Doctors for Patients UK

SUBMISSION

TO

THE PEOPLE'S VACCINE INQUIRY

10th June 2024

Home - Doctors for Patients UK

PREFACE

Established in September 2022, Doctors for Patients UK (DfPUK) was formed by a group of doctors alarmed by the disregard of medical ethics—a trend that endangers patient care and eroded public trust amid the Covid-19 pandemic. The group serves as a platform for sharing and voicing concerns and discussing critical health issues, which have been appropriated by global interests.

A primary concern among DfPUK members is the safety and ethical implications of Covid-19 vaccines, particularly regarding vulnerable populations such as children and pregnant women. Despite numerous adverse reaction reports submitted through the Yellow Card scheme to the Medicines and Healthcare Products Regulatory Agency (MHRA), the response from health authorities has been notably insufficient.

In response, DfPUK has proactively reached out to health agencies and government bodies, including the MHRA, The Joint Committee on Vaccination and Immunisation (JVCI) and the Royal College of Obstetricians and Gynaecologists (RCOG), and lawmakers. They have also issued a collective press release[1] and conducted meetings to advocate for urgent changes. However, many members report that their concerns are often met with silence or hostility, whilst some have incurred significant personal costs for using social media to disseminate their message.

Due to ongoing resistance and the lack of significant change, DfPUK has prepared this submission for "The People's Vaccine Inquiry" as part of a moral and public duty to address these issues, in alignment with GMC mandates that require doctors to act when patient safety is at risk.

After reviewing member testimonies, the authors reaffirmed their conclusion that the risks of mRNA and other Covid-19 vaccines outweigh their benefits. This further analysis compelled the creation of The Hope Accord, a petition that calls for an immediate halt and re-evaluation of these products.

It's important to note that no assumptions should be made about individual DfPUK members' endorsements of the views expressed in this document or The Hope Accord. Members are encouraged to endorse the Accord if they share its views, but some have explicitly stated that concerns about professional censure and potential repercussions have deterred them. This situation underscores the necessity of creating a supportive environment where medical professionals can freely express their diverse opinions and concerns without fear of disciplinary actions.

Disclaimer:

The views and opinions expressed in this report are those of the authors and are made in a personal capacity. They do not necessarily reflect the official policy or position of any affiliated medical institutions, organisations, or regulatory bodies. The authors are speaking as private individuals and not as representatives of any professional or governmental entity. This report is intended to provide personal insights and should not be construed as official medical advice or a directive.

SUMMARY

Contributing doctors from a range of specialities, express their concerns regarding the safety and management of Covid-19 vaccines, observing adverse reactions and systemic issues within the healthcare system. Their concerns encompass several key points:

1. **Adverse Reactions**: Doctors report observing severe and frequent adverse reactions following Covid-19 vaccination, including cardiac issues, blood clots, autoimmune disorders, and potential links to rapid cancer progression. These observations are reported both from within their patient populations and from personal experiences.

2. **Systemic Healthcare Failures**: There is a notable disappointment with the lack of support from healthcare institutions like the National Health Service (NHS), which are perceived as dismissing or inadequately addressing vaccine injuries. Many doctors report a lack of a dedicated response or treatment pathways for patients suffering from vaccine-related injuries. Patients also report reluctance to mention the onset of their symptoms from the time of vaccination to doctors for fear of not being acknowledged and concerns this will negatively affect their access to investigations.

3. **Professional and Social Backlash**: Doctors raising concerns about vaccine safety and the handling of the pandemic response describe facing professional consequences, ostracism, or hostility from peers and authorities. This includes threats of investigation and punitive actions from regulatory bodies like the General Medical Council (GMC).

4. **Challenges in Patient Care and Ethics**: The doctors raise concerns about the ethical implications of not fully informing patients about the potential risks associated with vaccines, particularly in vulnerable groups. Issues such as coerced consent, lack of transparent dialogue, and the disregard for established ethical practices in medicine are highlighted.

5. **Call for Transparency and Reform**: The doctors advocate for more open dialogue, thorough investigation of vaccine safety and systemic reforms. They stress the importance of informed consent, bodily autonomy, patient-centred care, the necessity of supporting medical professionals who voice concerns and the establishment of dedicated services to address and study vaccine injuries.

6. **Scepticism of Public Health Strategies**: Criticisms are directed at public health policies, including lockdowns and vaccine mandates, which are seen as disproportionate and causing more harm than benefit. There is a strong call for re-evaluating these strategies in light of observed adverse outcomes and the broader impact on societal health.

The overarching demand is for a reassessment of vaccine safety protocols, better support for vaccine-injured individuals, protection for whistleblowers and a more ethical, transparent approach to public health decision-making. The doctors underscore the need for a healthcare environment that respects scientific integrity, prioritises patient safety and maintains open channels of communication among professionals and with the public. Their testimonies follow below.

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DOCTORS' TESTIMONIES

1 Cardiology

Dr Dean Patterson, MBChB, FRCP, Consultant Cardiologist & General Physician, Guernsey

The Covid-19 Pandemic was deemed to be a devastating event for healthcare in Guernsey where the powers that be refurbished the Princess Elizabeth Hospital Day patient unit into an emergency 16-bed CCU (costing £250k) and the Medical Specialist Group where I am a partner, took out emergency life insurance (costing £50k) for the Specialists to prevent financial embarrassment should more than one of the consultants pass away from Covid-19. It turns out that not one of those emergency CCU beds were used and reassuringly no bereaved family had to rely on a life insurance payout. However, once the Covid-19 vaccines were given EUA and people were vaccinated I slowly became aware of serious adverse events. By the end of 2021, I was so concerned that I enquired with my partnership finance department to check whether the life insurance would cover death due to the EUA Covid-19 vaccines.

The first patient that made me stop and think for the first time in my career that a vaccine might have caused his 2 hospital admissions with identical symptoms and signs that mimicked an acute coronary syndrome, informed me in April 2021 “The only thing that occurred prior to my symptoms was that in October 2019 I had my flu vaccine 5 days before chest pain and the same symptoms occurred 4 days after my Covid-19 vaccine in 2021”. As this second admission was during Covid-19 restrictions the patient declined an off-island referral for cardiac MRI to look for myocarditis scar, especially as he had been airlifted to the UK for acute invasive coronary angiography in October 2019 which was unremarkable. Interestingly I saw this patient for follow-up in early 2024 where he described getting Covid-19 and was very ill for 3 weeks. Despite a severe Covid-19 illness he, unlike post-vaccination, had no chest pain at all, further evidence that Covid-19 does not cause myocarditis with any appreciable signal.

Thereafter there was a trickle of post-vaccine admissions with chest pain which came to a head when a patient in their 40s, known to me for 12 years with an extremely stable cardiomyopathy, was admitted with acute breathlessness after their first Covid-19 vaccine, which then deteriorated after the second Covid-19 vaccine with an admission in cardiogenic shock, which led to sudden death within 48hrs despite supportive management and close collaboration with a tertiary centre. As it turns out the patient's pre-existing haematological disorder is now a known contra-indication to Covid-19 vaccination, but this was not disclosed as a risk when they signed the patient information leaflet. I had to vocally and repeatedly stand my ground demanding a post-mortem be done. This was strange

considering we had administered a new therapeutic without medium to long-term safety data under an EUA and healthcare professionals were unwilling to perform a post-mortem. Alarmingly, the patient was found to have severe destructive mitral valve thrombotic endocarditis in addition to severe acute myocarditis at post-mortem. The patient had no sign of Covid-19 infection at that time. Had the patient been Covid-19 positive then there is no doubt that the coroner would have been content to put Covid-19 as the main cause of death. Despite the emerging data on post-Covid-19 vaccination myocarditis from Israel and my protestations, the coroner refused to put the Covid 19 vaccine down as a cause of death, but stated instead the "Covid-19 vaccine could not be excluded as a contributory cause of the death". How many people in 2020 had their death certified with the statement "Covid-19 infection cannot be excluded as a contributory cause for the patient's death?" I would say none, while many were certified as a Covid-19 death without even a positive PCR test or symptoms of severe Covid-19. Such has been the absolute and complete state control on integrity and critical thinking in the medical profession. Subsequent to this case there was a procession of myocarditis cases that ensued. I was so concerned about the Covid-19 management policy that I wrote to the Chief Minister for the Guernsey Government (see letter in Appendix).

I presented this case subsequently at a mortality and morbidity meeting at my hospital where my colleagues were happy to blame the patient's demise on the underlying health condition without any concern that vaccine safety should be questioned. In the main, my colleagues were happy that Covid-19 caused more myocarditis than the vaccines and the MHRA had the capacity to detect a safety signal early.

At this point, I started to seriously question the vaccine safety. I recalled a very unusual neurological presentation in February 2021. This patient was in their 20s and presented with hemiplegia of a nature, severity and rapidity of onset that I had never previously witnessed in my 32-year medical career. The patient had been admitted by our neurologist with transient hemiplegia that resolved over a few hours. The CT and Brain MRI that day was completely normal. I was on call and the ward asked me to review the patient. I found the patient to have complete and total loss of power on the whole of the left side of their body and face. This had occurred extremely quickly. **The patient had extremely elevated reflexes, with the most severe clonus that I have ever seen, which** was in keeping with a sudden onset of upper motor neuron disease. I transferred them urgently to our tertiary centre. In mid-2021 I made enquiries, and it appeared the diagnosis made was Miller Fisher Syndrome, a variant of Guillain Barré Syndrome. However, Miller Fisher syndrome presents with poor coordination, double vision and absent

reflexes while this patient had dramatically elevated reflexes. The diagnosis did not stand up to scrutiny.

It came to my knowledge through further inquiry the patient has indeed received the Covid-19 vaccine prior to their illness.

One of the most severe cases of post-Covid-19 vaccine myocarditis presented in a 20-year-old male who developed a rash 9 hours after his second Pfizer vaccination. 24 hours later he developed chest pain that escalated, and he called an ambulance. He was admitted for management and whilst an inpatient developed severe ST segment elevation compatible with acute myocardial infarction. In an older patient this would have been the knee jerk response even with the close proximity of the Pfizer vaccine. The patient survived with a significant scar on his cardiac MRI and is under ongoing follow up. He had no sign of Covid-19 and was tested to show he had never had Covid-19 as he was anti-nucleocapsid Ab negative.

I presented this and other myocarditis cases at the local MDT sessions and raised concerns with our Medical Director and head of clinical governance but was told the vaccines save lives, are safe and that Covid-19 causes more myocarditis than the vaccine.

Below is a summary of the numbers of myocarditis cases from 2020 onwards in Guernsey. There are 19 pending cases from 2023 awaiting CMRI and there have been 5 deaths in total. Prior to 2020, I would see 3-5 cases of myocarditis per annum, with serious cases being 1-2 every 5 years, and 2020 was no different.

	Myocarditis
2020	5
2021	25
2022	22
2023	11 (19 pending)

What worries me most about the “myocarditis” burden is not only the death and damage to healthy people trying to avoid Covid-19 infection with IFR of 0.2-0.4%, but that nobody seems to be questioning why the reactions have occurred. We knew nothing about the biodistribution, half-life of the active vaccine components or pathophysiology of the cardiac damage. Crucially if the heart could be damaged why would vascular damage not occur in other vital organs? It is also important to realise that the myocarditis signal ironically would have been missed completely had the powers that be, decided not to vaccinate people under the age of 35. Acute severe myocarditis presentations in the >35yr group were managed as an acute coronary syndrome, and in the heat of the chaos of post lockdown, Covid-19 measures, and paranoia, any myocarditis cases were blamed upon Covid-19 itself.

In regard to the damage to vascular beds in other organs, I have seen cases of sudden unprovoked bilateral pulmonary emboli, acute coronary thrombosis, DVT, POTS, pericarditis, peripheral neuropathy, atrial fibrillation, heart failure, strokes, shingles, Bell's palsy, Guillain Barré syndrome, spinal cord strokes, transverse myelitis, bowel and kidney thrombosis, acute mitral valve dysfunction and encephalitis strongly associated with the Covid-19 vaccination.

One area of particular concern is the frequency of thrombotic/marantic endocarditis, which ordinarily is a rare diagnosis. It is my opinion that some of the strokes, acute mitral valve dysfunction, and peripheral embolic events are due to thrombotic endocarditis. I have diagnosed 8 cases of thrombotic endocarditis since the vaccine rollout, which is unusual. One case presented as a splenic abscess. Only after valve surgery for suspected bacterial endocarditis and 6 weeks of intravenous antibiotics did I realise that something else was happening. The blood cultures throughout were negative. The patient’s blood parameters relapsed, and repeat imaging confirmed a second splenic infarction, and with MDT review the radiologist confirmed a splenic infarct in the place where the abscess developed, on a CT scan done 6 months before his presentation. I treated the patient with IV steroids and oral anti-coagulants, and he has now returned to good health.

At that time, I saw a patient in clinic with chest pain and TIA shortly after booster vaccination. I found a regional wall motion abnormality on echocardiogram, normal CT coronary angiogram, carotid ultrasound, and importantly an identical blood picture on his FBC, ESR, CRP, fibrinogen and factor VIII as the patient above with thrombotic endocarditis. I mentally dovetailed the cases, and this second patient I also treated with IV steroids (which is the standard treatment for vaccine-induced myocarditis) and anticoagulation. These patients were actually on the same ward together by chance and treated

successfully. Both patients were in addition treated with intermittent fasting and high dose vitamins C and D.

I have noted a dramatic increase in the frequency and intensity of patients with ventricular ectopy (VE) on ambulatory ECG monitoring. Prior to the vaccine rollout, I would see a VE range of 3-15%, but after the vaccine rollout, the frequency of VE burden in younger patients increased, but also the severity ranged from 5-45%. We have not vaccinated young patients in any volume for a while, but in the last 6 months, there appears to be a higher burden of older patients with conduction disturbances requiring pacemakers. These markers indicate a subclinical level of myocardial injury below the standard definition of acute myocarditis, which appears to have significant clinical impact.

I have submitted multiple Yellow card reports to the MHRA in the first 12 months of the vaccine rollout. The only reply I received was after I submitted the case of myocarditis in the 20-year-old man. I received a Word document called pericarditis and it contained a list of data requests that I had already submitted in my electronic report to the MHRA. I was dumbfounded by the MHRA response as it clearly indicated incompetence, malfeasance, mismanagement and ultimately a complete inability to successfully detect a safety signal. Were they intentionally trying to label my case of severe myocarditis as pericarditis and, by asking me to submit a Word document, take the case off the online database? I had been so busy focusing on the myocarditis cases that I had no time to submit yellow cards for most of the pericarditis cases I had seen. Pericarditis is a milder disease compared to myocarditis, so this was sensible action on my part, considering it takes 45 minutes to get the data and complete a yellow card report and that I had 25 cases of myocarditis to report. Pericarditis cases numbered 25-35. In a word, I was outraged and felt that my effort in submitting the yellow cards was futile and wasted. I was quite horrified in late 2021 to discover that some of my yellow card report summary PDFs were deleted from my MHRA yellow card account, which seemed very odd. I submitted a few more yellow card reports into 2022, but when I last tried to log into my account, being met with a pop-up saying account not recognised! I have lost faith in the yellow card reporting system due to the above problems compounded by a lack of support in the provision of time to submit this dramatic increase in yellow card reports. Since then, I have concentrated on other pathways of expressing my concerns on the safety profile of the Covid-19 vaccines.

Locally, after expressing my concerns at MDT and one-to-one with the medical director, I was told there would be an independent inquiry into the myocarditis cases, but this never happened. On 7th October 2021, I emailed the Guernsey Board of Health expressing my concerns further. This letter is referenced below.

Dear members of HSC

I write to you in my personal capacity, having read Deputy Ferbrache's recent "Statement by the Chairman, Civil Contingencies Authority on Thursday, 23 September 2021" about proposed legislation to transition the CCA towards permanent legislation.

I may have missed it but I could not find the definition of the word "emergency" in respect to this legislation? I would be most grateful if you would forward me the documentation that is being used to define this important criterion upon which the legislation pivots.

In addition, I would like to request a review of the effects of the legislation (from the start of the emergency power legislation being enacted in early 2020 to date) upon unintended consequences as below which, I would consider key performance indicators of health which your committee is duty bound to oversee.

The delay in diagnosis and treatment of cancer (in days)

The delay in diagnosis and treatment of coronary artery disease (in days)

The waiting list for orthopaedic surgery

The number of suicides

The number of days lost to school education per pupil per month.

The number of businesses that have been declared bankrupt as a consequence

The divorce rate.

The number of people harmed by domestic abuse

The number of people with alcoholism

The number of people with drug dependency

The number of people seeking help for anxiety disorder

The bed utilisation at PEH - admission numbers, duration of stay, number of days in delay to discharge,

Having recently witnessed for the first time in 14 years in Guernsey, the PEH reaching maximum bed capacity in late July and August, coupled with the busiest month ever for St John Ambulance service I

remain extremely concerned that the coming winter may be a major disaster for routine patient care independent of Covid-19 which is now recognized to be endemic.

I attach an interesting paper by S. V. Subramanian (European Journal of Epidemiology)[2] demonstrating the lack of efficacy of the vaccine in controlling case numbers and therefore any use of emergency legislation must be measured against the definite unintended harms caused to the KPIs listed above.

As stated above I write to you on this matter in my personal capacity and am most grateful for your time and help with the above which I am sure you are all committed to solving.

Finally, I wish to request a transcript of the concerns you have raised during the debate in the monthly re-enacting the emergency legislation and indeed the methods that you used to monitor the harms to the KPIs listed above which you would, of course, been deeply concerned about as have all healthcare providers.

Kind regards,

Dr Dean Patterson

I never received a response from the Guernsey Board of Health, but worryingly, a few days later I was requested by the Lead for Clinical Governance to have an Occupational Health assessment as they were concerned about my mental health. I asked who had made the suggestion to the Clinical governance lead, but they refused to identify the person involved. I took this action as an attempt to gaslight and threaten me for seeking information in relation to the safety of the vaccines and the lockdowns. Clearly, the powers that be did not like my email!

Subsequent to the above, I requested a meeting with the local head of Public Health and the hospital Medical Director to discuss my concerns about myocarditis cases, but this meeting took 6 months for a date to be confirmed by the head of public health. At this meeting I called for the vaccine rollout to be halted and an investigation to be done. I was ignored and not offered any time to investigate my concerns about the dramatic increase, nor offered funding for extra consultant time to keep up submitting the onerous yellow cards, despite my informing the medical director of the MHRA deleting my reports. I subsequently after witnessing further myocarditis cases, with Doctors for Patients UK called for the cessation of the vaccine rollout with the “Press Release video campaign”.

In 2022, I met with UK MP Sir Christopher Chope, explaining my concerns about Covid-19-vaccine myocarditis, but he explained the UK parliament had little appetite for discussing this issue.

In March 2024 I wrote to the GMC to express my concern for developments and the manner in which doctors like Dr Malhotra were being vilified for standing up for patient safety (Appendix).

