
From: DOH Information
Sent: 8/1/2022 10:38:55 AM
To: DOH WSBOH
Cc:
Subject: FW: Question/Comment from the public

attachments\00D2AB5206A94216_image001.png

Hello,

Below is public comment on one of your meetings.

Thank you,

Customer Service Specialist 2

Center for Public Affairs (C4PA)

Washington State Department of Health

DOH.Information@DOH.WA.GOV <mailto:DOH.Information@DOH.WA.GOV>

1-800-525-0127| www.doh.wa.gov
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.doh.wa.gov%2F&data=05%7

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.doh.wa.gov%2FNewsroom%

From: DOH Feedback <doh.information@doh.wa.gov>
Sent: Saturday, July 30, 2022 9:03 AM
To: DOH Information <DOH.Information@DOH.WA.GOV>
Subject: Question/Comment from the public

The following survey response is submitted:

1.

Please select one:

Other

2.

Please enter your comments or questions in the space provided below:

July 30, 2022, for Aug 10 meeting, Public Comment To Whom it May Concern, It concerns me greatly that the Board of Health may continue to insist that childhood vaccination is imperative to gain and retain health in our community. There is plenty of evidence to the contrary, and I urge you to look into the following scientific claims (and not label them "misinformation," which is the constant in today's discussions about pandemics & vaccinations). The citations listed are just a sampling of what is available online. Vaccinated children have spread the "virus" more than those who have not been jabbed: https://rumble.com/vkcljx-july-26-2021.html <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Frumble.com%2Fvkcljx-july-26-2021.html&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%7C
The vaccine insert states that it CANNOT stop the spread of the "virus.": https://www.naturalnews.com/2021-12-03-covid-vaccine-induced-diseases-public-health-threat.html <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.naturalnews.com%2F2021-12-03-covid-vaccine-induced-diseases-public-health-threat.html&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%7
The injection forces recipients to MAKE a virus, and not just a spike protein: https://www.bitchute.com/video/43olH6iAvT3f/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.bitchute.com%2Fvideo%2F4
Proper nutrition, vitamins C and D, and zinc are important tools in our personal medical cabinet: https://informedchoicewa.org/news/covid-19-key-insight-this-week/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finformedchoicewa.org%2Fnews%2Fcovid-19-key-insight-this-week%2F&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%7C
Dr. Fauci added HIV to the Covid virus from 2003 to 2019, the US patent office confirms: https://forbiddenknowledgetv.net/there-is-no-variant-not-novel-no-pandemic-dr-david-martin-with-reiner-fuellmich/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fforbiddenknowledgetv.net%2Fthere-is-no-variant-not-novel-no-pandemic-dr-david-martin-with-reiner-fuellmich%2F&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%
Natural Immunity IS real, IS important, and can save lives: https://informedchoicewa.org/covid-19/ican-vs-cdc-on-superior-natural-immunity/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finformedchoicewa.org%2Fcovid-19%2Fican-vs-cdc-on-superior-natural-immunity%2F&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%
The fertility of our children and young adults is at risk due to these injections: https://www.lewrockwell.com/2022/07/joseph-mercola/covid-jabs-impact-both-male-

and-female-fertility/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.lewrockwell.com%2F2022%
mercola%2Fcovid-jabs-impact-both-male-and-female-
fertility%2F&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%7
The CDC used flawed data when it claimed our children were at extreme risk from Covid:
https://childrenshealthdefense.org/defender/cdc-flawed-data-covid-shots-infants-
children/?utm_source=salsa&eType=EmailBlastContent&eId=a2d4ef24-7d8f-40e0-87aa-
10ac62a79d07
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fchildrenshealthdefense.org%2Fde
flawed-data-covid-shots-infants-
children%2F%3Futm_source%3Dsalsa%26eType%3DEmailBlastContent%26eId%3Da2d4ef24-
7d8f-40e0-87aa-
10ac62a79d07&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc
Be Strong, Be Smart! Stop believing the narrative that has been constructed to control
and manipulate the public. Today's mainstream propaganda has nothing to do with
“health and safety,” only absolute power over The People in perpetuity. Coercion is NOT
Consent, and the Constitution protects our Right to Choose. The rest of the World is
dropping the masks and the “vaccines.” Let's be on the right side of History for once. In
the name of Truth, Sue Coffman 714-337-4331 ICWA Team Leader Legislative District
#24 https://informedchoicewa.org/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finformedchoicewa.org%2F&data=

3.

If you are sending feedback on one of our Web pages, please paste the URL here:
(no answer)

4.

Would you like a response?

Tell us how to get in touch with you.

Name:
Sue Coffman
Email:
doulasue@yahoo.com <mailto:doulasue@yahoo.com>
Telephone:
7143374331

5.

To receive a confirmation of your submission, please enter your email address again in the space provided below.

_____

doulasue@yahoo.com <mailto:doulasue@yahoo.com>

From: DOH Information
Sent: 7/26/2022 9:04:41 AM
To: DOH WSBOH
Cc:
Subject: Vaccine feedback

attachments\92F50B1EAEDC4390_image002.png

Hello,

This feedback is intended for the Board.

Thank you

Alexandra Moore

Customer Service Specialist

Center for Public Affairs

Washington State Department of Health

DOH.Information@doh.wa.gov

800-525-0127 | www.doh.wa.gov

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.doh.wa.gov%2FNewsroom%

From: DOH Feedback <doh.information@doh.wa.gov>
Sent: Monday, July 25, 2022 3:47 PM
To: DOH Information <DOH.Information@DOH.WA.GOV>
Subject: Question/Comment from the public

The following survey response is submitted:

1.

Please select one:

Other

2.

Please enter your comments or questions in the space provided below:

_____

For months now, I've wanted to congratulate the WA Board of Health for NOT requiring the COVID vaccine for schools this fall. Thank you for making, in my professional and personal opinion, the right choice for the sake of our children!

3.

If you are sending feedback on one of our Web pages, please paste the URL here:
(no answer)

4.

Would you like a response?

Tell us how to get in touch with you.

Name:
Dr. Carol Volk

Email:
garycarols@hotmail.com <mailto:garycarols@hotmail.com>
Telephone:
(no answer)

5.

To receive a confirmation of your submission, please enter your email address again in the space provided below.

_____

garycarols@hotmail.com <mailto:garycarols@hotmail.com>

_____
From: Petra Hoy
Sent: 8/3/2022 10:29:53 AM
To: DOH WSBOH
Subject: WA Health District - School Safety - Secure Gun Storage

 *attachments\89C5A192DAD14D36_Model Secure Storage Notification_PRDTOOL_NAMETOOLONG.docx*

External Email

Good morning Washington Board of Health members,

I hope you are all enjoying this beautiful sunshine we've had lately. As the School District plans for the upcoming school year, I want to make sure that all School Board members are prioritizing the safety and security of students and staff.

Is this something the Washington Health District can help us with? This is such an important public safety issue.

Our Seattle School Safety Team has developed a relationship with the King County Lock it Up program through King Co Public Health, and now Lock It Up's webpage includes a link to Be SMART as a resource for families (https://kingcounty.gov/depts/health/violence-injury-prevention/violence-prevention/gun-violence/LOCK-IT-UP/parents-community.aspx <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fkingcounty.gov%2Fdepts%2Fheal injury-prevention%2Fviolence-prevention%2Fgun-violence%2FLOCK-IT-UP%2Fparents-community.aspx&data=05%7C01%7Cwsboh%40sboh.wa.gov%7C45540504e49a4fbd39e808da7575b332%). We have a great partner with other government agencies and would love to work with you.

As a volunteer for WA Moms Demand Action and a parent, I know that families and communities expect schools to keep their children safe from threats (human-caused emergencies such as school shootings) and hazards (natural disasters, disease outbreaks like COVID, and accidents). It is always important to be prepared for potential emergencies and to review safety plans regularly. You can refer to the Guide for Developing High-Quality School Emergency Operations Plans <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Frems.ed.gov%2Fdocs%2FSchool_ , the "Keeping Our Schools Safe <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Feverytownresearch.org%2Freport gun-violence-in-american-schools%2F&data=05%7C01%7Cwsboh%40sboh.wa.gov%7C45540504e49a4fbd39e808da7575b332%7C1 " report by Everytown for Gun Safety, as well as reference SchoolSafety.gov <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.schoolsafety.gov%2F&data= , for valuable resources to create safe and supportive learning environments.

In the wake of the horrific Uvalde school shooting, families are feeling increasingly concerned about the risk of gun violence on school grounds. In 2022, there were at least 95 incidents of gunfire on school grounds <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Feverytownresearch.org%2Fmaps%
on-school-
grounds%2F&data=05%7C01%7Cwsboh%40sboh.wa.gov%7C45540504e49a4fbd39e808da7575b332%7C
, resulting in 40 deaths and 76 injuries nationally. Here are some topline facts about youth gun violence in America:

* Approximately 4.6 million children live in a household with at least one gun that is stored, loaded and unlocked. In Washington State, there remains a high prevalence of unlocked household firearms, even in households with children (1).

* In cases of gun violence on school grounds, nearly 80% of all shooters under the age of 18 obtained the firearm from the home of a friend or family member (2). Safe gun storage is a vital practice to protect our entire school community.

* In incidents of averted school violence, nearly two-thirds of would-be perpetrators had access to firearms (3).

* Unintentional shooting deaths by children increased by over 30% in March - May 2020, as compared to the March-May average of the previous three years (4).

* Suicide is the second leading cause of death for youth 10-24 years old in Washington, with firearms being the leading method. 75% of adolescent firearm suicides are carried out with a gun from home, or the home of a friend or relative (5,6).

* Secure gun storage practices are associated with reduced rates of child firearm suicide, and can prevent unintentional shootings. One study showed that households that locked both firearms and ammunition had a 78 percent lower risk of self-inflicted firearm injuries among children and teenagers (7).

All of these statistics point to the urgency for school districts to educate parents and the community on safe firearm storage. More than 2 million students <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.everytown.org%2Fpress%2F
milestone-more-than-two-million-students-nationwide-now-attend-schools-with-secure-
firearm-storage-awareness-
policies%2F%3F_gl%3D1*dd5vn3*_ga*MTMzMTk4OTU1Ni4xNjU4NDIxMTEx*_ga_LT0FWV3EK3*MTY1ODc1
nationwide live in a school district that has already committed to sharing this lifesaving information with families. I urge our school districts to join the more than 45 school

districts across 11 states in signing and/or adopting a School Board Secure Storage Notification Resolution for 2022-23 (template attached), as well as sharing the BeSmartForKids.org <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fbesmartforkids.org%2F&data=05% website with all parents. Protecting our kids from gun violence starts in the home, and is a community effort.

Finally, it is important to understand that most school attacks are preventable. The National Threat Assessment Center's recent report, USSS Averting Targeted School Violence <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.secretservice.gov%2Fsites%2 03%2FUSSS%2520Averting%2520Targeted%2520School%2520Violence.2021.03.pdf&data=05%7C01%7C , found that "individuals contemplating violence often exhibit observable behaviors, and when community members report these behaviors, the next tragedy is averted." In fact, 94% of shooters communicate their intentions on social media and to others beforehand. This is why it is important that students know the best way to report these types of concerns, as well as concerns with bullying and harassment. Please be sure that any reporting tool available is communicated to all students, parents, and staff prior to the beginning of the school year. Also make sure that this information is quick and easy to find on our school district website and printed on student ID badges.

In summary, I ask that in preparation for the 2022/2023 school year, School Districts:

1) Review safety plans and procedures

2) Sign a Safe Storage Resolution and share educational information <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fbesmartforkids.org%2F&data=05% about the importance of safe firearm storage with parents

3) Remind students how they can report threats or concerns

I am happy to answer any questions you may have, and can provide further examples of how this information is being communicated with families across our Nation.

Thank you for your time, and for all you do for our children.

Sincerely,

Petra Hoy

Central Valley School District Parent

Volunteer, WA Moms Demand Action

Judy Bacon, Volunteer, WA Moms Demand Action

Connie Pittman, Volunteer, WA Moms Demand Action

Pastor Genavieve Heywood, CVSD Parent

Jerry Leclaire, Retired Physician

Anya Turner, Parent, Substitute Teacher and former Spokane Moms Demand Action lead

Jennifer Calvert, Educator

Patty Grandos, Volunteer WA Moms Demand Action, Educator, former Spokane Moms Demand Action lead

Maria Bachman, CVSD Parent

Chelsie Chatman, RN, Parent, Spokane Moms Demand Action Lead

Dr. Doug Danner, Physician, The Native Project; CVSD Parent

Heather Tanner, CVSD Parent

Bob West, CVSD Grandparent

Alison Ashlock, CVSD Parent, Educator

Stan Chalich, Active Retired CVSD Educator

Grace Wahlman, Students Demand Action, Volunteer

1. Firearm storage practices in households with children: A survey of community-based firearm safety event participants <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.sciencedirect.com%2Fscienc ; King, A., Simonetti, J., Bennett, E., Simeona, C., Stanek,L., Roxby, A., Rowhani-Rahbar, A.; University of Washington, Preventative Medicine, ScienceDirect.com <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fsciencedirect.com%2F&data=05%7

2. National Threat Assessment Center, "Protecting America's Schools."

3. National Threat Assessment Center. (2021). Averting Targeted School Violence: A U.S Secret Service Analysis of Plots Against Schools. U.S. Secret Service, Department of Homeland Security.

4. Everytown for Gun Safety Support Fund, "#NotAnAccident Index," 2020, https://everytownresearch.org/notanaccident <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Feverytownresearch.org%2Fnotana .

5. Washington State Department of Health, "Youth Suicide," 2020

6. University of Washington, "Pacific Northwest Suicide Prevention Resource," 2020, https://hiprc.org/outreach/suicide/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhiprc.org%2Foutreach%2Fsuicide

7. Grossman DC, Mueller BA, Riedy C, et al. Gun storage practices and risk of youth suicide and unintentional injuries. JAMA. 2005; 293(6): 707-714. Study found households that locked both firearms and ammunition had an 85 percent lower risk of

unintentional firearm deaths than those that locked neither.

https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePrevention/YouthSuicide/

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.doh.wa.gov%2FYouandYour

_____

From: Nancy the Soul Dancer
Sent: 6/23/2022 1:35:47 PM
To: DOH WSBOH
Cc:
Subject: episode 273 clarifies results of VRBPAC June 14, 2022

External Email

Hello. Members of WSBOH/DOH,

Please find below the link to some clarifying information about the recent decision by the CDC to authorized COVID 19 shots to babies and children 6 mos. to 5 yrs.

It is a long video, however, it is archives and can be watched in short intervals. At the end is an interview with pathologist Dr, Claire Craig, FSCPATH who sums up the Pfizer trials for this age group.

https://thehighwire.com/watch/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fthehighwire.com%2Fwatch%2F&d

I encourage everyone to watch this!

Thank you for your time and attention to this important issue and study!

From: j
Sent: 7/25/2022 11:56:21 PM
To: j
Cc:
Subject: VERY IMPORTANT!! from Mary Hath Spokane, Peace Prophet

External Email

Dear Ones,

This is the VERY BEST short and concise explanation of the 'shedding' aspect of the vaccines I have seen.

Please watch and KNOW THE TRUTH about the agenda of the World Economic. Forum/ Cabal to eliminate YOU and ME and 2/3rds of the world's population with these vaccines/bioweapons and 5G frequency.

We The People of the World MUST UNITE and STOP THIS EVIL AGENDA NOW.
1) Ask your county sheriff to ACT NOW!! 2) Vote in Republicans endorsed by Trump. 3) Support those bringing lawsuits against these evil people NOW!! 4) PRAY for personal strength to ACT NOW!! 5)FOCUS/VISUALIZE the END OF THIS EVIL CABAL. Love to all,
Mary www.maryhathspokane.com
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.maryhathspokane.com%2F&c

Dr. Abdul Alim - Avoid Vaccinated People!!! They will make you sick! I can attest to this! (bitchute.com)
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.bitchute.com%2Fvideo%2FG

From: Lisa Templeton
Sent: 8/5/2022 10:40:14 AM
To: DOH WSBOH
Cc:
Subject: Comments for BOH meeting on August 10

External Email

Dear Board members,

Since Covid began, the FDA and CDC have taught us that we should proceed with caution when it comes to their proclamations on public health. For example, a little over a year ago, they told us that the J&J Covid shot met the FDA's so-called "rigorous standards for safety, effectiveness, and manufacturing quality." Now the FDA essentially no longer approves of the use of J&J due to its adverse effects.

Have you listened to the recent VRBPAC and ACIP proceedings during which Covid shots were authorized then recommended for babies and toddlers? If you employed discernment, you know that the risks of the infection for children were exaggerated, the effectiveness of these consumer products was inflated, and the injuries from the shots were practically ignored.

Three members of Congress recently asked VRBPAC the following questions, which deserve answers before this mass human experiment is further unleashed on millions more Americans—our children.

* Why did the FDA lower its efficacy bar for Covid injections for the youngest children?
* How many lives does the FDA estimate will be saved in this age group?
* How will the FDA evaluate the injuries and deaths reported to VAERS compared to serious Covid outcomes?
* Why has the FDA been so slow to release the hundreds of thousands of pages of data from manufacturer studies and post-approval adverse events?

These are just four of many questions that bona fide science requires be answered before rolling ahead. It is evident that the risks of these experimental, liability-free shots outweigh the purported benefits, and our government barely seem to care. The public is taking note, however. I respectfully plead with each member of this Board to become informed of the many dangers of these for-profit products and stand for protecting the public from them.

Thank you,

Lisa Templeton

Covington

_____
From: John Anderson
Sent: 7/13/2022 7:44:17 AM
To: DOH WSBOH
Subject: Re: Comments on Public School MASK Policy

attachments\BA6AE21CFA03471A_CDC-Response-Letter-February-22-2_PRDTOOL_NAMETOOLONG.pdf

External Email

Greetings Working Group -

Also attached, as a convenience, is a document that is in the public record. This is the letter to the CDC containing the perspective and citations offered by Stephen Petty on the topic of whether masks are safe and effective.

Strength and Honor

John Anderson
President
GDP Group Ltd SPC
MOBILE: (253) 459-3447

On Wed, Jul 13, 2022 at 7:21 AM John Anderson <j2j.anderson@gmail.com <mailto:j2j.anderson@gmail.com> > wrote:

Greetings Working Group -

I wish to provide, for your consideration, the attached testimony (with numerous studies cited in bibliographical links) of Stephen Petty. a recognized expert on the protection offered by Masks, including N95 for both general population and for children.

in his testimony he specifically cites recent cases where his science prevailed against the flawed studies on N95 masking conducted by the CDC to promote masking of school children.

Your committee would be hard pressed to find a better compendium of information, and should you ignore this resource it could be at your peril. Note his citation of the regulatory and legal risks of advocating N95 masks without specific physician evaluation of patients over the warnings issued by the manufacturer.

Please keep our children safe!

(321) Ep. 141 The Ultimate PPE Expert with Incredible Insights into Mask Science! - YouTube <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv

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Strength and Honor

John Anderson
President
GDP Group Ltd SPC
MOBILE: (253) 459-3447

On Wed, Dec 29, 2021 at 1:11 PM John Anderson <j2j.anderson@gmail.com <mailto:j2j.anderson@gmail.com> > wrote:

Greetings Working Group

Personal Background

I am a vaccinated (2x), healthy 68 year old male. I have lived in Washington since 1993. My education includes science (BS Physics, Pre-med, Nuclear Engineering graduate school, and IT professional coursework) and business (MBA Marketing, graduate studies in Marketing and Strategy) from 7 universities. I have written US Patents on behalf of inventors who developed anti-viral, anti-bacterial, and other immunological effects. Currently, I lead the materials science Product Development efforts of a WA state clean energy venture. I review on a daily basis the many observational studies and Randomized Control Trials from select nations concerning COVID.

These reviews have included:

* Evidence comparing Vaccine immunity vs Natural Immunity.
* Breakthrough infection rates by immunity class (No Vaxx, Vaxx only, Natual Immunity Only, Vaxx after recovery from infection).
* Symptom and infection severity by Variant
* Viral load and transmissivity by immunity class.
* Infection rates and clinical outcomes by age group.
* Vaccine Adverse Effects (UK Yellow Card System, US VAERS, etc.)
* Infection and severity of symptoms serum nutrient content {Vit A, Vit D, Vit C, Vit K, Zinc, Iron}

DISCLAIMER

I am not a physician nor an academically-certified virologist nor nutritionist. My comments are not intended to make claims nor to provide advice.

COMMENTS FOR YOUR CONSIDERATION

Prudent policy decisions are always a risk-reward (or cost-benefit) trade-off. There literally is no free lunch. I suggest strongly that your deliberation consider the following facts:

* Herd immunity occurs when nearly all community members have immunity.
* Omicron is now outcompeting other variants. People get infected with OMICRON rather than Delta, Alpha, Beta etc.
* Omicron will likely infect everyone.
* Young people, unvaccinated, are most likely to be asymptomatic,

and acquire natural immunity superior to vaccine immunity.

* Young people, regardless of immunity class, will infect teachers and parents with OMICRON regardless of their immunity class.
* Unless the policy for IM injection returns to the international best practice of aspirating the syringe after insertion, young people will be placed at a statistical rick of adverse side effects (from injection into the vascular system) that is greater than the risk of severe infection from COVID.

ADVICE:

* Let the Omicron variant run its course, and monitor new variants for infection and severity.
* Do NOT mandate COVID vaccines as a condition of participation in classrooms.
* The risk TO unvaccinated and BY unvaccinated students is acceptable. The reward of vaccination is outweighed by the adverse affects, discrimination against children, and the further invasion of patient rights by government.

I am available for discussion should follow-up be desired.

Strength and Honor

John Anderson
MOBILE: (253) 459-3447

February 22, 2022

Rochelle P. Walensky, MD, MPH
Director, Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30329

Anthony S. Fauci, MD
Director, National Institute of Allergy and Infectious Diseases
National Institutes of Health
31 Center Dr # 7A03
Bethesda, MD 20892

Honorable Senator Ronald H. Johnson
328 Hart Senate Office Building
Washington DC 20510

Douglas L. Parker,
Assistant Secretary of Labor for Occupational Safety and Health
Occupational Safety & Health Administration
200 Constitution Ave NW
Washington, DC 20210

Mr. Jeffrey Zients
Coordinator and Counselor to the President
COVID-19 Pandemic Response
The White House
1600 Pennsylvania Ave. NW
Washington, DC 20500

Sent via US Mail Certified Return Receipt and e-mail

Re: Request for Immediate Corrections to the CDC Guidance on Masks and Respirators

Dear Dr. Walensky, Dr. Fauci, Senator Johnson, Mr. Parker, and Mr. Zients:

We the undersigned, professional experts in the field of industrial hygiene, with combined experience of nearly 150 years, are highly concerned with the inaccurate and misleading guidance being promoted by the CDC on its website regarding efficacy of masking to prevent COVID-19 and now similar guidance regarding respirators and request for immediate correction to said guidance. The guidance is overly broad, inaccurate, and especially inappropriate for children and the general public.

For reference, the field of industrial hygiene is defined as:

> *"That science and art devoted to the anticipation, recognition, evaluation, and control of those environmental factors or stressors arising in or from the workplace, which may cause sickness, impaired health and well-being, or significant discomfort among workers or among of the citizens of the community" (https://www.aiha.org/about-ih/Pages/default.aspx).*

The AIHA defines an Industrial Hygienist (https://www.aiha.org/ih-careers/discover-industrial-hygiene) as:

> *"Scientists and engineers committed to protecting the health and safety of people in the workplace and the community."*

Thus, our profession is dedicated, in part, to providing controls to exposures and rely upon what is known as the hierarchy of controls. The hierarchy of controls was first developed by the National Safety Council (NSC) in 1950. This guides us as to the most effective to least effective exposure controls (see Figure 1):

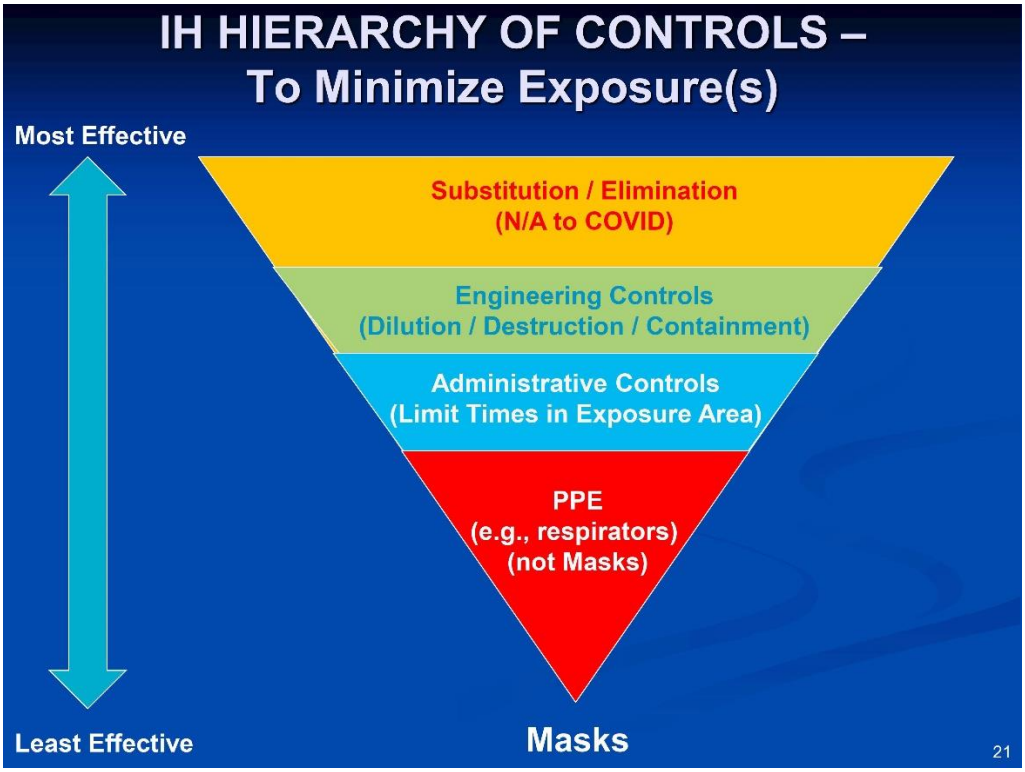
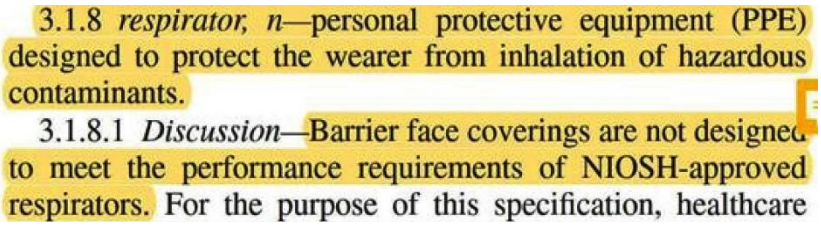


Figure 1: Hierarchy of Controls

Note that masks do not fit into the hierarchy of controls simply because they are not even personal protective equipment. This is recognized in the recent ASTM Face Covering (mask) Standard [ASTM F3502-21 – Standard Specification for Barrier Face Coverings (BFCs)] illustrated in Figure 2:



3.1.8 *respirator, n*—personal protective equipment (PPE) designed to protect the wearer from inhalation of hazardous contaminants.

3.1.8.1 *Discussion*—Barrier face coverings are not designed to meet the performance requirements of NIOSH-approved respirators. For the purpose of this specification, healthcare

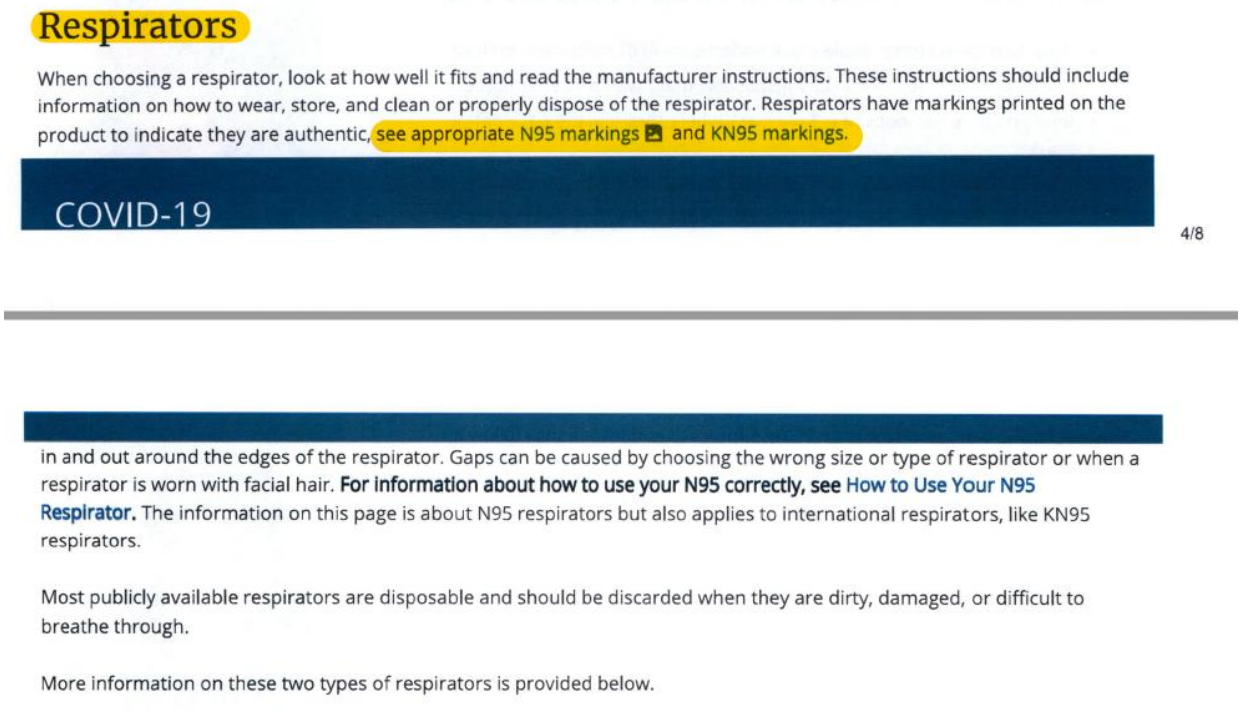
Figure 2: ASTM 2021 BFC Standard – Masks Not PPE (Respirators)

The best industrial hygiene solution has for decades been engineering controls of dilution with fresh air, filtration, and/or destruction – all of which are readily available technologies.

Given this background, we the undersigned have been increasingly concerned about the mis-information provided by the CDC to the public; often reflected by inappropriately conclusive language that *omits technical limitations and documented negative effects associated with masks and face coverings*. Examples of our concerns follow:

Issue #1: Recommending N-95 type masks is inappropriate for the general population and children:

The CDC's January 14, 2022 and January 28, 2022 webpage language have instructed people to move away from masks and toward N95-type respirators (see for example https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html), including KN95 respirators (Figure 3):



Respirators

When choosing a respirator, look at how well it fits and read the manufacturer instructions. These instructions should include information on how to wear, store, and clean or properly dispose of the respirator. Respirators have markings printed on the product to indicate they are authentic, see appropriate N95 markings and KN95 markings.

COVID-19

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in and out around the edges of the respirator. Gaps can be caused by choosing the wrong size or type of respirator or when a respirator is worn with facial hair. **For information about how to use your N95 correctly, see** How to Use Your N95 Respirator. The information on this page is about N95 respirators but also applies to international respirators, like KN95 respirators.

Most publicly available respirators are disposable and should be discarded when they are dirty, damaged, or difficult to breathe through.

More information on these two types of respirators is provided below.

Figure 3: CDC January 14 & January 28, 2022 Guidance on Respirators – pgs. 4-5

Under the topic of respirators, the CDC lists both N95 and KN95 respirators.

Moreover, as the CDC knows, persons or entities providing respirators in the workplace (unlike masks) must follow OSHA's Personal Protective Equipment Standard (OSHA 29 CFR 1910.132) to establish the nature of the hazard (Hazards Assessment) and the Respiratory Protection Standard (RPS) requirements (29 CFR 1910.134). Non-employees must also follow the RPS under the manufacturers' instructions (as we shall show later). These RPS requirements are substantial and include factors such as:

- Written RPS Plan
- Medical Clearance
- Initial Fit Test
- Annual Fit Test
- Training by a professional such as an IH on fit testing, cleaning, storage, and changeout.

As the CDC knows, or should know, movement from masks to respirators comes with significant requirements or as the manufacturers such as 3M state on their instructions, improper usage "may result in sickness or death".

In this context, we have recently been provided by the following request, and rejection by OSHA, to investigate improper usage of KN respirators by an employer (Figure 4):

U.S. Department of Labor

Occupational Safety and Health Administration
Toledo Area Office
420 Madison Ave, Suite 600
Toledo, OH 43604

February 9, 2022

[redacted]

RE: OSHA Complaint No. 1864651

Dear [redacted]

The Occupational Safety and Health Administration (OSHA) has received your notice of alleged workplace hazard(s) against notified Gun Lake Casino. After careful review we have decided not to conduct an inspection because:

On the basis of the information provided to our office during our phone conversation the employer has provided and is requiring employees to wear KN95 masks which are not NIOSH certified respirators and would not be covered by OSHA's respiratory protection standard.

If you do not agree with this decision, you may contact me for a clarification of the matter at (419) 259-7542.

