These transcripts serve to preserve the firsthand accounts, opinions, experiences, and perspectives of those directly impacted by or involved in the issues under investigation.

Title: Inquiry into the Appropriateness and Efficacy of the COVID-19 Response in Canada
Publisher: National Citizens Inquiry

First Publishing: PDF, English, Canada, November 28, 2023
https://nationalcitizensinquiry.ca/

ISBN 978-1-998416-04-2

National Citizens Inquiry, 2023. Inquiry Into the Appropriateness and Efficacy of the COVID-19 Response in Canada.

This title has three volumes:
Volume 1: Executive Summary
Volume 2: Analysis
Volume 3: Transcripts (Volume 3 is further broken out into sections by City.)

Commissioners: Kenneth R. Drysdale
Heather DiGregorio
Dr. Bernard Massie
Janice Kaikkonen

Thank you to the thousands of volunteers across Canada who worked tirelessly to make the hearings possible.

VOLUME THREE

Witness Transcripts

NCI NATIONAL CITIZENS INQUIRY
CANADA'S RESPONSE TO COVID-19

VOLUME THREE

Witness Transcripts

Part 11 of 11: **Virtual Testimony**

Table of Contents

Page numbers have been included in the original transcripts to facilitate ease of reference and navigation for readers.

Table of Contents

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, 2028–2023, 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 mute.

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/

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/

NATIONAL CITIZENS INQUIRY

Virtual Testimony **September 18, 2023**

EVIDENCE

Witness: Dr. William Makis
Full Timestamp: 00:01:48–03:01:54
Source URL: https://rumble.com/v3ipsi2-dr.-William-makis-september-18-2023-nci-virtual-testimony.html

[00:01:48]

Shawn Buckley
Good evening and welcome to this special sitting of the National Citizens Inquiry. My name is Shawn Buckley. I'm a lawyer that volunteers at the National Citizens Inquiry, and we're very pleased to have Dr. William Makis, who will be testifying for the first time at the National Citizens Inquiry.

For those of you who are not familiar with us, we are a citizen-led, a citizen-run, and a citizen-funded group that just decided to appoint independent commissioners and march them across the country. And we basically have created the largest library of under-oath testimony in the world on COVID-19 issues. What's been accomplished has been absolutely fantastic. But we have some holes in our evidence, including evidence on cancer and some other interesting things that Dr. Makis is going to share with us today.

I guess I will start formally: Commissioners, for the record, my name is Buckley, initial S. I'm attending this evening as agent for the Inquiry Administrator, the Honourable Ches Crosbie.

Dr. Makis, before we begin, can I ask you to state your full name for the record, spelling your first and last name?

Dr. William Makis
My name is Dr. William Makis, V-I-L-I-A-M M-A-K-I-S.

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

Dr. William Makis
I do.

Shawn Buckley
Now, by way of just some background— And I will indicate for both the commissioners who have received your CV earlier today and for those that will be watching your testimony that your CV has been entered as Exhibit VT-3 in these proceedings, so everyone can view your expertise. And I will also indicate that every document that you refer to today and the slide presentation that you're going to use are also entered as exhibits and will be available on your testimony page online.

But briefly, you, in 2001, received a degree in Immunology from the University of Toronto. In 2005, you graduated from the Faculty of Medicine in McGill, but you made a decision to train for five more years at McGill in the area of nuclear medicine to become an oncologist. And that's what you are: you're a nuclear medicine radiologist and oncologist. You worked at the Brandon Regional Health Centre, Department of Nuclear Medicine, and then more recently at the Cross Cancer Institute, Department of Diagnostic Imaging in Edmonton.

Now, we've asked you to testify on a number of topics today, including your experience with vaccine mandates in Alberta, with sudden deaths involving doctors—which you've been a pioneer in bringing attention to that. We want you to also share with us about the Alberta government deleting COVID-19 vaccine data from,

[00:05:00]

basically, the public website that they run. We want you to speak about the relationship, if any, between COVID-19 mRNA vaccines and cancer, and then also about sudden deaths and cancer.

So, Dr. Makis, I invite you to begin. You have a presentation for us [Exhibit VT-3a], and then, just as needed, I'll interrupt you to clarify and ask some questions.

Dr. Willliam Makis
Thank you very much.

I started raising concerns about COVID-19 vaccines on social media in August of 2021 [Exhibit VT-3b]. And it was at this time that Israel had just rolled out booster shots for its population. It was the first country that had rolled out COVID vaccine booster shots. And in my estimation, this was already an indication of failure of the first two doses of the COVID vaccines. Israel rolled out the boosters in people ages 60 and above, then 50 and above. And by the end of August of 2021, it was the country that had the highest COVID-19 infection rate in the world.

And it was right around this time that Alberta Health Services [AHS] announced that it was going to implement a vaccine mandate on all of its 105,000 health care workers. This was the announcement that Alberta Health Services had put out [Exhibit VT-3c]. And the announcement was really unilateral by AHS. There seemed to be no involvement of the Alberta provincial government, Jason Kenney's government.

It was announced by AHS president and CEO Dr. Verna Yiu. And the announcement stated that immunization against COVID-19 is the most effective means to prevent the spread of COVID-19 and that any AHS employee unable to be immunized due to a medical reason or a protected ground under the *Alberta Human Rights Act* would be reasonably accommodated. This announcement was carried in a number of mainstream media outlets [Exhibits VT-3d

to VT-3g] and one of these was the *Calgary Herald* [Exhibit VT-3d]. And I just wanted to bring this up—a statement from the Alberta Health Services CEO, Dr. Verna Yiu, stating that she is confident that most health care workers will want to get vaccinated and that if someone refuses and doesn't have a valid exemption that AHS officials would meet with them to discuss it and, quote, "provide educational resources," end quote. But that if this re-education was unsuccessful the employees would then be put on unpaid leave of absence.

I became involved at this point. There was tremendous opposition among Alberta health care workers to these COVID vaccine mandates. And there was an open letter that was authored and signed by over 3,500 Alberta health care workers. And I was one of those signatories. Seventy-three other physicians co-signed this letter, and it was then signed by nurses and other health care workers. This is an open letter to the president and CEO, Dr. Verna Yiu, and it outlined the reasons why Alberta health care workers, thousands of them, were opposed to COVID-19 vaccine mandates at this time.

I would like to highlight some of these. First of all, these mRNA vaccines had not been proven to prevent disease uptake or disease transmission. This was supported by the CDC's own data. The overall survival rate from COVID was approximately 99.7 per cent. The vaccine was already showing weakened efficacy after only a few months. Very importantly, United Kingdom and Israel, two highly vaccinated countries, had very high percentages of hospitalized patients who were fully vaccinated. Natural immunity was superior to vaccine immunity. And many health care workers, you know, had COVID already, had recovered, and already had natural immunity.

And the VAERS database at the time—this is the Vaccine Adverse Event Reporting System—this is as of August 27, 2021, had shown 650,000 people had been injured and 13,900 people had died soon after the administration of the vaccine. And we know that the VAERS reporting system has an underestimation factor of anywhere from 10- to 100-fold. So these numbers were much, much higher.

As health care workers, we believed that the vaccine mandate was contrary to

[00:10:00]

sections two and seven of the *Canadian Charter of Rights and Freedoms*. And so this letter respectfully requested that the vaccine mandate be rescinded immediately so that Alberta health care workers could continue to provide care for Albertans. This letter was sent to senior officials at Alberta Health Services. One of them was Dr. Francois Belanger, who is the Alberta Health Services vice president and chief medical officer. So he is the lead doctor in the province. It was also sent to the leadership of Covenant Health, which is a smaller health authority in Alberta.

It was signed by 3,544 health care workers, including 73 physicians, and I was one of those physicians.

Shawn Buckley
So can I just stop you, Dr. Makis? So I'm not aware of any other time in history where literally 3,500 health care professionals in Alberta would sign a letter to senior health officials. Are you aware of this ever happening before on any other issue?

Dr. William Makis
I'm not.

Shawn Buckley
And what was the response from these six senior health officials that the letter was sent to?

Dr. William Makis
As far as I know, there was never any response from Alberta Health Services.

However— So I signed the letter and I was very surprised to receive a letter about three weeks later from the College of Physicians and Surgeons of Alberta [Exhibit VT-3h]. And the College indicated to me that they had received a copy of this letter to Alberta Health Services regarding opposition to mandatory COVID vaccination for AHS employees. And they said, "You have been identified as a signatory on this letter." The College then says that it is their standard practice to maintain a copy of this on my record, on my permanent record at the College. And then a very interesting paragraph at the end—because they said that they've been made aware that some people who had signed the letter actually didn't agree to sign it or were not aware that their signature was on it and that if I personally did not agree to be a signatory on this letter that I should let the College know and then they would put that response on my permanent record as well. I took this—

Yes, go ahead.

Shawn Buckley
I was just going to ask you: How did you take this? Because it sounds pretty threatening.

Dr. William Makis
Well, I honestly took this letter as a threat. I took it as a threat on my medical licence and, really, on my medical career.

Now, I'd like to point out that there is no patient care issue here. So the College has jurisdiction, obviously, over patient care issues, licensing issues. You know, I had co-signed a letter in opposition to vaccine mandates that I felt were unethical, unscientific, abusive, and harmful. And, you know, I did not see a role for the College to put that letter on my record and then send me an intimidating letter like this.

So it is my understanding that the College probably sent this threatening letter to all 73 Alberta doctors who had co-signed the letter in opposition to the vaccine mandates. And, you know, I don't know what the other colleges did, like the nursing college, but, you know, I was very concerned to have been sort of implicitly threatened in this way.

Shawn Buckley
So I just want to be clear. So we have 3,544 health care workers sign a letter, citing specific concerns about the mandate, and there's no response by the four people that are basically heads of health authorities within the province of Alberta. But we have regulatory colleges, who the letter was not addressed to, responding, at least to doctors.

Dr. William Makis
Yes.

Shawn Buckley
Okay.

Dr. William Makis
And so, you know, I remain opposed to vaccine mandates to this day: I was opposed then and I'm still opposed now. I believe they're very harmful and that remains my stance to this day.

Shawn Buckley
It's quite fascinating. Now, you're moving now to doctor deaths, and I can tell you that I'm particularly interested in this one. So please proceed.

Dr. William Makis
This is a phenomenon— These sudden deaths of Canadian doctors was a phenomenon that I have been warning about since December of 2021.

[00:15:00]

And you will see this is my first post on the matter back in December of 2021 on Twitter. And the way I came to this topic and this phenomenon was there were two Canadian doctors—young Canadian doctors—who had died suddenly after taking the booster shot.

And the first of these doctors was Dr. Sohrab Lutchmedial. This was a 52-year-old interventional cardiologist from New Brunswick. Now he was one of the first doctors in Canada to take the COVID vaccine booster shot. He took his shot on October 24th, 2021. He described it on Facebook. He says, "Vax Shot Three: Electric Flu-Galoo." I'm assuming that he had some flu-like symptoms after he took the shot and people were asking him, "Is this the booster for health care workers?" He says, "Yes, exactly." And two weeks after he took the booster shot, he died in his sleep on November 8th, 2021.

And Dr. Lutchmedial was a very outspoken critic of people who didn't want to get vaccinated. And he made a number of Twitter posts that were controversial. I included some of them on this slide. In one of them, he says, "I think all of us would treat the unvaxxed patient with respect and to the best of our abilities, but the people that convinced them not to get vaxxed, I want to punch those people in the face." There was another post where he stated, "For those who won't get the shot for selfish reasons, whatever, I won't cry at their funeral."

So I was aware of these posts, and then when he took his booster shot, died suddenly. I was very interested in what had happened to this young doctor.

The second doctor who died suddenly, very shortly after, on December 23rd, 2021, it was Dr. Neil Singh Dhalla. This is a family doctor in Toronto, Ontario, who ran clinics called Activa Clinics. And he took his booster shot. And three or four days later, he was at a

friend's Christmas party, felt unwell; he lied down on the couch, and he died suddenly while sleeping on that couch. He died on December 23, 2021.

And there was a TikTok video that had been put out by a friend who said, you know, "He just had his booster shot three or four days ago and this is what happened. He died suddenly a few days later." There were claims that there was an autopsy showing myocarditis. I was never able to verify that claim.

And so when these two doctors had died suddenly, I realized something was very wrong. There was that temporal association with the booster shot—dying very shortly after the booster shot—and dying in their sleep, which is extremely rare: highly unusual for a young person to die in their sleep. And so I began posting about this on Twitter, and I was trying to alert some doctors about this.

Dr. Irfan Dhalla, who is a very prominent doctor in Toronto, he talked about the risk of booster shots. He made a post in January of 2022. He said, there's a "huge gap between what scientists and health care workers think [about] the risk of boosters being close to zero long-term risk and what the public thinks." I responded. I said, "Not true—the long-term risks remain unknown." And look, there's these two doctors that died shortly after their booster shots.

I continued trying to raise the alarm on Twitter. Unfortunately, a couple of months later, I was raising concerns about COVID vaccines in children five to eleven years old and my Twitter account was locked, and I was censored and terminated from Twitter. And so I continued doing research on my own, but again, I could not really alert anybody. And so I simply continued looking into the sudden deaths of Canadian doctors. And that's how this whole thing started for me.

Once I had found 32 sudden deaths of Canadian doctors, I decided to contact the authorities. And I wrote a letter to the Canadian Medical Association on September 3rd of 2022 to their president, Dr. Alika Lafontaine—who was the current president at the time—and Dr. Katherine Smart, who was the previous president for the previous year [Exhibit VT-3i]. I also sent copies of this letter to Alberta Premier Jason Kenney and Alberta Minister of Health Jason Copping.

And I raised concerns about these sudden deaths of 32 young Canadian doctors. I attached photos and information about them. And I said, "Look, these doctors died suddenly or unexpectedly in the past 16 months. They were double, triple, or quadruple COVID-19 vaccinated." I said that each of these deaths is suspicious for COVID vaccine injury

[00:20:00]

as these previously healthy doctors died suddenly while engaging in regular physical activity. They died unexpectedly in their sleep. They suffered heart attacks, strokes, unusual accidents, or developed sudden-onset aggressive cancers. And I was not familiar yet with the term "turbo cancer" at the time, but I had noticed that some of these doctors suffered very aggressive, unusual cancers.

And I asked the Canadian Medical Association and the presidents to use their platform to publicly call for the immediate termination of COVID vaccine mandates in Canada's healthcare and to call for urgent investigations and public inquiries into what was killing young, COVID-vaccinated Canadian doctors.

I did not receive a response to this letter from the Canadian Medical Association or from the Alberta Premier and Alberta Minister of Health.

At this time, there was a group of people who had contacted me privately and they said, "Look, we're willing to offer our services, our time, to help you build a database of all Canadian doctor deaths going back several years so that we could compare and see if doctors were dying at a higher rate than normal, or if this was just some kind of an aberration and was not a real phenomenon." And so we put a team together and we started assembling this database and, about a month and a half later, our group of sudden deaths had grown to 80.

And so I sent another letter to the Canadian Medical Association [Exhibit VT-3j]. And I said, "Look, I'm providing you an update. Now it's 80 young doctors who have died suddenly or unexpectedly since the rollout of the vaccines." And I specify, I say, "Look, you cannot continue ignoring this. My team has assembled a database of 1,638 Canadian doctor deaths during the period of 2019 to 2022." And we had actually obtained a lot of this data from the Canadian Medical Association's own website: 972 entries of those were from the CMA's own website.

