…show that “Covid-19 vaccines” and the technology behind them are dangerous

I’ve referred to the study by Rockenfeller and colleagues before. It is now officially published in Royal Society Open Science [1]. It produces a careful estimate of mortality trends in Germany for each age cohort, and from this can calculate what the presumed excess mortality was during the corona years. In the first corona year, 2020, the result is *undermortality* of about 18,500 people. That’s how many fewer died in the evil Corona year than expected, without vaccination. That’s a finding that gives the lie to all the scaremongering at this time.

Then, as we all know, the “corona vaccinations” came to the “rescue”, which were, after all, supposed to prevent so many people from dying. What happened in 2021 and 2022? In 2021, there was a slight excess mortality of just under 7,000 people, and in 2022, there was an excess mortality of about 41,000 people.

If one looks at a longer period from 2016 to 2020, then one recognizes that in the years before a clear under-mortality is to be registered, which is compensated just in the years 2021/2022. This can also be seen in the cohorts: the excess mortality in 2021/2022 is mainly due to higher mortality among the elderly and compares well with the mortality waves of earlier influenza years.

So what happened here? Nothing special, you might answer, except that old people have died in increased numbers during these Corona waves, just as they usually do during severe annual flu and other infectious waves, except that this time they have died of “Corona” under close scrutiny by the media, politicians, and an utterly hysterical nation (and this, of course, often includes an agonizing death, perhaps even more often a lonely death, sometimes perhaps even an accelerated one due to improper ventilation, but all that is not my focus today). About 66,700 deaths are attributable to corona infection, according to the estimate by Rockenfeller and colleagues, and these are almost exclusively in the 60-plus age group.

Vaccination has not changed mortality trends

Yet, something special has happened, namely above all: nothing. Because if one followed the general propaganda of politics and media, then the vaccination 2021 should have been the “gamechanger”. In that case, the mortality “by and with” Corona should have changed drastically. Which it did not, as the calculations of Rockenfeller and colleagues show. One looks for this change in vain. On the contrary: The 2022/23 flu season (always calculated

from fall to summer) is the highest of any excess mortality series since 2000, with nearly 52,000 excess cases, and well above the normal range of variation. When considering full years rather than flu cycles, the same is true: 2022, with more than 41,000 deaths, is well above average and the year with the highest excess mortality in the 20-year consideration of mortality cycles in Germany.

Another model [2] has also led to this insight, but it estimates much higher excess mortality (presumably because the modeling uses shorter data series).

Common to both is the simple statement:

What can be said with certainty is that the Covid-19 “vaccines” have not prevented any deaths.

Because the years in which vaccination has not only been introduced but potentiated by multiple vaccinations are those with the highest mortality. Whether and to what extent these vaccinations are causative for the increased mortality is highly complex. I want to add a small component to this discussion at this point:

A new, careful prospective study shows: Myocarditis is much more common after vaccination than previously thought

In our very first study, in which we published a cost-benefit calculation of the novel “vaccines” [3-5], we called for a large-scale prospective observational study to be conducted, independent of industry, supported by national funds, in which vaccinated persons would be closely observed over an extended period of time so that benefits and risks could be clearly determined. Because the accusation that has been made, quite rightly, against our analysis, namely that the passive adverse event databases are not systematic enough, goes both ways.

Now such a careful observational study has been conducted [6]. At the Basel Cantonal Hospital, all employees who received booster vaccination with the Moderna “vaccine” and were willing to be screened were included in an observational study. Of a total of 1871 people who would have been eligible, 835 agreed to be screened, and blood was then eventually drawn from 777 on the 3rd day after vaccination (something came up with the others).

The goal of the study was to find out if there were signs of myocarditis, or inflammation of the heart muscle. This, after all, has been repeatedly mentioned as a relatively commonly

reported side effect of such “vaccinations,” but downplayed. Troponin was measured in the blood. Troponin is a protein molecule that normally occurs in the muscles, where it is responsible for muscle mobility and contractility, among other things. It also occurs naturally in the heart muscle and leaks into the blood when the heart muscle is inflamed or damaged. That’s why cardiologists use elevated troponin in the blood, higher than in 99% of healthy people, as an indirect indication of myocarditis. And that’s what was measured here.

If elevated troponin was now found, all other causes were also clarified, and only then was “vaccination” seen as causative for the troponin elevation and thus for myocarditis. In addition, anyone with any history of heart disease was excluded from the study, so that only healthy individuals were included in the consideration.

The alarming result is that clear evidence of vaccine-induced myocarditis was seen in 22 or 2.8% 3 days after booster “vaccination,” in the majority in women, 20 women versus 2 men. Because two-thirds were women and one-third were men in the sample, this female preponderance is partly due to sampling, but not solely.

Reassuringly, this inflammation did not extend in any individual, and ECG signs showed no evidence of longer-term cardiac damage. The authors claim their close-knit care network in part for this. This is because those individuals with evidence of myocarditis were immediately urged to rest and observe, which controlled exacerbating factors.

An incidence of 2.8% is a factor of 800 more than has been estimated in previously published meta-analyses – all of which, of course, rely on passive adverse event databases! In my view, this is massive, especially since this study contains some elements that make the estimate very conservative: People with heart problems were not even included. That is not necessarily a given in ordinary vaccination practice. No baseline measurement was made (because the ethics committee forbade that), but values from healthy norm patients were used as a benchmark.

