InformedCHOICEWA.org

September 20, 2022

Brandy Chinn, Rules and Legislative Relations Manager
Office of Financial Management
PO Box 47500
Olympia, WA 98504

Sent via email to brandy.chinn@ofm.wa.gov

Dear Ms. Chinn and OFM Rule-Making Staff,

We are writing to oppose the rules in WSR 22-17-122 that the Office of Financial Management (OFM) has proposed. Informed Choice Washington is a nonprofit organization dedicated to healthy immunity, informed consent, and scientific integrity in public health policy.

Your proposed rules lack scientific integrity, they violate informed consent by adding coercion to the medical-decision process, and significant published evidence indicates that all of the spike-containing and spike-generating COVID-19 shots impair healthy immunity and present serious risks of harm, including death.

On August 4, 2022, we submitted our opposition in writing to OFM's earlier proposed rule-making on this subject under WSR 22-14-104, jointly with several attorneys, and separately with our own comments.

In a separate comment submission, we have again jointly provided our opposition to the new proposed rules in WSR 22-17-22. Here we present our own opinion from the viewpoint of our board and thousands of members who will be impacted by this rule-making either directly or indirectly.

Our opposition is grounded in the following:

1. **No statutory authority for adoption.** Neither the language nor the history of RCW 41.06.133 and RCW 41.06.150 confer upon OFM the authority to require any sort of medical intervention, including vaccination, for state employees.

2. **No statute being implemented**. There is no language in either RCW 41.06.133 or RCW 41.06.150 that requires any state employee to be vaccinated or that authorizes OFM to determine what medical interventions or vaccines state employees are required to receive. Further, these two statutes were already implemented in the past. There is no new legislation to implement.

3. **No statutory authority also means that a cost-benefit analysis has never been performed.** The CR-102 states that the proposed rule-making is exempt from cost-benefit analysis because "Rules are related to internal government operations and are not subject to violation by a nongovernmental party. See RCW 34.05.328(5)(b)(ii) for exemption." This exemption has merit when rule-making is legitimate because the statute that provides the authority will have been through the legislative process, complete with cost-benefit analysis if needed. In this case, the cost of imposing COVID vaccination requirements on employees has not been evaluated. The potential costs of these rules to the people of Washington State are staggering; they include:

    - Loss of bodily autonomy and the universally recognized right to make medical decisions free of coercion or undue influence, as outlined in numerous human rights declarations and federal regulations. There can be no price tag put on this loss. It's beyond tragic that federal and state agencies are ignorant of the human rights they are violating.
    - Employees injured by the shots. For those injured or killed and their families, the emotional and financial burden is incalculable. For the State of Washington, besides the abandonment of the principles enshrined in our Constitution, the financial cost of caring for the injured would be staggering.
    - The argument that COVID-19 harms more individuals than the COVID shots is both inaccurate and unethical.
        - CDC's claims about injury rates are contested by independent scientists. For instance, the article "Oxford Study Claims Myocarditis is Higher After Covid Vaccination and Actually Suggests Vaccines Increase Risk by 30%"[1] explains significant methodological shortcomings of the Oxford study, including its failure to monitor adverse events beyond 28 days post-vaccination and questionable seasonal adjustments of the baseline incident rate ratios, among several others.
        - None of the COVID shots prevents infection or hospitalization from COVID, and after a short time, data shows negative efficacy (increased risk of infection). This means an individual is at risk of myocarditis with every injection, and at risk from each infection.
        - It is the human right of the individual, in consultation with a trusted healthcare advisor if they choose, to decide what personal risks to take, prevention options, and treatment protocols.
        - Where there is risk, there must be choice. It is not the state's right or role to use blanket policies to push a medical intervention in a one-size-for-all policy.
        - The full extent of potential risks presented to the Vaccine & Related Biological Products Review Committee by the FDA and CDC, as well as the current Vaccine Adverse Event Data that reveal these events are happening,

[1] https://worldfreedomalliance.org/au/news/oxford-study-claims-myocarditis-is-higher-after-covid-vaccination-is-flawed-and-actually-suggests-vaccines-increase-risk-by-30/

are set forth in the attached documents (see "FDA Slide 16 & Table 2: Everything Being Reported to VAERS").
- The FDA requires every Pfizer COVID-19 shot recipient to receive a Fact Sheet prior to acceptance or refusal of the shot. The sheet lists as a potential risk:

"Myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining outside the heart) have occurred in some people who have received COMIRNATY (COVID-19 Vaccine, mRNA) or Pfizer-BioNTech COVID-19 Vaccine".

The sheet also states:

"These may not be all the possible side effects of these vaccines. Serious and unexpected side effects may occur. The possible side effects of these vaccines are still being studied."

4. **Discrimination Based on Representation Status, Medical Status, Religion**

- The CR-102 states the provisions are for "non-represented state employees," but the proposed WACs do not include such a limitation. Are the proposed rules intended to apply to employees within bargaining units as well as those who are not? Would OFM be in violation of collective bargaining contracts by adding this requirement outside of the bargaining process?
- If the intention is to implement rules only for non-represented workers, this would constitute discrimination.
- Given the history of the state's refusal to accept—or if accepted, its refusal to accommodate—those who file medical and religious exemptions, these individuals would face discrimination in hiring and firing practices.
- Individuals who received no COVID shots but have acquired natural immunity also face unethical and unscientific discrimination.

