NATIONAL CITIZENS INQUIRY

Virtual Testimony **July 19, 2023**

EVIDENCE

Witness: Dr. Peter McCullough
Full Timestamp: 00:00:00–00:59:35
Source URL: https://rumble.com/v30zcka-nci-virtual-testimony-dr.-peter-mccullough.html

[00:01:52]

Shawn Buckley
So I'd like to welcome everyone who is attending online and watching this as we commence only the second time that the National Citizens Inquiry has had virtual testimony [after the conclusion of hearings held in eight Canadian cities]. The commissioners have requested that we have Dr. Peter McCullough return and address some further issues.

Commissioners, for the record, my name is Buckley, initial S. I am attending today as agent for the Inquiry Administrator, the Honourable Chestopher [sic][Chesley] Crosbie.

Now, Dr. McCullough, could I begin by asking you to state your full name, spelling your first and last name for the record?

Dr. Peter McCullough
First name is Peter, P-E-T-E-R, last name McCullough, M-C, capital C-U-L-L-O-U-G-H.

Shawn Buckley
And Dr. McCullough, do you promise to tell the truth, the whole truth, and nothing but the truth, so help you God?

Dr. Peter McCullough
Yes, I do.

Shawn Buckley
Now, because we have only an hour with Dr. McCullough, Commissioners, I'm not going to go through the regular expert vetting process. I will advise you that we have as Exhibit VT-2, Dr. McCullough's CV, which is 177 pages in length. He has over a thousand peer-reviewed medical publications. He's likely the most published and recognized medical expert in the world, let alone in the United States.

We've also got, as exhibits, two publications that you have asked that he comment on, marked as exhibits. We have as Exhibit VT-2a, an article called "A Systematic Review of Autopsy Findings in Deaths After COVID-19 Vaccination." We have as Exhibit VT-2b, "COVID-19 Vaccines: The Impact on Pregnancy Outcomes and Menstrual Function."

So Dr. McCullough, I'll just march right in and ask if you can start discussing that first article, the systematic review of autopsy.

Dr. Peter McCullough
The context for this paper is that there have been autopsies performed in people who have died after COVID-19 vaccination, but they largely have come in as single case reports. And it's very hard to see patterns when there's a single case or just a small number of cases from a particular site. They have come in from all over the world.

So I was contacted by Nick Hulscher, who's a graduate student at the University of Michigan, who applied for a research project. It was approved by the University of Michigan, this systematic review. We said we were going to find every published autopsy done after COVID-19 vaccination. And once approved, we embarked on our project. We searched over 600 papers where an autopsy could have been done. And then we narrowed it down to the final number of papers in the manuscript—I believe the number is 44.

[00:05:00]

And in total, that was 324 autopsy cases.

Now, importantly, when autopsies were done early on, all of the mechanisms of injury and death the vaccines have been shown to do weren't known at the time. So an early autopsy could have had a patient die of a fatal blood clot, a pulmonary embolism, and the conclusion of the autopsy, early on, would be—not related to the vaccine. Well, we know today that wouldn't be true, so we needed a contemporary review.

We had three reviewers who are expert in pathology—particularly cardiac pathology—who had experience directly with autopsy reports and tissue specimens. And then we reviewed each case, all the published details, independently and had three reviewers, had a system for tie-breaking, in order to ascertain—was the death either directly due to the vaccine or did the vaccine significantly contribute to death?

And our top-line findings were that 73.9 per cent of the cases, the vaccine played a role in the death, either directly or significantly contributing. And in the remaining quarter of cases, we exonerated the vaccine. It looked like the vaccine didn't play a role.

Now, of those with vaccine-induced death, about 90 per cent of it was cardiac, cardiovascular. And the most common pattern was heart inflammation, called myocarditis, leading to sudden death, largely in young people. So the implications of this paper are the next young person who dies, unexplained, and they've taken a COVID-19 vaccine, it's more likely than not the COVID-19 vaccine is the cause of death.

Now, the autopsies came to attention typically within 30 days of taking the vaccine. We don't know, as months and years go on, what is the effect on the heart. But I can tell you, as a cardiologist and someone experienced in cardiopathology, I'm very concerned.

I'm also very concerned about what happened after we initially submitted this for peer review and preprint.

Shawn Buckley
Right, and so my understanding is the article was accepted by *The Lancet*, and then what happened after that?

Dr. Peter McCullough
We had submitted the paper to Lancet. Now, I had previously published in Lancet. I'm the most published person in my field, in the world, in history, prior to COVID, so I'm very familiar to all the journals: they know me, I know them. And I actually had a paper accepted to Lancet very early on in 2021—or 2020, in the pandemic.

So we submitted to Lancet at the editorial level, editorial office level. It was favourably reviewed, but triaged to a lower-level Lancet journal, of which, as a senior author, I respectfully declined because it needs to be published at a high-level journal. But I did accept the offer to have it go on *The Lancet* preprint server: SSRN.

And so, in that preprint submission, there's two rounds of checks to make sure everything is good to go up on the server, and it did. And it was getting surges of downloads over the first 24 hours—like I've never seen before for a preprint paper. To give you an idea: a typical preprint paper on vaccines gets about 50 downloads and reads, because the academic community has interest in it, but it may be sporadic and nominal. But about 50 reads would be common. But we had surges of downloads—I don't know how many thousands of downloads and reads—and the next morning, Lancet stopped it, and they put out a bogus claim. They said that the methodology did not support the conclusions, and yet that wasn't anything they found fault with during the review or preprint submission process.

