Doctors for Patients UK

SUBMISSION

TO

THE PEOPLE'S VACCINE INQUIRY

This document summarises and synthesises the testimonies of multiple contributors.

The main body of the document has been prepared by Dr Timothy Kelly, Dr Ayiesha Malik, Dr Dean Patterson and Professor Angus Dalgleish.

The full testimonies from all contributors are included in the Appendix.

10th June 2024

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FOREWORD

At a recent meeting of the Bristol Medico-Chirurgical Society the GMC employment liaison officer for the SW of England was asked why the GMC curtails free speech between doctors and patients. He denied this was the case but then added that "Of course you can't just allow doctors to say what they want over things like vaccines." There was a howl of protest from the doctors, and he tried to backpedal on his statement, but it was too late. The GMC viewpoint was clear… despite treating no patients and having no knowledge about Covid vaccinations, the ex civil servants of the GMC would not permit worried doctors to speak out about their concerns.

So why do these doctors want to have their say about the gene therapy masquerading as vaccination that is still being foisted onto the public? It is the experience that they have had of bad reactions to these "vaccines". These reactions are so common that almost anyone you chat to, can tell you a story about someone they know who suffered. These range from nasty flu-like symptoms and increased incidence of infections post-vaccination, through arthritis to sudden death in otherwise healthy individuals.

Perhaps some of this is hearsay or gossip, but much we have experienced ourselves, and one thing we have certainly noticed is the distinct lack of activity by the authorities who should be examining the situation. In the past it was *de rigueur* for a post-mortem and an enquiry to be carried out for every suspicious death within a short time of any medical intervention. This is no longer the case and when suspicion of vaccine harm is raised it is more than likely that the doctor raising the alarm will be disciplined for speaking out of turn. Despite myocarditis being a known side effect of the covid vaccine for more than 2 years, there are zero guidelines for pathologists when doing a post-mortem in a sudden death of a vaccinated person. Since the covid "vaccinations" are experimental and previously untried in human beings, the pharmaceutical firms, regulators and the government should be keeping a very close watch on all the harmful effects and continuing this vigilance over a period of some years. This does not appear to be the case.

That there is a problem is clear from the government's own massaged figures showing far more adverse reactions than from any conventional vaccine. And yet the Covid Inquiry has delayed the session on vaccines.

For the "vaccines" to be good science, they should be testable. The test of a vaccine must include the cost/benefit analysis. The benefits are usually obvious: the recipient should no longer be susceptible to the infection, and they should not pass it on to other people. The costs include the monetary expense incurred but also the potential harm to the person who is vaccinated.

In the case of the Covid vaccinations the benefits have become blurred. Initially it was hoped that the vaccine would convey protection for a long period of time but even the official UK Health Security Agency states that the protection wanes very quickly. The figures are incomplete and vague, but Pfizer and AstraZeneca appear to have waned in protecting against symptomatic

infection down to about 20% by four months and at six months the protection becomes negative, the recipient becoming more likely to be infected than the controls! The agency provides no information about mortality or transmission citing insufficient data. The UK is usually a frontrunner with information of this kind due to its nature as a nationalised health system. Do other countries have better information? The Florida administration has been condemned by pundits for suspending inoculations for the 18-35 years group. But given the lack of information about efficacy and in light of the knowledge of side-effects the Florida Department of Health would appear to be taking a sensible position.

The vast majority of people in the UK have come in contact with Covid-19 and have some natural immunity. Adding extra boosters increases the risk of developing reactions and interfering with the natural immunity whilst even possibly driving the emergence of new variants. The time has come in the UK for a moratorium on the Covid-19 vaccine programme.

The debate is difficult. Doctors against vaccination have been struck off or suspended when they have spoken out or refused to take part in the vaccination programme whilst those in favour have received vitriol online. That is not how science can progress. Pfizer wanted the data on reactions to be kept secret for many decades. If the vaccines cannot be tested, they are not science, they are simply untested and potentially dangerous technology.

This statement from concerned healthcare staff shows the bravery and deep compassion of the people taking part. They are in danger of losing their employment and damaging their futures but still they feel obliged to register their concern.

Read on but do so with an open mind and please ignore the propaganda fed to you by the government.

Professor Paul R Goddard, BSc (pharmacology), MBBS, MD, FRCR, FBIR, FHEA

Bristol, May 2024

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 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, detailed in Appendix A, 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.

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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**: Many 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.

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1. Introduction

The COVID-19 era revealed significant weaknesses in the global public health, scientific, and governance systems. These systems, already vulnerable due to excessive specialisation and centralisation, faced additional challenges from corporate and political influences. The perception of a dangerous virus served as a trigger, exacerbating these pre-existing vulnerabilities dramatically.

As the purported crisis unfolded, a dramatic inversion occurred where governments and authoritative bodies, expected to be bastions of truth and guidance, began mislabelling clear, factual information as “misinformation”. This not only catalysed the implementation of damaging measures but also fuelled a mass psychological phenomenon—a pervasive and deep-seated disruption in collective thought and perception, where widespread superficial narratives diverged from nuanced reality.

A critical misstep during this period was the stifling of freedom of speech within the medical and scientific communities. These communities, which should thrive on robust debate and dissent crucial for scientific advancement and medical safety, faced overwhelming pressure to conform to a consensus. Often shaped by the same political and corporate influences, this proclaimed “consensus” led to the suppression of diverse medical opinions and decisions about management strategies, including the safety and efficacy of vaccines. This suppression, facilitated by the centralisation of decision-making processes, meant that a few key organisations and governments set the global narrative and response strategies.

Suppression was facilitated not just by the centralisation of decision-making processes but also by a culture of self-censorship within the medical community itself. Many professionals, constrained by fears of ostracisation, loss of employment and other personal repercussions such as financial burdens from loans or not being able to provide for their families, opted to conform rather than champion their principles. Their self-censorship, combined with external suppression of free speech, quickly led to the abandonment of foundational principles vital to the integrity of medical practice, including:

- The Hippocratic Oath: "Primum non nocere" or "First, do no harm."
- Bodily autonomy
- Informed consent
- The precautionary principle

This culture of silence and conformity, fuelled by both external influences and the intrinsic fears within each individual—such as fear of ridicule or standing out—undermined these ethical principles, resulting in a significant shift in the collective moral compass.

2. Examples of Nuance vs Superficial ‘Narrowtive’

Aspect	Superficial 'Narrowtive'	Nuanced Reality
Deadly Virus	Portrayed as universally lethal, posing a severe threat to all.	Actual risk varied significantly by age and pre-existing conditions.
Universal Vulnerability	Everyone is equally at risk of severe outcomes.	Risk of severe outcomes not uniform; younger, healthier individuals often experienced milder symptoms.
Universal Susceptibility	Everyone would catch the disease as it was a ‘novel’ virus, and this would overwhelm health services.	Many people had innate immunity and infections come in self-limiting waves, no evidence of national health services being overwhelmed.
Stay-at-Home Directives	Lockdowns as the only effective measure to halt spread, necessary for everyone's safety.	Lockdowns were never part of previous established pandemic preparedness plans, specifically we have never quarantined the healthy. Lockdowns resulted in significant collateral damage to economies, mental health, and education, as well as delayed medical care for non-covid conditions.
‘Save the NHS’ & protocol-driven care	The public were advised not to contact a doctor unless blue and breathless to avoid overwhelming health services. PCR testing for all admissions with little regard to false positives.	Failure to provide standard community care. Hospital patients with positive PCR tests were denied antibiotics and pushed onto rigid protocols.
Spread by Close Contact	Emphasised need for lockdowns, masks, highlighting high transmissibility.	Aerosols as primary spread, indicating ineffectiveness of surface cleaning, masking and social distancing.
Social Distancing	Care homes closed to visitors	Care home residents died alone
Vaccine as the Sole Saviour	Vaccines as the definitive solution, essential until full global vaccination.	Discouraged the use of other public health measures and treatments such as Vitamins D, C, zinc, ivermectin, and initially corticosteroids. Downplayed the role of natural immunity.
“Warp” Speed Development	Hailed as a scientific triumph with assurances of safety despite rapid development.	Emergency-approval bypassed and undermined traditional long-term safety studies
Safety & Efficacy	Long-term safety and efficacy of vaccines asserted, despite lacking long-term clinical trials.	Asserting long-term safety without extensive trials created unrealistic expectations and has undermined public trust.
Necessary Censorship	Control over information deemed essential for public order and trust, with authorities seen as having the best solutions. Social media platforms censored alternative viewpoints.	Hindered essential scientific debate and suppressed dissent, crucial for robust scientific discussion and progress. Created a false impression that “*the science is settled*”.

3. Disproportionate Collateral Harm

The initial public non-pharmaceutical interventions (NPIs) in attempting to control COVID-19, inflicted widespread collateral harm. This was particularly true for those at minimal risk from the virus itself. The global response predominantly adopted a one-size-fits-all approach, indiscriminately applying measures meant to protect the most vulnerable to all population groups without individualised risk assessments. This broad strategy led to severe economic downturns, educational disruptions, a mental health crisis and healthcare setbacks. Similarly, the subsequent roll-out of vaccines continued this trend of universal application without sufficiently considering individual risk levels or the broader health implications. This lack of nuanced approach, coupled with stifled public debate on the sweeping nature of these interventions, raises concern about transparency and accountability in pandemic response strategies.

4. Vaccine Rollout and Its Implications

The rapid development and widespread deployment of COVID-19 vaccines were heralded as essential steps towards ending the pandemic. However, the approach to uniformly vaccinate all demographics, irrespective of their risk profiles, led to several notable controversies in development and deployment.

4.1 Critical Perspectives on Vaccine Development

- **Experimental Platforms and Safety Concerns:** The rapid development and rollout of vaccines using experimental gene-therapy platforms, such as mRNA and lipid nanoparticles, have raised significant concerns. Despite previous research indicating potential adverse outcomes, these technologies were expedited into public use without the customary long-term safety studies typically required for new medical interventions. This was a particular concern as novel treatments were being administered to pregnant women, a group where novel therapies are hardly ever justified and who were not included in the initial trials.

- Many of us became alarmed regarding the apparent emphasis on vaccination as the only solution and “way out” and were concerned about the proclaimed “warpspeed” pathway of development and proposed roll-out of an experimental gene-therapy based platform. Some of us knew from previous attempts that mRNA as a delivery system had failed (e.g. animal studies where the subjects died), with no track record of success in humans. Others knew that lipid nanoparticle technology was problematic, and also potentially toxic.

- The proposed novel injection was essentially an unstable pro-drug, a biologically active product. How could the scientists control where it distributed to and for how long it would stay active in the body? Furthermore, why would all the pharmaceutical companies (seemingly in lockstep) decide to base their gene target on programming the body to produce a modified version of the entire toxic SARS-CoV-2 spike protein in an unknown quantity for an unknown time?