Section 11(c) of the OSH Act provides protection for employees against discrimination because of their involvement in protected safety and health related activity. If you believe you are being treated differently or action is being taken against you because of your safety or health activity, you may file a complaint with OSHA. You should file this complaint as soon as possible, since OSHA normally can accept only those complaints filed within 30 days of the alleged discriminatory action.

Thank you for your concern for a safe and healthful workplace.

Respectfully,

For

Todd Jensen
Area Director

Figure 4: OSHA February 9, 2022 Response Letter to Gun Lake Casino Complaint

OSHA rejected the employee complaint on a technicality that the employer was not following the OSHA RPS because the respirator was a KN95 rather than an N95. And, as shown in Figure 5, NIOSH does not approve KN95's:

CDC Centers for Disease Control and Prevention

Promoting productive workplaces through safety and health research NIOSH

NIOSH-approved N95 Particulate Filtering Facepiece Respirators

This list is reviewed and updated weekly.

Manufacturers Listed from A to Z – L

The N95 respirator is the most common of the seven types of particulate filtering facepiece respirators. This product filters at least 95% of airborne particles but is not resistant to oil-based particles.

This web page provides a table of NIOSH-approved N95 respirators listed by manufacturer from A-Z. You can find a specific manufacturer by clicking on the first letter of their name on the index below. Web links in the table go to the NIOSH Approval Holder's website. See the Notes section for information about private labels.

NIOSH entered a Memorandum of Understanding (MOU) in 2018 with the Food and Drug Administration (FDA). This MOU granted NIOSH the authority to approve surgical N95 filtering facepiece respirators. Prior to this MOU, both NIOSH and FDA approved and cleared surgical N95s. The **Model Number/Product Line in bold text followed by (FDA)** indicates these surgical N95 respirators in the table below. NIOSH also provides a table of the surgical N95 respirators approved prior to the MOU. Surgical N95 respirators approved under the MOU do not require FDA's 510(k) clearance. These NIOSH-approved surgical N95 respirators are only on the Certified Equipment List (CEL).

A respirator labeled as a KN95 respirator is expected to conform to China's GB2626 standard. NIOSH does not approve KN95 products or any other respiratory protective devices certified to international standards. For more information, view Factors to Consider When Planning to Purchase Respirators from Another Country.

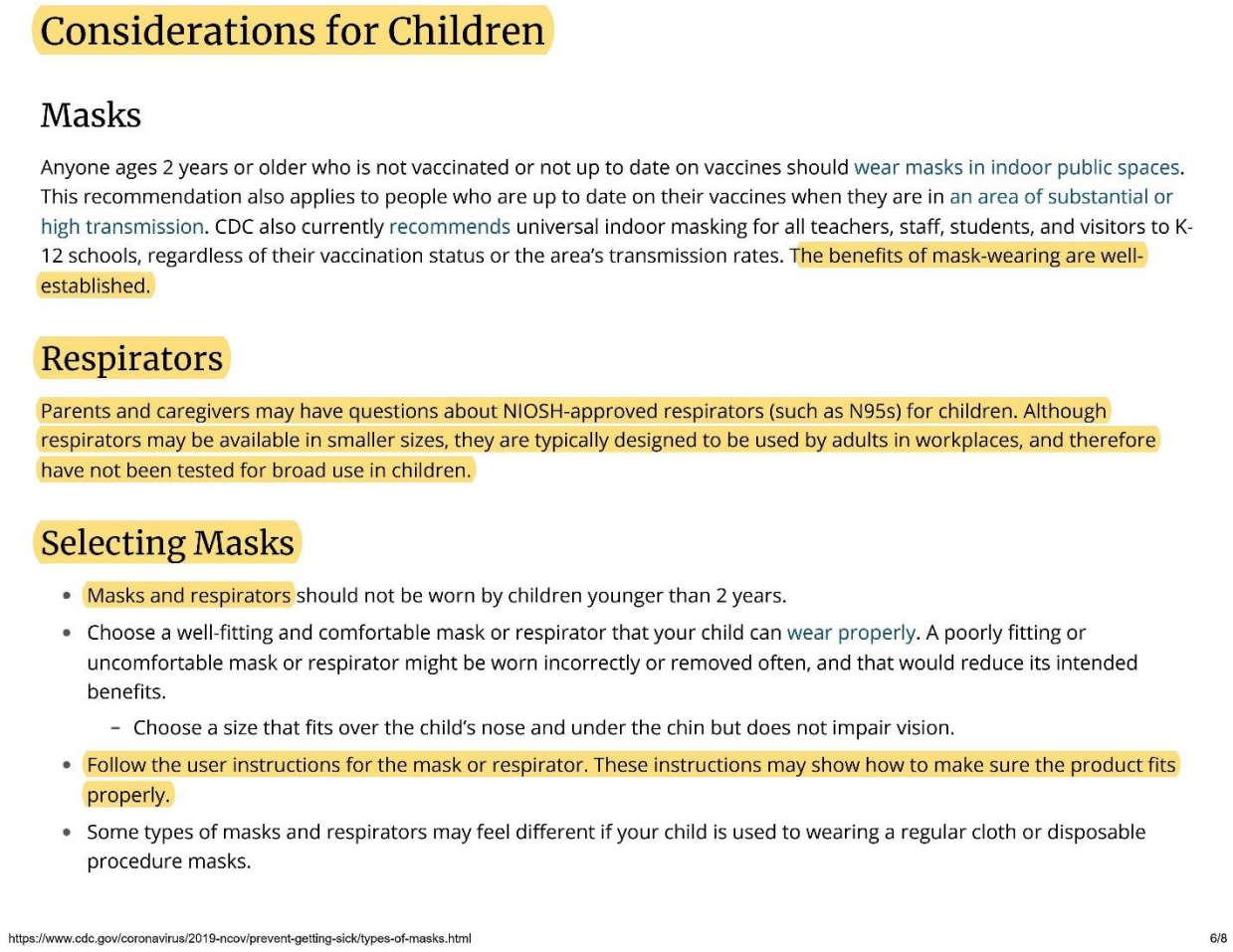
Figure 5: NIOSH Language Regarding Approval of KN95 Respirators

So, in an obvious case of deception, the CDC recommends the usage of N95 and KN95 respirators (see Figure 3) yet must know they are not approved by NIOSH and that OSHA will not enforce the RPS. The irony here is that NIOSH is part of the CDC (see Figure 5 letterhead), so the CDC clearly knows this. Note that it is known that KN95 respirators from China are known to be less expensive than those made with the N95 designation and find widespread usage; this too was known, or should have been known, by the CDC.

Thus, the CDC pushes KN95 respirators as part of the move toward respirators, knowing they are not approved by their sub-agency NIOSH, which allows employers to make employees wear respirators without the protections of OSHA's Respiratory Protection Standard (RPS). This is an unconscionable breach of the public health function and should be corrected immediately.

Issue #2: CDC has issued harmful guidance for masking children that contradicts manufacturers' recommendations, world-wide standard practice and CDC's own guidance, and without appropriate risk-benefit analysis:

The CDC's January 28, 2022 webpage language misleadingly implies respirators are acceptable for children yet knows that this is not the case simply based on manufacturer instructions, they link the reader to https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html – see Figure 6:



Considerations for Children

Masks

Anyone ages 2 years or older who is not vaccinated or not up to date on vaccines should wear masks in indoor public spaces. This recommendation also applies to people who are up to date on their vaccines when they are in an area of substantial or high transmission. CDC also currently recommends universal indoor masking for all teachers, staff, students, and visitors to K-12 schools, regardless of their vaccination status or the area's transmission rates. The benefits of mask-wearing are well-established.

Respirators

Parents and caregivers may have questions about NIOSH-approved respirators (such as N95s) for children. Although respirators may be available in smaller sizes, they are typically designed to be used by adults in workplaces, and therefore have not been tested for broad use in children.

Selecting Masks

- Masks and respirators should not be worn by children younger than 2 years.
- Choose a well-fitting and comfortable mask or respirator that your child can wear properly. A poorly fitting or uncomfortable mask or respirator might be worn incorrectly or removed often, and that would reduce its intended benefits.
  - Choose a size that fits over the child's nose and under the chin but does not impair vision.
- Follow the user instructions for the mask or respirator. These instructions may show how to make sure the product fits properly.
- Some types of masks and respirators may feel different if your child is used to wearing a regular cloth or disposable procedure masks.

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html 6/8

Figure 6: Misleading CDC Language Regarding Children Wearing Masks and Respirators

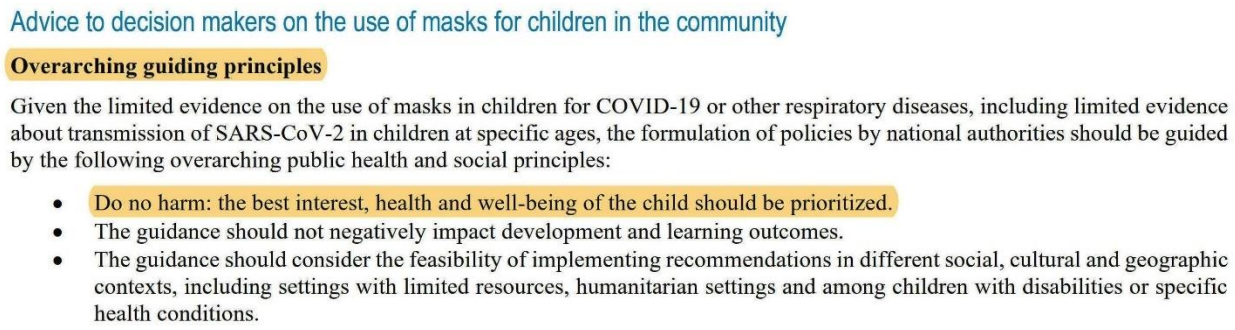
As illustrated in detail below, the CDC provided language in its January 28, 2022 guidance for children that is particularly misleading by obfuscating and omitting information readily known, or likely to have been known by the CDC.

<u>"The benefits of mask-wearing are well-established:"</u>

First, the benefits of children, or anyone for that matter, of wearing masks being well

established is simply false. A Brownstone paper by Paul Elias Alexander published December 21, 2021 (https://brownstone.org/articles/more-than-150-comparative-studies-and-articles-on-mask-ineffectiveness-and-harms/) shows both the effectiveness of masks and their harms, citing 150 studies. One of these author's testified in the Western District Court of Michigan on September 28, 2021, in a half-dozen interviews (e.g., Jeff Hayes Films: https://rumble.com/vrfoox-covid-revealed-episode-8b-bonus-video-stephen-petty.html), in his own podcasts (https://rumble.com/c/PettyPodcasts) and in the Liberty Dispatch in Canada (https://podcasts.apple.com/us/podcast/episode-99-masks-dont-work-an-interview-with-ppe/id1559570986?i=1000550149187). During this testimony it was shown that the nearly 50 studies cited by the CDC purportedly showing masks are effective did not support statements made by the CDC and most suffered from a lack of a control group (group similar to the mask study group not wearing masks) or cofounding factors (multiple factors such as changes in HVAC systems, distancing, quarantining, and masks) wherein one cannot determine the specific contribution by masking.

But the most egregious part of this statement is that it only addresses supposed benefits, not liabilities. Even the WHO - UNICEF (https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC_Masks-Children-2020.1) understands that risk-rewards analysis should be done before recommending unproven, unscientifically-supported policies before masking them. Remember – do no harm – is the overarching principle (Figures 7 & 8):



Advice to decision makers on the use of masks for children in the community

Overarching guiding principles

Given the limited evidence on the use of masks in children for COVID-19 or other respiratory diseases, including limited evidence about transmission of SARS-CoV-2 in children at specific ages, the formulation of policies by national authorities should be guided by the following overarching public health and social principles:

- Do no harm: the best interest, health and well-being of the child should be prioritized.
- The guidance should not negatively impact development and learning outcomes.
- The guidance should consider the feasibility of implementing recommendations in different social, cultural and geographic contexts, including settings with limited resources, humanitarian settings and among children with disabilities or specific health conditions.

Figure 7: WHO UNICEF Recommendations for Children and Masks

From Figure 7, the overarching guiding principle is to do no harm.

Advice on the use of masks in children

WHO and UNICEF advise decision makers to apply the following criteria for use of masks in children when developing national policies, in countries or areas where there is known or suspected community transmission[a] of SARS-CoV-2 and in settings where physical distancing cannot be achieved.

1. Based on the expert opinion gathered through online meetings and consultative processes, children aged up to five years should not wear masks for source control. This advice is motivated by a "do no harm" approach and considers:
    - childhood developmental milestones[b] [41]
    - compliance challenges and
    - autonomy required to use a mask properly.

The experts (following the methods described above) recognized that the evidence supporting the choice of the age cut-off is limited (see above, section related to transmission of COVID-19 in children), and they reached this decision mainly by consensus. The rationale included consideration of the fact that by the age of five years, children usually achieve significant developmental milestones, including the manual dexterity and fine motor coordination movements needed to appropriately use a mask with minimal assistance.

In some countries, guidance and policies recommend a different and lower age cut-off for mask use[42-45]. It is recognized that children may reach developmental milestones at different ages and children five years of age and under may have the dexterity needed to manage a mask. Based on the do no harm approach, if the lower age cut-off of two or three years of age is to be used for recommending mask use for children, appropriate and consistent supervision, including direct line of sight supervision by a competent adult and compliance need to be ensured, especially if mask wearing is expected for an extended period of time. This is both to ensure correct use of the mask and to prevent any potential harm associated with mask wearing to the child.

Children with severe cognitive or respiratory impairments who have difficulties tolerating a mask should, under no circumstances, be required to wear masks.

Other IPC, public health and social measures should be prioritized to minimize the risk of SARS-CoV-2 transmission for children five years of age and under; specifically maintaining physical distance of at least 1 meter where feasible, educating children to perform frequent hand hygiene and limiting the size of school classes. It is also noted that there may be other specific considerations, such as the presence of vulnerable persons or other local medical and public health advice that should be considered when determining if children five years of age and under need to wear a mask.

2. For children between six and 11 years of age, a risk-based approach should be applied to the decision to use of a mask. This approach should take into consideration:
    - intensity of transmission in the area where the child is and updated data/available evidence on the risk of infection and transmission in this age group;
    - social and cultural environment such as beliefs, customs, behaviour or social norms that influence the community and population's social interactions, especially with and among children;
    - the child's capacity to comply with the appropriate use of masks and availability of appropriate adult supervision;
    - potential impact of mask wearing on learning and psychosocial development; and
    - additional specific considerations and adaptions for specific settings such as households with elderly relatives, schools, during sport activities or for children with disabilities or with underlying diseases.

3. Advice on mask use in children and adolescents 12 years or older should follow the WHO guidance for mask use in adults[1] and/or the national mask guidelines for adults.

    Even where national guidelines apply, additional specific considerations (see below) and adaptions for special settings such as schools, during sport, or for children with disabilities or with underlying diseases will need to be specified.

Figure 8: WHO UNICEF Recommendations for Children and Masks by Age

Note that from Figure 8, WHO recommends against masking below age 6 and that children ages 6 to 11 may be masked upon completion of a risk assessment. England has similar guidance. But the CDC requires masks for children down to age 2 against WHO guidance and based on extensive reviews, has yet to perform any risk assessment on the net benefits of children wearing masks.

Specifically, it is well established that significant harms (i.e., reduced learning and development and physical, emotional, and social harms) have been reported in the literature (Figures 9-18):

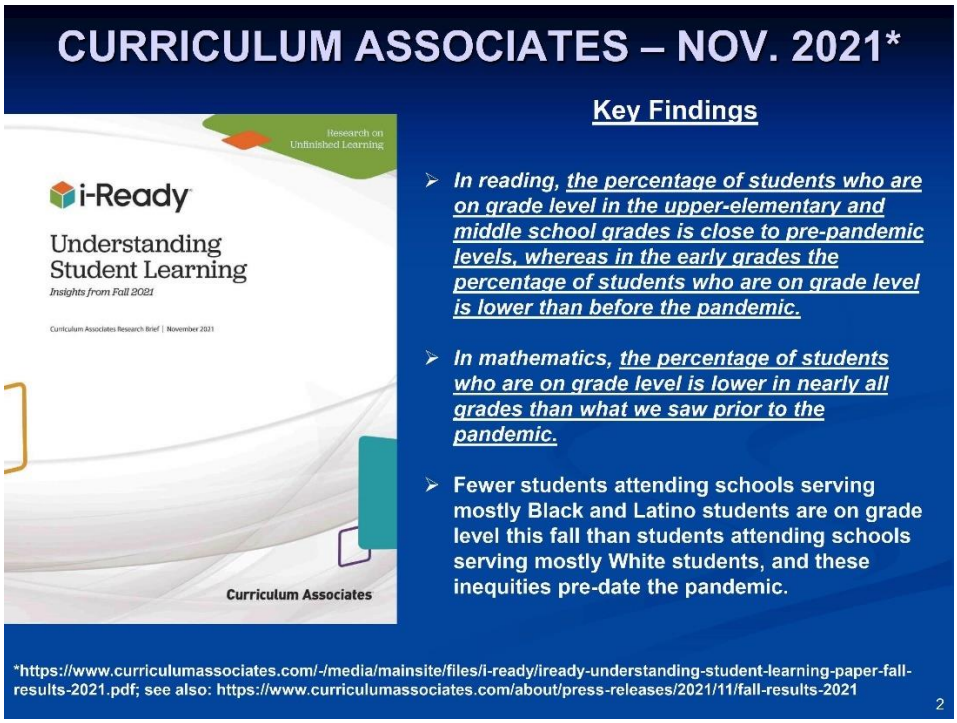


Figure 9: Curriculum Associates – Nov. 2021 – Title Page

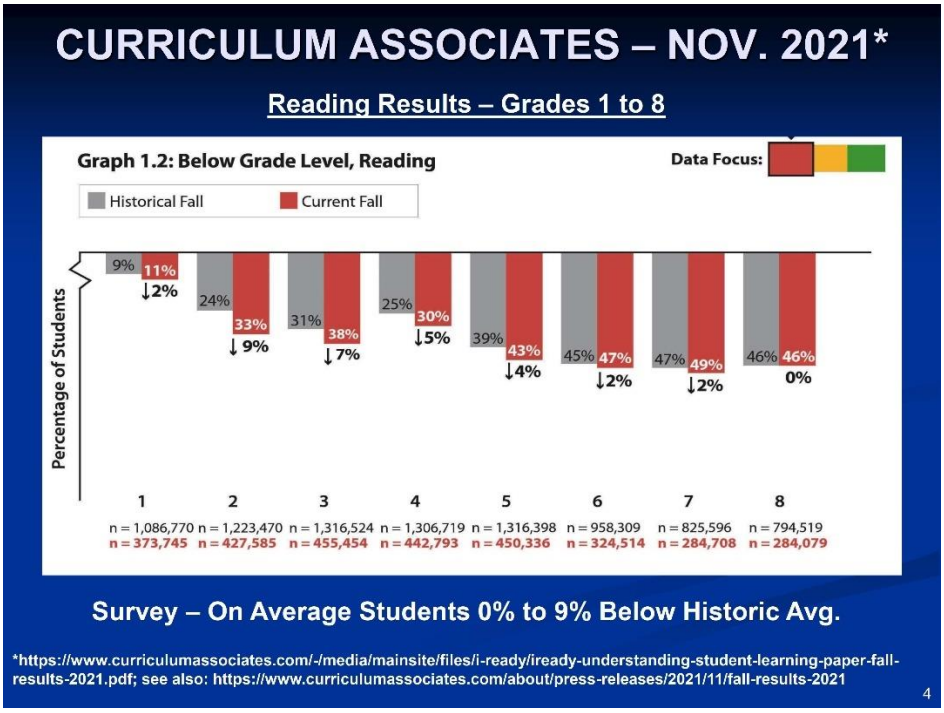


Figure 10: Curriculum Associates – Reading Deficits in 2021 vs. Prior Years

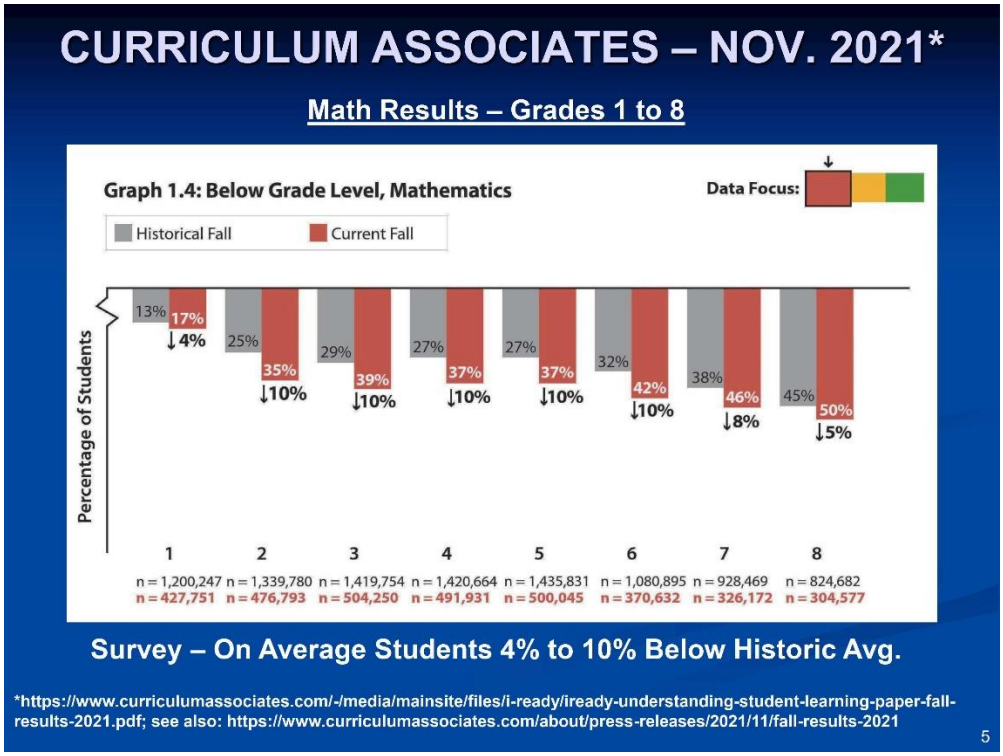


Figure 11: Curriculum Associates – Math Deficits in 2021 vs. Prior Years

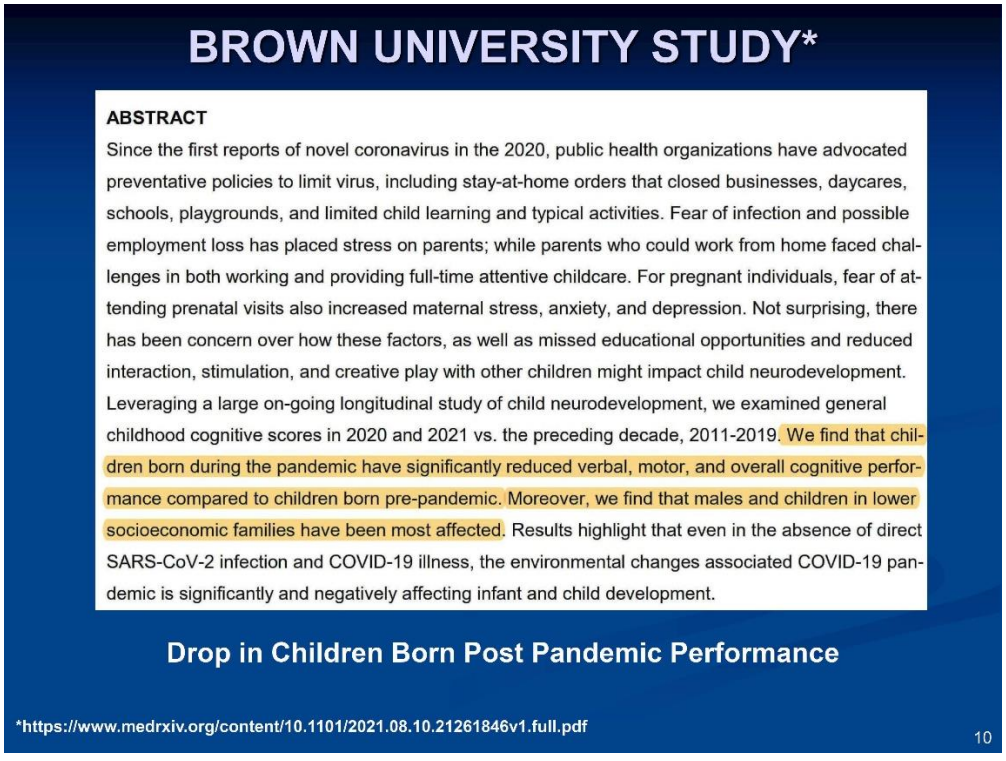


Figure 12: Brown University – Cognitive Deficits

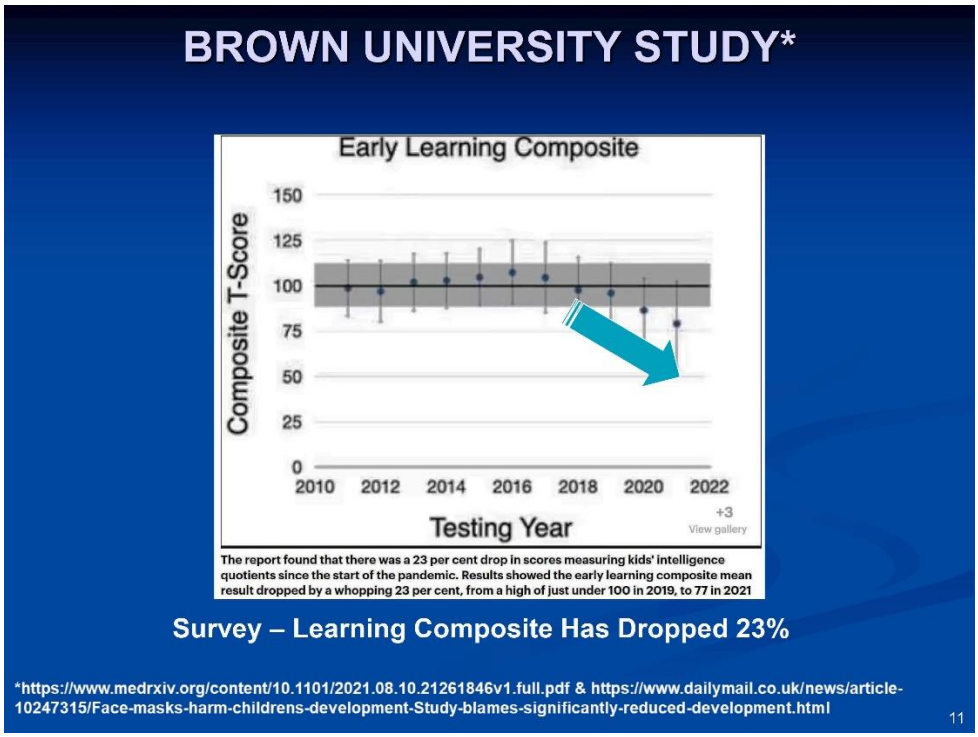


Figure 13: Brown University Study – Learning Loss of 23% for Children Born Since Pandemic

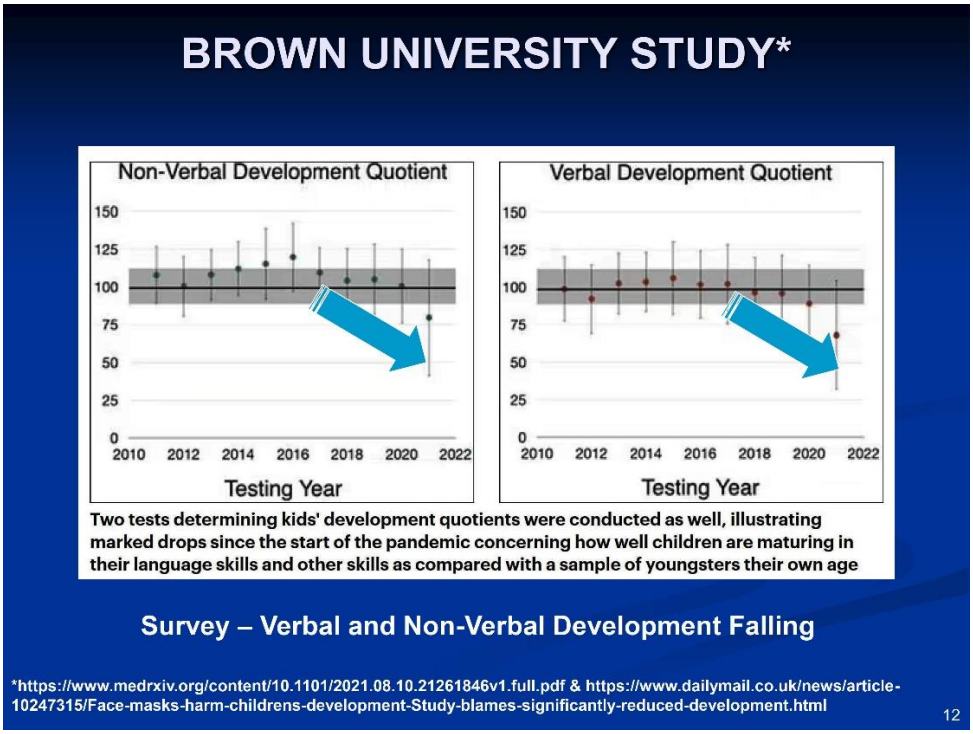


Figure 14: Brown University Study – Non-Verbal and Verbal Development Losses

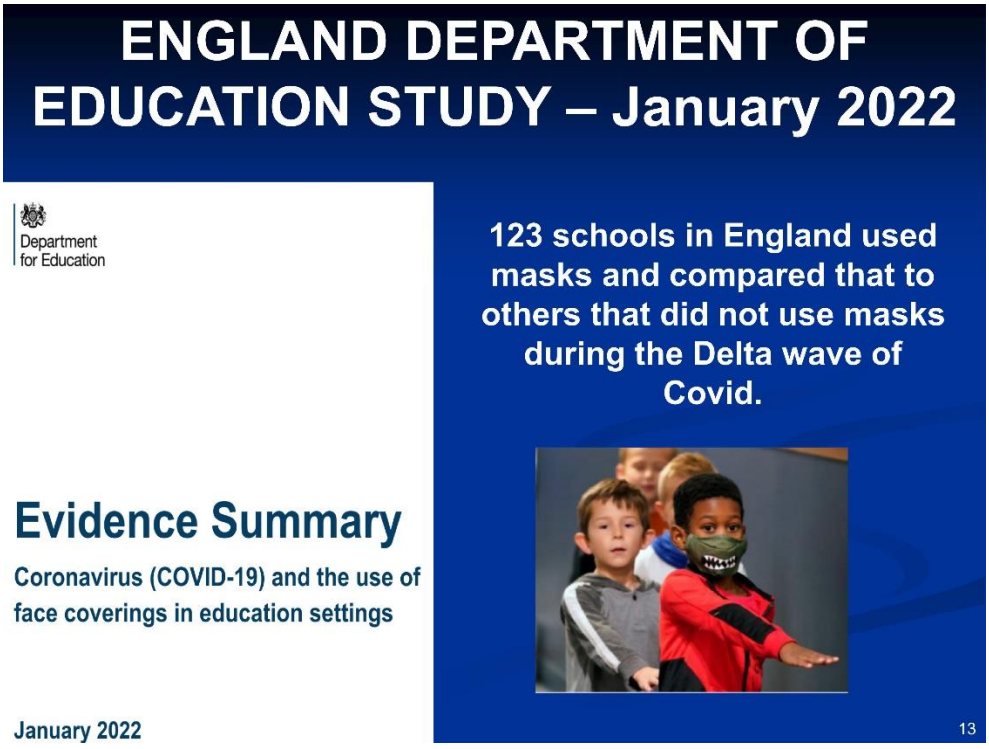


Figure 15: England Department of Education

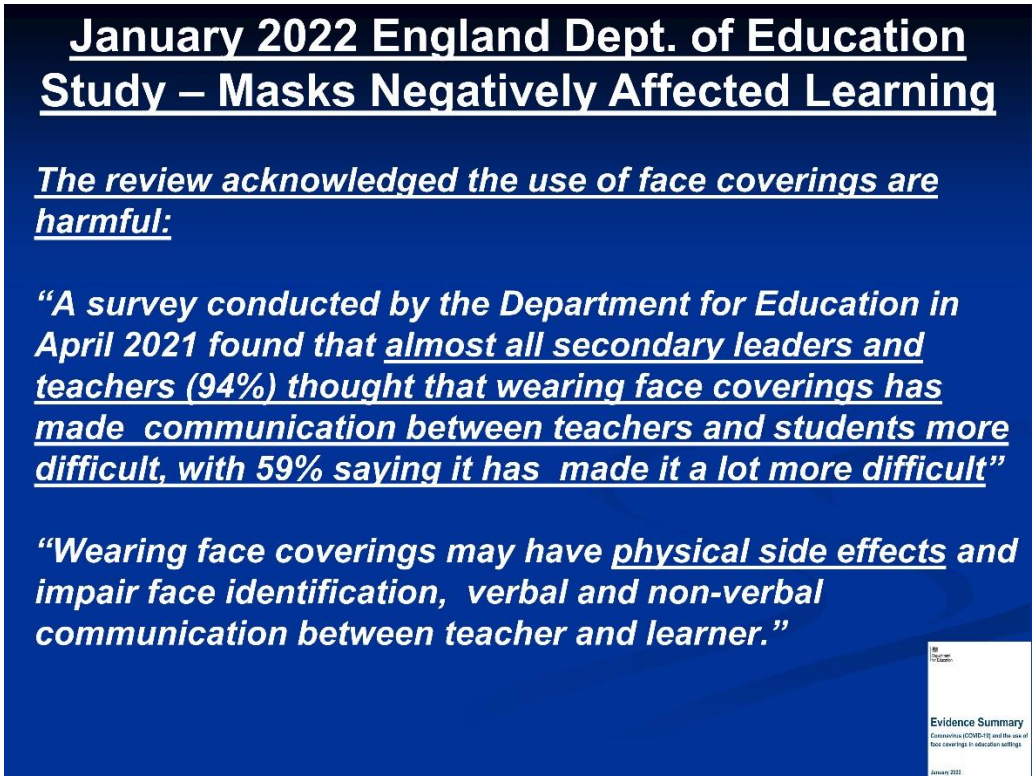


Figure 16: England Department of Education – Loss of Communication and Physical Effects

