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MEP VACCINE SAFETY REPORT

February 2018

PRIMER ON VACCINE SAFETY

This primer on *vaccine safety* was prepared after requests to address vaccine safety during a period of consultations on vaccination including mandatory vaccination across the European Union. This document does not address the environmental impact of vaccine production which is covered in a separate report.

Before we begin this discussion I think it is important to specifically address mandatory vaccination in the EU and note that a study performed by experts from the ASSET project found no evidence of a relationship between mandatory vaccinations and rates of childhood immunization in European countries. Specifically, the ASSET project stated:

From 2007 to 2013, the enforcement of mandatory vaccinations does not appear to be relevant in determining childhood immunisation rate in the analysed countries. Those where a vaccination is mandatory do not usually reach better coverage than neighbour or similar countries where there is no legal obligation.

Introduction

In order for any medical intervention including vaccination to be introduced and utilised by the general public, the evidence employed to persuade of that use, would need to be honest, accurate and reliable as to the effectiveness and need of implementation. In the case of vaccination before acting on such evidence, there are four fundamental questions that need answering in order that we have transparency:

1. Is the evidence provided in the scientific literature regarding vaccination honest, accurate and reliable?
2. Is the evidence provided by the institutions in the area of vaccination honest, accurate and reliable?
3. Is the evidence provided by the manufacturers in the area of vaccination honest, accurate and reliable?
4. And finally, therefore, is the evidence presented to health professionals that advise and administer vaccines honest, accurate and reliable?

Of course, the summation of those answers directly answers the question: is the evidence presented to the individual to be vaccinated honest, accurate and reliable?

Failure to satisfy any or all of the above four questions that address the body of evidence supporting vaccination, strongly argues against its intervention. By implication, **failure to satisfy those questions and to implement a policy of vaccination may lead in itself to litigation and may open up all willing participants to such a decision, to significant criminal prosecution.** Not least because of the human cost but also the financial one.

By the very nature of cooperation between government bodies, vaccine companies and medical professionals, there is some degree of overlap in the answers provided below and in order to keep this document brief, I have limited myself as to the number of examples given per question, of the many currently available from the scientific and legal literature.

1. Is the evidence provided in the scientific literature regarding vaccination honest, accurate and reliable?

There are many components and requirements that constitute good research, all chiefly concerned with removing bias from a study. Bias can skew a result to demonstrate, wrongly, that a vaccine is safe and effective when in reality it may be unsafe and ineffective. Bias can come in many areas that can be addressed by a good study design. Areas such as:

Funding, participant selection, statistics employed, study control, method of blinding, and many others will determine if the study successfully delivers an accurate, truthful and useful result that can be implemented. Many well respected academics have addressed the problem of biased and inaccurate literature. The leading expert in that field, Professor Ioannidis in a recent paper published in the European Journal of Clinical Investigation describes it thus[1]:

> Based on training thousands of attendees at our educational programmes and professional interactions with colleagues at all levels – from young trainees to top clinical and academic leadership – **we are convinced that very few healthcare professionals are aware of the pervasiveness of biased and inaccurate medical literature**. **It is our combined experience that ignorance of this problem, even at the highest levels of academic and clinical leadership is profound.** Evidence for this ignorance emerges also in several studies and surveys. In a study of journal reading habits, internists (approximately half of whom were alumni of the Robert Wood Johnson Clinical Scholars Program) reported they obtained information mostly from abstracts and not the full articles, stating that they relied on editors to assure rigour and study quality [20]. **Such trust may be misplaced. For example, a recent study showed that several editors of peer-reviewed journals could not tell whether a trial was randomised without a special checklist**. **Even then, of the 324 studies editorial staff considered as randomised trials, 127 (39%) were actually not randomised [21].** [My emphasis].

Jones *et al* reported in the British Medical Journal[2]:

> Among large randomized trials registered with ClinicalTrials.gov and closed prior to 2009, non-publication was common. **We identified an estimated 250 000 trial participants for whom we were unable to find results either in the published literature or in the result database of the registry, which was approximately 26% of the total participants in the included trials.** Our findings are consistent with previously observed rates of non-publication among trials representing a broad spectrum of clinical topics and funding sources.**9 21 24 25 26 27 28 29 30 31 32 Our results add to existing work by showing that non-publication is an important problem even among large randomized trials, and by providing an estimate of the number of trial participants who accepted the risks of participation in these trials but for whom no results are publicly available.**

> The present study also shows that among large unpublished trials completed prior to 2009, utilization of the results database remains limited. Even among studies completed after the results database became available in 2008, ClinicalTrials.gov contained results less than half of the time.
>
> **Prior investigations have shown evidence of publication bias against negative studies as one factor associated with non-publication.**[9] [11] [32] [33] [34]. [My emphasis].

The evidence strongly supports a culture of bias in published literature and, as stated by Jones *et al* is staggering in number.

That fact is not contained just within academic circles, popular science press has published on this. Jeremy Hsu writes in a Livescience health article[3] the following:

> Many patients may not know the full story about their drugs or medical treatments because of a widespread problem involving unpublished or biased clinical trials, according to mounting evidence.
>
> Oftentimes, medical journals or pharmaceutical companies that sponsor research will report only "positive" results, leaving out the non-findings or negative findings where a new drug or procedure may have proved more harmful than helpful.

It continues:

> "You can't say this is an isolated problem," said Beate Wieseler, deputy head of IQWiG's Drug Assessment Department. "It's widespread, and it affects drug companies, universities and regulatory authorities."
>
> Much of that problem arises from financial conflicts of interest when pharmaceutical or medical device companies fund the studies, according to Wieseler and her colleagues. They pointed to past research showing an association between industry sponsorship and positive outcomes or conclusions in studies.

The European Medical Agency is not immune from criticism. Professor Gøtzsche writing in the British Medical Journal[5]:

> Doctors cannot choose the best treatments for their patients despite the existence of hundreds of thousands of randomised trials. The main reason is that research results are being reported selectively. **Comparisons of published drug trials with unpublished data available at drug regulatory agencies have shown that the benefits of drugs have been much over-rated1 2 3 and the harms under-rated.4** Comparisons of trial protocols with published papers have also shown widespread selective reporting of favourable results.[5 6]

He continues:

> **Allowing researchers access to unpublished trial reports submitted to drug regulatory agencies is important for public health.** Such reports are very detailed and provide more reliable data than published papers,1 2 3 4 **but it has been virtually impossible to get access to them. We eventually succeeded in getting access to reports held by the European Medicines Agency (EMA) after three years of trying.** [My emphasis].

