows there was no excess mortality from March 2020 to July 2023, including during 2021 when most New Zealand adults were vaccinated.

Paragraph 14

42. I stand by the statements in my original affidavit that valid conclusions cannot be made without a control group and adjustment for comorbidities.

Paragraph 15

43. I agree that calculation of standard mortality ratios (SMR) is a valid epidemiological method, but I comment further on this below regarding paragraph 29.

Paragraph 16

44. I agree that Kaplan-Meier curves can be used to show survival, but they are only meaningful if there is comparison between vaccinated and a comparison group. Mr Young does not show any graphs or calculations using this method.

45. Further, this method cannot be adjusted for covariates (eg. age, sex, ethnicity, comorbidity), unless specialised software is used. I have seen no evidence, in the materials I have been sent to review, of the use of such software.

46. This method is most commonly used in randomised controlled trials, showing unadjusted curves, where confounding factors are balanced (equally distributed) between the comparison groups. That was not the case with the dataset used by Mr Young as it did not have a control group of unvaccinated people.

Paragraph 17

47. Analysis, which Mr Young has not undertaken in the materials I have been asked to review, would be required to exclude the possibility that temporal clustering of deaths in specific vaccination batches could have arisen by chance, with some batches showing higher than expected deaths and some showing lower. Unless there are prior grounds for deciding that a specific batch (or batches) will have higher than expected mortality, the most valid method is to combine all batches together and then analyse them to see if mortality is higher than expected.

Paragraph 18

48. The matter of excess deaths is addressed in my opening statement above.

Paragraph 28

49. Mr Young does not show any evidence in his calculations of use of person-years, Kaplan-Meier survival or IRRs (incidence rate ratios).

Paragraph 29

50. This shows calculation of an SMR based on observed and expected deaths. The calculation is correct for the numbers shown. However, I cannot independently verify how the observed and expected number of deaths were calculated. To verify the expected number of deaths would require the age- and sex-distribution of the vaccinated group, person-time for each individual up to death or date of data-extraction in that group, and the age-and sex-specific rates from the comparison population used to calculate the expected number of deaths. Mr Young should provide this information so that his calculation can be verified.

COMMENT ON OTHER FILES SENT TO ME BY THE PROSECUTOR FOR REVIEW

Benjamin Liu *Protecting public-sector whisteblowers against criminal liability*

51. Reference 9 in this article (by Igor Chudov) alleges a number of problems with the data extracted from the Ministry of Health database by Mr Young, which undermine the quality of his data analyses. The two problems are missing data and batches with multiple vaccine types (which means a batch cannot be linked to a specific vaccine if aggregate mortality data are shown for that batch).

52. The main problem is the missing data, according to the blog by Igor Chudov (a copy of which I have provided to the prosecutor for disclosure to Mr Young). Of the 2,215,729 individuals in the extracted data, over half (n=1,248,740) are missing vaccination Dose 1 and just under half (n=1,024,375) are missing both Doses 1 & 2.

53. The consequence of the missing data from the initial vaccinations is that follow-up time (from first vaccination to death or date of data analysis) has been greatly reduced. For example, a person who died after their 3rd vaccination would have lost more than 6 months in their total follow-up since their first vaccination.

54. Decreasing the person-time of follow-up for individuals, which is the denominator for calculating incidence rates (eg. of mortality) would have spuriously increased the mortality rate, such that the observed number of deaths was falsely elevated when compared to the expected number of deaths.

55. This assumes Mr Young corrected for person-years from the date of vaccination when he calculated age-standardised mortality rates. The information I have been asked to review is silent as to whether he did so. He may not have and may only have analysed individuals based on counts rather than person-time.

56. The failure of Mr Young to acknowledge the limitations in his data further undermines his position that he had the skills to appropriately analyse the COVID-19 data he extracted. Missing data is a major issue when analysing epidemiological sets. If the missing data are limited, it is possible to impute values which can be included in the data analysis. The level of missing data in that extracted by Mr Young is extremely large, and other approaches would have to be used.

