The Century of Evidence That Vaccines Cause Sudden Infant Deaths

The Disturbing Parallels between Sudden Infant Death Syndrome and Sudden Adult Death Syndrome

A MIDWESTERN DOCTOR

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Story at a Glance:

•To maximize profits, the pharmaceutical industry will often identify vulnerable groups who lack the ability to advocate for themselves and refuse pharmaceutical products.

•When the DPT vaccine was first developed over a century ago, it was tested at Irish orphanages. Recently mass graves of those early test subjects were discovered.

•Since the DPT vaccine hit the market, physicians around the world have observed waves of infant deaths following its use, which were often sudden and inexplicable (along with many other severe side effects).

•Numerous data sources correlate increasing childhood vaccination rates with increasing infant deaths. Those deaths played a key role in creating the 1986 National Childhood Vaccine Injury Act. That forgotten data compromises the majority of this article.

•When the COVID lockdowns happened, vaccine safety activists predicted the lockdowns would lead to an unprecedented drop in infant deaths since children were skipping their vaccines. This ended up being exactly what happened, and it was reconfirmed by infant deaths dropping in Florida after the pandemic prompted many parents to begin not vaccinating their children.

Note: due to the significant interest in this topic, this article is a revised version of a previously published article about it.

The Sudden Adult Death Syndrome (SADS) that was seen worldwide after the COVID-19 vaccines rolled out was so unmistakable that it made the general public see how much their governments had lied to them. What is less known, however, is the link between vaccines and the sudden death of children (euphemistically called Sudden Infant Death Syndrome or SIDS).

Like SADS, SIDS has a clear-cut relationship to vaccination, and in the case of SIDS, there is over a century of evidence to substantiate it. Like SADS, our healthcare authorities have worked tirelessly to conceal this link, even when faced with significant protests from the public who know what is happening. For the most part, these authorities have succeeded, and as a society, we have come to see SIDS as a normal event that does not require an investigation each time another child dies from vaccination.

I was compelled to write about this topic for a few key reasons:

•The children who died from SIDS and their parents deserve recognition and justice. Because of the attention highlighting SADS and vaccine dangers in general, I believe this may, at last, be possible.

•Infants cannot speak up for themselves (other than by crying, which is typically ignored). When you observe these vaccine injuries and the trauma they experience, it's very apparent what happened, but in almost all cases, those around them can't see it—so I feel I have a duty to speak out for those without a voice.

•Understanding how the government has handled SIDS provides essential context for understanding how it has dealt with SADS.

•New evidence supporting the link between SIDS and vaccination emerged during COVID-19.

In this article, I have done the best I could to provide all the evidence clearly demonstrating this link with a focus on that which can explain why vaccination causes SIDS. Additionally, I have also discussed much of this with a US government researcher who specializes in the vaccine most associated with SIDS and has requested their privacy be respected for understandable reasons.

The Forgotten Victims of Medicine

A key theme I have tried to illustrate is the need to stand up for the forgotten victims of medicine (over the years, I have formed a close connection with many of these victims). I believe we all must stand up for them because, in almost all cases, malicious agendas by those in power are first tested on vulnerable groups no one advocates for. Then, once the methods are sufficiently refined and implicitly condoned by the public, those same atrocities will always be committed on the general population.

For example, much of what has happened throughout COVID-19 parallels the early days of the AIDS epidemic. Fauci fought to keep a variety of effective treatments for AIDS off the market so that he could push through a deadly and ineffective (but highly lucrative) drug to treat HIV, AZT (which oddly enough has much in common with Fauci's recent pet project Remdesvir and the other COVID-19 medications). Once AZT entered the market, rather than end the epidemic, it significantly worsened the trajectory of AIDS (this book and this book provide the untold history of what happened). That tragic history hence allowed me, in late 2019, to predict the identical course that COVID-19 followed):

A mock graveyard during an ACT UP demonstration at the National Institutes of Health in Bethesda, Md. (Courtesy of Donna Binder)

Because the gay community was still heavily marginalized in the late 1980s, and despite being extraordinarily outspoken and often accusing Fauci of being a mass murderer, their plight was ignored. Fauci was never held accountable for his actions, and instead became the most powerful scientist in America. Since then, his influence has grown, and he has transformed the NIH (and related agencies) into pharmaceutical pipelines that prioritize profits over human lives.

Imagine how different our world would be now if we had taken the concerns of these protesters seriously. Unfortunately, the prevailing attitude within America is to never focus on issues that do not directly affect our lives (e.g., the human cost of our wars in the Middle East). Thus, there often ends up being no one left to speak out for everyday Americans when the same abuses they passively condone elsewhere finally arrive on their doorsteps (this is also the subject of a well-known poem about Nazi Germany).

Vulnerable Groups

Being successful in business is often a question of finding a way to break a rule that should not be broken, capitalize upon the economic benefit from doing so, and finally, leverage this newfound wealth to ensure that the rule can continue to be broken. For example, you are not supposed to bribe public officials. Still, if you find a way to (such as through "lobbying"), it creates a massive advantage over smaller competitors who still follow the rules, and as recent years have shown, the paid-off officials will eventually legalize each novel form of bribery.

Historically, the best example of this predatory capitalism is told within The Robber Barons. It tells the story of a group of conniving scoundrels, such as John D. Rockefeller, who broke every rule imaginable post-Civil War era and monopolized America's fledging industrial system to become some of the wealthiest individuals in history. This story is still relevant today because those economic predators defined our national character and, in the centuries since their rise to power, have applied similar tactics to dominate almost every facet of American life (my focus relates to how they transformed medicine).

Contemporarily, one of the best examples of this principle lies within the COVID-19 response, where pandemic profiteers flagrantly violated countless critical rules that had been well established before the pandemic. Deadly hospital protocols with no evidence supporting them were mandated throughout America, untested experimental vaccines with highly concerning safety data were rushed to the market, the manufacturers of these deadly products obtained complete immunity from any harm they caused, and the general populace lost their fundamental human rights through forced lockdowns and mandatory vaccinations. Much of this was illegal, but because an "emergency" situation was created, the wiggle room existed to bypass every legal protection afforded to the public. Pfizer bent every rule it could and gained significant power in the process all while making vast sums of money.

In the pharmaceutical industry, two recurring issues always emerge:

•How to regularly test countless experimental drugs with high potential toxicities to identify the one that could become a commercial success.

•How to create guaranteed markets for unsafe pharmaceuticals with questionable benefits.

In most cases, bribery plays a crucial role in addressing these challenges. For example, I documented the Bush family's involvement in forcing SSRI antidepressants onto the market and the FDA's subsequent decades of complicity in this disaster by suppressing all evidence of the extreme harm from these drugs—the FDA ignored a tsunami of credible adverse reports, put gag orders on employees who tried to report them, authored fake studies defending SSRIs and even fought against congressional investigations. The SSRI saga, I would argue, provides an excellent case study for understanding many aspects of the FDA's egregious conduct throughout COVID-19.

Then, once the regulatory hurdles have been cleared, these commercial needs are often fulfilled by exploiting vulnerable groups who are either experimented upon or forced to become a captive market for various lucrative pharmaceuticals.

Unethical Human Experimentation

In the earlier days of American medicine, dangerous medical treatments were often forcibly tested on prisoners, colonized indigenous populations, the mentally disabled, and orphans (some of the more well-known examples are summarized in this Wikipedia article). Following the Nuremberg trials (where many Nazi doctors argued they should not be convicted as their ethical principles in human experimentation matched that conducted throughout the United States) and the Anti-Vivisection movement campaigning against unethical human experimentation, a

changing political climate made it far more difficult to continue those experiments. The business-focused members of the medical field thus (reluctantly) switched to conducting future grotesque experiments less visibly.

This new approach included experiments on children in foster care that were no longer published in medical journals, outsourcing this research to the third world (where no one would raise questions), and regularly making use of the military's command structure to force lower-ranking servicemen to participate in highly controversial "research" studies.

Captive Markets

Almost every successful business is built upon creating a source of recurring revenue, and the entire pharmaceutical industry is structured to do this in as many ways as possible. For example, the industry continually funds corrupt guidelines that advocate for large segments of the population to consume countless non-beneficial and often harmful pharmaceuticals, then sells more drugs to treat the side effects of the original pharmaceutical they spread to every corner of America.

This process can best be observed in the elderly, upon whom countless drugs are prescribed until, eventually, the combined toxicity of these medications causes enough degeneration to land the patient in an isolated nursing home or hospital. After this, even more (sometimes necessary) medical therapies are provided until a critical point is inevitably reached and the elder dies (e.g., care in the final year of life accounts for approximately 25% of all spending by Medicare). In contrast, societies worldwide have more traditional forms of medicine that do not prioritize profit and emphasize cultivating vitality. Within them, you will often observe elders who maintain their health and functionality until the very end of their lives.
Note: one study found taking away a few non-necessary drugs from elderly patients reduced their overall risk of death by 56%.

I feel our approach to "managing" aging is particularly tragic because, in the quest to extract as many billable medical services as possible from the elderly (who often cannot refuse receiving said services), they are subjected to a variety of torturous medical interventions that directly disrupt the dying process (in contrast, doctors typically will refuse these interventions). One of my foundational beliefs (which is shared by many religious faiths) is that the death process represents one of, if not the most important, moments in our life, and medicine's interference with it has profound consequences for the human soul.

Amongst the most common recurring pharmaceutical products are the endless annual vaccinations, and those with knowledge of this business model suspected that once the COVID vaccines were shown to be highly ineffective, health officials would pivot to adopting an annual COVID immunization program instead of being discarded (which they tried to do but due to public resistance against the vaccines were unable to enshrine it upon the populace). Furthermore, a key driver behind the mRNA vaccine technology was its rapid production cycle, which enabled it to be deployed on short notice. In contrast, existing vaccines (e.g., influenza) must be manufactured far in advance, which explains why the annual flu shot almost always ends up not matching the circulating strain.

Something that is less appreciated about each of these universal vaccine programs is that when individuals are given a choice not to receive a vaccine, many will opt out. For example, between 80-90% of children are vaccinated (this figure includes influenza vaccinations). In contrast, last year, only 50.2% of the adult population received a flu shot, and in many cases, the adults who vaccinate only do so because of work requirements.

Note: the CDC recently admitted the COVID-19 mandates have significantly reduced the number of adults willing to get the other annual vaccinations.#

The key demographics I know of who are forced to receive vaccinations in the United States are pets, children, those in foster care, the elderly, prisoners, service members, students, and healthcare workers. In most cases, the business model around vaccines places intense pressures on the vaccinators to vaccinate:

- Veterinarians and pediatricians can only financially support their practices if they regularly vaccinate their patients.
- Corruption is rife throughout the military's experimental vaccine programs.
- Medicare, through "quality" measures (a component of Obamacare), such as this one, financially penalizes doctors who fail to vaccinate most of their elderly patients.

There are many sad stories of the forced medication of these groups (e.g., I have many astounding stories from friends who were subject to it). For the elderly, over the years, I have heard many stories of nursing homes where numerous residents suffered significant illnesses immediately following the annual vaccination of their facility, and I have admitted a few patients to the hospital for a severe injury that onset immediately following influenza or pneumococcal vaccination. During the recent vaccine push, I had numerous friends whose parents suffered a rapid and subsequently fatal cognitive decline immediately following COVID-19 vaccination, and I know someone who worked at a nursing home which experienced multiple deaths immediately after the vaccine was administered (similar stories have also been reported elsewhere).

This (abridged) comment I received after the previous article is an example of this tragedy. Sadly, I have run across many other similar cases, and in almost all instances, the vaccine is never considered as a potential cause:

> My dad developed dementia when he was 80. He was the picture of health and had not been in a hospital since the day he was born in 1928. The youngest of 4 brothers, his 3 older brothers all lived into their 90s with full mental faculties. Dad's dementia downfall was swift and sobering to watch. His decline frustrated him more as he was always a very healthy man. We had no idea what could cause this decline, but over the next 4 years, it was a contentious battle to get him the care he needed. He always knew who I was, not so much for other members of the family. When he died, he was 84, and I was beside myself to understand what the **** happened to my dad. Well, going through his papers and medical records, I found evidence that he had received the annual influenza vaccinations (pushed on him by his then-girlfriend who worked for the medical industrial complex) for several years immediately preceding his dementia downfall. Was THIS the cause of his dementia? Or was I just fishing for a cause? I don't know. But I will say that I can find very little research on flu vaccination and dementia.

How we treat our elderly is particularly tragic because they often hold the collective wisdom that can divert us from many of the catastrophic directions the predatory economic system has reshaped society to follow. Instead of listening to our elders, we warehouse them in facilities where they can be held out of sight and out of mind as their bodies decay from the inevitable consequences of a profit-driven medical model that does not cultivate health and vitality.

