Canadian Covid Care Alliance
Alliance canadienne pour la prévention et prise-en-charge de la covid
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The Case Against Mandatory Vaccines

To Whom It May Concern,

If your organization is considering implementing a new policy requiring mandatory vaccination against SARS-CoV-2 for all eligible members, especially children, youth, and yonger adults of child-bearing age, it is imperative for the safety of your members and for the liability protection of your organization, that you take note of the information in this letter.

It is the opinion of the Canadian Covid Care Alliance[i] that mandated vaccination may result in unnecessary adverse reactions and injuries to your members that you are obligated to protect. Your organization should exercise great caution. In the absence of professional qualifications related to vaccinology, the disbursement of any medical mandates that result in injury could carry legal liability.

Our opinion is derived from the following statements from our leader of the Vaccine Task Force of the CCCA's Scientific and Medical Advisory Committee, Dr. Byram Bridle.

> "My name is Dr. Byram Bridle and I am Associate Professor of Viral Immunology in the Department of Pathobiology at the University of Guelph.
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> My research program focuses on the development of vaccines to prevent infectious diseases and treat cancers, as well as studying the body's immune response to viruses. I teach several courses at the undergraduate and graduate levels on the topics of immunology, virology, and cancer biology. The overall aim of my research efforts is to develop safe and effective new immunotherapies for people. Indeed, one of my previous cancer vaccine strategies progressed into four human clinical trials.
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> I am also involved in training Canada's next generation of multidisciplinary researchers, especially in vaccinology. I received funding from the Ontario Government (COVID-19 Rapid Research Fund, Ministry of Colleges and Universities) and the Government of Canada (Pandemic Response Challenge Program, National Research Council of Canada) to develop vaccines against COVID-19. I also hold numerous grants in support of my cancer research and basic viral immunology research programs, including but not limited to the Canadian Institutes for Health Research, Natural Sciences and Engineering Research Council of Canada, Canadian Cancer Society, and Cancer Research Society.
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> Since the COVID-19 pandemic was declared, I have been actively involved in providing fact-based, balanced, scientific answers to questions posed by the public to help them make fully informed decisions. This has included ~250 media engagements ranging from radio shows, published articles, and appearances on televised news programs, spanning the local to international scope. I was also an invited keynote speaker for two international conferences that focused on COVID-19 and I served as an invited member of several COVID-19-focused discussion panels.

Vaccinology is a highly specialized sub-discipline of immunology. I am called upon as an expert in this specialized field to comment on the critical importance of high-quality, well-validated, robustly safety-tested vaccines and I routinely promote their use. I consider vaccines that have been developed on a foundation of sound science, to be the most efficient type of medicine; they have cost-effectively saved millions of people from sickness and/or death.

However, it is my professional opinion that the risk-benefit profile of SARS-CoV-2 vaccines currently being used in Canada demands that mandates for these vaccines be rescinded to avoid placing any more people, especially Canada's youth, at unnecessary risk.

Here are two examples that illustrate my successful track record for accurately predicting adverse safety signals that were eventually heeded by federal agencies managing our Canada's COVID-19 vaccine program:

Example #1. When Health Canada authorized the use of AstraZeneca's vaccine, I, along with two colleagues, wrote an open letter requesting that this vaccine not be used, in part on the grounds that it was being investigated for a link to potentially fatal blood clots in many European countries. I was accused by so-called 'fact checkers' of providing misinformation. Less than two months later, Canada suspended the AstraZeneca vaccination program, because it was deemed to be too unsafe as a result of causing blood clots that cost the unnecessary loss of lives of Canadians.

Example #2. More recently, I was heavily criticized for raising concerns in a short radio interview about a potential link between the Pfizer BioNTech COVID-19 vaccine and heart inflammation in young people, especially males. This is now a well-recognized problem that has been officially listed as a potential side-effect of the mRNA COVID-19 vaccines. It was also the subject of a recent Public Health Ontario Enhanced Epidemiological Summary Report highlighting the increased risk of myocarditis and pericarditis to young males following COVID-19 mRNA vaccination.