57. For example, the data analyses could be restricted to people with complete data, and then this group would be compared with the remainder who have missing data to determine if there are any differences between the two groups (eg. with regard to age, sex, date of vaccination, etc). This would provide insight into the external validity (ability to extrapolate to the wider population) of Mr Young's data.

58. A further limitation with the data extracted by Mr Young is that it only includes 2.2 million people out of the total 4.3 million vaccinated. Thus, we have no indication as to whether-or-not the people in Mr Young's data are representative of all the people vaccinated in New Zealand.

Email dated 5 September 2025

59. Crude mortality rates (which is the rate for all ages combined – on page 3 of my original report, not page 2) are always substantially lower than older age-specific rates (see Tables 1 & 2 below). The percent who died in the batch discussed in his email (25/63) is very high and statistically significant. But, as set out above, I would argue that a person with the appropriate level of knowledge for analysing data sets would not have focused on a single batch but would have combined the data from all batches. It is only reasonable to focus on a single batch if there is a prior reason for doing so. The fact that there is a high proportion of individuals who died following vaccination with vaccines from the batch is not a prior reason: focusing on the batch for this reason assumes that vaccination with vaccines from that batch causally contributed to the deaths, without adjusting for comorbidities and correcting for follow-up time from vaccination.

Email dated 19 September 2025

60. The same concerns as above apply to the data from the 5 batches in this email. From the description of Mr Young's method, it is very likely that Mr Young has gone through the data to select batches with the highest mortality. Yet, given there was no increase in excess mortality over the whole vaccination period, and that there is other evidence that vaccination prevented deaths (eg. Datta S, et al. cited above), it is likely there were many batches where the observed mortality was lower than expected, as one would expect the pattern for SMRs to have a normal distribution around the reference (control) value of 1. It is meaningless, and potentially misleading, to focus on a small number of batches and ignore the evidence from all batches.

Email dated 24 September and HNZ00080943 response

61. These documents compare the number of COVID-19 deaths who were vaccinated (84.7%) with the proportion of New Zealanders age 12+ years who had been vaccinated up to January

RS

2024 (83.3%). Mr Young claims that because the former percent is higher, this is evidence of harm from vaccination.

62. However, the two percents in paragraph 61 can only be compared after adjusting for age, sex, comorbidity and follow-up time (ie. person-time). The above two percents have not been adjusted or corrected for the variables listed in the previous sentence.

63. The correct analytical approach is to calculate the incidence rate (or cumulative incidence based on person-time) of death from COVID-19 in people who were vaccinated and compare this with the same metric in unvaccinated people. In doing this, there should be adjustment for age as older people are more likely to have been vaccinated and also to have died; plus, non-COVID deaths (ie. all-causes) should be included in the calculation as a significant percent of **excess** deaths during the COVID-19 epidemic (about 35%) typically would have been classified as being due to cardiovascular disease and respiratory disease in people with these pre-existing diseases, not due to the virus itself.

Email dated 4 October 2025

64. In this email Mr Young references a meta-analysis of 22 randomised controlled trials of vaccination and cohort studies (Voleti N, et al. Myocarditis in SARS-CoV-2 infection versus COVID-19 vaccination: a systematic review and meta-analysis. *Frontiers in Cardiovascular Medicine* 2022; 9: 951314).

65. The main aim of the publication was to compare the incidence of myocarditis from COVID-19 vaccines with that from COVID-19 infections. Mr Young has emphasised that myocarditis was twofold higher in vaccinated than unvaccinated people.

66. However, the authors in fact expressly state that 'the risk of myocarditis increased by a factor of 2 and 15 after vaccination and infection, respectively'. That is, myocarditis was 7 times more common after COVID-19 infection than after vaccination. This is the main finding from the paper. The authors conclude: 'These findings support the continued use of mRNA COVID-19 vaccines among all eligible persons as per CDC and WHO recommendations'.

67. I do not consider this provides evidence against the safety of COVID-19 vaccines when the infectious disease they are preventing is much more likely to cause myocarditis, which is a rare disease. A recent report based on 13.5 billion doses of COVID-19 vaccines globally states that three additional cases of myocarditis and pericarditis per million doses can be attributed to COVID-19 vaccination (https://www.phcc.org.nz/briefing/robust-vaccine-surveillance-shows-safety-we-need-communicate-better).

