Internet Resources Useful for Evaluating Covid-19 Pharmaceutical Outcomes

Review 04a of a Reference Manual for Improving Healthcare Through State and Local Action, based on the Covid-19 Experience

Abstract

This review paper is a compendium of references to websites that provide and use analytical tools to assess the effectiveness and adverse effects of the "vaccine". That these sites exist is due to the lack of transparency of national (US Federal) and regional (state) governments in providing informed consent to its citizens. Existing public data are woefully inadequate to make informed consent decisions and must, in fact, be classified as disinformation.

Individuals and organizations have created web sites to circumvent this disinformation, but they can only do so much. It is a crime, because the data are available, but not to the public, and this seems purposeful. South Carolina can fix this at the state level for its citizens with recommended legislation. The analytics described in this paper can be applied to a South Carolina dataset with little or no effort. The analytics and the commentary derived from them will provide informed consent to the public for all pharmaceuticals as well as improve healthcare protocols, measure pharmaceutical quality, effectiveness and adverse effects, providing early warning to patient and healthcare provider alike

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Contents

1 Motivation

Why should we care now? Isn't Covid-19 in the past? Not if you are on any media. Pfizer ads for the shots are everywhere. People are being mis-diagnosed because the diagnostic protocols are as much political as they are medical: "Save and effective" continue to me the message from health authorities from WHO to the CDC to DHEC. This is sad and is maiming and killing people.

Furthermore, this is an issue for South Carolina;s government as well as medical institution integrity. We, the citizens, have been lied to, persecuted for expressing the truth, and maimed and killed both through malfeasance and dereliction of duty. Restoring integrity, by Christian definition, includes (1) Corrective Actions, (2) admission(confession) of the acts of malfeasance and dereliction of duty, and (3) proportional discipline/repentance.

It would be best if those who participated in the malfeasance and dereliction of duty where to honestly (and scientifically) go through the Corrective Action process they demand of the public and establish and execute true Corrective Actions. It is clear from the September 12 2023 PPLS hearings, as well as the lack of response to my questions after the hearing, that won't happen voluntarily. It is also true that the silence of the Governor speaks volumes. He should be held accountable for the actions of DHEC as the head of the executive branch. But, then, he is term limited. Why bother? See above.

The proper action of the PPLS, given the lack of cooperation of DHEC leadership, as well as the performance of the Healthcare Systems of the state, is to define the corrective actions from the citizens' perspective and write legislation to protect citizens from the actions demonstrated during the Covid-19 era that were damaging or not-productive. It is also the responsibility of the legislature to establish integrity through the process defined above.

The purpose of this document is to provide a reference to legislators and those that work for the state, up to and including the governor, on the analytic tools currently being used on Covid-19 health data. Unfortunately, the validity of the analysis must be challenged because "garbage in, garbage out." The available data, which comes from governments, is known to be insufficient as well as manipulated to favor the government's propaganda. It is remarkable that, given this handicap, analysts have developed methods that do give some insight into what has happened. The analytic tools presented here can be used for the benefit of South Carolinians. The government needs to understand what these tools can do. Then the government needs to provide a health events database that will provide accurate results.

2 Introduction

This study provides brief reviews of web sites that provide analytical methods used for evaluating infectious disease effectiveness and adverse events, with an emphasis on the pharmaceuticals associated with Covid-19. It is only a sample of the what is available. Most advanced nations have such databases. In addition, many professionals with technical and medical knowledge have created specialized databases that present both common and unique analytical and visual techniques to report the results of analyses of available data. Those selected here are either in English or offer an English option. They are the sites most often cited in the media.

Note that the government, in their internal documents and even on their web site for "insurance" for adverse effects call the "vaccine" a "countermeasure." In fact, in some documents they go further and describe the m1ΨmRNA as a "**bioweapons countermeasure**."

The symbol **m1ΨmRNA** refers to the structural constituents of the countermeasure. m1Ψ refers to the special chemical makeup of the mRNA that gives it significantly different behavior from typical mRNA. It means that the uridine in the RNA molecule is replaced by N1-methyl-pseudouridine. Actually, to be accurate, it is advertised as the nominally active constituent of the countermeasure. We have found even in the PPLS event of September 12, 2023, there are contaminants in the vial, and there can be bits and pieces of the active ingredient.

We also know that there is another critical component of the countermeasure, the Lipid NanoParticle(s) used to encapsulate the m1ΨmRNA molecule. Therefore, the complete symbol for the active agent is m1ΨmRNA-LNP, with the LNP referencing the lipid nano-particle.

The government's use of "countermeasure" or "bioweapons countermeasure" tells us both the source of the contract to make it and the management process for research, development, and manufacturing. The controlling government entity for these processes is the Department of Defense, specifically, DARPA. This management process was chosen- at least the official reason it was chosen- to meet the time objectives of Operation Warp Speed. By using the DOD bioweapons countermeasure terminology, the Federal government bypassed the normal quality checks for research, development, and manufacturing, as well as the efficacy and adverse effects studies, both before the countermeasure was declared as EUA and to the current day, while continuing to declare it "safe and effective."

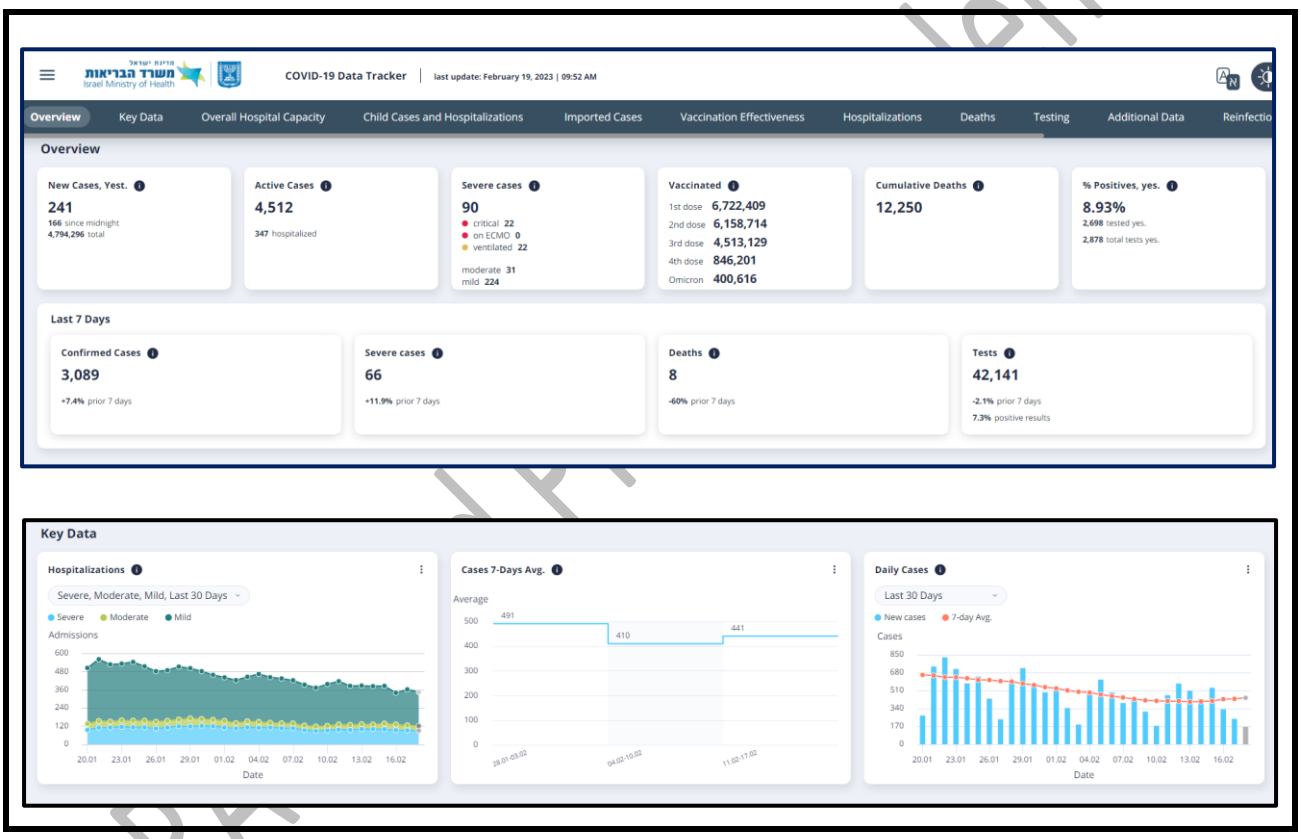
3 General Source Large Databases and Analytics

3.1 Israel

The primary web page dashboard for Covid-19 data is
https://datadashboard.health.gov.il/portal/dashboard/corona

Since Israel has among the highest rate of Covid-19 vaccination in the world and has been among the most aggressive countries to implement boosters and more boosters, their data is important to understand what might and might not happen in the US and South Carolina.

Though this is a paper on adverse effects, the accessible data on the Israeli web site has to do with typical efficacy data. This is a snapshot of the dashboard page as of February 19, 2023:[1]



[1] You will need to turn on your browser's translator. In Chrome, go to the page, which will be in Hebrew. Touch or click on the 3 vertical dots in the top right of the window. Select "translate," which may be pretty far down in the list of selections.

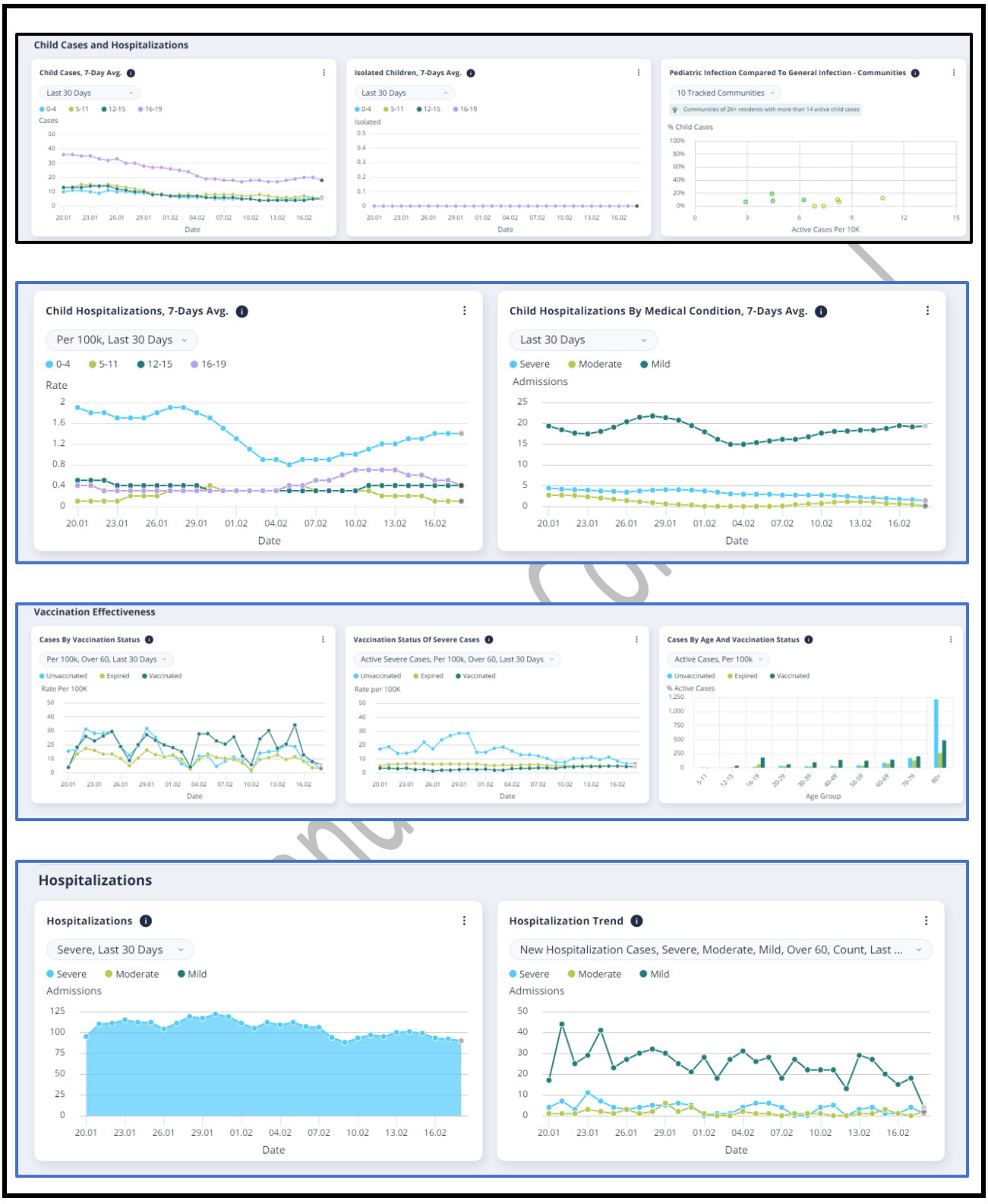

Child Cases and Hospitalizations
Child Cases, 7-Day Avg.
Last 30 Days
0-4 5-11 12-15 16-19
Cases
Date
Isolated Children, 7-Days Avg.
Last 30 Days
Isolated
Pediatric Infection Compared To General Infection - Communities
10 Tracked Communities
% Child Cases
Active Cases Per 10K
Child Hospitalizations, 7-Days Avg.
Per 100k, Last 30 Days
Rate
Child Hospitalizations By Medical Condition, 7-Days Avg.
Last 30 Days
Severe Moderate Mild
Admissions
Vaccination Effectiveness
Cases By Vaccination Status
Per 100k, Over 60, Last 30 Days
Unvaccinated Expired Vaccinated
Rate Per 100K
Vaccination Status Of Severe Cases
Active Severe Cases, Per 100k, Over 60, Last 30 Days
Rate per 100K
Cases By Age And Vaccination Status
Active Cases, Per 100k
% Active Cases
Age Group
Hospitalizations
Hospitalizations
Severe, Last 30 Days
Severe Moderate Mild
Admissions
Hospitalization Trend
New Hospitalization Cases, Severe, Moderate, Mild, Over 60, Count, Last ...
Severe Moderate Mild
Admissions
Date

Figure 1. Israel Government Health Dashboard.

There are several interesting plots further down the page. Some of them are active graphs, where you can select from more than one choice. Here are two graphs that can help establish lack of effectiveness of the vaccine and its association with multiple infections:

The first graph shows the proportion of the population by age bracket that got up to four doses:

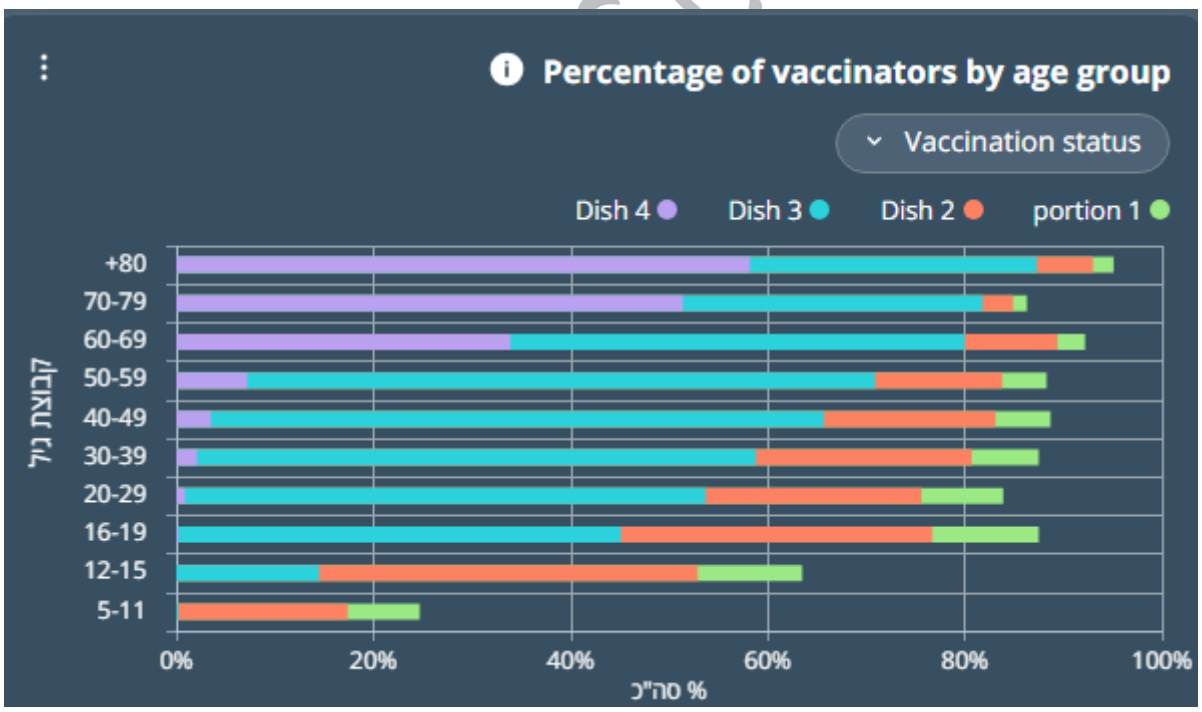


Figure 2. Israel Per Cent of Vaccinations at Various Dose Levels

And here is the number of active patients as of the report time:

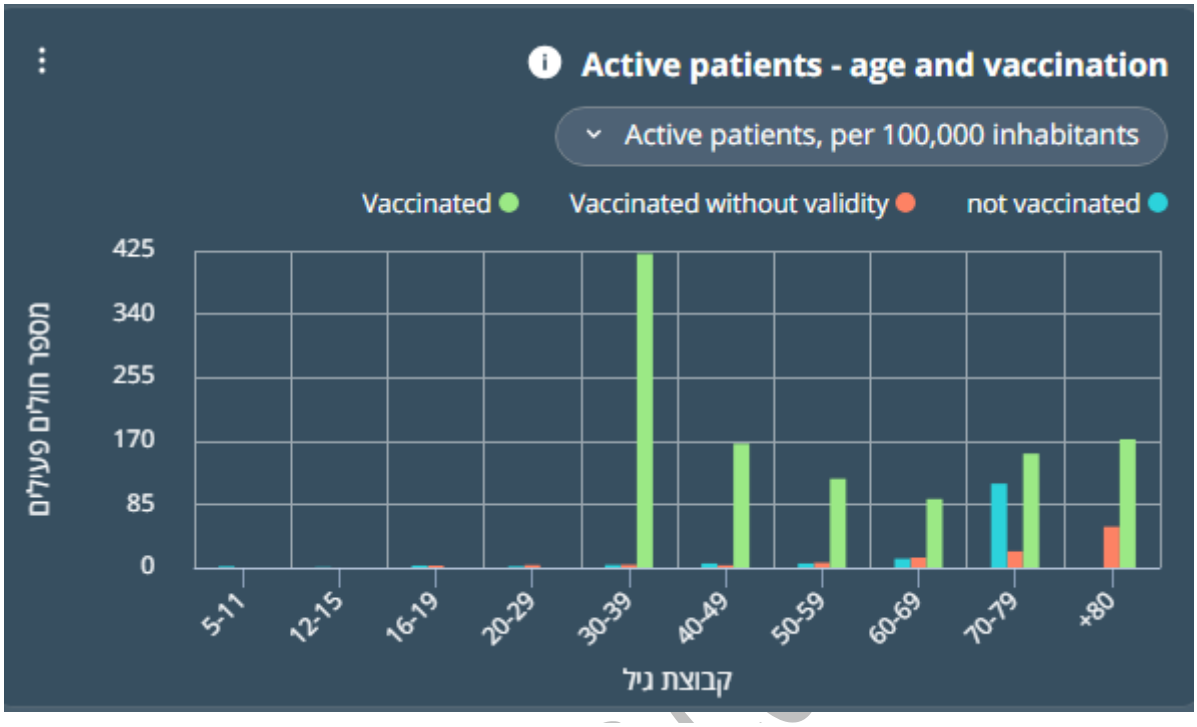


Figure 3. Israel Number of Active Patients per 100K Inhabitants As of Report Date (late 2023)

Let's look at the big spike in the second graph. The age group is 30-39. This plot is active patients per 100,000 inhabitants. Almost all the patients were vaccinated. Looking at the first graph, at least 80% of the age group had at least two doses. (Pfizer was the supplier of most of the vaccines.) This suggests compromised immune systems.

The adverse effects search for data leads to this page:

https://www.gov.il/en/service/adverse_effects_reports which looks like:

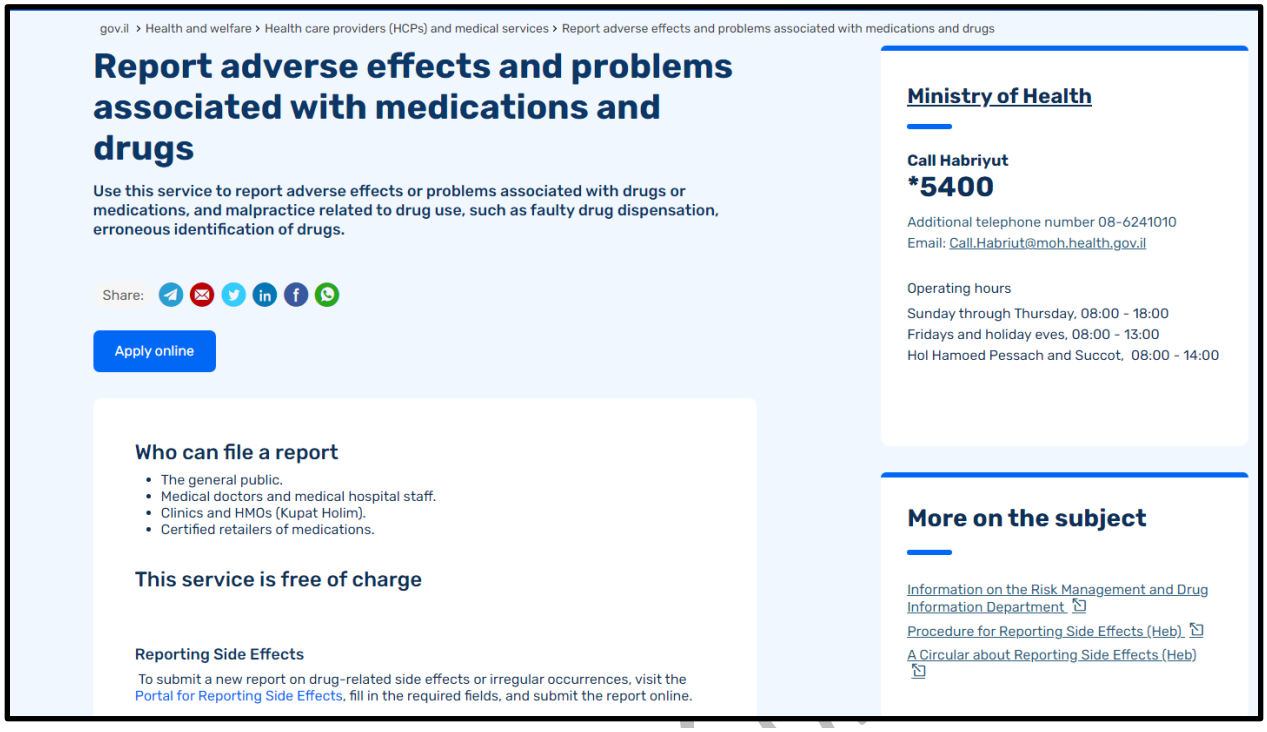


Figure 4. Isreal, web page providing access to functions to report an Adverse Evvent

There seems to be no page where analyses of the data can be performed by an independent analyst.

3.2 UK

The UK (and Scotland) data are important and informative. The primary entry points to Covid and Population data are through https://www.gov.uk/coronavirus. This is the landing page as of January, 2024:

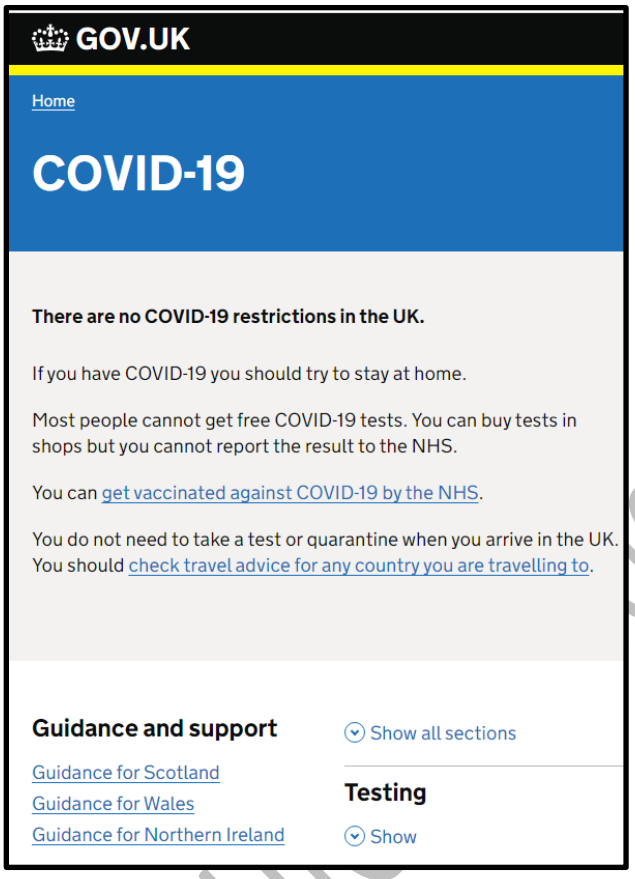


Figure 5. Landing Page for UK Covid-19 Data

Scrolling down this page, find the "More Covid-19 Information."

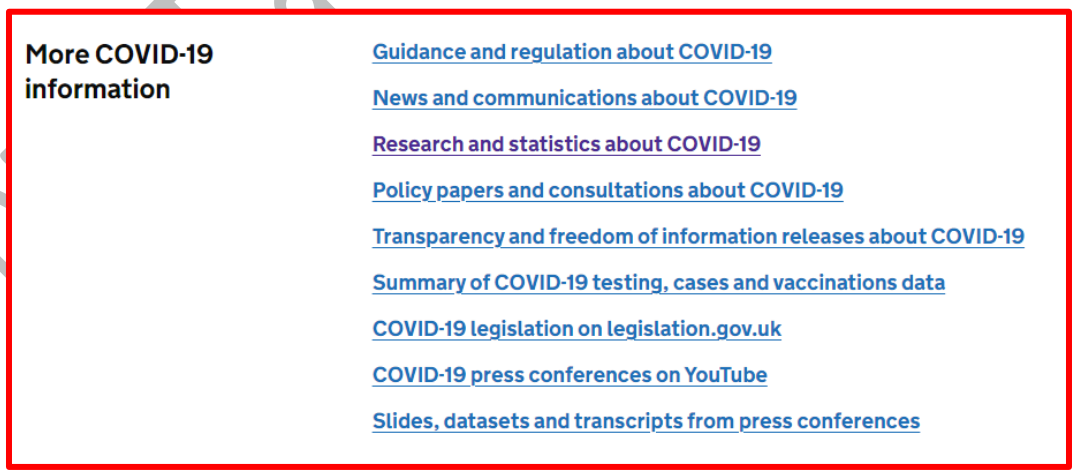


Figure 6. UK More Covid-19 Information section of the landing page

This web site contains information on all causes of deaths, from which you can, through manipulating provided excel files, tease out those who have died from Covid-19 and those who have IDC-10 U12.9 codes: death caused by Adverse Reactions to the vaccine. However, in early 2023 they did not track adverse reactions due to the vaccine other than death. Here is their statement.

FOI Reference: FOI/2022/3518

You asked

Could I request the following information please:

- *How many people have suffered serious illness and adverse reactions from all the Covid 19 vaccinations?*
- *How many people have died as a direct result of all Covid 19 vaccinations?*
- *How many of the CDC and WHO personal have not had the Covid 19 vaccination?*
- *How many MPs in the UK have not had the Covid 19 vaccination?*

We said

Thank you for your request.

Our data is derived from the death certificate, using information received at the point of death registration. For the vaccine to be mentioned on the death certificate the medical professional certifying the death must have believed, to the best of their knowledge, that the vaccine was part of the events that led to the death. Deaths reported as due to or involving the COVID-19 vaccination are recorded using ICD-10 code U12.9.

We do however hold and report on deaths attributed to adverse reaction to the COVID-19 vaccination monthly within our Monthly Mortality Analysis. The latest data available is December 2021.

There are currently 15 deaths registered in England and Wales with the aligning ICD codes for this, 10 of these deaths have ICD-10 U12.9 as the underlying cause.

However, please note that these are deaths across all age groups since the rollout of the vaccination in December 2020 and there are no deaths registered under the age of 35.

ONS do not hold data regarding adverse reactions to the COVID-19 vaccination that do not result in death.

The Medicines and Healthcare Regulatory Authority's (MHRA) role is to continually monitor the safety of any medicine or vaccine once they are approved for use. Yellow Card is a website where any member of the public or health professional can report any suspected side effect. This includes deaths, which are reported by others on behalf of the deceased person. As the information is self-reported, it means that the suspected side effects are not always proven and some of the side effects may have occurred regardless of the vaccine. MHRA are better placed to answer your enquiry, as they are responsible for the Yellow Card Scheme. They can be contacted using this form.

The situation had changed a little bit by 2024. *The Monthly Mortality Analysis* page has kept up to date until just recently. It includes an Excel spreadsheet: However, you will see that the page has a "Next Release" of "**Discontinued**." This is unfortunate given the increasing number of cases related to long term health conditions such as myocarditis, reproductive system AEs, nervous system AEs, and turbo cancers. These conditions take time to are revealed only over timespans of years, especially in death data. Of course, the accuracy of the data depends on the accuracy of reporting on death certificates, and then on autopsy results.

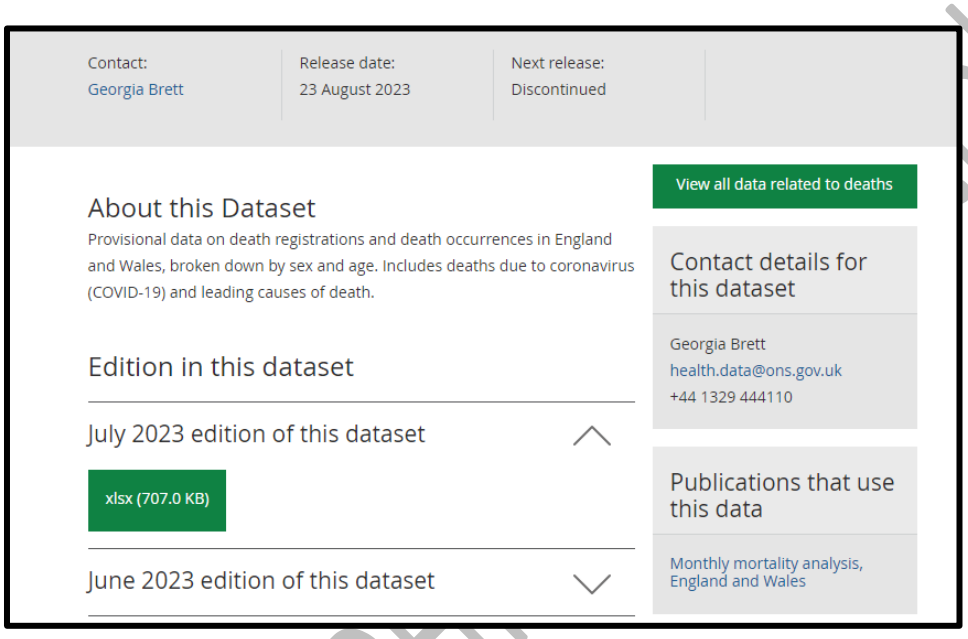


Figure 8. UK Monthly Mortality Analysis Web Page As of 4 January, 2024

Continuing: selecting the "Research and Statistics for Covid-19" option from the "More Covid-19 Information section:

On the landing page, scroll down to "More Covid-19 information:" The entry "Research and statistics about Covid-19" has been highlighted. Select that and the result is:

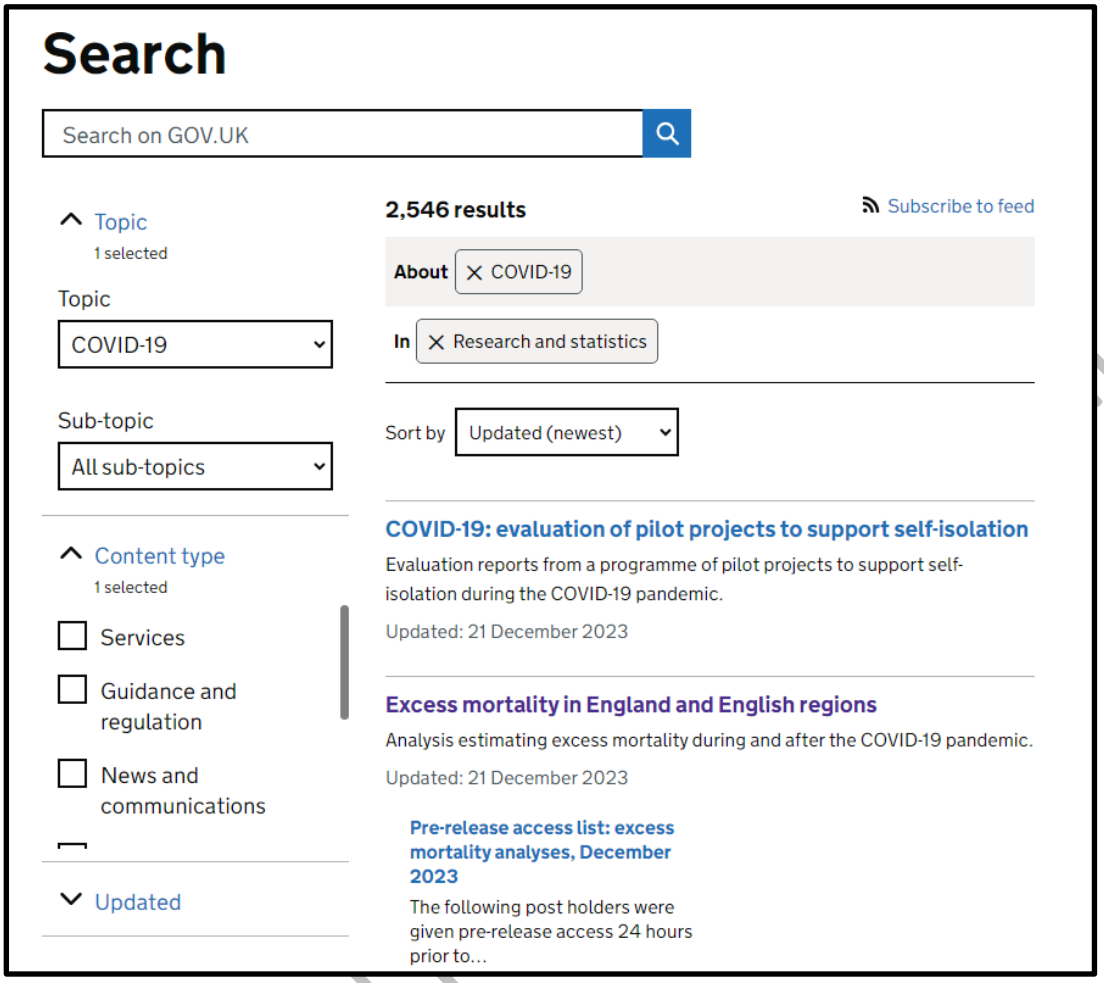
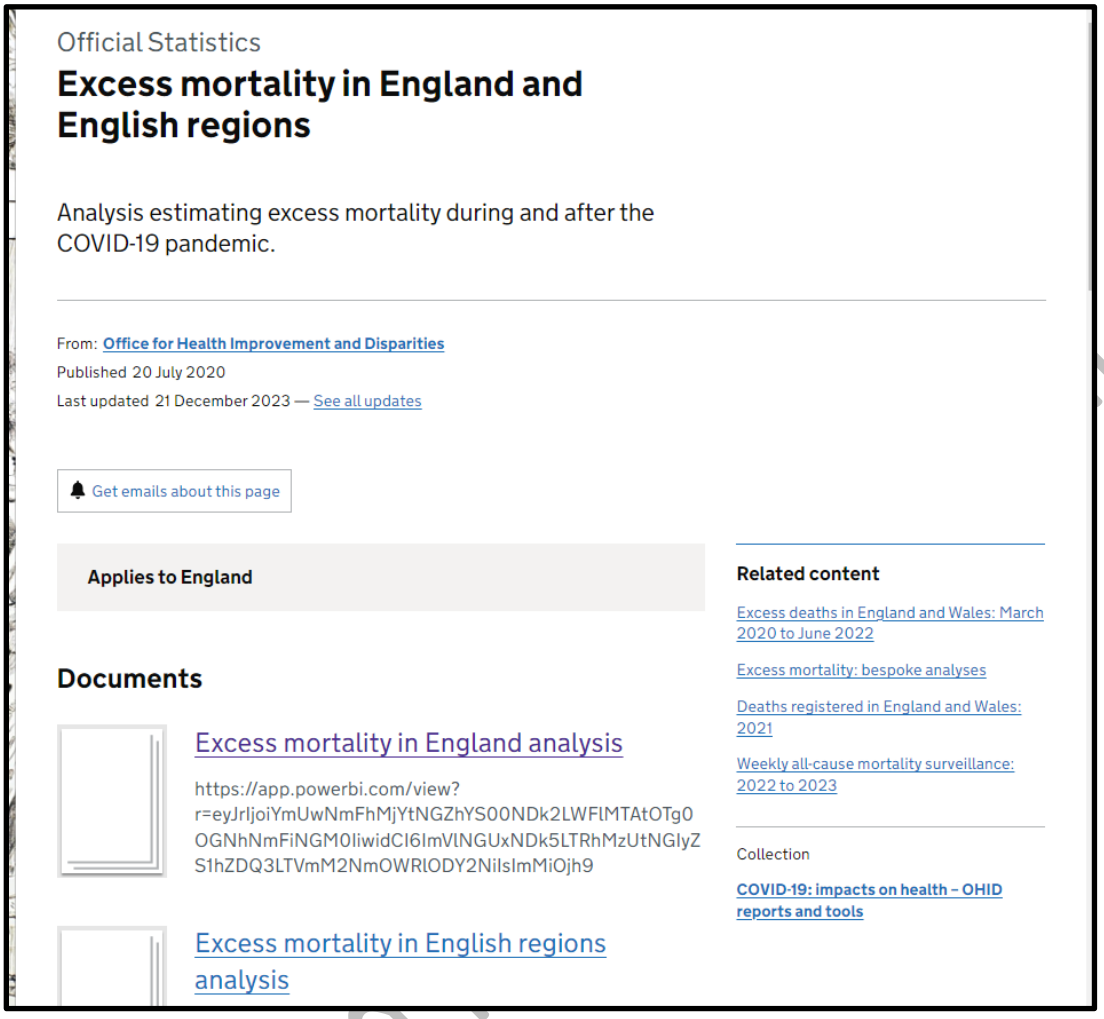


Figure 7. UK: The Research and Statistics about Covid-19 Search Page

From here it is a matter of using the interface to search for available data. In this screenshot, "Excess mortality in England and English regions is selected:

It turns out to be a rabbit hole search. The resulting page is:



Official Statistics

Excess mortality in England and English regions

Analysis estimating excess mortality during and after the COVID-19 pandemic.

