NATIONAL CITIZENS INQUIRY

Winnipeg, MB **Day 1**

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EVIDENCE

Witness 1: Dr. Jessica Rose
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Shawn Buckley
And our first witness that we have attending virtually is Dr. Jessica Rose. And so, Jessica, can you hear us?

Dr. Jessica Rose
I sure can. Can you hear me?

Shawn Buckley
We can hear you very well. I just wanted to start by asking if you could state your full name for the record, spelling your first and last name.

Dr. Jessica Rose
My name is Jessica Rose. J-E-S-S-I-C-A R-O-S-E.

Shawn Buckley
Jessica, do you promise to tell the truth, the whole truth, and nothing but the truth, so help you God?

Dr. Jessica Rose
I do.

Shawn Buckley
Now, my understanding is that you are a Canadian researcher. You've got a bachelor's degree in Applied Mathematics and a master's degree in Immunology from Memorial University of Newfoundland; you also hold a PhD in Computational Biology from Bar-Ilan University. And following your PhD, you have done two post-doctorate degrees: one in

Molecular Biology from the Hebrew University of Jerusalem and one in Biochemistry from the Technion–Israel Institute of Technology. Is that correct?

Dr. Jessica Rose
That's correct.

Shawn Buckley
And my understanding is you were also accepted for a two-month program as a senior researcher at the Weizmann Institute prior to the completion of your last post-doctorate degree.

Dr. Jessica Rose
Correct.

Shawn Buckley
And your most recent research efforts are aimed at, basically, what we call a descriptive analysis of the Vaccine Adverse Event Reporting System (VAERS). And you've analyzed this in efforts to make this data accessible to the public.

Dr. Jessica Rose
Yes.

Shawn Buckley
Now, you have sent us a CV, which I've had marked as an Exhibit WI-4. Is it fair to say that the CV you sent us is an accurate description of your experience in education?

Dr. Jessica Rose
If it's the one that I sent, then, yes.

Shawn Buckley
Okay, yeah. No, no, I promise you I didn't change it. So you've researched the effect of the vaccines. And you've done a whole bunch of research on the VAERS system. And we're inviting you to tell the Commission about your findings. So I just invite you to start presenting your findings.

Dr. Jessica Rose
Sure. I'm going to share my screen and so if you can just let me know if you can see my PowerPoint presentation [Exhibit WI-4g]. Can you see that?

Shawn Buckley
We can. We've got up there, "What dinosaurs would look like according to Neil Ferguson's models."
Dr. Jessica Rose

So first of all, I want to thank you for inviting me to provide testimony. Anytime I'm invited to speak or given any kind of platform to disseminate information is taken upon me, I always like to start out with jokes, just to lighten the mood because, yeah, we not only need to forgive each other, we need to forgive ourselves, and laughter is medicine.

I saw this on Flickr the other day, and it made me laugh so hard. For those of you who don't know, Neil Ferguson is the modeller for which his models basically were used as the justification to impose lockdowns on all of us. And if you read the articles that I've listed here at the bottom right, you'll see very clearly that he's kind of notorious for making bad predictions with his models. So it's kind of interesting that the policymakers went to this person in order to justify the lockdowns, isn't it? I thought this was hilarious, that this is what dinosaurs would look like according to his models.

And I needed to add this point as well: It's not really about the virus or anything. But it's relevant to what we've been going through in the past three years. It was very shortly, less than a day after you guys, the National Citizens Inquiry, posted that I would be presenting testimony here that somebody posted a Reuters fact check, which was basically a hit piece written on me with the claim that I was making false claims of death using VAERS data because I had not understood the data and that I was misrepresenting it. So whenever this kind of thing happens, sadly, I'm not a stranger to this kind of treatment at this point.

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But it usually means that you're over the target. So well done to you guys. And I leave it to everybody listening to this live and afterwards to make up their own mind as to whether or not I'm misinterpreting any data here because usually what I do is I present it in its raw form.

So this is my background. I'm not going to dwell on this. I do have a few degrees. But the most important thing that people should know is that data analysis has always been a critical component in each of these fields and/or disciplines that I've participated in. Doing your experiments isn't enough. You have to be able to present them and analyze the data in a clear way to your colleagues. So this is very important.

I really need to reinforce the fact that we're dealing with products, in terms of the COVID-19 products, especially the mRNA, that were rushed through clinical trial testing. Normally, a conventional vaccine takes approximately 10 years to get to market, and we reduced this time frame down to less than a year. And these trials are basically the foundations upon which all the decisions were made and the mantra that we've been hearing for three years, "safe and effective," are based on. Not only that, but these are kind of the springboard upon which all subsequent trials were based on. And these trials are exceedingly bad. And they not only do not provide evidence of safety and efficacy, they actually provide the opposite, in my opinion. I've gotten pretty deep into this data. The exclusion criteria list for the Phase III trial were huge. Basically, only people who were healthy and of a certain age requirement were allowed to participate. And so it's very difficult for me to understand how anybody could make claims of safety and/or efficacy when there simply wasn't enough time. Genuine safety testing was impossible. That is a fact.

And furthermore, instead of a two-year follow-up, what happened in the case of the Pfizer clinical trial, number here [NCTO4368728], is that the placebo participants were unblinded and injected with the product. So the placebo group was intentionally lost. And if you don't know what that means, it basically means that if you had any kind of trial or experimental data that was being collected, at some point, it's lost, at this point. Without a placebo group,

you have no comparison. So at this point, the whole thing should have been called off, if you ask me. There are so many stopgaps within the last three years.

I'm going to play this video and hopefully you can hear. This is Rachel Zhang.

[Played video clip of Rachel Zhang, MD, Team Leader, Clinical Review Staff, FDA]

[Video transcript]
"I'm not quite sure I'm going to address your question. But I guess it was the study P203, as I mentioned, because of the availability of an alternate COVID-19 vaccine, after a certain period of time, after basically end of May, we have lost the placebo groups. So we cannot really say anything about the duration [of the efficacy] because there's no more efficacy data, basically."

So exactly what she said is correct. If you heard what she said, she confirmed the fact that the placebo group was lost and that we can't say anything about efficacy after that. But what she missed out on saying is that we can't say anything about safety either.

So the biological products being rushed like this is absolutely unprecedented, and I'm talking about conventional vaccines when I say these words. It hasn't been done like this before. And the effects of doing this, this Operation Warp Speed rush-clinical-trial-thing in the context of novel transfection technologies is absolutely unknown. This is a fact. We don't know the effects. 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.

And just a really quick word on transfection for people who don't know: this is as opposed to exposure to foreign proteins, which is what conventional vaccines traditionally do. We either kill a virus or we send in proteins in a package, and the idea is to get the immune system to mount a response against these proteins. But that's very different from this, and I'm going to get a bit deeper on this.