He notes examples of such selective reporting that have resulted in significant harm to patients including 50,000 premature deaths.

The extent of this problem, if not already evident, is revealed by Professor Ioannidis when he stated that as much as ninety-percent of the published medical literature is flawed[6].

Opinion

According to the data and experts there is significant doubt that the evidence provided in the scientific literature can be relied on to be honest, accurate and reliable when making a decision on medical intervention regarding vaccination.

2. Is the evidence provided by government institutions in the area of vaccination honest, accurate and reliable?

We have already seen evidence suggesting endemic bias and sadly corruption that appears to exist throughout the scientific literature and medical institutions however there are specific examples that simply defy belief of which I will cite one case here.

Dr William Thompson, a senior researcher at the Centres for Disease Control and Prevention, a major US public body involved in medical research and regulation, in a statement read to congress by Senator Posey described Dr Thompson's role in the CDC's corruption regarding research on the MMR vaccine[7]:

> 'All the authors and I met and decided sometime between August and September 2002, not to report any race effects from the paper. Sometime soon after the meeting, we decided to exclude reporting any race effects. **The co-authors scheduled a meeting to destroy documents related to the study. The remaining four co-authors all met and brought a big garbage can into the meeting room, and reviewed and went through all the hardcopy documents that we had thought we should discard, and put them into a huge garbage can.** However, because **I assumed it was illegal** and would violate both FOIA and DOJ requests, I kept hardcopies of all documents in my office, and I retain all associated computer files**. I believe we intentionally withheld controversial findings from the final draft of the Pediatrics paper.'**

> "Mr. Speaker, I believe it is our duty to insure that the documents that Dr. Thompson are not ignored. Therefore I will provide them to members of Congress and the House

> Committees upon request. Considering the nature of the whistleblower's documents as well as the involvement of the CDC (Centres for Disease Control and Prevention), a hearing and a thorough investigation is warranted.
>
> "So I ask, Mr. Speaker, I beg, I implore my colleagues on the appropriations committees to please, please take such action." [My emphasis].

Dr Thompson and his co-authors destroyed evidence that proved a link between the MMR vaccine and autism and published a fraudulent landmark research paper in the Journal of Pediatrics absent those vital results. The implications are enormous and the effect, globally, almost incalculable. Still, as of this date of writing, the average consultant, GP, parent and government official worldwide, all participants in vaccination, do not know that. No effective action has been taken; the paper authored by Dr Thompson and co-authors has not been retracted; and the MMR vaccine is still being administered.

Government institutes often significantly exaggerate disease statistics to coerce the public into being vaccinated. One example of that concerns the flu vaccine. An excellent article by Lawrence Solomon entitled Don't Believe Everything You Read About Flu Deaths explains this well[8]:

> According to the National Vital Statistics System in the U.S., for example, annual flu deaths in 2010 amounted to just 500 per year -- fewer than deaths from ulcers (2,977), hernias (1,832) and pregnancy and childbirth (825), and a far cry from the big killers such as heart disease (597,689) and cancers (574,743)...
>
> Even that 500 figure for the U.S. could be too high, according to analyses in authoritative journals such as the American Journal of Public Health and the British Medical Journal. Only about 15-20 per cent of people who come down with flu-like symptoms have the influenza virus -- the other 80-85 per cent actually caught rhinovirus or other germs that are indistinguishable from the true flu without laboratory tests, which are rarely done. In 2001, a year in which death certificates listed 257 Americans as having died of flu, only 18 were positively identified as true flus. The other 239 were simply assumed to be flus and most likely had few true flus among them...

That contrasts with a CDC figure of 36,000 deaths from flu, part of a marketing campaign to scare the public into getting a flu vaccination.

> "U.S. data on influenza deaths are a mess," states a 2005 article in the British Medical Journal entitled "Are U.S. flu death figures more PR than science?" This article takes issue with the 36,000 flu-death figure commonly claimed, and with describing "influenza/pneumonia" as the seventh leading cause of death in the U.S...
>
> The CDC's decision to play up flu deaths dates back a decade, when it realized the public wasn't following its advice on the flu vaccine. During the 2003 flu season "the manufacturers were telling us that they weren't receiving a lot of orders for vaccine, "Dr. Glen Nowak, associate director for communications at CDC's National Immunization Program, told National Public Radio. "It really did look like we needed to do something to encourage people to get a flu shot."

> The CDC's response was its "Seven-Step 'Recipe' for Generating Interest in, and Demand for, Flu (or any other) Vaccination," a slide show Nowak presented at the 2004 National Influenza Vaccine Summit.
>
> 'Here is the "Recipe that fosters influenza vaccine interest and demand," in the truncated language that appears on his slides: "Medical experts and public health authorities [should] publicly (e.g. via media) state concern and alarm (and predict dire outcomes) - and urge influenza vaccination." This recipe, his slide show indicated, would result in "Significant media interest and attention ... in terms that motivate behavior (e.g. as 'very severe,' 'more severe than last or past years,' 'deadly')." Other emotive recommendations included fostering "the perception that many people are susceptible to a bad case of influenza" and "Visible/tangible examples of the seriousness of the illness (e.g., pictures of children, families of those affected coming forward) and people getting vaccinated (the first to motivate, the latter to reinforce)."
>
> The CDC unabashedly decided to create a mass market for the flu vaccine by enlisting the media into panicking the public. An obedient and unquestioning media obliged by hyping the numbers, and 10 years later it is obliging still.

In order to create the figure of 36,000 deaths they designed a computer program to find any deaths *associated* with “flu” and included those deaths in their final number. In other words, if you happened to have “flu” but died of something else then that was included.

As the article pointed out, that fraudulent practice is still being carried out on the public today, promoted via the governing bodies, medical profession, scientific community and media outlets.

