



NCI | CeNC

NATIONAL CITIZENS INQUIRY

**EVIDENCE
POST-HEARING**

NCI | CeNC

**Virtual Testimonies
June 28/July 19/Sept 18, 2023**

ABOUT THESE TRANSCRIPTS

The evidence offered in these transcripts is a true and faithful record of witness testimony given during the National Citizens Inquiry (NCI) hearings. These hearings took place in eight Canadian cities from coast to coast from March through May 2023.

Raw transcripts were initially produced from the audio-video recordings of witness testimony and legal and commissioner questions using Open AI's Whisper speech recognition software. From May to August 2023, a team of volunteers assessed the AI transcripts against the recordings to edit, review, format, and finalize all NCI witness transcripts.

With utmost respect for the witnesses, the volunteers worked to the best of their skills and abilities to ensure that the transcripts would be as clear, accurate, and accessible as possible. Edits were made using the "intelligent verbatim" transcription method, which removes filler words and other throat-clearing, false starts, and repetitions that could distract from the testimony content.

Many testimonies were accompanied by slide show presentations or other exhibits. The NCI team recommends that transcripts be read together with the video recordings and any corresponding exhibits.

We are grateful to all our volunteers for the countless hours committed to this project, and hope that this evidence will prove to be a useful resource for many in future. For a complete library of the over 300 testimonies at the NCI, please visit our website at <https://nationalcitizensinquiry.ca>.

TRANSCRIPT TEAM (English)

Managing Editor
Jodi Bruhn

Transcript Coordinators
Debbie Palmer, Erin Thiessen

Formatting and Analysis Leads
Veronica Bush, Melissa Neville

Whisper AI Transcript Creation
Madison Lowe

First Review

Anjum Ahmad-Donovan, Bill Allwright, Lisa Aschenbrenner, Anne Marie Baxter, Vanessa Behrens-Nicholls, Pamela Boese, Yvonne Cunnington, Michael Darmody, Teresa Dockstader, Heather Domik, Rita Mae Ewanchuk, Chantal Gutfriend, Monika Harynuk, Michelle Hughes, Karen Kimmet, Kathy Ladd, Lori Morrison, Ronald Mucklestone, Melissa Neville, Debbie Palmer, Joanne Plamondon, Susan Reh-Bosch, Elisa Rolston, Tanja Shields, Ronald Simpson, Elizabeth Sleight, Al Smigelski, Darlene Smigelski, Barbara Spencer, Dawn Sutherland Dort, Christine Taylor, Evelyne Therrien, Erin Thiessen, Ada VandenBerg, Rich VandenBerg, Sally Williams

Second Review

Veronica Bush, Elizabeth van Dreunen, Brigitte Hamilton, Rosalee Krahn, Val Sprott

Final Review

Jodi Bruhn, Anna Cairns, Margaret Phillips



NATIONAL CITIZENS INQUIRY

Virtual Testimony

June 28, 2023

EVIDENCE

Witness: Dr. Denis Rancourt

Full Timestamp: 00:00:00–02:56:57

Source URL: <https://rumble.com/v2wpyqu-national-citizens-inquiry-denis-rancourt-virtual-testimony.html>

[00:00:00]

Shawn Buckley

... short opening. Well, actually, let's have the commissioners up because I'll address them.

So welcome to the National Citizens Inquiry as we make history today. We're starting our very first virtual testimony.

By way of update, the commissioners had requested that we bring Denis Rancourt back to deal with a couple of specific things, which we will be doing. But I also wanted to give you a little bit of an update on the National Citizens Inquiry. The commissioners, who are all in attendance—Janice is also listening in and may appear on camera a little later. But the commissioners had made a request because of a couple of studies that—one which is published and one which is not published yet but is awaiting publication. They wanted Mr. Rancourt to speak to those, and so we've invited him back.

But the commissioners are also working quite hard on their report. For those of you who aren't aware, the National Citizens Inquiry held testimony in eight cities, in eight provinces, for a full 24 days. There is an amazing 300 separate witnesses that testified under oath on issues related to how all levels of government in Canada addressed the COVID-19 pandemic, which is just a monumental amount of evidence for the commissioners to digest. So I just wanted to thank them for the hard work that they're doing.

The NCI is also now in the process— There's a team of volunteers, I believe there's 70 of them, all volunteers, that have taken it upon themselves to go through three separate readings of each witness's testimony so that at the end of this we will have accurate transcripts of all of the testimony. And then there's a separate team working on the website so that each of the 300 witnesses will have their own webpage linking to their testimony, linking to their transcript, linking to exhibits and all done in a very highly searchable way. The NCI has accumulated the most impressive body of evidence on COVID of any group— government or non-government—in the world to date.

And I'm thankful for all of you that have participated and are participating. We actually haven't done a tally of volunteers, but we're probably 800 to 1,000 volunteers that, in one

way or another, have participated to make this a reality. As I indicated during our live hearings, we're a citizen-run, a citizen-led, and a citizen-funded initiative, and I'm so pleased to announce that with all of your donations, we are able to cover the cost of the hearings, and we're extremely grateful to you.

I'm almost going to choke up again because every time I talk about this, I'm just totally—I find myself in awe of what's happened, and I feel that what's happened is divine, and I feel that what's happened is unusual. I feel now that I'm part of a wider community, and no one anticipated that this would happen. But we're still getting report after report of persons telling us that they feel that they're part of something bigger, that they don't feel that they're alone anymore. And I know that I personally feel that. I feel that I've participated in something much larger, and I feel that I'm not alone, and I feel much more hopeful. I know that things are coming at us going forward, but I know that I'm going to act and stand differently than I did before and that I'm not going to be standing alone. And sometimes I still find myself really just unable to process what's happened.

I was on a Twitter call or, you know, a Twitter Spaces that the NCI did, so probably about four weeks ago now. And during the call, somebody stepped up from just being a listener to share that they had printed off a one-page form and had been, you know, trying to bring awareness to the NCI. So I assume this person even had created the form. And just how difficult it was and how some other people stood up to help her do this. So she had found this really emotionally difficult.

[00:05:00]

And what was interesting about her description and what was so touching about it was she almost seemed ashamed that that's all she was doing.

And I couldn't help but think about the Widow's Mite, you know, where Jesus is at the temple and he's watching people come and donate huge amounts—this was all done publicly. And this little widow comes and just puts in, you know, literally a cent. And he points out to his disciples that she gave more than anyone else. And they're like, "Well, what do you mean?" "Well, she gave all that she had."

And so I was touched because this person telling us on this Twitter Spaces call what she had done—it was clear that this was a big effort for her and that she found it very challenging, and yet it was so meaningful. And it was so meaningful for those listening. And that's what the NCI is. The NCI is people just stepping up and doing things because they feel led to do it, and it's their way of participating.

And so I want to thank everyone out there that has been doing what they feel they should be doing, because that's what this is all about. It's not about this small group of the NCI that got together to organize these hearings. It's about you deciding what you're going to do and stepping forward. And I think that's why we all just feel so touched. And we all—and I know the commissioners feel the same way—just honoured to be part of this process. So thank you for letting me give a short introduction.

Commissioners, for the record, my name is Buckley, initial S. I'm attending as agent for the Commission Administrator, the Honourable Ches Crosbie. I'm pleased to introduce again to the NCI, Mr. Denis Rancourt.

Denis, can you please state your full name for the record, spelling your first and last name?

Dr. Denis Rancourt

Yes, Denis Rancourt, D-E-N-I-S, and then Rancourt is R-A-N-C-O-U-R-T.

Shawn Buckley

And Denis, do you promise to tell the truth, the whole truth, and nothing but the truth today?

Dr. Denis Rancourt

I do.

Shawn Buckley

Now, for those who have not seen Mr. Rancourt testify before, he testified in Quebec City in French; he testified in Ottawa in English. His curriculum vitae is attached to the NCI record as Exhibit OT-1a, and anyone can go to the website and review that. It's quite impressive.

But by way of introduction, Mr. Rancourt, you have a Bachelor of Science, a Master of Science, and a PhD in Physics from the University of Toronto. You have been a Natural Sciences and Engineering Research Council of Canada [NSERC] international postdoctoral candidate in prestigious research laboratories in both France and the Netherlands. You became a National NSERC University Research Fellow in Canada. You were a professor of physics at the University of Ottawa for 23 years, attaining the highest academic rank of full tenured professor. And as a researcher at the university, you were a researcher in interdisciplinary research.

And I'm going to ask you to explain that because it's important for the audience to understand. You became much more than somebody who just researched physics and focused on physics.

Dr. Denis Rancourt

Yes, I mean, it's not uncommon for physicists to work in other areas, but I was working in many other areas and actually had large research grants and a large research team working on biogeochemistry for many years and things like that. So I prepared a slide to illustrate the interdisciplinary nature of my background, as well. Yeah.

Shawn Buckley

Well, we'll get to that in a second. I'll just inform those that are participating online that you were invited back to speak about a couple of studies, which we will get to later. But then, since you have testified, there's been further information released concerning all-cause mortality—not just in Canada, but some other countries—and we've invited you to give an updated presentation.

And I'd like to invite you to do that now. And so, if you want to bring up your slide presentation and present that to the commissioners [Exhibits VT-1a, VT-1b].

[00:10:00]

Dr. Denis Rancourt

Okay. Well, thank you again for this invitation. I consider it an honour and a privilege. I'm going to talk about Canada a lot more this time because I think there were so many concepts to cover in the first part of my testimony that I didn't go into much depth with Canada. So I'm going to do that more this time.

[Interdisciplinary scientist]

This is to describe that I'm an interdisciplinary scientist, and this is a list of all the different areas of science that I've published scientific articles in and that I've worked on. As you go down the list, you get closer and closer to tenure and to retirement, so you have much more freedom and you can really get into the in-depth things that, normally, granting councils wouldn't let you do. And so I achieved a high level of proficiency in all of these areas and was given large research grants in the great majority of them, as well.

And the last one is theoretical epidemiology. So with first author, Joseph Hickey, we now have two articles that have been peer-reviewed in that field. So it goes all the way into mortality, disease, health, psychology effects, individual psychology effects on health, and so on. Those have been my more current research areas.

[Nanoparticles / molecular science / statistical analysis / modelling / measurement]

This is a slide I showed last time just to explain the main areas of science that I'm an expert in, that I've written papers on and done research and made discoveries in. And there are five main ones that are especially relevant to study of COVID questions: nanoparticles; nanoparticles in the environment; molecular science, meaning everything from molecular dynamics to how molecules form and react and stick to surfaces, chemical reactions, and so on; statistical analysis, getting into sophisticated methods, like Bayesian inference theory, and so on—I've written papers about that; modelling, in the broad sense—everything from modelling at the molecular level to modelling cycles of nutrients in the environment, how they cycle in the environment, and now, recently, epidemiology; and measurement theory, which is a broad— It's the way in science that we know things.

So I'm an expert in all the ways that scientists can measure things. So the main areas are microscopy—I had an electron microscope in my laboratory, for example; diffraction methods, which there's a whole array there; and spectroscopic methods and various kinds of characterizations of substances, whether they're live or not. And so those are all areas that I've developed techniques in and actually written scientific papers about. And so it gives me that broad knowledge to be able to read scientific papers.

[Collaborators]

My main collaborators on the COVID research are the following people, and I especially want to mention Marine Baudin and Joseph Hickey because they contributed most of the new material for this particular update that I'm going to give now.

[Bilingual First Installment of this Testimony]

So this is a continuation of the testimony that I gave in Quebec City and in Ottawa. And the exhibits, you can find them now, there's a large Book of Exhibits on the website of the National Citizens Inquiry [Exhibit OT-1]

[Book of Exhibits of Expert Witness, NCI]

And the Book of Exhibits that I had prepared is up there—and it's almost 900 pages—and it contains the key scientific reports and articles that I have written about COVID and COVID-related matters. So this is just a screenshot to show what the index of that Book of Exhibits looks like. That index runs for three pages [slides 6, 7, 8].

[BoE, NCI]

And I put an arrow there for the very first scientific report that I wrote about all-cause mortality, and it was way back on the 2nd of June 2020. And at that time, I concluded that there was not excess deaths from a pandemic but that instead, there were hot spots where very aggressive methods had been used in hospitals and caused the death of people. And that was even the title of that paper. And we just then went on from there and made that research more and more specific and looking at more and more countries.

[My website, COVID section]

And also, you can go to my website. There are more than 30 articles about COVID-related things there on my website in the COVID section.

[00:15:00]

[First Installment – Conclusion]

And in the first installment of this testimony, I concluded that there was no pandemic causing excess mortality; that measures caused excess mortality; that COVID-19 vaccination caused excess mortality; and that if there had not been pandemic propaganda and if governments had not done anything special—had not responded because there was nothing to respond to—and there had not been all these coercive methods—

Basically, if the medical establishment and governments had just done business as usual, there would have not been any excess mortality. That is the conclusion of all my work on all-cause mortality, studied by jurisdiction, by age group, and as a function of time. And looking at vaccine rollouts in coincidence with that, and so on.

[First Installment – Made These Points]

So in the first installment, I mentioned that none of the modern pandemics that are promoted by the CDC that are said to have occurred—there have been three of them since the Second World War: in '57/'58, in 1968, and in 2009—none of them cause excess mortality that can be detected in any country. So that's very important. All of this noise about pandemics has not created excess mortality that one can measure.

Shawn Buckley

Can I just interrupt you, Denis?

Dr. Denis Rancourt

Yes.

Shawn Buckley

So I just want to make sure that I understand and that those watching understand. So, like, the 1968, that was called the Hong Kong flu, I think. And then 2009, we all remember that; there was actually, I think, a vaccine rushed out. And 1957–58, I don't recall that. But what you're saying is in every single country, there is not a single detection of all-cause mortality going up to indicate that there actually was a pandemic happening.

Dr. Denis Rancourt

That's correct. All the countries where you can get data, that I've looked for a signal that could be assigned and that would be comparable in magnitude to the various theoretical

estimates of deaths and so on—what I see is nothing. There is no signal. There is no measurable excess mortality that can be associated with those pandemics anywhere in the world.

Shawn Buckley

Okay, and you've told us the same in your first testimony in Quebec City and in Ottawa concerning COVID-19.

