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Review Article

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COVID-19 vaccines – An Australian Review

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Abstract

After millions of people have been vaccinated as often as four times within a year, the effects of these vaccinations are slowly becoming apparent. This review has been written from an Australian perspective with the main focus on the COVID-19 mRNA vaccines. We will look at the promises/predictions originally made and the actual facts. We will evaluate the safety and efficacy by looking at the literature and the data from government agencies. The literature review will be summed up in a table listing the so far reported side effects of which many are very serious including death, with this data coming from 1011 case reports. Long term side effects will also be covered and the risk benefit ratio will be explored. The review is ending with some very critical question that need further discussion.

Introduction

This review is written from an Australian perspective and will concentrate on the COVID-19 mRNA vaccines. In Australia the COVID vaccination is still heavily promoted. Until April 2022 only the mRNA vaccines Comirnaty (Pfizer) and Spikevax (Moderna), as well as the vector vaccines Vaxzevria (AstraZeneca) and COVID-19 Vaccine Janssen (Janssen) were preliminarily registered for use. Every one of these vaccines forces the vaccinees body to produce the spike protein for which the genetic code is delivered into the cells as mRNA via a nanoparticle or as double stranded DNA via a viral vector. (https://www.tga.gov.au/international-covid-19-vaccines-recognised-australia).

In April 2022 yet another vaccine, Nuvaxovid (Biocelect on behalf of Novavax, based on a new concept) received preliminary approval in Australian. Nuvaxoid contains a modified spike derived from moth cells cultured after transfection using Baculovirus, which express the spike protein on their cell membrane. This spike protein is harvested and assembled onto a synthetic lipid nanoparticle, which displays 14 spike proteins each. (https://www.precisionvaccinations.com/vaccines/novavax-covid-19-vaccine). The vaccine is registered for 18 years of age and older.

The government continues to push particularly the mRNA vaccinations by encouraging a fourth vaccination and recommending the vaccine for pregnant women as well as children 5 to 11 years old. The official public message is that the mRNA vaccines are safe. However, the Therapeutic Goods Administration (TGA), the medicine and therapeutic regulatory agency of the Australian Government, states quite clearly on their website that the large-scale trials are still progressing and no full data package has been received from any company. The TGA is currently getting rolling data and safety and effectiveness are still being assessed (https://www.tga.gov.au/covid-19-vaccines-undergoing-evaluation).

Initial information

The mRNA vaccines were supposed to remain at the injection site and be taken up by the lymphatic system. This assumption proved to be wrong. During an autopsy of a vaccinated person that had died after mRNA vaccination it was found that the vaccine disperses rapidly from the injection site and can be found in nearly all parts of the body [1]. The mRNA is enveloped in liquid nano particles (LNP) containing a mixture of phospholipids, cholesterol, PEGylated lipids and cationic or ionizable lipids [2]. Research has shown that such nanoparticles can cross the blood-brain barrier [3] and the blood-placenta barrier [4], so it came as no surprise that the European Medicines Agency assessment report for the Moderna vaccine on page 47 (https://www.ema.europa.eu/en/documents/assessment-report/spikevax-previously-covid-19-vaccine-moderna-epar-public-assessment-report_en.pdf) also noted that mRNA could be detected in the brain following intramuscular administration at about 2% of the level found in plasma. In 2021 researchers from Japan reported a disproportionately high mortality due to cerebral venous sinus thrombosis and intracranial haemorrhage. Despite not being able to prove a causal link with vaccines, as no autopsies were performed, they still believed that a link with vaccination is possible and further analysis is warranted [5].

It was furthermore stated that the mRNA will degrade quickly. Normally, mRNA breaks down within a few minutes to hours, however, the mRNA in these vaccines is nucleoside-modified to reduce potential innate immune recognition [6, 7] and it has been shown that production of the spike protein in some vaccines is kept up for an extraordinarily long time. A study by Röltgen et al. [8] found that the vaccine mRNA persists in the body up to 60 days, with 60 days being the end point of their study. It is thus unknown and impossible to define how much of the spike protein is actually produced in the vaccinated. It is a standard requirement for vaccine producers to define the amount of antigen in each injection. For a "so called "vaccine that is using the human body as the production facility there is no possible quantification of antigen. This is highly variable and dependant on the amount and stability of nanoparticles in the injection, age and fitness of the vaccinee, their immune status and the injection technique – if a blood vessel is directly injected, the nanoparticles will travel in minutes to all major organs including the brain. It is therefore impossible to assess how much spike protein any individual vaccinee produces following an inoculation. In summary, it is unknown where exactly the vaccine travels once it is injected, and how much spike protein is produced in which (and how many) cells.

Prominent cardiologist Dr Peter McCullough stated that the spike protein - a cytotoxin solely responsible for the severity of the respiratory infection - makes the use of it as immunizing agent dangerous. The spike protein in itself can produce COVID- 19 symptoms as shown in animal experiments. The S1 subunit of the SARS-CoV-2 spike protein when injected into transgenic mice overexpressing human ACE-2 caused a COVID-19 like response (a decline in body weight, dramatically increased white blood cells and protein concentrations in bronchoalveolar lavage fluid (BALF), upregulation of multiple inflammatory cytokines in BALF and serum, histological evidence of lung injury, and activation of signal transducer and activator of transcription 3 (STAT3) and nuclear factor kappa-light-chain-enhancer of activated B cells (NF-κB) pathways in the lung [9].

It was further shown that the spike protein S1 subunit, when added to red blood cells in vitro, could induce clotting by binding fibrinogen and ACE2 on platelets, thus triggering their aggregation [10]. The S protein also increases human cell syncytium formation, removes lipids from model membranes and interferes with the capacity of high-density lipoprotein to exchange lipids [11, 12]. Another in silico study showed that the spike protein S2 subunit specifically interacts with BRCA-1/2 and 53BP1 [13]. BRCA-1 is frequently mutated in breast cancer in women and prostate cancer in men, while 53BP1 is a well-established tumor suppressor protein.

A paper published by Liu et al. conducted single-cell mRNA sequencing of peripheral blood mononuclear cells (PBMCs) harvested from patients before and 28 days after the first injection of a COVID-19 vaccine [14]. While this vaccine was based on an attenuated virus and not a mRNA vaccine, it also is injected directly into the deltoid muscle, bypassing the mucosal and vascular barriers.

The authors found consistent alteration of gene expression following vaccination in many different immune cell types. One housekeeping gene of high importance is RNA polymerase I (POL I) which transcribes ribosomal DNA into RNA and monitors rDNA integrity in the process. Many of the downregulated genes identified by Liu et al. (2021) were linked to the cell cycle, telomere maintenance, and both promoter opening and transcription of POL I, indicative of impaired DNA repair processes [14].

Seneff et al (2022) describe another mechanism by which the mRNA vaccines could interfere with DNA repair [15]. The microRNA miR-148 has been shown to downregulate homologous recombination in the G1 phase of the cell cycle. MiR-148 is one of two microRNAs found in exosomes released by human cells following SARS-CoV-2 spike protein synthesis in the experiments by Mishra and Banerjea [16].