Dr Tomljenovic published an important paper examining the Joint Committee on Vaccination and Immunisation (JCVI), the main advisory body on vaccines in the UK entitled The vaccination policy and the Code of Practice of the Joint Committee on Vaccination and Immunisation (JCVI): are they at odds?[9] In the paper, she states:

> Universally, regulatory authorities are responsible for ensuring that new vaccines go through proper scientific evaluation before they are approved. An equal responsibility rests on the medical profession to promote vaccinations but only with those vaccines whose safety and efficacy has been demonstrated to be statistically significant. Furthermore, vaccination is a medical intervention and as such, it should be carried out with the full consent of those who are being subjected to it. This necessitates an objective disclosure of the known or foreseeable risks and benefits and, where applicable, a description of alternative courses of treatment. In cases where children and infants are involved, full consent with regards to vaccination should be given by the parents...

Dr Tomljenovic continues:

> Deliberately concealing information from the parents for the sole purpose of getting them to comply with an “official” vaccination schedule could thus be considered as a form of ethical violation or misconduct. Official documents obtained from the UK Department of Health (DH) and the Joint Committee on Vaccination and Immunisation (JCVI) reveal that the British health authorities have been engaging in such practice for the last 30 years, apparently for the sole purpose of protecting the national vaccination program.

Dr Tomljenovic's paper describes, over forty plus pages, the failings of the JCVI to protect UK citizens. She summarizes:

> In conclusion, by apparently prioritizing vaccination policy over vaccine safety, the JCVI, the DH and the Committee on Safety of Medicines (CSM) may have shown a disregard for the safety of children. Through selective data reporting, the JCVI in conjunction with the DH, has promulgated information relating to vaccine safety that may be inaccurate and potentially misleading, thereby making it impossible for the parents to make a fully informed consent regarding vaccination. Furthermore, by 1) apparently misleading patients about the true risks of adverse reactions as to gain their consent for the administration of the treatment and 2) seemingly siding with vaccine manufacturers rather than public health interests, the JCVI and the CSM appear to have signally failed their fiduciary duty to protect individuals from vaccines of questionable safety. If these provisional conclusions are indeed correct, then the information presented here may help us in understanding the UK government's and the JCVI's official position on vaccine damage, that is, one of persistent denial.

Opinion

According to the data and experts there is significant doubt that the evidence provided by government institutions can be relied on to be honest, accurate and reliable when making a decision on medical intervention regarding vaccination.

3. Is the evidence provided by the manufacturers in the area of vaccination honest, accurate and reliable?

Throughout history, vaccine manufacturers have fallen foul of corruption. Here are a few of those examples:

Excerpted from Buenos Aires Herald Jan 4, 2012 and reported by Sanevax[10]:

> GlaxoSmithKline Argentina Laboratories company was fined 400,000 pesos by Judge Marcelo Aguinsky following a report issued by the National Administration of Medicine, Food and Technology (ANMAT in Spanish) for the killing of 14 babies during illegal lab vaccine trials conducted between 2007 and 2008.
>
> Likewise, two doctors -Héctor Abate, and Miguel Tregnaghi- were fined with 300,000 pesos each for irregularities during the studies.
>
> The charges included experimenting with human beings, falsifying parental authorizations so babies could participate in vaccine-trials conducted by the laboratory from 2007 to 2008.
>
> Since 2007, 15,000 children under the age of one from Mendoza, San Juan and Santiago del Estero have been included in the research protocol, a statement of what the study is trying to achieve. Babies were recruited from poor families that attended to public hospitals.
>
> A total of 7 babies died in Santiago del Estero; 5 in Mendoza; and 2 in San Juan.
>
> Pediatrician Ana Marchese, who reported the case through the Argentine Federation of Health Professionals (FESPROSA in Spanish), and was working at the Eva Perón children's public hospital in Santiago del Estero when the studies were being conducted, said this

morning in conversations with Continental AM radio that “GSK Argentina set an protocol at the hospital, and recruited several doctors working there.”

“These doctors took advantage of many illiterate parents whom take their children for treatment by pressuring and forcing them into signing these 28-page consent forms and getting them involved in the trials.”

“Laboratories can’t experiment in Europe or the United States, so they come to do it in third-world countries.”

Antony Barnett and Tracy McVeigh writing for the Observer[11]:

Sunday June 30, 2002
The Observer

British drug giant GlaxoSmithKline has finally admitted that thousands of babies in this country were inoculated with a batch of toxic whooping cough vaccines in the 1970s.
Some experts believe that these Trivax vaccines - which had not passed critical company safety tests - may have caused permanent brain damage and even fatalities in young children.

In 1992, the family of an Irish boy, Kenneth Best, who suffered brain damage from one of these toxic vaccines, was awarded £2.7 million in compensation by the Irish Supreme Court.

Despite a long and fierce battle with the drug giant, the boy's family finally won this historic case after his mother Margaret made a startling find when sifting through tens of thousands of company documents.

She discovered that the Trivax vaccine used on her son, from a batch numbered 3,741, had been released by the company despite it having failed to pass a critical safety test. Documents revealed that the 60,000 individual doses within this batch were known to be 14 times more potent than normal.

At the time the Irish judge accused GlaxoSmithKline - then known as Glaxo Wellcome - of negligence and attacked the company's poor quality control at its Kent laboratory. Immunology experts condemned Glaxo in court for what one US scientist described as an 'extraordinary event'.

Last year an investigation by The Observer found evidence to suggest that vaccines from this faulty batch, which may have wrecked Kenneth Best's life, had also been used in Britain.

> Liberal Democrat MP Norman Baker raised questions in the House of Commons, asking whether vaccines from this batch had been given to British babies. Then Health Minister Yvette Cooper wrote to the company asking for information.
>
> Now, almost a year later, GlaxoSmithKline has replied that it is 'highly probable' the toxic batches had been used in Britain.
>
> The Department of Health is under pressure to make efforts to trace the children who received the suspect vaccines.

A suit filed under Case No. 2:10-cv-04374-CDJ UNITED STATES OF AMERICA et al. v. MERCK & CO. was brought by virologists that worked for Merck developing the MMR vaccine. The case was reported in an article entitled Merck Has Some Explaining To Do Over Its MMR Vaccine Claims[12].

