Propaganda with Professor Hannah Fry

In my previous article I committed the journalistic sin of predicting the future. I anticipated that the BBC's proposed documentary, "Unvaccinated with Professor Hannah Fry," would be little more than propaganda.

The BBC said it would place seven ordinary unvaccinated citizens in a house and then try to convince them that everything they thought they knew about the jabs was based upon mis/disinformation. The BBC claimed it wanted to provide viewers with an "eye-opening investigation" that would "fully explore this complex and deeply divisive debate."

While the press release for the program promised a "documentary," I ventured that the BBC would actually manipulate the reported data, cherry-pick the science, omit vital information and produce, in effect, a sales pitch for the COVID-19 jabs. So it is, I admit, with a degree of schadenfreude that I can now say this is precisely what the BBC did.

In my aforementioned article, I incorrectly interpreted the UK Health Security Agency's (UKHSA's) stated 70.2% total vaccine coverage figure as a mean and not the median that it was. Consequently, my estimation of 11M unvaccinated UK adults was wrong.

Nonetheless, as expected, the BBC opened its program with a statement that misreported the statistics. It claimed there were just 4M unvaccinated UK adults. For a multi-billion-pound media

operation like the BBC to repeatedly report the vaccination statistics incorrectly and consistently underreport unvaccinated numbers is not just an inadvertent error. It is a deliberate fabrication of the facts.

According to the Office For National Statistics (ONS) in mid-2020 the adult population of England (over 18) stood at just under 46M. Given population growth, we can safely use a figure of at least 46M adults in England in 2022.

UKHSA reports that approximately 44.5M people in England have received at least one dose of a vaccine. Approximately 3M of them are under 18. Thus, we can say that at least 4.5M adults in England, or around 9.7% of the English population, have not received a single dose of the vaccine. England accounts for about 84% of the UK population. Assuming almost identical vaccine coverage elsewhere in the UK, this suggests that approximately 5.3M UK adults have not received a single dose of the vaccine.

The UK government's definition of "vaccinated" is "2 doses of an approved vaccination, or 1 dose of the Janssen vaccine."

The Janssen vaccine is the only single-shot vaccine approved in the UK, and use of it is rare. To be considered "vaccinated," two doses of the Pfizer or AstraZeneca or Moderna jab are required. Therefore, UKHSA data indicates that there are approximately 40M "vaccinated" adults in England. This means that there are around 7.2M unvaccinated adults in the UK, representing approximately 13.5% of the UK adult population.

As we can see, Fry's opening statement that "there are still around 4M adults in the UK who remain unvaccinated" was flagrantly false.

After making that misleading remark, Prof. Fry questioned the rationale for remaining unvaccinated:

> I want to understand why and find out if anything can change their [the participants'] minds.

From the start of the BBC's program, it was clear that the filmmakers had an agenda: convince everyone to take the vaccines.

In short, the purpose of the program was not to explore the debate, as claimed in the BBC press release, but rather to persuade people to get the jab as well as maintain belief in the COVID-19 vaccine among those who are already jabbed.

The BBC never had any intention of objectively reporting the facts or encouraging any genuine discussion of the evidence. Its purpose, as usual, was to promote the government narrative. This was exemplified by Prof. Fry at the start of the program's penultimate segment when she said:

> I just want to remind everyone just how critical the vaccines have been in allowing us all to go back to normal.

Back to normal? The policy response to this alleged pandemic has so changed the public's relationship with the government that it can no longer be considered "normal." The removal of our freedoms and official denial of the existence of our natural rights has convinced most people to adapt to a new model of government. The illusory "social contract," neither seen nor signed by anyone, now demands total acquiescence to this "new normal."

Some might think that the UK government's reaction to the alleged existential threat was wise. Others will argue that government abuse of our inalienable rights is never justified under any circumstances. The point is that these are policy decisions, not the inescapable consequences of a so-called pandemic.

Recently UK junior health minister Syed Kamall said:

> If hospitalisations start affecting the NHS backlog then clearly measures may well have to be introduced[.] [. . .] If that gets out of control then of course we will stand up the measures that we have previously.

Syed Kamall

Kamall blithely announced that, if it's deemed necessary, the government will once again restrict our freedoms and ignore our rights. It might order us to stay at home (lockdown), deny our freedom of movement, ban us from gathering, decree whom we can meet, compel us to wear masks and demand that we prove our health status before we are "allowed" to participate in society.

Prior to the alleged COVID-19 pandemic, no way would the UK public have tolerated such a dictatorial proclamation from any politician. But now statements like Kamall's receive barely a murmur of dissent. The vast majority of the population meekly accepts that the government requires these draconian powers to impose its authoritarian will upon us whenever it claims there is good reason.

As a society we have been transformed to accept dictatorship without question. Irrespective of their impact upon public health, the jabs are part of the biosecurity controls that take precedence over everything and everyone whenever the government wishes to change our behaviour.

To sum up, the COVID-19 jabs most assuredly have not enabled us to return to any kind of recognisable "normal." Fry's claim was absurd. Indeed, "Unvaccinated with Professor Hannah Fry" could have more accurately been titled "Propaganda with Professor Hannah Fry." So let's take a closer look at the BBC's propaganda.

The Denial of Adverse Events

A participant named Nazarin was filmed telling Prof. Fry about her friend who started having neurological problems five days after the Pfizer jab and subsequently suffered a stroke and multiple heart attacks. Fry asked Nazarin:

> How can you be sure that was the vaccine, and not something that would have happened anyway?

Nazarin's reply was pertinent:

> If you've been completely healthy before, that one thing changed and then days later you're suddenly experiencing all these things you have never had before, like paralysis and seizures, the chance of that happening to someone so young. I would say, not possible. [. . .] It's not just her, there are so many people going through the same thing.

Fry's response to Nazarin sounded reasonable. Referring to the percentage chance that a healthy young person's severe health event soon after vaccination may not be attributable to the vaccine, Fry said:

> It's not zero, though. . . .

True enough. But what Fry did not concede, as highlighted by Nazarin, is that it was likely that the adverse event (AE) was caused by the jab, given the circumstances. Prof. Fry then added:

> I just don't think it's enough to say it's happening a lot, without the evidence for it.

Nazarin and fellow participant Vicki later gave an interview to GB News in which they revealed that the BBC excluded key witness accounts from the program. For example, Nazarin said she repeatedly told the BBC that her great-grandmother died shortly after receiving the jab and that her grandmother had a stroke following her jab.

Vicki reported that Nazarin wasn't the only participant among the seven to have told the BBC about family members who had possibly suffered a severe adverse event as a result of the jab. None of these personal accounts were reported by the BBC.

Prof. Fry's insistence upon evidence would have been reasonable only if the BBC had been willing to consider—and, perhaps more importantly, objectively report—all the evidence. But the BBC did not do that.

Prof. Fry invited the seven unvaccinated participants to discuss vaccine adverse events. Yet at no point throughout the whole program did Fry actually report what the numbers of reported AEs were. Instead, she was eager to repeatedly suggest that there wasn't really any link between reported AEs and the vaccines.

For instance, she cited a paper on the nocebo effect, which found that people sometime experience AEs as a psychosomatic reaction. Fry told the participants that 76% of claimed AEs "from the vaccine" could be attributed to this psychological quirk:

> There was one study in America, the overall result of that study was that 76% of common adverse effects from the vaccine were essentially down to the expectation that you would feel rubbish after the vaccine.

The professor's statement was highly misleading. What she said was not what the findings in the paper indicated.

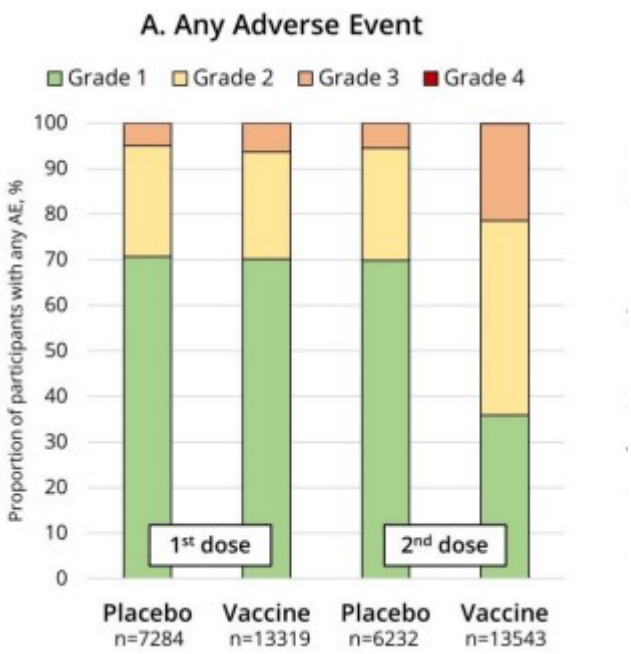
The paper was a meta-analysis (combining data from a number of studies) which looked at the systemic (common) AE statistics for two groups of almost equal size. One cohort of 22,578 people received an "inert placebo." The jab recipient group was a similarly sized 22,802. The paper stated:

Systemic AEs were experienced by 35% of placebo recipients after the first dose and 32% after the second. Significantly more AEs were reported in the vaccine groups, but AEs in placebo arms ("nocebo responses") accounted for 76% of systemic AEs after the first COVID-19 vaccine dose and 52% after the second dose. [. . .] [T]here were proportionally more moderate and severe AEs in the vaccine groups after the second dose.

This means that 76% of all systemic AEs across both cohorts—vaccinated and unvaccinated—were reported in the placebo (unvaccinated) arm. It in no way implies that 76% (or 52%) of the reported systemic AEs in the vaccinated cohort were attributable to the nocebo effect, as Fry tried to assert.

The paper graded AEs from 1 to 4 as follows: 1(mild), 2 (moderate), 3 (severe), 4 (life-threatening). A "systemic" AE (grades 1 and 2) is a mild adverse reaction, such as temporary swelling, brief headache or nausea. A "severe" AE (grades 3 and 4) is an adverse event that may "jeopardize the patient and may require medical or surgical intervention," according to the US Food and Drug Administration (FDA). Severe reactions include breathing problems, blood disorders, seizures, disability or permanent damage, hospitalisation, a threat to life and death. The BBC did not make this distinction clear.

