Mounties For Freedom

Standing Together for the Charter of Rights and Against Mandatory Vaccines

Open Letter to RCMP Commissioner Brenda Lucki

RCMP National Headquarters
73 Leikin Dr
Ottawa, Ontario K1A 0R2

October 21, 2021

Dear Commissioner Brenda Lucki:

We respectfully submit this open letter to express our most sincere concerns and resolute stand against the forced coercive medical intervention of Canadians, and against the undue discrimination experienced by those exercising their lawful right to bodily autonomy. We are not against vaccinations, but as law enforcement officers, we cannot in good conscience willingly participate in enforcing mandates that we believe go against the best interests of the people we protect.

EXECUTIVE SUMMARY

As Canadians, our constitutionally-protected freedoms precede the government, and may only be temporarily limited if the majority of evidence justifies such infringements as reasonable, provable, and guided by law. If presented with all available evidence in a court, we firmly believe the government implemented mandates would not hold up under scrutiny.

As experienced investigators, we look past *what* information is provided and focus on *how* the information is presented. A proper investigation should be conducted as objectively as possible, and follow the principle that it is better to have questions that cannot be answered than to have answers that cannot be questioned. A complete investigation must include full disclosure of all the facts of the case, even contradictory evidence. Why, then, is there little to no tolerance for free and open debate on this matter? Many credible medical and scientific experts are being censored. Accordingly, we rightly have concerns about "the science" we are being coerced to "follow".

As representatives of our communities within the RCMP and representatives of the RCMP in our communities, we have never witnessed such division in our country. This sense of "Us versus Them" will be further fueled by having a police force consisting only of "vaccinated" people, while serving communities consisting of "unvaccinated" people, which goes against the community policing model the RCMP has strived to achieve.

As law enforcement officers, we already face higher levels of stress and mental illnesses due to the nature of our work. These have been compounded – considerably – by mandates that we believe are deeply unethical, threatening our livelihood, and dividing society.

As federal employees, what is being done to mitigate this stress? Moreover, what assurances are we given that the injections will not cause short or long-term side effects? What steps will be taken to ensure members are compensated for adverse side effects?

Police officers are expected to preserve the peace, uphold the law, and defend the public interest. We strongly believe that forced and coerced medical treatments undermine all three and, thus, contradict our duties and responsibilities to Canadians. We remain loyal to the Charter and Bill of Rights and ask you to send investigators to collect statements from medical professionals (and other reliable witnesses) who allege they have been silenced – putting lives at risk. Allow us to make this information publicly available to all so the public can scrutinize it and achieve informed consent.

ABOUT US

This letter was created from the collective thoughts, beliefs, and opinions of actively serving police officers of the Royal Canadian Mounted Police (RCMP) from across the country. We have a wealth of experience which includes, but is not limited to, General Duty, Federal Serious and Organized Crime, School Liaison, Prime Minister Protection Detail, Emergency Response Team, Media Relations, and Combined Forces Special Enforcement Unit. We come from various ranks, levels of experience, communities, cultural backgrounds, religious beliefs, and vaccination statuses. Together we are the Mounties for Freedom. We are individual police officers who united in the belief that citizens, including federal employees, should not be forced and coerced into taking a medical intervention.

OUR STANCE

In August 2021, Canadian Prime Minister Justin Trudeau announced, “Federal public servants need to be fully vaccinated,” and that for those without a medical exemption who choose not to be vaccinated: “There will be consequences”[1].

Since that statement, many federal employees have been told they will be sent home without pay for refusing to receive a contested medical treatment. We have united in the belief that people should not be forced or coerced into receiving the current COVID-19 treatments – it should be voluntary. We stand united against the forced and coerced medical intervention of Canadians and against the discrimination faced by those who have exercised their right to bodily autonomy. We believe in democracy, the Canadian Charter of Rights and Freedoms, and the Bill of Rights.

This is not about whether people should be vaccinated – that is a personal choice.

THE LAW

Our primary duty as peace officers in the RCMP is the preservation of peace[2]. We have never witnessed the level of division in our country as we currently see from the COVID-19 pandemic. It is our responsibility, now more than ever, to make all efforts at preserving the peace in our country.

The Charter of Rights and Freedoms (the Charter) protects fundamental rights and freedoms essential to keeping Canada a free and democratic society[3]. The Canadian Bill of Rights adds, “… the Canadian Nation is founded upon principles that acknowledge … the dignity and worth of the human person and the position of the family in a society of free men and free institutions.[4]” It continues to say, “Affirming also that men and institutions remain free only when freedom is founded upon respect for moral and spiritual values and the rule of law.[5]”

We believe our federal and provincial governments have failed to uphold the Charter, Bill of Rights, and Constitution and we are witnessing the erosion of democracy in Canada. As you know, the Charter does not guarantee absolute freedoms. If the government is going to limit freedoms, it must establish the limitations are reasonable given all available facts. The government must adhere to a process to prove their actions are appropriate, called the Oakes test. We firmly believe, if presented with all available evidence in a court, the government implemented mandates would not pass the Oakes test. At the time of writing this letter, the Charter's section 33 Notwithstanding Clause has not been invoked for this pandemic.

Requiring mandatory COVID-19 treatment options is a slippery slope and allows the government to overstep its authority unchecked. It infringes on the fundamental belief in our society that the individual has the right and freedom to choose. The choice of whether to receive medical treatments has always been an individual's right in Canada. The Canadian National Report on Immunization (1996) stated "Immunization is not mandatory in Canada; it cannot be made mandatory because of the Canadian Constitution.[6]" Section 2 of The Charter guarantees these fundamental freedoms through the freedom of conscience (subsection a) and the freedom of thought, belief, opinion, and expression (subsection b)[7]. Without individuals having the freedom to choose, we would not have a democratic society.

Though the Nuremberg Code is not a law, it is internationally accepted and falls in line with the spirit of our Charter and Bill of Rights. A key component of the Nuremberg Code is that participants in a medical experiment need to participate voluntarily without any form of force or coercion[8]. We have obtained documentation from several Canadian doctors who have explained the current COVID-19 treatment options in Canada, being referred to as "vaccines", were recently authorized as new drugs despite the absence of long-term data[9]. According to these accredited Canadian doctors, these treatment options did not meet the criteria of true vaccines until very recently when the definition of vaccine was changed[10,11]. Without long-term data, these vaccines are still experimental. We believe the act of removing the rights and freedoms of citizens who refuse to participate in specific COVID-19 treatment options is a form of coercion.

The Criminal Code contains our country's Criminal Offences and explains that a person commits an assault by intentionally applying force to someone else without that person's consent[12]. The Criminal Code further explains that consent is not obtained from a person who submits, or neglects to resist, on the grounds of authority being exercised over them[13]. How then can someone give proper consent to a COVID-19 treatment injection when doing so under the threat of losing their job, freedoms, or livelihood? Canadian courts have already ruled that medical treatment without proper informed consent is an assault[14].

As law enforcement officers, we cannot in good conscience willingly participate in enforcing mandates that violate the laws of our country and breach the rights and freedoms of the people we protect.

LEST WE FORGET

Each year, on the 11th of November, we remember those who sacrificed their lives for our freedoms. From Flanders Field to Juno Beach, many Canadians have bled and died fighting tyrannical nations. We need to remember past events to prevent the repetition of history's greatest mistakes.

On the 30th of September, we had the opportunity to reflect on such times during our first National Day for Truth and Reconciliation. Under the direction of the Government of Canada, RCMP members were once issued lawful orders to remove children from their homes and transport them to residential schools. Canada is still recovering from the impact of those decisions and actions. The RCMP has yet to regain the trust of some citizens.

There was a time when scientists believed humans were divided into racial hierarchies and that a person's intelligence level and characteristics were determined by race[15]. These beliefs were not heavily contested and were widely accepted as scientific fact[16]. Phrenology was also widely accepted as being a legitimate scientific study[17]. These are not examples of science being wrong but of people conducting poor investigations or misunderstanding their findings. These are just two of several historical examples of widely accepted scientific truths, which became ridiculed practices.

We look back at those times of racial hierarchy and wonder how something so wrong could have been so widely accepted as truth. It is just as hard for many people to conceptualize how RCMP officers could have blindly followed lawful orders that devastated so many lives. Yet now we find ourselves in dangerous waters, when RCMP officers are being forced under coercion and duress to participate in actions they believe go against the spirit of Canadian laws.

We find it ironic that an organization that preaches the honour and respect of Canadian values, and the sacrifice of their veterans, would support actions that contradict the values our veterans fought to uphold. Enforcement of identification and checkpoints was an early step in what would become the Holocaust. Canadian citizens of various backgrounds are being segregated and punished for choosing not to disclose a personal medical decision. We cannot think of a more ironic and cruel way for our governments to pay homage to the sacrifices Canadians have made worldwide to protect individual freedoms than by participating in a process that takes those freedoms away.

Today, instead of having one version of scientific "truth" during this pandemic, we have versions that contradict one another. How can some professionals be so certain their interpretation of science is correct when others give evidence to the contrary? History has already demonstrated we get things wrong even when our scientists agree.

We acknowledge there is a spectrum filled with beliefs relating to this pandemic. For the sake of simplicity, we will refer to two main schools of thought: the common narrative (those who believe the current COVID-19 treatment injections are *the* way through the pandemic) and those who have concerns with the COVID-19 treatment injections. It's important to note we are not discussing "anti-vaxxers" in this letter. We are discussing people with various vaccination statuses who pose questions about the current COVID-19 treatment options being forced upon them.

THE SCIENCE

RCMP members are not scientists nor healthcare professionals; our profession is law enforcement. We do not pretend to be experts in medical or scientific fields, but we are experienced and professional investigators: we look for the facts. Proper investigations follow simple practices that remain consistent across most fields. These practices include but are not limited to: asking the right questions, following evidence, being aware of how biases may affect results, and allowing the evidence to point to the conclusion – not allowing the conclusion to point to the evidence. Most importantly, a proper

investigation should be conducted as objectively as possible and follow the principle that it is better to have questions that cannot be answered than to have answers that cannot be questioned. A complete investigation must include full disclosure of all the facts of the case, even contradictory evidence.

The COVID-19 pandemic has caused several scientists and medical professionals to provide us with information they described as “science”, “scientific”, or “facts”. The problem with many of these statements is that the provided information often contradicted another piece of “scientific fact” that an equally qualified professional had produced. This makes it near impossible for the average person to know what to believe and what not to believe.

As experienced investigators, we look past what information is provided and focus on how the information is presented. This allows us some insight into the credibility of the information. Some professionals make definitive statements such as “It’s safe and effective” or “This is the way”, giving little or no explanation of how they reached their conclusion. When the information provided is challenged or questioned, the response often indicates the answer is something that cannot be questioned. The CDC recently changed its definition of immunity and vaccine[10,11], allowing the current COVID-19 treatment injections to fit the definition. This is an example of actions taken when you allow your conclusion to point to your evidence.

Other qualified professionals have provided alternate pieces of information during this pandemic. It is not *what* their results were, but *how* they arrived at their results that we believe in. These professionals have all been able to articulate their findings quite well and are quick to admit the remaining questions they cannot answer. These professionals (from Canada[18] and abroad[19]) have expressed warnings and concerns with the current COVID-19 treatment options condoned by the governments. Some of these concerns suggest a higher-than-average number of moderate to severe side-effects from the COVID-19 “vaccinations” compared with our traditional vaccinations[19]. Others have stated the current COVID-19 treatment options are proving to be less effective than initially believed[20,21].

We have attached several documents as appendices to this letter which contain information we believe raises reasonable concerns with the current COVID-19 vaccination mandates seen across our country. We encourage you to review the documents and the work each document references thoroughly. Though we understand we have provided a lot of material - which will take time and resources to read - we believe the fact that there is so much evidence opposing the mandatory roll-out of the current COVID-19 treatments is reason enough to take our concerns seriously.

There have also been scientific papers that suggest natural immunity is a better form of protection than what the COVID-19 vaccination can give[21-24]. Why is antibody testing not being discussed as a potential option for RCMP members?

Here is a list of the documents we’ve attached to this letter. These documents are a sample of what is available and were written by people (or groups) of scientific or medical professionals in fields directly related to the COVID-19 pandemic. We defer to their expertise.

- Appendix A – This is an open letter from Dr. Eric Payne, a pediatric neurologist in Alberta, to the College of Physicians and Surgeons of Alberta. In his letter, Dr. Payne highlights several inconsistencies he has found with the common narrative. Dr. Payne provides several sources from around the world throughout his letter.

- Appendix B – This is the Canadian Covid Care Alliance Declaration. This heavily sourced document provides information on the current pandemic and makes recommendations based on their findings.

- Appendix C – This is a letter from Dr. Byram Bridle, a viral immunologist in Ontario, to the President of the University of Guelph. Dr. Bridle uses his extensive experience and qualifications to explain his concerns with the common narrative surrounding the COVID-19 treatment injections. Dr. Bridle also articulates his concerns with the COVID-19 health mandates.

- Appendix D – This is an open letter from Health Professionals United to the Alberta Health Services. The letter outlines reasons why several frontline healthcare workers in Alberta heavily oppose mandatory COVID-19 vaccination mandates.

- Appendix E – This is an open letter from frontline healthcare workers in British Columbia to Dr. Bonnie Henry, Adrian Dix, and Premier John Horgan. The author(s) state their experiences and expertise are being ignored and ask that the vaccination mandates be revoked.

- Appendix F – This is a report from Dr. Tess Lawrie from the United Kingdom. Dr. Lawrie demonstrates the abnormal number of reported adverse effects from the current COVID-19 treatment injections.

- Appendix G – This is a comprehensive report comparing natural immunity to COVID-19 vs Vaccine-Induced Immunity. It was comprised from several scientists from Ontario and British Columbia.

CENSORSHIP

We are not against vaccinations, and we are trying to aid our country through this pandemic. We want to participate in a way that is safe for both our physical and mental well-being. We believe it is essential for people to participate with full informed consent by understanding all the risks of what they are being asked (or in this case forced) to participate in.

As experienced police officers, we have become accustomed to the media portraying us negatively or experienced the media misrepresenting the outcome of a police incident. It would be little to no surprise for us to hear that a media agency misreported an incident. However, it was surprising for us to learn that several of these scientists and doctors, who questioned the information fueling the COVID-19 treatment mandates, also spoke of censorship[25-27].

As experienced investigators, we know it is our responsibility to present all available facts to the public - by proxy of the courts. It is not our place to decide what the outcome of an investigation should be. Our job is to collect all available facts so that the public (the courts) can make an informed decision. We have learned from past mistakes that presenting evidence that only supports one side, while ignoring or refusing to acknowledge evidence from another side, is wrong and tarnishes an investigation. We cannot provide evidence from witnesses who agree on one story while ignoring or hiding the witnesses who agree on a different account of an incident.

It would be unthinkable that RCMP members would blatantly disregard witnesses in an investigation to mislead the courts. The investigation would lose all integrity and the members would be criticized. Why then are we allowing this same behaviour to occur by other public figures? There are accredited medical professionals from our own country who are desperately trying to have their findings heard. Instead of allowing these professionals to speak freely and discuss their results publicly, they are being silenced by governing bodies[25-27].

Our experience in law enforcement and as investigators have allowed us to see how crucial it is that these professionals be allowed to speak openly and publicly. Without the information being included in discussions, we believe the citizens of Canada (including RCMP members) are not receiving the information they need to make an informed decision. This is contrary to our laws and beliefs, and we do not support it.

These medical professionals have tried to stand up and support their country. We are now standing up and supporting them. They must be allowed to share their information publicly to maintain people's faith in the government. If the people believe the government is continuing to censor experts, the country will fall into instability. This is common around the world in countries whose tyrannical governments sensor information from their people.

DISCRIMINATION

We strongly oppose the discrimination that has already begun to create segregation in our country. It has divided families, ended friendships, torn apart spouses, and entered the RCMP workplace. We believe the current messaging being put out by our provincial and federal governments is promoting the creation of an in-group referred to as "Vaccinated" and an out-group as "Unvaccinated". Even worse, the out-group has been labelled "Anti-vaxxers," a term used out of context in a negative and derogatory way. The messaging from our governments is causing the dehumanization of the "Unvaccinated" group. By dehumanizing the out-group, an institution creates a greater divide between them and the in-group.[28]

Police agencies across Canada pride themselves in their efforts to hire officers reflective of the communities they serve. This allows community members to relate to their officers and see them as part of the community. We are representatives of our communities within the RCMP and representatives of the RCMP in our communities. Having a police force consisting only of "vaccinated" people while serving communities consisting of "unvaccinated" people will tear down some of the similarities RCMP members share with their communities. This will create a greater sense of "Us versus Them" between communities and police, which contradicts the community policing model the RCMP has strived to achieve for decades. We anticipate that unless this is corrected soon, it will continue to increase the divide in our country.

Dehumanizing individuals is challenging. It is easier to attach a label and stigma to a group. That way, anyone or anything that comes from the group can be written off[28]. The term “Anti-vaxxer” is currently being used to mislabel and group people into a category to take away their credibility. This has allowed things to be written and said against this group that would be intolerable if written or said about any other group.

On August 26th, 2021, the Toronto Star ran an article that read in large bold letters, “I have no empathy left for the wilfully unvaccinated. Let them die. I honestly don’t care if they die from COVID. Not even a little bit. Unvaccinated patients do not deserve ICU beds. At this point, who cares. Stick the unvaccinated in a tent outside and tend to them when the staff has time.[29,30]” If “willfully unvaccinated” was replaced with “Black”, “Gay”, or “willfully Muslim”, this would have been labelled a Hate Crime. How then can we allow such things to be said about people who choose not to receive a medical intervention? Should we allow the same messaging for those who choose not to get a flu shot one season?

The boldness of this statement being printed in a major newspaper shows how acceptable it is in our society to treat people as a lower class of citizens. As RCMP members, we must preserve peace in our communities and put a stop to this.

PHYSICAL AND MENTAL HEALTH

This pandemic has increasingly made people feel isolated from their friends, families, and peers. RCMP members already face higher levels of stress and mental illnesses due to the nature of our work. Members affected by the double-vaccination mandate have faced greater stress and isolation as they have watched their status as citizens and regular members begin to diminish. There is currently insufficient support for these members, and there does not seem to be a plan insight to provide adequate support.

The recent vaccination update has left some people feeling more isolated than ever. In times like this, people need support from a community, and our membership is no different. We fear there are more members afraid to speak up about these recent updates for fear of being targeted. Many members may be trying to stick this out on their own, or worse, suffering in silence. We ask that you attempt to reach out in partnership with the NPF to all members who may be negatively affected by these mandates and let them know their employer and governments support them.

Though most people seem to have little to no side effects from the COVID-19 treatment injections, an abnormal number of moderate to severe adverse reactions have included death[31]. What assurances are we given that the injections will not cause short or long-term side effects? Studies show that stress and sleep can play a huge factor in whether a vaccine is effective or not[32,33]. Are you ensuring RCMP members are provided with the appropriate amount of rest before an injection? What steps will the RCMP take to ensure members are compensated for adverse side effects?

We also believe enough evidence has been presented to question whether our governments’ actions in this pandemic are the most appropriate. This is causing moral and ethical stressors for some members as they no longer believe their role as police officers is reflective of the democracy Canada claims to be. Mental health and stress levels will have an impact on how members interact with the public.

PARALLELING DOMESTIC VIOLENCE

The RCMP has taught us the importance and severity of domestic violence. Domestic violence is centred around power and control between an abuser and a victim. One of the biggest problems with domestic violence is there is often an escalation in the severity of abuse. RCMP members have been taught how to identify the signs that someone is involved in an abusive relationship. There are different types of abuse the abuser may engage in to keep control over their victim: Physical, Financial, and Emotional.

Emotional abuse is quite complex and will often include a variety of tactics such as socially distancing the victim from friends and family, discrediting the victim so they have difficulty obtaining support from others, and making the victim believe that their thoughts and beliefs are wrong – to the point the victim thinks they must be insane. When it comes to finances, an abuser will withhold money and assets from the victim. This ensures the victim cannot survive without remaining in the abusive relationship with the abuser. When an abuser feels they are losing control over their victim, it is quite common for them to escalate their tactics to maintain control.

The federal government is currently displaying several of those traits with its own employees, including the RCMP[34].

Commissioner Lucki, we understand your position is appointed, and we are concerned that you too may be subject to a similar relationship with the Prime Minister. Though you, as our top Mountie, should be impartial, you may be forced into supporting some of these actions out of duress. We ask that you do what we ask our domestic violence victims to do - to take a stand against the abuser. This country needs strong and supportive people in positions of authority. Please show Canadians that the RCMP will remain impartial to political agendas and true to the Charter and our Bill of Rights.

PUBLIC INTEREST

Lastly, we want to draw attention to the public safety issues that will arise if these COVID-19 mandates are upheld.

Pierre Elliot Trudeau once said, "There's no place for the state in the bedrooms of the nation.[35]" How is it our federal government is now saying it will be mandatory for employees working from home to receive the COVID-19 treatment injections?[36]

Regardless of their vaccination statuses, there are RCMP members who feel the steps taken by the federal and provincial governments are too extreme and do not have the best interest of Canadian citizens. Forcing these mandates will cause several RCMP officers to lose faith in the federal government's commitment to the Charter. These RCMP officers will not participate in actions they believe contradict their morals, ethics, and Canadian laws. These RCMP officers believe it is their responsibility to challenge the federal government in court if necessary.

The RCMP, which is already understaffed, will have additional gaps to fill across the country when these members are not working. Communities will have lost healthy and experienced officers, causing a decrease in available resources. There will also be an increase in taxpayers' spending as the federal government attempts to fill these gaps. Being short-staffed will have a trickle-down effect causing fewer RCMP bodies to be available to properly recruit, assess, and conduct adequate background checks on potential cadets.

Our experience in law enforcement and as investigators have allowed us to see how crucial it is that professionals be allowed to speak openly and publicly. Without including their information in discussions, we believe the citizens of Canada (including RCMP members) are not receiving the information they need to make an informed decision. This is contrary to our laws and beliefs, and we do not support it.

We want to reiterate a point stated earlier in this letter, so it is remembered. If the people believe the government is continuing to censor experts, the country will fall into instability. We are experts in law enforcement and investigations. We are losing faith in the motives of our government, and we will not willingly participate in actions against people whose Charter rights and freedoms are being violated.

CALL TO ACTION

Commissioner Lucki, we ask that you represent the best image of the RCMP by remaining loyal to the Charter and Bill of Rights and not to any particular public figure. Our job as Mounties is to preserve the peace. If we continue down this road of segregation and discrimination, we risk repeating past mistakes. The divide in our society is quickly leaning toward a level of national security. We ask that you open an investigation to ensure no criminal acts were committed in the dissemination of information from federal and provincial health authorities or public figures in positions of trust. We ask you to send investigators to collect statements from medical professionals (and other reliable witnesses) who allege they had been silenced - putting lives at risk. Allow us to make this information publicly available to all so the public can scrutinize it and achieve informed consent. As Canada's national police force, we are unique in our ability to conduct a large-scale cross-country investigation, which must be transparent to regain trust in the government.

We also ask that you challenge the Federal Government's decision to send Mounties home without pay for decisions they've made on beliefs protected by Canadian laws. Neither the RCMP, nor the communities they serve, can endure the loss of experienced police officers.

We await your response and your plan of action.

Respectfully,

Mounties for Freedom

cc. The Honourable Bill Blair, Minister of Public Safety and Emergency Preparedness
The Honourable Jean-Yves Duclos, President of the Treasury Board of Canada
Brian Sauvé, President of the National Police Federation

End Notes

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Appendix “A”

September 14, 2021

College of Physicians & Surgeons of Alberta (CPSA) Council
2700 – 10020 100 Street NW
Edmonton, AB Canada T5J 0N3

Dear CPSA council members,

RE: Mandatory mRNA vaccine mandate for Alberta physicians

Thank you for allowing me to listen Friday morning during council's discussion on a vaccine mandate for Alberta physicians. Let me please provide the perspective of a physician who loves his job, cares deeply about his patients, and continues to avoid the mRNA vaccines. I am a pediatric neurologist and researcher specializing in epilepsy and neurocritical care at Alberta Children's Hospital (ACH). I have a Master of Public Health from Harvard University and before returning to ACH in February 2020, I spent 6 years on staff at Mayo Clinic where I developed expertise in neuroinflammation. Both medical school and pediatric neurology residency were completed here in Calgary. I am also a father of 3 young children and remain ***very much pro-vaccine***. While I refuse to take this novel experimental mRNA therapy, my wife, children, and I are completely vaccinated, including yearly flu shots. This is not a contradictory stance as these current mRNA vaccines represent a dramatic departure from using, for instance, live attenuated viruses. Rather, they represent ***a completely novel and experimental therapy with no long-term data***. Consider that the CDC just updated the definitions of immunity and vaccine on September 1, 2021 - 13 days ago -swapping out the prior “produce immunity” to “provide protection” (1).

On August 31, 2021, AHS President and CEO Dr. Verna Yiu, issued a vaccine mandate to all staff, physicians and volunteers stating, “workers are required to be *fully* vaccinated for COVID-19, by October 31, 2021”. I am now faced with the impending possibility of “an unpaid Leave of Absence to allow for compliance”. ***I am so disappointed by this extreme AHS coercion,*** and truly hope that the CPSA will steer clear of mandating this as a condition of my license. You briefly covered the legal aspects during your meeting and a vaccine mandate would certainly appear to violate individual rights as protected under the Canadian Charter of Rights and Freedoms (2), but under the auspice of a pandemic, the Alberta provincial government is presently circumventing these rights with Bill 10 - the public health emergency powers amendment act (3). Of course, these forced experimental mRNA vaccine mandates also directly violate the internationally accepted Nuremberg code, which was developed in 1947 to protect patients from medical experimentation stating as its first declaration that “*the voluntary consent of the human subject is absolutely essential*” (4). **It is *because* I am informed, that *I do not* voluntarily consent to these injections.**

Despite only 3.6% of Alberta physicians continuing to avoid these shots (per CPSA internal survey), I appreciate that council remains concerned that an “unvaccinated” physician might spread SARS-CoV-2, resulting in possible patient harm and lawsuits to the CPSA. However, by forcing compliance based on the current data, ***you would be stepping on the bedrock principles of medical ethics – especially patient autonomy.*** The willingness to trample individual legal and moral rights in the name of perceived communal benefits, is ***not justified by the current medical science and will cause predictable and unpredictable harms***.

The ***medical evidence demonstrates*** that the effectiveness of the mRNA vaccines has decreased significantly, they do not prevent SARS-CoV-2 transmission or symptomatic disease, and while evidence for protection against serious illness continues to exist in Calgary, that too is dissipating globally. I will discuss that it is the vaccinated driving mutations, not the unvaccinated. I will show evidence that those who have been fully vaccinated generate similar or higher viral loads than the unvaccinated when challenged with Delta, and further clinical data suggesting that this widespread use of a "leaky" vaccine during a pandemic is leading to antibody-dependent enhancement, including evidence that this is already occurring with Delta. I will highlight some of the long-term safety concerns with these mRNA vaccines in the context of available biodistribution data. Finally, I will speak directly to the minuscule possibility of causing harm to my pediatric patients by transmitting SARS-CoV-2.

(1) Even with 100% forced compliance – you cannot eradicate SARS-CoV-2 through vaccination.

- **The initial randomized controlled clinical trial for the Pfizer/BioNtech mRNA vaccine** (BNT162b2), suggested **95% protection against COVID-19**, as defined by their **primary endpoint** "***efficacy of the vaccine against laboratory confirmed Covid-19 and [2 month] safety*"**. This was funded by BioNTech and Pfizer (5, 6). **The initial randomized controlled clinical trial for the Moderna mRNA vaccine (mRNA-1273) showed 94.1% efficacy at preventing COVID-19 illness, including severe disease**. This was funded by the National Institute of Allergy and Infectious Diseases (NIAID) and the Biomedical Advanced Research and Development Authority (BARDA) (7, 8).

- **As the virus continued to expectedly mutate**, **the real-world effectiveness derived from these mRNA vaccines has diminished substantially**. This was expected given these mRNA vaccines contain the genetic code for our bodies to produce the original SARS-CoV-2 Wuhan spike (s) protein/antigen only. It is this s protein which binds ACE2 receptors in our body for cell entry (9). The antibodies we generate in response, are directed towards this original s protein only, and as the s protein has continued to mutate away from the initial Wuhan strain, the antibodies produced in vaccinated individuals are having more difficultly recognizing the s protein of subsequent SARS-CoV-2 strains. While these antibodies demonstrate some cross-reactivity to other SARS-CoV-2 variants, the **decreasing vaccine effectiveness partly reflects mutations to the s protein**. Thus, the "vaccine" has become extremely "leaky" in its ability to recognize subsequent variants.

- Recently, Alberta Chief Medical Examiner of Health, Dr. Deena Hinshaw, shared evidence and publicly acknowledged that we cannot eradicate COVID-19 and are rather ***transitioning from a COVID-19 pandemic to endemic*** (8). This, ***despite widespread adherence to severe social restrictions*** including lockdowns, mandatory masks, prolonged quarantines, repeated testing and school closures, and the widespread gutting of pediatric social activities that allow for appropriate neurodevelopmental growth. Meanwhile, **68% of the Canadian population is now fully vaccinated** (11), **including 71% of eligible Albertans (12)**. These rates are comparative to other privileged countries with widespread access to mRNA vaccines and dwarf those rates among less affluent nations (13). Data suggests that **only 29% of the global population is currently fully vaccinated** (13).

- To date, smallpox is the only human virus successfully eradicated through vaccination and it was less transmissible and lacked an animal reservoir (14). **Even if we were to vaccinate all humans with a 100% effective vaccine, SARS-CoV-2 would continue to survive among animal reservoirs,** including the white-tailed deer (15).

(2) Is it really the unvaccinated driving SARS-CoV-2 virus mutations?

- Those who have received a COVID-19 vaccine presumably have generated antibodies that will detect the s protein of SARS-CoV-2 should it enter their body. While those **previously infected with SARS-CoV-2 have antibodies to the s protein AND other parts of the virus, including the nucleocapsid** (16). If the virus wants to replicate in these individuals it ***needs to mutate to evade destruction***. However, *those who did not receive a COVID-19 vaccine and did not become infected with SARS-CoV-2 presumably lack these antibodies and thus the virus does not need to mutate to enter host cells and replicate*.

- The argument that those without a COVID-19 vaccine are driving mutations then depends on the *notion that if we could achieve herd immunity or eradicate the virus more quickly, we would limit its ability to mutate*, which all coronaviruses naturally do. However, **this second argument fails** given our inability to eradicate SARS-CoV-2 through vaccines, including our inability to vaccinate enough people and animal reservoirs globally to achieve herd immunity (13-15). Moreover, as shown below, the current mRNA shots no longer prevent transmission and COVID-19 vaccinated individuals are comprising an ever-increasing proportion of symptomatic patients (17).

- With widespread dissemination of COVID-19 vaccines during the pandemic, we are **placing enormous evolutionary pressure on SARS-CoV-2 to continue mutating to evade our immune system**, gain cell entry, replicate, and possibly cause illness. And, we are **now using very "leaky" vaccines**, making **viral evasion from our antibodies that much easier**. Only the fit will survive. Consider the reasonable **analogy of antibiotic resistance** – this is driven by the widespread and inappropriate use of antibiotics, not by people avoiding antibiotics (18).

- A group of international experts recently stated in the New England Journal Medicine, "***viral variants of concern may emerge with dangerous resistance to the immunity generated by the current vaccines***" (19). Among their recommendations were: "***avoid the use of treatments with uncertain benefit that could drive the evolution of variants; and consider targeted vaccination strategies to reduce community transmission***" (19).

(3) As the effectiveness of mRNA vaccines to prevent transmission and severe disease continues to diminish – *the medical narrative for a forced vaccine mandate evaporated*.

- On July 30, 2021, the CDC director confirmed that "***Delta infection resulted in similarly high SARS-CoV-2 viral loads in vaccinated and unvaccinated people****. High viral loads suggest an increased risk of transmission and raised concern that, unlike with other variants,* ***vaccinated people infected with Delta can transmit the virus***" (20).

- On August 6, 2021, CDC Director Dr. Walensky stated on CNN: "*Our vaccines are working exceptionally well. They continue to work well for Delta, with regard to severe illness and death -- they prevent it.* ***But what they can't do anymore is prevent transmission***" (21).

- On August 19, 2021, the CDC issued a joint statement advocating for COVID-19 booster shots, citing evidence **that despite full mRNA vaccination, patients were experiencing "*reduced protection against mild and moderate disease*"** (20). This included a very recent U.S. national nursing home prospective observational study which demonstrated diminishing mRNA vaccine ability to prevent infection, with adjusted **effectiveness levels against the Delta variant of 53.1%** (95%CI = 49.1%-56.7%) (22).