From: Office for Health Improvement and Disparities
Published 20 July 2020
Last updated 21 December 2023 — See all updates

Get emails about this page

Applies to England

Documents

Excess mortality in England analysis

https://app.powerbi.com/view?r=eyJrIjoiYmUwNmFhMjYtNGZhYS00NDk2LWFlMTAtOTg0OGNhNmFiNGM0IiwidCI6ImVlNGUxNDk5LTRhMzUtNGIyZS1hZDQ3LTVmM2NmOWRlODY2NiIsImMiOjh9

Excess mortality in English regions analysis

Related content

Excess deaths in England and Wales: March 2020 to June 2022

Excess mortality: bespoke analyses

Deaths registered in England and Wales: 2021

Weekly all-cause mortality surveillance: 2022 to 2023

Collection

COVID-19: impacts on health – OHID reports and tools

The page provides a list of relevant documents and, at the bottom, a summary of the methodology and, in this case, a status of future documents:

The 2 reports on this page provide an estimate of excess mortality during and after the COVID-19 pandemic in:

- England
- English regions

'Excess mortality' in these analyses is defined as the number of deaths that are above the estimated number expected. The expected number of deaths is modelled using 5 years of data from preceding years to estimate the number of death registrations expected in each week.

In both reports, excess deaths are broken down by age, sex, upper tier local authority, ethnic group, level of deprivation, cause of death and place of death. The England report also includes a breakdown by region.

Excess deaths have been estimated from 21 March 2020 onwards.

The planned new version of the analysis, to be released alongside the update of the existing report on 21 December 2023, has been delayed. This to allow more time for quality assurance of the new analysis and to improve alignment with outputs across the health statistics system.

Other excess mortality analyses

We also publish a set of bespoke analyses using the same excess mortality methodology and data but cut in ways that are not included in the England and English regions reports on this page.

Read Excess mortality: bespoke analyses.

Selecting "Excess Mortality in England" leads to a page containing links to several kinds of analysis:

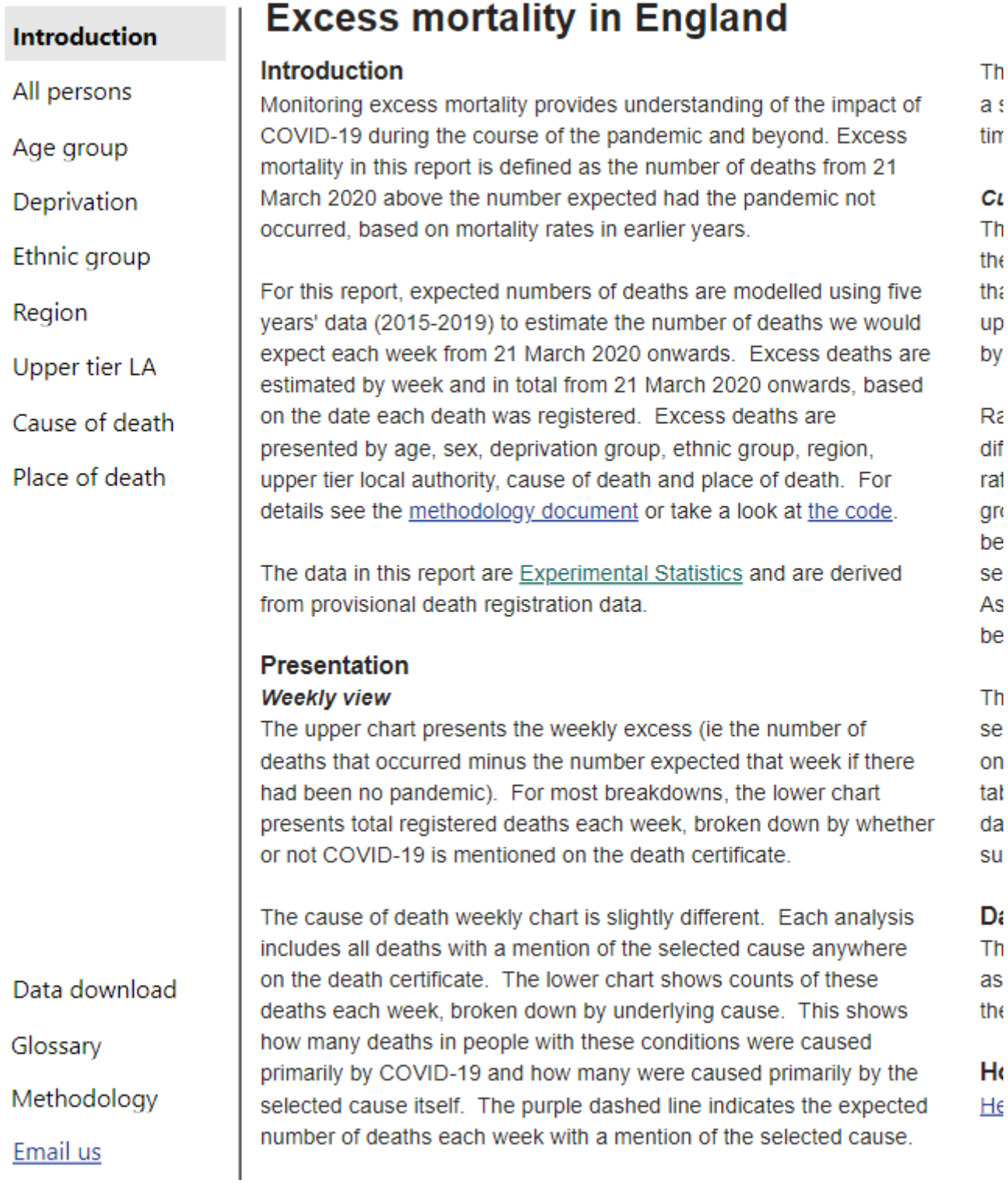


Figure 8. UK The Excess mortality in England web page

The navigation pane on the right leads to various graphs, depending on the selection.

Statistical data for the UK can also be found on the Office of National Statistics webpage: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases

There is a large number of links to various reports and data on this page. These data can be used to not only determine health related adverse effects, but economic effects. Also, various health-related protocols are defined and some metrics presented. It is a good reference page, with a number of older documents that are still referenced that can be used as evidence of malfeasance in healthcare management.

3.3 Our World in Data

This site, https://ourworldindata.org/coronavirus, is used by many researchers to obtain both Covid-19 data and analyses.

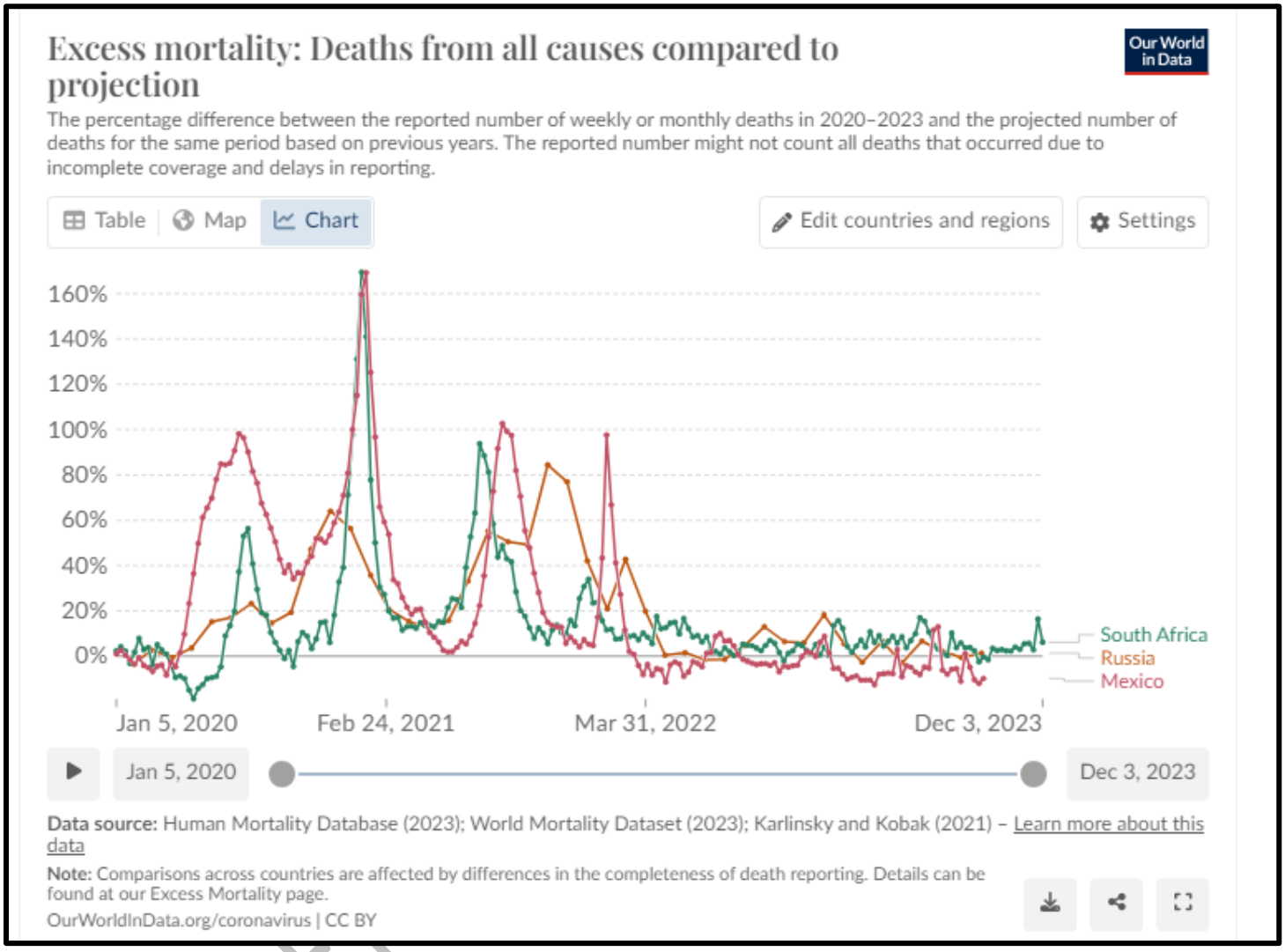
Our World in Data is a collaborative effort between researchers at the University of Oxford, who are the scientific editors of the website content; and the non-profit organization Global Change Data Lab (GCDL), who publishes and maintains the website and the data tools. It is obviously England-based. Politically, it seems to be mainstream European, which means that it has a tendency to a globalist, socialist philosophy. Nevertheless, its analyses are very useful; just be careful to understand the methodologies and the selection of the data.

The landing page for the site is:

Figure 9. One World Data Main Landing Page, Showing the Main Portals

For the most part, these data are on Covid-19 cases and outcomes. In some of the portfolio there is data that can be used to infer adverse effects in health, education, and economics. Obviously,

"Excess Mortality" would be a useful portal. There is a lot of text on this page. The text is important and should not be ignored. The first "graph" scrolling down the page shows Excess mortality using P-scores:



It is a highly interactive chart.

Another useful portal is "Policy Responses." Selecting that provides the following portals:

Figure 10. Our World Data Policy Responses to the Coronavirus Pandemic Portal Selections

These portals will be discussed in the appropriate context

3.4 Phinance Technologies Web Site

This is a premier website for many different Covid-19 Adverse Effects topics, including:

- Vaccine Damage: https://phinancetechnologies.com/HumanityProjects/The%20VDamage%20Project.htm
- Excess Mortality: https://phinancetechnologies.com/HumanityProjects/Resources.htm#ExcessDeathsMethodology.htm
- US Disabilities: https://phinancetechnologies.com/HumanityProjects/US%20Disabilities%20-%20BLS%20data.htm
- US BLS Absence Rates: https://phinancetechnologies.com/HumanityProjects/US%20Absence%20Rates%20-%20Part1.htm
- UK Cause of Death: https://phinancetechnologies.com/HumanityProjects/Projects.htm
- UK Disabilities: https://phinancetechnologies.com/HumanityProjects/Projects.htm

The website has many areas of focus, so providing a landing page and then working down a chain of links is not productive. Use the above links to go directly to the analysis. To give one example, pick the “Vaccine Damage” page. A chart on this landing page shows the organization of the project:

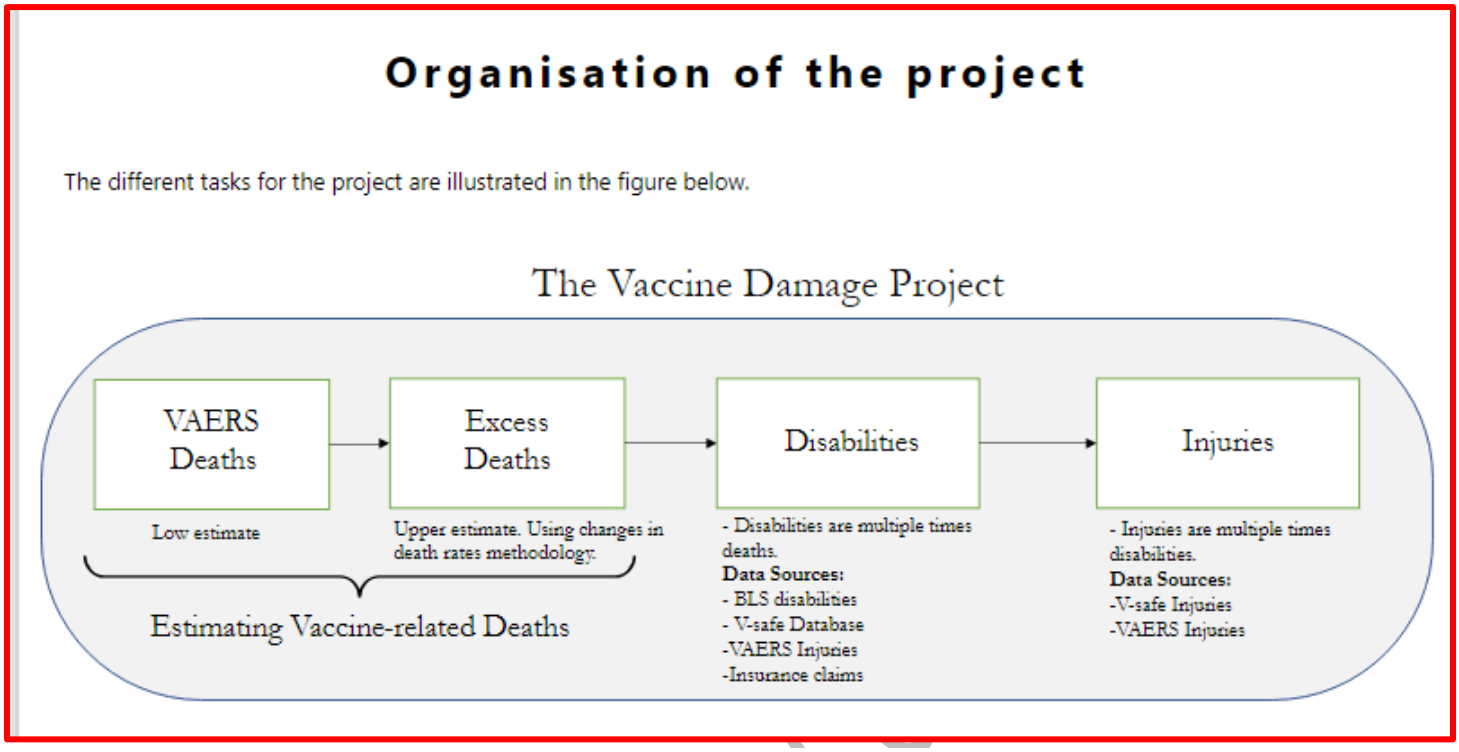


Figure 11. Phinance Vaccine Damage Project

The actual result is provided as text with graphs linked in context. The format is similar to a scientific paper. For example, the conclusion for this project is:

Conclusions

We summarised the human cost of the Covid-19 inoculations by identifying three broad groups of people who suffered varying levels of damage. We estimated the pool of individuals within the population who belong to each of these vaccine-damaged groups, using the US population as an example.
We investigated the human cost in relatively young and healthy age groups as these are the most representative for the productive population (workforce). For absences, we estimated the injured pool of individuals by using the full time workers aged 25-54, while for disabilities we use the employed workers aged 16-64 and for excess deaths we use the population aged 25-64.
Our results are summarised below:

Group 4: The most extreme damage (death).

- Excess deaths are estimated to have occurred at an absolute rate of about 0.1% of the population aged 25-64 for 2021 and 2022 combined (upper limit).
- This represents about 23% excess mortality for 2021 and 2022, relative to the expected baseline.
- In absolute numbers, this represents about 310,000 excess deaths.

Group 3: With severe damage (disabilities).

- The rise in disabilities in the Civilian Labor Force population since the start of 2021 was about 0.93%, corresponding to a 24.6% rise.
- In absolute numbers, an estimated 1.36 million individuals aged 16-64 that are actively engaged in the labour market, became disabled.

Group 2: With mild to moderate damage (injuries).

- About 18% of the Employed Labor Force aged 16-64 is estimated to have suffered injuries due to the Covid-19 vaccine rollout program that started in 2021.
- In absolute numbers, an estimated 26.6 million individuals have been injured by the inoculations.
- This corresponded to a 28.6% rise in absence rates in 2022 relative to 2019, and a 50% rise in lost worktime rates.

The site is Ed Dowd's project. His substack is https://totalityofevidence.substack.com. He has been a key economic analyst from the start of the Covid-19 era.

3.5 Data from Life Insurance Companies

Data is being released by life insurance companies. These data, along with data from mortuaries, would provide the most accurate information on what Covid-19 and the government management during this era, based on the death information they provide. The first release of information Here is one example, which can be found on the American Institute for Economic Research site (https://www.aier.org/article/all-cause-mortality-in-the-united-states-during-2021/) [1]:

> *The CEO of the OneAmerica insurance company recently disclosed that mortality in the 18-64 age group was 40 percent higher during the 3rd and 4th quarters of 2021 than during pre-pandemic levels. For reference, the CEO indicated that a 10 percent increase would have been a 1-in-200-year event. Furthermore, most of the deaths were not attributed to Covid.*

3.6 WHO

The World Health Organization has a web page for Covid-19, the WHO Covid-19 dashboard, https://data.who.int/dashboards/covid19/cases?n=c This page is long, too long for a snapshot. The data and information on the page relates to Covid-19 cases only.

The navigation is at the top of the page and has these links:

- Cases, the landing page.
- Deaths, reports on Covid-19 deaths
- Vaccines, reports on the total population vaccinated and/or boosted
- Variants, reports on the SARS-CoV-2 variants; interestingly the title for the lineage is “Pango lineage”. The WHO is sticking to the animal origin for the virus.
- Data, provides data downloads related to the previously listed reports.

The adverse events data web page is described in Section 4.10.

3.7 OECD

OECD is the Organization for Economic Co-operation and Development web site. It is difficult to classify the objective of the Covid-19 data on the web site other than to refer to the title of the organization that maintains the data. It does have what appears to be a very comprehensive data analysis of excess deaths from nations around the world. Other than that, the data analytics seem old. Whether this is due to data availability or the possibility that the available new data do not fit their narrative can not be determined. The address of the data analyses is http://stats.oecd.org. No, the site is not secure. The statistics related to Health are available under Health in the navigator on the left side of the main page:

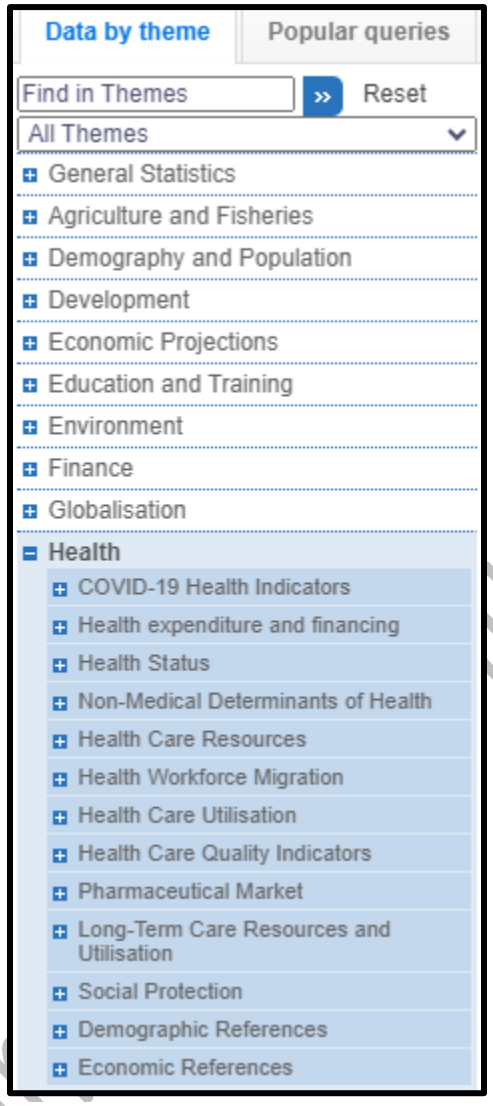
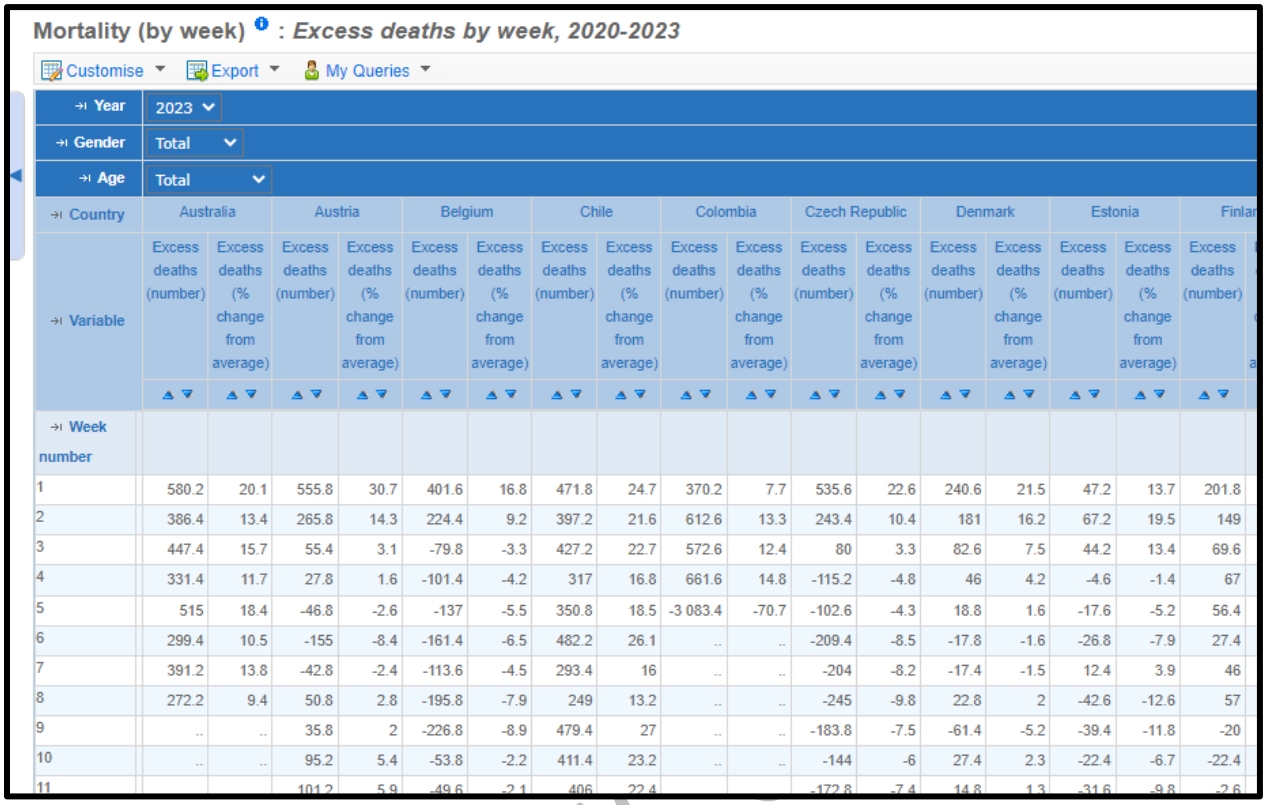


Figure 12. OECD Web site, health analyses options

Under Covid-19 Health Indicators is Excess deaths by week 2020-2023. A piece of the graph looks like this:



Mortality (by week) : *Excess deaths by week, 2020-2023*

Customise | Export | My Queries

Year	2023																	
Gender	Total																	
Age	Total																	
Country	Australia		Austria		Belgium		Chile		Colombia		Czech Republic		Denmark		Estonia		Finlar	
Variable	Excess deaths (number)	Excess deaths (% change from average)	Excess deaths (number)	Excess deaths (% change from average)	Excess deaths (number)	Excess deaths (% change from average)	Excess deaths (number)	Excess deaths (% change from average)	Excess deaths (number)	Excess deaths (% change from average)	Excess deaths (number)	Excess deaths (% change from average)	Excess deaths (number)	Excess deaths (% change from average)	Excess deaths (number)	Excess deaths (% change from average)	Excess deaths (number)	
Week number																		
1	580.2	20.1	555.8	30.7	401.6	16.8	471.8	24.7	370.2	7.7	535.6	22.6	240.6	21.5	47.2	13.7	201.8	
2	386.4	13.4	265.8	14.3	224.4	9.2	397.2	21.6	612.6	13.3	243.4	10.4	181	16.2	67.2	19.5	149	
3	447.4	15.7	55.4	3.1	-79.8	-3.3	427.2	22.7	572.6	12.4	80	3.3	82.6	7.5	44.2	13.4	69.6	
4	331.4	11.7	27.8	1.6	-101.4	-4.2	317	16.8	661.6	14.8	-115.2	-4.8	46	4.2	-4.6	-1.4	67	
5	515	18.4	-46.8	-2.6	-137	-5.5	350.8	18.5	-3 083.4	-70.7	-102.6	-4.3	18.8	1.6	-17.6	-5.2	56.4	
6	299.4	10.5	-155	-8.4	-161.4	-6.5	482.2	26.1	..	..	-209.4	-8.5	-17.8	-1.6	-26.8	-7.9	27.4	
7	391.2	13.8	-42.8	-2.4	-113.6	-4.5	293.4	16	..	..	-204	-8.2	-17.4	-1.5	12.4	3.9	46	
8	272.2	9.4	50.8	2.8	-195.8	-7.9	249	13.2	..	..	-245	-9.8	22.8	2	-42.6	-12.6	57	
9	..	..	35.8	2	-226.8	-8.9	479.4	27	..	..	-183.8	-7.5	-61.4	-5.2	-39.4	-11.8	-20	
10	..	..	95.2	5.4	-53.8	-2.2	411.4	23.2	..	..	-144	-6	27.4	2.3	-22.4	-6.7	-22.4	
11			101.2	5.9	-49.6	-2.1	406	22.4			-172.8	-7.4	14.8	1.3	-31.6	-9.8	-2.6	

Figure 13. OECD excess deaths report

3.8 USMORTALITY.COM

This website is supported anonymously but has great analytics. It does not specifically relate Covid-19 shot history to all cause death, but it provides the relationship of all cause deaths in recent years to the historic norms in all kinds of useful ways. The home page is:

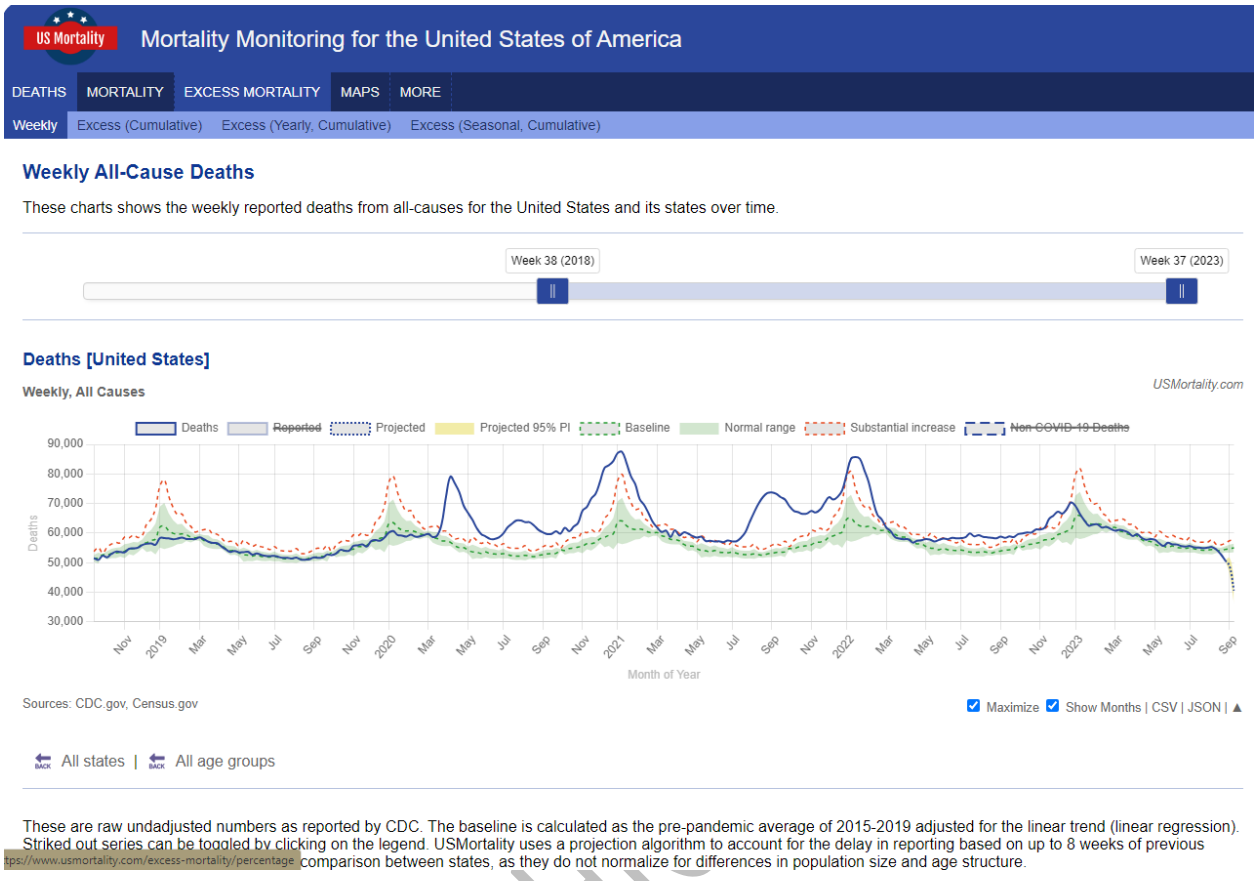


Figure 14. US Mortality.com report

3.9 OECD.Stat

This site offers data on many economic indicators that can be useful to policy makers, whether in private industry or government. In particular is the web page on Health. The web address is https://data-explorer.oecd.org/?fs[0]=Topic%2C0%7CHealth%23HEA%23&pg=0&fc=Topic&bp=true&snb=20 . This is a snapshot of the top of the page:

Figure 15. The Health Page of the OECD Data Explorer

Scroll down the page to either “Covid-19 mortality by week” or “Excess mortality by week” for the most relevant statistics. Filters can be set using the navigation pane on the left of the frame.

4 Adverse Events Large Databases

4.1 Introduction

In this section, we describe, in general terms, some of the important health databases relevant to Covid-19 adverse event reporting.

4.2 FDA

There are databases where adverse events are recorded. These databases range from available excellent resources at various levels of the government to resources not available to the public, usually maintained by big Pharma. Unfortunately, the US is one of the countries with the least admirable tracking record. For example, the various vaccines had to have, or should have, gone through extensive large trials to verify the efficacy and safety of their candidate vaccines before they were certified by the FDA. These data have only sparingly been given to the public: This is a typical extent to which the data are revealed, from the FDA qualification letter itself. [2]

FDA Announcement of the Approval of the Pfizer Vaccine

FDA Evaluation of Safety and Effectiveness Data for Approval for 16 Years of Age and Older

The first EUA, issued Dec. 11, for the Pfizer-BioNTech COVID-19 Vaccine for individuals 16 years of age and older was based on safety and effectiveness data from a randomized, controlled, blinded ongoing clinical trial of thousands of individuals.
To support the FDA's approval decision today, the FDA reviewed updated data from the clinical trial which supported the EUA and included a longer duration of follow-up in a larger clinical trial population.
Specifically, in the FDA's review for approval, the agency analyzed effectiveness data from approximately 20,000 vaccine and 20,000 placebo recipients ages 16 and older who did not have evidence of the COVID-19 virus infection within a week of receiving the second dose.
The safety of Comirnaty was evaluated in approximately 22,000 people who received the vaccine and 22,000 people who received a placebo 16 years of age and older.
Based on results from the clinical trial, the vaccine was 91% effective in preventing COVID-19 disease.
More than half of the clinical trial participants were followed for safety outcomes for at least four months after the second dose. Overall, approximately 12,000 recipients have been followed for at least 6 months.

The most commonly reported side effects by those clinical trial participants who received Comirnaty were pain, redness and swelling at the injection site, fatigue, headache, muscle or joint pain, chills, and fever. The vaccine is effective in preventing COVID-19 and potentially serious outcomes including hospitalization and death.