And I gave some statistics that the deaths were actually clustered around the young doctors. It was the young doctors who were dying at much, much higher rates than previously. At the time, doctors under the age of 30, it was looking like they were dying at an eight-fold rate higher in 2022 compared to the pre-vaccine rollout era. And I also made a note of young McMaster University medical residents: three of them had died suddenly in the summer of 2022. And I said, "Look, I'd never heard of anything like this in my career; this is unprecedented." And I once again asked, "Please call for the suspension of vaccine mandates and for investigations."

These are the three young McMaster residents who died suddenly in the summer of 2022. And look at their ages: Dr. Satyan Choudhuri, 25 years old, family medicine resident. Dr. Candace Nayman, 27 years old, pediatrics resident. Dr. Nayman was a triathlete, and she had actually participated in a triathlon that summer, and she collapsed during the swimming portion of the triathlon, and then died several days later. And Dr. Matthew Foss, 32-year-old anesthesiology resident who struggled with a very aggressive lymphoma.

I attached pictures and information of 80 Canadian doctors' sudden deaths. And I just wanted to bring up a few of those, if I may?

Shawn Buckley
Yes, please do.

Dr. William Makis
Just to highlight some of these sudden deaths.

Dr. Carl-Éric Gagné is a cardiologist from Trois-Rivières, Quebec, 56 years old, an avid cyclist. He was participating in a 100-kilometre cycling competition. He collapsed during the cycling event, and he died suddenly at the age of 56.

Dr. Paul Hannam, a 50-year-old emergency physician from Toronto. He's actually an Olympic athlete—an Olympian who went out for a jog. He collapsed while he was jogging, and he died suddenly during his jog.

Dr. Baharan Behzadizad was a 43-year-old family doctor from Newfoundland. She died in her sleep with no explanation.

Dr. Joshua Yoneda, 27-year-old medical student from UBC (University of British Columbia). He was mandated to take two COVID vaccines. A few months later, he develops back pain. It's discovered he has an extremely aggressive spinal cord tumour, and he died less than one year after diagnosis.

Dr. Bradley James Harris, a 49-year-old family doctor from Comox, BC, was out for a jog. He collapsed while he was jogging. He died suddenly.

Dr. Michael Stefanos, a radiologist from Mississauga, Ontario, 50 years old, died in his sleep.

Dr. Oliver Seifert, 58-year-old family doctor from Edmonton, again, died in his sleep.

[00:25:00]

Dr. Johannes Giede was a psychiatrist, 59 years old, from Prince George, BC. This is an interesting story because his son came out publicly, and he said, "My father had the booster shot." And a few days later, he started having stroke-like symptoms. And about a few weeks after that, he had a massive stroke, which was fatal. He died from that stroke.

There's a number of doctors who died after very brief illnesses.

Dr. Jun Kawakami, 48-year-old urologist from Calgary, died from a very, very aggressive pancreatic cancer.

Dr. Au, 53-year-old internist and geriatrician from Edmonton, Alberta. He was very athletic. He would go jogging every single morning and he would try to get his health care colleagues to go jogging with him every single morning. He died of a sudden cardiac vascular event.

Dr. Ainsley Moore, 57-year-old family physician from Hamilton, Ontario, died of a heart attack.

Dr. Inderjit Jassal, 42-year-old family physician from Surrey, BC, collapsed and died unexpectedly from a heart attack.

Dr. Mohammad Alam, 55-year-old family physician from High River, Alberta, had his first COVID vaccine, and he died within 24 hours of his first COVID vaccine.

Dr. James Tazzeo, 51-year-old family physician from Orillia, Ontario, died while he was cross-country skiing.

And so, you know, I gave all this information to the Canadian Medical Association.

Shawn Buckley
Dr. Makis, before you go on, I'll just let the commissioners know that your entire database, you've been gracious enough to share with us, and we have entered that as Exhibit VT-3m.

Dr. William Makis
Thank you.

And so, you know, I received a response that I really didn't expect. And these responses were in the form of personal attacks against me on social media.

The initial attacks came from a family physician in Ontario, Dr. Michelle Cohen, and she would refer to my database and my information as a "fake Canadian doctor vaccine death story." And so I included a number of posts here from Dr. Cohen that she made after my first letter to the CMA and after my second letter to the CMA as well. "The fake Canadian doctor vaccine death story continues to circulate." "This fake number keeps rising." So she's referring to the time when the doctor deaths went from 32 to 80. "We've gone from 'a few doctors died around the same time' to 'all doctor mortality is vaccine murder.' What a journey." And so there's a certain element of mockery in these posts. Another post: "It's easy to ridicule a conspiracy theory as absurd as one that claims all Canadian doctor mortality is vaccine murder." I never made any such claims.

Shawn Buckley
Now, Dr. Makis, did Dr. Cohen ever contact you to ask you about your data, maybe to get your— Basically relating to her what you were relying on and maybe even get a copy of the database that you were accumulating?

Dr. William Makis
Dr. Cohen never asked for this data.

Shawn Buckley
Okay, so you're being criticized without your data being looked at.

Dr. William Makis
That's right.

Shawn Buckley
Okay.

Dr. William Makis
And then another post: "The made-up number of Canadian doctors killed by COVID vaccines is now increased to 80." So now this is a made-up number.

Now, this is the only response that has ever been made by the Canadian Medical Association to my letters [Exhibit VT-3n]. And you can see it's not addressed to me; it's actually addressed to Dr. Cohen. And this was on October 20th, 2022, and the Canadian Medical Association actually quotes one of Dr. Cohen's posts, and it's a post with the pictures of the doctors who had died with a big red X crossed over their pictures. And the Canadian Medical Association says, "Thank you, Dr. Cohen, for standing up to disinformation. There's no evidence supporting the various theories that have been circulating. We encourage all Canadians to be up to date with all their vaccines to prevent serious health issues."

This is the only time that the Canadian Medical Association responded to my information. And you could see they're putting a picture, again, with a big red X across the pictures of deceased doctors.

Shawn Buckley
Now, you know what, can I just interrupt?

One thing that I find interesting about this is, pre-COVID, my understanding is, basically, there would be a problem with people running around doctors. Whether or not you take a vaccine is something that I used to think you would get your doctor's advice on. Like this is an experimental treatment. There's nobody can hide the fact that at the time that this is written,

[00:30:00]

really there was not any long-term or even medium-term data. And so it's interesting that here we have the Canadian Medical Association excluding doctors: just "we encourage all Canadians to be up to date." It's not that they're saying we encourage all Canadians to seek their doctor's advice as to whether or not they should get vaccinated.

Does that not strike you as odd, as a physician: that they're basically doing an end run around their own members when the safest thing is for people to get the advice, for them, from a qualified doctor?

Dr. William Makis
It is strange and, I'll be honest, the reason why I included, personally, my letters addressed to the presidents of the Canadian Medical Association—Dr. Alika Lafontaine; Dr. Katherine Smart—is because on their personal accounts, they were also encouraging people to get vaccinated.

One of the past presidents, Dr. Gigi Osler—who has been appointed to the Canadian Senate by Prime Minister Justin Trudeau recently—she was putting out pictures of having her daughter vaccinated with the Moderna vaccine. And she said, "Look, go get the Moderna vaccine," specifically. "I can tell you where you can get those appointments," and so on. So these individuals were, you know, very personally involved in recommending the vaccines.

One thing I would like to bring up with the Canadian Medical Association, another thing they said was that the In Memoriam service that the Canadian Medical Association offers to members to keep track of their colleagues and recognize their passing— Now this is an In Memoriam page on their website. And so they hosted this In Memoriam section on their website for many years, and it had thousands of doctor deaths, and this was a way to honour doctors who had died. And so they said, "Look, this is provided based on information sent to the Canadian Medical Association and should not be viewed as evidence to support theories surrounding COVID vaccines and other issues." And I gave a picture of what the In Memoriam page looked like.

Now, around this time, the Canadian Medical Association began deleting data from this In Memoriam website. They began deleting the doctor entries—the doctor deaths—and we had noticed this. We had downloaded all the data, but as we were trying to get some of the previous years, we noticed that the Canadian Medical Association had started to delete this

data. And eventually they deleted all the data from 2021 and prior, and they just left the 2022. And then by the end of the year, they deleted that as well.

And so I can tell you that we have a record of about 1,200 doctor deaths that we saved from their website but which they have since deleted. And so these entries are in the database that I've provided to the NCI [National Citizens Inquiry].

Shawn Buckley
It's interesting because— And you're going to go on to basically— How you were continually attacked about this. But we keep hearing about, you know, data disappearing or it being made very difficult.

We had witness after witness, Dr. Makis, testify—both professional and lay—on how it was near impossible to get an adverse reaction report actually filed with Health Canada. And the funny thing was, pre-COVID, citizens could file adverse reaction reports, but that was taken down pre-COVID. It's now back up because an access to information request was embarrassing them.

But it's just interesting that here we have one of the responses to you talking about doctor deaths is the medical association dropping that from their website.

Dr. William Makis
Yes. So, you know, we downloaded all the data from 2019 to 2022 because that was the only time period we were looking at. There were probably earlier entries that were deleted that we didn't save. But it was about 1,200 entries that we saved that the Canadian Medical Association subsequently deleted. And that website is no longer there. It might be accessible through the Wayback Machine, but they deleted all of it.

Now, shortly after I sent my letter about the 80 Canadian doctor deaths, I was attacked in a fairly coordinated mainstream media campaign and it was started by the *Toronto Star* [Exhibit VT-3p]. And the story that was put out by the *Toronto Star* was titled, "Why Won't a Debunked Conspiracy Theory About Doctors Harmed by the COVID Vaccine Go Away?" And in this *Toronto Star* piece, they featured this gentleman: Mr. Timothy Caulfield.

[00:35:00]

And at the bottom it says, Mr. Caulfield is the Canada Research Chair in Health Law and Policy at the University of Alberta. It says, "It's 'amazing' how the doctor conspiracy lives on 'as it was immediately debunked.'"

I had really not heard of Mr. Timothy Caulfield. He did not contact me before putting out the story, and so I really don't know what kind of debunking the *Toronto Star* is referring to here.

Shawn Buckley
So, Dr. Makis, can I ask—because you're going to explain that you were attacked a little more broadly than this—did anyone who attacked this doctor story ever contact you to have you share your actual data with them?

Dr. William Makis
I was contacted by two journalists, and I will mention that as I go through my presentation. But when I was contacted by those journalists—one was from Global News and the other one was from *Reuters*—they really contacted me with accusatory language right from the beginning, and they didn't ask to see my data. They said, you know, "You're lying. You're causing harm to families. Why are you causing harm to families?" This is the kind of language that I was approached with.

Shawn Buckley
Can I just add, because this is important and I want to make sure that your evidence is clear. So as a medical doctor, you didn't go looking for researching this. But you saw a couple of doctors had died suddenly and you became concerned, and so you started looking into it and then you basically had a team doing research.

And, I mean, you're a researcher. I'm just going by memory, but I think your CV lists 105 peer-reviewed published articles that you were an author in. I mean, you understand research, and you understand data needing to be correct. I mean, you do this wrong once, and your reputation is gone.

So you're looking into doctor deaths.

Dr. William Makis
Yes.

Shawn Buckley
And you're doing it in a robust way, and you're being attacked by the media, and not a single journalist or detractor asks to look at the data?

Dr. William Makis
No. And, you know, honestly, I've really been shocked at how this was approached by the media. And as I walk through some of these slides, you know, I think it'll become clear what the intent of the media was. It was not to, certainly, you know, look at the data themselves or look at what the real evidence is. It was, well— Let me move to the next slide.

I wanted to highlight some of the parts of the *Toronto Star* story. And Mr. Caulfield, who works at the University of Alberta—as I did—he said, "It's in my social media feed almost every day, if not every day. My hate mailers are emailing this to me," said Mr. Timothy Caulfield. So right there he's already coding it in a language of hate.

He says, "One of the things that's fascinating is that it was immediately debunked in the sense of 'No, this is wrong, *this* is actually how these individuals passed away.' But that didn't kill the story." And I think, again, here it sort of shows that—what is the intent? The intent here is to kill the story; it isn't to learn what the truth is.

"It's amazing how it won't die—and it's amazing the impact it continues to have." These are quotes from Mr. Timothy Caulfield.

Then the *Toronto Star* goes on to say, "To be clear, experts are united on the fact"—and I don't know who these experts are—"that this is a conspiracy theory. The causes of death

were well-documented by family in news stories and obituaries. It's not clear when they were vaccinated, and besides which, their symptoms do not match what we know about vaccine side effects from studies on millions of people." So now they're claiming that the obituaries had symptoms and there's studies on vaccine effects on millions of people? This is outright lying from the *Toronto Star*.

And interestingly, the *Toronto Star* now brings in Dr. Michelle Cohen, who had previously attacked me on social media saying that it was fake—it was a fake story; it was a made-up number—and she makes a couple of comments in this story as well. Dr. Cohen [sic] [The *Toronto Star*] says, it's "a particularly potent bit of misinformation, says Dr. Michelle Cohen, family doctor in Brighton, Ontario, who has been tracking the advance of the theory since summer. If you already believe that doctors are lying about the safety of vaccines, there is a 'dark joy' in the idea that those same health care professionals are being harmed, she argues."

I can tell you there's no dark joy in this at all, and this was highly offensive when I read this.

[00:40:00]

"The CMA does not note a connection between vaccines and sudden deaths." The CMA is quoted as saying, "'There's no evidence to confirm or support the various theories that have been circulated,' the CMA said in an email. The organization 'is concerned with misinformation and conspiracy theories spreading online about the recent deaths of physicians across the country.'"

Now, the Canadian Medical Association had not responded to my letter, had not asked to see my database. So they are responding without really having contacted me at all.

Shawn Buckley
You know, another interesting thing about this is, it would seem to me that if, you know, you're right—and I know that A, you've shared your database, and B, you're going to show us some of the actual figures—is you would think that both the media and the College of Physicians and Surgeons would be extremely interested in looking at your data and actually looking into the issue. Because if doctors are being harmed, then you would think that's the one group we need to protect. Because if the rest of us are in a world of hurt in this pandemic and what's appearing—starting to come from the data you're sharing—is vaccine injury, we need the medical professionals to be healthy. Like, that's the one group we need to protect.

So that's what I find interesting—is I would just assume that everyone would have been contacting you to verify your data out of concern that you would be right.

Dr. William Makis
I would think the only way to debunk—and they keep using this word "debunk"—would be to look at my data, have data analysts analyze it, and come out and say, "Look, there's nothing in this data; there's no evidence." But they're saying that there's no evidence without looking at any of the data.

And as I stated earlier, the majority of the data is taken from the Canadian Medical Association's own website. So they already had the majority of this data, but they didn't want to take a look at my data, which was more complete, because we obtained data from

other medical associations throughout the country: from the Royal College of Physicians and Surgeons [of Canada] in Ottawa, from the various provincial medical associations, from the various colleges, and from the various medical alumni associations from the various universities that have medical programs. And so I would have expected that they would have asked me for the copy of the data so that they could properly debunk it, and that simply never took place.

There were other media that got involved—international media [Exhibits VT-3q to VT-3s]. So *Reuters* from the United States, *Associated Press* [sic] [Agence France-Press (AFP)], and even the *Australian Associated Press* put a big red cross across my letter to the Canadian Medical Association saying it was an unproven conspiracy.