For the remainder of this article, I will review how unsafe pharmaceuticals have harmed another vulnerable demographic that cannot fully advocate for themselves. If you can review the previous installment in the series before reading the remainder of the article, it will provide valuable

context toward understanding the critical lessons to be learned from sudden infant death syndrome (SIDS):

Medical Blindness and SIDS

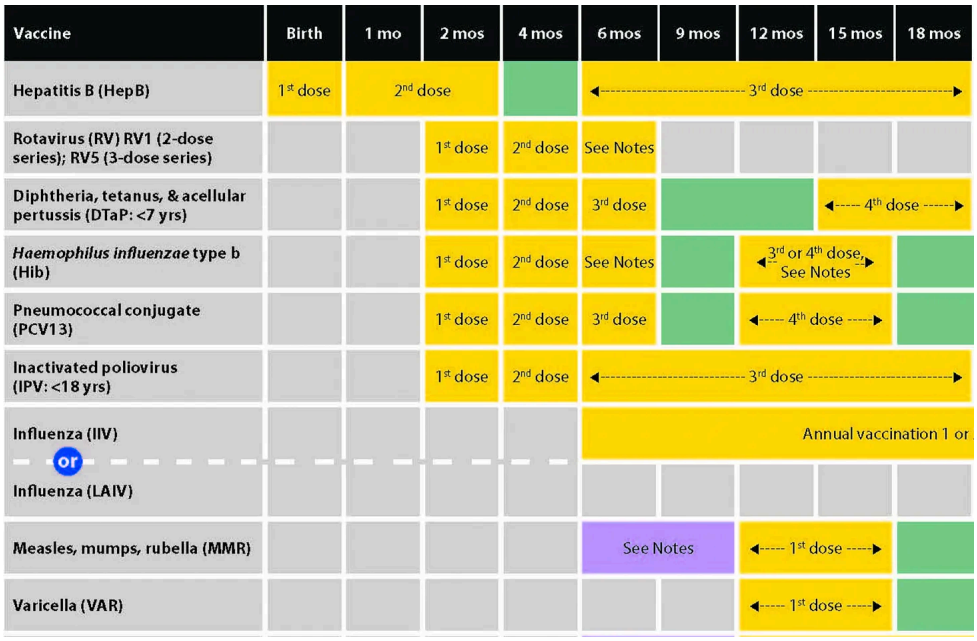
Although to this day, I harbor a great deal of animosity towards some of the physicians I trained under (that I believe is justified based on how they have conducted themselves throughout their careers), I also had the opportunity to train under many remarkable human beings I am forever grateful to. One pediatrician, for example, genuinely cared about his patients, was immensely intelligent, and, although we had radically different perspectives on many issues, was very kind and open-minded toward the parts of myself I shared with him.

At the very start of my medical education, he made a point during a lecture to state he believed with absolute certainty that vaccination was the most beneficial medical innovation in human history. A few years later, when I worked with him in clinic, over and over, I saw him perform a remarkable job caring for his patients, but I also periodically saw cases that led me to seriously question his judgment. For example, we once saw a patient who had an unambiguous adverse reaction to a vaccine, and upon being presented with clear evidence this had transpired, I observed the pediatrician suddenly enter a hypnotic trance where he became completely unable to recognize the existence of that evidence.

I share this story because I sincerely believe medical gaslighting is evil, but, at the same time, I think many of the gaslighters are anything but evil (e.g., often they are simply incapable of recognizing medical injuries). This pediatrician coincidentally was responsible for teaching us the lecture on SIDS. At the start of that lecture, I can still remember him stating the following:

> To this day, we are not sure what causes SIDS, but from a lot of research, we have determined that it clusters at two months of age, four months of age, and six months of age, after which point it sharply declines. Currently, we believe SIDS arises from infants suffocating after sleeping in a facedown position, and the Back To Sleep campaign, by preventing those deaths, has been one of the most successful public health accomplishments in history.

My immediate thought as the words exited his mouth was to look up the childhood vaccination schedule:



Note: the vaccine schedule has been repeatedly expanded since I first saw it in medical school (e.g., Hep A, HPV, and annual COVID-19 ones were added), but the relevant parts of it to this story have remained unchanged.

To this day, it still amazes me how few medical students had thought to ask the same question I did when this fact was shared in the lecture (there is so much to learn in medical school, which is by design, that students typically focus on memorizing information rather than critically examining it). I am immensely grateful to the pediatrician for explicitly stating his biases and blind spots at the very start. Had he not done so, I likely could have made a verbal misstep around him or his colleagues that would have prevented my graduation from medical school.

One of the most challenging experiences throughout my medical education was having to repeatedly bear witness to children being unambiguously injured from vaccinations (that, for some reason, the healthcare workers I trained with could never recognize) and again and again seeing the terror that would often appear in a child's eyes whenever they saw someone in a white coat because they knew what was coming next.

To this day, I vividly remember one girl screaming for her mommy and pleading for her not to break her promise the girl would not get shots that visit as the child was forcefully restrained by two nurses who joked about the fact it would be over before the girl even noticed the needle had gone in. I made a point to keep an eye on her after this ritualistic initiation. I observed her for approximately 30 minutes, throughout which her demeanor did not improve, and her vitality continually worsened.

In sharing all of this, I hope it helps to illuminate both the commercial advantages and ethical questions of pushing pharmaceutical products on individuals who cannot advocate for themselves and refuse those products. A large part of why I am putting so much into writing here is how much it gnawed at me that I could do nothing in these circumstances other than bear witness to what was occurring.

Historical Evidence Connecting Vaccination to SIDS

In many cases, the only ones who can recognize the impact of an environmental change contributing to a disease are those in practice before and after the toxin was introduced. One of my fundamental objections to evidence-based medicine is that our current religion of science believes that humans are irrational and incapable of accurately interpreting events in their environment. Because of this, whenever someone observes a correlation that questions a medical dogma, it is reflexively argued no causation (and often no correlation) exists, and that the perception one did was simply the product of a variety of erroneous cognitive biases.

The problem with this argument is that the "science" to establish causation on most controversial topics will never be done (due to the controversial nature of the subject), so an impossible standard is created for any unconventional viewpoint to meet. Additionally, while the unconscious biases explanation can be credibly argued to dismiss a causation that only has a weak correlation behind it, if a strong correlation is present and no other explanation exists for the correlation, the burden of proof (and the need for further scientific studies) rests on disproving rather than proving the causation.

These conflicting epistemological perspectives have far-reaching consequences. In the earlier days of medicine, countless valuable insights could be obtained by reading the early medical literature and the treatment successes of physicians trying to understand the diseases they were encountering. For example, many of my original (successful) protocols for treating COVID-19 were developed from studying the long-forgotten approaches to managing viral pneumonia devised by individual doctors on the front lines and subsequently proven throughout the 1918 influenza pandemic.

Nowadays, it is incredibly rare to read case reports highlighting the same vital investigative process by clinicians, as anyone who authors such a report exposes themselves to significant liability for violating the standard of care and "experimenting" upon their patients. I am only able to hear of these reports through word of mouth from many valuable contacts I have cultivated over the years, and as a result, the knowledge base that can successfully treat a wide range of complex illnesses is virtually inaccessible to most of the population who lack that same access.

Since its inception, the Diphtheria-Pertussis-Tetanus vaccination (DPT and DTP are used interchangeably) has been plagued with controversy. Before we continue, I should disclose that I am biased toward this vaccine because two members of my extended family experienced permanent brain damage from the original whole-cell formulation.

The early history of DPT is discussed in a previous article on the many attempts to create population-reducing vaccines:

> The DPT vaccine has a very questionable past. Due to a longstanding animosity between England and Ireland that originally arose over an English King wanting a divorce to be

> granted by the church, the English treated the Irish terribly. Unsuprisingly, Irish orphanages, were used to source (likely forced) research subjects for trials of the early vaccine prototypes.
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> In 2014, unmarked mass graves belonging to Irish orphans were discovered. Further research revealed these graves belonged to a group of 2,051 children upon whom an early diphtheria vaccine was covertly tested in the 1930s. Additionally, an earlier investigation had shown that early vaccine experiments (including DPT) were conducted in the 1960s to 1970s at Irish care homes and the test subjects included babies and handicapped children.

Note: as detailed by Sir Graham Wilson, in the early 1900s, there were over a dozen cases documented within the medical literature (and likely far more that weren't documented) where groups of children received an incorrectly prepared diphtheria vaccine, and collectively, thousands became severely ill with hundreds suffered an agonizing death. Diphtheria for reference is the D component of the DPT vaccine.

When the DPT vaccine entered the market, statements can be found from many physicians who observed it caused the emergence of SIDS (previously termed crib death due to babies being found dead in their cribs). Although these statements are likely authentic, in most instances, I have not found the source of the physician asserting that link and hence cannot reference them.

One exception would be Robert Mendelsohn, a remarkable pediatrician, patient advocate, and early pioneer for vaccine safety, whom I recently learned mentored a reader here. In our correspondences, that doctor informed me of a conversation that followed him asking Mendelsohn why he was willing to sacrifice the eminent position he had earned to speak out against the medical system:

> Mendelsohn told me that during his appointment as Medical Director of Project Head Start's Medical Consultation Service in 1968, he was horrified by the discussions held privately in the White House with his medical colleagues. **They were openly discussing how they could control the population of the poor** by promoting infant formula vaccinations, sadistic hospital birthing practices, deficient government schools, and neighborhood abortion clinics. This was just too much of an assault on his strong Jewish faith and his Hippocratic oath.

Note: one of the many benefits of breastfeeding is a significant reduction of SIDS.

In *How to Raise a Healthy Child in Spite of Your Doctor*, Mendelsohn wrote:

> "My suspicion, which is shared by others in my profession, is that the nearly 10,000 SIDS deaths that occur in the United States each year are related to one or more of the vaccines that are routinely given to children. The pertussis vaccine is the most likely villain, but it could also be one or more of the others."

Note: Although I believe pertussis (DPT) is the vaccine most strongly linked to SIDS, other vaccines also appear to share an association. For example, a 2007 VAERS analysis of neonatal (less than one month old) deaths evaluated the 29 unexplained deaths reported following the hepatitis B vaccine. Twenty-four were classified as SIDS; of the twenty- nine total deaths, 13.8 % died within 24 hours, 32 % within three days, and 44.8 % within seven days. Earlier in 1999, legislative testimony by Philip Incao, MD, made a case for the hepatitis B vaccine being associated with SIDS. A key piece of evidence Incao cited for this claim was that SIDS did not occur in those under two months of age until the hepatitis B vaccine entered the market. Hepatitis B is the only vaccine given before two months of age, a time when the immune system's ability to develop the desired antibodies that result from vaccination is impaired, and as the vaccine wears off over time, too early to later protect a child during the later years they might engage in the blood to blood contact (e.g., unprotected sex or sharing drug needles) necessary to transmit the disease.

A Shot in the Dark

In 1985, *DPT, A Shot in the Dark*, was published. This damning indictment of the DPT vaccine was pivotal in the cheaper but more dangerous whole-cell formulation being withdrawn from the domestic market (an acellular formulation replaced it). Its publication also helped create the political will for the National Vaccine Injury Compensation Program, established twenty months later because many of the parents who successfully lobbied members of Congress to take on the issue of vaccine injury had DPT-injured children. At the time, this law appeared to be a step in the right direction; unfortunately, the US government failed to uphold the spirit of what the law intended, and instead, it only served to grant vaccine manufacturers immunity for producing unsafe vaccines.

Note: the history behind that law is discussed in much more detail here (e.g., the activists who got it passed made creating the acellular DPT vaccine a condition of the act.

From that *DPT, A Shot in the Dark*, I learned that pertussis bacteria are highly immunogenic pathogens with many toxic components. As a result, the existing manufacturing techniques (based on culturing and then killing large numbers of the bacteria to create the raw vaccine material) could never produce a clean vaccine free of side effects. I also suspect the later development of a less toxic acellular DPT vaccine (which took quite a bit of work) was initiated in response to a wave of lawsuits for injuries by the more toxic whole-cell formulation.
Note: as mentioned before, there were also significant issues with inactivating the Diphtheria toxin.

As somewhat of a parallel, Meryl Nass, MD, is one of the foremost experts on anthrax vaccine injuries (which were what most likely caused the severe illness that afflicted over 100,000 service members). Nass (who was able to directly review documents unearthed by a congressional investigation of the vaccine) believes the most probable cause of the Anthrax vaccine's toxicity was it being an inherently dirty vaccine due to the raw material necessary to produce it. The vaccine manufacturer, Bioport, further worsened the vaccine by making the misguided choice to use larger filters (which let more problematic contaminants into the final vaccine) because the smaller filters were clogged by the vaccine ingredients (large quantities of killed, but still toxic, anthrax bacteria).

Due to the perceived danger of infection with the highly immunogenic pertussis bacteria, the medical field and the governing bodies overseeing immunization programs assumed that a certain number of injuries were an acceptable trade-off to mitigate the significant dangers posed by pertussis. However by the time pertussis became a relatively mild illness, most likely due to improvements in public sanitation or public nutrition (hence no longer justifying a dangerous vaccine), there was enough inertia behind DPT that attempts to curtail its use met fierce resistance.
Note: Pertussis can be treated with antibiotics while many outside the conventional medical system find vitamin C is remarkably effective for treating it.

