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Dear all

THE CONTROLLED DEMOLITION OF DEMOCRACY IN NEW ZEALAND – SECOND OPEN LETTER TO THE MEMBERS OF PARLIAMENT

1. I refer to my previous letter dated 25 August 2021. Once again, I write to you in my personal capacity and as a concerned citizen of New Zealand.

2. The democratic process is being demolished by an overreaching Government. Legislation is being passed without conventional parliamentary scrutiny, designed to protect against abuse of power. The Government has changed legislation in defiance of a High Court ruling, refused to consult with the public concerning Three Waters, covertly declared its commitment to Agenda 2030, introduced vaccine mandates resulting in financial hardship for many families and mandated vaccine passports despite the paradox of segregation given the vaccine does not provide immunity (i.e., it does not stop transmission or prevent infection).

3. The above issues are political, and there has been no healthy debate - let alone transparency. We are told to trust a Government that holds up science but goes out of its way to smear doctors and scientists that speak out against the Government's narrative. The term "*misinformation*" is now a euphemism for any statement that departs from the Government's declaration that it is the sole source of truth. Free and robust debate is at the heart of science, and preventing such debate is dangerous.

4. An article in the British Medical Journal[1] highlights how *"[p]oliticians and governments are suppressing science.* Veteran New Zealand doctor, René de Monchy[2], stated *"[a]t some point, it dawned on me: this is not so much about health, but more about politics, money, power, and social manipulation."*

5. The vaccine passports are an example of politics, money, power and social manipulation. There is no evidence that vaccine passports serve any purpose in preventing transmission of SARS-CoV-2 (i.e., the virus), let alone reduce the incidents of COVID-19 (i.e., the disease that may or may not develop from SARS-CoV-2). Dr Michael Baker was recently quoted in the Guardian[3] newspaper as follows:

> *"the traffic light system won't help us very much because it was never designed to dampen down transmission, it was only designed to nudge people towards vaccination,"*

[1] Covid-19: politicisation, "corruption," and suppression of science | The BMJ
[2] NZ doctor exposes 'Perverse' monetary incentives to vaccinate and 'hush money' aid to victims' families - Seemorerocks
[3] New Zealand not prepared for Omicron outbreak expected in 'matter of weeks', experts warn | New Zealand | The Guardian

6. Dr Ashley Bloomfield was quoted by Radio New Zealand[4] that:

> *"It's quite clear that Omicron does escape vaccinations."*

7. Omicron has swept through the U.K. and other countries and been found to be milder than the Wuhan, Alpha, Beta or Delta strains of SARS-CoV-2. Accordingly, the U.K. has recently announced that it is lifting almost all the restrictions, including the masks mandates and the vaccine passports[5].

8. The purpose of this letter is to raise concerns in regard to the following matters:

(a) The Government is allowing Pfizer's rights to trump those of good New Zealand citizens;
(b) The Pfizer trial is highly questionable;
(c) The vaccine does not stop transmission;
(d) The vaccine is not reducing serious outcomes.
(e) There is a lack of transparency in regards to the risks of the vaccine;
(f) The number of Cases and Deaths are not accurate;
(g) There are serious concerns about the ingredients in the vaccine;
(h) Why has the definition of vaccine changed?
(i) The Government knew in January 2021 that boosters were necessary;
(j) The Government is ignoring concern over vaccine selection pressure;
(k) There are effective early treatments
(l) The Government is ignoring concerns over vaccine-associated enhanced disease;
(m) The narrative is continually changing, the goalposts are being moved, and there are rules for some and not for others.

9. This letter is lengthy, but I want to ensure that you are aware, or at least in receipt of the information.

Big Pharma's Rights Trump New Zealanders' Rights and Freedoms

10. Medical interventions must be proven safe and effective before they are rolled out on a healthy population, let alone mandated under provisional consent. As you are aware, full consent has not been granted for the vaccine to date. Pharmaceutical companies have unsuccessfully attempted to bring an mRNA vaccine to market for decades, all of which have failed due to efficacy and safety concerns. Regardless, the Government has agreed for Big Pharma to vaccinate a predominately healthy population first and research later. The short-term safety and efficacy data changed significantly over 2021, which should have you worried, and the medium and long term effects will not be known for years.

11. The Government has signed a multi-million dollar contract, perhaps billions given the boosters, with Big Pharma. The Government refuses to disclose the contract to the public. Consequently, we can only speculate if any onerous terms and conditions are being hidden.

12. Wion TV[6] reports that Pfizer is holding governments to ransom, interfering with national legislation, and even demanding military bases as a guarantee. What security has the Government provided under the contract? Our military bases or perhaps our water? Is Big Pharma demanding the mandates under the contract?

13. Vaccines are big business, and often power, greed, and money lead to corruption. CNN[7] reported that Pfizer's earnings and sales doubled in the past quarter (as of November 2021) due to its Covid-19 vaccine with adjusted earnings of $7.7 billion, up 133% from a year earlier. Revenue soared to $24.1 billion, up 134%. The sky is the limit, with four monthly boosters as protection (if any) wanes quickly.

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[4] https://www.msn.com/en-nz/news/national/traffic-light-system-may-need-strengthening-or-adjusting-in-face-of-omicron-bloomfield/ar-AASSct3
[5] https://www.newstalkzb.co.nz/news/world/covid-19-omicron-outbreak-uk-lifts-covid-restrictions-says-omicron-wave-has-peaked/
[6] https://www.youtube.com/watch?v=2zoSSHx9QtA
[7] https://edition.cnn.com/2021/11/02/business/pfizer-earnings/index.html

14. Why is the Government trusting Pfizer with an experimental vaccine when the company has incurred $10,193,896,333[8] in fines since 2000? Would you travel on an aeroplane manufactured by a company with a similar record concerning false claims and safety violations? Why are we asking healthy children with a low risk of death or hospitalisation to participate in a vaccine trial for an experimental vaccine? If we are vaccinating children entering puberty, what is the impact on fertility? We will not know the answer to that question for years to come. I assume you are aware of the fact that Pfizer settled for $75,000,000.00 for the experiments that it ran on children in Nigeria[9].

15. New Zealanders are dying and being seriously injured from the vaccine. The Government is turning a blind eye as it does not require mandatory reporting of adverse reactions, nor does it actively investigate incidents. If the same amount of money that is being put into identifying Covid-19 cases in healthy people (a.k.a. asymptomatic cases with a probable false-positive PCR test) was put into looking at those suffering and dying from heart attacks, strokes and other injuries following the administration of the vaccine, it would show a different picture. If you disagree, please forward an affidavit stating the Government is undertaking standard monitoring, investigation and reporting, which would be undertaken for any other new and experimental vaccine or medicine.

16. Many doctors and scientists contend that the vaccine is doing more harm than good. Over 11,400 doctors and scientists have signed the Rome Declaration[10], over 15,000 medical and public health scientists and over 46,000 medical practitioners have signed the Great Barrington Declaration[11] , to name a few declarations. Various groups of doctors and scientists have been established, such as World Council for Health[12], America's Frontline Doctors[13], Canadian Covid Care Alliance[14] ("CCCA"), New Zealand Doctors Speaking Out with Science[15] , along with many other groups.

17. So why do we not hear about these groups and concerns in the mainstream media? In December 2020, Newshub NZ was purchased by Discovery Channel (an American company). Five months later, in May 2021, Discovery merged with Warner to create a mega mega-media company. Who owns this new behemoth? A company called AT and T own 71%, and Discovery owns 29%. So who are the top shareholders in AT and T? Vanguard and Blackrock. Who are the top shareholders in Vanguard? Blackrock Who are the top shareholders in Blackrock? Vanguard. Who are the top shareholders of Pfizer.....Blackrock and Vanguard[16].

The Pfizer Trial

18. Vaccine development is usually a slow and laborious process that takes between 5 to 10 years. Vaccine Safety requires proper animal trials and peer-reviewed data.

19. Dr Bridle and Dr Palmer[17]state that there were few animal studies for the vaccine. They found one study which Pfizer had submitted to the Japanese health authorities, which pertained to the distribution and elimination of a model vaccine. Dr Bridle and Dr Palmer summarised that:

> *"Pfizer's animal data clearly presaged the following risks and dangers:*
> - *blood clotting shortly after vaccination, potentially leading to heart attacks, stroke, and venous thrombosis*
> - *grave harm to female fertility*
> - *grave harm to breastfed infants*

[8] https://violationtracker.goodjobsfirst.org/parent/pfizer
[9] https://www.business-humanrights.org/en/latest-news/pfizer-settles-drug-testing-case-with-nigerian-state-for-75-million/
[10] https://concerneddoctors.org/rome-declaration/
[11] https://gbdeclaration.org/
[12] https://worldcouncilforhealth.org/
[13] https://americasfrontlinedoctors.org/
[14] https://www.canadiancovidcarealliance.org/
[15] https://nzdsos.com/
[16] https://money.cnn.com/quote/shareholders/shareholders.html?symb=PFE&subView=institutional&fbclid=IwAR3IoEQJkacZcj0cxfyfJel5_kGilAbr5HeKx7PiuzkyqNOcDySBY1Y2jzU
[17] https://doctors4covidethics.org/wp-content/uploads/2021/07/Pfizer-pharmacokinetics-and-toxicity.pdf

• *cumulative toxicity after multiple injections."*

20. The CCCA[18] reviewed Pfizer's trial design and its first and second reports. The CCCA's findings are alarming.

21. The CCCA states in the hierarchy of evidence, a randomised control trial is the gold standard. 43,548 people participated in Pfizer's Phase III randomised control trial, half received the vaccine, and the placebo group received saline for a period of 2 months. The blind trial was meant to run until 2 May 2023. However, Pfizer gave the vaccine to the majority of the placebo group in early 2021. The trial is no longer a randomised control trial as the control group is gone. As a result, the long-term safety data that was supposed to be assessed in 2023 is no longer possible. Deviating from well-established protocols is alarming.

22. Pfizer's original trial report was published on 31 December 2020 and claimed that the vaccines were safe and showed 95% efficacy seven days after the 2nd dose. But that 95% was the Relative Risk Reduction ("**RRR**") [19]. The Absolute Risk Reduction ("**AAR**") was only 0.84%. The RRR considers participants who could benefit from the vaccine, whereas the ARR (i.e. the difference between cases with and without a vaccine) considers the whole population. The author of a paper in The Lancet states that the omission of the ARR leads to reporting bias which affects the interpretation of vaccine efficacy and public health. In addition, the analysis of full datasets along with independent scrutiny is difficult to perform due to issues with the available data.

23. The CDC[20] reports that 95% of people who have died with COVID-19 disease have had at least one comorbidity listed as the cause of death. The average is four comorbidities. However, Pfizer chose participants from younger demographics. Only 4% of the trial participants were over the age of 75 years, and only 21% of the trial participants had a co-existing condition[21], and many health conditions were excluded. These included pregnant or breastfeeding women, people with allergies, psychiatric conditions, immunocompromised people, bleeding disorders, a previous positive test for SARS-CoV-2 (the virus, not the disease), and those who had been prescribed steroids, etc. No Pfizer Trial data exists to make safety claims about administering the vaccine to these groups. Yet these people are subject to mandates and vaccine passports, including my husband.

24. Information obtained under the Official Information Act ("**OIA**") shows that the Government knew that the above health conditions had been excluded from the trial. Regardless, the Government actively encourages these individuals to take the vaccine. In addition, the Government encourages organisations that support these communities to push the vaccine in exchange for continued Government funding.

25. In November 2021, the FDA released the first batch of documents under a Freedom of Information court order. The FDA did not want to release the documents and asked the Court to grant them 50 plus years to release the documents. The Court settled for the FDA to select which documents it releases over time.

26. Researcher Craig Paardekooper[22], Kingston University, London, claims that the U.S. Vaccine Adverse Event Reporting System ("**VAERS**") data shows vaccine batches are sequentially marked by varying toxicity and that there have been 33 confirmed lots of the vaccine. He also claims that manufacturing processes at different sites do not comply with `Good Manufacturing Practices', and as such, the production of the product is not consistent. Dr Michael Yeadon, former Vice President Respiratory & Chief Scientific Advisor of Pfizer, has also demonstrated how different batches are used to have an experiment within an experiment[23] and that 5-10% of the batches account for around 80% of the adverse reactions. New Zealand groups were tracking different lot numbers to identify the risky batches. Subsequently, the Government removed the lot numbers from the vaccine cards blocking transparency.

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[18] www.canadiancovidcarealliance.org

[19] *COVID-19 vaccine efficacy and effectiveness—the elephant (not) in the room,* Piero Olliaro*;* Els Torreele*;* Michel Vaillant (Published April 20, 2021) The Lancet Journals
https://www.thelancet.com/journals/lanmic/article/PIIS2666-5247(21)00069-0/fulltext

[20] https://www.cdc.gov/nchs/covid19/rands.htm

[21] https://www.nejm.org/doi/pdf/10.1056/NEJMoa2034577?articleTools=true

[22] https://www.bitchute.com/video/WMUvLcmP1Wtk/

[23] https://dailyexpose.uk/2022/01/06/death-by-covid-injection-is-premeditated-and-co-ordinated-experts-conclude/

27. A study out of the Penn Medicine Center for Evidence-based Practice published a meta-analysis of phase 1 and 2 clinical trials of several of the vaccines and found that *"[s]evere systemic adverse events were reported by 5 to 10 percent of trial subjects."*[24] . Such a percentage is relatively high for severe adverse events, orders of magnitude higher than the chances of dying from severe COVID-19 infection. The risks clearly outweigh the benefits of a mass-vaccination roll-out.

28. Recently the British Medical Journal[25] reported on an investigation into Ventavia, one of the research companies Pfizer hired to conduct the trials. A whistle-blower, the Regional Director, reported her company to the FDA for falsifying data, unblinding participants, not following up and testing participants who reported symptoms and mislabelling specimens. Several other employees backed up her account. Despite all this, neither Pfizer nor the FDA ever audited or investigated the research company, and Pfizer never disclosed the problems in its Emergency Use Application. Ventavia will continue to run four more COVID-19 clinical trials.

29. One example of Pfizer's "bias" in reporting adverse reactions concerns a 12-year-old girl who was classified as suffering from stomach issues in Pfizer's documents, yet she is now paralysed in a wheelchair, tube fed, suffers memory loss, and Pfizer will not return her parents telephone calls[26].

30. The CCCA produced a conflict of interest diagram for the authors of the Pfizer report and found that 84% had a conflict, including two founders of BioNTech whose stock value allegedly increased by $9 billion.

Reducing Transmission

31. High vaccination rates using traditional vaccines have been effective in reducing diseases such as measles, polio and smallpox. Accordingly, high vaccination rates were expected to reduce the transmission of SARS-CoV-2 (i.e. the virus) and thereby reduce the burden of the Covid-19 disease. However, this experimental mRNA vaccine has not been effective in reducing transmission or infection.

32. In early 2021 the CDC Director, Rochelle Walensky, said that:

> *"… our data from the CDC today suggests, you know, that vaccinated people do not carry the virus, don't get sick, and that it's not just in the clinical trials but it's also in real world data [27]".*

33. Our Government told us that the vaccine was 95% effective and sent us the following information:

34. In August 2021, Rochelle Walensky said fully vaccinated people who get COVID-19:

> *"breakthrough" infection can spread the virus to others even if they are not symptomatic*[28].

[24] mRNA vaccine review final.pdf (upenn.edu)
[25] https://www.bmj.com/content/375/bmj.n2635
[26] https://youtu.be/t4X6VMdTK8Y
[27] https://thehill.com/changing-america/well-being/546234-cdc-reverses-statement-by-director-that-vaccinated-people-are-no
[28] https://www.realclearpolitics.com/video/2021/08/06/cdc_director_vaccines_no_longer_prevent_you_from_spreading_covid.html

35. In September 2021, the Ministry of Health ("**MOH**") confirmed in writing that the vaccine was not designed to reduce transmission of Covid-19 (a copy of the letter is set out at **Schedule 1**).

36. Rochelle Walensky recently stated:

> *"...what they [the vaccine] can't do anymore is prevent transmission*[29]".

37. Regardless, our Government mandates vaccine passports despite there being no evidence that segregation prevents transmission hence Dr Baker and Dr Bloomfield's comments as set out above. The science which emerged over 2021 shows that the vaccinated have a similar viral load and spread the virus (refer to **Schedule 2**).

38. Our Government now proclaims that vaccines and boosters are necessary to prevent the hospitals from becoming overwhelmed and delaying those with cancer from receiving treatment. Ironically, my husband, who was on chemotherapy at the time, had to wait five days to get urgent tests over the August lockdown. One of his blood results which should have been under 60, was at 911, and he had been in ICU a few months earlier. However, he could not get an urgent ultrasound due to "Covid paperwork" even though there were only a handful of cases in Tauranga, and I am not aware that Tauranga hospital was overwhelmed with COVID-19.

