From: Alameda Renters Coalition
To: Marilyn Ezzy Ashcraft; Malia Vella; John Knox White; Tony Daysog; Trish Spencer; City Clerk
Subject: [EXTERNAL] Extend local emergency
Date: Tuesday, June 15, 2021 2:21:59 PM

Dear Mayor, Vice-Mayor, and City Councilmembers,

The Alameda Renters Coalition urges the City Council to extend the local emergency period in order to protect residents who are still suffering, directly or indirectly, from the health and economic effects of Covid-19. We are grateful for the city's protections during the last year, which we believe helped keep residents housed. Even though new coronaviruses cases are waning and vaccinations are increasing, we note that many local businesses have closed and may not be able to return and many people are still unemployed. The economy needs more time to rebound, so please keep the housing and business protections in place. Our concern for homelessness is still strong.

Alameda Renters Coalition (ARC)
P.O. Box 2322 Alameda, CA 94501
Leave us a message: (510) 473-2332
Email: alamedarenterscoalition@gmail.com
Web: www.TheAlamedaRentersCoalition.org
Follow us on Facebook and Twitter!

From:	F E Adelstein
To:	City Clerk; Marilyn Ezzy Ashcraft; John Knox White; Tony Daysog; Trish Spencer; Malia Vella
Subject:	[EXTERNAL] CDC VAERS summary : Agenda Item 5-I - for City Council Meeting, June 15th 2021
Date:	Tuesday, June 15, 2021 11:38:02 AM
Attachments:	We sent you safe versions of your files.msg Havard_Vaers-report-2011.pdf

For City Council of Alameda -

re my Email of June 14th -

CDC VAERS data - June 4th 2021

Covid19 Vaccine Injury reports summary https://www.openvaers.com/covid-data

5,888 Deaths

19,597 Hospitalizations

43,891 Urgent care

15,052 Severe allergic reactions

The Harvard Pilgrim Health Care study finding was that only 1% of vaccine injuries are reported to VAERS, (a voluntary reporting system), "fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of “problem” drugs and vaccines that endanger public health."

Grant Final Report

Grant ID: R18 HS 017045

Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP:VAERS)

Inclusive dates: 12/01/07 - 09/30/10

Principal Investigator:
Lazarus, Ross, MBBS, MPH, MMed, GDCompSci

Team members:
Michael Klompas, MD, MPH

Performing Organization:
Harvard Pilgrim Health Care, Inc.

Project Officer:
Steve Bernstein

Submitted to:
The Agency for Healthcare Research and Quality (AHRQ)
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
*****.ahrq.gov**

Abstract

Purpose: To develop and disseminate HIT evidence and evidence-based tools to improve healthcare decision making through the use of integrated data and knowledge management.

Scope: To create a generalizable system to facilitate detection and clinician reporting of vaccine adverse events, in order to improve the safety of national vaccination programs.

Methods: Electronic medical records available from all ambulatory care encounters in a large multi-specialty practice were used. Every patient receiving a vaccine was automatically identified, and for the next 30 days, their health care diagnostic codes, laboratory tests, and medication prescriptions were evaluated for values suggestive of an adverse event.

Results: Restructuring at CDC and consequent delays in terms of decision making have made it challenging despite best efforts to move forward with discussions regarding the evaluation of ESP:VAERS performance in a randomized trial and comparison of ESP:VAERS performance to existing VAERS and Vaccine Safety Datalink data. However, Preliminary data were collected and analyzed and this initiative has been presented at a number of national symposia.

Key Words: electronic health records, vaccinations, adverse event reporting

Final Report

Purpose

This research project was funded to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS), via the following aims:

Aim 1. Identify required data elements, and develop systems to monitor ambulatory care electronic medical records for adverse events following vaccine administration.

Aim 2. Prepare, and securely submit clinician approved, electronic reports to the national Vaccine Adverse Event Reporting System (VAERS).

Aim 3. Comprehensively evaluate ESP:VAERS performance in a randomized trial, and in comparison to existing VAERS and Vaccine Safety Datalink data.

Aim 4. Distribute documentation and application software developed and refined in Aims 1 and 2 that are portable to other ambulatory care settings and to other EMR systems.

Scope

Public and professional confidence in vaccination depends on reliable postmarketing surveillance systems to ensure that rare and unexpected adverse effects are rapidly identified. The goal of this project is to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS). This project is serving as an extension of the Electronic Support for Public Health (ESP) project, an automated system using electronic health record (EHR) data to detect and securely report cases of certain diseases to a local public health authority. ESP provides a ready-made platform for automatically converting clinical, laboratory, prescription, and demographic data from almost any EHR system into database tables on a completely independent server, physically located and secured by the same logical and physical security as the EHR data itself. The ESP:VAERS project developed criteria and algorithms to identify important adverse events related to vaccinations in ambulatory care EHR data, and made attempts at formatting and securely sending electronic VAERS reports directly to the Centers for Disease Control and Prevention (CDC).

Patient data were available from Epic System's Certification Commission for Health Information Technology-certified EpicCare system at all ambulatory care encounters within Atrius Health, a large multispecialty group practice with over 35 facilities. Every patient receiving a vaccine was automatically identified, and for the next 30 days, their health care diagnostic codes, laboratory tests, and medication prescriptions are evaluated for values

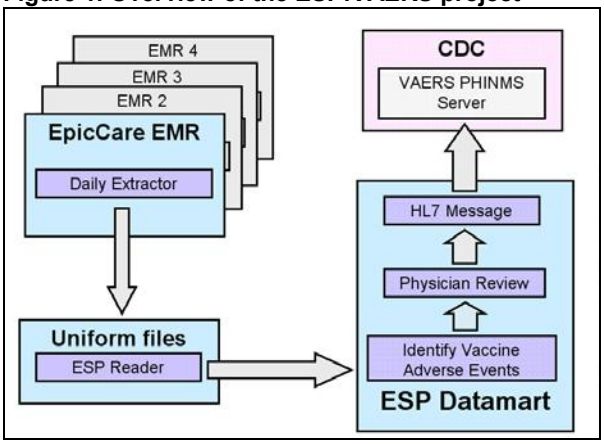
suggestive of an adverse vaccine event. When a possible adverse event was detected, it was recorded, and the appropriate clinician was to be notified electronically.

