Comment submitted by

Steve Kirsch

Executive Director of the COVID-19 Early Treatment Fund
stk@treatearly.org

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I am the founder of the COVID-19 Early Treatment Fund (www.treatearly.org). Our work in funding early treatments for COVID was featured on *60 Minutes*.

I have been vaccinated and my entire family has been vaccinated.

However, shortly after I was fully vaccinated, I began to hear stories from my friends that were very troubling. For example, one friend had three relatives who were formerly healthy die after getting the vaccine. Another friend had a heart attack 2 minutes after the injection and is now disabled, apparently for life.

I assembled a team of over 19 doctors and scientists listed at the end of this comment to investigate the available evidence.

Using the VAERS database and other official government data sources from the US and around the world (covering 35% of the world's population), we found evidence that clearly demonstrates that the current vaccines are significantly more dangerous than has been previously believed.

Our most important findings include:

1. The "real world" fatality data from VAERS does not match the fatality data from the Phase 3 trials. They aren't even close. Using multiple independent methods, we estimate that over 150,000 Americans have already been killed (see Attachment 2). It is urgent to resolve this discrepancy as soon as possible as we strongly believe that the real world data is right and the vaccines should be immediately stopped.
2. None of the COVID vaccines reduce all-cause morbidity. It's the opposite: they all significantly increase all-cause morbidity by as much as 4.2 times baseline ($p<=0.00001$). The CDC must know this since this information is hiding in plain sight in the published literature. What is the point of offering an optional medical intervention which significantly increases all-cause morbidity when safer alternatives such as early treatment are available?
3. There is an error in the adverse event detection formula used by the CDC that appears to have prevented the CDC from seeing the safety signals that were obvious to our VAERS experts.

4. Early treatment and prophylaxis protocols are a superior option to the current vaccines, yet have been inexplicably ignored by the NIH:
    a. Higher relative risk reduction (over 99%)
    b. Greater safety (minor temporary side effects, known safety profile)
    c. They lower both all-cause mortality and all-cause morbidity
    d. They work equally well on all variants
    e. They do not promote escape variants
    f. They do not cause vaccine enhanced infectivity/replication
    g. They do not cause prion diseases
    h. They prevent long-haul COVID syndrome nearly 100% of the time
    i. They enable people to acquire recovered immunity which is both 13 times stronger and more durable than vaccine-induced immunity

We recommend the committee take the following actions:

1. Require autopsies for all deaths within 4 weeks of any COVID19 vaccination so that data is available to compute an estimate of the true all-cause mortality.
2. Make available the analysis of the 11,000 deaths investigation in VAERS for public inspection. It's important for the public to understand why the CDC couldn't attribute a single death to the vaccine whereas one of the world's top pathologists ascribed at least 30% of all deaths to the vaccine.
3. Explain publicly why there is a death peak on the second day after vaccination if the vaccinations are perfectly safe and not causing deaths.
4. Explain publicly why the severe adverse side effects are dose dependent
5. Publish the proper elevated event table (see Attachment 2. Page 17)
6. Publish your analysis of the VAERS data including the propensity to report factor and the under reporting factor for fatalities or serious events. Please show us the correct analysis showing that there are no excess deaths this year as has been claimed.
7. Meet with our team as soon as possible to assess the validity of the points above.
8. Fix the adverse event signal detection system so it can at least recognize all the serious adverse events identified in Attachment 2, page 17.
9. Review the VAERS multiplier used in the myocarditis analysis. It appears to be 1. That makes absolutely no sense to us. How was that justified?
10. Recommend that vaccine mandates should not be issued without evidence of a statistically significant all-cause morbidity decrease (which there is not in this case).
11. Define a COVID vaccine stopping condition after which that vaccine should be halted until the stopping issues are addressed. In 1976, the stopping threshold was 35 deaths.
12. Ask the CDC to engage with us in a public discussion on vaccination issues so the public can hear first hand from qualified experts on both sides. This is a more effective way to combat vaccine hesitancy than censorship.

If the meetings with our team result in the validation of our assertions, then the following actions should be considered:

1. Recommend that at least three classes of people should not be vaccinated and should use early treatment if infected:
    a. Previously infected
    b. Women who are pregnant or might soon become pregnant
    c. Anyone under age 50
2. Inform the public of the complete list of elevated risks and their rates for the COVID vaccines.

THE MECHANISM OF ACTION OF THE COVID VACCINES IS DIFFERENT FROM THAT OF TRADITIONAL VACCINES

Dr. Robert Malone has described the vaccine as causing a cytotoxic spike protein to be produced throughout the body for up to 48 hours, with the potential to cause blood clots, inflammation, and permanent scarring. In addition, the spike protein (particularly the S1 segment) could break free of the cell and freely circulate, causing damage which could lead to a very wide range of pulmonary, cardiovascular, and neurological events.

