

The Covid Lies

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Summary

I contend that all the main narrative points about the coronavirus named SARS-CoV-2 are lies. Furthermore, all the “measures” imposed on the population are also lies. In what follows, I support these claims scientifically, mostly by reference to peer-reviewed journal articles. In 2019, World Health Organization (WHO) scientists reviewed the evidence for the utility of all non-pharmaceutical interventions, concluding that they are all without effect.

Given the foregoing, it is no longer possible to view the last two years as well-intentioned errors. Instead, the objectives of the perpetrators are most likely to be totalitarian control over the population by means of mandatory digital IDs and cashless central bank digital currencies (CBDCs).

There is no medical or public health emergency. We can and should take back our freedoms with immediate effect. Testing healthy people stops. If you’re sick, please stay home. Masks belong in the trash. The Covid-19 gene-based injections are not recommended and must not be coerced or mandated. Crucially, the vaccine passports database must be destroyed. Economic rectitude is recommended.

Serious crimes have obviously been committed. It is not the purpose of this document to accuse anyone or to assemble the evidence against them at this time. However, when this is all resolved, We The People are strongly recommended to pay much more attention to Washington than previously.

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THE NARRATIVE POINT

1. SARS-CoV-2 has such a high lethality that every measure must be taken to save lives.

Note: Covid-19 is the disease resulting from infection with the virus, SARS-CoV-2. They are often used interchangeably. Sometimes it doesn't much matter, but the confusion was sowed deliberately.

IMPORTANCE

Essential to claim high lethality in order that unprecedented responses may seem justified. To “pep up” the claim, recall “**falling man**” in Wuhan? The person was allegedly sick but walking about, before falling dead on his face. That was never real. It was theatre.

THE REALITY

Early estimates of lethality were very high with, in some reports, an “infection fatality rate” (IFR) of 3%. Seasonal influenza is generally considered to have a typical IFR of 0.1%. That means some seasons, IFR for flu may be 0.3% and other times, 0.05% or lower.

In practise, and this was usual, estimates of IFR for Covid-19 were revised downwards repeatedly and now are generally recognised as in the range of 0.1–0.3%. **It cannot now be argued that it is significantly different from some seasonal influenza epidemics.** Why, then, have we all but destroyed the modern world over it?

CONCLUSION AND VERDICT

FALSE

- The perpetrators knew that lethality estimates of new respiratory viral illnesses ALWAYS start high and reduce. This is because, early on, we do not have any estimate of the number of people infected but not seriously ill and the number infected with no symptoms at all.
- They created the impression of extreme danger, which was never true. **This is such a crucial point, for once one sees it for what it is, the rest of the narrative is superfluous.**
- Dr. John Ioannidis is one of the world's most-published epidemiologists and he has been scathing about the inappropriate responses to a novel virus of not particularly unusual lethality. Like most respiratory viruses, SARS-CoV-2 represents **no serious health threat** to those under 60 years of age, certainly not children, and is a serious threat only to those nearing the end of their lives by virtue of age and multiple comorbidities.¹
- Dr. Ioannidis's **current estimate** of global IFR is around 0.15%. For reference, a typical seasonal influenza outbreak has a typical IFR of around 0.1%, but can be markedly worse in bad winters.²

THE NARRATIVE POINT

2. Because this is a new virus, there will be **no prior immunity** in the population.

IMPORTANCE

Seems reasonable, doesn't it? This remark, made repeatedly early on, aimed to squash any notion that there was a degree of "prior immunity" in the population. Prior immunity and natural immunity are only now, two years in, not considered "misinformation".

THE REALITY

Within a few months, multiple publications showed that a large minority (ranging from 30%–50%, some later said even more) of the population had T-cells in their blood which recognised various pieces of the viral protein (synthesised, as no one seemed to have any real virus isolates to use).

While some people argued that recognition by T-cells didn't mean functional immunity, really it does.

We were prevented from learning that we already knew of six coronaviruses, four of which cause "common colds," which in elderly and infirm people can cause death.

CONCLUSION AND VERDICT

FALSE

- This was a straight lie. It's pretty much never true that there's no prior immunity in a population. This is because viruses are each derived from earlier viruses and some of the population had already defeated its antecedents, giving them either immunity or a big head start in defeating the new virus. Either way, a sizeable proportion of the population never had cause to worry.
- [This article](#) includes all the important peer-reviewed articles to mid-2020, with many showing at least 30%–50% having prior immunity (it depends upon the measure used to assess it).³

THE NARRATIVE POINT

3. This virus does not discriminate. **No one is safe until everyone is safe.**

IMPORTANCE

Intention was to minimise the numbers who might reason they're not "at risk" people.

THE REALITY

This claim was always absurd. The lethality of this virus, as is common with respiratory viruses, is 1000X less in young, healthy people than in elderly people with multiple comorbidities.

CONCLUSION AND VERDICT

FALSE

- In short, almost no one who wasn't close to the end of their lives was at risk of severe outcomes and death. In middle-aged individuals, obesity is a risk factor, as it is for a handful of other causes of death.
- [This intriguing review](#) details how the initial modelling induced fear and provided the excuse for heavy-handed measures, especially "lockdowns".⁴ It was, however, just that: an excuse. All experienced public health experts knew that lockdowns were absurd, ineffective, and hugely destructive. There's no way to sugar-coat this. It was wrong before it was ordered, and it's necessary to examine why those who knew did not protest. It's almost as if they were complicit.

THE NARRATIVE POINT

4. People can **carry this virus with no signs and infect others:** asymptomatic transmission.

IMPORTANCE

This is the **central conceptual deceit**. If true, then anyone might infect and kill you. **Falsely claimed asymptomatic transmission underscores *almost every intrusion*:** masking, mass testing, lockdowns, border restrictions, school closures, even vaccine passports.

THE REALITY

The best evidence comes from a **meta-analysis** of a larger number of good studies, examining how often a person testing positive went on to infect a family member (they compared as potential sources of infection people who had symptoms with those who did not have symptoms). **ONLY** those WITH symptoms were able to infect a family member at any rate that mattered.⁵

CONCLUSION AND VERDICT

FALSE

- Asymptomatic transmission is epidemiologically irrelevant. It's not necessary to argue it never happens; it's enough to show that if it occurs at all, it is so rare as not to be worth measuring.
- In this [video](#), we also have Fauci and a WHO doctor telling us exactly this.⁶ Also, I show why it is like it is. It's very clear.

