Federal Worker's Request for Exemption and Report of Government Wrongdoing

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Below is information that federal workers might find helpful in contesting President Biden's vaccine mandate if they determine that information applies to them. While I have written the document to address President Biden's order specifically, it contains legal and factual arguments that non-government workers can make if the information applies to their situation. Keep in mind that the Constitution is only a limit on government action. But the Constitution can limit a private company if it acts as a government agent. President Biden has mandated that employers who have 100 or more workers must require those workers to be vaccinated. A private employer of 15 or more employees[1] cannot discriminate against someone based on race, color, religion, sex, or national origin. Such discrimination would violate Title VII of the Civil Rights Act.[2] Thus, Title VII of the Civil Rights Act should protect a person's exercise during private employment of his sincere religious belief not to be vaccinated. Incidentally, Title VII of the Civil Rights Act also protects federal workers from religious discrimination.[3] There also could potentially be a claim brought by an unvaccinated person under the Americans with Disabilities Act (ADA)[4] or the Rehabilitation Act.[5] I have cited the authority for each point in the endnotes. You can thus assess for yourself the weight of the evidence and the validity of the legal arguments.

On September 9, 2021, President Joseph Biden issued an order requiring that federal workers and contractors be vaccinated. This memo provides authority for asserting constitutional and statutory rights and to respectfully request an exemption from the requirements of the President's order. None of the facts contained in this document are classified or derived from classified information.

To help verify the authority behind the arguments, I have placed hyperlinks in the text of this summary that will take you to the underlying authority in the memorandum. The hyperlinks are in blue underlined font.

The reason that it is necessary to make the constitutional and statutory arguments intermixed in such a large body of facts is that those arguments are based on the underlying waste, fraud, and abuse alleged in the memorandum. It is the medical fraud that has given rise to the constitutional and statutory claims. In essence, certain federal authorities are perpetrating a deception under the guise of a medical emergency. That fraud violates constitutional and statutory rights.

I will try to summarize the claim as briefly as possible. Federal government authorities have mandated that federal workers be vaccinated, ostensibly to prevent the infection and spread of COVID-19. But the government has acknowledged that the vaccine they are mandating does not prevent the infection or spread of COVID-19. I know it sounds bizarre, but it is true, and this

memorandum documents the facts supporting that truth. The federal medical authorities want obedience to their mandates, not because they are medically necessary, or even scientifically based, but because they are in positions of authority, and they want obedience.

Request for Exemption from Vaccination

I have a sincere religious objection to being vaccinated, the basis for which I have documented in this memorandum. I have other constitutional and statutory objections as well. But, for the most part, I will focus on the constitutional religious freedom claim in this summary because the gravamen of my claim is my request for a religious exemption. My claim is detailed, with authority, in the body of this memorandum.

The government must allow a medical exemption for the vaccine because there are immunocompromised persons who cannot be vaccinated under any circumstances. The U.S. Supreme Court has ruled that if the government allows a secular exemption, it must also necessarily allow a religious exemption. Providing medical exemptions while refusing religious exemptions indicates discriminatory intent, which cannot survive even intermediate, let alone strict scrutiny. As I explain in this memorandum, requiring testing and masking in lieu of vaccination is not a reasonable accommodation; it is an unconstitutional penalty. The President cannot offer an option that violates federal workers' constitutional rights and then claim that option is a reasonable accommodation. The option of wearing a mask and being medically tested is not a reasonable accommodation because those procedures infringe on the constitutional rights of federal workers.

Under the Religious Freedom Restoration Act, the government may not substantially burden a person's exercise of religion unless the government "demonstrates that application of the burden to the person (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." There is no way that the government can meet that burden for the vaccine. According to Supreme Court precedent, the government must necessarily also allow a religious exemption.

I respectfully request an exemption from vaccination on religious and other constitutional and statutory grounds. I also assert my constitutional right to bodily autonomy and all other constitutional and statutory rights outlined in this memorandum. I further maintain that any penalty or restriction, such as masking, testing, and social distancing, for refusal to take an experimental vaccine violates the informed consent requirements of 21 U.S. Code § 360bbb–3, 45 C.F.R. § 46.101, et seq., the Nuremberg Code, the Belmont Report, and the U.S. Constitution.

Request for Exemption from Masking

The government may impose masking and testing requirements and allege that such requirements are reasonable accommodations to those asserting their religious right not to be vaccinated. I say because on On July 29, 2021, President issued an order that allowed those accommodations before he superseded it with his September 9, 2021 order mandating vaccinations.

As I explain in this memorandum, requiring testing and masking in lieu of vaccination is not a reasonable accommodation; it is an unconstitutional penalty. The government cannot offer an option that violates federal workers' constitutional rights and then claim that option is a reasonable accommodation. The option of wearing a mask and being medically tested is not a reasonable accommodation because those procedures infringe on the constitutional rights of federal workers.

The government acknowledges that the masks do not prevent the wearer from getting COVID-19. The only reason to wear a mask is purportedly to prevent someone who has COVID-19 from spreading COVID-19 to others. That reason is premised on the discredited theory that asymptomatic carriers of COVID-19 can spread the disease. That theory has now been proven to be false—this memorandum documents the studies proving it. Thus, there is no reason to wear a mask. Furthermore, there is reasonable medical certainty that wearing a face mask will cause hypoxia, hypercapnia, and other conditions that would be dangerous to my health.

The vaccines the government is mandating do not prevent the infection or spread of COVID-19. The government acknowledges that fact.

An asymptomatic carrier would necessarily test positive for COVID-19. Testing positive for COVID-19 but not having symptoms of the disease is what it means to be an asymptomatic carrier. An asymptomatic carrier of COIVD-19 will be denied entry into a federal building. It is not a reasonable accommodation to force someone who tests negative for COVID-19 to nonetheless wear a mask. Since the person has tested negative for COVID-19, the mask serves no useful purpose. An uninfected person cannot spread COVID-19. It is irrational to require him to wear a mask. Vaccinated persons, who are just as likely to be infected and spread the infection, will not be required to be tested or wear masks. That suggests that the mask is a punishment for refusing to be vaccinated and not a reasonable accommodation.

The CDC has acknowledged that vaccinated persons can be infected by and spread COVID-19. Thus, there is now an interim requirement that even vaccinated persons wear masks. But that temporary masking requirement is subject to being lifted at any time. The fact remains that before that recent change, only unvaccinated persons were required to wear masks. Thus, there is a built-in secular exemption to the mask requirement that can be reinstated at any time. It is quite likely that as soon as the vaccine mandate is instituted the interim universal masking requirement will be rescinded. The President's vaccine mandate is separate and distinct. The interim masking order does not undermine the merits of my constitutional and statutory objections.

Studies have shown that masks are ineffective in preventing the spread of COVID-19. Thus, there is no rational reason to require masks and they thus cannot be considered a reasonable accommodation to an unvaccinated worker. Government officials have admitted that the real reason to wear a mask is symbolic. It shows that the wearer is "committed to the cause." That is, wearing a mask is communicative. That constitutes forced speech in violation of the First Amendment.

I am NOT "committed to the cause" because the cause is a deception. To signify to the world

that I am committed to the cause is a lie. To force me to wear an ineffective and unsafe mask that only serves to symbolize my agreement with the COVID-19 deception violates my sincerely held religious beliefs. "Abstain from all appearance of evil." 1 Thessalonians 5:22. Furthermore, the symbolic nature of masks is well known in pagan rituals. The symbolic wearing of a mask causes the person to take on an alter-ego, whereby a spirit being (i.e., a devil) acts through him. Wearing a mask ostensibly to prevent the spread of disease but is really for symbolic purposes that has the effect that the wearer takes on the alter-ego of a devil. Being required to wear a symbolic mask violates my sincerely held religious beliefs.

Request for Exemption from Testing

The government may impose a testing requirements and allege that such a requirement is an accommodation to those asserting their religious right not to be vaccinated. That supposition is based on the July 29, 2021 Presidential order that allowed a testing accommodations before he superseded it with his September 9, 2021 order mandating vaccinations. Testing federal employees in lieu of vaccination is not a reasonable accommodation because it does not accomplish its alleged purpose of detecting disease. It has been established that the PCR test is inaccurate and results in false-positive results. Indeed, the CDC has recommended a cycle rate (40 cycles) that is guaranteed to create false positives. Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID), stated that the chance of a true positive result from 35 or more cycles is "minuscule." The CDC knows this, which is why it has ordered state health authorities to only submit samples for vaccinated persons that have a cycle rate of no more than 28. The CDC is putting on a charade. The CDC has maintained its original advice of 40 cycles for PCR tests of unvaccinated persons, which has the effect of generating false-positive results and artificially inflating the number of unvaccinated COVID-19 cases, while at the same time trying to prevent false positives of COVID-19 by using a different standard when testing those who have been vaccinated. There are now different rules for reporting unvaccinated COVID-19 cases and vaccinated COVID-19 cases. The effect is to lower the reported number of vaccinated COVID-19 breakthrough cases while continuing the stratagem of inflating the reported unvaccinated COVID-19 cases. It is against my sincerely held religious beliefs to be a party to such unconscionable deception.

Testing unvaccinated workers is not a reasonable accommodation for an unvaccinated worker since the CDC is now on record acknowledging that a person who has been vaccinated can still spread COVID-19. Thus, the government's position is that a vaccinated person can spread COVID-19 in the same way as is an unvaccinated person. The testing of only the unvaccinated person, therefore, does not accomplish the alleged goal of preventing the spread of the COVID-19 disease because the equally contagious vaccinated persons are not tested. The government allows an exemption from COVID-19 testing for a vaccinated person; it must, therefore, allow that same exemption for a person who asserts his constitutional right to remain unvaccinated. The government acknowledges that both vaccinated and unvaccinated persons can spread COVID-19. If the government required testing only for the unvaccinated persons who assert their constitutional rights it would be a clear violation of the Constitution.

The government does not have a compelling interest in COVID-19 testing since the government gives an exemption to the tests for a secular reason (vaccination). It, therefore, must give an exemption for a religious reason. Since a person is given a secular basis (vaccination) for being exempt from testing, I, therefore, should also be exempted from taking part in any COVID-19 testing because of my sincerely held religious beliefs. The testing is not a reasonable accommodation; in reality, it is punishment for the unvaccinated worker who asserts his constitutional right not to be vaccinated.

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THE PRESIDENT'S ORDER

1. President Joseph Biden issued a COVID-19 vaccine mandate for all executive branch workers.

2. President Biden claimed his reason was to stop the spread of COVID-19.

3. **But President Biden admitted in his announcement that the vaccines he is mandating do not stop the spread of COVID-19.**

4. On July 29, 2021, the President of the United States, Joe Biden, announced the following:

> [E]very federal government employee will be asked to attest to their vaccination status. Anyone who does not attest or is not vaccinated will be required to mask no matter where they work; test one or two times a week to see if they have a — they have acquired COVID; socially distance; and generally will not be allowed to travel for work.[6]

5. Before the President put his July 29, 2021 order into effect, he issued a superseding order on September 9, 2021, requiring all federal workers and contractors to be vaccinated with one of the COVID-19 vaccines. He did not announce any exemptions to that requirement. In his announcement, he mischaracterized the COVID-19 vaccines as "safe, effective, and free."[7] President Biden stated:

> If you want to work with the federal government and do business with us, get vaccinated. If you want to do business with the federal government, vaccinate your workforce.

6. President Biden gave the reason for his order. That reason is to prevent the spread of COVID-19.

> It is essential that Federal employees take all available steps to protect themselves and avoid spreading COVID-19 to their co-workers and members of the public. The CDC has found that the best way to do so is to be vaccinated.[8]

7. President Biden suggests by that statement that a vaccinated person cannot be infected with COVID-19 or spread that disease to others. But the evidence is now in that the COVID-19 vaccines do not prevent infection or spread of the COVID-19. Indeed, President Biden knows it is not true that a vaccinated person is protected from being infected and spreading COIVD-19. When announcing his Presidential Order, President Biden further explained that he is mandating the vaccines to prevent unvaccinated persons from spreading COVID-19 to the vaccinated persons.

> The bottom line: We're going to protect vaccinated workers from unvaccinated co-workers. We're going to reduce the spread of COVID-19 by increasing the share

of the workforce that is vaccinated in businesses all across America.[9]

8. That statement makes no sense in light of his other statement that the mandated vaccines are intended to prevent infection and spread of COVID-19. If the vaccines are effective, the vaccinated person should not be in danger of infection from an unvaccinated person. The whole objective of a vaccination is to protect the recipient from disease. But the President knows that the vaccines are not effective. President Biden impeaches his credibility and undermines his stated reason for the COVID-19 vaccination mandate of stopping the spread of the disease by his admission that the vaccines do not protect the vaccinated persons from COVID-19. He implicitly admits that his mandate will be ineffective in achieving its objective. In the very announcement requiring vaccinations for federal workers, President Biden acknowledged that he knows the vaccines do not prevent infection or spread of COVID-19. He follows the convention of calling those vaccinated persons who subsequently become ill with COVID-19 "breakthrough" cases. President Biden admits that he is instituting a mandatory vaccination program that only helps with the symptoms of COVID-19 for the vaccinated persons and will not stop its spread. The President of the United States announced a mandatory vaccination program to stop the spread of COVID-19 while acknowledging that the vaccines are ineffective in preventing the spread of the disease. A vaccinated person is just as likely to spread COVID-19 as an unvaccinated person. President Biden stated:

> I understand the anxiety about getting a “breakthrough” case. But as the science makes clear, if you’re fully vaccinated, you’re highly protected from severe illness, even if you get COVID-19.[10]

9. President Biden further announced the need for a booster shot program, which is an implicit admission that he knows the initial vaccination does not give lasting protection from symptoms.

> As soon as they are authorized, those eligible will be able to get a booster right away in tens of thousands of site across the — sites across the country for most Americans, at your nearby drug store, and for free.[11]

10. On September 10, 2021, Lee J. Lofthus, Assistant Attorney General for Administration, sent out a department-wide email announcing that the September 9, 2021 executive order from President Biden mandating vaccinations for executive branch employees and contractors would be “subject to limited exceptions for disabilities or religious objections.” But, like President Biden, Lofthus falsely claims in his email that the COVID-19 “vaccines have been proven safe.”

11. This memorandum documents how the COVID-19 vaccine mandate announced by President Biden is not only ineffective, dangerous, and irrational, but it also violates the U.S. Constitution and federal statutes.

FDA COVID-19 VACCINE APPROVAL BAIT AND SWITCH STRATAGEM

12. On August 23, 2021, the FDA published the following announcement in a letter:

> On August 23, 2021, FDA approved the biologics license application (BLA) submitted by BioNTech Manufacturing GmbH for COMIRNATY (COVID-19 Vaccine, mRNA) for active immunization to prevent COVID-19 caused by SARS-CoV-2 in individuals 16 years of age and older.[12]

13. The letter contains the following pertinent information:

> [T]he EUA will remain in place for the Pfizer-BioNTech COVID-19 vaccine for the previously-authorized indication and uses.[13]

14. Please notice that there are two vaccines discussed in the letter with two distinct legal identities. The FDA pointed out in a footnote in the authorization letter that the vaccines are not identical. "The products are legally distinct with certain differences that do not impact safety or effectiveness."[14] The two distinct vaccines are:

> 1) COMIRNATY (COVID-19 Vaccine, mRNA) and
>
> 2) Pfizer-BioNTech COVID-19 vaccine.

15. The Pfizer-BioNTech COVID-19 vaccine remains unapproved and under its original emergency use authorization (EUA). At the same time, the FDA has approved COMIRNATY (COVID-19 Vaccine, mRNA).[15]

16. Vaccines can be authorized for use in an emergency by the FDA while undergoing experimental trials. Authorization for use in an emergency is not the same as approval. Such investigational vaccines are not approved by the FDA. COVID-19 vaccines are "investigational vaccines" authorized under an emergency use authorization (EUA). An investigational vaccine is, by definition, an experimental vaccine. Investigational vaccines being used under an EUA are "still in the testing and evaluation phase and are not licensed for use in the general public."[16]

17. The FDA states that "Comirnaty has the same formulation as the EUA vaccine and is administered as a series of two doses, three weeks apart."[17] The FDA further explains that "[t]he [approved] vaccine has been known as the Pfizer-BioNTech COVID-19 Vaccine, and will now be marketed as Comirnaty (koe-mir'-na-tee), for the prevention of COVID-19 disease in individuals 16 years of age and older."[18] But keep in mind that, while the two vaccines have the same formula, they are not identical. They have "certain differences," which were not specified; and they are "legally distinct."

18. Thus, we have two substantially similar vaccines, one being administered under an EUA and another under FDA approval. The problem is that the approved vaccine, COMIRNATY (COVID-19 Vaccine, mRNA), is now manufactured in Germany by Pfizer and BioNTech, a company that works in partnership with Pfizer.[19] A footnote in the letter states:

> Although COMIRNATY (COVID-19 Vaccine, mRNA) is approved to prevent COVID-19 in individuals 16 years of age and older, there is not sufficient approved vaccine available for distribution to this population in its entirety at the time of reissuance of this EUA.[20]

19. That means that it is not yet available in the U.S. Thus, all of the COVID-19 vaccines now being administered in the U.S. under the Pfizer-BioNTech partnership are being administered under the EUA. The effect of that is that the public thinks that it is getting an approved vaccine under the legal standards for an approved vaccine, but in reality, they are receiving an EUA vaccine that comes with all of the legal vulnerabilities of an EUA vaccine.

20. Why did the FDA not simply approve the Pfizer-BioNTech COVID-19 vaccine? Why are there two vaccines with the same formula made by the same company given different treatment? It makes no logical sense unless you understand the stratagem of Pfizer and the FDA. The FDA has slickly approved a vaccine that is not available. If the vaccine were to be made available, Pfizer-BioNTech and all other COVID-19 makers would lose their EUA's. The COVID-19 vaccines allowed under EUAs would all be taken off the market. That is because one of the legal requirements for an EUA is "that there is no adequate, approved, and available alternative to the product for diagnosing, preventing, or treating such disease or condition."[21] That means that if the COMIRNATY (COVID-19 Vaccine, mRNA) is made available, all other EUA vaccines would immediately be removed from the market. That would hit Moderna particularly hard since their COVID-19 vaccine is the only product they sell. Indeed, Moderna's COVID-19 vaccine is the first product they have ever sold.

21. Albert Bourla, Chairman and Chief Executive Officer of Pfizer, gives a hint to the reason for the strange approval of a vaccine with the same formula as an identical vaccine that remains unapproved: "I am hopeful this approval will help increase confidence in our vaccine."[22] It is a confidence game, which is popularly known as a con-game. The approval of the COMIRNATY (COVID-19 Vaccine, mRNA) is to increase the "confidence" in the Pfizer-BioNTech COVID-19 vaccine being administered under the EUA. People will be convinced to get the Pfizer-BioNTech COVID-19 vaccine under the mistaken belief that it is approved by the FDA, when in fact it is only authorized under the EUA.

22. Indeed, the FDA approval of the unavailable COMIRNATY (COVID-19 Vaccine, mRNA) is being used by President Biden to push the COVID-19 vaccine mandate he instituted on September 9, 2021. "[M]any said they were waiting for approval from the Food and Drug Administration — the FDA. Well, last month, the FDA granted that approval. ... The vaccine has FDA approval."[23] It is significant that President Biden did not mention that the FDA approved vaccine to which he referred is not available in the United States.

23. All the news services reported the approval of the Pfizer COVID-19 vaccine without mentioning that the only vaccine available in the U.S. is the EUA Pfizer experimental vaccine. Fox Business News segued into the motive behind the approval. "Full licensure has been widely

anticipated to boost confidence in those otherwise hesitant to receive the shot under emergency approval."[24] That was the pattern for all of the mainstream news outlets. One of the primary subscription services, the Associated Press (AP) news service, is an example of the kind of propaganda about the Pfizer approval being pushed. The AP did not mention anything about the only available COVID-19 vaccines in the U.S. being EUA experimental vaccines. Instead, the AP pushed the narrative that "[t]he U.S. gave full approval to Pfizer's COVID-19 vaccine Monday, potentially boosting public confidence in the shots and instantly opening the way for more universities, companies and local governments to make vaccinations mandatory."[25] The mainstream media outlets are giving people the false impression that the Pfizer COVID-19 vaccine they will be getting is approved. It is not.

24. Dr. Paul E. Alexander is an expert in clinical epidemiology; he is a former COVID Pandemic Advisor to the WHO and the Pan American Health Organization; he was a former senior advisor on the COVID Pandemic in the Department of Health and Human Services during the Trump administration. He opines that the COVID-19 vaccines are ineffective and unsafe and should be stopped. He explains that the spike protein that is being created by the body via the mRNA code in the COVID-19 vaccines is "the business end of the virus that causes the pathology."[26] The spike protein is what is killing people and making them ill. That confirms the opinion of Dr. Robert Malone, the inventor of the mRNA technology used in several COVID-19 vaccines. Dr. Malone has stated that the spike proteins generated by the cells through the mRNA code are cytotoxic.[27] Dr. Alexander reveals that the approval of the COMIRNATY (COVID-19 Vaccine, mRNA) is a trick to convince people to be vaccinated with the unapproved and experimental Pfizer-BioNTech COVID-19 vaccine that is being allowed under the EUA. It is a Machiavellian bait and switch. The people will think they are receiving an approved vaccine when, in reality, they will be getting the experimental vaccine.

25. What does that all mean? The key to understanding what is going on is in the footnote in the FDA approval letter. "The products are **legally distinct** with certain differences that do not impact safety or effectiveness."[28] Maintaining separate legal identities for the two vaccines with the same formula has the effect that those injured by the EUA Pfizer-BioNTech COVID-19 vaccine will be subjected to the exacting standards and limited compensation of the Public Readiness and Emergency Preparedness Act (PREP Act), which authorizes the Countermeasures Injury Compensation Program (CICP) to provide benefits to injured parties. A notable limitation under the CICP is that an injured party will be subjected to the statute of limitations that forecloses all legal actions not filed within one year of vaccination.[29] That is compared with the statute of limitations for an approved vaccine under the National Vaccine Injury Compensation Program (VICP) of 3 years from the occurrence of the first symptom of injury from the vaccine.[30] Experts specializing in vaccine injury cases say that the bar for obtaining compensation is very high under the PREP Act.[31] Over the last ten years, 94% of injured patients who filed claims under the PREP Act received no compensation.[32] In reference to the virtually insurmountable hurdles erected under the CICP, Renée Gentry, director of the Vaccine Injury Litigation Clinic at the George Washington University Law School, said COVID-19 vaccine claimants have two rights: **"You have the right to file," she said. "And you have the right to lose."**[33] Altom Maglio, whose 22 lawyer law firm, Maglio Christopher

& Toale, specializes in vaccine injury cases, says that you're out of luck if you've suffered an injury related to any of the COVID-19 vaccines in receiving any compensation for your injury.[34] That all is not intended to suggest that the VICP is fair. The VICP has its own problems which are beyond the scope of this memorandum. Two out of three claims filed under the VICP are denied.[35]

26. Visitors to the Health Resources & Services Administration website to find information about filing a VICP claim are met with a notice ribbon announcing: **"For claims associated with the COVID-19 vaccine or other COVID-19 related countermeasures, please file your Request for Benefits with the Countermeasures Injury Compensation Program."**[36] The ribbon provides a link directly to the CICP website. The premise of that advisory is that all COVD-19 vaccines are experimental vaccines allowed under an EUA. There is no separate advice on the FDA website for the approved COMIRNATY (COVID-19 Vaccine, mRNA) vaccine. That indicates that all vaccines administered in the United States for COVID-19 are experimental vaccines being administered under that EUA and are thus not allowed recovery ordinarily available for an approved vaccine under the VICP program.

27. It is unclear how the approval of the COMIRNATY (COVID-19 Vaccine, mRNA) was accomplished in nine months, particularly when, as of August 13, 2021, there were reported in the HHS Vaccine Adverse Event Reporting System (VAERS) 13,068 deaths correlated to the COVID-19 vaccines.[37] Recall that the FDA states that "Comirnaty has the same formulation as the EUA vaccine."[38] The Pfizer-BioNTech COVID-19 vaccine accounted for 9,024 of those deaths.[39] In this memorandum, you will read that a study funded by HHS determined that the VAERS program only reports 1% of the adverse events from vaccines.[40] Thus, we can extrapolate that the 9,024 deaths reported for the Pfizer-BioNTech COVID-19 vaccine in VAERS represent 902,400 deaths.

28. Please be mindful that VAERS is a system of correlation. HHS explains that an adverse event may be reported to VAERS for "clinically important adverse events that occur after vaccination of adults and children, even if you are not sure whether the vaccine caused the adverse event."[41] Thus, a person does not have to be "sure" of causation. But just because causation is not certain does not mean that causation cannot be inferred. One can infer probable causation even when it is not scientifically proven causation. The correlation of the reported adverse events to the vaccines is verified by the judgment of medical professionals. Eighty percent (80%) of the correlations reported in VAERS are based on the judgment of medical professionals that the adverse event was closely related to the vaccine and was probably caused by it. Otherwise, it would not have be reported in VAERS. Indeed, there is a disincentive against reporting a questionable adverse event. On the HHS VAERS website, it warns: "Knowingly filing a false VAERS report is a violation of Federal law (18 U.S. Code § 1001) punishable by fine and imprisonment."[42] Once the report is sent to VAERS, the CDC reviews and verifies it before it is logged and posted on the VAERS database. The adverse events reported on VAERS have not been scientifically proven to have been caused by the vaccines. And certainty of causation is not the test for reporting. The HHS website advises that the reporter to VAERS does not have to be "sure" of causation, and causation does not have to be "clear." But HHS otherwise implies that the reporter have a reasonable basis for believing the vaccine caused the injury reported to VAERS. If a medical professional does not reasonably believe that the vaccine

caused the reported injury, reporting that injury to VAERS as an adverse event could be punishable under federal law "by fine and imprisonment." The 1% of total vaccine injuries that make it into the VAERS database are mainly based on the judgment of medical professionals that the vaccine probably caused the reported injuries.

29. The unexpected approval by the FDA of the COMIRNATY (COVID-19 Vaccine, mRNA) changes nothing regarding the continued experimental status of the Pfizer-BioNTech COVID-19 vaccine. The COMIRNATY (COVID-19 Vaccine, mRNA) and the Pfizer-BioNTech COVID-19 vaccine have "certain differences," and they are "legally distinct." The COMIRNATY (COVID-19 Vaccine, mRNA) is not being administered in the U.S. The Pfizer-BioNTech COVID-19 experimental vaccine and the other COVID-19 experimental vaccines are the only vaccines available to any worker in the United States. None of them are approved by the FDA, and all of them are experimental vaccines. The argument against administering an experimental vaccine without informed consent is pertinent because all COVID-19 vaccines in the U.S. remain unapproved and experimental vaccines. They are all being administered under EUAs, and are not FDA approved, including the Pfizer-BioNTech COVID-19 vaccine.

EMERGENCY USE AUTHORIZATION

30. The vaccines referenced by the President are the COVID-19 vaccines. The COVID-19 vaccines are being administered to the public on what is known as an Emergency Use Authorization (EUA) by the FDA. The gravamen of the EUA standard is that the known and potential benefits of the COVID-19 vaccines when used to prevent COVID-19 outweigh their known and potential risks. The COVID-19 vaccines have not been demonstrated to be safe or effective by the FDA. The COVID-19 vaccines are authorized for use and are being monitored for safety and effectiveness.

COVID-19 VACCINES ARE EXPERIMENTAL

31. The safety studies are continuing during the EUA period. The COVID-19 vaccines are experimental. The COVID-19 vaccine trials are being opened up to include children as young as 6 months. All who participate in the COVID-19 vaccination program are *de facto* participants in a medical experiment that is being monitored for safety and effectiveness. But they are not being told this. The FDA explains the EUA vaccine program:

> FDA expects vaccine manufacturers to include in their EUA requests a plan for active follow-up for safety, including deaths, hospitalizations, and other serious or clinically significant adverse events, among individuals who receive the vaccine under an EUA, to inform ongoing benefit-risk determinations to support continuation of the EUA.
>
> FDA also expects manufacturers who receive an EUA to continue their clinical trials to obtain additional safety and effectiveness information and pursue licensure (approval).

> Post-authorization vaccine safety monitoring is a federal government responsibility shared primarily by FDA and the U.S. Centers for Disease Control and Prevention (CDC), along with other agencies involved in healthcare delivery. Post-authorization safety monitoring during the COVID-19 pandemic vaccination program will aim to continuously monitor the safety of COVID-19 vaccines to rapidly detect safety problems if they exist.[43]

AVAILABLE U.S. COVID-19 VACCINES ARE NOT APPROVED BY THE FDA

32. Vaccines can be authorized for use in an emergency by the FDA while undergoing experimental trials. Authorization for use in an emergency is not the same as approval. Such investigational vaccines are not approved by the FDA. COVID-19 vaccines are "investigational vaccines" authorized under an emergency use authorization (EUA). An investigational vaccine is, by definition, an experimental vaccine. Investigational vaccines being used under an EUA are "still in the testing and evaluation phase and are not licensed for use in the general public."[44] All manufacturers of COVID-19 vaccines explain in their information sheets the EUA legal status of the COVID-19 vaccines. For example, presently, the Moderna fact sheet states: "The Moderna COVID-19 Vaccine is an **unapproved vaccine** that may prevent COVID-19."[45] Substantially similar language is found in all the available COVID-19 EUA vaccine fact sheets. Following the approval of COMIRNATY (COVID-19 Vaccine, mRNA), the Moderna fact sheet removed the statement: "There is no FDA-approved vaccine to prevent COVID-19." Of course, that statement was also removed from the Pfizer-BiNTech fact sheet. The Pfizer-BiNTech fact sheet now explains that COMIRNATY (COVID-19 Vaccine, mRNA) is approved but that the Pfizer-BioNTech COVID-19 Vaccine remains a vaccine being administered under an EUA. Notably, the previous Pfizer-BiNTech fact sheet described its EUA Pfizer-BioNTech COVID-19 vaccine as "unapproved," but that unapproved language is nowhere found in the new fact sheet describing the Pfizer-BioNTech COVID-19 vaccine. It is now described as "the FDA-authorized Pfizer-BioNTech COVID-19 Vaccine under Emergency Use Authorization (EUA)."[46] The reality is that only unapproved, experimental vaccines being administered under an EUA are presently available to the U.S. population.

FEDERAL LAW REQUIRES INFORMED CONSENT

33. The President has stated that all federal workers must be vaccinated. The problem is that under federal law, no person can be compelled to take part in a medical experiment without their informed consent. Indeed, every COVID-19 vaccine manufacturer includes a notice that the recipient of the vaccine should be told that they have the option of accepting or refusing the experimental vaccines. For example, the Moderna fact sheet states: "It is your choice to receive or not receive the Moderna COVID-19 Vaccine. Should you decide not to receive it, it will not change your standard medical care."[47] They do that because it is a legal requirement. A person receiving the COVID-19 vaccine must be informed of its dangers and consent to being vaccinated. A person cannot be compelled to take the COVID-19 vaccine. 21 U.S. Code § 360bbb–3, which is the law governing the emergency use authorizations (EUA) of experimental vaccines, requires informed consent that

is more limited than in the federal regulations on informed consent for medical experiments. But the statute nonetheless requires certain information be provided to the patient before vaccination, and the patient has the option of withdrawing consent and refusing to be vaccinated. The statute, 21 U.S.C. § 360bbb–3(e)(1)(A)(i), requires informed consent for vaccines authorized under an EUA. That code section provides:

> Appropriate conditions designed to ensure that individuals to whom the product is administered are **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.

21 U.S. Code § 360bbb–3(e)(1)(A)(i) (emphasis added)

34. Why is informed consent required for a vaccine under an EUA? Because those vaccines are investigational vaccines (a.k.a., experimental vaccines) whereby stage 3 trials are still being monitored. That is why the manufacturers of the COVID-19 vaccines authorized under the EUA are under a continuing obligation to report all serious adverse events, including death and hospitalizations that result from the EUA administration of the COVID-19 vaccines. The vaccines are still being studied for safety and effectiveness. A person cannot be compelled to take the vaccine under the threat of any consequences for refusal.

35. The FDA's guidance on emergency use authorization of medical products requires the FDA to "ensure that recipients are informed to the extent practicable given the applicable circumstances … That **they have the option to accept or refuse the EUA product** …"[48] In the same vein, when Dr. Amanda Cohn, the executive secretary of the CDC's Advisory Committee on Immunization Practices, was asked if Covid-19 vaccination can be required, she responded that under an EUA, **"vaccines are not allowed to be mandatory. So, early in this vaccination phase, individuals will have to be consented and they won't be able to be mandatory."**[49] Cohn later affirmed that this prohibition on requiring the vaccines applies to organizations, including hospitals.[50] The EUAs for COVID-19 vaccines require facts sheets to be given to vaccination providers and recipients. These fact sheets make clear that getting the vaccine is optional. For example, the fact sheet for recipients states that, "[i]t is your choice to receive or not receive the Covid-19 Vaccine," and if "you decide to not receive it, it will not change your standard of medical care." Attorney Aaron Siri points out that the FDA's position that the COVID-19 vaccines authorized under an EUA cannot be mandated is because informed consent is required by federal statute. Siri explains that "the same section of the Federal Food, Drug, and Cosmetic Act that authorizes the FDA to grant emergency use authorization also requires the secretary of Health and Human Services to **"ensure that individuals to whom the product is administered are informed … of the option to accept or refuse administration of the product."**[51]

FDA INTERPRETATION OF EUA MEDICAL EXPERIMENTATION RULES

36. There are other regulatory provisions requiring informed consent for those taking part in medical experiments. The FDA has taken the unofficial position that compliance with the other statutory provisions requiring informed consent are not required for an EUA vaccine. The FDA alleges:

> Although informed consent as generally required under FDA regulations is not required for administration or use of an EUA product, section 564 [21 U.S. Code § 360bbb–3] does provide EUA conditions to ensure that recipients are informed about the MCM [Medical Countermeasure] they receive under an EUA.[52]

37. The FDA further states:

> FDA must ensure that recipients of the vaccine under an EUA are informed, to the extent practicable given the applicable circumstances, that FDA has authorized the emergency use of the vaccine, of the known and potential benefits and risks, the extent to which such benefits and risks are unknown, that they have the option to accept or refuse the vaccine, and of any available alternatives to the product. Typically, this information is communicated in a patient "fact sheet." The FDA posts these fact sheets on our website.[53]

38. The FDA thinks that providing a fact sheet to the recipients of the COVID-19 vaccines is sufficient. "Therefore, FDA recommends that a request for an EUA include a "Fact Sheet" for recipients that includes essential information about the product."[54]

39. The FDA is reading the statutory requirements under Section 564 [21 U.S. Code § 360bbb–3] for administering an unapproved MCM under an EUA as a waiver of the otherwise required informed consent. The FDA's position is presumably based on the following language in subsection (k) of 21 U.S. Code § 360bbb–3:

> If a product is the subject of an authorization under this section, the use of such product within the scope of the authorization shall not be considered to constitute a clinical investigation for purposes of section 355(i), 360b(j), or 360j(g) of this title or any other provision of this chapter or section 351 of the Public Health Service Act [42 U.S.C. 262].

DOJ OLC OPINION

40. Dawn Johnsen, Acting Assistant Attorney General Office of Legal Counsel, issued an opinion addressed to the Deputy Counsel to the President that that public and private entities can

legally mandate that employees get injected with the COVID-19 experimental vaccines as a condition of employment.[55] That opinion seems to be the legal justification for the President's September 9, 2021 decision to mandate COVID-19 vaccinations for the federal workforce.

41. In the legal opinion, Ms. Johnsen focused on the language found under 21 U.S. C. § 360bbb–3(e)(1)(A)(i) that requires a recipient to be "informed … of the option to accept or refuse administration of the product, of the consequences, if any, of refusing administration of the product." Ms. Johnsen opines that a person can either "accept or reject" the vaccine and a company can coerce the employee in making that decision as long as the company informs the employee "of the consequences, if any, of refusing administration of the product."

42. Ms. Johnsen reads the "option to accept or refuse" condition as merely informational and not conditional. That means that the employer only needs to tell the employee the consequences of not taking the vaccine. Then, with that information known, the employee can decide whether to suffer the consequences of accepting or refusing the vaccine.

43. Ms. Johnsen opines that "These provisions all appear to require only that certain factual information be conveyed to those who might use the product."

DOJ OPINES EMPLOYMENT IS ONLY A "DESIRABLE ACTIVITY"

44. Ms. Johnsen says it is okay that the recipient of the information is faced with a choice at *Morton's Fork*. The worker is between the proverbial rock and a hard place. He is put their by the employer. Ms. Johnsen is okay with that. When someone is at Morton's Fork with two unpleasant choices, his choice cannot in any way be characterized as a free choice. That is because the options are placed before him by the employer who wants him to choose vaccination. So the employer loads up the unpleasantness of not getting a vaccine to coerce him to get one. The employer controls the options. And so the choice is being coerced by the entity that is presenting the unpleasant options of accepting the vaccine or refusing the vaccine. The employer wants the employee to take the vaccine and thus sets dire consequences for not doing so. He will be fired if he chooses not to be vaccinated. Thus, according to Ms. Johnsen, the option to accept or refuse the COVID-19 need not be voluntary.

45. Ms. Johnsen argues that getting fired or expelled from school is only a secondary consequence of refusal. DOJ characterizes getting fired from your job as simply exclusion from a "desirable activity." Ms. Johnsen thinks that your ability to feed your family is not a necessity, it is only a "desirable activity." If you get fired for refusing to get vaccinated, DOJ considers you to have exercised your option, and to have chosen, of your own free will, to be excluded from a "desirable activity" of employment over getting vaccinated because you were told ahead of time you would be fired. On the other hand, if you get vaccinated because you have been threatened with being fired, DOJ considers that exercising your free choice to get vaccinated. The coercive threat of losing your job is perfectly fine to DOJ. Your choice does not have to be voluntary, according to DOJ.

DOJ VS. DOJ

46. The DOJ under the previous administration opined 14 months earlier, on May 30, 2020, that:

> There is no pandemic exception to the Constitution and its Bill of Rights. Indeed, "individual rights secured by the Constitution do not disappear during a public health crisis." *In re Abbott*, 954 F.3d at 784.[56]

47. The above sentiment would preclude any opinion from the DOJ authorizing the coercion of federal workers to be vaccinated with an experimental vaccine under the threat of being subjected to masking, testing, social distancing, and travel prohibitions if they refused. DOJ taking the view that there is no pandemic exception to the Constitution, certainly would not issue an opinion that working to feed your family is simply a "desirable activity" and therefore it would be no great loss if you were fired because you decide not to be injected with an experimental vaccine.

AARON SIRI'S REBUTTAL

48. Aaron Siri, attorney for the Informed Consent Action Network wrote a rebuttal to the DOJ OLC opinion. Mr. Siri wrote a letter of opinion to Dawn Johnsen, Acting Assistant Attorney General Office of Legal Counsel.[57] Mr. Siri pointed out that the DOJ argument that expulsion from a job, school, and civil society are only "secondary consequences," which does not remove the "option to accept or refuse" defies common sense. He points out that the statutory framework and implementation of 21 U.S. Code § 360bbb-3 "all reflect that 'the option to accept or refuse' was intended to continue the longstanding principle that it is not permissible to coerce anyone to receive an unlicensed medical product."

49. Mr. Siri points out that the principle of informed consent "was carried forward when Congress included the words 'the right to accept or refuse' in Section 564 [21 U.S. Code § 360bbb-3] is reinforced by the legislative discussions surrounding the passing of Section 564 [21 U.S. Code § 360bbb-3]." He explained:

> On July 16, 2003, in deliberating Section 564, Representative Hays said, without any objection, that:
>
> > [A]ny authority to actually use experimental drugs or medical devices in emergency situations has to be defined and wielded with nothing less than surgical precision. Prior informed consent in connection with the administration of experimental therapy is a basic human right, a right no one should be asked to surrender.
>
> Similarly, on May 19, 2004, Senator Kennedy said while deliberating regarding Section 564 that "[t]he authorization for the emergency use of unapproved products also includes strong provisions on informed consent for patients."

50. The statements of Representative Hays and Senator Kennedy indicate that Congress thought that the requirement in Section 564 that the patient be informed of the "significant known and potential benefits and risks of such use," and "of the option to accept or refuse administration of the product" established a requirement of "informed consent." Indeed, Senator Kennedy and Representative Hays were adamant that informed consent be required before anyone was subjected to the administration of an unapproved medical product of any kind when it is authorized for use in an emergency. Senator Kennedy described the language in Section 564 as constituting "strong provisions" requiring informed consent. Informed consent is a higher degree of consent, and all consent must be voluntary for it genuinely to be consent.

51. The American Medical Association (AMA) states that "informed consent to medical treatment is fundamental in both ethics and law." The AMA states that when a physician is obtaining a patient's informed consent, he should: "Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision."

52. The concept of informed consent for medical experiment subjects is found in every state. For example, in Virginia, the state provides that an agency must obtain the informed consent of anyone taking part in a medical experiment. The Virginia statutes state that the consent must be unconstrained by any coercion: "Informed consent" means the knowing and voluntary agreement, without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion, of a person who is capable of exercising free power of choice." 12VAC5-20-100.

53. Informed consent in the context of experimental vaccines requires that the patient be fully informed. But regardless of the information provided, his decision to obtain the vaccine must be the product of an unencumbered will that is free of coercion. The litigation regarding the admissibility of confessions offers guidance as to what it means for consent to be voluntary. In *Culombe v. Connecticut*[58], the U.S. Supreme Court stated that "[t]he ultimate test remains that which has been the only clearly established test in Anglo-American courts for two hundred years: the test of voluntariness. Is the confession the product of an essentially free and unconstrained choice by its maker?"[59] The *Colombe* Court explained that "The line of distinction is that at which governing self-direction is lost and compulsion, of whatever nature or however infused, propels or helps to propel the confession."[60] The critical distinction between a voluntary and an involuntary confession is whether the confessor was compelled to confess. For example, threatening to inform the prosecutor of a suspect's refusal to cooperate is viewed by courts to be coercive and render the resulting confession involuntary and inadmissible.[61] That same concept is found in family law statutes. In Kentucky voluntary, informed consent is defined by statute, in pertinent part, as:

> "Voluntary and informed consent" means that at the time of the execution of the consent, the consenting person was fully informed of the legal effect of the consent, that the consenting person was not given or promised anything of value except those expenses allowable under KRS 199.590(6), that the consenting person was not coerced in any way to execute the consent, and that the consent was voluntarily and

knowingly given.[62]

COERCED VACCINATIONS

54. Under no circumstances can the decision by a federal worker to be vaccinated with a COVID-19 vaccine be considered voluntary when it is given under the threat that refusal to do so will result in them being "required to mask no matter where they work; test one or two times a week to see if they have a — they have acquired COVID; socially distance; and generally will not be allowed to travel for work."[63]

55. Aaron Siri further explains:

> The FDA likewise viewed Section 564 as providing a substantive right to refuse when it explained the military exception:
>
> > [A]s a general rule, persons must be made aware of their right to refuse the product (or to refuse it for their children or others without the capacity to consent) and of the potential consequences, if any, of this choice. An exception to this rule is that the president, as commander in chief, can waive military personnel's right to refuse this product. If the right is not specifically waived by the president for a particular product given under EUA, military personnel have the same right to refuse as civilians.[64]
>
> The FDA thus makes clear that Section 564 provides a substantive right to refuse, and this right does not exist in the presence of a requirement that imposes negative consequences for refusing.
>
> Similarly, the CDC's Advisory Committee on Immunization Practices ("ACIP") has interpreted Section 564 as a consent provision and not merely a requirement to inform. When responding to an inquiry regarding whether the COVID-19 vaccines can be required, the Executive Secretary of ACIP publicly stated that "under an EUA, vaccines are not allowed to be mandatory. Therefore, early in the vaccination phase individuals will have to be consented and cannot be mandated to be vaccinated."
>
> ACIP's Executive Secretary then reaffirmed to the FDA's Vaccine and Related Biological Products Advisory Committee that no organization, public or private – including hospitals – can mandate the EUA COVID-19 Vaccines:
>
> > Organizations, such as hospitals, with licensed products do have [the] capability of asking their workers to get the vaccine. But in the setting of an EUA, patients and individuals will have the right to refuse the vaccine.

> Consistent with the foregoing, the U.S. General Services Administration's ("GSA") Safer Federal Workforce website, applicable to all federal employees and contractors, expressly provided that the EUA COVID-19 vaccines cannot be mandatory.[65]

56. The GSA's official position was that "COVID-19 vaccination should generally not be a pre-condition for employees or contractors at executive departments and agencies … to work in-person in Federal buildings, on Federal lands, and in other settings as required by their job duties."[66]

57. Siri reveals that the GSA changed its interpretation of the statute after DOJ released its slip opinion. Now, GSA states that an unvaccinated person can be required to wear a mask, physical distance, be tested, restricted from travel, and even quarantined.

58. The DOJ interpretation of Section 564 (21 U.S. Code § 360bbb-3) give short shrift to the concept of freedom of choice. Option is defined in the dictionary as "an act of choosing; the power or right to choose: freedom of choice."[67] The DOJ opinion eliminates the "freedom of choice" by allowing that the choice can be coerced by a threat of being fired, having to wear a mask, being tested, physical distance, etc.

59. Aaron Siri makes the common-sense observation that "[i]t is illogical that Congress would require that individuals be informed of a freedom of choice if that choice is illusory at the whim of any public or private entity."

NATIONAL RESEARCH ACT

60. Subsection (k) of 21 U.S. Code § 360bbb–3 indicates that an EUA is not to be considered a clinical investigation for purposes of section 355(i), 360b(j), or 360j(g) of this title or any other provision of this chapter or section 351 of the Public Health Service Act [42 U.S.C. 262]. But that language does affect other regulations that remain operative regarding an investigative vaccine under an EUA.

61. Aside from the misinterpretation of Section 564 (21 U.S. Code § 360bbb-3), coercing employees to get an experimental COVID-19 vaccine by the threat of masking, social distancing, medical testing, and travel prohibitions is a violation of the federal regulations and rulings passed under the authority of the National Research Act.[68]

62. In the wake of the infamous Tuskegee Syphilis Study, which was terminated on November 14, 1972, Congress enacted The National Research Act.[69] That law established a National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.

63. The commission was tasked with, among other things, conducting "a comprehensive investigation and study to identify the basic ethical principles which should underlie the conduct of biomedical and behavioral research involving human subjects."[70] In carrying out that task the

commission was ordered to "consider at least ... the nature and definition of informed consent in various research settings."[71]

THE BELMONT REPORT

64. The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research issued an authoritative report known as the Belmont Report.[72] That report summarized the basic ethical principles identified by the Commission that were to be followed by researchers using human subjects in biomedical research.

