# SARS-CoV-2

## Gain-of-Function Bioweapon - Clinical Consequences, Treatment, The Vaccines & Crimes Against Humanity.

**Richard M Fleming, PhD, MD, JD**

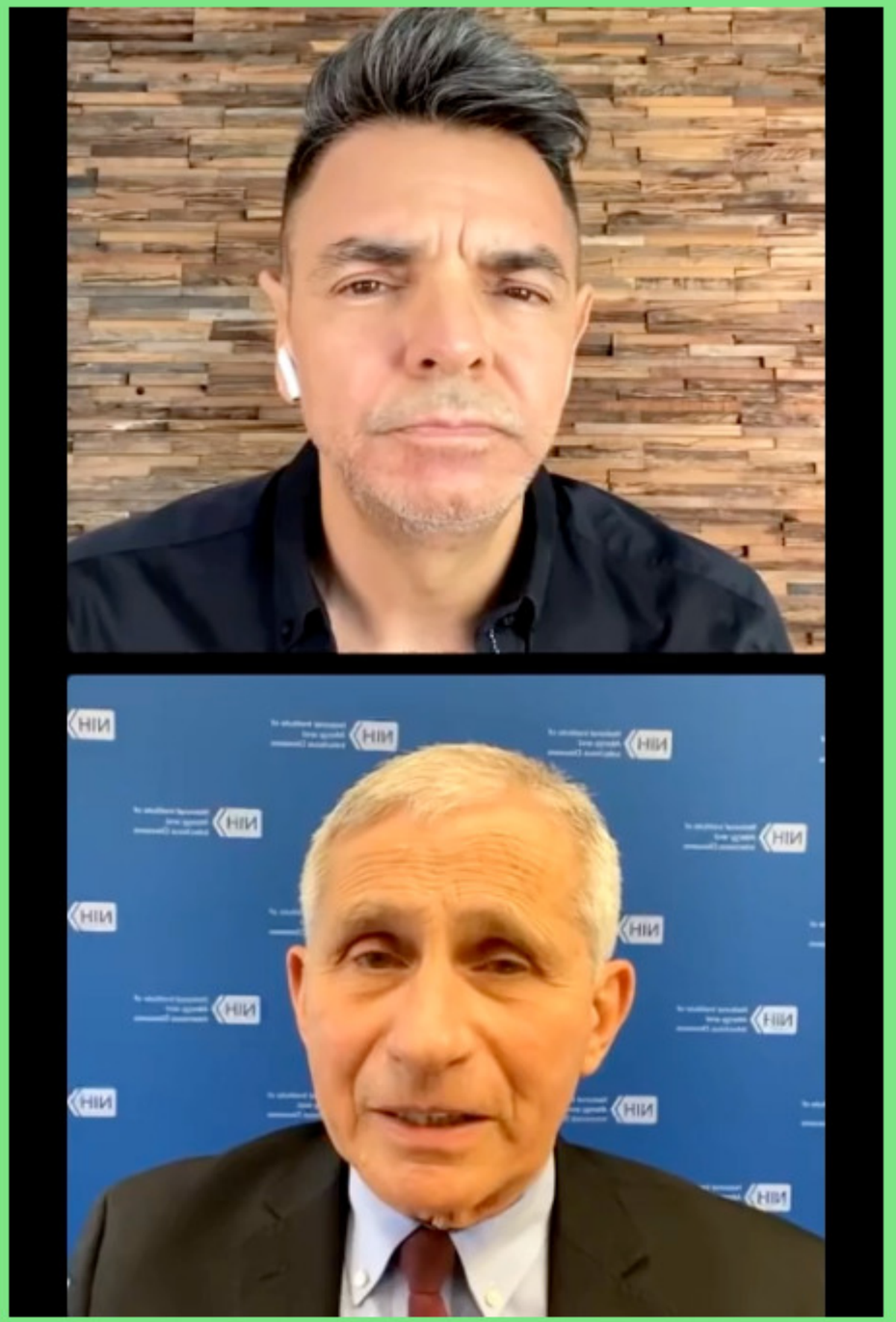
www.Fleming-Method.com

Potential Conflict of Interest (COI): FMTVDM, The Inflammation and Heart Disease Theory

# The Drug Vaccine Biologics - Can They Work?

# What is the Purpose of a Drug Vaccine Biologic?

- The purpose of a drug vaccine biologic is to expose you to a pathogen before you get infected by someone else
  - so that **when** you become exposed to the pathogen, it reduces the amount of time your immune system takes to respond to the infection
  - because your T and B memory cells will be activated when you get infected.
- In other words, **Drug Vaccines Biologics are only of benefit WHEN you get infected**.



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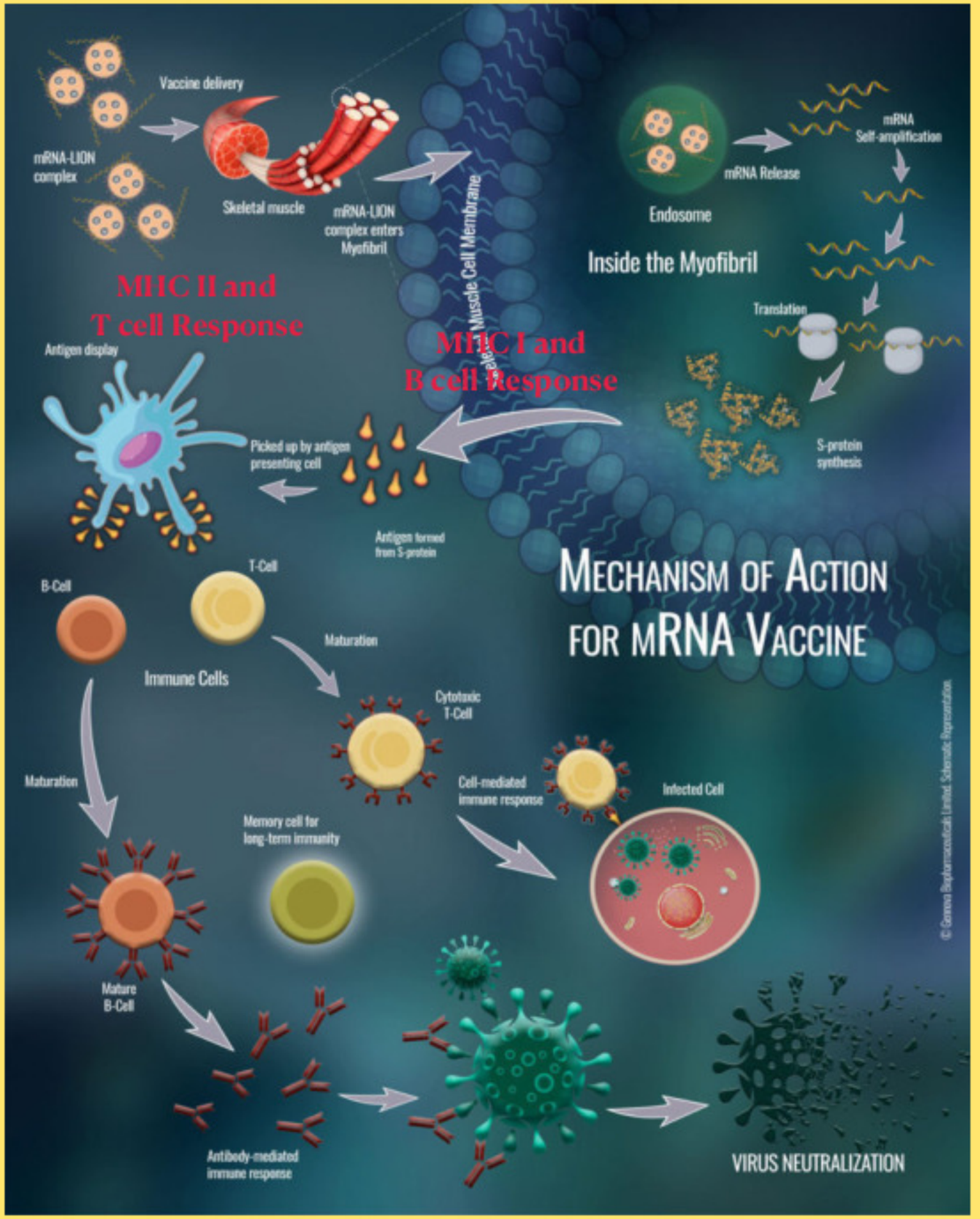
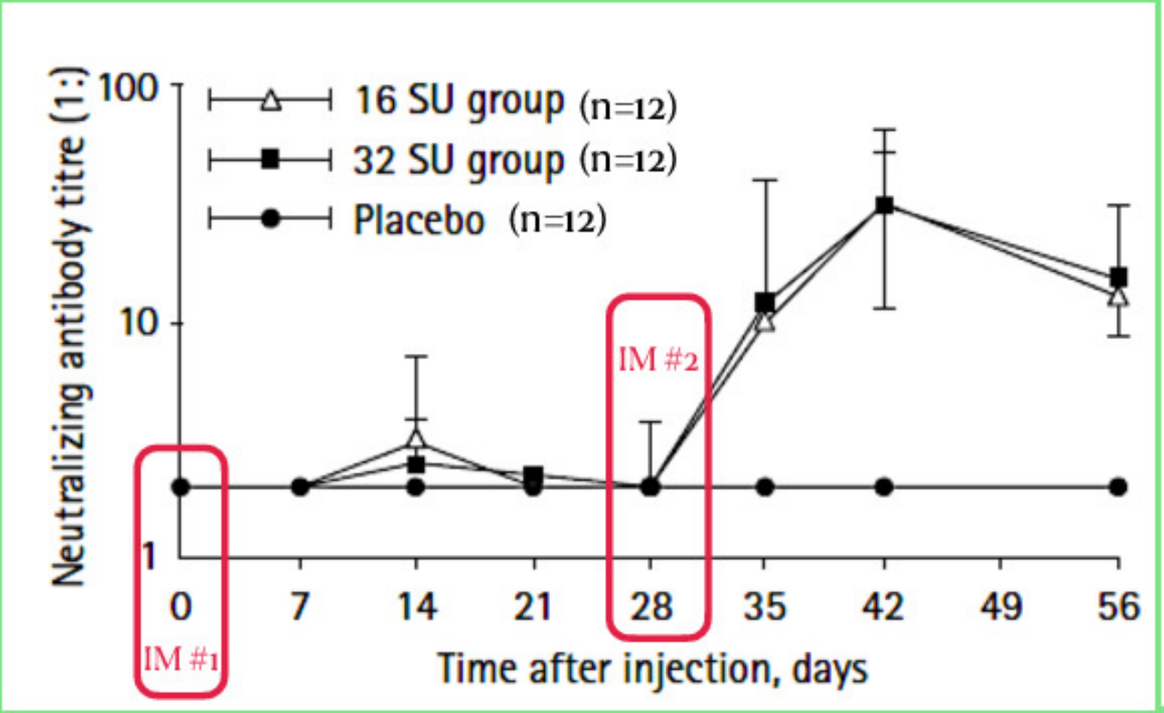


# In 2007 The Chinese Developed a Safe and Effective SARS-CoV-1 Drug Vaccine Biologic.

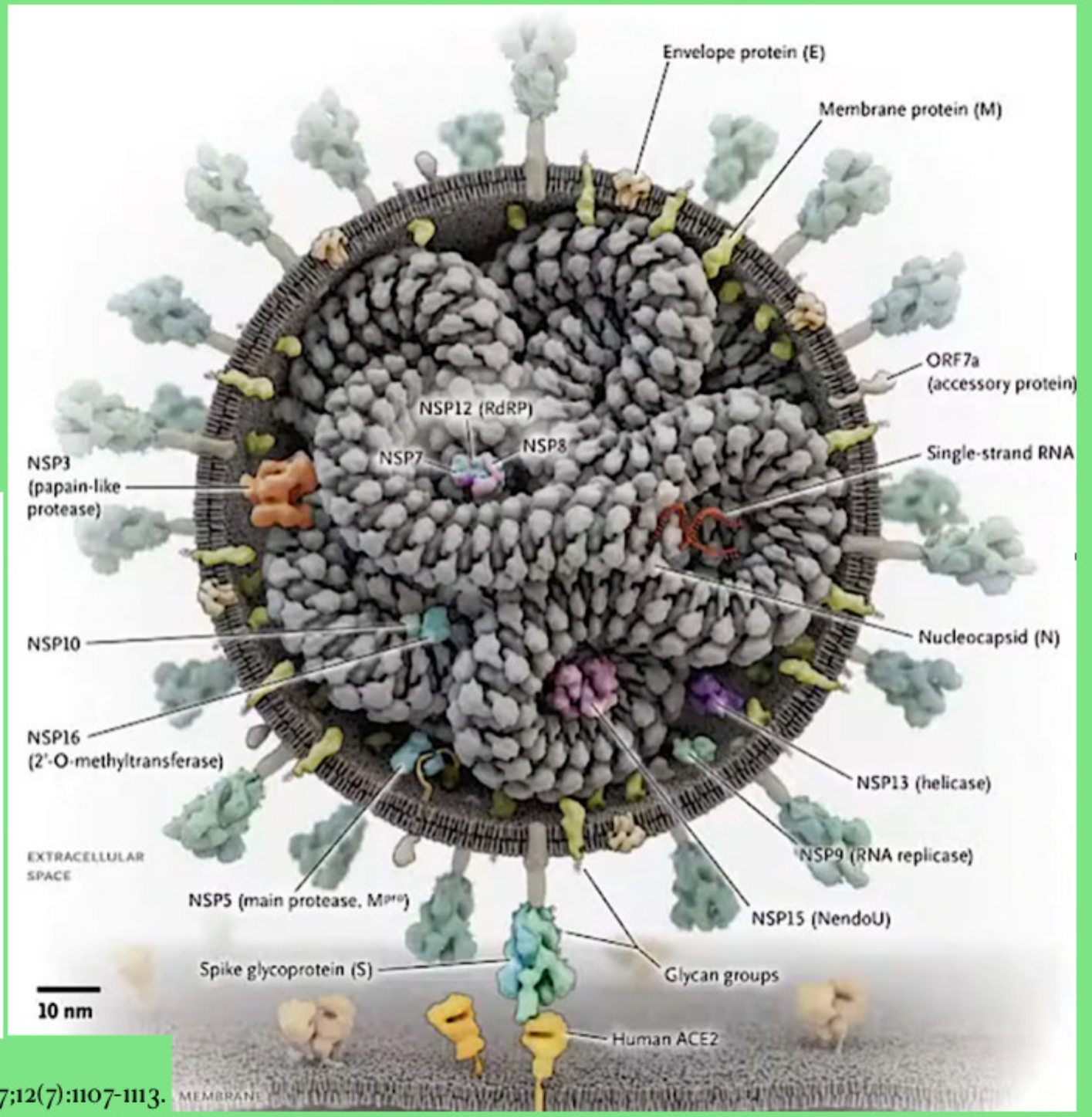
Using Attenuated SARS-CoV-1

18 healthy men and 18 healthy women

By day 42 100% seroconversion.




Lin, J-T, et al. Safety and Immunogenicity from a Phase I trial of inactivated severe acute respiratory syndrome coronavirus vaccine. Antiviral Therapy 2007;12(7):1107-1113.



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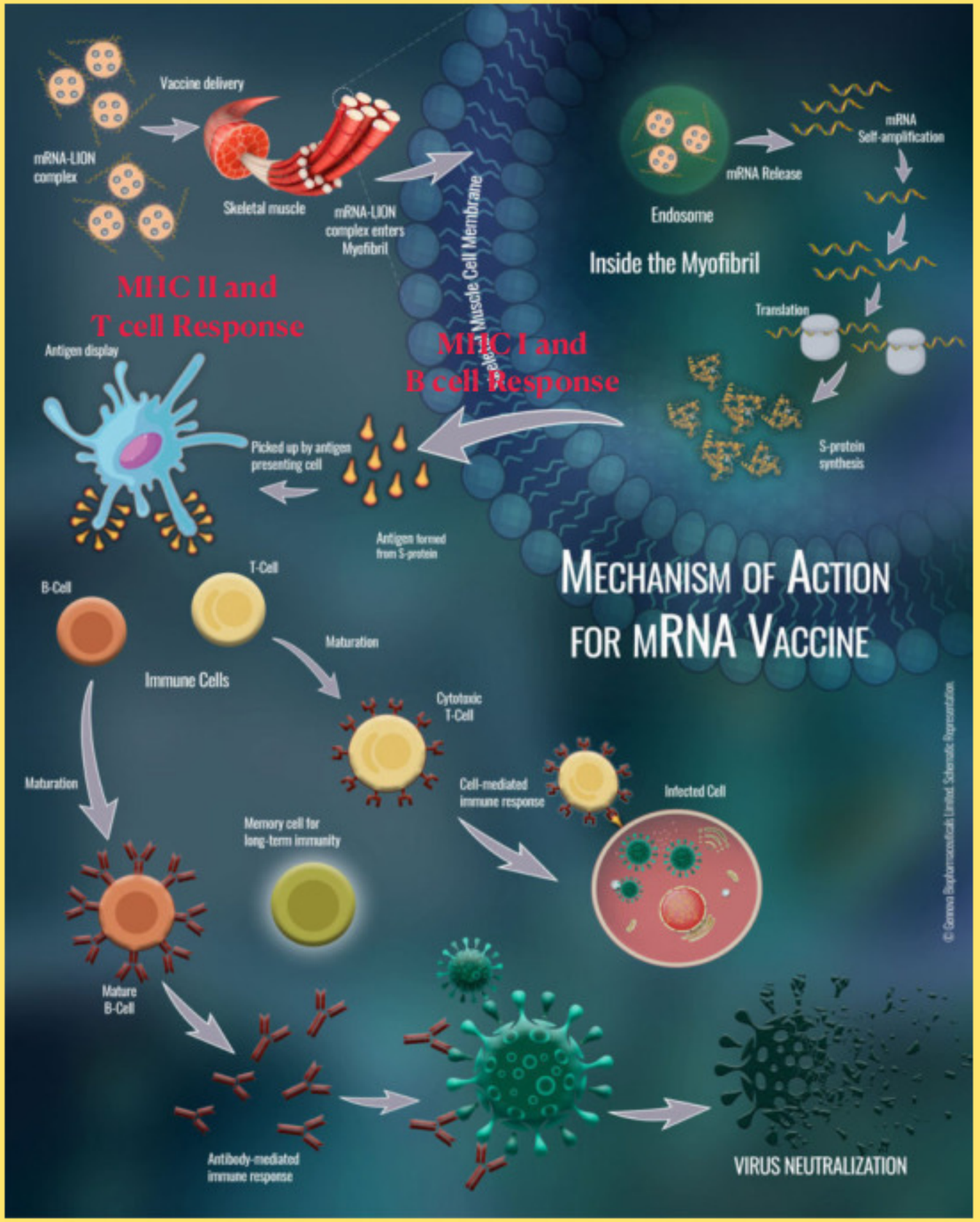
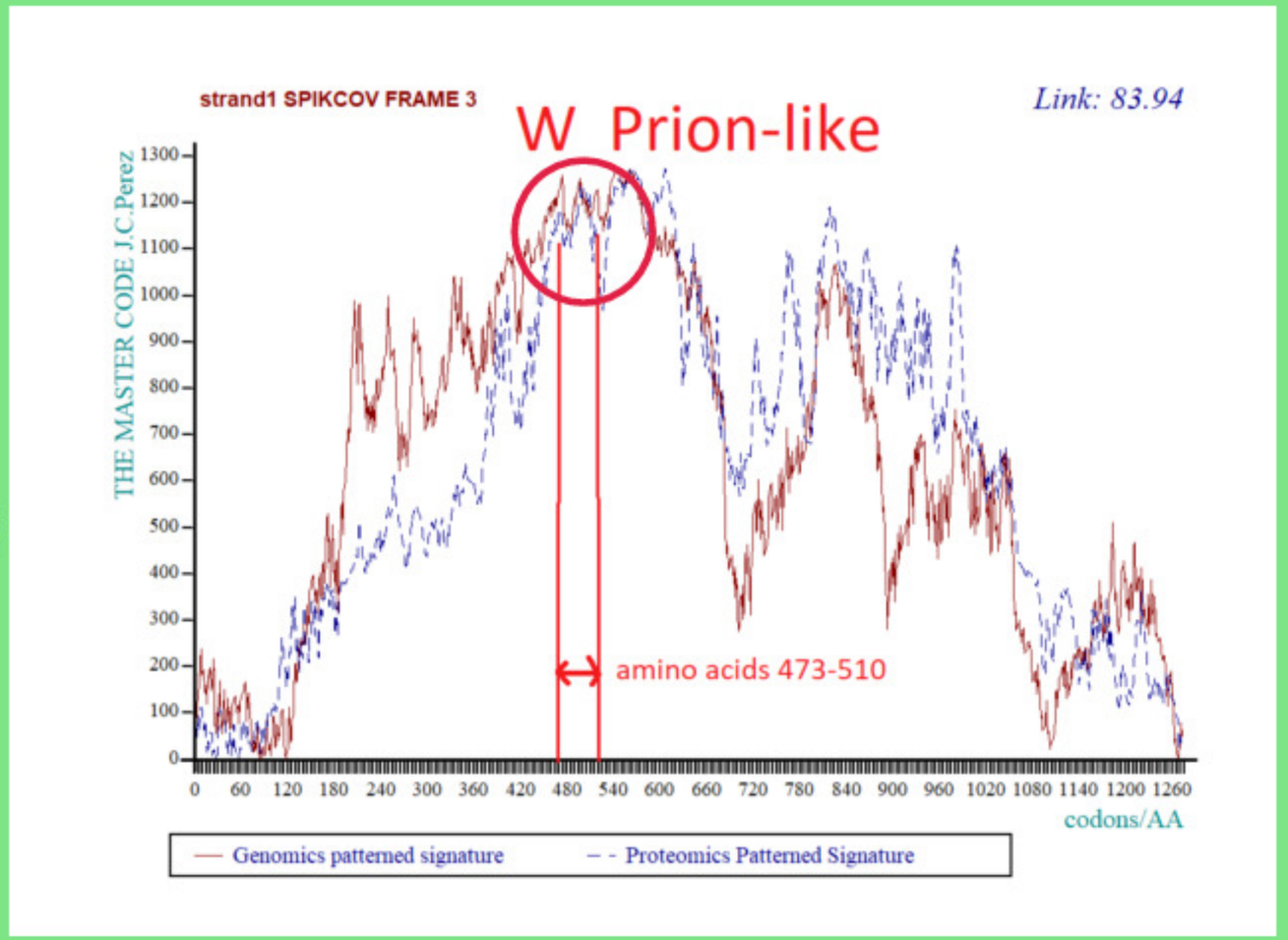
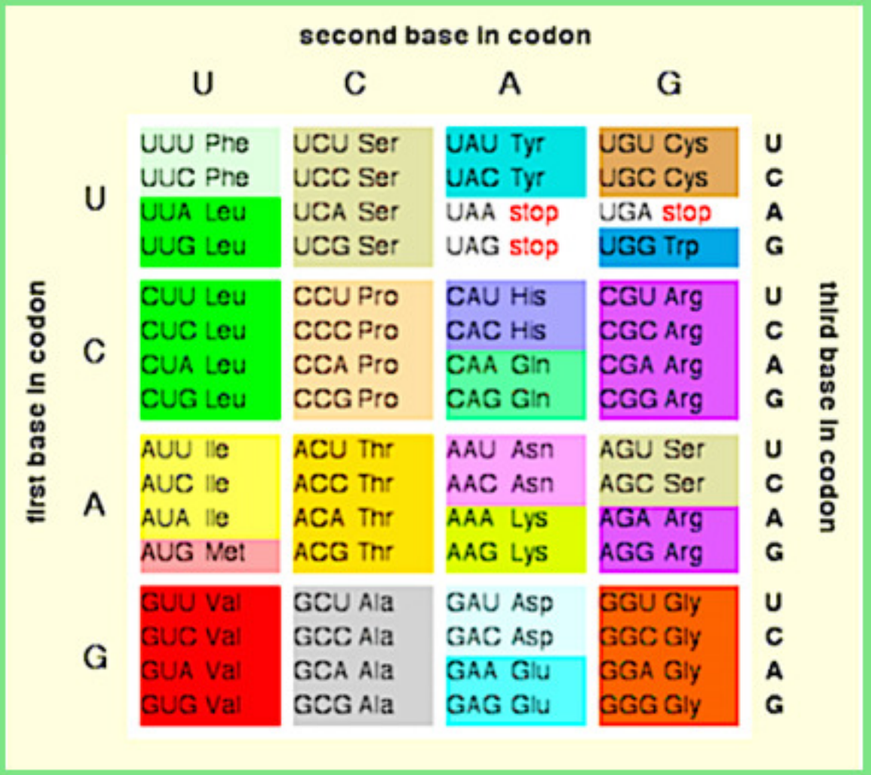


# Do the Pfizer, Moderna, Janssen and AstraZenica Drug Vaccines Genetic Codes Match the Genetic Code for the SARS-CoV-2 Wuhan Hu-1 Spike Protein.

Genes RED Proteins BLUE




Three Nucleotide Bases = One Amino Acid for the Protein

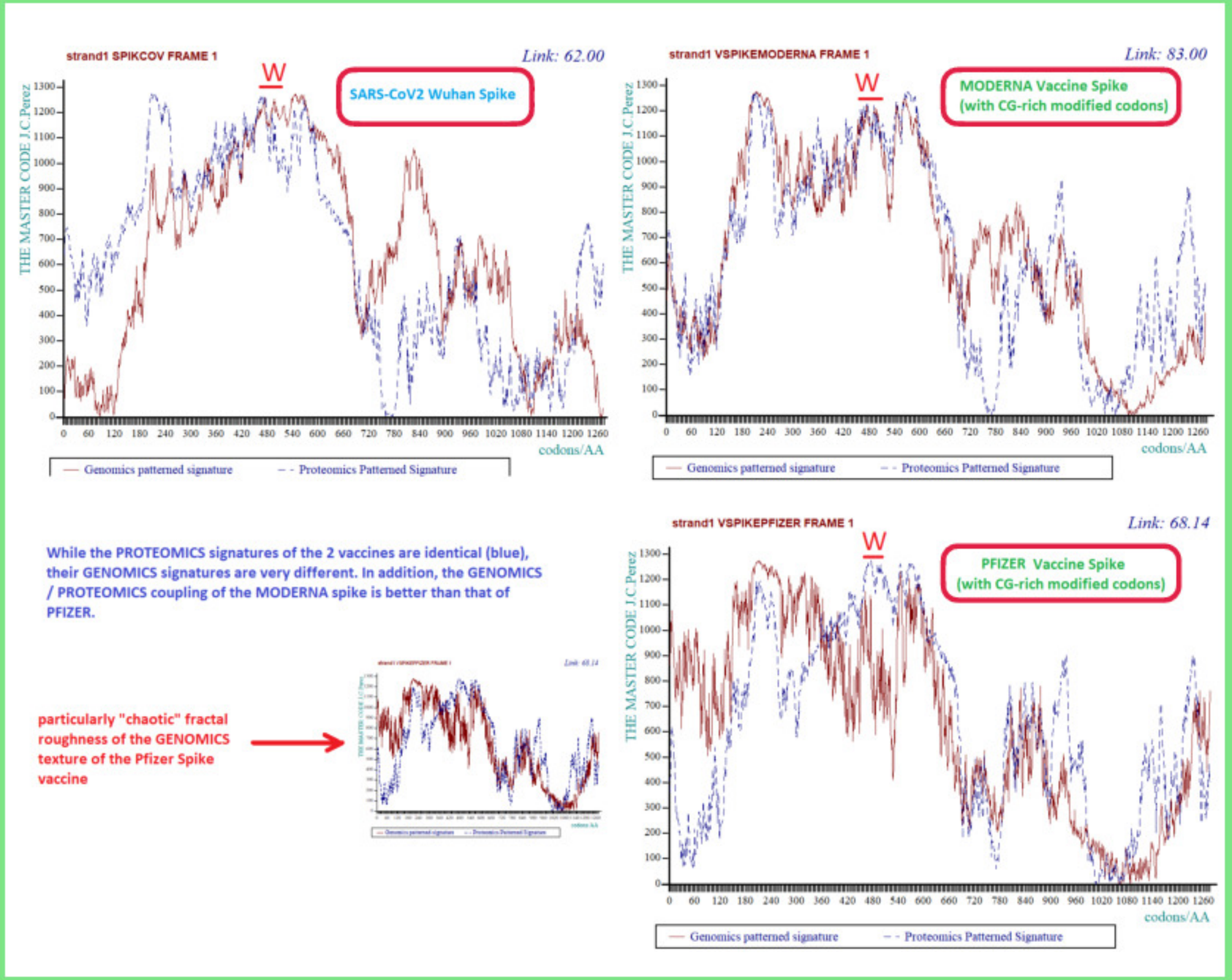



Jean-Claude Perez. Six Fractal Codes of Biological Life: Perspectives in Exobiology and Artifical Intelligence Biomimetism Decisions Making. doi: 10.20944/preprints201809.0139.v1

SARSCOV2 virus/mRNA Spike based vaccines/Prion like scenario/Magnetic properties. Personal correspondence Jean-Claude Perez 16 June 2021.

While the Spike Protein (**BLUE**) is Almost Identical, the nucleotide base sequences (**RED**) are not.

Analysis of the Pfizer and Moderna Nucleotide Bases and the Resulting Spike Proteins Reveal the Genetic Code for these Two Drug Vaccine Biologics Do NOT Match the SARS-CoV-2 Wuhan Hu-1 Virus Genetic Code.

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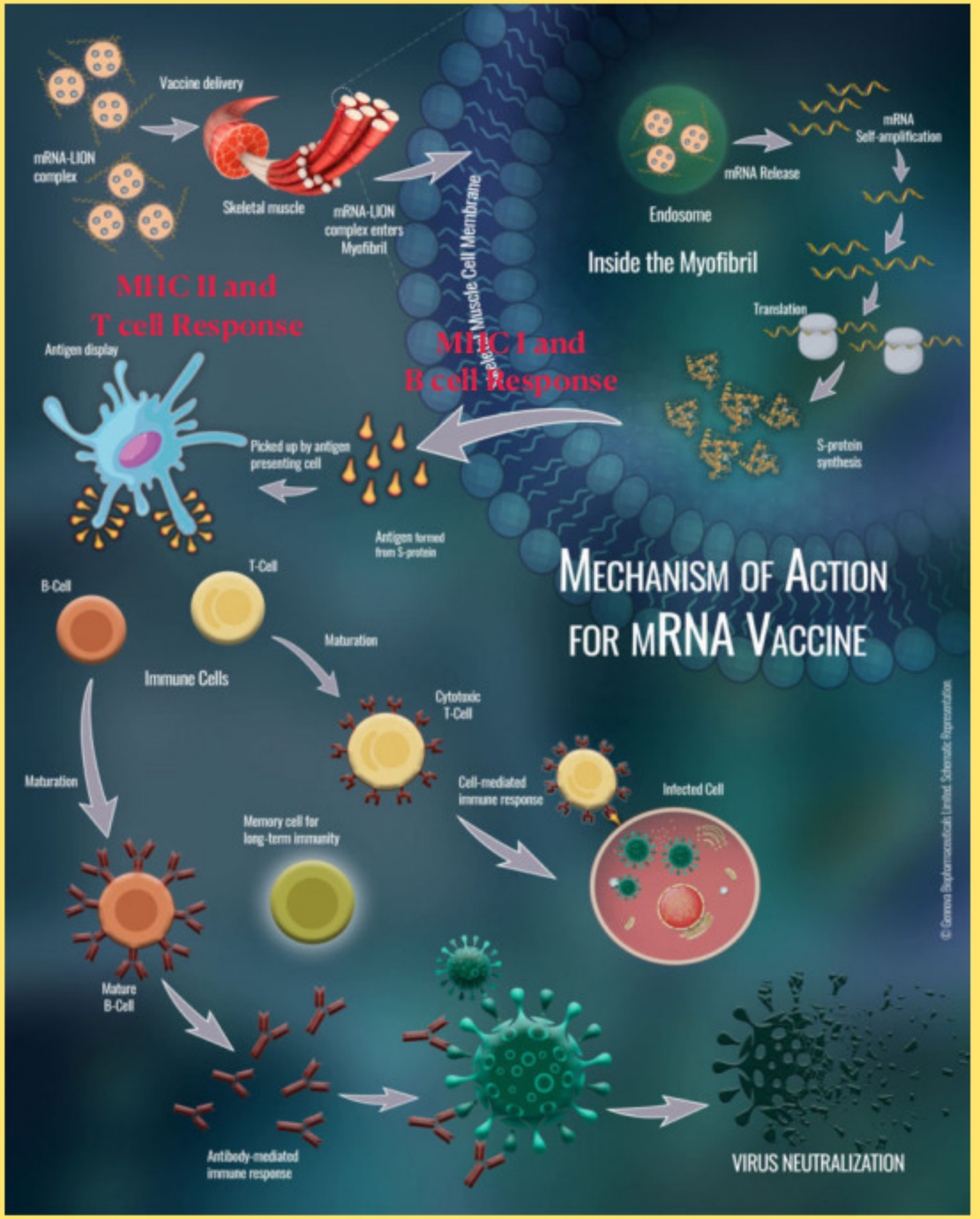
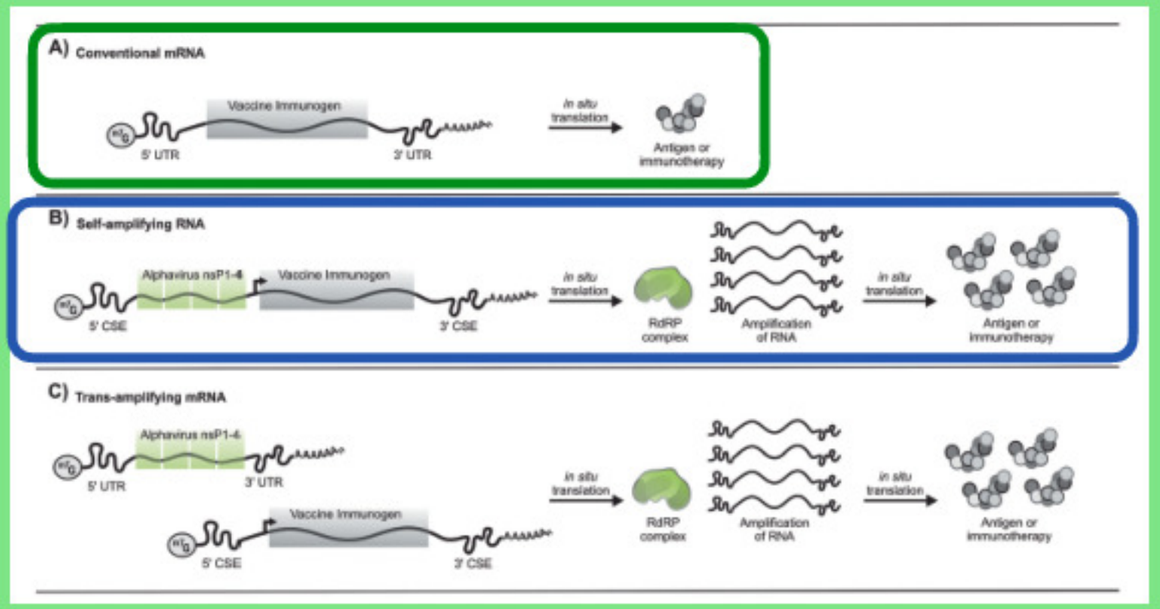
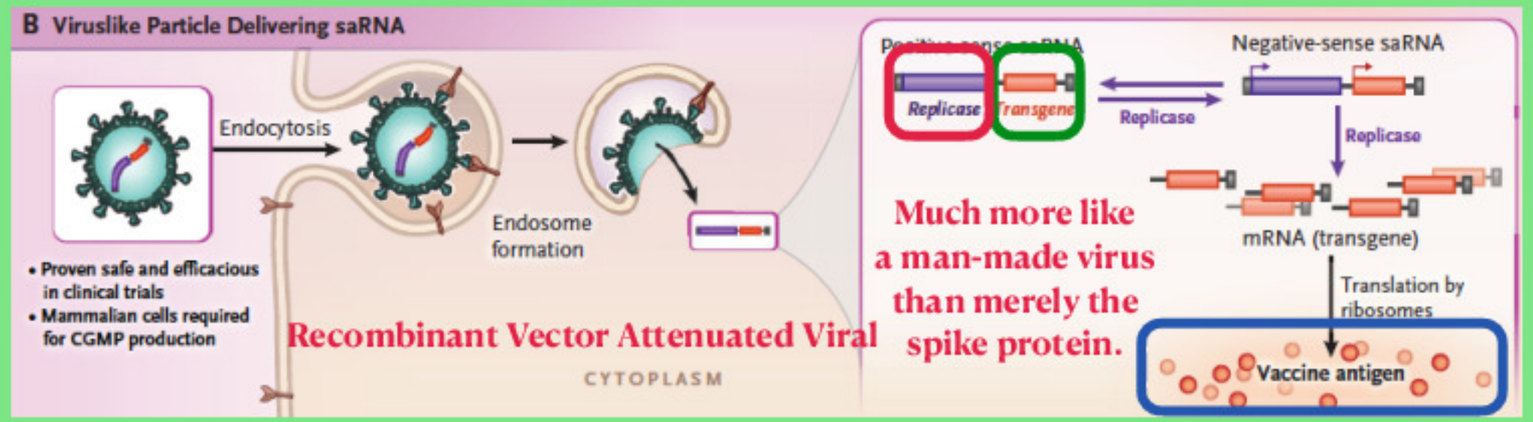


# This Raises Concerns Over What's Actually in the Drug Vaccine Biologics?

## Are These Self Amplifying mRNA Vaccines (SAM)* &/or Transmissible Vaccines**









* Fuller DH, Berglund P. Amplifying RNA Vaccine Development. N Engl J Med 2020 382(25):2469-2471.

** Nuismer SL, Bull JJ. Self-disseminating vaccines to suppress zoonoses. Nature Ecology & Evolution 2020;4:1168-1173.

# The Published Data Shows Research Being done with Self Amplyfying & Transmissible mRNA Drug Vaccines Including for SARS-CoV-2

JOURNAL OF VIROLOGY, Feb. 2000, p. 1114–1123 Vol. 74, No. 3
0022-538X/00/$04.00+0


## Horizontal Transmissible Protection against Myxomatosis and Rabbit Hemorrhagic Disease by Using a Recombinant Myxoma Virus

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*Centro de Investigación en Sanidad Animal (CISA-INIA), Valdeolmos, 28130 Madrid,[1] Departamento de Bioquímica y Biología Molecular, Instituto Universitario de Biotecnología de Asturias (CSIC), Universidad de Oviedo, 33006 Oviedo,[2] Departamento de Patología Animal, Facultad de Veterinaria, Universidad de Zaragoza, Zaragoza,[3] and Laboratorios Hipra S.A. Amer., 1710 Girona,[4] Spain*

Received 1 July 1999/Accepted 1 November 1999

**We have developed a new strategy for immunization of wild rabbit populations against myxomatosis and rabbit hemorrhagic disease (RHD) that uses recombinant viruses based on a naturally attenuated field strain of myxoma virus (MV). The recombinant viruses expressed the RHDV major capsid protein (VP60) including a linear epitope tag from the transmissible gastroenteritis virus (TGEV) nucleoprotein. Following inoculation, the recombinant viruses induced specific antibody responses against MV, RHDV, and the TGEV tag. Immunization of wild rabbits by the subcutaneous and oral routes conferred protection against virulent RHDV and MV challenges. The recombinant viruses showed a limited horizontal transmission capacity, either by direct contact or in a flea-mediated process, promoting immunization of contact uninoculated animals.**

Gene Therapy (2021) 28:117–129
https://doi.org/10.1038/s41434-020-00204-y

REVIEW ARTICLE

## Self-amplifying RNA vaccines for infectious diseases

Kristie Bloom[1] · Fiona van den Berg[1] · Patrick Arbuthnot[1]

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**Table 1** Clinical and preclinical synthetic saRNA vaccine studies for infectious diseases.

| Infectious disease | Replicon | Immunogen | Delivery | Animal | Year (reference) |
|---|---|---|---|---|---|
| Clinical studies | | | | | |
| Rabies | | [illegible] | CNE | Human | 2019 (NCT04062669) |
| COVID-19 | VEE | Spike protein | LNP | Human | 2020 (ISRCTN17072692) |
| Preclinical studies | | | | | |
| RSV | SFV | F glycoprotein | Naked | Mice[b] | 2001 [80] |
| | VEE–SINV | F glycoprotein | LNP | Mice, rats[b] | 2012 [81] |
| | VEE–SINV | F glycoprotein | CNE | Mice | 2014 [68] |
| Influenza | SFV | NP | Naked | Mice | 1994 [79] |
| | SFV | HA | Naked | Mice[b] | 2001 [80] |
| | VEE–SINV | HA | LNP | Mice | 2013 [14] |
| | CSFV | HA/NP | Chitosan NGA | Mice, rabbit | 2014 [71] |
| | VEE–SINV | HA | CNE | Mice[b], ferret[b] | 2015 [125] |
| | VEE–SINV | NP | LNP | Mice | 2015 [126] |
| | VEE–SINV | M1/NP | LNP | Mice[b] | 2016 [85] |
| | VEE | HA | MDNP | Mice[b] | 2016 [127] |
| | CSFV | HA/NP | CPP PEI | Pigs | 2017 [128] |
| | CSFV | NP | Cationic lipid | Mice | 2018 [129] |
| | – | HA | PEI | Mice[b] | 2018 [12] |
| | VEE | HA | Neutral LPP | Mice | 2019 [55] |
| | – | HA | MLNP | Mice | 2019 [54] |
| | Trans-amplifying | HA | Naked | Mice[b] | 2020 [62] |
| | VEE | HA | pABOL | Mice[b] | 2020 [50] |
| Coronavirus | VEE | Spike protein | LNP | Mice | 2020 [86] |
| LIV | SFV | prM-E | Naked | Mice[b] | 2001 [80] |
| TBEV | TBEV | Δ TBEV capsid | Gene gun | Mice[b] | 2004 [130] |
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| HIV | VEE–SINV | Env | LNP | Mice | 2012 [81] |
| | VEE–SINV | Env | Electroporation | Mice | 2013 [132] |
| | VEE–SINV | Env | CNE | Rabbit | 2014 [68] |
| | VEE–SINV | Env | CNE | NHP | 2015 [121] |
| | SFV | Gag/Pol mosaic | PEI | Mice | 2019 [123] |
| | VEE | eOD-GT8 | LNP | Mice | 2019 [120] |
| | VEE | Env | Exterior LNP | Mice | 2019 [58] |
| CMV | VEE–SINV | gB/pp65-IE1 | CNE | NHP | 2014 [68] |
| Ebola | VEE | Glycoprotein | MDNP | Mice[b] | 2016 [127] |
| Toxoplasma gondii | VEE | Multimer[a] | MDNP | Mice[b] | 2016 [127] |
| | SFV | NTPase-II | LNP | Mice[b] | 2017 [133] |
| GAS | VEE–SINV | SLOdm | CNE | Mice[b] | 2017 [134] |
| GBS | VEE–SINV | BP-2a | CNE | Mice[b] | 2017 [134] |
| Zika | VEE | prM-E | MDNP | Mice | 2017 [91] |
| | VEE | prM-E | NLC | Mice[b], guinea pigs | 2018 [90] |
| | VEE | prM-E | Naked | Mice[b] | 2019 [89] |
| VEE | VEE | Attenuated VEE | CNE | Mice[b] | 2019 [88] |
| Rabies | VEE–SINV | Glycoprotein G | CNE | Rats | 2020 [92] |
| | VEE–SINV | Glycoprotein G | Liposome, nanoparticle, CNE | Mice | 2020 [59] |

*BP-2a* GBS pilus 2a backbone protein, *CMV* cytomegalovirus, *CSFV* classical swine fever virus, *CNE* cationic nanoemulsion, *Env* envelope, *GAS* group A streptococci, *GBS* group B streptococci, *gB* glycoprotein B, *HA* haemagglutinin, *HIV* human immunodeficiency virus, *LIV* louping ill virus, *LNP* lipid nanoparticle, *LPP* lipopolyplexes, *M1* matrix protein 1, *MLNP* manosylated LNP, *MDNP* modified dendrimer nanoparticle, *NGA* nanogel alginate, *NHP* nonhuman primate, *NLC* nanostructured lipid carrier, *NP* nucleoprotein, *pABOL* poly(CBA-co-4-amino-1-butanol (ABOL)), *PEI* polyethylenimine, *Pol* polymerase, *prM-E* premembrane and envelope glycoproteins, *RSV* respiratory syncytial virus, *SFV* Semliki forest virus, *SINV* Sindbis virus, *SLOdm* double-mutated GAS Streptolysin-O, *TBEV* tick-borne encephalitis virus, *VEE* Venezuelan equine encephalitis virus, *VEE–SINV* alphavirus chimera based on the VEE and SINV replicons.