Within 24 hours, we submitted it on the European Commission preprint server, which is just showing the data to the world so people can look at it for themselves. It's not peer-reviewed, but it's on the Zenodo server and, astonishingly, it has—as we've seen here today—a hundred and fifty thousand downloads and reads.

Shawn Buckley
Well, I'm glad that we've entered it here as an exhibit.

Now, one thing that stuck out at me when I was reading the paper is that, basically, most of these deaths occurred within a week. And what I'm wondering is, so these are largely autopsies of what we could almost call, sudden deaths, very temporally related to the vaccine. Do you know of any work— We're hearing a lot about secondary mechanisms of death, like turbo cancers and the like. Do you know of any work, or is there any work in progress, to use autopsies to assess these other potential deaths being caused by the vaccines?

[00:10:00]

Dr. Peter McCullough
No, I don't. And I think it's particularly worrisome, since we showed such a high rate of causality that those who die months or even years after the vaccine, that, in fact, the vaccine could be a role.

And I've been particularly struck by a paper published by Li and colleagues—L-I and colleagues—demonstrating, even two years after initial shots of Pfizer and Moderna messenger RNA, two years later, there's an excess risk of retinal artery blood clots and retinal vein blood clots. Not everybody had them. But it was about a fourfold increased risk for those who took the shots compared to those who didn't: 750,000 sample size in the vaccinated; about double that in the unvaccinated comparator group.

So I'm worried the vaccines have long-lasting effects: certainly on blood clotting, maybe other factors.

Shawn Buckley
Now, the only other thing that I wanted to ask is, and I appreciate we're not in normal times where the government or the medical community reacts in the way we would anticipate pre-COVID. But what would you normally have anticipated with the publication of these findings? How the governments and medical community would react?

Dr. Peter McCullough
This paper would have been a high-level paper at any meeting. We clearly would have had interaction with the companies, the manufacturers, the FDA [Food and Drug Administration], the EMA [European Medicines Agency], TGA [Australian Therapeutic Goods Administration], SAHPRA [South African Health Products Regulatory Authority]—all the regulatory agencies. There'd be an invitation to make a presentation at one of the FDA vaccine meetings, which come up frequently. And then there would be a broader discussion of death after vaccination.

So when the Pfizer dossier was released— You know, Pfizer recorded 1,223 vaccine deaths within 90 days of release of their product. Five, 10, 15, no more than 50 deaths—back early in 2021, Pfizer should have pulled it off the market. That's my expectation. The FDA should have told them to do so. All the other regulatory agencies, worldwide, should have had alarms going off to get Pfizer off the market. Yet, 1,223 deaths and no one made the call to pull it off the market.

In fact, Pfizer tried to conceal that—and the lawyers from the FDA—for 55 years. Now we've had Moderna conceal their data. And under court order, finally, Moderna's data has been released to the ICAN [Informed Consent Action Network] NGO. Two years later, Janssen and Novavax and AstraZeneca still have not released their 90-day regulatory dossiers.

Shawn Buckley
So for those that may be watching, so you're referring to what's now called the "Pfizer dump," where Pfizer basically did not want—for 77 years—their clinical trial data to be released, and they were forced by a court to be releasing it in stages. That's what you're referring to?

Dr. Peter McCullough
That's correct. Remember: any product that's released on the market, the company has an obligation for 90 days to take phone calls from patients and their family members, and take down the report of any side effects. And when Pfizer was released—December 10th, 2020, in the United States—people started calling Pfizer, and the phone was ringing off the hook with complications, side effects, and, sadly, family members calling Pfizer and telling them that their loved ones had died after taking the Pfizer vaccine: sometimes in the vaccine centre—right where they took the vaccine—or within a few hours or a few days after taking Pfizer.

So it was an explosive number of deaths. And as you point out, the lawyer for the FDA wanted to block this release for 55 years and actually went further and extended it to 77 years during the proceedings. And finally, under court order, it was released—the Pfizer dossier was released. It's largely been analyzed by the analytic group at the *Daily Clout*. And Moderna will almost certainly be analyzed by the NGO ICAN [Informed Consent Action Network] because their attorneys forced release.

The public and doctors should be very disturbed that the companies are not publicly releasing their 90-day data. And in fact, they've intentionally tried to cover that up and not release it.

Shawn Buckley
Right, so that's the work of Aaron Siri, I believe, is the attorney's name for ICAN. Yeah, he does great work.

Now, one of the things that I understand has kind of come out from this Pfizer dump—and I want to use it to segue into the next article that we've entered of yours as an exhibit—is basically a focus on reproduction that one wouldn't anticipate. If you're doing clinical work on a vaccine for a respiratory virus, we wouldn't necessarily expect there to be much, or any, focus on reproductive health.

[00:15:00]

I'll ask you to comment on that, and then I'll ask you to basically discuss that paper that you participated in authoring, the miscarriage rate and other issues surrounding pregnancy and the COVID vaccines.