As reports of injuries from the DPT vaccine exploded following the continually increasing administration of the vaccine, widespread allegiance to the vaccine resulted in the victims of DPT and the physicians who reported the injuries being attacked instead of listened to. Some of these reports, including those resulting in death, were summarized within *DPT, A Shot In The Dark*, and the indented passages that follow are direct quotations from it.

Note: For those of you who are not able to locate an electronic copy of the book, many of the cited studies here are also synopsized within this committee's report (I do not agree with the committee's attempt to refute the link between DPT and SIDS, which like almost every other official evaluation of this issue

appears heavily biased towards arriving at its predetermined conclusion, but at the same time, I also believe it is imperative to consider both sides of each argument).

> Death was the first reaction to be associated with the pertussis vaccine. Thorwald Madsen, the Danish vaccine pioneer, published an article in 1933 describing the deaths of two babies a few hours after they had been vaccinated. One had hiccups and convulsions, while the other had nothing more visible than a bluish tint of the skin. Following his report, other physicians added their own case histories of infant deaths immediately following pertussis vaccination.

> In 1946, Werne and Garrow described the deaths of identical twins within twenty-four hours of their second shot.

Cases of identical twins developing a condition immediately following an intervention are often considered a gold standard in proving causality. If SIDS occurs spontaneously, it is virtually impossible it would happen in the same amount of time after vaccination in twin infants. That article reviewing thirteen cases of simultaneous twin deaths, 10 of which were officially certified as SIDS, discusses the near impossibility of these events being due to chance. Likewise, while we know of many cases of SIDS occurring immediately after vaccination, we do not know of any that happened prior to vaccination.
Note: this also holds true for sudden regressions into autism.

Due to the political ramifications of these types of reports, American physicians are highly reluctant to publish these incidents in the current era. Nonetheless, many case reports (such as the ten cited in the above article do exist). Some cases are as follows:

To quote a 2006 case report from Turkey: "*Twin girls (3.5-month-old) were found dead by their mother in their crib, **both in the supine position** [lying on their backs]. The infants were identical twins and delivered at a hospital by cesarean section. Both infants were healthy and did not have any serious medical history. Two days before the incident, the twins had received the second dose of oral polio, DPT, and the first dose of hepatitis B vaccines. They had a fever on the first day of the vaccination and were given a teaspoonful of acetaminophen [catastrophic vaccine injuries often follow the administration of tylenol for fevers and infant distress that follow vaccination—I have seen this first hand]. Death scene investigation, judicial investigation, parental assessment, macroscopic and microscopic autopsy findings, and the toxicological analysis yielded no specific cause of death.*"

Other case reports of twins dying immediately following vaccination include:

•A 1987 case report of twins who simultaneously succumbed to sudden unexpected deaths 3 hours after DPT vaccination

•A 2007 case report of healthy 15-week-old identical twins who both died suddenly two days after receiving oral polio, hepatitis B, and DPT vaccines and were found by their mother **both in the supine position**.

•A 2010 case report of 12-week-old identical twins who died "**lying on their backs**" 5 days after receiving six vaccines concurrently.

•A 2013 case report of 10-week-old twins who were found dead **both in the supine position** and ten days earlier they had received their first doses of DPT and oral polio vaccines.

Note: I emphasized them being in the supine position (on their backs) as SIDS is often blamed on infants sleeping face down and suffocating themselves.

> In 1947, Matthew Brody, at the Brooklyn Hospital, gave detailed descriptions of two cases involving brain damage leading to death after the [DPT] shot.

> In 1978, Griffith studied severe reactions occurring after fifteen million doses of pertussis vaccine were administered to children in England. He stated that one child "was admitted to the hospital with pyrexia, signs and symptoms of meningeal irritation; transferred after three days with provisional diagnosis of encephalomyelitis but died thirty days after vaccination; necropsy showed no specific changes; recorded cause of death: encephalopathy due to injection of triple vaccine."

> At the Thirty-fourth Annual Meeting of the American Academy of Neurology in 1982, Torch presented a study suggesting a link between the DPT shot and certain cases of SIDS. After observing four sudden deaths within nineteen hours of DPT vaccinations in Nevada, Torch studied the relationship between this shot and SIDS in over two hundred randomly reported SIDS cases.
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> In a preliminary report on the first seventy cases. Torch stated that two-thirds had been vaccinated prior to death. Of these 6.5 percent died within twelve hours of vaccination; 13 percent within twenty-four hours; 26 percent within three days; and 37, 61, and 70 percent within one, two, and three weeks, respectively. He found that SIDS frequencies peaked at age two months in the non-DPT group and had a biphasic peak occurrence at two and four months in the DPT group.
>
> Torch added that cot death occurred maximally in the fall/winter season in the non-DPT group, but was nonseasonal in the DPT group. Death occurred most often in sleep in healthy, allergy-free infants following brief periods of irritability, crying, lethargy, upper respiratory tract symptoms, and sleep disturbance. Autopsy findings in both groups were typical of SIDS (e.g. petechiae of lung, pleura, pericardium, and thymus; vascular congestion; pulmonary edema; pneumonitis; and brain edema)."
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> But it was Torch's conclusion that infuriated neurologists and government health officials attending the meeting: "These data show that DPT vaccination may be a generally unrecognized major cause of sudden infant and early childhood death, and that the risks of immunization may outweigh its potential benefits. A need for reevaluation and possible modification of current vaccination procedures is indicated by this study."
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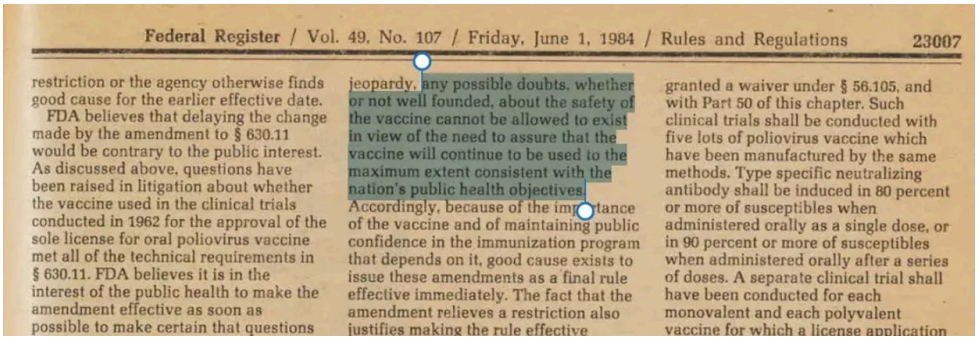
> *[In 1986, Torch also summarized case reports of more than 200 deaths that occurred following DPT vaccination, as reported by 37 authors in 12 countries. About half of these deaths occurred within 24 hours, 75 % within 3 days, and 90 % within 1-week post-vaccination. For most of these deaths a specific cause could not be found, although many were labeled as SIDS.]*

It should also be mentioned that the federal government has adopted a long-standing position that information that challenges public faith in the immunization program, for the sake of "the public good," must be censored and suppressed.



Federal Register / Vol. 49, No. 107 / Friday, June 1, 1984 / Rules and Regulations 23007

restriction or the agency otherwise finds good cause for the earlier effective date.

FDA believes that delaying the change made by the amendment to § 630.11 would be contrary to the public interest. As discussed above, questions have been raised in litigation about whether the vaccine used in the clinical trials conducted in 1962 for the approval of the sole license for oral poliovirus vaccine met all of the technical requirements in § 630.11. FDA believes it is in the interest of the public health to make the amendment effective as soon as possible to make certain that questions

jeopardy, any possible doubts, whether or not well founded, about the safety of the vaccine cannot be allowed to exist in view of the need to assure that the vaccine will continue to be used to the maximum extent consistent with the nation's public health objectives. Accordingly, because of the importance of the vaccine and of maintaining public confidence in the immunization program that depends on it, good cause exists to issue these amendments as a final rule effective immediately. The fact that the amendment relieves a restriction also justifies making the rule effective

granted a waiver under § 56.105, and with Part 50 of this chapter. Such clinical trials shall be conducted with five lots of poliovirus vaccine which have been manufactured by the same methods. Type specific neutralizing antibody shall be induced in 80 percent or more of susceptibles when administered orally as a single dose, or in 90 percent or more of susceptibles when administered orally after a series of doses. A separate clinical trial shall have been conducted for each monovalent and each polyvalent vaccine for which a license application

Although this policy was formally stated in 1984 (in reference to widespread and valid concerns about the purity of the polio vaccines), it appeared to have been in effect long before this date. It is hence insightful to observe how the frequent harm from the DTP vaccine was suppressed by the authorities, to the point the FDA even overrode a manufacturer who wanted to disclose the potential harms!

> The FDA's pertussis vaccine specialist, Charles Manclark, commented in 1976: "Pertussis vaccine is one of the more troublesome products to produce and assay. As an example of this, pertussis vaccine has one of the highest failure rates of all products submitted to the Bureau of Biologies for testing and release. Approximately 15-20 percent of all lots which pass the manufacturer's tests fail to pass the Bureau's tests."

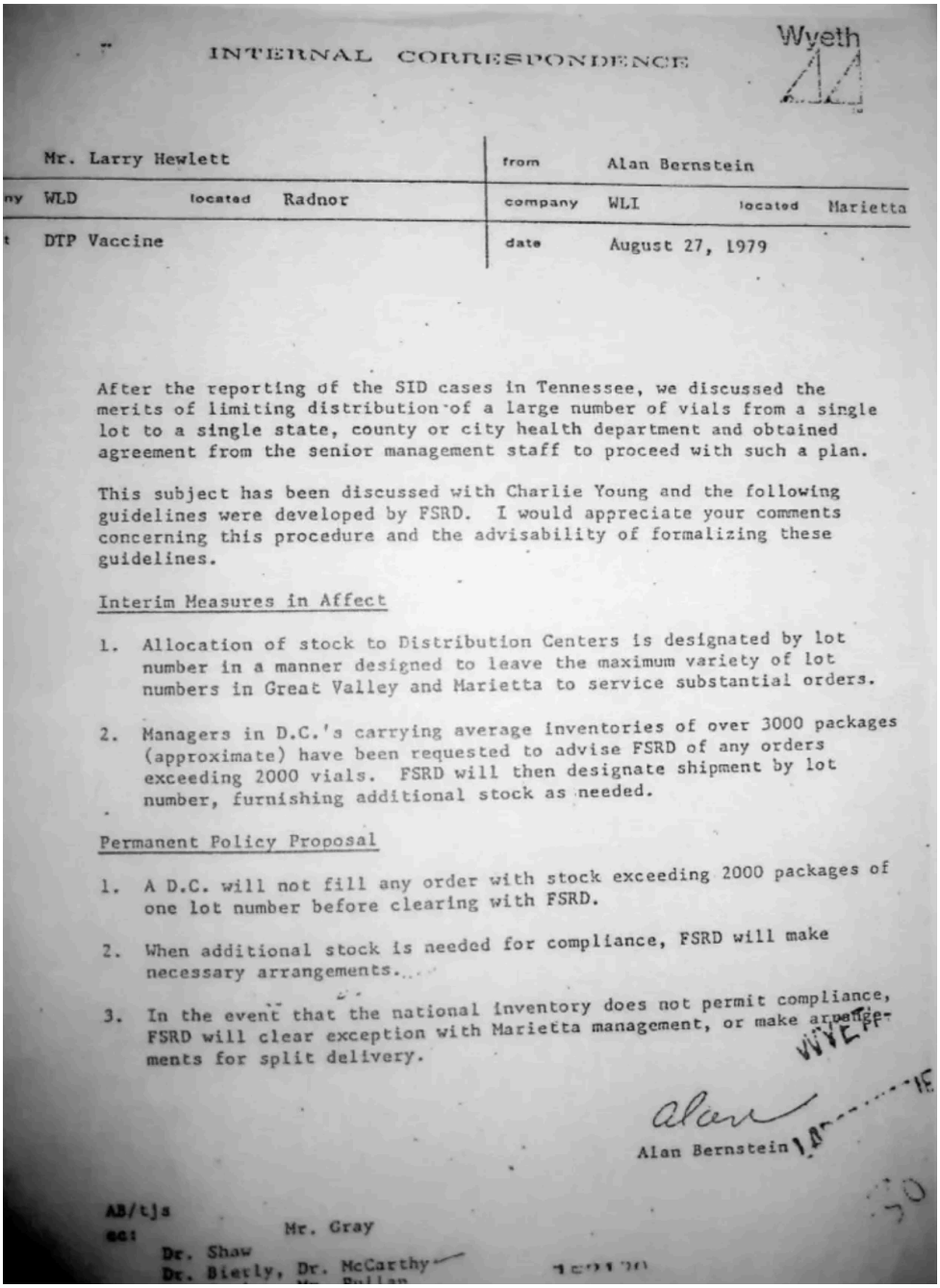
Note: as demonstrated by Wilson, abundant medical literature existed showing that hot lots were a frequent issue that often resulted in clusters of injuries and deaths.