Additionally, the FDA conducted a rigorous evaluation of the post-authorization safety surveillance data pertaining to myocarditis and pericarditis following administration of the Pfizer-BioNTech COVID-19 Vaccine and has determined that the data demonstrate increased risks, particularly within the seven days following the second dose. The observed risk is higher among males under 40 years of age compared to females and older males. The

observed risk is highest in males 12 through 17 years of age. Available data from short-term follow-up suggest that most individuals have had resolution of symptoms. However, some individuals required intensive care support. Information is not yet available about potential long-term health outcomes. The Comirnaty Prescribing Information includes a warning about these risks.

Ongoing Safety Monitoring

The FDA and Centers for Disease Control and Prevention have monitoring systems in place to ensure that any safety concerns continue to be identified and evaluated in a timely manner. In addition, the FDA is requiring the company to conduct postmarketing studies to further assess the risks of myocarditis and pericarditis following vaccination with Comirnaty. These studies will include an evaluation of long-term outcomes among individuals who develop myocarditis following vaccination with Comirnaty. In addition, although not FDA requirements, the company has committed to additional post-marketing safety studies, including conducting a pregnancy registry study to evaluate pregnancy and infant outcomes after receipt of Comirnaty during pregnancy.

FOIA requests have gone through the courts to require the FDA and, for example, Pfizer, to release the full data on the vaccine up to the point it was certified, as well as data it has collected since. Pfizer and the FDA refused, then agreed to release the data over a 75-year period. On appeal the presiding judge required that the FDA release the data at a rate of 55,000 pages a month, which would mean the full set would be released in about eight months.

The data released so far show the failure of Pfizer to follow safety standards in testing and that the data do not reflect well on the vaccine's efficacy or safety: [3] A partial review of these data are found on the DailyClout web site. (See Section 5.2)

4.3 CDC

It is difficult to find any trustworthy analysis of "vaccine" effectiveness or AEs on a CDC web site. On the site (https://www.aier.org/article/all-cause-mortality-in-the-united-states-during-2021/),[2] the same site and article referenced in the Insurance section, is a well-worded indictment of the CDC for their manipulation of all cause data as well as what the all cause data does tell us: He is referencing the following graph, constructed from CDC Data:

[2] AIER is the American Institute for Economic Research

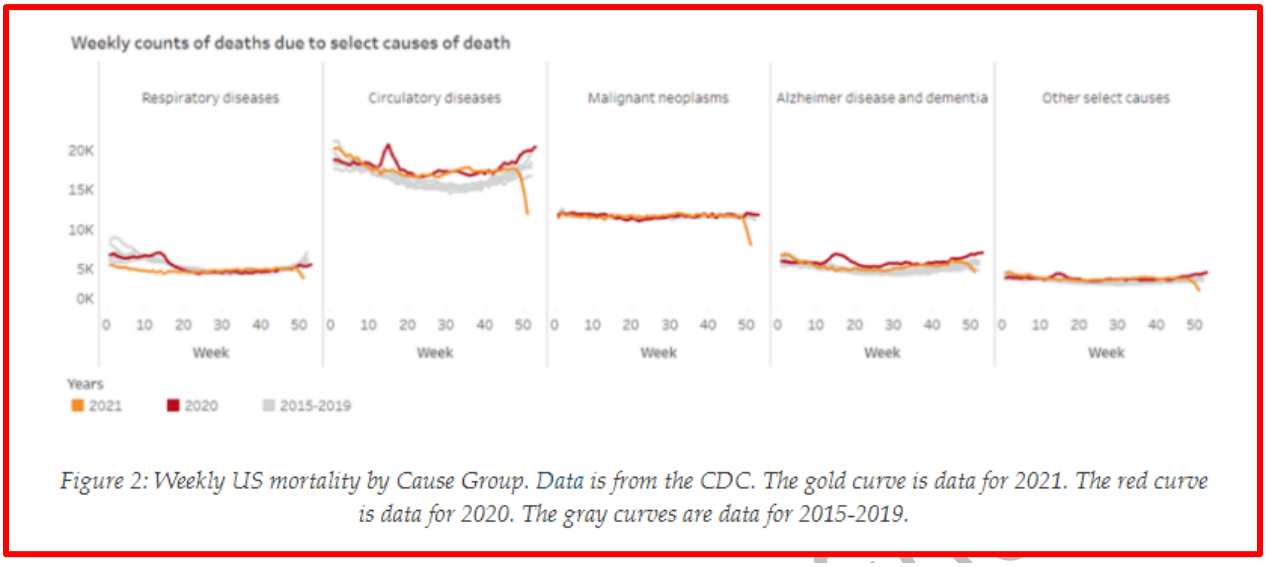


Figure 2: Weekly US mortality by Cause Group. Data is from the CDC. The gold curve is data for 2021. The red curve is data for 2020. The gray curves are data for 2015-2019.

Figure 16. CDC Weekly Cause of Deaths by Selected Causes, 2015-19 Compared to 2020 and 2021.

Here are the author's comments (Gilbert G. Berdine, MD):

Clearly there is a very significant above average number of deaths across the US that cannot be attributed to Covid. As was the case for the Age Group graphs, data for the last 10 weeks are incomplete due to delays in reporting of death certificates. Deaths attributed to Malignant Neoplasms were average during the entire pandemic period. Although there was an increase in deaths from Alzheimer Disease and dementia in 2020 after the onset of the pandemic, this was less apparent during 2021. There was an increase in deaths attributed to Other select causes (which include suicides and drug overdoses), but the magnitude was much smaller than what is seen in the Circulatory diseases category. Deaths attributed to Circulatory diseases include strokes, heart attacks, and heart failure (including myocarditis). The Circulatory diseases category is clearly the most important category for excess deaths during 2020 and 2021. Notably, deaths attributed to Respiratory diseases were below average during 2021 for the period of interest between Week 10 and Week 24 of 2021. Covid is a respiratory disease and leads to acute respiratory distress syndrome with hypoxemia and respiratory failure in severe cases. During the period of interest between Week 10 and Week 24 of 2021, Covid deaths were steadily declining, deaths attributed to Respiratory diseases were below average, but deaths due to Circulatory diseases were significantly above average. It is difficult to explain the data between Week 10 and Week 24 of 2021 on the basis of lung injury caused by Covid infection.

The spike protein enables entry of the virus into the host cells. The spike protein targets the angiotensin converting enzyme-2 (ACE-2) receptor. Angiotensin converting enzymes play an important role in the regulation of blood pressure. Angiotensin receptor blockers (ARB) and angiotensin converting enzyme (ACE) inhibitors are both important classes of drugs used to treat hypertension. It does not require a stretch of the imagination to suspect that the spike protein could cause elevation of blood pressure. Acute elevation in blood pressure is known to be a risk factor for stroke, acute myocardial infarction (heart attack), and congestive heart failure. Spike protein is also associated with clotting, presumably due to endothelial injury, which would also increase risk for myocardial infarction and stroke. It is not clear why spike protein from the Covid virus would explain above average deaths attributed to Circulatory diseases during a time period when Covid cases and deaths were declining. However, the Covid virus was not the only source of spike protein during this time period. The mRNA vaccines led to the production of spike protein by host cells and Weeks 10-24 of 2021 were immediately followed by the mass introduction of mRNA vaccines to the US public. The data is not proof, but it is certainly a red flag.

The appropriate method to assess vaccine efficacy and safety is all cause mortality. Deaths from all causes are compared between the vaccine group and a control unvaccinated group. This method has not been used. Rather, the CDC and FDA determine on a case-by-case basis whether reported adverse events can be attributed to the vaccine. If a footballer drops dead during a game, one would not be inclined to attribute the cause to a vaccine given 10 weeks earlier. However, when 5 footballers drop dead every week, one will be looking for ANY common denominator between the dead footballers.

Neither the CDC nor the FDA are impartial observers of vaccine safety. Both agencies have vested interests in promoting the vaccines. When the CDC or FDA analyze events on a case-by-case basis, they are inclined to say that an event was not due to a vaccine (especially if the people at the CDC and FDA include former executives from Pfizer). However, when the entire US population has a significant number of events compared to historic basis, one must look for the common denominators in the people with the events. The existing data is not proof that the vaccines are causing deaths due to Circulatory diseases. The burden of proof, however, lies with the CDC and FDA to prove that the vaccines are not causing deaths due to spike protein. It is scientific irresponsibility to eliminate the control group via vaccine mandates and make future assessment of vaccine safety scientifically impossible.

The Covid-19 Adverse Effects web page is: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html . As of 4 January, 2024 the site was last updated 12 September, 2023.

The entire page is included here to demonstrate the misinformation that continues as of 4 January, 2024.

Selected Adverse Events Reported after COVID-19 Vaccination

Updated Sept. 12, 2023

COVID-19 vaccine recommendations have been updated as of October 3, 2023 to add 2023-2024 updated Novavax COVID-19 vaccine. The content on this page will be updated to align with the new recommendations. Learn more.

At the April 19, 2023 meeting of the Advisory Committee on Immunization Practices, CDC presented data related to further analyses of a preliminary safety signal for persons ages 65 years and older who received the updated (bivalent) Pfizer-BioNTech COVID-19 vaccine in one safety monitoring system, the Vaccine Safety Datalink (VSD). Other safety monitoring systems have not observed similar findings. As time has passed and more safety data have accumulated, the initial finding has decreased, and scientists believe factors other than vaccination might have contributed to the initial finding. The current evidence does not support the existence of a safety issue. FDA and CDC will continue to evaluate data as they are available and update the public as needed.

Safety of COVID-19 Vaccines

Some people have no side effects. Many people have reported side effects—such as headache, fatigue, and soreness at the injection site—that are generally mild to moderate and go away within a few days.

Are the Vaccines Safe?

What You Need to Know

- The benefits of COVID-19 vaccination continue to outweigh any potential risks.
- Severe reactions after COVID-19 vaccination are rare.
- CDC recommends everyone ages 6 months and older get vaccinated to protect against COVID-19 and its potentially severe complications.
- Millions of people in the United States have received COVID-19 vaccines under the most intense safety monitoring program in U.S. history.
- CDC, the U.S. Food and Drug Administration (FDA), and other federal agencies continue to monitor the safety of COVID-19 vaccines.

Anaphylaxis after COVID-19 Vaccination

Anaphylaxis after COVID-19 vaccination is rare. It has occurred at a rate of approximately 5 cases per one million vaccine doses administered. Anaphylaxis, a severe type of allergic reaction, can occur after any kind of vaccination. If it happens, healthcare providers can effectively and immediately treat the reaction. Learn more about COVID-19 vaccines and allergic reactions, including anaphylaxis.

CDC scientists have conducted detailed reviews of cases of anaphylaxis and made the information available to healthcare providers and the public.

Scientific Publications about Anaphylaxis following COVID-19 Vaccination

Reports of Deaths after COVID-19 Vaccination

Multiple factors contribute to reports of death after COVID-19 vaccination, including heightened public awareness of COVID-19 vaccines, requirements under FDA authorization for COVID-19 vaccines that healthcare providers report any death after COVID-19 vaccination to VAERS (even if it is unclear whether the vaccine was the cause), and reporting requirements in CDC vaccine provider agreements. People receiving COVID-19 vaccines are less likely to die from COVID-19 and its complications **and are at no greater risk of death** from non-COVID causes, than unvaccinated people.

CDC scientists and partners have performed detailed assessments of deaths after COVID-19 vaccination and made the information available to healthcare providers and the public.

Scientific Publications about Death following COVID-19 Vaccination

Guillain-Barré Syndrome (GBS) after COVID-19 Vaccination

GBS is a rare disorder in which the body's immune system damages nerve cells, causing muscle weakness and sometimes paralysis. GBS has largely been observed among people ages 50 years and older.

Based on an analysis of data from the Vaccine Safety Datalink (VSD), the rate of GBS within the first 21 days following J&J/Janssen COVID-19 vaccination was found to be 21 times higher than after Pfizer-BioNTech or Moderna (mRNA) COVID-19 vaccination. After the first 42 days, the rate of GBS was 11 times higher following J&J/Janssen COVID-19 vaccination. The analysis found no increased risk of GBS after Pfizer-BioNTech or Moderna vaccination.

Similarly, CDC found higher than expected rates of GBS reported to VAERS after J&J/Janssen COVID-19 vaccination but not after mRNA COVID-19 vaccination. These observations contributed to the preferential recommendation by the Advisory Committee on Immunization Practices (ACIP) to use mRNA COVID-19 vaccines over the J&J/Janssen COVID-19 vaccine, which is no longer available in the United States.

CDC and FDA will continue to monitor for and evaluate reports of GBS occurring after COVID-19 vaccination and will share more information as it becomes available.

Myocarditis and Pericarditis after COVID-19 Vaccination

Myocarditis and pericarditis after COVID-19 vaccination are rare. Myocarditis is inflammation of the heart muscle, and pericarditis is inflammation of the outer lining of the heart. Most patients with myocarditis or pericarditis after COVID-19 vaccination responded well to medicine and rest and felt better quickly, and most cases have been reported after receiving mRNA COVID-19 vaccines.
To date, evidence indicates that **the benefits of mRNA COVID-19 vaccination outweigh the risk of myocarditis**. CDC and FDA will continue to monitor for and evaluate reports of myocarditis and pericarditis after COVID-19 vaccination. Learn more about myocarditis and pericarditis, including clinical considerations, after mRNA COVID-19 vaccination.
Data from VSD and from VAERS indicate that rates of myocarditis after COVID-19 vaccination are highest among males in their late teens and early 20s, usually following the second dose of the vaccine.
CDC scientists have conducted detailed reviews of cases of myocarditis and pericarditis after COVID-19 vaccines and have made the information available to healthcare providers and the public.

Scientific Publications about Myocarditis and Pericarditis following COVID-19 Vaccination

Thrombosis with Thrombocytopenia Syndrome (TTS) after COVID-19 Vaccination
Thrombosis with thrombocytopenia syndrome (TTS) has been rarely observed after J&J/Janssen COVID-19 vaccination and has occurred in approximately 4 cases per one million doses administered. TTS is a rare but serious adverse event that causes blood clots in large blood vessels and low platelets (blood cells that help form clots).

A review of reports indicates a causal relationship between the J&J/Janssen COVID-19 vaccine and TTS. This observation contributed to the preferential recommendation by ACIP to use mRNA COVID-19 vaccines over the J&J/Janssen COVID-19 vaccine, which is no longer available in the United States.

CDC scientists have conducted detailed reviews of TTS cases and have made the information available to healthcare providers and the public.

Scientific Publications about Thrombosis with thrombocytopenia syndrome following COVID-19 Vaccination

- Related Pages
- Safety of COVID-19 Vaccines

- Vaccine Adverse Event Reporting System (VAERS): What Reports Mean and How VAERS Works
- COVID-19 Vaccine Safety Publications

Last Updated Sept. 12, 2023

4.4 VAERS

4.4.1 Introduction

The VAERS[3] database is the US database for adverse event data. If you suffer an adverse event (How do you know?), the instructions are:

> *"the person who gave you the shot is required by federal law to file a report in this database...Healthcare providers are required by law to report to VAERS:*
>
> *Any adverse event listed in the VAERS Table of Reportable Events Following Vaccination that occurs within the specified time period after vaccination*
>
> *An adverse event listed by the vaccine manufacturer as a contraindication to further doses of the vaccine" [4]*

We all know this isn't what happens in practice. Most South Carolinians got their shots in one of the impersonal special locations manned by dozens of strangers who are qualified to give the shots. We don't see them again.

4.4.2 VAERS Front Ends

4.4.2.1 Introduction

There are "front-end" web sites that provide query access to the VAERS data and/or provide analysis and display tools. This is a review of some of these.

4.4.2.2 VAERS hhs.gov Interface

Note that there is a reference to https://vaers.hhs.gov where more advanced searches can be performed. The home page looks like this on January 22, 2023:

[3] Vaccine Adverse Event Reporting System

Figure 17. The VAERS Home Page Provided by HHS

This is the page where anyone can report an adverse event. In the top navigation bar is an entry "VAERS data." Navigating to that page, there are two major functions: "Search CDC Wonder" and "Download VAERS Data." The latter downloads raw data based on criteria. Each of these will be introduced.

4.4.2.3 The CDC Wonder Web Page

The Search CDC Wonder actually goes to this page: https://wonder.cdc.gov/controller/datarequest/D8. This is not access to the raw data; rather, it provides analytical tools that then access the database. Specifically, the Wonder page provides

several ways to enter search criteria to access information in the database. You can search for YouTube videos on how to use this interface, which is called the WONDERS system. It's a typical-for-government primitive-and-difficult-to-use system. This is the home page on January 22, 2023:

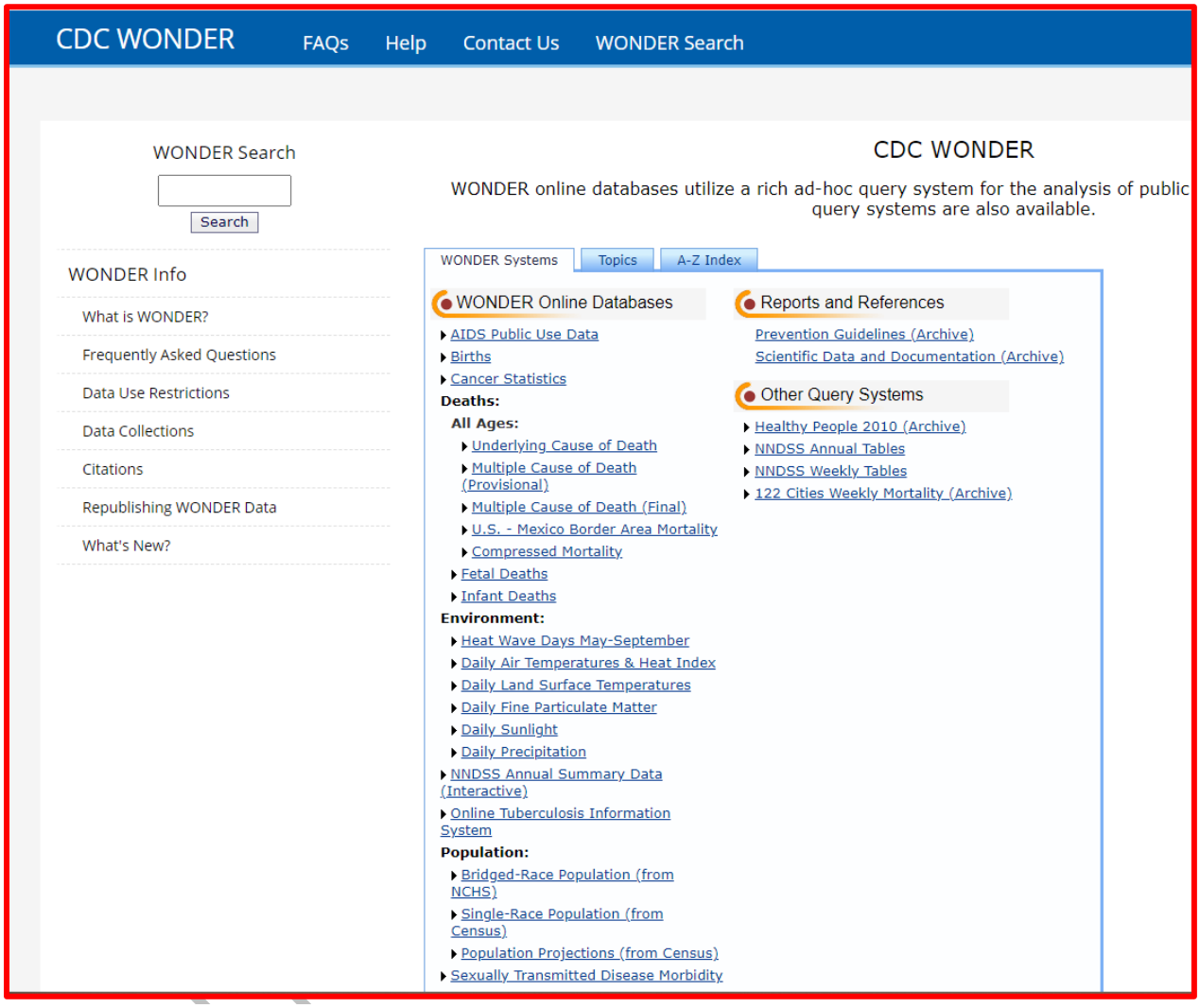


Figure 18. The WONDERS landing page

The "generate reports" function is actually found at https://wonder.cdc.gov/vaers.html. The search interface on this page is complicated and takes some time to learn to use efficiently. The reports can be downloaded for Excel analysis. This is an example of a report showing the description field of individual entries:

VAERS ID	Symptoms Code	Adverse Event Description
1033614-1	10034620	*Patient received first Moderna vaccine on 1/15/2021. Delayed injection site reaction which was warm and erythematous 1 week after vaccination on left arm for which was seen by PCP and prescribed Bactrim for 10 days. On 2/3/21 patient experienced itchiness in hands and feet with pins*

		and needles sensation. Seen by PCP on 2/4/21 and was started on Medrol Dose Pack for pruritis and paresthesias. 2/10/21 presented to ED with progressive sensory motor polyneuropathy and early gait dysfunction. Patient started plasmapharesis treatment for suspected Guillan-Barre Syndrome on 2/11/2021.
1059587-1	10034620	*Painful red blistered toes muscle aches and fatigue developed approximately 18 days after vaccine accompanied by painful sensory neuropathy. Covid test on 2/12/21 negative. Pain and rash persisted and worsened. I saw my primary doctor on 2/19/21 because my rheumatologist had left her practice. He checked my circulation and prescribed prednisone course to be taken if problem worsened. I waited another week because I am reluctant to take prednisone and was then advised by my friend who is a rheumatologist that I should go ahead with the steroid. This rash resembled the ""Covid toes "" phenomenon that has been reported in response to the actual Covid 19 viral infection and the neuropathic pain in my feet was very uncomfortable. I started prednisone course 40 mg QD on 2/26/21 with some improvement so far after one day.""*
1087488-1	10034620	*Abrupt onset of purely sensory neuropathy in tibial nerve distribution bilaterally in legs. Subsequent development a week later of purely sensory neuropathy in both arms and hands mainly in ulnar nerve distribution, and to a lesser extent median nerve distribution.*
1107253-1	10034620	*Appears to be peripheral and sensory neuropathy.; Appears to be peripheral and sensory neuropathy.; Woke up in middle of night with numbness and tingling and discomfort in both feet; Woke up in middle of night with numbness and tingling and discomfort in both feet; Woke up in middle of night with numbness and tingling and discomfort in both feet; touch sensitivity; This is a spontaneous report from a contactable nurse. A 77-years-old patient of an unspecified gender received the first dose of bnt162b2 (BNT162B2; Lot # EL9266), via an unspecified route of administration in the left arm on 18Feb2021 08:00 at single dose for covid-19 immunisation . Medical history included atrial fibrillation , supraventricular tachycardia, gastrooesophageal reflux disease , ocular myasthenia , arthritis (2 joint eplacements) , hiatus hernia , glucose tolerance impaired. Concomitant medication included apixaban (ELIQUIS), flecainide (FLECAINIDE), metoprolol tartrate (METOPROLOL TARTRATE), atorvastatin (LIPITOR [ATORVASTATIN]), estradiol (ESTRADIOL). The patient previously took cortisone and experienced rash, zocor and experienced myalgia, erythromycin and experienced vomiting, augmentin and experienced vomiting. The patient stated that woke up in middle of night with numbness and tingling and discomfort in both feet. Progressing (hands,legs,back) better in day but wake up at night. No diagnosis yet. Appears to be peripheral and sensory neuropathy. Hearing sensitivity, touch sensitivity. The events onset is 19Feb2021 01:00 the outcome is not recovered. The event peripheral neuropathy is an always serious event. Further information has been requested.; Sender's Comments: Based on available information, a possible contributory role of the subject product, BNT162B2 vaccine, cannot be excluded for the reported events of peripheral and sensory*

		neuropathy and other events due to temporal relationship. There is limited information provided in this report. Additional information is needed to better assess the case, including complete medical history, diagnostics including nerve conduction tests, counteractive treatment measures and concomitant medications. This case will be reassessed once additional information is available. The impact of this report on the benefit/risk profile of the Pfizer product is evaluated as part of Pfizer procedures for safety evaluation, including the review and analysis of aggregate data for adverse events. Any safety concern identified as part of this review, as well as any appropriate action in response, will be promptly notified to Regulatory Authorities, Ethics Committees and Investigators, as appropriate.
1123133-1	10034620	*mild peripheral neuropathy/sensory peripheral neuropathy around her gums and lips on her left side, as well as tingling on 4 of the 5 fingers of her left hand; paralysis in her lips and gums all the way down to her finger tips on the side of the injection which was the left side; portion of the trigeminal nerve on the left side seemed to have been impacted; blood pressure had sky rocketed; This is a spontaneous report from a contactable physician and a contactable consumer (patient). A 71-year-old female patient received first dose of BNT162B2 (Pfizer-Biontech Covid-19 Vaccine), lot no. EL9269, via an unspecified route of administration on 13Feb2021 at a single dose for COVID-19 immunisation. Medical history was not reported. There were no concomitant medications. The physician asked if there were any reports of paresthesia around the gums and/or tingling in the hands and fingers. The patient received the first dose of the Pfizer COVID-19 vaccine. About 1 week after receiving the vaccine (20Feb2021), she experienced symptom complex, consistent with a mild peripheral neuropathy/sensory peripheral neuropathy around her gums and lips on her left side, as well as tingling on 4 of the 5 fingers of her left hand, She was admitted and a full workup for central disorders and vascular disorders was negative (Feb2021). But her symptoms were continuing intermittently. She had numbness of the gums. A portion of the trigeminal nerve on the left side seemed to have been impacted. Also, peri-orally on the left side. The physician asked if this symptom complex has been reported and if there were reports of these mild sensory peripheral neuropathies coming from the vaccine. The physician stated that any info on dental paresthesia or any reports of other incidents of sensory paresthesia would be very helpful. The patient also called about the COVID 19 vaccine. On 13Feb, she got the vaccine in and then one week later on the following Saturday, the date would have been 20Feb, she started having a sensation of tingling and paralysis in her lips and gums all the way down to her finger tips on the side of the injection which was the left side and that has continued. She went to see the doctor the following Monday 22Feb and not knowing what it was, she sent her to the ER she was kept overnight, she was discharged 23Feb but her symptoms persisted even through today. These sensations were happening on average 3 times per day, sometimes many more anywhere from 3 minutes to 1 hour 45 minutes then it goes away. She did not go to her primary care. She confirmed her first dose was given 13Feb and the tingling and paralysis started the 20Feb it was still ongoing at this time. It has persisted but she can't tell whether it was getting better or not because sometimes it will last 3*

		minutes sometimes it will last 1 hour and 45 minutes. It started to effect other parts of her so she thinks it might be getting a little bit worse. It was starting to effect other parts of her body the progression goes, it started at the tip of her tongue and gums and then shortly within 30 seconds or less than a minute it spread to her upper and lower lip only on the left side and that was how it was on her gums as well it was only on the left side then she had the tingling in her finger tips on the left hand. She specified that she experienced these sensations on the tip of her tongue, left gums, lower left lip, and into the fingers on the left hand. She would like to know if these symptoms have been reported in association with the vaccine and if so, how long she can expect them to last. She stated that yesterday, a physician called in on her behalf for more information and said he received literature from 29Jan regarding reports that included information about dental paresthesia after the vaccine. She was planning not to get the second vaccine. She was not taking medications, she was in good health she did go and was admitted in the ER, they did a work up. Her blood pressure had sky rocketed on Feb2021 and since she mentioned sensation they ruled out a stroke. On Feb2021, they did blood work, MRI and CT scan and everything was they did not find anything linking to a stroke. She spent the night in observation. She was in the ER, they did put her in the main hospital but it was for observation from the emergency room. She went in on the 22Feb and was discharged home on 23Feb. She asked where this goes from here, these symptoms were concerning to her. She did not find any incidences at least in general of reporting this, asked if there were these kinds of things being reported, she didn't know how long it was going to last or if it will get worse. The outcome of blood pressure had sky rocketed was unknown while outcome of other events was not recovered.
1135230-1	10034620	*fever; Neuropathy; Headache; Tiredness; Pain in the vaccinated arm and shoulder; paresthesia (vaccinated arm and shoulder); motor and sensory neuropathy; sensory neuropathy; chills; sensory effect cranial nerves left side; weakness left arm; This is a spontaneous report from two contactable physician (including patient) downloaded from the Regulatory Authority-WEB, regulatory authority number . A 42-year-old female patient received 1st dose of BNT162B2 (COMIRNATY, lot number EJ6134) at single dose on 20Jan2021 via an unknown route in left arm for COVID-19 immunisation. Medical history included hypothyroidism. Concomitant drug included levothyroxine sodium (LEVAXIN) from 01Apr2010 for hypothyroidism. On 20Jan2021 about 4 hours after vaccination, the patient experienced fever developed around 38.5 degrees, headache, fatigue/ tiredness, pain and paresthesia in the shoulder and arm were vaccinated. Patient felt discomfort for about 3 days. The physician assessed the side effects as non-serious. Additional physician further reported side effect neuropathy, and the clinical course was reported as follows: Patient experienced motor and sensory neuropathy. Initial general symptoms with chills and severe local symptoms that debuted in connection with the vaccination and lasted for 4 days. Patient was completely on sick leave since Jan28. Patient experienced sensory effect left arm and leg and cranial nerves left side and weakness left arm. The recent days (as of 09Feb2021), patient had some improvement but residual sensory impact that partially changed*

		character. The physician assessed the event as serious as other medically important event. Outcome of chills and weakness left arm was not resolved. Outcome of the other events was resolved with sequel (reported as recovered with permanent injury). No follow-up attempts possible. No further information expected.
1218638-1	10034620	*About 30 min after leaving the vaccination site I was driving home and felt face getting flush and tingly, on one side of my face. Felt slight swelling of my mouth and tongue. Those lasted about 45 min to an hour and they dissipated and then about a week later I started having a full body sensation, I started feeling like a burning sensation all through my body, like an internal sunburn all through my body and I have been feeling like that ever since. It also started oscillating between the burning sensation and a cold sensation. I also feel like pins and needles and most recently numbing of my hands and arms. It has been chronic since then. My PCP told me to take Zyrtec 30mg a day OTC and it did not help. I then met with a neurologist and allergist. Allergist did not believe it was an allergic reaction. The neurologist prescribed prednisone and it did not help. She also prescribed B12 (I have a history of B12 deficiency) and she initially diagnosed me with sensory malfiber polyneuropathy. She has been running some auto immune tests and some have come back normal and she is trying to figure it out the next plan of care. It is not just a sensation, part of it is physiological because my ears for example sometimes get very red and hot to the touch and my hands get very cold.*
1291307-1	10034620	*I have sensory neuropathy a that causes muscle and joint pain on a daily basis. Hours after getting the Pfizer vaccine (on 09Apr2021) my pain became unbearable even after taking my pain meds.; Headache the following three days and still having the increased pain and sweats.; I have sensory neuropathy a that causes muscle and joint pain on a daily basis. Hours after getting the Pfizer vaccine (on 09Apr2021) my pain became unbearable even after taking my pain meds.; I have been having sweat break outs day and night.; Headache the following three days and still having; This is a spontaneous report from a contactable consumer (patient). A 65-year-old female patient received first dose of BNT162B2 (PFIZER-BIONTECH COVID-19 VACCINE), via an unspecified route of administration, administered in arm left on 09Apr2021 at 12:00 (Lot Number: EW0158) (at the age of 65-year-old) as single dose for COVID-19 immunisation. The patient was not pregnant. Medical history included peripheral sensory neuropathy (I have sensory neuropathy that causes muscle and joint pain on a daily basis), diverticulitis, colitis, Raynaud's phenomenon, Sjogren's syndrome, gastrooesophageal reflux disease (GERD), all from an unknown date and unknown if ongoing. The patient had known allergies: Sulfur, aspirin, cevimeline. The patient did not experience COVID-19 before vaccination. The patient did not receive any vaccination in four weeks prior COVID-19 vaccine. Concomitant medications included pregabalin (LYRICA); hydrocodone; pantoprazole and mirabegron (MYRBETRIQ), all concomitants taken for an unspecified indication, start and stop date were not reported. The patient reported that: ""I have sensory neuropathy that causes muscle and joint pain on a daily basis. Hours after getting the Pfizer vaccine (on 09Apr2021) my pain became unbearable even after taking my pain meds. I have been having*

		sweat break outs day and night. Headache the following three days and still having the increased pain and sweats. The events were serious, disabling. The patient outcome of the events was not recovered.""
1401131-1	10034620	*peripheral sensory motor polyneuropathy; This is a spontaneous report from a contactable Physician downloaded from the Agency EudraVigilance-WEB IT-MINISAL02-735953. A 74-year-old male patient received BNT162b2 (COMIRNATY; Formulation: solution for injection, Lot number: EX3599 (Also reported EY7065), Expiration date: Unknown), via an intramuscular route of administration in the deltoid left on 27Apr2021 as 1st dose, single dose for COVID-19 immunisation. Medical history and concomitant medications were not reported. On 07May2021, the patient experienced peripheral sensory motor polyneuropathy. The patient underwent lab test included lower limb electromyogram with no results reported on an unknown date. The outcome of the event was not resolved. sender comments the severity of the suspected adverse reaction is changed from 'non-serious' to 'serious - other clinically relevant condition' since it is an event included in the list.*
1454089-1	10034620	*Onset of tingling/numbness the day following 2nd covid vaccine. Diagnosis sensory ganglionopathy following a ""GBS like"" episode.""*

Figure 19. An example report from Wonder of the description field for several entries

The reason I included several samples is to show that, contrary to the majority of fact checkers who say data from the VAERS database is invalid and inconclusive'

Here is an example: [5]

> *A non-believer in the VAERS data, Jonathan Jarry, disputes the reliability of the VAERS reports. Jarry holds a master of science degree and is a molecular biologist and science communicator in McGill University's Office for Science and Society. He's an outspoken critic of VAERS.*
>
> *He claims that VAERS data is circumstantial, doesn't prove causality, and is used to induce fear. He rejects the accuracy of the high rates of injury and death reported there and claims it only contributes to anti-vaccination fear.*
>
> *"Don't fall for the "VAERS scare tactic," Jarry wrote in an article posted on the school's website.*
>
> *The office's mission articulated there is to "separate sense from nonsense." He also wants the public to doubt the credibility of VAERS data.*
>
> *"The Vaccine Adverse Event Reporting System, or VAERS, is being misused by anti-vaxxers to terrify the public," Jarry wrote. "Scrolling through a VAERS data set does not allow us to conclude anything. VAERS can be used to generate hypotheses but not to test them directly."*

As you can see from the sample, the data that are entered are very detailed in the vast majority of cases and there is little doubt of cause and effect.

4.4.2.4 OpenVAERS

A Dashboard for the VAERS system provided by a small team of people with vaccine injuries or who have children with vaccine injuries. It is called **OpenVAERS** (https://openvaers.com/). This is a picture of the landing page as of January 5, 2024.