39. The vaccine mandates are hypocritical, given other harmful lifestyle choices are permitted and allowed to have a hospital bed. For example, smoking and the dangers of second-hand smoke on others, obesity, unprotected sex and the potential impact on others, along with drugs and alcohol. There is a correlation between obesity and hospitalisation and mortality rates from COVID-19[30].

40. If the Government is concerned about the availability of medical treatment, why has it mandated health workers, which has resulted in large numbers of staff leaving hospitals and medical centres? I note that infected vaccinated staff are being recalled to work in overseas hospitals in breach of the protocols due to staff shortages[31].

41. The mainstream media is now reporting that the vaccinated are the ones in the hospitals. Two examples are set out below. However, I am happy to provide you with further examples.

    - The NSW government's COVID-19 Critical Intelligence Unit has revealed that as of Jan. 9, 68.9 percent of COVID-19 patients aged 12 and over in hospitals had two doses of the vaccine, with 28.8 percent unvaccinated (source: https://aci.health.nsw.gov.au/covid-19/critical-intelligence-unit/monitor); and

    - Covid Scotland: Case rates lowest in unvaccinated as double-jabbed elderly drive rise in hospital admissions (source: https://www.heraldscotland.com/news/19843315.covid-scotland-case-rates-lowest-unvaccinated-double-jabbed-elderly-drive-rise-hospital-admissions/)

42. The constant scapegoating of the unvaccinated does not stand up to scrutiny or evidence and is entirely unwarranted. The term "unvaccinated" should not be conflated with "infectious". If the vaccine worked, there would be no need for the vaccinated to shun the unvaccinated as they would have immunity (i.e. no transmission or infection).

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[29] https://www.msn.com/en-us/health/medical/cdc-director-covid-vaccines-cant-prevent-transmission-anymore/ar-AASDndg

[30] COVID-19-and-Obesity-The-2021-Atlas.pdf (worldobesityday.org); https://www.forbes.com/sites/jemimamcevoy/2021/03/04/obesity-and-covid-death-rate-closely-linked-in-new-study/?sh=40333a1a643e; https://onlinelibrary.wiley.com/doi/full/10.1111/obr.13128https://care.diabetesjournals.org/content/43/7/1392.abstract https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7385759/

31 https://www.theguardian.com/australia-news/2022/jan/03/covid-positive-nurses-are-working-in-nsw-hospitals-due-to-severe-staffing-shortages

43. Will the Government encourage Kiwis to collude, shun and hate their neighbours and loved ones for the sake of the vaccine which was developed for the alpha variant and has subsequently not stopped transmission of beta, delta, omicron and IHU variants to both the vaccinated and the unvaccinated? What is the next variant or pandemic? Marburg (refer to Schedule 4)?

Reducing Serious Outcomes

44. The majority will agree that there is no benefit to a reduction in cases if it comes at the cost of increased illness and death. We know that the vaccine does not stop transmission and infection. Accordingly, the Government asserts that the vaccine will reduce hospitalisation for COVID-19.

45. The recent U.K. Health Security Agency report[32] shows that despite the booster campaign being well underway, the majority of Covid-19 hospitalisations were among the fully vaccinated population (refer page 39).

Table 11. COVID-19 cases presenting to emergency care (within 28 days of a positive specimen) resulting in an overnight inpatient admission by vaccination status between week 49 and week 52 2021

Please note that corresponding rates by vaccination status can be found in Table 13.

Cases presenting to emergency care (within 28 days of a positive test) resulting in overnight inpatient admission, by specimen date between week 49 and week 52 2021	Total	Unlinked*	Not vaccinated	Received one dose (1 to 20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date[1]
	[These data should be interpreted with caution. See information below in footnote about the correct interpretation of these figures]					
Under 18	899	47	796	8	38	10
18 to 29	899	23	405	10	88	373
30 to 39	1,063	12	541	7	66	437
40 to 49	1,165	12	558	10	47	538
50 to 59	1,406	17	594	5	55	735
60 to 69	1,326	17	491	11	52	755
70 to 79	1,379	5	349	4	50	971
80 or over	1,844	1	322	5	52	1,464

46. Regardless, disease-specific primary endpoints are no longer used in many fields of medicine owing to the fact that they can conceal data that indicates the toxic effects of the vaccines. If a person dies from the treatment or is severely injured by it, even if the treatment helped block the progression of the disease they are being treated for, the end result is still a negative one. For this reason, the appropriate endpoint that should be used is all-cause mortality and morbidity.

47. Illness and death from all causes should be studied to ensure that the vaccines are not causing harm. We were not told that the all-cause mortality in the initial phase of the Pfizer trial was 30 % higher in the vaccinated group versus the matched control group. Pfizer's second report also showed an increase in illness and deaths. A recent article in Trends in Internal Medicine[33] concluded none of the vaccines provides a health benefit, and all pivotal trials show a statistically significant increase in *"all cause severe morbidity"* in the vaccinated group compared to the placebo group.

48. Dr Peter Schirmacher, Pro-Vaccine Director of the Pathological Institute and Chief Pathologist at the University of Heidelberg, recently announced that the Covid-19 vaccine caused the death of 30 to 40% of those who died shortly after vaccination[34].

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[32] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1045329/Vaccine_surveillance_report_week_1_2022.pdf

[33] *US COVID-19 Vaccines Proven to Cause More Harm than Good Based on Pivotal Clinical Trial Data Analyzed Using the Proper Scientific Endpoint, "All Cause Severe Morbidity",* J Bart Classen, MD (Received 24 July 2021, Accepted 25 August 2021) Trends in Internal Medicine, Classen Immunotherapies, Inc https://newsrescue.com/wp-content/uploads/2021/08/us-covid19-vaccines-proven-to-cause-more-harm-than-good-based-on-pivotal-clinical-trial-data-analyzed-using-the-proper-scientific-1811.pdf

[34] https://www.augsburger-allgemeine.de/panorama/Corona-Chef-Pathologe-der-Uni-Heidelberg-draengt-auf-mehr-Obduktionen-von-Geimpften-id60235361.html

49. Interestingly, the death rate in the U.S. for those aged 18-64 has risen an astonishing 40% over pre-pandemic levels. According to the CEO of Indianapolis-based insurance company OneAmerica "*We are seeing, right now, the highest death rates we have seen in the history of this business – not just at OneAmerica*[35]". OneAmerica is a $100 billion insurance company that's been in operation since 1877 and has approximately 2,400 employees.

Lack of Transparency of the Risks

50. Under medical ethics, any medical intervention must be proven safe before its roll out to the public. Once a new medical intervention is rolled out the accurate reporting and investigation of adverse events is essential. Unfortunately, our Government and others do not require mandatory reporting of adverse events for the vaccine. Reporting is voluntary.

51. The consequences of voluntary reporting systems have been studied in the U.S. and N.Z.:

    (a) A 2010 study performed by Harvard consultants found that *"fewer than 1% of adverse events*[36]" were reported to VAERS. Medical professionals claim that VAERS reports are time-consuming and a complex process.

    (b) The Centre to Adverse Reactions Monitoring System ("**CARMS**") is the early warning system in New Zealand. CARMS is contracted by Medsafe to collect voluntary reports of adverse reactions. Medsafe estimates that only 5% of all reactions are reported[37].

52. The low level of reporting is of great concern given U.S. Senator Ron Johnson's recent tweet that America had passed two milestones on their reporting system, 1 million adverse events and 21,000 deaths, of which 30% occurred within three days of the vaccine. What would be the real number of adverse events and deaths from the vaccine if reporting had been mandatory?

53. Regardless of voluntary reporting in New Zealand, safety signals have been found, and others are emerging for the vaccine.

54. It would seem that the Government is not being transparent about the adverse events. The Minutes of the Covid 19 Vaccine Technical Advisory Group[38] ("**TAG**") dated 11 May 2021 record the following at item 5:

> - The level of work is unprecedented; usually CARM receives about 5,000 reports a year but have already received around 2,600 reports since the beginning of the COVID-19 vaccine rollout.

55. The Minutes also show that TAG was investigating four signals, including thrombosis with thrombocytopenia syndrome, appendicitis, herpes zoster and myocarditis, in May 2021 while the unprecedented marketing campaign continued to state that the vaccine was safe and effective. The Summary of Medsafe's Investigations into possible safety signals is set out below:

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[35] Life Insurance CEO Says Deaths Up 40% Among Those Aged 18-64 | ZeroHedge
[36] https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf
[37] https://www.medsafe.govt.nz/Profs/PUarticles/ADRreport.htm
[38] https://fyi.org.nz/request/16691/response/65106/attach/5/H202112324%20documents%20redacted.pdf

Summary of Medsafe's investigations into possible safety signals

Safety signal	Outcome
Blood clots	Continue to monitor. See also the Monitoring communication
Appendicitis	Continue to monitor
Myocarditis/pericarditis	Information has been added to Comirnaty data sheet. See also the Alert communication. Medsafe will continue to monitor this closely.
Herpes zoster	Continue to monitor
Bell's palsy/facial paralysis	Continue to monitor
Menstrual disorder	Continue to monitor. See also the monitoring communication.
Stroke	Continue to monitor
Tinnitus	Continue to monitor
AEFIs in the elderly	Continue to monitor and updated data sheet
Pancreatitis	Continue to monitor
Glomerular diseases	Continue to monitor
Guillain-Barré Syndrome	Continue to monitor
Thrombocytopenia	Continue to monitor
AEFIs in children	Continue to monitor
Erythema multiforme	Continue to monitor
Pregnancy	Continue to monitor. See also the monitoring communication.

Myocarditis – What did the Government Know?

56. The Health and Disabilities Act and its Code require all health and disability services to comply with certain minimum standards of patient care, including the provision of adequate information so patients can make informed decisions. The principle of "*informed consent*" is fundamental. This requires information about risks, benefits and uncertainties as well as alternatives, and also that decisions are freely made, without duress.

57. The Government has known about the risk of myocarditis from at least May 2021. However, the Government should have known about the risk since October 2020 following the FDA ACIP Meeting.

58. The **FDA ACIP Meeting**[39] on 30 October 2020 set out a working list of possible adverse event outcomes:

FDA Safety Surveillance of COVID-19 Vaccines :
DRAFT Working list of possible adverse event outcomes
*****Subject to change*****

- Guillain-Barré syndrome
- Acute disseminated encephalomyelitis
- Transverse myelitis
- Encephalitis/myelitis/encephalomyelitis/ meningoencephalitis/meningitis/ encepholapathy
- Convulsions/seizures
- Stroke
- Narcolepsy and cataplexy
- Anaphylaxis
- Acute myocardial infarction
- Myocarditis/pericarditis
- Autoimmune disease
- Deaths
- Pregnancy and birth outcomes
- Other acute demyelinating diseases
- Non-anaphylactic allergic reactions
- Thrombocytopenia
- Disseminated intravascular coagulation
- Venous thromboembolism
- Arthritis and arthralgia/joint pain
- Kawasaki disease
- Multisystem Inflammatory Syndrome in Children
- Vaccine enhanced disease

59. Our Government's Clinical Evaluation[40] dated January 2020 (obtained under the OIA) does not seem to include the FDA's list of adverse reactions. Unless myocarditis is listed on one of the three redacted pages, which would raise a number of serious questions.

[39] https://www.fda.gov/media/143557/download
[40] https://static1.squarespace.com/static/612c674b10fbd22a00202ceb/t/614d72f6a8c6667866a71081/1632465696127/H202106950-+Response+Documents+%28redacted%29+%28003%29+%281%29.pdf

IX. SELECTED INITIAL ADVISORY GROUP COMMENTS

Responses to an early request (with very limited information) for advice from the Medsafe COVID-19 Vaccine Advisory Committee have included the following.

Covid-19 vaccines can be expected not to provide long term protection – the need for booster doses can be expected. (For viral vectored vaccines, heterologous boosting may be needed).

Significant delayed adverse consequences of vaccination, generally, are very uncommon. For example, a recent article highlighted vaccines that had been withdrawn for safety concerns. All of the events, resulting in withdrawal, occurred within 2 months of vaccine receipt (Reid S Vaccine Safety NZMJ 21 February 2020 Vol 133 No 1510. www.nzma.org.nz/journal-articles/vaccine-safety). Possible delayed AEs could include:

- VAERD in specific age groups (eg geriatric, pediatric) or in individuals with uncommon comorbidities (eg autoimmunity / immune deficiency)
- Guillain Barre Syndrome
- narcolepsy.

s 9(2)(b)(ii)

[redacted]

Pages 75- 77 withheld under section 9(2)(b)(ii) of the Act.

60. The Covid-19 Vaccine Technical Advisory Group ("TAG") raised numerous concerns in regard to myocarditis[41] [42] as set out below:

Date of Minutes	Concerns
11 May 2021	• Four signals are currently being investigated: thrombosis with thrombocytopenia syndrome (TTS), appendicitis, herpes zoster, and myocarditis.
25 May 2021	• Events of myocarditis post-vaccination are being evaluated by regulators, including the EMA and FDA. Preliminary evidence suggests that rates are low in the US, UK and the EU (~1 per million) and Israel (~6 per million).
8 June 2021	• Israel Health Ministry has concluded that the cases of myocarditis, predominantly in younger males, following the Pfizer vaccine are probably linked to the vaccine. The US and EU regulators have stated that a causal link is yet to be established.
22 June 2021	The decision to use Pfizer for 12 to 15 years • It would be advisable to delay until more safety data is available, especially with regards to potential safety signals such as myocarditis, which have been reported in some overseas rollouts eg, Israel
29 June 2021	**Myocarditis after Pfizer Vaccination** • Advice on the Decision to Use Pfizer for 12-15-year-olds was issued to Cabinet, however a decision has been deferred pending advice from CV TAG on myocarditis. • The FDA have added a warning for myocarditis and pericarditis to the Pfizer and Moderna vaccine data sheets, after observing a series of cases following vaccination. It is seen most predominantly in adolescent and young adults, particularly males aged <30 years, and after the second dose. CV TAG discussed the current evidence and risks. Key points of discussion: • The University of Auckland is leading a project estimating background rates of adverse events in New Zealand, including myocarditis, and is expected to report findings within the next 7-10 days. Data on the ethnic breakdown of cases was requested to be included. • CV TAG noted concern about the potential risk of myocarditis has grown and a sense of urgency to develop options, e.g., for alternative vaccine schedules, and advice.

[41] H202112324 documents redacted.pdf (fyi.org.nz)
[42] H202115494 Response.pdf (fyi.org.nz)

	• While evidence is still emerging, IMAC clinicians are already fielding requests on myocarditis. It was noted that because the issue is relatively rare, the true risk may not be known for some time until the vaccine rollout internationally has progressed further.
	• There is a need to communicate safety information to inform the public and present a balanced assessment of the risk and benefits. Science communicators who can appeal to a range of different ethnicities will be important.
	• Further information is needed on vaccine hesitancy among young adults and men <30 and how this may be impacted by a potential safety signal, to inform how the commentary would be managed.
	• Possible options raised by CV TAG included:
	  ○ Considering using only a single dose among people who are at higher risk (e.g. young males <30, people with a history of myocarditis) until further evidence is available. It was noted that Israel is actively considering this option
	  ○ Heterologous vaccine schedules (e.g., offering Janssen or another vaccine – when available - as a second dose).
	  ○ Considering the ongoing use of Pfizer in young males <30 until further evidence emerges. It was noted that many within this population would have been captured under groups 1-3. Data on the numbers in each of these groups, as well as when they are expected to be vaccinated, is needed from CVIP.
	It was agreed that a subgroup would be convened to draft advice which will be presented to the CV TAG next week (06 July) to inform recommendations around using the Pfizer vaccine in younger people.