[a]Multimer comprised of granule protein 6 (GRA6), rhoptry protein 2A (ROP2A), rhoptry protein 18 (ROP18), surface antigen 1 (SAG1), surface antigen 2A (SAG2A), and apical membrane antigen 1 (AMA1).

[b]Vaccination conferred protection.

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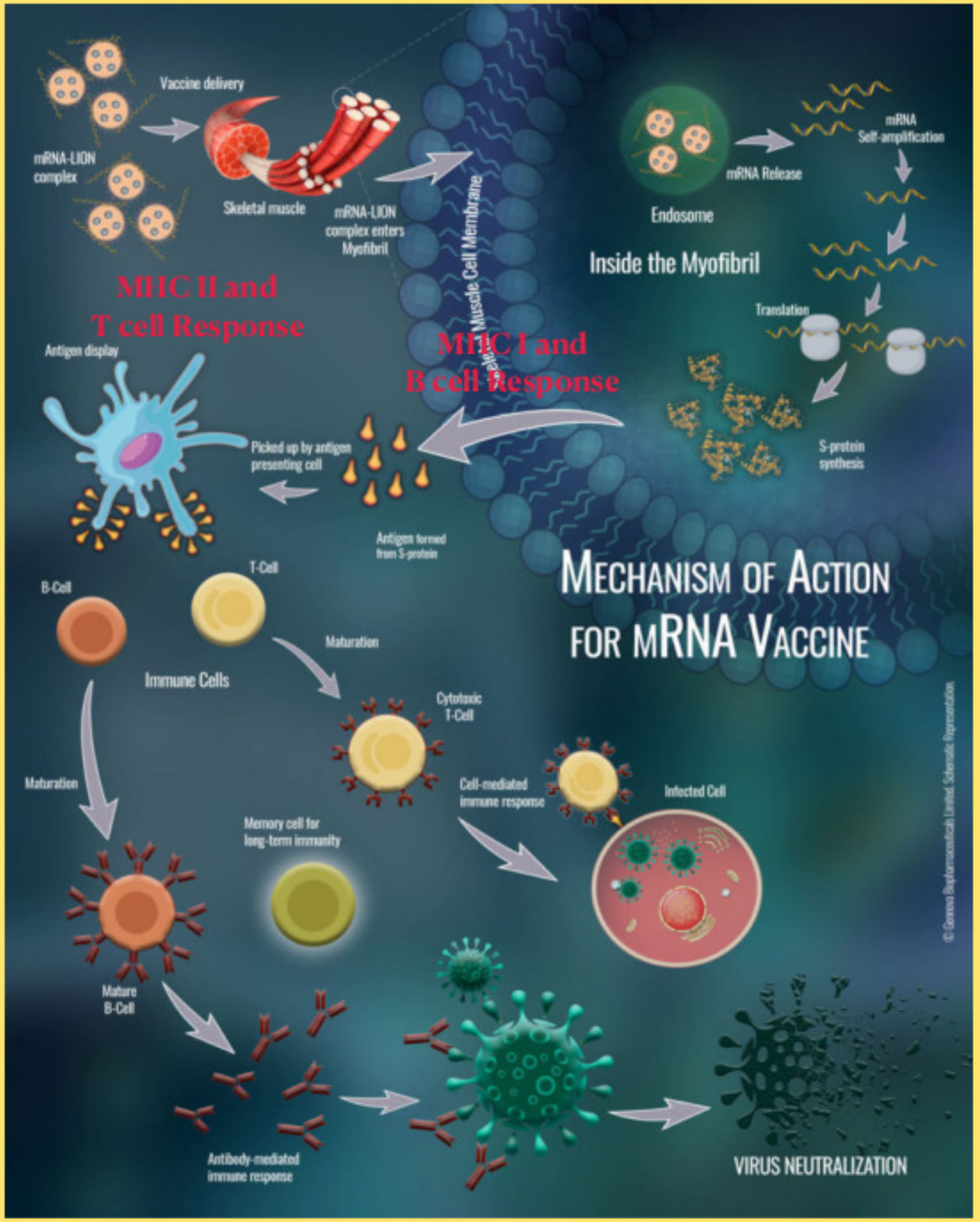


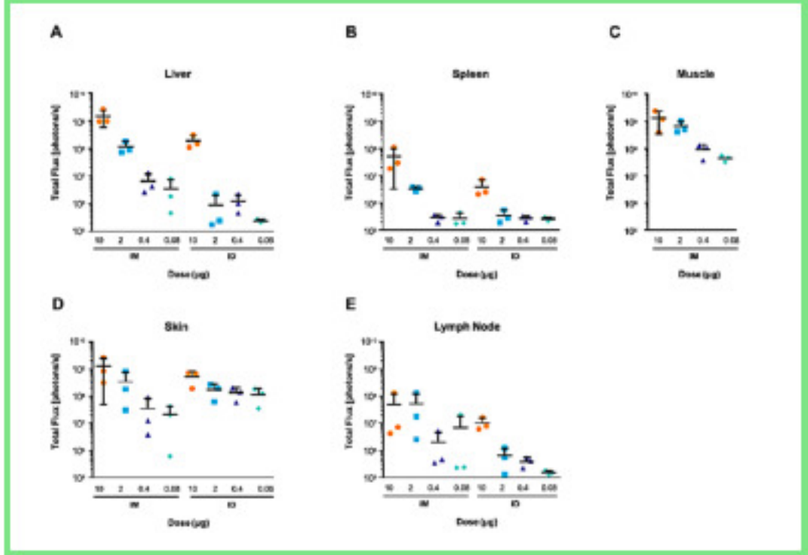
# My Next Concern is the Claim that mRNA LNP Vaccines stay at the Site of Injection - They Don't*.

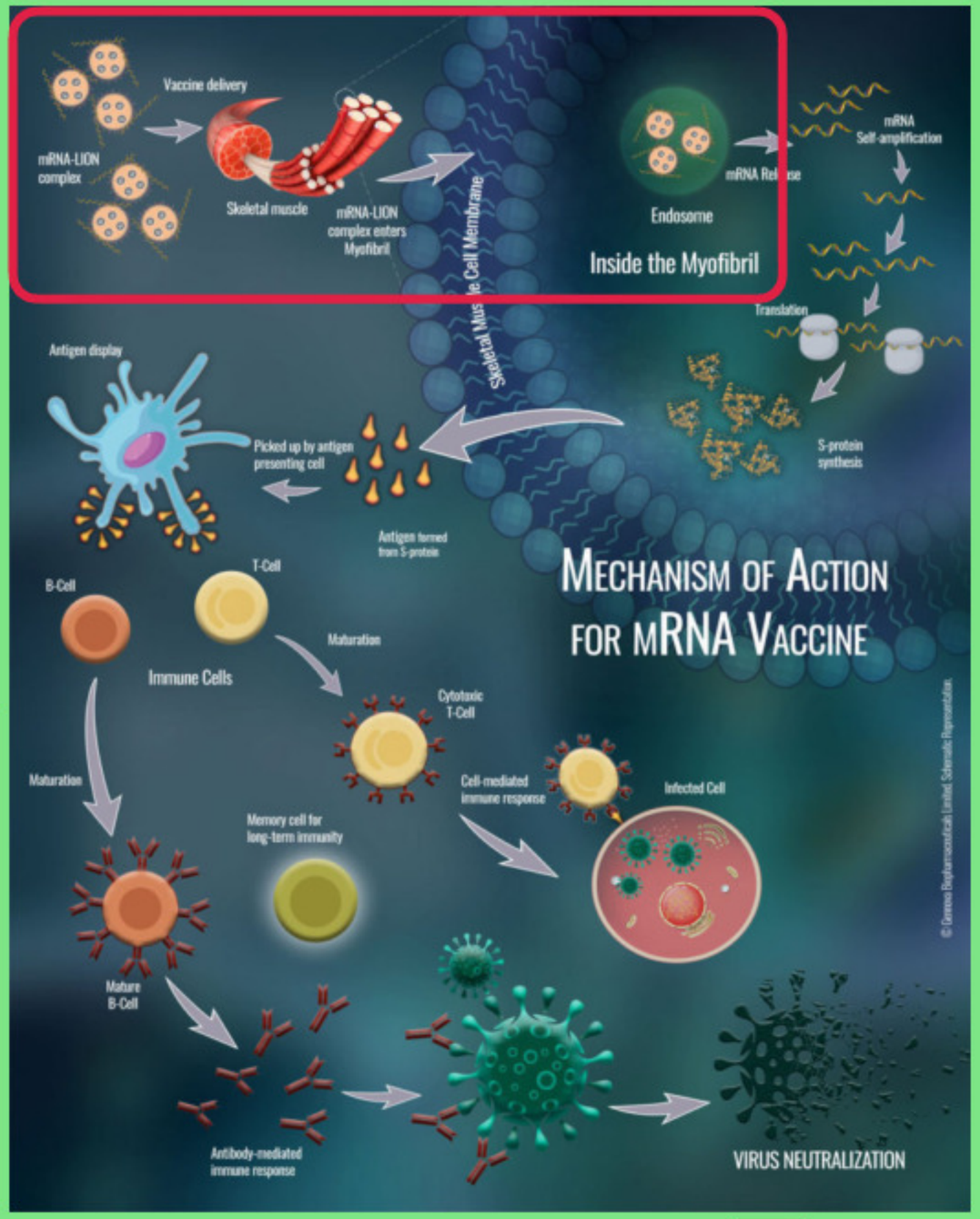
**Table 1. Biodistribution of H10 mRNA in Plasma and Tissue after IM Administration in Mice**

| Matrix | $t_{max}$ (hr) | $C_{max}$ (ng/mL) Mean | $C_{max}$ (ng/mL) SE | $AUC_{0-264\ h}$ (ng.hr/mL) Mean | $AUC_{0-264\ h}$ (ng.hr/mL) SE | $t_{1/2}$ (h) |
|---|---|---|---|---|---|---|
| Bone marrow | 2.0 | 3.35 | 1.87 | NA | | NC |
| Brain | 8.0 | 0.429 | 0.0447 | 13.9 | 1.61 | NR |
| Cecum | 8.0 | 0.886 | 0.464 | 11.1 | 5.120 | NC |
| Colon | 8.0 | 1.11 | 0.501 | 13.5 | 5.51 | NC |
| Distal lymph nodes | 8.0 | 177.0 | 170.0 | 4,050 | 2,060 | 28.0 |
| Heart | 2.0 | 0.799 | 0.225 | 6.76 | 1.98 | 3.50 |
| Ileum | 2.0 | 3.54 | 2.60 | 22.6 | 10.8 | 5.42 |
| Jejunum | 2.0 | 0.330 | 0.120 | 5.24 | 0.931 | 8.24 |
| Kidney | 2.0 | 1.31 | 0.273 | 9.72 | 1.44 | 11.4 |
| Liver | 2.0 | 47.2 | 8.56 | 276 | 37.4 | NC |
| Lung | 2.0 | 1.82 | 0.555 | 12.7 | 2.92 | 16.0 |
| Muscle (injection site) | 2.0 | 5,680 | 2,870 | 95,100 | 20,000 | 18.8 |
| Plasma | 2.0 | 5.47 | 0.829 | 35.5 | 5.41 | 9.67 |
| Proximal lymph nodes | 8.0 | 2,120 | 1,970 | 38,600 | 22,000 | 25.4 |
| Rectum | 2.0 | 1.03 | 0.423 | 14.7 | 3.67 | NR |
| Spleen | 2.0 | 86.9 | 29.1 | 2,270 | 585 | 25.4 |
| Stomach | 2.0 | 0.626 | 0.121 | 11.6 | 1.32 | 12.7 |
| Testes | 8.0 | 2.37 | 1.03 | 36.6 | 11.8 | NR |

Male CD-1 mice received 300 µg/kg (6 µg) formulated H10 mRNA via IM immunization. Two replicates of bone marrow, lung, liver, heart, right kidney, inguinal- and popliteal-draining lymph nodes, axillary distal lymph nodes, spleen, brain, stomach, ileum, jejunum, cecum, colon, rectum, testes (bilateral), and injection site muscle were collected for bDNA analysis at 0, 2, 8, 24, 48, 72, 120, 168, and 264 hr after dosing (n = 3 mice/time point). NA, not applicable AUC with less than three quantifiable concentrations; NC, not calculated; NR, not reported because extrapolation exceeds 20% or R-squared is less than 0.80.

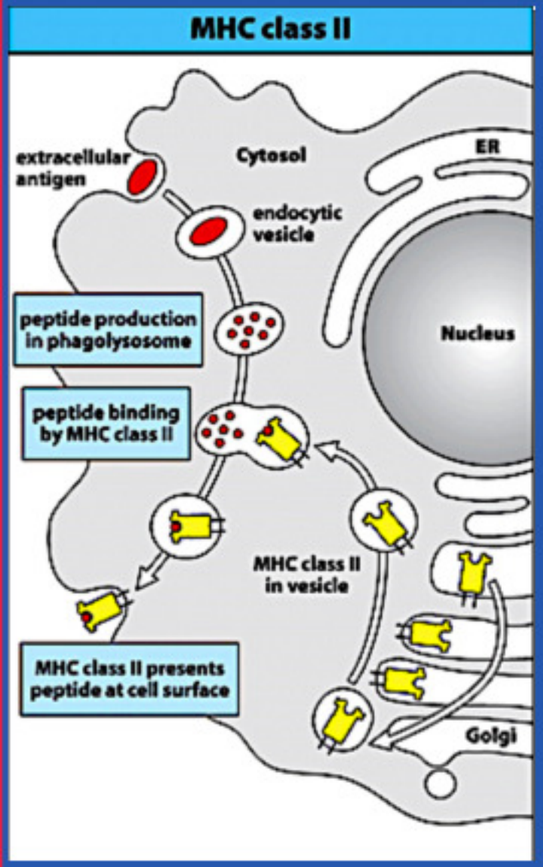
The biodistribution of the LNP mRNA vaccine was similar to the influenza virus inself and was measured outside of the IM injection site for 5-days.

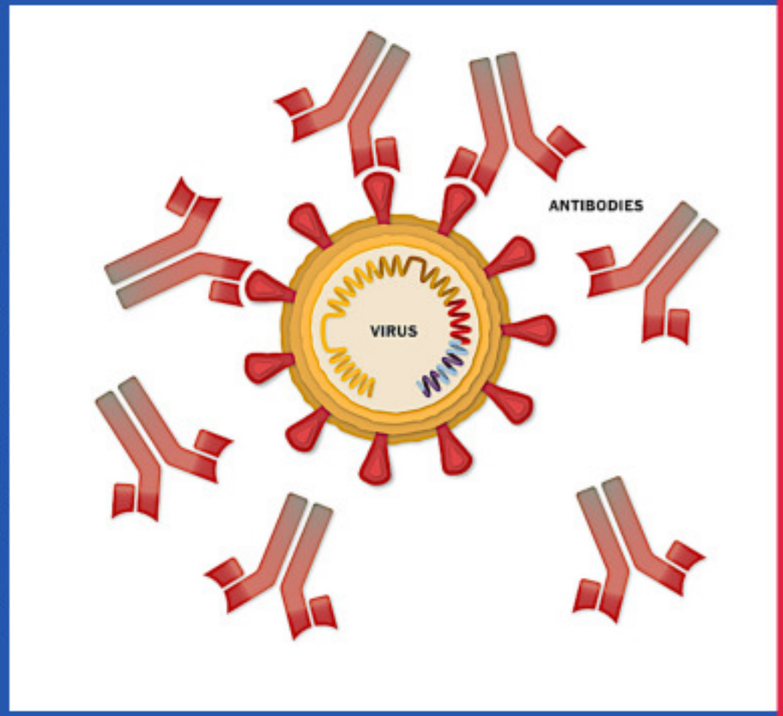


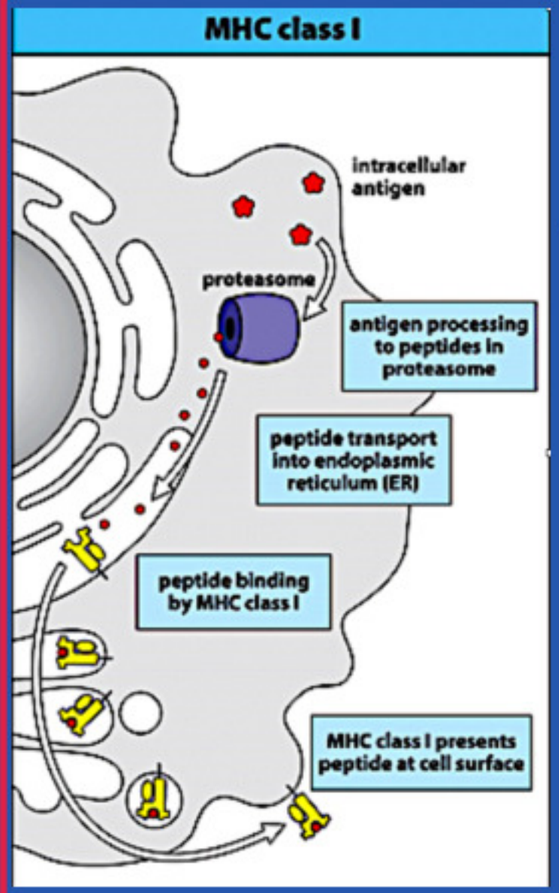

* Bahl K, et al. Preclinical and Clinical Demonstration of Immunogenicity by mRNA Vaccines against H10N8 and H7N9 Influenza Viruses. Molecular Therapy 2017 25(6):1316-1327.

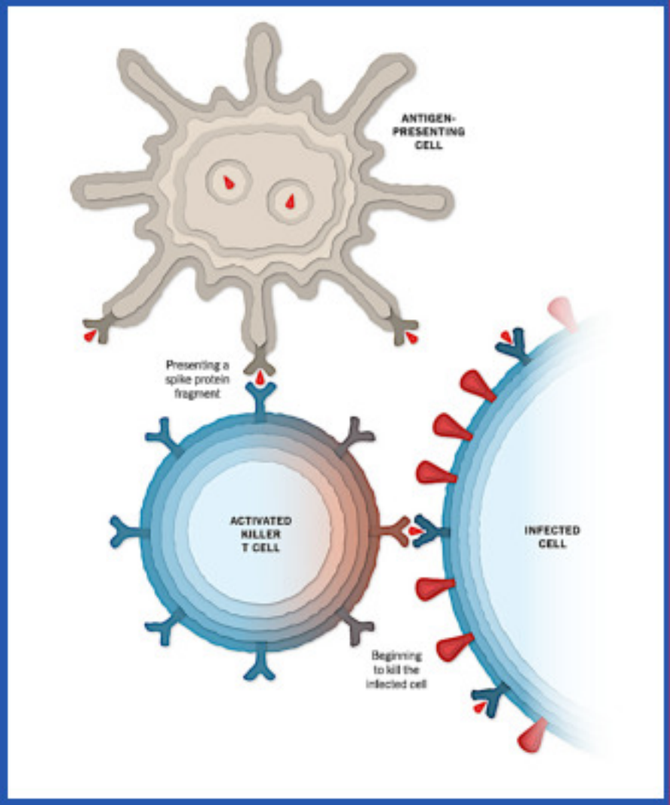
Person-to-Person and Prior Drug Vaccines activate CD4+ Helper first with MHC II following Phagocytosis and lysosomal degradation.
This allows Th2 activation to increase B cell antibody response.




**Adenovirus dsDNA & Novavax**

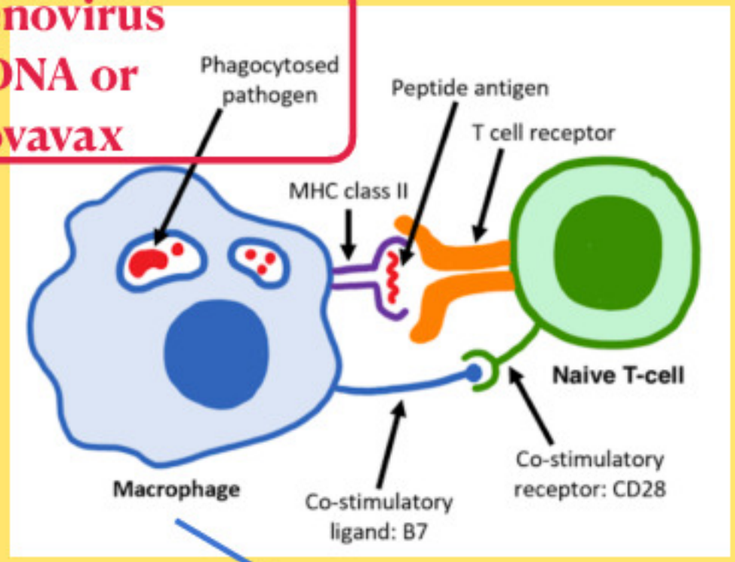


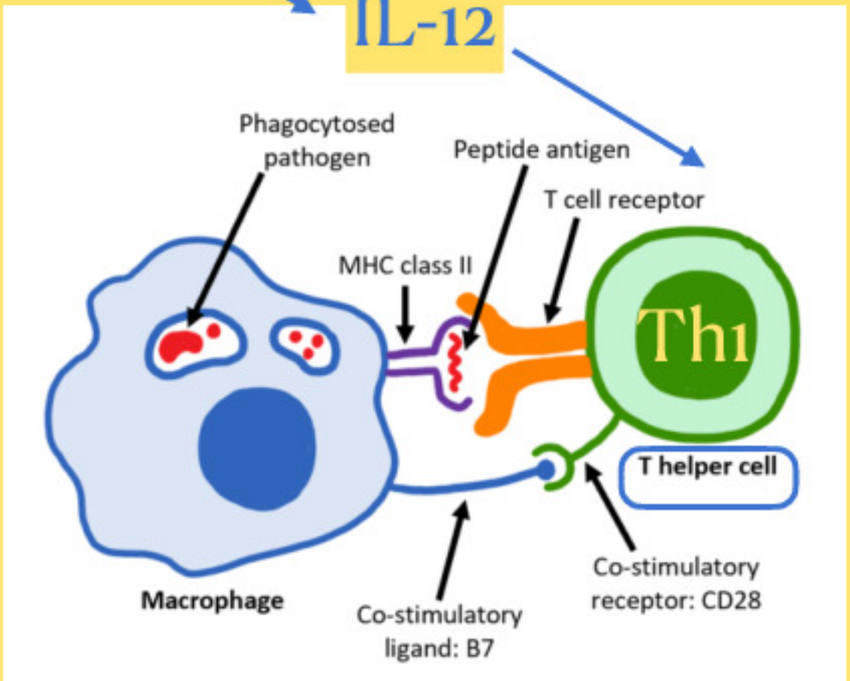

**LNP mRNAs**

# Using these Genetic Drug Vaccine Biologics

***Adenovirus dsDNA or Novavax**



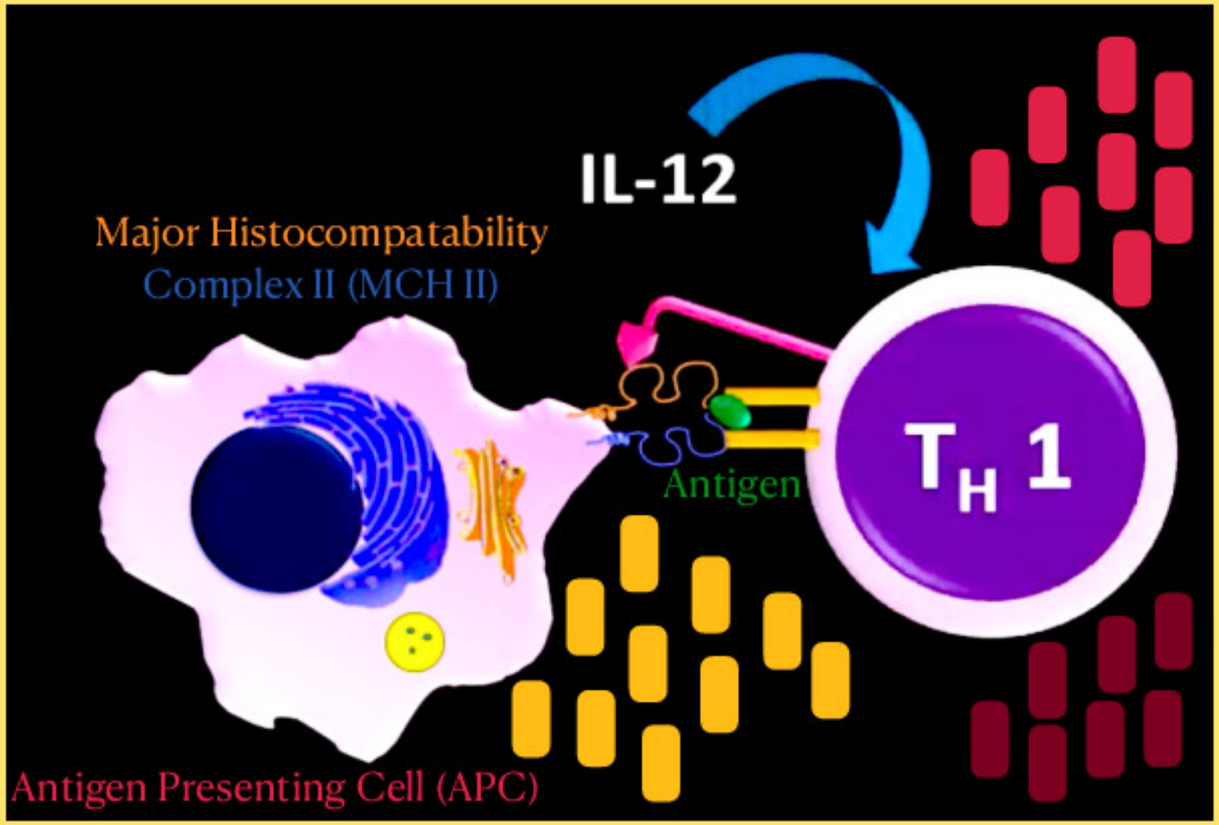

IL-12



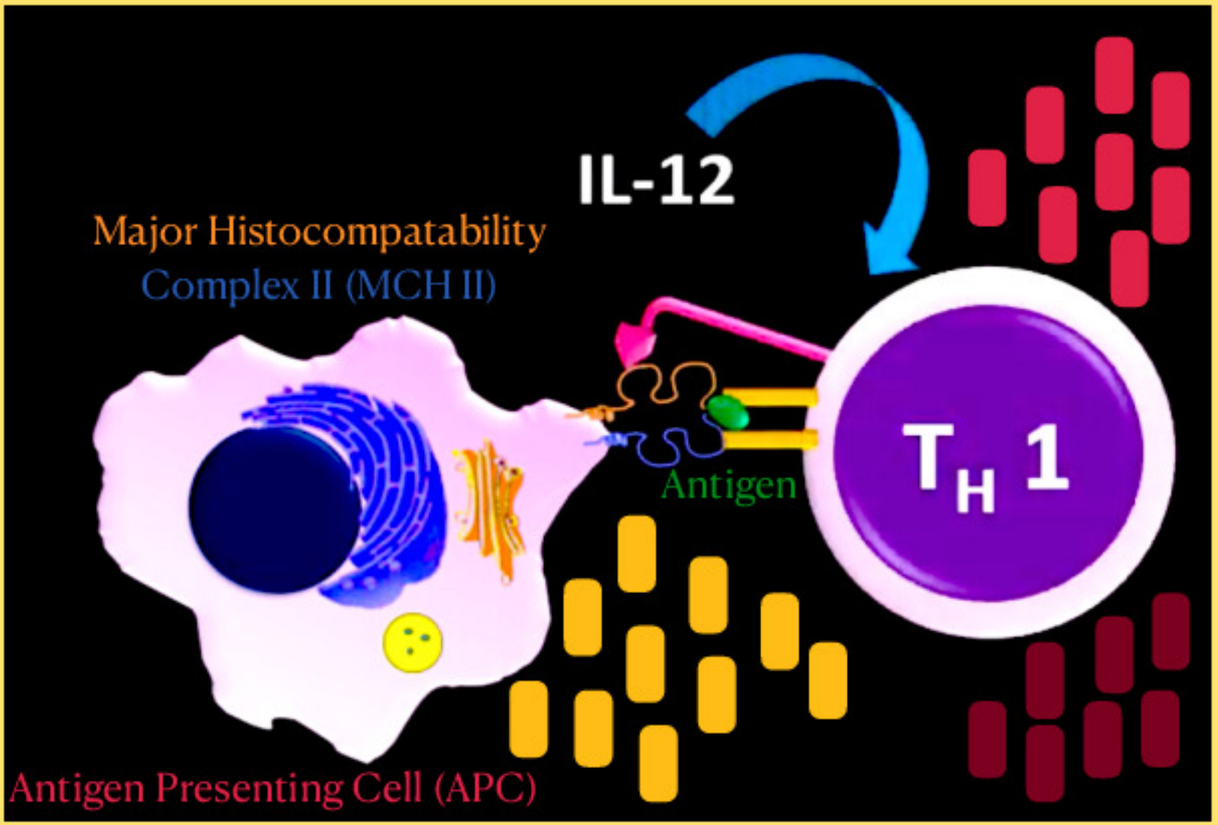

IFN-γ

TNF-α

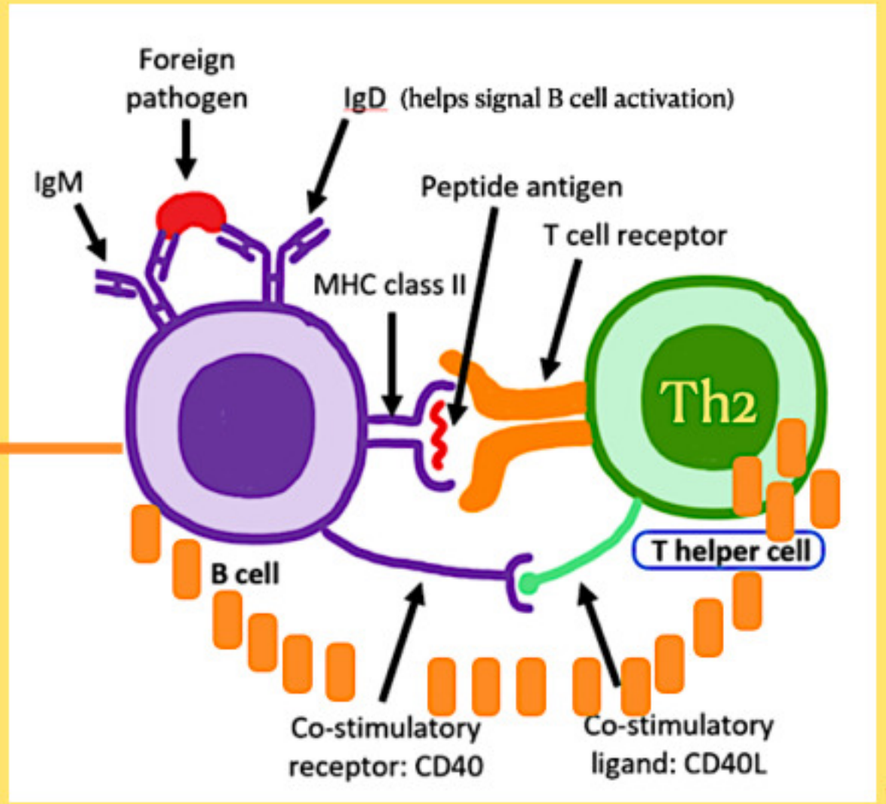
IL-2



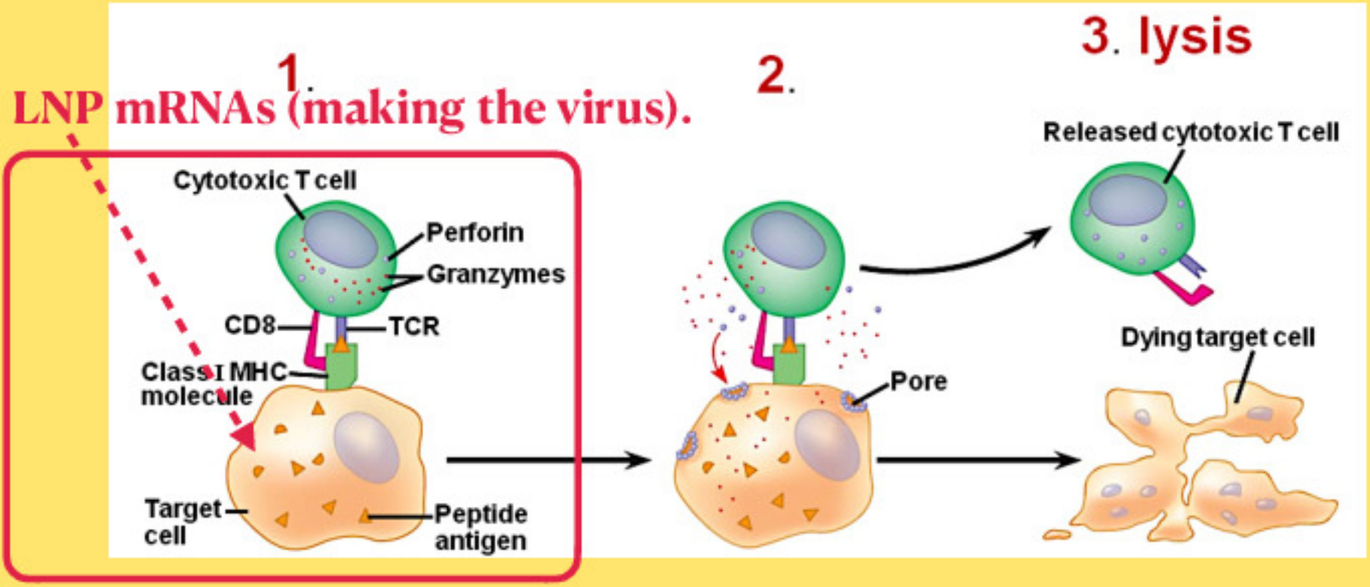

***Unfortunately, we're not trying to elicit a MHC II to the Adenovirus but to one of the genetic sequences of the Spike Protein. Similarly, the Novavax spike proteins are made by Moth Cells, nano-particles and Saponification material from plants to elicit immune response. The questions is to what? The soap, moth proteins, what exactly.**

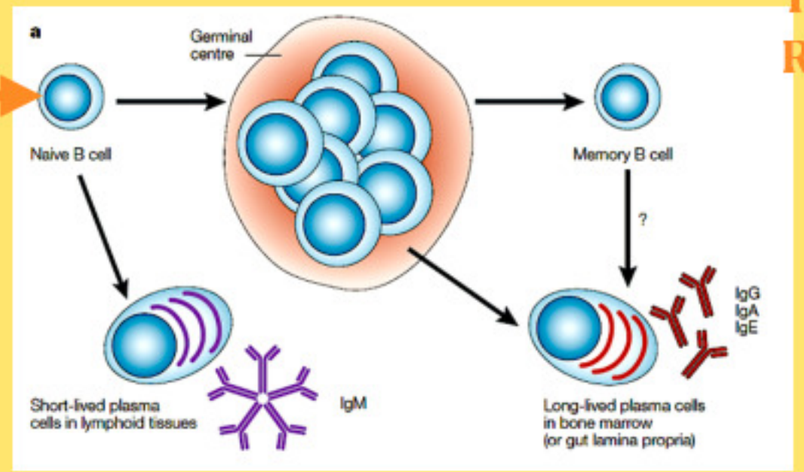



IFN-γ TNF-α IL-2 IL-4




IL-4 Critical for best Humoral Response

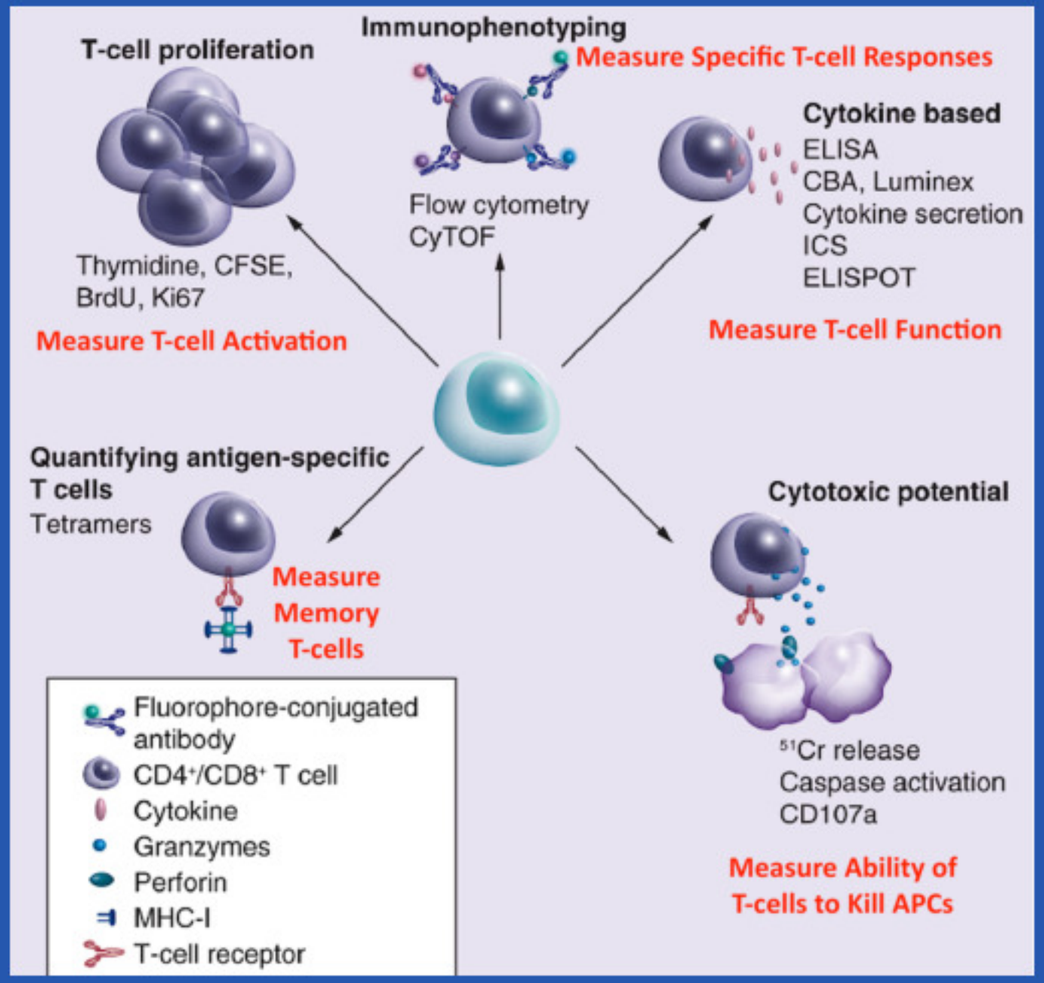


# How do we Know if an Immune Response Has Actually Occurred? We Measure It!

- The important distinction between Immunity & Disease.
- Is there a measureable immune response to the vaccine?
  - T-cell (cells and cytokines) and
  - B-cell (antibody) responses.

