30 INFORMATIVE YEARS
THE informed PARENT
ISSUE THREE 2023 A NEWSLETTER ON VACCINATION ISSUES AND HEALTH

OXFORD ASTRAZENECA COVID JAB WAS 'DEFECTIVE', CLAIMS LANDMARK LEGAL CASE

BY ROBERT MENDICK,
Chief Reporter
The Telegraph,
8 November 2023
https://tinyurl.com/bdzzrxz2

EXTRACTS

THE OXFORD-ASTRAZENECA Covid-19 vaccine has been branded "defective" in a multi-million pound landmark legal action that will suggest claims over its efficacy were "vastly overstated".

The pharmaceutical giant is being sued in the High Court in a test case by Jamie Scott, a father-of-two who suffered a significant permanent brain injury that has left him unable to work as a result of a blood clot after receiving the jab in April 2021. A second claim is being brought by the widower and two young children of 35-year-old Alpa Tailor, who died after having the jab made by AstraZeneca, the UK-based pharmaceutical giant.

The test cases could pave the way for as many as 80 damages claims worth an estimated £80 million over a new condition known as Vaccine-induced Immune Thrombocytopenia and Thrombosis (VITT) that was identified by specialists in the wake of the AstraZeneca Covid-19 vaccine rollout.

……In the months following the rollout, the serious side effect of the AstraZeneca jab was identified by scientists. Following this, it was recommended it no longer be given to the under-40s in the UK because the risk of receiving the jab outweighed the serious harm posed by Covid.

AstraZeneca last night told the Telegraph that patient safety was its "highest priority", that its vaccine, called Vaxzevria, had "continuously been shown to have an acceptable safety profile", and that regulators around the world "consistently state that the benefits of vaccination outweigh the risks of extremely rare potential side effects".

It is understood AstraZeneca, in its legal response, denies causing Mr Scott's injuries.

Official figures from the Medicines and Healthcare products Regulatory Agency (MHRA) show at least 81 deaths in the UK are suspected to have been linked to the adverse reaction that caused clotting in people who also had low blood platelets. In total, almost one in five people who suffered from the condition died as a result, according to the MHRA's own figures.

FAMILIES COMPLAIN OVER PAYMENT SCHEME

Victims and their lawyers question the Government's monitoring of the rollout and point out that while Germany suspended the vaccine's use for the under 60s at the end of March 2021 over the risk of rare blood clots, the UK stopped giving it to under 30s on April 7 and took another month to ban it for the under 40s.

Official figures obtained under a Freedom of Information request show that out of 148 payouts made by the Government under the Vaccine Damage Payment Scheme, which provides compensation to those injured by vaccines or to bereaved next-of-kin, at least 144 went to recipients of the AstraZeneca vaccine. Fewer than five people under the scheme received vaccines other than AstraZeneca.

Families complain the amount paid out under the scheme – a fixed tax-free sum of £120,000 – is insufficient, prompting them to bring the legal cases in the High Court against AstraZeneca.

WHATSAPP MESSAGES SUGGEST CONCERNS RAISED

The case will raise questions about what the UK authorities knew about concerns over the vaccine and how they were handled.

An examination of WhatsApp messages sent by or to Matt Hancock, the then health secretary, obtained by The Telegraph as part of the Lockdown Files and which have been passed to the Covid public inquiry, suggest concerns were aired by US authorities. AstraZeneca never in the end applied for a licence in the US.

…..At the time, a number of European countries were pausing the vaccine's rollout over fears it caused clotting in some people.

LEGAL CASE TO HOLD ASTRAZENECA TO ACCOUNT

The test case was lodged by Mr Scott after he almost died after receiving the vaccine. Mr Scott suffered a catastrophic bleed on the brain and doctors called his wife, Kate, three times to tell her to come to the hospital to say goodbye to him.

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Magda Taylor

Editor's note

THANK YOU very much for all the supportive messages regarding The Informed Parent newsletter – and the renewals and donations – all greatly appreciated and very much needed. Unexpectedly, soon after I posted out copies of Issue 2 2023, the Large letter 2nd class postage stamp increased dramatically from £1.05 to £1.55! There is still a need to have more subscribers – if you could encourage at least one friend each to take out a subscription this would help enormously!

As another year draws to an end the mainstream misinformation continues! However, at least there is some data breaking through as regards to the injuries and deaths from the covid injections. In the US alarming miscarriage data was presented to Congress. Here is a brief extract:

"I've never seen this before," testified Dr Kimberly Biss, an OB-GYN who has been involved in 8,000 pregnancies, before Congress in the "Injuries Caused by COVID-19 Vaccines" hearing Monday. "How many of your patients or pregnant women that you know of experience miscarriages after taking the COVID-19 vaccines — or injections?" asked representative Marjorie Taylor Greene (R-GA). Dr Biss first explained that the vaccination rate among her patient population was about 60% and that most of the patients received three injections. "Very few received four or more." "What's concerning," detailed Dr Biss, "is the majority of the patients received their injections in 2021 and early 2022. However, we're still seeing lingering effects."

The full "Injuries caused by COVID-19 Vaccines" hearing (13 Nov 2023) is available to watch at:
https://youtu.be/CNkWEcctCpc

Regarding an increase in heart attacks and strokes, particularly in younger people, some health professionals are suggesting that the increase is possibly due to the covid injections. However other 'experts' would rather have you believe that the covid 'infection' is behind the increase or that even the 'clocks going back could increase your risk of heart attack and stroke by 70%'! Yes it is astonishing what excuses are being proposed.
https://tinyurl.com/33vd4dzy *(Daily Mail, 28/10/23).*

Time will tell, providing that the actual data is reliable and not tampered with.

A recent announcement (14 Nov 2023 by UKHSA) that the JCVI has submitted their recommendations that the Chickenpox vaccine be added into the Childhood vaccination schedule to the Dept. of Health & Social Care. The DHSC will make a final decision on whether to implement the programme. As you can imagine we are now hearing about complications and deaths from chickenpox in order to create fear and to justify introducing yet another vaccine for children! One example on the Government website:

- *Professor Sir Andrew Pollard, Chair of the JCVI, said: 'Chickenpox is well known, and most parents will probably consider it a common and mild illness among children. But for some babies, young children and even adults, chickenpox or its complications can be very serious, resulting in hospitalisation and even death.'*
- *Dr Gayatri Amirthalingam, Deputy Director of Public Health Programmes at the UK Health Security Agency (UKHSA), said: 'Introducing a vaccine against chickenpox would prevent most children getting what can be quite a nasty illness – and for those who would experience more severe symptoms, it could be a life saver.'*

Many years ago I had a brief telephone conversation with Dr Adam Finn who is now head of the Bristol Children's Vaccine Centre. He was very keen for the chickenpox vaccine to be introduced as a 4 in one with the MMR back then, however due to public concerns regarding the 3 in one the MMRV was not introduced. I did mention to Dr Finn that acutes, such as chickenpox, if allowed to be expressed and not suppressed could play a beneficial role in a child's maturation. Dr Finn obviously had no knowledge of such views and was very dismissive. Since that time I have become aware of published medical papers regarding the possible benefits of developing chickenpox in childhood in relation to lessening the likelihood of more serious conditions later in life. For example, a positive history of chickenpox was associated with a 21% lower glioma risk and that the observed protective effect of chickenpox against glioma is unlikely to be coincidental. (Cancer Medicine 2016; 5(6):1352–1358).

Encourage your family and friends to ask questions and investigate – it is vital for a healthy future!

Wishing you health, happiness and free speech!

Magdalene Taylor, Editor, December 2023.

Mrs Scott said the couple were being forced to sue AstraZeneca because the Government's compensation scheme, and the £120,000 paid out to her husband, was inadequate.

Mr Scott, who was 44 when he had the jab, has had to give up his job as an IT software developer. Mrs Scott said: "We are private people but we cannot stand the injustice of it. We have been lobbying the Government for 18 months for fair compensation for the injury caused by the vaccine.

"We were told by the Government the vaccine was safe and effective but what's happened to Jamie has been life changing and their [AstraZeneca] vaccine caused that."

Mrs Scott is seeking to raise funds to pay for the legal cases. "AstraZeneca cannot continue to ignore the circumstances in which their vaccine has caused devastating injury and loss," Mrs Scott has written in an open letter. "Our legal case will seek to hold AstraZeneca to account but we need to build a significant fighting fund to get justice."

VACCINE EFFICACY TO BE CHALLENGED

As many as 80 claimants could lodge legal cases with the High Court by the end of the year in a class action that threatens to undermine faith in the rollout of the AstraZeneca vaccine that

was developed jointly with Oxford University.

In Mr Scott's claim, his lawyers argue that he suffered "personal injuries and consequential losses arising out of his sustaining Vaccine Induced Immune Thrombosis with Thrombocytopenia (VITT) as a result of his vaccination on 23 April 2021, with the AstraZeneca Covid-19 vaccination", which the legal claim alleges was "defective". They also argue that no warning of the risk of VITT was included in the product information on the date of supply of the vaccine.

AstraZeneca issued press releases following clinical trials saying the vaccine – known as Vaxzevria – was between 62 per cent and 90 per cent effective at preventing symptomatic Covid-19 depending on dosages, with an average of 70 per cent. The legal claim states: "In fact, the absolute risk reduction concerning Covid-19 prevention was only 1.2 per cent."

An absolute risk reduction measures how much the vaccine reduces an individual's baseline risk of getting ill from Covid at a particular time. If Covid levels are low, the absolute risk reduction rate will be much lower too.

This is different from a relative risk reduction, which compares the numbers of vaccinated people getting ill with those getting ill who did not receive the jab. In the case of AstraZeneca, a peer-review study showed the relative risk was reduced by an average of about 70 per cent. AstraZeneca has said it emphasised the higher figure – denoting the relative reduction in risk – because that did not alter regardless of the prevalence of Covid at the time.

Lawyers argued that information in the AstraZeneca press release on its efficacy was "misleading because members of the public… assume that the published efficacy rate was an absolute risk rate (in which case the published efficacy rate vastly overstated the efficacy of the vaccine)"……..

"The group of individuals whom we represent have always been clear: they do not dabble in anti-vaccine conspiracy theories. However, it is plainly factually inaccurate to claim that vaccines do no harm given the experience of our client group – the vaccine injured and bereaved."

LAWYERS TO EXAMINE GOVERNMENT REASSURANCE

The legal action will also examine the role of the Government in reassuring the public after Mr Hancock authorised an indemnity for AstraZeneca in the "very unexpected event of any adverse reactions that could not have been foreseen through the robust checks and procedures that have been put in place".

Lawyers point out in the legal claim that Mr Hancock, in an accompanying departmental minute, said: "The data so far on this vaccine suggests that there will be no adverse reactions, and so no liability."

The particulars of claim state: "Public statements by the Government as to the safety of the vaccine are relevant circumstances to be taken into account in considering the level of safety that persons generally were entitled to expect from the AZ vaccine."

Writing for The Telegraph, Sarah Moore, partner at Hausfeld, the law firm bringing the claim, says: "The group of individuals whom we represent have always been clear: they do not dabble in anti-vaccine conspiracy theories. However, it is plainly factually inaccurate to claim that vaccines do no harm given the experience of our client group – the vaccine injured and bereaved.

GOVERNMENT URGED TO SETTLE CASES

Sir Jeremy Wright KC, the former attorney general, urged the Government to step in and settle the legal claims before they came to court – given that ministers had indemnified AstraZeneca…..

… "The Government should not be washing its hands of this. None of us can be confident we won't have to go through all this again one day, and if we do, then confidence in mass vaccination needs to be in place."

'Patient safety is our highest priority'

The second claim is being brought by Anish Tailor, whose wife died in April 2021, just under a month after having the vaccine. An inquest in September 2021 determined she died from blood clots and bleeding on the brain caused by "vaccine-induced immune thrombosis and thrombocytopenia". According to the claim lodged in the High Court, Mrs Tailor's family are seeking damages of up to £5 million.

In a statement AstraZeneca said: "We do not comment on ongoing litigation matters," but it added: "Patient safety is our highest priority and regulatory authorities have clear and stringent standards to ensure the safe use of all medicines, including vaccines. Our sympathy goes out to anyone who has lost loved ones or reported health problems……

AstraZeneca also pointed out that it supplied three billion doses of the vaccine to more than 180 countries and that an independent study had found it had been responsible for saving six million lives.

Sir John Bell, who was chief adviser to the Government on life sciences and an adviser to the Joint Committee on Vaccination and Immunisation, said: "It is an asteroid-like risk from the AstraZeneca vaccine. There is a risk of getting hit by an asteroid but it isn't very big."

TiP editor: As always with mass vaccination programmes the authorities proclaim that vaccines have been responsible for saving millions of lives. This is just a hearsay not fact. Most individuals are not going to develop these 'alleged diseases' anyway.

PLEASE NOTE: THE PO BOX ADDRESS IS NO LONGER AVAILABLE. IF YOU WISH TO SEND ANY CORRESPONDENCE TO TIP PLEASE PHONE FOR ADDRESS DETAILS: 01903 212969.

IS THE US's VACCINE ADVERSE EVENT REPORTING SYSTEM BROKEN?