From the above witness statement, it is quite clear I have made multiple attempts to notify the regulators and local clinical governance of my concerns about the deleterious effects of the Covid-19 vaccine and lockdown policies on public health. It must also be said that as a clinician in Guernsey, I am contracted to provide specialty cardiology and general medical services to the island, but there has never been any provision within this contract for dealing with a post-pandemic rollout of novel vaccines under EUA. In my medical career prior to 2020, I would annually submit at most 0-1 yellow card reports on a small paper slip, usually in the rear of the British National Formulary that takes 10 minutes. Submitting 20- 30 online yellow card reports annually that take 45-60 minutes each while dealing with a post-pandemic/lockdown/Covid-19 vaccine surge in cardiology cases was impossible without investment in additional consultant time. Currently, cardiology referral records are being broken, with 135 referrals in a week becoming commonplace. My actions appear to have been thwarted by a major failure in the systems in place to protect patients, but these systems were not designed for a post-pandemic EUA vaccine rollout with a side effect profile of this intensity and magnitude. In fact, the MHRA had a budget cut of 25% in 2021 and suffered major vacancies due to this into 2022.

I believe that myocarditis is just one aspect of cardiac injury secondary to Covid-19 vaccination and that the injury extends to the whole vascular system. The myocardial injury ranges from severe myocarditis to acute and chronic mild and severe myocardial/endocardial/endothelial injuries that have serious long term health consequences. We know from the study done in Basel by Professor Christian Mueller that 2.8% of all subjects getting a Covid-19 booster had a significant rise in troponin T. Professor Mueller states this is not a serious problem, but he falsely assumes that detailed safety studies have been done to confirm this and demonstrate bio-distribution of the prodrug and the active recombinant spike protein. We have a wealth of published post-mortem data showing causality, increased non-Covid-19 mortality data post vaccine, and studies confirming that SAEs occur at a rate of 1:800 based upon the initial vaccine studies. We have no double-blind placebo-controlled studies to demonstrate booster safety. Even Dr Paul Offit, an eminent FDA vaccine safety panel member, has now publicly stated he has no faith in the safety or effectiveness of the Covid-19 boosters. Some of the injuries appear to be due to LNP issues while others are due to the mRNA technology itself and contamination with plasmid/DNA. We know there is evidence of mRNA activity for up to 6 months

after the first booster[3] but there is no data for people after 5-6 boosters. It appears the Covid-19 Vaccines are prodrugs that do not, as Dr Drew Weissmann (Nobel prize winner for his Covid-19 vaccine work), stay in the arm and disappear within a week. In addition, the UKHSA has data demonstrating high levels of antibodies in people vaccinated, which are then 10-fold higher in people who have had Covid-19 and the Covid-19 vaccines.

The time to stop the rollout of the Covid-19 vaccines was in mid-2021 once the elderly and high risk people had been vaccinated. Despite the catastrophic events described above, even as of 5 May 2024, there is zero data on the bioavailability of the Covid-19 vaccines based upon AI search engine review.[4]

An urgent investigation into the Covid-19 vaccines and pandemic management with an independent inquiry is overdue. Without redress, I fear vaccine hesitancy will rise to alarming levels.

2 Oncology

Professor Angus Dalgleish, MD, FRCP, FRACP, FRCPath, FMed Sci, Emeritus Professor of Oncology, St Georges Hospital, London; Principal, Institute for Cancer Vaccines & Immunotherapy

It is well over a year since I first raised the fact that I was seeing an extraordinary number of relapses in stable melanoma patients, some of whom had been stable for over 10 years.

Melanoma relapses after being stable for years are usually associated with prolonged severe stress such as bereavement, divorce, or business failure. The logical interpretation was that prolonged stress/depression suppresses the immune response, especially the T cell and innate immune system, which we know are major controllers of chronic infection and cancers.

None of these patients suffered from the above. However, the only thing they had in common was that they had had a booster mRNA vaccine, either under pressure from their GP/Consultant or reluctantly because they wanted to travel abroad.

As an experienced HIV and cancer vaccine researcher, I am aware of vaccine models where 1-2 shots are good, the 3rd shot negates any previous benefit, and the 4th induces the very disease it was trying to prevent!!

I did not have to wait long before my suspicion that this could be due to the booster vaccine was confirmed with the publication of immunological studies showing that cancer patients, in particular, had suppressed T cell responses after the 3rd jab. This was followed up by similar reports that the 3rd jab was associated with IgG antibody class switching from IgG1 and 3 to IgG4, which is tolerogenic and the ideal response in transplant patients.[5]

This data was followed by reports that the 3rd jab makes people far more likely to catch Covid-19 again, 3.6 times more so according to the excellent Cleveland clinic study.[6]

Not only melanoma patients were relapsing after the booster, but I personally became aware of 8 people who developed B cell lymphomas/leukaemias and myeloma after the 3rd shot.

More recently, it has become evident that colorectal and all abdominal tumours have not only increased in incidence but also aggressiveness, so-called turbo cancers. Other cancers which have increased after the booster include renal and gliomas (brain tumours, especially in young adults).

All these tumours are associated with marked immune suppression and /or response to Immunotherapy, thus supporting the perturbation of a successful innate and T cell control of the tumours. However, scanning the literature and daily reports there are several more ways that the mRNA vaccines could induce or promote cancers.

These include the major batch-to-batch variation including massive variation in concentration of DNA plasmids, (present in every vial that has been tested in independent labs internationally to date) and other agents such as the oncogenic SV40 promoter and this is before we get to reports of mRNA induced frame-shifting and imprinting.

There are several reports that mRNA-synthesised spike protein (specifically the S2 subunit) can bind p53 and MSH suppressor genes which will take longer to induce cancer growth than perturbing the immune response but may already be involved in the highly significant rise in cancers, especially in the young, being reported world wide.

The bottom line is that we have uncovered several different mechanisms whereby mRNA vaccines can induce cancer, so they must be withdrawn immediately.

3 Surgery

3.1 General surgery (GS), emergency GS, colorectal surgery

Mr T James Royle, MBChB, FRCS (Ed) MMedEd

My name is James Royle. I am a general and colorectal cancer surgeon working in the North East of England for the past 8+ years. My qualifications are MBChB (2002), MMedEd (2011), FRCS(Ed) (2012). I believe the comments in this statement are true to the best of my knowledge and belief. They are my own personal clinical observations and are not representative of my employer, or the NHS.

From around March of 2021, I started noticing potential problems; patterns of disease suddenly frequently appearing that I had never seen before in my patients:

- **Thromboses/vascular**

  - **Multiple bilateral pulmonary thromboses** (both lungs - clots in the pulmonary arterial vasculature - these were *not* pulmonary "emboli" (as thromboses seen in lung vessels are often called) because they did not usually result from embolisation of a DVT (clot in the leg) in these cases. These were occurring frequently as incidental findings on routine follow-up CT scans in my colorectal cancer follow-up patients (after curative resections)

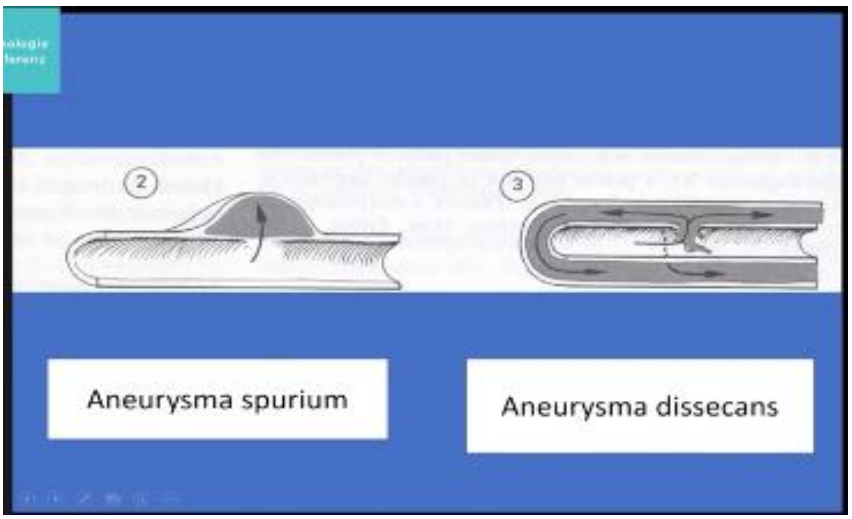
  - **A new triad of spontaneous (unprovoked) abdominal venous clots** that I had not ever seen before - affecting the same 3 main vessels in multiple patients: portal vein (from the gut to the liver), superior mesenteric vein (draining the small intestine) and splenic vein. These patients, typically middle-aged (range 31-77 years) presented with vague abdominal pain, with no underlying pathology to cause the thromboses (no classical risk factors e.g., absence of severe pancreatitis or advanced cancer) suddenly happening in multiple patients admitted under acute general surgery.

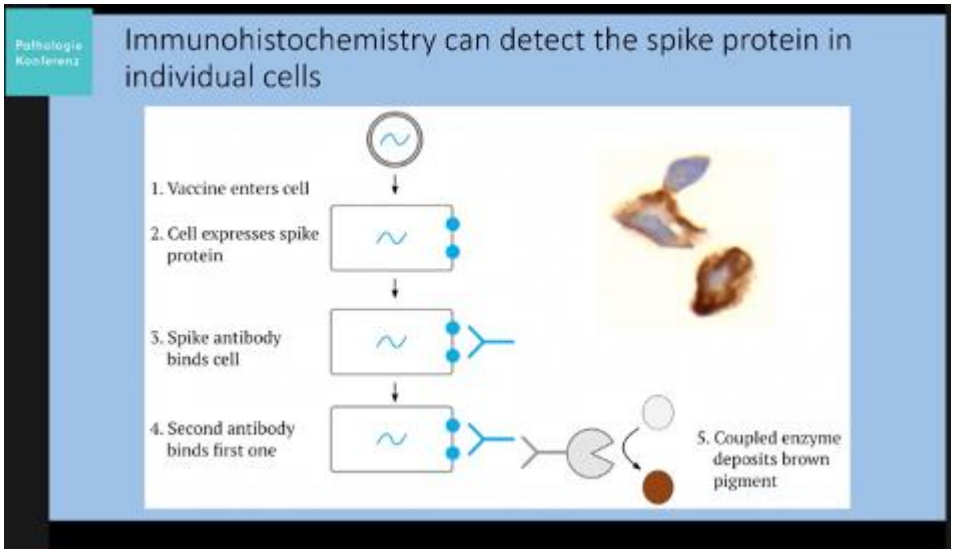
  - **Sudden increased incidence of ischaemic bowel cases** (usually uncommon) - many had no visible clots in their mesenteric arterial vessels on CT as would normally be expected. This could possibly be due to microclotting in multiple small vessels or capillaries, or perhaps from thrombotic endocarditis, as Dr Dean Paterson has suggested.

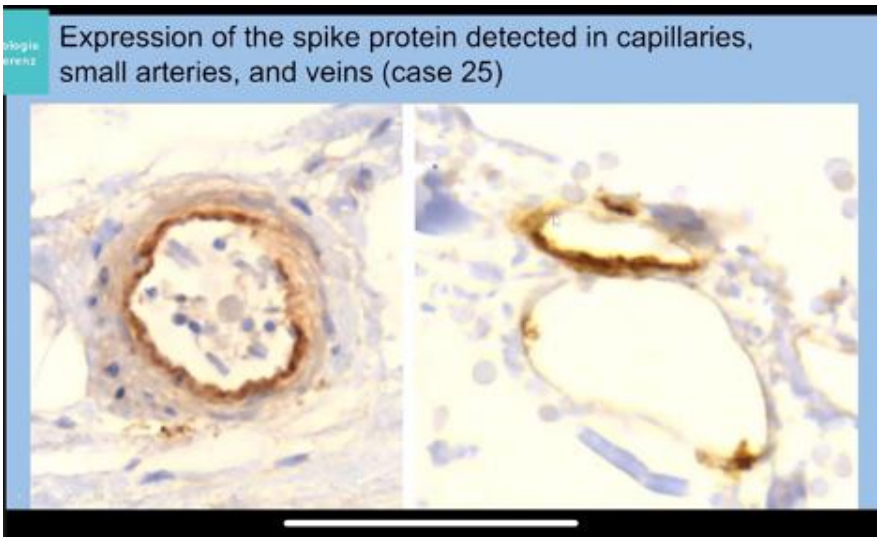
In these thrombotic cases, I had started testing for the **VITTS ("vaccine-induced thrombotic thrombocytopenia syndrome")** that had been defined in some patients after Astra-Zeneca vaccine; however, I was seeing these cases after the mRNA Pfizer and Moderna shots as well; typically without fulfilling the full criteria of VITTS, these patients had raised D-dimers, low fibrinogen, and some had low platelets.

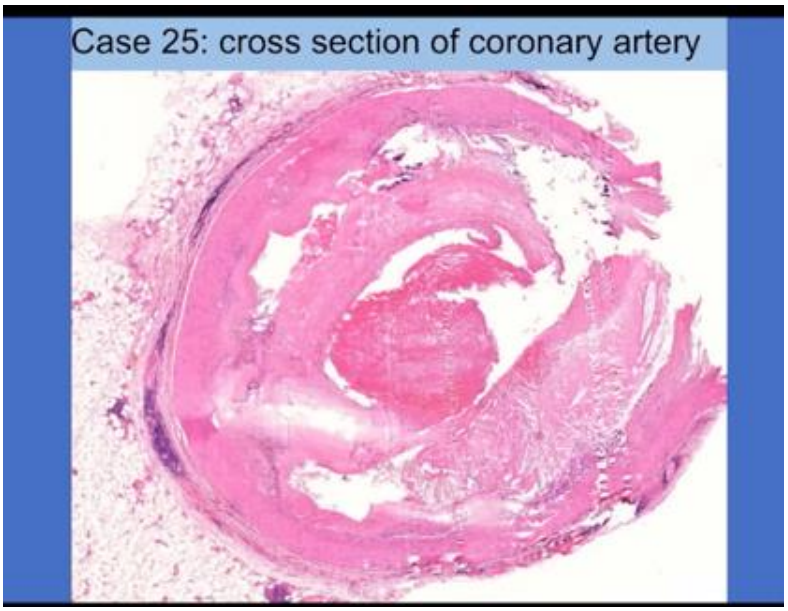
- Two pregnant women presenting in quick succession with ruptured **inflammatory** splenic artery **pseudoaneurysms**; (certainly not a recognised condition of pregnancy, but possibly the physiological changes may have interacted in some way?). One case I had to take to theatre for laparotomy and splenectomy. The other case went to a tertiary centre for embolisation; I do not know of the final outcome. The proposed pathophysiological mechanism of this (as related to Covid-19 vaccine spike protein) was first described by the late Dr Arne Burkhardt, a German pathologist. He demonstrated pathological specimens staining for vaccine-induced spike protein present in the vessel endothelium, leading to inflammation and damage to the vessel wall and spontaneous rupture. Spike protein has been found in many organs by Dr Arne Burchardt, work now replicated by others such as Dr Ryan Cole. The following slides are taken as screenshots from a video lecture Dr Burkhardt gave on March 11th 2022, freely available here.[7]

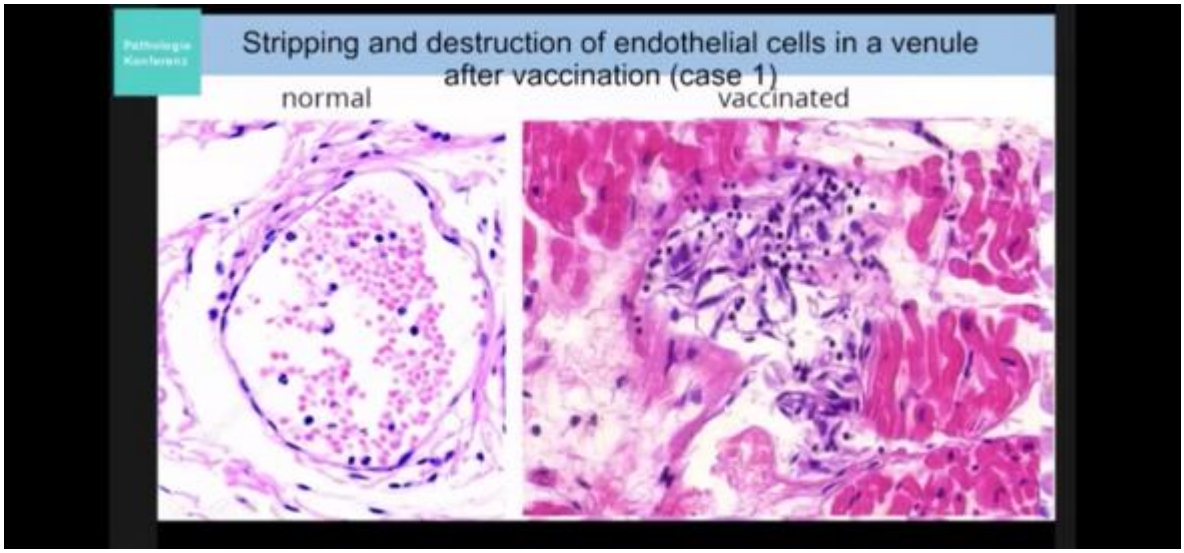
Mechanisms of inflammatory pseudoaneurysm formation:



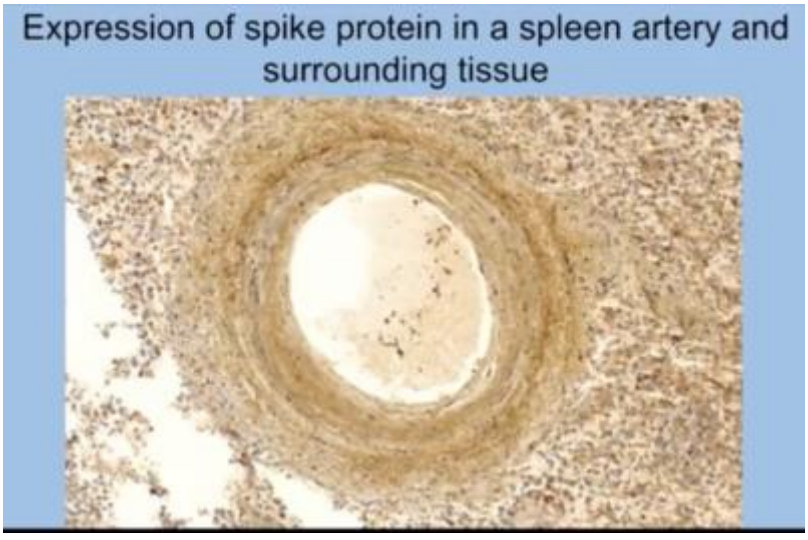

Immunohistochemistry can detect the spike protein in individual cells
1. Vaccine enters cell
2. Cell expresses spike protein
3. Spike antibody binds cell
4. Second antibody binds first one
5. Coupled enzyme deposits brown pigment


Expression of the spike protein detected in capillaries, small arteries, and veins (case 25)


Case 25: cross section of coronary artery


Stripping and destruction of endothelial cells in a venule after vaccination (case 1)
normal
vaccinated


Onion skin" inflammation of spleen artery (case 15)


Expression of spike protein in a spleen artery and surrounding tissue

- **Systemic inflammation**

A series of cases of non-specific **mild transient idiopathic colitis** (on CT imaging, resolving conservatively) admitted under general surgery were observed and corroborated by a senior GS/colorectal surgery colleague's observation in another centre.