> In 1978—79, eleven babies were found to have died within eight days of a DPT vaccination (in Tennessee). Nine of the eleven had been vaccinated with the same lot of pertussis vaccine, Wyeth #64201, and five (four from the same lot) had died within twenty-four hours of vaccination.
>
> A statistical analysis of the clustering of deaths revealed that the likelihood of observing four or more deaths occurring randomly on any of the first eight days after the use of lot #64201 was 3 in 100. This meant that such a clustering could occur purely by chance only 3 in 100 times. E. B. Mortimer later reported that the probability of this being a chance association was even lower—between 2 and 5 in 1,000.

> In June, CDC director Foege wrote a memo to the Surgeon General stating that the experts "did not feel that a causal relationship had been established between vaccination with DPT from Wyeth's lot #64201 and sudden infant death in infancy. **However they did not feel that a causal relationship could be totally excluded.**"
>
> Three weeks later, Foege's interpretation of the events stated in this memo to the Surgeon General was used by Harry Meyer, Director of the FDA Bureau of Biologies, as evidence to oppose a request by Wyeth Laboratories to list among its pertussis vaccine contraindications circumstances thought to predispose to SIDS. Meyer told Wyeth in a July 11 letter, "Based on the available data **we do not see a medical basis for listing circumstances thought to predispose to SIDS as contraindications to the use of DPT vaccine. We do not agree, therefore, with your proposal on page two of the circular under 'Contraindications.'** There is no evidence that such a change would prevent SIDS.

Wyeth apparently also decided to act to prevent a clustering of deaths following DPT vaccination from a single lot from ever occurring again in a single geographical area. This 1979 internal

memo (revealed through litigation) shows that Wyeth's senior management decided to solve this problem by making sure individual lots were distributed throughout the country so it would be much less obvious if one lot was hot as the deaths it created would not be concentrated in one area



INTERNAL CORRESPONDENCE

Wyeth

Mr. Larry Hewlett		from	Alan Bernstein
ny WLD	located Radnor	company WLI	located Marietta
t DTP Vaccine		date	August 27, 1979

After the reporting of the SID cases in Tennessee, we discussed the merits of limiting distribution of a large number of vials from a single lot to a single state, county or city health department and obtained agreement from the senior management staff to proceed with such a plan.

This subject has been discussed with Charlie Young and the following guidelines were developed by FSRD. I would appreciate your comments concerning this procedure and the advisability of formalizing these guidelines.

Interim Measures in Affect

1. Allocation of stock to Distribution Centers is designated by lot number in a manner designed to leave the maximum variety of lot numbers in Great Valley and Marietta to service substantial orders.

2. Managers in D.C.'s carrying average inventories of over 3000 packages (approximate) have been requested to advise FSRD of any orders exceeding 2000 vials. FSRD will then designate shipment by lot number, furnishing additional stock as needed.

Permanent Policy Proposal

1. A D.C. will not fill any order with stock exceeding 2000 packages of one lot number before clearing with FSRD.

2. When additional stock is needed for compliance, FSRD will make necessary arrangements.

3. In the event that the national inventory does not permit compliance, FSRD will clear exception with Marietta management, or make arrangements for split delivery.

Alan Bernstein

AB/tjs
cc: Mr. Gray
Dr. Shaw
Dr. Bietly, Dr. McCarthy

Note: if this practice became the industry standard, it helps to explain why similar incidents (many people dying in one area after a vaccination drive) have stopped repeating, and why it has become so much more difficult to trace hot lots. Nonetheless, since there were so many COVID-19 vaccine hot lots (due to the rushed production of these vaccines) researchers have nonetheless been able to identify them now.

> Vaccine manufacturers [**also**] **mention the connection to SIDS in their product information inserts.** In 1984, Wyeth Laboratories insert stated: "The occurrence of sudden infant death

> syndrome (SIDS) has been reported following administration of DTP. The significance of these reports is unclear. It should be kept in mind that the three primary immunizing doses of DTP are usually administered to infants between the age of two and six months and that approximately 85 percent of SIDS cases occur in the period 1 through 6 months of age, with the peak incidence at age 2 to 4 months." In 1986, Connaught's insert stated, "SIDS has occurred in infants following administration of DTP," but went on to state that one study showed that there was no causal connection.

> On March 19, 1979, a special meeting was called by the FDA on the Relation Between DPT Vaccines and Sudden Infant Death Syndrome. Daniel Shannon, MD, who is director of the Pediatric Pulmonary Unit at Massachusetts General Hospital and a principal investigator of SIDS, spoke about his research:
>
> "We do have a number of parents whose infants . . . have been doing entirely well after their initial near death spell who then go to the doctor, get a DPT and a polio and that is usually the two combined on the same day, and within twenty- four hours have either prolonged apnea [intermittent cessation of breathing] with the alarm going off or the need for resuscitation, having not needed one since the first time, perhaps a month preceding. Whether we would advise the parents to not have any further immunizations or not at that point does not really matter. They will not. Until we tell them that we feel the infant is out of danger, perhaps six or seven months later, you could not get them near the pediatrician's office."
>
> He added, "We do have this data. It is all recorded on tabular sheets and we have it on nearly 200 infants that we have evaluated this way. It is in a capacity that it can be pulled."
>
> In 1982, when Shannon published an extensive two-part study on SIDS in the New England Journal of Medicine, **a study which was financed in part by the Public Health Service**, he did not once mention his data on the near-miss SIDS infants who had prolonged apnea after their DPT shots. When questioned about this omission, he replied in a letter, "I did not mention DPT shots in my review article on SIDS in the New England Journal of Medicine because there are no data collected in a scientific way that support an association (Shannon at the time of this statement was also aware of Dr. Torch's report, which is detailed above)."

Shortly after the 1979 meeting, the CDC also completed its own analysis 1980 of 23 deaths within 28 days of DPT vaccination. 12 (52.2 %) occurred within 24 hours, and 18 (78.3 %) occurred within one week. In 16 of the 23 deaths, autopsy findings were consistent with SIDS. Of the 16 SIDS deaths, 6 (37.5 %) occurred within 24 hours, and 12 (75 %) occurred within one week.

Archie Kalokerinos

Archie Kalokerinos, MD, was a young Australian doctor who elected to pursue advanced medical training in England after graduation and returned to Australia in 1957. Uncomfortable with the profit-driven mindset he found had taken over the direction of medicine in his brief time away, he requested to be transferred from the wealthy urban parts of the country and assigned to care for the neglected rural Aboriginal communities. For context, the Aboriginal people have been subjected to the worst of colonialism for over a century, which included terrible social and physical living conditions (the extent of which are discussed further here).

In these communities, diseases such as pneumonia, severe ear infections, severe infant irritability, and a frequent inability to feed afflicted the children, and the infant mortality rate was over 10%, an unprecedented figure that greatly exceeded the 2% death rate found in the

surrounding white communities. The local medical authorities, in turn, wrote off the community's poor health as simply resulting from poor child-rearing habits by their uncivilized parents and the widespread filthy living conditions.

Kalokerinos became driven to address this problem, broke from his peers, and eventually discovered each of these issues primarily arose from severe vitamin C deficiencies (colonial powers often destroy the diets of native populations), and in many cases, saw infants on the verge of death recovering minutes after vitamin C injections (he also found their inability to feed was due to zinc deficiency rather than poor parenting alongside other issues arising from missing B vitamins). Initially, Kalokerinos faced significant opposition to this perspective. Still, after igniting a media firestorm to defend a woman accused of murdering her child (as the bruising that occurs from vitamin C deficiency was assumed in that case to have resulted from child abuse), the vitamin C approach was proven, accepted, and when implemented profoundly improved the childhood diseases that had plagued the Aboriginal communities.
Note: quite a bit of evidence (e.g., this paper, this paper, this paper, this medical report, and this rapid response) has been compiled that "shaken baby syndrome" actually is a result of vitamin C deficiency compounded by vaccination. Likewise, a recent review found that the evidence diagnosing "shaken baby syndrome" rests upon is quite weak.

Having already observed that vitamin C levels would often be depleted during viral infections (which sometimes caused the symptoms of severe vitamin C deficiency to emerge), Kalokerinos then witnessed the infant death rate in one Aboriginal community reach 50% (yes 50%) after an immunization campaign and realized that the same process occurred following vaccination. Kalokerinos proved that widespread vitamin deficiencies existed in the aboriginal community and postulated that vitamin C deficiency was likely why so many cases of infant diseases and deaths following vaccination campaigns. Kalokerinos later obtained proof in an animal model that vitamin C supplementation prevented the animal deaths commonly seen after vaccination and eventually convinced the local medical authorities to hear his case that the vaccines could be causing unintended deaths.

It should also be noted that at the same time, Kalokerinos developed his vitamin C protocols in Australia, Frederick R. Klenner MD independently discovered vitamin C (administered either orally or by injection at comparable doses to those used by Kalokerinos) yielded profound benefits similar to those observed by Kalokerinos for protecting pregnant women and their children. Klenner also discovered vitamin C could be used to treat various infectious diseases, including polio, effectively. It is quite sad that, to this day, no knowledge of their discoveries exists within either gynecology or pediatrics.

Lastly, in the same way that vaccines, particularly the DPT vaccine, have been connected to SIDS, the DPT vaccine has also been linked to childhood ear infections by many physicians, including Kalokerinos, who were able to observe the suspected causation directly. For myself, the strongest proof I've come across for this hypothesis came from a friend's brother, who was an American MD that spent time in an ashram (monastery) in India and decided as a medical missionary to provide all the children there with the DPT vaccine. Not long after, most of the children developed middle ear infections, a condition he had not seen once in the ashram in the years before his vaccination campaign. Since sharing this story, many parents who initially vaccinated their children but stopped in their later ones also noticed how the ear infections that so troubled their oldest children were absent in their younger unvaccinated children. From reviewing Kalokerinos's research (detailed within his 1976 book), I suspect the vitamin C deficiency induced by the DPT vaccine may be one of the factors that contribute to ear infections that follow that vaccination.

Raymond Obomsawin

Raymond Obomsawin PhD was a dedicated researcher (a recent obituary from the CHD can be read here) who unearthed many of the harms from the widespread vaccination programs (such as Canada's vaccine program in Thailand increasing death and disability for those vaccinated, which was of course never published).

While locating the sources (i,ii,iii) for this statement from Obomsawin:

> In the period of 1970-1974, when DPT vaccination was begun at 3 to 5 months of age, the Japanese national compensation system paid out claims for 57 permanent severe damage vaccine cases, and 37 deaths. During the ensuing six year period 1975-1980, when DPT injections were delayed to 24 months of age, severe reactions from the vaccine were reduced to a total of eight with three deaths. This represents an 85 to 90 percent reduction in severe cases of damage and death [per vaccine given].

> *Note: when the infant mortality rate (per 1000 births) in Japan during the mid-1970s was later compared to the mid-1980s (ten years after the age of vaccination was moved from 3 months to 2 years of age), it declined from 12.4 to 5.* ***That is a big deal, and in the context of Obomsawin's quote, again speaks to the massive underreporting factor in all vaccine injury reporting systems.***

I found this interview by him:

For those who cannot, the key points are:

•Obomsawin knew Kalokerinos personally and shared his stories of the forced vaccinations the Aborigines experienced and the hostility Kalokerinos received from the Australian medical system for challenging their entrenched dogmas.

•Global data shows infant mortality increases as more vaccines are given to children (a more recent study also confirmed this correlation).

•An Australian group developed a way to monitor infants at home continuously and, like many others, **was able to demonstrate non-fatal disruptions of breathing spiked following DPT and Polio vaccination** (this is the most likely cause of SIDS) and that this disruption continued for

over six weeks post-vaccination (hence overlapping with the typical period of death that has been observed to follow vaccination).

•Simultaneous administration of multiple vaccines can create brain damage.

•When SIDS cases at morgues are examined, **they cluster at precisely 2, 4, or 6 months of age** (rather than throughout the 2 to 6 month period), which can only be explained as a consequence of vaccination—however (like I saw in medical school) this association is rarely if ever considered by coroners.

•There are widespread and often severe contamination issues with many vaccines on the market (something we have also seen with the COVID-19 vaccines).

•Certain cases of SIDS are erroneously assumed to be due to abusive parents shaking or beating their children. **Because of this, parents have been unjustly jailed for a murder they never committed.** The only parallel I can draw to this evil are the many cases of mentally healthy individuals being placed on antidepressants, turning psychotic, brutally murdering a treasured loved one, and then being locked away for that murder.
Note: in addition to the articles above showing that vaccination causes what is termed "shaken baby syndrome" a compilation of many other references and testimonies on the topic can be found here.