5. **Rule-making overreach.** Proposed WAC 357-04-125 states the following: "Higher education employers, independent agencies, boards, councils, commissions, and separately elected officials **may require** an eligible candidate to meet the requirements of this section." (emphasis added) In addition to having no statutory authority to mandate vaccination on executive and small cabinet employees, OFM is grossly overreaching its authority by also attempting to grant medical-intervention powers to a broad range of state employers over their employees.

6. **Violation of Emergency Use Authorization (EUA) regulations.** Proposed WAC 357-01-1745 includes "COVID-19 vaccine authorized for emergency use" in the definition of "fully vaccinated." This violates federal law as follows:

- Federal Emergency Use Authorization allows for use of EUA products only during emergencies, and therefore EUA products cannot be part of non-emergency permanent rules[2].
- Even if the proposed definition included only FDA-approved and licensed products, subject employees would likely be unable to locate such a product in order to comply, as supplies of licensed COVID-19 vaccines are currently extremely low and mostly unavailable.
- EUA products cannot be mandated, as explained in the Fact Sheets: "Under the EUA, it is your choice to receive or not receive any of these vaccines."[3] The word "choice" means the free ability to choose, without threat or incentive motivating individuals to act in a manner they would not otherwise choose.
- While it is our position that all vaccine mandates are unethical and violate numerous human rights declarations and federal regulations, any future vaccination rule (which would require specific legislation that does not currently exist) would allow for prior receipt of EUA products to satisfy a vaccine requirement, but could not require an employee to be vaccinated when the only available product is under EUA, as that would violate federal law.

7. **Proposed rules cannot achieve stated goal.** "The vaccination requirements set forth in these proposed rules will help establish and maintain a healthy and safe work environment to protect the welfare of all state employees."
   - None of the COVID-19 shots prevents infection, transmission, hospitalization, or death.
   - Any protection temporarily afforded is short-lived and transitory, and may later result in negative protection, meaning increased risk of infection.[4]
   - Washington State Department of Health (DOH) provides data on reported breakthrough (vaccinated) cases, hospitalizations, and deaths.[5] From January 17, 2021, through August 31, 2022, **700,011 SARS-CoV-2 vaccine breakthrough** cases have been identified in Washington State. **Of these breakthrough cases, 18,832 were hospitalized, and 3,248 died of COVID-related illness**.
   - When examining the DOH data, it is important to note that "non-breakthrough cases" *include vaccinated individuals* diagnosed with COVID-19 within two weeks of having received a vaccine, as well as individuals who received one of a two-dose series. These data should be examined for (a) increased risk of infection due to exposure to the vaccine; and (b) vaccine injury symptoms that may be misdiagnosed as COVID-19.

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[2] https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization

[3] https://www.cdc.gov/vaccines/covid-19/eua/index.html

[4] https://www.jeremyrhammond.com/2022/06/22/original-antigenic-sin-is-a-real-problem-with-covid-19-vaccines/

[5] https://doh.wa.gov/sites/default/files/2022-02/420-339-VaccineBreakthroughReport.pdf

- Naturally-acquired immunity provides strong, broad, and durable protection that surpasses any protection conferred by the shots.[6] A new study in children shows their natural immunity is undermined if they are subsequently vaccinated.[7]
- Federal oversight agencies have acknowledged that the COVID-19 vaccines cause serious injuries in some individuals, such as myocarditis and blood clots. Current adverse event reporting data can be found at OpenVAERS.com/covid-data.
- Increasingly, studies are emerging showing the harm of COVID vaccination programs. Governor Inslee abandoned mandating booster doses, but he has directed OFM to investigate incentivizing them. Incentives that lead individuals to make medical decisions they would not otherwise make are coercive and unethical. It's very concerning the governor has directed use of taxpayer funded resources to compel unethical as well as dangerous policies. A newly released pre-print abstract about boosters for college students states[8]:

  "Students at North American universities risk disenrollment due to third dose COVID-19 vaccine mandates. We present a risk-benefit assessment of boosters in this age group and provide five ethical arguments against mandates. We estimate that 22,000 - 30,000 previously uninfected adults aged 18-29 must be boosted with an mRNA vaccine to prevent one COVID-19 hospitalisation. Using CDC and sponsor-reported adverse event data, we find that booster mandates may cause a net expected harm: per COVID-19 hospitalisation prevented in previously uninfected young adults, we anticipate 18 to 98 serious adverse events, including 1.7 to 3.0 booster-associated myocarditis cases in males, and 1,373 to 3,234 cases of grade ≥3 reactogenicity which interferes with daily activities. Given the high prevalence of post-infection immunity, this risk-benefit profile is even less favourable. University booster mandates are unethical because: 1) no formal risk-benefit assessment exists for this age group; 2) vaccine mandates may result in a net expected harm to individual young people; 3) mandates are not proportionate: expected harms are not outweighed by public health benefits given the modest and transient effectiveness of vaccines against transmission; 4) US mandates violate the reciprocity principle because rare serious vaccine-related harms will not be reliably compensated due to gaps in current vaccine injury schemes; and 5) mandates create wider social harms."

