Bread and Circuses: Who's Behind the Vaccine for COVID-19?

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'Give them bread and circuses and they will never revolt.' — Juvenal

Over the past week the race for a vaccine for COVID-19 has approached the finishing line, with the Oxford Vaccine Group looking to be the first to cross in the UK. This has occasioned a huge and relentless promotional campaign by the Department of Health and Social Care. In doing so, it has drawn on three media-friendly figures, in particular, to guarantee the safety of the vaccine: Dr. June Raine, Professor Andrew Pollard and Professor Jonathan Van Tam. The latter became a social media hit earlier this month after he compared the public's adherence to Government lockdown restrictions to footballers holding their nerve for a 'penalty shootout'; and likened the arrival of the COVID-19 vaccine to a 'train coming round the bend', with 'the guard making sure it's safe to open the doors' equated to the Medicine and Healthcare products Regulatory Agency. This, it turns out, is the way to speak to a terrorised and infantilised British public; but if I can attempt something a little less metaphorical and address myself instead to thinking adults, here is a brief resume of these three figures about whom the British public should know something before boarding this particular train.

Dr. June Raine

Dr. June Raine is the Interim Chief Executive Officer of the Medicines and Healthcare products Regulatory Agency (MHRA) responsible for overseeing the safety of medicines used in the UK, including the COVID-19 vaccine. Despite its status as a executive agency of the Department of Health and Social Care, over the past decade the MHRA has received $7.15 million from the Bill & Melinda Gates Foundation (BMGF), which in June this year invested $1.6 billion in GAVI, the Global Alliance for Vaccines and Immunisation. Ten years ago in January 2010, the BMGF invested $10 billion in vaccine production as part of its call for a 'Decade of Vaccines'. However, Dr. June Raine's association with the Bill & Melinda Gates Foundation is more than financial. In March 2015, she attended a lecture on 'Global health changes and overcoming regulatory challenges' delivered by Dr. Dan Hartman, Director of Integrated Development for the BMGF, at the tenth MHRA Annual Lecture. 6 months later, in September 2015, at a forum on 'Real world evidence' held by the Academy of Medical Sciences and the Association of the British Pharmaceutical Industry, Dr. Raine stated that, as regulation becomes increasingly proactive in planning active surveillance, 'the world of reactive regulation is the world of the past'.

Last year, Dr. Raine claimed £5,035.69 in expenses to attend a BMGF meeting regarding the Smart Safety Surveillance (3S) project in Seattle. In the same year, the MHRA received a grant worth £292,000 from the Bill & Melinda Gates Foundation. Two years before that, in 2017, Dr. Raine's predecessor as Chief Executive Officer of the MHRA, Dr. Ian Hudson, received £980,000 from the BMGF, before leaving in September 2019 to join the Foundation as Senior Advisor, Regulatory Affairs, Integrated Development, Global Health. The Office of the Advisory Committee on Business Appointments found 'no particular risk of impropriety' in this revolving door between a senior civil servant in a regulatory government agency funded by global investors in vaccines and a full-time, paid role in with the same investors.

Professor Andrew Pollard

This conflict of interest between producer and regulator is also present in the many roles of Professor Andrew Pollard, who is both Director of the Oxford Vaccine Group producing the COVID-19 vaccine in partnership with the British-Swiss pharmaceutical company AstraZeneca, and at the same time a member of the National Institute for Biological Standards and

Control (NIBSC) Scientific Advisory Committee, which advises the Medicines and Healthcare products Regulatory Agency (MHRA) that guarantees the safety of vaccines in the UK. The Chair of the NIBC Committee, Professor David J. Webb, is an MHRA Board Member.

Dr. Pollard's employer, the University of Oxford, where he is Professor of Paediatric Infection and Immunity, has received $11.64 million for vaccine development from the Bill & Melinda Gates Foundation over the past 3 years, and $208 million in grants over the past decade. In 2016, the BMGF gave $36.9 million for research into vaccine development by a team that included the Oxford Vaccine Group, which was headed by Professor Pollard. In addition, Professor Pollard's own Laboratory is also funded by the Bill and Melinda Gates Foundation.

As Director of the Oxford Vaccine Group, which in 2013 affiliated with the newly-created agency Public Health England, which itself has received $7.46 million in grants from the BMGF, Professor Pollard developed the Meningitis B vaccine Bexsero. Under pressure from the Secretary of State for Health, who at the time was Jeremy Hunt, following his appointment that same year as Chair of the Joint Committee on Vaccination and Immunisation (JCVI), Professor Pollard mandated the use of Bexsero for UK children, despite significant safety signals for Kawasaki Disease and the rarity of Group B meningococcal disease. There were 5 cases of Kawasaki Disease in 4,340 trial infants, and more than one-third of infants had high fever the day of vaccination, including 8 who had seizures. In 2015, production of the vaccine was taken over by GlaxoSmithKline (GSK), the British pharmaceutical company that in 2009 had developed the Pandemrix vaccine in response to the threat of swine flu, which was predicted to kill 65,000 people in the UK. In September 2010, an article published in the *Journal of the American Medical Association* showed that the risk of serious illness resulting from swine flu was no higher than that from seasonal influenza, and in actuality, swine flu killed 457 people in the UK. The 'independent' modeller who made these predictions was none other than Professor Neil Ferguson, who 11 years later estimated half a million deaths from COVID-19 in the UK, and whose long-discredited predictions are still being used to justify inflicting an equally unnecessary COVID-19 vaccine on the British people today.

Pandemrix, however, wasn't just unnecessary. It subsequently emerged that the vaccine can cause narcolepsy and cataplexy in about one in 16,000 people. By 2014, more than 800 children across Europe were known to have been made ill by the vaccine, with more expect to emerge. In the UK, 60 victims were expected to receive around £1 million each in compensation from the Government. 80 per cent of victims were children, but also included NHS staff who had been forced to take the vaccine in order to work. Since GSK had refused to supply the vaccine unless it was first indemnified against claims for damage, it paid the bill then claimed it back from the relevant governments. A decade later, pharmaceutical companies developing the COVID-19 vaccine have demanded the same indemnity.