Again, note that both cohorts—vaccinated and unvaccinated—in the cited study were of roughly equal size.



All AEs reported in the paper cited by Prof. Fry

Let's look at the placebo group. Following the first dose, out of the 7,284 claimed AEs, about 5% were allegedly severe, which equates to some 364 severe AEs in total. Following the second dose,

there were roughly 312 severe AEs. Given that the people in the placebo group received an inert substance, it's likely that a high proportion of their severe AEs were attributable to the nocebo effect.

Now the vaccinated cohort. The first dose produced 13,319 reported AEs, of which approximately 7%—or about 932—were severe. If we account for the likely nocebo effect, this suggests that around 570 of these severe AEs were potentially attributable to jabs. After the second dose there were 13,543 total AEs recorded. Approximately 22% of them were severe. Subtracting the likely nocebo numbers, this implies that, out of the vaccinated cohort of 22,802, there were more than 2,600 severe AEs possibly associated with the second jab.

The paper's findings indicate that approximately 11% of second dose COVID-19 jabs reportedly resulted in a severe adverse event. The BBC and Prof. Fry did not wish to report this.

Prof. Fry misrepresented the paper's finding in an attempt to convince both the participants and the BBC audience that more than three-quarters of reported AEs are probably attributable to the nocebo effect. Not only was this deceptive, but Fry failed to report the deeply concerning results that were reported in the paper with respect to severe AEs.

Later, Prof. Fry admitted that anaphylaxis and myocarditis are linked to the Pfizer jab. She also acknowledged that blood clots are associated with the AstraZeneca jab and that Bell's Palsy (BP) and Guillain-Barre Syndrome (GBS) have also been flagged as potential "rare side effects."

Prof. Fry illustrated one of her claims with jelly beans. Knowing that myocarditis—inflammation of the heart muscle—is the most commonly reported severe AE attributed to the COVID-19 vaccines, she claimed that only one of 33,000 jelly beans represented the alleged vaccine-induced case rate of myocarditis. However, as we shall see, there was no basis for her to claim such a low relative risk.

The professor isn't the only one to grossly underestimate the relationship between the jab and myocarditis. The UK Medicines and Healthcare Products Regulatory Agency (MHRA) has collated the Yellow Card surveillance reports, which suggest there may be 1,112 myocarditis AEs associated with the COVID-19 jabs in the UK. The MHRA calls such an event a possible adverse drug reaction (ADR).

It's important to note that in 2018 the MHRA estimated that only 10% of severe ADRs are reported to the Yellow Card system. Since then, the MHRA has done nothing to remedy the problem of an underreporting rate as high as 90%. Indeed, there could be more than 11,000 myocarditis ADRs associated with the COVID-19 jabs, for all we know.

In 2021 the MHRA updated its 2018 data with this caveat:

> These estimates [of 10% of severe ADRs] should not be used as indicators of the reporting rate for COVID-19 vaccines, for which there is high public awareness of the Yellow Card scheme and the reporting of suspected reactions.

Perhaps so, but the MHRA hasn't produced any estimates for COVID-19 vaccine ADR reporting rates. To what extent has "public awareness of the Yellow Card scheme" increased reporting rates, if at all?

Could reporting rates be up 50%? Or 20%? Or as little as 0.4%? How likely is it that doctors, who also submit Yellow Cards, correctly associate an adverse event with a vaccine? We have no idea. Nor, it seems, do the MHRA or Prof. Fry or the BBC.

The MHRA stresses that a reported ADR may or may not be caused by a jab. It has established a data analysis method that theoretically enables the MHRA to identify concerning signals in the data:

> We apply statistical techniques that can tell us if we are seeing more events than we would expect to see, based on what is known about background rates of illness in the absence of vaccination. [. . .] [W]e generally do not expect all suspected side effects to be reported on Yellow Cards.

For example, the MHRA contrasts the reported Yellow Card incidents of myocarditis to the background rate of the same disease. It then applies comparative statistical analysis to identify what it and Prof. Fry call a "rare" ADR associated with the jabs.

As frequently noted by the MHRA and as mentioned above, the Yellow Cards are only capturing a small proportion of the ADRs. The only question is, what proportion?

All we have from the MHRA is a published estimate that the Yellow Card reporting rate could be as low as 10%. Consequently, the possibility exists that 90% of potential ADRs are not captured by the reporting system. Presumably, the remaining unreported ADRs could then erroneously contribute to the observed background rate for that condition.

This skewed data then forms the inputs for the MHRA's statistical analysis. The MHRA may be significantly underestimating the possible ADRs while wildly overestimating the comparative background rate. There is no evidence that it has done anything about this problem, and there is a strong possibility that its so-called "analysis" is complete junk.

In regard to the monitoring of myocarditis, the MHRA claims:

> There has been a consistent pattern of higher reporting of these suspected events with the COVID-19 Vaccine Pfizer/BioNTech and COVID-19 Vaccine Moderna. [. . .] These reports are very rare[.]

Without fixing the underreporting problem, there is no reliable evidence to support the MHRA's claim that these possible ADRs are "very rare." On the contrary, the scientific evidence suggests reason for marked concern.

US and Israeli researchers found that the overall incident rates of myocarditis among those who received the Pfizer jab has more than doubled. Myocarditis impacts some demographic groups more than others. For people aged 18–24, particularly but not exclusively males, French scientists found that the rate increase following the Pfizer jab was more than eight times higher and following the Moderna jab a staggering thirty times higher.

For Prof. Fry to dismiss, by omission, these legitimate concerns using a spurious, statistically inaccurate jelly bean analogy is, frankly, appalling.

Throughout the program, Prof. Fry and the BBC persistently relied upon statistical claims that are officially acknowledged to be inaccurate. At no point did the BBC disclose this to its audience.

For example, Prof. Fry addressed an information leaflet produced by people who are concerned about vaccine safety. The document, titled "Consent Checklist," urges would-be jab recipients to consider some key information before they opt to get the jab.

The document reminds people that the manufacturers have no civil liability for any harm caused by their products, that the jabs don't protect against infection or stop transmission of SARS-CoV-2,

that AEs associated with the jabs are potentially serious and that, due to the lack of clinical trials, the long-term health impacts of the jabs are unknown. All of which is true.

In its unflinching investigation of the debate, the BBC didn't bother to reveal any of the points made by the "Consent Checklist." Instead, Prof. Fry called it "anti-vax propaganda." She was apparently irked because the document stated that there was a calculated 1:29,389 chance of dying from a jab. She said:

> It's my job to look into numbers like this and I can tell you, as an absolute fact, this is complete nonsense.

How does Prof. Fry know this? She didn't explain. She provided no sources. She simply threw out a claim without evidence. Perhaps we should trust her simply because she works for the BBC and says she's an expert?

We can be certain that people have been killed by the jabs. Sadly, this includes one of the BBC's own, Lisa Shaw. And there have been other proven deaths from the COVID-19 jabs. As of January 2022, the ONS has reported 15 UK deaths clinically coded as being caused by a COVID-19 jab.

As pointed out by Professor Lawrence Young, a virologist based at Warwick University, the official coding of a vaccine death alone is unlikely to reflect the totality. Given the data from the MHRA, he noted that the ONS figure was too low.

Prof. Young said that there was a need "for more detailed investigation to reconcile these different estimates." He added that to make this assessment a "detailed review of death certificates, autopsy (if available) and medical records" would be needed.

Professor Fry welcomes the subjects for the BBC "experiment"

Herein lies the problem with any claims made about UK mortality caused by the jabs, including Prof. Fry's. The MHRA has done nothing to investigate any of the reported vaccine-related deaths. It is content simply to continue to search for "signals" within officially recorded figures which, by its own admission, are wrong.

Consequently, all anyone can say is that the MHRA has recorded 2,207 possible vaccine-related deaths in the UK, which could equate to more than 22,000, given the estimate of 10% reporting. We also know from UKHSA that approximately 48M UK adults have been jabbed.

If we ignore the acknowledged underreporting problem, this currently suggests a possible 1:22,000 risk of death caused by vaccination. If we account for the possible scale of underreporting, though, the current jab-related mortality risk is potentially 1:2,200.

These calculations do not prove the mortality risk associated with the COVID-19 jabs; they merely suggest it. This was made clear in the document that Fry attacked for the cameras.

That document stated that the estimate of a 1:29,389 risk was based upon "officially reported" figures. It was an accurate estimate given the available evidence at the time. As the reported risk did not reflect the known Yellow Card underreporting issue, the quoted 1:29K risk was, in all probability, the lowest possible estimate.

As highlighted by Prof. Young, without a thorough investigation we don't know what the truth is. Absent further analysis, there is no reliable evidence to inform any assessment of the relative risks associated with the jabs.

So how Prof. Fry could be "absolutely certain" that the claims made about vaccine mortality rates were "complete nonsense" is mystifying. Despite her conviction and self-declared expert status, it was actually Prof. Fry's seemingly authoritative assertion that was complete nonsense.

What Prof. Fry asserted was entirely in keeping with the BBC's propaganda message.

During the documentary, the BBC downplayed and denied any adverse events associated with the COVID-19 vaccines wherever possible. It deliberately misinterpreted the available statistical evidence, omitted or misreported the science that ran contrary to its agenda and attempted to thoroughly deceive the participants and its viewers to encourage them to get potentially harmful jabs.

Obfuscating Concerns About The Trials

Prof. Fry held a discussion with two participants, Nazarin and Vicki, who asked her to clarify the vaccine's approval and trial status. Fry and the BBC gave an entirely false impression that "approval" signifies that the jabs have completed clinical trials.

For instance, Prof. Fry stated that the jabs had been through the same approval process as paracetamol. This was not true.

The Access Consortium of regulatory authorities from the UK, Canada, Australia, Switzerland and Singapore explain why this is not the case:

> Initial vaccine approvals or emergency authorisations may be based on interim analyses of ongoing randomised placebo-controlled phase 3 clinical trials.

Phase III trials do not need to be complete for a COVID-19 jab to be "approved." They remain incomplete for the original Pfizer and Moderna jabs to this day.