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[6] https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/

[7] https://www.nejm.org/doi/full/10.1056/NEJMc2209371?query=featured_home

[8] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4206070

- Successful alternative prevention measures (ivermectin, zinc, gargling/nasal flushes with hydrogen peroxide[9], for example), as well as treatments (see the FLCCC.net protocols) exist, and they spare the user from the risks of the shots.

For these reasons, the proposed regulations set forth in WSR 22-17-122 should not be adopted, and this rule-making effort should cease.

Respectfully,

The Board of Informed Choice WA

Enclosures

InformedCHOICEWA.org

We Stand For

Healthy Immunity ▪ Medical Freedom ▪ Informed Consent

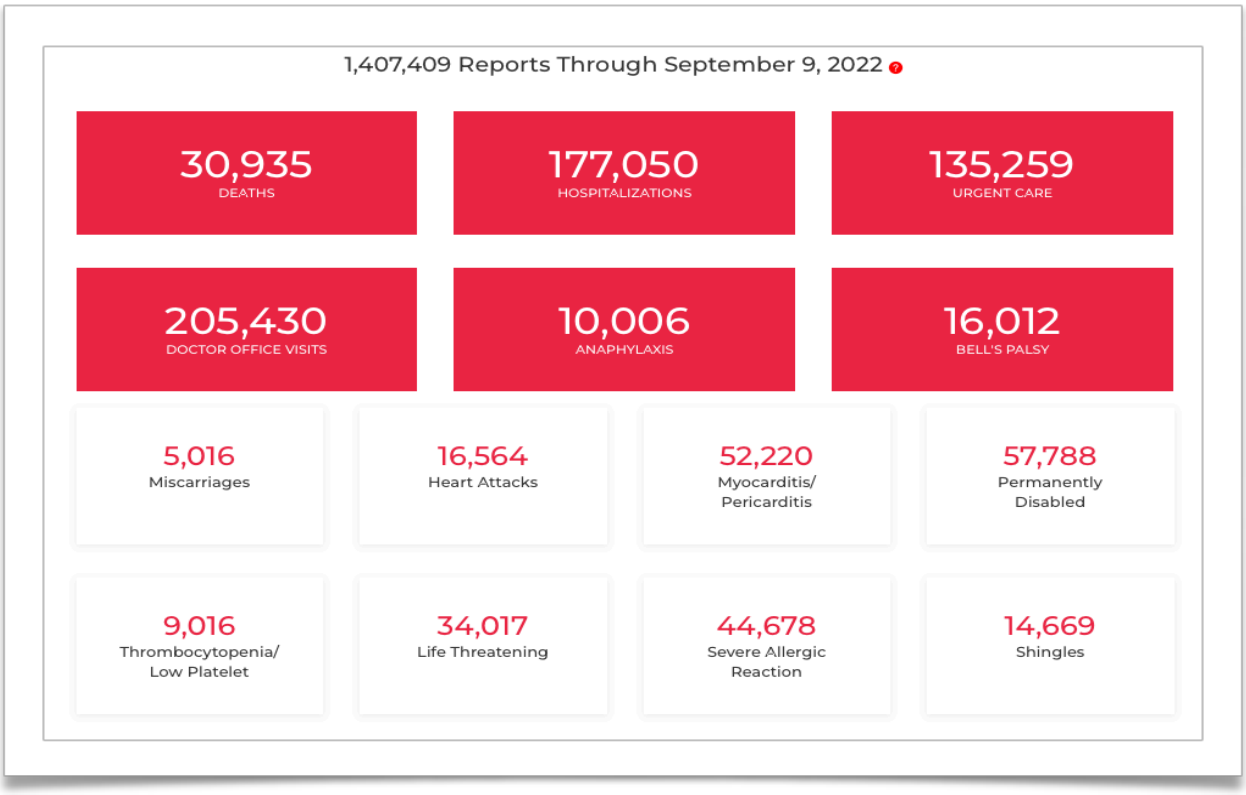
Scientific Integrity in Public Policy

[9] http://www.orthomolecular.org/resources/omns/v18n19.shtml

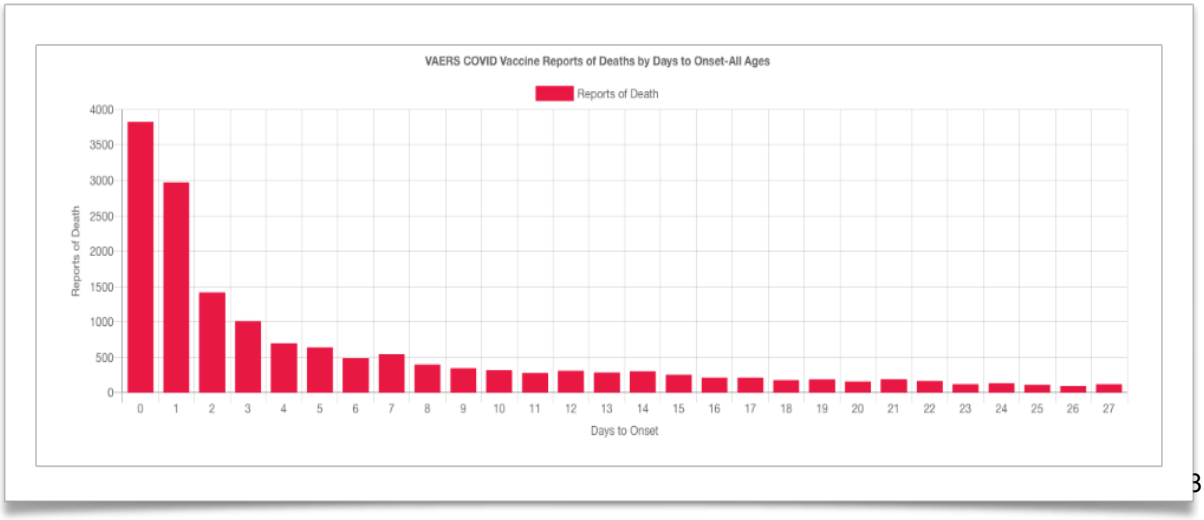
Resources & References

Federal Vaccine Adverse Event Reporting System (VAERS): https://vaers.hhs.gov

Easy-to-Use VAERS Data & Search: OpenVaers https://openvaers.com/covid-data



Note the majority of deaths reported are within a few days of injection, showing temporal association, inferring a causal or contributory relationship.