65. The pertinent section of the Belmont report is the section that addresses informed consent. The Belmont report expressly states that any research subject must be informed of the risks and alternative treatments prior to entering a research study involving an experimental medical treatment. Notably, that informed consent is defined in the Belmont Report as voluntary consent that is free from coercion and undue influence. The report notes explicitly that consent from unjustifiable pressure is not valid consent. "Unjustifiable pressures usually occur when persons in positions of authority or commanding influence -- especially where possible sanctions are involved -- urge a course of action for a subject." The Pertinent language in the Belmont Report explaining informed consent is as follows:

> **Informed Consent.** -- Respect for persons requires that subjects, to the degree that they are capable, be given the **opportunity to choose** what shall or shall not happen to them. This opportunity is provided when adequate standards for **informed consent** are satisfied.
>
> While the importance of informed consent is unquestioned, controversy prevails over the nature and possibility of an informed consent. Nonetheless, there is widespread agreement that the consent process can be analyzed as containing three elements: information, comprehension and **voluntariness.**
>
> ***
>
> **Voluntariness.** An agreement to participate in research constitutes a **valid consent only if voluntarily given.** This element of informed consent requires conditions **free of coercion and undue influence.** Coercion occurs when an overt threat of harm is intentionally presented by one person to another in order to obtain compliance. Undue influence, by contrast, occurs through an offer of an excessive, unwarranted, inappropriate or improper reward or other overture in order to obtain compliance. Also, inducements that would ordinarily be acceptable may become undue influences if the subject is especially vulnerable.
>
> **Unjustifiable pressures usually occur when persons in positions of authority or commanding influence -- especially where possible sanctions are involved** -- urge

> a course of action for a subject. A continuum of such influencing factors exists, however, and it is impossible to state precisely where justifiable persuasion ends and undue influence begins. But undue influence would include actions such as manipulating a person's choice through the controlling influence of a close relative and threatening to withdraw health services to which an individual would otherwise be entitled.[73] (emphasis added)

66. The U.S. Department of Health and Human Services has created a video wherein is explained the meaning and application of the Belmont Report. The video makes clear that "to deny someone autonomy is to deny them respect as an individual. ... Subjects must understand the extent of the risk they are taking. They must know that participation is **voluntary**, that they can withdraw from the research at any point if they choose. ... **Consent must be free of coercion or undue pressure.**"[74]

67. The very actions that the President proposed and are being advocated by DOJ and the FDA constitute coercion and undue influence as defined by the Belmont Report. Federal employees are being coerced into being vaccinated under the penalty of being fired. The threat is being made by the employer who controls their job. The employee is under pressure to please his employer who is exercising undue influence over the employees as he decides whether to take part in the experimental COVID-19 vaccine program. There is nothing in Section 564 (21 U.S. Code § 360bbb-3) that excuses compliance for an EUA with the standards of informed consent in the Belmont Report.

68. Padma Nambisan explains that the "[t]he Belmont Report has served as an ethical framework for protecting human subjects and its recommendations incorporated into other guidelines. It is an essential reference document for Institutional Review Boards (IRBs) that review and ensure that research proposals involving human subjects conducted or supported by the Human & Health Services (HHS) meet the ethical standards of the regulations."[75]

69. The ethical standards memorialized in the Belmont Report have been incorporated into Federal Regulations. The basic HHS Policy for Protecting Human Research Subjects "applies to all research involving human subjects conducted, supported, or otherwise subject to regulation by any Federal department or agency that takes appropriate administrative action to make the policy applicable to such research. This includes research conducted by Federal civilian employees or military personnel." 45 C.F.R. § 46.101(a). The regulations at 45 C.F.R. § 46.101, et seq., were enacted under the legislative authority of 5 U.S. Code § 301, 42 U.S.C. 300v-1(b), and 42 U.S. Code § 289.

70. 45 C.F.R. § 46.101(i) provided that "[u]nless otherwise required by law, department or agency heads may waive the applicability of some or all of the provisions of this policy to specific research activities or classes of research activities otherwise covered by this policy, provided the alternative procedures to be followed are consistent with the principles of the **Belmont Report.**" *Id.* (emphasis added). That means that no agency of the federal government may drop their ethical protections of research subjects below that which is provided in the Belmont Report. Essentially, the Belmont Report sets the minimum standards beneath which no department of the executive branch

may fall. Indeed, § 46.101(c) provides that "[d]epartment or agency heads retain final judgment as to whether a particular activity is covered by this policy and this judgment shall be exercised **consistent with the ethical principles of the Belmont Report.**" Thus no matter what an executive agency does, it must comply with the ethical standard of the Belmont Report, which includes the informed consent provisions. There is no wiggle room. The ethical standards of informed consent apply to all medical research involving human subjects.

71. 45 C.F.R. §46.116 codifies, in part, the informed consent standards of the Belmont Report. That section provides in pertinent part:

> (1) Before involving a human subject in research covered by this policy, an investigator shall obtain the legally effective informed consent of the subject or the subject's legally authorized representative.
>
> (8) A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled;[76]

72. 45 C.F.R. § 46.111(a)(5) requires that the informed consent must be documented in writing. The written documentation requirement can be waived but there is no allowance for a waiver of the informed consent requirement.

> Informed consent will be appropriately documented or appropriately waived in accordance with §46.117.

73. Please note that informed consent must be voluntary. If there is a penalty or loss of benefits of any kind, the consent is not voluntary.

NUREMBERG CODE

74. It is a well-established principle that non-consensual human medical experimentation violates the Nuremberg Code and customary international law. That principle was considered authoritative and applicable when determining the application of the Alien Tort Statute.[77]

75. The gravamen of the Nuremberg Code has been adopted in the United States in the *Belmont Report* and under 45 C.F.R. § 46.101, et seq.

76. The President may try to argue that he is informing the recipients of "the consequences, if any, of refusing the administration of the product." That is a misinterpretation of the statute. It would open the statute up to an interpretation that virtually any penalty is authorized as a punishment for refusing the vaccine as long as the patient is informed. It would turn restrictive statutory language on its head and make it permissive. It is basic that consent must be voluntary. The one obtaining the

consent cannot threaten, cajole, or use undue influence. Otherwise, the consent is not voluntary.

48. 21 U.S. Code § 360bbb–3(e)(1)(A)(I) requires informed consent. Such consent must be voluntary to be consent at all. All understand that fact. Indeed, as mentioned earlier, Dr. Amanda Cohn, the executive secretary of the CDC's Advisory Committee on Immunization Practices, stated that vaccines authorized under an EUA, "are not allowed to be mandatory. So, early in this vaccination phase, individuals will have to be consented and they won't be able to be mandatory." Informed consent is not informed consent if it is given under compulsion. The President can no more say that all who refuse the vaccine will be jailed until they agree to be vaccinated as he can require all who refuse to be vaccinated to be fired, wear a mask, be tested for COVID, social distance from others, and be prevented from traveling. That all assumes that the codification of the Nuremberg code in the Belmont Report and federal regulations is inapplicable to the EUA vaccines. Assuming they are applicable, it is clear that the President's edict is unlawful. 45 C.F.R. § 46.116(a)(1) explicitly states that "refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled."

NO EMERGENCY EXCEPTION TO CONSTITUTIONAL RIGHTS

77. The President's order stems from a declared state of emergency. There is no emergency exception to the Constitution. The U.S. Supreme Court has stated the legal maxim that "[t]he Constitution was adopted in a period of grave emergency. Its grants of power to the federal government and its limitations of the power of the States were determined in the light of emergency, and they are not altered by emergency." *Home Building & Loan Ass'n. v. Blaisdell*.[78]

78. In the context of unconstitutional COVID-19 restrictions under executive orders issued by the Pennsylvania Governor, the Honorable William S. Stickman explained in *City of Butler v. Wolf*[79]:

> [G]ood intentions toward a laudable end are not alone enough to uphold governmental action against a constitutional challenge. Indeed, the greatest threats to our system of constitutional liberties may arise when the ends are laudable, and the intent is good—especially in a time of emergency. In an emergency, even a vigilant public may let down its guard over its constitutional liberties only to find that liberties, once relinquished, are hard to recoup and that restrictions—while expedient in the face of an emergency situation—may persist long after immediate danger has passed.[80]

79. Judge Stickman concluded:

> [I]n an emergency, the authority of government is not unfettered. The liberties protected by the Constitution are not fair-weather freedoms—in place when times are good but able to be cast aside in times of trouble. There is no question that this Country has faced, and will face, emergencies of every sort. But the solution to a national crisis can never be permitted to supersede the commitment to individual

> liberty that stands as the foundation of the American experiment. The Constitution cannot accept the concept of a "new normal" where the basic liberties of the people can be subordinated to open-ended emergency mitigation measures. Rather, the Constitution sets certain lines that may not be crossed, even in an emergency. Actions taken by Defendants crossed those lines. It is the duty of the Court to declare those actions unconstitutional.[81]

80. The President lacks any authority to mandate vaccinations of any kind.

JACOBSON V. MASSACHUSETTS

81. This is a good point to address with the alleged precedent of *Jacobson v. Massachusetts*.[82] In *Jacobson*, the U.S. Supreme Court upheld a Massachusetts statute empowering municipal boards of health to require that smallpox vaccinations be given to all residents. Failure to obtain the vaccine subjected the violator to a civil fine.

82. The Honorable Judge Stickman explains the rather tenuous precedent of Jacobson:

> *Jacobson* was decided over a century ago. Since that time, there has been substantial development of federal constitutional law in the area of civil liberties. As a general matter, this development has seen a jurisprudential shift whereby federal courts have given greater deference to considerations of individual liberties, as weighed against the exercise of state police powers. That century of development has seen the creation of tiered levels of scrutiny for constitutional claims. They did not exist when *Jacobson* was decided. While Jacobson has been cited by some modern courts as ongoing support for a broad, hands-off deference to state authorities in matters of health and safety, other courts and commentators have questioned whether it remains instructive in light of the intervening jurisprudential developments.[83]

83. In *Bayley's Campground, Inc. v. Mills*,[84] where the court denied injunctive relief from COVID-19 restrictions, the court nonetheless stated:

> [T]he permissive *Jacobson* rule floats about in the air as a rubber stamp for all but the most absurd and egregious restrictions on constitutional liberties, free from the inconvenience of meaningful judicial review. This may help explain why the Supreme Court established the traditional tiers of scrutiny in the course of the 100 years since Jacobson was decided.[85]

84. Justice Alito's dissent (joined by Justices Thomas and Kavanaugh) to the U.S. Supreme Court's denial of emergency injunctive relief in *Calvary Chapel Dayton Valley v. Sisolak*, 140 S.Ct. 2603 (2020) (Alito, J., dissenting), calls into question whether *Jacobson* remains valid precedent. *Jacobson* is a phantom from a bygone era. Justice Alito argued that the Supreme Court should have granted the requested injunction: "We have a duty to defend the Constitution, and even a public

health emergency does not absolve us of that responsibility." *Id.* at 2604. Justice Alito argued that "a public health emergency does not give Governors and other public officials *carte blanche* to disregard the Constitution for as long as the medical problem persists." *Id.* at 2605. Justice Alito warned that "it is a mistake to take language in *Jacobson* as the last word on what the Constitution allows public officials to do during the COVID–19 pandemic." Id. at 2608. Indeed, he viewed it "a considerable stretch to read the [Jacobson] decision as establishing the test to be applied when statewide measures of indefinite duration are challenged under the First Amendment or other provisions not at issue in that case."[86]

85. Justice Gorsuch's concurrence in *Roman Cath. Diocese of Brooklyn v. Cuomo*[87], questions *Jacobson's* continued viability as the sweeping precedent many ascribe to it. Justice Gorsuch stated that "Jacobson hardly supports cutting the Constitution loose during a pandemic."[88] He had more to say:

> Why have some mistaken this Court's modest decision in *Jacobson* for a towering authority that overshadows the Constitution during a pandemic? In the end, I can only surmise that much of the answer lies in a particular judicial impulse to stay out of the way in times of crisis. But if that impulse may be understandable or even admirable in other circumstances, we may not shelter in place when the Constitution is under attack. Things never go well when we do.[89]

86. As noted by the U.S. Court of Appeals for he Second Circuit in *Agudath Israel of Am. v. Cuomo*[90]: "the *Jacobson* Court itself specifically noted that 'even if based on the acknowledged police powers of a state,' a public-health measure 'must always yield in case of conflict with ... any right which [the Constitution] gives or secures.'"[91] (brackets in original).

FREEDOM OF RELIGION

87. Requiring vaccination violates my sincerely held religious beliefs. It is a violation of my sincerely held religious beliefs to require that I get a vaccine under penalty of masking, social distancing, testing, and travel prohibition.

88. The U.S. Equal Employment Opportunity Commission (EEOC) states that "Title VII of the Civil Rights Act of 1964 requires employers to make a reasonable accommodation for an employee's sincerely held religious beliefs as long as doing so does not pose an undue hardship on the employer."[92] In a case involving a $300,000 judgment against a hospital for refusing to grant a religious exemption for an influenza vaccine, the EEOC has stated that "when considering requests for religious accommodation, the Health Center must adhere to the definition of 'religion' established by Title VII and controlling federal court decisions, a definition that **forbids employers from rejecting accommodation requests based on their disagreement with an employee's belief**; their opinion that the belief is unfounded, illogical, or inconsistent in some way; or their conclusion that an employee's belief is not an official tenet or endorsed teaching of any particular religion or denomination."[93]

89. If a person asserts a sincere religious belief, it is not the function of courts to further explore that belief. The U.S. Supreme Court, in *Thomas v. Rev. Bd. of Indiana*[94], explained that "the resolution of that question is not to turn upon a judicial perception of the particular belief or practice in question; religious beliefs need not be acceptable, logical, consistent, or comprehensible to others in order to merit First Amendment protection."[95] The *Thomas* Court further stated that "it is not within the judicial function and judicial competence to inquire whether the petitioner or his fellow worker more correctly perceived the commands of their common faith. Courts are not arbiters of scriptural interpretation."[96] The *Thomas* Court required that for the government to intrude on a person's religious liberty requires the government to show that "it is the least restrictive means of achieving some compelling state interest."[97] That is a very high hurdle indeed.

90. Furthermore, for the government to allow a medical exemption for the vaccine, which it necessarily must since there are immunocompromised persons who cannot be vaccinated under any circumstances, it must also necessarily allow a religious exemption. The U.S. Supreme Court in Church of the *Lukumi Babalu Aye, Inc. v. City of Hialeah*[98] explained:

> Neutrality and general applicability are interrelated, and, as becomes apparent in this case, failure to satisfy one requirement is a likely indication that the other has not been satisfied. A law failing to satisfy these requirements must be justified by a compelling governmental interest and must be narrowly tailored to advance that interest.[99]

91. That strict scrutiny hurdle is virtually insurmountable, and the *Lukami* Court said so.

> A law that targets religious conduct for distinctive treatment or advances legitimate governmental interests only against conduct with a religious motivation will survive strict scrutiny only in rare cases.[100]

92. The two factors, neutrality and generality, are closely related concepts. The vaccine rules of the President appear to be neutral on their face, but they are arguably not neutral in application. As the court stated in *Ward v. Polite,*[101] "[a] double standard is not a neutral standard."[102] The *Ward* court called for strict scrutiny when a secular exemption to a rule is allowed, but a religious exemption is disallowed. Even if facial neutrality is conceded, that is not enough. As the *Lukumi* Court held, the rule must also be of general application to avoid strict scrutiny. Here, there are medical exemptions allowed. If there is a medical exemption allowed, then the rule is by definition not of general application. The *Lukumi* Court explained:

> Where government restricts only conduct protected by the First Amendment and fails to enact feasible measures to restrict other conduct producing substantial harm or alleged harm of the same sort, the interest given in justification of the restriction is not compelling. It is established in our strict scrutiny jurisprudence that "a law cannot be regarded as protecting an interest 'of the highest order' ... when it leaves appreciable damage to that supposedly vital interest unprohibited."[103] (citation

omitted)

93. Judge (now U.S. Supreme Court Justice) Alito ruled applied that standard in a case where police officers were given medical exemptions from a department beard prohibition rule but not religious exemptions. In *Fraternal Ord. of Police Newark Lodge No. 12 v. City of Newark*,[104] the court ruled that providing medical exemptions while refusing religious exemptions indicates discriminatory intent, which cannot survive even intermediate, let alone strict scrutiny. Allowing a medical exemption while denying a religious exemption puts the vaccine requirement outside the category of general applicability. It would be necessarily discriminatory against religious beliefs, which requires heightened scrutiny. If the government is going to allow an exemption for a secular medical reason, it must also allow an exemption for a religious reason as well, unless there is a compelling government reason to discriminate against a person's freedom of religion in the least intrusive means possible. No such showing has been, nor can be, made here.

94. Anticipating a proposed accommodation of testing and masking, the government cannot offer an option that violates federal workers' constitutional rights and then claim that option is a reasonable accommodation. The option of wearing a mask and being medically tested is not a reasonable accommodation because those procedures infringe on the constitutional rights of federal workers. The U.S. Supreme Court in *Cruzan by Cruzan v. Missouri Dep't of Health*,[105] has advised that "the patient generally possesses the right ... to refuse treatment."The FDA has determined that face masks are medical devices, including cloth face coverings and surgical masks worn for COVID-19 medical purposes.[106] The *Cruzan* Court's ruling establishes a constitutional right to refuse to wear a medical device.[107] The same reasoning applies to medical tests that require the insertion of a swab deep into the nostrils of a government employee once every three days.[108] The federal worker has committed no crime, is not under arrest, is not even suspected of being ill. Such tests are a violation of a federal worker's bodily autonomy.

SINCERELY HELD RELIGIOUS BELIEFS

95. A little-known fact is that the ineffective and dangerous practice of vaccination can be traced not to Dhanwantari (1,500 B.C.), who was considered the Vedic Father of Medicine.[109] The practice of injecting vaccines is founded on a Hindu religious superstition. Vaccination is a religious practice that has been proven to be medically ineffective and harmful.[110]

96. The Hindu religion is a heathen religion. God commands us to have nothing to do with heathen practices. "And have no fellowship with the unfruitful works of darkness, but rather reprove them." Ephesians 5:11. We are called on to avoid such practices. "Beware lest any man spoil you through philosophy and vain deceit, after the tradition of men, after the rudiments of the world, and not after Christ." Colossians 2:8.

97. Christians have nothing religiously in common with Hindus. We are not to practice their heathen religion that masquerades under the guise of medicine. Christians are to separate themselves from the religious practices of heathens. "Be ye not unequally yoked together with unbelievers: for

what fellowship hath righteousness with unrighteousness? and what communion hath light with darkness? And what concord hath Christ with Belial? or what part hath he that believeth with an infidel? And what agreement hath the temple of God with idols? for ye are the temple of the living God; as God hath said, I will dwell in them, and walk in them; and I will be their God, and they shall be my people. Wherefore come out from among them, and be ye separate, saith the Lord, and touch not the unclean thing; and I will receive you, And will be a Father unto you, and ye shall be my sons and daughters, saith the Lord Almighty." (2 Corinthians 6:14-18)

98. The head of my religion is Jesus Christ, and he does not write notes directly. But you are fortunate in that Jesus Christ has documented his sentiment about vaccines in his writings and has given me the authority to speak on his behalf. Indeed, Jesus Christ has documented his objection to the vaccines in a book called the Holy Bible, passages of which I cite below. Furthermore, I hereby incorporate herein by reference the entirety of the Holy Bible, Authorized (King James) Version.

99. I do not need any alleged expert in religion to attest to my sincerely held religious beliefs. Such religious experts are anathema to God. We read in Revelation 2:6 that God hates the Nicolaitans. “But this thou hast, that thou hatest the deeds of the Nicolaitans, which I also hate.” (Revelation 2:6) Who are the Nicolaitans that God hates? The very name, Nicolaitans, contains within it the character of those described. The word Nicolaitans consists of two Greek roots. The first is a Greek word, *nikos,* which is a noun meaning victory or victor; it can also take the form *nike*.[111] The verb form of *nikos* is *nikao*, which means to prevail or overcome.[112] The second half of Nicolaitans is the word *laos*, which means laity or common people.[113] Putting the two words together, we understand that Nicolaitans are those in the church who have prevailed over the common people. It points directly to the distinction in the modern church between the clergy and the laity. It denotes those in the clergy who have worldly hegemony over the submissive laity or common church members.

100. The church is a kingdom. That kingdom has a King. And that King is Jesus Christ. Christ is the "head of the body." Christ has preeminence in "all things." Colossians 1:18. “And he is the head of the body, the church: who is the beginning, the firstborn from the dead; that in all things he might have the preeminence.” (Colossians 1:18) Preeminence means to have superiority over all others. Christ is to have preeminence in the church over “all things.” Christ will not share his preeminence with anyone. *See* Isaiah 42:8. The Bible speaks in condemnation of Diotrephes because he sought to have preeminence in the church. 3 John 1:9-10. Indeed, Jesus could not have made it clearer.

101. The church is not like any other organization found on earth. That is because, while church members are on earth, the church remains a spiritual assembly. Further, the church’s hierarchy is not like earthly hierarchies, where there is a progressive chain of authority leading to the head of the organization. The church’s hierarchy is that there is one head, Jesus Christ, and the body is made up of “ministers.” “As every man hath received the gift, even so minister the same one to another, as good stewards of the manifold grace of God.” (1 Peter 4:10) There is no authoritative structure in a chain of authority leading to Christ. All church members are answerable individually to Jesus Christ. All church members are kings and priests. "And hast made us unto our God kings and priests:

and we shall reign on the earth." (Revelation 5:10) That is why Jesus Christ is described as the **only potentate** and the **King of Kings**. Jesus is the King over his elect Kings, who are born again of the Holy Spirit. The authority of God's kingly elect is derived directly from Jesus Christ, through the Holy Spirit, because Jesus Christ is the ONLY potentate. "Which in his times he shall shew, who is the blessed and only Potentate, the King of kings, and Lord of lords;" (1 Timothy 6:15)

102. The head of my religion, Jesus Christ, speaks through the Holy Spirit, who has all authority on earth to speak on behalf of Jesus. The Holy Spirit leads God's elect to all truth. "Howbeit when he, the Spirit of truth, is come, he will guide you into all truth: for he shall not speak of himself; but whatsoever he shall hear, that shall he speak: and he will shew you things to come." John 6:13. Those who are the elect of Jesus Christ are led by his Holy Spirit and will bear the fruit of that leading. "For as many as are led by the Spirit of God, they are the sons of God." (Romans 8:14) John explains how the Holy Spirit abiding in the believer gives him the faith that moves him to keep the commandments to love God and love his neighbor: "And he that keepeth his commandments dwelleth in him, and he in him. And hereby we know that he abideth in us, by the Spirit which he hath given us." (1 John 3:24) Each church member has the unction of the Holy Spirit and has standing to speak on issues of faith and doctrine. "But ye have an unction from the Holy One, and ye know all things." (1 John 2:20) All who are saved are given the understanding of God's word. "All scripture is given by inspiration of God, and is profitable for doctrine, for reproof, for correction, for instruction in righteousness:" (2 Timothy 3:16) We see in Job that inspiration means understanding. "But there is a spirit in man: and the inspiration of the Almighty giveth them understanding." (Job 32:8) Inspiration through the unction of the Holy Ghost gives all who read God's word "understanding" of his word. His word is given by inspiration of the Holy Spirit to understand it. Jesus has documented his objection to the vaccines through his word in the Holy Bible, passages of which I cite below.

103. The gospel message is that those who have saving faith and are thus justified will live by that faith. Their faith is a living faith, not a dead faith. "For therein is the righteousness of God revealed from faith to faith: as it is written, The just shall live by faith." Romans 1:17. See also Galatians 3:11. Indeed, God has a warning for those who purport to believe but who do not live by faith. "Now the just shall live by faith: but if any man draw back, my soul shall have no pleasure in him." (Hebrews 10:38) "Not every one that saith unto me, Lord, Lord, shall enter into the kingdom of heaven; but he that doeth the will of my Father which is in heaven." (Matthew 7:21) Faith brings obedience. It is special obedience wrought by God through faith that God imparts in the believer. "But now is made manifest, and by the scriptures of the prophets, according to the commandment of the everlasting God, made known to all nations for the obedience of faith." (Romans 16:26) We are called on to have nothing to do with evil. We are to avoid even the appearance of evil. We are to "abstain from all appearance of evil." 1 Thessalonians 5:22. Indeed, we are to reprove evil. "And have no fellowship with the unfruitful works of darkness, but rather reprove them." (Ephesians 5:11)

104. Vaccines often contain aborted fetal tissue, and those that do not contain aborted fetal tissue are often developed using aborted fetal tissues. That practice is abhorrent to my sincerely held religious beliefs. My sincerely held religious belief is that abortion constitutes the unjustified killing

of an unborn child. I base that belief on the teachings of Jesus Christ as contained in the Holy Bible. For example, Dr. Brianne Barker, associate professor of biology at Drew University, explains that "in order to make the [Johnson and Johnson COVID-19] vaccine, the scientists give PerC6 [fetal] cells DNA so that they can make the parts of the virus and build that molecular machine—basically the PerC6 [fetal] cells are the factories that make the vaccine for us."[114] The PERC6 fetal cells are allegedly later filtered out of the J&J COVID-19 vaccine before it is put into vials for injection.[115] Pfizer/BioNTech and Moderna used the HEK293 fetal cell lines in their testing stages for their COVID-19 vaccines.[116]

a. The HEK293 fetal line derived from an elective abortion in the 1970s is routinely used to produce proteins and cultivate viruses.[117] HEK is an acronym for human embryonic kidney cells.

b. The WI-38 fetal line was derived from fetal tissues harvested from an elective abortion in the 1960s to generate the attenuated viruses.[118]

c. The MRC-5 fetal line was derived from fetal lung tissues harvested from an elective abortion in 1966. The abortion records indicate that it was taken from a 14-week male fetus removed for psychiatric reasons from a 27-year-old woman with a genetically normal family history. MRC-5 is used to generate the attenuated viruses.[119]

d. The origin of PER.C6 fetal line is documented through direct testimony before the Food and Drug Administration's Vaccines and Related Biological Products Advisory Committee from Dr. Alex Van Der Eb, who stated: "So I isolated retina [cells] from a fetus, from a healthy fetus as far as could be seen, of 18 weeks old. There was nothing special in the family history, or the pregnancy was completely normal up to 18 weeks, and it turned out to be a socially indicated abortus, abortus provocatus, and that was simply because the woman wanted to get rid of the fetus."[120] The PER.C6 fetal line is currently used in the research and development of vaccines.

105. I base my belief that abortion is the sin of unjustifiable homicide on the teachings of Jesus Christ as contained in the Holy Bible. To receive a vaccine that is the product of abortion violates my sincerely held religious beliefs.

a. God states that we are living souls from the moment of conception in the womb.

i. "For thou hast possessed my reins: thou hast covered me in my mother's womb. I will praise thee; for I am fearfully and wonderfully made: marvellous are thy works; and that my soul knoweth right well." (Psalms 139:13-14)

ii. "Listen, O isles, unto me; and hearken, ye people, from far; The LORD hath

called me from the womb; from the bowels of my mother hath he made mention of my name." (Isaiah 49:1)

b. Indeed, we are ordained to be living souls by God before our conception in our mothers' womb. We are formed by God in the womb.

i. "Before I formed thee in the belly I knew thee; and before thou camest forth out of the womb I sanctified thee, and I ordained thee a prophet unto the nations." (Jeremiah 1:5)

c. It is God who is the creator of all things, including the creator of each man in his mother's womb.

i. "As thou knowest not what is the way of the spirit, nor how the bones do grow in the womb of her that is with child: even so thou knowest not the works of God who maketh all." (Ecclesiastes 11:5)

d. God of the Lord of all, both born and unborn.

i. "I was cast upon thee from the womb: thou *art* my God from my mother's belly." (Psalms 22:10)

e. Fetuses in the womb are sentient. We see that in Luke when, Elizabeth was greeted by Mary, who was pregnant with Jesus. John the Babtist, who was unborn and in Elizabeth's womb jumped for joy upon hearing the Mary's greeting.

i. "And it came to pass, that, when Elisabeth heard the salutation of Mary, the babe leaped in her womb; and Elisabeth was filled with the Holy Ghost:" (Luke 1:41)

f. God hates the shedding of innocent blood.

i. "These six things doth the LORD hate: yea, seven are an abomination unto him: A proud look, a lying tongue, and **hands that shed innocent blood**, An heart that deviseth wicked imaginations, feet that be swift in running to mischief, A false witness that speaketh lies, and he that soweth discord among brethren." (Proverbs 6:16-19)

g. The Holy Bible states that God elected Jacob as the heir to the promise. God elected Jacob before he was born.

i. "That is, They which are the children of the flesh, these are not the children of God: but the children of the promise are counted for the seed. For this is

the word of promise, At this time will I come, and Sara shall have a son. And not only this; but when Rebecca also had conceived by one, even by our father Isaac; (For the children being not yet born, neither having done any good or evil, that the purpose of God according to election might stand, not of works, but of him that calleth;) It was said unto her, The elder shall serve the younger. As it is written, Jacob have I loved, but Esau have I hated." (Romans 9:8-13)

(1) Notice also what God states about Jacob and Esau. God elected Jacob before they were born and before either he or Esau had done any good or evil. That means that children who are aborted have not done any evil. There is no justification for their death; they are innocent. The killers are culpable, and those who encourage and abet them in their deadly scheme are accomplices in that sin. Unless they repent and turn in faith to Jesus Christ, they will be punished by God accordingly. *See* Matthew 25:31-46; Romans 2:3-9; 2 Corinthians 5:10; Revelation 20:11-15.

h. Abortion is homicide. God has commanded that we shall not kill one another.

i. "Thou shalt not kill." (Exodus 20:13)

106. My sincere Christian beliefs are founded on the Holy Bible. The Bible says:"For the life of the flesh is in the blood..." Leviticus 17:11, and "... the life of all flesh; the blood of it is for the life thereof." Leviticus 17:14.

a. Therefore, in order to preserve the life of my flesh, I must keep my blood unpolluted from foreign proteins, antigens, adjuvents, and other pollutants that are typically found in vaccines.

107. Vaccines are given to people who are well. It is against my faith to be injected with a vaccine when I am not ill. To do so is to take on a spirit of fear and reliance on man rather than God.

a. "But when Jesus heard that, he said unto them, They that be whole need not a physician, but they that are sick." (Matthew 9:12)

b. "For God has not given us a spirit of fear, but of power and of love and of a sound mind" (2 Timothy 1:7).

108. As a Christian, I am religiously bound to care for my body as it is the temple of the Holy Spirit.

a. "Know ye not that ye are the temple of God, and that the Spirit of God dwelleth in

you? If any man defile the temple of God, him shall God destroy; for the temple of God is holy, which temple ye are." (1 Corinthians 3:16-17)

b. "What? know ye not that your body is the temple of the Holy Ghost which is in you, which ye have of God, and ye are not your own? For ye are bought with a price: therefore glorify God in your body, and in your spirit, which are God's." (1 Corinthians 6:19-20)

c. It is the wish of God that we prosper in our physical health. "Beloved, I wish above all things that thou mayest prosper and be in health, even as thy soul prospereth." 3 John 1:2.

d. I sincerely believe that vaccines are detrimental to my health, and thus, it would violate my sincerely held religious beliefs to harm my body by being vaccinated.

i. Vaccine-Induced Allergies

(1) Vinu Arumugham, in an article written for the Journal of Developing Drugs, reveals that "Nobel Laureate Charles Richet demonstrated over a hundred years ago that injecting a protein into animals or humans causes immune system sensitization to that protein."[121] What does that mean for the person receiving the vaccine? Arumugham explains that "[s]ubsequent exposure to the protein can result in allergic reactions or anaphylaxis."[122] Thus, food proteins injected into a person through a vaccine can have the effect of causing a subsequent allergic reaction by that person who subsequently eats food that contains the food proteins in the vaccine. That means that vaccines can cause food allergies. Arumugham reveals that this scientific fact of vaccine-induced allergies "has since been demonstrated over and over again in humans and animal models."[123] Vaccines contain food proteins derived from chicken eggs, casein, gelatin, soy, agar, etc. Those ingredients sound innocent enough. And if they were eaten they would not be harmful, and indeed would be nutritious. But when those same ingredients are injected into a human body, in a significant number of cases, a person to develop an allergic reaction or even anaphylaxis to that food protein. The allergic reaction is caused because accompanying the food protein is an adjuvant whose purpose is to stimulate the immune response of the body to the antigen. The problem is that the stimulated immune response is not limited to the antigen. The body also develops an immune response to the food proteins in the vaccine. The stimulated immune response to the food protein causes an allergic response to the food when consumed. For example, casein is a phosphoprotein

derived from milk. Trace amounts of casein are often found in vaccines. Indeed, the DTaP children's vaccine is cultured using bovine casein as a medium. There has been an explosion of people who have developed allergies to milk. According to the American College of Allergy, Asthma, and Immunology, "cow's milk is the most common food allergy in children under the age of 5."[124] It is probable that milk allergies in young children are a direct result of the stimulated immune response to the bovine casein in the DTaP vaccine.

ii. Aluminum Adjuvants in Vaccines

(1) Vaccines contain adjuvants that are designed to stimulate the immune response to the antigen in the vaccine. A common adjuvant is aluminum.[125] Indeed, the CDC lists aluminum, aluminum hydroxide, aluminum phosphate, aluminum sulfate, or aluminum hydroxyphosphate sulfate as ingredients in 27 vaccines.[126] Aluminum is a dangerous neurotoxin and carcinogen. Research has established that "[t]he adverse neurologic, hematopoietic, skeletal, respiratory, immunologic, and other effects associated with excessive aluminum (Al) exposures are well known."[127] Research has proven that the neurological effects of aluminum include "impairment on neurobehavioral tests for psychomotor and cognitive performance and an increased incidence of subjective neurological symptoms."[128] Indeed, "studies clearly identify the nervous system as the most sensitive target of aluminum toxicity."[129] In studies involving "intramuscular administration of aluminum hydroxide or aluminum phosphate vaccine adjuvants in rabbits, increased levels of aluminum were found in the kidney, spleen, liver, heart, lymph nodes, and brain (in decreasing order of aluminum concentration)."[130]

iii. Mercury Preservatives in Vaccines

(1) On or about 1999, the U.S. Food and Drug Administration (FDA) determined that mercury in vaccines, in the form of thimerosal, exceeded FDA guidelines for mercury exposure. Mercury is a known neurotoxin. The mercury safety standards were determined by measuring methylmercury. But the mercury in thimerosal metabolizes in the body as ethylmercury. The FDA had no safety guidelines for ethylmercury. The FDA did not know what to do so, they correctly required vaccine companies to reduce or eliminate the use of thimerosal in vaccines. The CDC identifies thimerosal as a preservative that is still being used in vaccines. While thimerosal has

been removed from childhood vaccines, according to the CDC, it remains an ingredient in influenza and tetanus and diptheria vaccines.[131]

iv. Polyethylene Glycol (PEG) in Vaccines

(1) Both the Moderna and the Pfizer/BionTech COVID-19 mRNA vaccines contain lipids, which have polyethylene glycol as part if the lipid ingredients.[132] PEG has been proven to cause hypersensitivity reactions.[133] A hypersensitivity reaction is a type of exaggerated or inappropriate immune response that can include anaphylaxis.[134] "The Anaphylaxis is a medical emergency because can lead to an acute, life-threatening respiratory failure."[135] Indeed, as of March 5, 2021, "at least 1,689 recipients of the Pfizer and Moderna injections have reported anaphylactic or serious allergic reactions."[136] The anaphylaxis was predictable. Prior research documented the detrimental effects of PEG on drug delivery. On September 25, 2020, Robert Kennedy, Jr., warned the FDA and NIH about the dangers of PEG in the (at that time) proposed mRNA vaccines.[137] No action was taken by the FDA, NIH, Moderna, or Pfizer to mitigate the risk inherent in the mRNA vaccine PEG excipients.

v. Polysorbate 80 in Vaccines

(1) Polysorbate 80 is an excipient contained in the Johnson & Johnson (aka Janssen) COVID-19 vaccine.[138] It is also an ingredient in the following vaccines: DtaP-IPV, Hep B influenza Meningaogoccal, Pneumococcal, Rotavirus, Tdap, Shingles.[139] Polysorbate 80 has been proven to cause hypersensitivity reactions.[140] A hypersensitivity reacion is a type of exaggerated or inappropriate immune response that can include anaphylaxis.[141] "The Anaphylaxis is a medical emergency because it can lead to an acute, life-threatening respiratory failure."[142] Indeed, CNBC reported that "[t]wo trial participants suffered severe allergic reactions shortly after getting Johnson & Johnson's Covid-19 vaccine."

109. The Food and Drug Administration granted emergency use authorization (EAU) for the COVID-19 vaccines. None of the COVID-19 vaccines are approved by the FDA. Aaron Siri is the Managing Partner of Siri & Glimstad LLP. He has published a legal opinion that "federal law prohibits employers and others from requiring vaccination with a Covid-19 vaccine distributed under an EUA."[143] The FDA's guidance on emergency use authorization of medical products requires the FDA to "ensure that recipients are informed to the extent practicable given the applicable circumstances … That **they have the option to accept or refuse the EUA product** …"[144] In the

same vein, when Dr. Amanda Cohn, the executive secretary of the CDC's Advisory Committee on Immunization Practices, was asked if Covid-19 vaccination can be required, she responded that under an EUA, **"vaccines are not allowed to be mandatory. So, early in this vaccination phase, individuals will have to be consented and they won't be able to be mandatory."**[145] Cohn later affirmed that this prohibition on requiring the vaccines applies to organizations, including hospitals.[146] The EUAs for COVID-19 vaccines require facts sheets to be given to vaccination providers and recipients. These fact sheets make clear that getting the vaccine is optional. For example, the fact sheet for recipients states that, "It is your choice to receive or not receive the Covid-19 Vaccine," and if "you decide to not receive it, it will not change your standard of medical care." Aaron Siri points out that the FDA's position that the COVID-19 vaccines authorized under an EUA cannot be mandated is because of the fact that informed consent is required by federal statute. Siri explains that "the same section of the Federal Food, Drug, and Cosmetic Act that authorizes the FDA to grant emergency use authorization also requires the secretary of Health and Human Services to **"ensure that individuals to whom the product is administered are informed … of the option to accept or refuse administration of the product."**[147] Finally, it is well-established principle that non-consensual human medical experimentation is a violation of the medical ethical standards enumerated in federal regulations, the Belmont Report, the Nuremberg Code, and customary international law. *See Abdullahi v. Pfizer*, 562 F.3d 163, 174-188 (2nd Cir. 2009). Coerced vaccinations are also a violation of the supreme law of the land, the U.S. Constitution.

110. Christians are to avoid even the appearance of evil. We are to "abstain from all appearance of evil." 1 Thessalonians 5:22. Indeed, we are to reprove evil. "And have no fellowship with the unfruitful works of darkness, but rather reprove them." (Ephesians 5:11) "Let every soul be subject unto the higher powers. For there is no power but of God: the powers that be are ordained of God. Whosoever therefore resisteth the power, resisteth the ordinance of God: and they that resist shall receive to themselves damnation. For rulers are not a terror to good works, but to the evil. Wilt thou then not be afraid of the power? do that which is good, and thou shalt have praise of the same: For he is the minister of God to thee for good. But if thou do that which is evil, be afraid; for he beareth not the sword in vain: for he is the minister of God, a revenger to execute wrath upon him that doeth evil. Wherefore ye must needs be subject, not only for wrath, but also for conscience sake." (Romans 13:1-5) We are called on to submit to the supreme law of the land, which is the U.S. Constitution and constitutional statutes. We are to obey the civil authorities as long as such obedience conforms with God's precepts. When there is a conflict, "[w]e ought to obey God rather than men." Acts 5:29. When there is no conflict, and the government has not usurped power not granted to it in the U.S. Constitution, we are called on to obey the civil powers. However, when the government itself violates the constitution that violation is by definition illegal. Christians are to resist such illegal usurpations by the government. The vaccine requirement announced by President Biden is illegal. Edmund Burke said it best: "The only thing necessary for the triumph of evil is for good men to do nothing."

MORTON'S FORK - WEARING A MEDICAL DEVICE

111. The person who refuses to be vaccinated must wear a mask. A mask is a medical device. The FDA explains:

> **The FDA regulates face masks, including cloth face coverings, and surgical masks as medical devices when they are marketed for medical purposes. Medical purposes include uses related to COVID-19, such as face masks to help stop the spread of disease, surgical masks, and surgical masks with antimicrobial/antiviral agents.** Face masks marketed to the general public for general non-medical purposes, such as for use in construction and other industrial applications, are not medical devices.[148]

112. One who refuses to get vaccinated must be subjected to a medical test to determine if they are infected before entering a federal building or taking part in an official function other than teleworking. This proposed test must be performed once every three days.

113. Furthermore, if the person who must wear the mask is tested and shown not to have COVID-19, there is no threat of the spread of COVID-19 from the wearer, even if one were to believe the discredited theory of asymptomatic spread. That is because an asymptomatic carrier would necessarily test positive for COVID-19. Testing positive for COVID-19 but not having symptoms of the disease is what it means to be an asymptomatic carrier. It is not a reasonable accommodation to force someone who tests negative for COVID-19 to nonetheless wear a mask that serves no useful purpose. The person cannot spread COVID-19. It is irrational to require him to wear a mask. That suggests that the mask is a punishment for refusing to be vaccinated and not intended as a reasonable accommodation.

CONSTITUTIONAL RIGHT TO PRIVACY VIOLATION

114. Both the mask and testing mandates violate my constitutional rights. It is a long-established principle that a person has a constitutional right to be let alone. For example, in *Union Pac. R. Co. v. Botsford*, 141 U.S. 250, 251 (1891), the U.S. Supreme Court ruled:

> The single question presented by this record is whether in a civil action for an injury to the person, the court, on application of the defendant, and in advance of the trial may order the plaintiff without his or her consent, to submit to a surgical examination as to the extent of the injury sued for. We concur with the circuit court in holding that it had no legal right or power to make and enforce such an order. **No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.** As well said by Judge Cooley: **'The right to one's person may be said to be a right of complete immunity; to be let alone.'** Cooley, Torts, 29.[149] (emphasis added)

115. Indeed, in his dissenting opinion in *Olmstead v. United States*,[150] Justice Brandeis described the right to be left alone as the most valuable and comprehensive of rights. He stated that in the U.S. Constitution, the founding fathers, "conferred, as against the government, **the right to be let alone**-the most comprehensive of rights and the right most valued by civilized men."[151]

116. Part and parcel of that right to be let alone (a.k.a. the right to privacy) is the right to bodily integrity. The U.S. Supreme Court in *Cruzan by Cruzan v. Missouri Dep't of Health*,[152] has advised that "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment."[153] The *Cruzan* Court explained that a person has a constitutional right to refuse medical treatment. "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."[154] The *Cruzan* Court stated that the right to refuse medical treatment includes medical treatment deemed necessary to save one's life. The *Cruzan* Court stated that "for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."[155]

117. If a court cannot order a medical examination, neither can the executive. The same reasoning should apply to medical tests that require the insertion of a swab deep into the nostrils of a government employee once every three days. There is a constitutional right to be let alone recognized by the U.S. Supreme Court. In most cases, this right has been framed as a right to privacy. The U.S. Supreme Court has described this right to privacy as encompassed by penumbras spanning beyond the language in the Bill of Rights. For example, in *Griswold v. Connecticut*, 381 U.S. 479 (1965), the U.S. Supreme court explained that its precedent "suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance."[156]

118. Some states have a provision that specifically enumerates a state constitutional right to be let alone. That right prohibits the government from mandating medical tests and the wearing of medical devices, such as masks. For example, a recent decision by the Florida Court of Appeals ruled that a mandate to wear masks violated the enumerated right to be let alone in the Florida Constitution. In *Green v. Alachua City*,[157] the court ruled that "[a]lthough the constitutional text is silent on the point, the supreme court has explained repeatedly that within the right to be let alone is 'a fundamental right to the sole control of his or her person.'"[158] The court ruled that the mask mandate violated the Florida Constitution. The court said that the "guarantee of bodily and personal inviolability—which we are asked to follow—must include the inviolability of something so intimate as one's own face. **A person then reasonably can expect to be free from governmental coercion regarding what he puts on it."**[159] (emphasis added)

119. Although the U.S. Constitution does not have the specific provision enumerating a right to be let alone as does the Florida Constitution, as we have seen in *Botsford*, *Griswold*, and *Cruzan*, that right to be let alone is every bit a federal constitutional right. The *Griswold* majority specifically cited to the Ninth Amendment as a source for the penumbras in the Bill of Rights wherein is found the right to privacy. "The Ninth Amendment provides: 'The enumeration in the Constitution, of

certain rights, shall not be construed to deny or disparage others retained by the people.'"[160]

120. In his *Griswold* concurrence, Justice Goldberg recognized that the Ninth Amendment is one of the sources for the unenumerated right to privacy. Just Goldberg stated:

> The Ninth Amendment to the Constitution may be regarded by some as a recent discovery and may be forgotten by others, but since 1791 it has been a basic part of the Constitution which we are sworn to uphold. To hold that a right so basic and fundamental and so deeprooted in our society as the right of privacy in marriage may be infringed because that right is not guaranteed in so many words by the first eight amendments to the Constitution is to ignore the Ninth Amendment and to give it no effect whatsoever. Moreover, a judicial construction that this fundamental right is not protected by the Constitution because it is not mentioned in explicit terms by one of the first eight amendments or elsewhere in the Constitution would violate the Ninth Amendment, which specifically states that **'(t)he enumeration in the Constitution, of certain rights shall not be construed to deny or disparage others retained by the people.'**[161] (emphasis added)

121. It is a violation of my constitutional right to privacy (which is synonymous with my right to be let alone) to require me to wear a mask on my face in lieu of being vaccinated or to require me to be subjected to a medical test in lieu of being vaccinated. While there is no express right enumerated in the U.S. Constution that addresses masks or medical tests, the Bill of Rights recognizes that the people retain all God-given rights that are not specifically enumerated in the U.S. Constitution. I have a God-given right to bodily integrity, and as such, the government cannot mandate that I put a mask on my face or be subjected to a medical test.

122. In *Meyer v. Nebraska*,[162] the U.S. Supreme Court ruled that the due process rights protected by the U.S. Constitution include a litany of rights that are not explicitly enumerated.

> While this court has not attempted to define with exactness the liberty thus guaranteed [by the Fourteenth Amendment].... Without doubt, it denotes not merely freedom from bodily restraint but also the right of the individual to contract, to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, to worship God according to the dictates of his own conscience, and generally to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men.[163]

123. The U.S. Supreme Court in *Meyer* stated that regardless of the purpose of ensuring the state's collective safety, a statute cannot infringe on the constitutionally guaranteed freedom and autonomy of the individual. In *Meyer*, the noble purpose was to ensure that immigrant children learn the English language so that they would better be assimilated into the American culture. A statute that

punished a teacher for teaching a 10-year-old child the German language. The student had not yet passed the 8th grade and teaching a young child a foreign language before being fluent in English was thought to be a threat to the safety of the state and country because the student would revert to the ideas and sentiments of the foreign state.

124. The *Meyer* Court ruled that "[t]he established doctrine is that this liberty may not be interfered with, under the guise of protecting the public interest, by legislative action which is arbitrary or without reasonable relation to some purpose within the competency of the state to effect. Determination by the Legislature of what constitutes proper exercise of police power is not final or conclusive but is subject to supervision by the courts." Id. at 399-400.

125. The *Meyer* Court rebutted the public health and safety argument for justifying the statute. "[T]here seems no adequate foundation for the suggestion that the purpose was to protect the child's health by limiting his mental activities. It is well known that proficiency in a foreign language seldom comes to one not instructed at an early age, and experience shows that this is not injurious to the health, morals or understanding of the ordinary child." *Id.* at 403.

126. That is precisely the issue with which we are faced. The argument by the government that science shows us that face coverings can help stop the spread of the COVID-19 virus. The government's argument today is like argument of the state in *Meyer* that prohibiting children from learning a foreign language before passing the 8th grade is detrimental to the health and safety of the state. Both arguments are unsupportable by the evidence.

VIOLATION OF CONSTITUTIONAL RIGHT TO FREE SPEECH

127. The First Amendment to the U.S. Constitution provides:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.[164]

128. In *Gitlow v. New York*,[165] the U.S. Supreme Court ruled that "freedom of speech and of the press—which are protected by the First Amendment from abridgment by Congress—are among the fundamental personal rights and 'liberties' protected by the due process clause of the Fourteenth Amendment from impairment by the States." Id. at 666.

129. An expected mask requirement as an accommodation in lieu of a vaccine restrains verbal and non-verbal speech, both of which are critical for the ability of the citizens to communicate effectively. Both of which are protected by the U.S. Constitution.