But that wasn't the end of GlaxoSmithKline's long history of malpractice and fines. In 2012, GSK was fined $3 billion, until then the largest settlement in history, after admitting bribing US doctors and encouraging the prescription of unsuitable anti-depressants to children. And in 2016, GSK was fined over £37 million by the Competition and Markets Authority for paying bribes to keep generic varieties of the antidepressant, Paroxetine, out of the UK market. That seems a lot, but that same year GSK made $528 million from Bexsero; and in its *EvaluatePharma World Preview 2017, Outlook to 2022*, the life-science commercial intelligence firm, Evaluate, projected that sales of Bexsero to 2022 will more than double to $1.17 billion.

A senior figure at GlaxoSmithKline throughout this period was Dr. Patrick Vallance, who joined the company in 2006 as head of drug recovery, rose to head of medicines discovery and development in 2010, and finally, in 2012, was appointed President of Research and Development. In 2018 he left to become Chief Scientific Advisor to the UK Government, was knighted the following year, and in 2020 was appointed Chair of the Scientific Advisory Group on Emergencies, in which capacity it emerged Sir Patrick left GSK with shares worth £6.1 million at their current value, and still had £600,000 worth of shares in the company, which has deals to supply 60 million doses of a COVID-19 vaccine to the UK Government and 100 million doses with the US Government.

But to return to Professor Andrew Pollard, in April of this year, Oxford University entered into a partnership not with GlaxoSmithKline but with the British pharmaceutical company, AstraZeneca, to sell what subsequent

deals have established will be 400 million doses of its COVID-19 vaccine in Europe, 700 million to the US and GAVI, and 1 billion doses to India. Their latest figures are for a production capacity of 3 billion doses in 2021. As a result of these deals, AstraZeneca's net profit in the second financial quarter of 2020 rose to £581.18 million, compared to just £99.94 million in the same quarter last year. This made AstraZeneca the most valuable UK company by market capitalisation, and this October it was still the second most valuable. The COVID-19 vaccine should put them back in first place.

In September of this year, AstraZeneca and Oxford University's coronavirus vaccine trial was paused after a UK participant suffered spinal cord inflammation; yet it took a month for them to send the vaccine trial safety data to the US Food and Drug Administration (FDA). This was not the first time AstraZeneca has fallen foul of the FDA. Ten years earlier, in 2010, AstraZeneca had paid $520 million in fines to settle charges by the US Federal Government for illegally marketing the anti-psychotic drug Seroquel to children and elderly patients for uses not approved by the FDA. Just two years ago, in April 2018, it was revealed that AstraZeneca had paid €17.9 million in secret payments to 'independent' healthcare professionals to endorse their products, including the use of vaccines. Indeed, the day after we published this article, it was revealed that AstraZeneca's claim that its vaccine has an efficacy of 90 per cent is based on a test only administered to individuals aged 55 and below, a demographic with a far lower chance of developing COVID-19 symptoms requiring a vaccine. Since the announcement, London-listed shares in AstraZeneca have lost more than 6 per cent in value. This is the company that will be producing 3 billion doses of the Oxford vaccine for COVID-19.

After mandating the use of Bexsero, Professor Pollard has kept his position as Chair of the Joint Committee on Vaccination and Immunisation that advises UK health departments on vaccines; but because of this conflict of interests he recused himself from the first JCVI meeting on COVID-19, and will not take part in Committee discussions about the SARS-CoV-2 vaccine he is developing at Oxford.

Professor Jonathan Van Tam

Professor Jonathan Van Tam, who Chairs the SAGE SPI-Modelling subgroup responsible for the lockdowns and other restrictions, is also the UK's

Deputy Chief Medical Officer, a position he assumed in October 2017. Before that, Van Tam was in the pharmaceutical industry, joining the British multinational pharmaceutical company SmithKline Beecham as an Associate Director in 2000; moving to the Swiss healthcare company Roche as Head of Medical Affairs in April 2001; and finally, in February 2002, taking up the position of UK Medical to Aventis Pasteur MSD, the vaccines division of the French multinational pharmaceutical company Sanofi. In 2004 Van Tam returned to the public sector, joining the newly-created Health Protection Agency Centre for Infections, where he was Head of the Pandemic Influenza Office until October 2007.

According to Tom Jefferson in an article published in the *British Medical Journal*in December 2017 about the revolving doors between public and private positions in healthcare, Professor Van Tam is a regular attendee at conferences organised by the European Scientific Working Group on Influenza (ESWI), a well-known, industry-funded lobbying group. Indeed, his predecessor as Deputy Chief Medical Officer, Professor John Watson, was a founding member of the ESWI. And as head of the Pandemic Influenza Office, Professor Van Tam bears responsibility for decisions that were heavily criticised in 2013 by the Public Accounts Committee regarding the overlapping roles of pharmaceutical companies, lobbyists and regulators in the production, trial and use of the influenza antiviral drug Oseltamivir (Tamiflu). This was one of the highest revenue earners for its manufacturer and Van Tam's former employer, Roche. From 2006, the UK Government spent millions stockpiling Tamiflu in response to estimates that bird flu would kill 200 million people worldwide, and up to 710,000 people in the UK. In reality, around 600 people have died worldwide, and not a single person in the UK even contracted bird flu. Once again, the modeller who made these highly lucrative predictions was Professor Neil Ferguson.

If you're wondering why Professor Van Tam is so keen on us taking a COVID-19 vaccine — he has recently resorted to saying he would give it to his 78-year-old mother and be the first in the queue to take it himself were it ethical to do so — £424 million of taxpayers' money was spent on Tamiflu. Yet of the 123 clinical trials of the antiviral that were conducted, 74 were entirely funded by Roche, its manufacturer; and of those, the European Medicines Agency received just 15 incomplete accounts of trials, and the National Institute for Health and Care Excellence just 4 incomplete

accounts of trials. According to an article published in the *British Medical Journal*, it took Roche 4 years to hand over the full Clinical Study Reports. When they were finally available for scrutiny, these showed that the World Health Organisation (WHO), the European Medicines Agency (EMA) and the US Centers for Disease Control and Prevention (CDCP) had all approved, recommended and encouraged the stockpiling and use of Tamiflu without having first vetted the underlying data. This stockpiling earned Roche billions. Worse still, when this data was reviewed by the Cochrane Review Group, it concluded that there was no convincing trial evidence that Tamiflu affected either influenza complications in treatment or influenza infections in prophylaxis, as well as raising new questions about the drug's harms profile.