6 July 2021	**Myocarditis after Pfizer Vaccination** CV TAG discussed advice provided by the STA and a subgroup of CV TAG, on the current evidence on events of myocarditis/pericarditis post vaccination, and related questions. Key points: • Previous studies of US military personnel, that evaluated the risk of myocarditis following the smallpox vaccine, indicated that myocarditis was a potential safety issue, with cases usually occurring within a few days of vaccination. • Events of myocarditis tend to be associated with the second dose of mRNA COVID-19 vaccines, although some cases occur after the first dose. The rate of myocarditis tends to be higher in males and younger age groups, particularly in males aged 16-30. • There is limited information, to date, on the long-term outcomes and severity of myocarditis following vaccination. Of the 29 cases in the Vaccine Safety Datalink (VSD) reported in the US, 24 (83%) were hospitalised with a median stay of 1 day (range 0-13 days), including two who were admitted to the ICU. All cases were discharged, and nearly all cases had resolution of symptoms at follow up. • Overall, emerging evidence suggests that myocarditis is a largely self-limiting and rare event following mRNA vaccination, with the rate for Pfizer in the US being approximately 0.8 per 100,000 in 12-39 year-olds within 21 days following the second dose. • CV TAG discussed possibility of alternative vaccination schedules that might mitigate the risk in younger age groups. However, any change in dosing schedule will require Medsafe approval. • CV TAG discussed potential recommendations, including advice for those with rheumatic heart disease, those with a previous history of myocarditis, or those who develop myocarditis following the first dose. A subgroup of the CVTAG will meet 08 July to draft recommendations. The recommendations will be finalised by the end of week and discussed at the next CV TAG full meeting.
13 July 2021	**Myocarditis Recommendations** • Draft recommendations on the risk of myocarditis after mRNA vaccination were presented to CV TAG. • It was noted that, this is a developing issue, and there are still several uncertainties in the data. • Based on preliminary US data, the risk of myocarditis after Pfizer vaccination is approximately 1 in 25,000 for males 12-29 years, and 1 in 240,000 for females 12-29 years. For individuals 30 and over, the corresponding risks decrease to approximately 1 in 400,000 for males, and 1 in a million for females. While the risk for females is lower than for males, it is still greater for younger people, and therefore any recommendation should be applied to all people aged under 30.

	• CV TAG progressed to summarise an initial draft of the approach:
	  ○ The second dose of Pfizer vaccination could be deferred in individuals aged 29 years and under until further information is available about the risk, long-term outcomes of myocarditis and/or pericarditis, and protection offered by one dose for this age group.
	  ○ People 29 years of age and younger who require regular clinical review by a cardiologist are advised to discuss the risks and benefits of the first dose of COVID-19 vaccine for their specific situation with their healthcare team
	  ○ People aged 30 years and over should still receive two doses of the vaccine, 21 days apart as the risk of myocarditis and/or pericarditis post vaccination is less than 1 in 400,000 and risks of severe disease and sequelae due to COVID-19, including myocarditis, are substantially higher in this age group compared to people aged 29 years and under.
	  ○ Anyone who develops confirmed myocarditis and/or pericarditis after the first dose should not receive a second dose of the Pfizer COVID-19 vaccine. CV TAG will consider alternative options for a second dose of COVID-19 vaccination in this group at a future date as evidence emerges from overseas safety monitoring.
	  ○ CV TAG will continue to monitor all relevant effectiveness and safety data closely and advise on the need and options for the second dose for individuals aged 29 years and under at a future date. Options for the second dose may include: 1) proceeding with the second dose of the Pfizer COVID-19 vaccine after a longer interval between doses; 2) not administering a second dose; 3) administering a second dose of an alternative COVID-19 vaccine.

20 July 2021	• A Medsafe alert on myocarditis will be published later this week. The draft communication was shared with CV TAG, and feedback will be collated by the Secretariat to share back to Medsafe.
	• CV TAG discussed the background rates of myocarditis, and rates post-Pfizer vaccination, internationally and in Aotearoa New Zealand.
	  ○ It was agreed that the US rates provided the best available baseline for comparisons with Aotearoa New Zealand.
	  ○ The US data is broken down further by gender, age group and follow-up time, and notes a risk of 1 in 25,000 for males aged 12-29 within 7 days of the second dose, and 1 in 238,000 for females aged 12-29 within 7 days of the second dose, for mRNA vaccines.
	  ○ Severity measures should also be incorporated into the presentation of the data, for example hospitalisation and/or ICU admission rates, if data are available.
	• Draft recommendations on the risk of myocarditis after Pfizer vaccination were discussed.
	  ○ CV TAG noted that there is some evidence that young people aged 16 to 29 years have a strong immune response after one dose, however that two doses provide the best protection. A delayed schedule for the second dose was discussed. Whether this potentially reduces the risk of myocarditis, in addition to the severity of other adverse events, is unknown.

27 July 2021	**Myocarditis Recommendations Update** The final memo on Myocarditis after Pfizer mRNA vaccination was shared with CV TAG and discussed. • The final memo included input and advice from Medsafe. • The Director-General has received the recommendations, and an implementation plan is currently being prepared within the Ministry, once the recommendations have been agreed by Ministers • CV TAG discussed the data supporting longer dosing intervals for Pfizer; Data showed higher immunogenicity was associated with an extended dosing interval (median 10 weeks) compared to the usual 3-4 weeks. • CV TAG discussed the recommended dosing interval for people under 30 years. CV TAG discussed the while an 8-week interval is recommended for this age group, administering the second dose between 6 and 12 weeks is acceptable, and that the exact timing is a programming decision. • It was agreed that all changes must communicated in a way to provide clarity.

3 August 2021	**Myocarditis Recommendations Update** The Chair updated CV TAG on progress with the final recommendations on myocarditis. • The Director-General has accepted the recommendations. An announcement and implementation plan for extending the dosing interval is forthcoming. • It will result in significant programmatic changes and has important equity considerations, however the emphasis on distributing first doses to priority groups has been noted and accepted.
31 August 2021	**Myocarditis after Pfizer Vaccination** The recent death of a woman with myocarditis post-vaccination was discussed with CV TAG: • ISMB determined that vaccination was one of the causal factors. • It was noted that this myocarditis following vaccination is extremely rare. • The case is under review by a coroner and the case report will be published providing greater detail.
	I have been unable to locate information from August through October 2021
19 October 2021	**Myocarditis Update** • An update was provided from STA on the risk of myocarditis according to international evidence. Data presented at the latest US ACIP meeting on 30 August 2021 and data from Israel indicate that myocarditis reporting rates following mRNA COVID-19 vaccination continue to be rare overall, but highest risk tends to occur after the second dose, particularly in younger males. • Medsafe also shared the latest data on cases. The safety profile differs to the US in that New Zealand is seeing more cases after dose 1 than dose 2, however this could reflect the vaccine rollout with more young people being vaccinated later. Onset tends to be reported in the first five days for both dose. Data on dosing intervals has not been analysed, however it has been noted that cases have still occurred at an interval of 6-8 weeks. Overall, the rate is approximately 7 per million doses after dose 1, and 10 per million doses after dose 2. Peopled aged 30-39 are the most affected age group in New Zealand overall, and after dose 1, and people aged 20-29 are most affected after dose 2. Long-term follow-up data is expected by end of November. • ISMB shared that levels of reporting seem to correlate with the numbers of reports being received, looking at the number of hospitalisations in vaccinated individuals. Every case reported to CARM is reviewed by a medical assessor, and when there is insufficient data, further information is requested. If there is a risk of death, biopsies and post-mortems of myocardiums are requested. No long-term outcome data is currently available. • Information on symptoms to watch out for have been provided to all vaccinators, however it is possible that some centres are still using older booklets from before the advice was given. • Milder cases may benefit from further clinical investigation, and greater standardisation in management of care may be needed with ECGs and provision of troponins. Accessiblity of the guidance for general practice and primary care will be reviewed. • As previously noted, people who have myocarditis after their first dose should not be offered a second dose of an mRNA vaccine, and an alternative vaccine or no further doses should be considered for those people. • No further evidence had emerged that decreasing the dose interval had impacted myocarditis. • A clinical research project is one option to consider looking at myocarditis in greater detail.
2 November 2021	• There was discussion about the risks of mandating vaccinations for people at elevated risk of adverse events e.g., younger people aged 12-17 and the increased risk of myocarditis after the second dose, and a single dose may be sufficient
	Research Studies: Myocarditis research A request to support research myocarditis following COVID-19 vaccination was also considered. • An ongoing long-term follow-up study was discussed regarding cases with a clinical diagnosis of myocarditis and/or pericarditis following vaccination, as reported to CARM. • CV TAG members were requested to volunteer to form a subgroup to develop plans and present a proposal for additional research questions to the Post-Event team.

	Decision to Use for 5-11-year-olds • An initial discussion occurred on the Pfizer vaccine for 5–11-year-olds. • The recent clinical trial occurred among a relatively small sample of ~2000 children. Rare adverse events cannot be evaluated in a clinical trial of that size. New Zealand would be able to wait for the real-world data of the vaccine rollout internationally to evaluated safety and effectiveness. • The benefit:risk ratio was not as obvious for this group as for older populations, as COVID-19 presents as a mild disease in this age group and there appears to be an increased risk of myocarditis after vaccination in younger age groups. • Concern was also expressed on including 5–11-year-olds under vaccine certificates and mandates, with potential effects on education and wellbeing. • However, different risks for Māori and 5-11-year-olds vulnerable to severe COVID-19 or immunocompromise should be considered • A subgroup of CV TAG will be meeting to draft recommendations in the coming days.

61. On 8 November 2021, the **American Heart Foundation**[43] published the following:

> *"We conclude that the mRNA vacs dramatically increase inflammation on the endothelium and T cell infiltration of cardiac muscle and may account for the observations of increased thrombosis, cardiomyopathy, and other vascular events following vaccination".*

62. A preprint study has now been released showing that the risk of myocarditis for young people in the United States is greater than the risk of hospitalisation due to Covid-19, even in regions heavily affected by Covid-19[44]. This is also highlighted in Israeli studies,[45] which have exclusively used the Pfizer Comirnaty vaccine. One such study shows a 13.6-fold (1,260% increase) in new cases of myocarditis after the second vaccine in 16 to 19-year-old males, compared to background rates of the disease between 2017 to 2019.

63. Finally, on 15 December 2021, the MOH issued an update for myocarditis/pericarditis. Unfortunately, this warning came too late for many New Zealanders. As of 31 December 2021, Medsafe's website shows that 133 deaths were reported (which is under-reported). This included Rory Narin and my friend's sister.

64. Dr Noelyn Hung states the risk of myocarditis from the vaccine is less than the risk of myocarditis from Covid-19. Dr Hung[46] is one of the key personnel for Zenith Technology, a contract research organisation that provides clinical trial and analytical laboratory services for the international pharmaceutical industry and teaches at the department of pathology at Otago University. I could not locate any myocarditis or Covid-19 publications in her name.

65. Dr Peter McCullough[47] is a top cardiologist and the most highly cited physician on the early treatment of Covid-19 and has more than 600 citations in the National Library of Medicine. Dr McCullough disagrees with Dr Hung's suggestion and has warned that myocarditis due to the vaccine is far more serious than myocarditis contracted from the virus itself. Dr McCullough states that the difference is that the ailment produced by the natural infection tends to elevate troponin levels, which is a protein found in cardiac and skeletal muscle. *"[T]he myocarditis in COVID-19 is mild, it's inconsequential, and it's largely a component of election [of troponin]."* In contrast, Dr McCullough contends that contracting the ailment through the vaccine may cause

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[43] Abstract 10712: Mrna COVID Vaccines Dramatically Increase Endothelial Inflammatory Markers and ACS Risk as Measured by the PULS Cardiac Test: a Warning, Steven R Gundry (Originally published 8 November 2021) AHA Journals https://www.ahajournals.org/doi/10.1161/circ.144.suppl_1.10712

[44] *SARS-CoV-2 mRNA Vaccination-Associated Myocarditis in Children Ages 12-17: A Stratified National Database Analysis,* Tracy Beth Høeg; Allison Krug, Josh Stevenson; John Mandrola (8 September 2021) MedRxiv, The Preprint Server for Health Sciences https://www.medrxiv.org/content/10.1101/2021.08.30.21262866v1

[45] *SARS-CoV-2 mRNA Vaccination-Associated Myocarditis in Children Ages 12-17: A Stratified National Database Analysis,* Tracy Beth Høeg; Allison Krug, Josh Stevenson; John Mandrola (8 September 2021) MedRxiv, The Preprint Server for Health Sciences https://www.medrxiv.org/content/10.1101/2021.08.30.21262866v1

[46] http://www.zenithtechnology.co.nz/key-personnel/index.cfm

[47] https://www.youtube.com/watch?time_continue=17&v=lxfcP8wwt58&feature=emb_logo

lipid nanoparticles to go directly to the heart. *"The heart expresses the spike protein, the body attacks the heart. There are dramatic EKG changes. I don't want anybody to think that the myocarditis of a natural infection is anything like what we're seeing with the vaccines,"* the top cardiologist warned.

66. Dr McCullough claims that the heart injuries due to the vaccine are around 10-100 times higher than the troponin seen in natural infections. Worsening matters; the doctor states that when kids develop myocarditis after the vaccine, 90% require immediate hospitalisation to prevent heart failure. Dr McCullough states that *"Vaccine-induced myocarditis is a big deal, and in children, it's way more serious and more prominent than a post-COVID myocarditis."*

67. I find it hard to believe that heart inflammation from the vaccine is rare, given I am prepared to swear under oath as to the following:

(a) I know a young lady in her 20s that was previously fit and healthy prior to the vaccine. She emailed me two days after her first vaccination and stated the following:

"I have had bad heart pains this weekend so went to the Dr and she did an ECG and blood tests and they think I just have severe inflammation around the heart which is a big relief over being heart issues. She said she has had multiple girls my age with the same symptom after their first vaccine. So hopefully the medication they have given me will ease the pain and discomfort."

(b) The young lady also reported heart pain and required an ECG and bloods following her second vaccine.

(c) A staff member of the Tauranga Council sent me an email reporting that his young fit daughter suffered from myocarditis following the vaccine.

68. I have friends that have relatives and friends with heart issues (and other adverse reactions). One person I know reported that North Shore Hospital sees an average of 4 cases a day. Another contact said that there were over 30 heart attacks deaths in one month in Tauranga Hospital, which is well above the average.

The number of Cases and Deaths are not accurate

69. Public health policy should be based on accurate and independently verifiable data to identify infectious people and ensure sick people get medical attention. When in medical history has a public health authority needed to *"test, test, test"* healthy people with no symptoms to define a medical *"case"*.

70. The results of the RT-qPCR ("**PCR tests**") have driven the fear and extension of the pandemic, with cases (most of which are mild) being announced daily in a hypnotic fashion.

71. Dr Anthony Fauci[48], director of the U.S. National Institute of Allergy and Infectious Diseases, stated that when a cycle threshold of 35 or more is used for the PCR Test, the chances of it being replication confident is minuscule. There are false-positive results when the PCR Test is set to a cycle threshold of 40. The WHO [49] has confirmed that the PCR test has false positives.

72. The MOH confirmed in their letter in response to an OIA request (#H202007723[50]) that:

"Polymerase Chain Reaction (PCR) tests utilised in our accredited laboratories typically run for 40 cycles."

73. Why does the Government require the PCR test to be run at such a high threshold resulting in false positives? As of September 2021, the Government had spent approximately $617,306,580[51] to undertake 3,248,982

[48] https://www.bitchute.com/video/X0Z3Whf2SopB/
[49] https://web.archive.org/web/20210120083427/https://www.who.int/news/item/14-12-2020-who-information-notice-for-ivd-users
[50] https://fyi.org.nz/request/16779-effect-of-pfizer-vaccine-on-reducing-transmission I note that some OIA are not as easy to find as they were previously
[51] https://fyi.org.nz/request/15879-cycle-thresholds-of-positive-sars-cov-2-tests-in-new-zealand#incoming-59660

tests, which resulted in 3,242,989 negative tests and 5133 positive tests (some individuals produced more than one positive test due to weekly testing etc.).

74. The PCR Test has already been ruled inadmissible in at least two European courts. The Portuguese Court of Appeal[52] cited a study conducted by *"some of the leading European and world specialists"* which show that a cycle threshold of 35 or higher, the chances of that person being infected is less than 3%, and that *"the probability of… receiving a false positive is 97% or higher."*

75. People may die with a positive PCR test and not from Covid-19 but still, be counted as a Covid-19 death. One particularly fitting illustration of this is the 40-year-old Auckland man who died on 5th November 2021 of a gunshot wound and whose death was reported as a Covid-19 death[53].

76. Examples of the "revision" of number by other countries are set out below:

(a) In June 2020, The CDC revised the number of deaths attributable to Covid-19 and stated that *"For 6% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19, on average, there were 2.9 additional conditions or causes per death[54]"*.

(b) In 2021, the Italian Higher Institute of Health[55] showed only 2.9% of the 130,468 deaths registered by official statistics since the end of February 2020 would be due to Covid 19.

(c) A Lisbon court ruled only 0.9% of 'verified cases' died of COVID, numbering 152, not 17,000 claimed.

(d) In August 2021, the CDC adjusted the number down for Florida after State officials fought back. The CDC initially claimed 28,317 new cases, while the Florida DOH puts that number at 15,319. The CDC adjusted its number down to 19,584.