> Merck, the pharmaceutical giant, is facing a slew of controversies over its Measles-Mumps-Rubella (MMR) vaccine following numerous allegations of wrongdoing from different parties in the medical field, including two former Merck scientists-turned-whistleblowers...
>
> The first court case, United States v. Merck & Co., stems from claims by two former Merck scientists that Merck "fraudulently misled the government and omitted, concealed, and adulterated material information regarding the efficacy of its mumps vaccine in violation of the FCA [False Claims Act]."
>
> According to the whistleblowers' court documents, Merck's misconduct was far-ranging: It "failed to disclose that its mumps vaccine was not as effective as Merck represented, (ii) used improper testing techniques, (iii) manipulated testing methodology, (iv) abandoned undesirable test results, (v) falsified test data, (vi) failed to adequately investigate and report the diminished efficacy of its mumps vaccine, (vii) falsely verified that each manufacturing lot of mumps vaccine would be as effective as identified in the labeling, (viii) falsely certified the accuracy of applications filed with the FDA, (ix) falsely certified compliance with the terms of the CDC purchase contract, (x) engaged in the fraud and concealment describe herein for the purpose of illegally monopolizing the U.S. market for mumps vaccine, (xi) mislabeled, misbranded, and falsely certified its mumps vaccine, and (xii) engaged in the other acts described herein to conceal the diminished efficacy of the vaccine the government was purchasing."...
>
> [A second] case, Chatom Primary Care v. Merck & Co. relies on the same whistleblower evidence. This class action suit claims damages because Merck had fraudulently monopolized the mumps market. Doctors and medical practices in the suit would be able to obtain compensation for having been sold an overpriced monopolized product, and a defective one to boot, in that the mumps vaccine wasn't effective (indeed, the suit alleged that Merck expected outbreaks to occur and, as predicted, they did -- mumps epidemics occurred in 2006 in a highly vaccinated population and again in 2009-2010).

The major vaccine manufacturers, regardless of product, have all been fined for fraud, here are just some examples between 2008 and 2012.

Glaxo SmithKline that produces multiple iterations of DTaP, Hepatitis, HPV and Rotavirus vaccines was fined 750 million USD for sales of bad products and 3 billion USD for paying doctors and manipulating medical research to promote a drug.

Merck that produces Hepatitis, HPV, MMR, Pneumococcal, Rotavirus and Varicella vaccines was fined 650 million USD for kickbacks and overbilling to medical providers to induce them into prescribing their products. 950 million USD for inaccurate and misleading statements regarding safety to increase sales of their product Vioxx.

Pfizer that produces Prevnar 13 vaccine was fined 2.3 billion for deliberately misbranding a product and 14.5 million USD for illegally marketing practices.

Global Compliance News recently reported on a 2017 study by the European Commission[4] demonstrating widespread corruption:

> The 2017 Study concluded that the healthcare sector is one of the areas that is particularly vulnerable to corruption. The results of the study relevant for companies in the healthcare sector were that
>
> 1. bribery in medical service delivery remains one of the main challenges, especially in many Eastern and Southern European Member States.
>
> 2. transparent procedures are key in addressing corruption in procurement processes.
>
> 3. attempts to address improper marketing increase at both EU and national level.
>
> There were six typologies of corruption identified:
>
> 1. bribery in medical service delivery;
>
> 2. procurement corruption;
>
> 3. improper marketing relations;
>
> 4. misuse of (high) level positions;
>
> 5. undue reimbursement claims;
>
> 6. fraud and embezzlement of medicines and medical devices.

Opinion

According to the data and experts there is significant doubt that the evidence provided by vaccine manufacturers can be relied on to be honest, accurate and reliable when making a decision on medical intervention regarding vaccination.

4. Is the evidence presented to health professionals that advise and administer vaccines honest, accurate and reliable?

From the previous sections, we have seen multiple examples of fraud that directly impact health professionals, and significant fines being paid by vaccine manufacturers for misleading healthcare professionals about their products. We have seen direct corruption in the scientific literature; government bodies and vaccine manufacturers that would mislead even the most astute healthcare worker when deciding on the veracity of the claims made for vaccine products. And we have only really scraped the surface.

But what of other methods to mispresent a vaccine and to mislead as to its effectiveness?

When vaccine manufacturers or government bodies present data to healthcare workers it is usually via conferences or sales representatives in their practice or hospital. Perks (incentives) usually are attached and compelling statistics to persuade them to use their product. Doctors are usually paid a bonus if x % of their patients are vaccinated. Funding can be removed from a hospital if overall vaccine targets are not met. And, of course, as we see in the USA and the UK, healthcare workers can be removed from their position and lose their job or not allowed to complete their medical education if they do not comply with vaccine schedules.[28, 29, 30]

Misleading statistics are used to present data and persuade healthcare workers and their patients to comply with vaccine schedules. A simple example of the deceit employed is as follows:

A vaccine company sales rep presents data from a study that has a target population of 10 million people. In that population about 20 people get a disease called VBD (very bad disease) each year. Thankfully, the sales rep shows you data that their vaccine can reduce VBD to only 10 people infected per year. Of course, that is presented as a reduction of VBD by 50% and you immediately want to start using the vaccine with your patients. In fact, you're so impressed that you join the push to make it mandatory for everyone.

The question is: is the true risk reduction 50% for those vaccinated?

That use of the data is termed a Relative Risk Reduction and is a common tactic to grossly misrepresent the facts. There is another method called Actual Risk Reduction that more accurately demonstrates the true effectiveness of the vaccine.

In that example, prior to being vaccinated, there was a 20 in 10 million chance of catching VBD and after vaccination that was reduced to just 10 in 10 million. Which is an Actual Risk Reduction of one ten-thousandth of one percent. The rep overestimated the effectiveness of the vaccine 500,000 times!

A simple example but it illustrates the power of statistics and is consistently employed by governments, medical institutions and media to promote the use of vaccines. In any other industry, it would simply be called fraud.

Some topics we haven't considered but are worthy of their own report, that I'll briefly discuss:

The extent of adverse events from vaccination; EU law and their financial burden.

