Exhibit 378

There Was No Pandemic

Denis G. Rancourt, PhD

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There Was No Pandemic

By Denis G. Rancourt, PhD

June 22, 2023

https://denisrancourt.ca/entries.php?id=130

This is radical.

The essay is based on my May 17, 2023 testimony for the National Citizens Inquiry (NCI) in Ottawa, Canada, my 894-page book of exhibits in support of that testimony, and our continued research.

I am an accomplished interdisciplinary scientist and physicist, and a former tenured Full Professor of physics and lead scientist, originally at the University of Ottawa.

I have written over 30 scientific reports relevant to COVID, starting April 18, 2020 for the Ontario Civil Liberties Association (ocla.ca/covid), and recently for a new non-profit corporation (correlation-canada.org/research). Presently, all my work and interviews about COVID are documented on my website created to circumvent the barrage of censorship (denisrancourt.ca).

In addition to critical reviews of published science, the main data that my collaborators and I analyse is all-cause mortality.

All-cause mortality by time (day, week, month, year, period), by jurisdiction (country, state, province, county), and by individual characteristics of the deceased (age, sex, race, living accomodations) is the most reliable data for detecting and epidemiologically characterizing events causing death, and for gauging the population-level impact of any surge or collapse in deaths from any cause.

Such data is not susceptible to reporting bias or to any bias in attributing causes of death. We have used it to detect and characterize seasonality, heat waves, earthquakes, economic collapses, wars, population aging, long-term societal development, and societal assaults such as those occurring in the COVID period, in many countries around the world, and over recent history, 1900-present.

Interestingly, none of the post-second-world-war Centers-for-Disease-Control-and-Prevention-promoted (CDC-promoted) viral respiratory disease pandemics (1957-58, “H2N2”; 1968, “H3N2”; 2009, “H1N1 again”) can be detected in the all-cause mortality of any country. Unlike

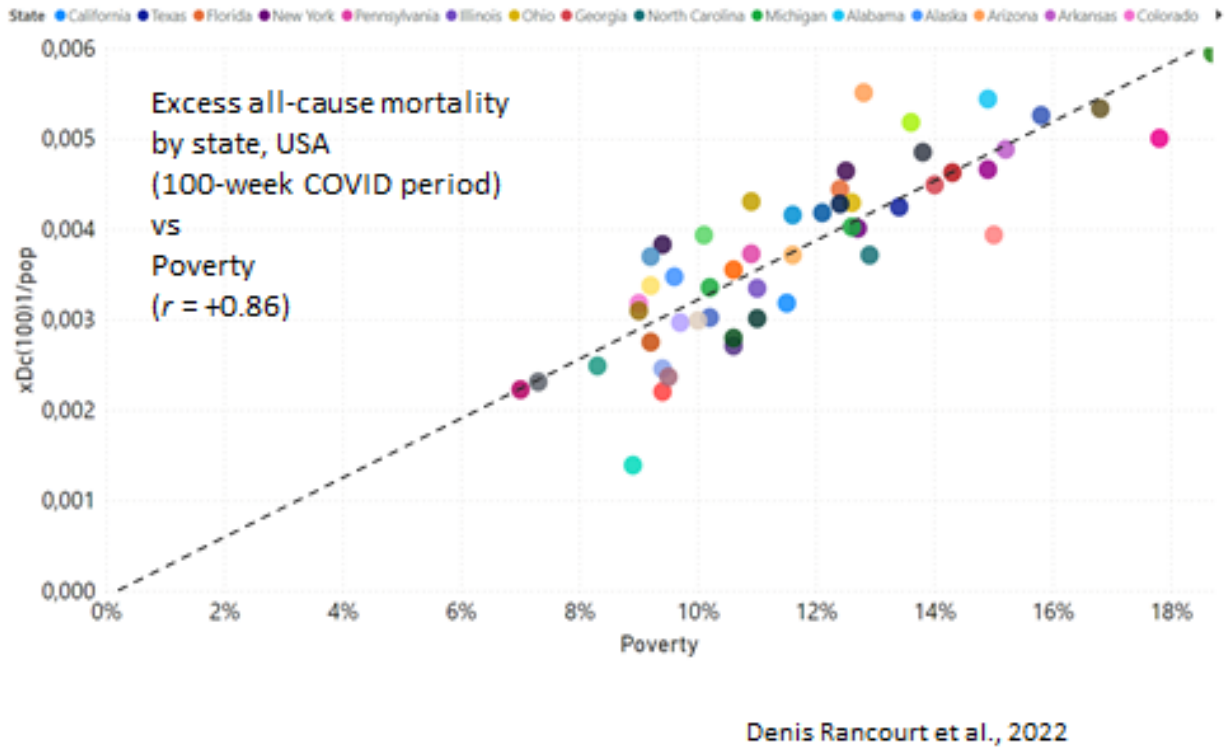
all the other causes of death that are known to affect mortality, these so-called pandemics did not cause any detectable increase in mortality, anywhere.