(e) Recently, the U.K. Office for National Statistics[56] has confirmed in response to a Freedom of Information request that as of the end of quarter 3 in 2021, 17,371 people had actually died of Covid-19 with no underlying causes. The media reports that 150,000 have died from Covid-19 but neglects to explain that people can die with the disease and not from the disease. On average, 30,000 people lose their lives during a single bad flu year in the U.K.

77. The New Zealand Government highlights all COVID-19 deaths even where an elderly person with underlying comorbidities was close to passing. In 2020, Dr Bloomfield stated:

> *"Right from the start of the pandemic we've been very inclusive in our approach to categorising deaths as Covid related deaths …The latest case we had was someone who had a confirmed C19 infection. Whilst they had a significant serious existing pre-existing condition, we have categorised the deaths as Covid related. You'll see most countries doing this."*

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[52] https://off-guardian.org/2020/11/20/portuguese-court-rules-pcr-tests-unreliable-quarantines-unlawful/

[53] https://www.washingtonexaminer.com/policy/healthcare/new-zealand-man-who-died-of-gunshot-wound-to-be-recorded-as-covid-19-death-report

[54] Conditions contributing to deaths involving COVID-19, by age group, United States, Week ending 2/1/2020 to 12/5/2020, National Center for Health Statistics. National Vital Statistics System (12 June 2020) Centers for disease control and prevention https://www.cdc.gov/nchs/data/health_policy/covid19-comorbidity-expanded-12092020-508.pdf

[55] Big mess in the death report. For the ISS, most of the deaths were not caused by Covid, Franco Bechis (21 October 2021) Il Tempo https://www-iltempo-it.translate.goog/attualita/2021/10/21/news/rapporto-iss-morti-covid-malattie-patologie-come-influenza-pandemia-disastro-mortalita-bechis-29134543/?_x_tr_sl=it&_x_tr_tl=en&_x_tr_hl=it&_x_tr_pto=nui and Fake Mortality Data Corrected: Italian Institute of Health Reduces Official Covid Death Toll from 130,000 to 4,000, Paul Craig Roberts and guest contributions (9 November 2021) Paul Robert Institute for political economy https://www.paulcraigroberts.org/2021/11/09/fake-mortality-data-corrected-italian-institute-of-health-reduces-official-covid-death-toll-from-130000-to-4000/

[56] https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/deathsfromcovid19withnootherunderlyingcauses

78. The mainstream media may or may not report the age of the deceased and state that no further details will be provided due to privacy reasons, as per the screenshot below. A source has alleged that the deceased in this case was elderly with terminal cancer. Why are these details be withheld from COVID-19 deaths but published for deaths from other causes? Why the doublespeak?

> **Covid-19 patient dies in Tauranga; 74 new community cases**
>
> A patient with Covid-19 in Tauranga Hospital has died.
>
> The Ministry of Health said that no further details will be released at this stage for privacy reasons. "Our thoughts are with the patient's whānau and friends at this deeply sad time," said a spokesperson.

79. The doublespeak was highlighted by the RSV outbreak in 2021 (which did overrun the hospitals). The media[57] reported that an "*older adult*" died in Tauranga after catching RSV. The cause of the adult's death was attributed to numerous underlying medical conditions, the Bay of Plenty District Health Board said.

80. Sadly, a vaccine death of an elderly person with underlying comorbidities is viewed as an unfortunate event as they were going to die anyway. Examples of the doublespeak are set out in Minutes of the TAG meeting dated 29 June 2021 and Clinical Evaluation dated January 2020, which was obtained under the OIA.

> - CV TAG were informed that there have been two recent incidences of frail elderly individuals passing away shortly following administration of the Pfizer vaccination. Each was showing serious progressive decline prior to vaccination, and there was a concern from the family and general practitioner that the vaccination may have played a role in their death.

> **V.8 Post marketing experience/Norway deaths**
>
> There are reports of deaths of 23 frail elderly patients shortly after receiving the Pfizer BioNTec vaccine. The Norwegian Medicines Agency (NOMA) has commented that there is no certain connection between these deaths and the vaccine.
>
> The agency has investigated 13 of the deaths so far and concluded that common adverse reactions of mRNA vaccines, such as fever, nausea, and diarrhoea, may have contributed to fatal outcomes in some of the frail patients. "There is a possibility that these common adverse reactions, that are not dangerous in fitter, younger patients and are not unusual with vaccines, may aggravate underlying disease in the elderly".
>
> Norwegian Authorities have prioritized the immunization of residents in Nursing Homes, most of whom are very elderly with underlying medical conditions and some which are terminally ill. NOMA confirms the number of incidents so far is not alarming, and in line with expectations.
>
> All reported deaths will be thoroughly evaluated by NOMA to determine if these incidents are related to the vaccine. The Norwegian government will also consider adjusting their vaccination instructions to take the patients' health into more consideration.
>
> *https://www.bmj.com/content/372/bmj.n149*
>
> News. Covid-19: Norway investigates 23 deaths in frail elderly patients after vaccination
>
> BMJ 2021; 372 doi: https://doi.org/10.1136/bmj.n149 (Published 15 January 2021)Cite this as: BMJ 2021;372:n149

Ingredients

81. Medsafe[58] lists the ingredients of the vaccine as BNT162b2 [mRNA] 0.5 mg/mL equivalent to 30 µg/0.3mL dose, 1,2-Distearoyl-sn-glycero-3-phosphocholine, ALC-0159, ALC-0315, Cholesterol, Dibasic sodium phosphate dihydrate, Monobasic potassium phosphate, Potassium chloride, Sodium chloride, Sucrose and Water.

[57] https://www.nzherald.co.nz/bay-of-plenty-times/news/rsv-in-tauranga-older-adult-dies-hospital-sees-hundreds-with-virus/X73EEAT5QNCH2TMN7BOVEKCXWU/

[58] Medsafe Product Detail, Medsafe (Revised 21 May 2019) New Zealand Medicines and Medical Devices Safety Authority https://medsafe.govt.nz/regulatory/ProductDetail.asp?ID=21938

82. The Consumer Medicine Information Summary on Medsafe's website states the vaccine should not be given to a person if they are allergic to BNT162b2. However, there is no test to ascertain if a person is allergic to BNT162b2 or not. Instead, an individual needs to play Russian roulette.

83. The Cayman Chemicals Safety Data Sheet for 1,2-Distearoyl-sn-glycero-3-phosphocholine states at 1.2 *"Relevant identified uses: For research use only, not for human or veterinary use"*[59]. Point 2.3 states under the heading `Adverse Human Health' "Material may be irritating to the mucous membanes and upper respiratory tract". Then under the `Effects and Symptoms' heading "May be harmful by inhalation, ingestion or my skin absorption … the toxicological properties have not been thoroughly investigated". Do you think it may be a good idea to do such an investigation before pushing four monthly boosters?

84. ALC-0159 and ALC-0315 are two patented ingredients that are manufactured by a Chinese pharmaceutical and medical company. Medsafe has responded to an OIA email request on 11 November 2021 and confirmed in writing that *"[w]e do not hold the MDSS [Material Safety Data Sheet] for these [ALC-0159 and ALC-0315]*".

85. The substances are manufactured by a company in China called Sinopeg. Sinopeg's website does not have any MDSS information either. However, the information does say that these substances are for *"research use only"*[60] [61].

86. Pfizer's Safety Data Sheet is set out at Schedule 3. Why is the Government forcing people to be injected with a substance when the Safety Data Sheet states the following:

(a) 2.2 Hazard Statements: "Not classified in accordance with international standards for workplace safety".
(b) 3.2 Mixtures: "no data available".
(c) 4.1 Most important symptoms and effects: "no data available".
(d) 5.3 Advice for Firefighters: "Firefighters should wear self-contained breathing apparatus and full firefighting turnout gear. Use personal protection equipment".
(e) 11 Toxicological Information: "Toxicological properties have not been thoroughly investigated".
(f) 11.2.2 Environmental Overview: "Environmental properties have not been investigated. Release to the environment should be avoided".
(g) 13.1 Waste Treatment Methods: "Consider the relevant known environmental and human health hazards of the material, review and implement appropriate technical and procedural wastewater and waste disposal measures to prevent occupational exposure and environmental release".

87. How can employers require employees to inject a substance into their bodies without holding the MDSS or information about the medium and long term data? Is this not a breach of the Health and Safety at Work Act 2015 under which directors and boards of trustees are personally liable. Would such directions by the Government and an employers be in breach of the International Covenant of Civil and Political Rights, which was adopted by the United Nations, and which New Zealand has ratified, states in Article 7:

> *"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to* **medical or scientific experimentation.***"*

Ingredients for the Children

88. The TGA's minutes dated 2 November 2021 state that section 12 the following[62]:

[59] https://www.caymanchem.com/product/15100
[60] https://www.sinopeg.com/2-polyethylene-glycol-2000-n-n-ditetradecylacetamide-alc-0159-cas-1849616-42-7_p477.html
[61] https://www.sinopeg.com/4-hydroxybutyl-azanediyl-bis-hexane-6-1-diyl-bis-2-hexyldecanoate-alc-0315-cas-2036272-55-4_p476.html
[62] https://fyi.org.nz/request/16691/response/66492/attach/3/H202115494%20Response.pdf

Decision to Use 5–11-Year-Olds

- Medsafe are expecting an application from Pfizer in mid-November. The US FDA are reviewing data for 5-11-year-olds at the end of October.
- Little information has been provided on the paediatric formulation which Pfizer are currently trialling, however it may be of importance.
- STA will convene a subgroup of CV TAG to discuss priority groups and equity considerations for recommendations and a Decision to Use.
- Whether the 5–11-year-olds and 12–15-year-olds who are of lower weight may need a lower dose was discussed. Medsafe are reviewing whether any dose ranging studies were included in Pfizer's initial application.

89. Why have the ingredients for the vaccine for children been changed from that of the adult dose? Page 14 of the Pfizer paperwork filed with the FDA states that tromethamine buffer instead of the phosphate buffered saline will be used for the vaccine administered to 5- to 11-year-olds. Why is a tromethamine buffer being used? Some say that this ingredient has been added due to storage issues of the vaccine. Does that mean that there have been issues with the storage that have emerged? Whistleblower Karen Kingston says tromethamine is used for two reasons, by surgeons to dissolve blood clots in the heart and in the lab to permeate the walls of cells to introduce new genetic material. Please could you provide me with the answer in a sworn affidavit? If you are not prepared to swear an affidavit, please explain why?

90. Please note that a brand of tromethamine was recalled in 2020[63] and then again in September 2021[64].

Definition

91. Merriam-Webster Dictionary changed the definition of vaccine early this year as mRNA products did not meet the definition of a vaccine.

Previous Definition	The definition changed as of 26 January 2021
vaccine noun vac·cine | \ vak-ˈsēn , ˈvak-ˌsēn \ **Definition of *vaccine*** : a preparation of killed microorganisms, living attenuated organisms, or living fully virulent organisms that is administered to produce or artificially increase immunity to a particular disease	**vaccine** noun Save Word vac·cine | \ vak-ˈsēn , ˈvak-ˌsēn \ **Definition of *vaccine*** : a preparation that is administered (as by injection) to stimulate the body's immune response against a specific infectious disease: **a** : an antigenic preparation of a typically inactivated or attenuated (see ATTENUATED sense 2) pathogenic agent (such as a bacterium or virus) or one of its components or products (such as a protein or toxin) **b** : a preparation of genetic material (such as a strand of synthesized messenger RNA) that is used by the cells of the body to produce an antigenic substance (such as a fragment of virus spike protein)

92. The definition was further changed again on 23 October 2021 and can be viewed at www.merriam-webster.com/dictionary/vaccine. How would you feel about mandating the vaccine if they were called something different—experimental gene therapy, for example?

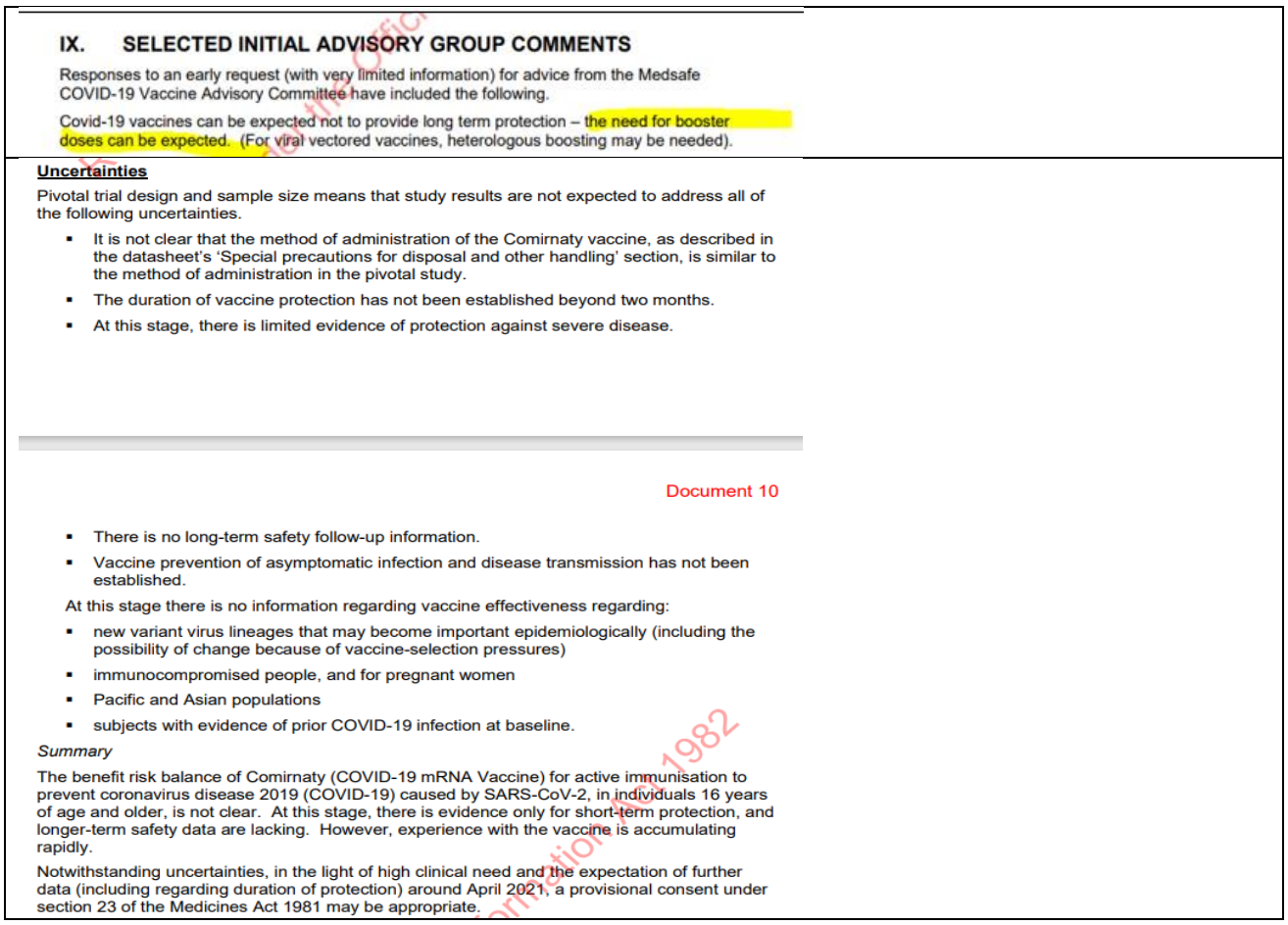
Boosters

93. The vaccine was developed for the alpha variant and has not subsequently stopped the transmission of beta, delta, omicron and IHU variants to both the vaccinated and unvaccinated. The data shows that the vaccine wanes quickly for the variants.

[63] https://www.fresenius-kabi.com/us/documents/Fresenius-Kabi-USA-Ketorolac-Tromethamine-Injection-USP-Nonc.pdf
[64] https://www.fresenius-kabi.com/us/documents/Fresenius-Kabi-USA-Ketorolac-Tromethamine-2nd-Noti-6SMxj0aVBvUT4G_PDaIjYuucW5ZyYXVXDn-yYoUisCY.pdf

94. The Lancet[65] reported that people that have had two doses of the vaccine have 5-6-fold lower amounts of neutralising antibodies, which suggested that further boosters will be necessary.

95. The Government promoted the "double jab" as effective even though its Clinical Evaluation from January 2021 stated that the need for boosters was expected. The Clinical Evaluation states that the Government did not know if the vaccine would provide protection beyond two months. Many people thought they were doing the "*right thing*" by taking the "*two shots*", not realising they were signing up for four monthly boosters.



IX. SELECTED INITIAL ADVISORY GROUP COMMENTS

Responses to an early request (with very limited information) for advice from the Medsafe COVID-19 Vaccine Advisory Committee have included the following.