Again, I was contacted by *Reuters* but in a very accusatory tone. I was not contacted by either of the *Associated Press* news outlets.

There was a big story that was carried in Global News [Exhibit VT-3t]. And I'd like to point out that Ashleigh Stewart did contact me, but she contacted me in a very accusatory manner, really accusing me of harming families, of making things up. And so I tried to answer her questions initially, but as her accusations grew stronger, I simply said, "Look, I don't want to talk to you anymore" because I understood that she was writing a hit piece and she didn't ask to see my database.

And so in the graphic that was used by Global News, I want to draw your attention: in the background, there are photos of the deceased doctors. And so on the red, behind the bird from Twitter, are actually the pictures of the deceased doctors, and then they made this graphic with this Pinocchio-like figure made out of a stethoscope. And the article is titled, "Kraken, Elon Musk and dead Canadian doctors: Disinformation surges three years into the pandemic." And in this Global News article, they state that Global News determined the cause of death of 48 of these doctors, and they talk about cancer and heart attacks and accidents and suicides.

Now, when I had this discussion before this article was published, I asked the reporter if she had any autopsy reports to justify her views and her accusations. And she was evasive and she said, "Even if I had autopsy reports, I wouldn't give them to you. I wouldn't share them with you." And in this newspaper article, there is no indication that there are any autopsy reports to substantiate Global News's claim that they were able to determine the cause of death of 48 of the 80 doctors.

[00:45:00]

In order to determine the cause of death, you must have an autopsy, and so what Global News did was they read the obituaries, and this was the extent of their investigation. They claimed they contacted some of the families, and so whatever the information the families shared with them. But there is no indication that they had any information about the autopsies of any of these doctors.

In this article they also say that while the efficacy of the vaccines is under debate, their safety is not. And so, again, this is the statement that the safety of vaccines is not under debate—is not debatable. They go on to say that 95 million vaccines were administered and only 0.01 per cent resulted in a serious adverse reaction and that there have been no deaths linked to the vaccine. I believe that they're referring to Health Canada and their adverse event reporting system.

And then, of course, there are the smears and personal attacks. They say, "Meanwhile, Makis continues to promote conspiracy theories online, most prominently on alt-right website Gettr." And I had an account on Gettr. Gettr is an alternative to Twitter. I did not see Gettr as an alt-right website, and I certainly did not promote conspiracy theories online, so I saw this as defamation by Global News.

So, you know, I continued despite these attacks. I continued. We continued to assemble our database. And I sent two more letters to the Canadian Medical Association. Really, I didn't expect any more response at this point, but I did it to simply document that, yes, I did try to contact the Canadian Medical Association. I gave them an update when it was 132 doctors [Exhibit VT-3k]. And at that point, we were able to calculate an excess mortality of physicians in 2022, which was 53 per cent excess mortality compared to 2019. And I sent one more letter on August 13, 2023 [Exhibit VT-3l], when it was 180 sudden deaths. And, again, I did not receive any response from the Canadian Medical Association.

I sent these letters to both Premier Jason Kenney and Alberta Premier Danielle Smith. I did not receive a response from their offices. And also to the Alberta Minister of Health Jason Copping and Alberta Minister of Health Adriana LaGrange, and I didn't receive a response from that office, either.

So this is the graph that I appended to my last two letters which contains the numbers from our database of the physician deaths, over time, going from 2019, 2021, and '22. And you can see a clear trend of a steady increase in physician deaths. And, really, the deaths are clustered in the younger physician population. We have calculated— And you could see in the physicians under the age of 30, if you look at 2019, there was one death; 2020, there were zero deaths. And in 2022, there were six deaths. If you average 2019 and '20, you get half a death a year. Now you've got six deaths in 2022. That's roughly about an 1100 per cent increase in mortality in the youngest doctors. You know, you see a similar pattern in doctors under the age of 40, under the age of 50.

And so, you know, this database is very robust. You know, the database that I gave to the NCI is about 2,300 Canadian doctor deaths over the period of 2019 to 2022. And honestly, you know, I don't know what else I could have done. I did everything I could to alert the proper authorities on this issue and I was ignored, I was ridiculed, I was insulted, I was smeared in the mainstream media, I was viciously attacked, and I was defamed for my efforts.

Shawn Buckley
And most surprisingly, no one asked to look at your database.

Dr. William Makis
No one has asked to look at the database.

Shawn Buckley
To me, that's the most interesting part about this, Dr. Makis, is just you went through all this trouble to create data. And we've asked you for it and thank you for sharing it. And so everyone can look at it. But it's curious that all this effort undertaken to debunk this without looking at the data. That's what I find very interesting.

Dr. William Makis
And I can tell you that this has taken a lot of my time over the past year and a half, and my volunteers have spent hundreds of hours putting this data together. You can see the data is extensive. And they have asked me to keep them anonymous because they are not comfortable sharing their names publicly,

[00:50:00]

and so I've honoured their request, but I have shared this database.

And so I would just like to close out this section with a couple of interesting observations: I was a longtime member of the Canadian Medical Association. I still receive the *Canadian Medical Association Journal*, which I receive a copy every single month. And I look at the journal fairly quickly. And in the April edition I noticed that the entire back cover of the *Canadian Medical Association Journal* was a Pfizer advertisement [Exhibit VT-3o]. And so I think that was relevant to note in my presentation that the Canadian Medical Association accepts advertisement money from Pfizer.

Recently, just a few weeks ago, the Canadian Medical Association held a health summit—an annual health summit—and the keynote speaker was Mr. Timothy Caulfield. And the keynote presentation was about "the spread of health misinformation" which "poses a genuine threat to Canadian health. But health providers can fight back. In this health summit presentation, [hear] from best-selling author Timothy Caulfield on the importance of debunking false and misleading health messages." I thought this was an interesting thing to note that the individual who started the media campaign to smear me and to kill the story—as the *Toronto Star* story said, that they wanted the story of Canadian doctor sudden deaths killed—is giving the keynote presentation at the Canadian Medical Association summit just a few weeks ago.

And, you know, the Canadian Medical Association now has a new president, Dr. Kathleen Ross. This is a family doctor from British Columbia. She just took over on August 16, 2023. And on August 17th, she's posted a picture with Mr. Timothy Caulfield, and she says she's excited to listen to his talk on fighting misinformation in health care at the Canadian Medical Association health summit.

And again, I'm a strong believer of disclosing conflicts of interest. And so I wanted to point out that Mr. Timothy Caulfield is a fellow of the Pierre Elliott Trudeau Foundation, and he also runs a social media project that has received federal funding. And this federal funding is to promote vaccination confidence. This social media project is called ScienceUpFirst, and it has been given $2.25 million as an investment, announced by the federal Minister of Health, Patty Hajdu, through the Immunization Partnership Fund. And this fund supports projects that encourage vaccine acceptance and uptake.

And so, in conclusion, I would just like to encourage— I'd like to encourage everyone to look at the data for themselves. I was more than happy to have the data analyzed. I believe there's a— To my analysis, I believe there's a very strong signal of excess deaths of Canadian doctors, which really is very significant after the rollout of the COVID-19 vaccines starting in December of 2020.

Shawn Buckley
Dr. Makis, did you notice, because you've been analyzing this data— So can you tell us, kind of temporally, was there an uptake— With COVID, was there any correlation between the

rollout of the first shot, the second shot, boosters, anything like that? Did you see anything that kind of correlated with any of those events?

Dr. William Makis
There is a mild increase in excess mortality in 2020. Now, of course, it would be ideal to have data going back maybe five years, maybe 10 years, and to compare to longer term baselines. And honestly, I simply didn't have the time or the access to that kind of data, so the best we could do was compare it to 2019.

There seems to have been a slight increase in 2020, but you see a significant increase in '21 and even a bigger increase in 2022. And again, I would encourage anyone with expertise in data analysis to analyze this data to see if there is something that—what I had seen.

I do believe, also, that there are spikes in deaths that cluster right around the rollout of the booster shots. So the first booster shot rollout: there seems to have been a spike in deaths just after the rollout of the first booster shot and the second booster shot, as well.

[00:55:00]

But I believe there is a very strong safety signal. I've been extremely disappointed that the Canadian Medical Association has ignored it. But I'm extremely pleased that I'm able to provide it to the public through this forum.

Shawn Buckley
Okay, Alberta government. This is interesting. So we have the Medical Association deleting information from their website—and the Alberta government. And it's fair to say, if the Wayback Machine didn't exist, you wouldn't have been able to recover some of this stuff.

Dr. William Makis
That's correct.

Shawn Buckley
Tell us how you became interested in this and what happened.

Dr. William Makis
You know, I had been tracking— When I was censored from Twitter, I was tracking all kinds of data. I was tracking the Canadian doctors' sudden deaths, but I was also tracking the data from the Alberta government website, from the BC government website, from the United Kingdom, from Australia. And the data was showing that, over time, the double vaccinated were filling the hospitals. And, you know, there was this push about the "pandemic of the unvaccinated," and the data just didn't support the claims that there was a pandemic of the unvaccinated in 2021 and 2022. It really showed that it was the vaccinated who were filling the hospitals.

But I was actually launching my Substack, and I wanted to launch my Substack with something substantial. And I did an investigation into the Alberta data, and I used the Wayback Machine, and I went through the data very carefully. And what I found was truly shocking, and so I wanted to share some of that tonight.

Shawn Buckley
Before you do, I'll just let the people watching— When we're saying Wayback or Wayback Machine, all that is, is it's a service that copies websites periodically. And so let's say there's a website that there used to be a page on, and you go back and it's missing. Well, you use a service like the Wayback Machine, and they'll go, "Oh, yes, well, six months ago we copied that page and here's the page." So it's a way of accessing old website pages that have changed or have been taken down.

Dr. William Makis
And, fortunately, for the Alberta.ca government website, which published vaccine outcome data, there were snapshots taken several times a day. And so there are thousands of these snapshots in the Wayback Machine that people can go and verify themselves. And so I'll start my presentation on that.

So on June 3rd, 2021, the Alberta government put a new section on the Alberta.ca website and it was called "Vaccine Outcomes." And the "Vaccine Outcomes" had tables of data and graphs. And one particular data set that grabbed my attention that I had seen many times before, and it was very interesting, and I wanted to see how that data set had evolved over time. It was a graph called Figure 11 [Exhibit VT-3u]. And Figure 11 was data that showed time from the first dose and second dose of the COVID vaccine to COVID diagnosis, and it was by age group. And so on the y-axis you have how many people are getting infected with COVID-19, and on the x-axis you have how long ago did they have their COVID vaccine.

And so you see these first three graphs on the left: these are people who had one vaccine. And you see there's a lot of infections initially, and then the infections sort of go down, suggestive of protection. And on the second group of graphs, these are the double vaccinated. And you see there's very few infections, very few hospitalizations, and very few deaths. And so as the government started putting out this initial data, the data was showing that the two-dose vaccine was protective against infections, hospitalizations, and deaths.

Now I show a set of graphs on the right to show how this data evolves over time, month to month, from July 2021 to August, September, October, November, and December. And these are the double vaccinated. And what it shows is specifically COVID infections in the double vaccinated.

As time goes on, the double vaccinated are doing worse and worse and worse. They're getting more and more infected. And by December, you see very large numbers of infections in the double vaccinated. And it seems to be worse the longer ago you've had your second vaccine dose. So if you've had your second vaccine dose six months ago, you're really doing quite badly, even compared to the people who've had their second vaccine dose recently.

[01:00:00]

So to me, this was already indicative that the double vaccinated, there was something wrong. Something had gone wrong with the vaccine, and their immune systems seem to be damaged over time, and this damage seemed to be getting worse as time went on.

By January of 2022, we are in the middle of the Omicron BA.1 outbreak, and this is the last data set that the Alberta government would publish. And there's a huge spike of COVID

infections. You can see the graph on the left: this is the double vaccinated. And there's a huge spike of infections: thousands. Thousands of infections in the double vaccinated and specifically individuals who've had their last dose five, six, or seven months ago, and they're doing really quite badly. In fact, they're the ones driving this outbreak, this Omicron BA.1 outbreak. And there's a cluster in the hospitalizations and deaths, as well, although it's not as prominent.

And if we compare how it started—how the double vaccinated looked in June of 2021 and how the double vaccinated looked in January of 2022 [Exhibit VT-3v]. These are infections in the double vaccinated. You can see that the double vaccinated are doing extremely badly. Thousands of them are getting infected with COVID-19. There seems to be no protective effect from the vaccines.

Shawn Buckley
And Dr. Makis, how does that compare with the unvaccinated? Because one factor could also be time of year, right? We, northern hemisphere, tend to— I call it low vitamin D season where we get more sickness in the winter months than we do in the summer months. Is there a comparison there?

Dr. William Makis
That's coming on the next set of graphs, yes.

And I just wanted to point out that this data had actually been shared internationally. It was all over Twitter. People were sharing it, and it was deleted. This figure was deleted by the Alberta government from the Alberta.ca website on January 14, 2022, and this data was never released again. So we never saw this data again.

Shawn Buckley
So was there any explanation as to why they would delete data? Because it certainly seems strange that here you have taxpayer-funded people putting out what should be as reliable as they can be, basically, data, while we're in the middle of a pandemic. It's of public interest. Did they give any explanation as to why they would take data down? So it's not that they even stopped publishing, but they took data down they'd already put up.

Dr. William Makis
That's right. And I want to point out that this data had been released daily. So every single day this data was updated, and it just disappeared from the Alberta.ca website on January 14th, 2022. As far as I'm aware, there was no announcement made on why this data disappeared on January 14th.

The next data set I'd like to show is Figure 10 [Exhibit VT-3v]. Again, this is in the same section: "Vaccine Outcomes." All of this data is in the "Vaccine Outcomes" section. This is just a different figure showing a different way that the data is formatted.

Figure 10 showed case rate: so COVID infection rate per 100,000 population by vaccination status. So as you brought up the question of, well, how does this compare to the unvaccinated?

This is the data set that compared the double vaccinated to the single vaccinated to the unvaccinated. And I'm showing here a graph from December 1st, 2021. And the graph really shows that the unvaccinated throughout all of 2021 seemed to have been doing poorly. There was some protective effect with one vaccine dose, and then there was a significant protective effect with two vaccine doses. Again, this is what you would expect if the COVID vaccines were protective. You would expect a much lower infection rate in the double vaccinated compared to the unvaccinated. And that's what the data showed initially in these graphs.

And so, again, when you look at the Omicron BA.1 outbreak in January of 2022, this data changes drastically [Exhibit VT-3v]. And what you find, especially on the figure on the right at the end of January, is that the double vaccinated are getting infected at the highest rate of all groups. And it's basically double the rate of the unvaccinated. And so once again, to me, this is evidence of immune system injury in the double vaccinated

[01:05:00]

where they are getting infected with COVID-19 at twice the rate as someone who is unvaccinated.

Interestingly, at some point in January, the government added data on the triple vaccinated. So you will see it as a purple line, and it is labelled as three doses. And initially it seems that the triple vaccinated are doing the best, that they have the lowest infection rate of all the groups, and they seem to be getting this protection that we were all told that the vaccines would provide and that the booster shots would provide. And even during the initial Omicron outbreak in January of 2022, the triple vaccinated are doing the best, which is why I feel—again, I'm just hypothesizing—that the government allowed the data to continue being published despite the fact of how poorly the double vaccinated were doing.