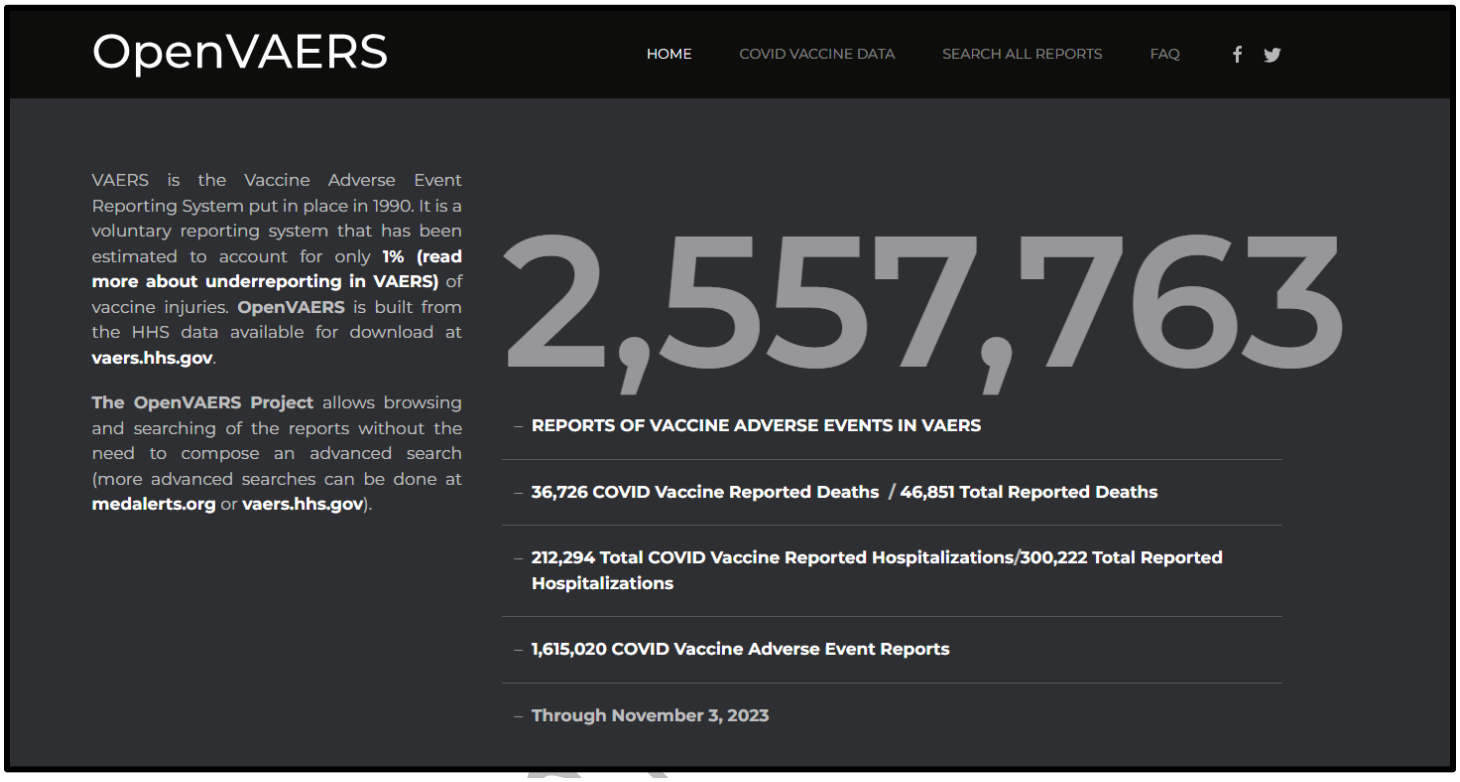


Figure 20. OpenVAERS Landing Page

This page is loaded with analyses on adverse effects, including deaths. The navigation bar at the top leads to detailed data as well. All analyses are based on VAERS.

- **COVID Vaccine Data** has many functions and kinds of reports
- **Search All Reports** is not specific to Covid-19, but you can build a query to select the reports you want, which can be downloaded.

4.4.2.5 The VAERSANALYSIS.info Web Site

A better website is https://vaersanalysis.info. It was privately developed. This analytical tool performs pre-processing on the data, so that sophisticated summary charts, updated weekly, are available. A portion of the Home page on January 22, 2023 looks like this:

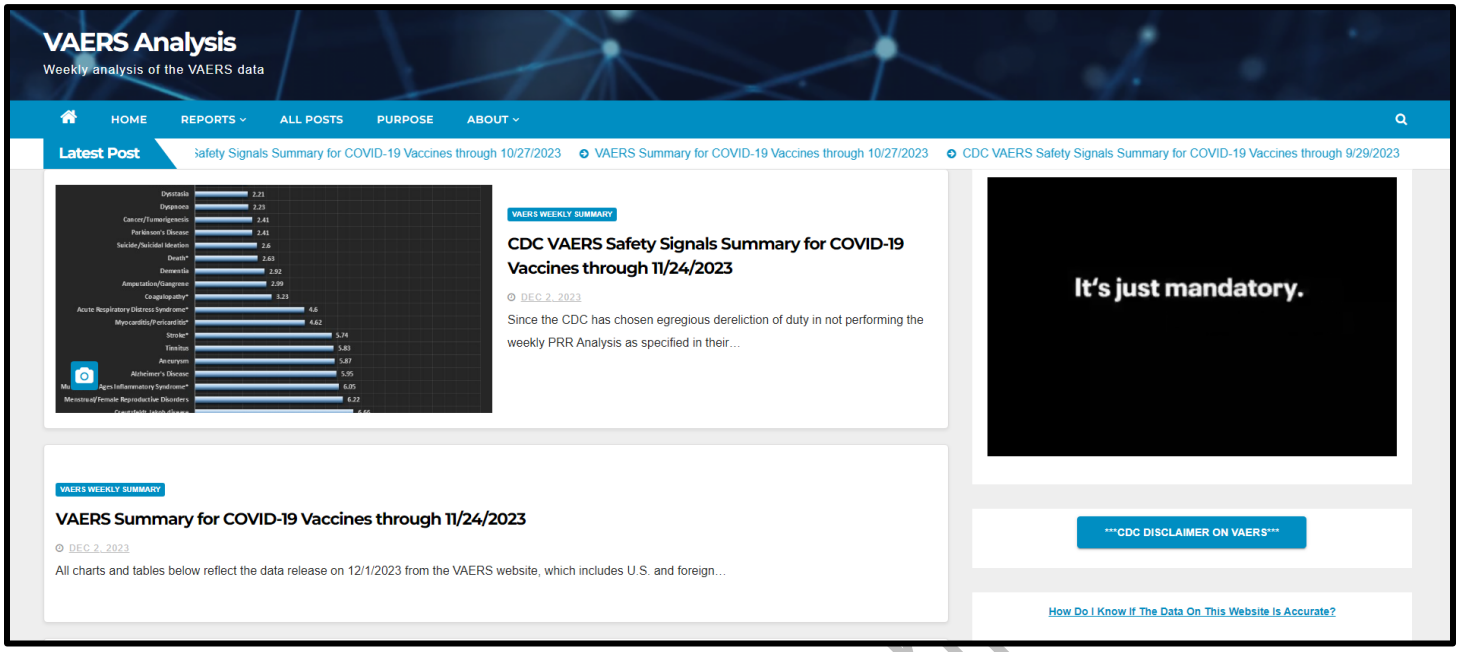


Figure 21. The VAERSAnalysis.info landing page

This landing page is long, with a time series of charts of safety signals by adverse event. The navigation header leads to important analyses. For example:

All charts and tables below reflect the data release on 12/1/2023 from the VAERS website, which includes U.S. and foreign data, and is updated through: **11/24/2023**

High-Level Summary	COVID19 vaccines (Dec'2020 – present)	All other vaccines 1990-present	US Data Only COVID19 vaccines (Dec'2020 – present)	US Data Only All other vaccines 1990-present
Number of Adverse Reactions	1,615,020	961,512	999,289	832,468
Number of Life-Threatening Events	38,959	15,499	14,849	10,447
Number of Hospitalizations	212,294	90,524	88,524	41,285
Number of Deaths	36,726*	10,551*	18,406	5,657
# of Permanent Disabilities after vaccination	68,819	22,592	17,655	13,875
Number of Office Visits	240,624	63,909	197,366	60,847
# of Emergency Room/Department Visits	153,281	218,887	117,846	208,690
# of Birth Defects after vaccination	1,300	229	603	122

***Note that the total number of deaths associated with the COVID-19 vaccines is more than TRIPLE the number of deaths associated with all other vaccines combined since the year 1990.**

Figure 22. VAERS data on severity of adverse events from VAERSanalysis.info

and

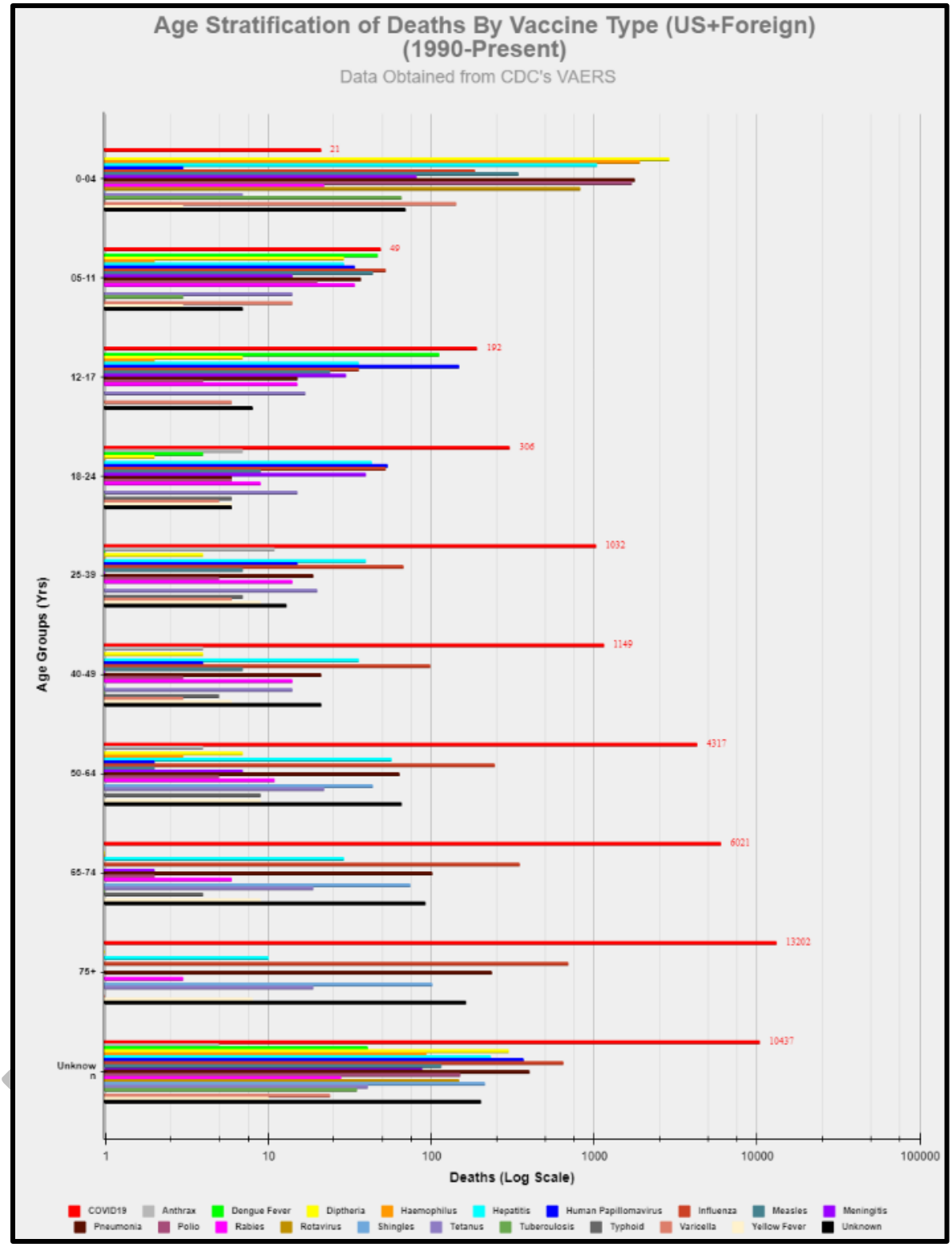


Figure 23. VAERSAnalysis.info Age Stratification of Deaths by Vaccine Type (1990-present)

This graph should be making news around the world. Even though it is just VAERS, it reveals the incredible impact the vaccine has had on the younger populations. Two notes:

1. The x-axis is a log scale, not a linear scale!
2. The death data for all but the Covid-19 entry is over 34 years; the Covid-19 data is over 4 years.

4.4.2.6 MedAlerts.org

MedAlerts.org provides sophisticated search of the VAERS database. The landing page is:

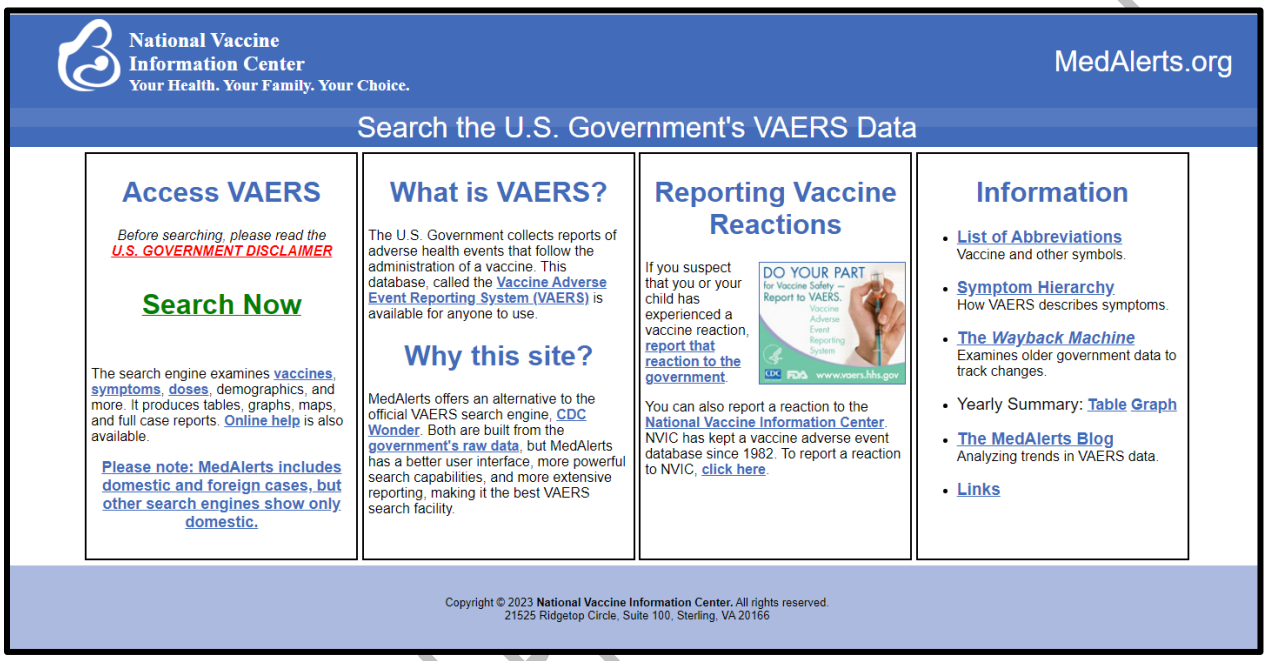
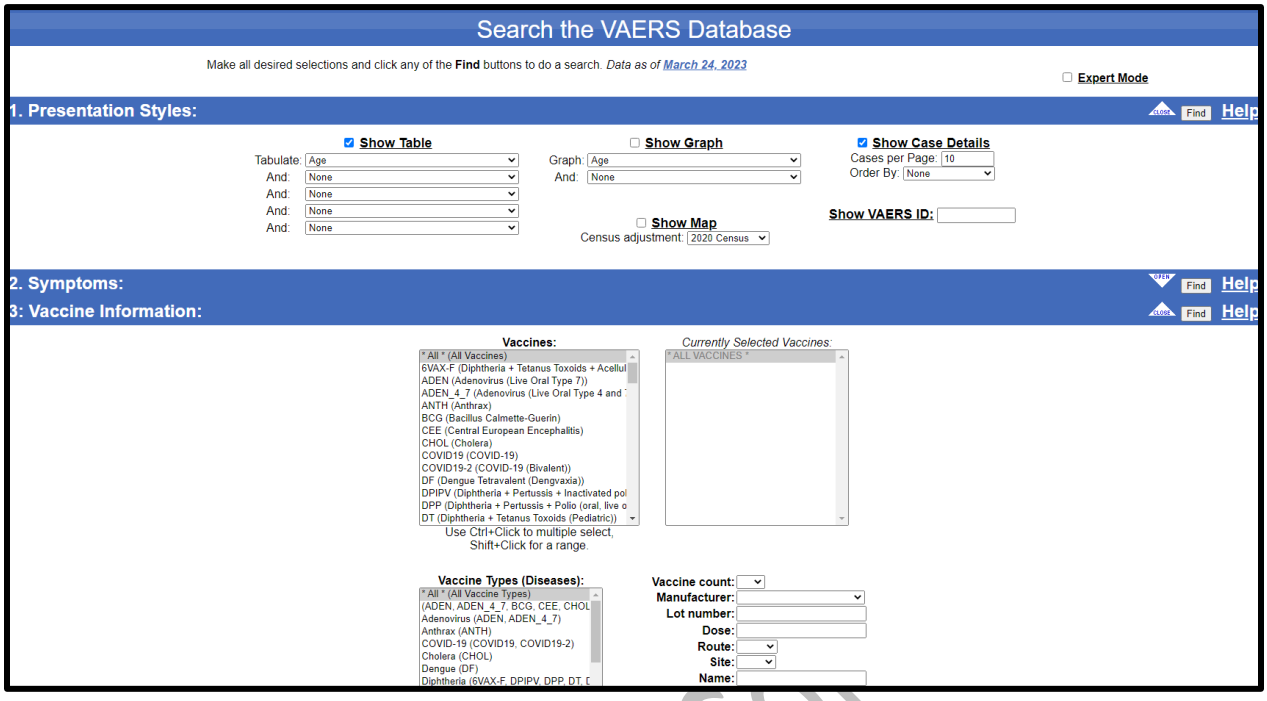


Figure 24. MedAlerts.org landing page

This is the VAERS Search Page:



It is a powerful interface. Lot number is an important field for quality studies.

MedAlerts has a unique feature: It has a database of every release of every change in VAERS from its beginning. Access is through the link “The Wayback Machine” in the Information column. The landing page for The Wayback Machine looks like this:

You can see from the picture that it provides the following functions:

- For the same case, compare the differences between entries at two different dates.
- Find cases added or removed between two different dates
- Search an older release of VAERS than the one currently available.

4.4.2.7 VAERSAware.com

VAERSAware.com the go-to website for the most accurate evaluation of Covid-19 data analysis available. It's data sources are primarily VAERS, but other sources are used as well. The landing page has a lot on it. The top is:

Figure 25. The top of the VAERSAware.com landing page

The WelcomeTheEagle and the substack entries refer to the related substack, where detailed explanations and discussions of the author's findings can be found.

The number of analyses is huge. Both the Notes and the Archive links in the navigation lead to them. An important feature of the analyses is the length the author goes to "repair" the data being analyzed. Two techniques at the top of the list are (1) to repair lot numbers, since the same lot can go by different names depending on fat fingering and conventions used by different reporting mechanisms, and (2) to extract data that properly belong in fields of the database but that are only available in the database's comments section.

As an example of the care the author takes is the following analysis:

Expert Level Critique About VAERS Dosing Analysis

The most complicated of all VAERS Analysis

Nov 24, 2023

There is a big difference between a "dose series" versus "dose units" which means a pretty dynamic algorithm script needs to be created and applied to properly calculate the doses administered for each report. Here is the general absolute counts of doses administered:

From the 10/27/2023 release of VAERS data:

Found 1,605,764 cases where Vaccine is COVID19 or COVID19-2

Government Disclaimer on use of this data

Vaccine Dose	Count	Percent
1	635,836	39.6%
2	514,409	32.04%
3	194,566	12.12%
4	46,994	2.93%
5	16,664	1.04%
6	1,737	0.11%
7+	545	0.03%
N/A	5,840	0.36%
UNK	278,378	17.34%
TOTAL	† 1,694,969	† 105.56%

† Because VAERS cases can have multiple vaccinations, symptoms, and event outcomes, a single case can account for multiple entries in this table. This is why the Total Count is greater than 1,605,764 (the number of cases found), and the Total Percent is greater than 100.

Could I say as an example, that 46,994 people received a "4th dose"? Could I also think of this as 46,994 x 4= 187,976 syringes were used? *That sound very reasonable but not exactly true.*

Let's take a look at summaries by dose:

From the 10/27/2023 release of VAERS data:

Found 631,818 cases where Vaccine is COVID19 or COVID19-2 and Vaccine Dose is '1'

Government Disclaimer on use of this data

Table

Vaccine Dose	Count	Percent
1	635,836	100.64%
2	39,561	6.26%
3	9,368	1.48%
4	2,343	0.37%
5	1,329	0.21%
6	65	0.01%
7+	24	0%
N/A	357	0.06%
UNK	4,891	0.77%
TOTAL	† 693,774	† 109.81%

† Because VAERS cases can have multiple vaccinations, symptoms, and event outcomes, a single case can account for multiple entries in this table. This is why the Total Count is greater than 631,818 (the number of cases found), and the Total Percent is greater than 100.

From the 10/27/2023 release of VAERS data:

Found 513,387 cases where Vaccine is COVID19 or COVID19-2 and Vaccine Dose is '2'

Government Disclaimer on use of this data

Table

Vaccine Dose	Count	Percent
1	39,743	7.74%
2	514,409	100.2%
3	10,826	2.11%
4	1,743	0.34%
5	375	0.07%
6	29	0.01%
7+	7	0%
N/A	153	0.03%
UNK	3,149	0.61%
TOTAL	† 570,434	† 111.11%

† Because VAERS cases can have multiple vaccinations, symptoms, and event outcomes, a single case can account for multiple entries in this table. This is why the Total Count is greater than 513,387 (the number of cases found), and the Total Percent is greater than 100.

From the 10/27/2023 release of VAERS data:

Found 194,237 cases where Vaccine is COVID19 or COVID19-2 and Vaccine Dose is '3'

Government Disclaimer on use of this data

Table

Vaccine Dose	Count	Percent
1	9,394	4.84%
2	10,841	5.58%
3	194,566	100.17%
4	3,336	1.72%
5	389	0.2%
6	23	0.01%
7+	22	0.01%
N/A	396	0.2%
UNK	2,590	1.33%
TOTAL	† 221,556	† 114.06%

† Because VAERS cases can have multiple vaccinations, symptoms, and event outcomes, a single case can account for multiple entries in this table. This is why the Total Count is greater than 194,237 (the number of cases found), and the Total Percent is greater than 100.

From the 10/27/2023 release of VAERS data:

Found 46,917 cases where Vaccine is COVID19 or COVID19-2 and Vaccine Dose is '4'

Government Disclaimer on use of this data

Table

Vaccine Dose	Count	Percent
1	2,413	5.14%
2	1,748	3.73%
3	3,331	7.1%
4	46,994	100.16%
5	1,149	2.45%
6	31	0.07%
7+	22	0.05%
N/A	365	0.78%
UNK	879	1.87%
TOTAL	† 56,932	† 121.35%

† Because VAERS cases can have multiple vaccinations, symptoms, and event outcomes, a single case can account for multiple entries in this table. This is why the Total Count is greater than 46,917 (the number of cases found), and the Total Percent is greater than 100.

From the 10/27/2023 release of VAERS data:

Found 16,643 cases where Vaccine is COVID19 or COVID19-2 and Vaccine Dose is '5'

Government Disclaimer on use of this data

Table

Vaccine Dose	Count	Percent
1	1,374	8.26%
2	389	2.34%
3	387	2.33%
4	1,148	6.9%
5	16,664	100.13%
6	130	0.78%
7+	21	0.13%
N/A	304	1.83%
UNK	522	3.14%
TOTAL	† 20,939	† 125.81%

† Because VAERS cases can have multiple vaccinations, symptoms, and event outcomes, a single case can account for multiple entries in this table. This is why the Total Count is greater than 16,643 (the number of cases found), and the Total Percent is greater than 100.

From the 10/27/2023 release of VAERS data:

Found 1,734 cases where Vaccine is COVID19 or COVID19-2 and Vaccine Dose is '6'

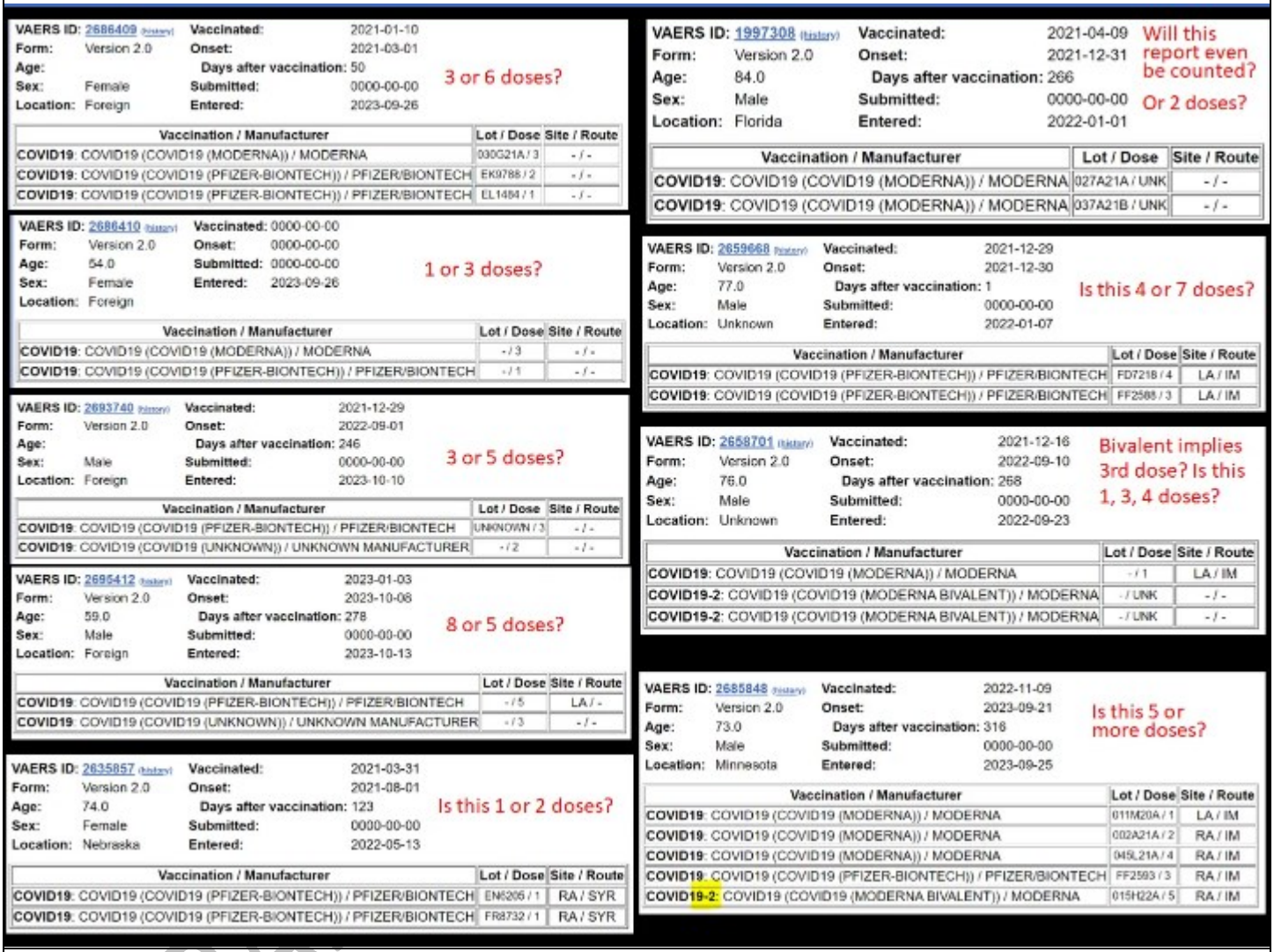
Government Disclaimer on use of this data

Table

Vaccine Dose	Count	Percent
1	80	4.61%
2	29	1.67%
3	23	1.33%
4	31	1.79%
5	130	7.5%
6	1,737	100.17%
7+	7	0.4%
N/A	13	0.75%
UNK	38	2.19%
TOTAL	† 2,088	† 120.42%

† Because VAERS cases can have multiple vaccinations, symptoms, and event outcomes, a single case can account for multiple entries in this table. This is why the Total Count is greater than 1,734 (the number of cases found), and the Total Percent is greater than 100.

Using this 5th dose summary as an example, you can see there are 16,643 people (cases) that had a 5th dose, and there were also a few of these same people that received a 6th & 7th dose. There looks to be at least a few thousand reports that also have an extra line item indicating 1,2,3, and 4 doses as well. There is actually ~21 records that have 5units twice, as in two line items with 5 doses apiece. Let's drill in a little further an look at some actual reports and the dosing combinations used:



VAERS ID: 2686409 (history) Vaccinated: 2021-01-10
Form: Version 2.0 Onset: 2021-03-01
Age: Days after vaccination: 50
Sex: Female Submitted: 0000-00-00
Location: Foreign Entered: 2023-09-26

3 or 6 doses?

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	030G21A / 3	- / -
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	EK9788 / 2	- / -
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	EL1484 / 1	- / -

VAERS ID: 2686410 (history) Vaccinated: 0000-00-00
Form: Version 2.0 Onset: 0000-00-00
Age: 54.0 Submitted: 0000-00-00
Sex: Female Entered: 2023-09-26
Location: Foreign

1 or 3 doses?

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	- / 3	- / -
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	- / 1	- / -

VAERS ID: 2693740 (history) Vaccinated: 2021-12-29
Form: Version 2.0 Onset: 2022-09-01
Age: Days after vaccination: 246
Sex: Male Submitted: 0000-00-00
Location: Foreign Entered: 2023-10-10

3 or 5 doses?

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	UNKNOWN / 3	- / -
COVID19: COVID19 (COVID19 (UNKNOWN)) / UNKNOWN MANUFACTURER	- / 2	- / -

VAERS ID: 2695412 (history) Vaccinated: 2023-01-03
Form: Version 2.0 Onset: 2023-10-06
Age: 59.0 Days after vaccination: 278
Sex: Male Submitted: 0000-00-00
Location: Foreign Entered: 2023-10-13

8 or 5 doses?

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	- / 5	LA / -
COVID19: COVID19 (COVID19 (UNKNOWN)) / UNKNOWN MANUFACTURER	- / 3	- / -

VAERS ID: 2635857 (history) Vaccinated: 2021-03-31
Form: Version 2.0 Onset: 2021-08-01
Age: 74.0 Days after vaccination: 123
Sex: Female Submitted: 0000-00-00
Location: Nebraska Entered: 2022-05-13

Is this 1 or 2 doses?

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	EN6206 / 1	RA / SYR
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	FR8732 / 1	RA / SYR

VAERS ID: 1997308 (history) Vaccinated: 2021-04-09
Form: Version 2.0 Onset: 2021-12-31
Age: 84.0 Days after vaccination: 266
Sex: Male Submitted: 0000-00-00
Location: Florida Entered: 2022-01-01

Will this report even be counted?
Or 2 doses?

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	027A21A / UNK	- / -
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	037A21B / UNK	- / -

VAERS ID: 2659668 (history) Vaccinated: 2021-12-29
Form: Version 2.0 Onset: 2021-12-30
Age: 77.0 Days after vaccination: 1
Sex: Male Submitted: 0000-00-00
Location: Unknown Entered: 2022-01-07

Is this 4 or 7 doses?

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	FD7218 / 4	LA / IM
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	FF2588 / 3	LA / IM

VAERS ID: 2658701 (history) Vaccinated: 2021-12-16
Form: Version 2.0 Onset: 2022-09-10
Age: 76.0 Days after vaccination: 268
Sex: Male Submitted: 0000-00-00
Location: Unknown Entered: 2022-09-23

Bivalent implies 3rd dose? Is this 1, 3, 4 doses?

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	- / 1	LA / IM
COVID19-2: COVID19 (COVID19 (MODERNA BIVALENT)) / MODERNA	- / UNK	- / -
COVID19-2: COVID19 (COVID19 (MODERNA BIVALENT)) / MODERNA	- / UNK	- / -

VAERS ID: 2685848 (history) Vaccinated: 2022-11-09
Form: Version 2.0 Onset: 2023-09-21
Age: 73.0 Days after vaccination: 316
Sex: Male Submitted: 0000-00-00
Location: Minnesota Entered: 2023-09-25

Is this 5 or more doses?

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	011M20A / 1	LA / IM
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	002A21A / 2	RA / IM
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	045L21A / 4	RA / IM
COVID19: COVID19 (COVID19 (PFIZER-BIONTECH)) / PFIZER/BIONTECH	FF2593 / 3	RA / IM
COVID19-2: COVID19 (COVID19 (MODERNA BIVALENT)) / MODERNA	015H22A / 5	RA / IM

OMG! talk about adding some layers of complexity, is a bivalent considered a booster or the 3rd dose? How do we treat UNK units? Do we at least treat UNK dose as a single dose? The answer is maybe and sometimes… There is actually quite a bit of UNK units.:

From the 10/27/2023 release of VAERS data:

Found 266,284 cases where Vaccine is COVID19 or COVID19-2 and Vaccine Dose is 'UNK'

Government Disclaimer on use of this data

Table

Vaccine Dose	Count	Percent
1	4,435	1.67%
2	2,784	1.05%
3	2,294	0.86%
4	793	0.3%
5	500	0.19%
6	35	0.01%
7+	11	0%
N/A	150	0.06%
UNK	278,378	104.54%
TOTAL	† 289,380	† 108.67%

† Because VAERS cases can have multiple vaccinations, symptoms, and event outcomes, a single case can account for multiple entries in this table. This is why the Total Count is greater than 266,284 (the number of cases found), and the Total Percent is greater than 100.

VAERS ID: 2658682 (history) **Vaccinated:** 2022-06-01
Form: Version 2.0 **Onset:** 2022-08-19
Age: 81.0 **Days after vaccination:** 79
Sex: Male **Submitted:** 0000-00-00
Location: Unknown **Entered:** 2022-09-23

Vaccination / Manufacturer	Lot / Dose	Site / Route
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	- / 1	LA / IM
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	- / UNK	- / -
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	- / UNK	- / -
COVID19: COVID19 (COVID19 (MODERNA)) / MODERNA	- / UNK	- / -

Administered by: Other **Purchased by:** ?
Symptoms: COVID-19, Decreased appetite, Fall, Muscle spasms, Muscular weakness, Myopathy, Pain, SARS-CoV-2 test positive
SMQs:, Rhabdomyolysis/myopathy (narrow), Peripheral neuropathy (broad), Dystonia (broad), Guillain-Barre syndrome (broad), Noninfectious encephalopathy/delirium (broad), Accidents and injuries (narrow), Drug reaction with eosinophilia and systemic symptoms syndrome (broad), Infective pneumonia (broad), Opportunistic infections (broad), COVID-19 (narrow)
Life Threatening? No
Birth Defect? No
Died? No
Permanent Disability? No
Recovered? No
Office Visit? Yes
ER Visit? No
ER or Doctor Visit? Yes
Hospitalized? Yes, ? days
Extended hospital stay? No
Previous Vaccinations:
Other Medications:
Current Illness:
Preexisting Conditions:
Allergies:
Diagnostic Lab Data:
CDC Split Type:
Write-up: Narrative: Facility-COVID +, Moderna #4, leg weakness, pain, fall, leg cramps, dec appetite, no treatment for covid, asymptomatic, myopathy, statin d/c

Can you start to see how badly your analysis can be led astray if one does not use any dynamic logic to get more appropriate counts?

If anybody has noticed I have never done a "dose" analysis myself because I know it would be a big pain in the ass to do one properly, and it would have to be a one off, because I myself do not have a dynamic algorithm to rely upon. No doubt in my mind IT CAN BE DONE! No doubt in my mind CDC could spit out a extra column of data with a summated dynamic count per report. It's one of those things I look forward to in the evolution of a real pharmacovigilance tool. Hopefully done by me or some other person down the road if we insist on marching down the road with these de-pop jabs.