- **Regulatory Oversights and Safety Assessments:** The “vaccines” were not subjected to the comprehensive pharmacokinetic and pharmacodynamic studies that are standard for other new drugs. This "light touch" regulatory approach, facilitated by the “vaccines” classification, allowed pharmaceutical companies to conduct much of the quality control internally, thereby reducing transparency and external accountability.[2]

- **Compromised Clinical Trials:** The initial clinical trials for COVID-19 vaccines included control groups, essential for accurately comparing the vaccine’s safety and efficacy against a placebo. However, post-emergency use authorisation, participants in these control groups were then offered the vaccine. This decision, framed under ethical considerations of not withholding a potentially beneficial treatment, effectively dissolved the control groups, removing the ability to obtain long-term comparative safety and efficacy data crucial for fully understanding the vaccine's impacts.

- **Ethical and Methodological Concerns:** Offering the vaccine to control group participants, especially to young and healthy individuals, raised profound ethical and methodological questions. The involvement of pharmaceutical companies in these decisions, combined with the novel nature of the mRNA technology and the immense pressure to deploy a solution to the pandemic, introduced significant conflicts of interest.

- **Legal and Financial Implications:** In many jurisdictions, vaccine manufacturers are largely shielded from liability for vaccine-induced injuries. This legal framework places the burden on public compensation schemes, i.e. the taxpayer, rather than on the companies themselves, which may influence the rigour of safety assessments and any reporting of adverse effects. In the USA once a vaccine has been added to the routine childhood vaccination schedule, the manufacturer cannot be sued for medico-legal negligence and any damages must be paid by the vaccine injury compensation scheme. This approach is mirrored across many countries in the world, with the UK adopting a similar policy for our covid vaccine compensation scheme.

4.2 Challenges in Vaccine Deployment Strategy

- **Pressure to Vaccinate Low-Risk Groups:** Young and healthy individuals who faced minimal risk from SARS-CoV-2 were unethically pressured into vaccination, despite the potential side

effects outweighing benefits for this demographic. For these low-risk groups, vaccination was promoted on the grounds of protecting vulnerable members of their family or wider community. “Nobody is safe until everyone is safe” was a phrase with no basis in science. This was particularly unethical when it came to children, for whom GMC guidance requires any treatment to be for the child’s own benefit and not that of the wider society.

- **Vaccine Mandates:** The very notion of vaccine mandates, let alone its implementation, is anathema to bodily autonomy and non coercion. Enforcing vaccination for the purposes of travel, work, and education compelled many, especially among low-risk populations, to make difficult decisions impacting their bodily autonomy and right to informed health choices.

- **Prioritisation and Natural Immunity:** Political decisions to prioritise vaccines for frontline health workers ignored the established science of natural immunity. Frontline health workers, repeatedly exposed during waves 1 and 2, had either proven not to be susceptible, or would already have gained broad and robust natural immunity. However, besides the deliberate downplaying of natural immunity, there was a political will to prioritise NHS staff for the jab, almost as a reward for selfless service and risking their lives, despite the fact that it was already too late to prevent them getting exposed or infected. Furthermore, it was already accepted that surgical masks have never worked, so for those who had worked in clinical areas with daily aerosolised exposure, established science told us they would not need the vaccine. This was compounded by the continued and often unnecessary use of ineffective PPE, which represented significant financial and resource misallocation. Indeed, mandating ineffective masks and PPE usage cost the taxpayer £12 billion in 2020.

- **Job Threats and Coercion:** Government and institutional policies that pushed for mandatory vaccination under threat of job loss, created ethical dilemmas and resistance among healthcare workers, many of whom were concerned about the vaccines' novelty and the lack of robust safety data. An organisation, NHS100k, was formed which campaigned to protest the freedom of choice of healthcare workers who were being coerced into vaccination against their will. The policy was reversed at the eleventh hour.

- **Long-Term Health Concerns:** The absence of comprehensive long-term safety data for these new vaccine technologies raises significant concerns, particularly for younger populations. Some research suggests there may be long term harm due to uptake into the genome and subsequent continued production of antigens. The UK government’s own figures indicated

that myocarditis due to the mRNA vaccines is more common in the younger population compared with the over 40s, although myocarditis in older age groups may be underdiagnosed, chest pain instead being labelled as a myocardial infarction.

- **Lack of Informed Consent:** Although leaflets describing potential adverse reactions were produced, they were not provided in sufficient numbers for the public to access and did not constitute informed consent. This was especially true for multidose vials. Some medication package inserts for the vaccines were even marked, 'Deliberately BLANK'. The use of large vaccine centres, often staffed by volunteers, made any individualised discussion of benefit and risk almost impossible.

4.3 Deployment Observations

- **Widespread Increase in Excess Mortality and Severe Health Events**: There has been a noticeable rise in excess mortality, sudden death, young adult cancers, strokes, heart failure and heart attacks. Disentangling these harms from the effects of widespread non-pharmaceutical interventions is challenging, especially given the compromised integrity of clinical trials. A large study confirming increased excess deaths across the western world has been published in BMJ Public Health on 3rd June 2024.[3]

- **Increased Illness Post-Boosters**: Contrary to expectations, a notable increase in minor illnesses such as repetitive colds or flu-like symptoms was observed among vaccinated healthcare staff following booster vaccinations, as evidenced by increased sick leave following inoculation. These prolonged symptoms challenge the purported protective effects of the boosters.

- **Reinfection Rates and Vaccine Efficacy**: It emerged early on that vaccine efficacy waned within 90 days of a second dose, leading to recommendations for boosters.[4] Studies indicate that vaccination following an initial infection may increase the susceptibility to reinfection. Additionally, subsequent boosters have been linked to higher rates of COVID-19 positivity, albeit often with milder symptoms, raising questions about the long-term efficacy of booster strategies.[5]

- **Cultural Shortcomings in Medical Practice:** It must be acknowledged that the slogan "safe and effective" has been in use for promoting vaccination for nearly a century; this has been so strongly reinforced that doctors have become completely convinced to accept that

vaccines are, indeed, not only safe, but routinely save countless lives. Therefore, it has not occurred to doctors to ever question vaccines, and those few who have dared to, have been publicly vilified as an example that continues to strike fear into the profession. This potential blind spot within the medical community also means doctors fail to appreciate the possible immediate, short and long-term harms of new vaccine platforms, and it can impact the completeness of medical histories and the detection of long-term side effects. For instance, there was no standard requirement to record COVID vaccine status and the date of the last dose as a routine part of the medical record. Additionally, the completion of Yellow Card reports is not mandatory, and many staff mistakenly believe they only need to report an event if they can directly link it to a recent vaccination, not understanding that the 'Black Triangle' system applies to all new drugs.

- **Lack of Auditing and Transparency**: The absence of rigorous auditing of actual COVID-19 case numbers is notably convenient for the vaccine industry, which continues to promote ongoing booster campaigns. This lack of transparency complicates accurate assessments of booster efficacy and may conceal the ineffectiveness of these strategies in delivering promised outcomes.

4.4 Plausible mechanisms of long-term harm

A major issue is the general lack of recognition of the potential for long-term harms associated with new vaccine platforms. This concern has not been given due attention by many health care professionals, who have been relying on the Government's authorisation of the vaccines to be comprehensive rather than their own clinical observations and patients' testimonies.

When undertaking the administration of any novel pharmaceutical product vigilance is necessary from all the medical professionals involved at every level in order to recognise and highlight short, medium and long-term adverse effects. Thorough medical histories that note vaccination dates, and the ability to consider and identify adverse reactions that may arise months or years after vaccination, are crucial. This scoping article reviews the mRNA technology itself and its potential for harms.[6]

The following bio-physiological pathways and potential mechanisms of harm need careful consideration:

- **Widespread Distribution of Lipid Nanoparticles (LNPs)**:
    - **Tissue Distribution**: Despite relentless public health messaging assuring the public and doctors that the injection stays in the arm, LNPs do *not* remain localised at the injection

site but can distribute throughout the body, including vital organs such as the heart, brain, and endothelium. (Indeed, they were designed to do so for the intended purposeful distribution of future cancer therapies). They are designed to cross cell membranes. It is their wide distribution which may explain the very wide range of adverse events which have been reported, potentially affecting any organ.

- **Foreign Protein Expression and Immune Activation**: The mRNA instructs the recipient's cells to make spike protein, hence cells expressing spike protein will be recognised by the body as 'foreign', potentially inducing localised immune responses in these critical areas, leading to inflammation and cellular damage.

- **Endothelial and Cardiac Impact**: The expression of the spike protein within endothelial cells could trigger inflammation and an autoimmune-like response against the endothelium itself, increasing the risk of thrombosis and cardiovascular events.[7] Similarly, expression in cardiac tissue could lead to myocarditis.[8] Scarring from myocarditis in proximity to cardiac conducting tissue has been implicated in sudden death.[9] In 2023, Moderna quietly halted a trial of a new mRNA virus for glandular fever, after a single adolescent developed myocarditis.[10] They show no such caution for covid-19 vaccines.

- **DNA Contamination with Oncogenic Potential**:

  - **SV40 Promoter**: DNA contamination, notably with sequences like the SV40 promoter, found in some vaccine batches,[11] raises concerns about oncogenic potential. If such DNA integrates into the genome of host cells, it could potentially activate oncogenes or silence tumour suppressor genes, leading to cellular transformation and cancer. All the trial vaccines were made by a synthetic pure method (process 1) but when the vaccines were scaled up for rollout to the public, a different method was used (process 2) and this product was not subjected to repeated testing.[12] Leaked Pfizer documents from the European Medicines Agency show they were aware of mRNA stability problems.[13] Indeed, Moderna have a patented method for dealing with this problem.[14]

  - **DNA integration:** We have repeatedly been told that mRNA vaccines cannot enter the human genome, but the appropriate studies were not done by the manufacturers. Independent researchers have demonstrated this is indeed possible. [15],[16]

- **IgG4 Class Switching**:

  - **Immunosuppression and Tolerance**: Repeated vaccine exposure may lead to a class switch towards IgG4, an antibody subtype associated with immune tolerance.[17] This might reduce the efficacy of immune responses to both the vaccine antigen and potentially other pathogens or tumours, altering immune surveillance and increasing susceptibility to infections and possibly cancers.[18]

- **Neurological Complications**:
    - **Neuroinvasion and Autoimmunity**: The presence of the spike protein or LNPs in the nervous system could provoke neurological complications either through direct cytotoxic effects or via an autoimmune response, potentially leading to conditions like Guillain-Barré Syndrome or severe neuropathies.[19] An aggressive form of new variant Creutzfeldt Jakob Disease (CJD) has also been described.[20]
- **Reproductive and Menstrual Health Concerns**:
    - **Hormonal Disruption**: The immune response triggered by the vaccine or the presence of LNPs in reproductive tissues might disrupt hormonal cycles, leading to menstrual irregularities and raises concerns about the potential impact on fertility in women of childbearing age.[21] Lipid nanoparticles were known to accumulate in the ovaries of rats in the preclinical Pfizer trials.[22]
- **Autoimmune Phenomena**:
    - **Molecular Mimicry**: Components of the vaccine might resemble self-proteins, leading to an autoimmune response where the body's immune system attacks its own tissues, potentially causing a wide range of autoimmune diseases.[23]
- **Systemic Effects and Chronic Symptoms**:
    - **Prolonged Spike Protein Expression**: Chronic expression of the spike protein could lead to persistent immune activation, resulting in symptoms such as chronic fatigue, muscle aches, joint pains, and systemic inflammation and crucially immune system suppression potentially increasing risk to infection and malignancy. Persistent spike protein antibodies have been shown in patients with chronic post-vaccination symptoms.[24]
- **Cancer risks**:
    - An increase in cancers, particularly in young adults,[25] has been noted in several countries from 2021 onwards, including an increase in 'cancer of unknown origin'. Concerns have been raised that this rise has coincided with the rollout of the mRNA vaccines[26]. A large number of potential mechanisms have been identified, as illustrated in Figure 1 below. A recent review paper[27] points out that cancer is a complex and dynamic disease and that cancer patients were specifically excluded from most of the vaccine clinical trials. Repeated boosters have been specifically recommended to cancer patients, despite a lack of safety data relevant to this group of patients. These concerns are discussed further in Paragraph 5.3.