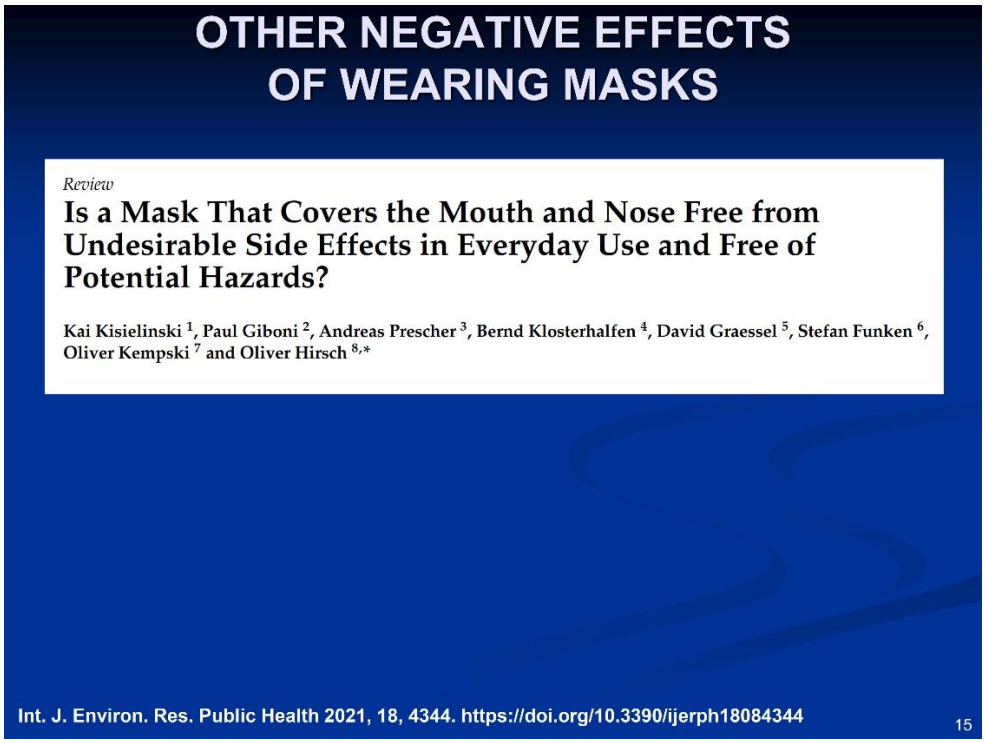


Figure 17: Kisielinski et al. – Mask Meta Study – Reviewed 1,226 Studies

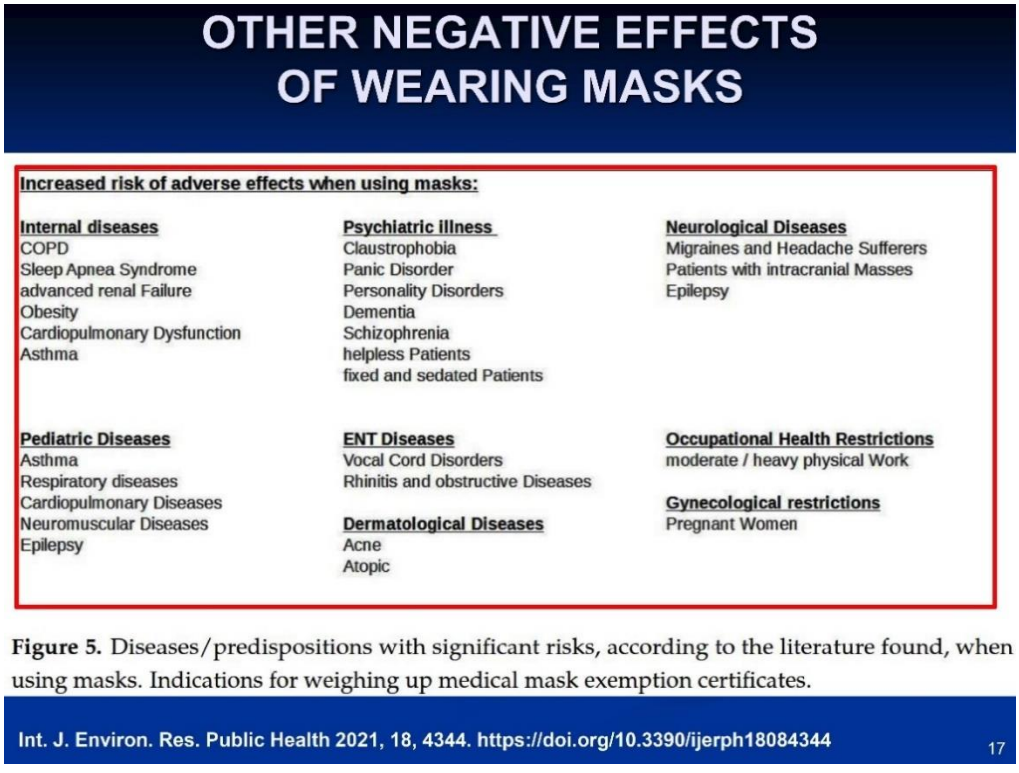


Figure 18: Kisielinski et al., – Areas of Quantitated Adverse Effects on Children and Adults

Clearly, the CDC has not conducted a net risk assessment and should have, and must do so to avoid continuing harms to children.

Even more disturbing, in their innocent looking, new Guidance for Children (Learn the Signs, Act Early) the CDC has in part, extended the timeframes for children to achieve learning outcomes (https://www.cdc.gov/ncbddd/actearly/milestones/index.html). Regarding these changes – Figure 19, CDC refers the reader to an American Academy of Pediatrics (AAP) webpage (https://publications.aap.org/pediatrics/article-abstract/doi/10.1542/peds.2021-052138/184748/Evidence-Informed-Milestones-for-Developmental?redirectedFrom=fulltext):

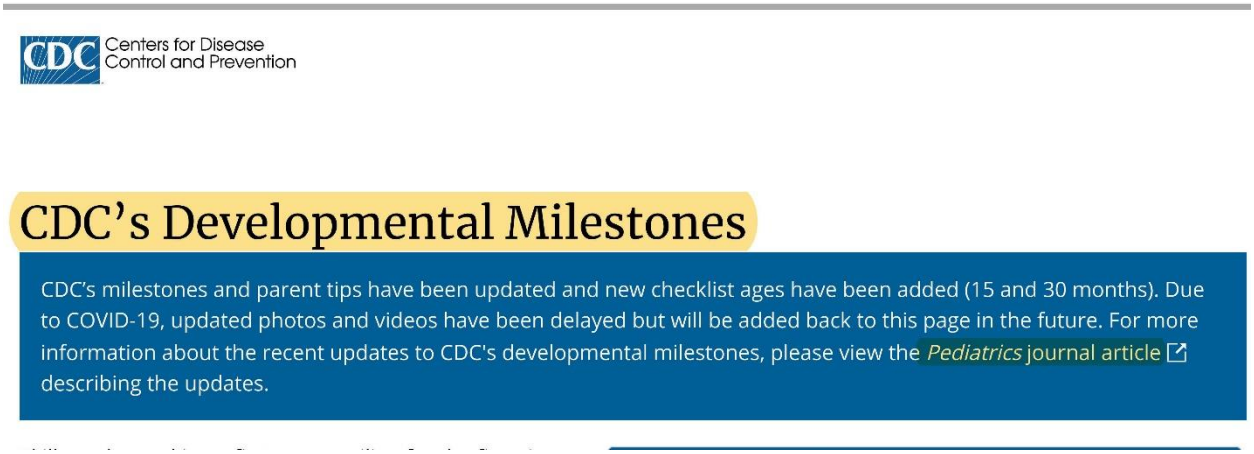


Figure 19: CDC Learn the Signs, Act Early New Webpage – Reference to AAP

The headlines for the reference paper are reproduced as Figure 20:

Figure 20: CDC Referenced AAP Paper by Zubler (CDC) et al. Dated February 8, 2022

Zubler et al., write in part:

"*The Centers for Disease Control and Prevention's (CDC) Learn the Signs. Act Early. program, funded the American Academy of Pediatrics (AAP) to convene an expert working group to revise its developmental surveillance checklists*. The goals of the group were to identify evidence-informed milestones to include in CDC checklists, clarify when most children can be expected to reach a milestone (to discourage a wait-and-see approach), and support clinical judgment regarding screening between recommended ages. Subject matter experts identified by the AAP established 11 criteria for CDC milestone checklists, including using milestones most children (≥75%) would be expected to achieve by specific health supervision visit ages and those that are easily observed in natural settings. A database of normative data for individual milestones, common screening and evaluation tools, and published clinical opinion was created to inform revisions. ***Application of the criteria established by the AAP working group and adding milestones for the 15- and 30-month health supervision visits resulted in a 26.4% reduction and 40.9% replacement of previous CDC milestones***. ***One third of the retained milestones were transferred to different ages; 67.7% of those transferred were moved to older ages.*** *Approximately 80% of the final milestones had normative data from ≥1 sources*. Social-emotional and cognitive milestones had the least normative data. These criteria and revised checklists can be used to support developmental surveillance, clinical judgment regarding additional developmental screening, and research in developmental surveillance processes. Gaps in developmental data were identified particularly for social-emotional and cognitive milestones.

Thus, at least 22.3% [67.7% of 33%] of the CDC child developmental milestones in place for ~18 years, were moved from a younger age to an older age in February 2022.

One must conclude the CDC, rather than acknowledging the harms being done to children's development by their COVID policies, including masking, is simply moving the goalposts for what constitutes normal child development rather than admitting and moving away from failed policies.

Statements under "Respirators" and "Selecting Masks":

- Parents and caregivers may have questions about NIOSH-approved respirators (such as N95s) for children. *Although respirators may be available in smaller sizes,* ***they are typically designed to be used by adults in workplaces****, and therefore have not been tested for broad use in children*.
- ***Masks and respirators should not be worn by children younger than 2 years.***
- Choose a size that fits over the child's nose and under the chin but does not impair vision. ***Follow the user instructions for the mask or respirator.*** *These instructions may show how to make sure the product fits properly.*

This language may be the most misleading and egregious given that the links CDC provides to manufacturers' instruction state that their N95s are not for use with children – the CDC has to know this.

The links to manufacturers' instructions from the January 28, 2022 mask and January 25, 2022 How to Use Your N95 Respirator are shown in Figures 21 and 22 respectively:

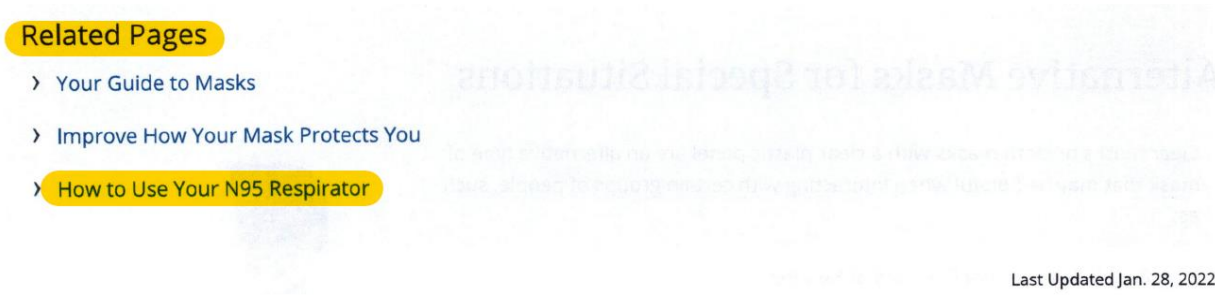


Figure 21: CDC January 28, 2022 Link – Bottom of Page and CDC January 25, 2022 Link to Manufacturers' Guidance and Warnings

The "How to Use Your N95 Respirator" is at the bottom of the CDC January 28, 2022 webpage.

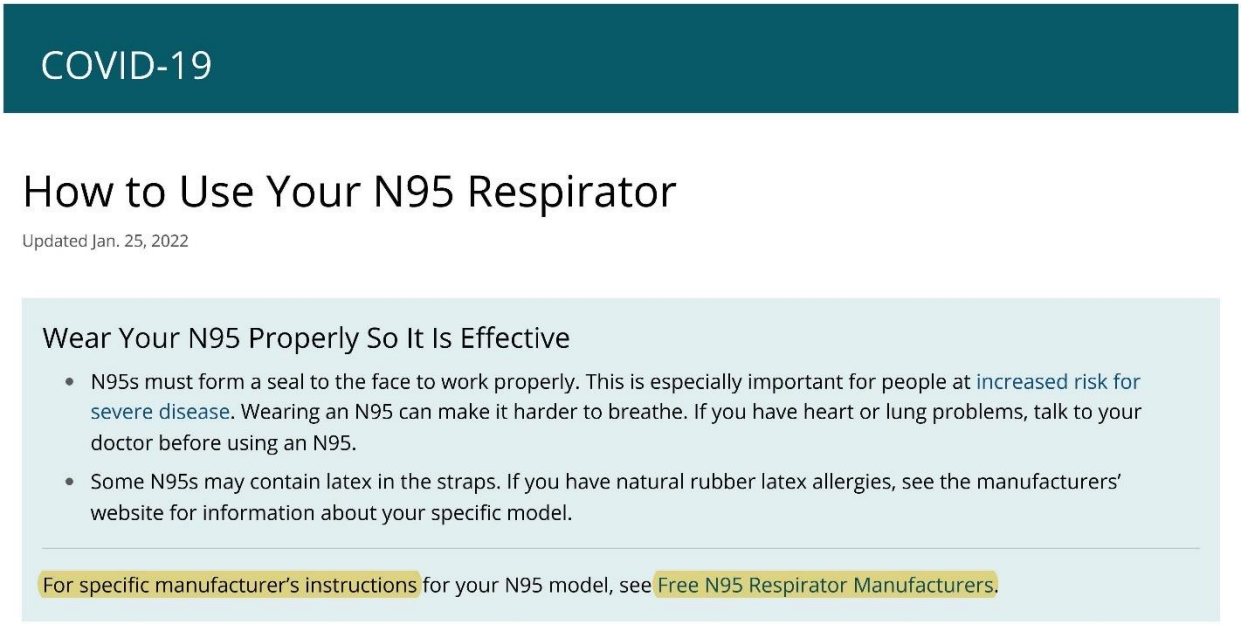


Figure 22: CDC January 15, 2022 Link to How to Use Your N-95 Respirator – Link to Manufacturers

The link in turn takes one to the following page (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/free-n95-manufacturers.html) (Figure 23):

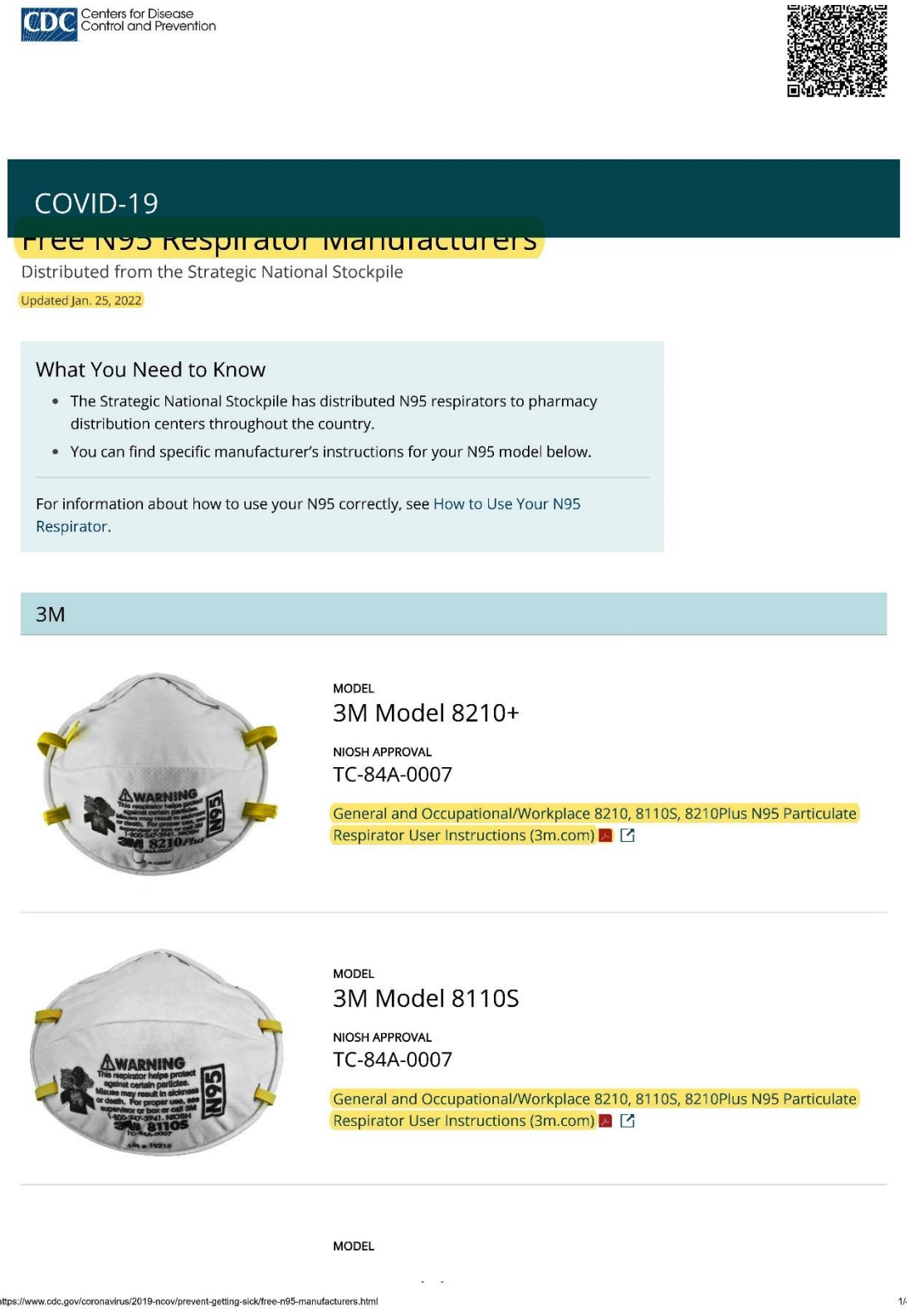


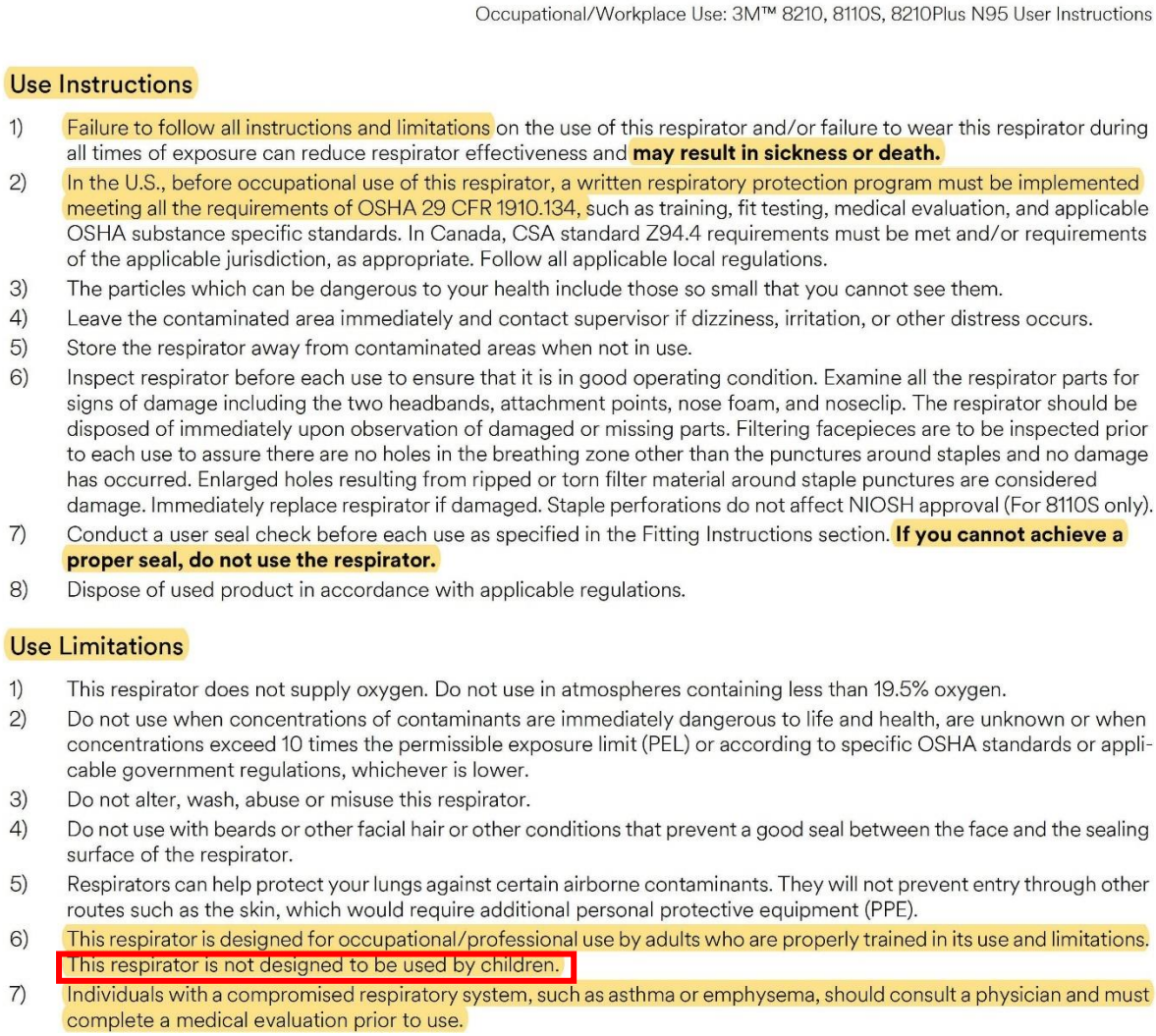
Figure 23: CDC January 15, 2022 Link to How to Use Your N-95 Respirator – Link to Manufacturers – pg. 1

From this webpage, four manufacturers are listed representing 12 respirators:

- 3M (6 models)
- Drager (1 model)
- Honeywell (2 models)
- Moldex (3 models).

For each model, the link can be clicked to get directly to the manufacturers' instructions for each respirator. For 3M and Moldex, major suppliers, only one set of instructions is used for each of their individually listed respirators. In other words, the same instructions were provided for each of the manufacturers' listed products.

Both 3M and Moldex explicitly state that their masks are not to be use by children (Figure 24).



Occupational/Workplace Use: 3M™ 8210, 8110S, 8210Plus N95 User Instructions

Use Instructions

1) Failure to follow all instructions and limitations on the use of this respirator and/or failure to wear this respirator during all times of exposure can reduce respirator effectiveness and **may result in sickness or death.**
2) In the U.S., before occupational use of this respirator, a written respiratory protection program must be implemented meeting all the requirements of OSHA 29 CFR 1910.134, such as training, fit testing, medical evaluation, and applicable OSHA substance specific standards. In Canada, CSA standard Z94.4 requirements must be met and/or requirements of the applicable jurisdiction, as appropriate. Follow all applicable local regulations.
3) The particles which can be dangerous to your health include those so small that you cannot see them.
4) Leave the contaminated area immediately and contact supervisor if dizziness, irritation, or other distress occurs.
5) Store the respirator away from contaminated areas when not in use.
6) Inspect respirator before each use to ensure that it is in good operating condition. Examine all the respirator parts for signs of damage including the two headbands, attachment points, nose foam, and noseclip. The respirator should be disposed of immediately upon observation of damaged or missing parts. Filtering facepieces are to be inspected prior to each use to assure there are no holes in the breathing zone other than the punctures around staples and no damage has occurred. Enlarged holes resulting from ripped or torn filter material around staple punctures are considered damage. Immediately replace respirator if damaged. Staple perforations do not affect NIOSH approval (For 8110S only).
7) Conduct a user seal check before each use as specified in the Fitting Instructions section. **If you cannot achieve a proper seal, do not use the respirator.**
8) Dispose of used product in accordance with applicable regulations.

Use Limitations

1) This respirator does not supply oxygen. Do not use in atmospheres containing less than 19.5% oxygen.
2) Do not use when concentrations of contaminants are immediately dangerous to life and health, are unknown or when concentrations exceed 10 times the permissible exposure limit (PEL) or according to specific OSHA standards or applicable government regulations, whichever is lower.
3) Do not alter, wash, abuse or misuse this respirator.
4) Do not use with beards or other facial hair or other conditions that prevent a good seal between the face and the sealing surface of the respirator.
5) Respirators can help protect your lungs against certain airborne contaminants. They will not prevent entry through other routes such as the skin, which would require additional personal protective equipment (PPE).
6) This respirator is designed for occupational/professional use by adults who are properly trained in its use and limitations. This respirator is not designed to be used by children.
7) Individuals with a compromised respiratory system, such as asthma or emphysema, should consult a physician and must complete a medical evaluation prior to use.

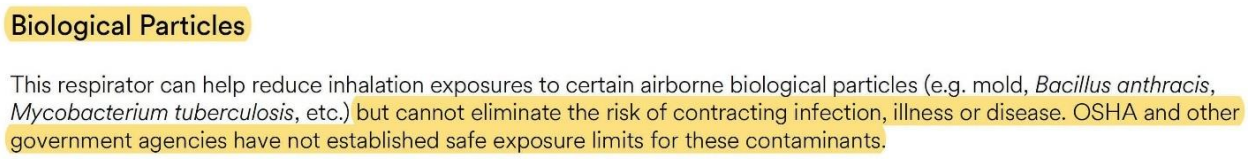
Figure 24: 3M Instructions for CDC Listed 3M N95 Respirators – Not Designed to be Used by Children

Note the following observations from Figure 24:

- ***This respirator is not designed to be used by children***!
- The respirator is only intended to be used for occupational or professional adults properly trained (e.g., under the RPS).
- Failure to follow instructions may result in sickness or death.
- A written respiratory protection plan, under the requirements of 29 CFR 1910.134 (RPS) must be in place prior to use of this respirator.

The Moldex instructions are essentially the same.

Moreover, 3M warns it is not protective against infectious diseases (Figure 25):



Biological Particles

This respirator can help reduce inhalation exposures to certain airborne biological particles (e.g. mold, *Bacillus anthracis*, *Mycobacterium tuberculosis*, etc.) but cannot eliminate the risk of contracting infection, illness or disease. OSHA and other government agencies have not established safe exposure limits for these contaminants.

5

Figure 25: 3M Instructions for CDC Listed 3M N95 Respirators – Not Protective Against Infection, Illness, or Disease

Note that anthrax and TB are much larger particles than virus particles like the COVID-19 virus.

In light of this discussion, the CDC should immediately correct their webpage stating explicitly that respirators, according to manufacturers' instructions, "Are not designed to be used by Children" and that anyone using a respirator must be doing so under a written respiratory protection plan that follows the OSHA RPS.

Issue #3: The CDC continues to ignore the fact that COVID-19 is primarily spread by aerosols (not droplets) making mask use mostly ineffective:

The CDC continues to make the misleading argument that masks stop COVID droplets. This is misleading because while masks do stop some droplets (> 50 to 10 micron), the vast majority of COVID particles are smaller aerosols (≤ 5 microns) – see Figure 26:

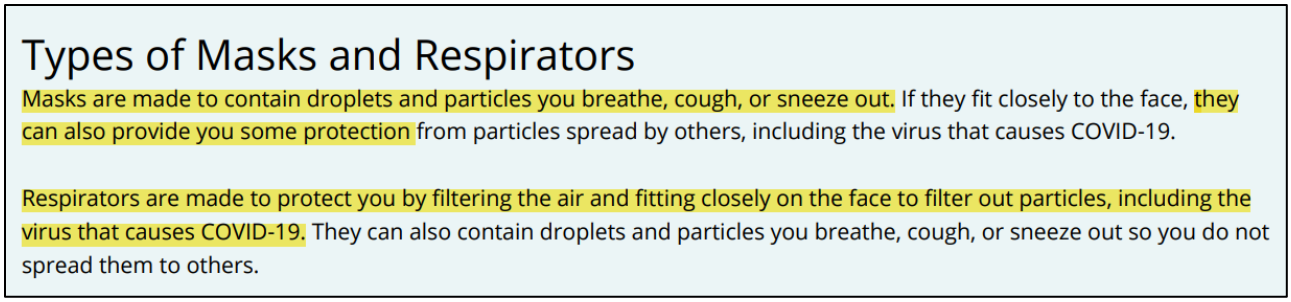


Figure 26: CDC – Misleading Guidance on Masks and Droplets

We are not the only ones who have written you regarding this issue. On February 15, 2021, the following scientists wrote a lengthy memo to you regarding your misleading language in this area and asked you to correct it:

- Rick Bright, PhD, Former Director of BARDA, Dept of Health and Human Services
- Lisa M. Brosseau, ScD, CIH, University of Minnesota CIDRAP
- Lynn R. Goldman, MD, MS, MPH, George Washington University
- Céline Gounder, MD, ScM, NYU Grossman School of Medicine & Bellevue Hospital Center
- Jose Jimenez, PhD, University of Colorado at Boulder
- Yoshihiro Kawaoka, DVM, PhD, University of Wisconsin-Madison and University of Tokyo
- Linsey Marr, PhD, Virginia Tech
- David Michaels, PhD, MPH, George Washington University
- Donald K. Milton, MD, DrPH, University of Maryland
- Michael Osterholm, PhD, MPH, University of Minnesota CIDRAP
- Kimberly Prather, PhD, University of California San Diego
- Robert T. Schooley, MD, University of California San Diego
- Peg Seminario, MS, AFL-CIO (retired)

They wrote in part:

> "To address and limit transmission via inhalation exposure and prevent COVID infections and deaths, we urge the Biden administration to take the following immediate actions:
>
> - Update and strengthen CDC guidelines to fully address transmission via inhalation exposure to *small inhalable particles* from infectious sources at close, mid and longer range. Updated guidelines should be informed by a risk assessment model that focuses on source and pathway (ventilation) controls first, followed by respiratory protection…

- *Issue an OSHA emergency standard on COVID-19 that recognizes the importance of aerosol inhalation, includes requirements to assess risks of exposure, and requires implementation of control measures following a hierarchy of controls*…

Edwards et al. (https://www.pnas.org/content/118/8/e2021830118) demonstrated that that the vast majority of COVID particles emitted during illness are aerosols not droplets (see Figure 27):

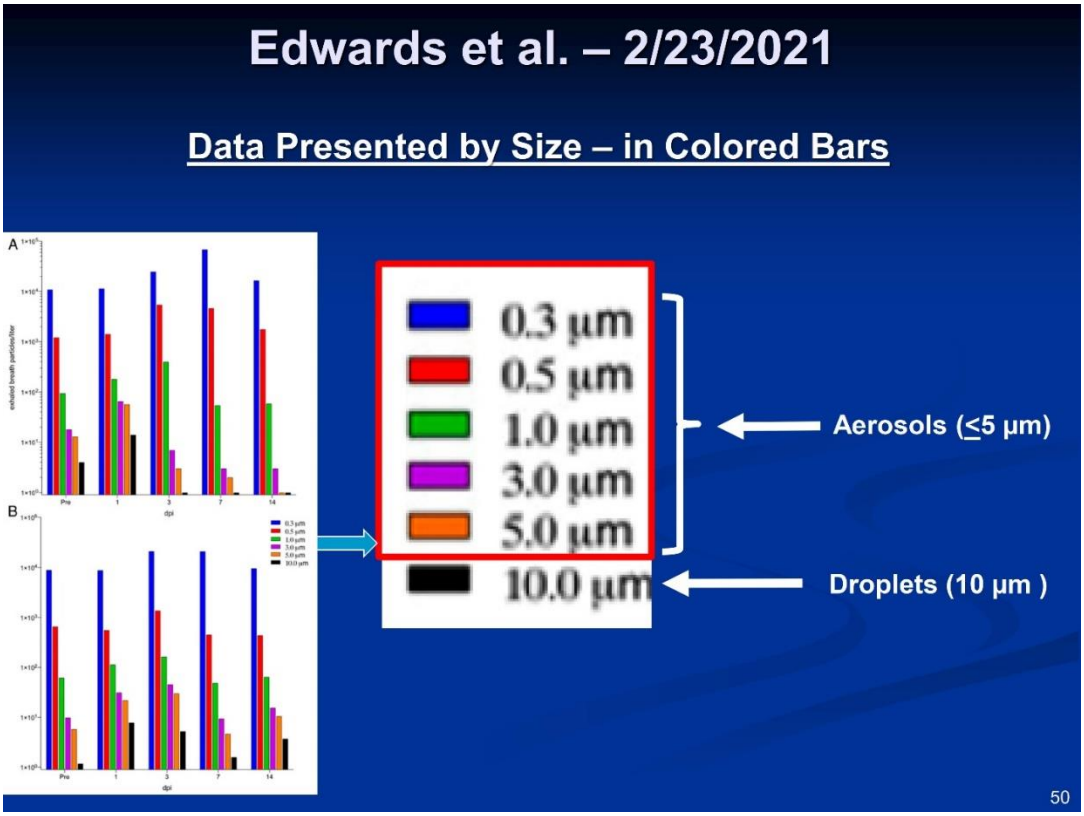


Figure 27: Edwards et al., 2021 – Particle Size Emissions by Size and Time

Edwards et al. concluded their paper with the following statements:

- Our finding that *the proportion of small respiratory droplets (i.e., aerosols) were the majority of particles exhaled in all subjects*.
- There may be an elevated risk of the airborne transmission of SARS CoV 2 by way of the very small droplets (aerosols) that transmit through conventional masks and *traverse distances far exceeding the conventional social distance of 2 m (~7').*
- Exhaled aerosol numbers appear to be not only an indicator of disease progression, *but a marker of disease risk in non-infected individuals.*

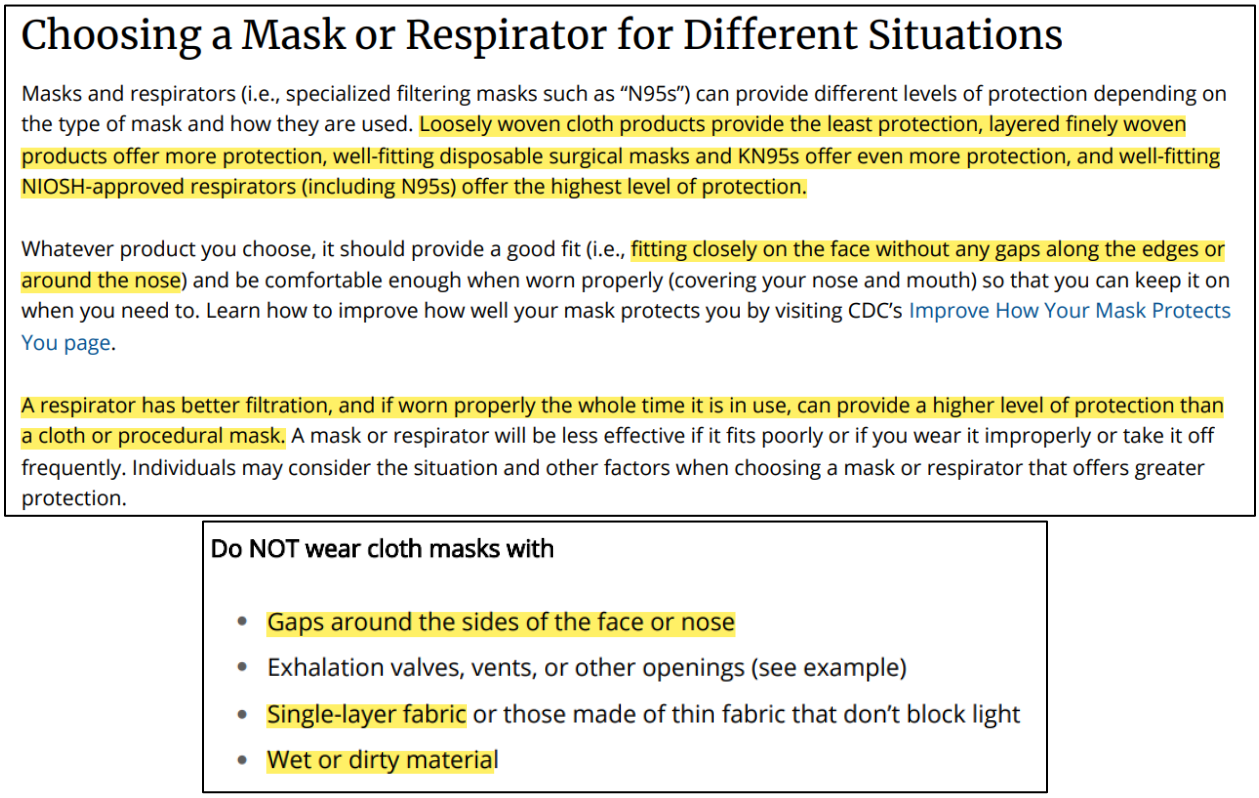
While the mask may contain droplets, they only do so for a period. As the masks are exposed to heat and moisture they suffer from degradation within a few hours.