68. I cannot comment on the photo/scan of a table at the end of this email as it is not referenced.

Email dated 13 October 2024 and H2025073069 Response

69. These files summarise adverse events following immunisation (AEFI) against COVID-19 infection up to 21 September 2025 reported to the Centre for Adverse Reactions Monitoring (CARM) based at the University of Otago in Dunedin, which collects safety reports on all medications for Medsafe. Anyone (patients or health professionals) can report an adverse reaction to CARM.

70. A measure of the safety of COVID-19 vaccines is that Medsafe no longer maintains reports on them (https://www.medsafe.govt.nz/COVID-19/vaccine-report-overview.asp). If it had deemed the vaccine to be unsafe, Medsafe would have continued to monitor its safety.

71. The number of reported vaccine doses per AEFI is 680 (13.9 million / 20,435). This number is much higher than the number of one in 200 vaccinated people reporting an AEFI, as stated by Mr Young in his email, because the average number of doses per person was more than 3.

72. A substantial proportion of these AEFI (around 45%) are unlikely to be due to the vaccine, given the finding in the main trial that adverse events were reported by 12.2% in the placebo arm compared to 26.7% in the vaccine arm (see above: Polack et al, *New Engl J Med*, 2020).

73. The following peer-reviewed scientific reports have data on the benefit from COVID-19 vaccination:

    73.1. Baker MG, et al. *NZ Med J* 2023: as described above, all-cause mortality did not increase in New Zealand from February 2021 to March 2022 when most vaccination doses were given (Figures 7 and 8).

    73.2. Datta S, et al. *Vaccine* 2024: COVID-19 vaccination prevented 6,650 deaths and 45,100 hospitalisations between January 2022 and June 2023.

74. Mr Young states that updated assessments of the last report in *Vaccine* are required for 2024-25. However, only a relatively small proportion of vaccine doses were given in 2024-25, and the findings from Datta et al (*Vaccine* 2024), which cover the period when most doses were given, are unlikely to be changed by additional data for the above two years (https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/covid-19/vaccine#total-vaccinations).

Covid 19 Vaccination claims refresh January 2025

75. I am not sure about the origin of this file. I assume it is in response to an OIA request sent to the ACC by Mr Young.

76. Without a control group, it is not possible to quantify what proportion of claims were due to the vaccine, although as much as 45% may not be due to it (see above).

CV-ISMB Final Report July 2023

77. This is the final report COVID-19 Vaccine Independent Safety Monitoring Board (CV-ISMB), which was established in February 2021 to provide advice to the Centre for Adverse Reactions Monitoring (CARM), Medsafe, the National Immunisation Programme, Te Whatu Ora and the Ministry of Health. The Board released its final report on 03 July 2023 (https://www.tewhatuora.govt.nz/publications/final-report-of-the-covid-19-vaccine-independent-safety-monitoring-board-cv-ismb).

78. The Board considered data provided by Medsafe up to and including 30 November 2022. With regard to death, in the monitoring period for the Pfizer/BioNTech COVID-19 vaccine (19 February 2021 to 30 September 2022), the observed number of deaths in the first 21 days

after vaccination was less than the expected number of natural deaths (Safety Report #46 – 30 November 2022).

79. This is completely opposite to the claims by Mr Young that the Pfizer vaccine increased mortality. This included the period (from March 2022) when cumulative mortality in New Zealand started to climb back up to what it would have been before 2020 (see figure above under heading of "Excess Mortality").

80. The only medical conditions linked to the Pfizer vaccine were myocarditis and pericarditis which are very rare (see "Safety of the Covid-19 Vaccine" above).

81. The Board concluded that "Throughout 2021 and 2022 the *benefits of vaccination greatly outweighed the risk of both COVID-19 infection and vaccine adverse reactions*" (emphasis added).

Official Records – COVID-19 Vaccine Adverse Events Summary

82. I identify that this document appears to have been written by Mr Young as it has the same formatting of the heading as his affidavit dated 23 May 2025.

