CLERK OF THE BOARD OF SUPERVISORS

EXHIBIT/DOCUMENT LOG

MEETING DATE & AGENDA NO. 08/16/2022 #21

STAFF DOCUMENTS (Numerical)

No.	Presented by:	Description:
1	County Staff	Powerpoint(10 pages)
2		
3		
4		

PUBLIC DOCUMENTS (Alphabetical)

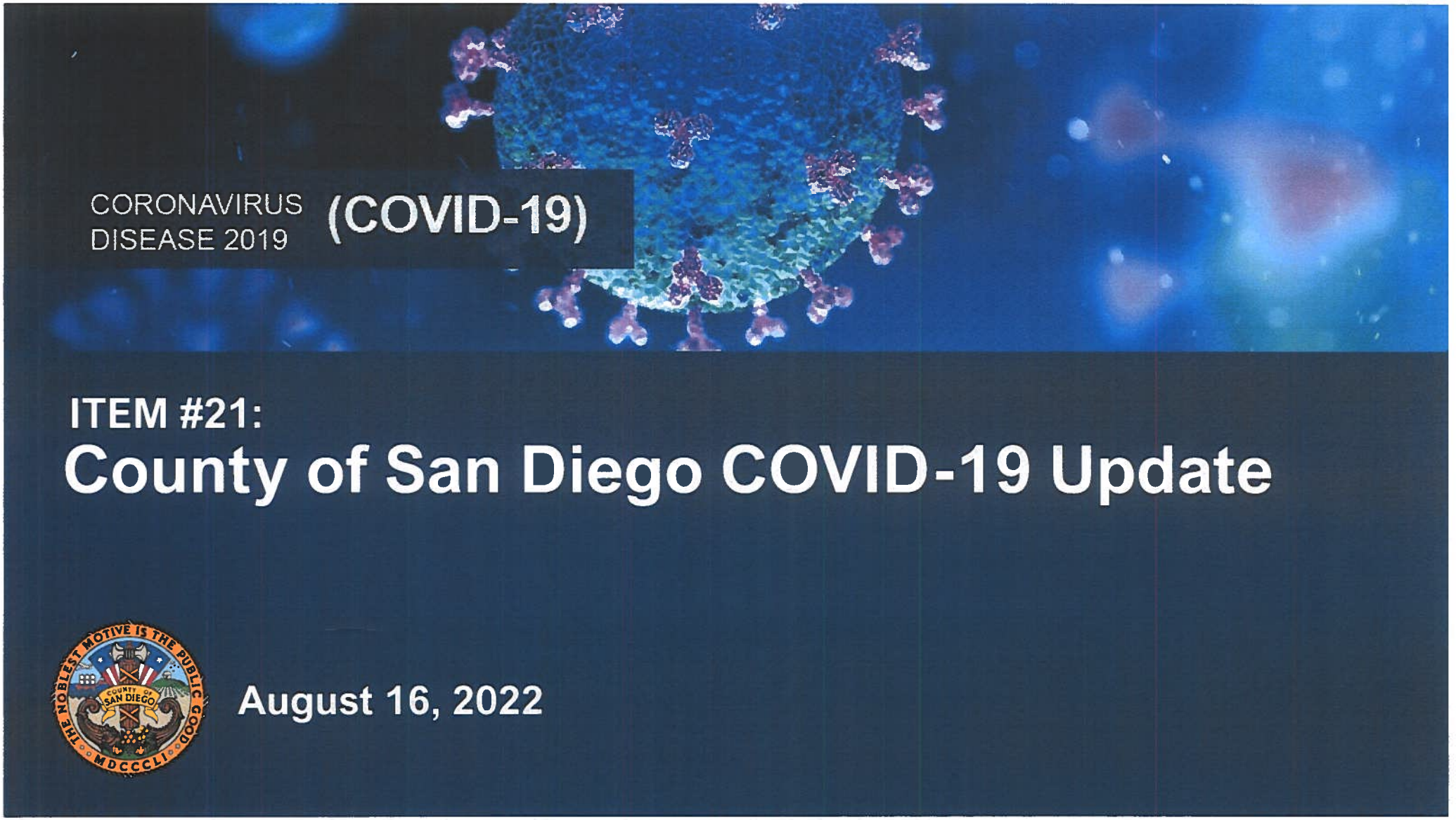
No.	Presented by:	Description:
A	Mike Borello	Vaccine Injury Report(112 pages)
B		
C		
D		
E		
F		
G		

OFFICIAL RECORD
Clerk of the Board of Supervisors
County of San Diego

Exhibit No. 1

Meeting Date: 8/16/22 **Agenda No.** 21

Presented by: County Staff, 10 pages



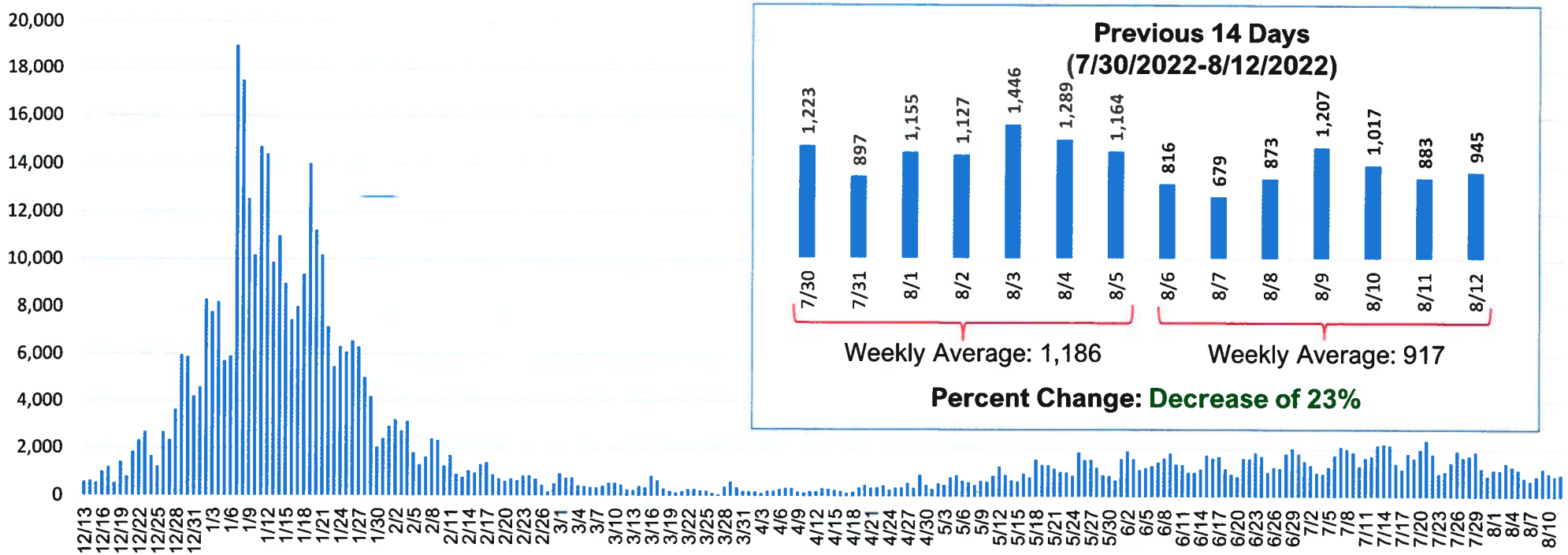
ITEM #21:

County of San Diego COVID-19 Update

August 16, 2022

COVID-19 Cases

COVID-19 Cases Among San Diego County Residents
New Cases by Date Reported Since December 15, 2021



*Includes backlog of cases that would have been reported 1/4/22-1/6/22.
**Due to issues with reporting systems, not all cases reported are included and was backlogged in subsequent day's reporting.
***The case count for 3/29/2022 includes a backlog of 457 cases from late December
Data through 8/12/2022
Updated 8/15/2022

Percent Change – One Month

Metric and Date Range	July 12, 2022	Metric and Date Range	August 12, 2022	% Difference
Case by Report Date (7-day average) 7/6/22 – 7/12/22	1,789	Case by Report Date (7-day average) 8/6/22 – 8/12/22	917	↓ 49%
Hospitalizations Census (7-day average, COVID-19 confirmed only) 7/6/22 – 7/12/22	368	Hospitalizations Census (7-day average, COVID-19 confirmed only) 8/6/22 – 8/12/22	346	↓ 6%
Deaths (7-day average, 14-day lag) 6/21/222-6/27/22	1	Deaths (7-day average, 14-day lag, data through 8/10/22) 7/21/22 – 7/27/22	2	↑ 100%

Data through 8/12/2022
Updated 8/15/2022

Percent Change – Two Weeks

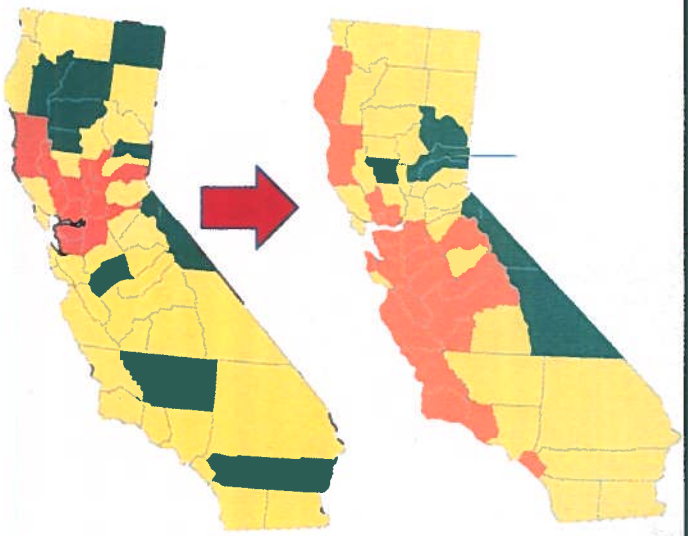
Metric and Date Range	July 30 – August 5	Metric and Date Range	August 6 – August 12	% Difference
Case by Report Date (7-day average)	1,186	Case by Report Date (7-day average)	917	↓ 23%
Hospitalizations Census (7-day average, COVID-19 confirmed only)	416	Hospitalizations Census (7-day average, COVID-19 confirmed only)	346	↓ 17%
Deaths (7-day average, 14-day lag, data through 8/10/22)	2	Deaths (7-day average, 14-day lag, data through 8/10/22)	2	No Change

Data through 8/12/2022, Updated 8/15/2022

CDC COVID-19 Community Levels

As of August 11, San Diego County = MEDIUM

June 13, 2022 August 11, 2022



COVID-19 Community Levels

Assignment Based on Highest Metric Among: 1) Case Rate, 2) New COVID-19 Hospital Admissions, and 3) Percent of Staffed Inpatient Beds Occupied by COVID-19 Patients

Community-level prevention strategies (as recommended by state or local authorities)

Low	Medium	High
Limited impact on healthcare system, low levels of severe disease	Some impact on healthcare system, more people with severe disease	High potential for healthcare system strain; high level of severe disease
• Administer vaccines with equity • Ensure access to testing • Community outreach and education	• Enhanced prevention measures in high-risk congregate settings • Protect people at high risk for severe illness or death by ensuring equitable access to vaccination, testing, treatment	• Consider setting-specific recommendations for prevention strategies based on local factors (indoor masking)

Data as of 8/9/2022. Data are preliminary and subject to change.
Source: CDC COVID-19 by County, https://www.cdc.gov/coronavirus/2019-ncov/your-health/covid-by-county.html, accessed 8/11/2022.

Vaccinations in San Diego County

Vaccination Status of San Diego County Residents

Doses Received	Doses Administered*
8,572,485	7,665,167

At Least One Dose	Fully Vaccinated**	Booster Dose***
Eligible Population (6 Months of Age or Older): 3,343,827 San Diegans		1st Booster Eligible Population^: 2,439,821 San Diegans 2nd Booster Eligible Population^^: 1,027,457 San Diegans
3,008,399	2,659,442	1,432,313 1st Booster / 277,757 2nd Booster
90.0%	79.5%	58.7% 1st Booster / 27.0% 2nd Booster

*May not include all administered doses and individuals vaccinated due to reporting delays. Total doses administered includes extra doses (booster doses and additional doses). Data sources include vaccines that have been recorded in SDIR and CAIR, and data provided by Veterans Affairs and Department of Defense. This includes doses from Federal Pharmacy Program and Federally Qualified Health Centers. Doses administered by some tribal providers, some prisons and federal detention facilities do not report to SDIR. Includes all doses administered in San Diego County as well as doses administered to San Diego County residents vaccinated in another California county.

**Fully Vaccinated is based on receiving either a single dose of Johnson & Johnson or both doses of Moderna or Pfizer, therefore completing the recommended vaccination series. However, individuals are not considered fully vaccinated until two weeks after completing the series, as defined by the Centers for Disease Control and Prevention (CDC).

***Booster doses includes only doses recorded in SDIR (excludes Veterans Affairs and Department of Defense).

^Booster Eligible Population is updated each week and is the number of San Diego County residents who are fully vaccinated and eligible to receive a booster dose. As of 1/26/2022, individuals are eligible for a booster dose if 1) they are 12 years of age and older, AND 2) at least 5 months have passed after the vaccination date of the second mRNA dose (Moderna or Pfizer-BioNTech) *or* at least 2 months have passed since the first Janssen/Johnson & Johnson dose.

^^Second booster eligibility is the number of San Diego County residents who received a first booster dose and are eligible to receive a second booster dose. Individuals are eligible for a second booster dose if:
1) they are 50 years of age and older AND 2) at least 4 months have passed after the vaccination date of the first booster dose AND 3) is an mRNA dose.

Eligible Population for the primary series (at least one dose and fully vaccinated categories) expanded to 6 months and older as of 6/17/2022. The Estimated eligible Population in San Diego County is 3,343,827 individuals, which is the total estimated San Diego County population as estimates are calculated by years. Population estimates are California Department of Finance 2021 Population Estimates, July 2021 release.
Data through 08/10/2022. Updated 8/12/2022

BE COVID SAFE

- Wash your hands
- Wear a mask
- If you have symptoms:
  - ➢ Stay home and get tested
  - ➢ Isolate according to CDC/CDPH guidance
- Follow current quarantine guidance
- Don't go to the emergency department for COVID-19 testing
- Get all recommended doses of the COVID-19 vaccine
- Get the influenza vaccine

www.coronavirus-sd.com

COVID-19 FINANCE UPDATE

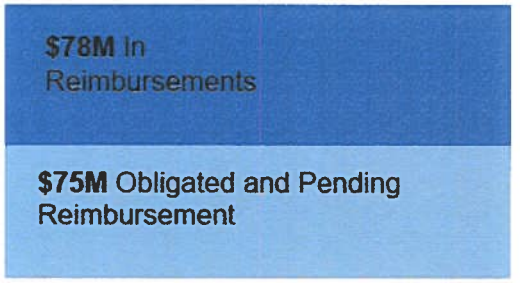
Spending Estimates for COVID-19 Response Effort (in Millions)

- **Vaccinations** **$0.2**
- **T3** **$1.3**
- **County Response** **$0.3**

$1.8 Million
Weekly Spend Rate

FEMA Reimbursement Progress

$404 million projected costs Through 6/30/2022



$153 million obligated, **$78 million** received

Recommendations

1. **Receive an update** on the COVID-19 response.
2. **Ratify all actions** taken in response to the local health emergency and local emergency.
3. **Authorize the acceptance** of $1,109,770 in additional funding to establish, expand, and sustain a public health workforce to support schools with COVID-19 and other school-age vaccinations.
4. **Adopt a resolution** entitled *Resolution Authorizing Continuance of Teleconferenced Public Meetings Pursuant to Government Code Section 54953.*

OFFICIAL RECORD
Clerk of the Board of Supervisors
County of San Diego

Exhibit No. A.

Meeting Date: 8/16/22 **Agenda No.** 21

Presented by: Mike Borrello, 112 pages

COVID-19 Vaccine Injury; a Compendium of Authoritative Resources

Prepared by: Mike Borrello[1]

Date: 16 August, 2022

Disclosure: *The information in this report is neither misinformation nor disinformation, nor is it intended to disparage beliefs or opinions of others. This report simply consolidates facts and information gathered from authoritative sources on the COVID-19 vaccines to provide a more complete and balanced perspective of COVID-19 vaccine harms.*

[1] Email contact: maborrello@roadrunner.com

Introduction

This report is intended to supplement information reported by San Diego County Health and Human Services (SD HHS) regarding the COVID-19 pandemic, particularly current information county health authorities do not address in their monthly COVID-19 report: **injuries and deaths associated with the COVID-19 vaccines**. SD HHS typically presents their report at the first monthly regular meeting of the County Board of Supervisors. County covid reports since the start of the pandemic have largely focused on: (1) "The number of COVID-19 cases" in San Diego County and (2) the percentage of population that has complied with vaccination programs. SD HHS has never offered any data or metrics addressing the safety, risks and efficacy of the vaccines within their jurisdiction nor any reports of injury or death caused by the vaccines – even if these number were determined to be zero. As a resident of the county, and one who has become actively involved in the pursuit of truth, I've personally encountered enough individuals that have been injured or likely killed by COVID-19 vaccines to convince myself of the reality the vaccines do cause harms that are not acknowledged by SD HHS nor the CDC. This report serves as one voice for many of the injured, and for those unfortunate few in SD, unknown names that died from vaccine side effects and their family and friends that continue to grieve their loss.

COVID-19 vaccinations began in December of 2020. After hundreds of millions of doses, there is now solid evidence from published, peer reviewed studies in well-respected scientific and medical journals: the COVID-19 vaccines have indeed caused injury and death, and in significant and unprecedented numbers. Numbers that, from prior FDA policies, would have normally called for immediate recall followed by a full blown investigation. But the federal government and public health continues on a misguided, if not ethically and morally corrupt mission to perpetuate a universal state of emergency when there is no emergency, and to continue vaccinating the entire American populace come hell or high water. Vaccination with a vaccine that clearly 'wanes' over several months' time, one that was designed to target a now extinct variant of the virus, and one that now has negative efficacy [2]. The COVID-19 pandemic and in particular the response by Public Health will turn out to be the largest health disaster in world history.

Summary of Changes in the Report for August

The vaccine injury report starts on page 7. All categorical and specific adverse events continue to increase as vaccine doses have exceeded 610 million in the USA with the most significant increases being inflammatory, thrombogenic or neurogenic in origin. This month's reported deaths associated with the vaccines now exceed 30,000. But at the same time, the rate of vaccine injury and death seems to be tapering off which, despite the approval of vaccines and boosters for very young children, is consistent with the decreasing rate of vaccine doses given. It seems for all of the CDC, FDA's effort most parents do not want to vaccinate their child.

While many specific adverse event categories added additional publications, there was only one new category added:

COVID-19 Vaccines Swamp Side Effects involving Cancer over all vaccines for all time
The occurrence of cancer after COVID-19 vaccination is unprecedented. For all vaccines over all time, the COVID-19 vaccines account for 80% of cancers associated with vaccination. See item (33.) in the report for full details.

When Public Health continues to promote and encourage the use of COVID-19 vaccines and condone mandates, it can no longer claim the role as the guardian society's health. Today the word 'Public Health' has become a contender in the dictionary of 1984 Double Speak. Public Health no longer compliments but rather contradicts and interferes with the institutions of established medical practice. It no longer offers any promise of health. The HHS become an institution of Public Harm: the **Department of Harm and Human Sacrifice**. HHS is a juggernaut, born from corruption and the paid henchman for the corporate policy of greed and profit.

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[2] https://dailysceptic.org/2022/03/20/vaccine-effectiveness-hits-as-low-as-minus-300-as-ukhsa-announces-it-will-no-longer-publish-the-data/

2022, the Year of Recompense

It appears the tide has finally turned. People are resisting the vaccines after now personally witnessing family and friend that have either suffered or died. There are a handful promoting that "2022 will be the year of recompense"[3]

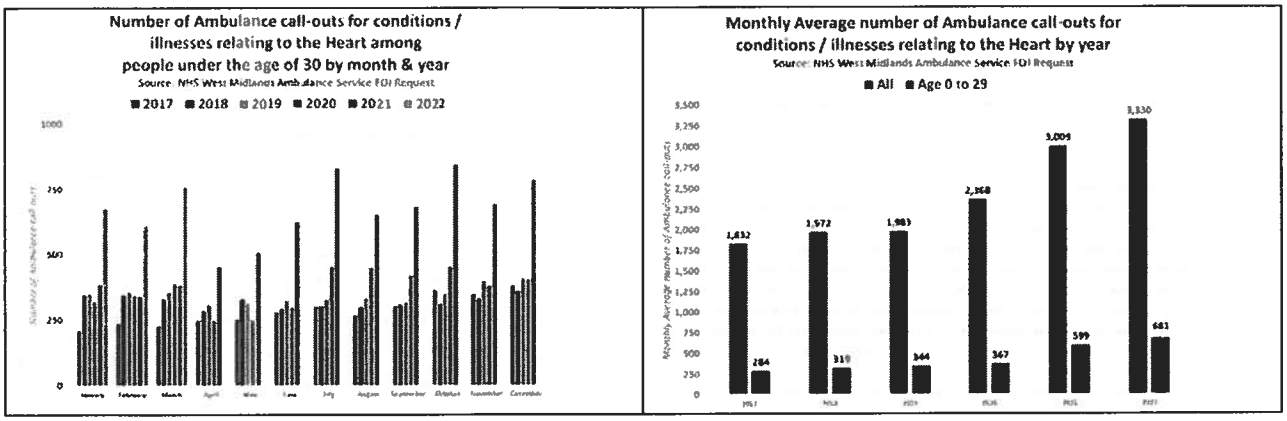
> *– IT SHALL BE THE YEAR OF RECOMPENCES FOR THE CONTROVERSY OF ZION. Though God may suffer the enemies of His people to prevail against them very far, and for a long time, yet He will call them to an account for it, and will lead those captive that led His people captive.*[4]

Those that have sought to bring forth truth will be well rewarded, and those that have continued to choose to hide truth will receive their just rewards. Everyone will be paid in a recompensatory manner.

PfizerGate

Early this year, FOIA's and a subsequent court order[5] revealed egregious management pf Pfizer's phase 3 trials. 1200 died. But it's not over. Just yesterday, August 15, 2022 The Exposé reported the headline: ***PfizerGate: Official Government Reports prove Hundreds of Thousands of People are dying every single week due to Covid-19 Vaccination***[6]. Prediction models had failed at determining infections at start of the plandemic early in 2020, and through the year up to when vaccines were deployed. Hospitals were nowhere near capacity as these models predicted. But now it seems those predictions are coming true, at least in the UK. But the deaths are not directly due to covid infection but rather suppressed immune systems. Most of those hospitalized are the *well vaccinated.* Here is what the UK is presently facing:

- Hospitals are being overrun by patients.
- Waiting times for ambulances are at an all-time high.
- The number of emergency calls due to people suffering cardiac arrest is at an all-time high.
- The number of people dying is at an all-time high
- Hundreds of thousands of excess deaths[7] are occurring around the world every single week.



The Exposé basically issued an indictment on Public Health and their Government sponsors for gross mismanagement, death and harm to society. It's the year of recompense. Time to pay up. The Exhibits of indictment include:

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[3] Tore Maras
[4] Bible:Sermons:Joel 3:1
[5] https://www.reuters.com/legal/government/wait-what-fda-wants-55-years-process-foia-request-over-vaccine-data-2021-11-18/
[6] https://expose-news.com/2022/08/14/gov-reports-prove-hundreds-thousands-dying-covid-vaccine/
[7] Rancourt, D.G, et al., 2022-08-02 ::: COVID-Period Mass Vaccination Campaign and Public Health Disaster in the USA

- Exhibit A: The Healthcare System is overwhelmed
- Exhibit B: Covid-19 Vaccination can damage the heart; that is a FACT
- Exhibit C: Hundreds of thousands of Excess Deaths are being recorded every week
- Exhibit D: Mortality Rates are lowest among the Unvaccinated in all age-groups
- Exhibit E: 1 in every 246 Vaccinated People died within 60 Days of Covid-19 Vaccination
- Exhibit F: COVID-19 Vaccines are at least a shocking 7,402% deadlier than all other Vaccines combined
- Exhibit G: Athlete Deaths are 1700% higher than expected since the COVID Vaccine roll-out
- Closing Arguments: The data doesn't lie

The trajectory of this indictment, forged by truth, and based on data and logical analyses.

NIH and Pharma Block Publication of Key Paper on the Effects of the COVID-19 Vaccine on Women's Health

During the deployment of COVID-10 vaccines many obstetricians recommended that their pregnant patients receive the vaccine. They assured them mother and child would be safe; that any risks the vaccine might impose were minor compared to what a covid infection might lead too. Like many these doctors parroted the public health mantra: "the benefits outweigh the risks". But time and truth have a way of shattering delusions, ignorance or malfeasance. It turns out these doctors were putting their patients at far greater risk by encouraging vaccines. But it wasn't all the doctor's fault. If they themselves couldn't muster a little common sense or raise an ounce of skeptical doubt, the public health institutions sure didn't make it any easier. In his very recent blog[8], Dr. Ah Kan Syed, aka Arkmedic presents evidence of fraud, collusion and conspiracy committed by the NIH and Pharma to intentionally block a publications that appeared in October of 2021 that might have led these doctors to opposite opinions.

Syed further argues we are now looking at a generation of women having received vaccines that could be at significant risk of ovarian & breast cancer. He cites the Jiang Paper:

viruses

MDPI

Article

SARS-CoV-2 Spike Impairs DNA Damage Repair and Inhibits V(D)J Recombination In Vitro

Hui Jiang [1,2,*] and Ya-Fang Mei [2,*]

[1] Department of Molecular Biosciences, The Wenner-Gren Institute, Stockholm University, SE-10691 Stockholm, Sweden
[2] Department of Clinical Microbiology, Virology, Umeå University, SE-90185 Umeå, Sweden
* Correspondence: hui.jiang@su.se (H.J.); ya-fang.mei@umu.se (Y.-F.M.)

Dr. Syed explains that the harms these women will suffer will be mediated through lymphadenopathy and caused by residual mRNA and spike protein from the vaccines. These residuals are not flushed from the body as originally reported by pharma, but rather many days if not months after vaccine injection. The incidence of lymphdenopathy and lymhadenitis are now included in this vaccine injury report and events have increased. Recall that immunosuppression not only opens the patient to infection; - it's an essential mechanism in the process of gene repair and prevention of p53-dependent ovarian and breast cancer.