In the Public Accounts Committee report on 'Access to clinical trial information and the stockpiling of Tamiflu' published in 2013, Dr. Fiona Godlee, Editor in Chief of the *British Medical Journal*, when asked why the UK Government had spent £424 million on a useless vaccine for a viral threat that had never existed, responded:

> *'I will give you my brief answer. I think it was politically expedient. There was an outbreak of potentially serious influenza. There was a World Health Organisation recommendation that countries should do this. I should say that there is a whole host of information about what led to that WHO recommendation, with industry-funded advisers helping WHO reach that decision. The UK was confronted with a situation in which it wanted something. There isn't anything else for pandemic flu. To cut a long answer short, I would say it was bread and circuses to keep the populace happy, and I think it was misleading and wrong, especially as the alternative, paracetamol, is well understood, and Tamiflu has adverse effects, apart from its cost.'*

Fast forward 7 years and we're back in the same but worse situation. Far from being 'unprecedented', as we are constantly being told, health 'crises' have been repeatedly manufactured by Big Pharma, with Professor Ferguson its go-to-man for prophecies of doom that have been consistently shown to be wrong by many orders of magnitude. This time, however, we're entering a new level of corruption and collaboration between the public and private sectors. Compulsory vaccination has always been the goose that will lay a trillion golden eggs for the pharmaceutical industry and its global

investors; and on 13 November, Conservative MP Lt Col Tom Tugendhat, who Chairs the Committee for Foreign Affairs, called for a COVID-19 vaccine to be made a condition of access to public transport, social venues and places of work. Throughout this manufactured health crisis, this has been how the Government has leaked future policy to the media to test the public's reaction. In this case, it looks very much like the first step in the mandating of mass vaccination as part of the programmes and technologies of the UK biosecurity state.

Making the World Safe for Vaccines

Finally, as further evidence of how ready the Government is to change legislation to accommodate these programmes, in a consultation document published on 28 August and closed on 18 September, the Department of Health and Social Care canvassed the responses of unidentified 'stakeholders' to proposed draft changes to the Human Medicine Regulations 2012, in order to support the issuing, advertising, distributing, selling and administering of COVID-19 vaccines. These changes would:

1. Change Regulation 74 to allow the Joint Committee on Vaccination and Immunisation (JCVI) to advise the Government to use a tested but unlicensed vaccine, which will instead be given a temporary authorisation by the UK's licensing authority, the MHRA.
2. Extend the scope of immunity from civil liability already conferred by Regulation 345 — which already indemnifies key actors in the medicines supply chain from being sued in the civil courts for the consequences resulting from the use of an unlicensed product that a national licensing authority has recommended in order to deal with certain specific health threats (which it calls 'unfair') — to provide 'complete immunity' not only to manufacturers and healthcare professionals but also to the pharmaceutical companies placing an unlicensed medicine such as a COVID-19 vaccine on the market.
3. Extend the workforce permitted under Regulation 214 to administer both the unlicensed COVID-19 vaccine and the expanded influenza vaccine from just doctors and other registered healthcare professionals to include midwives, nursing associates, operating department practitioners, paramedics, physiotherapists and pharmacists.

4. Disapply Part 14 of the Human Medicines Regulations to allow unlicensed medicine or medicinal product, such as the COVID-19 vaccine, to be promoted and advertised to both healthcare professionals and the public by the suppliers, and to permit such suppliers to participate in any public information campaign relating to the use of the medicine.
5. To remove the requirement, under Regulation 18, for distributors of an unlicensed medicine, including the COVID-19 vaccine, to have a wholesale dealer's licence. Such exemptions would be provided for service providers contracted by the NHS and the Armed Forces.

These proposed changes, which the DHSC justifies on the grounds of what it calls 'the biggest threat this country has faced in peacetime history', are not, however, limited to a COVID-19 vaccine, but 'will also facilitate the efficient mass distribution of treatments for . . . any other disease that poses a serious risk to public health.' On 16 October, these proposals were made into law by the Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020. On 3 December the Vaccine Damage Payments (Specified Disease) Order 2020 added COVID-19 to the list of diseases against which payments made to individuals who are severely disabled as a result of vaccination are limited to a one-off, tax-free, Vaccine Damage Payment of £120,000. Following their £3,360 pay rise to an annual salary of £85,291, that's the equivalent of an MP's salary for less than 17 months, not including their income as lobbyists, consultants and board members of pharmaceutical companies and healthcare firms. Since the vaccine manufacturers, non-registered health professionals administering it and pharmaceutical companies selling it are all indemnified from such claims, this sum would be paid by the UK Government.

On 20 November, a study published in *Nature Communications*, one of the world's most highly regarded peer-reviewed journals, titled 'Post-lockdown SARS-CoV-2 nucleic acid screening in nearly ten million residents of Wuhan, China' reported that, out of 9,899,828 residents and 92.9 per cent of the population of Wuhan tested between 14 May and 1 June a month after lockdown restrictions were lifted on 9 April, no new symptomatic cases and just 300 asymptomatic cases were identified. From the latter, no positive tests for SARS-CoV-2 were identified among 1,174 close contacts of asymptomatic cases. Further testing of 52,312 samples between 13 June 13 and 2 July found no positive results; and two months

after the screening of nearly 10 million residents, by 9 August there were still no newly confirmed cases of COVID-19 in the city most severely affected by COVID-19 in China. Statistically speaking, although there are some documented instances, the asymptomatic transmission of SARS-CoV-2 doesn't exist as a vector of infection requiring a vaccine.