More in-depth data and search: Medalerts https://www.medalerts.org/index.php

VAERS suffers from extreme underreporting. The article *Using CMS Whistleblower Data to Approximate the Under-Reporting Factor for VAERS* examined CMS data and estimated an "**Under-Reporting Factor for VAERS of 44.64. This corresponds to a true reporting rate in VAERS of 2.2% of all adverse events.**" https://vaersanalysis.info/2021/12/13/using-cms-whistleblower-data-to-approximate-the-under-reporting-factor-for-vaers/

Sampling of Websites That List Vaccine Injury Cases

- Real Not Rare https://www.realnotrare.com
- C19VaxReactions https://www.c19vaxreactions.com/
- React19 https://react19.org/stories/
- The Covid19 Humanity Betrayal Memory Project https://formerfedsgroup.org/the-covid19-humanity-betrayal-memory-project
- How Bad Is My Batch https://www.howbadismybatch.com/index.html and https://www.howbadismybatch.com/casereports.html

Roundtables and Conference Presentations

Sen. Ron Johnson COVID-19: A Second Opinion

Full Hearing: https://rumble.com/vt62y6-covid-19-a-second-opinion.html

Highlights: https://youtu.be/9jMONZMuS2U

Collection of Videos from Global Covid Summit https://globalcovidsummit.org

FDA Slide 16 & Table 2: Everything Being Reported to VAERS

informedchoicewa.org/news/fda-slide-16-table-2-everything-being-reported-to-vaers/