Here is a deep-dive into my current concerns:

Canada's mRNA-based COVID-19 vaccines (*i.e.* Pfizer BioNTech's newly named "Comirnaty" and Moderna's newly named "Spikevax") were authorized with mandatory commitments for the monitoring of long-term safety and efficacy. This means additional information is needed on the safety, efficacy, and quality of the vaccines.

There is uncertainty regarding the long-term safety of these COVID-19 vaccines in all individuals, and especially in children, youth, and young adults of child-bearing age. Indeed, some key safety studies appear to have been missed in the rush to roll out the vaccines, and more is being learned about the vaccines every day.

For example, there was a previously widely held assumption that vaccination with the mRNA vaccines is safe, because it is a localized event in the body, with the vaccine first believed to remain contained to the shoulder muscle following injection, causing the body to produce localized quanties of an antigenic viral spike protein that would then trigger an immune response in the local lymph nodes. However, research and clinical data have surfaced over the past few months that strongly suggest that the mRNA vaccines do not remain at the injection site. Rather, it is now suspected that once injected, vaccine contents may, in fact, be traveling extensively throughout the body, to the brain and other sensitive tissues, such as bone marrow, spleen, liver, adrenal glands, ovaries *etc.* Whether these body sites are involved in producing the spike protein is not known, as this was never studied. Nonetheless, new data have been published that, following vaccination, the spike protein produced by the body, can enter the circulatory system. Presumably, this means the spike protein can likewise travel extensively throughout the body.

Unanswered questions include:

- which organs in the body are producing the spike protein;
- what factors result in the spike protein entering the circulation;
- how long does the spike protein circulate; and
- in which body fluids (*e.g.*, semen, saliva, breast milk, urine) is the spike protein present?

This information is incredibly important, because recent data have come to light that the spike protein is “biologically active”. This means that the spike protein is not just an antigen that is recognized by the immune system as a target. It means that the spike protein, itself, can interact with receptors on cells like platelets throughout the body, called ACE2 receptors, potentially causing undesirable effects such as:

- damage to the heart and cardiovascular system;
- blood clots;
- bleeding; and
- neurological effects.

Although some might argue that the risk of the spike protein causing this type of damage is only a theoretical risk, there is absolutely no room for error when govermnents, public health agencies, and organizations such as yours, consider mandating these vaccines for a population of predominantly healthy people, including children, adolescents, and young adults of child-bearing age,.

The scientific uncertainties demand that the administration of COVID-19 vaccines, especially to children, adolescents, and young adults of child-bearing age, not even be considered until proper scientific studies that focus on the safety and pharmacokinetics and biodistribution of the vaccines and the vaccine-encoded spike protein can be conducted.

Avoiding mandating these vaccines can be done safely because:

- The risk of severe and potentially lethal COVID-19 in children, adolescents, and young adults of child-bearing age is so low that we need to be very certain that risks associated with vaccination are not higher.
- Asymptomatic members of this population are not a substantial risk for passing COVID-19 to others; and
- There are effective early-treatment strategies for the very few who may be at risk of developing severe COVID-19. These are supported by a mountain of scientific evidence and include ivermectin, fluvoxamine, colchicine, and budesonide, among others.

The risk of Harm must not outweigh the extent of Benefit.

It is not appropriate to mandate a vaccine in a population group unless the benefit of vaccination exceeds the risk of vaccination in that population group. With the risk of severe COVID-19 illness in children, adolescents, and adults of child-bearing age already so low, the benefit of vaccinating these population groups with a vaccine for which neither the long-term safety nor efficacy is known, cannot be concluded to exceed the risk.

Indeed, recent evidence from Israel suggests that the effectiveness of these vaccines against the delta variant of SARS-CoV-2 may be less than the 50% required to maintain their authorization. It has also come to light that the duration of immunity conferred by these vaccines is a dismal 4.5 to 6 months, hence the new push for third doses, with plans for a fourth dose within the span of one year having already been initiated.