Now we move on to March of 2022 and, again, something has changed in the data [Exhibit-3v]. And what has happened was the triple vaccinated now have the highest infection rate of any group. And so while the Omicron BA.1 outbreak in January was driven by the double vaccinated who had the highest infection rate with COVID-19, now it is the triple vaccinated who have the highest infection rate. And we were actually heading into another wave of COVID, and this was the Omicron BA.2 wave that was going to happen in March, April, and May. And you could tell that the triple vaccinated are actually leading this wave with the highest infection rate of any group. In my interpretation, this is evidence of COVID booster failure. This failure seems to occur in middle of February of 2022, when the triple vaccinated take over as the group that has the highest infection rate of all the other groups.

And then—

Shawn Buckley
So I'm just going to stop you so that people can understand the chart. So you're really looking at the right-hand side of this chart—

Dr. William Makis
That's right.

Shawn Buckley
—in February '22 where the triple vaxxed takes over. Now, what's interesting is just looking at all of this—and part of this was on a different slide—is at the beginning, the unvaccinated are doing worse.

Dr. William Makis
That's right.

Shawn Buckley
And then the vaccinated. But then, let's say, when we move a little over, two-thirds to the right, the double vaccinated are really doing poorly here. And then by the time we're almost at the end of this chart, I mean, the unvaccinated are doing really well, and now it's the triple. So your explanation is that as time goes by, the vaccines are creating a problem. Because as time goes by—people—the more shots you have, the worse you're doing. Is that what the data is showing us here?

Dr. William Makis
Exactly, and so you will see the double vaccinated are doing really poorly in the January outbreak, but then the government is rolling out booster shots during this time. And so, as a little bit of time has gone by with the booster shots, now you start seeing the triple vaccinated are doing very poorly— And they shouldn't. You know, you shouldn't see this if the booster shots were protective. You know, the triple vaccinated should be doing better than the unvaccinated and better than the single and double vaccinated. And that's simply not what the data is showing.

And that is—

Shawn Buckley
And this is just showing us COVID infections. It's not showing us other health outcomes also.

Dr. William Makis
That's right. So it's not showing us hospitalizations or deaths. It's simply showing us infections.

But again, you know, to my estimation and assessment, the triple vaccinated shouldn't be getting infected at the highest rate. I mean, that is simply contrary to what the boosters are supposed to do. And so, you know, I would have loved to have seen more of this data. The reason why I put this slide on March 22nd, 2022, is because this is the last slide that the Alberta government would ever release. They deleted this Figure 10 data, and it was never seen again. It was deleted on March 23rd, 2022.

The next data set I would like to show is a table—this is Table 2—and this is COVID case outcomes in Alberta by vaccine status. And now we are looking at hospitalizations: those currently hospitalized and how the total number of hospitalized breaks down by vaccine status.

[01:10:00]

So you could see how many have had three doses, two doses, one, and unvaccinated.

And so you will see that even in March of 2022, the triple vaccinated made up the biggest portion of the hospitalized individuals. And the total vaccinated were—72 per cent were vaccinated in the hospital and only 28 per cent were unvaccinated.

What is interesting, however, is the trend over time. And so when you look at the trend, by the time you get to July of 2022, now the triple vaccinated make up 50 per cent of all the hospitalizations. And all of the vaccinated, as a group, make up 81 per cent of the hospitalizations [Exhibit VT-3w]. The unvaccinated make up 19 per cent. And you can track— If anybody wants to go use the Wayback Machine, you can actually track this trend every single day from March until July of 2022. And you can see that the vaccinated are doing worse and worse, but it is really the triple vaccinated who are flooding the hospitals and in ever-increasing numbers.

And on July 21st of 2022, the Alberta government deleted this data set and did not release it again.

Shawn Buckley
Right, so you had mentioned earlier, we were getting public messaging that basically the unvaccinated were the ones filling up the hospitals and the ICU [the intensive care unit]. And what you're showing here is for Alberta, the provincial data doesn't bear that out at all, that messaging.

But one thing that I'm wondering—that would be helpful to even make this more meaningful—is an understanding, well, how many people are vaccinated? How many people have one dose? How many have two? How many have three? And what percentage of the population is unvaccinated? Because the earlier charts were per 100,000, so we actually had a good comparison. Were you aware of that data? Like, I'm just wondering if that would help us with a kind of more meaningful analysis of percentages in the—

Dr. William Makis
Yes, I'm going to show— I don't have it for Alberta here, but I will show data from British Columbia that'll sort of give you a better idea of that.

Just to continue on, you know, there was Table 7, which showed those who were in the intensive care unit. And again, the trend shows that, you know, back in March, the vaccinated made up a total of about 48 per cent of those in the ICU, and that rose to 69 per cent by July. And so this data was deleted.

All the data that I'm mentioning now was deleted at the same time: on July 21st, 2022. So Table 2; Table 7 was also deleted.

And then finally, this is the COVID death data [Exhibit VT-3w]. So this is who is dying from COVID-19. And when you look at March, 68.9 per cent of who were dying were vaccinated. That number rises to 83.4 per cent of those who were dying are vaccinated [July 20, 2022]. And this was a trend that really worried me. And so that, you know, the vast majority of the deaths were actually in the vaccinated. And you could see, if you look at the three doses with condition, you could see that that number rises from 35.3 per cent, it rises to 61.1 per cent. So it is really the triple vaccinated that are driving the COVID deaths.

And, you know, I would go as far as to say that this is not just evidence of vaccine injury in the triple vaccinated; this is actually evidence of vaccine injury leading to death because these are deaths from COVID-19 in the triple vaccinated.

And at this time, the triple vaccinated population was about 38 per cent, and they were making up 61 per cent of the deaths. And so, you know, people can verify this, that the triple vaccinated were dying in disproportionate numbers to their prevalence in the population. And so this data was deleted on July 21st by the Alberta government, as well.

Shawn Buckley
I'm wondering, Dr. Makis, just looking at the chart on the right about the deaths: it's striking, actually, how few deaths there are where somebody doesn't have another condition. And I'm wondering if that speaks to, you know, COVID not being that dangerous if you don't have a different condition that's affecting you. Is that wild speculation or could there be something to that?

[01:15:00]

Dr. William Makis
No, you're absolutely right. I mean, when you look at the— Again, if people want to focus on the three doses with and without condition, you could see that with no condition, in March, the deaths were 0.8 per cent. It rises a little bit to 1.9 per cent, but the numbers are very small. Whereas, with condition, there is a dramatic rise over time from 35 per cent to 61 per cent. And so this was, to me, very, very concerning data. And I would have loved to see more of this data. And it was deleted on July 21st, and we never saw this data again.

And I would like people to remember that we've had a second booster rollout. So we have people who are quadruple vaccinated in Alberta—thousands of them—and we also have thousands of people who are five-times vaccinated, and the Alberta government has released no data on how those are doing.

Shawn Buckley
Would I even be correct in suggesting— I mean, this here is March 31st and then July 20th, 2022, which— And July 20th is the latest data, but we're not talking about a long data set at all. Like, wouldn't I be correct that, I mean, even if it went to today, we're still just talking short-term for these types of treatments?

Dr. William Makis
That's right, but when it comes to immune system injury, you can see dramatic effects on the immune system over a matter of months. And so you could actually see dramatic differences in how the double, triple, or quadruple vaccinated are doing—even just over a course of six months, twelve months.

And I think this data was absolutely crucial. It was crucial for Albertans to be able to make informed decisions—an informed decision of whether to take the third vaccine or the first booster shot or the second booster shot—and to see how people were doing. Were they doing better? Were they in the hospitals? And I can tell you, this is the last data set of vaccine status of people in the hospital that we have. As of July 21st, 2022, we have no data

from the Alberta government as to who is in the hospital, what is their vaccine status, and how they're doing.

I wanted to show for comparison that it wasn't just the Alberta government that was deleting data, it was the British Columbia government, as well. And here, the British Columbia government was putting out these nice graphics as to the hospitalizations, intensive care, and deaths. But they also break down what portion of the population is triple vaccinated, double vaccinated, unvaccinated [Exhibit VT-3w]. And so you could actually compare to how it compares to the population.

And I'd like to point out that this is the last data that the British Columbia government ever put out. This is July 16th of 2022. And the deaths— The vaccinated make up 89 per cent of the COVID-19 deaths. And it is, again, driven by the triple vaccinated: 77 per cent of the deaths are triple vaccinated. And if you look at all the way to the left, it shows you what proportion of the population are the triple vaccinated. They are 52 per cent of the population, but they're making up 77 per cent of the deaths.

And so, if you had a vaccine that simply did nothing and didn't work, you would expect 52 per cent of the population would be having 52 per cent of the deaths. And in fact, they have a disproportionately higher percentage of deaths. And again, I interpret this as vaccine injury in the triple vaccinated leading to death.

And so this was the last data set that was put out by the British Columbia government. The BC government deleted this data set on July 28th. And I would like to make a comparison to the Alberta government in that the BC government actually put out a press release stating that they were stopping reporting of this data—case outcomes by vaccination status—that that they would be removing this data. And they put out this press release and the explanation they gave was that the data had become "hard to interpret." And compare this to the Alberta government: the Alberta government did not put out any press release when they deleted their data.

Shawn Buckley
It's an interesting explanation, isn't it? "Hard to interpret." Because, you know, what does that mean and why would that be an excuse for deleting data?

Now, do you know what BC— Because they were helpful to publish the percentage

[01:20:00]

of people that were triple vaccinated and double vaccinated and single and unvaccinated. Did they ever publish a breakdown of, you know, age groups? So when we have that 52 per cent is triple vaccinated, you know, I wonder if more of those were of an older age group because people in care homes and stuff like that couldn't avoid it. And I'm just speculating. But was there ever any breakdown that way, which would also be helpful for people analyzing data?

Dr. William Makis
I don't believe so. I've never seen any breakdown by age of this information.

Shawn Buckley
Yeah, it'll be interesting when the data finally is publicly available and what people like you will discover going forward, so—

Dr. William Makis
And so that sort of brings to conclusion my presentation on the data deletion by the Alberta government.

One other thing I wanted to mention was that I believe that publishing this data would have been the responsibility of the public health chief, Dr. Deena Hinshaw, and her office. And beyond that, I don't know what the involvement of the Health Minister was or the Premier's office. But, you know, I believe that this data was crucial for Albertans to be informed and to be informed what the vaccine outcomes are. In fact, I will point out that the government deleted the entire "Vaccine Outcomes" section from the Alberta.ca website on July 21st, 2022. And so really, as an Albertan myself, I could say that we've been blind in terms of crucial information to make informed decisions on vaccination.

Shawn Buckley
Now, we're about to segue into your discussion on cancer. And I wanted to start that by just having you explain something because you're an oncologist—which means you're a cancer doctor, for those of you that don't know what an oncologist is—and you've spent most of your career heavily involved in cancer diagnosis and treatment. And one thing that we heard kind of as a theme in the media after we were allowed to go back to hospitals—because remember, you and I both live in Alberta, and I think it was the same for most other provinces—is for a short period of time, we were discouraged from seeking healthcare. And a whole bunch of tests and procedures were cancelled for a period of time, including cancer tests.

And so one of the themes that I've heard in the media is, "Oh, yeah, well, our cancer rates have gone up because we weren't testing early; like we dropped our testing and treatment." And I know you and I had a conversation on Saturday about this, and I really want you to explain to the public— Because I asked you the question, "Well, is there any truth to this?" What type of pattern, as an oncologist, would you expect if we did stop testing and treatment for a period of time? Would we actually have increased cancer numbers? What would you expect? And if you could start with that explanation because I think that would be really helpful for people to get your opinion on that.

Dr. William Makis
Certainly. So if you stopped screening for and diagnosing cancers for a period of time, let's say for a period of six months, you would expect the cancer diagnoses to drop in numbers during that time, since you're not screening people; you're not diagnosing people. And then when cancer services resumed, you would expect there to be a corresponding rise of cancer diagnoses, and it should be proportionate to the cancer diagnoses that you've missed during that time when the services were not available. And then, you know, you could compare that to a longer-term trend to make sure that there's no other factors involved.

Now, what you would expect to see is, you would expect to see some of those cancers would be a bit more advanced. So most cancers are very slow growing, so you would not expect a drastic change in the staging for a lot of the Stage 1 cancers, Stage 2 cancers. There'll be a very small percentage of them that might advance to the next stage, and so

you would see a slightly more advanced stage at diagnosis. And then, of course, you know, the Stage 3, Stage 4 cancer—Stage 3 might become Stage 4 because the cancer might start to metastasize, and so you would see that. But you would certainly not expect the behaviour of the tumours themselves to be any different.

[01:25:00]

So you would—

Shawn Buckley
Right, and the overall trend— I mean, if you're not diagnosing for a period of time and then you start diagnosing, you're going to catch those ones you missed. But overall numbers, you are not expecting to change a whole bunch from the trend just because you stopped testing for a period of time. Did I get that right?

Dr. William Makis
Yes, exactly.

Shawn Buckley
Okay.

Dr. William Makis
And as I mentioned, you know, some Stage 3s will become Stage 4. Some Stage 4s will become a bit more extensive, but, again, the behaviour of the cancers is not going to change. And you would be able to see that, yes, some are a little bit more advanced, but you're not going to see a big difference, certainly not in a short period of time, like six months, for example.

Shawn Buckley
And it's important that I've asked that because, like I say, the media has messaged that this change in cancer behaviour and change in cancer numbers is explained by us not testing and treating for that period of time that we didn't. And your opinion, as I understand it, is that the media is not correct in their messaging.

Dr. William Makis
That is not correct. As an oncologist, what I'm seeing in terms of cancers that are being diagnosed and the behaviour of those cancers is unlike anything I've seen in my career. And I've diagnosed tens of thousands of cancer patients with CT [computerized tomography], with cutting-edge PET-CT [positron emission tomography-computerized tomography]. I was the lead PET-CT radiologist in the province of Alberta, and I've correlated with MRI [magnetic resonance imaging] findings, with pathology findings—in tens of thousands of cases—and I treated hundreds of cancer patients as a primary oncologist myself.

What I'm seeing now, since the rollout of the vaccines, I've never seen in my career. And I want to go a little bit more into depth about what that means.

I actually didn't catch on to this phenomenon. I only first saw it as my database of Canadian doctors' sudden deaths grew. And I started seeing these highly aggressive cancers in young Canadian doctors, and that is where I actually first noticed this phenomenon as it was happening.

So what I bring up here is these are three doctors at the same hospital—Mississauga Hospital, Trillium Health Partners—in Mississauga, Ontario. And these three doctors died within three days of each other: And so Dr. Lorne Segall died on July 17, 2022; Dr. Stephen McKenzie on July 18; and Dr. Jakub Sawicki on July 19th. And this was a few days after the rollout of the second booster shot.

So the fourth COVID-19 vaccine was rolled out; a few days later, we have this cluster of deaths. And the only reason we know about these deaths was because a concerned health care worker had actually leaked internal hospital memos. This was not initially publicized in the media, but there were leaked memos announcing the deaths of three doctors in the span of three days at the same hospital. And once that information was leaked, it went viral and then, of course, the media had to address it and then the hospital had to address it, as well.