Dr. Peter McCullough
The clinical trials of the COVID-19 vaccines were very similar to clinical trials of new pharmaceuticals. Pregnant women and women of childbearing potential, breastfeeding women—strictly excluded from these trials. And the institutional review boards that looked over these applications, the sponsors and the FDA, and all the regulatory agencies agreed: under no circumstances should a woman of childbearing potential without contraception, a pregnant woman, or breastfeeding woman take a COVID-19 vaccine because the vaccine could cause harm. So all those entities agree, and that's the reason why not a single woman in that category was allowed to take a vaccine.

And then in a shocking move—December 10, 2020—the FDA and the CDC [Centers for Disease Control and Prevention] in the United States, who were sponsoring the vaccine administration program, encouraged pregnant women to take the vaccine with no assurances on safety. None. And this was a shocking move. The FDA and CDC did this. The

vaccine administration centres didn't provide any oversight or any clinical judgment to exclude them.

In my clinical practice, I would never have a woman in that category take any experimental product. It's considered Pregnancy Category X, meaning it should not be used, has a dangerous mechanism of action, and has no assurances on safety. And I published an opinion editorial in *TrialSiteNews* with Dr. Raphael Stricker—who runs the largest fetal loss clinic in the United States—early in 2021 stating that: that the COVID vaccine should be Pregnancy Category X.

What we know from that point forward is, I think, alarming: that our CDC is reporting 65 per cent of women—over the course of 2021 and 2022—65 per cent of women who got pregnant either took a COVID-19 vaccine before the pregnancy or during the pregnancy. This is an astonishing observation that women themselves, their obstetricians, their gynecologists, and others would not have an eye towards safety.

We had a paper, by the way, in *Annals of Internal Medicine*, of pregnant women who got COVID, by Pineles and colleagues. Pregnant women have better COVID outcomes than non-pregnant women because pregnancy is an enhanced immune state. It's a natural state, and it's not an immunodeficiency state. So there was no clinical indication, there was no medical necessity, and there was no safety.

To make matters worse, we learned that the Biden administration and the Health and Human Services Department through the COVID Community Corps program—discovered under FOI, or release of information act—that the American College of Obstetrics and Gynecology [sic] [American College of Obstetricians and Gynecologists] [ACOG] took federal money to promote COVID-19 vaccines through gynecologists and obstetricians on pregnant women without having assurances on safety.

Shawn Buckley
And I just want to make sure that people understand. So what you're saying is that they— We'll just use Pfizer as the example. So the Pfizer clinical trial, like all clinical trials— We call it a new drug, in Canada and our regulations. But as all clinical trials on a new drug, pregnant women are excluded, and that's for ethical reasons. And so when the FDA—and here, Health Canada—is then approving the COVID-19 [vaccine] for pregnant women, you're telling us there actually was no research showing that it was safe to use on pregnant women at the time the FDA approved it for use in pregnant women.

Dr. Peter McCullough
No. So yeah, that's a correct statement for the FDA, Health Canada, TGA—any of the regulatory agencies that allowed pregnant women to be vaccinated with novel, experimental vaccines. Initially, it was Pfizer. That's the messenger RNA coding for the lethal Wuhan spike protein. No regulatory agency, in good conscience, could ever approve that for a pregnant woman. This was very early on.

And because human ethics committees and the FDA and the pharmaceutical companies, just four months earlier, excluded these women from studies,

[00:20:00]

it should have been a strong signal that under no circumstances should they allow them to take the vaccines. Yet, as I've told you, the majority of women who got pregnant and delivered babies through these years in the pandemic took the vaccines. And what we've learned is the outcomes have been horrific for these women.

Shawn Buckley
So can you discuss that? Because that's what's in your paper, the miscarriage rate and other issues surrounding pregnancy and the COVID vaccines.

Dr. Peter McCullough
Well, let's just take the mothers first. And I'll cite a paper by Hoyert, a single author, H-O-Y-E-R-T. It's published by the National Center for Health Statistics; it's on the CDC website. Hoyert is reporting, during these pandemic years when the women took the vaccines, record maternal mortality: mothers dying during the pregnancy and, in that study, up to 42 days afterwards. So maternal death is one of the ultimate outcomes, and it appears as if it's associated with administration of the COVID-19 vaccine. It's erased about four decades of progress in obstetrics. So pregnant women are dying at record numbers at this point in time, and it's in the National Center for Health Statistics in the United States.

Now, in terms of the maternal–fetal outcomes in those who survive pregnancy, there's about three dozen papers that have concluded that they don't see a safety signal in pregnant women. But these studies—including a very early one in *New England Journal of Medicine* by Shimabukuro and colleagues from the CDC—they were either biased because the FDA and CDC are the vaccine sponsors, they were publishing the studies, or they were biased because the authors were members of the American College of Obstetrics and Gynecology and they took federal funding to push the vaccine. So many of the papers can simply be discarded because they're biased by people who, basically, are being paid or told to promote the vaccines.

And on top of that, the papers have shortcomings: The windows are too short; they don't look at a full nine months of pregnancy. There's no comparator group. So we assembled a team led by Dr. James Thorp, an obstetrician/gynecologist—I'm the senior author—and we evaluated the U.S. Vaccine Adverse Event Reporting System [VAERS]. And we did what the CDC asked investigators to do, is we benchmarked it against another vaccine pregnant women take, and that's the inactivated flu vaccine.