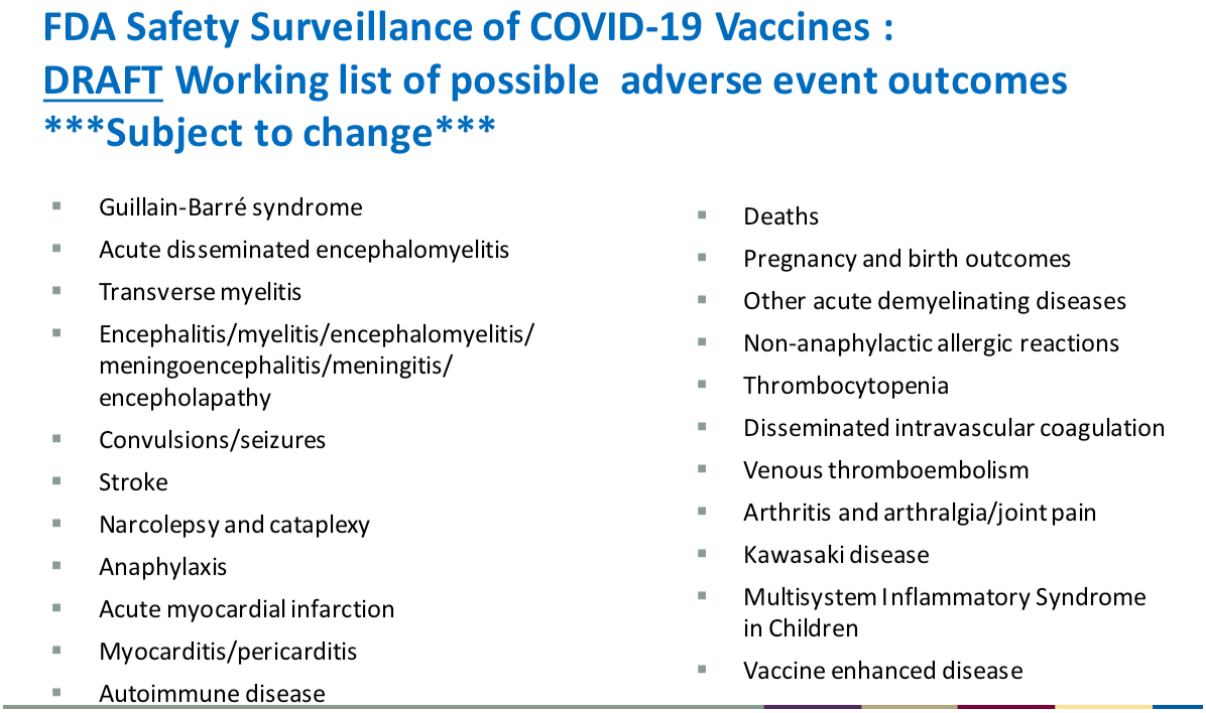
September 20, 2021

*First published **July 2, 2021***

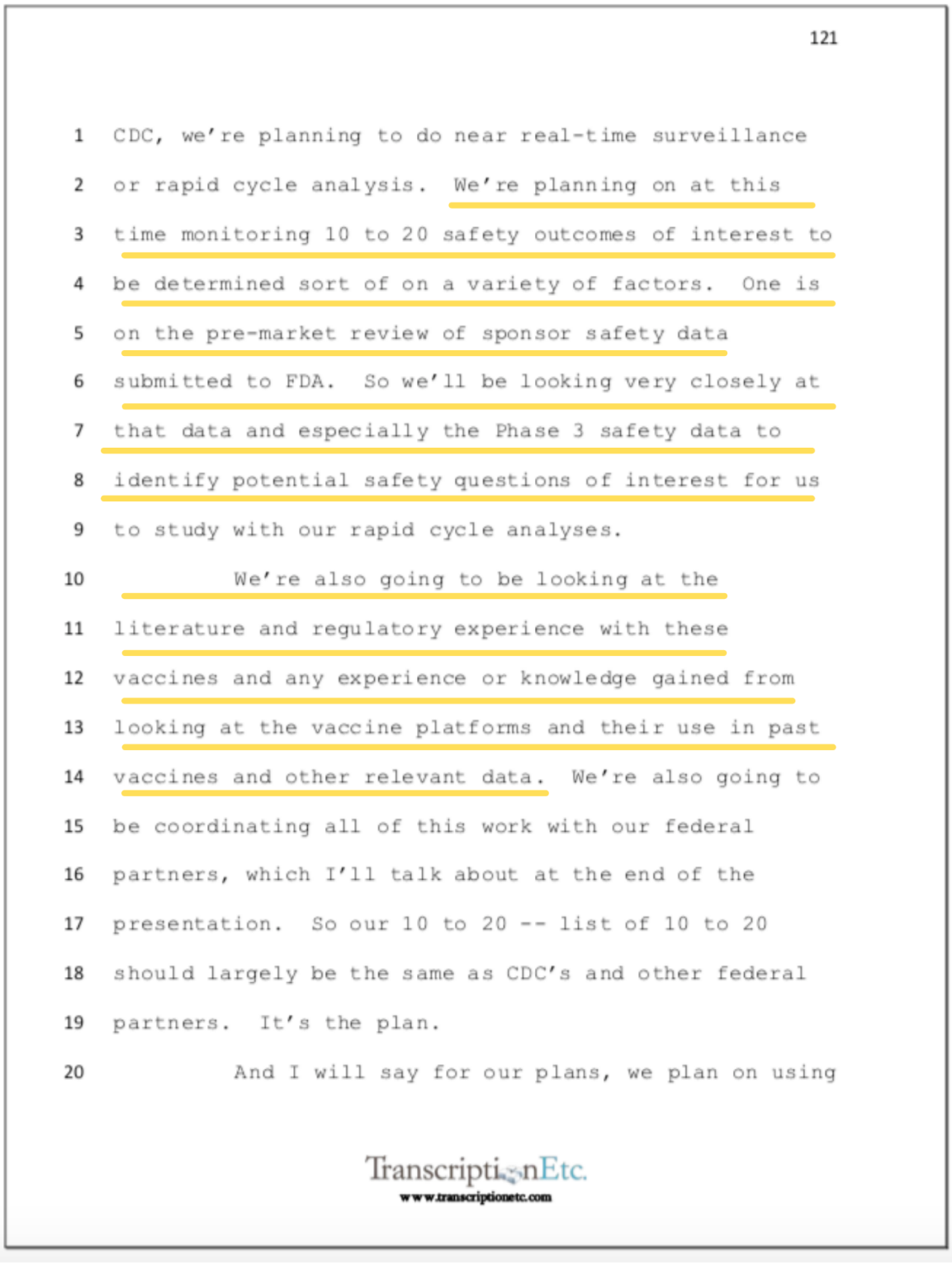
*Post Edited **September 20, 2022** to include updates.*

At the Vaccines and Related Biological Products Advisory Committee (VRBPAC) on October 22, 2020 Meeting, Steve Anderson, PhD, MPP Director, Office of Biostatistics & Epidemiology, Center for Biologics Evaluation and Research (CBER) gave a presentation on CBER "Plans for Monitoring COVID-19 Vaccine Safety and Effectiveness".