Figure 1: Potential cancer-promoting mechanisms for COVID-19 vaccines [28,29,30,31,32,33,34,35,36,37,38,39]

5. Summary of Testimonies

5.1 Pathology

Dr Ryan Cole, MD

Dr Cole is from the USA and is not a member of DfPUK. Dr Cole has been invited to present his concern to members of Parliament. Recently he gave an update lecture at a meeting of various experts for the Channel Islands (see Appendix C).

Introduction and Background: Dr Ryan Cole, a board-certified pathologist with extensive training at institutions such as the Mayo Clinic and Columbia University, begins his lecture by stating his qualifications and experiences, including his PhD research in dermatology, immunology, and

virology. He notes the destruction of his career due to his outspoken views, a sacrifice he claims he would willingly repeat.

Main Concerns with mRNA Vaccines: Cole articulates a strong stance against what he terms "synthetic DNA and modified RNA injections," arguing that these are not true vaccines but rather "genetic transfection agents." He highlights the absence of long-term safety data for these products, which are being developed for many other conditions beyond COVID-19. Cole criticises the push for ongoing booster shots, describing them as ineffective due to the rapid mutation rates of coronaviruses.

Pathological Evidence and Research Findings: Dr Cole provides detailed pathological evidence regarding the distribution and impact of the mRNA vaccine's components, particularly focusing on the spike protein facilitated by the vaccine. He claims:

1. **Lipid Nanoparticles (LNP) Distribution:**
    - Dr Cole mentions a study indicating that lipid nanoparticles do not remain localised at the injection site but instead disperse widely throughout the body.
    - He specifically points out that these particles are found in high concentrations in the ovaries, which raises concerns about potential reproductive health impacts.
2. **Persistence of Synthetic mRNA:**
    - According to Dr Cole, research from Stanford University found that synthetic mRNA from the vaccine was detectable in the body 60 days after administration, continuing to produce the spike protein.
3. **Spike Protein Accumulation:**
    - **Peripheral Nerves and Liver:** Evidence from Cole's own laboratory and others' shows that the spike protein is present in peripheral nerves and liver, where it is rapidly produced, potentially leading to rapid onset of autoimmune responses.
    - **Heart and Coronary Vessels:** He discusses findings showing spike protein in the coronary vessels and cardiac tissues, which could explain reports of cardiac issues post-vaccination.
    - **Adrenal Glands:** Dr Cole highlights concerns about spike protein found in the adrenal glands, emphasising the gland's role in numerous physiological processes and the potential for significant systemic effects.
    - **Brain and Central Nervous System:** Cole references a study indicating that spike protein deposits in the brain, a critical finding given the brain's sensitivity to foreign substances and the potential for neurological impact.

4. **Impact on Cancer Rates:**

    - Dr Cole suggests that the spike protein might interact with tumour suppressor genes, based on cancer samples showing expression of spike protein in tumour cells, which could potentially accelerate cancer progression. This interaction is highlighted in various cancers, including pancreatic and stomach cancer, as well as aggressive lymphomas observed shortly after booster vaccinations.

Implications for Public Health: Cole raises concerns about the broader implications of widespread mRNA vaccine use, including potential links to cancer. He references data indicating an increase in cancer rates and expresses concerns about the long-term immune system damage. Cole concludes with a call for a re-evaluation of the vaccine strategy, criticising the lack of transparency and data sharing regarding vaccine efficacy and safety.

Conclusion and Call to Action: In his closing remarks, Dr Cole emphasises the need for immediate cessation of mRNA vaccine use, urging for more thorough research and a shift towards treatment strategies that do not compromise long-term health. He invites questions, indicating a readiness to discuss further and substantiate his claims.

5.2 Cardiology

Dr Dean Paterson, Consultant Cardiologist (Guernsey): (MBCHB FRCP)

Dr Patterson has presented his concerns about the cardiac side effects in a recent ITV interview.[40] Here is a summary of his concerns.

Concerns Over Vaccine Safety: Dr Patterson expresses escalating concern regarding the adverse effects observed post-vaccination, supported by specific severe patient reactions. He links these adverse events, including myocarditis and sudden deaths, directly to recent vaccinations, observing patterns that deviate sharply from pre-vaccine health issues.

Increased Cardiological Issues Post-Vaccine: Cites statistical evidence of a stark increase in cardiac issues post-vaccination, including myocarditis, pericarditis, severe arrhythmias, and cardiac deaths, often in young, otherwise healthy individuals.

Allegations Against Dr Aseem Malhotra: Endorses Dr Malhotra, a cardiologist accused of spreading misinformation, emphasising his contributions to preventive cardiology and challenging existing medical paradigms. Asserts that Dr Malhotra's critiques are necessary for raising awareness about the vaccine's potential dangers.

Reporting and Data Management Challenges: Criticises the efficacy of the "yellow card" reporting system for adverse vaccine reactions. Dr Patterson describes issues such as non-responsiveness, deleted reports, and overall systemic failure in monitoring vaccine side effects.

Response and Acknowledgment from Health Authorities: Highlights the resistance he faces from health officials and colleagues when attempting to link vaccine administration to health complications. Describes a systemic unwillingness to investigate or recognize these potential links.

Advocacy for Ethical Medical Practices: Advocates for transparent, informed consent in the ongoing vaccination efforts, given the unknown long-term effects and the emergency use authorization of the vaccines. Dr Patterson presses for ethical scrutiny and debate around the accelerated vaccine rollout.

Challenges with Professional Feedback and Communication: Dr Patterson's communications with public health authorities go largely unanswered, reflecting a communication gap between frontline medical professionals and policy decision-makers. Accusations questioning his mental health following his outspokenness illustrate the personal and professional risks involved in voicing dissent.

Future Direction and Recommendations: Calls for an independent inquiry into the Covid-19 vaccines and pandemic management, recommending the cessation of current vaccination strategies in light of adverse effects. Advocates for the establishment of support systems for whistleblowers and those adversely affected by vaccines.

Need for Systematic Investigation and Support: Urges the establishment of a dedicated panel to thoroughly investigate vaccine safety issues and the setup of helplines to support both medical professionals afraid to voice concerns and patients who may have suffered vaccine injuries.

Broader Implications on Public Trust in Healthcare: Dr Patterson warns of a potential rise in vaccine hesitancy and a significant loss of trust in public health advisories due to mishandling of vaccine safety and adverse effects, calling for more open dialogue and transparent reporting.

5.3 Oncology

Professor Angus Dalgleish, MD, Emeritus Professor of Oncology, Principal Institute for Cancer Vaccines & Immunotherapy

Unexpected Melanoma Relapses: Reports experiencing an extraordinary number of relapses in stable melanoma patients, some of whom had been stable for over a decade. Normally, these relapses result from prolonged severe stress, but all patients had in common was having received a booster mRNA vaccine.

mRNA Booster Vaccines and Immune Suppression: Expresses concern, from his experience as an HIV and cancer vaccine researcher, about the debilitating influence of booster shots in the vaccination model. Cites published studies showing notably suppressed T cell responses for cancer patients after the third shot, correlating to his observed relapses.

Detrimental Impact of the Third Shot: Reports that the third jab is associated with IgG antibody class-switching from IgG1 and 3 to IgG4, a potentially tolerogenic response more suited to transplant patients. Follows up with reports suggesting the third shot increases susceptibility to COVID infection significantly, more than three-fold according to a Cleveland clinic study.

Rise in B Cell Lymphomas/Leukaemias and Myeloma after Third Shot: Refers to his personal observation of eight people developing B cell lymphomas/leukaemias and myeloma following the booster shot, suggesting a potential association.

Increased Incidence and Aggressiveness of Abdominal Tumours: Reports an apparent rise in incidence and aggressiveness in colorectal and other abdominal tumours post-booster vaccination. These "turbo cancers", along with kidney cancers and Gliomas (a type of brain tumour), are commonly associated with marked immune suppression and response to immunotherapy, bolstering the hypothesis of vaccine-induced disruptions to the immune system.

mRNA Vaccines' Potential Role in Cancer Development: Lists several reported mechanisms contributing to cancer development attributable to mRNA vaccines such as batch-to-batch variation, presence of DNA plasmids, SV40 oncogene promoter, mRNA-induced frame-shifting, production of IgG4 (tolerant) antibodies

Suppressor Genes Interaction: Mentions several reports showing that spike protein generated by the mRNA (in particular the S2 subunit) can bind p53 and MSH (melanocyte stimulating hormone) suppressor genes, with potential long-term effects leading to cancer growth, which could have contributed to the reported worldwide surge in cancers, especially among young people.

Call to Action: Calls for an immediate ban on mRNA vaccines, given the uncovered mechanisms by which these vaccines may induce or accelerate cancer development.

5.4 Surgery

5.4.1 Mr T James Royle, MBChB, FRCS, General and Colorectal Surgeon

Uncommon Disease Patterns Noticed Post-March 2021: Discusses several unusual patterns emerging post-vaccine rollout, including:

- Frequent occurrences of bilateral pulmonary thromboses and abdominal venous clots in unusual vessels with no clear underlying pathology.
- Increased cases of ischemic bowel without visible arterial clots and severe, rapid-progressing pancreatitis (even if triggered by gallstones) often leading to necrosis much sooner than typically observed.

- Reports these phenomena occurring in patients with no obvious predisposing factors.

- **Alarming Surge in Aggressive Cancers:** Notes a significant uptick in aggressive cancer cases, specifically colorectal cancers. These cancers show atypical rapid growth and progression, found across all age groups.

Potential Influence of mRNA Vaccines: Raises concerns that there are emerging plausible mechanisms by which the mRNA injections (and their contaminants e.g. DNA plasmids) might be accelerating cancer pathogenesis.

Impact on Immune System and Overall Health: The vaccines are suspected to cause generalised immunosuppression, potentially diminishing the body's ability to mount an effective tumour surveillance response and increasing susceptibility to severe forms of common diseases.

Mixed Medical Community Response: Reports mixed responses from the medical community, ranging from agreement and support from fellow surgeons to defensive reactions within local and larger medical assemblies. He highlights a general reluctance within the community to discuss these observations openly, attributed to fear of professional repercussions.