And what we found is that women who took the COVID vaccine compared to those who didn't and those who did take the flu shot as a comparator, we have a multifold increased risk of maternal hemorrhage, fetal loss in the first trimester, stillbirth, maternal hemorrhage after delivery, fetal hemorrhage, and then four fetal outcomes—including intrauterine growth retardation; oligohydramnios, that is a reduction in the amniotic fluid; fetal malformations; and then, sadly, fetal death.

So the Thorp paper is the safety signal of concern. It was done correctly, compared against the flu vaccine and the unvaccinated. And when we have three dozen papers that are biased or incomplete, but we have one paper showing a signal—I can tell you, I'm an expert in data safety monitoring—we follow the single paper that shows the safety concern. And so it's my testimony that the vaccines have been associated with maternal death at a record level and now, fetal loss, loss of pregnancy: the first trimester, that's a miscarriage; and then after 20 weeks, that's a stillbirth. Sadly, maternal hemorrhage after delivery and multiple fetal abnormalities.

Shawn Buckley
Now, is there— Because the governments will say, "Well, we're trying to protect the mothers and babies." And you've already indicated to us that, actually, a mother during pregnancy is in a kind of a hyperimmune state—the immune system is ramped up. Do babies and children face a risk from COVID that would justify the use of this vaccine during pregnancy?

Dr. Peter McCullough
They don't. I mean, infants have an imperceptible syndrome, if they have any. We had very positive data in using hydroxychloroquine, prednisone, aspirin, and other drugs—good clinical experience in women who are pregnant. They worked fine. Monoclonal antibodies were used, even if it was off-label, in pregnant women: they were safe and effective. So we had treatments for the pregnant women. They clearly didn't need to risk anything with a vaccine.

[00:25:00]

And then children had a negligible risk, particularly newborns.

So, you know, we have a situation now. Paper by Klaassen and colleagues, from Harvard, show that 94 per cent of Americans already through COVID; 97 per cent have some protection, even from subclinical illness. The COVID-19 vaccines and boosters are not clinically indicated or medically necessary, clearly in pregnant women but other populations as well. And that's evidenced by the fact that 15 per cent or fewer of Americans have even taken a booster.

And so we're largely through the pandemic. There are low-level residual cases that are very mild and we use the McCullough protocol or other standard published protocols to treat patients.

Shawn Buckley
Now, I'm going to go into that at the end of your testimony because I want to end on a positive note. So at the end of your testimony, I'm going to ask you about, how do we mitigate some of these things?

But because we're short on time, you only have an hour to spend with us, I want to invite the commissioners to ask you questions because I know they were looking forward to being able to ask you questions.

And Dr. Massie, who's unmuting, he used to run the National Research Council of Canada.

Commissioner Massie
Yeah, well, just to follow on the positive note about the protocol that's been developed to reduce spike toxicity. I've seen a number of reports on that and I know you're working on a publication that is probably going to come any time soon.

One of the things I was wondering, because this question has been asked to me by many people: if you think of the nattokinase, for example—which is an enzyme produced from a bacteria—and the route of administration, if I'm not mistaken, is you swallow a pill, so it goes in your gut. So the question that people were asking is, how is it possible that it can

actually reduce or destroy the spike protein if the spike protein is not accessible to the enzyme? If it's running in the blood, for example, what's the likelihood that this enzyme will actually get to the blood circulation? Do you have any indication on that?

Dr. Peter McCullough
That's certainly a fair question, and I can't make any therapeutic claims on nattokinase. We don't have large prospective, double-blind, randomized, placebo-controlled trials or a giant pharmaceutical dossier—like pharmacokinetics and pharmacodynamics. I can tell you no such studies are planned and that have been registered in clinicaltrials.gov.

But this is what we know: The Japanese have been eating natto for about a thousand years. It's the fermentation product of soy. It's broken down by *Bacillus subtilis* [*variant*] *natto*. It's been used as a cardiovascular supplement for a few decades. It is a thrombolytic, so we know that at a single dose administration of 5,000 FUs—or Fibrinolytic Units—that blood parameters change. It is an oral anticoagulant. We know that for sure.

Three papers—the lead one by Tanikawa and colleagues—shows that nattokinase does degrade the spike protein. Whether it's inside cell preparations or whether it is in cell lysates, it dissolves the spike protein. So the enzyme appears to have functions both intracellularly and extracellularly where it is a protease. And the human protease system does not seem to be able to break down the spike protein itself.

Bruce Patterson has shown this in IncellDx: after severe COVID, the S1 segment is within CD16-positive monocytes—probably extracellular, as well—up to 15 months afterwards, in his data; up to nine months afterwards, after the vaccine. That's as far as he's looked. The full-length spike protein, S1 and S2.

So we believe, based on the data, that nattokinase has a degradative effect on the spike protein. And it's been our clinical experience now, about three months on nattokinase, empirically, we're seeing clinical improvement.

Commissioner Massie
Thank you.

Commissioner Drysdale
Dr. McCullough, I have a number of questions for you. On the first study that you were talking about, I believe you said that you had identified 678 studies. And of that 678 studies,

[00:30:00]

they thought that 325 of them were pertinent to the investigation you were undertaking. Now, can you tell me, what was the population from which those studies were extracted? Was it just the United States? Was it the world?

Dr. Peter McCullough
Yeah, the population was the world. But like, a prototypical study—that was in the 600, that didn't get included—is a paper by Patone and colleagues published in *Circulation*

where they described a hundred fatal cases of vaccine myocarditis in the U.K. A hundred cases, but not a single one had an autopsy.