We ask that the CDC immediately suspend misleading statements in all their public information that masks stop droplets when the vast majority of particles are smaller aerosols that stay suspended for days to weeks (vs. minutes for droplets), readily pass through gaps around the masks, and can reach deep into the lungs (see for example Fennelly, Kevin, P., 2020, Particle sizes of infectious aerosols: implications for infection control, Lancet Respir Med 2020; 8: 914–24).

Issue #4: CDC's position for masks used by the general public lacks proper scientific justification and creates potential harm based on a false sense of security:

Statements that a mask can provide protection are false and mislead the public into a false sense of security. Industrial Hygiene solutions seek a more than 90% relative risk reduction, and this publication continues to focus on the lowest form of non-protection that does not meet the least desirable mode of protection (PPE) in the Hierarchy of Controls with PPE. The September 9, 2020 guidance from AIHA illustrated this concept of the need for a super reduction in relative risk, not a minor one (https://aiha-assets.sfo2.digitaloceanspaces.com/AIHA/resources/Guidance-Documents/Reducing-the-Risk-of-COVID-19-using-Engineering-Controls-Guidance-Document.pdf - pg. 4).

Moreover, the CDC continues to provide guidance that gaps in masks can be eliminated; in the real world that never happens (Figure 28):



Choosing a Mask or Respirator for Different Situations

Masks and respirators (i.e., specialized filtering masks such as "N95s") can provide different levels of protection depending on the type of mask and how they are used. Loosely woven cloth products provide the least protection, layered finely woven products offer more protection, well-fitting disposable surgical masks and KN95s offer even more protection, and well-fitting NIOSH-approved respirators (including N95s) offer the highest level of protection.

Whatever product you choose, it should provide a good fit (i.e., fitting closely on the face without any gaps along the edges or around the nose) and be comfortable enough when worn properly (covering your nose and mouth) so that you can keep it on when you need to. Learn how to improve how well your mask protects you by visiting CDC's Improve How Your Mask Protects You page.

A respirator has better filtration, and if worn properly the whole time it is in use, can provide a higher level of protection than a cloth or procedural mask. A mask or respirator will be less effective if it fits poorly or if you wear it improperly or take it off frequently. Individuals may consider the situation and other factors when choosing a mask or respirator that offers greater protection.

Figure 28: CDC Guidance Suggesting Gaps in Masks Can be Eliminated

The CDC statement that masks should not be worn if gaps cannot be eliminated is meaningless because this cannot occur; only properly selected and fitted respirators can accomplish this.

Masks cannot ever obtain a perfect fit to the face and efficiencies of masks when worn in real world scenarios (day-long usage). When the mask has more than a 3% gap, it offers effectively zero protection (Figure 29):

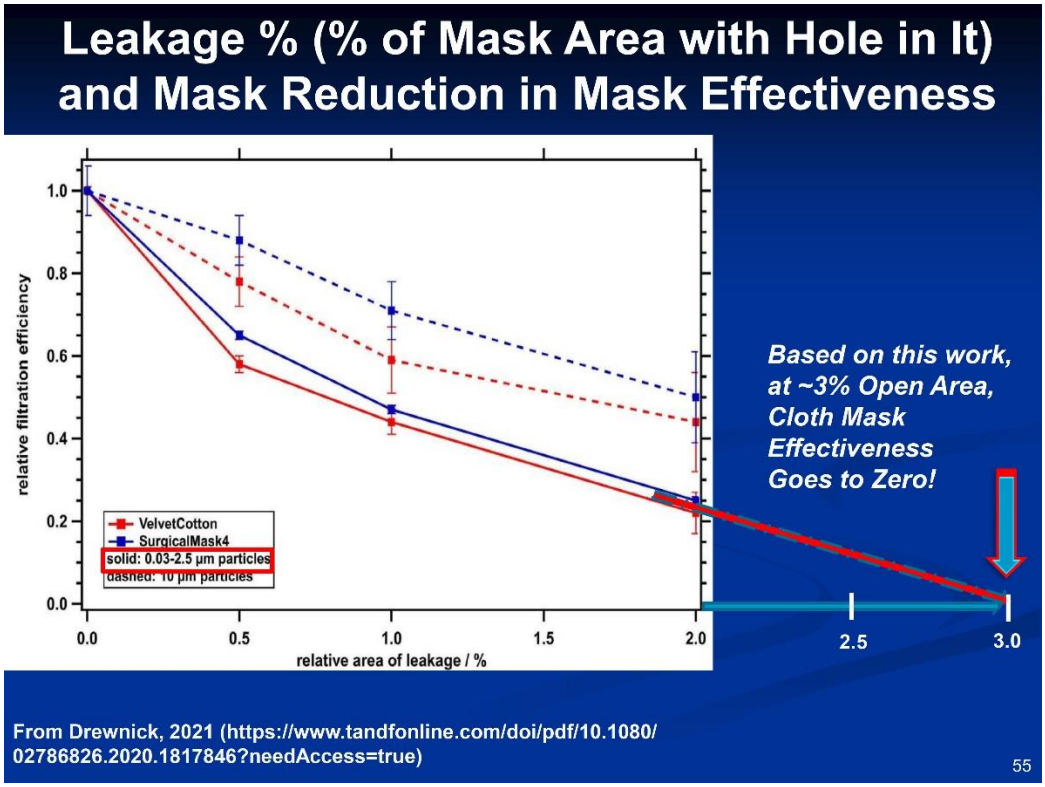


Figure 29: Loss of Mask Effectiveness in the Real World

Thus, the core issue with masks, and even respirators, is the seal – small gap areas effectively render these devices ineffective.

The American Society for Testing and Materials (ASTM) Standard Specification for Barrier Face Coverings F3502-21 Note 2 states, “There are currently no established methods for measuring outward leakage from a barrier face covering, medical mask, or respirator. Nothing in this standard addressed or implied a quantitative assessment of outward leakage and no claims can be made about the degree to which a barrier face covering reduces emission of human-generated particles.”

As well as, importantly, Note 5, “There are currently no specific accepted techniques that are available to measure outward leakage from a barrier face covering or other products. Thus, no claims may be made with respect to the degree of source control offered by the barrier face covering based on the leakage assessment.”

Every breath increases atmospheric viral load, or the amount of viral matter held aloft in an enclosed space. In instances when it does not take very much of an airborne pathogen for vulnerable individuals to get sick, a contagious individual should not wear a mask or respirator that creates a concentrated plume of aerosols, thinking they are protecting others from their respiratory emissions.

Explosive force-generating events, such as coughs and sneezes, increase the pressure behind exhaled matter. Masks can exacerbate the spread of airborne pathogens by creating focused plumes of fine particulates, in turn increasing emission trajectory, with the added concern of aerosolization of droplets through the mask membrane.

Finally, what is now most concerning, is that public entities are taking CDC guidance and making respirators available for free (Figure 30):

Figure 30: "Free" Open Contaminated N95s Being Given Away to the Public at Grocery Stores

These entities, based on CDC guidance, likely and/or unknowingly, do not address the requirements of the Respiratory Protection Standard and causing additional harm to the public by such a lack of understanding. Inevitably, this practice will result in harm and liability to their employees and customers for improper distribution and storage of respirators under the RPS.

Conclusion:

The CDC has built a series of recommendations for masking that are inconsistent with the technical and medical literature. The policy and procedural recommendations exaggerate the benefits, while ignoring the limitations and harms, especially for children and the general population. In addition, the CDC has taken a policy position of "it might work" and "it can't hurt" and use selective and weak observational data in the place of actual controlled scientific study to justify inappropriate recommendations for masks and face coverings.

Recently, the CDC has deployed a respiratory protection policy (i.e., masks to N95s) that dismisses the key principles in any Safety and Health program regarding the use of respirators – namely the Respiratory Protection Program. There is no mention of potential risks if the respirator is not properly used or fitted correctly. Moreover, it is clear that respirators are not intended for use with children. In our profession, if PPE and respiratory protection guidance was to ever be delivered without risk identification, fit testing, and training, we would be liable for putting personnel in a high-risk scenario, which is what the CDC is doing with their policy.

We would ask the CDC to accept these basic industrial hygiene facts that we have presented, update their public guidance accordingly regarding the issue of droplets vs. aerosols, stop confusing the public regarding the effectiveness of masks, and stop implying respirators are acceptable for children, and to be given generally to the public. In addition, it is clear the CDC knows, or should know, that gaps between the face and mask are a major problem for real mask effectiveness and could never have met our industry's requirement of 90% relative risk reduction.

The CDC is doing enormous damage to science and scientists by allowing politics to dictate public health policy rather than actual science. Increasingly, and for good reason as we have illustrated, the public does not trust the CDC and its science; this must change.

We recognize that it is easy to judge from afar and know that you and your team are under tremendous stress during this period. Our desire is to see the CDC and our country succeed in these efforts. As such, instead of just being critical, we want to offer our time to your organization to find solutions together. We would be willing to collaborate in the creation of a competent plan that will be based on the Hierarchy of Controls and will be tailored to various work and living environments. We will also help develop data points we can use to monitor and measure this program to enable proper adjustments as needed.

We look forward to your responses to our concerns as we continue to work to protect the public.

Sincerely:

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* Corresponding Author

From: Bill Osmunson
Sent: 8/4/2022 11:15:49 AM
To: DOH WSBOH
Cc:
Subject: My Public Comments

External Email

Washington State Board of Health For August 10, 2022 Meeting

I am a dentist in Bellevue, Washington, graduated in 1977 and have a Masters Degree in Public Health. For about 25 years I promoted community water fluoridation. However, after careful consideration of the scientific empirical evidence I no long support fluoridation.

It is my understanding, the Washington State Department of Health has determined the Board of Health has Jurisdiction over Community Water Fluoridation in Washington State. Your action to protect the public is urgently needed.

70% of children and adolescents have dental fluorosis. Two studies funded by the EPA for the EPA by Collins, University of Texas Health Science Center, San Antonio, reported more costs to treat functional damage from dental fluorosis than cosmetic damage. https://nepis.epa.gov/Exe/ZyPDF.cgi/2000TTWA.PDF?Dockey=2000TTWA.PDF <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fnepis.epa.gov%2FExe%2FZyPDF.

I treat dental fluorosis damage and have mixed feelings. On the one hand I should thank the Board for sending me business in the form of dental fluorosis harm, chipped, broken, warn, fractured teeth. On the other hand, I ach inside knowing the Board would not intentionally harm our children and youth.

Feels so good to "do good" and applaud our good intentions. And too easy to ignored the harm being caused by flawed policies.

Please respond to the questions previously sent to you.

Below are a few professionals in Washington State who have said they are opposed to community water fluoridation.

Sincerely,
Bill Osmunson DDS MPH
1418 – 112th Ave NE
Bellevue, WA 98004Public Comment for August 10, 2022

Washington Public Health and Scientific Professionals

Calling for an End to Artificial Water Fluoridation

* Helen Abay, RDH, BS, Lynnwood, WA
* Sheila Adkins, RN, Prosser, WA
* Rebecca Allen, RN, Shoreline, WA
* Jodie Anderson, MAT, Seattle, WA
Mary Lou Andersen, MS (biology), LPN, CHT, Nurse, Nutritionist, Bellingham, WA
* Julie Anderson, ARNP, Seattle, WA

* Linda L Andersson, EdD thereapist in private practice, Medina, WA
* Maryann Andonian, RDH, BA, Battle Ground, WA
* Denel Andreas, ND, Seattle, WA
* Nathan Banks, DC, Redmond, WA
* James Bentz, DC, Anacortes, WA
* Teresa Berry, RN, Tacoma, WA
* Toni Best, DC, ReDmond, WA
* Jeffrey T. Bland, PhD, (the father of functional medicine) Seattle, WA
* Mark Blessley, DC, NTS, BS, Vancouver, WA
* John Blye, DC, (Developer, Encephalitis /Resistance Model of Disease Instructor, Blye Cranial Technique) Lynnwood, WA
* Colleen Bolander, RN, Woodinville, WA
Russ Borneman, DDS, Anacortes, WA
* Michael Breneman, DC, Arlington, WA
* Jon Burke, PhD (Clinical Psychologist), Union, WA
* Valerie Burke, RN, MSN, Union, WA
Blair B. Burroughs, JD, Burroughs & Baker P.C., Seattle, WA
* Mikayla Byers, DC, Auburn, WA
* Paul Byers, DC, Auburn, WA
* Janell Chandler, DC, Vancouver, WA
* Wenliang Chen, PhD, Vancouver, WA
* Beverly Clark, RN, BSN, Seattle, WA
Lawrence A. Clayman, BS, DC, Roxbury Spine and Wellness Clinic, Seattle, WA
* Ann Clifton, RN, Olympia, WA
* Kevin Conroy, ND, Port Angeles, WA
* Louis Cook, DC, DesMoines, WA
* Deborah Cummings, OT (Occupational Therapist), LMP, Snohomish, WA
* James Robert Deal, JD, Lynnwood, WA
Armand V. DeFelice, DDS, Spokane, WA
* Resa Delany, PA-C (Physician Assistant-Certified), Shelton, WA
* Beth DiDomenico, ND, Family Practice, Federal Way, WA
* Debra DiPietro, RN, CGRN, Federal Way, WA
* Kenneth Dunning, MS, Mount Vernon, WA
* Richard Edlich, MD, PhD, Brush Prairie, WA
Roger Eichman, DDS (retired), Nordland, WA
* Karla Eilers, RN, Aberdeen, WA
* Dwight Erickson, DC, Diplomate American Board of Disability Analysts, Colville, WA
* Sylvia Ericson, MS, Certified Nutritionist Washington state, Mountlake Terrace, WA
* Daniel Eschbach, DC, Bellingham, WA
Diana L. Estberg, PhD, Chemistry (retired), Port Angeles, WA
Gerald N. Estberg, PhD, Professor Emeritus in Physics, University of San Diego, CA, resident Port Angeles, WA
* Gayle Eversole, PhD, DHom, MH, NP, ND, Spokane, WA
* Shannon Fisher, RD, Tacoma, WA
Paul Framson, PhD, Seattle, WA
* Sharon Frederick, RN, Tacoma, WA
* Robert Gabriel, PhD, Olympia, WA
* Erwin Gemmer, DC, Silverdale, WA
* Jill Goetsch, RN, MSN, Kirkland, WA
* Brandy Gove, RD, CD, CNSD, Shoreline, WA
* Sharon Greene, BSN, RN, MS, Pateros, WA
C. Jess Groesbeck, MD, Preventive Medicine, Mount Vernon, WA
James A. Gruber, former water superintendent, Lakeview Park Water Association (retired after 24 years service), near Soap Lake, WA
* Lois Gruber, RN (retired), Seattle, WA
* Jose Gude, MD, Seattle, WA
* John B. Hallawell, DC, Harbor, WA
* Michael Hanson, PhD, Shoreline, WA

* Loraine Harkin, ND, Yakima, WA
* Ruth Hawkinson, RN, Colbert, WA
* Joan Hill, ND, RN, Seattle, WA
* Holly Hochstadt, DC, Seattle, WA
* Cynthia Hodges, JD, LL.M, MA, Edmonds, WA
Debra Hopkins, DDS, Tacoma, WA
* Marlie Hostetter, RN, Redmond, WA
* Becki Hoyt, RN, Lynnwood, WA
* Charles W. Huffine, MA (Sociology), Pullman, WA
Shirley Jacobson, MSc (Nursing), USPHS Nurse Corps (retired), Bellingham, WA
* David John, MD, Mercer Island, WA
* Duane Jones, DDS, Federal Way, WA
* Lynn Jonsson, PhD, Tacoma, WA
Eloise Kailin, MD, Sequim, WA
* Dora Keating, ND (naturopathic physician), Seattle, WA
* Elton Kerr, MD, FACOG, FRSM, Pasco, WA
* Marga Kerr, RN, BS, Pasco, WA
Dietrich Klinghardt, MD, Seattle, WA
* Vernita C. Kontz, RN, BS, College Place, WA
* Brice Kovarik, DC, BS, Lynnwood, WA
* Michael Kucher, PhD, University of Washington (Tacoma), Seattle, WA
* Grace Lasker, PhD, MS, Kirkland, WA
* Alli Larkin, President, Board of Commissioners, King County Water District 54, Des Moines, WA
Todd Lawson, DMD, Aesthetic Dentistry of Bellevue, WA
* Richard Levine, DC, Bellevue, WA
* Susan D. Liddel-Jones, RN, BS, Nurse-Educator, Renton, WA
* Joanne Loudin, PhD (Psychotherapist), Fox Island, WA
* Cheryl Malcham, RD (Nutritionist), Mercer Island, WA
Avery N. Martin, BS, DC, Mt. Vernon, WA
* Elizabeth Martin, DC, Seattle, WA
* Matt McCann, DC, Marysville, WA
* Ben McCay, DC, Lynnwood, WA
* Carol McDowell, EFDA (Expanded Function Dental Auxiliary), DuPont, WA
* John McLean, Water System Manager (#5829) in the state of Washington, Camano Island, WA
* Mary Meier, RN, Seattle, WA
* Donald Miller, MD, Professor of Surgery, University of Washington School of Medicine; author Fluoride Follies, Seattle, WA
* Matthew Miller, DC, Vancouver, WA
* Joshua Minks, BSN, Bothell, WA
* John Mishko, DC, Fircrest, WA
* Bill Misner, PhD, Author: What Should I Eat? A Food-Endowed Prescription For Well Being, Spokane, WA
Jeffrey Morris, PhD (Economics), Sound Resource Management, Olympia, WA
* Richard Morrison, PhD, Bellingham, WA
* Jon R. Mundall, MD, Dipl. ABCMT, CNS, Connell, WA
* Michelle Murphy, Sr. Electrical Engineer, Mental Health Advocate for Washington State, Richland, WA
* Cheryl Murray, RN, Newcastle, WA
* Fred Neil, DC, Bellingham, WA
Helene R. (Vaughn) Newbaker, RN, DC (retired), Sedro Woolley, WA
* Judith Night, BA, BFA, MA, Ocean Park, WA
* Sheryl Nixon, RN, Toledo, WA
* Chris Nubbe, MA (Environmental Engineering), BS (Civil Engineering), Olympia, WA
* Lalania Olsby, RN, Seattle, WA
* Ann Olsen, LM, CPM (Licensed Midwife and Certified Professional Midwife), Enumclaw, WA

* Mike Pagan, CMPT, CCCE, PT (Physical Therapist), Seattle, WA
* Lisa Paulk, RN, Arlington, WA
* Margaret Piela, RN, Nutritional Counselor, Certified Herbalist, Sammamish, WA
* Wendy Phillips Piret, BS USNA 93', Pediatric Craniosacral Therapist, Licensed Brain Gym Practioner, Mercer Island, WA
* Terry K. Poth, DC, Bellingham, WA
Jody Prusi, RDH, dental hygienist, Seattle, WA
* Karen Ranheim, RN, Lake Stevens, WA
* Phillip Ranheim, MD, Lake Stevens, WA
* Danielle Reilly, BSN, RN, Bellevue, WA
* Jennifer Ricker, DC, BA, Edmonds, WA
* Patrick A. Robinson, DDS, Bellevue, WA
* Elizabeth Rosendahl, RN, Tacoma, WA
Darryl W. Roundy, DC, Gig Harbor, WA
* Judith Royse, BSRDH, Spanaway, WA
Paul G. Rubin, DDS, Seattle, WA
* Jessica P. Saepoff, DDS, Issaquah, WA
* David Schorno, Waste Water treatment Operator group II, Sedro-Woolley, WA
* Ruth W. Shearer, PhD, Lacey, WA
* John Sheridan, MAT (Education), Issaquah, WA
* John Sherman, ND, Renton, WA
* Barara Simons, PA-C (Primary Care Physician Assistant), Freeland, WA
* Lucy Smith, ND, Shoreline, WA
* Samantha South, MS (criminal justice), Renton, WA
Mark Stahl, DDS, Seattle, WA
* Katie Stamwitz, DC, Hoquiam, WA
* Gerald Steel, MS, PE, Esq., Olympia, WA
* Robert Stephan, DDS, BS, FAPD, Nine Mile Falls, WA
* Crystal Tack, ND, LAc, Sequim, WA
* Carol Taylor, PhD (Computer Science), Spokane, WA
J. Miranda R. Taylor, LAc, MTCM, Licensed Acupuncturist, Master of TCM, Gesundheit Acupuncture and Herbs PLLC, Seattle, WA
* Ruth Tudor, RN, Olympia, WA
* Joseph Ulrich, RRT, NPS, Respiratory Therapist for 34 years, Vancouver, WA
* Christine Walker, RD (Registered Dietitian), MS (Nutrition and Dietetics), CD (Certified Dietitian in the state of Washington), Bonney Lake, WA
* Stephen Walsh, MS (Mathematical Statistics), Research Scientist, Richland, WA
* Lee Whitmer, OD, Chattaroy, WA
Richard S. Wilkinson, MD, Yakima, WA
* Shirley Williams, RN, Ferndale, WA
* Carla Witham, RDH, Bellingham, WA
* Keith Wollen, PhD, Port Angeles, WA
* Julie Woodbury, RN, Pascoe, WA
* Linda Zachariah, JD, Bellevue, WA
* Marina Zherebnenko, LMP, Vancouver, WA

Link to the Fluoride Action Network's Professional's Statement to End Water Fluoridation:
http://fluoridealert.org/researchers/professionals-statement
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Ffluoridealert.org%2Fresearchers%2
statement&data=05%7C01%7Cwsboh%40sboh.wa.gov%7C0eff1b31e8bc4fd4c30c08da76455354%7C11d0
/

From: Garry Blankenship
Sent: 7/12/2022 8:26:17 AM
To: hcinfo.infosc@canada.ca,DOH
WSBOH,OADS@cdc.gov,sheriff@co.clallam.wa.us,ombuds@oc.fda.gov,mozias@co.clallam.wa.us,rjohnson@

Cc:
Subject: The mRNA Jabs Do not Work

attachments\F61279EA886C415C_Martin Kulldorf on mRNA Efficacy.docx

attachments\09E215F5D1EB4A35_Why The Jabs Do Not Work.docx

External Email

Multiple health professionals and publications have accurately reported that the Coronavirus is not a viable vaccine candidate because of it's mutation natural proneness. This cycle of rewarding pharma for drugs ineffective against current viruses must end. It is not possible to vaccinate out of a pandemic. Healthy living, (diet & exercise), optimum vitamin D levels, natural immunity, effective repurposed drugs, etc. are discounted by our health care system, while experimental drugs with unknown efficacy and side effects are solely promoted. This is irrational by any standard. While the harmful adverse events from these experimental drugs appear statistically small, repeated injections will ultimately render the harm inevitable, (if you have not been harmed yet, you will be). All associated mandates, (masks, proof of vaccination and isolation), are now known to be ineffective or health net negatives. No question isolation is in order for symptomatic individuals. Please consider the benefit of proof of vaccination when the vaccinated undisputedly become infected with, spreaders of and die from COVID. The "vaccine hesitation" the CDC hoped to lessen by censoring resultant mRNA data, has only served to solidify same. Please stop this madness and collectively study a rational approach to threatening viruses.

I / we want to believe in our health care professionals. Please restore that confidence by publicly acknowledging the shortcomings of the current COVID policy/s.

Please review supportive attachments,

Sincerely,

Garry Blankenship

_____
From: Jodi Dotson
Sent: 7/21/2022 10:30:59 AM
To: DOH WSBOH
Cc:
Subject: Dori: Local health stats show unvaxxed kids less likely to have COVID than vaccinated youth

External Email

<https://static.particlenews.com/logo/brand_logo_white.png> NewsBreak
Used by over 45 million people
Open APP
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fnewsbreakapp.onelink.me%2F211

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.newsbreakapp.com%2Fn%2

Dori: Local health stats show unvaxxed kids less likely to have COVID than vaccinated youth

MyNorthwest.com
I found this on NewsBreak: Dori: Local health stats show unvaxxed kids less likely to have COVID than vaccinated youth
<https://img.particlenews.com/img/id/3reTYF_0glccReD00?type=_180x000>
Click to read the full story
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.newsbreakapp.com%2Fn%2

Sent from my iPhone

_____

From: Enrique Leon (he/el)
Sent: 6/23/2022 1:01:19 PM
To: DOH WSBOH
Cc:
Subject: Communicating With Board Members - lack of Infectious disease consultation in Tacoma

External Email

Dear Health board,

Can your health board make recommendations to Multicare about finding an urgent safe long term solution for the lack of infectious disease doctors in hospital and outside of hospital for follow up. This has been a significant problem for 2 years but critical the last 6 months. We had only 2 ID doctors past 6 months with 2-4 month long out patient follow up appointment wait time. One doctor quit 2 months ago. The last one is quitting 7/16 th. There are no replacements identified yet.

There have been delayed and misdiagnosis throughout our system because of this problem. Many patient complications. Likely deaths, though none of my patients.

See the attached e mail from our chief medical officer.

Don't use my name as there may be retribution against me if you do. Thanks

From: Paula Loveless <Paula.Loveless@multicare.org <mailto:Paula.Loveless@multicare.org> > On Behalf Of Ralph Costanzo
Sent: Wednesday, June 22, 2022 3:22 PM
Subject: ALERT! No on-site Infectious Disease coverage at TGAH June 27 - July 10
Importance: High

Dear Colleagues,

Once again, I want to apologize because due to an ongoing staffing shortage, Tacoma General-Allenmore Hospitals will not have available on-site Infectious Disease consultation services next week from June 27 – July 10, including the absence of our wonderful ID Pharmacist, Julianna Van Enk, who is on much deserved PTO. Dr. Courtney Beuning's last week with us will be July 17. Please join me in wishing her all the best as she transitions from MultiCare. We have truly appreciated her engagement and dedicated work within our infectious disease program.

We also anticipate a lack of coverage the weeks of July 18 through August 7 although this could change depending upon locums provider availability.

I apologize for the interruption in this important care line and as previously communicated, we are actively working with MMA leadership on a plan to effectively rebuild our infectious disease program. We have several additional locums providers undergoing privileging along with offers to new full time physicians and APPs. Last, we are close to consummating a contract with a Tele-ID vendor, ID Connect, staffed by physicians at the University of Pittsburgh Medical Center. We believe that if all of these initiatives achieve fruition, we will have a much more stable program with expanded bench strength by Q3 of this year. In the meantime, we continue to ask for your understanding and collaboration as we navigate the gaps in coverage during the next few months.

At present, similar shortages at Good Samaritan Hospital will prevent them from acting as a resource for us. When possible, we ask that you work with our onsite pharmacy teams in making decisions about antibiotic treatment for your patients. Julianna Van Enk is also a very knowledgeable resource and would be available for advice on the days she is working at the facility.

Last, if you are caring for a patient that you believe requires an urgent/emergent in-person consult, please work with MC2 (transfer center) to affect a patient transfer to the most appropriate facility.

As always, I appreciate your collaboration and understanding. If you do have specific questions or concerns about the process, please feel free to reach out to me directly.

Best,

Ralph

Ralph M. Costanzo, MD, MHA

Chief Medical Officer | MultiCare Health System-Tacoma General/Allenmore Hospitals

Cell: 406.591.7839 | Work: 253.403.4925
Address: MS: 315-C3-AD 315 Martin Luther King Jr Way, Tacoma, WA 98405

_____
From: Jotform
Sent: 7/26/2022 10:25:40 AM
To: DOH WSBOH
Cc:
Subject: Re: Stop The Child Vaccine Mandate Petition - Kimberley Phillips

External Email

<https://cdn.jotfor.ms/assets/img/logo2021/jotform-logo.png>

Stop The Child Vaccine Mandate Petition

Name

Kimberley Phillips

Email

phillipskimberley1974@gmail.com

Zip

, , , , 98901

You can edit this submission
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.jotform.com%2Fedit%2F534
and view all your submissions
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.jotform.com%2Ftables%2F2
easily.

From: Joshua Allen
Sent: 7/15/2022 1:45:03 AM
To: DOH WSBOH
Cc:
Subject: Re: Now Available: June 8 Proposed Final Agenda for State Board of Health Public Meeting

attachments\81B58BCAC7E84918_image002.png

External Email

https://thinkcivics.com/scientists-say-government-main-source-of-covid-misinformation/

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fthinkcivics.com%2Fscientists-say-government-main-source-of-covid-misinformation%2F&data=05%7C01%7Cwsboh%40sboh.wa.gov%7Cd36a83f340484514994308da663e1f8
Sent from my iPhone

On Jun 1, 2022, at 5:15 PM, DOH WSBOH <WSBOH@sboh.wa.gov> wrote:

☐

The proposed final agenda <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fsboh.wa.gov%2Fsites%2Fdefault%06%2FTab01a-ProposedFinalAgenda-Jun2022.pdf&data=05%7C01%7Cwsboh%40sboh.wa.gov%7Cd36a83f340484514994308da663e1f8e%7C1 is now available for the State Board of Health's public meeting on Wednesday, June 8. We will meet from 9:30 a.m. – 4:30 p.m. Meeting materials are available on the meeting webpage.

