

Public Health Testimony

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February 8th, 2022

Dear Legislatures and Senators,

Thank you for providing a forum for the citizens of Connecticut and health care providers to speak out about the unending emergency mandates issued by the governor and supported by the Democratic leadership that have been imposed in the name of science and public health safety. My name is Linda Dalessio, and I am a board-certified acute care nurse practitioner and an associate professor of Nursing who teaches advanced pharmacology and other studies in Nurse Practitioner Programs. I am providing testimony based on my research and experiences and do not represent the views of the college I work for or the hospital system I am employed by. I have worked in medicine for 30+ years, specifically in critical care and have a second master's degree in Forensic Nursing. I respectfully provide the following statements with corresponding research and evidence to support the suspension of all Governor Lamont's overreaching executive mandates and **ask for an investigation by this body on why early treatments for SARS CoV2 as outlined in the following Senator Ron Johnson's presentation "A Second Opinion" was not used in Connecticut.**

<https://rumble.com/vt62y6-covid-19-a-second-opinion.html>

1. Surgical/cloth masks do not work to prevent the spread of Sars CoV2. That is a scientific fact. N-95 masks may protect the wearer, however, do not protect the general public. N-95 masks need to be fit tested, to be effective and should only be used in populations that are at high risk, or work with patients that are actively infected and hospitalized with Sars CoV2. Attached is an excellent article that provides a **Meta-Analysis** on face mask studies:

- a. <https://brownstone.org/articles/more-than-150-comparative-studies-and-articles-on-mask-ineffectiveness-and-harms/>

2. Lockdowns, quarantines, mRNA inoculations, contact tracing, and masking are not effective public health policies. Inoculations using mRNA technology are leaky and are driving new variants in healthy people. I am an educator/researcher and health care professional that has actively treated and cared for SARS CoV2 patients in this pandemic since February 2020. I have no fear of this virus and this pandemic ended in June of 2020. We have a pandemic of RT-PCR fraud and testing. **Case rates in asymptomatic patients does not equate to severe illness or hospitalization.** By not knowing the **cycle thresholds involved in the PCR testing or the symptoms of the patient** this test is meaningless. This is misleading and deceptive.

- a. Cochrane database on PCR limitations in testing.
<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013787/full>
- b. This is a well-sourced article explaining in plain English deficiencies in PCR testing and their limitations. <https://uncoverdc.com/2020/04/07/was-the-covid-19-test-meant-to-detect-a-virus/>

3. By continuing with government overreach through mandates, you are harming the citizens of Connecticut, politicizing medicine and public health, and violating all Connecticut citizens Constitutional rights. The medical profession has become more educated through unbiased research on this virus and can safely use effective

outpatient early treatment. That is, if we are “allowed” to without threat to our licenses. We need to end the fear, threats and coercion that have silenced scientific debate by our governing bodies and has threatened and labeled actual science as “misinformation”. <https://sites.krieger.jhu.edu/iae/files/2022/01/A-Literature-Review-and-Meta-Analysis-of-the-Effects-of-Lockdowns-on-COVID-19-Mortality.pdf> **The inoculations containing mRNA technology that used fetal cell lines for development do not prevent the spread or protect against Sars CoV2 viral disease. This is not a vaccine; it should be classified as a therapeutic.** The research is still developing on if mRNA Covid 19 inoculations prevent severe disease. This is due to emerging research on antibody dependent enhancement (ADE), that occurred in the original vaccines developed in animal studies for the original SARS CoV virus in late 2000: <https://pubmed.ncbi.nlm.nih.gov/22536382/>. Vaccines and boosters should never be mandated until research on safety and efficacy is completed. This is blatantly illegal and violates the Federal Food, Drug, and Cosmetic Act that states individuals to whom EUA products are administered must be informed— (I) that the Secretary has authorized the emergency use of the product; (II) of the significant known and potential benefits and risks of such use, and of the extent to which such benefits and risks are unknown; and (III) of the option to accept or refuse administration of the product, of the consequences, if any, of refusing administration of the product, and of the alternatives to the product that are available and of their benefits and risks. Title 21 U.S.C. § 360bbb-3(e)(1)(A)(ii)(I-III). Mandating vaccination also violates Title VII of the Civil Rights Act, the Emergency Use Authorization Act, the First Amendment to the United States Constitution, and other federal and state laws.

4. The reason for masks/vaccines/contact tracing/quarantines in the public and our schools is tied to the Federal American Rescue Plan (ARP) and Elementary and Secondary School Relief Funding (ESSER). This also involves the PREP Act, and the recent CT legislation for removal of religious exemptions for vaccines in children and allows further liability protection of pharmaceutical companies in vaccine development and testing, extending to the entire adult population.

A. <https://aspr.hhs.gov/legal/PREPA/Default.aspx>.

On page 19 of the ESSER funding the following statement is present “**your state commits to universal masking, social distancing, quarantines, isolation, contact tracing, testing, and vaccinations**” This current overreach of government, especially the Department of Education Commissioner, and Boards of Education does not support health and safety in our schools, but supports funding and money at the cost of **adverse vaccine injuries and deaths such as myocarditis, clotting in young adults, unknown fertility risks, spontaneous abortions, mental health and anxiety and the loss of education in our communities and children.** This is due to unscientific contact tracing and quarantines based on faulty EUA PCR testing of asymptomatic students. **There is no science in your science.**

b. <https://oese.ed.gov/files/2021/08/Connecticut-ARP-ESSER-State-Plan-Final-REDACTED.pdf>

Science in pharmaceuticals and vaccines development is based on efficacy, safety, benefit, risk, retrospective analysis of adverse events/deaths and cost. These mRNA inoculations should be labeled as therapeutics and have failed on all these measures based on VAERS data and Pfizer’s own 2.5-month post vaccination results which show that these are not safe

nor effective. To put VAERS data in perspective, health care providers are not educated on the mandatory reporting for VAERS. Many studies related to VAERS data have estimated an underreporting factor of 20 to 1. That means that for every 20 cases seen only 1 is reported. This study from Lazarus describes the CDC's known failures in the VAERS system using EHR data and the risk of underreporting. **How can medical providers report vaccine injury or death if there is no training or expectation/requirement that we need to report this? My major concern that should be addressed to the DPH is where is the analysis of CT data on this EUA mRNA inoculation, listing adverse effects and/or death with safety and efficacy data?**

<https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf>.