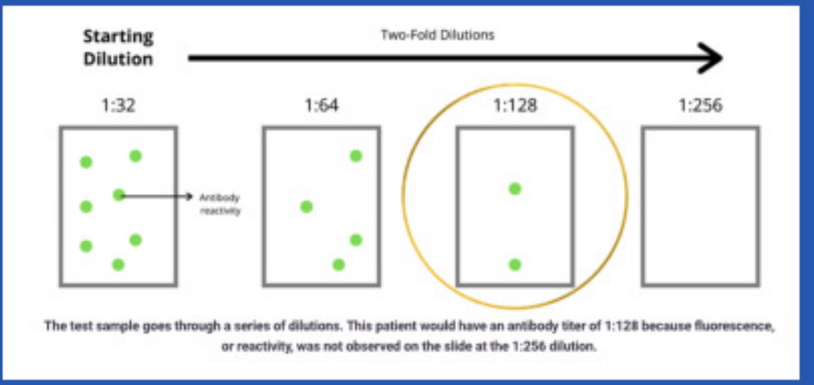
## Measuring T-cell Response:




## Measuring B-cell Response - Antibody Titers:

Blood is taken from someone and serially (1:2, 1:4, 1:8, etc.) diluted.

If the blood has antibodies (Abs) there will be measureable precipitation when the viral antigen (Ag) is added.



# Specific Concerns with SARS Drug Vaccines

# How do we Know What's Happening at the Tissue Level? We Measure It! Either Using FMTVDM (FlemingMethod) or Taking Tissue.

**In this study, mice showed life threatening allergic (eosinophil) Th2 Immunopathology responses when vaccinated mice were later exposed to the actual SARS-CoV-1 virus.**

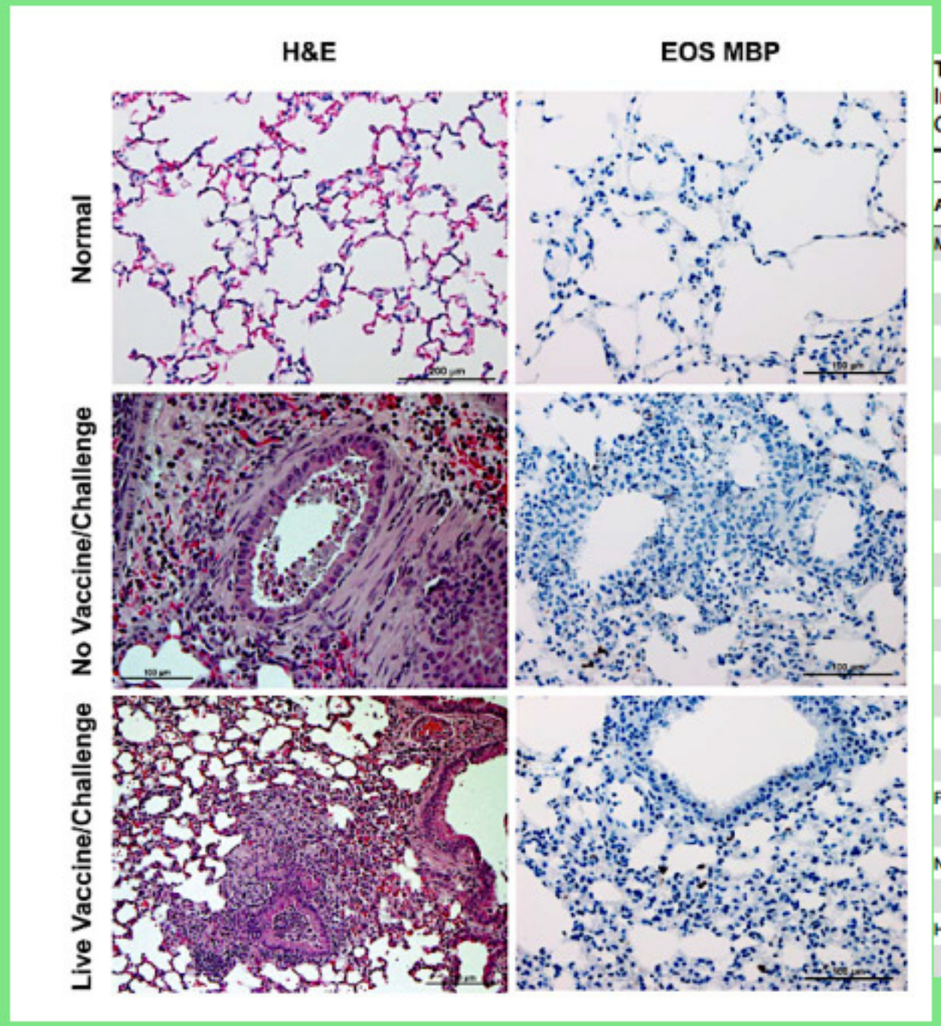
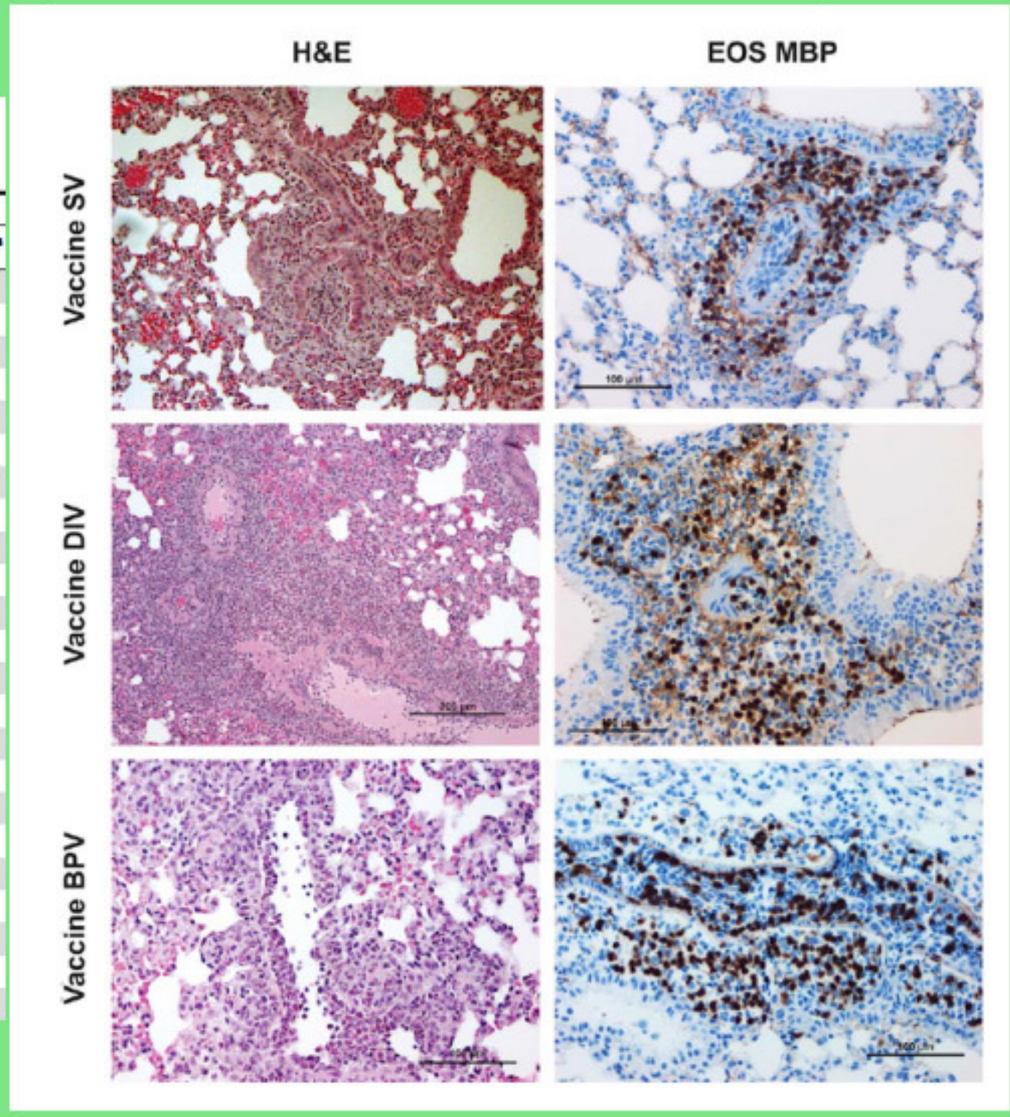



**Table 2.** Summary of Reported Protection and Immunopathology in Animal Model Studies with SARS Coronavirus Vaccines.

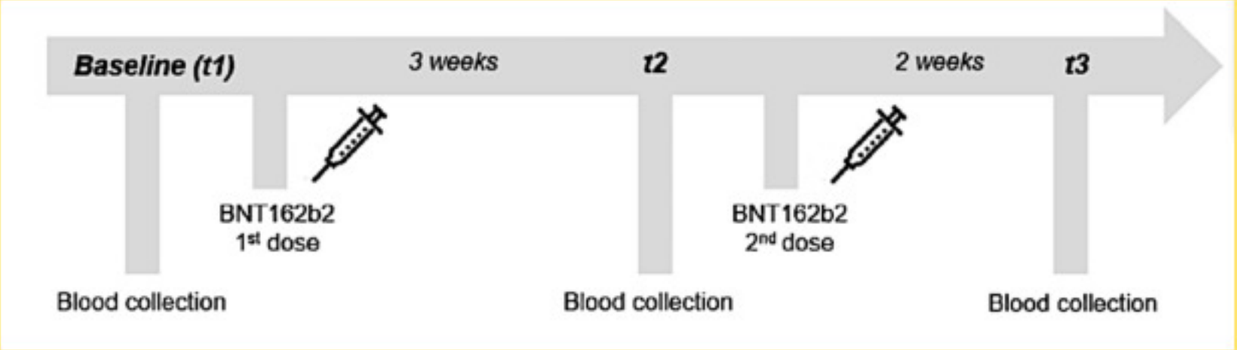
| Animal Model | Vaccine[1] | Protection[2] | Immunopathology[3] |
|---|---|---|---|
| Mice | Whole virus[tr] | | |
| | w alum | Yes | Yes |
| | Whole virus[25,tr] | | |
| | w alum | Yes | Yes |
| | wo alum | Yes | Yes |
| | VLP[17,tr] | | |
| | w alum | Yes | Yes |
| | wo alum | Yes | Yes |
| | S Protein[tr] | | |
| | w alum | Yes | Yes |
| | wo alum | Yes | Yes |
| | VEE Vector[15] | | |
| | for N protein | No | Yes |
| | for S protein | Yes | No |
| | Vaccinia vector[18] | | |
| | for N protein | No | Yes |
| | for S protein | Yes | ?No |
| Ferrets | Whole virus[11] | | |
| | w alum | Yes | Yes |
| Nonhuman Primate[4] | Whole virus[11] | | |
| | w alum | Yes | Yes |
| Hamsters | Whole virus[22] | | |
| | w ASO1 | Yes | No |



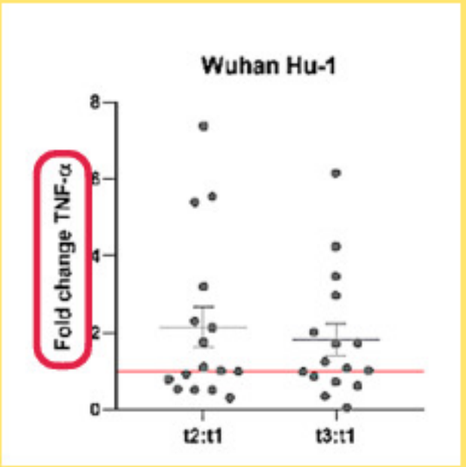

Tseng C-T, et al. Immunization with SARS Coronavirus Vaccines Leads to Pulmonary Immunopathology on Challenge with the SARS Virus. PLoS One 2012;7(4):e35421

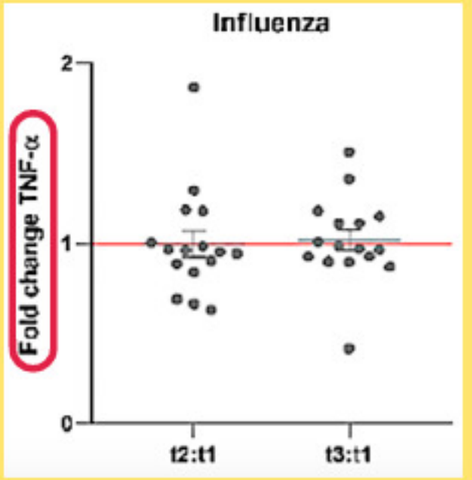
# Vaccine Reprogramming

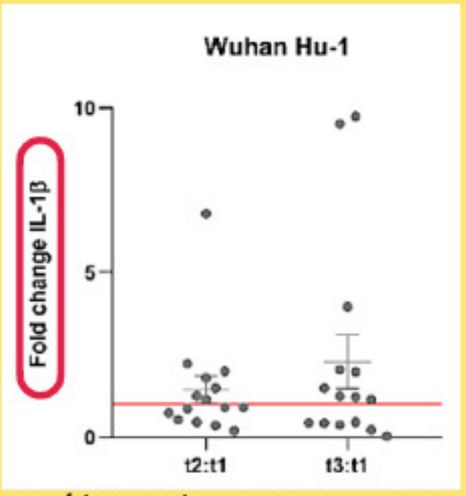
## of Innate Immune Response

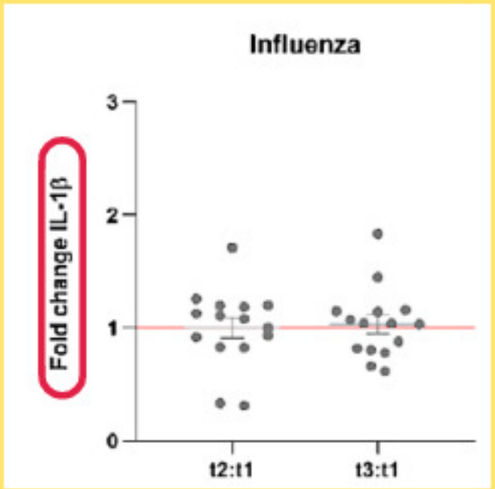



- Evidence suggests these vaccines can alter our **innate** immune response, actually producing tolerance to vaccines and infections.
- This study showed that the Pfizer Vaccine altered the **innate immune response,** producing "**vaccine interference**"& the potential for these vaccinated people to respond poorly to other vaccines (e.g. Influenza).



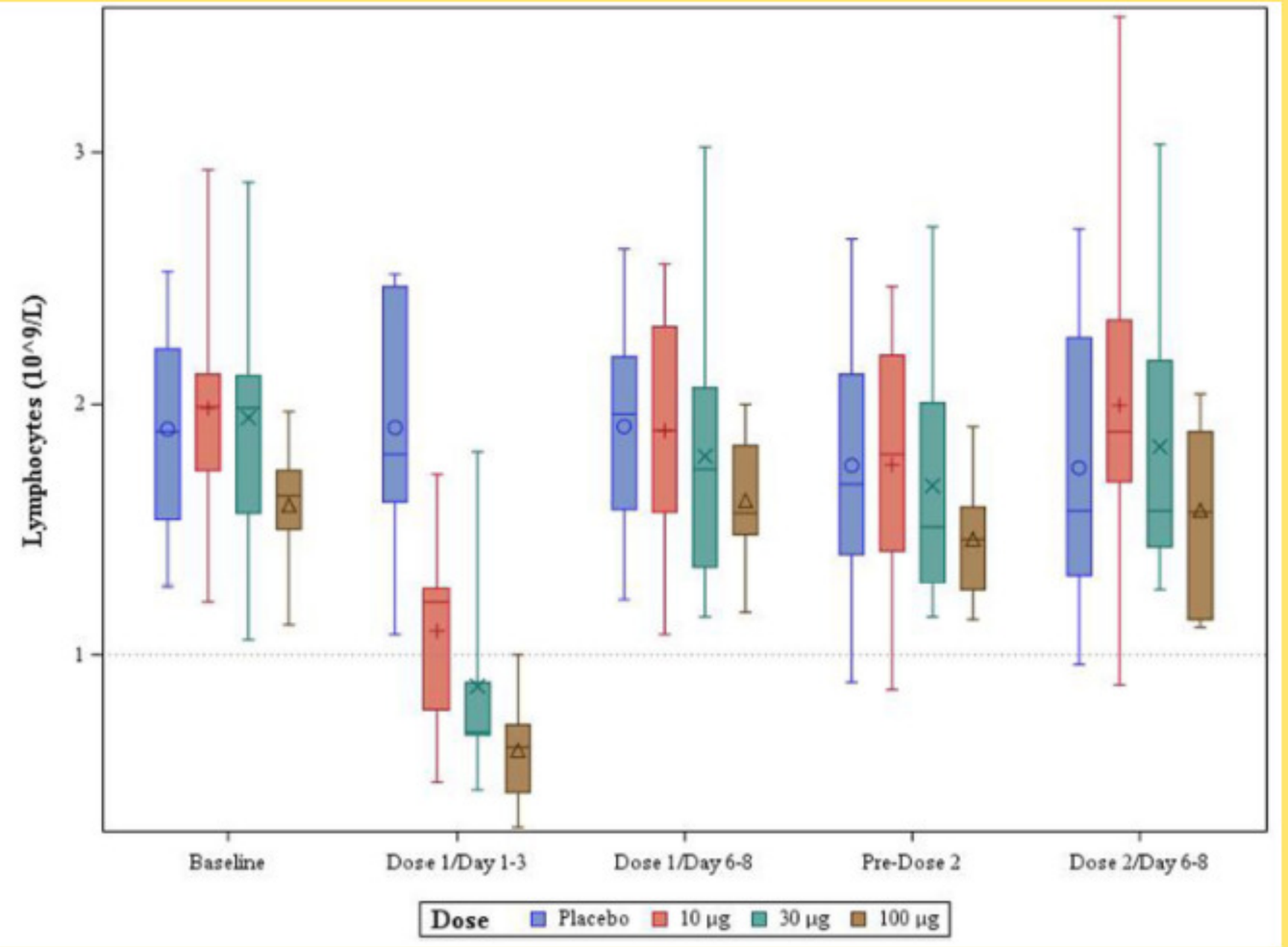

Föhse, FK, et al. The BNT162b2 mRNA vaccine against SARS-CoV-2 reprograms both adaptive and innate immune responses. doi: https://doi.org/10.1101/2021.05.03.21256520

# Pfizer Vaccine Reduced Innate T-Cell (Lymphocyte) Response

76 Healthy individuals were given one of three doses of Pfizer LNP mRNA drug vaccine biologic.

Lymphocyte (T-cell) counts actually decreased following vaccination.

This was most pronounced during the initial vaccination.




Mulligan MJ, el al. Phase I/II study of COVID-19 RNA vaccine BNT162b1 in adults. Nature 2020;586:589-593.

# T-cell Responses After

## Moderna mRNA-1273

24 Rhesus Macques revealed **low or undetectable Th2** or CD8+ Cytotoxic T-cells following vaccination.

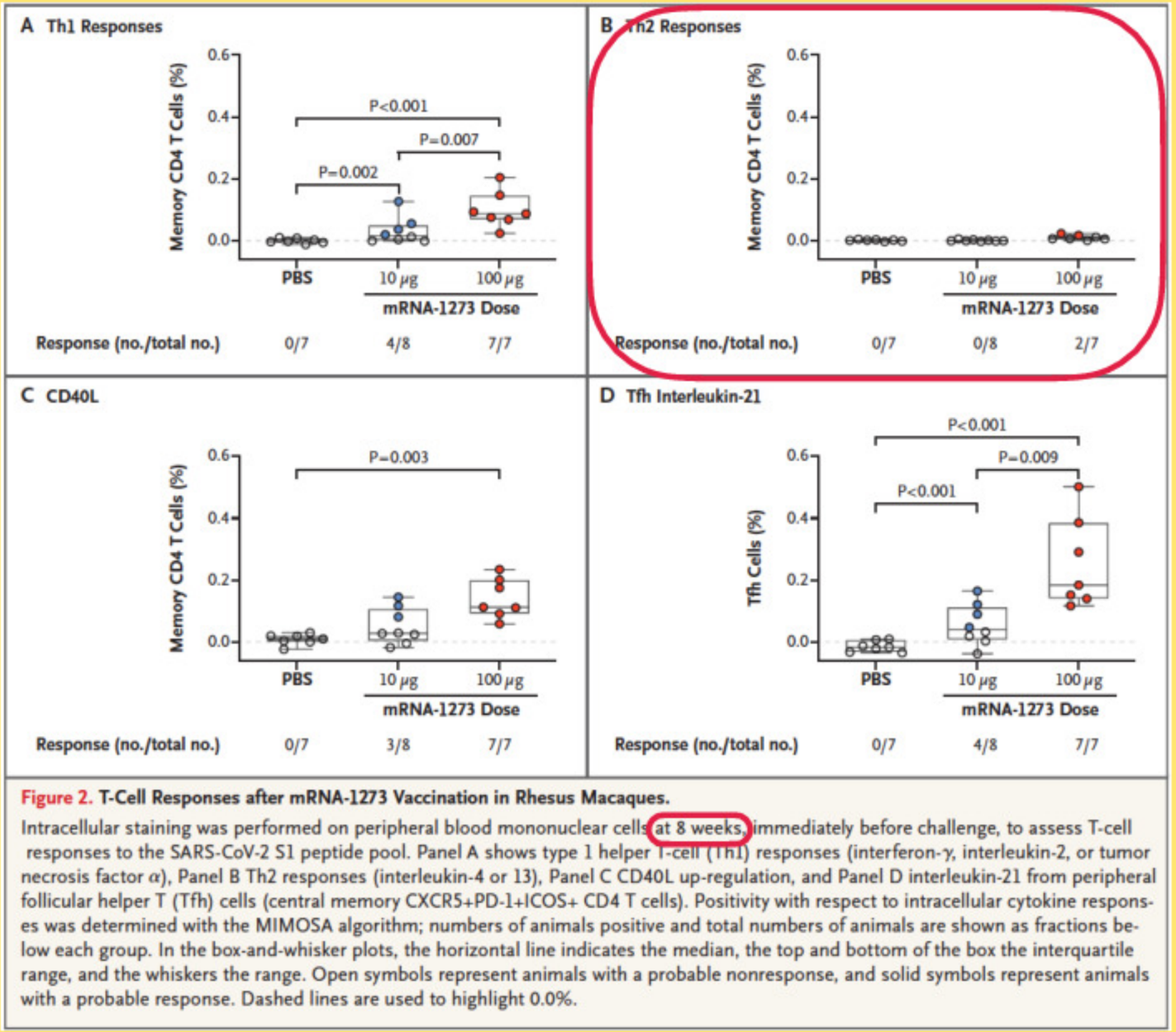


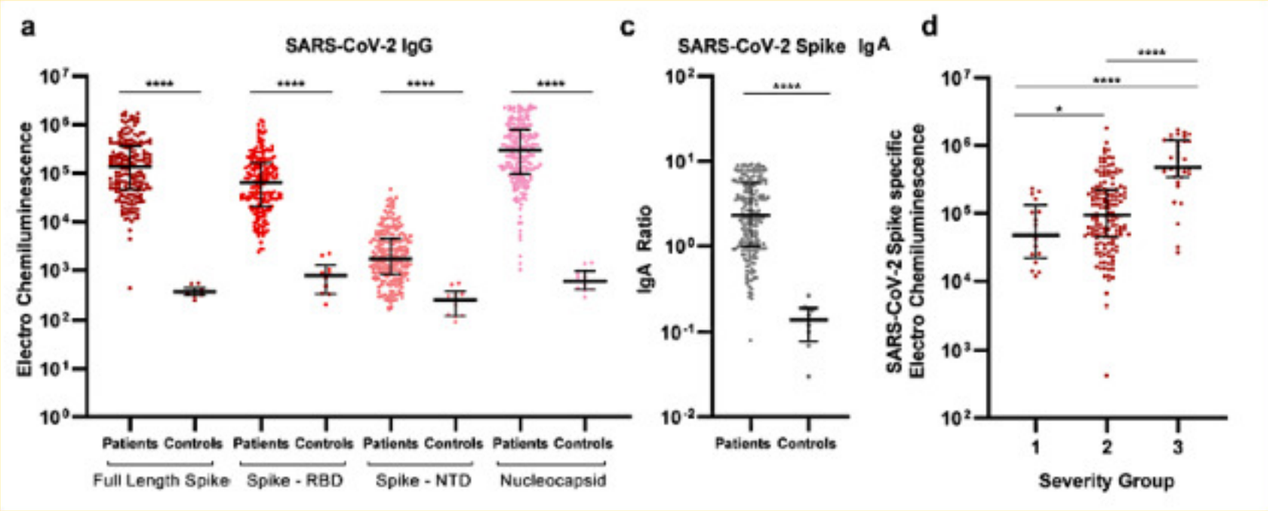

**Figure 2. T-Cell Responses after mRNA-1273 Vaccination in Rhesus Macaques.**

Intracellular staining was performed on peripheral blood mononuclear cells at 8 weeks, immediately before challenge, to assess T-cell responses to the SARS-CoV-2 S1 peptide pool. Panel A shows type 1 helper T-cell (Th1) responses (interferon-γ, interleukin-2, or tumor necrosis factor α), Panel B Th2 responses (interleukin-4 or 13), Panel C CD40L up-regulation, and Panel D interleukin-21 from peripheral follicular helper T (Tfh) cells (central memory CXCR5+PD-1+ICOS+ CD4 T cells). Positivity with respect to intracellular cytokine responses was determined with the MIMOSA algorithm; numbers of animals positive and total numbers of animals are shown as fractions below each group. In the box-and-whisker plots, the horizontal line indicates the median, the top and bottom of the box the interquartile range, and the whiskers the range. Open symbols represent animals with a probable nonresponse, and solid symbols represent animals with a probable response. Dashed lines are used to highlight 0.0%.

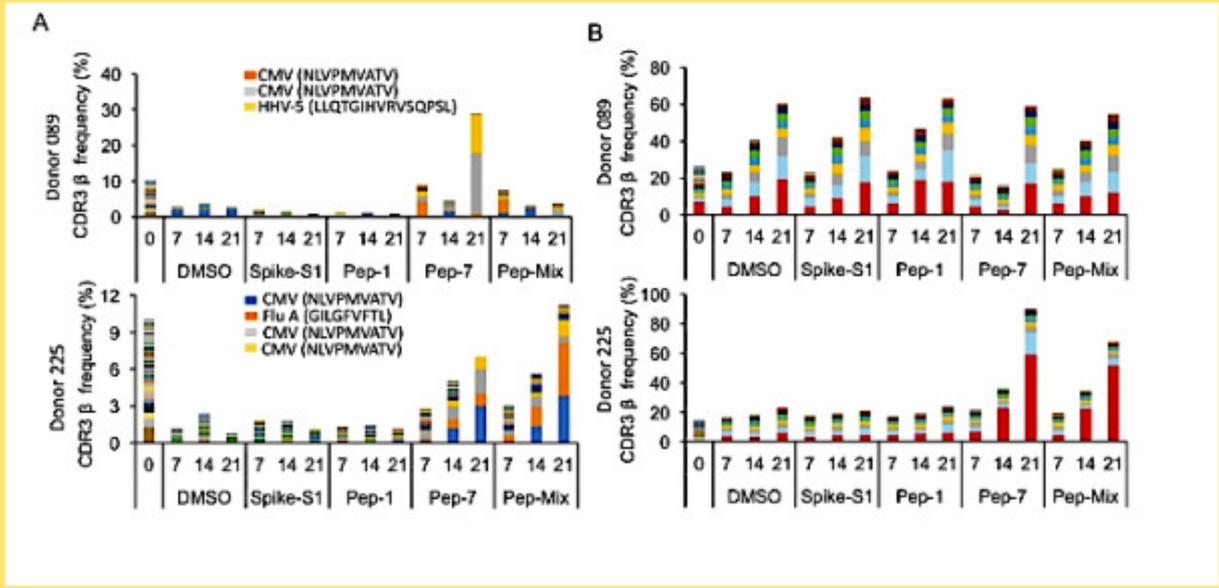
Corbett K.S., et al. Evaluation of the mRNA-1273 Vaccine against SARS-CoV-2 in Nonhuman Primates. N Engl J Med

# Robust Natural Immunity to SARS-CoV-2 Independent of the Severity of Infection & Immunity In People Who Have Had Other Viral Infections.

*Both IgG & IgA antibodies produced in patients exposed to SARS-CoV-2 independent of severity of infection.




**Pre-existing T-cell [T-cell receptor (TCR)] immunity to SARS-CoV-2 found in people who previously had influenza or cytomegalovirus but who had not been previously exposed to SARS.



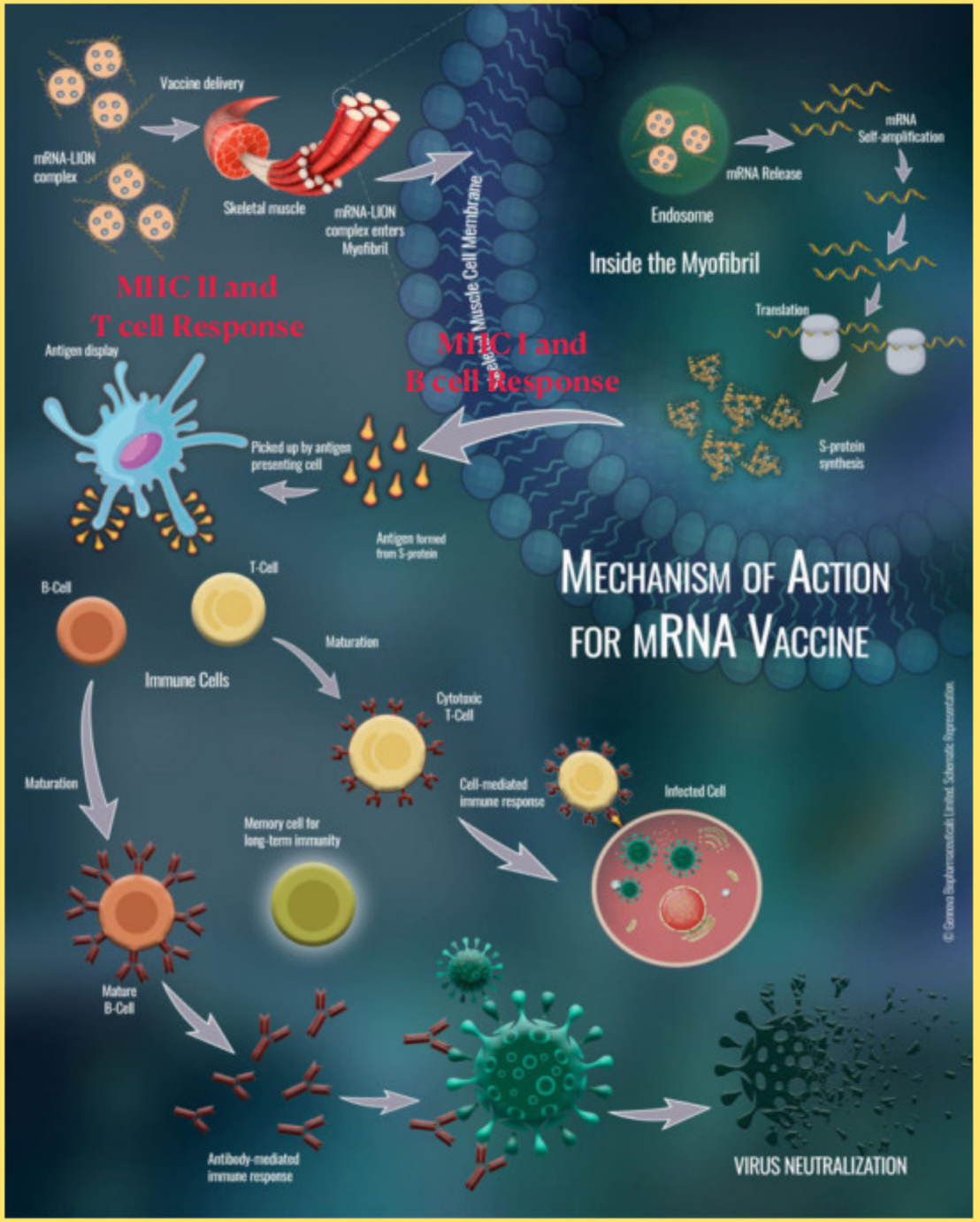


*Nielsen S SF, et al. SARS-CoV-2 elicits robust adaptive immune responses regardless of disease severity. EBioMedicine 2021;68. doi:10.1016/j.ebiom.2021.103410.

**Mahajan S, et al. Immunodominant T-cell epitopes from the SARS-CoV-2 spike antigen reveal robust pre-existing T-cell immunity in unexposed individuals. Scientific Reports 2021;11:13164. doi.org/10.1038/s41598-021-92521-4

# Some Basic Concerns with the New Drug Vaccine Biologics.

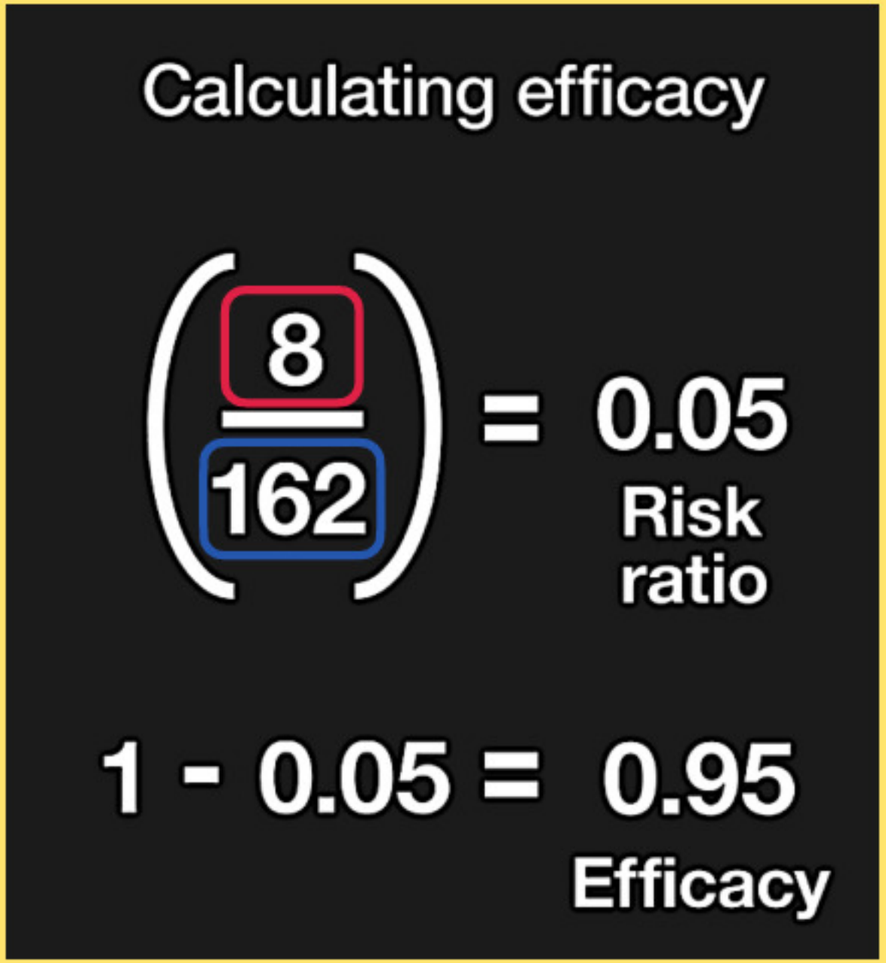
- 1) As already seen, the Chinese were able to create an effective SARS-CoV-1 vaccine that was produced using attenuated virus.
- 2) The spike proteins of Pfizer and Moderna do NOT ACTUALLY match the spike protein of SARS-CoV-2 Wuhan Hu-1 Virus.
- 3) Self Ampliyfying mRNA and Transmissible Vaccines have been undergoing testing for several years and yet they are NOT being discussed even though it is clear that this testing includes SARS-CoV-2.
- 4) The misinformation that these vaccines stay at the site of injection & that their very mechanisms of action, using either mRNA or dsDNA gene sequences, either circumvent the Innate Immune Response or provide misinformation (adenovirus) to the Innate Immune Response thereby either causing a MHC I B-cell response (cell made) **first & then** the MHC II T-cell Innate Component (foreign invader); OR by substituting the outer Adenovirus, causing at least a partial INNATE Immune Response to the Adenovirus instead of SARS-CoV-2 membrane, envelope, etc.
  - This INNATE IMMUNE response is critical for BOTH
  - T-cell immunity, and subsequent Th2 IL-4 release essential for increasing
  - B-cell proliferation, differentiation and antibody production.
- 5) The EUAs show no statistical reduction in COVID cases or deaths, but VAERS has shown a significant number of Adverse Events including death.
- 6) Finally, the Mass Vaccination program focusing on a single type of spike protein which does not even match the SARS-CoV-2 Wuahn Hu-1 Viral Spike protein has resulted in **pressure selection** of variants including Delta, Kappa, Iota, and others.



# What Does Vaccine Efficacy (RRR) Really Mean?

**Vaccine Efficacy** is 1 minus the Risk Ratio (x 100 for %).

**Risk Ratio**: The number of people diagnosed with COVID after receiving the Vaccine ÷ The number of people diagnosed with COVID who weren't vaccinated.



# Do The Vaccines Reduce Your Risk of COVID

| **Relative Risk Reduction (RRR/RR)** | **Absolute Risk Reduction (ARR)** | **Number Needed to Vaccinate** (NNV) = **1 ÷ ARR** |
|---|---|---|
| The **relative** decrease in being diagnosed with COVID between those vaccinated and those not. | The **actual** difference between those two groups - vaccinated vs non-vaccinated. | The number of people you need to vaccinate to prevent 1-person from being diagnosed with COVID. |

# So How Did They Decide Who Has COVID?

Diagnosing COVID-19 in Vaccine Trials = **PCR(+)** & **Symptomatic**.

## Pfizer

For the primary efficacy endpoint, the case definition for a confirmed COVID-19 case was the presence of at least one of the following symptoms and a positive SARS-CoV-2 NAAT within 4 days of the symptomatic period:

- Fever;
- New or increased cough;
- New or increased shortness of breath;
- Chills;
- New or increased muscle pain;
- New loss of taste or smell;
- Sore throat;
- Diarrhea;
- Vomiting.

For a secondary efficacy endpoint, a second definition, which may be updated as more is learned about COVID-19, included the following additional symptoms defined by CDC (listed at https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html):

- Fatigue;
- Headache;
- Nasal congestion or runny nose;
- Nausea.

For another secondary endpoint, the case definition for a severe COVID-19 case was a confirmed COVID-19 case with at least one of the following:

- Clinical signs at rest indicative of severe systemic illness (RR ≥30 breaths per minute, HR ≥125 beats per minute, SpO2 ≤93% on room air at sea level, or PaO2/FiO2 <300 mm Hg);
- Respiratory failure (defined as needing high-flow oxygen, noninvasive ventilation, mechanical ventilation, or ECMO);
- Evidence of shock (SBP <90 mm Hg, DBP <60 mm Hg, or requiring vasopressors)
- Significant acute renal, hepatic, or neurologic dysfunction;
- Admission to an ICU;
- Death.

## Moderna

**Primary Efficacy Endpoint**

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 (i.e., negative RT-PCR and negative serology against SARS-CoV-2 nucleocapsid on Day 1). The primary analysis was based on the Per-Protocol Set, defined as all randomized, baseline SARS-CoV-2 negative participants who received planned doses per schedule and have no major protocol deviations. 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 (≥38°C), 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.

**Secondary Efficacy Endpoints**

Secondary endpoints based on the Per-Protocol Set included the VE of mRNA-1273 to prevent the following:

- Severe COVID-19 (as defined below)
- COVID-19 based on a less restrictive definition of disease (defined below) occurring at least 14 days after the second dose of vaccine
- Death due to COVID-19
- COVID-19 occurring at least 14 days after the first dose of vaccine (including cases that occurred after the second dose)

One additional secondary endpoint was based on the Full Analysis Set (FAS): VE of mRNA-1273 to prevent COVID-19 occurring at least 14 days after the second dose, regardless of prior SARS-CoV-2 infection.

One of the secondary efficacy endpoints assessed COVID-19 as defined by a less restrictive definition: a positive NP swab, nasal swab, or saliva sample (or respiratory sample, if hospitalized) for SARS-CoV-2 by RT-PCR **and** one of the following systemic symptoms:

- fever (temperature ≥38°C), or
- chills,
- cough,
- shortness of breath or difficulty breathing,
- fatigue,
- muscle aches or body aches,
- headache,
- new loss of taste or smell,
- sore throat,
- nasal congestion or rhinorrhea,
- nausea or vomiting, or diarrhea

Another secondary endpoint assessed cases of severe COVID-19, defined as a case of confirmed COVID-19 plus at least one of the following:

- Clinical signs at rest indicative of severe systemic illness (RR ≥30 breaths per minute, HR ≥125 beats per minute, SpO2≤93% on room air at sea level, or PaO2/FiO2<300 mm Hg);
- Respiratory failure or Acute Respiratory Distress Syndrome, (defined as needing high-flow oxygen, noninvasive ventilation, mechanical ventilation, or ECMO);
- Evidence of shock (SBP <90 mm Hg, DBP <60 mm Hg, or requiring vasopressors)
- Significant acute renal, hepatic, or neurologic dysfunction;
- Admission to an ICU;
- Death

## Janssen (J&J)

| Moderate COVID-19 | Severe/Critical COVID-19 |
|---|---|
| **Any 1 of the following new or worsening signs or symptoms:**<br>• Respiratory rate ≥20 breaths/minute<br>• Abnormal saturation of oxygen ($SpO_2$) but still >93% on room air at sea level<br>• Clinical or radiologic evidence of pneumonia<br>• Radiologic evidence of deep vein thrombosis<br>• Shortness of breath or difficulty breathing<br><br>OR<br><br>**Any 2 of the following new or worsening signs or symptoms:**<br>• Fever (≥38.0°C or ≥100.4°F)<br>• Heart rate ≥90 beats/minute<br>• Shaking chills or rigors<br>• Sore throat<br>• Cough<br>• Malaise as evidenced by loss of appetite, fatigue, physical weakness, and/or feeling unwell<br>• Headache<br>• Muscle pain (myalgia)<br>• Gastrointestinal symptoms (diarrhea, vomiting, nausea, abdominal pain)<br>• New or changing olfactory or taste disorders<br>• Red or bruised looking feet or toes | **Any one of the following at any time during the course of observation:**<br>• Clinical signs at rest indicative of severe systemic illness (respiratory rate ≥30 breaths/minute, heart rate ≥125 beats/minute, oxygen saturation ($SpO_2$) ≤93% on room air at sea level, or partial pressure of oxygen/fraction of inspired oxygen ($PaO_2/FiO_2$) <300 mmHg)<br>• Respiratory failure (defined as needing high-flow oxygen, non-invasive ventilation, mechanical ventilation, or extracorporeal membrane oxygenation [ECMO])<br>• Evidence of shock (defined as systolic blood pressure <90 mmHg, diastolic blood pressure <60 mmHg, or requiring vasopressors)<br>• Significant acute renal, hepatic, or neurologic dysfunction<br>• Admission to the ICU<br>• Death |

*Kary Mullis & PCR

# Let's Look at Pfizer Vaccine Efficacy

The calculated Vaccine Efficacy was 95%. Page 24 of EUA.

