

I, like most folk, believe that the truth is powerful and that it will in time overcome all imposters. When my grandson became ill following MMR vaccination in 1998, and he began a long process of deterioration that was followed over a year later with the diagnosis of autism I immediately began campaigning for the simple recognition that the injection of multiple live virus vaccines directly into the bloodstream of children was damaging a susceptible sub-set of these same children. Also, importantly, by recognising the cause of the damage we would be better equipped and informed in how to treat the kids and alleviate their pain and misery. Perhaps even reverse the damage. Naively I did not appreciate how influential the interest groups involved in the issue of vaccine damage were: The governments who defend existing policy as if it were a religious creed; the pharmaceutical giants who believe in profit (greed) above all else; the health professionals who are driven by a collective fear of being exposed, both as charlatans and as a self interested, self engrossed cabal.

Ten years later, having made little progress, I have decided it is time to challenge these authoritarian groups by using a very different strategy: By engaging with their own professional bodies and internal democratic structures in order to question the ethics and principles of current vaccination policy. This complaint to the General Medical Council is hopefully the first of many such initiatives.

Bill Welsh

President

Autism Treatment Trust

Edinburgh.

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1.

**Formal complaint against Professor David M Salisbury  
Director of Immunisation, Department of Health (and others).  
On fitness to practice and professional conduct matters.**

This complaint will list a catalogue of decisions and actions taken over many years by Dr David M Salisbury, Director of Immunisation, Department of Health; decisions that have considerably weakened the effectiveness of the vaccination programme and that may have resulted in damage to thousands of UK children and a subsequent loss of public confidence in this important area of public health.

A list of other senior officials who have supported Dr Salisbury in this public health debacle by their unquestioning support of his decisions and policies is attached. (See **Appendix A**). The complaint is lodged simultaneously against these listed individuals, however for simplicity only Dr Salisbury is named in the body of the following document.

It is not in dispute that vaccines have saved many lives. The MMR/autism parents are not anti-vaccination in principle. These parents, by definition, all took children to be vaccinated. They all recognised the need to protect children from diseases.

But saving lives from diseases doesn't justify ruining significant numbers of lives from unrecognised and unmonitored vaccine damage.

Among the concerns that will be explored:

1. The inexplicable, and unforgivable, failure to react appropriately when it was established in 1998 that autistic children had a novel form of bowel disease/ inflammation.
2. An insistence on an "MMR or nothing" policy in face of the initial, and accumulative, scientific and anecdotal evidence re MMR's lack of safety for a sub-set of children. (See **Appendix B**).
3. A refusal to press for proper investigation, using the most appropriate scientific means of research, of the claims of thousands of parents that the MMR vaccine had damaged children.

## 2.

- 4 The promulgation, in conjunction with the Health Protection Agency, of information relating to MMR vaccine safety that is likely unreliable and potentially misleading in that context. (See **Appendix C**).
- 5 The recommendation that unethical treatments be given to children when there is no clinical need and irrespective of whether the child might be prone to adverse reactions.

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### **MMR.**

The MMR vaccine was introduced in the UK in 1988. Two of the early brands, Pluserix and Immravax, had to be withdrawn some years later due to the high number of reported adverse reactions. It took the UK Department of Health, under Dr Salisbury, a full four years to acknowledge these problems and to withdraw the two brands, in September 1992. It is understood that withdrawal was carried out at just 48 hours' notice. The withdrawal was because some children were experiencing febrile convulsions, which were thought to be due to mumps meningitis.

In a UK Public Health Laboratory Service report published later in *The Lancet*, in 1995, the authors noted that the measles component of any MMR vaccine could also cause febrile convulsions, six to eleven days after administration of MMR, (in 67% of a group of hospital admissions studied). The study did not look beyond eleven days after administration as that was the limit of the scope of the study! In fact it is important to note that there was already a range of adverse reactions to the vaccine that are recognised by the manufacturers themselves, if not by Dr Salisbury's Department.

The latter insists that the vaccine is safe. However, the February 2000 edition of the manufacturer's notes, issued by Merck & Co., lists the following possible adverse reactions reported during clinical trials:

- (body as a whole) panniculitis, atypical measles, fever, syncope, headache, dizziness, malaise, irritability
- (cardiovascular system) vasculitis

- (digestive system) pancreatitis, diarrhoea, vomiting, parotitis, nausea

### 3.

- (endocrine system) diabetes mellitus
- (hemic and lymphatic system) thrombocytopenia, purpura, regional lymphadenopathy, leukocytosis
- (immune system) anaphylaxis and anaphylactoid reactions, angioneurotic edema, bronchial spasm
- (musculoskeletal system) arthritis, arthralgia, myalgia
- (nervous system) encephalitis, encephalopathy, measles inclusion body encephalitis (MIBE), subacute sclerosing panencephalitis (SSPE), Guillain-Barre Syndrome, febrile convulsions, afebrile convulsions or seizures, ataxia, polyneuritis, polyneuropathy, ocular palsies, paresthesia. On encephalitis, the Merck notes state that “the data suggest the possibility that some of these (reported) cases may have been caused by measles vaccines.”
- (respiratory system) pneumonitis, sore throat, cough, rhinitis
- (skin) Stevens-Johnson syndrome, erythema multiforme, urticaria, rash, burning/stinging at injection site, wheal and flare, redness, swelling, induration, tenderness, vesiculation at injection site
- (special senses - ear) nerve deafness, otitis media
- (special senses - eye) retinitis, optic neuritis, papillitis, retrobulbar neuritis, conjunctivitis
- (urogenital system) orchitis
- (other) “death from various and in some cases unknown causes has been reported rarely following vaccination with MMR; however, a causal relationship has not been established”

The above does suggest that rare or relatively rare serious adverse events are not unknown and are already recognised by the manufacturers of MMR. In this context, the possibility of an unrecognised adverse event such as autism - particularly if its onset is subtle, insidious and unresearched - becomes much more credible. The early/