Natural immunity ignored

It is an amazing fact that natural immunity is completely disregarded by health authorities around the world. We know from SARS-CoV-1 that natural immunity is durable and persists for at least 12-17 years [17]. Immunologists have suggested that immunity to SARS-Cov-2 is no different. The human population has encountered and co-existed with a great number of coronaviruses throughout evolution. Most of us have cross-reacting T-cells, B cells and antibodies derived from encounters with common cold coronaviruses that can recognise SARS-CoV-2 [18-20]. A survey of more than 100 immunologists, infectious-disease researchers and virologists working on the coronavirus, who were asked whether the virus could be eradicated, showed that almost 90% of respondents believe that the coronavirus will become endemic [21]. The four human coronaviruses that cause common colds are also endemic, without there ever having been a vaccine for any of them. The existence of related viruses might explain that approximately 40% to 45% of COVID infected people are asymptomatic and about 80% of COVID cases are mild infections. In some cohorts, the asymptomatic infection figure jumps as high as 96% depending on the age and cross-immunity imparted by other viruses such as beta coronaviruses HCoV-OC43 and HCoV-HKU1, which have been proposed as a mitigating factor in the spread of SARS-CoV-2 [22-23].

The Brownstone institute has established the most updated and comprehensive library list of 150 of the highest-quality, complete, and robust scientific studies and evidence reports/position statements on natural immunity as compared to the COVID-19 vaccine-induced immunity. The consensus of these studies is that immunity induced by COVID infection is robust and long lasting (https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/).

When comparing the immune response to vaccination and natural infection, differences in the responses were detected. For example, a strong upregulation of genes associated with type I interferon production, cytotoxicity and an increase in circulating plasmablasts were only observed after natural infections [24]. In contrast, mRNA vaccines seem to suppress interferon responses [25]. A literature review by Cardozo and Veazev [26] concluded that COVID-19 vaccines could potentially worsen COVID-19 disease through antibody-dependent enhancement when natural infection occurs after vaccination, regardless of the delivery mechanism - vector or LNP containing RNA – of the nucleic acid coding for the spike protein.

A retrospective cohort study from Sweden revealed that individuals who survived and recovered from a previous infection had a lower risk of COVID-19 re-infection and hospitalisation for up to 20 months. The authors concluded that both previous infection and vaccination should be sufficient proof of immunity to COVID-19 [27, 28].

When comparing 2,653 fully vaccinated individuals with 4,361 individuals recovered from COVID-19, initial levels of antibodies were higher in the vaccinated but decreased exponentially and much faster than in individuals recovered from COVID-19 [29].

There have been discussions about risk and value of vaccination in the previously infected part of the population. Study results have shown that the second dose in people already exposed to the virus leads to a reduction of cellular immunity, inferring those individuals previously infected with COVID-19 should not get a second injection [30].

All of these facts should have led to the standard operating procedure of establishing antibody titres in patients before vaccination for SARS CoV-2, similar to other vaccinations. However, this did not happen and natural immunity is still not accepted as proof of immunity in Australia.

Protection

The vaccine was never meant to prevent the spread of the virus, but to decrease disease severity. A study at the University of California followed up on infections in the workforce after 76% had been fully vaccinated with mRNA vaccines by March 2021 and 86.7% by July 2021. In July 2021 75.2% of the fully vaccinated workforce had symptomatic COVID [31].

Paul Elias Alexander pointed out this troubling situation in an article published by the Brownstone Organisation by citing three studies where we see this emerging situation of the vaccinated increasingly being infected and transmitting the virus. The study by Chau et al. reported a seminal nosocomial outbreak occurring in fully vaccinated Hospital Care workers (HCW) in Vietnam in 2021 [32]. The second study described an outbreak in a Finnish hospital where the virus spread among HCWs and patients [33]. In this study the Delta variant of the virus was introduced by an inpatient. Both symptomatic and asymptomatic infections occurred among vaccinated HCWs. Secondary transmissions were observed from those with symptomatic infections despite the use of personal protective equipment. The third publication detailed an outbreak in an Israeli hospital, where the virus spread among vaccinated HCWs and vaccinated patients [34]. (https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/).

Acharya et al. (2021) and Riemersma et al. (2021) both showed that the vaccinated have very high viral loads similar to the unvaccinated and are therefore as infectious [35, 36]. Brown et al. (2021) and Servelitta et al (2021) suggested that vaccinated people with symptomatic infection by variants, such as Delta, are as infectious as symptomatic unvaccinated cases and will contribute to the spread of COVID even in highly vaccinated communities [37-38].

A study from the US found that increases in COVID 19 cases are unrelated to levels of COVID-19 vaccination across 68 countries and 2,947 counties in the United States. On the contrary, it seems that countries with higher vaccination rates have also higher caseloads. It was shown that the median of new COVID-19 cases per 100,000 people was largely similar to the percent of the fully vaccinated population [39].

Multiple recent studies have indicated that the vaccinated are more likely to be infected with Omicron than the unvaccinated. A study by Kirsch (2021) from Denmark suggests that people who received the mRNA vaccines are up to eight times more likely to develop Omicron than those who did not [40]. This and a later study by Kirsch (2022a) conclude that the more one vaccinates, the more one becomes susceptible to COVID-19 infection [41].

This has to be seen in context with the small risk of dying from COVID-19. A recent peer-reviewed review paper by one of the world's most cited and respected scientist, Professor John Ioannidis of Stanford University notes an infection fatality rate (IFR) for Covid of 0.00-0.57% (0.05% for under 70s), far lower than originally feared and no different to severe influenza [42]. The chances of someone under 50 years old with symptoms dying from COVID-19 is 0.05%. The chances of someone under 18 years old dying from COVID is near 0%. Those that die usually have severe underlying medical conditions. It is estimated that children are seven times more at risk to die from influenza than from COVID-19.

A worldwide Bayesian causal Impact analysis suggests that COVID-19 gene therapy (mRNA vaccine) causes more COVID-19 cases per million and more non-Covid deaths per million than are associated with COVID-19 [43]. An abundance of studies has shown that the mRNA vaccines are neither safe nor effective, but outright dangerous. Never in vaccine history have we seen 1011 case studies showing side effects of a vaccine (https://www.saveusnow.org.uk/covid-vaccine-scientific-proof-lethal).The

Covid-19 Vaccine Monitor, an interim study report for cohort event monitoring of vaccinated persons in the EU, published on June 9, 2022 concludes that across all sites 0.2-0.3% of participants reported at least one serious adverse reaction after receiving the first and/or second dose, and similar numbers are reported after the first booster. (https://zenodo.org/record/6629551)

We are now hearing that the EU issued a warning that taking the boosters may cause adverse effects to the immune system and may not be warranted [44]. A top Israeli immunologist has called on the leaders at the Israeli Ministry of Health to admit that the mass vaccination campaign has failed in Israel [45]. The vaccine is in trial phase and has been linked to not only instant side effects but also short to medium-term side effects [44]. Thorp et al. (2022) highlighted just a few of these side effects, such as miscarriage, foetal death and malformation, chronic autoimmune disease, permanent immune deficiency syndrome, chronic permanent CNS diseases and chronic cognitive disorders, seizure disorders and neonatal/infant cancers; and this only refers to foetuses and infants [46]. Not enough time has passed since administration of the first injections to know what the long-term effects might be.