- A **Mayo Clinic Health Systems observational cohort study showed that in July 2021** during a period in Minnesota where the **delta variant prevalence** surged from 0.7% to 70% and the alpha strain decreased from 85% to 13%, the effectiveness against hospitalization remained high for Moderna - 81% (95%CI: 33-96.3%) and Pfizer/BioNtech - 75% (95%CI: 24-93.9%) (15). **However, effectiveness against infection** was lower for **Moderna - 76%**, (95%CI: 58-87%); and **Pfizer/BioNtech – at only 42%** (95%CI: 13-62%). Note that **all COVID-19 vaccines approved by WHO and FDA are required to have an efficacy rate of 50% or above** (24, 25).

- A very recent population-based cohort study (n=4,204,859) from Norway showed that vaccine effectiveness against Delta variant among fully vaccinated individuals was 64.6% (95%CI: 60.6-68.2) compared with 84.4% (95%CI: 81.8-86.5) against the Alpha variant (26).

- On July 23, 2021, Israel's Health Ministry indicated that a **complete course of the Pfizer/BioNTech mRNA vaccine was just 39% effective at preventing infections and 41% effective at preventing symptomatic illness with the Delta variant** but remained 91% effective at preventing serious illness and hospitalization (27). However, by August 16, 2021, and despite having 78% of those 12 and older fully vaccinated, **59% of gravely ill patients in Israel were fully vaccinated** (28).

- These data likely explain why the CDC just changed the definition of immunity, from "producing immunity" to "providing protection" (1). While it might be appealing to state that *some protection is still better than no protection* - I will discuss why I do not feel that applies to these current mRNA vaccines - especially in very low risk groups.

(4) Natural immunity from SARS-CoV-2 is more durable and robust than the partial immunity achieved from the current mRNA vaccines.

- Intuitively, one would predict that our immune systems would generate a more complete, robust, and prolonged immune response to SARS-CoV-2, rather than the mRNA vaccines. Indeed, after about 6 months of progressively decreasing mRNA vaccine effectiveness, some governments are **already mandating boosters** with seemingly no end in sight (29). In contrast, those individuals with asymptomatic and symptomatic infections **developed a robust immune response to the entire virus**

(including the nucleocapsid), as opposed to only partial immunity derived through mRNA vaccines towards the s protein.

- A recent Nature paper showed that **17 years after the 2003 SARS outbreak, long-lasting memory T cells were still present to the nucleocapsid** (n protein) in those infected with SARS-CoV, **AND these T-cells displayed a robust cross-reactivity to the N protein of SARS-CoV-2** (16).

- Another recent Nature paper showed **memory B cell response to SARS-CoV-2 evolves between 1.3 and 6.2 months after infection in a manner consistent with antigen persistence**, evidenced by titres of IgM and IgG antibodies against the receptor-binding domain of the spike protein (30).

- A very recent large observational Israeli study **compared SARS-CoV-2 natural immunity to vaccine-induced immunity** during a period when Delta was dominant. "After adjusting for comorbidities, we found a **27.02-fold risk** (95% CI: 12.7-57.5) for ***symptomatic breakthrough infection as opposed to symptomatic re-infection ($p<.001$)*** (31).

- **Extremely low reinfection rates have been observed since pandemic onset.** For instance, "*with a total of 835,792 Israelis known to have recovered from the virus, the 72 instances of reinfection amount to 0.0086% of people who were already infected with COVID* (32).

- Yet, we are **using coercion to force individuals to take mRNA vaccines even if they have already had a prior COVID-19 infection, and even if they can provide lab confirmation of sustained immunity.**

- Perhaps at minimum, we could **assess for evidence of persistent immunity BEFORE we force EVERYONE to take the shot**, especially among young healthy populations. At present, we have **only 6-month longitudinal adult data to inform risks beyond the acute injection period.**

(5) From a long-term safety perspective, these novel mRNA vaccines should be treated as guilty until proven otherwise, especially in low-risk groups.

- **No crystal ball exists to predict long-term risks.** Do you recall when we received emails from leadership re-assuring us that all 3 shots, including Astra Zeneca, were safe, only to have it recalled a few months later? Do you remember when mRNA vaccines were not associated with myocarditis/pericarditis in male adolescents (33)?

- **Do you want to mandate these experimental mRNA vaccines despite the lack of long-term data?** *Perhaps there are certain vulnerable adult and pediatric groups who will prove to endure higher risk over time from the shots rather than from the virus itself?*

- Consider a young healthy woman who is coerced by AHS to take the experimental shot, and over the next few years it becomes clear that these "vaccines" are associated with fertility issues in some women? Crazy?

- The vaccine companies and medical officials have repeatedly claimed that when we are injected with these mRNA vaccines, **the lipid nanoparticles which contain the s protein mRNA** needed for our cells to produce the s protein **- *stay at the injection site***. ***This appears false***.

- In a recent **prospective** (December 2020 to March 2021) pilot **study of 13 healthcare workers** (≥ 18 years, mean age 24 years) at the Brigham and Women's Hospital, **Harvard investigators obtained longitudinal plasma samples of SARS-CoV-2 proteins from participants who received two doses of mRNA-1273 vaccine (Moderna)**, and lacked a prior history of SARS-Cov-2 illness. These antigens included SARS-CoV-2 antigens spike (S1-S2 unit), S1, and nucleocapsid and antibodies IgG, IgA, IgM against SARS-CoV-2 spike, S1, receptor binding domain (RBD), and nucleocapsid (34).

- **After the first dose**, the mRNA-1273 produced detectable levels of S1 antigen ***in plasma in 11 participants***, and spike antigen was detected in 3 of 13 participants, an average of 15 days post first injection. Protein clearance correlated with production of IgG and IgA. ***Their negative control*** – the ***nucleocapsid antigen from SARS-CoV-2 was expectedly absent***, as the vaccine does not lead to production of the SARS-CoV-2 nucleocapsid antigen. "*In all 13 participants, as expected, IgG levels against spike, S1, and RBD increased after the first injection, whereas IgG against nucleocapsid showed no change over time*" (34).

- Authors concluded, "***The mechanisms underlying release of free S1, and the subsequent detection of the intact spike protein remain unclear***. ***Nonetheless, evidence of systemic detection of spike and S1 protein production from the mRNA-1273 vaccine is significant and has not yet been described in any vaccine study"*** (34).

- ***Why has this not been described in the vaccine studies? Where is the biodistribution safety data?*** *If the s antigen is circulating in our plasma weeks later, could it be causing harm*? Note that the above Boston study was conducted in young healthy people with robust T-cell immunity. I wonder what we would see in a vulnerable elderly person with comorbidities. Does this contribute to SARS-CoV-2 vaccine-induced immune thrombotic thrombocytopenia (VITT) and other instances of adverse thrombotic events (35)?

- As a neurologist, I must wonder if these s proteins are circulating in our cerebral spinal fluid, given that the ACE2 receptors are also present in brain and could gain them access (36). Crazy?

- In a murine model, the virus "**SARS-CoV-2 crosses the blood-brain-barrier** accompanied with basement membrane disruption…," ensued by "inflammatory responses including vasculitis, glial activation, and upregulated inflammatory factors" (37).

- Further when ***injected intravenously, the S1 protein of SARS-CoV-2*** was found to **cross the blood-brain-barrier in mice**. Inflammation potentiated this uptake. ***The S1 protein entered all brain regions, with no statistically different differences among them, including cortex, olfactory bulb, striatum, thalamus and hypothalamus, hippocampus, cerebellum and brainstem*** (38).

- **Canadian immunologist and vaccine researcher Dr. Byram Bridle** (Guelph University) was awarded a large government grant for research on COVID-19 vaccine development. Only through a Freedom of Information Act, did he and other scientists subsequently gain access to Pfizer's rat biodistribution study from the Japanese regulatory agency (39). It clearly showed that **when injected**

intramuscularly, the concentration was highest at the dosing site, then the liver, and then detected in the spleen, adrenal glands, and ovaries (39)**.**

- ***<u>If you are not at least concerned by these studies</u>***, please ask yourself why the bioavailability and biodistribution data in humans, is not readily available to contradict these studies. There is no reason we should not have this data across many different patient populations, especially after 1 year of distributing the mRNA vaccines. I could not find one study that measured mRNA vaccine protein uptake in human CSF. While I understand very well the difficulty obtaining CSF, there are many clinical situations where this could have been readily collected.

- **Instead, they censor and aggressively attack one of our own!** If you search for Dr. Byram Bridle you will readily see the internet smear campaign against him. I listened to his initial interviews months ago when he received the Pfizer rat studies. *<u>He was genuinely petrified and shocked by the data and wanted to warn people</u>.* There is no denying that the mRNA vaccine injection distributes throughout our body based on the existing data. But just because it does circulate, does not mean it is causing harm either.

- Dr. Bridle was especially attacked for his comments that the s protein itself is toxic and can cause harm. Given the biodistribution data I have shared and what we know about some of the rare adverse events that occur post mRNA injection, his opinion is not one that should be aggressively dismissed immediately. It is incredible the attack he has endured for discussing the science. Below is a link to a brief article from the local Guelph News discussing Dr. Bridle. **<u>https://www.thestar.com/local-guelph/news/2021/06/21/immunologists-raise-concerns-on-u-of-guelph-prof-s-views-on-covid-19-vaccine-safety.html</u>**

- SARS-CoV-2 infection disturbs several pathways associated with neurodegeneration, including but not limited to Parkinson and Huntington disease. (40). "*<u>Given the neuroinvasive potential of SARS-CoV-2, deeper investigation is warranted into the virus' contribution to the long-term development of neurodegenerative disease</u>*" (41).

- <u>If some of the s antigen our bodies produce in response to the mRNA vaccine *is indeed entering our brains and cerebral spinal fluid*</u>*, then we should heed those warnings about the possibility of* ***early neurodegenerative diseases.***

- It was recently shown that "**<u>SARS-CoV-2 S1 RBD binds</u>** *to a number of aggregation-prone, heparin binding proteins including Aβ, α-synuclein, tau, prion, and TDP-43 RRM*. **These interactions suggests that the heparin binding site on the S1 protein might assist the binding of amyloid proteins to the viral surface and thus could initiate aggregation of these proteins and finally leads to neurodegeneration in brain**" (42).

(6) <u>The mRNA vaccine risk-benefit ratio in children</u>.

- **Children are at very low risk from COVID-19 infection itself, and rarely suffer severe disease and death** (43). Data from the American Academy of Pediatrics Children and COVID-19: State Data

Report, **found that 0.1-1.9% of their child COVID-19 cases resulted in hospitalizations, and 0.00-0.03% of all child covid-19 case resulted in death** (43).

- **In a pre-COVID-19 vaccine cohort of 1391 children, 171 (12.3%) were confirmed to have** SARS-CoV-2 infection and treated at the **Wuhan Children's Hospital from Jan 28 – Feb 26, 2020** (Note this is the only center assigned by the central government for treating infected children under 16 years of age in Wuhan). Median age was 6.7 years. 3 patients required intensive care and invasive mechanical ventilation – all had coexisting conditions. 1 patient died, a 10-month-old with intussusception and multiorgan failure (44).

- Currently in Alberta, the average age of COVID cases that died is 80 years, with a range from 20 -107 years (10). Thankfully, no pediatric patients have thus far died in Alberta. And, contrary to media portrayal, children with COVID-19 are **also very rarely susceptible** to *multisystem inflammatory syndrome* (45) and *neurological sequelae* (46). Since the pandemic, I have seen more devastating neurologic conversion disorders and psychiatric disease, including several heart-breaking teenage suicide attempts, then I have my entire career. In contrast, I have not encountered a single child with neurological sequelae from COVID-19 itself.

- The American Academy of Pediatrics also confirmed that ***while Delta is infecting more children, it is not causing increased disease severity*** (47).

- While many studies suggest pre-symptomatic/asymptomatic spread may comprise > 40% of vertical transmission, ***numerous large observational population studies show that children are POOR COVID-19 spreaders.*** This includes studies from Ireland, Iceland, Italy, France, and Australia (48, 49, 50, 51, 52). For a link to a more complete reference list, see Washington University Pediatric & Adolescent Ambulatory Research Consortium: http://wupaarc.wustl.edu/COVID-19-and-Children/Information-about-COVID-19-Transmission-in-Schools-and-Daycares

- The CDC and FDA's **Vaccine Adverse Reporting System (VAERS)** "*is the nation's **early warning system** that monitors the safety of vaccines after they are authorized or licensed for use by the FDA*" (53). It is a self-reporting system that does not prove causality but rather is designed to help identify adverse events signals (*i.e*., COVID-19 vaccine thrombotic events and myocarditis). "*VAERS **scientists look for unusually high numbers** of reports of an adverse event after a particular vaccine or a new pattern of adverse events*" (54).

- While you would certainly expect a spike in the reports submitted during a pandemic where we are using an experimental vaccine technology, it is also true that adverse events reported in VAERS are historically vastly underreported. In the 2009 Harvard Pilgrim Health Care study assessing the VAERS, "***fewer than 1% of vaccine adverse events are reported***" (55).

- During **1997-2013, VAERS received 2149 death** reports and "no concerning pattern" was observed (56). But as Senator Ron Johnson wrote August 22, 2021: "***the 12,791 deaths related to Covid-19 vaccines reported on VAERS over the period of 8 months, compares to 8,966 deaths related to all other vaccines reported on VAERS since the inception of VAERS – a period of 31 years***". He continues, *"VAERS is also reporting 16,044 permanent disabilities, 51,242 hospitalizations, and*

571,831 total adverse events related to the Covid-19 vaccines" (57). Anyone can verify these numbers and read individual case stems, as I have previously done, on the VAERS website.

- ***Why then, given these clearly unusually high numbers, does the CDC continue to refuse to allow an independent safety panel investigation of outside experts?*** Consider that on July 16, 1999, the CDC recommended that healthcare providers *suspend* the use of the licensed…RotaShield – a rotavirus vaccine – *after only 15 cases of intussusception were reported in VAERS!* (58)

- Recently, despite clear decreased mRNA vaccine effectiveness, *Dr. Fauci and President Biden have expressed their desire to start giving the mRNA shots to children aged 6 months – 11 years*, and indeed, trials with Pfizer/BioNtech and Moderna are underway. Dr. Fauci stated August 31, 2021: "I believe that mandating vaccines for children to appear in school is a good idea" (59). Further, President Biden said July 21, 2021, that children under age 12 could be eligible for a COVID-19 vaccine within the next few months, as results from clinical trial for ages 6 months to 12-years become available (60).

- **Even IF** these pediatric RCTs show efficacy and 2-month safety data similar to the initial Moderna and Pfizer-BioNtech trials, *are we still going to inject even low risk children*? Children seem to be their own best defense against SARS-CoV-2, are poor transmitters of the disease and have exceedingly low risk of death and severe disease from the virus. We now know that the real-world effectiveness of these mRNA vaccines is mediocre at best and continuing to diminish. And we have zero long-term data. **Just because industry funded studies may show "efficacy" in the pediatric trials, I strongly argue that we should not inject children with these very experimental therapies.** At least show us the biodistribution data first.

(7) Following the science?

- On August 31, 2021, despite several decade long careers with the FDA, the individuals leading the FDA office in charge of approving vaccines (Marion Gruber and Philip Krause), resigned over the Biden administration's booster-shot plan, ***saying it insisted on the policy before the agency approved it*** (61).

- And recently, ***the UK's vaccine advisory board REFUSED to approve mRNA vaccines for healthy 12- to 15-year-olds*** (62). Despite this, the government may overrule and is already telling teenagers they can circumvent their parents. ***How many of our teenagers are actually making an uncoerced informed decision?*** Do they really understand their risk-benefit analysis? This is what we are telling families at Alberta Children's Hospital (63).

- ***Many censored international experts*** in public health and virology have long-called for focused protection and the need to carefully weigh the risk-benefit of these experimental mRNA vaccines among those individuals with very low risk from the disease, including children (64).

1) The Great Barrington Declaration (2020) was co-authored by Dr. Martin Kulldorff (Harvard), Dr. Sunetra Gupta (Oxford) and Dr. Jay Bhattacharya (Stanford) – 3 giants in public health, epidemiology, and vaccines surveillance (https://gbdeclaration.org/). This declaration advocates for

"focused protections" for COVID-19 and currently has collected > 850,000 signatures worldwide including from > 58,000 medical professionals and scientists. Despite these credentials, and recommendations that were not novel but in fact reflected longstanding public health policy, Dr. Kulldorff, and the others have been heavily attacked and censored. I have provided a link to a fantastic interview with Dr. Kulldorff in the reference section. Towards the end, he addresses the censorship issue directly (65).

(8) Is it possible that antibody dependent enhancement (ADE) is contributing in some people to the aggressive Delta outbreaks seen in Israel, India and … Calgary?

- **ADE occurs when antibodies facilitate viral entry into host cells and enhance viral infection in these cells.** It is an appreciated concern of coronaviruses as described in a multicenter paper that included Dr. Zhengli Shi from the Wuhan Institute of Virology, known for her work with bat viruses (a.k.a. the "*Bat Lady*"), entitled "*Molecular mechanism for antibody-dependent enhancement of coronavirus entry*." This paper was published in the Journal of Virology on February 14, 2020 (submitted pre-pandemic November 27, 2019) (66).

- ***Animal model studies of prior SARS-CoV raise potential safety concerns*** (67). Decades ago, **kittens were immunized** with a viral recombinant encoding the **spike protein of the coronavirus**, producing low titres of neutralizing antibodies. After challenge with the feline virus, these animals succumbed earlier than did the control group – "*early death syndrome*" (68). More recently, the anti-S IgG produced in **macaques immunized** with a modified **viral vector expressing the SARS-CoV protein**, enhanced pulmonary infiltration of inflammatory macrophages, and resulted in more severe lung injury compared to unvaccinated animals (69). Similarly, **immunized macaques with four B-cell peptide epitopes of the S protein**, found that while 3 peptides elicited antibodies that protected the macaques from viral challenge, one of the peptides induced antibodies that enhanced infection *in vitro* and resulted in more severe lung pathology *in vivo* (70). Further, **pulmonary immunopathology was observed upon** a subsequent challenge to the SARS virus**, among SARS coronavirus vaccine-treated mice and ferrets** (71). However, it appears dependent on the vaccine type. In 2 studies with rhesus macaques, immunization with an **inactivated SARS-CoV vaccine**, did not show ADE (72, 73).

- A recent study of **healthcare workers in Vietnam** assessing the transmission of SARS-CoV-2 Delta variant found that **the previously mRNA double-vaccinated group had 251 times higher nasopharyngeal viral loads compared to those unvaccinated**. AND there was **no correlation between vaccine-induced neutralizing antibody levels and viral loads or the development of symptoms** (74).

- Very recently, **researchers found "facilitating" antibodies bound to the NTD region of the Delta spike variant** (located behind the contact surface so that it does not interfere with the virus-cell attachment). Their data suggests FcR-independent enhancement of infection induced by anti-NTD antibodies involving lipid rafts. "***Inasmuch as neutralizing antibodies overwhelm facilitating antibodies, ADE is not a concern. However, the emergence of SARS-CoV-2 variants may tip the scales in favor of infection enhancement. Our structural and modeling data suggest that it might be indeed the case for Delta variants***" (75).

- **More data is needed to determine what role is being played by ADE but the evidence that does exists, suggests that we should be concerned and following this carefully.** ***If ADE is not contributing, then prove the silenced experts wrong! If it is, the plan to double down on widespread leaky mRNA vaccines and boosters, needs to change.***

(9) Relevant Examples of Egregious Censorship and Misinformation.

**** I hesitate to include this section largely because the scientific data itself is so convincing and I do not want to detract from these arguments. However, you cannot understand why these data are so incongruous with the prevailing narrative, unless you appreciate the medical censorship for yourself. ****

Example 1: SARS-CoV-2 virus origin – manipulated in a lab or jumped species?

- Do you recall when SARS-CoV-2 escaping from a lab in Wuhan - as opposed to jumping from bats to humans - was a demonstrably false conspiracy theory? The Washington Post, among others, was even forced to retract prior statements claiming this was "debunked" (76). Based on the virus' genetic code, Prof. Montagnier, a virologist who shared the 2008 Nobel Prize for the discovery of HIV (see example #2 below) was among the first to state publicly and with extreme certainty that this virus was manipulated in a lab. He was heavily demonized at the time (77).

- **In March 2020**, it was Andersen and colleagues' paper appearing in Nature Medicine: "***Proximal origins of SARS-CoV-2***" – that framed this discussion early (78). They concluded: "*In the midst of the global COVID-19 public-health emergency, it is reasonable to wonder why the origins of the pandemic matter …. Although the* ***evidence shows that SARS CoV-2 is not a purposefully manipulated virus****, it is currently impossible to prove or disprove the other theories of its origin described here*."

- While 100% proof of origin is unlikely to arise, the media ***continuing to paint the issue so nebulously is also disingenuous***. I defy you to read this balanced and detailed pro and con argument for each origin theory and still perceive this to be a grey zone. (https://www.zerohedge.com/health/tracing-origins-covid-19).

- For those with basic science background, a more complex SARS-CoV-2 genetics analysis was provided by the **Chinese whistleblower Dr. Li-Meng Yan's original scientific paper** (79). This swayed me enough back in June 2021 when it first appeared on-line to realize that Fauci's earlier adamant assertions to the contrary were untrue. While there may not have been proof to definitively confirm one theory over the other when he made his statements in Spring 2020, **he certainly could not state that the lab manipulation theory was proven false. So why lie?**

- ***Why care? The evidence undeniably implicates Dr. Fauci's knowledge and involvement (including the proximal origin paper), and he indirectly continues to help inform policy in Canada.***

- It is likely impossible to wrap your head around what I am saying unless you see his duplicity for yourself. For a succinct, fact-based video of what we know for sure, including his own Senate testimony around his leaked emails at that time, please watch:

https://www.theepochtimes.com/five-questions-for-fauci-truth-over-news_3941146.html?&utm_medium=TruthOverNews&utm_source=EET&utm_campaign=FiveQ%20&utm_content=8-13-2021

- Alternatively, Tyler Durdin who wrote the ZeroHedge article above on the virus origins, outlines the Fauci emails and ties to the Wuhan Institute of Virology, with embedded links to original documents and his emails here: https://www.zerohedge.com/covid-19/emails-reveal-how-influential-articles-established-covid-19-natural-origins-theory-were

- If you watched the video, it is difficult to conclude that Dr. Fauci's actions can be dismissed by ignorance or incompetence. But even if you give him the benefit of the doubt, ***how has he maintained his job and remained a guiding voice in the context of these past actions and clear personal and financial conflicts of interest?***

Example 2: Nobel Prize winning French Virologist, Professor Luc Montagnier

- There are several impressive experts, including Professor Montagnier, who stated that **the COVID-19 vaccine is creating variants and NOT the unvaccinated.** He also **warned about the risks of trying to vaccinate everyone DURING a pandemic,** as you risk secondarily causing harm by perpetuating **antibody dependent enhancement**.

Please listen to the brief 2.5 min video link here: (https://www.youtube.com/watch?v=RZGuTNhNxOE)

****Not surprisingly, when I reviewed this letter to ensure all links worked, this video had been removed from YouTube for violating their platforms rules. It disappeared within 24 hr of grabbing the link. So, I found the video again on Vimeo and copied it with Camtasia. I can provide it to you if interested. ****

- As described, there is evidence emerging for ADE and Delta, but **regardless of whether Prof Montagnier proves to be correct –** the censorship is egregious. Science is about debate, especially during times of uncertainty. While I doubt, I would agree with everything Prof. Montagnier has said or done in his life, to censor a virologist and the 2008 Nobel Laureate in Medicine who helped to discover HIV, at a time when we are dealing with the novel pandemic and all its uncertainty, seems unbalanced. Given the seriousness of this issue - ***prove him wrong, do not censor!***

- It was not just that his videos were removed, BUT WORSE - a demonstrable lie was created on the internet and perpetuated in the media, stating that during the interview he also claimed everyone who took the mRNA vaccines would be dead in 2 years. He never said this, and yet there it remains as the prominent narrative on most internet search engines.

- ***Consider that while big tech and social media are still aggressively removing any video link to Prof. Montagnier's comments without evidence to dispute his claims, they are continuing to proliferate the character assignation lie on their platform that discredits him.***

- *Censoring facts and reasonable expert opinion **to prevent vaccine hesitancy, is coercive and unscientific nonsense**.*

Example 3: Dr. Robert Malone, co-inventor of mRNA vaccine technology

If you search in Google for Dr. Robert Malone, who holds multiple patents for mRNA vaccine technology, you will find that his provable accomplishments are discredited. They state he is an "antivaxxer" and zealot seeking media attention.

I have listened to Dr. Robert Malone speak during numerous interviews, and thus far have found him to be balanced scientifically, insightful, and sharing genuine concern with our course of action. He is not an antivaxxer, he has himself taking the mRNA vaccines but cautions about their widespread use during a pandemic, especially among low-risk groups. *Pease judge for yourself - even if you only watch the first 15 minutes of Part II* where he responds to the criticism and censorship.

1) Epoch TV, American Thought Leaders, September 2, 2021, interview with Dr. Robert Malone discussing the latest covid-19 data, booster shots and the shattered scientific consensus. Link to full PART 1 video: https://www.theepochtimes.com/dr-robert-malone-mrna-vaccine-inventor-on-latest-covid-19-data-booster-shots-and-the-shattered-scientific-consensus_3979206.html

2) Epoch TV, American Thought Leaders, September 4, 2021, interview with Dr. Robert Malone on ivermectin, escape mutants, and the faulty logic of vaccine mandates. Link to full PART 2 video: https://www.theepochtimes.com/part-2-dr-robert-malone-on-ivermectin-escape-mutants-and-the-faulty-logic-of-vaccine-mandates_3981859.html

10) Without a mRNA vaccine, DOES MY RISK TO PATIENTS increase?

- The mRNA vaccine effectiveness has decreased significantly to SARS-CoV-2. The fully vaccinated can transmit SARS-CoV-2, have similar or higher viral loads compared to the unvaccinated, and are comprising an ever-growing proportion of the symptomatic patients, including need for hospitalization and critical illness support.

- To *estimate my minuscule current risk to pediatric patients with or without mRNA vaccine*, consider that to date, 5.98% of Albertans have had COVID-19 (264,539 cases/divided by 4,421,876 total AB population). So, my risk of SARS-CoV-2 infection is about 6% every 12-18 months (but this could increase or decrease). *I would have to be a pre-symptomatic spreader since I would not come to work with symptoms, and if I developed symptoms I would get tested.* Reasonably assume 50% of all transmission is from pre-symptomatic individuals, so now the risk of catching the virus and spreading pre-symptomatically drops to 3% every 12-18 months. Then you consider all the handwashing, gloving, and PPE that I abide by, and my risk of transmission decreases further. I do not know by what factor all this PPE and hand hygiene lower my risk, but I would think substantially, perhaps even to 1% or less? If you multiply that by the child's starting absolute risk using the U.S. State data - *of all child COVID-19 cases* - 0.1-1.9% hospitalizations, and 0.00-0.03% death (41) - ***that suggests a hospitalization risk = 0.01 – 0.19%, and mortality = 0.00 – 0.0003%, every 12-18 months.***

CONCLUSIONS

Please judge the data and interviews for yourself and open your mind to the possibility that the blatant medical censorship is negatively impacting our profession, and our ability to make informed policy! Recall that we are living during a time when original articles in Lancet and the New England Journal of Medicine regarding COVID-19 treatment are being retracted because they were completely fabricated (80, 81).

While I grew to respect and trust long-standing health organizations like the WHO and CDC, financial and political interests have crippled their independence, and during this pandemic, they have egregiously misrepresented facts and helped to censor scientific experts worldwide. This is not surprising, as it has been proven in court that WHO did not act ethically during the 2009 H1N1 swine flu "pandemic" when it came to their global vaccine agreements (82). These organizations that inform Canada health policy are completely compromised by vaccine and big pharma interest money. Unfortunately, we can no longer rely on the global media cabal to be independent and forthcoming. Consider CDC Director Dr. Rochelle Walensky's July 16, 2021, declaration that we are facing "*a pandemic of the unvaccinated*" (83) which perpetuated unneeded societal hatred and division, seemed backwards scientifically, and is now contradicted by the global epidemiology as you have read.

Consider that 20-40% of vaccine eligible individuals living in countries with high mRNA vaccine availability like Canada, still REFUSE to take the jab, including many healthcare workers worldwide (84). And this is despite the enormous social backlash, despite the ongoing confusion & hatred received by others including family members, and despite being faced with ongoing and constantly increasing punitive restrictions including the inability to travel, visit family, enjoy a meal at restaurant, and EVEN earn a living. In my case, after 18 years of medical training and a highly specialized consultancy practice, and **despite my informed medical decision**, ***I either capitulate to medical tyranny or leave a dream job at the Alberta Children's Hospita***l (via the AHS mandate). I strongly urge you to fight back against this wave of medical tyranny and NOT mandate forced mRNA vaccinations among those remaining physicians who have made the informed medical choice to abstain.

Thank you for taking the time to read this. Please don't hesitate to contact me should you have any questions or concerns with the presented data. I would welcome the opportunity to discuss further. If nothing else, I hope that as you listen to the media and officials prospectively over the next few weeks to months, you consider if what they are saying aligns with the existing scientific data.

Yours Sincerely,

Eric T. Payne, MD, MPH, FRCP(C)
Pediatric Neurocritical Care & Epilepsy
Alberta Children's Hospital
Assistant Professor of Pediatrics & Neurology, the University of Calgary
Email: eric.payne@albertahealthservices.ca

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Appendix “B”

Canadian Covid Care Alliance
Alliance canadienne pour la prévention
et prise-en-charge de la covid

COVID-19
Canadian Covid Care Alliance
Declaration

September 24, 2021

The most up to date version of this document can be found at:

https://www.canadiancovidcarealliance.org/

20210924v1

THE COVID-19 CANADIAN COVID CARE ALLIANCE (CCCA) DECLARATION

September 24, 2021

To the Canadian Federal, Provincial and Municipal Governments, Public Health Agency of Canada (PHAC), Health Canada and the Media

Executive Summary

1) Revoke the Declarations of Emergency e.g., Emergency Management & Civil Protection Act, Emergency Programs Act (or similar Act).

2) Develop effective national outpatient treatment guidelines based on the most-up-to-date evidence. Instruct PHAC to inform and educate physicians and the general public about the importance of prophylaxis and early treatment of COVID-19. The government should ensure the necessary supply of repurposed medications and prophylaxis agents.

3) Pause the current COVID-19 vaccination program pending full evaluation of impacts and benefits.

4) Halt the Vaccination Passport ("Vax Pass") program and do not permit any company, agency, or organization to unlawfully mandate COVID-19 vaccinations.

5) Do not permit any infringement on medical privacy by governments and businesses and end all coercive measures limiting freedom of individual medical choice.

6) Do not permit any infringement on the ability to move freely, both within and between provinces as well as internationally (leaving/entering Canada).

7) Do not impose any future lockdowns or quarantines of healthy individuals in view of the enormous destabilizing impacts on the economy, mental health and society at large. The government should instead focus their attention and funding to help those who feel vulnerable, if they so choose to accept the government's assistance.

8) Recognize physicians and researchers of diverse opinions (from the CCCA and other affiliations) as **essential stakeholders** to: 1) engage in an open and public forum to discuss early treatment options, COVID-19 vaccine program, the proposed vaccine mandates, Vaccine Passports, lockdowns and masking; and 2) to participate in the COVID-19 Planning and Implementation Team(s), the COVID-19 Immunity Task Force, the National Advisory Committee on Immunization (NACI) and the provincial Science Tables to address the evidence-based science supporting non-pharmaceutical interventions (NPIs).

THE COVID-19 CANADIAN COVID CARE ALLIANCE (CCCA) DECLARATION

Introduction

We represent over 500 members, comprised of physicians, research scientists (including virologists, vaccinologists, and immunologists), and others; including highly accomplished professors from top Canadian universities, allied healthcare professionals, and lawyers from across Canada, who have serious concerns with respect to the management of the COVID-19 pandemic in this country. We are offering our assistance and have prepared this document to provide government, policy makers and other relevant stakeholders with a resource summarizing the most up-to-date scientific data, as well as legal and bioethical considerations that should be at the forefront of decision-making going forward.

Mortality data from Statistics Canada[1] demonstrates that we are no longer in a pandemic. Early modelling warned of alarmingly high rate of deaths across the country as a result of SARS-CoV-2 infection, but eighteen months later, this has not come to pass. It has since been shown, by real world data, that the model presented by Neil Ferguson at Imperial College London was fundamentally flawed from the outset and has been proven wildly inaccurate across the world[2], despite its projections acting as the basis for the reactionary lockstep response from most governments[3].