Clinicians in-basket messaging was designed to provide a preview a pre-populated report with information from the EHR about the patient, including vaccine type, lot number, and possible adverse effect, to inform their clinical judgment regarding whether they wish to send a report to VAERS. Clinicians would then have the option of adding free-text comments to pre-populated VAERS reports or to document their decision not to send a report. The CDC's Public Health Information Network Messaging System (PHIN-MS) software was installed within the facilities so that the approved reports could be securely transferred to VAERS as electronic messages in an interoperable health data exchange format using Health Level 7 (HL7).

Methods

The goal of Aim 1: *Identify required data elements, and develop systems to monitor ambulatory care electronic medical records for adverse events following vaccine administration*, and Aim 2: *Prepare, and securely submit clinician approved, electronic reports to the national Vaccine Adverse Event Reporting System (VAERS)*, was to construct the below flow of data in order to support the first two Aims:

Figure 1. Overview of the ESP:VAERS project



Existing and functioning ESP components are shown on the left, and Aims 1 and 2 on the right. ESP:VAERS flags every vaccinated patient, and prospectively accumulate that patient's diagnostic codes, laboratory tests, allergy lists, vital signs, and medication prescriptions. A main component of Aim 1 was to *Develop AE criteria to assess these parameters for new or abnormal values that might be suggestive of an adverse effect.* A reporting protocol & corresponding algorithms were developed to detect potential adverse event cases using diagnostic codes, and methods were tested to identify prescriptions or abnormal laboratory values that might be suggestive of an adverse effect. These algorithms were designed to seek both expected and unexpected adverse effects.

This reporting protocol was approved by both internal & external partners. We initially prepared a draft document describing the elements, algorithms, interval of interest after vaccination, and actions for broad classes of post-vaccination events, including those to be reported immediately without delay (such as acute anaphylactic reaction following vaccination), those never to be reported (such as routine check-ups following vaccination) and those to be reported at the discretion and with additional information from the attending physician through a feedback mechanism. The draft was then widely circulated as an initial / working draft for comment by relevant staff in the CDC and among our clinical colleagues at Atrius. In addition to review by the internal CDC Brighton Collaboration liaison, this protocol has also received review & comment via the CDC's Clinical Immunization Safety Assessment (CISA) Network.

The goal of Aim 2 was the *Development of HL7 messages code for ESP:VAERS to ensure secure transmission to CDC via PHIN-MS*. The HL7 specification describing the elements for an electronic message to be submitted to Constella, the consultants engaged by CDC for this project was implemented. Synthetic and real test data was been generated and transmitted between Harvard and Constella. However, real data transmissions of non-physician approved reports to the CDC was unable to commence, as by the end of this project, the CDC had yet to respond to multiple requests to partner for this activity.

The goal of Aim 3 was to *Comprehensively evaluate ESP:VAERS performance in a randomized trial, and in comparison to existing VAERS and Vaccine Safety Datalink data.*

We had initially planned to evaluate the system by comparing adverse event findings to those in the Vaccine Safety Datalink project—a collaborative effort between CDC's Immunization Safety Office and eight large managed care organizations. Through a randomized trial, we would also test the hypothesis that the combination of secure, computer-assisted, clinician-approved, adverse event detection, and automated electronic reporting will substantially increase the number, completeness, validity, and timeliness of physician-approved case reports to VAERS compared to the existing spontaneous reporting system; however, due to restructuring at CDC and consequent delays in terms of decision making, it became impossible to move forward with discussions regarding the evaluation of ESP:VAERS performance in a randomized trial, and compare ESP:VAERS performance to existing VAERS and Vaccine Safety Datalink data. Therefore, the components under this particular Aim were not achieved.

Aim 4 *Distribution of documentation and application software developed and refined in Aims 1 and 2 that are portable to other ambulatory care settings and to other EMR systems* has been successfully completed. Functioning source code is available to share under an approved open source license. ESP:VAERS source code is available as part of the ESP source code distribution. It is licensed under the LGPL, an open source license compatible with commercial use. We have added the ESP:VAERS code, HL7 and other specifications and documentation to the existing ESP web documentation and distribution resource center http://esphealth.org, specifically, the Subversion repository available at:
*******esphealth.org/trac/ESP/wiki/ESPVAERS.

Results

Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions (2.6 percent of vaccinations) were identified. This is an average of 890 possible events, an average of 1.3 events per clinician, per month. These data were presented at the 2009 AMIA conference.

In addition, ESP:VAERS investigators participated on a panel to explore the perspective of clinicians, electronic health record (EHR) vendors, the pharmaceutical industry, and the FDA towards systems that use proactive, automated adverse event reporting.

Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health. New surveillance methods for drug and vaccine adverse effects are needed. Barriers to reporting include a lack of clinician awareness, uncertainty about when and what to report, as well as the burdens of reporting: reporting is not part of clinicians' usual workflow, takes time, and is duplicative. Proactive, spontaneous, automated adverse event reporting imbedded within EHRs and other information systems has the potential to speed the identification of problems with new drugs and more careful quantification of the risks of older drugs.

Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation.

Inclusion of AHRQ Priority Populations

The focus of our project was the Atrius Health (formerly HealthOne) provider & patient community. This community serves several AHRQ inclusion populations, specifically low-income and minority populations in primarily urban settings.

Atruis currently employs approximately 700 physicians to serve 500,000 patients at more than 18 office sites spread throughout the greater Metropolitan Boston area. The majority of Atruis physicians are primary care internal medicine physicians or pediatricians but the network also includes physicians from every major specialty.