The early history of the removal after four years of two brands of MMR clearly illustrates that the vaccine had not been tested properly, and over a long enough period to identify long term adverse reactions, and in fact had been licensed prematurely. This was later confirmed by Dr Peter Fletcher who was Chief Scientific Officer at the Department of Health, and in the late seventies was Medical Assessor to the Committee on Safety of Medicines, responsible for deciding if new vaccines were safe. Recently Dr Fletcher has said he found “official complacency utterly inexplicable” in the light of an explosive worldwide increase in regressive autism and inflammatory bowel disease in children, which was first linked to the live measles virus in the MMR jab by clinical researcher Dr Andrew Wakefield (1998). Dr Peter Fletcher said the rising tide of autism cases and growing scientific understanding of autism-related bowel disease have convinced him the MMR vaccine may be to blame. "Clinical and scientific data is steadily accumulating that the live measles virus in MMR can cause brain, gut and immune system damage in a subset of vulnerable children,". "It is the steady accumulation of evidence, from a number of respected universities, teaching hospitals and laboratories around the world that matters here. There is far too much to ignore. Yet government health authorities are, it seems, more than happy to do so." (1).

Dr Peter Fletcher is correct, there are over 100 studies, reviews and academic letters that point towards the plausibility of gut/autism, MMR/gut/autism, thimerosal/autism and autoimmunity/autism links. (**Appendix B**).

Dr Salisbury has chosen to ignore or over-ride this accumulation of evidence.

The decision to withdraw single vaccines as a choice in 1998 marked a significant juncture in this debate and perhaps best illustrates Dr Salisbury’s lack of sound judgment in face of the growing scientific and anecdotal evidence pointing towards MMR’s involvement in the world autism pandemic. This one decision placed the public health authorities and their staff at local level at odds with the very people they were meant to serve, causing untold anger and bitterness throughout the UK. This unacceptable situation continues today.

The precautionary principle (single vaccines as a choice) could have been enacted at any time since 1998; that this has not happened appears to be testimony to the dogmatic and stubborn approach of David Salisbury.

We know from Department of Health records that single vaccines are more effective – it’s set out in two editions (1996 and 1988) of “Immunisation Against Infectious Disease”, published for professionals by HMSO. Dr Salisbury chaired the Committee responsible for that

admission (in the 1996 edition). His contention later, that MMR is more effective, cannot be sustained. Why if MMR was more effective would his Committee decide (in 1996) to/

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introduce the second dose of MMR?

MMR fails to protect around 10% of its recipients against measles, and 10% against mumps. These groups overlap: some are unprotected against both measles and mumps. Rubella in MMR works as well as when given singly.

Given singly, both rubella and measles vaccines protect at least 95% of recipients for 15 or more years; mumps for around 10 years. There was never any call for second doses when single vaccines were the policy, and therefore there would be no need now to repeat doses of single antigen vaccines. One successful dose provides immunity in the recipient for 15 years or more.

Dr Salisbury maintains that the use of single vaccines introduces unacceptable delay and cites the opinion of Dr Wakefield that a year should separate single vaccines. Actually it seems perfectly adequate to separate rubella and measles by 6 weeks, measles and mumps by 3 months according to the World Health Organisation.

The real delay is introduced by MMR. If the first dose fails to protect against mumps or measles, effective protection is delayed until the pre-school booster, 3 years later.

\*Dr David Salisbury has signally failed in his duty to ensure that the MMR vaccine was rigorously tested, and evaluations followed up over a long enough period to confirm that serious long term adverse events could be identified.

The refusal to make single vaccines freely available on the NHS is indicative of an ill thought through policy particularly when the man advancing the policy, Dr Salisbury, is on record as approving the effectiveness of single vaccines.

### **Ileal Lymphoid Nodular Hyperplasia.**

In 1998 a peer reviewed scientific paper was published in the Lancet detailing a novel form of bowel disease identified in a sub-set of regressive autistic children. (2)

“Ileal Lymphoid Nodular Hyperplasia, non-specific colitis, and pervasive developmental disorder in children”. The report in the Lancet was on the first 12 children, the addendum to the paper clearly states: *“Up to Jan 28, a further 40 patients have been assessed; 39 with the syndrome”*

In a press briefing called prior to the research paper's publication it was hypothesized that the MMR vaccine could be implicated in this new syndrome. By the end/

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By the end of 2001, over 200 children had been examined. It has been reported in the UK press that virtually all fitted the same pattern as the 12 original children.

In March 2004, six years after the paper was published, 10 of the 13 original authors issued a statement:

*“The main thrust of the paper was the first description of an unexpected intestinal lesion in the children reported..... We wish to make it clear that in this paper, no causal link was established between MMR vaccine and autism as the data were insufficient. However, the possibility of such a link was raised and consequent events have had major implications for public health. In view of this, we consider now is the appropriate time that we should together formally retract the interpretation placed upon these findings in the paper.”*

Three authors did not sign the statement, and indeed argued strongly to the contrary.

This statement was widely and erroneously publicised as a retraction of the paper, rather than a retraction of the interpretation of the paper- a crucial misunderstanding.

What they (the ten authors) did not dispute was the fact that these children had a form of inflammatory bowel disease. It is therefore simply not the case that the original Lancet report had been discredited.

The link between autism and a novel intestinal condition was not retracted, by any author.

According to Richard Horton, Editor of the Lancet,

*'The essential clinical findings remain unchallenged as far as their accuracy is concerned'* <sup>(3)</sup>.

Clinical scientific research did not cease following the publication of the Lancet paper; on the contrary ongoing, published and presented work provided strong and irrefutable evidence of:

- immunological differences present in children with Autistic Spectrum Disorder
- a particular form of developmental regression
- a novel form of inflammatory bowel disease
- onset contemporaneous with MMR exposure
- long-term infection with measles virus in key sites
- presence of lymphoid hyperplasia and acute and chronic mucosal inflammation.

