Witness Name: Ruth O'Rafferty
Dated: 28 August 2024

UK COVID-19 INQUIRY

WITNESS STATEMENT OF SCOTTISH VIG

I, Ruth O'Raffety, will say as follows: -

A brief overview of our organisation, including its history, purpose and aims.

1. The Scottish Vaccine Injury Group was formed initially to apply for Core Participant status in the Scottish Covid-19 Public Inquiry and to provide tailored support for Scottish people who had suffered an adverse reaction to the Covid-19 vaccine. All our applicants are rigorously screened to ensure everyone who joins had an adverse reaction to Covid-19 vaccines. It very quickly became apparent from the numbers that tried to join us that those that the vaccine had bereaved were desperately needing support, too. They faced the same disbelief and resentment as the vaccine injured did each time they mentioned vaccine adverse reactions. They, too, faced the same censorship on social and mainstream media, so we expanded our group membership to include them.

2. We were concerned that it might be upsetting for the injured or the bereaved to see each other's stories but instead found it created a non-judgemental, safe place to talk and grieve. Both the bereaved and injured have a great deal of loss to process. For the bereaved, the loss may seem obvious because they have lost someone precious to them; however, because it is a result of receiving the Covid-19 vaccine, their loss has an added sting. The subject of Covid-19 vaccines has become so polarised that even the suggestion that the vaccine could cause severe adverse reactions or death can lead to the loss of

friends, credibility and, ultimately, the loss of being allowed to discuss and process loss.

3. Our aims are:
   a. To prepare for the Scottish and U.K. Public Inquiries
   b. To provide support and encouragement for those who have suffered adverse reactions to the Covid-19 vaccinations (or their full-time carers if they are too sick to participate themselves) plus those who have lost a relative because of the Covid-19 vaccinations.
   c. This is achieved through our Facebook group, where our members offer peer support and organise social events with those who can attend in addition to Zoom chats.
   d. To share up-to-date information on treatments and therapies for vaccine injury from research studies or medical sources where possible and our own experiences. We post these on our Facebook page, Twitter and website.
   e. To raise awareness of vaccine injury to the public, media, political arena and healthcare system. We encourage our members to write to M.P.s and M.S.P.s and report to the Yellow Card - Adverse Drug Reactions Scheme.
   f. Signpost anyone in crisis to relevant help, for example, mental health support or institutions that can advise on financial support. We also connect members to a volunteer 'listening service' and have medical volunteers who can advise and signpost people to the most appropriate group or professionals.
   g. Campaigning for specialist funded research and specialist centres for treating Covid vaccine injury.
   h. To set up a charity to fund treatments that are not available through the NHS.

4. As of the 29th of September 2023, the group has 258 members, ranging between 22 and 76 years old, some of whom were born overseas but are now resident in Scotland, and all those affected received their vaccination in Scotland. Some members have been able to return to work, some have had to come to special arrangements with their employers for reduced hours or to

work from home, but many are unable to work. A few of our members are full-time carers and have had to give up their jobs to care for a loved one too sick to participate in group activities. Some are extremely ill, even after two or almost three years post-vaccination, and only a small minority are recovering.

5. When we first formed the group, most of our members were over 30, but now we have increasing numbers of younger people joining, all desperate for answers.

6. We liaise with other similar groups internationally, as far as Australia, U.S.A., South Africa, and several European nations, and are affiliated with the React19 International Coalition. We make a concerted effort to keep abreast of the latest medical research discoveries, treatments and diagnoses related to vaccine injury.

Vaccine Safety is of primary concern to our group, from trials, effectiveness, preparation, delivery and after-care. So, it is here that I will begin.

7. Trials are rushed, so extra vigilance is needed to look for adverse reactions.

8. Our understanding of clinical trials is that they usually take 10-15 years to complete, and during phases 1-3, participants are closely monitored for adverse reactions. Then, in phase 4, the vaccine's efficacy and safety would be observed in more extensive, diverse populations. Due to the urgency of the pandemic, the usual time it would have taken to complete these phases was accelerated; therefore, no data is available for long-term reactions. We also understand that some trials haven't yet completed phase 3 – see [RR/001 - INQ000503650] [RR/002- INQ000503651] [RR/003 - INQ000503653] and [RR/004 - INQ000503654] Therefore, logic would dictate that due to the speed of the phase 1-3 trials, there would have been even more rigorous monitoring of any adverse events.

9. The Medical And Healthcare Products Regulatory Agency (MHRA) promised 'Proactive Vigilance' [RR/005 - INQ000503655] This was supposed to have included doctors reporting to the yellow card system, analysing G.P. data on a weekly

basis to actively look for any increases in health conditions, proactive follow up a sample of the population after vaccination and conducting academic research studies of large medical databases. I will discuss the Yellow Card and proactive monitoring later, but the fact is that the amount of adverse reactions happening with Covid vaccines are extremely high. By November 2022, the Yellow Card – covering the UK alone – had received reports of 2,362 fatalities, 17,965 adverse events for Pfizer, 246,866 adverse events for AstraZeneca, and 47,045 for Moderna [RR/006 - INQ000503656].

10. A peer-reviewed study published in Science Direct concluded there was a 36% higher risk of serious adverse events in the vaccine group in the Pfizer trial, and 6% higher risk of serious adverse events in the vaccine group over the placebo group for Moderna [RR/004 - INQ000503654]. Since people hadn't been warned what these adverse events were, and doctors also were not actively looking for adverse reactions, this means that many people would have been searching for causes and solutions for new onset, unexplainable symptoms and, in some cases, irreversible damage has been done that could have been prevented, had the symptoms been caught sooner. The double stranded DNA viral vector vaccines and mRNA technologies were relatively unused in the wider population, yet were being rolled out on such a massive scale so early on in trials [RR/001 - INQ000503650], [RR/002- INQ000503651], [RR/003 - INQ000503653], [RR/004 - INQ000503654], [RR/007 - INQ000503657] This lends even more importance to closely and actively monitoring recipients.

11. The contract between the European Commission and Pfizer, pp. 48 and 49, states the member state acknowledges that the long term effects and efficacy are not currently known and that there may be adverse effects of the vaccine not currently known [RR/008 - INQ000503658].

12. We would also ask the Chair to explore how vaccine adverse reactions were prepared for in the strategic planning for the pandemic. The World Health Organisation's guidelines for the emergency use of unproven medical interventions include this paragraph:

"Ethical duty of care: "Duty of care" in this document refers to the ethical and professional obligation of healthcare workers to provide care to individuals who are ill and seeking assistance. It requires that they apply their knowledge and skills for their patient's benefit or best interests and explicitly acknowledge uncertainties about the risks and potential benefits of unproven interventions." [RR/009 - INQ000503659]

13. We have rarely experienced this. All medical staff and pathologists should have been briefed and on alert to expect patients presenting with side effects immediately following or during the weeks after vaccination. It didn't even occur to many of our group members that their illnesses were related to the vaccine, and when they presented to a doctor, that should have been one of the primary considerations. In some cases, the reactions were immediate and severe, so it was often obvious, but in other cases, only as their health deteriorated without any cause or explanation did they begin to correlate the vaccine and their ongoing health issues. One of our member's husbands **died** as a result of this. Others had significant, and in many cases, catastrophic post-vaccination reactions immediately following administration but were advised by their doctors that the vaccination could not be the cause. Some still face the same denial nearly three years later.

14. One of our members was told by two consultants they did not doubt that her illness was caused by her vaccine, yet when she moved house and had to find another G.P., they used words like "what you say has been the vaccine injury" and are careful not to say it themselves. In a poll we ran in our group, 46% of respondents said that even though their doctor said the vaccine was most likely the cause, they did not write this down on their medical notes. Many doctors managed to avoid this by saying 'the patient believes' the cause of their symptoms to be the vaccine.

Doctors are not reporting what they are seeing

15. One of our members was waiting in the admissions bay to see a neurologist with six other patients, all females under the age of 45. They had all had their AstraZeneca vaccine and were experiencing similar reactions to herself. When she spoke to the neurologist, he openly said that he was seeing a massive amount of patients presenting with the same issues after their Covid-19 vaccines. What were the rules then? Was this doctor legally required to pass on this information to anyone? Why didn't he submit a Yellow Card Report? The Green Book, the Government's own publication, states, "If there is any suspicion that the reaction is vaccine-induced, an A.D.R. should be reported. Many suspected A.D.R.s are actually medical conditions that have occurred spontaneously and coincidentally" **[RR/010 - INQ000398115].**

16. Because this neurologist was seeing distinct patterns forming, he surely had a duty to report this to avoid patients being told their symptoms were coincidental, as has happened to so many of us. Why wasn't this information included in the leaflets given out at vaccination centres? Another member was told by a doctor at A&E that he had heard that all the local health authority doctors were noticing people's platelet levels were low following the vaccine rollout. He jokingly asked her if she had been drinking because that could cause a temporary dip and said they would monitor hers and hopefully they go back up – they didn't because her bone marrow had been damaged.

Proceeding with second vaccine after an adverse reaction to the first

17. It is not unusual for members to go for a second vaccine despite having an adverse reaction to the first. One lady had already been to see a neurologist and told she had FND after her first AstraZeneca vaccine. Her speech and movement had both been affected. She returned for her second vaccine and ended up in a much more serious condition and is severely disabled. She has ticks, tremors, spasms and her speech is severely impaired. She has reactions to medications and is constantly getting infections and is in a lot of pain. Another group member had a reaction to her first vaccination, so her

G.P. contacted the World Health Organisation for advice, and she was told because of the reaction she had to the first vaccination if she didn't have the second, the likelihood was she could die. She expressed her doubts but felt she had no choice. They put her on steroids three days before administering the vaccine and then for seven days afterwards. She still has symptoms like rheumatoid arthritis and is on many medications for this, to which she responds, yet the rheumatologist says she doesn't have an autoimmune condition. Her G.P. has no idea what to do.

Doctors threatening or trying to hasten things along if the vaccine is mentioned.

18. Only days ago, one member was threatened by her G.P. that she needed to be careful what she said because she could be 'struck off from the NHS.' (contravening the NHS Charter for Patient's Rights, [RR/011 - INQ000503661] This phrase was repeated several times during her appointment. What confused her most was that the same G.P. had been open to her suggestion only a few days before that everything started following her vaccination. One of our group was recently in hospital following a collapse. She has been unable to walk unaided now since her vaccine over two years ago and recently collapsed and was vomiting blood so was hospitalised. This lady still has not had a lumbar puncture performed, despite presenting two years ago with part facial paralysis and loss of the use of her limbs and things progressively worsening.

19. This is how she described her hospital stay, where she was kept in a private room: "I also want to add they physically barred me from speaking to anyone on the ward - other patients, etc, who I know who are also injured and they know they are too! Because they don't want it spoken about and they try to shut it down! I believe then my duty of care got worse. I wasn't even given basics like - routine obs for 4 days when I had extreme drops in blood pressure and blood sugar to the point I was collapsing and seizuring and left on the floor for long periods of time - not checked over afterwards no follow up tests!"

20. This lady discharged herself in the end because she was given medication for schizophrenia which made her even more ill – she wasn't aware what it was for until she had a reaction to it and looked it up online. Since then, her physiotherapist pointed out that her liver function is reduced. This was after she checked her blood results from her time on the ward, yet no one had mentioned this to her – she is yellow. Another group member had the same experience when she arrived at a neurological ward and said it was the vaccine that caused it. She described how she was quickly put in the furthest away private room (she thought this was to keep her away from the other patients) and was often forgotten about when it came to meals. She was told she should buzz to remind them if she hadn't received any food.

Having to pay for treatment because of refusal to accept it is the vaccine.

21. The refusal of the N.H.S. to recognise that vaccination could cause adverse reactions has resulted in undiagnosed conditions, forcing many of our group to pay for private medical tests, scans and treatments, leading to various diagnoses. Some have even gone abroad for these. For example, one of our members went back to Bulgaria, where he is from, to see a cardiologist who told him he has an issue with his heart. He had received some scans on the N.H.S., but they had failed to pick up the issue, and the cardiologist in Bulgaria was able to explain why they could miss this particular information if the scans were conducted and read in a certain way. His GP refuses to accept this report or give him the treatment for this heart issue, because the N.H.S. didn't perform the test. Another member paid thousands of pounds for a heart scan that showed he had myocarditis when his own N.H.S. Cardiologist had refused to acknowledge for over a year that this could be a possibility. Two private consultants examined his scan and confirmed it was myocarditis, and he received treatment, which massively improved his quality of life. He still has not entirely recovered but is no longer bedbound.

22. The Inquiry itself raises the issue of myocarditis. I make reference to several exhibits [RR/012 - INQ000503662], [RR/013 - INQ000503663], [RR/014 - INQ000503664], [RR/015 - INQ000377504], [RR/016 - INQ000503666], [RR/017 - INQ000412951], [RR/018 - INQ000503663] and [RR/019 - INQ000503670].

relating to both myocarditis and pericarditis. A study conducted in youths aged 13-18 [RR/017 - INQ000412951] reported *"Cardiovascular manifestations were found in 29.24% of patients"* and "Hence, adolescents receiving mRNA vaccines should be monitored for cardiovascular side effects." A study of Twenty Three Million Nordic patients [RR/018 - INQ000503663] also reveals myocarditis following Covid-19 vaccine was greater in this age group also. This study, while larger, was not as controlled as the Thailand study in that Mansanguan et al. took baseline measurements of the patients and explored more than just myo/pericarditis.

23. Sadly, myocarditis and pericarditis are not the only adverse reactions our group has experienced, which have been widely reported to the yellow card scheme. (I will touch upon later).

24. It has come to light that there are tests available that can identify someone who has had an adverse reaction to the vaccine by identifying certain biomarkers. We would argue that this should be the kind of test offered quickly [RR/020 - INQ000503652].