THE NARRATIVE POINT

5. The PCR test **selectively identifies people with clinical infections.**

IMPORTANCE

This is the **central operational deceit**. If true, we could detect risky people and isolate them. We could diagnose accurately and also count the number of deaths.

Polymerase chain reaction (PCR), at its best, can confirm the presence of genetic information in a clean sample and is useful in forensics for that reason. It involves cycle after cycle of amplification, copying the starting material at the beginning of each cycle. The inventor of the PCR test, Kary Mullis, won a Nobel Prize for it and often criticised Fauci for misusing that test to diagnose AIDS patients, which Mullis insisted was inappropriate.

THE REALITY

In a “dirty” clinical sample, there is more than a possible piece of, or a whole, virus which might replicate. There are bacteria, fungi, other viruses, human cells, mucus, and more. It’s not possible unequivocally to know, if a test is judged “positive” after many cycles, what it was that was amplified to give the signal at the end that we call “positive”.

In mass testing mode, commonly used, no one ever runs so-called “positive controls” through the chain of custody. That’s diagnostic testing 101. It’s a deception.

Every test has an “operational false positive rate” (oFPR), where some unknown percent of samples turns positive, even if there is no virus present. A good oFPR would be less than 1%, but is it 0.8% or 0.1%? If you test 100,000 samples daily, and the oFPR is 0.8%, you will get 800 positive tests or “cases,” even if there is no virus in the entire community. Often, the “positivity,” the fraction of tests that are positive, is in that range, sub-1% or low-single-digit percent. I believe much or all of that can be caused by false positives. Note, criminals can manipulate the content of the test kits because there are very few providers in a territory, often just one. The conditions for running the test are also subject to variation by the authorities, like the CDC.

CONCLUSION AND VERDICT

FALSE

- You can be genuinely positive, yet not ill. There is no lower limit of true detection below which you’d be declared to have some copies of the virus, but declared clinically well. It’s an absurd idea.
- You can have no virus yet test positive (with or without symptoms). All of these are swept together and called “confirmed Covid-19 cases”. If you die in the next 28 days, you’re said to be a “Covid death,” no matter what the cause.
- Those using the test kits provided commercially are what are called “black box”. They are unable to say what is in the kit, because this is proprietary. The original “methods paper” was published in 48 hours, making a mockery of claimed peer review, by a

Berlin lab headed by Professor Christian Drosten, scientific advisor to Angela Merkel of Germany. The paper was comprehensively **rebutted** by an international team.⁷

- The WHO released a series of **guidance notes** on PCR,⁸ and it was clear that their technical staff did not approve of mass testing the population, because it's possible to return wholly false positives. Indeed, at times of low genuine prevalence, that's all they can be.
- I often wonder if this 2007 real-life example of a PCR-based testing system which returned **100% false positives**, yet convinced a major hospital that they had a huge disease outbreak for weeks, might have been the inspiration for the untrustworthy methods used in the Covid-19 deception?⁹
- Drosten also led the TV publicity around the idea of asymptomatic transmission. One lucky scientist is at the centre of the two most important deceptions in the entire Covid-19 event!
- Professor Norman Fenton here presents a **multi-part lecture** with two main elements.¹⁰ First, he describes how mass testing of people with no symptoms unavoidably drives up the proportion of positive PCR test results that are false. The second part deals with the possibility that data fraud entirely accounts for the apparent efficacy of the vaccines, while attempting to hide vaccine deaths, by classifying them as unvaccinated for 14 days after injection.

THE NARRATIVE POINT

6. Masks are effective in **preventing the spread of this virus.**

IMPORTANCE

This is mostly used to maintain the illusion of danger. You see others' masks and feel afraid. Complying is also a measure of whether you do what you're told, even if the measure is useless.

THE REALITY

We have known for decades that surgical masks worn in medical theatres do not stop respiratory virus transmission. Masks were tested across a series of operations by doctors at the Royal College of Surgeons (UK). No difference in post-operative infection rate was seen by mask use.

Cloth masks definitely don't stop respiratory virus transmission as shown by several large, randomised trials. If anything, they increase risk of lung infections. The authorities have mostly conceded on cloth masks.

Some people speak of "source control," catching droplets. Problem is, there is no evidence that transmission takes place via droplets. Equally, there is no evidence it occurs via fine aerosols. No one finds it on masks, or on air filters in hospital wards of Covid patients, either. Where is the virus?

CONCLUSION AND VERDICT

FALSE

- It's not necessary to use up time on this topic. It was known long before Covid-19 that face masks don't do anything.
- Many don't know that blue medical masks aren't filters. Your inspired and expired air moves in and out between the mask and your face. They are splashguards, that's all.
- This is a good [review](#) of the findings with masks in respiratory viruses by a recognised expert in the field. No effect.¹¹
- Neither masks nor lockdowns prevented the spread of the virus. This review summarizes [400 papers](#).¹²

THE NARRATIVE POINT

7. Lockdowns **slow down the spread** and reduce the number of cases and deaths.

IMPORTANCE

The most impactful yet wasteful intervention, accomplishing nothing useful.

Useful to the perpetrators, however, wishing to damage the economy and reduce interpersonal contacts. This measure was surprisingly tolerated in many wealthy countries, because “furlough” schemes were put in place, compensating many people for not working, or requiring them to work from home.

THE REALITY

The measure, though among the most repressive acts ever imposed on citizens in a democracy, was intuitively reasonable to many. This is an example of how far off-course uninformed intuition can be.

The core idea was simple. Respiratory viruses are transmitted from person to person. Reducing the average number of contacts surely reduces transmission? Actually, it doesn't, because **the transmission concept is wrong**. Transmission is from a SYMPTOMATIC person to a susceptible person. Those with symptoms are UNWELL. They remain at home in most cases with no action from the government. Transmission occurred mostly in institutions where sick people and susceptible people were forced into contact: hospitals, care homes, and domestic settings.

CONCLUSION AND VERDICT

FALSE

- A general lockdown had no detectable impact on epidemic spreading, cases, hospitalisations, or deaths.
- This is now widely accepted, after a [meta-analysis](#) by Johns Hopkins University (interestingly, as the JHU repeatedly features as an actor in a documentary about pandemic-related fraud by German journalist Paul Schreyer).¹³
- This is because those involved in the vast bulk of human-to-human contacts are fit and well and such contacts didn't result in transmission. Essentially, if you're fooled by the “asymptomatic transmission” lie, then lockdown might make sense. However, since it is epidemiologically irrelevant, lockdowns can never work, and of course, all the voluminous literature confirms this.
- This concept is unequivocally known to multiple public health scientists and doctors. This is why “lockdown” had never been tried before.
- Importantly, WHO scientists drafted a [detailed review](#) of all the non-pharmaceutical interventions (NPIs) in 2019 and distributed copies of the report to all member states.¹⁴
- This means that ALL member states already knew, late in 2019, that masks, lockdowns, border restrictions, and business or school closures were futile. Only “stay home if you're sick” works at all, and people don't need to be told this, for they are too unwell to go out.