His presentation included a slide, below, about COVID-19 vaccine adverse event outcomes (injuries and deaths) which the FDA and CDC would be specifically monitoring. But he did not show the slide to VRBPAC, or the viewing public. He clicked right by it.



These side effect choices were not random. He explained they were based on evidence from the clinical trial data and from known science on the vaccine platform and components. This is from the transcript of the meeting.



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CDC, we're planning to do near real-time surveillance or rapid cycle analysis. We're planning on at this time monitoring 10 to 20 safety outcomes of interest to be determined sort of on a variety of factors. One is on the pre-market review of sponsor safety data submitted to FDA. So we'll be looking very closely at that data and especially the Phase 3 safety data to identify potential safety questions of interest for us to study with our rapid cycle analyses.

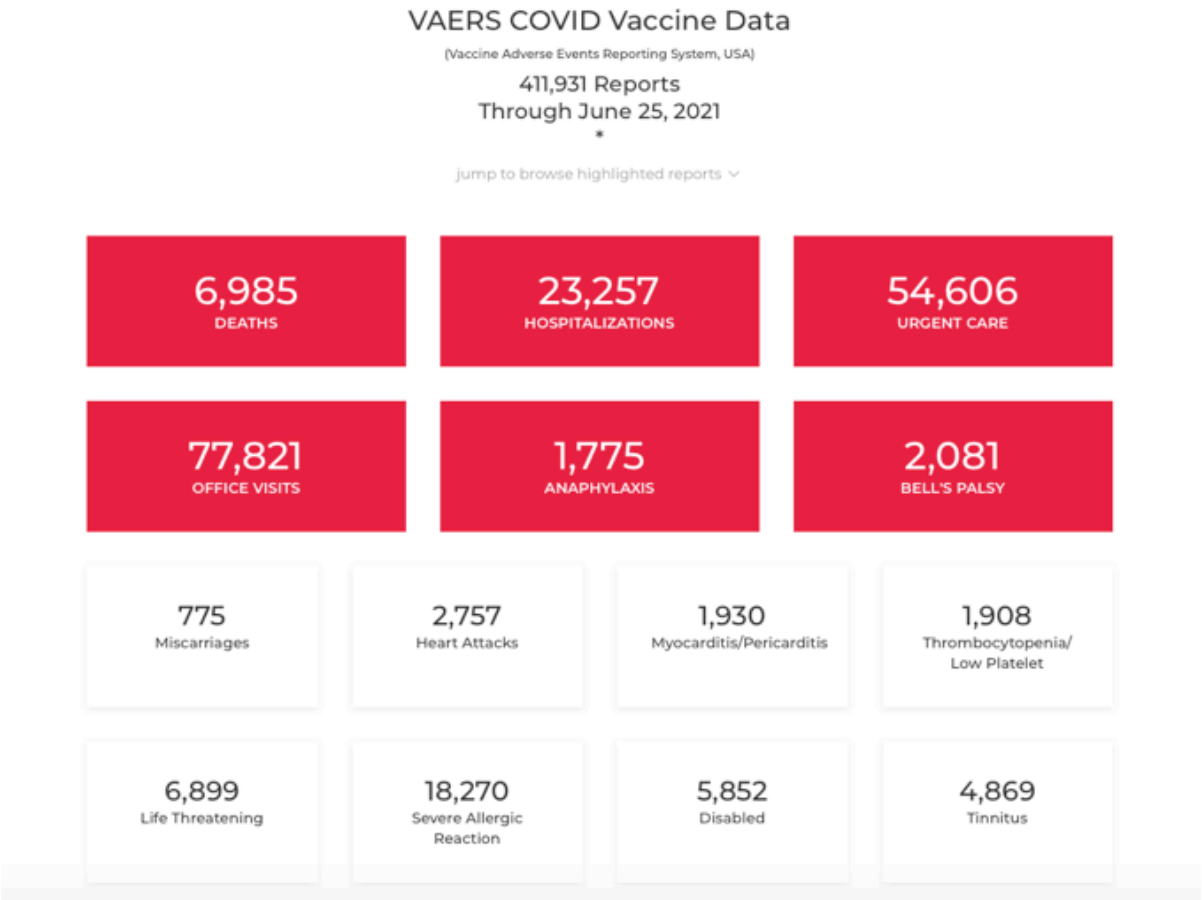
We're also going to be looking at the literature and regulatory experience with these vaccines and any experience or knowledge gained from looking at the vaccine platforms and their use in past vaccines and other relevant data. We're also going to be coordinating all of this work with our federal partners, which I'll talk about at the end of the presentation. So our 10 to 20 -- list of 10 to 20 should largely be the same as CDC's and other federal partners. It's the plan.