Pfizer's documents show lipid nanoparticles with their mRNA cargo being distributed throughout the entire body and passing through the blood brain, placental and foetal blood brain barriers and concentrate in the ovaries. From US life insurance reports we know that the all-cause death rates were up 40% in ages 18-64 years by the end of Q3 2021, and according to life insurance companies there are 100,000 excess deaths per month in the US in all age groups, which cannot be attributed to COVID-19 alone [46].

In a recently published study by Doshi et al from August [47], the authors looked for serious adverse events (SAE) and adverse events of special interest (AESI) in the randomized phase III trials of both Pfizer and Moderna. Because both companies began unblinding study participants and offering them the vaccines only weeks after the emergency use authorization was granted by the FDA, the interim datasets from the time point of the EUA was used. By looking in depth at the total number of SAE instead of only the number of participants reporting one or more SAE, they found that the Pfizer injection was associated with a 36% higher risk of SAE in the vaccine versus the placebo group, while the Moderna vaccine was associated with a 6% increase of SAE in the vaccine group. They concluded after a simple risk-benefit analysis using the companies' own data, that for both Pfizer and Moderna excess risk of serious AESI exceeded the benefit of reduction in Covid-19 hospitalizations. They finish with a request for full transparency of the Covid-19 vaccine clinical trial data which to this day are inaccessible.

In a study by Shimabukuro et al. [48] following 3,958 pregnant participants in the v-safe pregnancy registry only 827 (20.89%) women enrolled in the study completed pregnancy. In the v-safe table the number of pregnant women registered as pregnant was 30,887 and the number registered as pregnant after vaccination with either Moderna or Pfizer vaccine was 4,804, which suggests loss of pregnancy and stillbirths in 84.45% of the pregnant women [48].

In a study concentrating on the second booster dose by Regev-Yochay et al. (2022) breakthrough infections were shown to be common, mostly very mild, but with high viral loads [49]. The vaccine efficacy against infection was as low as 30% for BNT162b2 (Pfizer) and 11% for mRNA1273 (Moderna) with local and systemic adverse reactions reported for 80% of BNT162b2 recipients and 40% of mRNA1273 [50].

Children under 18 are 51 times more likely to die from the mRNA vaccines than from COVID-19 if unvaccinated. Young adults in the age range of 18 to 29 are eight times more likely to die from vaccination than from COVID-19. Adults from 30 to 39 are 7 times more likely to die from vaccination and those aged 40 to 49 are 5 times more likely to die after vaccination. People in the group aged 50 to 59 are still twice as likely to die after vaccination than after COVID-19. Only when over 60 years of age is the chance of death equal for both causes. Even when over 80 years old the likelihood of dying from Covid inoculation is just 0.13% lower than the risk of dying from the infection. The authors concluded that the protection from COVID-19 death falls far short of the risk of dying from the vaccine for people below 50 years old [51].

According to Kostoff [52] the number of deaths attributable to each inoculation is five times higher in the most vulnerable 65+ demographic than deaths attributable to COVID–19. With decreasing age, the risk of death from COVID-19 decreases drastically. Combined with the longer-term effects of the inoculations, most of which are still unknown, this increases the risk-benefit ratio, perhaps substantially, in the lower age groups.

A study looking at the length of protection over time indicated that immunity against the delta variant of SARS-CoV-2 waned in all age groups a few months after receiving the second dose of the vaccine [53]. Another study found that antibody titres increased significantly at five weeks after the first vaccination but decreased rapidly at four months after the second injection. This significant decrease was independent of gender or age [54]. The fact that immunity after vaccinations seems to wane over time has been reported by other researchers who also found that antibody titres are decreasing by up to 40% each months [55] with no detectable antibody levels recorded in 16.1% of the subjects in one study within six months. Therefore, booster vaccinations were recommended [56]. Another study found that decrease in neutralising antibody titres to alpha, beta, gamma and delta variants was not significantly different between the different vaccines. They used modelling and predicted below 50% protection against symptomatic infection within the first year, also urgently recommending booster shots [57]. Scientists agree though, that introducing a booster too early

and too frequently carries increased risks especially for vaccines that have immune-mediated side-effects, such as myocarditis, Guillaine-Barre syndrome and thrombosis [58].

Lui et al. [59] specifically looked at protection against Omicron and concluded that the Omicron variant of COVID-19 was remarkedly resistant to neutralization by serum from individuals vaccinated with one of the four widely used COVID-19 vaccines. Serum from persons vaccinated and boosted with mRNA-based vaccine was also showing substantially diminished neutralization of Omicron.

A study investigated the neutralizing antibody titres against the reference strain WA1/2020 and omicron subvariants BA.1, BA.2, BA.2.12.1 and BA.4 or BA.5. in participants that had been double vaccinated and boosted with the Pfizer mRNA vaccine versus participants that had been vaccinated (bar one) and infected with the BA.1 or BA.2 variant of omicron on average 29 days prior. Their conclusion was that compared to the reference strain neutralising antibody titres to the Omicron variants were substantially decreased in both groups (6.4, 7.0 and 14.1 times (vaccinated) and 6.4, 5.8 and 9.6 times (infected) lower against BA.1, BA.2, BA.2.12.1 respectively and 21.0 (vaccinate) and 18.7 (infected) times lower against BA.4 or BA.5), suggesting that the later variants increasingly escape neutralizing antibodies [60].

Even a fourth shot of a Covid-19 vaccine is “not good enough” to prevent Omicron, according to a preliminary study in Israel. Sheba Hospital tested a fourth shot given to more than 270 medical workers, with 154 getting the Pfizer jab and 120 receiving Moderna. The researchers found that both groups showed a “slight” increase in antibodies - but not sufficient to prevent Omicron. Disturbingly, the vaccinated infected health care workers had relatively high viral loads, which suggests that they were infectious [49].

In a letter to the editor Yamamoto (2022) sums up the literature pointing to the fact that 8 months after being vaccinated twice the immune functions are less than those of an unvaccinated person according to a study by Nordstroem et al (2022) [61]. Booster shots can impair immunity due to a variety of factors leading to the recommendation to discontinue further booster shoots.

A paper by John Gibson from the University of Waikato looked at the excess death rate in New Zealand and found that rising excess mortality was closely related to the booster rollout. The author calculated 16 excess deaths for each 100,000 booster doses (https://repec.its.waikato.ac.nz/wai/econwp/2211.pdf).

According to the Health NSW government site the data obtained in 14 days until 16th of July 2022 continues to show the trend of worsening effects after the booster shots. Figure 1 shows the hospitalisation, the ICU admission and deaths sorted by vaccination status with a total of 806, 77 and 142 respectively. Comparing data of people infected with COVID the figures provided by the NSW Health Department (Fig 1) seem to confirm this trend.