Vaccine adverse events

Briefly, vaccine adverse events can include anything from minor skin irritation to paralysis and death and are recorded in databases such as VAERS (Vaccine Adverse Events Reporting System) in the USA and Vigiaccess, the World Health Organisation (WHO) adverse events reporting system. Although, we cannot interpret the data presented there as *all* events being directly caused by vaccination, its scale gives an idea of potential dangers from vaccination. For example, if we search Vigiaccess for adverse events reported for Flumist a nasal spray flu vaccine given to children, we get 178,442 adverse events reported, broken down like this:

- Blood and lymphatic system disorders (4146)
- Cardiac disorders (4473)
- Congenital, familial and genetic disorders (188)
- Ear and labyrinth disorders (2768)
- Endocrine disorders (165)
- Eye disorders (7980)
- Gastrointestinal disorders (25954)
- General disorders and administration site conditions (110846)
- Hepatobiliary disorders (538)
- Immune system disorders (5749)
- Infections and infestations (20345)
- Injury, poisoning and procedural complications (14852)
- Investigations (17115)
- Metabolism and nutrition disorders (3624)
- Musculoskeletal and connective tissue disorders (35276)
- Neoplasms benign, malignant and unspecified (incl cysts and polyps) (314)
- Nervous system disorders (49487)
- Pregnancy, puerperium and perinatal conditions (561)
- Product issues (410)
- Psychiatric disorders (7341)
- Renal and urinary disorders (1637)
- Reproductive system and breast disorders (493)
- Respiratory, thoracic and mediastinal disorders (25058)
- Skin and subcutaneous tissue disorders (43616)
- Social circumstances (1730)

- Surgical and medical procedures (2036)
- Vascular disorders (8950)

Adverse events will require medical care and have a cost attached. They are generally accepted to be underreported by 1 in one-hundred (only 1% of events are reported). More recent research suggests that is incorrect and that the actual underreporting is more like 1 in 200 or only 0.5 % reported, leaving 99.5% unreported. [31, 32]

Using the intranasal flu spray, given to children, as an example, the UK National Health Service (NHS) states that it is very safe with a common side effect of a runny nose and, rarely, anaphylaxis. But if we apply the 1 in 200 weighting and search VAERS (USA) for adverse events reported after using intranasal flu spray between 2013 – 2015 we return the following:

Death 2,800

Life threatening events 14,000

Permanent disability 10,400

Hospitalised 74,800

Existing hospitalised prolonged 5000

Emergency room visits 241,400

If we only accept that 50% of those events reported are causally related, or maybe 10%, that significantly alters the safety profile of using the intranasal flu vaccine compared to that presented by the NHS. Of note: no parent, school member of staff or healthcare worker that is involved with the vaccine is told about that VAERS data.

The intranasal flu spray vaccine is presented as highly effective in the UK, using deceptive relative risk stats, but actual risk reduction is negligible. Would any parent consider a possible risk of death using a vaccine with negligible results? Thankfully, that vaccine has been dropped in the USA but is continued to be used in the UK.[36]

Intranasal flu spray licensing and research show there is a 1 in 10 chance of developing an influenza-like illness after receiving the vaccine and up to a 1 in 41.7 chance of acquiring the virus from a vaccinated person. Is it no wonder, then, that UK public health data revealed an increase of 2,630% in respiratory outbreaks in schools, where it is regularly administered en masse, *after* the introduction of the flu nasal spray vaccine? [14,15, 16]

Increase in disease, morbidity and death is reflected across the vaccine schedule and deserves a separate report; of particular concern is infant mortality.

Infant mortality

Miller and Goldman in their paper Infant mortality rates regressed against number of vaccine doses routinely given: Is there a biochemical or synergistic toxicity?[17] introduce data that are disturbing:

> The US childhood immunization schedule requires 26 vaccine doses for infants aged less than 1 year, the most in the world, yet 33 nations have better IMRs. Using linear regression, the immunization schedules of these 34 nations were examined and a

> correlation coefficient of 0.70 ($p < 0.0001$) was found between IMRs and the number of vaccine doses routinely given to infants. When nations were grouped into five different vaccine dose ranges (12–14, 15–17, 18–20, 21–23, and 24–26), 98.3% of the total variance in IMR was explained by the unweighted linear regression model. These findings demonstrate a counter-intuitive relationship: *nations that require more vaccine doses tend to have higher infant mortality rates*.

They continue:

> Efforts to reduce the relatively high US IMR have been elusive. Finding ways to lower preterm birth rates should be a high priority. However, preventing premature births is just a partial solution to reduce infant deaths. A closer inspection of correlations between vaccine doses, biochemical or synergistic toxicity, and IMRs, is essential. All nations—rich and poor, advanced and developing—have an obligation to determine whether their immunization schedules are achieving their desired goals

The unreported facts tell a very different story of vaccination: contrary to what is revealed to the public and medical profession at large, they suggest it can promote disease, morbidity and mortality.

Accuracy of cost data: flu vaccine

Detailed analysis of cost to benefit ratios across the vaccine spectrum is beyond this brief report but I will add some points for discussion. Below is excerpted from a paper entitled Annual public health and economic benefits of seasonal influenza vaccination: a European estimate[18].

> Out of approximately 180 million Europeans for whom influenza vaccination is recommended, only about 80 million persons are vaccinated. Seasonal influenza vaccination currently prevents an annual average of between 1.6 million and 2.1 million cases of influenza, 45,300 to 65,600 hospitalizations, and 25,200 to 37,200 deaths. To reach the 75% vaccination coverage target set by the EU Council Recommendation in 2009, an additional 57.4 million person would need to be vaccinated in the elderly and other risk groups. By achieving the 75% target rate set in EU-27 countries, average annual influenza-related events averted would increase from current levels to an additional +1.6 to +1.7 million cases, +23,800 to +31,400 hospitalization, +9,800 to +14,300 deaths, +678,500 to +767,800 physician visits, and +883,800 to +1,015,100 lost days of work yearly. Influenza-related costs averted because of vaccination would increase by an additional + €190 to + €226 million yearly, in vaccination target groups.