The entire adult and pediatric population served by Atruis was included in our adverse event surveillance system (ESP:VAERS). Atruis serves a full spectrum of patients that reflects the broad diversity of Eastern Massachusetts. A recent analysis suggests that the population served by Atruis is 56% female, 16.6% African American, 4% Hispanic. The prevalence of type 2 diabetes in the adult population is 5.7%. About a quarter of the Atruis population is under age 18.

List of Publications and Products

ESP:VAERS [source code available as part of the ESP source code distribution]. Licensed under the GNU Lesser General Public License (LGPL), an open source license compatible with commercial use. Freely available under an approved open source license at: http://esphealth.org.

Lazarus, R, Klompas M, Hou X, Campion FX, Dunn J, Platt R. Automated Electronic Detection & Reporting of Adverse Events Following Vaccination: ESP:VAERS. The CDC Vaccine Safety Datalink (VSD) Annual Meeting. Atlanta, GA; April, 2008.

Lazarus R, Klompas M Automated vaccine adverse event detection and reporting from electronic medical records. CDC Public Health Informatics Network (PHIN) Conference August 27, 2008.

Klompas M, Lazarus R ESP:VAERS Presented at the American Medical Informatics Association Annual Symposium; 2009 November 17th.

Lazarus R, Klompas M, Kruskal B, Platt R Temporal patterns of fever following immunization in ambulatory care data identified by ESP:VAERS Presented at the American Medical Informatics Association Annual Symposium; 2009 November 14–18: San Francisco, CA.

Linder J, Klompas M, Cass B, et al. Spontaneous Electronic Adverse Event Reporting: Perspectives from Clinicians, EHR Vendors, Biopharma, and the FDA. Presented at the American Medical Informatics Association Annual Symposium; 2009 November 14–18: San Francisco, CA.

From:	F E Adelstein
To:	City Clerk; Marilyn Ezzy Ashcraft; John Knox White; Tony Daysog; Trish Spencer; Malia Vella
Subject:	[EXTERNAL] Re: Agenda Item 5-I - DOCUMENTS
Date:	Tuesday, June 15, 2021 9:00:40 AM
Attachments:	We sent you safe versions of your files.msg ACPHDpress-release-2021.06.04.pdf Vaccine-Risk-Benefit_D4CE.pdf Havard_Vaers-report-2011.pdf

Attachment of documents referred to in my Email.

Fey Adelstein

FOR IMMEDIATE RELEASE
June 4, 2021

Neetu Balram
Public Information Manager
Alameda County Public Health Department
eoc-pio@acgov.org

Alameda County Updates COVID-19 Death Calculation to Align with State Definitions
This update will show fewer residents died as a direct result of COVID-19.

ALAMEDA COUNTY, CA –Today, June 4, Alameda County's COVID-19 dashboard will be updated to reflect the total number of COVID-19 deaths using the State's death reporting definition. Alameda County previously included any person who died while infected with the virus in the total COVID-19 deaths for the County. Aligning with the State's definition will require Alameda County to report as COVID-19 deaths only those people who died as a direct result of COVID-19, with COVID-19 as a contributing cause of death, or in whom death caused by COVID-19 could not be ruled out. Based on data available as of May 23, 2021, this update will decrease the overall number of deaths from 1,634 to 1,223.

Alameda County's system of reporting COVID-19 deaths on our dashboard and to the State was implemented early in the pandemic, prior to the establishment of State guidelines for reporting deaths due to COVID-19 in their disease reporting and surveillance system, CalREDIE. The State guidelines are consistent with national death reporting practices.

When the State implemented these guidelines, Alameda County became aware of the conflicting definitions and made a plan to conduct the update when cases and deaths stabilized. It is important to note that earlier adoption of the State reporting definition would not have changed the course of the pandemic, nor would it have affected the key measures, including case rate, test positivity and hospitalizations, that drove public health responses to the pandemic.

This update does not disproportionally impact reported deaths for any specific race or ethnic group or zip code.

Close observers of Alameda County's dashboard may have noticed a substantial increase in the COVID-19 death totals prior to this update, during the week of May 17. This increase was due to a separate quality assurance process intended to correct previously incomplete data; adjustments were made based on additional information that became available regarding date of death and county of residence. These corrections are unrelated to the current alignment with the State's definition of death due to COVID-19, and some of the deaths will be removed from the updated totals because COVID-19 was not a contributing cause.

Cause of death is routinely determined by medical providers or the County Coroner, not by County Public Health Department disease surveillance staff. Although the COVID-19 pandemic has caused nearly 600,000 deaths in the United States, the vast majority of infections do not result in death, and deaths due to other causes while infected with COVID-19 are not uncommon. It is important to accurately report deaths due to COVID-19 so that residents and health officials have a more precise understanding of the impact of the pandemic and response actions in our community.

Example scenario to illustrate the difference between the current practice of reporting COVID-19 deaths in Alameda County and how this differs from the State's guidelines: Using the older definition of COVID-19 deaths, a resident who had COVID-19 but died due to another cause, like a car accident, this person would be included in the total number of reported COVID-19 deaths for Alameda County. Under the updated definition of COVID-19 deaths, this person would not be included in the total because COVID-19 was not a contributing factor in the death.

Alameda County's COVID-19 dashboards are available at https://covid-19.acgov.org/data

###

COVID Vaccines: Necessity, Efficacy and Safety

Abstract: COVID-19 vaccine manufacturers have been exempted from legal liability for vaccine-induced harm. It is therefore in the interests of all those authorising, enforcing and administering COVID-19 vaccinations to understand the evidence regarding the risks and benefits of these vaccines, since liability for harm will fall on them.

In short, the available evidence and science indicate that COVID-19 vaccines are unnecessary, ineffective and unsafe.