A BMJ INVESTIGATION HAS RAISED CONCERNS THAT THE VAERS SYSTEM ISN'T OPERATING AS INTENDED AND THAT SIGNALS ARE BEING MISSED. JENNIFER BLOCK REPORTS.

10 Nov 2023
Jennifer Block investigations reporter
https://www.bmj.com/content/bmj/383/bmj.p2582.full.pdf

OVERVIEW & EXTRACTS

By Magdalene Taylor, TiP

THIS ARTICLE looks at the poor standard of the US VAERS and how the system is overwhelmed with reports not being followed up. The article opens with the description of an anaesthesiologist in Maryland, Robert Sullivan who collapsed at home three weeks after receiving a second dose of a covid vaccine.

Receiving a diagnosis of sudden onset pulmonary hypertension Sullivan decided to file a report in the VAERS. VAERS's main purpose is supposed to capture post-market safety signals as regards to the wide-array of vaccines given. After managing to submit his potential vaccine adverse event Sullivan did not hear back for a year.

Investigations by The BMJ uncovered that VAERS is not meeting its own standards, with inadequate staffing levels, failure to keep pace with the unprecedented number of reports since the rollout of covid vaccines, reports not being followed up…. meaning safety signals being missed.

'Our investigation has also found that, in stark contrast to the US government's handling of adverse reaction reports on drugs and devices, the publicly accessible VAERS database on vaccines includes only initial reports, while case updates and corrections are kept on a separate, back end system. Officials told The BMJ that this was to protect patient confidentiality—but this means that patients, doctors, and other public users of the database have access only to an incomplete and uncorrected version.'

According to the author of this article, VAER's standard operating procedure for covid-19 states that reports must be processed quickly, within days of receipt. The article continues:

'However, The BMJ has learnt that in the face of an unprecedented 1.7 million reports since the rollout of covid vaccines, VAERS's staffing was likely not commensurate with the demands of reviewing the serious reports submitted, including reports of death. While other countries have acknowledged deaths that were "likely" or "probably" related to mRNA vaccination, the CDC—which says that it has reviewed nearly 20 000 preliminary reports of death using VAERS (far more than other countries)—has not acknowledged a single death linked to mRNA vaccines.'

"I assumed that, since it was a catastrophic event, the safety committee would want to hear about it right away," he says. But, to his knowledge, nobody called or requested medical records."

Pre the pandemic VAERS was receiving nearly 60,000 adverse event reports annually. In 2021 the total number of reports shot up to a million, and a further 660,000 filed since.

The article continues with further examples of others who tried to file reports of a serious nature only to experience a patchy and frustrating service, some not hearing back for months, and others not hearing anything at all. Some were given conflicting information or even discouraged from making a report altogether. A couple of examples from the article, follow:

'Patrick Whelan, a rheumatologist and researcher at the University of California Los Angeles, who in 2022 reported how one of his patients, a 7 year old boy, had a cardiac arrest after covid vaccination. The patient was intubated when Whelan filed a VAERS report, and he expected a prompt follow-up call from a CDC investigator.

"I assumed that, since it was a catastrophic event, the safety committee would want to hear about it right away," he says. But, to his knowledge, nobody called or requested medical records. In an email sent to Whelan months later the FDA said that it had followed up "soon after" receiving his report and had made "several requests" for medical records. The agency added, "Generally speaking, staff might not reach out to providers unless they have specific questions about a case or a VAERS report."

James Gill has been a medical examiner and forensic pathologist for 25 years and is currently chief medical examiner for the state of Connecticut. In June 2021 he made the first VAERS report of his career. It was for a 15 year old boy who died suddenly days after getting a second jab—what Gill concluded on autopsy was "stress cardiomyopathy following second dose of the Pfizer-BioNTech covid-19 vaccine."

Gill, who has appointments at Yale University and the University of Connecticut, can't recall getting any calls from VAERS after he filled out the online form, and he still has only a temporary "e-report" number. After he published the case reports in the Archives of Pathology & Laboratory Medicine in February 2022, however, the CDC did respond—in the form of a letter to the editor contesting Gill's findings.'

An advocacy group, React19, of around 30,000 people who have experienced prolonged illness after covid vaccination reviewed 126 reports

to discover 22% had never been given a permanent VAERS ID number and 12% had disappeared from the system.

Further in the article a recent editor in chief of the International Journal of Risk & Safety in Medicine, Ralph Edwards explained that detecting new and unusual reactions after vaccination has been an ongoing challenge in the world of pharmacovigilance. Edwards said: *"If something hasn't been heard of before, it tends to be ignored." He explains that regulators may be relying too heavily on epidemiological evidence to acknowledge a signal. VAERS alone is unlikely to capture such long term adverse outcomes unless reports are regularly updated and reviewers are closely following such cases—"a real catch 22," he says. "You'll never get the evidence unless you have the idea to look for it in the first place."*

Apparently the EU has added hypoaesthesia and paraesthesia to the labelling on mRNA covid vaccines as well as including heavy menstrual bleeding. The last paragraph of this article reads:

'Harlan Krumholz, a cardiologist and researcher at Yale, has been recruiting members of React19 to study their reactions.12 "We are working hard to understand the experience, clinical course, and potential mechanisms of the ailments reported by those who have had severe symptoms arise soon after the vaccination," he tells The BMJ.

"There are so many people whose lives have been changed dramatically—but what I don't know is how many or why."'

I do hope the BMJ investigations Unit will look at how user (un)friendly the UK's Yellow Card reporting system is when it comes to vaccine adverse events reports!

PEER REVIEW AND SCIENTIFIC PUBLICATION AT A CROSSROADS

OVERVIEW BY MAGDALENE TAYLOR, EDITOR OF THE INFORMED PARENT

Published in JAMA online, Sept 22,2023.
Editorial by John P A Ioannidis, MD DSc;
Michael Berkwits, MD MSCE;
Annette Flanagin, RN MA;
Theodora Bloom, PhD.

THIS ARTICLE OPENS stating that the way science is assessed, published and disseminated has markedly changed since 1986, and how peer review and scientific publication are currently at a crossroads. The 'future is more difficult than ever to predict' and this article looks at what has been learned after decades of experience and research and the accumulation of a large body of empirical evidence which shows the functioning and mal-functioning of peer review practices. 'Research has revealed a fast growing list of biases, inefficiencies, and threats to the trustworthiness of published research.'

You may be aware of one of the authors, John Ioannidis who over the years has questioned the validity of most published research findings and in recent years been a critic of lockdowns and the over-reaction of 'covid' policies and coverage. Thankfully there are some medicsl and scientists with the courage to raise valid concerns.

The article points out that the emergence of electronic platforms and AI has resulted in peer review and scientific publication rapidly evolving and there is a lot of money at stake. Today scientific publishing is a huge market with one of the highest profit margins among all business enterprises, according to this article, and 'many stakeholders try to profit from or influence the scientific literature in ways that do not necessarily serve science or enhance its benefits to society.' As always money steers what is and what is not published as many of us who investigate this area have discovered.

The articles continues discussing ideas on how to improve dissemination of, and access to science. 'Deceptive, rogue actors, such as predatory and pirate publishers, fake reviewers, and paper mills continue to threaten the integrity' of peer review and the publications. The authors call for improving peer review and publication to address threats to their integrity for the future of science.

'By their very nature, peer review and scientific publication practices are in a state of flux and may be unstable as they struggle to serve rapidly changing circumstances, technologies, and stakeholder needs and goals.'

The authors state that research has never been needed more urgently to properly examine, test, and correct peer reviewed scientific claims for the sake of humanity's best interests. And some of you know from experience how many independent researchers, including parents, often experience verbal attack when raising concerns about, for example, vaccination with demands from skeptics for peer review publication references. It is good to point out to them that the peer review system is far from reliable.

The next International Congress on Peer Review and Scientific Publication is scheduled for September 2025 and the authors list the many areas that need to be researched, presented and discussed at this meeting to vastly improve the present state of the review system. Time will tell as to whether any improvements are achieved.

"MOTHER NATURE, MOTHERS, GRANDMOTHERS – YES, EVEN FATHERS, AND GRANDFATHERS – ARE THE BEST DOCTORS AROUND, BECAUSE THEY DO NOT SHARE THE TYPICAL DOCTOR'S COMPULSION TO INTERFERE WITH THE BODY'S EFFORTS AND ABILITY TO HEAL ITSELF. ~ **Robert S Mendelsohn MD**"

The Quanten Theory

www.pqliar.net

ASK QUESTIONS by Patrick Quanten MD

WE TELL OUR CHILDREN things like, "if you don't know it, then ask". We tell them that there are no stupid questions. If you don't ask, then you can't learn anything new. If you don't understand, you simply ask for an explanation, and you keep asking until you have understood it. To the children, adults such as their parents or the school teacher are the experts. They know 'everything'. And as the expert we, as parents, get quite annoyed when teenagers do not want to believe us. And yet, sometimes they don't, and they certainly don't have to. They simply want to believe something else. We may not like it but the truth is that it is part of the growing up process, which includes becoming more independent from their parents and 'knowing things' in a different way. Independency does include thinking for oneself, even if it is the wrong idea, for whatever reason. They are entitled to have that idea. Finding the truth is an individual process that should be worded as finding your truth.

Whether children have picked their ideas up from the parents, from family members, from school or from elsewhere, they will live by these ideas, which means that they will be confronted with the good and the not so good sides of these ideas. Their experiences will teach them to become critical of ideas, wherever they originated from. Ideas are theoretical concepts but the practicalities of life will test these ideas for truths and untruths. In fact, it is not because an idea seems to be true, confirmed by personal experience, that it actually is true. For a while it may look that way, but the future, a different set of circumstances, may provide proof that the idea is not the right one. That it is no longer 'the right one' for you, at that time. It may be that an idea is workable within a specific framework, a specific set of parameters, but as a general statement it may, in the end, turn out not to be correct. Hence, our experiences cannot really determine truths, as in 'absolute' truths, but they can show us for certain

Patrick Quanten MD

"If I ask "how do you find a covid virus?" I am branded a covid denier. How does that work? If I ask how you find gold, am I then a gold denier?"

that something is not, cannot be, true. So only untruths, in general and in specific circumstances, can be proven. Truths emerge when no untruth can be identified. It is what is leftover when all lies, half-truths and mistaken beliefs have been stripped from our reality.

And that is exactly how science works. It is impossible to prove that something is true, but once you have been exposed to the untruth of a certain concept or a specific idea, it would be wise, and scientifically correct, to accept it as an untruth in your life. If you don't, you are fooling yourself and the day will come when you are going to make the wrong decisions simply because you have been unwilling to acknowledge the truth. In other words, it is not wise to ignore what you know not to be true. If and when you do, we simply call it 'carry on dreaming'.

And yet, as adults we are told not to question certain things. We are told that it is unwise to not accept 'the truth' as it has been stated. We are shouted at simply for asking questions. It is as if they don't want us to learn anything anymore. If I don't know something or I don't understand something, I can simply ask, but that no longer extends to adults. Sometimes it appears to me as if they are telling people what questions to ask. Indeed, information websites have a section called 'Frequently Asked Questions', where they ask the question and they give the answer. Hardly ever does the section contain the question I want to ask, and what is so striking is that there either is no way of asking another question or I am given a telephone number, or, even worse, I am allowed to have a conversation, called a chat, with a computer. Neither the computer nor the receptionist on the telephone is able to give any answers to questions that don't line up as 'frequently asked'. It just strikes me that our modern society doesn't like me asking questions anymore, which equates to 'they don't want me to know more than they need me to know'.

If I ask "how do you find a covid virus?" I am branded a covid denier. How does that work? If I ask how you find gold, am I then a gold denier?

Simply asking questions so the person can justify himself, can come up with reasons, and simply accepting those answers as the explanation is what our modern journalism is all about. All this does is make it appear as if it is all based on solid ground, on indisputable facts. Investigative questions, however, move the conversation to a different level. You can either ask questions about the basis on which the statement rests or you can ask questions about extending the matter into a wider setting. The foundations of the statement we enquire about with such questions as how they came to their conclusion, and a detailed answer is required to get a better understanding. Any avoidance or passing the buck to 'experts' is unsatisfactory. It also includes definitions of whatever labels they use, such as terrorist, extremist, racist, freedom, equality, discrimination, and so on. The other set of questions are about using the principles of the statement and extending these into the future or into different areas of life, which are similar to the one the statement is about.

Important questions relate to extending an opinion to a wider realm. Here are some examples. All humans have the right to free expression. So, that includes terrorists. All humans are the

same in the eyes of the law. So that means that banks, governments, big tech, which are all set up by humans, are not allowed to steal my money or my personal data. All humans are equal with regards to race, religion or creed. Racism is defined as 'relating to, or characterized by the systemic oppression of a racial group to the social, economic, and political advantage of another'. Is it then not obvious that white heterosexuals are being treated differently to other people? What about statements such as 'everybody wants …'? Did you ask everybody what each individual wanted? Guess not. Then please, for future reference kindly adjust your statement to 'everybody except one', because I certainly don't want it. Whenever it is claimed that 'the people' of this nation, of this city, of this religion, of this company, of this association, are wanting or opposing something, the question is 'have you asked them?' A referendum is a way of asking 'the people' and experience tells us that people are always divided in their opinion. There is no such thing as 'the' people. There are individuals.