I will briefly comment on a couple of pertinent sentences:

> Seasonal influenza vaccination currently prevents an annual average of between 1.6 million and 2.1 million cases of influenza, 45,300 to 65,600 hospitalizations...

I have already discussed how misleading statistics can make a vaccine look effective when in reality it is not. Also, we saw how deaths from flu are inflated and in reality a fraction of claimed

deaths are directly caused by the flu. We have also seen how respiratory illness increased after introduction of the nasal flu spray in UK schools.

Regarding preventing hospitalizations, the well respected and independent Cochrane group published the following after extensive analysis of flu vaccine research[19]:

> [The flu vaccine] **had no effect on hospital admissions or complication rates.** Inactivated vaccines caused local harms and an estimated 1.6 additional cases of Guillain-Barré Syndrome per million vaccinations. The harms evidence base is limited. [My emphasis].

That study, including a 2018 update, does not see any significant effect on hospital admission. In addition, it highlights additional cost due to causing Guillain-Barré Syndrome.

Finally:

> [A]n additional 57.4 million person would need to be vaccinated in the elderly and other risk groups.

Many studies have dealt with this claim about the elderly. From JAMA[21]:

> Influenza vaccination in the United States has long been recommended for all persons 65 years or older.[9] Vaccination coverage for this age group increased from between 15% and 20% before 1980 to 65% in 2001. However, 3-year moving averages of unadjusted excess P&I mortality rates among people 65 years or older—compiled for the *Healthy People 2000* initiative[11] to track the effect of vaccination on US **influenza-related mortality—rose substantially during this period. This was surprising because influenza vaccination is thought to be highly effective at reducing influenza-related mortality...**
>
> "[Our] estimates, which provide the best available national estimates of the fraction of all winter deaths that are specifically attributable to influenza, show that the observational studies must overstate the mortality benefits of the vaccine**...[even during two pandemic seasons] the estimated influenza-related mortality was probably very close to what would have occurred had no vaccine been available."** [My emphasis].

Another study[22]:

> We studied trends in excess mortality after adjusting for population aging and analyzing separately seasons dominated by the severe A/H3N2 subtype and those dominated by other circulating influenza subtypes. **After the late 1980s, no decline in age-adjusted excess mortality was associated with increasing influenza vaccination distribution primarily targeted for the elderly.** [My emphasis].

The flu vaccine neither prevents hospital admissions nor protects the elderly. Multiple other studies could be referenced here regarding the flu vaccination, I'll just show a few more. Skowronski *et. al*[23]:

> Prior receipt of 2008–09 TIV was associated with increased risk of medically attended pH1N1 illness during the spring–summer 2009 in Canada.

That study demonstrated an increased susceptibility to a pandemic flu if the subject had been vaccinated for the flu. That is thought to be due to a mechanism called original antigenic sin (OAS) that suppresses the immune system. Simply put, your immune system's ability to protect you from a future infection depends upon prior infections. That effect may manifest as protection or loss of protection. Presently, we cannot predict what combination of infections whether wild type or vaccine type will either suppress or enhance your immune system against a future pandemic as the immune system mechanisms, including OAS, are complex.[37] Incredibly, that has not deterred the authorities from promoting the annual flu shot.

Cowling *et. al.* added to the controversy for flu vaccines[25]:

> We identified a statistically significant increased risk of noninfluenza respiratory virus infection among TIV recipients [flu vaccine], including significant increases in the risk of rhinovirus and coxsackie/echovirus infection, which were most frequently detected in March 2009, immediately after the peak in seasonal influenza activity in February 2009.

Those vaccinated were infected more with other respiratory viruses like rhinovirus and that effect, most likely, was due to the vaccine causing immune suppression that lasted well after the peak of the flu season. Of note: considering that vaccinating the elderly may not be effective and, as that study just demonstrated, increased their chances of contracting rhinovirus, it seems counterintuitive to be vaccinating them. Remember [8]:

> Only about 15-20 per cent of people who come down with flu-like symptoms have the influenza virus -- the other 80-85 per cent actually caught rhinovirus or other germs that are indistinguishable from the true flu without laboratory tests, which are rarely done.

Dierig *et. al.*[26] demonstrated that an unvaccinated group of children were healthier compared to a group of children given the flu vaccine; had less hospitalisations; they also noted:

> We did, however, unexpectedly find that non-influenza ILI (influenza-like illness) occurred about 1.6 times more commonly in children vaccinated with one or two doses of the influenza vaccine than in unvaccinated children.

Biondi and Aligne[27]:

> In an interview published in *The Atlantic*, Tom Jefferson, head of the Vaccine Field Group at the Cochrane Database Collaboration (the world's leading producer of evidence-based medical reviews), voiced serious reservations about the data supporting influenza vaccine recommendations, stating that "The vast majority of the studies [are] deeply flawed. *Rubbish* is not a scientific term, but I think it's the term that applies."

I will mention one more study: fully controlled, randomised and blinded looking at vitamin D3 against influenza[24].

> In conclusion, our study suggests that vitamin D_3 supplementation during the winter season may reduce the incidence of influenza A. This effect was prominent in specific subgroups of schoolchildren. Moreover, asthma attacks were also prevented by vitamin D3 supplementation.

The authors demonstrated that D3 supplementation was more effective than antiviral drugs and suggested that it would also outperform vaccines. The dose they used was less than naturopathic doctors use and was absent any additional supplements or natural medicines that would also be employed such as vitamin C, Beta Glucan etc. that combined would enhance that effect. A typical bottle of liquid vitamin D3 costs approximately 9 Euros and lasts a family of 5 at least 2 months.

The typical flu vaccine is approximately 13 Euros per shot; for a family of 5 that equates to 65 Euros.

We must also consider the negative effects and costs from the vaccine that are not present with vitamin D3. Of course, if we include all the other VAERS that have not been considered, then the negative costs as a result of using the flu vaccine, increase. Taking into consideration, the landmark CJEU ruling, then those costs including injury payouts may be significant.