Dr. Denis Rancourt

Yes.

Shawn Buckley

Because I think the average person is concerned that they're going to die.

Dr. Denis Rancourt

COVID-19 is a little bit—it requires more explanation. There is significant excess mortality in the COVID period. I explained in my testimony how you can prove that it cannot be due to a viral respiratory disease and why, instead, it is due to the measures and then, later, to the vaccines. But there is very significant measurable excess mortality in the COVID period, and it has a detailed time and spatial dependence and so on.

But these particular past pandemics, that were claimed, do not give a signal of all-cause mortality whatsoever. That's the point. And the CDC will bring us back to 1918 and claim that that was the Spanish Flu and that that is certainly an example of a pandemic that caused a lot of mortality. And it's true that there was a large peak in mortality in certain places, where a lot of deaths were occurring at that time. But it has been proven now by four or five independent studies from the preserved lung tissue of people who died that they all died of bacterial pneumonia. Okay?

And in addition to that, if you look at the all-cause mortality of that period, no one over 50 years old died, which is basically impossible for a classic viral respiratory disease. If you believe what we think we know about viral respiratory diseases, it normally kills elderly people. And so this is completely unusual but can be explained in terms of what was happening in the society at the time—just after world war and horrendous living conditions—families with their parents out of work in conditions that are just unbearable, these younger people and young adults died. But none of the elderly people who were established, who already were set for life,

[00:20:00]

they were not affected by this so-called pandemic.

So one can demonstrate logically and with known empirical data that that was most likely not the claimed viral respiratory disease pandemic, okay? And that's going to tie into what I'm going to explain today. I'm going to get into more of that, what actually causes death that you can measure in all-cause mortality.

[First Installment, cont'd]

So that was something I explained last time. I also explained last time that the excess mortality refused to cross national borders or state lines. In other words, this invisible virus targeted the poor and the disabled. There's very strong associations with whether you're poor and disabled and carried a passport, because it wouldn't cross borders. And it never killed until governments imposed these harsh socioeconomic and care-structure transformations—it never killed in jurisdictions until they did that.

And there was this vicious, new treatments that were applied in hospitals at the beginning, in the first months of the declared pandemic, and that caused death in hot spots—but nowhere else—and that death did not spread. And this was followed by very severe coercive measures that were squarely contrary to what is recommended for individual health. And we know what I'm talking about, all the horrible things that were done. And so those are the things that ultimately caused death. I explained that in some detail last time.

[Today: Testimony Update]

But today I'm going to concentrate on telling you much more about Canada and showing you the diversity of what death looks like in Canada as a function of time and place, so you can appreciate that it depends very much on their jurisdiction: what was happening to whom is what determines death, and so it can be dramatically different from one province to the next or one region to the next. I'm going to try to illustrate that with data. And then I'll take a quick look at the world because there's something very unusual happening in Canada that's also happening in many parts of the world, and I want to talk about that at the end.

And then in the second part, I'll be critiquing those articles that you asked me to look at, which are articles about—they tend to be large review articles which try to ascertain what we should have learned from the pandemic; what we can learn going forward.

[Theresa Tam and co.: 1M extra deaths scenario]

This is from the first part of my testimony where I showed that all-cause mortality in Canada basically didn't vary during the COVID period. So you can see a kind of flat line with the usual seasonal dependence there, and there's no big step. And I showed in red, there, what Theresa Tam and co-authors are saying would have been the mortality if they had not applied all the measures and vaccinated everyone: they are claiming that, in Canada, there would have been approximately a million extra deaths—which is completely absurd and impossible because what they're saying is, the complex measures that they applied would have brought us down to, basically, what is exactly the same level as if nothing was happening.

So it's important to understand that in Canada, the signal of excess all-cause mortality is very weak. It's very hard to see. There's almost no increase in excess mortality, unlike many other places in the world, like the United States, the Eastern Bloc countries, and Russia, and so on. There are many places where there's huge, immediate rises that are visible on a scale like this, of mortality, but you don't see that in Canada.

Shawn Buckley

And if I can just pause you for the benefit of the international viewers.

Dr. Denis Rancourt

Yes.

Shawn Buckley

So Theresa Tam is our federal [Chief] Public Health Officer that led for the federal government in imposing different restrictions upon Canadians, as far as the federal government had jurisdiction during COVID. And so, Mr. Rancourt, as I understand, so the blue line that you've got there just shows, basically, our excess mortality—

Dr. Denis Rancourt

No, no, no, no.

Shawn Buckley

Just our total mortality

Dr. Denis Rancourt

Yes.

Shawn Buckley

through normal years. And I'm sorry, thank you for correcting me. And for those international viewers that didn't experience this—so Theresa Tam claimed that the government measures saved one million deaths. And so, the red line is, you're showing what the mortality rate in Canada would have been

[00:25:00]

if what she said had any veracity at all.

Dr. Denis Rancourt

Yes.

Shawn Buckley

And by putting it on there, it kind of shows—it looks silly to us on the chart.

Dr. Denis Rancourt

And it should look silly. I mean, the y scale there, the axis, starts at zero. So they're claiming that overall mortality in the country would have more than doubled. More. Than. Doubled. It's absurd. You have to have a major war, a major meltdown of society, the economy. There are almost no times in history where this ever happened anywhere. It's just impossible. It's just crazy.

Shawn Buckley

I presume that other areas of the world that didn't impose the restrictions that Canada did, don't show a huge jump at all, either.

Dr. Denis Rancourt

That's right, that's right. And we'll get into that more as I show you the data. That's right.

So this was just to show that Theresa Tam and her co-authors—these scientists—are able to publish a scientific article where they claim, based on these very tenuous models and all kinds of incorrect assumptions, that they have saved a million lives. And they're able to get that published in a scientific journal which is funded by the state of Canada.

[All-cause mortality by Week – Canada 2019–2023]

So this is also from the last presentation. Okay, if I go back here [previous slide], I'm now going to concentrate on this region—the COVID period—and look at mortality in that region, just to show you a blowup of that. I showed this last time and I started describing the various features.

There are some features that are not the usual seasonal dependence of mortality. The seasonal dependence is a high of mortality in the winter, a trough of mortality in the summer, a high in the winter, and so on. There are many more features here. For example, *D* is simply a heat wave that occurred in British Columbia. And this is a common and known phenomenon. It lasts a few days or a week or so. And heat waves, very intense heat waves, always cause peaks in mortality like that.

This peak [*A*] is the peak of deaths from the aggressive protocols that were applied immediately in hospitals right after they announced the pandemic at this point [upward pointing arrow]. This is a very large winter peak [*B*], that is very large, that is right after they started applying the vaccine, starting in priority with the most elderly and the most frail. And this is a peak [*C*] that occurs mainly in Ontario, and it coincides exactly with the biggest rollout of the first injections: dose one.

Shawn Buckley

Which letter are you referring to?

Dr. Denis Rancourt

C. I'm talking about *C* now; I just talked about *B* before.

And *E* coincides to a peak that's higher than the last decade or more, and it coincides with a rapid rollout of the third dose of the vaccine, and so on. The fourth dose is over here, gives rise to this peak, *F*. And so we're going to look at that in some detail in the coming slides. But this is a blow-up. So even though overall mortality level did not increase very much in Canada, there are all these features that one can analyze and try to understand.

[All-cause mortality by week, Canada – all ages, 2010–2023]

And then this is what that region looks like when you look at more years, so a decade or more. And you can see the seasonal pattern there and you can see the details that I was just describing. And on this graph, now, what I've done is I've shown a dashed vertical line for the date at which the pandemic was announced—or the date at which “a pandemic” was declared, let's put it that way. And then, this is just a straight line that runs through the summer troughs in recent times. So it's the historic expectation of summer troughs in here. And you can see that mortality doesn't come back down to these summer trough levels during the COVID period. So, there is an excess mortality here. That is for all ages in Canada.

[All-cause mortality by week, Canada – 85+ years, 2010–2023]

And then we can look at what happens for different ages. So this is 85-plus-year-olds and you can see, now, that the summer troughs go lower than what you would expect

historically. And that's proof that you accelerated deaths here in hospitals in this large peak so that there were less 85-plus-year-olds to die immediately in the summer that followed. That's why the mortality comes down like that.

Same here. This was a very intense death period, and the mortality comes lower than you would expect historically

[00:30:00]

because there was some excess mortality in here that normally would not have occurred if you just follow the historic trend. So that's what we—

Shawn Buckley

And Mr. Rancourt, on your computer, are you using a mouse with an arrow?

Dr. Denis Rancourt

Yes.

Shawn Buckley

Okay, we're not seeing that. So just be aware you need to describe for us what you're referring to.

Dr. Denis Rancourt

Oh, sorry. Thank you for pointing this out to me. All right. That's why you're asking me about the letters. I am glad I realized that.

So the summer trough that follows the dashed vertical line is the first summer trough that is lower than the historic trend because of that very high peak that occurs immediately after the pandemic was announced. And then there is another pair of peaks, followed by a lower than normal trough after that. So it's just to illustrate that point in the 85-plus-year-olds.

[All-cause mortality by week, Canada – 65–84 years, 2010–2023]

And then if I go to the 65- to 84-year-olds, you can see that now you're in a higher regime of mortality. You've really raised the mortality up above the trend you'd expect from the summer troughs there. And so you can see that as you lower the age group, the seasonal amplitude decreases—this is well known—and the level of mortality, of course, decreases. Mortality decreases exponentially with age. That's a law of nature for humans.

[All-cause mortality by week, Canada – 45–64 years, 2010–2023]

And here we have these 45- to 64-year-olds, and I've again shown by this dashed line that's there, the vertical dashed line, that that's the date at which the pandemic was declared. And you can clearly see a different regime of higher mortality there for that age group.

[All-cause mortality by week, Canada – 0–44 years, 2010–2023]

And we can go to the group of younger people, so 0- to 44-year-olds. You really see a very sudden shift to a higher plateau of mortality that pretty closely coincides to the announcement of the pandemic and when all these measures were put in place across Canada. And so the younger people, in proportion, were dying far more than the older

people, in proportion, because they normally don't die that much. So you're increasing by more than 50 per cent the death of this group. And as you go younger, the amount by which you increase death—you anomalously have a high death rate—is greater and greater as you go to younger people.

But the point is that the vaccines— There is absolutely no evidence that the vaccine reduced death in any way. In fact, everything suggests that as soon as the measures were put in place, it had devastating effects on all age groups. And the rapid, military-style rollout of the vaccines, which started in the very end of 2020, had no net or visible systematic beneficial impact on mortality for any of these age groups but caused a large part of that mortality, especially for the elderly. And that's what I'm going to show a little later on. That is what the all-cause mortality for the different age groups in Canada looks like.

We can also look at specific provinces, and it's important to do that because the behaviour of the mortality is very different when you go to different provinces.

[All-cause mortality by week, Alberta (Canada) – all ages, 2010–2023]

This is Alberta, and now we see that same vertical dashed line is that same date at which a pandemic was declared. And we see that there is not a very large peak of deaths caused in hospitals by aggressive protocols. Alberta did not have that, unlike these very large peaks that occurred in Quebec and Ontario and in many hot spots in the world, such as New York City, Northern Italy, and so on. Alberta didn't have that.

But Alberta has a higher regime of mortality starting somewhat later, starting at the end of 2020. There's that very large winter peak, which is unlike anything in recent times. And then you see the next winter peak in mortality has a double peak structure, and that's directly associated with vaccination.

[All-cause mortality by week, Vaccine doses rollouts, Alberta (Canada) – all ages, 2018–2023]

I'll show that in another slide here. This is a blow up for Alberta, and the dark blue line is the cumulative rollout of all the vaccines.

[00:35:00]

And you can see that there's an increase in slope there that gives rise to that second peak in the winter—centred on 2022 there—and, generally speaking, the higher regime of mortality is occurring in the period when you're vaccinating.

Now, in addition to this problem of the COVID vaccines, the state decided that it would be a good idea, also, to vaccinate more than ever before and especially the elderly people for flu at the same time, especially that first winter after the pandemic was declared. So I don't have data for the rollout of the flu shots—which would typically be September, October, November—but we believe that's associated/partly causes the very high magnitude of that very first winter after the pandemic was announced. And then you've got the summer baseline trough there, just to give you a point of reference to show you that there's a regime of higher mortality in Alberta.

[All-cause mortality by week, Alberta (Canada) – 0–44 ages, 2010–2023]

And Alberta, for the younger group, 0- to 44-year-olds, looks like this. So for the younger people, you again have this sudden turn-on of a higher rate of mortality, pretty much exactly coincident with declaring the pandemic and then, a little later on, imposing all these

horrendous measures. And no sign of a beneficial effect from any vaccination or anything like that but rather, a steady plateau that does not appear to be coming back down to what we historically had in recent times. So, there's a permanent death effect for younger people in Alberta there.

Shawn Buckley

And I'll interject, just to ensure that people understand your chart. So on the left-hand side, going up, you have deaths per W . What's the W stand for?

Dr. Denis Rancourt

Per week.

Shawn Buckley

Oh, per week. Okay.

Dr. Denis Rancourt

Yes.

Shawn Buckley

So I noticed with different age groups, those numbers are larger and smaller. So that's important for us to pay attention to when you say, like, for the younger age group, maybe the overall numbers aren't significant, but the percentage of rise can be significant.

Dr. Denis Rancourt

Exactly.

Shawn Buckley

Sorry for interrupting, I just thought it was important.

Dr. Denis Rancourt

No, thank you. Thank you. I really appreciate that. Don't hesitate.

In Alberta, this rise in death for younger adults, and so on, is especially important in young adult males. I'm not showing the data here, but it's mostly due— Among the young adults, like 25 to 45, it's mostly males that died. Females almost did not die. And this, we believe, is associated with closing down the energy sector and the devastating effects of that and loss of livelihood, loss of meaningful work, and so on.

And I think that this is the population phenomenon that would have largely been catalyzing the truckers and that movement and so on—is the immense amount of suffering that you can see directly in the mortality. So if people are dying at this higher rate, it means that the suffering that does not include death is even much higher. And there is an increase in homicides at that time, an increase in suicides, as well, among young men. Okay, so Alberta was a hot spot of suffering for young men because of what was done in the name of the pandemic. Yeah.