Several important papers and studies, (4-10), were subsequently ignored by Dr David Salisbury and the others listed in Appendix A. Any one of these papers, in conjunction with the overwhelming and compelling anecdotal evidence of parents, should have caused, at the very/

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least, the precautionary principle to be invoked. That this did not happen has likely resulted in many more children being condemned to a life with inflammatory bowel disease.

In summary, a ‘novel form of bowel disease’ was identified in a sub-set of regressive autistic children and revealed in a peer reviewed research paper and published in the Lancet in 1998, and rather than embrace this potentially world altering discovery the medical establishment closed ranks, minds and hearts. Parents of regressive autistic children quickly discovered that their children had become disenfranchised from UK gastroenterological services as a result of what appeared to be medical politics. What other possible explanation could there be for the UK’s most senior doctors to neglect to urgently call for further research based on the clinical examination of this sub-set of regressive autistic children? What rational reason could there possibly be to ignore the fact these children had inflammatory bowel disease?

The hypothesis that so alarmed the medical hierarchy is as follows:

*There exists a subset of children who are vulnerable, for immunological reasons, to developing a particular form of developmental regression following previously normal development, in combination with a novel form of inflammatory bowel disease. Acute or insidious onset may be triggered by exposure to a measles-containing vaccine, usually MMR. Exposure leads to long-term infection with measles virus within key sites, including the intestine, where it is associated with lymphoid hyperplasia and acute and chronic mucosal inflammation.’*

The above hypothesis has not been “discredited” nor its author proved a “maverick”. The reverse is the case. It is the senior officials listed in Appendix A who have elected to operate within a coterie, ignoring the existing and emerging facts.

The medical establishment has repeatedly asked itself the wrong question. It has asked itself “Is MMR safe?” hoping for an affirmative answer. In contrast, parents have asked two very different questions: “What precisely is wrong with this child?”, and “Why did this child gradually or suddenly change from being healthy to being autistic?” It is answering these latter two questions that should have been the key issue.

The UK’s most senior doctors have individually and collectively failed thousands of British autistic children, and likely hundreds of thousands of autistic children worldwide by ignoring

the conclusion of a peer reviewed published study.

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8.

**New evidence from the USA.**

Very few studies, if any, authorised by the Department of Health in the UK have actually clinically investigated the sub-set of autistic children identified as having withdrawn into autism following MMR vaccination, and then revealed to have Ileal Lymphoid Nodular Hyperplasia. However a recent study in the USA, (11), (designed, as ever, to dismiss the hypothesis that the MMR vaccine is implicated in autism), nonetheless credited Dr Andrew Wakefield with being the *"first to recognize the importance of gastrointestinal disease in autism."*

Some quotes from the authors may prove informative in the context of this complaint:

Dr Ian Lipkin.

*"This study confirms that kids with autism often have "unrecognized and undertreated bowel complaints."*

Dr Mady Hornig.

*"These intestinal problems may well be linked to the developmental regression seen in about 25% of kids with autism".*

Timothy Buie, (gastro-enterologist).

*"Unless a treatment protocol is developed, many of these children will live with painful, undiagnosed medical conditions that will grow more serious as they become teenagers and adults.*

*Many of the symptoms of autism such as self abusive behaviour including self-mutilation, head-banging, unexplained outbursts, atypical sleep patterns, disrupted sleep or night awakenings, are actually symptoms of pain that a child is not able to communicate".*

These comments echo the demands of parents since 1998, demands that have apparently been ignored by the men listed in Appendix 'A'; men who occupy or occupied the most powerful positions within the fabric of medicine and government; men who could have at a stroke encouraged and stimulated action toward establishing the protocol suggested by Dr Timothy Buie. A protocol that might have taken thousands of autistic children out of pain.

That these men did not do so is a clear indication of their indifference to the suffering of this sub-set of autistic children:

*“Indifference elicits no response. Indifference is not a response. Indifference is not a beginning; it is an end. And, therefore, indifference is always the friend of the enemy, for it benefits the aggressor-never the victim, whose pain is magnified when he or she feels forgotten”.*

*“Indifference, then, is not only a sin, it is a punishment”.* (12).

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9.

It is important to look at the two other components of MMR.

### **Mumps.**

The decision to include mumps in the vaccination schedule requires detailed examination.

Mumps vaccine was not part of the UK vaccine schedule at all prior to its introduction in the MMR vaccine. Why not?

A quote from The British Medical Association ('BMA') and The Royal Pharmaceutical Society of Great Britain (RPSGB):-

*"Since mumps and its complications are very rarely serious there is little indication for the routine use of mumps vaccine"* (13)

In fact most medical practitioners believe that there has never been sufficient clinical benefit to children to introduce mass mumps vaccination.

Mumps vaccination from one year old, as at present, prevents safe acquisition of life-long protection as a juvenile, only to wear off just at the age when protection is really needed. No booster immunisation is currently offered when it could be, at age 10. Even if it were, the entire mumps vaccination campaign has created a new generation most of whom will be susceptible to mumps as adults. The occurrence of significant outbreaks of mumps in secondary schools and colleges around Britain (after mumps protection has worn off) indicates that we have not solved the problem of mumps, only postponed it to age-groups when it can do the most damage. And one consequence of this unnecessary measure is that we are now putting young male adults at risk of orchitis because they did not catch mumps harmlessly when children. MMR vaccination is not effective in conferring full or lasting immunity across an entire population. As a result, one effect of its introduction has been to push mumps outbreaks into older age groups. (14).

