

# The COVID Debacle: Merging Criminal Law and Medical Science for Accountability

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## Introduction

The Centers for Disease Control and Prevention (CDC), the primary federal agency responsible for managing infectious disease outbreaks, and the Food and Drug Administration (FDA), the federal authority over food, drugs, and medical device safety and efficacy, both failed completely during the 2020–2023 COVID-19 (CoronaVirus Disease of 2019) crisis.

The COVID-19 response required an immediate, aggressive, national antiviral drug program. Observational and international data showed the drug hydroxychloroquine (HCQ) to be an effective, safe treatment for early phase COVID-19 (up to seven days after symptom onset). With a short five-day quarantine at home, HCQ could control viral spread and minimize hospitalizations, while keeping the economy running.<sup>1</sup>

HCQ is one of the safest FDA-approved drugs known. It can be given to pregnant women and lactating mothers. Triggered in the Situation Room by the President's trade adviser Peter Navarro, the U.S. quickly stockpiled 22 million HCQ doses. By March 2020, the drug was being rushed out to pharmacies for off-label antiviral prescription for early suspected COVID-19 infections. The U.S. lacked adequate testing, but the drug is safe enough to use based on a clinician's judgment. More than 50 countries would successfully do the same.

Thousands of patients with chronic conditions have taken HCQ for courses as long as years, or even decades, without suffering serious adverse cardiac events, so early five-day outpatient prescriptions for HCQ would be unlikely to cause serious cardiac effects. Later studies would show that brief early HCQ treatment of COVID-19 outpatients was without serious QTc prolongation.<sup>2,3</sup> With hospitals overflowing, the U.S. needed an antiviral drug immediately. There was no time for lengthy clinical trials, and overseas data indicated that HCQ was that drug.

HCQ is a 59-year old drug that costs pennies to manufacture generically, and a five-day treatment course of 11 tablets in the U.S. cost roughly \$30 dollars. Early expectations were that the U.S. COVID crisis would be under control after an expected but "HCQ-controlled" second wave of infections during the summer of 2020.

Instead, a small number of senior federal bureaucrats promoted an experimental antiviral drug called remdesivir. This cost \$90 per treatment to manufacture and package, and was sold to the U.S. government for \$2,500 per treatment. Additionally, they pushed for a multi-billion dollar mass-immunization program using highly experimental single-antigen mRNA "pseudo-vaccines" that were still under development.

While the testing process of the new vaccines could be shortened, this could not occur if a safe, effective, antiviral treatment like HCQ was available. And that became the problem. Billions in pharmaceutical profits and patent royalties were at stake in the mRNA "pseudo-vaccines" that were being rushed through incomplete clinical trials by the manufacturers, with approval by an incompetent FDA. Note that these products are so different from traditional vaccines—they might be called "gene

therapy"—that CDC changed the very definition of "vaccine" to include them.

Almost immediately, senior personnel at both FDA and the National Institutes of Health (NIH) began to intentionally denigrate early-use HCQ. The NIH-COVID-19 Treatment Panel eventually declared that no outpatient treatments were acceptable, despite the accumulated safety and efficacy data for both HCQ and, later, ivermectin.

The toxic experimental drug remdesivir, backed by the NIH, suddenly became "safe" and the "standard of care" for hospitalized COVID-19 patients. However, it had never demonstrated any reduction in mortality, and in November 2020, the World Health Organization (WHO) announced that remdesivir was ineffective for treating any phase of COVID-19. Yet the U.S. continued to use this toxic drug in its hospitals. Thousands of preventable American deaths occurred while millions of doses of HCQ sat idle in the Strategic National Stockpile.<sup>4</sup>

## Three Years Later: What Are the Results of Early HCQ Treatment for COVID-19?

By October 2020, early-use HCQ had been shown to drastically reduce hospital admissions.<sup>1</sup> The first large controlled study on HCQ use for early-hospitalized COVID-19 patients had been published by the Ford Group in Detroit in July 2020.<sup>5</sup> If HCQ was given upon hospital admission, the drug showed a dramatic 51% improvement in COVID-19 survival. This was repeated in a large successful early-HCQ study by Mount Sinai in New York, and a 66% improved survival was observed in a large study in Spain. The drug triggered no adverse cardiac events.