This is deliberate introduction of nucleic acids that form, say, a modified mRNA, which is foreign, into the eukaryotic cells of the human

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for translation by the human cells, by the host cells. This is completely different from anything we've done before. And if we have time at the end, you should ask me about this last step.

And my question here for anybody listening comes down to informed consent. I really would like to know how many people of the billions who are injected with these products knew that they were being injected with something that wasn't a traditional vaccine. I'd really like to know because I can pretty much guarantee that most people didn't. I don't even think people know today. A lot of even medical professionals, they don't know this because they're turning a blind ear to it when it's suggested to them because it's been made out to be some kind of conspiracy theory.

A very important point. And I will provide some background on VAERS, but I want to throw this up here. It's very important. We had enough of a safety signal from VAERS to stop the rollout of these products from a safety signal perspective in January. I'm talking like the first month after the rollout started in December 17th. So on the left here, these are absolute numbers, which I chose to show here because I want to reinforce that these are

people, not data points. We had almost 90,000 entries into VAERS spread across many age groups and almost 700 deaths. Now, the last time, to my knowledge, a product went onto the market and killed more than 50 people, that product was pulled. VAERS has functioned and does function 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, causality assessment was done, and the rotavirus vaccine was subsequently pulled.

So my question here—this isn't intussusception, this is death—what's the cut-off for the number of people who are considered allowed to die or become disabled or have neurological conditions or, et cetera, et cetera, before the product is pulled? An even better question might be: Why aren't we even asking questions? Why aren't the CDC, the HHS, and the FDA, the owners of this data, asking questions? Why aren't they doing the assessments that they always have been doing in the past, such as causality assessments or Bayesian analyses or PRR [proportional reporting ratio] studies? Why?

So I propose something here, if I may. Because VAERS was introduced 30 years ago as a trade-off for immunity from liability from pharmaceutical companies: We got VAERS. And they got immunity from liability. So if they are not, since they are not using VAERS as a pharmacovigilance tool now—they've waived this tool—then I propose that the immunity from liability also be waived. It only seems fair, does it not?

So VAERS is a pharmacovigilance tool. All this means is that the safety signals that might originate from VAERS are used in causality assessments or any kind of assessment in order to determine whether or not these safety signals comprise a danger to human health in the context of a product.

Now, 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 one per cent of reports are ever filed to VAERS. That means for every 100 people who are suffering, only 1 of them might report. Now, I don't know if that's accurate in the COVID context, but you get the drift. There's only a percentage of people who are ever going to file a report to VAERS.

Now, this is a chart that demonstrates one of the things that I don't think you can confuse with interpretation. This is the raw data. I'm showing on the left the change, for some reason, in 2021 of the file size in VAERS. VAERS is a database that's very easy to access. You can just download CSV files, and they're of a certain size every week. Every week it's updated in megabyte format. So for the last 10 years, if you look at the file size and plot it like this on a two-dimensional plot—pretty simple—it's gone up a little bit over the last 10 years. And that makes sense

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because there are more products on the market and there are more shots going out. So there's a proportional increase in the number of reports. Normal, right?

This, that you see in 2021, is not normal. Something is strange there. Something is different. Something is atypical. And there's no way to misinterpret this. This is just what it is. This is the signal that you just can't look away from once you see it. It has to be addressed in some way. And on the right are the number of VAERS IDs and, naturally— This is just for 2021 domestic data, by the way. It's far worse than this. You see the same, which isn't a surprise. So we have a 1,400 per cent increase in file size and 1,300 per cent increase in the number of reports in the domestic set. There's no interpretation required here.

This is the same data, up to date as of April 7th, distributed by age group. This is according to CDC age grouping. On the left, you can see the absolute counts. And, again, I like to show this because these aren't simply data points. 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.

And on the right is the normalized data. I think that's important to show so that you can see, within each age group, how many people per 100,000 doses, for example, were reporting. And I can tell you that the 0 to 4 age group, the reporting rate is going up faster than I saw it go up for all these other age groups. So something is going on there as well, which, again, needs to be addressed by the owners of the data. So there's no age group that is immune from damages and/or reporting.

So why are we seeing these adverse events in association with these particular shots? So a good question to ask is— What's in them? So the Pfizer and the Moderna products both have modified mRNA. They're modified in specific ways, which I'll explain very quickly and briefly. And basically, they're useless without these lipid nanoparticle envelopes. So this is a very important secondary technology that's novel in this context.

Moderna and Pfizer both have their own recipes for the lipid nanoparticles. They comprise four lipids each: two of which include the stealth PEG, polyethylene glycol molecules, which coat the surface, hopefully, homogeneously, so that it can distribute efficiently, and cationic lipids, which are notoriously toxic. It's been the bane of the existence of this industry to design cationic lipids for use in humans that aren't hypertoxic. So magically, just about the same time when we needed them, both of these companies developed ionizable cationic lipids—which they only become active at certain pH, that's the so-called magic—at exactly the same time, that are allegedly safe for use in humans.

Now, the thing about this is in all of my research, I couldn't find safety data sheets that actually explicitly state that either of these have a version that's safe for use in humans. I'm looking for those documents if anybody has them. These safety data sheets both explicitly state that these two products are not safe for use in humans or for veterinary use. So that's a big question mark for me. And I'm always an Occam's razor person. And PEG does have a well-documented allergenic profile in humans: it induces anaphylaxis. And cationic lipids have a well-documented toxicity profile. So, for me, that makes me ask more questions than just to become docile and accept that it's safe.

The modified mRNA is modified in very specific ways, like I said. And I don't want to dwell on this, but what everybody really needs to know is that these things are very stable and stealthy. There are many papers that have been published to date that show that these things are very durable and long-lasting in the human. They're optimized for maximum protein expression using codon optimization. They have long poly(A) tails and five-prime caps to optimize protein synthesis and durability. They also, you've heard this before, they have had their uridines swapped out for pseudouridines. And what this does, essentially, is allow these mRNAs to evade immune detection by evading toll-like receptors, which are these little molecules that detect danger signals.

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So the bottom line here, without dwelling on this, is that these things were designed to be very stable and very durable and long-lasting.

And the by-product is this spike protein and a couple more modifications that included a couple of proline substitutions, which apparently made this version of the spike protein that was in the closed conformation— I guess they did this to ensure stability, again, durability, and so that maybe it didn't bind to ACE2? I'm not sure.

And again, I'm not going to dwell on this because I don't have time in this short presentation, but there are many insertions, let's call them, that raise question marks, such as the furin cleavage site, which makes this much more infectious. It also isn't found in the original version of SARS, which is one of the biggest question marks of all. It's surrounded by cutting sites, et cetera.