When that system no longer works, you set up a democracy. You work with percentages and whatever the highest percentage is becomes the truth, becomes the only real option. Through democracy you demonstrate that, in fact, 'the people want …' is a lie. You replace it by 'the majority knows best'. Now all of 'the people' have to endure what the statistics have determined to be the right answer. Simple questions expose the untruth within the statement.

When a doctor tells me that a certain treatment has an 80% success rate, two questions immediately spring to mind. One is, 'what do you see as a success?' The second is, 'can you guarantee me that I will fall into the 80% category?' To a surgeon the operation is successful when whatever he has fixed is in the right place and the wounds of the operation heal well. Whether or not the ailment of the patient has improved or not is not really any of his concern and doesn't affect his 'success rate'. So, in this instance, when you talk about an 80% success rate it actually indicates that the surgeon makes a mistake or is unable to bring the surgery to a satisfactory end in one in five cases. This always prompts

Photo by Artem Maltsev on unsplash.com

the question, 'how many of these operations have you recently performed?' And they are very proud to tell you that it 'never' goes wrong. That is the point when I would walk away! If one in five go wrong and nothing has recently gone wrong, he is due a failure. We are encouraged to ignore the smaller part of a statistic as non existent. And yet, it is obviously a part of life, so how wise is it to ignore it?

Considering life as a game of chance means that you haven't discovered the pattern behind it, the rules on which it is based. You view it as chaos and you fail to see the pattern within the chaos. And that is fine, but you do have to realise that whatever choices you make in life the outcome is totally unpredictable to the gambler. So whatever the odds are, it may entice him to go for the 'bigger' option, but he can never be sure because he doesn't understand under what circumstances you reach the higher percentages and which are the conditions that lead to the lower ones. Then I ask any casino owner, 'who gains the most money from gambling?' It certainly isn't the punter! The alternative to a life of gambling would be to continually ask questions, to continually search for untruths so I can increase my personal odds just because I know what is good for me right now. I need to learn more about what creates a specific outcome, and learning I can only do by asking questions.

If statistics show that I will live longer than my grandparents I would like to know how you have gathered your data, from which source, and how have you calculated it. When does, in your

opinion, life begin? Do we include unborn babies in this statistic? Abortions? If not, then all the abortions we perform on the basis of a test that says that there is a 50% chance the baby will have Down Syndrome, or be autistic, or dyslexic, or have mucoviscidose, lives that we expect to be shorter than that of the average human, are reducing the infant death rate, thereby increasing the statistic result of longevity without in fact lengthening the lifespan of human beings in general. Telling me that people live longer now than 'ever before' doesn't guarantee me a longer life. My life will still end when it ends. The statistical statement doesn't change that, even if I want to believe it is true. Any statistical knowledge is not knowledge. It doesn't contribute to my wellbeing or to life in general. It doesn't matter how big or small my chances are. All that matters is what happens to me. If there is one chance in a million I will die from a certain disease or a certain type of accident, according to statistics, it means nothing to me. When it happens to me my chances are 100%. Equally, it doesn't matter to me that I have 99% chance of recovering from a disease, when I don't.

When we are told that a test or a study has concluded something, has demonstrated something, the questions should be about how the test or study was done. What was the setup? What has been included, and what has been excluded? How do you gather the information you are studying? When they tell me how many people died of covid, I want to know how they determine the cause of death. I want them to explain to me every step of this process. I want to ask further questions about the methods they use and the relevance and accuracy of those methods. I want to know the details of their investigation so I can determine what possible mistakes have been made and where they linked data that are not connected. That is what is done in a court of law, where they examine how the evidence has been collected in order to establish whether there could be some truth in it. And that is what authorities do not want me to do. They don't want to be questioned on it.

When they tell me they have identified a specific virus I would like to know how they do this, bearing in mind that a virus is about a thousand times smaller than the smallest living cell. We can't see cells, so how can we identify a virus? If the speaker can't provide me with a satisfactory answer to that question, our conversation stops right here. If he wants to convince me he will have to produce an expert who can explain it to me. And here is a general rule that one should always bear in mind. If I don't understand the explanation then the explanation has no value to me, doesn't answer my question. Instead of believing that I am not smart enough to understand this complicated process, I believe that the expert is not smart enough to explain it to me properly, which means that he doesn't really understand it either. If he did, he could explain it to me in simple terms. I don't understand anything about a car engine but the mechanic is able to explain to me what the problem is, how it occurred and how it can be fixed.

"Instead of believing that I am not smart enough to understand this complicated process, I believe that the expert is not smart enough to explain it to me properly, which means that he doesn't really understand it either. If he did, he could explain it to me in simple terms."

Simple explanations are needed for people to understand the true reality of any statement. Explain what you are saying. Define words and concepts you are using, so I know what you are on about. You can ridicule me for not understanding but putting me down doesn't convince me of you being right.

Asking questions is not a conspiracy. It is a quest for knowledge. Getting angry when confronted by questions displays ignorance. People like to believe they are smart. They studied for a long time. They have a responsible job. They are full of confidence. What they don't like is a sense that all of that is just veneer and doesn't run deep at all, that it has no true roots, and that their cleverness is totally dependent upon the diploma they hold, the title they have been given, the esteem they have achieved within the population. Asking the right kind of questions is confronting them with their limited knowledge.

When a doctor tells me that he doesn't know what has caused my illness then I would be foolish to allow him to treat me. I wouldn't do it with my car, why would I do it with my life? When he does tell me the cause, I still need to ask him how he knows that. I need to know what he is basing his opinion – *it is nothing more than a human opinion*! – on, because the next step is to think about the way the test is performed and what that really means, not what he believes it means. He has been trained to believe certain things but I do not have to go along with that. I can question it. What causes diseases seems to me a mine field. Experts in that field find 'proof' in all sorts of directions. One says he 'knows' polio is caused by a viral infection and the other says it is a poisoning of the system. I found the same two answers with regards to mad cow's disease. I discovered that science says that no infectious disease is caused by an organism such as bacteria or parasites, and that these appear later in the disease process. The medical profession clings to their belief that infectious disease must be caused by the invasion of organisms and they extend this theory to include non-living things which they call viruses. The answer to these kind of opposing views our modern society has come up with is to suppress all knowledge of one side of the argument. Ask no questions. Believe what we tell you.

When medical science tells me a specific compound or a specific situation causes a specific disease my questions and observations have never confirmed that. Lyme Disease caused by the bite of a tick? I know lots of people who definitely had to remove ticks from their body and who never got ill. I also know that the majority of people with the diagnosis never remember ever being bitten by a tick. The answer from the medical profession is that you probably wouldn't have noticed a bite. In my experience, both in animals and in humans, when left ticks remain in place

for days. You can feel a little 'lump'. It may irritate a bit. What do you mean 'I wouldn't notice'?

Causing a disease should mean that when the said circumstances are present it always leads to the said disease. That is the definition of 'cause': something that brings about an effect or result. Not in the medical world. In that world something is the cause of a disease when the doctor says so, and it isn't when the doctor says so. Always believe the expert. Never question the expert. Going by your own observation, you can determine that not all diabetes is caused by an overconsumption of sweet things, and neither is tooth decay. Not all heart failures are caused by consuming too much fat. Mostly the medical profession puts the cause of a disease as a multifactorial cause. It is a combination of things. I am willing to accept that, as a general statement. Then my question is: 'Why is the treatment always the same and never directed to what you proclaim the cause to be?' When you include stress in the causes of my stomach ulcer, why is the treatment acid blockers? Why is drug addiction treated with drugs? Why is a distorted rheumatic joint treated by an operation as, surely, the operation does not remove the cause of the disease, which is being expressed in many other places of the body?

As far as your health is concerned it would be wise to take a more active part in understanding what you are being told. For this, it is necessary that you ask questions. And if you do, you need to aim those questions at understanding how the medical system works. If you don't know how they got to their opinion, you will not be in a position to evaluate that opinion. So your only option is to agree with them, to accept their opinion. Make sure the questions you ask dig into the soil on which the statement, the opinion, is based. If you don't understand how they reached their opinion, then it is time for you to walk away. Be wise enough not to engage in anything you don't understand.

Be wise enough to value your own opinion above all others by ensuring that you know what your opinion is based upon. When you know why you believe something you have the possibility to alter that belief when 'new' information reaches you. Be wise enough to be open to all other opinions. This means that you listen, you question, you examine. That is how one becomes wise.

November 2023.

'WORDS WERE MY LIFE BUT NOW THEY'RE GONE': ACTRESS, 42, LEFT UNABLE TO PERFORM AFTER SUFFERING STROKE TRIGGERED BY ASTRAZENECA COVID JAB

Dailymail.co.uk 10 November 2023
https://www.dailymail.co.uk/health/article-12733791/Words-life-theyre-gone-Actress-42-left-unable-perform-suffering-stroke-triggered-AstraZeneca-Covid-jab.html

AN AUSTRALIAN ACTOR who got a Covid jab while living in the UK has told of her heartbreak after suffering a rare but devastating side effect of vaccination.

SUMMARY OF THE ARTICLE BY MAGDALENE TAYLOR

Senior Health Reporter for Mailonline, John Ely reported how actress Melle Stewart now struggles to put a sentence together, speaking slowly, and 'grieving' for the successful stage career she has lost. Melle suffered a devastating blood clot complication from the AstraZeneca covid injection she received in May 2021. Along with other claimants Ms Stewart is now taking AstraZeneca to court. However I was astonished to read in this Mail article that despite having suffered greatly Ms Steward continues to be a 'staunch and proud' advocate for vaccination and gone on to receive other non-AZ covid vaccines since her injury. One wonders why she takes such a position on vaccination?

The article states: 'Just weeks prior, health officials had pulled the AstraZeneca jab for anyone under 40-years-of-age, spooked by a link to potentially deadly blood clots in this group. However, Ms Stewart corrected the volunteer, as she had turned 40 in November 2020. With that, she got the AstraZeneca jab, even getting a post-jab sticker to mark the occasion. Two weeks later she was fighting for her life.'

According to the Mail article surgeons battled to save her life eventually being forced to remove part of her skull to reduce the pressure in her brain. Investigations revealed she was a victim of Vaccine-Induced Thrombocytopenic Thrombosis (VITT).

Ms Stewart is now trying to relearn and regain mobility and speech and has received a no-fault £120,000 payment from the government vaccine injury fund. However Ms Stewart and her partner, now her full-time carer, are taking legal action against AstraZeneca as they say that the sum falls far short of their lost earnings.

An AZ spokesperson told MailOnline that: 'Patient safety is our highest priority' and that their vaccine 'has an acceptable safety profile and regulators around the world consistently state that the benefits of vaccination outweigh the risks of extremely rare potential side effects.'

The AZ vaccine, Vaxzevria, has been granted full marketing approval by the Medicines and Healthcare Regulatory Authority (MHRA).

The article highlights other claimants who have suffered after receiving the AZ injection resulting in permanent brain damage in one claimant, and another case where a 35 year old mother died from blood clots on her brain. 90 British families have similar situations and if these cases are successful vaccine damage payouts could be in the region of £90million.

As you may have guessed 'the British taxpayer is expected to foot the bill under an indemnity agreement signed by ministers in the darkest days of the Covid pandemic to get vaccines produced as quickly as possible.'

The article ends by stating the AZ vaccine has been credited with saving 6 million lives globally by offering protection against severe illness from the covid virus. This is so often the standard response from these companies and officialdom. They make highly presumed and unproven claims about a product which is supposed to offer protection from an alleged pathogenic virus which is also unproven!

BOOK NEWS!!

Both of these books are available via Amazon.

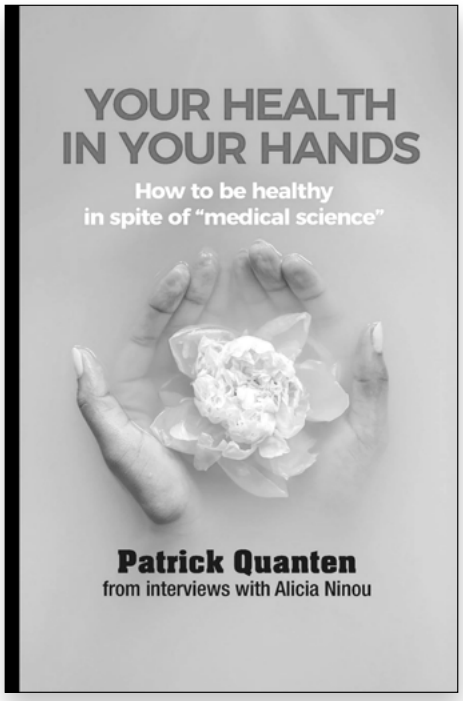
HEALTH IN YOUR HANDS; HOW TO BE HEALTHY IN SPITE OF "MEDICAL SCIENCE"

ISBN 9789082785463 By Patrick Quanten and Alicia Ninou. Oct. 2023

"WHAT DO I DO when my patients are not cured with what I can offer them?" This was the question that Patrick Quanten, a Belgian family doctor, asked himself when the official medical treatments he was taught at university proved to be ineffective.