Please read the proposed final agenda for more information about the meeting, including how to give public comments and when to give testimony on the Keeping of Animals rules hearing. We encourage you to submit written public comments to the Board in advance of the meeting. You may access the meeting in the following ways:

1. Online and register: https://us02web.zoom.us/webinar/register/WN_6vqdRyUmTamyb61z3wCSBA <https://us02web.zoom.us/webinar/register/WN_6vqdRyUmTamyb61z3wCSBA>

2. Call-in and participate using your phone:

0. Webinar Call in: +1 (253) 215-8782
1. Webinar ID: 847-8253-4990
2. Webinar Passcode: 887573

About Public Comment:

* We encourage you to submit written public comments to the Board in advance of the meeting. To help ensure Board members have an opportunity to read and consider your comments before the meeting, please email us your comments <mailto:wsboh@sboh.wa.gov?subject=My%20Public%20Comments> by Friday, June 3 by 12:00 Noon. Written comments received after 12:00 Noon on Friday will be shared with Board members; however, Board members may not have the capacity to read or consider your comments over the weekend before the meeting or during the meeting. You may give verbal comments at the meeting during the public comment or rules hearing segments.

Other Meeting Information:

* This meeting will be held online through the Zoom Webinar application.
* Board members, presenters, and staff will participate remotely.

Phone: (360) 236-4110

Mailing Address: P.O. Box 47990, Olympia, WA 98504-7990

Location
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.google.com%2Fmaps%2Fpla
122.9083621%2C17z%2Fdata%3D!3m1!4b1!4m5!3m4!1s0x549173f074205aa3%3A0x552ddc5f79ee44b6!
122.9061681%3Fhl%3Den&data=05%7C01%7Cwsboh%40sboh.wa.gov%7Cd36a83f340484514994308da6
· Website
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fsboh.wa.gov%2F&data=05%7C01%
· Email <mailto:wsboh@sboh.wa.gov> · Facebook
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Please send us an email with the subject "unsubscribe" if you no longer wish to receive communications from us

_____

From: Jodi Dotson
Sent: 7/13/2022 3:30:56 PM
To: DOH WSBOH
Cc:
Subject: Covid shots for children

External Email

Dear Board,

I am begging you people to stop this horendous act against humanity. The citizens of Washington State are at your mercy in the fact that they rely on your expert opinion. Most people have faith in your decisions to do NO HARM to the public. This whole agenda to force a deadly shot on children who have next to zero threat of death from the covid virus. I cannot fathom your reasoning to push for any human being to have this deadly shot.
The more I learn the more disheartening this whole situation has become. There are thousands of people who have been injured or dead from this shot and the numbers continue to rise. I am not sure if you people are not recieiving the studies and research on this stuff or you are receiving monetary gains to look the other way.

You know back in 1986 I was in school for healthcare and I had always wondered why you actually need an army. Why couldn't a person or persons just put a deadly virus in the air , water or a shot instead of the WARS. Well, low and behold 32 years later it was accomplished. The sad thing is it was man made and not something that occured naturally.

The very people who took oaths to protect the human race are trying to depopulize the world. I cannot fathom how anyone with a conscience could go along with this diabolical plan. It is bad enough that we loose children from other diseases but to knowingly put something in them to kill them is just so sick.

I beg you to do further research and not to just rely on the information provided to you from lord knows where. Does it really make sense to give children a shot that the mortality rate is 99.8%. Does it make sense to give them a shot that killed all the animals that were tested with it, so they decided to give it to the world. Why are children of all having heart problems and dropping dead? Why is anyone that recieved this shot getting mamed or killed? When does it stop? You people have the power to stop this crime against humanity here in Washington State. My heart is broken to know you would harm people and you are THE BOARD OF HEALTH.

I would like a response to this letter. I have written to you folks and have heard nothing back. I would like for the Board to do their own research in to the ingredients of all the manufacturers of this deadly liquid.

Sincerely,

Jodi Dotson

_____
From: John Anderson
Sent: 7/13/2022 7:21:59 AM
To: DOH WSBOH
Subject: Comments on Public School MASK Policy

External Email

Greetings Working Group -

I wish to provide, for your consideration, the attached testimony (with numerous studies cited in bibliographical links) of Stephen Petty. a recognized expert on the protection offered by Masks, including N95 for both general population and for children.

in his testimony he specifically cites recent cases where his science prevailed against the flawed studies on N95 masking conducted by the CDC to promote masking of school children.

Your committee would be hard pressed to find a better compendium of information, and should you ignore this resource it could be at your peril. Note his citation of the regulatory and legal risks of advocating N95 masks without specific physician evaluation of patients over the warnings issued by the manufacturer.

Please keep our children safe!

(321) Ep. 141 The Ultimate PPE Expert with Incredible Insights into Mask Science! - YouTube
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv

---
Strength and Honor

John Anderson
President
GDP Group Ltd SPC
MOBILE: (253) 459-3447

On Wed, Dec 29, 2021 at 1:11 PM John Anderson <j2j.anderson@gmail.com <mailto:j2j.anderson@gmail.com> > wrote:

Greetings Working Group

Personal Background

I am a vaccinated (2x), healthy 68 year old male. I have lived in Washington since 1993. My education includes science (BS Physics, Pre-med, Nuclear Engineering graduate school, and IT professional coursework) and business (MBA Marketing, graduate studies in Marketing and Strategy) from 7 universities. I have written US Patents on behalf of inventors who developed anti-viral, anti-bacterial, and other immunological effects. Currently, I lead the materials science Product Development efforts of a WA state clean energy venture. I review on a daily basis the many observational studies and Randomized Control Trials from select nations concerning COVID.

These reviews have included:

* Evidence comparing Vaccine immunity vs Natural Immunity.
* Breakthrough infection rates by immunity class (No Vaxx, Vaxx only, Natual Immunity Only, Vaxx after recovery from infection).
* Symptom and infection severity by Variant
* Viral load and transmissivity by immunity class.
* Infection rates and clinical outcomes by age group.
* Vaccine Adverse Effects (UK Yellow Card System, US VAERS, etc.)
* Infection and severity of symptoms serum nutrient content {Vit A, Vit D, Vit C, Vit K, Zinc, Iron}

DISCLAIMER

I am not a physician nor an academically-certified virologist nor nutritionist. My comments are not intended to make claims nor to provide advice.

COMMENTS FOR YOUR CONSIDERATION

Prudent policy decisions are always a risk-reward (or cost-benefit) trade-off. There literally is no free lunch. I suggest strongly that your deliberation consider the following facts:

* Herd immunity occurs when nearly all community members have immunity.
* Omicron is now outcompeting other variants. People get infected with OMICRON rather than Delta, Alpha, Beta etc.
* Omicron will likely infect everyone.
* Young people, unvaccinated, are most likely to be asymptomatic, and acquire natural immunity superior to vaccine immunity.
* Young people, regardless of immunity class, will infect teachers and parents with OMICRON regardless of their immunity class.
* Unless the policy for IM injection returns to the international best practice of aspirating the syringe after insertion, young people will be placed at a statistical rick of adverse side effects (from injection into the vascular system) that is greater than the risk of severe infection from COVID.

ADVICE:

* Let the Omicron variant run its course, and monitor new variants for infection and severity.
* Do NOT mandate COVID vaccines as a condition of participation in classrooms.
* The risk TO unvaccinated and BY unvaccinated students is acceptable. The reward of vaccination is outweighed by the adverse affects, discrimination against children, and the further invasion of patient rights by government.

I am available for discussion should follow-up be desired.

Strength and Honor

John Anderson
MOBILE: (253) 459-3447

From: Jessie Nearing
Sent: 7/6/2022 10:10:49 PM
To: DOH WSBOH,Davis, Michelle (SBOH),Hisaw, Melanie (SBOH),Hoff, Christy Curwick (DOH),Glasoe, Stuart D (SBOH),Pskowski, Samantha L (SBOH),Donahoe, Kaitlyn N (SBOH),Lang, Caitlin M (SBOH),lindsey.erendeen@sboh.wa.gov,Schreiber, Tracy N (SBOH),Haag, Hannah R (SBOH),Kahler, Kelie (SBOH),Thai, Nathaniel J (SBOH)
Cc:
Subject: Children Mandate Opposition for discussion 1/12/22.

attachments\1FD9D56CAD0F4737_Children Mandate Opposition.pdf

External Email

To the BOH or whomever this may concern:

I am writing this email to voice my strong stance **against** the COVID vaccines for our children of Washington state or anywhere for that matter. COVID vaccines should absolutely NOT be required for our children. Children are at extreme low risk for Covid and the vaccines are still ONLY EUA (emergency use authorization).

Here is Rep Jim Walsh's statement regarding this agenda item from his Facebook page:

"[Agenda]Item 9 is troubling–but not news. We've discussed it on this page and in Q&As many times. It's the section of WAC that allows local Health Dept's to set up isolation and quarantine facilities. And, in certain situations, send people to those facilities involuntarily. Against their will.
Again, this isn't new. That bad WAC has been in place for a while–even before COVID. It has never been used in WA. ***And it runs against various sections of the WA State Constitution. It's unconstitutional! The Board of Health's possible action is to extend this WAC. It should NOT do that. To extend the rule would just be bureaucratic rubber-stamping of the current Governor's unconstitutional excesses."***

I would also hope with such a bold, risk of our babies lives, unethical, and extremely quiet approach to your agenda that The Unity Project backed by globally esteemed experts in health care and science would hinder your approach to potentially hurt or kill our children.

Dr. Peter McCullough

The Unity Project – Strategic Advisory Council Member

MD, MPH, FACC, FAHA, FASN, FNKF, FNLA, FCRSA, internist, cardiologist, epidemiologist, Chief Medical Officer, Truth for health Foundation, most highly published cardiac and kidney specialist in history, globally

Dr. Robert Malone

Chief Medical & Regulatory Officer

MD, MS, Northwestern School of Medicine, Harvard Medical School fellow - Global Clinical Research Scholar (2016), original Inventor of the mRNA Vaccine Platform used in the Pfizer and Moderna COVID-19 vaccines

Dr. Paul Alexander

Chief Scientific Officer

MA, PhD, Oxford University, McMaster University, Former WHO Consultant and Senior Advisor to US Dept of HHS in 2020 for the COVID-19 response

Dr. Aaron Kheriaty

Chief of Medical Ethics

MD, Georgetown University, Notre Dame, Professor at University of California Irvine, Chairman, UCI Hospital's medical ethics committees and at the California Department of State Hospitals

I don't believe that the science behind these experts and the adverse effects that are proven towards children and the facts that continue daily to present themselves are unseen by caring humans with families like yourselves?

With this, I DO NOT APPROVE OF THIS AGENDA OF MANDATING CHILDREN. WAC 246-105. I APPOSE ALL THAT IS SPOKE OF IN THIS AGENDA. I DISAGREE WITH WAC 246-100-070. I DISAGREE WITH WAC 246-100-045. I DISAGREE WITH WAC 246-100-040.

Respectfully and devoted to our children's safety,

Jessie Nearing

Washington state resident of Grays Harbor County

From: karen raper
Sent: 6/26/2022 12:45:51 PM
To: DOH WSBOH
Cc:
Subject: Allergy Medication

External Email

I know people that need allergy medication with the decongestant this time of the year.

Having to spend over $10 or more just to run into town every week or so just to get over the counter medication can cause people to go without it.

Please consider allowing these people to get enough medication to last at least one month.

Sincerely
Karen

From: Garry Blankenship
Sent: 7/15/2022 10:40:35 AM
To: hcinfo.infosc@canada.ca,DOH
WSBOH,OADS@cdc.gov,sheriff@co.clallam.wa.us,mozias@co.clallam.wa.us,rjohnson@co.clallam.wa.us,sha

Cc:
Subject: Fauci; COVID Drugs Do Not Protect, (overly well)

attachments\A0E73EF0CE8C4DFB_Fauci Drugs Don't Work.docx

External Email

Attached is an article on the efficacy of COVID "vaccines". The world's number one promoter of our mRNA drug campaign now concedes they do not work well. Though this has long been known, government health management lock stepped with mass media have been resistant to admit same. Finally the pinnacle of world health management admits these drugs are not working. Adverse reactions aside, there is a huge takeaway from this. Recommending these drugs is now at best questionable. Mandating them or requiring proof of having taken them is a combination of incompetence and malpractice and should be punishable. Any requirement to take mRNA COVID "vaccines" is counter to now known science, data and studies. As people responsible for health management, please see that the proliferation of these dangerous chemical concoctions is halted. Please also investigate why effective and safe repurposed drugs have been blocked and why natural immunity is not acknowledged as being infinitely superior to vaccinated immunity. You cannot exclusively rely upon recommendations from the CDC, FDA or NIH. Please do your own homework, as your life is also at stake.

Sincerely,

Garry Blankenship

From: Gerald Braude
Sent: 8/5/2022 11:27:53 AM
To: DOH WSBOH
Cc:
Subject: COVID-19 shot mandates

External Email

I wanted to thank you for not putting COVID-19 shot mandates for Washington schools on the agenda for this meeting. I shall stay tuned to your meeting to make sure that you're still not interested on putting this on the school vaccine schedule. Although I am well past the parenting stage of my life, I still strongly believe parents have the right to decide whether their kids should take these experimental gene therapy shots. I would like to remind you that these shots do not prevent transmission, so requiring these shots to protect others in the classroom is an oxymoron.

Gerald Braude
Port Townwend

_____

From: Lisa Templeton
Sent: 8/5/2022 8:23:22 AM
To: DOH WSBOH
Cc:
Subject: Comments for BOH meeting on August 10

External Email

Dear Board members,

Since Covid began, the FDA and CDC have taught us that we should proceed with caution when it comes to their proclamations on public health. For example, a little over a year ago, they told us that the J&J Covid shot met the FDA's so-called "rigorous standards for safety, effectiveness, and manufacturing quality." Now the FDA essentially no longer approves of the use of J&J due to its adverse effects.

Have you listened to the recent VRBPAC and ACIP proceedings during which Covid shots were authorized then recommended for babies and toddlers? If you employed discernment, you know that the risks of the infection for children were exaggerated, the effectiveness of these consumer products was inflated, and the injuries from the shots were practically ignored.

Three members of Congress recently asked VRBPAC the following questions, which deserve answers before this mass human experiment is further unleashed on millions more Americans—our children.

* Why did the FDA lower its efficacy bar for Covid injections for the youngest children?
* How many lives does the FDA estimate will be saved in this age group?
* How will the FDA evaluate the injuries and deaths reported to VAERS compared to serious Covid outcomes?
* Why has the FDA been so slow to release the hundreds of thousands of pages of data from manufacturer studies and post-approval adverse events?

These are just four of many questions that bona fide science requires be answered before rolling ahead. It is evident that the risks of these experimental, liability-free shots outweigh the purported benefits, and our government barely seem to care. The public is taking note, however. I respectfully plead with each member of this Board to become informed of the many dangers of these for-profit products and stand for protecting the public from them.

Thank you,

Lisa Templeton

Covington

To the BOH or whomever this may concern:

I am writing this email to voice my strong stance **against** the COVID vaccines for our children of Washington state or anywhere for that matter. COVID vaccines should absolutely NOT be required for our children. Children are at extreme low risk for Covid and the vaccines are still ONLY EUA (emergency use authorization).

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I would also hope with such a bold, risk of our babies lives, unethical, and extremely quiet approach to your agenda that The Unity Project backed by globally esteemed experts in health care and science would hinder your approach to potentially hurt or kill our children.

Dr. Peter McCullough

The Unity Project – Strategic Advisory Council Member

MD, MPH, FACC, FAHA, FASN, FNKF, FNLA, FCRSA, internist, cardiologist, epidemiologist, Chief Medical Officer, Truth for health Foundation, most highly published cardiac and kidney specialist in history, globally

Dr. Robert Malone

Chief Medical & Regulatory Officer

MD, MS, Northwestern School of Medicine, Harvard Medical School fellow - Global Clinical Research Scholar (2016), original Inventor of the mRNA Vaccine Platform used in the Pfizer and Moderna COVID-19 vaccines

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MA, PhD, Oxford University, McMaster University, Former WHO Consultant and Senior Advisor to US Dept of HHS in 2020 for the COVID-19 response

Dr. Aaron Kheriaty

Chief of Medical Ethics

MD, Georgetown University, Notre Dame, Professor at University of California Irvine, Chairman, UCI Hospital's medical ethics committees and at the California Department of State Hospitals

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Respectfully and devoted to our children's safety,

Jessie Nearing

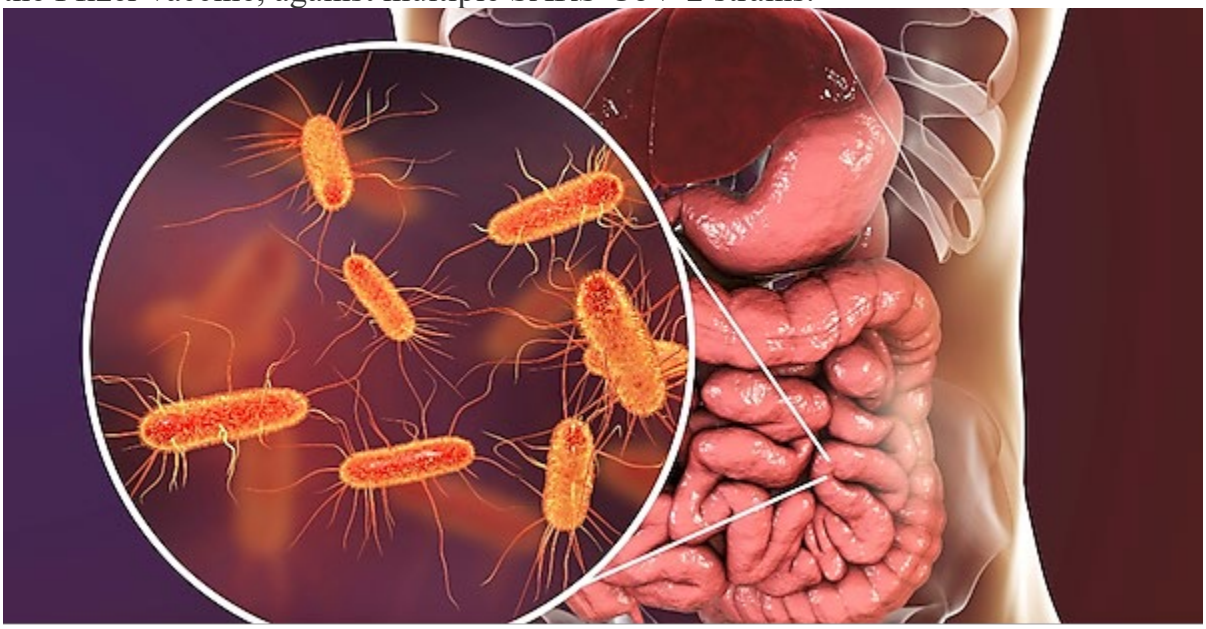
Washington state resident of Grays Harbor County

COVID-19 Jab Does Not Work. Here's Why

BY JOE WANG AND JENNIFER MARGULIS TIMEJULY 11, 2022 PRINT

A team of Harvard research scientists, publishing in the New England Journal of Medicine, have found that SARS-CoV-2 virus has mutated so much that the Pfizer mRNA vaccines developed against the original Wuhan strain now have little to no effect.

The study, "Neutralization Escape by SARS-CoV-2 Omicron Subvariants BA.2.12.1, BA.4, and BA.5," evaluated neutralizing antibody titers of participants vaccinated with the Pfizer vaccine, against multiple SARS-CoV-2 strains.



The scientists found that the titers dropped from 5,783 (against the WA1/2020 isolate, Wuhan strain) to 275 (against the BA.4 or BA.5 subvariant, omicron variants), by a factor of 21.

In other words, they found the mRNA vaccine to be essentially ineffective against Omicron variants currently in circulation.

SARS-CoV-2 Mutations

SARS-CoV-2 has been a quickly evolving virus since late 2019. Like all RNA viruses, it has a strand of RNA that is packaged in a delivery vehicle that allows it to attach

itself to host cells and inject its RNA into the cells and hijack the cells to make more copies of its RNA.

A virus must interact with living cells in order to reproduce. Without this interaction, the virus itself is inert. It has no metabolism. It cannot move. It doesn't eat. It cannot reproduce with other viruses. What this means is that a virus has none of the characteristics of living organisms. Because of this, some scientists want to classify viruses as part of life while others point out that viruses are not alive. At least not without hosts.

Life or not, all viruses must have genetic material RNA (ribonucleic acid) or DNA (deoxyribonucleic acid). RNA or DNA make copies using templates of complementary strands of RNA or DNA. There is always a chance for errors to happen during this process. We call these "errors" mutations.

Often these errors make the DNA or RNA too imperfect to carry on functioning, so the mutation goes nowhere. But if the mutated version is viable, the result is a new, slightly changed version of the DNA or RNA.

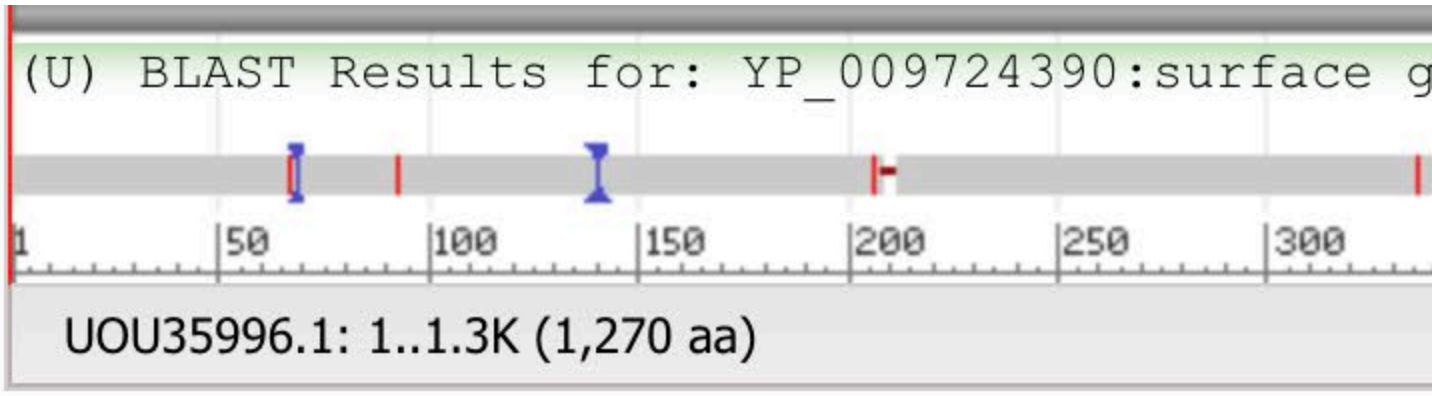
A virus that does not kill its host but is able to keep using the host to replicate itself is able to continue replicating. There is an advantage to a virus developing a way to become chronic or endemic, rather than being rabidly lethal to the host.

By every indication, that is what is happening with SARS-CoV-2, the novel virus that likely originated in Wuhan, China, and quickly spread around the globe, using humans and other animals as its host.

Anti-Spike Antibodies

Many of the mutations to the SARS-CoV-2 RNA do not change any of the proteins the virus needs to survive and proliferate. These are called silent or synonymous mutations. Others, known to scientists as non-synonymous mutations, do change the amino acid composition of the proteins.

The amino acid sequence differences (about 3 percent) observed between SARS-CoV-2 spike proteins from the original Wuhan strain (GenBank # YP_009724390) and an Omicron isolate from Norway on January 3rd, 2022 (GenBank # UOU35996.1) are the results of two years of evolution of the virus on its spike protein.



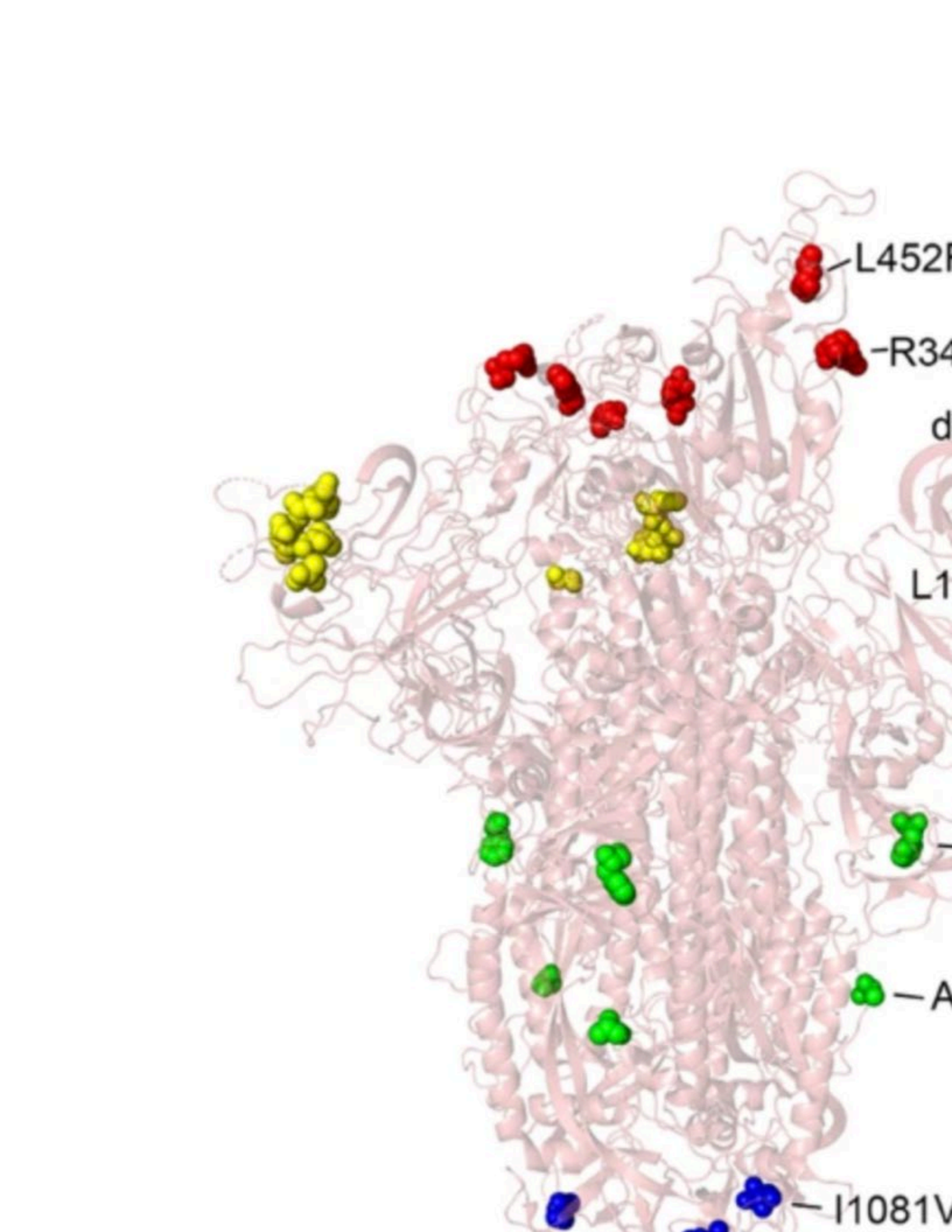
(National Library of Medicine's online Blast service)

Using the National Library of Medicine's online Blast service, the authors compared the spike protein sequences from the Wuhan strain and an Omicron variant. The red lines highlight the mismatches.

Compared to other parts of the virus genome, the gene that codes for the spike protein evolve faster, as the spike protein is on the surface of the virus and is under much more selection pressure.

This poses a problem for the current vaccines and any future vaccines based on the spike protein. The fast-changing spike protein would likely make the existing vaccines and any new vaccines less effective. In other words, the virus has moved on, but the vaccines have not.

Existing vaccines based on the spike protein generate multiclonal antibodies against different epitopes of the spike protein. If an antibody reacts to an epitope that is not affected by the mutations that Omicron has, then this antibody would be effective against Omicron. Otherwise, it will not be effective.


L452
R34
d
L1
A
I1081V

Structure of SARS-CoV-2 Omicron spike protein mapped with the novel mutations.
(Source: Tracking SARS-CoV-2 Omicron diverse spike gene mutations identifies multiple inter-variant recombination events)

When most, if not all antibodies that the COVID-19 mRNA vaccines developed based on the original Wuhan strain fails to react to the current SARS-CoV-2 variant, the vaccine becomes ineffective.

Vaccinated Have Negligible Antibodies Against Current Strain

In the new Harvard study, the scientists tested 27 participants who had been vaccinated with Pfizer's messenger RNA vaccine (BNT162b2) and 27 participants who had been infected naturally with the original Wuhan strain.

Most of those who had had COVID already had also been vaccinated, so most, but not all, had hybrid immunity.

Those who had recovered from COVID had a strong immune response to the original virus, which is no longer circulating in the world.

But those who had been vaccinated just six months prior to the test had only 1 percent as many antibodies as those who had recovered from having the virus.

Participants who had been boosted just two weeks before the test and were at the peak of their immunity did have a strong response, though it was still half as strong as those with natural immunity. Evidently their vaccine-acquired immune response was not long lasting, either.

And these results were only for the original, outdated virus, which is no longer a danger.

Against the strain currently dominant in the United States, those who had been vaccinated, even at the peak of their protection two weeks after the booster, had a very scant antibody response to the current virus, about 7 percent as strong as their antibody response to the original 2020 virus.

Those who were vaccinated six months before, but not boosted, had negligible antibodies against the current virus.

Natural Immunity Provides Substantial Immune Response

Those with natural immunity after recovering from COVID had a substantial immune response to the current virus.

Though it was only 10 percent as strong as their response to the original 2020 virus, their immune systems still responded with three times as many antibodies as the boosted group's peak response.

More importantly, compared to immunity acquired through the spike-protein-based vaccines, natural immunity from SARS-CoV-2 infections covers the whole spectrum of immunity, giving the body short-term antibody protection as well as memory B and T cells for long-term protection. In addition, the short-term antibodies cover not only the fast-changing spike protein (S), but also other viral proteins, such as nucleocapsid protein (N) and envelope protein (E), making natural immunity less vulnerable for immune escape.

The takeaway is that even for the brief period right after a booster, vaccination was not as effective as natural immunity. Six months later, it was essentially useless.

The good news is that almost everyone in the U.K. has SARS-CoV-2 antibodies. This suggests that almost everyone there has had a SARS-CoV-2 infection at some point, and so has some level of natural immunity.

This does not mean that COVID-19 is over. It does mean that nature has provided people in the U.K. with protection better than the current spike-protein-based vaccines. We believe that the same is true in the United States and Canada.

Take the jab, if you want, and get the boosters. But don't be fooled. They will not give you any more protection than what you already have.

DRAFT: School Boards Secure Storage Notification Resolution for States with Safe Storage or Child Access Prevention Laws

Whereas, Evidence strongly suggests that secure firearm storage is an essential component to any effective strategy to keep schools and students safe;

Whereas, An estimated 4.6 million American children live in households with at least one loaded, unlocked firearm;

Whereas, Every year, roughly 350 children under the age of 18 unintentionally shoot themselves or someone else. That's roughly one unintentional shooting per day, and 70 percent of these incidents take place inside a home;

Whereas, Another 1,200 children and teens die by gun suicide each year, most often using guns belonging to a family member;

Whereas, In incidents of gun violence on school grounds, 75 percent of active shooters are current students or recent graduates, and up to 80 percent of shooters under the age of 18 obtained their guns from their own home, a relative's home, or from friends;

Whereas, Research shows that secure firearm storage practices are associated with up to an 85 percent reduction in the risk of unintentional firearm injuries among children and teens;

Whereas, The U.S. Secret Service National Threat Assessment Center recommends the importance of appropriate storage of weapons because many school attackers used firearms acquired from their homes;

Whereas, Across the country, lawmakers, community members, and local leaders are working together to implement public awareness campaigns, such as the Be SMART program, which is endorsed by the National PTA and which encourages secure gun storage practices and highlights the public safety risks of unsecured guns;

Whereas, School districts across the country have begun to proactively send materials home to parents and guardians informing them of applicable firearm storage laws and firearm secure storage best practices;

Whereas, Keeping students, teachers and staff safe from the threat of gun violence should be the responsibility of all adult stakeholders at each of our school sites;

Whereas, State law imposes penalties on adults when a child gains unsupervised access to

unsecurely stored firearms;

Whereas, In order to continue with preventative measures to increase student and school safety we must act now; now therefore, be it

Resolved, That the Board directs the Superintendent and staff to update the Student Handbook to include information about parents' legal obligations regarding the secure storage of firearms;

Resolved further, That the Board directs the Superintendent to create an appropriate letter, in English and Spanish, to parents and guardians that explains the importance of secure gun storage and the legal obligations to protect minors from accessing irresponsibly stored guns, to be included in annual registration materials at each school site, and requiring a signature acknowledging awareness of secure gun storage responsibilities; and, be it finally;

Resolved, That the Board and the Superintendent will continue to work with local law enforcement agencies, health agencies and non-profits to collaborate and increase efforts to inform District parents of their obligations regarding secure storage of firearms in their homes.

VACCINES & SAFETY

Fauci Makes Surprising Concession Regarding COVID-19 Vaccines

By Jack Phillips

July 13, 2022 Updated: July 14, 2022

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White House COVID-19 adviser Anthony Fauci conceded Wednesday morning that COVID-19 vaccines don't protect "overly well" against the virus.

Speaking during a Fox News interview, Fauci told host Neil Cavuto that "one of the things that's clear from the data [is] that ... vaccines—because of the high degree of transmissibility of this virus—don't protect overly well, as it were, against infection."

But Fauci said later that the vaccines "protect quite well against severe disease leading to hospitalization and death" before he made note of his recent COVID-19 diagnosis.