The level of two of the measured immune parameters were lower in people with myocarditis than in those without: Interleukin lambda and granulocyte macrophage colony-stimulating factor (GM-CSF). Both are cytokines, immune system messengers that are important in defending against viral infections.

At one point in the discussion, I think the authors are arguing incorrectly (and in my correspondence with the authors, my suspicions have been confirmed: I guess they have conformed to the views or expectations of the reviewers or the editor or the prevailing opinion). They write that myocarditis is much more common in Covid-19 infections than in their study. In this regard, they cite studies documenting the occurrence of elevated troponin in *hospitalized* Covid-19 patients, where it is elevated in 20-60% of patients [7-10].

However, the publications all indicate that this is probably due to cardiac disease that the patients may have already had. And we should not forget: It is a minority of SARS-CoV-2 positive people who are hospitalized with Covid-19. Almost certainly, fewer than 2.8% of all people who have ever been exposed to SARS-CoV-2 will develop myocarditis.

It is due time now for such careful prospective studies to be done more frequently. After all, 777 people is a comparatively small number, far too small to clarify, for example, the number of deaths due to vaccination, especially if one excludes people with pre-existing conditions from consideration.

We now know from careful study: the risk of myocarditis is comparatively high. It would have to be put in proportion to other risks, such as dying from Covid-19. As we saw above, a look at mortality data shows little evidence that this risk would have been significant for healthy people under 70.

The mechanisms: mod-RNA and lipid nanoparticles trigger inflammation and overstimulate the immune system unnaturally

An illuminating essay by my colleague Klaus Steger, a molecular biologist who serves with me on the board of directors of the Doctors' Association Hippocratic Oath, shows why this is so, at least in part. In this well-written and easy-to-understand paper, he shows that what is used to "vaccinate" against Covid-19 is not normal messenger- or m-RNA, but modified RNA. This is because if the RNA were not modified, it would be disassembled in no time by our immune system or by the appropriate enzymes, just as the cell-internal m-RNA is when it has done its job. Only by packaging the mod-RNA in nanolipid particles can we, firstly, introduce it into the cells without it being immediately destroyed and, secondly, ensure that it remains active for a while. The point is: we don't know, and especially can't control, how long it stays active.

While in a viral infection the virus enters the cell as a whole and therefore the immune system develops antibodies and immune recognition not only against certain epitopes of the virus, but against different elements, in the case of mod-RNA it is only one element, the spike protein, that is encoded. And this is the actual toxic element of the virus. It gets into the cells, into the bloodstream, from there to other places in the body, for example to the epithelium of capillaries in the periphery or in the heart. Wherever the nanolipid particles with the mod-RNA as a load reach, these particles fuse with the cell membranes, which causes the corresponding cells to start working off the blueprint of the mod-RNA and form spike proteins. This happens in places where a normal virus would never have gone, except

in the case of a total failure of the immune system. This is because normally the virus, in this case the SARS-CoV-2 virus, is intercepted by the immune system in the mucous membranes, and only in very rare cases do virus-infected cells reach the bloodstream and thus other places in the body, where these infected cells are then destroyed. It is primarily this excessive inflammation that has led to the dangerous situations with severely sick Covid-19 patients. In people with functioning immune systems, these infected cells are destroyed and eliminated.

With the so-called "vaccination" with mod-RNA, the introduction of the spike protein, i.e. the most dangerous part of the virus, into the body is in a way pre-programmed and is intended. It was a capital and catastrophic lie to say the mod-RNA remains in the muscle cell. Anyone with a rudimentary knowledge of biology knows that the needles used to inoculate are larger than cells, and that muscles have a very large blood supply. Especially since, for some inexplicable reason, instructions were also issued that when vaccinating into muscle, one should no longer aspirate, i.e., pull back the plunger after insertion (to see if a blood vessel was injured). All of this leads to a high probability that this mod-RNA will reach various compartments of the body, especially epithelial cells of blood vessels, where it will induce body cells to produce spike proteins. This process, unlike a viral infection that usually clears up in a few days, can take weeks and months – and if the blueprint is incorporated into the genome, can even last a lifetime.

I recommend to everyone a thorough reading of Klaus Steger's essay, which is only part 1. Because it helps to understand better why this supposed "vaccination" is potentially dangerous. Then you will also understand that it is high time to stop this madness and above all to make sure that this mod-RNA platform is not made the basis of all other normal vaccinations, just because you can make money with it at the expense of the general public. This is to be feared, and from my point of view, this must be prevented. Therefore, it is important to get involved, e.g. by joining participation campaigns or by complaining against the pandemic treaty by which such supposed medicines will most likely become mandatory in the future.

It is time for those responsible to rethink and redirect their actions. The biblical term for this is "meta-noia," a fundamental rethinking or turning the rudder in a different direction. It is usually translated by the somewhat loaded term "conversion." It is about something very basic: Admitting that you were wrong and redirecting your thinking and actions. And doing it before it's too late. This is what a new book [11] is about, and I plan to write a few words about it soon.

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