One in four males who has achieved puberty and has not achieved immunity to mumps runs the risk of orchitis. Orchitis (usually unilateral) has been reported as a complication in 20-30% of clinical mumps cases in postpubertal males. Some testicular atrophy occurs in about

35% of cases of mumps orchitis: This means one of the male testicles shrivels up. Affected men can become sterile in one testicle. This affects one in every nine males who catch mumps after puberty compared with none who catch it before puberty. It is only because most men have two testicles and only one is affected that total sterility is rare. Most men/

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Most men would find that little consolation. Having a shrivelled testicle would carry psychological and practical consequences for any intimate physical relationship in adult life. The message seems to be it is better for a child to catch mumps naturally before puberty.

Dr Salisbury, on behalf of the medical profession and our Department of Health claims vaccination is a public health measure. It is claimed it is to prevent infectious diseases from circulating (achieving 'herd immunity') and thereby protecting the vulnerable. But as we can see with mumps vaccine, this is not the case and in fact the current scheduling exacerbates any potential problem of mumps.

Furthermore the recommendation of the BMA and RPSGB quoted above is unequivocally against mumps vaccination. It is clear that there is insufficient clinical benefit to very young children to introduce mass mumps vaccination. This in turn shows that exposing very young children to MMR vaccine cannot be justified on either clinical or ethical grounds.

How many parents are told before their child is given the MMR that the mumps vaccine is clinically unnecessary and giving the vaccine can expose their child to adverse reactions to the vaccines? The likely answer is, in general, "none". At the very least, administering any treatment in such manner, especially one that puts children at risk of adverse reactions is clearly unethical.

Dr Salisbury's policy on mumps vaccination may therefore take the medical profession clearly and firmly into the territory of criminal law. It puts most doctors and other medical professionals who administer the MMR into a potentially damaging position. Providing treatment to a patient that is not clinically needed and misleading patients as to the clinical need for a treatment so as to gain their consent can mean the administration of the treatment is a criminal offence. (15).

\*In view of the foregoing it is apparent that if vaccination against mumps were deemed necessary, although all the evidence is to the contrary, Dr Salisbury should have insisted that it be deferred to age 9-10 to permit natural infection in childhood and therefore better

protection.

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11.

### **Rubella.**

Aside from a rash the adverse effects of rubella for children are minimal. Vaccination against rubella is of no clinical benefit to a child.

If a pregnant woman catches rubella infection during the first three months of pregnancy and the child survives, this poses a risk to the unborn child of being born with congenital rubella syndrome (CRS), involving multiple congenital abnormalities. Prior to the introduction of rubella vaccine, the number of annual cases in the UK was small, around 50 per annum. Additionally, 92% of rubella cases deliver normal healthy children. (16).

This small risk can also be reduced either by making sure all women have caught rubella as children or by vaccinating those who have not prior to puberty. This minimises the exposure of children to the vaccine and hence to unnecessary risks of adverse vaccine reactions.

Dr Salisbury's policy of vaccinating over 600,000 children annually, without clinical benefit to a child, and for a very mild infection, is clearly unethical. As with mumps, the rubella vaccination, may take the medical profession into the territory of criminal law. That again puts most doctors and other medical professionals who administer the MMR into an interesting position:

Providing treatment to a patient that is not clinically needed and misleading patients as to the clinical need for a treatment so as to gain their consent can mean the administration of the treatment is a criminal offence. (15).

\*In view of the foregoing it is apparent that if vaccination against rubella were deemed important Dr Salisbury should have insisted that it be deferred to age 9-10 to permit natural infection in childhood and therefore better protection.

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### **Epidemiology**

David Salisbury has persisted over the years in promoting the MMR as safe by promulgating epidemiological studies that have variously proved to be irrelevant, inconclusive, or seriously methodologically questionable

Dr Salisbury and his department together with the Health Protection Agency have used approximately 35 epidemiological studies (**Appendix C**) to promote the MMR as safe and unconnected to the upsurge of bowel disease and autism worldwide. In referring to studies such as these, what is generally meant is that the authors have carried out large-scale population based studies, either by comparing cases (with autism) and controls (no autism) in terms of MMR exposure, or by comparing those exposed and unexposed to MMR in terms of autism or Autism Spectrum Disorder as an outcome. Whilst it is tempting to assume that studies of large populations are somehow 'better' by virtue simply of their size, this is by no means necessarily the case. Neither are they 'safety' studies. A fact of which Dr Salisbury is well aware.

The failure of the population based studies that are frequently cited as supporting the safety of MMR is in their total lack of reference to the original hypothesis formulated by Wakefield. In a recent presentation at the International Meeting for Autism Research (IMFAR) this year Dr Carol Stott (17) produced evidence to indicate that of over 50 studies claiming to test what can be referred to as the Wakefield hypothesis, only 5 actually addressed it fully, and four of these supported it, at least in part. Of these four, two were clinical studies and two were 'population' based.

Another significant failing is that whilst population based evidence from case-control or cohort studies might indicate a possible association between two or more factors – and to some extent be used to indicate causality - it can obviously not be applied to prove that in any particular case X did *not* cause Y.

Dr Bernadine Healy ex head of the National Institute of Health and a member of the Institute of Medicine in the USA has publicly stated on the issue of using epidemiology: “Populations do not test causality, they test associations. You have to go into the laboratory and you have to do designed research studies in animals”.

And on the vaccine/autism link: “Certain public health officials in the government, have been too quick to dismiss the concerns of these families without studying the population that got/

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sick. I haven’t seen major studies that focus on 300 kids who got autistic symptoms within a period of a few weeks of the vaccine. I think that the public health officials have been too quick to dismiss the hypothesis as “irrational” without sufficient studies of causation. I think that they often have been too quick to dismiss studies in the animal laboratory, in mice, in primates, that do show some concerns with regard to certain vaccines”.

In the assessment of adverse reactions, the only issue is biological plausibility. And it is important to note that there is no requirement to prove the presence of a pathogen.

Accordingly, negative studies are also irrelevant and especially negative studies undertaken some long time after the event. These can never disprove biological plausibility.

If we were to consider biological plausibility that MMR vaccine might be a cause of autism, then as rubella virus is the first proven cause of autism, it is entirely plausible that a live virus vaccine, particularly one containing rubella virus, could cause autism.