Oh, and by the way, I should mention that this has also been identified as a nuclear location site [NLS], which means that it allows for the translocation of this thing to the nucleus. And there's another published paper that shows that the presence of full-length spike protein in the nucleus prevents double-stranded DNA repair break.

So all of these papers, I think, that I've put here that you should all read. There are a number of different things that are questionable about this spike protein from the original Wuhan strain, upon which the spike in the shots have been mimicked after. So it raises serious questions about the way that spike is doing damage. And I'm going to get to a few of these if I have time.

Now, Laura Braden has shown you the figure on the right. We all know that the pharmacokinetic studies have been FOIA-requested that tested where these lipid nanoparticles and the PEG from the Pfizer shots go— And if they go these places, where they go and how they accumulate. So, shockingly, they do traffic to the ovaries and accumulate there. I'm not going to dwell on that. I've given many talks about the potential dangers associated with this. For the sake of time, I'm going to the left here and focusing on the liver. Because the liver is one of the organs where these things are found at the highest concentrations. I think second only to the injection site itself. And this is problematic.

And the reason it's problematic, it's for two big reasons I can think of off the top of my head. What you're looking at here are two systems that are in the human body that control blood pressure, electrolyte levels: in the case of the one on the left, which is the renin-angiotensin-aldosterone system [RAAS], and on the right is the coagulation pathway. So the liver is the source of many, many, many molecules and proteins that are absolutely essential to the closed loop functioning of both of these systems. My point here is if you happen to throw a wrench in either of these works, you're going to have clinical effects. That's a fact.

So the reason it's interesting—and I made a video about this you could watch on YouTube about the RAAS on the left—is that one of the mediators, one of the molecules, which is essential to this closed loop system is ACE-II. It binds angiotensin II, which is another mediator, which converts to something called angiotensin-1-7. All you need to know about that is this ebb and flow of vascular constriction and dilation is regulated by these molecules. Now, imagine you have something, like a wrench, that you throw into the system that binds ACE-II. What binds ACE-II? Well, we know that spike protein binds ACE-II, don't we? We know that it binds in the form of the virus. Maybe it also binds in the form of the free spike that's manufactured by the body as a by-product of being injected with these products. I can very easily imagine that if you throw a wrench in this system, it could get dysregulated. I'm not saying that it does; I'm saying that it could and it needs to be studied.

But more concerning is what might happen on the right because we're seeing massive numbers of reports of thrombotic events, clotting and micro-clotting. And it's also been documented that there are dysregulations in the clotting pathway itself in the context of the spike protein, either SARS-associated or these injection-associated spikes.

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The liver produces prothrombin and all these other mediators, which subsequently make the ebb and flow system of the clots and the things that break down the clots. And that's just as important as the clots themselves. This is all normal stuff. But if you imagine that you throw a wrench in this system as well, and you have problems with the development of fibrin or the degradation of the clots, you can imagine that you're going to have thrombotic issues.

So there might be a common etiology here with regard to many, many, many of the adverse events that we're seeing submitted to pharmacovigilance databases that revolve around these potential dysfunctions associated with the liver. And the reason why I'm starting to think that this is absolutely the case is because the liver is the place where the lipid nanoparticles traffic preferentially and accumulate. And if they are, in fact, dumping their modified mRNA payload, and those mRNAs are getting translated into spike protein in copious amounts, I can't imagine that the liver wouldn't be affected. So this is my idea.

So the coagulation, clotting, and wound healing mechanisms might have their "off button" modified somehow by these spike proteins. So all of these factors that you can see on the left—the platelets and the fibrin and the clots themselves that are formed—are scaffolds, so to say, to make bridges across wounds that are induced by the presence of spike protein. For example, say spike protein gets embedded in whatever cells that are in proximity or they're mounted on MHC [major histocompatibility complex] molecules for targeting from the immune system for destruction. And you get this clotting happening. So imagine that you have a problem with that.

So I'll get back to that. But I want to interject another critical component of the liver, and that's a protein called transthyretin. Amyloidosis, one of the two main types, is caused when these transthyretin proteins that are made in the liver misfold. And this can have direct negative effects for the heart in particular—all sorts of organs—but I just wanted to throw this in here because I'm going to circle back to this at the end if I have time. And I just want to point out another essential protein made by the liver.

The liver is the big detox organ, by the way. This is a paper that has shown recently that spike mRNA is persistent in hepatocytes. Hepatocytes are the main cells in the liver. And wherever you have spike mRNA, there's going to be spike. And this is just one of many, many, many studies that are going to start rolling in. Trust me, I'm going to circle back to that as well.

But just to get back to VAERS for a moment, to put some numbers on this. This is just a sample of some of the keywords that I use like "hepato" and "liver" from VAERS to get an idea of how many reports are being filed by age group. And there are tens of thousands. Again, I want to reiterate here, if I haven't said so already, the numbers that I report never include an underreporting factor. So whatever you believe it should be from 1 to 30—41, whatever—multiply these numbers by that, and you'll get a more accurate estimate of how many people are actually suffering. So, again, I normalized the data on the right. And you can see that no one is immune. And the 0- to 4-year-olds are definitely involved here.

I want to, again, remind everyone that the fibrinogen, the fibres that make these clots possible, and the plasminogen—which is the precursor to plasmin, which is this very important molecule that degrades the clots once they're formed—are both made in liver. So if you have a defect in the production or distribution of fibrin, for example, you can have all of these listed clinical problems in this chart.

So I just want to give you an idea of some of the things that can go wrong in one of the parts of this pathway, the coagulation pathway.

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And you'll see bleeding, amyloidosis, thrombosis, et cetera. These are just eight that are just pulled off of this chart. But everybody has to know that at this time point in VAERS, only in the context of the COVID products—there are four now—there are over 15,000 adverse event types listed. And that's of a possible 25,000 different MedDRA codes that you can choose from. And to put that into context, I went back to 2021: I pulled out all of the adverse-event types for the 14 flu vaccines that had been reported to VAERS that year, and there were just over 1,700 different types. And if you go and look at the COVID adverse event types for 2021, same thing, you find almost 11,000—it's well over 10,000. So there's 10 times more types of adverse events.

Shawn Buckley
Dr. Rose, can I just clarify something? So when you're showing us this figure of 15,000 adverse events just connected to the liver, that would just be, using some estimates, just one per cent of the actual adverse reactions connected to the liver?

Dr. Jessica Rose
Well, these are the types. And this is not just liver associated. These are all of the different MedDRA codes that are used—

Shawn Buckley
Okay, thank you.