The large 1918 mortality event, which was recruited to be a textbook viral respiratory disease pandemic ("H1N1"), occurred prior to the inventions of antibiotics and the electron microscope, under horrific post-war public-sanitation and economic-stress conditions. The 1918 deaths have been proven by histopathology of preserved lung tissue to have been caused by bacterial pneumonia. This is shown in several independent and non-contested published studies.

My first report analysing all-cause mortality was published on June 2, 2020, at censorship-prone Research Gate, and was entitled "All-cause mortality during COVID-19 - No plague and a likely signature of mass homicide by government response". It showed that hot spots of sudden surges in all-cause mortality occurred only in specific locations in the Northern-hemisphere Western World, which were synchronous with the March 11, 2020 declaration of a pandemic. Such synchronicity is impossible within the presumed framework of a spreading viral respiratory disease, with or without airplanes, because the calculated time from seeding to mortality surge is highly dependent on local societal circumstances, by several months to years. I attributed the excess deaths to aggressive measures and hospital treatment protocols known to have been applied suddenly at that time in those localities.

The work was pursued in greater depth with collaborators for several years and continues. We have shown repeatedly that excess mortality most often refused to cross national borders and inter-state lines. The invisible virus targets the poor and disabled and carries a passport. It also never kills until governments impose socio-economic and care-structure transformations on vulnerable groups within the domestic population.

(Figure on next page)



Here are my conclusions, from our detailed studies of all-cause mortality in the COVID period, in combination with socio-economic and vaccine-rollout data:

1. If there had been no pandemic propaganda or coercion, and governments and the medical establishment had simply gone on with business as usual, then there would not have been any excess mortality

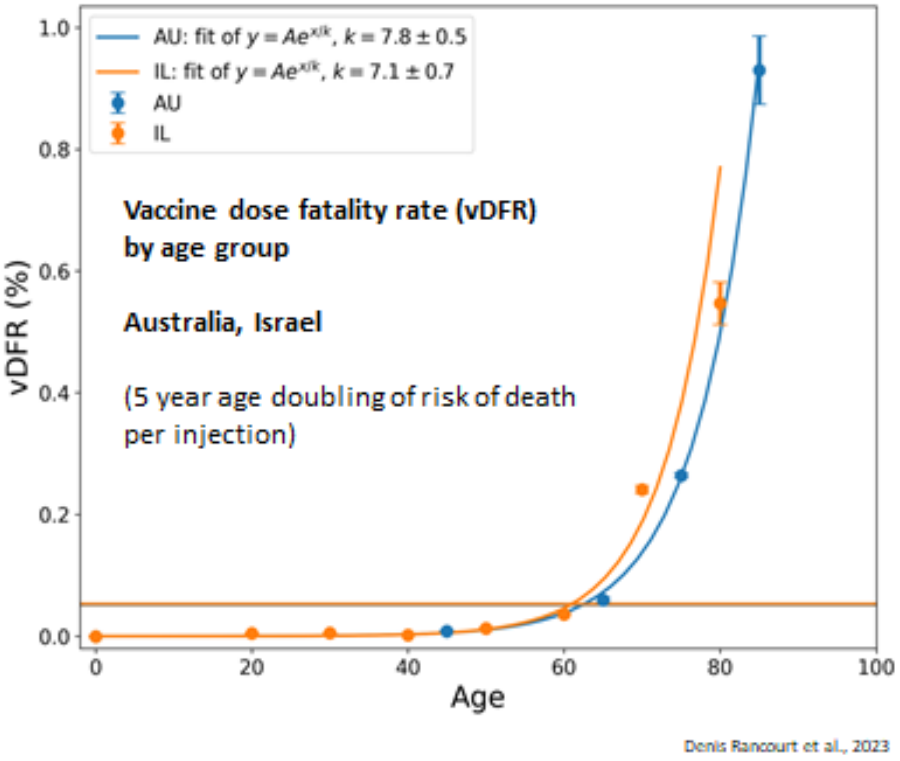
2. There was no pandemic causing excess mortality

3. Measures caused excess mortality

4. COVID-19 vaccination caused excess mortality

Regarding the vaccines, we quantified many instances in which a rapid rollout of a dose in the imposed vaccine schedule was synchronous with an otherwise unexpected peak in all-cause mortality, at times in the seasonal cycle and of magnitudes that have not previously been seen in the historic record of mortality.

