From: RL Brown
To: Community Support and Services Committee
Subject: NO EXTENSION of the Emergency Bill
Date: Friday, 4 March 2022 11:59:27 AM

To whom it may concern,

I am writing to you today to express my position that I DO NOT want ANY further extensions of the Emergency Bill, including the current one being considered for extension to 31st October 2022.

This is NOT remotely justifiable in ANY way. I have not spoken to / read anywhere on social media / heard from ANYONE who thinks that it is.

If this 'State of Emergency' is extended, it is not going to age well for the current government. There is no plausible reason to justify such an extension. There are any number of articles and evidence to support this statement. The 'vaccination' does not stop anyone getting covid nor passing it on. It has been proven that vaccinated persons carry just as high a viral load as unvaccinated. There has even been suggestion from well regarded scientists, immunologists and epidemiologists that it is actually the vaccine causing the variants.

According to our own statistics (Australian Bureau of Statistics), covid deaths have been grossly exaggerated.
Fully vaccinated Australians account for 9 in every 10 ICU admissions, and 4 in every 5 deaths.
Australia's record breaking wave of Covid-19 sees Fully Vaccinated account for 9 in every 10 ICU Admissions & 4 in every 5 Deaths

As per the below NZ newspaper article (copied and pasted below), the actual fatalities and serious adverse events linked to the vaccines may be much much higher than initially thought, due to the original narrow parameters doctors were told to look out for.

All of these companies have been previously criminally charged for wrongdoing, falsifying safety data, bribing doctors etc. Why is Pfizer currently spending vast amounts of money trying to keep its trial data hidden? If it was truly safe, would they not want to show off their achievements, not do everything possible legally to hide them from people?

THERE IS NO PANDEMIC. THERE IS NO EMERGENCY. THIS NONSENSE MUST END.

This is a rushed submission as I only found out about it at late notice, however I am willing to calmly discuss this if needed.

Thank you & kind regards,

Leanne Brown

1. Article by Gunter Kampf in The Lancet Medical Journal - Stigmatising unvaccinated is unjustified (20 November 2021) -
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02243-1/fulltext

COVID-19: stigmatising the unvaccinated is not justified

In the USA and Germany, high-level officials have used the term pandemic of the unvaccinated, suggesting that people who have been vaccinated are not relevant in the epidemiology of COVID-19. Officials' use of this phrase might have encouraged one scientist to claim that "the unvaccinated threaten the vaccinated for COVID-19". But this view is far too simple.

There is increasing evidence that vaccinated individuals continue to have a relevant role in transmission. In Massachusetts, USA, a total of 469 new COVID-19 cases were detected during various events in July, 2021, and 346 (74%) of these cases were in people who were fully or partly vaccinated, 274 (79%) of whom were symptomatic.

Cycle threshold values were similarly low between people who were fully vaccinated (median 22·8) and people who were unvaccinated, not fully vaccinated, or whose vaccination status was unknown (median 21·5), indicating a high viral load even among people who were fully vaccinated.

In the USA, a total of 10 262 COVID-19 cases were reported in vaccinated people by April 30, 2021, of whom 2725 (26·6%) were asymptomatic, 995 (9·7%) were hospitalised, and 160 (1·6%) died.

In Germany, 55·4% of symptomatic COVID-19 cases in patients aged 60 years or older were in fully vaccinated individuals, and this proportion is increasing each week.

In Münster, Germany, new cases of COVID-19 occurred in at least 85 (22%) of 380 people who were fully vaccinated or who had recovered from COVID-19 and who attended a nightclub. People who are vaccinated have a lower risk of severe disease but are still a relevant part of the pandemic.

It is therefore wrong and dangerous to speak of a pandemic of the unvaccinated. Historically, both the USA and Germany have engendered negative experiences by stigmatising parts of the population for their skin colour or religion.

I call on high-level officials and scientists to stop the inappropriate stigmatisation of unvaccinated people, who include our patients, colleagues, and other fellow citizens, and to put extra effort into bringing society together.

I declare no competing interests.

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Date: Sept 20, 2021

Date accessed: September 23, 2021

Article Info

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2. Article in The Lancet Medical Journal - The epidemiological relevance of the Covid-19 vaccinated population is increasing (1 December 2021) - https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00258-1/fulltext

The epidemiological relevance of the COVID-19-vaccinated population is increasing

High COVID-19 vaccination rates were expected to reduce transmission of SARS-CoV-2 in populations by reducing the number of possible sources for transmission and thereby to reduce the burden of COVID-19 disease.

Recent data, however, indicate that the epidemiological relevance of COVID-19 vaccinated individuals is increasing.

In the UK it was described that secondary attack rates among household contacts exposed to fully vaccinated index cases was similar to household contacts exposed to unvaccinated index cases (25% for vaccinated vs 23% for unvaccinated).
12 of 31 infections in fully vaccinated household contacts (39%) arose from fully vaccinated epidemiologically linked index cases.
Peak viral load did not differ by vaccination status or variant type [].

In Germany, the rate of symptomatic COVID-19 cases among the fully vaccinated ("breakthrough infections") is reported weekly since 21 July 2021 and was 16.9% at that time among patients of 60 years and older [].

This proportion is increasing week by week and was 58.9% on 27 October 2021 (Figure 1) providing clear evidence of the increasing relevance of the fully vaccinated as a possible source of transmission.

A similar situation was described for the UK. Between week 39 and 42, a total of 100.160 COVID-19 cases were reported among citizens of 60 years or older. 89.821 occurred among the fully vaccinated (89.7%), 3.395 among the unvaccinated (3.4%) [].
One week before, the COVID-19 case rate per 100.000 was higher among the subgroup of the vaccinated compared to the subgroup of the unvaccinated in all age groups of 30 years or more.

In Israel a nosocomial outbreak was reported involving 16 healthcare workers, 23 exposed patients and two family members. The source was a fully vaccinated COVID-19 patient. The vaccination rate was 96.2% among all exposed individuals (151 healthcare workers and 97 patients).
Fourteen fully vaccinated patients became severely ill or died, the two unvaccinated patients developed mild disease [].

The US Centres for Disease Control and Prevention (CDC) identifies four of the top five counties with the highest percentage of fully vaccinated population (99.9–84.3%) as "high" transmission counties [].

Many decision-makers assume that the vaccinated can be excluded as a source of transmission.

It appears to be grossly negligent to ignore the vaccinated population as a possible and relevant source of transmission when deciding about public health control measures.