[8] Dr Ah Kan Syed, Welcome to Gilead, Arkmedic's blog, July 30, 2022

CDC Malfeasance

The CDC is not only corrupt. It has no integrity. (Yes you can be corrupt and have integrity). Up till July 21, 2022, the CDC had published on their website[9]:

> The mRNA and the spike protein do not last long in the body.
>
> - Our cells break down mRNA from these vaccines and get rid of it within a few days after vaccination.
> - Scientists estimate that the spike protein, like other proteins our bodies create, may stay in the body up to a few weeks.

But after July 21 it was quietly removed without notice.

Archive Link: https://web.archive.org/web/20220721092000/https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html

Link Today: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html

BMJ Editor Reports Fraudulent Medical Research Rampant:

The BMJ is a once respected weekly peer-reviewed medical trade journal, published by the trade union of the British Medical Association. The BMJ has editorial freedom from the BMA. It is one of the world's oldest general medical journals. On July 5, 2021 Richard Smith, former editor of the BMJ, published an opinion: *Time to assume that health research is fraudulent until proven otherwise?*[10] Concluding remarks included:

"Everybody gains from the publication game, ... apart from the patients who suffer from being given treatments based on fraudulent data."

Smith mentioned Stephen Lock his predecessor was worried about research fraud in the 1980s, *..." and that people thought his concerns eccentric. Research authorities insisted that fraud was rare, [and] didn't matter because science was self-correcting, and that no patients had suffered because of scientific fraud. All those reasons for not taking research fraud seriously have proved to be false, and, 40 years on from Lock's concerns, we are realising that the problem is huge, the system encourages fraud, and we have no adequate way to respond. It may be time to move from assuming that research has been honestly conducted and reported to assuming it to be untrustworthy until there is some evidence to the contrary."*

CDC Admits Giving False Information on Vaccine Surveillance[11]

On August 11 the EPOCH Times reported the CDC had either lied or by sheer incompetence reported having performed vaccine surveillance of the covid-19 vaccines when in fact it had not. The CDC claimed that prior to October of 2021 they had not conducted any analysis associating myocarditis with mRNA COVID-19 vaccines. But that was wrong. They knew about it at least from reports the military sent them - but did nothing to investigate. Further culmination of information revealed that the CDC simply was not analyzing VAERS data since the COVID-19 vaccination program

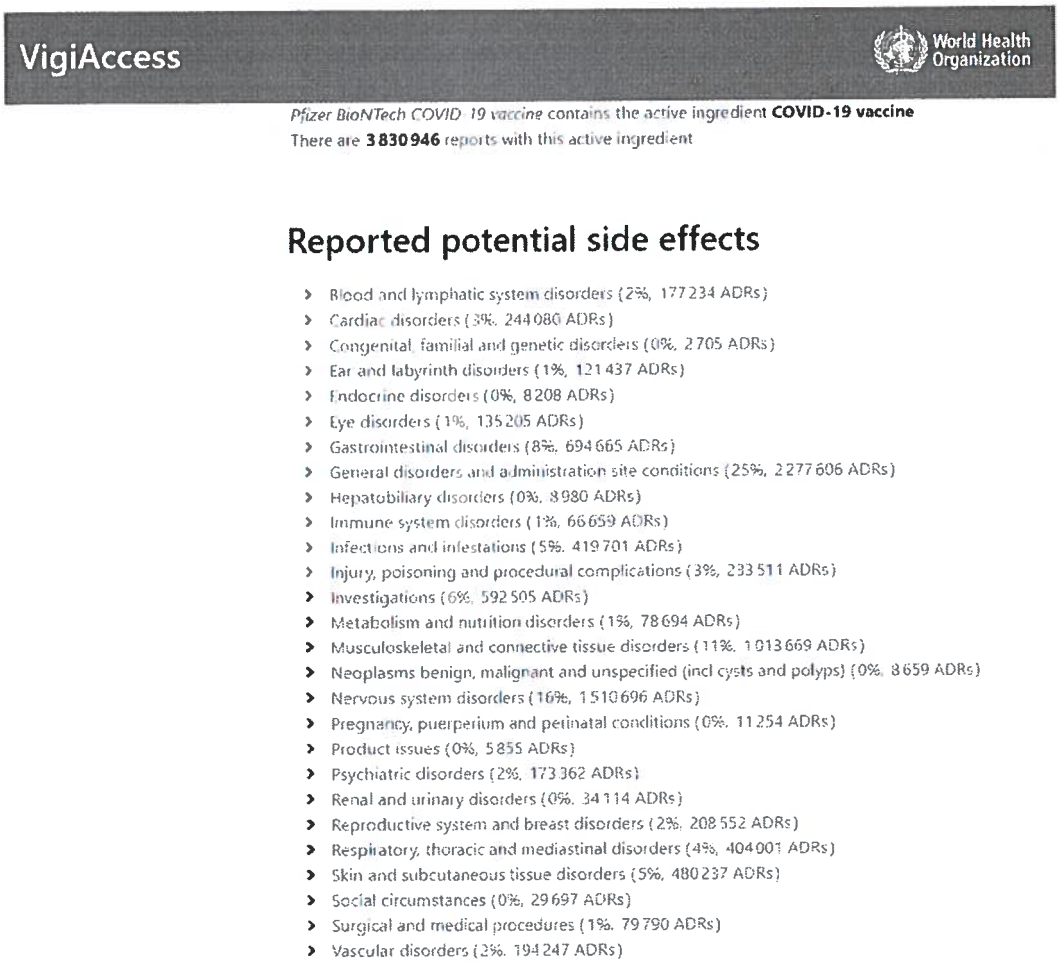
[9] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html
[10] https://blogs.bmj.com/bmj/2021/07/05/time-to-assume-that-health-research-is-fraudulent-until-proved-otherwise/
[11] https://www.theepochtimes.com/exclusive-cdc-admits-it-gave-false-information-about-covid-19-vaccine-surveillance_4657836.html

started. Their job was to look for early warning safety signals. This explains the incredulous disagreement in what independent researchers have been observing from VAERS and what the CDC and HHS denied existed.

Online tools, resources in researching vaccine injury outside of VAERS

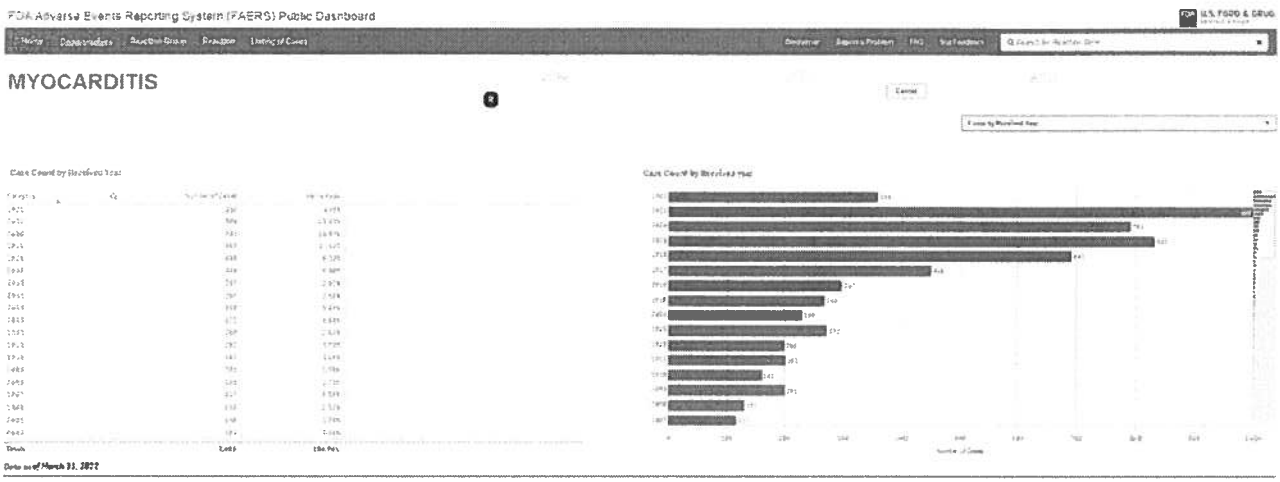
Vigiaccess

Public access site: VigiAccess https://vigiaccess.org/
VigiAccess is maintained by the World Health Organization and providing global scale access to adverse event reports for all medications including specific COVID-19 vaccines. It is very limited regarding detailed case information demographics, etc. only the numbers of events, at least on the public site. Only numbers and percentages are given in drop down categorized adverse events that are sorted according to highest incidence. An example of the search: covid-19 vaccines Pfizer is shown below.



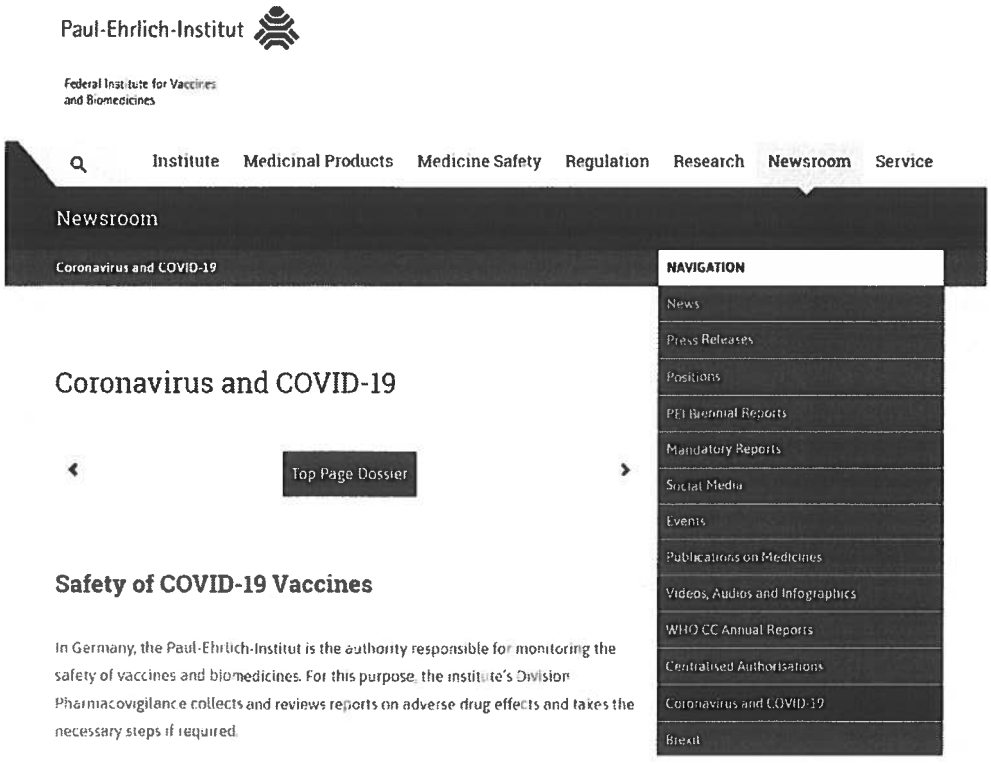
FAERS

FDA Adverse Event Reporting System (FAERS) https://www.fda.gov/drugs/questions-and-answers-fdas-adverse-event-reporting-system-faers/fda-adverse-event-reporting-system-faers-public-dashboard is another resource for all medications, maintained by the FDA. The advantage in FAERS is being able to associate. FAERS allows search by reaction.



Paul- Ehrlich-Institute

Germany's surveillance webpage for covid-19 vaccines. Reports only; no raw data: https://www.pei.de/EN/newsroom/dossier/coronavirus/coronavirus-content.html?nn=164146&cms_pos=6



On August 15, 2022, by
Mike Borrello

"The evil that men do lives after them; the good is oft interrèd with their bones" Mark Antony in Julius Caesar

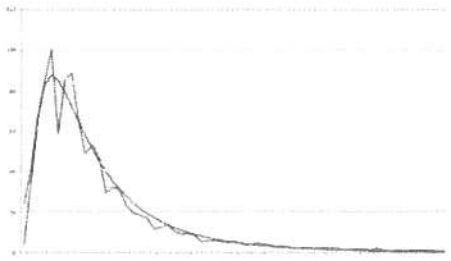
COVID 19 VACCINES INJURY REPORT, Mike Borrello August 15, 2022

1. United States Department of Health and Human Services (DHHS), Public Health Service (PHS), Centers for Disease Control (CDC) / Food and Drug Administration (FDA), Vaccine Adverse Event Reporting System (VAERS) 1990 - 08/05/2022, CDC WONDER On-line Database. Accessed at http://wonder.cdc.gov/vaers.html on Aug 15, 2022 6:45:24 AM

Common to all VAERS queries herein and unless otherwise specified: (1) All US COVID19 vaccines including Pfizer, Moderna & Jenssen, (2) All locations under jurisdiction of VAERS reporting, and (3) Onset interval of event relative to vaccine administration. Unless otherwise noted in the following reported data, percentage of events relative to the onset interval of 2 days is used as a basis for temporal correlation. Temporal correlation, if present, usually has structure. The structure for pharmacodynamics involving the occurrence of a discrete event (in this case vaccine reaction) is typically exponential in nature. Hickey and Rancourt explain in a paper[12] they co-authored; briefly:

> *The other important discovery is what the researchers refer to as "decay time." That is the time in which the risk of an adverse event "decays," or decreases. While there was a very high peak for adverse reactions found within the first five days post injection, that risk then persists before decreasing by about half approximately every two weeks (Figure S5). However, this phenomenon was still measurable up to 60 days post injection. "The fact that this is tied to the time since the injection, and not time alone, proves that this is due to the injection – it proves a causal relationship. If it were just accidental, if people just happened to die within those 60 days, then you would not get that decay of probability, it would be uniform," says Dr. Rancourt.*
>
> *Dr. Rancourt notes that he and Dr. Hickey are the first to show this exponential decay. "It's robust in that it happens to every adverse event [in the VAERS dataset] and it's consistent across all three manufacturers so it's a common feature seen across the data."*

By 'uniform' Rancourt means that the number of adverse events over time, on the average would be flat. Flatness would indicate independence of the event from vaccine injection, so definitely not causation. But that's not what we see in this data. Rancourt and Hickey suggest a suitable model as 'exponential', but considering that events cannot happen 'instantaneously' a more practical model might rather be a temporal Weibull model.



Weibull model fit to pharmacodynamic response

[12] Nature of the toxicity of the COVID-19 vaccines in the USA

VAERS presently does not provide query of adverse events at the county level; the finest resolution is at state level. The figures in this report as noted above, and unless otherwise specified address all locations to more easily provide comparison with the number of doses of vaccine across the nation.

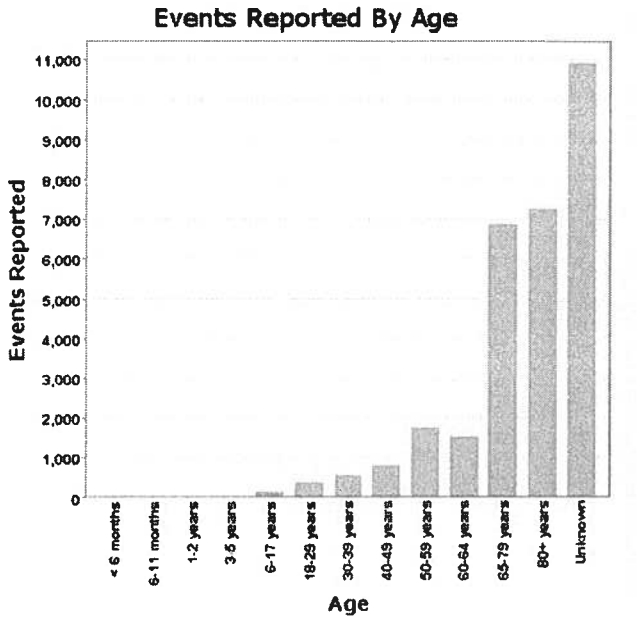
The covid-19 vaccines collectively account for more than 82% of deaths reported in VAERS for ALL the vaccines combined over the 30 year period VAERS has been in existence. But covid-19 vaccines have only been in existence for not even 2 years. Neither the FDA, CDC, NIH nor any Public Health Agency, nationally or locally has bothered to address this elephant in the room - one of MANY elephants surrounding the COVID-19 vaccines.

Vaccine	Events Reported	Percent (of 39,772)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	21,037	52.89%
COVID19 (COVID19 (MODERNA)) (1201)	9,189	23.10%
COVID19 (COVID19 (JANSSEN)) (1203)	2,630	6.61%
PNEUMO (PREVNAR13) (1141)	989	2.49%
PNEUMO (PREVNAR) (1001)	980	2.46%
POLIO VIRUS, ORAL (ORIMUNE) (17)	790	1.99%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	772	1.94%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	677	1.70%
HIB (ACTHIB) (256)	611	1.54%
HIB (HIBTITER) (35)	591	1.49%
DTP (NO BRAND NAME) (2)	567	1.43%
HEP B (ENGERIX-B) (38)	542	1.36%
ROTAVIRUS (ROTATEQ) (1096)	511	1.28%
HEP B (RECOMBIVAX HB) (25)	470	1.18%
PNEUMO (PNEUMOVAX) (30)	441	1.11%
DTAP + HEPB + IPV (PEDIARIX) (1082)	417	1.05%
HPV (GARDASIL) (1098)	387	0.97%
DTAP (INFANRIX) (286)	359	0.90%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	352	0.89%
INFLUENZA (SEASONAL) (FLUZONE) (7)	350	0.88%
POLIO VIRUS, INACT. (POLIOVAX) (9)	329	0.83%
DTP (TRI-IMMUNOL) (22)	313	0.79%
HEP B (NO BRAND NAME) (110)	313	0.79%
ROTAVIRUS (ROTARIX) (1124)	311	0.78%
HIB (PEDVAXHIB) (129)	298	0.75%
POLIO VIRUS, INACT. (NO BRAND NAME) (232)	269	0.68%
POLIO VIRUS, INACT. (IPOL) (1030)	268	0.67%
POLIO VIRUS, ORAL (NO BRAND NAME) (118)	255	0.64%
DTAP + IPV + HIB (PENTACEL) (1125)	234	0.59%
DTP + HIB (TETRAMUNE) (250)	220	0.55%
DTAP (TRIPEDIA) (242)	205	0.52%
HIB + HEP B (COMVAX) (287)	196	0.49%
ZOSTER LIVE (ZOSTAVAX) (1097)	187	0.47%
COVID19 (COVID19 (UNKNOWN)) (1202)	182	0.46%
DTAP+IPV+HEPB+HIB (INFANRIX HEXA) (1139)	178	0.45%
VARICELLA (VARIVAX) (269)	178	0.45%
HPV (NO BRAND NAME) (1102)	172	0.43%
HIB (NO BRAND NAME) (111)	161	0.40%
DENGUE TETRAVALENT (DENGVAXIA) (1195)	151	0.38%
PNEUMO (NO BRAND NAME) (120)	140	0.35%
DTAP (DAPTACEL) (1064)	137	0.34%
INFLUENZA (SEASONAL) (TIV DRESDEN) (1186)	118	0.30%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	115	0.29%
ZOSTER (SHINGRIX) (1192)	113	0.28%
DTAP (NO BRAND NAME) (258)	110	0.28%
RABIES (NO BRAND NAME) (57)	105	0.26%
HIB (HIBERIX) (916)	90	0.23%
MENINGOCOCCAL (NO BRAND NAME) (113)	89	0.22%
BCG (NO BRAND NAME) (102)	86	0.22%
MEASLES + MUMPS + RUBELLA (NO BRAND NAME) (114)	84	0.21%

Many of the VAERS queries reported herein were further substantiated by separate research from peer reviewed online medical and scientific journals. These studies provide further observations, analysis and evidence of the presence and significance of these adverse events from clinical experts. This report is a work

in progress as the VAERS numbers will be updated monthly, and new citations added as publications are brought to my attention.

2. **Number of deaths associated with the three COVID-19 vaccines: 30,162;** 27% of these deaths occurred within 2 days after injection. Of these reported deaths, **628** have been reported having occurred in California. Given that San Diego is the 2nd largest populated county among 58 counties in California, the likelihood is that some of those deaths were reported within San Diego. But County HHS does not report this number. From VAERS, the number of deaths, all locations according to age groups are plotted below on the left, where age data was available.



Reported deaths all COVID-19 vaccines, all locations

3. According to the CDC (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html) as of August 15, 2022 about 606 million doses of the COVID -19 vaccines have been administered over a period of about 20 months. This includes 1st, 2nd, & booster.

4. For the 14 seasonal influenza vaccines, there have been about 3.3 billion doses administered over 32 years[13]. For these vaccines, the reported deaths number much lower than the deaths from influenza vaccines: reporting a much lower death count: **2,204** deaths.

Contrasting the numbers: covid vs the 14 flu vaccines:

COVID-19	vs	FLU	
30,162	**vs**	**2,204**	**deaths**
0.61	**vs**	**3.3**	**billion doses**
1.7	**vs**	**32**	**years**
50	**vs**	**< 1**	**deaths/million doses**

[13] https://www.cdc.gov/flu/prevent/vaccine-supply-historical.htm

So the COVID-19 vaccines are more than 50 times deadlier than the influenza vaccines.

5. It's believed by at least several researchers that adverse events reported in VAERS are severely under-reported. This position is well justified because of the dearth of information that would otherwise provide evidence of reporting compliance. While the CDC mandates reporting of vaccine associated deaths, there's no apparent system for enforcing or monitoring. Many suggest that reported numbers could only represent 1% of actual adverse events whether the reporter, for some reason, fails to report the event believing there is a connection between the vaccine and the event or else failing to make any connection. Healthcare providers and manufacturers, are required to report deaths and life threatening events. But I am personally aware that this is not being done, at least at one institution. Regardless other researchers believe that a realistic under-reporting factor (URF) is somewhere between 10 and 40[14]. **Keep this in mind; that some (unknown) URF applies to all the numbers provided in this report**. In other words the numbers reported here is certainly a lower bound for observations. But in this report, the numbers are only what VAERS provides. So we might expect that the death toll for covid-19 vaccines is actually between 301,620 and 1,206,480 deaths. So perhaps over a million have died from the COVID-19 vaccines.

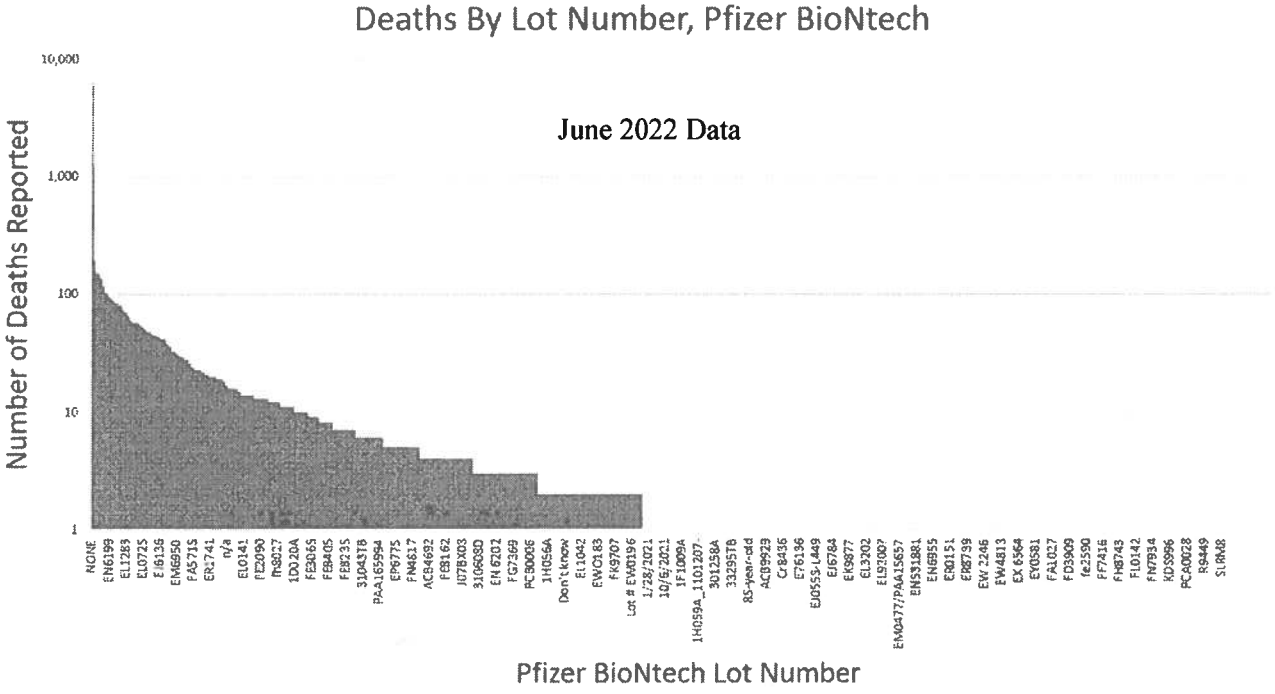
According to VAERS data, reported deaths are largely split between the first and second doses of the vaccine

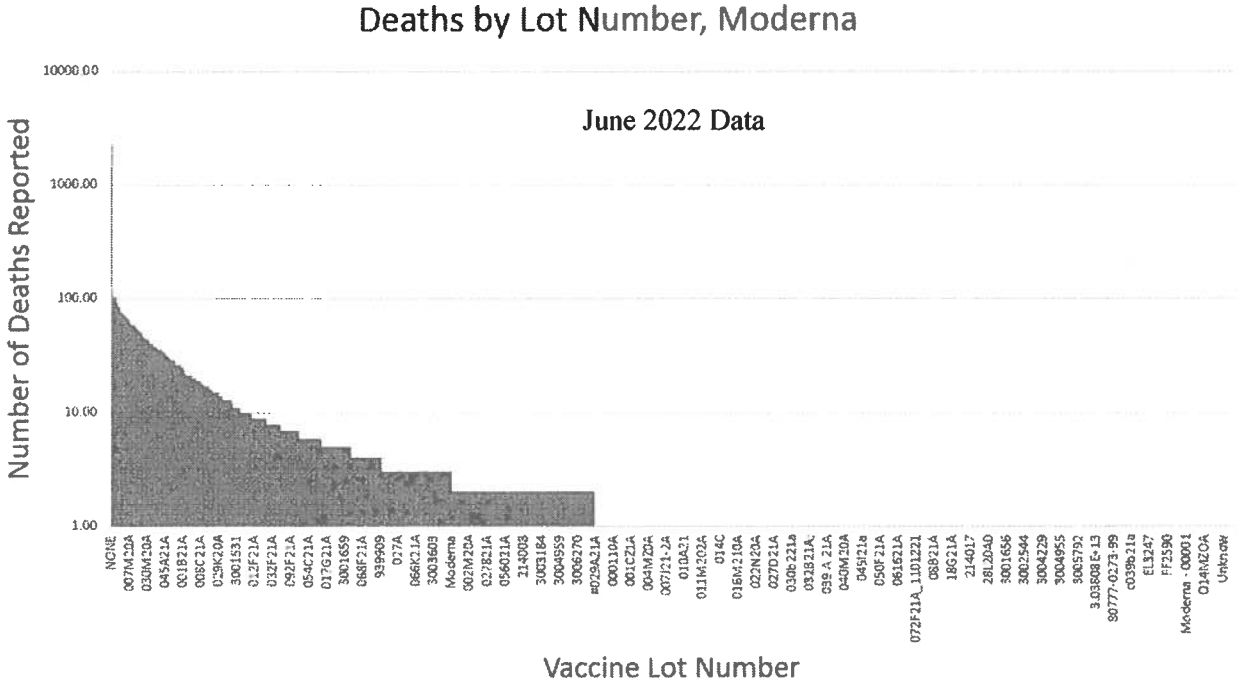
Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 30,162 total events.