What we're threatened by in the UK is not a virus but an epidemic of tests which, as I've covered in detail in my previous article, *The Betrayal of the Clerks*, have a far higher False Positive Rate (median of 2.3 per cent) than the 1.22 per cent of the population currently identified by those tests as having SARS-CoV-2. This includes those who have died of some other medical cause. As of 18 November, the NHS reports just 1,664 people whose deaths have been attributed to COVID-19 dying in English hospitals this year without a pre-existing medical condition. The so-called 'second wave' of 'COVID-19 deaths' is consistent with the annual rise in overall mortality in the UK at this time of year, particularly from respiratory diseases, which have inexplicably dropped over the four weeks to 13 November, the same weeks in which deaths attributed to COVID-19 have risen. In the same 4 weeks last year there were 5,399 deaths from respiratory diseases; this year there are 3,958.

Equally, the current slight increase in overall mortality over the five year average must be placed in the context of the effects of the ongoing reduction and withdrawal of medical care and treatment for the elderly and sick throughout this year. Back in July, after the 16,000 excess deaths in March and April not attributed to COVID-19, the Office for National Statistics estimated a further 26,000 excess deaths this year resulting from coronavirus-justified changes to emergency and adult social care, with thousands of additional deaths resulting from the postponement of diagnoses and cancellation of treatment and operations. To take just one of the major causes of death in the UK increased by Government imposed changes to healthcare, the *British Medical Journal* reported this month that even a month's delay in cancer surgery increases the risk of death by 6-13 per cent, with a 3-month delay increasing the risk by approximately 25 per cent, rising to 44 per cent for treatments like bowel cancer chemotherapy. As winter draws in, and the deaths not only from cancer but also from heart disease (25.9 per cent increase in deaths), diabetes (47 per cent increase) and dementia (79 per cent increase) mount up, only to be attributed to 'COVID-19' by a testing programme unfit for any other purpose than to

mislead the public, the Government's criminal decision to restrict and withdraw medical care for life-threatening conditions is beginning to reap its bloody harvest.

Against this indefensible massacre of the innocents in the circus of political expediency, the need for a vaccine for COVID-19 into which the Government has already sunk over £6 billion of public money would appear to exist only in the minds and wallets of the doctors, scientists, universities, government departments, executive agencies, regulatory bodies, pharmaceutical companies and global investors who will benefit and profit from producing, guaranteeing, advertising and enforcing a vaccine for COVID-19 — and any other threat to public health they can conjure into being — on the population not only of the UK but of the world.

Even to suggest this, however, or to ask the numerous questions the documented and verifiable evidence in this article must raise in the minds of the British public, means I and anyone sharing this article online can be censored or shut down by Government Communications Headquarters (GCHQ). This month the intelligence and security organisation launched a cyber offensive targeting social media accounts publishing content deemed 'propaganda' merely for raising concerns about COVID-19 vaccine development and the pharmaceutical companies and global investors involved. And if GCHQ reportedly being told by the UK Government to 'take out' anyone who questions the medical necessity or financial motivations for a COVID-19 vaccine (something it denounces as 'vaccine hesitancy', as if anything besides blind and immediate obedience is now a crime) wasn't enough of a deterrent, the Labour Party has now called for emergency legislation to issue criminal and financial sanctions against social media platforms that don't censor anyone who does so. But if the UK biosecurity state has to threaten people with being 'extremists' and a 'national security risk' in order to make us take the COVID-19 vaccine, we are within our rights — and in possession of our senses — to ask what cheerleaders like Dr. June Raine, Professor Andrew Pollard and Professor Jonathan Van Tam are hiding behind their brightly-coloured pompoms.

Addendum: The Pfizer-BioNTech Vaccine

Since publishing this article on 25 November, AstraZeneca has fallen behind in the race to be the first to release a vaccine for SARS-CoV-2 on the world,

which has instead been won by the US multinational pharmaceutical company Pfizer. In May, Pfizer began tests for a vaccine developed by the German biotechnology company BioNTech. In July, Pfizer's CEO, Albert Bourla, stated that companies in the private sector producing a vaccine for COVID-19 should make a profit, and dismissed suggestions they shouldn't as 'fanatic' and 'radical'. That same month, trials on the vaccine were fast-tracked by the Food and Drug Administration (FDA), and Pfizer struck a deal with the US Government to produce 100 million doses for $1.95 billion. The US deal priced the two-dose course at $39, and the Pfizer stated that it would not lower the rates for other developed countries until coronavirus is no longer deemed to be a pandemic. In September, Pfizer announced it had agreed to supply an initial 200 million vaccine doses to the EU, with the option to supply another 100 million doses at a later date. In October, Pfizer started testing the BioNTech vaccine on children as young as 12. In November, Pfizer claimed the vaccine is '95 per cent effective', and applied to the FDA for its Emergency Use Authorisation.

However, this doesn't mean that 95 out of every 100 people vaccinated will be protected from COVID-19. Pfizer recruited 43,661 people for their clinical trial, waited for 170 to show symptoms of COVID-19 and then get a positive test for SARS-CoV-2. Out of these, 162 had received a placebo shot, while just 8 had received the vaccine. Although the percentage of volunteers who fell sick was tiny in both the vaccinated and placebo groups (0.03% and 0.74% respectively), the relative difference between them is calculated as the vaccine's 'efficacy'. If there's no difference between them the efficacy is zero; if none of the people falling sick had been vaccinated, the efficacy would be 100 per cent. In contrast, the effectiveness of the vaccine in real-world circumstances is very different from its efficacy rating calculated from clinical trials. As the AstraZeneca trial of people exclusively under the age of 55 revealed, not only are volunteers likely to be a very different demographic from the people who have a myriad of health conditions, but given that up to 80 per cent of infections with SARS-CoV-2 are asymptomatic, there were almost certainly far more people in Pfizer's clinical trial who got infected after taking their vaccine. None of this is reflected in the company's claim of a '95 per cent efficacy' for the BioNTech vaccine.