**Table 6. Final Analysis of Efficacy of BNT162b2 Against Confirmed COVID-19 From 7 Days After Dose 2 in Participants Without Evidence of Prior SARS-CoV-2 Infection - Evaluable Efficacy Population**

| Pre-specified Age Group | BNT162b2 N[a] = 18198 Cases n1[b] Surveillance Time[c] (n2[d]) | Placebo N[a] =18325 Cases n1[b] Surveillance Time[c] (n2[d]) | Vaccine Efficacy % (95% CI) | Met Predefined Success Criterion* |
|---|---|---|---|---|
| All participants | 8<br>2.214 (17411) | 162<br>2.222 (17511) | 95.0<br>(90.3, 97.6)[e] | Yes |
| 16 to 55 years | 5<br>1.234 (9897) | 114<br>1.239 (9955) | 95.6<br>(89.4, 98.6)[f] | NA |
| > 55 years and older | 3<br>0.980 (7500) | 48<br>0.983 (7543) | 93.7<br>(80.6, 98.8)[f] | NA |

*Success criterion: the posterior probability that true vaccine efficacy > 30% conditioning on the available data is >99.5% at the final analysis

[a] N = number of participants in the specified group.

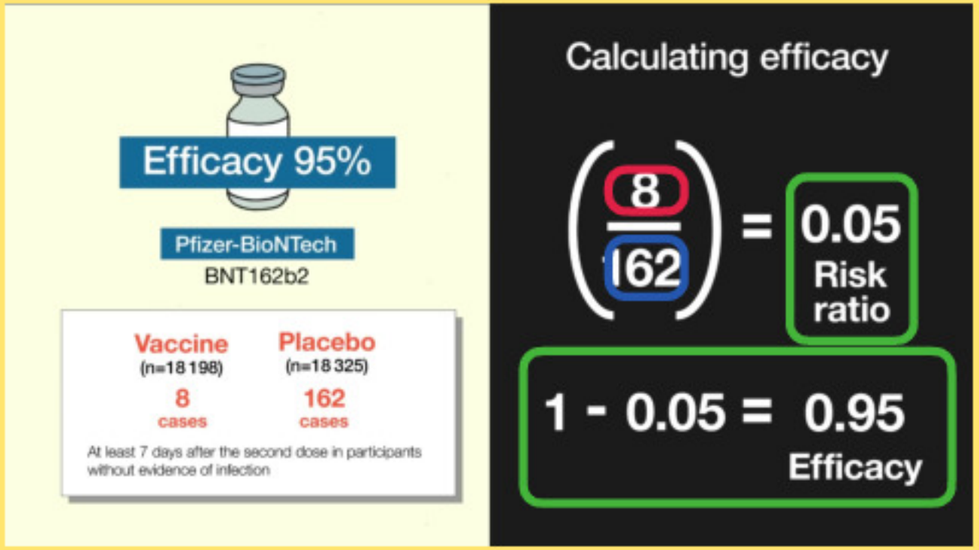
[b] n1 = Number of participants meeting the endpoint definition.

[c] Total surveillance time in 1000 person-years for the given endpoint across all participants within each group at risk for the endpoint. Time period for COVID-19 case accrual is from 7 days after Dose 2 to the end of the surveillance period.

[d] n2 = Number of participants at risk for the endpoint.

[e] Credible interval for VE was calculated using a beta-binomial model with prior beta (0.700102, 1) adjusted for surveillance time.

[f] Confidence interval (CI) for VE is derived based on the Clopper and Pearson method adjusted to the surveillance time.



# Does the Pfizer Vaccine Prevent COVID?

## The EUA Document Results Comparing Vaccinated with Non-Vaccinated Individuals

7 Days after 2nd Injection there were fewer cases of COVID but The Difference in the number of cases wasn't statistically significant. *p=NS*

**Table 6. Final Analysis of Efficacy of BNT162b2 Against Confirmed COVID-19 From 7 Days After Dose 2 in Participants Without Evidence of Prior SARS-CoV-2 Infection - Evaluable Efficacy Population**

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[a] N = number of participants in the specified group.

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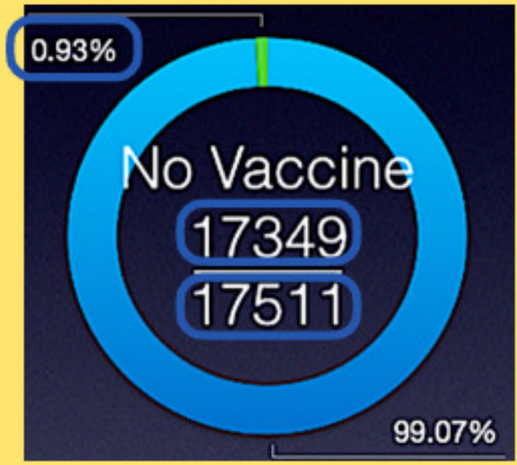
[f] Confidence interval (CI) for VE is derived based on the Clopper and Pearson method adjusted to the surveillance time.


| | Observed | Expected | Marginal Row Totals |
|---|---|---|---|
| Pfizer | 17403 (17326.25) [0.34] | 17249 (17325.75) [0.34] | 34652 |
| Nothing | 17349 (17425.75) [0.34] | 17502 (17425.25) [0.34] | 34851 |
| *Marginal Column Totals* | 34752 | 34751 | 69503 (Grand Total) |

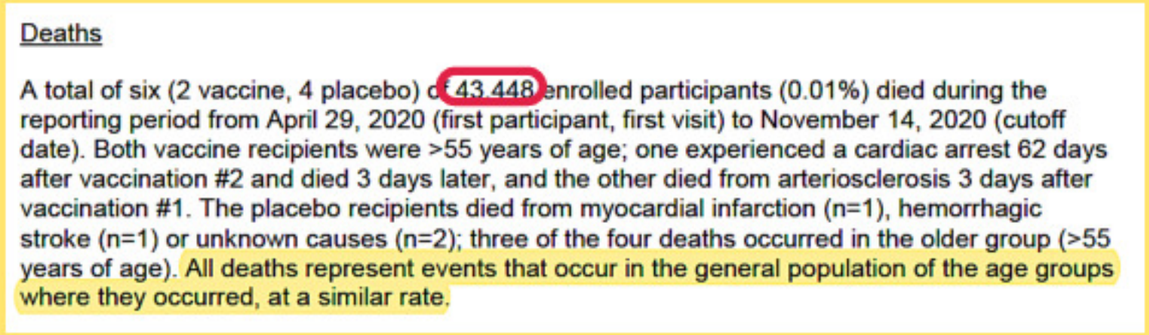
The chi-square statistic is 1.3561. The *p*-value is .244218. *Not* significant at $p < .05$.

The chi-square statistic with Yates correction is 1.3385. The *p*-value is .247304. *Not* significant at $p < .05$.

Absolute Risk Reduction (ARR) = 0.93% minus 0.05% = 0.88%

# Did the Pfizer Vaccine Reduce COVID Deaths?

Going to the Pfizer EUA Documents (page 41)
Where We Find this Information.



Deaths

A total of six (2 vaccine, 4 placebo) of 43,448 enrolled participants (0.01%) died during the reporting period from April 29, 2020 (first participant, first visit) to November 14, 2020 (cutoff date). Both vaccine recipients were >55 years of age; one experienced a cardiac arrest 62 days after vaccination #2 and died 3 days later, and the other died from arteriosclerosis 3 days after vaccination #1. The placebo recipients died from myocardial infarction (n=1), hemorrhagic stroke (n=1) or unknown causes (n=2); three of the four deaths occurred in the older group (>55 years of age). All deaths represent events that occur in the general population of the age groups where they occurred, at a similar rate.

| Issue | Pfizer | No Vaccine |
|---|---|---|
| Death | 2 of 21621 (0.0%) | 4 of 21631 (0.0%) |
| MI | | 1 |
| Cardiac arrest | 1 | |
| ASCAD | 1 | |
| Hemorrhagic CVS | | 1 |
| Unknown | | 2 |

**There is no statistically significant difference in the numbers of deaths and they represent what is seen in the general population.**

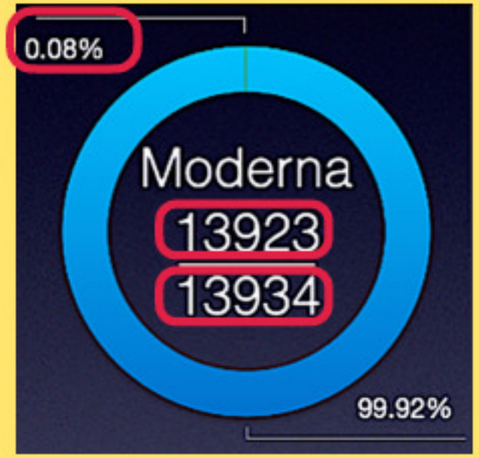
# Does the Moderna Vaccine Prevent COVID?

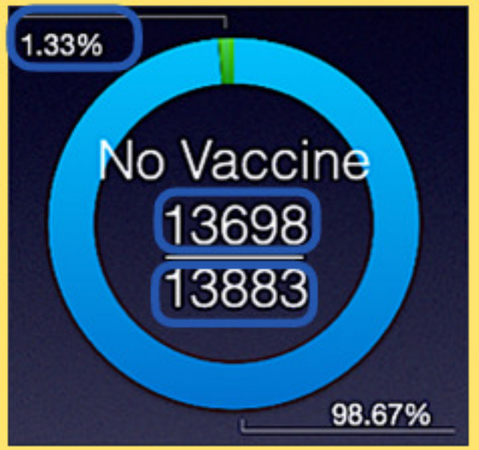
## The EUA Document Results Comparing Vaccinated with Non-Vaccinated Individuals

14 Days after 2nd Injection there were fewer cases of COVID but The Difference in the number of cases wasn't statistically significant. *p=NS*

**Table 17. Final Scheduled Efficacy Analysis, Primary Endpoint, COVID-19 Starting 14 Days After the Second Dose per Adjudication Committee Assessments, Per-Protocol Set**

| Primary Endpoint: COVID-19 (per adjudication committee assessment) | Vaccine Group N=13934 Cases n (%) (Incidence Rate per 1,000 person-years)* | Placebo Group N=13883 Cases n (%) (Incidence Rate per 1,000 person-years)* | Vaccine Efficacy (VE) % (95% CI)** | Met Predefined Success Criterion*** |
|---|---|---|---|---|
| All participants | 11 (<0.1) 3.328 | 185 (1.3) 56.510 | 94.1% (89.3%, 96.8%) | Yes |
| 18 to <65 years[1] | 7/10551 (<0.1) 2.875 | 156/10521 (1.5) 64.625 | 95.6%; (90.6%, 97.9%) | NA |
| 65 years and older[2] | 4/3583 (0.1); 4.595 | 29/3552 (0.8); 33.728 | 86.4%; (61.4%, 95.5%) | NA |




| | Observed | Expected | Marginal Row Totals |
|---|---|---|---|
| Moderna | 13923 (13836) [0.55] | 13749 (13836) [0.55] | 27672 |
| Nothing | 13698 (13785) [0.55] | 13872 (13785) [0.55] | 27570 |
| *Marginal Column Totals* | 27621 | 27621 | 55242 (Grand Total) |

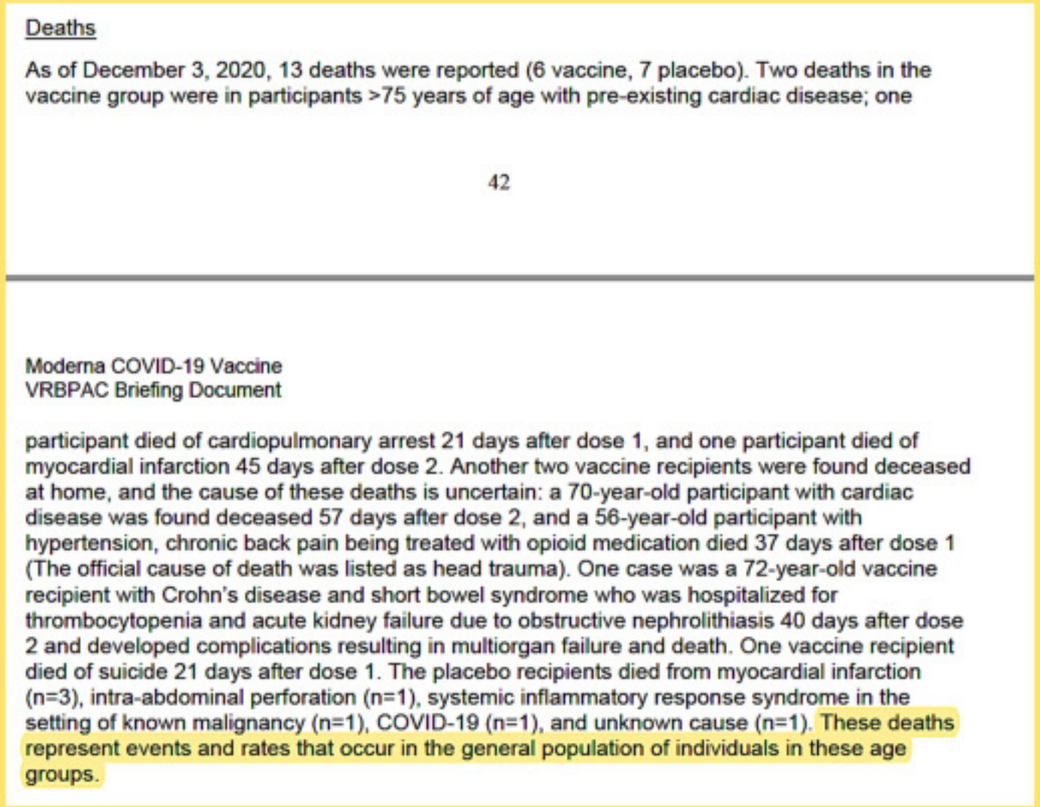
The chi-square statistic is 2.1923. The *p*-value is .138706. *Not* significant at $p < .05$.

The chi-square statistic with Yates correction is 2.1671. The *p*-value is .140989. *Not* significant at $p < .05$.

Absolute Risk Reduction (ARR) = 1.33% minus 0.08% = 1.25%

# Did the Moderna Vaccine Reduce COVID Deaths?

Going to the Moderna EUA Documents (pages 42-43) We Find this Information.



Deaths

As of December 3, 2020, 13 deaths were reported (6 vaccine, 7 placebo). Two deaths in the vaccine group were in participants >75 years of age with pre-existing cardiac disease; one

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Moderna COVID-19 Vaccine
VRBPAC Briefing Document

participant died of cardiopulmonary arrest 21 days after dose 1, and one participant died of myocardial infarction 45 days after dose 2. Another two vaccine recipients were found deceased at home, and the cause of these deaths is uncertain: a 70-year-old participant with cardiac disease was found deceased 57 days after dose 2, and a 56-year-old participant with hypertension, chronic back pain being treated with opioid medication died 37 days after dose 1 (The official cause of death was listed as head trauma). One case was a 72-year-old vaccine recipient with Crohn's disease and short bowel syndrome who was hospitalized for thrombocytopenia and acute kidney failure due to obstructive nephrolithiasis 40 days after dose 2 and developed complications resulting in multiorgan failure and death. One vaccine recipient died of suicide 21 days after dose 1. The placebo recipients died from myocardial infarction (n=3), intra-abdominal perforation (n=1), systemic inflammatory response syndrome in the setting of known malignancy (n=1), COVID-19 (n=1), and unknown cause (n=1). These deaths represent events and rates that occur in the general population of individuals in these age groups.

| Issue | Moderna | No Vaccine |
|---|---|---|
| Death | 6 of 15,184 (0.04%) | 7 of 15,165 (0.05%) |
| MI | 1 | 3 |
| Cardiac arrest | 1 | |
| Thrombocytopenia and Multiorgan failure | 1 | |
| Suicide | 1 | |
| Cancer | | 1 |
| Abdominal Perforation | | 1 |
| Head Trauma | 1 | |
| Unknown | 1 | 1 |

**There is no statistically significant difference in the numbers of deaths and they represent what is seen in the general population.**

# At 14-Days Does the Janssen Vaccine Prevent COVID?

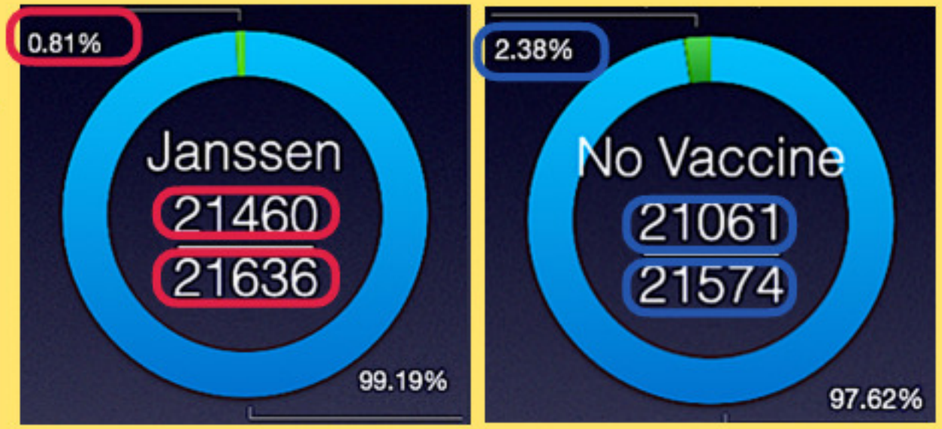
## The EUA Document Results Comparing Vaccinated with Non-Vaccinated Individuals

14 Days after the Injection there were fewer cases of COVID & The Difference in the number of cases was statistically significant. $p \leq 0.05$

**Table 14. Vaccine Efficacy of First Occurrence of Moderate to Severe/Critical COVID-19 Including Non-centrally Confirmed Cases, With Onset at Least 14 or at Least 28 Days After Vaccination, by Baseline SARS-CoV-2 Status[a], Per Protocol Set**

| | Onset at Least 14 Days | | | Onset at Least 28 Days | | |
|---|---|---|---|---|---|---|
| Baseline SARS-CoV-2 Serostatus[a] | Ad26.COV2.S Cases (N) Person-yrs | Placebo Cases (N) Person-yrs | VE% (95% CI) | Ad26.COV2.S Cases (N) Person-yrs | Placebo Cases (N) Person-yrs | VE%[b] (95% CI) |
| Regardless of baseline SARS-CoV-2 status | 176 21636 3450.2 | 513 (21574) 3409.8 | 66.1% (59.7, 71.6) | 114 (21424) 3436.3 | 326 (21199) 3385.9 | 65.5% (57.2, 72.4) |
| Positive | 3 (2122) 336.3 | 4 (2030) 320.8 | 28.5% (-322.8, 89.5) | 1 (2118) 336.1 | 2 (2021) 320.0 | |
| Negative | 173 (19514) 3113.9 | 509 (19544) 3089.1 | 66.3% (59.9, 71.8) | 113 (19306) 3100.3 | 324 (19178) 3065.9 | 65.5% (57.2, 72.4) |

Source: Sponsor tables GEFPE07A, GEFPE07C
N=Total number of participants at risk per category
[a] Based on serological test at baseline
[b] If fewer than 6 cases are observed for an endpoint then the VE is not shown




| | Observed | Expected | Marginal Row Totals |
|---|---|---|---|
| Johnson & Johnson | 21460 (21290.75) [1.35] | 21121 (21290.25) [1.35] | 42581 |
| Nothing | 21061 (21230.25) [1.35] | 21399 (21229.75) [1.35] | 42460 |
| Marginal Column Totals | 42521 | 42520 | 85041 (Grand Total) |

The chi-square statistic is 5.3895. The $p$-value is .020258. Significant at $p < .05$.

The chi-square statistic with Yates correction is 5.3577. The $p$-value is .020631. Significant at $p < .05$.

N.B. On page 6 of the EUA,

Absolute Risk Reduction (ARR) = 2.38% minus 0.81% = 1.57%

# At 28-Days Does the Janssen Vaccine Prevent COVID?

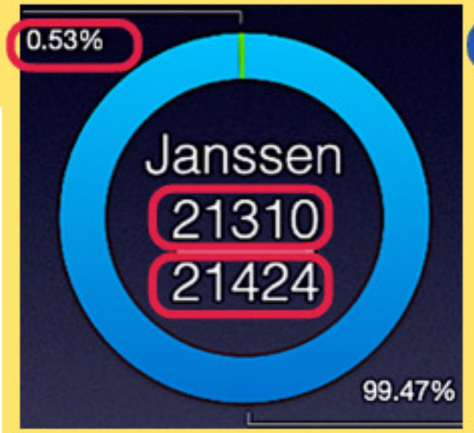
## The EUA Document Results Comparing Vaccinated with Non-Vaccinated Individuals

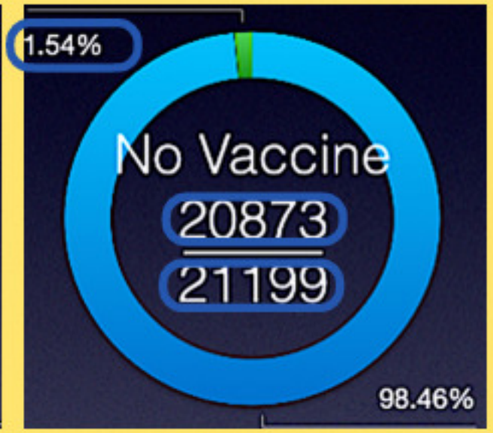
28 Days after the Injection there were fewer cases of COVID but The Difference was NO LONGER statistically significant. *p=NS*

**Table 14. Vaccine Efficacy of First Occurrence of Moderate to Severe/Critical COVID-19 Including Non-centrally Confirmed Cases, With Onset at Least 14 or at Least 28 Days After Vaccination, by Baseline SARS-CoV-2 Status[a], Per Protocol Set**

| | Onset at Least 14 Days | | | Onset at Least 28 Days | | |
|---|---|---|---|---|---|---|
| Baseline SARS-CoV-2 Serostatus[a] | Ad26.COV2.S Cases (N) Person-yrs | Placebo Cases (N) Person-yrs | VE% (95% CI) | Ad26.COV2.S Cases (N) Person-yrs | Placebo Cases (N) Person-yrs | VE%[b] (95% CI) |
| Regardless of baseline SARS-CoV-2 status | 176 (21636) 3450.2 | 513 (21574) 3409.8 | 66.1% (59.7, 71.6) | 114 (21424) 3436.3 | 326 21199 3385.9 | 65.5% (57.2, 72.4) |
| Positive | 3 (2122) 336.3 | 4 (2030) 320.8 | 28.5% (-322.8, 89.5) | 1 (2118) 336.1 | 2 (2021) 320.0 | |
| Negative | 173 (19514) 3113.9 | 509 (19544) 3089.1 | 66.3% (59.9, 71.8) | 113 (19306) 3100.3 | 324 (19178) 3065.9 | 65.5% (57.2, 72.4) |

Source: Sponsor tables GEFPE07A, GEFPE07C
N=Total number of participants at risk per category
[a] Based on serological test at baseline
[b] If fewer than 6 cases are observed for an endpoint then the VE is not shown




| | Observed | Expected | Marginal Row Totals |
|---|---|---|---|
| Johnson & Johnson | 21310 (21202.5) [0.55] | 21094 (21201.5) [0.55] | 42404 |
| Nothing | 20873 (20980.5) [0.55] | 21087 (20979.5) [0.55] | 41960 |
| Marginal Column Totals | 42183 | 42181 | 84364 (Grand Total) |

The chi-square statistic is 2.1916. The *p*-value is .138761 *Not* significant at $p < .05$.

The chi-square statistic with Yates correction is 2.1713. The *p*-value is .140607. *Not* significant at $p < .05$.

Absolute Risk Reduction (ARR) = 1.54% minus 0.53% = 1.01%

# And Finally When we Remove “Mild” COVID Cases.

**Also from page 6 of the Janssen EUA:** Note What Happens to these Numbers when the “Mild” Cases of COVID are Removed From the Centrally Confirmed Laboratory?

| | Vaccinated (14 days) | Placebo (14 days) | Vaccinated (28 days) | Placebo (28 days) |
|---|---|---|---|---|
| Table 14 (Not Centrally Confirmed) Moderate to Severe | 176 | 513 | 114 | 326 |
| Table 15 (Centrally Confirmed) Mild - Moderate - Severe | 117 | 351 | 66 | 195 |
| EUA page 6 (Centrally Confirmed) Moderate to Severe | 116 (65.9%) | 348 (67.8%) | 66 (57.9%) | 193 (59.8%) |

There were 32.2 to 42.1 % fewer COVID cases Confirmed by the Central Lab.

# Did the Janssen Vaccine Reduce COVID Deaths?

## Going to the Janssen EUA Documents (page 53) We Find this Information.

No autopsy results are reported and 64% of the cases are reported as either dying from COVID or UNKNOWN causes.

As of February 5, 2021, a total of 25 deaths were reported in the study (5 vaccine, 20 placebo). These deaths represent events and rates that occur in the general population of individuals in these age groups and include 7 deaths in the placebo group due to COVID-19 infection. Non-fatal serious adverse events, excluding those due to COVID-19, were infrequent and balanced between treatment groups with respect to rates and types of events (0.4% in both groups). A serious event of a hypersensitivity reaction, not classified as anaphylaxis, beginning 2 days following vaccination was likely related to receipt of the vaccine.

Page 34.
All of the reported COVID deaths were from South Africa with Comorbidities.

**COVID-19 Related Deaths**

As of February 5, 2021, there were 7 COVID-19-related deaths reported in the study. All participants had a documented positive SARS-CoV-2 RT-PCR around the time of the event, but not all have been centrally confirmed to date. All 7 deaths occurred in the placebo group and were in study sites in South Africa. All of these participants had one or more comorbidities which placed them at higher risk for severe COVID-19. One death was in a participant PCR positive at baseline, who had onset of illness 10 days after vaccination. These results suggest that the vaccine is efficacious against mortality associated with COVID-19. Outcomes related to an exploratory all-cause mortality endpoint are discussed in a separate section below.

**Table 19. COVID-19 Related Deaths**

| Arm | Study Day[c] | Age | Comorbidity |
|---|---|---|---|
| Placebo | 15 | 63 | Obesity, Hypertension |
| Placebo | 18[a] | 52 | Obesity, Diabetes |
| Placebo | 31 | 54 | Obesity, Hypertension, Diabetes, Heart failure |
| Placebo | 38 | 49 | Obesity, Hypertension |
| Placebo | 39 | 68 | Obesity |
| Placebo | 49[b] | 60 | Obesity |
| Placebo | 55 | 60 | Asthma |

[a] Participant with positive SARS-CoV-2 PCR at baseline
[b] Reported after the primary analysis cutoff date of January 22, 2021
[c] Study day of death

| Issue | Janssen | No Vaccine |
|---|---|---|
| Death | 5 of 21424 (0.02%) | 20 of 21199 (0.09%) |
| MI | | 1 |
| Suicide | | 1 |
| Pnuemonia | 2 | 2 |
| Dyspnea | 1 | |
| Drug Overdose | | 1 |
| Malaise | | 1 |
| Unknown | 2 | 7 |
| COVID | 0 | 7 |

**There is no statistically significant difference in the numbers of deaths and they represent what is seen in the general population.**

# Janssen Vaccine Thromboembolic Events.

## The EUA Documents reveal issues with Thrombotic and Neurologic Consequences beginning with page 7.

Among all adverse events collected through the January 22, 2021 data cutoff, a numerical imbalance was seen in non-serious urticaria events reported in the vaccine group (n=5) compared to placebo group (n=1) within 7 days following vaccination which is possibly related to the vaccine. Numerical imbalances were observed between vaccine and placebo recipients for thromboembolic events (15 versus 10) and tinnitus (6 versus 0). Data at this time are insufficient to determine a causal relationship between these events and the vaccine. There were no other notable patterns or numerical imbalances in the available data as of the cutoff date between treatment groups for specific categories of adverse events that would suggest a causal relationship to Ad26.COV2.S.

| Numerical "Imbalances" | Janssen | No Vaccine |
|---|---|---|
| Thromboembolic | 15 | 10 |
| Tinnitus | 6 | 0 |
| Non-fatal Urticaris | 5 | 0 |
| Convulsions | 4 | 1 |

**Table 31. SAEs Considered Related by Investigator, Full Analysis Set, Study 3001**

| Investigational Product | SAE (PT) | Age/Sex | Day of Onset | Resolution Status | Grade | Related (Sponsor Assessment) |
|---|---|---|---|---|---|---|
| Ad26.COV2.S | Radiculitis brachial | 30/M | 1 | Unresolved | 3 | Yes (Reassessed as injection site pain) |
| Ad26.COV2.S | Post-vaccination syndrome | 35/M | 2 | Resolved | 3 | Yes (Reassessed as reactogenicity) |
| Ad26.COV2.S | Facial paralysis | 62/M | 3 | Resolving | 2 | No |
| Ad26.COV2.S | Vaccination site hypersensitivity | 42/M | 3 | Resolved | 3 | Likely |
| Ad26.COV2.S | Facial paralysis | 43/M | 16 | Resolving | 2 | No |
| Ad26.COV2.S | Guillain-Barre Syndrome | 60/F | 16 | Unresolved | 4 | Possibly |
| Ad26.COV2.S | Pericarditis | 68/M | 17 | Resolved | 4 | Possibly |
| Placebo | Deep vein thrombosis | 44/M | 6 | Resolving | 4 | Indeterminate |

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Janssen Ad26.COV2.S (COVID-19) Vaccine
VRBPAC Briefing Document

| Investigational Product | SAE (PT) | Age/Sex | Day of Onset | Resolution Status | Grade | Related (Sponsor Assessment) |
|---|---|---|---|---|---|---|
| Placebo | Epstein-Barr infection[a] | 69/M | 14 | Resolved | 3 | No |
| Placebo | Atrial flutter[a] | 69/M | 21 | Resolving | 3 | No |

[a] Events occurred the same study participant

# If I've Already Been Infected Should I Get Vaccinated?

Pfizer EUA page 27

## INSUFFICIENT DATA

Pfizer-BioNTech COVID-19 Vaccine
VRBPAC Briefing Document

| Efficacy Endpoint Subgroup | BNT162b2 N[a]=19965 Cases n1[b] Surveillance Time[c] (n2[d]) | Placebo N[a]=20172 Cases n1[b] Surveillance Time[c] (n2[d]) | Vaccine Efficacy % (95% CI)[e] |
|---|---|---|---|
| Not Hispanic or Latino | 6<br>1.681 (13380) | 114<br>1.693 (13509) | 94.7 (88.1, 98.1) |
| Race | | | |
| American Indian or Alaska native | 0<br>0.011 (104) | 1<br>0.010 (104) | 100.0 (-3511.0, 100.0) |
| Asian | 1<br>0.095 (796) | 4<br>0.097 (808) | 74.4 (-158.7, 99.5) |
| Black or African American | 0<br>0.187 (1758) | 7<br>0.188 (1758) | 100.0 (30.4, 100.0) |
| Native Hawaiian or other Pacific Islander | 0<br>0.006 (50) | 1<br>0.003 (29) | 100.0 (-2112.1, 100.0) |
| White | 7<br>1.975 (15294) | 153<br>1.990 (15473) | 95.4 (90.3, 98.2) |
| Multiracial | 1<br>0.047 (467) | 1<br>0.042 (424) | 10.4 (-6934.9, 98.9) |
| Not reported | 0<br>0.010 (90) | 2<br>0.013 (112) | 100.0 (-581.6, 100.0) |
| Baseline SARS-CoV-2 Status | | | |
| Positive[h] | 1<br>0.056 (526) | 1<br>0.060 (567) | -7.1 (-8309.9, 98.6) |
| Negative[i] | 8<br>2.237 (17637) | 164<br>2.242 (17720) | 95.1 (90.1, 97.9) |
| Unknown | 0<br>0.039 (396) | 4<br>0.043 (421) | 100.0 (-68.9, 100.0) |

[a] N = number of participants in the specified group.
[b] n1 = Number of participants meeting the endpoint definition.
[c] Total surveillance time in 1000 person-years for the given endpoint across all participants within each group at risk for the endpoint. Time period for COVID-19 case accrual is from 7 days after Dose 2 to the end of the surveillance period.
[d] n2 = Number of participants at risk for the endpoint.
[e] Confidence interval (CI) for VE is derived based on the Clopper and Pearson method adjusted to the surveillance time.
[f] At risk is defined as having at least one of the Charlson comorbidity index (Appendix B, page 52) category or obesity (BMI ≥30 kg/m$^2$).
[g] Obese is defined as BMI ≥30 kg/m$^2$.
[h] Positive N-binding antibody result at Visit 1, positive NAAT result at Visit 1, or medical history of COVID-19.
[i] Negative N-binding antibody result at Visit 1, negative NAAT result at Visit 1, and no medical history of COVID-19.

Moderna EUA page 25

Only 2.2% of participants had evidence of prior infection at study enrollment, and there was only one COVID-19 case starting 14 days after dose 2 reported from this subgroup, which was in a participant in the placebo group. There is insufficient data to conclude on the efficacy of the vaccine in previously infected individuals.

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Janssen EUA page 6

In general, VE among the subgroups (age, comorbidity, race, ethnicity) appears to be similar to the VE in the overall study population. A lower VE estimate was observed for the subgroup of participants 60 years of age and older with comorbidities compared with the overall population, but with an observed trend of increasing VE with narrower confidence intervals as numbers of cases included in the analysis increased (i.e., counting cases from 14 days rather than 28 days and including cases not yet centrally confirmed). There were no COVID-19-related deaths and no COVID-19 cases requiring medical intervention occurring 28 days or more post-vaccination among participants age 60 years or older with medical comorbidities in the vaccine group. The VE results for some other subgroups with small numbers of participants (≥75 years of age, certain racial subgroups) have limited interpretability. Data were insufficient to assess VE in participants with evidence of prior SARS-CoV-2 infection.

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# COVID-19 Vaccine Efficacy & Effectiveness

| | RRR (RR) | ARR | NNV | Combining Vaccine Efficacy with Different Background Risks of COVID-19. |
|---|---|---|---|---|
| **Pfizer** | 95% | 0.84% | 117 | 0.9% |
| **Moderna** | 94% | 1.2% | 76 | 1.4% |
| **Gamaleya** | 90% | 0.93% | 80 | 1.0% |
| **Janssen** | 67% | 1.2% | 84 | 1.8% |
| **AstraZeneca** | 67% | 1.3% | 78 | 1.9% |

Olliaro P, Torreele E, Vaillant M. COVID-19 vaccine efficacy and effectiveness — the elephant (not) in the room. Lancet Microbe 2021; https://doi.org/10.1016/ S2666-5247(21)00069-0

# Why Did I Put You Through All Those Slides?

## So You & I Could Do the Scientific Review of the EUAs that the FDA Didn't.

1) Based Upon the FDA (EUA) Documents:

There is no statistical reduction in COVID rates.

There is no statistical reduction in COVID death rates.

There is an unacceptable VAERS death and adverse event rates.

The vaccine Absolute Risk Reduction (ARR) rate for developing COVID is really only

0.8 to 1.3%. Not the 67 to 95% you've been lead to believe.

2) Why did we go through these slides?

To provide you with the answers you need, when someone is trying to force you to get vaccinated.

Because the FDA, the Federal Government and the Media failed to do their job.

They failed to ask the Scientific Questions that should have been asked.