- ***Necessity:*** immunocompetent individuals are protected against SARS-CoV-2 by cellular immunity. Vaccinating low-risk groups is therefore unnecessary. For immunocompromised individuals who do fall ill with COVID-19 there is a range of medical treatments that have been proven safe and effective. Vaccinating the vulnerable is therefore equally unnecessary. Both immunocompetent and vulnerable groups are better protected against variants of SARS-CoV-2 by naturally acquired immunity and by medication than by vaccination.[1]
- ***Efficacy:*** Covid-19 vaccines lack a viable mechanism of action against SARS-CoV-2 infection of the airways. Induction of antibodies cannot prevent infection by an agent such as SARS-CoV-2 that invades through the respiratory tract. Moreover, none of the vaccine trials have provided any evidence that vaccination prevents transmission of the infection by vaccinated individuals; urging vaccination to "protect others" therefore has no basis in fact.
- ***Safety:*** The vaccines are dangerous to both healthy individuals and those with pre-existing chronic disease, for reasons such as the following: risk of lethal and non-lethal disruptions of blood clotting including bleeding disorders, thrombosis in the brain, stroke and heart attack; autoimmune and allergic reactions; antibody-dependent enhancement of disease; and vaccine impurities due to rushed manufacturing and unregulated production standards.

The ***risk-benefit calculus*** is therefore clear: the experimental vaccines are needless, ineffective and dangerous. Actors authorising, coercing or administering experimental COVID-19 vaccination are exposing populations and patients to serious, unnecessary, and unjustified medical risks.

1. The vaccines are unnecessary

1. Multiple lines of research indicate that immunocompetent people display "**robust" and lasting** cellular (T cell) immunity to SARS-CoV viruses [1], including SARS-CoV-2 and its variants [2]. T cell protection stems not only from exposure to SARS-CoV-2 itself, but from cross-reactive immunity following previous exposure to common cold and SARS coronaviruses [1,3–10]. Such immunity was detectable after infections up to 17 years prior [1,3]. Therefore, *immunocompetent people do not need vaccination against SARS-Cov-2.*
2. **Natural T-Cell immunity provides stronger and more comprehensive protection** against all SARS-CoV-2 strains than vaccines, because naturally primed immunity recognises multiple virus epitopes and costimulatory signals, not merely a single (spike) protein. Thus, *immunocompetent people are better protected against SARS-CoV-2 and any variants that may arise by their own immunity than by the current crop of vaccines.*
3. The vaccines have been touted as a means to prevent asymptomatic infection [11], and by extension "asymptomatic transmission." However, "**asymptomatic transmission" is an artefact** of invalid and unreliable PCR test procedures and interpretations, leading to high false-positive rates [12–15]. Evidence indicates that PCR-positive, asymptomatic people are healthy false-positives, not carriers. A

comprehensive study of **9,899,828** people in China found that asymptomatic individuals testing positive for COVID-19 never infected others [16]. In contrast, the papers cited by the Centre for Disease Control [17,18] to justify claims of asymptomatic transmission are based on hypothetical models, not empirical studies; they present assumptions and estimates rather than evidence. *Preventing asymptomatic infection is not a viable rationale for promoting vaccination of the general population.*

4. In most countries, **most people will now have immunity to SARS-CoV-2** [19]. Depending on their degree of previously acquired cross-immunity, they will have had no symptoms, mild and uncharacteristic symptoms, or more severe symptoms, possibly including anosmia (loss of sense of smell) or other somewhat characteristic signs of the COVID-19 disease. Regardless of disease severity, they will now have sufficient immunity to be protected from severe disease in the event of renewed exposure. *This majority of the population will not benefit at all from being vaccinated.*
5. **Population survival of COVID-19 exceeds 99.8% globally** [20–22]. In countries that have been intensely infected over several months, less than 0.2% of the population have died and had their deaths classified as 'with covid19'. It is typically a mild to moderately severe illness. Therefore, *the overwhelming majority of people are not at risk from COVID-19 and do not require vaccination for their own protection*.
6. In those susceptible to severe infection, **Covid-19 is a treatable illness**. A convergence of evidence indicates that early treatment with existing drugs reduces hospitalisation and mortality by ~85% and 75%, respectively [23–27]. These drugs include many tried and true antiinflammatory, antiviral, and anticoagulant medications, as well as monoclonal antibodies, zinc, and vitamins C and D. Industry and government decisions to sideline such proven treatments through selective research support [24], regulatory bias, and even outright sanctions against doctors daring to use such treatments on their own initiative have been out of step with existing laws, standard medical practice, and research; the legal requirement to consider real world evidence has fallen by the wayside [28]. The systematic denial and denigration of these effective therapies has underpinned the spurious justification for the emergency use authorisation of the vaccines, which requires that "no standard acceptable treatment is available" [29]. Plainly stated, *vaccines are not necessary to prevent severe disease*.

2. The vaccines lack efficacy

1. At a mechanistic level, the concept of immunity to COVID-19 via antibody induction, as per **COVID-19 vaccination, is medical nonsense**. Airborne viruses such as SARS-CoV-2 enter the body via the airways and lungs, where antibody concentrations are too low to prevent infection. Vaccine-induced antibodies primarily circulate in the bloodstream, while concentrations on the mucous membranes of lungs and airways is low. Given that COVID-19 primarily spreads and causes disease by infecting these mucous membranes, vaccines miss the immunological mark. The documents submitted by the vaccine manufacturers to the various regulatory bodies contain no evidence that vaccination prevents airway infection, which would be crucial for breaking the chain of transmission. Thus, *vaccines are immunologically inappropriate for COVID-19.*
2. **Medium to long-term vaccine efficacy is unknown.** Phase 3, medium term, 24-month trials will not be complete until 2023: *There is no medium-term or long term longitudinal data regarding vaccine efficacy.*
3. **Short term data has not established prevention of severe disease.** The European Medicines Agency has noted of the Comirnaty (Pfizer mRNA) vaccine that severe COVID-19 cases "were rare in the study, and statistically certain conclusion cannot be drawn" from it [30]. Similarly, the Pfizer document submitted to the FDA [31] concludes that efficacy against mortality could not be

demonstrated. Thus, *the vaccines have not been shown to prevent death or severe disease even in the short term.*