[All-cause mortality by week, Ontario & Quebec (Canada) – 0–44 years, 2010–2023]

This is what Ontario and Quebec look like, and this is for the 0- to 44-year-olds. So again, the young people. This is interesting because you see that stepwise rise in mortality in Ontario. It's not as important as in Alberta, but it's very visible—you have a higher plateau of mortality—but there is no such change in Quebec. So Quebec society, my interpretation is Quebec society is very different. Individual psychology, cultural differences, and so on are such that when you impose the measures that were imposed, it did not dramatically affect young adults and children to the same magnitude as it did in Ontario and a much greater magnitude in Alberta. So this is one of the very interesting differences from province to province.

I have to insist that what I'm showing you now and the tentative interpretation that I'm giving you and so on, government scientists aren't doing any of this.

[00:40:00]

This should give rise to huge amounts of research to do fieldwork: to go and find out what happened, where; who died, when. There should be forensic epidemiology that is done across Canada to understand these phenomena and to learn from them, but, to my knowledge, none of this research is being done. Government scientists are sitting at their computers, taking in the data as it comes in, doing this kind of analysis to some degree. But they're not planning to do the fieldwork and the real research that would allow us to understand with concrete information what exactly has happened and why. And so that's a main criticism that I have of the establishment that is supposed to study these questions.

[All-cause mortality by week, Ontario & Quebec (Canada) – all ages, 2010–2023]

This is now Ontario and Quebec but for all ages, and you can see that that very first sudden peak that occurs right after the announcement of a pandemic—the dashed vertical line—is much higher, in relative terms, in Quebec than in Ontario. Quebec was more aggressive in this regard. There was more abandonment of the elderly, who were particularly vulnerable and had comorbidity conditions, but both provinces are guilty of this.

And in Ontario, you see a large peak after the first winter following the announcement of the pandemic. There's a large peak immediately after, which is not as prominent in Quebec. And in Ontario, it coincides perfectly with the rollout of the vaccines. So there are all kinds of features like that that can be compared from province to province and analyzed in terms of the rollout of the vaccines.

Shawn Buckley

Can you just jump back to that other slide? Because if I recall correctly— So actually, no, to the next one. So you know, you've got that vertical line showing when a pandemic was implemented. My recollection of the Alberta one is there was no rise right after that declaration.

Dr. Denis Rancourt

Exactly, I pointed that out. I'm saying a lot of information very quickly. You're absolutely right.

Shawn Buckley

It's in theory, the same virus occurring at the same time. Like, Alberta was testing for— I mean, regardless of what anyone might feel about that, all the provinces are reporting, you know, a number of cases. And yet, in Quebec and Ontario, the statistics, as I understand it from your graph here, is showing a spike, an increase in death right after the pandemic's declared. And now, Alberta, there's no spike at all. In fact, if I remember, the mortality goes down after.

Dr. Denis Rancourt

I spent some time on this in the first part of my testimony. I mean, the virus, basically, was behind the gate waiting for the pandemic to be declared. And then it hit hotspots—only—in the world.

So only some provinces in Canada, but really it wasn't province-wide. It was certain big cities where there are big hospitals, right? And it did not affect 30 of the U.S. states. There's no peak like that in approximately 30 of the U.S. states. There is a prominent peak like that when you look at the high resolution, spatially, in Northern Italy, around Paris, one other spot in France where there is a large hospital, London. Stockholm, in Sweden, had a terrible peak of this type because they did the same things. Germany, as I said in the first part of my testimony, did not have anything like this and no excess mortality for quite a while because Germany did not apply these aggressive protocols, which I described last time, and just did business as usual in terms of clinical evaluation and then what to do about it in hospital.

So there is quite a story in that first peak. And it is the story of what vicious hospital protocols that you feel you can just apply because it's supposedly a new virus. So you can just try whatever you want because everyone's going crazy that it's going to kill everyone. So, therefore, MDs kind of have a licence to do whatever they think makes sense, you know? Whatever they think is logical and sometimes, quite often, they overdid it. And we identified specific drugs that were given at a toxic level. And, of course, the mechanical ventilators were extremely dangerous and were applied en masse in Northern Italy and in New York. And so, they are a big part of this peak.

Shawn Buckley

Right. And I'll let you go on. But just so that people watching understand—basically, it was the policies, not the virus, because the virus doesn't respect state lines. But it's policy difference from place to place.

[00:45:00]

Dr. Denis Rancourt

Absolutely. And this was the whole thrust of about an hour of testimony that I gave previously, where I tried to show many, many examples of that. Whereas this time, I'm just more trying to give a flavour of the different things that happened in Canada. That's right, yeah.

[All-cause mortality by week, New Brunswick (Canada) – all ages, 2010–2023]

This is New Brunswick. Now, New Brunswick and Nova Scotia are very special because there's the vertical dashed line where a pandemic was declared and nothing happens until much, much later. You have to get into September of 2021 before you can identify a transition to a higher regime of mortality. Okay, I put in a line there to guide your eye and

you can see that there's this higher mortality in New Brunswick—all ages here—but much, much later. Yeah?

Shawn Buckley

So, basically, we're hit with a pandemic that we're told is so deadly, we need to stay in our homes. We need to shut our economy down. We need to mask. And in New Brunswick, really—and we can see it—that there's no change in excess mortality at all when we're the most vulnerable. When we don't have any protection, let's say from a vaccine, all-cause mortality doesn't change. In fact, it almost looks like it decreased.

Dr. Denis Rancourt

Well, this rise that I'm illustrating in this figure, that happens late in the period that I'm illustrating here, coincides precisely with the vaccine rollout, and I'll show that in the next figure, okay?

So nothing happened. In terms of mortality in New Brunswick, there is no pandemic but—

[All-cause mortality by week, New Brunswick (Canada) – 65+ years, 2010–2023] Oh and by the way, this is the 65-plus-year-olds. It's to show that the phenomenon I'm talking about is affecting the elderly people in New Brunswick, okay? This is not a young person phenomenon, it's an elderly person phenomenon. And we showed in our research, as I mentioned last time, that the vaccines kill exponentially with age of the person.

[All-cause mortality by week, Vaccine doses rollouts, New Brunswick (Canada) – all ages, 2018–2023]

And now this next slide shows New Brunswick again, on a blow-up in time, but showing, also, the vaccine rollout. So in dark blue, you've got the cumulative vaccine doses of any dose that are being given. And you can see that as the vaccines are brought in, you've got that same vertical dashed line at the time of the announcement of the pandemic on the 11th of March 2020, and nothing happens. Then you can see how the vaccines are rolled out, and that's when you enter that high regime of mortality. You see that? And an increase in slope in the cumulative vaccine dose means a high rate of delivery of the doses, and that is corresponding to one or two of the peaks there when you analyze that in more detail. And so that is what's happening in New Brunswick.

[All-cause mortality by week, Vaccine doses rollouts, Nova Scotia (Canada) – all ages, 2018–2023]

And the same thing is happening in Nova Scotia, precisely the same phenomenon. You have no change in excess mortality. You can see the dashed vertical line is the announcement of a pandemic. Nothing happens. You roll out the vaccines, and you enter a regime of mortality where the mortality is much higher, and you have these peaks that coincide with the rollouts, the rapid rollout parts of the different doses of the vaccine. So this is very compelling evidence in terms of synchronicity and strongly suggests a relation of cause and effect between rolling out the vaccines and excess death of elderly people in Nova Scotia and New Brunswick, whereas nothing had happened before. Nothing that can be ascribed to the pandemic.

Now, I just want to point out before I go to the next slide that sometimes you can see it clearly like this—because there's not other factors causing excess death at the same time. In some jurisdictions, the people are so fragile that as soon as you lock them down and take

away their caretakers, they basically die within weeks, and so you do see excess mortality and that makes things complicated.

For example, in the United States, where there's 13 million mentally disabled people suffering from serious mental disease, there was huge mortality compared to Canada. There was 1.3 million people died, excess deaths in the U.S.,

[00:50:00]

whereas only about more than 300,000 of those we ascribe to the vaccine. So, it's more complicated to analyze. But Nova Scotia, New Brunswick are clear jurisdictions where nothing happened until you went in and vaccinated these elderly people and, exponentially with their age, there was a higher and higher probability that they would die from the injection, and they did.

And so, next. Now I want to show— Last time I talked about how you quantify the association between vaccine dose delivery and excess mortality. And I said that I wanted to do this for Canada, but we had only a rough estimate of the value at the time. So we've now done a more proper study, and I want to show you how that works.

[All-cause mortality by week, Canada 2016–2023 & weekly vaccine-dose administration]
This is a reminder of all-cause mortality for Canada, in the blue there. And that's what doses of vaccine per week now, instead of cumulative, look like in orange. And you can see peaks for the different doses that are being rolled out—doses one and two together, dose three, and then dose four, and five—you can actually see peaks. And it corresponds and gives rise to peaks in the mortality or peaks in the mortality that are higher than they would normally be or that are in places where you would normally have a summer trough. So you can see that correlation in time.

[All-cause mortality by week, Canada, all ages, 2018–2023]
And so what we do with Canada in order to estimate the deaths due to the vaccine is—we look at the period in which you were mostly vaccinating with the COVID-19 vaccine and we define a period for quantification from week 52 of 2020 to week 40 of 2022. And we're going to specialize on that in order to quantify this: the excess mortality in that period compared to the number of doses that were delivered in that period. We can do different periods and we can do specific peaks. We've done all that, and we're doing more and more of it in different jurisdictions.

[All-cause mortality by week, Canada – all ages, 2018–2023, Vaccine-period integration]
But this is what you get when you do what I just said. This is a graph, now, of all-cause mortality in blue, as usual. And now what we're going to do is we're going to integrate the mortality. We're going to add up all the deaths in that vaccination period that I described, which is between the two vertical dashed lines that you see there. And the result of that sum is represented by a dot that is on the graph there and corresponds to the y scale that's on the right. So it corresponds to more than 500,000 deaths total, okay?

And then we're going to back up that integration window by one step. We're going to say, well, a window of the same length, duration, and time, what are the total deaths just before, and then just before, and then just before? So the blue dots are these integration values for a period of 94 weeks, I believe, which is that vaccination period as we've defined it.

And so what you can see when you do this is that the integration values basically don't change in a period that would include the start of the declared pandemic. But the

integration value for the period when you were vaccinating and when you've vaccinated is significantly higher than the linear trend that is illustrated there, okay? That means that you are deviating from, historically, what has been happening in a significant way, and it means that the difference between that integrated value and what you would project with those straight lines is the excess mortality that is due to whatever happened that's different in that period. And what happened—that is different—is the vaccination, and it correlates in time with those peaks. So we're sure that it's the vaccination that's doing this, and so we can quantify it now.

And the biggest uncertainty in this quantification comes from how you extrapolate the historic trend. So you can include the point that includes the COVID period before vaccination or not include it. So we've got two straight lines there for two different ways of extrapolating the historic trend, and we can use those two and get the numbers.

[Vaccine Deaths in Canada]

And what we find is that in Canada, in the vaccination period, if you use the one approach, one of the straight lines—what we call the 6-point trend—you get 28,000 excess deaths. If you use the 5-point trend,

[00:55:00]

so not including what would have happened during COVID before vaccination, you get 31,000 deaths. So that's the number of deaths that are excess deaths, that are above the historic trend, clearly, in Canada. And this was at a time when a little over 90 million doses were administered to people. And therefore, the risk of dying from a given dose corresponds to 0.03 per cent. And that means one death for every 3,000 injections.

In the Western world, everywhere that we have quantified this, and on specific peaks that can be directly associated together like that—peaks of a rollout and peak of a mortality—every time we've quantified it, that's the kind of number we get in the Western world for when you consider the entire population, when you don't discriminate by age. When you do discriminate by age, you find that this risk of death increases exponentially with the age of the individual, with a doubling time of five years in age. So it's a dramatic effect which I described last time and I showed some graphs about it. Oh, I'm skipping ahead here.

So what's important from what I showed last time is that the risk of dying from being injected with the vaccine increases dramatically exponentially with age. And so this has not been considered in the risk-benefit analysis of whether or not you want to vaccinate the elderly. In fact, the States have done the opposite. They have gone and given priority to injecting the most fragile people who are most likely, by a long shot, to suffer from the vaccination itself. So there's huge problems with what was done by governments. And so, that's the story about the vaccines up to now. It's an update, really.

[Excess all-cause mortality 2020 – World map]

And now I want to show you, in the world, what's been happening. And so we're going to go now to a world map of all the countries that we've studied because we've got good data for it, and I'm going to show you the excess mortality by year on a world map.

And the thing that you've noticed so far in the data that I've showed you for Canada is that in Canada, the highest excess mortality is in the final year: it's when you roll out the vaccines. Very hard to quantify an excess in Canada until you do that, and you see it clearly in certain provinces. Apart from that very first peak of deaths in hospitals, there's nothing special happening in Canada until you roll out the vaccines. Now that is very special

because it means that there's more death after you've applied all the measures and vaccinated virtually everyone. Now there's more deaths than before, which is something of great concern.

So we wanted to see where in the world that occurs. And so we quantified excess mortality on a world map like this. There are a lot of countries that we have good data for, but they're too small to see on this map. And there's countries like— Africa does not have good all-cause mortality data, so you can't really do much with Central Africa. But this is what the world map looks like.

Now, in 2020, this year includes if you had that peak that was deaths in hospitals right after the pandemic was announced, and the very first part of the first winter of death is included in 2020. And so the Eastern Bloc countries and Russia had very high excess mortality compared to many other places. The U.S. had very high excess mortality compared to Western countries and compared to Canada. Canada has, as I said already, virtually no excess mortality, okay?

But now I'm going to go to the next two years and I want you to notice what happens to certain countries as I rolled through 2021 and 2022.

[Excess all-cause mortality 2021 – World map]

This is 2021: Canada is still white. Australia is still white. Germany is still white. Japan is still no excess mortality.

[Excess all-cause mortality 2020 – World map]

So let me start again, 2020: Japan has no excess mortality. Australia, New Zealand, Canada, Germany—no excess mortality.

[Excess all-cause mortality 2021 – World map]

2021: still no excess mortality in those places.

[Excess all-cause mortality, 2022 – World map]

2022: they change colours.