In Canada, as of September 20, 2021, 79% of eligible Canadians aged 12 and over are fully vaccinated with the advised two-dose regimen of mRNA and DNA injections[4]. Today, virtually all Canadians intending to receive vaccination have already done so[5], making the continued nationwide vaccination campaign redundant and overbearing with no reasonable expectation of benefit to public health. This is in addition to compelling evidence demonstrating waning efficacy of the vaccine products[6,7], especially when compared to protection offered by natural immunity, which we now know to

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be robust and long-lasting[8,9]. This is the ideal time to reassess the Government's, Public Health Agency of Canada's and Health Canada's recommendations for protecting public health and moving out of the pandemic response, as is being done by many other countries around the world.

Countries such as Sweden[10], Denmark[11] and the UK[12] are almost fully open. As of September 8, 2021, Denmark's and the UK's vaccination rates for those individuals who are eligible and have received two doses were 73.6% and 64%, respectively, according to https://ourworldindata.org/covid-vaccinations. As of September 3, 2021, Sweden's double vaccination rate was 57.9%[13,14]. The UK is able to cope with current delta infections and its hospitalizations have been consistently much lower than in previous waves[15]. In comparison, as of September 20, 2021, Canada's fully vaccinated rate is 79%, a double vaccination rate which is on par with these countries. Further reduction in Canada's hospitalizations can be readily achieved by greater utilization and awareness of the early treatment protocols (see below). We, therefore, strongly object to the unfounded fear-based messaging that the Canadian public is being targeted by.

Denmark's Health Minister, Magnus Heunicke, recently announced[16]: "The epidemic is under control. We have record-high vaccination rates." He also stated that, starting on September 10, "we can drop some of the special rules we had to introduce in the fight against COVID-19". In fact, all restrictions for COVID-19, including the CORONAPASS were dropped on that date in Denmark, and the UK has similarly followed suit. Meanwhile, the Swedish government has kept society relatively open and has only maintained limited but rather fixed NPIs (non-pharmaceutical interventions) throughout the pandemic. Experts opine that[17], "pre-immunity on a population level, could in fact be a consequence of large

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variability in individual-level susceptibility. Furthermore, this susceptibility may depend on innate immunity and cross-reactive protective immunity initiated by another virus or other factors."

Eighteen months into this pandemic and nine months into the vaccine program, there has been a tremendous amount of research completed around the world relating to SARS-CoV-2 virus, COVID-19 disease, its treatments and the vaccines. As a result of this research and growing bodies of evidence, we believe it is critical that the Canadian government and public health agencies take immediate action to engage stakeholders and re-examine public health measures with regards to the pandemic. As highly informed and educated health practitioners, researchers and professionals, members of the Canadian Covid Care Alliance (CCCA) are offering their assistance in this process. We offer this wealth of expertise with evidence-based knowledge to find viable, implementable solutions to end the pandemic restrictions to the benefit of all Canadians. It is time for Canada to set the stage for the return to a healthcare system based on evidence-based solutions, patient-provider trust and ethical regulation in government and industry.

Independent voices have always played an important role in the development of society, just as debate and critical thinking have been instrumental in the advancement of scientific research and knowledge. Based on the most current and verifiable scientific and medical data, it is now possible for the Canadian government to stand up as an international role model, acknowledge that COVID-19 is becoming endemic and move ahead with practical actions and solutions to finally end this extended crisis.

In this Declaration, we provide information and evidence regarding the following issues:

I. Early Treatment and Prophylaxis
II. Vaccine Safety and Surveillance
III. Immune Escape, Variants and Herd Immunity
IV. Informed Consent
V. Vaccine Passports ("Vax Pass") and Vaccine Mandates
VI. Censorship

I. Early Treatment and Prophylaxis

COVID-19 is the disease that develops in some people infected with the SARS-CoV-2 virus. While these two terms are often incorrectly interchanged by the public, it is crucial to understand their difference. SARS-CoV-2 is the virus that spreads via aerosols (very small droplets)[18,19] and enters the body primarily via the upper respiratory tract. Infection with this virus can lead to the development of the COVID-19 disease. To understand how to prevent or treat any disease, it is crucial to understand the pathophysiology of the disease[20]. Over the last 18 months, scientists and clinicians have described the cellular mechanisms of the SARS-CoV-2 infection[21,22]. **Practitioners tailor the disease management and treatment by targeting the distinct pathophysiological phases of the disease.**

With the current wealth of information and experience, the medical community has established that **COVID-19 is a treatable disease**. It is difficult to understand why so many of the expert panels advising governments have practically no personal experience with COVID-19 treatment, especially in its early stage when it is most amenable to therapeutic intervention and provides most impact to a patient's health and healthcare system in general. Countless doctors around the world, including some Canadian doctors, have been successfully treating the disease in its early stages on an outpatient basis using well-known, accessible and inexpensive anti-inflammatory and anti-coagulation medications, among others. These doctors and their extensive networks are at your disposal to help inform effective national treatment guidelines based on the most-up-to-date evidence and their own personal front line experience. **Leading outpatient doctors should be the backbone of the government's advisory teams.**

PROPHYLAXIS (i.e., PREVENTION) – There are a growing number of studies showing the benefits of supplements in reducing viral replication and, therefore, the duration and severity of COVID-19. Readily

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available supplements such as vitamin C[23], vitamin D[24,25], zinc[26], quercetin[27], selenium[28,29] and omega-3 fatty acids[30] have been shown to assist the immune system in the fight against COVID-19[31,32,33,34]. It has been shown in multiple studies that low levels of Vitamin D lead to more severe disease[35,36]. It is widely recognized that Canadians are typically vitamin D deficient[37], which may contribute to increased susceptibility to respiratory infections, especially during winter months. Ireland has recently recognized the importance of vitamin D supplementation in their national public health guidelines[38]. Nasal and

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throat hygiene was also shown to substantially decrease viral replication and severity of disease[39,40]. Several repurposed drugs with known antiviral effects have shown potent protection against infection (summarized here and here).

EARLY TREATMENT – As is now well accepted, both vaccinated and unvaccinated individuals are at risk to become infected with and transmit SARS-CoV-2, as well as become ill and even die from COVID-19[41,42]. As such, **it is imperative to implement early and effective treatments regardless of vaccination status.**

Since March 2020, numerous studies relating to early treatment of COVID-19 have demonstrated the effectiveness and safety of using several repurposed drugs with well-established safety profiles. For example, the inhaled steroid budesonide[43,44] has already been included in several Canadian and international treatment guidelines (UK, British Columbia, New Brunswick). However, for unknown reasons, this information has not reached many in the medical community, or the wider public. Information about early treatment has not even been adequately covered by the media, which is the primary source of pandemic-related information for most Canadians. Moreover, the biggest outpatient trial performed to date has been the Canadian COLCORONA trial, which showed a clear trend to benefit from a well-known drug, colchicine, on substantially decreasing hospitalizations and deaths[45]. Similar positive results have been also reported in top journals with another well-known drug - fluvoxamine[46,47,48].

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Some jurisdictions, such as Mexico City and El Salvador, have even deployed very successful public campaigns using treatment packs consisting of several medications and nutraceuticals[49,50].

A randomized, placebo-controlled, double-blind trial conducted in Israel from May 15, 2020, through to the end of January 2021 to evaluate the effectiveness of ivermectin in reducing viral shedding among non-hospitalized patients with mild to moderate COVID-19 concluded[51], "There were significantly lower viral loads and viable cultures in the Ivermectin group, which could lead to shortening isolation time in these patients." Calls to adopt the drug have been made, among others by its discoverer, Nobel Laureate Satoshi Omura, as well as Haruo Ozaki, chairman of the Tokyo Medical Association and U.S. and British frontline experts.

These are just some amongst hundreds of studies that support the early and efficacious treatment of COVID-19 with repurposed drugs. Well-known medications can be utilized much more easily than expensive monoclonal antibodies with limited availability and challenging administration. **Drug repurposing is the fastest, safest, and most readily deployable way to treat a pandemic disease.** Prophylaxis and early treatment protocols being used worldwide can be found at: The Association of American Physicians and Surgeons site: "Physician List & Guide to Home-Based COVID Treatment"; and the Front Line COVID-19 Critical Care Alliance (FLCCC) site.

Scientific studies have shown that multidrug early treatment with combinations of repurposed drugs and nutraceuticals is highly successful in preventing escalation of the disease. Physicians around the world are successfully managing COVID-19 in the outpatient setting using a variety of treatment and preventative protocols. The common message amongst them all is that treatment is most successful when initiated early.

It is the CCCA's strong recommendation that the government and PHAC re-focus their efforts to educate physicians and the general public about the importance of prophylaxis and early treatment in combating COVID-19.

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II. Vaccine Safety and Surveillance

Safe and effective vaccines can be an important tool in addressing a pandemic. Unfortunately, since the government's vaccination program was implemented, we have observed, first-hand, the warning signs regarding vaccine safety, including many of the potential adverse events presented during the VRBPAC meeting on October 22, 2020[52] (Slide #16 in Appendix A) before the vaccine rollout, including significant signs of micro-clotting and even deaths[53,54].

In early 2021, Dr. Charles Hoffe of Lytton, British Columbia, discovered that several of his patients had experienced adverse events after receiving the Moderna vaccine. He wrote an open letter to Provincial Health Officer Dr. Bonnie Henry sharing his findings and to seek guidance[55], but was dismissed, silenced and even sanctioned for his attempts to protect Canadians[56,57]. More recently, Dr. Hoffe discovered that the majority of his vaccinated patients tested for the D-dimer marker showed elevated D-dimer levels pointing to signs of micro-clotting, a potentially very serious condition whose long-term effects are yet to be determined. Our colleague Dr. Byram Bridle, Associate Professor of Viral Immunology at the University of Guelph, also sounded the alarm when he realized that the SARS-CoV-2 spike protein itself is almost entirely responsible for the adverse cardiovascular effects from both COVID-19 and the vaccine product[58]. He too was aggressively silenced and criticized for sharing his findings[59], which have been reiterated by numerous other experts. Increasing number of scientific studies show that the spike

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protein by itself is bioactive and can be toxic to tissues[60,61,62,63,64,65]. S1 subunit of the spike protein is sufficient to cause tissue damage[66,67,68,69]. These findings are concerning because COVID-19 vaccines also induce production of the spike protein by our own human cells. Moreover, we now know that some of the mRNA vaccine can leave the site of the injection and travel throughout the body[70,71]. The spike protein and its S1 subunit have also been found to circulate in some vaccinated individuals[72]. While damage is expected in an untreated COVID-19 patient, vaccines are administered to healthy individuals. It is therefore paramount to use immunization strategies that use benign viral components. This however does not seem to be fulfilled with currently deployed COVID-19 vaccines.

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Many other scientists, both in Canada and around the world, have expressed concerns regarding the potential development of antibody-dependent enhancement (ADE) in vaccinated individuals[73,74]. ADE typically results in serious illness and even death by allowing the virus to more easily replicate in a person who has produced non-sterilizing antibodies (antibodies that do not destroy the virus). A study[75] published on August 9, 2021, in the Journal of Infection confirmed ADE with the delta variant and the presence of infection-enhancing antibodies in symptomatic COVID-19 patients. ADE is a well-known phenomenon that has been previously reported with several different viruses, including coronaviruses and has hindered vaccine development in the past[76,77].

While we are seeing the acute and sub-acute adverse events of COVID-19 vaccination, the long-term effects of these still largely experimental genetic vaccines will not be known for some time to come. It is however already known that the spike protein can cause hyper-inflammation[78,79,80]. Numerous biological activities of the spike protein, the biodistribution and the mechanism of COVID-19 vaccines suggest that possible future increase in autoimmune diseases and cancers cannot be ruled out. For example, the relationship between the Pandemrix vaccine deployed in 2009 against influenza and narcolepsy in children was uncovered by Swedish and Finnish authorities only after its wide commercial deployment to over 30 million people[81].

It has been a well-established practice that any new medical product must be closely monitored at both the formal clinical trial and deployment stages. However, the presently used vaccines have been deployed on the general public with little systematic reporting of vaccine injury and highly biased analyses

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[73] ADE occurs when the antibodies generated bind to a pathogen but are unable to prevent infection. Instead, these antibodies act as a "Trojan horse," allowing the pathogen to enter cells, worsening the disease in persons already exposed to the virus through a previous infection or vaccination.

[74] It was also stated in the Health Canada Summary Basis of Decision (updated May, 2021) that "the possibility of vaccine-induced disease enhancement after vaccination against SARS-CoV-2 has been flagged as a potential safety concern that requires particular attention by the scientific community, including The World Health Organization (WHO),…"; [Full article: Vaccination against SARS-CoV-2 and disease enhancement – knowns and unknowns (tandfonline.com)]

[75] Yahi, N., Chahinian, H., and Fantini, J. (2021) *Infection-enhancing anti-SARS-CoV-2 antibodies recognize both the original Wuhan/D614G strain and Delta variants. A potential risk for mass vaccination?* J Infect. In press. https://doi.org/10.1016/j.jinf.2021.08.010

[76] Wan, Y., Shang, J., Sun, S. *et al*. (2020) *Molecular mechanism for antibody-dependent enhancement of Coronavirus entry.* J Virol. 94(5):e02015-19. https://doi.org/10.1128/JVI.02015-19

[77] Tseng, C-T., Sbrana, E., Iwata-Yoshikawa, N. *et al*. (2012) *Immunization with SARS coronavirus vaccines leads to pulmonary immunopathology on challenge with the SARS virus.* PLoS One. 7(8). https://doi.org/10.1371/annotation/2965cfae-b77d-4014-8b7b-236e01a35492

[78] Patra, T., Meyer, K., Geerling, L. *et al.* (2020) *SARS-CoV-2 spike protein promotes IL-6 trans-signaling by activation of antiotensin II receptor signaling in epithelial cells*. PLoS Path. 16(12):e1009128. https://doi.org/10.1371/journal.ppat.1009128

[79] Petruk, G., Puthia, M., Petrlova, J.*et al*. (2020) *SARS-CoV-2 spike protein binds to bacterial lipopolysaccharide and boosts proinflammatory activity*. J Mol Cell Biol. 12(12):916–932. https://doi.org/10.1093/jmcb/mjaa067

[80] Souchelnytskyi, S., Nera, A and Souchelnytskyi, N. (2021) *COVID-19 engages clinical markers for the management of cancer and cancer-relevant regulators of cell proliferation, death, migration, and immune response*. Nature Sci Rep. 11:5228. https://doi.org/10.1038/s41598-021-84780-y

[81] Sarkanene, T., Alakuijala, A., Julkunen, I. and Partinen, M. (2018) *Narcolepsy associated with Pandemrix vaccine.* Curr Neurol Neurosci Rep. 18:43 https://link.springer.com/article/10.1007/s11910-018-0851-5

of those reports that have been filed. Based on our experience, there is vast under-reporting of adverse events. Vaccine injuries are frequently downplayed or dismissed as mere coincidences, resulting in low reporting to the Canadian Immunization Surveillance Program (CAEFISS), rendering its reports unreliable.

Reports that do get submitted are frequently rejected despite sound clinical judgement from the primary care provider. This is clearly evident upon inspection of the Health Canada website (https://health-infobase.canada.ca/covid-19/vaccine-safety/) where the weekly reports of adverse reactions from May 1, 2021, onward surprisingly declined, despite increased rates of vaccine administration. Moreover, as the vaccination program has continued in recent months, the ratio of reports of serious adverse reactions (i.e., requiring hospitalization or deaths) versus mild reactions increased from ~15% to well over 40%. Finally, three-quarters of all the vaccine injury reports are for females, whereas a more equitable distribution between males and females would have been expected.

During the Emergency Use Authorization (EUA) process in the USA, the COVID-19 vaccines were considered for EUA pending reliance on the safety surveillance system called the Vaccine Adverse Events Reporting System (VAERS). As of September 10, 2021, VAERS has recorded 14,925 deaths, 60,741 hospitalizations, 19,210 permanent disabilities, 5,765 cases of myocarditis, 6,637 heart attacks, 1,862 miscarriages and more. These events are understood to be correlated and have been explored in clinical and research settings as they have emerged, such as with thrombocytopenia[82]. AstraZeneca vaccines were paused and then phased out in Canada in response to adverse events, though this has been an odd exception when compared to the multitude of similar and worse events reported in VAERS and other systems in relation to the mRNA vaccines.

Moreover, based on a 2009 Centers for Disease Control and Prevention (CDC) commissioned Harvard study, it is known that there is vast under-reporting of adverse events to the VAERS in general (less than 2% of valid adverse events get reported) and doctors are now finding that some of their reports to VAERS are either missing, or have been unjustifiably rejected. Over the last 30 years up to August 13, 2021, more than a third of all VAERS reports of vaccine injuries (1.4 million) have been linked to COVID-19 vaccines (595,622). As of August 13, 2021, there were a total of 184,886 Serious Adverse Events (SAE) for ALL vaccines, 80,850 of which were entirely for COVID-19 vaccines[83].

A Canadian researcher, Jessica Rose, PhD, MSc, BSc, recently authored a report entitled[84], "A Report on the U.S. Vaccine Adverse Events Reporting System (VAERS) of the COVID-19 Messenger

[82] Warkentin, T. E. and Cuker, A. (2021, August 20) *COVID-19: Vaccine-induced immune thrombotic thrombocytopenia (VITT).* UpToDate. https://www.uptodate.com/contents/covid-19-vaccine-induced-immune-thrombotic-thrombocytopenia-vitt.

[83] National Vaccine Information Center. (2021) *MedAlerts: Search the U.S. Government's VAERS Data*. https://medalerts.org/

[84] Covid Strategies. (2021, Jul 2) *Canadian researcher analyzes CDC VAERS data for COVID-19 vaccine safety POV – But is the other side of risk calculated.* https://www.covidstrategies.org/canadian-researcher-analyzes-cdc-vaers-data-for-covid-19-vaccine-safety-pov-but-is-the-other-side-of-risk-calculated/

Ribonucleic Acid (mRNA) Biologicals." Her results are found in Appendix C. Summarizing her findings[85], the researcher made the following conclusions:

- "[COVID mRNA] Vaccines are the likely cause of reported deaths, spontaneous abortions, anaphylactic reactions, in addition to cardiovascular, neurological, and immunological Adverse Events.
- There is a strong signal from the VAERS data that the risk of suffering Serious Adverse Events (SAE) shortly after injection is significant and the overall risk signal is high.
- Autopsies should be required in cases of deaths temporally associated with the COVID-19 injections.
- Investigation and focus on immunological issues must be a priority in future studies.
- The efficacy of the experimental vaccines needs to be assessed by immunological assays and long-term studies must be required.
- Extreme care should be taken when making a decision to participate in this mass vaccination experiment."

In the European Union, as of September 11 , 2021, EudraVigilance - which gathers adverse event reports from 27 EU member states out of a total of 50 countries in Europe - has recorded 24,526 deaths and 2.317 million vaccine injuries[86], of which almost 50% are considered serious in nature[87].

As a comparison, the 1976 swine flu vaccination program in the U.S., which was rushed to market based on incomplete knowledge, was halted within months once a temporal association was made with Guillian-Barre Syndrome[88]. In hindsight, that particular swine flu was not dangerous, and it did not result in a pandemic[89]. Over 40 million people in the U.S. had been vaccinated before the program was abandoned. A rushed vaccination campaign can ultimately result in more harm than benefit. In comparison, approved vaccines normally take 7-12 years to develop and properly test. It is, therefore, very worrying that COVID-19 vaccines have no predefined stoppage condition (i.e., number of severe adverse events that would trigger a halt and review of the vaccination program) and their safety is not monitored properly.

[85] Covid call to humanity. (2021, May 24) *New study: Vaccines are the likely cause of adverse effects and deaths following vaccination.* https://covidcalltohumanity.org/2021/05/24/new-study-vaccines-are-the-likely-cause-of-adverse-effects-and-deaths-following-vaccination/

[86] Shilhavy, B. (2021, Sep 3) *23,252 deaths, 2,189,537 injured following COVID shots: EU database of adverse reactions.* https://alethonews.com/2021/09/03/23252-deaths-2189537-injured-following-covid-shots-eu-database-of-adverse-reactions/

[87] Abbattista, M, Martinelli, I and Peyvandi, F. (2021) *Comparison of adverse drug reactions among four COVID-19 vaccines in Europe using the EudraVigilance database: thrombosis at unusual sites.* J Thromb Haemost. Online ahead of print. https://doi.org/10.1111/jth.15493 "This report on EudraVigilance data strengthens anecdotal findings on CVT [*cerebral vein thrombosis*] following COVID-19 vaccinations."

[88] Sencer, D. J., and Millar, J. D. (2006). *Reflections on the 1976 swine flu vaccination program.* Emerg Infect Dis. 12(1):29-33. https://doi.org/10.3201/eid1201.051007

[89] Fisher, R. (2020, September 21). *The fiasco of the 1976 'swine flu affair.'* BBC Future. https://www.bbc.com/future/article/20200918-the-fiasco-of-the-us-swine-flu-affair-of-1976

The Respiratory Syncytial Virus (RSV) vaccine candidate developed in the 1960s was not efficacious and actually enhanced disease when participants were subsequently exposed to RSV consistent with ADE. Hospitalizations were far more prevalent in the vaccinated group than among controls and there were two fatalities attributed to the vaccine[90]. The recent use of the Dengvaxia vaccine against Dengue Virus in the Philippines showed that vaccinated children without previous infection were at higher risk of severe disease upon reinfection compared to unvaccinated controls[91,92]. Due to this severe vaccine limitation, it has since been approved only for a specific group of people at high risk.

These cases further illustrate the need for thorough testing of vaccines before their population-wide deployment. As outlined above, numerous safety signals and red flags are also emerging today with respect to the COVID-19 vaccines. Therefore, it is imperative that the Canadian government must act swiftly and responsibly to pause the COVID-19 vaccine program, especially when vaccination of young children and additional boosters to the general public are being considered.

The CCCA opines that the number of deaths and serious adverse events caused by the vaccines both in Canada and worldwide, has significantly and devastatingly surpassed any reasonable measure that would keep a population-wide vaccine program in place. It is the opinion of the CCCA that the Canadian government's current COVID-19 vaccine program should be paused immediately for the safety of all Canadians, especially considering that those most at risk of the disease are already largely vaccinated. Additional vaccinations will produce more harm than benefit.

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[90] Hurwitz, J. L. (2014) *Respiratory syncytial virus vaccine development.* Expert Rev Vaccines. 10(10):1415-1433. https://doi.org/10.1586/erv.11.120

[91] Sridhar, S., Luedtke, A., Langevin, E. *et al*. (2018) *Effect of Dengue Serostatus on Dengue vaccine safety and efficacy.* N Engl J Med. 379:327-340. https://www.nejm.org/doi/full/10.1056/NEJMoa1800820

[92] Wilder-Smith, A, Flasche, S., Smith, P. G. (2019) *Vaccine-attributable severe dengue in the Philippines.* Lancet. 394(10215):2151-2152. https://doi.org/10.1016/S0140-6736(19)32525-5

III. Immune Escape, Variants and Herd Immunity

Prior to initiating the vaccine program, scientists warned the World Health Organization (WHO) against vaccinating amidst a pandemic, particularly with a "leaky," or non-sterilizing vaccine. The basis for this warning is the well-known paradigm that the use of a leaky vaccine can create ideal conditions for the proliferation of potentially dangerous variants within vaccinated individuals. In the poultry industry, use of leaky vaccines has allowed survival and spread of deadly strains of Marek's disease virus to the point that none of the farmed chickens can survive nowadays without vaccination. Prior to vaccine use, mortality of chickens infected with Marek's disease was rather low[93,94,95,96].

This is in stark contrast to sterilizing vaccines, such as the ones used for smallpox or polio, which prevent individuals from contracting, transmitting, falling ill and dying from the diseases against which they have been inoculated.

In March 2021, Dr. Geert Vanden Bossche, a Belgian virologist and vaccinologist who formerly worked with the Bill & Melinda Gates Foundation and GAVI, wrote an open letter[97] to the WHO about the consequences of vaccinating in the heat of a pandemic. In his August 12, 2021, document entitled *C-19 Pandemia: Quo vadis, homo sapiens?*[98] he explains, "As of the early days of the mass vaccination campaigns, at least a few experts have been warning against the catastrophic impact such a program could have on global and individual health. Mass vaccination in the middle of a pandemic is prone to promoting selection and adaptation of immune escape variants that are featured by increasing infectiousness and resistance to spike protein (S)-directed antibodies (Abs), thereby diminishing protection in vaccinees and threatening the unvaccinated. This already explains why the WHO's mass vaccination program is not only unable to generate herd immunity (HI) but even leads to substantial erosion of the population's immune protective capacity. As the ongoing universal mass vaccination program will soon promote dominant propagation of highly infectious, neutralization escape mutants (i.e., so-called 'S Ab-resistant variants'), naturally acquired, or vaccinal neutralizing Abs, will, indeed, no longer offer any protection to immunized individuals whereas high infectious pressure will continue to suppress the innate immune defense system of the non-vaccinated. This is to say that every further increase in vaccine coverage rates will further contribute to forcing the virus into resistance to neutralizing, S-specific Abs. Increased viral infectivity, combined with evasion from antiviral immunity, will inevitably result in an additional toll taken on human health and human lives. Immediate action needs, therefore, to be taken in order to dramatically reduce viral infectivity rates and to prevent selected immune escape variants from rapidly spreading through the entire population, whether vaccinated or not. This first critical step can only

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[93] Read, A.F., Baigent, S. J., Powers, C. *et al.* (2015) *Imperfect vaccination can enhance the transmission of highly virulent pathogens.* PLoS Biol. https://doi.org/10.1371/journal.pbio.1002198
[94] Boots, M. (2015) *The need for evolutionarily rational disease interventions: Vaccination can select for higher virulence.* PLoS Biol. https://doi.org/10.1371/journal.pbio.1002236
[95] Akpan, N. (2015, Jul 27) *This chicken vaccine makes its virus more dangerous.* PBS News Hour. https://www.pbs.org/newshour/science/tthis-chicken-vaccine-makes-virus-dangerous
[96] Yong, E. (2015, Jul 27) *Leaky vaccines enhance spread of deadlier chicken viruses.* National Geographic. https://www.nationalgeographic.com/science/phenomena/2015/07/27/leaky-vaccines-enhance-spread-of-deadlier-chicken-viruses/
[97] Vanden Bossche, G. (2021, Mar 6) *Public Health Emergency of International Concern: Why mass vaccination amidst a pandemic creates an irrepressible monster.* https://37b32f5a-6ed9-4d6d-b3e1-5ec648ad9ed9.filesusr.com/ugd/28d8fe_266039aeb27a4465988c37adec9cd1dc.pdf
[98] Vanden Bossche, G. (2021, Aug 12) *C-19 Pandemia: Quo vadis, homo sapiens?* https://www.geertvandenbossche.org/post/c-19-pandemia-quo-vadis-homo-sapiens

be achieved by calling an immediate halt to the mass vaccination program and replacing it by widespread use of antiviral chemoprophylactics while dedicating massive public health resources to scaling early multidrug treatments of COVID-19 disease."

Less than 6 months later, his predictions are coming true. We are now faced with variants that circumvent the first generation of these genetic vaccines - which were modelled off the now extinct SARS-CoV-2 Wuhan strain provided by China. These vaccines have become relatively ineffective in combating the transmission of the newer delta variant and are expected to be even less effective with the emerging mu variant[99]. According to CDC Director Rochelle Walensky, "…we are seeing concerning evidence of waning vaccine effectiveness over time, and against the delta variant." And the CDC's August 19, 2021, admission that, "those who were vaccinated early are at increased risk of severe disease as vaccine effectiveness is waning."

Currently, the scenario playing out around the world is seeing fully vaccinated individuals producing variants, as well as catching, transmitting, falling ill and dying from the virus[100,101,102,103]. We are seeing surges of COVID-19 in highly vaccinated places such as Israel, Gibraltar and Iceland[104]. Israel had 72.5% of its eligible population double vaccinated[105], yet it could not achieve herd immunity through vaccination. Consequently, they are now performing additional vaccinations with a third booster shot, without prior efficacy and safety studies, because long-lasting immune memory was not achieved with the first two injections of the Pfizer mRNA vaccine.

With an understanding that mass vaccination is likely significantly contributing to the development of concerning variants, and that the virus is fully circulating amongst and affecting even the fully vaccinated, it is scientifically inaccurate, divisive and vilifying to suggest that this is a 'pandemic of the unvaccinated'. This makes the language in Dr. Bonnie Henry's recent Public Health Order deeply concerning, as she unfoundedly describes the mere presence of "unvaccinated persons" as posing "risk of

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[99] United Nations. (2021, Sep 1) *COVID-19: New Mu variant could be more vaccine-resistant.* UN News. https://news.un.org/en/story/2021/09/1098942

[100] Beale, J. and Shearing, H. (2021, Jul 14) *HMS Queen Elizabeth: Covid outbreak on Navy flagship.* BBC News. https://www.bbc.com/news/uk-57830617

[101] Massi, A. (2021, Aug 23) *I went to a party with 14 other vaccinated people; 11 of us got COVID: COMMENTARY.* The Baltimore Sun. https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0804-breakthrough-covid-20210803-t32trfpiwzdf5okfar45f64whi-story.html

[102] The Gateway Pundit. (2021, Jul 25) *UPDATE FROM SYDNEY: Reporter apologizes for unclear numbers on vaccinated individuals.* NSW News 9 (Rumble). https://rumble.com/vkba8x-update-from-sydney-all-new-covid-hospitalizations-involve-vaccinated-indivi.html

[103] Markos, M., (2021, Jun 17) *Nearly 4,000 breakthrough COVID infections have now been reported in mass.* NBC Boston. https://www.nbcboston.com/news/local/nearly-4000-breakthrough-covid-infections-have-now-been-reported-in-mass/2408052/

[104] Salazar, A. (2021, Jul 30) *Gibraltar, Iceland see Massive Covid Spike despite over 90% of population vaccinated.* NOW Report. https://nworeport.me/2021/07/30/gibraltar-iceland-see-massive-covid-spike-despite-over-90-of-population-vaccinated/

[105] Estrin, D. (2021, Aug 20) *Highly vaccinated Israel is seeing a dramatic surge in New Covid Cases - Here's why.* NPR. https://www.npr.org/sections/goatsandsoda/2021/08/20/1029628471/highly-vaccinated-israel-is-seeing-a-dramatic-surge-in-new-covid-cases-heres-why

harm to residents of B.C.", while also conceding that vaccinated individuals are also at risk of spreading the virus and falling ill with COVID-19[106].

It is evident that no country, anywhere in the world, can eradicate the virus by indiscriminate vaccination and attempting to do so may in fact be dangerous as we create more resistant strains of SARS-CoV-2. Vaccination will not achieve herd immunity. We must instead move in the direction of natural immunity[107] for those at minor risk, which is the vast majority of the population, with the added protections of prophylaxis and early treatment. If we do otherwise, and continue with the current vaccination programs, we will face a waterfall of variants that will continue to pose a threat to the most vulnerable in our country, including those who are vaccinated. Also, since many diverse domestic as well as wild animals have been shown to be susceptible to SARS-CoV-2, containment of this virus by vaccination alone to prevent future infections of humans will be highly unlikely[108,109].

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[106] Henry, B. (2021, September 2). *FACE COVERINGS (COVID-19) – SEPTEMBER 2, 2021*. BC Ministry of Health. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/covid-19-pho-order-face-coverings.pdf.

[107] Cohen, K. W., Linderman, S. L., Moodie, Z. *et al.* (2021, June 18) *Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells*. MedRxiv preprint. https://www.medrxiv.org/content/10.1101/2021.04.19.21255739v1

[108] Cool, K., Gaudreault, N. N., Morozov, I. *et al*. *Infection and transmission of ancestral SARS-CoV-2 and its alpha variant in pregnant white-tailed deer.* BioRxiv preprint. https://www.biorxiv.org/content/10.1101/2021.08.15.456341v2

[109] Griffin, B. D., Chan, M., Tailor, N. *et al*. *SARS-CoV-2 infection and transmission in the North American deer mouse.* Nat Comm. 12:3612. https://www.nature.com/articles/s41467-021-23848-9

IV. Informed Consent

According to the Ontario Health Care Consent Act of 1996:

No treatment without consent: 10 (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless, (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

11 (1) The following are the elements required for consent to treatment:
1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

In this case, the "treatment" is the COVID-19 vaccine.