Undeterred by any of this, on 2 December the UK Government jumped the gun and approved the COVID-19 vaccine for emergency use, the first

country in the world to do so, even though studies of its unknown long-term effects are ongoing after just 7 months of clinical trials. But neither the Pfizer-BioNTech vaccine, nor those being developed by AstraZeneca and Moderna, have demonstrated that they prevent infection altogether, or reduce the spread of the SARS-CoV-2 in the population. Both the Pfizer and Moderna vaccine uses new and experimental mRNA technology, which encodes the viral protein spikes with synthetic genetic material, and has never been granted approval before. Its instability also means the Pfizer vaccine must be stored at minus 70 degrees celsius, which will present a challenge to the unlicensed wholesale distributors authorised by the amendments to Regulation 19 of the Human Medicines (Coronavirus and Influenza) (Amendment) Regulations 2020 to transport it. Despite all these concerns, on 8 December, the unlicensed Pfizer-BioNTech vaccine was released in the UK to be administered by unregistered healthcare professionals and promoted and advertised by the company manufacturing it.

Of even greater concern, however, is Pfizer's long history of paying out vast sums in out-of-court settlements to avoid prosecution on criminal charges and in civil cases resulting from the fraudulent promotion, illegal use and damaging effects of their products, as well as offering millions in payments and bribes to doctors and scientists to prescribe, test, approve and recommend them. Here is a brief summary of just some of the charges of health care fraud made against Pfizer.

- In 1992, Pfizer agreed to pay between $165 million and $215 million to settle lawsuits arising from the fracturing of the Bjork-Shiley Convexo-Concave heart valve which by 2008 was responsible for the deaths of 663 people.
- In 1996, Pfizer conducted an unapproved clinical trial on 200 Nigerian children with the experimental anti-meningitis drug, Trovan, that led to the death of 11 children from kidney failure and left dozens more disabled. In 2011, Pfizer paid $700,000 to four families who had lost a child, and set up a $35 million fund for the disabled.
- In 2004, Pfizer's subsidiary, Warner-Lambert, was fined $430 million to resolve criminal charges and civil liabilities for fraudulent promotion of unapproved uses for its epilepsy drug, Neurontin, paying and bribing doctors to prescribe it for uses not approved by the FDA.

- In 2009, Pfizer set a record for the largest health care fraud settlement and criminal fine of any kind, paying $2.3 billion to avoid criminal and civil liability for fraudulently marketing the anti-inflammatory drug, Bextra, which had been refused approval due to safety concerns.
- In 2009, Pfizer paid $750 million to settle 35,000 claims that its diabetes drug, Rezulin, is responsible for 63 deaths and dozens of liver failures. In 1999, a senior epidemiologist at the Food and Drug Administration warned that Rezulin was '*one of the most dangerous drugs on the market*'.
- In 2010, Pfizer was ordered to pay a total of $142.1 million in damages for violating a federal antiracketeering law in its fraudulent sale and marketing of its epilepsy drug, Neurontin, for uses not approved by the FDA, including for migraines and bi-polar disorder.
- In 2010, Pfizer admitted that, in the last 6 months of 2009 in the US alone, it had paid $20 million to 4,500 doctors for consulting and speaking on its behalf, and $15.3 million to 250 academic medical centres for clinical trials.
- In 2012, Pfizer paid $45 million to settle charges of bribing doctors and other health care professionals employed by foreign governments in order to win business. The Chief of the Securities and Exchange Commission Enforcement Division's Foreign Corrupt Practices Act Unit said: '*Pfizer subsidiaries in several countries had bribery so entwined in their sales culture that they offered points and bonus programs to improperly reward foreign officials who proved to be their best customers*'.
- By 2012, Pfizer had paid $1.226 billion to settle claims by nearly 10,000 women that their hormone replacement therapy drug, Prempro, caused breast cancer.
- In 2013, Pfizer agreed to pay $55 million to settle criminal charges of failing to warn patients and doctors about the risks of kidney disease, kidney injury, kidney failure and acute interstitial nephritis caused by the proton pump inhibitor Protonix.
- In 2013, Pfizer set aside about $288 million to settle claims by 2,700 people that their smoking cessation drug, Chantix, caused suicidal thoughts and severe psychological disorders. The Food and Drug Administration subsequently determined that Chantix is probably associated with a higher risk of heart attack.
- In 2013, Pfizer absolved itself of claims that its antidepressant, Effexor, caused congenital heart defects in the children of pregnant woman by arguing that the prescribing obstetrician was responsible for advising the patient about the medication's use.

- In 2016, Pfizer was fined a record £84.2 million for overcharging the NHS for its rebranded and deregulated anti-epilepsy drug, Phenytoin, by 2,600 per cent (from £2.83 to £67.50 a capsule), increasing the cost to UK taxpayers from £2 million a year in 2012 to about £50 million in 2013.
- In May 2018, Pfizer still had 6,000 lawsuits pending against claims that its testosterone replacement therapy products cause strokes, heart attacks, pulmonary embolism and deep vein thrombosis, and were fraudulently marketed at healthy men for uses not approved by the FDA.

Given this long history of ongoing corruption and malpractice from which only its enormous profits have saved it from criminal prosecution, it seems extraordinary that Pfizer is still permitted to manufacture and sell health care products. Yet this is the pharmaceutical company we're being asked by the UK Government to trust with the mass vaccination of 68 million people with a product that has been rushed through clinical trials in 7 months, using an experimental technology that has never before been approved and whose side effects are still unknown, for a disease with the fatality rate of seasonal influenza, which statistically is a threat only to those over 60 years old with pre-existing medical conditions, and for which there is no evidence that it prevents infection with a virus for which only 1 per cent of the population is currently testing positive even with our exaggerated testing programmes, and from which anything from 50-60 per cent of us have developed or already had immunity.