Dr. Jessica Rose
to describe what that person might have been suffering from: So you can have death. You can have chills. You can have fever. All of these things are called MedDRA codes. So the most important thing to know here is that the range of reported adverse-event types is far, far, far greater than we've ever seen in the past for any and all of the vaccines combined, as a matter of fact. Which, also, this is evidence. It's not proof, but it's very strong, compelling evidence that there's something very different about these shots. And that probably is liver related. But this involves the circulatory system, the immunological system, every system you can think of is basically affected here in some people.

Just to put some numbers on this and to incorporate this underreporting factor, if I put a number on each of these eight adverse events here that are associated with clotting pathway dysregulation, you get something that looks like this on the left. And the reason I used an underreporting factor or URF here of 31 is because this is a calculation that I've actually made and published in a peer-reviewed journal article, which is based on Pfizer's Phase III clinical trial data and their rate of severe adverse event occurrence, which is 0.7.

So I calculated an URF of 31. So if you multiply these numbers, these absolute counts on the left, by 31, you get these numbers on the right. And so this is a much more realistic depiction of how many people might actually be suffering here. And it's not an exaggeration in my opinion. If anything, it's an underestimation. And nobody that I know looking at this data would argue with that. They're probably looking at these numbers now, and they're saying, "Wow, Jess, you really went under the line here." We're talking about hundreds of millions, I think, in total. So this is a serious problem.

Another paper was recently published that provided evidence that spike was directly responsible for worse clotting. And they propose that this has to do with some kind of dysregulation of plasmin. And again, this is the molecule that breaks down the clots. So we're talking about clots that are really resistant to degradation in the context of the spike protein. This is SARS and/or the spike protein associated with the shots.

There are two more papers that confirm this. The one on the left did a study that confirmed ARDS in influenza and ARDS, acute respiratory distress syndrome, in COVID. And this other paper did a similar analysis. And they both found that the clots that are produced in the context of the SARS or some sort of the spike protein are bigger and hardier. And I'm wondering if, in addition to clotting dysregulation—something along the pathway that's being messed up—if this isn't being irritated, let's say,

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by the addition of amyloids. And I'm going to get into what that means, and why I might think that. Because amyloids are proteins that are very, very degradation resistant. They're unwanted proteins, absolutely, misfolded proteins. We don't want them around.

And just to reinforce here. If these dysregulations and if these adverse events are actually spike-mediated—and there's a large community of people that really stands behind this now—in addition to lipid nanoparticle-mediated, this is really bad news. Because, like I said, there are published papers now that confirm that the spike and the mRNA are really durable and persistent. We found spike protein and mRNA up to 60 days in the germinal centres of lymph nodes. This is just when they stopped measuring, by the way. So keep that in mind. Not to freak everyone out. But when you hear people talking about detoxing from spike, it might actually be a really good idea for us to put our energies into doing this. Because this stuff seems to be really persistent. And it's very inflammatory and it seems to be very, very cytotoxic, as well.

We're not just finding it in the germinal centres of lymph nodes. We're finding them in epithelial cells. This is from a teenager, more recent. And everybody needs to watch Arne Burkhardt's presentation he gave at a recent conference in Sweden that I also spoke at and look at his slides. He's got probably thousands of slides showing the presence of spike protein deposition in various and sundry places. And even earlier than that, this is Sucharit Bhakdi on the right here, presenting some of his work at a conference in Vienna. And it shows the presence of the spike proteins in the capillaries of the brain and the small vessels of the myocardium. He found it everywhere. So go watch that. There's a link at the bottom.

And to bring this back to VAERS, I pulled out thrombotic events. And again, this an underestimate. I'm just giving you an idea of what we're seeing here. But we're well into the 100,000 mark, without the underreporting factor, distributed across all ages. No one is immune, not even the babies. So this is definitely a thing, let's say. These reports are very prolific. And beyond VAERS, beyond pharmacovigilance databases, all you have to do is talk

to clinicians or anyone on the ground, and you're hearing about this. It's ubiquitous right now.

But this is a worse situation than just dysregulation of normal functions if amyloids are actually involved here. I'm going back to this now. If these clots, the scaffold created naturally as part of the clotting pathway, are not being degraded in the first place because of some dysfunction in that mechanism and amyloids—which are basically just like additional pieces of glued fabric, like being thrown on a ball—you can imagine what's going to happen. That ball is going to grow, and it's going to cause physiological problems.

There's a paper that's been published, a material science paper, which is really interesting, that shows that amyloidogenic peptides are actually a part of the spike protein, which is quite alarming. It's been shown in this paper that there's an enzyme called a neutrophil elastase, which is the by-product of a particular kind of lymphocyte called a neutrophil, that can cut the spike protein into smaller peptides. And one of these peptides that they managed to find and investigate were amyloidogenic, which means that they cause amyloids. They are fibrils. They can create these plaques that are notoriously bad for human health. It's basically like out-of-control protein deposition wherever they are.

This is a little slide that I made. Sorry, there's a lot of information here, but it's pretty basic. On the right here, this is one of the peptides that they found as part of their study. So what a peptide is, is just a short chain of amino acids. So this spike protein on the left—this is a crystal structure of a spike protein—is what we call the quaternary structure. But it all boils down to this original chain of amino acids that you see in colourful beads here.

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So if you have just a segment of this chain of amino acids, this is called a peptide. So this peptide is 10 amino acids long that they found. And it absolutely has amyloidogenic properties, and this came from the spike. So it begs the question: Is this what we've been seeing in terms of the emphasized problems with clotting? Because we have blood clots on one hand, which is this grape jelly stuff. And then we have proteinaceous collagen-rich deposits on the other. And we have these things together. So is this what we're seeing the embalmers talking about? I really have to wonder.

Shawn Buckley
Dr. Rose, can I just step in? So did you see the presentation of the embalmer, Laura Jeffery?

Dr. Jessica Rose
I did.

Shawn Buckley
There were some photographs shown, basically, I mean, they almost looked like earthworms or spaghetti. Is that the type of thing that you're now discussing?

Dr. Jessica Rose
Yes, that's the idea in my head. Now, I'm not an embalmer. I haven't seen these things with my own eyes. But what I have seen are white, rubbery, very, very strong, like rubber-band-strong things that the embalmers are claiming that they're pulling out of the bodies and

that are making it hard for them to actually do their work. Because something—not blood clots—is restricting the flow of the embalming fluid when they turn on their machine. And, so from what I understand, you have to actually physically cut open specific sites and take out these proteinaceous deposits, which actually fill the entire vessel cavity, before you can have the flow of the embalming fluid go through and flush out the actual clots, which are, you know, just jelly. So it's possible that that's what this is. I mean, I actually am pretty damn sure now that what we're seeing is systemic amyloidosis. It's fibrin-rich, collagen-rich, proteinaceous deposits wherever this spike is, basically. That's what I think is happening.