As health care providers managing the care of thousands of patients who have experienced adverse reactions to the vaccines (the "vaccine injured"), **it has become apparent that our patients have not been properly informed[110] regarding their individual risks and benefits of the COVID-19 vaccine products nor the nature of the underlying technology.** Moreover, when it comes to children over 12 providing consent to an investigational product/injection without parental guidance, we are even more so alarmed[111]. By the manufacturers' own definitions, these are investigational gene therapy products[112]. They were initially authorized by Health Canada under Interim Order and have recently been transition to an authorization under Division 8 (New Drugs) of the *Food and Drug Regulations*[113]. The regulatory decision itself states: "An important limitation of the data is the lack of information on the long-term safety and effectiveness of the vaccine"[114,115]. It is, therefore, entirely reasonable for individuals to take a

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[110] Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council (2019) *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans.* Government of Canada. https://ethics.gc.ca/eng/documents/tcps2-2018-en-interactive-final.pdf

[111] Bowden, O. (2021, May 21) *Do Ontario children 12-15 need parental consent to get COVID-19 vaccines? It depends where you live.* Toronto Star. https://www.thestar.com/news/gta/2021/05/21/do-ontario-children-12-15-need-parental-consent-to-get-covid-19-vaccines-it-depends-where-you-live.html

[112] "Moderna, Inc. Form 10-Q for the quarterly period ended June 30, 2020." *EDGAR*. Securities and Exchange Commission, 2020, https://www.sec.gov/Archives/edgar/data/1682852/000168285220000017/mrna-20200630.htm

[113] Food and Drug Regulations (CRC, c.870) New Drugs: C.08.001. https://laws-lois.justice.gc.ca/eng/regulations/c.r.c.,_c._870/page-141.html#h-578215

[114] Government of Canada. (2021) Regulatory Decision Summary – COMIRNATY – Health Canada. https://covid-vaccine.canada.ca/info/regulatory-decision-summary-detail.html?linkID=RDS00856

[115] Government of Canada. (2021) Regulatory Decision Summary – SPIKEVAX – Health Canada. https://covid-vaccine.canada.ca/info/regulatory-decision-summary-detail.html?linkID=RDS00855

cautious approach to a novel, not-fully-tested medical product that could present with short term, long term or potentially even transgenerational adverse events.

One of the concerns specifically related to the mRNA and adenoviral COVID-19 vaccines is their requirement for healthy cells to produce the spike protein of this virus, which sets them up for inflammatory responses to elicit antibody production. However, repeated inflammation of tissues is a well-known mechanism for breaking immune tolerance and induction of autoimmune diseases. Repeated immunizations, including with other vaccines that use the same technology but for other pathogenic viruses or bacteria, could be expected to cause new autoimmune disease or exacerbate pre-existing autoimmune disease.

Examples of some of the information with which Canadians should be provided prior to vaccination in order to give full informed consent include but are not limited to the following:

- **Adverse Events -** During the October 22, 2020, COVID-19 vaccine presentation[116] to the American Food and Drug Administration (FDA), a list of potential adverse events was presented (Appendix A). This list of potential adverse events was not exhaustive and was never presented to the Canadian public.

- **Risk/Benefit Calculations and Absolute Risk Reduction (ARR) -** PHAC has never provided a risk/benefit calculation based on health profile, age or gender for Canadians to consider, nor has it provided a true assessment of one's benefit from taking the vaccine. The high efficacy rate reported in the vaccine studies is a comparison of the ratio of illness prevalence in the treatment and placebo groups. It is called Relative Risk Reduction (RRR). This is a statistical comparison. However, to understand whether the vaccines reduce the risk of contracting COVID-19 one must examine the absolute risk reduction (ARR) value. According to the Pfizer trials, their vaccine afforded the individual less than a 1% reduction in the risk of contracting the disease compared to not receiving the vaccine at all. It is for this reason that the FDA clearly states in its *Communicating Risks and Benefits* guidelines[117]: ***"Provide absolute risks, not just relative risks. Patients are unduly influenced when risk information is presented using a relative risk approach; this can result in suboptimal decisions. Thus, an absolute risk format should be used."*** However, this information has not been communicated to Canadians.

- **Survivability -** In October 2020 prior to any COVID-19 vaccination campaign, the infection fatality rate (IFR) for COVID-19 was estimated by the WHO at 0.27%; with a **survivability rate of 99.73%**. The extent of actual infection of the Canadian public with SARS-CoV-2 is unknown as many

[116] Anderson, S. (2020, Oct 22) *CBER plans for monitoring COVID-19 vaccine safety and effectiveness.* US FDA. VRBPAC Meeting. https://www.fda.gov/media/143557/download
[117] Fischhoff, B., Brewer, N. T. and Downs, J. S. (2011) *Communicating risks and benefits: An evidence-based users' guide.* US FDA. https://www.fda.gov/about-fda/reports/communicating-risks-and-benefits-evidence-based-users-guide

asymptomatic cases would have been missed[118]. The American CDC estimates that only 1 in 4 infected have been identified by testing putting true IFR at a much lower value than what is assumed from positive PCR numbers only[119]. CDC further estimates these age stratified IFRs: 0-17 years: 0.002% (survivability 99.998%), 18-49 years: 0.05% (survivability 99.95%), 50-64 years: 0.6% (survivability 99.4%), 65+ years: 9% (survivability 91%)[120]. For a healthy person under age 70, IFR is 0.05% - this is the same daily risk as driving 23 km per day in Canada[121].

- **Susceptibility -** Prior to instituting the vaccine program, PHAC was aware that it was mainly institutionalized elderly individuals with comorbidities who were at greatest risk. COVID-19 poses increased risk only to a small subset of the population - frail, elderly people with comorbidities - these are the same people who are also at risk from other common infections. By contrast, for children, COVID-19 is less deadly than the flu[122].
  Consider:
  - 96.8% of COVID-19 deaths in Alberta had 1 or more comorbidities[123].
  - 95% of USA deaths had 1 or more comorbidities[124] (on average 4 comorbidities).
  - The vast majority of all Canadian COVID-19 deaths have been in long term care homes[125].
  - According to Statistics Canada, the average age at death in Canada in 2019 was 76.5 years. However, the average age of those who died of COVID-19 in Canada last year was higher at 83.8[126] and is still around 76 years when more recent data are included[127].

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[118] Since the extent of actual infection of the Canadian public with SARS-CoV-2 was not properly established, this is likely to be a substantial overestimate of the IFR.
[119] CDC. (2021, Jul 27). *Estimated COVID-19 Burden.* https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/burden.html
[120] CDC. (2021, Mar 19) *COVID-19 Pandemic Planning Scenarios.* https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html
[121] Joffe, A. R. (2021, Feb 26) *COVID-19: Rethinking the lockdown groupthink.* Front Public Health. https://doi.org/10.3389/fpubh.2021.625778
[122] Shekerdemian, L. S., Mahmood, N. R., Wolfe, K. K. *et al*. (2020) *Characteristics and outcomes of children with coronavirus disease 2019 (COVID-19) infection admitted to US and Canadian Pediatric Intensive Care Units.* JAMA Pediatr. *Characteristics and outcomes of children with coronavirus disease 2019 (COVID-19) infection admitted to US and Canadian pediatric intensive care units.* Critical Care Medicine | JAMA Pediatrics | JAMA Network
[123] Government of Alberta. (2021) *COVID-19 Alberta statistics.* COVID-19 Alberta statistics | alberta.ca
[124] CDC (2021) *Weekly updates by select demographic and geographic characteristics.* COVID-19 Provisional Counts - Weekly Updates by Select Demographic and Geographic Characteristics (cdc.gov)
[125] National Institute on Ageing. (2021) *NIA LONG TERM CARE COVID-19 TRACKER.* NIA LONG TERM CARE COVID-19 TRACKER - Empower Health (ltc-covid19-tracker.ca)
[126] Jackson, H. (2021, Jun 2) COVID-19 deaths lowered Canadians' averae life expectancy to 2013 levels: StatsCan. Global news. COVID-19 deaths lowered Canadians' average life expectancy to 2013 levels: StatsCan - National | Globalnews.ca
[127] Provisional death counts and excess mortality, January 2020 to May 2021. (2021, August 9) Government of Canada, Statistics Canada: The Daily. The Daily — Provisional death counts and excess mortality, January 2020 to May 2021 (statcan.gc.ca)

- **Childhood Risk -** It is known that children have not been contributing significantly to the transmission of the virus[128,129,130]. The overall survival rate of minors (under the age of 19 years) with COVID-19 is 99.997%[131,132]. With several serious adverse events being recognized only post-authorization (e.g. myocarditis and pericarditis), and potential yet unrecognized adverse events, it is possible that healthy children face similar or higher risks from vaccination than from the disease itself. As of September 17, 2021, only 2% of all hospitalized in Canada that tested positive for SARS-CoV-2 have been under the age of 20 and only 15 Canadians in this age group infected with the virus died[133]. For comparison, about 110 kids die annually in Canada from cancer[134]. Furthermore, a 13-year-old girl that participated in a Pfizer trial for 12-15 year olds, Maddie de Garay, has been permanently disabled, yet this information has not been reported in trial results pointing to possible trial irregularities[135]. (Further information regarding youth vaccination in Appendix B)

From December 13, 2020 to August 7, 2021, there have been 314 reports of myocarditis or pericarditis following receipt of COVID-19 mRNA vaccines in Ontario[136]. The highest reporting rate of myocarditis/pericarditis was observed in males aged 18-24 years following the second dose. The UK government's advisory body on vaccination has decided not to recommend universal COVID vaccination for 12–15-year-olds[137], because of the "very low risk, considerations on the potential harms and benefits of vaccination are very finely balanced."

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[128] Rajmil, L. (2020) Role of children in the transmission of the COVID-10 pandemic: a rapid scoping review. BMJ Paediatr Open. 4e000722. *Role of children in the transmission of the COVID-19 pandemic: a rapid scoping review.* BMJ Paediatrics Open

[129] Somekh, I., Boker, L. K., Shohat, R. *et al*. Comparison of COVID-19 incidence rates before and after school reopening in Israel. JAMA Netw Open. 4(4):e217105. https://doi.org/10.1001/jamanetworkopen.2021.7105

[130] Eberhardt, C. S. and Siegrist, C-A. (2021) Is there a role for childhood vaccination against COVID-19? Pediatr Allergy Immunol. 32(1):9-16. https://doi.org/10.1111/pai.13401

[131] Bhopal, S. S., Bagaria, J., Olabi, B., and Bhopal, R. (2021) Children and young people remain at low risk of COVID-19 mortality. Lancet Child Adolesc Health. *5*(5):E12–E13. https://doi.org/10.1016/s2352-4642(21)00066-3

[132] Smith, C., Odd, D., and Harwood, R. (2021) Deaths in children and young people in England following SARS-CoV-2 infection during the First pandemic year: A national study using linked mandatory child death reporting data. Res Sq. https://doi.org/10.21203/rs.3.rs-689684/v1

[133] Government of Canada. (2021, Sep 20) COVID-19 daily epidemiology update. https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html

[134] Ellison, L. F., Xie, L. and Sung, L. (2023, Feb 17) *Trends in paedratric cancer survival in Canada, 1992 to 2017.* Statistics Canada. https://www150.statcan.gc.ca/n1/pub/82-003-x/2021002/article/00001-eng.htm

[135] Giang-Paunon, S. (2021, Jul 2) *Mom details 12-year-old daughter's extreme reactions to COVID vaccine, says she's now in wheelchair.* Fox news. https://www.foxnews.com/media/ohio-woman-daughter-covid-vaccine-reaction-wheelchair

[136] Public Health Ontario. (2021) *Myocarditis and pericarditis following vaccination with COVID-19 mRNA vaccines in Ontario: December 13, 2020 to August 7, 2021.* Government of Ontario. https://www.publichealthontario.ca/-/media/documents/ncov/epi/covid-19-myocarditis-pericarditis-vaccines-epi.pdf

[137] Zhou, L. (2021, Sep 3) *UK Advisory Body not recommending CCP virus vaccines to healthy children under 16.* The Epoch Times. https://www.theepochtimes.com/mkt_app/uk-vaccines-advisory-body-not-recommending-ccp-virus-vaccines-to-healthy-children-under-16_3980285.html?v=ul

It is clear our patients were not provided with this information prior to inoculation, and they were not given the opportunity to discuss their risk/benefit ratio and/or alternative prophylaxis or treatment options (discussed above) with their primary care practitioners or those administering the injections. Those who experience a vaccine injury, some of which are debilitating and life-altering, are scared, confused and angry about the lack of information essential for informed consent. As there are no standards of care for these vaccine injuries, many patients feel abandoned by their own practitioners and are left to seek treatment guidance on their own.

We are seeing unnecessary harm come to patients who were not fully informed about the potential adverse events nor their risk-to-benefit ratio. Consequently, they were unable to give full informed consent. Many of these patients would most likely have fully recovered naturally from COVID-19, particularly if provided with early treatment (as discussed above). This has been a flagrant abuse by the government in pressing a vaccination agenda, while robbing individuals of the freedom to make informed decisions about their own health. Without full transparency and informed consent, and without a full appreciation and proper evaluation of the safety of these novel vaccines (both short and long term) the current COVID-19 vaccination programs should be paused immediately. We greatly support classical vaccine programs as developed over past decades and are therefore deeply concerned that this blatant disregard for medical ethics and most recent scientific data during COVID-19 vaccinations will irreparably damage Canadians' trust in the traditional vaccine programs.

V. Vaccine Passports ("Vax Pass") and Vaccine Mandates

On August 18, 2021, Prime Minister Justin Trudeau stated, "The bottom line is, if anyone who doesn't have a legitimate medical reason for not getting fully vaccinated chooses to not get vaccinated, there will be consequences"[138]. NDP Leader Jagmeet Singh issued a statement saying public servants who refuse a shot could be punished under collective agreements between unions and the federal government[139]. **This is totalitarianism, plain and simple**.

The implementation of vaccine passports and vaccine mandates in order to maintain employment, travel or avail oneself of an education has implications with issues of informed consent, medical privacy, the Canadian Charter of Rights and Freedoms and the (Ontario) Human Rights Code.

The CCCA strenuously objects to Vaccine Passports ("Vax Passes") and vaccine mandates of any kind for the following reasons:

THE LAW

1) **Informed consent:** We must examine the rights of a patient with respect to consenting to a medical treatment such as novel genetic vaccines. This fundamental principle is at the core of a person's bodily autonomy, integrity and dignity. Consent must be **informed** as set out in case law including the Supreme Court decisions of Parmley & Parmley v Yule[140], and Hopp v Lepp[141]. The patient must be 'sufficiently informed to enable him to make an informed choice' otherwise medical treatment is tantamount to assault or force. Is it truly "consent" to receive a vaccine when the individual's ability to work to feed one's family, educate him/herself or to travel is being threatened?

   The Supreme Court decision of Her Majesty the Queen v Steven Brian Ewanchuk[142] states that consent must be "**freely given"**. Consequently, if a person is fearful of losing his/her job, education or ability to travel, and is, therefore, being coerced to be vaccinated, consent is not freely given. The decision states: "As enumerated in **[of the Criminal Code],** these include submission by reason of force, fear, threats, fraud or the exercise of authority, and codify the longstanding common law rule that **consent given under fear or duress is ineffective**." [Author's emphasis]. "Authority" in this case could be someone's employer or the government (i.e., not permitting travel or access to funerals, weddings or restaurants).

2) Section 15 of the **Canadian Charter of Rights and Freedoms** – **Equality Rights** which states: "15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or

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[138] Tasker, J. P. (2021, Aug 17) *Trudeau warns of 'consequences' for public servants who duck COVID-19 shots.* CBC News. https://www.cbc.ca/news/politics/trudeau-consequences-public-servants-vaccines-1.6143735

[139] Gray, M. (2021, Aug 17) *President of the largest public sector union 'will not stand' for termination of unvaccinated civil servants.* CTV News. https://www.ctvnews.ca/politics/federal-election-2021/president-of-largest-public-sector-union-will-not-stand-for-termination-of-unvaccinated-civil-servants-1.5550820

[140] Parmley v. Parmley, 1945 CanLII 13(SCC), [1945] SCR 635. https://canlii.ca/t/21v4g

[141] Hopp v. Lepp, 1980 CanLII 14 (SCC), [1980] 2 SCR 192. https://canlii.ca/t/1mjv6

[142] R. v. Ewanchuk, 1999 CanLII 711 (SCC), [1991] 1 SCR 330. https://canlii.ca/t/1fqpm

physical disability." Persons in society being discriminated against—such as being unable to go into a theatre, concert or use public transportation - based on medical choice would be a violation of our human rights as per the Charter.

3) **Nuremberg Code** - Being coerced or forced into a mandated medical intervention is in violation of the Nuremberg Code principles. Article 6, Section 1 states: "Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be expressed and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice". Article 6, Section 3 states: "In no case should a collective community agreement, or the consent of a community leader or other authority, substitute for an individual's informed consent".

4) Section 6 of the **Canadian Charter of Rights and Freedoms – Mobility** "6. (1) Every citizen of Canada has the right to enter, remain in and leave Canada" without impediment. It is a violation of our Charter rights to prevent passage between provinces, at the Canadian/US border, at train stations or in airports.

5) Vax passes violate our medical privacy laws as per the Personal Information Protection and Electronic Documents Act (PIPEDA) and Personal Health Information Protection Act (PHIPA).

6) While the government suggests repeat PCR testing for those employees who refuse an injection and, therefore, cannot show proof of "vaccination", according to Bill S-201 or the Genetic Non-Discrimination Act, "federally regulated employers cannot use a person's genetic test results in decisions about hiring, firing, job assignments, or promotions; or request or require genetic test results of an employee." PCR tests are a form of genetic testing. PCR tests that require probing deep within the nasal cavities on a repeated basis can inflict discomfort and injury, and could be viewed as a form of abuse.

THE SCIENCE, MEDICINE AND LOGISTICS

7) SARS-CoV-2 is neither a particularly deadly nor exotic virus and may be considered similar to a bad flu with over 99% survivability rate for the majority of the population. There are readily available early treatments to lessen the duration and severity of the illness. There is no valid reason for either a vaccine passport or vaccine mandate to protect oneself or others with respect to the present measured threat to society. Only a small portion of society is at higher risk of developing severe disease (elderly, frail, people with comorbidities), particularly when untreated. These are the same people that are at higher risk with respect to other diseases for which we do not isolate the healthy general public. If vaccine passports are accepted for such a low level of threat demonstrated by this virus, it may follow suit that such requirements be enacted for other viruses such as HIV, hepatitis, papilloma virus, influenza, or bacteria such as Mycobacterium tuberculosis.

8) Vaccine passports will not stop the spread of the virus. It is now abundantly clear based on emerging studies and clinical observations that both the vaccinated and the unvaccinated can

contract, carry and transmit COVID-19 and carry similar viral loads[143]. **This fact alone entirely negates the purpose of a Vax Pass or vaccine mandates.** According to CDC Director Rochelle Walensky, "The increased viral load associated with the delta variant appears to make vaccinated people equal spreaders of the virus." A study by Chau *et al*.[144] showed that vaccinated health care workers with breakthrough infections of the delta strain carried 251 times the viral load in their nostrils compared to those infected with older strains detected between March-April 2020 (unvaccinated). This would explain the recent reports of fully vaccinated individuals infecting each other and demonstrates the futility in vaccinating groups at low risks of COVID-19[145,146,147,148]. Therefore, vaccine passports would give some a false sense of security.

9) As previously mentioned, apart from mounting evidence of waning[149] efficacy of the COVID-19 vaccines approved for use in Canada, there is also increasing evidence of a relatively high rate of injury from these particular vaccines.

10) As of December 2020, there were over 200 vaccine candidates for COVID-19 being developed and 52 were in human trials[150]. It will become logistically impossible for any one Vax Pass to keep up with the make, model and number of jabs required to stay current with respect to a vaccine schedule particularly when each product may require differing numbers of injections.

11) Newcomers or travelers will be forced to take more than one vaccine product to satisfy the country in which they wish to travel or live. Take for example the Canadian woman in China who has taken the Sinovac vaccine but wishes to return to Canada, a country which does not recognize that particular vaccine product. Consequently, she is forced to take a different vaccine product to satisfy Canada's requirements. The scientific community is unaware of the effects of combining these medical products. Furthermore, different countries have applied different standards in their acceptability of what constitutes proper vaccination protocols. For instance, the UK had required

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[143] Riemersma, K. K., Grogan, B. E., Kita-Yarbro, A *et al*. (2021) *Shedding of infectious SARS-CoV-2 despite vaccination.* MedRxiv preprint. https://doi.org/https://doi.org/10.1101/2021.07.31.21261387

[144] Chau, N. V., and Gnoc, N. M. (2021) *Transmission of SARS-CoV-2 delta variant among vaccinated healthcare workers, Vietnam.* Lancet preprint. https://doi.org/http://dx.doi.org/10.2139/ssrn.3897733

[145] Beale, J. and Shearing, H. (2021, Jul 14) *HMS Queen Elizabeth: Covid outbreak on Navy flagship.* BBC News. https://www.bbc.com/news/uk-57830617

[146] Massi, A. (2021, Aug 23) *I went to a party with 14 other vaccinated people; 11 of us got COVID: COMMENTARY.* The Baltimore Sun. https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0804-breakthrough-covid-20210803-t32trfpiwzdf5okfar45f64whi-story.html

[147] The Gateway Pundit. (2021, Jul 25) *UPDATE FROM SYDNEY: Reporter apologizes for unclear numbers on vaccinated individuals.* NSW News 9 (Rumble). https://rumble.com/vkba8x-update-from-sydney-all-new-covid-hospitalizations-involve-vaccinated-indivi.html

[148] Markos, M., (2021, Jun 17) *Nearly 4,000 breakthrough COVID infections have now been reported in mass.* NBC Boston. https://www.nbcboston.com/news/local/nearly-4000-breakthrough-covid-infections-have-now-been-reported-in-mass/2408052/

[149] Lovelace, B. Jr. (2021, Jul 23) *Israel says Pfizer Covid vaccine is just 39% effective as delta spreads, but still prevents severe illness.* CNBC news. https://www.cnbc.com/2021/07/23/delta-variant-pfizer-covid-vaccine-39percent-effective-in-israel-prevents-severe-illness.htm

[150] WHO. (2021, Jan 12) *The different types of COVID-19 vaccines.* WHO's Vaccines Explained Series. https://www.who.int/news-room/feature-stories/detail/the-race-for-a-covid-19-vaccine-explained

Canadians who have been fully vaccinated to undergo quarantine restrictions for entry, but not travelers from the European Union or the U.S.

12) Vaccine passports will have a greater negative impact on the poor, the homeless and those with mental illness or developmental delays as they may not have a mobile device or a printer to demonstrate their documentation. For those who choose to remain unvaccinated, vaccine passports may prevent them from accessing fitness facilities that help to prevent obesity, one of the co-morbidities of COVID-19.

13) Many people already have immune protection to SARS-CoV-2 virus or are healthy with no symptoms. This includes 1) those who can show a negative rapid COVID-19 test; 2) those who are COVID-19-recovered as confirmed with a PCR test for the virus during their illness; and 3) those who can demonstrate antibodies and/or T-cells reactive to SARS-CoV-2. After at least 18 months of exposure of our population to SARS-CoV-2, the percentage of Canadians that is estimated to have naturally acquired immunity is up to 90%, with broader testing needed to establish the country-wide level and how it may affect safety and efficacy of the vaccine product[151]. Moreover, immunity acquired by infection is more robust, broader and more durable than the temporary immunity acquired by vaccination[152], yet a vaccine passport would exclude these individuals from participating in society.

14) Vaccine passports and vaccine mandates discriminate against those who cannot be vaccinated either due to medical, religious or philosophical reasons.

15) Vaccine passports and vaccine mandates discriminate against those individuals who have had a "bad" reaction (as determined by the individual's experience) from a vaccine injection, and cannot or prefer not to take another injection, and cannot obtain a medical exemption. These individuals may never again be able to work or get onto a plane or participate fully in society. This may force many Canadians into poverty, depression and suicide. Moreover, more than 50% of double vaccinated individuals experience adverse reactions that provide symptoms equivalent to actual infection with the SARS-CoV-2 virus[153].

16) Vaccine passports will impose an additional tax burden on Canadians and will be an ongoing implementation burden for businesses. Moreover, in the government's haste to develop Vaccine Passports, they have not provided the public with any evidence of its efficacy, and therefore, no means of pulling back the program if or when it achieves its desired goal.

17) We cannot discriminate against our American neighbours and other international visitors who have not been vaccinated by barring their entry into Canada since those who are vaccinated also carry a substantial risk of carrying and transmitting the SARS-CoV-2 infection. We must consider,

[151] Majdoubi, A., Michalski, C., O'Connell, S. E. *et al*. (2021) *A majority of uninfected adults show pre-existing antibody reactivity against SARS-CoV-2.* JCI insight. 6(8):e146316. https://doi.org/10.1172/jci.insight.146316
[152] Cohen, K. W., Linderman, S. L., Moodie, Z. *et al.* (2021) *Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells*. Cell Rep. 2:100354. https://doi.org/10.1016/j.xcrm.2021.100354
[153] CDC. (2021) *Local reactions, systemic reactions adverse events, and serious adverse events: Pfizer – BioNTech COVID-19 vaccine.* Vaccines & Immunizations. *Reactions and adverse events of the Pfizer-BioNTech COVID-19 vaccine.* CDC

for instance, those Americans who own recreational property in Canada who would be unable to tend to their own real estate.

Every Canadian is entitled to enjoy their basic freedoms without having to succumb to a mandatory medical intervention, one which is a novel experimental technology. Medical decisions are made through consultation with one's primary physician based on the individual's existing medical condition(s) and history. Some Canadians wish to prudently wait for more safety and efficacy data before taking this specially authorized injection. Our government is ignoring this fact as it continues to strenuously promote mass vaccination while simultaneously fostering behaviours of discrimination, bullying, and intimidation in the workplace and in society at large. Under duress, Canadians are being forced into making impossible decisions between an invasive medical intervention with poorly understood short- and long-term safety and their job/education/leisure/travel. Of note, on September 12, 2021, the UK decided to abandon the idea of Vaccine Passports[154].

Canada has long stood as a beacon to other countries as a place of freedom from oppression. Let us not now shatter this pillar of Canadian democracy. Vaccine passports are reminiscent of the Nazi Reispass, which permitted only certain Germans to freely travel inside and outside of Germany. The implementation of vaccine passports and vaccine mandates creates a polarized country and only serves to divide society into an apartheid of "haves" and "have nots." Vaccine passports and mandates for SARS-CoV-2 are not scientifically supported for need or effectiveness, and they are anti-democratic, anti-human rights and freedoms and anti-choice. Vaccine mandates against those Canadians who simply wish to make their own personal choices around their bodies are completely unconstitutional. The Canadian government must immediately halt all vaccine passports and mandates relating to these still largely unapproved, investigational genetic technologies, and ultimately choice must be preserved.

[154] Jackson, M. (2021, Sep 12) *England vaccine passport plans ditched, Sajid Javid says.* BBC news. https://www.bbc.com/news/uk-58535258

VI. Censorship

The CCCA is calling out the government, mainstream media and social media platforms (including the "Trusted News Initiative") for their support of and collusion in the obvious censorship and suppression of valid and critical viewpoints regarding the COVID-19 pandemic and vaccination programs. Highly credentialed and well-respected physicians, scientists and academics are being purposely maligned, muzzled, threatened, sanctioned, smeared, de-platformed and canceled for simply advising their patients on well-researched treatments or for publicizing new research on vaccine safety whenever these views are contrary to the government narrative. **No democracy can survive such censorship.** If a democracy somehow exists amongst censorship, "then democracy will inevitably be snuffed-out there, and dictatorship will inevitably be the result" as "censorship blocks some essential truths from reaching the public"[155]. We must stop the censoring of opposing viewpoints as, not only will Canadian democracy be put in jeopardy, but the public will also lose confidence in the government, science, medicine and, in this case, future vaccines.

As an essential stakeholder, the CCCA is requesting an open public forum to discuss the early treatment, COVID-19 vaccine programs, the proposed mandatory vaccines and vaccine passes. The CCCA is requesting to participate as a valued stakeholder and member of the COVID-19 Planning and Implementation Team(s), the COVID-19 Immunity Task Force, and the provincial Science Tables to discuss repurposed pharmaceutical treatments and to address non-pharmaceutical interventions (NPIs).

[155] Zuesse, E. (2020, Feb 15) *Censorship is the way that any dictatorship—and NO democracy—functions.* Strategic Culture Foundation. https://www.strategic-culture.org/news/2020/02/15/censorship-is-way-that-any-dictatorship-no-democracy-functions/

APPENDIX A

Slide #16 - FDA Safety Surveillance of COVID-19 Vaccines October 22, 2020[156] before EUA (Emergency Use Authorization):

- Guillain-Barré syndrome
- Acute disseminated encephalomyelitis
- Encephalitis / myelitis / encephalomyelitis / meningoencephalitis / meningitis / encephalopathy
- Convulsions / seizures
- Stroke
- Narcolepsy and cataplexy
- Acute myocardial infarction
- Myocarditis / pericarditis
- Autoimmune disease
- Deaths
- Pregnancy and birth outcomes
- Transverse myelitis
- Other acute demyelinating diseases
- Anaphylaxis and non-anaphylactic allergic reactions
- Thrombocytopenia
- Disseminated intravascular coagulation
- Venous thromboembolism
- Arthritis and arthralgia/joint pain
- Kawasaki disease
- Multi-system Inflammatory Syndrome in Children
- Vaccine enhanced disease

All of these syndromes and more have been reported to the VAERS reporting system in the USA.

[156] Anderson, S. (2020, Oct 22) *CBER plans for monitoring COVID-19 vaccine safety and effectiveness.* US FDA. VRBPAC Meeting. https://www.fda.gov/media/143557/download

CCCA

APPENDIX B

Vaccination of Youth

According to the WHO, careful consideration must be given to make sure there is informed consent in the vaccination of children. https://www.who.int/publications/i/item/considerations-regarding-consent-in-vaccinating-children-and-adolescents-between-6-and-17-years-old

In Canada and most countries in the world, privileges and responsibilities are given to individuals in stages, as they develop and mature. This graded introduction to adulthood is logical, as MRI evidence shows that the human brain is not fully mature until, on average, age 24. In regards to COVID-19, the vast majority of teens under age 17 are unlikely to have the intellectual or educational capacity to make decisions about their medical health (in particular regarding experimental treatments), as well as often having little or no knowledge about their own medical profile or that of their familial health history. Moreover, as stated above, the public in general has not even been presented with transparent information comparing risks and benefits of these novel vaccines.

Allowing children as young as 12 to make significant decisions regarding potentially life-changing medical procedures involving experimental treatments could have serious long term medical implications. This policy removes parent's rights to protect their children and puts those rights into the hands of the government, essentially making children temporary wards of the state. These are decisions and rights that should rest with the parents and for which children are, in most instances, incapable of making informed decisions about and are incapable of giving informed consent for.

https://sites.duke.edu/apep/module-3-alcohol-cell-suicide-and-the-adolescent-brain/content-brain-maturation-is-complete-at-about-24-years-of-age/

https://www.nytimes.com/2016/12/21/science/youre-an-adult-your-brain-not-so-much.html

APPENDIX C

Recently published in the journal Science, Public Health Policy and the Law, Canadian Jessica Rose, PhD, MSc, BSc, authored a report titled, "A Report on the U.S. Vaccine Adverse Events Reporting System (VAERS) of the COVID-19 Messenger Ribonucleic Acid (mRNA) Biologicals,"[157]

This article[158] entitled New study: Vaccines are the likely cause of adverse effects and deaths following vaccination summarizes the results:

- 57% of reported deaths following vaccination occurred within 48 hours of inoculation.
- 66% of emergency room (ER) visits following vaccination occurred within 48 hours of inoculation.
- 63% of hospitalizations following vaccination occurred within 48 hours of inoculation.
- 70% of individuals developed symptoms within 48 hours following first or second doses.
- 79% of all VAERS reports were made after recipients received the first dose.
- 18% of all Adverse Events (AE) reports were cardiovascular, 12% were neurological, and 35% were immunological.
- Immunological AEs continue to rise with time even as other AEs have remained stable.
- Those aged 30 to 40 years old comprise the largest subset of reports overall.
- Higher absolute numbers of VAERS deaths and hospitalization are associated with the elderly aged 65 and above. 84% of deaths following vaccination belonged to those aged 70 to 90 years old.
- The highest frequency of cardiovascular AEs was by individuals aged 20 to 30 years of age.
- Spontaneous abortions recorded among women aged 20 to 40 years. 65% of these miscarriages happened after the first dose.