# Vaccine Adverse Event Reporting System

## https://vaers.hhs.gov/index.html

As of **19 April 2021** the Centers for Disease Control (CDC) reported on its Vaccine Adverse Event Reporting System (VAERS)

68,347 Adverse Events

Including

2,602 Deaths

8,285 Serious Injuries

As of **23 April 2021** the Centers for Disease Control (CDC) reported on its Vaccine Adverse Event Reporting System (VAERS)

118,902 Adverse Case Events

Including

3,544 Deaths

12,619 Serious Injuries

As of **7 May 2021** the Centers for Disease Control (CDC) reported on its Vaccine Adverse Event Reporting System (VAERS)

192,954 Adverse Case Events

Including

4,057 Deaths

17,190 Serious Injuries

As of **23 August 2021** the Centers for Disease Control (CDC) reported on its Vaccine Adverse Event Reporting System (VAERS)

650,075 Adverse Case Events

Including

13,911 Deaths

56,912 Serious Injuries

As of **3 September 2021** the Centers for Disease Control (CDC) reported on its Vaccine Adverse Event Reporting System (VAERS)

675,591 Adverse Case Events

Including

14,506 Deaths

58,440 Serious Injuries (Hospitalizations)


https://www.lifesitenews.com/news/latest-vaers-data-show-reports-of-blood-clotting-disorders-after-all-three-emergency-use-authorization-vaccines

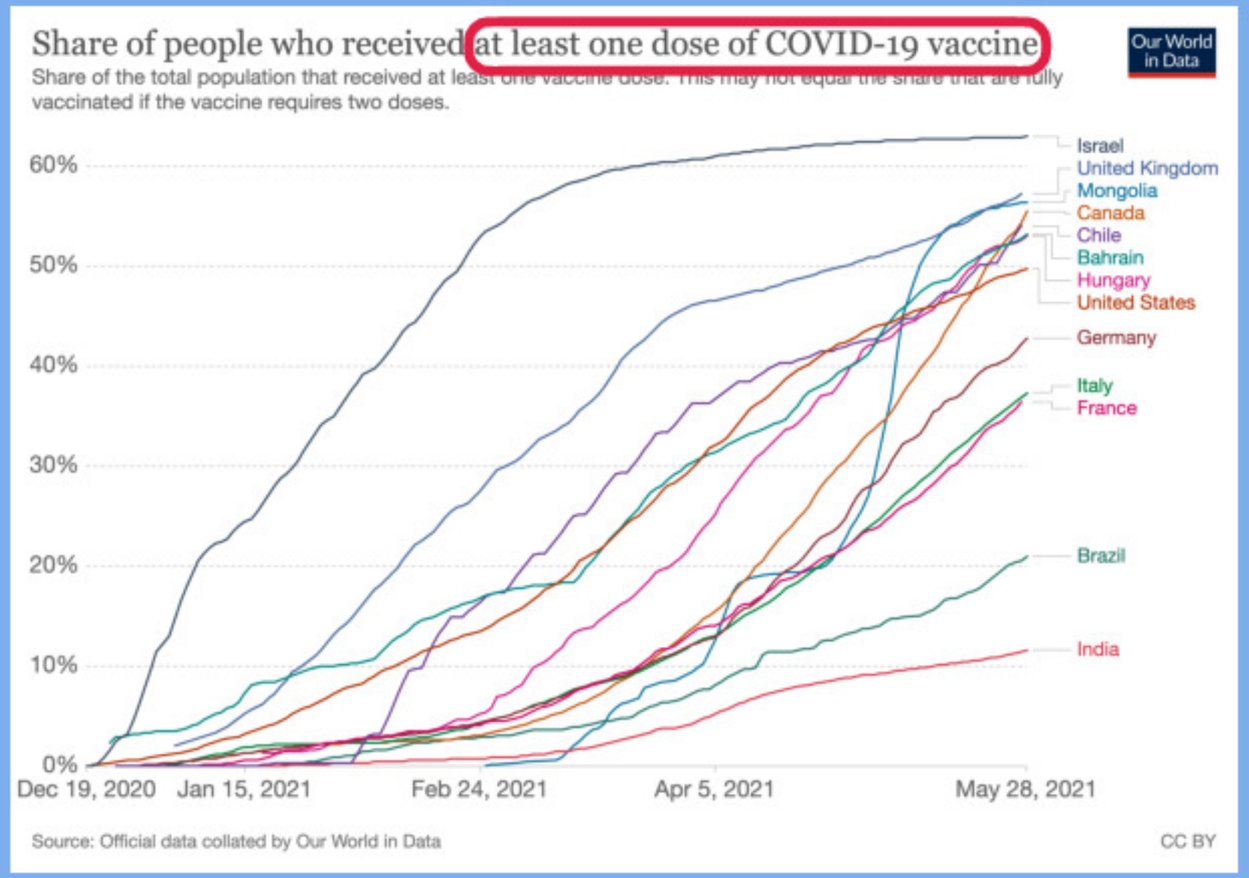
https://childrenshealthdefense.org/defender/vaers-significant-jump-reported-injuries-deaths-after-covid-vaccine/

https://childrenshealthdefense.org/defender/vaers-cdc-data-reported-deaths-covid-vaccines-kids-12-now-eligible/

https://www.openvaers.com/

# European Database (EudraVigilance)

## 22 May 2021



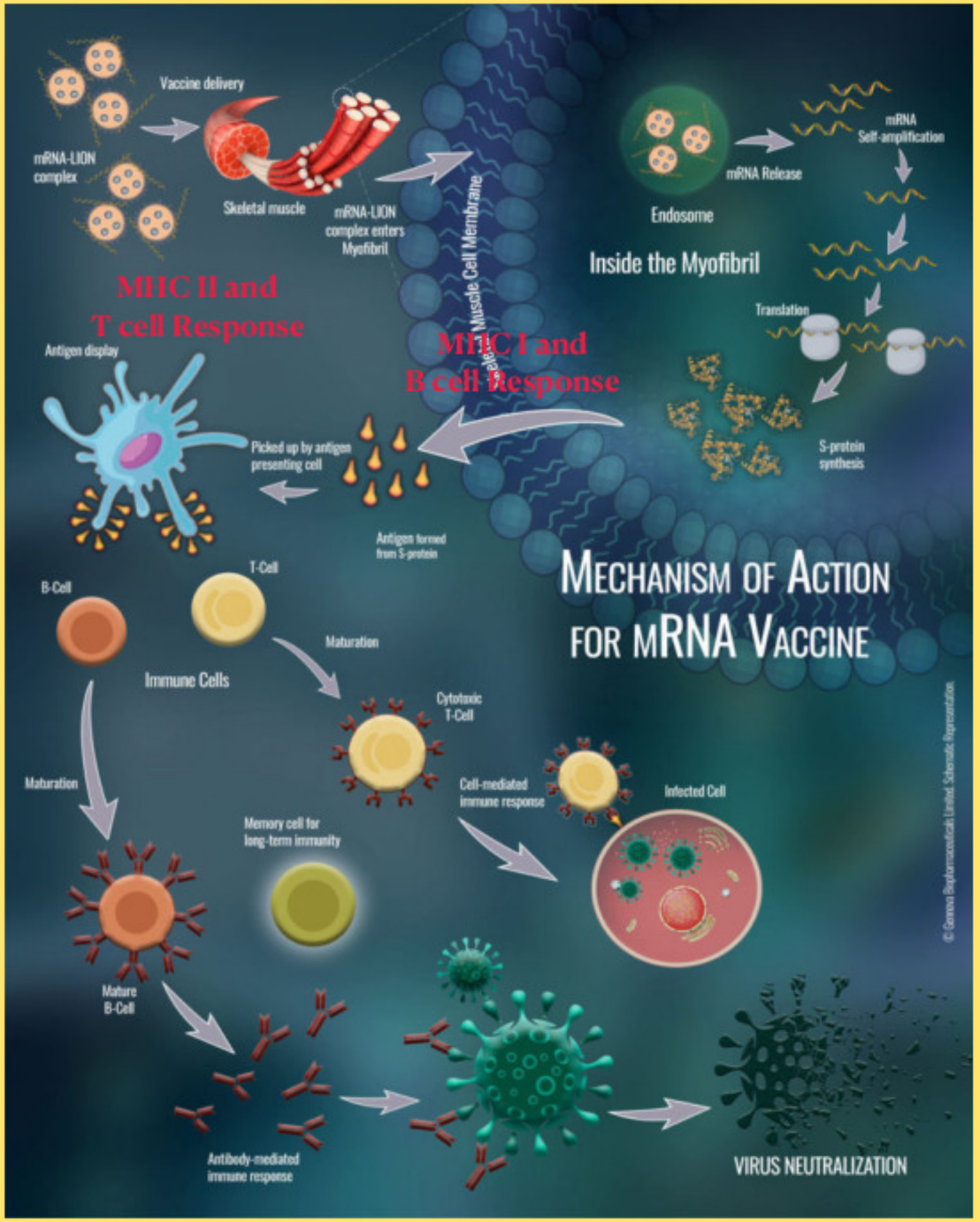

| 22 May 2021 | Reported Cases | Deaths | All Multiple Symptoms | Serious Injuries |
|---|---|---|---|---|
| AstraZeneca | 237,648 | 2,489 | 655,534 | 372,019 |
| Pfizer BioNTech | 191,215 | 5,961 | 452,779 | 186,308 |
| Moderna | 29,616 | 3,365 | 72,596 | 38,704 |
| Janssen | 4,997 | 369 | 15,281 | 7,713 |
| Total | 463,476 | 12,184 | 1,196,190 | 604,744 |

https://ourworldindata.org/covid-vaccinations

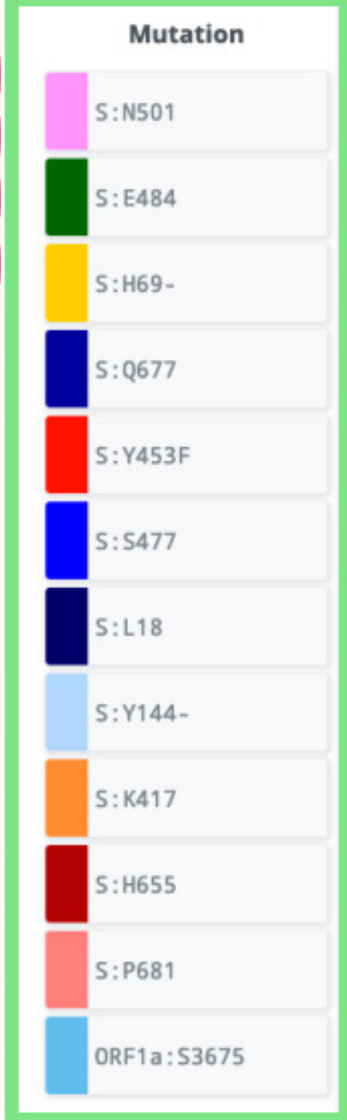
https://www.globalresearch.ca/12184-dead-1196190-injuries-europe

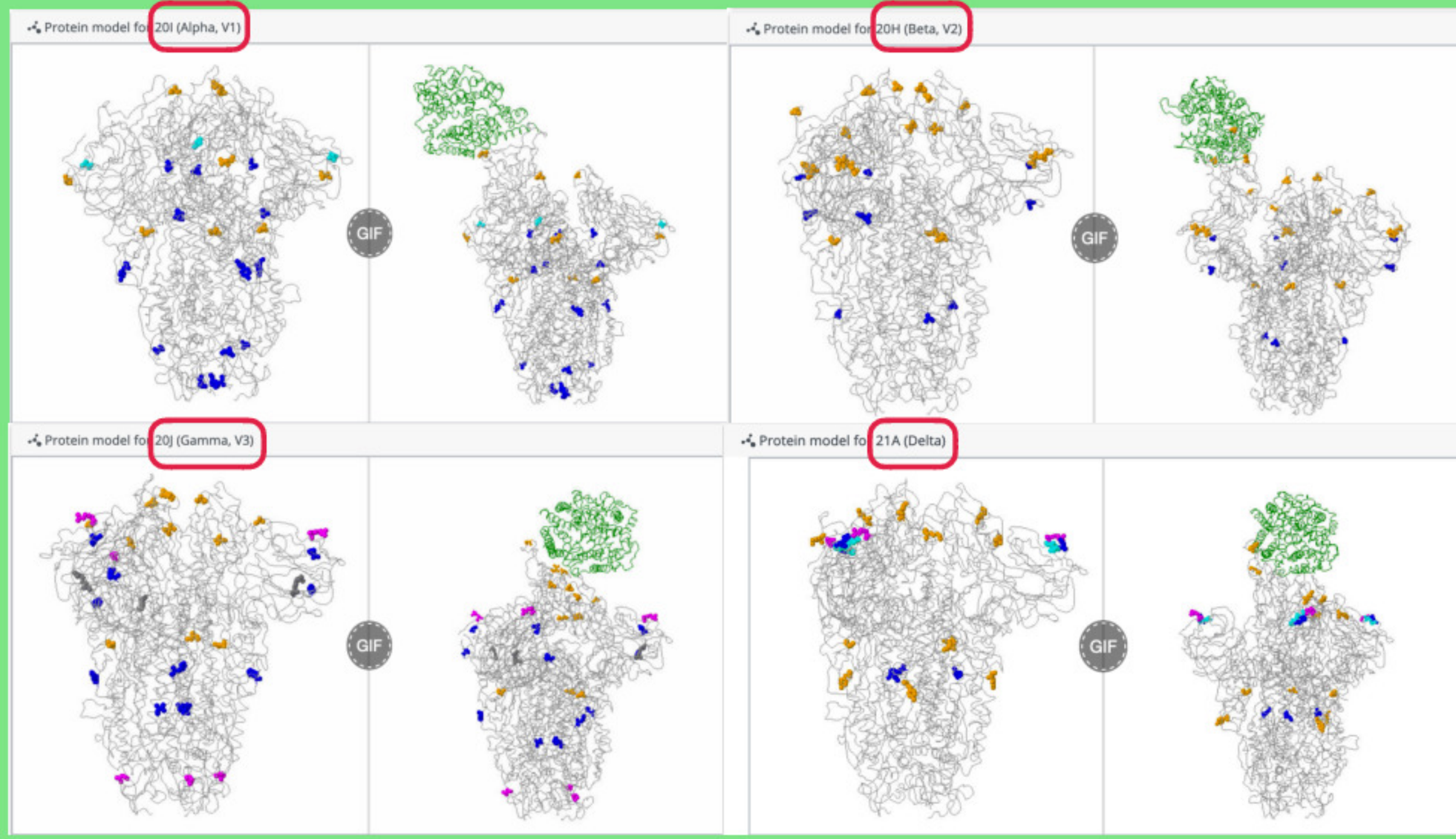
# Some Basic Concerns with the New Drug Vaccine Biologics.

- 1) As already seen, the Chinese were able to create an effective SARS-CoV-1 vaccine that was produced using attenuated virus.
- 2) The spike proteins of Pfizer and Moderna do NOT ACTUALLY match the spike protein of SARS-CoV-2 Wuhan Hu-1 Virus.
- 3) Self Ampliyfying mRNA and Transmissible Vaccines have been undergoing testing for several years and yet they are NOT being discussed even though it is clear that this testing includes SARS-CoV-2.
- 4) The misinformation that these vaccines stay at the site of injection & that their very mechanisms of action, using either mRNA or dsDNA gene sequences, either circumvent the Innate Immune Response or provide misinformation (adenovirus) to the Innate Immune Response thereby either causing a MHC I B-cell response (cell made) **first & then** the MHC II T-cell Innate Component (foreign invader); OR by substituting the outer Adenovirus, causing at least a partial INNATE Immune Response to the Adenovirus instead of SARS-CoV-2 membrane, envelope, etc.
  - This INNATE IMMUNE response is critical for BOTH
  - T-cell immunity, and subsequent Th2 IL-4 release essential for increasing
  - B-cell proliferation, differentiation and antibody production.
- 5) The EUAs show no statistical reduction in COVID cases or deaths, but VAERS has shown a significant number of Adverse Events including death.
- 6) Finally, the Mass Vaccination program focusing on a single type of spike protein which does not even match the SARS-CoV-2 Wuahn Hu-1 Viral Spike protein has resulted in **pressure selection** of variants including Delta, Kappa, Iota, and others.



# The Resulting Changes in the Spike Proteins of these Variants Can Be Seen Below.


With special thanks to the work of Professors Emma Hodcroft, Jean-Claude Perez, and Luc Montagnier. https://covariants.org/variants/S.Q677H.Robin1

# Vaccine Failure is Literally Nothing More Than Reduced SARS-CoV-2 Wuhan Hu-1 Spike Protein Antibody Recognition of the Variant Spike Proteins.

## 20I (Alpha, V1)

Also known as B.1.1.7 and α Alpha
Announced on the 14 Dec 2020, this variant appears to have arisen and/or initially expanded in the South East of England.

Variant 20I (Alpha, V1) is associated with multiple mutations in Spike. Most notably: S:N501Y (see Mutation S:N501), and a deletion at 69/70 (see Mutation S:H69-)).
But also Mutation S:Y144- (deletion) and S:P681H (adjacent to the furin cleavage site).
There is also a notable truncation of ORF8, with ORF8:Q27* (becomes a stop codon) (deletion of ORF8 was previously associated with reduced clinical severity (Young et al., Lancet)), and mutations in Nucleocapsid: N:D3L and N:S235F, as well as a deletion in ORF1a(Nsp6) 3675-3677 (also seen in 20H (Beta, V2) and 20J (Gamma, V3)).

The 69/70 deletion in this variant causes the S-assay within TaqPath tests to give a negative result, which can provide a useful proxy for prevalence of this variant (a phenomenon referred to as S-gene target failure or SGTF). However, as the 69/70 deletion is found in other variants/clusters (notably Variant 20A/S:439K and Mutation S:Y453F), sequencing is needed to confirm identity, particularly in countries where 20I (Alpha, V1) is not dominant.

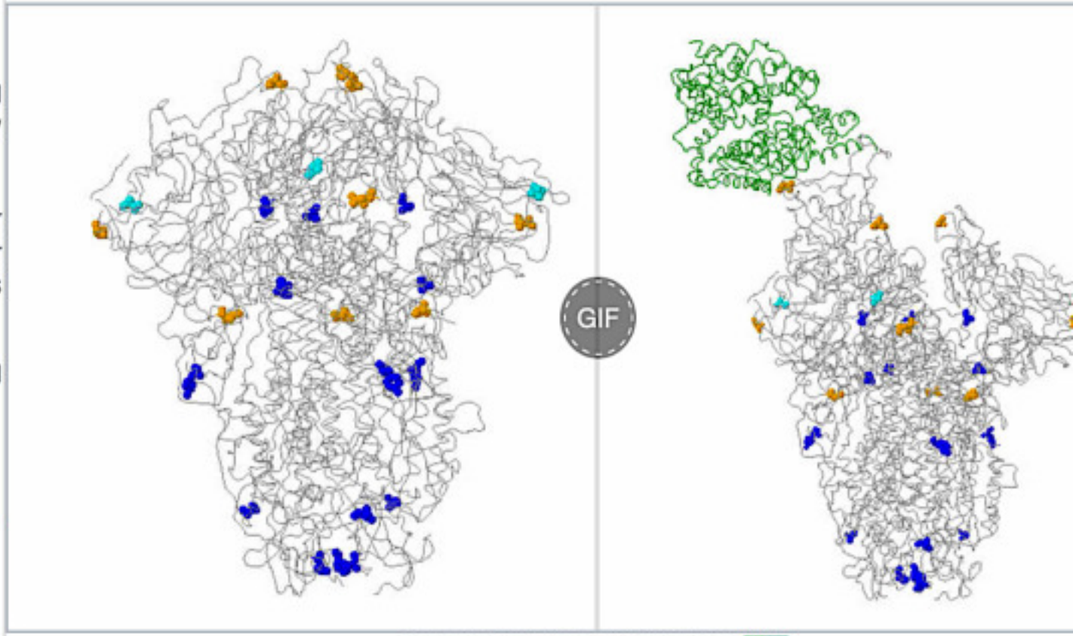
A small number of 20I (Alpha, V1) genomes have been observed in the UK featuring the S:E484K mutation (see these on the focal Mutation S:E484 Nextstrain build here).

Links to papers and reports on 20I (Alpha, V1):

- Sera from individuals vaccined with the Moderna vaccine showed no significant reduction of neutralization against 20I (Alpha, V1) and a 6-fold reduction in 20H (Beta, V2), but titers remained above levels expected to be protective (Moderna website)
- 40 participants vaccinated with the mRNA BTN162b2 vaccine had "slightly reduced but overall largely preserved neutralizing titers" against 20I (Alpha, V1) (Muik et al., Science)
- 20I (Alpha, V1) has little reduced neutralization by mAbs and a small reduction to convalescent sera (Wang et al., Nature)
- Reports on 20I (Alpha, V1) characterization: COG-UK Report, Rambaut et al., PHE Technical Briefings 1-5
- Early work suggests a possible increase risk of death with the 20I (Alpha, V1) variant (SAGE Meeting paper 2021/01/21)

See a focal S.N501 build filtered & zoomed to 20I (Alpha, V1)

Protein model for 20I (Alpha, V1)




Protein model for 20I (Alpha, V1). Figure made via GISAID

With special thanks to the work of Professors Emma Hodcroft, Jean-Claude Perez, and Luc Montagnier. https://covariants.org/variants/S.Q677H.Robin1

# Notice What Happens When Mass Vaccinations Begin - Pressure Selection

View data generation scripts

Variants

Select all Deselect all

- 20I (Alpha, V1)
- 20H (Beta, V2)
- 20J (Gamma, V3)
- 21A (Delta)
- 21B (Kappa)
- 21F (Iota)
- 21D (Eta)
- 20E (EU1)
- 21C (Epsilon)
- 20A/S:439K
- S:677H.Robin1
- S:677P.Pelican
- 20A.EU2
- 20A/S:98F
- 20C/S:80Y
- 20B/S:626S
- 20B/S:1122L

Countries

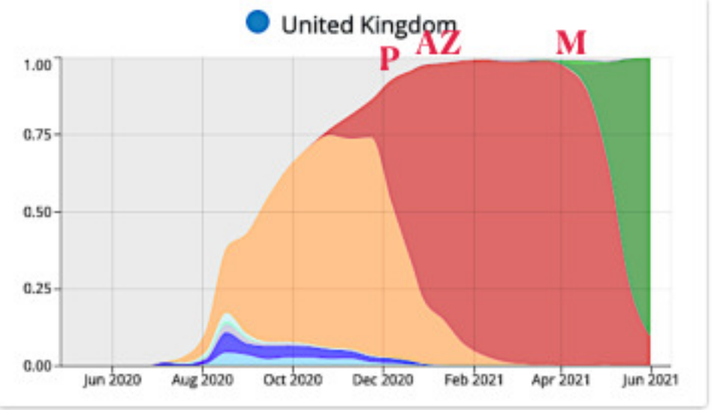
**AZ = AstraZenica = Adenovirus dsDNA**

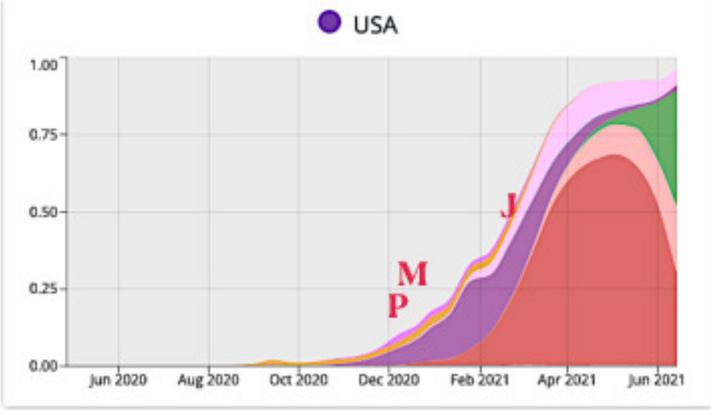
**J = Janssen = Adenovirus dsDNA**

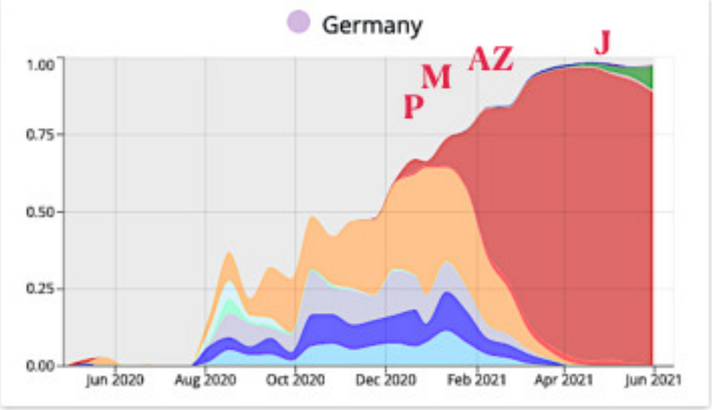
**M = Moderna = LNP mRNA**

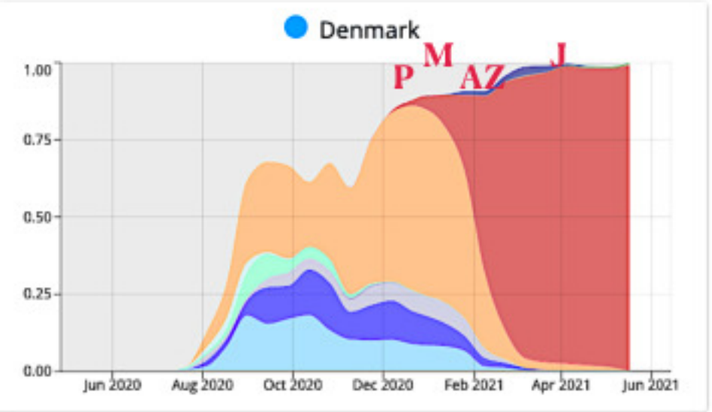
**P = Pfizer = LNP mRNA**

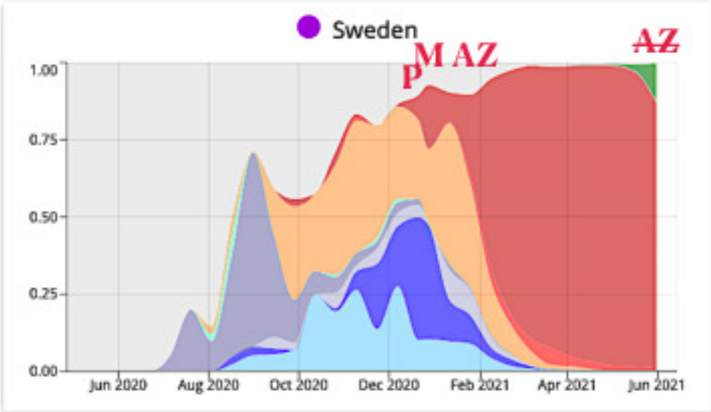
https://covariants.org/per-country

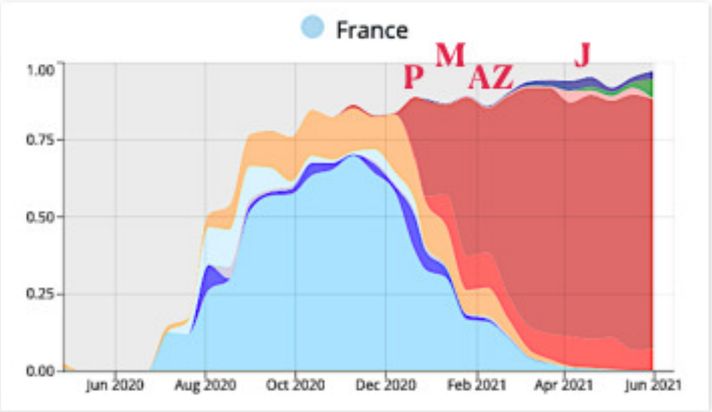


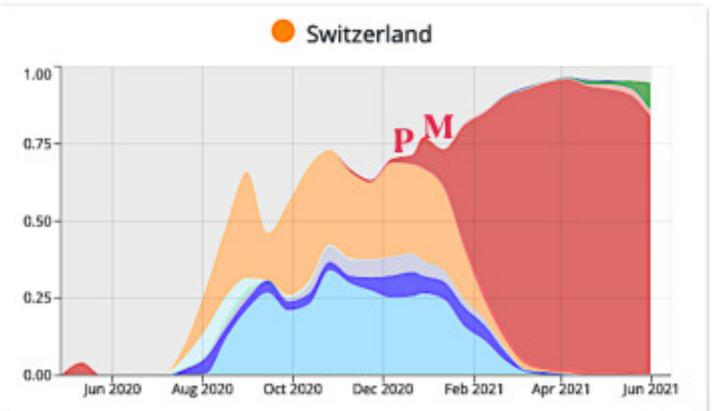



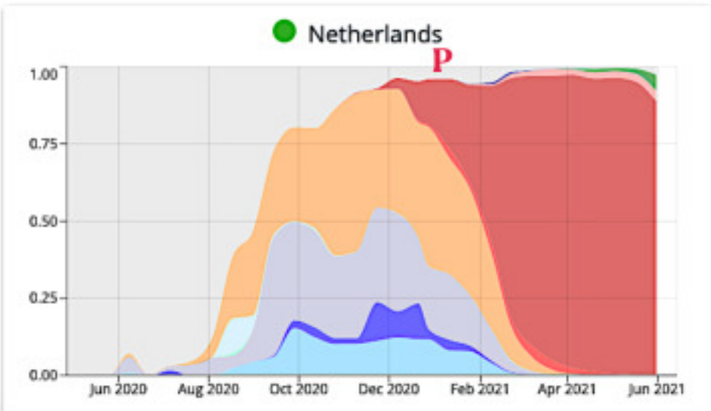



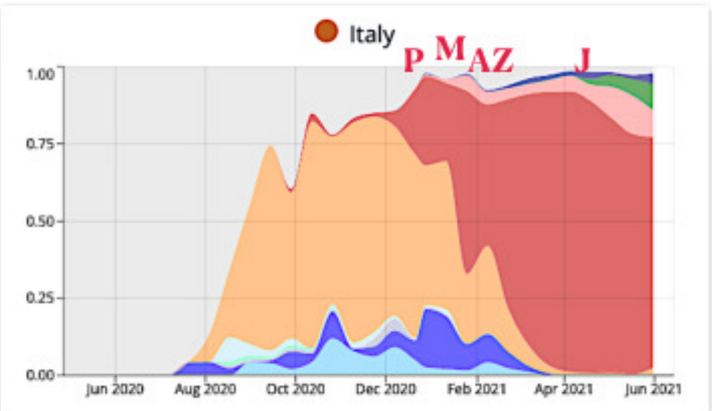



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- S:677P.Pelican
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- 20A/S:98F
- 20C/S:80Y
- 20B/S:626S
- 20B/S:1122L

Countries

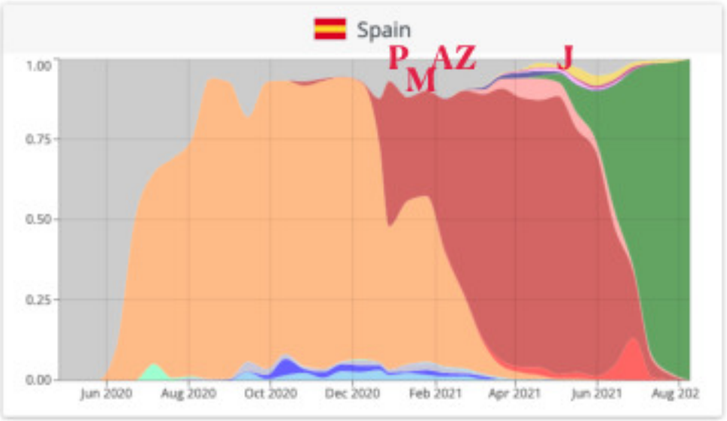
C = Covaxin = Inactivated Virus

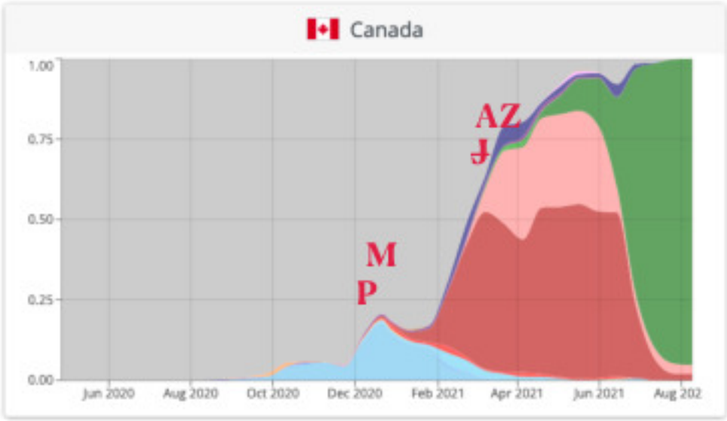
Ca = Cansino = Adenovirus dsDNA

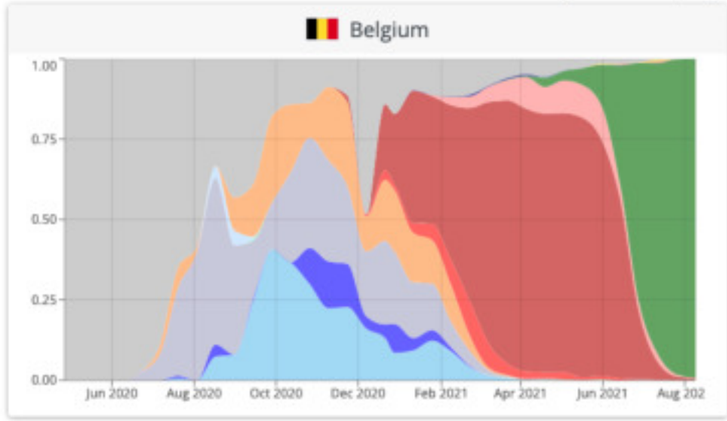
G = Gamaleya Adenovirus dsDNA

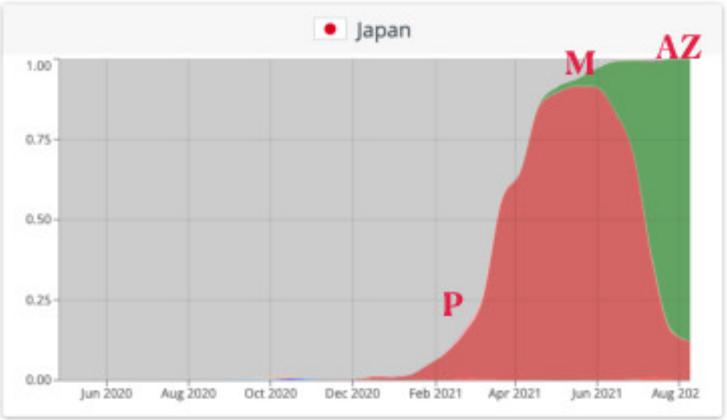
Si = Sinovac = Inactivated Virus

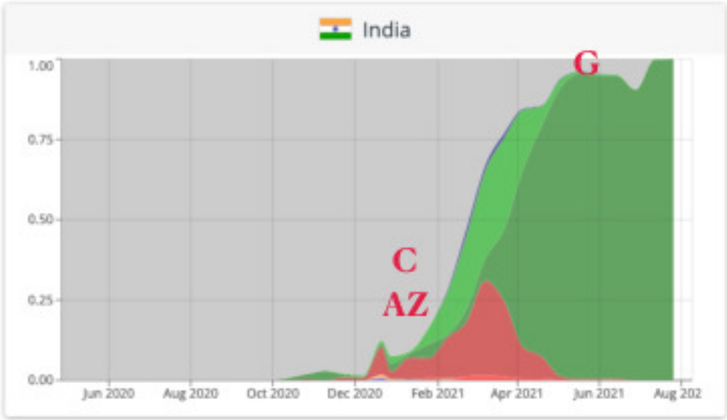
https://covariants.org/per-country

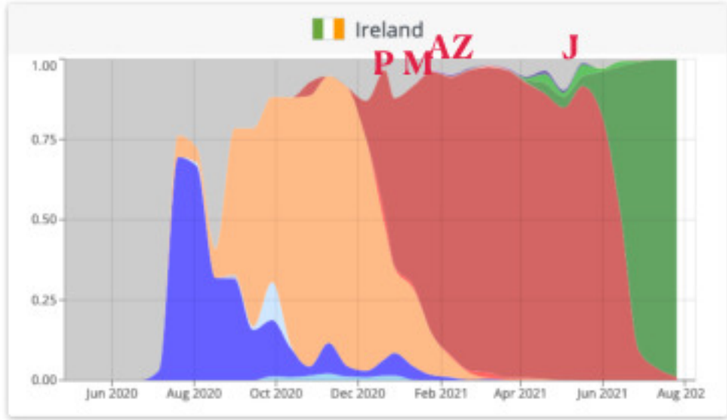


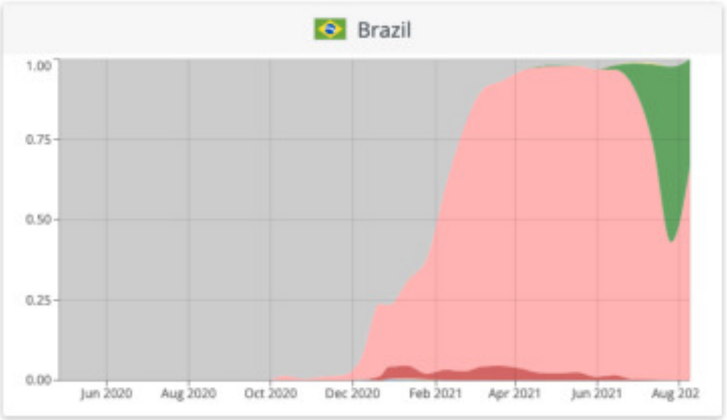



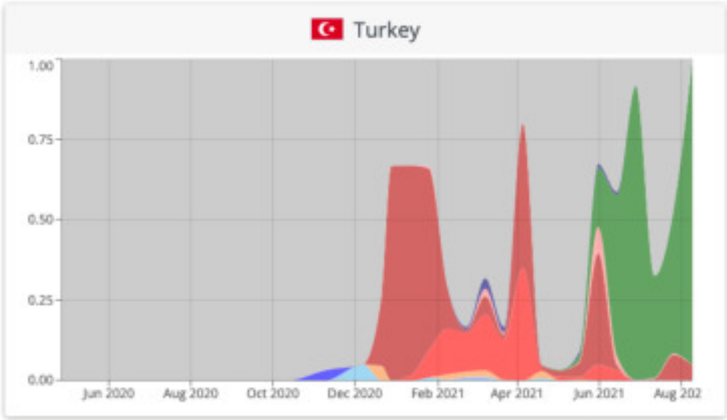



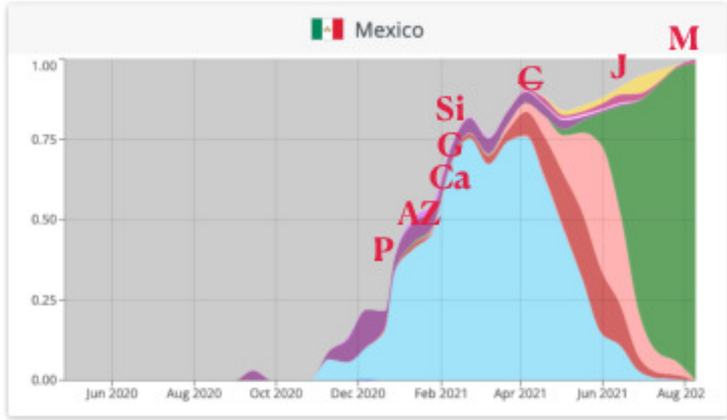



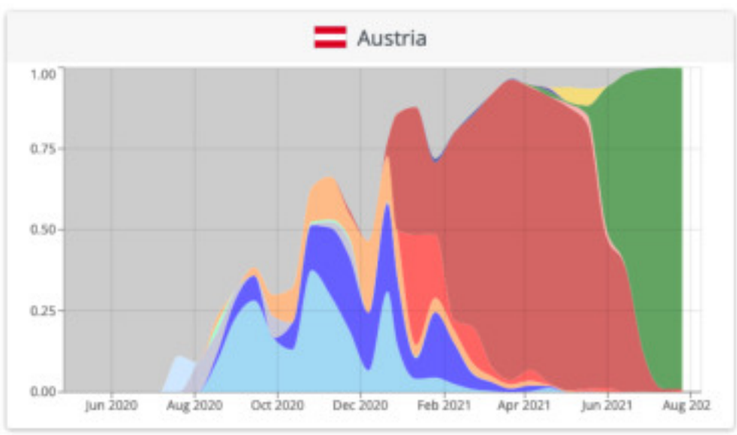



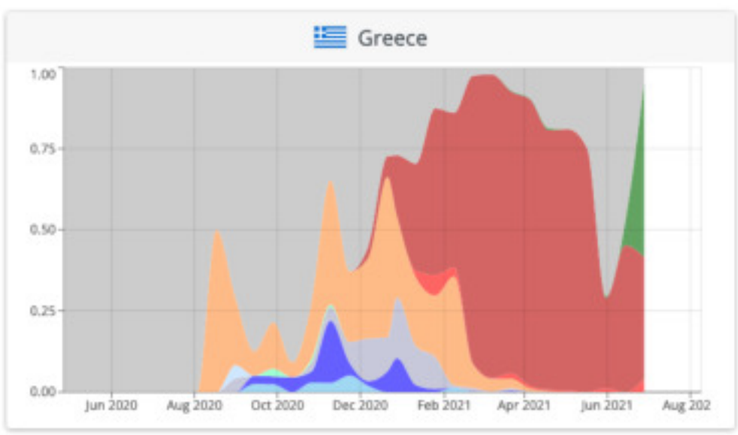



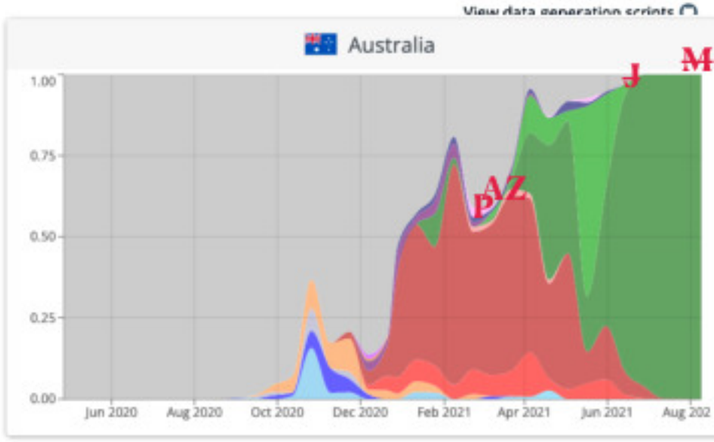



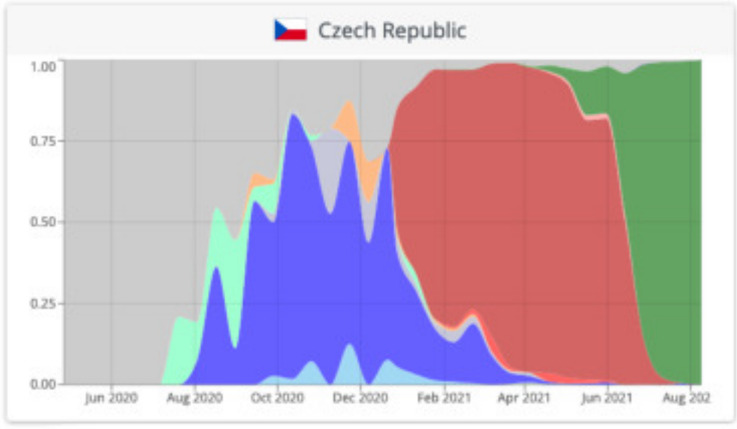



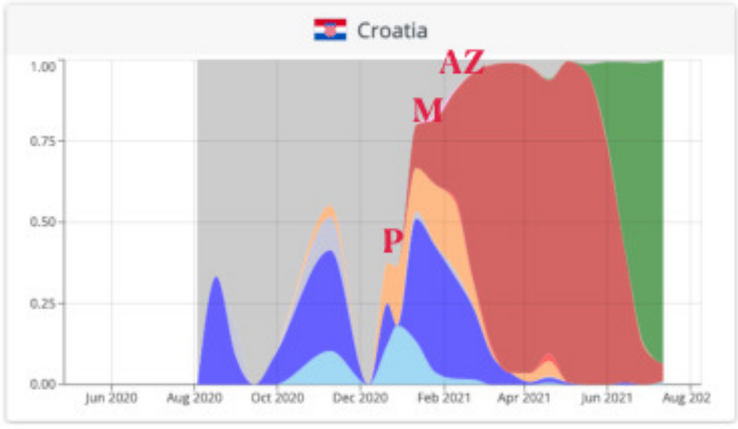
# Notice What Happens When Mass Vaccinations Begin - Pressure Selection