Call for Cessation of covid-19 Vaccines: Concludes with a strong stance against the continuation and promotion of mRNA vaccines until long term safety and efficacy data are obtained.

5.4.2 Mr Tony Hinton: ENT Surgeon (MB ChB, FRCS, FRCS(ORL))

Lost Faith in MHRA: Expresses his complete loss of faith in the MHRA, the regulatory body overseeing vaccines and medicines, due to their handling of vaccine injuries.

Non-Responsive to Reports: Criticises the MHRA for failing to respond to the 15 reports of vaccine injuries that he had submitted through the Yellow Card scheme, questioning their interest in these cases.

5.4.3 Mr Ian McDermott: Consultant Orthopaedic Surgeon (MB BS, MS, FRCS(Tr&Orth), FFESM(UK))

Principles of Good Medical Practice Ignored: Emphasises that key principles like risk vs. benefit analysis, individual patient treatment application, and the absence of coercion were inappropriately discarded during the mass rollout of the mRNA gene therapy injections for Covid-19.

Medical Profession Failures: Criticises the apparent failure of the medical profession to protect the public and each individual patient against political and peer pressure, coercion, or financial incentives during the covid-19 pandemic.

Injection of Unknown Substance: Notes that many medical practitioners injected patients with the mRNA vaccine, an unknown substance at the time, despite not understanding its components, working mechanism, possible side-effects, or potential long-term consequences.

Widespread Ignorance despite Evidence: Regrets that despite clear evidence of lack of efficacy and potential catastrophic harms from the vaccine, a majority of the medical profession still remains unaware of the facts, leading to wilful ignorance that has caused irreparable damage to public trust in the medical fraternity.

Mourning the Lost Nobility of Profession: Bemoans what he views as a degradation of the medical profession, which was once considered noble, due to the handling of the Covid-19 pandemic and its related vaccination campaign.

5.5 Psychiatry

Dr Ali Ajaz, Consultant Forensic Psychiatrist

Departure from NHS due to Vaccine Mandates: Discusses his decision to leave the NHS because of the organisation's push for Covid vaccine mandates, which he views as ethically and scientifically unsound.

Suppression of Open Dialogue: Criticises the lack of freedom within the NHS to question or discuss the Covid response, with defensive and dismissive reactions towards requests for open conversation and examination of evidence.

Concerns over Vaccine Rapid Development: Raises concerns about the fast development and endorsement of Covid vaccines, including overlooked red flags like prior failures in coronavirus vaccines and the impacts of lipid nanoparticles passing into various organs.

Dismissal of Historical Data from Vaccine Trials: Indicates that worries about the quick endorsement of vaccines—including significant historical data from animal trials of mRNA vaccines that showed adverse outcomes—were dismissed in favour of a narrative focusing on compliance.

Stifling Culture within the NHS: Critiques the NHS's handling of the Covid vaccine rollout, where frontline doctors were discouraged from applying medical scrutiny or expressing concerns due to a strong culture of conformity and stigmatisation of dissent.

Shift of Doctor's Role and Ethical Crisis: Argues that the role of doctors has shifted towards being employees who must follow corporate and governmental directives, often at the cost of medical autonomy and thorough consideration of patient health, signalling an ethical crisis.

Neglect of Broader Societal Health: Criticises the pandemic response's indifference to significant collateral damage, focusing instead on short-term measures with minimal evidence of efficacy and ignoring the broader impact on societal health and well-being.

Call for Value on Scientific Integrity and Consent: Ends with a call for a healthcare system that truly values scientific integrity, transparent evidence evaluation and the sanctity of informed consent; arguing that failing to address these issues will continue to disintegrate trust within the medical community and between healthcare professionals and the public.

5.6 Accident & Emergency

5.6.1 Dr. Scott Mitchell, MD

Concerns Over Healthcare Responses: Speaks on the challenges in healthcare responses during the COVID pandemic, including a lack of scientific justification and ethical foundation, particularly in the rollout of vaccines to younger children which led to his resignation from the NHS.

Shift in Public Health Strategy: Expresses concern over the swift change in handling the pandemic, from lack of initial preparedness to aggressive measures, influenced more by theoretical modelling than established scientific consensus.

Enforced Compliance Over Scientific Debate: Criticises the management of information and policies that prioritised obedience over open scientific discussion and the seemingly single-minded promotion of vaccines as the only solution to the pandemic.

Worries About Vaccine Technology: Discusses potential safety concerns related to the swift authorization and deployment of mRNA and viral vector vaccines, especially the role of lipid nanoparticles delivering genetic material beyond the injection site, and questions about long-term health outcomes.

Call for A Balanced Approach: Advocates for a thoughtful strategy considering broader impacts of measures like lockdowns on mental health and societal well-being, highlighting collateral damages such as delayed medical diagnoses and emotional and economic effects.

Criticism of Widespread Vaccination: Expresses discomfort with the drive for broad-based vaccination, especially in low-risk groups like children, without clear evidence about long-term safety, urging for a cautious, balanced approach in public health interventions.

Upholding Patient Safety & Ethical Principles: Insists on the importance for healthcare professionals to stick to principles that prioritise patient safety, informed consent and ethical integrity; encouraging an environment that promotes open, critical assessment of all medical interventions.

Reevaluating Responses to Health Crises: Calls to reassess approaches to health crises, ensuring that strategies are balanced, evidence-based and free from undue influence, to maintain public trust and deliver healthcare that truly serves the public good.

5.7 Anonymous hospital doctor from DfPUK

Noting Unexpected Staff Deaths: Highlights an unusual increase in sudden and unexpected staff deaths following the vaccine rollout—specifically, 18 sudden or unexpected deaths (including 3 young adults), and 3 cases of stroke in senior staff members who reportedly had no recognised risk factors.

Contrasting Pre-Vaccine Covid Mortality: In contrast, notes that only one out of approximately 7000 employees in their Trust reportedly died due to covid-19 during the first and second waves—prior to vaccine rollout—and no other staff members were reported to have died in the covid period prior to vaccine roll-out.

Unclear Causes of Death: Acknowledges a lack of detailed information about these deaths, noting that the announcements did not indicate the cause of death or the deceased's vaccine status.

Expressing Concern Over Death Announcements: Raises concern about these unexpected deaths, pointing out that the messages of condolence all seem to follow the same vague script, which they found "uncanny and chilling".

5.8 General Practice

5.8.1 Dr. Kathy Grieg, General Practitioner (RCGP, MBChB hons, Functional medicine IFM): A Vaccine-injured doctor

Personal Medical History: Experienced pericarditis, dysautonomia, and insomnia after receiving the Pfizer covid vaccination. This marked not only a turning point in her personal health but was also an unprecedented time in her career as a GP when she couldn't secure assistance for herself and her patients experiencing adverse vaccine effects.

Observations of Post-Vaccine Reactions: Reports recurrent incidents of cardiac episodes and blood clotting concerns in patients post-vaccination, paralleling her own experience.

Struggles within the Medical Community: Details her surprise and disappointment due to the lack of support from the NHS. She was curtailed from adding the reactions as an allergy and securing authority to prevent repeat exposure of her patients to the same vaccine. Instead, she was encouraged to promote more booster shots.

Recovery and Career Adaptation: Details a lengthy two-year period of personal recovery and physical fitness. She has since shifted her focus to a private clinic to assist patients who are suffering from vaccine injuries as well as complex chronic illnesses.

Addressing a Gap in Care: Highlights the NHS's continued lack of a dedicated medical service for vaccine injuries, signifying an unfulfilled need that she now strives to meet through her private practice.

5.8.2 Dr. Caroline Lapworth, General Practitioner (MBChB): An Out of Hours GP

Initial Pandemic Observations: Reflects on her experiences and reactions during the initial stages of the pandemic, including delayed repatriation from the USA. Expresses surprise at the discrepancy between the media portrayal of Covid-19 as an indiscriminate killer and her research findings that showed a risk of fatality largely similar to other viral illnesses, with increased age, comorbidities, obesity, diabetes among the risk factors.

Public Fear and Misunderstanding: Shares examples of public misconceptions and irrational fear about the virus due to the media portrayal, leading to under-utilisation of healthcare services even in life-threatening scenarios, thereby causing adverse healthcare outcomes.

"Do Not Resuscitate" Orders: Voices concern over the prevalent use of DNR orders for vulnerable groups without consultation with the patients, family or caregivers. Points out how this led to denial of healthcare treatments and unnecessary patient deaths, citing a personal example involving a care home resident with a heart attack.

Absence of Covid-19 Treatments: Highlights how patients with Covid-19 were denied treatments, and the harmful practices of not treating chest infections and other conditions, leading to avoidable deaths. Speaks of threats clinical researchers faced when attempting to disclose findings relating to early treatment of Covid-19.

Impact of Lockdowns: Discusses the detrimental effects of lockdowns on physical and mental health, drawing attention to the issues of increased suicide, domestic violence, and child protection issues. Criticises the unnecessary harm to society imposed by the lockdowns, especially considering the UK government no longer classified Covid-19 as a high-consequence infectious disease before the first national lockdown.

Importance of Vitamin D: Identifies the risk factors for Covid-19 death as akin to those for vitamin D deficiency, advocating for supplementation of vitamin D and adequate sunlight. Shows concern for the prohibition against supplementation in care homes potentially causing avoidable deaths.

Covid-19 Vaccine Rollout: Describes the rush for people to receive vaccines amidst the climate of fear, but notes reports of side effects worse than Covid-19 itself. Raises concerns over the presentation of vaccines as "safe and effective", given unknown long-term safety impacts and the possibility of antibody-dependent enhancement from prior vaccine research.

Personal Experiences of Vaccine Injuries: Shares several real-world incidences of death and severe health effects following vaccination from her own patient population, social circle, and community. Asserts that injury causation may be difficult to prove at the individual level, recommending the need for population-level data.

Hostility for Vaccine Critics: Discusses the hostility she faces for expressing concerns about vaccine safety and remembers doctors who have faced professional consequences for doing the same. Reflects on the negative personal impacts of her stance, including being reported to the GMC by a personal friend.

Vaccine Mandates: Reveals concerns about the toll of vaccine mandates on healthcare staff morale, leading to increased stress, guilt and healthcare staff shortages. Criticises the use of vaccine mandates by pharmaceutical companies despite vaccines not preventing virus transmission. Shares firsthand anecdotes of emotionally charged vaccination experiences within care homes.

Absence of Informed Consent: Censures the absence of informed consent in vaccination, arguing that potential for death and lifelong injuries were not adequately explained.

Excess Death Following Vaccine Roll Out: Points out the increase in mortality rates following the vaccine rollout, calling for serious investigations. She laments the preventable increase in deaths worldwide had voices of concern over vaccine safety not been silenced.

5.8.3 Dr. Ayiesha Malik, NHS and Private General Practitioner: (MBChB, MRCGP, LFHom)

Observation of side effects post-mRNA injections: Expresses concern regarding the large number of patients reporting side effects after receiving mRNA injections, as well as booster doses.