Being told it is anxiety

25. Discussions even took place within our group regarding if we would be better off not mentioning the vaccine at all when presenting at medical appointments so that routine tests would be conducted without question. In fact, I have been told by a vaccine injured person that their consultant said if they didn't mention the vaccine they would be more likely to receive investigation and treatment. We believe that Doctors should be proactively investigating the root cause. If someone had been involved in an accident and presented with dizziness and nausea, medics would assess them and question if they had banged their head. If someone presents with chest pain or limb weakness during the roll out of a vaccine, why are they not routinely investigating and examining all possible causes, including any recent treatments, which include vaccinations?

26. In contrast, one of our members was told that the blistering in her eyes was due to anxiety and another that she had brought on repeated extreme allergic responses herself due to the general air of tension during the pandemic. Another member was told that her cancer symptoms were due to anxiety because the vaccine couldn't possibly make her unwell. Sadly, her cancer developed rapidly, and the treatment she eventually needed was so radical her life will never be the same again.

27. Not all medical professionals have been insensitive – quite the opposite - some have been supportive, however, these are the minority. Sadly, though, the frequently dismissive and belittling reactions our members have faced have been unacceptable, heaping guilt and shame on top of the trauma of living with acute or chronic long-term illnesses with no explanation, no treatment options and no hope of recovery. Two of our members even went to see psychiatrists because they ended up believing what they had been told, only for the psychiatrist to say they did not have anxiety but physical problems that needed further investigation. It could be expected that these conditions could naturally lead to depression and anxiety. Still, members are then afraid to admit they are anxious or depressed in case their symptoms are then explained away as psychosomatic.

28. All of the above has happened, despite, in December 2022, the Medical and Healthcare Products Regulatory Agency publication listing 2,362 Yellow Card reports with a fatal outcome from COVID-19 vaccination. Considering it is widely accepted that reports to Yellow Card only represent a small proportion of all cases, it would be expected that doctors would take us seriously if we report an adverse reaction.

Health Care Issues

29. Due to the fact we took our vaccines and preparation appears not to have been made to expect some adverse reactions, we have been left with a list of issues. These include:

i. There are no NICE guidelines for our condition, and until recently there was seldom any recognition that adverse reactions to the Covid-19 vaccines existed. This has resulted in a failure to diagnose and offer any treatment plan for our 'conditions'.

ii. A 'snomed code' on the GP's systems in Scotland and England lets them see symptoms, other possible reasons for symptoms, treatments & referrals. We have been informed that doctors have a snomed code for Long Covid but not for Vaccine Damage, therefore, even though rare vaccine reactions are acknowledged, there is no path for diagnosis and investigation can only proceed for symptoms where agreed, not the underlying cause.

iii. GPs and fellow health professionals who are presented with new and complex symptoms are not, therefore, alerted to ask if the symptoms began shortly after receiving a vaccine and are not on the lookout for conditions such as Postural Orthostatic Tachycardia Syndrome (POTS), Mast Cell Activation Syndrome (MCAS), myocarditis or reactivation of Autoimmune Diseases such as Henoch Schonlein Puerpera [RR/021 - INQ000503671]. We have no idea what treatments we need or what conditions some of us even HAVE.

iv. GP appointments are short (10 minutes) and, as a result of the pandemic, often not face-to-face, which is inadequate for our complex health issues. It is not obvious if longer appointments can be requested.

v. There are NO MCAS specialists in Scotland who are not private. Despite it being widely known amongst our and the Long Covid communities that Mast Cell Activation Syndrome can be caused by Covid-19 itself in addition to the vaccines, frontline medical practitioners do not widely recognise it, and there are no consultants to which G.P.s can refer patients presenting with MCAS – if they have even heard of it themselves. The diagnostic tools used in other countries to identify MCAS are not employed in the U.K. GPs who could be capable of diagnosing if they were given permission (a common way to diagnose MCAS is to begin

treatment and assess if it is successful), have a very narrow drug formulary that they can prescribe from so are often unable to prescribe the medications required or they are unwilling to do so.

30. Many of our group display symptoms of MCAS, but because they cannot afford a private doctor, they remain undiagnosed and untreated, compared to a few in our group who have either recovered from it or whose symptoms are under control or improving and who HAVE accessed private medical care.

31. POTS – Postural Orthostatic Tachycardia Syndrome is also widespread in vaccine injuries. There is a lack of expertise regarding POTS in the NHS. Group members with POTS often don't receive a diagnosis and become bedbound or housebound for months. Some members have asked to be referred outside the health authority where they live to see a consultant in Inverness because doctors they have seen in the central belt either don't recognise it or don't know how to treat it.

32. Another issue is that it is common for our tests, if we get any, to come back clear when we know we are **far** from well. It is obvious to us that no one knows what they should be testing **for** (if the tests even exist in the U.K. – for example for MCAS). Often, diagnoses are not spotted early enough to stop them from becoming more serious. For example, vaccine induced small fibre neuropathy and a variety of autoimmune and neurological conditions.

33. One of our members, a nurse, received her first vaccine on the 5th of January 2021 and began to develop symptoms within two hours. No one could explain why, and she was treated for exhaustion and asthma. Eventually, her condition deteriorated so badly that she was taken to hospital by ambulance in March 2022, over one year later, and was diagnosed with cardiomyopathy. She had been told nothing had shown up in her blood tests or scans to suggest the cause; however, everything stemmed back to the 5th of January 2021 when she received her vaccination.

34. It is now September 2023, and this lady is still waiting to have a CRT-P fitted to help her heart to pump as her E.F. is at only 24% when it should be between 55% and 75%. (E.F. is a measurement that your physician may use to gauge how healthy your heart is) This device will also have an internal defibrillator to shock her if her heart stops. Currently, she is sometimes so unwell she is unable to climb the stairs and her cardiology nurse has to visit her at home because attending appointments is too demanding. She is a shadow of her former self and is now asking for help with her mental health. Her surgery has been postponed and now, in late September 2023, she still cannot return to normality, yet alone to work.

Long waiting lists – overseas and private treatments

35. We, like everyone else, experience long waiting times to see specialists. The N.H.S. guidelines of 12 weeks, recently updated to 18 weeks, must be a typing error – 12 months is more relevant or even 18 or in some cases 24. Many of us have had to pay privately for tests showing levels of disease, abnormalities, inflammation etc. This has sometimes been necessary to demonstrate we are unfit for work, for example, or because waiting lists are so long.

36. One of our members, who is in her twenties, was told that her sudden onset autoimmune condition was progressing so rapidly she HAD no choice but to go privately because the waiting times on the N.H.S. were too long and the risks to her health were considerable. The inflammation attacked her so fast that within only 8 weeks there were already erosions in her bones and joint deformities. This young woman has no family history of autoimmune conditions yet suddenly developed acute rheumatoid arthritis following her vaccine. When she did see a private rheumatologist, she was told that she had a very rare and aggressive case [RR/022 - INQ000503672].

37. Long waiting times are particularly problematic for a lot of our members because they present with complex co-morbidities, so wait a long time to see one specialist only to be referred to a different specialty. We question therefore

why it wasn't anticipated that specialist Clinics with multi-disciplinary teams would be necessary. We often have systemic conditions that do not fall neatly under standard medical teams. For example, one of our members had to see 5 different specialists and waited 19 months to see a neurologist while she suffered migraines every single week that lasted at least 3 days. Many of us have such complex co-morbidities which require specialists who understand how these pathologies interact.

38. This appears, from our experiences, to be unachievable with the current way the N.H.S. is run. Specialist Clinics would save the N.H.S. a lot of time and money as well as save our members repeated trauma and distress. For someone who is bedridden and can hardly process conversations due to neurological issues, even organising an appointment is a massive undertaking. Travelling to appointments then having to self-advocate over and over again, and continually be presented with disbelief is demoralising.

39. There are treatments and tests available that are not accessible to us, either because we live in the U.K. or because they are not done in the N.H.S. One member of the group went to Cyprus to receive Apheresis and her blood test results before and afterwards showed a significant improvement. This cost £10,000. Each treatment for these costs £1,600 and some people need ten or even as many as 25! Vaccine injury groups have noticed that the longer people remain untreated the more sessions they need. Then there is travel for the patient and their carer, plus food and accommodation to be paid for. Others pay for HBOT, red light therapy, cupping, and acupuncture as well as other treatments. Most of us buy significant amounts of costly supplements – under the supervision of a doctor – at our own expense. Some pay for off-label medications that considerably improve their symptoms. (G.P.s are given a list of medications that they are permitted to prescribe only for certain conditions and this list varies between health authorities. To prescribe a medication for a condition to which it is **not** allocated on this list means that it is 'off label'.) There have been indications that vaccines can lead to particular blood issues that could explain many of our symptoms – but we don't have access to tests to confirm or eliminate this possibility. Research has shown that amyloid

fibrins, or microclots, that are resistant to normal blood thinners can form and clog up small vessels, leading to poor oxygenation in muscles, brain, organs and extremities [RR/023 - INQ000503766], [RR/024 - INQ000503767], and [RR/025 - INQ000503673]. Doctors and researchers in the UK can do this test and it's available privately, why is it not being offered on the NHS when these Doctors and Consultants work within the NHS? One of our members was refused a D-dimer test for her elderly father, despite there being signs of clotting.

Issues of women's healthcare (See [RR/026 - INQ000503768], [RR/027 - INQ000503675], [RR/028 - INQ000503676], [RR/029 - INQ000503677].

40. The men and women of our support groups have been affected significantly in multiple ways; we would like to highlight to the Inquiry circumstances surrounding the following issues.

41. From our own group data, we are seeing a higher ratio of female to male injury. This brings forth the important aspect of women already being at a disadvantage regarding their healthcare for the following reasons:

- Medical knowledge is skewed toward knowing more about men and their bodies and their diseases.
- Gender bias affects diagnosis, treatment, and health outcomes, reducing the quality and effectiveness of healthcare.
- Women are far more likely than men to report they feel challenged to prove the legitimacy of their symptoms and pain levels, and the gender disparity rises even more sharply when the subject is a woman of colour.

42. Given we know these facts, I further the point regarding the importance of healthcare workers recognising vaccine adverse events and listening to all genders concerns regarding this. This is overlapped with the issues of censorship and subsequent medical gaslighting the vaccine injured have received globally.

Due to the disbelief that the vaccines could possibly be the root cause, members find it increasingly difficult to advocate for themselves in an increasingly overstretched N.H.S.

43. They have found:

i. Having to self-advocate when so unwell is impossible for most of us so our treatments have been delayed.

ii. Almost all of our vaccine injured members experience neurological symptoms which can include memory loss, working memory issues and brain fog, difficulty formulating arguments and sometimes even difficulty processing words, spoken or heard. Attending medical appointments alone has not only been traumatic but has led to not being able to adequately explain our case and complete dismissal if we raise the issue of the possibility of vaccines being the cause.

iii. Due to our neurological issues, some members forget vital information that is given to them by medical professionals during appointments and can be confused about their treatment and their condition.

iv. Failure by G.P. clinics to communicate test results has led to increased anxiety. Sadly, in order to get the treatment you need on the N.H.S. requires us to be assertive and persistent, the very thing severely sick people can't manage. This has been too much for many of us. In England, there is an app where patients can see all their test results. This would be useful in Scotland too. Instead of being faced with medical staff who would normally advocate for the patient, vaccine injured are often faced with health practitioners who can only see the benefits of the vaccines and not the potential side effects.

Other issues related to protracted illness

44. The protracted length of time our members have been ill has led to further issues. It is important to point out that group members who have no money to

go privately have been left bedbound for months, without any offer of physiotherapy to help prevent muscle wastage, an intervention that long Covid clinics routinely offer.

45. In addition to affecting our long-term physical health, the length of time it has taken to access effective treatments has isolated members from their social circle and the support they can offer. This also impacts on us psychologically, spiritually, affects our intimate marital relationships, friendships, and ability to care for our children. Some of us have simply been too ill and brain fogged to know where to begin to apply for benefits and therefore have been crippled financially.

46. The financial implications are touched upon elsewhere, but it is not uncommon for spouses or partners to be forced to give up work to become full-time carers. At one point it was unsafe for me to be alone and my husband was told he could work from home for a few weeks but after that he would need to consider resigning. The husband of one of our group members gave up his job for 18 months to care for her. Other family members, sometimes children, have to help care for some of us. The dynamics of family life are radically affected.

47. One of our main concerns is a developing hesitancy to ask for help due to all of the above or due to concerns that we will be viewed as time wasters – or – there is always the issue that if we are questioning the 'safety' of the vaccines, that this will be instantly dismissed.

48. All of the reasons mentioned above have had a massive toll on the group members' mental health which I will now address before going on to discuss further concerns we have about vaccine safety.

Emotional and mental impacts on the C19 vaccine injured and bereaved.

49. The emotional impact of being injured by Covid-19 vaccines was enormous because society has such polarised views on them and because of the fear levels surrounding Covid itself.

50. Suicidal tendencies are often expressed by members in our support group, which is run by volunteers who are themselves ill. This is extremely challenging. Not only are these people we feel a level of responsibility towards, but we have no resources to deal with such high levels of distress, often outside normal working hours. Added to this, we use Facebook so we don't know where someone lives so we can't drive around ourselves or organise for emergency services to go over. We have had to devise our own policy for dealing with suicide and the responsibility is left on us to follow up to ensure that person has accessed appropriate help. Members are often afraid of admitting to health professionals how they feel in case their symptoms are labelled as anxiety which might lead to them not being taken seriously at appointments. There are concerns that if they call helplines, the information will find its way back on to their medical records.