\*By using, almost exclusively, epidemiological studies as a means of persuading the UK public that MMR vaccination is totally safe Dr Salisbury has demonstrated either a disingenuous approach to this issue or a lack of understanding regarding the criteria required in the science of vaccine safety.

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### **MMR promotion**

It was reported in 2000 that the government had allocated over £3million for the purpose of reversing the downward spiral in MMR uptake in the UK. Among the many projects David Salisbury would personally oversee would be a television advertising campaign, a media awareness drive and sundry other schemes designed to alter the public’s growing belief that a public health catastrophe was being visited on them via the MMR vaccine. Keeping in mind that David Salisbury probably had at his disposal the PR and media sections of the Department of Health, plus the ever willing Health Protection Agency, all aided and abetted by countless public health officials, one would have thought that this funded onslaught, under

Dr Salisbury's personal stewardship, would have resolved the problem. Not so, there are pockets of the UK today (London for example) where uptake of MMR has plummeted below 50%. In parts of South Birmingham this figure is as low as 30%. (18).

Even with the resources at David Salisbury's disposal and the addition of considerable amounts of tax-payers' money it would appear he has failed to meet the basic target one assumes was set for him---the restoration of public confidence in MMR vaccination. The use/

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The use of skewed data, political spin, and inappropriate science rather than a thorough investigation of the public's concerns, based on clinical research, surely reveal a level of obstinacy over many years that make him unsuitable for his senior role in the civil service.

\*Dr David M Salisbury has demonstrated an inability to meet even the most basic of requirements of his position.

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#### **Ten Thousand Vaccines.**

On BBC-2's Newsnight programme, on 9<sup>th</sup> August 2004, Dr. Salisbury, asserted: "The immune system of a baby has got huge spare capacity to deal with challenge.....If we didn't, the human race would not survive, but let's look specifically at vaccines. This has been studied carefully. A baby's immune system can actually tolerate perfectly well a thousand vaccines."

Dr. Salisbury was quoting - or rather, mis-quoting - Dr. Paul Offit in the US. Dr. Offit had stated that (in his view) a young infant was fully capable of generating protective humoral and cellular immune responses to multiple vaccines simultaneously. He then had concluded that an infant "would have the theoretical capacity to respond to about 10,000 vaccines at any one time" (19).

It is not clear as to whether Offit (who is the owner of vaccine patents) was referring to live viruses or killed or attenuated viruses, but it is surely inconceivable that he meant live viruses. Offit's hypothesis has no experimental base and is a non-scientific proposition.

Dr Salisbury, on the other hand, was clearly discussing MMR, which contains three live viruses. He did not, however, go on to distinguish between live and attenuated/killed vaccines. Such imprecision has characterized Dr Salisbury's and other official "assurances" about MMR.

Dr Salisbury later contradicted his BBC interview by conceding that "At no point did I suggest that 1,000 vaccines would not increase the probability of adverse reactions" (20).

Note: The CDC was recently forced to withdraw 'Proquad' (MMRV) due to the number of serious adverse reactions experienced by children. Proquad contains four vaccines in combination, not 1,000, not 10,000, just four!

\*Dr Salisbury appears determined to promote the MMR vaccine as safe, with spin, and data that cannot be substantiated.

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### **Conclusions:**

As stated at the very beginning of this "complaint", it is not in dispute that vaccines have saved many lives. The MMR/autism parents are not anti-vaccination in principle. These parents, by definition, all took children to be vaccinated. They all recognised the need to protect children from diseases.

But saving lives from diseases doesn't justify ruining significant numbers of lives from unrecognised and unmonitored vaccine damage.

All affected parents are in the privileged position of having watched their child degenerate following MMR. It is a powerful first-hand experience. Comparing notes results in finding that other parents have undergone extremely similar experiences. Unfortunately, such experiences are not part of a scientifically-controlled study, so are routinely dismissed by the Department of Health as anecdotal:-

Usually there appears to be a very gradual degeneration over many weeks and months, not an acute event, more akin to (eg) the onset of cancer than to the rare acute reactions to vaccines seen in the past. (Nonetheless all the attention of the past upon possible adverse reactions to vaccines has focused upon acute near-immediate events).

The onset of gut/bowel problems and hyperactivity have accompanied the onset of autism in this sub-set of children. Some link between them is therefore likely, even without detailed research.

An anecdote is an anecdote. A consistent pattern of anecdotes is much more powerful. What we have is a consistent detailed pattern of reports from parents. The scientific and investigative importance of this pattern has been unaccountably ignored by the Department of Health, by Dr Salisbury and by the other 10 senior doctors listed in Appendix A.

Added to the parents' witness is a recent government study revealing that autism in the UK now stands at 1 child in 88. (21). The consequences, both for families and society, of this revelation, are immeasurable. It would appear our most senior doctors are indifferent.

Recent developments in the USA where a child (Hannah Poling) was awarded compensation by the US government in recognition that her autism was as a result of multiple vaccination, including MMR, is further confirmation that those charged with the guardianship of public health have been too quick to dismiss the evidence of parents in favour of government and pharmaceutical funded epidemiological research.

The decision to deny MMR involvement in the autism pandemic has directly resulted in many children being abandoned to a life of distress and pain.