Vaccine Dose	Events Reported	Percent (of 30,162)
1 Dose	11,311	37.50%
2 Doses	11,233	37.24%
3 Doses	3,023	10.02%
4 Doses	233	0.77%
5 Doses	8	0.03%
6 Doses	1	0.00%
7 or more Doses	8	0.03%
Unknown	7,193	23.85%
Not Applicable	28	0.09%

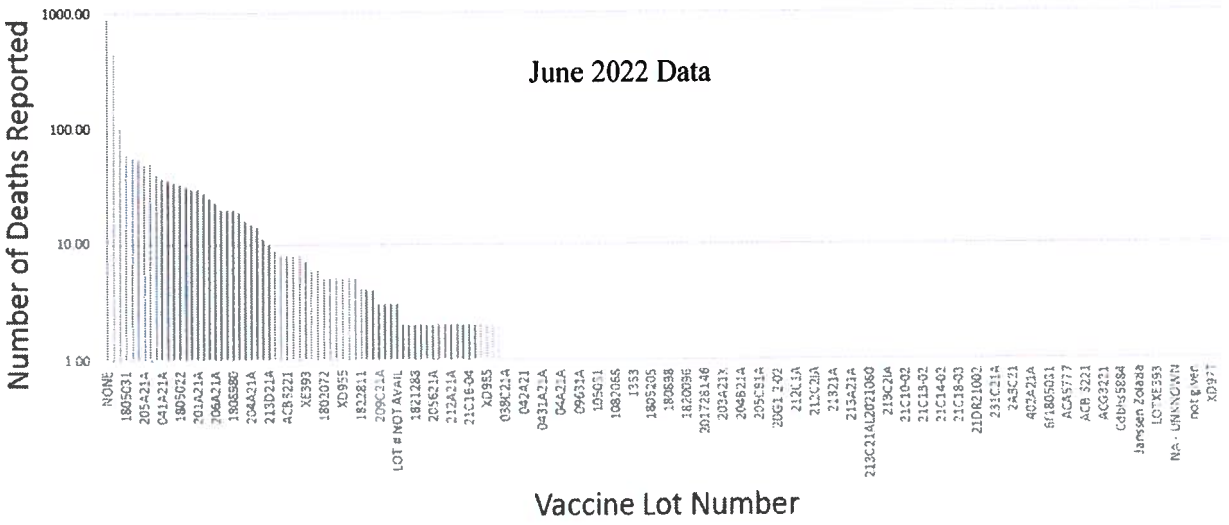
And there's a concerning disparity between the number of deaths across various vaccine lot numbers as shown by the following graphs. But it's not clear if (1) the number of vaccine vials per lot is the same or (2) that the number of administered doses per lot is somewhat uniform. If the lot size and administration of vaccines are somewhat consistent, the data below could suggest a serious quality issue: that something in the manufacturing process is yielding particular lots that are causing harm[15].

[14] Steve Kirsch Latest VAERS estimate: 388,000 Americans killed by the COVID vaccines
[15] https://www.nutritruth.org/single-post/covid-truths-hot-lots-deadly-batches-of-vaccines


Deaths By Lot Number, Pfizer BioNtech
June 2022 Data
Number of Deaths Reported
10,000
1,000
100
10
1
Pfizer BioNtech Lot Number


Deaths by Lot Number, Moderna
June 2022 Data
Number of Deaths Reported
10000.00
1000.00
100.00
10.00
1.00
Vaccine Lot Number

Deaths by Lot Number, Jannsen



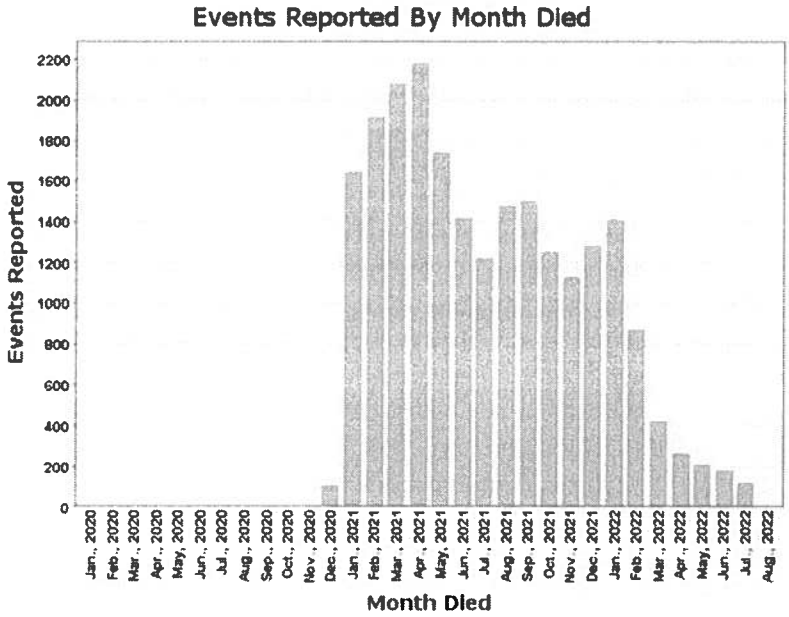
According to sex, the reported deaths associated with COVID-19 vaccines show that males are slightly more likely to be killed by the vaccines.

Messages:

- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 30,162 total events.**

Sex	Events Reported	Percent (of 30,162)
Female	12,626	41.86%
Male	15,991	53.02%
Unknown	1,545	5.12%

Considering many of the deaths reported are associated with cardio pulmonary events and stroke, that the hypothesis in the June report posits that young males are more able and tend to push the envelope of physical exertion, could indeed explain the higher percentage of male deaths.



Before getting into other adverse events, it's first important to note for the adverse event of death alone, there is a fundamental issue with vaccine ethics. Consider of these reported deaths, what are the chances that even 1 report of association is indeed caused by the vaccine. Then ask the question, knowing that the vaccine has the capability of killing the recipient, how is it ethical to vaccinate a population *en masse* when conceivably some people may die that never would have died from the infection, let alone be infected? The correct answer: it is NOT ethical.

Somehow Public Health Officials have managed to convince the public that it is ethical; to kill one group of people in order to save another group. This policy is maliciously labeled by the media as "the greater good" and it condones the twisted premise that some benefit risk analysis mitigates this fact. That there is some 'acceptable' number of vaccine induced deaths.

So far no one has addressed this grievous fault in policy, or perhaps recognized its existence. The policy is one of indiscriminant sacrifice; no different than throwing the virgin into the volcano to appease the gods. At present it's only investment and profits that are being appeased. The medical and scientific literature only touch lightly on the subject of vaccine ethics, and NONE has addressed the question posed above.

Kowalik M. **Ethics of vaccine refusal.** J Med Ethics. 2022 Apr; 48(4):240-243. doi: 10.1136/medethics-2020-107026. Epub 2021 Feb 26. PMID: 33637609. https://pubmed.ncbi.nlm.nih.gov/33637609/

Kowalick concludes:

> *... there is neither a moral obligation to vaccinate nor a sound ethical basis to mandate vaccination under any circumstances, even for hypothetical vaccines that are medically risk-free.*
>
> *Agent autonomy with respect to self-constitution has absolute normative priority over reduction or elimination of the associated risks to life. In practical terms, mandatory vaccination amounts to discrimination against*

healthy, innate biological characteristics, which goes against the established ethical norms and is also defeasible a priori.

Cheng FK. **Debate on mandatory COVID-19 vaccination**. Ethics Med Public Health. 2022 Apr;21:100761. doi: 10.1016/j.jemep.2022.100761. Epub 2022 Jan 24. PMID: 35097181; PMCID: PMC8784578. https://pubmed.ncbi.nlm.nih.gov/35097181/

Pomara C, Sessa F, Ciaccio M, Dieli F, Esposito M, Giammanco GM, Garozzo SF, Giarratano A, Prati D, Rappa F, Salerno M, Tripodo C, Mannucci PM, Zamboni P. **COVID-19 Vaccine and Death: Causality Algorithm According to the WHO Eligibility Diagnosis**. Diagnostics. 2021; 11(6):955. https://doi.org/10.3390/diagnostics1106095 https://www.mdpi.com/2075-4418/11/6/955

Maiese A, Baronti A, Manetti AC, Di Paolo M, Turillazzi E, Frati P, Fineschi V. **Death after the Administration of COVID-19 Vaccines Approved by EMA: Has a Causal Relationship Been Demonstrated?** Vaccines. 2022; 10(2):308. https://doi.org/10.3390/vaccines10020308 https://www.mdpi.com/2076-393X/10/2/308

Lv G, Yuan J, Xiong X, Li M. **Mortality Rate and Characteristics of Deaths Following COVID-19 Vaccination.** Front Med (Lausanne). 2021;8:670370. Published 2021 May 14. doi:10.3389/fmed.2021.670370 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8160119/

Conclusion from Lv et al: *The benefits of COVID-19 vaccines outweigh the potential risks in older frail populations, and our findings do not support actions to exclude older adults from being vaccinated. However, continued monitoring of COVID-19 vaccination is still warranted.*

One more time, an underwhelming candy coated conclusion.

6. Besides associated deaths, the COVID-19 vaccines are currently associated with the following numbers of noted categorical adverse events. These numbers are cumulative events entered since the roll out of the COVID-19 vaccines:

Messages:
- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 1,379,438 total events.**

Event Category	Events Reported	Percent (of 1,379,438)
Death	30,162	2.19%
Life Threatening	33,475	2.43%
Permanent Disability	56,477	4.09%
Congenital Anomaly / Birth Defect *	1,141	0.08%
Hospitalized	172,590	12.51%
Existing Hospitalization Prolonged	1,943	0.14%
Emergency Room / Office Visit **	120	0.01%
Emergency Room *	133,570	9.68%
Office Visit *	202,530	14.68%
None of the above	899,943	65.24%

7. **33,475 Life threatening events**; 39% within two days after injection.
8. **56,477 Permanent disabilities**; 50% within two days after injection.
9. **172,590 Hospitalized**; 32% within two days after injection.
10. **133,570 Emergency room visits**; 53% within two days after injection.

11. **202,530 Office visits**; 48% within two days after injection.

12. By restricting the query above to children (under age 18) we see there have been almost **54,000** adverse events reported, with **145** deaths.

Messages:

- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 53,787 total events.**

Event Category	Events Reported	Percent (of 53,787)
Death	145	0.27%
Life Threatening	655	1.22%
Permanent Disability	505	0.94%
Congenital Anomaly / Birth Defect *	17	0.03%
Hospitalized	4,267	7.93%
Existing Hospitalization Prolonged	90	0.17%
Emergency Room / Office Visit **	12	0.02%
Emergency Room *	5,081	9.45%
Office Visit *	7,317	13.60%
None of the above	39,710	73.83%

One of those 145 deaths occurred in California; a nine year old girl:

https://www.lucianne.com/2022/08/03/9-year-old_dies_two_weeks_after_taking_covid-19_vaccine_vaers_90842.html

Details for VAERS ID: 2377304-1

Event Information			
Patient Age	9.00	Sex	Female
State / Territory	California	Date Report Completed	2022-07-21
Date Vaccinated	2021-12-13	Date Report Received	2022-07-21
Date of Onset	2021-12-27	Date Died	2021-12-27
Days to onset	14		
Vaccine Administered By	Other	Vaccine Purchased By	Not Applicable *
Mfr/Imm Project Number	NONE	Report Form Version	2
Recovered	No	Serious	Yes

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"Not Applicable" will appear when information is not available on this report form version.

Event Categories	
Death	Yes
Life Threatening	No
Permanent Disability	No
Congenital Anomaly / Birth Defect *	No
Hospitalized	No
Days in Hospital	None
Existing Hospitalization Prolonged	No
Emergency Room / Office Visit **	N/A
Emergency Room *	No
Office Visit *	No

* VAERS 2.0 Report Form Only
** VAERS-1 Report Form Only
"N/A" will appear when information is not available on this report form version.

Vaccine Type	Vaccine	Manufacturer	Lot	Dose	Route	Site
COVID19 VACCINE	COVID19 (COVID19 (PFIZER-BIONTECH))	PFIZER\BIONTECH	NONE	1	SYR	UN

Symptom
ABDOMINAL PAIN UPPER
CHEST PAIN
DEATH
OROPHARYNGEAL PAIN

Adverse Event Description
Death after 2-3 days of stomach ache, sore throat and chest pain; two weeks after receiving the vaccination

Lab Data	Current Illness	Adverse Events After Prior Vaccinations

Medications At Time Of Vaccination	History/Allergies

Published information contained in either journals or the media tend to report these adverse events in terms of percentages rather than absolute number of persons affected. Whether the intent is accidental or

intentional, reporting of percentages tends to lessen the impact on the reader of how dangerous the vaccines are – compared to legacy vaccines. For example, given the total number of doses administered, the percentage of deaths associated with the vaccine is *less than* 0.005%. This appears to be a very small number, but because there were 606 million doses even a small percentage like this represents over 30,000 deaths! There is no consolation for the victims and friends and family that lost their loved ones – especially if they were young and fit and may have easily survived a covid-19 infection with early therapeutic treatment – or perhaps never infected in the first place. The magnitude of harm further amplifies the matter of this policy as unethical.

Since the beginning of vaccine distribution it's been difficult to establish solid evidence that COVID-19 vaccines provide benefits that exceed harms, since the number of true COVID-19 cases has been obfuscated by inaccurate PCR testing with a high rate of false positives[16], and the true number of deaths caused by COVID-19 infection confounded by the fact that many were actually persons "dying with covid" rather than "dying from covid". Indeed the enigma of correlation vs. causation cuts both ways. Add to this the confusion surrounding TRUE efficacy of the vaccines and the recent release of the phase 3 trial results from Pfizer to the FDA in early 2021. It took a FOIA, a lawsuit and court order to get the FDA to release. The, now publicly released report[17][18], reveals that Pfizer and the FDA have committed a crime, possibly colluding to hide damaging information from the public. The data should, at the very least, forced the FDA to black label the vaccine. But a more appropriate action would have been a recall. Yet MANY continue to receive the vaccines! About 16 million more Americans since the last report.

To further contrast the disparity of harm between the covid19 vaccines and legacy vaccines, all adverse events from all other vaccines collectively were compared over the 32 year timeline of vaccine tracking in VAERS. The blue spike on the following graph towards the right represents this last year where the covid-19 vaccine was rolled out. This graph obtained at https://vaersanalysis.info/2022/08/13/vaers-summary-for-covid-19-vaccines-through-8-5-2022/ , was last updated 8/5/2022.

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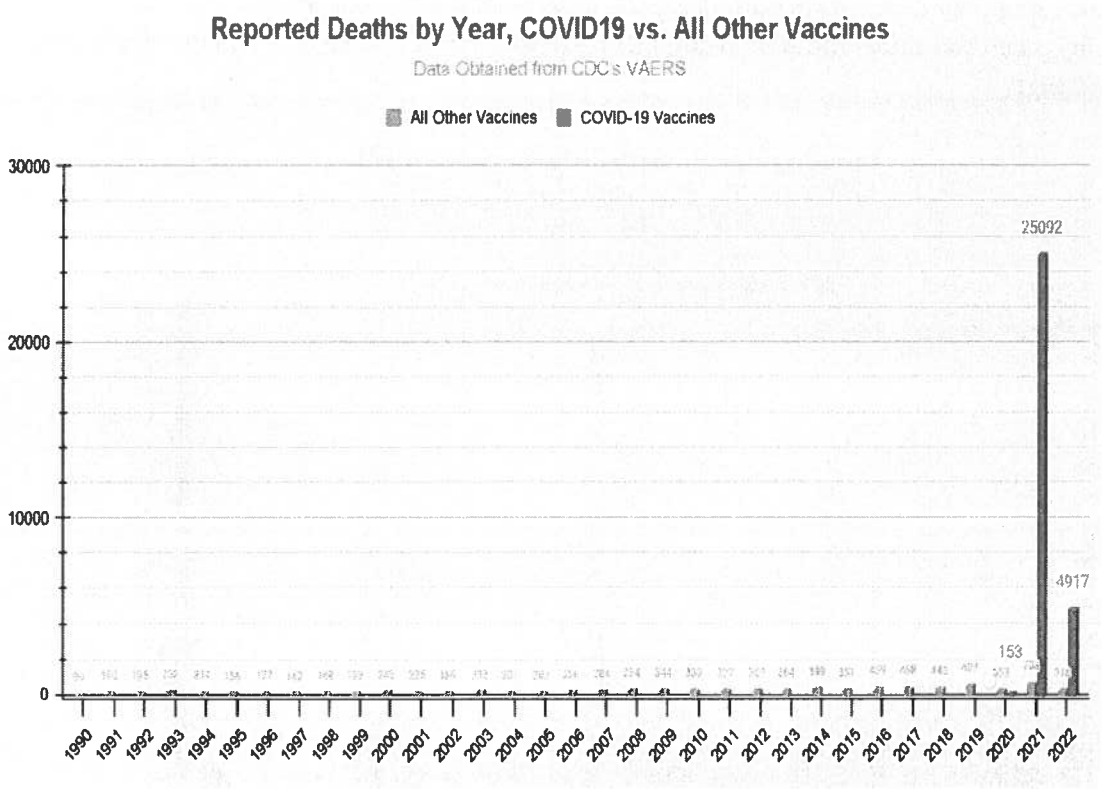
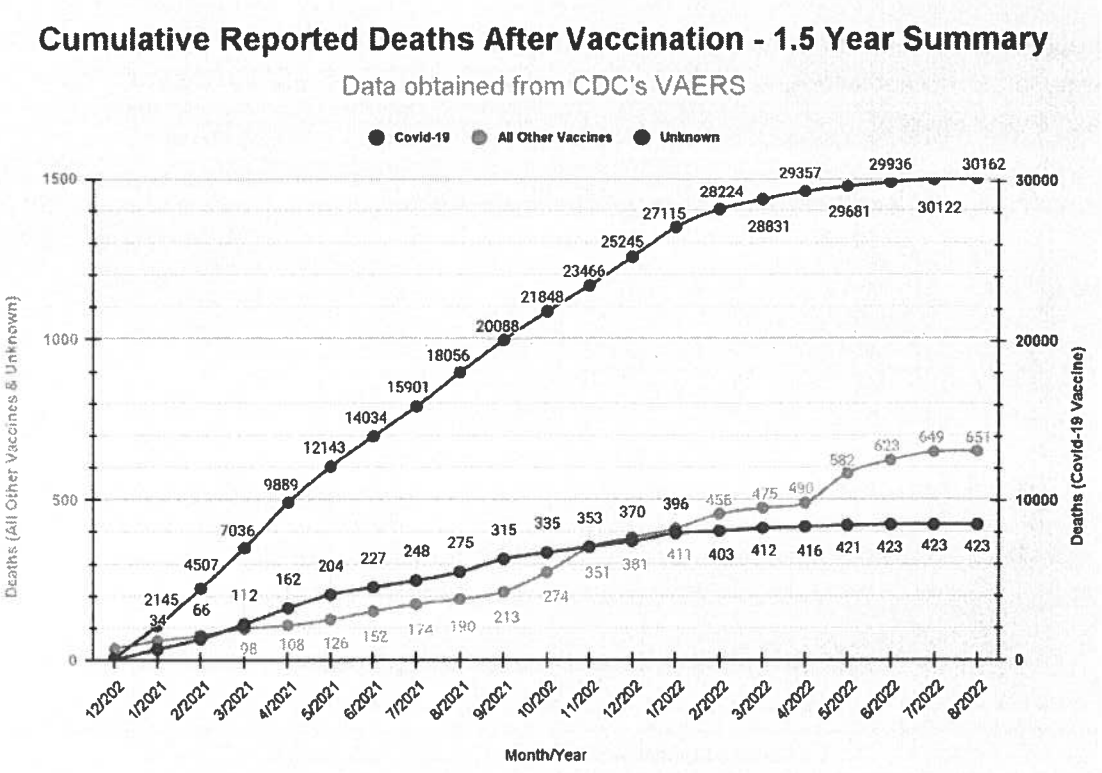
[16] Elena Surkova, Vladyslav Nikolayevskyy, Francis Drobniewski, **False-positive COVID-19 results: hidden problems and costs**, The Lancet Respiratory Medicine, VOLUME 8, ISSUE 12, P1167-1168, DECEMBER 01, 2020 https://www.thelancet.com/action/showPdf?pii=S2213-2600%2820%2930453-7

[17] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1063378/Vaccine_Analysis_Print_Pfizer_BioNTech_COVID-19_vaccine_16.03.2022_v3.pdf

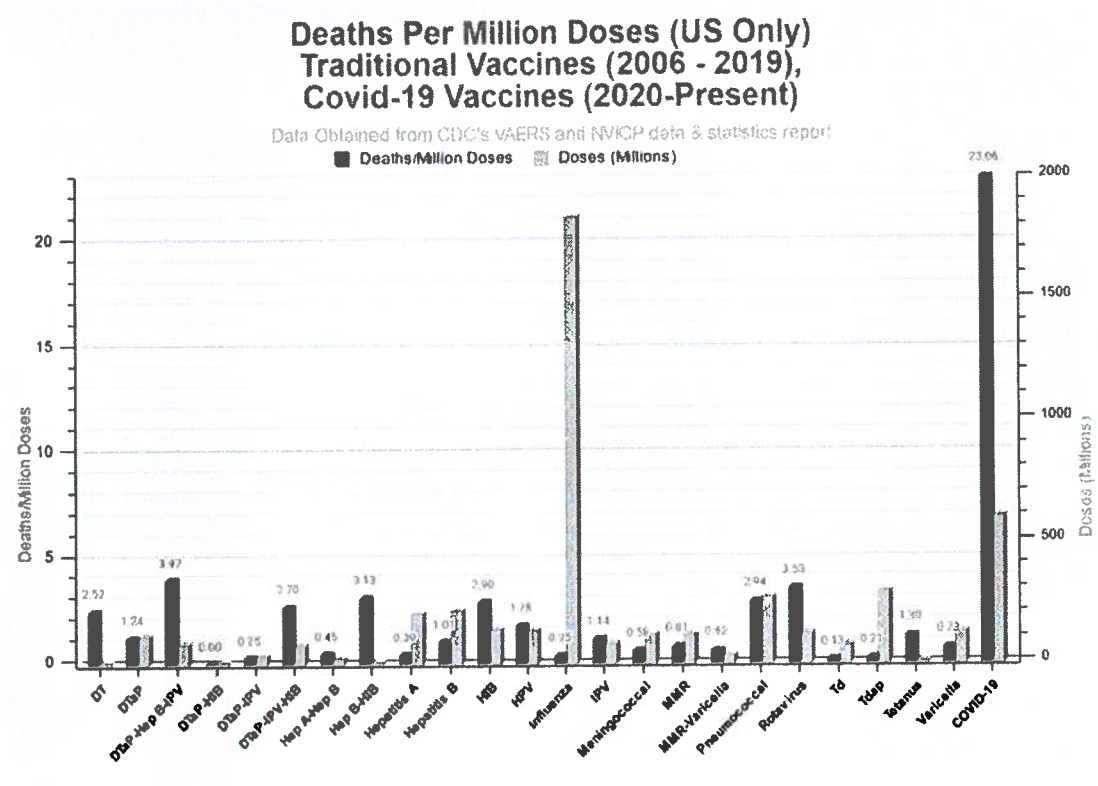
[18] CUMULATIVE ANALYSIS OF POST-AUTHORIZATION ADVERSE EVENT REPORTS OF PF-07302048 (BNT162B2) RECEIVED THROUGH 28-FEB-2021



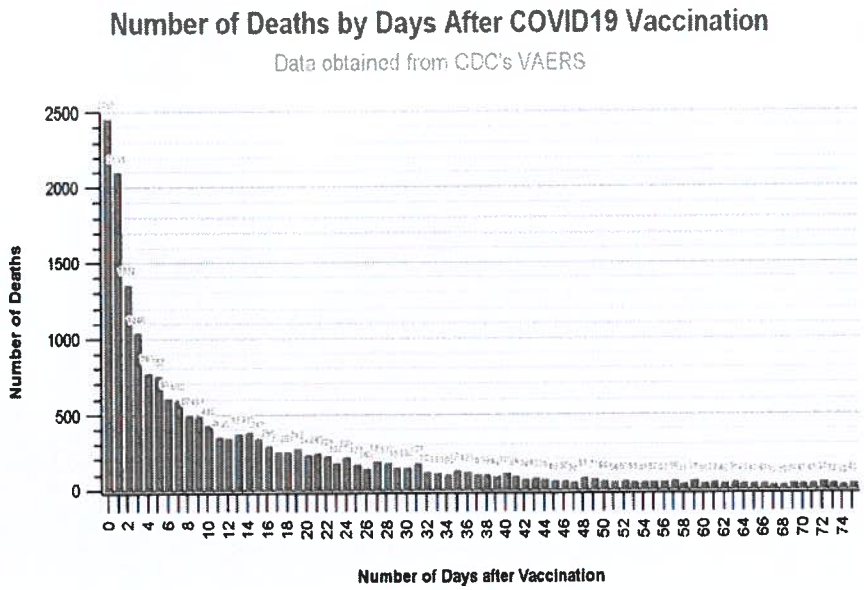
The following graph, obtained from the same source provides a year end summary (2021) of cumulative deaths comparing the covid 19 vaccines with all other vaccines.