Commissioner Drysdale
Well, you know, that's what I'm curious about because you went on to speak about the post-marketing informational dump from the vaccine manufacturer. And I believe that that study that they looked at, where they reviewed 42,086 cases of adverse reactions, was completed end of February 2021, was it not?

Dr. Peter McCullough
That's correct.

Commissioner Drysdale
So in the data that you talked about from that post-marketing study, you mentioned that there was 1,223 fatalities. Now, what you didn't mention was that in that same report, out of the 42,000, there were 9,400 cases they said the results were unknown. So there were 1,223 identified fatalities, 9,400 cases where the results were unknown—they could have been deaths, they could have been anything, they just weren't reported. But coming around to my point is, as early as February and with a sample size of only 42,000, BioNTech had identified 1,223 cases of death. And yet, years later, we could only find 370—plus or minus—autopsies that you could use in your study. How is that possible?

Dr. Peter McCullough
It's possible, and I distinctly remember this. I participated in a pathology lab on a regular basis, in a prior position. Most centres in the United States and worldwide shut down all autopsies during the pandemic. There was a great fear that the deceased body would transmit COVID to the people working on the body. And so we have an incredible dearth of autopsies because most clinical pathology programs shut them down for a couple years.

Commissioner Drysdale
Well, you, know that's interesting, Doctor, because we've had significant testimony from witnesses who said that by as early as March of 2020, the health profession understood that COVID really affected a particular age group and that is elderly people with comorbidities. And yet, healthy people— Health care workers were so afraid of it that they wouldn't do autopsies? I mean, that's incredible.

Dr. Peter McCullough
No, it was true. It's absolutely true. I can serve as a witness—as someone who regularly worked in a pathology lab—but that's in fact what happened. And when the Italians published the first autopsy papers in COVID, it was thought to be an amazingly courageous group that would perform a dissection on a patient who died of COVID, that they, quote, "took the risks of doing that." And the autopsies, as you alluded to, were incredibly valuable.

And what the original autopsies in COVID found—in COVID, not the vaccine, just COVID—is that people died of blood clots. Invariably, they had micro and macro blood clots in the lungs. So we learned from those papers that patients needed blood thinners. And in fact, in

the McCullough protocol—treated as an outpatient—we used very strong blood thinners in high-risk cases very early. And it's the lack of using blood thinners, I think, early that contributed to some COVID deaths.

Commissioner Drysdale
Well, you know, I want to switch over just a little bit and talk about the second study that you were discussing. How long did it take before the influenza vaccine was approved to be used on pregnant women? I mean, as I understand it, it took 10 months with this. How long did we wait before we were allowed to put the flu vaccines into pregnant women?

Dr. Peter McCullough
I don't know. As I sit here, I don't know. I would assume it probably took many years.

And it's still controversial, by the way, to give any pregnant woman a vaccine. And the reason being is that a vaccine—

[00:35:00]

if it's diphtheria, tetanus, pertussis, inactivated flu—the reason why it's controversial is that any vaccine can cause a fever. And a fever is a known precipitant for a spontaneous abortion or a stillbirth.

Commissioner Drysdale
So you don't really know how long, but how long have flu vaccines been on the market?

Dr. Peter McCullough
Flu vaccines have been on the market for many decades. I know, personally—I checked my own personal vaccine record—I've taken 40 flu shots in order to be a doctor and medical student, on staff. So I can tell you at least four decades because I'm a witness for that.

Commissioner Drysdale
So 40 years of influenza vaccines and they still caution to give them to pregnant women. But this mRNA vaccine was approved and encouraged for pregnant women within months of its development. Is that a fair statement?

Dr. Peter McCullough
That's correct. And, shockingly, it was encouraged by the U.S. FDA and CDC on the day it was released: December 10th, 2020. And yet, just two months earlier, pregnant women were prohibited from taking it in the clinical trials.

Commissioner Drysdale
Now, I also wanted to ask you a little bit about— You know, in listening to witness testimony and doing research for the report that the commissioners are writing, it seems that the mRNA vaccine—if you read the definition of these drugs from the CDC or Health Canada, the mRNA treatment—is really a biologic, is it not?

Dr. Peter McCullough
It's true. I would cite the work by Hélène Banoun—B-A-N-O-U-N, former INSERM [French Institute for Health and Medical Research] scientist in Marseille, France—where she's analyzed all the regulatory characteristics of messenger RNA. It's clearly gene therapy.

Commissioner Drysdale
But they took a gene therapy—a biologic—and the reason biologics undergo a much higher level of investigation of testing is because of the complexity of their manufacture and the way they interact with the body, with the cells of the body. So how is it that we took a biologic that would have normally taken years and years and years—because it's a biologic and not a vaccine—how is it that we classified it as a vaccine and tested it on the basis of it being a vaccine when it's clearly a biologic?

Dr. Peter McCullough
It was regulatory malfeasance. Never should have been considered as a vaccine and received a short-track approach. We needed, clearly, five years of safety testing and observation. Even if it was released early, there should have been monthly safety meetings; everybody should have been in a registry checking in. And as I've already testified, the vaccine should have been pulled off the market January 2021 for excess mortality.