The next time you see someone's analysis by dose, be sure to ask her what kind of algorithm are you using? Don't even mention the 30% of UNKNOWN AGES. Needless to say when actually reading thousands of reports the victim is indicating they were one their 2nd, 3rd, 4th dose, etc. but only record it as 1 aka a single dose! God Bless
Ahh Pooter! ;(

From the 10/27/2023 release of VAERS data:

Found 1,605,764 cases where Vaccine is COVID19 or COVID19-2

Government Disclaimer on use of this data

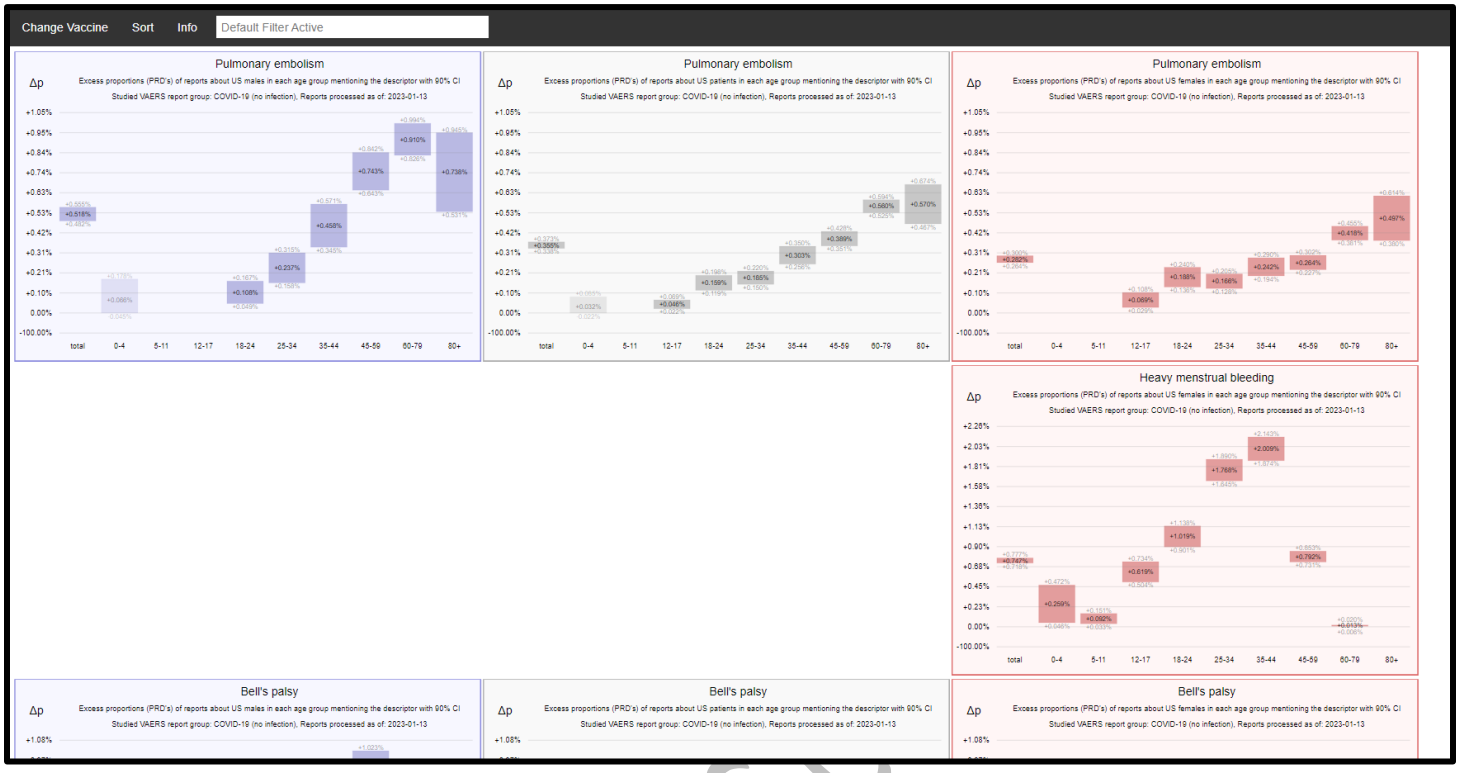
Table

Age	Count	Percent
< 6 Months	251	0.02%
6-11 Months	1,207	0.08%
1-2 Years	2,110	0.13%
3-5 Years	5,441	0.34%
6-17 Years	59,675	3.72%
18-29 Years	130,858	8.15%
30-39 Years	176,745	11.01%
40-49 Years	179,032	11.15%
50-59 Years	189,460	11.8%
60-64 Years	91,893	5.72%
65-79 Years	222,122	13.83%
80+ Years	67,673	4.21%
Unknown	479,297	29.85%
TOTAL	1,605,764	100%

Figure 26. An example analysis from VAERSAware.com

4.4.2.8 PerVAERS.com

This is an exceptional analytical site for safety analysis. The landing page defaults to a specialized safety analysis of VAERS data in chart form. It is very, very long, so here is just the top of the page:



The detail is incredible. This page lists all the safety signals contained in VAERS by MedDRA nomenclature.

The navigation bar across the top contains access to both objects and methods available in the database:

- The “Change Vaccine” option provides a list of all kinds of selections for the target vaccine. This is the top of the list:

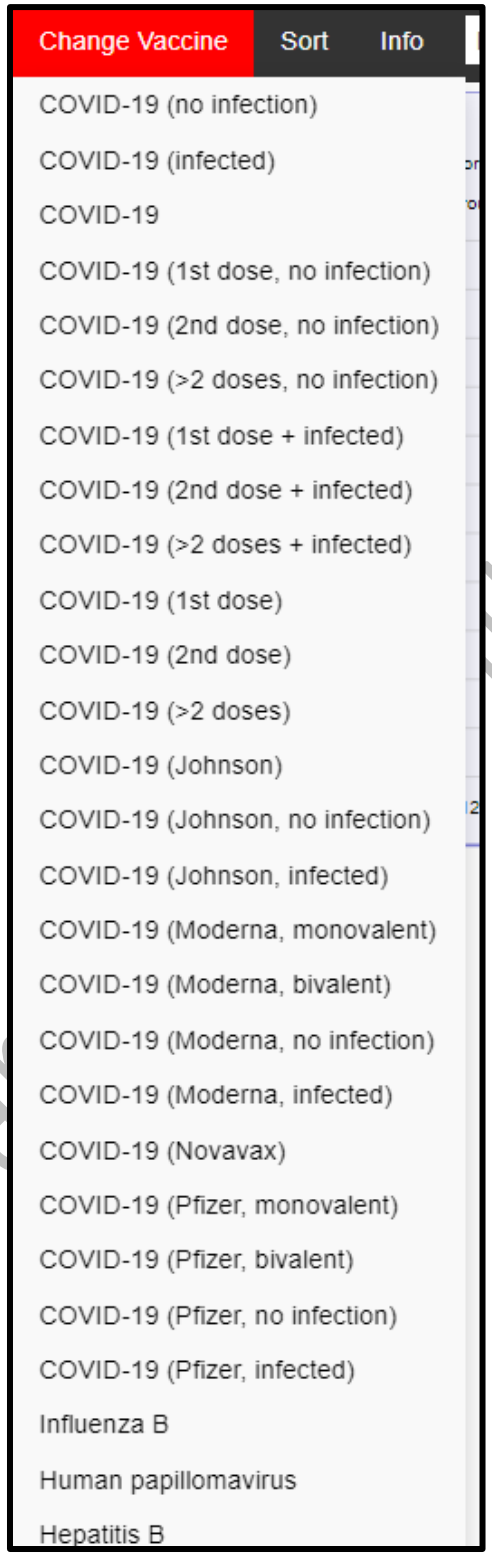


Figure 27. PerVAERS list of vaccines-sample

Depending on the selection, the analysis will be a safety signal or an “ineffective metric.” Incredible data!

The “Sort” option has these selections:

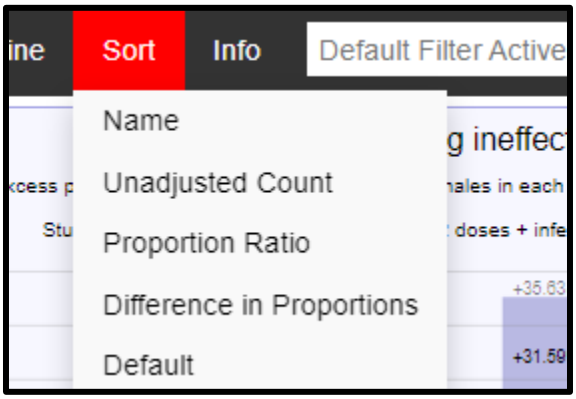


Figure 28. PerVAERS web site Sort options

The “Info” option provides documentation of the methodologies used for the various analyses.

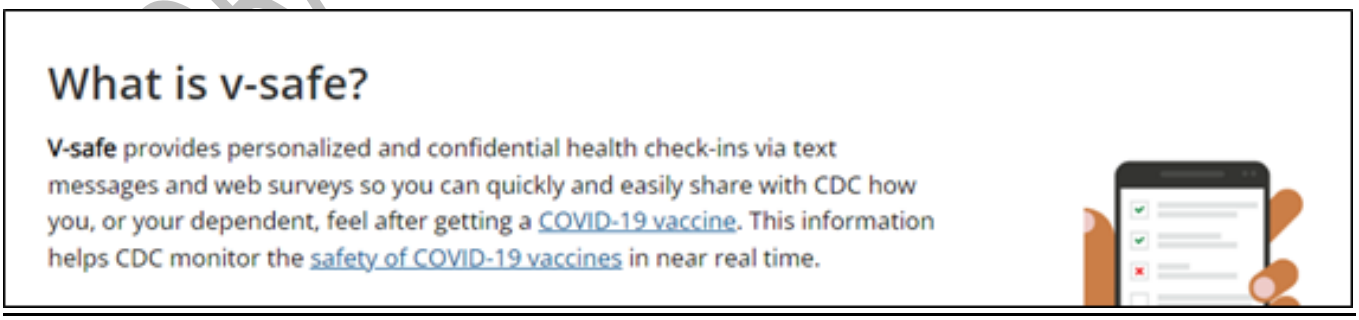
4.5 V-Safe

V-Safe is a CDC program where people who get the SHOT can sign up to be monitored on a periodic basis. Software, an app, is provided that sends users text messages and web surveys to facilitate reporting side effects.

The V-Safe Data is located here: https://data.cdc.gov/Public-Health-Surveillance/v-safe-COVID-19/dqgu-gg5d. You have to download the large 5G zip file. They are all .csv files, but they are huge. The contents of V-Safe is discussed in Section **Error! Reference source not found.**.

At this point an article on V-Safe is appropriate: [6]

> *v-safe is a smartphone-based program rolled out by the CDC alongside the first authorized Covid-19 vaccine in December 2020. Both FDA and CDC love to make claims based on v-safe, including that “Covid-19 vaccines are monitored by the most intense safety monitoring efforts in US history.” V-safe was designed and released specifically to track health impacts following Covid vaccination by asking users to complete health check-ins.*
>
> *As the CDC puts it:*



> *After an individual has registered for v-safe, he or she is asked to complete a health “check-in” the day they receive a Covid vaccine. These “check-ins” prompt users to answer questions about their health,*

most of which contain pre-populated answers to choose from. The program also includes a handful of free-text fields where users can provide a limited amount of "other" information without being limited by check-the-box responses.

Users are prompted to submit a "check-in" every day for a week after a shot. Users are then prompted to submit a "check-in" every week for six weeks. And then at six months and one year after the shot. This is the same process following every dose or booster. A user cannot submit data retroactively.

Here are screenshots of what a daily check-in would look like for the first seven days after vaccination (days 0-7):

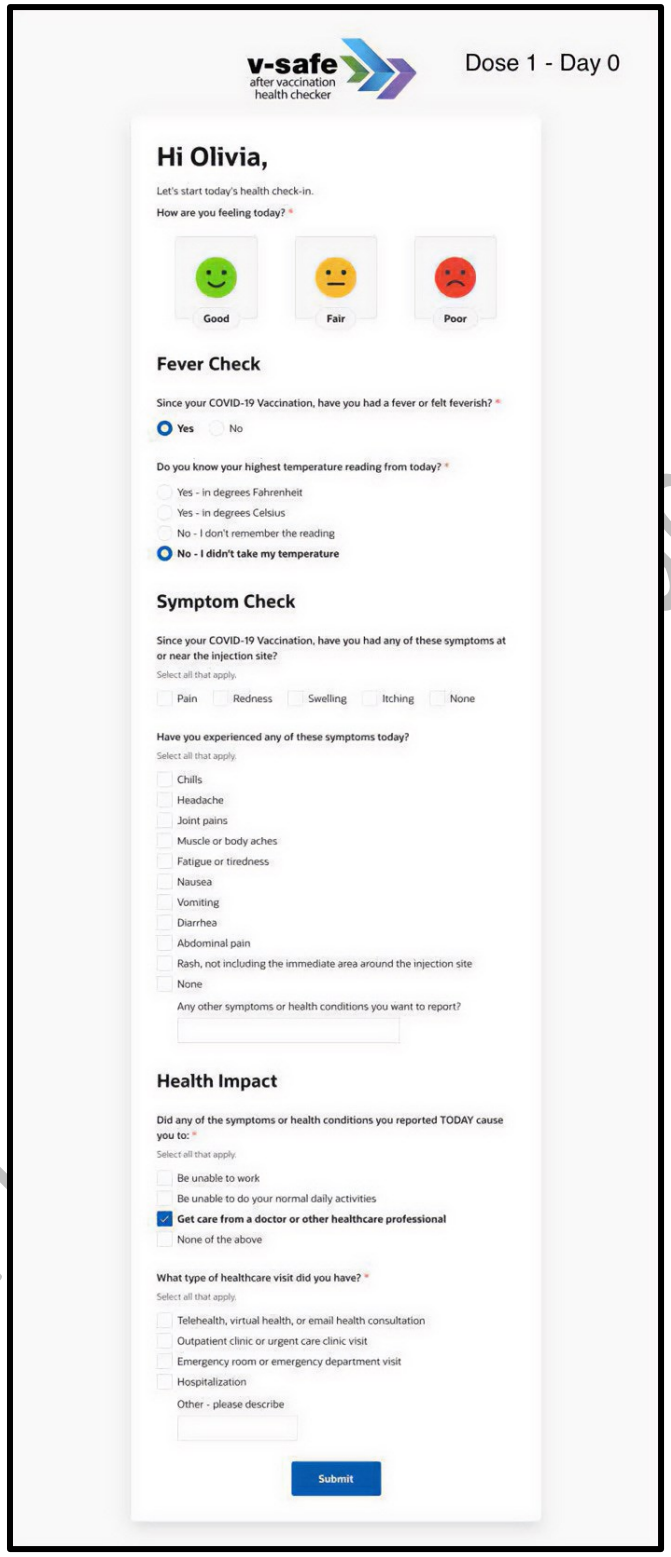


Figure 29. V-Safe Day 0 Questionnaire screen shot

The next 7 days Questionnaire on the app:

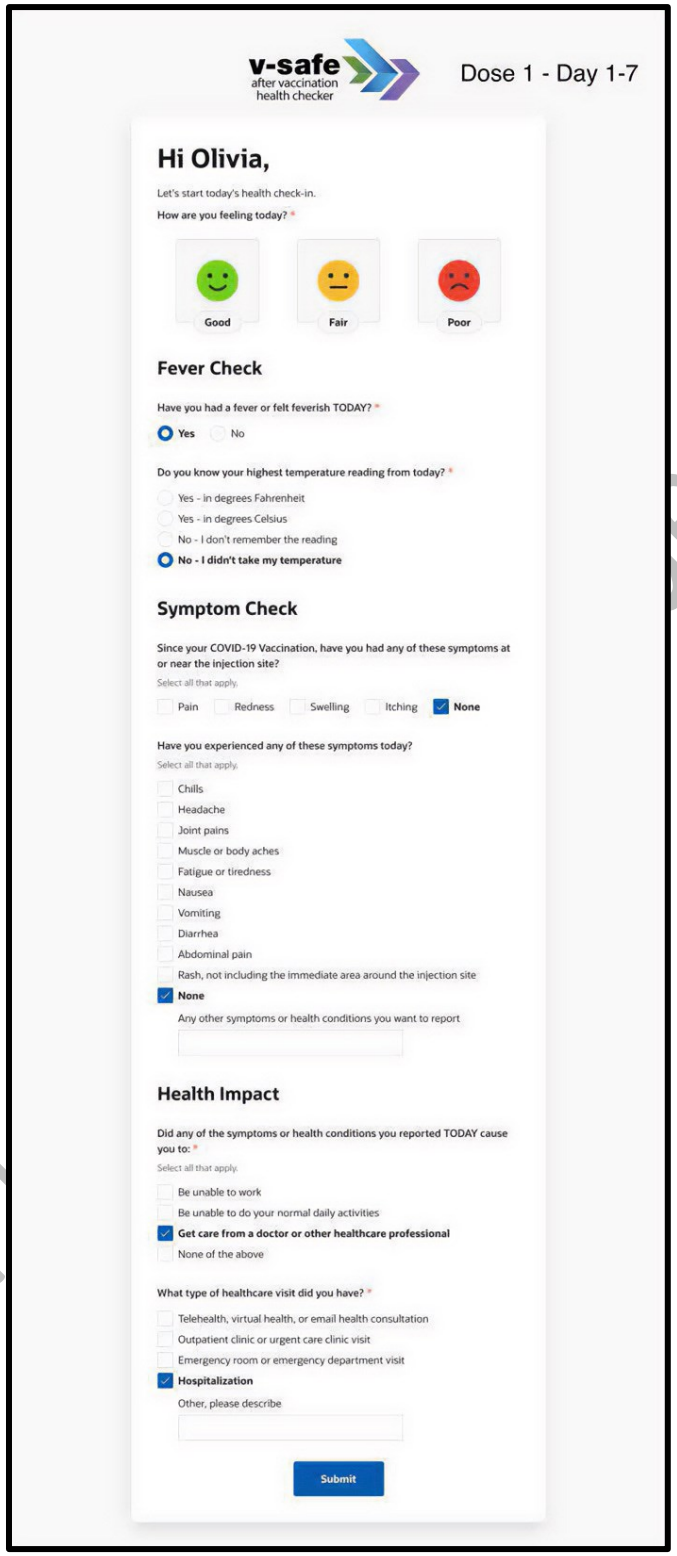


Figure 30. V-Safe Day 1-7 Questionnaire

The above reflects the information that is collected in the first seven days post-vaccination. Then, once a week for the next six weeks, users are prompted to complete check-ins like the following:

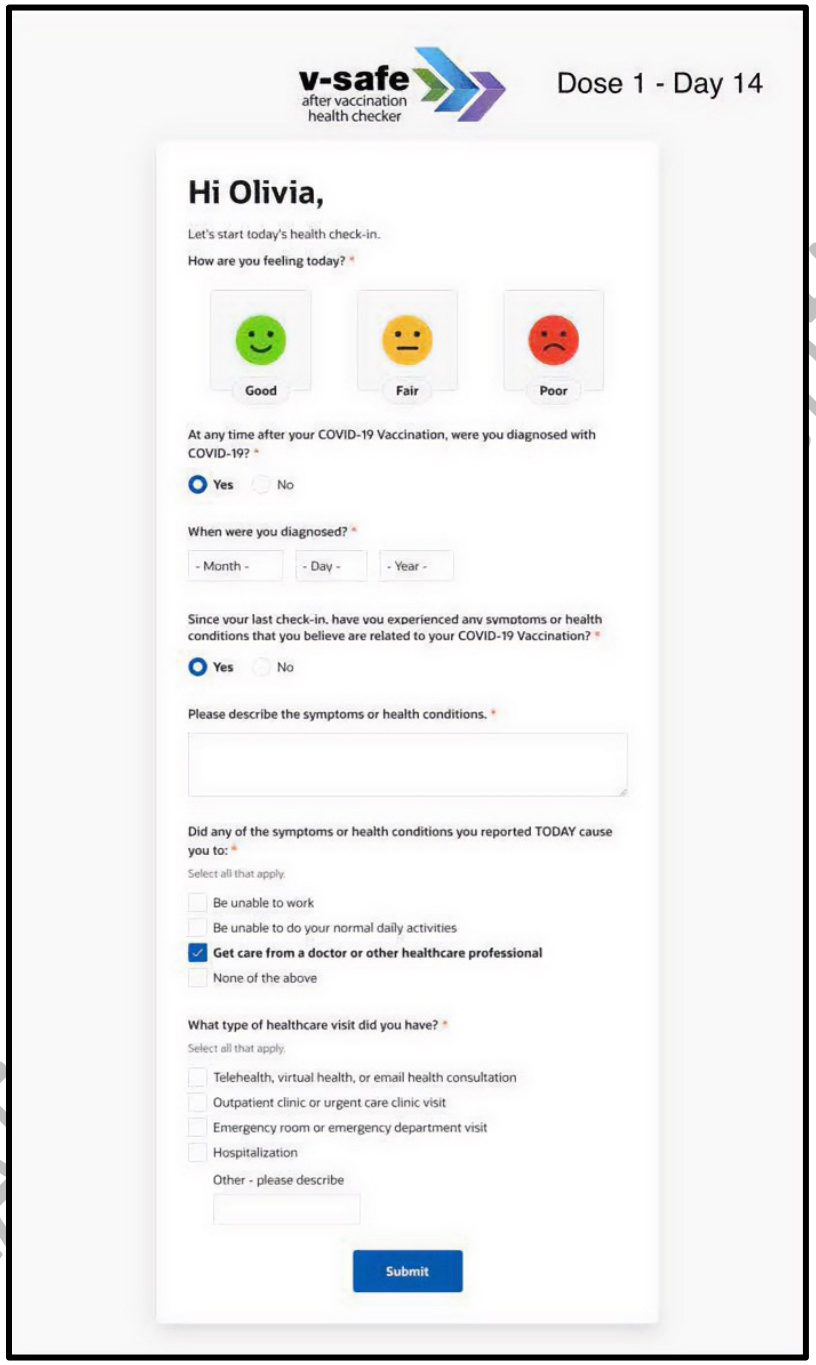


Figure 31. V-Safe, the Questionnaire on the app for the next six weeks

As you can see, v-safe only collected certain limited, pre-selected information in a systematic fashion. For the first seven days after a shot, it asked users to check one or more of the following symptoms:

- *chills*
- *headache*
- *joint pain*
- *muscle or body aches*
- *fatigue or tiredness*
- *nausea*
- *vomiting*
- *diarrhea*
- *abdominal pain*
- *rash*

During these first seven days, and then once a week for six weeks, and then at six months and one year, it asked users to pick, if applicable, one or more of the following three "health impacts:"

- *unable to perform normally daily activities*
- *missed work/school*
- *needed medical care*

Finally, if a user selected that he or she needed medical care, v-safe would ask the user to select one or more of these options:

- *hospitalization*
- *emergency room*
- *urgent care*
- *telehealth*

That is most of the safety information, other than the free text fields, that v-safe collected.

Precisely what v-safe data did the CDC produce?

So, precisely what v-safe health data did the CDC produce to ICAN? The data produced to date consists of responses to the check-the-box fields in the screenshots above. It is worth reviewing the relevant screenshots again so you can see the health information that was gathered and provided to ICAN, keeping in mind that only the responses to the check-the box questions (not the free-text questions) have been provided thus far. It is important to understand what was (and what was not) captured by v-safe as we continue to break down the v-safe saga.

You may also enjoy watching the CDC's 30 second promotional video about v-safe:

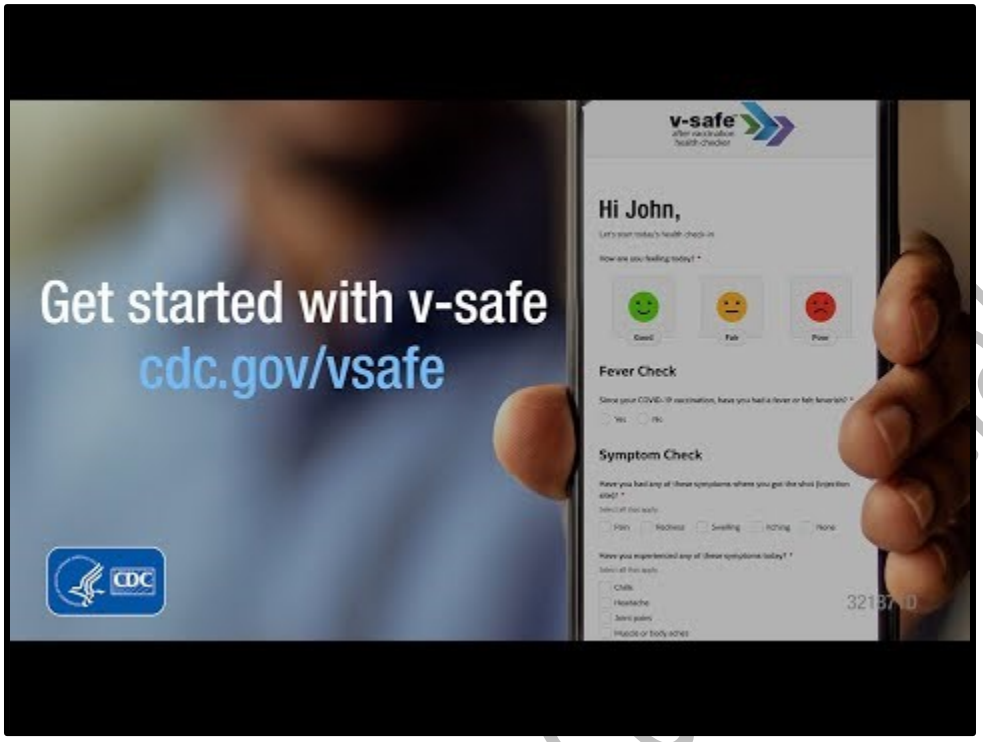


Figure 32. V-Safe, CDC 30 Second Video on YouTube

How did the CDC decide to ask for only the above information?

A simple review of the information requested in the health check-ins may leave you wondering why some obvious symptoms and adverse events you would expect v-safe to collect are not being collected – like chest pain or any other cardiac symptoms. You may ask how the CDC determined what to ask v-safe users. And that is a great question. First, let's remind ourselves what was known about potential adverse events before any Covid-19 vaccine was administered to the general public:

- *A July 2020 New England Journal of Medicine study titled "An mRNA Vaccine against SARS-Cov-2 – Preliminary Report" highlighted 35 adverse events that were related to the mRNA vaccination, including* ***eye disorders, gastrointestinal disorders, musculoskeletal and connective tissue disorders,*** *and* ***nervous system disorders****.*
- *An October 16, 2020 JAMA article titled "Postapproval Vaccine Safety Surveillance for COVID-19 Vaccines in the US" stated that "AESIs [Adverse Events of Special Interest] are likely to include* ***allergic, inflammatory, and immune-mediated reactions, such as anaphylaxis, Guillain-Barré syndrome, transverse myelitis, myocarditis/pericarditis, vaccine-associated enhanced respiratory disease,*** *and* ***multisystem inflammatory syndrome in children****."*
- *In a CDC presentation dated October 30, 2020, titled "CDC post-authorization/post-licensure safety monitoring of COVID-19 vaccines," a preliminary "list of VSD pre-specified outcomes for RCA [rapid cycle analysis]" and "list of VAERS AEs[adverse events] of special interest" both included* ***acute myocardial infarction, anaphylaxis, convulsions/seizures, encephalitis, Guillain-Barre syndrome, immune thrombocytopenia, MIS-C, myocarditis/pericarditis,*** *and* ***transverse myelitis****, among others.*

Again, the fact that mRNA can cause these serious conditions was raised before the first Covid-19 vaccine was authorized for use by the general public in December 2020 – in fact, months before.

Reflecting the concern that mRNA vaccines can cause these serious conditions, the CDC's own protocol for v-safe, at least as early as January 28, 2021 (we are, on behalf of ICAN, working to get earlier versions), identified "Adverse Events of Special Interest" which it placed in a chart entitled "Prespecified Medial Conditions." This included 15 serious conditions of special interest to track after Covid vaccination. Here is the relevant excerpt from the CDC's v-safe protocol:

v-safe protocol: Jan 28, 2021, version 2

Attachment 2: Adverse Events of Special Interest

Prespecified Medical Conditions
Acute myocardial infarction
Anaphylaxis
Coagulopathy
COVID-19 Disease
Death*
Guillain-Barré syndrome
Kawasaki disease
Multisystem Inflammatory Syndrome in children[1]
Multisystem Inflammatory Syndrome in adults[2]
Myocarditis/Pericarditis
Narcolepsy/Cataplexy
Pregnancy and Prespecified Conditions
Seizures/Convulsions
Stroke
Transverse Myelitis

* Capture of deaths through v-safe will be limited.

Figure 33. V-Safe, CDC Protocol 2021

Again, this list was from the CDC's own protocol used to develop v-safe. And, as seen above, this list included, among other serious concerns, myocarditis, pericarditis, acute myocardial infarction, stroke, GBS, and transverse myelitis. Yet v-safe was launched without including any check-the-box fields for these conditions and v-safe was never subsequently updated to include any check-the-box fields for these conditions.

Evidence of Premeditation

It is often difficult to obtain evidence showing premeditated wrongful conduct. In this instance, the choice by the folks at the CDC to not include these adverse events of special interest, which studies prior to the launch of v-safe had already reflected could be caused by mRNA vaccine, and which the CDC itself identified in its v-safe protocol, may be one of the best and most compelling pieces of evidence supporting premediated conduct by the CDC.

The CDC could have taken advantage of this incredible opportunity – wherein v-safe was already capturing health data from over 10 million users – and easily included these conditions as check-the-box options for v-safe users. Then it would be easy to calculate a rate for which v-safe users had myocarditis. Had a stroke. Had seizures. Etc. Instead, the CDC purposely chose to limit reporting of any such adverse events to the free text fields knowing full well that, among other issues, users often do not fill out free-text fields, that any entries received would not be easily standardized, and that the CDC could otherwise more easily hide those entries from the public (as the CDC is currently doing by refusing to make the free-text field data public).

Reflecting that the CDC knew these serious adverse events were critical to track, and that the CDC sought to obfuscate reports of these harms, the CDC created an incredibly complex system to deal with text field reports of these conditions. If a v-safe user reported one of these conditions, someone at the CDC would have to agree that what was written in a free text field actually reflected one of these conditions, then someone from the CDC was supposed to reach out to the v-safe user by telephone (which, as discussed in a future part, often did not occur or occurred months or years later), and if the CDC ever actually reached out and thought the condition described was on the list, then the CDC employee could assist the user in completing a VAERS report. And then, once in VAERS, the CDC, as it does, would say that VAERS reports (i) cannot ever be used to show a vaccine causes a harm and (ii) cannot be used to determine a rate at which it may cause a harm because VAERS receives reports from an unknown population size. Meaning, the CDC says it doesn't know the denominator needed to calculate a rate using VAERS data.

But had the CDC simply had a check-the-box field in v-safe for each of these conditions, it would have had a denominator. It could simply divide the number of v-safe users reporting the condition by the total number of v-safe users. And boom, there it would be! The rate. Instead, the CDC knowingly, consciously, chose to not create check-the-box options for these serious adverse events, even though it had itself identified them as safety issues to track prior to the launch of v-safe.

And what check-the-box options did the CDC include in v-safe? For the first week, a list of conditions (such as arm pain, fever, fatigue, etc.) the CDC does not label as adverse events, but rather as reactogenicity (which the CDC couches as a good thing because it shows, according to the CDC, that the vaccine is working). Meaning, the first week reactogenicity data collected by v-safe is effectively useless for assessing any actual safety concerns.

The only other significant safety data v-safe collected was the "health impact" data of whether someone could not perform normal daily activities, missed school/work, or needed medical care. As discussed above, it collected this data during the first week but also weekly thereafter for 6 weeks, and then once at 6 months and finally at one year.

Presumably, the CDC determined that collecting this health impact data would provide enough information to determine whether the vaccine is "safe." It is, after all, called "v-safe." And this is effectively the only actual potentially useful systematic data it collected in v-safe! So, presumably when 7.7% of users reported needing medical care, and an additional 25% reported being unable to perform normal activities and/or missed school or work, that would have raised alarm bells. But I am jumping at few parts ahead – more on that later.

Mr. Siri continued his evaluation in a subsequent post [7]

If you received a Covid vaccine, you may have received this flyer:

Get vaccinated.
Get your smartphone.
Get started with v-safe.

What is v-safe?

V-safe provides personalized and confidential health check-ins via text messages and web surveys so you can quickly and easily share with CDC how you or your dependent feel after getting a COVID-19 vaccine. It takes just a few minutes to enroll and your participation in **v-safe** helps us monitor the safety of COVID-19 vaccines for everyone.

V-safe features:

- **Enroll your dependents** and complete check-ins on their behalf
- **Enter** and report how you feel after **first, second, additional, and booster doses**

How can I enroll and how does it work?

You can enroll in **v-safe** after any dose of COVID-19 vaccine by using your smartphone and going to vsafe.cdc.gov.

During the first week after each vaccination, **v-safe** will send you a text message each day to ask how you are feeling. After that, you will receive occasional check-ins, which you can opt out of at any time. Depending on your answers, someone from CDC may call to get more information. Your personal information in **v-safe** is protected so it's safe and private*.

How can I enroll my child or dependent?

You can enroll any family member (or friend) who is eligible to be vaccinated in **v-safe.** Children under 16 years old must be enrolled using a parent or guardian's **v-safe** account. You can add a dependent to your existing account or create a new account if you don't have one yet. Creating an account to enroll a dependent does not require that you enter your own vaccination information or complete health check-ins for yourself.

Need step-by-step instructions? Go to: www.cdc.gov/vsafe

*v-safe uses existing information systems managed by CDC, FDA, and other federal agencies. These systems use strict security measures to keep information confidential. These measures comply, where applicable, with the following federal laws, including the Privacy Act of 1974; standards enacted that are consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Federal Information Security Management Act, and the Freedom of Information Act.

v-safe
after vaccination health checker

Sign up with your smartphone's browser at vsafe.cdc.gov

OR

Aim your smartphone's camera at this code

Need help with *v-safe*?
Call 800-CDC-INFO (800-232-4636)
TTY 888-232-6348
Open 24 hours, 7 days a week
Visit www.cdc.gov/vsafe

CDC

CS324195-L 06/10/2022

Figure 34. V-Safe Flyer

or otherwise learned about v-safe from one of the CDC's carpet bomb literature and promotional advertisements encouraging people to get the shot and register for v-safe.

And, as noted, v-safe was open to anyone with a smartphone to register. So, let's analyze who the individuals were who were registering for v-safe.

Here is a chart breaking down the number of new v-safe registered users by month:

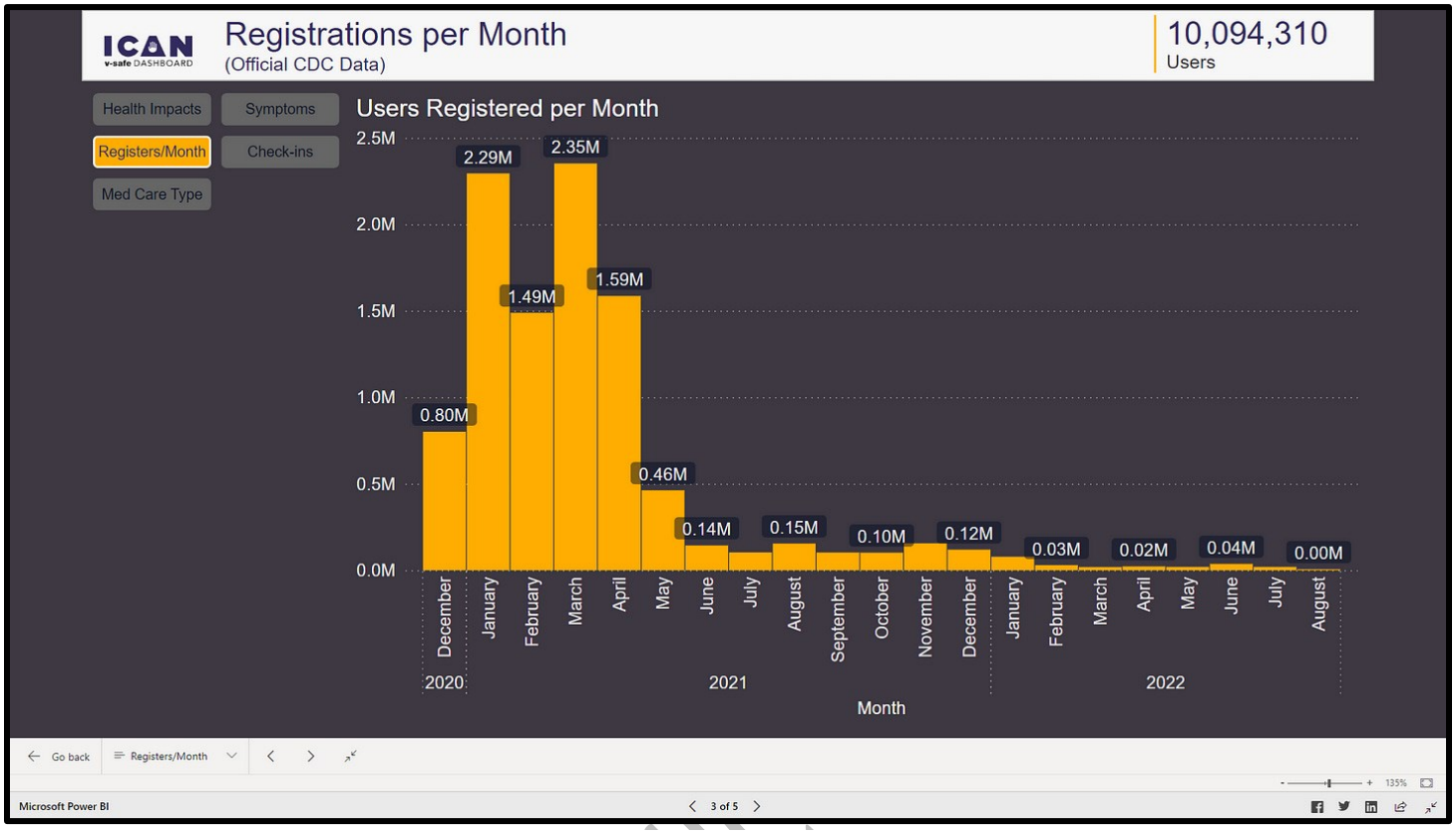


Figure 35. V-Safe ICAN Analysis of number of users registering for V-Safe per month

This pattern shows that most users registered during the early rollout before mandates and comports with the approach that most individuals who registered for v-safe were vaccine enthusiasts. Those who were excited about its rollout. The crowd that cheered with emotion as the vaccine was rolled out and who clamored to get the shot.