83. It summarises government reports that contain any information on the topic of adverse events (including death) and COVID-19 vaccination. It includes information on some of the reports discussed above. Specifically, this file includes the following sections:

83.1. **Medsafe – adverse Event Monitoring (CARM):** This section summarises the final report from the COVID-19 Vaccine Independent Safety Monitoring Board (CV-ISMB) (discussed above) prepared for CARM, which concluded that the benefits of vaccination greatly outweighed the risk of both COVID-19 infection and vaccine adverse reactions. In the screenshot of the SMARS search, 'tozinameran' is the generic name of the Pfizer vaccine.

83.2. **Health New Zealand & Ministry of Health Data**:

83.2.1. This section provides information from the report prepared for CARM (above), which concluded that myocarditis was increased by the Pfizer vaccine (as discussed above).

83.2.2. In addition, this section also repeats the data on COVID-19 deaths released under the OIA (HNZ0080943 – Response, discussed above). A different method of analysis is used to that presented in the 24 September email (discussed above). In this document, crude mortality proportions have been calculated for the COVID-19 deaths up to February 2024 with previous vaccination (n=2075) divided by the total number of people vaccinated (n=4,100,00) to give a crude proportion = 0.0506%. The number of remaining deaths from COVID-19 (2450 – 2075 = 375) has been divided by the approximate number of unvaccinated people (n=1,228,000) to give a crude proportion = 0.0305%.

83.2.3. Dividing the former percent by the latter gives a risk ratio = 1.66, implying that COVID vaccination increases mortality by 66%, a result that is not supported by other peer reviewed publications (discussed above).

83.2.4. The two main limitations of these calculations are that there is no age-standardisation (unvaccinated people were likely to have been younger) and no allowance for person-time from vaccination date (which would have been more than one year for the first cohorts of people who received vaccination and who were the elderly).

83.2.5. These calculations have no validity if they have not been adjusted for age, co-morbidity and person-time

83.3. **ACC – Vaccine Injury Claims**: This section summarises the ACC claims in the report discussed above ("Covid 19 vaccination claims refresh January 2025").

83.4. **Official Information Act (OIA) Material**: This section summarises several sources of information from the Government and also repeats the calculation of mortality percents by COVID vaccination status (0.03% in unvaccinated and 0.05% in vaccinated). These percents are incorrectly labelled as rates (which require a denominator of person-time – see my first formal witness statement).

83.4.1. The graph is incorrectly described as showing that vaccination does not save lives. This is incorrect, as the graph does not show any mortality data. Rather it is showing the vaccine status of the NZ population by age for those: fully vaccinated, partially vaccinated and unvaccinated. It shows clearly that older people were more likely to be fully vaccinated than younger, reinforcing the need for age-standardisation when comparing mortality between vaccinated and unvaccinated.

83.4.2. The "Penn State link" is to an article published by Voleti et al (*Frontiers in Cardiovascular Medicine* 2022), which shows that COVID vaccination does double the risk of myocarditis compared to unvaccinated people, but also shows that myocarditis is 7 times more common after COVID-19 infection than vaccination (discussed above under File 6: 4 October email).

83.4.3. The **Fairweather et al 2023 PDF** is a review on COVID-19 and myocarditis, which is very rare. This publication is discussed below under File 14.

83.5. **Other adverse events**: These 4 links are on COVID-19 vaccination and anaphylaxis. The Pfizer vaccine contains polyethylene glycol (PEG) which has been linked to increased risk of anaphylaxis. However, this outcome is extremely rare (5 to 11 per million doses) and is not sufficiently serious or important to withhold vaccination given the benefits from vaccination in preventing deaths and hospitalisations (see above, Datta, Vaccine 2024). The factsheet from the Immunisation Advisory Centre from the University of Auckland states that most patients with a history of anaphylaxis can be safely vaccinated (Comirnaty Allergic reactions to Comirnaty or a history of PEG allergy - Factsheets - Immunisation Advisory Centre). Further, the COVID-19 Vaccine Independent Safety Monitoring Board report (discussed above) monitored the

frequency of anaphylaxis at six of its meetings and decided on 24 June 2021 that "The Board agreed that if the numbers continue to track similarly (around 10 cases per million doses) that there is no need to continue to review in this forum".