Commissioner Drysdale
Now, with regard to the pregnant women, are you familiar at all with the, let's say, pre-2019, pre-COVID vaccine rate of mortality in women due to them being pregnant? What's the incidence that a pregnant woman—just from complications due to the pregnancy—what would that mortality rate be?

Dr. Peter McCullough
The absolute rate is in the Hoyert paper—H-O-Y-E-R-T. It's at the National Centre for Health Statistics. So I don't have it in my memory of the absolute number. But let me say, in the years prior to COVID, it was at a steady rate. It did go up in 2019 a little bit, more in 2020, and then it really jumped in 2021. And as I recall, in 2021, it's probably four times the baseline.

Commissioner Drysdale
My understanding that the number prior to COVID was somewhere in around 1 in 16,000, or in that range. Does that sound in the ballpark?

Dr. Peter McCullough
No, to me that sounds high, but go ahead.

Commissioner Drysdale
Okay, fair enough. The reason I was asking that is I wanted to compare—or I wanted you to compare or discuss—the risk of mortality due to being pregnant versus the risk of mortality for women of that age group dying of COVID-19.

Dr. Peter McCullough
Well, there were some maternal deaths due to COVID-19. They did occur; you can find them in the peer-reviewed literature. We do know that, again, pregnant women did better than non-pregnant women.

[00:40:00]

And just like the other patterns, the pregnant women who did die of COVID-19 tended to have baseline problems, like preeclampsia, systemic lupus, obesity, cystic fibrosis, other problems that they were carrying forward, and, so, they remained at risk.

But in my view, there wasn't justification for the vaccine because the vaccine—because it's applied to all women—if it caused harm, it would cause harm to a large number of women, as opposed to simply treating those isolated cases at high risk. We had success using hydroxychloroquine, prednisone, enoxaparin, corticosteroids: they were all safe and effective. Monoclonal antibodies: safe and effective. So we had a ready armamentarium.

It wasn't commonly done in the United States, but it was done extensively in Brazil: pregnant women could also receive ivermectin, and they did incredibly well. There's a published paper by Schechter and colleagues from Manaus, Brazil—where they had the gamma variant in the Amazon rainforest—and they clearly treated these women and they saved them, whereas without treatment, some died. So we knew that it was essential for some high-risk women to get early treatment.

Sadly, the vaccines have never been shown to reduce hospitalization and death in any prospective, double-blind, randomized, placebo-controlled trial. And that's the only design where we can ever make a claim regarding the vaccines.

Commissioner Drysdale
My last question, because other folks want to get in here—and I'm sorry for hogging the time here—but, you know, you talked about a significant increase in miscarriages and deaths in the fetus. But have you got any information with regard to the effect of fertility in the first place? In other words, we're talking about and counting deaths in the womb, but how many babies were prevented from getting in there in the first place due to fertility issues? Do we know that?

Dr. Peter McCullough
We know the basis for infertility is pretty strong because a bio-distribution study showed that the lipid nanoparticles do go to mammalian ovarian cells. We know the spike protein is damaging to cells and tissues.

Two studies—one by Gat, the other one by Huang—showed in men that the vaccine clearly reduces sperm count and motility: the two major indicators of male fertility.

And then I would say that one of the third largest sources of information on fertility is that the vaccines, in every study so far, disrupt the female menstrual period. A large study from the U.K. called the EVA project ["The Effect of Vaccination against SARS-CoV-2 on the Menstrual Cycle (EVA Project)"] showed this was the case. A very big study in *British Medical Journal* showed the same thing.

So here's the concept: you know, a woman only has a certain number of eggs and the ovulatory cycle needs to be precise—ovulation, fertilization, implantation. Anything that disrupts that cycle, which for sure the vaccines do, will reduce fertility. If the vaccines go to the ovaries and cause some loss of egg cells, that's going to reduce fertility. And on the male side, there's a range of fertility, and if the vaccines reduce some men's fertility into the infertile zone, we have a perfect storm for the vaccines lowering fertility. And now, all the data systems across Europe, which they have good tracking systems, show, indeed, population fertility is down since the vaccine campaign has started.

Commissioner Drysdale
So, I mean, what you're talking about is an unknown number of thousands and thousands of babies that may have died or may have not been conceived, and we just don't know the answer to this.

Dr. Peter McCullough
I agree with that.

Commissioner Drysdale
Thank you, sir.

Commissioner Massie
If I can jump back with another question. You actually did an interview with Christine Cotton and another French colleague about the clinical trial—the way they were actually executed with the Pfizer, and it was analyzed in a lot of details. So what is your overall take on the conversation you had with them, with respect to the, I would say, reliability of the clinical trial: both with respect to efficacy and safety, that the data that came out from this trial?

Dr. Peter McCullough
The registrational trials of Pfizer,

[00:45:00]

in my opinion, are invalid: that there were so many breaches of good study conduct that the results are not reliable. They didn't test each group equally to see if they got the infection on a regular basis. The groups weren't properly blinded: people knew if they took the vaccine or not. There were crossovers that occurred, dropouts. And putting this all together, we cannot conclude that the vaccines are either safe or effective.

Commissioner Massie
So I know that in the conversation, Christine Cotton was mentioning that she wanted to have an audit of the clinical trial. In your opinion, what would it take to get that audit?

Dr. Peter McCullough
The FDA simply can order an audit, and independent auditors or FDA auditors can audit the dossier. And it's Dr. Cotton's opinion and mine that the trial would not survive an audit.