Perhaps a more fair comparison normalizes the number of deaths relative to number of doses. The following graph still shows the stark truth; COVID-19 vaccines are far deadlier than any other vaccine ever administered.



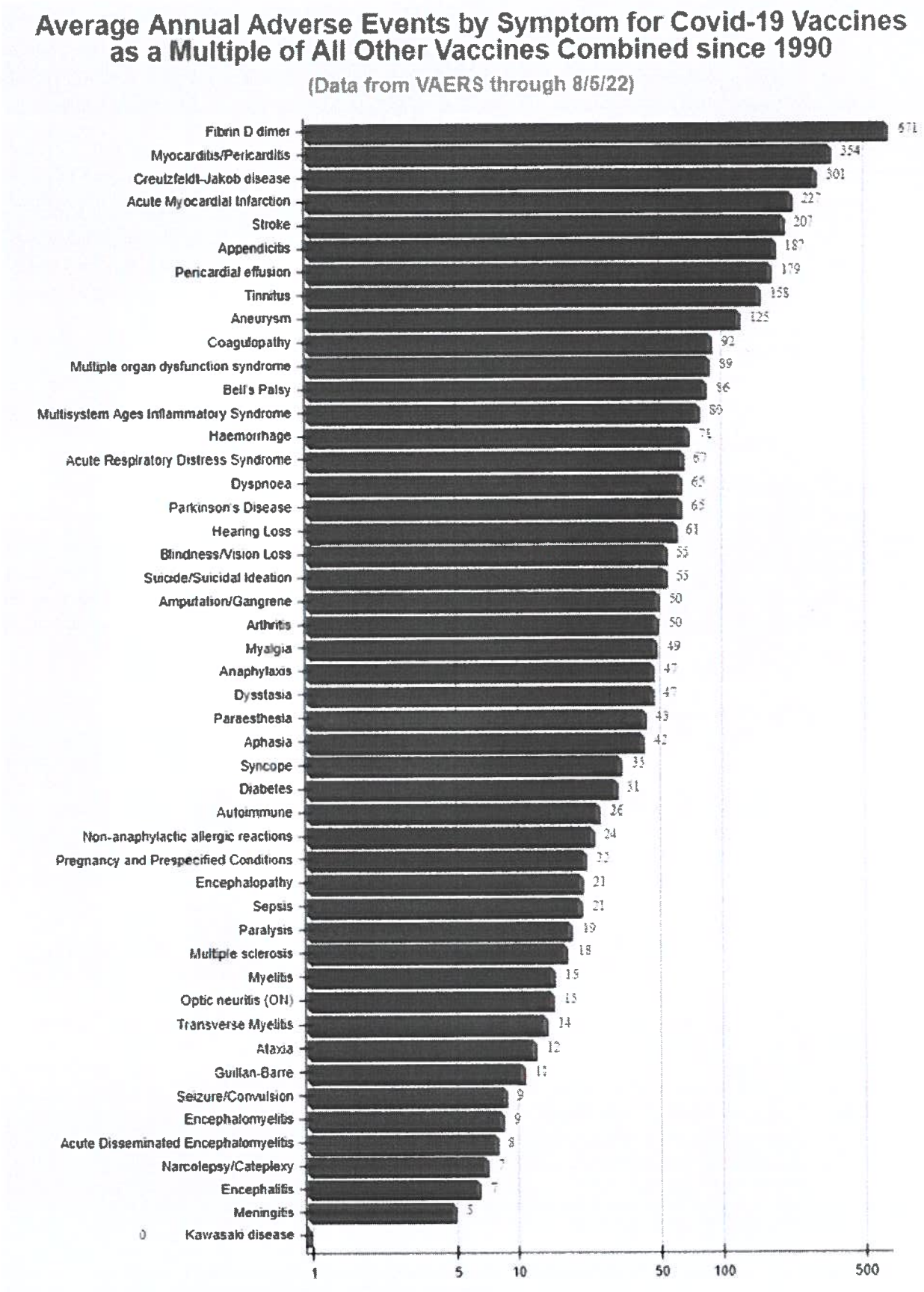
This graph plots the onset of death following the immunization event indicating strong correlation, a necessary (although not sufficient) condition to show causation. Roughly 1/3 of these deaths occurred within 2 days of injection.



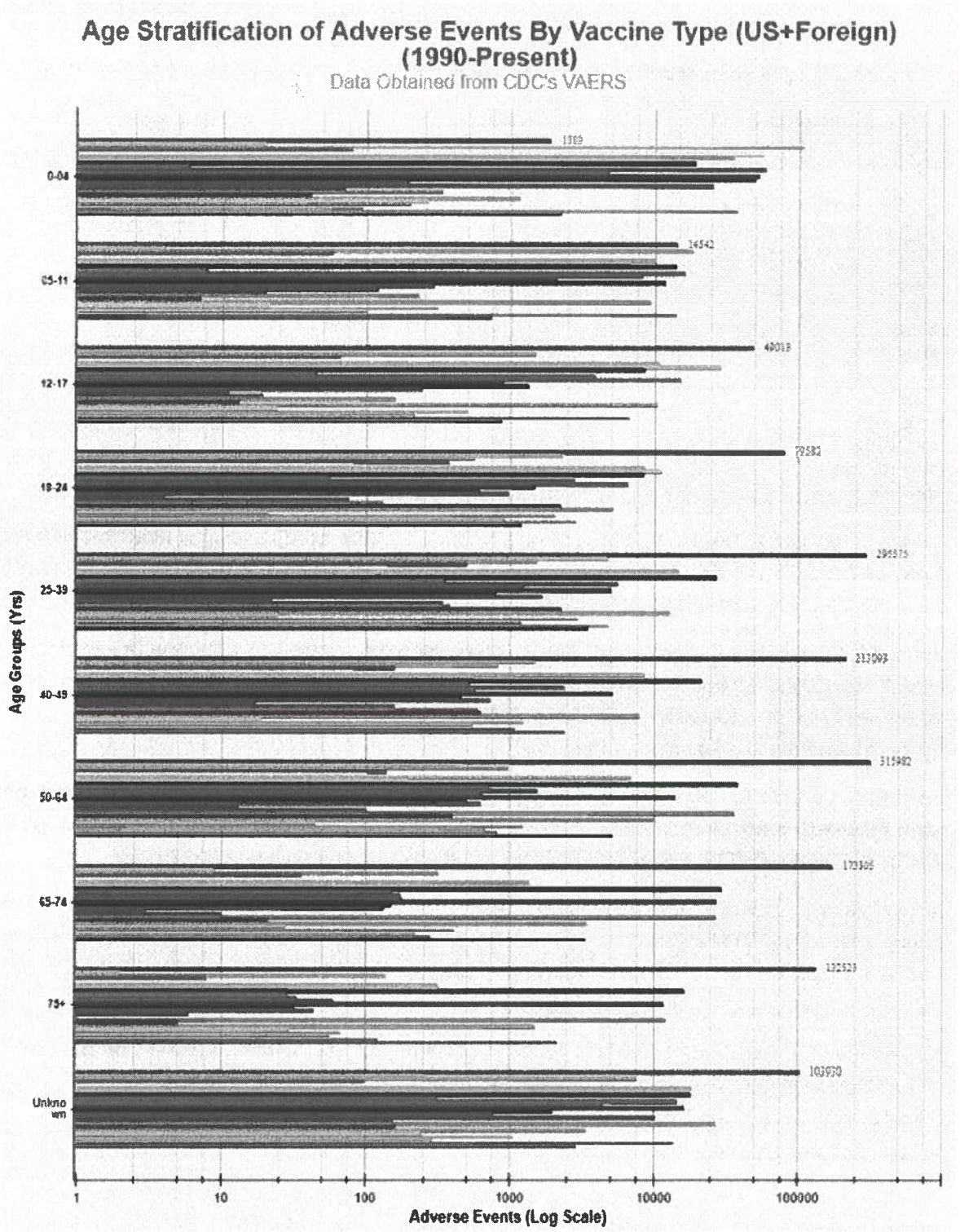
Again, to be fair, the 0th and 1st day data may be biased by reporters not knowing exactly which day death occurred so they entered either 0 or 1. This was confirmed by reading actual reports report descriptions for onset of zero and 1 data sets. The descriptions for some of these cases actually indicated longer onset intervals. Nevertheless, the preponderance of remaining reports indicate a trend showing definite temporal correlation.

The following graph reveals D-dimer tests top the list of 'events' reported for covid-19 vaccines. This is because events reported in VAERS are not necessarily outcomes, but can be procedures performed or tests ordered by physicians. This result is probably evidence that medical doctors treating vaccine recipients are truly *anticipating* thrombogenesis from the vaccines. The doctors may not be able to publicly come out and raise objections to the COVID-19 vaccines, but we see here they are acting in interest of their patient's health! High D-dimer indicates that clotting has been triggered in the bloodstream and there is increased risk for further clotting > platelets & fibrin attaching to red blood cells, at first creating 'micro-emboli' , clot structures that flow with the blood stream. These can combine and create larger emboli, and if large enough, can cut off blood supply which can be lethal. D-dimer is clinically used to determine stroke, pulmonary embolism or deep vein thrombosis.

The analysis from the graph indicates that the COVID-19 vaccines have thus far resulted in Fibrin "D-dimer tests" having a higher frequency (X 833) over all other vaccines combined. It also wasn't clear what was meant just by the tag "Fibrin D-dimer". Does that mean high level/low level? VAERS allows query of more detailed information and it further describes this tag as "Fragment D-Dimer" which I believe just means presence of the dimer which is presumably the byproduct of clot decomposition by the enzyme plasmin. There are other associated tags, and perhaps the FIBRIN D DIMER INCREASED tag would have been more appropriate.


Average Annual Adverse Events by Symptom for Covid-19 Vaccines as a Multiple of All Other Vaccines Combined since 1990
(Data from VAERS through 8/5/22)
Fibrin D dimer
Myocarditis/Pericarditis
Creutzfeldt-Jakob disease
Acute Myocardial Infarction
Stroke
Appendicitis
Pericardial effusion
Tinnitus
Aneurysm
Coagulopathy
Multiple organ dysfunction syndrome
Bell's Palsy
Multisystem Ages Inflammatory Syndrome
Haemorrhage
Acute Respiratory Distress Syndrome
Dyspnoea
Parkinson's Disease
Hearing Loss
Blindness/Vision Loss
Suicide/Suicidal Ideation
Amputation/Gangrene
Arthritis
Myalgia
Anaphylaxis
Dysstasia
Paraesthesia
Aphasia
Syncope
Diabetes
Autoimmune
Non-anaphylactic allergic reactions
Pregnancy and Prespecified Conditions
Encephalopathy
Sepsis
Paralysis
Multiple sclerosis
Myelitis
Optic neuritis (ON)
Transverse Myelitis
Ataxia
Guillan-Barre
Seizure/Convulsion
Encephalomyelitis
Acute Disseminated Encephalomyelitis
Narcolepsy/Cateplexy
Encephalitis
Meningitis
0
Kawasaki disease
671
354
301
227
207
187
179
158
125
92
89
86
80
78
67
65
65
61
55
55
50
50
49
47
47
43
42
35
31
26
24
22
21
21
19
18
15
15
14
12
11
9
9
8
7
7
5
1
5
10
50
100
500

The following graph compares deaths between all types of vaccines according to age group. Note that the horizontal scale is on a logarithmic scale since COVID-19 vaccine associated deaths above 18 years old would otherwise dwarf all other vaccines.



13. The following numbers consider more specific adverse events that have been reported to VAERS and associated with the COVID19 vaccines that may or may not have led to death (as of June 10, 2022). These numbers are cumulative events entered since the roll out of the COVID-19 vaccines. Published references and links that relate to these specific events connected with the COVID-19 vaccine are included as supplementary information.

14. **33,101 symptoms reported as syncope (fainting)**; 61% of cases IMMEDIATELY after injection.

Onset Interval ⇩	⇨ Events Reported ⇧⇩	⇦ Percent (of 33,101) ⇧⇩
0 days	20,128	60.81%
1 day	4,461	13.48%
2 days	767	2.32%
3 days	360	1.09%
4 days	267	0.81%
5 days	228	0.69%
6 days	137	0.41%
7 days	187	0.56%
8 days	120	0.36%
9 days	119	0.36%
10-14 days	413	1.25%
15-30 days	788	2.38%
31-60 days	454	1.37%
61-120 days	224	0.68%
Over 120 days	491	1.48%
Unknown	3,957	11.95%

Takase B, Hayashi K, Takei S, Hisada T, Masaki N, Nagata M. **Delayed Vasovagal Reaction with Reflex Syncope Following Covid-19 Vaccination**. Intern Med. 2022 May 14. doi: 10.2169/internalmedicine.9318-21. Epub ahead of print. PMID: 35569982. https://pubmed.ncbi.nlm.nih.gov/35569982/

Kimball E, Buchwalder K, Upchurch C, Kea B. **Intermittent complete heart block with ventricular standstill after Pfizer COVID-19 booster vaccination: A case report**. J Am Coll Emerg Physicians Open. 2022 Apr 20;3(2):e12723. doi: 10.1002/emp2.12723. PMID: 35475120; PMCID: PMC9020811. https://pubmed.ncbi.nlm.nih.gov/35475120/

Frustaci A, Verardo R, Galea N, Lavalle C, Bagnato G, Scialla R, Chimenti C. **Hypersensitivity Myocarditis after COVID-19 mRNA Vaccination**. J Clin Med. 2022 Mar 16;11(6):1660. doi: 10.3390/jcm11061660. PMID: 35329986; PMCID: PMC8949349. https://pubmed.ncbi.nlm.nih.gov/35329986/

Almohaya AM, Alsubie H, Alqarni B, Alzayad B, Alghar A, Alshahrani K, Barry M. **Acute unsolicited adverse events following BNT162b2 vaccine in Saudi Arabia, a real-world data. Vaccine**. 2022 Jan 24;40(3):477-482. doi: 10.1016/j.vaccine.2021.12.001. Epub 2021 Dec 13. PMID: 34916104; PMCID: PMC8668155. https://pubmed.ncbi.nlm.nih.gov/34916104/

Mohammed RA, Garout RM, Wahid S, Ayub F, Firas ZinAlddin LM, Sultan I. **A Survey on the Side Effects of Pfizer/BioNTech COVID-19 Vaccine Among Vaccinated Adults in Saudi Arabia**. Cureus. 2021 Nov 3;13(11):e19222. doi: 10.7759/cureus.19222. PMID: 34873547; PMCID: PMC8640570. https://pubmed.ncbi.nlm.nih.gov/34873547/

Azdaki N, Farzad M. **Long QT interval and syncope after a single dose of COVID-19 vaccination: a case report**. Pan Afr Med J. 2021 Sep 30;40:67. doi: 10.11604/pamj.2021.40.67.31546. PMID: 34804335; PMCID: PMC8590254. https://pubmed.ncbi.nlm.nih.gov/34804335/

We report a case of a 70-year-old man who presented to the hospital for some syncope, 3 days after his first COVID-19 AstraZeneca Vaccination. Initial electrocardiogram (ECG) showed a long QT interval (QTc = 600 milliseconds). Laboratory tests revealed elevated troponin and lack of evidence of viral infection. Further investigations revealed the vaccine-induced myocarditis and arrhythmias linked to it.

Kim MS, Jung SY, Ahn JG, Park SJ, Shoenfeld Y, Kronbichler A, Koyanagi A, Dragioti E, Tizaoui K, Hong SH, Jacob L, Salem JE, Yon DK, Lee SW, Ogino S, Kim H, Kim JH, Excler JL, Marks F, Clemens JD, Eisenhut M, Barnett Y, Butler L, Ilie CP, Shin EC, Il Shin J, Smith L. **Comparative safety of mRNA COVID-19 vaccines to influenza vaccines: A pharmacovigilance analysis using WHO international database**. J Med Virol. 2021 Oct 28:10.1002/jmv.27424. doi: 10.1002/jmv.27424. Epub ahead of print. PMID: 34709664; PMCID: PMC8662238. https://pubmed.ncbi.nlm.nih.gov/34709664/

Hause AM, Gee J, Johnson T, Jazwa A, Marquez P, Miller E, Su J, Shimabukuro TT, Shay DK. **Anxiety-Related Adverse Event Clusters After Janssen COVID-19 Vaccination - Five U.S. Mass Vaccination Sites,** April 2021. MMWR Morb Mortal Wkly Rep. 2021 May 7;70(18):685-688. doi: 10.15585/mmwr.mm7018e3. PMID: 33956781. https://pubmed.ncbi.nlm.nih.gov/33956781/

Syncope after Janssen COVID-19 vaccination was reported to VAERS (8.2 episodes per 100,000 doses). By comparison, after influenza vaccination, the reporting rate of syncope was 0.05 episodes per 100,000 doses.

The following chart reports incidence following vaccination for all vaccines that had the largest outcome of reported syncope. So COVID-19 vaccines accounted for over 65% of all reports.

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 51,357 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 51,357)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	21,839	42.52%
COVID19 (COVID19 (MODERNA)) (1201)	8,297	16.16%
HPV (GARDASIL) (1098)	5,261	10.24%
COVID19 (COVID19 (JANSSEN)) (1203)	3,376	6.57%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	1,890	3.68%
HPV (GARDASIL 9) (1170)	1,525	2.97%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	1,253	2.44%
HEP A (HAVRIX) (268)	1,077	2.10%
TDAP (BOOSTRIX) (1091)	1,075	2.09%
TDAP (ADACEL) (1092)	999	1.95%
VARICELLA (VARIVAX) (269)	906	1.76%
HEP B (ENGERIX-B) (38)	824	1.60%
HPV (CERVARIX) (1136)	682	1.33%
INFLUENZA (SEASONAL) (FLUZONE) (7)	596	1.16%
TD ADSORBED (NO BRAND NAME) (11)	556	1.08%
HEP B (RECOMBIVAX HB) (25)	465	0.91%
ZOSTER (SHINGRIX) (1192)	458	0.89%
MENINGOCOCCAL CONJUGATE (MENVEO) (1140)	455	0.89%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	421	0.82%
PNEUMO (PNEUMOVAX) (30)	403	0.78%
INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162)	399	0.78%
HEP A (VAQTA) (280)	384	0.75%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	376	0.73%
MENINGOCOCCAL B (BEXSERO) (1165)	355	0.69%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	344	0.67%
POLIO VIRUS, ORAL (ORIMUNE) (17)	334	0.65%
INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161)	328	0.64%
HPV (NO BRAND NAME) (1102)	296	0.58%
POLIO VIRUS, INACT. (IPOL) (1030)	281	0.55%
PNEUMO (PREVNAR13) (1141)	228	0.44%
HEP A + HEP B (TWINRIX) (1009)	213	0.41%
INFLUENZA (SEASONAL) (FLUCELVAX QUADRIVALENT) (1175)	209	0.41%
TYPHOID VI POLYSACCHARIDE (TYPHIM VI) (271)	207	0.40%
MENINGOCOCCAL B (TRUMENBA) (1169)	201	0.39%
INFLUENZA (SEASONAL) (AFLURIA QUADRIVALENT) (1177)	191	0.37%
DTP (NO BRAND NAME) (2)	169	0.33%
MENINGOCOCCAL (NO BRAND NAME) (113)	167	0.33%
POLIO VIRUS, INACT. (NO BRAND NAME) (232)	152	0.30%
DTAP (INFANRIX) (286)	149	0.29%
INFLUENZA (SEASONAL) (FLULAVAL QUADRIVALENT) (1166)	129	0.25%
INFLUENZA (SEASONAL) (AFLURIA) (1121)	129	0.25%
INFLUENZA (H1N1) (H1N1 (MONOVALENT) (SANOFI)) (1132)	126	0.25%

15. **3,932 symptoms reported as sudden cardiac death, cardiac death, sudden death or cardiac failure**; 36% within two days after injection.

Caturano A, Pafundi PC, Sasso FC, Dendramis G, Brugada P, Russo V. **Brugada syndrome and COVID-19 vaccines** [published online ahead of print, 2021 Aug 11]. Europace. 2021;euab211. doi:10.1093/europace/euab211
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8385984/pdf/euab211.pdf

16. **2,160 Symptoms reported as blindness**; 54% within two days after injection

Sanjay S, Acharya I, Kawali A, Shetty R, Mahendradas P. **Unilateral recurrent central serous chorioretinopathy (CSCR) following COVID-19 vaccination- A multimodal imaging study**. Am J Ophthalmol Case Rep. 2022 Sep;27:101644. doi: 10.1016/j.ajoc.2022.101644. Epub 2022 Jul 6. PMID: 35818570; PMCID: PMC9258414. https://pubmed.ncbi.nlm.nih.gov/35818570/

Alhamazani MA, Alruwaili WS, Alshammri B, Alrashidi S, Almasaud J. **A Case of Recurrent Acute Anterior Uveitis After the Administration of COVID-19 Vaccine**. Cureus. 2022 Mar 7;14(3):e22911. doi: 10.7759/cureus.22911. PMID: 35399463; PMCID: PMC8986516. https://pubmed.ncbi.nlm.nih.gov/35399463/

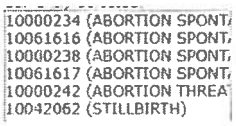
Joo CW, Kim YK, Park SP. **Vogt-Koyanagi-Harada Disease following mRNA-1273 (Moderna) COVID-19 Vaccination**. Ocul Immunol Inflamm. 2022 Apr 11:1-5. doi: 10.1080/09273948.2022.2053547. Epub ahead of print. PMID: 35404752. https://pubmed.ncbi.nlm.nih.gov/35404752/

Ishibashi K, Yatsuka H, Haruta M, Kimoto K, Yoshida S, Kubota T. **Branch Retinal Artery Occlusions, Paracentral Acute Middle Maculopathy and Acute Macular Neuroretinopathy After COVID-19 Vaccinations**. Clin Ophthalmol. 2022 Mar 31;16:987-992. doi: 10.2147/OPTH.S357359. PMID: 35392428; PMCID: PMC8980294. https://pubmed.ncbi.nlm.nih.gov/35392428/

García-Estrada, C, Gómez-Figueroa, E, Alban, L, Arias-Cárdenas, A. **Optic neuritis after COVID-19 vaccine application**. Clin Exp Neuroimmunol. 2021; 00: 1– 3. https://doi.org/10.1111/cen3.12682 https://onlinelibrary.wiley.com/doi/epdf/10.1111/cen3.12682

Nicholas Fowler, Noe R. Mendez Martinez, Bernardo Velazquez Pallares, Ramiro S. Maldonado, **Acute-onset central serous retinopathy after immunization with COVID-19 mRNA vaccine**, American Journal of Ophthalmology Case Reports, Volume 23, 2021, 101136, ISSN 2451-9936, https://doi.org/10.1016/j.ajoc.2021.101136. https://www.sciencedirect.com/science/article/pii/S2451993621001456

17. **3,528 Symptoms reported as miscarriage, stillbirth or spontaneous abortion;** 28% within two days after injection.



Dabbousi AA, El Masri J, El Ayoubi LM, Ismail O, Zreika B, Salameh P. **Menstrual abnormalities post-COVID vaccination: a cross-sectional study on adult Lebanese women**. Ir J Med Sci. 2022 Jul 26:1–8. doi: 10.1007/s11845-022-03089-5. Epub ahead of print. PMID: 35881229; PMCID: PMC9315076. https://pubmed.ncbi.nlm.nih.gov/35881229/

Pietrasanta C, Ronchi A, Crippa BL, Artieri G, Ballerini C, Crimi R, Mosca F, Pugni L. **Coronavirus Disease 2019 Vaccination During Pregnancy and Breastfeeding: A Review of Evidence and Current Recommendations in Europe, North America, and Australasia**. Front Pediatr. 2022 Apr 29;10:883953. doi: 10.3389/fped.2022.883953. PMID: 35573944; PMCID: PMC9099048. https://pubmed.ncbi.nlm.nih.gov/35573944/

Moro PL, Olson CK, Clark E, Marquez P, Strid P, Ellington S, Zhang B, Mba-Jonas A, Alimchandani M, Cragan J, Moore C. **Post-authorization surveillance of adverse events following COVID-19 vaccines in pregnant persons in the vaccine adverse event reporting system (VAERS), December 2020 - October 2021**. Vaccine. 2022 Apr 12:S0264-410X(22)00447-9. doi: 10.1016/j.vaccine.2022.04.031. Epub ahead of print. PMID: 35489985; PMCID: PMC9001176.

https://pubmed.ncbi.nlm.nih.gov/35489985/

Edelman A, Boniface ER, Benhar E, Han L, Matteson KA, Favaro C, Pearson JT, Darney BG. **Association Between Menstrual Cycle Length and Coronavirus Disease 2019 (COVID-19) Vaccination: A U.S. Cohort**. Obstet Gynecol. 2022 Jan 5. doi: 10.1097/AOG.0000000000004695. Epub ahead of print. PMID: 34991109. https://pubmed.ncbi.nlm.nih.gov/34991109/

Bartoszek K, Okrój M. **Controversies around the statistical presentation of data on mRNA-COVID 19 vaccine safety in pregnant women**. J Reprod Immunol. 2022 Mar 4;151:103503. doi: 10.1016/j.jri.2022.103503. Epub ahead of print. PMID: 35276571; PMCID: PMC8894688. https://pubmed.ncbi.nlm.nih.gov/35276571/

Shimabukuro, Tom T et al. **"Preliminary Findings of mRNA Covid-19 Vaccine Safety in Pregnant Persons."** The New England journal of medicine vol. 384, 24 (Apr 21 2021): 2273-2282. doi:10.1056/NEJMoa2104983
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8117969/pdf/NEJMoa2104983.pdf

Maria C. Magnus, Ph.D., Håkon K. Gjessing, Ph.D., Helena N. Eide, M.D., Allen J. Wilcox, M.D., Ph.D., Deshayne B. Fell, Ph.D., and Siri E. Håberg, M.D., Ph.D. **Covid-19 Vaccination during Pregnancy and First-Trimester Miscarriage** November 18, 2021 N Engl J Med 2021; 385:2008-2010 DOI: 10.1056/NEJMc2114466
https://www.nejm.org/doi/pdf/10.1056/NEJMc2114466?articleTools=true

Bailey Wallace, M.P.H., Ashley N. Smoots, M.P.H., Christine K. Olson .D. M.P.H., Titilope Oduyebo, M.D., M.P.H., Shin Y. Kim, M.P.H., Emily E. Petersen, M.D., Jun Ju, M.S., Jennifer Beauregard, Ph.D., M.P.H., Centers for Disease Control and Prevention (CDC), Atlanta, GA. Allen J. Wilcox, M.D., Ph.D., National Institutes of Health, Durham, NC, Charles E. Rose, Ph.D., Dana M. Meaney-Delman, M.D., M.P.H., Sascha R. Ellington, Ph.D., M.S.P.H. **Correspondence: Receipt of mRNA Covid-19 Vaccines and Risk of Spontaneous Abortion** October 14, 2021 N Engl J Med 2021; 385:1533-1535 DOI: 10.1056/NEJMc2113891
https://www.nejm.org/doi/pdf/10.1056/NEJMc2113891?articleTools=true

Joubert, E, Kekeh, AC, Amin, CN. **COVID-19 and novel mRNA vaccines in pregnancy: an updated literature review**. BJOG 2021; https://doi.org/10.1111/1471-0528.16973. 00: 1– 8.
https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.16973

Kachikis A, Englund JA, Singleton M, Covelli I, Drake AL, Eckert LO. **Short-term Reactions Among Pregnant and Lactating Individuals in the First Wave of the COVID-19 Vaccine Rollout**. JAMA Netw Open. 2021;4(8):e2121310. doi:10.1001/jamanetworkopen.2021.21310
https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2783112

Kharbanda EO, Haapala J, DeSilva M, et al. **Spontaneous Abortion Following COVID-19 Vaccination During Pregnancy**. JAMA. 2021;326(16):1629–1631. doi:10.1001/jama.2021.15494
https://jamanetwork.com/journals/jama/article-abstract/2784193

Sun H. **Approximation and evaluation of the spontaneous abortion rate following COVID-19 vaccination in pregnancy**. American Journal of Obstetrics & Gynecology MFM. 2021 Oct:100510.