His decision was radical: turn away from his medical training, abandon the dogma that fed him, and dive into new horizons - such as ancestral medicines, quantum physics, ayurveda or the new biology - something that would enlighten him about the real meaning of health. Written in the form of questions and answers, in this book, shrewd journalist Alicia Ninou asks Dr Quanten irreverent questions about life itself, in which we discover how medical science deviated from true science many years ago, becoming a ruthless structure at the service of the industry, without any relation to health.

Meanwhile, the ancestral knowledge of the structure of life or the brilliance of the energetic organization of the human body remain hidden from the eyes of the vast majority. If you are looking to understand what cancer is from a new perspective, learn about the history of the fallacious microbial theory or discover the seven types of external influences that affect us in our daily lives... you need to read this book.



MEDICAL DESPOTISM – ROB RYDER WITH CONTRIBUTIONS FROM PATRICK QUANTEN MD

Nov 2023

In one of the opening pages of this book it states:

This book is dedicated to historians and their pursuit of Truth, Justice, and Freedom – who have kept alive the knowledge of the true nature of human beings and suffered ridicule, injustice, and even death to set a foundation and example as mankind enters the end times'.

Chapters include: Health, the need for scientific answers, history lesson in germ theory, story of infectious disease, viruses, epidemics, vaccination on trial, history of modern medicine, medical doctors, the pandemic, the lockdown, MHRA, Climate changes, Self-empowerment and society.

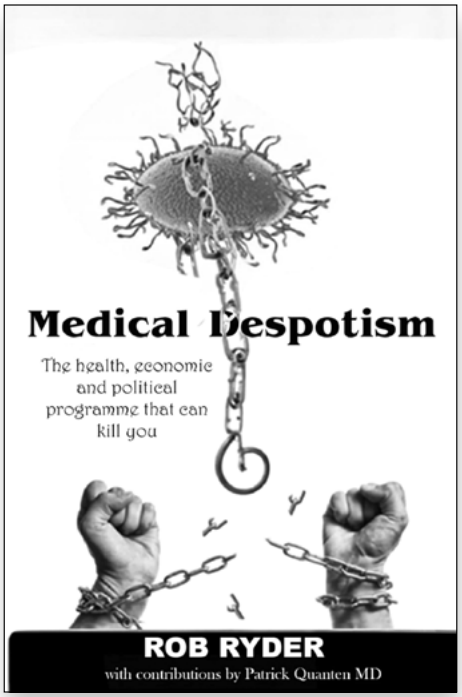
Here is a brief extract:

HEALTH

What is it to be healthy?

First, we have to understand that we are all individuals. So, for example, a man of 5 feet 8 inches may weigh ten stones and have a different blood pressure and other things to a man of the same height but who weighs 14 stones. Maybe one is a runner, the other a rugby player, both physically fit for their build and lifestyle.

So based on somebody's height it would be impossible to tell someone their perfect weight, blood pressure etc., as we are all different. Also, health cannot be defined by lack of symptoms, just as illness cannot be defined by the presence of symptoms. An example could be a fever; the body needs energy and vitality to produce a fever so the presence of a fever to burn up unhealthy tissues could be a sign of good health, healthy maintenance, whereas a person



who cannot produce a fever could be loaded up with toxins, lacking energy and struggling to expel them.

There are basic things a human needs to be healthy, which include having the body parts/organs in good working order, clean blood, a clean and healthy environment with sunlight and fresh air, living free from enforced stress, good nutrition, and to be completely aware and in control of who you are, freely expressing yourself. The sign of good health is known as vitality, the vital force that powers our cells. This we take from the energy source that is the sun, breathing clean fresh air and being true to ourselves and expressing our true individualism. Signs of vitality are people who are creative, happy, alert, heal quickly and have a thirst for life. Lack of vitality could include depression, fatigue, low energy, slow healing and no sense of purpose. As science has shown we are all energy at our source; our physical bodies are perfect expressions of our true energetic selves. Think of that when someone asks why they have cancer and the doctor just says, 'Bad luck.'

So, health could be best described as an individual being in balance with themselves and the world they find themselves in. They are living a life with purpose, following dreams and embracing the great game of life, and as we are all different – we like different foods, climates, lifestyles and have different personalities – we need to find

our own personal balance. So, if health is being in balance, then sickness could be described as being out of balance, or not being or expressing your true self.

We will now delve briefly into some theories of how we go from one state to the other. Please leave any preconceived ideas at one side and start with a blank page, and go with the evidence and what feels right for you. After all, the responsibility for your health is your own. In my opinion the main things needed for health are clean water, sunshine, fresh air, family and friends and a sense of purpose. These are the very things the lockdown has taken away from people in the name of health, not a coincidence in my opinion.

SYMPTOMS OF ILLNESS

Body going wrong
– Body doing right?

When we are ill we become aware of this as the body produces symptoms like fever, vomiting and rashes, etc., or just a feeling of being unwell. But what do these symptoms mean? Compare the view of your GP and, say, a homeopath.

GP, Allopathic
– Body malfunctions

Trained in allopathic thinking, so symptoms like a fever, rash, headache, and inflammation are seen as the body going wrong. Very little time is spent on asking why this has come about, only that it is a discomfort to you and it needs to be fixed. Therefore, the doctor will look at his list of drugs to find one that will stop or suppress the symptom, as they see the symptom as the problem.

So by taking away the discomfort (symptom) the patient feels well and believes all is fine again. Though doctors are aware that fevers are getting rid of cellular waste and toxicity, they still treat this as the problem most of the time, the body going wrong, a malfunction, part of a broken machine not knowing what it is doing. They normally get about ten minutes with patients, only enough time to look at symptoms.

Homeopath, Holistic
– Body rebalances

They are trained in seeing the body, when showing symptoms of illness, as the body trying to re-establish health and view symptoms, or patterns of symptoms, as an intelligent reaction by the body to try and bring back balance, basically a clearing-out of bad stuff. Therefore, they prescribe safe remedies that aid the body with whatever symptom is being shown, going with the body, kind of giving the body a helping hand, going with the intelligence of the body and trusting that the body knows what is best. After all, it has had plenty of time to evolve and perfect these responses. They normally give the patient an hour to listen and put together a holistic view of what's going on in that particular life.

As far as comparing going with or going against the body, I will give you a quote from Trevor Gunn in his must-read book, The Science of Health and Healing, when talking about possible outcomes of an acute illness.

- The individual resolves the illness and as a result their health is improved and they are stronger than they were before. They are less susceptible to those problems after the illness and more able to deal with them.
- The individual resolves the illness but there has been no learning as such, they are not stronger than they were before, they effectively carry on as they were before the illness, just as susceptible to succumbing to the illness as they were before.
- The illness is not resolved and as a result the health of the individual is worse than before and they descend into a lower level of chronic illness, more susceptible than before.
- The illness is not resolved and the patient is unable to react sufficiently to overcome the problem and dies.

THE STUPENDOUS VACCINE-ANTIBODY CONTRADICTION THAT NOBODY TALKS ABOUT ANYMORE

JON RAPPOPORT
Nov 21 2023

BRIEF EXTRACT

AS MY READERS KNOW, I've been taking two positions on the subject of viruses. The first and real position is: they're fictions. But at the same time, for purposes of discussion ONLY, I'll assume they're real, meaning I'll momentarily enter the fantasy bubble of conventional medical research, and show that within that fake bubble, there are piles of lies and internal contradictions.

That's what I'm doing in this piece.

Here we go. The official view of vaccines is: they produce antibody reactions against the "the virus in the vaccine." This is the accepted outcome that proves the vaccine is working as it should.

Up until AIDS and HIV, it was generally assumed that if a person NATURALLY produced antibodies against a virus, it meant the person's immune system was working properly: it had encountered and defeated the virus. Immunity had been achieved.

But then everything changed.

People who tested positive for HIV—meaning a blood test showed they were making antibodies against HIV—were told they were infected with a lethal virus. Infected, not immune.

In fact, during research for my 1988 book, AIDS INC., an FDA spokesperson told me that if a vaccine were developed for HIV, every person who got the shot would be given a letter to carry around with him:

The letter would essentially state that the vaccine recipient's antibodies were the result of vaccination—and that was a good thing—a sign that he was immune—not a sign that he was infected with the lethal HIV.

In other words, it was suddenly the official position that THE SAME ANTIBODIES had two different and opposite meanings, depending on how they were acquired:

If they occurred naturally, as a consequence of contracting the virus in real life, that meant disease and potential death. If they were acquired from vaccination, that meant the person was immune and protected.

WHAT IS CONSIDERED PROOF OF IMMUNITY TO MEASLES?

MAGDALENE TAYLOR, TIP EDITOR,
November 2023

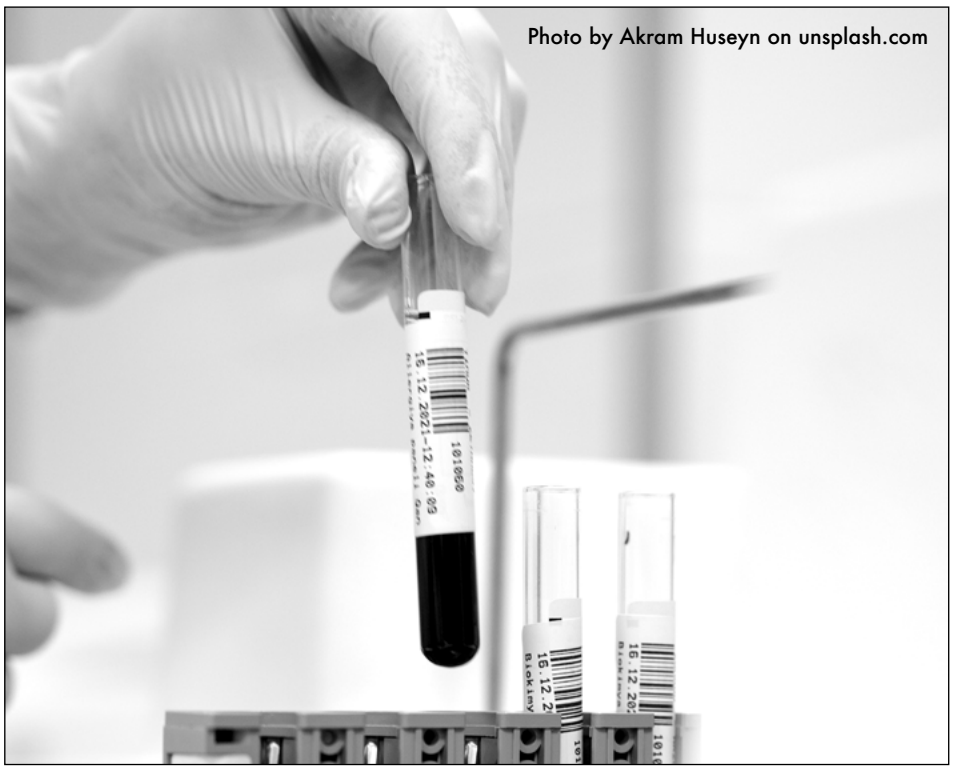


Photo by Akram Huseyn on unsplash.com

THIS IS THE QUESTION I typed into my search engine to see, out of interest, what information and links appear on my browser.

The text below appeared at the top of my screen:

A blood test is the most reliable method. The measles IgG test shows whether the body has antibodies to fight off the virus. If enough measles antibodies are present, then the person is said to have evidence of immunity to measles. Vaccination records are also reliable.

My first thought was 'blood test'? Given that there is growing concerns and a lack of evidence that the alleged pathogenic virus deemed responsible for measles appears not to have been truly isolated, purified, characterised, and then observed to cause measles – how can there be a blood test? And given that there are questions surrounding anti-bodies and that they are non-specific rather than specific – how can this test be reliable? Additionally, even if we accept there are measles IgG antibodies and that they show immunity what about cases of measles in previously vaccinated individuals with high levels of IgG antibody? Why did they develop measles?

Here is an extract from a paper published in the journal **'Clinical and Vaccine Immunology', Aug 8 2016, Vol 23, No. 8. Sowers S B et al.** Please note that high-avidity is defined as the strength of binding between IgG and its specific target epitope. (An epitope is the part of an antigen that the host's immune system recognizes, eliciting the immune response to an invading pathogen.) Therefore the term high-avidity should indicate strong immunity if we are to believe that germs cause disease and that we can gain immunity etc:

Individuals with confirmed measles and a prior immunologic response to measles virus (reinfection) from either vaccination or natural disease that occurred at least 4 months before symptom onset can be identified by the presence of high-avidity measles IgG antibody. A measles virus reinfection that occurs in an individual who had measurable specific antibodies after documented vaccination constitutes a secondary vaccine failure (SVF). However, the vaccination history of some persons with confirmed reinfections can be unknown, and among those with >1 documented doses of vaccine, evidence of a protective titer of antibody to measles following vaccination is rarely available. Therefore, the term reinfection case (RIC) can be universally applied to a confirmed measles case in a person with high-avidity measles IgG antibody.