The FDA and CDC refused to reassess the ever-accumulating positive data on HCQ and incorrectly blamed it for causing adverse cardiac events in late-phase critically ill hospitalized patients. Neither agency seemed to realize that the cardiac problems were due to the SARS-CoV-2 virus itself (and later due to the mRNA vaccines). Yet, numerous private practitioners continued to use HCQ "off label" because they saw it was safe and effective. A recent 2023 study, using a 50-state survey, indicates that ignoring the FDA advice, one out of 20 Americans were actually treated with outpatient HCQ or ivermectin during the COVID-19 pandemic.<sup>6</sup>

By September 2023, the accumulated evidence from 394 controlled studies conducted by 8,304 scientists from 58 countries involving 520,058 patients demonstrates the overwhelming safety and positive effects of HCQ on COVID-19 when administered early. Notably, 15 completed, true early-treatment clinical trials show a massive 72% [C.I. 57%-81%] reduction in virus mortality without any adverse cardiac effects.<sup>7</sup>

In September 2023, scientists examined the determinants of COVID-19 fatalities in a cross-country analysis involving Southeast Asia, Eastern Europe, and Western and Southern Africa. According to the coefficient estimate for HCQ in the paper, if the U.S. had made HCQ widely available, the recorded COVID-19 fatalities during the study period would have been reduced by at least 50%.<sup>8</sup>

### Three Years Later: What Are the Results of the mRNA Mass Vaccination Program?

At the time the FDA issued its vaccine Emergency Use Authorization (EUA), no clinical trial had ever properly tested the real efficacy of the mRNA vaccines. Americans were told incorrectly that the mRNA vaccines would prevent infection. Yet, predictably, within 4-weeks after their introduction, vaccine-escape variants of the COVID-19 virus began to appear and increase. By October 2021 “breakthrough” infections were common.<sup>9,10</sup> Eventually, the “vaccine-escape” viral populations would become so common that the CDC would stop recording the cases unless hospitalization occurred. COVID-19 was not going to be stopped by a single-antigen vaccine.

Americans were then told that although they were not protected against infection and transmission, the vaccines (and later boosters) would protect them from severe illness and death. Yet no clinical trial data, no observational data from Israel, the highest vaccinated population at the time, or the pandemic statistics, showed any convincing evidence for these endpoints.<sup>11</sup> CDC claimed thousands of individuals were saved by the mRNA vaccines; in reality, there was no data for this. The virus was becoming so heavily mutated by “Mueller’s Ratchet” that after the Delta variant it was causing only a predominantly mild pathogenicity.<sup>12</sup> Many were becoming infected, but the case fatality rate remained low.

In mid-2021, researchers showed that those fully vaccinated/boosted with the Pfizer product were actually likely to have a five times lower level of neutralizing antibodies against the Delta variant, making them more susceptible to infection.<sup>13</sup>

By September 2021, vaccinated individuals made up 23% of all U.S. coronavirus fatalities. By January/February 2022, this was up to 42%. By August 2022, some 58% of coronavirus deaths occurred in people who were fully vaccinated and/or boosted.<sup>14</sup>

### The CDC Minimized and Ignored the Early Danger Signals of mRNA Vaccination

On Dec 11, 2020, the highly experimental Pfizer-BioNTech COVID-19 mRNA product was released for voluntary use by individuals 16 years of age and older. On Dec 12, 2020, the Moderna mRNA product was also released for use.

Six days later, scientists reported that when injected into the bloodstream or sprayed into the nose, the S1-subunit of the COVID-19 viral spike protein could bypass the blood-brain barrier of mice and be abnormally deposited in neural tissue.<sup>15</sup>

If the mRNA-generated spike protein could be taken up through the blood-brain barrier, it was likely it could also pass through the placenta of pregnant women into the developing fetus.<sup>16</sup> Pfizer clinical trial documents obtained through Freedom of Information Act (FOIA) lawsuits indicated a possible doubling of the background miscarriage rate consistent with mRNA vaccine nanoparticles possibly transferring through the placenta to the fetus. Pfizer, FDA, and CDC had data in June 2021 showing this safety signal.<sup>17</sup> Yet, the American College of Obstetricians and Gynecologists still continued to recommend that the experimental mRNA COVID vaccines and later boosters be given to pregnant women. No analysis for the abnormal presence of the spike protein within the miscarried products of conception has ever been released.