There is a distinction between "approval," under emergency authorisation, and the "marketing authorisation" of a medication for distribution to the public. Or at least there used to be.

The Pfizer Comirnaty jab, for example, has yet to meet the required standard for full marketing authorisation. To get around this problem, in 2021 the MHRA and the EU regulator (the EMA) created something called Conditional Marketing Authorisation (CMA).

Explaining CMAs, the MHRA stated:

> The MHRA may grant a CMA where comprehensive clinical data is not yet complete, but it is judged that such data will become available soon.

In other words, this new licensing workaround enables the jabs to receive so-called "marketing authorisation" without the burdensome necessity of completing any Phase III clinical trials. That is precisely the current condition under which the MHRA gave Conditional Marketing Authorisation to Pfizer's Comirnaty jab.

Though Pfizer hasn't completed any trials or posted any trial results, it might in the future. That's good enough for CMA, as far as the MHRA is concerned. The MHRA has based its licensing of Pfizer's drug upon whatever Pfizer has chosen to report.

The BBC, represented by Prof. Fry, reported none of this crucial context. Instead of honestly answering the participants' questions, the BBC elected to thoroughly obfuscate the issue and redirected viewers attention toward out-and-out falsehoods via a series of highly misleading statements by Fry.

Responding the Vicki's legitimate question about the status of the trials, Prof. Fry concluded by saying:

> Vicki is right in some ways. The vaccines do indeed go on to Phase IV trials after approval. But this is normal. Phase IV trials are the ongoing surveillance of the drug after rollout.

While it is "normal" for jabs to go into Phase IV trials, it is also "normal" for drugs to complete Phase III trials before they are rolled out. The latter has not happened with respect to the COVID-19 jabs—but Fry forgot to mention that minor detail. Vicki was right in more ways than Prof. Fry cared to admit.

This lack of any genuine regulatory oversight has also become "normal." The MHRA no longer considers itself a safety monitoring regulator of pharmaceutical products.

Speaking at the MHRA Board meeting on the 24th of March 2022, the chief executive of the MHRA, June Raine, said that the MHRA is "an enabling regulator, no longer a watchdog." She added that its role is to accelerate "access to innovative products."

This is in line with the UK government's commitment to the G7's 100 Day Mission (100DM). This is a global public-private partnership initiative to develop a so-called "armamentarium" of diagnostics, therapeutics and vaccines (DTVs).

The extremely dangerous idea is that modern DTVs, largely built upon mRNA platform technologies, don't really need any extensive trials or safety surveillance. As soon as a global public health emergency is declared by the World Health Organisation (WHO), it will trigger governments around the world to feed taxpayer money to pharmaceutical corporations—government "partners"—who will get the DTVs on the market within 100 days.

As far back as March 2021, the MHRA was preparing to move away from acting as a public health "watchdog" and toward "enabling" pharmaceutical corporations to release their products as quickly as possible with the minimum amount of fuss. In reference to what were being called "tweaked" vaccines—namely, new iterations of existing jabs designed to tackle allegedly novel variants of COVID-19—the MHRA announced:

> Regulatory Authorities do not consider an updated coronavirus vaccine to be an entirely novel product with the resulting requirement for lengthy full-blown clinical studies. [. . .] Evidence gathered by the large pivotal clinical studies for initial authorisation and by mass vaccination campaigns is a strong foundation for this approach. [. . .] From a clinical perspective, clinical efficacy studies prior to approval are not required.

Leaving aside the fact that the "evidence gathered by the large pivotal clinical studies" came from trials for which "no results have been posted," the MHRA claimed that the mere act of it "approving" a COVID-19 jab somehow constituted a "strong foundation" for it not needing to bother reviewing any future clinical trial data before "approving" the next drug. Frankly, there is no reason to imagine that the MHRA is even interested in public health.

Yet the BBC's expert, Professor Hannah Fry, in response to Vicki and Nazarin, said:

> There are different versions of the vaccine. It is possible for one version to be approved while simultaneously companies and the researchers are running clinical trials for subsequent versions. So those two things are not in conflict with one another. So every time you get an adaptation to the vaccine, you have to go back through the whole process and demonstrate, not just that it works, but that it is safe.

The "whole process" is nothing like the one described by Fry. "Approval" is not based upon clinical trial results, as she intimated. Rather, it is based upon self-serving claims made by the manufacturers about their own trials of their own products.

Researchers may be "running" subsequent trials, but the regulators do not require evidence from them prior to subsequent "marketing authorisation" of the "tweaked" jabs. The pharmaceutical corporations do not have to "demonstrate" that the jabs work and are safe. They simply have to make claims to that effect, which the paradoxically named "regulators" will apparently accept without any scrutiny whatsoever.

In an effort to "fully explore this complex and deeply divisive debate" about the COVID-19 jabs, neither the BBC nor Prof. Fry felt it was necessary to even mention, let alone discuss, any of this.

Ignoring Fertility and Fetal Health Concerns

Fry enlisted from the British Medical Association a GP who specialises in vaccine promotion to speak to a participant called Ethan about his concerns over male fertility. The doctor told Ethan:

> All the research studies that have been done have shown that there is no impact on fertility in male or female patients. However, there have been recent studies and clinical evidence to show that if you have had COVID-19 infection that can, temporarily, effect sperm quality and count.

This was a partly false statement from the GP. A recent study from Israel does show a temporary reduction in male fertility following the Pfizer jab. The scientists concluded:

This longitudinal study focused on SD demonstrates selective temporary sperm concentration and TMC deterioration 3 months after vaccination followed by later recovery.

Another participant in the BBC program, Naomi, was concerned about female fertility. She spoke to the same BMA GP. The GP acknowledged that studies have shown a disturbance in the menstrual cycle following vaccination. The BBC broadcast the doctor telling Naomi:

> There are no longstanding issues or effect on fertility.

This statement was seemingly made in reference to the menstruation studies. We don't know what other advice the GP gave Naomi.

As yet, the jab's impact upon female fertility is unknown, but there are significant reasons for concern. There was no scientific basis for the BBC to broadcast the claim that there are no "longstanding" fertility issues. On the contrary, the BBC appeared to have once again deliberately misled viewers.

During its pre-clinical trial research, Pfizer found that the lipid nanoparticles (NPs) used in its COVID-19 jabs freely moved around the body. But Pfizer didn't make this known prior to the shot's subsequent "approval." The NPs accumulated in the liver, in the adrenal glands, in the spleen and in both the testes and particularly in the ovaries.

The "long-term" effect of the NPs on fertility may not be established, but there are solid grounds for concern about toxicity, which numerous studies have highlighted. A 2017 review article of these studies noted:

> Females are particularly more vulnerable to nanoparticle toxicity, and toxicity in this population may affect reproductivity and fetal development. Moreover, various types of nanoparticles have negative impacts on male germ cells, fetal development, and the female reproductive system.

Dr Luke McLindon, President of the Australasian Institute for Restorative Reproductive Medicine, the primary investigator for numerous clinical trials and the senior obstetrician and gynaecologist for Mater Health in Brisbane, is no longer listed as an employee of Mater Health and has reportedly been sacked.

Why? It seems he was trying to release research data showing that miscarriage rates among his patient group had climbed from a usual maximum of 16% to as high as 74% for his vaccinated patients. This has yet to be confirmed by Dr McLindon, but if his data is correct it only adds to existing concerns.

NP accumulation in the ovaries, as highlighted by Pfizer's own research, has been worrying scientists for years. The BBC's disinformation, clearly intended to encourage pregnant women to get the jabs, was potentially dangerous.

Two participants, Chantelle and Naomi, were later taken to visit Prof. Asma Khalil, who told them:

> We know for sure that the vaccine does not cause miscarriage. We know that the vaccine does not increase the chance of stillbirth. We really have good safety data from a very large number of women who have received the vaccines. [. . .] There have been no concerns so far. [. . .] Potentially the vaccine is potentially useful for you and the baby. The most recent data tells us that the vaccine could reduce the risk of stillbirth by about 15%.

Prof. Fry backed up Prof. Khalil's statement:

If you catch COVID while pregnant, your risk of losing the baby to stillbirth is 15% lower if you have had the vaccine.

To which Prof. Khalil added:

> We have found that the vaccine, given to pregnant women, prevents hospitalisation because of COVID in the infant for the first 6 months of age.

For reasons we will discuss in Part 2, these statements from professors Fry and Khalil should be viewed with extreme caution. There are disconcerting signs of infant mortality after the jab that require explanation. These concerns were not reported in "Unvaccinated with Professor Hannah Fry."

In the history of the US Vaccine Adverse Event Reporting System (VAERS), which began monitoring possible vaccine-related AEs in 1990, there have been 2,243 recorded miscarriage and fetal death events potentially linked to the US vaccination schedule over the last three decades. By contrast, in less than two years (2021 and 2022 to date) VAERS has recorded 4,358 miscarriage and fetal events conceivably as a result of the COVID-19 jabs.

Like the MHRA's Yellow Card system, VAERS is not designed to prove or disprove causality but rather to be analysed to identify concerning "signals." And, like the Yellow Cards, VAERS captures an unknown percentage of AEs. The US Department of Health and Human Services (HHS) puts it this way:

VAERS receives reports for only a small fraction of actual adverse events.

The HHS, like the MHRA, hasn't done anything to remedy its known underreporting problem. Its "safety analysis" is just as flawed as the MHRA's.

Meanwhile, in Scotland, a notable spike in infant mortality occurred in 2021. Despite suggestions that this may have been caused by COVID-19, a subsequent investigation by Public Health Scotland (PHS) found that this was not the case. Another spike was reported by PHS in March 2022:

> The neonatal mortality rate was 5.1 per 1,000 live births in September and 4.6 per 1,000 in March, against an average of 1.49 per 1,000 in 2019.

There is a correlation between the vaccine rollout and the Scottish infant mortality spikes. This correlation does not prove jab causation, but any objective investigation should explore the possibility. Dr Sarah Stock, who leads the COVID-19 in Pregnancy in Scotland (COPS) research project, which is partly funded by PHS, said:

> I think the numbers are really troubling, and I don't think we know the reasons why yet. [. . .] What we do know is that it's not neonatal Covid[.] [. . .] It is very unusual to see these outliers, and understanding why is going to be crucial.