As a possible indicator of this underlying systemic inflammation, I have noted abnormally high measurements of C-reactive protein (CRP) in many patients over the past 18 months. CRP is a useful but non-specific marker of acute inflammation or infection. It is particularly useful in trend to monitor response to antibiotic therapy, for example, and clinical recovery. Previously, a CRP of over 200 would be considered very high (e.g. emergency department may protocol immediate CT scan if presenting with abdominal pain) and indicative of a severe systemic acute inflammatory or infective process, and the patient would be clinically unwell consistent with that. However, I have now started seeing CRPs of up to or over 500 in patients who clinically don't appear that unwell and in whom often a CT scan doesn't show findings that would correlate in severity with that value; a number of colleagues (both in my department and others I correspond with nationwide) have independently commented to me they have been seeing this phenomenon as well. Could it be that these super-high CRP values are reflecting a form of systemic endothelial inflammation?

Significantly increased incidence of **severe (often gangrenous) pancreatitis** in patients who don't look that ill on presentation, but their initial admission CT scan already shows extensive pancreatic necrosis (this is a new phenomenon). Prior to the roll-out, necrosis was an unusual ***and late*** development of severe pancreatitis cases that would typically require support in an intensive/Critical care unit (ICCU) for a week or more before any necrosis developed. We noticed a difference in the natural history of this form of pancreatitis and its progression and severity.

Post-vaccine boosters, I have observed what seem to be a lot of sudden deaths from necrotising pancreatitis in elderly patients (new pattern). One case was associated with aberrant patterns of more widespread ischaemia affecting the stomach and small intestine. This patient had received a 4th booster less than two weeks prior, and spike antibodies were >2500.

A much higher proportion of "idiopathic" (no identified cause) pancreatitis (up to 40% in a recent audit); until recently, conventionally, around 95%+ of pancreatitis was either caused by gallstones or alcohol. As it is agreed we should investigate other causes rather than assume "idiopathic", I have been requesting other tests, including IgG4 antibodies that would indicate an autoimmune cause; this is interesting and may be relevant, as IgG4 class switching has been proposed to occur after multiple Covid-19 boosters.

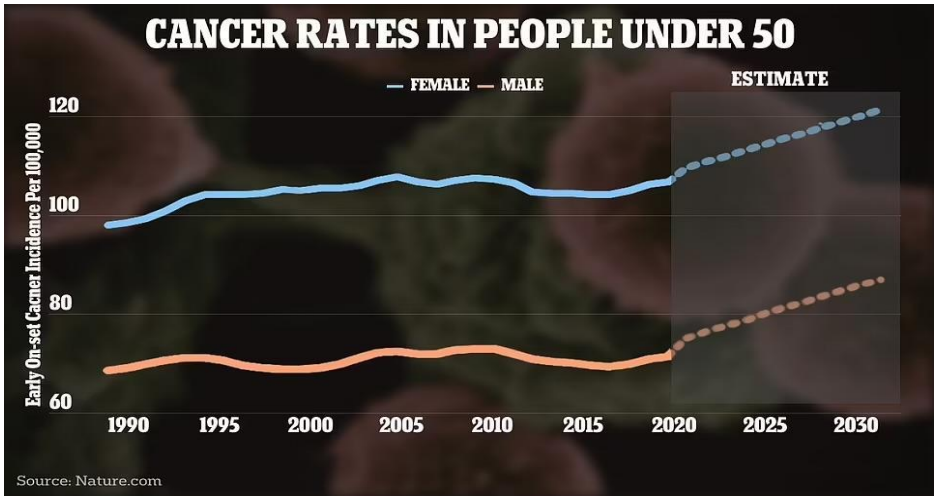
- **Infective/septic patterns in emergency general surgical cases**

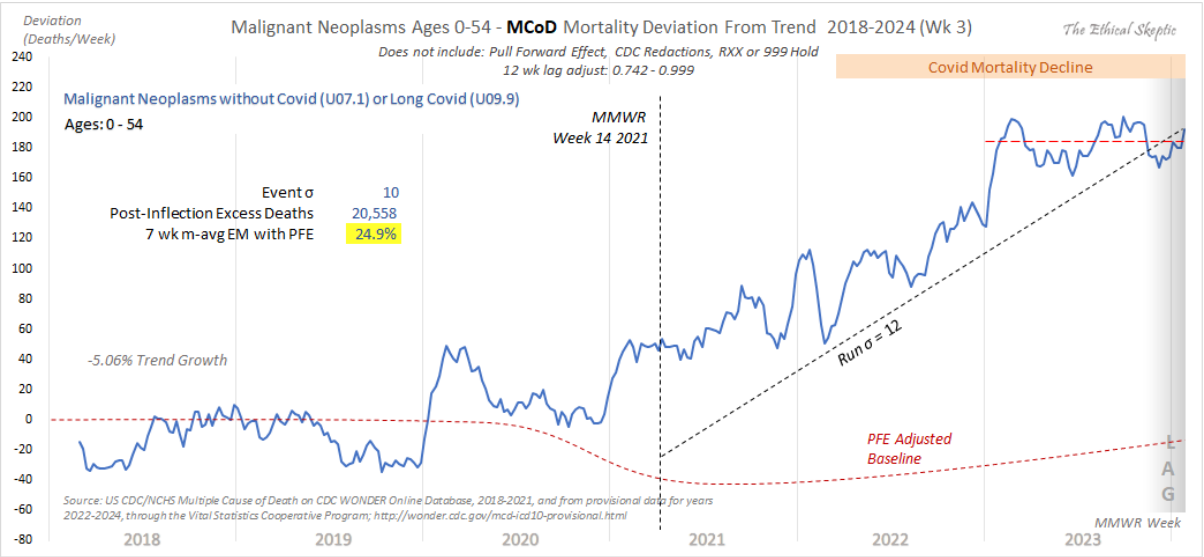
  Observation of increased incidence of **'nasty' (significantly inflamed/infected or gangrenous) cholecystitis**

  Increased incidence of **'nasty' (severely infected/perforated/gangrenous) appendicitis**, esp. in middle-aged patients; this is unusual; classically there is a bimodal distribution in appendicitis: in children and up to mid-20s and then in the elderly. Also, a notable increase in appendix cancers (considered rare) picked up incidentally in appendicitis specimens.

- **Colorectal cancers**

  In addition to the increase in all-cause excess deaths in all highly vaccinated countries since the gene-based injectable roll-out, there has been observed an alarming and significant increase in cancers. These cancers have been termed colloquially "turbo cancers". (Obviously, this is not a scientific term, but reflects the different aggressive-biological nature that seems to be being observed by the public, as well as clinicians). Despite recent articles claiming that the sudden growth in cancers is not new,[8] there is a clear inflection point that occurred in 2021, shortly after the roll-out, shown in the two figures below and which continues to climb alarmingly away from the previous trend.[9, 10]





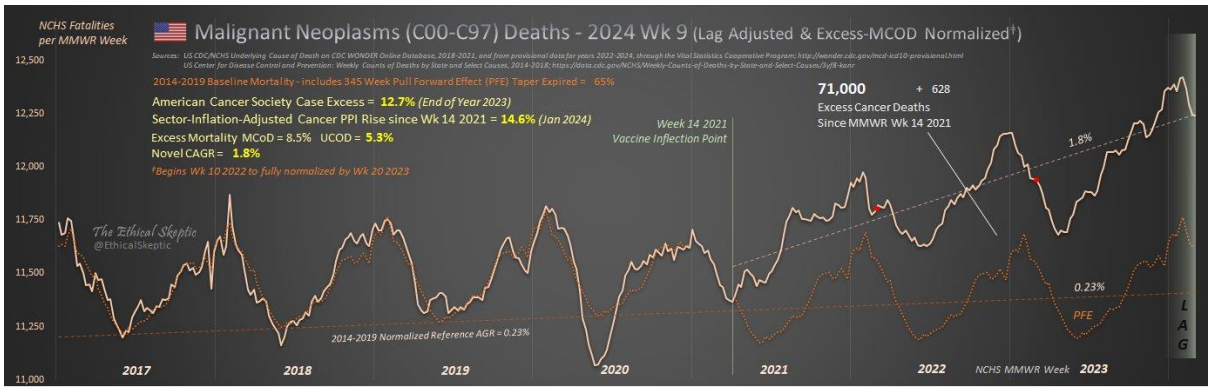
A robust study recently published from Japan,[11] shows cancer-related excess mortality in vaccinated populations but a reduction in colorectal, though increased in most other cancer types. I cannot explain the reason for this but certainly, it is my impression that in the UK we are seeing a significant increase in colorectal cancer mortality since the vaccine roll-out.

The cancers being observed are in all ages. It is my assertion (shared by many expert oncologists and clinical colleagues around the world) that the cancers we are seeing are aggressive and of a different biology.

In younger ages, a dramatic increase in presentation and diagnosis; through 2021 (5.6% increase), 2022 (7.9%) in the analysis below.[12],[13]

I have noticed **aggressive multi-area recurrences** in previously successfully treated bowel cancer cases that I'd considered cured. Many metastases in these cases are unusual or atypical e.g. pathologic humerus fracture with a humeral head destroyed by tumour (with CEA - colorectal cancer marker >5000).

Middle-aged and elderly people are presenting with aggressive stage 4 colorectal cancer who are incurable and die within weeks or months. In many of these cases, the entire liver appears to be filled with large round tumour masses. It is horrific to see on a weekly basis in my MDT. In my experience, it is rare for colorectal cancer to be as aggressive in elderly; usually, it is picked up co-incidentally or when investigating for iron deficiency and a tumour is found in the right colon that is amenable to resection. Elderly patients rarely present with stage 4 disease, and certainly not in the way I have started seeing. Recently, we have seen three patients presenting with synchronous cancers (2 separate bowel cancers in different areas of the colon presenting at the same time). This was previously considered rare (<3%). One was middle-aged, otherwise fit and well with two bulky locally invasive cancers, one was very elderly with 2 primary cancers and liver metastases.[14]



Many of my multidisciplinary team colleagues (fellow surgeons, oncologists, pathologists, radiologists, and specialist nurses) have acknowledged to me the sudden change in patterns and dramatic increase in these aggressive, incurable advanced cancers we have observed in the past two years. However, none of them can offer an explanation.

Suggested causes:

1 "Genetic cancer"?

There is an ever-increasing focus on genetics and cancers (and the NHS is currently

significantly increasing funding into genetics screening services).

Many of these post-2021 cancers unsurprisingly are expressing particular mutations; pathologists identifying these are then suggesting these cancers are likely "genetic" (or inherited). Despite this, after referral to the regional genetics service, further analysis in the majority of these suspected "genetic" cancers coming through our MDT are not found to have any known inherited gene mutations. It has been argued by some scientists therefore that it could be the other way round. Aggressive tumour biology will express more mutations; it does not necessarily mean the mutations have caused the cancer. Despite the current paradigm, these scientists argue convincingly that cancer is not principally a genetic (by which meaning inherited) disease. It has been alternatively postulated that cancer is primarily a mitochondrial (or metabolic) disease caused by multiple toxic factors including western diet (high processed carbohydrate, high sugar), increased exposure to multiple environmental toxins leading to mitochondrial DNA damage, production of free radicals (causing cellular mutations), abnormal cellular respiration (pyruvate-fermentation), which leads to proliferation of chromosomes with defective cell division leading to the typical histological appearance of cell nuclei packed with these abnormal chromosomes (pleomorphic). Cancer cells lose their ability to undergo apoptosis (programmed cell death). Cancers are also more likely to develop if someone's immune system is damaged or suppressed, as tumour surveillance mechanisms are impaired. Indeed, a recent published study suggests mechanisms of oncogenesis and autoimmunity as a result of mRNA Covid-19 vaccination.[15],[16],[17]

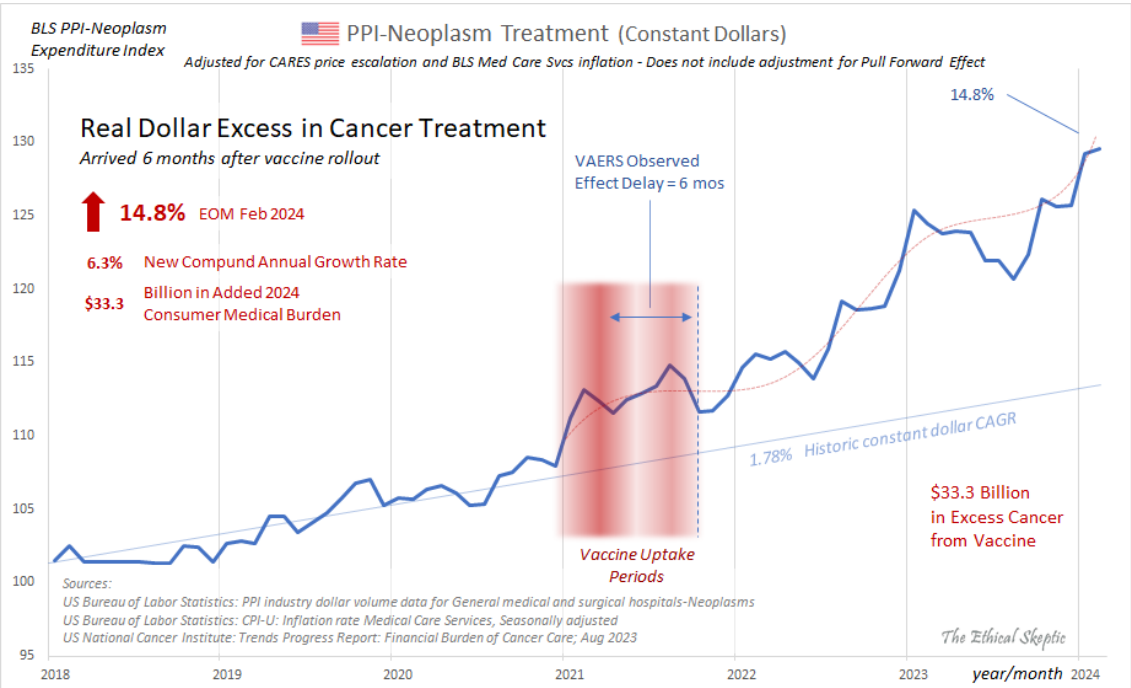
In 2022, I operated on two young men for colorectal cancer, both in their mid-30s. Thankfully, both remain in remission to date. One of them required an emergency operation, but fortunately I was able to remove the mass with clear margins, with a second operation later to close his necessary colostomy. He was later informed by the regional genetics unit that his cancer was genetic ("likely Lynch") because a particular mutation was found, and now his whole family are in the screening programme, with a psychological 'grey cloud' over them indefinitely. ***The ethics of this needs to be debated***. Lynch syndrome (hereditary non-polyposis colorectal cancer, or HNPCC syndrome) is suggested to cause an estimated mere 3% of colorectal cancer in all ages, and 8% among the young. So what then is causing the sudden increased incidence in the other 92% that we are seeing?

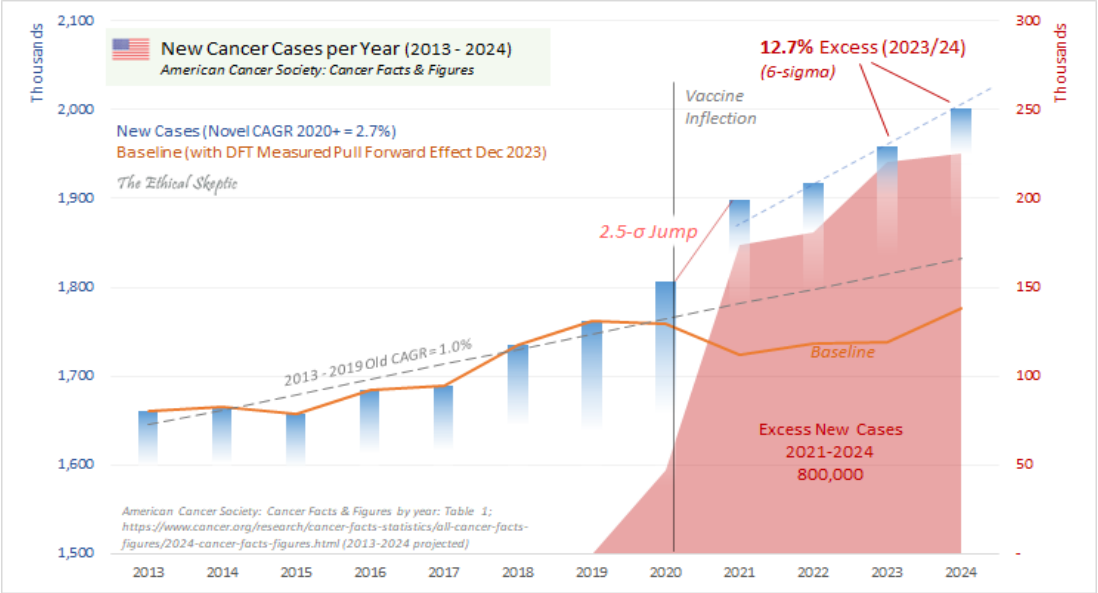
2. Western ultra-processed diet, obesity and sedentary lifestyles?

Whilst these things undoubtedly have played a major role in the steady increase in cancer over the last 3-4 decades, they do not explain the post-2021 sudden increase and change in biology (aggressive nature). This post-2021 increase cannot be explained by a sudden population-wide change in environmental toxins. Ultra-processed foods are not new. We already had an obesity epidemic prior to Covid-19.

3. Lockdowns causing delayed diagnosis, and suspended cancer screening programmes?

The post-2021 surge in aggressive cancers in all ages cannot be blamed on lockdown and delayed diagnosis. During the Covid-19 pandemic, we did not stop symptomatic 2-week wait (urgent cancer) colorectal pathways. We diagnosed (and treated) more - rather than fewer - cancers during lockdown, as the only pathway that GPs could access was the rapid access 2-week wait cancer pathway, so we saw more patients through it, not less. Therefore this argument - "stage migration", or missed or delayed diagnoses - does not hold for colorectal cancers. Furthermore, colorectal screening services were only stopped for a few months of the first and second wave. (In any case there is no valid argument that the increase is due to stopping screening, given we are seeing a particular increase in cancers in much younger people (20-45 years); screening services for colorectal cancer (and breast and others) typically start at age 60 years).