THE NARRATIVE POINT

8. There are unfortunately **no treatments for Covid** beyond support in hospital.

IMPORTANCE

Reinforced the idea that it was vital to avoid catching the virus.

Legally, it was essential for the perpetrators bringing forward novel vaccines that there be no viable treatments. Had there been even one, the regulatory route of Emergency Use Authorisation would not have been available.

THE REALITY

In my opinion, while all these measures were destructive and cruel, active deprivation of access to experimentally applied but otherwise known safe and effective early treatments led directly to millions of avoidable deaths worldwide. **In my mind, this is a policy of mass murder.**

Contrasting with the official narrative, the therapeutic value of early treatment was already understood and demonstrated empirically during spring 2020. Since then, a sizeable handful of well-understood, off-patent, low-cost and safe oral treatments have been characterised.

CONCLUSION AND VERDICT

FALSE

- The official position was that the disease Covid-19 could not be treated and the patient only “supported,” often by mechanical ventilation. Ventilation is wholly inappropriate because Covid-19 is rarely an obstructive airway disease, yet has a high associated morbidity and mortality. An oxygen mask is greatly preferred.
- In my view, due to the very large amount of empirical treatment and good communication, **Covid-19 is the most treatable respiratory viral illness ever.** We knew in the first three months of 2020 that hydroxychloroquine, zinc, and azithromycin were **empirically useful**, provided treatment was started early and tackled rationally.¹⁵
- It's very important to note that it has been known for a decade and more that elevating **intracellular zinc** acts to suppress viral replication.¹⁶
- There is no question that senior advisors to a range of governments knew that so-called “zinc ionophores,” compounds which open channels to allow certain dissolved minerals to cross cell membranes, were useful in severe acute respiratory syndrome (SARS) in 2003 and should be expected also to be therapeutically useful in SARS-CoV-2 infection.
- This is a starting point for all of the **clinical trials** in Covid-19,¹⁷ including especially **ivermectin** and hydroxychloroquine (which are zinc ionophores).¹⁸
- It should be noted that using known safe agents for experimental purposes as a priority has always been an established ethical medical practice and is known as “off-label prescribing”.

THE NARRATIVE POINT

9. It's not certain **if you can get the virus more than once.**

IMPORTANCE

The idea of natural immunity was flatly denied and the absurd idea that you might get the same virus twice was established. This ramped up the fear, which might otherwise have passed swiftly.

THE REALITY

Those with even a basic grasp of mammalian immunology knew that senior advisors to government, speaking in uncertain terms on this question, were lying. Certainly, in the author's case, it was a pivotal point. I shared a foundational education in UK universities at the same time as the UK government's Chief Scientific Advisor. This shared education meant we'd have had the same set texts. I reasoned that he knew what I knew and vice versa. I was as sure as it is possible to be that it wouldn't be possible to get clinically unwell twice in response to the same virus, or close-in variants of it. I was right. He was lying.

CONCLUSION AND VERDICT

FALSE

- There have been **scores** of peer-reviewed journal articles on this topic.¹⁹ Very few clinically important reinfections have ever been confirmed.
- Beating off a respiratory virus infection leaves almost everyone with acquired immunity, which is complete, powerful, and durable.
- You wouldn't know it for the misdirection around antibodies in blood, but such antibodies are not considered pivotally important in host immunity. Secreted antibodies in airway surface liquid of the IgA isotype certainly are, but most important are **memory T-cells**.²⁰
- Those infected with SARS in 2003 still had clear evidence of robust, T-cell mediated immunity **17 years later**.²¹

THE NARRATIVE POINT

10. Variants of the virus appear and are of great concern.

IMPORTANCE

I believe the purpose of this fiction was to extend the apparent duration of the pandemic—and the fear—for as long as the perpetrators wished it. While there is controversy on this point, with some physicians believing reinfection by variants to be a serious problem, I think untrustworthy testing and other viruses entirely is the parsimonious explanation.

THE REALITY

I come at it as an immunologist. From that vantage point, there is very strong precedent indicating that recovery after infection affords immunity extending beyond the sequence of the variant that infected the patient to all variants of SARS-CoV-2.

The number of *confirmed* reinfections is so small that they are not an issue, epidemiologically speaking.

We have good evidence from those infected by SARS in 2003: they not only have strong T-cell immunity to SARS, but cross-immunity to SARS-CoV-2. This is very important because SARS-CoV-2 is arguably a variant of SARS, there being around a 20% difference at the sequence level.

Consider this: if our immune systems are able to recognise SARS-CoV-2 as foreign and mount an immune response to it, despite never having seen it before, because of prior immunity conferred by infection years ago by a virus which is 20% different, it's logical that variants of SARS-CoV-2, like delta and omicron, will not evade our immunity.

No variant of SARS-CoV-2 differs from the original Wuhan sequence by more than 3%, and probably less.

CONCLUSION AND VERDICT

FALSE

- Normal rules of **immunology** apply here.²² Despite the publicity to the contrary, SARS-CoV-2 mutates relatively slowly and no variant is even close to evading immunity acquired by natural infection.
- This is because the human immune system recognises 20–30 different structural motifs in the virus, yet requires only a handful to recall an effective **immune memory**.²³
- The variants story fails to note “Muller’s Ratchet,” the phenomenon in which variants of a virus, formed in an infected person during viral replication (in which “typographical errors” are made and not corrected) trend to greater transmissibility but lesser lethality. If this was not the case, at some point in human evolution, we would have expected a respiratory viral pandemic to have killed off a substantial proportion of humanity. There is no historical record for such an event.
- I do not rule out the possibility that the so-called vaccines are so badly designed that they prevent the establishment of immune memory. If that is true, then the vaccines are worse than failures, and it might be possible to be repeatedly infected. This would be a form of acquired immune deficiency.

THE NARRATIVE POINT

11. The only way to end the pandemic is **universal vaccination**.

IMPORTANCE

This, I believe, was always the objective of the largely faked pandemic. It's NEVER been the way prior pandemics have ended, and there was nothing about this one that should have led us to adopt the extreme risks that were taken and which have resulted in hundreds of thousands, probably millions, of wholly avoidable deaths.