PHS and the COPS project say they do not know what caused the mortality spikes. They are looking at a range of potential reasons to account for these worrying spikes. There is only one potential cause that they have categorically ruled out and refuse to investigate.

When asked if the COVID-19 jabs could have contributed to the neonatal deaths, Dr Stock said that the spikes were:

> . . . absolutely not due to the Covid-19 vaccine[.]

Dr Stock and other public health experts claim to have no idea what caused the spikes in Scottish infant deaths. So how do they know that the vaccines are "absolutely" blameless?

We should note that Dr Stock's work is supported by the Wellcome Trust. The Wellcome Trust has invested £16bn in COVID-19 vaccine development.

The BBC program reported Prof. Khalil's denial of any reason for concern over neonatal health following vaccination. Perhaps she's right. Objective scientific research is needed to find out. But if that "science" is produced by the vaccine manufacturers, only an idiot would accept it without serious misgivings about a massive conflict of interest.

The BBC's so-called documentary was riddled with undisclosed conflicts of interest. Central to its propaganda was an agenda-driven approach to scientific, medical and statistical evidence that would have been apparent to viewers had the BBC been honest about the highly compromised positions of its "experts."

In its press release announcing the program, the BBC said that Prof. Fry's academic work "helped bring the UK out of its first lockdown." In truth, her work contributed towards putting us in lockdown. And not only that, but there is significant evidence to suggest that she was part of a BBC collaboration with the UK government that created the entire, highly dubious concept of a pandemic.

Part 2

I speculated in a previous article that the BBC would attempt to establish a narrative that would promote and support the UK government's proposed Online Safety Act. And that is precisely what it did in its would-be documentary, "Unvaccinated with Hannah Fry."

As presenter of the show, Prof. Fry got the relevant propaganda ball rolling when she introduced the segment that supported the UK government's censorship agenda. She said:

> I am really starting to realise that the problem here isn't so much about a lack of information as it is about this ocean of misinformation that is incredibly hard to wade through. [. . .] The question is how do you possibly tell, when you see things like this, how do you possibly distinguish fact from fiction.

How indeed.

Next, the BBC filmmakers turned their attention to Will Moy, who hammered home the same message when he spoke directly to the participants on the show. Moy is the founder and CEO of the online fact-checking service Full Fact.

When participant Nazarin suggested that the scientific and medical evidence raising concerns about the jabs should be given equal weight to the studies that support the jab rollout, Moy responded:

> Let's be careful about equal, right. I mean, there is very good evidence that the vaccines are safe and effective.

Was fact-checker Moy stating an actual fact?

In Part 1 of this series, we pointed out that the UK Medicines and Healthcare Products Regulatory Agency (MHRA) has not investigated the potentially huge number of serious adverse reactions and deaths that may have been caused by the jabs.

Absent reliable data on the overall level of risk, no plausible risk-benefit analysis exists. And, absent a risk-benefit analysis, there is no evidence, let alone any "good evidence," to prove that the jabs are "safe and effective." Thus, Moy's alleged fact wasn't a fact at all.

Moy's comment to Nazarin also exposed a recurrent theme that ran throughout "Unvaccinated with Professor Hannah Fry." Namely, the show was riddled with undisclosed conflicts of interest.

Conflict of Interest: Jab Science

Moy intimated that the evidence proving the jabs were "safe and effective" outweighed evidence to the contrary. He was correct only in the sense that the overwhelming number of papers produced thus far have been supportive of the jabs.

But just because there are more "pro-jab" papers it doesn't mean the evidence these papers provide is stronger than the contrary evidence found in the relatively few papers that question the jabs.

Prof. Fry chats with Nazarin and Vicki

What the proportionately large number of pro-jab papers does indicate, though, is that funding directly and measurably influences the premises and conclusions of so-called scientific research.

This funding bias has long been known to have contributed to a crisis in science. The crisis has been marked by far too many papers that are apparently producing weak conclusions to order.

On the subject of the COVID-19 jabs, for instance, research is frequently funded by the pharmaceutical corporations whose products the papers evaluate. And because government is in league with those very same pharmaceutical corporations, forming what are called public-private partnerships, government's funding can also present potential conflicts of interest and subsequent bias.

The Cochrane Collaboration conducted a systemic review, published in a February 2009 issue of the British Medical Journal, on the influence of industry funding of published papers studying influenza vaccines. Cochrane ascribed a "concordance" score to the papers, indicating the degree to which the conclusions were evidenced by the reported study results. If the results strongly supported the conclusion, the paper received a high score; if not, it was given a lower score.

In total, 70% of studies were favourable to the flu jabs but only 18% of papers received a high concordance score. The Cochrane review suggested a high degree of bias in more than half (56%) of the papers. The lowest bias risk was given to just 4% of the papers.

Cochrane established that higher concordance was dependent upon methodology. Where methodology was sound, the likelihood of the study supporting the "efficacy" of the respective jab was lower:

> [T]he higher the probability of concordance, the lower the probability that a study's conclusions were in favour of vaccines' effectiveness[.]

Cochrane also found that corporate and unknown funding was associated with low concordance and unjustified results in favour of the jabs:

> [P]oor methodological quality was associated with a discrepancy between results and conclusions, and this in turn was associated with optimistic conclusions in non-government sponsored studies.

Government funded 48% of the reviewed studies, pharmaceutical corporations 29% and 23% didn't disclose any funding source. Consequently, the Cochrane Collaboration could not establish a "direct association" between corporate funding and low concordance. All we know is that concordance was poor for the studies with declared corporate funding.

Cochrane also found that the 30% minority of reviewed papers that questioned the jabs had consistently higher concordance than the remaining 70% that promoted them. It also found that the lower-quality, more biased pharmaceutical corporation-funded studies were more likely to be published in so-called "prestigious journals."

Cochrane speculated that this may partly explain political support for global flu vaccination programmes that fail to properly recognise the risks:

> Studies partly or completely sponsored by industry, however, were published in more prestigious journals and are probably cited more[.] [T]hese findings might help to explain the continuation of a near global policy, despite growing doubts as to its scientific basis. [. . .] Those sponsored by industry had greater visibility as they were more likely to be published by high impact factor journals and were likely to be given higher prominence by the international scientific and lay media[.]

In short, Cochrane demonstrated that the funding of scientific research into influenza vaccines influenced both the conclusions and the reporting of those conclusions. Without being able to catagorically state it, due to the proportion of papers that did not disclose funding sources, Cochrane strongly suggested that "pro-jab" papers were biased by industry funding. Nothing has changed.

Moy's insinuation, that there is more evidence demonstrating COVID-19 jab safety and efficacy, was seemingly a reflection of the number of papers, not their quality or scientific merit. That this unequal distribution of findings in favour of the jabs constituted "very good evidence" was simply his opinion—but it was not a fact. The evidence suggests that he was probably wrong.

For example, the Lancet published a paper, with undeclared funding, that interpreted its own results on waning immunity levels following successive jabs as strong evidence to support "administration of a third vaccine dose as a booster." Cochrane referred to these kinds of findings as "optimistic conclusions."

As pointed out by cardiovascular surgeon Dr Kenji Yamamoto, the Lancet paper's experimental results also suggested that:

> [I]mmune function among vaccinated individuals 8 months after the administration of two doses of COVID-19 vaccine was lower than that among the unvaccinated individuals.

Dr Yamamoto also noted that the European Medicines Agency's (EMA's) strategy chief, Marco Cavaleri, had warned that repeated doses of the jabs could lead to problems with the vaccinated's long-term immune response. Consequently, Dr Yamamota interpreted the paper's results entirely differently and suggested that, "as a safety measure, further booster vaccinations should be discontinued."

This is not the kind of information the BBC reported in its "eye-opening investigation." It did not address the known conflict of interest that has led to the crisis in science. Had the BBC mentioned Dr Yamamoto's observations, it is likely that Prof. Fry would have called them "anti-vax propaganda."

Conflicts of Interest: Will Moy

"Misinformation" is information that is factually inaccurate but is passed along by a purveyor who is ignorant of the inaccuracy and does not intend to deceive. "Disinformation," on the other hand, is information the purveyor knows is false yet deliberatively imparts with the intention of deceiving or misleading.

As we shall see, however, both of these terms are being interpreted somewhat differently by the nascent fact-checking industry springing up across the globe.

At the very least, Moy effectively gave misinformation to the BBC's participants when he contradicted Nazarin. The BBC then offered him to the group as an expert on the subject of mis/disinformation. Moy told the participants:

> There is genuinely, I think, hard question about where is this balance between, we should all be able to share our own ideas, but some of those things can cause real harm.

The interpretation of "real harm," as Moy well knew, is key to the UK government's plans to roll out internet censorship through its proposed Online Safety Act. The legislation creates the concept of information that may be legal but is allegedly "harmful" to both adults and children. Since there is no definition of "harm" in the bill, the UK government can censor whatever it chooses simply by calling it "harmful."

Will Moy

Moy introduced the concept of unspecified "harm" into the BBC segment presumably because his company is lobbying and campaigning for the legislation. Belying his claim that it is an "independent" fact-checking organisation, Full Fact was initially set up with seed money from the City of London Corporation, from George Soros' Open Society Foundation and from Rolls Royce, to name a few of its funders.

We can only surmise that global financial institutions, international currency speculators and defence contractors have the interests of the public at heart and want to make sure everyone has access to only the "right" information.

Full Fact is part of the International Fact Checking Network (IFCN), established to police publicly available information on behalf of governments and multinational corporations.

Currently Full Fact earns a fair chunk of its money by providing so-called fact-checking services to social media giant Facebook (Meta). Not surprisingly, in response to these legislative moves by governments around the world, not just in the UK, Meta has already quadrupled its online safety and security teams.

Full Fact's role with Meta is not to check facts but rather, as explained by Meta CEO Mark Zuckerberg, to ensure that nothing contravenes what he calls "protected opinion." Meta's

investment will see the necessary expansion of its third–party fact–checking program, designed to "fight the spread of misinformation."