It is very convenient for the medical fraternity to come up with these definitions such as RIC (reinfection case), PVF (primary vaccine failure, SVF (secondary vaccine failure when measles cases occur in vaccinated individuals. They could just simply call them all VF – vaccine failure!

Reading more of the Sowers et al paper also provides more evidence that so much of what is presented as reliable is mostly just assumptions. For example, expanding on a reinfection case (RIC) the authors discuss that the best method for case confirmation of a RIC is RT-PCR testing! Yes, PCR, which as some of you know is not a diagnostic tool and should not be used to test for 'disease' of any sort. The authors write 'best method' but then when you read further, in my opinion you would be right in stating….' And this is their best method?'

So what do they write: *Therefore, the best method for case confirmation of a RIC is RT-PCR testing. However, reliable and dependable RT-PCR results depend on high-quality RNA extracted from specimens that have been adequately collected and transported to the laboratory in a timely manner. Because a good-quality specimen cannot be ensured, a negative RT-PCR result does not rule out a suspicious case. This may be especially problematic for RICs since the duration of viral shedding may be diminished and measles may not be initially suspected among those RICs with mild symptoms or unusual rash presentation and progression.*

Once again the methods used do not conjure up any sense of reassurance that these alleged 'test results' have any validity. Before moving from this paper, note the last sentence of the paper:

Measles reinfections are likely to become more common when measles is introduced into highly vaccinated populations; therefore, additional data should be collected to evaluate the settings in which these cases are most likely to occur and the potential for further transmission from such cases.

Returning to the first text I quoted at the beginning of this article the second option given to indicate proof of immunity is stated as – *'Vaccination records are also reliable.'*

I noted that similar was indicated on other links. For example:

Two documented doses of MMR vaccine given on or after the first birthday and separated by at least 28 days is considered proof of measles immunity, according to ACIP. (19 Jun 2023) ACIP stands for The Advisory Committee on Immunization Practices in the US.

Similarly on the University College London site:
https://www.ucl.ac.uk/ion/sites/ion/files/guidance_on_immunisation.pdf
MEASLES & RUBELLA: *Students must be able to prove their immunity to measles and rubella. This can either be with blood test results showing immunity (a positive IgG level) OR documentary evidence of two MMR vaccinations having been given.*

And yet another example – (Please note how it is worded 'acceptable presumptive evidence'. Since investigating vaccination and other aspects of modern medicine over more than three decades I personally think that most of modern medicine is based on presumptions that they deem acceptable!)
https://www.labcorp.com/tests/058495/measles-mumps-rubella-mmr-immunity-profile

MEASLES

Acceptable presumptive evidence of Measles Immunity (at least one of the following):

• Documentation of age-appropriate vaccination against measles virus.
• Laboratory evidence of immunity (IgG in serum; equivocal results should be considered negative).
• Laboratory confirmation of measles.
• Birth before 1957.

Persons who have measles-specific IgG antibody that is detectable by any commonly used serological assay are considered to have adequate laboratory evidence of measles immunity. Persons with an equivocal serologic test result do not have adequate presumptive evidence of immunity and should be considered susceptible unless they have other evidence of measles immunity.

Documented age-appropriate vaccination supersedes the results of subsequent serologic testing. If a person who has two documented doses of measles-containing vaccine is tested serologically and is determined to have negative or equivocal measles results, it is **not** recommended that the person receive an additional dose of vaccine. Such persons should be considered to have presumptive evidence of immunity.

And my last example:
https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-37-immunisation-health-care-staff

Measles, mumps and rubella (MMR) – this is particularly important to avoid transmission to people who are more vulnerable of health problems should they acquire the disease/infection. Evidence of satisfactory immunity to MMR is either:

1. *a positive antibody test to measles and rubella*
2. *having 2 doses of the MMR vaccine.*

Just the fact that an individual has received two doses of MMR is deemed proof of immunity even though there are so many PVFs, SVFs and RICs acknowledged throughout the medical literature!

Most vaccine recipients do not get 'tested' for the assumed 'immunity' anyway for any of the diseases they are deemed to be protected from. Neither do unvaccinated individuals get 'tested' as a control group with these presumed tests to see what their results indicate.

This article is only focusing on the presumed and established medical view that any pathogenic virus exist (I have used the example of measles). As many of you know there are a growing number of researchers, including doctors who no longer 'believe' in the germ theory, or as Tom Cowan MD refers to it as an *unproven hypothesis.* Secondly, exanthems whether it be called measles, chickenpox or rubella are considered to be one of the body's methods of elimination from a naturopathic view.

There are a variety of reasons you might produce these kind of rashes in childhood, including removing metabolic waste during stages of growth. If so, should we even be trying to suppress cases of these childhood acutes? And also if suppressed – preventing elimination - what long-term health issues will occur in the vaccinated as a result of this suppression?

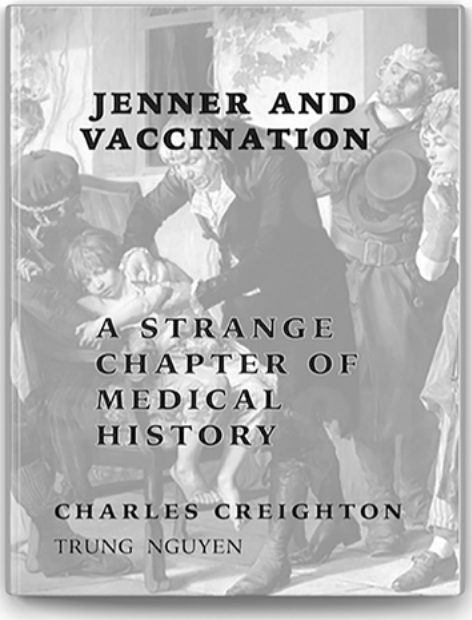
EXPOSURE FROM VACCINES BEFORE AGE 24 MONTHS AND PERSISTENT ASTHMA AT AGE 24 TO 59 MONTHS

2023 Jan-Feb;23(1):37-46
https://pubmed.ncbi.nlm.nih.gov/36180331/

ABSTRACT – EXTRACT

OBJECTIVE: To assess the association between cumulative aluminium exposure from vaccines before age 24 months and persistent asthma at age 24 to 59 months.
RESULTS: The cohort comprised 326,991 children, among whom 14,337 (4.4%) had eczema. For children with and without eczema, the mean (standard deviation [SD]) vaccine-associated aluminium exposure was 4.07 mg (SD 0.60) and 3.98 mg (SD 0.72), respectively. Among children with and without eczema, 6.0% and 2.1%, respectively, developed persistent asthma. Among children with eczema, vaccine-associated aluminium was positively associated with persistent asthma (aHR 1.26 per 1 mg increase in aluminium, 95% CI 1.07, 1.49); a positive association was also detected among children without eczema (aHR 1.19, 95% CI 1.14, 1.25).
CONCLUSION: In a large observational study, a positive association was found between vaccine-related aluminium exposure and persistent asthma. While recognizing the small effect sizes identified and the potential for residual confounding, additional investigation of this hypothesis appears warranted.

A STRANGE CHAPTER OF MEDICAL HISTORY: ANOTHER INSTALMENT



IN THE PREVIOUS EDITION, Issue 2 2023, I included a number of extracts from a book I was reading by Dr Charles Creighton entitled Jenner and Vaccination written in 1889. As I continued to read the latter half of the book more interesting texts appeared, therefore I have reproduced here further extracts which you may find eye-opening.

PAGE 183

We have thus far seen what kind of evidence the profession had before them, on the protective power of cowpox, and what kind of apologies they were prepared to make for failures and disasters. They never went deep enough into the anatomy and pathology to realize what sort of pox the cowpox actually was, and they had none of the milkers' experience to teach them in the most forcible of all ways.

Their behaviour over the variolous test was incredibly stupid and careless. Their chief apologetic plea of spuriousness was wholly alien to the spirit of logical investigation, and a flagrant example of the art of circumventing the unwelcome teachings of experience.

It is hard to believe that the many educated and conscientious men, who belonged to the medical profession of Britain in those years, had given their reasoned assent to a doctrine and practice so full of frauds and fallacies that a later generation will hardly bear to have the naked facts exhibited to the public gaze.

PAGE 197-198

Dr Bradley, physician to the Westminster Hospital (and editor of the Medical and Physical Journal, in which he had pledged himself to the utmost to back up Jenner), believed that cowpox will prevent smallpox to the extent of human life. Thinks that if Dr Jenner had settled in London and kept cowpox a secret, he might have made ten thousand a year for the first five years, and double that sum afterwards. Sir Walter Farquhar, M.D., had seen cowpox in one of his grandchildren, who had it very mildly and was protected by it. Thinks it a permanent security. Believes that an income of ten thousand a year was lost to Dr Jenner by making the secret public.

Dr James Sims, president of the Medical Society, thinks Dr Jenner might have become the richest man in these kingdoms by trading on his cowpox secret. The Medical Society of London sent through him a unanimous testimony in favour of cowpoxing.

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It was unfortunate that the only persons who had a motive for scrutinizing the Jennerian evidence, namely the friends of the old variolous inoculation, had also a motive for not inquiring too closely into the shadowy or formal type of the variolous test. They would probably not have been listened to; but, as it was, the opportunity was missed of showing how the profession had been deceived, or had deceived themselves, on the grand question of the antagonist character of cowpox. If the variolous test had been shown at that date to be the meaningless thing that it was afterwards admitted to be, even Admiral Berkeley and his fellow committee-men could hardly have reported as they did. It was part of the peculiar irony of the situation that the only opponents of the Jennerian doctrines were precluded, by their own interest in variolation, from attacking these doctrines on the ground of the variolous test.

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On the 2nd of June, 1802, Admiral Berkeley proposed in the House a grant to Jenner of £10,000, to which Sir Henry Mildmay moved an amendment (lost by 56 to 59) to make the sum £20,000. The prime minister, Addington, a notorious worshipper of authority, and more ignorant, naturally, of pathology and epidemiology than of most things, gave it as his opinion that cowpoxing was among the greatest, if not the very greatest of discoveries since the creation of man.

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Before remarking on the nature of the evidence which, in all good faith, served to convince the Comité Central, we may notice the criticisms that reached them from without, at successive stages of their inquiry. Their most trenchant critic was Verdier, who appeared only once in the field ; the other considerable antagonist was Dr Joseph Vaume, a retired surgeon-major, who issued three pamphlets.

The Committee replied to Vaume's several objections in the newspapers of the day, making him speak, as Vaume complained, in language of their own choosing ; his own rejoinders were refused admission by editors, and at the end of his third pamphlet he explains that, ''whether they answer me or whether they keep silence, this is the last time that I address the public on these chimaeras.

I have brought the dangers of them under notice; my task is fulfilled." Vaume's objections were partly of the dialectical sort, which the Committee had, of course no patience with, and made no answer to, and partly founded on the results of vaccination as observed by himself. He produced affidavits of several disasters and deaths from vaccine in Paris, which the Committee met by denials or explanations.

PAGE 247–248 THE WORDS OF CRITIC DR VERDIER

You have hastily taken this on trust, he continues, from the English, who are more eager for medical novelties than

any other nation; their reports are defective, unfaithful, often disfigured, and so drawn up as to serve only the glory of vaccine. Jenner's doctrine is " un systeme romanesque," which the natural course of things has already disavowed in its most considerable part [horse-grease] ; he deals merely in conjectures, most of which are refuted by his own data, although he erects them into indisputable axioms.

In one place he depicts cowpox as a very grave malady, and in another place tells us that it hardly deserves to be reckoned a disease at all. Everywhere there is inexactitude, vagueness, and palpable contradiction. To prove protection, cases are adduced by the thousand, but few details are ever given. We have more assurances than observations. The variolous tests are not reported with sufficient detail, and what little is said about them indicates a heedlessness which is not compatible with the scrupulous exactitude of true observers. All failures are ascribed to spuriousness of the vaccine, although it had come from the same source as matter counted genuine.

PAGE 271-272

Sacco's account of how he found original cowpox at Varese is so circumstantially conceived that its omissions call for remark. Was it with the crusts from the first drove, or with the thread soaked in matter from the two cows in the second, that he made his vaccinations? The existence of cowpox among the forty cows which had come down into Lombardy from the high Alpine pastures at the end of summer is intelligible enough. It was just when a cow was taken to market, being driven or kept standing with her udder full, that the pimples, cracks, or other common ailments would arise, out of which cowpox ulcers might be induced through the rough manipulation of the teats by the milkers, and might be conveyed by them to other cows. The market-cow sort was admitted by Jenner to be a common type of the spontaneous cowpox only he laid it down quite clearly in the Inquiry, but also quite arbitrarily to serve a disingenuous purpose, that it was at the same time spurious.

The crusts which Sacco took from the teats of these cows at Varese would doubtless have furnished the cowpox virus for inoculation indeed, the crusts of the sore teats were the only form in which Ceely could ever get original vaccine virus, notwithstanding all his careful search for fluid matter from unbroken vesicles in several outbreaks during a number of years at the dairy-farms near Aylesbury.