51. The impact on our families is also massive. One of our group has children at school. Due to vaccine injured people being called misinformation and the divisive culture encouraged by social media and the media they are afraid even to this day to tell their friends and peers at school that the reason their mum is now in a wheelchair every time they go out is because she is vaccine injured.

52. During a lunchtime debate club, the subject was the Covid vaccines and one senior pupil went as far as to say that everyone who did not get fully vaccinated was basically a murderer. They could not face going back to the club after that. This adds to the psychological stress our group member has had to endure because she has massive concerns for her children. Vaccinations were being delivered in schools and she was afraid that her

children might feel peer pressured to be vaccinated, such was the culture at the time.

53. Some of our members now have children who are now their carers. I am sure there is no need to point out the complexities of these situations.

54. Losing a loved one following the vaccine carries enormous emotional ramifications for the same reasons as above. No one wants to hear that the vaccine is not safe and effective and saying you think that the vaccine was the cause of death often elicits extreme reactions.

55. Bereaved members are tormented by the fact that the death certificates of their family members are not accurate, and they also face the same disbelief from their social circle and sometimes even family members over the cause of death; they cannot get closure. One of our members waited 7 months for the coroner's report to cite VITT (Vaccine Induced Thrombotic Thrombocytopenia) as the cause of her husband's death and then waited a year before an updated death certificate was issued. This delayed receiving the Vaccine Damage Payment Scheme.

56. Ridicule in social media added to this. There was an M.S.P. for example who tweeted about vaccine injury in derogatory ways. Standard responses in replies from M.P.s and M.S.P.s also add to emotional distress. Instead of addressing the issue of vaccine injury in responses, we are told how many lives have been saved by the vaccines, to report to the Yellow Card Scheme and apply for Vaccine Damage Payment Scheme. This does not address the issues we are facing or that doctors are not helping. It is dismissing and demeaning.

57. It is overwhelming to become chronically ill overnight without the challenges it poses to mobility, living arrangements, relationships and career. Added to this is the stigma associated with vaccine injury. Internally our members experience loss, grief, shock, anger, fear, hopelessness, trauma and isolation.

Mental health organisations require specific training to deal with supporting individuals who are vaccine-injured.

58. Access to counselling is virtually impossible without paying for it privately. Individuals who were diagnosed with VITT (Vaccine Induced Thrombotic Thrombocytopenia) automatically receive this so those with a diagnosis of other vaccine injuries should also.

59. Being contacted to receive further vaccines, despite taking ourselves off the lists has caused repeated trauma to some members.

60. The physical symptoms related to brain inflammation and neurological issues related to Dysautonomia and MCAS can cause emotional mood swings in addition to all the environmental stressors. People who have managed to get a diagnosis should immediately be offered access to therapeutic interventions.

Men's mental health

61. Men are often expected to be the breadwinners and to be strong, dominant and in control. As a result, this can make it harder for men to reach out for help and open up. We have found, within our groups, that men are, in addition to struggling physically, severely struggling mentally having gone from being the sole providers in their household to now being cared for and unable to work or cope with childcare on their own.

62. Here is a statement from one of our group members: "Men in particular are commonly seen as self-sufficient, unemotional, and tough and when they deviate from this, people can respond by being judgmental. This can make it difficult for men to seek help for mental health issues. The three biggest causes of mental health in men are work pressure, financial issues and our health. Imagine your health being ripped from you, unable to work and financial hardship. I can't watch my own kids! I can't go on dates with my wife! I can't have family holidays! I can't support my family! I can't work! I can't exercise! I can't socialise! I can't sleep! On the brink of losing my family home!

Struggle to look after myself! My circle of friends is getting smaller and smaller! Feeling a burden to my family. My children ask why I can't do the things I used to. The innocence in their eyes, the empathy they try to show. Your explanations feel useless, you're hurting because you're not the dad you used to be. Your wife telling you everything will be okay, but you can hear her cry in the next room, unable to console her as you have no idea what to say. Most often I put on a 'coping' front, when in reality I'm troubled with insecurities and anxieties! I find it difficult to open up about how I'm feeling. You probably won't be surprised to learn that I'm not alone, many men in the group find it challenging to talk about their struggles and suicidal thoughts. Finding self-acceptable isn't easy, especially when we feel abandoned!"

Trauma for the vaccine injured

63. Apart from the initial shock of having sudden onset illness, the group have been impacted by trauma in several ways:

a) The trauma of unmet need.
b) The trauma of anticipating belittling or disbelief at medical appointments, being faced by medical staff who are convinced of the benefits of vaccines and not the potential side effects.
c) The humiliation of being told 'nothing is wrong' when you know something is seriously wrong.
d) The trauma associated with the wider social stigma of saying you are vaccine injured (particularly strong with the Covid-19 vaccinations). Research in the field of neuropsychology [RR/030 - INQ000503769] has found that ostracism or social rejection lights up the same part of the brain as physical injury. One study (Purdue University) stating "Ostracism or exclusion may not leave external scars, but it can cause pain that often is deeper and lasts longer than a physical injury"
e) The trauma of living with chronic illness

f) The trauma of not knowing how long our illnesses will last or if symptoms will continue to progressively worsen as some appear to be.

g) The trauma of new symptoms appearing as time goes on and no one being able to explain these.

h) The trauma of losing livelihoods, homes, and for some, friends and family members

i) The trauma of 'trying' new treatments when no one knows what will actually work. This is particularly frightening for those with MCAS who are extremely reactive to chemicals, and they don't know if trying a new medication will lead to anaphylaxis or other life-threatening reactions.

Trauma for the bereaved

64. Suddenly losing a loved one following a 'safe and effective' vaccination is a massive trauma. Then being told that the cause of death is not related at all to the vaccine adds considerable distress. Our members who are still fighting for cause of death to be recognised are unable to get closure on the death of their loved ones.

Cause of death and safety monitoring – lack of post-mortems

65. It is very difficult to accurately establish the 'safety' of the vaccines in the general population when the cause of death has been so confused. A freedom of information request in Australia uncovered that the W.H.O. had issued instructions that it could be recorded that someone had died from Covid-19 when there was no positive test result [RR/031-INQ000503679] [RR/032-INQ000503680]. We would like an examination of procedures followed in the U.K. so that we can be reassured that the statistics presented to us by those in authority are in fact accurate and can be relied on.

66. The Office of National Statistics report on numbers of deaths in vaccinated and unvaccinated, however, they do not count someone as vaccinated until 21

days after they received their vaccination [RR/033 - INQ000271347] In the U.K., deaths were reported as Covid deaths if they happened within 28 days of a positive test [RR/034 - INQ000503682] but on the other hand, deaths contingent with an adverse reaction immediately following vaccination were not always investigated.

67. Some of our group members were refused post-mortems because of 'emergency regulations'. One of our members joined our group because his father, aged 79, who was fit and able to get out and about perfectly well by himself took an immediate reaction to a booster jab. His health declined over the next 17 hours before he passed away, apparently from a heart attack. Our group member believes that, pre-pandemic, the Procurator Fiscal would instruct a full investigation into his death, particularly as he had just received a vaccine that our group member knew was now causing cardiovascular events. In his own words "The institutional culture that by then was endemic within western institutions, and still exists to this day, was that the jab was not to be questioned at all".

68. His story is repeated throughout our group. Another member's husband had clear symptoms of blood clots but wasn't aware of what to look for – despite the fact that he had been given an AstraZeneca vaccine after the clots were known about – and died at home. In her words "I was told that he had hit his head, his face was in a pool of blood, the carpet is still stained. My first thought was that there has to be a murder investigation at least, surely, I was alone with him in the house, surely they had to investigate that? No. In the days that followed, we received the death certificate with "possible Myocardial Infarction". I was convinced that the vaccine had killed him. A neighbour, who is a doctor, agreed with me and said he thought that the lack of post-mortem was a "cover up". My husband was only 65, sudden death at home, no Covid outbreaks at this time, he had no symptoms of even a cold... The MCCD was also full of fabrication. The doctor said he had been in attendance, he wasn't, it was a telephone call with a paramedic. He said my husband had diabetes for 33 years, he had it for 54 years. He said he was found at 9am, he was found at 11am".

69. We have another example in the group of where initially the cause of death was stated on the death certificate as Sepsis of unknown cause and factors due to Type 2 diabetes but then a post-mortem WAS conducted, and it was attributed to the vaccine. A study that examined people who died post-Covid-19 vaccination found 5 out of the 18 examined were directly connected to the vaccines **[RR/035 - INQ000503683].** One died of undiagnosed myocarditis, and four from VITT (vaccine-induced immune thrombotic thrombocytopenia), only one of which had been diagnosed before death.

70. It concluded "The results of our study demonstrate the necessity of postmortem investigations on all fatalities following vaccination with COVID-19 vaccines. In order to identify a possible causal relationship between vaccination and death, in most cases an autopsy and histopathological examinations have to be combined with additional investigations, such as laboratory tests and neuropathological examinations"

71. Another group member lost her husband to the vaccine, and it took 7 months to receive a statement of cause of death and a year to receive a death certificate. We would question why post-mortems were not being conducted and ask that this never be allowed to happen again. The Independent Newspaper ran an article on the 20th of May 2020 stating that there had been so few post-mortems carried out, that it was hampering research into Covid-19 because there weren't enough tissue samples **[RR/036 - INQ000503684].**

72. Even if resources in the U.K. were limited and post-mortems could not be conducted, if samples could be taken and stored until after the pandemic was over and then evaluated, this may have helped. (In cancer patients, biopsies are stored for up to 10 years, so surely something similar could have been done?) There have been unexplained excess deaths without any formal investigation, and apparently, no evidence remains to help discern why.

Mechanism to update patient leaflets with new side effects and notify those who have already had the vaccine

73. Another issue related to 'safety' and 'monitoring' that concerns us is if emerging information from research is added quickly enough to information leaflets for people receiving their vaccine or quickly disseminated to frontline medical staff. Our group endeavours to keep abreast of new developments and is aware of large numbers of studies linking Covid-19 vaccines to a multitude of adverse reactions, as demonstrated in [RR/037 - INQ000503685] and [RR/038 - INQ000503686]. Awareness of cardiac issues has more recently become widespread, but our group members have suffered from these and more. Diagnosis of Guillain Barre syndrome, rheumatoid arthritis, Functional Neurological Disorder, myocarditis, postural orthostatic tachycardia syndrome, mast cell activation syndrome, acquired amegakaryocytic thrombocytopenia, migraines with aura, strokes, heart attacks, thyroid issues, heart failure, chronic obstructive pulmonary disease, lupus, seizures, non-Hodgkin's lymphoma, dysautonomia, blood clotting disorders, VITT, tinnitus, connective tissue disorders, arthritis, transverse myelitis, depression, a multitude of neurological issues, excessive pain due to neuropathy and brain fog have been attributed to the Covid-19 vaccine by doctors, either verbally or in writing.

74. This list is by no means exhaustive. Reports to the yellow card by December 2022 included Anaphylaxis, Bell's palsy, Guillain-Barre syndrome, immune thrombocytopenia, life-threatening blood clots, menstrual disorders, myocarditis, transverse myelitis and many more severe conditions, yet there is no evidence these are being investigated or that the literature is being updated to reflect these. Indeed, there are websites listing over 1200 peer reviewed journal articles of case studies and harms to date from these vaccines [RR/037 - INQ000503685] and [RR/038 - INQ000503686]. We understand that correlation does not always necessarily infer causation in every case, but we ask why, if there is evidence in medical journals that the vaccines can be the cause, is the idea dismissed so readily and it is not investigated? We understand that correlation does not necessarily infer causation, however, we would like to

know what steps were taken to investigate these reports and update patient leaflets accordingly to ensure informed consent is given.

75. In addition, as patient leaflets were updated to include new potential side effects, there should have been a mechanism by which those who had already received the vaccine could be updated with this information. For example, people who received AstraZeneca in our group were not contacted afterwards to warn them of the risks associated with blood clots, nor was anyone subsequently informed about the risks of myocarditis. Members could be experiencing unexplained symptoms related to those conditions listed and still be unaware of what to look out for.

There are other very important aspects of safety that concern our group members personally which I will now address.

Viral Vector products

76. One point of particular concern is the fact that we believe the U.K. still authorises the use of vector viral products. We are not sure of the current status for supply of Astrazeneca Vaccine; we cannot find an official statement regarding either continuing or stopping their use. An article published in Science Direct as early as 2007 stated that adenovirus-induced thrombocytopenia was an issue **[RR/039 - INQ000503687].** Other nations stopped using the AstraZeneca vaccine in early March 2021, yet on the 18th of March 2021, MHRA published this on their website, still encouraging people to get their vaccination **[RR/040 - INQ000408457].**

77. "The Medicines and Healthcare products Regulatory Agency is responsible for regulating all medicines and medical devices in the U.K. All our work is underpinned by robust and fact-based judgements to ensure that the benefits justify any risks".

78. One of our members, Alex Mitchell, received his AstraZeneca vaccination shortly after this date. He has since faced two emergency life-threatening

operations and has sadly lost a leg. Alex must take copious amounts of medication daily for the rest of his life. If he does not, "his blood will congeal like jam, and he could die" [RR/041 - INQ000503689], [RR/042 - INQ000503690], [RR/043 - INQ000503691], The suffering and pain Alex has gone through cannot be adequately described in just a few words. I personally received mine after this date and ended up with a diagnosis of mast cell activation syndrome and dysautonomia, along with a raft of undiagnosed neurological symptoms. Australia announced that AstraZeneca was no longer available from the 21st of March 2023 [RR/044 - INQ000503692] yet we are unaware of the MHRA's stance.