This is not a crowd that wants to report issues with the vaccine.

Meaning, the 10 million v-safe users, if anything, may have been prone to underreporting health impacts, not overreporting, and hence the concern may be that the symptoms and health impact rates reflected in the v-safe data may actually be higher among the general vaccinated population.

Another factor that may have depressed the adverse health impact rate in v-safe is that the vaccine was rolled out to the elderly as a high priority population. Yet this population was less likely to be adept at or to use a smartphone-based program to track their health following vaccination but at the same time may be more susceptible to adverse health effects from the vaccine. This may further reflect that the rate of health effects from the Covid-19 vaccine may be higher in the general population than what is reported in v-safe.

Bottom line: the v-safe data likely can be generalized to the larger vaccinated population and, if anything, likely underreports adverse health effects.

Ironically, CDC probably designed the v-safe system so that it could collect data that could be generalized to the larger population but, after the data it collected did not match its policy objectives of promoting the vaccine as safe, the CDC now would likely not agree that v-safe can be generalized to the

larger vaccinated population. That is reflected by the fact that the CDC initially planned to call anyone who reported an adverse health impact to v-safe (v-safe protocol v.2 at p.5) but had to abandon that plan early on after rolling out v-safe due to the volume of people reporting impacts (v-safe protocol v.3 at pp.7-8).

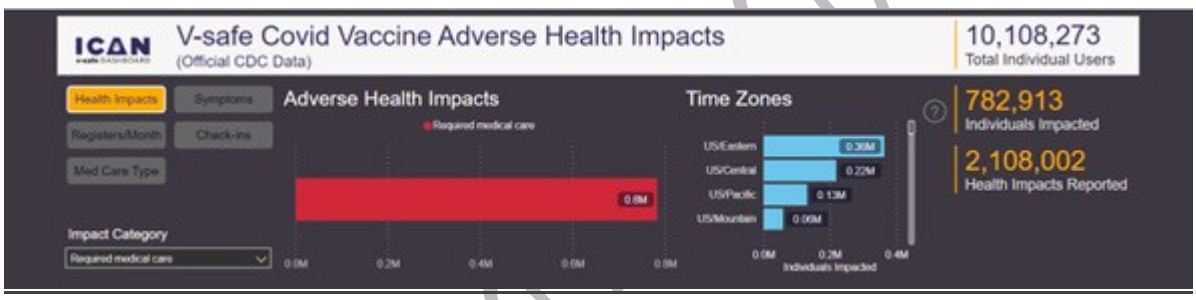
A third post on Mr. Siri's substack presented this comparison between V-Safe and VAERS: [8]

V-Safe Is Better Than VAERS

Let's start with the interplay of v-safe and VAERS and the question of whether v-safe is better (or at least has the potential to be better) than VAERS? It is – absolutely.

Unlike VAERS, the data in v-safe is gathered from a known and quantifiable universe of individuals. In fact, v-safe has precisely 10,108,273 registered users as of August 2022. These users are asked to answer the same questions. By aggregating answers to identical questions in v-safe, the rate of an adverse reaction can be calculated. That is not possible with VAERS.

For example, of the 10,108,273 registered v-safe users, 782,913 reported needing medical care after vaccination. So, you divide 782,913 by 10,108,273 and, poof, you now know that 7.7% of all registered v-safe users sought medical care at least once following vaccination. You can see these numbers for yourself on the ICAN v-safe dashboard:



(Note that if the approximately 528,381 individuals that registered but never completed a single health check-in were excluded from the 10,108,273 v-safe users it would make the denominator smaller and therefore the 7.7% percentage greater – to approximately 8.2%.)

VAERS, on the other hand, is a passive surveillance system and that type of math is not possible because there is no known number of VAERS "users" to use as a denominator.

(For what it's worth, VAERS has two advantages over v-safe. First, a user can submit an unlimited amount of information to VAERS about an adverse health impact. That is not true of v-safe which limits its free-text fields, where users can report symptoms, to 250 characters. Second, pursuant to federal law, certain deidentified information submitted to VAERS is supposed to be promptly made public, and while this does not always happen, there is no legal obligation for CDC to promptly make public the v-safe data.)

V-Safe Caused Under Reporting to VAERS

There are a lot of indications, including common sense, that v-safe users were less likely to report to VAERS, having already reported to v-safe. A key question is whether this was just an unintended consequence of v-safe.

Had v-safe not existed, there is a high likelihood that more people would have reported to VAERS and, again, theoretically, the public would have access to that data. We may never know the content or precise number of free-text field submissions in v-safe, which are still hidden from public view (although we continue to fight to obtain this data), whereas we would have access to public-facing VAERS reports.

The CDC knew that v-safe users would not also report to VAERS. This is reflected in the CDC's public guidance regarding v-safe. First, the CDC treated VAERS as the alternative if v-safe was not available. For example, it tells members of the public that, "If you cannot participate in v-safe, you can submit reports of adverse events following vaccination to the Vaccine Adverse Event Reporting System (VAERS)." Or, if a user misses a v-safe check-in and still wants to report, then they are to use VAERS.

Second, the CDC claimed it would follow-up with individuals making certain types of reports to v-safe and help them submit a VAERS report "if appropriate." CDC's January 28, 2021 v-safe protocol provided that any adverse health impact reported should result in a phone call. Presumably not realizing the volume of reports that would entail (millions!), by the next version of the v-safe protocol, issued May 20, 2021, the CDC limited active follow-up calls to "recipients reporting a significant, medically attended health impact during v-safe health check-ins." This is a far narrower group that would receive contact from CDC and, again, the agency would only make a VAERS report "if appropriate." In this way, the CDC has now made itself the middleman between vaccinated people and VAERS.

The biggest issue is that this plan to operate as a middleman to assist with VAERS reporting was seemingly theater. The "if appropriate" language likely means the CDC only made VAERS reports when dealing with injuries that were mandated to be reported to VAERS, and that is an extremely limited list of events. You can see the list here.

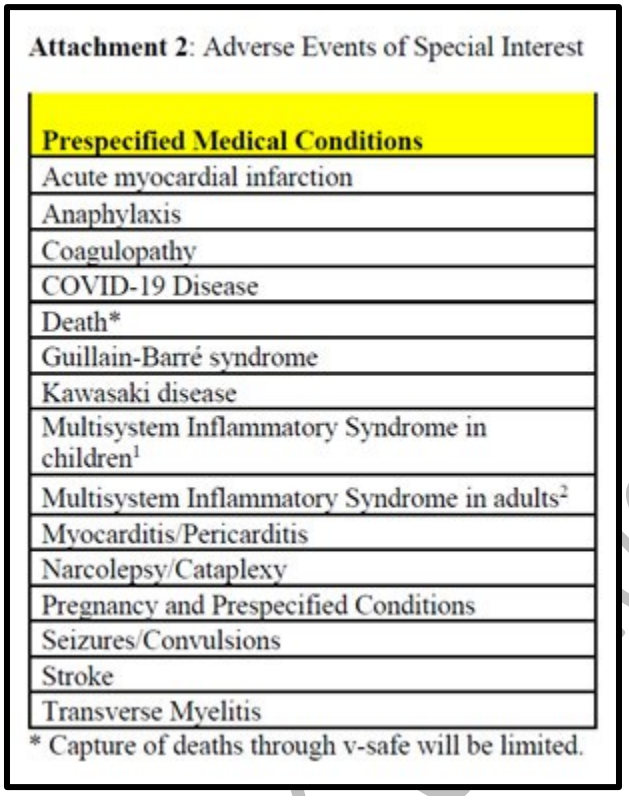
Meaning, instead of reports being made directly to VAERS, the CDC created a limited list of conditions for which it would even call v-safe users and then only assisted with a VAERS report if it deemed it appropriate. This, no doubt, resulted in a large number of reports of injuries that would have otherwise been reported to VAERS never making it into that system.

Confirmation the CDC Chose to Relegate Injuries to Free-Text Entries

CDC further "rigged" v-safe by relegating reported harms to free-text fields that kept them out of VAERS and hidden from the public.

In Part 2 of this Substack series, we discussed how the CDC failed to include check-the-box options for the serious harms it labeled "Adverse Events of Special Interest" and listed in a chart under the header "Prespecified Medical Conditions." The adverse events of special interest listed in this chart included myocarditis, pericarditis, acute myocardial infarction, stroke, GBS, and transverse myelitis, among other events. This chart was in version 2 of the CDC's v-safe protocol from January 28, 2021. You may recall that v-safe was launched in December 2020.

We have now obtained a copy of version 1 of the CDC's v-safe protocol dated November 19, 2020, before v-safe was launched. And version 1 shows the precise chart from version 2 of the CDC's v-safe protocol. Here is a copy of version 1 of the protocol and here is the relevant chart:



Attachment 2: Adverse Events of Special Interest

Prespecified Medical Conditions
Acute myocardial infarction
Anaphylaxis
Coagulopathy
COVID-19 Disease
Death*
Guillain-Barré syndrome
Kawasaki disease
Multisystem Inflammatory Syndrome in children[1]
Multisystem Inflammatory Syndrome in adults[2]
Myocarditis/Pericarditis
Narcolepsy/Cataplexy
Pregnancy and Prespecified Conditions
Seizures/Convulsions
Stroke
Transverse Myelitis

* Capture of deaths through v-safe will be limited.

Figure 36. CDC adverse events of special interest, Version 1, Nov,2020

Despite the foregoing, v-safe was launched without, and was never updated, to include any check-the-box fields for these conditions.

Had the CDC included the check-the-box options for these adverse events, it could have clearly calculated a rate for each harm for the 10 million v-safe users. For example, if 400,000 reported myocarditis, then that would be around a 4% reported rate for this condition. The CDC, however, chose not to include these harms as check-the-box options. It instead relegated them to only potentially be captured in free-text fields!

The CDC then engaged in the shell game of only calling certain v-safe users and then only making VAERS reports when it deemed doing so appropriate. In this way, it hid the adverse events of special interest in the free-text fields and kept them, no doubt, mostly buried and outside of public view by not having them all go into VAERS.

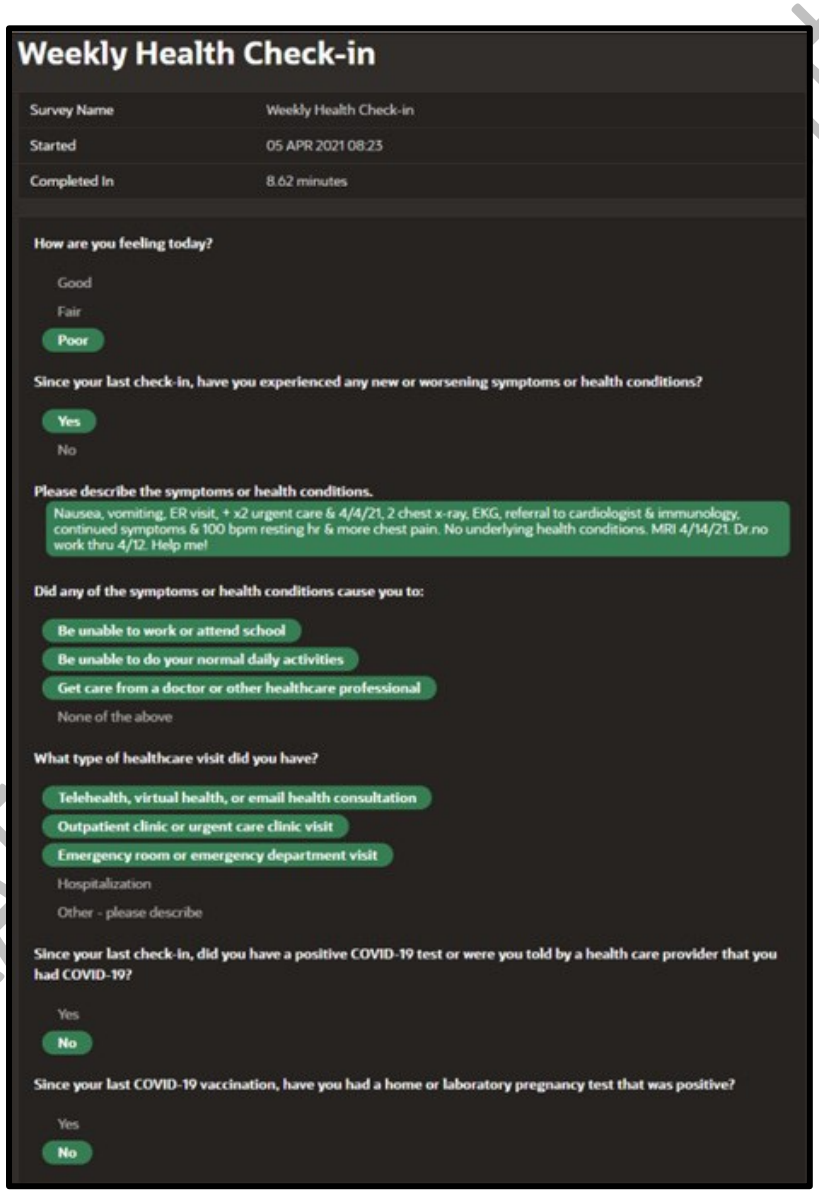
CDC Not Timely Contacting V-Safe Users Reporting Injuries

While the CDC avoided being able to easily calculate a rate of harm by not using check-the-box fields for adverse events of special interests, the hope would be that it at least timely followed up with v-safe users reporting serious harms in the free-text fields to learn more about their injuries. This way it can assess what harms the vaccine was causing and quickly address those harms. After all, the CDC claimed v-safe is a "real time" surveillance system for Covid-19 vaccines "so scientists can quickly study them and determine if there is a safety concern with a particular vaccine."

Well, the story of one Ph.D. who got vaccinated early to set an example and to encourage her students to do the same reflects otherwise.

Despite clearly reporting a significant medically attended health impact numerous times — which included brain swelling, toxic reaction, abnormal heart rhythm, numbness and tingling, high fever, chest pain, joint pain, light sensitivity, dizziness, impaired balance, nausea, vomiting, and lethargy — and begging for someone to help her in her v-safe reports, and trying to call v-safe herself, the CDC did not call her until over 200 days after she reported her serious injury!

Here, for example, is what she submitted to v-safe just a couple of weeks after her vaccination, which included the plea "Help me!":



Weekly Health Check-in

Survey Name	Weekly Health Check-in
Started	05 APR 2021 08:23
Completed In	8.62 minutes

How are you feeling today?

Good
Fair
Poor

Since your last check-in, have you experienced any new or worsening symptoms or health conditions?

Yes
No

Please describe the symptoms or health conditions.

Nausea, vomiting, ER visit, + x2 urgent care & 4/4/21, 2 chest x-ray, EKG, referral to cardiologist & immunology, continued symptoms & 100 bpm resting hr & more chest pain. No underlying health conditions. MRI 4/14/21. Dr.no work thru 4/12. Help me!

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional
None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation
Outpatient clinic or urgent care clinic visit
Emergency room or emergency department visit
Hospitalization
Other - please describe

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes
No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes
No

Figure 37. V-Safe submission by a patient, #1

Her pleas for help continued with every health check-in over the next few months which detailed serious and worsening medical condition from the vaccine and still no follow-up from the CDC. See her 6-month check-in below where she notes "still no response from CDC":

6 Month Health Check-in

Survey Name	6 Month Health Check-in
Started	12 SEP 2021 23:42
Completed In	6:57 minutes

How are you feeling today?

Good
Fair
Poor

Since we last contacted you, have you experienced any new symptoms or health conditions?

Yes
No

Please describe the symptoms or health conditions.

Confirmed elevated sCD40L & CCSL, diagnosed platelet activation, vascular inflammation, encephalopathy still full disability, not medically cleared to drive. Negative nucleocapsid test, 6 months of testing confirming no underlying health conditions.

Did any of the symptoms or health conditions cause you to:

Be unable to work or attend school
Be unable to do your normal daily activities
Get care from a doctor or other healthcare professional
None of the above

What type of healthcare visit did you have?

Telehealth, virtual health, or email health consultation
Outpatient clinic or urgent care clinic visit
Emergency room or emergency department visit
Hospitalization
Other - please describe 100+ days of speech, physical therapy and vestibular therapy & more to come; still no help from CISA after 6 months of trying, still no response from CDC, no help from public health, no help from FDA, needs to be moved under NVICP

Since your last check-in, did you have a positive COVID-19 test or were you told by a health care provider that you had COVID-19?

Yes
No

Since your last COVID-19 vaccination, have you had a home or laboratory pregnancy test that was positive?

Yes
No

How is your health now compared to before your COVID-19 vaccination?

Better
About the same
Worse

Do you believe your health problems might be related to your COVID-19 vaccination?

Yes
No

Figure 38. V-Safe submission by a patient #2

When the CDC did finally call her over 200 days after pleading for help, the CDC's first question was to ask the date she recovered. She explained she did not recover, was still on full disability, still not cleared to drive, still not cleared to walk more than a limited number of steps per day, etc. It was clear the CDC representative had not even read her v-safe reports and had no interest in actually assessing what had happened to this Ph.D. that was initially strongly advocating everyone get the shot!

Makes one wonder how long people who reported "just" being hospitalized or seeking emergency room treatment, without any pleas for help or descriptions of symptoms and medical testing, needed to wait to get a call from the CDC. And it is also clear that when a call finally arrived, it was not about improving safety of these products.

> *So much for the CDC's "real time" surveillance "so scientists can quickly study them and determine if there is a safety concern with a particular vaccine."*

Finally, the CDC announces it has stopped collecting V-Safe data as of June 30, 2023. [9]

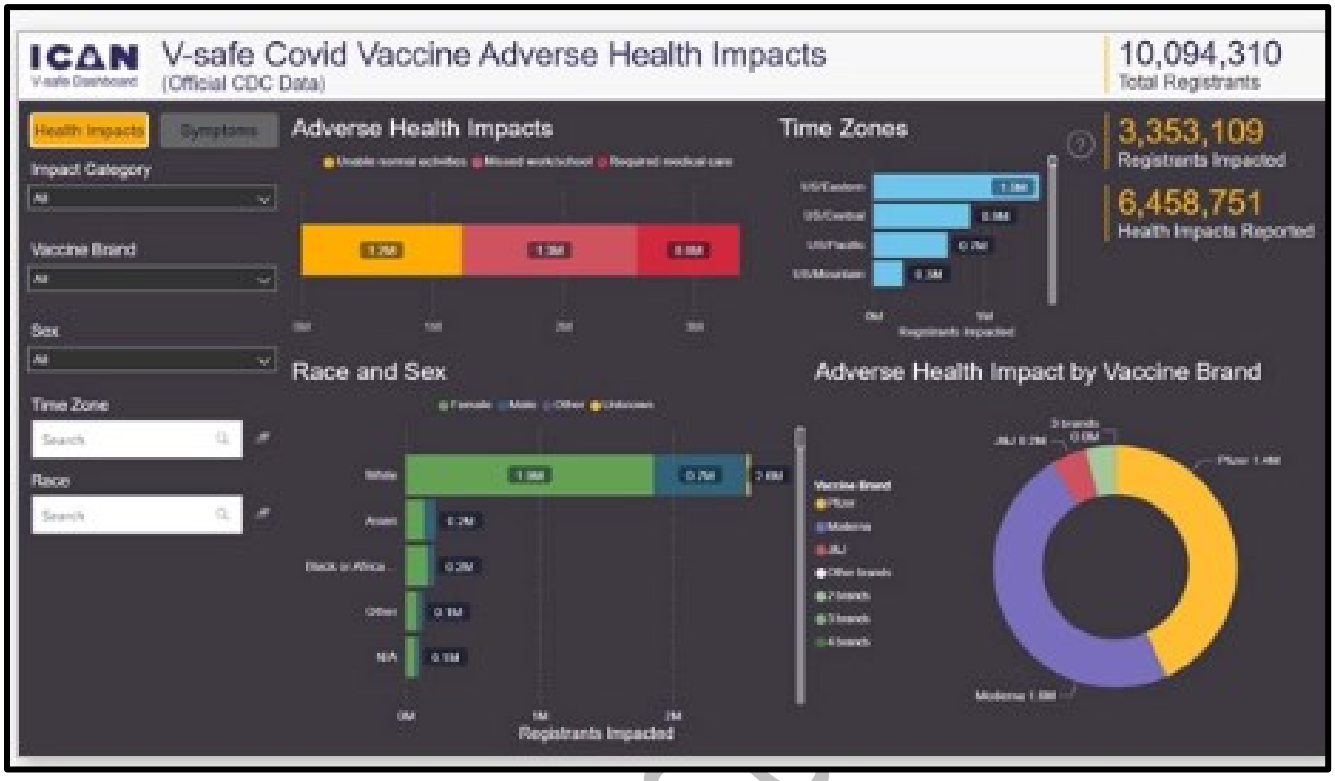
The conclusion is that data and any analysis of the V-Safe data is not going to accurately reflect effectiveness or safety.

4.6 ICAN

ICAN (Informed Consent Action Network) sued the CDC in 2021and then had to sue again. CDC stalled until September, 2022, when some or maybe all of the data were released.

According to ICAN, 7.7% of the V-Safe users -- 782,913 people -- reported seeking medical attention via a telehealth appointment, urgent care clinic, emergency room intervention or hospitalization following a COVID-19 vaccine. Twice that many missed work.

About 25% of V-Safe users said they experienced symptoms that required them to miss school or work or prevented them from doing other normal activities, according to ICAN's "dashboard" that summarizes the results:



The dashboard is interactive. Although it is useful in that it provides information from V-Safe up until the CDC closed the database down at the end of June, it is deprecated. The CDC wants the patients to go back to VAERS.

4.7 UK Yellow Card System

The web site https://coronavirus-yellowcard.mhra.gov.uk/, which is the Yellow Card Scheme, defines the procedure for filing adverse effects.

On the landing page are instructions and a search field for reporting adverse events.

In the search field you can select the Covid-19 vaccine you would like for which you would like to report an adverse effect. It is not where you will obtain a summary of the reports submitted. Relevant to understanding how this Yellow Card system works is the following, from the site's Privacy Policy:

> *The Yellow Card Scheme is the UK system for collecting and monitoring information on suspected safety concerns or incidents involving: medicines, medical devices and e-cigarette devices and liquids. The Scheme is run by the MHRA and currently relies on voluntary reporting of suspected safety concerns or incidents by healthcare professionals and members of the public (patients, users, or carers). The purpose of the Scheme is to provide an early warning that the safety of a product may require further investigation.*

The coronavirus Yellow Card reporting site allows reports to be made relating to suspected adverse drug reactions to medicines, or future vaccines, relating to coronavirus treatment, as well as report any faulty medical equipment. Our purpose is to investigate these reports and take any necessary regulatory action in line with our statutory duties.

We may occasionally conduct surveys of users of the coronavirus Yellow Card reporting site or Yellow Card app to help improve the user experience.

The Yellow Card database holds information of value to public health and patient care; as a result, we may receive requests for the information contained in Yellow Card reports for medicines for academic research purposes that have potential scientific and / or significant public health value. However, the MHRA is conscious of the duty of confidentiality to patients and reporters. Therefore, all applications for research using Yellow Card data will be reviewed and approved by an independent advisory Committee to ensure patient and reporter confidentiality is respected, and that information from Yellow Card reports which may indirectly identify individuals are used appropriately.

The last paragraph says that you have to apply for and receive approval to access the Yellow Card reports. So the database is not useful to anyone that would like to examine the database and create statistics without going through that approval process.

In the navigation bar is the selection “Summary of Yellow Card reporting”. The resulting page is:

The MHRA has played an active role in responding to the coronavirus pandemic. In relation to COVID-19 vaccines, the MHRA has authorised their supply following a rigorous review of their safety, quality and efficacy. The clinical trials of COVID-19 vaccines have shown them to be effective and acceptably safe; however, as part of its statutory functions, the MHRA is responsible for monitoring these vaccines on an ongoing basis to ensure their benefits continue to outweigh any risks. This is a requirement for all authorised medicines and vaccines in the UK. This monitoring strategy is continuous, proactive and based on a wide range of information sources, with a dedicated team of scientists reviewing information daily to look for safety issues or unexpected rare events.
This report summarises information received via the Yellow Card scheme and will be published regularly to include other safety investigations carried out by the MHRA under the COVID-19 Vaccine Surveillance Strategy.
https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions
COVID-19 Vaccine reports
The COVID-19 vaccine reports contain a complete listing of all suspected adverse reactions that have been reported to the MHRA via the Yellow Card scheme for all COVID-19 vaccines. This includes all reports received from healthcare professionals, members of the public, and pharmaceutical companies. The information in the reports is updated in line with our summary of Yellow Card reporting publication.
This information does not represent an overview of the potential side effects associated with the vaccines. A list of the recognised adverse effects of the COVID-19 vaccines is provided in the information for healthcare professionals and the recipient information here.
Conclusions on the safety and risks of the vaccines cannot be made on the data shown in the reports alone. Therefore, **when reviewing the data within the reports it is important to do so in the context of the essential guidance at the bottom of the report to ensure that you do not misinterpret the data.**
Please select from the links below to go to our Yellow Card website and view the reports for each vaccine.

- COVID-19 Vaccine Pfizer/BioNTech monovalent
- COVID-19 Vaccine Pfizer/BioNTech bivalent
- COVID-19 Vaccine AstraZeneca
- COVID-19 Vaccine Moderna monovalent
- COVID-19 Vaccine Moderna bivalent
- COVID-19 Vaccine - brand unspecified or not in routine use in the UK
- COVID-19 Vaccine Novavax

Figure 39. Yellow Card Reports Information Page

The various reports are provided as .csv datasets. For example, selecting the Pfizer monovalent downloads a zip file containing the following files:

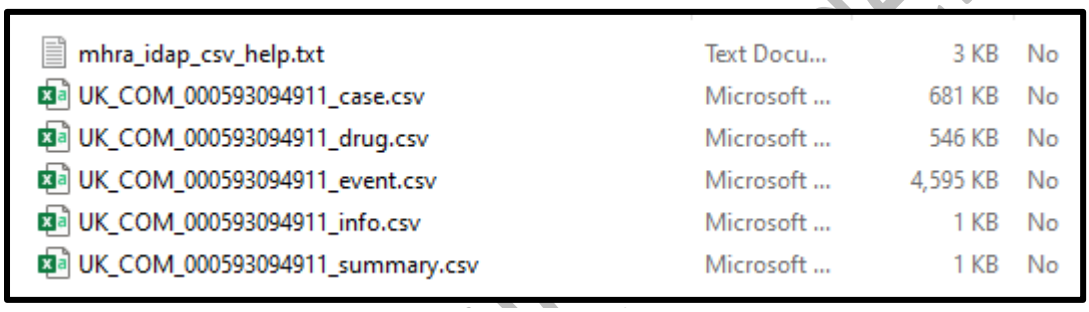


Figure 40. Contents of a zip file downloaded from the Yellow Card System

The event file contains the adverse events list. This is an example of the contents:

ADR	SEQ	PT	HLT	HLGT	SOC_ABBREV	FATAL_YN
1	1	Fatigue	Asthenic conditions	General system disorders NEC	Genrl	N
1	2	Headache	Headaches NEC	Headaches	Nerv	N
1	3	Pain in extremity	Musculoskeletal and connective tiss	Musculoskeletal and connective tissue d	Musc	N
2	1	Axillary pain	Pain and discomfort NEC	General system disorders NEC	Genrl	N
2	2	Chills	Feelings and sensations NEC	General system disorders NEC	Genrl	N
2	3	Flank pain	Musculoskeletal and connective tiss	Musculoskeletal and connective tissue d	Musc	N
2	4	Flushing	Peripheral vascular disorders NEC	Vascular disorders NEC	Vasc	N
2	5	Influenza	Influenza viral infections	Viral infectious disorders	Infec	N
2	6	Pain in extremity	Musculoskeletal and connective tiss	Musculoskeletal and connective tissue d	Musc	N
3	1	Anaphylactic reaction	Anaphylactic and anaphylactoid resp	Allergic conditions	Immun	N
4	1	Pain	Pain and discomfort NEC	General system disorders NEC	Genrl	N
4	2	Pyrexia	Febrile disorders	Body temperature conditions	Genrl	N
4	3	Vaccination site movement impairm	Vaccination site reactions	Administration site reactions	Genrl	N
4	4	Vaccination site pain	Vaccination site reactions	Administration site reactions	Genrl	N
5	1	Dyspnoea	Breathing abnormalities	Respiratory disorders NEC	Resp	N
5	2	Rash	Rashes, eruptions and exanthems N	Epidermal and dermal conditions	Skin	N
5	3	Tachycardia	Rate and rhythm disorders NEC	Cardiac arrhythmias	Card	N
5	4	Wheezing	Bronchospasm and obstruction	Bronchial disorders (excl neoplasms)	Resp	N
6	1	Dizziness	Neurological signs and symptoms N	Neurological disorders NEC	Nerv	N
6	2	Nausea	Nausea and vomiting symptoms	Gastrointestinal signs and symptoms	Gastr	N
6	3	Pain in extremity	Musculoskeletal and connective tiss	Musculoskeletal and connective tissue d	Musc	N
7	1	Dry eye	Lacrimation disorders	Eye disorders NEC	Eye	N
7	2	Dry mouth	Oral dryness and saliva altered	Salivary gland conditions	Gastr	N
8	1	Erythema	Erythemas	Epidermal and dermal conditions	Skin	N
8	2	Pruritus	Pruritus NEC	Epidermal and dermal conditions	Skin	N
8	3	Urticaria	Urticarias	Angioedema and urticaria	Skin	N
9	1	Chest pain	Pain and discomfort NEC	General system disorders NEC	Genrl	N
9	2	Dizziness	Neurological signs and symptoms N	Neurological disorders NEC	Nerv	N
9	3	Feeling abnormal	Feelings and sensations NEC	General system disorders NEC	Genrl	N
9	4	Hypotension	Vascular hypotensive disorders	Decreased and nonspecific blood pressu	Vasc	N
9	5	Muscle tightness	Muscle related signs and symptoms	Muscle disorders	Musc	N
9	6	Pruritus	Pruritus NEC	Epidermal and dermal conditions	Skin	N
9	7	Rash erythematous	Rashes, eruptions and exanthems N	Epidermal and dermal conditions	Skin	N
9	8	Supraventricular tachycardia	Supraventricular arrhythmias	Cardiac arrhythmias	Card	N

Figure 41. Contents of a Yellow Card adverse events "event" file

The columns:

- ADR: each unique number is one report. If there is more than one row with the same number, then that is one patient with multiple symptoms, one symptom per row.
- SEQ: the priority of the symptoms as listed in a patient's report.
- PT, HLT, HLGT, SOC-ABBREV are levels of the MedDRA dictionary, going from most specific to least.
- FATAL indicates death.

In this one table there were 166,426 AEs recorded.

4.8 DAEN (Australia)

The Database of Adverse Events Notifications, https://daen.tga.gov.au/medicines-search/, is the Australian equivalent of VAERS. Australia is one of the countries that had the most severe lockdowns coupled with the most draconian measures to force "vaccination." Therefore, they are the among the most vaccinated countries and among the countries that will have delayed epidemic levels for Covid-19.

4.9 SMARS (New Zealand)

Like Australia, New Zealand had severe lockdowns and draconian measures to force vaccination. Their database is called Suspected Medicine Adverse Reaction Search (SMARS), at https://www.medsafe.govt.nz/Projects/B1/ADRSearch.asp. This site is particularly interesting because the data screams for more detailed evaluation and critique. It does provide background in analysis to help with the evaluation. It should be educational, but we have not had the time to pursue it.

There are two tabs on the main landing page that could be of some interest. In the screen shot below, the "Safety" Tab has been selected from the main landing page. On the Safety Tab,the "Reports and Promotions" has been selected. From that tab, "Suspected Medical Adverse Reaction Search" has been selected.

The following is an example search for Covid-19:

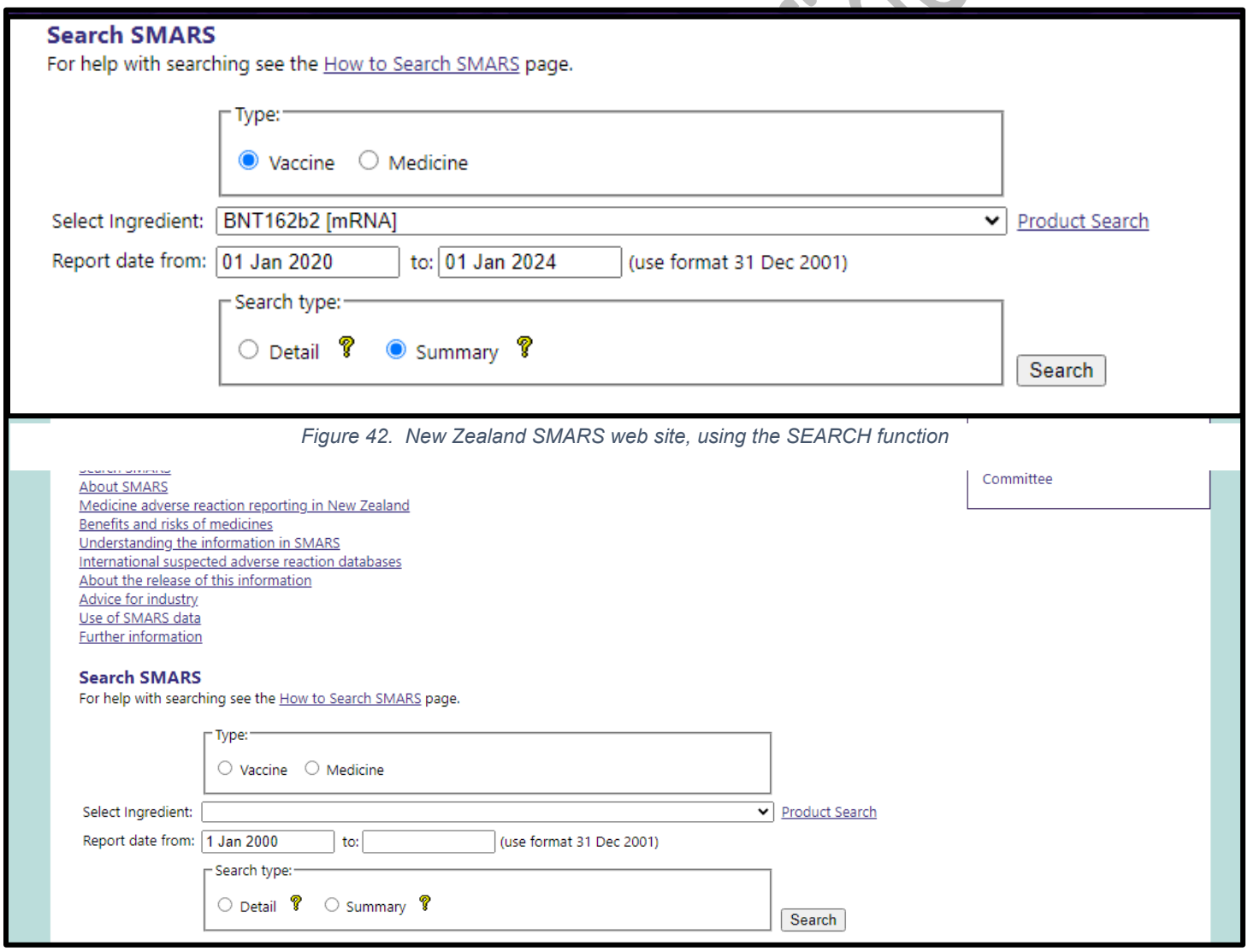


Figure 42. New Zealand SMARS web site, using the SEARCH function

The data are provided in tabular form according the MedDRA nomenclature: The search request was to the current date, which turned out to be 29 Sep 2023. The table is too long to print here, but a PDF file is attached:

Suspected Medicine Adverse Reaction Search

medsafe.govt.nz/Projects/B1/SearchResults.asp

Medsafe advises patients NOT to make any changes to their medicine treatment based on information contained in SMARS. Changes to treatment should only be made following consultation with a healthcare professional.