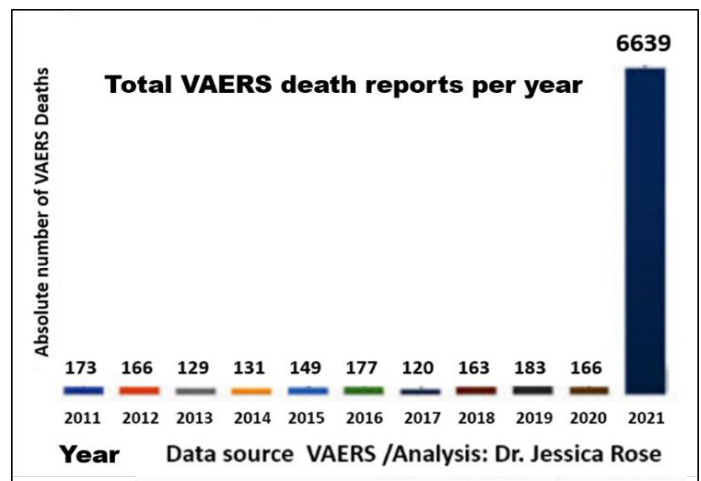
Three months later in March 2021, scientists reported that the isolated spike protein could itself induce major lung damage in mice.<sup>18</sup>

### The Recombinant Spike Protein Generated by the mRNA Injections Is Toxic to Humans

In December 2022, a FOIA lawsuit by Judicial Watch revealed that Pfizer and Moderna were allowed to bypass proper biodistribution and excretion studies, using a different mRNA than that which was used in the vaccines.<sup>19</sup> Millions of Americans were then injected with mRNA nanolipid particles containing mRNA that did not properly degrade. This would cause the continuous manufacture and build-up of a circulating toxic viral spike protein for weeks after a person received an mRNA injection.

Although the data is crude and under-reported, evidence of mRNA vaccine toxicity can be seen in the Vaccine Adverse Reporting System (VAERS) data. VAERS is the antiquated surveillance data tool used to detect and collate any vaccine side effects that might be missed in the vaccine clinical trials. A passive reporting system, VAERS is notorious for significantly under-counting, not over-counting, serious adverse vaccine events.<sup>20</sup>

As the mass-vaccination program imposed mandates, CDC used VAERS data to conduct a proportional reporting ratio (PRR) comparing the mRNA products against historical data for traditional vaccines.<sup>21</sup> This revealed more than 500 types of safety signals with reporting rates higher than those for myocarditis. FOIA lawsuits later revealed thousands of accumulated serious vaccine-induced injuries beginning in 2021 at the start of the ill-advised mRNA mass-vaccination program.<sup>22,23</sup> The number of deaths associated with mRNA vaccination for the first half of 2021 compared to the past decade’s average yearly deaths for all the other types of traditional vaccines combined, was alarming (Figure One).<sup>24</sup>



**Figure One.** VAERS death reports by year. For all vaccines combined through 2020. The first portion of 2021 contains only deaths associated with mRNA COVID vaccination.

The ten-year total for all vaccines combined is 1,577, compared with 6,639 for COVID shots alone in the first part of 2021. Vaccine proponents have claimed the reason for the excessive adverse events in VAERS was that more mRNA vaccines were dispensed. However, for the first part of 2021, the number of mRNA COVID doses administered was equivalent to the average number of annual influenza shots. In addition, the high death rate in the 2021 mRNA group was accompanied by an increased

variety of other mRNA vaccine-associated adverse events. The mRNA injections were clearly associated with pathology.<sup>25</sup>

In August 2021, this was conclusively proven when scientists demonstrated that the direct intravenous injection of the Pfizer mRNA vaccine into the tail vein of mice could cause severe heart and liver damage. This was aggravated by repeated “booster” mRNA injections.<sup>26,27</sup> It was conclusive proof in an accepted animal model that the spike protein generated by the COVID-19 mRNA vaccine could cause severe harm in a dose-response manner.