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### **Formal List of Complaints against David M Salisbury (and others):**

- 1) Published scientific evidence revealing a novel form of bowel disease in a sub-set of autistic children has been ignored for fear of incriminating MMR vaccination. This long running policy of denial has meant that the necessary research into treatments for damaged children has been inexcusably delayed.**
- 2) Balanced judgment has not been employed given the poor safety history of MMR and intransigence on the issue has arisen from a series of poor Departmental decisions, this is directly responsible for a huge (and legitimate) loss of public confidence in vaccination safety.**
- 3) Relicensing of single vaccines for rubella, measles and mumps in response to the accumulating scientific evidence on safety etc, and importantly, public demand, should have been exercised.**
- 4) The almost exclusive use of epidemiology in support of MMR safety is inappropriate and the public health officials listed should certainly have been aware of this. It is of serious concern that they were not!**
- 5) Given the spiraling rate of autism, as revealed in the government's own study (21), and in view of the scientific and anecdotal evidence pointing toward vaccination as a contributing factor it was Dr Salisbury's (and the others listed) responsibility to address this serious issue. They have not done so, deciding instead to deny any connection.**
- 6) Unethical treatments have been given to children when there is no clinical need and irrespective of whether a child might be prone to adverse reactions.**

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Federico Balzola

7. The American Journal of Gastroenterology 100 (4) Pg 979 - April 2005

*Panenteric IBD-Like Disease in a Patient with Regressive Autism Shown for the First Time by the Wireless Capsule Enteroscopy: Another Piece in the Jigsaw of this Gut-Brain Syndrome?*

Federico Balzola.

8. Poster Presentation: IMFAR; Boston 2005

*Polyvalent measles-containing vaccine (pMCV) and developmental regression. Data from a UK litigation cohort.*

Carol M. Stott.

9. Presented at IMFAR 2004, Sacramento.

*TaqMan RT-PCR Detection of Measles Virus Genomic RNA in Cerebrospinal Fluid in Children with Regressive Autism*

Bradstreet J.J

10. Paper presented to the Thoughtful House Conference April 2005

*Investigation of a Potential Viral Cause for Autistic Spectrum Disorder*

Steve Walker PhD, Wake Forest University Health Sciences.

Background: Have viruses been causally linked to childhood developmental disorders?

11. Hornig M, Briesse T, Buie T, Bauman ML, Lauwers G, et al. 2008 Lack of Association between Measles Virus Vaccine and Autism with Enteropathy: A Case-Control Study. *PLoS ONE* 3(9): e3140 doi:10.1371/journal.pone.0003140

12. Elie Weisel. Seventh White House Millennium Evening, Washington, 12 April 1999. *Speeches that changed the world*. Quercus publishing. ISBN 1 905204 16 7.

13. The British Medical Association ('BMA') and The Royal Pharmaceutical Society of Great Britain (RPSGB) 1985 & 1986.

14. Mumps and the UK epidemic 2005, R K Gupta, J Best, E MacMahon *BMJ* 2005;330:1132-1135 (14 May).

15. Cite: *Appleton v Garrett* (1995) 34 BMLR 23.

16. *Danish Medical Bulletin*. March 1987 - WAVES Vol. 11 No. 4 p. 21.

17. A novel form of Inflammatory Bowel Disease (IBD) with Pervasive Developmental Disorder: A Systematic Review of the state of the evidence" *Poster Presentation, IMFAR, London 2008*  
Stott CM.

18 *Birmingham Mail*, 2<sup>nd</sup> July 2008.

19 *Pediatrics*, Vol 109, No. 1, Jan 2002 pp 124-129.

20. *Silenced Witnesses, The Parents' Story*, edited by Martin J Walker. Chapter 2, page 54. Slingshot publications.

21. Prevalence of disorders of the autism spectrum in a population cohort of children in South Thames: the Special Needs and Autism Project (SNAP); *Lancet* 2006; 368:210 –15.

## **Appendix A.**

The children that have been MMR damaged have had their lives ruined. They were previously completely healthy. Some of them now have seventy or eighty years of mental handicap ahead.

Not one of the men listed below has shown an ounce of compassion toward these sick children preferring instead to unite in a freemasonry of denial, using high office as a shield against the truth.

The clinical examination of the children who became ill following MMR vaccination should have been a standard procedure aimed at preventing further pain and distress to each child. Instead, what parents have witnessed is a collective indifference. No succour was offered and no acknowledgement of the children's reported medical conditions.

These men have failed our most vulnerable children.

### **FULL LIST OF DOCTORS WHO ARE THE SUBJECT OF THIS COMPLAINT:**

#### **Director of Immunisation, Department of Health.**

Professor David M Salisbury.

**As director of Immunisation Dr Salisbury must carry most of the responsibility for the MMR safety debacle.**

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#### **Chief Medical Officers (England).**

**Each one of these men, at any time during their period in office, could have insisted that the children reported to have withdrawn into autism following MMR vaccination be comprehensively tested for underlying medical problem. They did not do so.**

Sir Kenneth Calman (1991-1998)

Sir Liam Donaldson (1998 to present)

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### **Joint Committee on Vaccination and Immunisation. Chairmen:**

**In the face of growing evidence of MMR vaccine damage to a sub-set of children, over a number of years, these doctors ignored the evidence and continued to promote the use of this multiple live virus vaccine.**

Prof Sir David Hull. (1996-1999)

Professor Michael J S Langman. (2000-2004).

Professor Andrew Hall. (2005- to present)

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### **Committee on Safety of Medicines. Chairmen:**

**Charged with the responsibility of ensuring the safety of vaccines the following doctors also chose to ignore the tide of clinical and anecdotal evidence placed before them.**

Professor Sir Alisdair Breckenridge (1999-2002).

Professor Gordon W Duff. (2005)

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### **Medicines and Healthcare products Regulatory Agency. (MHRA): Chairman:**

**Another government agency charged with the responsibility of ensuring the safety of vaccines and choosing to ignore the tide of clinical and anecdotal evidence placed before it.**

Prof Sir Alisdair Breckinridge (2003 to present)

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### **Medical Research Council. Chief Executives:**

**In 2001 and 2003 the MRC stated that “the role of bowel disease in autism is a priority area for research”. The following doctors stand condemned for neglecting to have this important research carried out, resulting in the halting of progress toward treatment of sick autistic children.**

Sir George Radda. (Now retired)

Sir Colin Blakemore. (Now retired)

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### **Health Protection Agency. Chairman.**

**This government advisory agency has been responsible for the promotion of MMR as safe using inappropriate epidemiological studies. The Health Protection Agency appears more intent in controlling public opinion on the MMR safety issue than in providing the contextual information on which people can make an informed judgement.**

Sir William Stewart.