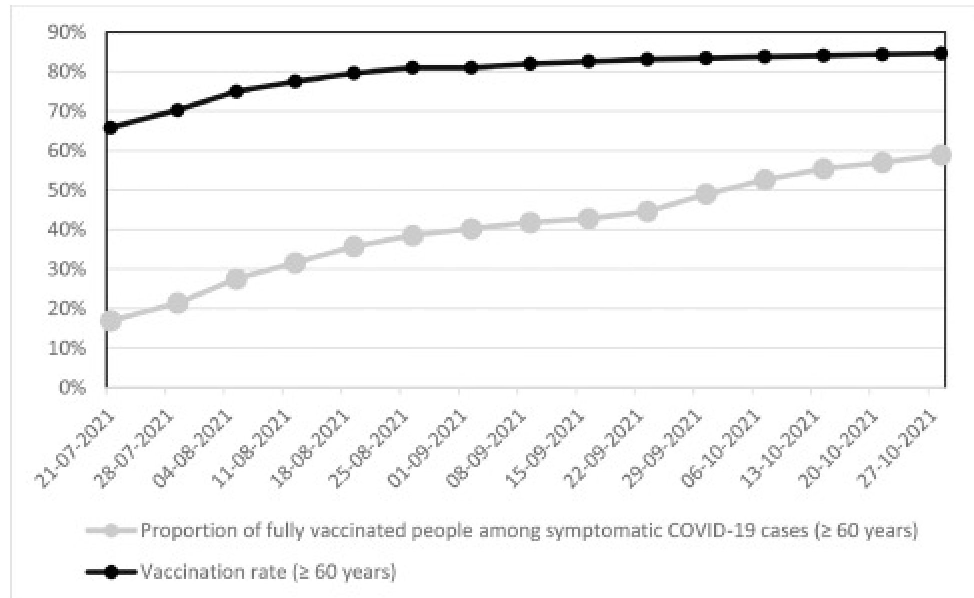

Figure 1Vaccination rates and proportions of fully vaccinated people among symptomatic COVID-19 cases (= 60 years) in Germany between 21. July and 27. October 2021 based on the weekly reports from the Robert Koch-Institute .

GK as the sole author of this Letter, contributed to all aspects of the text.

Declaration of Competing Interests statement

The author has no competing interests to declare

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3. Article in The British Medical Journal - Researcher blows whistle on data integrity issues in Pfizer's vaccine trial (2 November 2021) - https://www.bmj.com/content/375/bmj.n2635

Covid-19: Researcher blows the whistle on data integrity issues in Pfizer's vaccine trial

Feature *BMJ Investigation BMJ 2021; 375 doi: https://doi.org/10.1136/bmj.n2635 (Published 02 November 2021) Cite this as: BMJ 2021;375:n2635*

Paul D Thacker, investigative journalist

Revelations of poor practices at a contract research company helping to carry out Pfizer's pivotal covid-19 vaccine trial raise questions about data integrity and regulatory oversight. **Paul D Thacker** reports

In autumn 2020 Pfizer's chairman and chief executive, Albert Bourla, released an open letter to the billions of people around the world who were investing their hopes in a safe and effective covid-19 vaccine to end the pandemic. "As I've said before, we are operating at the speed of science," Bourla wrote, explaining to the public when they could expect a Pfizer vaccine to be authorised in the United States.1

But, for researchers who were testing Pfizer's vaccine at several sites in Texas during that autumn, speed may have come at the cost of data integrity and patient safety. A regional director who was employed at the research organisation Ventavia Research Group has told *The BMJ* that the company falsified data, unblinded patients, employed inadequately trained vaccinators, and was slow to follow up on adverse events reported in Pfizer's pivotal phase III trial. Staff who conducted quality control checks were overwhelmed by the volume of problems they were finding. After repeatedly notifying Ventavia of these problems, the regional director, Brook Jackson, emailed a complaint to the US Food and Drug Administration (FDA). Ventavia fired her later the same day. Jackson has provided *The BMJ* with dozens of internal company documents, photos, audio recordings, and emails.

Poor laboratory management

On its website Ventavia calls itself the largest privately owned clinical research company in Texas and lists many awards it has won for its contract work.2 But Jackson has told *The BMJ* that, during the two weeks she was employed at Ventavia in September 2020, she repeatedly informed her superiors of poor laboratory management, patient safety concerns, and data integrity issues. Jackson was a trained clinical trial auditor who previously held a director of operations position and came to Ventavia with more than 15 years' experience

in clinical research coordination and management. Exasperated that Ventavia was not dealing with the problems, Jackson documented several matters late one night, taking photos on her mobile phone. One photo, provided to *The BMJ*, showed needles discarded in a plastic biohazard bag instead of a sharps container box. Another showed vaccine packaging materials with trial participants' identification numbers written on them left out in the open, potentially unblinding participants. Ventavia executives later questioned Jackson for taking the photos.

Early and inadvertent unblinding may have occurred on a far wider scale. According to the trial's design, unblinded staff were responsible for preparing and administering the study drug (Pfizer's vaccine or a placebo). This was to be done to preserve the blinding of trial participants and all other site staff, including the principal investigator. However, at Ventavia, Jackson told *The BMJ* that drug assignment confirmation printouts were being left in participants' charts, accessible to blinded personnel. As a corrective action taken in September, two months into trial recruitment and with around 1000 participants already enrolled, quality assurance checklists were updated with instructions for staff to remove drug assignments from charts.

In a recording of a meeting in late September2020 between Jackson and two directors a Ventavia executive can be heard explaining that the company wasn't able to quantify the types and number of errors they were finding when examining the trial paperwork for quality control. "In my mind, it's something new every day," a Ventavia executive says. "We know that it's significant."

Ventavia was not keeping up with data entry queries, shows an email sent by ICON, the contract research organisation with which Pfizer partnered on the trial. ICON reminded Ventavia in a September 2020 email: "The expectation for this study is that all queries are addressed within 24hrs." ICON then highlighted over 100 outstanding queries older than three days in yellow. Examples included two individuals for which "Subject has reported with Severe symptoms/reactions … Per protocol, subjects experiencing Grade 3 local reactions should be contacted. Please confirm if an UNPLANNED CONTACT was made and update the corresponding form as appropriate." According to the trial protocol a telephone contact should have occurred "to ascertain further details and determine whether a site visit is clinically indicated."

Worries over FDA inspection

Documents show that problems had been going on for weeks. In a list of "action items" circulated among Ventavia leaders in early August 2020, shortly after the trial began and before Jackson's hiring, a Ventavia executive identified three site staff members with whom to "Go over e-diary issue/falsifying data, etc." One of them was "verbally counseled for changing data and not noting late entry," a note indicates.

At several points during the late September meeting Jackson and the Ventavia executives discussed the possibility of the FDA showing up for an inspection (box 1). "We're going to get some kind of letter of information at least, when the FDA gets here . . . know it," an executive stated.

Box 1

A history of lax oversight

When it comes to the FDA and clinical trials, Elizabeth Woeckner, president of Citizens for Responsible Care and Research Incorporated (CIRCARE),3 says the agency's oversight capacity is severely under-resourced. If the FDA receives a complaint about a

clinical trial, she says the agency rarely has the staff available to show up and inspect. And sometimes oversight occurs too late.