Historical Trends in SIDS

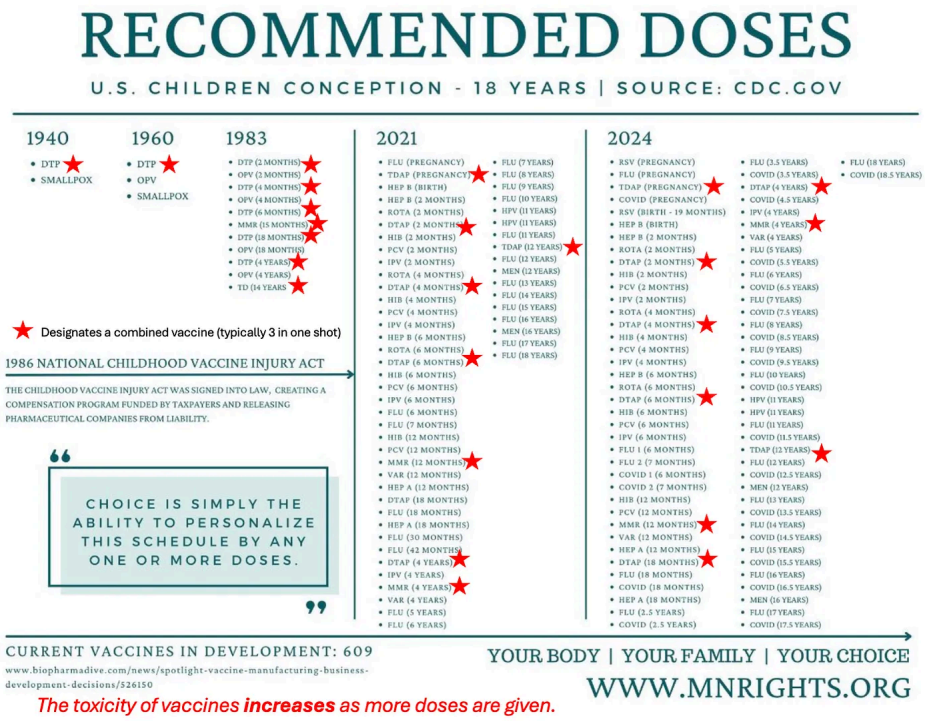
SIDS is defined as an infant's sudden and unexpected death, which remains unexplained after a thorough investigation, including the performance of an autopsy and review of the clinical history (both of which share many characteristic findings). My hope is that the following sections will illustrate why this definition is obscene.

It is often argued that SIDS is entirely due to vaccination (few were aware crib death even occurred before the national immunization programs that began in the 1960s where multiple vaccines were suddenly given throughout the country) and argued that SIDS subsequently increased as more and more vaccines were brought to the market.

This statement from James Howenstine, MD is one such example:

> The incidence of Sudden Infant Death Syndrome SIDS has grown from .55 per 1000 live births in 1953 to 12.8 per 1000 in 1992 in Olmstead County, Minnesota. The peak incidence for SIDS is age 2 to 4 months the exact time most vaccines are being given to children. 85 % of cases of SIDS occur in the first 6 months of infancy. The increase in SIDS as a percentage of total infant deaths has risen from 2.5 per 1000 in 1953 to 17.9 per 1000 in 1992. This rise in SIDS deaths has occurred during a period when nearly every childhood disease was declining due to improved sanitation and medical progress except SIDS. *These deaths from SIDS did increase during a period when the number of vaccines given a child was steadily rising to 36 per child.*

Note—this graphic helps one to fully appreciate how many more vaccines we give now:



*The toxicity of vaccines **increases** as more doses are given.*

The opposing (and far more common) narrative is that SIDS is an inexplicable phenomenon that suddenly emerged out of thin air and is due to infants suffocating from sleeping face down (which, for some reason, never was an issue prior to the 1960s). Thus, by having infants sleep face up, it resulted in a profound decline in infant deaths, and as existing data shows, the Back To Sleep campaign was one of the most successful public health measures in history.

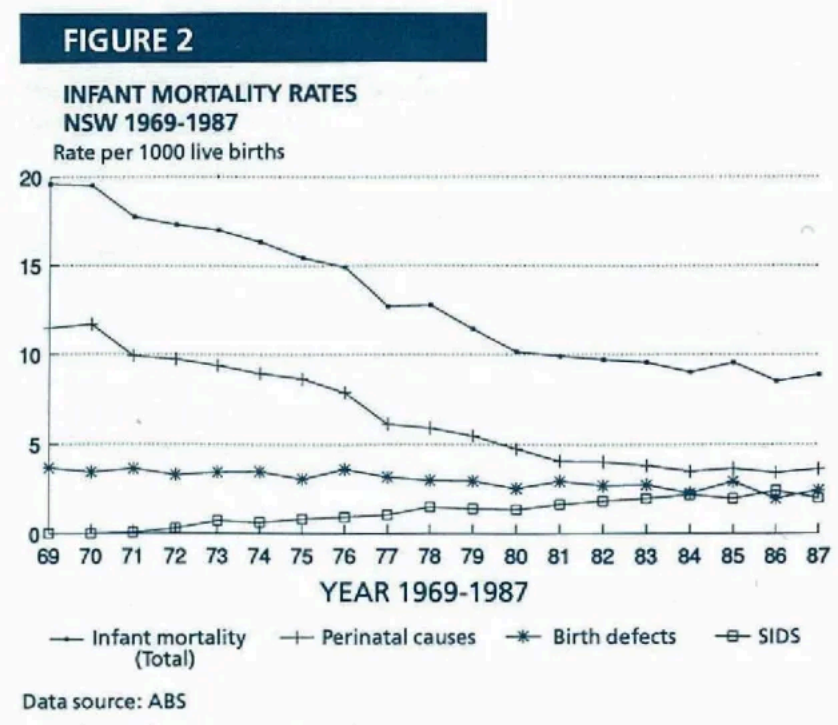
Despite some data that supports this narrative, I nonetheless question it. This is primarily because of how commonly I encounter cases of SIDS where the dead children were not lying face down (e.g., the many twin deaths referenced earlier were found on their backs alongside heartbreaking stories told to me by mothers who saw their babies die in other positions). Additionally, this campaign has always bothered me because a variety of subtle neurological issues result from the deformation (e.g., plagiocephaly) that often is found in infants who are forced to always lie on their backs.

I will also note a case can be made SIDS arises from the crib itself. This can either be due to their mattresses off-gassing toxic chemicals (which may be more toxic if the baby is face down) or from infants being at a greater risk of death when not sleeping with their parents (infants thrive from close contact with their mothers)—this was a potential cause of SIDS Mendelsohn frequently considered (as changing "crib death" to "SIDS" psychologically influenced where parents chose to have their babies sleep). While I believe it is possible these two factors could each influence the overall chance of SIDS occurring (in the same way breastfeeding reduces it), from a preliminary look at the evidence, I believe their possible influence on the disease process is much smaller than the effect of vaccination.

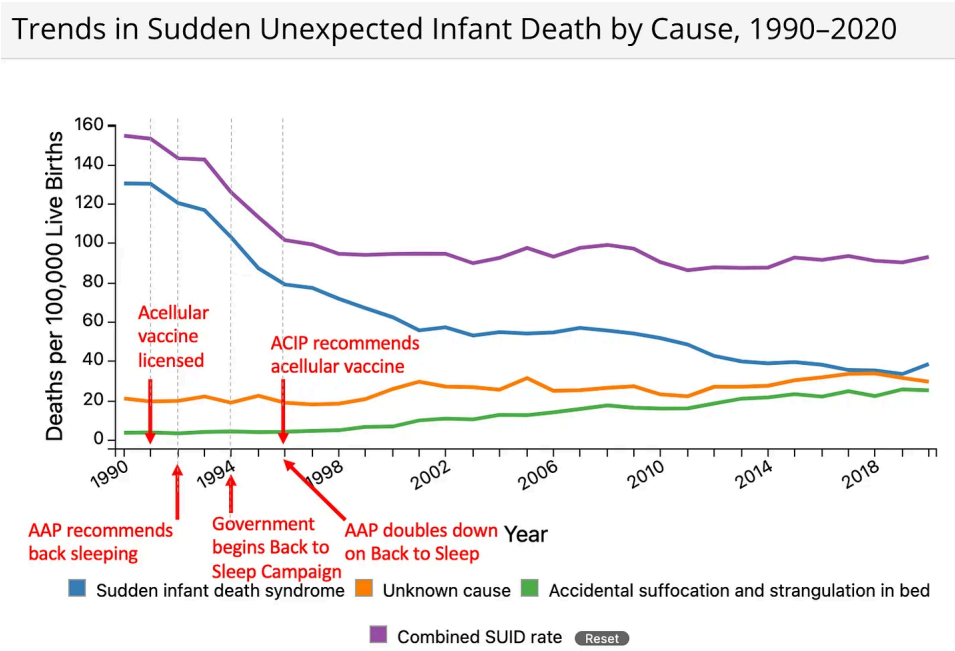
Many of the discrepancies between these two explanations for SIDS are challenging to clarify because, before 1969 (the time at which the condition had become too frequent to sweep under the rug), SIDS was not classified as a disease entity (and hence "crib death" was not documented in the vital statistics). By 1972, SIDS had become the leading cause of death in the first 1-12 months of life within the United States, and in 1973, the National Center for Health Statistics (part of the CDC), had made SIDS a category for documentation of infant deaths that occurred. Unfortunately, likely to conceal the chronology of these events, most references to the incidence of SIDS will only show you data starting when the Back To Sleep started (hence making it

impossible to determine if SIDS was increasing before the decline the compilers of those statistics wished to show).

The only dataset I have found so far that tracked the incidence of SIDS since 1969 came from Australia rather than the United States (where the trend, in theory, would be much more apparent), but does nonetheless confirm a gradually increasing incidence of SIDS.



Let's now review the CDC's (annotated) data:



Note: The sources for the annotations in the above chart can be found here and here. Additionally, it should be mentioned that no decrease in TDP vaccination occurred between 1990 to 1996.

From reading this annotated chart, two different interpretations emerge:

The first is that the decline in SIDS resulted from the acellular TDaP vaccine entering the market, and because it took time to be adopted (it only became the standard recommendation in 1996), the removal of the more harmful whole cellular TDwP was gradual. The missing data I could not locate to evaluate this argument further is the rate at which that shift occurred, but I feel it is reasonable to assume a gradual change occurred as more and more parties were trying to avoid being sued for TDwP injuries.

The second is that the Back To Sleep was a resounding success (which, conversely, some argue was simply a PR campaign to address the concerns of American parents surrounding the increasingly common cases of SIDS reaching a fever pitch—for example, in 1984 congressional hearings were conducted on vaccination and SIDS).

Although the above timeline appears superficially to support the success of Back to Sleep (and I will admit I have not researched the data on it in depth), I am nonetheless quite skeptical of the campaign's impact. The decline of SIDS began before Back To Sleep was launched, and the campaign had no appreciable effect on the existing trend of SIDS. The critical piece of data I am missing here is the effect of the American Academy of Pediatrics' 1992 recommendation to physicians to advocate for infants sleeping on their backs. Still, I am doubtful these recommendations could have had an impact that was in any way comparable to the later massive 1994 campaign by the federal government.

I thus suspect Back To Sleep (viewed as one of the most successful health initiatives in history) ultimately served to distract the public from the damage caused by the TDwP vaccine. This is somewhat analogous to the polio vaccine being introduced at the same time DDT was pulled from the market (DDT caused an illness indistinguishable from polio and produced nearly identical lesions to the spinal cord), and the polio vaccine then becoming a mythology the success of modern medicine was based upon.

Similarly, it can be credibly argued that the widespread adoption of lead (particularly in gasoline) was a key cause of the still unexplained explosion of heart disease we experienced in the last century. Hence the withdrawal of lead from the market was the actual factor responsible for the later reduction in heart disease the medical community has repeatedly claimed credit for through its severely misguided war on cholesterol.

These events are also analogous to the societal mythology that the earliest vaccines were responsible for ending the era of infectious disease, even though eradicating those diseases was most likely a result of improved living conditions, and most of the eradication preceded vaccination. The correlation is not causation argument is always thrown around to debunk any claim which challenges the authority of modern medicine, but as this example shows, some of the most sacred mythologies of medicine rest on shaky foundations and highly questionable correlations.

For those wishing to learn more about the actual early history of vaccination, the first article on this substack covers the early data on immunizations (many of the most deadly diseases that declined in that era never had a vaccine) and shows how smallpox vaccination (which killed many young children) was a century-long tragedy that was not in any manner responsible for eradicating smallpox.

Diagnostic Reclassification

There are two competing hypotheses (both of which I agree with) to explain the decline of polio after the polio vaccination campaigns. In addition to the DDT hypothesis discussed above, it has also been argued that the diagnostic criteria for polio were changed so that almost every condition that previously qualified as polio was relabeled as something else (e.g., now we have conditions such as **Non-Polio** Acute Flaccid Paralysis).

Bureaucrats love to tinker with classifications to advance political agendas, which recently came to the attention of the general public after it became recognized that most (but not all) of the deaths attributed to COVID-19 did not alter the total number of deaths occurring, demonstrating many COVID-19 "deaths" were simply other fatal conditions being reclassified as COVID-19 deaths.