This should have halted the experimental mass-vaccination program for a complete reassessment. However, after having already destroyed the concept of early antiviral drug treatment, no federal health agency was ready to admit that the experimental mass-vaccination program was a ballooning, tragically lethal failure.

In September 2022, the Moderna/Pfizer original clinical trial data (obtained by FOIA lawsuits), was reanalyzed. The review showed that the mRNA vaccines had a negative benefit-to-risk ratio. Adults subjected to mRNA “immunization” suffered a higher risk of post-vaccination hospitalization, serious disability, or a life-changing event, which was higher than the risk of naturally acquiring a COVID-19 infection and being hospitalized with it.<sup>28</sup>

Later studies would show that an increased risk of crippling injury and death was associated with the number of mRNA boosters an individual received.<sup>29</sup> The spike protein could also enter the brain and become neurotoxic through accumulation, with a spread and reconfiguring of its structure into pathologic amyloid (prion) depositions that could undergo enzymatic cleavage to form toxic microfibrils accompanied by biomarkers of neurodegeneration. The accumulation of spike protein inside cells could also have direct toxic and apoptotic effects.<sup>29</sup> Adult autopsies of vaccine-related deaths were confirming abnormal spike-protein amyloid prion deposits in the brain.<sup>30</sup> This had been predicted as early as Mar 29, 2020, from models of the amino-acid sequence and the 3-D structure of the spike protein, but it had never been tested in animals.<sup>31,32</sup>

Post-mortem spike protein-associated tissue damage was also observed in the liver, testis, spleen, bone marrow, and heart. There were also continuing worries by some scientists about vaccination in pregnancy and genotoxicity.

This is the protein that was coded by the mRNA of the COVID-19 vaccines that would be injected into the bodies of adults, children, and eventually infants causing them to manufacture circulating spike protein for days if not weeks. The long-term effects of this may not be known for years.

Some scientists were extremely worried about the deposition of insoluble spike protein causing amyloid (prion)-generated neurotoxicity and an increased progression rate of dementia in the elderly.<sup>33,34,35</sup> Yet the mRNA injections would soon be given to infants and children, with no idea of the long-term effects. We now ask whether the amyloid (prion) mRNA sequences have been engineered out of the spike protein for the latest XBB.1.5 shot, as well as whether a deletion was engineered into the staphylococcal enterotoxin-B motif on the S-1 protein subunit.<sup>36</sup> As the endless series of boosters roll out, these forensic questions must be answered.

### **Should the CDC’s Drive for Childhood Vaccination Be Considered Malfeasance?**

Young children seemed to be partially protected from COVID-19 due to their naturally low levels of the ACE-2 cell

surface receptor necessary for viral entry into their respiratory tract.<sup>37</sup> Evidence shows that the infection fatality rate (IFR) for COVID-19 in children is an almost an infinitesimal 0.001% to 0.002% in those aged 5-9 years, with a mean increase in the IFR of 0.59%, with each five-year increase in age past 10 years.<sup>38</sup>

Children were not efficient transmitters of the COVID-19 virus to adults or to each other, and multiple studies show that after a natural infection they develop a broad, durable, natural immunity that is resistant to later viral variants. The very small number of children who died from an active COVID-19 infection largely suffered from serious pre-existing medical conditions such as leukemia.

Earlier, CDC had stated that more than 75% of U.S. children already had partial or full immunity to COVID, and multiple papers were published suggesting this was superior to vaccine-induced immunity to COVID-19. Vaccinating the already immune population groups seemed superfluous and possibly harmful. Data suggested that children who had recovered from a previous COVID-19 infection appeared to have an increased risk of developing myocarditis if given an mRNA vaccination.<sup>39,40</sup> It was unknown whether the recombinant spike protein was also accumulating in their brains.

