# NATIONAL CITIZENS INQUIRY

**Regina, SK** **Day 1**

**May 30, 2024**

## EVIDENCE

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**Witness 2: Dr. Jessica Rose**
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**Shawn Buckley**
Our next witness is going to be Dr. Jessica Rose, who is attending virtually. And I'll first ask, Jessica, can you hear us? Good morning, Dr. Rose, can you hear us?

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

**Shawn Buckley**
We can. We can. So that's a good start to our testimony. So, Dr. Rose, I'd like to start by just asking, do you promise to tell the truth, the whole truth and nothing but the truth?

**Dr. Jessica Rose**
I do.

**Shawn Buckley**
And can you please state your full name for the record, spelling your first and last name.

**Dr. Jessica Rose**
J-E-S-S-I-C-A R-O-S-E Jessica Rose.

**Shawn Buckley**
And I'm just going to introduce you to the commissioners. So, Commissioners, Dr. Rose is a Canadian researcher. She has a master's degree in immunology. She holds a PhD in computational biology. She has two post-doctorate degrees: one in molecular biology and the other in biochemistry. And we will be introducing her CV as Exhibit R-246.

And Dr. Rose, you testified last year in the 2023 hearings, because one of the things that you had done was analyze the VAERS data, which is the Vaccine Adverse Reporting System in the United States. We've invited you to come today to cover that topic, but also some DNA topics and some other topics. And my understanding is you've prepared a

presentation. So I'll just invite you to start into that. And I may just ask you for some clarifications along the way.

**Dr. Jessica Rose**
I will share my screen. Let me know if you can see this.

**Shawn Buckley**
We can see your screen.

**Dr. Jessica Rose**
Awesome. Okay, so this should be about 45 minutes. I'll try and keep it at that. And I am going to be covering some VAERS data as corroborations. Mostly I'm going to provide a little synopsis of the harms relating to DNA contamination. And I'm sure you just heard a lot from Kevin, who just spoke, and the associated cancer risks. And at the end I'm going to speak a little bit about GMO issues, which a case is being brought in Australia. I'll get to that at the end.

I just want to start by pointing out that if you head to the CDC's [Centre for Disease Control] website, they maintain that the modified mRNA products are not doing anything negatively with regards to DNA. Even though they've fully admitted—many, many regulatory bodies have fully admitted—to contaminating DNA being present, they're still claiming that it's not a problem. So I'm going to speak a little bit about VAERS in the beginning, just to give everybody an update of what's going on in this database, and DNA contamination from three levels that is associated with cancer. I'm also going to talk a little bit about spike which can also do this, and some corroborative evidence for VAERS. And then, like I said, I'm going to speak a little bit about an Australian federal court case going on related to GMO issues.

Before I get into VAERS, it's very important that we remind ourselves that many people are saying that many of the adverse events, or all of the adverse events, are not caused by the shots. So the way that you provide evidence of causation using epidemiological data is using the Bradford Hill criterion, and plausibility is one of these.

So what you're looking at here is a screenshot of one of the manufacturing and supply agreements between South Africa and Pfizer. And in all of these manufacturing and supply agreement contracts that I've seen, as per country, there's this purchaser acknowledgement in section 5.5 which states that the long-term effects and efficacy of the quote unquote "vaccine" are not currently known and that there may be adverse events associated with it that are not known.

So what I would like to know or ask is: Since a universally-documented acknowledgement of unpredictable potential "long-term effects" is circulating and was circulated and signed, then why is it a preposterous idea that of the millions of adverse events reported to government pharmacovigilance databases like VAERS, for example, that some of them have a causal link?

So this information, by the way, has had to be FOIA [Freedom of Information Act] requested. This wasn't freely available, as far as I am aware. So the causal harms are plausible and predictable. Kevin might have pointed out in his presentation that Moderna have filed a patent in 2018 that absolutely speaks on the dangers associated with introducing foreign

DNA into human cells, because it can result in alterations to DNA, host cell genomic DNA. So again, this is providing evidence of plausibility of causal harms.

So, VAERS, just to reiterate, is the vaccine adverse event reporting system of the United States. It was incepted in 1990 as a way to detect safety signals in data that weren't detected in premarket testing. And it's very, very important in terms of determining potential causal effects between products and adverse events. So this is a general overview of what's going on in VAERS as of recently, May 2024. And besides the 1.6 million odd adverse events reported to this database, by the way, none of these numbers quoted here include the under-reporting factor, which it's a known downside of VAERS because it's a passive reporting system. It is highly under-reported.

But more importantly, in the yellow box beside the orange box, you'll see that 25% of this total list of adverse events are considered serious. And this includes death, disability, hospitalization, life threatening illnesses, et cetera. And this percentage is 10% above the maximum normal range of serious adverse events associated with any list of adverse events in VAERS. Fifteen is the top level that you should attain for a normal set of data. So this is very high. And as I said, it does include deaths. You can also see here the numbers for myocarditis, which are highly under-reported, cancer, and miscarriages. And if you look below, you'll see these are absolute counts of all the adverse event reports filed to VAERS for the past 30 years. In blue, it's all vaccines combined.

And then in 2021, something happens, something quite anomalous. And no one's given a good explanation as to why this is happening, as per the owners of the data—yet 93% of these reports filed in 2021 were associated with COVID products. And on the right of this, you can see that this is the same pattern for death. And I can guarantee you, if you go into the WONDER system, the CDC WONDER system, you will find this pattern for any adverse event that you choose. So I decided—

**Shawn Buckley**
Dr. Rose, can I just interrupt for a sec? So there's charts at the bottom. I just want to make sure that it's perfectly clear. So we basically have very, very low levels of adverse reaction reporting, and then that bar goes off the chart. Now, this is meant to be an early warning system. Is there any other example of where adverse reactions go off the chart and the regulatory body does not withdraw the drug from the market?

**Dr. Jessica Rose**
Not that I'm aware of. A safety signal for the withdrawal of the rotavirus vaccine in 1999 was a handful of reports—and I do mean a handful. It was for intussusception, which is folding over of the bowel in children, which is very serious. But we're talking about 753,000. And again, this is underreported, so the—

**Shawn Buckley**
Well, I just wanted to follow up because that's the second time you've said underreported. Just that so people understand, this is a voluntary reporting system. And am I correct that Harvard did a study which basically concluded that it's underreported by roughly, what, 100 times?

**Dr. Jessica Rose**
Yeah. So I'm not sure that that underreporting factor applies to the COVID era, but it could. We don't actually know exactly what the underreporting factor is, but I've calculated it based on the Pfizer Phase 3 clinical trial data and their serious adverse event rate, which was 0.7%. And according to that—again, government data—the reports are underreported by 31 times. So I think it's very safe to say that you can multiply all of these numbers by 31. And if that doesn't blow your mind, I don't know what will. Because, you know, I can't do the math in my head, but 1.6 million times 31 is a lot. And as you can see, it's not comparable to the past 30 years. The average number of adverse events for all the vaccines combined for the past 30 years is about 39,000.