"At my age, being vaccinated and boosted, even though it didn't protect me against infection, I feel confident that it made a major role in protecting me from progressing to severe disease," said Fauci, who is 81 and has worked in various capacities in the federal government since the late 1960s. He's also headed the National Institute of Allergy and Infectious Diseases since the Reagan administration.

Fauci then said it's because of the vaccination that it is "very likely why I had a relatively mild course."

Natural Immunity

The official's comments come just days after a bombshell study revealed that natural immunity, or the immunity conferred via a previous COVID-19 infection, provides superior protection against the virus when compared with vaccines.

Researchers in Qatar said that individuals who survived a COVID-19 infection and weren't vaccinated had very high protection against severe or fatal disease.

"Effectiveness of primary infection against severe, critical, or fatal COVID-19 reinfection was 97.3 percent … irrespective of the variant of primary infection or reinfection, and with no evidence for waning. Similar results were found in sub-group analyses for those ≥50 years of age," Dr. Laith Abu-Raddad of Weill Cornell Medicine–Qatar wrote.

But the researchers noted that both natural and artificial immunity conferred via vaccines waned over time. People who were previously infected with COVID-19 and were not vaccinated had half the risks of reinfection as compared to those that were vaccinated with two doses but not infected.

During an interview with the Washington Post this week, Fauci suggested that Americans aged 5 to 50 should be allowed to get a second booster shot.

The federal government, he argued, "need[s] to allow people who are under 50 to get their second booster shot, since it may have been months since many of them got their first booster."

"If I got my third shot [in 2021], it is very likely the immunity is waning," Fauci proclaimed.

Marina Zhang contributed to this report.

Jack Phillips

BREAKING NEWS REPORTER

February 22, 2022

Rochelle P. Walensky, MD, MPH
Director, Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30329

Anthony S. Fauci, MD
Director, National Institute of Allergy and Infectious Diseases
National Institutes of Health
31 Center Dr # 7A03
Bethesda, MD 20892

Honorable Senator Ronald H. Johnson
328 Hart Senate Office Building
Washington DC 20510

Douglas L. Parker,
Assistant Secretary of Labor for Occupational Safety and Health
Occupational Safety & Health Administration
200 Constitution Ave NW
Washington, DC 20210

Mr. Jeffrey Zients
Coordinator and Counselor to the President
COVID-19 Pandemic Response
The White House
1600 Pennsylvania Ave. NW
Washington, DC 20500

Sent via US Mail Certified Return Receipt and e-mail

Re: Request for Immediate Corrections to the CDC Guidance on Masks and Respirators

Dear Dr. Walensky, Dr. Fauci, Senator Johnson, Mr. Parker, and Mr. Zients:

We the undersigned, professional experts in the field of industrial hygiene, with combined experience of nearly 150 years, are highly concerned with the inaccurate and misleading guidance being promoted by the CDC on its website regarding efficacy of masking to prevent COVID-19 and now similar guidance regarding respirators and request for immediate correction to said guidance. The guidance is overly broad, inaccurate, and especially inappropriate for children and the general public.

For reference, the field of industrial hygiene is defined as:

> *"That science and art devoted to the anticipation, recognition, evaluation, and control of those environmental factors or stressors arising in or from the workplace, which may cause sickness, impaired health and well-being, or significant discomfort among workers or among of the citizens of the community" (https://www.aiha.org/about-ih/Pages/default.aspx).*

The AIHA defines an Industrial Hygienist (https://www.aiha.org/ih-careers/discover-industrial-hygiene) as:

> *"Scientists and engineers committed to protecting the health and safety of people in the workplace and the community."*

Thus, our profession is dedicated, in part, to providing controls to exposures and rely upon what is known as the hierarchy of controls. The hierarchy of controls was first developed by the National Safety Council (NSC) in 1950. This guides us as to the most effective to least effective exposure controls (see Figure 1):

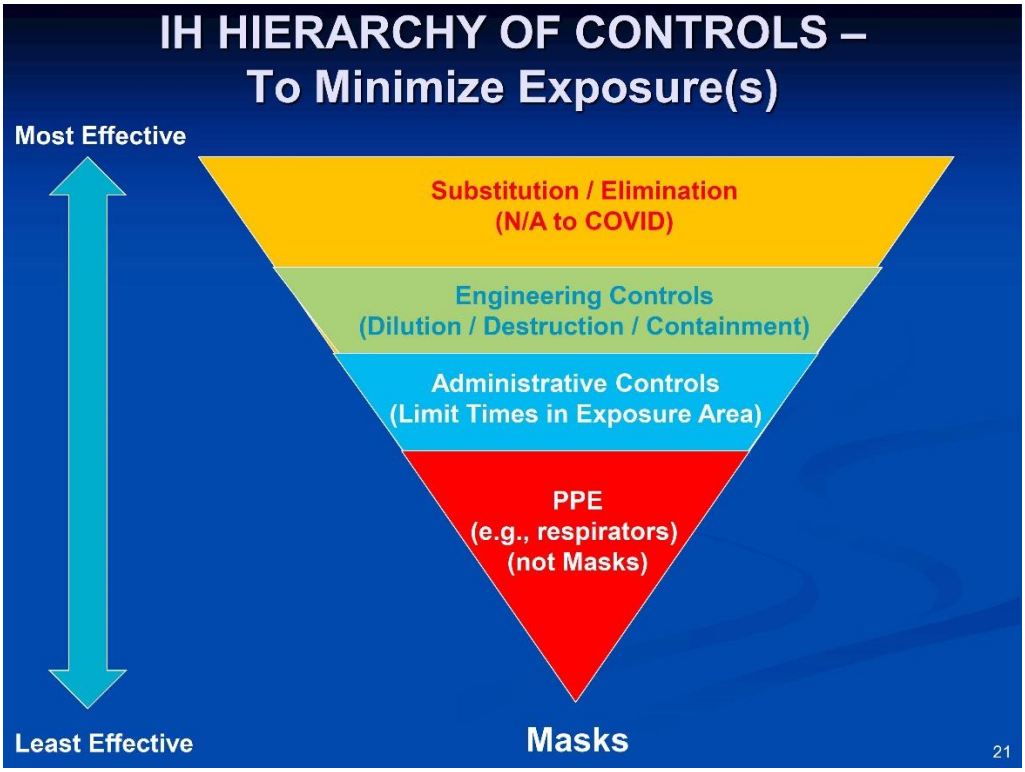
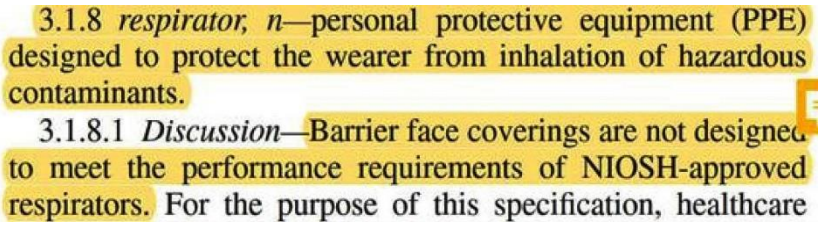


Figure 1: Hierarchy of Controls

Note that masks do not fit into the hierarchy of controls simply because they are not even personal protective equipment. This is recognized in the recent ASTM Face Covering (mask) Standard [ASTM F3502-21 – Standard Specification for Barrier Face Coverings (BFCs)] illustrated in Figure 2:



3.1.8 *respirator, n*—personal protective equipment (PPE) designed to protect the wearer from inhalation of hazardous contaminants.

3.1.8.1 *Discussion*—Barrier face coverings are not designed to meet the performance requirements of NIOSH-approved respirators. For the purpose of this specification, healthcare

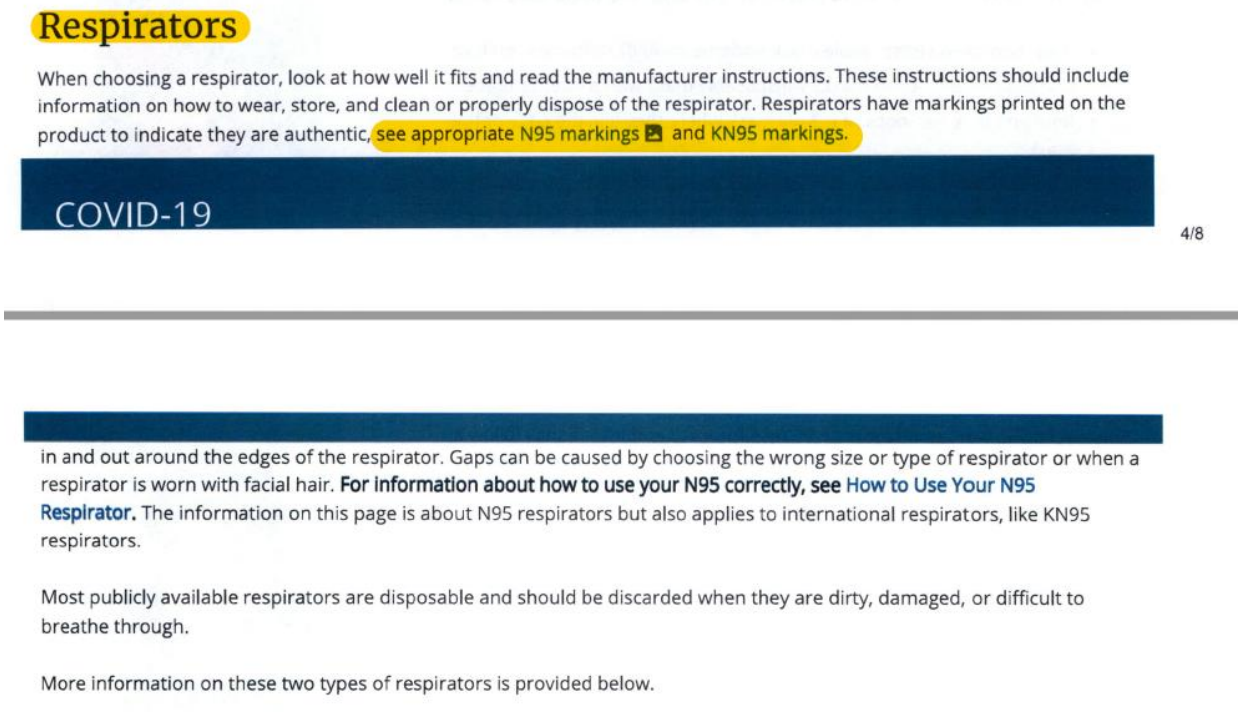
Figure 2: ASTM 2021 BFC Standard – Masks Not PPE (Respirators)

The best industrial hygiene solution has for decades been engineering controls of dilution with fresh air, filtration, and/or destruction – all of which are readily available technologies.

Given this background, we the undersigned have been increasingly concerned about the mis-information provided by the CDC to the public; often reflected by inappropriately conclusive language that *omits technical limitations and documented negative effects associated with masks and face coverings*. Examples of our concerns follow:

Issue #1: Recommending N-95 type masks is inappropriate for the general population and children:

The CDC's January 14, 2022 and January 28, 2022 webpage language have instructed people to move away from masks and toward N95-type respirators (see for example https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html), including KN95 respirators (Figure 3):



Respirators

When choosing a respirator, look at how well it fits and read the manufacturer instructions. These instructions should include information on how to wear, store, and clean or properly dispose of the respirator. Respirators have markings printed on the product to indicate they are authentic, see appropriate N95 markings and KN95 markings.

COVID-19

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in and out around the edges of the respirator. Gaps can be caused by choosing the wrong size or type of respirator or when a respirator is worn with facial hair. **For information about how to use your N95 correctly, see** How to Use Your N95 Respirator. The information on this page is about N95 respirators but also applies to international respirators, like KN95 respirators.

Most publicly available respirators are disposable and should be discarded when they are dirty, damaged, or difficult to breathe through.

More information on these two types of respirators is provided below.

Figure 3: CDC January 14 & January 28, 2022 Guidance on Respirators – pgs. 4-5

Under the topic of respirators, the CDC lists both N95 and KN95 respirators.

Moreover, as the CDC knows, persons or entities providing respirators in the workplace (unlike masks) must follow OSHA's Personal Protective Equipment Standard (OSHA 29 CFR 1910.132) to establish the nature of the hazard (Hazards Assessment) and the Respiratory Protection Standard (RPS) requirements (29 CFR 1910.134). Non-employees must also follow the RPS under the manufacturers' instructions (as we shall show later). These RPS requirements are substantial and include factors such as:

- Written RPS Plan
- Medical Clearance
- Initial Fit Test
- Annual Fit Test
- Training by a professional such as an IH on fit testing, cleaning, storage, and changeout.

As the CDC knows, or should know, movement from masks to respirators comes with significant requirements or as the manufacturers such as 3M state on their instructions, improper usage "may result in sickness or death".

In this context, we have recently been provided by the following request, and rejection by OSHA, to investigate improper usage of KN respirators by an employer (Figure 4):

U.S. Department of Labor

Occupational Safety and Health Administration
Toledo Area Office
420 Madison Ave, Suite 600
Toledo, OH 43604

February 9, 2022

[redacted]

RE: OSHA Complaint No. 1864651

Dear [redacted]

The Occupational Safety and Health Administration (OSHA) has received your notice of alleged workplace hazard(s) against notified Gun Lake Casino. After careful review we have decided not to conduct an inspection because:

On the basis of the information provided to our office during our phone conversation the employer has provided and is requiring employees to wear KN95 masks which are not NIOSH certified respirators and would not be covered by OSHA's respiratory protection standard.

If you do not agree with this decision, you may contact me for a clarification of the matter at (419) 259-7542.

Section 11(c) of the OSH Act provides protection for employees against discrimination because of their involvement in protected safety and health related activity. If you believe you are being treated differently or action is being taken against you because of your safety or health activity, you may file a complaint with OSHA. You should file this complaint as soon as possible, since OSHA normally can accept only those complaints filed within 30 days of the alleged discriminatory action.

Thank you for your concern for a safe and healthful workplace.

Respectfully,

For

Todd Jensen
Area Director

Figure 4: OSHA February 9, 2022 Response Letter to Gun Lake Casino Complaint

OSHA rejected the employee complaint on a technicality that the employer was not following the OSHA RPS because the respirator was a KN95 rather than an N95. And, as shown in Figure 5, NIOSH does not approve KN95's:

CDC Centers for Disease Control and Prevention

Promoting productive workplaces through safety and health research NIOSH

NIOSH-approved N95 Particulate Filtering Facepiece Respirators

This list is reviewed and updated weekly.

Manufacturers Listed from A to Z – L

The N95 respirator is the most common of the seven types of particulate filtering facepiece respirators. This product filters at least 95% of airborne particles but is not resistant to oil-based particles.

This web page provides a table of NIOSH-approved N95 respirators listed by manufacturer from A-Z. You can find a specific manufacturer by clicking on the first letter of their name on the index below. Web links in the table go to the NIOSH Approval Holder's website. See the Notes section for information about private labels.

NIOSH entered a Memorandum of Understanding (MOU) in 2018 with the Food and Drug Administration (FDA). This MOU granted NIOSH the authority to approve surgical N95 filtering facepiece respirators. Prior to this MOU, both NIOSH and FDA approved and cleared surgical N95s. The **Model Number/Product Line in bold text followed by (FDA)** indicates these surgical N95 respirators in the table below. NIOSH also provides a table of the surgical N95 respirators approved prior to the MOU. Surgical N95 respirators approved under the MOU do not require FDA's 510(k) clearance. These NIOSH-approved surgical N95 respirators are only on the Certified Equipment List (CEL).

A respirator labeled as a KN95 respirator is expected to conform to China's GB2626 standard. NIOSH does not approve KN95 products or any other respiratory protective devices certified to international standards. For more information, view Factors to Consider When Planning to Purchase Respirators from Another Country.

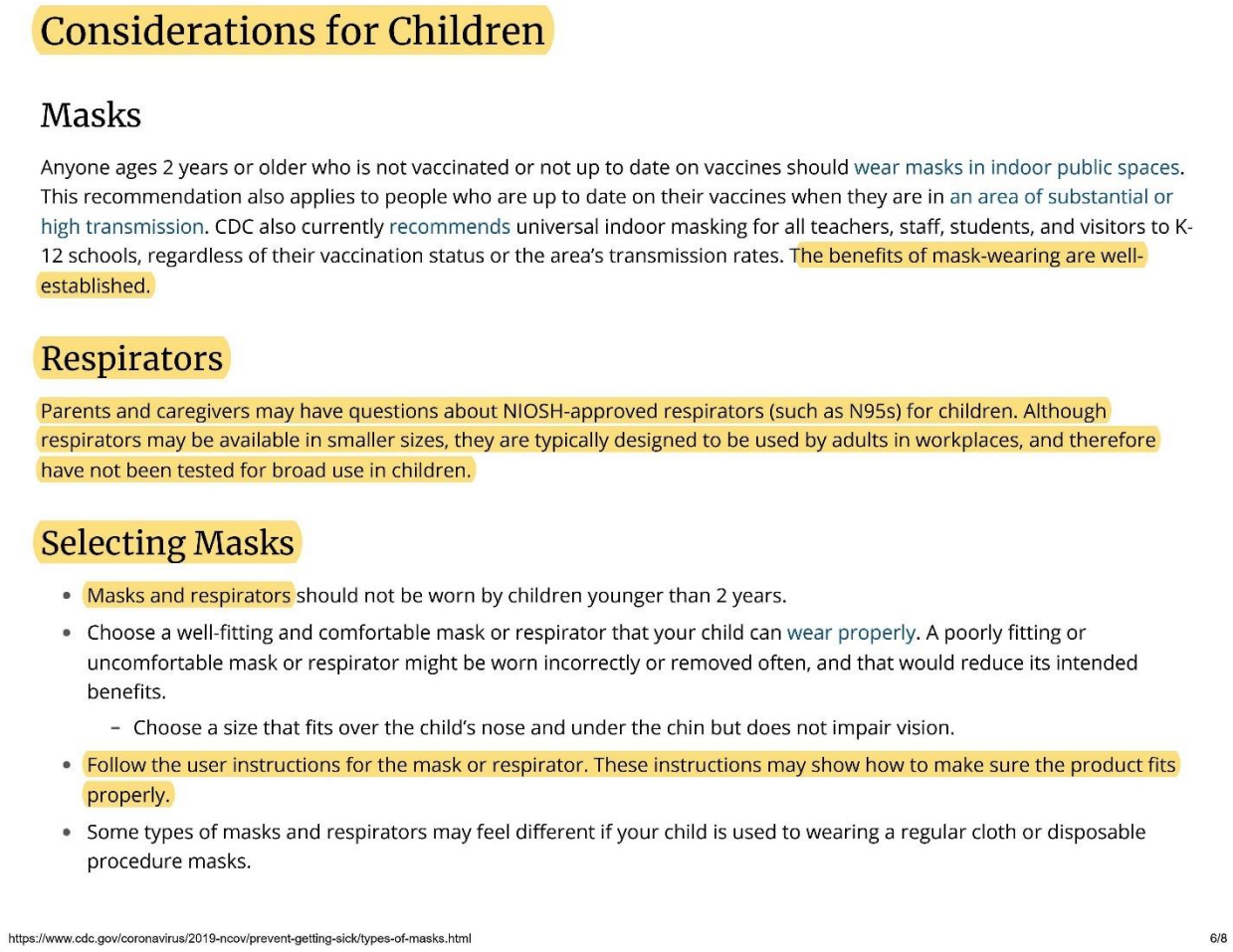
Figure 5: NIOSH Language Regarding Approval of KN95 Respirators

So, in an obvious case of deception, the CDC recommends the usage of N95 and KN95 respirators (see Figure 3) yet must know they are not approved by NIOSH and that OSHA will not enforce the RPS. The irony here is that NIOSH is part of the CDC (see Figure 5 letterhead), so the CDC clearly knows this. Note that it is known that KN95 respirators from China are known to be less expensive than those made with the N95 designation and find widespread usage; this too was known, or should have been known, by the CDC.

Thus, the CDC pushes KN95 respirators as part of the move toward respirators, knowing they are not approved by their sub-agency NIOSH, which allows employers to make employees wear respirators without the protections of OSHA's Respiratory Protection Standard (RPS). This is an unconscionable breach of the public health function and should be corrected immediately.

Issue #2: CDC has issued harmful guidance for masking children that contradicts manufacturers' recommendations, world-wide standard practice and CDC's own guidance, and without appropriate risk-benefit analysis:

The CDC's January 28, 2022 webpage language misleadingly implies respirators are acceptable for children yet knows that this is not the case simply based on manufacturer instructions, they link the reader to https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html – see Figure 6:



Considerations for Children

Masks

Anyone ages 2 years or older who is not vaccinated or not up to date on vaccines should wear masks in indoor public spaces. This recommendation also applies to people who are up to date on their vaccines when they are in an area of substantial or high transmission. CDC also currently recommends universal indoor masking for all teachers, staff, students, and visitors to K-12 schools, regardless of their vaccination status or the area's transmission rates. The benefits of mask-wearing are well-established.

Respirators

Parents and caregivers may have questions about NIOSH-approved respirators (such as N95s) for children. Although respirators may be available in smaller sizes, they are typically designed to be used by adults in workplaces, and therefore have not been tested for broad use in children.

Selecting Masks

- Masks and respirators should not be worn by children younger than 2 years.
- Choose a well-fitting and comfortable mask or respirator that your child can wear properly. A poorly fitting or uncomfortable mask or respirator might be worn incorrectly or removed often, and that would reduce its intended benefits.
  - Choose a size that fits over the child's nose and under the chin but does not impair vision.
- Follow the user instructions for the mask or respirator. These instructions may show how to make sure the product fits properly.
- Some types of masks and respirators may feel different if your child is used to wearing a regular cloth or disposable procedure masks.

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html 6/8

Figure 6: Misleading CDC Language Regarding Children Wearing Masks and Respirators

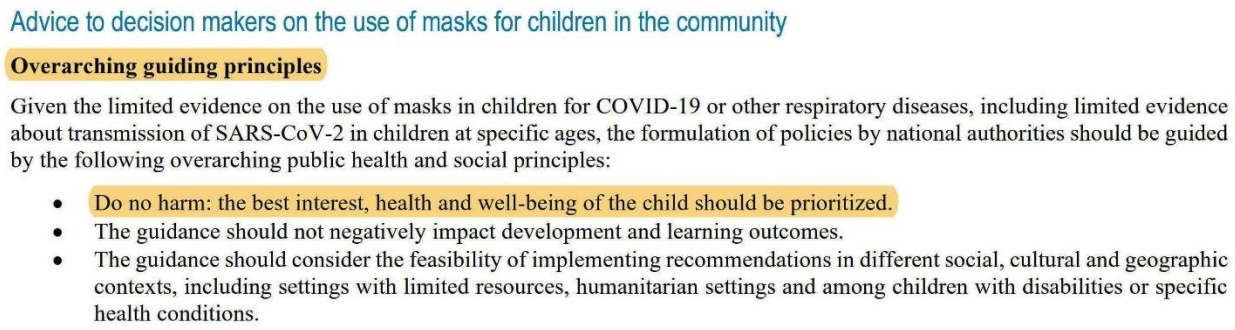
As illustrated in detail below, the CDC provided language in its January 28, 2022 guidance for children that is particularly misleading by obfuscating and omitting information readily known, or likely to have been known by the CDC.

<u>"The benefits of mask-wearing are well-established:"</u>

First, the benefits of children, or anyone for that matter, of wearing masks being well

established is simply false. A Brownstone paper by Paul Elias Alexander published December 21, 2021 (https://brownstone.org/articles/more-than-150-comparative-studies-and-articles-on-mask-ineffectiveness-and-harms/) shows both the effectiveness of masks and their harms, citing 150 studies. One of these author's testified in the Western District Court of Michigan on September 28, 2021, in a half-dozen interviews (e.g., Jeff Hayes Films: https://rumble.com/vrfoox-covid-revealed-episode-8b-bonus-video-stephen-petty.html), in his own podcasts (https://rumble.com/c/PettyPodcasts) and in the Liberty Dispatch in Canada (https://podcasts.apple.com/us/podcast/episode-99-masks-dont-work-an-interview-with-ppe/id1559570986?i=1000550149187). During this testimony it was shown that the nearly 50 studies cited by the CDC purportedly showing masks are effective did not support statements made by the CDC and most suffered from a lack of a control group (group similar to the mask study group not wearing masks) or cofounding factors (multiple factors such as changes in HVAC systems, distancing, quarantining, and masks) wherein one cannot determine the specific contribution by masking.

But the most egregious part of this statement is that it only addresses supposed benefits, not liabilities. Even the WHO - UNICEF (https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC_Masks-Children-2020.1) understands that risk-rewards analysis should be done before recommending unproven, unscientifically-supported policies before masking them. Remember – do no harm – is the overarching principle (Figures 7 & 8):



Advice to decision makers on the use of masks for children in the community

Overarching guiding principles

Given the limited evidence on the use of masks in children for COVID-19 or other respiratory diseases, including limited evidence about transmission of SARS-CoV-2 in children at specific ages, the formulation of policies by national authorities should be guided by the following overarching public health and social principles:

- Do no harm: the best interest, health and well-being of the child should be prioritized.
- The guidance should not negatively impact development and learning outcomes.
- The guidance should consider the feasibility of implementing recommendations in different social, cultural and geographic contexts, including settings with limited resources, humanitarian settings and among children with disabilities or specific health conditions.

Figure 7: WHO UNICEF Recommendations for Children and Masks

From Figure 7, the overarching guiding principle is to do no harm.

Advice on the use of masks in children

WHO and UNICEF advise decision makers to apply the following criteria for use of masks in children when developing national policies, in countries or areas where there is known or suspected community transmission[a] of SARS-CoV-2 and in settings where physical distancing cannot be achieved.

1. Based on the expert opinion gathered through online meetings and consultative processes, children aged up to five years should not wear masks for source control. This advice is motivated by a "do no harm" approach and considers:
    - childhood developmental milestones[b] [41]
    - compliance challenges and
    - autonomy required to use a mask properly.

The experts (following the methods described above) recognized that the evidence supporting the choice of the age cut-off is limited (see above, section related to transmission of COVID-19 in children), and they reached this decision mainly by consensus. The rationale included consideration of the fact that by the age of five years, children usually achieve significant developmental milestones, including the manual dexterity and fine motor coordination movements needed to appropriately use a mask with minimal assistance.

In some countries, guidance and policies recommend a different and lower age cut-off for mask use[42-45]. It is recognized that children may reach developmental milestones at different ages and children five years of age and under may have the dexterity needed to manage a mask. Based on the do no harm approach, if the lower age cut-off of two or three years of age is to be used for recommending mask use for children, appropriate and consistent supervision, including direct line of sight supervision by a competent adult and compliance need to be ensured, especially if mask wearing is expected for an extended period of time. This is both to ensure correct use of the mask and to prevent any potential harm associated with mask wearing to the child.

Children with severe cognitive or respiratory impairments who have difficulties tolerating a mask should, under no circumstances, be required to wear masks.

Other IPC, public health and social measures should be prioritized to minimize the risk of SARS-CoV-2 transmission for children five years of age and under; specifically maintaining physical distance of at least 1 meter where feasible, educating children to perform frequent hand hygiene and limiting the size of school classes. It is also noted that there may be other specific considerations, such as the presence of vulnerable persons or other local medical and public health advice that should be considered when determining if children five years of age and under need to wear a mask.

2. For children between six and 11 years of age, a risk-based approach should be applied to the decision to use of a mask. This approach should take into consideration:
    - intensity of transmission in the area where the child is and updated data/available evidence on the risk of infection and transmission in this age group;
    - social and cultural environment such as beliefs, customs, behaviour or social norms that influence the community and population's social interactions, especially with and among children;
    - the child's capacity to comply with the appropriate use of masks and availability of appropriate adult supervision;
    - potential impact of mask wearing on learning and psychosocial development; and
    - additional specific considerations and adaptions for specific settings such as households with elderly relatives, schools, during sport activities or for children with disabilities or with underlying diseases.

3. Advice on mask use in children and adolescents 12 years or older should follow the WHO guidance for mask use in adults[1] and/or the national mask guidelines for adults.

    Even where national guidelines apply, additional specific considerations (see below) and adaptions for special settings such as schools, during sport, or for children with disabilities or with underlying diseases will need to be specified.

Figure 8: WHO UNICEF Recommendations for Children and Masks by Age

Note that from Figure 8, WHO recommends against masking below age 6 and that children ages 6 to 11 may be masked upon completion of a risk assessment. England has similar guidance. But the CDC requires masks for children down to age 2 against WHO guidance and based on extensive reviews, has yet to perform any risk assessment on the net benefits of children wearing masks.