[157] Covid Strategies. (2021, Jul 2) *Canadian researcher analyzes CDC VAERS data for COVID-19 vaccine safety POV – But is the other side of risk calculated.* https://www.covidstrategies.org/canadian-researcher-analyzes-cdc-vaers-data-for-covid-19-vaccine-safety-pov-but-is-the-other-side-of-risk-calculated/

[158] Covid call to humanity. (2021, May 24) *New study: Vaccines are the likely cause of adverse effects and deaths following vaccination.* https://covidcalltohumanity.org/2021/05/24/new-study-vaccines-are-the-likely-cause-of-adverse-effects-and-deaths-following-vaccination/

Appendix "C"

AN OPEN LETTER TO THE PRESIDENT OF THE UNIVERSITY OF GUELPH

Friday September 17, 2021

University of Guelph
50 Stone Rd. E.
Guelph, ON,
N1E 2G1

Dear Dr. Charlotte A.B. Yates, President and Vice-Chancellor,

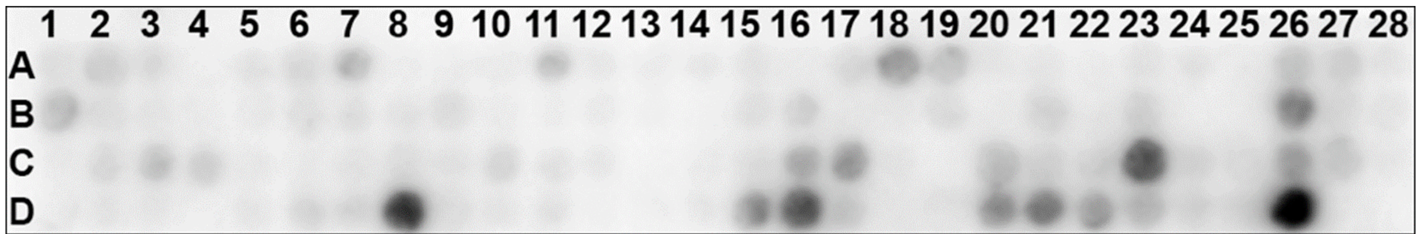
I will forewarn you that this is a lengthy letter. However, it only represents a fraction of the information that I would like to be able to share with you. I have found it necessary to write this so you can fully understand my perspective. With my life and that of my family, many friends and treasured colleagues being destroyed under your watch, I figure the least you can do is read and consider this very carefully. It is incredible to note that many, if not most, of my on-campus detractors have judged me without reading any of my scientific arguments or talking to me about them.

The COVID-19 Vaccine Mandate at the University of Guelph

You issued a mandate that everyone within the University of Guelph community must receive a COVID-19 vaccine. I have spent most of my lifetime learning to be a very deep and critical thinker and to follow the weight of scientific evidence. I am a well-recognized expert in vaccinology. As per my extensive funding, research, publication, and teaching records, I am a vaccine lover and an innovator in this field. I promote highly effective vaccines that have undergone extensive, rigorous, and proper safety testing as the most efficient type of medicines that exist. Vaccines that meet these criteria have prevented a vast amount of mortality and morbidities around the world. However, **I could not be in stronger disagreement with you forcing the current COVID-19 vaccines upon everyone** who is part of our campus community. I respect the challenges that a university president faces when trying to manage a large and dynamic academic institution. However, your roots are as a scholar. As a publicly funded institution of advanced learning, it is incumbent on us to demonstrate an ability to view the world around us in a constructively critical fashion such that we can improve the lives of others. We should be able to do this free of political or financial pressures and without bias or prejudice or fear of censorship and harassment. As a viral immunologist that has been working on the front lines of the scientific and medical community throughout the duration of the declared COVID-19 pandemic, I feel compelled to speak on behalf of the many who will not, due to extreme fear of retribution. We now live in a time when it is common practice for people to demand and expect to receive confidential medical information from others. I will not be coerced into disclosing my private medical information. However, for the sake of highlighting some of the absurdities of COVID-19 vaccine mandates I choose, of my own free will, to freely disclose some of my medical information here…

Those with Naturally Acquired Immunity Don't Need to be Vaccinated and are at Greater Risk of Harm if Vaccinated

I participated in a clinical trial that has been running for approximately 1.5 years. The purpose is to develop a very sensitive and comprehensive test of immunity against SARS-CoV-2; in large part to inform the development of better COVID-19 vaccines (https://insight.jci.org/articles/view/146316). My personal results prove that I have naturally acquired immunity against SARS-CoV-2. With this test, spots indicate a positive result for antibodies against a particular part of the virus. Darker spots correlate with more antibodies. Antibody responses correlate with the induction of memory B cells. Antibodies will wane over time, but B cells can survive for many years and rapidly produce massive quantities of antibodies upon re-exposure to a pathogen. On the following page are my results, along with a map of which part of the virus each spot represents…



Peptide Identification on CCJ SARS-CoV-2 SPOT peptide arrays

Row (positions 1–28)								
A	Spike S1	Spike S1 RBD	Spike S1	Spike S2				
B	Spike S2	Nucleocapsid	Memb.					
C	Nsp2	Nsp3	Nsp 1	Nsp2	Nsp3	Nsp4	Nsp 6	Nsp8+9
D	Nsp10 +11	Nsp12	Nsp13	Nsp14	Nsp15	Nsp 16	Orf3	Orf 8	IgG

The dark spot at position D26 is the positive control and indicates that the assay worked. My results demonstrate that I have broad immunity against multiple components of SARS-CoV-2, including the spike protein. Importantly, spot B26 shows that I have antibodies against the membrane protein. This protein is not highly conserved across coronaviruses. As such, it provides evidence that I was infected with SARS-CoV-2. Note that I was sick only once since the pandemic was declared. It was a moderately severe respiratory infection that took ~four weeks to recover from. The SARS-CoV-2 PCR test was negative, despite being run at an unreasonably high number of cycles. This suggests that I was one of the many for whom SARS-CoV-2 has proven to be of low pathogenicity or not even a pathogen (*i.e.* no associated disease). There is a plethora of scientific literature demonstrating that naturally acquired immunity against SARS-CoV-2 is likely superior to that conferred by vaccination only. Indeed, it is much broader, which means that emerging variants of SARS-CoV-2 will have more difficulty evading it as compared to the very narrow immunity conferred by the vaccines. Importantly, the duration of immunity (*i.e.* how long a person is protected) has proven to be far longer than that generated by the current vaccines. The duration of immunity for the mRNA-based COVID-19 vaccines appears to be a horrifically short ~4.5 months. I actually wrote a lay article back in February 2021 to explain why a vaccine of this nature would fail to be able to achieve global herd immunity on its own (https://theconversation.com/5-factors-that-could-dictate-the-success-or-failure-of-the-covid-19-vaccine-rollout-152856). This is why places like Canada, the USA, and Israel have found it necessary to roll out third doses. And now there is talk (and a commitment in Israel) to roll out fourth doses (yes, that's four doses within one year). The World Health Organization recognized the value of natural immunity quite some time ago. Unfortunately, in Canada and at the University of Guelph, we have failed to recognize that the immune system works as it was designed to. Its ability to respond is not limited solely to vaccines. Here are some references to support this: https://www.who.int/publications/i/item/WHO-2019-nCoV-Sci_Brief-Natural_immunity-2021.1; https://academic.oup.com/jid/advance-article/doi/10.1093/infdis/jiab295/6293992; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7803150/. As someone who develops vaccines, I can tell you that it is difficult to make a vaccine that will perform as poorly as the current COVID-19 vaccines. Indeed, most vaccines given in childhood never require a booster shot later in life. The take-home message here is that people like me, who have naturally acquired immunity, do not need to be vaccinated. Nor is it needed to protect those around the person who already has immunity. Worse, research from three independent groups has now demonstrated that those with naturally acquired immunity experience more severe side-effects from COVID-19 vaccines than those who were immunologically naïve prior to vaccination (https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(21)00194-2/fulltext; https://www.medrxiv.org/content/10.1101/2021.04.15.21252192v1; https://www.medrxiv.org/content/10.1101/2021.02.26.21252096v1). In other words, **for those with natural immunity, vaccination is not only unnecessary, but it would put them at enhanced risk of harm. Knowing this, nobody should ever mandate COVID-19 vaccination**. Instead, it would be in the best interest of helping everyone make the most informed health decisions for themselves to make voluntary testing for immunity available.

Testing for Naturally Acquired Immunity was a Viable Option but was Ignored

You and the provost met with me and two other colleagues back in March 2021 and we presented the opportunity for the University of Guelph to show leadership and offer testing for immunity to our campus community in support of a safe return to in-person teaching and learning. You embraced this idea with enthusiasm and promised to move forward with it. This did not materialize so one of my colleagues contacted you. Once again, you agreed it was an excellent idea and that you would move forward with it. Nothing happened. So, my two colleagues and I met with one of our vice-presidents in May 2021. They also thought that making an antibody test available was an excellent idea and promised to work on getting it implemented on campus. Nothing materialized. They were contacted again by one of my colleagues. There was no response. There is no excuse for forcing vaccines on people, especially after having been given the opportunity to implement testing for immunity and refusing to do so.

The University of Guelph won't pay for me to receive a booster vaccine against rabies unless I can demonstrate that my antibodies are below what has been deemed to be a protective titer. This is because it would not be appropriate to give me a vaccine that is not without risk if I don't need it. Also, the university does not want to pay the ~$850 cost of the vaccination regimen unless I absolutely need it. In short, you will not allow me to receive that booster vaccine without first evaluating me on an annual basis for evidence of immunity (or lack thereof). So why was this principle rejected for the SARS-CoV-2 vaccines, for which there is vastly less reliable safety data available, and none for the long-term? Canada should have been acquiring data about immunity starting a long time ago. It is a particularly poor precedent for a university to reject the concept of acquiring data that could inform safer and more effective COVID-19 policies. Immunity testing would even benefit vaccinated individuals. It is well known that responses to vaccines in outbred populations follows a normal curve and includes individuals that are non-responders (*i.e.* they are left without immunity and are, therefore, unprotected following vaccination) and low-responders (insufficient protection). In fact, this concept has been the focus of an internationally recognized research program on our campus that has brought many accolades and awards to our institution.

You have banned me from campus for at least the next year. I can show proof of immunity against SARS-CoV-2 but you will not allow me to enter buildings. But someone else can show a receipt saying that someone saw two needles go into their arm and you will allow them to enter. You actually have no idea if that person has immunity. There have even been reported cases of people accidentally or even intentionally (*e.g.* a case in Germany) being administered saline instead of the vaccine. **Does it make sense to ban someone who is immune from campus but allow people who are presumed, but not confirmed, to be immune?** This is a scenario that you have created. As a fellow academic, **I am requesting that you provide me with a strong scientific rationale why you are allowing thousands with an unconfirmed immunity status onto our campus, but you are banning people like me who are known to have immunity**. Further, **please explain how you feel it is ethical to force COVID-19 vaccines on people who are uncomfortable with being coerced when you do not know their immunity status**. Despite attempts to halt the spread of SARS-CoV-2 via masking and physical distancing, the reality is that the virus has not complied with these attempts to barricade it. Indeed, it has infected many people across Canada, many of whom may not have even realized it because it is not a dangerous pathogen for them. From the perspective of a medical risk-benefit analysis, this is a no-brainer. A medical procedure that adds no value but carries known and still-to-be-defined risks should never be mandated!

The University Back-Tracked on Advice from its Own Legal Counsel

I, along with two colleagues, attended a meeting with one of our vice-presidents in May 2021. In that meeting the legal advice that was provided to the University of Guelph was disclosed. We were told this included making COVID-19 vaccines voluntary, that nobody on campus should be made to feel coerced into being vaccinated, and that nobody should feel pressured to disclose their vaccination status. On this basis, I was to serve as one of the on-campus faculty contacts for anyone who experienced any of these issues. **Did Canada's laws change during the summer in a way that rendered this legal advice no longer valid?** Now I am having to spend an inordinate amount of time trying to help the many people whose lives have imploded due to the university's vaccine mandate.

I am a Scientist Who is Knowledgeable and Values Integrity Despite What So-Called 'Fact Checkers' Have Claimed

There are many on our campus who repeatedly put my name out to the public with claims that I disseminate misinformation. Not one of these individuals has ever given me the courtesy of a conversation prior to publicly attacking me. None of them will engage me in public discussions of the science to allow people to judge the legitimacy, or lack thereof, of what I am saying. Censorship on our campus has become as prevalent as it is off-campus. My detractors, rather than showing a deep understanding of the science underlying COVID-19 vaccines, continually refer to the so-called 'fact checks' that have been posted about me. Let me tell you some things about the so-called 'fact checkers'. Firstly, they give scientists and physicians of integrity unreasonably short periods of time to respond to their requests for answers. For example, as I write this letter, I have 13,902 unread messages in my inbox and my voice mail is at maximum capacity. I have yet to see a 'fact check' request prior to its expiry, which remarkably, is often within mere hours of an e-mail being sent. This is an unreasonable expectation from a busy professional. Also, many 'fact checkers' lack sufficient expertise. In some cases, 'fact checker' sites have had to rely on postdoctoral trainees in other countries to write responses.

Most of the harassment against me began after 'fact checkers' cherry-picked one short radio interview that I gave to a lay audience. Some have accused me of only giving half the story in that interview. They were most kind; I was only able to reveal ~0.5% of the story. It is unfair to critique a tiny portion of one's arguments that were presented off-the-cuff to a lay audience with no opportunity for me to respond in real-time. For your information, **I have rebutted every single one of the 'fact checks' that I am aware of** in various public interviews. Let me give you one example that some of our colleagues on our campus have repeatedly misused while harassing me in social media…

One of the many issues that I have raised with the vaccines is that should a reasonable concentration of the free spike protein get into systemic circulation, it could potentially harm the endothelial cells lining our blood vessels. I cited this study: https://www.ahajournals.org/doi/10.1161/CIRCRESAHA.121.318902. The authors were contacted, and they claimed I had misinterpreted the study. They said that spike-specific antibodies would mop up any spike proteins in the blood, thereby protecting the blood vessels. They argued that this demonstrated that vaccinating people against the spike protein is a good thing. However, the authors are not immunologists and they failed to recognize the limitations of their own study in drawing these kinds of conclusions. Specifically, they did not recognize that in a naïve individual receiving a mRNA-based COVID-19 vaccine, there are no antibodies; either pre-existing in the host, or in the vaccine formulation. In fact, it will take many days for the antibody response to be induced and for titers to begin reaching substantial concentrations. This leaves a large window of time in which any free spike proteins could exert their biological functions/harm in the body before there are any antibodies to neutralize them. Worse, most of the spike proteins should be expressed by our own cells. In that case, the antibodies will target and kill them in a form of autoimmunity. The authors of the paper forgot that their model was in the context of natural infection, where vaccination would precede exposure to SARS-CoV-2. In that case, I agree that there would be pre-existing antibodies that could neutralize spike proteins of viral origin entering the circulation. This was perceived to be one of the 'strongest' arguments used by others to try to discredit me. The reality is that it is completely incorrect and represents an embarrassing misinterpretation by the authors of the original paper and the many 'fact-checkers' that believed them without question.

Criminal Harassment

You have allowed colleagues to harass me endlessly for many consecutive months. They have lied about me, called me many names, and have even accused me of being responsible for deaths. I submitted a harassment claim and your administrators ruled that it did not meet the bar of civil harassment. In stark contrast, I have been contacted by members of off-campus policing agencies who have told me that it exceeds the minimum bar of criminal harassment. I am sorry, but a faculty member can only take so much bullying and see such a lack of adherence to scientific and bioethical principles before it becomes necessary to speak up. Under your watch, you have allowed my life to be ruined by turning a blind eye to on-campus bullying, ignoring our campus principles of promoting mental

well-being and a workplace in which I can feel safe. In addition to this you have banned me from the campus because I have robust, broadly protective, and long-lasting immunity against SARS-CoV-2 but lack a piece of paper suggesting that it was obtained via two injections. Did you see this front page of one of Canada's major newspapers?...

TORONTO STAR

If an unvaccinated person catches it from someone who is vaccinated, boohoo, too bad. I have no empathy left for the wilfully unvaccinated. Let them die. I honestly don't care if they die from COVID. Not even a little bit. Unvaccinated patients do not deserve ICU beds. At this point, who cares. Stick the unvaccinated in a tent outside and tend to them when the staff has time.

Simmering divide over who isn't vaccinated

It's a polarizing debate, but patience and understanding for those not getting shots is in short supply as we all look to heal from pandemic Story, A2

Air Canada staff who don't get jab face dismissal

Employees without valid reason for an exemption have until Oct. 30 to be vaccinated

Partisan jousting means little to struggling workers

THE SIGNAL

It's been mayhem — and Afghans are running out of time

…remarkably, the on-campus COVID-19 policies you are promoting fuel this kind of pure hatred from people, most of whom have not confirmed their own immunity status, against someone like me who is immune to SARS-CoV-2!!! **Does that make any sense?** My workplace has become a poisoned environment where the bullying, harassment, and hatred against me have been incessant. Are you ever going to put an end to the childish and irrational behaviours being demonstrated by our colleagues? I have received thousands of emails from around the world that indicate the university should be embarrassed and ashamed to allow such childish behaviour from faculty members to go unchecked in front of the public. I have invested a decade of my life into the University of Guelph. I have conducted myself professionally and worked to an exceptionally high standard. I have consistently received excellent ratings for my research, teaching, and service. I have received rave reviews from students for my teaching. I have received prestigious research and teaching awards. I have brought funding to our campus from agencies that had never partnered with the University of Guelph in our institution's history. I have brought in ~$1 million-worth of equipment to improve our infrastructure, etc., etc. I am a man of integrity and a devoted public servant. I want to make Canada a better place for my family and for my fellow Canadians. We are a public institution. My salary is covered by taxpayers. This declared pandemic involves science that is in my 'wheelhouse'. Since the beginning, I have made myself available to answer questions coming from the public in a fashion that is unbiased and based solidly on the ever-exploding scientific literature. My approach has not changed. Has some of it contradicted the very narrow public health narrative carried by mainstream media? Yes. Does that make it wrong? No. I will stand by my track record. When Health Canada authorized the use of AstraZeneca's vaccine I, along with two colleagues, wrote an open letter requesting that this vaccine not be used, in part on the grounds that it was being investigated for a link to potentially fatal blood clots in many European countries. I was accused at that time by so-called 'fact checkers' of providing misinformation. Less than two months later, Canada suspended the AstraZeneca vaccination program because it was deemed to be too unsafe as a result of causing blood clots that cost the unnecessary loss of lives of Canadians. More recently, I was heavily criticized for raising concerns in a short radio interview about a potential link between the Pfizer BioNTech COVID-19 vaccine and heart inflammation in young people, especially males. This is now a well-recognized problem that has been officially listed as a potential side-effect of the mRNA COVID-19 vaccines. It was also the subject of a recent Public Health Ontario Enhanced Epidemiological Summary Report highlighting the increased risk of myocarditis and pericarditis to young males following COVID-19 mRNA vaccination. As such, I have a proven track record of accurately identifying concerns about the COVID-19 vaccines.

A Lack of Safety Data in Pregnant Females as Another Example of Why Vaccines Should Not be Mandated

I would like to give another disconcerting safety-related example of why a COVID-19 vaccine mandate could be dangerous. We have pregnant individuals or those who would like to become pregnant on campus. There was a highly publicized study in the prestigious *New England Journal of Medicine* that formed the foundation of declaring COVID-19 vaccines safe in pregnant females (https://www.nejm.org/doi/full/10.1056/nejmoa2104983). The authors of this study declared that there was no risk of increased miscarriage to vaccinated females. This study resulted in

many policies being instituted to promote vaccination of this demographic, for which the bar for safety should be set extremely high. Did you know that this apparent confirmation of safety had to be rescinded recently because the authors performed an obvious mathematical error? I witnessed several of my colleagues from Canada and other countries bravely push for a review of this paper under withering negative pressures. Once the editor finally agreed to do so, the authors had no choice but to admit that made a mathematical error. Most of the world does not realize this. This admission of using an inappropriate mathematical formula can be found here: https://www.nejm.org/doi/full/10.1056/NEJMx210016. This means that **the major rationale for declaring COVID-19 vaccines safe in pregnant females is gone! How can someone force a COVID-19 vaccine on a pregnant female when there are insufficient safety data available to justify it?**

Advocating for the Vulnerable and Those Fearful of Retribution

My concern is not primarily for myself. I am using my case to highlight how wrong your vaccine mandate is. I am more concerned for the more vulnerable on our campus. I hold tenure, and if ever there was a time when this was important, it is now. However, I have had to bear witness to numerous horrible situations for students and staff members. Students have been physically escorted off our campus, sometimes being removed from their residence, sometimes with their parents also being escorted off. Staff members have been escorted off campus and immediately sent home on indefinite leaves without pay, leaving them unable to adequately care for their families. In many of these situations it seemed like the interactions intentionally occurred in very public settings with it being made clear to all onlookers that the person or people were not vaccinated. Parents have been denied attending meetings with their children who are entering the first year of a program. They recognize that adult learners would normally not have their parents accompany them, but we are living in unusual times with excessive and unfair (arguably illegal?) pressures being applied and these parents are entitled to advocate and defend the best interests of their sons and daughters. Many students have deferred a year in the desperate hope that our campus community will not be so draconian next year. Others fought hard to earn their way into very competitive programs and are not being guaranteed re-entry next year. Many faculty members refused to offer on-line learning options for those who did not wish to be vaccinated. On the flip-side, there are also faculty members, like many students and staff, who are completely demoralized. This includes some who were happily vaccinated but are upset by the draconian measures of your COVID-19 policies and/or will be unwilling to receive future booster shots. I can tell you many stories of students and staff members who couldn't resist the pressure to get vaccinated because they were losing vast amounts of sleep and experiencing incredible anxiety and were on the verge of mental and/or physical breakdowns. In some of these cases, they were crying uncontrollably before, during, and after their vaccination, which they only agreed to under great duress. This does not represent informed consent! I have had several members of our campus community contact me with concerns that they may have suffered vaccine-induced injuries ranging from blood clots to chest pain to vision problems to unexpected and unusual vaginal bleeding. Can I prove these were due to the vaccine? No. But can anyone prove they were not? No. And it is notable that these are common events reported in adverse event reporting systems around the world. In all cases, the attending physicians refused to report these events, even though it is supposed to be a current legal requirement to do so. These people obediently got vaccinated and were then abandoned when they became cases that did not help sell the current public health messaging.

A World Where Everyone is Vaccinated Looks Nothing Like Normal

The two-week lockdown that was supposed to lead into learning to live with SARS-CoV-2 has turned into the most mismanaged crisis in the history of our current generations. I ask you to look around with a very critical eye. You just reported that 99% of the campus community is vaccinated. Congratulations, you have far exceeded the stated standard for what is apparently the new goal of 'herd vaccination'. I cannot use the typical term 'herd immunity' here because immunity is not being recognized as legitimate; only inferred immunity based on receiving two needles counts. We were told that achieving herd immunity by vaccination alone was the solution to this declared pandemic. This has been achieved on our campus in spades. I sat in on our town hall meetings with our local medical officer of health who confidently told us that the risk of breakthrough infections in the vaccinated was almost zero. Why, then are people so petrified of the unvaccinated. Look at vaccines for travellers going to exotic locations.

These are vaccines of some quality. Travellers take these vaccines, and not only do they not avoid the prospective pathogen, but they happily travel to the location where it is endemic (*i.e.* they enthusiastically enter the danger zone because they are protected). So, what does our campus look like with almost every person vaccinated? Everyone must remain masked and physically distanced. There is no gathering or loitering allowed in stairwells or any open spaces in buildings or outside. People are still being told which doors to enter and exit, when they can do so, where to stand in line, when to move. Incredibly, time restrictions are even being implemented in some eating areas because some students were deemed to be "snacking too long" with their masks off and, therefore, putting others at risk of death. In short, the on-campus COVID-19 policies are even more draconian than they were last year, but everyone is vaccinated. It doesn't seem like the vaccines are working very well when a fully vaccinated campus cannot ease up on restrictions. But, of course, we already know how poorly these vaccines are performing. Based on fundamental immunological principles, parenteral administration of these vaccines provides robust enough systemic antibody responses to allow these antibodies to spill over into the lower respiratory tract, which is a common point at which pathogens can enter systemic circulation due to the proximity of blood vessels to facilitate gas exchange. However, they do not provide adequate protection to the upper respiratory tract, like natural infection does, or like an intranasal or aerosolized vaccine likely would. As such, people whose immunity has been conferred by a vaccine only are often protected from the most severe forms of COVID-19 due to protection in the lower lungs, but they are also susceptible to proliferation of the virus in the upper airways, which causes them to shed equivalent quantities of SARS-CoV-2 as those who completely lack immunity. Dampened disease with equal shedding equals a phenotype that approaches that of a classic super-spreader; something that we erroneously labeled healthy children as until the overwhelming scientific evidence, which matches our historical understanding, clarified that this was not the case. I have been in meetings where faculty have demanded to know who the unvaccinated students will be in their classes so they can make them sit at the back of the classroom! I can't believe that some of my colleagues are thinking of resorting to the type of segregation policies that heroes like Viola Desmond, Rosa Parks, Martin Luther King Jr., Carrie M. Best, and Lulu Anderson fought so hard against so many years ago.

The Exemption Fiasco

With respect to exemptions for COVID-19 vaccines, the University of Guelph provided a number based on creed or religion but then, remarkably, rescinded these. These previously exempt individuals were required to resubmit applications using a more onerous form; many that had been honoured previously were rejected upon re-submission. Many have been rejected since. Based on the reports I have received from many people these rejections of exemption requests were typically not accompanied by explanations. Nor have many been told, despite asking, who it is that sits on the committee making decisions about these exemptions. I would never be allowed to assign marks to students anonymously, nor without being able to justify them. Yet there seems to be a lack of transparency with exemptions and many of these decisions are destroying people's lives; the outcomes are not trivial. Could you please disclose the names of the people serving on the University of Guelph's committee that reviews exemptions? Also, could this committee please provide to applicants, retroactively, comments to justify their decisions? I have even heard it said in recent meetings that a lot of people are happy to hear that exemptions, including some medical exemptions are being denied. Why are our faculty celebrating refusals of medical exemptions for students?

A Lack of Consultation with the Experts on Vaccines

You have stated on numerous occasions that your COVID-19 policies have only been implemented after extensive consultation with local and regional experts. Interestingly, however, you have refused, for some unknown reason, to consult with any of the senior non-administrative immunologists on your campus. I would like to remind you that vaccinology is a sub-discipline of immunology. Notably, all three of us have offered repeatedly to serve on COVID-19 advisory committees, both on-campus and for our local public health unit, which also lacks advanced training in immunology and virology. The three of us have stayed on top of the cutting-edge scientific findings relevant to COVID-19 and meeting regularly with many national and international collaborative groups of scientists and physicians to debate and discuss what we are learning. I think it is notable that the senior non-administrative

immunologists unanimously agree that COVID-19 vaccines should not be mandated for our campus based on extensive, legitimate scientific and safety reasons.

Mandating COVID-19 Vaccines is Criminal

I am no legal expert but have consulted with many lawyers who have told me that these vaccine mandates break many existing laws. Here is one example copied from the Criminal Code of Canada:

Extortion

- ***346 (1)*** *Every one commits extortion who, without reasonable justification or excuse and with intent to obtain anything, by* ***threats****, accusations, menaces or violence* ***induces or attempts to induce any person****, whether or not he is the person threatened, accused or menaced or to whom violence is shown,* ***to do anything or cause anything to be done****.*

In your case, you are demanding that members of our academic community submit to receiving a COVID-19 vaccine against their will (a medical procedure that may very well be unnecessary and carry enhanced risk of harm) or face banishment from the campus. Again, I am not an expert in this area, but I am confident there will be lawyers willing to test this in court. Those responsible for issuing vaccine mandates will need to decide how confident they are that they will not lose these legal battles.

Integrity of Teaching

In this new world where followers of scientific data are vilified, I also worry about my ability to teach with integrity. Unbelievably, the Minister of Health of Canada, Patty Hajdu, told Canadians that vitamin D being a critical and necessary component of the immune system in its ability to clear intracellular pathogens like SARS-CoV-2 is fake news! Do you now that I have taught all my students about the importance of vitamin D (often in the historical context of how it was discovered as being critical for positive outcomes in patients with tuberculosis that were quarantined in sanatoriums). I also teach the concept of herd immunity, with vaccination being a valuable tool to achieve this. I do not teach the concept of 'herd vaccination' while promoting ignorance of natural immunity. There are other basic immunological principles that I teach that have either not been recognized during the pandemic as legitimate scientific principles or they have been altogether contradicted by public health and/or government officials. Will I still be allowed to teach immunology according to the decades of scientific information that I have built my course upon? Or will I be disciplined for teaching immunological facts? There are many attempts to regulate what I can and cannot say these days, so these are serious questions.

Instilling Fear of a Minority Group Breeds Hatred

We live in an era where issues of equity, diversity, and inclusion are supposed to be at the forefront of all discussions at academic institutions. However, you are openly discriminating against and excluding a subset of our community that happens to be highly enriched with people engendered with critical thinking; a quality that we are supposed to be nurturing and promoting. With COVID-19 mandates, an environment has been created on our university campus that promotes hatred, bullying, segregation, and fear of a minority group whose only wrongdoing has been to maintain critical thinking and decision-making that is based on facts and common sense. I have yet to meet an anti-vaxxer on our campus. Everyone I know of is simply against the mismanagement of exceptionally poor-quality COVID-19 vaccines. History tells us that instilling fear of a minority group never ends well. This scenario must be rectified immediately if our campus is ever to return to a safe and secure working and learning environment for all.

Committing to Abolishing the COVID-19 Vaccine Mandate

President Yates, **the favour of a reply is requested**. Not the kind that defers to public health officials, or a committee, or anyone else. Instead, a reply with the scientific rigour expected from a scholarly colleague rebutting each of my comments and addressing each question. Surely, you know the science underpinning COVID-19 vaccines inside and out by now. I strongly suspect that nobody would made a decision that disrupts an entire community and destroys the lives of some of its members without a fully developed rationale that can point to the weight of the peer-reviewed scientific literature to back it up. If it would be easier, I would be happy to have an open and respectful, but public and blunt moderated conversation about your vaccine mandate in front of our campus community; much like in the spirit of old-fashioned, healthy scientific debates. You can have your scientific and medical advisors attend and I will invite an equal number. I am not saying this to be challenging. I honestly think it would be a great way to educate our campus community and expose them to the full spectrum of the science. And, if I am as wrong as my 'fact checkers' say, I would love for them to demonstrate this for my own sake as much as anyone else's. So far, despite hundreds of invitations, not one person has done this in a scenario where I can respond in real-time. You need to understand; all I want is my life back and to be able to recognize my country again. I want to see the lives of the students, staff, and other faculty members that I have seen destroyed be restored again. I want to be able to return to my workplace and not be fearful of being hated or exposed to social, mental, and physical bullying. Instead, I want to be able to turn my talents and full attention back to being an academic public servant who can design better ways to treat diseases and help train Canada's next generation of scientific and medical leaders. I simply cannot know all that I have shared in this letter and have suffered as much as I have and be silent about it. My great uncles and family members before them served heroically in the World Wars to ensure Canada would remain a great and free democracy. I think they would be horrified by what they see in Canada today. Indeed, many of my friends who immigrated from Communist countries or countries run by dictatorships are sharing fears about the direction our country is heading; it is reminding them of what they fled from. Further, mandating COVID-19 sets a scary precedent. Did you know that multiplex tests for both SARS-CoV-2 and influenza viruses are on the horizon, along with dual-purpose vaccines that will use the same mRNA-based technology to simultaneously target SARS-CoV-2 and influenza viruses (https://www.ctvnews.ca/health/coronavirus/moderna-developing-single-dose-covid-19-flu-combo-vaccine-1.5578445). Rhetorically, will the University of Guelph consider masking, distancing, and/or mandating vaccines for influenza in the future? **Please rescind your COVID-19 vaccine mandate immediately**. **It is doing more harm than good**. **Unbelievably, among many other problems, it is even discriminating against those who can prove they are immune to SARS-CoV-2!**

Mandating COVID-19 Vaccines Creates Absurd Situations

In closing, and to highlight the absurdity of mandating COVID-19 vaccines…
President Yates, I have proven to you that I am immune to SARS-CoV-2, but you have banned me from the campus and ruined my life because I don't have a piece of paper saying that someone saw two needles go into my shoulder. You have a piece of paper that says that someone saw two needles go into your shoulder, but you have not proven that you are immune to SARS-CoV-2. However, you are allowed on campus and your life can proceed uninterrupted. **How is that fair?**

Respectfully and in the mutual interest of the health and well-being of **all** members of our community,

Dr. Byram W. Bridle, PhD
Associate Professor of Viral Immunology
Department of Pathobiology
University of Guelph

Appendix “D”

Open Letter to Dr. Bonnie Henry, Adrian Dix, and Premier John Horgan

We are a group of extremely concerned health professionals in the Okanagan Valley, B.C. We have some critical questions regarding COVID-19, specifically about the current reporting of case numbers, statistics, and testing, and the restrictions imposed by your health orders. While discussion of adjunctive and alternative safe and effective treatments is being stifled, the policies of mandatory experimental vaccines and vaccine passports are being forced upon our province, our country, and many other countries worldwide.