And so this was addressed in the mainstream media. And so I have some of the mainstream media outlets: here is the CTV News. And right away the hospital put out a statement and the statement said, "The rumour circulating on social media is simply not true. Their passings were not related to the COVID vaccine. We ask, please, to respect the families' privacy." Now, this was a very strange statement to me because there would have been no time to conduct autopsies in these three cases. And so there is no basis in reality for the hospital to make a statement like this, that their passings may or may not have been related to the vaccine.

And then additional information came out in subsequent days and weeks that all three of these doctors had cancer. And what caught my eye was the details of the types of cancer that they had.

Two of the doctors, we had more details on their cancer, and so Dr. Lorne Segall, a 49-year-old ENT specialist, just a year prior, had developed Stage 4 lung cancer, and he had died in less than a year. And Dr. Jakub Sawicki, 36-year-old family physician, had developed Stage 4 gastric cancer, and he had died less than a year. Both of these doctors would have presumably been double vaccinated, and then they would have developed this cancer that killed them in less than a year.

And to me, this was a big red flag because, you know, first of all, gastric cancers and lung cancers in individuals of this young age are unusual to begin with. So right there, you're already dealing with something that's quite unusual. But the fact that it killed them in less than a year, to me, was a big red flag that there was something very wrong here.

[01:30:00]

This is not how lung cancer behaves. This is not how gastric cancer behaves.

And again, you may have these situations once every few years in your career. So in my career, I would expect to see a case like this—very aggressive, young person with an aggressive cancer, kills them in less than a year—I might expect this once every few years. Here you have two young doctors, working at the same hospital, developing these extremely rare aggressive cancers: they're dead in less than a year. You know, it was a red

flag for me. This is what got me researching into what's happening with the vaccinated. Are we seeing cancers? What kind of cancers? And that really started my journey of investigating turbo cancers. And this was the summer of 2022.

I then became aware of other stories. You know, the tragic story of Dr. Joshua Yoneda, who was— I'd mentioned him earlier. This was the medical student, fourth year medical student at UBC (University of British Columbia), and I managed to obtain a lot more information about his tragic story. He was mandated to take two COVID vaccines to be able to continue his medical program. He was perfectly healthy and a few months after he took his second dose, he started having back pains. The back pains got worse. He was diagnosed with a spinal tumour. And initially, doctors felt that it was not an aggressive tumour, that it was treatable and that he would just have an operation and he would be fine. They did the operation and then they discovered that this was an extremely aggressive tumour, very rare. It was a spinal cord tumour, and they really struggled to offer him any kind of treatment, and he died less than a year after diagnosis.

And there were other physicians: Dr. Nadia du Toit from Edmonton, 44 years old, came down with an extremely aggressive brain cancer, died in less than a year; Dr. Murray Krahn, 65-year-old internal medicine doctor from Toronto, also developed an aggressive brain cancer and had died in less than a year.

And so at this point, I really suspected that there is something very wrong when it comes to the COVID vaccines and these aggressive cancers that, you know, I had really not seen in my career being this aggressive.

Shawn Buckley
And I just want to be clear because you basically just now walked us through five cases of young doctors that got aggressive cancers and died in a year. I appreciate there was a sixth, but you didn't have details to share with us. And as an oncologist, you wouldn't expect to see one of these, let alone five clustered together. Is that what you're sharing with us?

Dr. William Makis
I might expect to see one. And, again, you do see rare cancers in young people. I don't want to make it seem that you don't—you do, but it is exceedingly rare. And these are usually cases that we publish. I have published dozens of such cases: cancers behaving in unusual ways, unusual on imaging. This is something that is so rare you actually publish it in the medical literature to share with other doctors because they may not have seen a case like that in their career.

And so to have five of these cases of— And again, it's rare for a solid tumour to kill in less than a year. You know, even glioblastomas, which are very aggressive brain cancers, sort of the median survival is 18–24 months. And so to see lung cancer— And again, I'm going to talk about colon cancers, breast cancers, and so on, killing people in a matter of months or less than a year is just absolutely unheard of.

There is a case in the literature for those who want to look at— And I get attacked a lot with the line of attack that there's no such thing as "turbo cancer," and there's no literature about it. And there is actually a case published. Now, this is a case of a 66-year-old gentleman [Exhibit VT-3uu]. It was published by Serge Goldman: 66-year-old man who had two Pfizer vaccines and five months later he presents with enlarged lymph nodes. And so that is the scan on the left. This is a PET scan: a positron emission tomography. These are

the types of scans that I used to perform at the Cross Cancer Institute in Edmonton—thousands of these. I had analyzed over 10,000 scans like this at McGill University in Quebec. And he presents—and when you see these little dots around his neck and in his axilla,

[01:35:00]

and in his lower abdomen, these are tumours. These are lymphoma tumours. He was diagnosed with quite an aggressive angioimmunoblastic T-cell lymphoma five months after taking two COVID Pfizer vaccines.

Now, what is interesting about this story is that the doctors had no suspicion that his cancer may have been caused by the Pfizer vaccines. And so they were preparing a chemotherapy regimen for him, and they said, "Look, you're going to be immunosuppressed with chemotherapy. We're going to have to give you a Pfizer booster shot to protect you during chemotherapy." So they give him the Pfizer vaccine booster shot and within days he develops swelling in his neck—big swelling—he feels very sick.

And they did something brilliant, and we're all fortunate that they did this. They said, "Well, there's something very wrong. We should repeat the scan. Even though you just recently had the scan, we should repeat the PET scan just to have a more precise baseline before we give you chemotherapy." So they repeated the scan, and what they found was that the cancer had spread and it had spread to multiple new locations. It had grown in size—it had doubled or tripled in size—and it had spread extensively throughout the body. Now you see new lesions in the neck, in the axillae, in the mediastinum, and in the lower abdomen, and in the groin area. These lesions were not there before—

Shawn Buckley
So, Dr. Makis, according to this, it's only 22 days between those two scans?

Dr. William Makis
Yes.

Shawn Buckley
How often had you ever seen anything like this?

Dr. William Makis
You would not expect a lymphoma to progress in this way. It simply doesn't do that. And you know, it's very fortunate that they decided to repeat the scan because other oncology groups may not have repeated the scan at all. And so it's fortunate that we have this case where they repeated the scan.

And, you know, as the title says, "Rapid Progression of Lymphoma Following Pfizer mRNA Booster Shot." And they said, "We have no explanation other than the Pfizer vaccine, the booster shot, for this progression." And so this case is a stunning example, in my assessment, of what's being called "turbo cancer." These cancers that are arising after vaccination that are extremely aggressive, catching oncologists off guard, and they're behaving unlike cancers that we've seen before.

Shawn Buckley
Now, can I just ask you about that term? Because I'm obviously not an oncologist, and so I don't know what terms are used. But I had never, until recently, even heard the words "turbo cancer" together. Like, to me, turbo is something you put in a sports car to make it go faster, or a diesel truck. So is that a common term that oncologists use or is this a term that's just come up to explain something that's new?

Dr. William Makis
No, so this is a word that's not used by doctors and, certainly, I would not have used this term. It's not a medical term. It is a term that has arisen in the population. This is how these cancers are referred to by people on social media because of the aggressive nature of these cancers.

Shawn Buckley
Had you ever heard that term prior to the COVID-19 vaccines being used?

Dr. William Makis
No. No, I've never heard this term before. And, in fact, when you look at my initial letters to the Canadian Medical Association in September of 2022, I referred to "aggressive cancers." I don't refer to the term "turbo cancer." This is a recent term. I did not come up with this term. It had arisen on social media. That's as far as I'm aware of it. It is not a medical term.

However, there is no term to describe the phenomenon of what I would call COVID-vaccine-induced cancers. Because, really, the cancers that we see after COVID vaccination behave so differently that you really have to almost create a separate class of cancers associated with vaccination specifically [Exhibits VT-3aa to VT-3dd]. I believe we are dealing with a completely brand-new phenomenon.

Shawn Buckley
Okay.

Dr. William Makis
I had done some extensive research in the literature, and I've actually published in peer-reviewed literature on one of the possible mechanisms of how these COVID vaccines may be causing these cancers—these "turbo cancers"—and I will talk about that shortly.

But I was contacted by a journalist from *The Epoch Times*,

[01:40:00]

who asked me, "Look, we would like to write an article about what are the possible causes of turbo cancers, and would you be willing to tell us? And can you supply, actually, some research from the literature to back up the possible mechanisms?" And so I did that, and this article was published on July 28, 2023, in *Epoch Times* [Exhibit VT-3z]. And I supplied nine possible mechanisms by which these cancers may be arising. I don't know if we have time to briefly go over those.

Shawn Buckley
Actually, I don't want us to skip over this at all. So please give us a detailed explanation on this. When you get to the IgG4 publication, I'll just indicate that's been entered as Exhibit VT-3hh.

But no, please give us a— You're the only oncologist we've had, and I think part of the difficulty, Dr. Makis, is that when we were running our hearings earlier, this phenomenon was just evolving. And so I'd actually like you to give us a full explanation if you can.

Dr. William Makis
Certainly.

So I'd like to first say that the exact mechanism by which cancers are arising in those who have had at least one COVID-19 vaccine, the mechanism is unknown. So this is theoretical at this point. We have theories on how these cancers may be arising, and there is literature to back up some of those theories. But at this time, the exact mechanism of how these cancers are arising is unknown. So these are nine possible theorized mechanisms by which these cancers may be arising.

The first one is that the COVID-19 mRNA vaccines specifically have a modified RNA. The messenger RNA has been artificially modified to contain a pseudouridine. So instead of a uridine, you're now replacing it with a methylated pseudouridine, which has been artificially modified. And this was actually— This has come out of the research of Dr. Karikó and Dr. Weissman, who invented the mRNA vaccines, and they had studied these modifications for many years. And they had discovered that if you modify the mRNA in this way, you could actually dampen the initial immune response of the individual receiving the mRNA so that they wouldn't destroy the mRNA agent right away. It was actually designed to protect the mRNA [Exhibit VT-3ee].

However, what it does is it interacts with receptors on T-cells and other immune cells, called toll-like receptors, and toll-like receptors are involved in signaling. Immune system signaling is the easiest way to explain it. You have binding of these toll-like receptors, and then you have downstream, signaling effects. Well, some of these changes in signaling are actually implicated in cancer formation, and so this is one of the first mechanisms that should be looked at [Exhibit VT-3ff].

The mRNA vaccines, once they get into your body, they actually dampen— They interact with the toll-like receptors on the immune cells, they dampen the signaling of your innate immune system, and they cause disruptions in immune signaling, which could actually, downstream, lead to cancers being formed. So this is one mechanism.

Dr. Seneff had discovered that there is impairment of a different kind of T-cell signaling, immune signaling, called type I interferon, and this type of signaling is involved in cancer surveillance. So I've attached a publication to that [Exhibit VT-3gg]. And again, these haven't been proven to cause cancer in the COVID vaccinated, but these are lines of investigation. These are theories that should be investigated to see if they are causing these cancers.

Next one, number three, is what's called the IgG4 antibody shift, and this is a very fascinating discovery. It's a recent discovery that people who have been vaccinated at least two times start producing a different kind of antibody. So initially, you produce what's

called IgG1 and IgG3 antibodies against the spike protein, and these are antibodies that are involved in protecting us against viruses, but also protecting us against cancer.

And so initially, when you get the first mRNA Pfizer or Moderna vaccine dose, you get these antibodies produced. However, once you get the second shot, the body starts to change the composition of these antibodies, and it starts to produce a different kind of antibody called IgG4.

[01:45:00]

And this antibody is involved in immune tolerance. So it is there to actually get the immune system to tolerate this antigen that you're now being exposed to several times. And if you get the third dose, it really spikes. And the IgG4 really skyrockets, and you get decreased production of IgG1 and IgG3, and you get a massive rise in IgG4.

And I actually published a paper— We published a paper theorizing what this might be doing in the COVID-vaccinated, that it may be implicated in forming cancers. It may also be implicated in autoimmune diseases and autoimmune myocarditis. We published this recently. It has been peer-reviewed [Exhibit VT-3hh].

And when it comes to cancer, what the IgG4 does is, you know— You've got the IgG1 that actually coats cancer cells and calls the immune system to come and destroy the cancer cells. But the IgG4 actually blocks that process from happening. So it can bind the IgG1 and actually prevent the immune system from destroying the cancer cell, or it can occupy sites on the immune cells, like the NK [natural killer] cells or macrophages, and then those cells don't see the cancer cells. And this is called immune evasion of cancers. And so this is a mechanism that has been published in the literature a number of times, and we are seeing these antibodies in the vaccinated individuals.

And so now you've got an immune system that is basically trained to ignore cancer cells, and it then provides an environment for cancer cells to start replicating at an uncontrolled rate because there's nothing to stop those cancers from replicating, from growing rapidly, and from spreading. Now—

Shawn Buckley
And just for people watching this, my understanding is it's not like all of a sudden, you know, somebody develops cancer for the first time, and it becomes a problem. But actually, cancer is something we deal with from birth onwards, but our immune system deals with it. We have cells that are made to deal with it. So cancer's actually a normal process; it's just when it gets out of control.

But what you're describing is that normal process is potentially being interrupted by these IgG4 cells.

Dr. William Makis
Yes, and so we produce mutated cells, cancerous cells, all the time, as you've mentioned, and it's our immune system that destroys those cells. And that's why when I refer to cancer surveillance, it's actually the immune system that's surveying the body, the whole body, for these cancerous and mutated cells, and then destroying those cells as it sees them. And we have a very intricately beautiful immune system that takes care of all these mutated, damaged, and pre-cancerous cells and destroys them throughout our lives. And so when

something interferes with the immune system, and interferes in a major way, then you're actually removing that shield and then now some of these pre-cancerous cells can actually start growing rapidly and can spread and metastasize throughout the body.

So this is, again, one of the proposed mechanisms—what's called an IgG4 shift. Because when the body starts producing this IgG4—especially when you've had your third COVID vaccine dose, fourth COVID vaccine dose—it seems the more COVID vaccine doses you've had, the more IgG4 you produce and the less IgG1 and 3 you produce. So you're really removing that shield that you get with the IgG1 and 3 protection against cancers.

Then there are other mechanisms that are really worrying. The spike protein has been found to interfere with tumour suppressor proteins, P53 and BRCA1 (B-R-C-A-1) [Exhibit VT-3ii]. Now, BRCA1 is implicated in breast cancer, ovarian cancer, and P53 is involved in a number of cancers. It's damaged in a number of cancers. And the spike protein seems to interact or damage these tumour-suppressive proteins. Now, again, it has to be shown that, you know, it's the vaccine spike protein that's doing it as well, but that is a very concerning issue.

There's another paper that shows the spike protein interferes with DNA repair mechanisms [Exhibit VT-3jj; 3-vv]. That is problematic. There's another paper that shows that the RNA could integrate into our genome and that if it integrates in an area that is a proto-oncogene or a tumour-suppressive protein that it can lead to cancer. This has been shown in vitro [Exhibit VT-3kk].

[01:50:00]

It hasn't been shown in vivo, but again, another very concerning finding from the literature.

And then there's been a recent discovery by U.S. geneticist Kevin McKernan who actually did sequencing of Pfizer and Moderna mRNA vials. And he was looking for something else, and he actually discovered that there is DNA contamination in those vials—Pfizer and Moderna vials—and that there is actually a high percentage of contamination of DNA plasmids.