THE REALITY

The interventions imposed on the population didn't prevent spread of the virus. Only individual isolation for an open-ended period could do that, and that's clearly impossible (hospital patients and residents of care homes have to be cared for at very least and additionally, the nation has to be supplied with food and medicines).

All the interventions were useless and hugely burdensome.

Yet we have reached the end of the pandemic, more or less. We would have done so faster and with less suffering and death had we adopted measures along the lines proposed in the Great Barrington Declaration and used pharmaceutical treatments as they were discovered, plus general improvements to public health, such as encouraging vitamin supplements.

CONCLUSION AND VERDICT

FALSE

- It was NEVER appropriate to attempt to “end the pandemic” with a novel technology vaccine. In a public health mass intervention, safety is the top priority, more so even than effectiveness, because so many people will receive it.
- It's simply not possible to obtain data demonstrating adequate longitudinal safety in the time period any pandemic can last.
- **Those who pushed this line of argument and enabled the gene-based agents to be injected needlessly into billions of innocent people are guilty of crimes against humanity.**
- It quickly became apparent that **natural immunity** was stronger than any protection from vaccination,²⁴ and most people were **not at risk** of severe outcomes if infected.²⁵
- Even children who were **immunocompromised** are not at elevated risk from Covid-19, so advice that such children should be vaccinated is lethally flawed.²⁶
- These agents are clearly **underperforming** against expectations.²⁷

THE NARRATIVE POINT

12. The new vaccines are **safe and effective**.

IMPORTANCE

I feel particularly strongly about this claim. Both components are lies. I outline the inevitability of the toxicity of all four gene-based agents below.

Separately, the clinical trials were wholly inadequate. They were conducted in people not most in need of protection from safe and effective vaccines. They were far too short in duration. The endpoints only captured “infection” as measured by an inadequate PCR test and should have been augmented by Sanger sequencing to confirm real infection. Trials were underpowered to detect important endpoints like hospitalisation and death.

There’s evidence of fraud in at least one of the pivotal clinical trials. I think there is also clear evidence of manufacturing fraud and regulatory collusion. They should never have been granted emergency use authorisations (EUAs).

THE REALITY

The design of the agents called vaccines is very bothersome. Gene-based agents are new in a public health application. Had I been in a regulatory role, I would have informed all the leading R&D companies that I would not approve these without extensive longitudinal studies, meaning they could not receive EUA before early 2022 at the earliest. I would have outright denied their use in children, in pregnancy, and in the infected-recovered. Point blank. I’d need years of safe use before contemplating an alteration of this stance.

The basic rules of this new activity, gene-based component vaccines, are: (1) to select part of the virus that has no inherent biological action—that rules out spike protein, which we inferred would be very **toxic**, before they’d even started clinical trials;²⁸ (2) select the genetically most stable parts of the virus, so we could ignore the gross misrepresentations of variants so slight in difference from the original that we were being toyed with via propaganda—again, this rules out spike protein; (3) choose parts of the virus which are most different from any human proteins. Once more, spike protein is immediately deselected, otherwise unnecessary risks of autoimmunity are carried forward.

That all four leading actors chose spike protein, against any reasonable selection criteria, leads me to suspect both collusion and malign intent.

Finally, let nature guide us. Against which components of the virus does natural immunity aim? We find **90%** of the immune repertoire targets NON-spike protein responses.²⁹ I rest my case.

CONCLUSION AND VERDICT

FALSE

- These agents were always going to be toxic. The only question was, to what degree? Having selected spike protein to be expressed, a protein which causes blood clotting to be initiated, a risk of thromboembolic adverse events was burned into the design.

- Nothing at all limits the amount of spike protein to be made in response to a given dose. Some individuals make a little and only briefly. The other end of a normal range results in synthesis of copious amounts of spike protein for a prolonged period. The locations in which this pathological event occurred, as well as where on the spectrum, in my view played a pivotal role in whether the victim experienced adverse events, including death.
- There are many other pathologies flowing from the design of these agents, including, for the mRNA “vaccines,” that lipid nanoparticle (LNP) formulations leave the injection site and home to the liver and **ovaries**,³⁰ among other **organs**,³¹ but this evidence is enough to get started.
- See this **interview** for evidence of clinical trial and other fraud, publicised by Edward Dowd, a former BlackRock investment analyst.³²
- See this **video** for evidence of official data fraud (UK Office of National Statistics): especially at 2min 45sec for the heart of the matter.³³
- See **here** for evidence of manufacturing fraud.³⁴ The same methodology was used to obtain regulatory authorisations, and so it is my contention that there is also regulatory fraud.
- In the Pfizer clinical trial briefing document to FDA, which was used for issuing the EUA (on p. 40 or thereabout), there is a paragraph stating that there were approximately 2,000 “suspected unconfirmed Covid cases”—meaning people were sick with symptoms but were not tested (otherwise, it would be stated that the tests were negative). Of these, in the first seven days after injection, there were 400 in the vaccine arm and 200 in placebo. These subjects were excluded from the dataset used to assess efficacy. It’s as clear evidence of fraud as you can get; they admit to it in the FDA briefing! Nobody paid any attention to this that I am aware of.
- There’s also evidence of data fraud in that clinical trial as summarised by Dr. Peter Doshi, associate editor of *The BMJ* (formerly called the *British Medical Journal*).
- Though many people refuse to accept or even look at the evidence, it is clear that the number of adverse events and deaths soon after Covid-19 vaccination is astonishing and far in excess, in 2021 alone, than all adverse effects and deaths reported to the U.S. Vaccine Adverse Event Reporting System (VAERS) in the previous 30 years. Here is a simplified view of Covid vaccine-related **mortality reports** from VAERS.³⁵
- This excellent **presentation** by a forensic statistician, well used to presenting analyses for court purposes, dismantles the claims that the vaccines are effective and shows how toxicity is hidden (see the second half of the recording).¹⁰
- Another **paper** published by the same group questions vaccine efficacy.³⁶

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How Much of the Covid-19 Narrative Was True?

Additional Reflections

Introduction

The purpose of this document is to demonstrate that **all of the key narrative points about the SARS-CoV-2 virus said to cause the disease Covid-19 and the measures imposed to control it are incorrect**. Given that the sources of these points are scientists, doctors, and public health officials, it is evident that they were not simply mistaken. Instead, they have lied in order to mislead. I believe the motivations of those who I call “the perpetrators” become clear, once it is internalised that the entire event is based on lies.