130. Facial coverings severely limit the volume and reach of speech. It unconstitutionally impairs

speech and discourages people from speaking or communicating with others because the mask makes it difficult to hear the speaker's muffled voice. The speaker is restrained from conversion because the difficulty in breathing when wearing the suffocating mask requires the wearer to cut the conversation shorter than otherwise would be the case. Such mask requirements "abridge" the free speech rights of the people in violation of the Virginia and U.S. Constitutions.

131. Furthermore, non-verbal communication is protected by the right to free speech because facial expressions carry communicative information. While that truth is common sense, it is supported by studies that have shown that facial expressions carry communication. For example, a study by the Wellcome Trust Centre for Neuroimaging at UCL, Centre of Functionally Integrative Neuroscience, University of Aarhus concluded that "[t]he emotional expressions presented by faces are not simply reflexive, but also have a communicative component."[166] "For example, empathic expressions of pain are not simply a reflexive response to the sight of pain in another, since they are exaggerated when the empathizer knows he or she is being observed. It seems that we want people to know that we are empathic. Of especial importance among facial expressions are ostensive gestures such as the eyebrow flash, which indicate the intention to communicate. These gestures indicate, first, that the sender is to be trusted and, second, that any following signals are of importance to the receiver."*[167]*

132. The U.S. Supreme Court has recognized that the right to free speech includes the right to express oneself in ways that do not involve talking. For example, in *Tinker v. Des Moines Indep. Cmty. Sch. Dist.*,[168] the U.S. Supreme Court struck down a school regulation that prohibited the wearing of black armbands to protest the Vietnam war. The Court stated that the armbands, although they did not involve the use of words, were nonetheless protected by the Constitution as free speech because they were expressions of ideas and thoughts.

133. In *Texas v. Johnson*,[169] the U.S. Supreme Court stated that the First Amendment protects any conduct if "that conduct may be sufficiently imbued with elements of communication to fall within the scope of the First and Fourteenth Amendments."*[170]* The *Johnson* Court further stated that "the State's argument cannot depend here on the distinction between written or spoken words and nonverbal conduct. That distinction, we have shown, is of no moment where the nonverbal conduct is expressive."*[171]*

134. The mask regulation does limit free communication. But the mask mandate is not specifically designed to regulate speech. And thus it should be reviewed under the intermediate scrutiny standard, rather than the strict scrutiny standard required when the content of speech is being regulated.

135. To pass the intermediate scrutiny test, the President's orders must be narrowly tailored to accomplish a substantial government interest.[172] If the restrictions by the President are not narrowly tailored to accomplish the "substantial" government interest, then the restrictions are unconstitutional.

136. The President's order requires all federal employees to be vaccinated.

137. A masking requirement in lieu of a vaccine, as will likely be proposed for those who claim a religious exemption from vaccination, is not narrowly tailored to address the federal government's alleged interest in stopping the spread of COVID-19. A requirement to wear a mask is irrational. That truth is confirmed when one looks at the research reports establishing that masks are neither safe nor effective in preventing the spread of infectious diseases.

138. In a given context, a facial expression of a smile is as much communication of approval as would be spoken words. In a given context, a facial expression of a frown would be just as much a communication of disapproval as spoken words. To order that federal employee's faces be covered so that they cannot communicate with others through their facial expressions is an infringement of freedom of expression in violation of the U.S. Constitutions.

FACE MASKS ARE INEFFECTIVE

139. A mask requirement is based on the premise that wearing a face mask is safe and effective. Upon examination of the science, we find that supporting data for wearing masks is not only lacking, but the weight of the scientific evidence is that wearing a mask is unsafe and ineffective.

140. A landmark randomized study that included a control group found that face masks are ineffective in preventing the spread of COVID-19.[173]

141. Carl Heneghan and Tom Jefferson, writng for *The Spectator,* summarized the study: "In the end, there was no statistically significant difference between those who wore masks and those who did not wear masks when it came to being infected by COVID-19. 1.8 percent of those wearing masks caught COVID, compared to 2.1 percent of the control Group."[174]

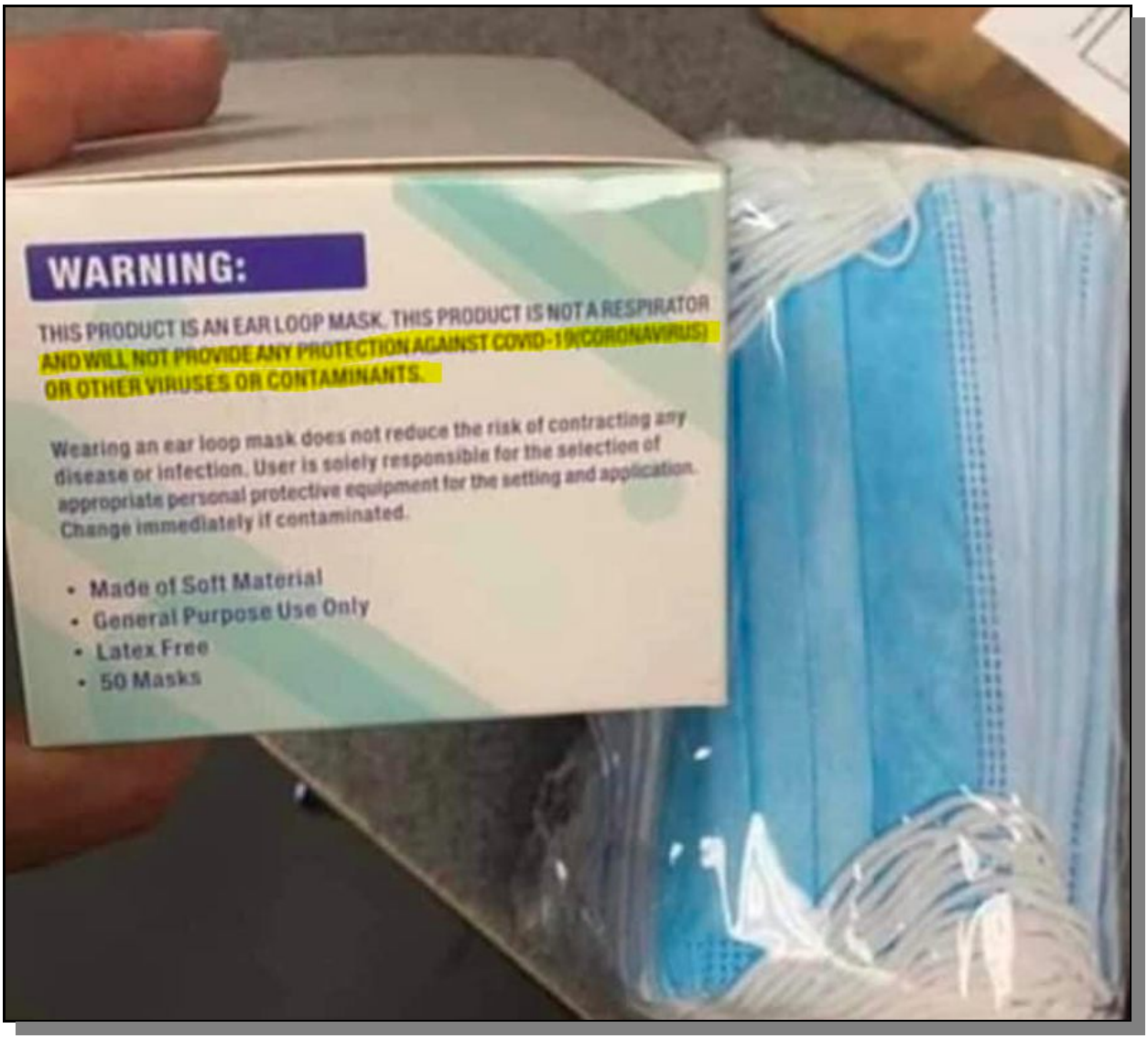


Figure 1: Warning On Box of Ear Loop Face Masks: **"THIS PRODUCT IS AN EAR LOOP MASK. THIS PRODUCT IS NOT A RESPIRATOR AND WILL NOT PROVIDE ANY PROTECTION AGAINST COVID-19 (CORONAVIRUS) OR ANY OTHER VIRUSES OR CONTAMINANTS."**

142. The randomized and controlled Denmark study contradicts the less scientific observational studies done in the Far East that alleged some benefit to wearing masks to prevent COVID-19. Observational studies have inherent deficiencies that often cause the observers to reach faulty conclusions. Heneghan and Jefferson point out that "observational studies are prone to recall bias: in the heat of a pandemic, not very many people will recall if and when they used masks and at what distance they kept from others. The lack of random allocation of masks can also 'confound' the results and might not account for seasonal effects."[175] A randomized controlled study, like the Denmark mask study, removes the inherent unreliability that attends observational studies.

143. William Kaplan, was appointed as an arbitrator to decide a dispute between the Ontario Hospital Association (OHA) and the Ontario Nurse's Association (ONA). The collective bargaining agreement allowed the nurses working in the association hospitals to refuse influenza (flu) vaccination. The HOA imposed a new policy whereby if a nurse refused the influenza vaccine she would have to wear a mask while in the hospital. It was called a vaccine or mask policy (VOM). The ONA brought a complaint that the policy was coercive and, thus, in violation of the collective bargaining agreement.[176]

144. The arbitrator in *St. Michael's Hospital* conducted 21 hearings spanning three years. He presided over testimony from many expert witnesses, reviewed many volumes of scientific studies, meta-analyses, commentaries, and expert commentaries. The arbitrator found that the VOM was not coercive, but he nonetheless struck it down because he determined that it was unreasonable.

145. In 2018 Kaplan rendered his opinion and determined that the scientific studies and expert testimony established that masks are ineffective in preventing nurses from spreading the flu to others. He further determined that masks are ineffective in protecting nurses from getting the flu. The arbitrator ruled that "[t]here is no persuasive evidence establishing a conclusive relationship between the use of surgical and procedural masks and protection against influenza transmission." The arbitrator cited one particular scientific study, which concluded that "there is a lack of substantial evidence to support claims that face-masks protect either patient or surgeon from infectious contamination." The arbitrator cited the U.S. Centers for Disease Control (CDC), which stated categorically: "No studies have definitively shown that mask use by either infectious patients or health-care personnel prevents influenza transmission."

146. Regarding the asymptomatic tor pre-symptomatic transmission of the flu, the arbitrator stated that "[a]t best, the evidence indicates that asymptomatic transmission is not a significant factor in nosocomial influenza." The arbitrator cited to a credible expert witness who testified that "[t]he evidence that pre-symptomatic or asymptomatic infections contribute substantially to influenza transmission remains scant."

147. On April 1, 2020, the New England Journal of Medicine published an article that concluded that "wearing a mask outside health care facilities offers little, if any, protection from infection." The article went on to state that "[t]he chance of catching Covid-19 from a passing interaction in a public space is therefore minimal."[177] The article was authored by:

> Michael Klompas, M.D., M.P.H.,
> Charles A. Morris, M.D., M.P.H.,
> Julia Sinclair, M.B.A.,
> Madelyn Pearson, D.N.P., R.N.,
> and Erica S. Shenoy, M.D., Ph.D.
>
> Author Affiliations: From the Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute (M.K.), Brigham and Women's

> Hospital (M.K., C.A.M., J.S., M.P.), Harvard Medical School (M.K., C.A.M., E.S.S.), and the Infection Control Unit and Division of Infectious Diseases, Massachusetts General Hospital (E.S.S.) — all in Boston.

148. In a bizarre twist, the New England Journal of Medicine posted the following notice in a ribbon above the study:

> Editor's Note: This article was published on April 1, 2020, at NEJM.org. In a letter to the editor on June 3, 2020, the authors of this article state "We strongly support the calls of public health agencies for all people to wear masks when circumstances compel them to be within 6 ft of others for sustained periods."

149. That strange statement contradicts the conclusion drawn from their study that "[t]he chance of catching Covid-19 from a passing interaction in a public space is therefore minimal. In many cases, the desire for widespread masking is a reflexive reaction to anxiety over the pandemic." Their study with attributed authority says wearing a mask is ineffective, but later without citing any reason or authority, they make what seems to be a political statement saying to wear those ineffective masks anyway. That nonsense statement that contradicted the results of the study was obviously the result of institutional pressure.

150. Denis G. Rancourt, Ph.D., researched the effectiveness of wearing a mask and concluded that masks and respirators do not work in preventing influenza-like illnesses. Dr. Rancourt concluded:

> There have been extensive randomized controlled trial (RCT) studies, and meta-analysis reviews of RCT studies, which all show that masks and respirators do not work to prevent respiratory influenza-like illnesses, or respiratory illnesses believed to be transmitted by droplets and aerosol particles.
>
> ***
>
> Furthermore, individuals should know that there is no known benefit arising from wearing a mask in a viral respiratory illness epidemic, and that scientific studies have shown that any benefit must be residually small, compared to other and determinative factors.[178]

151. The U.S. Centers for Disease Control (CDC) published a study showing that of the patients who tested positive for COVID-19, 85% (70.6% + 14.4% = 85%) of them either always wore a mask or often wore a mask. Thus, the study indicates that masks are largely ineffective in preventing the contraction of COVID-19.[179] Another interesting outcome of the study is that 88.7% of non-COVID-19 participants either always wore a mask or often wore a mask. They nonetheless were symptomatic with flu-like illnesses. There seems to be a high correlation between wearing a mask and becoming ill from disease.[180]

To assess community and close contact exposures associated with COVID-19, exposures reported by case-patients (154) were compared with exposures reported by control-participants (160). Case-patients were symptomatic adults (persons aged =18 years) with SARS-CoV-2 infection confirmed by reverse transcription–polymerase chain reaction (RT-PCR) testing. Control-participants were symptomatic outpatient adults from the same health care facilities who had negative SARS-CoV-2 test results.

Reported use of cloth face covering or mask 14 days before illness onset (missing = 2)

Characteristics	**Case Patients Symptomatic and Testing Positive for COVID-19** (n=154)	Control Participants Symptomatic But Testing Negative for COVID-19 (n=160)	P-Value
Never Wore Mask	6 (3.9%)	5 (3.1%)	0.86
Rarely Wore Mask	6 (3.9%)	6 (3.8%)	
Sometimes Wore Mask	11 (7.2%)	7 (14.5%)	
Often Wore Mask	22 **(14.4%)**	23 (14.5%)	
Always Wore Mask	109 **(70.6%)**	118 (74.2%)	

Figure 2: **Above is the pertinent mask portion of study published by the CDC regarding COVID-19 contact exposures with the notable statistics highlighted, bold emphasis added, and the description from the study moved and appended above the chart.**

152. Dr. Russell Blaylock is a nationally recognized board-certified neurosurgeon, health practitioner, author, and lecturer. Dr. Blaylock states that "a recent careful examination of the literature, in which 17 of the best studies were analyzed, concluded that, 'None of the studies established a conclusive relationship between mask/respirator use and protection against influenza infection.' Keep in mind, no studies have been done to demonstrate that either a cloth mask or the N95 mask has any effect on transmission of the COVID-19 virus. Any recommendations, therefore, have to be based on studies of influenza virus transmission. And, as you have seen, there is no conclusive evidence of their efficiency in controlling flu virus transmission."[181]

153. Dr. Brosseau is a national expert on respiratory protection and infectious diseases and professor (retired), University of Illinois at Chicago. Dr. Sietsema is also an expert on respiratory protection and an assistant professor at the University of Illinois at Chicago. The recommendation of the two doctors is based on a review of available literature and informed by professional expertise and consultation. These two eminent experts concluded: "Our review of relevant studies indicates that cloth masks will be ineffective at preventing SARS-CoV-2 transmission, whether worn as

source control or as PPE [Personal Protective Equipment]."[182]

154. The researchers further determined that "[t]here is no evidence that surgical masks worn by healthcare workers are effective at limiting the emission of small particles or in preventing contamination of wounds during surgery."[183]

155. That in and of itself is an astounding finding since we are so accustomed to doctors wearing masks during surgery to prevent them from contaminating their patients. The two researchers determined that "[c]linical trials in the surgery theater have found no difference in wound infection rates with and without surgical masks. Despite these findings, it has been difficult for surgeons to give up a long-standing practice."*[184]*

156. Checking the studies themselves bears out their conclusion. One research study conducted by Th. Goran Tunivall, M.D., spanned 115 weeks and involved 3,088 patients. There were 1,537 operations performed with face masks, resulting in 73 (4.7%) wound infections. But among the 1,551 operations performed without face masks, there were only 55 (3.5%) infections. Dr. Tunivall deemed the difference not to be statistically significant and confirmed the data from all other studies that face masks do not decrease postoperative infections. Indeed, Dr. Tunivall stated that "[i]t has never been shown that wearing surgical face masks decreases postoperative wound infections."[185]

157. "The AAPS [American Association of Physicians and Surgeons], a national association of doctors founded in 1943, accurately delineates the physics and dynamics of face masks. Any government official that mandates the wearing of masks to prevent the spread of COVID-19 is acting in complete defiance of proven scientific facts."[186]

158. The reason for requiring face masks is that the alleged threat of asymptomatic transmission of COVID-19. Asymptomatic transmission of COVID-19 is a theory that has never been proven. Indeed, it is a theory that an authoritative scientific study has refuted. A research study conducted between May 14 and June 1, 2020, involving almost 10 million residents of Wuhan, China, found zero transmission of COVID-19 from asymptomatic carriers of the disease. The report revealed that "[a]ll city residents aged six years or older were eligible and 9,899,828 (92.9%) participated." The researchers identified 300 asymptomatic positive cases. The researchers then closely contact traced the asymptomatic persons who tested positive for COVID-19. They found that "[t]here were no positive tests amongst 1,174 close contacts of asymptomatic cases."[187]

159. The ineffectiveness of masks is known among infectious disease experts. For example, In March 2020, Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID), told CBS News chief medical correspondent Dr. Jonathan LaPook that there's no reason people in the U.S. should wear a mask. Fauci stated that "right now in the United States people should not be walking around with masks ... there is no reason to be walking around in a mask."[188] Indeed, his statement is as true now as when he said it in March 2020. Dr. Fauci's advice has been confirmed as accurate by Dr. Juday Mikovits and Dr. Rahid Buttar.[189] The advice not to wear a mask is advice that is also verified by infectious disease experts Drs. Dan Erickson and Atin Massihi.[190]

The World Health Organization (WHO) has also stated that "[t]he only people who should be wearing masks are healthy people who are taking care of someone who is sick or sick people who are coughing or sneezing when they are in public."[191]

160. On February 29, 2020, the U.S. Surgeon General Jerome Adams firmly tweeted, "Seriously people- STOP BUYING MASKS!" The Surgeon General explained in the tweet that masks "are NOT effective in preventing the general public from catching coronavirus."[192] (Emphasis in original)

161. The Washington Post reported that the U.S. Surgeon General Jerome Adams said on "Fox & Friends" on Monday morning. **"There are things people can do to stay safe. There are things they shouldn't be doing. One of the things they shouldn't be doing, the general public, is going out and buying masks. It actually does not help, and it has not been proven to be effective in preventing the spread of coronavirus amongst the general public."**[193]

162. The U.S. Surgeon General explains that the surgical masks worn in hospitals serve one function only, and "that is mostly intended to protect the patient or outside world from the wearer's respiratory emissions. It is not considered to provide respiratory protection for the wearer."[194]

163. There is another kind of mask that is intended to partially protect a worker. An N-95 mask falls in that category. The Washington Post further reported that Surgeon General Adams said that as a health-care worker, he has to get "fit tested" when wearing protective masks, and those who do not wear the masks properly tend to fidget with them or touch their faces — **which "actually can increase the spread of coronavirus.**"[195]

164. That is correct. The U.S. Surgeon General said that the surgical masks that are commonly worn by the public can actually increase the spread of coronovirus.

165. On March 31, 2020, Fox News reported the Surgeon General saying:

> "What the World Health Organization [WHO] and the CDC [The Centers for Disease Control and Prevention] have reaffirmed in the last few days is that they do not recommend the general public wear masks."
>
> He then explained the reasons why.
>
> "On an individual level, there was a study in 2015 looking at medical students and medical students wearing surgical masks touch their face on average 23 times," Adams explained. "We know a major way that you can get respiratory diseases like coronavirus is by touching a surface and then touching your face so wearing a mask improperly can actually increase your risk of getting disease."[196]

166. Both Dr. Fauci and Surgeon General Adams later equivocated on their original no-mask opinions. But their reason for flip-flopping was based on a now discredited theory that asymptomatic

people can infect other people with coronavirus. President Donald Trump recognized the strange flip-flop of Dr. Fauci and the U.S. Surgeon General about wearing face masks; the president also recognized the danger of wearing face masks. During a July 19, 2020, interview with Fox News' Chris Wallace, President Trump stated: "Hey, Dr. Fauci said 'don't wear a mask.' Our surgeon general, a terrific guy, said 'don't wear a mask.' Everybody was saying 'don't wear a mask.' All of a sudden everybody's got to wear a mask. And as you know masks cause problems too."[197]

167. On April 3, 2020, the U.S. Surgeon General changed course and stated that masks are recommended to prevent the spread of COVID-19. But he explained that the mask is not a protective device. He did not back off on his reason for initially stating that masks are unnecessary and ineffective. He reiterated that a mask does not prevent a person from being infected, the mask only prevents a person who has COVID-19 from spreading it to another person. A mask does not protect a healthy person. A mask only prevents a person wearing the mask who is a carrier of COVID-19 from spreading the disease to another person.[198] He changed course because the CDC theorized that a person who does not have symptoms COVID-19 could nonetheless spread the disease to another. The theory that asymptomatic carriers of COVID-19 could spread the disease has now been proven false.[199]

MASK MANDATE IS COMPELLED SYMBOLIC SPEECH

168. Thus, masks do not prevent the spread of COVID-19, because asymptomatic carriers cannot spread COIVD-19, and thus, it is pointless for healthy people to wear masks. In addition, the masks do not prevent the wearer from being infected. Why then is the CDC now recommending that the public wear masks?

169. There is reason for wearing masks that has been revealed by government officials. They explain that masks are symbolic. In essence, the mask is virtue signaling. USA Today reported that "[t]op infectious disease specialist Dr. Anthony Fauci said Wednesday that he wears a mask as a **'symbol'** of what 'you should be doing' during the coronavirus pandemic."[200] You read that correctly. The mask is largely symbolic. Dr. Fauci elaborated:

> "I want to protect myself and protect others, and also because **I want to make it be a symbol for people to see that that's the kind of thing you should be doing,"** Fauci told CNN.[201]

170. Dr. Fauci knows that the masks are not effective. He is on record saying so. Dr. Fauci views mask wearing a way to show respect for others.

> When asked by host Jim Sciutto if his wearing of a mask encouraged their use, Fauci acknowledged masks aren't "100% effective" but are a "valuable safeguard" and part of **"respect for another person."**

171. CNN explained that "[a]mid coronavirus surge, health officials urge people to wear masks

as a symbol of respect."[202] CNN argued that government health officials think that "[a] face mask is more than a piece of cloth. It's a sign of respect."[203] CNN quotes Dr. Fauci saying **"It signifies one common good and that is care for the public health."**[204] The article continues:

> "This is not about politics," said Dr. Leana Wen, Baltimore's former health commissioner, an emergency physician and public health professor at George Washington University. "This is about each of us **showing that we care about one another, that we respect one another."**
>
> Noting that behavior change takes time, Dr. Joshua Barocas, an infectious diseases physician at Boston Medical Center, says wearing a mask can help reduce transmission, help form a good habit and serve as a **sign of respect**. "I think beyond simply the viral transmission, **wearing a mask can just be a symbol**," said Barocas. **"It can show people that you are committed to the cause,** that you're committed to fighting Covid-19 as a community... committed to protecting other people's lives and their children's lives and their families' lives... committed to having a strong economy open when we're fully ready."
>
> Dr. Jessica Justman, an infectious diseases specialist and epidemiologist at Columbia University and attending physician at the Columbia University Irving Medical Center, says that **messaging plays an important role in the implementation of public health strategies**, like this one. She says that **it can make a difference when a leader dons a face mask as an example to others.**[205]

172. Masks are essentially symbolic. Symbols are inherently communicative. A symbol is defined in the Merriam-Webster Dictionary as "an authoritative summary of faith or doctrine: creed."[206] The definition continues: "a visible sign of something invisible. ... an object or act representing something in the unconscious mind that has been repressed ... an act, sound, or object having cultural significance and the capacity to excite or objectify a response"[207] Thus, wearing a mask is symbolic of some invisible idea, and most significantly, religious doctrines or faith.

173. Everyone who wears a mask is communicating an invisible idea or doctrine to others.When the government forces a person to wear a mask, it forces that person to communicate an idea. The government medical professionals acknowledge that fact. They have stated that wearing a mask is the communication part of the public health strategy The mask communicates that the wearer is "committed to the cause," that you "care for the public health" and as a "sign of respect." But what if a person disagrees with the public health strategy? Should a dissenting person be forced to wear a mask that falsely communicates to the world that they are "committed to the cause?" Certainly not! Just as a Democrat should not be forced to campaign on behalf of a Republican, a person should not be forced to wear a mask that communicates that he is committed to a cause to which he is certainly not committed. Government mask mandates are essentially government compelled speech. To compel speech is to violate a citizen's Constitutional First Amendment Right to free speech.

174. The U.S. Supreme Court has ruled that "[j]ust as the First Amendment may prevent the government from prohibiting speech, the Amendment may prevent the government from compelling individuals to express certain views."[208] The U.S. Supreme Court has been strident on that point. "The right to speak and the right to refrain from speaking are complementary components of the broader concept of 'individual freedom of mind.'"[209] The state cannot require a person to carry an ideological message on his private property[210], in like manner, the state cannot require a person to wear a symbolic mask on his face that conveys an ideological message.

MASK MANDATE VIOLATES FREEDOM OF RELIGION

175. Professor William Schaffner, a preventive medicine professor at the Vanderbilt University School of Medicine, revealed one of the impulses to wear masks. Dr. Shaffner explained that it comes down to psychology. He said that "[b]y getting masks and wearing them, we move the locus of control somewhat to ourselves."[211] The masks don't do any good. They just make the wearer feel better. And that is just what Dr. Fauci said. Masks evoke an emotional response from the wearer.

176. Indeed, the Encyclopedia Britannica explains that mask-wearing is essentially a religious practice. Earlier in the Merriam-Webster Dictionary definition of symbol, we saw that symbols primarily convey "an authoritative summary of faith or doctrine: creed."[212] The government medical authorities mandating masks admit that the masks are primarily symbolic. The Encyclopedia Britannica explains that the concept of masks having medical efficacy is closely associated with social convention and religious superstition. "Many masks are primarily associated with ceremonies that have religious and social significance or are concerned with funerary customs, fertility rites, or the **curing of sickness**."[213] Masks are often worn by those taking part in occult and satanic rituals. According to Gayland Hurst, Ph.D., one of the characteristics of occult-related homicide is that the body is found wearing a mask.[214] The symbolic wearing of a mask causes the person to take on an alter-ego, whereby a spirit being (i.e., a devil) acts through him. The Encyclopedia Britannica explains the religious meaning behind the wearing of masks:

> The person who wears the mask is also considered to be in direct association with the mask's spirit force and is consequently exposed to like personal danger of being affected by it. ... Upon donning the mask, the wearer sometimes undergoes a psychic change and as in a trance assumes the spirit character depicted by the mask. Usually, however, the wearer skillfully becomes a "partner" of the character he is impersonating, giving to the mask not only an important spark of vitality by the light flashing from his own eyes but also bringing it alive by his movements and poses. But often the wearer seems to become psychologically one with the character he is helping to create. He seems to become an automaton, without his own will, which has become subservient to that of the personage of the mask. At all times there remains some important, even if sub rosa, association between the mask and its wearer.[215]

177. As we have seen, the wearing of a mask is not medically efficacious. The government

medical professionals claim the masks are efficacious but acknowledge that wearing a mask is primarily symbolic. Thus mask-wearing is, in essence, communicative. But the mask also has a spiritual effect on its wearer. To mandate the wearing of a mask is to impose a religious effect on the wearer in contravention of the wearer's Constitutional First Amendment right to freedom of religion and violates the establishment clause.[216]

178. It is my sincerely held religious belief that the mask mandate is part of Satan's plan to subjugate the world under the rule of his Antichrist. Jesus describes Satan as the father of lies. "When he speaketh a lie, he speaketh of his own: for he is a liar, and the father of it." John 8:44. The mask mandate is based on a lie. Wearing a mask gives testimony to the world that the wearer is "committed to the cause."[217] I am NOT "committed to the cause" because the cause is a deception. To signify to the world that I am committed to the cause is a lie. To force me to wear an ineffective and unsafe mask that only serves to symbolize my agreement with the COVID-19 deception violates my sincerely held religious beliefs. I am called on to walk uprightly and not to walk in a twisted deceitful way. "He that walketh uprightly walketh surely: but he that perverteth his ways shall be known." Proverbs 10:9. To walk with a mask that testifies to a lie is to walk in darkness. "If we say that we have fellowship with him, and walk in darkness, we lie, and do not the truth." 1 John 1:6. The mask has all of the appearance of evil, of which I am called on to eschew. "Abstain from all appearance of evil." 1 Thessalonians 5:22.

179. The government has acknowledged that the vaccines they are mandating do not prevent the infection or spread of COVID-19. They have given an exemption from wearing a mask to a vaccinated person who is just as likely to be infected and spread COVID-19 as the unvaccinated person. As explained in the FREEDOM OF RELIGION section, *supra*, since the government allows a secular medical exemption for the masks (vaccination), it must also necessarily allow a religious exemption. There is also the medical exemption allowed for those with medical conditions who cannot wear a mask. The U.S. Supreme Court in *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*[218] explained:

> Where government restricts only conduct protected by the First Amendment and fails to enact feasible measures to restrict other conduct producing substantial harm or alleged harm of the same sort, the interest given in justification of the restriction is not compelling. It is established in our strict scrutiny jurisprudence that "a law cannot be regarded as protecting an interest 'of the highest order' ... when it leaves appreciable damage to that supposedly vital interest unprohibited."[219] (citation omitted)

180. Furthermore, If the person who must wear the mask is tested and shown not to have COVID-19, there is no threat of the spread of COVID-19 from the wearer, even if one were to believe the discredited theory of asymptomatic spread. That is because an asymptomatic carrier would necessarily test positive for COVID-19. Testing positive for COVID-19 but not having symptoms of the disease is what it means to be an asymptomatic carrier. It is not a reasonable accommodation to force someone who tests negative for COVID-19 to nonetheless wear a mask.

Since the person has tested negative for COVID-19, the mask serves no useful purpose. An uninfected person cannot spread COVID-19. It is irrational to require him to wear a mask. That suggests that the mask is a punishment for refusing to be vaccinated and not a reasonable accommodation.

181. Since the weight of the evidence is against the efficacy and safety of wearing masks to prevent COVID-19 and the only other reason for the mask is symbolic, To wear the mask violates my sincerely held religious beliefs. Consequently, I must necessarily be granted a religious exemption from wearing a mask.

182. Furthermore, the mask requirement acts as a punishment for exercising my constitutional right not to be vaccinated.

RELIGIOUS EXEMPTION FROM TESTING

183. As explained in detail in this memorandum, both the PCR and Antigen tests for COVID-19 have been proven inaccurate. They have been proven to produce false-positive results. The testing is a charade where someone tests positive and is falsely deemed to be an asymptomatic carrier of COVID-19. When in reality, that person is not infected with COVID-19 at all. Furthermore, as this memorandum explains, the COVID-19 scare is just that, a scare. COVID-19 is not a deadly disease. It is no more harmful than the ordinary seasonal flu. It is against my sincerely held religious beliefs to take part in an evil and deceptive charade that needlessly puts people in fear to drive them to take an ineffective and unsafe vaccine. I am called on to "[a]bstain from all appearance of evil." 1 Thessalonians 5:22.

184. The government allows an exemption from the COVID-19 test if they take what has now been proven to be an unsafe and ineffective vaccine. As explained in the FREEDOM OF RELIGION section, *supra*, since the government allows an exemption for a secular reason (vaccination), it must also necessarily allow a religious exemption. The U.S. Supreme Court in *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*[220] explained:

> Where government restricts only conduct protected by the First Amendment and fails to enact feasible measures to restrict other conduct producing substantial harm or alleged harm of the same sort, the interest given in justification of the restriction is not compelling. It is established in our strict scrutiny jurisprudence that "a law cannot be regarded as protecting an interest 'of the highest order' ... when it leaves appreciable damage to that supposedly vital interest unprohibited."[221] (citation omitted)

185. The government does not have a compelling interest in COVID-19 testing since the tests do not have to be given if someone takes an ineffective and unsafe vaccine and the test itself is inaccurate. The government is on record stating that a person who has been vaccinated can still spread the COVID-19. Thus, the government's position is that a vaccinated person can spread

COVID-19 in the same way as is an unvaccinated person. But the government allows an exemption from COVID-19 testing for a vaccinated person. Since a person is given a secular basis (vaccination) for being exempt from testing, I, therefore, should also be exempted from taking part in any COVID-19 testing because of my sincerely held religious beliefs.

186. Furthermore, the testing acts as a punishment for exercising my constitutional right not to be vaccinated.

RELIGIOUS FREEDOM RESTORATION ACT

187. Under the Religious Freedom Restoration Act, the government may not substantially burden a person's exercise of religion unless the government "demonstrates that application of the burden to the person (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest."[222] There is no way that the government can meet that burden of demonstrating a compelling government interest for the vaccine, mask, or testing requirements because it offers secular exemptions to each condition. According to Supreme Court precedent of *Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*[223], the government must necessarily also allow a religious exemption for each of those requirements.

FACE MASKS ARE UNSAFE

188. Nationally-renowned board-certified neurosurgeon Dr. Russell Blaylock states that "[w]hile most agree that the N95 mask can cause significant hypoxia [reduction in blood oxygenation] and hypercapnia [elevation of CO2 in the blood], another study of surgical masks found significant reductions in blood oxygen as well. In this study, researchers examined the blood oxygen levels in 53 surgeons using an oximeter. They measured blood oxygenation before surgery as well as at the end of surgeries. The researchers found that the mask reduced the blood oxygen levels (pa02) significantly. The longer the duration of wearing the mask, the greater the fall in blood oxygen levels."[224]

189. Dr. Blaylock points out that "the importance of these findings is that a drop in oxygen levels (hypoxia) is associated with an impairment in immunity. Studies have shown that hypoxia can inhibit the type of main immune cells used to fight viral infections called the CD4+ T-lymphocyte. This occurs because the hypoxia increases the level of a compound called hypoxia inducible factor-1 (HIF-1), which inhibits T-lymphocytes and stimulates a powerful immune inhibitor cell called the Tregs. This sets the stage for contracting any infection, including COVID-19 and making the consequences of that infection much graver. In essence, your mask may very well put you at an increased risk of infections and if so, having a much worse outcome."[225]

190. Dr. Blaylock warns:

> There is another danger to wearing these masks on a daily basis, especially if worn for several hours. When a person is infected with a respiratory virus, they will expel

> some of the virus with each breath. If they are wearing a mask, especially an N95 mask or other tightly fitting mask, they will be constantly rebreathing the viruses, raising the concentration of the virus in the lungs and the nasal passages. We know that people who have the worst reactions to the coronavirus have the highest concentrations of the virus early on. And this leads to the deadly cytokine storm in a selected number. It gets even more frightening. Newer evidence suggests that in some cases the virus can enter the brain. In most instances it enters the brain by way of the olfactory nerves (smell nerves), which connect directly with the area of the brain dealing with recent memory and memory consolidation. By wearing a mask, the exhaled viruses will not be able to escape and will concentrate in the nasal passages, enter the olfactory nerves and travel into the brain.[226]

191. Dr. Blaylock specifically cites cancer as a risk of wearing a mask. Indeed, this has been known since Nobel Laureate Otto Warburg's discovery in 1931, and subsequent studies have confirmed that a reduction in oxygen level in the body increases the risk of cancer.

192. In a research study by Dr. Blaylock that was published by the National Institute of Health (NIH), Dr. Blaylock states that "[i]t is now known that angiogenesis [in cancer cells] is an early process and is driven by hypoxia."[227] Angiogenesis is the formation of new blood vessels. Angiogenesis is "a hallmark of cancer, being necessary for both the growth (progression) and spread (metastasis) of cancer." *Id.* Dr. Blaylock further found that "[h]ypoxia is also known to increase expression of CXCR4, which stimulates tumor cell migration and is associated with highly aggressive tumors and a poor prognosis."[228]

193. Dr. Blaylock states that "[p]eople with cancer, especially if the cancer has spread, will be at a further risk from prolonged hypoxia as the cancer grows best in a microenvironment that is low in oxygen. Low oxygen also promotes inflammation which can promote the growth, invasion and spread of cancers."[229]

194. Dr. Blaylock has further found that "[r]epeated episodes of hypoxia has been proposed as a significant factor in atherosclerosis and hence increases all cardiovascular (heart attacks) and cerebrovascular (strokes) diseases."[230]

195. Furthermore, according to the Occupational Safety and Health Administration (OSHA), "[o]xygen deficient atmosphere means an atmosphere with an oxygen content below 19.5%."[231]

196. Richard E. Fairfax, Director of the Directorate of Enforcement Programs for OSHA explains in an official post that "[p]aragraph (d)(2)(iii) of the Respiratory Protection Standard considers any atmosphere with an oxygen level below 19.5 percent to be oxygen-deficient and immediately dangerous to life or health."[232]

197. What would cause such an oxygen-deficient condition? According to OSHA, "[o]xygen-deficient atmospheres may be created when oxygen is displaced by inerting gases, such

as carbon dioxide."[233]

198. That displacement of air by exhaled carbon dioxide is precisely the condition a person finds himself in when wearing a mask over his mouth and nose. Such a practice lowers the oxygen level below the safe limit of 19.5%, which OSHA has deemed to be "immediately dangerous to life." That fact seems to be the cause of the deleterious health effects of wearing masks found in the studies cited by Dr. Blaylock.

199. The typical oxygen level is approximately 20.5%. But when a mask is put over the wearer's mouth and nose, the oxygen level being breathed back in by the wearer of a mask drops to a range between 17% and 18%.[234]

200. That reduced level of oxygen, according to OSHA, is "immediately dangerous to life." And it does not matter whether it is a surgical mask, an N95 mask, or a thin cloth covering. In tests using all different types of masks, the oxygen level for the wearer dropped to a level below 19.5%, which OSHA has determined is an "oxygen-deficient atmosphere" that is "immediately dangerous to life." Indeed, one woman wearing a mask while driving her car passed out unconscious from oxygen deprivation and crashed into a wooden telephone pole.[235]

201. But when pressed about wearing masks to prevent the spread of COVID, OSHA cleverly dodged the issue by stating that the oxygen level standards in their regulations "do not apply to the wearing of medical masks or cloth face coverings."[236] But the issue is not whether the regulations apply to wearing masks. Nobody argued that they do. The issue is whether the standard under their regulations for a safe oxygen level is true. On that matter, OSHA has not backed down. According to OSHA, an oxygen level below 19.5 percent to be oxygen-deficient and immediately dangerous to life or health."[237] Thus, wearing a mask that reduces the oxygen behind the mask to 17-18% is immediately dangerous to life.

202. Wearing masks creates an environment of moist warm air conducive to the incubation of pathogens. The breathing of those pathogens introduces them into the mouth and lungs and on the skin causing infections of the skin, tooth decay, and other illnesses. Some of those pathogens have been found to be resistant to antibiotics. For example, laboratory analysis of six face masks worn by children at a Florida school found that "five masks were contaminated with bacteria, parasites, and fungi, including three with dangerous pathogenic and pneumonia-causing bacteria."[238] One-third (33%) of the pathogens found in the masks were determined to be antibiotic-resistant pathogens.[239]

203. Dr. Margarite Griesz-Brisson M.D., Ph.D.,[240] is a Consultant Neurologist and Neurophysiologist. She has a Ph.D. in Pharmacology, specializing in neurotoxicology, environmental medicine, neuroregeneration and neuroplasticity. Dr. Grisz-Brisson is the founder and medical director of the London Neurology and Pain Clinic. Dr. Griesz-Brisson holds membership in the American Academy of Neurology, the European Federation of Neurological Societies (EFNS), the General Medical Council, United Kingdom, the German Medical Association, the Swiss Medical Society, the European Academy for Environmental Medicine, and the International Board for

Clinical Metal Toxicology. Dr. Griesz-Brisson holds medical licenses in Germany, USA, Switzerland, United Kingdom, Qatar, and Norway. She is one of the foremost experts in the world on the effects of oxygen deprivation on the brain. Dr. Griesz-Brisson states that wearing a mask over one's mouth and nose creates an oxygen deficiency and an increased intake of carbon dioxide. It causes an oxygen deficiency for the brain cells.[241] In essence, the brain is being suffocated, which causes irreversible degeneration of the brain. Depriving the developing brain of needed oxygen causes brain damage that "cannot be reversed." Dr. Griesz-Brisson unequivocally warned that prolonged mask-wearing for hours on end will cause irreversible brain damage. She explains that the effects of oxygen deprivation are irreversible. Dr. Griesz-Brisson stated:

> The rebreathing of our exhaled air will without a doubt create oxygen deficiency and flooding of carbon dioxide. We know that the human brain is very sensitive to oxygen deprivation. There are nerve cells for example in the hippocampus that can't be longer than 3 minutes without oxygen – they cannot survive. The acute warning symptoms are headaches, drowsiness, dizziness, issues in concentration, slowing down of the reaction time – reactions of the cognitive system.
>
> However, when you have chronic oxygen deprivation, all of those symptoms disappear because you get used to it. But your efficiency will remain impaired, and the undersupply of oxygen in your brain continues to progress.
>
> We know that neurodegenerative diseases take years to decades to develop. If today you forget your phone number, the breakdown in your brain would have already started 20 or 30 years ago.
>
> While you're thinking that you have gotten used to wearing your mask and rebreathing your own exhaled air, the degenerative processes in your brain are getting amplified as your oxygen deprivation continues.
>
> The second problem is that the nerve cells in your brain are unable to divide themselves normally. So in case our governments will generously allow us to get rid of the masks and go back to breathing oxygen freely again in a few months, the lost nerve cells will no longer be regenerated. What is gone is gone.
>
> ***
>
> When in ten years, dementia is going to increase exponentially, and the younger generations couldn't reach their God-given potential, it won't help to say "we didn't need the masks."

204. Sayer Ji, writing for *Green Med Info*, reports that a Meta-Analysis of 65 scientific studies reveals that wearing a face mask induces a serious medical condition that has been labeled: Mask-Induced Exhaustion Syndrome (MIES).[242] The research report, published in the *International*

Journal of Environmental Research and Public Health, was written by eight doctors and researchers with broad scientific expertise in cellular anatomy, neuroscience, pathology, pathophysiology, psychology, and medicine.[243]

205. The research paper reveals that "mask-related changes in respiratory physiology can have an adverse effect on the wearer's blood gases sub-clinically and in some cases also clinically manifest and, therefore, have a negative effect on the basis of all aerobic life, external and internal respiration, with an influence on a wide variety of organ systems and metabolic processes with physical, psychological and social consequences for the individual human being."[244]

206. **Masks Make Breathing Difficult:** The study proves that due to airway resistance of the mask, "the mask acts as a disturbance factor in breathing and makes the observed compensatory reactions with an increase in breathing frequency and simultaneous feeling of breathlessness plausible (increased work of the respiratory muscles). This extra strain due to the amplified work of breathing against bigger resistance caused by the masks also leads to intensified exhaustion with a rise in heart rate and increased CO2 production."[245]

207. **Neurological Disorders from Wearing Masks:** The restricted airflow causes a significant drop in oxygen intake and a concomitant increase in carbon dioxide intake. This causes the mask wearer to be confused, disoriented, and drowsy. The researchers found that these neurological impairments were a direct result of mask-wearing. "In view of the scientific data, this connection also appears to be indisputable."[246] The study shows that "masks also restrict the cognitive abilities of the individual (measured using a Likert scale survey) accompanied by a decline in psycho-motoric abilities and consequently a reduced responsiveness (measured using a linear position transducer) as well as an overall reduced performance capability (measured with the Roberge Subjective Symptoms-during-Work Scale)."[247]

208. **Susceptibility to Accidents While Wearing Masks:** The researchers determined that masks caused the wearer to suffer "confusion, impaired thinking, disorientation … and in some cases a decrease in maximum speed and reaction time …. This can become clinically relevant especially with regard to the further reduced ability to react and the additional increased susceptibility to accidents of such patients when wearing masks."[248]

209. **Bacterial Infections from Masks:** It was found that "germs (bacteria, fungi and viruses) accumulate on the outside and inside of the masks due to the warm and moist environment. They can cause clinically relevant fungal, bacterial or viral infections." The researchers cited a New York study that evaluated a random sample of 343 participants. The study found that frequent wearing of surgical mask type and N95 masks among healthcare workers during the COVID-19 pandemic "caused headache in 71.4% of participants, in addition to drowsiness in 23.6%, detectable skin damage in 51% and acne in 53% of mask users."

210. **Mask Mouth:** The researchers further also noted what has been come to be known as "mask mouth." "There are reports from dental communities about negative effects of masks and are

accordingly titled 'mask mouth.' Provocation of gingivitis (inflammation of the gums), halitosis (bad breath), candidiasis (fungal infestation of the mucous membranes with Candida albicans) and cheilitis (inflammation of the lips), especially of the corners of the mouth, and even plaque and caries are attributed to the excessive and improper use of masks."[249] The researchers found that "the main trigger of the oral diseases mentioned is an increased dry mouth due to a reduced saliva flow and increased breathing through the open mouth under the mask. Mouth breathing causes surface dehydration and reduced salivary flow rate. Dry mouth is scientifically proven due to mask wear. The bad habit of breathing through the open mouth while wearing a mask seems plausible because such breathing pattern compensates for the increased breathing resistance, especially when inhaling through the masks. In turn, the outer skin moisture with altered skin flora, which has already been described under dermatological side effects, is held responsible as an explanation for the inflammation of the lips and corners of the mouth (cheilitis). This clearly shows the disease-promoting reversal of the natural conditions caused by masks. The physiological internal moisture with external dryness in the oral cavity converts into internal dryness with external moisture."[250]

211. **Voice Disorders:** The report noted that "masks act like an acoustic filter and provoke excessively loud speech. This causes a voice disorder. The increased volume of speech also contributes to increased aerosol production by the mask wearer."[251]

212. **Masks Increase the Spread of Germs:** The researchers found that masks increase germs because "the masks act like nebulizers and contribute to the production of very fine aerosols. Smaller particles, however, spread faster and further than large ones for physical reasons. Of particular interest in this experimental reference study was the finding that a test subject wearing a single-layer fabric mask was also able to release a total of 384% more particles (of various sizes) when breathing than a person without."[252]

213. **Masks Cause Depression in Wearers:** There were also found severe psychological effects of mask-wearing. "[M]asks also frequently cause anxiety and psycho-vegetative stress reactions in children—as well as in adults—with an increase in psychosomatic and stress-related illnesses and depressive self-experience, reduced participation, social withdrawal and lowered health-related self-care. Over 50% of the mask wearers studied had at least mild depressive feelings."[253]

214. There is reasonable medical certainty that wearing a face mask will cause hypoxia, hypercapnia, and other conditions that would be dangerous to my health.

VIOLATION OF CONSTITUTIONAL RIGHT TO PEACEABLY ASSEMBLE

215. The President has become the bull in our china shop of rights. How so? One of the fragile rights violated by the laws he has passed in his vaccine coercion plan is the federal workers' right to peaceably assemble. In his July 29, 2021 order, he mandated social distancing for the unvaccinated. That will likely be one of the accommodations suggested for those granted a religious exemption from the vaccination mandate under this September 9, 2021 order.

216. The President's authority is limited. He does not have the constitutional authority to issue restrictions on the right of the people, wherever they are situated, to peaceably assemble.

