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A Vaxxing Question

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In 1956 German pharmaceutical company Chemie Grünenthal GmbH, licensed a new experimental drug designed to treat colds, flu, nausea and morning sickness. Known as Distaval in the UK, Distillers Biochemicals Ltd declared the drug could 'be given with complete safety to pregnant women and nursing mothers without adverse effect on mother or child' – a basic pre-requisite for licensing a drug.

While forty-nine countries licensed the drug under multiple different names, the then head of the FDA Dr. Frances Kelsey, a physician-pharmacologist with a profound interest in fetal development, refused authorization for use in the US market due to her concerns about the lack of evidence regarding the drug's safety.

The drug was also known as Thalidomide.

Sixty-five years on and the stringent safety measures brought in to avoid another scandal on the scale of Thalidomide have been swept aside in order to fast track the approval of experimental mRNA vaccines. This is in spite of concerns voiced by (among others) Dr Wolfgang Wodarg and Dr Michael Yeadon who petitioned the European Medical Agency (EMA) with a Administrative/Regulatory Stay Of Action in regard to the BioNtech/Pfizer study on BNT162b – not just in regard to concerns about pregnant women, the foetus and infertility – but also in regard to the effect of the mRNA vaccines on those with prior immunity, for whom immunization could lead to a hyperinflammatory response, a cytokine storm, and a generally dysregulation of the immune system that allows the virus to cause more damage to their lungs and other organs of their body.

No previous research into treating illness or disease with messenger RNA or mRNA vaccines has been successful and this is the first time mRNA vaccines have been used on humans.

The concerns of Yeadon, Wodarg and others appear to be borne out by data from the King's College Zoe app that records adverse events from the mRNA vaccines. Taken from a pool of 700,000, data reveals that 12.2% of those vaccinated with the Pfizer jab experienced adverse events or side effects, a number which tripled to 35.7% for those with prior immunity. Adverse events from the Oxford/AstraZeneca jab were already high at 31.9% but increased to 52.7% for people with immunity.

Ellie Barnes, professor of hepatology and immunology at Oxford University and a member of the UK Coronavirus Immunology Consortium referred to the discovery – that when you've

had a COVID-19 infection your T-cells become activated and become memory T cells – as 'emerging' as though this was something revelatory. Yet the dangers of over-immunization had been flagged up multiple times and well before vaccine rollout.

It gets worse.

In spite of additional research from New York's Mount Sinai Hospital and the University of Maryland which indicated that those who had previously developed Covid-19 were effectively already immune and wouldn't need a second dose (arguably they didn't need the first dose if they already had immunity), Eleanor Riley, professor of infectious diseases at Edinburgh University said that 'Incorporating this into a mass vaccination program, may be logistically complex', adding 'it may be safer overall to ensure everyone gets two doses'.

May be safer? Many in the study group had already had an adverse event from the first dose, so how could it be 'safer' when second doses have been shown to increase the adversity of an event.

And how is it logistically complex to notify those who have already experienced an adverse event? The medical data of the 700,000 patients has already been logged into the Zoe App system, otherwise the Zoe App wouldn't be able to differentiate between those with or without prior immunity. Therefore, those with prior immunity from having had Covid-19 – or those for whom an adverse event would perhaps indicate prior immunity – can be notified that there is no need for a second dose.

Moreover, why on earth aren't people tested for prior immunity before taking any vaccination considering the concerns associated with over-immunization?

Alarming data is also emerging from the Yellow Card Scheme.

Set up following the Thalidomide scandal, it allows both doctors and patients to record adverse medical events from drugs and vaccines circulating in the UK market. Up to and including 29 April 2021, the MHRA via Yellow Card Reporting received 149,082 suspected reactions from the COVID-19 mRNA Pfizer/BioNTech vaccine (from Dec 9 onwards) and 573,650 suspected reactions from the COVID-19 Oxford University/AstraZeneca (from Jan 4 onwards).

As of 29/4/21, the death toll from both vaccines stands at 1045. With 685 of those deaths from the AstraZeneca vaccine since Jan 4, that equates to 5.9 deaths per day for AstraZeneca alone. Deaths from COVID-19 on Monday 26th April stood at 6. And the data doesn't cover all those vaccinated. Only 3-5 cards per 1,000 of doses (0.3-0.6%) administered have been filed (10% reported side effects during trials) which may indicate that many people are unaware of the existence of the Yellow Card Scheme and that therefore adverse events are being underreported.