Shawn Buckley

Yeah, so just so that we're clear. I mean, the point of you breaking it up by years

[01:00:00]

is that when we are totally unprotected, in theory, during this pandemic that required draconian measures, we're not seeing excess mortality.

Dr. Denis Rancourt

That's right.

Shawn Buckley

So when it first hits us in 2020— And we shouldn't have any herd immunity because we haven't caught it yet. Like you would think even, you know, 2021, even without a vaccine, we'd be getting more and more herd mentality—or herd immunity, rather.

By 2022, my word, we should all be safe now because even without any vaccination, we would have had two years of exposure, all this herd immunity garnered. And this is why it's significant and why you've broken it down into years.

Dr. Denis Rancourt

Yes, you're describing exactly how an epidemiologist—no, sorry, an immunologist would describe it. They would say it's all about acquiring immunity by infection and vaccinating if you've got an effective vaccine. And once you do that, you're protected.

And what I'm saying is that in Canada, the opposite is true. Because of everything they've done, we're now in a regime of mortality that is higher than ever before, since the pandemic was announced. And that is a problem. And it is a problem in many countries.

And Japan is shocked by this. Australia, New Zealand, Germany—there are many other countries—and Canada are in this category. And so these are countries that did not mistreat their elderly too much, do not have particularly fragile populations in terms of, like, you have in the U.S. and in the Eastern bloc countries. For example, we have come to interpret that in Russia and Eastern European countries, the reason you have such high excess mortalities is because the baby boomers lost all of their security when the Soviet Union dissolved in the early 1990s. So these people have now aged, they are at an age where they are dying, and they do not have the social security system and network that had been promised to them and that was in place before the Soviet Union dissolved. So we think that that is a huge phenomenon in terms of determining the mortality in those countries.

So the lesson here is that mortality, and even susceptibility to be poisoned by this vaccine, is highly dependent on who you're vaccinating and what their conditions are: what their health conditions are; what their stress levels are like; what their social network is like. And so what we're seeing is much, much more variability due to, I guess, what some would call “the terrain”—the social and health terrain. The variability is there on the large scale: when you're comparing all countries, that's what causes it more than anything else. And so the simple story of immunology just is not the right approach if you want to understand these macro phenomena, if you like.

But the point of this map was to show that what's happening in Canada is very real, and it's happening in many other places as well.

[Conclusion – Vaccine Deaths]

So in conclusion regarding the vaccine deaths, and I said this last time and I'll just recap it. In the world, we estimate that 13 million people were killed by the injections and that the effective vaccine dose fatality rate for the world on average, all ages, is 0.1 per cent.

In India, we're quite certain that 3.7 million people were killed because it's absolutely stunning the magnitude of the excess mortality that coincides exactly with the rollout of the vaccines. And you can see videos on the internet of old people being held down, refusing to be vaccinated, and being forced to by police and so on, being injected in front of the camera. This is a very common thing. So India was particularly aggressive with their vaccination campaign. They even had a list of comorbidities and, if you had those, you especially were going to be vaccinated, and so on.

In the U.S., at least 330,000 people died as a result of the injections, we believe. And in Canada, there's a slightly lower vaccine dose fatality rate, but still around 28,000 to 31,000 people likely would have been killed by the vaccine.

Now because this death due to injection is exponential with age,

[01:05:00]

you don't see it. Because elderly people—the ones that are most susceptible to dying are the ones that are over 90, over 85, over 80—that's the majority of the deaths there. It's exponential with age and so you don't think of them dying from the injection. Or it's easy to cover it up, if you like, or it's easy not to see it if you don't want to see it. But typically, these elderly people would have been dying on the same day or in the days that followed the injection, and the cause of death on the death certificate would have been something else, whatever their preconditions were and so on.

So you're not going to see this. In a world where the entire establishment tells you that the vaccine is safe and effective, nobody dares—and this includes clinicians and MDs and heads of hospitals—no one is going to dare start to investigate whether or not, and look at the timing between injection and death and make graphs of that. Nobody is going to look into this. There is no forensic studies being done right now to look into these questions. The government is turning a blind eye to all of this. But our research shows that there has to have been a large number of deaths directly associated with the injections. And in Canada, we feel that that's the right number.

That was the new material that I had prepared to really concentrate on Canada, and I was going to be critical of the articles you had asked me to look at.

Shawn Buckley

Yes. So, let me, for the commissioners and those watching, just give a little bit of background.

And I will also say I forgot to mention that you had also written an essay to include some of this new information and we have appended that as an Exhibit OT-1e. So that will be available for the commissioners and the public, online, as part of your testimony because you adopt that essay as true?

Dr. Denis Rancourt

Yes, I do.

Shawn Buckle

So, basically, there were two different publications—although, like I say, one is in a pre-print version right now—that caught the commissioners' attention.

And one is now Exhibit OT-1c and the title is *How did the COVID pandemic response harm society? A global evaluation and state of knowledge review (2020–21)*. The author is Kevin Bardosh, and it's in a pre-print version. And I'll just read so that those watching and the commissioners— Well, the commissioners, already, will have reviewed it. But for those watching, just to get an idea of what it is, so I just pulled this out of the abstract. This is a 119-page document, but part of the abstract reads:

This cumulative academic research shows that the collateral damage of the pandemic response was substantial, wide-ranging and will leave behind a legacy of harm for hundreds of millions of people in the years ahead. Many

original predictions are broadly supported by the research data including: a rise in non-COVID excess mortality, mental health deterioration, child abuse and domestic violence, widening global inequality, food insecurity, lost educational opportunities, unhealthy lifestyle behaviours, social polarization, soaring debt, democratic backsliding and declining human rights. Young people, individuals and countries with lower socioeconomic status, women and those with pre-existing vulnerabilities were hardest hit.

And then the other study, which is now marked as Exhibit OT-1d, the title is *Did Lockdowns Work?* The authors are Jonas Herby, Lars Jonung, and Steve Hanke of the Institution of Economic Affairs, and they present this as a systematic review into the effects of lockdowns. And, basically, they use a couple of indexes. One, which they title a Stringency Index, shows that the average lockdowns reduced COVID mortality by 3.2 per cent, meaning 4000 [sic] [6,000] people in Europe were saved according to this calculation, 3,000 [sic] [4,000] in the U.S.

And then, just quoting from the abstract on a different index, they say, “Based on specific NPIs, we estimate that the average lockdown in Europe and the United States in the spring of 2020 reduced COVID-19 mortality by 10.7 per cent.

[01:10:00]

“This translates into approximately 23,000 avoided deaths in Europe and 16,000 in the United States. In comparison, there are approximately 72,000 flu deaths in Europe and 38,000 flu deaths in the United States per year.”

Now, because the commissioners have asked you to come and basically speak to those two studies, I understand you have some slides about that. So I'll invite you to give your presentation on these two studies.

Dr. Denis Rancourt

Okay. I have to warn listeners and the commissioners that I tend to be very critical of these studies. I admit that some of their conclusions may be comforting for us and we like to hear them, but I'm going to be radically critical of these articles. And by radical, I mean going to the root of what I think is fundamentally wrong with these articles, or the approach, okay? So it's going to have a critical slant. Because as a scientist, I don't just enjoy something because it gives a conclusion that I'd like to hear. I look at whether or not the conclusions actually follow from what you can measure and from empirical data. So that's the eye that I want to use to look at these studies.

[Part II: Critical review of a few recently published articles]

These are the two studies. I'm going to do the one about lockdowns first, and then the broader view about societal harms second. But overall, the critique I would make of these two, together—because both studies have the same problems, and this is the major problem—I would describe it in the next slide here.

[What did we learn?]

What did we learn? Well, the short answer that I would give is nothing that governments and scientists should have learned was learned or even questioned.

Okay, so it's a status quo. And what I mean by that is the disproved paradigm of “spreading pandemic-causing viral respiratory diseases” is completely intact in these studies that I'm

critiquing. And there is a problem with that because there is no empirical evidence of the spread of an agent that causes death, on the scale of the globe, that could cause something like a pandemic. Epidemics in care homes and hospitals due to bacteria and so on are very important and are very real, but large-scale, societal-scale spreading has never been demonstrated.

The so-called contact measurements that they do are completely fixed. If you want to understand spreading, all you have to do is look at a hundred years of epidemiological data. You look at all-cause mortality for the last hundred years across the world where they've been measuring it, and you have a regular seasonal pattern: there's a maximum in the winter, a trough in the summer. It's been that way forever. Everywhere. And when the maximum is a little higher in one place, it's a little higher everywhere, but synchronously in the entire hemisphere, either the northern hemisphere or the southern hemisphere, completely synchronously. These patterns are synchronous around the world, and in their distinctness, they are synchronous around the world.

This has been puzzling epidemiologists for more than a hundred years. And the great majority of them who have given it thought have concluded that the notion, the paradigm, that this is caused by spreading diseases, from person-to-person spreading of a disease, cannot hold up to this empirical data. Absolutely impossible.

So that paradigm has been severely questioned in the past by thoughtful people who are epidemiologists. And just because we have modern techniques and PCR instruments and so on, we think that we can stop thinking and we think that that hard data is going away. It's not going away. This disproves the notion that what could be causing those extra respiratory deaths in the winter is due to spreading across a territory, a province, a country, or even the world. It cannot be, given the hundred years of mortality data that we have.

[01:15:00]

So any scientist who starts their analysis with the notion that a disease can spread and cause a pandemic in the world— I'm not talking about very serious epidemics that occur in hospitals and care homes. That's not the point. The point is a completely different phenomenon where these things are supposedly spreading through the air and person to person, okay? So that is incorrect, in my view. And if you presuppose that, you're starting from a basis of something that's been disproved. That's the first problem.

Also, there is no admission of even the possibility— In these studies that I'm looking at now, that you've asked me to examine, there is no admission of even the possibility that excess mortality was exclusively due to the measures and to the vaccines. This is not even considered among any of the authors that are reviewed in these studies, okay? Because they reviewed— One of them reviewed 600 studies, the other did a detailed look at 22 studies. Everyone starts from the point that a particularly virulent pathogen was causing death, that's kind of a given—and now, did the measures also cause death? Did we do something to reduce the deaths that would have otherwise occurred because of this pathogen?

But nobody questions whether there's any hard evidence that there actually was a particularly virulent pathogen that appeared and had the kind of behaviour that you would predict from epidemiological theory. There is no such pathogen that you can see evidence for. In fact, the hard data disproves this notion: because there's no spreading; it doesn't

cross borders; it attacks the poor and the disabled. It doesn't behave at all like what is imagined of this viral respiratory disease—the cause of pandemic—so it's disproved.

So if there was no particularly virulent pathogen, then how can you talk about the excess mortality that was caused by it? You can't. The entire body of my work shows that there was no particularly virulent pathogen. And the only time that there was excess mortality is when you assaulted populations—either with vicious treatment protocols that were unusual and experimental in hospitals or with these incredible measures that destroyed people's lives. That's what caused death. Everywhere they did that, they did it. Everywhere they injected and rolled out—suddenly, all these injections—and went and got frail elderly people to inject them, they killed a certain number of them, and so on. So that's not acknowledged.

The other problem with both of these studies—and all of the studies that are reviewed in these studies—is that the dominant factors that determine public health and individual health are hidden from view in all of these studies. Because the dominant factors that determine the health of the individual are their living conditions, and that includes whether or not they're socially isolated; it includes the psychological stress that they are experiencing in their lives, which is related to their place in the societal dominance hierarchy. These are the things that determine whether you're going to live into old age and how sick you're going to be when you get sick and how often you're going to get sick. Science is clear and unambiguous on the dominant factors that determine individual health.

And these factors are not considered as dominant. What they say, instead, is the virus especially was hard on old people or the measures were especially hard on poor people, and so on. But they're not considering the basic medical knowledge—that's completely established—that what determines your health is whether or not you're healthy. And that is your ability to fight anything that you're assaulted with in the real world—any pathogen. There are always hundreds of pathogens. There are bacteria that are normally in your mouth that, under certain conditions, will invade your lungs and you get very sick. But there are hundreds of pathogens everywhere, all the time, and the notion that you're looking for and you think that a new one will come and cause a pandemic

[01:20:00]

is contrary to empirical results.

So that's my problem with these studies—is that they presume as true all these underlying assumptions that are false. And they ignore the really big factors that determine health. That's giving away my bias, before I look at these studies in more detail.

[Did Lockdowns Work?]

The first one that I can look at is relatively simple to analyze: *Did lockdowns work? The verdict on COVID restrictions*. Well, this is a study where they do what's called a meta-analysis of 22 studies. There's a problem here. So basically, a meta-analysis means you go and get studies that others have done and you try to put their results in a numerical form so that you can put them all together on a graph or in a statistical analysis. Okay, that's what meta-analysis means.

Now the problem with that is that—and this is well known—scientists know that there are big problems with meta-analyses. The problem is every study is different, meaning every study is of a different population, in very different circumstances, and was actually

performed in different ways. Very few studies are done, identically, in the same way. So you have these very different studies.

Now, the way, scientifically, to approach trying to understand a phenomenon is to look at one study at a time: The authors claim to have found results. They claim to be able to make conclusions that follow from what they did. What you need to do is you need to look at that study and see if there are any flaws, any errors, any uncertainties in that study. And instead, we've gotten into the nasty habit of doing these meta-analyses. And what that means is, instead of critically assessing one study at a time and recognizing that it is unique and that it needs to be criticized in its own right in every detail—what we do instead is we put a whole bunch of them together in a kind of an approximate way and see if they all kind of tend to give the same answer. And then estimate that that answer must be approximately right because they're mostly all giving that answer to some degree with some parameter that you use. That's what a meta-analysis does. It's a nasty way— It's an unscientific way to proceed, let me put it that way.

See, the problem here is many-fold. A given study that is published is necessarily biased by the environment in which the scientists worked. There are certain paradigms that are dominant and that you must accept or else the reviewers—when it's peer-reviewed—will simply choke, and the editors will simply reject the paper and not even allow it to be reviewed. So authors know this. They get promotions in their profession and grants to continue their research on the basis of publications, so the idea is to be published: so the idea is to say what you expect that the reviewers and editors want you to say.