Payments from the US system that processes vaccine injury claims are arguably underrepresented not only due to underreporting because few if any of those injured will make the association with the vaccine and their injury but also the hurdles involved including burden of proof are many. Below are some of the US vaccine injury payouts[20]:

1. Vaccine court settlement payouts increased in total $91.2 million in 2015, up from $22.8 million in 2014 to $114 million in 2015 — a 400% increase.
2. Vaccine court settlement payments for flu shots increased the most, from $4.9 million in 2014 to $61 million in 2015 — an increase of more than 1000%.
3. Varicella (chicken pox) had the third biggest increase — from $0 in 2014 to $5.8 million in 2015.
4. Hepatitis B was the fourth largest increase in vaccine court settlements, increasing 321% in 2015 to more than $8 million in 2015 from $1.9 million in 2014.
5. TDap/DTP/DPT and D/T shots were the fifth largest increase, leaping 75% in 2014 from $5.5 million to $9.8.

Because the burden of proof in the EU court is lower than the US and the EU population is approximately 1.6 times that of the US population, then the EU may need to brace itself for considerable vaccine injury payouts annually.

In closing this section, we have focused on the flu vaccine and the question is: do we need the flu vaccine? I believe, even in this short report, most of what we have already discussed casts significant doubt as to the need and effectiveness of the flu vaccine, and it strongly suggests that flu vaccines may be increasing disease, morbidity and death, not to mention the financial costs involved. I could apply the same analysis across the vaccine schedule which would multiply those negative costs.

EU Law

A recent case reported in the Medical Law Review[13] C-621/15 W and Others v Sanofi Pasteur MSDSNC[2017] ECRI heard at the Court of Justice of the European Union (CJEU), concerning its judgement in the matter between *W and Others* and *Sanofi Pasteur* concerned Sanofi's vaccine causing the Claimants to develop multiple sclerosis. The court found in favour of the Claimants' argument and is a landmark case. The court considered evidence from a small number of cases and found that:

> 'general considerations', such as the 'cost/benefit ratio of the vaccination;' Mr W's excellent health prevaccination; the lack of 'family antecedents' with regards to MS; and the close temporal proximity between the vaccinations and onset of MS, meant serious, specific, and consistent presumptions supporting the conclusion that there was causal link between the Hepatitis Vaccine, and onset of MS was sufficiently established.

Although, the article quoted was critical of that decision, precedent has been set: that using as evidence, a small number of cases and temporal proximity between administration of vaccine and adverse event(s), in otherwise healthy individuals prior to vaccination, can be deemed proof that a vaccine caused a serious adverse event such as multiple sclerosis.

Multiple reported adverse events from many vaccines could easily fit those criteria and potentially await challenge in the EU court. Which, if mandatory vaccination is effected, will leave the EU in the invidious position of mandating the use of products that its court, based on the *C-621/15* precedent, will establish *as causing significant disease, disability and death.*

I can see challenges in the EU court coming from across the vaccine spectrum but three jump out immediately: Diphtheria, Tetanus and Pertussis commonly combined and administered routinely. Accounting for $9.8 million USD in injury payouts in the US in 2015.

If Diphtheria, Tetanus and Pertussis are mandated and challenged in the EU court, the question would arise: why are they mandated? The answer would be to prevent the spread of infection in the community. The Claimant's expert witness would rebut with: they are not designed to stop the spread of infection in the community; they only act once infected. Further, they may leave the individual at increased risk of infection from another strain of pertussis and there is significant doubt over their use; also, once infected, those vaccinated make carry the disease for much longer (compared to those normally infected and unvaccinated) and not appear infected, thereby putting close contacts at significant risk of infection and endangering the community at large. Can I have my payout, please![33,34,35]

Incredibly, what has been (satirically) described there is simply not known by government officials, healthcare professionals and members of the public, and at what cost?

In summary

Research data and opinion of respected experts in science and medicine clearly demonstrate a culture of dishonesty surrounding the subject of vaccination and a practice of deceit, designed to mislead on a global scale. Because of that deceit, vaccination programs may be implemented resulting in wasting of precious financial resources, failing to protect citizens and increase their chance of disease, morbidity and in some cases, mortality. Until overseeing bodies that set healthcare policy within governments retain experts without affiliation to the vaccination industry and/or financial gain from said industry and ensure untainted, true, evidence based policy, then the corruption will continue costing lives, ill health and significant financial loss.

References

1. Ioannidis, J. P. A. *et al.* (2017). How to survive the medical misinformation mess. Eur J Clin Invest, 47: 795–802. doi:10.1111/eci.12834
2. Jones, C. W. *et al.* (2013). Non-publication of large randomized clinical trials: cross sectional analysis. BMJ 2013; 347 doi: https://doi.org/10.1136/bmj.f6104 (Published 29 October 2013)
3. Hsu, J. (2010). Dark Side of Medical Research: Widespread Bias and Omissions. Live Science. https://www.livescience.com/8365-dark-side-medical-research-widespread-bias-omissions.html
4. Behr, N. (2017). 2nd EU Study on Corruption in the Healthcare Sector released: What you should do to avoid falling into the corruption trap. Global Compliance News. https://globalcompliancenews.com/eu-study-corruption-healthcare-20171114/
5. Gøtzsche, P. C. (2011). Opening up data at the European Medicines Agency. BMJ; 342 doi: https://doi.org/10.1136/bmj.d2686 (Published 10 May 2011)
6. Strite, S. A. & Stuart, M. E. (2013). Basics for Evaluating Medical Research Studies: A Simplified Approach. Delfini Group, http://www.delfinigrouppublishing.com/basics-for-evaluating-medical-research-studies.html
7. Atkisson, S. (2015). CDC Scientist: 'We scheduled meeting to destroy vaccine-autism study documents'. Sharyl Atkisson.com. https://sharylattkisson.com/2016/03/23/cdc-scientist-we-scheduled-meeting-to-destroy-vaccine-autism-study-documents/
8. Solomon, L. (2014). Don't Believe Everything You Read About Flu Deaths. Huffington Post. http://www.huffingtonpost.ca/lawrence-solomon/death-by-influenza_b_4661442.html
9. Tomljenovic, L. (2011). The vaccination policy and the Code of Practice of the Joint Committee on Vaccination and Immunisation (JCVI): are they at odds? BSEM March 2011 The Health Hazards of Disease Prevention. https://anticorruptionsociety.files.wordpress.com/2016/02/health-hazards-of-disease-prevention-vaccines.pdf
10. (2012). GSK lab fined over vaccine tests that killed 14 babies. Sanevax, Inc. http://sanevax.org/gsk-lab-fined-over-vaccine-tests-that-killed-14-babies/
11. Barnett, A. and McVeigh, T. (2002). UK babies given toxic vaccines, admits Glaxo. The Observer. http://www.observer.co.uk/uk_news/story/0,6903,746568,00.html