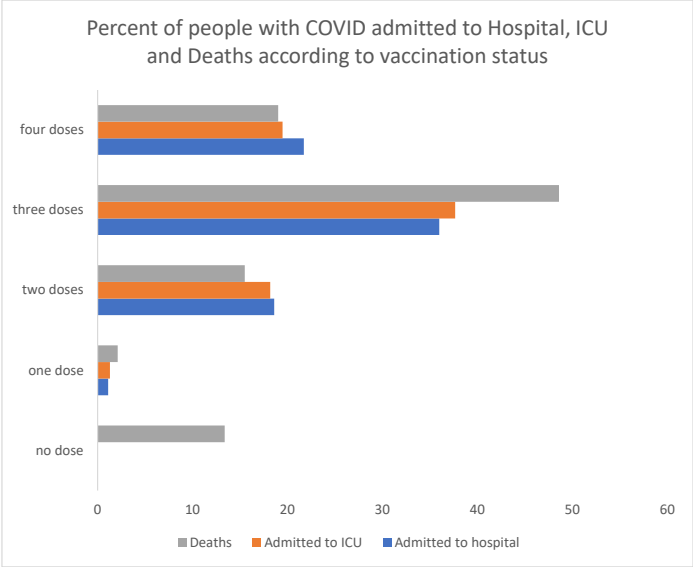

Figure 1: People diagnosed in 14 days up to the 16th of July 2022 who were submitted to hospital, ICU and died in New South Wales, Australia. Numbers represented as percentage of the total (https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-2-22-716.pdf)

Treatments

It is truly disturbing that treatments recommended by doctors in America, some of them having successfully treated COVID-19 patients, including very sick patients, have not been investigated in Australia. These treatments are mainly based on vitamins, zinc and zinc ionophores, such as ivermectin or hydroxychloroquine. The recommendation is to treat as early as possible. Scientific papers support the use of ivermectin according to Bryant et al. [62]. They found moderate to strong evidence that ivermectin can reduce COVID-19 deaths while being safe and inexpensive. The same was found for hydroxychloroquine in a review by McCullough et al, which also stated that a reduction of mortality strongly depends on an early start of the treatment. Hydroxychloroquine has been registered in the US since 1955 and has a well-characterized safety profile [63].

Yet here in Australia the recommendation is to isolate and monitor yourself. Only if you have difficulty breathing, experience loss of speech or mobility, confusion or chest pain should you contact the health care provider. Additionally, the government strongly advises not to use the following treatment for COVID-19 off label: Ivermectin, doxycycline, zinc and hydroxychloroquine (https://www.health.gov.au/health-alerts/covid-19/treatments).

The TGA provisionally approved the first oral treatments in January 2022 for Australia, Lagevrio® (molnupiravir) and Paxlovid® (nirmatrelvir + ritonavir) and recommend that both treatments should be started as soon as possible after diagnosis of COVID-19 (https://www.health.gov.au/health-alerts/covid-19/treatments/oral). The TGA also accepted - similar to the agreement for the

provisionally approved vaccines - rolling data for COVID-19 treatments, to enable early evaluation of data as it comes to hand (https://www.tga.gov.au/apm-summary/lagevrio). In other words, both drugs have been provisionally approved on the basis of short-term efficacy and safety data and permanent approval depends on the efficacy and safety data from ongoing clinical trials and post-marketing assessment. (https://www.ebs.tga.gov.au/ebs/picmi/picmirepository.nsf/pdf?OpenAgent&id=CP-2022-PI-01049-1)

Therefore, these treatments are still in trial phase and all patients treated with them are trial participants. Paxlovid has listed numerous potential complex and serious drug-drug interactions against its registration which could result in severe or life-threatening side effects(https://www1.racgp.org.au/newsgp/clinical/what-gps-need-to-know-about-the-new-covid-antivira).

Short Term Side Effects

Just to name a few short-term side effects: Death, Cardiac disorders such as Myocarditis, Blood and lymphatic system disorders, such as blood clots, thrombocytopenia, low platelet count, cerebral venous sinus thrombosis, capillary leakage syndrome, Congenital and genetic disorders, Eye disorders, Immune disorders, Muscular, skeletal and connective tissue disorders, Cancerous tumours, Nervous system disorders, Pregnancy and perinatal conditions, Guillain-Barre syndrome and the list goes on.

Pfizer's documents demonstrate lipid nanoparticles with their mRNA cargo being distributed to the entire body and pass through the blood brain, placental and foetal blood brain barriers and concentrate in the ovaries. The vaccine is in trial phase and has been linked to not only instant but also long-term side effects.

Thorp et al. [46] highlighted just a few of the side effects, such as miscarriage, foetal death and malformation, chronic autoimmune disease, permanent immune deficiency syndrome, chronic permanent CNS diseases and chronic cognitive disorders, seizures and neonatal/infant cancers; and this is only with regard to foetuses and infants.

The data from NSW (Figure 1) showed clearly that COVID injections were correlated with increases in hospitalization and ICU admissions and indicate a relation to death with COVID injections. The increase in hospitalisation, ICU admissions and deaths is very pronounced after the third injection although only 69% of the population took the booster shot versus 95% taking the initial series.

The Australian Bureau of statistics has just released the national death rate for March 20, 2021 up until 31 March 2022 (registered by 31 May 2022) as 44,331, which according to their own statement lies 6,609 (17.5%) above the historical average. These extra deaths cannot be explained by COVID alone (Fig 2) which is responsible for less than half of the excess deaths in the first 4 months of 2022 in Australia. Cancer, diabetes and neurodegenerative diseases are all above the baseline in this time frame (https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/latest-release?fbclid=IwAR3fpywSvxWCXTRUaZx99M6s_w_kBRdMa3b_13msQ3bNPRanFjGHi-wWTZQ).

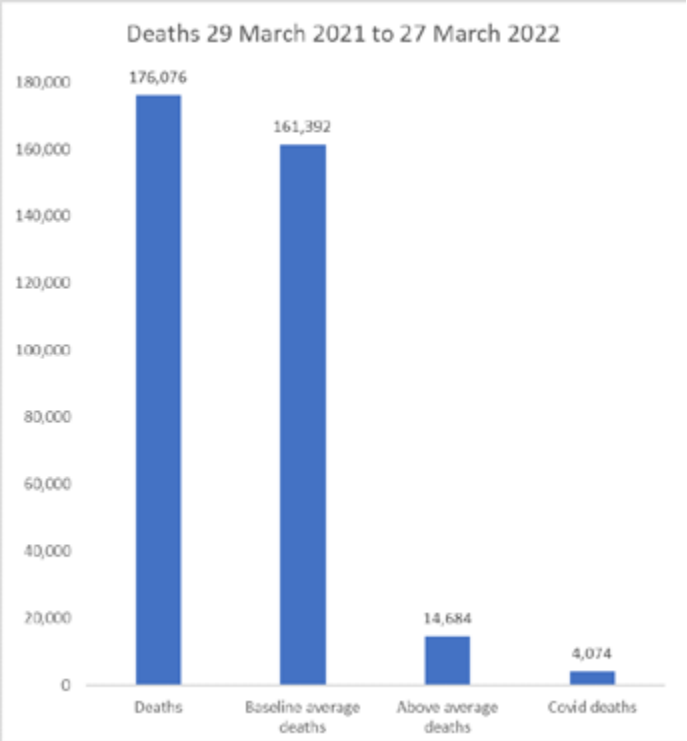

Figure 2: Death rate for Australia from 20th of March 2021 to 27 March 2022 according to the Australian Bureau of Statistics (https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/latest-release?fbclid=IwAR3fpywSvxWCXTRUaZx99M6s_w_kBRdMa3b_13msQ3bNPRanFjGHi-wWTZQ)