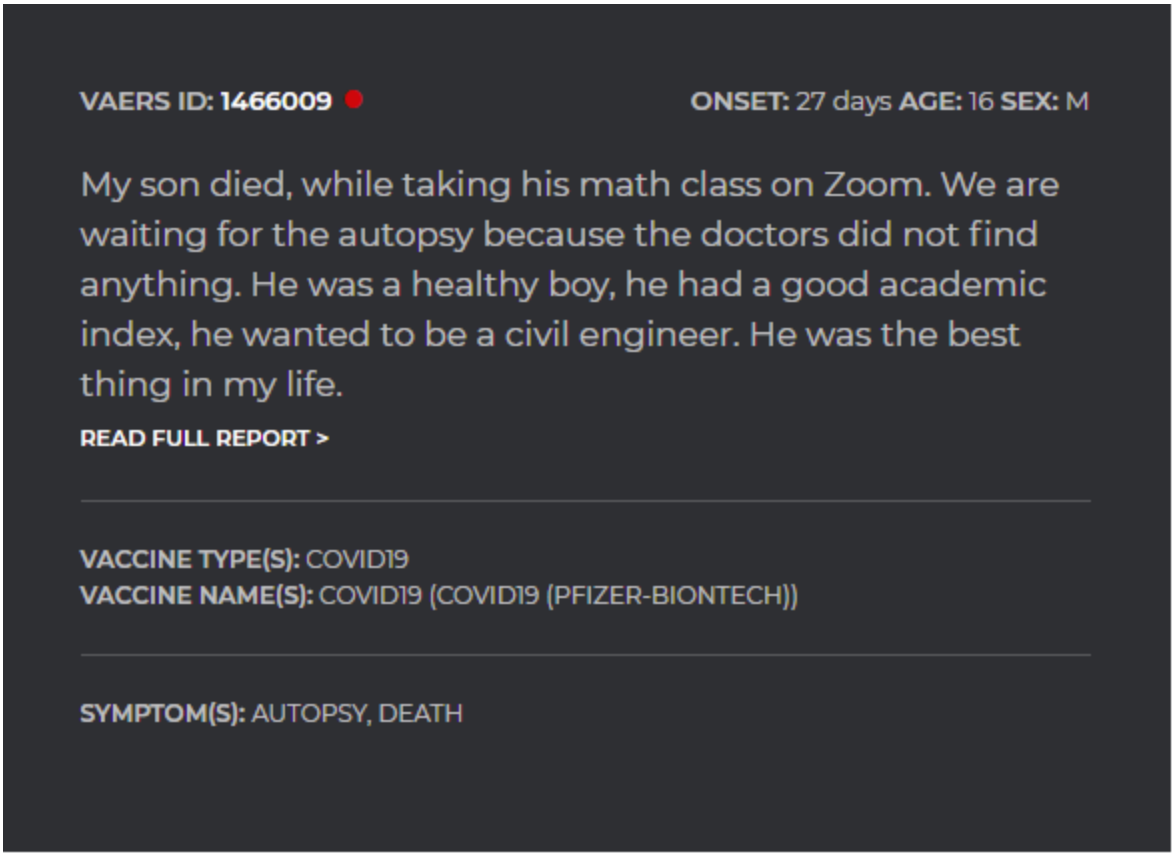
The gene-based vaccines (i.e., the 3 vaccines used in the US today) work in a completely different way than classical vaccines. With the latter, a fixed dose of killed or weakened pathogen or a toxin from the pathogen is injected and this sets a precise upper limit on how much foreign material is administered. In the former, while a fixed dose is also given, the upper limit of how much antigen is expressed depends on a series of steps each with substantial variability. This unavoidably greatly widens the range of amounts and concentrations of toxic spike protein in the body. Compounding this is the variability in anatomical distribution of the product with some body parts more prone to injury than others.

This built-in variability means that gene-based vaccines will likely always be much less safe than a classical vaccine. While the majority of people have no serious adverse events whatsoever, a significant number of people, perhaps in the millions, can be profoundly affected with one or more of a wide range of serious symptoms. Females are nearly 2.5 times as likely to be affected as males.

In particular, the VAERS data shows these symptoms include brain hemorrhages, strokes, heart attacks, multiple organ failure, pulmonary embolisms, and even sudden unexpected death.

A person can be perfectly normal and then just drop dead unexpectedly as the ACIP team already knows through their recent examination of the VAERS records of children 12-17 who died. For example, a 16 year old California student died unexpectedly in the middle of a Zoom math class. He had no prior health problems and appeared completely normal 20 minutes before his death.

If he didn't die from the vaccine, what did he die from? Can we see the autopsy report or is there a reason to keep it secret?



There is a partial list of the elevated symptoms identified by VAERS analysis in Attachment2, page 17.

Nearly every cardiovascular and neurological event occurred at a rate that was 10X or more than would be expected to be reported in a typical year by all of the vaccines in that year.

IT IS VITALLY IMPORTANT THAT ALL PHYSICIANS BE EDUCATED ON BOTH THE MECHANISM OF ACTION OF THE VACCINE AND THE RANGE OF SYMPTOMS THAT ARE BEING CAUSED ASAP BECAUSE IT IS COMPROMISING PATIENT CARE

Today, most doctors believe the vaccines are completely safe. There is virtually no knowledge of vaccine symptoms. This causes physicians to treat these symptoms as if they are caused by something other than the vaccine which results in treatments that are ineffective since they are not treating the underlying cause.

Maddie de Garay is a perfect example of this. She will pay the price of preventable misdiagnosis for the rest of her life because physicians were never informed that the vaccines could be causal for her symptoms; the doctors treated Maddie as if symptoms were all in her head.

Angela Wulbrecht who is a nurse at UCSF is another example. She was mistreated by the world's best experts. She only found relief when she consulted Dr. Bruce Patterson who

understood that the vaccines are deadly. She was able to get relief from her symptoms only when she was given drugs that targeted the vaccine damage.

Both of these people are public figures and are willing to speak out if you want to talk to them.

THE PROPER SAFETY TESTS WERE NEVER DONE

The FDA made the mistake of regulating the three COVID vaccines as a vaccine exclusively. As a result, the dose, duration, and amount of spike protein produced by these vaccines were never measured in advance of approval by the FDA.

Today, despite the evidence of unforeseen and unprecedented harm, these three critical parameters are still completely unknown.

Why haven't these tests been done in non-human primates with the actual vaccine?

THE D-DIMER AND CRP BIOMARKERS ARE A SMOKING GUN THAT THESE VACCINES ARE NOT SAFE

Even more concerning is that there has been no attempt to measure biomarkers that could clearly show that these vaccines are causing unexpected harm.

For example, measuring C-Reactive Protein and D-dimer of people before and after vaccination is a very simple experiment to show that the vaccines are causing problems.

