Hello,

A friend of mine gifted me with a copy of a book titled: ***Canary in a COVID World***. It consists of essays by 34 different authors on the topics of the COVID-19 pandemic and the COVID vaccines (volume 2 has recently been published).

I received permission from the publisher to copy & share various chapters from this book to bring awareness to these issues and publicize the availability of these books. I think Chapter 9 is contains very important information and I feel morally and ethically compelled to help publicize this information.

Chapter 9 from ***Canary in a COVID World*** is titled:

Interpreting Vaccine Adverse Events Reporting System Data (VAERS) to Show the Harms Caused by COVID-19 Vaccinations
By Dr. Jessica Rose

Here is Chapter 9 from ***Canary in a COVID World:***

Chapter 9:
Data analysis has always been a critical component in my academic life. As part of presenting final analyses or experimental results to colleagues, or for publication purposes, data analyses and clear presentation is vital. My role since 2020 has been to clearly and accurately present data in the context of the COVID-19 pandemic, and specifically, in the context of the potential harms of the COVID-19 injectable products.

The COVID-19 mRNA injectable products were rushed through clinical trials. A conventional vaccine typically takes about 10 years to get to market. This timeframe was reduced to less than a year in the context of the COVID-19 injectable products. The rushed trials have been used as the springboard upon which all safety evaluations have been subsequently made and they quite simply and clearly are not sufficient to prove safety or efficacy, as time has revealed.

The exclusion criteria lists for the Phase III clinical trials for the Pfizer and Moderna products was very long. Basically, only people who were healthy and of a certain age requirement were allowed to participate. It has been very difficult for me to understand how anybody could make claims of safety with regard to these products, when there simply wasn't enough time to make this assessment. **Genuine safety testing was not possible.** That is a fact. Furthermore, rather than a two-year follow up of the patients in the trial, in the case of the Pfizer phase III clinical trial, the placebo participants were unblinded and injected with the product, so the placebo group was intentionally lost. This means that any ongoing trial or experimental data being collected would be null and void - it's lost without a placebo group because you have no comparison. At that point, and perhaps many points prior, the trial should have been halted.

In her presentation to the FDA, Rachel Zhang, Team Leader Clinical Review Staff, confirmed that the placebo group was lost and that therefore we can't say anything about efficacy. But what she didn't say is that we can't say anything about safety either. To do this – to inject the placebo group during the Phase III trial was ghastly and is absolutely unprecedented. Furthermore, the (immunological) effects of rushing these trials in the first place and performing them improperly in the context of novel transfection technologies is absolutely unknown.

This is a fact. We do not know the effects – short term or long term. Although, we are beginning to learn the short-term effects through pharmacovigilance. We should have done studies for years, perhaps even decades, to see if this was going to become a problem from a genomic point of view. A quick word on transfection for people who do not know that transfection is not the same thing as exposure to foreign proteins which is the basis of conventional vaccines. We either kill/attenuate a virus or we send in proteins in a carrier package like an innocuous virus. The idea is to get the immune system to mount a response against these proteins such that an immune army is established ready to fight upon challenge with the 'real' virus. But that's very different from the mechanism of action of these COVID-19 injectable products.

As an aside, I really would like to know how many people of the billions who have been injected with these products knew that they were being injected with something that wasn't a traditional vaccine? I can pretty much guarantee that most people didn't know this. I don't even think people know today. Even a lot of medical professionals don't know this because they're turning a blind ear to it when it is merely suggested to them. Because it's been made out to be a conspiracy theory.

According to the United States pharmacovigilance database VAERS, there was enough of a safety signal emitted with respect to death reports to stop the roll-out of these products in January 2021. Yes, just one month after the roll-out began on December 17th, 2020. We had almost 90,000 reports in VAERS spread across many age groups, and almost 700 deaths in the context of just 3 products: the COVID Moderna, Pfizer and Janssen products.

The last time a product went onto the market and killed more than 50 people, that product was pulled. VAERS ***functions*** as a pharmacovigilance tool, in that when a safety signal is detected, such as was the case in 1999 when a handful of intussusception cases was detected in VAERS, a causality assessment was done, and the rotavirus vaccine was subsequently pulled based on a verdict of 'very likely' causal relationship. This isn't intussusception, this is death. What's the cut off for the number of people who are considered allowed to die, become disabled or have neurological conditions manifest before these products are pulled? Why aren't the CDC and the FDA asking these questions? The owners of this data are not asking these questions. Why aren't they doing the assessments that they always have done in the past, such as causality assessments or Bayesian analysis or PRR assessments?

VAERS was introduced 30 years ago essentially as a trade-off for immunity from liability for pharmaceutical companies. We got VAERS, and they got immunity from liability. So if they're not going to be using VAERS as a pharmacovigilance tool now, then I propose that the immunity from liability should also be waived. It only seems fair, does it not?

One of the main problems with VAERS, contrary to what you might have heard, is underreporting. There have been studies done that actually claim that only 1% of reports are ever filed to VAERS. That means for every 100 people who are suffering, only one of them might make a report. I don't know if that's accurate in the COVID-19 context, but there is only a percentage of people who ever file an adverse event report to VAERS.

VAERS is a database that is very easy to access. Anyone can simply download the CSV files for analysis. For the past ten years, the number of adverse event reports has increased slightly. That makes sense because there are more products on the market and there are more shots being administered indicating that there is a proportional increase in the number of reports. What we see in 2021 is not typical and certainly an exceedingly anomalous up-turn in the number of reports. Something is strange there. Something is different. Something is atypical. And there is certainly no way to misinterpret this. This is just what it is – it is raw data. This is a safety signal that you simply cannot ignore.