By mid-2021 it was clinically evident that the mRNA vaccines were not preventing infection or transmission and there was no statistically valid evidence that they prevented severe COVID-19 disease or deaths in children. Therefore, there was absolutely no ethical justification for this unnecessary vaccination that would put children at elevated risk of vaccine harm.

In early October 2021, the Scandinavian countries simultaneously halted or discouraged the use of Moderna’s COVID mRNA vaccine for males under 30. This was due to the incidence of mRNA vaccine-induced myocarditis. Yet, on Oct 29, 2021, the FDA Vaccines and Related Biological Products Advisory Committee (VRBPAC) voted 17-0 in favor of vaccination of 5–11-year-olds with the experimental Pfizer vaccine. When questioned on this decision, the CDC/Advisory Committee on Immunization Practices (ACIP) response to the press was that “the benefits of mRNA vaccination outweigh the risks.”

One voting VRRBPAC panelist, Eric Ruben, M.D., Ph.D., stated, “we’re never going to learn how safe this vaccine is unless we start giving it.”<sup>41</sup>

It must be noted that Dr. Ruben is editor-in-chief at the once prestigious *New England Journal of Medicine (NEJM)*, which refused to publish the groundbreaking June 2020 Ford study showing a 51% improved mortality in early hospitalized patients given early HCQ.

It must also be noted that in 2020, Janet Woodcock, M.D., was director of FDA’s Center for Drug Evaluation and Research. Concurrently she was also on *NEJM*’s editorial board. Woodcock was insubordinate to three levels of leadership—the President, the Secretary of Health and Human Services, and the Assistant Secretary for Pandemic Readiness and Responses—when she issued an emergency use authorization instead of the requested investigational new drug authority for HCQ. She then approved HCQ for only late-phase hospitalized patients, where it would show the least positive effect. Although Woodcock recused herself from vaccine decisions during 2020, she became the acting FDA commissioner in 2021.

Incredibly, on June 17, 2022, the mRNA vaccines were authorized for infants and children aged 6 months to 4 years: an age group with almost zero risk for dying and only minimal risk for hospitalization with COVID-19.

In contrast to natural infection, in which the human body is exposed to viral mRNA over a few days, the process of mRNA vaccination involved injecting several trillion mRNA molecules as a bolus over a few seconds.<sup>29</sup>

A 2021 Johns Hopkins University study monitoring 48,000 children diagnosed with COVID showed a zero mortality rate in children younger than 18 without comorbidities.<sup>42</sup> A study in *Nature* demonstrated that children younger than 18 with no comorbidities had virtually no risk of death.<sup>43</sup> Data from England and Wales, published on Jan 17, 2022, revealed that throughout 2020 and 2021, only one child under age five without comorbidities had died from COVID in the two countries, whose total population is 60 million.<sup>44</sup> A large study in Germany showed zero deaths for children aged 5–11 and a case fatality rate of three per million in all children without comorbidities.<sup>45</sup>

Yet, CDC published data stating that 203 children aged 6 months through 4 years died “with” COVID since the start of the pandemic, averaging 85 deaths per year in this age group. These figures are at complete odds with the results from other countries. Considering the subterfuge that has occurred with the CDC and the major problems associated with its PCR diagnostic test being run at a cycle threshold (Ct) above 35, there is reason to suspect that only a fraction of these children’s deaths was actually due to COVID-19.<sup>46</sup>

As the mass-vaccination policy continued to fail, CDC continued to counter this with misleading analysis in its own non-peer-reviewed journal, *Morbidity and Mortality Weekly Report*. When this failed to staunch online discussion of vaccine injuries, CDC co-opted Twitter, Facebook, Instagram, and Google to use advanced data-mining technology, some from the U.S. Census Bureau, to monitor and secretly censor (de-platform) scores of expert scientists and physicians who were trying desperately to warn the public and deliver accurate peer-reviewed information on early drug treatments and the dangers of the mRNA vaccines.<sup>47</sup>