Specifically, it is well established that significant harms (i.e., reduced learning and development and physical, emotional, and social harms) have been reported in the literature (Figures 9-18):

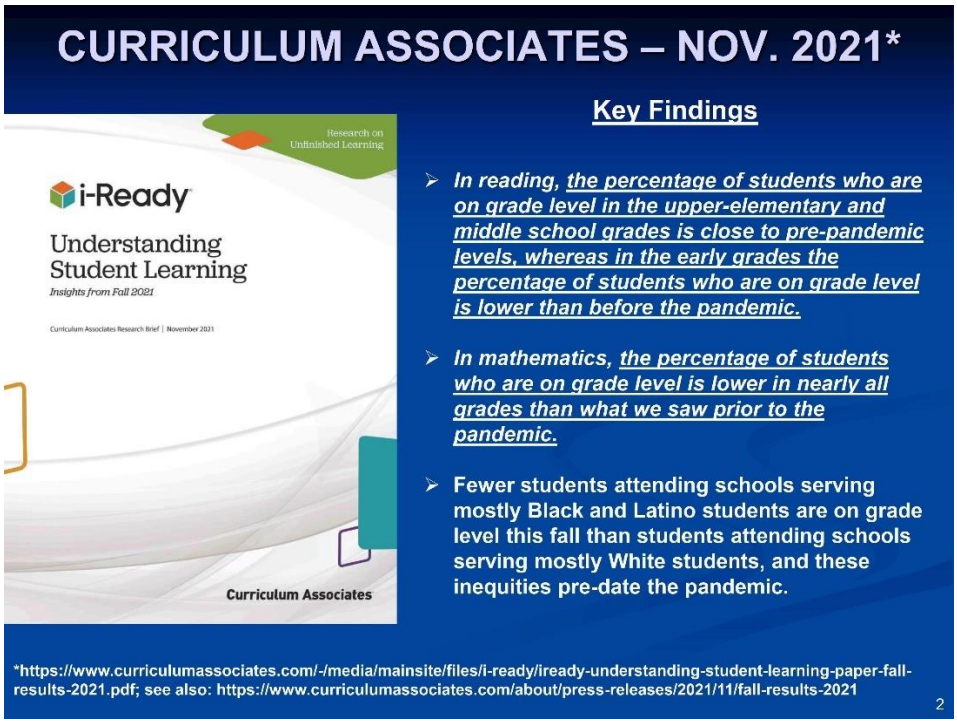


Figure 9: Curriculum Associates – Nov. 2021 – Title Page

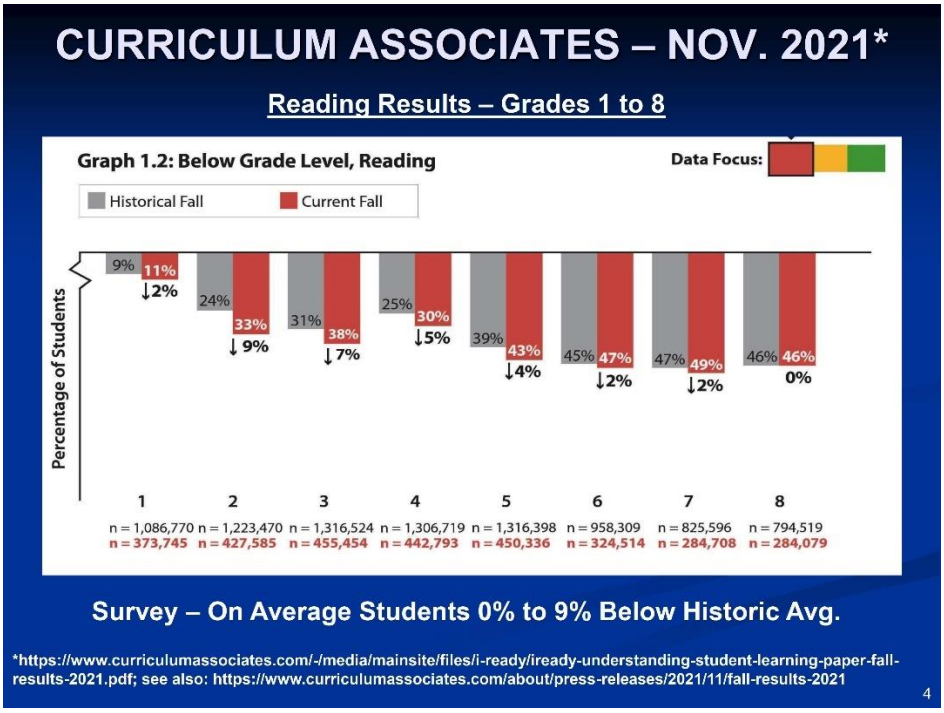


Figure 10: Curriculum Associates – Reading Deficits in 2021 vs. Prior Years

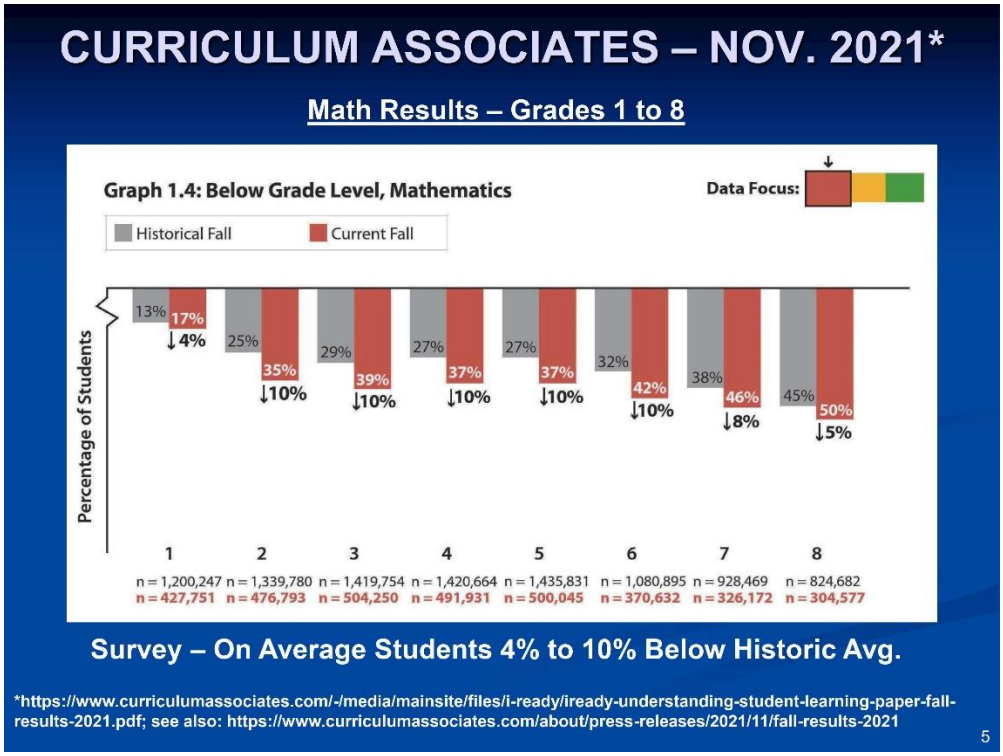


Figure 11: Curriculum Associates – Math Deficits in 2021 vs. Prior Years

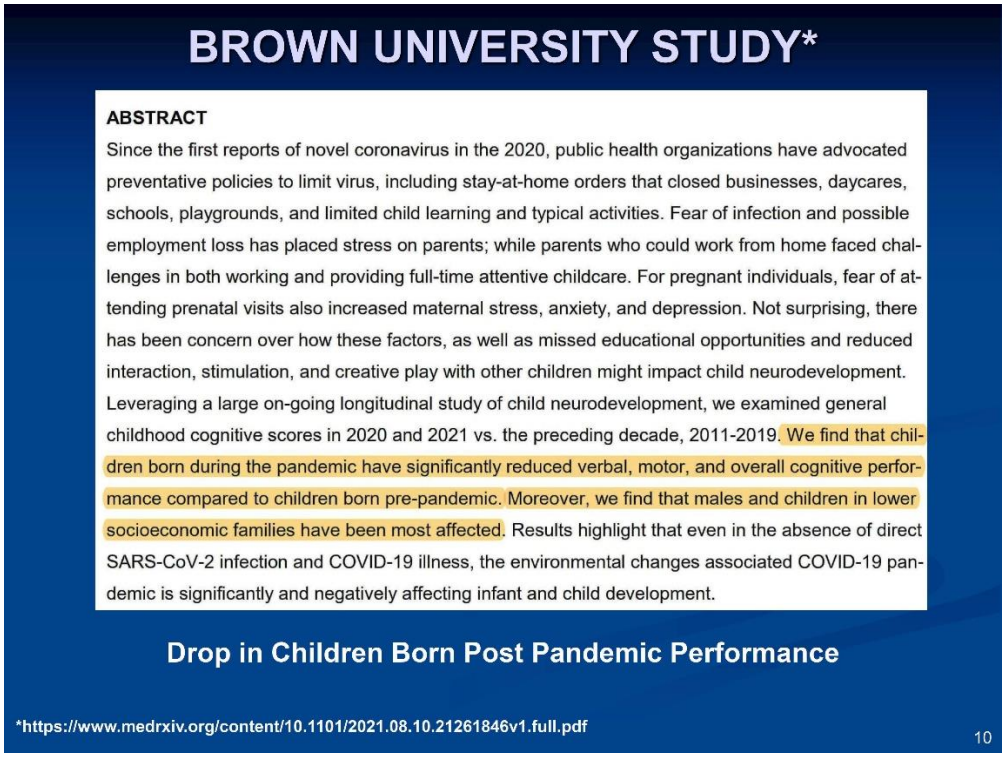


Figure 12: Brown University – Cognitive Deficits

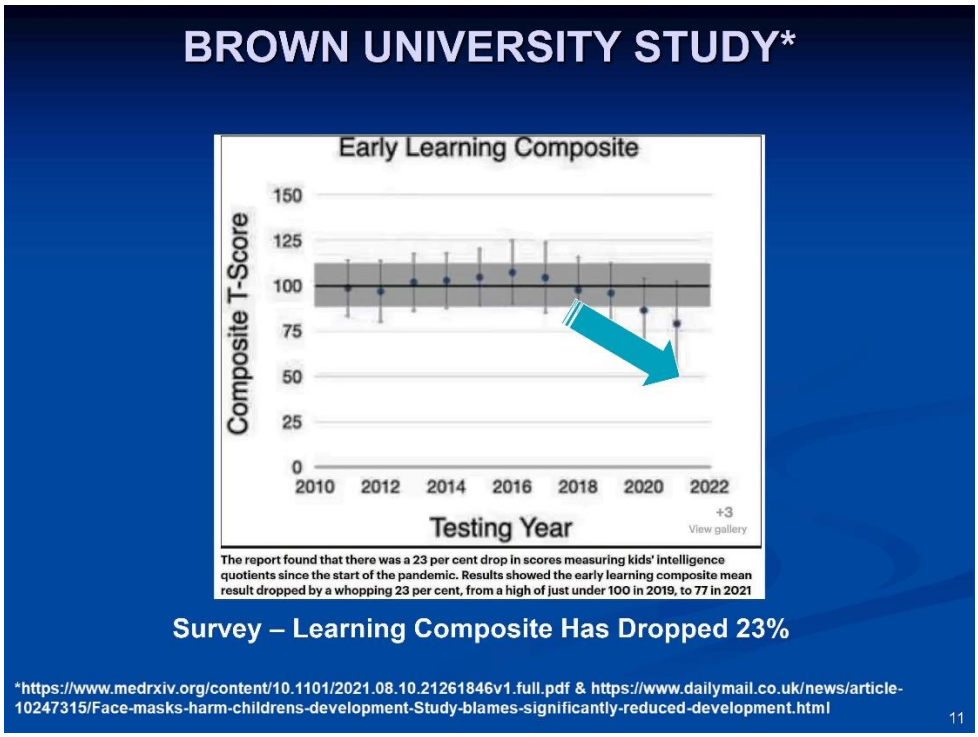


Figure 13: Brown University Study – Learning Loss of 23% for Children Born Since Pandemic

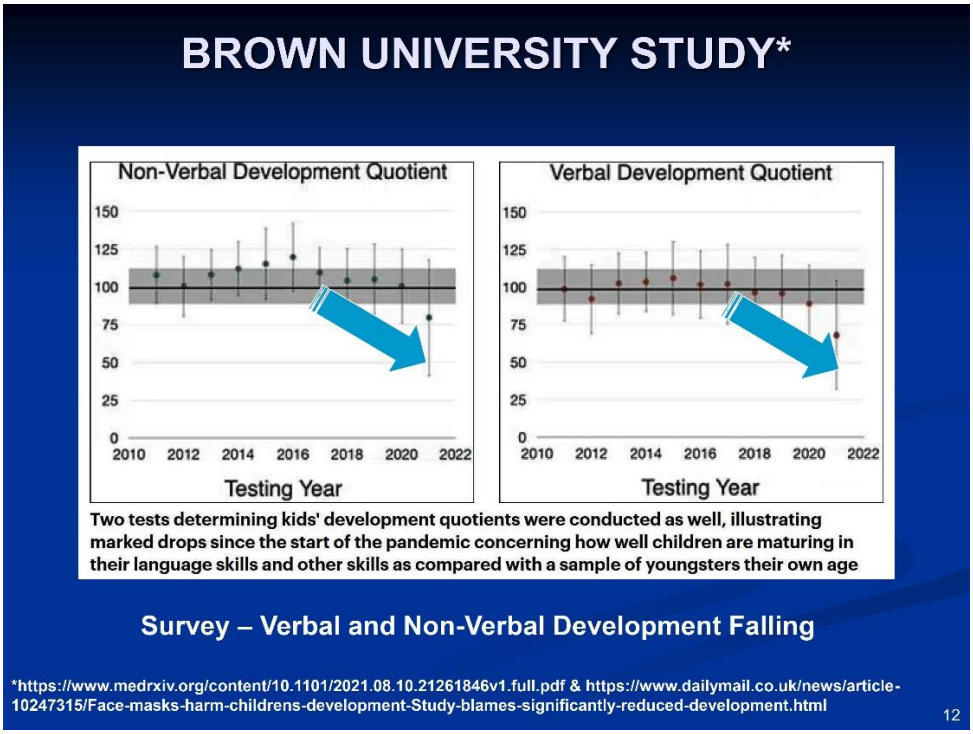


Figure 14: Brown University Study – Non-Verbal and Verbal Development Losses

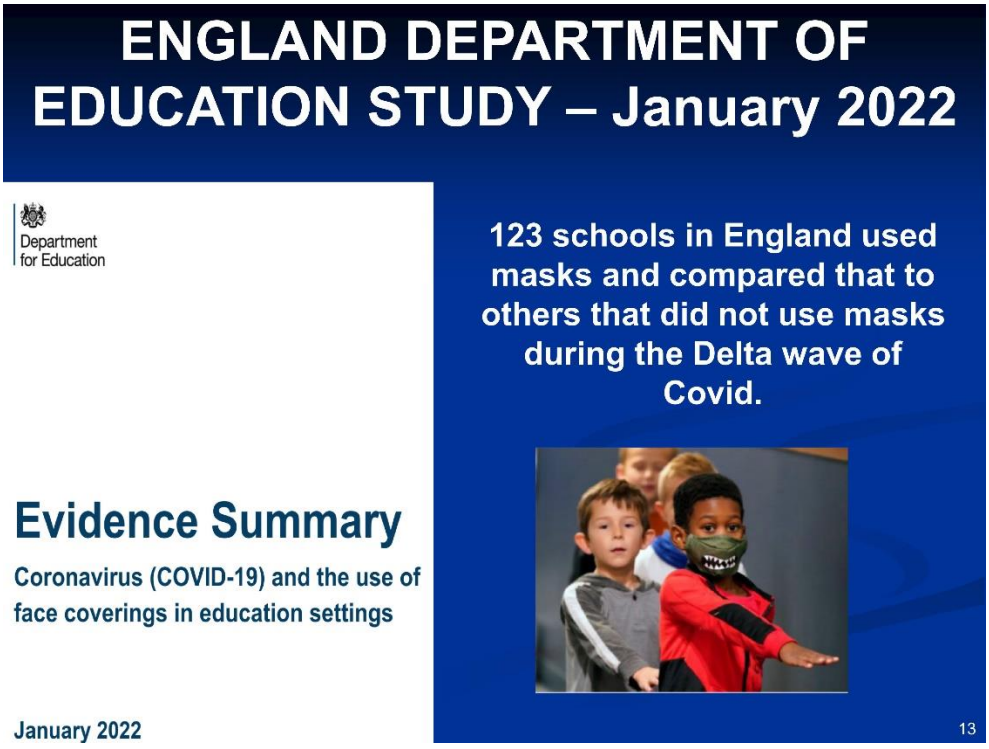


Figure 15: England Department of Education

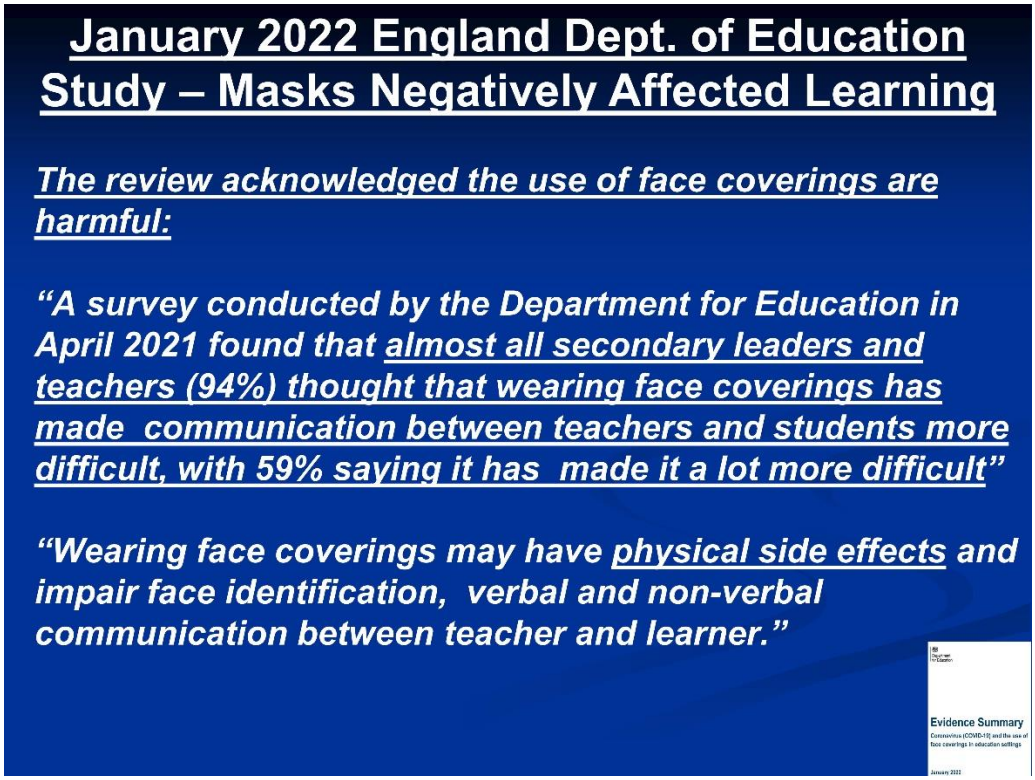


Figure 16: England Department of Education – Loss of Communication and Physical Effects

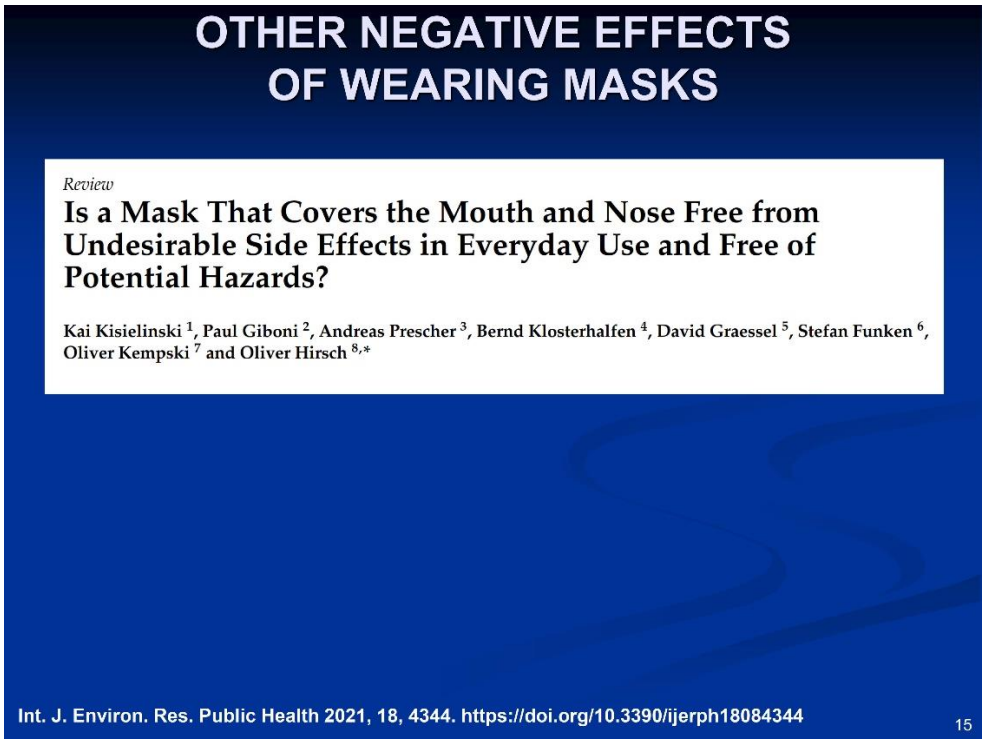


Figure 17: Kisielinski et al. – Mask Meta Study – Reviewed 1,226 Studies

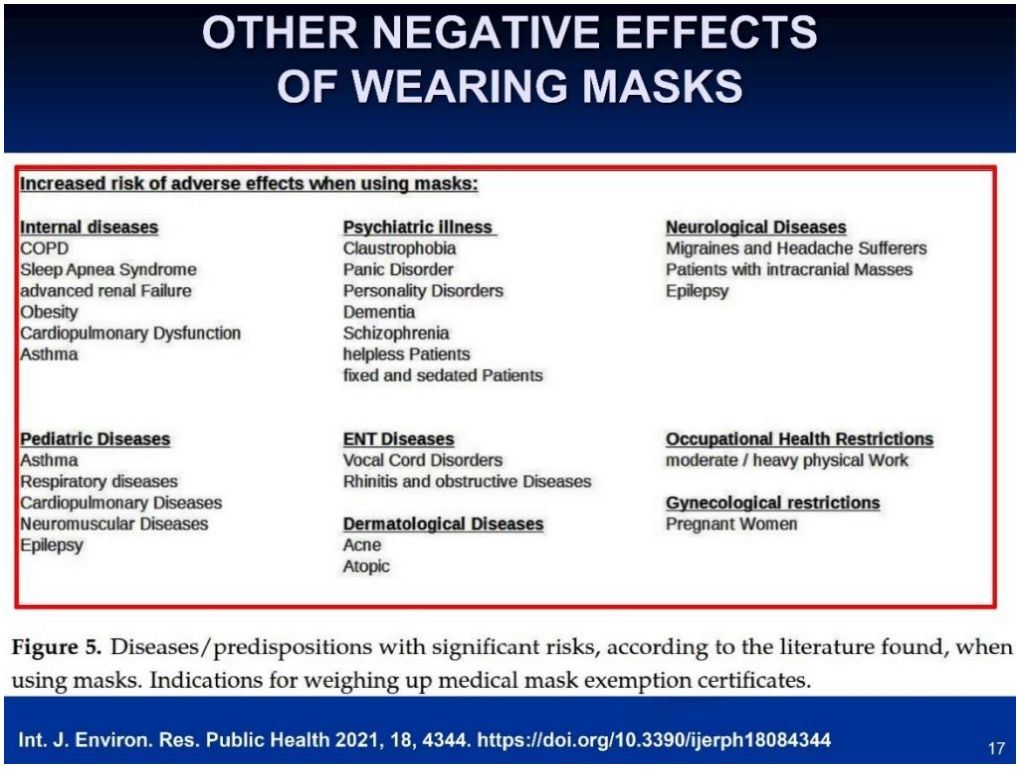


Figure 18: Kisielinski et al., – Areas of Quantitated Adverse Effects on Children and Adults

Clearly, the CDC has not conducted a net risk assessment and should have, and must do so to avoid continuing harms to children.

Even more disturbing, in their innocent looking, new Guidance for Children (Learn the Signs, Act Early) the CDC has in part, extended the timeframes for children to achieve learning outcomes (https://www.cdc.gov/ncbddd/actearly/milestones/index.html). Regarding these changes – Figure 19, CDC refers the reader to an American Academy of Pediatrics (AAP) webpage (https://publications.aap.org/pediatrics/article-abstract/doi/10.1542/peds.2021-052138/184748/Evidence-Informed-Milestones-for-Developmental?redirectedFrom=fulltext):

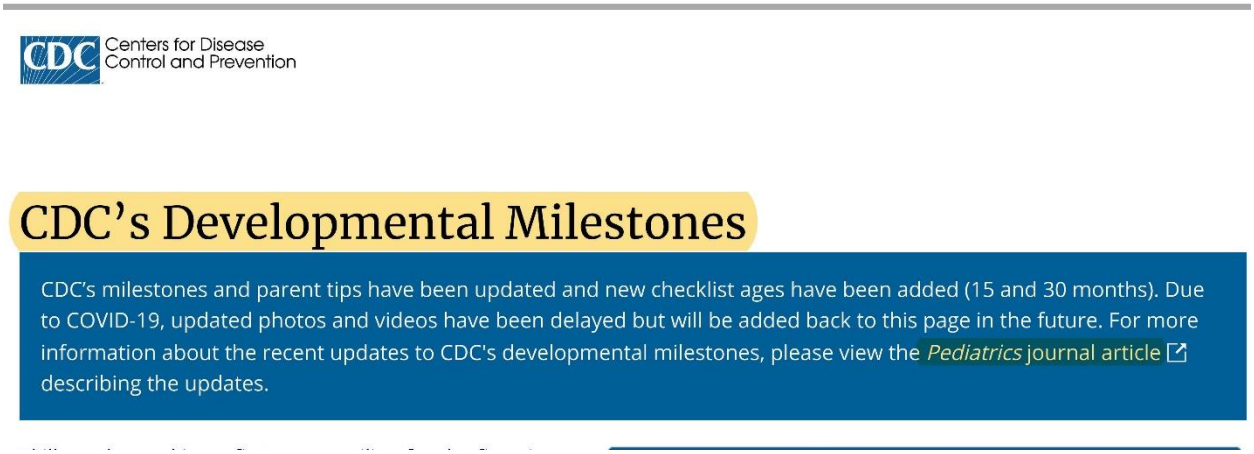


Figure 19: CDC Learn the Signs, Act Early New Webpage – Reference to AAP

The headlines for the reference paper are reproduced as Figure 20:

Figure 20: CDC Referenced AAP Paper by Zubler (CDC) et al. Dated February 8, 2022

Zubler et al., write in part:

"*The Centers for Disease Control and Prevention's (CDC) Learn the Signs. Act Early. program, funded the American Academy of Pediatrics (AAP) to convene an expert working group to revise its developmental surveillance checklists*. The goals of the group were to identify evidence-informed milestones to include in CDC checklists, clarify when most children can be expected to reach a milestone (to discourage a wait-and-see approach), and support clinical judgment regarding screening between recommended ages. Subject matter experts identified by the AAP established 11 criteria for CDC milestone checklists, including using milestones most children (≥75%) would be expected to achieve by specific health supervision visit ages and those that are easily observed in natural settings. A database of normative data for individual milestones, common screening and evaluation tools, and published clinical opinion was created to inform revisions. ***Application of the criteria established by the AAP working group and adding milestones for the 15- and 30-month health supervision visits resulted in a 26.4% reduction and 40.9% replacement of previous CDC milestones***. ***One third of the retained milestones were transferred to different ages; 67.7% of those transferred were moved to older ages.*** *Approximately 80% of the final milestones had normative data from ≥1 sources*. Social-emotional and cognitive milestones had the least normative data. These criteria and revised checklists can be used to support developmental surveillance, clinical judgment regarding additional developmental screening, and research in developmental surveillance processes. Gaps in developmental data were identified particularly for social-emotional and cognitive milestones.

Thus, at least 22.3% [67.7% of 33%] of the CDC child developmental milestones in place for ~18 years, were moved from a younger age to an older age in February 2022.

One must conclude the CDC, rather than acknowledging the harms being done to children's development by their COVID policies, including masking, is simply moving the goalposts for what constitutes normal child development rather than admitting and moving away from failed policies.

Statements under "Respirators" and "Selecting Masks":

- Parents and caregivers may have questions about NIOSH-approved respirators (such as N95s) for children. *Although respirators may be available in smaller sizes,* ***they are typically designed to be used by adults in workplaces****, and therefore have not been tested for broad use in children*.
- ***Masks and respirators should not be worn by children younger than 2 years.***
- Choose a size that fits over the child's nose and under the chin but does not impair vision. ***Follow the user instructions for the mask or respirator.*** *These instructions may show how to make sure the product fits properly.*

This language may be the most misleading and egregious given that the links CDC provides to manufacturers' instruction state that their N95s are not for use with children – the CDC has to know this.

The links to manufacturers' instructions from the January 28, 2022 mask and January 25, 2022 How to Use Your N95 Respirator are shown in Figures 21 and 22 respectively:

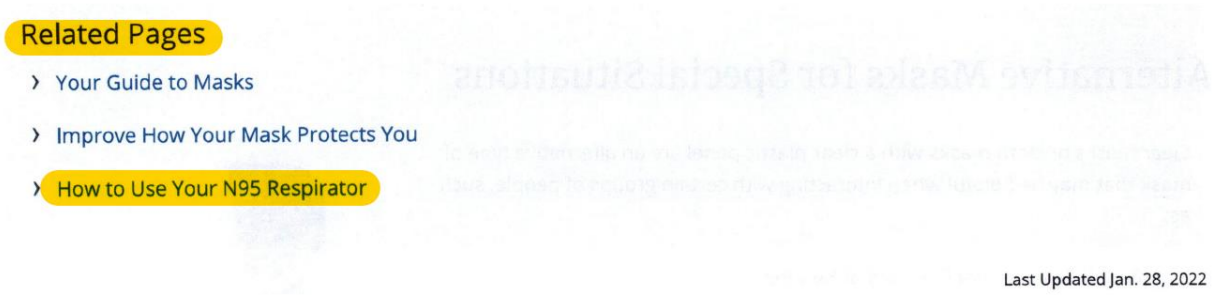


Figure 21: CDC January 28, 2022 Link – Bottom of Page and CDC January 25, 2022 Link to Manufacturers' Guidance and Warnings

The "How to Use Your N95 Respirator" is at the bottom of the CDC January 28, 2022 webpage.

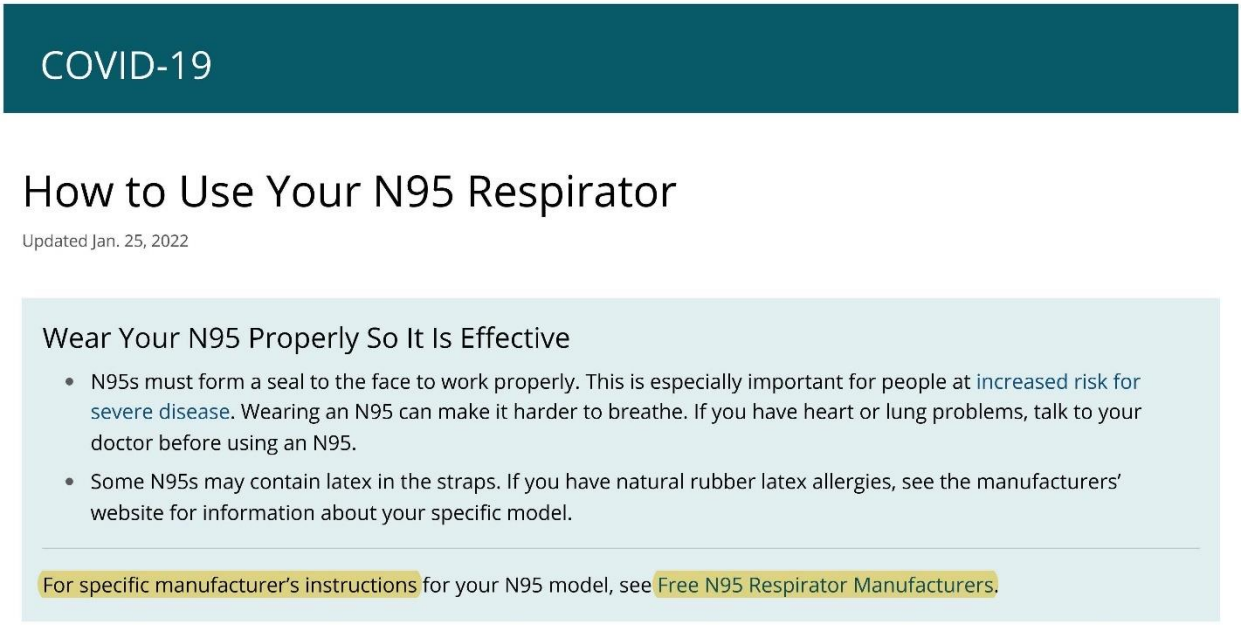


Figure 22: CDC January 15, 2022 Link to How to Use Your N-95 Respirator – Link to Manufacturers

The link in turn takes one to the following page (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/free-n95-manufacturers.html) (Figure 23):

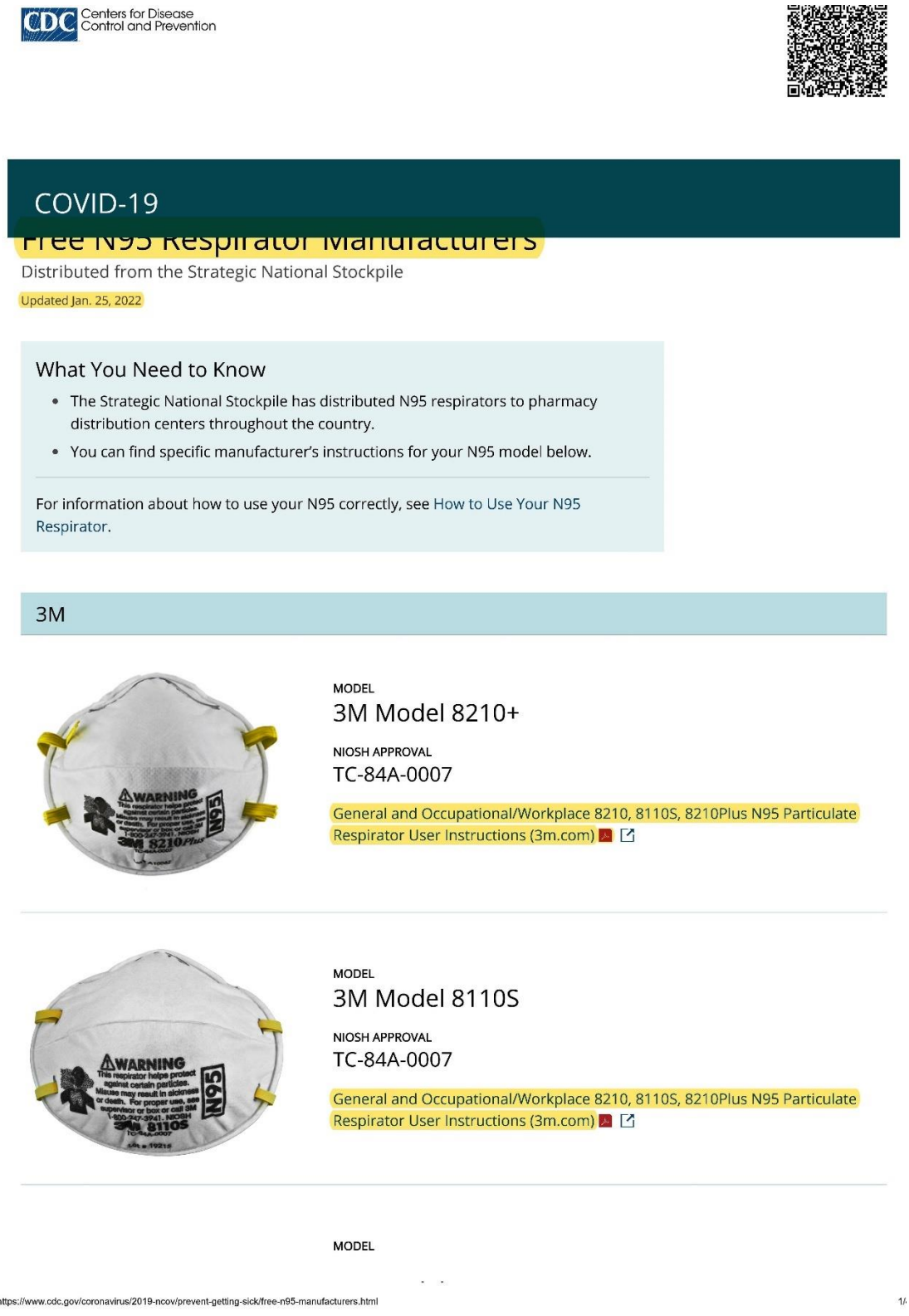


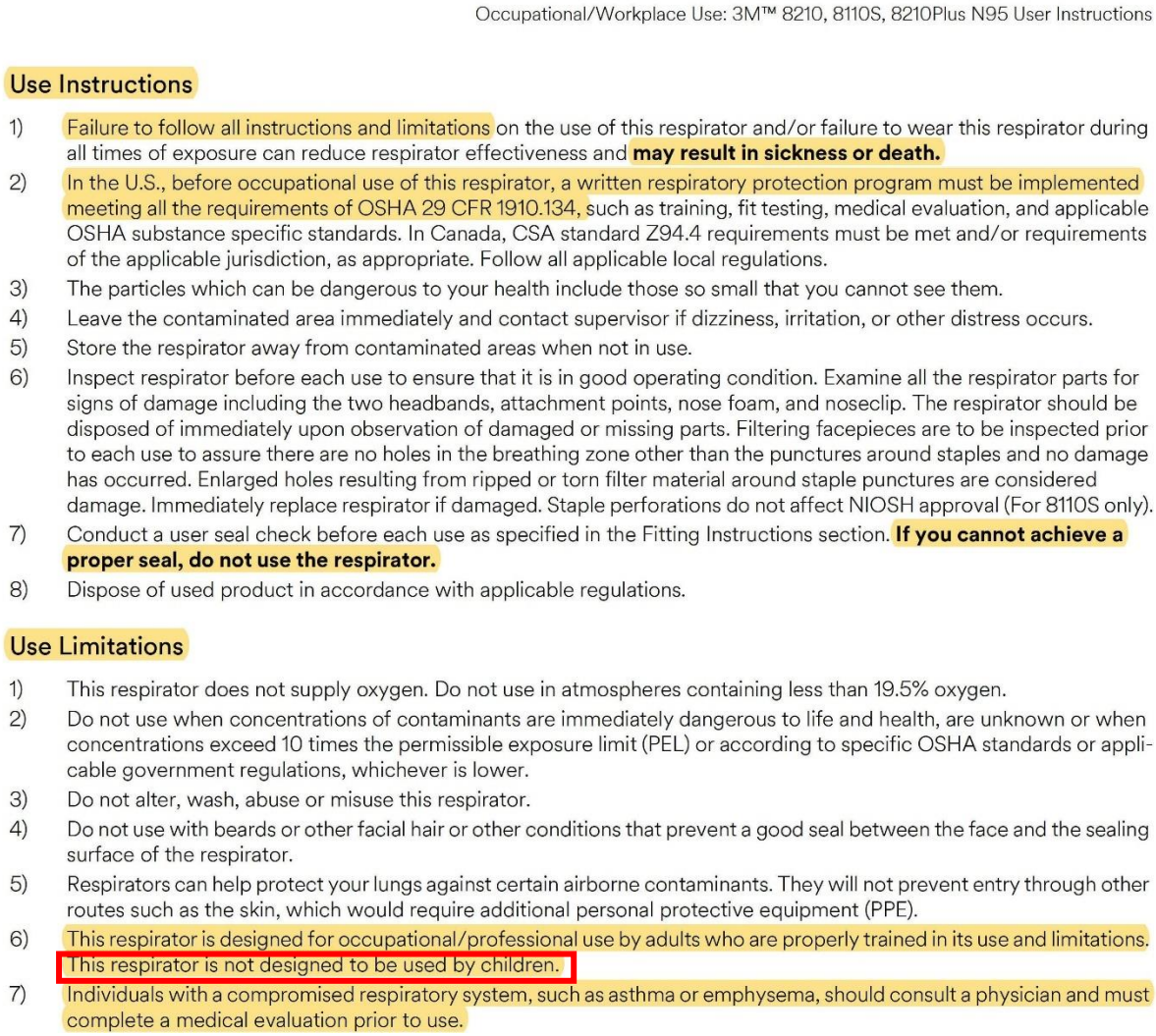
Figure 23: CDC January 15, 2022 Link to How to Use Your N-95 Respirator – Link to Manufacturers – pg. 1

From this webpage, four manufacturers are listed representing 12 respirators:

- 3M (6 models)
- Drager (1 model)
- Honeywell (2 models)
- Moldex (3 models).