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The protective power of cowpox against the smallpox of sheep is a delusion which has been confessed with brutal frankness by those whose pockets are concerned. It took some time to arrive at the truth of the case but as soon as the truth was apprehended, the sensible, practical step of ceasing to vaccinate for sheep-pox was taken, regardless of what might happen to the professional credit of those who had warranted it. The following is the authoritative summary by Dr William Budd, in 1863 :— " Against ovine smallpox, vaccination offers no specific protection at all. It has been proved by experiments on an enormous scale, performed under every condition to ensure accuracy, that vaccinated sheep, when afterwards exposed to the infection of clavelée, take the disease in large proportion in the natural way ; and that when inoculated with it, they not only incur the usual consequences, but suffer quite as severely as unvaccinated sheep."

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The last of Sacco's various services to the theory of cowpoxing is his enthusiastic adoption, in 1802 or 1803, of Jenner's doctrine of the horse-grease origin of genuine cowpox. The cowpox at Varese had clearly nothing to do with horse-grease, and

Edward Jenner vaccinating against smallpox, 1796.

Sacco, in his first book, criticised Jenner's facts and reasoning thereon with some severity ; he remarked that Jenner had nothing better than conjecture to base his theory on.

At the same time he had caught up the clap-trap talk about "genuine" and " spurious," although he does not seem to have apprehended Jenner's motive in making the spontaneous cowpox a spurious sort. Being a keen experimenter, he had not been long settled at Milan when he went back to the horse-grease question, and in course of time satisfied himself that Jenner's doctrine was correct, Jenner himself having meanwhile quietly dropped it, except in his private correspondence.

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It was not until a good many years after that the protective was put to a real test, on the revival of the smallpox epidemics after a rather longer interval than usual, which had been more than adequately filled by typhus.

Then the objections to vaccination began to find utterance, and were answered in the dexterous apologetic manner which we know so well. Sacco appeared at the Vienna meeting of the German Association of Naturalists and Physicians, on 26th September, 1832, and delivered a Latin oration on the need for compulsory vaccination all over the world, in which he said that all the objections that can be brought against vaccine yield to reason and experience (rationi ccdunt atque experientice), or, in other words, they yield to professional apologetics.

On that occasion the famous apology for cowpox was brought forward by Sacco, that, if it did not prevent smallpox, it reduced its attack to a mild type. This was promptly challenged by Schonlein (the future leader of German medicine and a man of deep learning, who had made epidemics his favourite study), on the grounds that there had been just as large a proportion of mild smallpox cases before the vaccination era as there ever was after it.

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(Note how Jenner – who fought the inoculators (variolation method) claiming vaccination was superior and yet allows his baby son to be inoculated in this situation!). Jenner did vaccinate his own child, Robert F. Jenner, aged eleven months, on the 12th of April, 1798, but, as often happened after he had vaccinated several in the first trials, he did not "take". Shortly after, when Jenner was living at Cheltenham, a medical friend came into the house, and, taking the child in his arms, remarked pleasantly that he had just left a family in the smallpox. "Sir," cried Jenner, "you know not what you are doing. That child is not protected." The boy was thereupon inoculated, but not with cow-pox ; he was inoculated with smallpox. This visit to Cheltenham seems to have been in the autumn and winter of 1798-99, when Jenner had no better stock of vaccine than the matter from the Stonehouse dairy which had produced alarming ulcerations both in his own trials of it and in the trials by two of the Stroud surgeons. That was not the sort of " lymph " which Jenner would care to use upon his own son ;

PAGE 293-294

And lastly, Jenner himself had struck the keynote of mystery in the opening pages of the Inquiry : "But what renders the cowpox so extremely singular is that the person who has been thus affected is for ever after secure from the infection of the smallpox." In support of "so extraordinary a fact," he proceeds to lay before the reader a great number of instances.

The fact was all the more extraordinary, as Jenner's readers quickly perceived, and he himself had pointed out, in that one attack of cowpox did not prevent a second of the same. If cowpox does not protect from itself, they asked, how can it possibly protect from smallpox ? This only made the mystery more mysterious.

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The profession were unwilling to admit that there was any real mystery. They reasoned : We are practical men ; it is not our affair to explain how or why cowpox wards off smallpox ; but we know from our experiments and our experience that it does so, and that is enough for us ;

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That the vaccine doctrine of protection is held with a real assent, or religiously, by vast multitudes of men and women is unquestionable; they believe it to be necessary for salvation in one small contingency of human life; and they are so sure of it that they even enforce it, or allow it to be enforced upon recalcitrating minds. Those who thus hold it are assenting only to each of the separate propositions that compose it, and not to the complex whole of the doctrine or to the mystery of it. The four stock component propositions, as laid down by Jenner and maintained by his contemporaries, are stated in concrete terms, and are simple, clear, brief, categorical. They are, that vaccine inoculation prevents smallpox, that it is itself not contagious, that it is unattended by a general eruption like that of smallpox, and that it is free from risk. These are the original component propositions; they have merely become rather less categorical with the lapse of time.

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In the progress of medical science the veil of mystery hanging over the vaccine doctrine as by law established has not been lifted. On one occasion we seemed for a moment to catch sight of the firm outlines of a scientific principle, but the vision proved to be an illusion.

When the Ministry of the day proposed in 1880 to relax the penal provisions of the compulsory vaccination law so far as to let a recalcitrant parent off with a single fine or imprisonment for each child, instead of fines or imprisonments at intervals of six months, more or less, until the child was fourteen years old, the project was defeated by the strong representations made to the Minister by those deputed from the medical and scientific corporations.

One of these deputations was organized by the President of the Royal Society, and consisted of himself and Professor Huxley, the President of the Royal College of Physicians, the President of the Royal College of Surgeons, the President of the General Medical Council, and others.

TiP editor: A few more extracts from this book to follow in the next edition.

SCIENTISTS 'SHOCKED' AND 'ALARMED' AT WHAT'S IN THE mRNA SHOTS

REBEKAH BARNETT

25 September 2023
https://tinyurl.com/42zm2aj9

EXTRACTS

Early in 2023, genomics scientist Kevin McKernan made an accidental discovery. While running an experiment in his Boston lab, McKernan used some vials of mRNA Pfizer and Moderna Covid vaccines as controls. He was 'shocked' to find that they were allegedly contaminated with tiny fragments of plasmid DNA.

McKernan, who has 25 years' experience in his field, ran the experiment again, confirming that the vials contained up to, in his opinion, 18-70 times more DNA contamination than the legal limits allowed by the European Medicines Agency (EMA) and the Food and Drug Administration (FDA). In particular, McKernan was alarmed to find the presence of an SV40 promoter in the Pfizer vaccine vials. This is a sequence that is, '…used to drive DNA into the nucleus, especially in gene therapies,' McKernan explains. This is something that regulatory agencies around the world have specifically said is not possible with the mRNA vaccines.

Knowing that the contamination had not been disclosed by the manufacturers during the regulatory process, McKernan raised the alarm, posting his findings to Twitter (now X) and Substack with a call-out to other scientists to see if they could replicate his findings. Other scientists soon confirmed McKernan's findings, though the amount of DNA contamination was variable, suggesting inconsistency of vial contents depending on batch lots. One of these scientists was cancer genomics expert Dr Phillip Buckhaults, who is a proponent of the mRNA platform and has received the Pfizer Covid vaccine himself.

'There is a very real hazard,' he said, that the contaminant DNA fragments will integrate with a person's genome and become a 'permanent fixture of the cell' leading to autoimmune problems and cancers in some people who have had the vaccinations. He also noted that these genome changes can 'last for generations'.

Dr Buckhaults alleges that the presence of high levels of contaminant DNA in the mRNA vaccines 'may be causing some of the rare but serious side effects, like death from cardiac arrest'. He added, 'I think this is a real serious regulatory oversight that happened at the federal level.'

In Australia, the Therapeutic Goods Administration (TGA) maintains that Covid vaccines cannot alter a person's DNA. A spokesperson for the TGA stated, 'The mRNA in the vaccines does not enter the nucleus of cells and is not integrated into the human genome. Thus, the mRNA does not cause genetic damage or affect the offspring of vaccinated individuals.'

They also said, 'All batches of Covid vaccines distributed to Australians have been tested for the presence of contaminants including residual DNA template levels.'

However, a legal case filed in the Australian Federal Court in July of this year alleges that the TGA is not the appropriate regulator of Covid mRNA vaccines because, under the Gene Technology Act (2000) definition, the DNA contamination is a genetically modified organism (GMO).

The plaintiff, Victorian doctor and pharmacist Dr Julian Fidge, is seeking an injunction to stop Pfizer and Moderna from distributing their mRNA Covid vaccines because they never obtained a license from the Office of the Gene Technology Regulator (OGTR), which is the agency that oversees all GMO related products.

The TGA did not require tests for genotoxicity or carcinogenicity before providing provisional approval and, eventually, full registration of both the Moderna and Pfizer Covid vaccines. OGTR guidance strongly suggests such tests should be undertaken where there exists a risk of harm to human health. McKernan, who provided expert advice on the case, agrees that the DNA contamination in the mRNA vaccines fits the Australian legal definition of a GMO……

Taking both the LNP-mod-RNA complexes and the recently discovered DNA contamination present in the mRNA Covid vaccines, acting solicitor Katie Ashby Koppens says, 'Every single person who has been injected with these products has received a GMO that has not been through the expert regulatory process in this country.' She adds, 'The human genome could be changed permanently, and no one was informed.'

Now, McKernan, Dr Buckhaults and other scientists are calling for urgent research to test whether the DNA contamination is lingering in the cells of mRNA vaccinated people, and whether the human genome has in fact been altered by mRNA Covid vaccines.

In recent years Tony Blair has been calling for Digital Vaccine IDs for every one! And yet back in 2001 when asked whether his son received the MMR he was keen on privacy!

THE PRIME MINISTER HAS TRIED, RATHER FEEBLY, TO PRETEND THIS IS A QUARREL ABOUT PRIVACY AND MEDICAL RECORDS. IT IS NOTHING OF THE SORT.

From: Does Tony Blair know something we don't? By Peter Hitchens, Mail On Sunday, December 23, 2001.

DO UK CHILDREN NEED A CHICKENPOX VACCINE? – NO

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THE 1971 paediatric text book (Patterson's) states, *"Chicken pox is one of the mildest diseases of childhood, but may occasionally take a very severe form."* Treatment – *"bed rest, keeping cool, avoiding scratching,"* and regarding shingles: *"Shingles is much less common in adult life than childhood and needs no special treatment other than calamine to dry up the lesions."*

The Merck manual of 1977 states *"Chicken pox in childhood is usually benign. However, it may be severe or fatal in patients with leukaemia or those receiving corticosteroids."* Treatment – *"Zoster immune globulin ...provides passive protection in exposed susceptible children within 72 hours of exposure."* This advice is, of course, before Merck had made their chicken pox vaccine in 1981.

SEVERE OR FATAL DISEASE – OR NORMAL DEVELOPMENTAL MILESTONE?

The outcome all depends upon **how you manage childhood fevers.** Do you open the window, put your child to bed, don't feed them unless they are starving and give them lots of pure, clean water to drink to support **elimination and externalisation** ? (for more details please see free A4 download 'General Measures for Nursing Children' & ebook 'Nursing Children Supportively through Acute Illness http://www.jayne-donegan.co.uk/articles).

Or the opposite? Suppress the fever with paracetamol & ibuprofen; dry up the cough with antihistamines and adrenaline like compounds; take non indicated antibiotics - wiping out the nice bugs and leaving the nasty ones to


DR Jayne L.M.Donegan

overgrow; keep the window closed; stuff your child up with food - especially formula, cow or soya milk - when they are not hungry and push the process in – back into the skin: severe bacterial infection; into the ears: ear infections; into the lungs: pneumonia, into the kidney: nephritis, into the brain: meningitis or encephalitis, or into the blood stream: septicaemia, which is more deadly than meningitis. These are all forms of invasive disease.

The itching in chickenpox and measles is helped by soaking in lukewarm baths with a cup of bicarbonate, or water run through oats in an old pair of tights tied round the tap, or a pot of chamomile tea – or all three - then patting dry. RHUS TOX 30c taken three times per day for up to five days also helps bring the rash out. Heinz Eichenwald, Professor of Paediatrics at the South Western Medical School, University of Texas, states in the Bulletin of the World Health Organization:

"Fever represents a universal, ancient, and usually beneficial response to infection, and its suppression under most circumstances has few, if any demonstrable benefits. On the other hand, some harmful effects have been shown to occur as a result of suppressing fever. It is clear, therefore, that the widespread use of antipyretics should not be encouraged either in developing countries or in industrial society."

Chicken pox is said to be caused by a virus because scientists have found particles of DNA which they call a herpes virus in the blood or vesicles of children with chicken pox. They find similar DNA particles in all the people that are tested who have chicken pox. Chicken pox involves cellular breakdown and elimination – out with the old, in with the new. Elimination that is particular to chicken pox, so obviously, the cells breaking down and their DNA will be particular to chickenpox as well, or else it would be called measles or hand foot and mouth or roseola, or something else. So it is not surprising that the DNA wrapped in lipid 'bin liners' looks the same. Are they infective particles though? That is the question. Did they cause the disease or are they merely the products of disease? For how epidemics can occur if viruses are not infective particles, please see my article TIP ISSUE 3 2021.