In health care, since mRNA vaccines started in Connecticut, I have seen unprecedented amounts of strokes, myocardial infarctions, cardiac arrests, myocarditis/pericarditis, blood clotting disorders (DVT and pulmonary emboli) progression of cancers, renal failure and decompensated diabetes since April 2021. This has caused the health care system to be over-burdened along with the firing of employees that refuse to take EUA mRNA inoculations. We are NOT overburdened with Covid 19. The health care bonuses to recruit and retain staff due to staff shortages is enormous. **The legislature needs to investigate pre and post vaccine data on the prevalence and incidence of these medical disorders prior to the governor mandating vaccination in businesses, colleges, and the health sector both pre and post vaccination. Only then can we see if there is a causal link.**

- a. **Pfizer mRNA vaccine 2.5-month post marketing data**
<https://phmpt.org/wp-content/uploads/2021/11/5.3.6-postmarketing-experience.pdf>
- b. **Open VAERS Data-** <https://openvaers.com/covid-data>
- c. **Evidence of Cardiovascular Disease**
<https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000001051>
- d. **Full article on mRNA development in animal studies**
<https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0035421>
- e. **Evidence of P53 genetic damage that may lead to cancers**
<https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC7324311/>
- f. **British Medical Journal Whistleblower report**
<https://www.bmj.com/content/bmj/375/bmj.n2635.full.pdf>
- g. **Myocarditis cases after Covid 19 vaccination.**
<https://jamanetwork.com/journals/jama/fullarticle/2788346>

5. Misleading guidance from the FDA and CDC on Hydroxychloroquine use or other repurposed drugs. The heading of the article does not match the body of the paper and is factually untrue. Note: "to treat hospitalized patients with COVID-19".

- a. <https://www.fda.gov/drugs/drug-safety-and-availability/fda-cautions-against-use-hydroxychloroquine-or-chloroquine-covid-19-outside-hospital-setting-or>

This does not discuss early treatment for Covid 19 in outpatient settings. Having used hydroxychloroquine in many patients with coexisting cardiac disease, this medication is safe and effective and clinically does not cause heart rhythm issues. Having treated by own SARS CoV2 infection with ivermectin, azithromycin, **steroids at appropriate doses** and

inhaled budesonide (Stoic and principal trials), this treatment works to prevent hospitalization and severe outcome sequelae of untreated viral load that advances to the inflammatory stages of SARS CoV2. This inflammatory stage causes severe irreversible interstitial lung disease. The current CDC/FDA guidance is faulty on the use of Remdesivir. Remdesivir has some effect on viral load, so should be given early in SARS CoV2 infection, however Ivermectin and Hydroxychloroquine has a much better safety profile than this drug, at significantly lower cost and can be given by mouth. In critical care we have not seen this drug to be effective in the inflammatory phase of SARS CoV2. Where are the studies that it is effective?

- a. **Meta-analysis on early treatment with repurposed drugs. There are many repurposed drugs that have shown amazing efficacy against SARS CoV2 virus in early treatment to prevent hospitalization and severe life altering lung disease.**
<https://covid19criticalcare.com/wp-content/uploads/2021/08/SUMMARY-OF-THE-EVIDENCE-BASE-FINAL.pdf>
- b. **Statistical database of meta-analysis of repurposed drugs for SARS CoV2**
<https://ivmmeta.com/>
- c. **Meta-analysis involving 223,128 subjects using Ivermectin prophylactically in Itajaí, Brazil for prevention of SARS CoV2.**
<https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8765582/>

There is a fundamental truth of public health policy that early prevention strategies and treatment should be the cornerstone in epidemiology and disease outbreaks. **This administration has failed dismally in providing early treatment of SARS CoV2 and mitigating harm in the public.** As a health care provider that tried to use repurposed drugs such as Hydroxychloroquine or Ivermectin in my patients, I was told by the pharmacies; that are only charged with dispensing, not prescribing, that these drugs were not approved by the CDC and FDA **or were not available in Connecticut for dispensing for SARS CoV2 treatment. When in medicine have prescribers been restricted by pharmacies or the government to prescribe off-label drugs for ANY disease? Since when have we told patients to go home and quarantine until they can't breathe, then come to the hospital?**

6. **Why are we not recognizing natural immunity to SARS CoV2? In all the history of public health and epidemiology, natural immunity has always been recognized as effective immunity in disease.** This is a well sourced article with a meta-analysis for natural immunity against SARS CoV2:
 - a. <https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/> P
Presentation roundtable by Dr Harvey Risch (epidemiologist from Yale University), facilitated by Rep. Kimberly Fiorello on 1/30/2022.
 - b. https://us02web.zoom.us/rec/play/Fn9sYzfsR8pEu584KTQZuvR-6SLF1EfroMh3d5knOyGIGbaCA_Ihjm-noUkcxltnofhvebli2AcdxOqf.vbG_F7p1trfa9vDk?continueMode=true&xzm_rtaid=TMNenblURQSEs8Byi9D9VA.1644021735744.68e4cadcf33dca938b816dd634bdf9&xzm_rtaid=538

Thank-you for your time,
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