217. The limitation on abridgment of the right of the people to peaceably assemble is found in the First Amendment to the U.S. Constitution. The United States Supreme Court has ruled that the First Amendment to the U.S. Constitution limits the authority of the government to infringe on the right of the people to assemble peaceably.[254] The First Amendment to the U.S. Constitution prohibits "any law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances."[255]

218. The U.S. Supreme Court has found that freedom of assembly "cannot be denied without violating those fundamental principles of liberty and justice which lie at the base of all civil and political institutions."[256] Indeed, the U.S. Supreme Court recognized, as should this court, that "[t]he very idea of a government, republican in form, implies a right on the part of its citizens to meet peaceably."[257]

219. The Ninth Amendment to the U.S. Constitution provides that "[t]he enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."[258]

220. William Pitt the Younger made a statement during a speech in the British House of Commons on November 18, 1783. "Necessity is the plea for every infringement of human freedom. It is the argument of tyrants; it is the creed of slaves." Indeed, that is true. Benjamin Franklin in reply to the Governor in the Pennsylvania Assembly on Nov. 11, 1755, put it this way: "Those who would give up essential Liberty, to purchase a little temporary safety, deserve neither Liberty nor Safety." Christopher Fox Graham puts it in plain terms: "[G]overnment tyranny invariably begins with popular support first to resisting a 'crisis' and then the tacit or explicit surrender of our liberties and freedoms in the name of safety and security."

221. But the announcement of "safety, safety, safety," rings from the White House to convince the people to surrender their freedom behind that shield of "safety." The gentle government is only looking out for the citizens' safety and just to make sure the citizens get that message, the sword is not far behind the shield. If a citizen does not want or need the safety offered by the gentle and caring government then he will be made to accept the offer of safety with force. The President is beginning with his employees. It matters not that the claim of peril is real or imagined, it all comes down to force. As George Orwell explained: "All tyrannies rule through fraud and force, but once the fraud is exposed they must rely exclusively on force."

222. The U.S. Supreme Court has foreclosed the "sky is falling" emergency excuse to infringe constitutional rights. "The Constitution was adopted in a period of grave emergency. Its grants of power to the federal government and its limitations of the power of the States were determined in the light of emergency, and they are not altered by emergency."[259]

223. The Supreme Court of Wisconsin struck down the stay-at-home orders of the Secretary of the State Department of Health Services as being unlawful and unenforceable. In *dicta,* the court noted that "[a]s the United States Department of Justice has recently written in a COVID-19-related case raising constitutional issues, 'There is no pandemic exception ... to the fundamental liberties the Constitution safeguards. Indeed, 'individual rights secured by the Constitution do not disappear during a public health crisis.' These individual rights, including the protections in the Bill of Rights made applicable to the states through the Fourteenth Amendment, are always in force and restrain government action.'"[260]

224. Justice Alito's dissent (joined by Justices Thomas and Kavanaugh) to the U.S. Supremen Court's denial of emergency injunctive relief to a church from the California Governor's COVID-19 restrictions, in *Calvary Chapel Dayton Valley v. Sisolak*,[261] made the point that "[w]e have a duty to defend the Constitution, and even a public health emergency does not absolve us of that responsibility."

225. But how could Justices Alito, Thomas, and Kavanaugh make such an argument in light of the precedent in *Jacobson v. Massachusetts*, 197 U.S. 11 (1905), that seemingly establishes a deferential approach to government action in a medical emergency? *Jacobson* seems to be the proverbial elephant in the room. But in reality, *Jacobson* is more a phantom than an elephant. And that phantom has been *de facto* abrogated by the U.S. Supreme Court over the past 100 years, although it has not been *de jure* overruled, yet.

226. Indeed, as mentioned earlier, the Honorable William S. Stickman IV, explained the tenuousness of the precedent in *Jacobson* that still remains in light of more than 100 years of Supreme Court rulings that have eviscerated the guts from that opinion.[262] The Honorable Judge Stickman explained that the "extraordinarily deferential standard based on *Jacobson* is not appropriate" when reviewing emergency executive orders. The *Butler* court ruled that intermediate constitutional scrutiny is the appropriate standard to apply to infringement of the right to assemble by medical emergency edicts. The *Butler* court stated: "Two considerations inform this decision—the ongoing and open-ended nature of the restrictions and the need for an independent judiciary to serve as a check on the exercise of emergency government power."[263]

227. The factors that the *Butler* court considered for eschewing the deferential standard of *Jacobson* are factors that impeach the legitimacy of the President's order.

> First, the ongoing and indefinite nature of Defendants' [Governor's] actions weigh strongly against application of a more deferential level of review. The extraordinary emergency measures taken by Defendants in this case were promulgated beginning in March—six months ago. What were initially billed as temporary measures necessary to "flatten the curve" and protect hospital capacity have become open-ended and ongoing restrictions aimed at a very different end—stopping the spread of an infectious disease and preventing new cases from arising—which requires ongoing and open-ended efforts. Further, while the harshest measures have

> been "suspended," Defendants admit that they remain in-place and can be reinstated *sua sponte* as and when Defendants see fit. In other words, while not currently being enforced, Pennsylvania citizens remain subject to the re-imposition of the most severe provisions at any time. Further, testimony and evidence presented by Defendants does not establish any specified exit gate or end date to the emergency interventions. Rather, the record shows that Defendants view the presence of disease mitigation restrictions upon the citizens of Pennsylvania as a "new normal" and they have no actual plan to return to a state where all restrictions are lifted. It bears repeating; after six months, there is no plan to return to a situation where there are no restrictions imposed upon the people of the Commonwealth.[264]

228. The *Butler* court was troubled by the virtually unlimited discretion given to the Governor of Pennsylvania. The deferential approach of *Jacobson* offered no check on that power.

> Absent a robust system of checks and balances, the guarantees of liberty set forth in the Constitution are just ink on parchment. There is no question that a global pandemic poses serious challenges for governments and for all Americans. But the response to a pandemic (or any emergency) cannot be permitted to undermine our system of constitutional liberties or the system of checks and balances protecting those liberties. Here, Defendants are statutorily permitted to act with little, if any, meaningful input from the legislature. For the judiciary to apply an overly deferential standard would remove the only meaningful check on the exercise of power.[265]

229. The right to peaceably assemble has traditionally been given the same protection by the courts as the right to freedom of speech.[266] In *De Jonge v. State of Oregon*,[267] the U.S. Supreme Court stated that "[t]he right of peaceable assembly is a right cognate to those of free speech and free press and is equally fundamental."[268] The *De Jonge* Court emphasized the importance of the right to peaceably assemble by noting that "the right is one that cannot be denied without violating those fundamental principles of liberty and justice which lie at the base of all civil and political institutions."[269] Where the restrictions on speech only go to time, place, and manner, they are afforded intermediate scrutiny by courts. In *Butler*, the court viewed intermediate scrutiny, rather than strict scrutiny, as the appropriate standard to review restrictions on the right to assemble by the Pennsylvania Governor's COVID-19 orders because the orders were content neutral.

230. In order pass the intermediate scrutiny test, the orders of the President must be narrowly tailored to accomplish a substantial government interest.[270] If the restriction by the government are not narrowly tailored to accomplish the "substantial" government interest then the restrictions are unconstitutional. In *Butler*, the court found that because the Pennsylvania Governor's orders permitted commercial gatherings at a percentage of occupancy, while other gatherings were limited based upon total number indicated that the orders were not narrowly tailored. The Butler court stated that "hundreds of people may congregate in stores, malls, large restaurants and other businesses based only on the occupancy limit of the building." The court found that incongruent with the hard numeric limitations on other activities. The *Butler* court ruled that "[t]he imposition of a cap on the

number of people that may gather for political, social, cultural, educational and other expressive gatherings, while permitting a larger number for commercial gatherings limited only by a percentage of the occupancy capacity of the facility is not narrowly tailored and does not pass constitutional muster."[271]

231. That very incongruency is found in the President's order. The President is treating those who do not get the vaccine as more likely to spread COVID-19. In fact, as we will see, the COVID-19 vaccines have been proven ineffective in preventing the spread of COVID-19. Thus, those who do not get the vaccine must be fired or offered some accommodation for their religious objections such as wearing masks, being tested, social distancing, and not traveling, when they are no more likely to spread COVID-19 than those who are vaccinated. A requirement to social distance does not accomplish the goal of preventing the spread of COVID-19. Indeed, the whole concept of social distancing is the threat of the asymptomatic spread of COVID-19. But the most authoritative study on that issue proves that there is no asymptomatic spread of COVID-19.[272]

SOCIAL DISTANCING BASED ON HIGH SCHOOL SCIENCE PROJECT

232. A little known fact is that the approach of business and school shutdowns, self-isolation, and social distancing was born, not from rigorous scientific studies, but from a 15-year-old child's high school science project.[273]

233. You read that correctly; the basis for the social distancing to arrest the spread of COVID-19 came from the mind of a 15-year-old. Laura Glass was an Albuquerque High sophomore student in 2006 when she came up with the idea of social distancing and shut-downs for stopping the spread of pandemics. She laid out her plan in a science project. She received the third place prize in the Intel International Science and Engineering Fair.

234. Laura's father, Robert J. Glass, at the time was working at the National Infrastructure Simulation and Analysis Center (NISAC) at Sandia. When the NISAC received a request to brief Secretary Michael Chertoff of the U.S. Department of Homeland Security on how best to respond to bioterrorism, Glass ran his daughter's science project through the NISAC computers and presto-chango out came the theory of shut-downs and social distancing as the response to bioterrorism. After a review by the Centers for Disease Control (CDC), the social distancing and business and school shutdowns became federal policy.

SOCIAL DISTANCING IS INEFFECTIVE

235. Social distancing is not based on rigorous science. The commonly accepted theory of illness spread by human contact is just a theory. It has never been proven. Indeed, there is significant evidence that it is wrong. Dr. Milton J. Rosenau, M.D., conducted a landmark study in 1919 that seemingly has been lost to history.[274]

236. Most people, and even most doctors, are ignorant of Dr. Rosenau's experiments. Dr. Rosenau

conducted experiments during the height of the Spanish Flu epidemic in 1919. He wanted to establish the means by which influenza was spread. He took 100 healthy volunteers who agreed to be exposed to the Spanish Flu. They were exposed to influenza under controlled conditions, but none of them contracted the flu.

237. Dr. Rosenau explained that his medical team "proceeded rather cautiously at first by administering a pure culture of bacillus of influenza, Pfeiffer's bacillus, in a rather moderate amount, into the nostrils of a few of these volunteers."[275] None of the volunteers came down with the flu.

238. He next obtained the extractions from the lungs of recently deceased flu victims. He then lined up 19 volunteers and used an atomizer to spray the suspensions of the flu extractions into the noses and into the eyes, and back into the throats of 19 volunteers. None of the volunteers contracted the flu.

239. Dr. Rosenau then obtained material and mucous secretions from the mouth and nose and throat and bronchi of live persons who had the Spanish Flu and transferred that to 10 volunteers by spraying the infected phlegm directly "into each nostril and into the throat, while inspiring, and on the eye."[276] None of the volunteers got sick.

240. Next, Dr. Rosenau's team used cotton swabs to transfer infected "material directly from nose to nose and from throat to throat, using a West tube for the throat culture, so as to get the material not only from the tonsils, but also from the posterior nasopharynx."[277] None of the 19 volunteers who received the infected swabs got sick.

241. Dr. Rosenau explains that "[o]ur next experiment consisted in injections of blood. We took five donors, five cases of influenza in the febrile stage, some of them again quite early in the disease. We drew 20 'c.c. from the arm vein of each, making a total of 100 c.c, which was mixed and treated with 1 per cent, of sodium citrate. Ten c.c. of the citrated whole blood were injected into each of the ten volunteers. None of them took sick in any way."[278]

242. Dr. Rosenau was not done. "Then we collected a lot of mucous material from the upper respiratory tract, and filtered it through Mandler filters. While these filters will hold back the bacteria of ordinary size, they will allow 'ultramicroscopic' organisms to pass. This filtrate was injected into ten volunteers, each one receiving 3.5 c.c. subcutaneously, and none of these took sick in any way."[279]

243. Dr. Roseneau thought perhaps that influenza was passed by direct human contact. So he had 10 volunteers engage in social contact with persons known to be infected with influenza.

> The volunteer was led up to the bedside of the patient; he was introduced. He sat down alongside the bed of the patient. They shook hands, and. by instructions, he got as close as he conveniently could, and they talked· for live minutes. At the end of the five minutes, the patient breathed out as hard as he could, while the volunteer,

> muzzle to muzzle (in accordance with his instructions, about 2 inches between the two), received this expired -breath, and at the same time was breathing in as the patient breathed out. This they repeated five times, and they did it fairly faithfully in almost all of the instances. After they had done this for five times, the patient coughed directly into the face of the volunteer, face to face, five different times. … After our volunteer had had this sort of contact with the patient, talking and chatting and shaking hands with him for five minutes, and receiving his breath five times, and then his cough five times directly in his face, he moved to the next patient whom we had selected, and repeated this, and so on, until this volunteer had had that sort of contact with ten different cases of influenza, in different stages of the disease, mostly fresh cases, none of them more than three days old.
>
> We will remember that each one of the ten volunteers had that sort of intimate contact with each one of the ten different influenza patients. They were watched carefully for seven days—and none of them took sick in any way.[280]

244. After failing to transmit influenza to any of the volunteers during his many experiments, Dr. Rosenau concluded that he did not know how influenza is contracted. "As a matter of fact, we entered the outbreak with a notion that we knew the cause of the disease, and were quite sure we knew how it was transmitted from person to person. Perhaps, if we have learned any thing, it is that we are not quite sure what we know about the disease."[281]

245. In a study published in the Journal of Infectious Diseases on November 15, 2008, researchers determined that social distancing did not reduce the febrile respiratory illness rates.[282]

246. The researchers gathered data from "13,114 male military recruits (mean age, 19 years) at the Marine Corps Recruit Depot in San Diego, California"[283] The data were collected between February 2004 and March 2005. The study involved military recruits that were distributed among a total of 196 housing units. The researchers explaind that "[i]n the present study, we investigate the usefulness of social distancing in an environment in which high rates of febrile respiratory illness (FRI) are endemic."[284] The researchers stated that "[b]ecause the primary means of transmission was presumed to be person-to-person transmission, we expected that groups that were socially distanced from potentially infectious individuals who were new to the group would incur rates of illness lower than those noted for groups that were not socially distanced."[285] But the researchers found that not to be the case.

> The original hypothesis was rejected. There was not a statistically significant difference between the FRI [febrile respiratory illness] rates in the open and closed units as a whole, although the tendency was for the closed units to exhibit higher rates. The rejection of the hypothesis suggests that the primary route of transmission of FRI is not via the MCU/PCU recycling protocol (i.e., not via person-to-person contact between unit members and members newly introduced to the unit [i.e., potentially infectious convalescents]). The social distancing instituted in this setting

was not successful in decreasing FRI rates.[286]

247. Below is the opinion of an expert in the medical field on the approach of masking, testing, and social distancing. Dr. Roger Hodkinson, MA, MB, FRCPC, FCAP, CEO is the medical director of Western Medical Assessments. He explains:

> I'm a medical specialist in pathology which includes virology. I trained at Cambridge University in the U.K. I'm the ex-president of the pathology section of the Medical Association. I was previously an assistant professor in the Faculty of Medicine doing a lot of teaching. I was the chairman of the Royal College of Physicians of Canada Examination Committee and Pathology in Ottawa, but more to the point I'm currently the chairman of a biotechnology company in North Carolina selling the COVID-19 test.
>
> ***
>
> There is no action of any kind needed other than what happened last year when we felt unwell. We stayed home, we took chicken noodle soup, we didn't visit granny, and we decided when we would return to work. We didn't need anyone to tell us.
>
> **Masks are utterly useless.** There is no evidence base for their effectiveness whatsoever. Paper masks and fabric masks are simply virtue-signaling. They're not even worn effectively most of the time. It's utterly ridiculous. Seeing these unfortunate, uneducated people — I'm not saying that in a pejorative sense — seeing these people walking around like lemmings, obeying without any knowledge base, to put the mask on their face.
>
> **Social distancing is also useless** because COVID is spread by aerosols which travel 30 meters or so before landing. Enclosures have had such terrible unintended consequences. Everywhere should be opened tomorrow as was stated in the Great Barrington Declaration that I circulated prior to this meeting.
>
> And a word on testing: I do want to emphasize that I'm in the business of testing for COVID. I do want to emphasize that positive test results do not – underlined in neon – mean a clinical infection. It's simply driving public hysteria and **all testing should stop.** Unless you're presenting to the hospital with some respiratory problem.[287]

248. Dr. Hodkins' opinion on this is not an isolated one. More than 14,879 medical and public health scientists and 43,804 public health practitioners have signed the Great Barrington Declaration against the prevailing COVID-19 masking, social distancing, and testing policies.[288]

249. Dr. Paul E. Alexander is an expert in clinical epidemiology; he is a former COVID Pandemic Advisor to the WHO and the Pan American Health Organization; he was a former senior advisor on

the COVID Pandemic in the Department of Health and Human Services during the Trump administration. Dr. Alexander states that there is no COVID pandemic, and the masking, social distancing, and vaccines recommended by the state and federal governments are unnecessary. He considers the COVID-19 virus no more virulent than the common flu.[289]

ARTIFICIALLY INFLATED COVID-19 NUMBERS

250. The CDC and NIH are fanning the hysteria of a health emergency that does not really exist. It is doing so by artificially inflating the COVID-19 numbers in order to portray a false sense of emergency to justify its own draconian COVID-19 orders.

251. Dr. Kristin Held is the President of the Association of American Physicians and Surgeons (AAPS). She explains the trickery used by the CDC and the State Boards of Health to inflate the COVID-19 infection and death rates.

252. Dr. Held revealed a little known fact that "[t]he Council of State and Territorial Epidemiologists (CSTE) adopted new definitions of COVID-19 cases and COVID-related deaths in April [2020] that were adopted by the Centers for Disease Control and Prevention (CDC) in May. The states were then encouraged to adopt the new definitions."

253. These new definitions had the direct effect of artificially inflating the COVID-19 case and death statistics. Dr. Held reveals that under the new criteria "COVID-related deaths can include anyone who has COVID-19 listed on their death certificate as one of the causes of death- it doesn't have to be the first or second cause, and no COVID-19 testing is required."[290]

254. Dr. (and Minnesota State Senator) Scott Jensen revels that the guidance by the CDC is to put COVID-19 down as the cause of death even though the death actually resulted from something else. Indeed, the CDC is advising that COVID-19 is to be considered not on testing and a diagnosis that COVID-19 is the cause of death but rather based upon it being "suspected or likely." Health officials and doctors are being asked to put on the death certificate "probable" or "presumed" death from COVID-19 based upon a clinical judgment (i.e., a guess) without any actual scientific test or diagnosis.[291]

255. The CDC guidance referenced by Dr. Jensen states in pertinent part:

> In cases where a definite diagnosis of COVID–19 cannot be made, but it is suspected or likely (e.g., the circumstances are compelling within a reasonable degree of certainty), it is acceptable to report COVID–19 on a death certificate as "probable" or "presumed." In these instances, certifiers should use their best clinical judgement in determining if a COVID–19 infection was likely. However, please note that testing for COVID–19 should be conducted whenever possible.[292]

256. The CDC states that testing for COVID-19 is ideal but not necessary in order to categorize

a death as being COVID-19 as long as the "circumstances are compelling within a reasonable degree of certainty." Basically, that means whatever a particular doctor wants it to mean. The CDC instructions for filling out death certificates are contrary to the traditional method of only putting down the scientific finding for a "cause of death." The CDC guidance opens the door for a doctor to opine under a "reasonable degree of certainty" standard that virtually any death is a COVID-19 death. And that is precisely what the CDC wants. The CDC guidance states:

> Ideally, testing for COVID–19 should be conducted, but it is acceptable to report COVID–19 on a death certificate without this confirmation if the circumstances are compelling within a reasonable degree of certainty.[293]

257. Early on, the states adopted the new CDC guidelines. For example, Virginia Department of Health (VDH) states that "VDH adopted the updated CDC confirmed and probable surveillance case definitions on August 27, 2020."[294]

258. Indeed, the VDH provided a link directly to the CDC website defining confirmed and probable cases.[295]

259. The VDH is like most state health departments who follow the new guidance for reporting COVID-19 cases and deaths. The VDH acknowledges that when it reports COVID-19 cases they are not based on a medical diagnosis of COVID-19. Thus, a person does not need to actually have COVID-19 to be included in the Virginia COVID-19 statistics. The VDH explains:

> Public health uses standardized case definitions to count cases. These case definitions make it easier to compare data over time, across states, or even between different counties. A case definition is different from a diagnosis, and is used for a different purpose. A diagnosis is helpful for treatment and medical billing while a case definition is used for public health surveillance. For COVID-19, Virginia uses the CDC COVID-19 confirmed and probable case definitions. These definitions suggests that we report two case statuses:
>
> Confirmed cases – Confirmed cases include anyone who tests positive for SARS-CoV-2 RNA in a clinical or autopsy specimen using a molecular amplification test.
>
> Probable cases – There are a few ways to identify a probable case. In Virginia, anyone who is positive using an approved antigen test or anyone who displays a specific set of symptoms and has an epidemiologic linkage (contact with another confirmed or probable case or part of a risk cohort), or anyone whose death certificate mentions COVID-19 or SARS-CoV-2 without a positive lab result counts as a probable case.[296]

260. The VDH further acknowledes that the COVID-19 statistics received from hospitals overstate

the COVID-19 risk. The hospitalization statistics include "those who have [COVID-19] tests pending" but who have not actually tested positive for COVID-19. The VIDH explains that "[t]hese data do not have the same kind of rigorous case definition that epidemiologic case data do because they are not intended for the same purpose. For healthcare system preparation, an overestimation is better than an underestimation."[297]

261. The VDH explains that in order to be consistent it must use that same overstatement across the board when reporting COVID-19 statistics. "For our purposes, it's important that the same case definition be applied to the numerator (the number of cases that result in hospitalization) and the denominator (the total number of cases)."[298]

262. The inflated COVID-19 numbers can be explained in part by the buit-in financial incentive for medical professionals to diagnose a patient with COVID-19. USA TODAY revealed that "[t]he coronavirus relief legislation created a 20% premium, or add-on, for COVID-19 Medicare patients."[299] There are financial incentives in addition to the 20% premium. Dr. Jensen explained the additional financial incentive for hospitals to make a diagnosis of COVID-19:

> Hospital administrators might well want to see COVID-19 attached to a discharge summary or a death certificate. Why? Because if it's a straightforward, garden-variety pneumonia that a person is admitted to the hospital for – if they're Medicare – typically, the diagnosis-related group lump sum payment would be $5,000. But if it's COVID-19 pneumonia, then it's $13,000, and if that COVID-19 pneumonia patient ends up on a ventilator, it goes up to $39,000.[300]

263. USA TODAY checked out the claim by Dr. Jensen. "USA TODAY reached out to Marty Makary, a surgeon and professor of health policy and management at Johns Hopkins Bloomberg School of Public Health, about the claim. Makary said in an email April 21 that 'what Scott Jensen said sounds right to me.'"[301]

264. USA TODAY determined that Jensen's claim was accurate.

> We rate the claim that hospitals get paid more if patients are listed as COVID-19 and on ventilators as TRUE.
>
> Hospitals and doctors do get paid more for Medicare patients diagnosed with COVID-19 or if it's considered presumed they have COVID-19 absent a laboratory-confirmed test, and three times more if the patients are placed on a ventilator to cover the cost of care and loss of business resulting from a shift in focus to treat COVID-19 cases.[302]

265. Andrew Mark Miller, reporting for the Washington Examiner, revealed that because U.S. hospitals are reimbursed 13,000 for every COVID-19 diagnosis and 39,000 for every COVID-19 patient put on a ventilator, "U.S. Centers for Disease Control and Prevention Director Robert

Redfield agreed that some hospitals have a monetary incentive to overcount coronavirus deaths."[303] Dr. Redfield expressed that opinion while testifying before a U.S.House of Representatives Panel. Dr. Redfield acknowledged that the federal reimbursement scheme creates a perverse monetary incentive for U.S. hospitals to inflate the COVID-19 infection rate. Dr. Redfield explained that "when it comes to hospital reimbursement issues or individuals that get discharged, there could be some play in that for sure."[304]

266. Edwin Mora, reported for *Breitbart* that "[a]ccording to Congressman [Blaine] Luetkemeyer, Adm. Brett Giroir from the U.S. Health and Human Services (HHS) Department has conceded that there is an economic incentive for hospitals to inflate their coronavirus fatalities. Giroir 'acknowledged that the statistics he is getting from the states are over-inflated,' the Republican lawmakers said."[305]

267. According to Becker's Healthcare, as of April 2020, Virginia hospitals received from HHS $201,000 reimbursement per COVID-19 case. That figure was obtained from Kaiser Health News, which "used a state breakdown provided to the House Ways and Means Committee by HHS along with COVID-19 cases tabulated by The New York Times for its analysis."[306]

268. Despite the over reporting, the the VDH nonetheless claims that the "the number of cases we have on record is an underrepresentation of the true burden."[307] That nonsensical statement is based in part on the premise that there are people walking around with COVID-19 who show no symptoms. But that statement is based on the unproven premise of asymptomatic spread of COVID-19. The asymptomatic carrier theory was born from the fact that the PCR test for COVID-19 has potentially up to a 78% false positive rate. The medical authorities came up with a way to explain how people who are not sick with COVID-19 nonetheless test positive for the disease. They argue that the well-person tests positive for the disease because he is an "asymptomatic" carrier of COVID-19. Thus, the false-positive test problem is solved.

269. Researchers Torsten Engelbrecht and Konstantin Demeter concluded:

> Lockdowns and hygienic measures around the world are based on numbers of cases and mortality rates created by the so-called SARS-CoV-2 RT-PCR tests used to identify "positive" patients, whereby "positive" is usually equated with "infected."
>
> But looking closely at the facts, the conclusion is that these PCR tests are meaningless as a diagnostic tool to determine an alleged infection by a supposedly new virus called SARS-CoV-2.[308]

270. The researchers concluded that the RT-PCR test used to detect COVID-19 is so inaccurate that there may be between 22% and 78% false positives. But there is no way to be sure because there is no gold standard against which to verify the accuracy of the tests.

271. One study gives an example of the test's inaccuracy. "[A] study from Singapore in which

tests were carried out almost daily on 18 patients and the majority went from 'positive' to 'negative' back to 'positive' at least once, and up to five times in one patient."[309]

272. The apparent preponderance of false positives for asymptomatic subjects means that the people are asymptomatic because they do not have COVID-19. The asymptomatic carrier model that is being sold to the public is a myth. The positive tests are bogus results. The COVID-19 "outbreaks" and "hotspots" are really not "outbreaks" or "hotspots" at all.

273. The PCR COVID-19 test is done using reagents to extract a sample of RNA. An enzyme called reverse transcriptase converts the RNA to a complementary sequence of DNA. That DNA (called a primer) is replicated (amplified) many times over so the particular targeted DNA sequence in it can be detected. The more stages of replication the more likely the targeted sequence will be detected.

274. Each time the DNA in the sample is amplified it doubles the number of molecules. The doubling is exponential after each cycle of amplification. But the number of cycles can vary from laboratory to laboratory. The probability of testing positive increases as a function of the number of cycles. The PCR cycles for a COVID-19 test from most laboratories are set at 40 cycles.[310]

275. Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID), told other scientists during a video conclave moderated by *This Week in Virology* that PCR tests run at 35 or more replication cycles will give false-positive results. Anthony S. Fauci is the Director of the National Institute of Allergy and Infectious Diseases (NIAID). Dr. Fauci stated that the chance of a true positive result from 35 or more cycles is "minuscule." He stated that the PCR tests that are being run at cycles of 36, 37, or 38 cycles are simply detecting dead nucleotides and then falsely reporting them as positive COVID-19 results.

276. Dr. Fauci stated: "If you get a cycle threshold of 35 or more, the chances of it being replication-confident are minuscule…you almost never can culture virus from a 37 threshold cycle… someone does come in with 37, 38, even 36, you gotta say it's just dead nucleotides period."[311]

277. How did most laboratories come up with their 40 cycle standard? It was recommended by the U.S. Centers for Disease Control (CDC), Division of Viral Diseases. The CDC recommendation that no more than 40 cycles but also stated that a positive test at 40 cycles is a positive test for COVID-19 (it is called 2019-nCoV by the CDC, which means 2019 novel coronavirus).[312]

278. The CDC has recommended 40 cycles for the PCR test, and most laboratories are performing tests using that recommended 40 cycle standard. But Dr. Fauci admits that performing PCR tests to detect COVID-19 at 35 or mores cycles will result in false-positive and the confidence in any such positive result for COVID-19 is "minuscule."

279. "Any test with a cycle threshold above 35 is too sensitive, agreed Juliet Morrison, a virologist at the University of California, Riverside. 'I'm shocked that people would think that 40 could represent a positive,' she said."[313]

280. Mancavilli reported that experts with whom she conferred determined that "[i]n Massachusetts, from 85 to 90 percent of people who tested positive in July with a cycle threshold of 40 would have been deemed negative if the threshold were 30 cycles."[314] Dr. Michael Mina, an epidemiologist at the Harvard T.H. Chan School of Public Health, said about the Massachusetts findings that "I would say that none of those people should be contact-traced, not one,"[315]

281. The Portugal Court of Appeals in Lisbon agreed with the trial court, which granted a *writ of habeas corpus* on behalf of German tourists. The court of appeals ruled that German tourists were illegally detained by the Azores Regional Health Authority and ordered to be quarantined because the PCR test that was the basis of the detention is unreliable for detecting COVID-19. Peter Andrews reported that the Portuguese court cited a study conducted by "some of the leading European and world specialists," proving that the usual testing standard for a PCR test results in a COVID-19 false-positive result 97% of the time.[316]

282. The Portugal Court of Appeals in Lisbon, based upon a study by some of the leading European and world specialists, concluded that "[t]his means that if a person has a positive PCR test at a cycle threshold of 35 or higher (as in most laboratories in the USA and Europe), the chances of a person being infected are less than 3%. The probability of a person receiving a false positive is 97% or higher."[317]

283. There is another test used to detect COVID-19. It is a COVID-19 antigen test. The problem with the antigen test is that it is even more unreliable than the PCR test. Indeed, the FDA has gone on record warning about false-positives from the COVID-19 antigen tests. Interestingly, while the FDA warning was to specifically address the false positive COVID-19 antigen test results, the FDA stated that "all laboratory tests" pose the risk of false-positive results.

> The FDA reminds clinical laboratory staff and health care providers about the risk of false positive results with all laboratory tests. Laboratories should expect some false positive results to occur even when very accurate tests are used for screening large populations with a low prevalence of infection.[318]

284. The FDA did not limit its warning to apply to only the COVID-19 antigen tests. The FDA acknowledges "the risk of false positive results with all laboratory tests." And indeed, how could it not make that admission in light of overwhelming evidence of false-positive tests. Notice that the warning goes to "all laboratory tests," including both antigen and PCR tests. That astounding admission by the FDA has gone unreported by the major media outlets, even as many states, including Virginia, are issuing more draconian social distancing and masking orders based on those inaccurate false-positive COVID-19 test results.

285. The FDA explains the scope of the false positives using the antigen test. The following is guidance from the FDA:

> Remember that positive predictive value (PPV) varies with disease prevalence when

> interpreting results from diagnostic tests. PPV is the percent of positive test results that are true positives. **As disease prevalence decreases, the percent of test results that are false positives increase.**
>
> For example, a test with 98% specificity would have a PPV of just over 80% in a population with 10% prevalence, meaning 20 out of 100 positive results would be false positives.
>
> The same test would only have a PPV of approximately 30% in a population with 1% prevalence, meaning 70 out of 100 positive results would be false positives. This means that, in a population with 1% prevalence, only 30% of individuals with positive test results actually have the disease.[319]
>
> At 0.1% prevalence, the PPV would only be 4%, meaning that 96 out of 100 positive results would be false positives.

286. Assuming federal workers would fall in the lowest COVID-19 prevalence, the predictable false positives from the antigen test will likely be somewhere between 70% and 96%. What is the point of even testing with such inaccuracies in the testing?

287. Word has gotten out about the inaccuracies of the PCR test, and so the CDC's hand was forced to stop using it. On July 21, 2021, the CDC announced that laboratories should cease using the PCR to test for COVID-19 beginning on December 31, 2021.[320] If the PCR test is so inaccurate as to cause the CDC to recommend against using it, why is the CDC waiting until December 31, 2021, to transition to a more accurate test? Its seems that the CDC is not at all concerned about the accuracy of its COVID-19 testing. The PCR test will be replaced with the antigen test, which the FDA acknowledges is also inaccurate.

288. It must be understood that most states report Total Deaths as being the number of confirmed and probable COVID-19 deaths. Virginia is one example. The Total Deaths number for Virginia from COVID-19 is a scam on two levels. First, a probable case does not require that the person test positive for COVID-19. In the written guidance, the CDC has told local officials to put on the death certificate "probable" or "presumed" death from COVID-19 based upon a clinical judgment (i.e., a guess) without any actual scientific test or diagnosis.

289. It does not take much to be a probable case of COVID-19. One could have a headache and have recently been within 6 feet for at least 15 minutes of someone who is himself is a probable case of COVID-19 or a member of a risk cohort for COVID-19 as defined by public health authorities during an outbreak. Thus, neither the person who is supposed to be the spreader of the disease nor the person supposed to have gotten COVID-19 needs to have COVID-19 to be included in the statistics for COVID-19 Total Cases or Total Deaths.

290. It gets worse. The confirmed cases of deaths from COVID-19 are not what you would think

they are. A confirmed COVID-19 death does not mean that the person died *from* COVID-19. It means that the person died *with* COVID-19.

291. A close reading of the Virginia Department of Health (VDH) rules for reported deaths reveals that the "VDH is counting any death that occurs in a person who was reported to the health department as having COVID-19."[321]

292. Thus, the VDH is not reporting only those people who died *from* COVID-19. They are artificially inflating the numbers by including the numbers of people who died from some other cause and tested positive for COVID-19 prior to their death. The VDH death statistics include both those who died *from* COVID-19 and those who died *with* COVID-19, even though those who died *with* COVID-19 actually died from some cause other than COVID-19. The department of health states that it will not include those who died from "an injury or accident" among the COVID-19 deaths. But that is the only exclusion. All other people who die *with* COVID-19 from some other cause other than injury or accident are listed by the VDH as a COVID-19 death. Thus, if someone dies of cancer but tests positive for COVID-19 he will be listed as a COVID-19 death.

293. Furthermore, the VDH exclusion criteria only excludes from the COVID-19 statistics deaths due to "injury or accident." What about non-traumatic causes of death like cancer, diabetes, emphysema, heart disease, or stroke? Is someone who dies of any of those illnesses listed, nonetheless, as a COVId-19 death? Apparently so.

294. How inflated are the death statistics? The CDC offers an answer. That answer is that only 6% of reported COVID-19 deaths died only from COVID-19. All other reported deaths are people who had comorbidities. The CDC explains that its reported statistics show "health conditions and contributing causes mentioned in conjunction with deaths involving coronavirus disease 2019 (COVID-19). For 6% of the deaths, COVID-19 was the only cause mentioned. For deaths with conditions or causes in addition to COVID-19, on average, there were 2.6 additional conditions or causes per death."[322]

295. Some of the comorbidities listed by the CDC include cardiac arrest, diabetes, Alzheimer disease, renal failure, injury (intentional, unintentional, poisoning, and other adverse events), malignant neoplasms (a.k.a. cancerous tumors). In that partial list, the only comorbidity that is not reported as a COVID-19 death in Virginia by the VDH are those who die from "an injury or accident."

296. Dr. Anthony Fauci is the Director of the National Institute of Allergy and Infectious Diseases (NIAID), an agency in the National Institute of Health (NIH). The CDC and the NIH are both operational agencies in the Department of Health and Human Services. Anthony Fauci is portrayed as the nation's top infectious disease expert. He is a member of the White House coronavirus task force. Dr. Fauci does not realize it, but he has confirmed that the fraud by the CDC is knowing and intentional. He did this by trying to explain the acknowledged fact that 94% of COVID-19 decedents had on average 2.5 comorbidities. Dr. Fauci did not dispute that fact. He accepted that fact as true.

But how he characterized that fact was breathtaking in its incredulity. Dr. Fauci told an ABC News interviewer on September 1, 2020, that it "does not mean that someone who has hypertension or diabetes who dies of COVID didn't die of COVID-19. They did." Dr. Fauci further stated that "it's not 9,000 deaths from Covid-19, it's 180-plus-thousand deaths."[323]

297. That statement by Dr. Fauci is telling. Dr. Fauci is stating a hypothetical case, but he is perfectly comfortable to say that someone (anyone) who is listed in the CDC COVID-19 death list who died with 1) hypertension (i.e., high blood pressure), or 2) diabetes, and 3) COVID-19 most definitely died of COIVDI-19. Dr. Fauci picks one of the three illnesses (COVID-19), and without even knowing the facts or the patient, he is able to divine that every decedent with those simultaneous illnesses always dies from COVID-19.

298. Dr. Fauci did not equivocate. He emphatically stated that all the diabetics and people with high blood pressure listed by the CDC as having died of COVID-19, in fact died of COVID-19 regardless of the seriousness of their hypertension or diabetes. No, ifs, ands, or buts about it. He stated emphatically that every person listed by the CDC as a COVID-19 death actually died "from" COVID-19 regardless of the comorbidity. Dr. Fauci was forcible and clear: "So the numbers you've been hearing — there are 180,000-plus deaths [as of September 1, 2020]— are real deaths from Covid-19. Let (there) not be any confusion about that."[*324*]

299. Not only is Dr. Fauci's statement incredible on its face. It is contrary to the known facts. States are reporting persons *with* COVID-19 as being COVID-19 deaths, regardless of their comorbidities that could be the real cause of the deaths. The states are doing that under the specific guidance from the CDC. The CDC is receiving that data from the states that they requested the states to send them. Indeed, an Illinois State Health Official announced during a press conference: "Technically, even if you died from a clear alternate cause but you had COVID at the same time, it is still listed as a COVID death."[325]

300. The former Coronavirus Response Coordinator for the White House Coronavirus Task Force was Dr. Deborah Birx (now retired). During an April 7, 2020, task force press briefing, Dr. Birx was asked by a reporter about the allegations by many that the coronavirus deaths have been artificially inflated. The reporter asked: "Can you talk about your concerns about deaths being misreported by coronavirus because of either testing or standards for how they're characterized?" Dr. Birx then admitted that in fact that the COVID-19 deaths are being inflated. Dr. Birx explained the reason is that the United States has taken a "liberal approach" to reporting COVID-19 deaths. She stated that it is "straightforward." That "straightforward" approach is to report someone who dies "with" COVID-19 as a COVID-19 death. Implied in her statement is that any deceased person who tests positive for COVID-19 is recorded as dying "of" COVID-19, regardless of the actual cause of death. To put it more succinctly, every person who dies "with" COVID-19 is recorded as dying "of" COVID-19. Dr. Birx stated:

> Right now, we're still recording it, and we'll — I mean, the great thing about having forms that come in and a form that has the ability

> to mark it as COVID-19 infection — the intent is, right now, that those — **if someone dies with COVID-19, we are counting that as a COVID-19 death.**[326] (emphasis added)

301. In a Johns Hopkins News-Letter dated November 22, 2020, (later retracted) "Genevieve Briand, assistant program director of the Applied Economics master's degree program at Hopkins, critically analyzed the effect of COVID-19 on U.S. deaths using data from the Centers for Disease Control and Prevention (CDC)."[327] She found that there was zero increase in deaths across the United States between 2018 and 2020. She determined that "the percentages of deaths among all age groups remain relatively the same." She thus concluded that COVID-19 "has relatively no effect on deaths in the United States."[328] Briand was puzzled because the CDC had reported a sudden increase in deaths due to COVID-19. There should have been an increase in total deaths reported to the CDC by approximately 267,000. But there was no such increase. When Briand examined the death statistics from the CDC, she made the disturbing discovery that deaths from heart disease, respiratory disease, influenza, and pneumonia dropped during the COVID-19 outbreak. She saw in the statistics that deaths were being shifted from those other categories to COVID-19. "Briand believes that deaths due to heart diseases, respiratory diseases, influenza and pneumonia may instead be recategorized as being due to COVID-19."[329]

302. The Briand article was retracted for the reason that Johns Hopkins was concerned that the article "has been used to support dangerous inaccuracies that minimize the impact of the pandemic."[330] But in the retraction notice, Johns Hopkins actually acknowledged the principal finding made by Briand that the number of deaths due to heart diseases, respiratory diseases, influenza and pneumonia had been shifted to the COVID-19 list of deaths. The retraction states that "Briand also claimed in her analysis that deaths due to heart diseases, respiratory diseases, influenza and pneumonia may be incorrectly categorized as COVID-19-related deaths. However, COVID-19 disproportionately affects those with preexisting conditions, so those with those underlying conditions are statistically more likely to be severely affected and die from the virus."[331] Notice that the retraction does not dispute Briand's finding, but rather tries to explain it as being caused by the fact that "those with those underlying conditions are statistically more likely to be severely affected and die from the virus."[332] The retraction notice did not contradict the conclusion of Briand's study that the COVID-19 death statistic is a statistic that lists those who die "with" COVID-19 and not necessarily those who die "from" COVID-19.[333]

INFLATING THE DANGER POSED BY COVID-19

303. What is the danger from COVID-19? Anthony S. Fauci is the Director of the National Institute of Allergy and Infectious Diseases (NIAID). He is in charge of the federal response to the Covid-19 threat. On March 4, 2020, Dr. Anthony Fauci testified in a public hearing before the U.S. Congress. During his testimony, Dr. Fauci stated ominously that "the mortality for seasonal flu is point one percent (.1%). So even if it [the mortality rate for COIVID-19] goes down to one percent, it's still 10 times more fatal [than the seasonal flu]."[334] On March 11, Dr. Fauci repeated that statistic in testimony before the U.S. Congress. "I think if you count all the cases of minimally symptomatic

or asymptomatic infection, that probably brings the mortality rate down to somewhere around one percent, which means it is 10 times more lethal than the seasonal flu."[335]

304. Yet, when Dr. Fauci is talking to doctors, he changes his tune. The New England Journal of Medicine is typically only read by doctors and scientific researchers. And so, what did Dr. Fauci say about the COVID-19 virus when writing to doctors? In a March 26, 2020 article in the New England Journal of Medicine, Dr. Fauci stated that "the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately 0.1%)."[336]

305. Keep in mind that statement in the New England Journal of Medicine by Dr. Fauci was made in the midst of medical emergencies being announced in many states that included school and business closures, recommendations of social distancing, and state government-mandated limits on public gatherings. All of these measures were recommended by Dr. Fauci, who had fanned the flames of hysteria over the medical danger of COVID-19 among the public. But while Dr. Fauci was telling the public that COVID-19 was ten (10) times more deadly than the flu, he was telling doctors and scientists that "the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately 0.1%)."

306. By the way, Dr. Fauci was joined in that article by his co-author, Robert R. Redfield, who is the Director of the U.S. Center for Disease Control (CDC). Basically, the U.S. health czars are on record admitting that what they continue to tell the public is a deadly virus is not really deadly at all. The COVID-19 scare is a scam. Fauci and Redfield confessed that COVID-19 is no more deadly than the ordinary flu in the middle of the hysteria they created.

307. In early March, 2020, Dr. Fauci told the public that the COVID-19 is ten (10) times more deadly than the ordinary flu. After that, on March 26, 2020, Dr. Fauci writes to doctors in the New England Journal of Medicine that "the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately 0.1%)." Then after he writes that statement, he continues to tell the public that COVID-19 is one of the worst pandemics in history and warns against lifting the draconian restrictions on social gathering and mask-wearing.

308. How was Dr. Fauci able to pull off that statistical sleight of hand, trick Congress, and bring about the hysteria that that COVID-19 was ten-time more deadly than the common flu? Dr. Ronald B. Brown of the School of Public Health and Health Systems at the University of Waterloo explains that when Dr. Fauci Fauci testified before Congress, he compared apples with oranges. Dr. Brown reveals that Dr. Fauci misleadingly compared the Infection Fatality Rate (IFR) for the seasonal flu with the Case Fatality Rate (CFR) for COVID-19.[337] That resulted in the incorrect conclusion that the novel coronavirus was ten times deadlier than the average flu.

309. Both the CFR and IFR report in the numerator those who die from the disease. But they each have different denominators. The difference is that a Case Fatality Rate (CFR) only includes in the

denominator those who actually are diagnosed with and have symptoms of the disease, whereas the Infection Fatality Rate (IFR) includes in the denominator cases and undiagnosed, asymptomatic, and mild infections. CFR is a subset of IFR. All cases are infections, but not all infections are cases. Thus, there is a greater population of infections than cases. That means that the CFR ratio will always be a larger percentage than the IFR ratio. The graphic below is from Brown's report and illustrates the difference between the CFR and the IFR.

310. Dr. Fauci erroneously reported the CFR for the seasonal flu as being .1%. He then stated that the CFR for COVID-19 was 1%. He ominously testified before Congress that simple math reveals that COVID-19 is ten (10) times deadlier than COVID-19. It turns out that Dr. Fauci was reporting the IFR for the seasonal flu and misrepresenting it as the CFR for the seasonal flu. The actual CFR for the seasonal flu is 1%. That is virtually the same as the CFR for COVID-19. Thus, the lethality of COVID-19 is about the same as the seasonal flu. Dr. Fauci's testimony that COVID-19 is ten (10) times more deadly than the flu was wrong.

311. When Dr. Anthony Fauci testified in a public hearing before the U.S. Congress on March 4, 2020, and ominiously said that "the mortality for seasonal flu is point one percent (.1%). So even if it [the mortality rate for COIVID-19] goes down to one percent, it's still 10 times more fatal [than the seasonal flu],"[338] he knew that was not true because in a March 26, 2020 article in the New England Journal of Medicine, Dr. Fauci stated that "the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately 0.1%)."[339]

312. At no time did Dr. Fauci ever retract his misleading public pronouncement that COVID-19 is ten-times more deadly than the flu. Indeed, he doubled down. On July 29, 2020, ABC News reported that Dr. Fauci upped the hysteria another notch when Dr. Fauci "suggested Wednesday that Americans should consider wearing goggles or a face shield in order to prevent spreading or catching COVID-19."[340] On that same day (July 29, 2020) in an interview with ABC News commentator Dr. Jen Ashton, Dr. Fauci ominously states: "Look at the number of deaths—that's the worst we've had in respiratory outbreak in over 100 years, since the 1918 outbreak of the Spanish Flu. And we still have a ways to go."[341]

313. It turns out that the evidence is beginning to show that the actual mortality rate for COVID-19 is indeed more akin to the seasonal flu, just as Dr. Fauci admitted in his New England Journal of Medicine article. Dr. John Ioannidis, who is a professor of medicine and epidemiology at Stanford University has looked at the worldwide COVID-19 mortality data and concluded that "[a]t a very broad, bird's eye view level, worldwide the IFR [infection fatality rate] of COVID-19 this season may be in the same ballpark as the IFR of influenza."[342]

314. Dr. Ionnidis stated that the fatality rate could be as low as 0.2%, but no higher than 0.4%. That higher number (0.4%) was gathered from infections among elderly patients and healthcare workers. The more likely 0.2% rate is much lower than the 1-3% range of figures often bandied about by the government fear-mongers. Keep in mind that Dr. Ionnidis is using government-reported

figures, which have been proven to be inflated anyway.[343]

315. Please recall, as explained above, that the statistics include all deaths "involving" COVID-19 not deaths "from" COVID-19. That means that the persons could have died from some other cause, but the decedent was determined to have COVID-19 at the time of death. Thus they are reported as a death "involving" COVID-19.[344]

316. The CDC admits that they double count deaths. "Deaths involving more than one condition (e.g., deaths involving both diabetes and respiratory arrest) were counted in both totals."[345] That means that a person who is murdered but tests positive for COVID-19 is tallied as both a murder death and a COVID-19 death. It is for that reason that the CDC advises: "To avoid counting the same death multiple times, the numbers for different conditions should not be summated."[346]

317. Furthermore, the CDC admits that its statistics of COVID-19 deaths are not confirmed to have COVID-19. The COVID-19 statistics include both "[d]eaths with confirmed or presumed COVID-19."