Cardiac Symptoms and Fertility Issues: Notes a prevalent occurrence of cardiac symptoms, including confirmed cases of myocarditis, and menstrual irregularities—which is seen as a potential fertility issue. Particular concern about guidance encouraging vaccination in young patients who had suffered confirmed myocarditis - to the mRNA injection - to undergo further vaccination. Clinically consulted a patient who again developed myocarditis after his booster.

Support from Medical Community: Finds agreement in her statements with other GPs and medical specialists from various parts of the country, who have also noticed similar patterns. These shared concerns led to the formation of Doctors for Patients UK, which has become a constructive and supportive community of over 130 doctors addressing concerns about vaccine harms.

Difference in Vaccine Safety: Asserts that the COVID-19 vaccines represent a unique case amidst the standard reassurances provided to patients regarding the safety of vaccines.

Concerns for Vaccination in Pregnancy: Displays her worry about vaccination during pregnancy, and has issued a rapid response in the British Medical Journal in addition to co-signing a letter by a healthcare research group that raises safety concerns about COVID-19 vaccinations in pregnant women.

Inadequate Response from NHS Whistleblowing Department: Shares her attempts to raise patient safety issues with her local NHS whistleblowing department. However, she only received government guidelines on vaccination and no concrete actions were taken to thoroughly investigate her concerns.

Threat of GMC Investigation for Doctors Raising Concerns: Mentions warnings issued to doctors about potential General Medical Council (GMC) investigations should they raise concerns about the COVID-19 vaccine.

Global Concern Among Medical Professionals: Acknowledges that there is an international concern among the medical fraternity. Points out multiple studies, indicating a higher than expected incidence of adverse reactions to the vaccine.

6. Conclusion

In summary, the collective insights presented here expose a deeply concerning landscape within the broader context of public health, characterised by a significant rise in adverse reactions following COVID-19 vaccination and a disconcerting failure of healthcare systems to adequately acknowledge and address these issues. The suppression of dissenting voices within the medical community further amplifies these concerns, creating an environment where patient safety and informed consent are compromised. This convergence of systemic failures necessitates a radical re-evaluation of current public health strategies and a renewed commitment to the fundamental principles of ethical medical practice.

This document, the culmination of extensive clinical observations and professional testimonies, has given rise to The Hope Accord (Appendix A), a petition addressing the significant health impacts of experimental COVID-19 therapies and systemic failures in public health management and ethical governance.

The Hope Accord represents our unified call for immediate action, demanding the suspension of mRNA vaccines, rigorous investigation into all COVID-19 therapies, comprehensive support for affected patients, and the restoration of fundamental ethical principles in medicine. It provides a structured framework for addressing the concerns we have consistently raised.

We urge health authorities and policymakers to act decisively, ensuring unwavering commitment to transparency, safety, and patient-centred care in all future endeavours.

APPENDIX A

THE HOPE ACCORD

THE HOPE ACCORD

WE, THE UNDERSIGNED DOCTORS, CALL FOR:

1. THE IMMEDIATE SUSPENSION OF THE MODIFIED mRNA PRODUCTS

Our collective observations signal a significant increase in disabling and fatal conditions impacting all body systems including sudden cardiac death, stroke, disseminated thrombotic events and cancer. These incidents are temporally associated with the experimental mRNA COVID-19 injections and until proven otherwise lack any other plausible explanation. The cumulative evidence for the above is continually mounting worldwide.

2. INVESTIGATIONS INTO THE HARMS OF ALL EXPERIMENTAL COVID-19 THERAPIES

These investigations must explore plausible mechanisms of harm, assess toxicity, and identify treatments. They should include both autopsies and biopsies, utilising specific pathological techniques, to accurately determine the true extent of damage caused by these therapies and provide deeper insights into their impact on the human body.

3. IMMEDIATE RECOGNITION AND SUPPORT FOR THE PATIENTS INJURED BY THESE PRODUCTS

Injured patients must be recognised. Support should include establishing nationwide multidisciplinary clinics offering comprehensive investigations and treatment by specially trained healthcare workers, as well as adequate compensation for all those adversely affected.

4. THE RESTORATION OF FUNDAMENTAL MEDICAL AND ETHICAL PRINCIPLES ABANDONED DURING THE COVID-19 ERA

There must be a thorough reassessment of pandemic interventions that deviated from well-established norms. These posed unnecessary risks of harm, especially to healthy young people, including children. This process should address root causes including corporate malfeasance, conflicts of interest, public health groupthink, and the suppression of scientific debate. It must reaffirm the principle of informed consent.

WE HOPE THAT BY LEARNING FROM RECENT CHALLENGES AND REAFFIRMING THE CORE PRINCIPLES OF ETHICAL MEDICINE, WE CAN INSPIRE A RENEWED COMMITMENT TO INTEGRITY, TRANSPARENCY, AND ACCOUNTABILITY THAT EXTENDS TO ALL CORNERS OF SOCIETY

https://thehopeaccord.org/th/

APPENDIX B

MEMBERS' TESTIMONIES

B1 Cardiology

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

The Covid 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 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. 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 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 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 and was very ill for 3 weeks. Despite a severe covid illness he, unlike post vaccination had no chest pain at all, further evidence that Covid 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 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 postmortem be done. This was strange considering we had administered a new therapeutic without medium to long term safety data under a EUA and healthcare professionals were unwilling to perform a postmortem. Alarmingly, the patient was found to have severe destructive mitral valve thrombotic endocarditis in addition to severe acute myocarditis at postmortem. The patient had no sign of covid infection at

that time. Had the patient been covid 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 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 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 infection cannot be excluded as a contributory cause for the patient's death?” I would say none, while many were certified as a covid death without even a positive PCR test or symptoms of severe covid. 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 management policy that I wrote to the Chief Minister for the Guernsey Government (see letter in Appendix C).

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 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 Southampton. In mid-2021, I made inquiries, and it appeared the diagnosis 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 yr 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 and was tested to show he had never had covid 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 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 measures and paranoia, any myocarditis cases were blamed upon covid itself.

In regard 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 special 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 ? 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 anticoagulants, and he has now returned to full health.

At that time, I saw a patient in clinic with chest pain and TIA shortly after booster vaccination and 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 vitamin 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 roll out 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 focussing upon 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 I was unable to as it appeared to have been completely deleted! 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 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 to diagnosis and treatment of cancer (in days)

The delay to 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 numbers of people with drug dependency

The number of people seeking help for anxiety disorder

The bed utilization 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 which is now recognized to be endemic.

I attach an interesting paper by S. V. Subramanian (European Journal of Epidemiology)[41] 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, but rather to keep up submitting yellow cards, despite me informing the clinical director of the MHRA deleting my reports. I subsequently with Doctors for Patients UK called for the cessation of the vaccine rollout with the "Stop the shots video campaign".

In 2022 I met with UK MP Sir Christopher Chope explaining my concerns about covid 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 C).

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 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 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 postmortem data showing causality, increased non covid 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 injury appears 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[42] 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 and the covid 19 vaccines.

The time to stop the rollout of the Covid 19 vaccines was in mid-2021 once the elderly had been vaccinated. Despite the catastrophic events described above, even as of the 5 May 2024, there is zero data on bio-availability of the Covid 19 vaccines based upon AI search engine review.[43]

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.

B2 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 who 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, and 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.[44]

This data was followed by reports that the 3rd jab makes people far more likely to catch COVID again, 3.6 times more so according to the excellent Cleveland clinic study.[45]

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.

B3 Surgery

B.3.1 Mr T James Royle, MBChB, FRCS, General surgery (GS), emergency GS, colorectal surgery

I am a general and colorectal cancer surgeon working in a busy district hospital for the past 8+ years. My qualifications are MBChB, FRCS. 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)

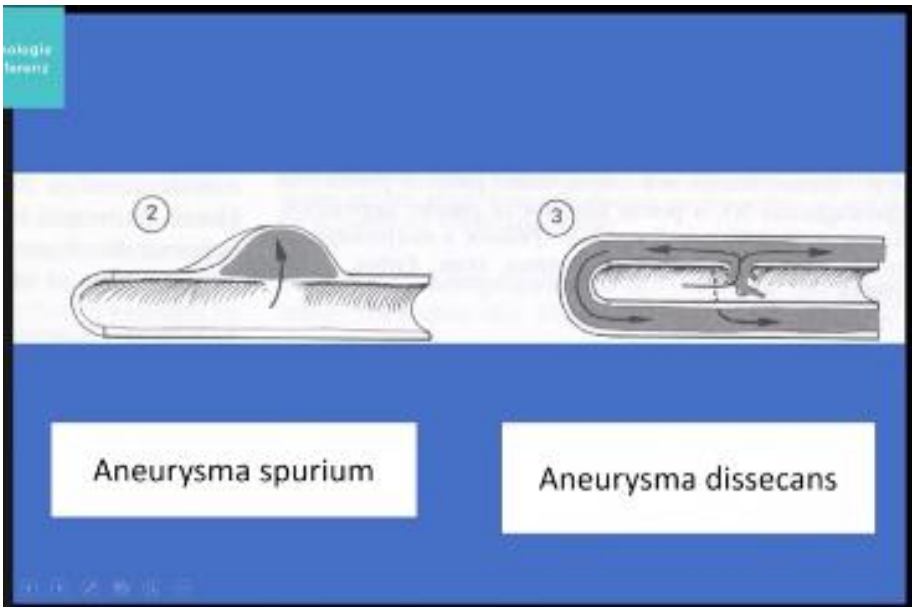
  A new triad of spontaneous (unprovoked) abdominal venous clots that I had not ever seen before - affecting the same 3 main vessels in multiple patients; portal vein (from the gut to the liver), superior mesenteric vein (draining the small intestine) and splenic vein. These patients typically middle-aged (range 31-77 yrs) 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.