And just to reinforce that point. I think that's maybe why the range of adverse events that I was talking about—this 15,000—refers to just about any problem you can imagine having physiologically. The problems from the very beginning— By the way, when I was looking at this in January 2021, there's a systemic nature to the adverse events that are being reported. It's not exclusive to the cardiovascular system or to the neurological system or to the immunological system. I mean, the immunological system is the basis. But it's affecting everything. So it's like, what's the consensus here?

This is my last point, and this is just my own idea. Myocarditis is one of the things that has been my meat in all of this, in the descriptive analysis of VAERS data. I penned a paper with Peter McCullough that got force withdrawn. And, interestingly enough, this was five days before this open public hearing that I was speaking at. I'm not going to play this video now because I don't have time. But I've submitted it as part of my testimony [Exhibit TR-4f] so you can hear this, and it's also online. And it's interesting because this hearing was to provide an opportunity for us, the medical scientist research community, to tell the FDA why we shouldn't put these things in 5- to 11-year-olds.

And the main finding of the paper, besides a much higher background reporting rate of myocarditis in kids— So what you're looking at here are the myocarditis reports—the reports that were filed, diagnosis: myocarditis in VAERS—for all the people, all age groups, as per dose. This is dose one, two, three. And this is the Moderna, the Pfizer, and the Janssen products in this plot. So what you see here in green is something like a four times higher reporting rate of myocarditis in young people. This is a very, very, very compelling slide in terms of causality. Because if there was no effect, if there was no impact on subsequent shots, then we wouldn't see this difference. And this is not seen, and I looked, in any other type of adverse event; this is very unique to myocarditis in kids. And, again, I just want to reiterate: This is not a secret.

[00:45:00]

Everybody's talking about this, even the CDC has admitted that this is a problem. I think they even have this on package inserts now. This is not a secret. This is well known. So this was one of the main findings that was in the paper that got published with Peter that was subsequently force withdrawn. By the way, it remains in limbo.

Shawn Buckley
Can I just interject? I just want to make sure that everyone listening to you fully understands what you're saying. So you were co-author and the lead author on a paper with Dr. Peter McCullough, who is a renowned cardiologist. That paper was accepted in a peer-reviewed journal to be published and was published. But a few days before there is a meeting to determine whether or not these vaccines should be approved for use in children, the journal pulls your report or your publication from the journal.

Dr. Jessica Rose
That's right. So you can see that here. This is prior to the title being tagged with "temporarily withdrawn" and then, subsequently, "withdrawn" from this journal. And, yes, it was five days before the testimony. So I don't believe in coincidences. I think this was done intentionally. And the reason that was given was that it was their prerogative to do so. They said, at any point during the publication process, even in the final, final stages, they can decide not to publish. So that was the reason. There was nothing wrong with the science: Nobody argued that what we had said was questionable. Nothing wrong with the content whatsoever. And, wow, yeah, there were a lot of people who did hit pieces on this. So yeah, that's the story. And like I said, it remains in limbo.

And it's a real heartbreak for me because this had gained so much traction in the stages that lead up to final publication, like tens of thousands of people had downloaded it. It's something that everybody wanted to read about: the pediatricians, the researchers, the parents. I mean, the thing that breaks my heart the most is that people didn't have an opportunity to freely read this material that was peer-reviewed and make their own damn mind up. That's criminal. Because so many kids have been injected with this stuff because they thought it was safe and effective because of the hearing. They voted 16 to 0 that this was perfectly fine to put it into 5- to 11-year-old kids after this meeting, despite my testimony and everybody else's. Yeah, it's a tragedy. There's no other word for it. It's an absolute tragedy.

Shawn Buckley
Dr. Rose, I'll just let the commissioners know, this report titled *A Report on Myocarditis Adverse Events in the U.S. Vaccine Adverse Events Reporting System (VAERS) in Association with COVID-19 Injectable Biological Products* is entered as Exhibit WI-4c. So both you and people following the NCI can see that.

Dr. Rose, we're also going to enter as exhibits your report on the *U.S. Vaccine Adverse Events Reporting System (VAERS) of the COVID-19 Messenger Ribonucleic Acid Biologicals* [Exhibit WI-4b] and your report on the *Critical Appraisal of VAERS Pharmacovigilance: Is the U.S. Vaccine Adverse Events Reporting System (VAERS) a Functioning Pharmacovigilance System*? [Exhibit WI-4d] And I'll just ask— There might have been some changes in your opinion since you wrote those. Would you make any additions to those at this point in time or are they still, would be your full opinion?

Dr. Jessica Rose
Yeah, they're all valid. Who came up with those titles, though? That was me. I'm just making a joke.

They remain valid. The first paper that you mentioned is just my first descriptive analysis which showed two things: It showed that there were clustering of reports related to neurological and cardiovascular and immunological damages. That's what I was talking about before. From the get-go, I noticed that there was no organ system that was immune from damage here.

And the second one was a test of the pharmacovigilanceness of VAERS. I wanted to see what was going on with regard to reports that VAERS reports were going missing. And this was coming from people who had filed, who said, "Where's my VAERS report?" It's absolutely true. And I showed—go read that paper—that VAERS reports are just removed

[00:50:00]

following this extremely difficult procedure of getting a VAERS report filed and entered on the front-end system. I think everyone should go to OpenVAERS. This is a very good friend of mine who has written a lot of articles on the ins and outs of VAERS and how there are probably up to three sets of books of VAERS data. Please go there and read her stuff. I don't really have enough time to go into the details. But the VAERS front-end data set from which I'm doing my analysis is, again, it's an underestimate-galore of what's actually going on. It's a nice representation. It's a sample. We have 1.5 million reports, which is a nice-sized data set. But it's still just a fraction of what's going on. So go read those papers and go to OpenVAERS.

I'm going to close with my last point. I'm wondering if the myocarditis diagnoses being made— Because cardiac amyloidosis is very often under- and misdiagnosed. It looks a lot like myocarditis. Myocarditis is basically just a general descriptive term for inflammation of the myocardium, which is the middle muscly layer of the heart that allows it to beat. So if there was a further examination in the right way and the right testing was done to examine the nature of the scar tissue of the myocardium, I'm almost certain that we would find out that these myocarditis cases could actually be referred to as cardiac amyloidosis: deposition of fibrous tissue and scar tissue on the myocardium.