In one example CIRCARE and the US consumer advocacy organisation Public Citizen, along with dozens of public health experts, filed a detailed complaint in July 2018 with the FDA about a clinical trial that failed to comply with regulations for the protection of human participants.4 Nine months later, in April 2019, an FDA investigator inspected the clinical site. In May this year the FDA sent the triallist a warning letter that substantiated many of the claims in the complaints. It said, "[I]t appears that you did not adhere to the applicable statutory requirements and FDA regulations governing the conduct of clinical investigations and the protection of human subjects."5

"There's just a complete lack of oversight of contract research organisations and independent clinical research facilities," says Jill Fisher, professor of social medicine at the University of North Carolina School of Medicine and author of *Medical Research for Hire: The Political Economy of Pharmaceutical Clinical Trials*.

Ventavia and the FDA

A former Ventavia employee told *The BMJ* that the company was nervous and expecting a federal audit of its Pfizer vaccine trial.

"People working in clinical research are terrified of FDA audits," Jill Fisher told *The BMJ*, but added that the agency rarely does anything other than inspect paperwork, usually months after a trial has ended. "I don't know why they're so afraid of them," she said. But she said she was surprised that the agency failed to inspect Ventavia after an employee had filed a complaint. "You would think if there's a specific and credible complaint that they would have to investigate that," Fisher said.

In 2007 the Department of Health and Human Services' Office of the Inspector General released a report on FDA's oversight of clinical trials conducted between 2000 and 2005. The report found that the FDA inspected only 1% of clinical trial sites.6 Inspections carried out by the FDA's vaccines and biologics branch have been decreasing in recent years, with just 50 conducted in the 2020 fiscal year.7

RETURN TO TEXT

The next morning, 25 September 2020, Jackson called the FDA to warn about unsound practices in Pfizer's clinical trial at Ventavia. She then reported her concerns in an email to the agency. In the afternoon Ventavia fired Jackson—deemed "not a good fit," according to her separation letter.

Jackson told *The BMJ* it was the first time she had been fired in her 20 year career in research.

Concerns raised

In her 25 September email to the FDA Jackson wrote that Ventavia had enrolled more than 1000 participants at three sites. The full trial (registered under NCT04368728) enrolled around 44 000 participants across 153 sites that included numerous commercial companies and academic centres. She then listed a dozen concerns she had witnessed, including:

- Participants placed in a hallway after injection and not being monitored by clinical staff

- Lack of timely follow-up of patients who experienced adverse events
- Protocol deviations not being reported
- Vaccines not being stored at proper temperatures
- Mislabelled laboratory specimens, and
- Targeting of Ventavia staff for reporting these types of problems.

Within hours Jackson received an email from the FDA thanking her for her concerns and notifying her that the FDA could not comment on any investigation that might result. A few days later Jackson received a call from an FDA inspector to discuss her report but was told that no further information could be provided. She heard nothing further in relation to her report.

In Pfizer's briefing document submitted to an FDA advisory committee meeting held on 10 December 2020 to discuss Pfizer's application for emergency use authorisation of its covid-19 vaccine, the company made no mention of problems at the Ventavia site. The next day the FDA issued the authorisation of the vaccine.8

In August this year, after the full approval of Pfizer's vaccine, the FDA published a summary of its inspections of the company's pivotal trial. Nine of the trial's 153 sites were inspected. Ventavia's sites were not listed among the nine, and no inspections of sites where adults were recruited took place in the eight months after the December 2020 emergency authorisation. The FDA's inspection officer noted: "The data integrity and verification portion of the BIMO [bioresearch monitoring] inspections were limited because the study was ongoing, and the data required for verification and comparison were not yet available to the IND [investigational new drug]."

Other employees' accounts

In recent months Jackson has reconnected with several former Ventavia employees who all left or were fired from the company. One of them was one of the officials who had taken part in the late September meeting. In a text message sent in June the former official apologised, saying that "everything that you complained about was spot on."

Two former Ventavia employees spoke to *The BMJ* anonymously for fear of reprisal and loss of job prospects in the tightly knit research community. Both confirmed broad aspects of Jackson's complaint. One said that she had worked on over four dozen clinical trials in her career, including many large trials, but had never experienced such a "helter skelter" work environment as with Ventavia on Pfizer's trial.

"I've never had to do what they were asking me to do, ever," she told *The BMJ*. "It just seemed like something a little different from normal—the things that were allowed and expected."

She added that during her time at Ventavia the company expected a federal audit but that this never came.

After Jackson left the company problems persisted at Ventavia, this employee said. In several cases Ventavia lacked enough employees to swab all trial participants who reported covid-like symptoms, to test for infection. Laboratory confirmed symptomatic covid-19 was the trial's primary endpoint, the employee noted. (An FDA review memorandum released in August this year states that across the full trial swabs were not taken from 477

people with suspected cases of symptomatic covid-19.)

“I don’t think it was good clean data,” the employee said of the data Ventavia generated for the Pfizer trial. “It’s a crazy mess.”

A second employee also described an environment at Ventavia unlike any she had experienced in her 20 years doing research. She told *The BMJ* that, shortly after Ventavia fired Jackson, Pfizer was notified of problems at Ventavia with the vaccine trial and that an audit took place.

Since Jackson reported problems with Ventavia to the FDA in September 2020, Pfizer has hired Ventavia as a research subcontractor on four other vaccine clinical trials (covid-19 vaccine in children and young adults, pregnant women, and a booster dose, as well an RSV vaccine trial; NCT04816643, NCT04754594, NCT04955626, NCT05035212). The advisory committee for the Centers for Disease Control and Prevention is set to discuss the covid-19 paediatric vaccine trial on 2 November.

Footnotes

Provenance and peer review: commissioned; externally peer reviewed.

Competing interests: PDT has been doubly vaccinated with Pfizer’s vaccine.

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https://bmj.com/coronavirus/usage
View Abstract

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4. Recent NZ Daily Telegraph newspaper article, regarding serious concerns with the Pfizer vaccine & omissions (5 December 2021) -
https://dailytelegraph.co.nz/news/pfizer-document-concedes-that-there-is-a-large-increase-in-types-of-adverse-event-reaction-to-its-vaccine/

Guy Hatchard: Pfizer document concedes that there is a large increase in types of adverse event reaction to its vaccine

December 5, 2021

- **Document released by Pfizer apparently as a result of a Freedom Of Information court order in the USA reveals a vast array of previously unknown vaccine adverse effects compiled from official sources around the world.**
- **Pfizer concedes this is ‘a large increase’ in adverse event reports and that even this huge volume is under reported.**
- **Over 100+ diseases are listed, many very serious.**

- **This document was compiled by Pfizer in the very early days of the vaccine rollout in NZ but was possibly not supplied to our government.**
- **We examine the implications for government.**

Up until now, New Zealand GPs and hospitals have been provided with a fact sheet from Pfizer listing 21 possible adverse events as a result of vaccination.