"Misinformation," it seems, is now considered to be any information that government has labelled as "harmful" or any that contradicts "protected opinion."

Will Moy is deeply connected within government, having "served on advisory groups" for the UK government's Economic and Social Research Council and for the Treasury and having regularly given "evidence to select committees." For example, Moy was invited to contribute to the February 2021 House of Lords Select Committee on Communication and Digital, where the role of the alleged "fact checker" was discussed.

During that hearing, Dr Lucas Graves, a senior research fellow at the UK Reuters Institute, suggested that the Committee might consider:

> [. . .] what sorts of policies we might choose to layer on top of the work of fact-checkers[.]

He also observed:

> [F]act-checking organisations such as Full Fact [. . .] almost never think of themselves as wanting to police speech. That is a burden that they are very reluctant to take on[.]

In so saying, Graves revealed the fundamental problem that undermines the entire concept of fact-checking. That is, fact checkers like Full Fact have been empowered to define and arbitrate the "official" truth. Whether "reluctant" or not, they have assumed the mantle of king, on the "fact" throne, from which they rule over not just their own nation-state's "truth" but also global "truth."

Take UNESCO's recent campaign "Think Before Sharing," which makes the allegation that so-called conspiracy theories are dangerous. It suggests that social media users can protect themselves from these dangers by ensuring the authors are suitably qualified and by assessing whether "the tone" of the content is factual.

Putting aside that UNESCO's first recommendation is to indulge in logical fallacies and its second to value subjective judgements that have nothing to do with evidence, the UNESCO—a global intergovernmental organisation—is also urging people to make sure their sources are approved by "fact-checking sites." Today we see fact-check services being used across social media precisely for the purpose of "policing speech."

The industry would not exist were it not for the age-old but heightened political obsession with controlling information. Politicians seek to use the fact checkers' "rulings" as justification for their policy decisions.

When those same fact checkers are political lobbyists, whose close relationship with the political class enables them to sell services that are dependent upon policy decisions, the conflict of interest is so profound there is little reason to believe anything they say. Fact checkers are first and foremost defenders of the establishment's preferred narrative—of "protected opinion," as Zuckerberg put it.

In the aforementioned House of Lords select committee, Moy tossed around words like impartiality, transparency, accountability. But those noble-sounding goals were betrayed by his rank admission:

> [. . .] we are first responders to the emergence of misinformation.

So, who made Full Fact the “truth” authority? For the answer, we need only look at its funding sources: the same corporations, foundations and billionaires who fund political parties and spend millions lobbying for policies that favour their interests. Indeed, Moy exemplified the incestuous relationship between the fact-checking industry and the politicians when he told the select committee:

> [. . .] we can identify emerging harms. [. . .] The keystone for us is thinking about harm: what harm would be done if this thing were wrong?

Moy’s testimony to the House of Lords almost certainly followed the advice of Full Facts’ head of policy and advocacy, Glen Tarmen, whose stated remit is:

> [. . .] securing changes from those in governments, parliaments, the media, internet companies and beyond that influence people’s exposure to bad information and its harms.

Full Fact is actively influencing government to secure the changes that bolster its business opportunities. Contradicting government on major policy initiatives such as universal vaccinations programmes, is not in Full Fact’s interest.

Back to Moy’s objective in speaking with the participants on the BBC programme. His suggestion that some of their “anti-vaxx” opinions could “cause real harm” was a sales pitch. The BBC’s participants and audience didn’t known that, because the BBC didn’t disclose Moy’s massive conflict of interest.

Conflict of Interest: Professor Adam Finn

During the BBC programme, Prof. Fry took three of the participants to visit Professor Adam Finn. She told them that he has been “instrumental in COVID-19 vaccine research.” Her narrated introduction to Professor Finn noted:

Having led clinical trials for Oxford AstraZeneca and Janssen and the newest vaccine, Valneva, Professor Finn is an expert in how vaccines work.

For some reason, the BBC did not disclose that Prof. Finn is also the leader of the Pfizer Centre of Excellence for Epidemiology of Vaccine-preventable Diseases at the University of Bristol—as later pointed out by Professor Norman Fenton. The Vaccine Centre of Excellence was opened in May 2021 by then-UK Health Secretary Matt Hancock. Prof. Finn remains its director (official title “lead”) to this day.

In Part 1, we explored the appalling lack of regulation and almost the complete absence of any oversight by the MHRA. Pharmaceutical corporations were able to acquire emergency use authorisation and Conditional Marketing Approval (CMA) for their products without even producing completed trial results.

When BBC participant Ethan asked Prof. Finn how it was possible for the jabs to be developed and approved so quickly, Finn replied:

> The speed with which these vaccines were developed was unprecedented. The way it was done, was not by missing out steps that we normally do, it was by taking an enormous financial risk that you wouldn’t normally take.

If we look at the study design of Pfizer's BNT162b jab, which was the first COVID-19 jab given emergency use authorisation by the MHRA in December 2020, the stated primary completion date for the trial is February 8, 2024.

"Primary completion" means:

> The date on which data collection is completed for all the primary outcome measures.

The secondary outcomes have the same completion date. There are "no results posted for this study," and much of the crucial testing and surveillance was incomplete when the jab was "approved" via emergency use authorisation. For example, the trial design necessitated collection of the following data:

In Phase 1 participants, SARS-CoV-2 serum neutralizing antibody levels, expressed as GMTs
[Time Frame: Through 2 years after the final dose]

Prof. Adam Finn

Pfizer didn't even submit this data until April 2022, more than a year after millions of people had already been injected with its product. By then Pfizer had rebranded its drug Comirnaty to enable the MHRA to give it Conditional Marketing Authorisation.

Comirnaty and BNT162b2 are one and the same, but branding is required for marketing approval. Yet, though Comirnaty now has marketing approval, it still hasn't completed trials.

So it is difficult to know what Prof. Finn was talking about. The jabs were not developed with "unprecedented" speed. Development is dependent upon trial results. Trials were planned as usual but aren't complete and have largely been abandoned. The jabs are yet to be fully "developed," while experimental testing on the population continues.

How Prof. Finn could describe this as not "missing out steps that we normally do" is equally unfathomable. Pfizer didn't complete any of the normal steps. The "steps" were ignored.

Then there was his claim about the "enormous financial risk." This wasn't a financial risk that the pharmaceutical corporations bore alone, or barely at all. They were supported by their government partners, which pumped billions of taxpayers' money into jab development.

For example, COVAX brought together the Coalition for Epidemic Preparedness Innovations (CEPI) and Gavi and the World Health Organization (WHO) to "accelerate the development, production, and equitable access to COVID-19 tests, treatments, and vaccines."

CEPI's "investors and partners" include the UK, US, Canadian, German and Australian governments alongside the likes of the Wellcome Trust, the Bill and Melinda Gates Foundation and the EU. It seems it was actually the taxpayers who were taking the "financial risk." But they certainly didn't receive a share of the profits.

AstraZeneca posted a 48% revenue increase to just over £22Bn across its entire business for the first half of 2022. Similarly, Pfizer reported all–time high revenue and excellent profits for 2021, representing 92% operational growth that was mainly driven by sales of its Comirnaty (BNT162b2) jab. Pharmaceutical corporations have enjoyed fantastic growth and revenues as a result of the pseudopandemic.

The manufacturers of the jabs would not even begin testing their products on the public without government guarantees of immunity from civil prosecution for any harm they caused, which they duly received.

The pharmaceutical corporations' development costs were supported by government, intergovernmental organisations, philanthropic foundation and other corporate partners, and they had a guaranteed market. Their limited, alleged "financial risk" looks like a sound, very low-risk investment.

There was no "enormous financial risk," despite Professor Finn's claim to the contrary. There was an "enormous" taxpayer-funded investment, but the risk, from a corporate perspective, was virtually nil. The product manufacturers faced no liability risk and hardly any investment risk, and the products they delivered weren't even trialled before being sold and distributed.

Professor Finn appeared to have been eulogising the jab developers, alleging they took enormous risks on behalf of the public. In reality, nearly the entire risk was shouldered *by* the public. There seems a distinct possibility that Finn's role, as the head of Pfizer's Centre of Excellence, influenced his opinion. Given his position, it is incredible that he also told the BBC's participants:

> People like me and people like the regulatory authorities exist as a kind of buffer in between them [the pharmaceutical corporations] and the public. And if results come out that companies might not like the look of, it's my job to publish them and make sure that everyone knows what's going on.

Prof. Finn suggested that he and the regulators were somehow independent of the drug industry. Nothing could be further from the truth. The UK regulatory authority, the MHRA, no longer considers itself to be a "watchdog" but rather an "enabler" for pharmaceutical products.

The cost of the MHRA's alleged regulation is "met by fees from the pharmaceutical industry." In the UK, as elsewhere, the pharmaceutical corporations fund their own regulatory body.

In response to concerns about Prof. Finn's undisclosed conflict of interest, raised by Prof. Fenton, the BBC said:

Professor Finn leads a research group within the Pfizer Vaccine Centre of Excellence – where his work in relation to Covid-19 vaccines is independent of Pfizer.

This was another disingenuous side-step by the BBC. Unsurprisingly, the Pfizer Centres of Excellence are funded by Pfizer. And since Prof. Finn heads up the UK Center, he is presumably being paid by Pfizer—unless he's doing that work for free.

His claim that he will keep the public informed about the science that could damage industry profit margins can and should be questioned, due to his apparent conflict of interest that neither he nor the BBC chose to disclose. In light of the BBC's edited broadcast of Prof. Finn's statements, made during the programme, the chance of him telling the public anything that suggests reason for concern seems remote.

Conflict of Interest: Professor Asma Khalil

In Part 1, we discussed some of the scientific and statistical evidence that brings into question the claims made by Professor Asma Khalil during the BBC programme. Yet her statements were reported by the BBC as if they were unassailable facts.

Specifically, Prof. Khalil told concerned participants that the jabs were beneficial for pregnant women and that "studies show" that the jabs reduce the chance of stillbirth by 15%. She made this claim based upon her own research paper [Prasad et al. — 2022] on prenatal outcomes following the injection of pregnant women with the mRNA jab.