In recent days, breaking news indicates that coronavirus antibodies are present in blood stored in European blood banks [from 2019](#).¹ The implications are momentous.

Unprecedented Pronouncements

In the first three months of the Covid event, I started noticing senior scientific and medical advisors on UK television saying things that I found disturbing. It was hard to put my finger on the specifics, but they included remarks like:

- “Because this is a new virus, there won’t be any immunity in the population”.
- “Everyone is vulnerable”.
- “In view of the very high lethality of the virus, we are exploring how best to protect the population”.

I had been reading extensively about the apparent spread of SARS-CoV-2 in China and beyond, and had already arrived at a number of important conclusions. Essentially, I was sure that, objectively, we weren’t going to experience a major event. I based some of my conclusions on the Diamond Princess cruise ship experience. Note that no crew members died, and only a minority on the ship even got infected, suggesting substantial prior immunity, a steep age-lethality relationship, and an infection fatality ratio (IFR) not much different, if at all, from prior respiratory virus infections. But what was happening was that, in my view, senior people were acting a lot more frightened than seemed appropriate.

It was with this heightened interest that I began to closely examine all aspects of the alleged pandemic. I suspected something very bad was happening when the Imperial College released its modelling paper by Neil Ferguson. This claimed that over 500,000 people in the UK would die unless severe “measures” were put in place. Ferguson had over-projected all of the last five disease-related emergencies in the UK and had been responsible for the destruction of the beef herd through his modelling of the spread of foot-and-mouth disease.

I had also been reading about all sorts of “non-pharmaceutical interventions” (NPIs), and what this had taught me was that there was absolutely no experimental literature around any of the NPIs being spoken of, except masks—which were clearly ineffective in blocking respiratory virus transmission. Moreover, the non-experts in the

mainstream media drew on a very limited group of experts, and I noticed that none were immunologists.

I had, in parallel, watched the evolving scene in Sweden and was pleased to note that the Swedes' chief epidemiologist, Anders Tegnell, seemed to know what he was doing and had dismissed the panic. I knew he had been the deputy of his predecessor, Johan Gieseke, who was still around in an emeritus role. Gieseke was also reassuringly calm.

The final straw was when on March 23, 2020, the British prime minister initiated the first “lockdown”. This was wholly without precedent. I knew Sweden had rejected lockdown measures as wholly unnecessary and extremely damaging.

Instigating Fear

From that day forward, the team from the UK Scientific Advisory Group for Emergencies (SAGE) put up one or more members every day to appear alongside the prime minister or the health minister. These press conferences were meandering affairs, and it wasn't clear what their purpose was. The questions asked never sought to place things in context, but instead seemed to always explore the outer edges of possible outcomes and then follow up with remarks that didn't seem adequately prepared.

In retrospect, I think the aim was to make the press conferences the only “must watch” thing on TV, and with such a large, captive audience, a form of fear-based hypnosis was instigated. Much later, Belgian professor and clinical psychologist Mattias Desmet informed us that this was indeed the aim, calling the process “[mass formation](#)”.² This process can become malignant, as have past beliefs in events that were later conceded to have been episodes of societal madness, like the Salem witch trials, satanic abuse of children, and other delusions.

Some experts believe that modern societies are more—and not less—susceptible to mass panics because of the ubiquity of easily-controlled messaging (properly termed “propaganda,” since it was completely deliberate and carefully planned). An August 2021 animated [video](#) titled “*Mass Psychosis – How an Entire Population Becomes Mentally Ill*” illustrates this phenomenon; despite the animation format, the film leans heavily on academic research from luminaries such as Gustave Le Bon, Sigmund Freud, Edward Bernays, Stanley Milgram, and Solomon Asch, as well as later researchers and studies.³

It is important to be cautious about the purported importance of “mass formation,” however. In a sense, it might be seen as wholly impersonal and something that is thrown at the population and lands more or less effectively on people at random. Worse, it comes with the notion that, if you are susceptible, it cannot be resisted. There is a contrasting school of thought that holds that information technology (IT), data, and artificial intelligence (AI) are capable of assembling a “digital prison” that is [tailored to each individual](#) and shaped over time by choices that we each make.⁴ The outcome isn't in any way preordained. However, [incentives and deterrents](#) are associated with innumerable decisions we make, such as how to pay for something, whether we sell our data for tiny rewards, whether we consciously decide to open links suggested for us, whether we leave location services running permanently, and more.⁵

Using Mass Testing to Promote Fear

As soon as the UK lockdown was initiated, the focus turned full force onto mass testing, and especially on testing people without symptoms. I knew this didn't make any sense, because if a large enough number of people are tested daily, without knowledge of the false-positive rate, it could certainly very quickly panic people into thinking there were lots of people walking around with the virus, unaware they had it and allegedly spreading it to others.

Once the lockdown was in place, in addition to testing, the press conferences focused on numbers in hospital, numbers on ventilators, and ultimately, the daily deaths "with Covid". Early treatments and improved lifestyle were never spoken of. The first lockdown lasted 12 weeks, with most office staff told to work from home while being paid "furlough" (a word never before used in Britain). The "fear porn" continued all the way into high summer, long after daily Covid deaths had reached approximately zero. The introduction of mandatory masking in all public areas in the heat of summer, when they had never been required before, was the last straw for me. It was all theatre.

At that point, I set out to investigate a couple of core concepts: the "PCR test" and "asymptomatic transmission". I'm embarrassed to say, however, that it wasn't until the autumn of 2020 that I had clear in my mind, with mounting horror, that the entire event, if not completely manufactured, was being grossly exaggerated, with the intent of deceiving the entire "liberal democratic West". Scores of countries were economically being squeezed to death. I knew that from a financial perspective, borrowing or printing enough money to subsidize tens of millions to remain at home could not be long sustained without destroying the sovereign currency. Strangely, exchange rates didn't move much—another clue that powerful forces were managing this event as well as its consequences. Around this time, country leaders started talking about "Build Back Better," and Klaus Schwab's book, *COVID-19: The Great Reset*, appeared.

All of this contributed to my developing the idea of "The Covid lies". It seemed to me that everything we had been told about the virus wasn't true, and also that all the NPIs imposed upon us couldn't work, and so were for nothing more than show.