All of these are minor, requiring little or no treatment other than rest, with the exception of severe allergic reactions, myocarditis and pericarditis (inflammation of the heart). As a result, most of the many thousands of New Zealanders reporting adverse effects post vaccination have been sent home with little more than advice to take an aspirin and rest. Some have been told that their conditions may be unrelated medical events, psychosomatic, or due to anxiety on their part.

Relying on the short official Pfizer fact sheet as a guide, Medsafe, our NZ medicines regulatory body, has only accepted one out of the 100+ deaths actually reported to them as related to vaccination. Most are listed as unrelated, under investigation, or unknowable. By contrast, the NZ Health Forum and other groups have collected unofficial reports of adverse effects and death proximate to vaccination. Out of 670+ reports of death compiled by the Forum, 270 have already been investigated by medical professionals and closely linked to known adverse effects. Following the publication of the new Pfizer document many more are expected to be connected with vaccination. Reports describe symptoms such as chest pain, brain fog, extreme fatigue, neurological symptoms, tachycardia, stroke, heart attacks, and many more. Collected data suggests that as many as two-thirds of adverse event enquiries made to medical staff by vaccine recipients have not been reported to CARM—the NZ system of adverse event reporting. Medsafe itself estimates in its Guide to Adverse Reaction Reporting that in NZ only 5% of adverse events are reported. As a result the NZ public is completely unaware of the extent of reported possible risks of vaccination.

The just released Pfizer document which is being circulated widely in the public domain and can downloaded from websites is entitled:

5.3.6 CUMULATIVE ANALYSIS OF POST-AUTHORIZATION ADVERSE EVENT REPORTS OF PF-07302048 (BNT162B2) RECEIVED THROUGH 28-FEB-2021

Therefore the reported side effects predate the vaccine rollout in New Zealand. The report itself was finalised by Pfizer on 30 April 2021. Did Pfizer supply this information to our government during the early days of our universal vaccination programme? If so the results should have been shared with our medical professionals, politicians, and the public. Many of the new 100+ listed new adverse event types now released by Pfizer in this 38 page document pose long term risks to health. Until very recently, the document was being withheld by Pfizer who maintained it should be kept confidential. There is a strong possibility that very large numbers of New Zealanders will suffer long term injury as a result.

How did this happen without anyone's knowledge?

Even though the Pfizer vaccine had undergone very short trials and had provisional approval only, Medsafe did not update its CARM adverse event reporting system to make it mandatory rather than voluntary.

Medsafe did not advise GPs and Hospital staff to be on high alert for adverse events and report them rapidly and in detail.

The Government ignored the unprecedented numbers of adverse events being reported to Medsafe and circulating in the community and on social media.

The Government instituted a public relations, promotional, and media campaign advising the public that the Pfizer covid-19 mRNA vaccine was completely safe and free of serious side effects, giving the impression that there were no side effects—not even the known serious effects of heart inflammation that Pfizer had already admitted.

Unaccountably, conditions imposed by the contract that our Government signed with Pfizer for the supply of vaccines have not been made public. We suspect that the contract contains standard clauses similar to those used with drugs that have completed safety trials, such as a provision that public discussion of adverse events may only be undertaken in conjunction with the company supplying the drug. If this is the case, it will have hamstrung Medsafe and our Government in their approach to assessment and public discussion of adverse events.

What are the new risks of vaccination?

Anyone reading the new Pfizer adverse event report compilation will be staggered. The sheer density of the technical medical terms and disease names are nevertheless broken down into recognisable and serious categories of illness—kidney failure, stroke, cardiac events, pregnancy complications, inflammation, neurological disease, autoimmune failure, paralysis, liver failure, blood disorders, skin disease, musculoskeletal problems, arthritis, respiratory disease, DVT, blood clots, vascular disease, haemorrhage, loss of sight, Bell's palsy, and epilepsy.

How has this affected New Zealand?

Whilst even the official Medsafe record of adverse effects and the unofficial lists show that the immediate risks of covid vaccination could be as much as 50 – 300 times greater than even the most risky of previous traditional vaccines (such as the smallpox jab), and whilst the long term effects are unknown, 90% of eligible New Zealanders have gone ahead with vaccination having accepted the assurances of safety and efficacy from the government, or having been forced to get vaccinated under threat of loss of employment and freedom of movement. Feeling the fear of covid that has been generated by reports in the international and local media, most people completing vaccination heaved a great sigh of relief—that is one huge worry off my mind, now I can get on with my life.

Those finding that no immediate insurmountable reaction had surfaced (the majority) understandably agreed with the government: "What is all the fuss about? Why shouldn't everyone do this, or be made to do this? It is a social good that will protect everyone"

BUT there is a huge iceberg in the path of the good ship New Zealand hidden under the waves of relief. Thousands are quietly suffering debilitating illness, unacknowledged and in some cases untreated by their doctors. For those who survived vaccination without immediate injury this was not a problem because they didn't know about it apart from one or two complaints from friends that might just be random coincidences.

This has brought about a division in New Zealand society which the government created in the name of public safety. Thousands of dedicated servants of the nation including teachers, health workers, and others are being stigmatised and forced out of their jobs in a manner horrifyingly reminiscent of the treatment of Jews in Nazi Germany. The government did this despite knowing that the Pfizer vaccine was neither fully tested, safe, nor particularly effective. Judges handed down decisions in courts supporting the government mandates unaware of crucial mRNA vaccine safety data, all because Pfizer

had withheld this information, and the government had not done its due diligence. Had the true position been known, the High Court's NZ Bill of Rights analysis may well have been different and its provision which guarantees that every individual should be able to make their own medical choices might still be intact.

Pfizer's conclusions

Pfizer concludes the released document with a statement "Review of the available data for this cumulative PM experience, confirms a favorable benefit:risk balance for BNT162b2." PM stands for the Post Marketing data set they are evaluating of 42,086 reported adverse events. Pfizer makes this bald claim of benefit despite admitting that "the magnitude of underreporting is unknown". This document contains no further substantive information in support of this claim of benefit:risk balance other than a mysterious reference to "the known safety profile of the vaccine".

The benefit:risk argument is in essence saying: covid-19 is a serious illness and our calculations show that more people will be injured by the disease than are being injured by the vaccine, therefore there will be a net benefit. This argument falls over because of at least three very important factors: Firstly treatment options have improved and thereby the risk of serious illness and death from covid has been greatly reduced.

Secondly the risk of covid is not evenly spread. People with comorbidities (other conditions) and the elderly are at very high risk. Most other people are at very low risk. Thus vaccination could subject people at low risk from covid to a higher risk from vaccination. Approaches to preventive health education can reduce the covid risk to people with comorbidities more than vaccination can. For example a study published in the BMJ found that people following a plant based diet have a 73% reduced risk of serious illness. Data from the UK Biobank has been analysed by researchers from Manchester and Oxford Universities and the West Indies who found that shift workers (who typically have disrupted bioclocks) have three times the risk of being hospitalised with covid. Preventive remedies include changes in diet such as the introduction of more fresh fruit, vegetables, and fibre, and reductions in known unhealthy habits such as smoking, excess alcohol consumption, an overly sedentary lifestyle, a predominance of ultra processed foods, and many more.