Vaccines in Pregnancy

79. The second point of concern is the use of vaccines in pregnant women. According to the Cochrane Library [RR/045 - INQ000503693], none of the randomised control trials included pregnant participants. Pfizer's leaflet for medical practitioners states, "Available data on COMIRNATY administered to pregnant women are insufficient to inform vaccine-associated risks in pregnancy." ([RR/046 - INQ000503694]). At the time of writing this document, a trial on the efficacy and safety of Pfizer in pregnant women still cannot provide all the data gathered [RR/007 - INQ000503657]. We would ask why pregnant women were therefore told they were at more risk of harm from Covid-19 than anyone else and that they should take the vaccine? We would like to see the statistics verifying these statements. There have been significant increases in stillbirths and infant mortality recently [RR/047 - INQ000503695] and [RR/048 - INQ000503696], so much so that the Scottish Government investigated, yet they refused to include a very important variable – the vaccines.

80. A group member went for her vaccine in August 2021, when she was 8 weeks pregnant and within 14 days miscarried. No-one mentioned that there was no current data on the safety of the vaccines during pregnancy and during the miscarriage no-one mentioned it either. This lady already had two normal pregnancies and no previous miscarriages and has subsequently gone on to have a normal pregnancy and safe delivery (with no vaccination). Imagine how she felt when she came across information that the guidelines at that time

were that the vaccines were only recommended during 14 and 33 weeks [RR/049 - INQ000503771]?

Data on how they impact those with comorbidities

81. Another concern is that many of us had previous medical conditions and were urged to receive our vaccines. For some, our condition became far worse afterwards. We were not only told it wasn't the vaccine that could be to blame, but because we had previous illnesses, we have no chance of ever receiving any vaccine damage payment. The Cochrane Library [RR/045 - INQ000503693] points out that only 3 out of all the 41 trials included immunocompromised individuals. We would like to know how many studies recruited participants with existing comorbidities, what these were, and how many had trial participants with 'unstable' medical conditions. What was the definition of 'stable' when choosing participants? The vaccine was offered first to people on an ‘at risk’ register this seems pertinent.

82. One group member realised that she had an undiagnosed condition that became acute following her vaccination (Mast Cell Activation Syndrome), and another has developed issues with hyperglycaemia (raised blood sugars). He was a well-controlled Type 2 diabetic whose HBAIC dramatically rose one month post-vaccine and continues to rise last HBAIC. His blood sugar levels have ranged from 18 to 37.9. The normal range should be under 7mmol/l. He has not responded to any of the standard oral medications. He has had severe adverse effects due to increased drug sensitivity, requiring hospitalisation. He needs to test his blood sugar levels four times a day to monitor him in case he develops DKA (Diabetic Ketoacidosis). This has affected his eyesight, and he has frequent eye infections, shingles, geographic tongue blistering and oral thrush, plus peripheral neuropathy, which is a loss of sensation in his fingers and toes. This has severely impacted his mobility, independence and ability to drive. He is commencing on insulin with the possibility of being insulin-dependent for life. There have been cited articles showing patients developing Type 1 diabetes mellitus following SARS-CoV-2 mRNA vaccination

[RR/050 - INQ000503697] and [RR/051 - INQ000503698]. Another had ME/CFS & Fibromyalgia which was considerably worsened following the vaccine.

Concerns in those of reproductive age

83. A female in our group who is at reproductive age has been told that the seizures she has experienced since receiving her vaccine may have a genetic component to them and could be passed on to her children. She is naturally concerned and wonders if taking the vaccine has 'switched on' a gene that triggers the seizures. Has this caused something that her children might inherit? Naturally she would like some research done into this area. She is not the only person of reproductive age in our group. Has taking the vaccines potentially put any children they have at risk? We have no answers to these questions.

MHRA stating they have transformed from a watchdog to an enabler

84. Obviously, considering the adverse reactions we have experienced and the lack of response to us, we have serious concerns about a statement from the Medical And Healthcare Products Regulatory Agency (MHRA), that they intend to facilitate roll outs of new products more quickly. Dame June Raine, the head of the U.K. drug regulator, the MHRA, stated, "The Covid pandemic has catalysed the transformation of the regulator from a watchdog to an enabler."

The journey to confusion – who can we trust and who can we believe?

85. There is a journey our group members go through when they first realise they are vaccine injured. There is the initial relief that we have found an answer or shock that we have reacted. Then there is the dawning awareness that our doctors don't know what to do with us. Somewhere along the road, we start to share our story and then get censored. Before I observed this and experienced it personally, I welcomed careful screening of social media and mainstream media to ensure misinformation and propaganda wasn't being

used to manipulate people and that children weren't being exposed to inappropriate material. But suddenly, we were being fact checked for sharing our stories. We are not misinformation. What happened to us and members of our group is not misinformation. Now we question the motives behind censorship- who WAS it there to protect? Even the videos shared on TikTok of the U.K. Public Inquiry were removed [RR/052 - INQ000503772]. These posts were simply the recording on the Inquiry's own website. It can take months to find another person with an adverse reaction to the Covid-19 vaccine – not because there aren't many but because they are so heavily censored. The Telegraph printed an article [RR/053 - INQ000503773]. describing a Government 'counter disinformation unit' with up to 50 staff that was set up to counter disinformation during the pandemic. They trolled through social media posts and alerted social media platforms about posts that needed to be removed. Information like this makes us feel abandoned, marginalised and unfairly silenced.

86. The next step of the journey is coming to terms with the fact that the vaccines weren't as safe and effective as the Government was making out. . At first a reasonable person would give the authorities the benefit of the doubt, that they had the best of intentions and were making the best of the information they had at the time in an extremely pressured situation. Meanwhile, any sensible person, when faced with a doctor who doesn't know what to do to help and a desperate need to get well, would start to conduct their own research. Sadly, during those investigations it is so easy to stumble across information that causes massive disillusionment; documents that authorities agreed to keep secret for 75 years [RR/054 - INQ000503699]. vaccine trials that were rushed or trial participants who were seriously injured and their details misrepresented in trial results. Maddy de Garay is a teenager who participated in the Pfizer trial and had a severe and life-altering reaction that the trial dismissed as 'functional abdominal pain' [RR/055 - INQ000503774]. She is confined to a wheelchair, is on a feeding tube and needs constant care. Breanne Dressen was a participant in AstraZeneca's clinical trial. She experienced severe neurological side effects after her first dose and was removed from the trial. Her data was also removed [RR/056 - INQ000503700].

87. Auguso German Roux, a lawyer who took part in the Pfizer trial, ended up with pericarditis, which he has evidence to show was recorded as Covid-19 in the trial [RR/057 - INQ000503701]. They are not the only ones. The impact of all this is devastating. We all assumed that research trials were conducted without any bias and that due diligence would absolutely be met. Instead, we discovered that individuals with financial or social connection to pharmaceutical companies conducted trials. For example, Pfizer funded the Pollack trial, and the discussion section emphasises the merits of the new mRNA technology; this is not the only example. Kathryn Edwards, a former Pfizer consultant, was on the DSMB (data and safety monitoring board) for the Pfizer trial [RR/058 - INQ000503702] and [RR/059 - INQ000503703]. When watching the opening two days of the Scottish Public Inquiry, I discovered that the Polack trial lost a considerable amount of its participants before completion. Why? [RR/060 - INQ000377682].

88. Another question is who decides, during trials, if a reaction is due to the vaccine or not? How do they decide? Deaths are mentioned yet not attributed to the vaccine – why? Who decides this? Who pays their salaries? Has there been any observation or active surveillance of trial participants when they went on to receive their 3rd, 4th or 5th vaccine? How can Pfizer explain the nine pages of "adverse reactions of significant interest" which only came to light after legal action to release the documents (pp. 30-38, [RR/054 - INQ000503699]?

89. As part of my education, I touched briefly on statistics and how anything can be presented how the researchers wish it to be. I began to familiarise myself again with how to 'read' and interpret research studies, but with my brain fog, neurological issues, and extreme fatigue, it was virtually impossible. So I asked a statistician to help. The little I already knew was confirmed. I am not able to comment as an expert on statistics, nor could I get my head around a small proportion of what I was subsequently shown, but I have serious concerns about the reliability of the research on which the MHRA based their decisions about my health, the health of my family, our group members – of everyone. There are many variables that can affect the outcomes of reporting

on statistics – for example, is there a delay between the variable and it being reported on, how long did it take for people to be categorised as vaccinated after receiving their vaccinations? Or did they need to be double vaccinated to be referred to as vaccinated? What happens if someone receives a vaccine and becomes infected within a few days but is not yet categorised as vaccinated? How is their data analysed? For example, in the study in [RR/061 - INQ000503705], people were not categorised as vaccinated until 28 days following their injection.

90. I would ask that the Inquiry consider making a recommendation that, in the interests of informed consent, it would be helpful if all trial data was explained more simply to the public in easy-to-understand terms. For example, at the moment, results are given in terms of absolute and relative risk reduction, which is necessary for researchers but confusing for most of us. For example, it would be easier to use absolute risk reduction – or risk difference – when explaining results. This is simply explained in [RR/062 - INQ000503706]. So if 100 people receive a placebo, and 100 a vaccine, and 8 people in the placebo group get sick, but only 2 in the vaccinated group get sick, the absolute risk of getting the virus in the placebo group is 8%, and the absolute risk in the vaccinated group is 2%. This is probably what the average person wants to know – that and how many people out of the 100 people treated had adverse reactions. Researchers go further and calculate the absolute risk reduction – the difference between the two – which is 6%, which is also simple to understand.

91. So, in this theoretical example, having a vaccine reduces the likelihood of you getting sick by 6%, assuming there are no adverse reactions that can cause sickness. However, the relative risk reduction is calculated by taking the percentage of people who fell ill in the vaccinated group divided by the rate of people in the placebo group who caught the virus and multiplying that by 100. So that is 2 divided by 8 = 0.25 x 100 = 25%. The truth is that taking a vaccine has reduced your likelihood of catching the illness by 6%, but this figure of 25% could be used to infer a more significant advantage of taking the vaccine.

This is what happened with the Covid-19 vaccines. We were told, for example, that the Pfizer vaccine was 95% effective [RR/063 - INQ000503707]. This could be explained even more simply. If one person out of 1000 participants in the TREATED group died, and two people out of the control group died (placebo), it could be claimed the treatment is 100% effective using the relative risk reduction figure. The reality is that the treatment saved only one person out of 2000.

92. The Association of British Pharmaceutical Industries has a Code of Practice (see Clause 6.1 Supplementary information p15, [RR/064 - INQ000413039].

93. It states: "Referring only to relative risk, especially with regard to risk reduction, can make a medicine appear more effective than it actually is. In order to assess the clinical impact of an outcome, the reader also needs to know the absolute risk involved. In that regard, relative risk should never be referred to without also referring to the absolute risk. Absolute risk can be referred to in isolation".

94. We were told continually that Pfizer was 95% effective. The average person wouldn't know where to look for the trial data, nor how to interpret it. This was misleading.

What did the MHRA know that we didn't? Lipid Nanoparticles? Pfizer Docs?

95. We are not experts, and we know what we see on social media is often unreliable. What is troubling is that what we know from our own experience does not always match what the Government publishes, and what we uncover ourselves from other sources is more accurate and helpful. We humbly ask the Inquiry to examine what information the MHRA and the Government had about the vaccine trials, what the vaccines contained, and what information they agreed to withhold before and after the rollout.

96. One example, came to light that legal action was required to force the F.D.A. to release documents from Pfizer trials, which were being kept from the public

for 75 years. Why? [RR/065 - INQ000503709]. These contain nine pages of 'adverse events of special interest', specifically a list of conditions named one after another – some of them life-threatening. Another example is a freedom of information request that revealed that the Australian Regulatory Body knew about the risks associated with encasing the mRNA material in Lipid Nanoparticles [RR/066 - INQ000503710]. This information was also released by the FDA after a court order [RR/066 - INQ000503710]. A study involving rats [RR/066 - INQ000503710] concluded that lipid nanoparticles migrated quickly to other parts of the body: "The concentrations of [3 H]-08-A01-C01 were greatest in the injection site at all time points, with levels peaking in the plasma by 1-4 hours post-dose and distribution mainly into liver, adrenal glands, spleen and ovaries over 48 hours".

97. Drew Weissman, the scientist who is being awarded the nobel prize, conducted a study himself, published in 2015, illustrating that how the injection is delivered can determine how widespread it would travel in the body [RR/067 - INQ000503711]. Was this researched in the Covid vaccines? We would ask how much training was given to those administering the vaccines to avoid it getting into the bloodstream, i.e. we have learned that aspiration wasn't policy [RR/068 - INQ000503712]? We know from other research mentioned in this document that spike protein has been found circulating in the bloodstream for some time post-vaccination [RR/069 - INQ000377592].

98. Other research has found that if mRNA material is delivered to the liver, it can be taken up by the nucleus of the cell and converted and transcribed into the cell's DNA within only six hours [RR/070 - INQ000503714]. What does this mean? Does it mean our livers will become spike protein producing factories? Considering that spike protein was still detected in the bloodstream six months after vaccination this is concerning. How quickly is the mRNA material transcribed into other organs or into our brain? SARS-CoV-2 Spike protein has been shown to be toxic, to cause damage to endothelial cells (these line all blood vessels and lymphatic system), enlarge heart cells and disrupt the blood brain barrier amongst other things [RR/071 - INQ000503715] [RR/072 - INQ000503716] and [RR/073 - INQ000503776]. Why was this chosen to be the part of the virus that would

be introduced into our bodies? If the DNA of our livers is altered, are these cells that reproduce? Will it be replicated? Can this happen in other cells? Will this replicated DNA be passed down to our children? What will it do to the functioning of our bodies?

