NATIONAL CITIZENS INQUIRY

Truro, NS **Day 1**

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EVIDENCE

Witness 2: Dr. Peter McCullough
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Nicolle Snow
Good morning, everyone. Can you hear me okay? My name is Nicolle Snow, and I'm an injury and insurance lawyer with McIlvery Law. And I am honored and very happy to be a part of this process. Thank you for being here. We're just waiting for the witness, who's virtual.

Nicolle Snow
Good morning, Dr. McCollough.

Dr. Peter McCullough
Good morning. Can you hear me?

Nicolle Snow
Not well, so we're going to work with that. We'll keep going here, Dr. McCullough, so they can sort out the sound. I can hear you; it's just not projecting that well.

My name is Nicole.

Dr. Peter McCullough
I have until the top of the hour.

Nicolle Snow
Okay, yes, no problem at all, and I do apologize for being late. We're running a little bit late. We had some technical issues. So we're going to move through, and I'll have you out here by the top of the hour. Thank you for being here. We're going to put you under oath.

Ches Crosbie
Thank you, Dr. McCullough. Do you affirm to tell the truth, the whole truth, and nothing but the truth?

Dr. Peter McCullough
Yes, I do. Thank you.

Nicolle Snow
Dr. McCullough, we know you're a cardiologist, an internist, an epidemiologist. Could you start by giving a summary of your qualifications and experiences?

Dr. Peter McCullough
I'll do so quickly, I'm in practice in Dallas, Texas, in internal medicine and cardiology. I hold degrees from Baylor University, University of Texas Southwestern Medical School, University of Michigan School of Public Health, and Southern Methodist University Graduate School. I've been in practice now for greater than four decades and I have published extensively on the interface between heart and kidney disease. In the last three years, I have directed my clinical and research focus on COVID-19. I have over 60 peer-reviewed papers on SARS-CoV-2 infection, COVID-19 illness, and I've commented extensively in the US Senate, multiple state senates, as well as in the media.

Nicolle Snow
Thank you. And Dr. McCullough, you also have a clinical practice whereby you've had opportunity to treat COVID-19 or vaccines.

Dr. Peter McCullough
Yes.

Nicolle Snow
Okay, I want to turn to SARS-CoV-2, Dr. McCullough. The Government of Canada determined in the early stages of the COVID crisis—so in and around early March 2020—that the virus was highly transmissible and a virulent pathogen with an approximate 1 per cent fatality rate, for which there was no natural immunity and no effective antivirals. Can you comment on those conclusions?

Dr. Peter McCullough
I disagree that SARS-CoV-2 infection was one that was early on well-characterized. It was highly transmissible from symptomatic person to susceptible person. It had an overall case fatality rate far less than 1 per cent available to risk stratification. So, the elderly, those with multiple risk factors, at risk for death. And we knew early on that the virus was amenable to antivirals and, more importantly, use of drugs to reduce inflammation and thrombosis.

Within a few months of the onset of the pandemic, myself and researchers had already synthesized and then quickly published the first peer-reviewed paper describing the treatment of SARS-CoV-2 infection at home to reduce the risk of hospitalization and death.

And that was ultimately well-supported over the next few months with multiple comparative studies.

Nicolle Snow
Thank you. What do we know about the virulence of the virus now, Dr. McCullough?

Dr. Peter McCullough
It's greatly reduced with the continued progression of mutations to the Omicron and the sub-variants.

Nicolle Snow
Dr. McCullough, Canadians were advised that until a vaccine was created, the only available interventions were non-pharmaceutical measures to reduce transmission in the population—such as frequency of contact reduction, such as isolation, as well as probability of transmission-reducing measures such as social distancing, hand-washing, mask-wearing and so forth.

Can you comment on the assertion,

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that these were the only available measures prior to the vaccine rollout?

Dr. Peter McCullough
Yeah, I disagree with that. Before the vaccine rollout, we had dozens of very viewed manuscripts: comparative studies that sequence multidrug therapy for the acutely ill worked to reduce the risk of hospitalization and death. And just shortly after 2021, we had a breakthrough paper showing that virucidal nasal sprays and gargles markedly reduced PCR positivity and reduce the risk for hospitalization. And there were no published studies at any time showing that public masking, social distancing, hand sanitizers or locking down those people without the illness had any impact on the pandemic.

Nicolle Snow
And Dr. McCullough, is there any real scientific logic to social distancing and masking and lockdowns in the context of this virus?

Dr. Peter McCullough
Not among well people, so there were no data suggesting that somebody perfectly well could transmit the disease and make somebody symptomatic who was adjacent to them. So the only thing that clinically was practical is somebody acutely ill with a characteristic signs and symptoms to keep distance from others. So the only people who needed to go into quarantine were those acutely ill with SARS-CoV-2, not the universe of people without the illness.