Well-substantiated FOIA-recovered documents (the “Twitter Files”) were brought to light by lawsuits conducted by America’s First Legal (AFL). Active spying and intentional blocking of scientists and physicians’ freedom of speech in a public square is well outside CDC’s mandate.<sup>47</sup> A later FOIA document release from America’s First Legal on Dec 15, 2022, showed that for months CDC had been conducting an overt drive to vaccinate children against COVID-19, despite overwhelming evidence that children were not a COVID risk.<sup>48</sup> One presentation titled “Policy Considerations” discussed how CDC could promote the mRNA vaccine injection of children when a parent was not present. This was clearly a federal agency out of control.<sup>49</sup>

### **Vaccine-Associated Myocarditis Is More Common and More Serious than Initially Thought**

CDC has repeatedly claimed that the observed myocarditis in children and young adults was rare and only a mild adverse vaccine side effect. This was in sharp contrast to the statements by some leading U.S. cardiologists that there was no such thing as a “mild” myocarditis. Three years into the disastrous COVID-19 vaccine campaign, we are learning that probably every mRNA-vaccinated individual may have sustained some degree of heart dysfunction with or without small areas of myocardial damage, within 48 hours of the mRNA injection.

Metabolic disruption of isolated cardiomyocytes occurs after exposure to mRNA vaccines. Isolated rat ventricular cardiomyocytes exposed to nanolipid particles from the Moderna

(mRNA-1273) vaccine produce recombinant spike protein 48-hours later. Its appearance coincides with arrhythmic and irregular contractions and conduction abnormalities in the cardiac muscle cells consistent with a significant dysfunction of the cardiac ryanodine receptor (RyR2). Exposure of cardiomyocytes to the nanolipid particles from the Pfizer (BNT162b2) vaccine increases cardiomyocyte contraction via a significantly increased protein kinase A (PKA) activity at the cellular level.<sup>50</sup>

According to a study of 777 hospital employees who received the Moderna booster vaccination, one in 35 persons developed myocarditis, as evidenced by an acute elevation of high-sensitivity cardiac troponin (hs-cTn) above the sex-specific upper limit of normal at 48–96 hours after vaccination. This was mild and temporary.<sup>51</sup>

High levels of recombinant circulating spike protein were found in cases of post-vaccine myocarditis, using a new mass-spectroscopy method. No free spike protein was detected in asymptomatic vaccinated control subjects.<sup>52</sup>

The exact incidence of vaccine-associated myocarditis is unknown. Myocarditis cases may be subclinical, misclassified, or missed. Even specialized imaging may under-diagnose it. With the uncertainty of asymptomatic myocarditis in the pediatric population, there can be no proper assessment of the risk/benefit ratio for childhood vaccination with mRNA vaccines.

The preliminary data from CDC’s own ACIP reported on Feb 4, 2022, that nearly half of the young people diagnosed with myocarditis still had symptoms 3 months later, and 39% had their physical activity restricted by their physician.<sup>53</sup> Cardiac MRI dye-retention studies indicate that asymptomatic adolescent myocarditis can be seen for at least 6 to 12 months after an initial COVID mRNA vaccination. This is true even when troponin, electrocardiographic changes, and left ventricular systolic function have returned to normal.<sup>54</sup>

The point is that myocarditis can be hard to diagnose, and even if asymptomatic, minor cardiac fibrosis may later develop into small arrhythmogenic foci leading to later potentially fatal arrhythmias or a progressive cardiomyopathy with heart failure. Nonetheless, FDA and CDC proceeded to promote the COVID-19 mRNA immunizations down to the level of 5-month-old infants, and later added boosters. Their decision was based on something other than public health.

### **Lot-to-Lot Variance (LTLV) of the mRNA Vaccines**

Since the spike protein is clearly toxic, why do not all recipients suffer a serious adverse vaccine event? About 30% of individuals who receive an mRNA vaccine have zero-to-minimal side effects. Roughly 70% develop moderate side effects, missing work or seeking outpatient clinic advice. However, a third small group (roughly 4%) go on to suffer severe adverse vaccine events. The same approximate numbers have been reported in Europe.