The current mRNA vaccine take-up suggests many believe the vaccines will prevent transmission and that the 90-95% vaccine efficacy reported by the BBC equates to a high chance of prevention. These figures are taken from the FDA's report on the efficacy of the mRNA Pfizer vaccine, which itself refers to the potential of reduction of the viral load – i.e. symptomatic COVID-19 – not transmission. It does not mean that 95% of people vaccinated are protected from contracting the virus, something The Lancet refers to as 'a misconception'.

Even the 90-95% claim of reduction in viral load is questioned by a BMJ report (and others), which estimates the mRNA vaccine's efficacy in the reduction of COVID-19 symptoms to be more within the 19-29% range – less than the 35% efficacy of dexamethasone used by the NHS.

This appears to be backed up by further reporting from Shahriar Zehtabchi, MD who explains why 'suspected but unconfirmed' COVID-19 cases cannot clarify which study patients had the disease in any group.

It would be hard to see therefore how vaccine efficacy could be determined if those taking the vaccine had not been tested for prior immunity or if those on trials were only 'suspected' of having had the disease, without having had a test to confirm it. The mRNA vaccines are also predominantly for those with high risk of complications from COVID-19 which – judging by ONS statistics – is a minority.

According to ONS figures, the number of those under sixty-five with no serious underlying health issues who died 'due' to Covid-19 in 2020 was 1,549. For the healthy 30-year-old age group (i.e. those with no serious underlying health issues), taking the experimental mRNA vaccine would be the statistical equivalent of 164,125 people jumping off a cliff because a hungry bear was approaching. The bear only wants one meal and he's going to get the slowest runner. If you are fit, you have little to no chance of the bear getting you. Jumping off the cliff however can lead to injury or death. It is a leap into the unknown. As are the mRNA vaccines.

Yet there are still those who believe they need a vaccination in order to travel. Not so. Greece, Cyprus, Portugal, France, Austria and Israel are the first to announce they will accept proof of antibodies and/or a negative COVID-19 test in order to visit. Furthermore, the vaccinated will also need to show proof of a COVID-19 negative test, presumably because there are still doubts from these countries and others as to the efficacy levels of the vaccines in regard to transmission. Not even British Airways demands proof of vaccination. The airline was quick off the blocks to offer a subsidized £33 online Covid-test for those planning to travel. After the financial losses of lockdown, most airlines and countries will no doubt follow suit. Demand is what fuels the market.

Not that any of the above will slow down the UK Government's manic roll out of the vaccine drive to the next 40-49-year-old target range of guinea-pigs. Do the majority of these 40-49-year-olds need the mRNA vaccine? Not according to WHO and ONS data. For a healthy 40-49 year old, the chances of dying from COVID-19 is 1 in 46,242. Will this next target range group be put off by the fact so many doctors and healthcare workers are refusing to take the vaccine? They should be.

It took five years after the initial licensing of Thalidomide before anyone realised Thalidomide crossed the placental barrier and caused serious birth defects, a discovery hampered by the fact the drug had been marketed under multiple different names across 49 countries. It took a further five years to mount a legal challenge. Nobody was found guilty. Not until the mid-seventies following a fierce moral crusade by the late, great investigative journalist and editor Harold Evans (who referred to investigative journalism as 'attacking the devil') did the families of those children who died or who were born with limb, eye and heart problems receive commensurate compensation. Fifty years later, Chemie Grünenthal GmbH apologised. Evans believed the Thalidomide scandal was a lesson in how a government can betray its duty. They're still doing it.

Chief Executive of the MHRA Dr. June Raine was ‘delighted’ to approve the AstraZeneca vaccine for use on the citizens of the UK. ‘No stone is left unturned when it comes to our assessments’ she said. That there had been ‘a robust and thorough assessment of all the available data’ and that her staff had ‘worked tirelessly to ensure we continue to make safe vaccines available to people across the UK’.

I doubt Dr. Frances Kelsey would see it that way. Or Harold Evans.

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Suzie Halewood is a mathematician and filmmaker.

Featured image: Dr Frances Kelsey receiving the President’s Award for Distinguished Federal Civilian Service from President Kennedy in 1962, for successfully preventing Thalidomide being approved for use in the USA. (Source: OffGuardian)

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