In this way, we showed that the vaccination campaign in India caused the deaths of 3.7 million fragile residents. In Western countries, we quantified the average all-ages rate of death to be 1 death for every 2000 injections, to increase exponentially with age (doubling every additional 5 years of age), and to be as large as 1 death for every 100 injections for those 80 years and older. We estimated that the vaccines had killed 13 million worldwide.



If one accepts my above-numbered conclusions, and the analyses that we have performed, then there are several implications about how one perceives reality regarding what actually did and did not occur.

First, whereas epidemics of fatal infections are very real in care homes, in hospitals, and with degenerate living conditions, the viral respiratory pandemic risk promoted by the USA-led "pandemic response" industry is not a thing. It is most likely fabricated and maintained for ulterior motives, other than saving humanity.

Second, in addition to natural events (heat waves, earthquakes, extended large-scale droughts), significant events that negatively affect mortality are large assaults against domestic populations, affecting vulnerable residents, such as:

- sudden devastating economic deterioration (the Great Depression, the dust bowl, the dissolution of the Soviet Union),

- war (including social-class restructuring),
- imperial or economic occupation and exploitation (including large-scale exploitative land use), and
- the well-documented measures and destruction applied during the COVID period.

Otherwise, in a stable society, mortality is extremely robust and is not subject to large rapid changes. There is no empirical evidence that large changes in mortality can be induced by sudden appearances of new pathogens. In the contemporary era of the dominant human species, humanity is its worst enemy, not nature.

Third, coercive measures imposed to reduce the risk of transmission (such as distancing, direction arrows, lockdown, isolation, quarantine, Plexiglas barriers, face shields and face masks, elbow bumps, etc.) are palpably unscientific; and the underlying concern itself regarding "spread" was not ever warranted and is irrational, since there is no evidence in reliable mortality data that there ever was a particularly virulent pathogen.

In fact, the very notion of "spread" during the COVID period is rigorously disproved by the temporal and spatial variations of excess all-cause mortality, everywhere that it is sufficiently quantified, worldwide. For example, the presumed virus that killed 1.3 million poor and disabled residents of the USA did not cross the more-than-thousand-kilometer land border with Canada, despite continuous and intense economic exchanges. Likewise, the presumed virus that caused synchronous mortality hotspots in March-April-May 2020 (such as in New York, Madrid region, London, Stockholm, and northern Italy) did not spread beyond those hotspots.

Interestingly, in this regard, the historical seasonal variations (12 month period) in all-cause mortality, known for more than 100 years, are inverted in the northern and southern global hemispheres, and show no evidence of "spread" whatsoever. Instead, these patterns, in a given hemisphere, show synchronous increases and decreases of mortality across the entire hemisphere. Would the "spreading" causal agent(s) always take exactly 6 months to cross into the other hemisphere, where it again causes mortality changes that are synchronous across the hemisphere? Many epidemiologists have long-ago concluded that person-to-person "contact" spreading of respiratory diseases cannot explain and is disproved by the seasonal patterns of all-cause mortality. Why the CDC *et al.* are not systematically ridiculed in this regard is beyond this scientist's comprehension.

Instead, outside of extremely poor living conditions, we should look to the body of work produced by Professor Sheldon Cohen and co-authors (USA) who established that two dominant factors control whether intentionally challenged college students become infected and the severity of the respiratory illness when they are infected:

- degree of experienced psychological stress
- degree of social isolation

The negative impact of experienced psychological stress on the immune system is a large current and established area of scientific study, dutifully ignored by vaccine interests, and we now know that the said impact is dramatically larger in elderly individuals, where nutrition (gut biome ecology) is an important co-factor.