In 2023, Danish researchers reported that a periodic safety update report (PSUR) seemed to show a large variation in the number of severe adverse events between different lots of the Pfizer BNT162b2 product. This indicated the possibility of sub-par quality vials in different lots.<sup>55</sup>

In any manufactured product, LTLV or batch variability can arise due to slight changes in the quality, stability, and manufacturing processes of key reagents, as well as the storage and handling conditions of raw materials and the final product before use.

The mRNA vaccines are inherently unstable colloid

suspensions requiring ultra-cold storage, shipment in dry ice, and precise thaw-and-use protocols. Abnormal freeze-thaw cycles, encapsulation capacity changes, hydrolysis, polyethylene glycol or mixed lipid impurities, or cholesterol oxidation may all affect the mRNA packaging inside the lipid nanoparticles of the vaccines.<sup>56</sup>

Variance in the amount of synthetic mRNA inside the colloidal particles is likely a critical factor relating to vaccine safety and one difficult to control and assess during rapid lot manufacturing. This suggests a narrow safety margin for the mRNA vaccines. Any incorrect dosage, faulty injection procedure, manufacturing defects in batches or lots, improper sub-zero storage conditions, colloid disruption with free ultra-stable mRNA release, or inadequately tested product components, could conceivably all lead to toxic effects.<sup>57</sup>

Poor manufacturer quality control has now been well documented, showing lot contamination with extraneous bacterial plasmid DNA, 72-base pair viral enhancers, and SV-40 viral promoter segments found in shipped vials of the Moderna and Pfizer mRNA vaccines.<sup>58, 59</sup>

This residual DNA contamination was derived from plasmid DNA vectors, and it exceeded FDA guidelines of less than 10 ng/dose of double-strand DNA in a final product dose. The oncogenic potential of this cocktail in relation to subsequent LINE-1 transposon activity or other genomic integration processes is still under investigation. Physicians worldwide are describing “turbo-cancer” progressions and incidences outside of the normal age groups, but data remains limited. This reflects poorly on the FDA and its capability for facility and product inspection.

### Basic Toxicology Research Not Done

In the mad rush for commercial and individual profit, no manufacturer or federal regulating agency ever bothered to first check to see whether the spike protein, the selected antigenic target, was toxic. Genetic material to cause the vaccinee’s cells to manufacture this protein in possibly unlimited amounts—which is the supposed equivalent of the antigen injected in limited amount in traditional vaccines—has now been injected, sometimes repeatedly, and sometimes under duress, into 75% of the U.S. population.

The spike protein is unequivocally toxic. It is at least one of the causes of myriad adverse effects. As of June 2023, the website [www.react19.org](http://www.react19.org) lists more than 3,400 published papers and case reports of COVID-19 vaccine-associated harms to more than twenty different organ/tissue systems.

For this reason alone, the mRNA vaccines were not mature technology. Not a single human should have been given an mRNA vaccine, much less mandated to receive such a defective product, even if there were any chance of new booster developments staying ahead of a rapidly mutating virus.

### Conflicts of Interest (COI) in the Federal Health Agencies

The boards overseeing the COVID-19 vaccine trials are known as data and safety monitoring boards (DSMBs). The clinical trials for the Moderna mRNA vaccine were overseen by a DSMB created by Dr. Anthony Fauci’s National Institute of Allergy and Infectious Diseases (NIAID-DSMB), which holds patents on mRNA vaccine technology. The clinical trial for Pfizer’s experimental mRNA vaccine was overseen by a five-person DSMB, called simply the “Pfizer DSMB.”

For years, outside investigators have warned of ethical concerns over the use of “independent” physician reviewers to serve as external experts on FDA or CDC advisory committees. Such experts are usually from academia and may receive large payments from pharmaceutical companies after voting to approve drugs—a clear conflict of interest that has undergone little reform.<sup>60</sup>

An investigation of drug approvals from 2013–2016 found that 40 out of 107 physician advisors “received more than \$10,000 in post hoc earnings or research support from the makers of drugs that the panels voted to approve or from competing firms,” including 26 who received more than \$100,000, and seven who received \$1 million or more.<sup>61</sup>