Bowling for Pfizer

Of equal concern, perhaps, is who and what is promoting — if not yet advocating mandating — the taking of vaccines for COVID-19 by the entire UK population. To take just one example of the vast campaign of propaganda conducted in the lead up to the release of the vaccine not only by the Governments of the UK, Scotland, Wales and Northern Ireland, the Department of Health and Social Care, Public Health England, Scotland and Wales, the National Health Service, the Medicine and Healthcare products Regulatory Agency, the Prime Minister, the Health Secretary, the First Minister of Scotland, the Chief and Deputy Chief Medical Officers, but also by every privately-owned newspaper and media outlet in the UK, last week the *Telegraph* published an article titled 'Is the COVID vaccine safe and will it work? Three experts answer your questions'. These three experts were:

- Trudie Lang, Professor of Global Health Research at the University of Oxford, who works in malaria vaccine development and sat on the Ebola vaccine safety board;
- Heidi Larson, Professor of Anthropology, Risk and Decision Science at the London School of Hygiene and Tropical Medicine and Director of the Vaccine Confidence Project;
- Dr. Michael Fitzpatrick, GP and author of *MMR and Autism: What Parents Need to Know.*

As we have already seen, the University of Oxford has received $208 million in grants over the past decade from the Bill & Melinda Gates Foundation, including $11.64 million for vaccine development over the past 3 years. But in addition, Professor Lang's Global Health Research programme has received $7.68 million in 2020 alone from the Foundation. Again, we've seen that the London School of Hygiene and Tropical Medicine has received $190 million in grants from the Bill & Melinda Gates Foundation over the past decade, $5.8 million of it this year, of which $1.5 million has been for vaccine development. But in addition, Heidi Larson's Vaccine Confidence Project, which has been given a platform on the BBC's Newsnight programme, has received funding from vaccine manufacturers GlaxoSmithKline and Merck, as well as the Bill & Melinda Gates Foundation, the Wellcome Trust, 3ie, Innovative Medicines Initiative and others.

Financial influence, of course, isn't proof of influence over the opinions of those being funded. But in this interview with these three 'experts' there are numerous examples of statements that display such influence. Professor Lang, for instance, when asked about the fact that Pfizer still hasn't published the data from it trial, responded that 'when you submit to a regulatory body — the MHRA, the FDA or EMA — you have to send absolutely everything, the good, the bad, the whole lot'. As we've seen from the investigation by the Public Accounts Committee into the funding, withholding and selective vetting by Roche of the data for Tamiflu, regulatory bodies, including the European Medicines Agency (EMA), all approved, recommended and encouraged its use without having first vetted the underlying data. This is, at best, naivety or ignorance unforgivable in a designated 'expert' given such a platform; at worst, even more unforgivable and deliberate lying to the public. Throughout this year, doctors and scientists have been exposed for making decisions about what they think the public should know in order to ensure compliance with what they have

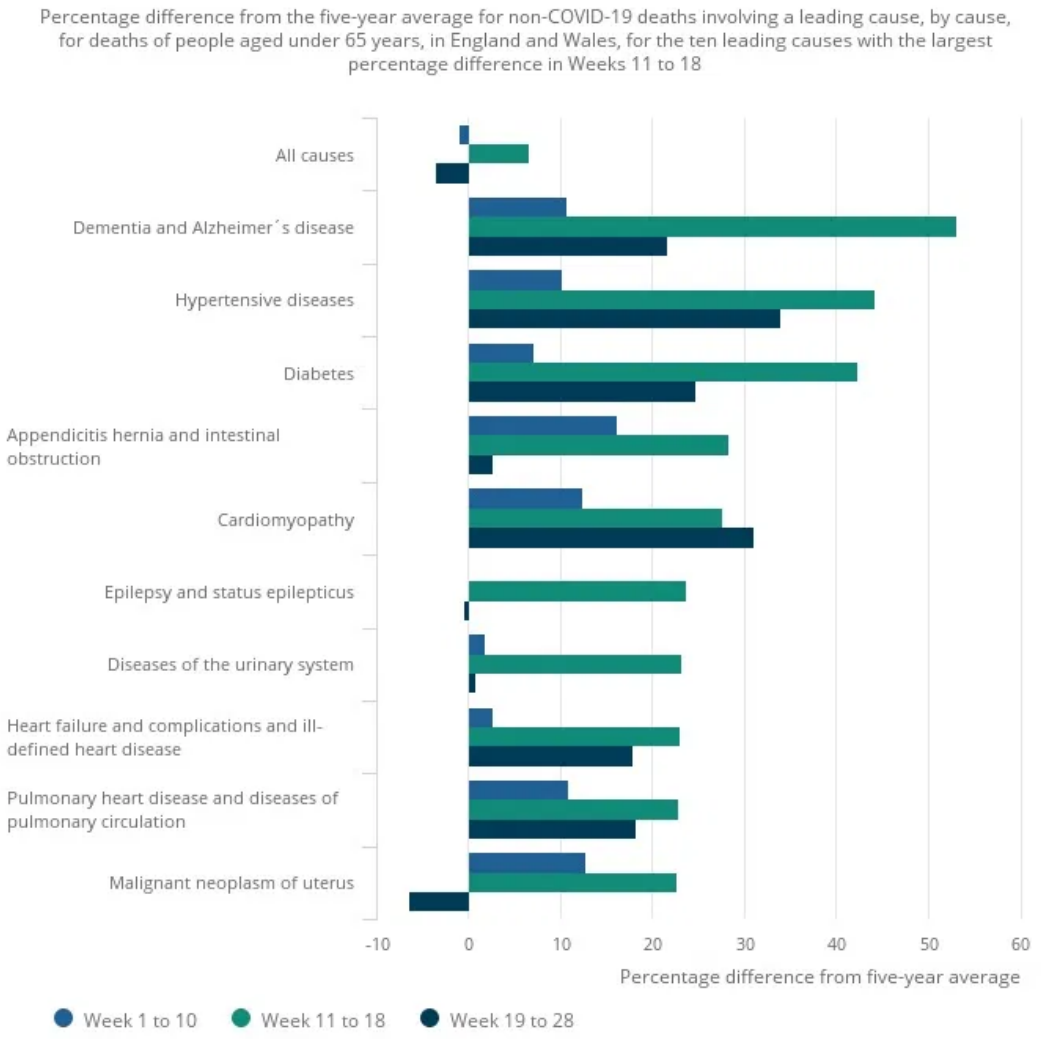
decided in advance is the best course of action. This sounds very much like another instance; but it is not for scientists funded by global investors in and manufacturers of vaccines to decide for us what information we should have before deciding what we allow in our body. Perhaps most revealingly, neither these experts nor the interviewer raises the burning question of why we need such a vaccine and to what ends.