99. Concerns have been raised in the British Medical Journal [RR/074 - INQ000503717], that the MHRA did not have enough information concerning the safety of Pfizer vaccinations manufactured under two different processes. Data had been gathered and shared regarding the 44,000 trial participants who received the vaccines from process one but 500 were given a version of the vaccine created using a completely different process for mass manufacture, 250 from one batch and 250 from another. These batches were EE8496Z and EJ0553Z. The latter is the same batch of Pfizer/BioNTech's mRNA Covid-19 injectable that the UK began using on the general public in December 2020 under a temporary supply authorisation.

100. It is important at this point to understand that the viral vector and mRNA vaccines are biologic products, not traditional vaccines and the challenges facing the industry to supply biologics safely on such a massive scale was enormous. Sufficient quantities could be made in a lab for process 1 – and these were used for the trials and MHRA emergency authorisation. The second process – the one used for mass production – was completely different. It involved the use of plasmids – genetically altered 'templates' from which RNA material could be formed. The European Medical Agency stipulated the acceptable limits of the amount of contamination from the original plasmids allowed to remain due to this 2nd manufacturing process. Viral Vector vaccines may also have host cell proteins present in the finished product.

101. The second process was necessary because it was not practical or economical to employ the 1st manufacturing process for mass production. According to leaked documents mentioned in the British Medical Journal, the European Medicines Authority was not satisfied that it had been demonstrated that the batch 2 process produced a comparable product to the batch 1

process (which had been the one used in the vast majority of trial participants and from which the safety data was published and advertised) [RR/075 - INQ000503718], 66 and 68). When the placebo group were then vaccinated, Pfizer's data showed a much higher serious adverse event rate than in the original vaccinated group, "as expected" [RR/076 - INQ000503719]. Why was it expected? Was it because they knew they were receiving the live vaccine? Which manufacturing process did the vaccine they received involve? We would like to know when the MHRA saw the data published on the 500 recipients of EE8496Z and EJ0553Z? A letter written by the MHRA [RR/077 - INQ000503777] states:

> *"To provide helpful context and background, in the early stages of the pandemic, before BNT162b2 was authorised or approved, improvements were made to the manufacturing process to adjust the scalability, robustness, and productivity in preparation for large scale manufacture (Process 2); scaling of manufacturing processes is a common occurrence in the manufacture of medicines. Manufacturing steps that were not scalable were replaced with those designed to provide a similar or better impurity profile.*
>
> *Typically, such changes can be supported by analytical data; however, due to the nascent regulatory landscape for COVID-19 vaccines, in October 2020 an exploratory objective was added in the C4591001 study to describe safety and immunogenicity of vaccines produced by manufacturing "Process 1" or "Process 2" in participants 16 to 55 years of age. This exploratory objective was removed and documented in protocol amendment 20 in September 2022 due to the extensive usage of vaccines manufactured via "Process 2". Thus, this process comparison was not conducted as part of the formal documentation within the protocol amendment."*

102. My understanding is that this means that there was no testing data available for process 2 when the MHRA made the decision to authorise the widespread

delivery of vaccines produced with this new manufacturing process. This gets even worse with the information that has further come to light.

103. At a Senate hearing in South Carolina, Professor Buckhaults shared how he tested samples of the two batches of Pfizer that had been used in that State [RR/078 - INQ000503778] He found short pieces of DNA materials which were remnants of the plasmid DNA (used in the 2nd manufacturing process mentioned above). Plasmid DNA was not used in the first manufacturing process, the one tested on the 44,000 participants in the trial. The plasmid DNA is used as a template to produce the RNA material which is then encased in pseudouridine and lipid nanoparticles). He describes how this is extremely concerning because the lipid nanoparticles in which the mRNA is encased, will enable this DNA to enter human cells and alter their own cell DNA permanently. He suggests a very simple test be conducted on large samples of Pfizer participants globally. He also highlighted grave concerns about the regulatory process that allowed this mass manufacturing process, which, it seems, is very flawed.

104. Sampling of Astrazeneca's Viral Vector Vaccine by the University of Ulm, Germany, has further revealed considerable contamination way above the European Medical Agency's limits with Host Cell Proteins from the mass manufacturing process two. This is both published and peer reviewed [RR/079 - INQ000503720] Further similar findings were also discovered by University of Medicine Greifswald in Germany and published by the NIH National Institutes for Health [RR/080 - INQ000503721]. Note that the University of Medicine Greifswald was also at the forefront of identifying VITT, Vaccine Induced Thrombotic Thrombocytopenia.

105. I cannot speak with any authority on these issues, but I can relate how discoveries like these only add to the trauma of having an adverse reaction because they raise confidence issues in the manufacturing, testing and regulatory processes. It is important to maintain freedom of information and discussion. It is only because so much was hidden from the public, which in itself has created mistrust, that data like this cause us concern. Previously, we

would just get on with our lives and trust the scientists to work it out amongst themselves and inform us when we needed to know something important, fully confident that there was transparency and free debate. Discoveries like These also severely undermine our confidence in any future 'regulated' medicines. We can only conclude that June Raine was, therefore, not being completely straight with us in December 2020 when she said that no corners were cut. Her agency didn't follow its own regulations for production process validation.

What authorisation procedures were used?

106. The MRNA and Viral Vector D.N.A. products are technologies that have not been used at such scale in healthy populations before, and their long-term safety has not been established. They are not traditional vaccines that use a live or dead virus. Instead the mRNA & Viral Vector material injected into the muscle was intended to cause a localised production within our own cells of a small amount of spike protein. This is not meant to go into the nucleus of the cell, only into the cytoplasm, where the 'blueprint' is replicated and spike protein is produced (however a study found that it can enter the nucleus of liver cells and alter the DNA within 6 hours [RR/070 - INQ000503714]. Our body then develops antibodies to the spike protein so that when the whole virus enters the body it recognises it also ([RR/081 - INQ000503722]. The AstraZeneca vaccine was also a gene therapy, not a standard vaccine [RR/082 - INQ000503723], that was designed to make our cells produce spike protein [RR/083 - INQ000503724].

107. We would request an examination of what procedures the Medical And Healthcare Products Regulatory Agency followed. Were these the same used to authorise traditional vaccines or for new technologies? Vector Viral products have already been used – the Ebola vaccine & Kymriah (a leukaemia treatment under strict medical supervision due to extensive and interesting side effects, for example) – but mRNA products have had no previous use.

Further Safety Concerns

108. A Danish study [RR/084 - INQ000503725] found spike protein in the blood 28 days following vaccination, stating: "We expect that vaccine mRNA detected in plasma is contained within LNPs and that the LNPs in plasma have been slowly released from the injection site either directly to the blood or through the lymph system. Without the LNPs protecting the mRNA, the mRNA would rapidly degrade."

109. The study went on to say that this by no means undermined the current belief that the vaccines were safe and effective. This was not reassuring for those of us experiencing multi-system reactions following our vaccines and had believed that the spike proteins were supposed to be encapsulated in the arm muscle and not in the bloodstream at all. The study stopped after the 28 days were over, so we were left wondering.

110. Of all the parts of the Covid Virus, the Spike Protein was probably the most potentially problematic to use as part of a vaccine [RR/071 - INQ000503715], [RR/072 - INQ000503716] and [RR/073 - INQ000503776]. This was known before the pandemic and indicated within the document Corona Vaccine Development SARS to MERS to Covid19 [RR/085 - INQ000503726].

111. An Italian research study [RR/086 - INQ000377570] published August 2023 found spike protein in the blood of 50% of vaccinated participants as long as 6 months after vaccination. They ensured antibodies that would specifically indicate that the participants had been infected by Covid-19 were absent, leading them to conclude that, as long as six months after vaccination, our blood can still contain spike protein. The study offered several explanations – either that bacteria in the blood are replicating the DNA, or that the mRNA material migrated to other parts of the body where the cells began to produce spike protein, or that a spike protein is being continually produced in the injection site. The study said it was still to collect data on other tissue samples and was stopped after six months, so we are waiting to see the results. We

don't know how much longer spike protein can remain in the blood, or what the explanation is.

112. We don't know if our cells within multiple systems and locations – have been programmed to produce spike protein also. It doesn't take much imagination to know how we as vaccine injured individuals feel about the lack of research into this. We are desperately seeking answers and the doctors who are helping us are not sure what they are dealing with. If we knew our bodies were still producing spike protein that would be one clue. Research studies have shown that spike protein does cross the blood brain barrier [RR/087 - INQ000503728] and [RR/088 - INQ000503729] which could explain a lot of our neurological issues – but what to do about it?. Many of our group are told they have Functional Neurological Disorder – and told to go home with very little treatment. Some discover they have Multiple Sclerosis or transverse myelitis. Those with a Functional Neurological Disorder diagnosis are turned down straight away by the vaccine damage payment scheme who do not recognise a correlation between that and the vaccines.

113. Another study showed: "Free spike antigen was detected in the blood of adolescents and young adults who developed post-mRNA vaccine myocarditis, advancing insight into its potential underlying cause" [RR/089 - INQ000503730].

114. Considering the billions of profits that the pharmaceutical industry makes each year, we are overwhelmingly disheartened at the sporadic research into what is wrong with us and how we can be treated. Instead we are hidden away from plain view and sometimes intimidated into silence. We trusted that research had been done, that the vaccines were indeed safe. Now we are discovering it isn't the case in everyone and we want to know what separates us from those who have not adversely reacted. Surely everyone should want to know that?

115. Dr Malone and Dr Philip McMillan did a video chat explaining that, not only can the mRNA end up in different parts of the body and that spike protein can be

found in the blood, but that the spike protein binds to ACE2 receptors in multiple tissue cells at locations across the body, which could lead to autoimmune conditions as our immune system begins to attack our own bodies. This particular aspect of the interview can be viewed from around 45 minutes in [RR/090 - INQ000503731]. They refer to a study [RR/069 - INQ000377592]. where spike protein was found in the blood of nurses. Dr Malone expresses concerns that there could potentially be a lot more spike protein which is not circulating in the blood because it has already bound to ACE2 receptors in blood vessels or the heart.

116. More and more research is coming out illustrating that the trials did not cover all the bases. Recently a research study used PET scans to measure the effects of the mRNA on vaccinated people's hearts [RR/091 - INQ000503732]. The findings illustrated that damage was occurring in people's hearts that was, as yet, undetectable without using particular techniques to investigate. We ask, was this conducted in the clinical trials? Or were the 'adverse events' dependent upon already fully emerged symptoms and a diagnosable condition? As it takes time, up to 2 years, for autoimmune disorders to develop, is adequate research being done over the longer term?

117. With all this as background, and considering the risk of myocarditis in young people, we would like to understand the government decisions on the very targeted messaging to this group through social media giant Snapchat who reach 75% of 13 to 34 year olds in the UK.

118. The government web page continues, "Advice and information on the benefits of vaccination have been shared at every opportunity, including through a range of partnerships with industries catering for predominantly younger audiences" [RR/092 - INQ000503733]. Nowhere does it list that the risks will also be explained. This is obviously very disconcerting to parents, particularly those injured themselves, that true informed consent can be given by this young group.

Storage and Distribution - Serialisation

119. Our understanding is that there are two types of pharma products:

a. Small Molecule, something like Aspirin, which can be easily produced en masse in fully understood and easy to replicate from site to site, both small laboratory & large production batch and they can be moved easily and will store a long time!
b. Biologics (Large Molecule)
Biologics are inherently difficult under normal circumstances to guarantee site to site or batch to batch consistency for safety & efficacy.

As stated previously, all the Western supplied Covid-19 vaccines are Biologics.

120. The Journal of Biomedical Science published a manuscript that highlighted the advantages and disadvantages of different types of vaccines. For Viral Vector vaccines they stressed the complicated manufacturing process and the risk of genomic integration plus a damped response due to pre-existing immunity against the vector. For mRNA they highlighted that there is lower immunogenicity, the potential risk of RNA induced interferon response and the issues surrounding low temperature storage and transportation. I am not a scientist but they all appear quite clear and point to challenges in maintaining quality control in rushed mass production and mass transportation **[RR/085 - INQ000503726]**

121. We would like to bring to the Inquiry's attention our concern over a lack of serialisation. Serialisation is a global requirement and helps to avoid counterfeit medications being dispersed. The contract between the European Union and Pfizer (on page 48) shows that serialisation was waived due to the emergency conditions **[RR/008 - INQ000503658].**

122. Our understanding is that each dose would normally receive its own unique serial number, in addition to being assigned to a specific batch and a specific lot of vaccines. In the case of the Pfizer mRNA vaccines, five doses were batched in

each vial, leaving the onsite staff to dilute and measure out each dose. We would also like the Inquiry to investigate whether adequate training was given for this process. Our understanding is that each dose would normally receive its own unique serial number, in addition to being assigned to a specific batch and a specific lot of vaccines. In the case of the Pizer mRNA vaccines, five doses were batched in each vial, leaving the onsite staff to dilute and measure out each dose, so instead of carefully measured and serialised doses, there were unserialised vials which then had to be measured and mixed on site.

123. A European Medicines Agency spokesperson said these vaccines: " are biological products. Even tiny differences in the manufacturing conditions can result in differences in the final product. The manufacturing process defines the finished product" **[RR/093 - INQ000503799].** It stands to reason therefore that even slight variations between batches could be problematic and need responding to quickly which makes serialisation even more important so that the vials could be recalled.

124. There are examples where bad batches had to be withdrawn due to contamination. Here are two:

a. 60 million doses of Johnson and Johnson vaccine made at its Baltimore plant had to be withdrawn **[RR/094 - INQ000503734].**
b. Another example was in Japan, where a batch of Moderna mRNA vaccine had to be recalled due to apparent contamination **[RR/095 - INQ000503735].**

125. We have a list that has been circulating of the top ten most reported batch numbers for different vaccines **[RR/096 - INQ000377540]**, and some of our members have confirmed they were given those batches. We ask why this doesn't appear to have been monitored, recorded and investigated, nor has any information on the next 10 or 20 batches with problems been made available.

