**The Covid Vaccines: A Betrayal in Three Acts**

*By Dr Jonathan Engler MBChB LLB (Hons) DipPharmMed*

The story around the covid vaccines can be looked at as a tragedy comprising 3 acts of betrayal:

1. Betrayal of the clinical trial participants;
2. Betrayal of the public by the regulators;
3. Betrayal of the injured, vanishingly few of whom look likely to receive adequate compensation.

## Act 1: Betrayal of the participants in the clinical trials

Participants volunteered for the clinical trials hoping that taking that risk could lead to evidence that would benefit others. Those running the trials betrayed them in numerous ways.

On the day she took the AstraZeneca product in the trial, 41 year old pre-school teacher Brianne Dressen lost the ability to walk and became doubly incontinent. Her symptoms were dismissed as anxiety related. AstraZeneca were in contact with her initially but she stopped hearing from them 60 days following her injury, despite fighting for her life in hospital. She had to battle to finally be diagnosed in June 2021 with vaccine related neurological damage. She remains sick to this day.

The trial design itself was deeply flawed and could never have supported the claims made for the vaccine.

Looking specifically into the product called the Pfizer vaccine – which is in fact a product manufactured by BioNTech and sold under license by Pfizer - the main phase 3 trial used to support the claims made for the product has numerous problems.

Tchis is certainly not an exhaustive list, but highlights some of the critical design flaws that would influence the results:

1. ***The trial was not double-blinded.*** Site staff knew whether subjects were on the active or placebo drug, giving the potential to treat subjects differently. This

leads to bias in the results, especially in relation to the decision as to whether to send the patient for a PCR test, which was how they were measuring covid 'cases'.

2. Even supposing that a PCR test was a meaningful indicator of active infection (a very dubious claim) the endpoint chosen - that being any symptom in addition to a positive test - has little relevance in the real world.
3. Hardly any of the sort of people known to be at risk of serious illness were included in the trial. In particular, the elderly.
4. The duration of the trial was far too short at only a few months of follow-up. It completely ignores what happens when any purported benefit has waned.
5. Long-term safety could not be measured because the placebo group were almost all given the vaccination after just a few months, obliterating the control group. This is reckless in the extreme when one considers the drive to inject every man, woman and child.
6. There was no basis for extrapolating a purported reduction in the number of people who had mild cold-like symptoms and a positive test to mean that the product would protect those at risk from severe illness or death.
7. A covid-only analysis ignores non-covid related effects. On an 'all-cause' basis there was no evidence of mortality reduction.
8. The above assumes the actual results can be trusted, yet there are several red flags in that regard. It is to be noted in particular that all PCR tests were carried out at Pfizer's central lab and the raw data has not been made available.
9. Even if the results were trustworthy and meaningful clinically, the focus on a 95% relative risk reduction that was derived from the finding of 162 cases in the placebo group vs 8 in the active group was very misleading. Those numbers are out of around 22,000 subjects, so the actual reduction in risk of having cold or flu-like symptoms with a positive PCR test was from a little under 1% down to a little over zero.
10. Put differently, the trial results (even if fully trusted) are more usefully and accurately described in this way: If you give 2 doses to just over a hundred people you will prevent one person from having cold or flu symptoms combined with a positive PCR test. And this is without considering adverse effects.

Although the above refers specifically to the Pfizer product, the same, or similar issues, are present for the other covid vaccines. We use this example here purely because the Pfizer product has the highest profile.

## Act 2: Betrayal of the public by the regulators

As a member of staff at Great Ormond Street Hospital, Dr Stephen Wright was at the front of the queue for a vaccine He was killed by the AstraZeneca vaccine on 16th January 2021 which caused a brain haemorrhage associated with thromboembolism with thrombocytopenia, or low platelets. He left a widowed wife and two fatherless sons. In November 2021, the MHRA acknowledged over 70 suspected fatalities from thromboembolic events associated with low platelet counts after the AstraZeneca vaccine in the first 10 months of use, about one every four days. In April 2021 they estimated the incidence of this condition to be 4 per million. By February 2022 they raised this to nearly 15 per million, but were still saying *"further investigations are underway to understand the biological mechanisms and whether the association is related to the vaccine platform." Yet nearly a year earlier in March 2021 the Danish regulators suspended use of the vaccine, and* described the relationship of this condition to the vaccine as causal, stating that *"Nothing but the vaccine can explain why these individuals have had this immune response."*

The following certainly isn't a full list of the failures of our regulator, but highlights some of the most important points.