## **Appendix B.**

### **Over 100 Studies and Papers That Point Towards The Plausibility Of Gut/Autism, MMR/Gut/Autism, Thimerosal/Autism or Autoimmunity/Autism Links**

Paper by Nelson & Gottshall, Applied Microbiology, May 1967  
Paper by Eggers, Klinical Paediatrics, March 1976  
Weizman, Weizmann et al Study, Am. J of Psychiatry, Nov. 1982  
Delgiudice-Asch and Hollander Study  
Paper by Dr. H. Fudenberg  
Paper by Dr. Reed Warren  
Warren and Singh Study, Immunogenetics, 1992  
Singh, Warren, Odell, Warren and Cole Paper, March 1993  
Singh, Warren, Odell et al Study, Brain Behaviour, March 1993  
Oleske and Zecca paper  
Binstock paper  
Anne-Marie Plesner Letter, Lancet, February 1995  
Paper by Thompson, Montgomery et al, Lancet, April 1995  
Gupta, Aggarwal & Heads Study, J of Autism and Dev Disorders, 1996  
Montinari, Favoino and Roberto paper, Naples conference May 1996  
Auwaerter & Griffin paper, Clin Immunol & Immunopath, May 1996  
Cook, Courchesne et al Paper, Molecular Psychiatry, May 1996  
Griffin and Hussy Study, Journal of Infectious Diseases, June 1996  
Martinez et al Study, Proceedings of National Acad of Sciences, 1997  
Paper by Zecca, Graffino et al, Meeting of Nat Inst of Health, Sept. 1997  
Weibel, Caserta and Evans Study, March 1998  
Wakefield et al "Early Report", Lancet, February 1998  
Paper by Montgomery, Morris et al (pub. date/details not yet known)  
Sabra, Bellanti and Colon letter, Lancet, July 1998  
Further Paper by Singh and Yang, Pharmaceutical Jnl, October 1998  
Uhlmann, Sheils et al Paper  
Bitnun et al Study, Clinical Infectious Diseases Journal, October 1999  
Paper by Horvath, Papadimitriou et al, J of Pediatrics Nov 1999  
Paper by Singh to the US Committee on Govt Reform, April 2000  
O'Leary Paper Presented to Congressional Oversight C'ttee, April 2000  
Kawashima, Takayuki et al Study, Digest Dis and Sciences, Apr 2000  
Confidential Review, US CDC, Simpsonwood, June 2000  
Hagenbuch, Kullak-Ublick et al Study, J of Pharm Exp Ther, July 2000

Wakefield et al Paper, American J. of Gastroenterology, September 2000  
Statement by Professor Walter O. Spitzer, December 2000  
Furlano, Anthony et al Study, Journal of Pediatrics, 2001  
Paper by Enayati et al, Medical Hypotheses, 2001  
Study by Jyonouchi, Sun and Le, J. of Allergy & Clin. Immun., Feb. 2001  
Study by Jyonouchi, Sun and Le, J of Neuroimmunology, 2001  
Paper by Spitzer, Aitken et al, J of Adverse Drug Reactions & Tox., 2001  
**Appendix B continued:**

Study by Holmes, Cave et al, June 2001  
Paper by Blaxill, Institute of Medicine, July 2001  
Paper by Dr. Ken Aitken to the Scottish Society for Autism, 2001  
Paper by Imani and Kehoe, Clinical Immunology, September 2001  
Paper by Redwood, Bernard et al, Neurotoxicology, October 2001  
Paper by Buie, Oasis 2001 Conference for Autism, Portland, US  
Paper by Uhlmann, Wakefield et al, J. of Clinical Pathology, Feb. 2002  
Paper by Singh and Nelson, February 2002  
Review by Wakefield, Pulestone et al, Aliment Pharm. Ther. 2002  
Report of Study, Comi et al, Johns Hopkins Hosp, Baltimore, Apr 2002  
Paper by Torrente, Ashwood, Day et al, Lancet, May 2002.  
Paper to 102nd GM of Am. Soc for Microbiology, Singh et al, May 2002  
Study by O'Leary et al to Path Soc of GB and Ireland July 2002  
Wakefield Paper Presented to US Govt Reform Committee, June 2002  
Paper to US Government Reform C'ttee by Dr Krigsman, June 2002  
Unpublished Research by Shattock, Un. of Sunderland, June 2002  
Paper by Sheils, Smyth, Martin & O'Leary, Trinity Coll Dublin, 2002  
Paper by Dr. Vijendra Singh, Utah State University, August 2002  
Paper by Finegold, Molitoris, Song, J. Of Clin. Infect. Dis., Sept 2002  
Further paper, Jyonouchi, Sun & Itokazu, Un. of Minnesota, Oct 2002  
Paper, Treat. of Late Onset Autism, Matarazzo, U.S-Paulo, Nov 2002  
Paper by Makani, Gollapudi et al, Genes & Immunity, 2002  
Paper by Westphal, Asgari et al, Arch of Toxicology, August 2002  
Unpublished letter by Wakefield to New Eng. J. of Medicine, Nov 2002  
Study by Croonenberghs et al, University of Antwerp, December 2002  
Paper by Holmes, Blaxill & Haley, Internat J of Toxicology 2003  
Paper by Singh and Jensen, Pediatric Neurology 2003  
Paper by Geier & Geier, Soc. for Experimental Biology & Med. 2003  
Study by Geier and Geier, International Pediatrics, May 2003  
Further Paper by Geier & Geier, Ped. Rehabilitation, Apr-June 2003  
Further Paper by Geier & Geier, J of Am Phys and Surg, Spring 2003  
Paper by Blaxill, Redwood & Bernard, Safe Minds  
Paper by Bradstreet, Geier et al, J of Am Phy and Surg Summer 2003  
Letter by Geier & Geier, J of Am Phys. & Surgeons, Summer 2003  
Paper by Baskin, Ngo et al, Toxicology Science Aug 2003  
Paper by Via, Nguyen et al, Envir. Health Perspectives August 2003  
Paper by Sweeten, Bowyer et al, Pediatrics, November 2003  
Paper by Ashwood, Murch et al, J of Clinical Immunology, Nov 2003  
Study by Ueha-Ashibishi, Oyama et al, Toxicology, Jan 2004