**Shawn Buckley**
And this is just data for a single country, United States.

**Dr. Jessica Rose**
That's right, the ones on the bottom. The ones on the top include the foreign data set. So about half of them come from the States, and half of them come from reports from around the world, from US citizens, and also people who are living outside of the United States reporting directly to the pharmaceutical companies. So, yeah.

**Shawn Buckley**
Thank you. Carry on.

**Dr. Jessica Rose**
You're welcome. So, on the right, what I decided to do—because there are a lot of people saying many things to try and debunk the idea that the COVID products are problematic—so I took a time frame of 462 days, which is just a little bit over a year, which represents kind of a flu season, and I took the COVID products and I compared them to the influenza products. There are 14 influenza products in this report and three COVID-19. So I wanted to see exactly how many more shots were actually doled out, or administered, with regard to the COVID shots. Because, yes, there were more COVID shots given out in a 462-day time frame. And this was up until and including, I think it was May 2022. Don't quote me on that exact day, but it was prior to 2023.

So there are 2.3 times more COVID shots doled out in this time frame as for flu. So I was anticipating if there isn't something fundamentally different about the COVID shots, that we would see about 2.3 times more adverse event reports. So, as you can see here with the chart on the far right, there are 118 times more reports of adverse events in the context of the COVID shots for an exact time frame. And even more alarmingly perhaps, next to this bar graph is the difference in the number of types of adverse event reports. So the adverse event reports are filed according to a measure code, which is basically like a diagnostic term for what the person is suffering from, like myocarditis, for example.

So there are 6.2 times as many types of adverse events being reported, which is really alarming. And it points to a much more systemic problem. And in my opinion, it points very clearly to an immune system dysfunction, which I've been saying for years—and I absolutely maintain this idea. So if you've heard, and I'm sure that everybody here has, that many people will pooh pooh the idea that there are far more adverse event reports being filed for the COVID shots because there were far more shots doled out, well, that's not true.

So what you're looking at here is a comparison, again, between the influenza shots in 2019—I did that to remove the bias from 2020—and the COVID shots for 2021 per million doses administered. So these are normalized plots. And you can see quite clearly on the left in yellow, that there are 25 times more reports in the context of the COVID products. And if you look at death on the right in red, there are 70 times more. So it's absolutely false that the increase in reporting is due to the number of shots being higher. It's absolutely clear in this plot. The thing about it is, this is a repeat phenomenon. Like I said before, you can basically pick and choose whatever adverse event you want. Myocarditis is a stunning 200 times higher.

And just on the subject of myocarditis, I want to point out another three Bradford Hill criteria that are satisfied just by looking at these two plots here. Now, I generated these plots as part of a paper that me and Peter McCullough and Nicholas Hulscher published in *Therapeutic Advances in Drug Safety* recently. And what these represent on the left is the Bradford Hill criterion reversibility, and on the right is dose response and specificity. So on the left, what you see are two sets of data. The blue trajectory are the new injections, as per Our World in Data. And again, this is government data, it's CDC data. And in red, you see the myocarditis reports that I pulled out of VAERS. And I superimposed these according to matched dates.

And as you can see, it's actually quite striking how they follow each other. They are covariate and they correlate. And, I mean, maybe it would be a little bit of a coincidence if all we had was an up and a down, right? But what we have is an up and a down, and an up and a down that follow each other. And the only anomaly here is this blue blip at the end, which I think represents the booster shots. And I dare say that once the backlog of data for myocarditis cases gets filled in, there's going to be a little blip there, too.

And so reversibility is when you remove the drug, you have the symptoms go away. So basically, that's what we're seeing here. The shot administration goes down, the myocarditis reporting goes down, and up and up. And on the right, we see a plot which represents all the myocarditis cases in VAERS according to age on the x-axis, and the number of reports on the y [axis] by adults. So in green, this is dose two, so, as you can see quite clearly here following dose two, there's about a three to four times higher number of adverse events being reported in 15 year-olds. And although it's not shown in this specific plot, this is primarily in boys. It's a little over 80% young boys. So this is indicative of a dose response. There's some kind of two-shot phenomenon going here, and specificity because of the young age group, and also being prevalently male. So if the shots weren't causing the myocarditis, then I don't think we would see either of these effects.

And moving back to the comparison per million doses, I want to go into cancer now, because this is going to be the subject matter of most of what I'm going to talk about now. And the pattern repeats. It's 33 times higher in the case of cancer. So again, no matter what adverse event you select, there's a signal in VAERS in the context of the shots, normalized and by absolute count.

So let's focus on cancer now. Just so that everybody knows, I love the term "cancering," which is something that Kevin McKernan says quite often. We are cancering all the time—it's absolutely true. So just for background: Just as part of normal functioning, there are about a million DNA changes per cell per day in our bodies. And we make about 6 billion base pairs, or 6 billion base pairs need to be copied every day, wherein about 120,000 mistakes are made per cell. So there's a lot going on there with regard to DNA repair.

But magically and wonderfully, because we are human beings, we have these mechanisms in place as proofreading and prevention of the outgrowth of cells that are carrying too many mutations, or that have too many double-stranded DNA breaks. It's a wonderful, balanced system which can go out of balance, for example, if you're exposed to too many epigenetic factors: like smoke, or chemicals, or radiation—or experimental injected products that induce these epigenetic changes.

So just so that everybody knows, we have this ebb and flow of beautiful mechanisms in place, most of it tied to the immune system, that keep us from being big tumours all the time. And as indicated by the Moderna patent that I showed, the foreign introduction of DNA into cells can lead to genomic damage and cancer, so there's a link here.

So let's talk about DNA contamination. First of all, I'm sorry if this is repetitive, but how did it get there? How did it get in the vials? So, as part of the manufacturing process of the modified mRNA, we have this Process 2 system. When the products were made for the clinical trials, they used something called the Process 1 system, whereby the DNA was produced using PCR. Now this is expensive and time-consuming, so what they did was they switched to an upscaling method that exploits the rapid growth and reproduction of E. Coli bacteria.

So you can simply make a circular plasmid, insert a gene of interest, like the spike gene, insert that into E. Coli, give them lots of love and warmth and shake them up a bit, and some glucose, and they double every 20 minutes. Voilà, you have tons of DNA. You linearize that plasmid, you do your in-vitro transcription reaction, and in this case, you add N1-methyl-pseudouridines—and this is important. And then hopefully at the end, once you have the final product, you use something called DNase, which is an enzyme that eats up DNA, and you remove the DNA.

But what we think happened at the end of this process is that mRNA hybrids formed. And this has a lot to do with the N1-methyl-pseudouridines, because they're stickier. They don't come apart easily at low temperatures; you need quite a high temperature. And basically what this means is because DNA has introns, these get excised and form these things called R-loops. And I'll talk a little bit more about that after. But the bottom line here is that what was supposed to be encased in the lipid nanoparticles, the fat bubbles, was modified mRNA. But what we think happened is that it carried over this DNA, hybrids potentially, and also adsorbed DNA on the outside of lipid nanoparticles. So what you're talking about is a lot of carryover of DNA.