Nicolle Snow
Dr. McCullough, I know that you and a group of doctors had did some early research on the COVID in the early stages, treatment of COVID in the early stages. You touched on that a bit earlier. Can you speak about your findings in a bit more detail and how those findings were received once published?

Dr. Peter McCullough
The very first paper published on sequence multidrug therapy for COVID-19 in the *American Journal of Medicine*, August 7, 2020—myself as the first author—was widely applauded. It's still the most frequently read paper from the *American Journal of Medicine* over the last three years. It's listed as a top paper of interest. It received multiple letters to the editor as interest with replies, and it became the base standard of the Association of American Physician and Surgeons Home Treatment Guide in October of 2020.

So it was a breakthrough piece of information, a breakthrough paper. And it was followed up in December of 2020 in an updated protocol, which included now more drugs available to use, in *Reviews in Cardiovascular Medicine* in December of 2020.

Nicolle Snow
Thank you. I want to turn your attention now to the COVID injection. It is sometimes, well it's most often called a vaccine; it's sometimes called gene therapy. Are you able to speak to just what the injection is and how it operates?

Dr. Peter McCullough
In the United States, 92 per cent of those who've received a COVID vaccine—I'll just use the word "vaccine"—have received messenger RNA vaccines. And the messenger RNA vaccines, in my interpretation, are synthetic genetic materials: a genetic code with a three prime and five prime synthetic nucleoside analog caps, which make the messenger RNA essentially indestructible. They are loaded on lipid nanoparticles to provide distribution throughout the body, including the brain, the heart, the adrenal glands, reproductive organs—all the critical organs in the body. Messenger RNA has been demonstrated to be circulatory in the bloodstream for at least 28 days. We know that it codes for the spike protein of SARS-CoV-2. The spike protein was engineered by the University of North Carolina Chapel Hill and published by Manchurian colleagues in 2015. This work was done in the Wuhan Institute of Virology, Biosecurity Annex Level 4.

This messenger RNA that people have received codes for is the lethal part of the virus. And then once the messenger RNA is in the body, there is an uncontrolled production of the spike protein in terms of quantity and duration. The spike protein is proven in over 1,000 peer-reviewed papers to cause damage to the brain, the heart, the blood vessels; to cause blood clotting; and to cause immunologic problems in the bone marrow.

Nicolle Snow
Thank you, Dr. McCullough. It sounds like, then, that the COVID injection doesn't operate like a true vaccine. Is that correct?

Dr. Peter McCullough
The messenger RNA vaccines harnessed the body's own genetic material to produce the spike protein.

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And the spike protein causes damage to the body, as I've described. Now, the aspiration I anticipate was that the spike protein would induce immunity. But we understood very quickly that there was no effective immunity from the vaccines. And so within 90 days of the release of the Pfizer vaccine in the Pfizer post-marketing data—which they kept as regulatory documents and were released under court order to the public—Pfizer had recorded dozens of fatalities due to COVID in people who were fully vaccinated with the product. And sadly, Pfizer recorded 1,223 deaths directly attributable to the vaccine.

Nicolle Snow
Dr. McCullough, are you able to speak on the research and development process for this product? In other words, did it follow established regulatory standards for vaccines?

Dr. Peter McCullough
In a paper by Lalani and colleagues in the *British Medical Journal* in the last month, the description of messenger RNA development is laid out in a timeline since 1985. So the United States has had a long-standing interest in the development of messenger RNA. And then in 2012, DARPA, the research division of the U.S. military, created a program called the ADEPT-P3 program. It's on their website even today stating that the military had a desire to use messenger RNA to end pandemics within 60 days. So the United States made an unprecedented government investment in messenger RNA. However, human studies were never performed until we had a condensed, rushed production of the vaccines for COVID-19 in Operation Warp Speed.

So, it had a very long development cycle. There were many issues to tackle, and then it was in a condensed set of prospective randomized trials to gain emergency use-authorized approval.

Nicolle Snow
Did safety and efficacy have to be proven in the production of the product?

Dr. Peter McCullough
Safety and efficacy always have to be proven. With genetic products, the safety by regulatory standards takes a five-year timeline. So the safety study should have been started way in advance, since the United States been working on this since 1985 and they simply weren't done. Efficacy had to be proved for the outcome of hospitalization and death. And hospitalization and death were never a primary or secondary endpoint of any trial. And so there can be no claims that the vaccines reduced hospitalization and deaths, since they weren't assessed in these trials. Where recorded, there was no reduction in hospitalization and death. In fact, deaths were more frequent in those who took a vaccine. And in the United States, the consent form doesn't make the claim that the vaccines reduced hospitalization and death.