Neither Prof. Khalil nor the BBC informed either the participants or the BBC audience that Prof. Khalil's statement was "not entirely accurate." Other researchers have been unable to replicate the results of Prasad et al. When they applied that same statistical analysis to the same datasets, they concluded:

> Prasad et al. does not support the statement that vaccination decreases the risk of stillbirth. [. . .] [T]he results cannot be replicated using the same software, the same statistical package, and the same choice as deducted from the publication. [. . .] We notified the authors of these findings, to which we received the reply that the study design stratified analysis is not entirely accurate[.] [. . .] [I]t is perhaps best if such findings are purposefully downgraded to prohibit any grand claims on the protective effects of vaccinations[.] [. . .] [T]hat is not what evidence-based medicine should be about.

Prof. Asma Khalil

As we discussed, Prof. Khalil's other claims about safety in pregnancy do not chime with the current statistical evidence, either. Prof. Khalil hasty assertions would probably have received more scrutiny had the BBC chosen to disclose her conflicts of interest.

The Ethical Considerations section of Prasad et al. lists Prof. Khalil as the Principle Investigator (PI) for "Pfizer COVID vaccination in pregnancy trial." The Contribution section of Prasad et al. notes that she also "interpreted data and revised the manuscript for important intellectual content."

NHS England describe Professor Khalil as "one of the UK's leading medical entrepreneurs." She is a former director of Trakka Medical ltd, which developed the HaMpton app for monitoring pregnant women's blood pressure. The HaMpton app monitors the patient's biomedical data and links it to public health service patient monitoring systems in real time.

Prof. Khalil is a fellow of the NHS Innovation Accelerator, which, coincidentally, supported her in developing and marketing her app. Her product development, safety licensing and ethical approval were also assisted by the MHRA's innovation accelerater, whose "innovative licensing and access pathway" enabled Prof. Khalil to "accelerate the time to market."

This experience may have influenced the advice she gave to the COVAX Maternal Immunisation Committee. The Committee concluded that policy makers need to be educated to address "misconceptions" about the risk/benefits of the jab. So Prof. Khalil's "misconception" about reduced stillbirth risks being attributable to the jabs was unfortunate.

The NHS Innovation Accelerator, of which Prof. Khalil is a fellow, is hosted by UCL Partners, which is billed as the largest academic health science centre in the world. UCL's research partners include the London School of Hygiene and Tropical Medicine (LSHTM), UCL (University College London) and Queen Mary University London.

These academic institutions have been instrumental not only in Prof. Fry's research but also in creating one of the most amazing coincidences in the history of global public health—one that has the BBC right at the heart of it. It is this unbelievable coincidence and its staggering implications that we will investigate in Part 3.

Part 3

In Part 1 we looked at the propaganda and manipulation techniques used throughout the BBC programme "Unvaccinated with Professor Hannah Fry." In Part 2 we considered the undisclosed conflicts of interest that apparently led some of the BBC's chosen "experts" to make some misleading statements.

Yet perhaps the greatest single deception of all was in the BBC press release announcing the programme, which read:

> Professor Hannah Fry is a British Mathematician who worked on the data that helped bring the UK out of its first lockdown.

This was incredibly disingenuous from the BBC. Prof. Fry worked on the data that helped put the UK *into* lockdown.

She was a major contributor to what became known globally as the BBC Pandemic Dataset, which, as we shall see, was central to creating of the myth of a pandemic—central, that is, to creating a pseudopandemic.

The Pseudopandemic

Absent the perception of a pandemic, there could have been no possible justification to advocate a universal vaccination campaign. Yet, from the start, many scientists pointed out that there was little-to-no evidence to substantiate the WHO's declaration of a "global pandemic."

There was virtually no asymptomatic transmission; there was no proof that children were at risk or presented an infection risk; in the UK, the average age of mortality "with" COVID-19 was 82, at a time when the average age of mortality from life (all cause) was 81 for men and 83 for women.

Such evidence was ignored by the BBC and Prof. Fry, who maintained that the "global pandemic" necessitated mass vaccination.

People in the UK widely believed that the pseudopandemic was real, not because the scientific or statistical evidence was clear but because the government spent billions with PR firms to run "hard-hitting" media campaigns designed to convince them of it. This intense propaganda, combined with the censoring or deplatforming of any scientist or expert who questioned the COVID-19 narrative and/or the COVID vaccine narrative, ensured that the general public never learned the real, relevant facts about either the disease or the jab.

The vast majority who believed the pandemic was real were willing to accept a government policy response that, prior to the vaccine rollout, was based upon non-pharmaceutical interventions (NPIs). Lockdowns, social distancing, mask-wearing and track and trace are all examples of NPIs.

Even if the pseudopandemic were not pseudo but a genuine pandemic—which it wasn't—the NPIs deployed by the UK government would have been justified only in the most extreme circumstances.

In 2019, the WHO published a piece titled "Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza." In it, the WHO concluded that lockdowns—the "quarantining of healthy individuals"—were "not recommended because there is no obvious rationale for this measure."

The WHO also advised that social isolation for the sick should be done only for limited period of time. It did not recommended isolation for "individuals who need to seek medical attention." It ruled out work closures because of their destructive impact on the economy. The WHO advised shutting down business activity only in "extraordinarily severe pandemics."

The WHO found "no obvious rationale" for contact tracing—test and trace. It did not recommend the widespread use of face masks, for "there [was] no evidence that this is effective in reducing transmission."

The prevailing epidemiological understanding was that lockdowns and other NPIs were largely counterproductive. Yet, in defiance of the WHO's statements and rationale, governments around the world wilfully pushed these NPI measures on their citizens just a few months later.

It would not be long before the so-called science emerged to back up these policy decisions. One of the first was reported by Flaxman et al in 2020. It was funded, not surprisingly, by the Bill and Melinda Gates Foundation (BMGF) and the US government. Based on "pandemic models" produced by Imperial College London (ICL), the Flaxman et al. paper suggested that, suddenly, lockdowns reduced the rate of infection by 82%.

When a team of German researchers tried to replicate the paper's results, they found that the published conclusions were mainly based on assumptions and circular reasoning. The German adademics said:

> Purported effects are pure artefacts, which contradict the data. Moreover, we demonstrate that the United Kingdom's lockdown was both superfluous and ineffective.

Researchers from Stanford University said the Flaxman paper was "highly misleading" and suffered from "serious selective reporting, providing the most favorable estimates for lockdown benefits." Turning their attention to the ICL models, the team of epidemiologists at Stanford concluded:

> Lockdown appeared the most effective measure to save lives in the original analysis of 11 European countries performed by the Imperial College team[.] [. . .] These impacts were highly exaggerated[.][. . .] Claimed effects of lockdown are grossly overstated[.] [. . .] This bias can have devastating implication if it leads to adoption of harmful measures.

Many epidemiologists and other experts were angered by the Flaxman et al. paper. They made it clear that most governments, the UK's among them, were pursuing NPIs contrary to all epidemiological understanding.

In 2006, Prof. Donald A. Henderson, the person largely credited with winning the fight against smallpox, published Disease Mitigation Measures in the Control of Pandemic Influenza. His refutation of NPIs noted:

> There are no historical observations or scientific studies that support the confinement by quarantine of groups of possibly infected people for extended periods. [. . .] Such a policy would also be particularly hard on and dangerous to people living in close quarters, where the risk of infection would be heightened. [. . .] Travel restrictions, such as closing airports and screening travelers at borders, have historically been ineffective [. . .] It might mean closing theaters, restaurants, malls, large stores, and bars[.] [. . .] Implementing such measures would have seriously disruptive consequences[.] [. . .] [A] manageable epidemic could move toward catastrophe.

In the years since Henderson's 2006 paper, epidemiologists, immunologists, virologists and public health statisticians have not changed their views, as the WHO's 2019 publication demonstrates. There was no evidence-based reason to change their opinion.

Prof. Knut M. Wittkowski

The UK government acknowledged and understood all of this. In its 2011 Influenza Pandemic Preparedness Strategy, the UK Department of Health (its name at the time) did not recommend any of the NPIs that the government subsequently rolled-out for COVID-19. No lockdowns, no masks (except in exceptional circumstances), no school closures and no travel restrictions were advised.

The Department considered business and economic continuity absolutely essential, for public health reasons as much as any other. Public health officials knew that pointless NPIs would mean "a manageable epidemic could move toward catastrophe."

As part of that 2011 strategy, the UK government said that vaccine development should be prioritised only "[i]f it is not possible to limit the spread by achieving herd immunity, where so many people are immune that the disease cannot continue to infect people to maintain itself in the population. "

This is what the science of epidemiology suggests to this day. Nothing has changed.

Prof. Knut M. Wittkowski is one of world's leading epidemiologists. He developed the science behind—and has coined the term—"reproduction number" (R0). Speaking in April 2020, he said:

> With all respiratory diseases, the only thing that stops the disease is herd immunity. About 80% of the people need to have had contact with the virus. [. . .] We are experiencing all sorts of counterproductive consequences of not well-thought-through policy[.] [. . .] [W]e will see more cases among the elderly[.] [. . .] [W]e will see more death because of this social distancing. [. . .] I have been an epidemiologist for 35 years, and I have been modeling epidemics for 35 years [. . .] but it's a struggle to get heard.

Prof. Wittkowski was censored online and "cancelled" by the MSM for expressing his eminently qualified opinion. The way his voice was suppressed exemplifies how impossible it has been for scientists who question the pseudopandemic to reach the public. Policymakers refused to listen, preferring to hear only from the scientists whose work supported their policies.

Without any apparent explanation, epidemiology was flipped on its head during the pseudopandemic. The resultant NPIs did nothing but deepen the crisis.

The UK government reduced NHS capacity and then told citizens they needed to "stay home to protect the NHS" by "flattening the curve." Again, locking down was already known to be both pointless and likely to increase mortality.

Nobel chemist and statistician Prof. Michael Levitt analysed the outbreak of COVID-19 in Wuhan from the beginning. He published his findings and reported that infection rates peaked and then started to decrease in Wuhan in early February 2020. He demonstrated from this distribution that he could calculate what the infection and death toll would eventually be—regardless of NPIs. His predictions of around 3,250 deaths and 80,000 infections by mid-March were unerringly accurate.