The third and most significant reason the benefit:risk argument falls over is the sheer range of adverse reaction types observed by Pfizer and kept hidden until now.

How could a single vaccine have such a wide range of effects?

The technical reasons why mRNA vaccines can have such broad effects on human health are understood by those working in gene therapy. Perfectly stable DNA function is critical to life. In turn, cell function integrity is critical to maintaining DNA. Individual cells contain mechanisms to repair their own DNA as many as 70,000 times a day. From this perspective, the in vitro laboratory study recently published in Viruses 2021, 13,2056, is indicative. It suggests a possible mechanism for vaccine harm. The study found that the spike protein localises in the nucleus and inhibits DNA damage repair by impeding access of key DNA repair proteins. The findings reveal a potential molecular pathway by which the covid spike protein might impede adaptive immunity. They underscore the potential side effects of the full-length spike-based mRNA vaccines.

Despite a degree of cellular autonomy, the nervous system and the physiology must and does function as a whole. The entire nervous system including the immune system is a 'part and whole' network. The whole is in every part, the DNA is in every cell, but cell

function is also related to a generalised and interconnected genetic network—the holistic functioning of the physiological network is critical to its efficiency. Thus physiological network stability (health) can be impaired by the introduction of pieces of active genetic code (biologic instructions) like those contained in mRNA vaccines.

An analogy will make this clear. We are familiar with computer networks. A very common backbone of most commercial systems is produced by Microsoft. Each computer contains the Microsoft system and the network also runs under its system. The system is supported by computer code—a set of complex instructions written by Microsoft. Individual computers can perform standalone tasks and can communicate with other computers to keep the organisation running smoothly. This can be compared to our physiology. There are many systems in the body: immune system, circulatory system, digestive system, limbic system, homeostatic mechanisms, musculoskeletal structure, neural networks, and so on. They perform apparently stand alone functions, but all run on the basis of the same genetic code contained in our DNA and communicate with one another during the process of maintaining health. Back to our analogy: office staff sometimes send messages full of spelling errors to one another but this doesn't harm the network. If however a computer virus written in code is sent by one computer it can overwhelm and crash network function because it affects the operating system. Some networks are protected by good firewalls and others are vulnerable. The Covid vaccine introduces a sequence of information written in genetic code into our physiology. It is no wonder that it could elicit such a very broad range of adverse effects, some of which are so serious as to be analogous to a computer network crash. Some individuals have strong immune systems and are little affected, others experience problems in one or other systems. The fact that a sequence of foreign code has been introduced into the physiology produces major risks to health, risks that those working in gene therapy for the last few decades are very familiar with.

The extremely broad range of adverse effects revealed by the Pfizer document is the physiological signature of a general control system failure, a failure of the body's overall integration and function. It is not plausible to suggest otherwise. That is why experts in genomics, even as I write, are pondering fundamental questions about the action and safety of mRNA vaccines. They are also urging caution.

Conclusion

The NZ government agreed commercial terms with a single company for vaccine supply. It is possible that vital information was withheld. The public was kept in ignorance of known risks. This has divided our society and undermined our fundamental Kiwi tolerance on the basis of not only incomplete but misleading safety data. The government is asleep at the wheel. Knowing full well that safety trials were incomplete, the government apparently accepted information supplied by multinational commercial interests at face value. This should be a 'never again' moment. There are huge lessons to be learned and an apology owed to the whole population. The provisions of the NZ BIll of Rights should be given constitutional status. The vaccine mandates should be withdrawn and those affected by them compensated. The proposed vaccination of 5 -11 year olds should be stopped.

You can purchase a copy of Guy's book 'Your DNA Diet: Leveraging the Power of Consciousness To Heal Ourselves and Our World. An Ayurvedic Blueprint For Health and Wellness' from Amazon.com.

The statements, views and opinions expressed in this column are solely those of the author and do not necessarily represent those of dailytelegraph.co.nz.

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5. Link - '8 Prominent Doctors & Scientists Engage In An Extraordinary Discussion' - 10 October 2021 - https://www.youtube.com/watch?v=pR5sdbkOdM4 Features Dr Robert Malone, creator of mRNA technology.

" In this video, panelists Dr. Pierre Kory, Dr. Ryan Cole, Dr. Brian Tyson, Dr. Richard Urso, Dr. Robert Malone, Dr. Heather Gessling, D. Brian McDonald, and Dr. John Littell discuss "Kids and covid", "covid vaccines", "variants", and "your immune system".

They also discus the controversy around Ivermectin and why that drug has not been approved to fight covid.

Most importantly, all 8 panelists call for the adoption of early treatment to turn covid from the terrible killer virus we now know, into one that even many of the most vulnerable can expect to survive.

Watch this remarkable discussion to learn why covid is NOT a "Pandemic of the Unvaccinated", but an "EMERGENCY of Under-Treatment".

Be sure to watch this one to the VERY end. "

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6. Link - QLD Senator Gerard RENNICK addressing Parliament regarding Covid-19 Vaccine Mandates - 22 November 2021 *(37,000 'likes / loves', as at 12 January 2022)* - https://fb.watch/auaPVaRzlu/ - 13 mins

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7. Link - Perth Radio 6PR882 NewsTalk - 'Union Officials Exempt From Covid-19 Vaccine Mandate' - 1 December 2021 - https://www.6pr.com.au/union-officials-exempt-from-covid-19-vaccine-mandate/

Union officials exempt from COVID-19 vaccine mandate

It's been revealed all union officials are exempt from the state's COVID-19 vaccine mandate, which comes into force today.

State Secretary for the Australian Nursing Federation, Mark Olson, told Liam Bartlett he can't understand why he is not required to get the jab.

"If I have a right of entry permit, either a federal or state one … then you're exempt from the orders," he said on 6PR Mornings.

"I don't understand why, any other contractor going into a hospital is required to be vaccinated … and what's even more curious Liam is that this exemption doesn't extend to the flu jab in aged care.

"If me or any of my staff want to go into aged care, we need to have the flu jab, but we don't need to be vaccinated against COVID-19 to go visiting and working in our public or private hospitals.

"I think it's something the government has to explain Liam, as to why they have given this exemption, there is absolutely no logic for it."

*** Could this be Australia-wide? Might explain why QPUE jumped right on board with QLD CoP's Direction?
*** Politician's also exempted themselves.