H2025073069 Response

84. This file is a response from Medsafe dated 10 October 2025 regarding an OIA request to the Ministry of Health numbered H20250703069 (presumably from Mr Young) dated 22 September 2025.

85. This file contains the same table showing the number of adverse events following immunization (AEFI) as shown in the 13 October email discussed above.

86. The link to www.medsafe.govt.nz/SMARS/Disclaimer was inactive at the time of my review.

14_fairweather et al 2023 – covid-19 – myocarditis and pericarditis

87. This publication is a review of the pathophysiology of myocarditis and pericarditis with COVID-19. The risk of getting myocarditis is elevated about 15-fold after COVID-19 infection compared to people without COVID-19. Table 1 summarises studies by the following categories:

    87.1. Non-COVID: 0.55 cases up to 10 cases per 100,000

    87.2. COVID-19 infection: two studies – 150 cases and 1000-4000 cases per 100,000

    87.3. COVID-19 vaccines: mostly less than 3 cases per 100,000, aside from studies reporting 9.2 cases, 11 cases and 410 cases per 100,000 (the latter was in hospitalized patients).

88. Thus, risk of myocarditis is elevated after COVID-19 vaccination, but the increase is much greater after COVID-19 infection.

SUMMARY

89. The epidemiological evidence from both New Zealand and overseas clearly shows that COVID-19 vaccination, particularly with the Pfizer vaccine, did not increase mortality. Instead, it prevented both deaths and hospitalisations.

90. The analyses used by Mr Young in support of his claim that COVID-19 vaccination increased mortality are selective and cannot be verified without him providing further details of his calculations.

91. It appears that many people in the dataset he extracted from the Ministry of Health have missing data, with about half missing information on their first and second vaccination doses. This casts further doubt on the validity of his calculations.

92. The clinical trial evidence from the large US vaccination study, which found that about 45% of people in the placebo arm reported side-effects, indicates that a large proportion of adverse

events reported to Medsafe and ACC were unlikely to have been caused by the COVID-19 vaccine.

93. The international epidemiological evidence does show that the COVID-19 vaccine increases the risk of myocarditis, but not as much as does COVID-19 infection.

94. The possible link between polyethylene glycol (PEG), which is in the Pfizer vaccine, and anaphylaxis, was reviewed by the COVID-19 Vaccine Independent Safety Monitoring Board which found no evidence of an increase in this outcome from vaccination.

This statement is true and correct to the best of my knowledge and belief. I make the statement with the knowledge that it is to be used in court proceedings. I am aware that it is an offence to make a statement that is known by me to be false or intended by me to mislead.

SIGNED: _____

Robert Keith Rhodes Scragg

DATED: 08 December 2025

APPENDIX A: STATISTICAL ANALYSES

Table 1: New Zealand mortality (data from: 'https://infoshare.stats.govt.nz/')

	Death rates per 100,000					Rate Difference from 2015-19 (per 100,000)			
Age (yrs)	2015-19	2020	2021	2022	2023	2020	2021	2022	2023
0-4	112	86	106	82	84	-25	-6	-30	-27
5-9	9	7	9	7	6	-2	0	-3	-4
10-14	13	14	13	11	10	1	1	-2	-2
15-19	42	40	41	34	43	-2	-1	-8	1
20-24	56	51	54	55	57	-5	-2	-1	1
25-29	56	54	52	61	61	-3	-4	5	5
30-34	66	54	63	66	66	-12	-3	0	0
35-39	82	78	84	83	79	-4	2	1	-3
40-44	120	115	123	120	127	-5	3	0	7
45-49	187	180	170	195	188	-7	-17	8	1
50-54	297	283	296	301	282	-14	-1	4	-15
55-59	446	430	436	479	466	-16	-11	33	20
60-64	667	625	652	717	701	-42	-14	50	34
65-69	1,043	982	996	1,069	1,044	-61	-46	26	2
70-74	1,715	1,551	1,610	1,700	1,654	-164	-105	-16	-61
75-79	2,994	2,767	2,810	3,052	2,908	-227	-184	58	-86
80-84	5,604	5,013	5,180	5,560	5,467	-590	-423	-43	-137
85-89	10,571	9,583	10,105	10,890	10,237	-988	-466	319	-334
90+	21,584	19,785	21,248	24,277	23,048	-1,800	-337	2,693	1,463
Total	681	643	687	758	729	-38	6	77	48