Nicolle Snow
I want to turn your attention to the vaccine event recording systems, Dr. McCullough. I know in the U.S. where you are, there's the VAERS [Vaccine Adverse Event Reporting System]. In Canada, we have CAEFISS, that's the Canadian Adverse Events Following Immunization Surveillance System. There's the yellow card system in the U.K. and the European Safety Monitoring System. These systems have been in place for decades, as I understand it, at least in Canada. CAEFISS has been in place since 1987.

Can you speak about what, if any, unusual findings are showing up in these vaccine reporting systems following the rollout of the COVID injection?

Dr. Peter McCullough
In June 11, 2022, the World Council for Health summarized those safety data systems: 39 total, but four major ones, including VAERS, YellowCard, the EUGIS system, and the WHO VIGI-safe system. All of them have been recording record numbers of injuries, disabilities, and deaths.

For example, in the U.S. VAERS system, all vaccines combined and accumulating all injections before COVID, a child would receive greater than 70 injections over the course of childhood. Per American child—and we knew 98 percent of Americans were taking vaccines at this level—there was a total on average of 158 deaths per year in this entire data system, which is the best. With COVID-19 vaccines as we sit here today, as of March 3rd, 2023, for U.S. domestic cases only, VAERS has recorded 17,071 deaths that have occurred within a few days of taking the COVID-19 vaccines, and 16,454 permanently disabled Americans.

The VAERS reports are largely done by doctors, nurses,

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and those caring for patients where they believe the vaccine is the cause of the injury or death.

Nicolle Snow
Dr. McCullough, is there an accepted percentage of adverse events that are considered medically tolerable, if you will, beyond which the product would be removed from the market for safety concerns?

Dr. Peter McCullough
I've chaired over two dozen data safety monitoring boards as the head of the board or a member, including those for the NIH [National Institutes of Health], BARDA [Biomedical Advanced Research and Development Authority], the Military Research Division of the NIH, as well as pharmaceutical companies—in vitro diagnostic companies. It's my testimony that five, 10, 15, no more than 50 deaths—even for the largest program—would ever be tolerable. That programs would be shut down. And then a deep dive on safety to figure out why people are dying after taking an injection.

It's my testimony that, knowing what we know— The rollout of Pfizer in the United States was started December 10th, 2020. Pfizer should have been pulled off the market before the end of January of 2021, with fewer than 27 million Americans being injected. Moderna

probably should never have rolled out. And if it rolled out, it would have been pulled off the market shortly afterwards. Janssen, again, should have never had market entry because Pfizer and the entire product line would be off the market because there would be an understanding that the spike protein being produced is lethal to the human body.

Nicolle Snow
Dr. McCullough, you spoke a little bit on adverse events already, but would you speak in a little more detail on the cardiovascular events that are medically known to be connected to these COVID vaccines?

Dr. Peter McCullough
There are over 200 peer-reviewed papers published on cardiovascular syndromes directly attributed to COVID-19 vaccination and agreed to by regulatory authorities. One of them is myocarditis or heart inflammation. Two studies have indicated that 2.5 per cent of people who take a vaccine suffer heart damage. About half of them, it's symptomatic. Half of them, it's not: the peak age is 18 to 24 years, 90 percent are men, 10 per cent women. It's a skewed distribution with a tail up into the 60s and 70s.

There have been fatal cases, autopsy-proven, by Verma, Choi, Patone, and Gill. It is conclusive that in a fraction of those who have received the COVID-19 vaccine, heart inflammation or myocarditis is fatal; and the mechanism of death is sudden cardiac death, a sudden arrhythmic death, a young person collapsing and not being resuscitated by CPR.

This is now well described here in the peer-reviewed literature. An important paper by Yonker and colleagues in circulation from Harvard has shown, in young boys and girls hospitalized at Massachusetts General Hospital with myocarditis, about 90 per cent acutely are hospitalized to recognize the symptoms. Those who are having myocarditis have unopposed spike proteins circulating in the body damaging the heart. Those not affected with myocarditis actually have appropriate antibodies neutralizing the spike proteins. What I conclude is that, unfortunately, a small number of people do produce spike protein that is not effectively neutralized by the antibodies and so they have unevaded heart damage.