318. On February 1, 2021, Patrick Howley, writing for National File, reported that an investigation by the Public Health Policy Initiative uncovered evidence that the Centers for Disease Control and Prevention (CDC) violated federal law by fraudulently inflating COVID-19 fatality numbers.[347] Howley reported that the investigation revealed that the "CDC illegally inflated the COVID fatality number by at least 1,600 percent."[348] Howley explained how that was done:

> On March 24th the CDC published the NVSS COVID-19 Alert No. 2 document instructing medical examiners, coroners and physicians to deemphasize underlying causes of death, also referred to as pre-existing conditions or comorbidities, by recording them in Part II rather than Part I of death certificates as "…the underlying cause of death are expected to result in COVID-19 being the underlying cause of death more often than not." This was a major rule change for death certificate reporting from the CDC's 2003 Coroners' Handbook on Death Registration and Fetal Death Reporting and Physicians' Handbook on Medical Certification of Death, which have instructed death reporting professionals nationwide to report underlying conditions in Part I for the previous 17 years. This single change resulted in a significant inflation of COVID-19 fatalities by instructing that COVID-19 be listed in Part I of death certificates as a definitive cause of death regardless of confirmatory evidence, rather than listed in Part II as a contributor to death in the presence of pre-existing conditions, as would have been done using the 2003 guidelines. The research draws attention to this key distinction as it has led to a significant inflation in COVID fatality totals. By the researcher's estimates, COVID-19 recorded fatalities are inflated nationwide by as much as 1600% above what they would be had the CDC used the 2003 handbooks.[349]

319. Howley explains the effect of the CDC fraud and what should be done about it:

> By enacting these new rules exclusively for COVID-19 in violation of federal law, the research alleges that the CDC significantly inflated data that has been used by elected officials and public health officials, in conjunction with unproven projection models from the Institute for Health Metrics and Evaluation (IHME), to justify extended closures for schools, places of worship, entertainment, and small businesses leading to unprecedented emotional and economic hardships nationwide. A formal petition has been sent to the Department of Justice as well as all US Attorneys seeking an immediate grand jury investigation into these allegations.[350]

320. The report from the Public Health Policy Initiative is titled COVID-19 Data Collection, Comorbidity & Federal Law: A Historical Retrospective.[351] The report explains the method used by the CDC to artificially inflate the COVID-19 death statistics.

> The CDC published guidelines on March 24, 2020 that substantially altered how cause of death is recorded exclusively for COVID-19. This change was enacted apparently without public opportunity for comment or peer-review. As a result, a capricious alteration to data collection has compromised the accuracy, quality, objectivity, utility, and integrity of their published data, leading to a significant increase in COVID-19 fatalities. This decision by the CDC may have subverted the legal oversight of the OMB as Congressionally authorized by the PRA & IQA as well.[352]

321. The Public Health Policy Initiative report explains that under this newly adopted CDC reporting scheme, "COVID-19 became emphasized as a cause of death as frequently as possible, while comorbidity was simultaneously deemphasized as causes of death."[353] Figure 9 below is from the Public Health Policy Initiative report and illustrates how the new CDC's new rules for reporting COVID-19 deaths had the effect of inflating the reported COVID-19 deaths.

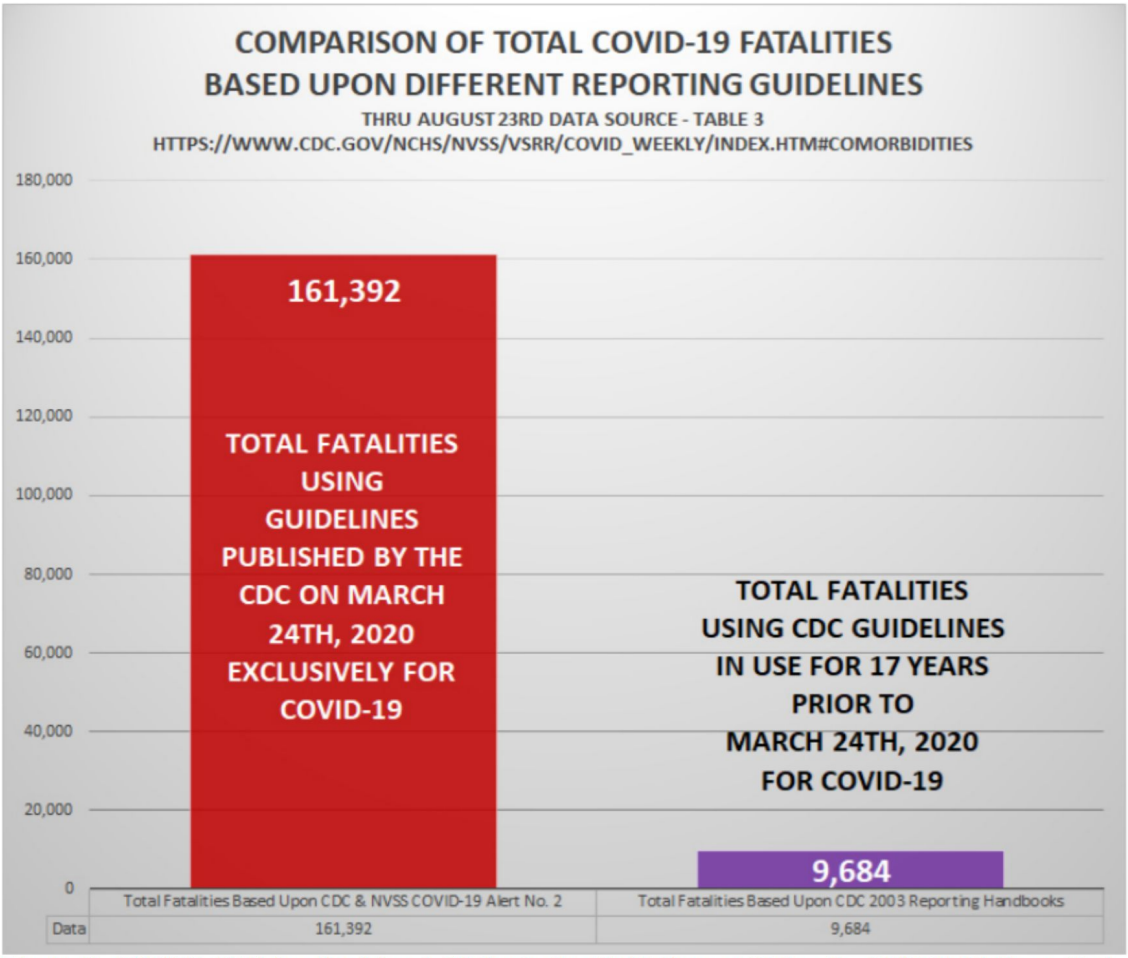


Figure 9. COVID-19 Using the March 24 Exclusive Guidelines vs Using the 2003 Guidelines. Had the CDC used the 2003 guidelines, the total **COVID-19** be approximately 16.7 times lower than is currently being reported. [1][30][State & Territory Health Departments]

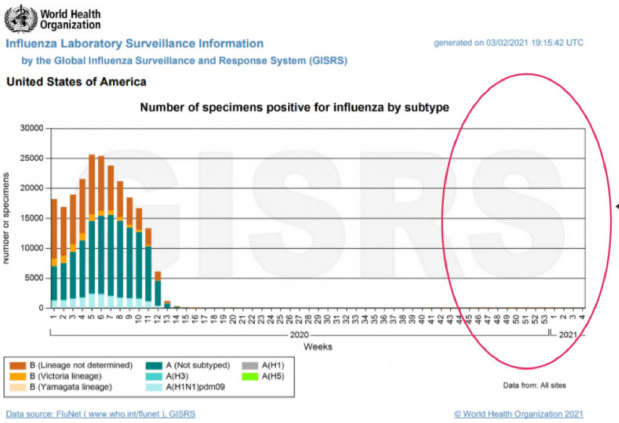
322. The March 24, 2020 COVID-19 Alert No. 2[354] from the CDC referred to additional documents providing further guidance, which seemed to be a reference to a March 4, 2020 CDC document titled Guidance for Certifying COVID-19 Deaths,[355] which explained how to list COVID-19 in Part I of the Death Certificate to show how to list COVID-19 as the "underlying cause" of death. Since the new rules were such a clear departure from the prior practice, it was necessary for the CDC to elaborate with further guidance in April 2020.[356]

323. The chart below is annotated from the World Health Organization. It reveals that the COVID-19 statistics are being padded by falsely reporting influenza cases as COVID-19 cases. To suggest that influenza cases are being misrepresented as COVID-19 cases is simply not allowed to be mentioned in the mainstream media. Peter Andrews, writing for Russia Today, reveals that there

has been a 98% plummet in flu infections. He then reveals it is impolite within the scientific community to suggest that doctors are misclassifying influenza cases as COVID-19 cases. Andrews explains that "it only seems like the flu has disappeared because doctors and scientists have been wrongly classing other respiratory diseases as Covid. Please note that the boffins are already treating this suggestion as something akin to flat-Earth theory."[357]

324. The chart below reveals a complete collapse in U.S. cases of influenza after COVID-19 made its appearance in the spring of 2020. Notice the complete disappearance of the flu during the 2020-2021 fall and winter seasonal flu period. That disappearance of flu correlates directly with the reported second-wave of COVID-19 cases and suggests that flu cases are being misreported as COVID-19 second-wave cases.

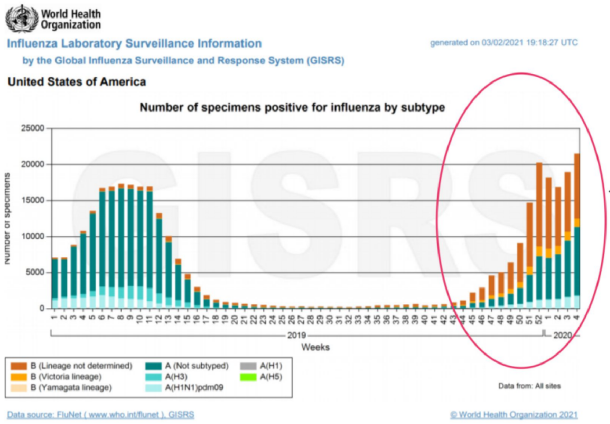
United States Influenza Cases



Flu disappears during the 2020-2021 Fall and Winter Flu Season in Direct Correlation with the Alleged COVID-19 Second Wave

The above World Health Organization (WHO) chart shows the number of people infected by influenza in the United States. Each Bar represents the number of infections in the United States for each week of 2020 through week number 4 of 2021. Notice that the influenza infections disappeared in the United States during week 15 of 2020. This correlates very closely with the emergence of COVID-19.

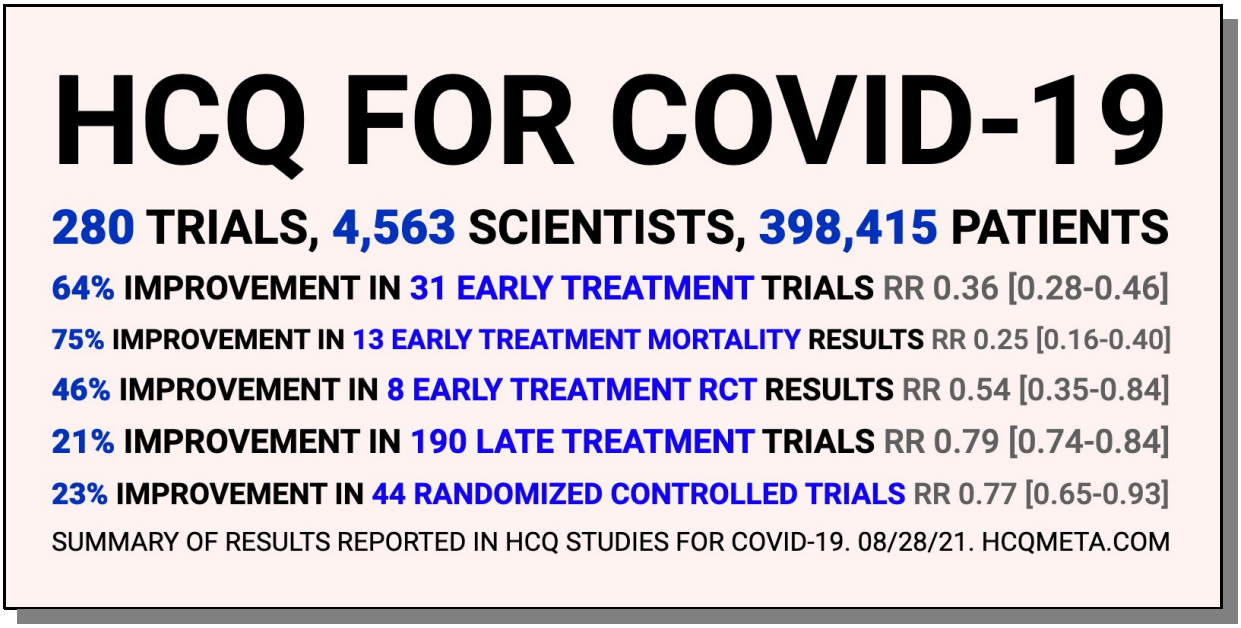
For comparison, below is a WHO chart that shows the number of people infected by influenza in the United States for the entire year of 2019 and the first 4 weeks of 2020. Each Bar represents the number of people infected in the United States for each week of 2019 through week 4 of 2021. Notice the difference from the chart above. This suggests that the disappearance of the influenza in week 15 of 2020 through week 4 of 2021 is because Influenza is being reported as COVID-19 infections. The complete disappearance of the flu during the fall and winter flu season of 2020-2021 suggests that the second wave of COVID-19 cases reported during that period are actually flu cases being falsely reported as COVID-19 cases.



2019-2020 Fall and Winter Flu Season

EUA MUST HAVE NO ADEQUATE ALTERNATIVE

325. The pharmaceutical companies and the FDA had a problem on their hands. To have the COVID-19 vaccines allowed under an emergency use authorization, Section 564 (21 U.S. Code § 360bbb–3 (c)(3)) required them to prove that "that there is no adequate, approved, and available alternative to the product for diagnosing, preventing, or treating such disease or condition." There were several drugs, most notably hydroxychloroquine (HCQ), that had proven to be safe and effective treatment against viral infections, including COVID-19. HCQ has a 60 year track record of safety and efficacy.[358]



326. HCQ had to be removed as an effective treatment for COVID-19 in order for the COVID-19 vaccines to be given their EUAs. And so, on June 15, 2020, the FDA issued a decision letter revoking the EUA for hyrdroxychloroquine (HCQ), stating that "it is no longer reasonable to believe that oral formulations of HCQ and CQ may be effective in treating COVID-19, nor is it reasonable to believe that the known and potential benefits of these products outweigh their known and potential risks."[359]

327. The decision letter had attached to it a memorandum explaining the alleged scientific basis for the decision. The memorandum stated that Biomedical Advanced Research and Development Authority (BARDA) considered several studies in determining that HCQ was not a safe and effective treatment for COVID-19.

328. There is a notable conflict of interest. Moderna, one of the manufacturers of an mRNA COVID-19 vaccine, published a 2019 letter to shareholders from Stéphane Bancel, Chief Executive Officer, in which she revealed:

> The Phase 1 study of mRNA-1893 is ongoing and is being advanced with funding from the U.S. Department of Health and Human Services (HHS); the Office of the Assistant Secretary for Preparedness and Response; and the Biomedical Advanced Research and Development Authority (BARDA).[360]

329. You read that correctly. Moderna received funding from BARDA to develop its mRNA vaccine technology. That technology was used to make their COVID-19 vaccine. That COVID-19 mRNA vaccine could not have been granted an EUA from the FDA unless there was no adequate, approved, and available alternative to the vaccine. HCQ was such an alternative. BARDA, who funded the Moderna mRNA research, steps in and issues a memorandum stating that studies show that HCQ is not a safe and effective alternative treatment for COVID-19. That cleared the path being blocked by HCQ for the FDA to grant the EUA to Moderna.

330. Let us read the BARDA memorandum. One of the studies BARDA said it evaluated but said it "will not be included in this Memerorndum."[361] The study was not included in the BARDA memorandum because before publishing the BARDA memorandum that study was publicly exposed as a fraudulent study. That study that purported to prove that HCQ was ineffective and unsafe in treating COVID-19 was shown to be an embarrassing fraud and was retracted by The Lancet.[362]

331. The fake study falsely showing hydroxychloroquine was unsafe and ineffective was published in The Lancet and The New England Journal of Medicine. The Lancet and The New England Journal of Medicine are the top two most respected medical journals in the world. The study published by those two journals was exposed as based upon fabricated data and performed by a false-front company.

332. *The Guardian* investigated the study, known as the Surgishere Study, and determined that it was a fabricated study performed by a scam organization whose principal employees included a sci-fi writer and adult content model. *The Guardian* reported:

> A search of publicly available material suggests several of Surgisphere's employees have little or no data or scientific background. An employee listed as a science editor appears to be a science fiction author and fantasy artist whose professional profile suggests writing is her fulltime job. Another employee listed as a marketing executive is an adult model and events hostess, who also acts in videos for organisations.[363]

333. The discovery that the study was completely made up from fabricated data forced The Lancet and The New England Journal of Medicine (NEJM) to retract their publication of the study. The odd thing is that it only took a modicum of review to discover the fraud. That is something that could easily have been done by the editors of The Lancet and the NEJM.

334. The article had the effect of halting all studies by the World Health Organization (WHO) into the effectiveness of hydroxychloroquine.[364] The WHO subsequently reintroduced HCQ into its

Solidarity Trial. The Solidarity Trial is a story in and of itself and will be discussed below.

335. Many governors in the United States prohibited hydroxychloroquine to treat COVID-19 based upon that fraudulent study. Those governors continued their bans on HCQ long after the study was exposed as a fraud.

336. What is amazing is that the study was announced by the NEJM as being retracted not because the data was shown to be fabricated (which it was), but rather "because all the authors were not granted access to the raw data and the raw data could not be made available to a third-party auditor, we are unable to validate the primary data sources underlying our article." But the article was a complete fraud. It should be announced as such. But, instead, it was announced as being retracted because the data could not be verified. That is how the NEJM rolls.

337. What did The Lancet say? In much the same way as the NEJM, The Lancet stated that "our reviewers were not able to conduct an independent and private peer review and therefore [the authors] notified us of their withdrawal from the peer-review process."

338. Both The Lancet and the NEJM rushed a fraudulent study to press without adequate peer review and a shocking lack of due diligence because it supported the narrative that hydroxychloroquine was unsafe and ineffective. Indeed, a typical medical study sometimes takes years to get through the peer-review process for publication. But this article was seemingly not reviewed at all. Why would the world-renowned NEJM and The Lancet publish garbage? That was answered by Dr. Douste-Blazy, who spilled the beans and revealed the control of pharmaceutical companies over The Lancet and NEJM. Philippe Douste-Blazy, MD, is a cardiologist and former French Health Minister who served as Under-Secretary-General of the United Nations. He was a candidate in 2017 for the Director of the World Health Organization. Vera Sharav reported in the Alliance for Human Research Protection the following information from Dr. Douste-Blazy:

> In a videotaped interview on May 24, 2020, Dr. Douste-Blazy provided insight into how a series of negative hydroxychloroquine studies got published in prestigious medical journals.
>
> He revealed that at a recent Chatham House top secret, closed door meeting attended by experts only, the editors of both The Lancet and the New England Journal of Medicine expressed their exasperation, citing the pressures put on them by pharmaceutical companies.
>
> **He states that each of the editors used the word "criminal" to describe the erosion of science.**[365] (emphasis added)

339. He who pays the piper calls the tune. Digging further, we find that the fraudulent study itself was financed by a pharmaceutical company that is trying to market a substitute for hydroxychloroquine as a treatment for COVID-19.[366] Sharav reveals:

> Dr. Mandeep Mehra, the lead co-author [of the fraudulent article] is a director at Brigham & Women's Hospital, which is credited with funding the study. Dr. Mehra and The Lancet failed to disclose that Brigham Hospital has a partnership with Gilead and is currently conducting TWO trials testing Remdesivir, the prime competitor of hydroxychloroquine for the treatment of COVID-19, the focus of the study.[367]

340. Sharav explains that within days of the study being published "Dr. Anthony Fauci, head of the National Institute of Allergy and Infectious Diseases (NIAID) declared on CNN "The scientific data is really quite evident now about the lack of efficacy."[368] And right on cue, there was a media blitz against hydroxychloroquine. Sharav reports:

> A media blitz against hydroxychloroquine (HCQ) created panic: clinical trials aimed at testing hydroxychloroquine for COVID-19 were suspended by International public health institutions including the World Health Organization the UK government regulatory agency and the French government.[369]

341. Sharav concluded:

> WHY are very powerful corporate-government stakeholders so intent on killing a drug with a 70 year track record? Because the drug works against the pandemic; it is readily available, and costs very little. Therefore, it poses a financial threat to both pharma companies and their partners in government and academia, those who are intent on profiting from the COVID-19 pandemic.
>
> As uncovered by Science Defies Politics: 16 of the panel members selected by NIH to formulate the official COVID-19 Treatment Guidelines – including two of the three co-chairs – were paid by Gilead. They issued guidelines that raised fear, uncertainty, and doubt about the use of HCQ combined with AZ, while raising no fear, doubt, or uncertainty about using Gilead's unproven, unapproved, drug remdesivir; a drug that has shown mediocre performance in clinical trials. Seven of the NIH panelists failed to disclose their financial ties to Gilead. They are listed here.
>
> The medical scientific literature is infested with financially motivated, shoddy, studies aimed at promoting products and, when a life-saving, non-patentable product, proves effective, scientists are hired to author study reports that are designed to tarnish scientists' reputations, and to proclaim findings that refute legitimate findings. In this case, studies designed to "debunk" the effectiveness of hydroxychloroquine against COVID-19.
>
> Examples of countries and physicians who have witnessed the effectiveness of the HCQ – Az combination as a treatment for covid-19, are viewed by corporate-government collaborating partners as posing a major threat to their marketing agendas.[370]

342. Incidentally, On May 12, 2020, the NIH recommended the use of Veklury® (remdesivir) for severe cases of COVID-19.[371] At that time, Veklury® (remdesivir) was an unapproved experimental drug made by Gilead Sciences. The FDA authorized it for emergency use treatment of COIVD-19.

343. The May 12, 2020 recommendation from the NIH to use Veklury® (remdesivir) to treat COVID-19 came from the NIH Panel on COVID-19 Treatment Guidelines. There were nine (9) people on the NIH Panel on COVID-19 Treatment Guidelines with financial ties to Gilead Sciences, the maker of Veklury® (remdesivir). The following is a list of those people on the NIH Panel on COVID-19 Treatment Guidelines who had financial ties to Gilead Sciences, the manufacturer of Veklury® (remdesivir):

> Rajesh Gandhi is on the advisory board of Gilead Sciences.
>
> David Glidden is a consultant for Gilead Sciences.
>
> Adaora Adimora is a consultant for Gilead Sciences and received research support from Gilead Sciences.
>
> Eric Daar is a consultant for Gilead Sciences and recieves research support from Gilead Sciences.
>
> Judith Aberg received research support from Gilead Sciences.
>
> Jason Baker received research support from Gilead Sciences.
>
> Susanna Naggie received research support from Gilead Sciences.
>
> Pablo Tebas received research support from Gilead Sciences.
>
> Roger Bedimo received an honoraria from Gilead Sciences.

344. The panel tried to steer doctors away from Hydroxychloroquine, by stating that "[t]here are insufficient clinical data to recommend either for or against using chloroquine or hydroxychloroquine for the treatment of COVID."[372]

345. Many of the studies cited in support of NIH's recommendation to use Veklury® (remdesivir) were in vitro studies or animal studies. A couple of the human studies were at best a mixed bag. Two of the most authoritative studies showed Veklury® (remdesivir) to be ineffective and unsafe. On or about May 12, 2020, the FDA reported the following summary for study GS-US-5773:

> In a randomized, open-label clinical trial (Study GS-US-540-5773) of remdesivir in 397 subjects with severe COVID-19 treated with remdesivir for 5 (n=200) or 10 days (n=197), adverse events were reported in 71% and 74% of subjects, respectively,

> serious adverse events were reported in 21% and 35% of subjects, respectively, and Grade=3 adverse events were reported in 31% and 43% of subjects, respectively. Nine (5%) subjects in the 5-day group and 20 (10%) subjects in the 10-day group discontinued treatment due to an adverse event. All cause mortality at Day 28 was 10% vs 13% in the 5- and 10-day treatment groups, respectively.[373]

346. Please do not miss the fact that there were reported 71% adverse events in the 5-day study and 74% adverse events in the 10-day study for patients taking Veklury® (remdesivir). 21% suffered serious adverse events in the 5 day study and 35% of the patients suffered serious adverse events in the 10-day study. Yet, the FDA granted an EUA for Veklury® (remdesivir), despite the studies showing it was unsafe.

347. Dr. Bryan Ardis, CEO of Ardis Labs, states that the NIH pushed the use of Veklury® (remdesivir) as a treatment for COVID-19 knowing that it would be unsafe and ineffective for patients. Veklury® (remdesivir) is a nucleotide analogue RNA polymerase inhibitor.[374] Dr. Ardis reveals that the symptoms of lungs filling with fluid and the other alleged COVID-19 symptoms were actually side effects of kidney poisoning and other organ damage that are known side-effects of Veklury® (remdesivir). Dr. Ardis alleges that the devestating health toll allegedly caused by COVID-19 was actually caused by the NIH recommended treatment of Veklury® (remdesivir).

348. Let us get back to the BARDA HCQ memorandum. Two other studies cited in the BARDA Hydroxychloroquine (HCQ) memorandum are known as the UK Recovery trial and the WHO Solidarity trial. BARDA alleged that "the RECOVERY Trial results offer persuasive evidence of a lack of benefit of HCQ in the treatment of hospitalized patients with COVID-19."[375] The WHO Solidarity trial was ongoing and not yet completed, but it was nonetheless cited in the memorandum. Odd that BARDA would cite to a study the outcome of which was at that time unknown. Both trials showed HCQ to be unsafe and ineffective in treating COVID-19. But medical and scientific experts who have reviewed the trials have concluded that they were rigged to falsely show that HCQ was unsafe and ineffective. For example, Dr. Merul Nass, M.D. studied both trials and concluded that "[i]n the UK Recovery trial, and in WHO Solidarity trial, HCQ is used in a non-therapeutic, toxic and potentially lethal dose."[376] She concluded that the patients in those studies were being poisoned with toxic levels of HCQ for the purpose of falsely showing that HCQ was unsafe and ineffective. She states that "WHO and other national health agencies, universities and charities have conducted large clinical trials that were designed so hydroxychloroquine would fail to show benefit in the treatment of Covid-19, perhaps to advantage much more expensive competitors and vaccines in development. ... In so doing, these agencies and charities have de facto conspired to increase the number of deaths in these trials."[377]

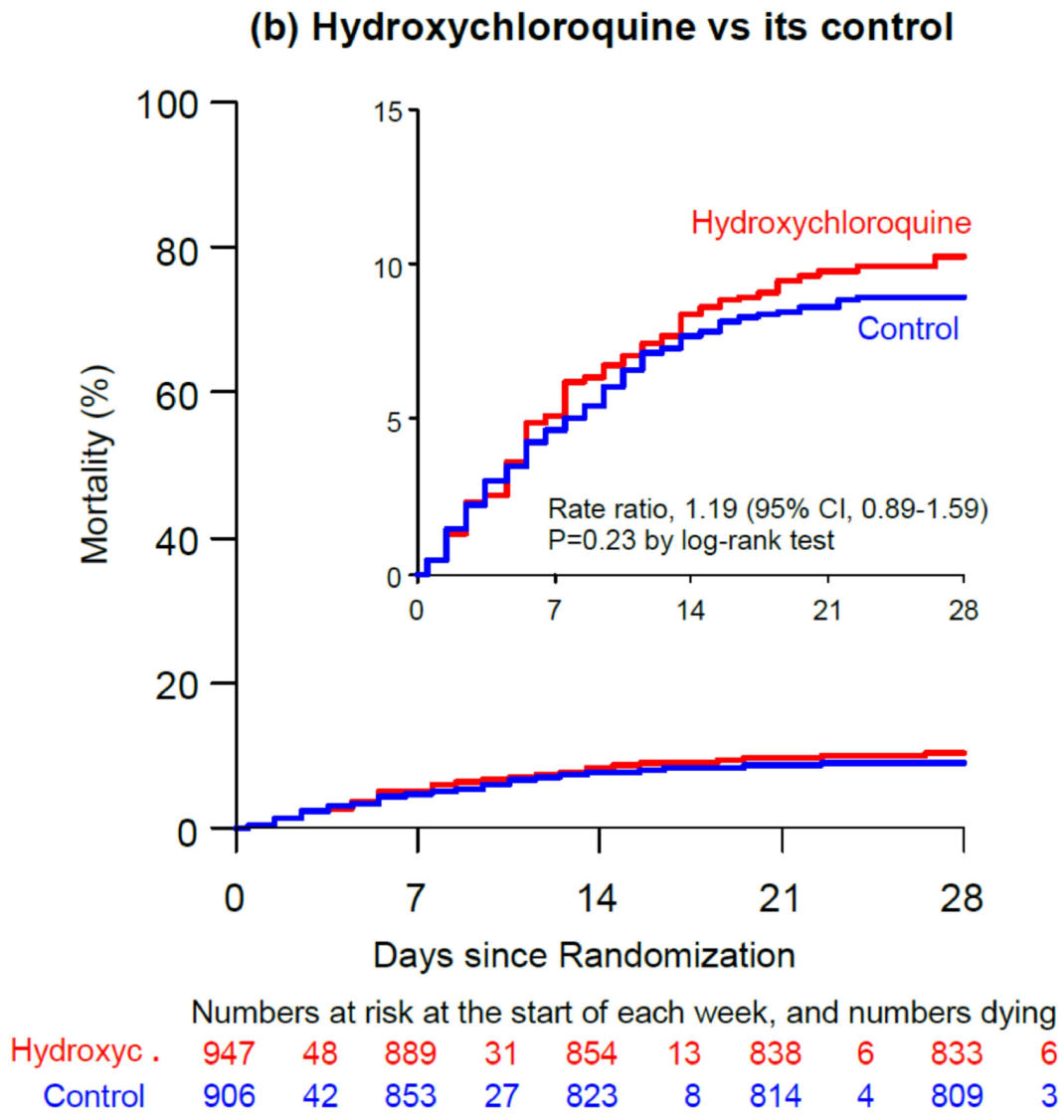
349. With HCQ out of the way, the FDA could issue an EUA for the experimental COVID-19 vaccines. On December 11, 2020, the Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for emergency use of Pfizer-BioNTech COVID-19 Vaccine for the prevention of COVID-19. In it announcement, it stated one of the required legal bases was fulfilled, that being "There is no adequate, approved, and available alternative to the emergency use of

Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19."[378]

350. Let us explore the WHO Solidarity trial and see how it was rigged to falsely show that HCQ was unsafe and ineffective.

351. Dr. Claus Kohnlein, the author of *Virus Mania*, reveals how the World Health Organization (WHO) has scammed the public into thinking that hydroxychloroquine is unsafe and ineffective as a therapy for COVID-19.[379] Dr. Kohnlein explains how the WHO published a study, known as the Solidarity Trial,[380] during which the study scientists gave the study participants toxic dosages of hydroxychloroquine (HCQ) to falsely show it is unsafe and ineffective.

352. The phony WHO study presents a graph comparing the mortality percentage of those alleged to have COVID-19 who took hydroxychloroquine and those alleged to have COVID-19 in the control group who did not take hydroxychloroquine. You will notice immediately that those that took the hydroxychloroquine died at a higher rate than those that received no medication. This is supposed to be scientific proof for the public and the medical community that hydroxychloroquine is unsafe and ineffective in treating COVID-19.



Kaplan-Meier graphs of in-hospital mortality. The inset shows the same data on an expanded y-axis

353. Hidden deep in the study is the little-publicized fact that the patients receiving the

hydroxychloroquine were given toxic doses. That is correct. The doctors were poisoning the patients. Hydroxychloroquine is very safe when the dosage is kept between 200 mg and 400 mg per day. But hydroxychloroquine has a narrow therapeutic index. That means that while hydroxychloroquine is otherwise safe, it does not take very much over the therapeutic dosage to be toxic.

354. Studies have shown that a toxic daily dosage of hydroxychloroquine is 20 mg per kg weight of the patient. Four grams 4 g of Hydroxychloroquine is considered a potentially lethal dose (4 g = 4,000 mg). The WHO study involved males and females from all over the world. The average weight of all persons in the world, male and female, is 136 pounds (62 kg). That means that the toxic dosage for hydroxychloroquine for the average person in the world is 1.24 g (62 kg x 20 mg = 1,240 mg). A common symptom of hydroxychloroquine poisoning is cardiac arrhythmia leading to death.

355. What dosage of hydroxychloroquine was administered to the WHO study group? the study reported:

> Hour 0, four tablets; Hour 6, four tablets; Hour 12, begin two tablets twice daily for 10 days. Each tablet contained 200mg Hydroxychloroquine sulphate.[381]

356. They administered to each of the study patients a dosage of 2.4 g (2,400 mg) of hydroxychloroquine in the first 24 hours of the study. That dosage of 2.4 g (2,400 mg) is 12 times the recommended dosage, which is 200 mg, and almost twice the daily toxic dosage, which is 1.24 g (1,240 mg). The doctors were poisoning the patients in the study.

357. The doctors followed that initial poisoning with 10 days of 800 mg, which is four (4) times the recommended daily dosage, and 60% of what would be considered a daily toxic dosage. The doctors were conducting the study across 30 countries and involving more than 405 hospitals. Weren't they concerned that somebody might notice that they were using suspiciously high dosages of hydroxychloroquine? Of course they were. They tried to cover themselves with the following statement:

> Despite concerns that the loading dose could be temporarily cardiotoxic, in neither trial was there any excess mortality during the first few days, when blood levels were highest. Neither trial recorded dosage/kg, obesity, or cardiac parameters, and cardiac deaths were too few to be reliably informative.[382]

358. They knew full well that they were poisoning the study patients. They identified the first-day "loading" dosage as "temporarily cardiotoxic." They started the study patients off with almost twice the toxic dose of Hydroxychloroquine. They admitted that that dose was "cardiotoxic." They were poisoning their study patients and gave no explanation for why they would do such a thing. But they made sure they kept their study patients on the edge of death over the next ten (10) days by continuing to administer four (4) times the recommended daily dosage of hydroxychloroquine.

359. The study scientists argued that there was no "excess mortality during the first few days" and

the few who died of cardiac arrest didn't matter to the study. What they did not say was that the cumulative effect of the hydroxychloroquine over the next 10 days acted to cull the herd in the hydroxychloroquine group just enough to show that hydroxychloroquine was unsafe and ineffective.

360. The doctors discuss the "few" who died from cardiac arrest. They cleverly avoid discussing those who died because the toxic dosages of hydroxychloroquine compromised the immune systems of the study patients. Hydroxychloroquine is a drug that is sometimes used to modulate the immune system. That is why hydroxychloroquine is used to treat autoimmune diseases like lupus. The doctors conducting the study knew that hydroxychloroquine is immunosuppressive when it is dispensed in high dosages. Suppressing a patient's immune system would make the patient less able to fight off an infectious disease.

361. The study doctors did not want to give the recommended dosage of 200 mg per day because they knew it would not kill anyone and it would likely show hydroxychloroquine to be both safe and effective. Instead, they decided to poison their patients the first day with a "cardiotoxic" dosage of hydroxychloroquine and then keep the toxic level up for ten (10) straight days. They knew full well that they would kill some of them but "too few to be reliably informative."[383]

362. We do not know the numbers of those who died of cardiac arrest from hydroxychloroquine poisoning because the study did not report that result. All who died were listed as having died of COVID-19. Certainly, the toxic dosages of hydroxychloroquine increased the deaths by suppressing the immune systems of the patients, 65% of whom were over 50 years old and in frail health. The deaths for the Hydroxychloroquine group included those who died from the effects of hydroxychloroquine poisoning, but they were reported as COVID-19 deaths. The scientists claimed that only a few died from cardiac arrest. But they make no mention of the immunosuppressive qualities of the toxic hydroxychloroquine dosages. Are we supposed to believe mad scientists who poison study patients to be honest in reporting what happened in the study?

363. The worldwide medical establishment had to prove that hydroxychloroquine was an ineffective treatment so that they could push the emergency use of the dangerous COVID-19 vaccines on the public with the argument that "[t]here is no adequate, approved, and available alternative to the emergency use of [Pfizer-BioNTech and Moderna] COVID 19 Vaccine[s] to prevent COVID-19."

364. Keep in mind that he who pays the piper calls the tune. The Bill and Melinda Gates Foundation is the second-largest donor in the world to the WHO, which in turn funded the fraudulent Solidarity Trial. Only the U.S. Government surpasses the Bill and Melinda Gates Foundation in funding the WHO. The Bill and Melinda Gates Foundation has donated billions for the administration of vaccines, including the COVID-19 vaccines, worldwide.

365. You must look at the donations coming from the Bill and Melinda Gates Foundation as strategic investments with a big payoff in the future. Bill Gates is probably the single person on the planet who will benefit the most financially by the imposition of the COVID-19 vaccine. Gates and

his foundation have close financial ties with Moderna, one of the COVID-19 vaccine manufacturers.[384] The mainstream media tries to keep a lid on that information. But it is a fact that is published on the Moderna website.[385] The Bill & Malinda Gates Foundation is listed as one of Moderna's strategic collaborators.[386] Indeed, Bill gates admitted in a CNBC interview he has turned an initial $10 billion investment in vaccine manufacturing into $200 billion.[387]

366. The FDA and the vaccine makers have another problem. And that problem is that scientific studies have proven that ivermectin is a safe and effective (and inexpensive) treatment for COVID-19. To continue the EUA for the COVID-19 vaccines, they need to maintain that "that there is no adequate, approved, and available alternative to the product for diagnosing, preventing, or treating such disease or condition." The FDA controls what is approved. All the FDA needs to do is not approve ivermectin, and the EUA for the COVID-19 vaccines continue. And so, ivermectin must go. Thus, the FDA has announced:

> The FDA has not authorized or approved ivermectin for the treatment or prevention of COVID-19 in people or animals. Ivermectin has not been shown to be safe or effective for these indications.[388]

367. On what basis does the FDA make that judgement that ivermectin is not safe or effective? The FDA claims:

> Currently available data do not show ivermectin is effective against COVID-19. Clinical trials assessing ivermectin tablets for the prevention or treatment of COVID-19 in people are ongoing. Taking large doses of ivermectin is dangerous.[389]

368. That statement by the FDA is not true. There have been 63 studies of the safety and effectiveness of ivermectin in treating COVID-19.[390] Meta-analysis of those studies found an average of 69% and 86% improvement for early treatment and prophylaxis.[391] Those numbers are probably conservative because researchers found a negative bias against ivermectin in a review of the studies. The researchers determined that the statistical probability for the studies to falsely portray a positive outcome for ivermectin is one in one trillion.

- Meta analysis using the most serious outcome reported shows 69% [54-79%] and 86% [75-92%] improvement for early treatment and prophylaxis, with similar results after exclusion based sensitivity analysis and restriction to peer-reviewed studies or Randomized Controlled Trials.
- Statistically significant improvements are seen for mortality, hospitalization, recovery, cases, and viral clearance. 29 studies show statistically significant improvements in isolation.

	Studies	*Prophylaxis*	*Early treatment*	*Late treatment*	*Patients*	*Authors*
All studies	63	**86%** [75-92%]	**69%** [54-79%]	**40%** [24-52%]	26,422	613
Peer-reviewed	44	**86%** [73-92%]	**70%** [52-81%]	**43%** [21-59%]	17,082	479
Randomized Controlled Trials	31	**84%** [25-96%]	**64%** [48-74%]	**30%** [2-50%]	6,561	359

Percentage improvement with ivermectin treatment

- There is evidence of a negative publication bias, and the probability that an ineffective treatment generated results as positive as the 63 studies is estimated to be 1 in 1 trillion.

369. In the face of that evidence of ivermectin efficacy, the FDA claims that "[c]urrently available data do not show ivermectin is effective against COVID-19."[392] There is no other way to put it: the FDA is lying.

COVID-19 VACCINES ARE UNSAFE

370. The CDC runs a reporting program known as the Vaccine Adverse Events Reporting Service (VAERS). The VAERS program reports adverse events that correlate to vaccinations in the U.S. The VAERS program relies, for the most part, on reporting of practitioners of adverse events from vaccines. Keep in mind that the VAERS data discloses correlation and it does not prove causation. But that does not mean that the COVID-19 vaccine did not cause the adverse event; it simply means that the causation has not yet been proven with scientific certainty. I would suggest, though, that the VAERS data establishes probable cause to believe that the COVID-19 vaccines are responsible for a significant plurality of the reported adverse events.

371. On April 16, 2021, Megan Redshaw published a report for *The Defender* about the Vaccine Adverse Event Reporting System statistics about the COVID-19 vaccines.[393] There are two important statistics that she revealed. Redshaw's analysis of the deaths from the COVID-19 is illuminating. Redsaw breaks down the time between the vaccination and the death. That data makes a very strong inference of causation. Redshaw reported the following about the deaths associated with the 174.9 million COVID-19 vaccinations administered in the United States as of April 8, 2021: Of the 2,602 deaths reported as of April 8, 27% occurred within 48 hours of vaccination, 19% occurred within 24 hours and 41% occurred in people who became ill within 48 hours of being vaccinated.

372. The breakdown by Redshaw of the VAERS statistics is illuminating. The statistics reveal that

87% of those that died following the COVID-19 vaccine became ill within 48 hours of receiving the vaccine. Of all the people who died from the COVID-19 vaccine, 46% died within 48 hours of receiving the vaccine.

373. We are working with the VAERS numbers from April 8, 2021. For simplicity's sake, I will stick with those numbers and not update them to today's date. Incidentally, there have been 12,791 COVID-19 vaccine deaths reported to VAERS as of August 6, 2021.

From the 4/8/2021 release of VAERS data:

Found 68,347 cases where Vaccine is COVID19

Table

Event Outcome	Count	Percent
Death	2,602	3.81%
Permanent Disability	950	1.39%
Office Visit	10,692	15.64%
Emergency Room	32	0.05%
Emergency Doctor/Room	10,046	14.7%
Hospitalized	5,064	7.41%
Hospitalized, Prolonged	10	0.01%
Recovered	26,727	39.1%
Birth Defect	57	0.08%
Life Threatening	1,506	2.2%
Not Serious	25,205	36.88%
TOTAL	† 82,891	† 121.28%

† Because some cases have multiple vaccinations and symptoms, a single case can account for multiple entries in this table. This is the reason why the Total Count is greater than 68347 (the number of cases found), and the Total Percentage is greater than 100.

374. It is fair to infer that a very high percentage of those who showed symptoms within 48 hours of receiving the vaccine and later died did so from the vaccine. But I will take the most conservative approach and only count those who died within 48 hours of vaccination. Multiplying the 2,602 total VAERS reported deaths as of April 8, 2021, by the 46% who died within 48 hours of injection, we come up with a conservative figure of 1,197 persons whose deaths were probably caused by a COVID-19 vaccine.

375. Please be mindful that the VAERS database suffers from a systemic flaw that is known to HHS. That flaw is that the VAERS database underreports the vaccine adverse events by a factor of 100. A Harvard study of the VAERS database that was commissioned by HHS revealed that "fewer than 1% of vaccine adverse events are reported."[394] That statistical finding in the Harvard study has been confirmed to be accurate in a subsequent scientific study.[395]

376. The Journal of the American Medical Association (JAMA) reported that the Adverse Events Reporting System (VAERS) reports that occurrence of anaphylaxis from the COVID-19 Vaccines is "4.7 cases/million Pfizer-BioNTech vaccine doses administered and 2.5 cases/million Moderna vaccine doses administered, based on information through January 18, 2021."[396] In a March 30, 2021 posting, the CDC reported similar statistics alleging that "[a]naphylaxis after COVID-19 vaccination is **rare** and occurred in approximately 2 to 5 people per million vaccinated in the United States based on events reported to VAERS."[397] (bold emphasis in original)

377. The problem with that reports from JAMA and the CDC is that they are contradicted by another, more recent, March 8, 2021 report from JAMA. That study of Mass General Brigham (MGB) employees receiving COVID-19 vaccines, was published by the JAMA reveals that "severe

reactions consistent with anaphylaxis occurred at a rate of 2.47 per 10,000 vaccinations."[398]

378. Elizabeth A. Brehm, wrote a letter on behalf of the Informed Consent Action Network (ICAN) to Dr. Rochelle P. Walensky, the Director of the Centers for Disease Control and Prevention.[399] Brehm pointed out that the MGB study reveals that the VAERS is under-reporting the accounts of anaphylaxis from the COVID-19 vaccines by a factor of between 50 and 120 times. ICAN complained that "[t]he underreporting of anaphylaxis by the CDC and VAERS is particularly troubling because it is mandatory for medical providers to report anaphylaxis after any COVID-19 vaccine to VAERS."[400] The most salient point in the letter from ICAN is the revelation from the MGB study that "the rate of reporting [of COVID-19 vaccine anaphylaxis adverse reactions] still appears to be only around 0.8 to 2 percent of all cases of anaphylaxis." The ICAN letter goes on to point out the obvious:

> This raises serious concerns regarding (1) under-reporting of other serious adverse events following COVID-19 vaccination, and (2) adverse events following other vaccines for which there has not been the same push to report adverse events. The anaphylaxis study highlights the urgency of the ongoing, well-known problem with adverse event reporting post-vaccination.[401]

379. The recent MGB study confirms the previous study done by Harvard that indicated that "fewer than 1% of vaccine adverse events" are reported in the VAERS system. Thus you can take any statistic from the VAERS system and multiply it by 100, and you will have a better idea of the real number for that category of adverse events. Thus, deaths reported under VAERS would likely be subject to the same under-reporting as would anaphylaxis. As with anaphylaxis, we can expect that only 1% of all deaths from COVID-19 vaccines are being reported in the VAERS system.

380. That means that, in actuality, as of April 8, 2021, 119,700 deaths occurred in the U.S. within 48 hours of receiving the COVID-19 vaccine. Thus, we can conservatively infer that there is more than a fair probability that as of April 8, 2021, approximately 119,700 deaths were caused by one of the three authorized COIVD-19 vaccines in the United States.

381. Redshaw also revealed in her article that the VAERS data shows "[t]here were 77 reports of Guillain-Barré Syndrome with 55% of cases attributed to Pfizer, 40% to Moderna and 10% to J&J."[402] Recall that the VAERS database only reflects 1% of actual injuries. Thus, as of April 8, 2021, we can reasonably infer that there have been 7,700 cases of Guillain-Barré Syndrome correlated to COVID-19 vaccines. Guillain-Barré is an autoimmune disorder that causes a person's immune system to damage the body's nerves. This autoimmune response causes severe muscle weakness and sometimes paralysis. The paralysis can be transitory, but it can also be permanent.

382. Only Janssen (J&J) mentions Guillain-Barre Syndrome in its fact sheet as a risk from its COVID-19 vaccine.[403] Guillain-Barre Syndrome is not mentioned as an adverse event outcome in either of the COIVD-19 vaccine fact sheets provided to recipients and caregivers from Moderna or Pfizer-BiNTech.[404] But Guillain-Barre Syndrome was listed by the FDA among the possible "adverse

event outcomes" being monitored during the COIVD-19 vaccine trials. Figure 9, *infra*, is a screenshot of a slide from a presentation by Steve Anderson, Director of Biostatistics and Epidemiology for the FDA, at the October 22, 2020 Vaccines and Related Biological Products Advisory Committee meeting.[405] The slide lists Guillain-Barre Syndrome as one of the possible adverse event outcomes being monitored by the FDA during the COVID-19 vaccine trials. They knew what to look for because they knew what they were seeing. The slide was shown for only a split second before it disappeared from view, and Dr. Anderson made no mention of it. No doubt they discovered Guillain-Barre Syndrome in all the vaccines, but only Janssen would admit to it.