There are many ways in which people receive remuneration unethically but without breaking the law. These include consulting fees, speaking fees, NIH funding for research, even stock or stock options, from pharmaceutical manufacturers (or their competitors). There is also what is called the revolving door through which high-ranking CDC or FDA employees who oversee clinical trials of the drug or vaccine manufacturers leave their federal agency for high-paying jobs with those same companies.<sup>62,63</sup>

One example is former FDA Commissioner Dr. Scott Gottlieb’s 2019 move to join Pfizer’s board of directors. Since 2020, Dr. Gottlieb has insisted and continues to insist that HCQ has no value for treating COVID-19, despite repeatable, early-treatment clinical trials that show a massive 72% reduction in virus mortality without any adverse cardiac effects.<sup>7</sup>

The most recent case of a revolving door involves former FDA Commissioner Stephen Hahn, M.D. In 2020, Dr. Hahn knew that early outpatient HCQ was being used successfully in other countries. Yet he did nothing to reestablish the EUA for HCQ after it was overwhelmingly obvious the drug was safe and very effective if given early. Six months after leaving office in 2021, Dr. Hahn assumed a senior position with the venture capital firm Flagship Pioneering, which funded the launch of Moderna in 2010.<sup>64</sup>

In October 2020, *Science* magazine reviewed more than 1,600 official inspection and enforcement documents from 2009–2019, and concluded that FDA oversight of clinical trials is secretive and inadequate and that it often fails to take action when the manufacturers break the law, as by falsifying clinical trial results and asking for an extended (75-year) period to release its clinical trial data. This request was denied. Instead, a federal court ordered the expedited release of these documents. Following the release of a paper in the *British Medical Journal*, suggesting that falsified data may have been used in Pfizer’s phase III clinical trial, a formal investigation concerning all aspects of the ill-advised, mass-vaccination program now seems to be a legal and moral necessity.<sup>65-67</sup>

Thousands of Americans have been permanently injured or killed by the experimental mRNA mass vaccination program, and young children and infants have been placed at risk of possible long-term medical complications caused by the administration of dangerous, unneeded vaccines with a negative benefit/risk ratio. Yet, as evidenced by the 2023 XBB.1.5 booster roll out, the mRNA manufacturers continue collusion with the conflicted federal health agencies in search not of public health, but rather of the last drop of vaccine profit.

The challenges of such an investigation will require the dedicated merger of legal experts, forensic accountants, scientific experts, and physicians, to navigate the quagmire of the U.S. COVID-19 response. Such a unified legal/medical task

force must examine the panel decisions of the DSMBs, the FDA VRBPAC, and the CDC's ACIP concerning the mRNA vaccines and boosters. This must be done by Presidential Executive Order if necessary. A full investigation will involve multiple offices of CDC and FDA, and the attendant NIH-COVID-19 Treatment Panel, as well as several prominent U.S. professional medical groups, such as the American Medical Association. Any role of the drug companies in influencing article publications by journals such as the *New England Journal of Medicine* and the *Lancet* need to be made public as well.

The fact that CDC has its own "non-profit" (tax-exempt) organization (the CDC Foundation), which takes large donations from the pharmaceutical industry, needs a close examination. CDC's relationship with the social media companies who colluded in the censorship and malignment of dissenting scientific and medical opinions during the COVID-19 response—and its Constitutional (First Amendment) implications—must be examined. The presence of COI in the national professional medical associations should be openly assessed.

CDC needs to be returned to its original mandate of early infectious disease warning with an added emphasis on training and facilitating bottom-up local authority pandemic control. FDA itself requires a drastic reorganization with close supervision and monitoring of COI by an outside congressional watchdog. This is reminiscent in some respects to the former congressional Office of Technology Assessment (OTA), which was completely independent of the pharmaceutical industry.

As the world now waits to see whether a debilitating lethal spongiform encephalopathy similar to Creutzfeldt-Jakob disease will appear in relation to the mRNA vaccines, the injections continue to be recommended to children and infants, with a zero benefit-to-risk ratio. On Nov 17, 2023, the mRNA vaccines were added to the U.S. Childhood Immunization Schedule, apparently giving their manufacturers further immunity from legal action.

This madness must stop now. It is time for individual and group accountability.

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