The conclusion would be that the registrational trial is invalid. If the trial is invalid, therefore, the approval never should have happened.

Commissioner Massie
So if the FDA is not moving forward with the audit, is there any other way to enforce it?

Dr. Peter McCullough
Another regulatory agency could step forward—the EMA, the Canadian authorities, MHRA [Medicines and Healthcare products Regulatory Agency], SAHPRA. FDA is not the only game in town. Many of the other regulatory agencies actually relied on the U.S., so it would be nice to see an outside regulatory agency call for an audit, request the dossier, and analyze the procedures that were taken and, basically, the results of that flow process.

Commissioner Massie
And in your opinion, what would be the timeline in terms of asking for the audit? Is there sort of a defined window after which you can no longer do it?

Dr. Peter McCullough
Audits can be done retrospectively, particularly if we think there's malfeasance that's occurred. They can be done. Research centres, by the way, are required to keep records for years and years and years. So they could call an audit for any time, and particularly if we think malfeasance is a concern.

Commissioner Massie
Thank you.

Shawn Buckley
So if there are no further questions, I know that I have some because we wanted to speak at the end of your testimony about, basically, some positive solutions. But I think it would be important to explain to the people watching, basically what are the mechanisms of harm? Like, what is the concern—short of death—that you're seeing in the research and in your own clinical practice concerning vaccine injury? And I mean concerning COVID-19 vaccines.

Dr. Peter McCullough
There's over 4,300 papers in the peer-reviewed literature describing vaccine injuries, disabilities, and deaths—4,300. And the regulatory agencies agreeing the vaccines cause many serious syndromes, including myocarditis, heart inflammation, stroke—both hemorrhagic and ischemic stroke—other neurologic problems, including Guillain–Barré syndrome, small fibre neuropathy, seizures, blindness, hearing loss, blood clotting. All the regulatory agencies, all the peer-reviewed papers agree blood clotting is a major problem: deep venous thrombosis, pulmonary embolism, blood clots in the retinal arteries and veins—virtually every thrombotic syndrome one can imagine.

Fourth category is immunologic. Immunologic is disorders of the immune system: multisystem inflammatory disorder, vaccine-induced thrombocytopenic purpura, and now,

lingering immune systems called autoimmune problems, characterized by a positive ANA—or antinuclear antibody or an antinuclear cytoplasmic antibody—response.

So it's a broad breadth of problems. Most appear to be related to the spike protein, excessive production of the Wuhan spike protein. That's the spine on the ball of the virus.

The code for that was intentionally manipulated in the Wuhan Institute of Virology to be more infectious and more damaging. All of that has come out in the U.S. House of Representatives Select coronavirus investigations. A report was issued by that committee July 11th, 2023, outlining the fact that the virus was indeed engineered in the Wuhan lab. The U.S. regulatory officials had a role—including Dr. Anthony Fauci; Dr. Francis Collins; academic investigators—including Dr. Ralph Baric at the University of North Carolina at Chapel Hill; and NGO EcoHealth Alliance—led by Peter Daszak; and, of course, the Wuhan Institute of Virology—led by Dr. Shi Zhengli. So that now is all in the open.

[00:50:00]

We're left with the spike protein damaging the Canadians, Americans, others who took the vaccine. The spike protein, as we've outlined, does not appear to get out of the body quickly at all. It may be in the body for months or years.

To make matters worse, now, multiple labs have discovered the vials were contaminated with DNA—what's called cDNA, which comes off the manufacturing process. During the clinical trials, Pfizer and Moderna used naked DNA to produce the messenger RNA. And towards the very end, they switched to mass production using *E. coli*—not naked DNA, but *E. coli* DNA—to produce the code, the messenger RNA code. And that *E. coli* required certain additional elements called promoters: promoters that actually enhanced the production of the DNA, which made the RNA in *E. coli*. About 250 people— Out of the 48,000 in the clinical trial, 250 got the new manufacturing process compared to the old manufacturing process. So only about 250 do we have anything to rely on in terms of who got the new stuff.

To make matters worse, in the clinical trials they use single-use vials: one vial per person. And in the public program, they used the new process made from *E. coli* and multi-use vials where six different doses came from a vial—air is introduced through using multiple needle punctures through the diaphragm of the vial.

And now a lead paper by Kevin McKernan, validated by three other labs: the vials are contaminated with this *E. coli* DNA, and there's fragments of the DNA, including the promoter. There's both the promoter and the enhancer of what's called SV40—or simian virus 40. Not the full viral code, but the promoter that promotes the production of the DNA. The reason why this is concerning is SV40 is a known promoter of cancers. It actually promotes proto-oncogenes and oncogenes.

Separately, in a paper by Singh and colleagues, the S2 segment of the spike protein, which is in people who took the vaccine—not in people who got COVID, but those who took the vaccine—S2 segment seems to inhibit the P53 and BRCA tumour suppressor systems. So we have a perfect storm of cancer promotion and, then, inhibition of our cancer-surveillance system.

So what I'm leading to is, there's a great concern that the skyrocketing rates of cancer we're seeing worldwide—and there's no dispute that cancer is up—in fact, that may be due to COVID-19 vaccination, besides all of the known syndromes that I've outlined.