Number of reports: 65,956
Number of reports where death was reported: 184
Number of reactions: 238,606

System Organ Class	MedDRA Reaction Term	Number of Reports
Blood and lymphatic system disorders	Anaemia	17
	Autoimmune haemolytic anaemia	1
	Eosinophilia	6
	Immune thrombocytopenia	3
	Iron deficiency anaemia	2
	Leukocytosis	4
	Leukopenia	3
	Lymph node pain	8
	Lymphadenitis	212
	Lymphadenopathy	7396
	Lymphocytic infiltration	1
	Lymphocytosis	6
	Lymphopenia	4
	Monocytosis	1
	Neutropenia	9
	Neutrophilia	6

1/38

Note that the report is to the MedDRA 2nd level (out of 5). The reader can explore these data. It should be noted that the VAERSAware.com web site provides extensive analysis of leaked data that strongly suggests that there are two databases, one for public consumption and one not.

Also, in the tabs across the top of the landing page is “Covid-19.”

This is the web page:

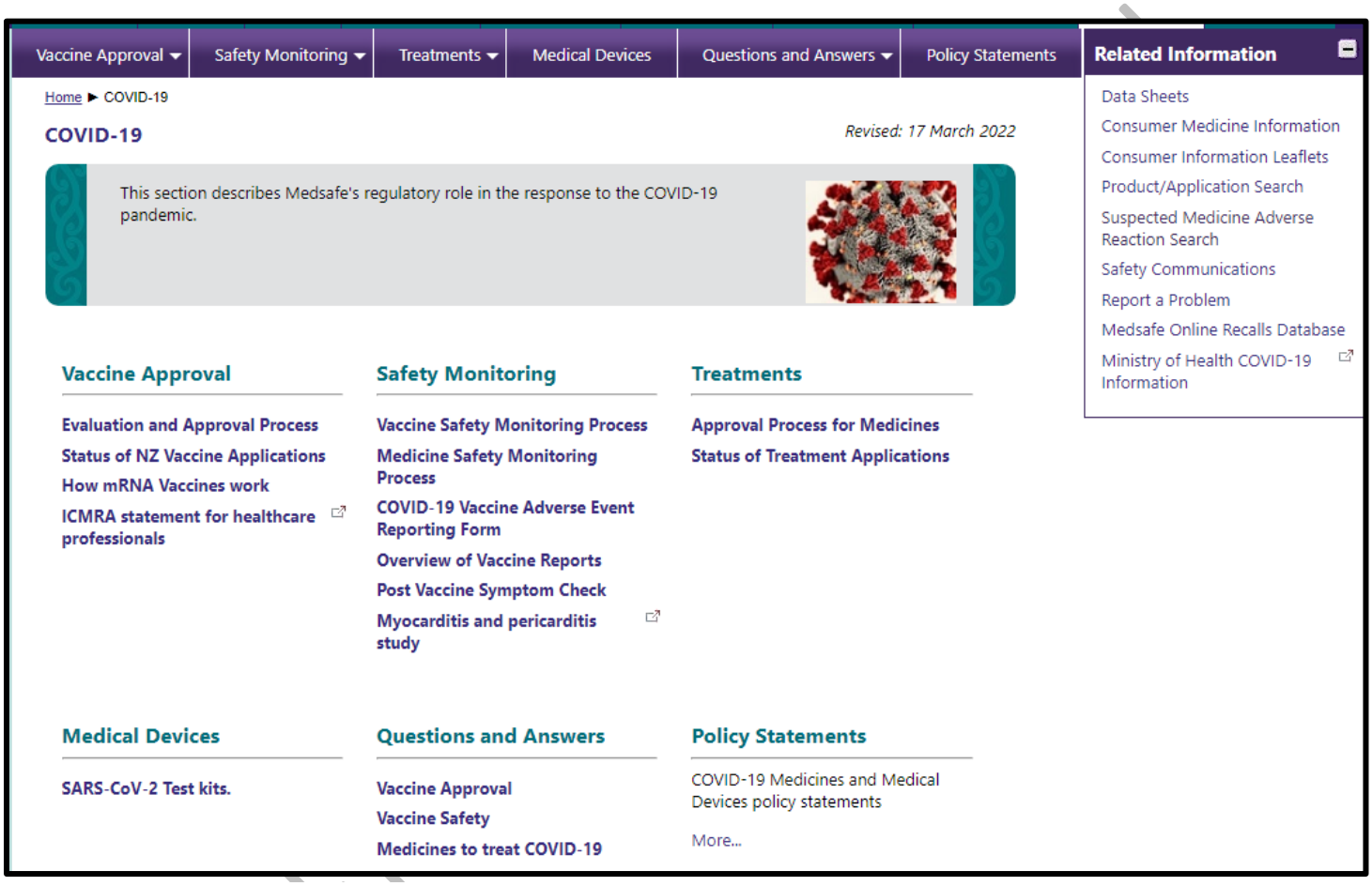


Figure 43. New Zealand SMARS web site, Covid-19 tab

This page is mostly policy-related.

4.10 WHO

The WHO database for adverse events is called **Vigibase** [10]. From the Vigibase description:

> ***VigiBase is the unique WHO global database*** *of reported potential side effects of medicinal products. It is the largest database of its kind in the world, with over 30 million reports of suspected adverse effects of medicines, submitted, since 1968, by member countries of the WHO PIDM. It is continuously updated with incoming reports.*

In general, VigiBase access is fee-based. It is not accessible to this author. There is another interface to the data called Vigilyze. This is the description from this landing page:

> ***VigiLyze is a signal detection and signal management tool*** *that uses insights into the safer use of medicines from members of the WHO Programme for International Drug Monitoring (WHO PIDM) as a starting point for efficient quantitative signal detection. It supports national signal management processes, including qualitative assessments.*
>
> ***VigiLyze provides a global context for your national data*** *through its close integration with VigiBase, WHO's global database of reported potential side effects of medicinal products. This huge collection of data supports assessments of emerging domestic issues. Through VigiLyze you have easy access to post-marketing safety information for medicinal products that are new to your national market but marketed in other parts of the world.*
>
> ***VigiLyze is provided free of charge*** *to national centres in all member countries of the WHO PIDM. Major strengths include the ability to recalculate disproportionality based on any chosen country or group of countries within seconds and ready access to related investigations, shared nationally or globally, when searching for the same (or similar) medicinal products and reactions.*
>
> ***By sharing their data and knowledge with the global database****, member countries help increase each other's understanding of potential safety concerns and reduce the risk of harm from medicines.*

Unfortunately, this is a closed system, as you can see above.

4.11 The Collateral Global Database

This is a web site: https://collateralglobal.org/. It is a UK non-profit that is dedicated to "Cultivating a better understanding of the impact of the Covid-19 responses." It focuses on the social, economic, and psychological impact of government Covid-19 policy. It is a almanac of adverse effects in these domains, going back to the beginning of 2020. Both articles and videos are featured.

The top of the landing page looks like this:

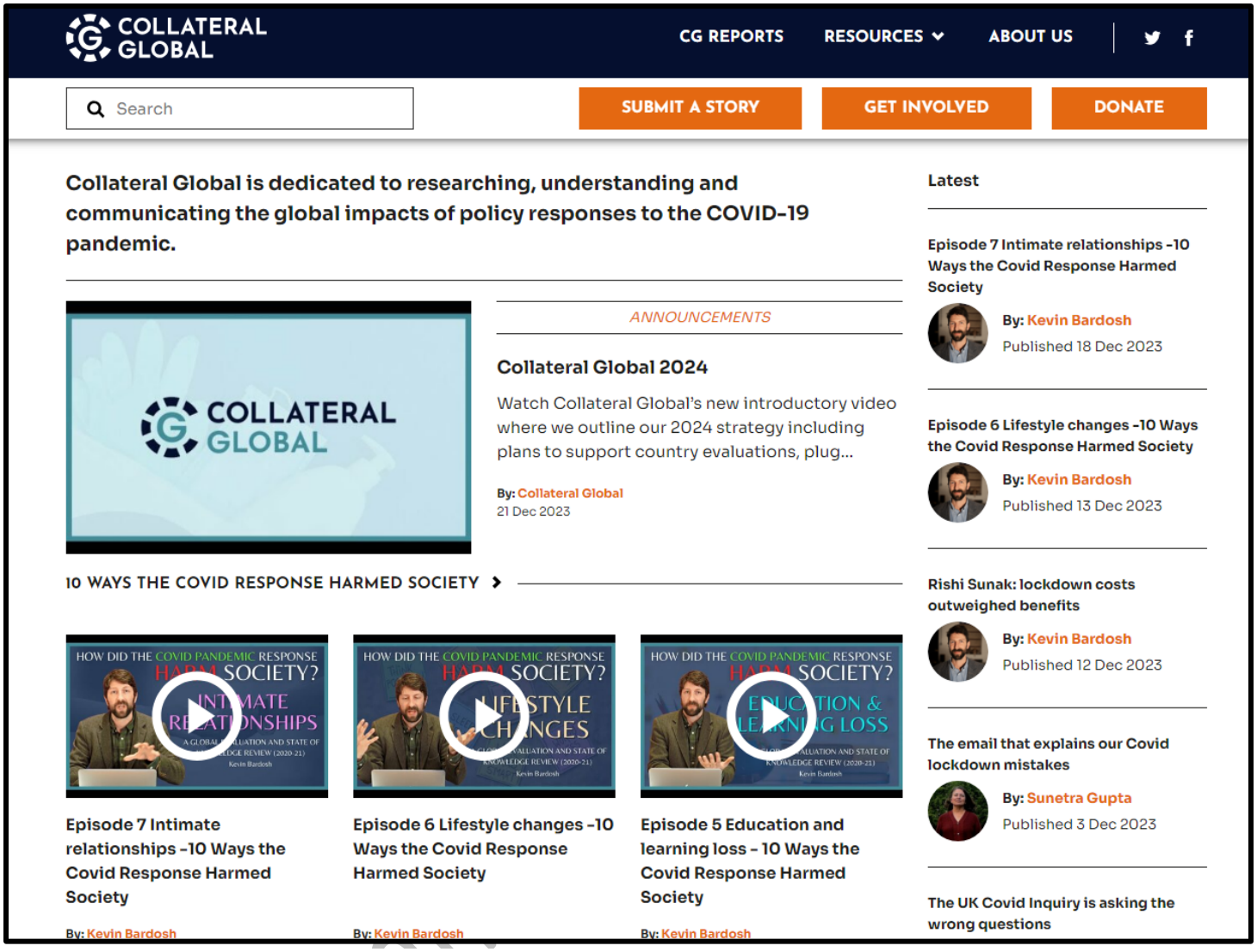


Figure 44. The Collateral Global landing page

4.12 Data from the Military

The primary database for adverse effects is the Defense Medical Surveillance System (DMSS) The front end it the Defense Medical Epidemiology database. http://www.afhsc.mil/. It is interesting that this is a non-secure landing page. But you have to register to gain access. Registering, given the position on "domestic terrorists" including those who are questioning Covid-19 policy, is a security problem for the individual.

This is a quotation on what is in this database regarding adverse effects: [11]

> *Military medical whistleblowers have come forward with a trove of data on vaccine safety that they claim is the most accurate available.*

On Monday, Sen. Ron Johnson (R-Wisc.) hosted "COVID-19: A Second Opinion," a livestreamed discussion panel featuring world-renowned doctors and medical experts who provided an alternative take on the public health response to COVID-19.

One of the panelists was Ohio attorney Thomas Renz, who is representing clients who have brought lawsuits against the COVID vaccine mandates, The Blaze reported.

Renz's whistleblower clients found information on common vaccine injuries in DOD medical billing data from the Defense Medical Epidemiology Database (DMED).

The DMED is the Armed Forces Health Surveillance Branch's (AFHSB) "web-based tool to remotely query de-identified active component personnel and medical event data contained within the Defense Medical Surveillance System (DMSS)."

The database contains every International Classification of Diseases (ICD) medical billing code for all medical diagnoses submitted by the military for medical insurance billing.

In sworn statements that Renz intends to submit in court, three military doctors — Samuel Sigoloff, Peter Chambers, and Theresa Long — detailed the information they found.

Renz said that according to the data the doctors found, there was a 300% increase in miscarriages in the military during the first 10 months of 2021 over the five-year average.

From 2016 through 2020, there were 1,499 codes for miscarriages each year, TheBlaze reported. From January through October 2021, there were 4,182.

The doctors analyzing the data queried the numbers for hundreds of codes throughout the five-year time period. The codes that were examined are generally for ailments that have been established as potential adverse effects of the vaccines in medical literature, according to the news outlet.

During 2020, the number of miscarriage codes dipped slightly below the five-year average at 1,477. But the billing codes were not sufficiently below the average in any particular category to suggest that a 2020 decrease in doctor's visits during pandemic lockdowns accounted for the subsequent increase in 2021 diagnoses.

While the database includes ICD codes for both military hospital visits and ambulatory visits, the data Renz presented is from ambulatory diagnosis data.

Johnson mentioned during the panel that data on myocarditis cases appears to have been doctored, as the whistleblowers found that the number of codes for the diagnosis was about 28 times higher in August 2021 than when they checked again this month, where it was only two times higher.

"[T]here appears to be doctoring of the data," Johnson said. "Now, my staff has already sent — this morning, we sent a record preservation letter to the Department of Defense to try and protect this data."

According to the data found by the military doctors, there was also a nearly 300% increase in cancer diagnoses, from a 38,700-per-year average to 114,645 in 2021.

For neurological issues diagnosis codes, there was a more than 1,000% increase in 2021 over the five-year average, from 82,000 to 863,000. Renz noted during the panel that neurological issues "would affect our pilots."

"Our soldiers are being experimented on, injured, and sometimes, possibly, killed," he added.

Additional data The Blaze received from Renz showed: a 269% increase in myocardial infarction, 291% increase in Bell's palsy, 156% increase in congenital malformations of military members' children, 471% increase in female infertility, and 467% increase in pulmonary embolisms.

The news outlet reported that one of the sworn declarations from one of the military doctors said, "It is my professional opinion that the major increases (sic) incidences of the above discussed instances of miscarriages, cancers, and disease were due to COVID-19 'vaccinations.'"

The codes for the diagnoses are not representative of the number of people who were diagnosed with these ailments, but simply the total number of diagnoses, as one person could have multiple ailments.

4.13 Data From Morticians and Autopsies

Unfortunately, no requirements have been set by any level of government anywhere in the world to perform autopsies after deaths where the primary cause could have been mRNA "vaccine" related. Such a requirement would be a reliable indicator of the true death rate associated with mRNA adverse events.

There are individual papers reporting snippets of data. For example:

- An embalmer discusses her findings: 93% of the last 30 people she embalmed had clots. Another embalmer saw 65% of his cases [12] This suggests that embalmers would be an early warning system to medical examiners and that the medical examiner should be notified.
- A paper out of Colombia reported that in a postmortem study of 121 deaths primarily "vaccinated" with the CoronaVac whole virus "vaccine," 57% were classified as sudden cardiac death (SCD) with the same cardiovascular pathologies of the mRNA shots. 21% of the cases had pulmonary embolism. This suggests that any Case Triage include any SCD deaths, regardless of vaccination brand.
- A 48 page review paper was preprinted online by SSRN in July, 2023 entitled *A Systematic Review of Autopsy Findings in Deaths after COVID-19 Vaccination* [13] that:
    - *We searched for all published autopsy and necropsy reports relating to COVID-19 vaccination up until May 18th, 2023. We initially identified 678 studies and, after screening for our inclusion criteria, included 44 papers that contained 325 autopsy cases and one necropsy case. Three physicians independently reviewed all deaths and determined whether COVID-19 vaccination was the direct cause or contributed significantly to death.*
    - Their findings:

      The most implicated organ system in COVID-19 vaccine-associated death was the cardiovascular system (53%), followed by the hematological system (17%), the respiratory system (8%), and multiple organ systems (7%). Three or more organ systems were affected in 21 cases. The mean time from vaccination to death was 14.3 days. Most deaths occurred within a week from last vaccine administration. A total of 240 deaths (73.9%) were independently adjudicated as directly due to or significantly contributed to by COVID-19 vaccination.

- Their interpretation

  Interpretation: The consistency seen among cases in this review with known COVID-19 vaccine adverse events, their mechanisms, and related excess death, coupled with autopsy confirmation and physician-led death adjudication, suggests there is a high likelihood of a causal link between COVID-19 vaccines and death in most cases. Further urgent investigation is required for the purpose of clarifying our findings.

- An important observation about this paper is that it included several authors from the **Wellness Company**, known for their advocacy for early treatment and long covid treatment protocols for Covid-19, as well as a representative from the HHS.

The FDA is not releasing details of autopsy results:

From [14]:

The U.S. Food and Drug Administration (FDA) is refusing to release the results of autopsies conducted on people who died after getting COVID-19 vaccines.

The FDA says it is barred from releasing medical files, but a drug safety advocate says that it could release the autopsies with personal information redacted.

The refusal was issued to The Epoch Times, which submitted a Freedom of Information Act for all autopsy reports obtained by the FDA concerning any deaths reported to the Vaccine Adverse Event Reporting System following COVID-19 vaccination.

Reports are lodged with the system when a person experiences an adverse event, or a health issue, after receiving a vaccine. The FDA and other agencies are tasked with investigating the reports. Authorities request and review medical records to vet the reports, including autopsies.

The FDA declined to release any reports, even redacted copies.

The FDA cited federal law, which enables agencies to withhold information if the agency "reasonably foresees that disclosure would harm an interest protected by an exemption," with the exemption being "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy."

Federal regulations also bar the release of "personnel, medical and similar files the disclosure of which constitutes a clearly unwarranted invasion of personal privacy."

An FDA spokesperson noted that deaths following COVID-19 vaccination are rare, citing the number of reports made to VAERS.

As of Sept. 14, 16,516 reports of death following COVID-19 vaccination have been reported. Approximately 616 million doses have been administered in the United States through September.

The spokesperson declined to say whether the FDA would ever release the autopsy results, but pointed to a paper authored by researchers with the FDA and the Centers for Disease Control and Prevention (CDC).

The paper, which has not been peer reviewed, analyzed the approximately 9,800 reports of death to VAERS following COVID-19 vaccination lodged from Dec. 14, 2020, to Nov. 17, 2021. Researchers found that reporting rates were lower than the expected all-cause mortality rates.

"Trends in reporting rates reflected known trends in background mortality rates. These findings do not suggest an association between vaccination and overall increased mortality," the researchers wrote.

4.13.1 Coroner Autopsy Guides

4.13.1.1 Guide to Specimen Collection of Persons with Confirmed or Suspected Covid-19

The CDC has published a postmortem guidance document for those confirmed or suspected to have died with or from Covid-19. Though this is written assuming that Covid-19 was a potential precursor to death, it could provide some guidance for the situation where the person died with or from an adverse effect of the vaccine. More research would need to be done. The guidelines are located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-postmortem-specimens.html

The document is focused on specimens, and the intent is that the specimens be sent to the CDC for testing. Here is the list from the document:

> Recommendations about the type of postmortem specimens to collect vary based on whether the case of COVID-19 is suspected or confirmed, as well as whether an autopsy is performed.
>
> The following factors should be considered when determining if an autopsy will be performed for a deceased person with confirmed or suspected COVID-19:
>
> - Medicolegal jurisdiction
> - Facility environmental controls
> - Availability of recommended PPE
> - Family and cultural wishes
>
> **If an autopsy is performed for a *suspected* COVID-19 case,** collection of the following postmortem specimens and performance of the following testing are recommended:
>
> - Postmortem swab specimens for SARS-CoV-2 testing:
> - Specimens:
> - Upper respiratory tract swab: Nasopharyngeal Swab (NP swab)
> - Lower respiratory tract swab: Lung swab from each lung
> - Testing:
> - Laboratory based nucleic acid amplification tests (NAATs), including reverse transcription polymerase chain reaction (RT-PCR), remain the "gold standard" for clinical diagnostic detection of SARS-CoV-2.

- Postmortem swab specimens for testing of influenza viruses and other respiratory pathogens. For more information on influenza testing methods, please refer to Information for Clinicians on Influenza Virus Testing.
    - Collection of separate swabs will be needed if multiplex assays for the simultaneous detection of SARS-CoV-2, influenza viruses, and other respiratory pathogens are not available. Work with public health or clinical laboratories to determine what type of testing is available.
- Other postmortem microbiologic and infectious disease testing, as indicated.
- Formalin-fixed paraffin-embedded (FFPE) autopsy tissues from lung, upper airway and other major organs (e.g., heart, liver, kidney). Submission of FFPE autopsy tissues to CDC for SARS-CoV-2 testing may be indicated in some scenarios.

If an autopsy is NOT performed for a suspected COVID-19 case, collection of the following postmortem specimens and performance of the following testing are recommended:

- Postmortem NP swab specimen for SARS-CoV-2 testing
    - Laboratory based NAATs, including RT-PCR, remain the "gold standard" for clinical diagnostic detection of SARS-CoV-2.
- Postmortem swab specimens for testing for influenza viruses and other respiratory pathogens. For more information on influenza testing methods, please refer to Information for Clinicians on Influenza Virus Testing.
    - Collection of separate swabs will be needed if multiplex assays for the simultaneous detection of SARS-CoV-2, influenza viruses, and other respiratory pathogens are not available.

If an autopsy is performed for a *confirmed* COVID-19 case, collection of the following postmortem specimens should be considered:

- Postmortem swab specimens for testing for influenza viruses and other respiratory pathogens. For more information on influenza testing methods, please refer to Information for Clinicians on Influenza Virus Testing.
- Other postmortem microbiologic and infectious disease testing, as indicated.
- Formalin-fixed paraffin-embedded (FFPE) autopsy tissues from lung, upper airway and other major organs (e.g., heart, liver, kidney). Submission of FFPE autopsy tissues to CDC for SARS-CoV-2 testing may be indicated in some scenarios.

In addition to postmortem specimens, any remaining specimens (e.g., NP swab, sputum, bronchoalveolar lavage) that were collected prior to death should be retained. Please refer to Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for COVID-19 for more information.

The CDC guidelines focus on detecting the SARS-CoV-2 virus, but they are the beginnings of a checklist for adverse effects as well.

4.13.1.2 National Association of Medical Examiners (NAME) Protocol

This is a copy of the protocol for a medical examiner encountering a death occurring after Covid-19 Vaccination, downloaded from the NAME website (Note this is the best that is provided, and it is 2021!):

Protocol for Deaths occurring after COVID-19 Vaccination	
Scene Investigative Questions	• Date/time of vaccination? • What type of vaccine (manufacturer, dose #1 or 2, lot #?) • Facility where vaccine administered? • Body site including right or left where vaccine was injected. • Date/time of symptom onset? • Specify symptoms experienced (e.g., local reactions, systemic symptoms, cough, sore throat/ILI, rash/urticaria, wheezing, stridor, angioedema, shortness of breath, chest pain) • Any other recent vaccinations? • History of adverse events after other vaccinations? Describe. • Specify all current medications (including herbal & dietary supplements?) • Specify any known allergies • Specify other comorbidities. • Recent history of COVID-19? Describe. • Describe any laboratory testing results • Occupation/indication for receiving COVID-19 vaccine • Describe any other pertinent exposure history (e.g., recent trauma, surgery, hospitalization, travel, sick contacts)
Case Triage	• As resources and jurisdiction allow, autopsy should be considered for deaths occurring after COVID-19 vaccination. The following are some broad guidelines: ○ Most anaphylactic events attributable to vaccination occur within minutes to hours: thus, individuals expiring suddenly post-vaccination (i.e. within 24 hours) should be prioritized for autopsy ○ Individuals should be prioritized for autopsy if there is no readily obvious and plausible explanation for cause of death OR there are new onset signs/symptoms not fully explained by underlying conditions (i.e. within a year of vaccination) ○ Individuals with suspected COVID-19 should be prioritized for autopsy. For more information, see: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-postmortem-specimens.html
Autopsy	• Perform full autopsy (preferably including brain and spinal cord) • Perform thorough histologic sampling to evaluate for cause of death; including collection of lung and upper airway tissues if COVID-19 is suspected • Carefully assess for findings consistent with anaphylaxis, i.e. laryngeal edema, pulmonary hyperinflation, mucus plugging of airways, tissue eosinophilia • Carefully examine the vaccine injection site for evidence of inflammation/infection
Ancillary Testing	• In cases of suspected anaphylaxis, consider serum tryptase, serum IgE analysis • Consider freezing serum or tissue • Toxicologic analysis • COVID-19 PCR • Routine postmortem microbiologic and other infectious disease testing, as indicated by gross findings and clinical history • Request antemortem laboratory specimens, if available • Other tests as appropriate for diagnoses under consideration
Death certification	• When completing the death certificate, if it is the opinion of the medical certifier that the vaccine caused death, the vaccine and its fatal complications should be reported in the proper sequence in Part 1.

	• If the vaccine is determined to be a significant contributing factor, it should be reported in Part 2. • If it is determined that the vaccine is not a cause or contributing factor to death, it should not be reported on the death certificate. • More information on cause of death certification can be found in the Handbooks for Death Registration (https://www.cdc.gov/nchs/nvss/handbooks-and-guides.htm).
VAERS Reporting	• ME/C are strongly encouraged to report deaths occurring after COVID-19 vaccine administration, irrespective of attribution to vaccination, to VAERS** online at: https://vaers.hhs.gov/reportevent.html • If assistance with reporting to VAERS is needed, email info@VAERS.org or call 1-800-822-7967
Other Public Health Reporting	• ME/C should consult with their state or local health department to determine if there are any other jurisdiction-specific public health reporting or investigative preferences or requirements. A health department directory is located here: https://www.cdc.gov/publichealthgateway/healthdirectories/index.html

**VAERS=Vaccine Adverse Event Reporting System

Some comments on this guidance:

1. The Coroner and Medical Examiner should become fluent in the adverse effects of the vaccine. These are covered in Volume 06 of this series. The Case Triage is inadequate. The FDA, the CDA and the SC DHEC continue to downplay the adverse effects. We request that the Medical Examiners review Volume 06 and establish a SC state Case Triage criteria list. Specifically, damage can occur in any organ, and damage can result in miscarriages, still births, and a myriad of other reproductive system adverse effects. These adverse effects can be caused by the spike protein and/or the LNP (Lipid Nano Particle) complex.

2. For the same reason, the Autopsy and Ancillary Testing section should be expanded to examine damage in all organs. Thrombosis,including microclots, should be expected whenever failure of the circulatory system or nervous system is a suspected primary or secondary cause of death.

3. VAERS Reporting: Though this should be done, the record of the FDA/CDC/SC DHEC taking this system seriously is dismal. We recommend that a SC organization associated with the medical examiners create their own medical database and information exchange. Skills should be exchanged through a blog. If none exists, the PHIC can assist.

4. The overall web page of the NAME society for Covid-19 is https://www.thename.org/index.php?option=com_content&view=article&id=89:covid-19&catid=20:site-content&Itemid=282

5. The web page has interesting and important information, but the impression given by an examination of the entire NAME web site as well as the contents of the Covid-19 web page is that medical examiners have little information and don't want to know and study adverse effects of the vaccine. They are CDC pill swollowers, perhaps not individuals, and most likely there will be examiners of integrity in South Carolina, but the evidence needs to be provided.

4.13.1.3 Other Papers and media for Specific Tests

4.13.1.3.1 Brain

A paper by Michael Morz, published in October, 2022 [15] provides undisputable histopathological symptoms of damage due to the mRNA vaccine. There's a number of pictures that show the symptoms.

4.13.1.3.2 Cardio Vascular System

An embalmer discusses her findings: 93% of the last 30 people she embalmed had clots. Another embalmer saw 65% of his cases [12] This suggests that embalmers would be an early warning system to medical examiners and that the medical examiner should be notified.

A paper out of Colombia reported that in a postmortem study of 121 deaths primarily "vaccinated" with the CoronaVac whole virus "vaccine," 57% were classified as sudden cardiac death (SCD) with the same cardiovascular pathologies of the mRNA shots. 21% of the cases had pulmonary embolism. This suggests that any Case Triage include any SCD deaths, regardless of vaccination brand.

4.14 Data From Health Insurance Companies

One paper published in JAMA Pediatrics [16], was used as a reference when the CDC admitted there was a safety signal risk for myocarditis and pericarditis for children aged 5-17 years. Quoting from a substack article by Dr. Jennifer Brown [17], who was quoting from the JAMA article:

"Researchers identified 89 cases among 12- to 15-year-olds and 64 cases among 16- and 17-year-olds after reviewing records from commercial databases run by CVS Health, HealthCore, and Optum."

To be clear, the researchers did not use the database the FDA and CDC organizations have established to capture adverse events: VAERS. They used insurance databases. At first blush, this sounds like a great idea. The insurance companies get a time sequence of ICD-11 codes for a patient. If they are coded accurately, perhaps you would conclude going to insurance databases would be almost as good as having direct access to healthcare system medical databases. Not so.

Dr. Brown comments:

> *So to be clear here, they used insurance company data to gather this info, not VAERS. Here is the problem with that: do you know how many times people change health insurance?! I have some patients who have had 3-4 different insurance plans in a year span of time. Job changes, divorce, marriage…how can you accurately track data when the kid was vaxxed with Blue Cross, but then dad got a new job and now Cigna covers the kiddo when the post vax incident occurred? You cannot. They did not even bother to track all insurance providers. The data here is woefully underreported and YET……the cases still met threshold for safety signal concerns.*

Dr. Brown also points out that the study:

> *Exclude[ed] those who lost their insurance during a certain window of time, which was 365 days for most outcomes. Yup, there it is……if you LOST insurance, you were excluded from data collection.*

The message is: Insurance data studies are probably seriously defective because there is so much data that will be omitted due to movement of individuals in and out of plans. The only valid use would be to study a single adverse event, which presumably would be within one insurance plan (but not always, such as an adverse event near the end of an insurance year).

5 Web Sites

5.1 Introduction

There are websites that have been created in most western nations to document the personal stories of those suffering from adverse effects. Movies and television documentaries have also been made. This is just a sampling of what is available. We recommend that you search “adverse effects” or “adverse reactions” and then a country name to find the database and/or the testimony databases for that country.

5.2 How Bad and How Bad Is My Batch

These connected web sites, HowBad and HowBadIsMyBatch, will be important to any future South Carolina effort to re-establish integrity in its Public Healthcare organization.

HowBad is an encyclopedia of Covid-19 pharmaceutical and policy effectiveness and adverse events. It is a one stop shop for those who want the analysis reports, though it does provide links to the analysis engines for do-it-yourselfers. HowBadIsMyBatch provides a field for a user to enter the batch number for a Covid-19 shot when they want to determine how many adverse effects reported in some database are associated with that batch.

It is really hard to provide the reader with a snapshot of the landing page. But here goes, not as a snapshot, but as a “copy and paste, so the hyperlinks actually work. Content is changing all the time, so it is recommended that the web page be used for the latest information.

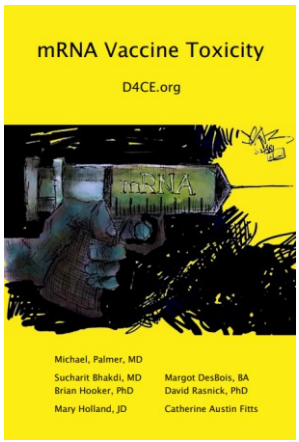
SAFETY SIGNALS FOR ANY VACCINE : SEARCH ENGINE :
Based on 33 years of VAERS data for 99 different vaccines and 16849 different symptoms, (read more here), SAFETY SIGNAL is a search engine for checking out any vaccines.

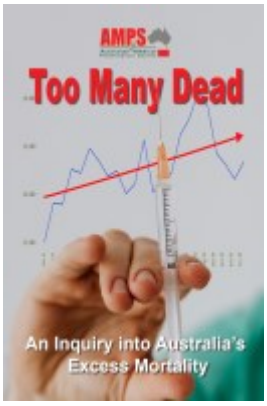
- Enter a vaccine name and it will display all the symptoms for that vaccine ranked by strength of safety signal.
- Enter any symptom and it will display all the vaccines with that symptom ranked by safety signal.

SAFETY SIGNAL - (datasets : analysis / lookup) - (background : ppt / pdf) - (demos : do any vaccines cause autism?) - (observations : summary of signals)
NEW : FOR OTHER VACCINES : PLOTTING SYMPTOM FREQUENCIES BY AGE :
To see graphical plots of symptoms for any other vaccine, you can use the search engine here - PerVaers

LOT NUMBER SEARCH :
Are You In The Clear ? | **Check Lot Number** | **Lots by Zip Code** | **Vaers-Aware** | **EU Deletions** | **Under-Reporting-Factor (URF)**

FREE BOOKS & NEWSLETTERS :





INJURED GROUPS :
The Control Group | Health Care Workers. Full | Nurses | 900 Nurse Testimonies | Vaccination Clinic Code Blue | Military | Navy | Pilots | Athletes | Civilians | Journalists | Adolescents | Children | Babies | Mothers | Aged | Gender Differences | National Differences | Targetting Countries | Japan | Domestic vs Foreign | State Differences | Database of 631 Victims of Death Protocol

WHISTLEBLOWERS :
Doctors | Coroners | Undertakers | Insurance Companies

SYMPTOMS :
Overview | How to check if you have been secretly vaccinated | Data-mining association rules | 3400 Case Reports | Dr Trozzi Library | Myocarditis | Blood Effects | Bleeding | Blood Clots | Blind (clots in eyes) | Amyloid Clot Mechanism | Amyloid Clot Cases | Liver Damage | Brain Damage 1 | Brain Damage 2 | Dementia | Nerve Damage | Bells Palsy | Tremor | Paralysis | Cancers & Neoplasms | DNA Modification 1 : LINE 1 | DNA Modification 2 : Dr Phillip Buckhaults | DNA Modification 3 : Dr Kevin McKernan | DNA Modification 4 : Dr Jürgen O. Kirchner paper | DNA Modification 5 : Manufacture Whistleblowers | Immune Deficiency | Autopsies

CAUSATION & CORRELATION : : **Determining Causality** + Notes. The Proportional Reporting Ratio is the method used by the EMA and CDC to detect safety signals.
[Please download this info to protect from censorship]
A. PROPORTIONAL REPORTING RATIO :

- **ANALYSIS :** Covid vs Flu Jabs + more
- **ANALYSIS :** Not the Same
- **ANALYSIS :** VAERS PRR Death Ratings (1990-2022)

- **ANALYSIS :** WHO PRR Cardiac Ratings
- **ANALYSIS :** Safety Analysis of All Vaccines (1990-2022) + Methodology + Supplementary

- **SEARCH :** Vaccine Safety Search Engine (based on data above)
- **SEARCH :** CSV : Safety Ratings Grouped by Vaccine (1990-2022)
- **SEARCH :** CSV : Safety Ratings Grouped by Symptom (1990-2022)
- **SEARCH :** PRR Graphs (all Jabs) + Search

- **FOI :** request by Epoch Times for CDC to release PRR scores
- **FOI :** CDC Releases PRR Scores (2009-2022) part 1
- **FOI :** CDC Releases PRR Scores (2009-2022) part 2
- **FOI :** CDC Releases PRR Scores (2009-2022) part 3
- **FOI :** FDA Refuses to provide COVID vaccine analysis
- **FOI :** Senator Ron Johnson: Requests to CDC for PRR analyses

B. PERCENTAGE OF REPORTS : A high % of reports with a symptom is an indictor, but for accurate comparison between vaccines use PRR ratios above.