There is DNA in the vials that have been tested. It's been reproduced in at least four labs that I'm aware of. Kevin McKernan discovered this quite by accident. He was doing an experiment that required a positive control using RNA, and he had a vial of the stuff in his freezer. And lo and behold, when he tested it, about 20% to 35% of the nucleotides were DNA. Like, this is a lot. Not only that, but the levels of DNA were above what would be considered the commercial acceptance criterion, as per the WHO and the EMA [European Medicines Agency].

So this is quite concerning. I mean, the results have been reproduced, and this is exceedingly important. And they show the presence of residual DNA in the commercial products—these are the ones that went into people—and they exceed the current EMA limits. And I'm going to get back to "current?" with the question mark at the end, because this is really important.

Now, this is also really important. Maarten Fornerod presented a presentation with the World Council for Health not long ago, and he brought up this amazing paper which shows that we don't— Oh, I'm sorry, I'm skipping ahead of myself. Sorry. Remove what I just said.

There's a lot of research examining the effect of cytosolic DNA, foreign DNA, and cancer. So this is just two examples here that you can see of papers published in 2020 and 2023 that links only having the DNA in the cytosol of the cell. This has nothing to do with the nucleus engaging the cancer pathway. In this case, there's something called the cGAS STING pathway, which Kevin might have spoken about, and this other pathway.

So I'm not going to talk too much about these papers. It's just, it's important for us to realize that we don't actually need the integration piece of evidence—even if we have it when we have it—in order to make a case, a very strong case, a documented case in the literature that the mere introduction of DNA, foreign DNA, by lipid nanoparticles—which is an extremely efficient way to deliver nucleotides into a cell—can cause cancer, or is linked to cancer. So cytosolic DNA contamination is definitely something to worry about with regards to cancer.

Now, this is the next important point: Can the DNA get to the nucleus of the cell? So it turns out that one of these gene therapy tools that's being used—and this is also published—to get things to the nucleus of a cell is called SV40 enhancer. So basically, the bottom line here is if you want to get DNA or plasmid to the nucleus, you use SV40 as a trafficker. This is known; it's published. And so basically what this means is that you can have— Well, let me tell you the punchline here.

One of the DNAs that Kevin originally discovered in sequencing was the SV40 enhancer and promoter, and you're probably all aware of this by now. And this is alarming for two main reasons. The first reason is it's not required in this system. The T7 promoter is the promoter that you use to get the gene going in this case. And another very strange thing is that the originally-disclosed plasmid map by Pfizer that you can see on the left here with mostly yellow, which does show the T7 promoter included, does not have the SV40.

And according to Kevin, I mean, he's a genomics expert, if you make these maps using some kind of application or software like SnapGene, this is one of the first things that's going to be drawn in. So you'd have to take it out in this case. Because on the right, you can see in the plasmid map that Kevin made with SnapGene, it's absolutely there. So we know that it's there. And this has also been confirmed.

So it's—it's horrific, actually, that these are in the plasmids. They're in the vials, they're part of the DNA contamination, and they have a very functional role—and they weren't disclosed in the original plasmid map. So this is—I mean, it's very suspect.

So we know that there's a type of DNA that can transport things to the nucleus of cells. So we know that the DNA can get to cells—so kind of gets into the genome. So this is the next level: Once you're inside the nucleus, does it integrate into the genome itself? So Kevin has also provided evidence in his lab that integration is occurring. So he found two evidences of this in human chromosome 9 and 12. And I don't have many details on this, and it's very preliminary, so we really, really need to reproduce these results.

But I'll just let you know that there are genes that are associated with very important mechanisms as per human cells, like antiapoptotic mechanisms of neurons in chromosome 12—one of them is called FAME2—that if they were disturbed or dysregulated, this would be very bad. It would represent an imbalance that would probably lead to pathology.

So I have a little squiggly line beside the check mark for intergenomic, because we definitely need more evidence of this. But just to get back to what I've already said: We don't actually need this evidence, because we already know that cytosolic presence of DNA can cause cancer. But I want to hammer this point home, because if we do actually have DNA integration events occurring, this leads to oncogenic activity. This is well known. This is why we test for residual DNA in things before we put them into animals or humans. So the potential for disruption of the tumour suppressor gene p53, which is the guardian of the genome, is of great interest.

I'm sure Kevin spoke about this, that there's a lot of new information about the interaction between p53 and SV40 itself, and these other two elements: the mutation of a dominant proto-oncogene to an oncogene can occur, or the introduction of a dominant oncogene. So if you have an integration of a small piece of DNA into a gene that's really important, and that gene gets disrupted, this can be very bad—and it can help lead to cancer. You need a whole bunch of mutations for an actual outgrowth to occur, an overproliferation to exist, and a tumour to form, for example. But all of these hits coming from so many places, it absolutely raises red flags with regard to cancer.

So this p53 is exceptionally important with regard to giving the self-destruct signal to cells. It's just one of the things that's really important as a role in—like, it also aids in as part of the cell cycle. So let's just say a cell has too many mutations, or it has too many double-stranded DNA breaks that can't be repaired, p53 will come along and say, "Hey," and it will signal that cell to implode, basically. So that's one of the mechanisms by which it's very importantly preventing tumours from forming, or outgrowths of cells. It's just one example.

And I want to get back to this R-loop thing that I mentioned before with these hybrids, because I think this is really important. So we have this going on in our bodies. This isn't something unique to what I'm talking about here, with these modified mRNA products. We have hybrids in our bodies all the time. We have R-loop formation. But like everything, there's a balance. There's a give and take. There are factors that come into play that remove these, such that they don't accumulate. And so the problem becomes, or the problem that I see, that I anticipate, is that because you're bombarding the cell that gets transfected via this lipid nanoparticle with all of these foreign nucleotides—DNA, mRNA, hybrids, R-loops—the cell doesn't know what to do. And this is just normal.

So I don't have a great analogy in the top of my head, but if you imbalance a system, the system's either going to be able to right itself or it won't. In the case of cells and tissues, you're going to have associated pathologies if the systems can't get counterbalanced. So R-loops are actually really potent inducers of DNA damage, and roadblocks to DNA repair. This is known. All of these things are documented in literature already. And there's a pathway that leads to cancer here, too.

And interestingly enough, these R-loop diseases, this accumulation of R-loops, is also associated with neurological disorders and autoimmune diseases. Which, if you're paying any attention to the adverse event-types of reports that are being filed to pharmacovigilance databases, or even what your friends or family are saying, this rings bells. So I wonder how much of a role these are actually playing.

So this is a little side dish that I started talking about by mistake at the beginning there, that spike itself can induce cancer. So we're moving away from DNA now and we're talking about spike protein. So this is the paper that Maarten Fornerod brought up in a presentation recently, and it shows that the spike protein itself can bind to estrogen

receptors. And what they showed in one of their brilliant experiments is that it caused proliferation in breast cancer cell line called MCF-7.

This is very concerning, absolutely concerning, because it might— Say you already have breast cancer, or you have a mutation in your BRCA gene and you have a predisposition. The spike protein can bind to your estrogen receptors, and perhaps it can have an effect on the proliferative ability of your cells, the cancer cells that you have. It's just, we don't have a direct line to this yet, but this paper suggests that we should absolutely be paying attention to this possibility. And it could actually explain the breast cancer uptick in VAERS, or at least partially—and also in observational data.