So this is just leaves rustling in the wind, some more VAERS data. But I looked in VAERS for reports related to amyloids, fibrin, and syncope, which is fainting, because amyloidosis, when there's heart involvement, is often associated with syncope or pre-syncope. So I looked at this. And I noticed something I don't notice when I look at many other types of adverse events or clusters and that's a clustering of reports in the younger age groups between 12 and 39. And so something's definitely going on here in our young people. And I don't think anybody can refute that at this point, either, because we're seeing a lot of young people, in fact, dying. And I'm wondering if the ones that are related to cardiac issues don't have, say, myocardial tissue replaced with scar tissue so that their little hearts can't beat anymore. It's just an idea. I'm not a cardiologist. But it's just one of the ideas that I had.

I think everybody needs to follow Arne Burkhardt's methodology. He's a pathologist and he's done brilliant work, like I've said. He probably has thousands of images of spike deposition in and around every single part of the body. He's doing autopsies. He's staining for amyloids. He's staining for spike-specific protein or spike protein deposition, and he's finding a lot. I don't have time to show you any of his work, but here's a link at the bottom where you can watch an entire presentation in Sweden. It was quite the honour to watch this live. I literally took a photograph with my camera of every single one of his slides. It was extremely compelling.

Shawn Buckley
Dr. Rose, we will enter your slideshow as an exhibit [Exhibit WI-4g] so that both the commissioners and anyone following the NCI can view that. I'm wondering if you would be open to questions from the commissioners at this time.

Dr. Jessica Rose
Yes, I'm done anyway. What perfect timing. Here's Buckminster Fuller, a slide, whom I love. So yes, I'm absolutely open to questions. Well done, Jess, good timing.

Shawn Buckley
Okay, are there any questions from the Commission? Yes, so there are.

Commissioner Massie
Thank you, Dr. Rose, for your very thorough and enlightening presentation. I have a number of questions. But I guess that we have to review your material in detail to dive deeper in a lot of the things that you're showing.

I'm a little puzzled by some analyses and studies that have shown that there are, indeed, in some studies, protection from COVID death

[00:55:00]

following vaccination, so if you just focus on cases where you could actually document, reasonably well, protection from death from the vaccine. And this argument is used over and over again as a line to promote vaccination and repeated booster, and so on. So what is your thought on these studies that have been done to show potential protection from death following vaccination?

Dr. Jessica Rose
Well, to be honest with you, the studies that I've seen—there are some coming out of Israel—they don't show that at all. As a matter of fact, what I've seen— Maybe I haven't seen the right study. But the studies that I've reviewed show more people are ending up in the hospital and dying in the group that were injected.

There are also a number of problems with repeat injections that are related to issues of tolerance by the immune system. It seems like there's a very clear story developing now that tolerance is being induced by repeated exposure to the spike antigen. And basically, what that means is that you're not going to be mounting any kind of immune response to that protein or anything related to it. So, basically, if you're exposed to this virus, challenged by it, then you're not going to mount an effective immune response. So I'm not sure I agree that these products have saved many lives. I'm much more focused on the damages that they've done. That's my meat. That's what I'm primarily focused on because I don't think that the people who were injured have a voice. It's been taken away from them, and I want to be a voice for them. So this is my focus. And I was going to say something else, but I don't remember.

Commissioner Massie
Okay. My other question would have to do with the cytotoxicity of spike, which is now, actually, I would say, fairly well documented by many, many reports. It seems to me that this knowledge that spike could be potentially cytotoxic was probably known somewhat in the scientific literature before we decided to go ahead. So why is it that it was dismissed or ignored?

Dr. Jessica Rose
I don't know. It's an excellent question. I can't imagine that the people who are working on this didn't hypothesize that—since the modus [operandi] of this technology is to induce an immune response, an inflammatory response against the spike protein—that they wouldn't have anticipated that wherever the spike was going to be presented on MHC molecules, or

embedded in whatever cell, that an immune response wasn't going to be mounted in order to kill those cells. And that would cause, in some people, hyperinflammation. I mean this comes back to the original trials where the exclusion criteria lists were so long. They discounted people with pre-existing autoimmune conditions, for example. And a lot of these have to do with hyperinflammation or a hyper-inflamed state. So it could be, this is one of the things that I've hypothesized, that we're seeing the worst effects of these products in people who had pre-existing conditions, like some kind of hyper-inflamed state, which a lot of people have.

I find it impossible to imagine that they didn't anticipate a potential problem or the potential problem that most people who are reporting adverse events are reporting on. And this is the systemic, notorious damage being done, say, to blood vessels or wherever the spike protein lands, like I said.

And just to reinforce this, we were explicitly told that the contents of the needle were going to remain primarily at the injection site. This was hammered home. And they also knew, I want to reiterate this and make this very clear—as we know from the FOIA-requested pharmacokinetic data and also from a paper, which you can find in the supplementary material in my slides, from 11 years ago that confirms that they knew—this is published in the literature that these types of lipid nanoparticles traffic to the ovaries in the same animals.

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And the reason we do animal models is because we basically have the same organ systems. So traffics to the ovaries in Wistar rats or mice, probably traffics to the ovaries in humans. And low and behold, it does.

I know it's a long-winded answer. But there are a lot of things that they did know. And we know that they knew now because of forced FOIA requests. We wouldn't know half of what we know about the data or the studies that they did and didn't do if we weren't asking for this data that they don't want to reveal. So I dare say that there's a lot that they knew. There's a lot that they know now. And they're obfuscating from the public because it would be bad for the program.

Commissioner Massie
If I can ask one last question. What could be a little bit misleading is that spike will be produced from the viral infection and should you be unlucky and get the virus invading the blood circulation, you will get spike protein produced from the virus. So it could actually probably trigger all kinds of phenomenon [like] the one you're describing in the adverse event.

What would be, in your opinion, the differences between the spike protein produced from, say, an infection that is not properly controlled versus the spike protein that you are producing following the injection of the messenger RNA?

Dr. Jessica Rose
It's the scale. It's a very, very simple, quick answer. The transfection technology is designed to make massive amounts of spike protein. And with repeated injections, you're going to have massive amounts of spike protein being continuously produced. This is very, very, very different from being exposed to a virus with many, many, many different proteins. You

don't just have the spike protein. You have all these other proteins against which your body will form, say, antibodies and mount T-cell responses against. So you're going to have a robust, multifold fighting force aimed at a number of proteins. It's a systemic fight against a viral pathogen, let's say. You have the introduction of the virus. You have viral expansion. You have the immune response kicking in, and then you have the decline. So there's this natural process: this ebb and flow between the introduction of a foreign pathogen-like virus and the immune system.

This is not that. This is massive in comparison. There are many people who know the numbers. I don't know them off the top of my head. But it's multifold higher amounts of spike protein. It's a deluge. And in some cases, let's say it gets into the blood because the person wasn't aspirated and it disseminates everywhere. And wherever those lipid nanoparticles dump that payload, that spike protein is going to be manufactured. It's so, so, so different from the natural immunity course. Yeah, it's the scale.