Addressing Dr. Henry, Mr. Dix and Mr. Horgan: We—as healthcare practitioners and citizens—expect and deserve answers that address these concerns directly. Proclaiming that vaccine therapies are “safe and effective” is misleading and sloganistic. The reports of vaccine injuries are increasing every day, yet are being ignored. We are witnessing an increase in Covid illness occurring in fully vaccinated individuals and, irrationally, that is being followed by a promise of mandated boosters.[1] The lack of answers and the vague information being provided over the past 18+ months do not instill confidence in British Columbians.

This lack of transparency has resulted in unprecedented divisiveness amongst citizens, families and friends. There are individuals who are angry that some concerned citizens are not complying and are comparing our current circumstances to the Holocaust. While this may seem extreme, the Holocaust also began with the small removal of freedoms[2], just as we are seeing today. This historical atrocity started out as a slow and seemingly innocent removal of rights by the government, but quickly morphed into media control, divisiveness between groups of people, and limitations to what one select section of society could do. In this way, the ordinary citizen easily became an enemy of the state. Today a one-sided, politically-driven narrative, which is being fuelled by politicians and the media, is causing a similar divisiveness. When only one side of the story is made available to the public, it is easy to understand how individuals can become disgruntled toward other citizens who are fighting to maintain their freedom and bodily autonomy. A political agenda is clearly being pushed here, and the refusal to address questions and concerns of healthcare practitioners and citizens of B.C. speaks volumes. We hope all of B.C. and Canada will carefully consider the information included in this document and join us in demanding clear, direct and truthful answers.

You must recognize and acknowledge the problems our country faces with our media and with our supposed leaders. We are on a dangerous trajectory and we must STOP —NOW! The media’s control of information and the censorship of knowledgeable and experienced physicians, scientists, and lawyers are preventing access to the two sides of the story. The introduction of "Fact checkers"—who are wholly owned by Big Tech, Big Pharma, and Big Media — being paid to censor anyone who does not support the government narrative. The tools of intimidation, coercion, and bribery are being used to divide our society, and all of this is happening right in front of us. Obviously, this type of behaviour is not a reflection of good people with good ideas; to the contrary, it is criminal activity.

Groups of doctors are forming international networks to investigate public health measures and to raise questions and concerns.[3] We call on all Canadians to join the rapidly growing movement of ordinary citizens who are standing up against tyranny and violation of our human rights and freedoms!

Please answer the 12 questions below directly, clearly and truthfully, with references to the data from the scientific research on which you are basing your decisions and policies:

1.) **DEATH PERSPECTIVE – There are currently ZERO deaths from COVID-19 for ages 12-19 in B.C., and 12 deaths in ALL children aged 0-19 in ALL of Canada**

Question: Why are you aggressively pressuring 12 through 19-year-old children to get the experimental COVID-19 vaccine when NO DEATHS have occurred in this age group due to COVID-19 in B.C. to date, according to the B.C. Centre for Disease Control? [4]

Background:

In general, we have observed extremely low mortality in B.C. and across Canada from COVID-19. As identified in the preceding link, only two COVID-19-*related* deaths have occurred in the past 18 months in the 0 to 11 age range in BC.

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[1] https://www.timescolonist.com/news/local/booster-shots-for-long-term-care-vaccine-mandate-for-hospital-staff-on-their-way-henry-1.24354874

[2] https://living-diversity.org/wp-content/uploads/2018/12/Just-like-any-other-day-ENG.pdf

[3] https://www.greenmedinfo.com/blog/130-uk-doctors-failed-covid-policies-caused-massive-harm-especially-children?utm_campaign=Daily%20Newsletter%3A%20130%2B%20UK%20Doctors%3A%20Failed%20COVID%20Policies%20Caused%20%27Massive%27%20Harm%2C%20Especially%20to%20Children%20%28XumiVc%29&utm_medium=email&utm_source=Daily%20Newsletter&_kx=PGxyCCxqAWnu4Hn6Ma46U0jfSKIocNqXr-YAOgMHa4Csby-Ao46hRNXEjcRJUBbL.K2vXAy

No deaths have occurred in the age range of 12 through 19. In these childhood deaths, the influence of comorbidities was not revealed.

On the BCCDC website[4], in the Situation Report listed below in the footnotes, these statistics can be viewed on page 9.

With only 2 deaths occurring in the 1 million children and adolescents aged 0 to 19 that reside in B.C., why are we even considering mandating vaccinations, masks, isolation, and restrictions at school?

B.C. has a population of 5.17M people. As of August 21, 2021, there have been a total of 1,804 deaths due to—or related to—COVID-19. These deaths occurred over the span of 18+ months dealing with COVID-19 in our province. Further calculation demonstrates that this represents a 0.023% COVID-19 yearly mortality rate for our entire B.C. population. Does an annual 0.023% risk of death, heavily skewed towards the elderly with comorbidities, justify a mandatory vaccine policy and a vaccine passport?

Moreover, in the age range of 0 to 59, there have been 127 deaths related to or from COVID-19 in the entirety of B.C across an 18+ month duration. Why is this information not being openly shared? Does this data not represent a very different reality than we are being led to believe in the media and in your press conferences?

The total number of people that the Government of Canada says died WITH COVID-19 (not necessarily FROM Covid-19) since the beginning of the pandemic, is 26,873 as of September 3, 2021. You can view these numbers directly on the Government of Canada InfoBase website[5], using the link in the footnote (find Figure 7, and change the drop down to "deceased"). There you will find the breakdown of the 26,873 of total COVID-19 deaths by age group in Canada. To see these numbers here, we show both the BC and CANADA total deaths, said to be WITH Covid-19, broken down by age, and the percentage of those deaths by age, over the past 18+ months:

- **Age 0-19 = 2 (0%) BC 12 (0%) Canada**
- **Age 20-29 = 0 (0%) BC 68 (0.3%) Canada**
- **Age 30-39 = 2 (0%) BC 152 (0.6%) Canada**
- **Age 40-49 = 16 (0.8%) BC 354 (1.3%) Canada**
- **Age 50-59 = 30 (0.16%)BC 1,033 (3.8%) Canada**
- **Age 60-69 = 77 (0.4%) BC 2,620 (9.7%) Canada**
- **Age 70-79 = 178 (9.8%) BC 5,747 (20.5%) Canada**
- **Age 80+ = 1,117 (62%) BC 17,160 (63.9%) Canada**

Total Deaths = 1,804 (100%) BC 26,872 (100%) Canada
Total Population = 5,145,851 BC 38,067,903 Canada

It should surprise all Canadians that there has been **a total of 12 children between the ages of 0 and 19 across the entire nation that have died WITH (not necessarily FROM) COVID-19 in 18+ months**. Co-morbidities have not been made public. With this data, it is reasonable to ask why the government seeks to vaccinate all children to "protect" them? It is obvious that they do not need protection.

If we compare this to the number of 0-19 year olds in Canada who typically die from influenza (the flu) each year, the public health pressure on children to get vaccinated becomes even more troubling. The only breakdown shown for pediatrics (assuming age 0-16) in Canada showed that 10 children died of the flu in 2018 over a 12 month period.[6] Data for deaths of children from the flu between the ages of 0 and 19 was not shown, which makes it difficult to precisely compare, but the figures are still telling. According to the Government of Canada, ten children 0-16 years old died from the flu in 12 months versus 12 children who died with COVID-19 over the last 18+ months (proportionately 8 children per 12 months). This means that COVID-19 is less dangerous than the flu for this age group. Why then is the Government pressuring children to get vaccinated?

Given 84.3% of all people who are said to have died *with* COVID-19 are age 70 and over, and 94% of all people who are said to have died *with* COVID-19 are age 60 and over, how do you justify applying public health restrictions on the rest of the population?

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[4] http://www.bccdc.ca/Health-Info-Site/Documents/COVID_sitrep/Week_33_2021_BC_COVID-19_Situation_Report.pdf

[5] https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html?stat=num&measure=deaths&map=pt#a2

[6] https://www.canada.ca/en/public-health/services/publications/diseases-conditions/fluwatch/2018-2019/annual-report.html

2.) PCR TESTING – Invalid test used to create fear based on 90%+ false positives

Question: Why are we still using polymerase chain reaction (PCR) tests to detect COVID-19 cases in B.C.?

Background:

The World Health Organization (WHO) originally stated that PCR tests were the "gold standard" for COVID-19 testing, recommending it as the universal test (as of March 21, 2020 laboratory testing strategy recommendations for COVID-19 interim guidance). Now the WHO admits what scientists have been saying since the beginning of the pandemic, that the PCR test is not an accurate diagnostic tool, and is in fact recommending a completely different testing protocol[7]. Also, the U.S. Centre for Disease Control (CDC) has said that it will ask the U.S. Food and Drug Administration (FDA) to withdraw its emergency use authorization (EUA) of the PCR test as of December 31, 2021[8].

The entire pandemic and associated restrictions are based upon the number of "cases"; however, the number of "cases" is based upon a positive PCR test result. These PCR tests are falsely inflating the "case" numbers of people who are sick with COVID-19. This creates fear and misleading statistics.

It is important to note that the inventor of the PCR test, Kary Mullis, stated many times that "PCR tests cannot be used to detect viruses"[9]. It is now admitted that the PCR cannot tell the difference between a common cold, the flu, or any virus or variant. Also, the PCR cannot differentiate between live and dead matter meaning whether something is infectious or not.

Additionally, former Pfizer Vice President and Chief Science Officer, Dr. Michael Yeadon announced "…this is nothing but fear-mongering based on junk science and fraud."[10] He too claims that "almost all" of the tests being conducted for the Wuhan coronavirus (COVID-19) are "false positives", a phenomenon that has been observed in Florida and around the world. Yet, we still continue to use PCR tests to manufacture fear and compliance.

Since speaking out, Dr. Yeadon has been censored and smeared in order to prevent the distribution of, and to discredit, the critical information he is sharing. He has risked his reputation, career, and his life to share this information. Dr. Yeadon has joined forces with a group of 160 doctors, who are in agreement with issues of regarding the COVID-19 narrative. [11] Why would these highly credentialed professionals willingly put themselves in this position, where there is so much to lose, and nothing to gain, other than trying to save people from harm?

Dr. Yeadon's credentials are impressive and include: BSc (Joint Honours in Biochemistry and Toxicology) PhD (Pharmacology), Formerly Vice President & Chief Scientific Officer Allergy & Respiratory, Pfizer Global R&D; Co-founder & CEO, Ziarco Pharma Ltd.; Independent Consultant (Scientist) (United Kingdom).

It is prohibited under the ***Genetic Non-Discrimination Act of Canada***[12] to require someone to take a genetic test such as the PCR test as a condition of their employment or as condition of providing goods or services to that individual. It is also prohibited for any person to collect, use or disclose the results of a genetic test of an individual without the individual's written consent. Anyone involved in contravening this law is liable to a fine of up to 5 years in jail and up to a $1,000,000 fine.

We note that all of your health orders contravene this law and that you are encouraging employers and business owners to do the same. Why aren't you advising the public of the legal responsibility and consequences under the GNDA?

3.) CASES – An overused term and count that means nothing in the actual diagnosis of disease

Question: What actually constitutes a legitimate COVID-19 case?

Background:
You state a case is confirmed based on a positive PCR test; however, as per Question #2, we know these tests are shown to be inaccurate (90% false positives). Moreover, cycling of PCR tests (often in excess of 35+ amplifications) is being

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[7] https://www.who.int/publications/i/item/WHO-2019-nCoV-lab-testing-2021.1-eng
[8] https://www.cdc.gov/csels/dls/locs/2021/07-21-2021-lab-alert-Changes_CDC_RT-PCR_SARS-CoV-2_Testing_1.html
[9] https://brandnewtube.com/watch/kary-mullis-what-he-said-about-the-pcr-test-covid1984_83H2TKPRvA1udPu.html
[10] https://brandnewtube.com/watch/ex-pfizer-vp-concerned-about-experimental-covid-vaccine_WjmMVkNrgHqrZgP.html
[11] https://doctors4covidethics.org/about/
[12] https://laws-lois.justice.gc.ca/eng/acts/G-2.5/page-1.html

used incorrectly for the detection of this virus. With the knowledge of these inflated false positives, we absolutely should not be counting these as "cases".[13]

4.) SPREAD – Vaccinated individuals spread COVID-19 just as much—or more—than unvaccinated individuals

Question: What science or information are you relying upon when you say in your health orders that unvaccinated individuals are at higher risk than vaccinated persons of being infected with and transmitting COVID-19, or that the presence of an unvaccinated staff member constitutes a health hazard under the Public Health Act?

Background:

Several studies as well as CDC data demonstrate evidence that vaccinated persons have high potential to spread the COVID-19 Delta variant [14]. It has been well documented that vaccinated people can—and do—spread the virus.[15]

A recently published medical study found that infection from COVID-19 confers considerably longer lasting and stronger protection against the delta variant than the current vaccines do.[16] Vaccinated individuals were found to be 27 times more likely to experience a symptomatic COVID-19 infection than those with natural immunity from COVID-19.[17] Why are we discriminating against unvaccinated people, when the spread is clearly happening also amongst vaccinated individuals. Furthermore, those that have had a natural COVID-19 infection have been proven to have longer-term and more robust protection compared to those with the vaccine.[18]

5.) VARIANTS – Vaccines are causing the variants, and the vaccinated are more affected by variant strains than those with naturally conferred immunity

Question: What source are you looking at when you declare that the variant(s) are being caused by unvaccinated individuals?

Background:

Dr. Byram W. Bridle (Professor of Viral Immunology at University of Guelph) explains that similarly to antibiotic resistance, COVID-19 variants are caused by not fully killing the virus, allowing for mutation.[19] Therefore, only individuals who are vaccinated can be creating the variants. As with any variant, as the CDC and WHO also state, mutations lead to a weaker and more transmittable viral strain. That is why the Delta will not have the same potential for causing deaths as the original COVID-19 strain. As evidenced by Dr. Bridle, the continual application of COVID-19 vaccinations, and furthermore boosters, will exacerbate the development of more variants. Finally, there is no current evidence that suggests that unvaccinated individuals are causing a rise in cases. [20]

6.) VACCINE EFFECTIVENESS – Exposing the true effectiveness rate of vaccines and approval concerns

Question: Why is the inflated Relative Risk Reduction (RRR) of 94.0% utilized in reporting of vaccine effectiveness instead of the Absolute Risk Reduction (ARR) of less than 1.0%? What information are you relying upon when you say vaccines prevent or reduce the risk of infection with covid-19?

Background:

Promoting the RRR instead of the ARR misleads the general population, exacerbating the non-factual concept that these vaccines prevent getting and spreading COVID-19. The National Library of Medicine website linked below states "… the absence of the ARR in COVID-19 trials can lead to outcome reporting bias that affects the interpretation

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13 https://brandnewtube.com/watch/dr-mike-yeadon-on-pcr-tests-for-covid19_L2vEhfBrzbkYAyX.html

14 https://www.theglobeandmail.com/amp/world/article-people-who-are-fully-vaccinated-have-high-potential-of-spreading-covid/

15 https://www.globalresearch.ca/study-fully-vaccinated-healthcare-workers-carry-251-times-viral-load-pose-threat-unvaccinated-patients-co-worker s/5753908?pdf=5753908&fbclid=IwAR3oPOpu9TA8VlKGYmSyGWvUa8BHwwSnEQgDfGMPq6p2qSXBkzCyrGEbiGA

16 https://www.nature.com/articles/d41586-021-02187-1

17 https://www.science.org/content/article/having-sars-cov-2-once-confers-much-greater-immunity-vaccine-vaccination-remains-vital

18 https://www.lewrockwell.com/2021/09/no_author/harvard-epidemiologist-the-case-for-vaccine-passports-was-demolished/

19 https://undercurrents723949620.wordpress.com/2021/08/16/the-lies-behind-the-pandemic-of-unvaxxed/

20 https://www.lifesitenews.com/news/no-pandemic-of-the-unvaccinated-covid-jab-skeptic-doctor-interviewed-on-fox/

of vaccine efficacy."[21] Saying that vaccinations are 94.0-95.0% effective is very misleading,[22] as people often assume this means they have a 94.0% chance that they will not become sick from COVID-19. This is not true.

To explain how RRR and ARR works in layman's terms requires much detail. Simplifying this information, RRR signifies the risk of a health event occurring in a group of vaccinated individuals versus a group of unvaccinated individuals. This number is incorrectly interpreted to represent that 94 out of every 100 people vaccinated will be protected from COVID-19. Although this number is compelling, this is an incorrect statement regarding what that 94% means. This number does not tell you what your chances are of becoming sick if you get vaccinated.

The more valuable and accurate value that needs to be used is that of the ARR. The ARR represents the ACTUAL likelihood of disease risk between the placebo (non-vaccinated individuals) and treatment (vaccinated individuals) groups.

The ARR data directly from Pfizer and Moderna was calculated as 0.7% and 1.1% respectively. In contrast, the RRR calculated as 95.0% and 94.0% for Pfizer and Moderna, respectively. See the Abstract in this NIH document that presents the vaccine RRR/ARR data direct from Pfizer and Moderna.[23]

If individuals knew that the current vaccinations only confer a 0.7% to 1.1% reduction in chances of getting ill with COVID-19, would they have still have taken the vaccine given its risks?

It is imperative to clarify that the COVID-19 vaccines do NOT prevent COVID-19, nor do they stop the transmission of COVID-19. The vaccines have only been designed to reduce severity of symptoms in the individual who receives the vaccine. As previously discussed, the virus is still transmissible by both vaccinated and non-vaccinated individuals. Breakthrough cases are occurring regularly in fully vaccinated individuals at an increasing rate, which is pushing the requirement for booster vaccinations. The push by Government to require booster vaccinations at this early stage only serves to confirm that the original vaccine program being pushed is failing.[24]

7.) VACCINE SAFETY/INJURY STATS – Missing full details of the magnitude of Vaccine injuries and deaths

Question: Where is the transparency for the current statistics and details regarding counts of B.C. vaccine-related injuries and deaths?

Background:

Adverse reaction statistics and data is imperative to ensure that British Columbians can exercise their constitutional right to free and voluntary informed consent. This information should be presented daily, alongside the Covid-19 "case" numbers, so people can decide whether they want to freely accept the experimental vaccinations.

The Government of Canada Vaccine Injury website states as of September 3, 2021 that 14,101 adverse reactions have been reported. Of those 14,101 reports of adverse reactions there are currently 3,768 reported as serious. "Serious" adverse reactions include death; however, death counts are not separately recorded on this database. [25] Why is there this lack of transparency?

Specifically, on Sept 3rd, a report quietly released by Public Health Ontario reported 106 youth, under the age of 25, were hospitalized with heart inflammation following mRNA vaccination. [26]

These vaccine injuries and deaths are not just in Canada, but all over the world:

- (EU Vaccine injury:1.9 Million, Vaccine deaths: 20,595)[27]
- (US Vaccine injury reported in VAERS: 650,075, Vaccine deaths: 13,911)[28]

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[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7996517/

[22] https://rumble.com/vm026d-ex-pfizer-employee-tells-us-the-horrifying-truth-about-the-covid-19-vaccine.html

[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7996517/

[24] https://www.timesofisrael.com/virus-czar-calls-to-begin-readying-for-eventual-4th-vaccine-dose/

[25] https://health-infobase.canada.ca/covid-19/vaccine-safety/summary.html

[26] https://theprovince.com/news/provincial/over-100-ontario-youth-have-been-sent-to-hospital-for-vaccine-related-heart-problems/wcm/d3720dc4-1435-4c7e-9573-b7d658b075b1

[27] https://www.globalresearch.ca/20595-dead-1-9-million-injured-50-serious-reported-european-union-database-adverse-drug-reactions-covid-19-shots/5751904

[28] https://www.openvaers.com/covid-data

yet the true numbers are not being disclosed accurately—if at all. Investigations show that very few vaccine injuries and deaths are actually approved and reported to government reporting agencies.[29] An article from Harvard states "manufacturers of vaccines must comply with the more expansive requirements of §600.80 of the C.F.R. Because VAERS is a passive reporting system, many adverse reactions to vaccines may not be reported." [30]

Lastly, the Harvard Pilgrim Study[31] states "Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health."

Dr. Patrick Phillips, an emergency room physician in Ontario stated that the forms are not easy to fill out, and that they are very cumbersome. Dr. Phillips also had a few reports returned to him marked as 'invalid'.[32] It is critical to properly compare the risk of COVID-19 to the risk of vaccine injury knowing they are not fully disclosed. This is even more important when we see the pharmacies including more warnings on the Vaccines.[33]

A true clinical trial of this vaccine would include transparency where health officers would clearly provide vaccine injury details and fully track these occurrences without hesitation. Without this information and data, proper free and full informed consent cannot occur. The above included links are just some of the reporting systems, but the numbers are still very high and show much more injury than should be acceptable to any PHO or Government.

8.) PASSPORTS –Will NOT be temporary and soon the 2 shots will NOT be sufficient to obtain a valid passport

Question: You have recently stated that vaccine passports will be temporary, expiring at the end of January 2022. However, with 1 billion dollars being offered as an incentive by the Government of Canada[34] for provinces who implement this system, it is hard to imagine this system will be scrapped by January 31, 2022, after only 5 months of use. It is difficult to rely on your statement given what you said on May 25, 2021on television (see 2:52 into the video):

> …there is no way that we will recommend inequities be increased by use of things like vaccine passports for services, for public access here in British Columbia, and that's my advice and I've got support from the Premier and I have talked about this Minister Dix and others." [35]

Prime Minister Trudeau made a similar commitment to Canadians on January 14, 2021 (see 3:30 into the same video).

Current studies (footnoted earlier) show that vaccinated individuals spread COVID-19 as well. This begs the question, if all people spread the virus why are we segregating people?

While it is understandable that fully vaccinated individuals are looking forward to getting their passport so life "can go back to normal" or so they "can travel", they should be made aware that once a booster is mandated, their passport will no longer be considered valid until they are post 7 days after receiving a booster. Countries around that world that are implementing booster programs are already indicating that boosters will be needed to maintain a valid and up-to-date vaccine passport. [36] The booster system will ensure that this vicious cycle never ends and one will need regular boosters of the vaccine to keep their passport valid.

9.) TREATMENTS – There are better inpatient and at home treatments that can reduce illness severity and death

Question: Why are we not using approved and well-researched antivirals like FDA approved Ivermectin? [26] Why are we providing no out-patient treatment for at home use when other doctors in many countries are successfully doing so?

Background:

Doctors are avoiding or being prohibited from prescribing pharmaceuticals that are known to help with COVID-19 symptoms that are safe, such as Ivermectin. The negative spin being put on Ivermectin by mainstream media, that it is

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[29] https://digital.ahrq.gov/ahrq-funded-projects/electronic-support-public-health-vaccine-adverse-event-reporting-system
[30] https://dash.harvard.edu/bitstream/handle/1/9453695/Davenport%2c_Katherine_NVICP.pdf?sequence=2&isAllowed=y
[31] https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf
[32] https://action4canada.com/medical-censorship-and-tyranny-exposed/
[33] https://21stcenturywire.com/2021/07/12/breaking-fda-warning-for-johnson-johnson-vaccine-linked-to-autoimmune-disease/
[34] https://www.cbc.ca/news/politics/trudeau-promises-1b-vaccine-passports-1.6155618
[35] https://rumble.com/vm7uzj-b.c.-vax-pass-punishes-young-health-care-worker-who-cant-walk-following-mod.html
[36] https://www.lifesitenews.com/news/countries-now-cancelling-covid-vaccine-passports-for-those-without-booster-shots/

only used in horses, is not true. These statements being made about Ivermectin are malicious and false as it has been safely and effectively used for years in humans.[37] In 2015 William C. Campbell, emeritus research fellow at Drew University in Madison, New Jersey and Satoshi Omura, professor emeritus at Kitasato University in Japan, jointly received one half of the Nobel Prize for their work with Ivermectin that was discovered in 1975 and approved for safe use in humans in 1987. In delivering his Nobel Prize lecture on December 7, 2015, Dr. Campbell confirmed the safety and effectiveness of using Ivermectin in humans, and noted that part of the ground breaking research was done in partnership with the WHO, the World Bank, and others.[38] It was noted that because of its excellent safety profile and broad spectrum of activity, Ivermectin was catalogued by the World Health Organization as an essential medicine and is regarded by many as a "magic bullet" for global health. [39]

On February 9, 2021, the chairman of the Tokyo Medical Association, Haruo Ozaki, announced that Ivermectin seemed to be effective at stopping Covid 19 and publicly recommended that all doctors in Japan immediately begin using Ivermectin to treat Covid 19.[40]

It is interesting to note that only since the covid-19 pandemic began has the WHO changed its stance on the effectiveness of Ivermectin. While the WHO still admits that Ivermectin is on its essential medicines list (and therefore safe), the WHO now simply says that the evidence to support using Ivermectin as an effective treatment for Covid 19 is inconclusive, and that the guideline development group that they convened did not look at the use of Ivermectin to prevent Covid 19. One can only speculate as to why this group was not asked to look at that essential question. The WHO only says that this question was outside the scope of the current guidelines.[41] It would seem that these much more expensive, experimental vaccines that were rushed to market under an emergency use authorization only, without proper testing and scrutiny, would be at least as inconclusive as the safe, tried and tested Ivermectin.

Additionally, Hydroxychloroquine is an approved and well-known treatment. Medical professionals have been coerced and forced to prescribe less efficacious, and even harmful, drugs. Deaths associated with adverse drug events (i.e. related to the use of Remdesivir[42]) should be considered as a separate count from COVID-19 deaths, as those deaths could have been avoided if these effective pharmaceuticals were implemented in a timely manner.

Simple home remedies such as zinc, vitamin D, vitamin C, N-acetylcysteine, and quercetin are also well known and effective at helping COVID-19 patients to recover[43]. Dr. Vladimir Zev Zelenko has led the way with these treatments. In contrast, many doctors are still sending patients with COVID-19 home without any of these treatment options.

Why have you not promoted other effective treatment apart from the experimental vaccines, or even healthy lifestyle choices and vitamin D, since it is clear that obesity, high blood pressure and inactivity were largely responsible for COVID-19 related deaths? The opposite has happened with your policies of lockdowns, closures of parks, gyms, and sports programs, and the creation of fear and anxiety through constant media messaging. These all lower the function of the immune system and increase blood pressure, which are undesirable outcomes.

10.) DEFINITION AND COUNTS OF THE VACCINATED VS. UNVACCINATED

Question: Why have you made the definition of vaccinated and unvaccinated in your public health orders so misleading and contrary to common understanding? Why do use different definitions of what it means to be "vaccinated" in your different health orders that are still in effect?

Background:

In your August 20, 2021 provincial health order, which has already gone missing from the B.C. government website, you define "vaccinated" as any individual who is 14 days post receipt of the full series of a WHO approved vaccine, or combination of approved WHO vaccines. This means that anyone who is sick or hospitalized with COVID-19 within 13 days of their 2nd shot is considered "unvaccinated". This is just like people who have had one shot, and are counted in

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37 https://journals.lww.com/americantherapeutics/fulltext/2021/08000/ivermectin_for_prevention_and_treatment_of.7.aspx
38 https://www.nobelprize.org/prizes/medicine/2015/campbell/lecture/
39 https://www.isglobal.org/en/healthisglobal/-/custom-blog-portlet/ivermectina-un-medicamento-de-nobel-pero-poco-accesible/91127/0
40 https://www.lifesitenews.com/news/breaking-japanese-medical-association-chairman-tells-doctors-to-prescribe-ivermectin-for-covid/v
41 https://www.who.int/news-room/feature-stories/detail/who-advises-that-ivermectin-only-be-used-to-treat-covid-19-within-clinical-trials
42 https://www.bmj.com/company/newsroom/who-guideline-development-group-advises-against-use-of-remdesivir-for-covid-19/
43 https://vladimirzelenkomd.com/treatment-protocol/

the statistics that you put forth. These definitions are very misleading and help promote the false narrative that the unvaccinated are driving the upward trend of "cases".

You alluded to the fact that boosters are likely to be required in B.C., at least for certain populations. As we are witnessing the rollout in other countries, we predict that the plan will be to require everyone to have a booster, or several boosters, eventually. Once 2 shots are no longer what is recommended as a full series of COVID-19 vaccines approved by the WHO, then no British Columbian will be considered "vaccinated" until a booster vaccine is taken.

Also, it has been noted that the WHO does not approve of mixing and matching vaccines. This is contrary to your definition of "vaccinated" in your current health order wherein you do approve of this practice. The WHO says this should not be done unless supportive evidence is available. What evidence are you relying upon to tell British Columbians that mixing and matching of COVID-19 vaccines is acceptable or safe? The WHO recommends that if someone has mixed and matched 2 different vaccines, no additional doses of either vaccine should be administered to that person.[44] Why are you ignoring this advice? What science are you relying upon?

Finally, Dr. Bonnie Henry, you quietly issued an additional health order on August 31, 2021 [45], replacing the August 20, 2021 health order. The new order issued on August 31, 2021 removed some terms and added others which included changing the definition of "vaccinated" from 14 days post a full series of vaccination approved by the WHO, down to 7 days post-vaccination of an approved full series of WHO approved vaccines. Your September 2, 2021 Residential Care Staff Covid-19 Preventative Measures health order[46] uses the same 7 day period. What science are you relying on to justify this change, as you have previously stated that it requires 14 days for the vaccines to work?

11.) TESTING ONLY UNVACCINATED INDIVIDUALS —August 20, 2021, August 31, 2021 and September 2, 2021 Health Orders

Question: In your public health order dated August 20, 2021—and now August 31, 2021 and September 2, 2021 —you are only requiring unvaccinated individuals to undergo rapid antigen testing and PCR testing. In light of the evidence and scientific research showing that vaccinated individuals are significantly more likely to contract the Delta variant than unvaccinated individuals[47]. You also say in your September 2, 2021 health order that you will not allow any staff member to be hired after October 11, 2021 unless they meet your definition of "vaccinated". What science are you relying on to justify this policy of testing and discriminating against unvaccinated citizens?

Background:

You continue to state that you are following the science, however, you have yet to provide ANY reference to the science you are following despite being asked for this information numerous times over the last 18+ months. We demand that you be transparent and honest with the public you serve by posting the scientific studies and data you are relying upon to support your policies and health orders on the BC government website alongside your public health orders so we can review this information.

12.) MASKS – under OATH Dr. Bonnie Henry admitted that there is scant evidence that masks are effective at preventing spread of the influenza virus but felt that can be an effective coercive tool when staff refuse to accept a vaccine

Question: Where is the evidence that your mask mandates in your health orders actually work? You define "face coverings" in your September 2, 2021 health order[48] as including a medical mask, or a non-medical mask, or a tightly woven fabric but does not include a clear plastic face shield. Where is the evidence that a non-medical mask, or a piece of tightly woven fabric, is an effective means of preventing the spread of a virus?

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[44] https://www.who.int/news/item/10-08-2021-interim-statement-on-heterologous-priming-for-covid-19-vaccines

[45] https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/covid-19-pho-order-vaccination-status-information.pdf

[46] https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/covid-19-pho-order-residential-care-staff.pdf

[47] https://www.covid-datascience.com/post/israeli-data-how-can-efficacy-vs-severe-disease-be-strong-when-60-of-hospitalized-are-vaccinated

[48] https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/covid-19-pho-order-face-coverings.pdf?bcgovtm=20210311_GCPE_Vizeum_COVID___Google_Search_BCGOV_EN_BC__Text

Background:

Dr. Henry's testimony under oath in 2015 [49] in an arbitration hearing in Ontario as an expert witness for the Sault Area Hospital (SAH) and the Ontario Hospital Association (OHA) against the Ontario Nurses Association (ONA) is informative. The issue in that arbitration was that the hospital required healthcare workers to wear surgical/procedure masks each year throughout the 5 to 6 month flu season if they had not received the vaccination for influenza. The Nurses Union alleged that the policy was an unreasonable exercise of management rights and a breach of employee privacy rights. At the time that Dr. Henry advocated in favor of the policy, she was the Deputy Provincial Health Officer for British Columbia.

Dr. Henry's testimony in that arbitration hearing is eerily similar to the narrative she has been telling British Columbians about the Covid 19 virus. Dr. Henry was a strong proponent that there was asymptomatic spread, that unvaccinated nurses and healthcare workers should wear masks, and supported mandating forcing employees to wear masks as a consequence of choosing not to get the vaccine.

On cross-examination Dr. Henry reluctantly admitted (at paragraph 161 of the arbitration decision) that there was not a lot of evidence to support the suggestion that asymptomatic shedding actually leads to effective transmission of the virus.