This is clear evidence that the vaccines are of low quality and are becoming outdated in the context of the new variants. Also, the vaccines, at best, only dampen the severity of illness and those who are double-vaccinated have been shown to be capable of shedding as much of the delta variant of SARS-CoV-2 following infection as the unvaccinated.

What about those who have recovered from COVID-19 and have acquired natural immunity?

Of major concern is information arising from three recent scientific studies all showing that vaccine-induced adverse events (*i.e.* unwanted side-effects) are more severe in people who are forced to be vaccinated after having recovered from COVID-19 and acquiring naturally induced immunity to the SARS-CoV-2 virus. Indeed, the science clearly demonstrates that naturally acquired immunity against SARS-CoV-2 is more broadly protective, more durable, and more appropriate with respect to the type of antibody response at the site of SARS-CoV-2 infection in the lung and airways than vaccine-induced immunity.

Knowing that naturally acquired protection is routinely developed in COVID-recovered patients, should automatically set aside any mandated need for vaccination in this population.

Recent published studies have indicated that about a third of the population in the US has already acquired natural immunity, and serological studies performed in Canada indicate much higher levels of natural immunity in our country. As such, mandating COVID-19 vaccines with no knowledge of the immunity status of an individual would be completely inappropriate and could be dangerous. Therefore, mandated vaccination of youth should not be instituted.

I would also strongly recommend that organizations consider offering testing for evidence of immunity against SARS-CoV-2. This would equip the organization, their leaders, members, and their family members, with solid evidence to guide personal choices about COVID-19 vaccines.

Remember, the goal is not to vaccinate as many people per se. Instead, it is to achieve protective immunity against SARS-CoV-2 in a maximum number of people. Vaccines represent a tool to potentially help achieve this for those without natural immunity.

It is also important to note that some people are non-responders to vaccines, meaning that they fail to generate a protective immune response after receiving their injections. Thus, having evidence of immunity, or lack thereof, among both the vaccinated and unvaccinated would allow both groups to make fully informed decisions about how to best manage their health.

What about the known adverse effects?
Heart inflammation (myocarditis and pericarditis) is now well known to occur in some people who receive COVID-19 vaccines. The risk is greater in younger people, especially males. The risk is also greater after the second dose of the vaccine, indicating that even some of those who do not experience this clinical condition may suffer from sub-clinical damage (ie damage that is too subtle to be readily detected by the individual but is still equally worrisome).

In the case of sub-clinical heart damage, this could potentially reveal itself as a decrease in peak performance in sports organizations' members who push their bodies to the limit. In a recent study from California, using the United States Vaccine Adverse Event Reporting System (VAERS) data, it was noted that in boys 12 to 15 years of age, **the risk of cardiac complications due to vaccination is 6X greater than the risk of hospitalization from COVID-19**.

Unfortunately,the risk of cardiac complications in males 12 to 15 years of age who are vaccinated on top of already having had a recent SARS-CoV-2 infection has not been characterized.

When investigating cases of post-vaccination myocarditis in the United States using the U.S. VAERS data, my colleagues and I have noticed that, in those 21 years of age and younger who developed myocarditis after only the first dose, several had positive antibodies for SARS-CoV-2. This means that the risk of myocarditis can be seen as significantly elevated after only one dose in youth previously infected with SARS-CoV-2.

Given the potential for risk and the zero potential for benefit, an organization's **members who are previously infected with SARS-CoV-2 should not be vaccinated**.

It is also noteworthy that in the US, in view of these issues, the newly approved Pfizer COVID-19 RNA vaccine Comirnaty is not to be used in children under 16 years of age unless they are immune-deficient. However, Health Canada has very recently approved both the Pfizer and Moderna RNA vaccines for those over 12 years of age, despite these well recognized problems of vaccine safety.