And I will say for our plans, we plan on using

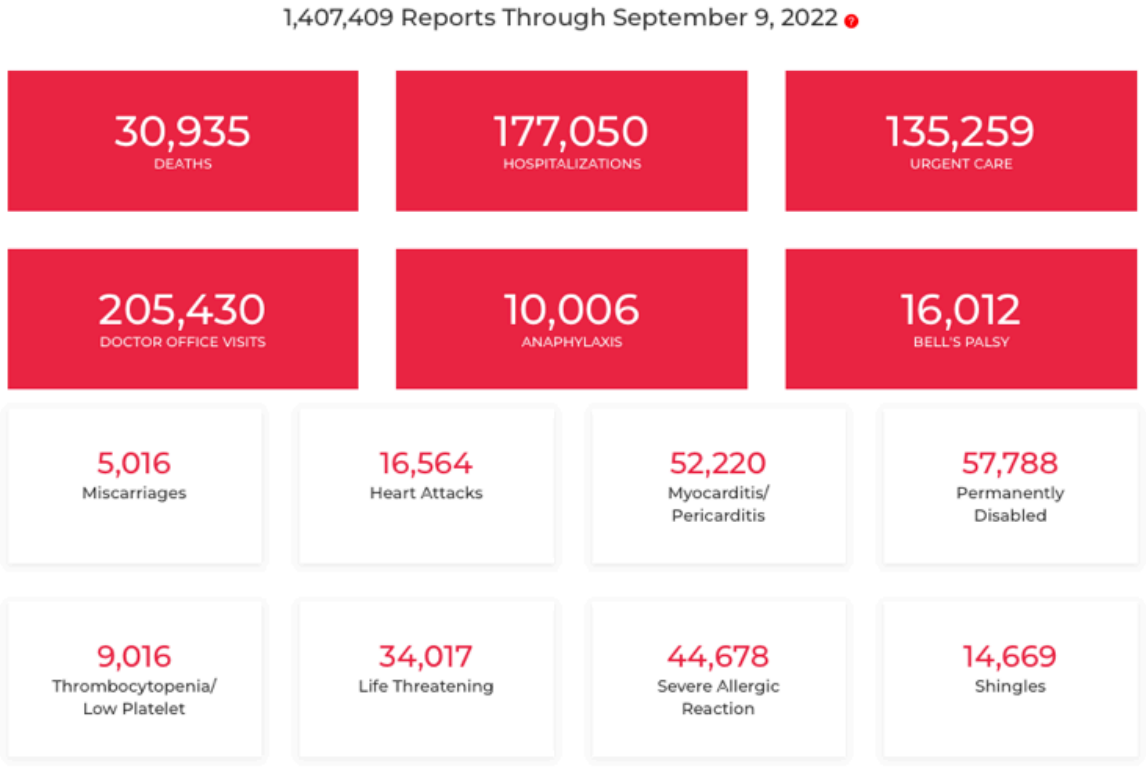
TranscriptionEtc.
www.transcriptionetc.com

Anderson stated in the above transcript that "we'll be looking very closely at that data and especially the Phase 3 safety tads to identify potential safety questions . . ." However, since he made that statement, the FDA has allowed all of the COVID-19 vaccine makers to unblind their trials and offer shots to the control group, effectively ending the Phase 3 trials.

These vaccine adverse event outcomes are being reported to VAERS in unprecedented numbers. Here are the numbers from the date of our post in June 2021.



And here are the numbers as of September 9, 2022



In the 2020 VRBPAC presentation, Anderson says that “Tom” also has information about adverse outcomes. By “Tom” he means Tom Shimabukuro of the CDC, and his presentation started at about 1:59 in the video — before Anderson — but Shimabukuro didn’t talk about the information at all and he also clicked right through two slides without pausing. One was a list of vaccine adverse event outcomes they would be looking for in the passive Vaccine Adverse Event Reporting System (VAERS).

Preliminary list of VAERS AEs of special interest

- COVID-19 disease
- Death
- Vaccination during pregnancy and adverse pregnancy outcomes
- Guillain-Barré syndrome (GBS)
- Other clinically serious neurologic AEs (group AE)
  - Acute disseminated encephalomyelitis (ADEM)
  - Transverse myelitis (TM)
  - Multiple sclerosis (MS)
  - Optic neuritis (ON)
  - Chronic inflammatory demyelinating polyneuropathy (CIDP)
  - Encephalitis
  - Myelitis
  - Encephalomyelitis
  - Meningoencephalitis
  - Meningitis
  - Encephalopathy
  - Ataxia
- Seizures / convulsions
- Stroke
- Narcolepsy / cataplexy
- Autoimmune disease
- Anaphylaxis
- Non-anaphylactic allergic reactions
- Acute myocardial infarction
- Myocarditis / pericarditis
- Thrombocytopenia
- Disseminated intravascular coagulation (DIC)
- Venous thromboembolism (VTE)
- Arthritis and arthralgia (not osteoarthritis or traumatic arthritis)
- Kawasaki disease
- Multisystem Inflammatory Syndrome (MIS-C, MIS-A)

The other was a list of vaccine adverse event outcomes they would be looking for in CDC's Vaccine Safety Datalink System (VSD). The public and most independent researchers have no access to this data for independent review.