4. The **correlates of protection against COVID-19 are unknown.** Researchers have not yet established how to measure protection against Covid-19. As a result, efficacy studies are stabbing around in the dark. After completion of Phase 1 and 2 studies, for instance, a paper in the journal *Vaccine* noted that "without understanding the correlates of protection, it is impossible to currently address questions regarding vaccine-associated protection, risk of COVID-19 reinfection, herd immunity, and the possibility of elimination of SARS-CoV-2 from the human population" [32]. Thus, *Vaccine efficacy cannot be evaluated because we have not yet established how to measure it.*

3. The vaccines are dangerous

1. Just as smoking could be and was predicted to cause lung cancer based on first principles, **all gene-based vaccines can be expected to cause blood clotting and bleeding disorders** [33], based on their molecular mechanisms of action. Consistent with this, diseases of this kind have been observed across age groups, leading to temporary vaccine suspensions around the world: *The vaccines are not safe.*
2. Contrary to claims that blood disorders post-vaccination are "rare", many **common vaccine side effects** (headaches, nausea, vomiting and haematoma-like "rashes" over the body) **may indicate thrombosis and other severe abnormalities**. Moreover, vaccine-induced diffuse micro-thromboses in the lungs can mimic pneumonia and may be misdiagnosed as COVID-19. Clotting events currently receiving media attention are likely just the "tip of a huge iceberg" [34]: *The vaccines are not safe.*
3. Due to immunological priming, **risks of clotting, bleeding and other adverse events can be expected to increase with each re-vaccination** and each intervening coronavirus exposure. Over time, whether months or years [35], this renders both vaccination and coronaviruses dangerous to young and healthy age groups, for whom without vaccination COVID-19 poses no substantive risk.

   Since vaccine roll-out, COVID-19 incidence has risen in numerous areas with high vaccination rates [36–38]. Furthermore, multiple series of COVID-19 fatalities have occurred shortly after the onset vaccinations in senior homes [39,40]. These cases may have been due not only to antibody-dependent enhancement but also to a general immunosuppressive effect of the vaccines, which is suggested by the increased occurrence of Herpes zoster in certain patients [41]. Immunosuppression may have caused a previously asymptomatic infection to become clinically manifest. Regardless of the exact mechanism responsible for these reported deaths, we must expect that the *vaccines will increase rather than decrease lethality of COVID-19—the vaccines are not safe*.

4. **The vaccines are experimental by definition**. They will remain in Phase 3 trials until 2023. Recipients are human subjects entitled to free informed consent under Nuremberg and other protections, including the Parliamentary Assembly of the Council of Europe's resolution 2361 [42] and the FDA's terms of emergency use authorisation [29]. With respect to safety data from Phase 1 and 2 trials, in spite of initially large sample sizes the journal *Vaccine* reports that, "the vaccination strategy chosen for further development may have only been given to as few as 12 participants" [32]. With such extremely small sample sizes, the journal notes that, "larger Phase 3 studies conducted over longer periods of time will be necessary" to establish safety. The risks that remain to be evaluated in Phase 3 trials into 2023, with entire populations as subjects, include not only thrombosis and bleeding abnormalities, but other autoimmune responses, allergic reactions, unknown tropisms (tissue destinations) of lipid nanoparticles [35], antibody-dependent enhancement [43–46] and the impact of rushed, questionably executed, poorly regulated [47] and reportedly inconsistent manufacturing

methods, conferring risks of potentially harmful impurities such as uncontrolled DNA residues [48]. *The vaccines are not safe, either for recipients or for those who use them or authorise their use*.

5. Initial experience might suggest that the adenovirus-derived vaccines (AstraZeneca/Johnson & Johnson) cause graver adverse effects than the mRNA (Pfizer/Moderna) vaccines. However, upon repeated injection, the former will soon induce antibodies against the proteins of the adenovirus vector. These antibodies will then neutralize most of the vaccine virus particles and cause their disposal before they can infect any cells, thereby limiting the intensity of tissue damage.

   In contrast, in the mRNA vaccines, there is no protein antigen for the antibodies to recognize. Thus, regardless of the existing degree of immunity, the vaccine mRNA is going to reach its target—the body cells. These will then express the spike protein and subsequently suffer the full onslaught of the immune system. **With the mRNA vaccines, the risk of severe adverse events is virtually guaranteed to increase with every successive injection.** In the long term, they are therefore even more dangerous than the vector vaccines. Their apparent preferment over the latter is concerning in the highest degree; *these vaccines are not safe.*

4. Ethics and legal points to consider

1. Conflicts of interest abound in the scientific literature and within organisations that recommend and promote vaccines, while demonising alternate strategies (reliance on natural immunity and early treatment). Authorities, doctors and medical personnel need to protect themselves by evaluating the sources of their information for conflicts of interest extremely closely.
2. Authorities, doctors and medical personnel need to be similarly careful not to ignore the credible and independent literature on vaccine necessity, safety and efficacy, given the foreseeable mass deaths and harms that must be expected unless the vaccination campaign is stopped.
3. Vaccine manufacturers have exempted themselves from legal liability for adverse events for a reason. When vaccine deaths and harms occur, liability will fall to those responsible for the vaccines' authorisation, administration and/or coercion via vaccine passports, none of which can be justified on a sober, evidence-based risk-benefit analysis.
4. All political, regulatory and medical actors involved in COVID-19 vaccination should familiarise themselves with the Nuremberg code and other legal provisions in order to protect themselves.

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Doctors for Covid Ethics, April 30, 2021

Grant Final Report

Grant ID: R18 HS 017045

Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP:VAERS)

Inclusive dates: 12/01/07 - 09/30/10

Principal Investigator:
Lazarus, Ross, MBBS, MPH, MMed, GDCompSci

Team members:
Michael Klompas, MD, MPH

Performing Organization:
Harvard Pilgrim Health Care, Inc.