DNA plasmids are rings of DNA that contain the spike protein sequence, and it's actually part of the normal manufacturing process of Pfizer and Moderna. The way they produce these mRNA vaccines is they put the sequence of the spike protein into a ring of DNA called a plasmid. They then insert that plasmid into *E. coli* bacteria. They grow those bacteria in large numbers, billions and billions of copies. They then extract those plasmids from the *E. coli*, and they then transcribe that DNA into the mRNA, and then that mRNA is packaged into the vials and sent out as the Pfizer and Moderna vaccine.

Now, in the quality control process, they are supposed to actually enzymatically destroy all DNA so that there is no DNA contamination from the manufacturing process. And what this geneticist discovered—and it has been replicated in several labs since then, internationally, as well—was that there is a high amount of DNA plasmid contamination in these vials, and that up to 35 per cent of the genetic material in the Pfizer or Moderna vials, up to 35 per cent is actually DNA contamination. And that's potentially millions or billions of copies of these DNA plasmids.

This is concerning because DNA is much easier to integrate into our genome than mRNA would be. And so if you've got all this DNA contamination with the spike protein sequence in it, and you have billions of these DNA plasmids that are injected into you, there is

actually a significant risk that these plasmids may integrate into your genome. And again, if it integrates in the wrong place—in a proto-oncogene or a tumour suppressor gene area—you can get cancer that way.

And so this is a recent finding, highly concerning. And I've included Kevin McKernan's extensive documentation and sequencing of this, of these DNA plasmids, as evidence [Exhibit VT-3nn to VT-3pp].

Shawn Buckley
And we've entered that as an exhibit. It's just the list of exhibits— Just so that the Commissioners are aware: almost everything that Dr. Makis is referring to from a research perspective, he's provided to us, and we've included it as part of the record.

Dr. William Makis
Now, just the last two potential mechanisms.

When Kevin McKernan discovered these DNA plasmid contamination in these Pfizer and Moderna vials, he discovered that—specifically in the Pfizer vials; not in the Moderna vials, but the Pfizer vials—the DNA plasmid contained additional genetic information in the DNA plasmid. And this additional genetic information sits before the spike protein sequence, and it's called the SV40 promoter or the simian virus-40 promoter [VT-3ll]. And this sequence, no one knows why it's there. Pfizer has not explained why the sequence is there in these DNA plasmids. Simian virus 40 causes cancer in humans [Exhibit VT-3mm] and the cancers that it causes specifically are lymphomas [Exhibit VT-3qq] and glioblastomas—brain cancers.

Now, it is of course a portion of that virus. It is not the entire virus. So only a portion of it was discovered. But again, the concern is it's a promoter. So it is the sequence that could then encourage transcription of an entire sequence afterwards. So again, if this oncogenic piece of DNA integrates into our genome in the wrong place, it could eventually lead to cancer. So this is another concerning finding that has not been explained by Pfizer, and it's another potential mechanism by which these cancers may be arising.

And finally, there are sequences in the Pfizer vaccine and Moderna vaccine which are called microRNAs. These are non-coding sequences, so these are additional sequences present, which don't seem to code for anything. But when they are transcribed, they themselves are potentially oncogenic and cancer-causing [Exhibit VT-3ss].

[01:55:00]

So I've attached literature concerning all of these potential mechanisms—these nine different mechanisms—and as I've stated, it is unclear at this time which of these mechanisms is the one that's causing cancer, and it may be more than one of these mechanisms that are causing cancers in different individuals.

Shawn Buckley
No, and I appreciate you being fair with us and making it clear that these are just now theories. There's not enough research. And I also thank you for providing the research articles. For those that are interested, it will all be part of the record and attached to your witness page. So thank you for doing that.

Dr. William Makis
I wanted to summarize the features of these turbo cancers, just briefly. I have documented over 200 of cases of what I believe are turbo cancers in COVID-vaccinated individuals on my Substack. I have documented these cancers in doctors, in nurses, in teachers, in young people, in pregnant women. And my concern here is that these seem to be arising in greater numbers in professions that had COVID-vaccine mandates implemented on them. So these are, again, doctors—had vaccine mandates—nurses, teachers, military, police officers, firefighters, city workers, and so on, and that is where I'm seeing a greater number of these cancers arising.

So the features of these turbo cancers: They present in young individuals. They can present in teenagers, people in their 20s, 30s, 40s. I do suspect that because I focus on younger individuals, then I'm seeing more of these in younger individuals. It is possible that they may occur across all ages.

Shawn Buckley
Can I just clarify, though, because at the beginning of your testimony on cancer, you were saying, you know, you just weren't seeing this type of thing before. So even though you're maybe focusing more on young people, is it still a type of cancer you just wouldn't expect to see in young people?

Dr. William Makis
I would not expect to see this, and I can tell you I have not seen cancers behaving this way in young people before the rollout of the vaccines. I've never seen this in my career. So when I write my Substack, I focus on young people because I feel that, you know, these vaccines should be stopped in young people. But it really— You know, I believe that these are probably occurring across all ages.

These cancers tend to present at Stage 4. They present late. They don't seem to be picked up. You know, I have not seen stories of Stage 1 and then, you know, it progresses extremely rapidly. They seem to be presenting at a late stage—Stage 3 and Stage 4. They have very rapid growth. And whatever the type of cancer it is, whether it's breast cancer or colon cancer, lung cancer, they grow so rapidly that they always catch the oncologists off guard.

And you will see these stories anecdotally, if you go to GoFundMe. And we're not seeing these stories from the medical establishment. This is what's so frustrating, is that doctors are not publishing these cases. We are seeing these cases on social media. We are seeing them on places like GoFundMe, where the patient will tell us what their experience and what their oncologist told them. And their oncologist will say, "I've not seen this. This is 10 years of growth in a month or two, you know?"

And so these tumours grow very, very rapidly over a very short period of time. They are highly metastatic, and what I mean by that is that they spread, and they spread to multiple locations in a very short time. So you know, in some of these cancers, like breast cancer or— Let's take colon cancer. You know, when colon cancer metastasizes, you expect the first metastasis to show up in the liver, for example, and then, you know, you can actually track that; you can actually surgically remove that, and you can deal with it. These seem to spread to multiple locations in a very, very short period of time.

And another feature which is fascinating, which I have no explanation for, is they seem to be quite resistant to conventional chemotherapy and conventional radiation therapy and other conventional treatments. And what you will find— Again, anecdotal evidence, but what you will find is people will say that they had partial response, but then it was very short-lived. And sometimes the patients will say that the tumour didn't respond at all to chemotherapy or radiation therapy. And that, again, is really quite unusual.

[02:00:00]

And again, something I really have not seen in my career, that you would have tumours that you would expect to respond to conventional regimens and they're not responding to chemo or radiation therapy.

And then I'd like to briefly talk about what kinds of cancers we're seeing. That I'm seeing. And I've tried to document, at least on an anecdotal level, how common some of these cancer types are. And it seems that lymphoma is the most common one, closely followed by glioblastoma: these are Stage 4 brain cancers. And then breast, colon, and lung seem to be the common ones. I have seen cancers of the hepatobiliary system: these are the gallbladder cancers; these are pancreatic cancers. They also seem to be happening at a higher rate than I would expect. And the leukemias.

Now, the leukemias. What's fascinating about the leukemias is that they are so aggressive that the time from diagnosis to death can be a matter of weeks, days, or even hours. I've reported on my Substack several cases of leukemia where a young person will feel unwell: they will present to emergency; they will have blood work done; and the doctors discover you have leukemia, and they will die a few hours after diagnosis. And this is, again, something that I have never seen in my career. To die in a matter of hours, even days, after diagnosis is something that I have simply not seen. That is another feature that is really frightening with these turbo cancers.

When it comes to fatality, they kill much more quickly than you would expect tumours of their type. And so, you know, the leukemias are particularly aggressive and deadly, as I had mentioned, but typically, you will see a lot of these cancers kill in a matter of three to six months. And the majority of them, it'll be six to twelve months. And again, you expect patients with breast cancer, lung cancer, colon cancer to live more than six to twelve months. Even at Stage 4, you expect them to live several years. You know, we have those survival charts, the five-year survival charts, and that's simply not what we're seeing. These are lethal, and they kill much more quickly than anything I've seen in my career.

And so, you know, that sort of concludes my presentation on the turbo cancers.

Shawn Buckley
Now, I know we were planning on doing sudden deaths during vaccination. Could we just do that in a minute or so? Just we're running a little late, and I'd like to leave this open for questions from the commissioners.

Dr. William Makis
Absolutely. I would just like to mention that we've coauthored a paper [Exhibits VT-3jjj and VT-3kkk]. Now, Dr. Peter McCullough has led this initiative. Dr. McCullough is a Texas cardiologist, and he's been at the forefront of warning about sudden deaths, specifically

cardiac-related sudden deaths, after a COVID vaccination—and Dr. Paul Alexander, Dr. Richard Amerling, Dr. Roger Hodkinson, and Dr. Mark Trozzi: a number of us had gotten together, and we'd conducted the largest review of autopsies that has ever been done of sudden deaths of COVID-19 vaccinated individuals. This is now a pre-print on the Zenodo server. It is under peer review.

We reviewed 325 autopsy cases, and we found that 74 per cent of those deaths were either directly caused by the vaccine or there was a major contribution by the vaccine. And these are sudden deaths shortly after COVID vaccination: the mean time to death was 14 days. And so, you know, this has been seen and downloaded hundreds of thousands of times. We submitted this to *The Lancet*, and *Lancet*, within 24 hours, removed it from their server. It was being downloaded hundreds of times a minute and I believe, as an act of censorship and to stop this finding from being peer-reviewed and published, *Lancet* removed our paper from their server. And so, you know, this is now under peer review and I hope that other researchers will— You know, I hope we get this published, and I hope that other researchers will sort of follow on and build on our research.

We've done a similar review of—

Shawn Buckley
Can I just stop you there? *The Lancet*, it was peer-reviewed and they accepted it for publication, right?

Dr. William Makis
It wasn't peer-reviewed. Now, it had gone through an initial review and so they saw that, you know,

[02:05:00]

this is an extensively referenced, big paper, so it passed initial reviews. They put it on their preprint server and then, 24 hours later, they removed it from their server; didn't really give a legitimate explanation why they removed it.

Shawn Buckley
And it was being downloaded extensively.

Dr. William Makis
Yes. And as you can see, it's been viewed and downloaded, you know, several hundred thousand times. But *Lancet*, in what appears to be an act of censorship, removed this paper from their preprint server.

Now this paper is being hosted on CERN [Conseil Européen pour la Recherche Nucléaire (European Council for Nuclear Research)], on a Zenodo server, which is sponsored by CERN in Switzerland. And so now people have access to it. They can download it; they can read it. We found that the majority of the sudden deaths of COVID-19-vaccinated individuals are cardiovascular. There's also a large component of hematological, so blood clots. I think it is a fantastic paper. And I think it sheds a light on the phenomenon of sudden deaths after COVID vaccination.

We wrote a similar review and a paper with myocarditis [Exhibit VT-3lll]. We looked at all the myocarditis cases in the literature in those who were COVID-vaccinated. And we found that 100 per cent of the myocarditis deaths were due to the vaccine. This is also under peer review right now.

And so I'd be happy to move on to answer questions.

Shawn Buckley
Let's open it up to the commissioners, except if you want to comment. In this slide that you just took down, you're calling for the suspension of COVID-19 vaccines?

Dr. William Makis
Yes, and so if I may just show the last slide. You know, the purpose of me presenting all this evidence and also giving documentary evidence, I feel very strongly about what I've seen in terms of the adverse events of the COVID-19 vaccines. And I am calling for the immediate suspension of the use of COVID-19 mRNA vaccines, especially in children of all ages and pregnant women.

Because the sudden deaths that I described, that we have reviewed—autopsy cases of these sudden and unexplained deaths when people are dying in their sleep or they're collapsing when they're playing sports or doing a physical activity, out for a jog, or they're collapsing in the classroom. I'm seeing this in teenagers—in vaccinated teenagers. I'm seeing these sudden deaths in children—elementary school children. I'm seeing these sudden deaths in pregnant women. It is very disturbing to me as a physician to watch these deaths and watch the injuries, as well [Exhibits VT-3xx to VT-3zz; Exhibits VT-3aaa to VT-3ddd].

I believe there is a substantial body of evidence of very serious adverse events, including deaths, caused by or significantly contributed to by the COVID vaccine [Exhibit VT-3tt; Exhibit VT-3rr]. And it is my conclusion that these pharmaceutical products are neither safe nor effective. And furthermore, I call for the immediate suspension of all remaining COVID vaccine mandates, especially in healthcare. And I hope that other physicians will join me and will find their voice and will find courage to stand up for their patients, to stand up for the Hippocratic Oath to do no harm, and to stand up for the ethical practice of medicine in Canada.

Shawn Buckley
Thank you. So I'll open this up for questions now. But just, you know, you actually calling for a stop of the vaccinations was worth us coming back to and having you comment on that.

So just go ahead and unmute yourself, Commissioner Drysdale.

Commissioner Drysdale
Dr. Makis, thank you very much. It is a very good presentation. There is a lot of pieces to it, so I want to kind of roll back to the beginning and ask some, probably, what are very fundamental questions.

In your opening part of your presentation, you talked about the Alberta Health Services' mandates to health care professionals. I believe in that slide you talked about how the—or

at least you showed—and I'm just taking a look at the slide right now. You showed how Alberta Health Services had made the statement that immunization against COVID-19 is the most effective means to prevent the spread of COVID-19. Do you have any information as to what scientific basis the Alberta Health Services used to make that statement?

[02:10:00]

Dr. William Makis
I have not seen any document that would support that statement from AHS.

Commissioner Drysdale
My second question, again, has to do with the Alberta College of Physicians and Surgeons. How is a mandate of a medical procedure, specifically a vaccine or a biologic—a lot of the testimony we had said this is not a vaccine, it's a biologic, but be that as it may—how does the mandating of this medical procedure square with the requirement for informed consent?

And before you answer that, I just want to take a look in— The College of Physicians and Surgeons of Alberta, they define exactly what is required to get informed consent. And one requirement is that the person making the decision to take the procedure has to be free of any undue influence, duress, coercion, or anything else that might influence their decision to give informed consent.

So once again, my question is: How does mandating a medical procedure adhere to the principles of informed consent, particularly when your job is at threat? How did the College of Physicians and Surgeons, do you believe, square that circle? It seems to me, in reading it on the face of it, that mandating a procedure with the threat of losing your job is against the, you know, it certainly violates the coercion part of informed consent. Would you agree with that or do you have any more information to add to that?

Dr. William Makis
Certainly. So I would like to clarify that the mandate was issued by Alberta Health Services. It seems to have been issued unilaterally by the leadership of Alberta Health Services. I know that at the time, the media was asking Jason Kenney, the Alberta Premier, for comment, and the Alberta Minister of Health for comment, and they deferred to Alberta Health Services. And so this was a unilateral imposition of a vaccine mandate.

And you can see in the letter of opposition to the vaccine mandates, the health care workers are clearly stating the scientific basis for opposing these mandates. I consider these mandates highly unethical, unscientific. The health care workers documented the hundreds of thousands of injuries in the VAERS reporting system, you know, over 10,000 deaths. And so I found this a gross violation of medical ethics, of the Canadian Medical Association code of ethics.