126. Regulatory authorities are required to check for compliance to good distribution practices across every supply chain or company involved in medicines **[RR/097 - INQ000503783].**

127. Vital advice in the WHO's Covid-19 Safety Surveillance Manual. Section 2.4 said that if two or more adverse events following immunisation (AEFIs) occurred after vaccination from the same vaccine batch, or due to the same reason, or were reported from the same place, group screenings must be undertaken. A Freedom of Information request shows that there are many batches with more than two reactions. The worst batch so far is Oxford/AstraZeneca's batch number 4120Z003 with 7,394 adverse events recorded and 18 deaths.

128. One member of our group received a batch that hit headlines because it was one of these 'Indian' batches and if anyone had received one of those, they were not recognised by the European Union for travel. The three batch numbers in question are: 4120Z001, 4120Z002, 4120Z003. On investigation, she discovered that vaccine recipients in Canada with the same batch numbers had the name Covishield and others with the same batch in the UK were named Vaxzevria. She would like an explanation. India's foreign Secretary stated that the UK government had requested and received five million doses and that it was "*a licensed product of a UK company, manufactured in India*".

129. An article printed in "Money Control" **[RR/098 - INQ000503784]** describes how Covishield was not approved under EU rules (see also **[RR/099 - INQ000503737].** The European Medicines Agency spokesperson said: "This is because vaccines are biological products. Even tiny differences in the manufacturing conditions can result in differences in the final product, and EU law, therefore, requires the manufacturing sites and production process to be assessed and approved as part of the authorisation process," the EMA spokesperson noted."

130. A Danish study found significant variability in the rate of serious adverse events across 52 different lots of Comirnaty, again raising questions about batches, manufacturing processes, storage or transportation **[RR/100 - INQ000503738].**

131. Good quality control is imperative and needs to be established, as exists with other medical products, with full transparency of the ingredients and potential adverse effects, including severe ones, which will allow recipients to give informed consent.

132. As mentioned above, all Western produced Covid-19 vaccines are biologics and therefore more complex to manufacture. It could be argued that the small quantity of vaccine put through trials is a lot easier to control and monitor than when the vaccines are mass produced and delivered globally by vaccinators with a wide range of qualifications and awareness. The emergency licence quotes amounts of contamination allowed in batches, illustrating that some contamination is expected. This doesn't just happen by 'accident' – it happens because of the process of manufacture and it is expected that small amounts of the manufacturing contaminants might remain. However, to roll out a vaccine on such a large scale in such a short timeframe does call into question if proper quality controls were met.

133. Calling this process "Safe & Effective" is a glossing over of the truth as the adverse effects are clearly higher than in all previous vaccines. This appears to be an acceptable situation for the Government.

134. Analysis was conducted on the AstraZeneca vaccine in July 22 by the Dept of Gene Therapy, University of Ulm, Germany [RR/101 - INQ000377886] and it found: "The HCP (Host Cell Protein) content exceeded the 400 ng specification limit per vaccine dose, as set by the European Medicines Agency (EMA) for this vaccine, by at least 25-fold and the manufacturer's batch-release data in some of the lots by several hundred-fold. In contrast, three tested lots of the Ad26.COV2.S vaccine contained only very low amounts of HCPs. As shown for Ad26.COV2.S production of clinical grade adenovirus vaccines of high purity is feasible at an industrial scale. Correspondingly, purification procedures of the ChAdOx1 nCov-19 vaccine should be modified to remove protein impurities as best as possible. Our data also indicates that standard quality assays, as they are used in the manufacturing of proteins, have to be adapted for vectored vaccines."

135. The 'host cell proteins' from the production process should be removed as much as possible and are strictly limited by agreement with EMA as part of the authorisation licence. Possible results of these contaminants would be to cause a much more reactive immune response than in trial batches and therefore much greater autoimmunity issues for the recipient.

136. The editor of e-Life, the publisher of the University of Ulm research, added: "This research shows that a commonly used commercial vaccine for COVID-19 harbours contaminating proteins derived from the human cell line in which it is produced. The health significance of these contaminants (if any) remains unknown. This paper is important because lot purity and processing of vaccines is rarely scrutinised in the scientific realm, and instead is typically analysed only by the companies themselves."

137. As already indicated, researchers at the University of Medicine Greifswald in Germany investigated the contents of adenoviral vector-based vaccines, they found significant quantities of HCP.2 This has been linked to the incidences of VITT - vaccine-induced thrombosis with thrombocytopenia syndrome **[RR/102 - INQ000503740].**

138. According to Dr Thomas Kofoed, co-founder of Alphalyse, the effects of host cell proteins can manifest in several ways **[RR/103 - INQ000503741].**

139. "HCPs can be very critical because they can have biological activity and interfere with how the drug works or, maybe worse, act on the patient directly. Even if the HCP isn't bioactive, it can act as an adjuvant to raise an undesired immune response in the patient that could result in multiple organ failure."

140. It appears that not only might viral vector vaccines be contaminated and lead to autoimmune conditions but carry the risk of potentially altering a person's DNA. An article in the Journal of Biomedical Science **[RR/104 - INQ000503742]** states: "The manufacturing process for viral vector vaccines is more complicated than other approaches, including the optimization of cellular systems and the

exclusion of contaminants, which can greatly affect the efficiency of viral vectors [57]. Moreover, recombinant viruses carry the risk of integrating their genome into the human host, so additional biosafety assessment will be required before entering clinical trials. Finally, if the chosen viral vector can infect the general populations, the pre-existing immunity on the viral vector could dampen the induced immune response, which has been seen in adenovirus- and measle virus-based vaccines [72, 73]"

141. Another article, in the 'Times of India' highlights the need for appropriate labelling for virals to check for heat damage [RR/105 - INQ000503743]. China apparently was using these and India used them routinely for the polio vaccine. This, again, raises questions about if 'Good Distribution Practice' was maintained.

142. We submit that there should have been a mechanism to inform people who have received vaccination from a batch that appears to be problematic, or at the very least, to be able to keep a record of which batches have caused adverse reactions.

143. All of this information can come across to the reader as academic research, but to us this can mean the difference between life or death, health or disablement. It is crushing to know that we believed the 'Safe and Effective' narrative and are now paying the price. All of this information is playing out in real life in real people – in US. How many of the population are also affected and don't know it yet?

Conflicts of Interest in our regulatory bodies

144. The UK Joint Committee for Vaccination and Immunisation (JCVI) is clearly not independent or unbiased according to an article written by Dr Zoe Harcombe (PHD): "None of the members of the COVID-19 sub-committee of the JCVI declared conflicts of interests. Five of the 14 non-lay members provided additional information in their 'non-declaration' that revealed conflicts of interest. A cursory search on the remaining nine revealed that six had

conflicts of interest – from running a COVID-19 vaccine trial to being their organisation's representative for Pfizer. One member failed to declare that he leads the Pfizer Vaccine Centre of Excellence. The members work for organisations, which collectively have received approximately $1,000,000,000"

[RR/106 - INQ000503744].

145. Experiences our members had at vaccination centres were also highly concerning. When one of the ladies in our group had her vaccine, there was no policy of asking people to wait for a few minutes before leaving. She asked if she should go over and sit by the door but was told no, that area was only for people who had previously had anaphylactic episodes. By the time she reached her car, she had the sensation of water running down the back of her neck, blinding pain in her head and lost sensation in her hand – the side where she had received her injection. By the following day, she had lost feeling in her arms and legs on both sides. Due to public messaging, she opted not to take herself immediately to a hospital, believing it was only permissible for those dying or seriously ill. She developed flu-like symptoms also, and when she called the doctor, she was told to go to the pharmacist instead. Her mother went on her behalf, and the pharmacist insisted a doctor see her because of the numerous people they had seen over the past two days with severe reactions, and they were very concerned. The doctor only gave her a callback after he had spoken to another woman describing the same symptoms, and only then did the G.P. arrange for bloods to be taken. Interestingly, by the time she got to see a neurologist, she was told it was biologically impossible to have a reaction so quickly.

146. Another of our members, a man in his thirties, was asked to sit before leaving. Under five minutes after receiving his vaccination, he had the sensation of being choked and difficulty breathing. At the same time, he felt like he was having electric shocks throughout his body. He started trying to call for help, and other members of the public managed to find staff members for him. Two nurses came over, and neither examined him but told him to drink some water, wait for ten minutes, and then leave – that he was having a panic attack. He did just that and set off for work, feeling wave after wave of electric shocks

throughout his body. After an hour and a half at work, he collapsed and was sent home. By the time he reached home, an ambulance had to be called. The paramedics told him he had most likely had a mild reaction to the vaccine, which should hopefully pass, and offered to take him to the hospital – but the public messaging at the time was that it is better to stay away from hospital and the 'safe and effective' vaccine couldn't cause lasting adverse reactions, so he chose not to.

Nurse showed up to deliver the vaccine with no prior warning.

147. The father of one of our members had a health condition so was isolating at home. He had an unexpected visit from a local community nurse who told him she was there to give him his vaccination, which he gladly took – but there was no forewarning, no explanation of side effects and no leaflet or card provided before the nurse left. Almost immediately, he lost feeling and muscle strength in his legs, so he was confined to the couch. Like everyone else, he believed the vaccines wouldn't cause permanent or dangerous symptoms, so he didn't do anything but died – still at home on his couch seven days later.

148. Yet another group member had power of attorney over her father. He had taken two AstraZeneca vaccines but had told his daughter he didn't want to touch any more. His health drastically declined, and he ended up very quickly diagnosed with Alzheimer's and needed to be transferred into a home. His daughter gave the care home strict and clear instructions that he should not have any vaccines because he had a history of medication reactions. (See [RR/107 - INQ000401211] open letter to managers of care homes explaining why informed consent is a legal requirement). She was then told that her father had had a fall, and the staff member from the home said it must have been because he had received his vaccine.

149. When she managed to see her father, he had haematomas (burgundy bruises) that began where his lymph nodes were behind his ear. These kept coming and going over several weeks but never changed colour or faded in the same manner bruises do. She was extremely worried, but the care home refused to

bring in a doctor – saying doctors don't visit homes – and instead, a nurse practitioner came to see him, and photos were taken to show to the doctor. His daughter was asking for him to see a haematologist and to be given a d-dimer but instead, he was referred to dermatology. Sadly, he was taken to hospital for another condition and died a few days later. Even while he was in hospital, our group member asked for the haematomas to be investigated but was refused. Here are just four out of many examples of where delivery of the vaccine has been questionable.

150. We would like to know when the decision was made that people should sit and wait for 15 minutes before leaving vaccine centres and why this was changed? Why was it that our group member who was having difficulty breathing depended on other public members for help? Why would a community nurse turn up at someone's home and deliver a vaccine without prior warning or proper informed consent? This gentleman was under the impression he would never get past his front door again without taking a vaccine, so he wasn't about to refuse it.

Proper informed consent

151. For various reasons, many of our group feel they did not give informed consent, which is a fundamental human right. Dr Sarah Myhill (GP) sent an Open Letter to GMC Chair, Dame Clare Marx, highlighting that informed consent was not being given in November 2020 [RR/108 - INQ000503746] in addition to another by doctors of the UK Medical Freedom Alliance highlighting concerns not only about lack of informed consent but grave questions about the vaccines' safety. We feel it's imperative the Inquiry examines how these concerns were addressed and subsequently dismissed. What decision making took place and by whom to establish this as irrelevant, particularly when placed together with the evidence stated within this document.

152. Informed consent involves not only knowing the risks but also not being coerced and knowing all the alternatives. Many of us feel very strongly about this. One group member particularly so. Both he AND his wife have been

extremely ill since their vaccines and very brain-fogged – indeed, he still is and has been told by his doctor that it is likely he will have a heart attack or a stroke. Therefore, he is desperate for his truth to be heard, so he wrote to the N.H.S. and Ombudsman about it, only to be told he had left it too long so his complaint would not be upheld [RR/109 - INQ000503785], [RR/110 - INQ000503786], [RR/111 - INQ000503787].

153. Another serious issue that came to our attention was that it appears that either people were vaccinated by mistake with a version of AstraZeneca which was not even in trials yet, or that there was a clinical error and the wrong information was negligently added to medical records. Patient records listing adverse reactions state that the product AZD2816 was administered as early as January 2021, however this did not enter clinical trials until June 2021 [RR/112 - INQ000503747], [RR/113 - INQ000503748], and [RR/114 - INQ000503749]. The AstraZeneca vaccine that was licenced by the MHRA under article 174 was AZD1222. It was later marketed as Vaxzeveria. The product AZD2816 was a slightly modified mark two version that allowed for later Covid variants. It was not put forward for provisional emergency use as it was not a sufficient improvement to warrant the effort and should not have been administered to anyone without their full consent to participate in a clinical trial.

Information leaflets are not being handed out, or they do not contain a complete list of potential side effects.

154. Information leaflets were not handed out in many Scottish vaccination centres until after vaccination, and even then they did not contain all the possible side effects we know are possible. Indeed, a list of 43 have even been paid out for by the vaccine damage payment scheme [RR/115 - INQ000503750]. I have even mentioned an example where the vaccine was given against consent, but there is more to informed consent than that.

Not feeling coerced

155. Informed consent is not just about knowing the risks involved but also depends on not being coerced and knowing all the alternative options available to you. It didn't even occur to many of us to question what we were being told. The strong public message was to go for vaccines, that we were selfish not to, that they were safe and effective, and there was no other option for a return to 'normal'. We were bombarded with tv, newspapers, radio, posters – everything telling us the vaccines were safe and effective. A BBC article published even had Boris Johnson getting his vaccination and quoted: On Thursday, the prime minister reiterated that the jab was safe and urged people to take the vaccine if they were offered it. He said: "The thing that isn't safe is catching Covid, which is why it's so important that we all get our jabs as soon as our turn comes."