383. Why am I focussing only on VAERS data of deaths and Guillain-Barré Syndrome? That is because death and Guillain-Barré Syndrome were the two events that caused the swine flu vaccine to be abruptly pulled from the market. Recall that the swine flu vaccine was administered to 40 million people over a 10 week period in 1976. That vaccine program was stopped within 10 weeks because 25 people died and 500 people developed Guillain-Barré Syndrome.[406]

384. Guess what else Dr. Anderson listed on his slide among the possible adverse event outcomes from the COVID-19 vaccine trials? — "Deaths."[407] As I said earlier, they knew what to look for because they knew what they were seeing. They were not going to waste their time looking for things that they did not expect to find. And they could not avoid seeing people drop dead. The FDA and the vaccine makers knew that the COVID-19 vaccines would kill people. That revelation in the flashed slide seemed to be inadvertent because the slide with that information disappeared within a split second with no comment on it from Dr. Anderson. Almost certainly, the adverse event outcome of 'deaths" were found during the COVID-19 vaccine studies because we see COVID-19 vaccine deaths happening throughout the country. But death is not listed as an adverse event in the COVID-19 vaccine fact sheets provided to the recipients and caregivers from the vaccine makers.

385. The swine flu vaccine program is generally recognized as a "debacle" of epic proportions because of the debilitating injuries and deaths caused by it. But we have the same thing happening with the COVID-19 vaccines but on an exponentially greater level, and yet the COVID-19 vaccines are still being promoted as safe.

386. The deaths from the COVID-19 vaccines (119,700) in the U.S. are exponentially greater than the deaths from the swine flu vaccine (25). The same goes for the cases of Guillain-Barré Syndrome from the COIVD-19 vaccine (7,700) versus the swine flu vaccine (500).

387. To put this in perspective, let us examine the death rate for each of the vaccines. As of April 8, 2021, 174.9 million COVID-19 vaccinations were administered in the United States, from which we can conservatively infer from the VAERS data that approximately 119,700 died from those vaccinations. That is a death rate from the COVID-19 vaccines of .065%. Compare that to the 25 people who died out of 40 million people who received the swine flu vaccine and we have a death rate from the swine flu vaccine of .0000625%. That means that the COVID-19 vaccine is 1,000 times more deadly than the disastrous swine flu vaccine.

388. The above data is from April 2021 data. The carnage and devastation from the COVID-19 vaccines are continuing. The CDC and the mainstream media persistently promote the COVID-19 vaccines like circus barkers drawing in the suckers to their destruction. President Biden characterizes the COVIID-19 vaccines as "safe, free, and effective vaccines."[408] When he announced his vaccine requirement for federal workers he said: "The vaccines are safe, highly effective."[409]

389. The President's order must be considered in light of the carnage caused by the COVID-19 vaccines. As of August 13, 2021, there were reported in the HHS Vaccine Adverse Event Reporting System (VAERS) 13,068 deaths correlated to the COVID-19 vaccines.[410] The Pfizer-BioNTech COVID-19 vaccine accounted for 9,024 of those deaths.[411] A research team from the American Frontline Doctors (AFLD) found that the VAERS database indicates that the total reported vaccine deaths in the first quarter of 2021 represents a 12,000% to 25,000% increase in vaccine deaths, year-on-year.[412] The AFLD determined that there were more deaths (approx. 4,000) from the COVID-19 vaccines reported in VAERS in the first four months of 2021 than deaths reported in VAERS for all other vaccines combined (1,529) over the ten year period from 2009 to 2019.[413] The AFLD research team determined that COVID-19 Vaccines have caused 99% of all reported vaccine deaths in 2021.[414] All other vaccines combined account for the remaining 1% of vaccine deaths.

390. Dr. Peter McCullough, M.D., is a consultant cardiologist and Vice Chief of Internal Medicine at Baylor University Medical Center in Dallas, TX. He is also a Principal Faculty in internal medicine for the Texas A & M University Health Sciences Center. Dr McCullough is an internationally recognized kidney and cardiovascular authority. He has more than 1000 publications. In fact, Dr. McCullough is reputed to be the most cited medical doctor on COVID-19 treatments at the National Library of Medicine, with more than 600 citations. Dr. McCullough has testified before Congress. Dr. McCullough is a medical expert on vaccines. Indeed, he has chaired more than two dozen vaccine safety monitoring boards for the FDA, and National Institute for Health.[415] Dr. McCullough's expert medical opinion is that the COVID-19 vaccines are unsafe and ineffective.[416]

391. Dr. McCullough continues by explaining that the COVID-19 experimental vaccine is "the largest application of a biological product with the greatest amount of morbidity and mortality in the history of our country."[417]

392. Dr. McCullough details the malfeasance of the government regulatory agencies. "With this program, there is no critical event committee, there is no data-safety monitoring board, and there's no human ethics committee. Those structures are mandatory for all large clinical investigations, and so the word that's really used for what's going on is malfeasance, that's wrongdoing of people in authority."[418]

393. In an interview, Dr. McCullough gave listeners some perspective on just how dangerous the COVID-19 vaccines are. He explains that "[a] typical new drug at about five deaths, unexplained deaths, we get a black-box warning, your listeners would see it on TV, saying it may cause death," McCullough said. "And then at about 50 deaths it's pulled off the market."[419]

394. Dr. McCullough juxtaposes that with what he has been able to gather from confidential sources that "[w]e think we have 50,000 dead Americans. Fifty thousand deaths. So we actually have more deaths due to the vaccine per day than certainly the viral illness by far. It's basically propagandized bioterrorism by injection."[420]

395. Dr. McCullough was not using hyperbole when he called the COVID-19 vaccines bioterrorism. Other highly respected doctors share that opinion. Dr. Barthelow Classen likens the COVID-19 vaccines to bioweapons. Dr. Barthelow Classen, M.D., has published a report revealing that the Pfizer-BioNTech COVID-19 vaccine uses an RNA sequence known to cause prion diseases such as Alzheimer's and amyotrophic lateral sclerosis (ALS).[421] Dr. Classen states that "[t]he current analysis indicates Pfizer's RNA based COVID-19 vaccine contains many of these RNA sequences that have been shown to have high affinity for TDP-43 or FUS and have the potential to induce chronic degenerative neurological diseases."[422] Dr. Classen reveals that the manifestation of the disease may take many years after the vaccination to develop in the vaccine recipient.

396. There is a government database that, unlike VAERS, is not public. That database is found in the Centers for Medicare and Medicaid Services (CMS). A whistleblower, who is a computer programmer with subject matter expertise in the healthcare data analytics field, has filed a sworn affidavit in a lawsuit that the CMS data collated with VAERS data shows 45,000 deaths from COVID-19 vaccines.[423] The affiant stated under oath the following:

> It is my professional estimate that VAERS (the Vaccine Adverse Event Reporting System) database, while extremely useful, is under-reported by a conservative factor of at least 5. On July 9, 2021, there were 9,048 deaths reported in VAERS. I verified these numbers by collating all of the data from VAERS myself, not relying on a third party to report them. In tandem, I queried data from CMS medical claims with regard to vaccines and patient deaths, and have assessed that the deaths occurring within 3 days of vaccination are higher than those reported in VAERS by a factor of at least 5. This would indicate the true number of vaccine-related deaths was at least 45,000. Put in perspective, the swine flu vaccine was taken off the market which only resulted in 53 deaths.[424]

397. Dr. McCullough's estimate of 50,000 deaths and the CMS expert's estimates of 45,000 deaths from the COVID-19 vaccines may yet still be exponentially under reporting because the sources are relying on government data. Such data suffers from under reporting. The VAERS data study commissioned by HHS concluded that the under reporting in VAERS was by a factor of 100. The VAERS system was only capturing 1% of the adverse events.

398. Please be mindful that as of August 13, 2021, there were reported in the HHS Vaccine Adverse Event Reporting System (VAERS) 13,068 deaths correlated to the COVID-19 vaccines.[425] The Pfizer-BioNTech COVID-19 vaccine accounted for 9,024 of those deaths.[426] Those deaths must be read in context. The HHS-funded Harvard study revealed that the VAERS data represents only 1% of the total adverse events.[427] Death is listed as one of the adverse events. Please understand the

limitations of VAERS. The VAERS data system reports correlation. The adverse events have not been clinically proven to have been caused by the listed vaccine. But we can reasonably infer that those who died within 48 hours of vaccination died from the vaccine. Megan Redshaw determined that 46% of those reported in VAERS as dying after receiving one of the COVID-19 vaccines died within 48 hours of injection. We will consider that as establishing a reasonable belief that the COVID-19 vaccines were the cause of the deaths. Thus, we come up with a conservative figure of 6,011 persons we have probable cause to believe died from the COVID-19 vaccine. The Pfizer-BiNTech COVID-19 vaccine accounts for 4,151 of those deaths. Understanding that the VAERS system only reports 1% of the actual deaths, we find that the actual deaths in the U.S. from the COVID-19 vaccines are 601,100 people, with the Pfizer-BiNTech vaccine killing 415,100 people. And the carnage continues. Yet, the President says that the COVID-19 vaccine is "safe." And the FDA has now approved the Pfizer-BiNTech vaccine.

399. Why are the COVID-19 vaccines so harmful? Dr. Robert Malone has the answer. Dr. Malone is a medical doctor and a world-famous infectious disease expert. Dr. Malone has close to 100 peer-reviewed publications and published abstracts and has over 11,477 citations of his peer reviewed publications. **Most notably, Dr. Malone is the inventor of the mRNA technology used by Pfizer-BioNTech and Moderna in their COVID-19 vaccines.**[428] Vaccines using mRNA technology are not like conventional vaccines, which use weakened forms of the virus. An mRNA vaccine uses only part of the virus's genetic code. An mRNA vaccine carries code into the body, where it enters cells. The mRNA instructs those cells to create spike proteins that are associated with COVID-19. These spike proteins are recognized by the immune system, which then attacks them. **Dr. Malone has stated that the spike proteins generated by the cells through the mRNA code are cytotoxic.**[429] That means that the spike proteins are toxic to living cells. Thus, the COVID-19 mRNA vaccines made by Pfizer-BioNTech and Moderna allowed under the EUA cause the body to create spike proteins that kill the cells in the body. That cytotoxicity is the cause of the many adverse events being reported in VAERS. Malone explained that he is a regulatory professional and has connections with persons in senior positions in the FDA. On or about June 13, 2021, Malone stated that he alerted those senior officials in the FDA to the cytotoxicity of the spike protein being generated by the mRNA vaccines "months-and-months ago."[430]

400. Yumiko Urasaki and Yuko Nomura, Nikkei staff writers, reported on August 26, 2021, that the Japanese Ministry of Health, Labor, and Welfare had pulled 1.6 million vials of the Moderna vaccine from circulation in Japan because the vaccine was found to contain a substance that reacts to magnets.[431] The article states that "Prime Minister Yoshihide Suga told reporters on Thursday afternoon that he had instructed the ministry to look into the case with safety as the top priority."[432]

401. Some suggest the vials could have been contaminated with some kind of metal. But Tyler Durden, reporting for Zero Hedge, states that "[s]ome believe the reported magnetism can be explained by graphene oxide, a magnetic nanoparticle studied[433] for its use as a drug delivery platform[434] and other biomedical applications."[435] Indeed, graphene oxide has been studied as an ingredient for use in hydrogels.[436] Hydrogels are used to protect the otherwise fragile mRNA in the COVID-19 vaccines. One of the characteristics of graphene oxide is that it develops a rare form of

magnetism when it is stacked and twisted.[437]

402. Angus Liu reported on February 17, 2021. for Fierce Biotech, that "Scientists at China's National Center for Nanoscience and Technology (NCNST) have designed a hydrogel to deliver an mRNA vaccine with an immune-stimulating adjuvant."[438] China's National Center for Nanoscience reported that their new hydrogel contains graphene oxide.[439] Liu reported:

> [T]he NCNST team designed a hydrogel with graphene oxide and low-weight polyethyleneimine. The graphene oxide can efficiently load drug substances thanks to its large surface area, and the polyethyleneimine binds the mRNA content for translation.[440]

403. The article by Liu was written on the day that the NCNST published their findings about the efficacy of their graphene oxide infused hydrogel, February 17, 2021. But certainly, the use of graphene oxide was likely already incorporated into the COVID-19 vaccines. Please be mindful that communist countries are parasitic. They steal technology developed by the west. The alleged development by the NCNST of hydrogel using graphene oxide was, in all likelihood, reverse engineering of that technology developed by Moderna, Pfizer-BioNTech, and others.

404. Why is this a problem? Graphene Oxide is cytoxic. That means it is a poison that kills cells. If the hydrogels used in the COVID-19 vaccines contain graphene oxide, that would make the vaccines dangerous to those being injected. Do the COVId-19 vaccines contain graphene oxide? There is at least probable cause to believe that they do.

405. Robert Young, M.Sc., D.Sc., Ph.D., used phase-contrast microscopy, transmission and scanning electron microscopy, and energy-dispersive x-ray spectroscopy to analyze the following COVID-19 vaccines: Pfizer--BioNTech mRNA Vaccine, the Moderna-Lonza mRNA-1273 Vaccine, the Serum Institute Oxford Astrazeneca Vaccine, and the Janssen COVID -19 Vaccine. Dr. Young concluded:

> The Pfizer, Moderna, Astrazeneca and Janssen drugs are NOT "vaccines" but complexed Graphene Oxide nano particulate aggregates of varying nano elements attached to genetically modified nucleic acids of mRNA from animal or vero cells and aborted human fetal cells.[441]

406. Dr. Young found the presence of graphene oxide using advanced microscopy. Some would consider that presumptive proof but not confirmatory. Some suggest that mass spectrometry analysis is necessary to confirm of Dr. Young's findings. It is fair to say that Dr. Young's advanced microscopy evidence, along with the other circumstantial evidence, establishes at least probable cause that the COVID-19 vaccines contain graphene oxide.

407. The companies making the COVID-19 vaccines tested by Dr. Young did not list graphene oxide as an ingredient in any publicly available documents. Dr. Young concluded that graphene

oxide in the COVID-19 "vaccines" renders them poisonous to the body's cells. The toxicity of graphene oxide is a generally known fact among scientists, which may explain why the companies did not reveal it as an ingredient in their COVID-19 "vaccines." Dr. Young explains:

> [T]he ingredients in these so-called vaccines are highly magneticotoxic, cytotoxic and genotoxic to plant, insect, bird, animal and human cell membranes and their genetics.[442]

408. None of the side effects from the COVID-19 vaccines have been a surprise to the vaccine makers or the FDA. Before the FDA issued the EUA for the COVID-19 vaccines, the Vaccines and Related Biological Products Advisory Committee held a meeting on October 22, 2020. Steve Anderson, Director of Biostatistics and Epidemiology for the FDA, gave a slide presentation at that meeting.[443] Anderson inadvertently showed a slide that he had no intention of discussing. The slide appeared for a split second at the 2:33:40 mark in the video before he suspiciously clicked past it and continued his presentation without mentioning any of the facts on the slide. The slide presented the possible adverse events from the COVID-19 vaccines. They knew what to look for because they knew what they were seeing. They were not going to waste their time looking for things that they did not expect to find. They are the very adverse events that are being witnessed in the VAERS reporting. A screenshot of the slide as it flashed on the screen is below:

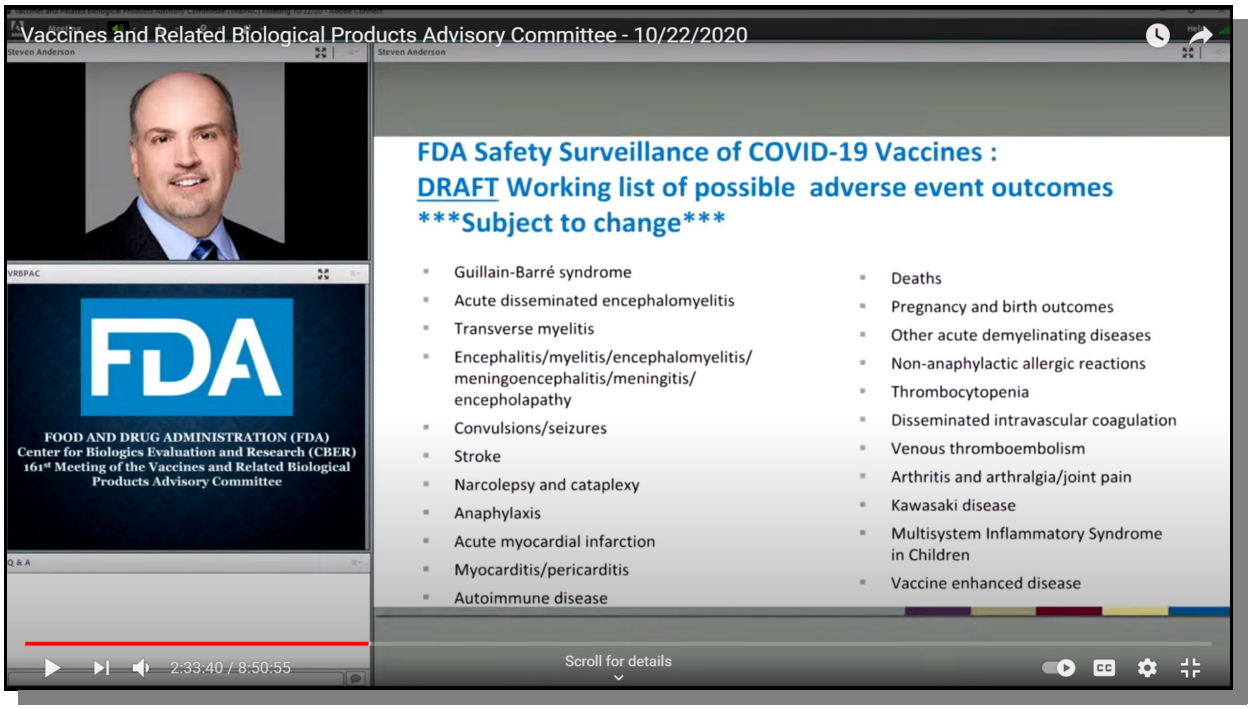


Figure 9: PowerPoint flashed on screen for a split second as Steve Anderson, Director of Biostatistics and Epidemiology for the FDA, gave a slide presentation at the October 22, 2020 Vaccines and Related Biological Products Advisory Committee meeting.

PROOF THAT COVID-19 VACCINES CAUSE MYOCARDITIS IN YOUTHS

409. Dr. Toby Rogers points out that "Pfizer's clinical trial in kids was intentionally undersized to hide harms. This is a well-known trick of the pharmaceutical industry. The FDA even called them out on it earlier this summer and asked Pfizer to expand the trial, and Pfizer just ignored them because they can."[444] Dr. Rogers explains the trick: "To put it simply, if the rate of particular adverse outcome in kids as a result of this shot is 1 in 5,000 and the trial only enrolls 1,518 in the treatment group then one is unlikely to spot this particular harm in the clinical trial. Voilà "Safe & Effective(TM)".[445]

410. Another trick vaccine makers use is to have a brief period to monitor test participants for adverse events. Pfizer only followed cohort 1 for two months and cohort 2 for 17 days for adverse events. But many adverse events take much longer to show up. Dr. Rogers observed: "As the old saying goes, 'you can have it quick or you can have it done right, but you cannot have both.' Pfizer chose quick."[446]

411. Such short observation periods acts to conceal the harm done to the heart. Dr. Rogers explains that "the harms of myocarditis from these shots will likely unfold over the course of years." The Pfizer study seemed designed to conceal the danger of myocarditis. For example, "they estimate 'excess' (read: caused by the shot) myocarditis using data from the private 'Optum health claim database' instead of the public VAERS system."[447] That is odd indeed. Why use a private database and eschew using the government-administered VAERS database? There was something in the VAERS system that Pfizer and the FDA did not want known.

412. Drs. Peter McCullough and Jessical Rose found out why the FDA and Pfizer steered clear of the VAERS database. Drs. McCullough and Rose jointly published an article that revealed how the VAERS database showed a substantial cause and effect relationship between the COVID-19 vaccines and myocarditis.[448]

413. Peter McCullough, M.D., is an American cardiologist. He was vice chief of internal medicine at Baylor University Medical Center and a professor at Texas A&M University. He is editor-in-chief of the journals Reviews in Cardiovascular Medicine and Cardiorenal Medicine. He is one of the most highly respected and published cardiologists in the U.S. Jessica Rose, PhD is a specialist in Orthopedics and Sports Medicine at Stanford Children's Health Specialty Services.

414. The McCullough & Rose report revealed the following startling facts.

> Within 8 weeks of the public offering of COVID-19 products to the 12-15-year-old age group, we found 19 times the expected number of myocarditis cases in the vaccination volunteers over background myocarditis rates for this age group.[449]

415. Another fact that the McCullough & Rose report revealed was that the incidence of myocarditis among teenagers is much worse than even the raw statistics obtained from the Vaccine

Adverse Events Reporting Service (VAERS) indicate. The report states:

> Because of the spontaneous reporting of events to VAERS, we can assume that the cases reported thus far are not rare, but rather, just the tip of the iceberg. Again, under-reporting is a known and serious disadvantage of the VAERS system.[450]

416. The VAERS system only reports about 1% of the actual adverse events.[451]

417. VAERS is a reporting system that shows correlation. Further analysis is required to prove causation. Drs. McCullough and Rose did that further analysis and opined that the VAERS data indicates a cause and effect between the vaccinations and teenage myocarditis. Their report indicates:

> It is noteworthy that 'Vaccine-induced myocarditis' was in fact used as the descriptor by medical professionals as the reason for the myocarditis in the VAERS database.[452]

418. The report concluded:

> Thus, due to both the problems of under-reporting and the known lag in report processing, this analysis reveals a strong signal from the VAERS data that the risk of suffering CIRM [COVID-19-Injection-Related Myocarditis] – especially males is unacceptably high. Again, children are not a high-risk group for COVID-19 respiratory illness, and yet they are the high-risk group for CIRM.[453]

419. That information reported by McCullough and Rose was in the VAERS database and was known to the FDA when it authorized the use of the unsafe and ineffective COVID-19 vaccines for children 5 through 11 years of age. That seems to be why the FDA and Pfizer steered clear of the VAERS data and instead used the private data from Optum Health.

420. Myocarditis is irreversible. Once the heart muscle is damaged, it cannot be repaired by the body. It is a devastating condition. Dr. Rogers explains that "over the course of several years many of those children will die. Dr. Anthony Hinton ('Consultant Surgeon with 30 years experience in the NHS') points out that myocarditis has a 20% fatality rate after 2 years and a 50% fatality rate after 5 years."[454] Dr. Hinton poignantly explains that "you can't have 'mild myocarditis' — in the same way you can't be 'a little bit pregnant.'"[455]

KILLING 117 CHILDREN FOR EVERY CHILD PURPORTEDLY SAVED

421. The FDA's 242-page manual titled *Communicating Risks and Benefits: An Evidence-Based User's Guide* explains that the "number needed to treat" (NNT) is one of the three most important statistics for describing the risk and benefits of any drug or vaccine.[456] Toby Rogers, Ph.D., explains that the CDC and the FDA violated their own standards and the fundamental norms of science by not revealing the NNT when reviewing the Emergency Use Authorizations (EUA) and Biologics License Application from Pfizer-BioNTech when reviewing its COVID-19 vaccine for use in

children ages 5 to 11.

422. Dr. Rogers explains that the pharmaceutical industry hates talking about NNT. They hate talking about NNT even more when it comes to COVID-19 vaccines because the NNT is so high that the COVID-19 vaccines could not pass any honest risk-benefit analysis.[457]

423. The NNT can be reported for any number of variables, such as deaths, ICU admissions, hospitalizations, etc. Taking death as an example, the death NNT for 5 to 11 year-olds from COVID-19 would tell the researchers and the public how many children need to be vaccinated to prevent a single death from COVID-19.

424. The lower the risk from the disease, the higher the NNT. Children ages 5 to 11 are at extremely low risk of hospitalization, ICU admission, or death from COVID-19. Indeed, there were no hospitalizations, ICU admissions, or deaths in either the vaccine group or the control group in the Pfizer-BioNTech trials involving 5 to 11 year-olds. Dr. Rogers explains:

> [The NNT] is calculated by dividing 1 by the Absolute Risk Reduction. But there was no risk reduction in hospitalizations, ICU admissions, nor death for 5 to 11 year olds. So if one remembers grade school math, 1/0 is "undefined" since one cannot divide by zero.
>
> This means one could vaccinate every child age 5 to 11 in the U.S. and not prevent a single hospitalization, ICU admission, or death from coronavirus — according to Pfizer's own clinical trial data as submitted to the FDA.
>
> It appears Pfizer was not even trying to conduct a responsible clinical trial of its mRNA shot in kids ages 5 to 11. Pfizer submitted an EUA application to the FDA showing no health benefit in children ages 5 to 11 and the FDA's Vaccines and Related Biologics Products Advisory Committee approved it anyway, 17 – 0 with 1 abstention.[458]

425. Dr. Rogers assumed a very generous 80% efficacy in preventing hospitalizations and deaths of 5 to 11-year-olds. He extrapolated that efficacy rate from the FDA claim that Pfizer-BioNTech has an 80% efficacy rate for COVID-associated hospitalizations for ages 20+ years old. The FDA used that 80% figure to estimate the efficacy rate for the Pfizer-BioNTech COVID-19 vaccine for 5 to 11-year-olds. Using the FDA's very optimistic benefit of the Pfizer-BioNTech COVID-19 vaccine, Dr. Rogers calculated the death NNT for children 5 to 11 years old.

426. Dr. Rogers used the optimistically reported efficacy of 80% from the FDA and applied that figure to the reported fatalities for COVID-19 for 5 to 11-year-olds and calculated the death NNT for the Pfizer-BioNTech COVID-19 vaccine was 630,775. That means that the vaccine must be given to 630,775 children to save one child.

427. But that astronomical death NNT does not tell the whole story. We must compare that death NNT to the death risk from the vaccine. Dr. Rogers used the nearest age group vaccine risk data (12 to 15-year-olds) available and applied that data to the 5 to 11-year-olds. This is known as immuno-bridging of data. The VAERS data under-reports adverse events by a factor of 100. But Dr. Rogers multiplied the reported death numbers by a more conservative 41 times. By doing that, he determined that there were 5,248 deaths in the 12-15-year-old age group from the COVID-19 vaccines. Dr. Rogers compared the death rate to the death NNT and concluded:

> Simply put, the Biden administration plan would kill 5,248 children via Pfizer mRNA shots in order to save 45 children from dying of coronavirus.
>
> **For every one child saved by the shot, another 117 would be killed by the shot.**
>
> The Pfizer mRNA shot fails any honest risk-benefit analysis in children ages 5 to 11.
>
> ***
>
> The Biden Administration, the FDA, and the CDC claim they "follow the science" and yet they violate their own standards and scientific norms in order to exaggerate the benefits and hide the harms from vaccines.
>
> The FDA refused to calculate an [NNT], not because it forgot, but because agency officials knew the number and corresponding side effects are so high it would destroy the case for mRNA vaccines in children this age.[459] (emphasis added)

PROOF OF INTENT TO INJURE AND KILL

428. On October 31, 2021, investigative reporters from *The Expose* published a research investigation revealing that official data from the U.S. Government Vaccine Adverse Event Reporting Service (VAERS) showed 5% of the COVID-19 vaccines lots caused 100% of the COVID-19 deaths.[460] The Expose report uncovered evidence that the vaccine makers, Moderna and Pfizer, each distributed a small set of immediately dangerous vaccine batches entirely differently from their more benign vaccine batches. The more immediately dangerous vaccine lots were distributed more widely across the United States. In contrast, the more benign vaccine lots that caused few injuries or adverse events were not given the same broad distribution.

429. The fact that the vaccine companies distributed the more immediately deadly batches differently from the more initially benign batches means that the companies knew that those immediately deadly batches were distinctly different before distribution. That means that it was planned out in advance to distribute widely the death and hospitalizations from the COVID-19 vaccines. This proves intent!

430. *The Expose* researchers asked:

Why is it that the most harmful and deadly Covid-19 vaccines were distributed across the entire USA, whilst the least harmful and deadly were only ever distributed to a few states? Was this done on purpose?[461]

431. The answers to their questions are obvious; think about it logically.

- The evidence establishes that the most immediately harmful lots of COVID-19 vaccines were distributed more broadly to more states than the more benign (in the short term) lots of COVID-19 vaccines.

- That necessarily means that the companies purposely manufactured non-uniform formulations of their vaccines while representing to the public that all COVID-19 vaccines from a given manufacturer were uniform in their formulation.

- That also means that the vaccine makers identified the more immediately dangerous vaccines as such.

- In order to identify the more immediately hazardous vaccines required that the vaccine makers know that certain lots were more immediately hazardous formulations of the COVID-19 vaccines.

- They distributed those known dangerous vaccine lots differently.

- That different distribution scheme means that the vaccine makers distributed the more immediately dangerous lots differently because they had a purpose in doing so.

- The different distribution scheme for the more immediately dangerous vaccine lots suggests that the vaccine manufacturers knew that those particular vaccine lots would imminently kill and hospitalize more people per lot over a broader area of the U.S.

- This is evidence of premeditated intent to injure and kill the public by distributing a dangerous vaccine broadly across the country that the vaccine makers knew would kill and hospitalize the recipients shortly after being vaccinated. It seems that their purpose was to spread the death and injury broadly to conceal the deliberate suffering caused by the vaccines that would be camouflaged by the many uninjured vaccine recipients.

432. The more deadly batches were being spread broadly over the country to disperse the adverse events more evenly. A concentration of adverse events in any given area would raise concerns. But a sprinkling of adverse events among those who had none could be explained away as unusual. The benign vaccine recipients could say that they received the COVID-19 vaccine with no adverse symptoms.

433. They could not have a concentration of persons receiving a vaccine being hospitalized and dying all at once. So they sprinkled the poison broadly across the country.

434. The day after publication of the report by *The Expose*, Dr Mike Yeadon, former Vice-President of Pfizer, explained that the report has astounding implications. Dr. Yeadon stated:

> This information about different safety profiles of different "lots" (batches of finished product of covid19 vaccines) is completely without precedent.[462]

435. Dr. Yeadon said that it is unimaginable that having batches of vaccines benign and others deadly could happen by mistake. He said:

> Errors made in the final steps of manufacturing which resulted in certain batches bring reasonably benign & others extraordinarily deadly. I just cannot imagine the kind of mistakes which could produce such radically different clinical profiles.[463]

436. Dr. Yeadon's only rational conclusion is that there was intentional modification of the vaccines.

> At some point in manufacturing, someone or some entity actively modified what was being filled into vials, and it was this which resulted in extreme skew of clinical safety profile.[464]

437. Dr. Yeadon said that it is possibly intentional conduct by the vaccine makers. Indeed, how could anyone conclude otherwise given the different distribution schemes for the immediately dangerous lots of vaccines? Dr. Yeadon concluded:

> There has been so much truly awful behaviour of "elites" that I'm simply not willing (as I would have historically) to dismiss the possibility that this has been done on purpose.[465]

438. Dr. Yeadon called for all COVID-19 vaccinations to cease.

> What I do know, and this is a test of whether there's the slightest sign of integrity from these companies as well as the regulatory agencies, is that all use of the affected produce must immediately cease, all batches of drug substance & lots of drug product should cease.
>
> The materials should be recalled to a place of stable storage & an intense analytical investigation initiated.
>
> Unless factors are found which adequately explain the huge differences in clinical adverse event profiles, administration to humans must not restart.

> If the manufacturers do not exhibit sufficient control of drug product, the authorisation they hold from various regulatory authorities are utterly voided.
>
> Just when you thought this debacle couldn't possibly get any worse, it gets much worse.
>
> Expect to hear more about this.
>
> Meanwhile, who in their right mind would roll up their sleeve?[466]

439. What I found interesting about Dr. Yeadon's review of *The Expose* report was that he only addressed the disparity in the deadliness of the vaccines. He did not address the elephant in the room. He did not mention that the drug makers distributed the immediately deadly vaccines entirely differently. That different distribution indicates that the drug makers knew which batches were deadly. Otherwise, they would not know which batches to distribute more broadly. That fact alone shows intent to harm and kill. Dr. Yeadon, Pfizer's former vice president, ignored the evidence implicating Pfizer and Moderna in premeditated criminal conduct.

440. Dr. Yeadon calls for a cessation of vaccination while a safety investigation is conducted. He should be calling for a cessation of vaccination while a criminal investigation is conducted.

441. Karl Denninger is a technology expert, businessman, and political activist who is credited with starting the Tea Party Movement. He runs a blog called The Market Ticker. On November 2, 2021, Karl Denninger posted an article that characterized the allegation that the vaccine makers were distributing certain bathes of COVID-19 vaccines to kill and injure people, a tinfoil hat conspiracy theory.[467]

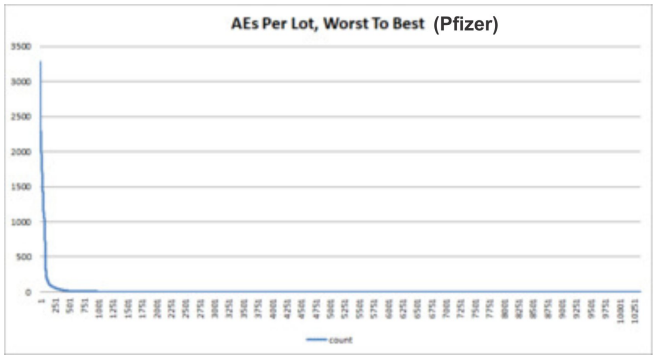
442. Denninger set out to disprove that theory and show just how ridiculous it was. But, as he used his software skills to mine the Vaccine Adverse Events Reporting System (VAERS) data, he came to a disturbing conclusion. He found that, indeed, the vaccine makers had created a certain small number of batches of vaccines that caused almost all of the deaths and adverse events. Denninger explained:

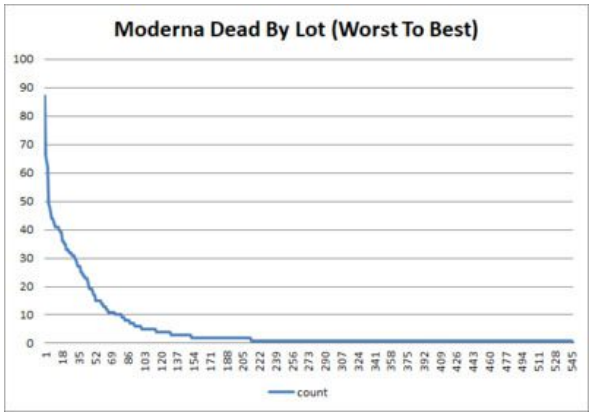
> What originally got my attention was the tinfoil hat crowd screaming about lots being intentionally distributed to certain people to kill them — in other words certain Covid-19 vaccine lots were for all intents and purposes poisoned. That was wildly unlikely so I set out to disprove it and apply some broom handles to the tinfoil hatters heads. What I found, however, was both interesting and deeply disturbing.[468]

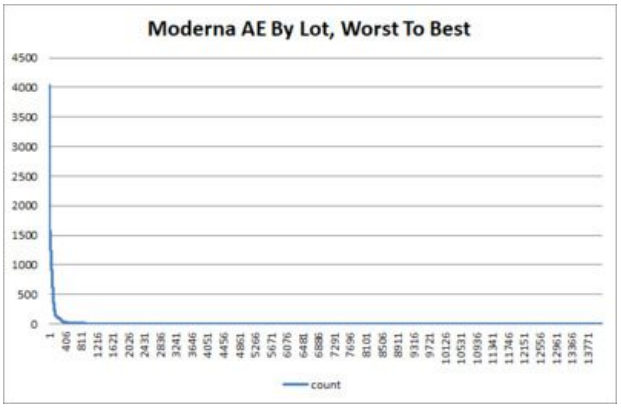
443. Denninger was flummoxed by his findings that the phenomenon of a few lots of COVID-19 vaccines were causing almost all of the deaths and hospitalizations. He was further mystified that the same activity was displayed by the makers of each of the three COVID-19 vaccines used in the U.S. Denninger found those facts very troubling. How could the same manufacturing anomaly

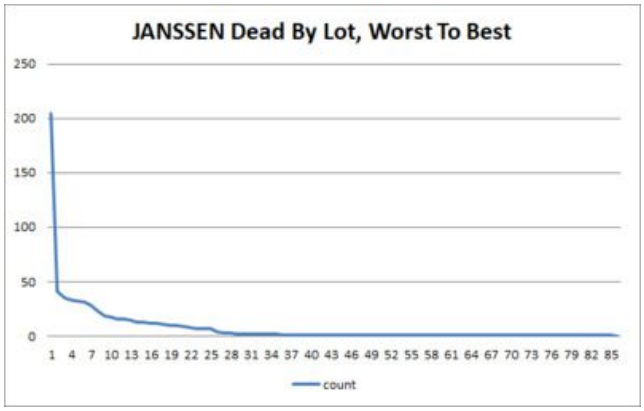
happen across all three manufacturers unless it was part of a plan to do so?

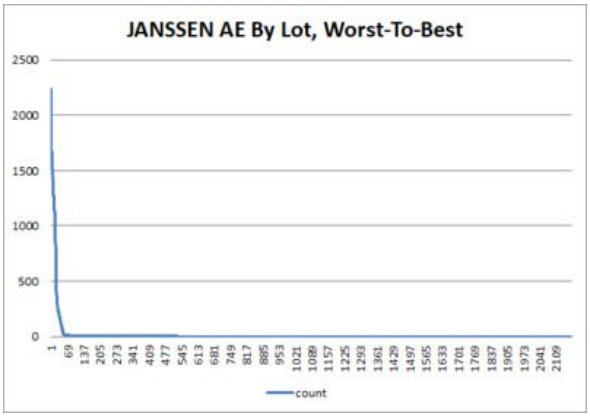
444. Notice in the charts prepared by Denninger that all three of the COVID-19 vaccine manufactures did the same thing. They all manufactured a concentration of immediately deadly lots of COVID-19 vaccines. This phenomenon cannot be by chance. Denninger points out that these are independent companies; the concentration of deadly vaccines into a few batches by all companies "cannot be explained as random chance." It is a joint effort; the data shows a conspiracy to kill and injure.











445. Denninger was also troubled that the CDC, which runs the VAERS system, knows about this. He deduced that the CDC is keeping it hidden from the public by configuring VAERS in such a way to make it very difficult for the public to find the information. Notably, neither the CDC nor the FDA is doing anything about it. Denninger explains:

> Something is very wrong here folks and the people running VAERS either aren't looking on purpose, know damn well its happening and are saying nothing about it on purpose — never mind segregating the data in such a fashion that casual perusal of their downloads won't find it — or saw it immediately and suppressed reporting on purpose.[469]

446. As with Dr. Mike Yeadon, Karl Denninger does not examine the elephant in the room other than to notice it is there. Denninger states: "Oh if you're interested the nastiest lot was literally everywhere in terms of states reporting adverse events against it; no, they didn't concentrate them in one state or region either." That statement is meaningless without giving it context. Denninger fails to explore the implications that the more immediately dangerous COVID-19 vaccine lots were distributed over a broad geographic area. In contrast, the more immediately benign vaccines were

concentrated in particular geographic areas of distribution. That unique treatment for the more deadly vaccines suggests prior knowledge of their deadliness and an intent to spread the harm over a broad area.

MORAL HAZARD OF IMMUNITY FROM LIABILITY

447. The vaccine manufacturers are virtually immune from liability for their negligence in manufacturing vaccines.[470] This creates a moral hazard where there is no financial incentive for the vaccine manufacturers to make their vaccines safe.

448. Mary S. Holland has written an excellent law review article in the Emory Law Journal that explains the moral hazard created by Congress in enacting the 1986 U.S. National Childhood Vaccine Injury Act (NVICP) and the subsequent 2005 PREP Act.[471]

449. The NVICP had the effect of protecting vaccine manufacturers from civil liability for injuries caused by vaccines that they manufactured. A plaintiff must first pass through the rigorous legal labyrinth of a special vaccine court to obtain compensation from the government. There are a few who push their cases and are able to win in that court.

450. The vaccine court wears down the plaintiffs. Thus, there are many thousands of vaccine injury victims who suffer in silence. You can expect the same with the COVID-19 vaccine. Indeed it will be even worse. In 2005, Congress passed a tort shield law, the PREP Act, to protect manufacturers of drugs and other "covered countermeasure[s]," including vaccines, from the risk of damages in the event of a declared public health emergency. The standards for recovery for injuries due to the COVID-19 vaccine under the PREP Act are even more onerous than those under the NVICP. "The Countermeasures Injury Compensation Program (CICP) is a Federal government program that administers the compensation Program specified by the Public Readiness and Emergency Preparedness Act (PREP Act)."[472] There is a strict one year statute of limitations under the PREP Act. Except under rare exceptions, an injured person must fill suit within one year of receiving the vaccine alleged to have caused the injury.[473] Of the thousands of injuries suffered by people from vaccines, the CICP program has only compensated 29 claimants since 2005, paying out a total of $6 million.[474]

451. Vaccine Manufacturers have little concern about the safety of the vaccines because when you are injured by their experimental vaccine, they will be immune from liability.

452. The vaccine manufacturers are cheering on vaccine mandates. That is why the vaccine manufacturers work so closely with the ultimate force, governments. The governments of the world are their real customers. The governments pay for the vaccines. And the governments will then force those overpriced, ineffective, and unsafe vaccines on their people. On July 22, 2020, the Wall Street Journal Editorial Board pointed out that "[l]ife probably won't return to normal until we have a widely distributed Covid-19 vaccine."[475]

COVID-19 VACCINES PURCHASED PRIOR TO EUA

453. Indeed, the ultimate customer, the U.S. Government, agreed to pay billions of dollars to purchase vaccines prior to the passage of the EUA. The testing for safety and efficacy had not yet been completed on the vaccines when the government agreed to buy them. On July 22, 2020, Jared S. Hopkins and Chris Wack writing for the Wall Street Journal reported that "[t]he U.S. has agreed to pay Pfizer Inc. and BioNTech SE nearly $2 billion to secure 100 million doses of their experimental COVID-19 vaccine to provide to Americans free of charge."[476]

454. The context for that announcement to pay $billions must be understood. Neither Pfizer nor BioNTech nor any other pharmaceutical company had, as of that date, yet proven that their proposed vaccines were safe or effective. It seems that the government and drug companies did not care. We were going to be vaccinated regardless. What do you think that the chances were of the FDA not issuing an EUA for the experimental vaccines for which the U.S. Government had already paid $2 billion? The chances of the EUA not being allowed was slim to none, and slim has left town.

455. Hopkins and Wack revealed some important details. The U.S. Government had also agreed on or before July 2020 to acquire an additional 500 million vaccine doses. That is despite the fact, as reported by Hopkins and Wack at that date (July 22, 2020) "[n]o Covid-19 vaccine in development has proven to work safely yet, although dozens are being studied."[477]

COVID-19 VACCINES ARE INEFFECTIVE

456. President Biden's claim that "[t]he vaccines are safe, highly effective,"[478] is provably false. As we have seen, the data shows that the COVID-19 vaccines are unsafe. I will now prove that they are also ineffective.

457. Dr. Nina Pierpont (MD, Ph.D.), has a BA in biology from Yale University, MA and Ph.D. in population biology/evolutionary biology/ecology from Princeton University, and MD from Johns Hopkins University School of Medicine. Dr. Pierpont has been a Clinical Assistant Professor of Pediatrics at Columbia University's College of Physicians & Surgeons. She is currently in private practice in upstate New York, specializing in behavioral medicine. Dr. Pierpont reviewed the available data, principally from three scientific studies, and concluded that COVID-19 vaccine mandates have no justification because "current vaccines do not prevent transmission of SARS-CoV-2."[479]

458. The United Kingdom Health Security Agency COVID-19 Vaccine Surveillance Report published on October 21, 2021, reveals that "[i]n individuals aged greater than 30, the rate of a positive COVID-19 test is higher in vaccinated individuals compared to unvaccinated."[480] But that statement from the British Government understates the ineffectiveness of the COVID-19 vaccinations. Indeed, when looking at the population from 18 years old and up, we find that the infection rate among the vaccinated population is significantly higher than the infection rate for the unvaccinated population. The British Government report reveals that over a monitoring period

spanning week 38 to week 41 of 2021, the COVID-19 case rate for the vaccinated group over 18 years old was significantly more than the case rate for the unvaccinated group. There were 5,871 cases of COVID-19 for every 100,000 vaccinated persons more than 18 years old. In contrast, there were only 3,584 COVID-19 for every 100,000 unvaccinated persons more than 18 years old.[481] The workforce would fall largely in the over 18-year-old age bracket. Those statistics mean that a vaccinated person in the workforce is more likely to be infected with COVID-19 than an unvaccinated person.

459. Data from the government health authorities in Scotland showed that the fully vaccinated accounted for 89% of COVID-19 deaths, whilst also accounting for 77% of COVID-19 hospitalizations, and 65% of alleged COVID-19 cases from October 9 through November 5, 2021.[482]

460. In Antwerp, Belgium, 100% of the hospitalized "COVID cases" are fully vaccinated persons. The Hall Turn Radio Show reported that "CEOs and medical directors of Antwerp hospitals met this week and the mood was worrying. They're having another COVID outbreak, but this time, ALL the patients . . . are fully vaccinated."[483] Kristiaan Deckers, Medical Director of the Antwerp GZA, remarked that "the question is whether the vaccines will still work."[484] It was further reported:

> Other officials, who asked to not be named for fear of retribution were far more candid. Said one CEO "Either the vaccines just don't work or, worse, it is the vaccines themselves causing COVID in these people. But if we are publicly quoted as stating the obvious, we will be driven out of our jobs and out of our profession. There is an almost cult-like zeitgeist that no one is allowed to say anything against the vaccines, even if they don't work or are hurting people.[485]

461. What is the cause of this phenomenon? The UK Health Security Agency data shows that the COVID-19 vaccine efficacy drops at a steady 5% average rate per week.[486] One would think that fact would only indicate that the vaccine is losing efficacy, ultimately dropping to zero. But that is not the case. The hard data from the UK government indicates that, in fact, the 5% loss of efficacy actually continues past zero. What that means is that the vaccine increases the likelihood of COVID-19.

462. The UK Health Security Agency COVID-19 data indicates that the COVID-19 vaccines have not merely lost their efficiency; they damage and suppress the immune system. Over time, a vaccinated person is less able to fight off infection and ends up hospitalized. They test positive for COVID-19 and are labeled a breakthrough COVID case. In fact, they are likely a case of antibody-dependent enhancement (ADE), wherein they are ill not because the vaccine did not work but because the vaccine worked to make them sick.

463. The method used by the vaccine makers for reporting the efficacy of the COVID-19 vaccines (relative risk reduction) is to subtract the percentage of infected vaccinated persons from the percentage of infected unvaccinated persons and divide that number by the percentage of infected unvaccinated persons (U-V/U). Using that formula, and applying it to the UK government data, I

calculated that the actual effectiveness of the COVID-19 vaccines in the real world is minus-64%.[487] That means that a vaccinated person is 64% more likely to catch COVID-19 than an unvaccinated person.[488]

464. That calculation of minus-64% COVID-19 vaccine efficacy was from the official reported data of the UK Health Security Agency.[489] That minus-64% means that the immune system of the person who is vaccinated is so debilitated by the vaccine that, on a percentage basis, he is 64% more likely to be infected with COVID-19 as an unvaccinated person. That is data from week 42 of 2021. The UK Health Security Agency data shows that when comparing the number of persons with COVID-19 per 100,000 vaccinated persons to the number of persons with COVID-19 per 100,000 unvaccinated persons, the vaccinated group has significantly higher rate of COVID-19 cases than the unvaccinated group. That indicates that over time the vaccines have a negative efficacy. The COVID-19 vaccines make a person more susceptible to COVID-19. Recall that the efficacy of the COVID-19 vaccines have been calculated to drop at an average rate of 5% per week.[490] As time passes, the likelihood of COVID-19 infection (or more likely, antibody-dependent enhancement (ADE)) increases for the vaccinated persons.