- Report % Cardiac (1990-2008)
- Report % Thrombosis (1990-2022)
- Report % Death : (1990-2022)

C. NARANJO ALGORITHM :

- Naranjo Algorithm

D. TEMPORAL ASSOCIATION :

Time till onset | Second Peak | Second Peak - additional info | Long-term Effects | Six Months Later | One Year Post Jab

E. MECHANISMS (BIOLOGICAL PLAUSIBILITY) :

3400 Case Reports | Dr Trozzi Library | **mRNA Vaccine Toxicity** | **Clots and Leaky Vessels** | **Virus vs Vax** See Video | **Outline of mechanisms**

F. TOXIC LOTS :

Alphabet-Toxicity | **Danish Study : Placebo Batch Numbers** | **USA Study : Clusters of Toxicity** | **Chance of a bad batch** | Placebo Lots | LNP Toxicity | Lethal Dose Testing | All or Nothing | Clusters | Lot Expiry Dates | Lot Variation | 5% of Doses Toxic pdf | Severe | Lethality | RNA Degradation

G. CORRELATION :

- Correlation
- Dose-Effect Correlation
- Adverse Effects and Lot Sizes

[Additional information on lot sizes : Pfizer Lot Sizes USA (ICANN FOI) | Lot Sizes]

HARM CALCULATORS :

Denmark : Chance of a bad batch | **Denmark : Placebo Batch Numbers** | **USA Study : Clusters of Toxicity** | **USA : Alphabet-Toxicity Calculator** | **Deaths per Dose** | **Risk of Vision Impairment** | **Hospitalization** | **Disability** | **Recovery** | **Emergency Room** | **74% of Deaths**. Study | **V-Safe** | **Open Vaers** | **Per Vaers** | **Virus vs Vax** See Video | **Excess Mortality** See also Campbell |

EFFICACY CALCULATORS :

Efficacy Calculator | **World Council for Health** | **Efficacy of Partial vs Full Vaccination** | **Cause of Death**

CLINICAL TRIAL DATA :
Clinical trial data

FALSE PANDEMICS :
Previous Swine Flu Plandemic | Jane BurgerMeister | Wolfgang Wodarg : False Pandemics Book | Attempted plandemics

PCR :
False Positive | False Positive for ANY Disease | PCR Accuracy | Viral Samples ? Doc | 10 Fatal Errors with the PCR | 20th December 2020 Article | Wuhan Study | PCR Papers

CENSORSHIP :
Federal Censorship Policy | Biden Administration Covid Censorship | Injunction Issued Against Federal Gov for Censorship | Doctors | Medical Boards | Search Engines | Social Media | Data Sources

2020 DEATH PROTOCOLS :
Database of Victims of Death Protocol | **Dr John Campbell** | **Dr Chris Martenson** | **A "Good" Death** | **Dr Mike Yeadon** | **Teresa Tannahill** | **Do Not Resuscitate Orders** | **Matt Hancock : DNR Orders** | **Removing Legal Protections**

SUPPRESSION OF HEALTH PROTOCOLS :
Effective health protocols that were suppressed | **Josh Mittledorf** | **Meryl Nass PDF: "Recovery" Trials** | **"Solidarity" Trials** | **"Discovery" Trials** | **Palmer Foundation : Recovery Trial**

PANDEMIC TREATY / PANDEMIC PUSHERS :
Issues with Globalism | Timetable for Tyranny | Sep 20th 23 : UN declaration to extend Covid measures indefinitely | Analysis | Pandemic Treaty | International Health Regulations | Download : letter to MPs | Analysis | **Urgent Petition : Stop International Health Regulations** | Dr John Campbell : analysis of International Health Regulations | Parliamentary Discussion 1 | Parliamentary Discussion 2 | Surveillance and speech control | Crimes of WHO Director Tedros | WHO Depopulation Program 1 | WHO Depopulation Program 2

VACCINE ADMINISTRATORS :
Companies | Hospitals | Universities | Indemnity | Liability | Vaccine Distribution by Zipcode

THE VACCINE CONTRACTS :

Safety Unknown | Covax Contract | Pfizer Manufacturing Agreement | Pfizer Manufacturing & Supply Amendment | Pfizer Binding Terms | Janssen Advance Purchase Agreement | Janssen Additional Doses | Janssen Terms Sheet | Serum Purchase Agreement | Serum Term Sheet

GOVERNMENT & REGULATORY CAPTURE :
Perseus MHRA Report | Pre-Plandemic Research | Pre-Plandemic Patents | Pre-Plandemic Record-keeping | WHO & Sterilization | Intent to Harm in 2020 | False Positive | No independent testing allowed | Hiding mRNA in other vaccines | Bacterial Strategies | Federal Worker Exemption

KNOW YOUR RIGHTS - THE LAW :
Rights Resource | Legal Resources (Healthy American) | Informed Consent | Human Rights Law 1 | Human Rights Law 2 | Nuremberg Code: Did They Break it ? | Public Health Emergency ? | Common Law | Health & Safety Law | Medical Law | Clinical Trial Law | Misleading Information | Censorship Law | Thoughts & Beliefs | Discrimination Law | Privacy Law | Exemptions | Absolute vs Conditional Rights | Adam's Clothes | Coronation Oath of King Charles III | Lawlessness

COURT OF PUBLIC OPINION :
Evidences

POWER TO THE PEOPLE :
Politics or Puppetry

DIVINE LAW ? :
Lawlessness | An Apocalypse ?

OFFICIAL DATABASES :
Government Databases | Deletions | Jab Rejection

SYMPTOM SEARCH :
Jessica's Table | **ONS 2021** | **ONS 2022** | **Vaers Analysis (USA)** | **Open Vaers** | **Per Vaers** | **CAERS (Canada)** | **V-Safe**

ARCHIVE DATA:
Moderna 2021 Archive Data | Pfizer 2021 Archive Data | Janssen 2021 Archive Data | Moderna (outside USA) 2021 Archive Data | Pfizer (outside USA) 2021 Archive Data | Janssen (outside USA) 2021 Archive Data

ABOUT US :
Background |

Total Visitors for HowBad.info and HowBadisMyBatch.com since December 2021 : 178,414,955 (last updated June 11th 2023)

5.3 DailyClout

The dailyclout web site, https://dailyclout.io, is one of the most important web sites for adverse event data, analysis, and political action. This is Naomi Wolf's web site. It is an incredible resource documenting such issues as the Pfizer documents; ie, the adverse events documented before FDA approval but ignored during the approval process.

The landing page is very busy. It provides the latest news. For today the top of the page is:

Figure 45. DailyClout.io Landing Page

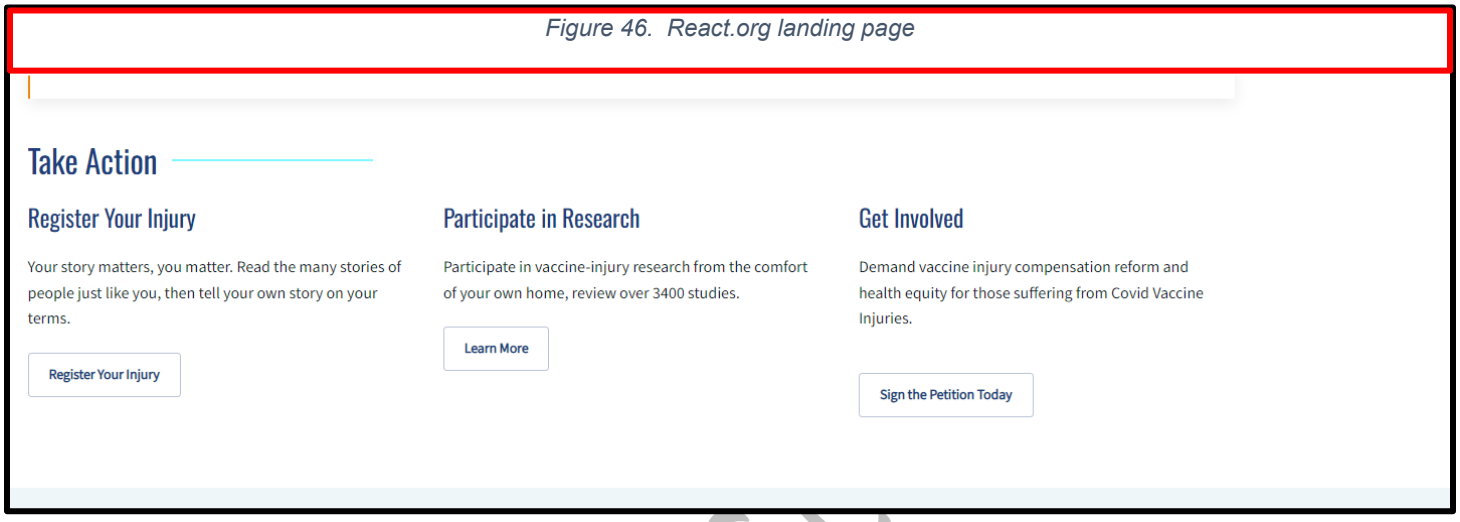
The specialty of DailyClout are the reports from the Pfizer papers, which detail the research ~~done~~ by Pfizer to qualify the Pfizer countermeasure for EUA status. Daily clout has published two books, seen to the right on the above screenshot. One is a report on the Pfizer documents; the second is a historical account of the adverse effects on society of the management of the Covid-19 era.

5.4 React19.org

React19 provides data on specific adverse reaction issues Go to this website for case testimonies, scientific studies on adverse effects, treatment options, and support groups.

This is the main part of the landing page:

Figure 46. React.org landing page



There are a couple of pages that are of particular interest. The “For Patients” page contains the following:

Figure 47. React19, Features on the For Patients page

The “Science and Research” page has these functions:

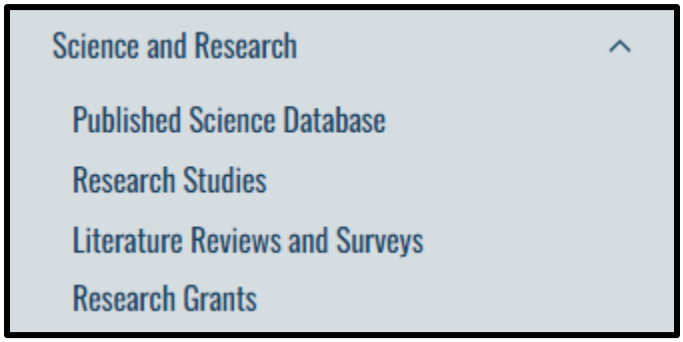


Figure 48. React19, Science and Research page features

This page provides a huge inventory of scientific and investigative journalism papers regarding adverse effects. For example, as of this writing, the "Publish Science Database" includes 3,580 entries.

This is a valuable resource for legislators.

5.5 Truth for Health Foundation

The Truth for Health Foundation (https://www.truthforhealth.org/) has a mission and function similar to React19.org but, in addition, is overtly Christian in its mission statement. It also has a broader scope, covering all vaccines. The landing page is long, making it difficult to demonstrate its contents. The navigation bar at the top is:

Figure 49. The Truth for Health Foundation landing page navigation bar

5.6 Real Not Rare Website

The https://realnotrare.com website provides personal stories of people harmed by the VAX. It provides a large number of support groups organized by adverse event.

The landing page has many stories. The navigation bar and top of the landing page snapshot:

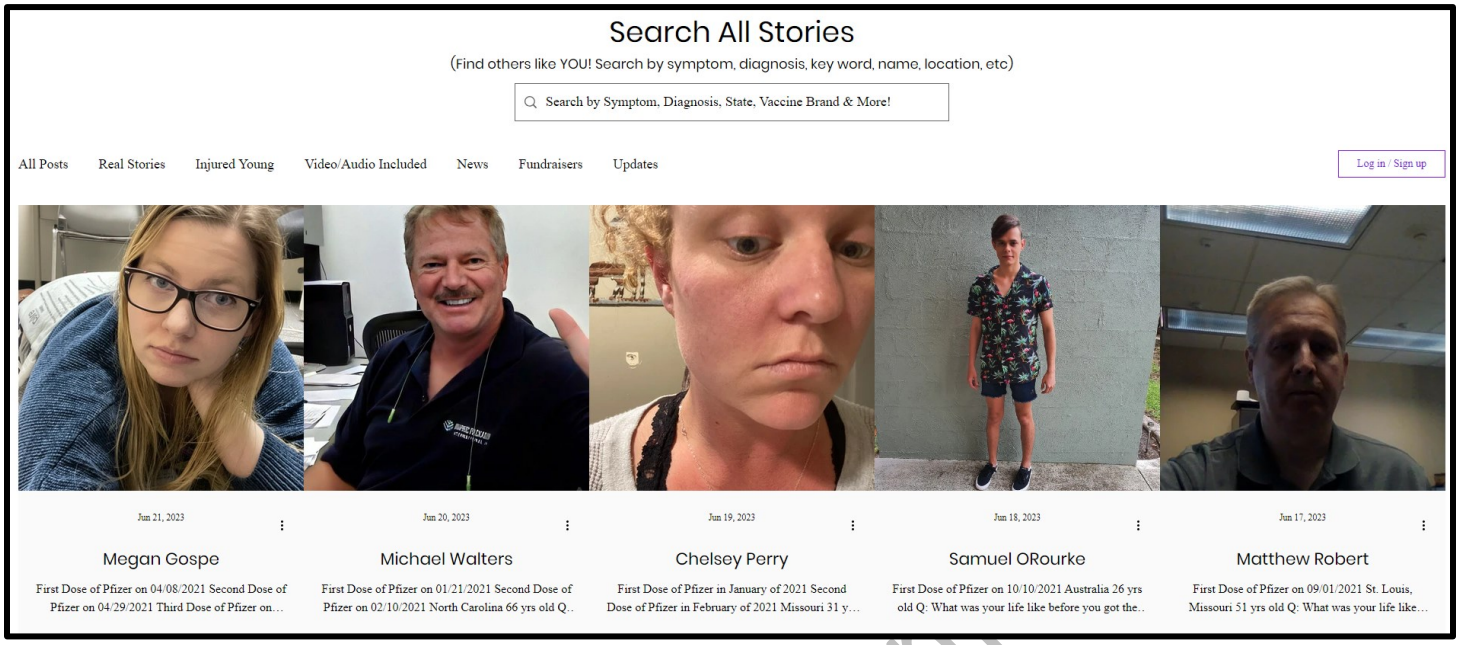


Figure 50. The Real Not Rare landing page

5.7 Doctors for Covid Ethics

This is a web site where “hundreds of doctors and scientists” speak out about the behavior of the medical and political bureaucracies regarding the Covid-19 response. There’s a lot of educational papers and videos about Adverse Effects, as well as debunking of the deceits of the power elites. https://doctors4covidethics.org/.

A snapshot of the top of the landing page:

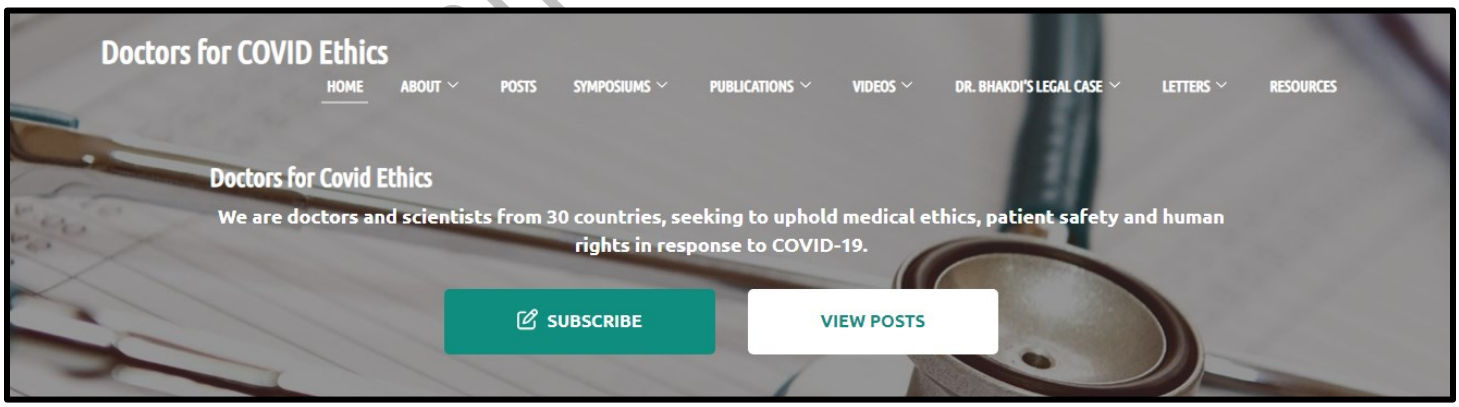


Figure 51. The Doctors for COVID Ethics landing page

Youtube provides many videos on the Covid-19 countermeasures, but censors them. For example, John Campbell is one popular channel. (The censoring algorithms haven’t taken into account facial expressions associated with the text, so some of his real analysis is provided through “the look.”) Furthermore, the search engines used in browsers, at least the popular ones, such as Google, censor

and manipulate search results to hide available videos. This is one source of videos you might not see anyplace else. They are also from US and international sources. For example:

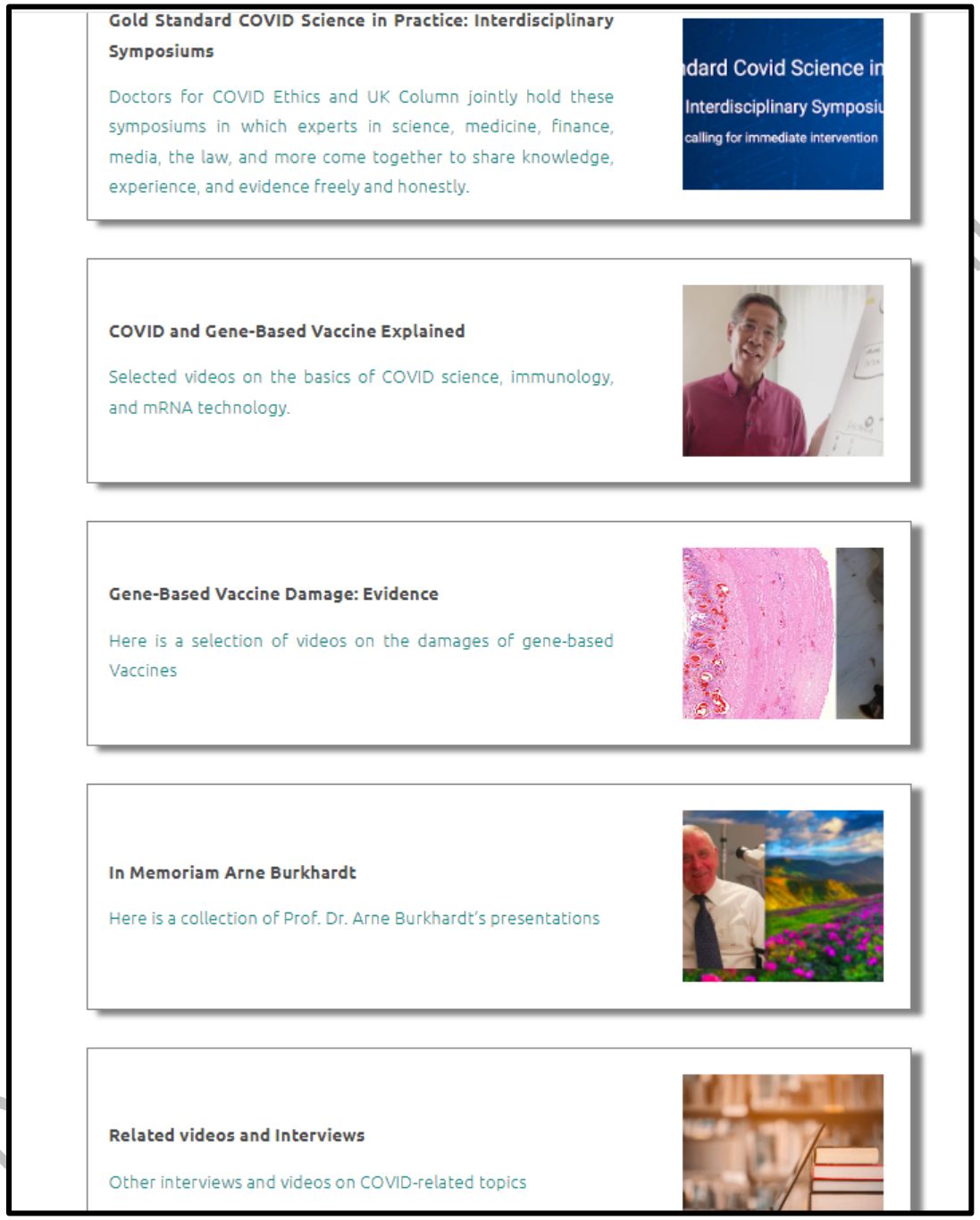


Figure 52. Doctors for Covid Ethics Videos

5.8 TrialSiteNews.com

This site focuses on the legal aspects of the management of Covid-19. It has lots of adverse effect analyses presented in a way that can be useful in any legal or legislative actions. https://trialsitenews.com. The site is free but requires registration. It has many links to articles and support groups. The landing page emphasizes articles published somewhere in the websphere. The "Groups" page provides various topical groups to join. A snapshot of the top of this page:

Figure 53. TrialSiteNews Groups web page

5.9 The Epoch Times

Regardless of your political persuasion or your opinion of the Covid-19 era management, the Epoch Times is a daily source of news and videos regarding Covid-19 era management. Usually, the articles are critical of Covid-era management. However, most are not opinion pieces, but straight reporting, with citations. It is helpful to read all and follow the citation links to form your own opinion

5.10 Substack.com

Substack is a primary source of professional and amateur information on Covid-19 era management. Substack has become a major source of such information since world-wide censorship has been

imposed on science and medicine. The reader can select from hundreds of posters/authors. Subscribing to an author is free, but the author may place important articles behind a paywall. Typical cost per author is in the $5-$8 per month range. Many of the most studied, most renowned authors post most everything for free. Almost all articles are cited, so the reader can follow the links to original scientific articles or online analyses, which are censored by search engines, the government, professional organizations, and the media if Substack didn't publish or cite them.

6 A Legislative Solution

The state legislative solution, the Corrective Action, to the problems of analysis and garbage in garbage out is a reliable, non-political, independent, timely medical data source is defined by the following resolution:

6.1 The Problem

Nationally and internationally, poll after poll shows a significant drop of confidence in science, healthcare, government management of healthcare, the media, and, specifically, the ability of all these organizations to manage and provide truthful information about Covid-19.

The largely unknown heath impact of the Covid-19 shot endangers public health. There is an urgent need for a South Carolina Vaccine Safety Database (SCVESD). The SCVESD, which would be developed using the RHIO architecture, security, and management standards as understood in the medical database world, will remove our state's dependency on the federal government and will fill the void in the ability to study vaccine safety issues potentially impacting South Carolinians of all age groups and demographics.

> The proposed name for this initiative was SCVESD. However, this does not reflect the scope of functionality of the proposal. Specifically, it is more than Vaccine Safety; it is pharmaceutical efficacy, adverse effects as well as treatment protocol efficacy and adverse effects. It can also serve as an early warning system for new health issues. Therefore, we propose to name the proposal SCHIAS (South Carolina Health Information Analytics System). We will use that acronym from here on.

In South Carolina there is a distinct widespread dissatisfaction with the handling of the COVID-19 response by our elected officials, state health agencies, and state healthcare facilities. Based on existing evidence there was a lack of communicating an objective disclosure of existing data and evidence about Covid-19 and Covid-19 public mitigation strategies including vaccination at all levels of government.

VAERS, the CDC's own reporting system for adverse effects shows there have been over 9,000 Covid-19 vaccine adverse events reported by South Carolinians of all ages. It is widely acknowledged that vaccine adverse events are significantly under reported. At the international level, the computed figure for serious adverse effects is about 7%, with the understanding that the serious adverse effects can be delayed; that damage can be for a life-time, with infertility and death a real possibility.

The state legislature, the executive branch, and, above all, DHEC are silent in saying, "this isn't good enough for South Carolinians". DHEC has repeatedly messaged that the Covid-19 vaccine is "safe and effective." It does to this day even though it is clear that vaccinations are not "safe and effective" for everyone.

We now understand that the federal government does not endorse gold standard science when studying vaccines on the existing and future recommended vaccines we are being asked to accept.

This reality makes it not possible for citizens of SC, or even professionals, to transparently assess the safety profile of new and old vaccinations we are repeatedly asked to accept further highlighting the need for the SCHIAS to be created in our state.

South Carolinians understandably will be questioning why our elected officials are not acting in our best interests to further investigate vaccine safety and are not passing legislation to protect medical choice and Informed consent which is in alignment medical ethics. State legislators allowing mandates of liability-free shots places the burden of risk squarely on South Carolinians instead of on pharmaceutical companies where it belongs. This is not good enough for South Carolinians.

6.2 Objectives

- Re-establish integrity and trust in public health in South Carolina.
- Remove the dependency on the federal government and transparently provide data and analysis support for pharmaceutical effectiveness and adverse effects which will support public health in South Carolina.
- Establish a culture in the medical community that questions whether health problems are associated with pharmaceuticals as either unintended consequences or adverse effects which threatens public health. Provide funding to study and identify these threats.
- Change state laws, as reflected in already submitted bills to the legislature, to protect the citizens from Constitutional overreach by the federal government and manipulation, incompetence, and poor policy recommendations regarding health and education by the executive branch of state government. Additional state initiatives are necessary to ensure that citizens of all ages can critically assess information in general, but especially information related to their own and their family's health.
- Change state laws, as reflected in already submitted bills, to protect SC citizens from Corporate and Institutional overreach, manipulation, incompetence, and poor policy recommendations regarding health.
- Identify South Carolina office holders that do not support efforts to improve public health, to protect the informed consent ethic, or to protect human rights, and work to unseat them through the primary process.

6.3 Tasks

1. Establish a document of understanding with either the legislature (a bill?) or the SC state executive branch to pursue the following tasks.
2. Establish state commitment to RHIO concept and its two dependencies on quality assurance testing and autopsy protocolsby the state executive branch provide education to legislature and provide legislators with the information required to write bills to establish a state RHIO called the **SCHIAS.**
3. Find a regional healthcare system with EPIC that would work with him and a professor from Clemson to prototype the technology. (The server configuration would be housed at Clemson.)
4. Coordinate communication with interested parties, research, strategizing on how to

accomplish objectives.

5. Establish coordination of -SC Healthcare system(s)- Coordinate and cooperate in developing a project plan for the SCHIAS as a stakeholder and technical, and administrative support for their components of the SCHIAS. Establish workflows and plans to effectively use the data from the SCHIAS. We expect healthcare systems to have an interest in participating as they are an important stake holder in individual health and public health. This database should not significantly burden South Carolina healthcare systems. Protection of confidentiality/privacy of patient's data is a priority and is part of a RHIO design.
6. Educate and gain support of the Governor and Lt. Governor, requesting that one or the other publicly support and champion all the objectives of this roadmap
7. DHEC: Support the objectives of this roadmap; realign DHEC or its successor to establish appropriate Corrective Actions to assure future events like Covid-19 are managed with integrity and using the full RHIO process.

6.4 Funding

Funding will be provided through a yet to be identified state source to support Dr. Leet and Dr. Kulldorff through the planning phase of the new RHIO. Epic, through its representative, Jeremy Aikins (608.777.5620) says that any work needed to define the queries and to set them up would be supported by Epic as part of their ongoing contracts. Deliverables before a final bill is written would include:

1. An RFI to potential service providers and response,
2. an RFQ to service providers and implementers and response, and
3. a full project plan and budget, with all operating protocols, including security design,

The budget would be presented to the legislature as a bill for development funding during the 2024 spring session.

To avoid political influence and data corruption, there cannot be 1 dollar of funding from any source other than the state legislature. The executive branch has control over the implementation and operation only in that the governor, in consultation with the Surgeon General, will recommend members of the RHIO steering committee, which will have executive responsibility over the entire project.

Once operational, the database (front end phara product quality control, through EMR records, through autopsy results) will be available for analysis by anyone, including DHEC and/or its successor. Fees may be charged for data extraction and, if analytic services are desired, for analysis.

6.5 Further Remarks on the SCHIAS RHIO

6.5.1 Benefits

- The RHIO will be an essential state resource and service for the future, from Covid on, and for both infectious disease and other healthcare issues. The opportunities offered by the SCHIAS

for thorough investigations of vaccine safety concerns and well-designed, planned, retrospective vaccine studies in South Carolina health care systems databases will lead to heightened interest by researchers, advocacy groups, members of the State Legislator, members of Congress, and others. The interest in the SCHIAS shown to date as it is presented has brought increasing attention that this database is urgently needed.

6.5.2 Requirements

- The RHIO Board must be independent of all healthcare organizations. This means the voting members can not be or have been executives or employees of healthcare organizations or state government. All non-voting members will receive no compensation. The objective is to preserve the integrity of the Board.
- The SCHIAS will provide deidentified data on patient characteristics, health outcomes (according to data resulting from inpatient, outpatient, and emergency- room records), and vaccination history (vaccine type, date of vaccination, manufacturer, lot number, and injection site). Researchers interested in particular vaccine safety hypotheses will have access and analyzing SCHIAS data
- To enable studies on whether health problems are associated with vaccinations, the database includes data on vaccination histories, health outcomes, and characteristics of South Carolina patients in participating state healthcare systems. Researchers, members of the State Legislature, managed care groups and the public will have the ability to have access to the SCHIAS.
- Four overarching principles became clear from the COVID-19 era related to the need for a SCHIAS are the following:
  1. **Independence.** Ensure that potential biases and potential conflicts of interest are minimized, balanced, or otherwise managed in the design and implementation of all processes, practices, and policies related to the SCHIAS.
  2. **Transparency.** Ensure that all processes, practices, and policies related to the SCHIAS are developed in the spirit of openness, clearly articulated, and easily available to interested persons or entities, and that any deviations from them are documented and justified.
  3. **Fairness.** Ensure that all processes, practices, and policies related to the SCHIAS are designed and implemented in a fair manner.
  4. **Protection of confidentiality.** Ensure that the design and implementation of the SCHIAS protect the confidentiality of individually identifiable information while enabling traceback to patients when adverse effects are detected that should be addressed by other patients that have the same medical situation
- South Carolina House and Senate Committees must be charged with, and held accountable for, oversight to ensure that the policies and procedures of the SCHIAS and its data sharing program are implemented as fairly and openly as possible.

6.5.3 Status

We have identified at least two premier principal investigators with both biological science and technological analytics background to anchor the professional team.

Dr. Leet has extensive project management experience- over 60 years- with projects like this and can deliver the funded project to the project manager on the RHIO team.

We have briefly looked at the Health Sciences SC organization, https://healthsciencesc.org, with the hope that their database initiative could be extended to encompass this proposal. Unfortunately, we found:

1. The database is limited to a few hospitals.
2. The contents of the database are not known.
3. Access to the database is severely restricted to research institutions. It appears, due to the need for IRBs, that the resource is for those doing human experimental research, rather than analytics.
4. PHI data? The database we propose is like VAERS, but more timely and more current- near real time. It is also "raw." It has no PHI identifying information.[4]
5. VAERS is accessible to anyone, including the new SC state health organization, as are country and regional databases around the world.) Correspondingly, for healthcare quality, we would like as many people as possible to be able to run analytics on the data.
6. If some special form is necessary, then that can be accommodated, though I'm not sure what that form would contain.
7. The data in SCHIAS would be air gapped. No one can run a query directly. Queries would be defined via simulator available to the user. The actual query would be run by staff. The analytics would be defined by the user, though there would be a suite of analytic tools available with interfaces already built. The results would be returned to the user.
8. These data may or may not be used for human experimentation, just like VAERS. If there is a stipulation for IRB due to human experimentation, that could be set up.
9. The organizational setup for HSSC could be expected to result in bias and data control that would be unacceptable to a quality control and reporting system. The management of VAERS, as well as most other similar databases around the world, has proven that the temptation of managers to manipulate the data, removing those data that reflect poorly on the managers, is too great to resist. The data have become untrustworthy. The SCHIAS RHIO Board for our proposal can not include voting members that are associated with healthcare institutions or government organizations. There are probably other stipulations that would need to be made in order to retain the data's integrity, such as exclusion of certain university faculty. This is basically a data analytics function, and would best be served by experts in data analytics as a profession.

6.6 Legislative Summary

The attachment is an executive review of the proposal, in legislative-like language.

[4] Mechanisms exist in advanced database design that can be used to trace patient data back- in our case to an attending physician- without any person, even if they were able to hack the entire database, being able to decode the link. Our principal investigators have knowledge of these techniques. Physician data, as well as location and time data regarding events, will be masked by this technology.

Proposed SCHIAS

Title: Establish a State-wide Reliable, Timely Disease Data Management and Control System Base on the RHIO Design

WHEREAS: No specifications for quality control were contained in the development and manufacturing contracts for the Covid-19 mRNA "vaccines" and, to date, there is no evidence of adequate quality control. Evidence is available and documented in research papers of contamination and various parts and pieces of the primary components of the vaccine. **There is no data on how this impacted South Carolinians**.
WHEREAS: Both the federal and state governments used the psyOps weapon of FEAR to ~~motivate~~ force citizens to accept the "vaccine" without full informed consent. The federal and state governments, as well as the media, falsified data, manipulated hospital records, used funding to ~~force~~ encourage compliance, mismanaged and misapplied protocols, etc., emphasized cases rather than severe outcomes, used "fact checking" to provide misinformation, ALL to instill FEAR. **We stipulate that this was morally reprehensible.** DHEC "passed through", apparently without critical review, the federal government's faulty information. DHEC continues to report on their web page that the mRNA "vaccines" are "safe and effective." Both are demonstrably untrue and legally open the state up to civil and perhaps criminal suits because those statements are misleading and negate "informed consent." **On the other hand, DHEC did not and does not have available accurate, dependable effectiveness and adverse effects data in order to provide accurate advice to the SC government and its citizens.**
WHEREAS: All available AE data show the severe AEs are running somewhere between 7% and 15% of the population, but we do not have accurate data on SC**.** Through FOIAs, DHEC has admitted there is no system for tracking effectiveness and adverse effects of pharmaceuticals. For the Covid-19 era, the only real attempt at accurate data was to track shots in the arm. This is a faulty metric for pharmaceuticals and the responsibility for such metrics goes up to Governor McMaster. No doubt he was misinformed on the correct metrics for managing infectious disease, which then goes back to DHEC. **The state does not have an effective and responsive methodology for tracking the effectiveness and adverse effects of a pharmaceuticals or, for that matter, treatment procedures. Neither does it have an effective earlier warning system and early treatment procedure methodology for future disease management.**

THEREFORE, BE IT RESOLVED: An independent (of DHEC) laboratory should be established or contracted to evaluate the quality of certain pharmaceuticals circulated in South Carolina. An independent assessment of the toxicity of all the ingredients should be established, where the definition of

toxicity shall be adhered to regardless of the advertised effect. A database should be established with the findings and the finding should be connected to a database of those pharmaceuticals distributed by lot and by location of sale or administration.
BE IT FURTHER RESOLVED: An independent commission be established to evaluate the good manufacturing practices of pharmaceutical manufacturing companies supplying pharmaceuticals distributed in the state. A database should connect the findings to a database of those pharmaceuticals distributed by lot.
BE IT FURTHER RESOLVED: An independent organization be established that manages a new statewide database for anonymously tracking and analyzing patient data to faithfully and accurately measure effectiveness and safety. This organization, management methodology, and database system is an industry standard and is called a RHIO, or Regional Health Information Organization.
BE IT FURTHER RESOLVED: An autopsy protocol be established that (1) defines criteria for conducting an autopsy based on patient records at the time of death when there is an indication that the "vaccine" contributed to the cause of death, and (2) that defines the required autopsy procedures to accurately determine if the "vaccine" contributed adverse effects present at the time of death. Governor McMaster and the Legislature shall immediately request that the county coroners and their medical examiners establish such a system, activate it, and provide any budget requirements for the next legislative session.
BE IT FURTHER RESOLVED: The pharmaceutical quality, the manufacturing quality, the database managed by RHIO, and the autopsy database should be integrated into one analytical database called the SCHIAS.

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1. https://ohie.org/framework/
2. https://www.cms.gov/eHealth/downloads/Accelerating_HIE_Principles.pdf
3. https://digital.ahrq.gov/health-information-exchange-policy-issues
4. https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/health-information-exchange
5. https://www.techtarget.com/searchhealthit/definition/Regional-Health-Information-Organization-RHIO (read the references at the end of the article too)

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