Multiple researchers (contact us for the details) have done such a study in hundreds of patients and found that both biomarkers are elevated above normal levels for around three months in over 60% of patients.

This is very serious. It is a smoking gun that indicates that something is very wrong with these vaccines. For example, a 73 year-old female on her second dose had a D-dimer of 1186 ng/mL (normally it is less than 250 ng/mL) two weeks after the shot. **It remained above normal for three months.**

AN OVER-RELIANCE ON DELEGATED TRUST HAS MAGNIFIED SMALL ERRORS INTO LARGER ERRORS

We live in a world of delegated trust. But if the root of that trust makes a mistake, it creates a ripple effect where the consequences are magnified exponentially.

Our first example of amplified errors due to delegated trust is the safety signal detection of the VAERS database that John Su at the CDC has been monitoring.

The ACIP committee trusts the CDC staff to monitor VAERS. If there is a bug in the monitoring algorithm used by the CDC, the CDC will miss the critical safety signals and the ACIP

committee will not be alerted. ACIP members do not have the time or expertise to analyze the VAERS data themselves, as it is not a simple task, requiring many months of dedicated effort using specialized tools. If such a critical safety signal is missed by the CDC, there are immeasurable consequences and harm to the public.

When we looked at the VAERS database, we found dozens of very serious safety signals that the CDC failed to detect.

The attached analysis (see Attachment 2, page 17) shows that every neurological and cardiovascular event that we investigated was strongly elevated as compared to previous vaccines, most by at least 10X and some by as much as 473 times higher than what is normally expected in a typical year across all vaccines. This is impossible to explain if the COVID vaccines are perfectly safe.

We just received a similar analysis from a Professor in Israel which can be viewed at Attachment 3, in Table 1. For example, death is happening at a rate 91X higher than normal.

In addition, all of the neurological and cardiovascular symptoms with elevated event counts were consistent with the mechanism of action described at the start of this comment. Each and every symptom we looked at satisfies all the traditional Bradford-Hill causality criteria using both absolute rate elevation compared to baseline rates as well as Dose 1 vs. Dose 2 response disparities.

A BUG IN THE SAFETY SIGNAL ALGORITHM ALLOWS SAFETY SIGNALS TO ESCAPE DETECTION

Why was the CDC oblivious to these same signals? The answer: a bug in the algorithm used by the CDC. This bug only manifests itself when the vaccine being monitored produces a wider than normal range of side effects. This has not been the case with earlier vaccines which is why it wasn't detected earlier.

The bug in the safety signal algorithm is documented in this post: https://roundingtheearth.substack.com/p/defining-away-vaccine-safety-signals-572 (this is Part III, which contains links to Parts I and II). We would be happy to meet with CDC staff to go over this in detail.

WHY ARE YOU IGNORING PEOPLE WHO ARE TRYING TO HELP YOU SPOT SAFETY SIGNALS?

Repeated attempts to inform any ACIP committee member of this anomaly were unsuccessful. Considering that the ACIP committee is tasked with the critical monitoring of safety in the world's single most important drug, we are puzzled by the lack of interest in receiving safety

information from qualified researchers. We were directed to submit comments to a non-existent docket number.

Failing to get anyone on the ACIP committee to respond, we next attempted to communicate the signal error to the CBER group at the FDA. Not one person responded, including Dr. Steven A. Anderson and his staff, despite multiple emails and phone calls. Again, we are puzzled by the lack of interest in receiving safety information from qualified researchers. Dr. Anderson had said in a video call that he was the main person responsible for the safety monitoring.

Emails to both John Su and Anne M. Hause were also not responded to.

Perhaps the FDA and CDC should simply let people know that "**if you find an urgent safety problem, don't bother to contact us because we aren't interested in hearing what you have to say.**"

If this were more well known, it would have saved our time and yours.

MYTH BUSTED: "VAERS CANNOT BE USED TO SHOW CAUSALITY"

For the current COVID vaccines, our team is extremely confident that we can meet all the Bradford-Hill criteria for causality using VAERS analysis alone. Will our statisticians and VAERS experts be permitted to meet with any ACIP members to discuss the data?

For example, it is well established that a clear dose dependency relationship can be used to satisfy one of the Bradford-Hill criteria. Because two of the vaccines are multi-dose vaccines, a Dose 1/Dose 2 ratio analysis shows a very clear signal. Sadly, this type of analysis is currently being completely ignored by the CDC.

THE FDA HAS ASSUMED THAT VAERS WAS JUST OVER-REPORTED THIS YEAR

Our second example of amplified errors due to delegated trust is the calculation of the VAERS event counts.

A detailed analysis of the VAERS data (Attachment2 and Attachment3) both show that the FDA has made a very serious error in assuming (without any evidence whatsoever as far as we've been able to determine) that the propensity to report to VAERS is much higher this year and that these are simply all background events that can safely be ignored. The two analyses found the same thing and were done by different people, in different countries, who never met. The results were the same.

FDA FALSE STATEMENT: "DEATHS CAUSED BY THE VACCINE ARE EXTREMELY RARE"

In a letter dated August 23, 2021, Janet Woodcock writes to Senator Johnson, “Reports of death after COVID-19 vaccination that are found to be related, or even possibly related, to vaccination with COVID-19 vaccines have been extremely rare.”

Where are the 249 autopsies on which that statement was made? Has the committee reviewed all 249 autopsy reports?

We were able to prove causality using the Bradford-Hill criteria from just the VAERS data alone. We didn’t need the autopsies.

It was shocking to us that the CDC and FDA couldn’t find these signals despite access to 249 autopsy reports.

There is something seriously wrong here. You cannot have a few excess deaths from the vaccine when both the VAERS database itself and the data from other countries shows that there have to be 150,000 deaths. They both cannot be right. We think the CDC is mistaken because the death data we used to compute the 150,000 deaths comes from 35% of the world’s population. This error needs to be corrected as soon as possible.