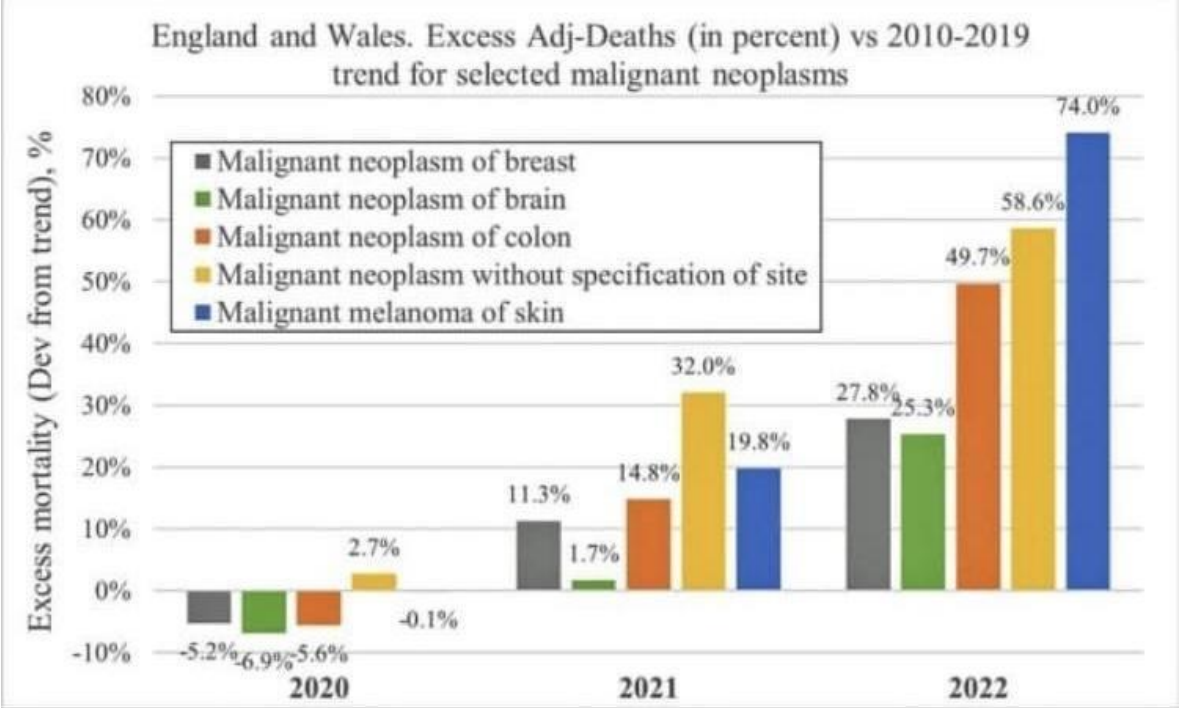


4. Close temporal association of the increase in cancers and rollout of population wide mRNA Covid-19 vaccinations

This evident correlation fulfils at least eight of the nine Bradford-Hill epidemiological criteria for causation (see Appendix B).[18]

There are multiple plausible mechanisms by which cancer could be induced or potentiated (accelerated) by the mRNA gene injectables, including the discovery of the sv40 tumour promoter, disruption of the p53 tumour suppressor, dna plasmid contamination, etc. These mechanisms are discussed in both Professor Angus Dalgleish's statement, and Dr Ryan Cole's evidence (Appendix A.2) and have been discussed on numerous international calls.[19]

More generally, the shots are clearly causing generalised immunosuppression. The immune system is grossly underestimated in its complexity, and importance in tumour surveillance, in destroying mutated cells before they become cancers.



I have had a number of conversations with two colorectal colleagues, in other areas of the country, who have similar shared experiences and are in agreement with the observed patterns of thrombotic, infective/inflammatory, and malignant disease I describe above.

I submitted over 20 Yellow Cards from June 2021. I could have submitted many more, but it was becoming very apparent that the MHRA was ignoring the data. I was never given any feedback on any analysis of my cases, or even acknowledgement, except for 2 or 3 cases where further clarifying information (that I had already provided) was requested. I was given no information back from MHRA to indicate they were looking at Yellow Card data or analysing it.

Presenting this information formally, I have received mixed responses. More recently in my departmental morbidity and mortality meetings, there has been a more open acknowledgment that perhaps some observed events (e.g. ischaemic bowel cases) may have been related to the vaccines.

I had the opportunity to give a presentation to an international surgical meeting in London in March 2023 (slides available here.[20]) - at the end, I was congratulated on my perceived courage in standing up and speaking about these concerns; there was general agreement in the room (30+ surgeons), many offered acknowledgement and similar observations but had been unwilling to raise their concerns for fear of repercussions. In fact, a rather alarmed eminent retired surgeon present stated "*it was our **duty** to raise these concerns*".

In conclusion, the data are clear that there are serious questions still to be answered regarding the Covid-19 vaccines' safety and efficacy. My own personal observations have been increasingly backed up by other data around the world and research studies, as well as expert opinion in other centres. Until all such questions can be answered, I personally believe that these injections and any promotion of them should be stopped with immediate effect.

3.2. Mr Ian McDermott, MB BS, MS, FRCS(Tr&Orth), FFESM(UK), Consultant Orthopaedic Surgeon, London Sports Orthopaedics, Honorary Professor Associate, Brunel University:

Within the whole of medicine, there is NO treatment that is ever 100% safe or 100% effective.

One of the key tenets of medicine is evaluating the balance between risk and benefit. One of the key principles of good medical practice is to then apply the generalities of that overall risk: benefit analysis to the individual patient. One of the key foundation stones of ethical medical practice is to engage the individual patient in that discussion and to then support each patient in making whatever decision suits them best, as an individual, without pressure or coercion.

With the Covid-19 mRNA gene therapy injection mass rollout to the population, every single one of the fundamental principles of Good Medical Practice listed above was discarded and ignored, to catastrophic effect.

The medical profession should be there, standing firm, relying on evidence-based decision-making, and protecting the public and each individual patient irrespective of political pressure, peer pressure, coercion or financial incentivisation. It would appear that our profession, as a whole, failed — and really quite abysmally.

Many thousands of doctors and nurses injected many millions of doses of what, at the time, was an unknown substance, for a disease that was, for the vast majority of people, no worse than the common cold. They didn't know what was in the vials. They didn't understand how it worked. They had no idea about any potential side effects. They were utterly oblivious to what the potential long-term consequences might be. They injected people who were under obvious direct coercion ('have the jab or you can't work', 'have the jab or you can't go on holiday', 'if you don't have the jab, you're a 'granny killer'!').

And what's most bizarre is that STILL, despite blatant evidence of lack of efficacy, and despite overwhelming evidence of catastrophic harms, a majority of the medical profession remain ignorant of the facts and blind to their errors. This 'wilful ignorance' has now gone way beyond the line of forgiveness, and understandably, confidence in the medical profession has been shattered.

Whatever became of our once-noble profession?!

3.3. Mr Tony Hinton MB ChB, FRCS, FRCS(ORL), Consultant Surgeon:

I have lost all faith in the MHRA as a regulator. I have filed 15 yellow card reports for vaccine injuries in my patients and heard nothing back from the MHRA - are they not interested?

4 Psychiatry

Dr Ali Ajaz, MBBS, BSc, MRCPsych, PGCert

I am Dr Ali Ajaz, a Consultant Forensic Psychiatrist with over 18 years in practice. My disillusionment with systemic issues in healthcare culminated in my departure from the NHS due to the proposed enforcement of Covid-19 vaccine mandates, which I believed were ethically and scientifically unsound.

My concerns were amplified by an inability within the NHS to freely question or debate the Covid-19 response. Requests for open dialogue with senior figures were consistently met with defensive and dismissive attitudes. Efforts to critically assess the evidence supporting various medical interventions were systematically obstructed. Historical concerns raised by previous medical studies were disregarded, in favour of a narrative driven by authorities lacking medical expertise. This approach prioritised conformity and compliance over rigorous scientific scrutiny and open debate.

Concerns about the rapid development and endorsement of vaccines were obstructed, including significant historical data on mRNA vaccine trials on animals which indicated adverse outcomes. Previous failures in developing coronavirus vaccines and the problematic implications of lipid nanoparticles—which are known to permeate various bodily organs—were also overlooked. These red flags were dismissed in favour of a narrative driven by authorities lacking in medical qualifications,

emphasising compliance over critical scientific evaluation The vaccine's rapid development and endorsement involved overlooking substantial red flags—such as the prior failures in developing a coronavirus vaccine and the problematic implications of lipid nanoparticles that permeate various bodily organs.

The NHS's handling of the Covid-19 vaccine rollout exemplified a top-down approach where frontline doctors, including myself, were discouraged from applying medical scrutiny or expressing concerns. Institutional pressure to conform without question, and the stigmatisation of dissent within the trust, particularly highlighted by how critical thinkers often become silent adherents upon ascending to middle management roles, convinced me of a profound ethical crisis.

Concerns raised regarding mRNA vaccines and lipid nanoparticles were obstructed. Historical data on mRNA vaccine trials on animals, which showed significant adverse outcomes, were overlooked in favour of a narrative pushed by authorities unqualified in medical science, prioritising compliance over critical evaluation.

The role of doctors has increasingly shifted towards that of employees who must adhere to corporate and governmental directives, often at the expense of medical autonomy and the broader, holistic consideration of patient health. This undermines the physician’s ability to advocate for long-term, sustainable health solutions over immediate, but potentially harmful, interventions.

The pandemic response ignored significant collateral damage and prioritised short-term measures with scant evidence of efficacy, illustrating a neglect of the broader implications on societal health and well-being.

This inquiry is an opportunity to confront these critical issues. It is imperative that we advocate for a healthcare system that genuinely values scientific integrity, transparent evidence evaluation, and the sanctity of informed consent. Without addressing these fundamental issues, the trust between healthcare professionals and the public, and among the medical community itself, will continue to erode.

5 Accident & Emergency

5.1 Dr Scott Mitchell, MD

This statement is based on a presentation I gave entitled, 'What is the Truth?' Presentation to the **Covid-19 Vaccines - The Devastating Health Crisis in the Channel Islands & Around the World [Webinar]**

I was formerly an emergency department doctor in Guernsey, in the Channel Islands. For reasons I'll come to later, I resigned from that post and am now working privately. In this presentation, I will cover the following five areas:

- Pandemic mortality
- Measures taken – were they appropriate and proportional?
- The vaccine solution?
- Ability to raise concerns and censorship?
- Potential signals of harm and excess deaths?

Pandemic Mortality:

- Novel coronavirus emerged in Wuhan, China late 2019
- Early mortality data - CFR as high as 4.19% (based only on severe cases attending hospital)
- Ioannidis (2022)[21] reported IFR in <70s of 0.1%, for 0-19s 0.0003% when based on all infections including mild ones.

Response:

- Solution was not to do nothing
- However, existing strategic pandemic plans were thrown out of the window (these contained no plans for lockdowns, mask mandates etc)[22]
- Early treatment and targeted protection, as per the Great Barrington Declaration (the majority, especially the young and healthy, were at very low risk)
- Collateral damage of measures taken (impacts on economics, mental health, and delayed access to health care eg for cancer diagnosis and treatment)

The vaccine solution:

- All eggs in one basket? The great gamble?
- Novel technology, unlike traditional vaccines
- Why were simple interventions and repurposed drugs vilified?
- Overemphasis of efficacy?
- Relative risk reduction
- No medium or long-term safety data
- Worth the risk for the vulnerable?

Children:

I signed up to the Hippocratic Oath - First do no Harm"

- Benefits of an intervention must exceed the risk
- Known serious short-term risks (myocarditis). Unknown longer terms risks.
- I raised these concerns, and I sadly resigned my post as I did not agree with the government approach in Guernsey.

Health Professionals and Concerns:

- Should be able to raise concerns without fear of reprimand, even if later proven wrong
- Why was I sent for investigation by the Guernsey Medical Director for doing so?
    - Using my work email to raise concerns
    - Speaking to the media without stating it was my own opinion
    - Potentially violating the Civil Service Code
- To this day I have had no response to the concerns I raised in September 2021

Risk of Serious Adverse Events:

- Analysis of original trial data suggested 1:800[23] serious adverse event
- Signals of harm in Guernsey.
    - Annual deaths in 2020 were low average for the decade. But deaths in 2021 and 2022 are the highest since 2010.
    - Record numbers of ambulance callouts
    - 50% increase in A&E attendances
    - Hospital bed crisis

Recommendations

- An investigation is needed into whether mRNA therapeutics are causing harm, even if in a minority
- Suspend their use until this is done
- Is there any benefit from further boosters?
- Acknowledge those affected and offer help and compensation, where appropriate

5.2 Hospital doctor, anonymous contribution - Sudden /unexpected deaths in staff

"During the Covid-19 'pandemic' waves 1 and 2, I noted one staff member from our Trust (around 7000 employees) who sadly died having tested positive for Covid-19; this was announced and shared through the staff e-bulletin. Since that time, I have been watchful for any other sad news of staff members dying. To my knowledge, no other staff members were noted to have succumbed during the Covid-19 period prior to the vaccine roll-out. One nursing colleague became critically ill and was in ICCU for some weeks but recovered and was discharged home.

However, since the vaccine roll-out, three senior members of staff have unexpectedly sustained strokes; none had recognised risk factors. There have been 18 sudden or unexpected deaths (including 3 young adults) announced through the staff e-bulletins since the vaccine roll-out. Of course, these may not be related at all, and I have no details other than the brief statement in the bulletin. I have no knowledge of their medical conditions or vaccine status. However, appearances like these would have been extremely unusual prior to this period. None of the usual phrases e.g. "As many of you know, 'Geoff' fought a brilliant fight against lung cancer…". When one reads these messages of condolence they read as the same vague script; it is uncanny and chilling:

> *"We are very sad to share the news of the sudden passing of our colleague…"*
>
> *"It is with great sadness that we inform you of the death of our friend and colleague…"*

6 General Practice

6.1. Dr Kathy Grieg, RCGP, MBChB hons, Functional medicine IFM.

I was a GP working in the NHS until I developed pericarditis, dysautonomia and insomnia following the Pfizer Covid-19 vaccination. I witnessed similar cardiac episodes as well as blood clotting issues post-vaccination. It was the first time in my life and my career that I could not find help or support for myself or my patients harmed by the Covid-19 vaccine.

It was the first time I was not allowed to add it to the medical record as an allergy and give authority to ensure they never received it again. In fact, I was actively encouraged to support more boosters.

It has taken over 2 years to regain my physical fitness. I now work helping vaccine injured as well as complex medical chronic illnesses. Unfortunately, this is in a private clinic, as the NHS still does not have a dedicated medical service for vaccine injuries.

B.6.2. Dr Caroline Lapworth MBChB, General Practitioner:

My Experience and Thoughts as an Urgent Care GP re Covid-19, and the Ensuing Events.

March 2020, the world stopped! Or so it seemed. I was in the USA visiting our future son-in-law and his parents, our flight home was cancelled. The whole world together, in the short time we were on holiday in the USA, had decided that there was a deadly virus on the loose, so deadly that international flights were to be cancelled, shops, workplaces and schools were to be closed, and we were all to stay at home, unless we were an essential worker on our way to work, or really needed food. Suddenly most of the world, in lockstep, all issued the same advice. Stay at home, stay safe!

The Risk of Dying from Covid-19

I started to research information regarding the virus. To my surprise, I began to realise that Covid-19, although sadly a killer virus, did not kill indiscriminately as the media was leading us to believe. The media said healthy young people were just as likely to drop dead as the elderly. But in fact, the risk factors were quite similar to other viral illnesses: increasing age, comorbidities, obesity, diabetes, etc. Strangely the very young who are at high risk from respiratory viruses usually, seemed to be unaffected.

I found out that my 18-year-old son, for example, had less than a one in a million chance of dying from Covid-19 and even my father in his 80's with comorbidities had an estimated risk of 0.23%.[24] Around this time the information on the mainstream media was causing people to think that there was a very high chance that they would die of Covid-19. One lady I work with thought that 30% of the population had already died of Covid-19. I confirmed with her that she really thought over 20 million people in the UK had died and she confirmed that she did. She worked in a healthcare setting and was not an uneducated individual. The fear deliberately put out by the media had led to people's understanding of what was happening around them being clouded by an irrational fear that did not match the genuine risk, which was significantly smaller than was portrayed. At that point, the total number of deaths, (where there had been a positive Covid-19 test, followed by a death that may or may not have been caused by Covid-19), were in the low thousands.

At this point in time, the GP urgent care unit where I was working was quiet, with few calls. The population was being told to save the NHS at all costs. Unless you were very seriously ill, you were told not to contact healthcare. The only patients we generally heard from were those seriously ill. Many patients were so scared of catching Covid-19, that they would not come to the urgent treatment centre, even when invited to a face-to-face appointment. They would not want to go to hospital, even with life-threatening conditions. I remember one lady I spoke to on the phone who was vomiting blood. My advice was that we needed to call an emergency ambulance for her. She was so scared of catching Covid-19 in hospital that she did not want an ambulance for a serious life-threatening condition. She was at much greater risk of dying from vomiting lots of fresh blood, than a hypothetical risk that she may catch Covid-19, which may then kill her. Sadly, there were many, many cases of patients just too scared of Covid-19 to receive appropriate healthcare that would have helped their situation.

Do Not Resuscitate Orders (DNR)

My biggest concern in those first few months of Covid-19 were the "Do Not Resuscitate" (DNR) orders that were put on patients. Sadly, whole groups of people, such as people in care homes or the disabled, elderly, or those with learning disabilities, had blanket orders applied to them with no discussion with the patient, their relatives, or next of kin. DNR orders written in the notes should mean that in the event of a cardiac arrest, the patient is not resuscitated. Sadly, this leads to a slippery slope, where they are refused treatments or hospital admission, because of the DNR order in the notes. At the same time, hospitals were being told not to treat the same groups of people; a situation developed, where large numbers of care home residents were being denied access to healthcare. GPs were infrequently visiting care homes; ambulances were not allowed to take the residents to hospital. I still

feel quite distressed by a case that I was involved in where an ambulance crew contacted me as the Urgent Care GP to ask me to prescribe morphine for the patient. The ambulance had been called to the care home because the patient had chest pain. The patient had an MI (heart attack) on the ECG. But the paramedics were being told that they were not allowed to take the lady to hospital. Under normal circumstances, this lady would have gone to hospital and received treatment for an MI, but the paramedics were telling me that they were not allowed to take her. They had administered her morphine to reduce her pain at the time, but as they could not stay there with her indefinitely and were not allowed to take her to the hospital, they were trying to get a prescription for pain relief for her. These paramedics were doing their best to help her, and there seemed to be nothing that I, as a doctor, could do to get her to hospital. The policies were all in place to prevent it. If they were not actually written down, everyone involved seemed to believe that they were.

This was not an isolated incident. The number of patients in hospitals was at a record low level. The nurses had time to practise TikTok dance routines, and the patients were being told that they had to stay at home and die, to protect the NHS!

No Treatment for Covid-19

At this time patients with Covid-19 were also being denied treatments. The general advice given was to wait at home until you turn blue, then ring an ambulance. There were no early treatment protocols in place, and GPs who were used to treating patients with a variety of viral respiratory infections, were told not to do what they usually do, such as giving antibiotics or steroids for secondary bacterial infections. All respiratory symptoms were considered to be due to Covid-19 until proven otherwise, and you were not given access to a doctor if you had Covid-19 unless you were blue, so basically most normal chest infections etc. were not treated.