And that is very much affected by the overall propaganda that is occurring in the society. There is no doubt about that and this has been demonstrated. John Ioannidis, a very famous epidemiologist, wrote a paper some years ago explaining that more than half of scientific research is wrong. That was the title of his paper. And so he looked at these biases and showed that they were necessarily present and that, therefore, in medical research anyway, more than half of the results were wrong. Well, you're taking these results and you're putting them all together and you're giving yourself the illusion that now you must be getting the right answer because they all agree. Well, they necessarily all agree because they're all confined to the same biases; they're all confined to the same limits. They cannot go outside of that. So a meta-analysis is of no help in any area.

For example, if you do randomized controlled trials, which is a strict way of doing science, you get a certain result and that can be criticized. And what people are doing now, is they're doing meta-analyses of 10 or 20 or 30 of these randomized controlled trials and coming up with kind of average answers.

[01:25:00]

It's wrong because each randomized control trial might give a slightly positive result, like the one that you know the editors want to hear, so you fudge everything you can to get a slightly positive result. And you say, but it's not statistically meaningful. But then when you put 20 together, who all got slightly positive results, you say, well, how could 20 of them all have gotten a positive result? Therefore, this average must be valid and the error on it must be small because there's now 20 of them. This is where we're going with these meta-analyses. So just the fact that it's a meta-analysis of 22 studies done in this kind of environment is already a big problem.

Shawn Buckley

Right. Well, you know, it's interesting because there's that kind of common saying that two wrongs don't make a right, but if I'm hearing you correctly, 10 wrongs might make a right.

Dr. Denis Rancourt

Here, let me put it this way. Yeah, that's one way to put it. Or another way to put it would be 10 slightly rights, maybe, still don't make a right pretty sure. You know what I'm saying? Like in terms of what they're thinking is right. But what they're thinking is right is the result of their bias and the very stringent limitations that they have if they want to advance their careers. And this is in an area where you're trying to evaluate the impact of lockdowns.

Now, they did this using so-called lockdown stringency indices, or an index in particular that's maybe a popular one. These are very flimsy parameters to describe the impact of a complex lockdown that is different in every single jurisdiction, on a complex population that is completely different in every jurisdiction. To summarize that as a number, which you call the stringency index value, is almost absurd, okay?

Shawn Buckley

If I might just interject—and it supports what you're saying—one thing that I experienced travelling with the National Citizens Inquiry to the different provinces is it was striking, actually, how different the experience was in each province. So I mean, just using the National Citizens Inquiry as an example, it validates what you're saying, is that each place will have a different experience because we noticed that just going from place to place and hearing what people had to say.

Dr. Denis Rancourt

Yeah. I mean, this is the opposite of the studies that should be done because they didn't look at time series analysis. In other words, they didn't look at the timing. They didn't say, "Well, the lockdown came in at this date and people started feeling sick and calling in or taking more drugs at this date." They didn't try to relate it on a temporal basis, but, also, they were not specific: what kind of lockdown and how did it affect which community? That's what you need to do to understand the phenomenon.

And that means you need to do field work. You actually need to send sociologists and a whole team of people going into a community to find out how people are affected by what and what that lockdown means in that community. Because in some communities, the sheriff is going to be very strict and others not so strict and doesn't really care, and considers that it's a federal thing, but, you know, "You can't tell these people what to do," and so on. So everything is different, everywhere. And the way to answer this—if you want to understand the mechanisms of harm—is to do field work: to do field work where you're looking for these causes, so you have to do the kind of investigation that a detective would do to understand a crime and you have to go in there and actually see and actually get the records and actually talk to people, and so on.

And that kind of field work was very common in the '50s and '60s, when scientists were trying to understand society, and is virtually non-existent now. And it doesn't get funded and nobody wants to do it because it does not give you research grants, and it does not advance your career, and it's just easier to do a spreadsheet, and so on. I do the kind of research I do because I can access the data, and because I can do it and I know how to do

statistical analysis. But really, in society, to understand these problems, we need to send teams out of researchers into the field to see what's happening. And that's not being done.

So this is a substitute for the real science that should be done to understand the phenomenon.

[01:30:00]

And it's done under a set of assumptions that we're just going to say that lockdowns were harmful; that lockdowns were not effective in stopping death. I mean, when you hear that the lockdowns reduced mortality by 3 per cent, that's completely obscene. There is no way that their study—so-called study—can deduce with certainty that there's a reduction in death of 3 per cent. First of all, for there to be a reduction, you presuppose that there's something else causing death and that you've alleviated that, which is nonsense because you can prove that there was not that something else.

But, also, 3 per cent is nothing. There's no way that that is a reliable number compared to the uncertainties that are involved here. So as soon as you read something like that in the abstract, you have to say, “Oh, my, what are they doing?” And I know what they're doing. They're taking averages of many studies to get a net positive that comes out in the average. You see, there's a law of statistics that tells you that the more measurements you do of the same thing in the same conditions, when you take the average of those measurements, the more you have, the smaller the error in the average. You can be more and more certain in the average. That's only true if they're independent measurements. That's only true if the measurements were done identically. That law does not apply to meta-analyses of these kinds of studies. It. Does. Not. Apply. And they have to wrap their head around this.

This is complete— Okay, I'm just going to be blunt: This is garbage science, in my view, okay? And I'm sorry, but there's a lot of it that's being published, and I think it's intended to cool us down. I don't think the authors are consciously intending their work to be used this way, but I think that it serves—in effect, serves—in society to “cool the mark out.” We're the mark. We're the ones who have suffered this, and now we've got scientists telling us that, yeah, “No, you shouldn't have suffered that because it wasn't effective, it didn't really help you.”

So in effect, psychologically, the social scientists would say, this has the effect of cooling the mark out. That's the purpose that it has. It's not good science. It's not reliable. It's not meaningful in terms of reliable results. It might be something that you want to hear because you've suffered these conditions, and it seemed absurd to you that the government was doing this and this paper is now confirming that. But it's confirming it only in words. It's not based on a rigorous analysis. That would be my criticism of this paper. I'm sorry to say.

Now, the other one—

Shawn Buckley

Well, I'll just say, I think it's inappropriate for somebody like you, who's been called in as an expert to comment on a paper, to apologize that you find the paper's research methods to be flawed and that they can't reach the conclusions because, then, that's the evidence we need to hear. We want to hear your opinion, so don't presuppose. These papers came up, and the commissioners— They were brought to the commissioners' attention, one way or

another, and they want to know what your opinion is. So I think you can give us a candid opinion.

Dr. Denis Rancourt

I'm really apologizing to all the people who are comforted by this and, you know, people out there—whether they're scientists or people in the public—who are comforted by hearing a headline along the lines of these studies, and who say, "Well, good, see, we knew it." And I'm apologizing to them because I'm basically telling them, "I'm sorry, but you can't have that comfort. You have to think again, and more deeply. This is part of how they're manipulating you. They've really done something vicious to you and your family, and this is how they're getting you to accept it. They're saying, 'Yeah, we made a mistake.'" So I'm apologizing in that sense, you know?

Shawn Buckley

Right, but we thank you for telling us what you actually think. And, actually, we thank you for doing the analysis because it's not like we asked you to—"oh, here's a 10-page paper and here's a 5-page paper." I mean, we're over 300 pages here, between the two. So, Mr. Rancourt, we appreciate you being candid with us.

Dr. Denis Rancourt

I looked at it in detail,

[01:35:00]

and its references and its graphs and its methods. And, you know, I'm used to reading these papers—I've read so many of them—so I tend to pick up quickly what they're doing and the line that they're following, if you like. But, yeah.

Shawn Buckley

And I also realized, I mean, I should be calling you Dr. Rancourt because you have a PhD. You're just one of those people that aren't so concerned about that title.

Dr. Denis Rancourt

Yes, that's right. I have a physicist friend who used to tell members of his family that he was a "real" doctor. That's a physics joke, I guess. Or a PhD joke.

[How did the COVID pandemic response harm society?]

Okay, the next paper that you asked me to look at—this is a much broader look at all the different harms that could have come from the pandemic response. So you have to admire this author for, you know, making a list of all the potential harms. I really believe that he has put his finger on at least naming all the different things that he could think of. He pretty well covers the full spectrum. It even includes the degradation of institutions, the loss of civil rights, and so on. It's great to do this effort, but what I'm bothered by is the underlying presuppositions that are incorrect.

So, for example—I'm taking, now, lines from the abstract that I think you read in part just to illustrate the points: his "analysis synthesizes 600 publications with a focus on meta-analyses, systematic reviews, global reports, and multi-country studies." So this is

important to understand. He's saying that he's really tried to capture all the literature that's in the published scientific journals, and he's especially interested in studies that are, themselves, meta-analyses; that are, themselves, systematic reviews; and that treat more countries—that are global reports; multi-country studies. So he's concentrating on those things.

So that tells you that he's picking from all the studies that each, individually, has this bias that I was describing to you: this incredible built-in bias that you don't publish what editors, reviewers, and society at large don't want to hear. So there's a built-in bias, and this is the basis for this big review, is all of these individual studies. And the meta-analyses that I've just been criticizing, he gives them more weight because they're meta-analyses, so there are more studies being included in those analyses. I think that's the wrong approach.

And he's concentrating on studies that studied more countries. I don't think, at this stage, we need to study more countries in thinking that that will give us more insight. It is important; you have to look at everything you can and all the data you can get. But you have to go into your own country, to your own community—to the major hospitals where people died, to the major places where people died and suffered and got sick—and find out what happened and find out how they were treated. Every time I talk to people who survived being in hospitals during the COVID period, I learn incredible things about what they were doing in hospitals. Absolutely incredible things. Why aren't we hearing this in scientific papers that go in and do that kind of study, where you interview people and you interview the staff and you find out what was going on?

So it's the opposite of the kind of study that I think we need, to really understand what was going on. So I don't think the purpose here is to really understand. The purpose is to review what scientists in science journals are saying. That's what the purpose is.

Then he goes on to say, “The cumulative academic research shows that the collateral damage of the pandemic response was substantial. . . .” See, here's the problem: it's not collateral damage because you weren't doing anything that was beneficial. So it's not something collateral on something beneficial that you were doing—because what you were doing, none of it was beneficial. So you see the bias is built right into the language here. It can't be collateral damage. Like when you have a worthy purpose and you're motivated to do something

[01:40:00]

and you have a good reason to do it, and everyone would agree that it needs to be done, then that can have associated collateral damage. But this was not a case like that. This was a case where everything they did was harmful to people. It was an assault against people and it was unnecessary. So, again, it shows you that this is the kind of study that, in effect, will cool out the mark or will “cool the mark out,” I believe is the expression from the scientific literature.

He goes on to say, “Many original predictions are broadly supported by the research data including: a rise in non-COVID excess mortality. . . .” Well, that presupposes there is a COVID excess mortality. Well, I haven't seen one, and I've looked everywhere. And I only see a phenomenon that is inconsistent with the idea of a pandemic spread and of an especially virulent pathogen coming down on the planet. I believe that that has been disproved by the empirical data that I've been describing for three years. So there can't be non-COVID excess mortality—because there is no COVID excess mortality. That's the bias I was telling you about, again.

In the list, here, of harms, there's something called “democratic backsliding.” And I don't like that expression for the following reason: he's suggesting that in a time of turmoil or in a time of crisis, democracy, the institutions, and the functioning backslid. That presupposes that it can come back to normal. I don't see any evidence that the system wants to come back to normal, really. The people who practised the non-democratic behaviour have not all of a sudden realized that they were wrong and that now they're going to start behaving democratically—and I'm talking about judges and professionals and so on, and the institutions that change their rules to be able to behave in a non-democratic way because there's a crisis. They're going to put those things in place again next time.

So the term “backsliding” suggests that we can fix this. Or that they intend to fix this or that the system—that the establishment—would intend to fix this. I see the opposite: I see a march towards less democracy, and I've talked about that in the past. So that's my problem with that way of seeing it.

Shawn Buckley

Can I just interject on that?

Dr. Denis Rancourt

Sure.

Shawn Buckley

I'm just curious if you can comment. If it wasn't last week, it was the week before, but it was reported about a doctor in Germany that had written some COVID exemptions. And so here we are out of the pandemic, in, you know, the late spring of 2023, and she's sentenced to two and a half years of prison. Which is just outlandish that you could be in proceedings that you would face jail as a physician for writing— Like, when has that happened before? But then two and half years.

And I can tell you what I thought—and this is what I want you to comment on—is that this had nothing to do with punishing that doctor. It had everything to do to ensure that the next time we're in a similar situation, there won't be a single German doctor stepping out of line because they will all know that if they step out of line, they're actually facing prison. Which is a completely different kettle of fish than, perhaps, losing their licence to practise, as we've seen doctors in Canada. Plus, doctors in Canada will have to pay the hearing fees, which can be crippling. But I'm just curious on what your thoughts are in light of this democratic backsliding.

Dr. Denis Rancourt

My experience talking to many professionals, scientists and MDs, is that anyone who publicly stepped out of line or acted professionally with professional freedom and independence, using common sense and their medical knowledge, they were all systematically disciplined, one way or another. They were all told that this was completely unacceptable, and that's a huge damage that is not described in this list. The harm to the professions, where you take the independent-thinking professionals

[01:45:00]

who are just following what they believe to be right, and you systematically punish them severely—whether they're university professors or practising MDs or even scientific researchers—and you, basically, take them out of circulation: You damage them. This has wounded all their colleagues. As you say, the message to all their colleagues is, "Well, I'll never do that," and, "Oh, my god, you know, too bad he did that, he used to be a friend of mine."

We're in a Stalin-like system. This is horrible, and they expect all the other professionals to go along with this. They expect unions not to protect employees fully and not to go after the root problem at all but to be minimalistic, and so on. So you, as a lawyer, have seen this everywhere. I've seen it everywhere, talking to people. The damage is huge to professional independence. The damage to professional independence: I don't know when it can be repaired.

Shawn Buckley

And like, as you've got expertise in the area of academics and, you know, how it's affected there. It's interesting because I wonder, well, who would be willing—what type of personality now would be willing to become a medical professional when you know that, basically, you're in a situation where you have to go along with what is an official narrative, as opposed to using your professional judgment, now, in a physician/patient relationship?