1. The regulators either knew (or ought to have known) the above shortcomings of the clinical trials at all material times.
2. The regulators applied some strict conditions to the temporary authorisation approval under Regulation 174 of the Human Medicine Regulations 2012 but for many of these – in relation to pharmacovigilance in particular – there is no evidence that the conditions were satisfied by the manufacturer.
3. Red flags in relation to safety have been continually raised since the earliest days of the rollout and yet all have been summarily ignored. To take one example, in its cumulative safety report of post-rollout experience, Pfizer reported that within a few months it had received well over a thousand reports of serious

cardiovascular adverse events with a median onset of less than 24 hours after injection.

4. Despite this, the regulator allowed the public to believe that the product would be broken down in the arm with no systemic effects. Cardiovascular events as well as the range of other organ system adverse events were reported and this fact is incompatible with anything other than widespread distribution of the product throughout the entire body.
5. The regulator knew (or ought to have known) that readily available biodistribution data showed that in rats the product became widely distributed. Moreover, it should have extrapolated that the covid products use lipid nanoparticles which are designed to optimise the delivery of cancer drugs to their target by crossing cell membranes.
6. The regulator treated the product as a 'vaccine' when in fact it was no such thing. They are in fact complex biologics never before rolled out en masse. The companies themselves referred to these products as gene therapies in financial regulatory submissions. The categorisation as a vaccine allowed certain preclinical steps which would ordinarily be required, to be truncated or skipped entirely. Because of this a number of concerning biological effects are only now coming to light after billions of injections have been given.
7. The regulator knew that the process used to manufacture the product in the larger quantities needed to roll out the product to the public was completely different to the process used in the clinical trial. The production of this 'process 2' (upscaled) product jettisoned the long-held requirements to show equivalence in all material regards. This has resulted in the final product now being confirmed by researchers around the world to contain DNA contamination at levels far in excess of previously established safety levels. The full implications of this may not be known for years to come.

## Act 3: Betrayal of the victims in terms of proper redress for their injuries.

Adam Rowland was a fit professional sports physiotherapist until he had his AstraZeneca vaccine in January 2021 to protect his elderly mother-in-law. The first dose disabled him. He developed autonomic dysfunction, mild neurological problems and some heart symptoms. His GP told him he was suffering from anxiety and encouraged him have a second dose. He then became sicker still and consequently has separated from his wife and is being looked after by his mother as he cannot live independently. He has essentially been abandoned by the system in terms of any legal redress.

Important legal points to note are as follows:

1. In the UK, the manufacturers have an indemnity written into the contracts with the government. It is commonly assumed that means the manufacturers cannot be sued. This is wrong. An indemnity is not the same as legal immunity. All the indemnity means is that the government - instead of the company - foots the legal bills for defending any claims and pays any damages. It has no bearing on who is liable and whether the injured can sue.
2. That is a strictly legal analysis. It obviously benefits the government financially and politically if a barrage of claims can be resisted and / or defeated.
3. There are many impediments to claims being successfully brought against manufacturers in the UK. These include but are not limited to:
    a. Low confidence in success because of government propaganda about the safety of the products means that solicitors are unwilling to cover work in progress costs or expert fees as part of “no win no fee” type structures.
    b. A relatively low level of damages means that it is unattractive for third party funders to fund claims for a cut of damages.
    c. The censorious attitude towards those speaking out about vaccine harms is limiting the availability of the experts necessary to prove linkage of harms to the vaccine to the level of certainty required by the courts.

d. In the early stages of the covid era we saw reluctance on the part of judges to go against the official narrative and there is no indication that this has changed.
e. The slow-burn nature of the injuries which manifest in autoimmune and / or inflammatory issues that can appear months or years after injection mitigate against these problems being linked to vaccine harm. This is not helped by the false propaganda being spread about the long-term effects of the illness referred to as 'covid'. 'Long-vaccine' might be a more appropriate moniker.
f. There is a 3-year limitation period in the UK within which claims for personal injury must be filed, otherwise the claim is time-barred. There are some exceptions mainly around establishing exactly when the claimant could have legitimately known they had a valid claim.

4. The situation might be reversed if the government had concerns that it – rather than the manufacturer – was going to be footing huge legal bills and suffering enormous political fallout. Then, it might change tack, claiming the indemnity to be null and void based on wilful misrepresentation of data by the manufacturers. This is probably the most likely route towards any form of proper redress for the vaccine-injured. This is much more likely to happen if the government sees that making the manufacturers – not the taxpayers – foot the bill is politically attractive.
5. There is of course also the potential for legal breakthroughs in other countries to cause a domino effect whereby ultimately governments are forced to accept that there are substantial numbers of valid claims, and that for justice to be done they must find a way to ensure these are satisfied.