Since the view of Prof. Levitt, like that of many other scientists, contradicted the BMGF-funded alarmism of ICL's models that were instrumental in providing alleged justification for NPIs, his work was censored and removed from search engine results.

Shortly after the WHO declared the pseudopandemic, then-UK Prime Minister Boris Johnson announced the measures the UK government intended to take in response. Those measures included numerous NPIs.

The only path offered by the UK government out of the social, economic and public health disaster that NPIs created was the so-called vaccines.

According to the official narrative, "vaccines" were the only possible salvation from COVID-19. Whenever potential COVID-19 treatments were found, the WHO and governments around the world ensured that they wouldn't be adopted. Protecting vaccine development superseded saving lives.

The reality on the ground: the damage supposedly caused by COVID-19 was overwhelmingly the direct result of the policy decision to use NPIs. The "catastrophe" this would cause was already understood and entirely predictable. Catastrophe was actively pursued by the policymakers.

In announcing that it had decided to ignore established epidemiology, the UK government (like many other governments) simultaneously claimed that all of its decisions were "led by science." However, given that this science was actually contrary to the prevailing "science," we must ask: Where did it come from and who were the scientists pushing it?

At this point, you may be asking still another question: What has any of this got to do with Prof. Fry and BBC programming?

BCC Contagion and the The Haslemere Experiment

"Unvaccinated" is hardly the first questionable "documentary" the BBC has broadcast. In 2018, it produced another called Contagion: The BBC4 Pandemic. The programme chronicled the activities of Prof. Fry as she presented the public face of a BBC data-harvesting operation that began in 2017.

In preparation for "Contagion," the BBC commissioned the development and rollout of a smartphone app:

> The Pandemic app has been created as part of a BBC citizen science event that aims to identify the human networks and behaviours that spread infectious diseases.

The idea was that the GPS location of the app users would be tracked and contact between users recorded. A large database of people's movements and interactions would be created, enabling mathematicians, statisticians and data modellers to create simulacra of epidemics and pandemics. The BBC added:

> [W]e hope the research will benefit everyone in the UK by helping plan for future outbreaks. [. . .] This anonymous information will be stored on secure servers and only accessed by the App developers and the researchers.

An excellent researcher called Pighooey pointed out the key objective of the BBC experiment, as stated in its own "about the app" description:

> The data collected between December 2017 and December 2018 will contribute to this new gold-standard set for use in future simulations and in wider Pandemic research.

In other words, the data harvested by the BBC was intended to create simulated, not real, pandemics. This may seem obvious, but it is key to understanding the impact that BBC's Pandemic Dataset would have. This was not a "model" of a pandemic based upon "real-world" data, but rather a mathematical construct dependent upon assumed epidemiological inputs.

The BBC also said of this app:

> The BBC Pandemic App received an Invest Northern Ireland Grant for Research and Development.

Invest Northern Ireland (INI) is a part of the UK government's Department for the Economy. INI says of itself that its purpose is to "provide strong government support" focused upon "delivering the government's economic development strategies."

The BBC went on to say:

> The study is funded by the BBC and organised by the London School of Hygiene and Tropical Medicine [LSHTM] and University of Cambridge, in collaboration with app developers Big Motive and programme makers 360 Production.

The fact that the UK government and the BBC "invested" in the data-gathering project means that the effort was paid for by UK taxpayers and license-fee payers.

Prof. Julia Gog

The experience benefited Big Motive—the BBC's app developer. Big Motive subsequently produced the UK's first COVID-19 contact tracing app in Northern Ireland—the StopCOVID NI app. Similarly, the eventual NHS Test and Trace app for England and Wales was, in part, developed by Zühlke Engineering, whose UK academic partners are Imperial College London (ICL) and the University of Cambridge (UoC).

Again, it seems that UoC's collaboration with the BBC and the UK government in the "Contagion" experiment proved valuable for Zühlke. As we shall see, the BBC Pandemic Dataset certainly did.

The Surrey town of Haslemere was carefully selected as the epicentre of the simulated outbreak with Prof. Fry playing the role of "patient zero." The choice of Haslemere initially led to some consternation among the mathematicians involved in the modelling.

In an article published in the Journal of Epidemics, Prof. Julia Gog said:

> In the TV programme we first simulated a detailed outbreak in the town of Haslemere, and this was to be the seed of the national outbreak. [. . .] In particular, we were asked to ensure that the epidemic was seeded in Haslemere. [. . .] It is commonly believed that these epidemic establishment sites are likely to be major population centres. [. . .] While the single introduction in Haslemere may be contrived, there is also no reason to reject the possibility of a major outbreak being introduced in such a town.

Prof. Gog has never disclosed who it was that insisted the BBC's fake pandemic should be "contrived" to start in the relatively small town of Haslemere. We might suspect that the request came from either the BBC or the government. Both, after all, were paying for the research.

It is almost an incalculable *coincidence* that the next pandemic in the UK, called COVID-19, supposedly broke out in Haslemere. The first patient in the UK to be treated for COVID-19 was a man who flew in from China. But the first supposed UK infection befell a man who, remarkably, lived in Haslemere.

The BBC reported that he was “from Surrey” yet didn’t think it worth mentioning the town he lived in. The local press, for whom Prof. Fry’s 2018 “Contagion” experiment had been a big deal, did think it interesting. Calling the coincidence “bizarre,” Surrey Live wrote:

> The coronavirus outbreak in Haslemere has thrown up a bizarre coincidence to a BBC Four experiment series that was also filmed in the town two years ago. [. . .] The outbreak in the Surrey town has drawn spooky comparisons to the programme ‘Contagion: The BBC Four Pandemic’, which aired in March 2018. [. . .] The confirmed case on Friday (February 28) was the first patient to have contracted the virus from within the UK.

Just as the BBC’s “Contagion” team modelled.

The BBC Pandemic Dataset

The BBC Pandemic Dataset, as referenced in Klepec et al. 2018, enthused statisticians and mathematical modellers around the globe. Researcher Pighooey tracked down footage of Prof. Gog speaking in 2017, prior to “Contagion,” explaining the reason for their excitement:

> This is the big one for us, [. . . .] [T]his data set will be made available to all scientists. [. . .] I don’t know anything like it. So there is a lot of interest from colleagues who have got in touch, [asking for access to the data—asking] “is there anything other people can have?” And it’s like, yeah, you can have all of it. [. . .] Off you go, and it will be the BBC Pandemic Dataset.

This anonymised dataset has been publicly available since 2020 and available to the global scientific community since 2018.

Encouraged by its initial success with the app in Haslemere, the BBC began the second phase of its data-gathering experiment. This time it rolled the app out nationally. Aiming to recruit at least 10,000 people, the BBC successfully enrolled nearly 29,000. In “Contagion,” Prof. Fry claimed that the data would enable scientists to predict the impact of various non-pharmaceutical interventions (NPIs):

> What’s so exciting about the data we have gathered is that mathematicians can now use it to test a range of interventions. What if we closed schools? How would that impact the number of people infected? And shutting down places where people gather, or asking them to stay at home? Now that we have this data there are all manner of possibilities that could be tested.

Fry opined:

> The BBC Four pandemic experiment has created a valuable legacy. [. . .] We now have a new gold standard dataset for pandemic research. A vast amount of information that will be shared with mathematicians from the Department of Health and pandemic researchers nationwide. [. . .] Better models mean better health care for all of us.

BBC Four’s “Contagion” experiment with Prof. Hannah Fry was more than 70 minutes long. It had plenty of time to mention sharing the data with the UK government but did not do so until the last minute. Encouraging as many people as possible to download the BBC’s forerunner to the Track and Trace apps, Prof. Fry concluded the programme by claiming that the BBC and the “Contagion” team had helped to unleash “the life saving power of mathematics on what the government considers the greatest threat to our society.”

We should ask if it was not, in fact, the BBC and the subsequent exploitation of the “Contagion” experiment by the UK government that created the greatest threat to our society.

Multiple Frys

The BBC Pandemic Dataset Model

The harvested dataset enabled the BBC “Contagion” team to model a national pandemic and to claim various benefits for NPIs. This virtual reality simulation assumed a set of disease characteristics. They assumed the disease was spread through asymptomatic transmission. Prof. Fry said:

> You can be infectious for a whole day without feeling ill. Meaning you can carry on about your normal everyday business without realising that you’re spreading a disease.

The team assumed a high and consistent reproduction number, or R0 value, of 1.8. This refers to the number of other people a single infected person infects. The assumption in the model was that 1 person infects 1.8 others. Thus, as more people were infected, they each spread the disease asymptomatically. The rate of growth was fixed and, assuming no one was immune, drove the simulated “contagion” unendingly.

Starting their simulation in Haslemere, assuming an R0 of 1.8 and almost instant asymptomatic transmission with no possible immunity, the BBC plugged its app data into its model.

It predicted 43M infections and assumed every one of those would result in illness—and could therefore legitimately be called a “case.” The BBC also assumed a “worst case scenario” case fatality rate (CFR) of 2% and predicted 900,000 deaths in less than nine months.

Following the “worst case scenario” predictions, Dr Adam Kucharski from the LSHTM speculated that the next pandemic would be a zoonotic virus that might break out in rural Southeast Asia. The prediction of a zoonotic virus was reinforced by Prof. Wendy Barclay from Imperial College

London. Prof. Barclay also explained how mutation of spike proteins could leave us with no immunity to “new strains.”

Dr Chloe Sellwood, head of pandemic planning for NHS England, spoke about how the NHS would cope if the “worst case scenario” occurred:

> So if you think about 50% of the population being affected [. . .] if all of those cases happened in one week, that’s a really big short, sharp peak. Lots of cases. If we can slow the spread over a much longer period[,] that reduces the impact on the NHS and makes it much more manageable.

Her concerns were echoed by Dr Chris Chiu, a researcher for Imperial College London, who said that pandemics were “regular occurrences.” He stated:

> What we saw from the last flu pandemic in 2009, which was a relatively mild disease, was that our health service was almost unable to cope.

In truth, there was no 2009 “pandemic.” There were just 18,500 confirmed H1N1 influenza deaths globally. It didn’t even constitute a bad flu season.