465. Ralph Baric, is the William R. Kenan Jr. Distinguished Professor in the Department of Epidemiology, and Professor in the Department of Microbiology and Immunology at the University of North Carolina at Chapel Hill. Dr. Baric stated that with the COVID-19 vaccines "[t]here is the potential for ADE, but the bigger problem is probably Th2 immunopathology."[491] Indeed, that very thing was seen by Dr Ryan Cole, who runs the largest independent testing lab in Idaho. Dr Cole has performed more than 100,000 pathology lab examinations from COVID patients. *The Expose* reported that "[h]e identified what he is seeing as a form of AIDS (reverse HIV he called it – where you lose CD8 killer T cells rather than CD4 Helper T cells)."[492] What does that mean? The researchers for *The Expose* explained that "[t]his suggests that the vaccines are giving people vaccine mediated immune deficiency, which therefore suggests the vaccines are giving people a form of AIDS (Acquired Immune Deficiency Syndrome)."[493]

466. The null hypothesis in a recent study was that areas with low vaccination rates drive the ongoing surge of new COVID-19. The study disproved that null hypothesis. That study by S. V. Subramanian from the Harvard Center for Population and Development Studies published on the NIH website concluded that "increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States."[494] The study determined that the COVID-19 vaccines are not effective. While the study disproved the null hypothesis, one finds that the data goes beyond showing ineffectiveness of the COVID-19 vaccines. The data showed a positive correlation between vaccine rate and infection rate. The data indicate that COVID-19 vaccines are driving the infection. For example, the study presented data showing that U.S. counties with higher COVID-19 vaccine rates had higher rates of COVID-19 cases. The study states:

> Of the top 5 counties that have the highest percentage of population fully vaccinated (99.9–84.3%), the US Centers for Disease Control and Prevention (CDC) identifies 4 of them as "High" Transmission counties. Chattahoochee (Georgia), McKinley

> (New Mexico), and Arecibo (Puerto Rico) counties have above 90% of their population fully vaccinated with all three being classified as "High" transmission. Conversely, of the 57 counties that have been classified as "low" transmission counties by the CDC, 26.3% (15) have percentage of population fully vaccinated below 20%.[495]

467. When looking at the country-level data, the reader finds the same correlation. In disproving the null hypothesis, the study determined there was no relationship between the percentage of the population fully vaccinated and new COVID-19 cases. The study concluded that the COVID-19 vaccines are ineffective. But the data goes beyond showing the vaccines are ineffective. The study shows that vaccines cause a higher rate of COIVD-19 infection. The study showed that the higher the COVID-19 vaccine rate in a country, the higher is its COVID-19 infection rate. The study reveals that "[i]n fact, the trend line suggests a marginally positive association such that countries with higher percentage of population fully vaccinated have higher COVID-19 cases per 1 million people." Thus, the vaccines seem to drive the COVID-19 infection. The study states:

> At the country-level, there appears to be no discernable relationship between percentage of population fully vaccinated and new COVID-19 cases in the last 7 days. In fact, the trend line suggests a marginally positive association such that countries with higher percentage of population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days. The lack of a meaningful association between percentage population fully vaccinated and new COVID-19 cases is further exemplified, for instance, by comparison of Iceland and Portugal. Both countries have over 75% of their population fully vaccinated and have more COVID-19 cases per 1 million people than countries such as Vietnam and South Africa that have around 10% of their population fully vaccinated.[496]

468. What accounts for the phenomenon of vaccines that offer no protection? Some think that the answer has been found in a massive study involving approximately 620,000 U.S. Veterans who received COVID-19 vaccines. The researchers determined that "[t]he proportionate reduction in infection associated with vaccination declined for all vaccine types, with the largest declines for Janssen followed by Pfizer-BioNTech and Moderna."[497]

469. The decline in protection for the Johnson & Johnson (Janssen) COVID-19 vaccine was significant. The protection from COVID-19 dropped from 88% protection against COVID-19 in March 2021 down to 3% protection, just five months later in August 2021. The protection from infection for Pfizer-BioNTech dropped from 91% in March to 50% in August. The Moderna vaccine protection dropped from 92% in March to 64% in August. The vaccines' problem is that they only provide a few months of protection before that protection drops precipitously. What is the point of getting a vaccination that offers only a few short months of protection?

470. But the waning vaccine efficacy is not why the risk of COVID-19 infection is the same for the vaccinated as it is for unvaccinated. The data indicates that the risk of COVID-19 is actually worse for vaccinated more than 30 years old. It is not that the vaccines are ineffective that is the reason for the COVID-19 infections among the vaccinated; the vaccines drive an illness called antibody dependent enhancement (ADE). ADE is being reported as COVID-19 because the patients are testing positive for COIVD-19. ADE is discussed further below under the section titled *Antibody Dependent Enhancement*.

471. Furthermore, the vaccine manufacturers used misleading statistics to report the effectiveness of their vaccines. The vaccine manufacturers and also the persons running the above study of 620,000 veterans, are reporting the relative efficacy of the COVID-19 vaccines. What is happening in the real world is a reflection of the absolute (total) risk reduction. The difference between the two is explained below under the section titled *Irregularities in the Vaccine Efficacy Studies*.

472. Moderna, for example, reported to the FDA that their studies showed a 94.1 % efficacy for their Moderna COVID-19 mRNA vaccine. But that figure is the relative risk reduction and not the total (absolute) risk reduction. The total risk reduction for the Moderna vaccine is only 1.25%. That means that one can expect that there will be a reduction of 1.25% in COVID-19 infections in the population after being vaccinated. Thus you would have to vaccinate 100,000 persons to protect the 125 people at risk from COVID-19. That means that the federal government is needlessly paying to vaccinate 99,875 persons. Such a massive vaccine program to protect so few people only benefits the vaccine makers. And when one realizes that the vaccine is driving ADE, which the medical community is reporting as COVID-19, it explains perfectly why the data shows that more vaccinated persons are being infected and hospitalized with COVID-19 than unvaccinated persons.

473. When a vaccinated person is diagnosed with COVID-19 it is called a breakthrough case. Even with the efforts of the CDC to under-report COVID-19 breakthrough cases involving vaccinated persons, while at the same time inflating the unvaccinated COVID-19 infection numbers, the data shows a growing trend of vaccinated persons being infected, hospitalized, and dying from COVID-19. While the data shows that the vaccines are ineffective, the federal and state governments are still pushing COVID-19 vaccines as safe and effective. For example, the State of Maryland Department of Health vaccine information website states:

> Vaccines are an effective and critical tool to bring the pandemic under control by helping to prevent infection, serious illness, hospitalization and death due to COVID-19. **Although there are cases of people who become sick after they are fully vaccinated, cases where fully vaccinated people are hospitalized or die from COVID-19 are rare and vaccines remain the best way to prevent COVID-19 and its complications.**[498]

474. The problem with that statement is that it is not true. Writing for the Gateway Pundit, Joe Hoft revealed that the state government statistics from the Maryland Department of Health (MDH) contradict the above statement.[499] The MDH data showed that "[b]etween Sept 22, 2021, and Oct

10, 2021, Maryland had an additional 21,864 Covid-19 cases which 7,233 or 33.1% of the cases were classified as breakthrough cases. ... During this same period, Maryland lost 259 citizens to Covid-19. Of those 259 souls, 77 or 29.7% were fully vaccinated."[500] The MDH has the temerity to claim that it is rare for fully vaccinated people to be hospitalized or die from COVID-19, when its own statistics show that a significant plurality of the population dying from COVID-19 are those who have been vaccinated.

475. None other than the former CDC Director, Robert Redfield, refuted the false claim made by the State of Maryland Department of Health that it is rare for a fully vaccinated person to die from COVID-19. On or about October 25, 2021, Redfield responded to a question from Martha MacCallum on FOX News about Colin Powell's recent death that his family states was caused by the COVID-19 vaccine:

> I hear a lot of times people feel it's a rare event that fully vaccinated people may die. I happen to be the senior advisor to Governor Hogan in the state of Maryland. In the last 6-8 weeks, more than 40 percent of people who died in Maryland were fully vaccinated."[501]

476. Jim Hoft explained that "Andy Owen, a spokesperson for the Maryland Department of Health had a different claim that from Sept. 1 to Oct. 15, only about 30% of Marylanders who died of confirmed COVID-19 were fully vaccinated."[502]

477. Whether it is 30% or 40%, is really of no import. The fact that any vaccinated persons, let alone such a significant plurality of vaccinated people, are being diagnosed as having COVID-19 and dying from it is stark proof that the COVID-19 vaccines are ineffective. Assuming those deaths are actually from ADE caused by the COVID-19 vaccines proves that the vaccines are also unsafe. But what is really disturbing is that in the face of such evidence that a significant number of persons vaccinated with COVID-19 vaccines are dying, state health authorities claim that "cases where fully vaccinated people are hospitalized or die from COVID-19 are rare and vaccines remain the best way to prevent COVID-19 and its complications."[503] That is an unconscionable lie.

478. That kind of deception by state health officials is being played out all over the country. Hoft explains:

> In Pennsylvania, the acting Sec. of Health Alison Beam stated at a news conference at Lancaster General Hospital, "With nearly seven million Pennsylvanians fully vaccinated, the data makes it clear: the vaccines are safe and effective at preventing severe illness from Covid-19."
>
> However, recent analysis of cases and deaths between September 15 and Oct 4 show that in 132k cases, 26.1% of them were classified as breakthrough and 305 (26.5%) deaths out of a total of 1,153 were in fully vaccinated people. But Sec. of Health Alison Beam makes no mention of that.[504]

479. Hoft cites a UK Government Health report showing "that between week 37 and week 40, there was a total of 2,805 COVID-19 deaths and 2,136 or 76.1% were fully vaccinated. These deaths happened within 28 days of a positive Covid-19 test."[505] Yet, in the face of that data, the British Government health officials still promote the COVID-19 vaccines as effective in preventing COVID-19, and they claim that the COVID-19 vaccines provide a high level of protection against death from COVID-19.[506]

480. The State of Vermont has had a very similar experience to that of England. The Vermont Daily Chronicle reported that 76% of COVID-19 deaths in the State of Vermont during September 2021 were of persons who had received COVID-19 vaccinations.[507] Yet, the State of Vermont Department of Public Health claims that "[v]accines are the best tool we have to protect ourselves against COVID-19, especially from severe illness, hospitalization and death."[508]

481. On or about July 27, 2021, Dr. Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID), and member of the White House coronavirus task force, said

> When you look at the virus in the nasal pharynx of a vaccinated person who gets a breakthrough infection with [the] delta [variant of COVID-19], it is exactly the same as the level of virus in a unvaccinated person who is infected. That's the problem.[509]

482. On or about August 7, 2021, CDC Director Rochelle Walensky stated the following during a CNN interview:

> Our vaccines are working exceptionally well. They continue to work well for Delta with regard to severe illness and death, they prevent it. **But what they can't do anymore is prevent transmission.**[510] (emphasis added)

483. That was a retraction of Walensky's earlier mistaken claim in March 2021 that vaccinated people almost never carry COVID-19.

> The Washington Post reported on an internal document from the CDC:
>
> It cites a combination of recently obtained, still-unpublished data from outbreak investigations and outside studies showing that vaccinated individuals infected with delta may be able to transmit the virus as easily as those who are unvaccinated.[511]

484. On or about April 9, 2021, the Prime Minister of England, Boris Johnson, advised persons that they may not meet indoors with vaccinated persons. He admitted that the vaccines do not prevent transmission of COVID-19. He responded to a question that he read outloud during a briefing:

> "Can I now meet my friends and family members indoors if they are vaccinated?" There I am afraid the answer is no, because we're not yet at that stage, we're still very much in the world where you can meet friends and family outdoors, under the rule

> of six, or two households. And even if your friends and family members may be vaccinated, the vaccines are not giving 100% protection and that's why we need to be cautious. We don't think that they [COVID-19 vaccines] entirely reduce or remove the risk of transmission."[512]

485. That was not a slip of the tongue or a mistake. Johnson's opinion was based on the data coming from the British health authorities. On or about October 23, 2021, The Prime Minister emphatically repeated that the COVID-19 vaccine "doesn't protect you against catching the disease, and it doesn't protect you from passing it on."[513] Johnson, curiously, went on to promote the COVID-19 vaccine booster, even though the first course of the vaccine has been proven ineffective in preventing infection and the spread of the disease. He trumpeted the new mantra justifying the vaccine booster; it is supposed to lessen the symptoms of COVID-19.

486. The CDC and the vaccine manufacturers are on record admitting that the COVID-19 vaccines do not prevent the spread of COVID-19. Indeed, before the EUA authorization by the FDA of the Pfizer-BioNtech vaccine, the Daily Mail reported that on or before December 4, 2020, "Pfizer CEO [Albert Bourla] admits he is 'not certain' their COVID-19 shot will prevent vaccinated people from spreading the virus."[514]

487. Moderna Chief Medical Officer Tal Zaks is on record saying that the Moderna vaccine can prevent someone from getting sick from COVID-19 but that there is no evidence that it can prevent someone receiving the vaccine from carrying the vaccine and infecting others. Before the FDA issuance of the EUA for the Moderna vaccine, on or before November 23, 2020, Zaks stated: "our results show that this vaccine can prevent you from being sick, it can prevent you from being severely sick. They do not show that it prevents you from potentially carrying this virus transiently and infecting others."[515]

488. Because it became clear early on that the COVID-19 vaccines did not prevent the spread of COVID-19, the CDC found it necessary to issue a press release on March 8, 2021, saying that that fully vaccinated Americans must "continue to take these COVID-19 precautions when in public."[516] That included wearing masks, staying six feet apart from other people, and avoiding large crowds.

489. The predictions of Moderna and Pfizer have proven correct. A very high percentage of new COVID-19 cases are from vaccinated persons. Britain's Chief Scientific Adviser Patrick Vallance claimed that he mistakenly said that 60% of people being admitted to hospital with COVID-19 are fully vaccinated. He later clarified that he meant to say that 60% of those admitted for COVID-19 to the hospital are unvaccinated.[517] Please don't miss the significance of that admission. It means that the England health authorities recognize that 40% of COVID-19 hospitalizations are from fully vaccinated persons.

490. There are many anecdotal examples of fully vaccinated persons being subsequently infected with COVID-19. For example, it was reported by COVID Legal USA on March 12, 2021, that there was a COVID-19 infection outbreak at the Cottonwoods Care Centre retirement facility in Kelowna,

British Columbia, even though 82% of the residents were fully vaccinated. Eight out of the twelve COVID-19 confirmed cases were fully vaccinated persons.[518] That means that 66% of confirmed COVID-19 cases were from those who were fully vaccinated.

491. On August 6, 2021, the CDC published a report that 346 out of out of 469 COVID-19 cases (74%) in a breakout in Barnsdale County, Massachusetts, were of people who were fully vaccinated.[519] The COVID-19 vaccines are proving to be ineffective in preventing infection.

492. Indeed, the COVID-19 infection rate for vaccinated persons has gotten so out of hand that on July 27, 2021, the CDC had to change their guidance because of the alleged spreading of COVID-19 by vaccinated persons. NBC News reported:

> The Centers for Disease Control and Prevention issued new guidance on Tuesday recommending indoor mask use in areas with high transmission rates after new data suggested fully **vaccinated individuals are not just contracting Covid-19 but could potentially infect others.**
>
> CDC Director Rochelle Walensky said recent studies had shown that those **vaccinated individuals who do become infected with Covid have just as much viral load as the unvaccinated, making it possible for them to spread the virus to others.** Based on that finding, Walensky said the CDC is also recommending that all school children wear masks in the fall.[520] (emphasis added)

493. Emily Kopp, writing for Roll Call, reported that a confidential congressional briefing revealed that "[t]here are 35,000 symptomatic breakthrough cases each weeks." Kopp concluded that vaccinated persons can be "superspreaders" of COVID-19.

> The newly released report showing that vaccinated people can still be superspreaders drove the recent decision by the CDC to once again recommend masks for vaccinated people indoors where case counts are high or substantial.[521]

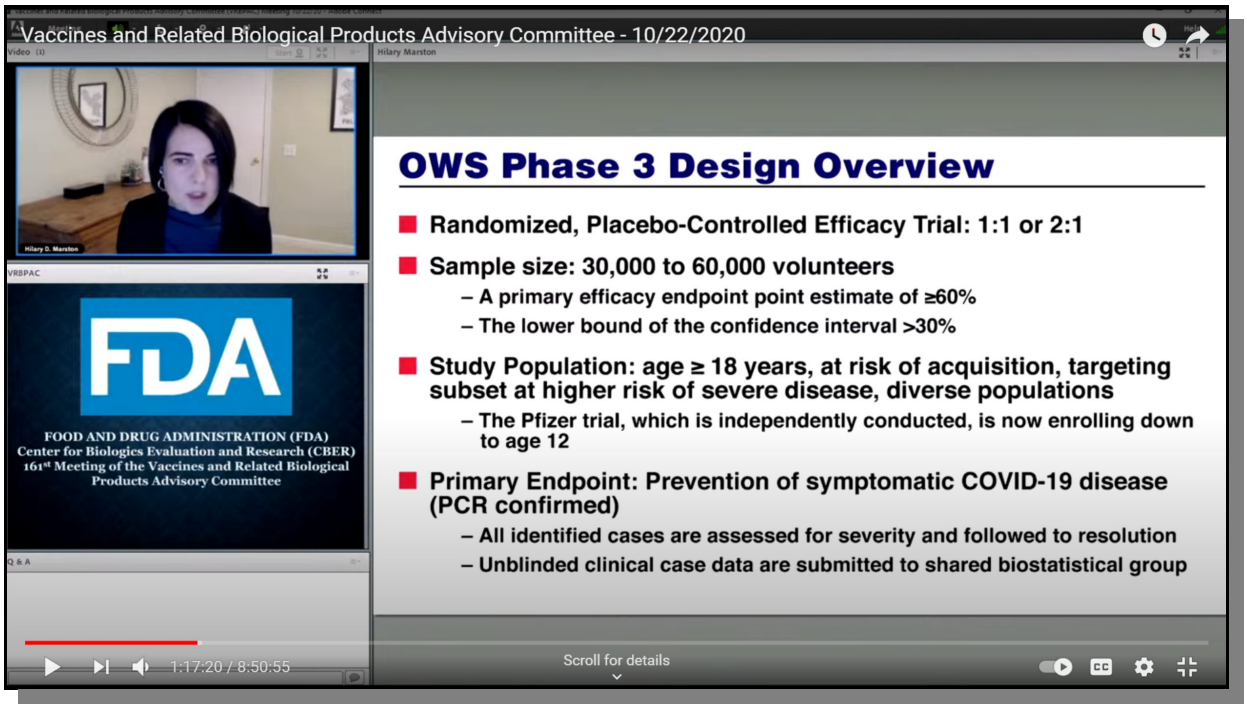
494. In a complaint filed in a federal lawsuit, the plaintiffs made the following common-sense observation:

> [T]he logic for the COVD-19 vaccines breaks down when one considers the Defendants' theory of asymptomatic spread. For over a year now, these Defendants and state-level public health authorities have told the American public that SARS-CoV-2 can be spread by people who have none of the symptoms of COVID-19. If that is the case, then a vaccine that merely reduces symptoms yields no benefits - the virus spreads anyway. If that is not the case, and asymptomatic spread is not real, then asymptomatic individuals do not need to be vaccinated with a vaccine that neither prevents infection with SARS-CoV-2 nor prevents its transmission.

495. What is the point of forcing all federal workers to get the COVID-19 vaccine when they have now been proven to be ineffective? There is no reason to get the vaccine if prevention of infections and spread is the objective. Why make those who are not getting the vaccine wear masks, get tested, social distance, and not travel if they don't get the vaccine when they are no more likely to spread the alleged COVID-19 virus than those who are fully vaccinated?

ANOTHER BAIT AND SWITCH

496. Please be mindful that the COVID-19 vaccines were authorized because they purportedly prevented infection and the spread of the disease. Dr. Hilary Marston of the National Institute of Allergy and Infectious Disease at the NIH, gave a presentation during an October 22, 2020 meeting of the Vaccines and Related Biological Products Advisory Committee.[522] That meeting was before the issuance of the EUAs for the COVID-19 vaccines. During her presentation, she explained that the primary endpoint for all COVID-19 vaccine studies was to prevent COVID-19. Below is one of her slides where it states: **"Primary Endpoint: Prevention of symptomatic COVID-19 disease (PCR confirmed)."**[523]



497. Indeed, the pertinent criteria announced by the FDA for the EUA granted to the Pfizer-BioNTech COVID-19 vaccine said nothing about lessening symptoms. The criteria for the EUA was simply that the vaccine may be effective in "preventing" COVID-19.

Based on the totality of scientific evidence available to FDA, it is reasonable to

> believe that Pfizer-BioNTech COVID-19 Vaccine may be effective in **preventing COVID-19**, and that, when used under the conditions described in this authorization, the known and potential benefits of Pfizer-BioNTech COVID-19 Vaccine when used to **prevent COVID-19** outweigh its known and potential risks.[524]

498. And when on August 23, 2021, the FDA approved the substantially similar COMIRNATY (COVID-19 Vaccine, mRNA), it said nothing about lessening symptoms. The FDA only mentioned the alleged effectiveness of the approved vaccine to prevent COVID-19. The FDA stated that that "[t]he [approved] vaccine has been known as the Pfizer-BioNTech COVID-19 Vaccine, and will now be marketed as Comirnaty (koe-mir'-na-tee), for the **prevention of COVID-19** disease in individuals 16 years of age and older."[525]

499. When it became clear, though, that the vaccines were ineffective in preventing COVID-19, the standard for effectiveness had to be changed to something else. The standard for effectiveness is now no longer prevention of COVID-19 infection or preventing the spread of COVID-19. The standard has shifted to lessening the symptoms of COVID-19. It seems that the vaccine manufacturers and the CDC knew from the beginning that the COVID-19 vaccines would be ineffetive in preventing the spread of the disease. Indeed, as early as October 26, 2020, prior to the EUA issuance, Anthony Fauci, Director of the National Institute of Allergy and Infectious Diseases (NIAID), stated that preventing infection with COVID-19 was only a secondary endpoint. The primary purpose of the vaccine was not to prevent infection or spread but rather only to lessen symptoms.[526]

500. Dr. Fauci claims that preventing COVID-19 is only a secondary endpoint of the vaccines. He made that statement just four (4) days after his subordinate, Dr. Hilary Marston, gave a presentation during an October 22, 2020 meeting of the Vaccines and Related Biological Products Advisory Committee, where she explained that the **primary endpoint** of the COVID-19 vaccine trials was the **prevention** of COVID-19.[527]

501. Please recall that before the FDA issuance of the EUA for the Moderna vaccine, Moderna Chief Medical Officer Tal Zaks stated on or before November 23, 2020: "our results show that this vaccine can prevent you from being sick, it can prevent you from being severely sick. **They do not show that it prevents you from potentially carrying this virus transiently and infecting others.**"[528] Yet, the basis on which the EUA was granted to Moderna was that it was allegedly effective in preventing infection. There was no basis for authorizing the EUA based on the vaccines ability to only lessening the symptoms of COVID-19, while not preventing infection. Moderna limited the measure of efficacy for their COVID-19 vaccine, in pertinent part, as follows: "**The primary efficacy endpoint was efficacy of the vaccine to prevent protocol-defined COVID-19 occurring** at least 14 days after the second dose in participants with negative SARS-CoV-2 status at baseline."[529] The EUA was based on the representation by Moderna that their study proved that the vaccine would prevent infection. But the Moderna's Chief Medical Officer Tal Zaks knew from the beginning that the vaccine was ineffective in preventing infection, and he said so.

502. The efficacy studies done for the EUA only measured the prevention of COVID-19. There was no publication of any studies that were the basis for EUA that measured lowering symptoms. For example, When you read page 35 of the Pfizer-BioNtech publication titled *Fact Sheet for Healthcare Providers Administering Vaccine*, it reveals that the only criterion reported for establishing the effectiveness of the COVID-19 vaccine is the subsequent infection rate in the study groups.[530] The study compared the COVID-19 infection rate among the vaccine group and the placebo group to come up with an effectiveness of 95% for the COVID-19 vaccine. The study announced that the "Vaccine Efficacy" was based upon a finding of the "First COVID-19 Occurrence From 7 Days After Dose 2."[531]

503. That fact sheet indicates that "FDA issued this EUA, based on Pfizer-BioNTech's request and submitted data. Although limited scientific information is available, based on the totality of the scientific evidence available to date, it is reasonable to believe that the Pfizer-BioNTech COVID-19 Vaccine **may be effective for the prevention of COVID-19** in individuals as specified in the Full EUA Prescribing Information."[532]

504. Pfizer-BiNTech and the FDA now claim that the COVID-19 vaccines do not prevent COVID-19 but only lessen the symptoms of the disease. But lowering symptoms was not a criterion of the study. The study and approval under the EUA were based on the vaccine's purported ability to prevent COVID-19.

505. This bait and switch strategy was brought to light publically when on January 30, 2021, Andrew Court reported for The Daily Mail that "Democrat Rep. Stephen Lynch has tested positive to COVID-19 after receiving both shots of the Pfizer vaccine."[533] In a that news article it was explained that the reason that Rep. Lynch was infected with COVID-19 after being vaccinated is that "Pfizer's vaccine does not necessarily prevent COVID-19 infection, but is said to be 95 percent effective in stopping the serious symptoms that are caused by the coronavirus."[534]

506. Pfizer-BioNtech announced that their COVID-19 vaccine was 95% effective in "preventing" COVID-19. They did NOT announce that it was 95% effective in reducing symptoms of COVID-19. The FDA allowed the EUA of the Pfizer COVID-19 vaccine because the COVID-19 vaccine study claimed a 95% effectiveness in "preventing" the recipient from getting COVID-19 after they had been vaccinated.[535] Indeed, the FDA states the reason for the EUA of the Pfizer-BioNtech COVID-19 vaccine was that it is theorized to be effective in "preventing" the COVID-19 infection. The FDA explicitly states:

> Pfizer-BioNTech COVID-19 Vaccine is authorized to **prevent** coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in individuals 16 years of age and older.[536]

507. The argument that the COVID-19 vaccines lessen symptoms is a smokescreen. The report from Britain's Chief Scientific Adviser, Patrick Vallance, proves it. He stated that 40% of all COVID-19 patients being admitted to hospitals with COVID-19 are fully vaccinated.[537] That fact

alone proves that the COVID-19 vaccines do not lessen symptoms. Persons are admitted to the hospital when they have severe symptoms. The fact 40% of those being hospitalized for COVID-19 are fully vaccinated indicates that the patients are suffering severe symptoms and thus the vaccines do not lessen the symptoms. You cannot have droves of vaccinated people jamming into hospitals after coming down with COVID-19 and maintain that the vaccines lessen symptoms.

508. Indeed, the FDA explicitly states that it does not know if the Pfizer-BiNTech COVID-19 vaccine reduces symptoms. The FDA has stated that the Pfizer-BioNtech COVID-19 vaccine has been authorized under the EUA hoping that it will **"prevent"** COVID-19 and NOT in the hope it will reduce the severity of COVID-19.

> To date, only a small number of severe cases have occurred during the study, which makes it **difficult to evaluate whether the vaccine reduces the severity of COVID-19.** Pfizer-BioNTech COVID-19 vaccine is **authorized to prevent coronavirus disease** 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in individuals 16 years of age and older.[538]

509. The CDC has expressed hope that the COVID-19 vaccines will prevent infection, but the evidence is that the vaccines do no such thing. The CDC claims that a person who is vaccinated is unlikely to be infected with COVID-19, but then they give the following guidance, which suggests that they know that the likelihood of a vaccinated person getting COVID-19 is significant:

> Fully vaccinated people who have come into close contact with someone with COVID-19 should be tested 3-5 days following the date of their exposure and wear a mask in public indoor settings for 14 days or until they receive a negative test result. They should isolate if they test positive.[539]

510. That advice indicates that the CDC has no confidence in the efficacy of the COVID-19 vaccines in preventing the disease.

511. CDC Director, Dr. Rachelle Walensky has even less faith in the COVID-19 vaccines. She revealed that not only do the vaccines not lessen the symptoms, but NPR reports that "Walensky noted that data from Israel suggests 'increased risk of severe disease amongst those vaccinated early.'"[540]

512. Writing for Roll Call, Emily Kopp reported that data presented at a confidential congressional briefing showed that "[u]p to 15 percent of deaths in May were among vaccinated people."[541]

513. A government report from Public Health England reveals that persons who have been vaccinated are six (6) times more likely to die from the delta variant of the SARS-COV-2 (a.k.a. COVID-19) than those who are unvaccinated.[542] The report shows that 26 out of 4,087 fully vaccinated persons died from the variant. Whereas 34 out of 35,521 unvaccinated persons died from the variant.[543] That is a 665% greater death rate among the vaccinated group. So much for lessening

symptoms.

514. If it has now been shown that the vaccine is truly ineffective in "preventing" a vaccine recipient from getting COVID-19, it should be announced as ineffective. The vaccine should be taken off the market. Apparently, that will not happen. Instead, there is now being announced a new criterion for effectiveness that was never studied. And that new criteria is lessening of symptoms. This bait and switch strategy for vaccines has been around since the 1800's. Dr. Suzanne Humphries reveals that "[w]hen it was clear that the smallpox vaccine was not able to prevent disease, the medical profession tried to justify vaccination by changing the goalposts from lifelong 'perfect' immunity to "milder disease.'"[544] Dr. Humphries revealed that bait and switch from immunity to milder symptoms was used to justify getting ineffective pertussis and influenza vaccines in 2013.

515. So if the vaccines do not prevent the COVID-19 infection, it makes no sense to require unvaccinated federal employees working under religious exemptions to wear masks, get tested, and social distance, while the vaccinated persons are free from those restrictions. Masking, testing, and social distancing are purportedly being done to prevent the spread of COVID-19. The vaccine has been proven ineffective in stopping infection and spread of COVID-19, but the vaccinated persons do not have to wear masks, be tested, and social distance.

IRREGULARITIES IN THE VACCINE EFFICACY STUDIES

516. The 94.1 % efficacy results for the Moderna COVID-19 mRNA vaccine reported by the FDA is misleading because they are not telling you that is a relative risk reduction and not an absolute (total) risk reduction.[545]

517. In the Moderna study, the subsequent COVID-19 infection rate for the vaccinated group was .079%. The COVID-19 infection rate for the placebo group was 1.33%. That means that the rate of those who were infected by COVID-19 after receiving the vaccine was reduced by 1.22% as compared to those who were infected by COVID-19 after receiving a placebo (1.33% – .079% = 1.25%). Thus, the vaccine has an absolute efficacy of 1.25%. One can expect that there will be a reduction of 1.25% in COVID-19 infections in the population after being vaccinated. Out of a group of 10,000 people who are vaccinated with the Moderna mRNA COVID-19 vaccine, there will be approximately125 fewer illnesses from COVID-19.

518. But that is not how Moderna reported the results. Instead of a 1.25% efficacy rate, which is the absolute (total) efficacy rate, the FDA review indicates that Moderna reported a 94.1% efficacy rate, which is a relative efficacy rate.[546] The relative efficacy rate is misleading because it gives the false impression that out of 10,000 people, 9,410 people would be protected from getting COVID-19. How did Moderna come up with the 94.1% figure? They divided the rate of subsequent COVID-19 infection in the vaccinated group (.079%) by the rate of subsequent COVID-19 infection in the placebo group (1.33%) and then subtracted that difference (.059) from one (1) to arrive at (.941) to arrive at 94.1%. After rounding, the FDA reported the interim effectiveness for the Moderna mRNA COVID-19 vaccine of 94.1%. But that is not the absolute (total) efficacy, which is what people want

to know. That 94.1% figure is a relative risk reduction, which is different from a absolute (total) risk reduction.

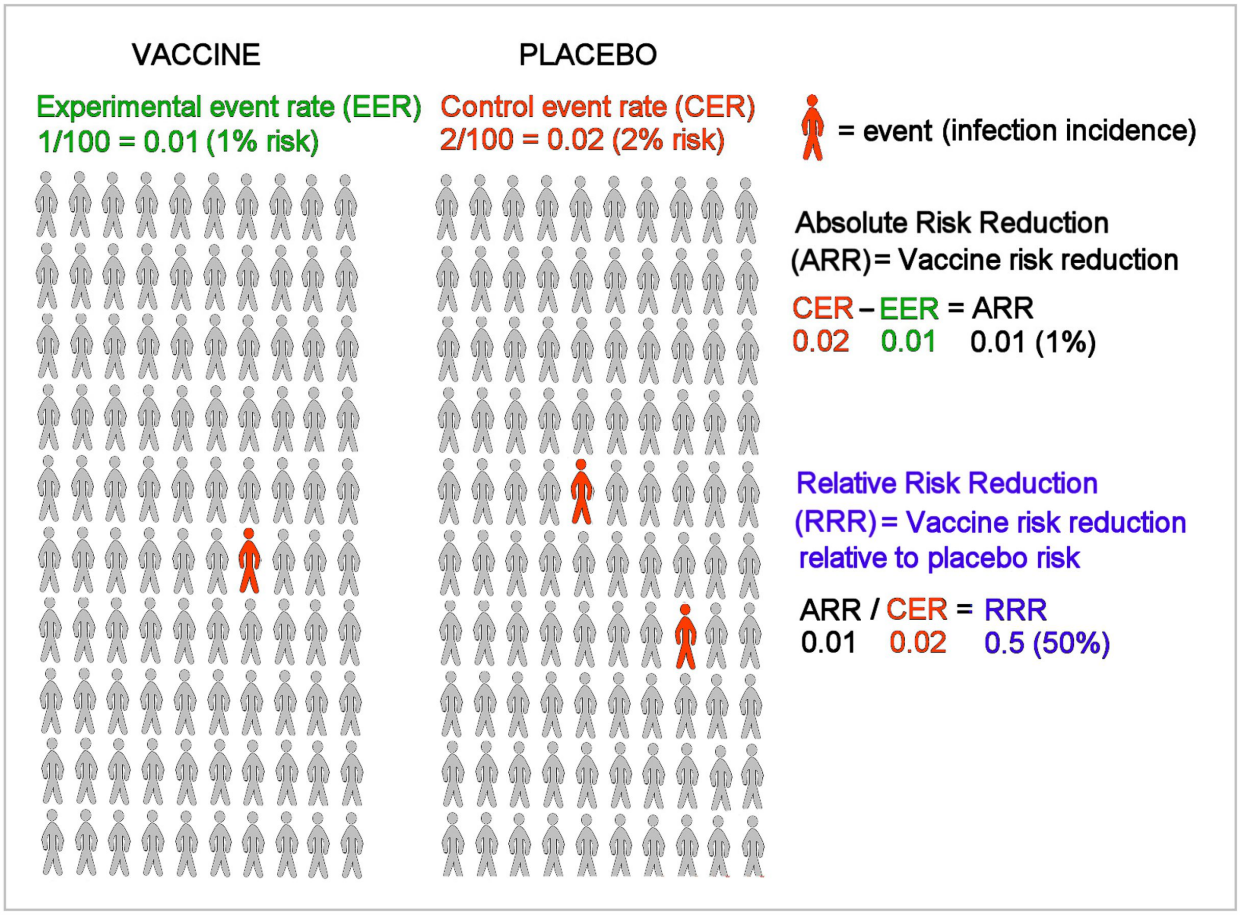
519. The false impression given by that figure is that the vaccine will effectively protect 9,410 out of 10,000 people from COVID-19. In reality, 9,867 are at no risk of getting COVID-19 (10,000 – 133 = 9,867). That means that out of every 10,000 people vaccinated with the COVID-19 vaccine, it will only prevent 125 people from becoming ill from COVID-19 (133 - 8 = 125). According to the study, a total of only 133 people out of every 10,000 are at risk to get COVID-19, and the vaccine will protect 125 of those 133 people. When the relative efficacy rate of 94.1% is reported, most people do not understand that it ignores the 9,867 people out of 10,000 who are at no risk of getting COVID-19 and do not need to be vaccinated. Thus, the true efficacy rate is the absolute efficacy rate. The absolute efficacy rate takes into account the entire population of people. The absolute (total) efficacy rate for the vaccine is only 1.25 % (125 people out of 10,000). That is the efficacy rate the public should have been informed about, and not 94.1 %, which gives the false impression that the vaccine will protect 9,410 people out of 10,000.

520. Dr. Ron Brown of the University of Waterloo explains that Moderna's and Pfizer-BioNTech's reporting of their vaccine's relative efficacy rate (a.k.a. risk reduction) is misleading to the public.[547] Researchers often use relative risk reduction, but it should not be announced to the public as the vaccine's efficacy because it always gives an elevated sense of the vaccine's efficacy.[548] The public was thus given an artificially inflated impression of effectiveness of the COVID-19 vaccinesis.[549] Dr. Brown stated that absolute risk reduction should be given to clinicians and the public. Indeed, in a draft advisory, the FDA stated that relative risk reduction should never be given to the public without also mentioning the absolute risk reduction.[550] The FDA explained, "that research suggests that consumers do not understand relative frequencies." The FDA explained that "[c]onsumers may also find the efficacy or risk probability described as a relative frequency harder to comprehend and more favorable as compared to the absolute frequency."[551] The concern of the FDA is that the consumer will view the benefit from a vaccine much greater than it is in reality if they are only informed of the relative efficacy rates. The FDA recommended that the public always be given the absolute efficacy rate.

521. Dr. Brown states that "selective reporting of vaccine efficacy measures can cause a type of outcome reporting bias that misrepresents health information disseminated to the public."[552] Dr. Brown presents an example in an article he prepared to show how misleading relative risk reduction can be. Dr. Brown explains how a risk reduction of only 1% can be sold to the public as a risk reduction of 50%:

> Figure 1 shows an example of a vaccine clinical trial for an infectious disease. The vaccine and placebo groups in Figure 1 each have 100 randomly assigned individuals with no history of infection, and an event is defined as the incidence of infection among all individuals during the course of the trial. The percentage of events in the vaccine group is the experimental event rate (EER) or the risk of infection in the vaccine group (1/100 = 1%), and the percentage of events in the placebo group is the

control event rate (CER) or the risk of infection in the placebo group (2/100 = 2%). Absolute risk reduction (ARR) is the disease risk difference between the placebo and vaccine groups, i.e., the CER minus the EER (2% - 1% = 1%). The ARR is also known as the vaccine disease preventable incidence (VDPI). Relative risk reduction (RRR) or vaccine efficacy (VE) is the reduced risk from vaccination, the ARR or VDPI, relative to or divided by the risk in unvaccinated individuals, the CER (1%/2% = 50%)



522. The same issue explained above with the Moderna report, Dr. Brown found in the Pfizer-BiNTech study. He explains how the absolute risk reduction of the Pfizer-BiNTech COVID-19 vaccine of 0.7% tells a very different story from the much-publicized relative risk reductions of 95.1% for that vaccine. While the relative efficacy rate was widely publicized, the absolute efficacy rate was not shared with the public.

523. The COVID-19 vaccines are unsafe and ineffective. As we have seen, the manufacturers and some insiders in the federal regulatory agencies knew before the EUA was issued that the vaccines would not prevent COVID-19 infections. If that is the case, why did the FDA give them EUA status?

The vaccines were given EUA status based on the clinical studies performed by the vaccine manufacturers. An objective review of the data in the studies and the protocols reveals that they were rigged to falsely show that the vaccines were effective.

524. Dr. David Martin reveals that Moderna concealed the evidence that their vaccine was ineffective by waiting 14 days to perform a confirmatory RT-PCR test on the test subjects.[553] The reported that the Moderna study shows that within 7 days of both the first and the second vaccinations, the group receiving the Moderna COVID-19 vaccines displayed greater systemic symptoms of COVID-19 than the control group.[554] But Moderna ignored those systemic COVID-19 symptoms by reporting them not as symptoms of COVID-19 caused by the vaccine but systemic adverse reactions to the vaccine.

525. Moderna avoided reporting the COVID-19 systemic symptoms caused to the vaccine recipients within 7 days of receiving the first and the second vaccinations as being "confirmed COVID-19 cases" by not testing the vaccine recipients with the RT-PCR test during that time. By not performing the RT-PCR test, Moderna was able to report the COVID-19 symptoms during that 7 day period under a category of "systemic adverse reactions" to the vaccine instead of "systemic symptoms" of COVID-19 caused by the vaccine that were confirmed COVID-19 cases. Moderna did not do any confirmatory RT-PCR tests on the test subjects until 14 days following the second vaccination. Thus, by waiting until 14 days after the second vaccination to conduct the confirmatory RT-PCR tests, Moderna was able to report that their vaccine was 94.1% (interim results were 94.5%) effective in preventing COVID-19.

526. The FDA reported that Moderna limited the measure of efficacy for their COVID-19 vaccine as follows: "The primary efficacy endpoint was efficacy of the vaccine to prevent protocol-defined COVID-19 occurring at least 14 days after the second dose in participants with negative SARS-CoV-2 status at baseline."[555]

527. What is a confirmed COVID-19 case? Moderna defined it thusly in its study submitted to the FDA:

> For the primary efficacy endpoint, the case definition for a confirmed COVID-19 case was defined as:
> • At least TWO of the following systemic symptoms: Fever (=38ºC), chills, myalgia, headache, sore throat, new olfactory and taste disorder(s), or
> • At least ONE of the following respiratory signs/ symptoms: cough, shortness of breath or difficulty breathing, OR clinical or radiographical evidence of pneumonia; and
> • NP swab, nasal swab, or saliva sample (or respiratory sample, if hospitalized) positive for SARS-CoV-2 by RT-PCR.[556]

528. Notice in the chart below the systemic symptoms for COVID-19 **(fever, chills, myalgia, and headache**) were significantly greater within 7 days of the second vaccination. But Moderna did not

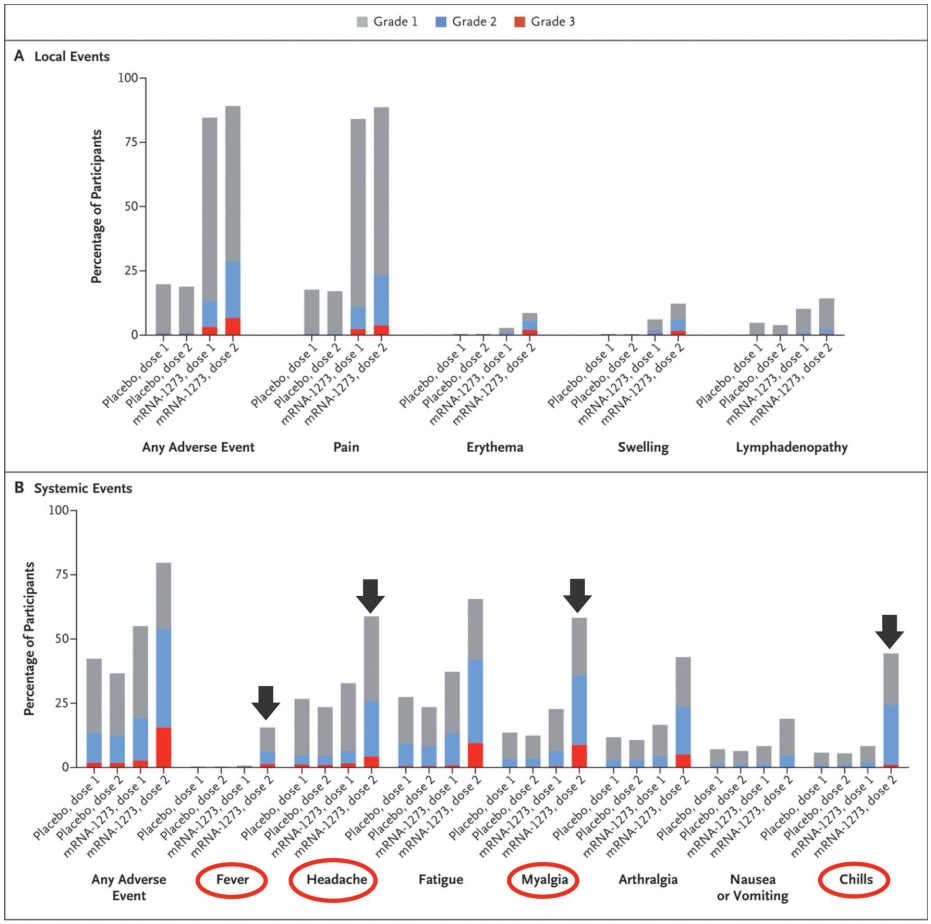
perform any confirmatory RT-PCR test during that period. Consequently, those systemic symptoms of COVID-19 were reported not as systemic symptoms of COVID-19 caused by the vaccine that were confirmed COVID-19 cases but as "systemic adverse reactions" to the vaccine.

529. Moderna reported that an astounding **81.9%** of the vaccinated group aged 18-64 years old suffered systemic adverse events after the second vaccination. That is more than double the systemic adverse events occurring in the placebo group. Even more telling is that **17.4%** of the vaccinated group aged 18-64 years old suffered grade 3 systemic adverse events after the second vaccination. A grade 3 adverse event is defined as a severe adverse event. That is more than eight (8) times the grade 3 severe systemic adverse events in the placebo group. Furthermore, 10 people in the vaccine group suffered a grade 4 systemic adverse event. A grade 4 adverse event is a life-threatening adverse event. That is more than five (5) times the rate of the placebo group's grade 4 systemic adverse events.

Table 23. Frequency of Solicited Systemic Adverse Reactions Within 7 Days Following Either the First or Second Dose of Vaccine, Participants Age 18-64 years, Solicited Safety Set*[a]

Adverse Reaction	Vaccine Group Dose 1 n/N (%)	Placebo Group Dose 1 n/N (%)	Vaccine Group Dose 2 n/N (%)	Placebo Group Dose 2 n/N (%)
Any Systemic	6503/11405 (57.0)	5063/11406 (44.4)	8484/10358 (81.9)	3967/10320 (38.4)
Grade 3	363/11405 (3.2)	248/11406 (2.2)	1801/10358 (17.4)	215/10320 (2.1)
Grade 4	5/11405 (<0.1)	4/11406 (<0.1)	10/10358 (<0.1)	2/10320 (<0.1)

530. The chart below is from the Moderna COVE Study Group and published in the New England Journal of Medicine.[557] I annotated it to indicate certain percentages and circle the "systemic symptoms" of COVID-19 as defined by Moderna but reported by Moderna as "systemic adverse events."



Shown is the percentage of participants who had a solicited local or systemic adverse event **within 7 days** after injection 1 or injection 2 of either the placebo or the mRNA-1273 vaccine. The above chart was provided by the Moderna COVE Study Group and published in the New England Journal of Medicine. It was annotated by Edward Hendrie with arrows to indicate the percentages for participants suffering adverse events from the second COVID-19 vaccine dose for systemic symptoms and red circles indicating the systemic symptoms of COVID-19 as defined by Moderna.

For the primary efficacy endpoint of preventing COVID-19, Moderna defined, in pertinent part, the case definition for a **confirmed COVID-19 case** in their report presented to the FDA to obtain Emergency Use Authorization (EUA) as:
• At least TWO of the following systemic symptoms: **Fever** (=38ºC), **chills**, **myalgia**, **headache**, sore throat, new olfactory and taste disorder(s), and
• Positive test for SARS-CoV-2 by RT-PCR.