The most vulnerable in society were neglected. Consider a young patient with learning disabilities who lived in a care home and had previously been admitted to the hospital with a chest infection for antibiotics and oxygen: that was not now permitted. As the patient lived in a care home, he may have had a DNR order, meaning they would not take him to hospital for treatment. If he died of the chest infection it was probably recorded as a Covid-19 death (if anyone in the care home had tested positive for Covid-19). The death would have been completely avoidable.

Some doctors started to do successful research on early treatment of Covid-19. But the information was not made available to the wider medical community. The doctors doing this work, often very

eminent, well-published senior doctors, found that they were unable to publish their findings. Worse still, they were threatened with losing their jobs or licences if they continued to share the positive findings of their research.

Lockdowns

I saw the same damage happening to society around me. The lockdowns were extremely harmful to the physical and mental health of society. Attempts at raising concerns about the damage of lockdowns were dismissed as uncaring for people dying of Covid-19. But people were dying because of the lockdowns, from suicide, domestic violence and child protection issues. The mental health crisis was out of control with no one allowed to visit to help people.

People were dying alone, relatives were not allowed to visit, it was shocking. The ongoing trauma of people who never got to say goodbye to their loved ones is still affecting many today.

Weddings were banned, funerals restricted, moving house was against the law, even visiting a relative was illegal. Businesses were closed, some never to reopen, and schools also were closed. The normal functioning of society was put on hold. This was just not necessary nor justified.

On 19th March 2020 the UK Government declared "As of 19 March 2020, Covid-19 is no longer considered to be a high consequence infectious disease (HCID) in the UK." [25]

This was before the first national lockdown in England was officially declared!

The whole of society was in lockdown and in fear of an illness, that the UK government itself did not consider an infectious disease of high consequence!

Vitamin D

When I saw the risk factors of those dying of Covid-19, I realised very early on that they were almost identical to the risk factors for a low vitamin D level. I tried to advise people I knew on the importance of taking vitamin D supplements and getting enough sunlight. The lockdowns made it difficult for people to get outside and get sufficient sunlight, and for some populations, such as those in care homes, rules were put in place to prevent them from going outside. People in care homes were only allowed to take medications prescribed by their GP, and few GPs were prescribing vitamin D routinely to the

residents. Relatives were not allowed to visit and bring in vitamin supplements. We had a situation where the most vulnerable in society were being denied a vitamin that may have saved their lives. Studies have since shown those with low vitamin D levels were much more likely to become seriously ill and die of Covid-19 than those with a high vitamin D level. [26,27,28] I have included a quote from one of these studies below. [29]

"This study illustrates that, at a time when vaccination was not yet available, patients with sufficiently high D3 serum levels preceding the infection were highly unlikely to suffer a fatal outcome. The partial risk at this D3 level seems to vanish under the normal statistical mortality risk for a given age and in light of given comorbidities. This correlation should have been good news when vaccination was not available but instead was widely ignored."

Covid-19 vaccines

The whole of society was brought to a situation where they were afraid of a killer virus, with no treatment. Society as a whole became stressed, anxious and weary and wanted a way out of the lockdowns. The vaccines were presented as the saviour. People were rushing to get injected as soon as they could. But people started to experience side effects, often worse than Covid-19 itself. People were being told that the side effects were just the vaccine working and nothing to worry about. The 'Safe and Effective' motto started to be regularly used by the government and media. But at that time, we had no real knowledge that the vaccines were either safe or effective. They were under an emergency use authorization licence. It was impossible to know the long-term safety of these vaccines as insufficient time had passed to reveal the effects. Previous attempts at making vaccines for coronaviruses had failed, often due to antibody-dependent enhancement. This is where at first the vaccine seemed to produce antibodies, but when the individual came into contact with the virus a second time, instead of protecting them, the virus caused a response that made the person more ill than they would have been if they had not taken the vaccine. There was insufficient time to do these studies, so vaccine safety was very questionable.

The media were complicit in this, but they could not completely cover up all the deaths. For example, BBC presenter Lisa Shaw's death seemed to be clearly caused by the vaccines. But still we were told the vaccines were safe.

In my personal experience, I saw many of my friends, neighbours, colleagues and acquaintances affected by the vaccinations. A close neighbour, who was a good friend in her 80s, took one of the

vaccines within days of the first rollout. She lived independently and was not particularly unwell prior to the vaccine. Immediately after her first injection, she became very unwell, her son called the rest of the family from afar, and they were preparing for her death. She recovered, but a few weeks later she was contacted to receive her second injection. Despite my advice to her not to take the vaccine, she took it. She told me that the GP surgery had phoned her and had told her to take it. Nothing I said could persuade her otherwise, she considered it her duty as a good citizen to do her part and take the injection as advised. Sadly, a short time after the second injection she died.

I have several other examples of people I know seriously affected by the vaccines. The sister of a friend of mine who is a doctor, died of thrombocytopenia, caused by the Covid-19 vaccines. Someone else I know developed serious thrombocytopenia after the vaccines, but he was not told it had anything to do with them, he continued to receive boosters and was admitted to hospital multiple times with life-threateningly low platelets. I tried to warn him, but he was concerned that as he had diabetes, he might die of Covid-19. He was so scared of Covid-19 that another very serious life-threatening condition seemed nothing to him compared to his fear of death from Covid-19.

A friend of mine, not too long after her Covid-19 vaccines, collapsed at work. The following night her husband collapsed in the middle of the night with a cardiac arrest. He was a previously fit and healthy man in his 50s, whose job required him to have regular health checkups. He would have died of a cardiac arrest if his wife had not been at home to resuscitate him.

An acquaintance of mine, to whom I had spoken extensively regarding my concerns about the Covid-19 vaccines, dropped dead at work completely unexpectedly. He was healthy and had no reason to drop dead in his 50s. Another acquaintance dropped dead unexpectedly in his 40s leaving a wife and three school-aged children.

People have come to me in my social circle, with all sorts of concerns of side effects from the Covid-19 vaccines, menstrual abnormalities, pulmonary emboli, autoimmune hepatitis, cardiac arrhythmias, MIs, cancers and often generally “not being the same” since receiving the vaccines.

Due to the nature of vaccine injuries, it can be very difficult to prove that any individual's problem was a direct result of the vaccine; people do get ill, they do have heart attacks, cancers etc. That is why it is so important for genuine statistical information at population levels, to be made available, of the incidence of illnesses and deaths in the vaccinated and unvaccinated populations.

My experience in Urgent Care as a GP

As well as in my own social circle, once the vaccines started to roll out, work started to get busy again. I was regularly seeing young patients with chest pain. I had never seen so many young people presenting with chest pain before. I had patients spontaneously tell me that since taking the Covid-19 vaccines, they have never been the same, they kept getting ill. Not one or two, but in the first year after the vaccine rollout, with no prompting, many patients told me how the vaccines had affected them. I had people ringing with direct side effects like fever, headache and a flu-like illness immediately after the vaccine. But I also had a mother of a 12-year-old girl ring up asking if it was normal to get swelling under her arm after the vaccine. When I asked how large this swelling was, she told me it was as large as a melon! That was a case that definitely warranted a yellow card report. But after dutifully filling it in, I never heard anything more about the case.

One patient of mine particularly disturbed me when she described what had happened to her. I was speaking to her after the events had happened and she was telling me her background history in relation to her present concerns. She was of working age with children. She took her first vaccine and felt like she had been hit by a brick. She spent 3 weeks so ill she was unable to get out of bed. But considered it was the price to pay to do the right thing and get vaccinated as she had been told. She took her second vaccine and exactly the same thing happened, she felt so unwell she could not get out of bed for 3 weeks. She felt like a brick had hit her on the head. No one told her not to get another vaccine, so she went to get her booster. She collapsed at the vaccine centre but was not sent to hospital, she went home and doesn't remember much of the next 2 months as she was so ill at home. She then went into cardiac arrest. Fortunately, she lived very near an ambulance station and a paramedic was at her house very fast. She was taken to hospital, and it was found that she had a very large pulmonary embolus. She had no risk factors and the doctor in the hospital said that it was the vaccines that had caused it. She has never fully recovered and is quite severely affected every day since with her health.

I have also seen patients severely affected by the bereavement of loved ones. Many of the deaths were people who went to hospital, no visitors allowed, and the loved one died and was never seen again. I have spoken to patients whose loved ones died suddenly in the year after the vaccine rollout. Some of their loved ones were not old and definitely not expected. Individually the link between cause of death and the vaccines can be difficult to prove. But it is clear at a population level that since the rollout of the vaccines excess deaths and disabilities have increased significantly.

Hatred Against Those Raising Concerns

My personal research, experience from patients, friends, and neighbours, at this point, was making me increasingly concerned about the safety of Covid-19 vaccines. I had already decided not to take any of the vaccines myself. The next concern I faced was the hatred and propaganda being unleashed against anyone who had not taken the vaccines, or was trying to raise concerns about the vaccines. It is a doctor's duty to raise concerns about a pharmaceutical product they see as unsafe. But somehow Covid-19 vaccines were different, doctors raising concerns were being threatened with losing their registration and rights to practise as doctors. Prominent doctors had already been suspended for raising concerns so it was a very hostile environment for doctors with genuine concerns. I spoke to anyone who would listen, but the 'safe and effective' mantra was so strong, the message that if you love your neighbour and granny, you should take the vaccine, was so persuasive that I was now a public enemy! I shared as much factual information as I could with friends and family, but screenshots from my private Facebook page were sent off to the GMC by a 'friend', someone I knew in person, not a random Facebook friend that I didn't even know. The media had almost a witch hunt on anyone who appeared to be spreading 'misinformation', Even if it was a fact from a government website. My 'friend' was prepared for me to be struck off as a doctor for raising legitimate concerns. How did we get to the place where friends turn on friends to betray them to government organisations for raising concerns about the side effects of pharmaceutical products? The evidence for everything that I put out on social media has just increased in the last few years. The vaccines do not stop you from contracting Covid-19, spreading it, or dying from it.

The Vaccine Mandates

Next came the vaccine mandates. I had to attend meetings with my managers, and I was 3 weeks away from losing my job and never working as a doctor in England again. No one can underestimate the pressure exerted on a doctor to lose their income, job, and all the years of work they have put in to become a doctor, not to mention a job they actually enjoy! The pressures were just too much for many people. The mortgage, the children, the loss of status etc was too much, and many, many NHS staff sadly took the vaccines because of the pressure of never working in the NHS again. At the last minute, these mandates were quietly dropped. But the effects still linger on. Those who took the vaccines against their will are left feeling guilty or betrayed, some have vaccine injuries and will never work again. Many are scared for their future health as more and more long-term side effects of the vaccines start to take effect.

Sadly, the mandates were imposed on care homes. I was contacted by many desperate staff who were on national minimum wage, doing a very difficult job, in difficult circumstances. Many were in tears as they did not want to take the vaccines. They had personally seen the effects of the vaccines on the residents of their care homes, and they were scared of suffering side effects, but also scared of not being able to pay their bills. Many took the injections to stay in their job, but many left, and all those years of experience have been lost. Many will never go back. Many are now being paid a higher wage for an easier job. However much they loved the job, they will not go back. We now have a massive crisis in the care sector. Hospital beds are blocked with patients who cannot be discharged to care homes. We are still experiencing the effects of these vaccine mandates, even though they have since been dropped.

The pharmaceutical companies knew that the vaccines would not stop you catching, dying from, or spreading Covid-19, but they still pushed the governments to mandate the vaccines. If the vaccines do not prevent the spread of Covid-19, then there is no benefit to anyone else, whether you take or do not take the vaccines. The mandates were completely illogical as they were never actually going to reduce the deaths or incidences of Covid-19. The whole foundation of vaccine mandates was flawed.

Before the vaccine mandates, the pressure on staff to be vaccinated was also very great. A close family member of mine was working in a care home in the early days of the vaccine rollouts; the staff in the home were asked to fill in a consent form for the vaccines, many did not sign them, but wrote instead that they did not consent to be vaccinated. The day that the nurses came to the care home to vaccinate the patients and staff, these nurses put great pressure on the staff members to be vaccinated. The staff were told that they would kill all the patients if they were not vaccinated, they were told that they would not be allowed to travel or do anything. The young woman, who was a family member of mine, was being pressured to receive a vaccine that was later banned for people of her age. One female staff member hid in the laundry cupboard because of the pressure they were putting on the staff to get vaccinated there and then, even though they had signed forms saying that they did not consent. My family member felt like she was in the middle of some apocalyptic movie. She was under immense psychological pressure to be injected with a drug that was still under emergency licence and turned out to be neither safe nor effective. Staff members who took the vaccine under duress later expressed regret that they had given into government coercion. Some experienced side effects, with long-term consequences.

The care home residents were sadly not given the option of informed consent.

Informed consent

Informed consent is a basic principle of health care. The principle of informed consent was forgotten when the Covid-19 vaccines were involved. Before an operation, a consent form must be signed stating that the patient understands the main risk factors for the surgery. Despite death being a possible side effect of the vaccines or lifelong injuries, no genuine informed consent information was given to vaccine recipients.

Excess deaths

Since the vaccine rollout, mortality rates have increased. A recent debate in the British Parliament exposed this fact, with many facts and figures set out in detail. Regarding excess deaths, this unfortunate reality can be seen in countries around the world with high rates of Covid-19 vaccination which is not seen in low vaccination areas. This needs serious investigation. Thousands of people every year since the vaccine rollout, have been dying at a rate higher than would be expected. Each death is someone's loved one and not just a statistic on government paper. It is tragic that this preventable increase in excess deaths was not averted sooner. If the voices of those concerned about the safety and effectiveness of the vaccines had not been silenced, the outcome would be very different.

B. 6.3. Dr Ayiesha Malik MBChB, MRCGP (2014), LFHom

I am a General Practitioner (GP) in the Midlands. I've been concerned that so many patients have reported side effects since having an mRNA injection, including the boosters.

Patients are reporting many symptoms, including cardiac symptoms, with cases of myocarditis being confirmed by cardiologists- which is a serious heart condition, and menstrual irregularities, which is an indicator with regard to fertility. I've discussed this with other GPs and medical specialists across the country who are also observing similar patterns- regularly.

Doctors across the country from different specialities were experiencing similar concerns and we collectively formed Doctors for Patients UK and have over 130 doctors wanting to participate in our discussions regarding concerns about vaccine harms.

Many doctors have spent years reassuring patients about the safety of vaccines, but in the case of the Covid-19 vaccines, there is something different.

I've also been concerned about vaccination in pregnancy and submitted a rapid response in the BMJ[30] and co-signed this letter. [31]

I have raised concerns about patient safety with my local NHS whistleblowing department and was sent government guidelines on vaccination, but no action was taken to investigate my concerns. Doctors have been warned they are "vulnerable" to a GMC investigation if they raise concerns about the Covid-19 vaccine.[32]

There is international concern amongst the medical profession and studies are also showing that there are more cases of adverse reactions than there should be.

A Generalist's Perspective - Beyond Blame: The Root Causes Of Societal Disease Dr Tim Kelly, MB BCh, PGCert Clin Sci, Locum Junior Doctor & Systems Analyst

(note this section has its own references section)

Beyond Blame: Dissecting the Systemic Roots of Societal Disease of the Covid Era (version 0.2)

PREFACE

As a physician and systems analyst, I've been examining the COVID-19 pandemic to uncover the systemic issues it has exposed. While I'm working on a book to explore these topics in depth, I've decided to share summaries of my rough notes and preliminary findings in the meantime.

These evolving insights may be helpful for those trying to make sense of this complex period. Please keep in mind that this is not a final, polished work, but rather a glimpse into my ongoing analysis. I'll be providing updates as my thinking develops and the book takes shape.

My aim is to spark thoughtful discussions and encourage a deeper understanding of the forces at play during this transformative time. I welcome feedback and insights from others as we work together to build a more resilient future.

INTRODUCTION

In the post-Covid-19 era, society is grappling with the fallout from a breakdown in critical thinking, ethics, and rational decision-making. Extreme measures like lockdowns, mandates, and the rapid deployment of novel therapies were widely accepted, despite their initial violation of the precautionary principle and subsequently mounting evidence of their inefficacy and potential harm [1]. The stark contrast between mainstream narratives and reality underscores the need for a thorough examination of the factors that rendered society susceptible to such widespread folly.

While it's tempting to attribute failures to simple explanations like corporate greed or fall into the "cockup versus conspiracy" trap, I advocate for a more nuanced approach. Blaming bad actors is easy, but even they can only exploit existing systemic vulnerabilities. To create meaningful change, we must move beyond assigning blame and focus on addressing the underlying frailties exposed by this crisis.

This essay is divided into three parts:

Part I: Surveying the Wreckage: A brief summary of the tangible and intangible consequences, including the formation of a dystopian belief paradigm.

Part II: Examining the Root Causes: Delves into societal structural / cultural vulnerabilities and dynamic forces

Part III: Exploring Solutions: Proposes immediate priorities and long-term strategies to build a more resilient society.

PART I - SURVEYING THE WRECKAGE

Tangible Harms: The COVID-19 era has left a trail of devastation, with several trillion dollars transferred from the poorest to the wealthiest and hundreds of billions added to national debts [2]. The misguided "measures" have led to economic fallout, lost education, surging mental health crises, increased addiction, reduced fertility and rising obesity rates [3, 4]. Perhaps most alarming are the persistent rates of excess mortality and morbidity, particularly among the young, seen around the world, likely stemming from a complex interplay of factors, including stress induced by severe

restrictions, healthcare disruptions, and the potential adverse effects of novel therapies [5, 6]. Disentangling the precise contributions of each factor is challenging, particularly given the lack of incentive for policymakers to investigate the consequences of their own decisions.

The Rise of an Inverted Belief Paradigm: The era has given rise to an inverted belief paradigm, where platitudes are embraced as truths, truths are labelled misinformation or disinformation, and government advice often contradicts what is truly beneficial [7]. This distorted world view is reinforced by oversimplified "narrowtives" that promote binary thinking and resist nuance. Slogans like "nobody is safe until everyone is safe" epitomise this absurdity, disregarding individual variability in risk and potential harms of interventions that can exacerbate the very problems they aim to solve. The handling of these novel therapies exemplifies this paradigm, with regulatory failures allowing them to bypass important safety testing and a lack of transparent communication about risks and uncertainties, leading to a betrayal of public trust and medical ethics [8].

The False Dichotomy of "Safe and Effective":

In this section, I will reference Dr. Clare Craig's comprehensive submission to the inquiry, "Unsafe and Defective," [9].

The notion that any therapy can be universally 'safe and effective' ignores the nuanced balance of risks and benefits for individual patients. For healthy individuals under 50, the risk posed by SARS-CoV-2 is minimal, with an infection fatality rate of approximately 0.009% (1 in 11,111), which is lower than that of the flu [10]. Conversely, a reanalysis of clinical trials suggests a 1 in 800 risk of serious adverse events from these therapies [11]. This blanket assertion of safety and efficacy is dangerously neglectful of individual patient needs.