Covid-19 vaccines can be expected not to provide long term protection – the need for booster doses can be expected. (For viral vectored vaccines, heterologous boosting may be needed).

Uncertainties

Pivotal trial design and sample size means that study results are not expected to address all of the following uncertainties.

- It is not clear that the method of administration of the Comirnaty vaccine, as described in the datasheet's 'Special precautions for disposal and other handling' section, is similar to the method of administration in the pivotal study.
- The duration of vaccine protection has not been established beyond two months.
- At this stage, there is limited evidence of protection against severe disease.

Document 10

- There is no long-term safety follow-up information.
- Vaccine prevention of asymptomatic infection and disease transmission has not been established.

At this stage there is no information regarding vaccine effectiveness regarding:

- new variant virus lineages that may become important epidemiologically (including the possibility of change because of vaccine-selection pressures)
- immunocompromised people, and for pregnant women
- Pacific and Asian populations
- subjects with evidence of prior COVID-19 infection at baseline.

Summary

The benefit risk balance of Comirnaty (COVID-19 mRNA Vaccine) for active immunisation to prevent coronavirus disease 2019 (COVID-19) caused by SARS-CoV-2, in individuals 16 years of age and older, is not clear. At this stage, there is evidence only for short-term protection, and longer-term safety data are lacking. However, experience with the vaccine is accumulating rapidly.

Notwithstanding uncertainties, in the light of high clinical need and the expectation of further data (including regarding duration of protection) around April 2021, a provisional consent under section 23 of the Medicines Act 1981 may be appropriate.

96. An article in the New England Journal of Medicine[66] showed that immunity against the Delta variant of SARS-CoV-2 waned in all age groups a few months after receipt of the second dose of vaccine. Many more studies confirmed waning immunity[67].

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[65] *Neutralising antibody activity against SARS-CoV-2 VOCs B.1.617.2 and B.1.351 by BNT162b2 vaccination,* Emma C Wall; Mary Wu; Ruth Harvey; Gavin Kelly; Scott Warchal; Chelsea Sawyer (Published June 03 2021) The Lancet Journals https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)01290-3/fulltext

[66] *Waning Immunity after the BNT162b2 Vaccine in Israel,* Yair Goldberg, Ph.D.; Micha Mandel, Ph.D.; Yinon M. Bar-On, M.Sc.; Omri Bodenheimer, M.Sc.; Laurence Freedman, Ph.D.; Eric J. Haas, M.D.; Ron Milo, Ph.D.; Sharon Alroy-Preis, M.D.; Nachman Ash, M.D.; and Amit Huppert, Ph.D. (October 27 2021) The New England Journal of Medicine https://www.nejm.org/doi/10.1056/NEJMoa2114228

[67] Canaday, D. H. (2021). Significant reduction in humoral immunity among healthcare workers and nursing home residents 6 months after COVID-19 BNT162b2 mRNA vaccination. MedRxiv. Israel, A. (2021). Large-scale study of antibody titer decay following BNT162b2 mRNA vaccineor SARS-CoV-2 infection. MedRxiv.https://www.medrxiv.org/content/10.1101/2021.08.19.21262111v1
Levine-Tiefenbrun, M., Yelin, I., Alapi, H., Katz, R., Herzel, E., Kuint, J., Chodick, G., Gazit, S., 9 Patalon, T., & Kishony, R. (2021). Viral loads of delta-variant SARS-CoV-2 breakthrough infections after vaccination and booster with BNT162b2. Nature Medicine. Published. https://doi.org/10.1038/s41591-021-01575-4
Nordstrom, P. (2021). Effectiveness of covid-19 vaccination against risk of symptomatic infection, hospitalization, and death up to 9 months: A Swedish Total-Population cohort study. SSRN. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3949410
Saade, C., Gonzalez, C., Bal, A., Valette, M., Saker, K., Lina, B., Josset, L., Trabaud, M. A., Thiery, G., Botelho-Nevers, E., & On Behalf Of COVID-SER Study Group. (2021). Live virus neutralization testing in convalescent patients and subjects vaccinated against 19A, 20B, 20I/501Y.v1 and 20H/501Y.v2 isolates of SARS-CoV-2. Emerging Microbes & Infections, 10(1), 1499–1502. https://doi.org/10.1080/22221751.2021.1945423

97. The Nature Public Health Emergency Collection[68] raised the question of the vaccine and the various variants.

> *"More importantly,* ***the variants have shown more than 10 amino acid mutations in the SARS-CoV-2 spike (S) protein, which has been an area of concern for the effectiveness of the BNT162b2 vaccine against these variants****."*

98. Dr Robert Malone reports on a recent study in medRxviv, which highlighted that vaccine effectiveness against Omicron was 37% (95%CI, 19-50%) ≥ seven days after receiving an mRNA vaccine for the third dose[69].

99. As I am sure you are aware, Israel is now up to their 4th vaccination and Turkey up to their 5th vaccination but still reaching record high infections. How many boosters will the Government require for the vaccinated to maintain their freedoms under the vaccine passport? How will the Government monitor cumulative toxicity with more and more boosters required?

100. Why is natural immunity being ignored? It is highly likely that many New Zealanders travelling in late 2019 and early 2020 contracted SARS-CoV-2 but did not develop COVID-19. Emerging data show that natural immunity confers longer-lasting and stronger protection against infection, symptomatic disease and hospitalisation, compared to the two-dose vaccine-induced immunity.

101. The U.K. Health Secretary Sajid Javid recently visited King College Hospital in London and asked the staff about the mandates. Steve James, a consultant anaesthetist who has been treating coronavirus patients since the start of the pandemic replied:

> *"I'm not happy about that," he said. "I had COVID at some point, I've got antibodies, and I've been working on COVID ICU since the beginning .."I have not had a vaccination, I do not want to have a vaccination. The vaccines are reducing transmission only for about eight weeks for Delta, with Omicron it's probably less …And for that, I would be dismissed if I don't have a vaccine? The science isn't strong enough[70]."*

Vaccine Selection Pressure

102. The Government dismisses concerns about vaccine selection pressure to increase the dominance of immune-escape variants and safety concerns from highly credible and independent international doctors, scientists and vaccine developers.

103. The 'Covid-19 Vaccine Surveillance Report – 2022 – Week 1'[71] was published by the U.K. Health Security Agency (formerly Public Health England) on 6 January 2022, and it shows that the vast majority of Covid-19 cases between 6th Dec 21 and 2nd Jan 22 were among the fully vaccinated population (refer page 38).

Suthar, M. S. (2021). Durability of immune responses to the BNT162b2 mRNA vaccine. BioRxiv. https://www.biorxiv.org/content/10.1101/2021.09.30.462488v1

[68] *Tozinameran (BNT162b2) Vaccine: The Journey from Preclinical Research to Clinical Trials and Authorization,* Nimrat Khehra; Inderbir Padda; Urooj Jaferi; Harshan Atwal; Shreya Narain; Mayur S. Parmar (June 7 2021) National Library of Medicine, National Center for Biotechnology Information https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8184133/

[69] https://doi.org/10.1101/2021.12.30.21268565

[70] https://news.sky.com/story/covid-19-sajid-javid-directly-challenged-on-mandatory-coronavirus-jabs-by-unvaccinated-nhs-doctor-12511224

[71] COVID-19 vaccine surveillance report - week 1 (publishing.service.gov.uk)

Table 10. COVID-19 cases by vaccination status between week 49 and week 52 2021
Please note that corresponding rates by vaccination status can be found in Table 13.

Cases reported by specimen date between week 49 and week 52 2021	Total	Unlinked*	Not vaccinated	Received one dose (1 to 20 days before specimen date)	Received one dose, ≥21 days before specimen date	Second dose ≥14 days before specimen date[1]
	[These data should be interpreted with caution. See information below in footnote about the correct interpretation of these figures]					
Under 18	429,155	32,145	308,183	7,104	72,620	9,103
18 to 29	628,127	52,666	102,948	5,532	36,594	430,387
30 to 39	529,948	38,026	75,057	2,973	20,676	393,216
40 to 49	408,892	24,189	35,758	1,206	9,075	338,664
50 to 59	308,585	17,250	17,385	568	4,430	268,952
60 to 69	148,836	8,902	6,419	313	1,659	131,543
70 to 79	70,723	4,297	2,098	116	515	63,697
80 or over	32,314	2,589	1,214	50	395	28,066

104. On 21 January 2021, Stuff reported that more than a third of Covid-19 cases caught at New Zealand's border over the space of one week were unvaccinated or ineligible due to their age, a snapshot of data shows[72]. Meaning over 60% of the cases were vaccinated.

105. A landmark 2004 paper outlying a "phylodynamic" framework to describe the evolution of RNA viruses under epidemic conditions theorises that viral adaptation occurs at the highest rate under intense immune-selection pressure and high infectious pressure[73].

106. Dr Geert Vanden Bossche is an independent vaccine expert and a former academic at universities in Belgium and Germany, who has since served in various R&D and senior program roles at GSK Biologicals, Novartis Vaccines, Solvay Biologicals, Bill & Melinda Gates Foundation and GAVI, has been an outspoken critic of the mass vaccination campaign.

107. Dr Vanden Bossche is warning humanity of the devastating impact of mass vaccination with non-sterilising vaccines on a background of high infectious pressure. On 6 March 2021, Dr Vanden Bossche published an open letter on his website to appeal to the WHO[74] to immediately open the channels for scientific debate and declare a public health emergency of international concern, given the paradigm of mass vaccination ever pressurising the spike protein towards full immune escape. Dr Vanden Bossche has not wavered from his thesis on the folly of the current strategy. Regrettably, his thesis is increasingly being vindicated through the research of molecular and genomic epidemiologists and the number of "breakthrough" cases.

108. Data from California already suggests that fully vaccinated individuals are significantly more likely than unvaccinated (77.6% vs. 47.7%) to be infected with antibody-resistant SARS-CoV-2 variants[75].

109. Dr Chris Martenson interviewed [76] Dr Geert Vanden Bossche in June 2021. In September 2021, Dr Phillip McMillan (U.K.) hosted a meeting between two of the world's prominent voices Geert Vanden Bossche, expert vaccine developer (Belgium) and Robert Malone MD, the inventor of mRNA (USA). Please watch these interviews.

110. Vanden Bossche takes the current Israeli data and shows how the widespread vaccination rate is creating pressure on the virus to mutate into variants with higher levels of contagion. The unvaccinated group has been keeping the pressure down by defeating the virus and carrying natural immunity. However, as the

[72] Covid-19: One third of border cases over one week were unvaccinated | Stuff.co.nz
[73] https://collaborate.princeton.edu/en/publications/unifying-the-epidemiological-and-evolutionary-dynamics-of-pathoge
[74] Open Letter to the WHO: Immediately Halt All Covid-19 Mass Vaccinations-Geert Vanden Bossche, DMV, PhD – Freedom Of Speech (fos-sa.org)
[75] *Area FB, Servellita CV, Morris M-K, et al. Predominance of antibody-resistant SARS-CoV-2 variants in vaccine breakthrough cases from the San Francisco Bay Area, California. medRxiv: the preprint server for health sciences. Published online August 25, 2021. doi:10.1101/2021.08.19.21262139*

[76] https://www.youtube.com/watch?v=cjMZvpmuaKY

unvaccinated population is increasingly made smaller, the pressure on the virus to mutate increases. Subsequently, these mutations stay at higher or more effective levels of infection. The meeting can be watched at: Meeting of the COVID-19 Giants with Geert Vanden Bossche and Robert Malone MD - YouTube

111. Virologist Prof Luc Montagnier, the co-discoverer of HIV and 2008 Nobel Prize Winner in Medicine, stated in a video interview translated and published by the RAIR Foundation U.S.:

> *"It's an enormous mistake, isn't it? A scientific error as well as a medical error. It is an unacceptable mistake... The history books will show that because it is the vaccination that is creating the variants…It is clear that the new variants are created by antibody-mediated selection due to the vaccination…"Many epidemiologists know it and are 'silent' about the problem known as 'antibody-dependent enhancement.[77]"*

Vaccine-associated enhanced disease

112. Vaccine-associated enhanced disease (VAED, also known as AED), including vaccine-associated enhanced respiratory disease (VAERD), is a known risk. With ADE, the vaccines suppress the innate immune response so that the immune system fails to neutralise the viruses as they enter the body instead of allowing them to replicate in the body. The infection is amplified rather than killed off. Moreover, the vaccine primes the immune system for a potentially deadly overreaction known as a "hyperinflammatory response" to subsequent infections. This paradoxical reaction has repeatedly been seen in other vaccines and animal development trials, especially coronavirus vaccine trials[78] (as noted above).

113. According to a recent peer-reviewed article,[79] a study was undertaken to determine if sufficient literature exists to require clinicians to disclose the specific risk that COVID-19 vaccines could worsen disease upon exposure to challenge or circulating virus. The study found:

> *"COVID-19 vaccines designed to elicit neutralising antibodies may sensitise vaccine recipients to more severe disease than if they were not vaccinated. Vaccines for SARS, MERS and RSV have never been approved, and the data generated in the development and testing of these vaccines suggest a serious mechanistic concern: that vaccines designed empirically using the traditional approach (consisting of the unmodified or minimally modified coronavirus viral spike to elicit neutralising antibodies), be they composed of protein, viral vector, DNA or RNA and irrespective of delivery method, may worsen COVID-19 disease via antibody-dependent enhancement (ADE). This risk is sufficiently obscured in clinical trial protocols and consent forms for ongoing COVID-19 vaccine trials that adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials.*

114. In 2020, the New Zealand Ministry of Health Committee noted that:

> *"…low prevalence of COVID infection in New Zealand means that vaccine-associated enhanced disease (VAED) may be less of a risk compared with other countries[80]"*

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[77] Mass vaccination during pandemic a historic blunder: Nobel laureate Luc Montagnier. Zee News. Published May 25, 2021. Accessed September 5, 2021. https://www.msn.com/en-in/news/world/mass-vaccination-during-pandemic-a-historic-blunder-nobel-laureate-luc-montagnier/ar-AAKmnJ

[78] *COVID-19 Vaccines: Should We Fear ADE?* , Scott B Halstead; Leah Katzelnick (12 August 2020) The Journal of Infectious Diseases https://academic.oup.com/jid/article/222/12/1946/5891764

[79] *Informed consent disclosure to vaccine trial subjects of risk of COVID-19 vaccines worsening clinical disease,* Timothy Cardozo; and Ronald Veazey, Department of Biochemistry and Molecular Pharmacology (n.d) https://www.researchgate.net/publication/346464618_Informed_consent_disclosure_to_vaccine_trial_subjects_of_risk_of_COVID-19_vaccines_worsening_clinical_disease/fulltext/5fc3873e458515b79784d097/Informed-consent-disclosure-to-vaccine-trial-subjects-of-risk-of-COVID-19-vaccines-worsening-clinical-disease.pdf?origin=publication_detail

[80] *Minutes Of The Out Of Session Medicines Adverse Reactions Committee Meeting,* Medsafe (20 January 2020) New Zealand Medicines and Medical devices Safety Authority https://www.medsafe.govt.nz/profs/adverse/minutesOoS-20-jan-2021.htm?fbclid=IwAR1ilZ86hJ1doeAZlkfdsirpevhDwlAK0yt0r91Yf2igrXiwnax7qh4FBsk

115. How does this statement hold up now that we are being told that we will have high numbers of cases in New Zealand? BUT ADE does not solely apply to Covid-19 infections. The phenomenon equally applies to any virus that enters the body. It is more than fortuitous that the "worst cold ever" has been reported as sweeping through the U.K.

Alternative Treatments

116. In June 2020, John Ioannidis, a professor of epidemiology and population health at Stanford University, published a paper [81] stating that the *"seroprevalence studies",* which measure infection rates using the presence of antibodies in blood samples, *"typically show a much lower fatality than initially speculated in the earlier days of the pandemic."* The professor concluded that the infection fatality rate (as opposed to the case fatality rate, which is different) for COVID-19 is now estimated to be 0.15% (similar to that of the flu). For people under 70, the IFR is 0.05% and is likely lower in people without serious comorbidities.

117. For most people, the risk of developing COVID-19 and being hospitalised or dying is low. So why is the Government determined to vaccinate and boost a predominantly healthy population rather than use well established early treatment protocols? Why is the Government and the Medical Board sanctioning doctors that use or prescribe these early treatment protocols? Does the Big Pharma contract prevent the promotion of these early treatment protocols in favour of its sales targets?