With Phase 3 clinical trials still ongoing, the COVID-19 vaccines cannot ethically be administered to anyone in the absence of fully informed consent. Mandating vaccines that have known, emerging, and still-to-be-determined long-term safety issues would represent coercion and contravene the foundational principles of bioethics.

Are there potential legal consequences of vaccination mandates imposed by organizations, especially those involved in youth sports?

To equip you with all the information you need to make a fully informed decision, it is incumbent on me to share that I have consulted with a team of lawyers who have advised that individuals who mandate COVID-19 vaccines are at risk of having their members and other stakeholders file complaints to police claiming that either or both of the following two crimes have been committed against them. It would then be incumbent on the police to investigate these crimes.

Under **Canada's Criminal Code (R.S.C. 1985, c.C-46, last amended on August 27, 2021)**, the following offences that lawyers may be willing to prosecute in court are as follows:

1. <u>Extortion</u>

- **Section 346 (1) states: '**Every one commits extortion who, without reasonable justification or excuse and with intent to obtain anything, by **threats**, accusations, menaces or violence **induces or attempts to induce any person**, whether or not he is the person threatened, accused or menaced or to whom violence is shown, **to do anything or cause anything to be done**.'

In our opinion, the definition of extortion would be met if an organization demands proof of vaccination from its members and threatens the members with banishment from their organization if they do not provide said proof.

2. <u>Intimidation</u>:

Section 423 (1) states: Everyone is guilty of an indictable offence and liable to imprisonment for a term of not more than five years or is guilty of an offence punishable on summary conviction who, **wrongfully and without lawful authority, for the purpose of compelling another person to abstain from doing anything that he or she has a lawful right to do, or to do anything that he or she has a lawful right to abstain from doing**,

(a) uses violence or threats of violence to that person or their intimate partner or children, or injures the person's property;

(b) **intimidates or attempts to intimidate that person** or a relative of that person **by threats** that, in Canada or elsewhere, violence **or other injury will be done to or punishment inflicted on him or her** or a relative of his or hers, or that the property of any of them will be damaged;

In our opinion, the definition of intimidation under the Criminal Code would be met if an organization's members are being threatened with a mandate to receive a COVID-19 vaccine where:

- there are known, emerging, and still-to-be-determined long-term safety issues;
- Phase 3 clinical trials are still ongoing to assess safety; and
- the COVID-19 vaccines are known to cause injuries and even death in some people.

Thus ultimately concluding that children, youth, and young adults of child-bearing age are being subject to intimidation when the risks of serious side-effects from mandated vaccines exceeds the risks of COVID-19 illness, especially for those with naturally acquired immunity.

In conclusion, for all of the reasons stated above, I re-emphasize that organizations should not consider implementing a mandatory vaccination policy for their members.

Respectfully and in the shared interest of the health and happiness of our youth,

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[i] About the Canadian Covid Care Alliance

The Canadian Covid Care Alliance (CCCA) is a group of independent research scientists, doctors, registered nurses and nurse practitioners, and other health care practitioners, as well as lawyers, ethicists and other professionals. The Alliance is dedicated to providing balanced, scientific evidence-based information related to the prevention, tracking and treatment of COVID-19 so that hospitalizations can be reduced, lives saved, and our country safely restored as quickly as possible.

Our representative credentials and expertise within our Alliance include, but are not limited to, the following:

MD, Family Practitioner	PhD, Immunogenetics	PhD, Epidemiology	Chiropractic
MD, Coroner	PhD, Immunology	EdD, Psychology	Integrative Medicine
RN, Primary Care	PhD, Molecular Virology	DPhil, Bioanalytics	Physiotherapy
PhD, Biomedical Research	PhD, Viral Immunology	PhD, Methodology	Osteopathy
Doctor of Dental Surgery	PhD, Pharmacology	PhD, Ethics	Naturopathy
Doctor of Veterinary Medicine	PhD, Biochemistry	LL.B., B.B.A, Personal Injury	Occupational Therapy

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