156. The word SAFE was used 8 times in this relatively short article **[RR/116 - INQ000503751].**

157. We quote Boris Johnston introducing the UK Government "Life Sciences Vision for UK, Build Back Better, Our Plan for Growth": *"Yet these extraordinary achievements are not merely the product of brilliant science, they have also required a radically different way of supporting it.* ***Driven by an urgency for results and a willingness to take risks,*** *the Vaccine Taskforce used government funding to mobilise private sector investment and inspire a seamless collaboration between our scientists, pharmaceutical companies, regulators, and NHS"* **[RR/117 - INQ000503752].**

158. There were no debates or opposing views to this narrative allowed, and, in fact, we now know that large amounts of money were being spent to stem any opposing views in mainstream and social media. We were told that being overweight was problematic, but why weren't we educated about other self-help preventions against infection, such as vitamin D? Or zinc and Vitamin C? In addition to being bombarded with the message to take our vaccines, we were informed weekly how many people had died from Covid-19. One of our

members was tracking all the statistics very closely. The Scottish Government published data on what percentage of the population was vaccinated, unvaccinated, how many were hospitalised, and the percentage of those who were vaccinated or not, but as time went on these figures stopped being published. We want to know why?

159. In addition to strong public messaging about Safe and Effective and protecting our Granny, many of us faced exclusion from workplaces and social events or even travel for work without taking vaccines. Christian Buckland, Doctor of Psychology in Psychotherapy and Counselling and Chairman of the Board of the U.K. Council for Psychotherapy (UKCP), wrote an open letter to the U.K. Prime Minister Rishi-Sunak condemning the coercive tactics used and thereby undermining informed consent:

160. Christian Buckland wrote, "I do, however, wish to highlight one extremely serious consequence that I believe has occurred as a direct result of the use of unethical psychological techniques/behavioural insights on the unknowing public: by adopting the techniques used, the Government significantly and materially undermined, if not removed, the U.K. population's ability to give valid informed consent to taking a Covid-19 vaccine."

> *"For consent to immunisation to be (sic) valid, it must be given freely, voluntarily and without coercion by an appropriately informed person who has the mental capacity to consent to the administration of the vaccines in question". (Gov.uk, 2021)*

> *"The threat or use of punitive measures against states, groups or individuals in order for them to undertake or desist from specified actions. In addition to the threat of or limited use of force (or both), coercion may entail economic sanctions, psychological pressures, and social ostracism." (Encyclopedia Britannica, 2023).* **[RR/118 - INQ000503753].**

161. The N.H.S. Behavioural Change Unit published a document outlining strategies to persuade people expressing concerns to take the vaccine

[RR/119 - INQ000503789]. We would ask the inquiry to examine carefully if these tactics undermine patient autonomy.

162. Another issue we would like to address is coercion in the workplace to take a vaccine. In Scotland, the Government claimed vaccines were not mandated, but this was not how members of our group perceived it, and it was implied that they would either lose their jobs or not be allowed into the workplace. Others were shamed by having emails circulated among their work colleagues naming those who hadn't yet been vaccinated. As a result, some took the vaccine against their better judgement, and as a result, their finances have been drastically impacted. We would like the Inquiry to consider in circumstances when it can be illustrated it was inferred that the vaccination was required for work that employers should have treated vaccine injury as a workplace injury.

163. The message 'safe and effective' was widely promoted to increase vaccine confidence and avoid vaccine 'hesitancy' (We dislike this word because it implies fault instead of curiosity). In contrast, the levels of censorship our members have faced on social media are astonishing. We cannot mention the word vaccine or name any vaccine in our Facebook support groups. Our posts, even of the U.K. Public Inquiry, have been torn down from YouTube and from TikTok [RR/052 - INQ000503772]. Our accounts are frozen, and we are shadow-banned or prevented from sharing posts. Imagine having cancer and being unable to mention the word cancer in your support group or having your Social Media account frozen for talking about it?

164. Not receiving proper informed consent creates feelings of betrayal and being unsafe. Carers feel guilty for persuading loved ones to be vaccinated, having believed it to be in the best interests of all due to the advice given by health professionals, scientists, and Government.

165. We would also ask that the Inquiry examines the use of the word 'safe' in all Government promotion of the vaccines. The Association of British Pharmaceutical Industries has a Code of Practice [RR/064 - INQ000413039] that has

strict guidelines about the use of the word SAFE in relation to pharmaceutical interventions. On Page 15, clause 6.4 it states:

> *"Information and claims about adverse reactions must reflect available evidence or be capable of substantiation by clinical experience. It must not be stated that a product has no adverse reactions, toxic hazards or risks of addiction or dependency. The word "safe" must not be used without qualification"* [this is supplement at top of Page 16].

166. Because the words 'safe' and 'effective' were so widely used and are ingrained into our psyches, our group has faced astonishment, denial and even accusation amongst the general public when we say we have a vaccine injury. Vaccine safety has become a very polarised topic when it should not be in order to encourage widespread and safe adoption of safe vaccines.

167. Also, as time passed, news about ivermectin and hydroxychloroquine began to spread. This was then heavily censored, and public messages appeared everywhere that ivermectin was a horse medication and dangerous for people. I have done some research of my own because I now depend on Ivermectin [RR/120 - INQ000503790] – it is the primary medication, along with the treatments for Mast Cell Activation, that I need to have any quality of life. From my research, it appears to be one of the safest and cheapest medications available. Indeed, I have been told by people with experience in the pharmaceutical industry that it takes nine years to thoroughly test and approve such medications – in contrast to the speed at which the vaccines were rolled out. Ivermectin comes with an information leaflet explaining all the risks – I didn't receive that when I took my vaccine.

168. There was such a massive smear campaign that the reactions I receive when I say how effective it is for me are almost comical. I am not alone because large numbers of the vaccine-injured community take ivermectin. One of our group members dared to show her G.P. the FLCCC protocol because she had heard it was helping others [RR/121 - INQ000503791], and she was told ivermectin was a horse dewormer. When she then asked for a referral back to neurology

because her symptoms were worsening, her G.P. wrote in the referral that she was doing an unhealthy amount of research online into non-evidence-based medications and inferred that she was not in a good place psychologically. The neurologist then wrote back to refuse her referral and told the GP to send the patient to a psychologist. This group member still experiences neurological issues and only found out what was in the letter when she asked for a copy of her medical records. She is a young professional woman with a law degree and had a job that involved massive responsibilities (until the vaccine). She isn't emotionally or psychologically unstable!

169. We would ask the Inquiry to please investigate all the options for alternative treatments being discussed and available at the time of the vaccine rollout in addition to the reasons why these were dismissed, in fact, maligned, which reinforced the message that emergency use of new mRNA technology was necessary.

170. We would ask the Inquiry to please ask an expert witness to closely examine the research studies conducted that discredited those alternative therapies. Again, the U.K. Government's own independent report stated: "Crucial research evidence that should help shine a light on what are safe and effective interventions is neither prioritised nor funded. And we heard about research that is funded by manufacturers that never sees the light of day because it is negative or inconclusive for the product in question, or is less than transparent in its declaration of conflicts of interest when positive findings are reported" [RR/122 - INQ000486333] We would like to be reassured that any research studies either into the safety of vaccines or the alternatives were conducted rigorously and without bias.

171. Due to the fact that this was a 'novel' virus and a brand-new vaccine was necessary, there should have been policy changes to allow doctors more autonomy to prescribe off-label to find out which would have the best outcomes for their patients without fearing repercussions. For example, some of our group members HAVE found off-label medications work but have to pay for these privately. The FLCCC 'Long Vax' treatment protocol and 'Long Covid

treatment protocol uses everyday, standard medications to treat Covid/long Covid and vaccine injury but for off-label conditions. Non vaccine/preventative treatments should have received more research and promotion for those who did not wish to receive vaccines.

172. I wish to clarify that we are fundamentally not anti-vaccination – indeed, our members voluntarily went to receive their vaccines in good faith to protect themselves and those around us - but we do wish to raise concerns about vaccine efficacy. Those of us who have been adversely impacted by the vaccines and have then gone on to catch Covid-19 have, in some cases, found the improvements we had made in our health have been badly impacted, so we are even worse off. It is massively discouraging to think we exposed ourselves to so much risk by taking the vaccine for little return. I have considered some peer-reviewed studies regarding vaccine efficacy [RR/123 - INQ000503755], [RR/124 - INQ000412932], [RR/125- INQ000503757], [RR/126- INQ000408421], [RR/138 - INQ000503756], [RR/127- INQ000503759]. We recognise that we are not experts and would like clarification from experts in epidemiology and further note this research continues to evolve.

173. Most vitally, because the vaccines were rolled out under emergency legislation, we would also question if the same urgency still exists to justify their continued use without more thorough research [RR/128- INQ000503794].

Active rather than passive reporting.

174. According to an article published in PUBMED [RR/129 - INQ000503760], a joint council in the Ministry of Health, Labour and Welfare in Japan is held every two to three weeks to summarise information on the adverse events following COVID-19 vaccination, with careful assessment of individual case safety reports and comparison with background incidence rates. To our knowledge, there is no such thing in Scotland or the United Kingdom.

175. A global group to gather and extrapolate data and disseminate vaccine reactions/treatments should have been established. Intensive care staff, GPs,

etc., should be able to share what they are seeing and hearing from patients. Vaccine damage wasn't considered in planning.

176. Data should have been collected for those with underlying health conditions before administering the vaccines; then, further data should be collected to evaluate if their health conditions were impacted post-vaccinations.

Yellow Card System

177. Before we talk about the experiences of our group trying to report to the Yellow Card Scheme, we will highlight some issues that cause us concern.

178. A study in the European Journal of Heart Failure [RR/016 - INQ000503666] highlights the inadequacies of relying on a passive reporting system. 1 in 35 participants' blood results showed underlying myocardial injury following their vaccine. This study illustrated that only severe cases requiring hospitalisation are reported. Yet, active surveillance revealed both women as well as men had underlying non-symptomatic heart irregularities following their vaccines that could have resulted in sudden onset symptoms had they remained undetected. They could have resulted in serious complications had they not been put under a doctor's care.

179. The results showed a massively higher rate of adverse reactions than those reported to a passive reporting system like the Yellow Card. One finding of concern is that this study revealed women had a higher incidence of heart irregularities than men – when currently, the general understanding from self-reporting is that myocarditis is more common in men. The concern raised by this study is the implications of repeated vaccination in members of the public who are currently asymptomatic so unaware of the risk they are exposing themselves to. Another massive concern is that people who have received the Moderna vaccine should be told not to exercise immediately afterwards!

180. According to a reply to a freedom of information request by Cheryl Grainger [RR/130 - INQ000503761], 12,932 participants out of 29,832 participants in the yellow card vaccine monitoring scheme reported an adverse reaction. We do not know how serious those reactions were, but this illustrates how large the issue of under-reporting is, using a passive reporting system. The population of the U.K. is approximately 67,000,000 so even if only 50% of these were vaccinated, those figures would mean 14,405 000 could have suffered some kind of adverse event. Only 303,203 had reported to the Yellow Card Scheme by the date of this report.

181. In July 2020, The U.K. Government stated that: "There is a need for more robust, publicly accessible post-marketing surveillance. This should include mandatory requirements on healthcare organisations to report adverse events within a designated time period" and "The spontaneous reporting platform for medicines and devices, the Yellow Card system, needs reform. It needs to provide a user-friendly, accessible, transparent repository of adverse event reports" [RR/122 - INQ000486333].

182. The U.K. Government's own website states that "It is estimated that only 10% of serious reactions and between 2 and 4% of non-serious reactions are reported" [RR/131 - INQ000503762].

183. Yellow Card ceased publishing results for adverse events associated with Covid-19 Vaccines. According to Dr Croft in his testimony to the Scottish Public Inquiry, Day 2, they also removed the December 2022 report from their website – or at least Dr Croft could not find it [RR/006 - INQ000503656].

184. There is a Yellow Card Vaccine Monitor [RR/132 - INQ000503795]. Still, there are no results anywhere that we are aware of except a report released in response to a freedom of information request [RR/130 - INQ000503761]. We would request an investigation as to why there hasn't been one, where and when we can see a full report of the results and if data is still being gathered. This article states that 53% of people participating reported an adverse reaction. The vaccine-injured and bereaved have been left to do our own research and rely

on independent researchers publishing peer-reviewed publications to confirm adverse reactions are happening.

185. It is worth noting here the much more open information produced in Germany. In late 2022, according to the Paul-Ehrlich-Institute, all adverse events were at 1.8 per 1000 vaccinations and serious adverse events were at a rate of 0.3 per 1000 vaccinations **[RR/133 - INQ000503796].**

186. The experiences reported to us by our members of completing Yellow Card reports have been mixed. To begin with, most of them were unaware that it even existed. Then, most have reported that it was highly challenging for a layperson, and they were disappointed that their doctors weren't doing it for them. Of course, this wasn't surprising since many of our doctors were reluctant to write on our records that we were having an adverse reaction even though they verbalised it. The process of filling out the questionnaire is complex. The user has to use a drop-down list to find each symptom separately, but these are described in terms many of us don't understand. Also, each symptom must be reported separately, so it takes a long time. Some members said they couldn't find their symptoms on the drop-down lists, so they just gave up on those ones.

Brain fog and fatigue also made this an overwhelming task.

187. I completed my questionnaire on the 30th of December 2021. In April 2022, I wanted to update it with my diagnosis and further symptoms that had developed, but I couldn't access my report. When I emailed MHRA to explain I couldn't access my account and sent them all the new information, they said they would update it for me. Another few months later (August 2022), I emailed again to explain I still couldn't log in and was told that I must have initially logged in as a guest user and not created an account – something I wouldn't normally do -, but I accepted their explanation because I was so ill when I completed the report, I couldn't be certain. They assured me they would update the information for me, so I sent it.