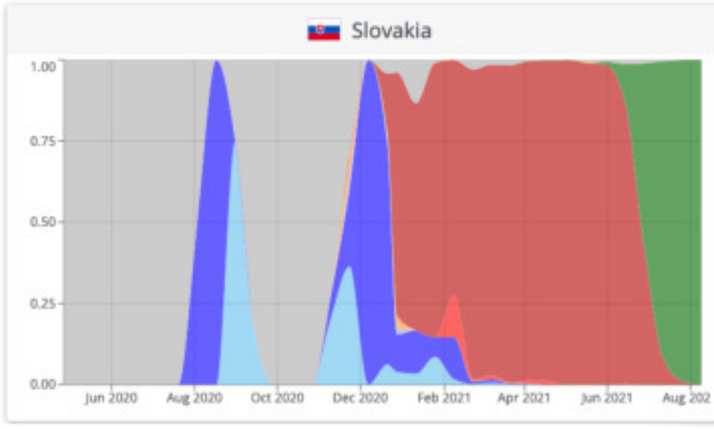




https://covariants.org/per-country

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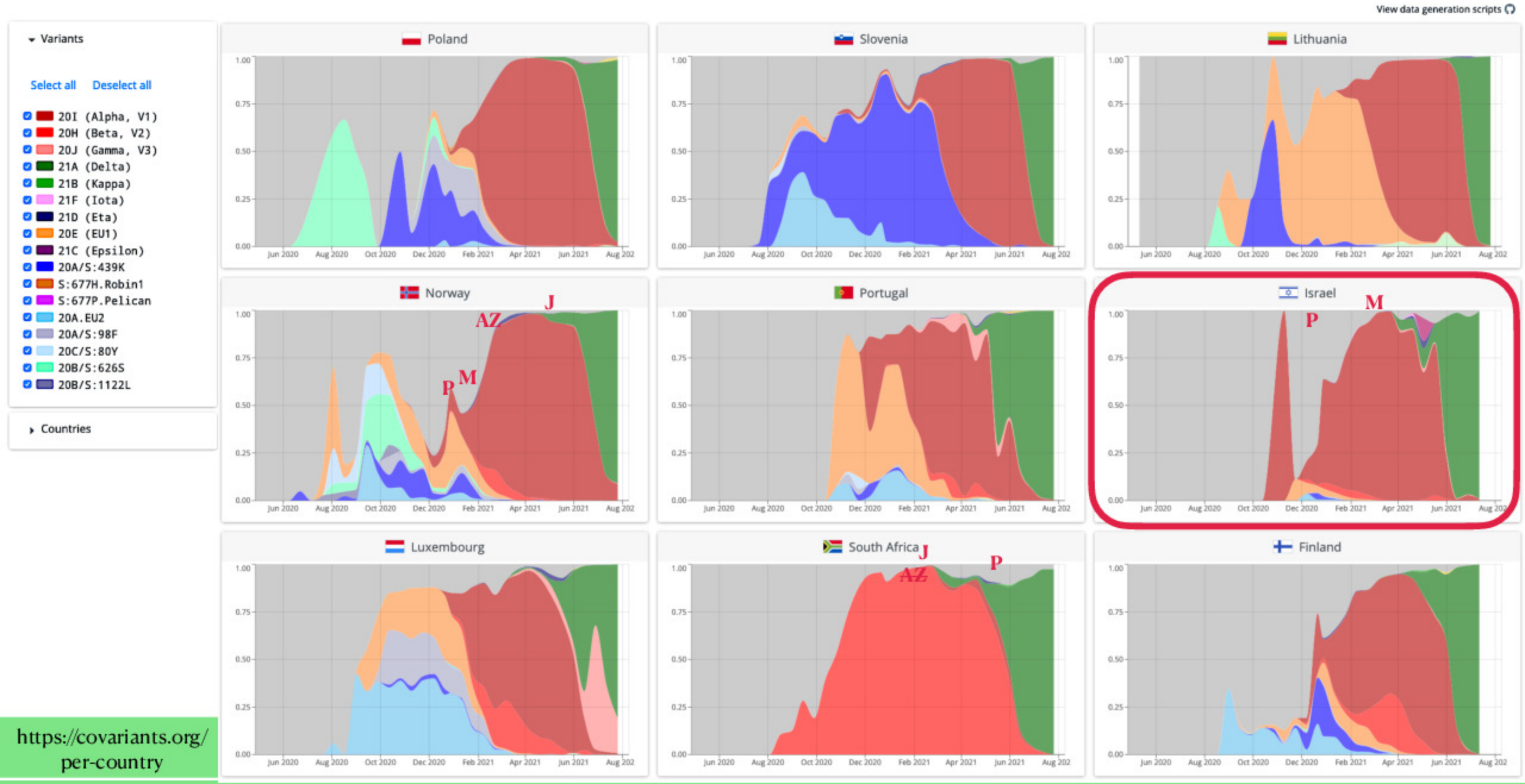



https://covariants.org/per-country

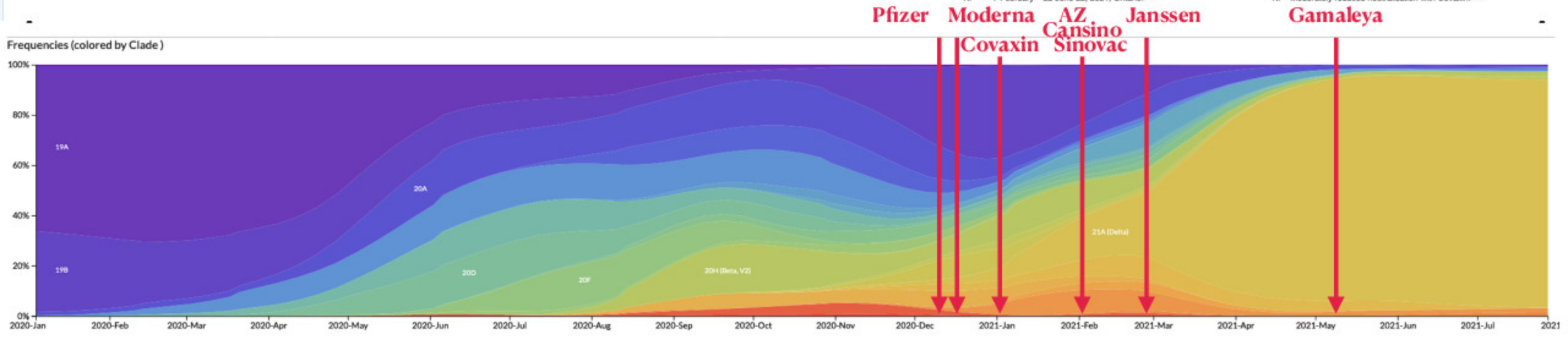
# Mass Vaccination Pressure Selection on Variants

https://en.wikipedia.org/wiki/Variants_of_SARS-CoV-2

| Identification[19] | | | | Emergence | | | Changes relative to previously circulating variants at the time and place of emergence | | | | Neutralising antibody activity (or efficacy when available) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WHO label | PANGO lineage | PHE variant [A] | Nextstrain clade | First outbreak | Earliest sample[22] | Designated VOC | Notable mutations | Transmissibility | Hospitalisation | Mortality | From natural infection[B] | From vaccination |
| Alpha | B.1.1.7 | VOC-20DEC-01 | 20I (V1) | United Kingdom | 20 Sep 2020[23] | 18 Dec 2020[24] | 69–70del, N501Y, P681H[25][26] | +29% (24–33%)[27][C] | +52% (47–57%)[D][C] | +59% (44–74%)[D][C] CFR 0.06% for <50 age group, 4.8% for >50 age group[29] | Minimal reduction[12] | Minimal reduction[12] |
| | B.1.1.7 with E484K[E][13] | VOC-21FEB-02 | | | 26 Jan 2021[30] | 5 Feb 2021[31] | E484K, 69–70del, N501Y, P681H[25][26] | | | | Considerably reduced[20] | Considerably reduced[20] |
| Beta | B.1.351 | VOC-20DEC-02 | 20H (V2) | South Africa | May 2020 | 14 Jan 2021[32] | K417N, E484K, N501Y[25] | +25% (20–30%)[27] | *Under investigation* | Possibly increased[14][19] | Reduced, T cell response elicited by D614G virus remains effective[12][19] | Efficacy: reduced against symptomatic disease,[F] retained against severe disease[19] |
| Gamma | P.1 | VOC-21JAN-02 | 20J (V3) | Brazil | Nov 2020 | 15 Jan 2021[33][34] | K417T, E484K, N501Y[25] | +38% (29–48%)[27] | Possibly increased[19] | +50% (50% CrI, 20–90%)[G][I] | Reduced[12] | Retained by many[J] |
| Delta | B.1.617.2 | VOC-21APR-02 | 21A | India | Oct 2020 | 6 May 2021[37] | L452R, T478K, P681R[38] | +97% (76–117%)[27] | +85% (39–147%) relative to Alpha[L] | +137% (50–230%)[K] CFR 0.04% for <50 age group unvaccinated, 6.5% for >50 age group unvaccinated[29] | Reinfections happened, with smaller occurrence rate than vaccinated infections[M][41][42] | Efficacy reduction for non-severe disease[19][42][N] |

Very high risk | High risk | Medium risk | Low risk | Unknown risk

A. ^ Name format updated March 2021, changing year from 4 to 2 digits and month from 2 digits to 3 letters, for example, VOC-**2021**01-02 to VOC-**21**JAN-02.[13]
B. ^ Efficacy of natural infection against reinfection when available.
C. ^ a b c B.1.1.7 with E484K assumed to only differ from B.1.1.7 on neutralising antibody activity.[15]
D. ^ a b 23 November 2020 – 31 January 2021, England.[28]
E. ^ B.1.1.7 with E484K has not received a WHO label; it is listed here with the same label as its parent lineage, B.1.1.7
F. ^ Oxford-AstraZeneca, NovaVax.
G. ^ The reported confidence or credible interval has a low probability, so the estimated value can only be understood as possible, not certain nor likely.
H. ^ a b Differences may be due to different policies and interventions adopted in each area studied at different times, to the capacity of the local health system, or to different variants circulating at the time and place of the study.
I. ^ March 2020 – February 2021, Manaus.[35] Preliminary results from a study in the Southern Region of Brazil found lineage P.1 increases mortality for healthy young people much more. In groups without pre-existing conditions, the variant was found to increase mortality by 490% (220–985%) for men in the 20–39 age group, 465% (190–1003%) for women in the 20–39 age group and 670% (401–1083%) for women in the 40–59 age group.[36][H]
J. ^ Except Pfizer–BioNTech.[14]
K. ^ a b 7 February – 22 June 22, 2021, Ontario.[40]
L. ^ 1 April – 6 June 2021, Scotland.[39] Another preliminary study in Ontario found that hospitalization by Delta increased by 120% relative to non-VOC lineages.[K][H]
M. ^ The study in Israel tracked 46035 unvaccinated recovered and 46035 vaccinated people of the same age distribution, to compare their infection occurrence in the follow-up period. 640 infections in the vaccinated group and 108 infections in the recovered group were recorded.
N. ^ Moderately reduced neutralisation with Covaxin.[43]



# As this Pressure Selection Continues The Antibody Response Will Become Less and Less Effective with New Variants Emerging.

## Variant: 21A (Delta)

also known as 21A/S:478K

Propose changes to this section

Dedicated 21A (Delta) Nextstrain build

Also known as B.1.617.2 and δ Delta

The Pango lineage B.1.617 includes both Variant 21B (Kappa) and its sister lineage Variant 21A (Delta).
B.1.617 was first detected in late 2020 in India, and has appeared to expand rapidly.

These sequences have Spike mutations at positions S:L452R (see Variant 21C (Epsilon) page for more details) and Mutation S:P681, both of which impact antibody binding.

In addition, many sequences have mutation S:G142D, in the N-terminal domain, which is an escape mutant to some antibodies (McCallum et al., bioRxiv) and has appeared in viruses grown in the presence of a monoclonal antibody (Suryadevara et al, Cell).

These sequences therefore have mutations in the N-terminal domain, receptor binding domain (RBD), and furin cleavage site of the spike protein, which could impact a variety of antibodies.

- A study found that titers against B.1.617 were reduced roughly 2-fold compared to 20I (Alpha, V1) and wild-type (Yadav et al., bioRxiv)

### 21A (Delta)

Variant 21A (Delta) has additional spike mutations at positions S:T19R, S:R158G, S:T478K, and S:D950N. Additionally, it has a deletion at positions S:E156- and S:F157-.
Many sequences in Variant 21A (Delta) also have a deletion at positions ORF8:D119- and ORF8:F120-.

*Little else is known about this variant. Please let me know if you have more information!*

https://www.eurekalert.org/pub_releases/2021-06/tfci-pvr060321.php

https://covariants.org/variants/S.Q677H.Robin1

EurekAlert! | AAAS

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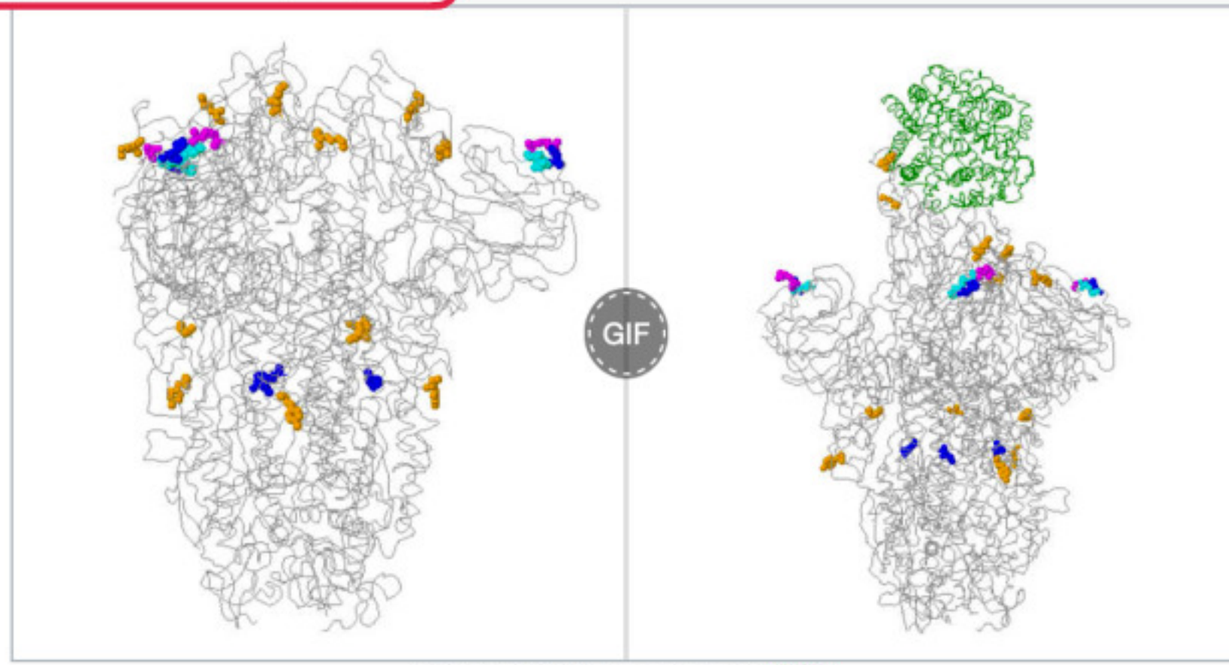
NEWS RELEASE 3-JUN-2021

### Pfizer-BioNTech vaccine recipients have lower antibody levels targeting the Delta variant

THE FRANCIS CRICK INSTITUTE

Protein model for 21A (Delta)

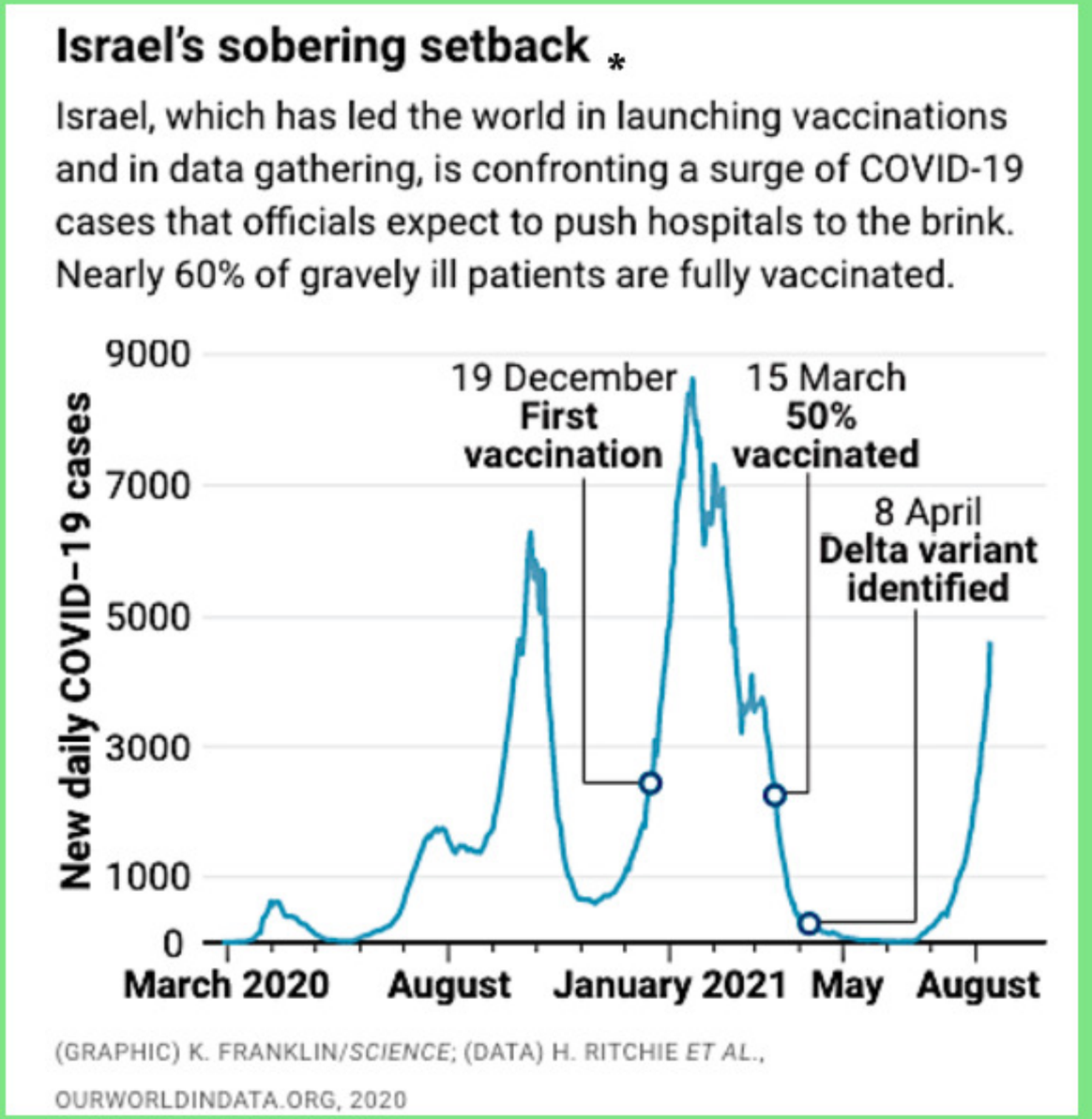



Protein model for 21A (Delta). Figure made via GISAID

# Hard Data from Israel*

## A Consequence of Pressure Selection

- Retrospective analysis** of 1,395,134
- Results were adjusted for comorbidities.
- As of 15 August 2021 there were 514 Israelis hospitalized with severe or critical COVID-19.
- Of these 514, 59% were fully vaccinated.
  - Of the vaccinated, 87% were 60+ years of age.



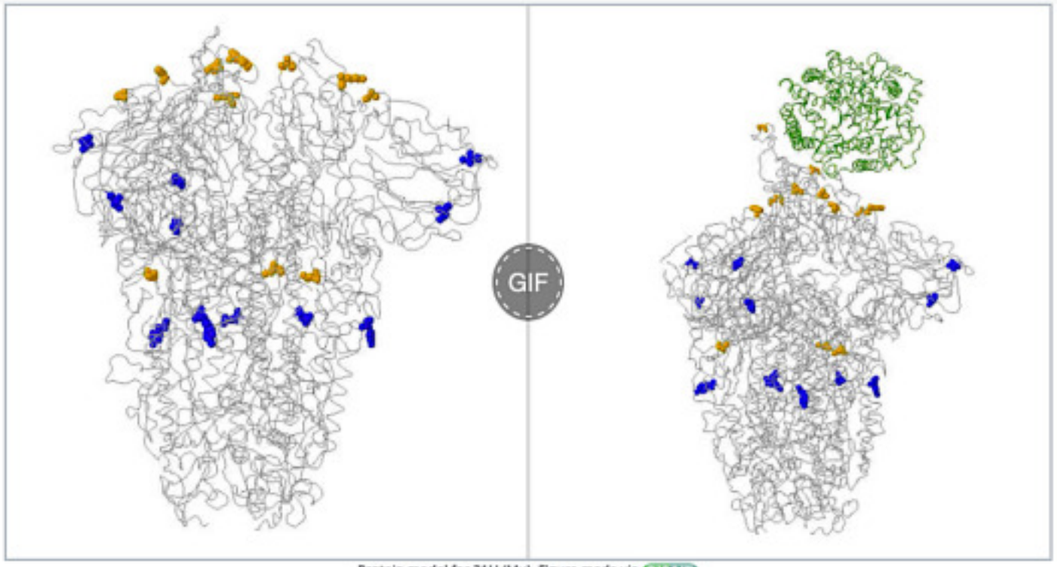

*https://www.science.org/news/2021/08/grim-warning-israel-vaccination-blunts-does-not-defeat-delta

**Mizrahi B, et al. Correlation of SARS-CoV-2 Breakthrough Infections to Time-from-vaccine; Preliminary Study. 31 July 2021; https://www.medrxiv.org/content/10.1101/2021.07.29.21261317v1

# Shared Mutations of the Variants

| Nextstrain Clade | Pango Lineage | WHO Label | Other Names | Old CoVariants Names |
|---|---|---|---|---|
| 20I (Alpha, V1) | B.1.1.7 | α Alpha | VOC 202012/01 | 20I/501Y.V1 |
| 20H (Beta, V2) | B.1.351 | β Beta | 501Y.V2 | 20H/501Y.V2 |
| 20J (Gamma, V3) | P.1 | γ Gamma | | 20J/501Y.V3 |
| 21A (Delta) | B.1.617.2 | δ Delta | | 21A/S:478K |
| 21B (Kappa) | B.1.617.1 | κ Kappa | | 21A/S:154K |
| 21C (Epsilon) | B.1.427, B.1.429 | ε Epsilon | CAL.20C | 20C/S:452R |
| 21D (Eta) | B.1.525 | η Eta | | 20A/S:484K |
| 21F (Iota) | B.1.526 | ι Iota | (Part of Pango lineage) | 20C/S:484K |
| 21G (Lambda) | C.37 | λ Lambda | | |
| 21H (Mu) | B.1.621 | μ Mu | | |
| 20E (EU1) | B.1.177 | | EU1 | 20A.EU1 |
| 20B/S:732A | B.1.1.519 | | | |
| 20A/S:126A | B.1.620 | | | |
| 20A.EU2 | B.1.160 | | | |
| 20A/S:439K | B.1.258 | | | |
| 20A/S:98F | B.1.221 | | | |
| 20C/S:80Y | B.1.367 | | | |
| 20B/S:626S | B.1.1.277 | | | |
| 20B/S:1122L | B.1.1.302 | | | |

Protein model for 21H (Mu)




Protein model for 21H (Mu). Figure made via CoV-3D

Many of variants that have emerged at the end of 2020 and beginning of 2021 share defining amino acid mutations. Some of these are mutations that are of interest to scientists. This table displays the amino acid mutations shared by the variants below (top), and the other defining mutations of these variants (below). You can toggle how the shared mutations are sorted.

You can read more about each of the variants on the pages for 20I (Alpha, V1), 20H (Beta, V2), 20J (Gamma, V3), 21A (Delta), 21B (Kappa), 21C (Epsilon), 21D (Eta), 21F (Iota), and 21H (Mu).

If you need a reminder of how the nomenclature lines up, you can see a table on our homepage!

View data generation scripts

| 20I (Alpha, V1) (B.1.1.7) | 20H (Beta, V2) (B.1.351) | 20J (Gamma, V3) (P.1) | 21A (Delta) (B.1.617.2) | 21B (Kappa) (B.1.617.1) | 21C (Epsilon) (B.1.427/9) | 21D (Eta) (B.1.525) | 21F (Iota) (B.1.526) | 21G (Lambda) (C.37) | 21H (Mu) (B.1.621) | 20A/S:126A (B.1.620) |
|---|---|---|---|---|---|---|---|---|---|---|
| **Shared mutations** | | | | | | | | | | |
| Sort by: | Commonness / Position | | | | | | | | | |
| | S:L18F | S:L18F | | | | | | | | |
| | | S:P26S | | | | | | | | S:P26S |
| S:H69- | | | | | | S:H69- | | | | S:H69- |
| S:V70- | | | | | | S:V70- | | | | S:V70- |
| | | | | | | | S:T95I | | S:T95I | |
| S:Y144- | | | | | | S:Y144- | | | S:Y144S | S:Y144- |
| | S:L241- | | | | | | | | | S:L241- |
| | S:L242- | | | | | | | | | S:L242- |
| | S:A243- | | | | | | | | | S:A243- |
| | | | | | | | S:D253G | S:D253N | | |
| | S:K417N | S:K417T | | | | | | | | |
| | | | S:L452R | S:L452R | S:L452R | | | S:L452Q | | |
| | S:E484K | S:E484K | | S:E484Q | | S:E484K | S:E484K | | S:E484K | S:E484K |
| S:N501Y | S:N501Y | S:N501Y | | | | | | | S:N501Y | |
| S:D614G | S:D614G | S:D614G | S:D614G | S:D614G | S:D614G | S:D614G | S:D614G | S:D614G | S:D614G | S:D614G |
| S:P681H | | | S:P681R | S:P681R | | | | | S:P681H | S:P681H |
| | S:A701V | | | | | | S:A701V | | | |
| | | | S:D950N | | | | | | S:D950N | |
| | | S:T1027I | | | | | | | | S:T1027I |
| S:D1118H | | | | | | | | | | S:D1118H |
| **Other mutations** | | | | | | | | | | |
| S:A570D | S:D80A | S:T20N | S:T19R | S:E154K | S:S13I | S:Q52R | S:L5F | S:G75V | S:Y145N | S:V126A |
| S:T716I | S:D215G | S:D138Y | S:E156- | S:Q1071H | S:W152C | S:A67V | | S:T76I | S:R346K | S:H245Y |
| S:S982A | | S:R190S | S:F157- | | | S:Q677H | | S:R246- | | S:S477N |
| | | S:H655Y | S:R158G | | | S:F888L | | S:R247- | | |
| | | S:V1176F | S:T478K | | | | | S:R248- | | |
| | | | | | | | | S:R249- | | |
| | | | | | | | | S:R250- | | |
| | | | | | | | | S:R251- | | |
| | | | | | | | | S:R252- | | |
| | | | | | | | | S:F490S | | |
| | | | | | | | | S:T859N | | |

With special thanks to the work of Professors Emma Hodcroft, Jean-Claude Perez, and Luc Montagnier. https://covariants.org/variants/S.Q677H.Robin1

# Vaccine Chasing!

**Which Brings Us to the Current Model Being Used by Most Countries Around the World to Address SARS-CoV-2/ COVID-19.**

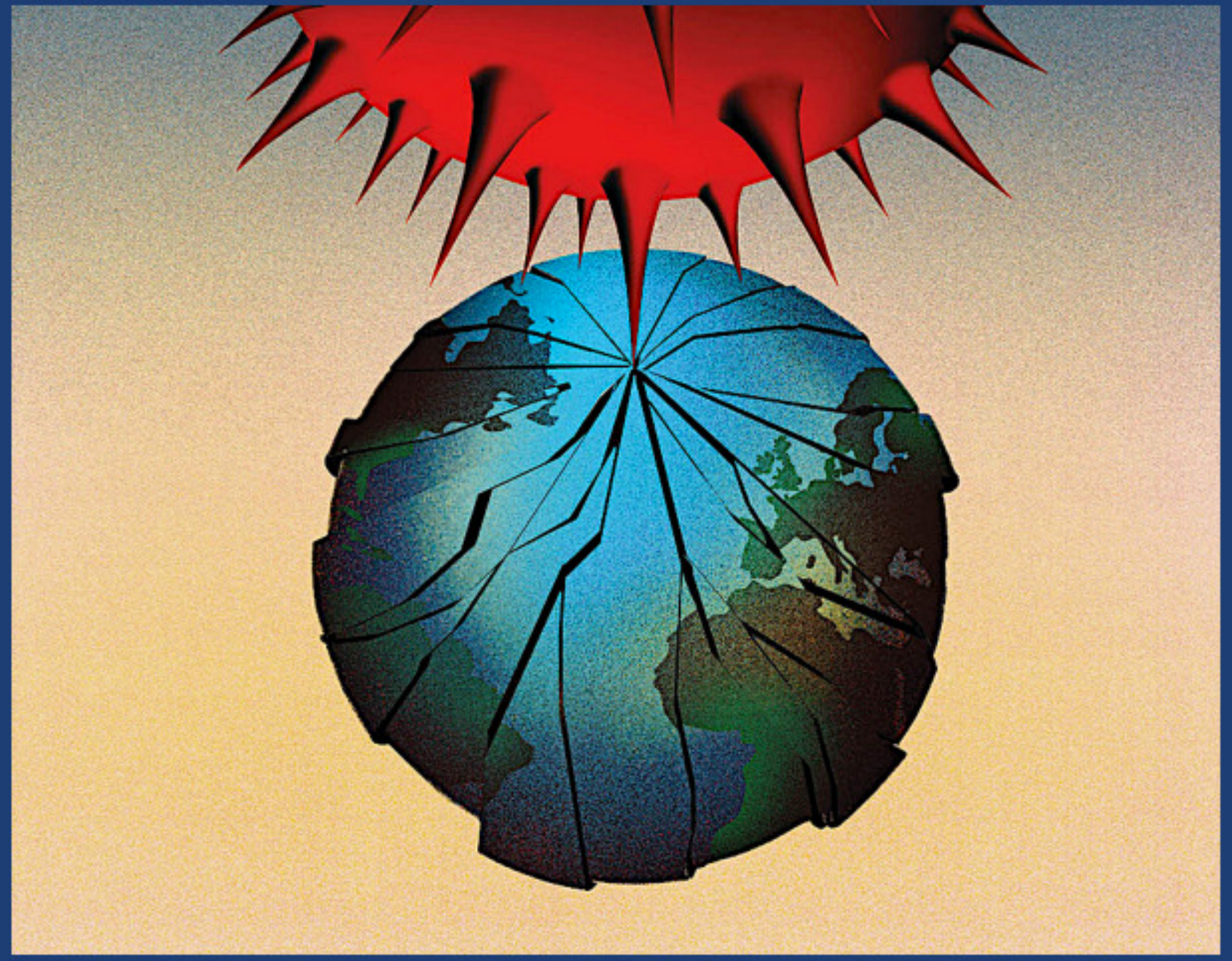
petsami

# Gain-of-Function Bioweapon - Clinical Consequences, Treatment, The Vaccines & Crimes Against Humanity.

Richard M Fleming, PhD, MD, JD
www.Fleming-Method.com

Potential Conflict of Interest (COI): FMTVDM, The Inflammation and Heart Disease Theory

# Such Bioweapons are Literally Crimes Against Humanity.



**crime a·gainst hu·man·i·ty**

*noun*

1. **a deliberate act, typically as part of a systematic campaign that causes human suffering or death on a large scale:**

   "he was handed over to the International Criminal Court in The Hague to face charges of crimes against humanity"

Powered by Oxford Dictionaries

PLOS

**Discovery of a rich gene pool of bat SARS-related coronaviruses provides new insights into the origin of SARS coronavirus**

"... we successfully cultured an additional novel SARSr-CoV Rs4874 from a single fecal sample... we constructed a group of infectious bacterial artificial chromosome (BAC) clones with the backbone of WIV1 and variants of S genes from 8 different bat SARSr-CoVs. Only the infectious clones for Rs4231 and Rs7327 led to cytopathic effects in Vero E6 cells after transfection..."

Peter Daszak, Zheng-Li Shi and others
November 30, 2017

# Violations of
# The Biological Weapons Convention (BWC) Treaty

## The Biological Weapons Convention (BWC) At A Glance

FACT SHEETS & BRIEFS

**Last Reviewed:** March 2020

**Contact:** Daryl Kimball, *Executive Director,* (202) 463-8270 x107

The Biological Weapons Convention (BWC) is a legally binding treaty that outlaws biological arms. After being discussed and negotiated in the United Nations' disarmament forum starting in 1969, the BWC opened for signature on April 10, 1972, and entered into force on March 26, 1975. It currently has 183 states-parties, including Palestine, and four signatories (Egypt, Haiti, Somalia, Syria, and Tanzania). Ten states have neither signed nor ratified the BWC (Chad, Comoros, Djibouti, Eritrea, Israel, Kiribati, Micronesia, Namibia, South Sudan and Tuvalu).

**Terms of the Treaty**

The BWC bans:

- The development, stockpiling, acquisition, retention, and production of:
  1. Biological agents and toxins "of types and in quantities that have no justification for prophylactic, protective or other peaceful purposes;"
  2. Weapons, equipment, and delivery vehicles "designed to use such agents or toxins for hostile purposes or in armed conflict."
- The transfer of or assistance with acquiring the agents, toxins, weapons, equipment, and delivery vehicles described above.

The convention further requires states-parties to destroy or divert to peaceful purposes the "agents, toxins, weapons, equipment, and means of delivery" described above within nine months of the convention's entry into force. The BWC does not ban the use of biological and toxin weapons but reaffirms the 1925 Geneva Protocol, which prohibits such use. It also does not ban biodefense programs.

The BWC bans biological agents that have NO justification for prophylactic, protective or other "peaceful" purposes.

*Seventh Review Conference*

The seventh BWC review conference was held in December 2011. The Final Declaration document concluded that "under all circumstances the use of bacteriological (biological) and toxin weapons is effectively prohibited by the Convention and affirms the determination of States parties to condemn any use of biological agents or toxins other than for peaceful purposes by anyone at any time."

"under all circumstances ... biological and toxic weapons ... effectively prohibited ... condemn any use...

# The 1975 Biological Weapons Convention Treaty

## Crimes Against Humanity

**CONVENTION**
**ON THE PROHIBITION OF THE DEVELOPMENT, PRODUCTION AND STOCKPILING OF BACTERIOLOGICAL (BIOLOGICAL) AND TOXIN WEAPONS AND ON THEIR DESTRUCTION**

The States Parties to this Convention,

Determined to act with a view to achieving effective progress towards general and complete disarmament, including the prohibition and elimination of all types of weapons of mass destruction, and convinced that the prohibition of the development, production and stockpiling of chemical and bacteriological (biological) weapons and their elimination, through effective measures, will facilitate the achievement of general and complete disarmament under strict and effective international control,

Recognising the important significance of the Protocol for the Prohibition of the Use in War of Asphyxiating, Poisonous or Other Gases, and of Bacteriological Methods of Warfare, signed at Geneva on 17 June 1925, and conscious also of the contribution which the said Protocol has already made, and continues to make, to mitigating the horrors of war,

Reaffirming their adherence to the principles and objectives of that Protocol and calling upon all States to comply strictly with them,

Recalling that the General Assembly of the United Nations has repeatedly condemned all actions contrary to the principles and objectives of the Geneva Protocol of 17 June 1925,

Desiring to contribute to the strengthening of confidence between peoples and the general improvement of the international atmosphere,

Desiring also to contribute to the realisation of the purposes and principles of the Charter of the United Nations,

Convinced of the importance and urgency of eliminating from the arsenals of States, through effective measures, such dangerous weapons of mass destruction as those using chemical or bacteriological (biological) agents,

Recognising that an agreement on the prohibition of bacteriological (biological) and toxin weapons represents a first possible step towards the achievement of agreement on effective measures also for the prohibition of the development, production and stockpiling of chemical weapons, and determined to continue negotiations to that end,

Determined, for the sake of all mankind, to exclude completely the possibility of bacteriological (biological) agents and toxins being used as weapons,

Convinced that such use would be repugnant to the conscience of mankind and that no effort should be spared to minimise this risk,

Have agreed as follows:

https://www.un.org/disarmament/biological-weapons

ARTICLE I

Each State Party to this Convention undertakes never in any circumstances to develop, produce, stockpile or otherwise acquire or retain:

(1) microbial or other biological agents, or toxins whatever their origin or method of production, of types and in quantities that have no justification for prophylactic, protective or other peaceful purposes;

(2) weapons, equipment or means of delivery designed to use such agents or toxins for hostile purposes or in armed conflict.

ARTICLE II

Each State Party to this Convention undertakes to destroy, or to divert to peaceful purposes, as soon as possible but not later than nine months after the entry into force of the Convention, all agents, toxins, weapons, equipment and means of delivery specified in Article I of the Convention, which are in its possession or under its jurisdiction or control. In implementing the provisions of this Article all necessary safety precautions shall be observed to protect populations and the environment.

ARTICLE III

Each State Party to this Convention undertakes not to transfer to any recipient whatsoever, directly or indirectly, and not in any way to assist, encourage, or induce any State, group of States or international organisations to manufacture or otherwise acquire any of the agents, toxins, weapons, equipment or means of delivery specified in Article I of the Convention.

ARTICLE IV

Each State Party to this Convention shall, in accordance with its constitutional processes, take any necessary measures to prohibit and prevent the development, production, stockpiling, acquisition or retention of the agents, toxins, weapons, equipment and means of delivery specified in Article I of the Convention, within the territory of such State, under its jurisdiction or under its control anywhere.

ARTICLE V

The States Parties to this Convention undertake to consult one another and to co-operate in solving any problems which may arise in relation to the objective of, or in the application of the provisions of, the Convention. Consultation and co-operation pursuant to this Article may also be undertaken through appropriate international procedures within the framework of the United Nations and in accordance with its Charter.

ARTICLE VI

(1) Any State Party to this Convention which finds that any other State Party is acting in breach of obligations deriving from the provisions of the Convention may lodge a complaint with the Security Council of the United Nations. Such a complaint should include all possible evidence confirming its validity, as well as a request for its consideration by the Security Council.

(2) Each State Party to this Convention undertakes to co-operate in carrying out any investigation which the Security Council may initiate, in accordance with the provisions of the Charter of the United Nations, on the basis of the complaint received by the Council. The Security Council shall inform the States Parties to the Convention of the results of the investigation.

ARTICLE VII

Each State Party to this Convention undertakes to provide or support assistance, in accordance with the United Nations Charter, to any Party to the Convention which so requests, if the Security Council decides that such Party has been exposed to danger as a result of violation of the Convention.

ARTICLE VIII

Nothing in this Convention shall be interpreted as in any way limiting or detracting from the obligations assumed by any State under the Protocol for the Prohibition of the Use in War of Asphyxiating, Poisonous or Other Gases, and of Bacteriological Methods of Warfare, signed at Geneva on 17 June 1925.

ARTICLE IX

Each State Party to this Convention affirms the recognised objective of effective prohibition of chemical weapons and, to this end, undertakes to continue negotiations in good faith with a view to reaching early agreement on effective measures for the prohibition of their development, production and stockpiling and for their destruction, and on appropriate measures concerning equipment and means of delivery specifically designed for the production or use of chemical agents for weapons purposes.

ARTICLE X

(1) The States Parties to this Convention undertake to facilitate, and have the right to participate in, the fullest possible exchange of equipment, materials and scientific and technological information for the use of bacteriological (biological) agents and toxins for peaceful purposes. Parties to the Convention in a position to do so shall also co-operate in contributing individually or together with other States or international organisations to the further development and application of scientific discoveries in the field of bacteriology (biology) for the prevention of disease, or for other peaceful purposes.

(2) This Convention shall be implemented in a manner designed to avoid hampering the economic or technological development of States Parties to the Convention or international co-operation in the field of peaceful bacteriological (biological) activities, including the international exchange of bacteriological (biological) agents and toxins and equipment for the processing, use or production of bacteriological (biological) agents and toxins for peaceful purposes in accordance with the provisions of the Convention.

# The 1975 Biological Weapons Convention Treaty

ARTICLE XI

Any State Party may propose amendments to this Convention. Amendments shall enter into force for each State Party accepting the amendments upon their acceptance by a majority of the States Parties to the Convention and thereafter for each remaining State Party on the date of acceptance by it.

ARTICLE XII

Five years after the entry into force of this Convention, or earlier if it is requested by a majority of Parties to the Convention by submitting a proposal to this effect to the Depositary Governments, a conference of States Parties to the Convention shall be held at Geneva, Switzerland, to review the operation of the Convention, with a view to assuring that the purposes of the preamble and the provisions of the Convention, including the provisions concerning negotiations on chemical weapons, are being realised. Such review shall take into account any new scientific and technological developments relevant to the Convention.

ARTICLE XIII

(1) This Convention shall be of unlimited duration.

(2) Each State Party to this Convention shall in exercising its national sovereignty have the right to withdraw from the Convention if it decides that extraordinary events, related to the subject matter of the Convention, have jeopardised the supreme interests of its country. It shall give notice of such withdrawal to all other States Parties to the Convention and to the United Nations Security Council three months in advance. Such notice shall include a statement of the extraordinary events it regards as having jeopardised its supreme interests.

ARTICLE XIV

(1) This Convention shall be open to all States for signature. Any State which does not sign the Convention before its entry into force in accordance with paragraph 3 of this Article may accede to it at any time.

(2) This Convention shall be subject to ratification by signatory States. Instruments of ratification and instruments of accession shall be deposited with the Governments of the United Kingdom of Great Britain and Northern Ireland, the Union of Soviet Socialist Republics and the United States of America, which are hereby designated the Depositary Governments.

(3) This Convention shall enter into force after the deposit of instruments of ratification by twenty-two Governments, including the Governments designated as Depositaries of the Convention.

(4) For States whose instruments of ratification or accession are deposited subsequent to the entry into force of this Convention, it shall enter into force on the date of the deposit of their instruments of ratification or accession.

https://www.un.org/disarmament/biological-weapons

(5) The Depositary Governments shall promptly inform all signatory and acceding States of the date of each signature, the date of deposit of each instrument of ratification or of accession and the date of the entry into force of this Convention, and of the receipt of other notices.

(6) This Convention shall be registered by the Depositary Governments pursuant to Article 102 of the Charter of the United Nations.

ARTICLE XV

This Convention, the English, Russian, French, Spanish and Chinese texts of which are equally authentic, shall be deposited in the archives of the Depositary Governments. Duly certified copies of the Convention shall be transmitted by the Depositary Governments to the Governments of the signatory and acceding States.


https://en.wikipedia.org/wiki/Biological_Weapons_Convention

# The 1947 Nuremberg Charges are the 2021 Nuremberg 2.0 Charges

## The Charges

As the Allied Powers worked to gather evidence, they also had to determine who should be included in the first round of proceedings. It was ultimately determined that 24 defendants would be charged and put on trial beginning in November 1945; these were some of the most notorious of Nazi's war criminals.

The accused would be indicted on one or more of the following counts:

1. Crimes of Conspiracy: The accused was alleged to have participated in the creation and/or implementation of a joint plan or conspired to assist those in charge of executing a joint plan whose goal involved crimes against the peace.

2. Crimes Against the Peace: The accused was alleged to have committed acts that including planning for, preparation of, or initiation of aggressive warfare.

3. War Crimes: The accused allegedly violated previously established rules of warfare, including the killing of civilians, POWs, or malicious destruction of civilian property.

4. Crimes Against Humanity: The accused was alleged to have committed acts of deportation, enslavement, torture, murder, or other inhumane acts against civilians before or during the war.