So I want to go on a little bit of a tangent now, because in my previous testimony I talked a lot about amyloids. I talked a lot about this proteinaceous buildup that's very hard to break down. Basically, it's impossible to break down by proteases. So in my research about estrogen receptors, when I was reading this paper I just brought up that Maarten brought up, I learned a lot of really interesting things about these guys.

So they primarily bind estradiol, which is a hormone that's circulating in order to affect. And once they bind estradiol, they undergo a conformational change, like a shape change, in order to accommodate something called "dimerization." So that's when two of them come together to form a new entity, and then they can affect their actual function, which is to bind to specific DNAs. So they don't just bind any DNA, these are very special genes, sections of DNA that they can bind. And one of them is collagenase.

So everyone knows what collagen is. Collagen is this thing that's very, very important to wound healing. And "ase" is the suffix that you add to something, like an enzyme that breaks up something. So this is something that breaks up collagen—very important for effective wound healing. If you don't have collagen, then you don't have effective wound healing, effectively.

So this is just an hypothesis. I'm not saying this is happening. It's just that I'm a scientist and I like asking questions, and sometimes they're even a little out to lunch. But I think that this has merit. The modus operandis of the Pfizer and Moderna products is for the lipid particles carrying the modified mRNA to get dumped into the cell, the modified mRNA binds itself to the machines that make proteins, which are called ribosomes, and these are translated into proteins.

And so let's just say that we're getting full-length spike, because that was what was supposed to happen. I don't think that's happening, but let's assume we're getting, you know, the large version of the spike. If the spike, according to this paper, combined the estrogen receptor, then I think it's plausible that it will prevent the dimerization. For some reason it'll interfere with the conformational changes that have to happen in order for the dimerization to occur, and therefore that prevents the activation of these essential genes, like collagenase.

And it begs the question: If we have this happening in this competitive binding kind of way, maybe this is explaining these collagenous obstructions—these proteinaceous things that people are saying that they're finding in cadavers. It's just an idea, but it's something I found very interesting and plausible.

So now we're onto corroborative evidence from VAERS after all that. So this is a chart that shows all the breast cancer adverse event reports from VAERS for all the vaccines combined for 2018, 2019 and 2020. And for the COVID products for 2021, 2022, 2023. So

there are two things here that are notable: One is the change from 2020 to 2021—this is per 100,000 adverse events total, by the way, per year. So you see more than three times increase in reporting for 100,000 AEs.

But even more concerning is the escalation. So this is one of the things that is mind-boggling about—like, how are the owners of the data not making these charts and asking the question: "Okay, why is there an uptick?" in coming up with a rational explanation if it's not, you know, "Breast cancer cases are going up because of the shots," for example. And on the right is the exact same idea, except with only the modified mRNA COVID-19 products. So you can see the trend is exactly the same. They're highly implicated, is the bottom line. So the breast cancer signal itself is getting stronger.

Now I want to go back to an important reminder about the EMA limits. For many of the people who measured the DNA, they were exceeding the set limits, which are—they're kind of, I'm not sure—Kevin can explain this better—but I'm not sure they're based on anything solid. I'll just put it that way. But more importantly than that, the limits were designed based on naked DNA. So we're not dealing with naked DNA here. We're dealing with DNA wrapped in a fat bubble that very efficiently delivers these things to cells. So this is a completely different way to introduce DNA to cells. So we need those limits to be looked at again. They're certainly lower—the amounts that should be "allowable," let's say, quote unquote.

The regulators know, like I mentioned before—I think I mentioned it before—about the SV40 in particular. And they're persisting in underplaying the real dangers associated here, especially in the context of cancer and genomic alterations. October 19th and November 1st, Health Canada and EMA confirmed the presence of this SV40. And by the way, this was all learned about by the hard work and diligence of many independent journalists and scientists who are doing FOIA requests. A lot of thanks to them. The FDA knows this as well. And these regulators haven't really acted, and we know that they haven't acted because we've read the emails that they were writing to each other by FOIA request.

And more recently, thanks to Noé Chartier, we've learned that Health Canada won't say if they asked Pfizer to remove the SV40 sequence in the COVID shot. So this kind of comes down to something that sounds like: "We don't have to tell you." And it's like, again, I think they're missing the point. There might be a real concern here. And if there is, we need to find out so that we can help people.

Our data, the DNA data from Canada, David Speicher tested 27 vials that were a Pfizer and Moderna product that were delivered in Canada exclusively. We wrote up a preprint, a paper that is up on the OSF [Open Science Framework] preprints online. And this has sparked the interest of many people who absolutely know what we're saying and what the dangers associated are, including the Surgeon General of Florida, Joseph Ladapo. And he actually used this data to call for a halt or a moratorium on the modified mRNA products until we know more, which is prudent. The precautionary principle is very much being ignored.

**Shawn Buckley**
And Dr. Rose, can I just clarify that point? Because some of the people watching may not understand that Joseph Ladapo is the Surgeon General for the State of Florida. So we have the Surgeon General of the State of Florida who ceases all COVID-19 vaccination based primarily on the evidence brought forward of significant DNA contamination. Is that correct?

**Dr. Jessica Rose**
That is correct.

**Shawn Buckley**
Okay, thank you. Some people may not know who he is. And here in Canada, we're still pushing the shots. And basically you're telling us Health Canada isn't even telling us whether they've asked Pfizer to remove SV40, which is a known toxic element, let alone remove them from the market when a state like Florida has ceased all vaccination.

**Dr. Jessica Rose**
Yeah. They're also claiming that it's not functional. It has no functional aspect, which is so wrong. You know, it's a nuclear localization sequence. It's known. It's absolutely bonkers to say something like that. Besides the fact that it has no role. It has no purpose to be in the shots. None. It doesn't have a—you know, anyway, I already talked about that. But yeah, you are correct. Surgeon General is a pretty high ranking position.

So very recently, one of the people who confirmed Kevin's original work, Brigitte König and her colleague, Jürgen Kirchner, published their own findings in *Methods and Protocols*. This is very recent. And so basically, as Kevin stated, we're not dealing with a debate as to whether or not the shots are contaminated with DNA. We know that they are. We have tested enough files to know that this is a fact. What we're debating now is how contaminated they are. And we need to start testing people's cells, in my opinion. I really believe that this is important—especially germline cells.

I think recalls are in order, just like Ladapo said. I've been saying this for quite a while now. And in case people aren't aware, the Vaxzevria product from AstraZeneca, their COVID-19 product, was recently recalled. They're claiming, and Reuters will claim that, you know, it's because people aren't taking them anymore, because they already had them, or something like this. But if you've been paying attention at all to the adverse event association with these particular shots and also the Janssen shots, you'll know that there's an association with TTP and other types of clotting. So, like, technically I wrote an article on this. It's not common for a vaccine or a product to be recalled. And this statement here that you see on the right is actually a quote from CDC.