DOI: 10.1016/j.ajogmf.2021.100510. PMID: 34656736; PMCID: PMC8516121.
https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC8516121&blobtype=pdf

Megan E. Trostle, Meghana A. Limaye, Valeryia Avtushka, Jennifer L. Lighter, Christina A. Penfield, Ashley S. Roman, **COVID-19 vaccination in pregnancy: early experience from a single institution,** American Journal of Obstetrics & Gynecology MFM, Volume 3, Issue 6, 2021, 100464, ISSN 2589-9333, https://doi.org/10.1016/j.ajogmf.2021.100464.
https://www.sciencedirect.com/science/article/pii/S2589933321001592

Stuckelberger S, Favre G, Ceulemans M, Gerbier E, Lambelet V, Stojanov M, Winterfeld U, Baud D, Panchaud A, Pomar L. Current Data on COVID-19 mRNA-Vaccine Safety during Pregnancy Might Be Subject to Selection Bias. Reply to Stroobandt, S.; Stroobandt, R. **Data of the COVID-19 mRNA-Vaccine V-Safe Surveillance System and Pregnancy Registry Reveals Poor Embryonic and Second Trimester Fetal Survival Rate.** Comment on "Stuckelberger et al. **SARS-CoV-2 Vaccine Willingness among Pregnant and Breastfeeding Women during the First Pandemic Wave: A Cross-Sectional Study in Switzerland**. Viruses 2021, 13, 1199". Viruses. 2021; 13(8):1546.
https://doi.org/10.3390/v13081546
https://www.mdpi.com/1999-4915/13/8/1546#cite

The researched medical journal publications on miscarriage, stillbirth or spontaneous abortion associated with Covid-19 vaccines mostly agree with a similar common narrative:

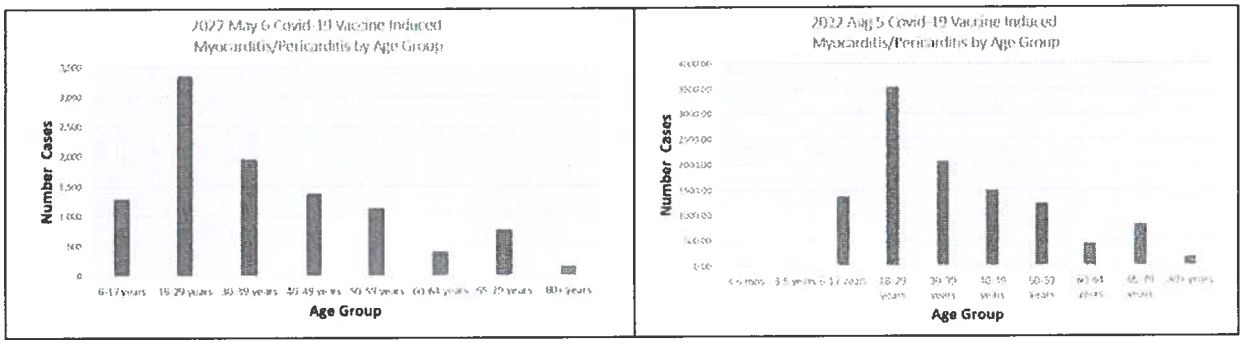
1. "the scientific data suggest no evidence that the COVID-19 vaccines currently used in the United States have any negative effects on female reproductive health" and
2. Nevertheless "the CDC recommended that any American who is pregnant, planning to become pregnant, or currently breastfeeding get vaccinated against COVID-19 as soon as possible"

Some, but most do not mention that the data is lacking relative to the fact that the vaccines have only been out 11 to 12 months (or at time of publication less than that!) and the human gestational time frame is on the same order, 9 months. It takes time to collect and analyze data in this instance for cause and effect. Also not mentioned there are possible adverse events by the vaccine that could indirectly lead to spontaneous abortion or stillbirth - many of the other adverse events listed in this report (e.g. thrombocytopenia, CVST or simply death).

18. **23,894 Symptoms reported as myocarditis, pericarditis or myopericarditis;** 35% within two days after injection.

The charts below plot the number of myocarditis cases by age group. Current data on the right is compared to data from May 6 on the left. Since vaccination for younger children gained approval by the FDA earlier this year, CDC VAERS has added additional age stratification. Graphs, although showing increased numbers are showing a lesser rate of increase in cardiac cases from previous months. Perhaps that is because vaccine intake has now decreased for the 6-12 year age group either due to 'hesitation' or by improved medical vigilance. (Note these graphs exclude a significant number of data (~12,778) where the event does not include associated age group data.). Note also that for ages less than 6 years, there are only a few cases

reported (6). It seems that although the FDA 'approved' the vaccines, only a small percentage of Americans participated in gettingb their child vaccinated.



Myocarditis or any instance of heart inflammation as a result of COVID-19 vaccine deserves special attention since it's not only become an officially confirmed 'signal' in VAERS, but it's critically and permanently affecting cardio health of our youth without providing any benefit of protection that a true vaccine is expected to offer.

On Jan 24, 2022 Senator Ron Johnson of Wisconsin hosted a "Covid 19 Response" panel including renowned doctors and medical experts to provide a "different perspective" on the global pandemic response. The video record is 5 ½ hours long, but it's **strongly recommended that all officials having authority over covid-19 vaccine policies take the time to view it.** Since that meeting and in lieu of the pharmaceutical companies stepping up to take responsibility, Johnson, Braun and Hyde-Smith have begun drafting a bill to address these large numbers of vaccine injuries.[19]

One of the more striking testimonies during the Jan 24 meeting came from Dr. Peter McCullough, a world renowned cardiologist. In the meeting, McCullough mentioned damning evidence that the covid19 vaccines are causing the myocarditis and pericarditis. (index to 17:45) McCullogh mentioned about 200 papers have been published addressing the issue of COVID-19 vaccines and cases of myocarditis. Indeed McCullough, and Dr. Jessica Rose in Israel applied the Bradford Hill analysis to VAERS in a paper they co-authored[20] using other associated vaccine injury data to demonstrate causation.

McCullogh and other doctors have said it, but it's a well-known fact that myocytes (heart cells) are not replaceable:

> *"Similar to skeletal muscle tissue,* ***cardiac muscle does not regenerate to a great extent. Dead cardiac muscle tissue is replaced by scar tissue, which cannot contract****. As scar tissue accumulates, the heart loses its ability to*

[19] Countermeasure Injury Compensation Program with respect to COVID–19 vaccines

[20] Jessica Rose PhD, MSc, BSc , Peter A. McCullough MD, MPH , **A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Reporting System (VAERS) in Association with COVID-19 Injectable Biological Products**, Current Problems in Cardiology (2021), doi: https://doi.org/10.1016/j.cpcardiol.2021.101011 Unpublished Preprint Here

pump because of the loss of contractile power." From on-line Anatomy & Physiology, OSU

'Mild Myocarditis' or 'Benign Myocarditis' are oxymoron's; a phrase fabricated by vaccine proponents. It's a lie to soften the true nature of the harmful effects of the vaccine that could forever limit performance of a would-be athlete or lead to long term heart disease. An inflammation of the heart muscle (myocardium). The inflammation can kill tissue, reduce the heart's ability to pump and cause rapid or irregular heart rhythms (arrhythmias). Signs and symptoms of myocarditis include chest pain, fatigue, shortness of breath, and rapid or irregular heartbeats. In a small percentage of cases persons with myocarditis can be at risk of sudden death following strenuous activity.

Some sufferers of myocarditis may require heart surgery or a heart transplant later in life. And there are no benefits from the vaccine to balance the risk of myocarditis for the younger age groups. Especially now since the vaccines in circulation were designed for the alpha variant, now extinct. The mainstream media is also culpable, promoting narratives to promote fear and cause coercion. Permanent heart damage does occur, however 'mild' the case might be – and the most vulnerable victims are our children and young adults. Does the risk of Covid-19 sequelae exceed the risk of reduced cardiac capacity for these young people? No one has offered any evidence, any calculations or rigorous analysis that warrants such a decision being made.

The paper McCullough co-authored with Rose completed peer review and was approved for publication, but the publisher, Elsevier, assigned it a "temporary removal" — without any explanation or cause.[21] One can only assume Elsevier purposely removed the publication because it went against the narrative of the political machine established to protect the vaccines or fear they would lose sponsorship or funding from pharma. This was done without consideration of the harm to people they might be causing by limiting essential information.

Here is one paper published by Oster et al addressing the harm of vaccine induced myocarditis:

> Oster ME, Shay DK, Su JR, Gee J, Creech CB, Broder KR, Edwards K, Soslow JH, Dendy JM, Schlaudecker E, Lang SM, Barnett ED, Ruberg FL, Smith MJ, Campbell MJ, Lopes RD, Sperling LS, Baumblatt JA, Thompson DL, Marquez PL, Strid P, Woo J, Pugsley R, Reagan-Steiner S, DeStefano F, Shimabukuro TT. **Myocarditis Cases Reported After mRNA-Based COVID-19 Vaccination in the US From December 2020 to August 2021**. JAMA. 2022 Jan 25, 327(4): 331-340. https://jamanetwork.com/journals/jama/fullarticle/2788346

Oster's yearlong study of vaccine rollout addressed the question: What is the risk of myocarditis after mRNA-based COVID-19 vaccination in the US? The main finding was that, of 1626 adjudicated cases of reported myocarditis, occurring within 7 days after vaccination, exceeded the expected rates across multiple age and sex strata. These rates were highest after the second vaccination in males aged 12 to 15 years (70.7 per million doses of the BNT162b2 vaccine), in males aged 16 to 17 years (105.9 per million doses of the BNT162b2 vaccine), and in males aged 18 to 24 years (52.4 and

[21] https://retractionwatch.com/2021/10/17/paper-linking-covid-19-vaccines-to-myocarditis-is-temporarily-removed-without-explanation/

56.3 per million doses of the BNT162b2 vaccine and the mRNA-1273 vaccine, respectively). The researchers used as their source of data, the CDC's VAERS database.

Despite persistent castigation of VAERS by vaccine proponents and mass news media narratives, Oster describes how his researchers carefully and procedurally adjudicated data to provide a confident and reliable analysis. They indeed reported the limitations, however most important to note they believe their estimates are low due to the expectation that the biases are in the direction of under-reporting:

> *"This study has several limitations. First, although clinicians are required to report serious adverse events after COVID-19 vaccination, including all events leading to hospitalization, VAERS is a passive reporting system. As such, the reports of myocarditis to VAERS may be incomplete, and the quality of the information reported is variable. Missing data for sex, vaccination dose number, and race and ethnicity were not uncommon in the reports received; history of prior SARS-CoV-2 infection also was not known. Furthermore, as a passive system, VAERS data are subject to reporting biases in that both underreporting and over reporting are possible.38 Given the high verification rate of reports of myocarditis to VAERS after mRNA based COVID-19 vaccination, underreporting is more likely. Therefore, the actual rates of myocarditis per million doses of vaccine are likely higher than estimated."*

Oster is one of the few that didn't candy coat his conclusions and warned that the cases are probably being under-reported.

Citations on myocarditis comprise of at least 186 papers listed here, all addressing studies and case reports of COVID-19 vaccine induced myocarditis or pericarditis. Note the term 'fulminant' indicates that the condition requires some means of intervention to ensure sufficient circulation to continue life. Covid vaccination and the outcome of heart inflammation cannot be undone. There is no antidote or treatment that will restore the heart to its original state.

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> *Myocarditis following COVID-19 vaccination is often mild, seen more commonly in young healthy males and is followed by rapid recovery with conservative treatment. The emergence of this adverse event calls for harmonizing case definitions and definite treatment guidelines which require wider research.*
>
> AND
>
> *Only 6 patients died among 1317 of whom data was available*

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Power Paper:

> *Medical history has little influence on the risk-benefit profile of COVID-19 vaccination except in the case of prior myocarditis or pericarditis.*
>
> *A CDC analysis published in June 2021 determined that for every million males age 12–29 who underwent a 2-dose regimen of mRNA COVID-19 vaccine, "11,000 COVID-19 cases, 560 hospitalizations, 138 ICU admissions, and six deaths due to COVID-19 could be prevented, compared with 39–47 expected myocarditis cases after COVID-19 vaccination."" [105] This analysis was based on May 2021 rates of COVID-19 prevalence, morbidity, and mortality and served as the basis for CDC recommendations to vaccinate children age 12–15 [106]. In a more flexible risk-benefit model, Gurdasani et al. estimated that in children age 12– 17, the number of prevented COVID-related hospitalizations exceeds the incidence of mRNA vaccine-associated myocarditis as long as the incidence of COVID-19 is greater than 30/100,000 teenagers per week, a level unseen in England throughout 2021 [107].*

The fault in this analysis is that public health is attempting to treat the population as a whole "for the greater good" and by that philosophy willing to incur vaccine killed or injured cases; cases that may have managed fine from any injury from infection or even infection itself. These protective measures might improve statistical measures but can unneccesatrily sacrifice individual health.

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Amir paper:

> *Late CMR follow up demonstrated resolution of the edema in all patients, while **some had evidence of residual myocardial scarring**.*

So I ask, residual myocardial scarring can be considered a 'mild' effect from vaccination? NO!!!

I'll add that the death of cardiocytes, ANY necrosis of cardiac muscle tissue, which subsequently results in replacement by non-contractile collagenic tissue constitutes PERMANENT diminished reduction in cardiac capacity.

- Reduced athletic ability
- Risk for future serious cardiac events including death
- Increased risk for LVD surgery, heart transplant later in life

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Cited in the conclusion of the paper by Ilonze:

> *Because fatal cases occur at any age, no case should be dismissed as just having "benign myocarditis," especially if left ventricular ejection fraction is compromised and if it occurs in older female patients.*

Karlstad Ø, Hovi P, Husby A, et al. **SARS-CoV-2 Vaccination and Myocarditis in a Nordic Cohort Study of 23 Million Residents**. JAMA Cardiol. Published online April 20, 2022. doi:10.1001/jamacardio.2022.0583 https://jamanetwork.com/journals/jamacardiology/fullarticle/2791253

> *Results of this large cohort study indicated that both first and second doses of mRNA vaccines were associated with increased risk of myocarditis and pericarditis. For individuals receiving 2 doses of the same vaccine, risk of myocarditis was highest among young males (aged 16-24 years) after the second dose. These findings are compatible with between 4 and 7 excess events in 28 days per 100 000 vaccinees after BNT162b2, and between 9 and 28 excess events per 100 000 vaccinees after mRNA-1273. This risk should be balanced against the benefits of protecting against severe COVID-19 disease.*

The statement: *This risk should be balanced against the benefits of protecting against severe COVID-19 disease* seems to be a common statement in many of the papers where the findings reveal what appears to be significant risks of harms from the vaccines. Yet none of these studies delve any further into researching what that tradeoff might be. This is irresponsible and neglectful reporting. Candi coating to get past the peer review and be published. Unethical and criminal.

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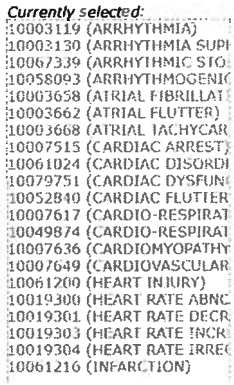

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> Chida et al: *Here, we reported two cases of VADA that ruptured immediately after the administration of different mRNA antiCOVID-19 vaccines. In both*

cases, caliber irregularity of the VA was retrospectively identified on MRA before vaccination, suggesting that unruptured VA dissection had already developed. Then, these VADAs ruptured immediately after the vaccination.[23]

Jeet Kaur R, Dutta S, Charan J, Bhardwaj P, Tandon A, Yadav D, Islam S, Haque M. **Cardiovascular Adverse Events Reported from COVID-19 Vaccines: A Study Based on WHO Database**. Int J Gen Med. 2021 Jul 27;14:3909-3927. doi: 10.2147/IJGM.S324349. PMID: 34349544; PMCID: PMC8326931. https://pubmed.ncbi.nlm.nih.gov/34349544/

> ***Results***: *For the cardiovascular system, 4863 adverse events (AEs) were reported from BNT162b2 Pfizer, 1222 AstraZeneca, Moderna, and other COVID-19 vaccines. Common adverse events observed with vaccines under study were tachycardia (16.41%), flushing (12.17%), hypertension (5.82%), hypotension (3.60%) and peripheral coldness (2.41%). Based on disproportionality analysis (IC025 values), acute myocardial infarction, cardiac arrest, and circulatory collapse were linked to the vaccines in the age group >75 years. Hypertension, severe hypertension, supraventricular tachycardia, sinus tachycardia, and palpitations were associated across all age groups and either gender. Amongst the investigations, abnormal ECG findings raised C-reactive protein, elevated D dimer, and troponin were reported in specific age groups or gender or all subjects.*
>
> ***Conclusion***: *Although cardiovascular events have been reported with the COVID-19 vaccines, the causality is yet to be established because such CVS AEs are also usually associated with the general public even without intervention. Hence, people should be administered these vaccines, and sustained monitoring of these AEs should be done.*

OK – so then why didn't the researchers design their study with a control group? Junk Science

Sun CLF, Jaffe E, Levi R. **Increased emergency cardiovascular events among under-40 population in Israel during vaccine rollout and third COVID-19 wave**. Sci Rep. 2022 Apr 28;12(1):6978. doi: 10.1038/s41598-022-10928-z. PMID: 35484304; PMCID: PMC9048615. https://pubmed.ncbi.nlm.nih.gov/35484304/

The Sun paper is in a Nature Journal and was featured in the May 4-10 issue of the Epoch Times

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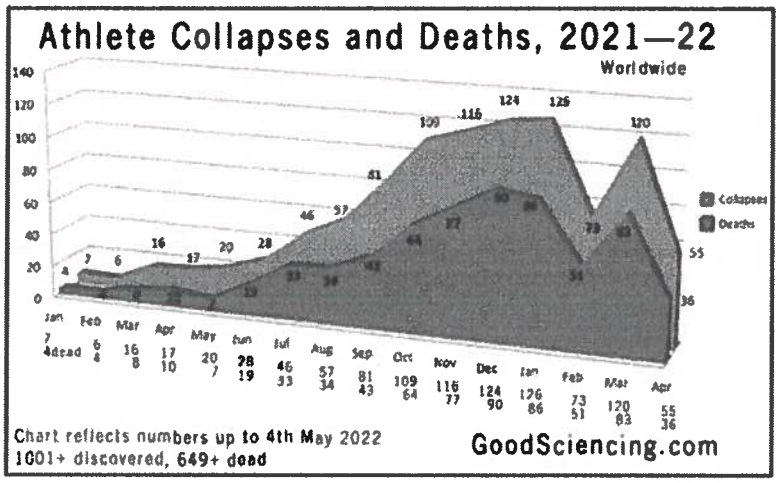
[23] Although this paper makes no reference to blood pressure in the case reports, see the high incidence of hypertension associated with COVID-19 vaccines in this report which appears to occur immediately after vaccination. Perhaps this was the trigger for aneurysm existing unruptured dissections.

Mohamed E, Coyle P, Kumar TS, Molokhia A, Harris T. **Cardiac arrest secondary to Covid19 pneumonia post full vaccination**. Am J Emerg Med. June 19 2021 ;49:257-258. doi:10.1016/j.ajem.2021.06.027 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8214330/pdf/main.pdf

see also a list of athletes killed or injured by the vaccines:

Big List of Athletes After Jab



From: https://stevekirsch.substack.com/p/more-troubling-data-for-the-vaccine?s=r

20. **614 Symptoms reported as myositis;** 39% within two days after injection

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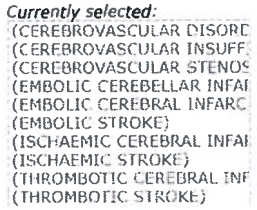
D J Theodorou, Drs, S J Theodorou, A Axiotis, M Gianniki, N Tsifetaki, **COVID-19 vaccine-related myositis, QJM: An International Journal of Medicine**, Volume 114, Issue 6, June 2021, Pages 424–425, https://doi.org/10.1093/qjmed/hcab043
PDF

M. Blaise,F. Rocher,H. Spittler,A. Sanchez,E. Lanteri,L. Coco,A. Puma,A. Martel,G. Gonfrier,T. Passeron,H. Montaudié, **Severe necrotizing myopathy after COVID-19 vaccine with BNT162b2 and regimen with ipilimumab plus nivolumab in a patient with advanced melanoma,** First published: 17 October 2021, Journal of the European Academy of Dermatology and Venerology.
https://onlinelibrary.wiley.com/doi/full/10.1111/jdv.17760

21. **2,856 Symptoms reported as ischemic stroke;** 30% within two days after injection



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22. **884 Symptoms reported as cerebral venous sinus thrombosis (CVST);** 37% within ten days after injection.

Eric Kowarz, Lea Krutzke, Marius Külp, Patrick Streb, Patrizia Larghero, Jennifer Reis, Silvia Bracharz, Tatjana Engler, Stefan Kochanek, Rolf Marschalek (2022) **Vaccine-induced COVID-19 mimicry syndrome** eLife 11:e74974 https://doi.org/10.7554/eLife.74974 https://elifesciences.org/articles/74974

> In Kowarz et al: *In some rare cases, cerebral venous sinus thromboses (CVST) have been reported as a severe side effect occurring 4–14 days after the first vaccination and were often accompanied by thrombocytopenia. Besides CVST, splanchnic vein thromboses (SVT) and other thromboembolic events have been observed.* ***These events only occurred following vaccination with adenoviral vector-based vaccines*** *but not following vaccination with mRNA-based vaccines. Meanwhile, scientists have proposed an immune-based pathomechanism and the condition has been coined vaccine-induced immune thrombotic thrombocytopenia (VITT). Here, we describe an unexpected mechanism that could explain thromboembolic events occurring with DNA-based but not with RNA-based vaccines.* ***We show that DNA-encoded mRNA coding for Spike protein can be spliced in a way that the transmembrane anchor of Spike is lost, so that nearly full-length Spike is secreted from cells. Secreted Spike variants could potentially initiate severe side effects when binding to cells via the ACE2 receptor.***

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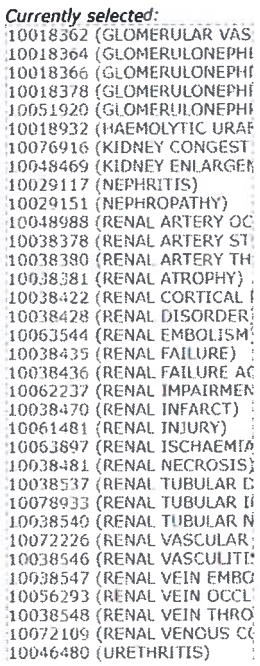
24. **3,236 Symptoms reported as of kidney or renal failure, nephritis, Glomerulonephritis, Hemolytic uremic syndrome (HUS) or other urinary system failures;** 29% within two days after injection.



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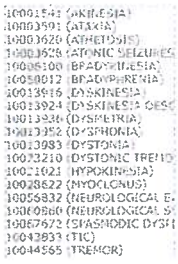
26. **31,232 Symptoms reported as tremor, dyskinesia, dystonia, myoclonus, tics, rigidity, spasmodic dysphonia, akinesia, bradykinesia, hypokinesia, Ataxia, dysmetria, asynergia, Athetosis, Bradyphrenia or other neurological pathologies;** 69% within 2 days of injection.



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27. **2,881 Symptoms reported as Guillain-Barré syndrome**; 22% within 2 days after injection.

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28. **456 Symptoms reported as myasthenia gravis**; 23% within 2 days after injection

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30. **10,356 Symptoms reported as of convulsions or seizure;** 62% within 1 day after injection.