Of course, I do not mean that causal agents do not exist, such as bacteria, which can cause pneumonia; nor that there are not dangerous environmental concentrations of such causal agents in proximity to fragile individuals, such as in hospitals and on clinicians' hands, notoriously.

Fourth, since our conclusion is that there is no evidence that there was any particularly virulent pathogen causing excess mortality, the debate about gain-of-function research and an escaped bioweapon is irrelevant.

I do not mean that the Department of Defence (DoD) does not fund gain-of-function and bioweapon research (abroad, in particular), I do not mean that there are not many US patents for genetically modified microbial organisms having potential military applications, and I do not mean that there have not previously been impactful escapes or releases of bioweapon vectors and pathogens. For example, the Lyme disease controversy in the USA may be an example of a bioweapon leak (see Kris Newby's 2019 book "Bitten: The Secret History of Lyme Disease and Biological Weapons").

Generally, for obvious reasons, any pathogen that is extremely virulent will not also be extremely contagious. There are billions of years of cumulative evolutionary pressures against the existence of any such pathogen, and that result will be deeply encoded into all lifeforms.

Furthermore, it would be suicidal for any regime to vehemently seek to create such a pathogen. Bioweapons are intended to be delivered to specific target areas, except in the science fiction wherein immunity from a bioweapon that is both extremely virulent and extremely contagious can be reliably delivered to one's own population and soldiers.

In my view, if anything COVID is close to being a bioweapon, it is the military capacity to massively, and repeatedly, rollout individual injections, which are physical vectors for whichever substances the regime wishes to selectively inject into chosen populations, while imposing complete compliance down to one's own body, under the cover of protecting public health.

This is the same regime that practices wars of complete nation destruction and societal annihilation, under the cover of spreading democracy and women's rights. And I do not mean China.

Fifth, again, since our conclusion is that there is no evidence that there was any particularly virulent pathogen causing excess mortality, there was no need for any special treatment

protocols, beyond the usual thoughtful, case-by-case, diagnostics followed by the clinician's chosen best approach.

Instead, vicious new protocols killed patients in hotspots that applied those protocols in the first months of the declared pandemic.

This was followed in many states by imposed coercive societal measures, which were contrary to individual health: fear, panic, paranoia, induced psychological stress, social isolation, self-victimization, loss of work and volunteer activity, loss of social status, loss of employment, business bankruptcy, loss of usefulness, loss of caretakers, loss of venues and mobility, suppression of freedom of expression, etc.

Only the professional class did better, comfortably working from home, close to family, while being catered to by an army of specialised home-delivery services.

Unfortunately, the medical establishment did not limit itself to assaulting and isolating vulnerable patients in hospitals and care facilities. It also systematically withdrew normal care, and attacked physicians who refused to do so.

In virtually the entire Western World, antibiotic prescriptions were cut and maintained low by approximately 50% of the pre-COVID rates. This would have had devastating effects in the USA, in particular, where:

- the CDC's own statistics, based on death certificates, has approximately 50% of the million or so deaths associated with COVID having bacterial pneumonia as a listed comorbidity (there was a massive epidemic of bacterial pneumonia in the USA, which no one talked about)
- the Southern poor states historically have much higher antibiotic prescription rates (this implies high susceptibility to bacterial pneumonia)
- excess mortality during the COVID period is very strongly correlated (r = +0.86) — in fact proportional to — state-wise poverty

Sixth, since our conclusion is that there is no evidence that there was any particularly virulent pathogen causing excess mortality, there was no public-health reason to develop and deploy vaccines; not even if one accepted the tenuous proposition that any vaccine has ever been effective against a presumed viral respiratory disease.

Add to this that all vaccines are intrinsically dangerous and our above-described vaccine-dose fatality rate quantifications, and we must recognize that the vaccines contributed significantly to excess mortality everywhere that they were imposed.

In conclusion, the excess mortality was not caused by any particularly virulent new pathogen. COVID so-called response in-effect was a massive multi-pronged state and iatrogenic attack

against populations, and against societal support structures, which caused all the excess mortality, in every jurisdiction.

It is only natural now to ask “what drove this?”, “who benefited?” and “which groups sustained permanent structural disadvantages?”

In my view, the COVID assault can only be understood in the symbiotic contexts of geopolitics and large-scale social-class transformations. Dominance and exploitation are the drivers. The failing USA-centered global hegemony and its machinations create dangerous conditions for virtually everyone.

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