Dr. Denis Rancourt

I want to step in and answer that question. The same people that used to go into medicine before. Because the main drivers if you're going to put up with medical school and be indoctrinated to that level and put up with everything they put you through—you're doing it for the social status of the position, recognition among your peers, and the comfortable lifestyle you will have. And that's why you do it, and that's why most professionals do what they do, and they put up with the indoctrination of their profession. And that was the same before. That's been the same pretty much always, and it continues to be the same.

But there used to be space for some professional independence. And professional independence is one of the main balancing forces in a democracy so that institutions don't become totalitarian and don't go overboard and continue to self-correct in a way. You know, you didn't have to have whistleblower protection laws before because people would bravely whistle-blow, and they would survive it. Because it was more common and because the backlash against the employer—if they were punished too harshly when they actually came up with something that was important—would have been too hefty. Now, that is completely absent. They can destroy you if you whistle-blow, and that's why there's talk about this whistleblower protection. In my view, that's one way to look at it, anyway.

But the point is, professional independence is one of the huge mechanisms that counterbalances against runaway totalitarianism. One of the other big counterbalances is individual resistance or autonomy. In other words, independent-thinking people, generally, not just professionals. But these are the forces that keep everything in line so that the elite cannot change the laws to their advantage, corrupt the system, and degrade and erode the institutions and all of the public services towards only serving them. There's always a tendency to go there.

And, traditionally, in a working democracy, the balancing forces are either strong institutions that have a sense of what the role of their profession is to protect that institution—and that includes professional independence—and the individual is

independent thinking. So they're going to complain; they're not just going to be programmed by the propaganda. Those are the balancing forces, and they're being removed systematically, completely removed.

We're marching towards a very dangerous place, especially at a time when the U.S. is talking about war with China. Not just talking about it, the Pentagon budget is mainly geared towards

[01:50:00]

encircling and isolating China, and threatening China. So this is a very serious time. And add to that the war in Ukraine, which is no small matter. These are very serious times and, at this time, instead of having a working democracy, they're pushing us to the brink: complete obedience and a totalitarian system.

There you go, I went too far.

Shawn Buckley

Yeah, well, no, no. I mean, it's an interesting conversation, and there's kind of two thoughts. I mean, we could add what Catherine Austin Fitts testified about at the National Citizens Inquiry: that, you know, we have the danger of it's time for this system to collapse. You go to war at these times so that the economic system, which was designed to fail eventually, isn't blamed for the misery—the war is blamed.

But when we're having a conversation about professionals losing their autonomy, and I'd suggested that who would go into medicine now? We could switch—and I don't think you'd be as pessimistic about it—into the areas of natural health practitioners: so your naturopathic doctors and traditional Chinese practitioners and nutritionists. I mean, they don't have social status, like medical doctors, and they definitely don't have the financial benefit.

I see two assaults. So in British Columbia, basically, if you're going to be a natural health practitioner, you basically have to accept that the government can tell you, “You need to take this vaccine or that vaccine or this medical treatment,” or that.

And we just had, last week, come into law—snuck into the federal budget bill—basically applying what is known in Canada as Vanessa's Law [the *Protecting Canadians from Unsafe Drugs Act*] penalties on natural health practitioners because many of them advertise and sell natural health products. And the fine structure has just gone from a maximum of \$5,000, a week ago, to \$5 million per day of a violation. And I just wonder, well, who would go into those disciplines now, knowing that you anger a bureaucrat and you and your family are destroyed, because we have a responsibility to our children not being on the street?

So it's such an interesting time. And we've totally segued, so I'm going to ask you to carry on with your critique.

Dr. Denis Rancourt

Okay.

Shawn Buckley

But I've enjoyed the conversation, and it has been meaningful because it's part of what you're saying is the problem with this type of study.

Dr. Denis Rancourt

Yeah, I just want to comment, though, that these disproportionately large fines or punishments work against a stable democracy.

You know, I'm a physicist, and there's a physics paper that was written a couple of years ago by one of my collaborators, Joseph Hickey, that studied, theoretically, the stability of democracy from first principles. And he showed that in his work—which I think is very important—he showed that the stability of a democracy operates in a parameter space where you have two important parameters that control whether or not it will be stable. One is how authoritarian is the system: meaning when you have a conflict or a fight with another party, if the other party has a higher social status, does that pretty much guarantee that they will win? In that case, that's very authoritarian—the authoritarian parameter is very high.

The other parameter that controls the stability of a democracy is how violent it is: By that, it means, when you have a struggle or a conflict or a fight with another party or between companies or whatever, what is the loss that you suffer when you lose? How big is that loss? How big is the fine? How big is the jail time? If you go too far on one of these two parameters, or both of them, you create a structure that is completely unstable for runaway totalitarianism. Where you completely eliminate the strata of the different strata and societies, the middle class, everything goes away. You have an elite and its professional cadres—the high priests, if you like—and then everybody else is at the bottom. That's runaway totalitarianism, and it's those two parameters that theoretically control that stability.

And so, when you're making laws, it has to be fair punishment and the judicial system has to be one that is fair and doesn't just gauge what is your social status and make that person win. Well, we have evolved to a place where that's where we're at now, in my view.

Shawn Buckley

So, I mean, you know, I'm working on my 29th year of practising law in Canada,

[01:55:00]

and a large part of my practice has been resisting Health Canada on behalf of clients in the area of natural remedies because our drug laws are not designed for health outcomes, but they're designed to protect intellectual property rights, and there's a lot of money involved. So when you have a natural remedy that is tremendously effective for a serious health condition, the system has to take it away and it uses the court system for that. And sometimes when egregious things happen, you'll want to go to court and get a declaration that something violated the Constitution. But I've reached the place where I would do everything as a lawyer to discourage anyone from ever going against the federal government because it's like there's a playbook.

See, now understand: if you wanted the rule of law vis-à-vis the government—if that's what the government wanted—then whenever the government is engaged by the citizen in court, what the government should do is, well, what are the real issues? Let's admit

everything else, and let's just get down to it and have a judge decide. But, instead, they have a playbook to do everything they can to exhaust you financially, spiritually, and emotionally. So there's a large number of cases never even get to trial. And for sure, a litigant will never, ever dare go against the government again. And that's always grieved me because it's inconsistent with the rule of law, and it's one of the reasons I've reached the conclusion that a professional Department of Justice eventually is inconsistent with a liberal democracy.

Dr. Denis Rancourt

Well, this is a whole other discussion. I hear you. I hear you.

Shawn Buckley

We must get back on track, Denis. I'm sorry. I apologize to the commissioners.

Dr. Denis Rancourt

I hear you. And it ties into the theoretical paper that I was telling you about, which is fascinating, and I've given talks about that paper. It ties into that, and I hear you, and I know that, in practice, this is what it means. I know it's real.

But, okay, let's get back to this paper that I'm being critical of.

At one point, they say, "... it is likely that many COVID policies cause more harm than benefit. ..." Well, I'm sorry, there is no detectable benefit. There is only harm. If you say that you're admitting that some of these policies caused more harm than benefit, you're basically saying that only some of the policies caused more harm than benefit and that there was benefit somewhere. There was no benefit whatsoever, in terms of human suffering, in terms of death, and in terms of anguish.

The only people who were comfortable in all of this was the professional class that could work from home, didn't have to fight with traffic, could have everything delivered to their home—because there was this huge delivery system that was now put in place where they could receive everything at home—spend more time with their kids and family. They were better off for a while, you know, and they could still go outside, do their exercise, and so on. They're the only social class where there wasn't a serious harm. Everybody else suffered serious harm, and there was no benefit, apart from that ad hoc, kind-of-weird benefit that I just mentioned. No benefit at all. So that's why I'm very bothered by an article like this. It, in effect, is cooling the mark out.

Then the other last point is that— This is very disturbing because they say that "Planning and response for future global health emergencies must integrate a wider range of expertise to account for and mitigate social harms associated with government intervention." What these authors are saying, who reviewed 600 papers and are writing this authoritative paper—one author—is that we completely accept that there can be global health emergencies where you have to do these dramatic things to the entire world, but we should have experts look into how to mitigate these harms. I mean, that's obscene.

There is no empirical evidence that there ever was a pandemic. There is no empirical evidence for such a thing. And all the health emergencies that arise are basically local and need to be treated in terms of looking at the actual causes, locally, with the people who are having particular problems.

Shawn Buckley

And it goes back to one of your very first points. As you said, you looked at the three earlier pandemics.

Dr. Denis Rancourt

Yes.

Shawn Buckley

So 2009, you know, 1968, and then the '54/'55 [sic] ['57/'58],

[02:00:00]

and there was no excess mortality. So even if this urban myth that we have—that we face these pandemics, that the popular belief is a whole bunch of us die—you're saying that's a complete fallacy. And here we have this author basically perpetuating that for COVID.

Dr. Denis Rancourt

Exactly. There is a constructed and highly funded pandemic-response industry that is in place because, I'll call it, the USA-centred empire wants it in place. They want this, the ability to do this. And they have been working with the CDC for a long time, and this is part of one of their tools.

And the 1918 so-called pandemic was very special circumstances. And if you can analyze it and you can understand what actually happened there—although we're limited by having less data and it was long ago. But there is no reason to believe that these horrific things that happened in the past were not simply a consequence of horrendous living conditions of certain social classes.

Of course, bacteria are a problem. There are some vicious bacteria in hospitals that can be a real problem with people that have comorbidities and that are already sick that are in hospitals. There are horrendous things that, you know, it's absolutely necessary that clinicians and nurses wash their hands. I'm not saying that none of that is true.

What I'm saying is that population-scale health problems are due to regional circumstances and social economic circumstances of certain people. The wealthy won't die. There's very strong correlation that I found between excess mortality and poverty in the United States, for example. That's one of the strongest correlations I've ever seen in the social and medical sciences. There was a Pearson correlation coefficient, you'll remember, between excess mortality during the COVID period and the percentage of the population in the U.S. that was living in poverty: the Pearson correlation coefficient was plus 0.86, which is unheard of. And it was not just a correlation, it was a proportionality: the trend line went through the origin. This directly tells you that it's all about—if you were in these conditions that are represented by this poverty statistic, you had a high chance of dying. And in a state that didn't have anyone living in poverty, no one would have died. That's one interpretation of that graph.

So this is the kind of thing that is happening everywhere, all the time. Yeah, so, in fact, I'm going to conclude that way. I'm going to wrap this up. I'm going to say that I've critiqued these papers enough, now, without getting into the details, and I'm going to move on to my conclusions.

[Conclusions (Parts I & II)]

So, my overall conclusions are, regarding mortality, is that in addition to natural events— There are natural events that cause excess mortality, and they're heat waves, earthquakes, and extended, large-scale droughts that cause excess mortality that's visible. Those are natural events.

You also have events that cause excess mortality that are large assaults against domestic populations and that affect vulnerable residents in those populations. And what are they? They are sudden, devastating economic deterioration. So, for example, I see the excess mortality directly related to the Great Depression, the Dust Bowl, the dissolution of the Soviet Union—without a doubt—and so on.

Another one is war, and war includes complete social class restructuring because it's not every social class goes to war equally. It's the poor and the working class that end up being the soldiers on the front line. And so, war and social class restructuring are devastating in terms of mortality. They create excess mortality, obviously, and I can see that in the data in Canada, in the USA, in many European countries, obviously. You can see the Second World War; you can see the remnant excess mortality related to the Vietnam War, and you can see that it is young men that die in those periods much more than women, and so on. The age and the sex is a characteristic of that excess mortality.

[02:05:00]

Imperial or economic occupation and exploitation: that means big corporations, protected by the U.S. military, occupying entire countries in Africa or Latin America, imposing a certain use of the land on a large scale, displacing all the people who normally use the land and putting them under horrendous conditions where the only thing left is to go into the city and work in factories. This has a devastating effect on health—on population health—and when that happens, you can see it in the excess mortality. And you can see it in how it changes the age structure of the population, as well.

And now we've got a new thing, which we've just demonstrated by a huge, global experiment. We now know— We have this well-documented case where these measures and the destruction that was applied during the COVID period can cause excess mortality, and certainly does. So that's the same kind of assault against a population that we know, historically, can cause excess mortality. And it has done it again—except that it was globally planned and executed across the world in different forms, in different jurisdictions, and it did cause havoc, and it is measurable as excess mortality in the all-cause mortality data.

And finally, there is no empirical evidence that excess mortality can be caused by the sudden appearance of a new pathogen. That's important. I believe that, historically, you cannot find and demonstrate that a new pathogen has all of a sudden appeared that causes the Black Plague, or whatever, by the mere fact that it's a new pathogen that has now come onto the planet. I believe that that is most likely not true. And with the modern examples where you have enough data, it is not true.

So there's probably— I would venture that there is probably no example in humanity where a new pathogen has appeared and caused massive excess mortality in a population. I think that the whole concept needs to be seriously questioned because what causes death is social economic changes—that give large pools of extremely fragile people living in very unhealthy conditions, and that will always be associated with death because there are always pathogens around.

You will always die of cancer, heart attacks—lung infections are very common. The lung is an organ that has a huge surface area of contact with the air. So whatever is in the air—and what's in the air you breathe, includes the bacteria that are in your mouth that you're breathing in. And so that's a place where there are— That's a huge problem in terms of a cause of death, is the lungs and respiratory problems. Heart attacks are also very intimately related to experience, stress, and so on.

You know, there are dozens and dozens of animal studies that conclusively show that in any animal population that forms a dominance hierarchy, the factor that determines whether or not individuals are relatively healthy and live longer and die and so on, is their position within that dominance hierarchy. And it's been shown now, more and more, that that gives rise to a dominance hierarchy stress and that stress—directly and at a molecular level—suppresses the immune system. So you're more susceptible to dying from all these causes. All these causes, and there are many more causes than the ones we know. And so that is the story that we need to start thinking about.

And scientists have the problem that they only look at what they're looking at. They only look at one thing at a time. And so, they get the impression that it's about the particular pathogen that they're studying, and so on. Okay.

Shawn Buckley

I'm just going to rein us in because I think you've given a pretty fulsome discussion. I'll ask the commissioners if— I know that they're going to have questions of you. So, if we can bring the commissioners on. Now, my understanding is that we have lost one commissioner. There we go, we've got three. So the rules obviously permit us to proceed with three. So this is why we kept going.