Commissioner Massie
Thank you very much.

Commissioner Drysdale
Good morning, Dr. Rose. In your presentation, you talk about the VAERS system. In Canada, we have a system that most people have never heard of. It's called the CAEFISS system [Canadian Adverse Events Following Immunization Surveillance System]. And what we heard from previous testimony was that reports to the CAEFISS system were being screened or triaged, if you will, by public health officers. And doctors were suspended and punished for making reports to that CAEFISS system. Was that the case with VAERS as well, or are you aware of what went on in Canada with the CAEFISS system?

Dr. Jessica Rose
I am. It's appalling. But from what I understand, it was far worse in Canada. Now, that's not to say that this absolutely wasn't happening, not only in the U.S. but in the U.K. with the Yellow Card system, the EudraVigilance system for the EU, and the DAEN system in Australia. It's been kind of a global phenomenon where reporting adverse events is not only not the first thing that someone would do, necessarily—maybe it's because they just had a 14-hour shift in the ER—but because it was discouraged.

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This is what I've heard from doctors in hospitals, the ones on the ground, and the nurses. And nurses know everything. They're saying that they feel there's like an air of threat if you even suggest that someone might have suffered an adverse event in the context of this shot.

So it was very highly discouraged to file a report. That's why it's kind of remarkable to me that there are still over 1.5 million in the VAERS system. And that's why I also made the comment about the fact that this might even just be the tip of an iceberg. I'm not sure how bad it is. But certainly, when you factor in the under-reporting factor, it definitely is contained within medical professionals being discouraged to report. There's also the human component. I mean, some people just will never be compelled to report something. Maybe they won't think of it. I mean, I'm vaccinated out the yin-yang for most things, not these things. But if something had happened to me, I can't think of something. But I never, never in a million years would have thought it was because of one of the vaccines I got. I'm

one of those people. I really empathize with this because I mean there's so many reasons why people wouldn't be reporting. But I can absolutely tell you that it was discouraged.

Commissioner Drysdale
Next question. You had referenced Dr. Braden, I believe, in one of your reports. And we had her give a presentation to us in Truro, Nova Scotia, some weeks ago. Some of the things that Dr. Braden talked about was— I don't want to put words in her mouth, but in my interpretation, a systematic failure from the system, from the theoretical point of view right up to application. What she was talking about was she questioned the mRNA technology itself. She questioned the manufacturing process in that she referenced a number of tests of the actual vaccines, which showed a number of foreign particles and all kinds of unknown things. I believe she referenced that there were portions—and this is an engineer talking, not a doctor—of RNA that had remained in the *E. coli* they used to create this stuff. And so there was a potential that this RNA had affected the genome, and it was in *E. coli*. And then the last thing she talked about, and you referenced a couple of times, had to do with the actual administration of the injections in that the manufacturer said that it was going to be intermuscular. But many of the injections were not aspirated. If I understand, aspiration is when you put the needle in, you pull the plunger back to see if you're in a vein or not, and if you're not in a vein, you go ahead.

Can you comment on how all of those different things might be contributing to the 15,000 or so different types or classifications of adverse events out of a total of 24,000?

Dr. Jessica Rose
Yeah, I sure can. And I love that you've put all this together because this is such a tricky pony. I mean, there are so many factors that could lend to the outcome. The predictability here is absolutely almost zero, in my opinion, because it's going to be based on the person's age, the person's immune age, what other vaccines they have, if they're on medication, if they have co-factors, how the needle went in, what was in that syringe, et cetera, et cetera, et cetera. There are so many factors that are going to lend to the outcome. I can't stress that enough.

So my idea of a worst-case scenario is this, that will bring up all of the things that you asked about. Aspiration, first of all, is when you pull back on the syringe, and if you hit a vessel, you're going to get some red. And that means you're in the wrong place, right? You don't want to inject it into the blood because that's not where it's supposed to go. It's supposed to go to the muscle, like you said. They were actually recommending, and by they, I mean the CDC on their website, not to aspirate. And I can't figure out why they would have been doing that because everyone should have been doing that. So what that would mean is that you would get dissemination of the lipid nanoparticles carrying the payload where they weren't supposed to go necessarily.

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That's number one. That could be bad news in terms of adverse event.

Number two is this polyethylene glycol. This is the molecule that coats the lipid nanoparticle. And if it's coated homogeneously, which means that it's evenly coated around the whole surface, then it's going to be the nice slippery, little ball that it's supposed to be that can traffic to wherever and get wherever it's going optimally. So if for example, if you have a bunch of vials that weren't handled properly or in the manufacturing process, the

lipid nanoparticles weren't coated homogeneously, and you have, say, holes in the sphere where there's supposed to be PEG, that's actually going to bode well, in my opinion, for the person who's injected. Let's say that they got their injection into the muscle. Because those lipid nanoparticles aren't homogeneously coated, they're going to break down much easier at that site. So you're not going to have dissemination of either the lipid nanoparticles or the payload. That's number two. It's just an idea, but I think it has merit. There's a working group of German researchers who actually proposed this as well. It's in one of my presentations.

And as for contamination, a colleague of mine has recently been sequencing— He started with the bivalent products, the Pfizer and the Moderna, and he's moved on to sequencing the monovalent products and has found double-stranded DNA contamination in all of them. Not some, all of them. And what this double-stranded DNA contamination is, are the plasmids that are used in the production line to produce the mRNA. And what's supposed to happen at the end of the production line—you'll appreciate this as an engineer; there's like five steps that I showed in my slide—is that the mRNA is supposed to be purified. You're supposed to take that out at the end stage. It's expensive to do this. And because we have so many evidences now that good manufacturing processes weren't abided by, it's possible, I will say, I'll be generous, that the mRNA wasn't purified properly. That's exactly what this indicates because the presence of the double-stranded DNA is not explainable otherwise. It shouldn't be there.

And so we can't say definitively what the clinical outcome of that contamination is going to be. But we can say, based on his findings that he has recently put to preprint, is that the levels of double-stranded DNA that are "EMA permissible" far exceed any levels that they've written down in the literature. So we know that there's contamination of certain kinds. And it's kind of scary to think about. We know that corners were cut all along the way here. I mean, there just simply wasn't enough time to do everything right. That's a fact. But it's scary to think about what actually might be in the vials themselves.

I want to make one more point here. Even if everything was done perfectly and we had our homogeneously-coated lipid nanoparticles (LNP) with our full-length spike protein—I didn't even mention per cent RNA integrity here; I don't have time—which when delivered, translates to full-length spike, this is probably the worst scenario you can have because of the papers that have been released that show that the double-stranded DNA repair mechanisms are impaired when spike is found in the nucleus. And it does get trafficked there because of this furin cleavage site. So no aspiration; full-length spike protein; homogeneously-coated LNP; and somebody with, say, a pre-existing autoimmune condition or is hyper-inflamed and old, perhaps, infirm—this is the worst-case scenario, in my opinion.