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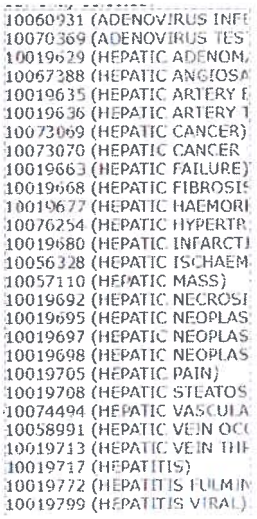
31. **1,693 Symptoms reported as hepatitis, hepatic sarcomas, hepatic vasculature embolism, thrombosis, hemorrhage or adenoviral infection**; 30% within 2 days after injection


10060931 (ADENOVIRUS INFE
10070369 (ADENOVIRUS TES
10019629 (HEPATIC ADENOM
10067388 (HEPATIC ANGIOSA
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10019663 (HEPATIC FAILURE)
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10019677 (HEPATIC HAEMORI
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10074494 (HEPATIC VASCULA
10058991 (HEPATIC VEIN OC
10019713 (HEPATIC VEIN THI
10019717 (HEPATITIS)
10019772 (HEPATITIS FULMIN
10019799 (HEPATITIS VIRAL)

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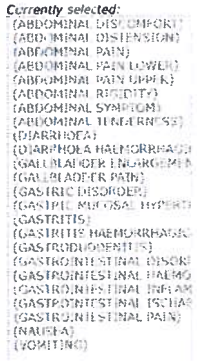
32. **184,539 Symptoms reported as diarrhea, abdominal pain, gastritis, vomiting or other digestive system pathology**; 69% within two days of injection



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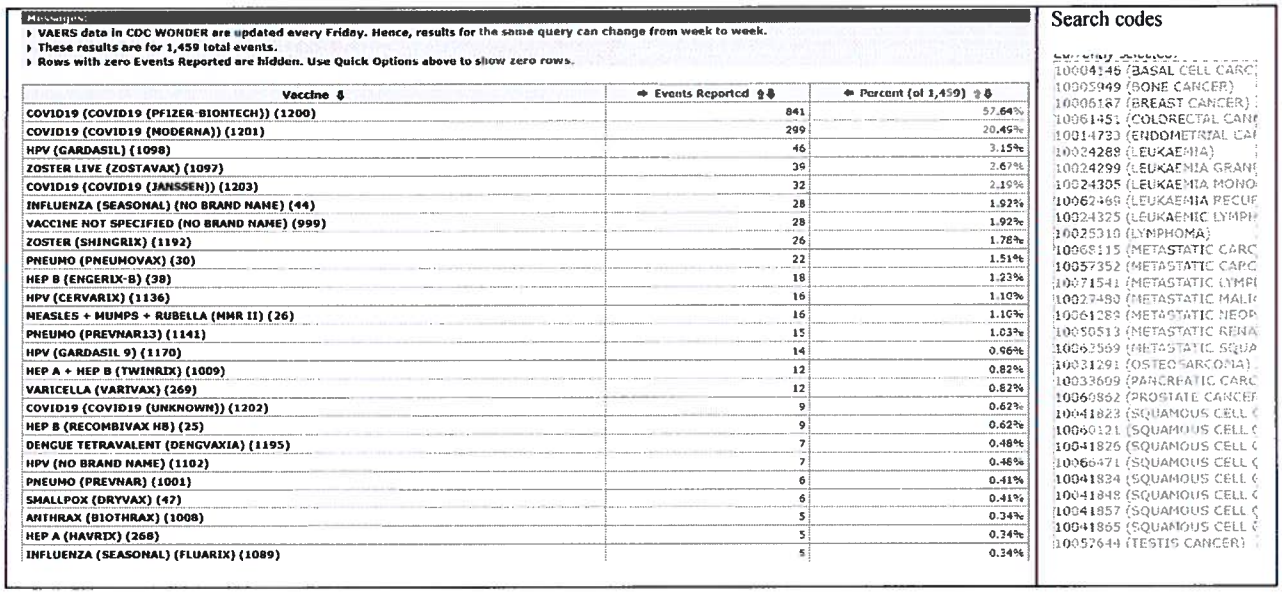
33. **1,172 Symptoms reported as Cancer;** COVID-19 vaccines account for over 80% of all cancers associated with all vaccinations over 30 years (1,459)



Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 1,459 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 1,459)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	841	57.64%
COVID19 (COVID19 (MODERNA)) (1201)	299	20.49%
HPV (GARDASIL) (1098)	46	3.15%
ZOSTER LIVE (ZOSTAVAX) (1097)	39	2.67%
COVID19 (COVID19 (JANSSEN)) (1203)	32	2.19%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	28	1.92%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	28	1.92%
ZOSTER (SHINGRIX) (1192)	26	1.78%
PNEUMO (PNEUMOVAX) (30)	22	1.51%
HEP B (ENGERIX-B) (38)	18	1.23%
HPV (CERVARIX) (1136)	16	1.10%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	16	1.10%
PNEUMO (PREVNAR13) (1141)	15	1.03%
HPV (GARDASIL 9) (1170)	14	0.96%
HEP A + HEP B (TWINRIX) (1009)	12	0.82%
VARICELLA (VARIVAX) (269)	12	0.82%
COVID19 (COVID19 (UNKNOWN)) (1202)	9	0.62%
HEP B (RECOMBIVAX HB) (25)	9	0.62%
DENGUE TETRAVALENT (DENGVAXIA) (1195)	7	0.48%
HPV (NO BRAND NAME) (1102)	7	0.48%
PNEUMO (PREVNAR) (1001)	6	0.41%
SMALLPOX (DRYVAX) (47)	6	0.41%
ANTHRAX (BIOTHRAX) (1008)	5	0.34%
HEP A (HAVRIX) (268)	5	0.34%
INFLUENZA (SEASONAL) (FLUARIX) (1089)	5	0.34%

Search codes

10004146 (BASAL CELL CARC
10005949 (BONE CANCER)
10006187 (BREAST CANCER)
10061451 (COLORECTAL CAN
10014733 (ENDOMETRIAL CA
10024289 (LEUKAEMIA)
10024299 (LEUKAEMIA GRAN
10024305 (LEUKAEMIA MONO
10062469 (LEUKAEMIA RECUR
10024325 (LEUKAEMIC LYMPH
10025310 (LYMPHOMA)
10068115 (METASTATIC CARC
10057352 (METASTATIC CARC
10071541 (METASTATIC LYMPH
10027480 (METASTATIC MALI
10061289 (METASTATIC NEOP
10050513 (METASTATIC RENA
10062569 (METASTATIC SQUA
10031291 (OSTEOSARCOMA)
10033609 (PANCREATIC CARC
10060862 (PROSTATE CANCER
10041823 (SQUAMOUS CELL C
10060121 (SQUAMOUS CELL C
10041826 (SQUAMOUS CELL C
10066471 (SQUAMOUS CELL C
10041834 (SQUAMOUS CELL C
10041848 (SQUAMOUS CELL C
10041857 (SQUAMOUS CELL C
10041865 (SQUAMOUS CELL C
10057644 (TESTIS CANCER)

34. **40,288 Symptoms reported as Lymphadenopathy or Lymphadenitis**; 66% within two days of injection

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35. **11,511 Symptoms reported as Cognitive Disorder or Confusional State**; 60% within two days of injection

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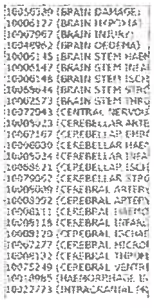
36. **6,829 Symptoms reported as intracranial hemorrhage or brain bleed;** 33% within two days of injection



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Purkayastha P, Mckechnie C, Kalkur P, et al **Rare case of COVID-19 vaccine-associated intracranial hemorrhage with venous sinus thrombosis** BMJ Case Reports CP 2021;14:e245092. https://casereports.bmj.com/content/bmjcr/14/9/e245092.full.pdf

37. **3,031 Symptoms reported as alopecia;** 30% within two days of injection

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May Lee M, Bertolani M, Pierobon E, Lotti T, Feliciani C, Satolli F. **Alopecia areata following COVID-19 vaccination: vaccine-induced autoimmunity?** Int J Dermatol. 2022 May;61(5):634-635. doi: 10.1111/ijd.16113. Epub 2022 Feb 2. PMID: 35107173. https://pubmed.ncbi.nlm.nih.gov/35107173/

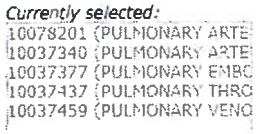
Rossi A, Magri F, Michelini S, Caro G, Di Fraia M, Fortuna MC, Pellacani G, Carlesimo M. **Recurrence of alopecia areata after covid-19 vaccination: A report of three cases in Italy.** J Cosmet Dermatol. 2021 Dec;20(12):3753-3757. doi: 10.1111/jocd.14581. Epub 2021 Nov 6. PMID: 34741583. https://pubmed.ncbi.nlm.nih.gov/34741583/

38. **3,509 Symptoms reported as aphasia**; 51% within two days of injection

Saleh M, Zimmermann J, Lehnen NC, Pötzsch B, Weller JM. **Late-Onset Vaccine-Induced Immune Thombotic Thrombocytopenia (VITT) with Cerebral Venous Sinus Thrombosis.** J Stroke Cerebrovasc Dis. 2022 Apr;31(4):106311. doi: 10.1016/j.jstrokecerebrovasdis.2022.106311. Epub 2022 Jan 29. PMID: 35093626; PMCID: PMC8799476. https://pubmed.ncbi.nlm.nih.gov/35093626/

Aphasia can be caused by the COVID vaccine Steve Kirsch, March 30, 2022

39. **13,398 Symptoms reported as pulmonary embolism, pulmonary thromboembolism or pulmonary thrombus;** 42% within 10 days of injection



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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8280905/pdf/bcr-2021-243975.pdf

40. **7,851 Symptoms reported as pneumonia, adenoviral pneumonia or pulmonary edema**; 26% within 2 days of injection

Yoshikawa T, Tomomatsu K, Okazaki E, Takeuchi T, Horio Y, Kondo Y, Oguma T, Asano K. **COVID-19 vaccine-associated organizing pneumonia**. Respirol Case Rep. 2022 Mar 29;10(5):e0944. doi: 10.1002/rcr2.944. PMID: 35386579; PMCID: PMC8965045.
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41. **619 Symptoms reported as interstitial lung disease**; 22% within 2 days of injection

So C, Izumi S, Ishida A, Hirakawa R, Kusaba Y, Hashimoto M, Ishii S, Miyazaki H, Iikura M, Hojo M. **COVID-19 mRNA vaccine-related interstitial lung disease: Two case reports and literature review**. Respirol Case Rep. 2022 Mar 23;10(4):e0938. doi: 10.1002/rcr2.938. PMID: 35355663; PMCID: PMC8942814.
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DeDent AM, Farrand E **Vaccine-induced interstitial lung disease: a rare reaction to COVID-19 vaccination** Thorax Published Online First: 11 September 2021. doi: 10.1136/thoraxjnl-2021-217985
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Miqdadi A, Herrag M (October 21, 2021) **Acute Eosinophilic Pneumonia Associated With the Anti-COVID-19 Vaccine AZD1222**. Cureus 13(10): e18959. doi:10.7759/cureus.18959
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42. **9,298 Symptoms reported as Deep vein thrombosis (DVT), phlebitis or thrombophlebitis;** 45% within 10 days of injection

Roncati L, Manenti A, Corsi L. **A Three-Case Series of Thrombotic Deaths in Patients over 50 with Comorbidities Temporally after modRNA COVID-19 Vaccination**. Pathogens. 2022 Apr 3;11(4):435. doi: 10.3390/pathogens11040435. PMID: 35456110; PMCID: PMC9032304.
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Vallone MG, Falcón AL, Castro HM, Ferraris A, Cantarella RF, Staneloni MI, Aliperti VI, Ferloni A, Mezzarobba D, Vázquez FJ, Ratti MFG. **Thrombotic events following Covid-19 vaccines compared to Influenza vaccines**. Eur J Intern Med. 2022 May;99:82-88. doi: 10.1016/j.ejim.2022.03.002. Epub 2022 Mar 9. PMID: 35288031; PMCID: PMC8904150.
https://pubmed.ncbi.nlm.nih.gov/35288031/

The Vallone study found twice the number of thrombotic events for covid-19 vaccines over flu vaccines; statistically significant, and cited the following conclusion:

> *This study shows a significant increase in thrombotic events in subjects vaccinated with Covid-19 vaccines in comparison to a control group. The clinical implication of these findings should be interpreted with caution, in light of the high effectiveness of vaccination and the inherent risk of thrombosis from Covid-19 infection itself.*[24]

Bhan C, Bheesham N, Shakuntulla F, Sharma M, Sun C, Weinstein M. **An unusual presentation of acute deep vein thrombosis after the Moderna COVID-19 vaccine-a case report**. Ann Transl Med. 2021 Oct;9(20):1605. doi: 10.21037/atm-21-2772. PMID: 34790811; PMCID: PMC8576696.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8576696/pdf/atm-09-20-1605.pdf

43. **566 Symptoms reported as coma or brain death;** 34% within 2 days of injection

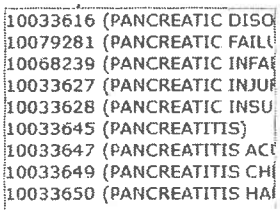
Uzun G, Bohnert BN, Althaus K, Nann D, Nadalin S, Heyne N, Fend F, Haap M, Bakchoul T. **Organ Donation From a Brain Dead Donor With Vaccine-induced Immune Thrombotic Thrombocytopenia After Ad26.COV2.S: The Risk of Organ Microthrombi**. Transplantation. 2022 Mar 1;106(3):e178-e180. doi: 10.1097/TP.0000000000004039. PMID: 34974451; PMCID: PMC8862669.
https://pubmed.ncbi.nlm.nih.gov/34974451/

Guditi S, Setty G, Verma M, Reddy R, Devraj R, Raju SB, Gokhale GK. **Vaccine-Induced Thrombotic Thrombocytopenia Due to Coronavirus Disease 2019 Vaccine From a Deceased Donor: A Case Report**.

[24] This last sentence candy coats the conclusion, and the paper further offers no substantial statistics to firmly support the statement. In court a defense attorney for the case would call *hearsay*.

Transplant Proc. 2021 Nov 12:S0041-1345(21)00794-6. doi: 10.1016/j.transproceed.2021.11.002. Epub ahead of print. PMID: 34916063; PMCID: PMC8585593. https://pubmed.ncbi.nlm.nih.gov/34916063/

44. **1,229 Symptoms reported as Pancreatitis;** 32% within 2 days of injection



Parkash O, Sharko A, Farooqi A, Ying GW, Sura P. **Acute Pancreatitis: A Possible Side Effect of COVID-19 Vaccine**. Cureus. 2021;13(4):e14741. Published 2021 Apr 28. doi:10.7759/cureus.14741 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8163516/pdf/cureus-0013-00000014741.pdf

45. **22,675 Symptoms reported as tinnitus, hearing impairment, auditory disorder, auditory nerve disorder;** 51% within 2 days of injection

Saunders GH, Beukes E, Uus K, Armitage CJ, Kelly J, Munro KJ. **Shedding Light on SARS-CoV-2, COVID-19, COVID-19 Vaccination, and Auditory Symptoms: Causality or Spurious Conjunction?** Front Public Health. 2022 Feb 22;10:837513. doi: 10.3389/fpubh.2022.837513. PMID: 35296050; PMCID: PMC8919951. https://pubmed.ncbi.nlm.nih.gov/35296050/

Shirai T, Suzuki J, Kuniyoshi S, Tanno Y, Fujii H. **Granulomatosis with Polyangiitis Following Pfizer-BioNTech COVID-19 Vaccination**. Mod Rheumatol Case Rep. 2022 Mar 4:rxac016. doi: 10.1093/mrcr/rxac016. Epub ahead of print. PMID: 35246689; PMCID: PMC8903471. https://pubmed.ncbi.nlm.nih.gov/35246689/

Ulrich AK, Sundaram ME, Osterholm MT. Rare Sudden Sensorineural Hearing Loss Potentially Associated With COVID-19 Vaccination Does Not Outweigh the Benefit of COVID-19 Vaccines. JAMA Otolaryngol Head Neck Surg. 2022 Feb 24. doi: 10.1001/jamaoto.2021.4279. Epub ahead of print. PMID: 35201285. https://pubmed.ncbi.nlm.nih.gov/35201285/

Formeister EJ, Chien W, Agrawal Y, Carey JP, Stewart CM, Sun DQ. **Preliminary Analysis of Association Between COVID-19 Vaccination and Sudden Hearing Loss Using US Centers for Disease Control and Prevention Vaccine Adverse Events Reporting System Data**. JAMA Otolaryngol Head Neck Surg. 2021;147(7):674–676. doi:10.1001/jamaoto.2021.0869 https://jamanetwork.com/journals/jamaotolaryngology/fullarticle/2780288

Briggs SE, Brenner MJ, Chandrasekhar SS. **Sudden Sensorineural Hearing Loss and COVID-19 Vaccination**. JAMA Otolaryngol Head Neck Surg. Published online November 24, 2021. doi:10.1001/jamaoto.2021.3384 https://jamanetwork.com/journals/jamaotolaryngology/article-abstract/2786751

46. **629 Symptoms reported as Rhabdomyolysis**; 39% within 2 days of injection

Kalekar TM, Jaipuria RK, Navani RS. **MRI Findings in Case of Post-COVID-19 Vaccination Rhabdomyolysis: A Rare Postvaccination Adverse Effect**. Indian J Radiol Imaging. 2022 Jul 13;32(2):256-259. doi: 10.1055/s-0042-1748534. PMID: 35924123; PMCID: PMC9340183. https://pubmed.ncbi.nlm.nih.gov/35924123/

Unger K, Ponte CD, Anderson D. **A Possible Case of COVID-19 Booster Vaccine-Associated Rhabdomyolysis and Acute Kidney Injury**. J Pharm Technol. 2022 Aug; 38(4):247-250. doi:

10.1177/87551225221093944. Epub 2022 May 3. PMID: 35832563; PMCID: PMC9272487. https://pubmed.ncbi.nlm.nih.gov/35832563/

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Ajmera KM. **Fatal Case of Rhabdomyolysis Post-COVID-19 Vaccine.** Infect Drug Resist. 2021;14:3929-3935. Published 2021 Sep 24. doi:10.2147/IDR.S331362 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8478340/pdf/idr-14-3929.pdf

Gelbenegger G, Cacioppo F, Firbas C, Jilma B. **Rhabdomyolysis Following Ad26.COV2.S COVID-19 Vaccination.** Vaccines. 2021; 9(9):956. https://doi.org/10.3390/vaccines9090956 https://www.mdpi.com/2076-393X/9/9/956

Hakroush S, Tampe B. **Case Report: ANCA-Associated Vasculitis Presenting With Rhabdomyolysis and Pauci-Immune Crescentic Glomerulonephritis After Pfizer-BioNTech COVID-19 mRNA Vaccination.** Front Immunol. 2021 Sep 30;12:762006. doi: 10.3389/fimmu.2021.762006. PMID: 34659268; PMCID: PMC8514980. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8514980/pdf/fimmu-12-762006.pdf

47. **15,867 Symptoms reported as Hypertension**; 54% within 1 days of injection.

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For COVID-19 vaccines, Pfizer accounts for over 70% of the cases of hypertension, but this may only be due to Pfizer being the the major vaccine distributed.

Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 15,867 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 15,867)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	11,340	71.47%
COVID19 (COVID19 (MODERNA)) (1201)	4,108	25.89%
COVID19 (COVID19 (JANSSEN)) (1203)	900	5.80%
COVID19 (COVID19 (UNKNOWN)) (1202)	63	0.40%

48. **318 Symptoms reported as Multisystem Inflammatory Syndrome**; 20% within 2 days of injection.

Although MIS, and in particular MIS-C has been in the news and published literature as a concern, VAERS is showing relatively few reported cases. Of these cases the breakdown according to vaccine and age group is summarized in the following table. Regardless of this low number, the number that immediately jumps out from the table is that the Pfizer vaccine accounts for 45% of these reports for the age group 6 to 17 years. This might be worth a deeper dig into the specific adverse event details - 160 cases.

Messages:

- **VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.**
- **These results are for 318 total events.**
- **Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.**

Vaccine Manufacturer	Age	Events Reported	Percent (of 318)
JANSSEN	18-29 years	1	0.31%
	30-39 years	1	0.31%
	65-79 years	1	0.31%
	Unknown	2	0.63%
MODERNA	6-17 years	5	1.57%
	18-29 years	6	1.89%
	30-39 years	3	0.94%
	40-49 years	2	0.63%
	50-59 years	3	0.94%
	60-64 years	1	0.31%
	65-79 years	7	2.20%
	Unknown	5	1.57%
PFIZER\BIONTECH	1-2 years	1	0.31%
	3-5 years	14	4.40%
	6-17 years	160	50.31%
	18-29 years	11	3.46%
	30-39 years	2	0.63%
	40-49 years	3	0.94%
	50-59 years	3	0.94%
	60-64 years	2	0.63%
	65-79 years	5	1.57%
	80+ years	2	0.63%
	Unknown	110	34.59%
UNKNOWN MANUFACTURER	6-17 years	1	0.31%
	Unknown	3	0.94%

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10.1016/j.ijid.2021.12.339. Epub 2021 Dec 24. PMID: 34954311; PMCID: PMC8702592. https://pubmed.ncbi.nlm.nih.gov/34954311/

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Yalçinkaya R, Öz FN, Polat M, Uçan B, Teke TA, Kaman A, Özdem S, Savaş Şen Z, Cinni RG, Tanir G. **A Case of Multisystem Inflammatory Syndrome in a 12-Year-old Male After COVID-19 mRNA Vaccine**. Pediatr Infect Dis J. 2022 Mar 1;41(3):e87-e89. doi: 10.1097/INF.0000000000003432. PMID: 34978781; PMCID: PMC8828314. https://pubmed.ncbi.nlm.nih.gov/34978781/

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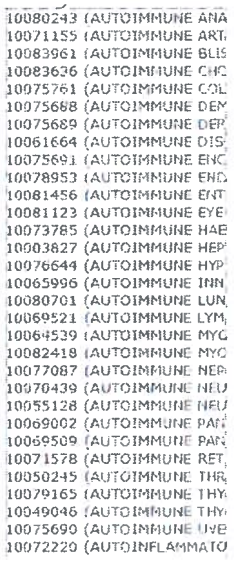
Nune A, Iyengar KP, Goddard C, Ahmed AE. **Multisystem inflammatory syndrome in an adult following the SARS-CoV-2 vaccine (MIS-V)**. BMJ Case Rep. 2021 Jul 29;14(7):e243888. doi: 10.1136/bcr-2021-243888. PMID: 34326117; PMCID: PMC8323360. https://pubmed.ncbi.nlm.nih.gov/34326117/

There was great concern for MIS-C from SARS-Cov-2, but after vaccines were 'approved' for children it was found that the vaccine itself could cause MIS-C. The number of papers, studies just provided here suggest that the number of vaccine associated MIS cases are under-reported in VAERS.

49. **2,453 Symptoms reported as either auto-immune or auto-inflammatory response**; 31% within 2 days of injection.



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Summary – Adverse Events

Unlike mathematics, where propositions can be *proven* with certainty, scientific hypotheses in the strict sense can never be proven. Hypotheses can only be *supported* by presenting evidence that sufficiently *infers* their truth or else *falsified* by as little as one instance of a counter example. Mathematical proof, except for practicing skills, never requires *repetition*. But good science should continually be repeated, even when a hypothesis has been falsified; something could have been improperly assumed or a detail missed. Mathematics is exact, science is not. There is no 'proof' in science. This fact places considerable burden on scientists, much more so than the mathematician. It also raises the question: what is considered *sufficient* to warrant a hypothesis as highly probable? Scientists rely on confidence intervals (CI) but proper use requires the associated (and assumed) statistical models (distributions) represent the reality of the data set. Too often they do not. For vaccines, adverse events occur in the 'noise' over the entirety of data and exist on *fat tailed*[25] distributions. These distributions are NOT normal (Gaussian). For fat tailed distributions, what matters is not so much frequency of occurrence, but rather the *consequences* of these events. Too much attention on low frequency of occurrence over consequence. The consequences for the vaccines, which Bayesian adherents may label 'outliers' to the statistics include the suffering and loss of human lives. Too many fooled by randomness and statistics.

Searching Pubmed (https://pubmed.ncbi.nlm.nih.gov/) today with the search string:

((covid-19 vaccine) OR (covid 19 vaccine) OR (covid-19 vaccines) OR (covid 19 vaccines)) AND ((adverse reaction) OR injury OR death OR VAERS)

Brings up 3,446 results, of course all having been published after December of 2020. This number is overwhelming in such a short time period and we cannot expect the medical community to digest it all, let alone know that such a body of work exists to address the outcome. PubMed unfortunately does not track publications by day or month, only year. But by publishing this compendium report on a monthly basis there is a sense that the growth of publications are exponential. The intent of this report is to make public health officials and other readers aware that despite the public narrative, the vaccines are doing significant harm and causing death. It is hoped that this report will

[25] Taleb NN, Bar-Yam Y, Cirillo P. **On single point forecasts for fat-tailed variables**. Int J Forecast. 2020;10.1016/j.ijforecast.2020.08.008. doi:10.1016/j.ijforecast.2020.08.008 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7572356/

help wake them from the spell this narrative has captured them and that they confirm – or else deny – what is in this report is real. Unless they do that, they are complicit in the narrative and the death and destruction the vaccines have caused.

A high percentage of many of the adverse events noted above having occurred within 2 days of injection of a COVID-19 vaccine substantiates strong temporal correlation[26], but as many will point out, correlation may not necessarily imply causation. Correlation is however a *necessary* condition for causation. Causation is not easy to determine, but scientists typically use the *Bradford Hill* criteria to test for causation. One publication by MacIntyre applies this criteria to thrombocytopenia to successfully argue indeed these events are being caused by the vaccines:

> MacIntyre, C.R., 2021. **Using the Bradford-Hill criteria to assess causality in the association between CHADOX1 NCOV-19 vaccine and thrombotic immune thrombocytopenia**. Global Biosecurity, 3(1), p.None. DOI: http://doi.org/10.31646/gbio.109

Thrombocytopenia is one of the several adverse events in VAERS that that's even been now accepted by the vaccine manufacturers as a strong signal, and now written as a risk in their FACT sheet for informed consent. Thrombocytopenia has been attributed to many of the deaths reported. MacIntyre concludes his study that indeed the vaccines are causing thrombocytopenia:

> *"**In summary, all criteria for causation are met**, with consistency, specificity, temporality and biological plausibility being very clearly met. Strength of association is met, but more data required to establish the precise estimate of the association, as case ascertainment may be variable between countries, resulting in varied estimates of incidence rates from 25 to 0.5 per 100,000 (2, 4). The application of the modified Bradford-Hill criteria to VITT following **CHADOX1 NCOV- vaccine strongly supports a causal relationship**."*

Myocarditis is now also listed in the vaccine FACT sheets as a risk; particularly the number of cases in young male adults. A great number of published and peer reviewed papers, many cited above substantiate causation and should give pause to immediately stop vaccination, at least for these higher risk age groups and revisit the benefit risk analysis. It appears the vaccine manufacturers are NOT taking that action, and the FDA is not enforcing it. But lives appear to be at risk. With such poor response, more doctors, scientists and public health officials must break from the political paralysis that's binding truth for the welfare of a generation. Publications should not hold back in spreading this truth.