Defendants in the dock in Room 600 at the Palace of Justice, during proceedings against leading Nazi figures for war crimes at the Nuremberg Trials. Front row: Goering, Hess, Ribbentrop and Keitel. Back row: Donitz, Raeder, Schirach, Sauckel and Jodl. (Photo by Raymond D'Addario/Galerie Bilderwelt/Getty Images)

https://www.thoughtco.com/the-nurembergtrials-1779316#:~:text=The%20first%20attempt%20to%20punish%20the%20perpetrators%20was,Goering%2C%20Martin%20Bormann%2C%20Julius%20Streicher%2C%20and%20Albert%20Speer.

# During his 1947 Nuremberg Trial Göring Said The Following.

… it is the leaders of the country who determine the policy and it is always a simple matter to drag the people along, whether it is a democracy or a fascist dictatorship or a Parliament or a Communist dictatorship.


…voice or no voice, the people can always be brought to the bidding of the leaders. That is easy. *All you have to do is tell them they are being attacked and denounce the pacifists for lack of patriotism and exposing the country to danger.* It works the same way in any country.

# The Initial 1947 Nuremberg Trials had 24 Defendants
# Adolf Hilter and Joseph Goebbels Committed Suicide before they Could be Held Accountable

| Name | Position | Found Guilty of Counts | Sentenced | Action Taken |
|---|---|---|---|---|
| Martin Bormann (in absentia) | Deputy Führer | 3,4 | Death | Was missing at time of trial. Later it was discovered Bormann had died in 1945. |
| Karl Dönitz | Supreme Commander of the Navy (1943) and German Chancellor | 2,3 | 10 Years in Prison | Served time. Died in 1980. |
| Hans Frank | Governor-General of Occupied Poland | 3,4 | Death | Hanged on October 16, 1946. |
| Wilhelm Frick | Foreign Minister of the Interior | 2,3,4 | Death | Hanged on October 16, 1946. |
| Hans Fritzsche | Head of the Radio Division of the Propaganda Ministry | Not Guilty | Acquitted | In 1947, sentenced to 9 years in work camp; released after 3 years. Died in 1953. |
| Walther Funk | President of the Reichsbank (1939) | 2,3,4 | Life in Prison | Early release in 1957. Died in 1960. |
| Hermann Göring | Reich Marshal | All Four | Death | Committed suicide on October 15, 1946 (three hours before he was to be executed). |
| Rudolf Hess | Deputy to the Führer | 1,2 | Life in Prison | Died in prison on August 17, 1987. |
| Alfred Jodl | Chief of the Operations Staff of the Armed Forces | All Four | Death | Hanged on October 16, 1946. In 1953, a German appeals court posthumously found Jodl not guilty of breaking international law. |
| Ernst Kaltenbrunner | Chief of the Security Police, SD, and RSHA | 3,4 | Death | Chief of the Security Police, SD, and RSHA. |
| Wilhelm Keitel | Chief of the High Command of the Armed Forces | All Four | Death | Requested to be shot as a soldier. Request denied. Hanged on October 16, 1946. |
| Konstantin von Neurath | Minister of Foreign Affairs and Reich Protector of Bohemia and Moravia | All Four | 15 Years in Prison | Early release in 1954. Died in 1956. |
| Franz von Papen | Chancellor (1932) | Not Guilty | Acquitted | In 1949, a German court sentenced Papen to 8 years in work camp; time was considered already served. Died in 1969. |
| Erich Raeder | Supreme Commander of the Navy (1928-1943) | 2,3,4 | Life in Prison | Early release in 1955. Died in 1960. |
| Joachim von Ribbentrop | Reich Foreign Minister | All Four | Death | Hanged on October 16, 1946. |
| Alfred Rosenberg | Party Philosopher and Reich Minister for the Eastern Occupied Area | All Four | Death | Party Philosopher and Reich Minister for the Eastern Occupied Area |
| Fritz Sauckel | Plenipotentiary for Labor Allocation | 2,4 | Death | Hanged on October 16, 1946. |
| Hjalmar Schacht | Minister of Economics and President of the Reichsbank (1933-1939) | Not Guilty | Acquitted | Denazification court sentenced Schacht to 8 years in a work camp; released in 1948. Died in 1970. |
| Baldur von Schirach | Führer of the Hitler Youth | 4 | 20 Years in Prison | Served his time. Died in 1974. |
| Arthur Seyss-Inquart | Minister of the Interior and Reich Governor of Austria | 2,3,4 | Death | Minister of the Interior and Reich Governor of Austria |
| Albert Speer | Minister of Armaments and War Production | 3,4 | 20 Years | Served his time. Died in 1981. |
| Julius Streicher | Founder of Der Stürmer | 4 | Death | Hanged on October 16, 1946. |

https://www.thoughtco.com/the-nurembergtrials-1779316#:~:text=The%20first%20attempt%20to%20punish%20the%20perpetrators%20was,Goering%2C%20Martin%20Bormann%2C%20Julius%20Streicher%2C%20and%20Albert%20Speer.

# 12-Death Sentences, 3-Life Imprisonments, 4-Sentenced to 10-20 years in Prison

## Three Acquitted.

A total of 24 defendants were originally slated to be put on trial during this initial Nuremberg trial, but only 22 were actually tried (Robert Ley had committed suicide and Gustav Krupp von Bohlen was deemed unfit to stand trial). Of the 22, one wasn't in custody; Martin Bormann (Nazi Party Secretary) was charged *in absentia*. (It was later discovered that Bormann had died in May 1945.)

Although the list of defendants was long, two key individuals were missing. Both Adolf Hitler and his propaganda minister, Joseph Goebbels, had committed suicide as the war was coming to an end. It was decided that there was enough evidence regarding their deaths, unlike Bormann's, that they were not placed on trial.

The trial resulted in a total of 12 death sentences, all of which were administered on October 16, 1946, with one exception -- Herman Goering committed suicide by cyanide the night before the hangings were to take place. Three of the accused were sentenced to life in prison. Four individuals were sentenced to jail terms ranging from ten to twenty years. An additional three individuals were acquitted of all charges.

Although the initial trial held at Nuremberg is the most famous, it was not the only trial held there. The Nuremberg Trials also included a series of twelve trials held in the Palace of Justice following the conclusion of the initial trial.

The judges in the subsequent trials were all American, as the other Allied powers wished to focus on the massive task of rebuilding needed after World War II.

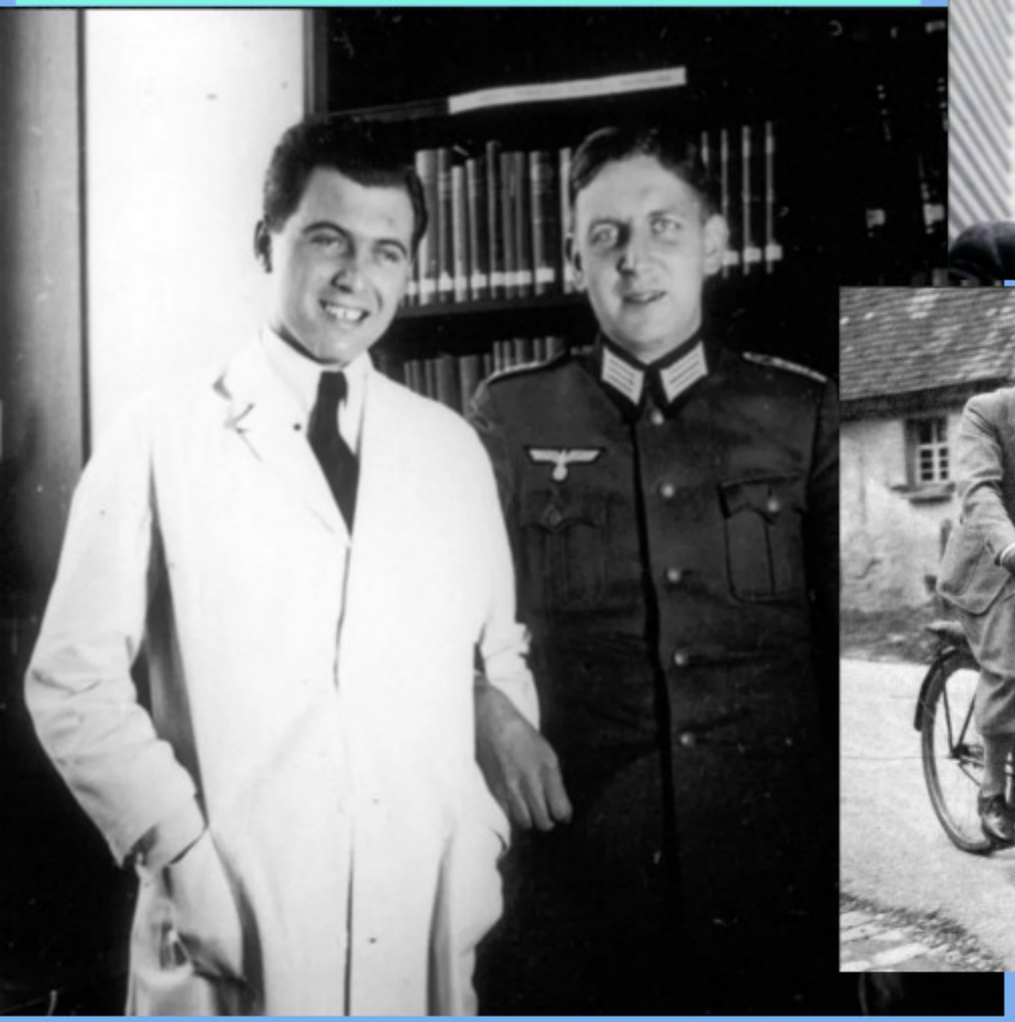
Additional trials in the series included:

The Doctor's Trial
The Milch Trial
The Judge's Trial
The Pohl Trial
The Flick Trial
The IG Farben Trial
The Hostages Trial
The RuSHA Trial
The Einsatzgruppen Trial
The Krupp Trial
The Ministries Trial
The High Command Trial

https://www.thoughtco.com/the-nurembergtrials-1779316#:~:text=The%20first%20attempt%20to%20punish%20the%20perpetrators%20was,Goering%2C%20Martin%20Bormann%2C%20Julius%20Streicher%2C%20and%20Albert%20Speer.

# Dr. Josef Mengele "Angel of Death"

From Wealthy Family, Not in charge of Auschwitz but SS Doctor with Government Grant to Study Genetics & Diseases.




https://www.thoughtco.com/the-nuremberg-laws-of-1935-1779277

https://www.thoughtco.com/ten-facts-about-dr-josef-mengele-2136588

The United States Holocaust Memorial Museum commemorates the fiftieth anniversary of

**The Doctors Trial (the Medical Case of the Subsequent Nuremberg Proceedings)**

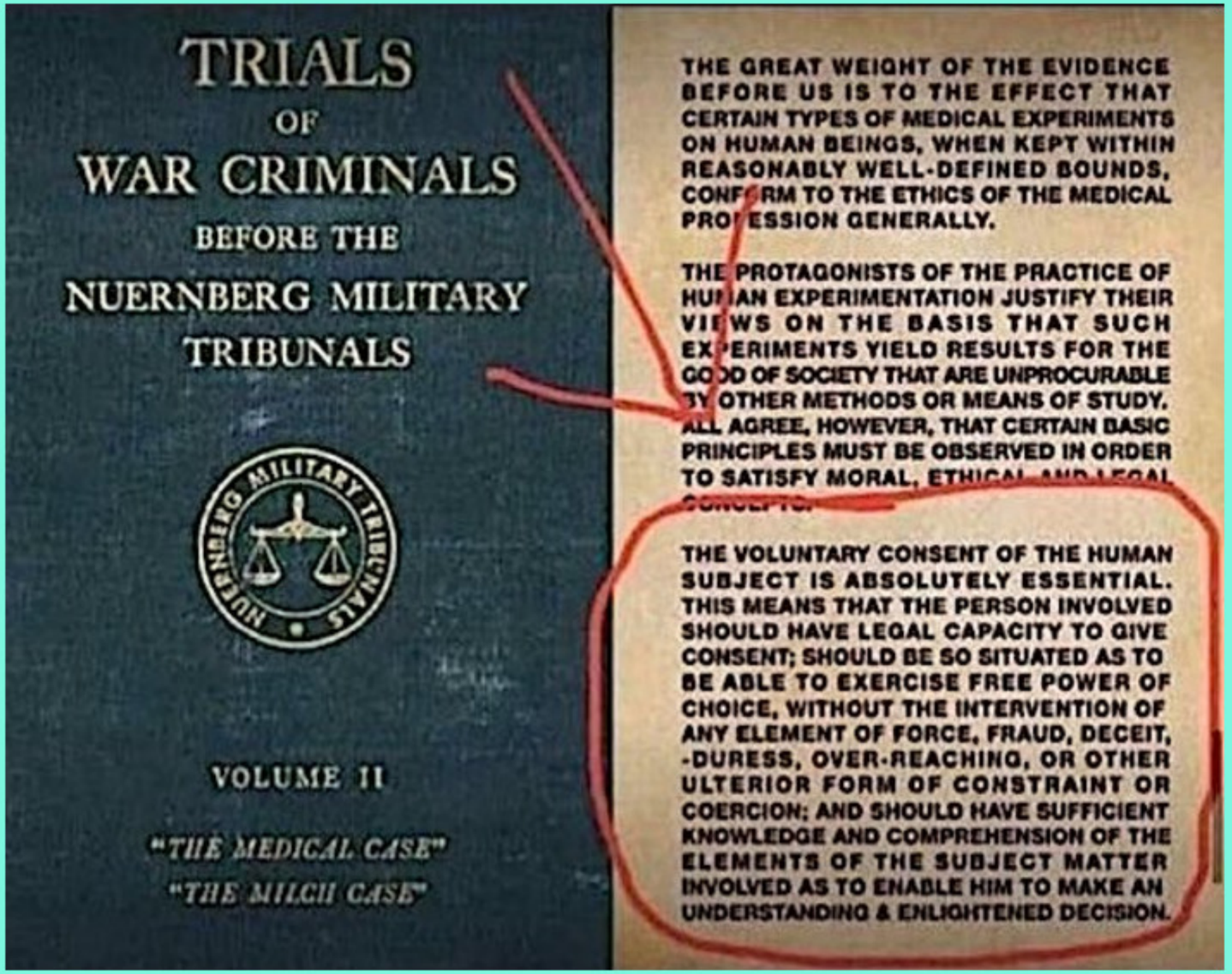
# THE NUREMBERG CODE

**[USHMM note]**

On August 19, 1947, the judges of the American military tribunal in the case of the USA vs. Karl Brandt et. al. delivered their verdict. Before announcing the guilt or innocence of each defendant, they confronted the difficult question of medical experimentation on human beings. Several German doctors had argued in their own defense that their experiments differed little from previous American or German ones. Furthermore they showed that no international law or informal statement differentiated between legal and illegal human experimentation. This argument worried Drs. Andrew Ivy and Leo Alexander, American doctors who had worked with the prosecution during the trial. On April 17, 1947, Dr. Alexander submitted a memorandum to the United States Counsel for War Crimes which outlined six points defining legitimate research. The verdict of August 19 reiterated almost all of these points in a section entitled **"Permissible Medical Experiments"** and revised the original six points into ten. Subsequently, the ten points became known as the "Nuremberg Code." Although the code addressed the defense arguments in general, remarkably none of the specific findings against Brandt and his codefendants mentioned the code. Thus the legal force of the document was not well established. The uncertain use of the code continued in the half century following the trial when it informed numerous international ethics statements but failed to find a place in either the American or German national law codes. Nevertheless, it remains a landmark document on medical ethics and one of the most lasting products of the "Doctors Trial."

https://web.archive.org/web/19970403044532/http://www.ushmm.org/research/doctors/code_expl.htm

# The 1947 Nuremberg Code



# Violation of The 1947 Nuremberg Code

BRITISH MEDICAL JOURNAL No 7070 Volume 313: Page 1448,
7 December 1996.

**Introduction**

The judgment by the war crimes tribunal at Nuremberg laid down 10 standards to which physicians must conform when carrying out experiments on human subjects in a new code that is now accepted worldwide.

This judgment established a new standard of ethical medical behaviour for the post World War II human rights era. Amongst other requirements, this document enunciates the requirement of *voluntary informed consent* of the human subject. The principle of voluntary informed consent protects the right of the individual to control his own body.

This code also recognizes that the risk must be weighed against the expected benefit, and that unnecessary pain and suffering must be avoided.

This code recognizes that doctors should avoid actions that injure human patients.

The principles established by this code for medical practice now have been extended into general codes of medical ethics.

## The Nuremberg Code (1947)

**Permissible Medical Experiments**

The great weight of the evidence before us to effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

   The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

For more information see Nuremberg Doctor's Trial, *BMJ* 1996;313(7070):1445-75.

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Human Medical experimentation must be conducted by trained personnel based upon animal studies and following informed consent.

# Nuremberg 2.0

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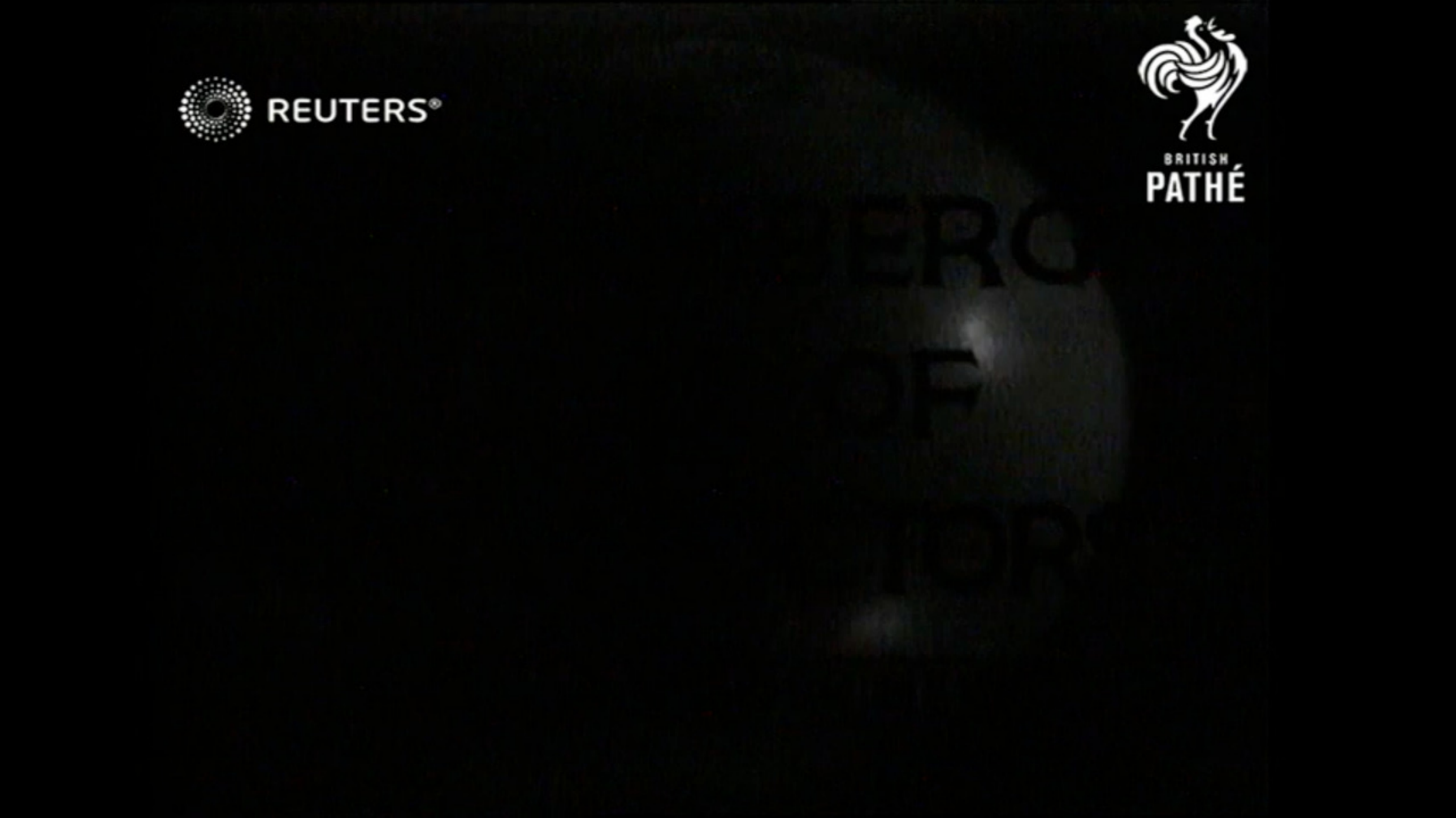

REUTERS
BRITISH
PATHÉ

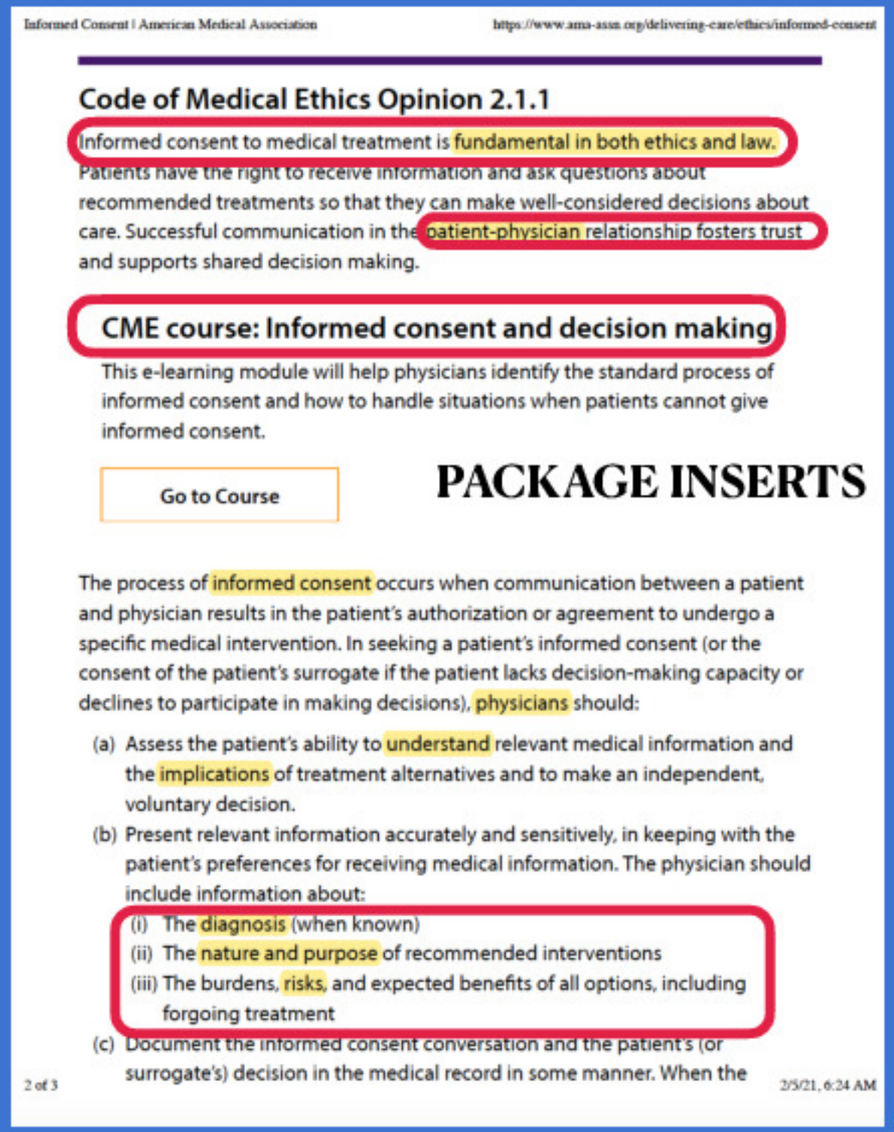
The Doctors Trial considered the fate of twenty-three German physicians who either participated in the Nazi program to euthanize persons deemed "unworthy of life" (the mentally ill, mentally retarded, or physically disabled) or who conducted experiments on concentration camp prisoners without their consent. The Doctors Trial lasted 140 days. Eighty-five witnesses testified and almost 1,500 documents were introduced. Sixteen of the doctors charged were found guilty. Seven were executed.

Defendant Doctors

Indictments
Count I--The Common Design or Conspiracy
Count II--War Crimes
Count III--Crimes Against Humanity
Count IV--Membership in a Criminal Organization

https://web.archive.org/web/19970403043340/http://www.ushmm.org/research/doctors/index.html

# Physician Violation The American Medical Association (AMA) Code of Medical Ethics





**Code of Medical Ethics Opinion 2.1.1**

Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

**CME course: Informed consent and decision making**

This e-learning module will help physicians identify the standard process of informed consent and how to handle situations when patients cannot give informed consent.

Go to Course

**PACKAGE INSERTS**

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:

(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.

(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:

(i) The diagnosis (when known)
(ii) The nature and purpose of recommended interventions
(iii) The burdens, risks, and expected benefits of all options, including forgoing treatment

(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the

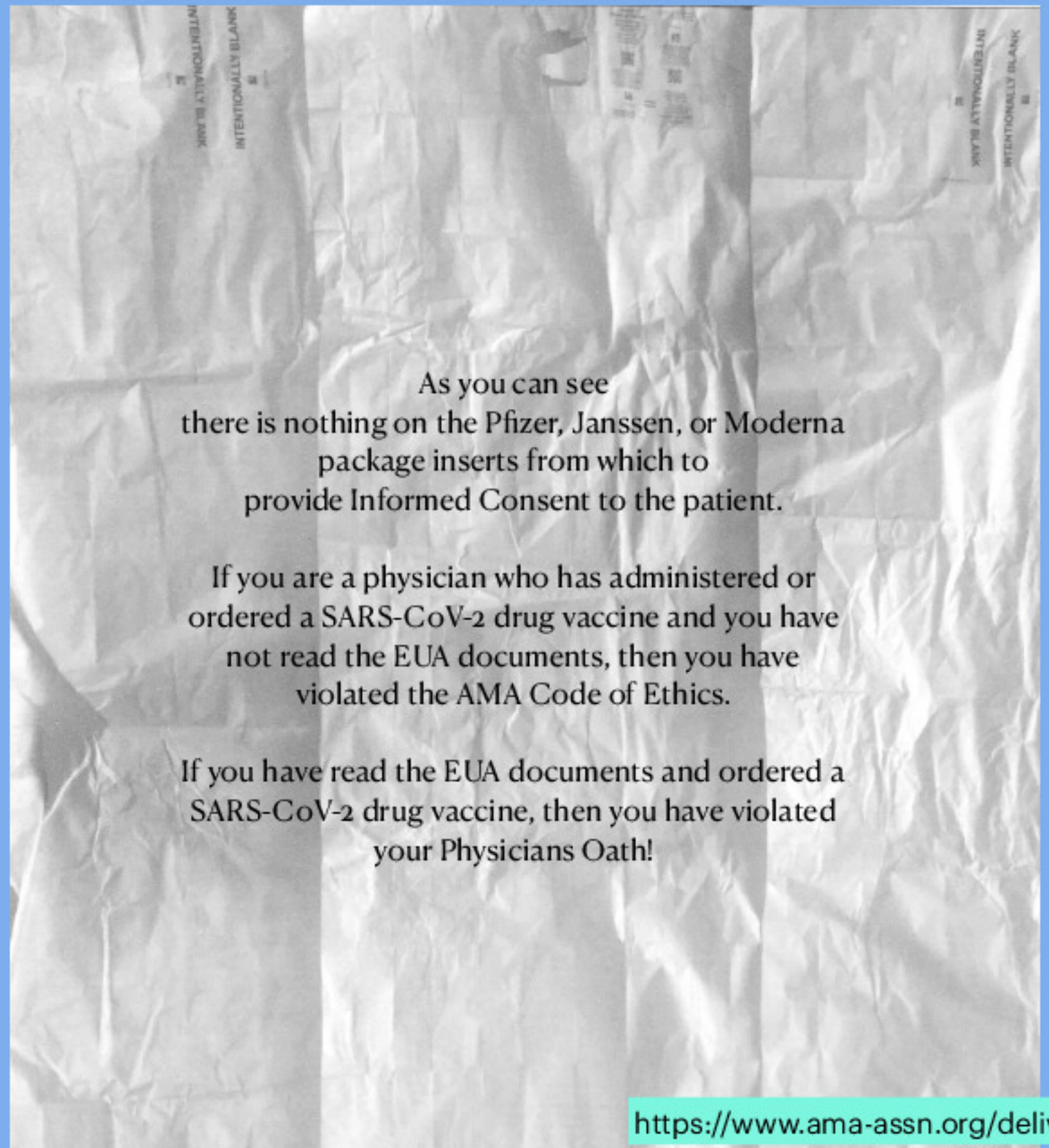


Patient Informed Consent is Fundamental to both Medicine and Law.

Informed Consent is between the patient and physician.

Informed Consent requires patients being made aware of the purpose, risks & benefits of a test or treatment.

# American Medical Association Code of Ethics

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(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

*AMA Principles of Medical Ethics: I, II, V, VIII*

https://www.ama-assn.org/delivering-care/ethics/informed-consent

https://www.ama-assn.org/delivering-care/ethics/code-medical-ethics-consent-communication-decision-making

# World Medical Association (WMA) Declaration of Helsinki- Ethical Principles for Medical Research Involving Human Subjects

Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964
and amended by the:
29th WMA General Assembly, Tokyo, Japan, October 1975
35th WMA General Assembly, Venice, Italy, October 1983
41st WMA General Assembly, Hong Kong, September 1989
48th WMA General Assembly, Somerset West, Republic of South Africa, October 1996
52nd WMA General Assembly, Edinburgh, Scotland, October 2000
53rd WMA General Assembly, Washington DC, USA, October 2002 (Note of Clarification added)
55th WMA General Assembly, Tokyo, Japan, October 2004 (Note of Clarification added)
59th WMA General Assembly, Seoul, Republic of Korea, October 2008
64th WMA General Assembly, Fortaleza, Brazil, October 2013

## Preamble

1. The World Medical Association (WMA) has developed the Declaration of Helsinki as a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data.

The Declaration is intended to be read as a whole and each of its constituent paragraphs should be applied with consideration of all other relevant paragraphs.

2. Consistent with the mandate of the WMA, the Declaration is addressed primarily to physicians. The WMA encourages others who are involved in medical research involving human subjects to adopt these principles.

## General Principles

3. The Declaration of Geneva of the WMA binds the physician with the words, "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that, "A physician shall act in the patient's best interest when providing medical care."

4. It is the duty of the physician to promote and safeguard the health, well-being and rights of patients, including those who are involved in medical research. The physician's knowledge and conscience are dedicated to the fulfilment of this duty.

5. Medical progress is based on research that ultimately must include studies involving human subjects.

6. The primary purpose of medical research involving human subjects is to understand the causes, development and effects of diseases and improve preventive, diagnostic and therapeutic interventions (methods, procedures and treatments). Even the best proven interventions must be evaluated continually through research for their safety, effectiveness, efficiency, accessibility and quality.

7. Medical research is subject to ethical standards that promote and ensure respect for all human subjects and protect their health and rights.

8. While the primary purpose of medical research is to generate new knowledge, this goal can never take precedence over the rights and interests of individual research subjects.

9. It is the duty of physicians who are involved in medical research to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects. The responsibility for the protection of research subjects must always rest with the physician or other health care professionals and never with the research subjects, even though they have given consent.

https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/

# World Medical Association (WMA) Declaration of Helsinki- Ethical Principles for Medical Research Involving Human Subjects

10. Physicians must consider the ethical, legal and regulatory norms and standards for research involving human subjects in their own countries as well as applicable international norms and standards. No national or international ethical, legal or regulatory requirement should reduce or eliminate any of the protections for research subjects set forth in this Declaration.

11. Medical research should be conducted in a manner that minimises possible harm to the environment.

12. Medical research involving human subjects must be conducted only by individuals with the appropriate ethics and scientific education, training and qualifications. Research on patients or healthy volunteers requires the supervision of a competent and appropriately qualified physician or other health care professional.

13. Groups that are underrepresented in medical research should be provided appropriate access to participation in research.

14. Physicians who combine medical research with medical care should involve their patients in research only to the extent that this is justified by its potential preventive, diagnostic or therapeutic value and if the physician has good reason to believe that participation in the research study will not adversely affect the health of the patients who serve as research subjects.

15. Appropriate compensation and treatment for subjects who are harmed as a result of participating in research must be ensured.

## Risks, Burdens and Benefits

16. In medical practice and in medical research, most interventions involve risks and burdens.

Medical research involving human subjects may only be conducted if the importance of the objective outweighs the risks and burdens to the research subjects.

17. All medical research involving human subjects must be preceded by careful assessment of predictable risks and burdens to the individuals and groups involved in the research in comparison with foreseeable benefits to them and to other individuals or groups affected by the condition under investigation.

Measures to minimise the risks must be implemented. The risks must be continuously monitored, assessed and documented by the researcher.

18. Physicians may not be involved in a research study involving human subjects unless they are confident that the risks have been adequately assessed and can be satisfactorily managed.

When the risks are found to outweigh the potential benefits or when there is conclusive proof of definitive outcomes, physicians must assess whether to continue, modify or immediately stop the study.

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# World Medical Association (WMA) Declaration of Helsinki- Ethical Principles for Medical Research Involving Human Subjects

## Vulnerable Groups and Individuals

19. Some groups and individuals are particularly vulnerable and may have an increased likelihood of being wronged or of incurring additional harm.

All vulnerable groups and individuals should receive specifically considered protection.

20. Medical research with a vulnerable group is only justified if the research is responsive to the health needs or priorities of this group and the research cannot be carried out in a non-vulnerable group. In addition, this group should stand to benefit from the knowledge, practices or interventions that result from the research.

## Scientific Requirements and Research Protocols

21. Medical research involving human subjects must conform to generally accepted scientific principles, be based on a thorough knowledge of the scientific literature, other relevant sources of information, and adequate laboratory and, as appropriate, animal experimentation. The welfare of animals used for research must be respected.

22. The design and performance of each research study involving human subjects must be clearly described and justified in a research protocol.

The protocol should contain a statement of the ethical considerations involved and should indicate how the principles in this Declaration have been addressed. The protocol should include information regarding funding, sponsors, institutional affiliations, potential conflicts of interest, incentives for subjects and information regarding provisions for treating and/or compensating subjects who are harmed as a consequence of participation in the research study.

In clinical trials, the protocol must also describe appropriate arrangements for post-trial provisions.

## Research Ethics Committees

23. The research protocol must be submitted for consideration, comment, guidance and approval to the concerned research ethics committee before the study begins. This committee must be transparent in its functioning, must be independent of the researcher, the sponsor and any other undue influence and must be duly qualified. It must take into consideration the laws and regulations of the country or countries in which the research is to be performed as well as applicable international norms and standards but these must not be allowed to reduce or eliminate any of the protections for research subjects set forth in this Declaration.

The committee must have the right to monitor ongoing studies. The researcher must provide monitoring information to the committee, especially information about any serious adverse events. No amendment to the protocol may be made without consideration and approval by the committee. After the end of the study, the researchers must submit a final report to the committee containing a summary of the study's findings and conclusions.

## Privacy and Confidentiality

24. Every precaution must be taken to protect the privacy of research subjects and the confidentiality of their personal information.

## Informed Consent

25. Participation by individuals capable of giving informed consent as subjects in medical research must be voluntary. Although it may be appropriate to consult family members or community leaders, no individual capable of giving informed consent may be enrolled in a research study unless he or she freely agrees.

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# World Medical Association (WMA) Declaration of Helsinki- Ethical Principles for Medical Research Involving Human Subjects

26. In medical research involving human subjects capable of giving informed consent, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail, post-study provisions and any other relevant aspects of the study. The potential subject must be informed of the right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. Special attention should be given to the specific information needs of individual potential subjects as well as to the methods used to deliver the information.

After ensuring that the potential subject has understood the information, the physician or another appropriately qualified individual must then seek the potential subject's freely-given informed consent, preferably in writing. If the consent cannot be expressed in writing, the non-written consent must be formally documented and witnessed.

All medical research subjects should be given the option of being informed about the general outcome and results of the study.

27. When seeking informed consent for participation in a research study the physician must be particularly cautious if the potential subject is in a dependent relationship with the physician or may consent under duress. In such situations the informed consent must be sought by an appropriately qualified individual who is completely independent of this relationship.

28. For a potential research subject who is incapable of giving informed consent, the physician must seek informed consent from the legally authorised representative. These individuals must not be included in a research study that has no likelihood of benefit for them unless it is intended to promote the health of the group represented by the potential subject, the research cannot instead be performed with persons capable of providing informed consent, and the research entails only minimal risk and minimal burden.

29. When a potential research subject who is deemed incapable of giving informed consent is able to give assent to decisions about participation in research, the physician must seek that assent in addition to the consent of the legally authorised representative. The potential subject's dissent should be respected.

30. Research involving subjects who are physically or mentally incapable of giving consent, for example, unconscious patients, may be done only if the physical or mental condition that prevents giving informed consent is a necessary characteristic of the research group. In such circumstances the physician must seek informed consent from the legally authorised representative. If no such representative is available and if the research cannot be delayed, the study may proceed without informed consent provided that the specific reasons for involving subjects with a condition that renders them unable to give informed consent have been stated in the research protocol and the study has been approved by a research ethics committee. Consent to remain in the research must be obtained as soon as possible from the subject or a legally authorised representative.

31. The physician must fully inform the patient which aspects of their care are related to the research. The refusal of a patient to participate in a study or the patient's decision to withdraw from the study must never adversely affect the patient-physician relationship.

32. For medical research using identifiable human material or data, such as research on material or data contained in biobanks or similar repositories, physicians must seek informed consent for its collection, storage and/or reuse. There may be exceptional situations where consent would be impossible or impracticable to obtain for such research. In such situations the research may be done only after consideration and approval of a research ethics committee.

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# World Medical Association (WMA) Declaration of Helsinki- Ethical Principles for Medical Research Involving Human Subjects

## Use of Placebo

33. The benefits, risks, burdens and effectiveness of a new intervention must be tested against those of the best proven intervention(s), except in the following circumstances:

Where no proven intervention exists, the use of placebo, or no intervention, is acceptable; or

Where for compelling and scientifically sound methodological reasons the use of any intervention less effective than the best proven one, the use of placebo, or no intervention is necessary to determine the efficacy or safety of an intervention

and the patients who receive any intervention less effective than the best proven one, placebo, or no intervention will not be subject to additional risks of serious or irreversible harm as a result of not receiving the best proven intervention.

Extreme care must be taken to avoid abuse of this option.

## Post-Trial Provisions

34. In advance of a clinical trial, sponsors, researchers and host country governments should make provisions for post-trial access for all participants who still need an intervention identified as beneficial in the trial. This information must also be disclosed to participants during the informed consent process.

## Research Registration and Publication and Dissemination of Results

35. Every research study involving human subjects must be registered in a publicly accessible database before recruitment of the first subject.

36. Researchers, authors, sponsors, editors and publishers all have ethical obligations with regard to the publication and dissemination of the results of research. Researchers have a duty to make publicly available the results of their research on human subjects and are accountable for the completeness and accuracy of their reports. All parties should adhere to accepted guidelines for ethical reporting. Negative and inconclusive as well as positive results must be published or otherwise made publicly available. Sources of funding, institutional affiliations and conflicts of interest must be declared in the publication. Reports of research not in accordance with the principles of this Declaration should not be accepted for publication.

## Unproven Interventions in Clinical Practice

37. In the treatment of an individual patient, where proven interventions do not exist or other known interventions have been ineffective, the physician, after seeking expert advice, with informed consent from the patient or a legally authorised representative, may use an unproven intervention if in the physician's judgement it offers hope of saving life, re-establishing health or alleviating suffering. This intervention should subsequently be made the object of research, designed to evaluate its safety and efficacy. In all cases, new information must be recorded and, where appropriate, made publicly available.

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# The Hippocratic Oath
(Modern Version)

I SWEAR in the presence of the Almighty and before my family, my teachers and my peers that according to my ability and judgment I will keep this Oath and Stipulation.

TO RECKON all who have taught me this art equally dear to me as my parents and in the same spirit and dedication to impart a knowledge of the art of medicine to others. I will continue with diligence to keep abreast of advances in medicine. I will treat without exception all who seek my ministrations, so long as the treatment of others is not compromised thereby, and I will seek the counsel of particularly skilled physicians where indicated for the benefit of my patient.

I WILL FOLLOW that method of treatment which according to my ability and judgment, I consider for the benefit of my patient and abstain from whatever is harmful or mischievous. I will neither prescribe nor administer a lethal dose of medicine to any patient even if asked nor counsel any such thing nor perform the utmost respect for every human life from fertilization to natural death and reject abortion that deliberately takes a unique human life.

WITH PURITY, HOLINESS AND BENEFICENCE I will pass my life and practice my art. Except for the prudent correction of an imminent danger, I will neither treat any patient nor carry out any research on any human being without the valid informed consent of the subject or the appropriate legal protector thereof, understanding that research must have as its purpose the furtherance of the health of that individual. Into whatever patient setting I enter, I will go for the benefit of the sick and will abstain from every voluntary act of mischief or corruption and further from the seduction of any patient.

WHATEVER IN CONNECTION with my professional practice or not in connection with it I may see or hear in the lives of my patients which ought not be spoken abroad, I will not divulge, reckoning that all such should be kept secret.

WHILE I CONTINUE to keep this Oath unviolated may it be granted to me to enjoy life and the practice of the art and science of medicine with the blessing of the Almighty and respected by my peers and society, but should I trespass and violate this Oath, may the reverse by my lot.