We get an insight into what is really going on in England where the government released COVID related death data (if the death certificate mentioned COVID) and all other death data sorted by vaccination status (Figure 3). The overall death rate for the unvaccinated was 17% while for the vaccinated it was 83%. The trend seems to be an ever increasing all causes death rate with added vaccinations without getting any protection from additional injections.

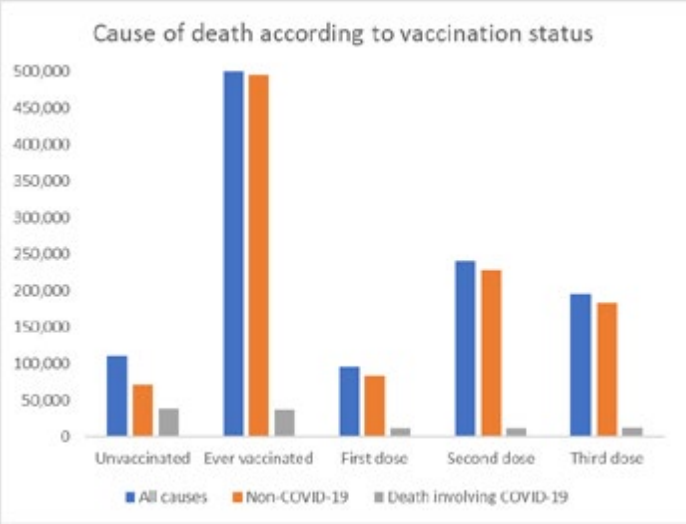

Figure 3: The cause of death according to vaccine status in the UK from the 1 January 2021 to the 31 May 2022 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsbyvaccinationstatusengland

Unexplained deaths in Germany have been shown to be the consequence of mRNA vaccines causing an autoimmune response of CD8 T killer lymphocytes in all organ systems throughout the body. Dr Sucharit and Dr Burkhardt stated that the mRNA vaccine is killing the young and the old (https://doctors4covidethics.org/on-covid-vaccines-why-they-cannot-work-and-irrefutable-evidence-of-their-causative-role-in-deaths-after-vaccination/).

According to the VAERS database over 22,000 deaths have been associated with the COVID-19 vaccine. This is particularly alarming as according to the VAERS website adverse events including deaths are underreported by an unknown factor which could be between 10 and 100, so the actual number of deaths is likely much higher and could be over a million.

From large insurance companies in the US we know that the all-cause death rates are up 40% in ages 18-64 years and there are 100,000 excess deaths per month in the US across all age groups, which cannot be attributed to COVID-19 alone. However, caution has to be taken in interpreting these data as deaths due to suicides and delayed hospital treatment are not taken into consideration. Nevertheless, the trend seems to be the same and should raise alarm.

A study by Gat et al. on semen of male semen donors revealed a transient decrease in semen concentration and a reduction in the total motile count (TMC) after COVID-19 vaccination [64].

In January 2022 the "Save us now" organisation put together a list of 1011 case studies reporting side effects after vaccination (Table 1) (https://www.saveusnow.org.uk/covid-vaccine-scientific-proof-lethal/). Most of these side effects have not been listed in any of the vaccine brochures or on the Australian Government websites. Knowing that the mRNA vaccine can be found in nearly all organs including the brain the involvement of so many organs and tissues is not surprising. The explanation for multiple disorders and multiple affected organs post-vaccination is the toxicity of the S1 subunit of the spike protein which creates similar symptoms as the viral disease. Additionally, the lipid nanoparticles alone cause inflammation and vascular damage [65].

Table 1 A and B: All symptoms reported from the 1011 case studies listed by the "Save us now organisation" and some additional case studies by Di Mauro et al. [66]; Erro et al. [67]; Garreffa et al. [68]; Jabagi et al. [69] and Jee-Eun et al. [70] https://www.saveusnow.org.uk/covid-vaccine-scientifc-proof-lethal/

A

System organ class	Vaccine-induced SE	Pfizer/ BioNTech	Moderna	Oxford/ Astra Zeneca	Johnson & Johnson
Auditory and balance disorders	Acute vertigo [71]	x			
	Sudden sensorineural hearing loss			x	
Autoimmune disease	Autoimmune encephalitis			x	
	Autoimmune hepatitis	x	x	x	
	Graves' disease	x			
	Limbic encephalitis	x			
	Multiple sclerosis	x	x	x	
	Myasthenia gravis	x			
	Psoriasis	x		x	

	Severe autoimmune hemolytic anemia		x		
	Systemic lupus erythematosus	x			
	Vogt-Koyanagi-Harada Syndrome	x		x	
Cardiac disorders	Arrhythmia		x		
	Cardiac tamponade	x			
	Cardiomyopathy	x			
	Endocarditis		x		
	Kounis hypersensitivity-associated acute myocardial infarction	x			
	Myocardial infarction	x	x	x	
	Myocarditis *	x	x	x	x
	Myocarditis-induced Sudden Death	x			
	Myopericarditis	x	x		
	Pericarditis	x	x	x	x
	Takotsubo cardiomyopathy	x	x	x	
	Transient Cardiac Injury	x			
Death		x	x	x	x
Dermal disorders	Chilblains	x	x		
	Delayed adverse skin reactions *2	x	x	x	
	Dermal hypersensitivity (Covid arm)	x	x	x	
	Exacerbated Hailey-Hailey	x	x		
	Petechiae and peeling of fingers	x	x		
	Purpuric rash *1	x	x	x	
	Reactivation of alopecia areata	x		x	
	Reactivation of Bacille Calmette-Guérin scar	x	x		
	Sweet's syndrome	x		x	x
	Toxic epidermal necrolysis			x	
Endocrine disorders	Menstrual disorders, heavy menstrual bleeding	x	x	x	x