Table 2: Data from Stats NZ Excel file called 'births-and-deaths-year-ended-december-2023'

Age-specific death rates[1]

2010–2023

Age group (years)	December year													
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
0–4	1.2	1.1	1.0	1.0	1.2	1.0	0.8	0.9	0.9	1.1	0.9	1.1	0.8	0.8
5–9	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
10–14	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1
15–19	0.5	0.6	0.5	0.5	0.4	0.5	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.4
20–24	0.6	0.7	0.6	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.5	0.5	0.5	0.6
25–29	0.6	0.6	0.6	0.5	0.5	0.5	0.5	0.6	0.6	0.6	0.5	0.5	0.6	0.6
30–34	0.6	0.8	0.6	0.6	0.6	0.6	0.6	0.7	0.7	0.7	0.5	0.6	0.6	0.7
35–39	0.9	0.9	0.8	0.9	0.8	0.8	0.8	0.9	0.8	0.8	0.8	0.8	0.8	0.8
40–44	1.4	1.4	1.3	1.3	1.2	1.2	1.3	1.2	1.2	1.2	1.1	1.2	1.2	1.3
45–49	2.1	1.9	2.1	2.0	1.9	2.0	1.8	1.9	1.7	1.9	1.8	1.7	1.9	1.9
50–54	3.0	2.9	3.0	3.1	3.1	2.9	3.0	2.9	2.9	3.1	2.8	2.9	3.0	2.8
55–59	4.6	4.8	4.3	4.4	4.5	4.3	4.6	4.4	4.6	4.4	4.3	4.3	4.7	4.6
60–64	7.0	7.2	6.8	6.8	6.8	6.6	6.5	6.9	6.7	6.5	6.2	6.4	7.1	6.9
65–69	11.7	12.0	11.3	10.6	10.7	10.7	10.4	10.5	10.2	10.3	9.8	9.9	10.6	10.3
70–74	19.0	19.1	18.7	18.2	17.8	18.3	16.6	17.5	16.7	16.7	15.4	15.9	16.7	16.2
75–79	32.2	33.3	32.3	31.5	31.7	31.3	29.0	31.0	29.3	29.2	27.5	27.8	30.0	28.5
80–84	59.6	59.9	58.8	56.0	59.0	58.3	55.2	57.4	55.7	53.5	49.8	51.3	54.7	53.6
85–89	105.7	112.0	111.4	107.2	107.5	105.4	102.7	108.7	103.8	107.5	95.4	100.2	107.5	100.5
90+	210.8	225.8	224.1	206.4	221.7	220.9	210.7	216.1	214.8	215.1	194.6	207.4	234.8	220.1

1. Per 1,000 mean estimated population in each age group.

Source: Stats NZ

RS

APPENDIX B: INFORMATION PROVIDED BY PROSECUTOR FOR REVIEW

1. MEMORANDUM_IN_RESPONSE_TO_PROFESSOR_SCRAGG_REPORT.pdf
2. ssrn-528783 (Benjamin Liu article)
3. 5 September Email
4. 19 September Email
5. 24 September Email
6. 4 October Email
7. 13 October Email
8. HNZ00080943 Response Deaths from covid.pdf
9. covid-19-vaccination-claims-refresh-january-2005.pdf
10. Affidavit 23 May 2025.pdf
11. CV-ISMB-Final-Report-July-2023-For-Publication.pdf
12. Official_Records-COVID-19_Vaccine_Adverse_Events_SUMMARY.pdf
13. H2025073069 Response.pdf
14. fairweather-et-al-2023-covid-19-myocarditis-and-pericarditis.pdf