Commissioner Drysdale
The last question and that has to do with— A previous witness had talked about the potential contamination of the genome. And I think you mentioned, yourself, about that this has been found in the nucleus of cells. If this has penetrated all of the organs of the body and if you're finding it in the nucleus of the cells,

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can you comment on the potential for an effect on the overall genome?

Dr. Jessica Rose
Let me just say that I think the potential is there. The proof of integration is not there yet. But I have no doubt in my mind that this paper is on the way, based on the evidences that we've accumulated to date. I want to be careful here about what I say because I don't know yet. I don't think that it's impossible that germline integration is going to be something that we're talking about soon. I think that if it happens, it's going to be a rare event. But the thing about it is if it happens at all— Again, this is absolutely inexcusable because I cannot imagine that all of the brilliant minds behind this technology couldn't have anticipated the possibility here. If they knew about the reverse transcription, which has been shown—this is in the literature now that LINE-1, which is an endogenous retrotransposon in humans, can convert this mRNA back to DNA—then why wouldn't it be able to integrate? I mean, again, I'm not saying that we have definitive proof of that yet. But I wouldn't be surprised if that paper is in the pipeline right now.

Commissioner Drysdale
And I apologize. I said that was my last question. But it just occurred to me in listening to you. You know, I got up this morning and I looked at the news, and there was this incredible story about the James Webb telescope. And it was looking into the eternal reaches of our universe, and it'd taken in these incredible pictures of Jupiter, and it was gathering all this data that was so far away. And, yet, when we were in Toronto, we had an embalmer telling us about these fibrous masses in the veins and, to my knowledge and to the knowledge of that witness, no one had dived in like the James Webb telescope to find out what these things were. And my question is, do we not have the technology to go to a funeral home when someone's reporting this and take a sample and test it and tell me what it is?

Dr. Jessica Rose
And I have the same question. It's the same thing to me about the autopsies. I'm dying to know why we're not autopsying everyone now. Like, why aren't people whose kids are dying demanding autopsies? I mean, that's what I would do. This is like the microscope into the forensic data collection of why the person passed away. I mean, it's like the most important thing of all. So I can't answer you because I just don't know.

What I can suggest is that there's a movement to suppress this from being done, just like there was a movement to suppress autopsies from being done because it was "too dangerous" in the beginning. So okay, fine. We'll give you that, it was too dangerous back then before we had all this figured out, quote-unquote. What's stopping us now? I don't understand.

And there is one group who analyzed this proteinaceous stuff. And the only thing that I remember that they found is that they classified it as organic. And that makes a lot of sense to me because I think it's just collagen. So I mean, I'm not in a lab now. But if I was in a lab, that would be the very first thing I would do. I'm like, I've got to find out what this material is because, if it's collagen and it's just, you know, the natural things of the body in "on" mode, like I said, then, basically that confirms what I said. And then we can solve the problem.

Well, actually, the first stage of solving the problem is to stop injecting these things into people because they are causing problems in some people. And because we're not being allowed to acknowledge this or ask questions, we're not able to come up with viable solutions out in the open. I mean, we humans are so much better together. So you know,

even if the people who are promoting this stuff came to, so-called, our side and our brains got put together and we collaborated, we could solve this real quick. I'm the forever optimist.

Commissioner Drysdale
Thank you, Dr. Rose.

[01:20:00]

Dr. Jessica Rose
Ooh, he's a happy guy. Ooh, he's happy. That's my cat. He's very happy.

Shawn Buckley
We have one more question for you.

Commissioner DiGregorio
Hi, Dr. Rose. Thank you so much for your testimony today. I think I heard you say that a number of your studies involved you downloading a lot of VAERS data. And I understand that your expertise is in the VAERS data and not our CAEFISS Canadian database. But I'm just wondering if you know whether or not the same type of data is downloadable from the Canadian CAEFISS database.

Dr. Jessica Rose
I'm going on memory now. And I got to tell you my memory is not so good. I don't think so. Definitely, I know this: VAERS is the database that I chose because it was very accessible. You literally just go to the VAERS website and download CSV file, very large now. And if you're going to have a crack at this, I don't recommend using Excel because it gets stuck. I recommend using R. But as for the CAEFISS system, I'm trying to remember if I even tried, but if I did—I know that I looked at it once. I don't have a good answer.

Commissioner DiGregorio
And then my last question is about the VAERS database itself since that's where your expertise is. If you could make one improvement to it to help gather better data and do better analysis, what would that be?

Dr. Jessica Rose
Hand it over to different owners, that's what I would do. I was actually in a kind of task force at the very beginning of this to try and design a new system. And the fact of the matter is VAERS is very antiquated. The move to paper forms to online has been kind of, you know, it's a good attempt type-thing. All that aside though, like I said, it still works. It's annoying. It's underreported. But it still works.

The problem with VAERS right now is not all of those things. It's not the fact that it's antiquated. It's not the fact that it's underreported. It's the fact that the data they're in, the people they're in, who are filing reports, are being ignored. The people who own the data are not handling the data in an appropriate way. They're ignoring it. And not only that, but

there are smear campaigns out there against people like me who are, like, public citizens who are trying to bring this data to light. So that people understand, this isn't an interpretation thing. This isn't about, the fact that they've put so many shots into people. I've done a napkin math to show that that's not true. This is literally about the owners of the data not doing what they've always done.

Josh Guetzkow is a friend and colleague of mine. And he's done many FOIA requests to show that they're not doing PRR [proportional reporting ratio] analysis, which they've always done. They're not doing Bayesian analysis, which they said they would do in lieu of the PRR. And they're absolutely not doing causality assessments, which is like the main claim to fame here. I mean, it's absolutely ludicrous for anybody to claim that if you have half of any subset of adverse events, like death, being reported within 48 hours of injection, that there's no causal effect. I mean, come on now. Come on now. Why aren't the alarm bells being rung? And, clearly, it's because they're not motivated to do so. So long answer short, I would change the owners.

Commissioner DiGregorio
Thank you.

Shawn Buckley
Dr. Rose, I think those are our questions. On behalf of the National Citizens Inquiry, I sincerely thank you for taking the time to share with us today. Your testimony is appreciated.

Dr. Jessica Rose
Thanks so much. It was my pleasure. And yeah, let's keep talking.

[01:24:29]

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The evidence offered in this transcript is a true and faithful record of witness testimony given during the National Citizens Inquiry (NCI) hearings. The transcript was prepared by members of a team of volunteers using an "intelligent verbatim" transcription method.

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