There is a 1,400% increase in file size and 1,300% increase in the number of reports in the domestic set between 2020 and 2021. There is no interpretation required here. These are people who have submitted reports of injury and/or suffering in the context of a biological product that was meant to be prophylactic, for a virus that has a near zero infection fatality rate. There is no age group that is immune from damages or reporting.

Why are we seeing these adverse events in association with these particular shots? What is in them? The Pfizer and the Moderna products both have specifically modified mRNA. Basically, as we understand the technology today, the mRNA is useless without lipid nanoparticle envelopes (LNPs). This is a very important secondary technology that is also novel in this context. Moderna and Pfizer both have their own recipes for the LNPs. They comprise four lipids each, two of which include polyethylene glycol (PEG) molecules which coat the surface, and cationic lipids, which are notoriously toxic. It has been the bane of the existence of this industry to design cationic lipids for use in humans that are not hyper-toxic. Just at about the same time when we needed them, both of these companies developed ionizable cationic lipids that are allegedly safe for use in humans. In all of my research, I couldn't find safety data sheets that explicitly state that either of these have a version that is safe for use in humans. The safety data sheets, in fact, both explicitly state that these two products are not safe for use in humans or for veterinary use. This remains a big question mark for me.

PEG does have a well-documented allergenic profile in humans. It induces anaphylaxis. Cationic lipids have a well-documented toxicity profile. There are many papers that have been published to date that show that both the modified mRNAs and the spike protein are very durable and long lasting in the human body. There are a number of different characteristics of this spike protein that remain questionable from a safety perspective according to published studies. The ubiquitous adverse event reporting and case study reports raise serious and fundamentally vital questions about the way in which the spike protein is doing damage, and where the lipid nanoparticles traffic. They have been shown to traffic to the ovaries and accumulate there, and also in the liver which is one of the organs where the LNPs are found at the highest concentrations - second only to the injection site itself. This is problematic for two reasons: complications with both the Renin Angiotensin Aldosterone System (RAAS) and the clotting pathway. The RAAS regulates blood pressure and electrolyte levels.

There might be a common etiology with regard to many of the adverse events that we are seeing submitted to pharmacovigilance databases that revolve around these potential dysfunctions associated with the liver-thrombotic events, clotting and micro-clotting. The reason why I am starting to think that this is absolutely the case is because the liver, our big detox organ, is the place where the LNPs traffic to and accumulate at the highest levels.

The numbers that I report never include an underreporting factor. The range of reported adverse event types is far greater than has ever been reported in the past for any and all of the vaccines combined. This is also compelling evidence that there is something very different about these shots and that it might be liver-related.

The number of thrombotic adverse event reports in VAERS as of mid-May, 2023 is well into the hundreds of thousands without the underreporting factor, distributed across all ages. No one is immune, not even the babies. All you have to do is talk to clinicians or anyone on the ground. It’s ubiquitous right now.

When I began investigating the VAERS data in January 2021, I noticed that there was a systemic nature to the adverse events being reported. It was and is not exclusive to the cardiovascular system or to the neurological system or to the immunological system. The adverse events were involving every system.

Myocarditis is one of the adverse events that has come to the attention of even the lay-person. The VAERS myocarditis reports have a very interesting dose response pattern. There is an approximate four times higher reporting rate of myocarditis in young people – as in, 15 years old – following dose 2. This is most prevalently reported in males. This is a very compelling finding in terms of causality because if there was no causal effect, if there was no impact of subsequent shots, then we would not see this difference. Or at the very least, what else could explain this difference if not a causal effect? This is not seen in any other type of adverse event and this finding is very unique to myocarditis in

young children. This is not a secret. The CDC has admitted that this is a problem and amended their website to include warnings about myocarditis as a potential 'side effect.'

I was lead author on a paper with Dr. Peter McCullough, a renowned cardiologist. That paper, entitled "A Report on Myocarditis adverse events in the U.S. Vaccine Adverse Events Reporting System," was accepted in a peer-reviewed journal to be published, but five days before a Vaccines and Related Biological Products Advisory Committee (VRBPAC) meeting to determine whether or not these COVID-19 injectable products should be approved for use in children aged 5-11, the journal withdrew our paper. I do not believe in coincidences. I think this was done intentionally to hide the findings.

The thing that breaks my heart the most is that people did not have an opportunity to freely read this paper and to make their own minds up having done so. It is criminally tragic because many children have been injected with the COVID-19 shots unnecessarily (infection fatality rate of next to 0 in children) because their parents thought they were safe and effective because they were told they were. It is a tragedy. There is no other word for it. We have 1.5 million reports in VAERS, which is a nice sized data set, but it is still just a tip of the iceberg in one dataset.

Author Bio: Dr. Jessica Rose is a Canadian researcher with a bachelor's degree in applied mathematics and a Master's degree in Immunology from Memorial University of Newfoundland. She also holds a PhD in Computational Biology from Bar Ilan University and 2 Post-Doctoral degrees in Molecular Biology from the Hebrew University of Jerusalem, and in Biochemistry from the Technion Institute of Technology. Her more recent research efforts are aimed at descriptive analyses of the Vaccine Adverse Event Reporting System (VAERS) data in efforts to make this data accessible to the public.

Both volume 1 & 2 of Canary in a COVID World are available on Amazon.com. Here are the links: *Canary* volume 1 as well as volume 2, which just came out a few months ago.