Project Officer:
Steve Bernstein

Submitted to:
The Agency for Healthcare Research and Quality (AHRQ)
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
*****.ahrq.gov**

Abstract

Purpose: To develop and disseminate HIT evidence and evidence-based tools to improve healthcare decision making through the use of integrated data and knowledge management.

Scope: To create a generalizable system to facilitate detection and clinician reporting of vaccine adverse events, in order to improve the safety of national vaccination programs.

Methods: Electronic medical records available from all ambulatory care encounters in a large multi-specialty practice were used. Every patient receiving a vaccine was automatically identified, and for the next 30 days, their health care diagnostic codes, laboratory tests, and medication prescriptions were evaluated for values suggestive of an adverse event.

Results: Restructuring at CDC and consequent delays in terms of decision making have made it challenging despite best efforts to move forward with discussions regarding the evaluation of ESP:VAERS performance in a randomized trial and comparison of ESP:VAERS performance to existing VAERS and Vaccine Safety Datalink data. However, Preliminary data were collected and analyzed and this initiative has been presented at a number of national symposia.

Key Words: electronic health records, vaccinations, adverse event reporting

Final Report

Purpose

This research project was funded to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS), via the following aims:

Aim 1. Identify required data elements, and develop systems to monitor ambulatory care electronic medical records for adverse events following vaccine administration.

Aim 2. Prepare, and securely submit clinician approved, electronic reports to the national Vaccine Adverse Event Reporting System (VAERS).

Aim 3. Comprehensively evaluate ESP:VAERS performance in a randomized trial, and in comparison to existing VAERS and Vaccine Safety Datalink data.

Aim 4. Distribute documentation and application software developed and refined in Aims 1 and 2 that are portable to other ambulatory care settings and to other EMR systems.

Scope

Public and professional confidence in vaccination depends on reliable postmarketing surveillance systems to ensure that rare and unexpected adverse effects are rapidly identified. The goal of this project is to improve the quality of vaccination programs by improving the quality of physician adverse vaccine event detection and reporting to the national Vaccine Adverse Event Reporting System (VAERS). This project is serving as an extension of the Electronic Support for Public Health (ESP) project, an automated system using electronic health record (EHR) data to detect and securely report cases of certain diseases to a local public health authority. ESP provides a ready-made platform for automatically converting clinical, laboratory, prescription, and demographic data from almost any EHR system into database tables on a completely independent server, physically located and secured by the same logical and physical security as the EHR data itself. The ESP:VAERS project developed criteria and algorithms to identify important adverse events related to vaccinations in ambulatory care EHR data, and made attempts at formatting and securely sending electronic VAERS reports directly to the Centers for Disease Control and Prevention (CDC).

Patient data were available from Epic System's Certification Commission for Health Information Technology-certified EpicCare system at all ambulatory care encounters within Atrius Health, a large multispecialty group practice with over 35 facilities. Every patient receiving a vaccine was automatically identified, and for the next 30 days, their health care diagnostic codes, laboratory tests, and medication prescriptions are evaluated for values

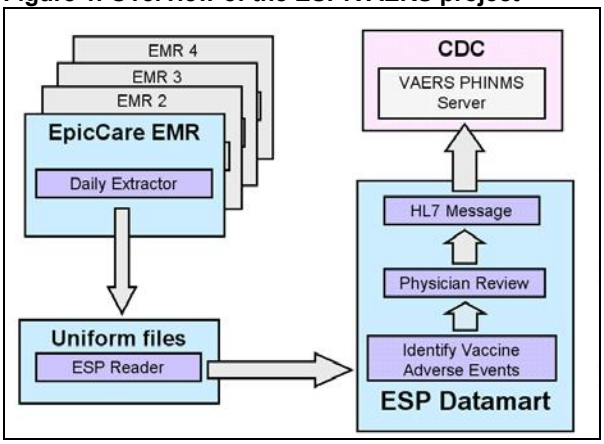
suggestive of an adverse vaccine event. When a possible adverse event was detected, it was recorded, and the appropriate clinician was to be notified electronically.

Clinicians in-basket messaging was designed to provide a preview a pre-populated report with information from the EHR about the patient, including vaccine type, lot number, and possible adverse effect, to inform their clinical judgment regarding whether they wish to send a report to VAERS. Clinicians would then have the option of adding free-text comments to pre-populated VAERS reports or to document their decision not to send a report. The CDC's Public Health Information Network Messaging System (PHIN-MS) software was installed within the facilities so that the approved reports could be securely transferred to VAERS as electronic messages in an interoperable health data exchange format using Health Level 7 (HL7).

Methods

The goal of Aim 1: *Identify required data elements, and develop systems to monitor ambulatory care electronic medical records for adverse events following vaccine administration*, and Aim 2: *Prepare, and securely submit clinician approved, electronic reports to the national Vaccine Adverse Event Reporting System (VAERS)*, was to construct the below flow of data in order to support the first two Aims:

Figure 1. Overview of the ESP:VAERS project



Existing and functioning ESP components are shown on the left, and Aims 1 and 2 on the right. ESP:VAERS flags every vaccinated patient, and prospectively accumulate that patient's diagnostic codes, laboratory tests, allergy lists, vital signs, and medication prescriptions. A main component of Aim 1 was to *Develop AE criteria to assess these parameters for new or abnormal values that might be suggestive of an adverse effect.* A reporting protocol & corresponding algorithms were developed to detect potential adverse event cases using diagnostic codes, and methods were tested to identify prescriptions or abnormal laboratory values that might be suggestive of an adverse effect. These algorithms were designed to seek both expected and unexpected adverse effects.

This reporting protocol was approved by both internal & external partners. We initially prepared a draft document describing the elements, algorithms, interval of interest after vaccination, and actions for broad classes of post-vaccination events, including those to be reported immediately without delay (such as acute anaphylactic reaction following vaccination), those never to be reported (such as routine check-ups following vaccination) and those to be reported at the discretion and with additional information from the attending physician through a feedback mechanism. The draft was then widely circulated as an initial / working draft for comment by relevant staff in the CDC and among our clinical colleagues at Atrius. In addition to review by the internal CDC Brighton Collaboration liaison, this protocol has also received review & comment via the CDC's Clinical Immunization Safety Assessment (CISA) Network.