Shingles/ Herpes zoster is said to occur when the chickenpox/ herpes/ varicella zoster virus hides in a nerve junction – the ganglion. It is then said to be 'latent'. Then at some point when you are over 50 years of age, not very healthy and not meeting many children with chicken pox – who boost your chicken pox status– the virus is said to become 'reactivated' and travels down the nerve from the ganglion and causes the rash. A rash like chicken pox – vesicles filled with clear fluid which dry up into a scab over a few days. The rash occurs over the sensory area of a nerve. It is called *zoster* – 'belt' in Greek – as the rash is over a belt like distribution, but only on one side of the body. It is worst if it occurs in the distribution of the ophthalmic division of the facial nerve which can involve the eye and the ear; or the dreaded 'postherpetic neuralgia.'

If chicken pox is it a delineated form

"IT SHOULD ALWAYS BE BORNE IN MIND, WHEN THINKING OF COMPLICATIONS, THAT THEY TOO OFTEN WAIT, NOT UPON THE ORIGINAL DISEASE, BUT UPON THE TREATMENT OF IT."
~ Harry Clements, Doctor of Naturopathy

of detox which produces, as part of this physical process, particular forms of DNA produced by the breakdown of particular cells, is shingles a reactivation of this breakdown process when the adult needs to re-detox from the same factors that were not finished in childhood, maybe due to suppressive treatment of the original disease, or have reappeared as the body ages? We know that shingles often occurs after some form of physical or emotional stress ie the person with shingles is usually not 'well' before they get it. 'Precipitants' of shingles are said to be: being over 50y of age, being immunosuppressed, having had chicken pox below 1y of age, described as due to '*poor cell mediated response to virus at younger ages*' (This would be 'incomplete' clearance from a holistic point of view), and, crucially, not being around children with chicken pox which 'boosts' immunity to shingles. Does proximity to children with chickenpox stimulate a subclinical (no symptoms) form of elimination? And their absence push the body into a more overt form? *Virus* is Latin for 'poison.' This is exactly true – poison that the body is trying to get rid of. When we make vaccines out of 'attenuated' virus, it is 'attenuated' poison, so to speak, that we then inject back in. No wonder it causes an immune reaction.

Childhood exanthems (red spotty rashes) and fevers not only help children go up a developmental step, they also improve their overall health. Natural chickenpox is good for you. A 2011 case-control study by Dr Jonathan Silverberg and colleagues at the State University of New York of children who had natural chicken pox showed that they had a lower incidence of atopic dermatitis/ eczema and asthma compared to those who had not had chickenpox. This advantage persisted for ten years. Even those who developed eczema had milder cases and required fewer physician visits. There are other studies supporting this finding. The Government wants us to give our children a vaccine that by stopping a mild childhood illness makes them more likely to get asthma - and shingles. Not a good exchange.

Why does it matter? - Because if chickenpox may not be infective, if in any case it represents a detox of the body and a developmental leap and if it leads to quantifiable and nonquantifiable health benefits - why on earth would you want to stop a child getting it? Even if there were a totally safe and effective vaccine, and there is no such vaccine in existence. Keep in mind the old immunological adage: "*Autoimmunity is the price paid for eradicating infectious diseases.*"

CHICKENPOX VACCINE: WHAT HAPPENED IN THE USA?

NB Chicken pox/ varicella/ shingles vaccines are made by **GSK/ Glaxo Smith Klein** (UK) and **MSD/ Merck Sharp & Dohme** (USA)

Back in 1995 an editorial in the BMJ by Dr Lainie Ross, a paediatrician at MacLean Center for Clinical Medical Ethics, Chicago and her colleague Dr John Lantos said, *"Better to confine immunisation to those at high risk."* They state that the main arguments for universal immunisation against chickenpox in childhood are that it is good for children to be immunised 1. So their immunocompromised friends are not exposed to chicken pox and, 2. Their parents do not have to take time off work to look after them.

However they believed these arguments are not powerful enough to justify vaccinating all children as: chicken pox is a more serious disease in adults; in the first six months of pregnancy it may result in embryopathy (developmental abnormality of an embryo); in the last three months the baby may get neonatal chicken pox which has a fatality rate of 30%. All this is compared to the mild illness that children get from natural chickenpox disease - unless they are immunocompromised. In their words:

"A programme of universal immunisation to benefit immunocompromised children would require doctors to ask parents to authorise the immunisation of their children not for their own benefit but for the benefit of their less fortunate classmates. Parents would be asked to place their children at potentially increased risk of primary chickenpox as adults. This is compulsory altruism. Given that we do not compel adults to serve as kidney or even blood donors, it seems unfair to require children to be "splendid Samaritans." This also contradicts the "best interest of the child" standard, which is the usual guiding principle for parental decision making."

'The best interest of the child'? – This is especially poignant in 2023 when children have been made to have covid and 'flu shots to *'save granny'* and judges have ordered forced covid vaccination of vulnerable people who do not have capacity to consent or refuse for themselves on the basis that the young person would 'want to protect' other people: the judge thinking he knew the supposed opinions of young persons better than their parents. Drs Ross & Lantos remind me of how medicine used to be - when doctors really did put the best interest of their patients first; when doing so did not mean you would be reported to the General Medical Council; when it was regarded as normal medical practice.

Nonetheless in their own country, the USA, universal chickenpox vaccine was put on the schedule the following year. It was claimed to be a great success, by which was meant fewer cases of chickenpox - which is no great benefit; fewer hospitalisations and deaths - which are almost non existent in immunocompetent children with competent-to-manage-fever parents; while at the same time losing lifelong immunity to chicken pox. In any event how can you know the full impact of a vaccine program starting in 1995 in a country where States did not report chicken pox deaths to the USA Centers for Disease Control until after 2003.

By the 2000s there were many cases of chickenpox in vaccinated children. In an outbreak in a Michigan school in 2003, transmission of varicella was sustained at the school for nearly 1 month despite 97.5% vaccination coverage. Being vaccinated less than *only* four years before was found to be a risk factor for vaccine failure however vaccinated patients were said to have substantially milder disease (<50 lesions). By milder they mean less of a rash, but anyone who knows how the body really works knows this is a bad sign. It is a failure of elimination. A nice rash is a good sign – it is the *whole point* of getting the disease. Vaccine failure was such a problem that another dose of vaccine was ›

added to the schedule in 2006, meanwhile cases of shingles continued to rise with more children and adults being on steroids, immunosuppressive therapy for cancer, and having HIV. Vaccinated children and adults can also get shingles, particularly those children who get a rash after the vaccine.

CHICKENPOX VACCINE: WHAT HAPPENED IN THE UK?

The Joint Committee on Vaccination and Immunisation (JCVI) 'advises' the Department of Health and Social Care (DHSC) on which vaccines should be used in the UK vaccination program. I do not know of a time when the DHSC has disagreed. So, basically the JCVI sets the vaccine policy in the UK. The JCVI describes itself as independent but many of the members receive grants from pharmaceutical companies for their work. When vaccine manufacturers make presentations at JCVI meetings these are considered *'commercially confidential'* and therefore are not minuted, so the public cannot judge the robustness of the presentation. The studies the JCVI rely on are funded by the vaccine industry.

Authors state ingenuously that it is their institution not themselves that receive grants, that they do not receive any (direct or indirect) financial benefit or personal remuneration for their work. As if the existence of the institution at which they work and having a job there were not personal benefits. **Professor Adam Finn**, a member of the JCVI, the UK national immunisation technical advisory group and chair of the WHO European Technical Advisory Group of Experts (ETAGE) on immunisation is a very influential man in vaccine policy setting world wide. He is also the investigator in clinical vaccine trials funded by GSK and co-investigator of similar studies of varicella epidemiology funded by both GSK and MSD - the two chickenpox vaccine manufacturers. He declares that he 'receives no personal remuneration' for this work.'

Despite these conflicts, the JCVI resisted putting routine chicken pox vaccine on the UK schedule as they could not make it 'cost effective' because *"modelling at the time indicated that a varicella vaccination programme could be cost-effective only after a long period of time (80 to 100 years), and in the medium term (30 to 50 years) was not likely to be cost-effective."* This would be due to a predicted increase in middle aged adults (when the disease is more severe) due to lack of 'exogenous boosting' – coming into contact with children with chickenpox.

So what to do? - Frame the narrative.

HOW TO GET AN UNNECESSARY VACCINE PUT ON THE UK SCHEDULE

STEP 1: Make it compulsory for healthcare workers

In 2005, A BMJ editorial by Professor Judy Breuer lamented the fact that although varicella vaccine was licenced in 2003 in the UK, a year later it was not being administered to all staff. As a nudge, she said, *"Hospitals have a duty of care to staff and patients and failure to implement guidelines from the Department of Health on vaccinating against varicella may expose them to medicolegal challenge."* Prof Breuer is reimbursed by Aventis Pasteur, MSD and GlaxoSmithKline, the manufacturers of Oka (chickenpox) vaccines, to attend conferences and is principal investigator on a Medicines and Healthcare products Regulatory Agency commissioned GSK post-licensure study and a member of the JCVI Varicella Zoster subcommittee.

STEP 2 Disprove the idea that chickenpox is a mild disease that everybody – parents and children – cope with just fine.

A Belgian study (Blumental et al 2016), supported by an unrestricted grant from GSK Belgium, and with an author actually on the board of GlaxoSmithKline Biologicals, noted that *"most European countries remain hesitant to implement varicella UV (only implemented in 5 out of 28 European Union countries). The main reasons are a poorly defined cost–benefit balance in their own socioeconomic setting and important concurrent priorities for healthcare resource allocation."*

They set out to 'correct' this by scouring hospital notes to make a case for more severe disease. How representative is this group? Most parents do not take their children with chickenpox to their GP never mind a hospital. Their conclusion: *"Varicella demonstrated a substantial burden of disease in Belgian children, especially among the youngest. Our thorough nationwide study, run in a country without varicella Universal Vaccination, offers data to support varicella Universal Vaccination in Belgium."*

This was followed in the same year by two members of Public Health England, Drs Amirthalingam & Ramsay writing a paper asking, *"Should the UK introduce a universal childhood varicella vaccination programme?"* quoting the Belgian study and emphasising that, *"The risk of severe chickenpox is higher in immunocompromised individuals, pregnant women and neonates, although* ***most hospitalisations for severe complications are in previously healthy children."*** These only occur in children whose parents do not manage their fevers correctly and health professionals who encourage this by not following the UK's own national guidelines – NICE.

STEP 3: Say exogenous boosting is not so effective as thought in preventing shingles

Forbes et al (2020) at the London School of Hygiene and Tropical Medicine, London, authors include **Adam Finn**, Judy Breuer and Robin Marlow, concluded: *"The relative incidence of zoster was lower in the periods after exposure to a household contact with varicella, with modest but long lasting protective effects observed. This study suggests that exogenous boosting provides some protection from the risk of herpes zoster,* ***but not complete immunity, as assumed by previous cost effectiveness estimates of varicella immunisation."***

They maintain that *"varicella is likely to be under-ascertained in UK electronic health records" as; "varicella tends to be a mild, self limiting condition that does not require a visit to the doctor, and consultations with doctors".* Yes, exactly. It is a really mild disease which UK parents cope with very well, even if they don't get all the fever management correct. *"Consultations with doctors for varicella have been* ***declining*** *in the UK (between 2004 and 2014 by around 20% in 1-3 year olds and 6% in 4-6 year olds)."* 'Declining' and yet they are trying to add a vaccine to the UK schedule.

STEP 4: See how easy it will be to get parents to accept a chicken pox vaccine
A 2023 study by Sherman et al supported by British Psychological Society Undergraduate Research Assistantship awards found that *"most parents would accept a varicella vaccination. These findings highlight parents' preferences for varicella vaccine administration, information needed to inform vaccine policy and practice and development of a communication strategy."* - Yes, a strategy.

We have seen how the British public were psychologically manipulated by the members of the Scientific Advisory Group for Emergencies (SAGE) during Covid to follow orders, and the British Psychological Society, to the best of my knowledge, did not speak out against this abuse, despite their Code of Ethics requiring Competence, Responsibility and Integrity. Here they are again, helping the UK Government implement policy by canvassing people's views to be used to manipulate them later. One of their findings was that parents say, *"Generally I do what my doctor or health care provider recommends about vaccines for my child/children."* Indeed.

STEP 5: Coup de Grâce
Commission a study in the UK to replicate or even outdo the Belgian study with all the usual players, Marlow, Finn (*cherchez le Finn*)) - and get them to present their findings to the JCVI varicella subcommittee with data that have not been peer reviewed or even published; along with presentations by GSK about their chickenpox and shingles vaccines that were deemed *"commercially confidential and therefore not minuted".*

Manufacturers of vaccines that are going to be virtually forced on every child in the country – technically they are voluntary but the pressure and intimidation with which they are pushed and the fact that every judge in a parental disagreement will order them – are allowed to make presentations to an already conflicted JCVI – and we the people who pay for the committee and the vaccines are not allowed to know what was said. Such is the hubris of those tasked with protecting our health and safety that they care not one whit, so long as they can continue to get their unrestricted grants, funding and career progressions.