SYMPTOM CODE FOR A VACCINE DEATH

What is the SYMPTOM code for a vaccine death? We looked at all the VAERS records with autopsies and we couldn’t find a single record with a coding for a COVID VACCINE DEATH.

OUR ANALYSIS SHOWS THAT IT IS HIGHLY LIKELY THAT OVER 150,000 PREVIOUSLY HEALTHY AMERICANS HAVE BEEN KILLED BY THE COVID VACCINES IN 2021

The analysis in Attachment 2 shows that 150,000 previously healthy vaccinated Americans have had their lives cut short prematurely due to the vaccines. We confirmed this number using independent methods from independent researchers. We used both US data and data from other countries. Our analysis used data from over 35% of the world’s population.

Our results are also consistent with reports from doctors we know who report that they have lost more patients to the vaccine than to COVID. For example, one doctor with 700 patients lost 2 patients to the vaccine and no patients to COVID. These doctors are special because they are “vaccine aware” and understand the mechanisms of action. In another case, one nursing home with 132 beds lost two patients within hours after vaccination.

Unfortunately, most doctors are blind to the association between the COVID vaccines and deaths and if asked, always report 0 vaccine deaths because they believe the narrative that the vaccines are “safe and effective.” Any deaths would be anecdotes and ascribed to some other cause. For example, when the fetus of a recently vaccinated pregnant woman had a massive

brain hemorrhage, the doctor considered the event caused by a “genetic defect.” The vaccine is never even considered as a possible cause.

As far as we know, not a single doctor in the US has determined that any deaths were caused by the COVID vaccines. There isn’t even a column in the CDC weekly report for deaths from the COVID vaccine. Apparently, it is impossible to die from the COVID vaccines if you live in the US.

However, a methodology based on excess death analysis (as detailed in Attachment 2) and autopsy results in other countries of people who died after getting the vaccine tells a completely different story: a story of a very deadly vaccine that has likely killed over 150,000 Americans so far.

It has been enormously frustrating to us that the CDC and FDA look the other way and have ignored all our attempts to share our analysis. That is not a good safety practice to ignore qualified people who disagree with you, especially when 150,000 lives are at stake. This is not serving the public interest. Safety must be a top priority at these agencies but when there are deaths from the vaccine, people are simply looking the other way and don’t want to hear it. This is why all our attempts to contact people were ignored.

If the CDC or FDA engages with us and finds an error in our analysis and can show evidence that no lives have been lost to the vaccine, then this would do wonders for reducing vaccine hesitancy. Conversely, if the CDC or FDA confirms we are correct, we can immediately stop future loss of life by aborting the vaccination campaign.

Whichever way it ends up, the clarity that happens when both sides engage in an open public discussion of the methods and evidence used will benefit all parties and the public.

THERE IS NO EVIDENCE ANYWHERE OF AN ALL-CAUSE MORBIDITY BENEFIT. WITHOUT THAT, DEPLOYING THESE VACCINES MAKES NO SENSE, ESPECIALLY SINCE SUPERIOR ALTERNATIVES ARE AVAILABLE

When a vaccine class is generating a huge number of adverse events in 8 months that are more than the events from all 70 vaccines over the past 30 years, it is reasonable to assume that there might be a significant safety problem with the vaccine.

In such a case, rather than focusing on the reduction of relative and absolute risk provided by the vaccine, it is instead more important to focus on whether there is a significant reduction in all-cause morbidity.

For the three vaccines, using data from the original clinical trials, it has been shown that in all cases, **the all-cause morbidity is significantly elevated by all the vaccines**. The elevation ranges from 1.5X to 4.2X. That is a **large move in the wrong direction.** It is **highly statistically significant** for all three vaccines. This of course is consistent with what we find in VAERS.

With respect to efficacy, nobody argues that the vaccines have saved people from dying from COVID. But the problem is that this benefit comes at a steep cost: an increase in death from other causes that completely negates the benefit of the reduction in COVID-related deaths.

But could an all-cause mortality benefit compensate for the higher all-cause morbidity? Our best data on that is the Pfizer 6-month study. A 50% reduction in COVID deaths was more than offset by a four times higher rate of cardiac arrest. As a result, the all cause mortality rate was higher in the treatment group than in the placebo group. This was true in **both** the pre-unblinding and post-unblinding phases. **The numbers were small but the point is that there is no demonstrable all-cause mortality benefit. Zero. If anything it was the other way around.**

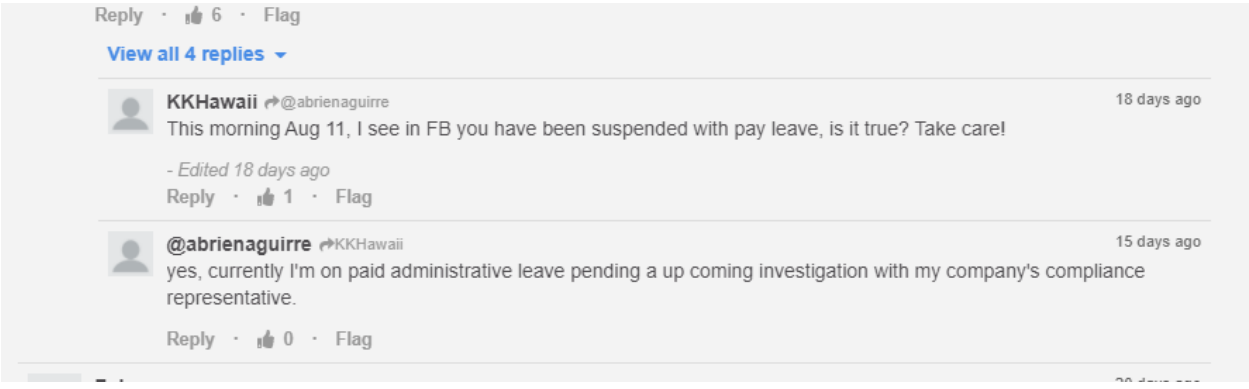
As evidenced by the high number of reported deaths to the VAERS system, it is the all-cause morbidity statistic that is the new elephant in the room. If you can't show a lower all-cause morbidity, there is no reason to vaccinate.