An Israeli study by Mevorach et. al. also establishes a causal relationship, increased risk of myocarditis in young male persons receiving the Pfizer BioNtech mRNA vaccines:

Liu R, Pan J, Zhang C, Sun X. **Cardiovascular Complications of COVID-19 Vaccines**. Front Cardiovasc Med. 2022 Mar 18;9:840929. doi: 10.3389/fcvm.2022.840929. PMID: 35369340; PMCID: PMC8971371. https://pubmed.ncbi.nlm.nih.gov/35369340/

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[26] Imran Sulemankhil, Mohammad Abdelrahman, Smita I. Negi, **Temporal association between the COVID-19 Ad26.COV2.S vaccine and acute myocarditis: A case report and literature review**, Cardiovascular Revascularization Medicine, 2021,: https://www.sciencedirect.com/science/article/pii/S1553838921005789

Mevorach D, Anis E, Cedar N, et al. **Myocarditis after BNT162b2 mRNA Vaccine against Covid-19 in Israel**. N Engl J Med. 2021;385(23):2140-2149. doi:10.1056/NEJMoa2109730
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8531987/pdf/NEJMoa2109730.pdf

They write:

> *"The incidence of myocarditis, although low, increased after the receipt of the BNT162b2 vaccine, particularly after the second dose among young male recipients. The clinical presentation of myocarditis after vaccination was usually mild."*

But as I've mentioned above using 'mild' to describe myocarditis is misdirection. Myocarditis leads to necrosis of cardiac tissue. The dead tissue is replaced with collagen fibers (scar tissue). Scar tissue, unlike healthy myocytes, cannot function to contract the heart. This causes permanent diminished cardiac output however small that might be. The changes might not result in death or injury of the person but the changes could be a deciding factor in athletic ability especially in peak performers. Describing myocarditis as 'mild' is medical malfeasance, and the authors are clearly softening the tone for publication so that the paper is not rejected in peer review. This must stop NOW. The present academic dogma is choking scientific expression and harming individuals as much as are the contagion, the vaccines and policy.

> *"The evil that men do lives after them; the good is oft interred with their bones." – Julius Caesar*

Many researchers will do anything to get published; including omission of proper conclusions and bending the truth to satisfy editors. These evil deeds indeed will live after them, frozen in ink. Their published legacy will only reveal them as cowards that participated in the sacrifice of lives. History will regard them as self-indulging enemies of mankind during this tumultuous time.

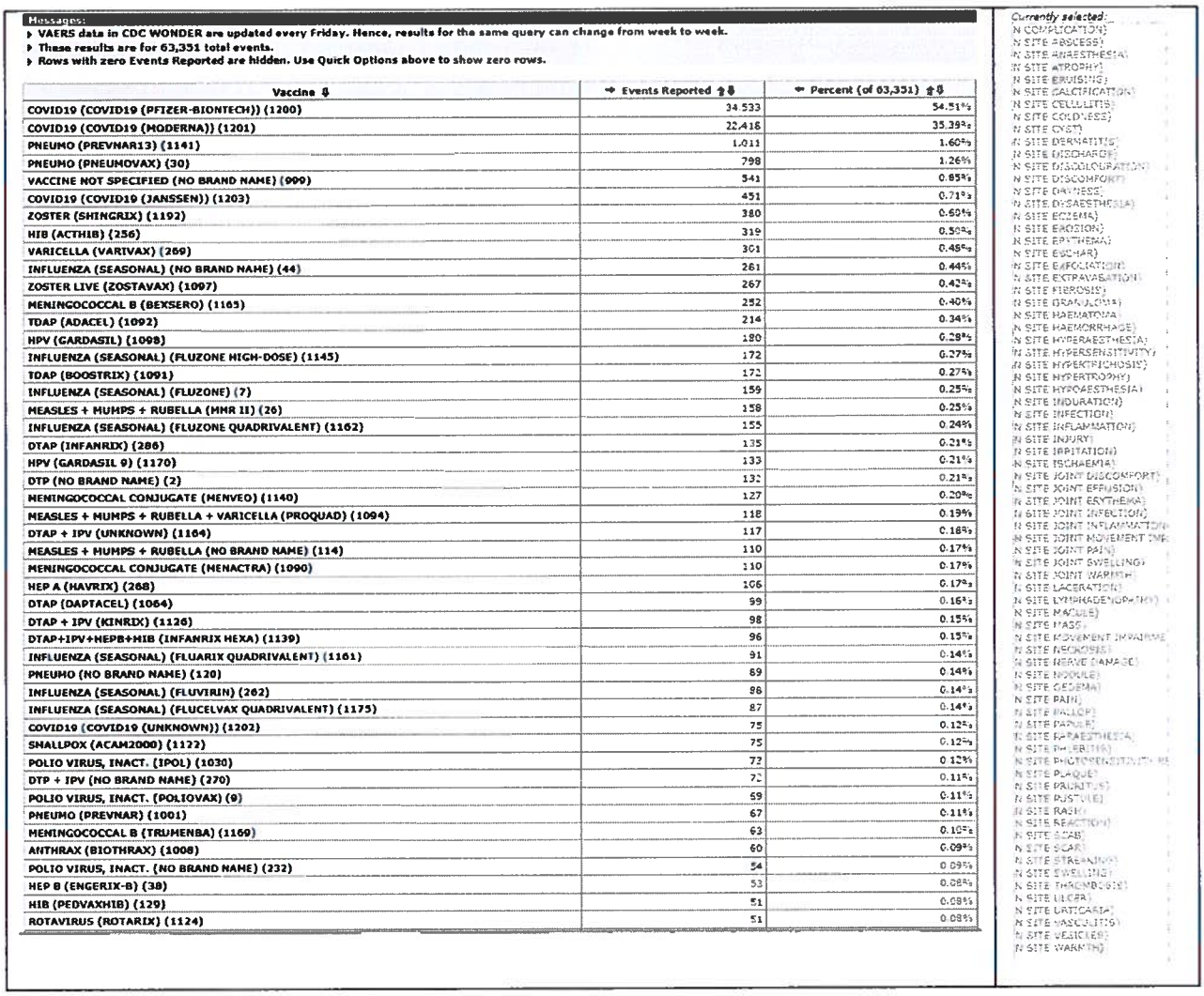
Considering a preponderance of evidence that COVID-19 vaccines are causing harm, the prudent response by officials should at least be NOT demanding that everyone be vaccinated or arranging expensive and intrusive measures to track vaccinated individuals (vaccine passports). These are the same officials that chant "Trust the Science" But the evidence is showing that the vaccines are causing harm. Acting with force and coercion on the order of a 'higher authority' are the actions of mindless zealots, not leaders. We need only to look at history to realize very bad decisions have been made by public health officials in crusades to 'save lives' or 'make lives better'. Some have been by unwitting, negligent people. But others are more surreptitious in their actions driven by power and lucrative profits. Recall the Thalidomide tragedy in the 50's and how long that took to come to an end? From a Nov 2021 report on CNN:

> *"This year, the Covid vaccine has brought in revenue of $24.3 billion. And Pfizer said it expects a total of $36 billion from the vaccine for all of 2021 -- nearly $12 billion more in revenue the final quarter of the year. And it said based on contracts it now has signed it expects revenue $29 billion from the Covid vaccine in 2022. And that's not necessarily all it will bring in."*

This figure now exceeds $40 billion. When this much money is involved, it's difficult to NOT have corruption and influence that's counterproductive to health. As the [illicit] drug cartels have shown, money buys loyalty, obedience and protection.

This website https://www.topmastersinpublichealth.com/10-biggest-medical-scandals-in-history/ chronicles the 10 biggest medical scandals in history last updated in 2017. But given the numbers seen in VAERS alone the COVID-19 vaccine assault on humanity will be the largest ever.

50. VAERS currently reports **63,351 vaccine site complications** for all vaccines, all time with Pfizer and Moderna COVID-19 vaccines alone reporting **56,953** complications (about 90% of vaccination site complications for all vaccines). The Janssen COVID-19 accounts for less than 1%. This is an astounding observation that warrants full investigation.



Messages:
- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 63,351 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine	Events Reported	Percent (of 63,351)
COVID19 (COVID19 (PFIZER-BIONTECH)) (1200)	34,533	54.51%
COVID19 (COVID19 (MODERNA)) (1201)	22,418	35.39%
PNEUMO (PREVNAR13) (1141)	1,011	1.60%
PNEUMO (PNEUMOVAX) (30)	798	1.26%
VACCINE NOT SPECIFIED (NO BRAND NAME) (999)	541	0.85%
COVID19 (COVID19 (JANSSEN)) (1203)	451	0.71%
ZOSTER (SHINGRIX) (1192)	380	0.60%
HIB (ACTHIB) (256)	319	0.50%
VARICELLA (VARIVAX) (269)	301	0.48%
INFLUENZA (SEASONAL) (NO BRAND NAME) (44)	281	0.44%
ZOSTER LIVE (ZOSTAVAX) (1097)	267	0.42%
MENINGOCOCCAL B (BEXSERO) (1165)	252	0.40%
TDAP (ADACEL) (1092)	214	0.34%
HPV (GARDASIL) (1098)	180	0.28%
INFLUENZA (SEASONAL) (FLUZONE HIGH-DOSE) (1145)	172	0.27%
TDAP (BOOSTRIX) (1091)	172	0.27%
INFLUENZA (SEASONAL) (FLUZONE) (7)	159	0.25%
MEASLES + MUMPS + RUBELLA (MMR II) (26)	158	0.25%
INFLUENZA (SEASONAL) (FLUZONE QUADRIVALENT) (1162)	155	0.24%
DTAP (INFANRIX) (286)	135	0.21%
HPV (GARDASIL 9) (1170)	133	0.21%
DTP (NO BRAND NAME) (2)	132	0.21%
MENINGOCOCCAL CONJUGATE (MENVEO) (1140)	127	0.20%
MEASLES + MUMPS + RUBELLA + VARICELLA (PROQUAD) (1094)	118	0.19%
DTAP + IPV (UNKNOWN) (1164)	117	0.18%
MEASLES + MUMPS + RUBELLA (NO BRAND NAME) (114)	110	0.17%
MENINGOCOCCAL CONJUGATE (MENACTRA) (1090)	110	0.17%
HEP A (HAVRIX) (268)	106	0.17%
DTAP (DAPTACEL) (1064)	99	0.16%
DTAP + IPV (KINRIX) (1126)	98	0.15%
DTAP+IPV+HEPB+HIB (INFANRIX HEXA) (1139)	96	0.15%
INFLUENZA (SEASONAL) (FLUARIX QUADRIVALENT) (1161)	91	0.14%
PNEUMO (NO BRAND NAME) (120)	89	0.14%
INFLUENZA (SEASONAL) (FLUVIRIN) (262)	88	0.14%
INFLUENZA (SEASONAL) (FLUCELVAX QUADRIVALENT) (1175)	87	0.14%
COVID19 (COVID19 (UNKNOWN)) (1202)	75	0.12%
SMALLPOX (ACAM2000) (1122)	75	0.12%
POLIO VIRUS, INACT. (IPOL) (1030)	72	0.12%
DTP + IPV (NO BRAND NAME) (270)	72	0.11%
POLIO VIRUS, INACT. (POLIOVAX) (9)	69	0.11%
PNEUMO (PREVNAR) (1001)	67	0.11%
MENINGOCOCCAL B (TRUMENBA) (1169)	63	0.10%
ANTHRAX (BIOTHRAX) (1008)	60	0.09%
POLIO VIRUS, INACT. (NO BRAND NAME) (232)	54	0.09%
HEP B (ENGERIX-B) (38)	53	0.08%
HIB (PEDVAXHIB) (129)	51	0.08%
ROTAVIRUS (ROTARIX) (1124)	51	0.08%

Currently selected:
- N COMPLICATION
- N SITE ABSCESS
- N SITE ANAESTHESIA
- N SITE ATROPHY
- N SITE BRUISING
- N SITE CALCIFICATION
- N SITE CELLULITIS
- N SITE COLDNESS
- N SITE CYST
- N SITE DERMATITIS
- N SITE DISCHARGE
- N SITE DISCOLOURATION
- N SITE DISCOMFORT
- N SITE DRYNESS
- N SITE DYSAESTHESIA
- N SITE ECZEMA
- N SITE EROSION
- N SITE ERYTHEMA
- N SITE ESCHAR
- N SITE EXFOLIATION
- N SITE EXTRAVASATION
- N SITE FIBROSIS
- N SITE GRANULOMA
- N SITE HAEMATOMA
- N SITE HAEMORRHAGE
- N SITE HYPERAESTHESIA
- N SITE HYPERSENSITIVITY
- N SITE HYPERTRICHOSIS
- N SITE HYPERTROPHY
- N SITE HYPOAESTHESIA
- N SITE INDURATION
- N SITE INFECTION
- N SITE INFLAMMATION
- N SITE INJURY
- N SITE IRRITATION
- N SITE ISCHAEMIA
- N SITE JOINT DISCOMFORT
- N SITE JOINT EFFUSION
- N SITE JOINT ERYTHEMA
- N SITE JOINT INFECTION
- N SITE JOINT INFLAMMATION
- N SITE JOINT MOVEMENT IMP
- N SITE JOINT PAIN
- N SITE JOINT SWELLING
- N SITE JOINT WARMTH
- N SITE LACERATION
- N SITE LYMPHADENOPATHY
- N SITE MACULE
- N SITE MASS
- N SITE MOVEMENT IMPAIRME
- N SITE NECROSIS
- N SITE NERVE DAMAGE
- N SITE NODULE
- N SITE OEDEMA
- N SITE PAIN
- N SITE PALLOR
- N SITE PAPULE
- N SITE PARAESTHESIA
- N SITE PHLEBITIS
- N SITE PHOTOSENSITIVITY RE
- N SITE PLAQUE
- N SITE PRURITUS
- N SITE PUSTULE
- N SITE RASH
- N SITE REACTION
- N SITE SCAB
- N SITE SCAR
- N SITE STRAINING
- N SITE SWELLING
- N SITE THROMBOSIS
- N SITE ULCER
- N SITE URTICARIA
- N SITE VASCULITIS
- N SITE VESICLE
- N SITE WARMTH

51. VAERS currently reports:

    29 cases of **Vaccine Associated Enhanced Disease**

    4 case of **Vaccine Virus Shedding** and surprisingly only

    5,502 Vaccine Breakthrough Infections, considering that Omicron BA.4 and BA.5 variants were reporting high breakthrough cases in the news

It's well published now that the COVID-19 vaccines offer little to no protection from delta or omicron variants of the virus. But this figure aligns with reports that the vaccinated, if expressing flu-like symptoms, are NOT being routinely tested for COVID-19[27].

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[27] Carolyn Crist CDC: Fully Vaccinated Can Skip Routine COVID Testing WebMD June 4, 2021

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The Elisha paper says: Subjective perceptions of physicians, nurses, and researchers involved with vaccines through practice and/or research and who take a critical view on vaccines reported being subjected to a variety of censorship and suppression tactics, including

- retraction of papers pointing to vaccine safety problems

- negative publicity
- difficulty in obtaining research funding
- calls for dismissal
- summonses to official hearings
- suspension of medical licenses, and
- self-censorship

Scientific discourse is a hallmark of science and its suppression endangers proper interpretation of the facts by propping up a false impression of scientific consensus.

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Regarding the Röltgen paper, on Feb 8, 2022 Dr. Schooley, an Infectious Disease Specialist at UCSD was featured at the County Board of Supervisors meeting on agenda item 16, the monthly COVID-19 status report from Wilma Wooten at HHS . Schooley addressed immunology as it relates to SARS-Cov-2 infections, the variants and vaccination. In his presentation he explained how the mRNA introduced by the vaccine degrades in 12 hours and that the spike protein, an agent produced by the body's own cells after being reprogrammed by vaccine induced mRNA, disappears over 48 hours. He also mentioned that the mRNA coding, although originally coded to address the alpha variant, still provides protection from the delta and omicron variants. But only a week after Schooley's lesson, Röltgen's work was published indicating otherwise. The residence time of mRNA introduced by the vaccine and spike protein antigen is significantly longer than 12 days. The study detected presence of both factors for up to 60 days in some subjects; that's when the study ended. So it's very possible residence times could be even longer.

Main results from the Röltgen paper:

> •Viral variant infection elicits variant-specific antibodies, but prior mRNA vaccination imprints serological responses toward Wuhan-Hu-1 rather than variant antigens. (that's the alpha variant)
>
> •In contrast to disrupted germinal centers (GCs) in lymph nodes during infection, mRNA vaccination stimulates robust GCs containing vaccine mRNA and spike antigen up to 8 weeks post vaccination in some cases.
>
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> *Large-scale COVID-19 vaccinations are currently underway in many countries in response to the COVID-19 pandemic. Here, we report, besides generation of neutralizing antibodies, consistent alterations in hemoglobin A1c, serum sodium and potassium levels, coagulation profiles, and renal functions in healthy volunteers after vaccination with an inactivated SARS-CoV-2 vaccine. Similar changes had also been reported in COVID-19 patients, suggesting that vaccination mimicked an infection. Single-cell mRNA sequencing (scRNA-seq) of peripheral blood mononuclear cells (PBMCs) before and 28 days after the first inoculation also* ***revealed consistent alterations in gene expression of many different immune cell types. Reduction of CD8+ T cells and increase in classic monocyte contents were exemplary. Moreover, scRNA-seq revealed increased NF-κB signaling and reduced type I interferon responses****, which were confirmed by biological assays and also had been reported to occur after SARS-CoV-2 infection with aggravating symptoms.*

Altogether, our study recommends additional caution when vaccinating people with pre-existing clinical conditions, including diabetes, electrolyte imbalances, renal dysfunction, and coagulation disorders.

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Papers Addressing Excess All Cause Mortality

The problem with determining the difference between causality and correlation is there may be many inputs to the system that can also lead to adverse effects and which may not be observable or even known. The benefit of excess all cause mortality (aka excess deaths) analysis is it doesn't care about inputs. It assumes ALL inputs and depends on a historical trend to determine if more recent outcomes are falling out of line with the trend. So at least several researchers in public health have turned to this tool.

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Revisiting Efficacy of the COVID-19 Vaccines

The fact that the COVID-19 vaccines are causing significant injury and death, and accepting the flawed policy that it's ok to injure some to protect others is an egregious act by public health officials. But wait, there's more. We can still ask the basic question: are the vaccines really providing protection? This question more pertinent than ever considering the vaccines were designed to vector the alpha variant of SARS-Cov2, which no longer exists.

Even the phase 3 Pfizer and Moderna vaccine trials, accepted by the FDA is flawed since the studies used deceptive relative risk reduction (RRR) metrics. In a paper by Brown[29] Brown demonstrated in simple language and mathematics that the number needed to vaccinate to prevent one COVID-19 infection was

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roughly between 80 to 120 persons. That was for the alpha variant. Just how effective now are the vaccines at preventing infection or else the severity of infection? More recently the EPOCH Times[30] addressed this very question by listing summaries of 44 published papers that collectively show evidence the vaccines are NOT effective. The article summaries and links to the original papers are offered here as evidence the vaccines were never effective:

1) Gazit et al. out of Israel showed that "SARS-CoV-2-naïve vaccinees had a **13-fold (95% CI, 8-21) increased risk for breakthrough infection with the Delta variant** compared to those previously infected." When adjusting for the time of disease/vaccine, there was a 27-fold increased risk (95% CI, 13-57).

2) Ignoring the risk of infection, given that someone was infected, Acharya et al. found "**no significant difference in cycle threshold values between vaccinated and unvaccinated**, asymptomatic and symptomatic groups infected with SARS-CoV-2 Delta."

3) Riemersma et al. found "**no difference in viral loads when comparing unvaccinated individuals** to those who have vaccine "breakthrough" infections. Furthermore, individuals with vaccine breakthrough infections frequently test positive with viral loads consistent with the ability to shed infectious viruses." Results indicate that "if vaccinated individuals become infected with the delta variant, they may be sources of SARS-CoV-2 transmission to others." They reported "low Ct values (<25) in 212 of 310 fully vaccinated (68%) and 246 of 389 (63%) unvaccinated individuals. Testing a subset of these low-Ct samples revealed infectious SARS-CoV-2 in 15 of 17 specimens (88%) from unvaccinated individuals and 37 of 39 (95%) from vaccinated people."

4) In a study from Qatar, Chemaitelly et al. reported vaccine efficacy (Pfizer) against severe and fatal disease, with efficacy in the 85-95% range at least until 24 weeks after the second dose. As a contrast, **the efficacy against infection waned down to around 30% at 15-19 weeks after the second dose**.

5) From Wisconsin, Riemersma et al. reported that **vaccinated individuals who get infected with the Delta variant can transmit SARS-CoV-2 to others**. They found an elevated viral load in the unvaccinated and vaccinated symptomatic persons (68% and 69% respectively, 158/232 and 156/225). Moreover, in the asymptomatic persons, they uncovered elevated viral loads (29% and 82% respectively) in the unvaccinated and the vaccinated respectively. This suggests that the vaccinated can be infected, harbor, cultivate, and transmit the virus readily and unknowingly.

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[30] Paul Alexander of the Brownstone Institute, **44 Studies on Vaccine Efficacy That Raise Doubts on Vaccine Mandates,** March 19.2022 https://www.theepochtimes.com/44-studies-on-vaccine-efficacy-that-raise-doubts-on-vaccine-mandates_4348494.html?est=gYnejqpgBhlRYe8DWNMS6DtsftRxBdG34hlgoSzz5Zdb5BcGfM82X8DjTvXf1y0nLRk3cW4%3D

6) Subramanian reported that "at the country-level, there appears to be no discernable relationship between percentage of population fully vaccinated and new COVID-19 cases." When comparing 2947 counties in the United States, there were slightly less cases in more vaccinated locations. In other words, there is no clear discernable relationship.

7) Chau et al. looked at transmission of SARS-CoV-2 Delta variant among vaccinated healthcare workers in Vietnam. Of 69 healthcare workers that tested positive for SARS-CoV-2, 62 participated in the clinical study, all of whom recovered. For 23 of them, complete-genome sequences were obtained, and all belonged to the Delta variant. "Viral loads of breakthrough Delta variant infection cases were 251 times higher than those of cases infected with old strains detected between March-April 2020".

8) In Barnstable, Massachusetts, Brown et al found that among **469 cases of COVID-19, 74% were fully vaccinated**, and that "**the vaccinated had on average more virus in their nose than the unvaccinated who were infected.**"

9) Reporting on a nosocomial hospital outbreak in Finland, Hetemäli et al. observed that "both symptomatic and asymptomatic infections were found among vaccinated health care workers, and secondary transmission occurred from those with symptomatic infections despite use of personal protective equipment."

10) In a hospital outbreak investigation in Israel, Shitrit et al. observed "high transmissibility of the SARS-CoV-2 Delta variant among twice vaccinated and masked individuals." They added that "**this suggests some waning of immunity**, albeit still providing protection for individuals without comorbidities."

11) In the UK COVID-19 vaccine Surveillance Report for week #42, it was noted that there is "waning of the N antibody response over time" and "that N antibody levels appear to be lower in individuals who acquire infection following 2 doses of vaccination." The same report (Table 2, page 13), shows the in the older age groups above 30, the double vaccinated persons have greater infection risk than the unvaccinated, presumably because **the latter group include more people with stronger natural immunity from prior Covid disease**. As a contrast, the vaccinated people had a lower risk of death than the unvaccinated, across all age groups, indicating that vaccines provide more protection against death than against infection. See also UK PHE reports 43, 44, 45, 46 for similar data.

12) In Israel, Levin et al. "conducted a 6-month longitudinal prospective study involving vaccinated health care workers who were tested monthly for the presence of anti-spike IgG and neutralizing antibodies". They found that "six months after receipt of the second dose of the BNT162b2 vaccine, humoral response was substantially decreased, especially among men, among persons 65 years of age or older, and among persons with immunosuppression."

13) In a study from New York State, Rosenberg et al. reported that "During May 3–July 25, 2021, the overall age-adjusted vaccine effectiveness against hospitalization in New York was relatively stable 89.5%–95.1%). The overall age-adjusted vaccine effectiveness against infection for all New York adults declined from 91.8% to 75.0%."

14) Suthar et al. noted that "Our data demonstrate a **substantial waning of antibody responses** and T cell immunity to SARS-CoV-2 and its variants, at 6 months following the second immunization with the BNT162b2 vaccine."

15) In a study from Umeå University in Sweden, Nordström et al. observed that "vaccine effectiveness of BNT162b2 against infection waned progressively from 92% (95% CI, 92-93, P<0·001) at day 15-30 to 47% (95% CI, 39-55, P<0·001) at day 121-180, and from day 211 and onwards **no effectiveness could be detected** (23%; 95% CI, -2-41, P=0·07)."

16) Yahi et al. have reported that "in the case of the Delta variant, neutralizing antibodies have a decreased affinity for the spike protein, whereas facilitating antibodies display a strikingly increased affinity. Thus, antibody dependent enhancement may be a concern for people receiving vaccines based on the original Wuhan strain spike sequence."

17) Goldberg et al. (BNT162b2 Vaccine in Israel) reported that "immunity against the delta variant of SARS-CoV-2 waned in all age groups a few months after receipt of the second dose of vaccine."

18) Singanayagam et al. examined the transmission and viral load kinetics in vaccinated and unvaccinated individuals with mild delta variant infection in the community. They found that (in 602 community contacts (identified via the UK contract-tracing system) of 471 UK COVID-19 index cases were recruited to the Assessment of Transmission and Contagiousness of COVID-19 in Contacts cohort study and contributed 8145 upper respiratory tract samples from daily sampling for up to 20 days) "vaccination reduces the risk of delta variant infection and accelerates viral clearance. Nonetheless, fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts."

19) Keehner et al. in NEJM, has recently reported on the resurgence of SARS-CoV-2 infection in a highly vaccinated health system workforce. Vaccination with mRNA vaccines began in mid-December 2020; by March, 76% of the workforce had been fully vaccinated, and by July, the percentage had risen to 87%. Infections had decreased dramatically by early February 2021..."coincident with the end of California's mask mandate on June 15 and the rapid dominance of the B.1.617.2 (delta) variant that first emerged in mid-April and accounted for over 95% of UCSDH isolates by the end of July, infections increased rapidly, including cases among fully vaccinated persons...researchers reported that the "dramatic change in

vaccine effectiveness from June to July is likely to be due to both the emergence of the delta variant and waning immunity over time."