One Dominant Narrative

As already mentioned, repetition and fear were key to instigating "mass formation" as described by Mattias Desmet.² This narrowing of focus, according to Desmet, means those "in the mass" (crowd) literally are incapable of hearing anything that challenges the narrative of which they've been convinced. Any explanation other than the truth is marshalled to dismiss rational counter-arguments. And indeed we saw that anyone challenging the dominant narrative was attacked, smeared, censored, and cancelled on social media, and no reasonable and independent voices were ever seen or heard on TV or radio.

Desmet argues that mass formation, to be successful, requires that certain conditions be in place: high levels of free-floating anxiety; a strong degree of social isolation (where devices replace real human interactions); and finally, low levels of "sense-making," that is, many things do not make sense to many people. When a crisis is dropped into a population where these conditions obtain and is repeated ad nauseam, it is possible in effect to hypnotise them.

When the narrative has taken hold, what happens next?

- Now, the population's anxiety has an obvious focus, which is felt as a relief.
- The routines—masking, lockdowns, testing, hand sanitizing—become for some a ritual, which provides daily meaning.
- Finally, so many people are acting the same way and echoing the same lines (the lines they've heard time and again on TV, radio, newspapers, and their devices), that people can feel part of a national effort in a way they've not felt before.
- This combination, coupled with visible and strong punishment for anyone who questions the narrative or simply refuses to comply, reinforces the groupthink.

It is, according to crowd psychology experts, nearly impossible to extract those who are this deeply “in the mass”. However, there is always another group of individuals who never fall for such tricks. Outwardly pleasant and easygoing, these individuals typically are sceptical and go along with things only if they make sense to them personally, and not because an authority figure tells them to.

There is also a third group in the middle—individuals who often sense that something is wrong but lack the courage of their own convictions and tend to side with whatever they're told to do, rather passively. They are not hypnotised, but to third parties, they can seem to be.

Crowd psychology experts encourage those who've seen through the lies (the second group) to speak out and continue to do so. This legitimises speaking out by all others not persuaded by the narrative and might even extract some from the middle group. Even those in the “mass” group will be prevented from sinking yet more deeply into the narrative, from where those orchestrating events can otherwise prompt such people to commit atrocities.

Vaccine Lies

In the second half of 2020, the conversation turned to the oncoming vaccines. Having spent 32 years in pharmaceutical research and development (R&D), I knew that what we were being told about vaccines was just lies. It's not possible to bypass a dozen years of careful work or to compress it into a few months. The product that was to emerge was almost certain, to my mind, to be very dangerous. And after I began reading my way into this area, I grew more concerned still.

In my “Covid Lies” comments, I isolate ONLY the major narrative points themselves and show that none of them are true. In other words, this was not just a little lying here and there—no, the entire construct was false. After I describe all the main lies, I show how the perpetrators were able to get away with it. At the conclusion, I believe the reader will share my view that the whole event was manufactured or exaggerated from a mild situation.

Remember, no alternative views were permitted in the “public square”. In fact, in July 2019—well before the declared pandemic—a group of powerful media organisations had already assembled and founded the [Trusted News Initiative](#) (TNI). The purpose of TNI was both to control mass media messages and crush alternative voices from any direction.⁶

Again, all of the Covid narrative was lies. Not mistakes. Many of the politicians who repeated others' lines might try to offer as defence that they relied on experts to inform them. U.S. Centers for Disease Control and Prevention (CDC) director Rochelle Walensky recently did just that when she said that the CDC made vaccination recommendations because CNN published Pfizer's press release saying that their Covid-19 vaccine was 95% effective. (You can't make this up.) However, the true subject matter experts who promoted the false narrative from the public health departments—such as Chief Scientific Advisor Sir Patrick Vallance in the UK and National Institute of Allergy and Infectious Diseases (NIAID) director Dr. Anthony Fauci in the U.S.—knew their statements were untrue.

The Question of Motive

The question of motive has to arise. What possible motive might there have been to create this state of fear? Who must have been involved to have granted authorisation to do it?

I have tried to find benign explanations and have failed to do so. The logical conclusions I'm drawn to make for very disturbing reading. I look forward to discussing them with you and indeed with anyone. Although it's unlikely I am correct on every point, what I am sure of is that the overall picture is one of extreme deception and a highly-organised fraud. Moreover, I am not alone in reaching this view. For example, in an essay titled "if I were going to conquer you," one author walks us through what the perpetrators **would do** in order to take over the world through a simultaneous "coup d'état" of the liberal democracies.⁷ Robert F. Kennedy, Jr. summarised a plausible explanation in a **speech** in Milan in November 2021.⁸

I appear to be the **ONLY** former executive-level scientist from big pharma anywhere in the world speaking out. I have invested two years pro bono in identifying the key elements of the fraud, in the sincere hope I can connect with upright individuals who can help bring this to wider attention and, ultimately, to a halt and to justice. As a result of these efforts, I can describe a global fraud operating for two years at tremendous cost in lives, the economy, and the very structure of human societies, which could only have been undertaken by powerful people, organised for a purpose that is not to the benefit of ordinary people.

Additional Observations

Though not all central, there are a large number of ancillary points that reinforce my conclusions. I have assembled some of them below. This list is not exhaustive and may be added to.

Fraud Assessed

In a series of **five short videos**,⁹ you will find remarkable similarities in a Canadian team's interpretation of the same fraud. Note, in particular, the **second film** (3.5 minutes) on non-pharmaceutical interventions.¹⁰

Fraud Rehearsed

German investigative journalist Paul Schreyer shows that this fraud was **rehearsed** for many years, increasingly, with all the stakeholders now running the alleged Covid-19 fraud.¹¹

Autopsies

Why were autopsies strongly discouraged worldwide in 2020 and still today? My conclusion is that this was to cover up the lack of Covid-19 deaths. **After vaccination**, a large fraction of deaths have been judged to be due to the vaccines, and the lack of autopsies covers them up, too.¹²

PCR Test

The Nobel-prize-winning inventor of the PCR test, Dr. Kary Mullis, stated definitively that PCR **must not be used to diagnose** viral illnesses.¹³ On what basis, therefore, were “cases” determined purely by the results of this one test, much disputed as to its appropriateness?

Cause of Death

A death from any cause, within 28 days of a positive test for SARS-CoV-2, is recorded as a “Covid death”. It’s absurd—we have never assigned cause of death like this before, ever. The effect of untrustworthy PCR tests and the arbitrary assignment of a dubious “positive” as somehow causative of death has been a very effective way to fool and frighten people. Most do not know that there are literally scores of viruses, even common cold viruses, which can infect human airways, some of which—in elderly and infirm people—can give rise to severe illness.