Gastrointestinal disorder	Appendicitis	x			
	Gastroparesis	x			
	Oral aphthous ulcers	x			
Immune and Lymphatic disorders	Allergy to PEG-ASNase	x	x		
	Anaphylaxis *4	x	x	x	
	Antibody-dependent cell cytotoxicity			x	x
	Arthritis	x			
	Complement-dependent cytotoxicity			x	x
	Hemophagocytic lymphohistiocytosis			x	
	Immune-mediated disease outbreaks	x	x	x	
	Lymphadenopathies *3	x	x	x	
	Multisystemic inflammatory syndrome	x		x	
	Rapid Progression of Angioimmunoblastic T Cell Lymphoma	x			
	Seronegative Polyarthritis	x		x	
	Splenic infarction			x	
	Thymic hyperplasia		x		
Infections	Covid-19	x	x	x	x
	Herpes Simplex	x	x	x	
	Herpes Zoster (Shingles)	x	x	x	
	Hepatitis C reactivation	x			
	Non-disseminated herpes zoster	x			
Liver and gallbladder disorders	Acute liver injury		x		
	ANCA glomerulonephritis		x		
Musculosceletal disorders	Amyotrophic neuralgia			x	
	Fasciitis		x		
	Myositis (inflammatory)	x		(x)	
	Polyarthralgia and Myalgia Syndrome			x	
	Polymyalgia rheumatica	x		x	

	Rhabdomyolysis	x	x		
	Still's disease			x	
	Synovitis	x			

*Acute Fulminant Myocarditis and Cardiogenic Shock, lymphocytic, eosinophilic, infarct-like and autoimmune myocarditis, acute haemorrhagic encephalomytitis [72].

*1 Haemorrhagic rash, Cutaneous thrombosis
*2 Eczematous, Shingles-like skin lesion, Pityriasis rosea-like reaction, Urticaria, Lichen planus-like dermatitis, Bullous drug eruption, Pruritus, Spongiotic dermatitis, Morbiliform rash, Papulovesicular reaction, Purpura annularis telangiectodes
*3 Cervical lymphadenopathy, Axillary lymphadenopathy (Garreffa et al, 2021), [68]
*4 Prolonged anaphylaxis, biphasic anaphylaxis, Anaphylactoid reaction and coronary thrombosis

B

System organ class	Vaccine-induced SE	Pfizer/ BioNTech	Moderna	Oxford/ Astra Zeneca	Johnson & Johnson
Neurological disorders	Acute inflammatory neuropathies	x	x	x	
	Abducens Nerve Palsy	x			
	Adrenomyeloneuropathy				
		x			
	Bell's palsy	x	x	x	
	Cerebral hemorrhage *8	x	x	x	x
	Cerebral venous sinus thrombosis	x	x	x	x
	Cerebral venous sinus thrombosis (CVST) with thrombocytopenia				x
	CNS demyelination	x	x	x	x
	CNS inflammation	x	x		
	Distal small fiber neuropathy			x	
	Encephalomyelitis *5	x		x	
	Encephalopathy (acute)	x	x		
	Guillain-Barré syndrome (Jee-Eun, 2022)	x	x	x	x
	Miller-Fisher syndrome	x		x	
	Myelitis *9	x	x	x	
	Neuro-ophthalmic complications with VITT			x	
	Optic neuritis	x			
	Parsonage-Turner Syndrome	x	x		
	Stroke (Jabag et al, 2021) *6	x	x	x	x
	Status epilepticus, seizures*7	x	x	x	
Olfactory disorders	Phantosmia	x			

Optical disorders	Acute corneal endothelial graft rejection	x			
	Bilateral choroiditis			x	
	Central Serous Chorioretinopathy	x			
	Diplopia			x	
	Immune mediated keratolysis			x	
	Macular Neuroretinopathy			x	
	Oculomotor palsy			x	
	Retinal necrosis due to varicella zoster reactivation	x			
	Transient visual field loss	x			
	Tolosa-Hunt syndrome	x			
	Uveitis, Panuveitis	x			
Other disorder	Pancreas allograft rejection			x	
	Pancreatitis	x			
Pregnancy outcomes	Miscarriage (Pfizer's own data)	x			
Psychiatric disorder	Depression			x	
Pulmonary disorder	Acute eosinophilic pneumonia			x	
	Squamous cell carcinoma of the lung with hemoptysis	x			
Renal and urinary disorders	Acute renal failure		x		
	Crescentic Pauci-Inmune glomerulonephritis	x	x		
	Genital necrosis with cutaneous thrombosis	x			
	IgA nephropathy	x	x		
	Lipschuetz ulcer			x	
	Nephrotic syndrome			x	x
	Macroscopic hematuria	x	x		
	Minimal change disease and acute kidney injury	x		x	
Respiratory and thoratic disorders	Asthma exacerbation	x			
	Pulmonary embolism	x	x	x	x
	Semi Occluded Vocal Tract			x	
	Vaccine-induced interstitial lung disease	x			
Tissue disorders	Hemophagocytic lymphohistiocytosis			x	

Vascular disorders	Accelerated hypertension				
	Diffuse prothrombotic syndrome			x	
	Fatal systemic capillary leak syndrome			x	
	Giant cell arteritis	x			
	Haemolysis	x		x	
	Haemorrhage *10	x	x	x	
	Inflammation and platelet activation			x	x
	Limb ischemia			x	
	Microscopic polyangiitis	x			
	Symptomatic carotid occlusion				x
	Thrombocytopenia *11	x	x	x	x
	Thromboembolic events *12	x	x	x	
	Thrombotic events *13	x	x	x	x
	Vasculitis *14	x	x	x	x

*5 Acute disseminated Encephalomyelitis, acute demyelinating Encephalomyelitis, acute haemorrhagic encephalomyelitis (Ancau et al, 2022) [72]

*6 Ischemic stroke, acute ischemic stroke and hemorrhage, haemorrhagic stroke

*7 Acute hemichorea-hemiballismus, Dyskinesia (Erro et al, 2021) [67]

*8 Intracerebral hemorrhage and thrombocytopenia, Intracerebral hemorrhage associated with vaccine-induced thrombotic thrombocytopenia

*9 Extensive longitudinal transverse myelitis, Transverse myelitis, acute transverse myelitis, partial transverse myelitis, Myelitis, Acute bilateral optic neuritis/chiasm with longitudinal extensive transverse myelitis, Neuromyelitis optica (Devic's disease)

*10 Acral hemorrhage, Pulmonary hemorrhage, Retinal haemorrhage, Lobar hemorrhage with ventricular rupture

*11 Thrombotic thrombocytopenia, Thrombocytopenia and splanchnic thrombosis, Thrombotic thrombocytopenic purpura, Immune thrombocytopenic purpura

*12 Venous thromboembolism and mild thrombocytopenia

*13 Arterial thrombosis, Cerebral venous sinus thrombosis, Both transverse sinuses thrombosis, Left sigmoid sinus thrombosis, Portal vein thrombosis, Bilateral superior ophthalmic vein thrombosis, Major artery thrombosis, Idiopathic external jugular vein thrombophlebitis, Disseminated intravascular coagulation, Ophthalmic vein thrombosis, Central retinal vein occlusion

*14 Cutaneous vasculitis, Leukocytoclastic vasculitis, Small-vessel vasculitis, Granulomatous vasculitis, Vasculitis and bursitis, ANCA-associated vasculitis, Urticarial vasculitis, Neutrophil anti-cytoplasmic antibody-associated vasculitis, Cutaneous leukocytoclastic vasculitis

Side Effects (SE) are listed by organ class in alphabetical order, not by severity. To keep these tables manageable, we sorted subclasses of specific side effects under one heading and the foot notes below explain which subclasses can be found under the listed SE. Note that not all subclasses of SE have been demonstrated for all 4 vaccines.