Dr. Craig highlights the limitations of the initial safety data due to the short trial duration and the inability to detect rare adverse events [9]. Moreover, the original trial data showed concerning signs, such as a higher risk of serious adverse events compared to the chance of preventing severe covid cases [9]. Crucially, important safety studies, such as comprehensive research into carcinogenicity, genotoxicity, and the behaviour of nanoparticles, were lacking, representing a significant oversight with potentially catastrophic outcomes [9].

The adverse event monitoring systems failed to adequately capture the full extent of the harm due to issues like underreporting and the lack of sensitivity for systemic issues [9]. Real-world signals of harm

emerged, such as the increase in cardiac arrest calls, cardiac deaths, and excess mortality, particularly among the young, temporally associated with the vaccine rollout [9, 12].

With billions of doses administered, a 1 in 800 risk equates to millions experiencing serious adverse effects. Justifying this individual harm for a perceived population-level benefit is a profound violation of medical ethics, especially when those at higher risk of harm are not the same ones who stand to benefit [9].

Underappreciated Mechanisms for Long-Term Harms: It was absurd to assert the long-term safety of new, experimental therapies without the crucial element of time for follow-up. Lipid nanoparticles, used to deliver modified mRNA, are known to distribute widely throughout the body, leading to the uncontrolled and unpredictable expression of toxic foreign proteins [9, 13]. In stark contrast to a natural infection, where a respiratory virus is typically confined to the nose and throat, these therapies permit foreign protein production across vital organs [9].

Multiple potential mechanisms of harm, including direct cell damage, autoimmune reactions, and the effects of contaminants like bacterial DNA, could affect various organs and cause a multitude of conditions [9]. The long-term consequences of mRNA persistence, foreign protein production with potential immune exhaustion, and the potential for DNA contamination could be devastating, yet they remain insufficiently examined [9, 14].

Dr. Craig emphasizes that the absence of comprehensive research into carcinogenicity, genotoxicity, and the behaviour of nanoparticles represents a significant oversight with potentially catastrophic outcomes [9]. The fact that such crucial safety studies were not conducted before the widespread administration of these therapies is a testament to the regulatory failings and the rush to deploy them without adequate precautions [9, 15].

*[**Personal anecdote**: "The price we have to pay...": In the early days of the rollout of these novel therapies, I was deeply troubled by instances where young patients died of severe side effects, such as sinus venous thrombosis, that were dismissed as "rare." Hearing medical professionals justify these tragedies as "the price we have to pay to keep everyone safe" was a stark reminder of the cognitive dissonance that had taken hold. How could sacrificing the health and lives of some, especially those not at significant risk, be considered a path to safety for all? I was shocked by the extent to which the prevailing narrative had clouded judgement and seemingly blinded them to the unfolding tragedy before our very eyes.]*

Summary: As we survey the "smouldering ruins" [16] left in the wake of this era, we must confront the deep-rooted structural and cultural failings that rendered our society vulnerable to such a brazen divergence from ethical and rational norms. The universal assertion by authorities that these novel therapies were "safe and effective" for all, including children, despite the absence of long-term safety data and the low risk posed by the virus to many groups, epitomises just how far we strayed from science, reason, and medical ethics. That such a narrative was accepted and acted upon, leading to the mass administration of inadequately tested therapies to populations at minimal risk, is a damning indictment of the systemic failures that allowed this tragedy to unfold. The credibility crisis, worsened by these failures across multiple levels, casts serious doubt on the integrity of public health institutions and underscores the need for transparency and accountability in all medical interventions.

PART II - EXAMINING THE ROOT CAUSES

This era has exposed deep-seated frailties within our societal structures, cultural norms, and decision-making processes. Extreme measures like lockdowns, mandates, and the rapid rollout of novel therapies were widely implemented with minimal consideration of potential downsides. Dissenting voices were actively silenced and marginalised as dominant narratives oversimplified complex issues.

To understand how we got to this point, it's important to examine the interplay of factors which the pandemic period amplified and exposed. Certain dynamics generated overly rigid and simplistic narratives that took hold in the collective consciousness, shaping beliefs and behaviours in ways that inverted truth and created a paradigm divorced from objective reality. These factors can be likened to a societal disease or cancer, where unhealthy patterns and structures spread and undermine the health of the entire system. In the following sections, we will explore the key ingredients that contributed to this societal malaise.

Key structural vulnerabilities:

Hyper-specialisation:

Throughout this debacle, my friends and family have often responded to my scepticism with comments like, "If you're right, there'd need to be a grand conspiracy with all the doctors and scientists in on it." This perspective, however, misses a crucial point—it's not so much that they

are 'in on it' but rather 'out of it'—a situation which manifests from the hyper-specialisation and compartmentalisation of knowledge in fields like healthcare and science [17]:

1 **Cogs in a machine and tunnel vision:** - In a highly specialized system, individuals function as cogs in a larger machine. Each specialist focuses on their narrow role, contributing to the machine's overall function. However, this myopic focus can blind them to the bigger picture and the broader implications of their collective work. They become so engrossed in their specific tasks that they fail to question whether the machine's output aligns with the intended goals of healthcare and public well-being.

2 **Wilful blindness through separation of concerns:** - Rather than grappling with systemic issues that challenge ethical foundations, specialists retreat into a principle of separating concerns. This allows disengaging from ethical implications as long as they adhere narrowly to their role's parameters - a form of subconscious denial.

3 **Chilling effect silencing dissent:** - Voicing concerns in these professions can be suppressed by fear of professional repercussions and economic insecurity. This chilling effect fortifies wilful blindness and resistance to challenging the established order, even if harmful practices exist.

[Personal anecdote: "The price of speaking out": *In 2020, I personally experienced the chilling effect of dissent within the medical profession. After voicing my concerns about lockdowns on radio and writing an essay about the cognitive contagion, a senior colleague and friend warned me that the matter had been raised at work. They cautioned that my job would be at risk if I continued to speak out.]*

In essence, excessive specialisation enables an outsourcing of critical thinking paired with wilful blindness to disturbing broader realities. The polymath with broad expertise across disciplines is no longer respected, contributing to a lack of interdisciplinary understanding. A misplaced trust in authority narratives flourishes when dissenting voices are systematically silenced. This dangerous confluence of hyper-specialisation, dismissal of polymaths, and suppression of dissent gravely undermines the ability to holistically address multifaceted issues in medicine, science, and beyond.

Centralisation: A critical structural factor contributing to societal vulnerability, manifests in various forms, including the concentration of power in a few large entities, top-down pyramid governance structures, the influence of supranational organisations, and the dominance of big-tech

platforms. This concentration not only hinders local adaptability and resilience in the face of complex challenges but also fosters an environment conducive to groupthink and the suppression of diverse perspectives.

1. **Corporate capture and regulatory capture:** The power concentrated in a few large pharmaceutical companies and regulatory agencies often leads to a prioritisation of corporate interests over public health. This is evident in the revolving door between industry and regulatory bodies and the significant funding regulatory agencies receive from the corporations they are meant to oversee.
2. **Conflicts of interest and funding bias:** Conflicts of interest and funding bias further exacerbate the issue, shaping research, policy, and public health messaging [18]. The influence of major funders creates an implicit form of centralisation, linking seemingly independent organisations through common funding sources and interests.
3. **Media influence and communication platforms:** Media influence, shaped by corporate interests through advertising and ownership, further amplifies this problem, eroding critical thinking and promoting simplistic narratives aligned with corporate agendas. The centralisation of communication platforms, like social media, also plays a role. A few big tech organisations wield significant control over these platforms, and their policies can have far-reaching consequences.
4. **Supranational organisations and top-down decision-making:** Supranational organisations, such as the WHO, while potentially serving coordinating functions, become vectors for corporate influence and top-down decision-making that do not reflect local needs and concerns [19].

Broader cultural context:

Identity politics: An emphasis on group identity and conformity together with a cancel culture that can discourage dissent and critical thinking. The intertwining of politics and medicine during this period has proven to be a recipe for disaster, as it amplifies divisions and stifles open dialogue.

Malthusian perspectives: Malthusianism, based on the 18th-century economist Thomas Malthus, emphasises potential limits to growth and societal collapse [20]. In the pandemic context, this mindset manifested in worst-case scenario modelling, concerns about devastating future pandemics, and fears of catastrophic death tolls without strict measures. This

catastrophic thinking made drastic pandemic policies seem more acceptable, even when based on overestimated projections.

Scientism: In an increasingly secular age, science has in many ways filled the void left by the decline of traditional religion, occupying for some a 'god-shaped hole' as the ultimate source of truth and authority on questions of human life and flourishing. An unhealthy elevation of science to a quasi-religious status, forbidding questioning of scientific authorities results in a dogmatic scientism that is paradoxically antithetical to true science [21].

Safetyism: The prioritisation of eliminating risk and discomfort has led to societal fragility, erosion of critical thinking, and unquestioning acceptance of extreme pandemic measures, paradoxically making us less safe by impairing our ability to rationally assess and manage threats [22].

Infantilisation Through Simplified Messaging: The increasing reliance on soundbites and oversimplified political messaging, such as 'flatten the curve' and 'safe-and-effective,' contributes to the erosion of critical thinking. This trend towards simplification fosters a form of collective self-hypnosis, where both the government and the governed are subject to the same simplifications. Since the government is comprised of individuals from the population, this hypnotic effect functions inwardly on the government itself as well as outwardly on the public. Phrases like 'stay home, protect the NHS, save lives' exemplify how government-promoted slogans not only simplify complex issues but also promote a passive acceptance of authority, reinforcing a simplistic understanding of multifaceted challenges among all parties involved.

Rise of social media / 'Fact-checking': The rise of social media and the practice of 'fact-checking' reveal Orwellian trends within the digital age. Social media platforms, often acting as echo chambers, amplify biases, and 'fact-checking'—often biased and influenced by government directives—serves as a tool that can undermine free expression. This concentration of power among a few tech giants, effectively taking cues from governmental authorities, exemplifies a form of centralisation that suppresses legitimate debate and dissent. Furthermore, the digital age's capability for near-instantaneous communication has the potential to accelerate the formation of global groupthink. Additionally, the censorship of dissenting views, particularly those opposing government policy by social media platforms, acts to remove crucial negative feedback from the system, risking a homogenisation of thought that can stifle innovation and critical discourse.

Overreliance on modelling: There was a pervasive and misguided overreliance on modelling. As a computer science graduate with experience in modelling, I can attest that models dealing with complex, nested biological systems are inherently limited and easily manipulated. With more than a handful of variables, models must be tweaked to produce plausible answers, introducing subjectivity and bias [23].

Worse still, many COVID-19 models focused solely on the virus itself, neglecting the broader societal impacts of proposed interventions. This narrow focus led to policies that caused significant harm to mental health, education, and the economy. Policymakers and the public must recognise the severe limitations of modelling in such complex scenarios and approach their results with extreme scepticism.

Cognitive Biases:

Cognitive dissonance: solidifies beliefs even when faced with contrary evidence. The interplay of ego, reputation, tribal mindset, and a desire for stability influences how we process challenging information. Shifting one belief necessitates reevaluating interconnected beliefs, which can be psychologically taxing [24].

Wilful blindness: leads individuals to overlook uncomfortable truths, thus preserv ing personal comfort or stability. This was evident during the COVID-19 crisis as misleading narratives were accepted and dissent was dismissed. Wilful blindness fosters echo chambers, reinforces confirmation biases, and curtails critical thinking [25].

Ethical Outsourcing: This occurs when individuals or organisations deflect ethical accountability by assuming 'someone else must be dealing with it'. This outsourcing of responsibility can happen through hyper-specialisation or compartmentalisation, where roles are so narrowly defined that broader ethical implications are either ignored or unnoticed, allowing individuals and institutions to sidestep moral accountability [26].

[**Example 1 (non-covid)**: "Factory farming": Ethical outsourcing in the context of factory-farmed eggs allows consumers to distance themselves from the harsh realities of how their food is produced. While most people would not personally confine hens in cramped, overcrowded conditions, they often buy eggs produced this way. This disconnection occurs because the harsh conditions are out of sight, consumers trust in regulatory oversight, and there's a lack of immediate personal involvement. This allows

individuals to enjoy the benefits of inexpensive eggs without directly confronting the ethical dilemmas associated with their production.]

[**Example 2 (relevant)**: During the era, many people outsourced their ethical concerns about the rapid deployment of novel therapies to health authorities. Trusting in the expertise and oversight of these agencies, they accepted these treatments based on official assurances, rather than personal informed consent. This reliance exemplifies ethical outsourcing, where individual responsibility for ethical scrutiny is delegated to perceived experts.]

Framing of statistics: The selective presentation of risks and benefits can significantly influence perception and decision-making. Emphasising relative risk reduction whilst downplaying absolute risk reduction and potential harms can lead to a skewed understanding of the real-world impact of interventions. Transparency in communicating statistical information is crucial for informed choices [27].

[**Example "Relative vs Absolute Risk":** Consider an umbrella promoted as '95% effective at preventing lightning strikes!' This highlights the benefit in relative terms, making the umbrella appear exceptionally effective. However, the actual risk of being struck by lightning is originally about 0.0001% (1 in 1 million), dropping to 0.000005% (1 in 20 million) with the umbrella. The absolute risk reduction is merely 0.000095%—virtually negligible in practical terms. Conversely, the umbrella increases the risk of tripping and sustaining a serious injury from 1 in 10,000 to 1 in 800, a 12.5-fold relative increase in harm, which is often downplayed by expressing it in absolute terms. This dual framing tactic, common in pharmaceutical marketing, skews perception towards benefits whilst underplaying drawbacks.]

Positive Feedback Loops: These were a major cause of harm, occurring within and between the structural, cultural, economic, social, and cognitive domains discussed above. In biological disease, positive feedback loops are often the basis for pathology, such as in infection (where pathogen replication leads to more infection), cancer (where growth signals further growth), or anaphylaxis (where immune responses trigger more severe responses). Similarly, in the societal context, these loops arise when actions reinforce similar subsequent actions within their own domain and exacerbate issues in other domains, creating a compounded effect [28].

The power of these amplification cycles should not be underestimated; they are responsible for much of the societal pathology we observe today, making what many find an inexplicable era more understandable. Understanding these feedback loops is crucial for diagnosing and addressing the underlying causes of our current societal challenges. Here are some examples:

[**Example 1: Fearmongering in public health messaging** can create a demand for stricter measures, which further fuels the initial fear. Government and media, susceptible to these narratives, can amplify them, perpetuating a cycle of fear and control. This fear narrative can then spread to other domains, such as the economy, where it stifles activity and innovation, further reinforcing a sense of crisis that fuels the original fearmongering.]

[**Example 2: Early misguided ventilation of COVID-19 patients** led to high mortality rates. These deaths were then used to reinforce the perceived seriousness of the disease, fuelling more aggressive interventions. This led to a cycle where the iatrogenic harms of ventilation were attributed to the disease itself, reinforcing the initial misguided clinical approach and obscuring the need to reexamine the intervention strategy.]

[**Example 3: Centralising power** can lead to policy failures, which are then used as justifications for even more centralised control, worsening the initial problem. For instance, the WHO vying for more powers for pandemics exemplifies how initial policy shortcomings can prompt calls for further centralisation, thereby exacerbating the underlying issues.]

*[**Personal Anecdote : "Vaccine side-effects":** I observed a similar feedback loop in the context of vaccine side effects. Some doctors, unaware of plausible mechanisms of long-term harm of the novel therapies, wouldn't consider the vaccine as a potential cause for adverse events that manifested beyond the initial few days post-vaccination. This hesitancy stemmed from a lack of awareness about plausible mechanisms of harm. Consequently, these events were not reported to adverse event reporting systems, perpetuating the belief that such side effects did not occur and reinforcing the perception of the vaccine's safety. This cycle of under-recognition and under-reporting obscured the need for a more comprehensive assessment of the vaccine's potential long-term effects.]*

BioPsychoSocial interconnection: The societal disease we have described, with its interconnected structural vulnerabilities, cultural patterns, cognitive biases, and reinforcing feedback loops, does not exist in isolation. In line with George Engel's biopsychosocial model, we can expect this societal pathology to manifest across the biological, psychological, and social domains in an interconnected fashion [29]. For example, the prevalence of metabolic disorders fuelled by corporate interests and

poor lifestyle choices (social) can make populations more susceptible to viruses (biological). The resulting fear then fuels psychological patterns like catastrophic thinking, which drives societies further into the grips of centralised control, corporate capture, simplistic thinking, and unwillingness to question authority - the very same forces that enabled the original societal dysfunction. This creates a vicious cycle across the biopsychosocial realms, where disease in one domain propagates and reinforces pathology in the others. Recognising these interconnections is crucial for breaking the cyclical patterns that have undermined human flourishing during this era. Only by addressing the root dysfunctions across the biological, psychological, and social domains in an integrated manner can we hope to restore holistic health and resilience.

Summary: As I've delved into the root causes of our era's challenges, a clear pattern has emerged: the tendency to meddle with complex, nested systems with little to no understanding of the potential downstream consequences. The COVID-19 pandemic has been a prime example of this phenomenon, with hasty interventions leading to a cascade of consequences across multiple domains.

Worse still, these interventions have created a self-perpetuating "mega-loop", where the problems created by our meddling become justifications for further profitable interventions. The push for lockdowns and universal vaccination, despite the lack of long-term safety data and the low risk posed by the virus to many groups, sets the stage for a vicious cycle of pharmaceutical dependence and societal damage. This pattern is not unique to the pandemic; it can also be observed in chronic health treatments that often mask symptoms and disincentivise patients from addressing root causes, with anti-depressants being a prime example.

This approach to problem-solving is akin to attempting to solve one face of a Rubik's cube without considering the impact on the other faces. By focusing on a single aspect of a complex system, we create new problems and further complicate the overall situation.

As someone with a background in systems analysis, I cannot help but view this pattern as a fundamental flaw in our approach to problem-solving. Only by cultivating a deeper understanding of these systems and approaching interventions with humility and caution can we hope to break free from this destructive cycle.

PART III – EXPLORING SOLUTIONS

Shifting the entrenched paradigm will not be easy, as those in power are deeply invested in the current system. There is a "chicken and egg" dilemma at play - the solutions outlined below are difficult to implement while decision-makers remain captured by the inverted paradigm. Our most urgent task is to amplify our message and help the masses recognise the authenticity of our perspective. In the meantime, we must build parallel structures to counter the "official narrative" and ineffective policies. Groups like the Health Advisory and Recovery Team (HART) in the UK, which aim to provide objective information and analysis, are a good example of this.

Immediate priorities: While there are likely pressing issues to address across various sectors, the following immediate priorities focus specifically on mitigating the harms and restoring integrity in the context of pharmaceutical interventions:

1. The immediate suspension of the modified mRNA products;
2. Detailed investigations into the harms of all experimental Coronavirus therapies;
3. Immediate recognition and support for the patients injured by these products.