The goal of Aim 2 was the *Development of HL7 messages code for ESP:VAERS to ensure secure transmission to CDC via PHIN-MS*. The HL7 specification describing the elements for an electronic message to be submitted to Constella, the consultants engaged by CDC for this project was implemented. Synthetic and real test data was been generated and transmitted between Harvard and Constella. However, real data transmissions of non-physician approved reports to the CDC was unable to commence, as by the end of this project, the CDC had yet to respond to multiple requests to partner for this activity.

The goal of Aim 3 was to *Comprehensively evaluate ESP:VAERS performance in a randomized trial, and in comparison to existing VAERS and Vaccine Safety Datalink data.*

We had initially planned to evaluate the system by comparing adverse event findings to those in the Vaccine Safety Datalink project—a collaborative effort between CDC's Immunization Safety Office and eight large managed care organizations. Through a randomized trial, we would also test the hypothesis that the combination of secure, computer-assisted, clinician-approved, adverse event detection, and automated electronic reporting will substantially increase the number, completeness, validity, and timeliness of physician-approved case reports to VAERS compared to the existing spontaneous reporting system; however, due to restructuring at CDC and consequent delays in terms of decision making, it became impossible to move forward with discussions regarding the evaluation of ESP:VAERS performance in a randomized trial, and compare ESP:VAERS performance to existing VAERS and Vaccine Safety Datalink data. Therefore, the components under this particular Aim were not achieved.

Aim 4 *Distribution of documentation and application software developed and refined in Aims 1 and 2 that are portable to other ambulatory care settings and to other EMR systems* has been successfully completed. Functioning source code is available to share under an approved open source license. ESP:VAERS source code is available as part of the ESP source code distribution. It is licensed under the LGPL, an open source license compatible with commercial use. We have added the ESP:VAERS code, HL7 and other specifications and documentation to the existing ESP web documentation and distribution resource center http://esphealth.org, specifically, the Subversion repository available at:
*******esphealth.org/trac/ESP/wiki/ESPVAERS.

Results

Preliminary data were collected from June 2006 through October 2009 on 715,000 patients, and 1.4 million doses (of 45 different vaccines) were given to 376,452 individuals. Of these doses, 35,570 possible reactions (2.6 percent of vaccinations) were identified. This is an average of 890 possible events, an average of 1.3 events per clinician, per month. These data were presented at the 2009 AMIA conference.

In addition, ESP:VAERS investigators participated on a panel to explore the perspective of clinicians, electronic health record (EHR) vendors, the pharmaceutical industry, and the FDA towards systems that use proactive, automated adverse event reporting.

Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health. New surveillance methods for drug and vaccine adverse effects are needed. Barriers to reporting include a lack of clinician awareness, uncertainty about when and what to report, as well as the burdens of reporting: reporting is not part of clinicians' usual workflow, takes time, and is duplicative. Proactive, spontaneous, automated adverse event reporting imbedded within EHRs and other information systems has the potential to speed the identification of problems with new drugs and more careful quantification of the risks of older drugs.

Unfortunately, there was never an opportunity to perform system performance assessments because the necessary CDC contacts were no longer available and the CDC consultants responsible for receiving data were no longer responsive to our multiple requests to proceed with testing and evaluation.

Inclusion of AHRQ Priority Populations

The focus of our project was the Atrius Health (formerly HealthOne) provider & patient community. This community serves several AHRQ inclusion populations, specifically low-income and minority populations in primarily urban settings.

Atruis currently employs approximately 700 physicians to serve 500,000 patients at more than 18 office sites spread throughout the greater Metropolitan Boston area. The majority of Atruis physicians are primary care internal medicine physicians or pediatricians but the network also includes physicians from every major specialty.

The entire adult and pediatric population served by Atruis was included in our adverse event surveillance system (ESP:VAERS). Atruis serves a full spectrum of patients that reflects the broad diversity of Eastern Massachusetts. A recent analysis suggests that the population served by Atruis is 56% female, 16.6% African American, 4% Hispanic. The prevalence of type 2 diabetes in the adult population is 5.7%. About a quarter of the Atruis population is under age 18.

List of Publications and Products

ESP:VAERS [source code available as part of the ESP source code distribution]. Licensed under the GNU Lesser General Public License (LGPL), an open source license compatible with commercial use. Freely available under an approved open source license at: http://esphealth.org.

Lazarus, R, Klompas M, Hou X, Campion FX, Dunn J, Platt R. Automated Electronic Detection & Reporting of Adverse Events Following Vaccination: ESP:VAERS. The CDC Vaccine Safety Datalink (VSD) Annual Meeting. Atlanta, GA; April, 2008.

Lazarus R, Klompas M Automated vaccine adverse event detection and reporting from electronic medical records. CDC Public Health Informatics Network (PHIN) Conference August 27, 2008.

Klompas M, Lazarus R ESP:VAERS Presented at the American Medical Informatics Association Annual Symposium; 2009 November 17th.

Lazarus R, Klompas M, Kruskal B, Platt R Temporal patterns of fever following immunization in ambulatory care data identified by ESP:VAERS Presented at the American Medical Informatics Association Annual Symposium; 2009 November 14–18: San Francisco, CA.

Linder J, Klompas M, Cass B, et al. Spontaneous Electronic Adverse Event Reporting: Perspectives from Clinicians, EHR Vendors, Biopharma, and the FDA. Presented at the American Medical Informatics Association Annual Symposium; 2009 November 14–18: San Francisco, CA.