So, Commissioners, if you have any questions, I'll just give the floor to you.

[02:10:00]

Commissioner Massie

I have a few questions. Do you hear me?

Shawn Buckley

Yes.

Commissioner Massie

Okay. Actually, I have three questions, so to make sure that I can go through all of these questions, I'll start with the shortest one.

Your critique of the paper: knowing you now, I'm not surprised of the critique. I was going to ask you, when I was doing research— And one of the things that came very popular in the last 10 years of my career was that every time I would submit a grant application, there was a section we had to file, or to fulfill, and it says, "What's going to be the impact of your project or your research?" And I was always struggling with that, and I said, "Can somebody give me an "impact-o-metre" so I can measure the impact of my research?" I'm wondering whether the so-called stringency index is kind of suffering from the lack of a good "lockdown-o-metre." How do we assess that?

Dr. Denis Rancourt

I think it's not fruitful to search for a good index, or a better index, of lockdown because as I was trying to explain, the system is very heterogeneous. Populations are extremely different from one county to the next, one state to the next, one country to the next. And it's the population and, in particular, the vulnerable groups within that population that determine how susceptible they are going to be to death when you start perturbing the society. And so, even exactly the same lockdown on different populations can have dramatically different effects.

And so it's not about a— The stringency index has to be—I'll use a mathematical term—it has to be a convolution between the vulnerability of the population and the physical impact of the measure, okay? It has to be a convolution of the two. And none of the indexes come close to that. In other words, they're not dealing with reality.

And so, as I tried to say in my testimony, I think the proper approach to understand a phenomenon is to be able to actually look at the phenomenon. So you have to do field work. You have to go in and see, what did that lockdown mean in this community? What impact did it have? Who did it affect? How did it affect them? Why did these 15 people here die, and these 23 people here, and is it different, and so on? You have to interview people: you have to figure out what's going on because health is not just the result of the tests that MDs will give. It's not the result of a PCR test. It is a much broader concept, and we need those kinds of interdisciplinary teams to go in and figure out what's really going on.

And they need to have more of a voice than the MDs and the people who are designing how to do contact tracing and all these “spreadsheet scientists,” and so on. They have to go away and give their place to real, committed people who really want to understand what's happening in the community. I think that would be part of my answer.

I know I applied for grants a lot and I know that they wanted to know, what is the benefit to Canada going to be? And what they really meant was, what is the benefit to collaborating corporations that you have contacts with going to be, in terms of them making money and being able to hire people, and so on? That's the kind of thing they meant. They didn't mean understanding phenomena, changing paradigms, helping society move to a better place. They didn't mean any of that when they asked those questions. That's what it was like when I was writing grant applications. It was very frustrating.

I don't know if I answered that first question, but—

Commissioner Massie

To come back to your critique about the meta-analysis, I don't know whether you've seen the meme on—I think it was on Twitter or some other source—of these Swiss cheese model for— You have ten slices of protection, personal and populational,

[02:15:00]

and at the end, each of them doesn't work very well. But if you stack them, in the end you'll get something, right? And the first time I saw that, I was thinking, it's almost as if somebody is asked to do 10 additions from the same numbers, same table, and he ends up with 10 different responses, and he says, “Okay, well, that's bad. I'll just average it.”

Dr. Denis Rancourt

Yes, the answer is the average. That's right. That's the problem.

Also, another way that you can think of it is, when I was teaching at the university level, I would often ask the students in a class discussion, you know, difficult questions so that we could discuss and think about things. And I would often pick questions that they thought they knew the answer to, to see if everyone agreed that the answer that everyone thought was right was actually the right one.

And so, for example, in a physics course I would ask even a graduate class to explain a Newton's law of action and reaction. And I would draw a picture and I would say, "Here's the action, tell me what the reaction is, and so on, of a man standing on the floor." And they would give my answers, and almost everyone would give the wrong answer but the answer that they had kind of presumed from their first-year physics courses. One person, typically, in the class—sometimes no one, sometimes two or three people—would actually know the answer. If you said, "Well, most of these students who are graduate students must be right, this has to be; I've got to change how I teach it, how I understand it." You'd be completely wrong. But once you explain to them why they're wrong, they're just baffled. They argue among themselves, and when they actually get to understand it, they've understood that law of physics for the first time ever, even though they're graduate students. I've experienced this several times in my teaching.

Coming back to these meta-analyses: don't do meta-analyses, don't do that. Take one study that you consider a good study: look at it in detail; go talk to the authors; find out what they actually did; find out what tests they used that is supposedly certified; find out what the limits of that test are and what the caveats are; find out all the errors that they didn't think of, that they probably made or didn't even consider; go in great depth into that paper and show that, basically, they wrote this to get a paper published and it's very tenuous and they never should have done this, right? You're going to learn a lot more if you try to do that and if you do it, than if you read the 50 papers on this question and they're all agreeing and so that must be it, and I'll teach that.

Commissioner Massie

My last question will concern the Quebec data, in terms of excess mortality, that seems to somehow be different from the other provinces, okay? In terms of—

Dr. Denis Rancourt

Yeah, it's similar—

Commissioner Massie

I mean, in terms of significant excess mortality, for example, following vaccine period, let's put it this way. So I was kind of aware of this kind of result, and I agree with you that it's very difficult to explain all of these things unless we really go on the terrain and trying to understand what's happening. Are you aware that, in Quebec, they had a fairly different vaccination schedule?

Dr. Denis Rancourt

How different? No, I'm not sure. I don't know what you're referring to.

Commissioner Massie

Typically, the manufacturer would say you have to vaccinate at three-week interval for the second dose. Maybe sometimes they would do it a little longer than that, but typically it was three weeks. In Quebec, for all kinds of reasons, most of the vaccination, at least in the first year, was done at months interval. The reason was because they didn't have enough, I think, in stock. That could be one of the reasons. And there's been some analysis that was done after that to try to actually

[02:20:00]

assess whether this was good or bad. And when you look at the antibody, which is a matter you can examine, I mean, it turns out that spacing it was better, but, you know, in terms of antibody, okay?

Dr. Denis Rancourt

Yeah.

Commissioner Massie

I think that has not been done by the manufacturer. There's no real randomized clinical trial on that. I mean, it's just an observation. So my hypothesis is that if the vaccine has some toxicity and you space it in time, maybe you give the time to the most vulnerable people to recover from the first dose before they get the second or the third.

Dr. Denis Rancourt

Yes.

Commissioner Massie

Is that something you think is reasonable with what you've observed?

Dr. Denis Rancourt

Well, we are looking into this, and I presented some data to that effect at the first part of my testimony back in May. We're looking at the toxicity of the vaccine as a function of dose, not only as a function of age of the recipient. And you'll remember that I showed a graph where the toxicity was increasing with the dose number. And the problem is there are not very many jurisdictions where you have enough detail in both the vaccine rollout and mortality and by age and by dose to do that, but we now have several jurisdictions, so we're really looking at that more carefully.

The other interesting thing is, when they roll out these different doses at different times, the rollouts themselves tend to be very rapid, especially for a given age group. So that helps us a lot because we can really see if it is associated with an immediate peak in all-cause mortality, and we are seeing that systematically. So in jurisdictions where the third dose is rolled out sooner or later, the mortality peak also occurs sooner or later. So we are convinced that there is a very strong, non-coincidental relationship. There is no doubt about that in our minds, but I have not yet seen that the spacing would make a big difference.

The first and second dose, generally, in most jurisdictions are very close together in time and they seem to be less toxic, even together, than the third dose. The third dose is a real killer for a lot of jurisdictions. You see that third dose rollout and it really—

But, you know, yeah, there's a lot of complexity here because there's a seasonal pattern on top of it. We're doing excess mortality. Yeah, I could get into the details, but I haven't seen what you're referring to yet. But we're keeping an eye out for it and we're looking for it, yes.

Commissioner Massie

Maybe I can [ask] just one last question about the issue with the toxicity and the so-called risk-benefit analysis. You mentioned that based on what you've done on analysis of all-cause mortality, you cannot do such analysis for lockdown because there's no benefit. There was nothing to begin with to benefit from. Is that correct?

Dr. Denis Rancourt

That's right. I mean, if you take an objective look at empirical data, you have to conclude that the evidence is contrary to the idea of a spreading viral respiratory disease that killed people. The evidence is contrary to that. If you accept epidemiological theory, which is contact spreading between individuals—you have to spend enough time close together, breathing the same air, and then you get infected by the person who was infectious and that's how it spreads and everything—and you model that. And I've done the modelling, written papers about it, and so on. No matter how you slice the modelling, no matter what input parameters you put in, no matter how you design the model, all the things you predict—none of it is seen empirically in the mortality data, okay?

If it's a pandemic, it has to spread. That's the whole idea. We're seeing proof that it doesn't spread. You have hotspots of mortality that stay in one place; they don't expand outside of that place. You see mortality that does not cross borders—very strict borders—in Europe, between countries, et cetera. These are all completely contrary to the idea of a pandemic.

Commissioner Massie

I just want to— I understand that, and I'm wondering whether we can expand this idea

[02:25:00]

to the risk-benefit analysis of the vaccine? Because there's clearly some risk associated, excess death mortality associated with the vaccine.

Dr. Denis Rancourt

Yes. Well, as I said, there should not have been a vaccine because there's no empirical evidence that there was a particularly virulent pathogen for which you need a vaccine.

Commissioner Massie

Exactly. Exactly.

Dr. Denis Rancourt

So there should not have been a vaccine, and there can be no benefit from the vaccine because we've proven that there was no pathogen that could be given immunity to by this vaccine. So in my book, I put that side to zero, immediately, on the basis of empirical measurements. And it's over. The discussion is over, as far as I'm concerned.

So the only way that they can show benefit is to talk about so-called spread, which is a very tenuous thing to measure. You're coughing up particles. We're going to do PCR on those particles— You know, they do all this stuff. But in the end, the only real reliable data, I believe, is mortality. And the whole idea of a pandemic, and the reason everyone is afraid of pandemics, is it causes death. And so, I know there's an effort to redefine the pandemic so it doesn't matter that people died or not, and it's still a pandemic. But we're getting into nonsense land when we go in that direction.

You know, I think we have to rely on the hard data. If it's not killing anyone, what is it? And if what you're doing is clearly, synchronous in time, killing people in significant numbers, then why are you doing it? To me, it's just so clear, you know? I can't— I know everyone always asks me to think like the immunologists and, you know, to consider it this way and calculate this and calculate that. But I can't get past my grounding in what I've seen from the empirical data. I just can't get past it, myself.

Commissioner Massie

Thank you, Denis.

Dr. Denis Rancourt

You're welcome.

Commissioner Massie

You're muted.

Dr. Denis Rancourt

Commissioner Ken?

Commissioner Drysdale

I had to find the arrow on my mouse. It was on the other screen.

Dr. Rancourt, thank you very much for coming back and talking with us. My first question has to do with the stats that you showed for Canada, and I just want to make sure that I got that right. There was a thunderstorm going on here, and it was going in and out.

Did I understand you correctly, you talked about there were approximately 30,000 vaccine-related deaths in Canada that you were estimating?

Dr. Denis Rancourt

Yes.

Commissioner Drysdale

What was the total number of deaths that you're estimating are related to the vaccine plus the mandates and measures that were put in place?

Dr. Denis Rancourt

Yeah, I don't remember if I reported that last time, but I scribbled it down somewhere. You can do it by year, by calendar year, and get a pretty good number. It's not much more than that.

Commissioner Drysdale

Oh, really? Okay.

Dr. Denis Rancourt

In Canada, you have that first peak of deaths in hospitals, which is pretty significant, and that contributed to the first calendar year of deaths. There was also a more severe winter, just before the COVID vaccine started. So there's maybe—I don't remember exactly what the number was—but roughly another 15,000, giving you 45,000 total. So when you quantify excess mortality for that entire period for Canada, you get about 45,000.

Commissioner Drysdale

Okay.

Dr. Denis Rancourt

Yeah.

Commissioner Drysdale

You know, I have to say, there's been a number of testimonies we've heard that have terrified me and— My apologies to you, but your testimony has terrified me. It made me think about a time long ago when people were murdered because they said the earth turned around the sun—and they were murdered for that. And that made me think of times just recently. You may or may not be aware of Dr. Susan Crockford from Victoria who was a sacrifice on the altar of another theory. In 2018, I think, she was fired from her position for going against the orthodoxy.

[02:30:00]

And we're seeing that happening now: we're seeing doctors fired; we're seeing researchers afraid to speak up; we're seeing all of our institutions falling in line with this. This is terrifying to me.

Have you got any suggestions at what we can do to strengthen our ability to fight this? You know, we have laws in place, we have institutions in place. We have ethics and medicine that were thrown out the window, you know. We have laws against discrimination and genetic testing, and that was thrown out, you know, while the 16-year-old kid at the restaurant was asking what your medical history was—that's illegal. Have you got any suggestions as to what we might be able to do to counter this, coming forward?

Dr. Denis Rancourt

Well, I think that one chance that we have is through popular politics. I mean, there is still a remnant of democratic structures, and they still have to have elections, and there are still representatives. And so, if one can get people in position that potentially can be elected and then have a voice, that can certainly play a big role.

I think that there is clearly a class war, at the moment, in many countries: in France, you have the yellow vests; in the U.K., there was a Brexit movement; in the USA, there was the Trump movement, which is undeniably tied to the working class. But not just the working class, a lot of the professional class, as well, but people who are more into independence: independent thinking, small business, that kind of approach. These are very real political movements. There was recently a person like that elected in Italy and so on, right?

In fact, the establishment—the globalist establishment—openly says that this is what they're afraid of and openly manipulates elections in order to avoid this. And openly creates propaganda and AI systems to affect people's opinions in order to fight against this—because they call it the “populist threat.” And they mean that another social class could actually acquire some political power and influence. You know, the working class—the small business class—could actually acquire some pushback within society, and this is a huge threat for them.

So there's always a chance that these movements can rise and can have their day. I don't think that things are going to be fixed through a recipe of, “this is how we fix it, now let's all agree that we're going to apply these new rules.” It's going to be fixed through the usual struggles and battles that societies have. And they're going to try to take our tools away. They're going to try to fix elections through the usual propaganda methods, and so on. They're going to try to ensure that a lot of people are not represented in the system, and so on, in order to keep their relative advantage. It's a constant struggle.