So normally, how it works, I guess, is they find a physical-related contaminant, like maybe the vial has metal in it, or— And by the way, this happened in Japan. They actually found steel in some of the vials, and they recalled millions of a certain batch in Japan. I think two men died. But I want to make a point here about the Pfizer and Moderna products, because I don't know of any collection of data or a study that was done on how many of the vials that came to the administrators that went into bodies were cloudy versus clear. And I still don't really have a solid answer as to whether it's supposed to be perfectly clear or a little bit opaque. I think it's supposed to be a little tiny bit opaque, but I don't know.

The reason I'm curious about this is because this is their first criteria. There's signs of a contamination. So tens of thousands of shots went into arms, according to VAERS data, of outdated products. And if the product is outdated, it could mean that it wasn't refrigerated properly, you know, blah, blah, blah—it wasn't handled properly. So it's possible that the lipid nanoparticles, you know, they changed shape, morphology, or they degraded and this

might actually have leant to a suspension that was more cloudy. So I'm very curious as to: If we actually had done that, what would have been the results?

But counter to what they're saying here, we don't need to actually see physically with our eyes product contamination. Because the second step is to go to VAERS and see if anyone's been hurt, which seems kind of backwards to me. But that's how they do it. Because the signal is so strong in VAERS, in the context of these products. So I think recalls are definitely in order for these modified mRNA shots. They do happen. We don't know if they'll happen with these, but hope springs eternal.

So going back to the plot that I generated for breast cancer, this is the exact same idea, but for cancer, just general cancer. You can see the measure codes and the keywords that I used to pull out the cancer reports. And it's exactly the same story, except for the shift from 2020 to 2021. So basically it's stable 2018, 2019, 2020 for all vaccines combined—and then this is per hundred thousand on first-event totals per year—and then you have a little bit of an uptick in 2021. But the bad part is here: the bad news is that there's an escalation. And again, it's the same thing when you look only at the modified mRNA products, so the cancer signal is getting stronger.

And this is the last part of my testimony today, and it's very important. We owe—I mean we as a species—owe a huge debt of gratitude to Julian Gillespie, who's the guy on the left here; he's speaking to John Campbell. There's a video that everybody needs to go watch on YouTube of his conversation with John Campbell. He's explaining all about what he's doing. So he's very, very prominent in an Australian federal court case that is providing evidence that claims that all the COVID-19 shots are GMOs—genetically modified organisms.

In case people don't know here—I actually didn't know this until recently—the AstraZeneca product, the one that I just told you got pulled, and the Janssen products are actually officially classified as GMOs because they use the adenovirus as a vector. So they did the right thing here, the AstraZeneca people. They went and got a GMO license because they have a GMO product. If it turns out at the end of the day here that Pfizer/Moderna fulfilled GMO requirements, since they failed to get the GMO licenses, they're going to be in a lot of trouble—which wouldn't be the first time. But this is very serious if this is actually the end point.

By the way, the case had been brought under the Australian Gene Technology Act 2000, Section 10. So the Section 10 of Gene Technology Act defines what a genetically modified organism is, and it's the following. So I highlighted in red the main things that you should have your attention called to: "altered," "manipulation," "modifying." These are all basically the same word "of DNA." You can also have an alteration by deleting or adding "genetic material"—genetic material, okay, keep that in mind.

So the question is: Are the modified mRNA products GMOs? So when I started thinking about this— By the way, everybody watch that video, it's brilliant. Julian's a lawyer, but he describes biochemistry in a way that is kind of supernatural. So there are two issues here with respect to GMOs: there's the products and the people. And it's important to bear in the back of your mind whether or not the gene expression is transient or stable. And I'll get back to that.

So the products themselves have—I'm sure you've heard this before; I think I might have spoken to this in my last testimony—they have modified mRNA. The uracils were swapped out for N1-methyl-pseudouridines, okay? That's a fact. Everybody knows that. So my

question is: Doesn't this qualify as both a deletion and an addition of genetic material, which is one of the criteria for a GMO? Just a question.

More importantly: the people. So all of the DNA that was used in these products for all the manufacturers was codon optimized. What that means is that the sequence of DNA was changed, the proteins were not. So you mix and match these things called codons, and these are sets of three nucleotides, bases. And you do this, it's called codon optimization because you want to optimize the amount of protein that is being produced in the domain of interest. And in this case, the domain is us, the humans.

So you want to codon optimize, you want to select the codons that the humans like to use according to these things called transfer RNAs, et cetera. I'm not going to get into that now, but all you need to know here is that when you codon optimize a DNA, you are changing the nucleotides. You're changing the codons. You're not changing the protein. You're not changing the amino acids. You're just swapping out these little triplicates, these little triplets of bases. And when you do that in one domain and you transfer it to a new domain, the human, this is called heterologous expression.

So, again, I believe this satisfies the definition of a GMO. Anyone can challenge me on this. But I thought about this a lot, and it seems to me that it absolutely means that the manipulation of the DNA during the codon optimization qualifies these things as GMOs. There is altered DNA: The in-vitro transcription modified mRNA products are transfected into human domains—organisms—and therefore, I would argue, the answer to both of the questions I asked, especially since we have evidence of stable gene expression integration.

So I want to remind everyone here, you know, we cannot even talk about DNA. This is published, that the modified mRNA itself can reverse transcribe to DNA using an endogenous retrotransposon called LINE-1. So we carry these reverse transcriptases. We're about 8% retrovirus—I don't know if you know that, but it's true. And so this can be used in order to reverse transcribe the modified mRNA back to DNA, *which means* that it can potentially integrate, *which means* it can be stably expressed, *which means* or explains probably why a lot of people are still showing signs of spike protein a long time after being injected.

These papers that I have in the footnotes here are very important to read. This is the Aldén paper. The Zhang paper shows integration. These are cultured human cells. So again, we need to keep doing experiments. And the Domazet paper that you see here, published in *Genes*, is also a must read. He says in the abstract, "I conclude that it is unfounded to a-priori assume that mRNA-based therapeutics do not impact genomes," and I absolutely agree with this guy on this point, as do a lot of my colleagues. So it could integrate into the genome already, this DNA, without the contaminant DNA, and make expression stable.

So the Australian federal court case is ongoing, and if it's decided— Oh, by the way, yeah, it's like a tennis match. You know, Julian's working really hard to keep this going, and he's not going to give up, which means he's going to succeed, in my opinion. So if the judge decides that the Pfizer and Moderna products fulfill the GMO requirements, then since they both failed to obtain GMO licenses, this is a serious criminal offence. So they will probably have to face massive fines, which, again, won't be the first time.

But it's also horrific from the point of view of the people. Because, as you know, the first slide showed that the contract stated that there were potentially serious adverse events that were unknown. And if the leader of a country who signs that contract with Pfizer read

that passage and didn't make that knowledge available to the people that were being mandated to take them—you see where I'm going with this.

So this is my last slide. I think it's really important to focus on definitions and adopt them accordingly, especially pertaining to the DNA thresholds, because the limits aren't set properly now. So they can claim that, "No, no, no, the limits that they're detecting fall under our EMA limits," but they're the wrong limits. They're based on naked DNA. So they need to be reset according to this brand new technology that we're talking about. We need to get with the program. They need to get with the program. They need to update their books. They need to update their brains. Like, this is something brand new that we're talking about. We can't fall behind because our genomes are at stake, quite frankly.