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8. Summit News article regarding questionable interpretation & use of data (11 January 2022) - https://summit.news/2022/01/11/cdc-admits-over-75-of-covid-deaths-were-people-who-had-at-least-four-comorbidities/

CDC Admits Over 75% of COVID Deaths Were People "Who Had at Least Four Comorbidities"

They were "unwell to begin with."

Published **14 hours ago** on **11 January, 2022** **Paul Joseph Watson**

CDC Director Rochelle Walensky acknowledged that over 75% of COVID deaths were people "who had at least four comorbidities" and were "unwell to begin with."

Walensky made the remarks during an appearance on Good Morning America.

"The overwhelming number of deaths, over 75%, occurred in people who had at least four comorbidities," said Walensky. "So really these are people who were unwell to begin with."

The numbers, which other sources suggest could be even higher, once again emphasize how the vast majority of healthy people survive COVID, even in the higher age bracket.

As we highlighted yesterday, a study conducted by top epidemiologist Professor John Ioannidis found that more than 95% of elderly people over the age of 70 survived COVID, with that number rising to 97.1% for those not in a care home.

Amongst people under the age of 20, the survival rate was 99.9987%.

The study used numbers from before the advent of mass vaccination programs.

Much of the scaremongering surrounding COVID that was utilized to justify lockdowns, mask rules and vaccine mandates was predicated on the myth that COVID was killing huge numbers of healthy people, which just wasn't the case.

This left much of the population bewildered and frightened as to the true scale of the threat posed by the virus.

A poll conducted in summer 2020 found that on average, Americans thought 9 per cent of the population, around 30 million people, had died from coronavirus when the actual figure at the time was less than 155,000.

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9. Article in 'The Australian' newspaper regarding vaccine mandates (31 December 2021) -https://edition.pagesuite.com/popovers/dynamic_article_popover.aspx?artguid=1aa737f3-e9c0-496b-af31-1d3fc9423516&fbclid=IwAR02TeuSdsG0hJgCmAwYDGkuacxAcoERj_s5zJW7uMl2Hw4VdC9H1L5xvew

The dangerous path towards segregation and despotism

Those who are considering the implementation of vaccine mandates need to think again

Vaccine mandates are a terrible mistake. They are illiberal. They segregate members of society, jettisoning equality before the law.

To be remotely defensible, the disease against which they are aimed should surely be very lethal indeed, like the Spanish flu or the Black Death. Yet Covid-19 comes nowhere near the level of lethality needed to justify what amounts to a huge inroad into the basic standards of a functioning liberal democracy.

If your inclination is to support mandates, remember this: for those who catch Covid-19 and who are not vaccinated, 99.7 per cent survive.

For those under 50, you'll get about one death for every 50,000 people who catch it. This virus is dangerous, but it is selectively dangerous. If you are over 80, or obese, or have a number of comorbidities, then look out.

Of course all of those dangers diminish with widespread vaccination.

But the question here is whether you wish to throw away the core elements of living in a liberal democracy to move towards soft despotism and soft segregationism – whether you support segregating certain people, thereby making it impossible for them to work or go to entertainment venues or do much other than eat – for a disease with that level of danger.

I certainly do not. I think it's disgraceful. And to be clear, I have been double vaccinated.

I never imagined a day would come when almost everyone in the public-health hierarchy would be chanting "group benefits should trump any and all individual decision-making

calls". Yet that is precisely what the doctorly caste (and their enablers in the political class) are proposing, however they try to disguise it.

For that to make sense, first there needs to be clear evidence that unvaccinated people are considerably more likely to transmit Covid than the vaccinated. You won't hear this much in the media, but there is no such evidence. Indeed, most of the recent studies point the other way. A November Yale study concluded "clinicians and public health practitioners should consider vaccinated persons who become infected with SARS-CoV-2 to be no less infectious than unvaccinated persons".

One in the scientific journal Nature showed the effectiveness of vaccines in reducing transmission fades to practically zero after three months. In heavily vaccinated Germany, things are worse on all metrics in 2021 than in 2020, when there were no vaccines.

The latest UK Health Security Agency surveillance reports of hospital admissions, while showing the vaccinated do significantly better, also show the vaccinated can still be infected, pass on infection, become ill and die. They make up 52 per cent of hospital admissions and 73 per cent of deaths. The realworld data – not computer modelling – gives evidence for personal protection but provides no reason for supporting vaccine apartheid.

And for those for whom credentialism is the be-all and end-all, this position is supported by professors, epidemiologists and doctors from the likes of Oxford, Harvard and Stanford (check out the signatories to the Great Barrington Declaration) who put to shame the qualifications of the chief health officer types here in Australia.

Leave aside the real questions about the effectiveness of lockdowns, though I believe they were a terrible error and will be seen that way in the next few years. Sweden, which never locked down, now shows that its age-adjusted excess deaths through this pandemic are below the rolling 2015-19 average.

And its Covid rate is down in the bottom half in Europe. Deaths due to lockdowns are starting to become plain and will dwarf those saved by lockdowns. Meanwhile, of the 50 US states, right now the one with the lowest Covid rates is Florida – a state with no mask rules for the past 10 months or so, no vaccine mandate, no lockdowns and indeed a mandate against vaccine mandates.

The other no-vaccine mandate US states are outperforming the mandate states.

This is the bottom line for anyone who cares for freedom, civil liberties and living in a country with equality before the law.

The facts are now clear that the gains (if any) from heavy-handed vaccine mandates (that would cost people jobs and severely affect dissenting students) are so marginal that they patently do not justify the restriction of liberty.

Moreover, once we have started down a path on which tiny gains in public health do justify the suspension of our liberties, that opens the door to many more restrictions in return for other supposed benefits.

You have to have heroic levels of trust in government to think mandates are a good idea, especially now it is plain that the overwhelming benefit of the vaccine flows to those who take it for a few months per shot, and almost none to bystanders.

Remember, Omicron was spread rapidly all over the world solely by the fully vaccinated

and masked-while-flying travellers, as only they could travel internationally during this time.

Vaccine mandates amount to terrible, illiberal public policy. The government says it is against such mandates but it takes virtually no concrete steps to put its money where its mouth is, preferring weasel-word formulations about leaving it to businesses to decide.

Florida Governor Ron DeSantis knew this was a bogus formulation and acted accordingly. But even if you buy the Morrison line, look at all the things of which the federal government is the main funder – think universities, the public service, the military and more.

Will the government prohibit all of these from bringing in vaccine mandates? Because right now Coalition MPs who say they are against vaccine mandates are not leaving cabinet on the issue, not speaking out for action, not criticising businesses or states. They're not walking the walk, just murmuring a bit of cheap talk.

I'll say it again. Vaccine mandates are a terrible, illiberal, slippery-slope idea. Speak now or forever expect despotic, heavyhanded government.

James Allan is Garrick professor of law at the University of Queensland.