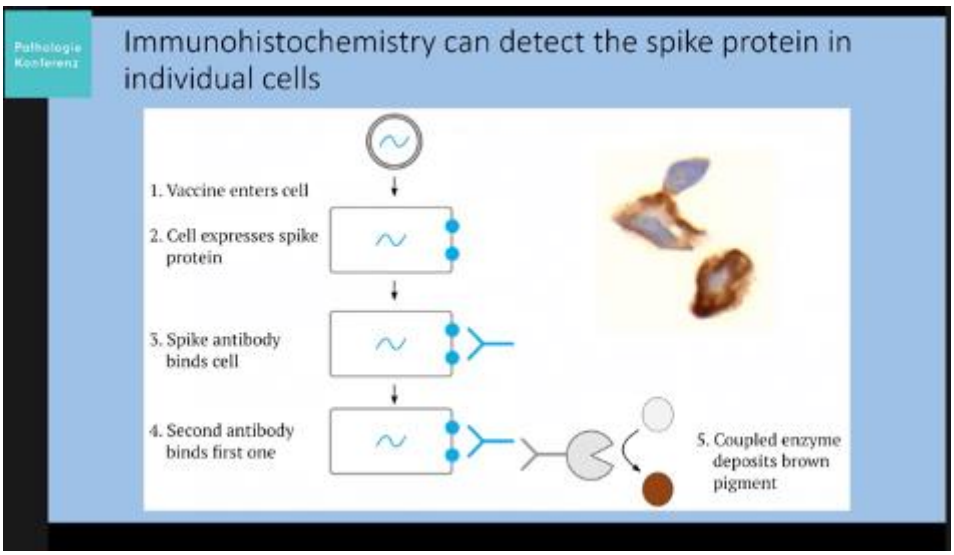
  Sudden increased incidence of ischaemic bowel cases (usually uncommon) - many had no visible clots in their mesenteric arterial vessels on CT as would normally be expected. This could possibly be due to microclotting in multiple small vessels or capillaries, or perhaps from thrombotic endocarditis, as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

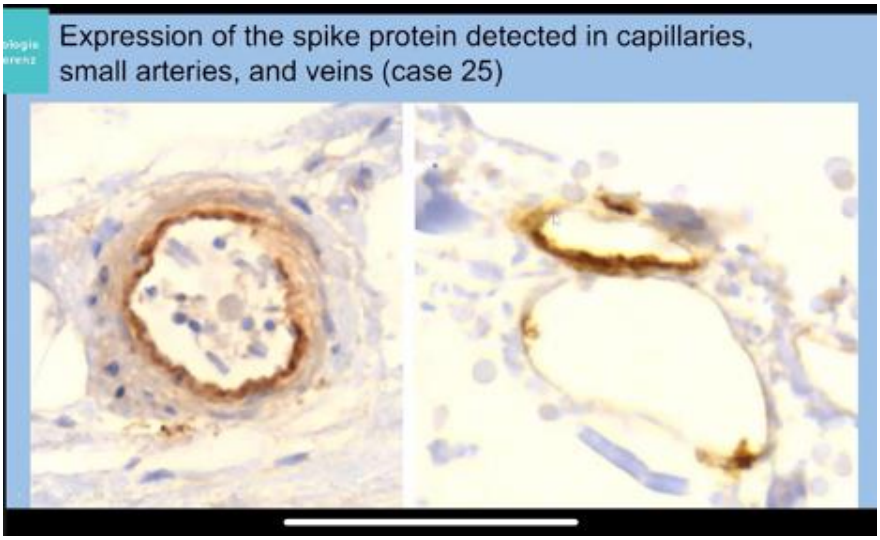
In these thrombotic cases, I had started testing for the **VITTS ("vaccine induced thrombotic thrombocytopenia syndrome")** that had been defined in some patients after Astra-Zeneca vaccine; however, I was seeing these cases after the mRNA Pfizer and Moderna shots as well; typically without fulfilling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

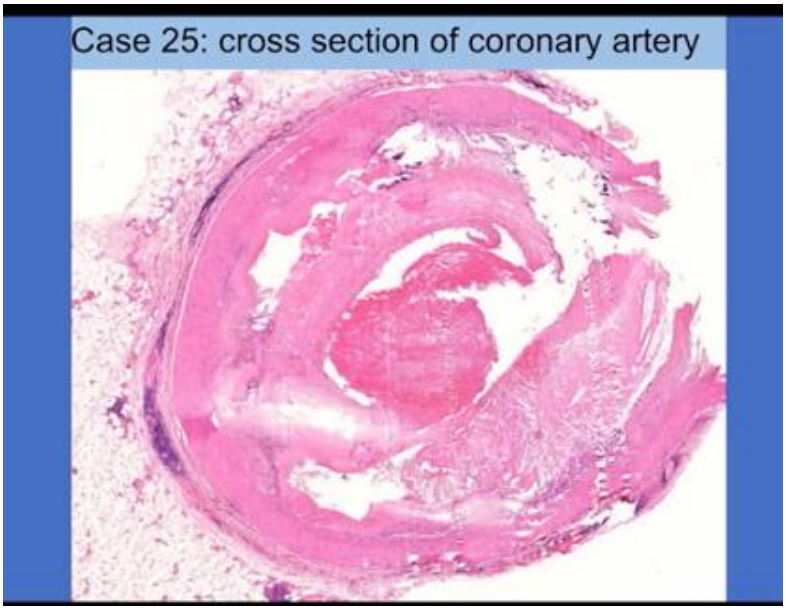
Two pregnant women presenting in quick succession with ruptured **inflammatory** splenic artery **pseudoaneurysms**; (certainly not a recognised condition of pregnancy but possibly the physiological changes may have interacted in some way?). One case I had to take to theatre for laparotomy and splenectomy. 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 March 11th 2022, freely available here.[46]

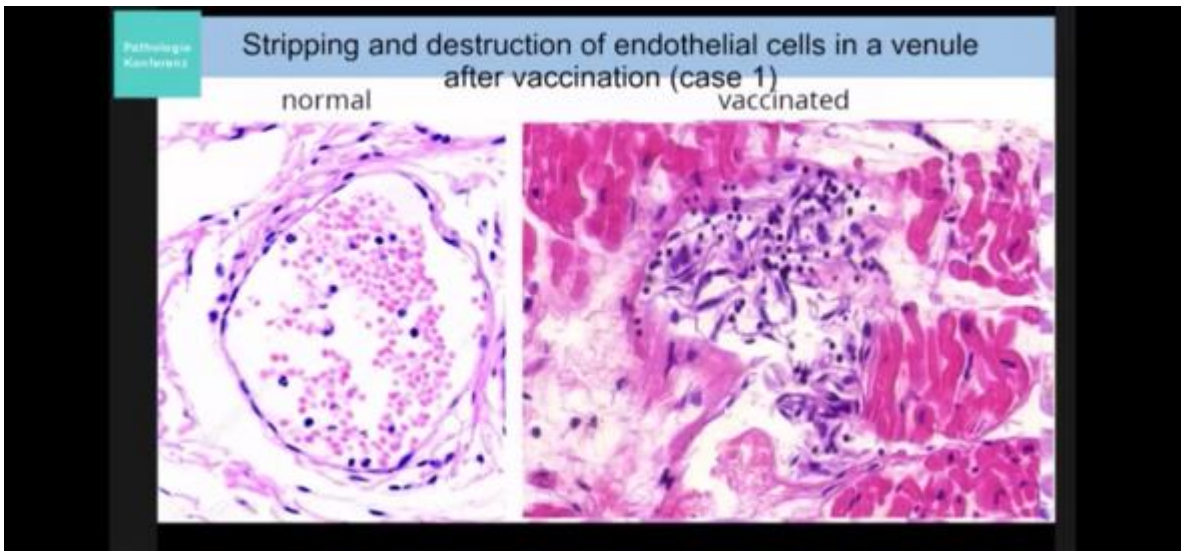
Mechanisms of inflammatory pseudoaneurysm formation:



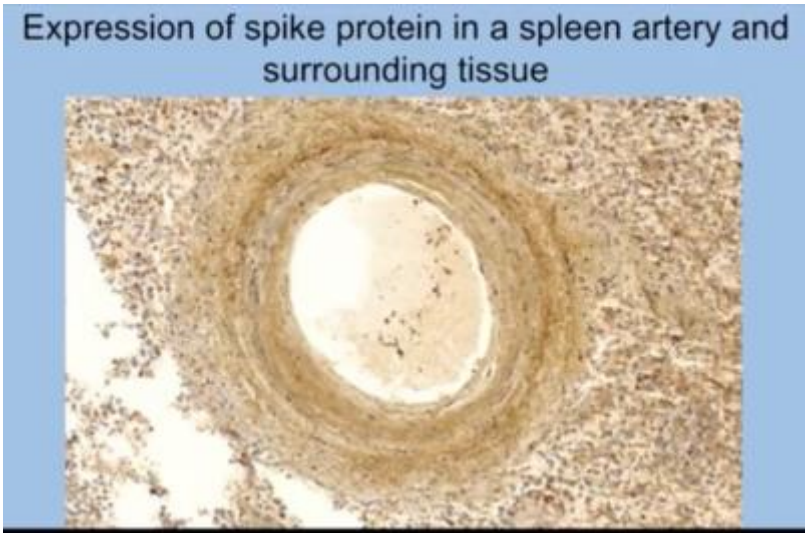

Pathologie Konferenz
Immunohistochemistry can detect the spike protein in individual cells
1. Vaccine enters cell
2. Cell expresses spike protein
3. Spike antibody binds cell
4. Second antibody binds first one
5. Coupled enzyme deposits brown pigment


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 colleague's observations 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 an 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 in 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 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**