For each model, the link can be clicked to get directly to the manufacturers' instructions for each respirator. For 3M and Moldex, major suppliers, only one set of instructions is used for each of their individually listed respirators. In other words, the same instructions were provided for each of the manufacturers' listed products.

Both 3M and Moldex explicitly state that their masks are not to be use by children (Figure 24).



Occupational/Workplace Use: 3M™ 8210, 8110S, 8210Plus N95 User Instructions

Use Instructions

1) Failure to follow all instructions and limitations on the use of this respirator and/or failure to wear this respirator during all times of exposure can reduce respirator effectiveness and **may result in sickness or death.**
2) In the U.S., before occupational use of this respirator, a written respiratory protection program must be implemented meeting all the requirements of OSHA 29 CFR 1910.134, such as training, fit testing, medical evaluation, and applicable OSHA substance specific standards. In Canada, CSA standard Z94.4 requirements must be met and/or requirements of the applicable jurisdiction, as appropriate. Follow all applicable local regulations.
3) The particles which can be dangerous to your health include those so small that you cannot see them.
4) Leave the contaminated area immediately and contact supervisor if dizziness, irritation, or other distress occurs.
5) Store the respirator away from contaminated areas when not in use.
6) Inspect respirator before each use to ensure that it is in good operating condition. Examine all the respirator parts for signs of damage including the two headbands, attachment points, nose foam, and noseclip. The respirator should be disposed of immediately upon observation of damaged or missing parts. Filtering facepieces are to be inspected prior to each use to assure there are no holes in the breathing zone other than the punctures around staples and no damage has occurred. Enlarged holes resulting from ripped or torn filter material around staple punctures are considered damage. Immediately replace respirator if damaged. Staple perforations do not affect NIOSH approval (For 8110S only).
7) Conduct a user seal check before each use as specified in the Fitting Instructions section. **If you cannot achieve a proper seal, do not use the respirator.**
8) Dispose of used product in accordance with applicable regulations.

Use Limitations

1) This respirator does not supply oxygen. Do not use in atmospheres containing less than 19.5% oxygen.
2) Do not use when concentrations of contaminants are immediately dangerous to life and health, are unknown or when concentrations exceed 10 times the permissible exposure limit (PEL) or according to specific OSHA standards or applicable government regulations, whichever is lower.
3) Do not alter, wash, abuse or misuse this respirator.
4) Do not use with beards or other facial hair or other conditions that prevent a good seal between the face and the sealing surface of the respirator.
5) Respirators can help protect your lungs against certain airborne contaminants. They will not prevent entry through other routes such as the skin, which would require additional personal protective equipment (PPE).
6) This respirator is designed for occupational/professional use by adults who are properly trained in its use and limitations. This respirator is not designed to be used by children.
7) Individuals with a compromised respiratory system, such as asthma or emphysema, should consult a physician and must complete a medical evaluation prior to use.

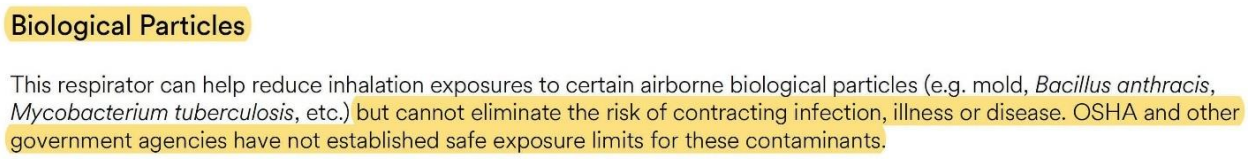
Figure 24: 3M Instructions for CDC Listed 3M N95 Respirators – Not Designed to be Used by Children

Note the following observations from Figure 24:

- ***This respirator is not designed to be used by children***!
- The respirator is only intended to be used for occupational or professional adults properly trained (e.g., under the RPS).
- Failure to follow instructions may result in sickness or death.
- A written respiratory protection plan, under the requirements of 29 CFR 1910.134 (RPS) must be in place prior to use of this respirator.

The Moldex instructions are essentially the same.

Moreover, 3M warns it is not protective against infectious diseases (Figure 25):



Biological Particles

This respirator can help reduce inhalation exposures to certain airborne biological particles (e.g. mold, *Bacillus anthracis*, *Mycobacterium tuberculosis*, etc.) but cannot eliminate the risk of contracting infection, illness or disease. OSHA and other government agencies have not established safe exposure limits for these contaminants.

5

Figure 25: 3M Instructions for CDC Listed 3M N95 Respirators – Not Protective Against Infection, Illness, or Disease

Note that anthrax and TB are much larger particles than virus particles like the COVID-19 virus.

In light of this discussion, the CDC should immediately correct their webpage stating explicitly that respirators, according to manufacturers' instructions, "Are not designed to be used by Children" and that anyone using a respirator must be doing so under a written respiratory protection plan that follows the OSHA RPS.

Issue #3: The CDC continues to ignore the fact that COVID-19 is primarily spread by aerosols (not droplets) making mask use mostly ineffective:

The CDC continues to make the misleading argument that masks stop COVID droplets. This is misleading because while masks do stop some droplets (> 50 to 10 micron), the vast majority of COVID particles are smaller aerosols (≤ 5 microns) – see Figure 26:

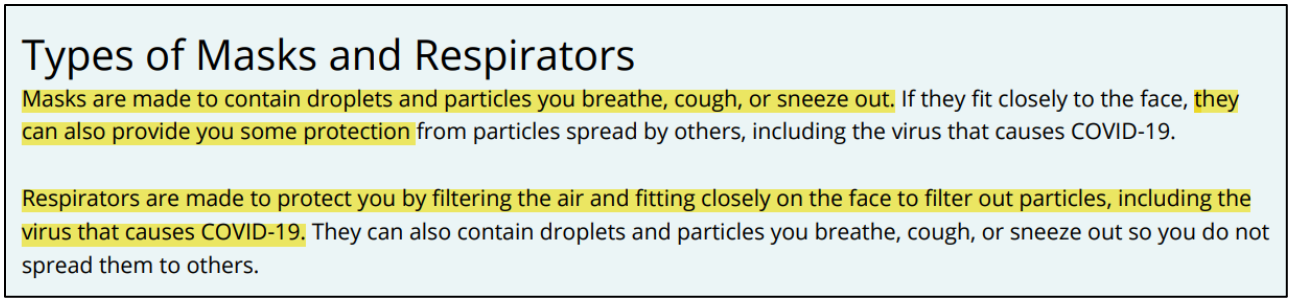


Figure 26: CDC – Misleading Guidance on Masks and Droplets

We are not the only ones who have written you regarding this issue. On February 15, 2021, the following scientists wrote a lengthy memo to you regarding your misleading language in this area and asked you to correct it:

- Rick Bright, PhD, Former Director of BARDA, Dept of Health and Human Services
- Lisa M. Brosseau, ScD, CIH, University of Minnesota CIDRAP
- Lynn R. Goldman, MD, MS, MPH, George Washington University
- Céline Gounder, MD, ScM, NYU Grossman School of Medicine & Bellevue Hospital Center
- Jose Jimenez, PhD, University of Colorado at Boulder
- Yoshihiro Kawaoka, DVM, PhD, University of Wisconsin-Madison and University of Tokyo
- Linsey Marr, PhD, Virginia Tech
- David Michaels, PhD, MPH, George Washington University
- Donald K. Milton, MD, DrPH, University of Maryland
- Michael Osterholm, PhD, MPH, University of Minnesota CIDRAP
- Kimberly Prather, PhD, University of California San Diego
- Robert T. Schooley, MD, University of California San Diego
- Peg Seminario, MS, AFL-CIO (retired)

They wrote in part:

> "To address and limit transmission via inhalation exposure and prevent COVID infections and deaths, we urge the Biden administration to take the following immediate actions:
>
> - Update and strengthen CDC guidelines to fully address transmission via inhalation exposure to *small inhalable particles* from infectious sources at close, mid and longer range. Updated guidelines should be informed by a risk assessment model that focuses on source and pathway (ventilation) controls first, followed by respiratory protection…

- *Issue an OSHA emergency standard on COVID-19 that recognizes the importance of aerosol inhalation, includes requirements to assess risks of exposure, and requires implementation of control measures following a hierarchy of controls*…

Edwards et al. (https://www.pnas.org/content/118/8/e2021830118) demonstrated that that the vast majority of COVID particles emitted during illness are aerosols not droplets (see Figure 27):

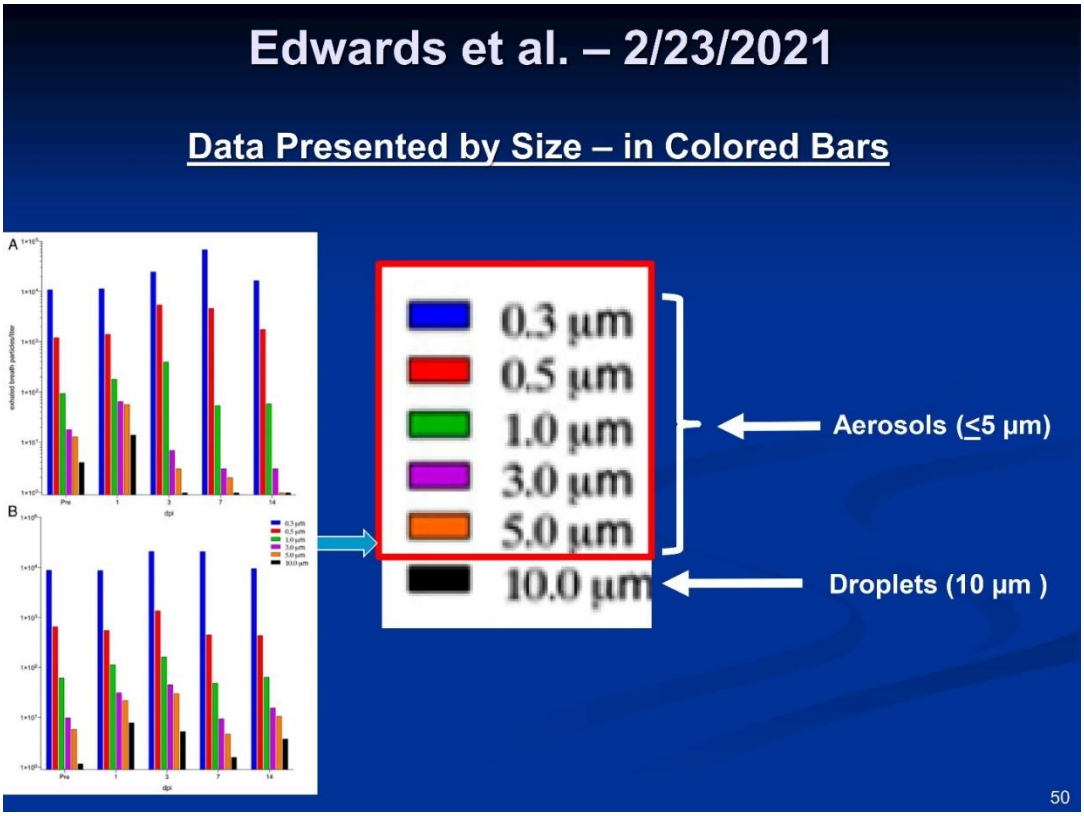


Figure 27: Edwards et al., 2021 – Particle Size Emissions by Size and Time

Edwards et al. concluded their paper with the following statements:

- Our finding that *the proportion of small respiratory droplets (i.e., aerosols) were the majority of particles exhaled in all subjects*.
- There may be an elevated risk of the airborne transmission of SARS CoV 2 by way of the very small droplets (aerosols) that transmit through conventional masks and *traverse distances far exceeding the conventional social distance of 2 m (~7').*
- Exhaled aerosol numbers appear to be not only an indicator of disease progression, *but a marker of disease risk in non-infected individuals.*

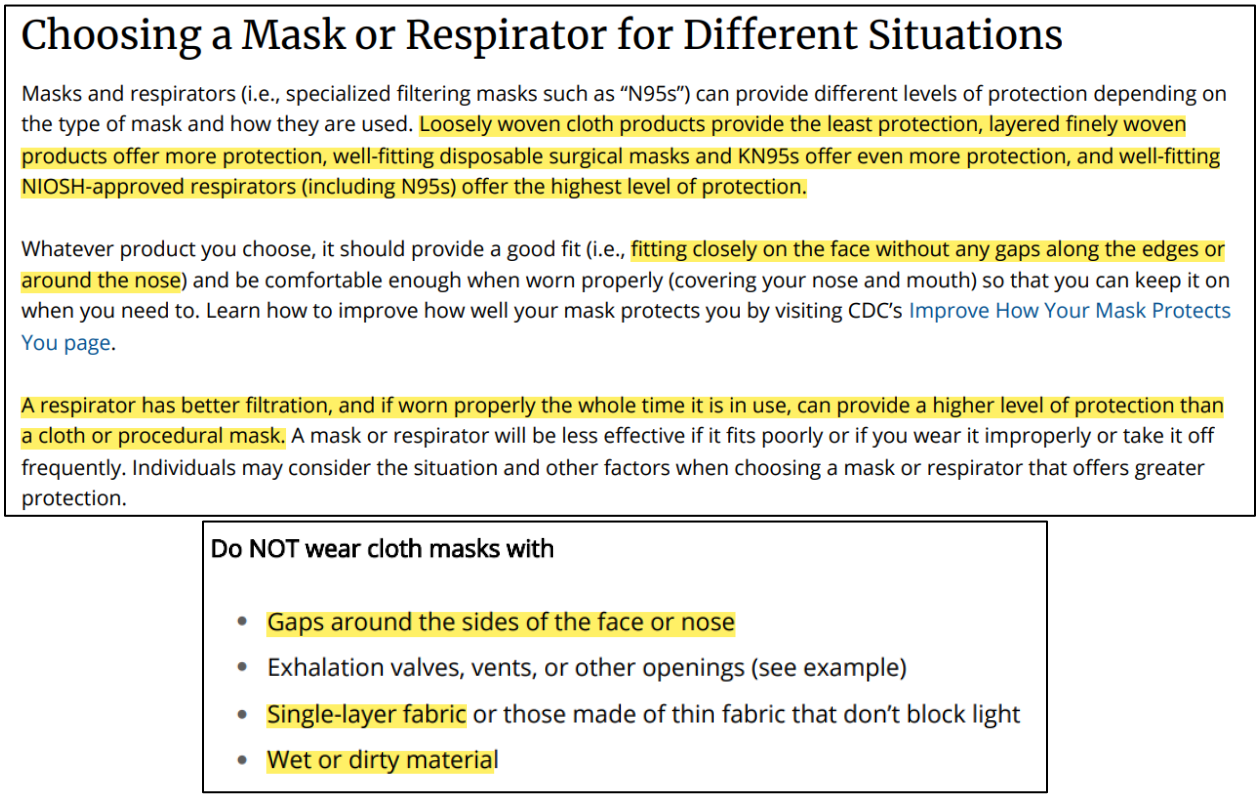
While the mask may contain droplets, they only do so for a period. As the masks are exposed to heat and moisture they suffer from degradation within a few hours.

We ask that the CDC immediately suspend misleading statements in all their public information that masks stop droplets when the vast majority of particles are smaller aerosols that stay suspended for days to weeks (vs. minutes for droplets), readily pass through gaps around the masks, and can reach deep into the lungs (see for example Fennelly, Kevin, P., 2020, Particle sizes of infectious aerosols: implications for infection control, Lancet Respir Med 2020; 8: 914–24).

Issue #4: CDC's position for masks used by the general public lacks proper scientific justification and creates potential harm based on a false sense of security:

Statements that a mask can provide protection are false and mislead the public into a false sense of security. Industrial Hygiene solutions seek a more than 90% relative risk reduction, and this publication continues to focus on the lowest form of non-protection that does not meet the least desirable mode of protection (PPE) in the Hierarchy of Controls with PPE. The September 9, 2020 guidance from AIHA illustrated this concept of the need for a super reduction in relative risk, not a minor one (https://aiha-assets.sfo2.digitaloceanspaces.com/AIHA/resources/Guidance-Documents/Reducing-the-Risk-of-COVID-19-using-Engineering-Controls-Guidance-Document.pdf - pg. 4).

Moreover, the CDC continues to provide guidance that gaps in masks can be eliminated; in the real world that never happens (Figure 28):



Choosing a Mask or Respirator for Different Situations

Masks and respirators (i.e., specialized filtering masks such as "N95s") can provide different levels of protection depending on the type of mask and how they are used. Loosely woven cloth products provide the least protection, layered finely woven products offer more protection, well-fitting disposable surgical masks and KN95s offer even more protection, and well-fitting NIOSH-approved respirators (including N95s) offer the highest level of protection.

Whatever product you choose, it should provide a good fit (i.e., fitting closely on the face without any gaps along the edges or around the nose) and be comfortable enough when worn properly (covering your nose and mouth) so that you can keep it on when you need to. Learn how to improve how well your mask protects you by visiting CDC's Improve How Your Mask Protects You page.

A respirator has better filtration, and if worn properly the whole time it is in use, can provide a higher level of protection than a cloth or procedural mask. A mask or respirator will be less effective if it fits poorly or if you wear it improperly or take it off frequently. Individuals may consider the situation and other factors when choosing a mask or respirator that offers greater protection.

Figure 28: CDC Guidance Suggesting Gaps in Masks Can be Eliminated

The CDC statement that masks should not be worn if gaps cannot be eliminated is meaningless because this cannot occur; only properly selected and fitted respirators can accomplish this.

Masks cannot ever obtain a perfect fit to the face and efficiencies of masks when worn in real world scenarios (day-long usage). When the mask has more than a 3% gap, it offers effectively zero protection (Figure 29):

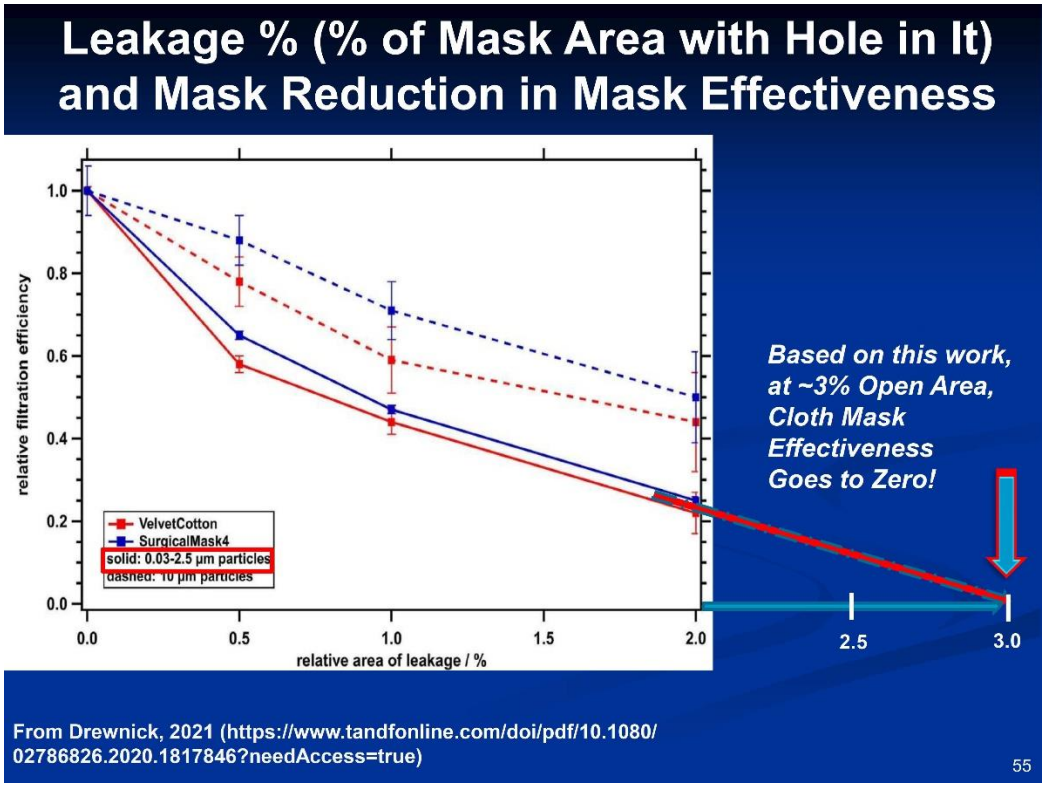


Figure 29: Loss of Mask Effectiveness in the Real World

Thus, the core issue with masks, and even respirators, is the seal – small gap areas effectively render these devices ineffective.

The American Society for Testing and Materials (ASTM) Standard Specification for Barrier Face Coverings F3502-21 Note 2 states, “There are currently no established methods for measuring outward leakage from a barrier face covering, medical mask, or respirator. Nothing in this standard addressed or implied a quantitative assessment of outward leakage and no claims can be made about the degree to which a barrier face covering reduces emission of human-generated particles.”

As well as, importantly, Note 5, “There are currently no specific accepted techniques that are available to measure outward leakage from a barrier face covering or other products. Thus, no claims may be made with respect to the degree of source control offered by the barrier face covering based on the leakage assessment.”

Every breath increases atmospheric viral load, or the amount of viral matter held aloft in an enclosed space. In instances when it does not take very much of an airborne pathogen for vulnerable individuals to get sick, a contagious individual should not wear a mask or respirator that creates a concentrated plume of aerosols, thinking they are protecting others from their respiratory emissions.

Explosive force-generating events, such as coughs and sneezes, increase the pressure behind exhaled matter. Masks can exacerbate the spread of airborne pathogens by creating focused plumes of fine particulates, in turn increasing emission trajectory, with the added concern of aerosolization of droplets through the mask membrane.

Finally, what is now most concerning, is that public entities are taking CDC guidance and making respirators available for free (Figure 30):

Figure 30: "Free" Open Contaminated N95s Being Given Away to the Public at Grocery Stores

These entities, based on CDC guidance, likely and/or unknowingly, do not address the requirements of the Respiratory Protection Standard and causing additional harm to the public by such a lack of understanding. Inevitably, this practice will result in harm and liability to their employees and customers for improper distribution and storage of respirators under the RPS.

Conclusion:

The CDC has built a series of recommendations for masking that are inconsistent with the technical and medical literature. The policy and procedural recommendations exaggerate the benefits, while ignoring the limitations and harms, especially for children and the general population. In addition, the CDC has taken a policy position of "it might work" and "it can't hurt" and use selective and weak observational data in the place of actual controlled scientific study to justify inappropriate recommendations for masks and face coverings.

Recently, the CDC has deployed a respiratory protection policy (i.e., masks to N95s) that dismisses the key principles in any Safety and Health program regarding the use of respirators – namely the Respiratory Protection Program. There is no mention of potential risks if the respirator is not properly used or fitted correctly. Moreover, it is clear that respirators are not intended for use with children. In our profession, if PPE and respiratory protection guidance was to ever be delivered without risk identification, fit testing, and training, we would be liable for putting personnel in a high-risk scenario, which is what the CDC is doing with their policy.

We would ask the CDC to accept these basic industrial hygiene facts that we have presented, update their public guidance accordingly regarding the issue of droplets vs. aerosols, stop confusing the public regarding the effectiveness of masks, and stop implying respirators are acceptable for children, and to be given generally to the public. In addition, it is clear the CDC knows, or should know, that gaps between the face and mask are a major problem for real mask effectiveness and could never have met our industry's requirement of 90% relative risk reduction.

The CDC is doing enormous damage to science and scientists by allowing politics to dictate public health policy rather than actual science. Increasingly, and for good reason as we have illustrated, the public does not trust the CDC and its science; this must change.

We recognize that it is easy to judge from afar and know that you and your team are under tremendous stress during this period. Our desire is to see the CDC and our country succeed in these efforts. As such, instead of just being critical, we want to offer our time to your organization to find solutions together. We would be willing to collaborate in the creation of a competent plan that will be based on the Hierarchy of Controls and will be tailored to various work and living environments. We will also help develop data points we can use to monitor and measure this program to enable proper adjustments as needed.

We look forward to your responses to our concerns as we continue to work to protect the public.

Sincerely:

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new scientific study entitled *"Serious adverse events of special interest following mRNA vaccination in randomized trials"* provides the best evidence yet concerning the safety of the mRNA Covid vaccines. For most vaccines in common use, benefits far outweigh risks, but that may not be the case for the mRNA covid vaccines, according to this study by Joseph Fraiman and his colleagues. It depends on your age and medical history.

The randomized controlled clinical trial is the gold standard of scientific evidence. When regulators approved the Pfizer and Moderna mRNA vaccines for emergency use in December 2020, two randomized trials showed that the vaccines reduced symptomatic covid infection by over 90% during the first few months after the second dose.

Pfizer and Moderna did not design the trials to evaluate long-term efficacy or the more important outcomes of preventing hospitalization, death, or transmission.

The randomized trials did collect adverse event data, including the presence of mild symptoms (such as fever) and more serious events requiring hospitalization or leading to death. Most vaccines generate some mild adverse reactions in some people, and there were considerably more adverse such reactions after the mRNA vaccines compared to the placebo.

That is annoying but not a major issue. We care about severe health outcomes. The key question is whether the vaccine's efficacy outweighs the risks of severe adverse reactions.

The Fraiman study uses data from the same Pfizer and Moderna-sponsored randomized trials presented to the FDA for vaccine approval, but with two innovations that provide additional information.

First, the study pools data from both mRNA vaccines to increase the sample size, which decreases the confidence intervals' size and the uncertainty about the estimated harms.

Second, the study focuses only on the severe adverse events plausibly due to the vaccines. Serious adverse events such as gunshot wounds, suicide, animal bites, foot fractures, and back injury are unlikely to be due to a vaccine, and cancer is unlikely to be due to a vaccine within a few months after vaccination. By removing such random noise, the ability (statistical power) to detect genuine problems increases. If there is no excess risk, shorter confidence intervals bolster confidence in the safety of the vaccines.

Classifying adverse events into the two groups is not a trivial task, but Fraiman et al. do an excellent job to avoid bias. They rely on the pre-defined Brighton Collaboration definitions of adverse events of special interest (AESI). Founded in 2000, the Brighton Collaboration has two decades of experience using rigorous science to define clinical outcomes for vaccine safety studies.

Moreover, Fraiman and colleagues blinded the process where they classified the clinical events as AESIs. Adjudicators did not know whether the individual had received the vaccine or the placebo. Hence, any criticism of so-called p-hacking is unwarranted.

So, what are the results? There were 139 AESIs among the 33,986 people vaccinated, one for every 244 people. That may sound bad, but those numbers mean nothing without comparison against a control group. There were 97 AESIs among the 33,951 people who received a placebo. Combining these numbers implies 12.5 vaccine-induced AESIs for every 10,000 people vaccinated, with a 95% confidence interval of 2.1 to 22.9 per 10,000 people. To phrase it differently, there is one additional AESI for every 800 people vaccinated (95% CI: 437-4762).

That is very high for a vaccine. No other vaccine on the market comes close.

The numbers for the Pfizer and Moderna vaccines are 10 and 15 additional events per 10,000 people, respectively, so both vaccines contributed to the finding. The numbers are similar enough that we cannot confidently say that one is safer than the other. Most excess AESIs were coagulation disorders. For the Pfizer vaccine, there was also an excess of cardiovascular AESIs.

While these safety results are concerning, we must not forget the other side of the equation. Unfortunately, the study does not calculate composite estimates that also included the reduction in serious covid infections, but we have such estimates for mortality.

Dr. Christine Benn and her colleagues calculated a combined estimate of the effect of vaccination on all-cause mortality using the same randomized trial data as Fraiman et al. They did not find a mortality reduction for the mRNA vaccines (relative risk 1.03, 95% CI: 0.63-1.71).

One important limitation of both Fraiman's and Benn's studies is that they do not distinguish the adverse reactions by age, comorbidities, or medical history. That is not their fault. Pfizer and Moderna have not released that information, so outside researchers do not have access.

We know that the vaccine benefits are not equally distributed among people since covid mortality is more than a thousand times higher among the old. Thus, risk-benefit calculations must be done separately for different groups: with and without prior covid infection, by age, and for the first two doses versus boosters.

1. Covid-recovered people have natural immunity that is stronger than vaccine-induced immunity. So, the benefit of vaccination is – at best – minimal. If the risk of adverse reactions is the same as in the randomized trials, there is a negative risk-benefit difference. Why are we mandating people in this group to be vaccinated? It is both unethical and damaging to public health.
2. While everyone can get infected, children have a minuscule risk of covid mortality. There is very limited safety data from the trials on children. If the risk of adverse reactions is the same as for adults, the harms outweigh the risks. Children should not receive these vaccines.
3. Older people above 70 have a much higher risk of covid mortality than the population in the Fraiman study. If their risk of adverse reaction is the same, then the benefits outweigh the harms. Hence, older people who have never had covid and are not yet vaccinated may benefit from these vaccines. However, we do not know if they are better than the Johnson & Johnson and Astra-Zeneca vaccines.

4. It is unclear from the clinical trial data whether the benefits outweigh the risks for working-age adults who have not been vaccinated and who have not already had covid. This is true both historically, for the original covid variants, and currently for the newer ones.
5. The Fraiman study analyzes data after the first and second doses. Both risks and benefits may differ for booster shots, but no randomized trial has properly evaluated the trade-off.

These results concern only the Pfizer and Moderna mRNA vaccines. Fraiman et al. did not analyze data on the adenovirus-vector vaccines marketed by Johnson & Johnson and Astra-Zeneca. Benn et al. found that they reduced all-cause mortality (RR=0.37, 95% CI:0.19-0.70), but nobody has used trial data to analyze AESIs for these vaccines.

Critically, the Fraiman and Benn studies had a follow-up of only a few months after the second dose because Pfizer and Moderna, unfortunately, terminated their randomized trials a few months after receiving emergency use authorization. Of course, a longer-term benefit can provide a basis to tolerate negative or neutral short-term risk-benefit differences. However, that is unlikely since we know from observational studies that mRNA vaccine efficacy deteriorates a few months after the second dose.

There may also be long-term adverse reactions to the vaccine regarding which we do not yet know. Since the randomized trials ended early, we must look at observational data to answer that question. The publicly available data from the Vaccine Adverse Event Reporting System is of low quality, with both under- and over-reporting. The best observational data is from CDCs Vaccine Safety Datalink (VSD) and FDA's Biologics and Effectiveness Safety System (BEST), but there have only been limited reports from these systems.

Fraiman and colleagues have produced the best evidence yet regarding the overall safety of the mRNA vaccines. The results are concerning. It is the responsibility of the manufacturers and FDA to ensure that benefits outweigh harms. They have failed to do so.

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