118. There are numerous alternative safe and effective treatments for COVID-19. These alternative treatments are supported by hundreds of studies, including randomised controlled studies. Treatments such as Ivermectin, Budesonide, Dexamethasone, convalescent plasma and monoclonal antibodies, Vitamin D, Zinc, Azithromycin, Hydroxychloroquine, Colchicine and Remdesivir are being used effectively[82].

119. The Government's Clinical Evaluation[83] (refer V.1) states:

> *Treatment of acute Covid-19 disease has improved, and several medicines are recognised to have a role in treatment.*

120. Dr Peter McCullough stated in an interview with Dr Reiner Fuelmich that 85 percent of the more than 600,000 U.S. deaths could have been prevented with a multi-drug treatment given in the early to mid-point of the disease [84].Dr Peter McCullough's [85] testimony (19 minutes) to the senate looked at the veracity of early treatment protocols can be viewed by copying and pasting the link in the footnotes below. On 19 November 2020, Dr Peter McCullough testified to the senate (2:20:27):

> *"I'm in close communication for this worldwide disaster with many countries, and I can tell you I did a program with Eamonn Mathieson at the Covid Medical Network in Australia to show you how off-kilter the world is. [Webinars: https://www.covidmedicalnetwork.com/webinars/prof-peter-mccullough.aspx EARLY COVID TREATMENTS: Guest Speaker - Prof Peter McCullough MD, Presented by Dr Eamonn Mathieson, Anesthetist, Covid Medical Network, Convenor. 14 Nov 2020 (32:46)] In Queensland, Australia a doctor will be put in jail for prescribing hydroxychloroquine. If you go over to India they're going to give it to you right away. In Greece they're going to give it to you right—it's in their guidelines."*

121. The Association of American Physicians & Surgeons have published a Physician List & Guide to Home-Based Covid Treatment[86].

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[81] https://www.who.int/bulletin/volumes/99/1/20-265892.pdf
[82] Numerous studies can be reviewed here: https://c19early.com
[83] Clinical Evaluation (response documents at www.covid19openletter.co.nz)
[84] Dr. Peter McCullough on with Reiner Fuelmich June 11, 2021 (bitchute.com)
[85] https://www.youtube.com/watch?v=QAHi3lX3oGM
[86] Physician List & Guide to Home-Based COVID Treatment - AAPS | Association of American Physicians and Surgeons (aapsonline.org)

122. On 17 June 2021, the American Journal of Therapeutics [87] published a peer-reviewed meta-analysis of 15 trials that found that ivermectin reduced the risk of death compared with no ivermectin. The study found that ivermectin probably reduced deaths by 62% and possible transmission by 86%.

123. Dr Lawrie (one of the authors of the meta-analysis) has also sent numerous letters with evidence to Matt Hancock and the U.K. Government regarding ivermectin and COVID 19[88]. She and others have started a non-for-profit organisation with the 1st International Ivermectin for Covid Conference.

124. In addition, a recent peer-reviewed study by Dr Pierre Kory and colleagues on ivermectin has been published in the American Journal of Therapeutics [89]. The study summarises the evidence base for the use of ivermectin and concludes that:

> *"Meta-analyses based on 18 randomised controlled treatment trials of ivermectin in COVID have found large, statistically significant reductions in mortality, time to clinical recovery, and time to viral clearance. Furthermore, results from numerous controlled prophylaxis trials report significantly reduced risks of contracting COVID with the regular use of ivermectin. Finally, the many examples of ivermectin distribution campaigns leading to rapid population-wide decreases in morbidity and mortality indicate that an oral agent effective in all phases of COVID has been identified."*

125. Uttar Pradesh, India, announced that the state is COVID-19 free after using early treatment protocols.[90]. This state will have an estimated population of 241 million people in 2021 and has the highest population in India. This population is almost two-thirds of the United States population in 2021, yet it is now a COVID-19 free nation.

126. The Gauteng High Court [91], Pretoria, has recently issued an order allowing for medicine that contained ivermectin as an active ingredient to be used to treat Covid-19 if prescribed by a doctor.

127. The Indian Bar Association is officially suing the WHO's chief scientist for spreading misinformation about ivermectin[92].

128. Hydroxychloroquine became a political controversy last year when former President Donald Trump touted it to cure COVID. However, experts are reporting that politics have cost and is costing lives. A study published by Dr Peter McCullough in January 2021 in the American Journal of Medicine found that early treatment of coronavirus patients with hydroxychloroquine lowered the mortality rate for the disease. Refer above for the link to his paper.

129. Dr Emanuel Garcia[93] has stated:

> *"Where is the emphasis on treating this? On finding a cure, on finding a mitigating agent [for covid]... There are some very effective treatments & preventative measures."*
> *"I was astonished to find out what the Lancet did with Hydroxychloroquine. They published an article slamming it, talking about all the dangers & then they retracted it because it was complete propaganda. It could have saved a lot of lives."*

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[87] https://journals.lww.com/americantherapeutics/Abstract/9000/Ivermectin_for_Prevention_and_Treatment_of.98040.aspx
[88] http://medisolve.org/yellowcard_urgentprelimreport.pdf
[89] https://journals.lww.com/americantherapeutics/Fulltext/2021/00000/Review_of_the_Emerging_Evidence_Demonstrating_the.4.aspx
[90] HUGE: Uttar Pradesh, India Announces State Is COVID-19 Free Proving the Effectiveness of "Deworming Drug" IVERMECTIN (thegatewaypundit.com)
[91] Doctors can now prescribe ivermectin as treatment for Covid-19 (iol.co.za)
[92] Legal-Notice-to-Dr.-Soumya-Swaminathan_Chief-Scientist-WHO-1.pdf and Sync.com - Legal-Notice-to-Dr.-Soumya-Swaminathan_Chief-Scientist-WHO-1.pdf and WHO Celebrates As Indian Health Regulator Removes Ivermectin From Its COVID Protocol | ZeroHedge and VERMECTIN - The COVID Blog

[93] Dr Emanuel Garcia On The Abrogation Of Human Liberties & A Delusional Belief In Vaccines As Saviour (odysee.com)

130. Vitamin D is known to help people with COVID-19. The Journal of Clinical Endocrinology & Metabolism [94] reported on 17 June 2021 that vitamin D deficiency is associated with higher hospitalisation risk from COVID.

The Narrative, Goal Posts and Rules

131. The Government continues to change the narrative and move the goal posts.

132. In 2020 the Government narrative was structured on the following points:

(a) The death rate was going to be devastating in New Zealand. On 27 February 2020, Mr Bloomfield received a report from Mr Baker and his colleagues from the University of Otago Wellington COVID-19 Response Group (UOWCRG) in which they "estimate[d] likely deaths to be between 12,600 and 33,600, which Bloomfield "thought was likely an underestimation", despite 33,600 or 0.67% of the N.Z. population equating to over 52 million deaths worldwide[95]";

(b) A national emergency was declared, and the "team of 5 million" needed to "go hard, go early" and "two weeks to flatten the curve;

(c) "There is no need to wear a mask" and "masks are useless" but "wash your hands";

(d) "be kind" and "we are all in this together";

(e) "vaccines will not be compulsory".

133. In 2021 the Government flipped the narrative, and face coverings (including cloth coverings) are mandated, vaccines are mandated, vaccine passports are mandated, and Ms Ardern gleefully admits on camera that she is creating a segregated society.

134. Almost two years on from the modelling, which terrified a nation, there have been 52 deaths in New Zealand and approximately 5,500,000 deaths around the world. The numbers of deaths are questionable (as set out later in this letter), but the economic and social destruction is undeniable.

135. Should vaccine be mandatory when you still need a booster to maintain your fully vaccinated status and freedoms? When you still need to be tested despite being fully vaccinated. When do you still need to wear a mask after being fully vaccinated? We you still transmit, get infected and may end up in hospital despite being fully vaccinated?

136. Why are there rules for some but not for others?

137. As you are aware, the vaccinated British DJ brought Omicron into New Zealand as he did not follow the protocols. It is beyond belief that the vaccinated British DJ did not face charges. Yet New Zealanders that attended freedom protests (especially during level 2) causing no harm to our communities are arrested and face jail time.

138. A quick scan of the Gazette Notices for November and December 2021 shows the following exemptions granted:

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[94] Vitamin D deficiency is associated with higher hospitalisation risk from COVID-19: a retrospective case-control study | The Journal of Clinical Endocrinology & Metabolism | Oxford Academic (oup.com)

[95] Lucy Barnard, Nick Wilson, Amanda Kvalsvig, Michael Baker, "Modelled Estimates for the Spread and Health Impact of Covid-19 in New Zealand: Revised Preliminary Report for the NZ Ministry of Health", University of Otago Wellington (27 February 2020), 1, 5, 11, 12: https://www.health.govt.nz/publication/covid-19-modelling-reports; Bloomfield, Affidavit (13 Jul 20), 101.4.

(a) Class Exemption for New Zealand Based Aircrew on Jetconnect Limited Flights Traveling From Auckland to Los Angeles From Requirements of the COVID-19 Public Health Response (Air Border) Order (No 2) 2020[96];
(b) Exemption of Bangladesh Men's Cricket Team From Requirements of the COVID-19 Public Health Response (Isolation and Quarantine) Order 2020[97];
(c) Exemption of New Zealand Black Caps Cricket Team From Requirements of the COVID-19 Public Health Response (Isolation and Quarantine) Order 2020[98];
(d) Exemption for the crew on board the United States Coast Guard Cutter (USCGC) Polar Star[99].

139. Interestingly, I note that the Police have recently been exempted from Health and Safety in the Workplace for Gases under Pressure[100]. Please could you explain what the intention of this exemption is? Perhaps tear gas for protests as Ms Ardern's pushes her segregated society?

The World Economic Forum and Agenda 2030

140. The World Economic Forum ("**WEF**") has been involved in the strategic management of the coronavirus pandemic, with a major emphasis on using the pandemic as a catalyst for digital transformation and the global introduction of digital identity systems.

141. Klaus Schwab, the founder and executive chairman of the WEF, is the champion of the Fourth Industrial Revolution (also referred to as the Great Reset and Agenda 2030). Schwab states:

> *"The Fourth Industrial Revolution, as I wrote in the book four years ago when I coined the expression, many of those technologies just look at facial recognition, just look at the technologies which you need for tracking people. What we are seeing now with some of the companies engaged into research for vaccines using completely new methods based on synthetic biology. A tremendous challenge we have in creating this Great Reset".*

142. Ms Ardern is committed to creating the Great Reset. She told the audience at an event arranged by Goalkeepers in 2019, an organisation set up by the Gates Foundation, that:

> *"…my Government is doing something not many other countries have tried. We have incorporated the principles of the 2030 Agenda into our domestic policy-making in a way that we hope will drive system-level actions… I believe that the change in approach that we have adopted in New Zealand is needed at a global scale…[101]"*

143. Ms Ardern, the former President of the International Union of Socialist Youth and a frequent user of the word "comrade" [102], has been connected with Klaus Schwab and the WEF for many years. It would seem that Ms Ardern also has some other interesting connections, as discussed in this OIA request Final-Open-Letter-to-Jacinda-Ardern-PDF-1.pdf(Shared)- Adobe Document Cloud. Please could you provide me with the response to this OIA request?

144. In 1992, Klaus Schwab established a parallel institution to the WEF, the Global Leaders for Tomorrow school, which was re-established as the Young Global Leaders in 2004. Members of the school's very first class in 1992 already included many who went on to become important political figures, such as Angela Merkel, Nicolas Sarkozy, and Tony Blair (who Ms Ardern worked for in the U.K.[103]). Ms Ardern is on the alumni list, and in 2014 she was picked as one of 200 Young Global Leaders by the WEF.

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[96] https://gazette.govt.nz/notice/id/2021-go5362

[97] https://gazette.govt.nz/notice/id/2021-go5164
[98] https://gazette.govt.nz/notice/id/2021-go5165
[99] https://gazette.govt.nz/notice/id/2021-go5480

[100] https://gazette.govt.nz/notice/id/2021-au5511
[101] https://youtu.be/1XsUV7pwSRg
[102] https://youtu.be/ZSMYa-JOwKg
[103] https://www.youtube.com/watch?v=3kcWHiTehF8

145. Not only political figures went through the programme but many that have risen to influence, such as Mark Zuckerberg[104], Jeffrey Zients (US White House Coronavirus Response Coordinator since 2021, selected in 2003), Jeremy Howard (founder of influential lobby group "masks for all"), Leana Wen (zero-covid CNN medical analyst), Eric Feigl-Ding (zero-covid Twitter personality), Gavin Newsom (Governor of California, selected in 2005), Devi Sridhar (British zero-covid professor) and numerous executives at Blackrock and Goldman Sachs, two of the world's largest investment firms.

146. Ms Ardern is also a member of the WEF[105] and has attended meetings at Davos. On 23 November 2020, the Office for the Prime Minister received a copy of the book "*Covid-19 – The Great Reset*" from Klaus Schwab himself (he is also one of the authors), and on 3 February 2021, the Office of the Prime Minister received a copy of the book "*Stakeholder Capitalism*" also from Klaus Schwab[106].

147. Interestingly, in 2016 the WEF made the following predictions for 2030[107] :

(a) All products will become services. "*You will own nothing. And you'll be happy*". This includes everything from your home down to what you wear via digital passports[108]. Whatever you want, you'll rent. And it'll be delivered by drone.

(b) The U.S. won't be the world's leading superpower. A handful of countries will dominate.

(c) You won't die waiting for an organ donor. Organs will be 3-D printed. Klaus Schwab made the following statements in "Shaping the Fourth Industrial Revolution.

Section 1 The Fourth Industrial Revolution – Chapter 2

"Fourth Industrial Revolution technologies will not stop at becoming part of the physical world around us—they will become part of us. Indeed, some of us already feel that our smartphones have become an extension of ourselves. Today's external devices—from wearable computers to virtual reality headsets—will almost certainly become implantable in our bodies and brains. Exoskeletons and prosthetics will increase our physical power, while advances in neurotechnology enhance our cognitive abilities. We will become better able to manipulate our own genes, and those of our children. These developments raise profound questions: Where do we draw "the line between human and machine? What does it mean to be human?"

Section 2.3 Altering the Human Being – Chapter 11

The future will challenge our understanding of what it means to be human, from both a biological and a social standpoint. Emerging biotechnology agendas promise to improve and augment human lifespans and to enhance physical and mental health. The opportunity for the integration of digital technologies with biological tissues is also growing, and what that portends for the next decades is inspiring a range of emotions, from hope to wonder to fear."

These technologies will operate within our own biology and change how we interface with the world. They are capable of crossing the boundaries of body and mind, enhancing our physical abilities, and even having a lasting impact on life itself. They are more than mere tools and demand special "consideration for their ability to augment or intrude upon human beings, human behaviors and human rights."

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104 https://www.younggloballeaders.org/community?utf8=%E2%9C%93&q=zuckerberg&x=0&y=0&status=&class_year=&sector=&region=
105 https://www.weforum.org/people/jacinda-ardern
106 https://fyi.org.nz/request/16378/response/62394/attach/3/03.09.2021%20Letter%20to%20Benseman%20PMO%202021%20180.pdf
107 https://www.bitchute.com/video/kTNQ31tG0VAp/
108 https://www.weforum.org/agenda/2021/05/tracking-fashion-clothes-sustainable/

(d) You will eat much less meat (but more of Bill Gate's bugs[109]).
(e) A billion people will be displaced by climate change.
(f) Polluters will have to pay to emit carbon dioxide.
(g) You could be preparing to go to Mars.
(h) Western values will have been tested to the breaking point.

148. Last year, the WEF[110] released its idea of a 15-minute city after the world experienced lockdowns. Digital vaccine passports have been introduced, and many have been programmed to accept track and trace. Zuckerberg has launched Meta to bring "*3D spaces in the metaverse will let you socialise, learn, collaborate and play in ways that go beyond what we can imagine*[111]".

149. Given Klaus Schwab's comments in regards to the need to track people for the Great Reset and Ms Ardern's commitment to Agenda 2030, it is easy to see how an extension of the vaccine passport in a few simple steps will see a totalitarian New Zealand. I note that the Government is also trying to bring in a digital currency and the Digital Identity Services Trust Framework Bill.

150. Microchips implanted in a human arm to scan for COVID-19 and provide your vaccine status are just a conspiracy theory, right(just as vaccine passports were a conspiracy theory not so long ago)? Well, not according to the Pentagon[112] and microchip technology start-up Epicentre[113]. Klaus Schwab made the following statement in "Shaping the Fourth Industrial Revolution.