Hospital Protocols

Hospital treatment protocols, where I have explored them, look designed to kill:

- In the UK, the pathway starts with everyone being tested with untrustworthy PCR tests, which are applied repeatedly for an inpatient. Given that 2% of hospital admissions end in a hospital death, repeated poor testing guarantees a lot of “Covid deaths”.
- A patient “diagnosed” as “positive” Covid is then placed in isolation, and visitors are not allowed until the patient is moribund.
- A standard treatment involves intravenous midazolam (a benzodiazepine used for sedation) and morphine from a syringe driver, at doses up to 10 times greater than advisable for a patient capable of breathing unaided. This often results in respiratory failure and either immediate death or mechanical ventilation, accompanied by withdrawal of all care; of course, these patients then expire. It’s murder.

In the UK, we have documentary evidence that the UK National Health Service (NHS) stockpiled a year’s supply of midazolam by ordering it normally but banning 2019 prescriptions. By April 2020—over no more than two months—the entire supply was exhausted. Another year’s supply was then bulk-purchased from a generics company in France, cleaning out their stock.

Something similar occurred in U.S. hospitals, with ramped-up cash bonuses for each stage passed, up to and including mechanical ventilation.

Mechanical ventilation is rarely appropriate, because Covid-19 is NOT an obstructive lung disorder. Blood oxygen desaturation is best addressed using non-invasive masks with elevated oxygen levels. When hospitals tried this in Italy in February 2020, they ceased mechanical ventilation within a week, so stark were the differences in outcomes; that is, most ventilated patients died, while most masked patients survived. Apparently, the method of treatment the Italian health care providers had been given from “colleagues in Wuhan” was what they called “the Wuhan protocol”. In this, the guidance given was that the sooner they sedated and ventilated an agitated patient, the better the patient’s chances. This was a lie. Panicked patients needed anxiolytics (anti-anxiety drugs) and an oxygen mask, but instead, they were killed.

Experimental Vaccines

I have been incensed by the misuse of novel, experimental “vaccines,” particularly in Covid-recovered individuals, pregnant women, and children.

- Recovered individuals are immune, and the risks of adverse events are greatly increased because the body is already poised to attack any cells expressing spike protein.
- Pregnant women are not at greatly elevated risks from Covid-19 because they tend to be young and healthy. NEVER, since thalidomide (1956–1962), have we approved the use of experimental agents in pregnant women, and certainly not without reproductive toxicology studies. None of the vaccines have a completed “Reprotox” package (summaries on the reproductive effects of chemicals, medications, physical agents, or biologics). I filed a short [expert opinion](#) in court with America’s Frontline Doctors (AFLDS) on this topic.¹⁴ The vaccine makers also didn’t complete something called an ADME-Tox (Absorption Distribution Metabolism Excretion-Toxicity) package. Documents obtained in March 2022 through Freedom of Information Act (FOIA) requests show that Pfizer was “planning to study” vaccination in maternity as of April 30, 2021—that is, after they had already manufactured and shipped close to 100 million doses.
- The misuse of these agents in healthy children has, without question, reverse risk/benefit: the injections kill far more children than the virus could.

The whole thing stinks of a purpose different from public health, because if it was a legitimate public health effort, we definitely would NOT do any of these things. When I co-authored the world’s first treatise explaining some of these concerns, officials lied on the nationally broadcast BBC and other media outlets, smearing me and others like me who were raising questions. Note that the [petition](#) in question, filed with the European Medicines Agency (EMA), was co-authored by Dr. Wolfgang Wodarg, the public health doctor and minor politician from Germany who stopped the fraudulent “swine flu pandemic” in 2009.¹⁵

Revised Definitions

I observed two strange occurrences. First, the WHO [altered](#) the definition of “immunity” from “that obtained after natural infection or vaccination,” only mentioning vaccination and excluding “natural immunity”.¹⁶ That meant that only

vaccination could accomplish the goal. They eventually changed this back, but for many, the damage was done, leaving non-experts not trusting natural immunity, even though it is superior to that from vaccination because the body has been exposed to all parts of the virus and will, therefore, respond to any part of it if reinfected. The definition of a “vaccine” was also changed, so that it wasn’t necessary to prevent infection or transmission, whereas traditional vaccines almost always do this. They do so because they prevent the development of clinical illness and, in the case of respiratory viruses at least, lack of symptoms renders the person all but incapable of infecting anyone else.

In addition, the WHO changed the definition of “pandemic.” Previously, “pandemic” meant the simultaneous spreading across many countries of a pathogen, causing many cases and deaths. The definition was changed to eliminate the need for many deaths. (See Dr. Wolfgang Wodarg [at 45 min, 50 sec], [interviewed](#) on UK TV in 2010 after the exaggerated swine flu pandemic, which I now believe was something of a rehearsal for the 2020 Covid-19 pandemic.)¹⁷

This is a critical point, because PCR can be designed against any pathogen, and protocols can be adopted such that a large number of false positives appear. This grants bad actors the ability, relatively easily, to create the illusion of a pandemic, almost to order. Dr. Wodarg recaps his 2009 experiences and shows interesting [similarities with recent events](#) in an January 2021 interview.¹⁸

Many people simply don’t believe experts when they talk of a “very high fraction of positive test results being false positives”. I assure you, however, there have genuinely been a number of events where the entire suspected epidemic was an illusion, and 100% of positives were false positives. In 2007, the *New York Times* reported on an [example](#) of “an epidemic that wasn’t” which, when I first read it, gave me a crawling sensation.¹⁹ I wonder if it was this genuine event—a false alarm in which experts admitted placing “too much faith in a quick and highly sensitive molecular test that led them astray”—that birthed the method for exaggerating (or even fully faking) a pandemic such as the one we are currently living?

Bizarre Statements

I noticed early on that Bill Gates said, “We won’t return to normal until pretty much the whole planet has been vaccinated”. This is a bizarre statement from a person with no medical or scientific training (or indeed a college degree in anything). It is never necessary to vaccinate the entire population, when only the elderly and infirm are at serious risk of death if infected. Note, too, that the median age of deaths from/with Covid was the same or even older than the median age of death due to all causes.

For his part, former UK prime minister Tony Blair insisted that vaccine passports would be essential to restore confidence. Again, this was absurd, especially once we learned that these vaccines do not prevent transmission. Once this became clear, the case for coerced vaccination vanished, and this is still the present position. Yet, my unvaccinated relatives may not enter the U.S. If you fear infection, the safest person to be around isn’t a vaccinated person but a person who is fit and well, with no respiratory symptoms.