We also have troubling anecdotes like the nursing home with 132 beds where the residents are given the booster and two of them die within 24 hours. Or the Hawaii nursing home with 32 vaccine deaths vs. 16 COVID deaths. If it wasn't for one whistleblower, we'd never have known this because the nursing homes keep all this information secret so the public never knows about it.

The data, if confirmed, shows that the vaccines caused twice as many deaths as could have possibly been prevented even with a perfect vaccine.

Is this an inconvenient truth?

Was Abrien Aguirre lying or telling the truth? Read this:



In short, Aguirre basically put all his income on the line. For what? This suggests he was telling the truth. This needs to be investigated. Someone is not telling the truth.

For the three vaccines, using data from the original clinical trials, it has been shown in the peer-reviewed literature that in all cases, the all-cause morbidity is significantly elevated. The elevation ranges from 1.5X to 4.2X. That is a large move in the wrong direction. It is highly statistically significant for all three vaccines. This of course is consistent with what we find in VAERS.

CALCULATION OF REDUCED LIFESPAN

It is difficult to make a tradeoff between the elevated morbidity that reduces lifespan and the number of COVID deaths saved.

The COVID vaccines introduce both morbidity and mortality risks.

We believe that if we just look at the increased mortality due to the 1) direct deaths caused by the vaccine and 2) the reduction in total lifespan from all serious adverse events elevated by the vaccine, it would be clear that there is no mortality benefit.

We can see that from the Pfizer Phase 3 6 month study where more people in the treatment group died both pre- and post-unblinding. An the Hawaii nursing home data is consistent: there there was a 2:1 vaccine caused death:max possible vaccine saved death ratio which also supports stopping the vaccine.

Therefore, it seems likely to us that not only is there no morbidity benefit from the vaccines, but there is no all-cause mortality benefit from the vaccines either.

This makes the vaccines very hard to justify.

If we are wrong, we'd like to see the analysis.

WE ESTIMATE THAT APPROXIMATELY 574 KIDS HAVE BEEN KILLED BY THE VACCINE SO FAR; THAT'S MORE THAN HAVE DIED FROM COVID. WE ARE MAKING A HUGE MISTAKE. WE ARE KILLING OUR KIDS, NOT SAVING THEM.

The ACIP committee recently analyzed the cause of death of the 14 kids (aged 12 to 17) whose fatalities were recorded in the VAERS system. Had they had the table in the attached document, they would have realized that in every case (where there was sufficient symptom detail), the main cause of death was consistent with a symptom that was strongly elevated by the COVID19 vaccines. This should have led to a different outcome Mortality Among Teenagers Aged 12-19 Years: United States, 1999-2006 than simply listing the causes of death of the kids with no further discussion. No concern over the lack of autopsies was noted in the meeting notes. It is very likely that none of the kids had an autopsy done. There was no mention of this in the report.

We believe the lack of autopsies is a huge oversight for a vaccine that is generating so many legitimate adverse events. We believe it is imperative for the ACIP committee to immediately demand that autopsies be done. How many more kids must die before we look to find the real cause of death?

These children are dead now and their lives can never be recovered. But we can learn from their death if the ACIP committee members would simply read the 14 VAERS reports on each child and compare the cause of death with the symptoms listed in the table in the attached paper.

Five kids dying from cardiac arrest is not normal. Kids between 12 and 17 are twice as likely to die from cancer (6%) as from heart disease (3%). In this case, 38% died from heart disease and 0% died from cancer. That's statistically very unlikely. It points to the undeniable fact that these kids did not die of natural causes. Therefore, the hypothesis that the vaccines are safe seems highly unlikely. How does the ACIP panel explain this?

One of the children died with an intracranial hemorrhage. How could that have not raised a huge red flag. Kids that age never die from an intracranial hemorrhage.

We did a search in VAERS searching every record, over 70 vaccines over the last 30 years. There were only two deaths of kids aged 12-17 with "HAEMORRHAGE INTRACRANIAL" in the history of VAERS and both were associated with the recently approved Pfizer vaccine. There weren't any deaths caused by an intracranial hemorrhage in the entire history of VAERS in that age range until the COVID vaccines arrived on the scene. One event could be written off as a fluke--- very bad luck. But two events are a complete train wreck. How this didn't raise any red flags in the ACIP committee is a mystery to us.

As this note is being written the BBC News just reported that BBC presenter Lisa Shaw died of a brain haemorrhage. The coroner determined the cause was the COVID vaccine. All of the causal factors in her death were consistent with the elevated symptoms we found in VAERS. Note that the Astra-Zeneca vaccine has a nearly identical mechanism of action as the mRNA vaccines.

Each of the 14 children who died in the CDC study represents 41*14=574 real deaths (as noted in the attached paper). Thus, more American kids have already been killed by the COVID vaccines than have been killed in the entire history of COVID to date (361). That's tragic.

Two of the kids died from a pulmonary embolism, a symptom that is very strongly caused by the vaccines. Over 5 years in VAERS, you'll find just one PE death. So to get one PE death in a year, that's bad luck. To get two, you have to at least say that it's more likely than not that it wasn't just random. Yet the CDC report dismissed it without comment.

AN ACCURATE MYOCARDITIS COST-BENEFIT ANALYSIS IS MISSING

The CDC myocarditis cost-benefit analysis omitted the determination of the VAERS under-reporting factor for “mild” events.

While we think myocarditis is a serious event, the CDC characterizes these events as “mild” and thus would be less likely to be reported than something “severe” like death.