Preliminary list of VSD pre-specified outcomes for RCA

- Acute disseminated encephalomyelitis (ADEM)
- Acute myocardial infarction (AMI)
- Anaphylaxis
- Acute respiratory distress syndrome (ARDS)
- Arthritis and arthralgia / joint pain
- Convulsions / seizures
- Disseminated intravascular coagulation (DIC)
- Encephalitis / myelitis / encephalomyelitis / meningoencephalitis / meningitis / encephalopathy (not ADEM or TM)
- Guillain-Barré syndrome (GBS)
- Immune thrombocytopenia (ITP)
- Kawasaki disease (KD)
- Multisystem Inflammatory Syndrome in Children (MIS-C)
- Myocarditis / pericarditis
- Narcolepsy / cataplexy
- Stroke
- Transverse myelitis (TM)
- Venous thromboembolism (VTE)

The FDA has a new system launched in 2017 (a full decade after FDA Amendments Act of 2007 that required them to create an active postmarket risk and analysis system covering at least 100 million persons) called Biologics Effectiveness and Safety (BEST) System. The BEST system is now being used

to try to establish background rates for the COVID-19 vaccine “Adverse Events of Special Interest” that the CDC and FDA will be monitoring with their systems.

Table 2. List of Adverse Events of Special Interest (AESIs)

Safety AESI	Age Group of Interest	Care Setting	Clean Window**
General Population Outcomes			
Guillain-Barré syndrome	All	IP- primary position only	365 days*
Facial nerve palsy	All	IP, OP, PB	183 days*
Anaphylaxis	All	IP, OP, PB	30 days
Encephalomyelitis	All	IP	183 days*
Narcolepsy	All	IP, OP, PB	365 days*
Appendicitis	All	IP, OP-ED	365 days*
Non-hemorrhagic stroke	All	IP	365 days*
Hemorrhagic stroke	All	IP	365 days*
Acute myocardial infarction	All	IP	365 days*
Myocarditis/pericarditis	All	IP, OP, PB	365 days*
Deep vein thrombosis	All	IP, OP, PB	365 days*
Pulmonary embolism#	All	IP, OP, PB	365 days*
Disseminated intravascular coagulation	All	IP, OP-ED	365 days*
Immune thrombocytopenia	All	IP, OP	365 days*
Transverse myelitis	All	IP, OP-ED	365 days*

Given that global data analysis has shown a possible association between seasonal flu vaccination and COVID-19 disease severity, it’s interesting that the BEST study says:

> To estimate incidence rates of AESIs in special populations of interest stratified by calendar year, sex, age group, and race/ethnicity (where reliably available) in each data source over the period 2017–2020. These populations will include:
>
> o Older adults(i.e.,65 years old and abovea tcohort entry)
> o Pediatric population(i.e.,0–17 years old at cohort entry)
> o Pregnant women
> o **Individuals who received a seasonal influenza vaccine in the previous calendar year**

During this COVID-19 crisis, both the FDA and CDC have made decisions that have not been in the best interest of the population or individuals. They have approved investigational products without sufficient safety or efficacy data, and they have actively censored or ignored existing treatments and natural immunity. They are actively partnering with the COVID-19 vaccine makers.

There are two important aspects of establishing whether reported adverse events are related to receipt of a vaccine. One is epidemiological. The rates of certain health issues in the general population are compared to the rates in people getting vaccinated. That's what the FDA's BEST study is about. Obviously, this information alone cannot rule causation in or out. Biological studies are also needed. Can the product cause the outcome seen? Ever since the 1986 National Childhood Vaccine Injury Act passed, removing liability from vaccine makers for injury or death for products recommended to children and pregnant women, the CDC has been in charge of vaccine safety and utterly failed in their duties. Biological studies are almost non-existent. The CDC prefers to use weaker epidemiological studies that are easily manipulated to desired outcome, to try to claim reported events are not associated.

Will they do the same for the COVID-19 vaccines? If so, will they get away with it? Since we first wrote that question, it has been answered. Yes, the federal oversight agencies are using contrived epidemiological studies, avoiding biological studies of their own while ignoring very concerning independent studies that are revealing the mechanisms of action that lead to harm. To find the latest, search Pubmed using keyword "COVID-19 vaccine" and an injury reported to VAERS, such as myocarditis, tinnitus, Guillain-Barre syndrome, Bell's Palsy, etc.

Fortunately during COVID, researchers around the world have been awakened to the capture and corruption of public health agencies and they are beginning to do their own, independent studies. They are starting their own journals that have no ties to governments or the drug industry. A revolution is beginning within the ranks of doctors and scientists who believe in honest and ethical science and medicine.

Post References:

Tom Shimabukuro's slides: https://www.fda.gov/media/143530/download

Steve Anderson's slides: https://www.fda.gov/media/143557/download

Video of the meeting: https://youtu.be/1XTiL9rUpkg

Meeting transcript: https://www.fda.gov/media/143982/download

FDA page with links to all materials: https://www.fda.gov/advisory-committees/advisory-committee-calendar/vaccines-and-related-biological-products-advisory-committee-october-22-2020-meeting-announcement#event-materials

BEST Background Rate study: https://www.bestinitiative.org/wp-content/uploads/2021/01/C19-Vaccine-Safety-AESI-Background-Rate-Protocol-2020.pdf