At paragraph 178 of the arbitration decision, the arbitrator notes that Dr. Henry concluded after admitting that "I am not a huge fan of the masking piece", that "there is not a lot of evidence to support mask use…"

At Paragraph 219 Dr. Henry's evidence is summarized in part as follows:

> It is a challenging issue and we have wrestled with it. I am not a huge fan of the masking piece. I think it was felt to be a reasonable alternative where there was a need to do-to feel that we were doing the best we can to try and reduce risk. I tried to be quite clear in my report that the evidence to support masking is not as great and it is certainly not as good a measure.

In the arbitration, the Nurses Union submitted that Dr. Henry was instrumental in the introduction of the "vaccinate or mask" policy in British Columbia (paragraph 256) and therefore Dr. Henry's objectivity was suspect. The arbitrator preferred the evidence of other experts over Dr. Henry and her colleagues' evidence.

The arbitrator noted that Dr. Henry defended the vaccine or mask policies as a way of preventing transmission from unvaccinated healthcare workers to their patients before symptom onset, or in cases of asymptomatic infection (paragraph 287). However, the arbitrator also noted (at paragraph 294) that while Dr. Henry stated there was "some evidence that people shed prior to being symptomatic and some evidence of transmission" but "there is not a lot of evidence around these pieces". Two other experts who testified on behalf of the hospital, one of whom Dr. Henry acknowledged her expertise, both admitted that the evidence of asymptomatic spread was "scant".

The arbitrator held (at paragraph 297), while "bearing in mind the concessions made about the quality of the evidence by Dr. McGeer and Dr. Henry", that the following opinion of another expert was more accurate:

> Although symptomatic individuals may shed influenza virus, studies have not determined if such people effectively transmit influenza… Based on the available literature, we found that there is scant, if any, evidence that asymptomatic or pre-symptomatic individuals play an important role in transmission."

The arbitrator held that the patient safety purpose and effect of masking was not established on the evidence and that the "vaccine or mask" requirement was reduced to a "coercive tool", a situation that would be troubling if made out. The arbitrator also noted (at paragraph 326) Dr. Henry's recognition that the wearing of a mass could be reasonably regarded as a "consequence" for failure to consent to vaccination.

The arbitrator concluded (paragraph 327) that the vaccine or mask policy did not provide a legitimate accommodative purpose for healthcare workers who conscientiously object to immunization, but rather more closely resembled an unacceptable Hobson's choice (free choice). The arbitrator did not accept the argument that requiring unvaccinated staff to wear a mask may encourage truly voluntary immunization, nor did the arbitrator accept that the continuance of the minority employee group who choose to mask disproves the effectively coercive aspect of a vaccine or mask policy. The arbitrator noted that one of the nurses told her managers that "I felt I was being publicly put on display for choosing not to get the flu shot. I told her I felt I was being bullied into it and harassed."

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[49] https://www.canlii.org/en/on/onla/doc/2015/2015canlii62106/2015canlii62106.pdf

The arbitrator concluded that the vaccine or mask policy was unreasonable and contravened KVP principles. Similar findings were made by another arbitrator in 2018 involving the St. Michael's Hospital and the Ontario Hospital Association v. The Ontario Nurses Association.[50] [51]

The vaccine or mask policy in issue in the Ontario Nurses arbitrations is very similar to what is going on in British Columbia with covid-19. Just as the arbitrator found that a masking policy amounted to a coercive tool that was troubling, your policies requiring rapid antigen testing, PCR testing, and masking as a condition of employment, is nothing more than a coercive tool to pressure people to accept the experimental vaccine. As the arbitrator held in 2015, a policy with this purpose is "troubling".

You stated numerous times in your television briefings in 2020 that masks were not effective at preventing the spread of the Covid 19 virus. [52] Now you claim that masks do work and that you never said they did not. There is a glaring discrepancy between the statements that you made under oath in 2015, and in your television briefings in 2020, compared to what you are saying now in your current health orders in 2021.

Please refer to the additional published studies confirming masks are not effective.[53] [54] Also, Dr. Byram Bridle's video also demonstrates that wearing 5 masks do not stop droplets from escaping and certainly do not prevent the Covid-19 virus from passing through a non-medical mask or tightly woven clothing.[55]

Requiring people to wear masks harms the user by reducing availability of oxygen, increasing bacterial growth within the fabric of the masks, leads to social issues for individuals that cannot mask for medical reasons, creates waste of materials and money, and contributes to further pollution and negative environmental impact.

Please provide the evidence you are relying upon that prove masks work.

Call To Action:

Dr. Henry, Mr. Dix and Mr. Horgan, the citizens of this province call on you to answer to these questions, directly and truthfully. British Columbians will no longer tolerate the trampling of our rights, segregation, and division amongst neighbors and families. We respect different perspectives and opinions; however, everyone deserves to see the scientific evidence you are relying upon to justify your public health orders. All British Columbians thank you in advance for your much-anticipated response.

To our fellow British Columbians, you are our friends and family, and we need you to carefully consider the information above and be open to what is being said. We urge you to join us in fighting for the restoration of our freedoms and putting an end to the restrictions that have no basis in science and are designed only to promote fear and division and to give the government control over our lives.

Now is the time to take a stand, before it is too late.

Please share this with all your friends, family, media and everyone you can think of.

Sincerely,

Voices Of Silenced Okanagan Health Professionals
A concerned group of health professionals who choose to remain anonymous due to threats of discipline and termination, by our own various professional governing bodies, for all who dare to question the B.C. government narrative on COVID-19 policies.

All of the documentation and websites linked in the footnotes have been archived to preserve their contents.

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[50] https://www.ona.org/wp-content/uploads/ona_kaplanarbitrationdecision_vaccinateormask_stmichaelsoha_20180906.pdf
[51] https://www.canadianlawyermag.com/practice-areas/privacy-and-data/ona-wins-second-arbitration-against-hospitals-on-vaccinate-or-mask-policy/275455
[52] https://www.youtube.com/watch?v=-CefaYs_pFs
[53] https://rationalground.com/masks-children-and-covid-19-published-studies/
[54] https://showmeyoursmile.org
[55] https://www.youtube.com/watch?v=tIaul0U83d0

Appendix “E”

HEALTH PROFESSIONALS UNITED
Standing Together Against Mandatory Vaccines

Open Letter to AHS

Alberta Health Services Corporate Office
Seventh Street Plaza
14th Floor, North Tower
10030 – 107 Street NW
Edmonton, AB T5J 3E4

Sent via email

September 20, 2021

Dear Dr. Verna Yiu:

This open letter is in response to your announcement of mandatory full vaccination for all AHS staff by Oct 31, 2021. We represent a wide range of vaccinated and unvaccinated health care professionals from multiple disciplines, who are deeply concerned about these mandatory vaccinations.

There are many reasons why we stand against mandatory vaccination and highlight some of them below. These concerns are supported by peer reviewed publications and statements by established organizations:

• These mRNA vaccines have NOT been proven to prevent disease uptake nor disease transmission supported by the CDC’s Morbidity and Mortality Weekly Report August 6, 2021 / 70(31);1059-1062 (among other reports) where it is stated “Real-time RT-PCR Ct values in specimens from 127 fully vaccinated patients (median = 22.77) were similar to those among 84 patients who were unvaccinated, not fully vaccinated, or whose vaccination status was unknown (median = 21.54)”. Asymptomatic unvaccinated people have never been proven to be more infectious or transmit more disease than vaccinated individuals.

• The overall survival rate from covid is approximately 99.7% and varies by age and underlying health status.

• The vaccine is showing weakened efficacy after only a few months. AHS’s own data shows currently approximately 25% of all new cases are in fully vaccinated patients and over 18% of hospitalizations are also fully vaccinated with percentages increasing as weeks go by.

• The United Kingdom and Israel – two highly vaccinated countries have extremely high percentages of hospitalized patients being fully vaccinated. Indeed, the Israeli Public Health Department recently estimated the efficacy of the Pfizer vaccine had fallen to 39% against the Delta variant and another recent study from the Mayo clinic had similar numbers at 42%

• Historically, scientific consensus has been that natural immunity is superior to vaccine immunity. Many health care workers are already Covid recovered and immune. What evidence does AHS have for mandatory vaccines in those individuals?

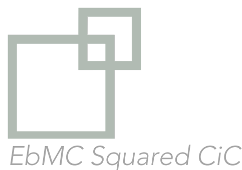
As front-line health care workers, we have witnessed serious adverse events, including deaths, that were temporally, closely associated from the administration of these vaccines.

• As per VAERS data (US vaccine injury database), Aug 27, 2021, at least 650,077 people in the US have been injured and 13,911 people have died soon after the administration of the Covid vaccine. These numbers could actually be 10-100x higher as a Harvard study showed only 1-10% of all adverse events are actually recorded. The Harvard study's findings are corroborated by our experience that the vast majority of temporally related adverse events are not being correlated and reported by healthcare workers. If we don't correlate these temporally related events and report them, the data will never be there to accurately assess causality and truly ensure safety, which is the bedrock to obtaining proper informed consent.

We believe that the proposed vaccine mandate is contrary to section 2 of the *Canadian Charter of Rights and Freedoms* "freedom of conscience and religion" as well as section 7, "the right to life, liberty and the security of the person and the right to not be deprived thereof except in accordance with the principles of fundamental justice."

Based on our experience, the above arguments (plus others not listed in this letter) and our evaluation of the current literature, we decisively conclude that we are in strong opposition to mandatory vaccination. As of Nov 1, 2021, or earlier, AHS's decision to implement such a mandate will prevent many dedicated health care workers and other AHS staff from performing the jobs they have done valiantly over the past eighteen months. This will put our currently severely strained health care system under further undue and needless pressure and put more Albertans at risk due to our inability to provide care for our patients. We respectfully request that the vaccine mandate be rescinded immediately so that AHS Health care workers can continue to provide care for Albertans.

cc. Dr. Laura McDougall, Senior Medical Officer of Health, AHS
Dr. Francis Belanger, Vice-President of Quality and CMO, AHS
Dr. Debrah Wirtzfield, Associate CMO, Physician Health, Diversity & Wellness, AHS
Patrick Dumelie, Covenant Health
Dr. Owen Heisler, Covenant Health



9 June 2021

Medicines and Healthcare Products Regulatory Agency

Dear Dr. Raine,

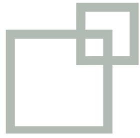
RE: Urgent preliminary report of Yellow Card data up to 26th May 2021

As the Director of the Evidence-based Medicine Consultancy Ltd and EbMC Squared CiC, I am writing to share with you this urgent preliminary report on the Yellow Card data up to 26th May 2021. Please note that EbMC Squared CiC is a Community Interest Company that conducts research mandated by the public and funded by public donations. We have no conflicts of interest and do not engage in industry-funded work.

The MHRA describes the purpose of its Yellow Card system as providing "an early warning that the safety of a medicine or a medical device may require further investigation. It is important for people to report problems experienced with medicines or medical devices as these are used to identify issues which might not have been previously known about."[1] Furthermore, the MHRA recognises that the conditions under which medicines are studied in clinical trials do not reflect how the medicines will be used in hospitals or clinical practice once they are rolled out. This means that some adverse drug reactions "may not be seen until a very large number of people have received the medicine."

The Covid-19 vaccines were rolled out in the UK on the 8th of December 2020. As of the 6th May 2021 nearly 39 million people have received their first dose of the Covid-19 vaccine, and 24 million both doses. Sufficient data have now accumulated to get a good overview of adverse

[1] https://yellowcard.mhra.gov.uk/the-yellow-card-scheme/



drug reactions (ADRs). I would, therefore, like to draw your attention to the high number of covid-19 vaccine-attributed deaths and ADRs that have been reported via the Yellow Card system between the 4th January 2021 and the 26th May 2021. In total, 1,253 deaths and 888,196 ADRs (256,224 individual reports) were reported during this period.

To facilitate a better clinical understanding of the nature of the adverse events occurring, primarily to inform doctors at the frontline, we have searched the Yellow Card reports using pathology-specific key words to group the data according to the following five broad, clinically relevant categories:

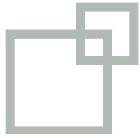
A. Bleeding, Clotting and Ischaemic ADRs
B. Immune System ADRs
C. 'Pain' ADRs
D. Neurological ADRs
E. ADRs involving loss of Sight, Hearing, Speech or Smell
F. Pregnancy ADRs

After running each search, we entered the results into an Excel spreadsheet, excluding ADRs that were clearly irrelevant or appeared in duplicate. These spreadsheets will be used going forward to facilitate the weekly monitoring of Yellow Card data. We recognise that keywords may need expanding to capture category relevant ADRs that may have been missed in this preliminary ADR scope and analysis.

A. Bleeding, Clotting and Ischaemic Adverse Drug Reactions (Table 1)

We used the following SEARCH TERMS to identify bleeding, clotting and ischaemic ADRs: **bleed, haemo*, thrombo*, emboli*, coag*, death, ischaem*, infarct*, angina, stroke, cerebrovascular, CVA**.

We included the term 'death' in this search group, as this term accounted for many reported fatalities (438) without specific details. Given the large number of fatalities without a specific cause of death, we considered that ADRs reported in this way, in particular as 'sudden death', would be most likely to occur from haemorrhagic, thrombo-embolic or ischaemic events. Given the seriousness of this ADR, we considered it justifiable to do this pending a Freedom of Information (FOI) request to clarify the cause of death in these 438 people.



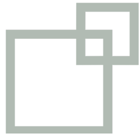
Using these search terms, 13,766 bleeding, clotting and ischaemic ADRs were identified – 856 of which were fatal. Government reports have highlighted the occurrence of cerebral venous sinus thrombosis, apparently accounting for 24 fatalities and 226 ADRs up to the 26th May 2021. However, our analysis indicates that thromboembolic ADRs have been reported in almost every vein and artery, including large vessels like the aorta, and in every organ including other parts of the brain, lungs, heart, spleen, kidneys, ovaries and liver, with life-threatening and life-changing consequences. The most common Yellow Card categories affected by these sorts of ADRs were the nervous system (152 fatalities, mainly from brain bleeds and clots), respiratory (with 103 fatalities, mainly from pulmonary thromboembolism) and cardiac categories (81 fatalities).

B. Immune System Adverse Drug Reactions (Infection, Inflammation, Autoimmune, Allergic) (Table 2)

We used the following SEARCH TERMS to identify immune system ADRs: **INFECTION (category), IMMUNE DISORDERS (category), -itis; immun, multiple sclerosis, lupus, myasthenia, pernicious, diabetes, Addison, Crohn's, Coeliac, Graves, alopecia, amyloidosis, antiphospholipid, angioedema, Behcet's, pemphigoid, psoriasis, aplasia, sarcoidosis, scleroderma, thrombocytopenia, vitiligo, Miller Fisher, Guillain-Barre; allerg*, urticaria, rash, eczema, asthma**

To the 26th May, a total of 54,870 ADRs and 171 fatalities fell into this category, which comprised the second most common cause of post-vaccination fatalities after 'Bleeding, Clotting and Ischaemic ADRs'. However, only 4 associated fatalities were reported under the Yellow card 'IMMUNE DISORDERS' category, with the majority (141 fatalities associated with 19,474 ADRs) reported under the 'INFECTIONS' category. Among 1,187 people for whom post-vaccination COVID infection was reported, there were 72 fatalities (6% of reported COVID infection ADRs).

Many 'INFECTION' category ADRs indicated the occurrence of re-activation of latent viruses, including Herpes Zoster or shingles (1,827 ADRs), Herpes Simplex (943 ADRs, 1 fatal), and Rabies (1 fatal ADR) infections. This is strongly suggestive of vaccine-induced immune-compromise. Bell's palsy, also associated with latent virus re-activation, is reported in the Neurological ADRs section of this report (D). Also suggestive of vaccine-induced immunocompromise was the high number of immune-mediated conditions reported, including Guillain-Barré Syndrome (280 ADRs, 6 deaths), Crohn's and non-infective colitis (231 ADRs, 2 deaths) and Multiple Sclerosis (113 ADRs).



Allergic responses to the vaccines comprised 25,270 reported ADRs, with 4 fatalities occurring among 1,001 people experiencing anaphylactic reactions.

C. 'Pain' Adverse Drug Reactions

We used the following SEARCH TERMS to identify pain ADRs: **pain, -algia**.

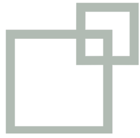
Pain ADRs accounted for at least 157,579 ADRs (18%) in total. A large number of these were arthralgias (joint pains – 24,902 ADRs) and myalgias (muscle pains – 31,168 ADRs), including fibromyalgia (270 ADRs), a long-term condition that causes pain all over the body. Among Congenital Disorders (usually conditions present from birth) there were 11 reports of Paroxysmal Extreme Pain Disorder (PEPD), which is an extremely rare inherited disease caused by a genetic mutation leading to dysfunction of voltage-gated sodium channels. The head was the most common location for pain, but abdominal pain, eye pain, chest pain, pain in extremities, and anywhere else that pain can be imagined was reported. Headaches were reported more than 90,000 times and were associated with death in four people (excluding deaths reported to be from other causes, that may also have involved headache).

D. Neurological Adverse Drug Reactions

In addition to examining ADRs in the **NERVOUS SYSTEM DISORDERS (category),** we used the following SEARCH TERMS to identify neurological ADRS specifically involving paralysis, neurological degeneration, and convulsive ADRs as follows**: (paralysis), palsy, paresis, neuropathy, incontinence, Guillain-Barre, Miller Fisher, multiple sclerosis; (neurodegeneration) encephalopathy, dementia, ataxia, spinal muscular atrophy, delirium, Parkinson; (seizure), convuls, seizure, fit, -lepsy**

Twenty-one percent (185,474) of ADRs were categorized as Nervous System Disorders in the Yellow Card system. A wide variety of neurological ADRs were noted, including 1,992 ADRs involving seizures and 2,357 ADRs involving some form of paralysis, including Bell's palsy (626 ADRs). Other ADRs involving encephalopathy (18), dementia (33), ataxia (34), spinal muscular atrophy (1), Parkinson's (18) and delirium (504) may reflect post-vaccination neurodegenerative pathology.

The majority of fatalities associated with Nervous System ADRs occurred as a result of central nervous system haemorrhages – 127 fatalities out of the 186 fatalities reported as Nervous



System fatalities. These 127 have been counted in group A (Bleeding, clotting and Ischaemic ADRs).

More information is needed to determine the extent of the morbidity associated with this alarmingly large category of ADRs. Access to the full Yellow Card database and consultation with clinical specialists, along with follow up of these reports, is urgently needed.

E. Adverse Drug Reactions involving loss of sight, hearing, speech or smell

We used the following SEARCH TERMS**: speech, taste, smell, olfactory, blind, sight, visual, vision, deaf, hearing.**

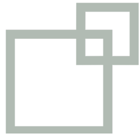
There were 4,771 reports of visual impairment including blindness, 130 reports of speech impairment, 4,108 reports of taste impairment, 354 reports of olfactory impairment, and 704 reports of hearing impairment.

F. Pregnancy Adverse Drug Reactions

Given that vaccinated pregnant women comprise a small proportion of the vaccinated population in the UK up to 26th May 2021, there appear to be a high number of Pregnancy ADRs (307 ADRs), including one maternal death, 12 stillbirths (reported as 6 stillbirths and 6 foetal deaths, but only 3 listed as fatal(?)), one newborn death following preterm birth, and 150 spontaneous abortions. We have submitted a FOI request as to the cause of the maternal death and will look into pregnancy and congenital ADRs in more detail in our next report.

Limitations of this rapid report

This report is not comprehensive, and analysis of Yellow Card data is ongoing. The process of defining the search terms was iterative and we trust that it provides a basis for discussion among clinicians and scientists. We have not compared the frequencies of ADRs between different vaccines; however, our impression is that ADRs were not limited to any particular vaccine brand (AstraZenenca, Pfizer and Moderna) or type (mRNA and DNA) currently used in the UK. UK ADR data mirror data reported on the World Health Organization's pharmacovigilance database



(www.Vigiaccess.org). On the latter, most reported ADRs to date (941,774 ADRs and 5,474 deaths) have occurred among individuals in the 18 to 44 years and 45 to 64 years of age categories (38% and 35%, respectively); the vast majority (72%) of reported ADRs have occurred among women. Unfortunately, we have been unable to examine the UK Yellow Card data according to age and gender due to lack of data availability.

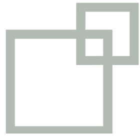
We are aware of the limitations of pharmacovigilance data and understand that information on reported Adverse Drug Reactions should not be interpreted as meaning that the medicine in question generally causes the observed effect or is unsafe to use. We are sharing this preliminary report due to the urgent need to communicate information that should lead to cessation of the vaccination roll out while a full investigation is conducted. According to the recent paper by Seneff and Nigh (1), potential acute and long-term pathologies include:

- Pathogenic priming, multisystem inflammatory disease and autoimmunity
- Allergic reactions and anaphylaxis
- Antibody dependent enhancement
- Activation of latent viral infections
- Neurodegeneration and prion diseases
- Emergence of novel variants of SARSCoV2
- Integration of the spike protein gene into the human DNA

The nature and variety of ADRs reported to the Yellow Card System are consistent with the potential pathologies described in this paper and supported by other recent scientific papers on vaccine-induced harms, which are mediated through the vaccine spike protein product (2,3). It is now apparent that these products in the blood stream are toxic to humans. An immediate halt to the vaccination programme is required whilst a full and independent safety analysis is undertaken to investigate the full extent of the harms, which the UK Yellow Card data suggest include thromboembolism, multisystem inflammatory disease, immune suppression, autoimmunity and anaphylaxis, as well as Antibody Dependent Enhancement (ADE).

Due to the need for expedience, we have not detailed all ADRs in this preliminary report. The existing Yellow Card data covering just under a five-month period indicate that the extent of morbidity and mortality associated with the COVID-19 vaccines is unprecedented.

Age and gender specific data, as well as the time from vaccination, are required to further our analysis of these data and we have sent Freedom of Information Requests (FOIRs) to the MHRA in this regard.



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In addition, urgent independent expert evaluation and discussion is required to assess whether the novel vaccines may be causing gene mutations among recipients, as suggested by the occurrence of usually extremely rare genetic disorders, such as Paroxysmal Extreme Pain Disorder (PEPD). In addition to the 11 cases of PEPD on the Yellow Card system, there are currently 12 reports of this extremely rare condition on the WHO's Vigiaccess.org database and 10 on the European Medicines Agency's (EUDRA) pharmacovigilance database. Are these ADRs occurring in babies of vaccinated pregnant women, or spuriously among vaccinated adults? This question needs urgent attention.

As pharmacovigilance data are known to be substantially under-reported, we recommend that the MHRA urgently publicises these ADR data and assists people with their ADR reporting, to facilitate full elucidation and clarification of the extent of the problem.

The MHRA now has more than enough evidence on the Yellow Card system to declare the COVID-19 vaccines unsafe for use in humans. Preparation should be made to scale up humanitarian efforts to assist those harmed by the COVID-19 vaccines and to anticipate and ameliorate medium to longer term effects. As the mechanism for harms from the vaccines appears to be similar to COVID-19 itself, this includes engaging with numerous international doctors and scientists with expertise in successfully treating COVID-19.

There are at least 3 urgent questions that need to be answered by the MHRA:

1. How many people have died within 28 days of vaccination?
2. How many people have been hospitalised within 28 days of vaccination?
3. How many people have been disabled by the vaccination?

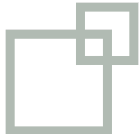
EbMC Squared CiC remains at your service to assist with further analysis. We kindly request full access to the Yellow Card database with immediate effect to enable a comprehensive, independent and accurate evaluation of the Yellow Card data, which will be undertaken in collaboration with clinical experts.

Yours sincerely,

Dr. Tess Lawrie (MBBCh, PhD)

Director, Evidence-based Medicine Consultancy Ltd and EbMC Squared CiC

Bath, UK



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2. Kowarz E, Krutzke L, Reis J, Bracharz S, Kochanek S, Marschalek R. "Vaccine-induced covid-19 mimicry" Syndrome: Splica reactions withing the SARS-CoV-2 spike open reading frame result in spike protein varienat that may cause thromboembolic events in patients immunized with vector-based vaccines. Research Square. DOI: https://doi.org/10.21203/rs.3.rs-558954/v1.
3. Ogata AF, Cheng C-A, Desjardins M, Senussi Y, Sherman AC, Powell M, et al. Circulating SARS-CoV-2 vaccine antigen detected in the plasma of mRNA-1273 vaccine recipients. Clinical Infectious Diseases. https://doi.org/10.1093/cid/ciab465.

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Table 1. Bleeding, Clotting and Ischaemic Adverse Drug Reactions (up to 26th May 2021 – Week 18)

YELLOW CARD CATEGORY	SEARCH: death	SEARCH: Haemorrhage, bleed, haemo	SEARCH: ischaem, infarct, angina, stroke, cerebrovascular, CVA	SEARCH: Thrombo, emboli, coag	Total Week 18
	All ADRs (fatalities)	All ADRs (fatalities)	All ADRs (fatalities)	All ADRs (fatalities)	All ADRS (fatalities)
Blood disorders		42 (1)	11	930 (8)	**983 (9)**
Cardiac disorders		7 (4)	654 (73)	20 (4)	**681 (81)**
Congenital disorders		3		1	**4**
Ear disorders		14			**14**
Endocrine disorders		10		1	**11**
Eye disorders		239	8	16	**263**
Gastrointestinal disorders		482 (4)	37 (4)	35 (1)	**554 (9)**
General disorders	438 (438)	47		1	**486 (438)**
Hepatic disorders		2	3 (1)	78 (4)	**83 (5)**
Immune system disorders		6			**6**
Infections		1		1	**2**
Injuries		20 (1)	2	2	**24 (1)**
Investigations		12		157	**169**
Muscle & tissue disorders		5			**5**
Neoplasms		1		3	**4**
Nervous system disorders		361 (64)	1730 (59)	342 (29)	**2433 (152)**
Pregnancy conditions	8 (8)[2]			37	**43 (8)**
Renal & urinary disorders		59 (1)	11	10	**80 (1)**
Reproductive & breast disorders		2802		2	**2804**
Respiratory disorders		138 (1)	12 (1)	1365 (101)	**1515 (103)**
Skin disorders		55			**55**
Surgical & medical procedures				4	**4**
Vascular disorders		777 (4)	64 (2)	2702 (43)	**3543 (49)**
Grand Total	**(444)**	**5083 (80)**	**2532 (140)**	**5707 (190)**	**13766 (856 fatalities)**

[2] 1 maternal death, 1 newborn death, 6 stillbirths

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Table 2. Immune System Adverse Drug Reactions (up to 26th May 2021 – Week 18)

YELLOW CARD CATEGORY	SEARCH: inflammation (-itis), infection, infections (category)	SEARCH:[3] Immun (term), immune system (category)	SEARCH: allerg,[4] asthma, eczema, urticaria, rash	Total Week 18
	All ADRs (fatalities)	All ADRs (fatalities)	All ADRs (fatalities)	All ADRs (fatalities)
Blood disorders	123	253		**376 (4)**
Cardiac disorders	131 (2)	1		**132 (2)**
Congenital disorders	2	2		**4**
Ear disorders	12	1		**13**
Endocrine disorders	21	12		**33**
Eye disorders	178	6	46	**230**
Gastrointestinal disorders	611 (3)	110		**721 (3)**
General disorders	942		92	**1034**
Hepatic disorders	49 (1)	6		**55 (1)**
Immune system disorders		3150 (4)		**3414 (4)**
Infections	19472 (141)			**19472 (141)**
Injuries	25			**25**
Investigations	1	24	2	**27**
Metabolic disorders		165 (1)		**165 (1)**
Muscle & tissue disorders	1503	51		**1554**
Nervous system disorders	201	472 (7)		**673 (7)**
Pregnancy conditions		10		**10**
Renal & urinary disorders	41 (1)			**41 (1)**
Reproductive & breast disorders	19		5 (1)	**24 (1)**
Respiratory disorders	69 (2)	4	46	**119 (2)**
Skin disorders	470	1041	25,077 (1)	**26588 (1)**
Surgical & medical procedures		2	1	**3**
Vascular disorders	419 (3)	2		**421 (3)**
Grand Total	24289 (153)	5312 (16)	25270 (2)	**54870 (171 fatalities)**

[3] multiple sclerosis, lupus, myasthenia, pernicious, diabetes, Addison, Crohn's, Coeliac, Graves, alopecia, amyloidosis, antiphospholipid, angioedema, Behcet's, pemphigoid, psoriasis, aplasia, sarcoidosis, scleroderma, thrombocytopenia, vitiligo, Miller Fisher, Guillain Barre

[4] 1265 allergic responses were included in the Yellow Card 'IMMUNE SYSTEM DISORDERS' category and are not included in this column – these included 1001 anaphylactic ADRs with 4 associated deaths.

Which is better for future COVID-19 prevention:

Immunity Following Natural Infection or Vaccine-Induced Immunity?

A review of a collection of 15 studies compiled by Daniel Horowitz at TheBlaze.com - all credit to Horowitz with additional references and commentary prepared for the Canadian Covid Care Alliance (https://www.canadiancovidcarealliance.org/)

Bonnie A. Mallard[a], Niel Karrow[b], Byram Bridle[c], David Speicher[d], Liam Sturgess[e] , Chris Shaw[f], Steven Pelech[g]

[a] Professor of Immunogenetics, Department of Pathobiology, University of Guelph, Ontario, Canada
[b] Professor of Immuno-toxicology, Department of Animal BioScience, University of Guelph, Ontario, Canada
[c] Assoc. Professor of Viral Immunology, Department of Pathobiology, University of Guelph, Ontario, Canada
[d] Research Associate Molecular Virology, Department of Pathobiology, University of Guelph, Ontario, Canada
[e] Independent Freelance Writer, CCCA External Communications Committee Member
[f] Professor of Neuroscience, Department Neuroscience, University of British Columbia, Vancouver, BC
[g] Professor of Neurology, Department of Medicine, University of British Columbia, Vancouver, BC

Reviewed by the CCCA Scientific and Medical Advisory Committee

October 8, 2021

1) *Discrete Immune Response Signature to SARS-CoV-2 mRNA Vaccination versus Infection |* New York University, May 3, 2021[1]

The authors of this study examined the contrast between vaccine-induced immunity and immunity from SARS-CoV-2 infection as it relates to stimulating innate host defense as well as B- and T-cell immunity. It is relevant to note that the appropriate combination of innate and adaptive host defense mechanisms generally generates more durable adaptive immunity than antibodies alone. The authors concluded, "In COVID-19 patients, immune responses were characterized by a highly augmented interferon response which was largely absent in vaccine recipients. Increased interferon signaling likely contributed to the observed dramatic up

[1] Ivanova, E., Devlin, J., Buus, T. *et al.* (2021, May 3). *Discrete immune response signature to SARS-CoV-2 mRNA vaccination versus infection.* medRxiv. Preprint. https://doi.org/10.1101/2021.04.20.21255677.

regulation of cytotoxic genes in the peripheral T cells and innate-like lymphocytes in patients but not in immunized subjects."

Other authors established that early in the pandemic, the interferon class of cytokines were important in control of viral replication and in making the appropriate transition from innate to adaptive immune responses.[2]

The study by Ivanova *et al*.[1] - currently still a preprint - further notes, "Analysis of B and T cell receptor repertoires revealed that while the majority of clonal B and T cells in COVID-19 patients were effector cells, in vaccine recipients clonally expanded cells were primarily circulating memory cells." Horowitz suggests this could indicate that, "Natural immunity conveys much more innate immunity, while the vaccine mainly stimulates adaptive immunity." The authors write in the discussion that, "**We observed the presence of cytotoxic CD4 T cells in COVID-19 patients that were largely absent in healthy volunteers following immunization.** While hyper-activation of inflammatory responses and cytotoxic cells may contribute to immunopathology in severe illness, in mild and moderate disease, **these features are indicative of protective immune responses and resolution of infection.**"

These authors also point out that, "COVID-19 patients had a striking expansion of antibody-producing plasmablasts, with evidence of clonal cells in this cluster. However, **we did not detect appreciable expansion of plasmablasts in circulation of individuals immunized with SARS-CoV-2 BNT162b2 mRNA vaccine,** despite a robust antibody response." Plasmablasts are the cells specialized to go on to produce large amounts of antibodies.