Therefore, we’d estimate that the VAERS under-reporting of such an event might be somewhere around a factor of 100.

My question to the panel is whether **a 100 times greater rate than the rate reported in the report would make a difference in the recommendation of the ACIP panel?** We would be very surprised if this doesn’t change the recommendation.

Also, as a sanity check on our results, please refer to Table 1 in Attachment3 which is Joshua Guetzkow’s analysis showing a 91-fold increase over baseline myocarditis rates.

Also, it would be good to estimate the effect of this heart damage **(and all other conditions elevated by the vaccines)** on expected lifespan so it is clear that the shortened lifespan is worth the savings in the amount of deaths. This way, we can do a pure mortality tradeoff.

For a lot of AEs, the quality adjusted life years (QALYs) is not significant. For young people, myocarditis represents an enormous QALY calculation. This will include some deaths, but most of a lifetime of a large range of reduction of life value.

For public health officials to discard the data without acknowledging something like a QALY comparison (and the deaths) is inappropriate.

TRUSTING THE PHASE 3 TRIAL RESULTS AS THE “GOLD STANDARD” IS NOT A GOOD IDEA

When there is a disagreement between real-world results and the Phase 3 clinical trial, we think it is better to trust reality. Here are some of our reasons:

1. The paralysis of Maddie de Garay was not reported in the Pfizer 12-15 year old clinical trial, and the FDA failed to investigate this case even though they knew about it. This is serious misconduct happening and nobody is holding the FDA accountable.
2. Adverse events were difficult to impossible to report (and Facebook conveniently removed the evidence of people complaining about that)
3. At least one death that happened didn’t show up. Who knows how many more?
4. The cohorts were not representative of the population as a whole (they were much healthier, e.g., rate of heart attacks was 10X lower than the overall population rate)

5. Five times as many people were disqualified from the treatment arm (311) compared to the control arm (61) for protocol violations even though the trial was supposed to be double blind.
6. Read this article on the Pfizer consent form. The consent form allows for participants who need emergency care and go straight to their doctor or hospital to be ejected from the study. But that's hardly the only problem.
7. Pfizer paid one of the largest criminal fines ever imposed on a drug company for the arthritis drug Bextra.
8. The company can't seem to find any safety signals even though it is obvious in VAERS.
9. **No autopsies to determine cause of death done in the treatment group**. This was a **very serious** oversight in our opinion.

THE LACK OF AUTOPSIES IS INEXPLICABLE

Autopsies are the gold standard for determining causality.

How can the CDC say confidently that there have only been a few deaths? May we see the 249 autopsies? If not why not?

In Germany, soon after the vaccines rolled out and deaths after vaccination started happening, the Federal Association of German Pathologists called upon the German authorities to require autopsies to validate the cause. Their requests were ignored presumably because nobody wants to know the answer.

In America, few people are asking for autopsies. And when they do, they are being denied

If we had the autopsies available, we wouldn't have to debate whether we are right or wrong about the numbers of deaths -- we'd have the data.

The Norwegian Medicines Agency linked 13 deaths to vaccine side effects. At the time that article was published, there were only 13 assessments completed. So in 100% of the cases, the deaths were deemed to be caused by the vaccine by the official government agency.

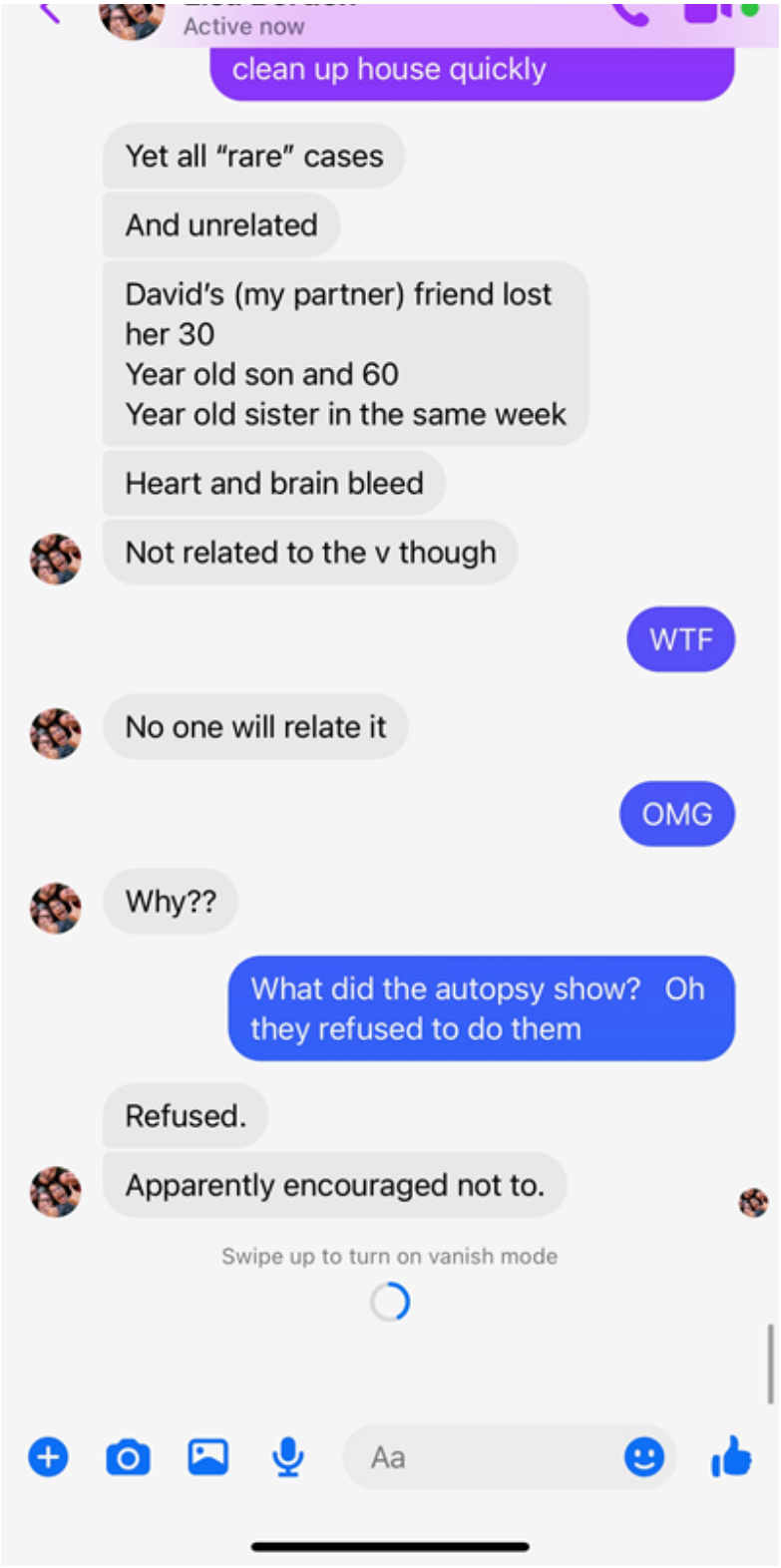
In Germany, they actually did autopsies of 40 people who died within 2 weeks after vaccination. They determined that at least 30% to 40% really did die from the vaccine. From Media Blackout: Renowned German Pathologist's Vaccine Autopsy Data is Shocking... and Being Censored:

> Dr. Peter Schirmacher is not just an average pathologist. The German doctor is world-renowned in his field, honored by The Pathologist as one of the 100 most influential in the world. He is the acting chairman of the German Society of Pathology, director of the Institute of Pathology at Heidelberg University Hospital, and president of the German Association for the Study of the Liver. Bottom line, this professor and doctor understands pathology like very few on the planet.

It is puzzling to us that nobody on the ACIP committee is calling for mandatory autopsies. Only 249 have been done on the 11,000 people who have died. It would be nice to know what they said.

Does ACIP think we should not have autopsies? I think it is important to clarify the committee's opinion on whether we should have the data on why people are dying after the vaccine or whether ACIP would rather have coroners look the other way.

Right now, it seems to be difficult to have an autopsy done, so if you want to gather the data, I think it is important to say something rather than remain silent on this issue.


Active now
clean up house quickly
Yet all “rare” cases
And unrelated
David’s (my partner) friend lost her 30
Year old son and 60
Year old sister in the same week
Heart and brain bleed
Not related to the v though
WTF
No one will relate it
OMG
Why??
What did the autopsy show? Oh they refused to do them
Refused.
Apparently encouraged not to.
Swipe up to turn on vanish mode
Aa

IT IS BECOMING CLEAR THAT THE VACCINES ARE RAPIDLY BECOMING LESS EFFECTIVE

As far as effectiveness, we believe the recent paper from a team of Japanese researchers, "The SARS-CoV-2 Delta variant is poised to acquire complete resistance to wild-type spike vaccines" shows that the vaccines we received will soon become completely useless to protect us and, to make matters worse, are already enhancing the ability of current variants to infect us through **vaccine enhanced infection and/or replication** (rather than "classical ADE" which so far appears not to be happening).

From the abstract:

> Although Pfizer-BioNTech BNT162b2-immune sera neutralized the Delta variant, when four common mutations were introduced into the receptor binding domain (RBD) of the Delta variant (Delta 4+), some BNT162b2-immune sera lost neutralizing activity and **enhanced the infectivity.**

In short, even if the vaccine were perfectly safe and killed no one, vaccinating with a non-sterilizing vaccine in the middle of a pandemic is going to have a net negative benefit, exactly as Geert Vanden Bossche has been trying to tell the world since shortly after the vaccination program began. He called it a very serious mistake. Nobody in power listened.

The latest UK government data (Briefing #20), shows you are 57% more likely to die if you get delta and you are vaccinated than if you are unvaccinated. The computation for age<50 and fully vaxed vs. unvaxed is 13/48*147612/25536=1.57 which is consistent with the Japanese paper.

Therefore, not only are the vaccines not safe, but they are quickly becoming useless and may shortly be a liability as far as effectiveness is concerned.

EARLY TREATMENTS HAVE ALWAYS BEEN THE SAFER, MORE EFFECTIVE OPTION

Meanwhile, early treatments have been virtually ignored by mainstream academia and the NIH. Lack of suitable guidance from the NIH has caused the entire world to avoid early treatments. These treatments are both extremely safe and very effective. They work against all variants as well. For example, the protocols used by George Fareed and Bryan Tyson against COVID continue to work well against COVID and with over 6,000 patients treated in an area with one of the highest CFRs in the country, it is very rare for a patient to be hospitalized for COVID in their clinic; it only happens if the patient presents late. They have more than a 99% relative risk reduction against all COVID variants if the patients get treated early. The NIH has expressed no interest in trying to replicate this success despite the tremendous lifesaving potential and negligible risk. They are more interested in waiting for a new, unproven drug from Merck for treatment.

EARLY TREATMENTS HAVE BEEN CENSORED. NOBODY IN MEDICINE SEEMS TO MIND.

One of the earliest pioneers of early treatment, George Fareed, is banned for life from YouTube for trying to spread life-saving treatment protocols that work..

The Nobel Prize winning inventor of ivermectin, Dr. Satoshi Omura, had his video on ivermectin for COVID blocked on YouTube.

Ivermectin has a peer-reviewed systematic review and meta-analysis, the highest level of evidence in evidence based medicine.

We find it troubling that so few in the medical community are speaking out about such abuses.

These individuals are giving life-saving advice and have been censored and there are dozens of examples of many others that have been censored, banned for life, and/or demonetized.