From:	Rachel Lee
To:	City Clerk
Subject:	[EXTERNAL] For June 15 City Council meeting - yes on item 5-I
Date:	Monday, June 14, 2021 8:20:02 PM

Dear Mayor and City Councilmembers,

Please vote to continue the declaration of a local emergency due to COVID-19. The protection that this declaration offers renters is vital, and it is too soon to lift that protection. Ending the emergency now, before the county rent relief is fully rolled out could result in a bad situation for our most vulnerable citizens.

Thank you,
Rachel Lee

From:	Laura Gamble
To:	City Clerk
Subject:	[EXTERNAL] Item 5I on the 6/15 Agenda
Date:	Monday, June 14, 2021 7:41:38 PM

Dear Mayor and City Council Members,

Please vote yes on item 5I to extend the Declaration of the Existence of a Local Emergency in Response to the COVID-19 Pandemic and its vital protections for both tenants and landlords.
As you all surely know, the county rent relief program is still being rolled out and takes time to qualify. In the meantime, it is of the utmost importance to keep people housed. Allowing evictions and rent increases now will render these protections fruitless as they have not given tenants the chance to get back on their feet as we safely move towards normalcy.

Thank you, Laura Gamble

From:	Ezra Denney
To:	City Clerk; Trish Spencer; Tony Daysog; Malia Vella; Marilyn Ezzy Ashcraft; John Knox White
Subject:	[EXTERNAL] Please Continue Critical Protections for Tenants & Landlords (Item 5-I)
Date:	Monday, June 14, 2021 6:21:23 PM

Members of City Council,

I write today as a tenant urging you to vote to continue to the Local Emergency declaration, which offers vital safeguards for Alameda's tenants and landlords during the Pandemic. Without the continued protections, evictions and legal cases will skyrocket and both landlords and tenants will suffer.

The county rent relief program (which the City suggests is the first line of defense) is still being rolled out, and enrollment is a long process. The rent increase and eviction moratoriums are critical to protect those who are still getting back on their feet.

We are not out of the many impacts of the Pandemic yet, and it is imperative that we protect our tenants and landlords for the duration. Please extend the declaration.

Thanks!

Ezra Denney

From:	F E Adelstein
To:	City Clerk; Marilyn Ezzy Ashcraft; John Knox White; Tony Daysog; Trish Spencer; Malia Vella
Subject:	[EXTERNAL] Agenda Item 5-I - for City Council Meeting, June 15th 2021
Date:	Monday, June 14, 2021 3:05:54 PM

Dear City Council of Alameda,

I look forward to the Tuesday evening discussion of agenda item 5-I,

CONTINUING THE DECLARATION OF THE EXISTENCE OF A LOCAL EMERGENCY IN RESPONSE TO THE COVID-19 PANDEMIC

I assume you are aware of the ACPHD's recent revision of the COVID-19 death count (down 25%), as stated in press release of June 4th,

https://covid-19.acgov.org/covid19-assets/docs/press/press-release-2021.06.04.pdf

Please address my following questions :

1.) What metrics and criteria do you use to declare and continue a state of emergency ?

2.) What metrics and criteria have you determined will end your declared state of emergency ?

3.) What responsibilities has the City of Alameda assumed with respect to the authorization of Covid19 vaccines ?

A video published by the City of Alameda on June 4th, https://www.youtube.com/watch?v=mNdnOCNrm0I The agency that you represent clearly promotes Covid-19 vaccines for youth. I ask that each of you, as individual representatives of that agency, consider the following information.

The CDC is holding an emergency meeting on June 18th, https://www.cdc.gov/vaccines/acip/meetings/downloads/agenda-archive/agenda-2021-06-18-508.pdf to discuss "higher-than-expected reports of heart inflammation following doses of Pfizer and Moderna COVID vaccines, particularly in people younger than 30. According to the CDC, a total of 475 cases of myocarditis or pericarditis were recorded in patients 30 and younger."

I call to your attention the fact that, all Covid-19 vaccines are investigational/experimental and currently under going trial. There exists no long term safety data for any of them.

The known adverse side effects of the Covid-19 vaccines as documented in the CDC VAERS database include : Heart attacks, Blood disorders, Strokes, Blood clots, Seizures, Guillaume Barre, Anaphylaxis, Miscarriages and numerous other dangerous conditions, Please visit the CDC VAERS database to read the reports of adverse events resulting from Covid19 vaccines.

For months now scientists, doctors, and organizations around the world have been calling for the removal of these vaccines from the market. CHD is one of many organizations in the USA doing so, following reports of injury from the Covid19 vaccines. Here you can read an article published by CHD that reviews Covid19 vaccine injury data. https://childrenshealthdefense.org/defender/vaers-data-injuries-deaths-vaccinating-5-year-olds/?itm_term=home

In addition, please read carefully the following report, DOCTORS for COVID ETHICS - Vaccine Risk Benefit Report

https://doctors4covidethics.org/covid-vaccine-necessity-efficacy-and-safety/

"Abstract: COVID-19 vaccine manufacturers have been exempted from legal liability for vaccine-induced harm. It is therefore in the interests of all those authorising, enforcing and administering

COVID-19 vaccinations to understand the evidence regarding the risks and benefits of these vaccines, since liability for harm will fall on them."

Please especially note item #4)

The vaccines are experimental by definition. They will remain in Phase 3 trials until 2023. Recipients are human subjects entitled to free informed consent under Nuremberg and other protections, including the Parliamentary Assembly of the Council of Europe's resolution 2361 [42] and the FDA's terms of emergency use authorisation [29].

Please be reminded that informed consent requires that recipients of experimental vaccines receive information about known adverse reactions.

Please be reminded that informed consent also requires that recipients be able to make their informed choice free of coercion and pressure. If proper conditions of informed consent are not met, then individuals involved in authorizing, enforcing and administering experimental vaccines can be held personally accountable.

Also attached, a Harvard Pilgrim Health Care, Inc. study that determined that the CDC's VAERS system significantly under reports vaccine injuries. The study concludes, "Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health."

Thank you for your attention,

Fey Adelstein