Boosters and Antibodies

The practise of “boosting”—giving people dose after dose of poorly-designed agent, ostensibly to reinforce their immunity—has no immunological basis. No genuine immunity wanes in a few months, or sometimes even in a few weeks. The perpetrators have exploited the public’s understanding of the annual influenza vaccine to somehow normalise something that is both dangerous and ineffective.

I also noticed that early on, in discussing immunity, antibodies were the discussion topic, whereas T-cells were an “extremist plot”. This is another absurdity. I can assemble expert witnesses who will attest alongside me that blood-based antibodies are relatively unimportant, potentially irrelevant to infection by respiratory viruses. This is because the virus infects the air side of the airways and blood-based antibodies cannot leave the blood and enter this “compartment”. Blood antibodies and respiratory viruses never meet except under unusual circumstances. On the contrary, T-cells leave the blood and migrate through infected airway tissue, removing infected cells.

Ferguson Track Record

Professor Neil Ferguson at Imperial College has a [poor record](#) of modelling and predictions.²⁰

Prescient Testimony

A former WHO staffer, Jane Bürgermeister, shared frighteningly prescient testimony in 2010. Her understanding was that respiratory virus pandemics will be used to force [near universal vaccination](#) and that this had sinister motives.²¹ I dismissed this the first time I saw it. Many of us turn away instinctively from evil because we cannot or do not want to believe that other humans are capable of that which our logic tells us is happening. I now no longer reject it. It fits far too well with the totally independent Paul Schreyer [documentary](#).¹¹

More Prescient Testimony

Another doctor, Dr. Rima Laibow, made [similar claims](#).²² This testimony speaks of population rejection, and like Jane Bürgermeister, locates the fraud in a conceptual world government. Again, one can reject it, or consider it alongside other pieces of information.

Conclusions

I think it’s worth developing the theme of turning away from evidence of sheer evil, and I have to say more, because it is THE pressing issue today. The evidence I set forth makes it perfectly plain that the entire world is being lied to in ways that led—predictably—to huge suffering and death. Given that none of the “measures” imposed could have mitigated illness and death from a respiratory virus, the only outcome was to be the fracturing of civil society and damage, potentially fatal, to the economy and financial system. I emphasise again here that WHO scientists had conducted a detailed [review of control measures](#) for respiratory virus epidemics and pandemics as recently as 2019, and they concluded that no imposed NPI measures make any difference at all.²³ The claims made for control in Wuhan are not credible.

The stakeholders who must have approved this action own or control the majority of the world's capital and assets. Their motivation cannot be for money, for they stand astride the money-creating apparatus in the central and private banks. Equally, it cannot be to obtain gross control over the population, since they already demonstrably have that. This is what leads me inexorably to propose that the motives behind this are terrible—at the very least, to secure totalitarian control through mandatory, digital IDs (in the guise of useless “vaccine passports,” useless because none of these so-called vaccines reduce transmission, the only possible justification for them). Add to this a “financial great reset” with withdrawal of cash and introduction of central bank digital currencies (CBDCs), and we have a wholly controlled population, controlled automatically without human intervention on the ground. All that's needed is to require the population to show their health passport or else they will not be allowed to cross a regulated threshold, like accessing a food store, or make a transaction using digital money unless the AI algorithm permits it. If those operating this takeover of humanity wished then to eliminate a portion of the population, with plausible deniability, I doubt a more propitious starting point could be had.

I do not believe it's a fault in those who fall for the narrative that they cannot see the lies. People want to believe that governments and experts, for all their well-known flaws and occasionally uncovered corruption, are trying to do the best they can. They cannot accept the truth, that there is a group of powerful people who regard the ordinary members of the public as surplus to requirements. They want to deny evil because it makes them feel bad, sad, and uncomfortable to think about the world this way. They want to deny reality; that's their coping mechanism, which is being exploited by the perpetrators of evil. It gives a cloak of invisibility to those who want to commit mass murder, quite literally, since so many people are so willing to imagine that it is not happening.

It is not clear to me what to do with the information I've gathered here. I believe that a calm review of the summary that I call “The Covid Lies” will result in any open-minded person agreeing that we all have been subjected to a monstrous fraud with lethal consequences, and that there is overwhelming evidence of long-term planning and deliberately injurious acts. There is no easy way to say that, but it could be represented objectively and taught, in the manner of a workshop, so that participants get to derive their own conclusions (albeit being led by the evidence).

I doubt just talking to a group of people who hold the dominant narrative view as “true” would respond at all well to this, delivered as a lecture. Nobody wants to accept that they've been fooled, even if the blow is softened by telling them that this has been brought about by highly experienced professionals in the covert services and has required huge amounts of money to buy off several groups. On the positive side, an increasing number of people have detected that fraud is ongoing. A particularly good example comes from the financial analyst community and refers to [life insurance](#) claims among many other pieces of evidence of wrong-doing.²⁴

Ignoring this and hoping it will go away is naïve and very dangerous for us all. The perpetrators have not gone away and will likely return in the fall. I expect this year or the next will see them assume totalitarian tyranny, if we have not, before then, “inoculated” important stakeholder groups to understand what has happened so far and cautioned them to be alert to the many potential presentations of the next fear-provoking episode.

Best wishes and thanks for reading.

About Dr. Mike Yeadon

I am an experienced life sciences R&D professional, with 32 years in commercial R&D. There is no reason for me to be saying the things I do, other than that I believe them to be true. I have never campaigned for or against anything in my life, and I had never made public comment on anything outside the narrow confines of my professional roles, prior to Covid-19.

I hugely enjoyed my years with Pfizer. They were a good employer, and I left on excellent terms as they shuttered their UK R&D base. Evidence of this is that I formed a business partnership with Pfizer the year after I left (2012), and we worked together on an ultimately **successful venture**, which concluded profitably for all in 2017.²⁵

I am the most highly- and broadly-qualified scientist speaking out about this alleged fraud. I have no financial or other conflicts of interest, unlike most of those who I assert are deceiving the public, everywhere.

Professional Profile

- Currently Chief Scientific Advisor to America's Frontline Doctors and to the Truth For Health Foundation.
- Former founder and CEO of Ziarco, a biotech acquired by Novartis (2017).
- Former VP and worldwide head of Allergy & Respiratory Diseases research at Pfizer, UK (1995–2011).
- Independent consultant to over 30 biotech companies, mostly U.S. (2011–2021).
- PhD in respiratory pharmacology (1988) and double 1st class honours degree in biochemistry and toxicology (1985).

Endnotes

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