The protocol for the study from Bristol and Portugal had been published (2023). The study was supported by matched investigator initiated funds from GSK and Merck. Dr Rodrigues received honoraria for consultancy and/or lectures from GSK and MSD. Dr Marlow 'received investigator led grants from GSK and MSD that are *'paid to his institution and he does not receive any (direct or indirect) financial benefit from them'.* Apart, of course from his job and the department he works in.

As chickenpox is so mild, most people do not attend the GP never mind a hospital so Marlow et al decided to enrol chickenpox cases from childcare facilities, and all the other children in the same room at the time. They also searched hospital cases and decided to include cases of stroke up to 12 months after the child had chickenpox. Can you imagine a vaccine study where they decided to attribute an adverse reaction to a vaccine TWELVE MONTHS after receiving it?

One of their findings regarding the infectiousness of chicken pox, supposed to be next most infectious childhood disease to measles, is that of 40 children 'in the same room' as a 'case' not one of them got chickenpox. This is exactly the experience with my own children. Despite sleeping in the same bed, when the three year old had chicken pox her 19 month old sister did not 'catch' it from her. She waited until she was at playgroup and needed to go up the 'chickenpox step' to get it along with her little friends who were going up the same step.

The Outcome: After unpublished data were presented on 68 families many of whom had never accessed any healthcare, the conflicted committee decided that chicken pox really did place a very heavy burden on carers – 1.5 days off work – and children really suffered. That *"complications of varicella severe enough to warrant admissions to hospital are common[?], costly and burdensome to families."* That 'boosting' of immunity from natural disease was not very long lasting and that parents would accept a vaccine because they trusted their doctors. Even though in their modelling they took no account of vaccine failure when working out cost effectiveness. Even though their model was based on a four in one MMR+V vaccine which is known to double the rate of febrile seizures to one in 2300 children compared with MMR and a varicella vaccine separately. That was it. Chickenpox vaccine will be on the UK schedule from spring 2024. Way to go!

THE VACCINES

GSK: Varilix (V) and Priorix Tetra (MMRV)
MSD: Varivax (V) and Proquad (MMRV)

They are all 'live attenuated virus' meaning they are supposed to give you a 'mild' dose so you become immune without the 'danger' of the real disease, which we know is not dangerous for well children, indeed, it is beneficial. The varicella vaccine strain is the varicella Oka strain. The varicella component in all of them is propagated in MRC-5 cells. MCR-5 cells are made up of fibroblasts isolated from the lung tissue derived from an aborted white, male, 14-week-old embryo by J.P. Jacobs in 1966.

Both MSD vaccines state in the U.S. Food and Drug Administration (FDA) package insert (but not the Electronic Medicines Compendium (EMC) data): *"The product also contains* ***residual components of MRC-5 cells including [human] DNA and protein and trace quantities of neomycin and bovine calf serum*** *from MRC-5 culture media."*

GSK does not say this but they are propagated on the same cells and I have no reason to think they are any different, except in omitting the information, and not answering my request for that information. The MSD vaccines contain monosodium glutamate, GSK states, 'amino acids' and refuses to confirm if these include MSG. MSD products contain hydrolyzed gelatine.

The GSK vaccines contain phenylalanine and should be avoided in persons with phenylketonuria.

Adverse reactions include getting vaccine chickenpox and getting vaccine shingles (detox reactions from what was injected). To see a list in the summary of product characteristics put `emc drug' into your search engine and then 'varicella' into the *CONTINUED ON P23* ›

TIP ARCHIVE

THOSE IMMUNISATIONS STATISTICS

TEXT FROM THE NATIONAL ANTI-VACCINATION LEAGUE LEAFLET. C1951

TiP editor: Very interesting and not surprising as there have always been issues surrounding the classification of immunised and unimmunised. Also re-diagnosis or reclassification of a disease in the immunised was occurring with the smallpox vaccination back in the 19th century.

THE LEAFLET READS:

Readers of The Vaccination Inquirer sometimes ask why the official returns of diphtheria in the immunised show twice as many unimmunised cases as immunised. Here is the answer:

(1) The official figures are inaccurate.

To begin with, the Immunisation Return sent in by medical officers does not state the number of cases and deaths in unimmunised children. The only figures regarding diphtheria asked for are those that occur in immunised children. The Registrar-General admits that he deduces from these returns and the quarterly returns sent in by medical officers of health the number of unimmunised cases. He simply subtracts the number returned as immunised from the total notifications, and assumes that the remainder had not been immunised. (See p.295 of the Registrar-General's Statistical Review of England and Wales for the two years 1946-1947. Test, Vol. 1, Medical.) No Medical Officer of Health has stated in the Return that such and such a number of unimmunised children contracted diphtheria in his area. Just as no information was available respecting the vaccinal condition of thousands of smallpox deaths over the years when smallpox epidemics occurred in England and Wales, so we can be sure that no information was available respecting the condition as to immunisation of a large number of diphtheria cases in 1942 to 1949. The Registrar-General has simply assumed that those not included in the immunised were unimmunised.

(2) The Registrar-General admits in the Report already quoted that some of the returns were unsatisfactory. Part B is that part of the return which gives the "numbers of notifications and of deaths with numbers of these known to have been immunised, by age groups." The Registrar-General says that some of these returns were unsatisfactory because "The column giving the number known to have been immunised is left blank; this may or may not mean that none of the notifications or deaths occurred among the immunised." According to Table A (1946) of the Report, 458 areas with a population of 1,187,949 did NOT render valid returns in 1946 and according to Table A (1947) 558 areas with a population of 2,154,766 did NOT return valid returns in 1947. (See pp.299 to 307 of the Report.) How then can the Registrar-General know how many of the diphtheria cases from these areas were immunised since in the return the column giving the number known to have been immunised has been left blank? Has he put all the cases and deaths from these areas into the unimmunised section? (Note the expression: "known to have been immunised.")

Thirdly, in 1944 of 29,949 cases originally diagnosed as diphtheria 6,797 were taken out of the diphtheria classification, in 1945 of 25,246 cases 6,675 were taken out. In 1946 of 18,283, 6,316 were taken out, and in 1947 of 10,465, 4,873 were taken out. The proportion of re-diagnosed cases rose from 23 percent in 1944 to 46 per cent in 1947. Later figures reported in the Medical Officer of 14th April 1951, show that 55 percent of the cases were re-diagnosed in 1948 and 62 per cent , in 1949. Mr Viant asked the Minister of Health what was the condition as regards immunisation of these re-diagnosed cases and he was informed that the information was not available. Our assumption is that they were largely immunised cases and were re-diagnosed because they had been immunised. Out justification for this assumption is based, in part, on statements made at a meeting of the Fever Hospital Medical Services group of the Society of Medical Officers of Health, on 18th June 1943, reported in The Lancet, 21st August 1943. The doctors who met on that occasion wanted cases notified as diphtheria in the immunised to be entered as "observation cases" until the diagnosis was confirmed.

Dr Scott (Fulham) said the diagnostic error was high and correction of notifications was not automatic. "Thus," he said, "the full effect of immunisation might be masked and a misleading impression given of the incidence of diphtheria in the immunised population." Neither he or any other doctors who spoke at the meeting said anything about mistaken diagnosis in the unimmunised.

Dr Begg (LCC) remarked: "An acute aspect of the problem was the readiness with which diphtheria was diagnosed and formally certified in immunised children. In a series of 66 such admissions diphtheria was confirmed in only 13 cases and four of the cases had contracted diphtheria before immunisation was complete." Had these doctors looked back to the returns for the years prior to the introduction of immunisation they would have found that year after year 25 to 30 per cent or more of diphtheria notifications were re-diagnosed at the hospitals, if not by the Registrar-General. Fourthly, only children who had had either two or three injections (according to the kind of toxoid used) and had them at least three months before the attack of diphtheria are included in the immunised class. A child who had a single injection, or whose full number of injections had been given less than three months before the attack would

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CONTINUED FROM P21

EMC search. They currently only include the single chickenpox vaccines. You can get Proquad data by searching that name and 'FDA'; and the Priorix Tetra by name alone. The GSK vaccines are not licenced in the USA. Remember that clinical trials are skewed to minimise adverse reactions. The post marketing reactions are the more useful but only about 1-10% of all drug reactions are reported.

FERTILITY

What about the effects on fertility of these vaccines that we are told to administer to our healthy children? Obviously they are tested for this crucial piece of safety - aren't they?

MSD -VARILRIX 'Fertility - No data available.' EMC 4.6

GSK - VARIVAX 'Fertility - 'Animal reproduction studies have not been conducted with VARIVAX.' VARIVAX 'has not been evaluated for potential to impair fertility.' EMC 4.6

MSD - PROQUAD 'Carcinogenesis, Mutagenesis, Impairment of Fertility - ProQuad has not been evaluated for its carcinogenic, mutagenic, or teratogenic potential, or its potential to impair fertility.' FDA PACKAGE INSERT

GSK - PRIORIX TETRA does not have any reference to fertility at all. GSK SOUTH AFRICA PACKAGE INSERT. [I have not been sent one by GSK UK and it is not licenced in the USA]

Natural chicken pox reduces atopic dermatitis / eczema and asthma. So many children have asthma nowadays and are treated with steroid inhalers and other immune suppressants – so we give them a vaccine that by stopping a mild childhood illness makes them more likely to get asthma, and shingles from the vaccine ingredients.

WHAT DOES THE WORLD HEALTH ORGANISATION SAY IN THEIR 2014 POSITION STATEMENT?

"Countries where varicella is an important public health burden could consider introducing varicella vaccination in the routine childhood immunization programme. However, resources should be sufficient to ensure reaching and sustaining vaccine coverage ≥80%.
Vaccine coverage that remains <80% over the long term is expected to shift varicella infection to older ages in some settings, which may result in an increase of morbidity and mortality despite reduction in total numbers of cases."

It is interesting that it is only the middle to high income countries where chicken pox is deemed *'an important public health burden.'* In low income countries with their fewer resources, people somehow manage to just get along with chicken pox – or is it that as they don't have the money to pay for a vaccine program, pharmaceutical companies are not interested enough to 'invent' a need.

WHAT TO DO?

Stick with chicken pox and all the other healthful, healing, strengthening fevers that your child may develop in the course of their maturation. Manage the fevers correctly and watch your child grow into a strong, healthy adult. You may have to take a bit of time off your paid work to do this but in making the decision to have children, did you not realise that child rearing and running a home is a job in itself, only it is unpaid? Looking after a sick child is actually a form of love, bonding and source of immense satisfaction, especially when you see the reward for your efforts. Remember, raising healthy children, including nursing them through their childhood fevers, is the biological reason for our existence.

2023 Dr Jayne LM Donegan, MBBS DRCOG DCH DFFP
03 Dec 2023.

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https://www.jayne-donegan.co.uk

To attend her regular online lectures please visit:
https://www.eventbrite.co.uk/o/dr-jayne-lm-donegan-30030351200

RESOURCES

Ross L F, Lantos J D. Immunisation against chickenpox BMJ 1995; 310 :2 doi:10.1136/bmj.310.6971.2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2548429/ *free full text and pdf*
History of Chickenpox - National Vaccine Information Center (NVIC)
www.nvic.org/disease-vaccine/chickenpox/history

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not be classed as immunised. It will be realised by this time that since no returns of unimmunised cases are sent in, that from areas covering more than two million children no valid returns were sent in in 1946 and 1947, that many thousands of cases originally diagnosed as diphtheria are re-diagnosed and there is every reason to believe the majority of those were immunised cases, and that large numbers of inoculated children whose injections were done less than three months before the attack of diphtheria are excluded from the immunised class, there is every reason to doubt the accuracy of the Ministry of Health's figures regarding diphtheria in the immunised and the unimmunised.

It is quite likely that even if more accurate records were available there would still be more uninoculated cases since diphtheria is, generally speaking, more prevalent amongst neglected, badly-fed children and such children are more likely to escape inoculation than better cared for children. The uninoculated also include delicate children. As, however, the decline in diphtheria has been as great amongst the uninoculated as amongst the inoculated it is obvious that inoculation does not govern the matter.

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Buy direct from Zoe Scanlan's website: www.zoescanlan.com/booklet

HOMEOPATHY INTERNATIONAL (HINT)

A new homeopathy body supporting the profession has released a position statement regarding vaccination and informed consent. They are looking to engage with government bodies to find out why the NHS has not been keeping doctors up to date about their professional liability regarding informed consent. Their statement can be found at: http://www.hint.org.uk

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AIMS & OBJECTIVES OF THE *informed* PARENT GROUP

1. To promote awareness & understanding about vaccination in order to preserve the freedom of an informed choice
2. To offer support to parents regardless of their decisions
3. To inform parents of the alternatives to vaccinations.
4. To accumulate historical & current information about vaccination & to make it available to members & interested parties.
5. To arrange & facilitate local talks, discussions and seminars on vaccination, childhood illnesses & the promotion of health.
6. To establish a nationwide support network and register (subject to members permission).
7. To publish a newsletter for members.
8. To obtain, collect and receive money and funds by way of contributions, donations, subscriptions, legacies, grants or any other lawful methods; to accept and receive any gift of property and to devote the income, assets or property of the group in or towards fulfilment of the objectives of the group.

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