Overarching these specific priorities is the urgent need to restore fundamental medical and ethical principles that were abandoned during this era. Central to this restoration is the reclamation of freedom of speech from cancel culture, as open discourse and the ability to challenge dominant narratives are essential for dampening the positive feedback loops that perpetuate harmful practices and stifle critical thinking.

Broader solutions: I recognise that developing comprehensive solutions to these complex issues requires careful thought and consideration. I don't want to fall into the trap of presenting interventions that haven't been fully thought out, as that would make me guilty of the very same oversimplification and lack of nuance that I've criticised throughout this essay. So, given the complexity and importance of these issues, at this stage I have decided to take the necessary time to develop comprehensive solutions rather than presenting half-baked ideas.

However, I can say with confidence that any effective solutions will require a significant shift in our approach to problem-solving. We must foster a culture of open dialogue, encourage red-teaming and devil's advocacy, and embrace the complexity and uncertainty inherent in dealing with multifaceted challenges. By cultivating a greater appreciation for nuance, context, and the interconnectedness of

systems, we can begin to develop more holistic and adaptive strategies for addressing the root causes of our societal issues.

This will likely involve a combination of structural reforms, such as increasing transparency and accountability in decision-making processes, as well as cultural shifts towards more critical thinking, intellectual humility, and a willingness to challenge established narratives. Ultimately, the path forward will require a collaborative effort from individuals across all sectors of society, working together to build a more resilient and enlightened future.

I will release further versions of this essay as my thinking develops. For those interested in staying informed about developments in this area, I encourage you to follow @DrTimothyKelly on X, where I will share updates and insights or tune into my monthly podcast available at www.nuanceovernarrowtives.com.

Final Words

The path to healing and progress requires us to acknowledge the profound pain and suffering inflicted upon countless individuals caught in the crossfire of systemic failures. While justice demands accountability, it is equally crucial to foster a culture of understanding and compassion. Assigning blame solely to individuals within a flawed system risks overlooking the root causes that enabled such widespread harm. Instead, we must redirect our energy towards dismantling the structures and narratives that led us astray, and rebuilding a society grounded in truth, transparency, and the unwavering protection of individual rights.

The lessons of this era are harsh, but they offer an opportunity for profound transformation. By embracing humility, recognising our shared humanity, and valuing open dialogue, we can forge a path towards a more enlightened future. The journey ahead is not one of retribution, but of collective healing and the unwavering pursuit of a society where every individual is empowered to thrive, free from the shackles of fear, manipulation, and systemic dysfunction. Only then can we truly honour the sacrifices made and strive to prevent history from repeating its most painful patterns.

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Prof Bret Weinstein - “Smouldering ruins”;[35]

and Dr Clare Craig for her comprehensive witness statement "Unsafe and Defective".[36]

APPENDIX A

THE DEVASTATING HEALTH CRISIS IN THE CHANNEL ISLANDS & AROUND THE WORLD

A.1. Introduction

A recent meeting was organised by two of our committee members, Dr Dean Paterson and Dr Scott Mitchell, to present their concerns about the Covid-19 injections to the population of the Channel Islands, where they both served as medical doctors. The meeting was chaired by US Senator Ron Johnson with other international medical experts also bearing witness to harms, notably Dr Ryan Cole, a pathologist and Dr Peter McCullough, a world-renowned cardiologist. The link to the meeting is below. We would strongly urge all with an interest in this inquiry to watch it in its entirety here.[37]

A.2. Dr Ryan Cole, US Pathologist, transcript of his presentation

Thank you, Senator Johnson. And thank you to the great people of the UK and the Channel Islands. It's an honour to be here. I am Dr Ryan Cole. I am a Board-certified anatomic and clinical pathologist. I did my training at the Mayo Clinic. I did a year of surgical pathologies, as the chief fellow at the Mayo Clinic. I did a year as the chief fellow at Columbia University in dermatopathology, did PhD research in immunology and virology and I've seen a half million patients in my career and ran an independent lab for 21 years. And yes, my career has been destroyed for speaking out, and I would do it all over again. I'm gonna quickly go through what some of my colleagues have touched on.

Okay. What do we know?

Well, I have no conflicts of interest. We are unfortunately in an era of wealth and hellness and not in an era of health and wellness. So we need to change this. Synthetic DNA and modified RNA injections are not vaccines, never have been, never will be. They are genetic transfection agents and therapies. According to the filings of Moderna and Pfizer, they know this.

We don't know the long-term consequences of these, and they're still being developed for hundreds of other conditions. It's not just these Covid-19 shots. I know everybody has Covid-19 fatigue, I understand that. What we need to do is stop this platform. It's not meant for human use. It's not right for human use.

For a successful technology, reality must take precedence over public relations, for nature cannot be fooled. We are fooling ourselves, and we're fooling nature. More injections, plain and simple equals more infections due to immune suppression, that Dr Dalgleish covered. Cleveland Clinic showed this in a very straightforward study on their 50, 000 employees.

I'm not here to judge anyone that did or didn't get a shot. I'm just saying no more genetic shots, please. These are expired shots. These variants don't even exist, yet boosters continue to be pushed. From day one, chasing a coronavirus with the vaccine was a scientific impossibility, always has been and always will be, because of the mutation rates of this family of viruses.

Your body was turned into a factory for producing proteins. Human cells are meant to make human proteins, not foreign viral proteins. The cells don't lie. I'll show that. This is the pathology - I'm not gonna turn you into pathologists in seven minutes here, but I will show you what happens. That needle

goes in the arm, vessels are broken, and then your cells start to produce this foreign protein. These are the brown dots. This is from my colleague Dr Burkhart, the late great Dr Burkhart from Germany.[38] You know, these cells start to make this foreign protein. This is the toxic part of the virus, this spike protein. The lipid nanoparticles were known from day one to be dangerous.[39] They accumulate all throughout the body. They don't stay in the arm. They go everywhere. This is from Japan, a FOIA study from Dr Byron Bridle that he was able to obtain. They concentrate highest in the ovaries, which is highly concerning. The lipid nanoparticles are not for human or veterinary use. And yet they went into billions of people.

As my colleague was mentioning, this synthetic mRNA, though Weissman received the Nobel prize, in that Zoom video, he lied. This is the mRNA, this is a study out of Stanford by Dr Röltgen and colleagues. Sixty days later, the synthetic mRNA was still persistent, still present and still producing this foreign toxic protein. Dr Brogna, as mentioned, showed that this spike protein from the injections was still circulating up to 6 months later,[40] we still don't know for how long. And in addition, excellent research out of Oxford and Cambridge showed that this synthetic RNA causes shifting and it's not just producing spike protein, but it's making Frankenstein proteins. It's making other proteins that can trigger the immune system.

The spike protein can deposit in the brain. This is a study from Dr Mörz out of Germany.[41] This is one out of Dr Burkhardt's lab. This is one out of my laboratory showing spike protein in peripheral nerves. Spike protein accumulates and actually produces very quickly in the liver.[42] And causes autoimmune diseases.[43] Obviously the heart damage will be addressed by my colleagues, but this is showing spike protein in the coronary vessels in the cardiac tissues.

Spike protein is abundant within those tissues and again, these shouldn't be in the human body. This is in the adrenal glands important for so many physiologic functions of the human body. These are all things that should have been known and disclosed before it went into one human. That’s advanced ageing, we know the spike protein binds to the elastic fibres of the skin. There’s all these black streaks, those are the elastic fibres. These are being destroyed by the spike protein. We also know that spike protein from the injections accumulates in the placenta, in the uterine lining and in the testicles within the gametes, the sperm.

It causes other viruses to reactivate, alters the innate immune response. That's the marines of your immune system. It makes them drunk and they go back to the barracks and they're not on the front lines fighting other infections as well. These are known to cause clotting. It inflames the lining of the

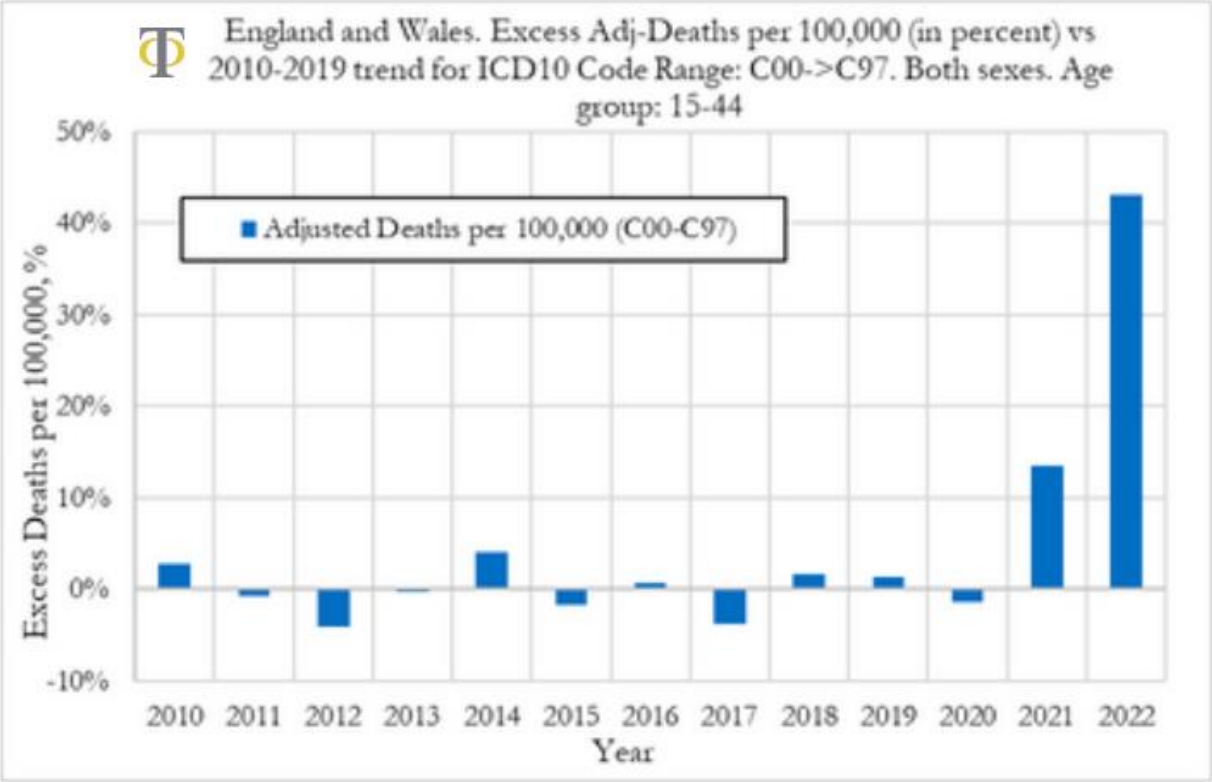
blood vessels and induces some interesting clotting pathways. We'll have more papers coming out on that soon.

Several increases in rupture of the biggest vessel in your body, the aorta and forms unusual amyloid rubber clot like proteins.[44] I've been working with some analytical chemists. We're going to have a paper coming out in the next couple of months. I think we know exactly what's causing these fibrous clots now. Unfortunately, there's a high percentage of people forming micro versions of these larger clots, which induces a lot of pathology. It's happening in the living, not just being found in the dead.

These shots are causing a rise in your IgG4. Everybody hears about antibodies. This antibody is what I want on my farm. I'm a beekeeper. So I want to build up a tolerance to different proteins. You know, if I get stung, I don't want to hyper-react. You don't want to build up tolerance to pathogens, in life, because then you're a sitting duck, you're a ship without a keel, your immune system won't recognize future variants. This is critically important.

So, cancer, that's the big question. We know countless mechanisms already whereby these mRNA injections, these synthetic mRNA can cause cancer promotion pathways. Turbo cancer is just a colloquial term, advanced progression of disease is the clinical term. Dr Dalgleish talked about it. It [spike protein] binds to an important tumour suppressor family of genes.[45] This is a tumour - every tumour cell in this particular cancer from the stomach is expressing spike protein. Here's a pancreatic cancer - every single cell in this cancer is expressing spike protein. These are binding to these tumour family of genes and allowing them to move forward. Here's a patient on the left who had an aggressive lymphoma 3 weeks after a booster - on the right you can see the aggressive nature of his tumour. And again, that's immune suppression amongst many other mechanisms.

Here are the cancer trend rates. Just look at the line at the end on the right. I'm going to just show you the trend lines, trend lines, trend lines, all going up - great data out of the UK, except they're not reporting it anymore. And your disability data sets showed that by. 2022, there was a 35% increase in claims for disability from cancer in your PIP (personal independence payment) UK disability clearances. These are the cancer death rates for 10 years running in ages 15 to 44. Look what happened in 2021 and 2022. [46]


England and Wales. Excess Adj-Deaths per 100,000 (in percent) vs 2010-2019 trend for ICD10 Code Range: C00->C97. Both sexes. Age group: 15-44
Adjusted Deaths per 100,000 (C00-C97)
Excess Deaths per 100,000, %
50%
40%
30%
20%
10%
0%
-10%
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
Year

A.3. Letters from Dr Dean Patterson to public bodies

To Mr Ferbrache
Chief Minister, Guernsey

Dear Mr Ferbrache *20/06/2021*

I write this letter with a burning conviction that I have never experienced in my 27 year professional career as a doctor, which has motivated me to relate my views regarding the public health proceedings that have unfolded over the past 18 months. I understand that in your position time is at a premium, however I urge from the outset, that you carefully consider the statements and recommendations below. I am one of a growing previously silent group of medical professionals, businesspeople and well meaning individuals, who up to now have been willing to give the "team in charge" of the pandemic the benefit of doubt when we were faced with many unknowns. However, the material facts relating to the core issues are now known and many untruths have subsequently been exposed.

At present we all face a crossroads in our lives due to the clear and imminent danger of our freedoms and values being permanently and irreversibly expunged. I make this profound statement for the following reasons:

1. *The proposed use of lockdowns and travel restrictions which were stated to be transient initially in march 2020 to "flatten the curve" are clearly going to be maintained by the incumbents as there is clear evidence of back tracking from the initial limited lockdown for a finite purpose, resulting in the destruction of many businesses, personal lives, and avoidable deaths through suicide and the delaying of critical medical and mental care. Urgent decisive action is required by yourself and the CCA to permanently move away from the use of travel restrictions, vaccine passports and lockdowns. In short the emergency status needs to be rescinded. Travel should be allowed with a health questionnaire and temperature check either upon departure, en route or on arrival. Those with a positive findings should be offered a medical opinion as to whether further investigation is required. We now have excellent treatment for early and late disease as well as a significant portion of the population vaccinated or having prior immunity.*
2. *The Covid-19, while a potentially lethal virus to some people with underlying health issues, is not the pandemic that it was made out to be by the so-called leading establishment epidemiologists across the world. The average infection mortality rate is only 0.2% for the whole population yet these "leaders" have failed us all and caused more harm through their obsessive, pessimistic and highly inaccurate modelling. Prior to 2020 the world lived with the corona virus and its mutations with good and bad years, as we did with influenza and other respiratory viruses. We humans live in a constantly evolving mutating environment, a carefully balanced ecosystem, that despite the attention of epidemiologists over the last 50 years has resulted in who we are, and the planet around us. I do not believe public health has a role or responsibility towards human evolution and more importantly the evolution of my personal cultivated ecosystem, the microbiome in which you, me and every individual thrives.*

3. *The Coronavirus-19 is a mutation of an endemic virus, and it will continue to mutate and evolve as all viruses do. If we allow ourselves to be misled into believing the mainstream mantra, then the world as we know it will be controlled by a Biosecurity State backed by a small group of unelected unaccountable elite globalists and their foot soldiers.*

4. *The CCA has been led without interruption by the medical team of Dr Brink (a virologist) with support from Dr Rabey (an anaesthetist). They have been backed up by a "medical cell" with representation across medical specialities. I have huge admiration for the CCA's efforts from the start and during the initial phase, in particular for Dr Brink"s dedication and tenacity of approach to the outbreak. I have however realised that I need to voice my concerns, and my writing therefore is not to praise the many valiant efforts over the past 18 months but rather to focus upon the future. I feel that now is an appropriate time to review where we are headed. There has been an absence of open debate regarding the policies that have been implemented. I have been concerned from the start of this pandemic that there was no-one with real world clinical experience of dealing with patients with respiratory infections included at a top level. In addition the CCA and the medical leadership appear to have committed themselves to a policy that gives no exit from the current core strategy of viral variant/PCR test/"virus detection wave"/lockdown/repeat.*

5. *I, as a General Physician responsible for the care of hospitalised Covid-19 patients, have felt my views have not been given a fair hearing for the following reasons.*

    1. *I emailed Dr Brink on 27th march 2020 explaining my concerns that I felt a total lockdown was unnecessary due to the clear evidence for the pivotal early data from the quarantined cruise ship the Princess Diamond where there were 10 deaths out of a total of 712 patients who were infected giving an infection mortality rate of 1.4% . The average age of those that died was circa 75-78. I recommended based upon these data we should use a policy of focused protection and isolate the ill and those at high risk from Covid-19 mortality and morbidity. I had no response, while I can understand at that time she was very busy, I felt that a response to that email should have been made as it was a serious enquiry from an experienced general physician.*

    2. *At Dr Brink"s first presentation at academic half day in the summer of 2020 I enquired what she thought of the Swedish approach to the viral outbreak. She had no real answer but dismissed their response out of hand, making mention that she would come back to it later. She never did but since then the final analysis of the Swedish approach has shown it to be the correct one with age standardised mortality ratio in 2020 being no different that the mean of the previous 5 years. In addition at the peak of the pandemic with schools open and no masks there was zero child mortality out of a total of 1.8million school children.*

    3. *It became clear later in autumn of 2020 that the PCR test upon which the management of Covid-19 was built had serious flaws. I requested information from the head of pathology at the PEH as to the accuracy of the Covid-19 PCR test. He specifically replied that the cycle threshold (CT) for the Guernsey tests were <38 and 40. A freedom of information request in 2021 on this matter states that the CT being used is 40 and 45. There is now clear evidence that a CT above 30 is detecting background noise and not that of live viable virus. The inventor of the PCR technique*

Kary Mullis (Nobel prize winner) stated clearly that if you cut off the upper limit at 20 everybody will be negative and at 50 everyone would be positive. On 21 May 2021 I requested from Paul Sutton that my personal PCR test results are listed on my medical record with the CT value used and the false positive and negative rates for the particular test used, but I received no reply.The PCR test must not be used alone to diagnose Covid-19 or indeed exclude Covid-19. Guernsey has run many Covid-19 PCR tests the majority of which were done without the required clinical assessment.