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10. Article written by Rod Lampard (26 November 2021) - https://caldronpool.com/australian-medical-association-you-wont-be-able-to-hide-your-life-will-be-miserable/?fbclid=IwAR2aFPI0FG1uA7LsNeoRzsSj2BkWoop4xmTB2gPN7gXkfsU5Fnm9b3hieyw

Australian Medical Association: "You Won't Be Able to Hide. Your Life Will Be Miserable"

"'No jab, no job' is political, not medical. It is a fierce medical violation of a person's conscience, rights, body, and consent. It is not patient care."

A history of the Australian Medical Association, from its conception in the BMA (British Medical Association), shows a long history of political activism.

Most appear to agree that the AMA is a powerful union and lobbyist group.

At one time benevolent, their foundation included as a condition of AMA membership the acceptance of the obligation "to observe the highest standard of professional integrity in the conduct of medical practice."

Given that many Australians hear the term AMA, and instantly think expert opinion, it's important to question the AMA's behaviour over the course of the past two years.

At what point does their political activism become more about pushing a political agenda than it does healthcare?

Is the AMA's direction violating its vocation by breaking with a clear tradition of doctors helping other doctors better serve and care for their patients?

Does the AMA represent the majority of doctors anymore?

Is the AMA an unsightly anachronism attached to Australia's bloated bureaucracy?

In his 2016 exposition for the online journal, The Conversation, Stephen Duckett described the AMA as the "foremost medical lobby group'; a 'key player in Australia's strife-ridden health politics, which is riddled with self-serving interest groups."

It's clear that the AMA is a politically motivated organisation. The AMA doesn't just appear to support the politicisation of medicine, they're actively lobbying for it.

This is backed by Dr. Chris Perry, Queensland's Australian Medical Association director recently cheering on the idea that life will be very difficult for the unvaccinated.

The QLD AMA executive told the fiendish COIVD Stasi collaborators, aka Channel Nine: "You won't be able to hide. You will be miserable. You will have a very lonely life and you won't be able to maintain your employment."

During the interview, Dr. Perry failed to distinguish between support for traditional, tried and true vaccines, and support for the COVID-19 varieties.

The AMA director claimed to speak for all Queensland doctors, stating that "99.97% support vaccines."

It seemed bold for Dr. Perry to claim total representation of every doctor in Queensland, when, according to Duckett's 2016 exposition, as of 2016 the AMA 'represented only 30% of the medical profession.'

What the rather abrasive Dr. Perry also failed to mention was the large number of doctors who are not legally allowed to voice their opinion, or offer medical advice which goes against the politically approved narrative.

To add, the AMA executive refused to be transparent about such things as:

- There being no long-term COVID "vaccine" data.
- There is likely to be no transparency until 2075.
- The censorship of medical professionals.
- Doctors cannot give an honest medical opinion because of politics.
- Adverse reactions are being dismissed or downplayed by doctors for fear of punitive government reprisal.
- The destruction of doctor/patient confidentiality.
- The end of informed consent.
- High survivability rates.

The level of happy hubris from Dr. Perry may help to unpack why Duckett states, 'the AMA, as an organisation is in decline.'

Surprisingly, Duckett categorises the AMA's political alignment as "conservative."

An assessment contradicted by the AMA backing of SSM, abortion (including late-term abortion), the Marxist Black Lives Matter movement, and the AMA's soft opposition to

responsible border control.

The recent history of the AMA indicates that politics is masquerading itself as medicine.

Take a closer look at what happened in Victoria this week to Dr. Mark Hobart.

Take an even closer look at the mistreatment of Dr. Robert Malone, and a whole range of other medical professionals who would struggle to be represented honestly by legacy media, let alone the AMA.

Why is the AMA seemingly defending the Government, and not those they say they represent: the doctors and their patients?

For an organisation representing physicians, the AMA has been squeamishly quiet on coming to the defence of medical practitioners hounded into silence by the State.

Additionally, the AMA's position on abortion and their concerns about the potential 'compromise of patient care', is itself contradicted by their support of vaccine mandates.

For instance, the AMA states: "Any decision on abortion is between the doctor and patient. There is no place for third parties – governments, over-zealous politicians and lawyers, hospital committees, or even the spectre of legal action."

The AMA (*we should include Fair Work Australia, along with 99% of other Unions*) all seem too eager to support COVID-19 authoritarian precedents that compromise patient care.

Politicians now dictate how physicians treat, and what physicians prescribe, and say to their patients.

This turns physicians into a puppet of the State.

The Hippocratic oath has been exchanged for an oath of loyalty to the current prevailing political narrative.

As myself, Ben Davis, and the brilliant Mark Powell covered at length during the beginning of 2020. The World Health Organisation has followed a similar path.

Rather than fight COVID with medicine, they took up a political fight against imaginary racists.

I don't think it's a stretch to say that these organisations are quintessential examples of politics hijacking medicine, and ideology hurting healthcare.

To borrow from Bill Muehlenberg: "The right to choose and bodily autonomy are basic human rights in health care. Deny these or take them away and you have gone straight back to tyranny and despotism – no different from what we saw happening in Germany in the 30s and 40s."

He isn't clutching at straws.

For those ready to pound out "you can't use Nazi parallels with COVID," let the record show history begs to differ: "The Nazi group in charge of the actual killing in the gas chambers was called the General Welfare Foundation for Institutional Care…" (Dean Stroud, 2013 *'Preaching in Hitler's Shadow'*)

Wilhelm Busch, a Confessing Church Pastor wrote:

> When Hitler came to power and everything was shaking, the word was: 'Up to such and such a date you can still join the party!' Or, 'Up to such and such a date you can still become a member of the "German Christians". Then the lists will close. Hurry!' [Yet] I seemed still to hear Christlieb's voice: 'Only the devil is in a hurry. If you have no clarity…wait.' So, I let all the dates pass and remained a free man.

Busch added:

> We'd discovered that my son had haemophilia, yet later they conscripted him for the war in Russia.
>
> I ran to see the army doctor who examined him. But a pastor who belonged to the 'Confessing Church' and was not 'standing without reserve behind our beloved Führer' did not get a hearing.
>
> I can still see the little troop standing on the station. Destination Russia! They were just children, eighteen years old. I could have screamed when I saw my child marching away, looking so pale. What did this tender artistic soul have to do with an unjust war? He had been caught in a pitiless machine.
>
> Then somewhere in Russia he bled to death. Abandoned and alone!
>
> No! Not alone! In his wallet was found a bloodstained scrap of paper with the words: 'The Lord is my Shepherd; I shall not want… And though I walk in the dark valley, I fear no evil; for you are with me.' (*Christ or Hitler?*)

When it comes to abortion, patient care and bodily autonomy apply just as much to the baby as it does to the mother.

With the "*no jab, no job*" COVID-19 "vaccine" mandates the same argument for patient care and bodily autonomy stands.

"*No jab, no job*" is political, not medical. It is a fierce medical violation of a person's conscience, rights, body, and consent. It is not patient care.