During “Contagion,” Prof. Gog spoke to Prof. Fry about targeted vaccination of alleged “super spreaders.” All this chatter was based upon the assumption that infection is asymptomatic and practically instant.

Prof. Fry suggested:

> So if you take those out, vaccinate them so they are immune to the virus, and see how it changes.

Assuming that vaccination would stop transmission, Prof. Gog adjusted the simulation and Prof. Fry concluded that targeting just 10% of alleged super-spreaders would reduce infection rates by 40%.

She added:

> Our app enabled us to identify super-spreaders in Haslemere. But in the real world people who work in busy places like schools could also be super-spreaders.

Prof. Gog then simulated the impact that handwashing could have in the faux pandemic. Gog’s subsequent model produced results that suggested handwashing could save 13M lives and slow the transmission of an airborne respiratory virus.

This led Prof. Fry to conclude:

> If we all commit to changing our behaviour, there are ways to slow the pandemic.

Summary of the BBC Contagion Model

A zoonotic virus emerges in Southeast Asia. It soon spreads to the UK, where the first domestic infection is identified in Haslemere. From Haslemere, as a consequence of asymptomatic transmission and a high R0, the contagion spreads around the UK, striking the major urban areas first and hardest. Super-spreaders create hotspots of infection that rapidly overwhelm health services.

No one is immune. Contagion is more or less instant, and infection and transmission are asymptomatic. Consequently, just being infected makes you a “case” of the disease, symptoms or not. The only hope is a vaccine that stops transmission of the virus. But the virus mutates into potentially more dangerous forms (variants).

Due to the high death rate, until a life-saving vaccine stops infection and transmission, the people need to follow government orders, change their behaviour and commit to using NPIs.

Measures that could be useful focus upon “slowing the spread” (flattening the curve) in order to protect the NHS. Other suggested measures could include telling people to “stay at home” (lockdown), “shutting down places where people gather” (social distancing) or closing schools and businesses. Handwashing (hands, face, space) could also flatten the curve and reduce the spread of an airborne respiratory virus.

Sound familiar?

Who Used The BBC’s Dataset and the Model

Throughout pseudopandemic, the UK government said it took its scientific advice from the Scientific Advisory Group for Emergencies—SAGE.

In 2021, Prof. Gog spoke about how the BBC Pandemic Dataset was used and by whom. She revealed that the Scientific Pandemic Influenza Group on Modelling (SPI-M), the modelling experts within SAGE, picked up the Dataset and were looking at her research in 2018, following the BBC’s experiment.

The World Health Organisation declared a global pandemic on the 11th of March 2020, but SPI-M had already been modelling future pandemics, using the BBC data, for more than a year. Prof. Gog also spoke about her own participation in SPI-M and SAGE that began in February 2020. She noted:

> SPI-M was all about gearing up for having the modelling groups at the ready in the case of a pandemic. [. . .] With COVID-19 a lot of people are asymptomatic, and there are other diseases which look like COVID-19, so you’ve got to have testing. [. . .] [S]ome types of tests have imperfect sensitivity. So even understanding surveillance of the current situation has been surprisingly complex. [. . .] We’d guessed already at that time that closing schools would do immense harm to children, and now the evidence for that is much clearer.

SPI-M were focused on predictive models that could inform policy decisions. In February 2020, shortly after she’d joined SPI-M, Prof. Gog gave an interview to the Centre International de Rencontres Mathématiques (CRIM) in which she revealed more about how SPI-M were working during the pandemic.

Prof. Gog acknowledged the paucity of empirical data SPI-M could access. She seemed uneasy:

> It might be more comfortable for us to say “we don’t have enough data, we can’t do this,” but we should try and do what we can.

Prof. Wendy Barclay

Prof. Gog was an academic caught in a dilemma. Her expertise was in constructing models from empirical data. Once in SPI-M, however, she was asked to produce models, based upon little evidence, predicting empirical data. A very different proposition.

Given what we now know about the harm caused to children by the lockdown measures, for example, the professor's discomfort was understandable. But it is not as if these harms were unknown. Many warned about them prior to any decision being made to shut schools.

Prof. Gog wasn't the only scientist involved in the BBC "Contagion" experiment who later advised the government as a member of SAGE. Prof. Wendy Barclay (SAGE) and Dr Adam Kucharski (SAGE and SPI-M) joined her. Dr Chloe Sellwood became a member of the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG).

Many of the first to write papers based upon the BBC Pandemic Dataset also "advised" the UK government's COVID-19 response. Dr Petra Klepac (SPI-M and TCF), Dr Stephen Kissler (SPI-M), Dr Joshua Firth (SPI-M) and Dr Lewis Spurgin (SPI-M) added to the group of scientists who based their advice upon the BBC Pandemic Dataset.

But what did this "advice" amount to?

In 2009, the UK government's senior scientific advisor on the Misuse of Drugs, Prof. David Nutt, was effectively sacked by then-Labour Home Secretary Alan Johnson. Nutt was forced to resign after he delivered a briefing paper in which he said that the scientific evidence showed that LSD, ecstasy and cannabis were less harmful than tobacco and alcohol.

Nutt's crime was not that he was wrong but that he had questioned the government. His scientific advice had damaged the government's policy decision to "give the public clear messages about the dangers of drugs." It didn't matter to the government that its advice and prohibition polices were causing harm to public health. It mattered only that its pet scientist had undermined its authority.

As pointed out by Prof. Andrew Maynard:

> Perhaps Nutt's greatest crime is that he sincerely – and altruistically[,] I believe – tried to speak truth to power. He attempted to provide decision-makers with a sound scientific and evidence-

> based foundation on which to base policies that would improve people's lives. [. . .] His downfall was that he was working with a government that seems to believe in speaking power to truth rather than truth to power – deciding what is right first, then bolstering this up with evidence!

Hypothesis

In 2018, using data they started gathering in 2017, the BBC modelled the future UK pseudopandemic in minute detail, right down to where it allegedly began.

Many will argue that this is to be expected: the scientists knew what they were doing and their predictions turned out to be accurate. That is possible, though the Haslemere coincidence stretches plausibility beyond breaking point.

There is another major problem with that argument. The BBC "Contagion" team did not predict a "real pandemic." They modelled a fake pandemic based upon epidemiological assumptions that do not match the subsequent empirical data observed during the COVID-19 disease outbreak.

Asymptomatic transmission, no possible immunity, a persistently high R0, all infections leading to "cases," high disease mortality and near-instant infection and transmission were not features of COVID-19 epidemiology. COVID-19 (symptomatic illness) did not spread through populations like wildfire. Only a few were affected; most were not.

So, if the dynamics of COVID-19 were completely different from those assumed in the Contagion model, how is it possible that the supposed COVID-19 "pandemic" appears to have been practically identical to the fake one made up by the BBC in 2018? Right down to where it began.

The BBC's model mirrored the pseudopandemic because the MSM and the government portrayed "the COVID-19 pandemic" as described by the model, not by the empirical data. There may well have been a novel respiratory disease making the rounds. Some will say even this isn't true, but given all we know now, it is evident that the "pandemic" narrative we were told to unquestioningly accept is the fictional one broadcast by the BBC in 2018.

To further substantiate this hypothesis, consider this: The NPIs that were foisted upon us all, had no epidemiological basis. There was no aspect of the COVID-19 disease that warranted any of the NPIs that were deployed. Again, the use of NPIs was only suggested by the models—most specifically by the BBC's "Contagion" model and later by Imperial College's Report 9, which was yet another "model."

Earlier we asked who the scientists were who were "pushing" the science that ran contrary to all known epidemiology. We've just listed some of the many scientists involved with the BBC "Contagion" experiment who worked with the BBC Pandemic Dataset and were "selected" by the government to allegedly provide it with "advice."

They weren't chosen simply because they were leading scientists. They were chosen because they were already working on scientific research that the government could exploit to justify policy decisions it had already taken.

NPIs were the objective, not the response. COVID-19 was the excuse, not the cause.

Government policies caused the turmoil and misery that the vast majority perceived to be a pandemic. Government policies increased the mortality risks for the most vulnerable and perpetuated the myth of a rampant disease. The government turned a relatively minor disease outbreak into a “catastrophe.”

The government “invested” in the BBC’s “Contagion” experiment and then used the subsequent “science” to simulate a national pandemic. It was a pseudopandemic designed with the complicity of the BBC, which then acted as one of the government’s leading propagandists, selling the model it created to a terrified public.

Conclusion

There is no criticism of the principle of vaccination made in this series of articles. To question the COVID jabs is not to question vaccination as a potentially useful public health strategy. There may be questions to be asked about vaccine schedules, but they are not asked here.

The BBC’s “Unvaccinated with Professor Hannah Fry” was a disgraceful piece of propagandist junk. The BBC set out to deceive its audience and promote government policy, and that is all that its programme achieved.

The whole premise of the so-called debate, that the majority of the population need to take the jabs but that some refuse to do so, was a lie. The vast majority of those who chose not to take the jab didn’t need one in the first place. Unfortunately, the injected were predominantly coerced. Coercion was the basis of the so-called vaccine’s widespread adoption.

The programme presented by Prof. Fry was scientifically illiterate. It denied the scientific principle of doubt and omitted all evidence that undermined its propagandist message. There was no debate, no “exploration” and no value in it for anyone except the pharmaceutical corporations and the government.

The BBC had no right to deceive the public by claiming that Prof. Fry “helped bring the UK out of its first lockdown.” Nothing could be further from the truth.

It is truly amazing that the UK public continues to pay for propaganda through the BBC license fee. The people face a crushing cost-of-living crisis that, despite attempts to blame everything on the Ukraine conflict, began long before the 2020 pseudopandemic.

That cost-of-living crisis was exacerbated by another NPI, as the government printed money like confetti to fund an unemployed populace—a populace locked up and isolated in their homes. The majority have already sacrificed many of their freedoms on the altar of the "new normal." When the heating is rationed this winter, we might wonder what else people will forego to afford to watch their tell-lie-vision.

If you value my work please consider supporting my work

[Support page url - https://iaindavis.com/donorsupport/]