COVID-19 vaccines cause more side effects than any other vaccine, a fact that is attributed to its interactions with the immune system. Not only does spike protein produces unwanted side effects, but mRNA and nanoparticles do as well. Seneff et al [15] enumerated Covid-19 vaccine effects on the innate immune system, importantly a decrease of type I interferon signalling, as well as disturbances in the regulation of protein synthesis affecting the formation of immune cells and the apoptosis of tumor cells. These are major disturbances that in turn can lead to a multitude of disorders such as those listed in Table 1. The suppression of the interferon response by the mRNA vaccines alone can lead to a wide variety of disorders, such as reactivation of viral infections and reduce the immune system's ability to not only fight disease but to keep tumors and autoimmune reactions suppressed [73]. A case report by Glas et al from [74] illustrates the effects of a disseminated viral infection on an immune-suppressed patient: In this instance fatal multiorgan failure associated with disseminated Herpes simplex virus-1 infection. Considering that reactivation and spread of dormant viral infections including Herpes simplex and Herpes zoster are listed as side effects from both mRNA injections as well as the Astra Zeneca vaccine, it is maybe not surprising that pathology reports by Dr Sucharit and Dr Burkhardt (2021) show multiorgan failure as cause of death in several cases of post-vaccine deaths.

Spike proteins enter the circulation when the cell they were attached to is destroyed by the immune system. The freely circulating spike proteins attach to any cell that expresses ACE2 receptors, explaining the multitude of sites where disorders occur [75]. Another method of viral spread that escapes the immune system is the formation of syncytia which can be induced by the spike protein itself. Heterotypic cell-in-cell structures with lymphocytes inside multinucleate syncytia are prevalent in the lung tissues of coronavirus disease 2019 (COVID-19) patients. This membrane fusion is dictated by a bi-arginine motif within the polybasic S1/S2 cleavage site leading to the formation of multinucleate syncytia. Host metalloproteases (ADAM-17 and ADAM-10) promote such spike protein-mediated lung cell fusion [76, 77]. Pepe et al (2022) [77] showed furthermore that the formation of tunneling nanotubes can be induced by Covid-19 in a so far undisclosed way and used to transport viral particles or indeed viral components like S and N proteins from infected to ordinarily non-permissive cells, e.g. neuronal cells. There are multiple ways in which the virus and the spike protein can spread throughout the body and from cell to cell without attracting too much attention from the immune system. Further weakening of the immune system through rashly promoted genetic intervention can only lead to more severe disease.

What needs to be further emphasised is that the majority of deaths with and from COVID- 19 occur in the elderly with multiple co-morbidities and generally weaker immune systems. Yet they are vaccinated with an injection that amplifies underlying disorders (Fig 4) and is dependent on a strong immune response. Ironically, the survival of many of those patients is probably due to their immune system not being able to mount a significant response to the induced spike protein production.

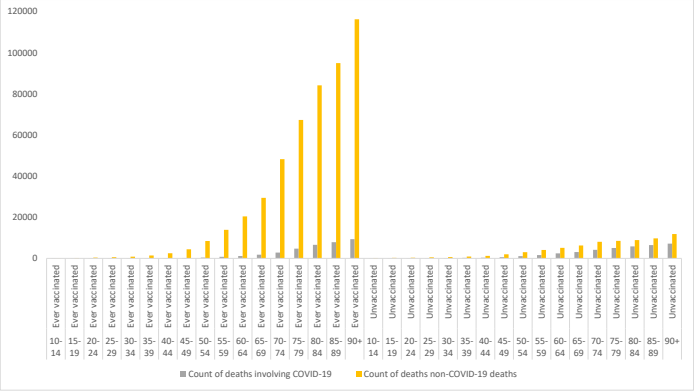

Figure 4: Death rate due to COVID and other causes comparing the vaccinated (at least one vaccination) and unvaccinated in each age group. The data of deaths occurring was for the period of the 1st of January 2021 to 31st of May 2022 in England (https://www.ons.gov.uk/)

Long Term Side Effects

Long-term risks of vaccination as predicted by scientists, many already validated by scientists and doctors:

Vaccine-induced autoimmunity, pathogenic priming, multisystem inflammatory disease and autoimmunity, antibody dependent enhancement (ADE), activation of latent viral infections, neurodegeneration and prion disease, increased thrombosis, cardiomyopathy and other vascular events following vaccination, babies suffering enduring adverse consequences, mRNA reverse transcribing intracellularly into the DNA and death due to autoimmune disease long after vaccination [78-84].

Some More Details

Autoimmune Disease

A study by Lyons-Weiler [79] revealed that over 1/3 of SARS CoV-2 proteins, including the spike protein show problematic homology to key proteins in the human adaptive immune system which might lead to autoimmune reactions against these proteins. Kelleni [78] reports on the potential risk of the vaccine to induce auto-immune diseases such as thrombocytopenia, myocarditis and immune induced thrombosis and thromboembolism which can have fatal outcomes and might be behind some of the post vaccination reports on sudden deaths.

Antibody Dependent Enhancement (ADE)

Hasan et al. [80] analysed data from the National Health Service published by Public Health England and showed that the death rate due to the Delta variant infection was eight times higher in fully vaccinated than in unvaccinated infected people. The authors suggest that in a subset of individuals the pre-existing anti-S-IgG titre induced by vaccination may be sub-neutralizing and leading to accelerated infectivity via ADE, which is displayed as higher death rates.

Prion Disease

The potential risk factors of the mRNA or vector DNA vaccine are protein sequences that can induce TDP-43 and FUS to aggregate into prion configuration, which might lead to neurodegenerative diseases, such as Alzheimers [85]. The spike protein encoded by the mRNA binds to the ACE2 receptor which releases zinc molecules. Zinc also causes TDP-43 to transform into a pathological prion [81]. The link with neurodegenerative disease is the ability of the spike protein to interact with the heparin binding amyloid forming proteins. A study indicated that the S1 protein forms a stable bond with the aggregation-prone proteins, which might initiate aggregation of brain proteins and thereby accelerate neurodegeneration [82]. Finisterer and Scorza [86] further stated that SARS-CoV-2 vaccines trigger neurological adverse reactions and both mild and severe neurological side effects have been occasionally reported. Studies support the theory that the onset and progression of neurodegenerative diseases such as Alzheimer and Parkinson disease, including TDP-43 proteinopathy, are associated with propagation of protein aggregates between neuronal cells. These speculations are supported by a case report of prion disease due to vaccination from Turkey [87, 88].