188. In October, I emailed once more with more updates to add but asked this time to see my report because others had informed me that their reports had gone missing. I requested that an account be created for me with all my information in it so I could access it. I received no response. In January 2023, I created another account and wrote, asking that my information be transferred to that account. I still didn't receive a response. In February, I tried to log in to my new account, but it was asking for an account number I never received – I hadn't received an email confirming the account had been set up. So, I emailed again explaining what had happened. I still received no response.

189. In the end, in June 2023, I emailed and CC'd in the Scottish Vaccine Injury Group email address, and then received an email in July apologising, saying someone would be in touch. Then, in August, I received an email with a copy of my yellow card report, which did not include all the information I had sent and an assurance that my data would be transferred to my new account. I tried logging in to my new account again and this time it worked. In late September 2023 my data still wasn't transferred across.

190. I would add to this that the symptoms I reported are very serious, yet MHRA has not contacted me to investigate. I do not currently know how many people in our group MHRA have followed up on, but I will ask that question.

191. Another of our members who experienced a spinal stroke following his vaccine was told by the doctor in the hospital that they would be completing a Yellow Card report, and, indeed, this is noted in his hospital records [RR/134 - INQ000503797]. When he applied to the vaccine damage payment scheme, the report couldn't be found, and the hospital had no record of it being done. This seriously undermined his credibility, and he was turned down for his vaccine damage payment and is now appealing. He wrote to someone in N.H.S. Grampian to ask why the report hadn't been submitted and has received no reply.

192. Considering the scale of the Covid-19 vaccine rollout, it is not unreasonable that a bespoke reporting system should have been implemented that would have fed information in both directions. Perhaps the Yellow Card Vaccine

Monitor WAS such a system, but we know nothing about it, nor have we seen a full report from this. We would envisage an effective scheme that would capture age, gender, race, blood type, co-morbidities, family history etc and perhaps help shed light on why certain people have certain reactions. It should also make completing a report more streamlined and accessing and updating reports easier and would also allow for a more long-term collection of data, offering a longitudinal view of how symptoms develop and emerge and how the vaccines impact on people with prior health conditions. Then, if clinics or treatments were available, or further research uncovered other potential complications, those who had submitted a report could be contacted.

Vaccine Damage Payment Scheme (VDPS)

193. Benefits do not cover household bills. Many of our group worked before being adversely affected by the vaccine and some cannot return to work because of continual delays in treatment and waiting lists. Since vaccine injury is not a recognised condition, this makes accessing financial support more difficult and subsequently, we would like Disability Payment Schemes to add vaccine injury as a recognised condition and to understand how debilitating this condition can be. There are several reasons why many of our members have not even submitted a claim to the Vaccine Damage Payment Scheme.

194. These include:

    a. Lack of a diagnosis/cause of death on death certificates. Even though doctors often give a verbal reason for our members' condition as the vaccine, they will rarely write it on medical records. One of our members, who has no shadow of a doubt that her husband's death was due to the Covid-19 vaccine, is still distraught that 'possible Myocardial Infarction' was put on his death certificate. There was no post-mortem despite it being a sudden death at home. In a poll we ran in our group, 46% of respondents said that even though their doctor said the vaccine was most likely the cause, they did not write this down on their medical notes. Many

doctors managed to avoid this by saying 'The patient believes' the cause of their symptoms to be the vaccine.

b. Many assume that they won't meet the 60% disability threshold, despite not being well enough to function in their jobs or to work at all. This is compounded by hearing reports from other group members saying they have been refused.

c. Observing everyone being turned down discourages people who are already struggling with everyday life to take on such an overwhelming task. As we have said previously, simply advocating for ourselves at medical appointments is overwhelming without adding on applying for benefits and then the VACCINE DAMAGE PAYMENT SCHEME.

d. Accessing medical records can take weeks. One of our members has been waiting for 7 months for his records, despite chasing them up.

195. There are other issues surrounding the VACCINE DAMAGE PAYMENT SCHEME which, from our perspective, need to be overhauled:

a. Other short-term financial support should be considered while Vaccine Damage Payment Scheme claims are being processed.

b. Despite the knowledge that there would be mass vaccination, the Vaccine Damage Payment Scheme remained understaffed for a considerable time and took months, even up to two years, to process claims. One group member was told that, had their claim been assessed more efficiently, they would have received payment because they had undoubtedly been 60 per cent disabled and there was an obvious causal link to the vaccine. However, because it took so long and they were now not disabled enough (estimated at 40 per cent) they were no longer eligible.

c. Historically, the Vaccine Damage Payment Scheme processed an average of 76 claims per year. The system has not been modernised and prepared to expand, but Covid-19 vaccine claims were simply incorporated into it without any additional work being done to prepare for the new claims. The Government's own publication indicates that 670 claims were expected (based on figures for the H1N1 vaccine). There was already a backlog of claims BEFORE the pandemic.

d. The Vaccine Damage Payment Scheme also does not consider ongoing issues that are indirectly caused by the vaccine. For example, we might be able to get medications that make us stable, but that means medications for life/long term. These come with side effects and can affect our health in other ways.

e. The 60% threshold is unreasonable. Anyone who is injured should receive some recompense for the trauma, loss of working hours. How can anyone judge between 59 or 60%?

f. According to a freedom of information request by Sheila Ward of VIBUK, on the 22nd of May 2023, 5,708 claims had been received and 1,710 had been processed and only 6% of those had been successful. I only know of 3 members of our group who have received an award so far. I am unsure how many have applied because it is hard to gather information from everyone, but I will send out a questionnaire next spring.

g. Another freedom of information request was received in September 2023 [RR/115 - INQ000503750]. So far, 6,885 claims have been received by the VDPS in respect of a Covid vaccine. Peter Todd, a solicitor fighting for appeals for VDPS applicants pointed out that this is an additional 486 since the 11th of July 2023, a rate of over 17 a day. 2,713 applicants have been notified of an outcome that means over 60% of applications are still waiting to be decided. 2,576 claims have been rejected so far. 2,375 were rejected as it was considered the vaccine did not cause any disability. 201 claims were rejected because the person was not considered disabled enough. 427 of these claims have been waiting over 12 months, 131 over 18 months.

h. Note that the conditions the VDPS has paid out for, do not include neuropathy, dysautonomia, mast cell activation disorder or postural orthostatic tachycardia or functional neurological disorder. These are all very common in our group members.

i. Members have claimed that there is a lack of a trauma-informed approach to the claiming process, from start to finish. Another issue that has been raised by one member is the lack of support after receiving a refusal. This member said they were lucky they have a supportive partner because the refusal can be humiliating and crushing. The appeal process is daunting

for someone who already struggled to apply the first time around and since then has felt defeated. This same group member raised the lack of communication they received. They don't recall receiving one phone call from anyone and they have had to keep chasing things up themselves.

j. The Scottish Social Security department is extremely compassionate and supportive to applicants and there is a service offered to help complete forms. Given that applicants to the Vaccine Damage Payment Scheme who are themselves vaccine injured, can be extremely ill, we would ask that this is added as a recommendation. One member spoke to me only this week and said that, despite having a diagnosis and level of disability that would surely entitle them to compensation, they are unable to use their hands to type or to write. They are currently working with Citizen's Advice to get help to claim benefits and then will ask them to help fill out the forms for the Vaccine Damage Payment Scheme.

k. We would ask that the Inquiry investigates who the 'independent assessors' are and their qualifications. Some of our members have been treated very unfairly. One member who rarely drinks but who had a couple of glasses of wine at new year told the assessor. When she received her written report, it stated that she had been refused because her acquired amegakaryocytic thrombocytopenia [RR/039 - INQ000503687] – a condition that affects your bone marrow and your blood, which doctors had indicated was caused by the Covid-19 vaccine, was brought on by her drinking too much over Christmas and New Year. She had 2 drinks. A freedom of information request revealed that the Vaccine Damage Payment Scheme did not hold information about their assessor's experience. They are unwilling to reveal their GMC registration for obvious reasons. Considering physiotherapists can have GMC registration [RR/135 - INQ000377802] and [RR/136 - INQ000503763], we would like an investigation into what experience the assessors have.

l. The award for Vaccine Damage Payment Scheme (£120,000) was set in 2007 and takes no account of inflation. This sum is inadequate to cover household bills for any length of time, nor does it come close to compensating someone who has to rebuild their life following a bereavement. Nor does it cover the cost of adapting your home if you are

now wheelchair bound or a myriad of other expenses. For example, travelling overseas with a medical condition can be significantly expensive.

m. We would also ask the Chair to examine vaccine injury payment schemes in other nations and see if we can learn anything from them. The UKCV Family has produced a list of different schemes from around the world. In Australia, for example, claimants can claim for funeral costs, carers, loss of earnings, pain and suffering, medical costs – these would add up to considerably more than £120,000 [RR/137 - INQ000503764].

196. In addition to the Vaccine Damage Payment Scheme, there are other factors that we would like to be considered. First, life insurance. When one of our members asked if their life insurance is still valid after being told their health issues were a result of the vaccine, despite repeated requests for a response, they have not been able to elicit an answer. This raises a very large question about the regulation of insurance and the validity of life insurance policies.

In summary, these are the points that we would highlight as vital in planning for future pandemics:

i. Patients should be listened to and not dismissed. Just because the science doesn't indicate what they are saying is correct, it could be that the data just hasn't presented itself yet. Pfizer – in the contracts with the EU – stated themselves that there was no data available for long term effects or safety.

ii. If a brand new technology is introduced, it is common sense to expect the unexpected.

iii. If vaccines have to be rolled out in an emergency situation, G.P.s, emergency care doctors and consultants should be informed immediately about any adverse reactions that occurred during trials.

iv. Health professionals should be able to speak up about adverse reactions to vaccines and issue exemption certificates without fear of repercussions and also complete Yellow Card reports.

v. Delayed diagnosis has led to more serious or permanent damage. This cannot be allowed to continue or to happen again.

vi. Patients attending medical appointments should never be forced to attend alone. A relative or advocate should be allowed to attend, even via a Zoom. Even though this is included in N.H.S. guidelines, patients during the pandemic were told they were not allowed to be accompanied.

vii. In the event of a pandemic and emergency rollout of vaccines, emotional support should be made available for those impacted. The emotional impact of being vaccine injured in this case was massive because society has such polarised views on the vaccines and because of the fear levels surrounding Covid itself.

viii. Vaccine injury should be included in training syllabuses for all health practitioners, including mental health.

ix. Any underlying discrimination against the vaccine injured in medical settings should be challenged.

x. G.P.s need training in how to recognise, diagnose and treat MCAS, dysautonomia, M.E. and P.O.T.s without referring to specialists. They need the authority to prescribe the necessary medications without a consultant diagnosis.

xi. A media campaign should have been run to raise awareness of vaccine injury and what symptoms have been discovered and this would prevent people from not receiving treatments and also remove any stigma.

xii. The Yellow Card System needs an overhaul. Currently, causal risks are only identified by population based signals, but a lack of these signals does not preclude causality. Yellow Cards should therefore employ a multitude of methods to infer causality. The customer interface on the website is overwhelming to use for a member of the public and very off-putting for someone who is extremely ill and trying to self-report.

xiii. Censored in social media over adverse reactions should be recognised for what it is – a violation of democratic rights. (Facebook pages closed down, Tik-Tok and bans etc) and vaccine

injury is censored in the mainstream media. Group members have been branded as 'anti-vax' for sharing their own medically validated vaccine injury. This is extremely damaging to those adversely affected.

xiv. Vaccination campaigns should respect a person's right to choose and not imply that we are being selfish by not taking vaccines that are still in development phases and as such have not gone through the normal rigorous trials process.

xv. Mental Health is an issue for the vaccine injured that needs to be examined.

xvi. Public figures should be accountable for what they say in any public setting.

xvii. Stating cause of death needs to be far more accurate. If someone is admitted to hospital due to adverse events from the vaccine but catches Covid during their hospital stay, then both need to be mentioned on the death certificate.

xviii. Reassurances should be made that we will never again be in a situation where post-mortems can be forfeited at the behest of doctors who never attended the death.

xix. The legal requirement for a post-mortem on all sudden deaths that occur at home should always be enforced.

xx. Manufacturers of vaccines should never be granted indemnity. Vaccine manufacturers should be required to work with others to investigate adverse reactions and their mechanisms and find solutions.

xxi. All trial data should be freely available for anyone considering taking a vaccine. It was NOT available.

xxii. Trial data should be presented in a transparent and accurate manner that is easy for anyone to understand.

xxiii. It should be compulsory for information leaflets to be sent out to recipients before administering vaccines.

xxiv. Proper informed consent should be obtained in every situation. This includes having all the information available about the product and any alternatives and not being coerced.

xxv. Transparency – regarding gifts/money from pharma to doctors and nurses, clinics etc should be investigated.

xxvi. In future, alongside the development of vaccines, there should be the development of screening tests so that those who already have natural antibodies do not have to receive vaccines.

xxvii. Vaccines should never again be made mandatory. Even though the Scottish Government claimed they were not, group members were given the impression they would lose their jobs if they did not take a Covid-19 vaccine. Where vaccination was required for work, employers should treat vaccine injury as a workplace injury.

xxviii. In order for there to be trust in future vaccination programs, recognition, treatment and support need to be provided to those already adversely impacted by the Covid-19 vaccines.

xxix. The Vaccine Damage Payment Scheme needs a massive overhaul.

xxx. Given that all accept there are side effects to any drug or treatment, there should be preparation in all parts of the health system that this is a real effect and to watch for & capture that information and not assume that someone else does that.

xxxi. All the above undermines confidence in future vaccination rollouts.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 28/8/2024