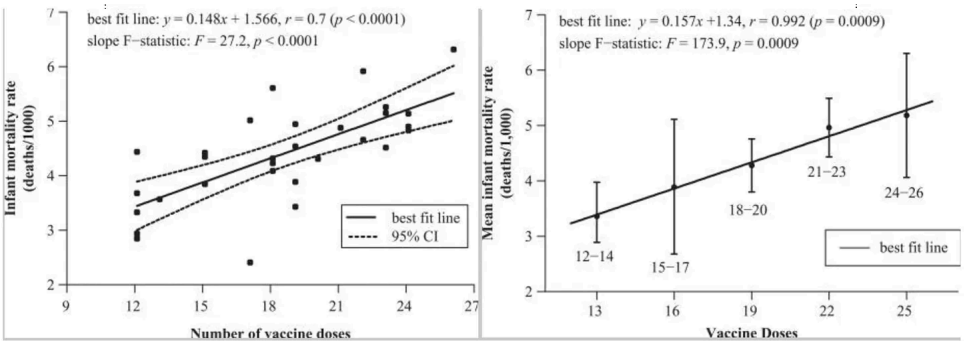
A similar situation also may exist here as a change in diagnostic classifications could explain the decline I attribute to removing the TDwP vaccine from the market. Prior to 1979, the WHO's ICD system (which is required to be utilized in the paperwork for every death that occurs) listed vaccinations as a cause of death. In 1979, ICD permanently removed this classification, thereby making it impossible, even if the doctor wished to, for there to be any official record of vaccines causing an infant's death (instead, these deaths were shunted to the nebulous category of SIDS where debunkers could then argue the deaths had nothing to do with vaccination). It is difficult for me to believe this was not done intentionally to conceal the issue.

There is also data suggesting this diagnostic shunting expanded during Back to Sleep, and the campaign's benefit was primarily an artifact of different ICD codes for death being utilized after the campaign started (potentially because doctors believing in the value of their advice, did not then want to classify the death of an infant whose mother had followed the doctor's instructions to sleep on their back as SIDS).

> The all-cause postneonatal mortality rate declined 27% and the postneonatal SIDS rate declined 55% between 1992 and 2001. However, for the period from 1999 to 2001 there was no significant change in the overall postneonatal mortality rate, whereas the postneonatal SIDS rate declined by 17.4%. Concurrent increases in postneonatal mortality rates for unknown and unspecified causes and suffocation account for 90% of the decrease in the SIDS rate between 1999 and 2001.

However, while this explanation is also compelling, it does not match the above trends with the CDC's data (combined SUID encompasses all of these classifications) or trends I found on overall infant mortality. This suggests an error exists in the data underlying these opposing viewpoints, and I must acknowledge it is beyond my ability to determine where that error lies (a more detailed discussion on the misclassifications of SIDS that potentially extends beyond the three categories contained within SUID can be found here).

Lastly, although some inherent challenges exist in comparing the historical trends of SIDS to vaccination, a recent 2011 study found another means to assess this association by comparing the current infant mortality rates of the 34 nations with the lowest infant mortality (34 were chosen since the USA is #34) to the number of required childhood vaccines in the country. The relationship is unmistakable..



Whole Cell Pertussis in Africa

Because the whole cell pertussis vaccination is cheaper to produce than the safer acellular formulation, its primary use shifted to the third world once it was removed from the Western marketplace.

Peter Aaby, a renowned vaccine scientist and promoter of vaccination, was commissioned by the WHO to study the effects of vaccines commonly utilized in charitable programs by the international community on infant mortality. For context, these types of studies are rarely conducted, which is why we still do not have the data to determine if the vaccines we give our children provide a net benefit or harm.

The results were not what Aaby expected. While a significant reduction in death was observed from MMR (to my knowledge, this is one of the only studies that has ever found a clear benefit from a vaccination program, likely on account of the immune stimulation from the MMR vaccine to protecting against a variety of often fatal infectious diseases endemic to the area), the opposite was found for DTP and Aaby's data suggested the program needed to be scrapped:

> *"**DTP was associated with 5-fold higher mortality than being unvaccinated** [DPT increased deaths 3.93 times in boys and 9.98 times in girls] . No prospective study has shown beneficial survival effects of DTP. Unfortunately, DTP is the most widely used vaccine, and the proportion who receives DTP is used globally as an indicator of the performance of national vaccination programs."*
>
> *"It should be of concern that the effect of routine vaccinations on all-cause mortality was not tested in randomized trials. All currently available evidence suggests that DTP vaccine may kill more children from other causes than it saves from diphtheria, tetanus or pertussis. Though a vaccine protects children against the target disease, it may simultaneously increase susceptibility to unrelated infections."*

Aaby's results were, not surprisingly, buried. Since his publication, instead of being re-evaluated, the distribution of DPT has only increased, largely due to Bill Gates, through his foundation shifting the focus of the WHO towards vaccination (rather than public health projects that save lives, a concern that has been repeatedly shared with me by employees of the WHO).

Peter Gøtzsche, MD, is a renowned expert on research fraud and has been a critical reformer in evidence-based medicine who has repeatedly stuck his neck out to speak truth to power (Gøtzsche nonetheless fully supports most but not all vaccines). After Aaby's report, Gøtzsche was requested to provide a systematic review of the DPT program. Gøtzsche, in turn, concluded, "Evidence tells us that it is likely that the DTP vaccine increases total mortality in low-income countries." This is about as strong an indictment of a vaccine as can be stated within a scientific publication.

Exacerbating Factors

Standard criteria for proving causality are if a dose-response relationship exists between a disease-causing agent and a disease and if logical predisposing factors increase the likelihood of an agent causing it's associated disease. In *Miller's Review of [400] Critical Vaccine Studies*, *Neil Miller* located a series of studies published within the peer-reviewed literature demonstrating those relationships, and that hard work made this section possible.

The particularly sad thing about these exacerbating factors is that if the medical field acknowledged them, immunization could be easily modified to continue vaccinating but avoid many of the high-risk immunization strategies. However, this is never done because it requires acknowledging vaccines are not 100% safe, which is fundamentally unacceptable to the medical field (pediatricians who still vaccinate but space them out are frequently retaliated against). I have discussed the evidence outlined in this section with colleagues who are trained pediatricians, and without exception, they all told me they were never aware this evidence existed.

Hexavalent Vaccines

Existing data suggests that multiple vaccines being given simultaneously (e.g., through vaccines that combine multiple immunizations into a single shot), particularly the hexavalent vaccines (DTP + Polio + Haemophilus Influenza B + Hepatitis B) correlate with an increased incidence of SIDS. The following three studies support that link:

1. After GSK's hexavalent vaccine was made available in Europe in 2000, several reports of infant deaths immediately following the administration of that vaccine emerged. This prompted a 2005 study of Germany's adverse event database that analyzed the risk of sudden unexpected death in young children within 1 to 28 days after receiving a hexavalent vaccine. The study found standardized mortality ratios (SMR) were non-significantly higher than expected on the first day after receiving a hexavalent vaccine during infancy and that in the second year of life, children were significantly more likely to die within one day (SMR = 31.3) or two days (SMR = 23.5) after hexavalent vaccination.

2. A follow-up to the German study using Italy's national database of death certificates found that administering a hexavalent vaccine to infants of 1-24 months of age increased their risk of death in the 14 days after vaccination by 2.2 times (when six antigens were administered differently, a more minor increase was also observed). Although these results were statistically significant, the authors nonetheless concluded they did not present a substantial concern for vaccine safety (a conclusion I suspect was either due to an existing bias or because the authors did not understand the underreporting factor for most vaccine injuries).

3. Because of data suggesting a link between hexavalent vaccines and SIDS, in 2011, an Italian judge ordered the release of GlaxoSmithKline's confidential safety monitoring data within Italy. Although GSK's report argued that fewer deaths than would naturally be expected occurred following vaccination (which suggests fraud as none of the vaccinated diseases cause sudden death—suspect government COVID-19 data sets have made similar claims it was reducing deaths unrelated to COVID-19), but even though GSK claimed this, their database revealed **that approximately 90% of the reported infant deaths occurred immediately following vaccination**.

Later, a confidential report by GSK was submitted to European regulators in 2015. Of the vaccine-linked deaths that were reported, 52.5 % clustered within three days post-vaccination and 82.2 % occurred within seven days post-vaccination, and 97.9 % of all sudden deaths

following the first dose of hexavalent vaccination (four doses are recommended) happened in the first ten days post-vaccination while just 2.1 % occurred in the next ten days.

GSK's reports again substantiate the link countless others have found that SIDS disproportionately occurs immediately after vaccination. If, by some quirk of fate, those suspect vaccines had coincidentally been administered at the same time SIDS would have occurred naturally (which is what debunkers have the audacity to argue), the timing that is consistently found for SIDS would not occur, and the cases of death would be evenly spaced out over the entire 2-6 month period rather than being clustered immediately following vaccination.

Premature Infants

Providing vaccines earlier in life, particularly to premature infants, has been observed to correlate with an increased likelihood of a potentially fatal disease episode (e.g., severe inflammatory responses, heart issues, and most importantly, impairment or cessation of breathing, which, when sufficiently severe, results in SIDS). This association **is common enough** that many studies have been conducted on the subject, and mainstream journals have published articles suggesting the need to monitor these complications in premature infants.

Beyond the critical systems of the body being less able to tolerate the stress of immunization in an incompletely developed (premature) body since vaccine doses are not calibrated to an infant's weight (instead, a one size fits all model is followed), premature infants effectively receive a much higher vaccine dose. Since this "higher" amount correlates to a higher likelihood of a life-threatening vaccine injury, a dose-response relationship to vaccination is again demonstrated. In each of these studies where premature infants were evaluated, "cardiorespiratory events" typically referred to interruptions of breathing (apnea), a slowed heart rate (bradycardia), and or reduction of tissue oxygenation.

Note: a dose-response relationship is considered a key criteria for determining causality in toxicology.

If cardiorespiratory events are not addressed, they are often fatal. Since premature infants are often kept in the hospital for monitoring, they represent the one cohort whose vital signs will be monitored following vaccination (as the primary job of the NICU is to do this and intervene to save babies who develop unsafe vital signs). Based on the evidence presented here, I believe it is fair to advance the argument that many cases of SIDS involved incidents of vaccine-induced cardiorespiratory events that progressed to death while the infant could not be unattended to as they lay in their crib. Furthermore, this was also demonstrated by the previously mentioned Australian study where a specialized device was made to monitor an infant's breathing at home following vaccination.

Some of the studies assessing the effect of vaccination on at-risk infants are as follows:

•A 1997 study monitored premature infants for 24 hours before and after being vaccinated at two months. Before vaccination, 1 of 98 preterm infants had a cardiorespiratory event, while 17 of 98 had one after vaccination. Of those 17 who did, 29% required respiratory support.

•A 1998 study found that 30% of premature infants had a cardiorespiratory event within 24 hours after vaccination (and in all but one infant, key inflammatory markers rose to abnormal levels after vaccination).

•A 2001 study found adverse vaccine reactions occurred in 38% of premature infants, and 20% of the premature infants (who were significantly younger and smaller at the time of vaccination than the uninjured) developed cardiorespiratory events following vaccination. One-third (33%) of

premature infants vaccinated at 70 days of age or less had major adverse reactions compared with none when vaccinated over 70 days of age.

•A 2005 study found recurrent or increased severity of cardiorespiratory events occurred in 13% of preterm infants following vaccination.

•A 2006 study found that vaccinated preterm infants were 2.41 times more likely to have a resurgence of or increased cardiorespiratory events than unvaccinated controls. Low weight at the time of vaccination increased the risk of these events.

•A 2007 study found 11% percent of vaccinated premature newborns experienced cardiorespiratory events. Of the infants with existing chronic diseases, 21.7% experienced these reactions.

•A 2007 study found cardiorespiratory events were observed in 0-22% of infants who received a single vaccine (this rate varied by the vaccine, TDaP was the highest at 22%) and in 32% of those who received multiple vaccines simultaneously (who were on average 3.62 times more likely than those receiving a single vaccine to develop a cardiorespiratory event). 13% of those receiving multiple vaccines subsequently required ventilation, and abnormal elevation of inflammatory markers occurred in up to 70% of those given a single vaccine, and 85% of infants administered multiple vaccines.

•A 2008 study found that 51.5% of all vaccinated premature infants had a cardiorespiratory event after their first vaccination, and 18% had a recurrence after their second vaccination.

•A 2010 study found cardiorespiratory events occurred in 10.8% of very low birth weight infants after vaccination and that when apnea occurred, they were 6.4 times more likely to develop bradycardia.

•A 2011 study found that of preterm infants who experienced apnea after their initial vaccinations, 18% had recurrent apnea with subsequent vaccinations.

•A 2012 study found that cardiorespiratory events occurred in 35% of very low birth weight preterm infants after vaccination, and this risk increased with low gestational age or the infant already requiring respiratory support prior to vaccination.

•A 2012 study found nearly 32% of vaccinated premature infants had cardiorespiratory events following vaccination. Adverse reactions were more common in younger and lower-weight infants.