Myocarditis is lethal and, of course, a single death in a young person is unacceptable, because young people are not at risk for hospitalization and death with the virus. The COVID-19 vaccines should have always been contraindicated for young people not at risk for the illness. In addition to that, the vaccines cause a progression of atherosclerotic cardiovascular disease. They precipitate coronary atherosclerotic plaque rupture in traditional plaque, cardio infarction. The vaccines are proven to cause blood clots, both in arteries and in veins. The U.S. FDA [Food and Drug Administration] has published on this. In a paper, Wu and colleagues have demonstrated thousands of Americans developing blood clots after COVID-19 vaccines, where the FDA agrees that vaccines cause the blood clots, describing them going from the ankle to the hip. So, very large blood clots in the venous system: in the Wu paper, 11 per cent are fatal.

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Additionally, the COVID-19 vaccines have been associated with a whole variety of other cardiovascular manifestations, including vasculitis, a problem of inflammation in the blood vessels in the kidneys. In a paper in the *Journal of the American Society of Nephrology*, Wu

and colleagues describe the progression of the vasculitic and nephritic kidney disease in those, worsening their chances of survival free of dialysis.

In summary, the COVID-19 vaccines, by the mechanism of myocarditis progression of cardiovascular disease and blood clots, are believed to be the cause of unknown death in any individual where the vaccine is known to be taken by that person.

Nicolle Snow
Thank you. Dr. McCullough, the Canadian government has maintained that the COVID vaccines are both safe and effective, and continues to encourage Canadians to take them, including children: to vaccinate and to booster.

Given what you have had to say about COVID-19, its virulence, the vaccine, and the statistics on adverse events, what is your opinion on whether the vaccine is both safe and effective?

Dr. Peter McCullough
The decision on safe and effective is made by senior care doctors with medical authority. I would have—and I do have—medical authority over government officials in Canada. It's my testimony today that the vaccines are neither safe nor effective. And that opinion has superiority and supersedes any government statement.

Nicolle Snow
Thank you, Dr. McCullough.

My last question is really just about corrective measures. A lot of people the world over have taken the injections. What, if anything, can they do to mitigate the damage they have incurred in their bodies?

Dr. Peter McCullough
Two points. One is the toxicity and the risk of death appear to be cumulative. So the first point is to take no more injections because the next one could be fatal or disabling. Second point is to be vigilant. Blood clots, heart damage, neurologic damage, intracranial hemorrhage stroke: all these need to be clinically recognized and treated the best they can conventionally.

None of the governments have started large research programs into vaccine injuries, disabilities, and death, and that research is greatly needed. Very similar to the tobacco settlement and the final recognition that tobacco causes disease in the U.S. tobacco settlement: much of the money received by the tobacco industry had to be turned around into research for doctors to learn how to treat patients. We'll need a similar type of program with COVID-19 vaccine injuries.

A paper by Zogby and colleagues, a representative survey in the United States, showed that 15 per cent of those who've taken a vaccine have some new medical illness—some new disease that we're dealing with. I've covered just the tip of the iceberg in terms of the cardiovascular complications, but they also span the fields of neuropsychiatric problems, autoimmune problems, and so there's a great medical need to care for those individuals. And I would just say there's also an acute medical need, even though very few people now are taking COVID-19 vaccines. This CDC V-safe data, which was released under court order,

reveals 7 per cent to 8 per cent of people who take a vaccine have to acutely go to the hospital and be hospitalized in the emergency room or urgent care center. So there's a great need to still manage the acute problems that develop within a few hours of taking it in a shot.

Nicolle Snow
Thank you, Dr. McCullough. I thank you sincerely for giving evidence here at this Inquiry today.

Don't go away just yet. I'm leaving a few minutes here in case any of the commissioners would have questions for you. Thank you very much.

Commissioner Massie
I have some expertise in biotechnology and vaccine, so I've been following everything you've published and said on many conferences. One other thing that really puzzles me is: What's happening with all the evidence that has been pouring in for more than two years?

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What's happening that the medical establishment and all the health institutions are still promoting that kind of intervention?

Dr. Peter McCullough
In the United States, the medical establishment, I think, has been greatly influenced by the COVID Community Corps program. The COVID Community Corps program announced early in 2021 that over $13 billion was sent out by the White House and the Department of Health and Human Services to a variety of health institutions, thousands of media outlets, Hollywood pro sports teams—all to promote the vaccines. We know separately that Pfizer and Moderna contracted a public relations firm called Weber Shandwick. And Weber Shandwick initiated a corporate program called Plan VX. Plan VX promoted vaccine mandates within large companies.

Then lastly, Weber Shandwick had an installed marketing unit within the CDC vaccine office. This has all been uncovered by Senator Rand Paul in October of 2022 and is publicly disclosed.

Commissioner Massie
Thank you.

Nicolle Snow
Okay, those are all the questions. Thank you so much, Dr. McCullough, for appearing here today.

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