Finally, Dr. Michael Fitzpatrick's hysterical and contemptuous dismissal in the *Daily Mail* of valid concerns about a vaccine produced so quickly by pharmaceutical companies with a record of corruption, bribery and malpractice as the 'wild conspiracy theories and political propaganda' of 'anti-vaxxers' shows that he is on the side of fear and not science, which progresses by questions, not threats, smears and crude attempts to silence questioners. Just as Hilary Benn MP did during the House of Commons debate on the Health Protection (Coronavirus, Restrictions) (All Tiers) (England) Regulations 2020, Dr. Fitzpatrick raises the case of Dr. Andrew Wakefield, who in 1998 falsely linked the vaccine for measles, mumps and rubella to autism; but he says nothing about the numerous examples of established links between vaccines and medicines and the injuries, disabilities and death they have caused, not least by the pharmaceutical companies developing the vaccine for COVID-19. In this respect, the Wakefield case is a prime example of how conspiracy theories are being used to dismiss valid concerns about the vaccination programme which no scientist, let alone doctor, should be dismissing with the contempt and violence Dr. Fitzpatrick displays in this article.

Even if all the data from the trials of all the COVID-19 vaccines was studied by individuals and institutions without the financial ties the existing ones have to the manufacturers, distributors and investors in the products they are responsible for approving before released onto the public; even if it could be proven that there was a need for such a programme of mass vaccination for a virus that everything suggests has largely left the country and which presents no threat of overwhelming the capacity of the NHS to treat those few endangered by its development into COVID-19; even if the deliberately inaccurate RT-PCR testing programme was replaced with one that accurately showed the actual presence, spread and dangers of the virus on which the claim for the need for a vaccine for COVID-19 was based and assessed; even if pharmaceutical companies and health professionals were not indemnified but held liable for civil claims and criminal prosecution

resulting from the consequences of taking a vaccine they have developed, tested, manufactured, authorised, advertised, distributed and administered; even if the vaccination was not being rolled out as part of the increasingly mandatory programmes and technologies of surveillance and control that have been implemented throughout this year on the basis of combatting this virus, and which have transformed the UK into a totalitarian state ruled by Government decree; even if the vaccine was made available on a voluntary basis, just like any seasonal flu jab, and not weaponised by the Government as part of a threat to remove our human right and civil liberties until we take it in sufficient numbers, to make taking it a condition of our access to public life, including work, or even to enforce the vaccine on the UK population through new legislation; even if all these conditions were met — none of which are even vaguely likely, all of which should be an unnegotiable requirement for any rational person before taking this vaccine — there would still be the question of why every Government spokesman, every executive agency, every newspaper, every news programme, every social media platform, has for 10 months conducted a campaign of propaganda, fear, terror, slander, lies, misinformation and censorship of anything and anyone that tries to question or contradict the official line about this crisis. If coronavirus presented anything like a threat that might possibly justify the temporary restrictions that have been legislated into our lives permanently under its cloak, there would be no need for the vast cloud of deception, fabrication and manipulation that has been thrown around everything to do with this crisis. Although not in itself proof — of which there is an overwhelming and irrefutable preponderance — this is, perhaps, the strongest indication that we are being lied to at a level and to an extent that, unlike the coronavirus, truly can be described as ‘unprecedented’.

Simon Elmer
Architects for Social Housing



Further reading by the same author:

The Betrayal of the Clerks: UK Intellectuals in the Service of the Biosecurity State

Bonfire of the Freedoms: The Unlawful Exercise of Powers conferred by the Public Health (Control of Disease) Act 1984

When the House Burns: Giorgio Agamben on the Coronavirus Crisis

The Infection of Science by Politics: A Nobel Laureate and Biophysicist on the Coronavirus Crisis

The New Normal: What is the UK Biosecurity State? (Part 2. Normalising Fear)

The New Normal: What is the UK Biosecurity State? (Part 1. Programmes and Regulations)

The Science and Law of Refusing to Wear Masks: Texts and Arguments in Support of Civil Disobedience

Lockdown: Collateral Damage in the War on COVID-19

The State of Emergency as Paradigm of Government: Coronavirus Legislation, Implementation and Enforcement

Manufacturing Consensus: The Registering of COVID-19 Deaths in the UK

Giorgio Agamben and the Bio-Politics of COVID-19

Good Morning, Coronazombies! Diary of a Bio-political Crisis Event

Coronazombies! Infection and Denial in the United Kingdom

Language is a Virus: SARs-CoV-2 and the Science of Political Control

Sociology of a Disease: Age, Class and Mortality in the Coronavirus Pandemic

COVID-19 and Capitalism

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Five Stories Under Lockdown →

8 thoughts on “Bread and Circuses: Who’s Behind the Vaccine for COVID-19?”

Barbara McKenzie says: November 28, 2020 at 2:20 pm

Exceptional article, thank you, packed with important information, especially (but not only) with regard to conflicts of interest. Recommend printing it out.

Loading...

REPLY

Tee says: December 2, 2020 at 11:36 am

Really great article! Thank you for sharing and providing so many references.

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REPLY

david says: December 2, 2020 at 3:24 pm

The Nature Comms article you cite on Wuhan (not Nature as you say, although still a “prestigious” journal) – this relies on 9,899,828 PCR tests carried out in less than a month, via the same assay that everyone else is using. Based on the other things I’ve read here on PCR testing: where have all the false positives gone?