An analysis of VAERS also supported this association:

A 2012 analysis found 38,801 reports in VAERS that occurred in infants between 1990–2010 (keep in mind these injuries are massively underreported—often in the range of only capturing 1-3% of the actual instances) were filtered for cases of hospitalizations (6279) and deaths (1881) and then compared to the number of vaccines received and the child's age. The hospitalization rate increased linearly from 11.0% (107 of 969) for two doses to 23.5% (661 of 2817) for eight doses and decreased linearly from 20.1% (154 of 765) for children aged <0.1 years to 10.7% (86 of 801) for children aged 0.9 years. Children who received 5-8 vaccine doses were 1.5 times as likely to die as children who received 1-4 doses (3.6% to 5.5%), and boys were 1.4 times as likely to die as girls.

Were the COVID-19 Lockdowns a Blessing in Disguise?

A key reason why it has been impossible to improve the safety of existing vaccines is that clinical trials that evaluate the safety of vaccinations are, for all practical purposes, forbidden (and when they are conducted, the researchers experience extreme persecution many believe is designed to discourage other researchers from pursuing the same research).

The rationale for this prohibition is that vaccines are so incredibly safe and effective that it is unethical to conduct a trial that withholds these life-saving therapies from children who serve as the controls. Conversely, any evidence that argues vaccines are unsafe is **always** dismissed by stating no placebo control data exists to substantiate that harm.

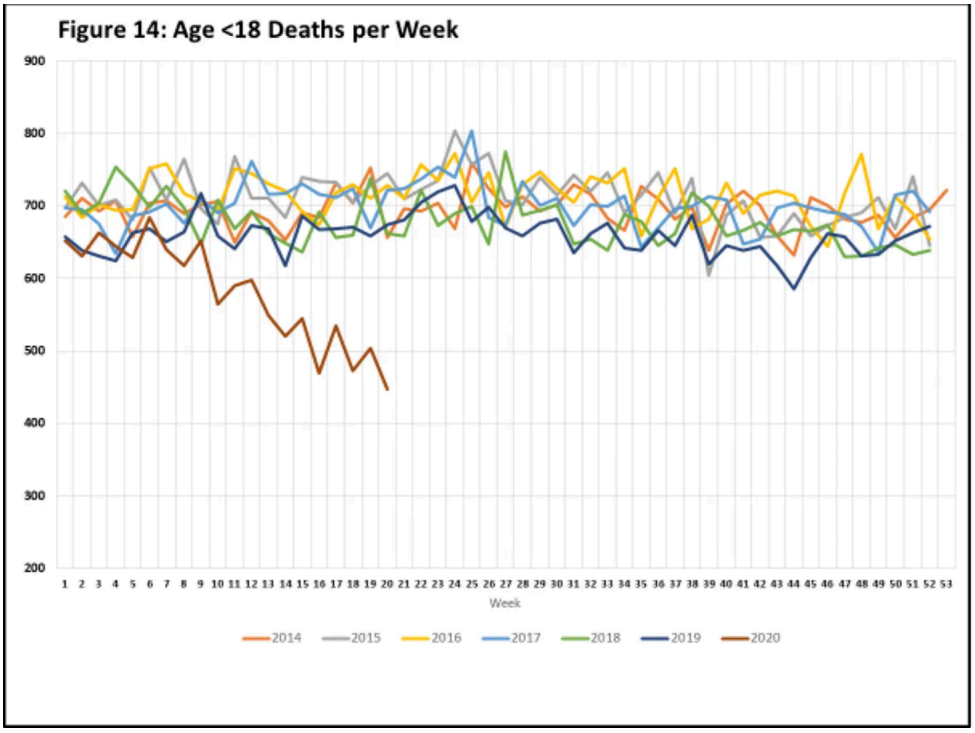
This circular logic designed to shield the available vaccinations from any scrutiny (which, due to their toxicity profiles, they could not stand up to) has been an endless source of frustration for vaccine safety advocates. Because the harms from vaccination are so far-reaching, they only become apparent in control groups (which still exist and consistently show an absence or significant reduction of most chronic illnesses). This is likely why such a relentless push has been made to ensure unvaccinated comparison groups cannot exist (this was also floated as a reason for governments around the world having a fanatical drive to vaccinate the population as otherwise, they will face profound liability for the obvious wave of injuries that only occurred in those who received the spike protein vaccines).

At this point, we have witnessed a century-long cat-and-mouse game of authorities concocting reason after reason to reject each new way that is found to prove profound adverse vaccination reactions occur. I hope this article provides sufficient evidence to demonstrate a clear and indisputable between vaccination and SIDS has existed for decades. In this type of situation, it is imperative for clinical trials to be conducted to settle the question (which I would argue has always been prohibited because they would show vaccines kill babies). However, while much work has been done to maintain that prohibition, the embargo was inadvertently broken in 2020.

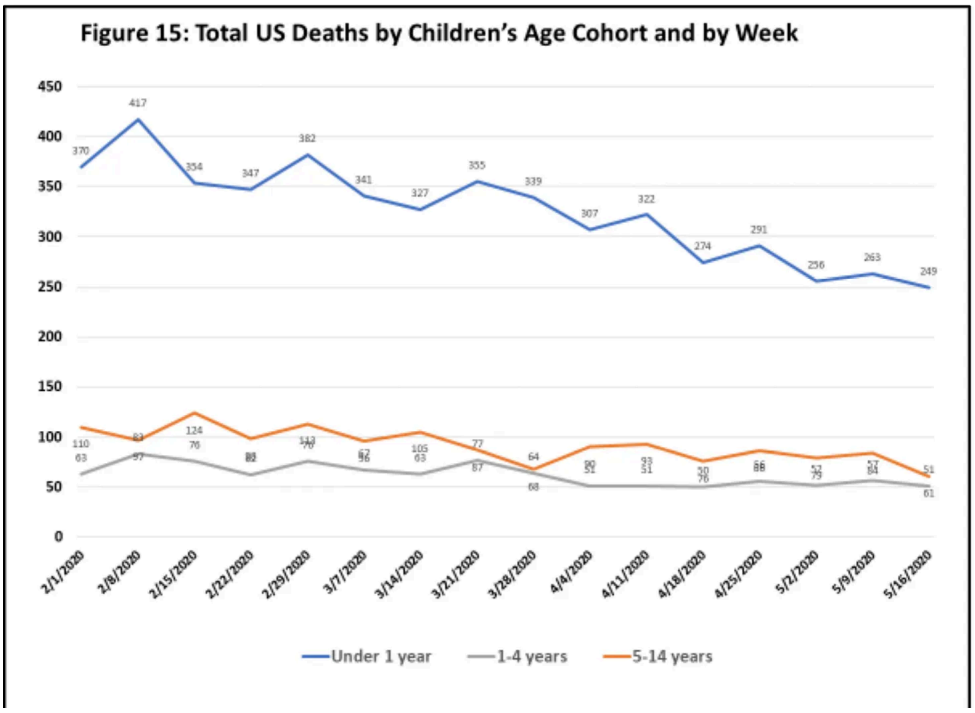
When the COVID-19 lockdowns were enacted, and nonessential medical services were terminated (including the routine visits with the pediatrician for the scheduled immunizations), the vaccine safety advocates realized this represented a once-in-a-lifetime chance to prove the immunization schedule caused SIDS because there would be a brief period where the childhood vaccine uptake substantially dropped.

Before we go any further, I want to note that this was, for all practical purposes, this was a prospective study (which is considered to be far more valid than a retrospective study) because so many physicians in the communities I belonged to announced their intent to study this issue the moment the lockdowns were announced. I will now cite a few figures from a report compiled on this data.

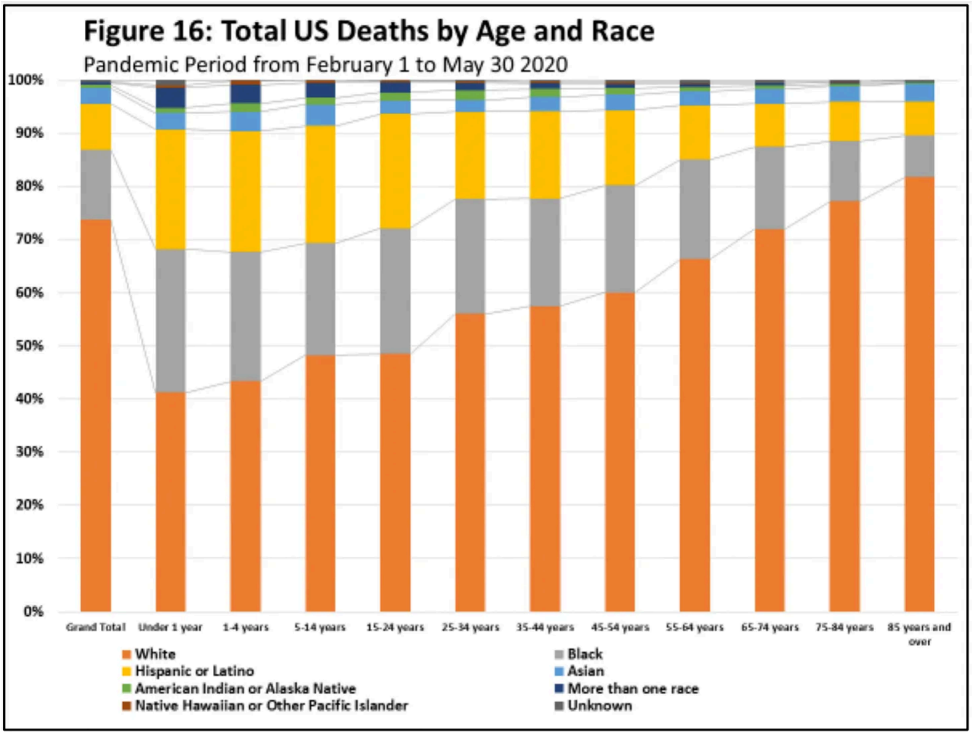
Although deaths for many segments of the population increased during the early days of COVID-19, one group instead experienced an unexpected decline:



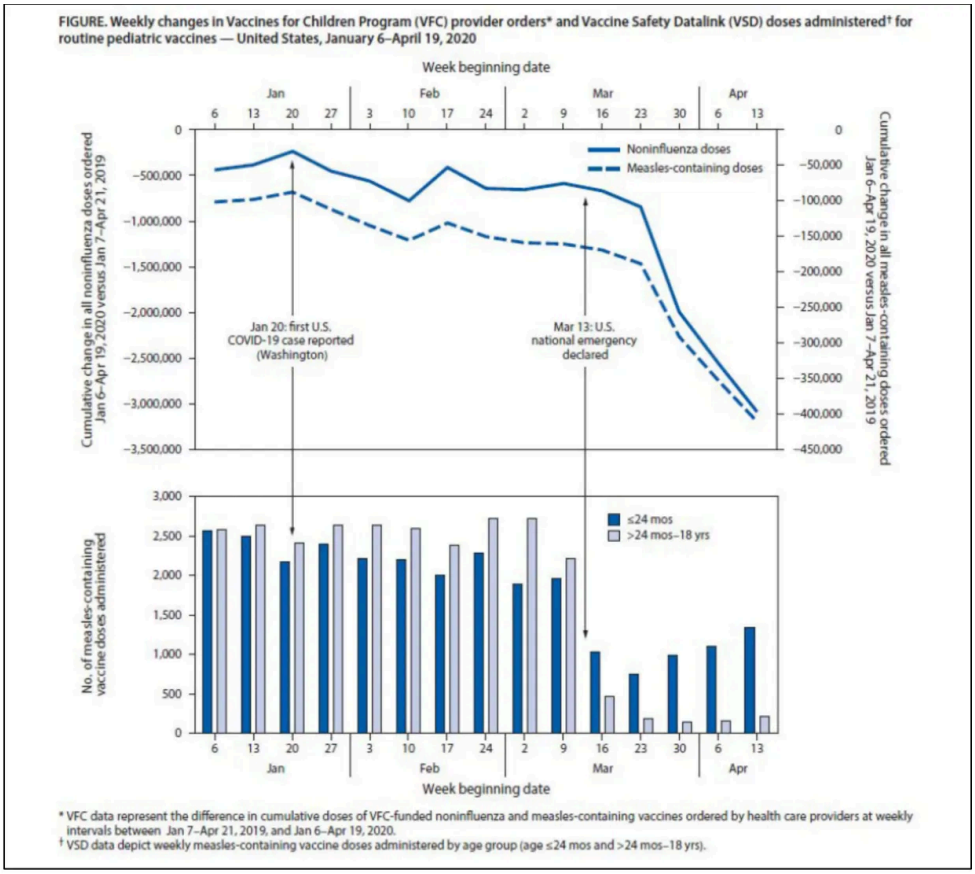
More curiously, this decline was primarily found in children at the same age as those who experienced SIDS:



Oddly enough, the greatest reduction in mortality occurred in ethnic minorities (who often experience the most severe vaccine injuries):



Odder still, an unprecedented decline in vaccination also occurred at this time within the United States:



Furthermore, this effect was not confined to the United States. For example, WHO also issued a press release on May 22, noting that "*Since March 2020, routine childhood immunization services have been disrupted on a global scale that may be unprecedented since the inception of expanded programs on immunization (EPI) in the 1970s.*"

It should also be noted the most common refutation of this data set suggesting declining vaccination rates reduced infant deaths was the CDC recording a slight increase in the cases of SIDS in 2020; however, given that such a significant drop in overall childhood mortality occurred in 2020, I am not sure if this slight increase is substantial (and whether or not it is the result of erroneous classifications in death that occurred during 2020 such as those resulting from less diagnostic resources being available).