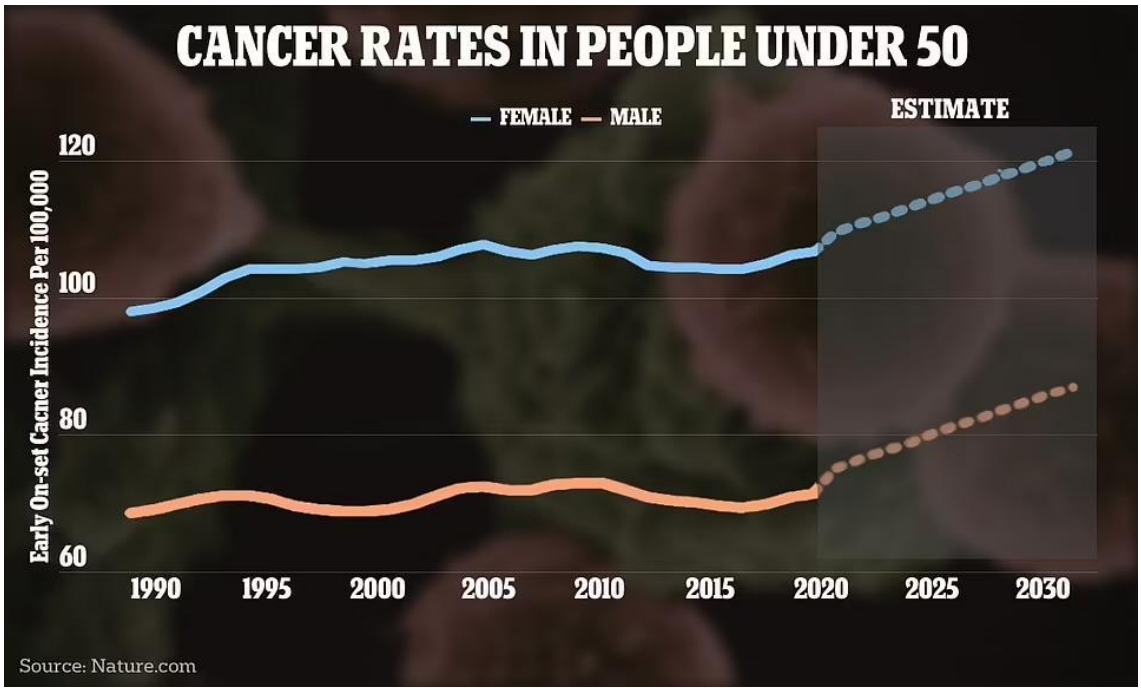
gangrenous) cholecystitis

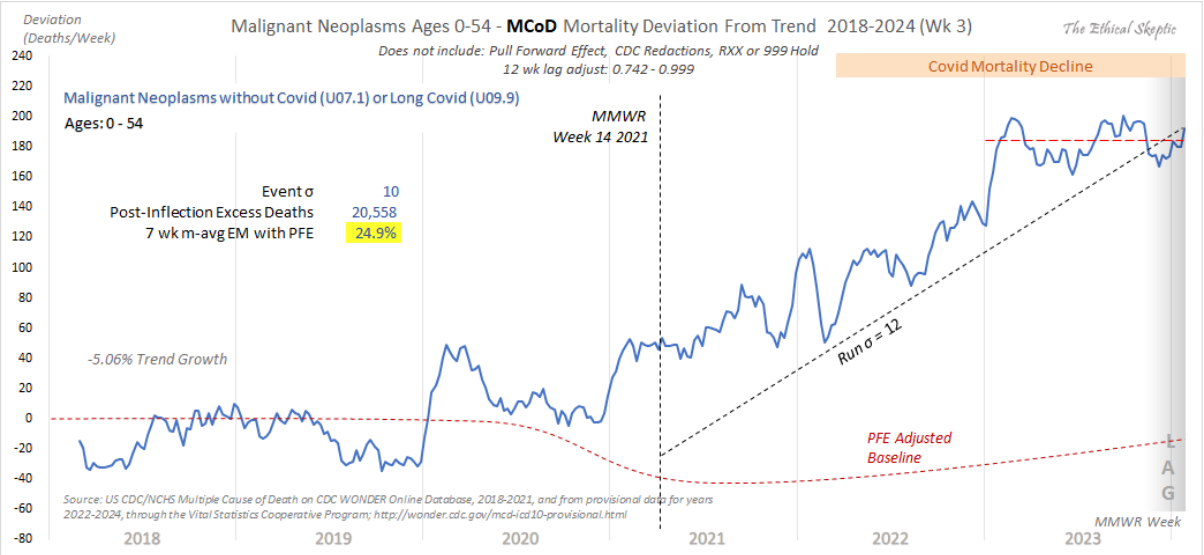
Increased incidence of **'nasty' (severely infected/perforated/gangrenous) appendicitis**, esp. in middle-aged patients; this is unusual; classically there is a bimodal distribution in appendicitis; in children and up to mid-20s and then in the elderly. Also, a notable increase in appendix cancers (considered 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 "turbo cancers". Despite recent articles claiming the sudden growth in cancers is not new,[47] there is a clear inflection point that occurred in 2021, shortly after the roll-out* which continues to climb alarmingly away from the previous trend.

The following robust study recently published, from Japan, 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 UK we are seeing a significant increase in colorectal cancer mortality since the vaccine roll-out. [48],[49],[50]



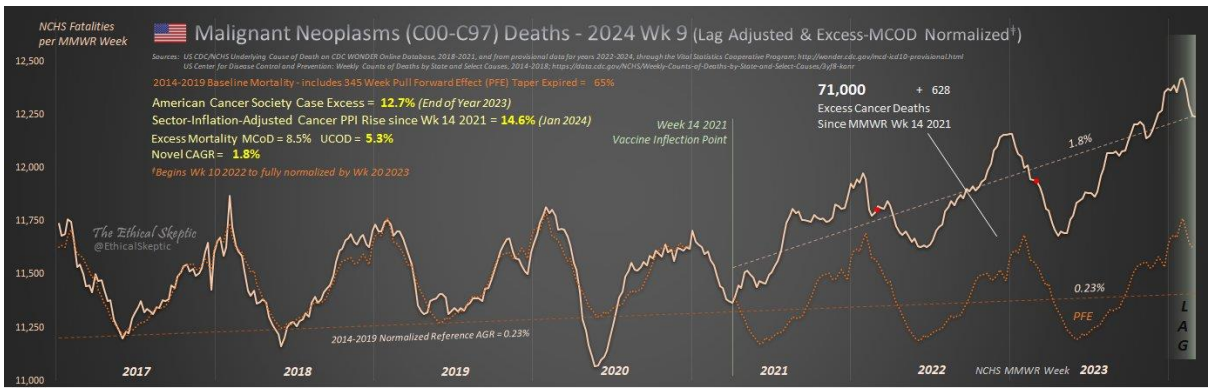


The cancers being observed are in all ages. It is my assertion (shared by many expert oncologists and clinical colleagues around the world) that the cancers we are seeing are aggressive and of a different biology.

In younger ages, a dramatic increase in presentation and diagnosis; through 2021 (5.6% increase), 2022 (7.9%) in the analysis below.[51],[52]

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.[53]



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.[54],[55],[56]

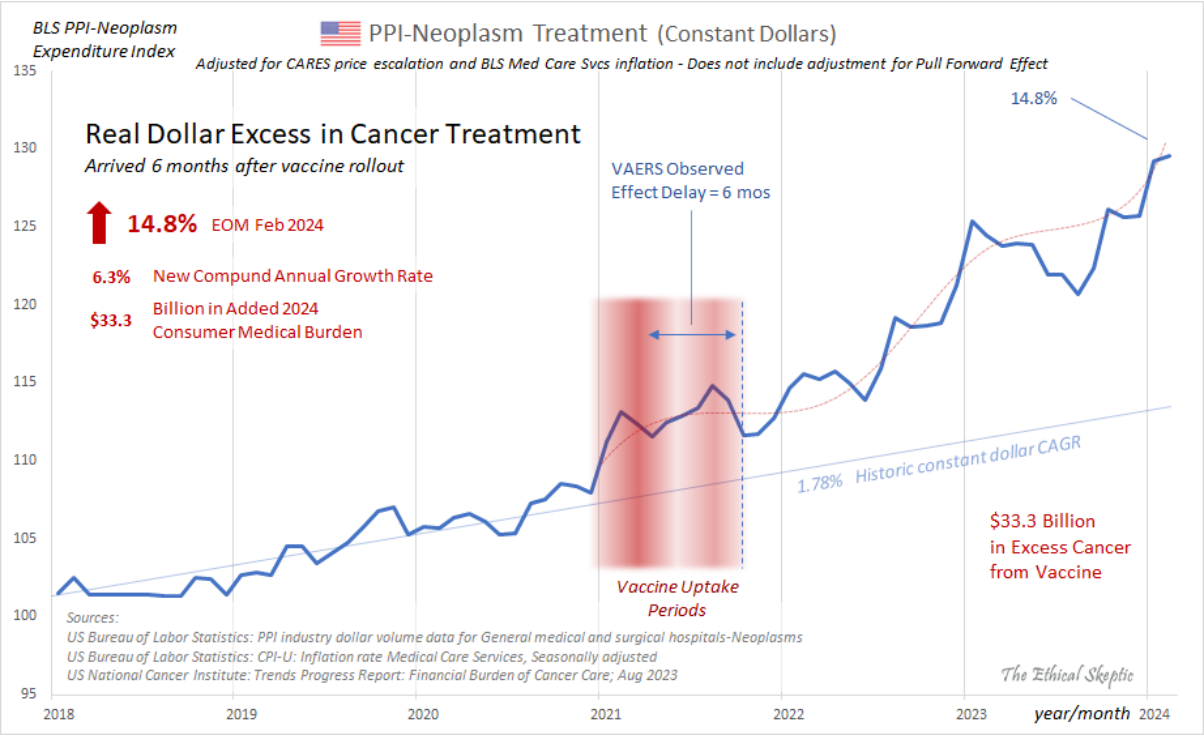
In 2022, I operated on two young men for colorectal cancer, both in their mid-30s. Thankfully, both remain in remission to date. One of them required an emergency operation, but fortunately I was able to remove the mass with clear margins, with a second operation later to close his necessary colostomy. 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?

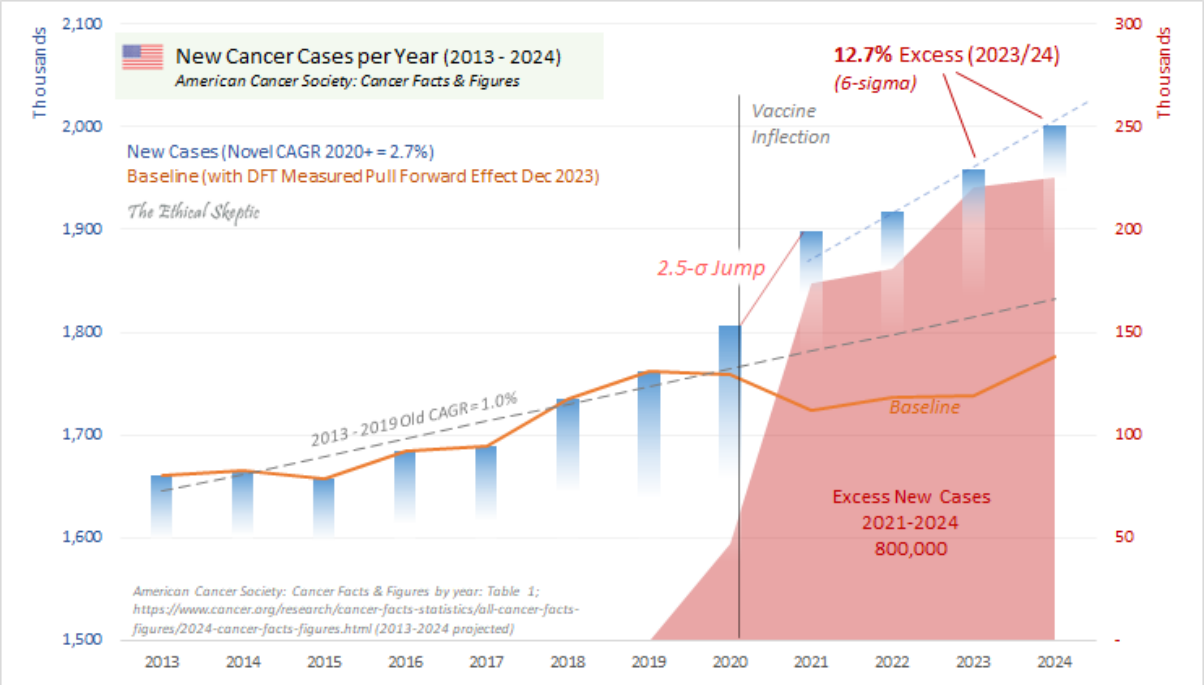
2. Western ultra-processed diet, obesity and sedentary lifestyles?

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.

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 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).