It is important to understand that **not all antibodies are created equal**. Some can neutralize viruses and others do not. Some antibodies are more important at mucosal surfaces, such as IgA which can be found in the upper respiratory tract. Antibodies of the IgG class are found lower in the respiratory tract and play a more important role than IgA at that location. Since natural exposure to SARS-CoV-2 is via the upper respiratory tract, which later can move down to lower regions of the tract, this has a propensity to generate both IgA in the upper track and IgG antibodies in the lower airway to various components of the virus. Conversely, intramuscular vaccination is known to preferentially generate IgG, but not necessarily mucosal IgA. Consequently, upon re-exposure, people who have previously been exposed to the live virus will quickly generate a robust and broad-based set of innate and adaptive immune responses, both IgA and IgG, along with other cellular responses. This is why immunity following natural exposure is durable, often lasting the duration of the declared pandemic as discussed in various reports below. In contrast, **vaccine-induced immunity is clearly shorter term and must lack the breadth of immunity following natural exposure since the response is limited only to the viral spike (S) protein.** Consequently, multiple vaccine boosters have been rapidly rolled out. Testing for evidence of immunity

[2] Lei, X., Dong, X., Ma, R. *et al.* (2020, July 30). *Activation and evasion of type I interferon responses by SARS-CoV-2*. Nat Commun 11, 3810 (2020). Published. https://doi.org/10.1038/s41467-020-17665-9.

following natural infection would negate the need for mandatory vaccination, spare vaccine doses, and certainly multiple booster shots. Although not mentioned in the manuscript by Ivanova *et al.*[1] another important consideration is that with natural exposure, the polyclonal antibody response will allow for the generation of a wide variety of memory cells. When the virus mutates, the immune response can respond with expansion of appropriate neutralizing effector cells. In contrast, vaccination will elicit a much smaller diversity of memory cells that are more likely to result in antibody-dependent enhancement, often due to non-neutralizing antibodies that actually facilitate the uptake of virus into the host cells.

To summarize, **the results of this paper demonstrate distinct differences in the quality, quantity, location, and the overall nature of the innate and adaptive immune responses generated following vaccination versus natural infection**. Understanding these differences is important to determine who needs to be vaccinated and for designing better vaccines that more closely mimic the responses of immunity following natural infection, for example mucosal delivery systems. It has always been the goal of immunologists and vaccinologists to design vaccines that mimic the protective and durable immunity found in those who successfully recovered from natural infections.

2) ***SARS-CoV-2 Infection Induces Long-lived Bone Marrow Plasma Cells in Humans* | Washington University, St. Louis, Missouri, May 24, 2021, published in Nature**[3]

As Horowitz states, the media has been promoting the idea that if antibody levels wane, it means immunity is weakening, as we are indeed seeing with the vaccines today. But as author Ewen Callaway writes in a Nature News article entitled, Had COVID? You'll probably make antibodies for a lifetime,[4] as he highlights this paper by Turner *et al*., **"People who recover (even) from mild COVID-19 have bone-marrow cells that can churn out antibodies for decades."**

More specifically, Turner *et al.*[3] explained in the primary research article that, "After a new infection, short-lived cells called plasmablasts are an early source of antibodies. But these cells recede soon after a virus is cleared from the body, and other, longer-lasting cells make antibodies: memory B cells patrol the blood for reinfection, while bone marrow plasma cells (BMPCs) hide away in bones, trickling out antibodies for decades" as needed. Turner and colleagues conclude in the discussion section of the paper, "**Overall, our data provide strong evidence that SARS-CoV-2 infection in humans robustly establishes the two arms of humoral immune memory: long-lived bone marrow plasma cells (BMPCs) and memory B-cells.**" This means that even though

[3] Turner, J.S., Kim, W., Kalaidina, E. *et al.* (2021, May 24). *SARS-CoV-2 infection induces long-lived bone marrow plasma cells in humans*. Nature 595, 421–425 (2021). Published. https://doi.org/10.1038/s41586-021-03647-4.

[4] Callaway, E. (2021, May 27). *Had COVID? You'll probably make antibodies for a lifetime*. Nature. Published. https://www.nature.com/articles/d41586-021-01442-9.

antibody levels will eventually wane, there are long-lived cells in the bone marrow that have memory of the virus and can quickly produce the needed antibodies against the virus upon re-infection.

Horowitz then went on to correctly point out, "It's therefore not surprising that early on in the pandemic, an in-vitro study in Singapore published in Nature found **immunity against SARS-CoV-2 to last even 17 years later from SARS-1-infected patients who never previously had COVID-19."**[5] This paper by Le Bert *et al.* looked specifically at T-cell responses against the structural nucleocapsid (N) protein of the virus and found both CD4 and CD8 T cells that recognized multiple regions of the N-protein. The CD4 and CD8 T-cells are lymphocytes critical in generating both helper and cytotoxic T-cell responses. The authors conclude, **"**Thus, infection with betacoronaviruses induces multi-specific and long-lasting immunity against the structural N protein."

3) ***Necessity of COVID-19 Vaccination in Previously Infected Individuals*** | Cleveland Clinic, June 19, 2021[6]

Howowitz then talked about a study involving **1,359 previously SARS-CoV-2 infected health care workers** in the Cleveland Clinic system, where "**not a single one of them was re-infected 10 months into the pandemic**, despite some of these individuals being around COVID-positive patients more than the regular population."

The idea of reinfection with SARS-CoV-2 is a contentious one, being dependent on individual health status and stress levels, but most studies indicate that reinfection is rare and the immunity following natural infection is highly protective even against any new variants to date. A large study of UK health workers discussed by Nature News in January 2021 concluded that, "The data suggest that repeat infections are rare — they occurred in less than 1% of about 6,600 participants who had already been ill with COVID-19."[7] In the original paper published by Hall *et al.* in the Lancet,[8] the authors interpreted their findings as follows, "A previous history of SARS-CoV-2 infection was associated with an 84% lower risk of infection, with median protective effect observed 7 months following primary infection. **This study shows that previous infection with SARS-CoV-2 induces effective immunity to future infections in most individuals**." Further, a May 2021 paper published in the Lancet's EClinicalMedicine elaborates that, "based on current evidence, we hypothesize that antibodies to both S and N-proteins after natural infection may persist for longer than previously thought, thereby providing

[5] Le Bert, N., Tan, A.T., Kunasegaran, K. *et al.* (2020, July 15). *SARS-CoV-2-specific T cell immunity in cases of COVID-19 and SARS, and uninfected controls.* Nature 584, 457–462 (2020). Published. https://doi.org/10.1038/s41586-020-2550-z.

[6] Shrestha, N. K., Burke, P. C., Nowacki, A. S. *et al.* (2021, June 19). *Necessity of COVID-19 vaccination in previously infected individuals.* medRxiv. Preprint. https://www.medrxiv.org/content/10.1101/2021.06.01.21258176v3.

[7] Ledford, H. (2021, January 14). COVID reinfections are unusual — but could still help the virus to spread. Nature News. Published. https://www.nature.com/articles/d41586-021-00071-6.

[8] Hall, V. J., Foulkes, S., Charlett, A. *et al.* (2021, April 9). *SARS-CoV-2 infection rates of antibody-positive compared with antibody-negative health-care workers in England: a large, multicentre, prospective cohort study (SIREN).* The Lancet, 397(10283), 1459–1469. Published. https://doi.org/10.1016/s0140-6736(21)00675-9.

evidence of sustainability that may influence post-pandemic planning."[9] Their hypothesis was indeed correct since the authors, "demonstrated a sustained positivity rate of antibodies against the SARS-CoV-2 spike protein past ten months post-PCR confirmed COVID-19 infection using data from over 39,000 patients, with linear trends indicating a substantial population half-life."

In immunology anything is possible, but not everything is probable. Therefore, although a few people have shown to test positive more than once for SARS-CoV-2, these occurrences appear rare.[7] They may indicate a true reinfection, persistence of viral RNA in phagocytic cells, a false positive PCR test, or may even be due to SARS-CoV-2 RNA integration into the host genome later expressed in human cells, although the latter needs to be confirmed in vivo.[10]

Cumulatively, these studies indicate that there is no need of further vaccination or advantage of vaccinating those previously infected with SARS-CoV-2. Although vaccination following natural infection may increase antibody titers to the spike protein, this is not required for further protection. Additionally, as discussed above the responses induced by the vaccine are distinct from that of natural infection and much less durable. Further, amplification of naturally induced antibody responses by vaccination cannot be recommended in the absence of long-term safety studies. This is important because overly robust antibody responses can predispose people to unwanted autoimmune sequelae.

4) ***Longitudinal Analysis Shows Durable and Broad Immune Memory after SARS-CoV-2 Infection with Persisting Antibody Responses and Memory B and T Cells*** | Fred Hutchinson Cancer Research Center, Seattle/Emory University, Washington, July 14, 2021, published in Cell Medicine[11]

The study found that most recovered patients produced durable antibodies, memory B cells, and durable poly-functional CD4 and CD8 T cells that target multiple parts of the virus. Horowitz concluded, "Taken together, these results suggest that **broad and effective immunity may persist long-term in recovered COVID-19 patients.**" Horowitz, in support of the growing body of literature, stated, "unlike with the vaccines, **no boosters are required to assist natural immunity."**

[9] Alfego, D., Sullivan, A., & Poirier, B. (2021, May 14). *A population-based analysis of the longevity of SARS-CoV-2 antibody seropositivity in the United States*. EClinicalMedicine, 36, 100902. Published. https://doi.org/10.1016/j.eclinm.2021.100902.

[10] Zhang, L., Richards, A., & Barrasa, M. I. (2021, May 25). *Reverse-transcribed SARS-CoV-2 RNA can integrate into the genome of cultured human cells and can be expressed in patient-derived tissues.* Proceedings of the National Academy of Sciences, 118(21), e2105968118. Published. https://doi.org/10.1073/pnas.2105968118.

[11] Cohen, K. W., Linderman, S. L., Moodie, Z. *et al*. (2021, July 14). *Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells.* Cell Reports Medicine. Published. https://www.cell.com/cell-reports-medicine/fulltext/S2666-3791(21)00203-2.

5) ***Single Cell Profiling of T and B cell Repertoires Following SARS-CoV-2 mRNA Vaccine*** | University of California, Irvine, July 21, 2021[12]

Horowitz quotes the authors conclusion on their preprint paper - "**Natural infection induced expansion of larger CD8 T cell clones occupied distinct clusters**, **likely due to the recognition of a broader set of viral epitopes presented by the virus not seen in the mRNA vaccine.**" This makes sense given that following vaccination, a person is only exposed to the viral spike protein; whereas, following natural infection the person is exposed to all components of the virus giving the individual the opportunity to make a much broader immune response using multiple T cell clones that recognize various parts (epitopes) of viral antigens. This becomes highly pertinent when a person comes in contact with the virus for a second time, since even if the spike protein has been altered producing a variant of concern (VOC), the immune system still can activate other clones against the membrane protein for example, as well as other components of the virus.

In fact, each infected person can have antibodies generated against hundreds of epitopes in the virus. VOC's typically differ by less than 0.5% from other strains in their overall protein structures. Moreover, the actual regions in which the mutations associated with the common VOC's are located do not appear to be particularly immunogenic in patients that recovered from COVID-19.[13] Consequently, the mutations in the known VOC's should not readily impact overall immunity following natural exposure to the virus.

6) ***mRNA Vaccine-induced T Cells Respond Identically to SARS-CoV-2 Variants of Concern but Differ in Longevity and Homing Properties Depending on Prior Infection Status*** | University of California, San Francisco, May 12, 2021[14]

This preprint article concluded that, **"In infection-naïve individuals, the second (vaccine) dose boosted the quantity but not quality of the T cell response, while in convalescents (recovered individuals), the second dose helped neither.** Spike protein-specific T cells from convalescent vaccinees differed strikingly from those of infection-naïve vaccinees, with phenotypic features suggesting superior long-term persistence and ability to home to the respiratory tract including the nasopharynx." This reiterates the findings of Ivanova[1] and further supports that the nature of the immunity generated following natural infection is distinct from that following vaccination.

[12] Sureshchandra, S., Lewis, S. A., Doratt, B. *et al*. (2021, July 15). *Single cell profiling of T and B cell repertoires following SARS-CoV-2 mRNA vaccine.* bioRxiv. Preprint. https://www.biorxiv.org/content/10.1101/2021.07.14.452381v1.

[13] Pelech, S. University of British Columbia, Vancouver, B.C., Canada, Personal Communication.

[14] Neidleman, J., Luo, X., McGregor, M. et al. (2021, July 29). *mRNA vaccine-induced T cells respond identically to SARS-CoV-2 variants of concern but differ in longevity and homing properties depending on prior infection status.* bioRxiv. Preprint. https://www.biorxiv.org/content/10.1101/2021.05.12.443888v2.

Horowitz correctly explains that, "Given that we know the virus spreads through the nasopharynx, **the fact that natural infection conveys much stronger mucosal immunity makes it clear that the previously infected are much safer to be around than infection-naïve people with the vaccine**. The fact that this study artfully couched the choices between vaccinated naive people and vaccinated recovered rather than just plain recovered doesn't change the fact that **it's the prior infection, not the vaccine, conveying mucosal immunity**. In fact, studies now show that **infected vaccinated people contain just as much viral load in their nasopharynx as those unvaccinated**, a clearly unmistakable conclusion from the **virus spreading equally or in greater amounts among the vaccinated."**[15] The CDC also recognized in its July 28, 2021 report that, "preliminary evidence suggests that fully vaccinated people who do become infected with the Delta variant can be infectious and can spread the virus to others"[16]; this is now commonly acknowledged.

It is relevant to mention at this point that **there are also risks associated with the current nucleic acid vaccines against SARS-CoV-2.** These have been recently discussed in several papers, including one by Kostoff *et al.*[17] in Toxicological Reports entitled, "Why are we vaccinating children against COVID-19?". These authors stated, **"**A novel *best-case scenario* cost-benefit analysis showed *very conservatively* that there are **five times the number of deaths attributable to each inoculation versus those attributable to COVID-19** in the most vulnerable 65+ demographic. The risk of death from COVID-19 decreases drastically as age decreases, and the longer-term effects of the inoculations on lower age groups will increase their risk-benefit ratio, perhaps substantially." Similarly, a paper by Walach and colleagues, which appeared in Science, Public Health Policy and the Law, calculated the Number Needed to Vaccinate (NNTV) to prevent one death from a field study.[18] They used the Adverse Drug Reactions database of the Dutch National Register (Lareb) to extract the number of cases reporting severe side-effects and the number of cases reporting fatal side-effects and concluded that for 6 deaths prevented by vaccination, approximately 4 deaths were reported to Dutch Lareb that occurred after vaccination, yielding a potential risk/benefit ratio of 2:3. Their overall conclusion was that, "**these data indicate a lack of clear (vaccine) benefit**, which should cause governments to rethink their vaccination policy." The Ontario Civil Liberties Association has concluded the same in a recent Open Letter to Public Health by Canadian virologist, Dr. John Zwaagstra, posted on their website September 21, 2021.[19]

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[15] Riemersma, K. K., Grogan, B. E., & Kita-Yarbro, A. et al. (2021, August 24). *Shedding of infectious SARS-CoV-2 despite vaccination.* medRxiv. Preprint. https://doi.org/10.1101/2021.07.31.21261387.

[16] National Center for Immunization and Respiratory Diseases. (2021, July 7). *Interim Public Health Recommendations for Fully Vaccinated People.* Centers for Disease Control and Prevention. Published. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html.

[17] Kostoff, R. N., Calina, D., & Kanduc, D. (2021). *Why are we vaccinating children against COVID-19?* Toxicology Reports, 8, 1665–1684. Published. https://doi.org/10.1016/j.toxrep.2021.08.010.

[18] Walach, H., Klement, R. J., & Aukema, W. (2021, August). *The Safety of COVID-19 Vaccinations—Should We Rethink the Policy?* Science, Public Health Policy, and the Law, 3, 87–99. Published. https://www.researchgate.net/publication/354223836_The_Safety_of_COVID-19_Vaccinations_-_Should_We_Rethink_the_Policy_newly_and_independently_peer-reviewed_version.

[19] Zwaagstra, J., PhD. (2021, September 21). *Vaccine concerns weighed against natural immunity.* Ontario Civil Liberties Association. Published. https://ocla.ca/vaccine-concerns-weighed-against-natural-immunity/.

7) ***Large-scale Study of Antibody Titer Decay Following BNT162b2 mRNA Vaccine or SARS-CoV-2 Infection*** | Israeli researchers, August 22, 2021[20]

Regarding this preprint paper, Horowitz says, "Aside from more robust T cell and memory B cell immunity, which is at least as important as antibody levels, Israeli researchers found that **antibodies wane slower among those with prior infection**. Specifically, "In vaccinated subjects, antibody titers decreased by up to 40% each subsequent month while in convalescents they decreased by less than 5% per month." This supports the studies mentioned above which show evidence of long-term antibody producing cells following natural infection that are not necessarily found post-vaccination.

8) ***Quantifying the Risk of SARS-CoV-2 Reinfection Over Time*** | Irish researchers, published in Wiley Review, May 18, 2021[21]

In this study, the researchers conducted a review of 11 cohort studies with over **600,000 total recovered COVID-19 patients** who were followed up for more than 10 months. Horowitz provided the key finding, stating that **unlike the vaccine, after about four to six months, they found "no study reporting an increase in the risk of reinfection over time**."

9) ***SARS-CoV-2 Antibody-positivity Protects against Reinfection for at Least Seven Months with 95% Efficacy*** | Cornell University, Doha, Qatar, published in the Lancet, April 27, 2021[22]

Horowitz describes this study as, "one of the only studies that analyzed the population-level risk of reinfection based on whole genome sequencing in a subset of patients with supporting evidence of reinfection. Researchers estimate the risk at 0.66 per 10,000 person-weeks". Most importantly, **the study found no evidence of waning of immunity for over seven months of the follow-up period.** The few reinfections that did occur, "were less severe than primary infections," and "only one reinfection was severe, two were moderate, and none were critical or fatal." Also, unlike many vaccinated breakthrough infections in recent weeks that have been very symptomatic, "most reinfections were diagnosed incidentally through random or routine testing, or through contact tracing."

[20] Israel, A., Shenhar, Y., Green, I. et al. (2021, August 22). *Large-scale study of antibody titer decay following BNT162b2 mRNA vaccine or SARS-CoV-2 infection.* medRxiv. Preprint. https://www.medrxiv.org/content/10.1101/2021.08.19.21262111v1.

[21] O Murchu, E., Byrne, P., Carty, P. G. *et al.* (2021, May 27). *Quantifying the risk of SARS-CoV-2 reinfection over time.* Reviews in Medical Virology, 2021;e2260. Published. https://doi.org/10.1002/rmv.2260.

[22] Abu-Raddad, L. J., Chemaitelly, H., & Coyle, P. *et al*. (2021, May 1). *SARS-CoV-2 antibody-positivity protects against reinfection for at least seven months with 95% efficacy.* EClinicalMedicine, 35, 100861. Published. https://doi.org/10.1016/j.eclinm.2021.100861.

10) ***Protection of Previous SARS-CoV-2 Infection is Similar to that of BNT162b2 Vaccine Protection: A Three-month Nationwide Experience from Israel*** | Israeli researchers, April 24, 2021[23]

As Horowitz explained, “Several months ago, **Israeli researchers studied 6.3 million Israelis and their COVID status and were able to confirm only one death in the entire country of someone who supposedly already had the virus**, **and he was over 80 years old**.” Horowitz contrasted that to the hospitalization and deaths now reported in the vaccinated in Israel. There are other studies in Israel, Vietnam and elsewhere confirming breakthrough infections despite full vaccination. For example, the study of Vietnamese health care workers concluded, “**Breakthrough Delta variant infections are associated with high viral loads**, **prolonged PCR positivity, and low levels of vaccine-induced neutralizing antibodies**, explaining the transmission between the vaccinated people.”[24] In this study, the viral loads in the vaccinated people with COVID-19 with the Delta variant were estimated to be 251-times higher than in unvaccinated people previously diagnosed with COVID-19 a year before with earlier strains.[24]

11) ***Live Virus Neutralisation Testing in Convalescent Patients and Subjects Vaccinated against 19A, 20B, 20I/501Y.V1 and 20H/501Y.V2 Isolates of SARS-CoV-2*** | French researchers, May 11, 2021[25]

Horowitz described in this preprint article, “Researchers tested blood samples from health care workers who never had the virus but got both Pfizer shots against blood samples from those health care workers who had a previous mild infection and a third group of patients who had a serious case of COVID.” The authors state that they found, "No neutralization escape could be feared concerning the two variants of concern [Alpha and Beta] in both populations of those previously infected.”[25] However, the authors state, “The reduced neutralizing response observed towards the 20H/501Y.V2 (variant 2) in comparison with the 19A (initial strain) and 20I/501Y.V1 (variant 1) isolates in fully immunized subjects with the BNT162b2 vaccine is a striking finding of the study.”[25] In other words, **the virus neutralizing capacity of the antibodies in the previously infected were minimally impacted by the variants** examined in this study compared to the vaccinated where viral neutralization to certain variants was substantially reduced.

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[23] Goldberg, Y., Mandel, M., Woodbridge, Y. *et al.* (2021, April 24). *Protection of previous SARS-CoV-2 infection is similar to that of BNT162b2 vaccine protection: A three-month nationwide experience from Israel.* medRxiv. Preprint. https://doi.org/10.1101/2021.04.20.21255670.

[24] Chau, N. V. V., Ngoc, N. M., & Nguyet, L. A. *et al.* (2021, August 10). *Transmission of SARS-CoV-2 Delta variant among vaccinated healthcare workers, Vietnam.* SSRN Electronic Journal. Published. https://doi.org/10.2139/ssrn.3897733.

[25] Gonzalez, C., Saade, C., Bal, A. *et al.* (2021, May 11). *Live virus neutralisation testing in convalescent patients and subjects vaccinated against 19A, 20B, 20I/501Y.V1 and 20H/501Y.V2 isolates of SARS-CoV-2*. medRxiv. Preprint. https://doi.org/10.1101/2021.05.11.21256578.

12) ***Highly Functional Virus-specific Cellular Immune Response in Asymptomatic SARS-CoV-2 Infection*** | Duke-NUS Medical School, Singapore, published in Journal of Experimental Medicine[26]

Horowitz posed the question that many people are asking, “If they got only an asymptomatic infection, are they less protected against future infection than those who suffered infection with more evident symptoms?” This research study by le Bert *et al.*[26] showed the opposite to be true. "**Asymptomatic SARS-CoV-2–infected individuals are not characterized by weak antiviral immunity; on the contrary, they mount a highly functional virus-specific cellular immune response,**" Horowitz pointed out, “If anything, they found that those with asymptomatic infection only had signs of non-inflammatory cytokines, which means that **the body is primed to deal with the virus without producing that dangerous inflammatory response that is killing so many hospitalized with the virus.”** The fact that asymptomatic people infected with SARS-CoV-2 recovered with minimal disease clearly demonstrates a high degree of immunological responsiveness in these individuals in the first place. Likewise, anyone who fully recovers from SARS-CoV-2 ultimately has had to develop an effective immune response to overcome the viral infection. In vaccinated people, the effectiveness of the induced immunity remains equivocal until tested, due to large variability in the antibody and T-cell responses amongst individuals, especially when narrowly focused on a single viral protein.

13) ***SARS-CoV-2-Specific T cell Memory is Sustained in COVID-19 Convalescent Patients for 10 Months with Successful Development of Stem Cell-like Memory T Cells*** | Korean researchers, published in Nature Communications on June 30, 2021[27]

Horowitz highlighted this paper by Jing *et al.*[27] by saying, “The authors found that the T cells created from convalescent patients had "stem-cell like" qualities. After studying SARS-CoV-2-specific memory T cells in **recovered patients** who had the virus in varying degrees of severity, the authors concluded that **long-term "SARS-CoV-2-specific T cell memory is successfully maintained regardless of the severity of COVID-19."**

14) ***Anti-SARS-CoV-2 Receptor Binding Domain Antibody Evolution after mRNA Vaccination*** | Rockefeller University, July 29, 2021[28]

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[26] le Bert, N., Clapham, H. E., & Tan, A. T. (2021, March 1). *Highly functional virus-specific cellular immune response in asymptomatic SARS-CoV-2 infection*. Journal of Experimental Medicine, 218(5). Published. https://doi.org/10.1084/jem.20202617.

[27] Jung, J.H., Rha, MS., Sa, M. *et al.* (2021, June 30). *SARS-CoV-2-specific T cell memory is sustained in COVID-19 convalescent patients for 10 months with successful development of stem cell-like memory T cells*. Nature Commun 12, 4043. Published. https://doi.org/10.1038/s41467-021-24377-1.

[28] Cho, A., Muecksch, F., Schaefer-Babajew, D. et al. (2021, August 30). *Anti- SARS-CoV-2 receptor binding domain antibody evolution after mRNA vaccination.* bioRxiv. Preprint. https://doi.org/10.1101/2021.07.29.454333.

In agreement with the other papers referenced here, Horowitz made a remark about this preprint article by Cho *et al.*[28] stating, "The researchers note that far from suffering waning immunity, memory B cells in those with prior infection **express increasingly broad and potent antibodies that are resistant to mutations found in variants of concern.**" The authors concluded that, "**memory antibodies selected over time by natural infection have greater potency and breadth than antibodies elicited by vaccination**."

15) ***Differential Effects of the Second SARS-CoV-2 mRNA Vaccine Dose on T Cell Immunity in Naïve and COVID-19-recovered Individuals*** | Researchers from Madrid and Mount Sinai, New York, March 22, 2021[29]

In this final Camara *et al.*[29] preprint cited by Horowitz, he concluded, "Until now, we have established that natural immunity provides better adaptive B cell and innate T cell responses that last longer and work for the variants as compared to the vaccines. Moreover, those with prior infection are at greater risk for bad side effects from the vaccines, rendering the campaign to vaccinate the previously infected both unnecessary and dangerous. But the final question is: **Do the vaccines possibly harm the superior T cell immunity built up from prior infection?"**

Immunologists from Mount Sinai in New York and Hospital La Paz in Madrid have raised serious concerns about this question. In a remarkable discovery, after monitoring a group of vaccinated people both with and without prior infection, they found, "**in individuals with a pre-existing immunity against SARS-CoV-2, the second vaccine dose not only failed to boost humoral immunity but determines a contraction of the spike-specific T cell response**." They also noted that other research has shown, "**the second vaccination dose appears to exert a detrimental effect in the overall magnitude of the spike-specific humoral response in COVID-19 recovered individuals.**"

CONCLUSION and FURTHER READING

We would be remiss not to mention several other key studies demonstrating the value of immunity following natural infection with SARS-CoV-2 that are published in reputable peer-reviewed journals. These include the early studies of Sette and Crotty that showed that CD4 T cells, CD8 T cells, and neutralizing antibodies all contributed to control of SARS-CoV-2 in non-hospitalized and hospitalized patients with COVID-19.[30]

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[29] Camara, C., Lozano-Ojalvo, D., Lopez-Granados, E. *et al.* (2021, March 22). *Differential effects of the second SARS-CoV-2 mRNA vaccine dose on T cell immunity in naïve and COVID-19 recovered individuals*. bioRxiv. Preprint. https://doi.org/10.1101/2021.03.22.436441.

[30] Sette, A., & Crotty, S. (2021, February 18). *Adaptive immunity to SARS-CoV-2 and COVID-19*. Cell, 184(4), 861–880. Published. https://doi.org/10.1016/j.cell.2021.01.007.

A Canadian study also demonstrated that 90% of healthy adults tested in the Greater Vancouver area had antibodies or cross-reactive antibodies to various components of the virus using a highly sensitive multiplex array.[31] This evidence of immunity in non-vaccinated Canadians was recently substantiated in a small pilot study of unvaccinated individuals between June-August 2021 residing in South Western Ontario using the same assay.[32]

Another study by Braun *et al.* showed that both healthy donors and patients with COVID-19 have SARS-CoV-2 reactive T-cells.[33] The study concluded, "the presence of spike-protein cross-reactive T cells in a considerable fraction of the general population may affect the dynamics of the current pandemic, and has important implications for the design and analysis of upcoming trials investigating COVID-19 vaccines."

A recently published study by Wang *et al.* also showed **stable B-cell immunity six to 12 months following infection.**[34] The authors reported, "In the absence of vaccination, antibody reactivity to the receptor binding domain (RBD) of SARS-CoV-2, neutralizing activity and the number of RBD-specific memory B cells remain relatively stable between 6 and 12 months after infection. They did however see increases in antibodies to the viral spike protein following vaccination of these individuals, which would be expected. However, keep in mind as explained above, the nature of vaccine-induced immune responses is not the same as that following natural infection. In fact, when all the evidence is considered, there appears to be no additional protective benefit from vaccinating those previously recovered from COVID-19. **This would impose an unnecessary risk of vaccination**. Whether vaccinating those previously immune from natural infection reduces or enhances the clonal diversity against SARS-CoV-2 remains controversial. This may differ depending on whether or not the studies examined B or T cell clones. Either way, the functionality and location of the clones post-vaccination would be critical to know when addressing this question.

Collectively, the current literature unequivocally demonstrates protective immunity following natural infection with SARS-CoV-2 that is durable and long lasting. Therefore, there is no need for mandated vaccination of individuals with previous SARS-CoV-2 infection, particularly in those with proof of previous immunity based on evidence of antibody or T-cell responses. This becomes increasingly important now that it is

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[31] Majdoubi, A., Michalski, C., & O'Connell, S. E. (2021, March 15). *A majority of uninfected adults show preexisting antibody reactivity against SARS-CoV-2.* JCI Insight, 6(8). Published. https://doi.org/10.1172/jci.insight.146316.

[32] Mallard, B. University of Guelph, Guelph, Ontario, Canada, Personal Communication.

[33] Braun, J., Loyal, L., & Frentsch, M. (2020, July 29). *SARS-CoV-2-reactive T cells in healthy donors and patients with COVID-19*. Nature, 587(7833), 270–274. Published. https://doi.org/10.1038/s41586-020-2598-9.

[34] Wang, Z., Muecksch, F., & Schaefer-Babajew, D. (2021, June 14). *Naturally enhanced neutralizing breadth against SARS-CoV-2 one year after infection*. Nature, 595(7867), 426–431. Published. https://doi.org/10.1038/s41586-021-03696-9.

As we reference several preprint articles, we do not claim to represent those current findings as conclusive as they may continue to change until accepted for publication. However, the accumulating body of evidence in the preprint articles cited here also supports the published literature in support of long-lasting and durable immunity following natural exposure to SARS-CoV-2.

clear that both fully and partially vaccinated people, without prior viral exposure, can become infected and transmit the pathogen.

It is also important to accurately classify people based on their prior vaccine exposure. It is not reasonable to classify individuals as completely unvaccinated simply because they have not yet received the full series or the next booster in the series. Therefore, a standard system needs to be adopted to identify people who have received one, two or even three shots, and the timing of those injections. Maximum immune responses will be mounted differently depending on whether this is the first or subsequent exposure to the virus or the vaccine. More rapid anamnestic (memory) responses are generally generated on subsequent exposures. It is essential to keep in mind that the timing of maximal immune responses will differ from the reported timing of vaccine injury, and these timelines should not be confused. For example, immediate hypersensitivity reactions (e.g. anaphylaxis) can occur within minutes of exposure to a foreign substance, intermediate reactions can occur hours to days later, and long-term reactions may occur even years later. These timelines are distinct from the normal acquired immune responses which generally peak 7-21 days following primary exposure and 3-7 days following secondary exposure. The exact timeline of the immune response can vary somewhat depending on the antibody isotype (e.g. IgM versus IgG), the antigenic dose, the route of injection, and the genetics of the host. It is pertinent to mention here that the actual dose of spike antigen given with the current nucleic acid vaccines is essentially unknown. The amount of nucleic acid (DNA or mRNA) delivered is known but because each person generates the foreign protein within their own cells after nucleic acid delivery, the amount of spike protein generated by each individual can differ depending on age, gender, body metabolism and so on. This is in contrast to traditional vaccines where the amount of foreign protein in each dose is precisely known.

Moreover, as described earlier, vaccination of individuals with established immunity may place them at greater risk of vaccine injury. From a societal perspective to help end the SARS-CoV-2 pandemic, the establishment of immunity from natural acquisition plays an important role given the scope and durability of these immune responses. **The relevance of natural immunity needs to be fully recognized and accepted by society as one of the valid means of achieving protection as has long been the case with other infectious diseases.** Natural immunity has several protective advantages as outlined above and also reduces the vaccine implementation costs which are solely relying on extensive and repeated inoculations. The various societal damages associated with recurring lockdowns of the population must also be considered. Safe and selective vaccination of those at the highest risks of severe COVID-19 and the adoption of a myriad of effective early treatment protocols is the most logical course of action at this time.

Finally, **the spread of the virus in unvaccinated people recovered from COVID-19 is highly unlikely** given their broad and durable immunity shown to date. As such, **it makes sense to abandon the notion of separating society into two groups based on variable vaccination status**. Individuals have the right to consent to medical treatments that align with their needs and preferences, and the COVID-19 vaccines are no different**. We**

propose a multi-faceted path forward that fully embraces the underlying immunology demonstrated in the above series of articles, as well as integrating preventative and early treatment protocols into outpatient and healthcare systems to best serve patients in Canada.

Original article: https://www.theblaze.com/op-ed/horowitz-15-studies-that-indicate-natural-immunity-from-prior-infection-is-more-robust-than-the-covid-vaccines, Daniel Horowitz is senior editor.