Furthermore, due to the political climate of Florida, the state was uniquely suited to lead this trend (as far as I know, no other state has had a similar decline in vaccine uptake). In 2021, Florida's childhood vaccination rate decreased from 93.4% in 2020 to only 79.3% in 2021. At the same time this happened, all-cause infant mortality under one year of age in Florida also decreased by 8.93% (a reversal of 2020's trend where infant mortality had increased by 0.67%). As a 14 percent decrease in vaccination coverage was associated with a 9 percent decrease in infant mortality, this led Chudov to conclude **that roughly half of the infant deaths in Florida could potentially be attributed to vaccinations**.

VAERS

Lastly, to assess the evidence concerning this hypothesis, I consulted VAERS, where I discovered many compelling (and tragic) cases (some are listed here) whose descriptions identically match the patterns described in this article and often include the key objective diagnostic findings that have been associated with vaccine caused SIDS (the consistent autopsy findings, such as those reported here and here, are another critical piece of evidence for vaccines causing this disease will be discussed in the final part of this series).

It is also clear (you can quickly replicate my work in VAERS) that the DPT vaccine was:

•The vaccine most commonly linked to infant deaths (however, it is also one of the only ones given in that age range).

•Deaths in infants that occurred following vaccination in the first year of life were much more common in the 2-6 month DPT age range (which technically does not refute the conventional hypothesis that SIDS spontaneously occurs at this age for no apparent reason).

•That the timing of deaths was dramatically more common in the days immediately following vaccination (which skeptics could attribute to a tendency for parents to be more likely to erroneously associate a spontaneous death with vaccination if it occurred immediately following vaccination).

Historically, I could not determine if the trends reviewed earlier during the 1990s were supported or refuted by the VAERS data of the time, while during the year of the COVID-19 lockdowns, a decrease in reported infant deaths did occur that reversed the following year in 2021.

From further investigating this issue, I discovered Miller (the author referenced before) performed a much more comprehensive 2019 review of the existing VAERS data as a statistically significant association between the timing of death and vaccination would provide evidence for

causality. In his analysis of all infant deaths in VAERS restricted to those within 60 days of vaccination (87.2% of the total deaths), he found:

> •Of the 2605 reported infant deaths, 58% clustered within 3 days post-vaccination and 78.3 % within 7 days post-vaccination. The remaining deaths occurred between 8 days and 60 days post-vaccination at a rate approximately 69 times less than that found during the first week. This difference is statistically significant ($p < 0.00001$).
>
> •Of the 1048 SIDS cases within that sample, 51 % clustered within 3 days post-vaccination and 75.5 % within 7 days post-vaccination. The remaining SIDS cases occurred between 8 days and 60 days post-vaccination, at a rate approximately 57 times less than that found during the first week. This difference was also statistically significant ($p < 0.00001$). A male-to-female ratio was 61.6%–38.4% was present in these cases and 89.9 % of the cases occurred in infants under 6 months of age.

This once again confirms the association between vaccination and infant deaths.

Motivations

One of my major questions with the COVID-19 vaccine program was what motivation could have justified forcing such a dangerous and ineffective vaccination on the public, given that while this initially made money, it would cost everyone a lot long term (e.g., due to the economic damage that wave of disabilities created and the public becoming much less willing to purchase future pharmaceutical products).

Since initially publishing this article, a former executive from a major vaccine manufacturer reached out to me to share a few things that helped to answer this question. They told me that because of how quickly executives cycle in and out of top positions at these companies, their focus is often on what will get short-term stock increases that translate to bonuses for the executive.

Furthermore, they told me that the unit profitability with selling adult vaccinations is much greater than with infant ones (additionally, the adult ones are often sold on an annual recurring basis—yielding much more long-term profitability). Additionally, while much of their company's portfolio was in childhood vaccines, Pfizer's was not, and they believed that Pfizer threw their competitors under the bus to make money off the COVID-19 vaccine franchise.

Conclusion

When the mandatory vaccination laws for school children were pushed through at a state level in the years before COVID-19, a highly polarized political climate emerged, making it virtually impossible for members of the medical community who were opposed to those mandates to question them around their colleagues. One of the most common arguments cited by that pro-mandate crowd was that anyone who opposed vaccinating the children of America was, for all practical purposes, a "baby killer."

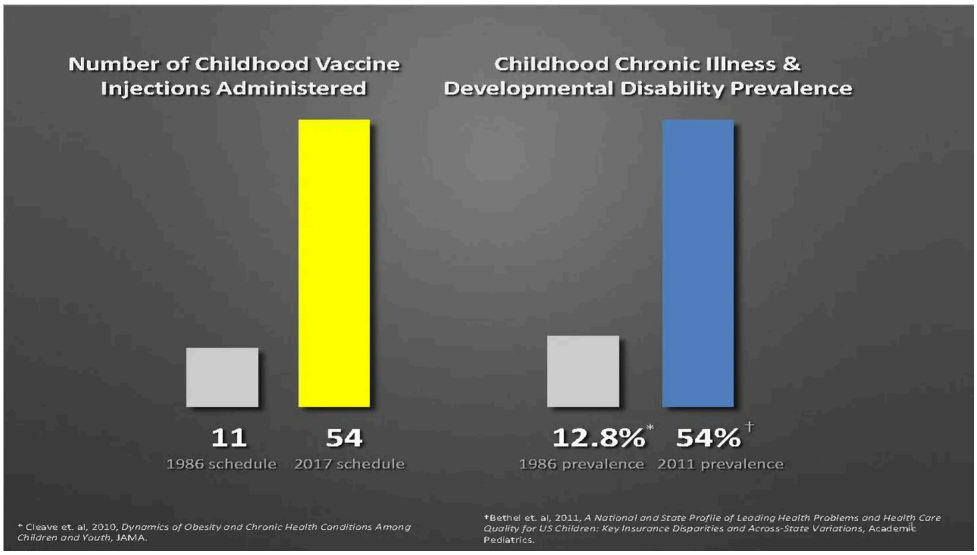
In truth, that argument is absurd because almost none of the childhood vaccinations are for a life-threatening illness (and in the cases where they are, the vaccine often fails to prevent the disease, and an unvaccinated child could rarely develop a fatal infection of the illness).

Data aside, this rhetorical framing left many of us in a situation where we felt we were being accused of being baby killers for being opposed to a practice that did, in fact, kill babies (and,

more importantly, cannot be justified based on the minuscule benefits that arise from vaccination). Fortunately, in just a few years, a titanic shift has occurred, and it appears that things have evolved enough in the culture that perspectives like the ones I shared here can finally be heard. From the bottom of my heart, I sincerely thank you for being a receptive audience to something that has been weighing on me for a very long time (and for taking the time to read all of this).

As we conclude this piece, we must remember that two critical themes mentioned throughout this Substack are also pivotal to the story of SIDS and everything we have seen with the COVID-19 vaccine injuries.

The first is that physiologic responses to a toxin always distribute on a bell curve. This means that the most severe reactions (e.g., deaths) lie at the edge of the bell curve and, in fact, only represent the tip of an iceberg, while under the water lie far more chronic injuries that have rapidly become so prevalent in the culture we no longer even think to question their presence. It is by no means an exaggeration to claim books could be written (many already have been) on the widespread chronic neurological and immunological disorders that are a direct result of childhood (and, to some extent, adult) vaccination programs.



Note: as it just so happens, infants born during the lockdowns (and hence less vaccines) were observed to have lower rates of a variety of chronic diseases.

The second is that a central mechanism of corruption within the medical establishment stems from the committee model we utilize, where "unbiased" panels of experts review evidence to produce guidelines everyone else is expected to follow. In almost all cases, these experts are arbitrarily appointed and hold significant financial interests that make them beholden to advancing the commercial needs of the pharmaceutical industry. As a result, they will consistently produce guidelines crafted to support their pharmaceutical sponsors' needs regardless of the evidence against those decisions.

The CDC's Advisory Committee on Immunization Practices (ACIP) is one such repeat offender, as without exception, whenever the FDA approves a vaccination, ACIP will assume solely by virtue of it being a vaccine it is 100% safe and effective, which is a major reason why our ever-expanding vaccine schedule has never been directly tested for safety (even though evidence like that cited in this article shows vaccine toxicity cumulative increases with the number of vaccines given).

Following FDA approval, ACIP will always economically support its manufacturer and vote to add it to the vaccination schedule. ACIP's recommendation, in turn, almost always results in the vaccine becoming mandated throughout America (hence creating a guaranteed market that incentivizes the overproduction of unnecessary vaccines), and many harmful vaccines that should not have entered the market have sailed in on the ACIP's good graces.

For example, immediately following the FDA's widely protested EUA's of Pfizer and Moderna's vaccine for young children in June (this brief review of one trial unambiguously shows the decision could not in any way be justified), "ACIP determined that the benefits of COVID-19 vaccination outweigh the known and potential risks" and without hesitation recommended vaccinating our children—despite children having no risk of dying from COVID-19 and a very real risk of a severe injury from the vaccine.

As I detailed in an earlier article, the reason why we have not been able to end COVID-19 is because Fauci appointed a committee of corrupt colleagues who remdesivir's manufacturer was paying off, and as a result, the official treatment guidelines for COVID-19 created by that committee have not permitted any of the proven but no longer patented treatments to enter the official COVID-19 treatment guidelines. Although guidelines have been ruled in federal court to not constitute law, the medical, industrial complex frequently uses them to bypass the legislative process and have their policies become the de facto law because so many other institutions that wield significant power in our lives inappropriately treat these guidelines as law.

This model has to change.

This is an extremely important story that has not yet received significant exposure, so I have spent a lot of time compiling this article and trying to vet it for accuracy. Fortunately, when my colleague recently shared it on Twitter, it received more than half a million views, which indicates many are at last open to hearing this story.

Now that the evidence has been presented to show that vaccines (especially multiple ones given in succession to premature infants) can cause fatal respiratory arrests, the next question is, “Why?”

The best model put forward is that the vaccination causes blood in the body to clump together, triggering microstrokes in the brain and symptoms of those strokes, which can easily be recognized by a trained observer (all of which are discussed in detail here). In the case of SIDS, these microstrokes appear to occur in the area of the brain which regulates breathing (discussed here), hence leading to the abnormal findings repeatedly observed in hospitals and with home monitoring.

I have been trying to expose this issue and its treatments for the last year because the COVID-19 vaccines can severely impair the vital circulation of blood and other fluids. I believe this accounts for many of the side effects attributed to them (discussed in detail here). To illustrate the difference between the COVID-19 vaccines and those that preceded them, I am now observing many clinical signs of a previous microstroke appearing in adults following COVID-19 vaccination I had previously only seen in vaccine-injured children.

I sincerely thank each of you for your support of this publication and taking the time to read this and to share it with the appropriate audiences so that this vital story can at last be heard.

In the next few weeks, I will publish a companion article which synopsizes many other long forgotten vaccine disasters that happened almost a century ago .

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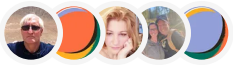

868 Likes · 178 Restacks

Discussion about this post

Comments Restacks

Write a comment...

A Midwestern Doctor Mar 21 · *edited Mar 21* Author

I received this comment from a reader over email:

I am not sure if this email will reach you, but I feel compelled to write to you. It's not about childhood vaccines, but rather vaccines for adults. Two years ago, my 97 year old father had his annual physical. At this physical, his doctor told him he needed to update his DTAP vaccine. My father, who still lived on his own, in his own apartment, agreed, although I didn't. My father had refused to get the Covid vaccine and received a clean bill of health, with an EKG.

I took my dad to get his DTAP and five days later I found him dead in his apartment. We didn't have an autopsy done as it wouldn't change things. Our health system is in a horrible state, in my opinion. I will not consent to vaccines.

Thank you for allowing me to comment. I love your articles and read them faithfully.

Susan

I have had a few times where I admitted adults to the hospital that have somewhat severe vaccine reactions and I have numerous adult patients who suffered long term complications from flu or pneumonia (pneumococcal) vaccines.

LIKE (81) REPLY SHARE

20 replies

Elizabeth Krispin Elizabeth's Substack Mar 21 Liked by A Midwestern Doctor

This makes me so angry.

Also, read this article:

Driving Under the Influence of mRNA: Collapsing and Crashing Your Car While COVID-19 Vaccinated - Global Research

https://www.globalresearch.ca/driving-under-influence-mrna-collapsing-crashing-your-car-while-covid-19-vaccinated/5852662

This would have been me, except for the fact that I realized I was passing out in my chair at home, requested a seven day 24 hour heart monitor and discovered that when my heart was stopping cold for 3 to 4 seconds at a time, my cardiologist quickly scheduled me for a pacemaker.

I was forced to get the VAX or would have lost my job. Sole income. I'm positively livid. Yet I am alive while others aren't.

LIKE (58) REPLY SHARE

24 replies

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