At the professional level, you have to fight to be whistleblowers and have professional independence. At the individual level, you have to fight for your own bodily autonomy and the right to raise your children how you see fit. We all have to fight for these things.

I was explaining from a theoretical perspective that these are the forces that push back against the corrosion of institutions that is created by the elite manipulating things to their favour and having too much influence in which laws are written and how they're written, and so on. By the elite, I mean, these days, the corporations and big finance, and so on. So there is always this corruption that the deep state is happy to go along with because it gives them more absolute power, and it eliminates the domestic threat that they're challenged in any way when they want to do something in the world. So, we have to do all of these things. We have to—

And it helps me, anyway—personally—to understand the phenomenon: to be able to, you know, understand the theory of stability of democracy and what the parameters are and what they're doing and the big picture. And so, it helps me to— Because I'm an intellectual, I like to analyze it and explain it to others and understand it. And part of that is studying geopolitics because what is happening now in Ukraine,

[02:35:00]

and in the struggle between the U.S. and China for economic dominance of large parts of the world, that is going to determine our civil liberties and how we are in our own country, more than anything else. Those are the big factors that are going to affect our lives. Because

our government justifies its own corruption because it considers itself at war against this kind of “threat.”

The globalist class feels threatened by a system that is based on actual production and actual development in Eurasia. They're threatened by that. They want to control a finance-centred system that just exploits everybody. They're very threatened by this alternative, and China and Russia have understood that that alternative is the way that their nations can survive. So this is the geopolitical fight of the century, and it will determine what our democracies look like, what our social—

You know, even wokeness and all of this gender fluidity—all these things came up as part of globalization. I've written about this. I explained what the origin of the whole gender debate was, originally, in the United Nations. Most of these ideas that were instilled in universities and eventually into the public schools, originated at the same time, directly following the dissolution of the Soviet Union. The globalists decided, it's our day.

There was a globalization of finance—an acceleration of it like we'd never seen. The last time there was such an acceleration of globalization—which means the U.S.-centred system takes everything—was the unilateral withdrawal of the USA from the Bretton Woods Agreement in the '70s. So that was the last time that the U.S. decided, our allies can't be as developed as us, we can't have this, we're going to withdraw from this, we're going to completely put Europe and Japan in their place. And the next big, tectonic shift was the dissolution of the Soviet Union.

This is the world we live in, and those struggles and those fights determine our freedom. We had freedom after the Second World War. The '50s, '60s, and '70s were amazing in terms of professional development, democracy, everything. But the elite saw those freedoms as a threat and organized, systematically, against those freedoms. This is where we're at now, today. So every time they have a campaign, whether it's the wars following 9/11 or anything like that, they ratchet back our freedoms more and more. Unfortunately, the Supreme Courts are not able to balance things whatsoever, or are unwilling or are corrupt, or whatever.

But these big forces are— From my view as an observer of the world, this is going to determine what our societies are like more than anything. That and the local struggles that we fight every day.

Commissioner Drysdale

Well, you know, you had mentioned changing language, and we heard quite a bit of testimony on that: the definition of vaccines was changed; the definition of a pandemic has changed—it used to contain a clause about the number of deaths, it doesn't anymore; the terms for genetic treatment have now been used for vaccines and vice versa. You know, there appears to be an attack on the very fundamental way that people perceive the universe around them.

And just judging from what I see in media lately—and this is what I'd like you to comment on—you know, they appeared to use or we had testimony that they used, all kinds of techniques to get people to fall in line. Name-calling: we were “misogynists,” we were “unscientific,” we were “anti-vaxxers.” And I think the measure of the success that they've had is that I see that starting up again. Mr. Buckley mentioned the legislation, or regulations, coming out against health food products. And just the other day on the news—

I don't remember which network it was—I was watching a news broadcast and they were now calling people

[02:40:00]

“health food cult.” So they're starting to attack that in the same way they attack people during the pandemic, and it seems to be that they're believing that to be a successful ploy.

Dr. Denis Rancourt

Yes, but do you see that there's a pattern?

Commissioner Drysdale

Yes.

Dr. Denis Rancourt

There's a very definite pattern. It's not just to change the language to better manipulate everyone. They're actually attacking the groups that are a threat to them: small business; independent-thinking people; people who don't politically see things the same way; people who want society to be structured around the family unit, and that's how they see a stable community for themselves, and they want to preserve that. So all of these people—the working middle class—these are groups that are clearly threats to the globalist agenda and to keeping control of that agenda. So anyone who doesn't believe in climate change, anyone who doesn't side with wanting to help Ukraine—doesn't side with Ukraine.

And within those fights, there's horrible propaganda techniques that are being used that we don't even see, often. Even us who are used to seeing them, some of them we don't see.

For example, there is a real concerted and well-funded effort to get the right-thinking people—what I mean is the people on the right of the political spectrum—who see through a lot of this other stuff related to COVID, and so on, to get them to consider that China is the enemy. This is extremely well-funded that propaganda, and you can find its roots— You can go right down into the Pentagon to find the roots of that.

If you look at the roots of Epoch magazine, that everyone considers does really good reporting. It's true, they do very good reporting, and they're very critical of these social issues. But the one issue that they're uniform on is that China is the problem, okay? So they're making sure that all the different groups, when it comes down to it, will align on those things. They know that the left will go along with a war in China because it's in their interest because they're already the privileged class, okay? But if the right gives us trouble, then we might have a bit of trouble. So they have to continually fabricate, manipulate, but what they have in mind is geopolitical dominance and conquest and crushing systems.

You have to try and see it all. I spent a lot of my time agreeing with people on the right, but then explaining to them that I don't agree with them on China, and why I don't. And there's some fantastic researchers that are exposing all of this propaganda, you see.

Trump is really good on China. He has said many times, well, they just want to have families, they just want to live. Call them names, if you want, but we can get along with them. He's said that, and he's completely right, and that's the way to go to avoid pushing a whole nation towards war, you know.

Commissioner Drysdale

Have you considered that the pandemic is real, but the real pandemic is this globalization that you're talking about? Because it crosses international borders, it crosses boundaries, it crosses households, it crosses every artificial boundary in the world, and it's attacking people and causing death.

Dr. Denis Rancourt

Yeah, that's an interesting idea, but these corrupt elite are not infected by a pathogen. That's not what makes them corrupt. They are deeply corrupt because they are classist: They don't consider that the others are equal to them. They consider that they're entitled to their privilege, and they justify their actions in those terms. They basically see themselves as better people that can do whatever they want. So I don't think it's a pathogen that's infecting them. I think it's the usual class nastiness, you know, that makes them this way.

Commissioner Drysdale

Well, you know, I designed a correctional centre in Nunavut some years ago, and I learned that the Nunavut people don't believe that person does evil because they're evil. They do evil because they're sick,

[02:45:00]

is what their belief system is. They kept telling me, in a way that I look at things, that I was not designing a prison, but I was designing a health-correctional centre. And perhaps they're right in all of this.

Dr. Denis Rancourt

Well, the difference between Aboriginal communities and societies is that they're traditionally, historically, much less hierarchical than a highly technological society that is globalized, that has professional classes and elite classes and everything. So, as soon as you are very hierarchical, there's going to be exploitation between the different layers. And if you are more horizontal, and really living off the land and depending on each other, there's going to be less of that and you'll have a different world view, I think, of things.

Commissioner Drysdale

Yes, absolutely.

Dr. Denis Rancourt

Different politics and so . . .

Commissioner Drysdale

Thank you, sir.

Dr. Denis Rancourt

You're welcome. I really flew off the end there on a few—

Commissioner DiGregorio

So, if I could just come in with a last, few questions.

Dr. Denis Rancourt

Oh, okay. Sorry.

Commissioner DiGregorio

Yes, thank you, Dr. Rancourt, for coming today.

I am going to bring you back, a little bit, to your excess mortality testimony that you were providing to us earlier. I really appreciate the Canadian update that you've given us today. I'm hoping you can help me understand a little bit more about this vaccine-dose fatality rate that you talked about, which I think I heard you say that you've calculated, or estimated, in Canada to be something around the area of 0.03 per cent. But then you had higher numbers for other places, such as the USA and, I think, India, maybe even the world overall. I'm just wondering if you can help me understand what's the reason why that number would vary.

Dr. Denis Rancourt

Yes. So that number, when I—The numbers that I gave, they were whole population numbers. And, by that, I mean that those numbers were not discerning age group. They were not discerning the very important age-dependence, okay?

So in a society that has a lot of elderly and fragile people, and you give, let's say, a thousand injections, more people are going to die in that society than one that has young, strong people. So that number is for an entire region, or country, and it's going to depend on which population you're injecting.

And, I have to admit, it's probably going to depend on the manufacturer, on the type of injection that you're using, but less so. I don't see a big difference there, okay, but we can see some difference.

But it is a population average number. And so it will not only depend on what the structure of the population is, but it will depend also on the clinical judgment culture when they inject someone. So there's a clinical judgment that you don't inject someone who is days from dying, who is on their deathbed. You don't inject them with, even, something that would cause discomfort and could be fatal to them. You avoid that. So the people who are in ICUs and have been there for a while and have horrible comorbidity and could die any time, generally most will not sign off on injecting them, okay? In many countries or in many hospitals.

Others, they just won't care. Like India, they didn't care. They even had a list of comorbidities and they were chasing these people down to inject them. I talked to a clinician in Quebec who said, "Yeah, that's what we do. We very carefully evaluate whether or not this person can be injected." So the culture of how you consider, even, flu shots or any vaccination of fragile elderly people is also going to affect this number, because it's an average number.

So if you're injecting less of those fragile ones, which have the highest probability of dying on being injected, then your average population-based rate is going to be lower, you see? So

it suggests to me that Canada probably has, on average, better clinical judgment and healthier populations, maybe,

[02:50:00]

or better protocols of who you inject when they're in ICU and this kind of thing, than places like Israel and Australia—which both have exactly the same population value of 0.05 per cent. A little higher. So it's going to depend on all those things.

So that is an average number. But every time I look at a jurisdiction, I can discriminate by age, and then I always see an exponential increase with age. And it always has a doubling time, per age of the person, of five years in age. So every five years in age older, you double your risk of dying per injection. So when you get into the 80s and 90-year-olds—whether it's Australia, Israel, Canada—you approach the 1 per cent mark, which is what they experienced in India.

Commissioner DiGregorio

Okay, thank you.

My last question, which, hopefully, is a quick one, given that we have been going for so long. And I apologize, everybody, that I'm still going. But at one point you showed—I think it was a world map with excess mortality by country, year over year, and of note in it was that certain countries did not appear to show a lot of excess mortality—such as Canada, Australia, Japan, New Zealand—until 2022. And so, leaving aside sort of the issue of vaccines and potentially causing the 2022 increase in deaths, wouldn't some people be able to look at these maps that you've showed us and said, “Well, this actually supports the view that these countries' lockdowns worked?” And I'm just interested what you would have to say to that.

Dr. Denis Rancourt

Well, you know, you can— There's just so much heterogeneity across the world. We have these lockdown indexes, and we look for correlations, and so on.

I mean, they can always make these counter arguments. But then I would answer, “Why is the mortality significantly higher now than before? And this is excess mortality, so you're above what, historically, you should be seeing. And why did young people experience, immediately, a higher mortality in many provinces and that that was maintained? And why is it that in Nova Scotia and New Brunswick, the mortality is clearly temporarily associated with the only thing that changed at the time which is the vaccine rollouts?” And, you know, I would send back all of those counter examples, would be my response.

But a lot of people do take the approach that you are suggesting. And the way that they approach it, in terms of statistical analysis, is they try to look for correlations between excess mortality in a given time period on one axis and stringency of lockdowns, let's say, over that same time period on the other axis, and they look for a correlation. And I've done this kind of work, for example, in the United States, in detail because you have 50 states, so it's almost like you have 50 countries. And generally, when people try to do that—it's difficult enough to do—there is no significant correlation. You get a big scatter plot, okay? It's just all over the place. There's no clear-cut correlation.

Now, in our study of the USA, what we did is we said, “Well, let's be a little bit more clever,” we think. We'll compare states that share a border, and one did not lock down whatsoever, and the other did lock down whatsoever. And we'll pick pairs of states that are very similar in terms of their populations, the number of poor people in the state, and so on. And we found something like a dozen pairs of states that we could directly compare in that way. And we found that there was, statistically, a very large, significant difference in excess all-cause mortality between the two groups of pairs, within pairs, and it was clearly higher in the lockdown states and lower in the non-lockdown states. So we did a study like that. I did that in collaboration with a professor, John Johnson, from Harvard University, and that was taken up by a corporation who published the article, as well.

[02:55:00]

So you can try to get around the difficulty that just looking for a correlation—with all these different jurisdictions—is just going to give you a scatterplot. You try to refine it. And when you do refine it, you find what we found, I think. And when you don't refine it, you just look for that. And it's a good idea to look for it because what if you did find a strong correlation, you know? That would show it. But what we find is that nobody can show a strong correlation when they look at many different countries like that, so I don't think it would be a good—

In other words, a lot of countries that had very strong lockdowns equal to Canada had very high mortality. So you can't make the relationship.

Commissioner DiGregorio

Thank you, that's helpful. That's all the questions I had.

Shawn Buckley

So I'll take it that the commissioners have no further questions.

So Denis Rancourt, on behalf of the National Citizens Inquiry, I sincerely thank you for coming and sharing with us today. I know that I am not a commissioner, but I really found your evidence interesting and rewarding to listen to, and enjoyed the dialogue that the commissioners had with you. I appreciate—and this is for the commissioners and the audience—that it was a lot of work to prepare for this and analyze those things, and we don't take your effort for granted. We sincerely appreciate it.

And then, on behalf of the National Citizens Inquiry, we thank everyone for supporting us by watching the testimony. For all of the witnesses, it is meaningful because you participate, and we thank you for your encouragement and your support.

And, so, good night.

[02:56:57]

Final Review and Approval: Margaret Phillips, September 9, 2023.

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.

*For further information on the transcription process, method, and team, see the NCI website:
<https://nationalcitizensinquiry.ca/about-these-transcripts/>*