Also for GMOs, I mean, we are embarking on the era of gene therapy, quite frankly. If we're not there now, we're going to be soon. So we need to define a GMO. We need to decide whether or not these modified mRNA things that are codon optimized are GMOs. And maybe we need to just change the name to, like, genetically modified domains. I'm not sure, GMDs. And, you know, I'm sure that there's going to be debate about what an organism is. And the counter argument would be, well, these are absolutely not GMOs because we're not going from an organism to an organism. But I mean, some people believe that viruses are organisms. I've always kind of felt that they were genetic material wrapped in protein-protective bubble. So anyway, that's up for debate, but we need to decide on these things, and we need to do it fast.

So I think eventually the CDC, like the other points that they had on their website that they had to take down, will take down this particular point once more information comes to light and the actual data isn't suppressed the way that it's being suppressed. And where we go from here is the same direction that I've been saying for quite a while. We need a moratorium on these products. The platform, the lipid nanoparticles are as insidious as the rest of it. We need to help the injured. We're working really hard to just acknowledge them, to prevent them from being gaslit, so that we can actually say, "Yes, this was caused by the shots. And here, we have a way to help you." Hold all responsible accountable. So hopefully Julian will succeed. And hold on very firmly to personal sovereignty and national sovereignty.

Because if another "pandemic," quote unquote, is declared and "pandemic preparedness measures" are put into place again, who knows what the next product is going to be that we will "have to take" for the "greater good." These are all in air quotes for people who are just listening. And that's all I have to say.

**Shawn Buckley**
That was quite something. So just following up on some of the things that you've said, you indicated that there's evidence that the spike expression is ongoing. Am I correct?

**Dr. Jessica Rose**
Yes.

**Shawn Buckley**
That you mean by that, our bodies seem to be still making spike protein long after vaccination?

**Dr. Jessica Rose**
That's right. So the claim was always that this is only mRNA. It's transient. It's absolutely not going to last more than a certain amount of time. You don't have to worry about, like, DNA. Everything that they said as fact has been proven wrong. And it goes back to this plausibility. Like, we've known about LINE-1. We know that this can be used as a reverse transcriptase to take mRNA back to DNA. So it's just an example. So it's absolutely not true. I can't quote the papers off the top of my head like Peter McCullough can, but there are a number of papers that indicate that the spike protein is absolutely found to be present after 60 days in the germinal centers of lymph nodes—I think it's over a year. There are a number of examples of papers in the literature right now that clearly indicate that the spike protein is continually being produced.

**Shawn Buckley**
And am I correct—and I expect you've read these papers—that the papers don't say, "Oh, but it ends after a certain point," it's just they stopped measuring at a certain point. We don't really know how long spike proteins will be expressed. And am I also correct?

**Dr. Jessica Rose**
That's correct.

**Shawn Buckley**
Okay. And I'm also correct that spike protein is one of the most toxic substances that we're aware of?

**Dr. Jessica Rose**
Well, it seems to cause hemagglutination, which is when your red blood cells stick together. And what is it that we're hearing a lot of reporting on? Clotting? What happens is, and this is published as well, the spike protein and potentially the lipid nanoparticles themselves lower the zeta potential, which is the forces that repel red blood cells naturally in the blood. So you don't want red blood cells sticking to each other all the time, because you're just going to have sticky clumpy blood, right?

So they have these repulsive forces that keep them away from each other. They have zeta potential. So what the spike protein does once it gets into the blood, is it gets in between these two guys and it kind of brings them together, and so it creates kind of like a velcro effect. So this is just one example of how it's destructive. Now, if cells of the lining of the blood vessels get transfected and massive amounts of spike protein are being made, then naturally, due to just the immune system doing what it does, those little bits of the spike protein are going to get eaten up and mounted on these molecules called MHC molecules, which are basically little flags on the surface of the cells that tag them for destruction by the immune system, by the T-cells and B-cells.

So, yeah, cytotoxic T-cells come along and kill those cells. And if you have that happening in your blood vessels or in a concentrated area in your blood vessels, you're going to have inflammation. You can have inflammatory mediators—like chemokines are going to tell everyone to go to that site. And you're going to have a whole bunch of other problems. There's other indications that the clotting pathway is impaired. So there are a lot of

indications, and these are published, that the spike protein itself is very dangerous, but it doesn't stop at spike. The lipid nanoparticles are horrific. The cationic lipids are highly, highly toxic.

**Shawn Buckley**
Yeah. No, I was thinking as you were doing the presentation: So it seems that this RNA that makes the spike protein is being incorporated into our permanent genetic genome, and these cells keep making the spike protein with no off switch.

**Dr. Jessica Rose**
Yeah. Reverse—

**Shawn Buckley**
Oh, sorry.

**Dr. Jessica Rose**
No, go ahead.

**Shawn Buckley**
I mean, one of your slides is we might be at the edge of a genetic precipice, which is quite alarming. So basically you're communicating: We are altering our basic genetic makeup, and that's one of the reasons why we need to stop this until we understand it better?

**Dr. Jessica Rose**
We could be. And even if there's a remote possibility of polluting germline cells—sperm cells, eggs, whatever, or even stem cells—we need to stop. Like, the moment the regulators learned that there was DNA contamination in vials, there should have been an immediate recall, because of the potential. It's just potential, but the thing is, because this is being hidden and blown off and undermined as a problem, we're not doing what we should be doing as follow up—i.e., testing people's cells. Because maybe there's no integration to worry about. Maybe the stem cells are fine. Maybe the germline cells are fine—but maybe they're not. So we need to find out. And there are going to be flags, right? Certain people do have adverse event profiles that are way more serious than others. I mean, I don't know what the actual percentage is, but most people who got injected are not suffering symptoms or adverse events.

**Shawn Buckley**
Right. Before I turn you over to the commissioners for questions: Your evidence raised an interesting legal point when you started talking about GMOs. Because let's say we have a GMO crop in one field and the adjacent field is a regular crop, but the pollen blows over from the GMO crop, and so the regular crop becomes genetically modified with no action on behalf of the other farmer. The owner of that genetic modification has now a property interest in the genetically modified organism. And the same logic would apply to humans.

So you just got me thinking as a lawyer that, going forward, we're going to have some very interesting intellectual property law cases if our genome is affected. Because if, let's say,

Pfizer or Moderna has the patent to the spike protein RNA and it's incorporated in the human body permanently, there's a property interest. So you've just raised an interesting legal question for us, but I'll turn you over to the commissioners for questions.

**Commissioner Kaikkonen**
Thank you, Dr. Rose. My question has to do with research around infants and whether that research in infant deaths, if there was a particular spike in infant deaths in a particular area, could it be related back to the vaccine? I know that when we think of myocarditis and we think of how it's affected young males, that research is evident and I think it's substantial and significant. But has there been any research that has been done for infants, particularly infants that are still in the breastfeeding stage with vaccinated mothers?