The AMA are only showing their age, and hypocritical irrelevance when spokesmen like Dr. Perry step onto live television and proudly promote the dehumanisation of those who don't want, don't need, and may not be able to get the COVID-19 "vaccines."

The generation susceptible to COVID-19 can be protected without raping, disfiguring, and potentially killing the generations under them.

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11. Summit News article regarding doctor's statement re efficacy of masks upheld by High Court (6 December 2021) - https://summit.news/2021/12/06/doctor-banned-for-questioning-efficacy-of-masks-wins-high-court-case/?fbclid=IwAR0XsvAmF_6JkGpNn6zlRSe4UQoL8nwZApCml17V1aRtN6Xw1tQmvFhXXDg

Doctor Banned For Questioning Efficacy of Masks Wins High Court Case

Paul Joseph Watson **6 December, 2021**

Censorship was "clearly wrong and cannot stand."

A doctor in the UK who was banned from using social media by the General Medical Council for claiming "masks do nothing" has won his case in the High Court.

Dr. Samuel White was slapped with and 18 month ban by the GMC after he posted a video to Instagram and Twitter in June questioning the efficacy of face coverings.

In the video, White said why he could no longer tolerate working in his previous roles because of the "lies" around the NHS and the government's response to the pandemic, which were "so vast" he could no longer "stomach" them.

White also committed the ultimate sin of remarking, "masks do nothing" to stop the spread of COVID, despite this being the consensus medical opinion at the start of the pandemic before it mysteriously switched almost overnight.

The doctor also expressed concerns about the safety of vaccines and the reliability of COVID tests.

White took his case against the GMC to the High Court on the basis of his freedom of expression "to engage in medical, scientific and political debate and discussion," White's barrister, Francis Hoar, told a hearing at the Royal Courts of Justice.

Hoar added that White's opinions were "supported by large bodies of scientific and medical opinion" and had been "statements of fact and opinions about pharmaceutical and non-pharmaceutical interventions in response to the pandemic."

GMC's Alexis Hearnden claimed that White's views were not only misinformation, but posed a "risk" to the public because they didn't align with official pronouncements.

However, the court ruled in favor of White, asserting that the tribunal which banned him from speaking had violated the 1998 Human Rights Act.

The ruling concluded that the tribunal's decision was "an error of law and a clear misdirection," meaning the decision was "clearly wrong and cannot stand."

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12. Forbes article regarding the risks of using QR Codes (dated 1 June 2020) - https://www.forbes.com/sites/forbestechcouncil/2020/06/01/i-dont-scan-qr-codes-and-neither-should-you/?fbclid=IwAR3CAph0nSPvVh_dFej_dg3_cbXCnG8UwF5sgWdZnTp8l5bXwuDdIjbRrRQ&sh=61be10c551d1

I Don't Scan QR Codes, And Neither Should You

Morey Haber 06:50am EDT

CTO and CISO at BeyondTrust, overseeing the company's technology for privileged, remote access and vulnerability management solutions.

I don't scan QR codes, and neither should you, especially if you care about cybersecurity.

A QR code is a two-dimensional barcode that is readable by a smartphone with a camera or a mobile device with a similar type of visual scanning technology. It allows the encoded image to contain over 4,000 characters in a condensed, machine-readable format and was designed as a rapid method to consume static content based on a specific task. Once a program generates a static QR code (as opposed to a dynamic QR code that can change fields like a URL), that code cannot be modified to perform another function.

Surprisingly, that is not the source of cybersecurity risk, even for dynamic QR codes. The risk is in the content itself that has been generated and potentially displayed for an unsuspecting user to scan. Once they do, it can be the prelude to an attack.

To dive a little deeper, a QR code can contain the following risks:

Contact details: A QR code is similar to a virtual business card or VCD file that includes all your contact details such as phone number, email address and mailing information. This information is automatically stored in the device's contact list when scanned. If the data is malicious, it could trigger an exploit on the device or place a rogue entry in your phone for your favorite airline or credit card.

Phone: Scanning a QR code automatically loads or starts a phone call to a predefined number. With all the recent robocall and SIM-jacking attacks, this is another method for a threat actor to access your phone and identity. You are basically calling someone you do not know and handing over your caller ID information.

SMS: Scanning a QR code initiates a text message with a predetermined contact by name, email address or phone number. The only thing the user needs to do is hit send, and you could potentially reveal yourself to a threat actor for SMS spam attacks or trigger the beginning of a SIM-jacking attack. A little social engineering is all it takes to convince the user to hit the send button

Text: Scanning a QR code reveals a small amount of text in the code. While this seems low risk, QR codes are not human-readable and unless you scan one, you have no idea that the contents are actually just a text message.

Email: Scanning a QR code stores a complete email message with the subject line and recipient. All that is required is to hit send, and this could be the beginning of any form of phishing or spear-phishing attack. The threat actor knows your email address because you validated it by hitting send to an unknown destination.

Location coordinates: Scanning a QR code automatically sends your location coordinates to a geolocation-enabled application. If you are concerned about your data and location privacy, why would you ever do this?

Website or URL: Scanning a QR code can automatically launch and redirect you to a website. The contents could contain malware, an exploit or other undesirable content.

Calendar event: Scanning a QR code automatically adds an event to the device's calendar, with the option of a reminder. Outside of a vulnerability in the local calendar

application, the contents may be unwanted in a business or personal calendar, and deleting a recurring meeting is an annoyance if it was improperly entered.

Social media profile: Scanning this type of QR code initiates a “follow” for a specific profile on sites such as Instagram or Twitter, using the scanner’s personal profile. Depending on the social media platform, the account being followed may have access to your personal information and be aware that you are following them.

Wi-Fi network: This QR code stores Wi-Fi credentials for automatic network connection and authentication. If you consider all the threats of open Wi-Fi networks and even closed networks that use WPA2, the introduction of an unknown or insecure network to your preferred list is just a bad idea.

App store: Scanning links to a page directly on an app store can make an application simple to download. While this is convenient, the listing could be malicious (especially on Android devices) or could be a spoofed page using an embedded URL to trick you into loading an unsanctioned malicious application. Your best bet is to always navigate to an application yourself and not rely on a hotlink.

Finally, let's address dynamic QR codes. These codes are generated once, but the data stored on them can be edited at any later date. They can include password protection and embedded analytics so creators can track how they are used. Dynamic QR codes can even add simple logic such as device-based redirection to have different behaviors for Apple iOS devices versus Google or Android. For example, based on the device, they can be redirected to the appropriate app store or music library. That alone allows a threat actor to target device and application exploits to specific assets to ensure a higher rate of success.

If you are ever out and about and see a QR code on a wall, building, computer screen or even a business card, do not scan it. A threat actor can easily paste their malicious QR code on top of a real one and create their own copies, and based on appearance, you have no idea if the contents are safe or malicious. To that end, I never scan QR codes, and neither should you.