20) Juthani et al. sought to describe the impact of vaccination on admission to hospital in patients with confirmed SARS-CoV-2 infection using real-world data collected by the Yale New Haven Health System. "Patients were considered fully vaccinated if the final dose (either second dose of BNT162b2 or mRNA-1273, or first dose of Ad.26.COV2.S) was administered at least 14 days before symptom onset or a positive PCR test for SARS-CoV-2. In total, we identified 969 patients who were admitted to a Yale New Haven Health System hospital with a confirmed positive PCR test for SARS-CoV-2"...Researchers reported "a higher number of patients with severe or critical illness in those who received the BNT162b2 vaccine than in those who received mRNA-1273 or Ad.26.COV2.S..."

21) A very recent study published by the CDC reported that a majority (53%) of patients who were hospitalized with Covid-19-like illnesses were already fully vaccinated with two-dose RNA shots. Table 1 reveals that among the 20,101 immunocompromised adults hospitalized with Covid-19, 10,564 (53%) were fully-vaccinated with the Pfizer or Moderna vaccine (Vaccination was defined as having received exactly 2 doses of an mRNA-based COVID-19 vaccine ≥14 days before the hospitalization index date, which was the date of respiratory specimen collection associated with the most recent positive or negative SARS-CoV-2 test result before the hospitalization or the hospitalization date if testing only occurred after the admission). This highlights the ongoing challenges faced with Delta breakthrough when vaccinated.

22) Eyre, 2021 looked at The impact of SARS-CoV-2 vaccination on Alpha & Delta variant transmission. They reported that "while vaccination still lowers the risk of infection, similar viral loads in vaccinated and unvaccinated individuals infected with Delta question how much vaccination prevents onward transmission... transmission reductions declined over time since second vaccination, for Delta reaching similar levels to unvaccinated individuals by 12 weeks for ChAdOx1 and attenuating substantially for BNT162b2. Protection from vaccination in contacts also declined in the 3 months after second vaccination...vaccination reduces transmission of Delta, but by less than the Alpha variant."

23) Levine-Tiefenbrun, 2021 looked at Viral loads of Delta-variant SARS-CoV-2 breakthrough infections after vaccination and booster with BNT162b2, and reported the viral load reduction effectiveness declines with time after vaccination, "significantly decreasing at 3 months after vaccination and effectively vanishing after about 6 months."

24) Puranik, 2021 looked at a Comparison of two highly-effective mRNA vaccines for COVID-19 during periods of Alpha and Delta variant prevalence, reporting "In July, vaccine effectiveness against hospitalization has remained high (mRNA-1273: 81%, 95% CI: 33–96.3%; BNT162b2: 75%, 95% CI: 24–

93.9%), but effectiveness against infection was lower for both vaccines (mRNA-1273: 76%, 95% CI: 58–87%; BNT162b2: 42%, 95% CI: 13–62%), with a more pronounced reduction for BNT162b2."

25) Saade, 2021 looked at Live virus neutralization testing in convalescent patients and subjects vaccinated against 19A, 20B, 20I/501Y.V1 and 20H/501Y.V2 isolates of SARS-CoV-2, and reported as "Assessed the neutralizing capacity of antibodies to prevent cell infection, using a live virus neutralization test with different strains [19A (initial one), 20B (B.1.1.241 lineage), 20I/501Y.V1 (B.1.1.7 lineage), and 20H/501Y.V2 (B.1.351 lineage)] in serum samples collected from different populations: two-dose vaccinated COVID-19-naive healthcare workers (HCWs; Pfizer-BioNTech BNT161b2), 6-months post mild COVID-19 HCWs, and critical COVID-19 patients... finding of the present study is the reduced neutralizing response observed towards the 20H/501Y.V2 variant in fully immunized subjects with the BNT162b2 vaccine by comparison to the wild type and 20I/501Y.V1 variant."

26) Canaday, 2021 looked at Significant reduction in humoral immunity among healthcare workers and nursing home residents 6 months after COVID-19 BNT162b2 mRNA vaccination, reporting "Anti-spike, anti-RBD and neutralization levels dropped more than 84% over 6 months' time in all groups irrespective of prior SARS-CoV-2 infection. At 6 months post-vaccine, 70% of the infection-naive NH residents had neutralization titers at or below the lower limit of detection compared to 16% at 2 weeks after full vaccination. These data demonstrate a significant reduction in levels of antibody in all groups. In particular, those infection-naive NH residents had lower initial post-vaccination humoral immunity immediately and exhibited the greatest declines 6 months later."

27) Israel, 2021 looked at Large-scale study of antibody titer decay following BNT162b2 mRNA vaccine or SARS-CoV-2 infection, and reported as "To determine the kinetics of SARS-CoV-2 IgG antibodies following administration of two doses of BNT162b2 vaccine, or SARS-CoV-2 infection in unvaccinated individuals...In vaccinated subjects, antibody titers decreased by up to 40% each subsequent month while in convalescents they decreased by less than 5% per month. Six months after BNT162b2 vaccination 16.1% subjects had antibody levels below the sero-positivity threshold of <50 AU/mL, while only 10.8% of convalescent patients were below <50 AU/mL threshold after 9 months from SARS-CoV-2 infection."

28) Eyran, 2020 examined The longitudinal kinetics of antibodies in COVID-19 recovered patients over 14 months, and found "a significantly faster decay in naïve vaccinees compared to recovered patients suggesting that the serological memory following natural infection is more robust compared to vaccination. Our data highlights the differences between serological memory induced by natural infection vs. vaccination."

29) Salvatore et al. examined the transmission potential of vaccinated and unvaccinated persons infected with the SARS-CoV-2 Delta variant in a federal prison, July-August 2021. They found a total of 978 specimens were provided by 95 participants, "of whom 78 (82%) were fully vaccinated and 17 (18%) were not fully vaccinated....clinicians and public health practitioners should consider vaccinated persons who become infected with SARS-CoV-2 to be no less infectious than unvaccinated persons."

30) Andeweg et al. analyzed 28,578 sequenced SARS-CoV-2 samples from individuals with known immune status obtained through national community testing in the Netherlands from March to August 2021. They found evidence for an "increased risk of infection by the Beta (B.1.351), Gamma (P.1), or Delta (B.1.617.2) variants compared to the Alpha (B.1.1.7) variant after vaccination. No clear differences were found between vaccines. However, the effect was larger in the first 14-59 days after complete vaccination compared to 60 days and longer. In contrast to vaccine-induced immunity, no increased risk for reinfection with Beta, Gamma or Delta variants relative to Alpha variant was found in individuals with infection-induced immunity."

31) Di Fusco et al. conducted an evaluation of COVID-19 vaccine breakthrough infections among immunocompromised patients fully vaccinated with BNT162b2. "COVID-19 vaccine breakthrough infections were examined in fully vaccinated (≥14 days after 2nd dose) IC individuals (IC cohort), 12 mutually exclusive IC condition groups, and a non-IC cohort." They found that"of 1,277,747 individuals ≥16 years of age who received 2 BNT162b2 doses, 225,796 (17.7%) were identified as IC (median age: 58 years; 56.3% female). The most prevalent IC conditions were solid malignancy (32.0%), kidney disease (19.5%), and rheumatologic/inflammatory conditions (16.7%). Among the fully vaccinated IC and non-IC cohorts, a total of 978 breakthrough infections were observed during the study period; 124 (12.7%) resulted in hospitalization and 2 (0.2%) were inpatient deaths. IC individuals accounted for 38.2% (*N* = 374) of all breakthrough infections, 59.7% (*N* = 74) of all hospitalizations, and 100% (*N* = 2) of inpatient deaths. The proportion with breakthrough infections was 3 times higher in the IC cohort compared to the non-IC cohort (*N* = 374 [0.18%] vs. *N* = 604 [0.06%]; unadjusted incidence rates were 0.89 and 0.34 per 100 person-years, respectively."

32) Mallapaty (NATURE) reported that the protective effect of being vaccinated if you already had infection is "relatively small, and dwindles alarmingly at three months after the receipt of the second shot." Mallapaty further adds what we have been warning the public health community which is that persons infected with Delta have about the same levels of viral genetic materials in their noses "regardless of whether they'd previously been vaccinated, suggesting that vaccinated and unvaccinated people might be equally infectious." Mallapaty reported on testing data from 139,164 close contacts of 95,716 people infected with SARS-CoV-2 between January and August 2021 in the United Kingdom, and

at a time when the Alpha and Delta variants were competing for dominance. The finding was that "although the vaccines did offer some protection against infection and onward transmission, Delta dampened that effect. A person who was fully vaccinated and then had a 'breakthrough' Delta infection was almost twice as likely to pass on the virus as someone who was infected with Alpha. And that was on top of the higher risk of having a breakthrough infection caused by Delta than one caused by Alpha."

33) Chia et al. reported that PCR cycle threshold (Ct) values were "similar between both vaccinated and unvaccinated groups at diagnosis, but viral loads decreased faster in vaccinated individuals. Early, robust boosting of anti-spike protein antibodies was observed in vaccinated patients, however, these titers were significantly lower against B.1.617.2 as compared with the wildtype vaccine strain."

34) Wilhelm et al. reported on reduced neutralization of SARS-CoV-2 omicron variant by vaccine sera and monoclonal antibodies. "*in vitro* findings using authentic SARS-CoV-2 variants indicate that in contrast to the currently circulating Delta variant, the neutralization efficacy of vaccine-elicited sera against Omicron was severely reduced highlighting T-cell mediated immunity as essential barrier to prevent severe COVID-19."

35) CDC reported on the details for 43 cases of COVID-19 attributed to the Omicron variant. They found that "34 (79%) occurred in persons who completed the primary series of an FDA-authorized or approved COVID-19 vaccine ≥14 days before symptom onset or receipt of a positive SARS-CoV-2 test result."

36) Dejnirattisai et al. presented live neutralisation titres against SARS-CoV-2 Omicron variant, and examined it relative to neutralisation against the Victoria, Beta and Delta variants. They reported a significant drop in "neutralisation titres in recipients of both AZD1222 and BNT16b2 primary courses, with evidence of some recipients failing to neutralise at all."

37) Cele et al. assessed whether Omicron variant escapes antibody neutralization "elicited by the Pfizer BNT162b2 mRNA vaccine in people who were vaccinated only or vaccinated and previously infected." They reported that Omicron variant "still required the ACE2 receptor to infect but had extensive escape of Pfizer elicited neutralization."

38) Holm Hansen et al.'s Denmark study looked at vaccine effectiveness against SARS-CoV-2 infection with the Omicron or Delta variants following a two-dose or booster BNT162b2 or mRNA-1273 vaccination series. A key finding was reported as "VE against Omicron was 55.2% initially following primary BNT162b2 vaccination, but waned quickly thereafter. Although estimated with less precision, VE against Omicron after primary mRNA-1273 vaccination similarly indicated a rapid decline in protection. By comparison, both vaccines showed higher, longer-lasting protection against Delta." In other words, the vaccine that has failed against Delta is even far worse for Omicron. The table and figure below paint a devastating picture. See where the green dot is (Omicron variant) in the vertical

lines (blue is Delta) and the 2 edges of the bars (upper and lower lips) 91 days out for Omicron (3 months). Both Pfizer and Moderna show negative efficacy for Omicron at 31 days (both are below the 'line of no effect' or '0'). The comparative table is even more devastating for it shows how much less vaccine effectiveness there is for Omicron. For example, at 1-30 days, Pfizer showed 55.2% effectiveness for Omicron versus 86.7% for Delta, and for the same period, Moderna showed 36.7% effectiveness for Omicron versus 88.2% for Delta.

39) UK reporting showed that boosters protect against symptomatic COVID-19 caused by Omicron for about 10 weeks; the UK Health Security Agency reported protection against symptomatic COVID-19 caused by the variant dropped from 70% to 45% following a Pfizer booster for those initially vaccinated with the shot developed by Pfizer with BioNTech. Specifically reporting by the UK Health Security Agency showed "Among those who received an AstraZeneca primary course, vaccine effectiveness was around 60% 2 to 4 weeks after either a Pfizer or Moderna booster, then dropped to 35% with a Pfizer booster and 45% with a Moderna booster by 10 weeks after the booster. Among those who received a Pfizer primary course, vaccine effectiveness was around 70% after a Pfizer booster, dropping to 45% after 10-plus weeks and stayed around 70 to 75% after a Moderna booster up to 9 weeks after booster."

40) Buchan et al. used a test-negative design to assess vaccine effectiveness against OMICRON or DELTA variants (regardless of symptoms or severity) during November 22 and December 19, 2021. They included persons who had received at least 2 COVID-19 vaccine doses (with at least 1 mRNA vaccine dose for the primary series) and applied multivariable logistic regression modelling analysis to "estimate the effectiveness of two or three doses by time since the latest dose." They included 3,442 Omicron-positive cases, 9,201 Delta-positive cases, and 471,545 test-negative controls. Following 2 doses, "vaccine effectiveness against Delta infection declined steadily over time but recovered to 93% (95%CI, 92-94%) ≥7 days after receiving an mRNA vaccine for the third dose. In contrast, **receipt of 2 doses of COVID-19 vaccines was not protective against Omicron**. Vaccine effectiveness against Omicron was 37% (95%CI, 19-50%) ≥7 days after receiving an mRNA vaccine for the third dose."

41) Public Health Scotland COVID-19 & Winter Statistical Report (Publication date: 19 January 2022) provided startling data on page 38 (case rates), page 44 (hospitalization), and page 50 (deaths), showing that the vaccination has failed Delta but critically, is failing omicron. The 2nd inoculation data is of particular concern. Table 14 age-standardized case data is very troubling for it shows across the multiple weeks of study that across each dose (1 vs 2 vs 3 booster inoculations) that the vaccinated are greatly more infected than the unvaccinated, with the 2nd dose being alarmingly elevated (see grey rows). Age-standardized rates of acute hospital admissions are stunningly elevated after 2nd inoculation (over the

unvaccinated) during January 2022. Looking at table 16 that reports on the number of confirmed COVID-19 related deaths by vaccination status, we again observe massive elevation in death at the 2nd inoculation. **This data indicates to us that the vaccine is associated with infection and is not optimally working against omicron and that the protection is limited, waning rapidly**.

42) The UK's COVID-19 vaccine surveillance report Week 3, 20 January 2022, raises very serious concern as to the failure of the vaccines on Delta (which is basically now being replaced by omicron for dominance) and omicron. When we look at table 9, page 34 (COVID-19 cases by vaccination status between week 51 2021 and week 2 2022), we see greater case numbers for the 2nd and 3rd inoculations. The important table on page 38, Figure 12 (unadjusted rates of COVID-19 infection, hospitalization and death in vaccinated and unvaccinated populations) shows us a continual pattern in the UK data over the last 2 to 3 to 4 months, with **the present reporting showing that persons in receipt of the 3rd inoculation (booster) at far greater risk of infection/cases than the unvaccinated** (30 years of age and above age strata).

43) In the recent UK Public Health surveillance reports Week 9, Week 8, as well as week 7 (UK COVID-19 vaccine surveillance report Week 7 17 February 2022), week 6 (COVID-19 vaccine surveillance report Week 6 10 February 2022) and week 5 for 2022 (COVID-19 vaccine surveillance report Week 5 3 February 2022) as well as the reports accumulated for 2021 since vaccine roll-out, **we see that the vaccinated are at higher risk of infection and especially for age groups above 18 years old, as well as hospitalization and even death**. This is particularly marked for those in receipt of double vaccinations. There is increased risk of death for those who are triple vaccinated and especially as age increases. The same pattern emerges in the Scottish data.

44.) Regev-Yochay et al. in Israel looked at (publication date March 16th 2022) the immunogenicity and safety of a fourth dose (4th) of either BNT162b2 (Pfizer–BioNTech) or mRNA-1273 (Moderna) administered 4 months after the third dose in a series of three BNT162b2 doses). This was an open-label, nonrandomized clinical study assessing the 4th dose in terms of need beyond the 3rd dose. Among the '1050 eligible health care workers enrolled in the Sheba HCW COVID-19 Cohort, 154 received the fourth dose of BNT162b2 and, 1 week later, 120 received mRNA-1273. For each participant, two age-matched controls were selected from the remaining eligible participants'. Overall, 25.0% of the participants in the control group were infected with the omicron variant, as compared with 18.3% of the participants in the BNT162b2 group and 20.7% of those in the mRNA-1273 group. **Vaccine efficacy against any SARS-CoV-2 infection was 30%** (95% confidence interval [CI], −9 to 55) for BNT162b2 and 11% (95% CI, −43 to 44) for mRNA-1273

The article concludes:

> *What these studies show, are that vaccines are important to reduce severe disease and death, but unable to prevent the disease from spreading and eventually infect[ing] most of us. That is, while the vaccines [may] provide individual benefits to the vaccinee, and especially to older high-risk people, the public benefit of universal vaccination is in grave doubt. As such, Covid vaccines should not be expected to contribute to eliminating the communal spread of the virus or the reaching of herd immunity. This unravels the rationale for vaccine mandates and passports.*

And here are other papers that address the concern on effectiveness of the COVID-19 vaccines:

Pilar T V Florentino, Tristan Millington, Thiago Cerqueira-Silva, Chris Robertson, Vinicius de Araújo Oliveira, Juracy B S Júnior, Flávia J O Alves, Gerson O Penna, Srinivasa Vital Katikireddi, Viviane S Boaventura, Guilherme L Werneck, Neil Pearce, Colin McCowan, Christopher Sullivan, Utkarsh Agrawal, Zoe Grange, Lewis D Ritchie, Colin R Simpson, Aziz Sheikh, Mauricio L Barreto, Igor Rudan, Manoel Barral-Netto, Enny S Paixão, **Vaccine effectiveness of two-dose BNT162b2 against symptomatic and severe COVID-19 among adolescents in Brazil and Scotland over time: a test-negative case-control , study**, The Lancet, Infectious disease, August 8, 2022, https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00451-0/fulltext

Pavan M, Bassani D, Sturlese M, Moro S. **From the Wuhan-Hu-1 strain to the XD and XE variants: is targeting the SARS-CoV-2 spike protein still a pharmaceutically relevant option against COVID-19?** J Enzyme Inhib Med Chem. 2022 Dec;37(1):1704-1714. doi: 10.1080/14756366.2022.2081847. PMID: 35695095. https://pubmed.ncbi.nlm.nih.gov/35695095/

Le Gars M, Hendriks J, Sadoff J, Ryser M, Struyf F, Douoguih M, Schuitemaker H. **Immunogenicity and efficacy of Ad26.COV2.S: An adenoviral vector-based COVID-19 vaccine**. Immunol Rev. 2022 Jun 11. doi: 10.1111/imr.13088. PMID: 35689434. https://pubmed.ncbi.nlm.nih.gov/35689434/ [31]

Ssemaganda A, Nguyen HM, Nuhu F, Jahan N, Card CM, Kiazyk S, Severini G, Keynan Y, Su RC, Ji H, Abrenica B, McLaren PJ, Ball TB, Bullard J, Van Caeseele P, Stein D, McKinnon LR. **Expansion of cytotoxic tissue-resident CD8+ T cells and CCR6+CD161+ CD4+ T cells in the nasal mucosa following mRNA COVID-19 vaccination**. Nat Commun. 2022 Jun 10;13(1):3357. doi: 10.1038/s41467-022-30913-4. PMID: 35688805. https://pubmed.ncbi.nlm.nih.gov/35688805/ [32]

Kouhpayeh H, Ansari H. **Adverse events following COVID-19 vaccination: A systematic review and meta-analysis**. Int Immunopharmacol. 2022 May 30;109:108906. doi: 10.1016/j.intimp.2022.108906. Epub ahead of print. PMID: 35671640; PMCID: PMC9148928. https://pubmed.ncbi.nlm.nih.gov/35671640/

Singh H, Dahiya N, Yadav M, Sehrawat N. **Emergence of SARS-CoV-2 New Variants and Their Clinical**

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[31] Note this paper was supported by grants from Janssen Vaccines & Prevention B.V., NH/NIH HHS/United States, the National Institute of Allergy and Infectious Diseases and the Biomedical Advanced Research and Development Authority

[32] This study was supported by the Bill and Melinda Gates Foundation

Significance. Can J Infect Dis Med Microbiol. 2022 May 28;2022:7336309. doi: 10.1155/2022/7336309. PMID: 35669528; PMCID: PMC9167142. https://pubmed.ncbi.nlm.nih.gov/35669528/

> Singh et al: *These new strains occur due to unique mutations in the spike protein, which modify SARS-CoV-2 transmission and infection capabilities, limiting the efficacy of the COVID-19 vaccination. Hence, there is a need to find a potential vaccine against it.*

Buisson Y. **Covid-19, an unfinished story**. Presse Med. 2022 Jun 3:104131. doi: 10.1016/j.lpm.2022.104131. Epub ahead of print. PMID: 35667598. https://pubmed.ncbi.nlm.nih.gov/35667598/

Salari N, Vepa A, Daneshkhah A, Darvishi N, Ghasemi H, Khunti K, Mohammadi M. **Efficacy of COVID-19 vaccines by race and ethnicity**. Public Health. 2022 May 5;208:14-17. doi: 10.1016/j.puhe.2022.04.009. Epub ahead of print. PMID: 35660280; PMCID: PMC9069229. https://pubmed.ncbi.nlm.nih.gov/35660280/

Wang K, Wang L, Li M, Xie B, He L, Wang M, Zhang R, Hou N, Zhang Y, Jia F. **Real-Word Effectiveness of Global COVID-19 Vaccines Against SARS-CoV-2 Variants: A Systematic Review and Meta-Analysis**. Front Med (Lausanne). 2022 May 19;9:820544. doi: 10.3389/fmed.2022.820544. PMID: 35665358; PMCID: PMC9160927. https://pubmed.ncbi.nlm.nih.gov/35665358/

Leong C, Jin L, Kim D, Kim J, Teo YY, Ho TH. **Assessing the impact of novelty and conformity on hesitancy towards COVID-19 vaccines using mRNA technology**. Commun Med (Lond). 2022 May 31;2:61. doi: 10.1038/s43856-022-00123-6. PMID: 35664455; PMCID: PMC9156695. https://pubmed.ncbi.nlm.nih.gov/35664455/ [33]

Olliaro P, Torreele E, Vaillant M. **COVID-19 vaccine efficacy and effectiveness-the elephant (not) in the room**. Lancet Microbe. 2021 Jul;2(7):e279-e280. doi: 10.1016/S2666-5247(21)00069-0. Epub 2021 Apr 20. Erratum in: Lancet Microbe. 2021 Jul;2(7):e288. PMID: 33899038; PMCID: PMC8057721. https://pubmed.ncbi.nlm.nih.gov/33899038/

Dean Follmann, Holly E. Janes, Olive D. Buhule, Honghong Zhou, Bethany Girard, Kristen Marks, Karen Kotloff, Michaël Desjardins, Lawrence Corey, Kathleen M. Neuzil, Jacqueline M. Miller, Hana M. El Sahly, Lindsey R. Baden, **Anti-nucleocapsid antibodies following SARS-CoV-2 infection in the blinded phase of the mRNA-1273 Covid-19 vaccine efficacy clinical trial**, , medRxiv 2022.04.18.22271936; doi: https://doi.org/10.1101/2022.04.18.22271936

The Follmann study, et. al. looked at two sides of the Moderna Phase 3 vaccine trial: the vaccinated group and the control group. They looked at unvaccinated people having Covid, versus vaccinated people having so called "break-through Covid infections". The question that they asked, was: do the vaccinated acquire the same full-spectrum immunity as the unvaccinated? The answer was no. Vaccinated people were much

[33] It's interesting to consider the word 'novel' is nowhere found in product labeling of the vaccines however present in disclosure of investment risks for the company's FY 2021 SEC 10-K filings. Investors can sue; vaccine recipients

LESS likely to develop broad natural immunity, compared to unvaccinated people. Discussed here: https://igorchudov.substack.com/p/moderna-knew-vaccinated-people-will?r=47l49&s=r&utm_campaign=post&utm_medium=email

Singanayagam A, Hakki S, Dunning J, Madon KJ, Crone MA, Koycheva A, Derqui-Fernandez N, Barnett JL, Whitfield MG, Varro R, Charlett A, Kundu R, Fenn J, Cutajar J, Quinn V, Conibear E, Barclay W, Freemont PS, Taylor GP, Ahmad S, Zambon M, Ferguson NM, Lalvani A; ATACCC Study Investigators. **Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study**. Lancet Infect Dis. 2022 Feb;22(2):183-195. doi: 10.1016/S1473-3099(21)00648-4. Epub 2021 Oct 29. Erratum in: Lancet Infect Dis. 2021 Dec;21(12):e363. PMID: 34756186; PMCID: PMC8554486. https://pubmed.ncbi.nlm.nih.gov/34756186/

Please contact maborrello@roadrunner.com to request this file for easy access to hyperlinks to all cited references.

About the Author: Mike Borrello is an Engineer & Scientist that specializes in feedback control systems and dynamic simulations. For decades he has provided control designs for the defense, aerospace and medical device industries and until recently was employed by Philips Respironics but terminated by corporate policy that required him to disclose his "vaccine status" which he refused to do. Despite what the mainstream or others wish to label him, Mike Borrello is NOT an 'Anti-Vaxxer'. Up until covid he annually received influenza vaccines and during covid the shingles vaccine. In fact he volunteered on-line for the Pfizer Phase 3 trials for the covid vaccine with pure altruism in mind but Pfizer never contacted him, and as he awaited authorization to vaccinate by age group in winter of 2021, by curiosity he ran queries on VAERS to confirm what he had seen in social media. The numbers of deaths and other adverse events he saw reported with the vaccines caused him concern to the point he decided to wait and see what the CDC or FDA might publicly offer to dispel any concerns over what was happening on the CDC's own website. That explanation never happened and continues to be a void. Only media narratives that VAERS was 'unreliable'. Eventually Borrello decided he would avoid vaccination at all costs and that in his good health he could better manage infection by the virus with therapeutics than risking some of the potential harms he's seen reported in VAERS – however little the risk might be.

Borrello's experience prompted him to become more involved in researching the data and publications that continue to examine the covid-19 vaccine injuries. Since June of 2021 he has publicly engaged Wilma Wooten and the San Diego HHS each month with others by presenting the materials contained in this report. He is asking that officials stop all vaccinations, especially for younger people who potentially have so much to lose, and little or nothing to gain by being vaccinated. He is asking that the officials investigate these harms, the deception used by pharma to show vaccine efficacy is high, and to remove the emergency orders to prevent the collateral damage caused by this destructive policy.