**Dr. Jessica Rose**
Yes. Well, there are published papers that provide evidence of the transfer of the byproducts of the injections from mothers to infants via breast milk. And, wow, it's been a long time since I presented this data, but I can tell you way back when, there were 17 reports of babies, infants, that had very serious adverse events, very soon after feeding—and what I mean by that is like the induction of a febrile seizure.

So when you think about causation, when you think about, like, "Okay, did my baby just have a febrile seizure?"—and I mean like less than six months when they can't hold up their neck, and if you're having that kind of seizure, it can damage you for life. It's very serious. When that happens within moments of an exposure—and again, this is in the literature, the name is Hannah et al., I believe; my memory is not good for the names—I mean, as a mother you would think, "Okay, this happened moments after I breastfed my kid, it's related."

So there are testimonies in VAERS. We have this column of data called Symptom Text, which is basically where the reporter does the doctor's notes thing. So you find out a lot of information about who the experiencer of the adverse event is and exactly what happened to them. So you have mothers being quoted as saying, "I know that this happened because of what's in my breast milk," in 17 cases. And that might not sound like a lot, but when you're talking about infants and you're talking about shedding, essentially, this is very serious.

So, yeah, there are connections. There are absolutely connections. I always listen to the direct testimonies of people, and I know this has also been blown off as anecdotal evidence, but it's not when it's millions. And maybe it's not millions for this particular subject matter with the babies and fetuses, but it's an outlier, let's say. It's anomalous.

**Commissioner Kaikkonen**
Thank you.

**Commissioner Drysdale**
Good morning, Dr. Rose. Thank you very much. It's good to see you again. Can you go back to your general harm slide? I think it was your 2nd or 3rd, 2nd slide, 3rd slide?

**Dr. Jessica Rose**
Sure. Sorry, I'm just—

**Commissioner Drysdale**
That's fine. On that slide, you had a number of coloured boxes and they displayed the number of cancer cases and the number of deaths and the number of pericarditis and a number of other things on there. Is that correct?

**Dr. Jessica Rose**
Yeah. Here, I'm going back to it as we speak. Zoom is so neat. Can you see it?

**Commissioner Drysdale**
We can. Thank you. And my question is this: I see there's 38,559 deaths and so many miscarriages and cancers. Is a miscarriage not a death?

**Dr. Jessica Rose**
It is.

**Commissioner Drysdale**
How many of those 14,225 cancer patients died of that cancer?

**Dr. Jessica Rose**
Exactly. So, oh gosh, I had a statistic on this and I don't remember. Oh, I think it's 13%, but please don't quote me on that. I'm not saying this is the truth. I really just don't remember. But yes, there are a proportion of people, of those cancer reports, that have died. Myocarditis is the same thing. Now I want to make a point here, though. If you file a VAERS report, say for myocarditis, and the person ends up dying, then a family member or the doctor, even if they try to make a follow-up report to say that the person is now deceased, it's very unlikely that that will ever get to the front end system of VAERS. So the number of deaths associated with any primary reported adverse event is "really" underreported. But I can still see a signal.

**Commissioner Drysdale**
Well, of course. There's so many questions I have based not only on what you said, but what we've heard in other testimonies. I mean, we heard in testimonies from doctors in Canada that they were not only discouraged from reporting to our reporting system, but some were fired from their positions for having done it. And we also heard from paramedics who had people coming into the emerge after vaccination saying they had an adverse reaction, but the medical system saying, "No, no, no, it's not related." So having said all of that and listening to what you said about that VAERS is meant to be a safety signal. In other words, VAERS or CAEFISS in Canada has never been intended to be counting all of the deaths. It's like the fire alarm in your house. You know, when the fire alarm goes off, you're supposed to take action.

**Dr. Jessica Rose**
That's right.

**Commissioner Drysdale**
And when I see the graphs and the charts that you've shown in a whole bunch of different regions, certainly the fire alarm has gone off. Do you have any explanation as to why we haven't taken any action?

**Dr. Jessica Rose**
Because it would put a damper on the program. I think that—this is just my opinion now—I think that the COVID modified mRNA shots were the segue for the almost extensive and solo use of this lipid nanoparticle modified mRNA platform. And so if it's admitted that these harms are real, then people—they would start questioning the platform and then the entire program. And I do think it's a program that is fully, intentionally going to be rolled out. I mean, we're seeing it already, aren't we? Like they're designing an H1N1 vaccine based on it. They already did it. They already made a modified mRNA LNP-based flu vaccine, or whatever you want to call it. They're already doing it. So it's not even that it's my opinion. It's happening.

So I guess the opinion part is that was the intention. And so it would put a damper on the progression of that plan to make everything "plug and play." So if they admitted that there was a problem with the plug and play—the, "You know, we can just swap out whatever we want here for, you know, and stuff it in a fat bubble, it's no problem"—it's just they can't have that. They definitely can't have people saying that the lipid nanoparticle itself is toxic, which it is. It has a long documented toxicity profile, the cationic lipid specifically. So, yeah.

**Commissioner Drysdale**
Well, you know, before we go on to the next question, I don't want to leave that point just yet. Because what I have seen in the press—and, you know, you try not to take press verbatim—but my understanding is that they're talking about an mRNA-based cure for cancer, an mRNA-based cure for all kinds of things. So we're not just talking about flu shots, we're not just talking about COVID shots, we're talking about a shot for whatever ails you. And that market is unimaginably large. So is that what you're saying is the motivation here—this unimaginably large universal market that is the potential?

**Dr. Jessica Rose**
Yeah, and that also kind of explains the mandates too, in a weird way. So, yeah, there is an mRNA product for cancer right now. And there are also claims—which is kind of ironic and I shouldn't laugh, because it's not funny—that the cancers that are probably in all likelihood—I would bet money on it if I was a betting woman—caused by the shots, the modified mRNA shots, are going to be cured by modified LNP technology. I mean, it couldn't get more ridiculous if you ask me. Which is another reason why they can't admit that, "Houston, we have a problem." We have a serious problem. And you can't fix it with the problem itself. That's ridiculous.

**Commissioner Drysdale**
Okay, Dr. Rose, I have another question, and that has to do with: You were talking about how these spike proteins and other different things affect the cells. And both you and the

previous witness were talking about foreign DNA or foreign contamination in these vaccines, causing trouble. But let's just say for the matter of argument that there was no foreign contamination in these vaccines. Do we know how they would have performed even without contamination? And do we know what effects they would have had on our bodies even if the contamination wasn't there?

**Dr. Jessica Rose**
Excellent point. So in the frame shifting study that came out in *Nature* recently, I mean, you're exactly right. We don't even need to talk about DNA. Like I said, there's so many directions that you can come from that provide evidence of why we're seeing particular harms. So because of codon optimization, and because they swapped out the uracils for N1-methyl-pseudouridines, what this paper showed—and this is *Nature*, this is the godspeak of science—that these N1-methyl-pseudouridines in particular—and let me make a point here—in the sequence of the spike, they had swapped out all the uracils. There were 801 substitutions—all of them. They didn't swap out some, they swapped out all of them: 801 new pseudouridines, N1s. And what that does is it caused slippage, let's say, okay?