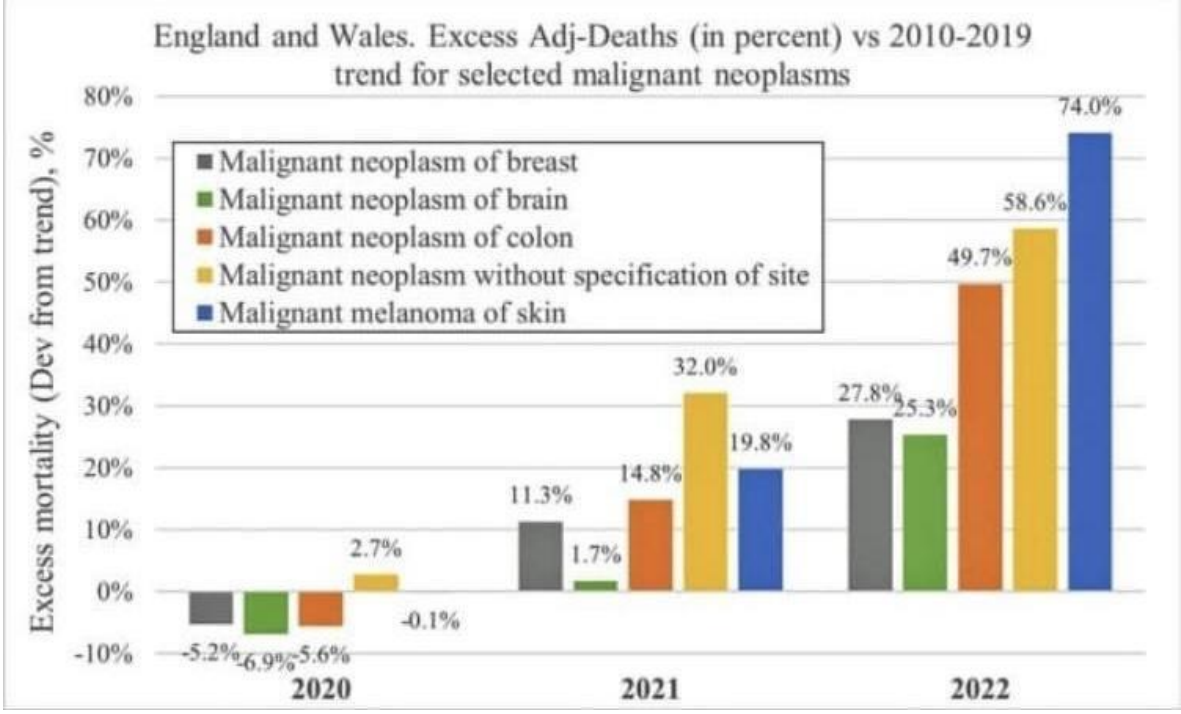
4. Close temporal association of the increase in cancers and rollout of population wide mRNA covid-19 vaccinations

This evident correlation fulfils at least eight of the nine Bradford-Hill epidemiological criteria for causation (see Appendix D).[57]

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 elsewhere in this document (section 4.4, and in both Professor Angus Dalgleish's statement, and Dr Ryan Cole's evidence) and have been discussed on numerous international calls.[58]

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 experience and are in agreement of 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 locally to my own consultant colleagues in a formal meeting in December 2022, I received mixed responses. The majority of colleagues appeared to be in stunned silence; a few were understandably quite defensive and challenging of my views; others were supportive and acknowledged my observations might be related. More recently in my departmental morbidity and mortality meetings, there has been 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.[59]) - at the end I was congratulated on my perceived courage at 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.

B.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?!

B.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?

B4 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 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 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. Any questions concerning 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 NHS's handling of the Covid 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.

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.

B5 Accident & Emergency

5.6.1 Dr. Scott Mitchell, MD

This statement is based on a presentation I gave entitled, 'What is the Truth?' Presentation to the **Covid 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:

i. Pandemic mortality
ii. Measures taken – were they appropriate and proportional?
iii. The vaccine solution?
iv. Ability to raise concerns and censorship?
v. 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)[60] 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)[61]
- Early treatment and targeted protection, as per 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[62] 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

B5.6.2 Anonymous contribution - Sudden / unexpected deaths in staff

"During the covid '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 period prior to 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…"

B6 General practice

B.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 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 and my patients harmed by the covid 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%.[63] 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. One lady I work with thought that 30% of the

population had already died of covid, 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 health care 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 test, followed by a death that may or may not have been caused by covid), 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, 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 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, that may then kill her. Sadly, there were many, many cases of patients just too scared of covid 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 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 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

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 give antibiotics or steroids for secondary bacterial infections. All respiratory symptoms were considered to be due to covid until proven otherwise, and you were not given access to a doctor if you had covid 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 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 death (if anyone in the care home had tested positive for covid). 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 of the damage of lockdowns were dismissed as uncaring for people dying of Covid. 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, 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." [64]

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 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 than those with a high vitamin D level. [65,66,67] I have included a quote from one of these studies below. [68]

"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 roll out. 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 vaccines. Someone else I know developed serious thrombocytopenia after the vaccines, but he was not told it was 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. He was so scared of covid that another very serious life-threatening condition seemed nothing to him compared to his fear of death from covid.

A friend of mine, not too long after her covid 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 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 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 the 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 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 and 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 roll out. 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 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 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 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 contracting covid, 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, 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 that 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, but they still pushed the governments to mandate the vaccines. If the vaccines do not prevent the spread of covid, 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. 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 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 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 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 vaccines, there is something different.

I've also been concerned about vaccination in pregnancy and submitted a rapid response in the BMJ[69] and co-signed this letter. [70]

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.[71]

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.

B7 A Generalist's perspective

Dr Tim Kelly, MB BCh, PGCert Clin Sci, Locum Junior Doctor & Systems Analyst

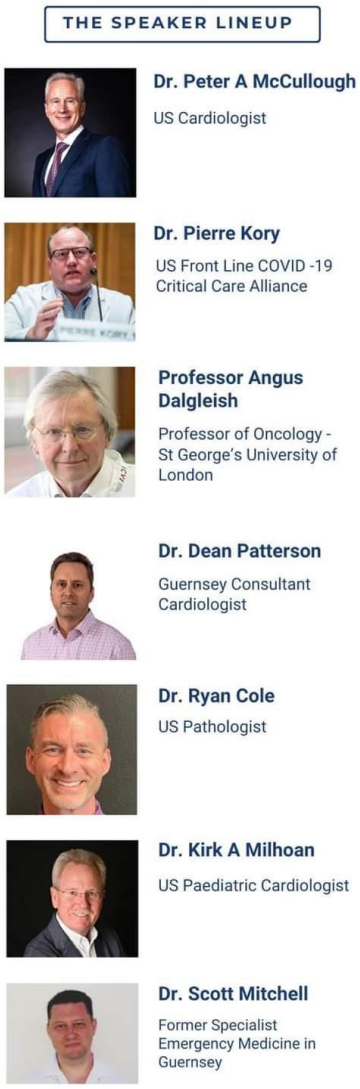
APPENDIX C

THE DEVASTATING HEALTH CRISIS IN THE CHANNEL ISLANDS

& AROUND THE WORLD

C.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, 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.[72]



C.2. Dr Ryan Cole, Consultant Pathologist, transcript of 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, 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 going to 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 shots. I know everybody has covid 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 going to 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.[73] 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.[74] 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,[75] we still don't know 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.[76] 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.[77] And causes autoimmune diseases.[78] 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.

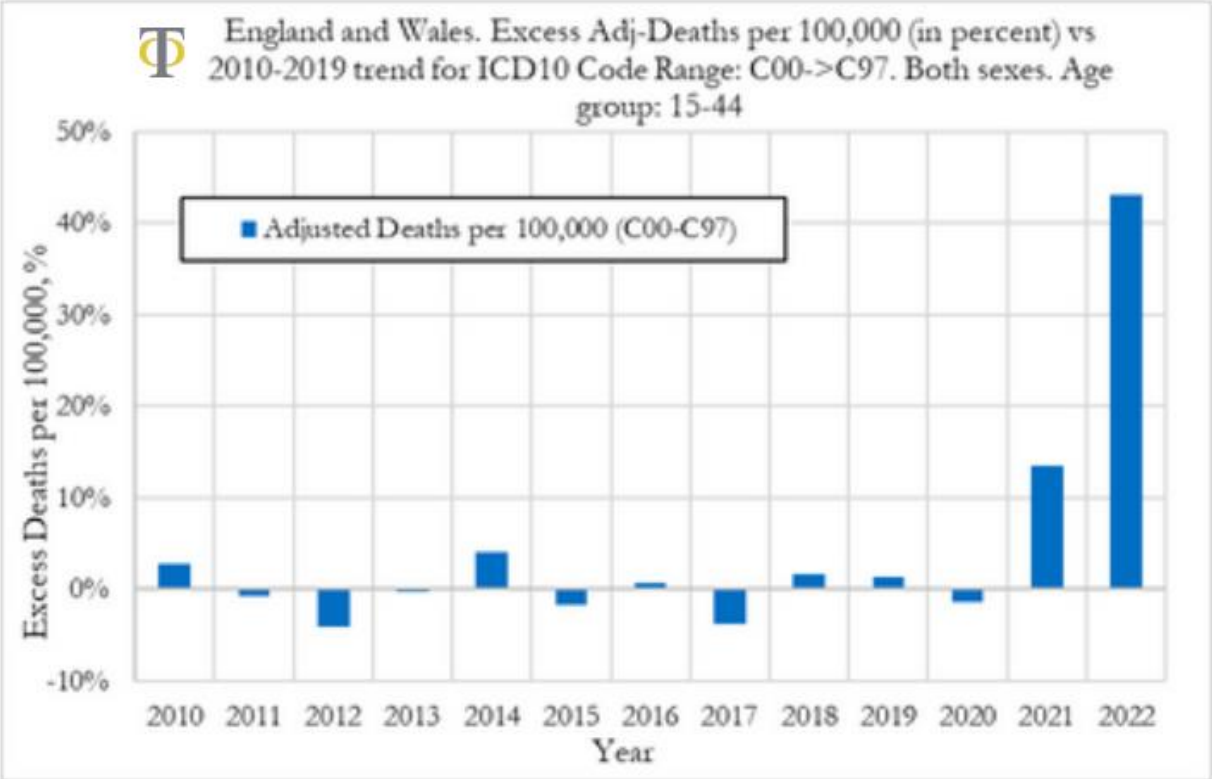
Several increases in rupture of the biggest vessel in your body, the aorta and forms unusual amyloid rubber clot like proteins.[79] I've been working with some analytical chemists. We're going to have a paper coming out in the next couple of months. I think we know exactly what's causing these fibrous 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.[80] 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. [81]



C.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 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 than 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 was built had serious flaws. I requested information from the head of pathology at the PEH as to the accuracy of the covid 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 or indeed exclude covid. Guernsey has run many covid 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 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*

   I. *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?*

   II. *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*

   III. *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 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.*

   IV. *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 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.*

   V. *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.*

VI. *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.*

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

VIII. *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 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

misinformation 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 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 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 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 yr 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 yr 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 yr 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 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 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 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 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[82]) shows significant side effects based upon this known under reporting.

Cardiologists in the main, continue to blame Covid itself as the cause for the harms I am seeing, however I have not diagnosed a single case of post covid myocarditis prior to the vaccine rollout in Guernsey. The UK government website from 2021 to date, states that covid causes myocarditis. The evidence they list for this was flawed. One study they use as evidence by Buckley et al[83] concluded that myocarditis had a prevalence of 5% in covid 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 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, 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 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 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 University College London long covid 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,[84] which erroneously concluded that 78 of 100 subjects recovered from mild covid 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 D: 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

Fetal hemophagocytic lymphohistiocytosis with intravascular large B-cell lymphoma following coronavirus disease 2019 vaccination in a patient with systemic lupus erythematosus: an intertwined case. *Ueda Y, Sakai T, Yamada K et al.* April 2024. https://doi.org/10.1080/25785826.2024.2338594

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 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/1781034789325177338

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