It would be interesting to hear the ACIP members speak out on this subject, either endorsing the censorship or condemning it. Remaining silent on such an important issue will not help advance science and save lives. Normally, ACIP shouldn't have to do this, but everyone else is remaining silent.

THE UK SAID THE VACCINE IS NOT RECOMMENDED FOR THOSE < 18 YEARS OLD

The UK panel said the data doesn't justify vaccination of those under 18

Jul 19: UK opts not to vaccinate most under 18 against COVID-19

Then they changed their minds just 2 weeks later:

Aug 4: UK to roll out COVID-19 vaccines to 16 and 17-year-olds

Did the science really change that quickly? What new things were learned? Or is science being driven by politics which would be a new low point. If there was new science, it would be useful for everyone to know what it was.

20% NEVER CAME BACK FOR A SECOND SHOT. WHY?

62% of Americans are fully vaccinated vs. 52% of single dose. So that's 20% (62/52=1.20) more vaccinated than unvaccinated.

Why is there such a large gap when in order to do anything (like keep your job, go to school, etc) you need to be fully vaccinated? We understand why people don't get vaccinated at all (they are well informed). But what's the reason for the 20% gap?

We know from user surveys that 3% of people who took the vaccine required treatment by a doctor. And 5% are still suffering from side effects. So that explains half of the gap. Basically 10% of people who got the vaccine had a large enough bad first experience, they aren't going back for a second shot.

We think that 15M injured Americans is a lot of people, but that's just our opinion. I think it would be helpful for the ACIP panel to note that 15M seriously injured people from the vaccine is a good tradeoff to make, especially in light of the lack of an all cause mortality benefit and a clear lack of all-cause morbidity benefit. That's a lot of people who have been injured for no proven net benefit (yes, COVID lives were saved, but it was an overall cost of lives).

SUMMARY

Analysis of multiple researchers using different sources confirms that the current COVID vaccines are very dangerous and are significantly increasing all-cause morbidity. The vaccines can trigger a wide range of serious neurological and cardiovascular symptoms, re-activate latent viruses, trigger flare-ups in people with cancer, and more. Multiple studies show 60% of patients have elevated D-dimers that persist for 3 months after vaccination. These vaccines should be immediately halted. If they cannot be halted, then it is imperative that we inform the American public of the risks. Children, pregnant women, and previously infected people should be instructed to avoid vaccination. All vaccine mandates should end immediately until there is scientific proof of an all-cause morbidity benefit.

Early treatment has always been a superior strategy for treating COVID: it is safer, more effective, and has a number of other important benefits.

Virtually none of the people diagnosed with COVID in the hospital today were treated early. That is the message we should be sending to America.

OUR TEAM OF EXPERTS

1. **Dr. Robert Malone**, widely recognized as the inventor of the mRNA vaccine. He immediately recognized the dangers of the current vaccines when the biodistribution data was revealed after a FOIA request. He was one of the first people to go on record warning the world about vaccine enhanced infection and replication.
2. **Dr. Geert Vanden Bossche**, one of the few virologists in the world to warn the world about vaccinating with a non-sterilizing vaccine against a virus capable of mutation in the middle of a pandemic.
3. **Dr. Byram Bridle,** a highly respected viral immunologist at University of Guelph, did the FOIA request that exposed the biodistribution data showing the vaccines do not stay at the injection site like people thought, but instead cause the production of a toxin in all parts of the body including the brain.

4. **Dr. Peter McCullough**, Professor of Medicine, is the author of over 1,000 peer reviewed publications, He serves as editor of two journals and sits on the editorial boards of multiple specialty journals.
5. **Dr. Ryan Cole,** one of the few pathologists who has been unafraid to speak out.
6. **Dr. Bret Weinstein** host of the DarkHorse podcast, expert in evolutionary biology.
7. **Dr. Chris Martenson,** pathologist and host of Peak Prosperity on YouTube. Chris's videos on YouTube are the most insightful videos about the virus and the vaccines.
8. **Dr. Pierre Kory** is our ivermectin expert, and one of our experts on early treatment.
9. **Dr. Paul Alexander** has expertise in the teaching of epidemiology (clinical epidemiology), evidence-based medicine, and research methodology. He is a former professor at McMaster University in evidence-based medicine; former COVID pandemic advisor to WHO-PAHO in Washington, D.C. (2020); and a former senior advisor on COVID pandemic policy at the U.S. government's Department of Health and Human Services (HHS) in Washington, D.C.
10. **Dr. Ira Bernstein**, a physician in Canada. Bernstein replicated Hoffe's D-dimer test which is extremely frightening.
11. **Dr. Jessica Rose** is an expert on the VAERS system. Her YouTube video on VAERS have never been challenged. She has a published paper on VAERS with several more on the way.
12. **Dr. Meryl Nass,** is a physician and VAERS expert.
13. **Dr. Sin Hang Lee,** an expert on DNA sequencing.
14. **Mathew Crawford**, is a mathematician and statistician who writes frequently about the pandemic including two articles on a serious CDC math error that no other person had noticed (Part I and Part II)
15. **Dr. Charles Hoffe**, is a physician in Canada.
16. **Marc Girardot**, is a member of PANDA. https://www.pandata.org/team/. PANDA is a politically and economically independent organization, focused on science-based explanations and tests them against international data. Marc has published extensively on the pandemic.
17. **Dr. George Fareed,** a physician in southern California who developed an extremely effective protocol for treating COVID-19 infections with a 99.76% risk reduction which is far more effective and safer than any vaccine
18. **Tyson Gabriel** is our mask expert. He produced this 1 hour instructional video. Nobody wants to challenge him to a debate on mask wearing.
19. **Stephanie Seneff**, senior research scientist at MIT. Although her field is computer science, she has an amazing breadth of knowledge in biology.