And when you're talking about— So codons are sets of three bases that are read as a unit, and they translate into an amino acid. So if you have sets of threes in a row, each of them represents an amino acid. If you slip out a frame, then those codons aren't being read properly and the translation will be incorrect then. And the bottom line is that you end up getting proteins being translated that are so-called off-target. They're not desired, in all likelihood. And even more importantly, they're probably misfolded. And a misfolded protein could teach another protein to misfold. It can cause all sorts of horrendous damages.

So again, they kind of slip and slided around this being a problem. And, oh, yes, we can fix it by doing this and this and— But the thing is, it's another thing that could have been anticipated, in my opinion. These are smart people we're dealing with who are designing these technologies. I mean, it is kind of brilliant from a biological point of view, and a gene therapy point of view, and a biotech point of view, what they're doing. But these things should never have been put into humans—at all. I really, I will never stop saying that.

It's a gorgeous thing to do on a bench. Don't put it into humans, no. Because even if you have a really excellent idea, you're 99% sure that it's going to work this way, when you put it into a human, it's completely unpredictable. You cannot predict what's going to happen in the human body, especially considering the fact that we have all these other things going on.

I mean, not to get too off topic because it's on topic, but we're constantly being bombarded with epigenetic things, like things that might be inducing mutations: pollution, crap in our food, in our water, smoking, all these things that are already causing problems and ensuring that our bodies have to summon these mechanisms to balance all these things. All of a sudden now we're introducing this weird, horribly large amount of foreign genetic material. And I mean, I just, it boggles my mind. It boggles my mind that this was done. I'm, I don't really have any—

Yeah, to answer your question, we don't need to talk about DNA for all these other potential issues to have caused harm. I mean, any cell that gets transfected is flagged for destruction. So if you have this happening in the blood vessels, it was doomed to fail. I just, I don't believe in the platform and I don't believe at all in the plug and playness of it, not at all. I think it was always going to be dangerous.

**Commissioner Drysdale**
Now you partially answered my next question during your presentation, but I just want to make sure I understand it carefully. Now, my understanding is that we're finding spike proteins and the effects of these vaccines in pretty much all over the body. I heard a testimony about it in the brain and the testicles and the ovaries, in the heart muscle. I've heard it in everywhere. And just about every person who testified on this said they were finding it everywhere in the body. Now, you testified a little earlier today that there's some evidence that this gets transmitted from the mother to the child through breast milk. Is that the only transmission vector? Like if I haven't taken the injection and I'm sitting next to someone who has, or I'm with my wife who has, or my husband who has, has anybody studied whether or not this transmits through other methods from a vaccinated person to an unvaccinated person?

**Dr. Jessica Rose**
So I'm a little ignorant on the shedding topic, but I can tell you that Pierre Kory has delved into this. He's an ICU specialist, and he's been on the front lines of trying to discover what the hell's been going on for the past few years, pardon my language. And he's done a lot of work on this, and he says it's absolutely a real thing. So any body fluid where you might have proteins or even lipid nanoparticles being carried: breast milk, sorry to be graphic, but semen, blood. Any kind of bodily fluid is suspect in— I will just say suspect for now.

So it really raises a serious issue about blood transfusions. If you have spike being continuously produced in somebody, let's just say—you know, you have continued expression—and that person gives blood, is the person who's receiving the blood receiving a dose of spike? And what are the effects of that going to be? Are they getting something other than spike? I mean, there are a whole bunch of questions that we can ask that need to be answered.

But herein lies the problem again. Because there's so much suppression, because there's absolutely no way these shots are harmful in the eyes of the safe-and-effective people, we're not doing these necessary studies that I'm aware of. There's also Marian Laderoute who's going to present some solid evidence of shedding today, I believe—or maybe not today, but in the next few days. So she's the best one to answer this question.

But I've been pondering this for a long time, and I have no reason to think that it wouldn't be obvious that shedding wouldn't be an issue, because we're shedding proteins all the time. It's just whether or not those proteins are going to have some kind of pathophysiological effect. That would be the question I would want to answer. And, I mean, from what I told you—the transfer of breast milk to the baby, baby has a febrile seizure—it seems like the answer is, yes. But we don't know the exact mechanism of action yet. So, yeah, we need to be allowed to ask the questions and do the studies. That's it.

**Commissioner Drysdale**
Well, you know, you had another slide that you showed with regard to incidence of cancer. And you showed it going up. It didn't go up that much in 2020, and it went up more in 2021 and 2022, and it's even gone up more in 2023. But the vaccine injection numbers have been going down at the same time. Do you suggest that, or are you suggesting, or can you suggest that there is a latent effect from these vaccines that is continuing to cause cancers?

**Dr. Jessica Rose**
Yes, that's what I would suggest. And there are so many different types of cancers, right? And the cancer reports in VAERS, I noticed a long time ago, it was two years ago now at least, that there were a lot of rare cancers being reported: breast cancers in males, acute lymphocytic leukemia in grownups, which is a childhood leukemia—the average age of the people reporting was 50. So there are these weird cancers. And if you listen to what oncologists are saying, you're hearing them say a lot of their patients who are in remission are coming out of remission.

And I don't know enough about cancer—I don't know if anybody does, actually—to say why it takes someone longer to progress to a massive tumour than another person. It has to do with a lot of factors, right?—your genetics, your diet, your environment, your all these things. So I would definitely say there's a period of latency.

**Commissioner Drysdale**
You know, you're a scientist, and what we've always heard through the last three years is, "Follow the science, follow the science." But I'm an engineer. That means I'm in a practical science, and I was always taught that "follow the science" meant question. You're supposed to question. You're supposed to discuss. You're supposed to debate. That's science. How did we get to a point where we were told that this is the way it is? We had someone, as a matter of fact, very famously saying "they" were the science. How did—I mean, and I know this is not in your presentation, but you're in this community—how did this happen? How did we pervert the very fundamentals of science?

**Dr. Jessica Rose**
That's a complicated question. Manipulation of people following appointing—and I didn't mean appointing—placing the wrong people. There's too many self-interested people who are pooh poohing human beings. I mean, you cannot make statements that are definitive about anything in science. You can't do that. It's ignorant to do that. And the psychological operations part of it is using this wrong information to mislead the public, which is what the last four years was about. It's the wrong people being put in positions where they really do have the power to convince most of the world of what they're saying, and that what they're saying is true. It's shocking and alarming, but most people are really good, and they find it really hard to believe that especially public health officials would ever lie to them: "That doesn't happen." So, yeah, it's a tough pill to swallow, but there we are.

**Commissioner Drysdale**
Thank you, Dr. Rose. Anyone else?

**Shawn Buckley**
Thank you, Dr. Rose. That appears to be the questions by the commissioners. So on behalf of the National Citizens Inquiry, Dr. Rose, I sincerely thank you for testifying with us today. We certainly appreciate your testimony and you sharing with us.

**Dr. Jessica Rose**
It's my pleasure. And if you want to invite me back again, I'm sure we'll have some good news by then. I'm the eternal optimist.