4. *There has been no recognition that immunity from corona virus infection is long lasting. There are papers showing T cell immunity from patients 17 years after the outbreak of SARS 2004 (80% shared genes with Covid-19) and similar papers now show that Covid-19 recovered patients have excellent immunity too. There is good evidence that the background level of T cell immunity against Covid-19 in the UK is 26%. There are now 2 validated T cell tests currently available, one from Oxford Immunotec (CE marked) at a cost of £65 per test and another from Adaptive Biotechnologies in the USA (FDA validation March 05 2021). Despite the above factors for unknown reasons, it appears that patients in Guernsey who have just recovered from Covid-19 have been pushed to have the vaccination which has no scientific validation while T cell testing has been ignored as a strategy to determine people who are immune and do not require the vaccine. I have aired my concerns at the physicians' meetings but have not received a satisfactory explanation for the policy.*

5. *At the Departmental Physicians meeting I voiced my concerns that the strategy of the CCA by relying on a poor PCR test will result in perpetual lockdown due to what's known as a case-demic. With a low viral load in the population of 1.3% but a false positive rate that is 2.3% between 60% -70% of the results in the UK were in fact false positives ie 2.6-2.9 million of the 4.3 million positive tests. My physician colleagues agreed with my interpretation. I asked that my findings be submitted to the medical cell for comment and feedback.*

6. *At the last academic half day presentation from Dr Brink, I challenged her about the false positive rate and its dire effect on tests' accuracy when the incidence of the virus in the community being tested is low. To my surprise, Dr Brink's reply was completely incorrect, in that she stated that the false positive rate would have very little effect. I am seeking a meeting with Dr Brink to get her clear views on this matter as a priority.*

6. *I have over the last few months realised that the vaccination policy is flawed for the following reasons*

    1. *The strategy of vaccinating all subjects is unheralded and not necessary. Only people at risk require the vaccine as Covid-19 poses a very low risk to healthy people. We have never mandated vaccinating the whole population for influenza, so why vaccinate the healthy for Covid-19?*

    2. *The vaccines have little long-term safety data and have emergency use authorisation. We should never offer these vaccines to children or pregnant women. The safety data for these subjects will take much longer than that for a 75 yr + person*

3. *I have, over the last few months, seen an increasing signal of major vaccine side effects which I have been reporting to the authorities and the Physicians group. I have written to the MHRA and the GMC to express my concerns. It is clear that these data are not reaching you. This includes 2 cases of myocardial infarction (incontrovertible proof of cause and effect), one serious myocarditis, one cardiovascular collapse requiring critical care admission, 2 cases of headache and mild neurological impairment with a severely raised d-dimer, one severe stroke and one case of large pulmonary embolism. I strongly believe there is a signal of damage to the cardiovascular system from the current vaccines. In addition we have seen an inexplicable increase in the number of culture negative infections of the heart valve over the last 6 months to 6 cases while we normally see 1 case every 12-18 months. You can rest assured I have and will be raising my concerns about these issues with Dr Rabey and Dr Brink.*

4. *The current Pfizer and AZ vaccines have emergency use authorisation and have incomplete phase 2 and 3 trials, due to complete in 2022 and 2023. When the trial data was submitted to the MHRA to enable their emergency use authorisation in late 2020, it would have been incumbent upon the drug company to inform the placebo group subjects of the potential benefit and offer them the vaccine. In addition, over the last few months there has been a major drive towards vaccination of the whole population irrespective of the risk that Covid-19 poses to those subjects. In effect this means that the placebo group in these studies has been severely depleted meaning the power of the study to detect side effects has been severely reduced. Considering the high take up of the vaccine in the UK, it is highly likely that these safety data have been completely invalidated.*

5. *This major failing of the safety studies taken together with the ineffectiveness of the MHRA and the yellow card scheme in being able to actually determine vaccine attributable safety signals, means it is incumbent upon me to draw these failings to the General Medical Council.*

6. *As things stand, I believe the de- facto failure of vaccine phase 2 and 3 studies, together with the MHRA's inability to compensate for this crucial loss of study patient safety data, effectively means that the process of informed consent (where these vaccines are stated to be safe) for the subjects of the Covid-19 vaccination programme is null and void. As such it appears that any doctor and healthcare worker employed in the current Covid-19 vaccine programme is in breach of Domain 2 of the General Medical Council where a doctor must respond to risks to patient safety and contribute and comply with systems to protect patients.*

7. *As the vital safety data for the phase 2 and 3 Covid-19 trials has been invalidated by the mandatory vaccination programme, the current use of the vaccines now constitutes a medical experiment.*

8. *Patients being given the vaccine must be informed of this vital fact, as well as their rights under the Nuremberg code.*

In closing you may be aware I have been closely involved with patient care as a General Physician in the management of the Covid-19 outbreak management at the PEH site, but more importantly I have been analysing the impact of the CCA strategy and have serious concerns that I do feel require further discussion. I am sure you will have further questions which I will embrace with the fervour that motivates me to seek resolution to the impasse. Finally I wish to express to you that this letter in no way should be misconstrued as a criticism of any particular person or committee, but rather it is my assessment of how we can move forward as an island to a prosperous future.

Yours sincerely,

Dr Dean Patterson

Consultant General Physician & Cardiologist

The Medical Specialist Group and Princess Elizabeth Hospital

To Mr Massey
Chief Executive, General Medical Council

Dear Mr Massey, *19/02/2024*

I am writing to express my enthusiastic support for Dr Aseem Malhotra, a distinguished medical professional who has through his dedication to improving public health and promoting evidence-based medicines, inspired numerous medical professionals to speak out in support of non-pharmaceutical management of chronic illness. He has been attacked for his stance in the past, in respect to his views on sugar and statins. He today again stands accused of spreading dangerous mis-information by a group of medical professionals who appear dedicated to reducing science and medical practice to an echo chamber.

Over the last 10-15 years I have become increasingly aware of Dr Aseem Malhotra as a cardiologist who has made significant contributions to the field of preventive cardiology and lifestyle medicine. His commitment to challenging conventional medical wisdom and advocating for a more holistic approach to healthcare has earned him widespread respect and admiration within the medical community and beyond. That said, he has also faced opposition over the years from critics. He has faced these criticisms openly and encouraged debate on the science. This is a foundation cornerstone of the scientific method. I have been inspired by Dr Malhotra's bravery. He is the UK standard bearer for integrity and bravery in speaking out for patient safety. The world needs more doctors like

him. Many doctors are too afraid to challenge mainstream dogma. Enabling doctors with opposing views to shut down Dr Malhotra's freedom to speak, will damage patient safety.

I recall prior to the Covid-19 Pandemic watching a lecture given online by Dr Malhotra on December 15th 2019 "Evidence Based Medicine has been hijacked". This lecture succinctly explains why the doctors of today are not adequately equipped with the training to explain risk/benefit ratios of drugs and interventions to their patients. Not only is Dr Malhotra an accomplished physician, but he is also a passionate advocate for addressing the root causes of chronic disease, particularly through lifestyle interventions and dietary modifications. His efforts to raise awareness about the impact of excessive sugar consumption and the overuse of medications in the treatment of chronic illnesses have been instrumental in sparking important conversations about the need for a paradigm shift in healthcare.

It is indeed a sad irony that Dr Malhotra has been labelled an anti-vaxxer conspiracy theorist, as he himself took the initial Covid-19 vaccine, recommended it to others and his father. He later realised that serious safety signals were being reported and understandably he has concern that the Covid-19 vaccine may have contributed to accelerated fatal acute myocardial infarction in his father.

Over the past 18 years I have been a partner, consultant cardiologist and general physician at the Medical Specialist Group and Princess Elizabeth Hospital in Guernsey with a population of 63000. Here I am proud to say, we provide a consultant only service which leads to exceptional continuity of care compared to the NHS where multiple tiers of doctors working shifts, care for patients. In my personal experience the Covid-19 Vaccine has caused me intolerable concern for patient safety here in Guernsey. In my 33 yrs of medical practice I have never witnessed such harm from a therapeutic intervention. I lost a female patient due to myocarditis aged 42 in 2021. A 63 year fit woman died from myocarditis 1 month after her booster vaccine in late 2021 after getting breathless within 1 week of the injection. In addition, I personally cared for a 20 year male with severe myocarditis which developed within 24 hrs of his second Pfizer vaccine. In the first year of the rollout, I diagnosed 25 patients with myocarditis (16 hospital admissions) and 20 cases of pericarditis, including one death (42yr old) and another who required an ICD (79 male). In the 16 years prior to this I would on average diagnose 2-3 myocarditis cases pa, with serious cases being limited to 1 every 3-4 years. The UK ONS data for England and Wales shows 250 hospital admissions for myocarditis over 10 years. This equates to 2 per 10 years for Guernsey. In the first year of the rollout, we had 16 hospital admissions for myocarditis. In the second year of vaccine rollout I have seen another 21 myocarditis cases, including 12 admissions and the death of the 63 year woman listed above. In addition, I have noticed an increase in the number of heart failure and acute myocardial infarction cases. I am currently auditing the ambulatory ECG data as I believe there has been an increase in arrhythmia burden. Incredibly the side effects don't stop there as I have been informed of a doubling of the stroke referral numbers recently with an increase in overall thrombo-emboli disease since the rollout

of the Covid-19 vaccines. I am therefore writing not only in support of Dr Malhotra's views on this matter but to inform you that the medical establishment appears blind to the harm. I am extremely concerned that medical practice itself will be irreparably damaged by the fallout from the mishandling of the Covid-19 vaccine side effects. Dr Malhotra must be supported in his endeavours to shine a light on this. While the GMC is mandated to protect patients and regulate doctors, currently the GMC finds itself in a regulatory vacuum where it, like many mainstream doctors, is unable to openly support what should be an urgent independent investigation into Covid-19 vaccine safety.

It is my opinion that the side effects being detected are the tip of the iceberg. Healthcare professionals are quite poor at reporting yellow card cases, while the NHS doctors are overburdened and unlikely to spend 30-45 minutes submitting a yellow card incident. This is particularly the case when the same doctors have been indoctrinated with the statement that the Covid-19 vaccines are safe and effective, while the evidence for this safety and effectiveness from double-blind placebo-controlled studies is extremely weak. The initial Covid-19 studies were due to complete in Q4 2023, and we await the final report, notwithstanding the major flaw that most of the placebo group have been vaccinated in 2021. A paper published very recently (Faksova et al, 2024[47]) shows significant side effects based upon this known under reporting.

Cardiologists in the main, continue to blame Covid-19 itself as the cause for the harms I am seeing, however I have not diagnosed a single case of post Covid-19 myocarditis prior to the vaccine rollout in Guernsey. The UK government website from 2021 to date, states that Covid-19 causes myocarditis. The evidence they list for this was flawed. One study they use as evidence by Buckley et al[48] concluded that myocarditis had a prevalence of 5% in Covid-19 patients. This study used data from the USA EMR records, which is poisoned by the flow of money. It is well documented that hospitals in the USA were paid $37000 if a patient with Covid-19 was admitted to ICU. ICU admissions would be promoted in patients with "multisystem involvement". A rise in troponin, however insignificant, would be the rationale for diagnosing myocarditis and the accompanying $37000 payment when the patient was admitted to ICU. It is well known within the cardiologist circle pre Covid-19, that patients with sepsis often have a rise in troponin and the rise is proportional to age and co-morbidities and not indicative of myocarditis or a heart attack. Between 2020 and mid 2021 Guernsey had 20000 Covid-19 positive PCR tests which resulted in 1-2000 cases, which according to the paper by Buckley et al, would lead to 50-100 cases of myocarditis, but incredibly I have not diagnosed a single case of Covid-19 myocarditis prior to vaccine rollout. In fact I had the pleasure of reviewing Guernsey's sickest ventilated post Covid-19 survivor, who was ventilated for months and kept alive on adrenalin infusions, only to find his cardiac MRI was completely normal with not even the slightest evidence of myocarditis.

Dr Melissa Heightman, a UCL long Covid-19 expert, is on record when speaking at the Acute & General medicine conference in 2022, stated that after MDT with cardiologists about the late gadolinium being seen on CMRI scans, they concluded it was just the usual background noise. In the paper by Buckley et al above they reference a paper by Puntmann et al, [49] which erroneously concluded that 78 of 100 subjects recovered from mild Covid-19 without cardiac symptoms had myocarditis. The correct interpretation is that the abnormalities seen were due to the same background noise referred to by Dr Heightman, amplified further by the study done in Germany using 3 Tesla MRI scanners. In the UK we use, in the main, 1.5 Tesla MRI scanners. More power = more noise!

It is my opinion that the GMC must not only support whistleblowers like Dr Malhotra, but urgently put in place the following:

1. A working group of healthcare professionals to investigate the Covid-19 vaccine safety. May I suggest you speak with Dr Yvonne Young from the UKHSA and Dr Melissa Heightman (UCL) to invite their views on this matter? I am part of a growing group of doctors who would like to be part of this investigation, as I am sure Dr Malhotra would be.
2. A helpline to support doctors afraid of speaking out.
3. A helpline to assist patients who may be vaccine injured. Clearly the GMC should seek support from the MHRA and UK gov with funding for this work.
4. A panel should be established to enable open discussion and reporting the above strategy in the media, in a calm, unbiased manner to avoid undue stress on the general population and the healthcare system.

In conclusion, I wholeheartedly endorse Dr Aseem Malhotra and believe that his unwavering commitment to advancing a more patient-centric, evidence-based approach to healthcare makes him a valuable asset to the medical community. I am confident that his contributions in relation to exposing the truth about the Covid-19 vaccine safety, will continue to have a lasting impact on the health and wellbeing of countless individuals. There are many doctors and healthcare professionals who will openly endorse my view, but sadly there are a silent majority who will only endorse my view quietly in private conversation.

Unfortunately, Medicine now finds itself standing at a crossroads. There are significant seeds of division. The question for you is therefore; Are you going to heal these wounds or empower the irreversible split of healthcare that beckons in an increasingly uncertain future?

Sincerely,

Dr Dean Patterson

APPENDIX B:

FURTHER USEFUL REFERENCES & LINKS

Jessica Rose Breaks Down 1.6 Million Adverse Event Reports in VAERS, Definitive Evidence of Causality. 7 March 2024 https://www.theepochtimes.com/epochtv/jessica-rose-breaks-down-1-6-million-adverse-event-reports-in-vaers-definitive-evidence-of-causality-5603019

MHRA stops publishing regular Covid vaccines Yellow Card reports (how very convenient) *Gyngell, K.* 14 March 2023. https://www.conservativewoman.co.uk/mhra-stops-publishing-Covid-vaccines-yellow-card-reports-how-very-convenient/

Are the MHRA releasing all of their injury reports? *Feldman, S.* 5 April 2023. https://feldmans.substack.com/p/are-the-mhra-releasing-all-of-their?utm_source=substack&utm_campaign=post_embed&utm_medium=web

Court Orders CDC to Release of Millions of Texts from V-Safe Covid-19 Vaccine Safety Monitoring System.

Hendler C. 29 January 2024. https://thevaccinereaction.org/2024/01/court-orders-cdc-to-release-millions-of-texts-from-v-safe-Covid-19-vaccine-safety-monitoring-system/

New Case Reports released for Pfizer Ages 12-15 and Moderna ages 18+ show myocarditis, appendicitis, intestinal perforation and more. 10 March 2024. https://icandecide.org/press-release/new-case-reports-released-for-pfizer-ages-12-15-and-moderna-ages-18-show-myocarditis-appendicitis-intestinal-perforation-and-more/

Severe inflammatory disorders of the musculoskeletal system after mRNA vaccines. Korean study confirms Segalla and McCullough's alarm. Also about dangers to the heart. 27 December 2023. IN: FRONTNIEUWS https://www.frontnieuws.com/ernstige-inflammatoire-aandoeningen-van-het-spier-skeletstelsel-na-mrna-vaccins-koreaanse-studie-bevestigt-alarm-van-segalla-en-mccullough-ook-over-gevaren-voor-het-hart/

SARS-CoV-2 spike S2 subunit inhibits p53 activation of p21(WAF1), TRAIL Death Receptor DR5 and MDM2 proteins in cancer cells. *Zhang S and El-Deiry WS.* 15 April 2024. https://doi.org/10.1101/2024.04.12.589252

Primary Cutaneous Adenoid Cystic Carcinoma in a Rare Location With an Immune Response to a BNT162b2 Vaccine. *Yilmaz A, Goker B, Gedikoglu MG, Ayvaz M, Tokgozoglu AM.* April 2024. http://dx.doi.org/10.2106/JBJS.CC.23.00499

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A Case Report of Acute Lymphoblastic Leukaemia (ALL)/Lymphoblastic Lymphoma (LBL) Following the Second Dose of Comirnaty®: An Analysis of the Potential Pathogenic Mechanism Based on the Existing Literature. *Gentilini P, Lindsay J C, Konishi N, Fukushima M, Polykretis P.* 1 April 2024. https://doi.org/10.20944/preprints202403.1661.v2

The Bradford-Hill Criteria

The most frequent response raised when questions emerge about potential harm from the Covid-19 vaccines is "Correlation is not causation!" While this is a vital epidemiological principle, it is precisely the reason why the Bradford-Hill Criteria were established. These criteria, when largely met, are considered robust enough to assert causation from a potential exposure. In the case of the Covid-19 vaccines, several international experts have indicated that all of these criteria are met. Furthermore, given that these vaccines were introduced as new, experimental treatments, it would typically be appropriate to assume potential causative effects **until proven otherwise**, shifting the burden of proof away from those raising concerns.

1. **Strength of the association**. - According to Hill, the stronger the association between a risk factor and outcome, the more likely the relationship is to be causal.

2. **Consistency of findings** - Have the same findings must be observed among different populations, in different study designs and at different times?

3. **Specificity of the association** - There must be a one-to-one relationship between cause and outcome.

4. **Temporal sequence of association** - Exposure must precede outcome.

5. **Biological gradient** - Change in disease rates should follow from corresponding changes in exposure (dose-response).

6. **Biological plausibility** - Presence of a potential biological mechanism.

7. **Coherence** - Does the relationship agree with the current knowledge of the natural history/biology of the disease?

8. **Experiment** - Does the removal of the exposure alter the frequency of the outcome?

9. **Analogy** - The use of analogies or similarities between the observed association and any other associations.

BRADFORD-HILL CRITERIA - Austin Bradford Hill (1897-1991), a British medical statistician published in ***J Roy Soc Med* 1965**;58:295-300 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1898525/pdf/procrsmed00196-0010.pdf

For more details on our activities and to view the speak-up video, please visit the following links:

- Press Release and Video on DfPUK Website (https://doctorsforpatientsuk.org/press-release)
- Video on Rumble Channel (https://rumble.com/v26ft7s-uk-doctors-call-for-government-to-urgently-pause-mrna-Covid-vaccines.html)
- https://doctorsforpatientsuk.org/videos/clinical-concerns-from-a-surgeon-is-this-the-new-normal/
- Talk Radio interview July 2021 stating why children did not need the Covid-19 mRNA shots https://x.com/talktv/status/1410513502138142720
- Guernsey Covid Conversations III meeting 2/2/22
- Interview by Prof. Angus Dalgeish April 2024 highly relevant; https://x.com/heartsofoakuk/status/1781034789325177338References

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We would also like to take this opportunity to express our gratitude to the many speakers who have delivered presentations at our CPD meetings.

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