Paper by Jyonouchi, Geng et al, Jan 2004  
Paper by Singh, presented to the Inst. of Med, Washington, Feb 2004  
Paper by Bradstreet, Inst of Medicine, Washington, Feb 2004  
Paper by Bradstreet, O'Leary et al, Inst of Medicine, Feb 2004  
Further Paper by Bradstreet, Institute of Medicine, Feb 2004  
Presentation by Geier and Geier to the Institute of Medicine, Feb 2004  
Letter by Geier, Genetic Centers of Am, to Pediatrics, March 2004  
**Appendix B continued:**

Paper by De Water, Ahwood et al, MIND Instit, California, May 2004  
Study by Deth et al, Journal of Molecular Psychiatry, Apr 2004  
Paper by Torrente, Anthony et al, Am. J of Gastroenterology, Apr 2004  
Presentation by Prof. Boyd Haley, Canada Autism Conference, Apr 2004  
Presentation by Buttar, US Congress Cttee on Govt Reform May 2004  
Paper by Bradstreet Dahr et al, J of Am Phys & Surg, Summer 2004  
Paper by Deth, Health & Wellness Committee, Sept 2004  
Paper by Hornig, Chian, Lipkin et al, Mol Psychiatry June 2004  
Letter by Geier and Geier, Pediatrics, September 2004  
Paper by Ashwood et al, J of Clinical Immunology, November 2004  
Paper by Slikker et al, Neurotoxicology, December 2004  
Paper by the Environmental Working Group on Mercury, Dec 2004  
Paper by Blaxill et al, Medical Hypotheses, 2004  
Paper by Havarinasab et al, Toxicology & App Pharmacology, 2005  
Press Report, Los Angeles Times, February 2005  
Study by Palmer & Miller, Health and Place journal, March 2005  
Paper by Jyonouchi, Geng et al, Neuropsychobiology, February 2005  
Letter by Balzola, Barbon et al, Am J of Gastroenterology, April 2005  
Paper by Balzola, Daniela et al, Am Gastroenterological Assoc, May 2005  
Paper by Humphrey, Cole et al, Neurotoxicology, June 2005  
Paper by Burbacher et al, Environmental Health Perspectives, 2005  
Paper by Wakefield, Ashwood et al, European J of Gastro and Hep, 2005

## Appendix C.

The following studies are epidemiological and are in the main inappropriate as a tool to establish causation.

Many of these studies have been used/quoted by Dr Salisbury's department in support of MMR safety.

### Studies Seeking To Deny Any MMR/Thimerosal/Autism Link

Stokes et al paper, J of American Medical Assoc. (JAMA), Oct. 1971  
Study by Peltola and Heinonen, Lancet, April 1986  
Paper by Miller, Miller et al, The Practitioner, January 1989  
Gillberg Study, Sweden, British Journal of Psychiatry, 1991  
Commentary by Gillberg and Heijbel, Autism, 1998  
Letter by Fombonne, Pediatrics, March 1998  
UK Committee on Safety of Medicines Study, June 1999  
Paper By Taylor, Miller and Farrington, Lancet, June 1999  
Paper by Miller & Farrington to US Govt Reform Committee, Apr 2000  
Patja, Peltola et al Study, Finland, Pediat. Infect Disease J. Dec. 2000  
Kaye, Melero-Montez and Jick Study, British Medical Journal, 2000  
Dales, Hammer and Smith Study, JAMA, March 2001  
De Wilde, Carey & Richards Study, Br. J. of General Practice, Mar 2001  
Davis et al study, Archive Pediatrics Adolescent Medicine, 2001  
Further Paper by Farrington, Miller and Taylor, Vaccine Journal, 2001  
Fombonne & Chakrabarti Study, Pediatrics, October 2001  
Further Paper by Taylor, Miller et al, BMJ.com, February 2002  
Review by Donald and Muthu, Bazian Ltd, British Medical J. June 2002  
Study into Childhood Gastrointestinal Disorders and Autism, Aug 2002  
Madsen et al, Population-Based study, MMR/Autism, Denmark, Nov 2002  
Study on Mercury by Pichichero, Lancet, November 2002  
Study by Makela et al, Finland, Pediatrics November 2002  
Commentary by Nelson & Bauman, Pediatrics March 2003  
Paper, Madsen et al, Thimerosal/Aut in Denmark, Pediatrics, Sep 2003  
Paper by Hviid, Stellfeld et al, Denmark, J of Amer. Med Assoc Oct 2003  
Paper by Miller, Taylor et al, Archives of Diseases in Childhood 2003  
Paper by Taylor et al, Archives of Diseases in Childhood, 2003  
Article by Verstraeten et al, Pediatrics, Nov 2003  
Paper by Stehr-Green et al, American J of Preventative Medicine 2003  
Paper by DeStefano, Yeargin-Allsopp et al, Pediatrics, January 2004  
Paper by Williams et al, Aberdeen University, Neuroimage June 2004

Paper by Smeeth, Cook, Fombonne et al, Lancet, September 2004

Paper by Heron, Golding et al, Pediatrics, September 2004.

Paper by Barbaresi et al, Arch of Ped & Adolescent Medicine, Jan 2005

Paper by Honda & Rutter, J of Child Psychol & Psychiatry, March 2005

Study by Seagroatt, British Med Journal, May 2005