So this is bad news for those who took the vaccine. Most of this is dose-related, so if someone's following the U.S. schedule right now, they're on their seventh dose of messenger RNA—seven. Many people just stopped at one or two doses.

We know in a paper from Schmeling and colleagues—good news—a third of the batches, there were zero side effects. This is in Denmark. They had Pfizer, they had all the side effects. Zero side effects. Two thirds have some mild side effects. And yet the third batch, only 4.2 per cent of the vials had side effects through the roof, including fatal side effects that we've covered in this testimony.

So it looks like we have a product production problem. This small number of vials may have hyper-concentrated messenger RNA, contamination, other factors, but there are lethal vials of the vaccine. All of them should have been pulled off the market in 2021. The batch differences were submitted to the CDC and FDA in 2022 by Senator Ron Johnson. Those regulatory agencies dismissed that concern. Now we have this paper by Schmeling and colleagues, out of Denmark, clearly showing it's a batch problem, both good news and bad news. The good news, most people look like they probably will be unharmed, but a small number of people, sadly, have paid the ultimate price.

[00:55:00]

Shawn Buckley
Before we switch to the solution, one burning problem that I've wondered about—and you might be the perfect person to answer it because you're so connected with the research—is it seemed that early on, they knew the spike protein was the dangerous part of the virus, and yet that's the part that they chose to have manufactured within our bodies, when they could have chosen a more benign part of the virus for us to get immunity from. And then we've continued on with that. I mean, with other vaccines, once the delivery mechanism is approved, they can change the viral part without having to go through all the regulatory process. So is there any explanation as to why they chose the spike protein, and then why they haven't substituted to a less dangerous part of the virus?

Dr. Peter McCullough
The code of the spike protein appears to have been known years ahead of time. Years ahead of time. We've learned that vaccine developer Peter Hotez, in Houston, had biodefense grants based on that spike protein receptor-binding domain with the Chinese in 2015 through the National Institute for Allergy and Immunology [sic] [National Institute for Allergy and Infectious Diseases]. So the spike protein was known years ahead of time, and it was ready-made.

Within three days of President Trump declaring a COVID-19 disaster, Moderna declared they had a vaccine—within three days. And the only way they could have done that is they knew the code for the spike protein ahead of time. And they chose it, and it appears to be an intentional choice.

Shawn Buckley
Right, and an intentionally dangerous choice is what you mean.

Dr. Peter McCullough
Well, it was dangerous. Now there are papers and discussion about benign proteins and making a vaccine from the benign proteins. From the very beginning, the Chinese had a killed vaccine where they presented the whole virus to the body and that didn't work. That was exactly what Ralph Baric did in 2015: the whole virus vaccine didn't work. The spike protein clearly produced neutralizing antibodies and looked good, and they went with it largely, I think, because they had the genetic code ahead of time. We learn now that Moderna had a material transfer agreement with UNC-Chapel Hill with Ralph Baric before COVID was known. So this looked like it was all prearranged.

Shawn Buckley
Yeah, I wish we had more time for that conversation.

Can I have you address that last point that you wanted to address: just, kind of, the positive news about that there are some ways of addressing the primary problems with the vaccines because I think it would be helpful to leave people with some positive news.

Dr. Peter McCullough
Right, just in the last minute, let me say: there's no methods of getting messenger RNA out of the body. It appears as if Pfizer and Moderna is pseudouridinated, and there's no way to get it out of the body. It does produce the spike protein for an undisclosed duration and quantity. It may be forever.

But we do have a remedy for the spike protein to degrade it. One is with nattokinase, we've covered. A second is with a natural product called bromelain, also an enzyme—a family of enzymes that's FDA-approved for use topically for some deep wound problems, but it is orally available and does work in the human body. Both nattokinase and bromelain are blood thinners. And then the third natural product is curcumin, derived from turmeric: that even has randomized trial support that it reduces inflammatory factors in patients.

So we have a paper that's been accepted, it'll be out in the peer-reviewed literature, that a triple combination—what we call "Base Spike Detox"—of nattokinase, bromelain, and curcumin—nattokinase, 2000 units, twice a day; bromelain, 500 milligrams a day; and curcumin, 500 milligrams, twice a day—is a reasonable, empiric approach to try to detoxify the bodies that have been loaded with the spike protein. And this base, which is a natural, over-the-counter approach, can be something people can do with the caveats that we're using two blood thinners, there can be allergies, people need to be cautious. But it almost certainly will have a salient effect on the blood clotting problem and the spike protein issue in the tissues and cells. And then doctors can work on other advanced therapies, as needed, for the specific syndrome.

So spike detox, I've been doing this in my clinical practice now for months. I found very good success, a reasonable safety profile with the caveats: I can't make any therapeutic claims, and there are no large, randomized trials planned. There's no funding planned for this. It looks like we're going to have to be on our own in terms of our clinical judgment.

Shawn Buckley
Well, I don't know how it is in the U.S., but our drug approval laws really are there to protect intellectual property rights because they're so expensive that in my lifetime, there's

only been one product go through the new drug approval process that didn't have a patent, and that was funded by government. So, likely have the same problem in the States.

Are there any quick, final questions? We're at the end of our hour. So Dr. Peter McCullough, on behalf of the National Citizens Inquiry, we sincerely thank you for coming and testifying again with us today.

Dr. Peter McCullough
Thank you.

[00:59:35]

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/