Chapter 5 – New Computing Technologies

> *"External wearable devices, such as smart watches, intelligent earbuds and augmented reality glasses, are giving way to active implantable microchips that break the skin barrier of our bodies, creating intriguing possibilities that range from integrated treatment systems to opportunities for human enhancement…Biological computing could soon allow us to replace specialised microchips with custom-designed organisms, a key aspect of a new cultural form of expression and consumption called "biohacking."*

151. Klaus Schwab has also stated:

> *"People assume that we are just going back to the good old world which we had and everything will be normal again. This is, let's say, fiction. It will not happen. The cut which we have now is much too strong in order not to leave traces. We know that the world will look differently. There will be a lot of anger. We have to prepare for a more angry world. Social revolution. Anger on the streets. We are at a rapture point terminating of human kind"*

152. As noted above, Ms Ardern wishes to create a segregated society where the unvaccinated will not enjoy freedoms and face financial hardship. Strangely, Ms Ardern's fellow WEF members (she is a member) are also set on dividing society and creating an angry world. Justin Trudeau is also set to divide society by stating that unvaccinated persons who were hesitant about an experimental medical treatment were likely to be misogynists and racists, and Emmanuel Macron said unvaccinated people were irresponsible and as such were not citizens, and he wanted to make those citizens lives as unbearable as possible.

153. The WEF's Great Reset website can be viewed at https://www.weforum.org/great-reset, which sets out how Covid-19 has presented an:

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[109] https://www.weforum.org/agenda/2019/09/sustainable-food-alternative-proteins/
[110] https://www.weforum.org/agenda/2021/11/15minute-city-falls-short/
[111] https://about.facebook.com/meta/

[112] https://www.thesun.co.uk/news/14623566/pentagon-microchip-skin-detects-covid-before-symptoms/
[113] Tech firm develops microchip that can be implanted in your arm to track Covid vaccine status with just a cell phone scan (the-sun.com)

"unique window of opportunity to shape the recovery [from the Pandemic], this initiative will offer insights to help inform all those determining the future state of global relations, the direction of national economies, the priorities of societies, the nature of business models and the management of a global commons."

154. Steve Levitsky once wrote:

"One of the great ironies of how democracies die is that the very defense of democracy is often used as a pretext for its subversion," he wrote. "Would-be autocrats often use economic crises, natural disasters, and especially security threats—wars, armed insurgencies, or terrorist attacks—to justify antidemocratic measures."

155. Why are we being forced to be repeatedly "*jabbed*" with an experimental vaccine in exchange for the reward of a vaccine passport? This is a digital I.D. Will vaccine passports be extended to control every aspect of our lives? Will cash be cancelled? The ability to enter a supermarket and buy food? To get on a bus or train? Moving further than a short distance from our homes? No passport, no access to our own lives?

156. We seem to be standing on the knifes edge of democracy. *Blackrock's CEO, Larry Fink, stated that "Markets like Totalitarian Governments"*[114]. Will you support Big Pharma and the WEF? Both of which are de facto controlled by Vanguard (the largest shareholder in Blackrock) and Blackrock (the world's largest asset manager)[115][116] , or will you serve "us the people"?

Yours sincerely

Kirsten Murfitt

[114] https://youtu.be/MFVecfbffUE
[115] https://www.weforum.org/organizations/blackrock-inc
[116] https://fintel.io/so/us/pfe/blackrock

Schedule 1

MOH Letter re Transmission

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

10 September 2021

Josephine Marsden

By email: josephinemarsden10@gmail.com
Ref: H202110912

Tēnā koe Josephine

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to the Ministry of Health (the Ministry) on 22 August 2021 for:

> *"copies of all Pfizer Vaccine studies and Pfizer Vaccine trials that relate to the demonstration of the efficacy of the vaccine in reducing the transmission of Covid-19 in the community."*

Reducing transmission was not an outcome measured in trials of the Pfizer vaccine. Therefore, your request is refused under section 18(g)(i) as the information requested is not held by the Ministry of Health and there are no grounds for believing it is held by another agency subject to the Act.

Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Ministry website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

Nick Allan
Manager OIA Services
Office of the Director-General

Schedule 2

Recent Studies on Transmission and Viral Load

1. A summary of the recent studies on transmission is set out below.

2. The Lancet Regional Health Europe[i] published on 19 November 2021 the following statements:
   "Recent data, however, indicate that the epidemiological relevance of COVID-19 vaccinated individuals is increasing. In the U.K. it was described that secondary attack rates among household contacts exposed to fully vaccinated index cases was similar to household contacts exposed to unvaccinated index cases (25% for vaccinated vs 23% for unvaccinated)."

3. A recent preprint study[ii] reviewed the viral load of SARS-CoV-2 in swab specimens from 36 counties in Wisconsin. There was effectively no difference between the symptomatic vaccinated and unvaccinated in terms of who was carrying and spreading the virus. The asymptomatic vaccinated individuals had a higher percentage with a high viral load.

4. A study published in The Lancet[iii] found that:
   "fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts".

5. The CDC[iv] study of an outbreak in Barnstable County, Massachusetts, found that 74% of those infected were fully vaccinated for Covid-19 and that the vaccinated had on average more virus in their nose than the unvaccinated who were infected.

6. A Tel-Aviv University[v] study of a SARS-CoV-2 outbreak among 42 patients in a hospital setting PPE, 39 were fully vaccinated. The authors wrote that this *"outbreak exemplifies the high transmissibility of the SARS-CoV-2 Delta variant among twice vaccinated and masked individuals."*

7. Data from Public Health England[vi] collected between mid-September to mid-November for the vaccinated confirms that case rates for all age groups between 0-79 years have increased at a greater rate (31 to 42%) than unvaccinated rates (-7% to 25%).

8. Requiring the segregation of residents for protection is a paradox. There is no evidence that segregation prevents transmission. A vaccinated person is equally—if not more—likely to transmit the virus as a non-vaccinated person.

9. The vaccine is leaky and has resulted in significant numbers of *`breakthrough cases'*. The constant scapegoating of the unvaccinated does not stand up to scrutiny or evidence and is entirely unwarranted. The term "unvaccinated" should not be conflated with "infectious".

10. The CDC data shows that the vaccines are ineffective in treating or preventing SARS-CoV-2 or COVID-19. Deaths from COVID-19 in those who have received the recommended dosages of the vaccines increased from 160 as of April 30, 2021, to 535 as of June 1, 2021. Further, a total of 10,262 SARS-CoV-2 *"breakthrough infections"* of those who had already received the full recommended dosage of the vaccines.

11. The administration did not like this emerging trend. As of 1 May 2021, the CDC changed its policy and stopped reporting weekly COVID-19 "breakthrough infections" unless they resulted in hospitalisation or death.

12. I draw attention to one of the latest studies in The Lancet. The peer-reviewed prospective observational study of 1,072,313 patients, the U.K. group, was unable to tell the difference between vaccine effects and COVID-

19[vii]. In addition, it was reported by Reuters on 11 December 2021 that most of the U.S Omicron cases have hit the fully vaccinated[viii].

Refer to the endnotes for references.

Schedule 3

Safety Data Sheet

SAFETY DATA SHEET

Revision date 19-Mar-2021 Version 2 Page 1 / 12

Section 1: IDENTIFICATION OF THE SUBSTANCE/MIXTURE AND OF THE COMPANY/UNDERTAKING

1.1. Product identifier

Product Name Pfizer-BioNTech COVID-19 Vaccine

Product Code(s) PF00092
Form nanoform
Synonyms Comirnaty; PF-07302048 containing PF-07305885 (BNT162b2); CorVAC Containing PF-07305885 (BNT162b2) ; CoVVAC Containing PF-07305885 (BNT162b2); COVID Vaccine Containing PF-07305885 (BNT162b2); COVID-19 Vaccine Containing PF-07305885 (BNT162b2)
Trade Name: Not applicable
Compound Number PF-07302048
Item Code H000022941: H000023057;H000024547: H000024742
Chemical Family: Lipid Nanoparticles containing PF-07305885 (BNT162b2) and Lipids

1.2. Relevant identified uses of the substance or mixture and uses advised against

Recommended Use Pharmaceutical product

1.3. Details of the supplier of the safety data sheet

Pfizer Inc
235 East 42nd Street
New York, New York 10017
1-800-879-3477

Pfizer Ireland Pharmaceuticals
OSG Building
Ringaskiddy, Co. Cork.
Ireland
+353 21 4378701

1.4. Emergency telephone number

Emergency Telephone Chemtrec 1-800-424-9300 International Chemtrec (24 hours):+1-703-527-3887
E-mail address pfizer-MSDS@pfizer.com

Section 2: HAZARDS IDENTIFICATION

2.1. Classification of the substance or mixture

Not classified as hazardous

2.2. Label elements

Signal word Not classified

Hazard statements Not classified in accordance with international standards for workplace safety.

2.3. Other hazards

Other hazards An Occupational Exposure Value has been established for one or more of the ingredients (see Section 8).

Note: This document has been prepared in accordance with standards for workplace safety, which require the inclusion of all known hazards of the product or its ingredients regardless

of the potential risk. The precautionary statements and warnings included may not apply in all cases. Your needs may vary depending upon the potential for exposure in your workplace.

Section 3: COMPOSITION/INFORMATION ON INGREDIENTS

3.1 Substances

Substances Not applicable

3.2 Mixtures

Hazardous

Chemical name	Weight-%	REACH Registration Number	EC No	Classification according to Regulation (EC) No. 1272/2008 [CLP]	Specific concentration limit (SCL)	M-Factor	M-Factor (long-term)
Sucrose 57-50-1	< 10		200-334-9	No data available	Not Listed	No data available	No data available
SODIUM CHLORIDE 7647-14-5	< 10		231-598-3	No data available	Not Listed	No data available	No data available
Potassium phosphate 7778-77-0	< 1		231-913-4	No data available	Not Listed	No data available	No data available
POTASSIUM CHLORIDE 7447-40-7	< 1		231-211-8	No data available	Not Listed	No data available	No data available

NonHazardous

Chemical name	Weight-%	REACH Registration Number	EC No	Classification according to Regulation (EC) No. 1272/2008 [CLP]	Specific concentration limit (SCL)	M-Factor	M-Factor (long-term)
Water 7732-18-5	*		231-791-2	No data available	Not Listed	No data available	No data available
ALC-0315 2036272-55-4	< 2		Not Listed	No data available	Not Listed	No data available	No data available
PF-07305885 -	<1		Not Listed	No data available	Not Listed	No data available	No data available
PF-07302048 -	< 1		Not Listed	No data available	Not Listed	No data available	No data available
PEGA / ALC-0159 -	< 1		Not Listed	No data available	Not Listed	No data available	No data available
Disodium phosphate dihydrate 10028-24-7	< 1		Not Listed	No data available	Not Listed	No data available	No data available
Cholesterol 57-88-5	< 1		200-353-2	No data available	Not Listed	No data available	No data available
1,2-Distearoyl-sn-glycero-3-phosphocholine 816-94-4	< 1		212-440-2	No data available	Not Listed	No data available	No data available

Full text of H- and EUH-phrases: see section 16

Acute Toxicity Estimate

Chemical name	Oral LD50	Dermal LD50	Inhalation LC50 - 4 hour - dust/mist - mg/L	Inhalation LC50 - 4 hour - vapor - mg/L	Inhalation LC50 - 4 hour - gas - ppm
Water 7732-18-5	89838.9	No data available	No data available	No data available	No data available
Sucrose 57-50-1	29700	No data available	No data available	No data available	No data available
SODIUM CHLORIDE 7647-14-5	3000	10000	No data available	No data available	No data available
Potassium phosphate 7778-77-0	3200	No data available	No data available	No data available	No data available
POTASSIUM CHLORIDE 7447-40-7	2600	No data available	No data available	No data available	No data available
Cholesterol 57-88-5	No data available	2000	No data available	No data available	No data available

Additional information

- Not Assigned
* Proprietary
Non-hazardous ingredients provided for completeness. Ingredient(s) indicated as hazardous have been assessed under standards for workplace safety. In accordance with 29 CFR 1910.1200, the exact percentage composition of this mixture has been withheld as a trade secret.

Section 4: FIRST AID MEASURES

4.1. Description of first aid measures

Inhalation Remove to fresh air. Seek immediate medical attention/advice.

Eye contact Rinse thoroughly with plenty of water for at least 15 minutes, lifting lower and upper eyelids. Consult a physician.

Skin contact Remove contaminated clothing. Flush area with large amounts of water. Use soap. Seek medical attention.

Ingestion Never give anything by mouth to an unconscious person. Wash out mouth with water. Do not induce vomiting unless directed by medical personnel. Seek medical attention immediately.

4.2. Most important symptoms and effects, both acute and delayed

Most important symptoms and effects No data available

4.3. Indication of any immediate medical attention and special treatment needed

Note to physicians None.

Section 5: FIRE-FIGHTING MEASURES

5.1. Extinguishing media

Suitable Extinguishing Media Dry chemical, CO2, alcohol-resistant foam or water spray.

5.2. Special hazards arising from the substance or mixture

Specific hazards arising from the chemical	Fine particles (such as mists) may fuel fires/explosions.
Hazardous combustion products	Formation of toxic gases is possible during heating or fire.

5.3. Advice for firefighters

Special protective equipment for fire-fighters	Firefighters should wear self-contained breathing apparatus and full firefighting turnout gear. Use personal protection equipment.

Section 6: ACCIDENTAL RELEASE MEASURES

6.1. Personal precautions, protective equipment and emergency procedures

Personal precautions	Personnel involved in clean-up should wear appropriate personal protective equipment (see Section 8). Minimize exposure.
For emergency responders	Use personal protection recommended in Section 8.

6.2. Environmental precautions

Environmental precautions	Place waste in an appropriately labeled, sealed container for disposal. Care should be taken to avoid environmental release.

6.3. Methods and material for containment and cleaning up

Methods for containment	Prevent further leakage or spillage if safe to do so.
Methods for cleaning up	Contain the source of spill if it is safe to do so. Collect spill with absorbent material. Clean spill area thoroughly.
Prevention of secondary hazards	Clean contaminated objects and areas thoroughly observing environmental regulations.

6.4. Reference to other sections

Reference to other sections	See section 8 for more information. See section 13 for more information.

Section 7: HANDLING AND STORAGE

7.1. Precautions for safe handling

Advice on safe handling
Restrict access to work area. No open handling permitted. Minimize generating airborne mists and vapors. If solvent based liquid, ground and bond all bulk transfer equipment. Use appropriate engineering controls to maintain exposures below the B-OEB taking all applicable routes of exposure into consideration. A change area to facilitate 'good laboratory/manufacturing' decontamination practices is recommended. Avoid inhalation and contact with skin, eye, and clothing. When handling, use appropriate personal protective equipment (see Section 8). Wash hands and any exposed skin after removal of PPE. Releases to the environment should be avoided. Review and implement appropriate technical and procedural waste water and waste disposal measures to prevent occupational exposure or environmental releases. Potential points of process emissions of this material to the atmosphere should be controlled with dust collectors, HEPA filtration systems or other equivalent controls.

General hygiene considerations	Handle in accordance with good industrial hygiene and safety practice.

7.2. Conditions for safe storage, including any incompatibilities

Storage Conditions	Store at < -70 °C in properly labeled containers. Keep away from heat, sparks, and flames.

7.3. Specific end use(s)

Specific use(s)	Vaccine.

Section 8: EXPOSURE CONTROLS/PERSONAL PROTECTION

8.1. Control parameters

Exposure Limits
Refer to available public information for specific member state Occupational Exposure Limits.

Sucrose	
ACGIH TLV	10 mg/m³
Bulgaria	10.0 mg/m³
Estonia	10 mg/m³
France	10 mg/m³
Ireland	10 mg/m³ STEL: 20 mg/m³
Latvia	5 mg/m³
Spain	10 mg/m³
OSHA PEL	15 mg/m³ 5 mg/m³ (vacated) TWA: 15 mg/m³ total dust (vacated) TWA: 5 mg/m³ respirable fraction
United Kingdom	TWA: 10 mg/m³ STEL: 20 mg/m³
SODIUM CHLORIDE	
Latvia	5 mg/m³
Russia	MAC: 5 mg/m³
Potassium phosphate	
Russia	MAC: 10 mg/m³
POTASSIUM CHLORIDE	
Bulgaria	5.0 mg/m³
Latvia	5 mg/m³
Russia	MAC: 5 mg/m³

Pfizer OEB Statement: The Biotherapeutic Occupational Exposure Band (B-OEB) is an acceptable daily intake (ADI) range, based on available hazard data with appropriate safety factors applied. Engineering control measures should be utilized to bring exposures into the relevant B-OEB; supplementary administrative controls and personal protective equipment are to be used to achieve exposure control to the bottom of the band.