12. Solomon, L. (2014). Merck Has Some Explaining To Do Over Its MMR Vaccine Claims. Huffington Post. http://www.huffingtonpost.ca/lawrence-solomon/merck-whistleblowers_b_5881914.html
13. Smillie, L. R. *et al.* (2017). Medical Law Review, Vol. 0, No. 0, pp. 1–12 doi:10.1093/medlaw/fwx049
14. Package Insert and Patient Information - FluMist® Quadrivalent. https://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM294307.pdf
15. Harper, S. *et al.* (2003). MMWR September 26, 2003 / 52(RR13);1-8 https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5213a1.htm
16. Surveillance of influenza and other respiratory viruses in the United Kingdom: Winter 2015 to 2016. Public Health England. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/526405/Flu_Annual_Report_2015_2016.pdf
17. Miller, N. Z. and Goldman, G. S. (2011). Infant mortality rates regressed against number of vaccine doses routinely given: Is there a biochemical or synergistic toxicity? Hum Exp Toxicol. 2011 Sep; 30(9): 1420–1428. doi: 10.1177/0960327111407644
18. Preaud, E. *et al.* (2014). Annual public health and economic benefits of seasonal influenza vaccination: a European estimate. BMC Public Health 201414:813 https://doi.org/10.1186/1471-2458-14-813
19. Jefferson, T. *et al.* (2010). Vaccines for preventing Influenza in Healthy Adults. Cochrane Library. 10.1002/14651858.CD001269.pub4
20. Gregory, L. M. (2016). US Vax Court Sees 400% Increase in Vaccine Injury Payouts,Flu Shot Wins Top Honors for Biggest Payout. The Mom Street Journal. http://www.themomstreetjournal.com/increase-in-vaccine-injury-payouts/
21. Simonsen, L. *et. al.* (2005). Impact of Influenza Vaccination on Seasonal Mortality in the US Elderly Population. Arch Intern Med. 165(3):265-272. doi:10.1001/archinte.165.3.265
22. Rizzo, C. *et. al.* (2006). Influenza-related mortality in the Italian elderly: No decline associated with increasing vaccination coverage. Vaccine. Volume 24, Issues 42–43, 30 October 2006, Pages 6468-6475. https://doi.org/10.1016/j.vaccine.2006.06.052
23. Skowronski, D. M. *et. al.* (2010). Association between the 2008–09 Seasonal Influenza Vaccine and Pandemic H1N1 Illness during Spring–Summer 2009: Four Observational Studies from Canada. https://doi.org/10.1371/journal.pmed.1000258
24. Vit d3 Urashima, M. *et al.* (2010). Randomized trial of vitamin D supplementation to prevent seasonal influenza A in schoolchildren. The American Journal of Clinical Nutrition, Volume 91, Issue 5, 1 May 2010, Pages 1255–1260, https://doi.org/10.3945/ajcn.2009.29094
25. Cowling, B. J. *et. al.* https://academic.oup.com/cid/article/54/12/1778/455098
26. Dierig *et al*. (2014). Epidemiology of respiratory viral infections in children enrolled in a study of influenza vaccine effectiveness. Influenza and Other Respiratory Viruses 8(3), 293–301. DOI: 10.1111/irv.12229
27. Bondi, E. A. and Aligne, C. A. (2015). Flu Vaccine for All: A Critical Look at the Evidence - Medscape - Dec 21, 2015. https://www.medscape.com/viewarticle/855937
28. Offit PS. (2010). Mandating Influenza Vaccine: One Hospital's Experience. Medscape. https://www.medscape.com/viewarticle/728352
29. Cosford, P. *et. al.* (2013). Vaccination of health and social care workers against flu, 2013/14 DOH, PHE & NHSE

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/244941/13_09_25_-_Seasonal_flu_letter_on_HCW_FINAL.pdf

30. England, C. (2017). Cardiff University Expels Student Who Refused to be Vaccinated. Health Impact News. https://healthimpactnews.com/2017/cardiff-university-expels-student-who-refused-to-be-vaccinated/
31. Scott, *et. al*. (1987). Rhode Island physicians' recognition and reporting of adverse drug reactions. RIMed J. 70:311 316. https://www.ncbi.nlm.nih.gov/pubmed/3476980
32. Cunningham, A. (2010). Underreporting Vaccine Adverse Events. *BMJ* 2010; 340 http://www.bmj.com/rapid-response/2011/11/02/underreporting-vaccine-adverse-events
33. Kwon, J. Dubberke, E. (2015). Why the Increase in Pertactin-Deficient Pertussis? Medscape. Mar 31. https://www.medscape.com/viewarticle/842151
34. Abdalla, S. Dhea, T. (2017). Resurgence of Whooping Cough May Owe to Vaccine's Inability to Prevent Infections. Boston School of Public Health. http://www.bu.edu/sph/2017/09/21/resurgence-of-whooping-cough-may-owe-to-vaccines-inability-to-prevent-infections/
35. Warfel, J. *et. al*. (2014). Acellular pertussis vaccines protect against disease but fail to prevent infection and transmission in a nonhuman primate model. Proc Natl Acad Sci U S A. Jan 14;111(2):787-92. doi: 10.1073/pnas.1314688110. Epub 2013 Nov 25.
36. (2015). Advisory Committee on Immunization Practices (ACIP) reaffirms recommendation for annual influenza vaccination. CDC. February 26. 2015. https://www.cdc.gov/media/releases/2015/s0226-acip.html
37. Vatti, A. *et. al.* (2017). Original antigenic sin: A comprehensive review. Journal of Autoimmunity. Volume 83, September 2017, Pages 12-21. https://doi.org/10.1016/j.jaut.2017.04.008