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REPLY

architectsocialhousing says: December 3, 2020 at 9:54 am

> Although Dr. Mike Yeadon (see our article on The Betrayal of the Clerks) has pointed out that not everyone infected with SARS-CoV-2 will produce antibodies, especially when the viral dose has been weak, the Nature Communications article reports that 190 of the 300 asymptomatic ‘cases’ had a positive Immunoglobulin

G, the most common antibody, which protects against bacterial and viral infections. This indicates that 63.3% of the asymptomatic positive cases were actually infected. However, 36.7% of the asymptomatic 'cases' had negative Immunoglobulin G and M, 'indicating the possibility of infection window or false positive results of the nucleic acid testing'.

In considering the limitations of the study, the authors conclude that 'although a positive result of nucleic acid testing reveals the existence of the viral RNAs, some false negative results were likely to have occurred, in particular due to the relatively low level of virus loads in asymptomatic infected individuals, inadequate collection of samples, and limited accuracy of the testing technology.' However, they point out that 'even if test sensitivity was as low as 50%' (a meta-analysis reported a pooled sensitivity of 73%), 'then the actual prevalence would be twice as high as reported in this study, but would still be very low.'

Importantly, for the RT-PCR tests used in Wuhan, a cycle threshold value (Ct-value) less than 37 was defined as a positive result, and no Ct-value or a Ct-value of 40 or more was defined as a negative result. For Ct-values ranging from 37 to 40, the sample was retested. If the retest result remained less than 40 and the amplification curve had obvious peak, the sample was classified as positive; otherwise, it was reported as being negative. These diagnostic criteria were based on the Chinese Government's official recommendations.

In comparison, in the UK the False Positive Rate has not been disclosed by the Government; but Public Health England's guide for health-protection teams published in October, 'Understanding cycle threshold (Ct) in SARS-CoV-2 RT-PCR', it states that 'a typical RT-PCR assay will have a maximum of 40 thermal cycles.' In the Wuhan test scheme, these would all qualify as a negative result.

I think the difference is that, in China, the Government is trying to establish the minimum safety requirement required to get the population back to work; whereas in the UK the Government is trying to keep the population out of work for as long as possible, and only to allow us back to work on the condition of our compliance with the programmes and technologies of the biosecurity state, including mandatory vaccination, immunity passports, mask wearing, contact tracing, health monitoring, etc.

So although there are 'indications' of false positives in the Wuhan tests, it wasn't what the authorities were looking for; whereas in the UK our entire Test and Trace programme, and the erasure of our civil liberties it justifies, is based on the production of thousands of False Positives. In the PHE guide it states very clearly that 'RT-PCR detects presence of viral genetic material in a sample but is not able to distinguish whether infectious virus is present' (p. 6). The RT-PCR test was never designed either to prove infection or to diagnose an infectious disease. What it is very good at, however, is what it is being used by the UK Government to do,

> which is produce 100% false positives for a virus that has all but disappeared from the country.
>
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> REPLY

 **Universal Octopus** says: December 3, 2020 at 10:20 am

I cannot praise this article enough.

The layout, the sourcing, the presentation and the logic are impeccable and are just what is needed at the present moment to awaken the victims of this political manipulation and consequential economic ruin to the situation they are in.

Except that they cannot be awakened! And will not be before it is too late.

Please don't be disheartened, though. There are many (if proportionately few) who will see and be able to take precautions to prepare themselves and hopefully join in the efforts of those like you who are sounding your warnings.

Please don't think I am being facetious when I say that, on an almost equally vast and serious historical landscape, it has echoes of Karl Marx and Das Kapital. Then, the few who had the education to see what was happening in terms of the exploitation of the disadvantaged by the greed and unscrupulousness of the powers that be, were unable to reach the awareness levels of the victims until violence entered the equation on a level which subsequently produced revolution and war.

It could happen again. Please keep up your good work.

Brian Taylor

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REPLY

Pingback: The Betrayal of the Clerks: UK Intellectuals in the Service of the Biosecurity State – Architects for Social Housing (ASH)

 **SteveH** says: December 6, 2020 at 4:05 pm

The share price of GSK, AZ and Pfizer are down or flat compared to January. They aren't in it for the money

Loading...

REPLY

architectsocialhousing says: December 6, 2020 at 7:19 pm

GlaxoSmithKline started the year at £17.77 a share and has fallen to £13.74. AstraZeneca started at £76.66 and is now on £79.58, having fallen from £87.85 on 11 November when it looked like it would be the first pharmaceutical company to release a vaccine for COVID-19, before it was revealed they'd lied about the tests. Pfizer started the year at $37.08 and is now on $40.34, having risen from $35.36 on 16 November, shortly before they announced the COVID-19 vaccine.

So what you've said is factually incorrect. The share price of these pharmaceutical companies this year is directly linked to their success in finding an unlicensed vaccine for COVID-19 and how it's been greeted by the market. I don't know whether your incorrect assertion is because you haven't bothered to look at the statistics or because you're trying to dismiss with unfounded assertions the valid questions I've raised in this article about the rapidity of the vaccine's production, the inadequacy of its testing, the financial motivations and history of corruption of all the individuals, companies and government organisations involved in this race for a COVID-19 vaccine, let alone the need for it or how legislation is being changed by the UK Government to accommodate and, possibly, mandate it. But either way, your assertion that some of the most powerful and wealthy companies in the world, which have repeatedly broken the law and paid millions and – in the case of GlaxoSmithKline and Pfizer – billions in out-of-court settlements to escape prosecution for malpractice and manslaughter, 'aren't in it for the money' shows your naivety about the pharmaceutical industry and the revolving door between it and Government regulators.

Unfortunately, however, the manufacture of this coronavirus isn't merely about the vast sums these companies are going to make selling needless and unlicensed vaccines for a virus that presents a threat to a tiny proportion of the population and has the fatality rate of seasonal influenza, but is also about the political control being exerted through the requirement to take such vaccines on the basis of the naivety and ignorance you've demonstrated.

I have left your comment here to demonstrate how easy it is to refute these bullish assertions of falsehood, but if you wish to make any further comments please do some research and thinking first. Thank you.

Loading...

REPLY

Leave a Reply

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