The mandates came from Alberta Health Services. Now, what's interesting is that the College of Physicians and Surgeons of Alberta, they did not put a mandate themselves, but they stepped in and they sent threatening letters to doctors who were opposed to these vaccine mandates. And so there's an additional layer of coercion where it's not just that you're being threatened by your employer, that you will lose your job, or, as was stated, that you will be put on unpaid leave. And we know that there were many health care

workers who lost their jobs or were forced into early retirement. But now, here you have the College providing an additional layer of coercion and intimidation by saying that we're aware of your opposition: we're putting it on your permanent record, and we're giving you the opportunity to withdraw your opposition to these vaccine mandates. That, again, to me, was a gross violation of everything I know about medical ethics.

Commissioner Drysdale
Well, you know, you make a point that Alberta Health Services unilaterally imposed these mandates. But the bottom line is that the injections were given by physicians or pharmacists or nurses, and they are all regulated under— At least the doctors are regulated under the Alberta College of Physicians and Surgeons. So the Alberta College of Physicians and Surgeons was directly involved in that they weren't regulating their members to adhere to the principles and requirements of informed consent.

I mean, I don't know how it is in Alberta, but I know that in Ontario, it's not just a regulation under the Ontario College of Physicians and Surgeons. But there's actually an Act that regulates informed consent in the medical profession outside of that. And I don't know if that's the way it is in Alberta or not.

[02:15:00]

Do you know that answer?

Dr. William Makis
So it wasn't part of my presentation tonight, but I am aware that the College of Physicians and Surgeons of Alberta had sent out a memo to all Alberta physicians indicating that they were not to do anything that would create vaccine hesitancy—and that conflicted with providing informed consent. And furthermore, you know, this includes discussion of risks of the COVID-19 vaccines, and informed consent requires that you discuss both the benefits and the risks.

I have run clinical trials in Alberta. You know, we had regulations that we adhere to very strictly. I had to provide to my end-stage cancer patients a detailed assessment of all the benefits—but of all the risks, as well, with whatever pharmaceutical product that I was going to give them. And in the end, there was no coercion. It was completely up to the patient whether they wanted the product or not.

I'm aware that the College put tremendous pressure on Alberta doctors where doctors were not allowed to provide this kind of informed consent to their patients when the vaccines were rolled out—the first two doses, the booster shots. In fact, that remains the case to this day.

Commissioner Drysdale
Yes, I mean, are you aware of the fact that the CDC and the FDA have approved a new COVID-19 vaccine? And it is my understanding that as of this date, the Pfizer documentation on this actually says that they don't know what the long-term side effects are. They don't know what all the side effects are, and they're still examining this. So that's current as of September 11th, 2023.

If we don't know all the side effects and the manufacturer is saying within the last week—September 11th, 2023—that they don't know all the side effects, how is it possible that they knew all the side effects in December of 2020 when Health Canada approved these vaccines for use in the general population?

Dr. William Makis
Well, I will go one step further: On September 12th of this year—this was a week ago—Canada's public health chief, Dr. Theresa Tam, and chief adviser to Health Canada, Dr. Supriya Sharma, approved the newest COVID-19 booster shot against XBB.1.5 and recommended these vaccines in children as young as six months old and in pregnant women at all stages of pregnancy. And I've read the document that shows the safety studies that were done, and there were no safety studies done on this product in regards to children or in regards to women in pregnancy.

And so, to me— And again, I don't know what to say about this as a physician, that we have our federal bodies—Health Canada, public health chief—recommending pharmaceutical products on which there were no safety studies done in populations like children as young as six months old and pregnant women.

Commissioner Drysdale
Well, I've also read those documents, and I wanted to ask you about that because in the Pfizer document, with regard to the new COVID-19 vaccine, it's my understanding that there were no clinical trials on it and that they relied on the original clinical trial information.

And also, when I read that documentation, I'm just wondering—since I believe you have read it, as well—they list what they believe are all the side effects for children and they don't mention death in that list. I mean, you've talked about death. I've heard many other witnesses talk about death in patients who receive the vaccines, and yet death is not a side effect listed in the Pfizer document. Is that unusual that they wouldn't list— I mean, that's a fairly serious side effect, I would think.

Dr. William Makis
It is very unusual, and I find it extremely unusual that to date, Health Canada has stated that there have been zero deaths linked to any of the of the COVID-19 vaccines. When in the United States, in the VAERS reporting system, we have something like over 30,000 deaths reported. Now, of course, you know, these should be investigated.

[02:20:00]

And this is the other part of it—that proper investigations aren't being done; proper autopsies are not being done. And so, you know, this entire process is, to me, very controversial and questionable.

Commissioner Drysdale
Well, Dr. Makis, that brings me to my next question. And you keep talking about the VAERS system. And for our listeners, the VAERS system is a— I would describe it as a voluntary reporting service for vaccine injuries in the United States. But Canada has its own system called CAEFISS [Canadian Adverse Events Following Immunization Surveillance System]

and I don't believe I heard you mention that word. Have you reviewed the data from the CAEFISS system? Is there a reason you relied on the VAERS system rather than the CAEFISS system?

Dr. William Makis
I have been anecdotally informed by a number of doctors who have submitted vaccine injury reports that whatever reports they submit come back rejected. And this is within Alberta Health Services. Their reports don't make it to Health Canada. And so their reports are rejected at the level of Alberta Health Services, and they've been very frustrated. They've of course asked me to remain anonymous. They fear retaliation because they are still working in the system.

Basically, I've relied on anecdotal evidence that I've seen, and I've relied on VAERS reports. I've also looked to the WHO VigiAccess database as well in my research.

Commissioner Drysdale
Well, we heard evidence from a number of doctors across the country that corroborate what you just said. As a matter of fact, there was one doctor, I believe, who testified in Truro who reported a number of adverse reactions, according to his testimony, and was dismissed, I believe, because of that, or was at least alleged to be dismissed.

But moving on, you talked about a fellow by the name of Tim Caulfield, who is— I think your title that you had in your slide was Canada Research Chair in Health Law and Policy. And I noticed that when they list him, it doesn't say doctor. Is he a doctor?

Dr. William Makis
No, Mr. Timothy Caulfield is a professor of law at the University of Alberta.

Commissioner Drysdale
How does a professor of law become the Research Chair in Health [Law and Policy] for the University of Alberta and make commentary on medical matters that you, as a qualified doctor, have made comment on?

Dr. William Makis
I honestly— I can't answer that question.

Commissioner Drysdale
I have another question that has to do with some of the slides that you had up. And I was searching for one of the references you made. And one of the references was in the slide that you had up and I'm just going to read it.

I don't see a number on your slide, but it says— It's a quote out of—oh, gosh, I can't remember—one of the newspapers who were critiquing what you were saying. And the newspaper said, "According to a recent *Epoch Times* story," and then it goes, "—an anti-China publication associated with Falun Gong." And when they referred to Gettr, they said, "a right-wing" whatever-it-was. And it seems that in a lot of these editorials or these

commentaries you've got, they put these labels on certain things, and other things they don't comment on.

And for instance, with Mr. Tim Caulfield, they didn't say, "a professor of law with no experience in medicine," which would have been consistent with "Epoch Times—an anti-China publication associated with Falun Gong," which really didn't have anything to do with the article.

Have you seen much of that, where the media seems to be putting labels on these outlets in order to— I can only guess it was to characterize them a certain way. Have you seen much of that?

Dr. William Makis
Yes, well, I can tell you— I can specify that the reference to the "anti-China publication" associated with Falun Gong, this was the *Toronto Star*. This was the *Toronto Star* article by reporter Alex Boyd. And then the reference to Gettr being an "alt-right" website, this is Global News by reporter Ashleigh Stewart.

These are mainstream media publications. I am not alt-right. I don't see Gettr as an alt-right website. I certainly don't subscribe to any of these labels, and I see these labels as, really, a smear tactic.

[02:25:00]

It is a tactic to smear me in their article and to really tarnish my reputation and tarnish my credibility, and really tarnish anything that I have to say.

You will notice that there is no reference that I have won 15 scholarships at the University of Toronto, that I have a four-year undergraduate degree in immunology with honours from the University of Toronto, that I have a five-year specialization from the best medical school in Canada—McGill University. There's never any reference to my qualifications. There's no reference to the fact that I'm a cancer researcher with over 100 peer-reviewed publications in international medical journals.

And so, you know, I see these as smear tactics, and I believe I was the victim of a smear campaign by the mainstream media.

Commissioner Drysdale
My next question has to do with Table 2 of the information that you are providing from the **Alberta government and particularly— Well, it doesn't matter which one. You have two different versions of it: one from March 31st, the second one from July 20th. But I'm just looking down and it talks about currently hospitalized—three doses, two doses, one dose, unvaccinated. But when I looked down into the notes, the asterisk says, "Table does not include those with one dose." But one dose is— Am I misreading this? I mean the table has one dose, but the asterisk in the notes to this Alberta government document says that it doesn't include with one dose. Am I reading that wrong or is that a mistake by them?**

Dr. William Makis
I do see that. And I honestly, you know, I took these—these are snapshots from the government website as it was at the time, in both of those times. I don't have an explanation of why that statement is there.

Commissioner Drysdale
And we heard testimony from other researchers that— And as a matter of fact, the CDC now says on their website that people who have had COVID-19—I can't remember if it was boosters or injections—have a higher risk of contracting COVID-19. And where I'm going with this question is, again, going back to Table 2: the government says that within 14 days of getting the vaccine, they don't consider you protected. But if that's the risk zone in which you might be getting COVID as a result of the vaccine, aren't they masking—? Is it possible they're masking those results?

Dr. William Makis
Yes. So what I would like to say about this data that was being put out by the Alberta government is that, you know, I'm taking this data at face value. I, personally, as a physician, have a problem with the designation within the first 14 days after vaccination that someone would be labelled as "unvaccinated." I know that this happened and that this was part of the problem with the data throughout the pandemic. And I certainly don't subscribe to that.

And I believe that data manipulation was used to hide a lot of adverse events following vaccination. And we know that, actually, the majority of the deaths happened in the first two weeks after vaccination. And then those injuries and deaths were actually blamed and labelled as "unvaccinated."

Commissioner Drysdale
Well, didn't Pfizer actually say in their monograph that you were considered vaccinated within seven days of receiving the dose? I thought— I'm going by my memory, but I thought we had some testimony on that previously. Are you aware of that, Dr. Makis?

Dr. William Makis
I'm not aware of that. But I know that in Alberta, you know, the definition was 14 days. And it is my belief that initially, when the public health chief, Dr. Deena Hinshaw, talked about the pandemic of the unvaccinated—and then similar sentiments were echoed by Dr. Theresa Tam, Canadian public health chief—that this pandemic of the unvaccinated didn't exist. That it was a manipulation of the data where— And this was one of the manipulations: that people in the first 14 days after vaccination were labelled as "unvaccinated."

Commissioner Drysdale
Well, I have two more questions. I know Dr. Massie is anxious to ask some questions, but I have two more questions.

Your specialty is oncology, so you're a cancer doctor, if you want to call it that. My understanding is that

[02:30:00]

the vaccines were tested initially for a period of about two or three months and then they were unblinded, which means that the side that received the placebo then received the vaccine. So they studied these vaccines—these biologics, as some other witnesses testified—for a period of a few months, two or three months at most.

As an oncologist, if I tested cigarette smokers for two months, would I discover that they got cancer from cigarettes?

Dr. William Makis
No. And there is no long-term testing on any of these products, whether it was the first doses or whether it was the booster shots, Pfizer or Moderna. There has been no long-term testing on any of these products, and this is one of the reasons I was opposed to vaccine mandates, to mandating these experimental products: that we had absolutely no data on what the long-term consequences were of mandating this product on all the health care workers, for example. That was just absolutely unconscionable, unscientific, unethical. And that is why I started my presentation with the vaccine mandates that were imposed in Alberta and, really, throughout Canada.

Commissioner Drysdale
Well, you know, talking about pregnant women: I mean, thalidomide was a drug that was prescribed to women in the early '60s, I believe, and caused significant issues with birth defects. And once again I ask the question: If you were testing thalidomide now on pregnant women and you tested it for two or three months, would you know whether or not you were going to have birth defects on those women nine months later or six months later?

Dr. William Makis
Well, again, the problem is that even the animal studies that they did were, in my view, insufficient. And when it comes to pregnancy— Sorry, that is my cat. When it comes to pregnancy, where I'm really concerned is that there is a blanket recommendation of these products in pregnancy. And I have published on my Substack, I have reviewed the VAERS database extensively in terms of what has been reported, the problems that have been reported in pregnancy, and there are very serious problems that have been documented in the VAERS reporting system.

When you take the COVID vaccines in early pregnancy, there are congenital malformations of the heart, of the brain, of the limbs [Exhibit VT-3ggg]. When you take them in the second trimester, the fetus can stop growing within 24 hours of taking the Pfizer or Moderna vaccine. There are many such reported cases. There's a cessation of fetal growth that can lead to miscarriages or stillbirths [Exhibit VT-3fff]. And in the third trimester, there are many cases of stillbirth [Exhibit VT-3hhh], of premature labour, of maternal death, death during delivery of the mother or the baby, postnatal deaths [Exhibit VT-3eee] . These are very highly concerning cases, and that's why I want to see these products stopped. It should not be recommended for pregnant women until there's much more robust studies done.

Commissioner Drysdale
We also heard significant— And I'm going to ask you this question because you talked about cancers, that there was no screening done for a year or two and that, of course, there was an increase in the number of cancers detected after they started screening again. So they essentially stopped screening for cancers. And my question to you, or at least what I'm wondering about is, we heard testimony after testimony after testimony from medical professionals who said the hospitals were empty, who said that there was nothing going on. We saw commercials of nurses dancing in the emergency rooms. I, myself, had an experience in an emergency room during the lockdowns, and the emergency room and the hospital was empty.

So my question is, how in good conscience did we stop doing cancer screenings with the full knowledge of what the impact that would have when the medical system was not overloaded? At least according to the testimony we had: the hospitals were not overloaded; the emergency wards were not overloaded. And yet we stopped all these preventative measures. And according to your testimony, you're expecting an increase,

[02:35:00]

or you have seen an increased number of cancers detected, partially because we weren't doing screening for a year and a half or two years. Have you any insight into how they decided to stop doing those screenings, knowing what the risk was, and knowing that the hospitals were not overloaded in the first place?

Dr. William Makis
Again, I can't really speak to the decision making. Certainly, I would not have stopped those visits or cancelled those visits, or cancelled the surgeries. There were many surgeries that were cancelled, as well.

I don't believe it was that long of a period of time. I believe it was a number of months. I can't tell you exactly the length of time, but I don't believe it was more than a year.

And in terms of the expected increase you would see, as we would sort of catch up on those patient visits and screenings, again, it does not explain the phenomenon that I'm seeing with these cancers that are arising, and very, very aggressive cancers. And I am seeing this phenomenon in the United States. I'm seeing this phenomenon in the United Kingdom, in Australia, in all the countries that have a high uptake of the COVID-19 vaccine—specifically the mRNA vaccines—and also have high booster uptake. I'm seeing the same types of cancers in these different countries. And these countries, some of them didn't have, you know, closures or cancellations of cancer screenings or cancer visits, so this is a completely separate phenomenon.