Thrombosis, Capillary Leakage Syndrome and Myocarditis

Scientific studies have raised serious concerns about the safety of AstraZeneca after reports of cerebral venous sinus thrombosis and a variety of other thrombotic events the AstraZeneca vaccination with studies reporting such events in medical journals. Kircheis [22] reported that other serious conditions have been reported for COVID vaccines such as capillary leakage syndrome

(AstraZeneca) and coronary myocarditis (Pfizer).

Pregnancy and Vaccination

Some concerns about vaccinating pregnant women were voiced by Anand and Stahel [83]. Walsh et al. [89]. reported that the results of the Pfizer vaccine demonstrate a broad immune response to vaccination with stimulation of neutralizing antibody responses, stimulation of CD4+ cells and growth of effector memory CD8+T cells in men and women. Anand and Stahel [83] hypothesised that one could assume this would also happen in pregnant women. This would not be favourable for a perinatal outcome and might lead to preterm birth and fetal loss, as a good outcome relies on amplifcation of helper T cell type 2 and regulatory T cell activity coupled with decreased Th1 response [90]. Evidence has suggested that mothers with variant CD4+ T cell responses give birth to babies that may suffer enduring adverse consequences [91].

Side Effects Acknowledged but Played Down as Extremely Small Risk

The TGA report in Australia on a weekly basis and the report of the 2nd of September 2021 mentioned nine more blood clots and low platelet counts, confirmed as probably Thrombocytopenia syndrome linked to the AstraZeneca vaccine with two connected deaths during that week, one from Queensland and one from NSW. An assessment of the 125 cases of thrombosis with thrombocytopenia syndrome (TTS) showed that women in the younger age groups were slightly more likely to develop TTS in more unusual places such as brain and abdomen with more serious outcomes projected (TGA).

Another rare side effect is Guillian-Barre syndrome (GBS), which affects the nerves. Up to the 29 August 99 reports of GBS after vaccination have been received. Further 61 reports of immune thrombocytopenia were lodged after AstraZeneca vaccination. For the Pfzer vaccine the TGA reports 293 instances of suspected myocarditis and/or pericarditis following vaccination to the 29 August 2021. Nine of these reports were from children 16 to 17 years of age. A study concluded that observations of increased thrombosis, cardiomyopathy and other vascular events following vaccination might be caused by the mRNA vaccines dramatically increasing inflammation of the endothelium and T cell infiltration of cardiac muscle [92].

Whistleblowers

At a parliament enquiry by US senator Ron Johnson lawyer Thomas Renz presented three US military doctors, Drs. Samuel Sigoloff, Peter Chambers, and Theresa Long, whose declarations he planned to use in federal court under penalty of perjury. These doctors revealed a 300% increase in miscarriages in the military above the five-year average in 2021 with the five-year average being 1,499 miscarriages per year while in the first 10 months of 2021 the registered miscarriages were 4,182. Other diseases went up in a similar fashion such as an almost 300% increase in cancer diagnoses (from a five-year average of 38,700 per year to 114,645 in the first 11 months of 2021). Neurological issues increased by 1000% from a baseline average of 82,000 to 863,000 in 2021. Some other increased conditions were:

- 269% increase of myocardial infarction
- 291% increase of Bell's palsy
- 156% increase of children's congenital malformations of military personnel
- 471% increase of female infertility
- 467% increase of pulmonary embolisms

https://newlifenarrabri.wordpress.com/2022/02/01/jo-nova-huge-spike-in-us-military-injuries-from-covid-vaccinations/ and https://www.ronjohnson.senate.gov/2022/2/sen-johnson-to-secretary-austin-has-dod-seen-an-increase-in-medical-diagnoses-among-military-personnel

According to an interview in February 2022 with Julian Gillespie, who is currently fighting in court against the vaccine mandates, an evaluation of the TGA reports revealed that Australia's average of adverse events after vaccination since 1971 up to 2020 is recorded as 2.4 death per year and up to 3,500 adverse events per annum. Since the rollout of the COVID vaccines there have been 755 deaths and 105,000 adverse events in a year with these figures likely to be underreported. https://rumble.com/vtv5pe-julian-gillespie-update-on-avn-judicial-review-to-stop-vaccines-in-australi.html?fbclid=IwAR34RTAAYX_nf9eTe1LOJSxuZ0-TbUFasXPQ37qhPEqrQI9wNe8Yig4ZwQ8

The question is how many deaths and side effects are we accepting as normal for vaccines and where do we draw the line to say more investigations need to be done before any further vaccines are distributed?

Conclusion

Never in Vaccine history have 57 leading scientists and policy experts released a report questioning the safety and efficacy of a vaccine [93]. They not only questioned the safety of the current Covid-19 injections, but were calling for an immediate end to all vaccination. Many doctors and scientists around the world have voiced similar misgivings and warned of consequences due to long-term side effects. Yet there is no discussion or even mention of studies that do not follow the narrative on safety and efficacy of Covid-19 vaccination.

In the USA, as Blaylock [94] states it very nicely, federal bureaucrats have forced the acceptance of special forms of care and prevention, which includes experimental mRNA vaccines [93]. Medical experts that have questioned the safety of these vaccines have been attacked and demonised, called conspiracy theorists and have been threatened to be de-registered if they go against the narrative. Alternative treatments were prohibited and people who never practised medicine are telling experienced doctors how to do their job. AHPRA is doing the same here in Australia to the detriment and in ignorance of science. When Adjunct Professor John Skerritt, who is currently the Deputy Secretary and directly responsibility for both the Therapeutic Goods Administration and the Office of Drug Control, was asked why the registration process for vaccines was shortened he wrote: "It is nonsense to assert that vaccines typically take 10 years to licence. The standard regulatory process for vaccines is about 10-12 calendar

months and in the case of COVID-19 vaccines this period was shortened by accepting data on a rolling basis, teams reviewing different parts of the dossier in parallel, working collaboratively with international regulators, and by many members of the teams working long hours" (personal e-mail communication). One has to wonder how they propose to assess long-term side effects. Can we really trust any pharmaceutical drug approval by the TGA after this statement?

Pfizer never planned to reveal its clinical trial data and had to be ordered by a judge in the USA to release the data to the public. Even then they and the CDC tried to limit the number of pages published per month which would have made the full study data public knowledge sometime in the 2070ies. The reason given was that some proprietary information had to be blacked out before release to the public. Again, it is inconceivable why it would be impossible to go through the study data in a few months, when it took the CDC less than 4 weeks to give the injections emergency use authorization - unless you want to entertain the idea that the study data were never actually read and scrutinised, a frightening perspective.

As scientists we put up hypotheses and test them using experiments. If a hypothesis is proven to be true according to current knowledge it might still change over time when new evidence comes to light. Hence, sharing and accumulating knowledge is the most important part of science. The question arises when and why this process of science has been changed. No discussion of new knowledge disputing the safety of the COVID-19 vaccines is allowed. Who gave bureaucrats the means to destroy the fundaments of science and tell scientists not to argue the science?

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