Notice that within **7 days** a significantly greater percentage of the COVID-19 vaccine recipients displayed COVID-19 **"systemic symptoms"** (circled in red) than the placebo group. But they were not reported as COVID-19 infections because no RT-PCR test was done to confirm them as COVID-19 cases. By not performing the RT-PCR test the symptoms could be reported under a category of **"systemic adverse reactions"** to the vaccine instead of **"systemic symptoms"** of COVID-19 caused by the vaccine that were confirmed COVID-19 cases. Moderna did not do any RT-PCR tests until **14 days** following the second vaccination. Thus, by waiting until **14 days** after the second vaccination to conduct the RT-PCR tests, Moderna was able to report that their vaccine was 94.1% effective in preventing COVID-19.

531. Peter Doshi, Ph.D., is Associate Professor of Pharmaceutical Health Services Research at the University of Maryland School of Pharmacy. He is also a senior editor at the British Medical Journal (aka, BMJ).

532. Dr. Doshi wrote an opinion in the BMJ wherein he criticized the Pfizer COVID-19 safety and efficacy trials. He noted several irregularities in the study. Dr. Doshi explains:

> All attention has focused on the dramatic efficacy results: Pfizer reported 170 PCR confirmed covid-19 cases, split 8 to 162 between vaccine and placebo groups. But these numbers were dwarfed by a category of disease called "suspected covid-19"—those with symptomatic covid-19 that were not PCR confirmed. According to FDA's report on Pfizer's vaccine, there were **"3410 total cases of suspected, but unconfirmed covid-19 in the overall study population, 1594 occurred in the vaccine group vs. 1816 in the placebo group."**
>
> With 20 times more suspected than confirmed cases, this category of disease cannot be ignored simply because there was no positive PCR test result. Indeed this makes it all the more urgent to understand. A rough estimate of vaccine efficacy against developing covid-19 symptoms, with or without a positive PCR test result, would be a **relative risk reduction of 19%** (see footnote)—far below the 50% effectiveness threshold for authorization set by regulators.[558]

533. You read that correctly; there were 3,410 cases of suspected COVID-19 with no indication in the report whether or not they were tested. The report only indicated that the participants were not confirmed to be COVID-19 via a PCR test. It gets worse. That information was not revealed in the 92-page report filed by Pfizer-BioNTech. Dr. Doshi reveals:

> There is a clear need for data to answer these questions, but Pfizer's 92-page report didn't mention the 3410 "suspected covid-19" cases. Nor did its publication in the New England Journal of Medicine. Nor did any of the reports on Moderna's vaccine. The only source that appears to have reported it is FDA's review of Pfizer's vaccine.[559]

534. One can reasonably infer that the reason Pfizer did not reveal the 3,410 cases of suspected COVID-19 is that the revelation of that data would undermine the safety and efficacy of the COVID-19 vaccine under study.

535. Dr. Doshi was also troubled by the unusually unbalanced and unexplained numbers of people excluded from the efficacy analysis. There were five (5) times more people lost in the vaccine group due to protocol deviations than the control group. 311 were excluded from the vaccine group vs. 60 on placebo. Dr. Doshi was perplexed:

> What were these protocol deviations in Pfizer's study, and why were there five times

> more participants excluded in the vaccine group? The FDA report doesn't say, and these exclusions are difficult to even spot in Pfizer's report and journal publication.[560]

536. Not mentioned by Dr. Doshi was that in the Pfizer trial, as in the Moderna trial, those that had suspected COVID-19 within seven (7) days of vaccination were not publically reported by Pfizer. The FDA auditors found that data. The FDA explained that "[s]uspected COVID-19 cases that occurred within seven (7) days after any vaccination were 409 in the vaccine group vs. 287 in the placebo group."[561] You read that correctly; there were more suspected COVID-19 cases within seven (7) days in the vaccinated group than in the placebo group. They manifested clinical symptoms of COVID-19. They got ill from the vaccine. Those persons were likely not given confirmatory COVID-19 PCR tests and thus were left in the suspected category, just as was done in the Moderna trial. That way, Pfizer could be sure not to contradict their desired outcome of preventing COVID-19. But the suspected COVID-19 cases within seven (7) days were not reported by Pfizer in their published reports. The government auditors were left to guess that "[i]t is possible that the imbalance in suspected COVID-19 cases occurring in the seven (7) days postvaccination represents vaccine reactogenicity with symptoms that overlap with those of COVID-19."[562] But that is just a guess by the auditors, as Pfizer, apparently, provided no explanation.

537. There is a reason that Moderna and Pfizer did not PCR test those who showed symptoms of COVID-19 within seven (7) days of vaccination. They knew the results would likely be positive. Indeed, that is what we see in the real world. For example, 35 nuns received COVID-19, and within two days, 28 nuns fell ill and tested positive for COVID-19, with two of the nuns dying during those two days.[563] A third nun also died days later. That is clear evidence of ADE within days of being vaccinated. It is the very evidence that both Moderna and Pfizer sought to conceal in their studies.

538. Dr. Doshi was further troubled by the fact that the adjudication committee for the Pfizer adjudication committee consisted of three Pfizer employees. The study could hardly be unbiased when it is being run by Pfizer employees being paid by the company that is banking on a favorable outcome. Pfizer published its study results on November 30, 2020, but four months earlier, on or before July 22, 2020, the U.S. government had already placed a $1.95 billion order for the Pfizer COVID-19 vaccine.[564] At that time Pfizer had just begun to enter its late-stage, 30,000-person study. The study had not begun and no data had even been generated. But recall, Pfizer ran the study and was able to rig it to say what they wanted it to say. The skids were greased. There were 1.95 billion reasons for making sure the Pfizer COVID-19 vaccine study showed safety and efficacy. "The love of money is the root of all evil." 1 Timothy 6:10.

539. Amazingly, the financial deals were being struck when the U.S. government did not know what it was buying. Indeed, the dosage has not even been determined because the late-stage trials have not been conducted. On July 22, 2020, Jared S. Hopkins and Chris Wack, writing for the Wall Street Journal, reported, "Pfizer and BioNTech said they expect to seek emergency use authorization or some form of regulatory approval as early as October."[565] To do that meant that the favorable results from the testing must have been baked into the study. Hopkins and Wack noted that "[v]accines typically take years to develop and prove they work safely, and many fail during the

process."[566] But in July of 2020, Pfizer confidently expected "approval as early as October." So was the FDA, as the Federal Government had already agreed to pay billions of dollars to buy the untested vaccine.

540. How were the vaccine manufacturers cutting the time for development so drastically? Simple, they were ramping up the manufacturing of their vaccines as they were testing them. I kid you not. Hopkins and Wack revealed that in July 2020, "Covid-19 vaccine developers are also combining phases of studies and studying their vaccines at the same time they are ramping up manufacturing capabilities, industry and health officials say."[567] That means that the pharmaceutical companies already manufactured the same vaccine that they had not yet finished testing for safety and efficacy. Pfizer Chief Business Officer John Young admitted this. Young stated: "This is unprecedented, and that is the only way you can really move at this kind of speed—is to do so many stages over your development and manufacturing process in parallel, rather than doing them sequentially."[568] Pfizer is not financially stupid. This was not a gamble; this was a sure thing. The fix was in, and Pfizer knew it. With the COVID-19 vaccines, the drug companies were expecting favorable results from their trials. And, as we now know, they got them. Of course, they did. They preordained the favorable results. The pharmaceutical companies are experts in those kinds of shenanigans.

541. Indeed, it has been now confirmed that the COVID-19 vaccines from both Moderna and Pfizer-BioNtech do not prevent COVID-19. The vaccines were authorized to be used on an emergency basis to prevent COVID-19, but they have been shown not to do that. So, the pharmaceutical companies just changed the rules for what it means to be effective. Now the standard is no longer whether the vaccine prevents COVID-19 but, instead, whether it lessens the symptoms of COVID-19. When Democrat Rep. Stephen Lynch tested positive to COVID-19 after receiving both shots of the Pfizer vaccine, the Daily Mail explained that "Pfizer's vaccine does not necessarily prevent COVID-19 infection, but is said to be 95 percent effective in stopping the serious symptoms that are caused by the coronavirus."[569]

542. Moderna knew from the outset that their vaccine would not prevent COVID-19. A careful reading of Moderna's study indicates that its vaccine likely causes COVID-19. Indeed, there have been many reported cases since the use of both the Moderna and Pfizer-BioNtech vaccines were authorized under the FDA's EUA where the recipient of a COVID-19 vaccination became subsequently ill from COVID-19 and the COVID-19 illness was determined to have been caused by the COVID-19 vaccination.

543. The insiders seemed to have known from the outset that the COVID-19 vaccines would not prevent COVID-19 and very likely cause COVID-19. Before either vaccine was authorized, Anthony Fauci explained that reducing symptoms of COVID-19 was the "primary endpoint" of the vaccines. Fauci said that getting rid of the virus through immunity was only a "secondary endpoint." On October 28, 2020, Carol Crist, writing for WebMD, summarized Dr. Fauci's argument as meaning that "with reduced severe symptoms, the coronavirus would pose a lower threat as a pandemic. Then scientists could focus on developing a solution that would reach the full goal of preventing initial infection."[570]

544. On October 29, 2020, Dr. Fauci explained: "If the vaccine also allows you to prevent initial infection that would be great," Fauci said. "But what I would settle for, and all my colleagues would settle for, is the primary endpoint, which is to prevent clinically recognizable disease. That's what we hope happens."[571]

545. Dr. Fauci said that reducing symptoms of COVID-19 was the "primary endpoint" of the COVID-19 vaccines and not the prevention of COVID-19. But Fauci's statement is contradicted by the FDA. The FDA reported that the primary efficacy endpoint when reviewing the data in deciding whether to grant Moderna's petition to obtain an Emergency Use Authorization (EUA) for their COVID-19 vaccine was its ability to prevent COVID-19. The FDA review states that **"[t]he primary efficacy endpoint was efficacy of the vaccine to prevent protocol-defined COVID-19."**[572]

546. Moderna and Pfizer-BioNtech got their COVID-19 vaccines authorized by the FDA under EUAs based on their alleged effectiveness in preventing COVID-19. They then promoted the vaccines to the public on that basis. When the vaccines are increasingly proving ineffective in preventing COVID-19, they just change the standard for success to lessening symptoms. They knew full well that the FDA could not approve an EUA for lessening symptoms and nobody would take a vaccine that would not prevent the targeted disease. So they used the classic bait and switch strategy with a willing partner in the FDA.

ANTIBODY DEPENDENT ENHANCEMENT

547. Likely, the deaths and hospitalizations suffered by those vaccinated for COVID-19 are not because the vaccines have failed to protect those who were vaccinated, but rather because the vaccines are causing the deaths and hospitalizations.

548. Taiwan health authorities report that the number of people dying in Taiwan after their COVID-19 vaccination exceeds the number of deaths from the virus itself. The health authorities reported that as of October 11, 2021, deaths after COVID-19 vaccination reached 865. In comparison, the deaths from the virus are 845.[573] The COVID-19 vaccines used in Taiwan include Moderna, Pfizer-BioNTech, AstraZeneca, and a Taiwanese vaccine, Medigen.

549. Most of the serious adverse event outcomes from the COVID-19 known to the FDA and the vaccine manufacturers are not listed in the COVID-19 fact sheets from Pfizer-BioNTech or Moderna.[574] For example, deaths and antibody-dependent enhancement (ADE) were possible "adverse event outcomes" being monitored by the FDA during the COIVD-19 vaccine trials. They knew what to look for because they knew what they were seeing. None of the vaccine makers listed death or ADE in their fact sheets for recipients and caregivers as a risk from its COVID-19 vaccines.[575] Figure 9, *supra*, is a screenshot of a slide from a presentation by Steve Anderson, Director of Biostatistics and Epidemiology for the FDA, at the October 22, 2020 Vaccines and Related Biological Products Advisory Committee meeting. The slide lists ADE, which Dr. Anderson labeled "vaccine enhanced disease," as one of the possible adverse event outcomes being monitored

by the FDA during the COVID-19 vaccine trials. The FDA was keyed in and knew from the animal trails for SARS-CoV that ADE was something for which to be on the lookout. And that is why ADE was listed among the possible adverse event outcomes to monitor during the COIVDI-19 vaccine trials. There is no doubt they found ADE during the trials because we are seeing ADE from the COVID-19 vaccines being administered throughout the country.

550. Renowned virologist and Nobel Prize Laureate Prof. Luc Montagnier explained that the so-called breakthrough COVID-19 infections being suffered by the fully vaccinated persons are infections caused by the COVID-19 vaccines.[576] Dr. Montagnier said that the high rate of COVID-19 infections among the fully vaccinated population is due to "Antibody-Dependent Enhancement" (ADE).

551. The Children's Hospital of Philadelphia (CHOP) offers a concise explanation of ADE:

> Many vaccines work by inducing neutralizing antibodies. However, not all antibody responses are created equal. Sometimes antibodies do not prevent cell entry and, on rare occasions, they may actually increase the ability of a virus to enter cells and cause a worsening of disease through a mechanism called antibody-dependent enhancement (ADE).[577]

552. One would think that all antibodies are good, and thus, you would want to enhance the antibodies. But that is not the case because there are two kinds of antibodies. There are neutralizing antibodies and binding antibodies. Neutralizing antibodies, as the name suggests, neutralize the virus. Binding antibodies do not neutralize the virus; they bind to it and enhance the virus's ability to infect cells. This increases disease. The COVID-19 vaccines cause the production of higher levels of binding antibodies. That causes the disease to spread. This effect was seen when the ADE killed coronavirus (SARS-CoV) vaccine test animals who received the vaccines.[578] Dr. Joseph Mercola gives more details of the SARS-Cov ferret experiments:

> In my May 2020 interview above with Robert Kennedy Jr., he summarized the history of coronavirus vaccine development, which began in 2002, following three consecutive SARS outbreaks. By 2012, Chinese, American and European scientists were working on SARS vaccine development, and had about 30 promising candidates.
>
> Of those, the four best vaccine candidates were then given to ferrets, which are the closest analogue to human lung infections. In the video below, which is a select outtake from my full interview, Kennedy explains what happened next. While the ferrets displayed robust antibody response, which is the metric used for vaccine licensing, once they were challenged with the wild virus, they all became severely ill and died.
>
> The same thing happened when they tried to develop an RSV vaccine in the 1960s.

> RSV is an upper respiratory illness that is very similar to that caused by coronaviruses. At that time, they had decided to skip animal trials and go directly to human trials.
>
> "They tested it on I think about 35 children, and the same thing happened," Kennedy said. "The children developed a champion antibody response — robust, durable. It looked perfect [but when] the children were exposed to the wild virus, they all became sick. Two of them died. They abandoned the vaccine. It was a big embarrassment to FDA and NIH."[579]

553. Dr. Robert Malone, M.D., M.S., the inventor of the mRNA technology used by Pfizer-BioNTech and Moderna in their COVID-19 vaccines, states that the COVID-19 vaccines are causing ADE. Dr. Malone indicates that the scientific evidence is becoming increasingly clear that the COVID-19 vaccines are causing the virus to replicate at higher levels than would be the case in the absence of the vaccination.[580] He said that this phenomenon of ADE was predictable because ADE has happened in every coronavirus study ever conducted. He said the data indicates that as the immune response from the COVID-19 vaccines wanes after six months, the ADE is kicking in, and we see the result with increased hospitalizations. The hospitalizations are not from breakthrough infections in those vaccinated but rather from ADE brought on by the vaccine itself. The ADE causes the virus to replicate more efficiently than it would otherwise. Dr. Malone further states that those in the vaccinated population are generating the delta variant of COVID-19 due to the COVID-19 vaccine.

554. One research study explained:

> There are also immunopathological complications associated with the SARS-CoV and MERS-CoV vaccines that require addressing and further optimization. One adverse effect is the induction of antibody-dependent enhancement (ADE) effect, which is usually caused by vaccine-induced suboptimal antibodies that facilitates viral entry into host cells.[581]

555. Since the investigational vaccines for SARS-CoV caused ADE, it is thus not a surprise to find that the SARS-CoV-2 (COVID-19) vaccines also cause ADE.

556. Researcher Ken Garber explains:

> There are mounting theoretical concerns that vaccines generating antibodies against SARS-CoV-2 may bind to the virus without neutralizing it. Should this happen, the non-neutralizing antibodies could enhance viral entry into cells and viral replication and end up worsening infection instead of offering protection, through the poorly understood phenomenon of ADE. ADE "is a genuine concern," says virologist Kevin Gilligan, a senior consultant with Biologics Consulting, who advises thorough safety studies. "Because if the gun is jumped, and a vaccine is widely distributed that is

> disease enhancing, that would be worse than actually not doing any vaccination at all."[582]

557. A study was conducted by Timothy Cardozo of the Department of Biochemistry and Molecular Pharmacology, NYU Langone Health, New York, and Ronald Veazey of the Division of Comparative Pathology, Department of Pathology and Laboratory Medicine, Tulane University School of Medicine, Tulane National Primate Research Center. The scientists determined in their research that the COVID-19 vaccines caused an increase in the risk of more severe diseases caused through ADE. They concluded that recipients of COVID-19 vaccines should be warned about all the dangers of ADE before being vaccinated. The scientists determined that the COVID-19 vaccines worsen COVID-19 disease via antibody-dependent enhancement (ADE). They were concerned that the dangers are kept secret in clinical trial protocols and consent forms.[583] The researcher stated:

> Results of the study: COVID-19 vaccines designed to elicit neutralising antibodies may sensitise vaccine recipients to more severe disease than if they were not vaccinated. Vaccines for SARS, MERS and RSV have never been approved, and the data generated in the development and testing of these vaccines suggest a serious mechanistic concern: that vaccines designed empirically using the traditional approach (consisting of the unmodified or minimally modified coronavirus viral spike to elicit neutralising antibodies), be they composed of protein, viral vector, DNA or RNA and irrespective of delivery method, may worsen COVID-19 disease via antibody-dependent enhancement (ADE). This risk is sufficiently obscured in clinical trial protocols and consent forms for ongoing COVID-19 vaccine trials that adequate patient comprehension of this risk is unlikely to occur, obviating truly informed consent by subjects in these trials.
>
> Conclusions drawn from the study and clinical implications: The specific and significant COVID-19 risk of ADE should have been and should be prominently and independently disclosed to research subjects currently in vaccine trials, as well as those being recruited for the trials and future patients after vaccine approval, in order to meet the medical ethics standard of patient comprehension for informed consent.[584]

558. Many other researchers have determined that the COVD-19 vaccines pose a clear danger of ADE. In another study, the researchers concluded:

> Antibody-based drugs and vaccines against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) are being expedited through preclinical and clinical development. Data from the study of SARS-CoV and other respiratory viruses suggest that anti-SARS-CoV-2 antibodies could exacerbate COVID-19 through antibody-dependent enhancement (ADE).[585]

559. Another researcher pleaded for caution in the administration of the COVID-19 vaccine:

> [B]ecause ADE of disease cannot be reliably predicted after either vaccination or treatment with antibodies-regardless of what virus is the causative agent-it will be essential to depend on careful analysis of safety in humans as immune interventions for COVID-19 move forward.[586]

560. As we have learned, there are two kinds of antibodies. "There are neutralizing antibodies and binding antibodies (aka, non-neutralizing antibodies). We want neutralizing antibodies but not the binding antibodies. Binding antibodies do not 'neutralize' the virus when they bind, and rather, their presence indicates a potential problem."[587] The current vaccines have been touted as successful, but their "success" is based on antibody production. It is not based on challenging the test participants with the virus to see if there is successful protection from the virus or whether they would be an antibody-dependent enhancement that would make the test participant ill.[588] Why was that not done? Presumably, it is because the researchers knew from the SARS-CoV animal studies that the test subjects would suffer ADE. A vaccine producing ADE could never be approved.

561. The ADE is manifesting among the vaccinated. For example, it was reported on August 26, 2021, that the hospitals in Israel were filling up with vaccinated patients. Dr. Steven Li reported for the Vision Times:

> On Aug. 5, Dr. Kobi Haviv, medical director of Herzog Hospital in Jerusalem, said in a Channel 13 TV News interview, "95% of the severe patients are vaccinated." Furthermore, "85-90% of the hospitalizations are in fully vaccinated people" and the hospital is "opening more and more COVID wards."[589]

562. ADE was predictable. Pfizer-BiNTech was aware of the risk of ADE. They knew all about it from the SARS-CoV animal trials. Pfizer-BiNTech, in their briefing document sent to the FDA in their request for an EUA, claimed that the available data did not show any vacccine-enhanced disease during the short follow up period of their study. But in the next sentence, the company warned that the risk of ADE remains unknown and needs to be evaluated in ongoing trials.

> However, risk of vaccine-enhanced disease over time, potentially associated with waning immunity, remains unknown and needs to be evaluated further in ongoing clinical trials and in observational studies that could be conducted following authorization and/or licensure.[590]

563. Notice that Pfizer-BiNTech states that there was a risk of ADE "potentially associated with waning immunity."[591] That is precisely what the animal studies showed. And that is why Pfizer-BiNTech said that. Pfizer-BioNTech knew that there was a risk of ADE "with waning immunity." The statement that the risk was unknown is misleading. They knew there was a general risk and that the risk was real; they just did not know it with precision. That is what Dr. Malone explained. He said that this phenomenon of ADE was predictable because ADE has happened in every coronavirus study ever conducted.[592] Pfizer-BiNTech and Moderna certainly knew that. Dr. Malone also revealed that the studies showed that the ADE could be expected to show up as the immune response from

the COVID-19 vaccines wanes. He put the time frame at six months for the immune response wanting at six months. Moderna and Pfizer-BiNTech knew that also. Indeed, they said that the risk of ADE was "potentially associated with waning immunity."[593] The ADE from the COVID-19 vaccines we are witnessing is not a surprise to the CDC, the FDA, Moderna, or Pfizer-BioNTech. It was predictable. Both Pfizer and Moderna state that the risk of ADE "needs to be evaluated further in ongoing clinical trials and in observational studies that could be conducted following authorization and/or licensure."[594] But no such trials are being conducted. All we hear from both companies and the CDC is that the hospitalizations and deaths of the vaccinated population are from breakthrough infections. They now deny that ADE is a reality.

564. Identical language about the risk of ADE can be found in the Moderna briefing document. ADE is a known risk for the mRNA coronavirus vaccines. That is why both Pfizer and Modern mentioned it. ADE perfectly explains the VAERS reporting of 595,620 adverse events, including 13,068 deaths, 17,228 permanent disabilities, and 54,142 hospitalizations as of August 13, 2021.[595] The VAERS system reports correlation; it does not mean that causation has been proven. Recall that the HHS-funded study reported that the VAERS database is only catching 1% of all of the vaccine-related adverse events.[596] The means that each of the above numbers can be multiplied by 100 to get the true scope of the damage being done by the COVID-19 vaccines. For example, the 13,068 VAERS deaths represents 1,306,800 actual deaths. The VAERS system reports correlation; it does not mean that causation has been proven. Recall that Megan Redshaw determined that 46% of those getting a COVID-19 vaccine died within 48 hours of injection.[597] We will consider that as establishing a reasonable belief that the COVID-19 vaccines were the cause of the deaths. Thus, we come up with a conservative figure of 601,100 persons we have probable cause to believe died from the COVID-19 vaccines.

565. Please understand that some pharmaceutical companies are notorious for committing criminal fraud. One of them happens to be the manufacturer of a COVID-19 vaccine. On September 2, 2009, the U.S. Department of Justice announced that Pfizer "agreed to plead guilty to a felony violation of the Food, Drug and Cosmetic Act for misbranding Bextra with the intent to defraud or mislead."[598] As part of that settlement, Pfizer "agreed to pay $2.3 billion, the largest health care fraud settlement in the history of the Department of Justice."[599] Pfizer is a repeat offender.[600] Between 1991 and 2017, Pfizer entered into 34 civil and criminal settlements with the federal and state governments totaling $4.7 billion.[601] Past behavior is the best predictor of future conduct. The VAERS data indicates that Pfizer-BiNTech is responsible for 69% of the COVID-19 vaccine deaths reported in VAERS.[602] Extrapolating from the VAERS data, as explained above, I have probable cause to believe that out of the 601,100 persons who have died from the COVID-19 vaccines, Pfizer and its German partner, BioNTech, are responsible for killing 415,100 of those people.[603] Those figures are as of August 13, 2021; the carnage continues.

COVID-19 VACCINE BLOOD CLOTTING DANGER

566. Dr. Charles Hoffe, M.D., explains in straightforward terms how the mRNA COVID vaccines cause the body to create the spike proteins that in turn cause widespread microscopic blood clotting.

567. Dr. Hoffe reveals that when someone is given an mRNA vaccine, "it is literally collected by your lymphatic system and fed into your circulation. So these little packages of messenger RNA — and by the way, in a single dose of a Moderna vaccine, there are 40 trillion mRNA molecules that are injected into your arm ... they go into your blood stream in these little packages that are designed to be absorbed into your cells."[604]

568. Dr. Hoffe reveals that the absorption of the mRNA is most notable in the capillary networks, which are the tiniest blood vessels in the body. Because they are so small, the blood slows down while flowing through the capillaries. The little packages of mRNA from the vaccine are absorbed into the cells around the blood vessels (the vascular endothelium). There, the mRNA packages are absorbed, and the body goes to work reading the mRNA code. The blood vessel cells (the endothelium) begin manufacturing trillions and trillions of COVID spike proteins. There are 40 trillion mRNA packets per vaccine dose; each of those gene packets can produce many, many spike proteins.

569. The theory behind the mRNA COVID-19 vaccines is that your body will recognize the spike protein created by your cells as a foreign protein and make antibodies against it. Theoretically, you are then [theoretically] protected against COVID-19. But Dr. Hoffe explains the problem with how the mRNA acts in the body. The spike proteins are jutting from the cell walls in the very tiny capillaries in the body and block the blood flow.

> In a virus — in a coronavirus — that spike protein becomes part of the viral capsule — like the cell wall around the virus called the viral capsule. But it's not in a virus — it's in your cells. So therefore it becomes part of the cell wall of your vascular endothelium — which means that these cells that line your blood vessels, which are supposed to be smooth so that your blood flows smoothly, now have these little spiky bits sticking out. So it is absolutely inevitable that blood clots will form — because your blood platelets circulate around in your blood vessels — and the purpose of blood platelets is to detect a damaged vessel and block that vessel to stop bleeding. So when the platelet comes through the capillary, it suddenly hits all these COVID spikes that are jutting into the inside of the vessel — it is absolutely inevitable that a blood clot will form to block that vessel. That's how platelets work.[605]

570. Dr. Hoffe is presently treating patients suffering from COVID-19 vaccine injuries. He reveals the health dangers of mRNA vaccines.

> So the most alarming thing about this is that there are some parts of your body — like your heart and your brain, and your spinal cord and your lungs, which cannot regenerate — when those tissues are damaged by blocked vessels, they are permanently damaged. So I now have 6 people in my medical practice who have reduced effect tolerance, which means they get out of breath much more easily than they used to….literally what's happened to them is they have plugged up thousands of tiny capillaries in their lungs — and the terrifying thing about this is….that once

> you block off a significant number of blood vessels in your lungs, your heart is now pumping against a much greater resistance to trying and get the blood through your lungs — a condition called pulmonary artery hypertension. A condition of high blood pressure in your lungs because the blood can't get through because so many of the vessels are blocked. People with pulmonary artery hypertension usually die of right sided heart failure within three years.
>
> So the huge concern about this mechanism of injury is that these shots are causing permanent damage — and the worst is yet to come. Some tissues in your body like intestine and liver and kidneys that can regenerate to quite a good degree — but brain and spinal cord and heart muscle and lungs do not. When they are damaged, it's permanent — like all these young people who are now getting myocarditis from these shots — they have permanently damaged hearts — it doesn't matter how mild it is, they will not be able to do what they used to be able to do….but with each successive shot, the damage will add and add and add. It's going to be cumulative because you are getting progressively more damaged capillaries.[606]

SCUTTLING THE CONTROL GROUP TO HIDE ADE AND CLOTTING

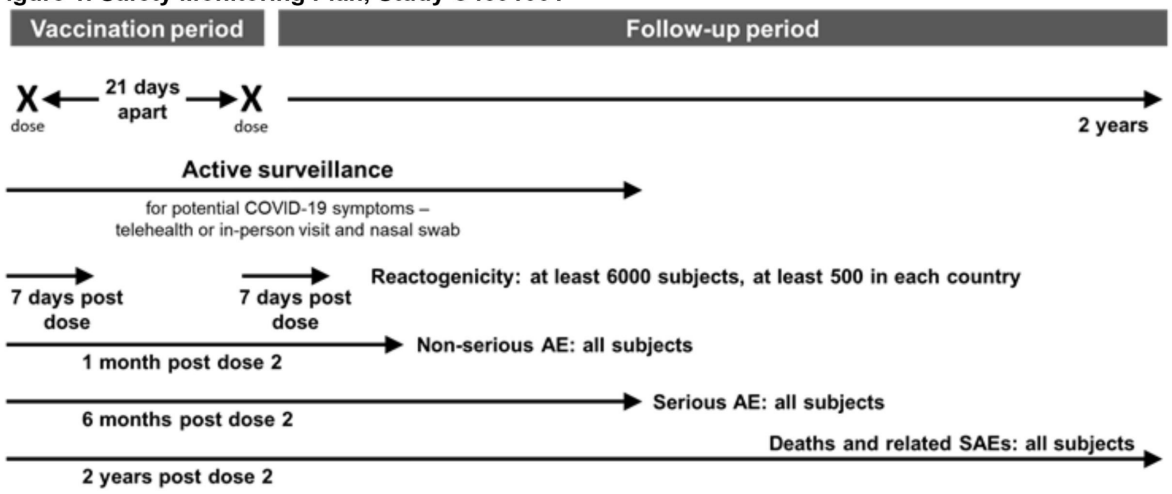
571. The only way to scientifically measure the onset of ADE and blood clotting is to conduct a placebo trial and monitor the vaccinated group with a placebo group. Both Moderna and Pfizer-BiNTech know that. They also knew that such a study would be devastating to the continued viability of their vaccines. So what did they do? After the EUAs for the Moderna and Pfizer vaccines were granted, both Moderna and Pfizer vaccinated the placebo group in their trials.[607] There are no longer control groups against which to compare the onset of ADE or blood clotting in a follow-up investigation. The vaccine companies knew that they needed to monitor their trial groups over the long term. They said so in their briefing documents. They said the risk of ADE "needs to be evaluated further in ongoing clinical trials and in observational studies that could be conducted following authorization and/or licensure." They already had the groups in place with whom they could study ADE. They knew that was the way to determine if there was ADE. The pharmaceutical companies purposely scuttled the placebo group to conceal that their vaccines cause ADE.

572. Steven Goodman, Professor of Epidemiology and Population Health and Medicine at Stanford University explains that "losing the those control groups makes it more difficult to answer some important questions about COVID-19 vaccines."[608] He said we now have no way of knowing how long the protections last or the efficacy against variants. There is no way to measure differences in any of the parameters by age, race, or infirmity. And there is no way to measure ADE or blood clotting quantitatively. The usefulness of the study has been destroyed. And that is the reason that the companies vaccinated the control group. Writing for *Natual News*, Lance Johnson explains that without the placebo group, "[t]here is no data to guarantee the safety and effectiveness of these shots and there is no longer any route to obtain that data from a clinical standpoint."[609] Johnson, writing his article on August 10, 2021, before the approval of the COMIRNATY (COVID-19 Vaccine, mRNA), opined that there is no way to scientifically or legally approve a vaccine that does not have

a control group for long-term monitoring. But that is just what the FDA did. On what basis did the FDA approve the COMIRNATY (COVID-19 Vaccine, mRNA) vaccine when there was no control group?

573. Figure 1 below is from page 15 of the FDA briefing document for the Pfizer COVID-19 vaccine.[610] It shows the planned follow-up period for further monitoring of the test subjects to continue for two (2) years. But Pfizer has now made it impossible for any follow-up comparison of ADE between the vaccinated and placebo groups by purposely vaccinating the placebo groups.

Figure 1. Safety Monitoring Plan, Study C4591001



574. The briefings for both the Moderna and Pfizer-BiNTech COVID-19 vaccines included the following proviso from the FDA:

> FDA does not consider availability of a COVID-19 vaccine under EUA, in and of itself, as grounds for immediately stopping blinded follow-up in an ongoing clinical trial or grounds for offering vaccine to all placebo recipients.[611]

575. Yet, both Moderna and Pfizer-BioNtech disregarded that guidance from the FDA and instead purposely sabotaged their studies by vaccinating the control groups and thus making it impossible to do long-term efficacy and safety studies on their vaccines.

ARTFUL DATA MANIPULATION

576. The CDC is playing a game of trying to obfuscate the ADE cases (which the CDC calls breakthrough COVID-19 cases) suffered by vaccinated persons while continuing to inflate the alleged COVID-19 cases suffered by the unvaccinated population. As explained above, the false narrative of a killer COVID-19 virus has been generated by two principle methods. 1) false-positive PCR tests which can be manipulated into reporting an artificially high number of false-positives by

altering the cycle threshold (CT value), and 2) inflating the case count by a broad definition of what is a COVID-19 case, such as listing a positive PCR test as a COVID-19 case, even if the person never experienced any symptoms. But it seems that inflation strategy is backfiring. It is becoming an embarrassment to the FDA, CDC, and the vaccine makers because it presents a very high number of breakthrough infections (which are really ADE cases) for vaccinated persons. The CDC announced new rules for reporting breakthrough cases of vaccinated persons that they do not apply to unvaccinated persons. First, the CDC instructed local health officials, when reporting breakthrough COVID-19 infections for vaccinated persons, to "submit only specimens with Ct value ≤28 to CDC for sequencing."[612] To further lower the reported numbers of breathrough cases, the CDC announced that "[a]s of May 1, 2021, CDC transitioned from monitoring all reported vaccine breakthrough cases to focus on identifying and investigating only hospitalized or fatal cases due to any cause."[613] Neither of these two new strategies were applied to the unvaccinated reporting. There are now different rules for reporting vaccinated COVID-19 cases and unvaccinated COVID-19 cases. The effect is to lower the reported number of vaccinated COVID-19 breakthrough cases while continuing the stratagem of inflating the reported unvaccinated COVID-19 cases.

577. Reporting for *Off Guardian*, Kit Knightly explains how the CDC manipulates data to prop up vaccine efficacy while keeping the COVID-19 scare going. In a series of examples, she describes how under similar circumstances one could be reported as a COVID-19 case when unvaccinated but not reported as a COVID-19 case when vaccinated under the CDC reporting standards.

> Person A has **not been vaccinated**. They test positive for COVID using a PCR test at 40 cycles and, despite having no symptoms, they are officially a "COVID case". [But the person would NOT be a COVID case if he were **vaccinated**.]
>
> Person B has been **vaccinated**. They test positive at 28 cycles, and spend six weeks bedridden with a high fever. Because they never went into a hospital and didn't die they are NOT a COVID case. [But the person would be reported as a COVID case if he were **not vaccinated**.]
>
> Person C, who was also **vaccinated**, did die. After weeks in hospital with a high fever and respiratory problems. Only their positive PCR test was 29 cycles, so they're not officially a COVID case either. [But the person would be reported as a COVID case if he were **not vaccinated**.][614]

THE CDC'S DECEPTIVE AND DANGEROUS ADVICE

578. Writing for Science Magazine, Meredith Wadman summarized a massive research study[615] in Israel that proves natural immunity is superior to immunity from vaccines.

> The new analysis relies on the database of Maccabi Healthcare Services, which enrolls about 2.5 million Israelis. The study, led by Tal Patalon and Sivan Gazit at KSM, the system's research and innovation arm, found in two analyses that people

> who were vaccinated in January and February were, in June, July, and the first half of August, six to 13 times more likely to get infected than unvaccinated people who were previously infected with the coronavirus. In one analysis, comparing more than 32,000 people in the health system, the risk of developing symptomatic COVID-19 was 27 times higher among the vaccinated, and the risk of hospitalization eight times higher.[616]

579. Indeed, studies have shown that "'[i]ndividuals who have recovered from COVID-19 have a substantially lower risk of reinfection with SARS-Cov-2."[617] The NIH confirms this. In a study funded by NIH's National Institute of Allergy and Infectious Diseases (NIAID) and National Cancer Institute (NCI), Daniela Weiskopf analyzed immune cells and antibodies from almost 200 people exposed SARS-CoV-2 and recovered. She said "our studies showed that natural infection induced a strong response, and this study now shows that the responses last."[618]

580. The natural immunity from COVID-19 is robust and long-lasting. Researchers opine that the natural immunity from COVID-19 should last a lifetime.

> For SARS-CoV, a coronavirus very like SARS-CoV-2 that was originally identified in 2003 and causes severe acute respiratory syndrome (SARS), the continued presence of high concentrations of neutralizing antibodies in blood serum for more than 17 years was reported in 2020. Wang and colleagues' results suggest that long-term immunity might also be expected for SARS-CoV-2.[619]

581. A recent Emory University study debunked the common myth that natural immunity to COVID-19 (i.e., SARS-CoV-2) wanes quickly, leaving the person subject to reinfection.

> Last fall, there were reports that antibodies wane quickly after infection with the virus that causes COVID-19, and mainstream media interpreted that to mean that immunity was not long-lived," said senior author Ali Ellebedy, PhD, an associate professor of pathology & immunology, of medicine and of molecular microbiology. "But that's a misinterpretation of the data. It's normal for antibody levels to go down after acute infection, but they don't go down to zero; they plateau. Here, we found antibody-producing cells in people 11 months after first symptoms. These cells will live and produce antibodies for the rest of people's lives. That's strong evidence for long-lasting immunity."[620]

582. A study conducted at the Washington School of Medicine in St. Louis found that even "mild cases of COVID-19 leave those infected with lasting antibody protection and that repeated bouts of illness are likely to be uncommon."[621] Another study concluded that substantial immune memory is generated after natural infection with COVID-19.[622]

583. The CDC and the Pharmaceutical companies have a problem because there are increasing numbers of vaccinated persons suffering what the CDC calls breakthrough COVID-19 infections

(which are actually ADE). So the CDC has announced a booster shot program. The CDC states that "with the Delta variant, public health experts are starting to see reduced protection against mild and moderate disease. For that reason, the U.S. Department of Health and Human Services (HHS) is planning for a booster shot so vaccinated people maintain protection over the coming months."[623] In reality, it is the COVID-19 that is causing hospitalizations and deaths from ADE. The booster shots will continue the deadly cycle.

584. It would seem, therefore, common sense that there would be no need for a person to be vaccinated if he has been infected with COVID-19 and already has a robust natural immunity to the virus. It is especially nonsensical for such persons to be vaccinated in light of the fact that the COVID-19 vaccines have been shown to be ineffective. But that is not the guidance being given by Dr. Fauci and the CDC. The CDC provides the following advice on its website:

> If I have already had COVID-19 and recovered, do I still need to get vaccinated with a COVID-19 vaccine?
>
> Yes, you should be vaccinated regardless of whether you already had COVID-19.[624]

585. The CDC relied on a single research study[625] in giving that advice. That research study is full of holes. The CDC represents the study as meaning "that people get better protection by being fully vaccinated compared with having had COVID-19."[626] But the study is a retrospective study that relies on the accuracy of the records in databases. There was no validation of the data. One significant problem with the survey goes to the heart of its conclusions regarding the infection rate. The study states that "reinfection was not confirmed through whole genome sequencing, which would be necessary to definitively prove that the reinfection was caused from a distinct virus relative to the first infection."[627] Without that confirmation, the study scientists are left to merely guess that "reinfection is the most likely explanation."[628] Guessing is not science. And it seems that they guessed wrong because the study from Israel impeaches their results.

586. It is pointless to vaccinate someone who has already been infected with COVID-19 (a.k.a. SARS-CoV-2) and has developed a natural immune response. It is also dangerous. Dr. Hooman Noorchashm, is an accomplished surgeon and staunch supporter of the new COVID vaccines, states that vaccinating persons with COVID-19 is dangerous if that person has already contracted COVID-19 and has the antibodies for the virus.[629] He has written to the FDA and advised that there should be screening to prevent those who have already contracted COVID-19 from being vaccinated. He stated that such persons are in danger of injury or death from the vaccine. Megan Redshaw, reporting for The Defender, reveals:

> According to Noorchashm, it is scientifically established that once a person is naturally infected by a virus, antigens from that virus persist in the body for a long time after viral replication has stopped and clinical signs of infection have resolved. When a vaccine reactivates an immune response in a recently infected person, the tissues harboring the persisting viral antigen are targeted, inflamed and damaged by

the immune response.[630]

587. Dr. Noorchashm explains:

> "In the case of SARS-CoV-2, we know that the virus naturally infects the heart, the inner lining of blood vessels, the lungs and the brain," explained Noorchasm. "So, these are likely to be some of the critical organs that will contain persistent viral antigens in the recently infected — and, following reactivation of the immune system by a vaccine, these tissues can be expected to be targeted and damaged."[631]

588. Dr. Noorchashm states: **"It is my professional opinion as an immunologist and physician that this indiscriminate vaccination is a clear and present danger to a subset of the already infected."**[632] That opinion is coming from a doctor who is an advocate in favor of the COVID-19 vaccines.

589. How can the CDC recommend vaccinations of persons who already have natural immunity to COVID-19 when in both Moderna[633] and Pfizer-BiNTech[634] Both Moderna and Pfizer-BioNTech performed Serological tests on all trial participants to specifically screen out those with COVID-19 natural immunity. Those persons necessarily had been infected previously with COVID-19 and had thus developed natural immunity. They were excluded from particpating in the COVID-19 vaccine trials. If the argument is that the COVID-19 vaccine enhances natural immunity, that group would be the ideal group with which to test that hypothesis. The CDC knew that group was not tested and yet still recommends the vaccination of that same group. But if as Dr. If persons with natural immunity are susceptible to a cytokine storm caused by an immediate ADE reaction, as Dr. Hooman Noorchashm has opined, such a group would reveal the danger posed to the naturally immune population. Arguably, Moderna and Pfizer-BioNTech ensured that would not happen by disqualifying all persons with serological tests that showed that the persons already had natural immunity.

590. Congressman Thomas Massie (R-Ky.), an award-winning scientist, said that the CDC is providing misinformation to the public by recommending that those who have already recovered from COVID-19 should still be vaccinated. Massie told the CDC that their report alleging the efficacy of vaccinating those who already had COVID-19 immunity was flat wrong. How did the CDC respond to Massie's objection? Megan Redshaw reports:

> Massie contacted officials at the CDC about the misinformation. They acknowledged it was false, but instead of correcting it, tried to rephrase their mistake. Massie and other scientists said the new wording still wrongly implies vaccines work in people who previously had COVID.
>
> "And instead of fixing it, they proposed repeating it and just phrasing their mistake differently. **So, at that point, right now I consider it a lie. I think the CDC is lying about the efficacy of the vaccine** based on the Pfizer trials, for those who have

already had the coronavirus,"[635] Massie said. (emphasis added)

591. The CDC is knowingly and intentionally lying to the American people and advising those who already have a natural immunity to COVID-19 to nonetheless be vaccinated. It is ineffective and dangerous for a person who has natural immunity to COVID-19 to be vaccinated against it. The CDC acknowledges that their advice is wrong, but they are continuing with it.

592. Why is the CDC recommending COVID-19 vaccinations that have now been proven to be ineffective? Whatever immunity they offer is temporary. Because of their short-lived effectiveness, the CDC is starting a booster shot program. With that in mind, the CDC advises those who have a natural immunity that is robust and long-lasting to receive a COVID-19 vaccine. It makes no sense to advise the injection of a vaccine that has been proven to offer only short-duration benefit (if any) to a person who already has lifelong immunity. There is something else at play here other than the health of the citizens. It is like handing an umbrella to a skydiver with a parachute strapped to his back and telling him the umbrella will slow his descent. The COVID-19 vaccines (like the umbrella) do more harm than good for someone with natural immunity. The primary agenda of the CDC seems to be the vaccination of American citizens and not their good health.

593. The Israeli COVID-19 study was published on August 26, 2021.[636] The study was worldwide news among epidemiologists. But, on September 9, 2021, when he was asked about the study, Dr. Anthony Fauci feigned ignorance of its implications. Dr. Fauci is the Director of the National Institute of Allergy and Infectious Diseases (NIAID). Dr. Fauci is alleged to be "the nation's top infectious disease expert"[637] and "one of the world's leading clinicians and researchers on the pathogenesis and treatment of immune-mediated diseases."[638] Dr. Fauci is also a member of the White House Coronavirus Task Force. But he did not have an answer to the study that made worldwide news in the scientific community proving that natural immunity to COVID-19 was superior to vaccinated immunity. Let us read the exchange between Dr. Sanjay Gupta, the CNN Chief Medical Correspondent and Dr. Fauci:

> GUPTA: And just real quickly, there was a study that came out of Israel about natural immunity, and basically, the headline was that natural immunity provides a lot of protection, even better than the vaccines alone. What do people make of that? So as we talk about vaccine mandates, I get calls all the time, people say, I've already had COVID, I'm protected. And now the study says maybe even more protected than the vaccine alone. Should they also get the vaccine? How do you make the case to them?
>
> FAUCI: You know, that's a really good point, Sanjay. **I don't have a really firm answer for you on that.** That's something that we're going to have to discuss regarding the durability of the response. The one thing that paper from Israel didn't tell you is whether or not as high as the protection is with natural infection, what's the durability compared to the durability of a vaccine? So it is conceivable that you got infected, you're protected, but you may not be protected for an indefinite period of time. So, I think that is something that we need to sit down and discuss seriously,

> because you very appropriately pointed out, it is an issue, and there could be an argument for saying what you said.[639]

594. Dr. Fauci, "the nation's top infectious disease expert,"[640] does not know what to say about a study that confirms the well-known fact that natural immunity is superior to vaccinated immunity. All of the questions he raised about the study are answered in numerous other studies and research proving robust and long-lasting protection from natural immunity. Juxtaposing that research against the data showing the short-lived COVID-19 vaccine immunity that requires booster shots and the answers to his questions are ineluctable. He is an epidemiological expert. He must already have known the answers to his own questions. His questions were a smokescreen. Dr. Fauci is feigning ignorance of the Israeli study's implications because the study impeaches the CDC protocol calling for the vaccination of those with natural immunity.

595. Compare Dr. Fauci's response to the Israeli study to that of Former FDA Commissioner Scott Gottlieb, a Pfizer board member. Although Gottlieb's opinion is decidedly against the pecuniary interests of Pfizer, Gottlieb had little trouble acknowledging that the Israeli study showed that natural immunity confers durable protection from COVID-19.

> "The balance of the evidence demonstrates that natural immunity confers a durable protection," Gottlieb said during an Aug. 30 interview, referring to a landmark new preprint Israeli study that found that prior COVID-19 infection confers more protection against the virus than any of the vaccines. "It's fair to conclude that."[641]

596. George Orwell explained: "All tyrannies rule through fraud and force, but once the fraud is exposed, they must rely exclusively on force." The fraud behind the unsafe and ineffective COVID-19 vaccines is increasingly being exposed. Since so many people are not being tricked by the fraud, the government is resorting to its only remaining option, force. And that explains President Biden's edict for federal workers to get vaccinated.

ASSERTION OF LEGAL RIGHTS

597. I reasonably believe that the aforementioned facts reveal wrongdoing by government officials, agencies, and others. I reasonably believe that the wrongdoing constitutes violations of law, rules, regulations, or the U.S. Constitution. I further reasonably believe that the facts constitute gross mismanagement, gross waste of funds, abuse of authority, and a substantial and specific danger to public health or safety. None of the facts contained in this document are classified or derived from any classified information.

598. I hereby claim all legal rights afforded to me by U.S. Constitution and Federal Statutes, including, but not limited to, those provided in 5 U.S.C. § 2302(b), in particular, the immunities and protections outlined in paragraphs (8) and (9) and all other pertinent parts.

ENDNOTES

1.42 U.S. Code § 2000e(b). See also Arbaugh v. Y&H Corp., 126 S.Ct. 1235 (2006).

2.42 U.S. Code § 2000e–2.

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