SODIUM CHLORIDE	
Pfizer Occupational Exposure Band (OEB):	OEB 1 (control exposure to the range of 1000ug/m³ to 3000ug/m³)
ALC-0315	
Pfizer Occupational Exposure Band (OEB):	OEB 3 - Contact Hazards Unknown (control exposure to the range of 10ug/m³ to < 100ug/m³)
POTASSIUM CHLORIDE	
Pfizer Occupational Exposure Band (OEB):	OEB 1 (control exposure to the range of 1000ug/m³ to 3000ug/m³)
PF-07305885	
Pfizer Occupational Exposure Band (OEB):	B-OEB Default (control exposure to the range of 10 µg/day to <100 µg/day)
PF-07302048	
Pfizer Occupational Exposure Band (OEB):	B-OEB 5 (control exposure to <10 µg/day)

8.2. Exposure controls

Engineering controls Engineering controls should be used as the primary means to control exposures. Use process containment, local exhaust ventilation, biosafety cabinet, or other engineering controls to maintain airborne levels within the B-OEB range. It is recommended that all large scale operations should be fully enclosed. Air recirculation is not recommended.

Environmental exposure controls	No information available.
Personal protective equipment	Contact your safety and health professional or safety equipment supplier for assistance in selecting the correct protective clothing/equipment based on an assessment of the workplace conditions, other chemicals used or present in the workplace and specific operational processes. Refer to applicable national standards and regulations in the selection and use of personal protective equipment (PPE).
Eye/face protection	Wear safety glasses as minimum protection (goggles recommended). (Eye protection must meet the standards in accordance with EN166, ANSI Z87.1 or international equivalent.).
Hand protection	Wear impervious disposable gloves (e.g. Nitrile, etc.) as minimum protection (double recommended). (Protective gloves must meet the standards in accordance with EN374, ASTM F1001 or international equivalent.).
Skin and body protection	Wear impervious disposable protective clothing when handling this compound. Full body protection is recommended (scale dependent). Wear impervious protective clothing when handling this compound. (Protective clothing must meet the standards in accordance with EN13982, ANSI 103 or international equivalent.).
Respiratory protection	Under normal conditions of use, if the applicable Biotherapeutic Occupational Exposure Band (B-OEB) is exceeded, wear an appropriate respirator with a protection factor sufficient to control exposures to below the B-OEB (e.g. particulate respirator with a full mask, P3 filter). (Respirators must meet the standards in accordance with EN136, EN143, ASTM F2704-10 or international equivalent.).
General hygiene considerations	Handle in accordance with good industrial hygiene and safety practice.

Section 9: PHYSICAL AND CHEMICAL PROPERTIES

9.1. Information on basic physical and chemical properties

Physical state	Liquid
Color	milky white
Odor	No information available.
Odor threshold	No information available
Molecular formula	Mixture
Molecular weight	Mixture

Property	**Values**
pH	7.4
Melting point / freezing point	No data available
Boiling point / boiling range	
Flash point	No information available
Evaporation rate	No data available
Flammability (solid, gas)	No data available
Flammability Limit in Air	
Upper flammability limit:	No data available
Lower flammability limit:	No data available
Vapor pressure	No data available
Vapor density	No data available
Relative density	No data available
Water solubility	No data available
Solubility(ies)	No data available
Partition coefficient	No data available
Autoignition temperature	No data available

Decomposition temperature	No data available
Kinematic viscosity	No data available
Dynamic viscosity	No data available
Particle characteristics	
Particle Size	No information available
Particle Size Distribution	No information available
Explosive properties	No information available

9.2. Other information
No information available

9.2.1. Information with regard to physical hazard classes
No information available

9.2.2. Other safety characteristics
No information available

Section 10: STABILITY AND REACTIVITY

10.1. Reactivity
Reactivity No data available.

10.2. Chemical stability
Stability Stable under normal conditions.

Explosion data
Sensitivity to Mechanical Impact No data available.
Sensitivity to Static Discharge No data available.

10.3. Possibility of hazardous reactions
Possibility of hazardous reactions No information available.

10.4. Conditions to avoid
Conditions to avoid Fine particles (such as mists) may fuel fires/explosions. As a precautionary measure, keep away from heat sources and electrostatic discharge.

10.5. Incompatible materials
Incompatible materials As a precautionary measure, keep away from strong oxidizers.

10.6. Hazardous decomposition products
Hazardous decomposition products No data available.

Section 11: TOXICOLOGICAL INFORMATION

11.1. Information on hazard classes as defined in Regulation (EC) No 1272/2008

General Information: Toxicological properties have not been thoroughly investigated. The following information is available for the individual ingredients.

Known Clinical Effects: Based on clinical trials in humans, possible adverse effects following intravenous exposure to this compound may include: injection site pain, muscle pain, headache, fever, chills, tiredness, joint pain, abnormal redness of skin (erythema), and sleep disturbances. Serious allergic reactions, including anaphylaxis, have been reported.

Acute Toxicity: (Species, Route, End Point, Dose)
Sucrose
Rat Oral LD 50 29,700 mg/kg

SODIUM CHLORIDE
Rat Sub-tenon injection (eye) LC50/1hr > 42 g/m³
Rat Oral LD 50 3 g/kg

Mouse Oral LD 50 4 g/kg
Rabbit Dermal LD 50 > 10 g/kg

POTASSIUM CHLORIDE
Rat Oral LD50 2600 mg/kg

Potassium phosphate
Rat Oral LD50 3200 mg/kg
Rabbit Dermal LC50 > 4640 mg/kg

Chemical name	Oral LD50	Dermal LD50	Inhalation LC50
Water	> 90 mL/kg (Rat)	-	-
Sucrose	= 29700 mg/kg (Rat)	-	-
SODIUM CHLORIDE	= 3 g/kg (Rat)	> 10000 mg/kg (Rabbit)	> 42 g/m³ (Rat) 1 h
Potassium phosphate	= 3200 mg/kg (Rat)	-	-
POTASSIUM CHLORIDE	= 2600 mg/kg (Rat)	-	-
Cholesterol		> 2000 mg/kg (Rat)	-

Irritation / Sensitization: (Study Type, Species, Severity)
SODIUM CHLORIDE
Skin irritation Rabbit Mild
Eye irritation Rabbit Mild
POTASSIUM CHLORIDE
Eye Irritation Rabbit Mild

Repeated Dose Toxicity: (Duration, Species, Route, Dose, End Point, Target Organ)
PF-07302048
4 Week(s) Rat Intramuscular * 10 µg LOAEL Skin, Blood forming organs, Blood, Skeletal muscle, Lymphoid tissue, Spleen
Repeated Dose Toxicity Comments: PF-07302048: * Doses were administered once a week.

Reproduction & Development Toxicity: (Duration, Species, Route, Dose, End Point, Effect(s))
PF-07305885
Fertility & Embryonic Development - Females Rat Intramuscular 30 µg NOAEL No effects at maximum dose, Not teratogenic
Potassium phosphate
Reproductive & Fertility Rat No route specified 282 mg/kg/day NOAEL No evidence of impaired fertility or harm to the fetus
Reproductive & Fertility Mouse No route specified 320 mg/kg/day NOAEL No evidence of impaired fertility or harm to the fetus

Genetic Toxicity: (Study Type, Cell Type/Organism, Result)
Potassium phosphate
Bacterial Mutagenicity (Ames) *Salmonella* Negative

Carcinogenicity See below
Cholesterol
IARC Group 3 (Not Classifiable)

Data for the Drug Product

Reproduction & Development Toxicity: (Study Type, Species, Route, Dose, End Point, Effect(s))

Fertility & Embryonic Development - Females	Rat	Intramuscular	N/A	Not specified	No effects at maximum dose

11.2. Information on other hazards

11.2.1. Endocrine disrupting properties
Endocrine disrupting properties No information available.

11.2.2. Other information
Other adverse effects No information available.

Section 12: ECOLOGICAL INFORMATION

Environmental Overview: Environmental properties have not been investigated. Releases to the environment should be avoided.

12.1. Toxicity

Aquatic Toxicity: (Species, Method, End Point, Duration, Result)
POTASSIUM CHLORIDE
Gambusia affinis (Mosquitofish) LC50 96 hours 920 mg/L
Lepomis macrochirus (Bluegill Sunfish) LC50 96 hours 2010 mg/L
Daphnia Magna (Water Flea) EC50 48 hours 825 mg/L
Scenedesmus subspicatus (Green Alga) EC50 72 hours 2500 mg/L

NO RESULTS

12.2. Persistence and degradability

Persistence and degradability No information available.

12.3. Bioaccumulative potential

Bioaccumulation No information available.

12.4. Mobility in soil

Mobility in soil No information available.

12.5. Results of PBT and vPvB assessment

PBT and vPvB assessment

Chemical name	PBT and vPvB assessment
SODIUM CHLORIDE	The substance is not PBT / vPvB PBT assessment does not apply
Potassium phosphate	The substance is not PBT / vPvB PBT assessment does not apply
POTASSIUM CHLORIDE	The substance is not PBT / vPvB PBT assessment does not apply
Cholesterol	The substance is not PBT / vPvB

12.6. Endocrine disrupting properties

Endocrine disrupting properties No information available.

12.7. Other adverse effects
No information available.

SAFETY DATA SHEET

Section 13: DISPOSAL CONSIDERATIONS

13.1. Waste treatment methods

Dispose of waste in accordance with all applicable laws and regulations. Member State specific and Community specific provisions must be considered. Considering the relevant known environmental and human health hazards of the material, review and implement appropriate technical and procedural wastewater and waste disposal measures to prevent occupational exposure and environmental release. It is recommended that waste minimization be practiced. The best available technology should be utilized to prevent environmental releases. This may include destructive techniques for waste and wastewater.

Section 14: TRANSPORT INFORMATION

The following refers to all modes of transportation unless specified below.

Not regulated for transport under USDOT, EUADR, IATA, or IMDG regulations.

(CBI = CONFIDENTIAL BUSINESS INFORMATION)

Section 15: REGULATORY INFORMATION

15.1. Safety, health and environmental regulations/legislation specific for the substance or mixture

SEE "LEGEND" PAGE 12

Water	
CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
TSCA	Present PROPRIETARY (P)
EINECS	231-791-2
AICS	Present P CBI
Sucrose	
CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
TSCA	Present P CBI
EINECS	200-334-9
AICS	Present P CBI
SODIUM CHLORIDE	
CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
TSCA	Present P CBI
EINECS	231-598-3
AICS	Present P CBI
ALC-0315	
CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
EINECS	Not Listed
Potassium phosphate	
CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
TSCA	Present P CBI
EINECS	231-913-4
AICS	Present P CBI
POTASSIUM CHLORIDE	
CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
TSCA	Present P CBI

SAFETY DATA SHEET

EINECS	231-211-8
AICS	Present P CBI
Standard for Uniform Scheduling of Medicines and Poisons (SUSMP)	Schedule 4

PF-07305885 P CBI

CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
EINECS	Not Listed

PF-07302048 P CBI

CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
EINECS	Not Listed

PEGA / ALC-0159 P CBI

CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
EINECS	Not Listed

Disodium phosphate dihydrate

CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
EINECS	Not Listed
AICS	Present P CBI
Standard for Uniform Scheduling of Medicines and Poisons (SUSMP)	Schedule 5

Cholesterol

CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
TSCA	Present P CBI
EINECS	200-353-2
AICS	Present P CBI
Standard for Uniform Scheduling of Medicines and Poisons (SUSMP)	Schedule 4

1,2-Distearoyl-sn-glycero-3-phosphocholine

CERCLA/SARA Section 313 de minimus %	Not Listed
California Proposition 65	Not Listed
EINECS	212-440-2

France
Occupational Illnesses (R-463-3, France)

Chemical name	French RG number	Title
SODIUM CHLORIDE 7647-14-5	RG 78	-
POTASSIUM CHLORIDE 7447-40-7	RG 67	-

European Union
Take note of Directive 98/24/EC on the protection of the health and safety of workers from the risks related to chemical agents at work

Authorizations and/or restrictions on use:
This product does not contain substances subject to authorization (Regulation (EC) No. 1907/2006 (REACH), Annex XIV) This product does not contain substances subject to restriction (Regulation (EC) No. 1907/2006 (REACH), Annex XVII)

Persistent Organic Pollutants
Not applicable

Ozone-depleting substances (ODS) regulation (EC) 1005/2009
Not applicable

SAFETY DATA SHEET

Plant protection products directive (91/414/EEC)

Chemical name	Plant protection products directive (91/414/EEC)
Sucrose - 57-50-1	Plant protection agent
SODIUM CHLORIDE - 7647-14-5	Plant protection agent

Legend:
TSCA - United States Toxic Substances Control Act Section 8(b) Inventory
EINECS/ELINCS - European Inventory of Existing Chemical Substances/European List of Notified Chemical Substances
AICS - Australian Inventory of Chemical Substances

15.2. Chemical safety assessment

Chemical Safety Report No information available

Section 16: OTHER INFORMATION

Key or legend to abbreviations and acronyms used in the safety data sheet

Data Sources:	Pfizer proprietary drug development information. Publicly available toxicity information.
Reason for revision	Updated Section 1 - Identification of the Substance/Preparation and the Company/Undertaking. Updated Section 3 - Composition / Information on Ingredients. Updated Section 11 - Toxicology Information. Updated Section 15 - Regulatory Information.
Revision date	19-Mar-2021
Prepared By	Pfizer Global Environment, Health, and Safety

Pfizer Inc believes that the information contained in this Safety Data Sheet is accurate, and while it is provided in good faith, it is without warranty of any kind, expressed or implied. If data for a hazard are not included in this document there is no known information at this time.

Schedule 4

Marburg

- Bill Gates GAVI published an article on 22-Apr-2021 titled "The next pandemic: Marburg?". There have been numerous Mainstream Media articles highlighting an upcoming threat Marburg and referencing the WHO in recent months.
- Marburg Virus is a relatively rare haemorrhagic fever which was first described in 1967; there have only been a total of 376 related deaths and only 16 deaths since 2005.
- Primerdesign developed a one-step Real-Time PCR test genesig® in 2018 for Marburg haemorrhagic fever. Why would they develop a test in 2018 for an illness which has not had a major outbreak since 2005?
- Soligenix, are currently rushing to trial a ricin-rich vaccine RiVax® for Marburg haemorrhagic fever. RiVax has a Fast Track designation for the prevention of ricin intoxication by the US FDA. Approval of ricin toxin vaccine will utilise the FDA Animal Rule to eliminate the phase 1, 2 & 3 trials. Why such a rush now to trial a vaccine for which there has only been a total of 376 deaths since 1967 and only 16 deaths since 2005? The main component of the Rivax vaccine is Ricin is a lectin and a highly potent toxin produced in the seeds of the castor oil plant.
- Soligenix shareholders include Blackrock Fund Advisors, Goldman Sachs & Co. LLC, etc.
- Ricin is a lectin and a highly potent toxin produced in the seeds of the castor oil plant. Ricin is very toxic if inhaled, injected, or ingested. It acts as a toxin by inhibiting protein synthesis. It prevents cells from assembling various amino acids into proteins according to the messages it receives from messenger RNA in a process conducted by the cell's ribosome (the protein-making machinery) – that is, the most basic level of cell metabolism, essential to all living cells and thus to life itself.
- A paper tilled Asymptomatic Infection of Marburg Virus was published by the NIH in January 2021.

https://www.lewrockwell.com/2021/09/no_author/a-possible-marburg-rivax-final-solution/

WHO warns of Marburg

https://mobile.twitter.com/artvalley818_/status/1444162117746274305

Refer to Section 2 from the World Economic Forum website

https://www.weforum.org/agenda/2021/08/covid-19-coronavirus-pandemic-20-august-2021/

Notice the author

https://www.weforum.org/agenda/2015/05/what-ebola-teaches-us-about-pandemics-and-inequality/

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iii *Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study.* Anika Singanayagam, PhD; Seran Hakki,, PhD; Jake Dunning et al.(Published: October 29, 2021) The Lancet Journal https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00648-4/fulltext

[iv] *Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings - Barnstable County, Massachusetts.* Catherine M Brown; Johanna Vostok; Hillary Johnson; Meagan Burns; Radhika Gharpure; Samira Sami; Rebecca T Sabo; Noemi Hall; Anne Foreman; Petra L Schubert; Glen R Gallagher; Timelia Fink; Lawrence C Madoff; Stacey B Gabriel; Bronwyn MacInnis; Daniel J Park; Katherine J Siddle; Vaira Harik; Deirdre Arvidson; Taylor Brock-Fisher; Molly Dunn; Amanda Kearns; A Scott Laney (July 2021) National Library of Medicine, National Center for Biotechnology Information https://pubmed.ncbi.nlm.nih.gov/34351882/

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[viii] Most reported U.S. Omicron cases have hit the fully vaccinated -CDC | Reuters