One thing I would like to add is that it is impossible to get good data on the rate of cancers. I've tried to get this data. I've gone to Statistics Canada. I've gone to the Public Health Agency of Canada. You know, I've looked at the Canadian Cancer Society. None of these institutions, which should be releasing this data to the Canadian public, none of them are releasing this data. These three institutions put out a report in 2022 where the data only goes up to 2018. So we're actually not seeing any data—any data—on the incidences of cancer in 2021 and 2022, which is the data that we need to see to be able to assess this phenomenon of these aggressive cancers arising. You know, what is the rate of increase of these cancers and the particular types of cancers, as well?

I mentioned that there seems to be, anecdotally, a huge spike in lymphomas, glioblastomas, Stage 4 breast cancer, Stage 4 colon cancer, Stage 4 lung cancers, but we need broader data from these institutions—Statistics Canada, Public Health Agency—and we're not getting them.

Commissioner Drysdale
Well, your commentary on that particular item seems to be confirmed by Dr. Denis Rancourt, who testified here three times, and testified a third time because during the first two testimonies, the Canadian data was not available and he had used data from other parts of the world.

But those are my questions, Dr. Makis. Thank you very much for your time and your expertise and your courage to come before this committee.

Dr. William Makis
Thank you very much.

Commissioner Massie
Good evening, Dr. Makis. Thank you very much for this very detailed and, I would say, comprehensive presentation. What you've covered actually overlaps with a lot of other stories we've got from many other experts. But the emphasis you're putting— And I will focus my question mostly around the cancer and the potential mechanism for the cancer.

I have some knowledge in the tumour biology: I've been trying to develop protocols to fight cancer with gene therapy and stuff like that, so I have some knowledge. And it seems to me that one of the keys in cancer is really the immune surveillance of cancer. And one of the things that I've heard anecdotally from people in my surroundings is that some people have had cancer in the past that would seem to have been completely cured for, sometimes, decades. And after their second or third shot, it just went back, and they basically died from cancer in a couple of weeks or months. So how could you actually explain these kinds of cancers that seem to have been completely cured for decades, but all of a sudden are coming back following the immunization with these mRNA vaccines?

[02:40:00]

Dr. William Makis
I would like to state that Professor Angus Dalgleish in London, in the United Kingdom, has made a public statement—exactly what you are mentioning, as well—that he, as an experienced oncologist, has seen a number of instances of cancer patients who had been stable—for example, melanoma cancer patients who had been stable on a certain kind of immunotherapy for many, many years. And then they take a COVID-19 booster shot, and then their cancer just explodes and spreads. And he said other patients who've been in remission and then their cancer returns, and it is aggressive and it is much more aggressive than before.

And again, I don't have an explanation for this phenomenon. You know, again, it's theoretical at this point. And again, it may have to do with some kind of suppression, immune suppression: that could be why these cancers can suddenly come back, but, again,

it's something that really needs to be researched. And I don't believe this kind of research is being done because there's no acknowledgement within oncology, as a medical specialty, that this phenomenon exists or that this phenomenon could even be a problem in the COVID-vaccinated. And so I think this is something that requires research. But it would first require an acknowledgement that the problem exists, that it is something that needs to be researched.

I'm sorry, I don't really have a theory right now on that phenomenon.

Commissioner Massie
On a follow-up question on that: when I look at your different mechanisms you're proposing as potential triggers for these cancer, some of them seem to qualify, what I would call, hit-and-run. That is, something would trigger the initiation of the cancer, and then it might take some time before the cancer really flourishes and, in fact, affects the individual up to the point that they will die. So what kind of research would be required in order to really link the occurrence of the cancer to that kind of triggering, which sometimes may or may not leave a trace of the initial event?

Dr. William Makis
Well, you know, I wonder about these events where the RNA is reverse transcribed into our DNA, or this issue with the DNA plasmids potentially integrating. So there would probably need to be some kind of sequencing testing done on people who've been vaccinated to see if there have been any integration events.

And I know that this is a concern of a number of doctors: that it's one thing to have the mRNA persist for a certain period of time and have the spike protein being produced for a certain period of time, and then, you know, eventually the mRNA degrades. Even the modified mRNA—which is supposed to last longer now that it's been modified with the pseudouridine—it degrades at some point, and the spike production may cease. But the concern is—is this spike protein sequence being integrated, in certain cells, into our genome? And then you're now faced with a situation where you're potentially producing spike protein indefinitely, and it's causing all kinds of immune issues.

And so I would love to see much more research around this problem of this integration of this spike protein sequence into our genome. And I don't have the expertise in that to really go beyond that. But I think that, for me, that would be an area of really strong interest.

Commissioner Massie
So I understood from your previous answer that, at this point, we don't gather enough data, maybe, to get a good assessment of the occurrence of this phenomenon in terms of a serious side effect of the vaccination?

Dr. William Makis
I don't believe the research is being done.

Commissioner Massie
So my question would be:

[02:45:00]

Your best assessment based on what you've scanned or the data you gathered, how would you compare that to, say, the occurrence of myocarditis? Is it, like, much lower in terms of rate? Is it same ballpark? Is it higher?

Dr. William Makis
Well, so myocarditis is a very interesting issue because I believe we've been lied to by the public health authorities about myocarditis, specifically the incidence of myocarditis in the COVID-vaccinated. I know that public health officials in Ontario, for example, have admitted a rate of one in 5,000. You know, there's been different numbers published in the literature: one in 10,000; one in 20,000 per dose.

But then you have the studies, like the prospective study in Thailand by Mansanguan, which shows a potential of subclinical myocarditis as high as 1 in 30. One in 30 young boys—you know, the teenage boys. You have the study from Switzerland by Dr. Christian Mueller who had looked at, you know, 800, approximately, health care workers after taking the booster shot and finding some evidence of cardiac damage—and he says it's mostly mild damage, but some evidence of cardiac damage in 1 in 35.

So there's a huge disparity in terms of what the public health officials are willing to admit in terms of how frequent these events are and what is happening on the ground. When you look at large databases like the WHO VigiAccess database, which has five million adverse events reported from COVID-19 vaccines, there's a disconnect there. And so I think when it comes to the cancers, as well, we have a worse situation because there's actually no admission from any of the public health authorities in Canada or the United States that this phenomenon even exists.

So it's one thing to have public health officials admit, yes, the vaccines cause myocarditis, it's rare and mild—and that's the lie. But there is an admission that it can cause myocarditis; it can cause blood clots. But in the case of cancer, there is no admission by any health authority in the world that this is even a possibility.

I'm sorry, you're muted.

Commissioner Massie
So, yeah, when you do autopsy for myocarditis, you can find the spike protein in cardiac cells and cardiac tissue and get some sort of reasonable assessment that seems to be a mechanism that linked the two events. But in cancer, what kind of autopsy could you do in order to link the cancer with the vaccine? Can you think of ways that we could actually sort that out?

Dr. William Makis
This is going to be a lot more difficult. I am aware of some work done by Dr. Arne Burkhardt in Germany, pathologist, who has done some staining for the spike protein. I believe he's done some staining on tumour tissue. Dr. Ryan Cole in the United States, pathologist, has talked about this phenomenon of at least staining for the spike protein in the tumour itself.

And that's not being done. That's not being done in Canada. That's not being done, you know, in the United States by any of the medical authorities, but at least this would be a start. This would be a start: Is there presence of the spike protein in these tumours and how much spike protein is present? That would at least be the starting point for me.

Now again, that may not be sufficient in terms of linking many of these cancers to the vaccines, but at least we could start with that. And unfortunately, that's not being done.

When it comes to these cancers, I can tell you, we are so far behind in terms of approaching this topic in any scientific way that I feel very alone on this topic. As I mentioned, there's Professor Dalgleish in London, in the United Kingdom, an oncologist who is also calling for investigations into these types of aggressive cancers. Of course, Dr. Roger Hodkinson, pathologist in Alberta, you know, believes this phenomenon of turbo cancer is happening. Dr. Ryan Cole in the United States, Dr. Arne Burkhardt in Germany, Dr. Peter McCullough in the United States, as a cardiologist.

[02:50:00]

Recently, Dr. Harvey Risch has talked about turbo cancers, as well. But this is a very, very small group of us that are sounding the alarm on what we are seeing on the ground level—at the anecdotal level, really. And unfortunately, the medical community is simply not willing to look at this. Really, similar to the way the Canadian Medical Association is not willing to look at the phenomenon of sudden deaths of Canadian doctors. There's just no interest in looking for answers.

Commissioner Massie
I have another question. I was really curious about one of the mechanisms you mentioned about microRNA that could actually perturb the gene expression in the cell. Have you looked at some of the data showing that these microRNA can actually be derived either from the plasmid that uses a template to make the RNA vaccine, or is it possible that in the process of generating the RNA, you are generating the short segment? And do we know anything about whether these segments can actually have been shown to be a potential sequence to affect gene expression? Have we done some genomic analysis on that?

Dr. William Makis
I'll be honest, this is not my expertise. You know, this is beyond my expertise. You know, I'm aware that some of these sequences could act as either tumour suppressors or proto-oncogenes, but this is really not my area of expertise.

Commissioner Massie
So let me get back to immunology because that seems to be one of your expertise. I'm really concerned about the IgG4 potential role in the triggering of cancer because you would actually interfere with normal immune surveillance and you would generate an environment that is conducive to growth of cancer.

So I have two questions here. The first question is, it seems that from the literature, the occurrence of IgG4 increased with the number of doses of the mRNA—at least starting at the third dose and after that it seems to be pretty high: stable high.

So my first question is about these new vaccines that the health authorities are pushing for the fall. And they somewhat changed the message, at least in the States. I don't know in Canada whether they're going to use the same spin on it, which is this is not a booster: this is just a new vaccine for a seasonal, if you want, COVID strain similar to flu seasonal vaccine. But it seems to me that if you use the same mRNA technology, it's another injection that actually should be on top of what you already have. So should that actually further stimulate IgG4 or maintain it at high levels for people that have been previously injected, say, twice, and they decided to get their shot in the next fall?

Dr. William Makis
I believe so. I believe the antigen is almost virtually the same as the initial vaccines that you would have been exposed to the first dose, the second dose, you know, the first and second boosters. You know, they may have made some very minor modifications in terms of, you know, the Omicron XPV.1.5, but it is my understanding that the body would recognize it as just another exposure and that would probably continue driving this mechanism, this IgG4 shift. And really, it's very interesting that there's a very minor rise in IgG4 with the second shot. But it is the third shot that seems to make a very dramatic increase in this production of these IgG4 antibodies. And so just continuing along this path, I think, is just absolutely reckless.

And, you know, I see this departure from the word booster as a marketing ploy. Canadians, by and large, have stopped taking booster shots. I believe only five or six per cent of Canadians are considered up to date on their booster shots or have taken a booster shot in the past six months. And so it's clear that booster shots are unpopular—highly unpopular—even among people who have taken vaccines before.

[02:55:00]

And so I have actually read in the literature—now this is referred to as vaccine hesitancy literature—that they want to actually change the marketing of these vaccines, remove the word booster, and make them appear as annual, updated shots that you would get at your regular doctor visit, just like you would get your flu shot. And they really— It seems to be that there's this desire to now move towards this idea that these are harmless, annual shots just like the flu shots because the flu shot is seen in the literature as being very successful in the way it was marketed. And the uptake of the booster shots over a number of years: that the marketing involves removing the word booster and now changing the name of these shots as "updated shots" as opposed to "booster shots."

But they are booster shots. It's the same antigen. I believe you're just exposing your body to more of the same antigen. And if you are on this IgG4 shift, I presume that just taking another shot only worsens the situation.

Commissioner Massie
So maybe one last question. I mean, there could be many more, but it's been a long night.

We started to see in the literature a lot of study around what they call "spikopathy," which means that the spike protein itself is toxic and creating all kinds of pathology. It could come from the infection with the virus, as well as the vaccine, and it could be a combination of both.

But there is a push, it seems to me, to say, "Okay, in the mRNA platform, the problem could have been the spike protein, but if we now develop other types of vaccine with other antigens, then it's going to be fine": In other words, the mRNA lipid [nano]particle platform is fine, is perfectly effective and safe. It's just maybe the spike, which was not a good idea. But now if we put something else for RSV [respiratory syncytial virus] or any other of this long list of vaccines that they want to shift—I think they want to do flu, as well—then it's going to be fine because these other potential antigens will not have the issue of the COVID because it was spike.

So what is your take on that? Is it mainly the spike that's responsible for the issues we're seeing with these type of mRNA vaccines, or is it also the platform?

Dr. William Makis
I believe it's the platform. I believe the entire lipid nanoparticle mRNA platform is problematic. And I've noticed this same kind of phenomenon in terms of blaming the spike protein of the coronavirus and actually rehabilitating the platform and saying the platform is fine. I've seen this talked about with the protein they plan to use with influenza vaccines, for example, that it's less likely to mutate and it's not like the spike protein; it's not going to cause the same problems. I believe the lipid nanoparticle mRNA platform is the problem, and the problem is that the lipid nanoparticles, when they're injected with mRNA, regardless of the mRNA, they go systemic. And I believe that it is this systemic distribution that is the source of virtually all the injuries that we're seeing—the vaccine injuries.

Now, of course, the spike protein is highly inflammatory and its expression in the various organs and the distal expression is highly problematic. But I believe that we would see similar kinds of problems with any other protein, whether it's from influenza or RSV or HIV [human immunodeficiency virus] or CMV [cytomegalovirus]. I know that all these vaccines are planned, and I believe we're going to see similar proteins because the lipid nanoparticle does not stay in the arm. There's no mechanism for it to stay in the arm. It very quickly ends up in the bloodstream, is delivered systemically, and I believe that's where you run into the problems: you're delivering this mRNA systemically, which shouldn't be delivered systemically.

Then you've got the translation of this foreign protein, and being expressed in tissues that should not be expressing this protein, causing all kinds of immune reactions and just causing immune havoc, which then leads to— You know, you've got the myocarditis, you've got the blood clots, you've got various autoimmune injuries.

[03:00:00]

And, of course, the lipid nanoparticles crossing the blood-brain barrier is a problem, crossing the placenta is a problem. This has not been addressed at all.

And I have seen a presentation by Stéphane Bancel, the CEO of Moderna, saying very clearly, "We're going to use this same exact technology in all our future vaccines. We're going to use the same production method, the same manufacturing methods." And so I believe that this entire platform, this lipid nanoparticle mRNA platform has to be shut down, has to be stopped. There have to be a lot more independent studies, or what have you, before this is ever brought back again. I believe that this platform is the problem. It's not the spike protein—it is the entire lipid nanoparticle mRNA platform.

Commissioner Massie
Thank you very much, Dr. Makis.

Shawn Buckley
Well, that being all the questions, Dr. Makis, first of all, on behalf of the National Citizens Inquiry, I want to sincerely thank you for coming and testifying. You have provided some information— And perhaps it's fortunate that your testimony got delayed. We did want to fit you in earlier, but we had scheduling problems. But you were able to share something that you couldn't have talked about until now. And I think this is going to go down as extremely important testimony, and I think a lot of people watching this are going to be really shocked by what you had to say. And so I sincerely thank you for taking the time and effort to attend at the National Citizens Inquiry and testifying with us today.

Dr. William Makis
Thank you very much for giving me the opportunity to testify.

[03:01:53]

Final Review and Approval: *Margaret Phillips, October 27, 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/