# *Physician's Oath*

## *From the Declaration of Geneva*

**At the time of being admitted as a member of the medical profession**

**I solemnly pledge myself to consecrate my life to the service of humanity.**

**I will give to my teachers the respect and gratitude which is their due;**

**I will practice my profession with conscience and dignity;**

**The health of my patient will be my first consideration;**

**I will respect the secrets which are confided in me;**

**I will maintain, by all the means in my power, the honor and the noble traditions of the medical profession;**

**I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;**

**I will maintain the utmost respect for human life; even under threat, I will not use my medical knowledge contrary to the laws of humanity.**

**I make these promises solemnly, freely and upon my honor.**

**Oath sworn on May sixteenth**
**Nineteen hundred and eighty-six**
**The University of Iowa**
**College of Medicine**

# Violation of The International Covenant on Civil and Political Rights (ICCPR) Treaty on Human Experimentation.

**International Covenant on Civil and Political Rights**

Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 23 March 1976, in accordance with Article 49

Article 7

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

# 1967 International Covenant on Civil & Political Rights

Text in PDF Format

## International Covenant on Civil and Political Rights

**Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 23 March 1976, in accordance with Article 49**

Preamble

The States Parties to the present Covenant,

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Recognizing that these rights derive from the inherent dignity of the human person,

Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights,

Considering the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms,

Realizing that the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant,

Agree upon the following articles:

https://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx

**PART I**

***Article 1***

1. All peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

2. All peoples may, for their own ends, freely dispose of their natural wealth and resources without prejudice to any obligations arising out of international economic co-operation, based upon the principle of mutual benefit, and international law. In no case may a people be deprived of its own means of subsistence.

3. The States Parties to the present Covenant, including those having responsibility for the administration of Non-Self-Governing and Trust Territories, shall promote the realization of the right of self-determination, and shall respect that right, in conformity with the provisions of the Charter of the United Nations.

**PART II**

***Article 2***

1. Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

2. Where not already provided for by existing legislative or other measures, each State Party to the present Covenant undertakes to take the necessary steps, in accordance with its constitutional processes and with the provisions of the present Covenant, to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant.

3. Each State Party to the present Covenant undertakes:

(a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;

(b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;

(c) To ensure that the competent authorities shall enforce such remedies when granted.

# 1967 International Covenant on Civil & Political Rights

***Article 3***

The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all civil and political rights set forth in the present Covenant.

***Article 5***

1. Nothing in the present Covenant may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms recognized herein or at their limitation to a greater extent than is provided for in the present Covenant.

2. There shall be no restriction upon or derogation from any of the fundamental human rights recognized or existing in any State Party to the present Covenant pursuant to law, conventions, regulations or custom on the pretext that the present Covenant does not recognize such rights or that it recognizes them to a lesser extent.

***Article 7***

No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

***Article 9***

1. Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.

2. Anyone who is arrested shall be informed, at the time of arrest, of the reasons for his arrest and shall be promptly informed of any charges against him.

3. Anyone arrested or detained on a criminal charge shall be brought promptly before a judge or other officer authorized by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release. It shall not be the general rule that persons awaiting trial shall be detained in custody, but release may be subject to guarantees to appear for trial, at any other stage of the judicial proceedings, and, should occasion arise, for execution of the judgement.

4. Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.

5. Anyone who has been the victim of unlawful arrest or detention shall have an enforceable right to compensation.

https://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx

After the Prosecution of these Criminals
Who Ran Nazi Germany, and
The Doctors Who Carried Out Experimental
Atrocities On the People,
Came The Trials for the **Judges** That Made it Possible
for These Atrocities to Occur in Nazi Germany.

# The Juristenprozess; or, the **Justice Trial**, Viz. The Judges Trial

Defendants [ edit ]

| Name | Image | Position |
|---|---|---|
| Josef Altstötter |  | Chief of the civil law and procedure division of the Ministry of Justice |
| Paul Barnickel [de] |  | Senior public prosecutor of the People's Court |
| Hermann Cuhorst [de] |  | Chief justice of the Special Court |
| Karl Engert [de] |  | Chief of the penal administrative division in the Ministry of Justice |
| Günther Joël [de] |  | Legal advisor and chief prosecutor of the Ministry of Justice |
| Herbert Klemm [de] |  | State Secretary in the Ministry of Justice |
| Ernst Lautz [de] |  | Chief Public Prosecutor of the People's Court |
| Wolfgang Mettgenberg [de] |  | Representative of the criminal legislation and administration division of the Ministry of Justice |
| Günther Nebelung [de] |  | Chief justice of the Fourth Senate, People's Court |
| Rudolf Oeschey [de] |  | Chief judge of the Special Court at Nuremberg |
| Hans Petersen [de] |  | Chief justice of the First Senate, People's Court |
| Oswald Rothaug |  | Senior public prosecutor of the People's Court; Chief Justice of the Special Court |
| Curt Rothenberger |  | President of the Court of Appeals in Hamburg from 1935-1942, later became State Secretary in the Ministry of Justice |
| Franz Schlegelberger |  | State Secretary, later Acting Minister of Justice |
| Wilhelm von Ammon [de] |  | Counsellor of criminal legislation and administration division in the Ministry of Justice |
| Carl Westphal [de] | | Counsellor, criminal legislation and administration in the Ministry of Justice |

https://en.wikipedia.org/wiki/Judges%27_Trial#:~:text=The%20Judges%27%20Trial%20%28%20German%3A%20Juristenprozess%3B%20or%2C%20the,Nuremberg%20after%20the%20end%20of%20World%20War%20II.

## Crimes of Conspiracy, Crimes Against Peace, War Crimes & Crimes Against Humanity

- For the **development** of a Biological Weapon in violation of the Biological Weapons Convention Treaty.
- For the **testing** of a Biological Weapon in violation of the Biological Weapons Convention Treaty.
- For the **release** of a Biological Weapon in violation of the Biological Weapons Convention Treaty.

# Crimes of Conspiracy, Crimes Against Peace, War Crimes & Crimes Against Humanity

- For the **interference** with the practice of medicine prohibiting physicians from prescribing medical **treatment** to those who were **infected** with the developed and released Biological Weapon.

- For the **interference** with the practice of medicine prohibiting physicians from prescribing medical **treatment** to those who developed the **InflammoThrombotic Release (ITR) and subsequent Disease COVID-19** resulting from infection with the developed and released Biological Weapon.

# Crimes of Conspiracy, Crimes Against Peace, War Crimes & Crimes Against Humanity

- For the **failure to follow the required testing of drugs** in tissue and animal models prior to giving experimental drug vaccines to humans as required by

  The 1947 Nuremberg Code

  The 1964 Declaration of Helsinki

  The 1976 International Covenant on Civil and Political Rights

  The American Medical Association Code of Medical Ethics

- For the **failure to obtain Informed Consent** before testing experimental drugs including the drug vaccines as required by

  The 1947 Nuremberg Code

  The 1964 Declaration of Helsinki

  The 1976 International Covenant on Civil and Political Rights

  The American Medical Association Code of Medical Ethics

# Crimes of Conspiracy, Crimes Against Peace, War Crimes & Crimes Against Humanity

- For **Experimentation upon Citizens, including the frail, elderly, those with physical and mental diseases** using Experimental Drug Vaccines without following the required testing of drugs in tissue and animal models prior to giving experimental drug vaccines to humans as required by

  The 1947 Nuremberg Code

  The 1964 Declaration of Helsinki

  The 1976 International Covenant on Civil and Political Rights

  The American Medical Association Code of Medical Ethics

- For **Experimentation upon Children using Experimental Drug Vaccines** without following the required testing of drugs in tissue and animal models prior to giving experimental drug vaccines to humans as required by

  The 1947 Nuremberg Code

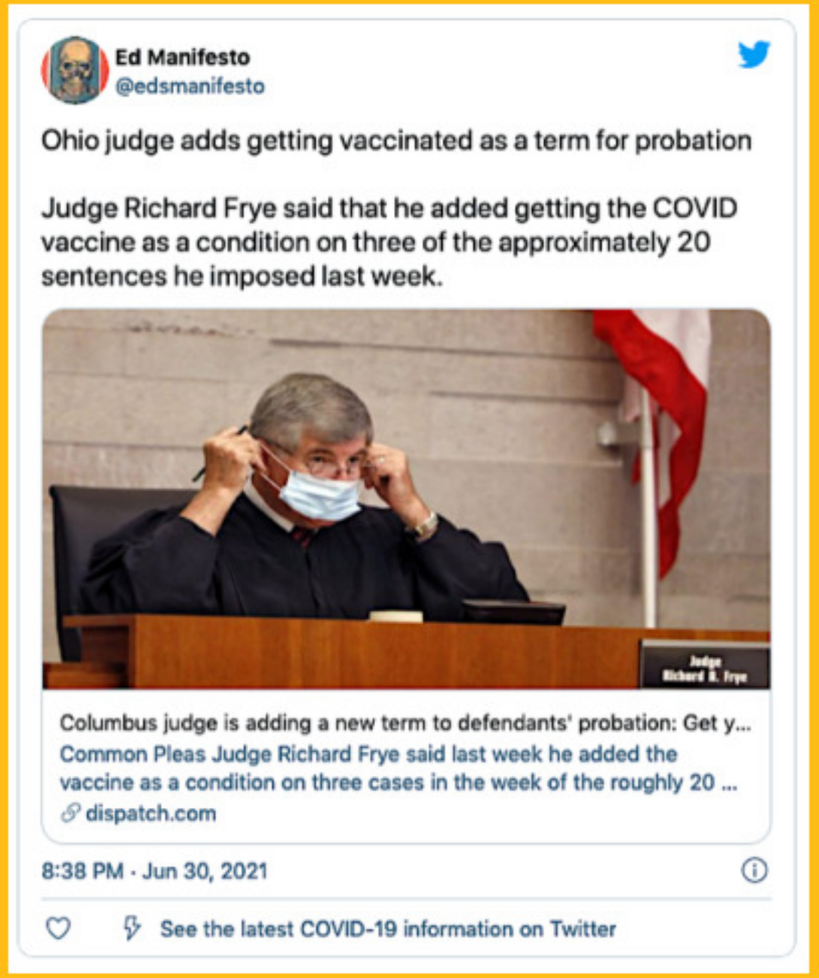
  The 1964 Declaration of Helsinki

  The 1976 International Covenant on Civil and Political Rights

  The American Medical Association Code of Medical Ethics

# Crimes of Conspiracy, Crimes Against Peace, War Crimes & Crimes Against Humanity

- For **Experimentation upon Prisoners and defendants in Court**
  - The 1947 Nuremberg Code
  - The 1964 Declaration of Helsinki
  - The 1976 International Covenant on Civil and Political Rights
  - The American Medical Association Code of Medical Ethics



# Crimes of Conspiracy, Crimes Against Peace, War Crimes & Crimes Against Humanity

- For the **loss of personal liberties, income, assault, threat and coercion of citizens** to participate in an experimental drug vaccine study following **suppression of treatments**, and **failure to follow the required testing** of drugs including **drug vaccines** in tissue and animal models prior to giving experimental drug vaccines in violation of

  The 1947 Nuremberg Code

  The 1964 Declaration of Helsinki

  The 1976 International Covenant on Civil and Political Rights

  The American Medical Association Code of Medical Ethics

# Crimes of Conspiracy, Crimes Against Peace, War Crimes & Crimes Against Humanity

- For the **loss of personal liberties, income, assault, threat and coercion** of citizens to participate in **forced quarantine, lockdown** and **masking** in violation of

  The 1947 Nuremberg Code

  The 1964 Declaration of Helsinki

  The 1976 International Covenant on Civil and Political Rights

  The American Medical Association Code of Medical Ethics

- For the subsequent **morbidity and mortality** associated with the development, release, and testing of this Biological Weapon in violation of

  The 1975 Biological Weapons Convention Treaty

  The 1947 Nuremberg Code

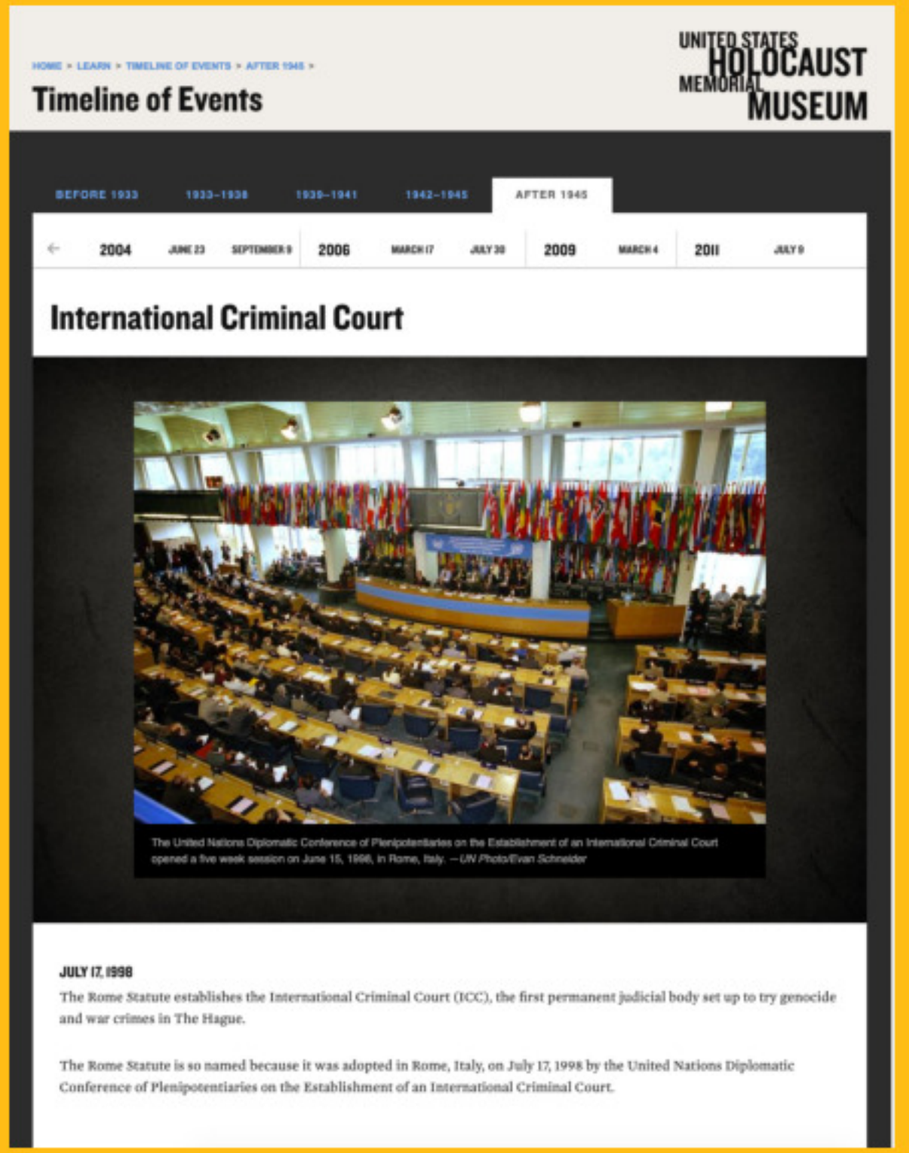
  The 1964 Declaration of Helsinki

  The 1976 International Covenant on Civil and Political Rights

  The American Medical Association Code of Medical Ethics

# Joint ICC Claims

## 143/21 (UK), 133/21 (Slovakia), 271/21 (France), 326/21 (Czech Republic), ...



HOME > LEARN > TIMELINE OF EVENTS > AFTER 1945 >

Timeline of Events

UNITED STATES HOLOCAUST MEMORIAL MUSEUM

BEFORE 1933 | 1933–1938 | 1939–1941 | 1942–1945 | AFTER 1945

2004 JUNE 23 SEPTEMBER 9 2006 MARCH 17 JULY 30 2009 MARCH 4 2011 JULY 9

### International Criminal Court

The United Nations Diplomatic Conference of Plenipotentiaries on the Establishment of an International Criminal Court opened a five week session on June 15, 1998, in Rome, Italy. — *UN Photo/Evan Schneider*

**JULY 17, 1998**

The Rome Statute establishes the International Criminal Court (ICC), the first permanent judicial body set up to try genocide and war crimes in The Hague.

The Rome Statute is so named because it was adopted in Rome, Italy, on July 17, 1998 by the United Nations Diplomatic Conference of Plenipotentiaries on the Establishment of an International Criminal Court.

https://www.ushmm.org/learn/timeline-of-events/after-1945/rome-statute

I am Calling for
**Nuremberg 2.0**

These and others

**Investigated**
**Indicted**
**Prosecuted**
**Held Accountable**

Preliminary Group of Defendants )

V )

Lloyd Austin Secretary Department of Defense; )
Xavier Becerra, Secretary of Health and Human )
Services; )
David Franz, Former Commander Fort Detrick; )
Alejandro Mayorkas, Secretary of the Department )
of Homeland Security; )
Chris Hassell, Chariman of HHS P3CO Review )
Committee; )
Rochelle P. Walensky, Director of the Centers )
Disease Control and Prevention; )
Janet Woodcock, Commissioner of the U.S. )
Food and Drug Administration; )
F. Fleming Crim, Chief Operating Officer National )
Science Foundation; )
Francis Sellers Collins, Director National Institute )
of Health; )
Anthony Stephen Fauci, Director National Institute )
of Allergy and Infectious Diseases, Second Chief )
Medical Advisor to the President of the United States; )
Peter Daszak, EcoHealth Alliance; )
Ralph S Baric, University of North Carolina Chapel Hill; )
Shi Zhengli, Wuahn Institute of Virology; )
William Henry Gatess III, Bill and Melinda Gates )
Foundation. )

)

Defendants )

Case No:

(1) Immediate cessation of any Mandatory Masking or Vaccination Requirements or Identification of Vaccination Requirements;
(2) Immediate cessation of interference with the practice of medicine by Federal Agencies;
(3) Immediate action to hold Executive and Legislative Branches of the U.S. Government accountable for violating their authority under the U.S. Constitution;
(4) Immediate call for investigation, indictment & prosecution of those responsible for gain-of-function research, development of SARS-CoV-2, and consequential deaths resulting from COVID-19.

# We For Humanity

We are an international association of lawyers, doctors, scientists, journalists as well as representatives of other professions.

We represent interests of all people in the world who aspire to live in freedom, self-determination, dignity and truthfulness.

We For Humanity, trust-in-humanity@pm.me

The International Criminal Court
Office of the Prosecutor
Post Office Box 19519
2500CM The Hague
The Netherlands
E-mail: otp.informationdesk@icc-cpi.int

September 20, 2021

**Letter in support of the joint 'Request for Investigation' to the ICC from the UK, Slovakia, France and the Czech Republic**

Dear Prosecutor of the International Criminal Court, Mr Karim Khan,

We the undersigned, as Nazi Concentration Camp survivors of the atrocities committed against humanity during the Second World War, feel bound to follow our conscience and write this letter in support of the joint 'Request for Investigation' to the International Criminal Court submitted on behalf of the United Kingdom (143.21), Slovakia (133.21), France (271/21) and the Czech Republic (326/21) on the 12th of August 2021. The contents of the 'Request' include sworn affidavits from expert witnesses Dr. Richard Fleming, Professor Luc Montagnier and Dr. Kevin McCairn.

It is obvious to us that another horrific series of events, this time affecting all people around the world, is taking place before our eyes. However, the majority of the world's populace do not yet realise what is happening, for the magnitude of an organized crime such as this is beyond their scope of experience. We, however, know. We remember the name Josef Mengele. Some of us have personal memories. We experience a déjà vu that is so horrifying that we rise to shield our poor fellow humans. The threatened innocents now include children, and even infants.

In just four months, the COVID-19 'vaccines' have killed more people than all available vaccines combined from mid-1997 until the end of 2013 — a period of 15.5 years. And people between 18 and 64 years old who were barely at risk from COVID-19 and consequently barely showed up in mortality statistics on or with COVID-19, account for up to 80% of records as victims of 'vaccination'. The EudraVigilance database reports that through September 18, 2021 there are 14,863 deaths and 3,691,366 injuries reported following injections of four experimental COVID-19 so-called vaccines. As of the real numbers the famous Lazarus report from Harvard Pilgrim Health Care inc. in 2009 revealed that in general only 1% of adverse events from vaccines is ever being reported:

*"Adverse events from drugs and vaccines are common, but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported."*

**We call upon you to help stop this ungodly and criminal medical experiment on humankind immediately.**

What is called 'vaccination' against the SARS-Cov-2 virus is in truth a blasphemy encroachment into nature. Never before has immunization of the entire planet been accomplished by delivering a synthetic mRNA into the human body. It is a medical experiment to which the Nuremberg Code *must* be applied. The 10 ethical principles in this document represents a foundational code of medical ethics that was formulated during the Nuremberg Doctors' Trials to ensure that human beings would never again be subjected to involuntary medical experimentation and procedures, but yet this is exactly what is happening around the world now.

We remind you of the following. Principle 1 of the Nuremberg Codex:

(a) ***"The voluntary consent of the human subject is absolutely essential.*** *This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.* (b) *This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.*
(c) *The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity."*

Re. (a): There is no question of a free decision. Governments and mass media spread fear and panic and use the rule of Goebbels' propaganda by repeating untruths until they are believed. For weeks now they have been calling for the ostracism of the unvaccinated. If 80 years ago it was the Jews who were demonised as spreaders of infectious diseases, today it is the unvaccinated who are being accused of spreading the virus. Physical integrity, freedom to travel, freedom to work, all coexistence has been taken away from people in order to force 'vaccination ' upon them. Children are being enticed to get vaccinated against their parents' judgement.

Re (b): The 22 terrible side effects already listed in the FDA emergency-use authorization were not disclosed to the subjects of the experimental trial. They are as follows :

1. Guillain-Barré syndrome
2. Acute disseminated encephalomyelitis
3. Transverse myelitis
4. Encephalitis/encephalomyelitis/me ningoencephalitis/meningitis/encepholapathy

5. Convulsions/seizures
6. Stroke
7. Narcolepsy and cataplexy
8. Anaphylaxis
9. Acute myocardial infraction
10. Myocarditis/pericarditis
11. Autoimmune disease
12. Deaths
13. Pregnancy and birth outcomes
14. Other acute demyelinating diseases
15. Non-anaphylactic allergic reactions
16. Thrombocytopenia
17. Disseminated intravascular coagulation
18. Venous thromboembolism
19. Arthritis and arthralgia/joint pain
20. Kawasaki disease
21. Multisystem inflammatory syndrome in CHILDREN
22. Vaccine enhanced disease.

By definition, there has never been informed consent. In the meantime, thousands of side-effects recorded in numerous databases are on record. While the so-called case numbers are being bleeped in 30-min-intervals by all mass media, there is neither any mentioning of the serious adverse side effects nor how and where the side-effects are to be reported. As far as we know, even recorded deaths and adverse events have been deleted on a large scale on some databases.

Principle 6 of the Nuremberg Code requires: "*The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment*".

'Vaccination' against COVID-19 has proven to be more dangerous than the disease COVID-19 for approximately 99% of all humans. As documented by Johns Hopkins, in a study of 48,000 children, children are at zero risk from the virus. The data shows that children who are at no risk from the virus, have had heart attacks following 'vaccination'; pending update since August 2021, more than 15,000 have suffered adverse events – including more than 900 serious events. At least 16 adolescents have died following 'vaccination' in the USA. And the numbers are increasing rapidly as we write.

Yet Principle 10 of the Code says : "*During the course of the experiment, the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject .*"

Allegedly around 52% of the world population has received at least one injection. Honest disclosure of the true number of 'vaccine' injured, terminally injured as well as deceased worldwide is long overdue. We fear that there are millions already.



We as survivors of the concentration camps, witnessed many atrocities being committed in the Second World War and we were told this would never happen again , but yet it *is* happening again.

What a damning realisation: How many elderly people were coerced by fear to take the 'vaccine' and have not survived? How many survived the Holocaust but didn't survive the COVID-19 injection? How many survived the medical experiments in Auschwitz and Birkenau but didn't survive this contemporary medical experiment?

We therefore implore you to accept the joint 'Request for Investigation' from the United Kingdom, Slovakia, France and the Czech Republic and immediately and without further delay, open an urgent investigation into the crimes against humanity, the genocide and the breaches of the Nuremberg Code by numerous Perpetrators, which has resulted in so many needless deaths and serious injuries and continues to do so on a daily basis. The International Criminal Court as the court of last resort, has a duty to investigate these, the most heinous of crimes and to bring the Perpetrators to justice.

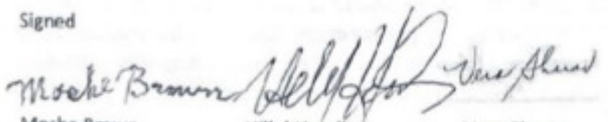
It is in your power to save lives. We are aware that several criminal charges have been dismissed by you on formal grounds. Regardless of technicalities, you have read them. We know that you are aware because of these claims, that millions of people are being hurt and dying by the so-called vaccination . For example, the Israeli lawyers have provided casualty figures in Israel and access to the EMA database of side effects. That was more than three months ago. Since that time, more people have died, become terminally ill, or been injured (see above). And you have not intervened. You further condone the fact that children are now increasingly among the victims of 'vaccination'. It is up to you to punish the deliberate acts against life and limb, not to carry yourself with intent by an approving acceptance of attack on human life.

Every day that you waste idly, human lives are destroyed, children's lives. We demand an immediate end to the vaccination campaign and an immediate investigation of the evidence available to you. People will forgive a mistake. A deliberate murder of their children - not. Do the right thing.

**History will not look kindly upon you if you fail in your duty to do this. Know that our eyes and those of the peoples of the world are upon you - the responsibility is yours. You know what is happening, you have the evidence and now you must act.**

Yours sincerely,

Signed



Moshe Brown Hillel Handler Vera Sharav

Nazi Concentration Camp survivors

# The International Criminal Court

The first permanent court set up to try those accused of:

- **War crimes**
- **Crimes against humanity**
- **Genocide**

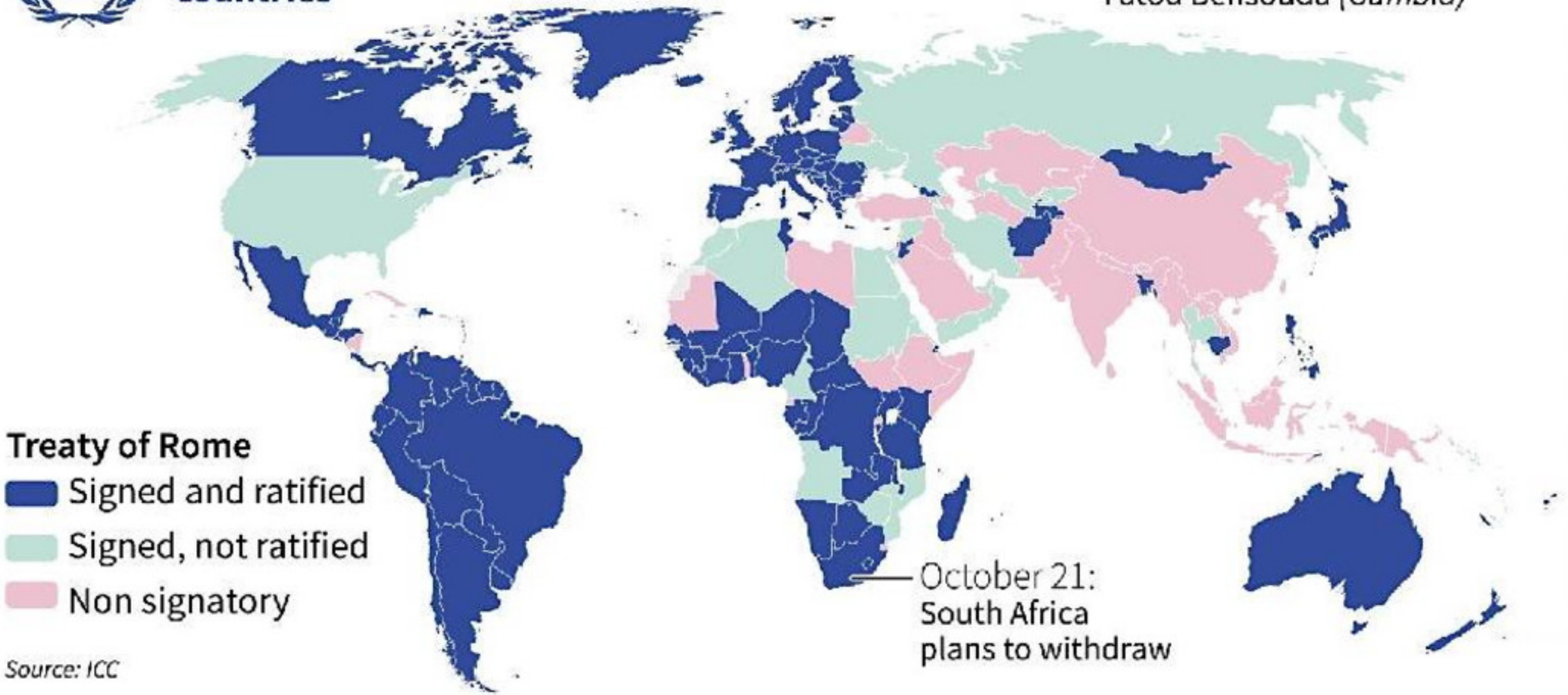
**124 member countries**

## Created

- July 2002
  Entry into force of the Rome Statute, the founding treaty
- January 2003
  The courts begins its work

## Organisation

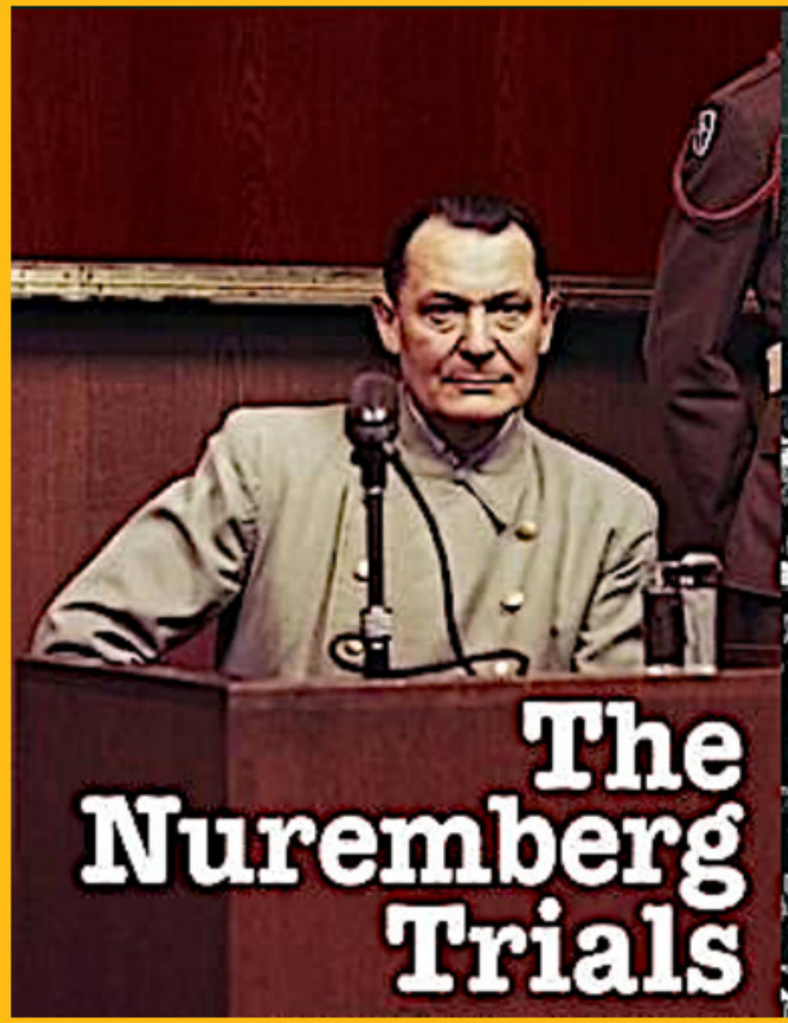
- Based: **The Hague** *(Netherlands)*
- **18 judges**
- President:
  Silvia Fernandez de Gurmendi *(Argentina)*
- Prosecutor:
  Fatou Bensouda *(Gambia)*

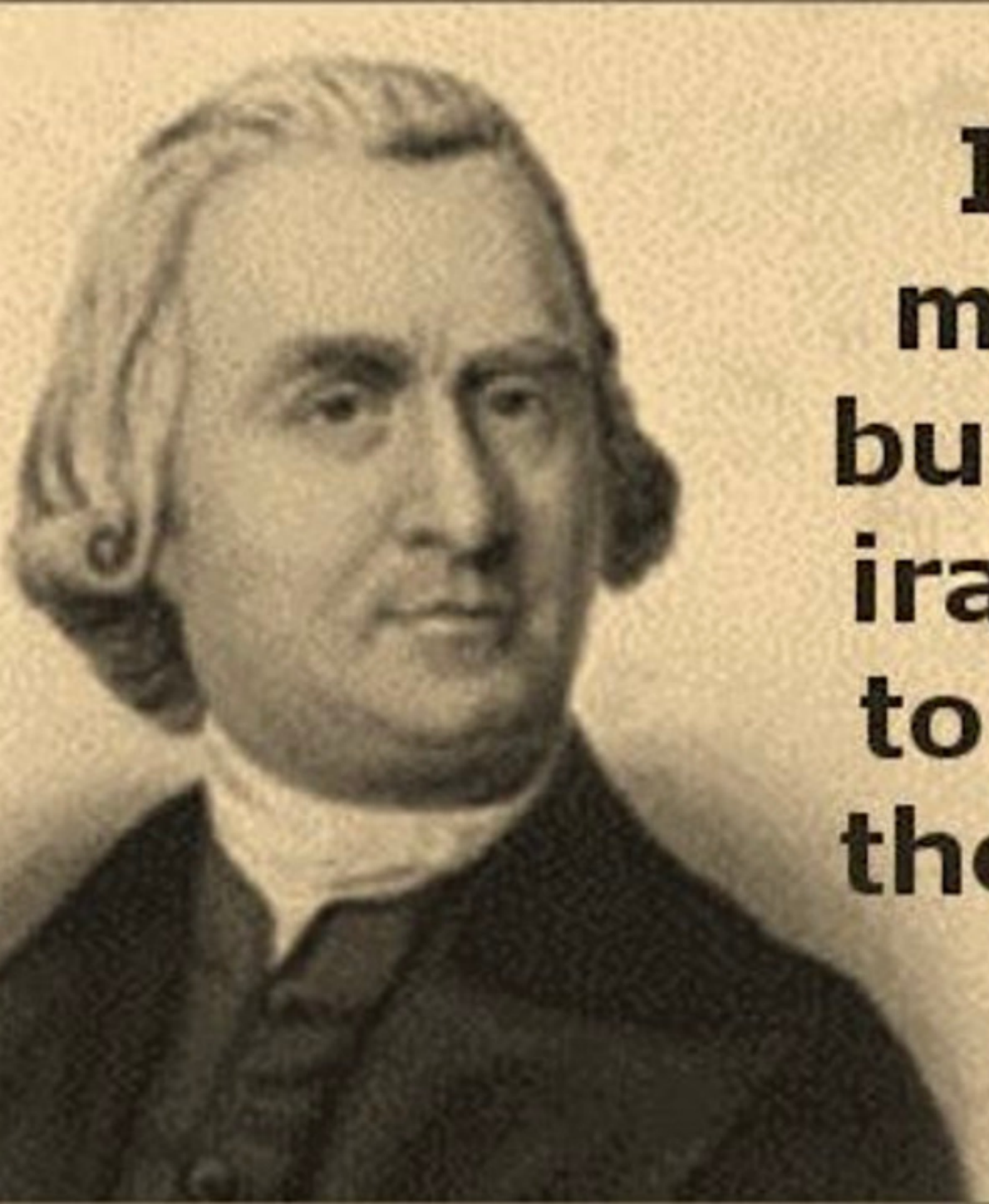



*Source: ICC*

# Together We Shall Prove Hermann Wilhelm Göring Wrong!

**Because the Alternative is to Prove He was Right.**

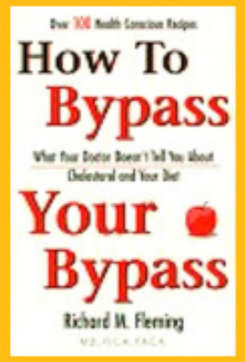


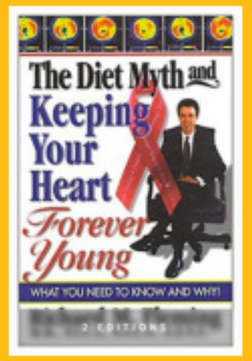



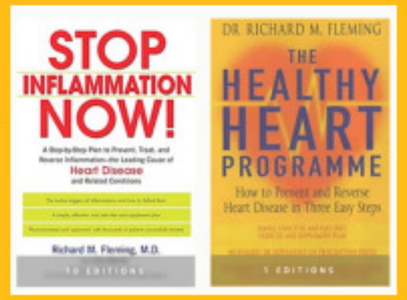
It doesn't take a majority to prevail but rather a tireless, irate minority, keen to set brush fires in the people's minds.

*Samuel Adams*

# Available Books With More Information For Both Medical Professionals & The General Public.

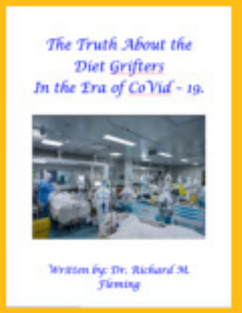


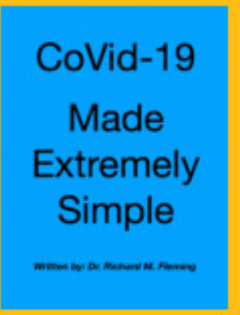



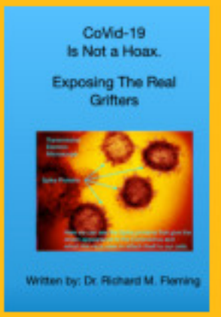







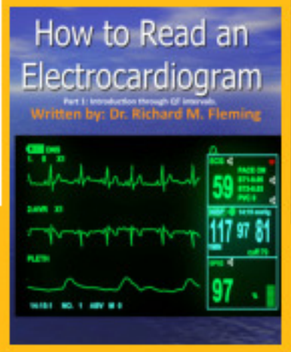


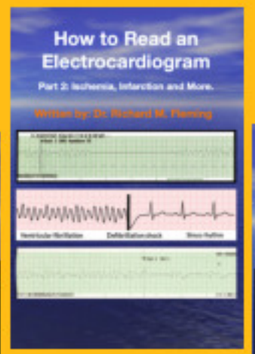



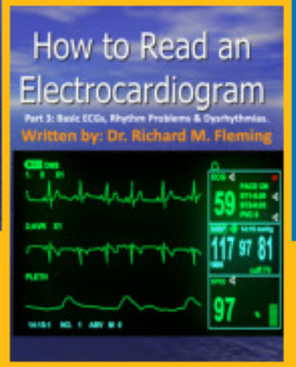



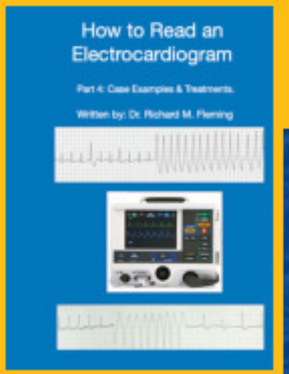


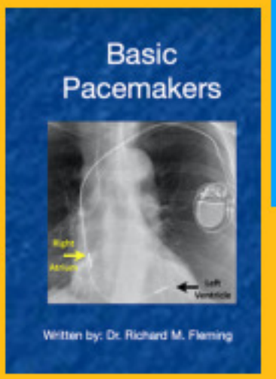


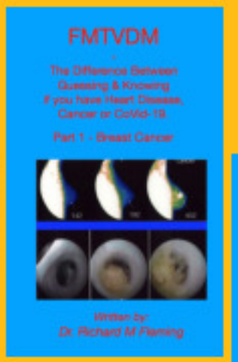


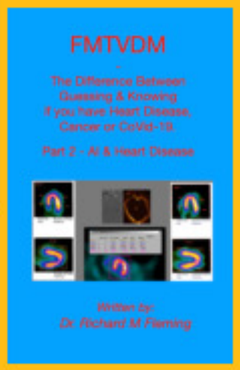

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# Is COVID-19 a Bioweapon?

*(continued from front flap)*

which violates the Biological Weapons Convention (BWC) treaty, exposing those who have committed crimes against humanity. Dr. Fleming will reveal the ultimate conspiracy: one that puts the future of the entire world at stake.

**Dr. Richard M. Fleming** is a physicist, nuclear cardiologist, and attorney with fifty-three years of research experience. He has spent decades investigating what causes multiple health problems including heart disease, cancer, and SARS-CoV-2/COVID-19. He joined the American Heart Association in 1976 and actively began teaching and researching heart disease; including both what causes heart disease and how to accurately find heart disease. In 1994 he presented his original theory on "Inflammation and Heart Disease" which was published in a cardiology textbook in 1999 and presented on *20/20* in 2004. His research career has also involved investigating and correcting errors made in medical testing including coronary arteriography and nuclear imaging for both heart disease and cancer. In 2017, after two decades of work, he patented the first method capable of measuring regional blood flow and metabolic changes occurring inside the body. This method known as FMTVDM (Fleming Method) makes it possible to accurately determine what is happening inside the body as well as whether treatments prescribed for patients are working or not.

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"What is as remarkable as it is rare in science in Dr. Richard Fleming's book is this systematic, exhaustive, 'bulldozer' approach. Like these immense GMO agricultural robot-machines guided by GPS, capable of stopping on the slightest mound or suspicious anomaly, he leaves nothing in the shade; he 'plows' this enigma of the birth of SARS-CoV-2, going back to its distant genealogical ancestors, also already manipulated in the laboratory. Like a criminal investigation, it tracks down the slightest patent or conflict of interest among these illustrious scientists with an unassailable aura, or among these respected foundations that were believed to sow good for humanity."

—PROFESSOR JEAN-CLAUDE PEREZ

"This richly informed book takes you through the nefarious intersection of politics and the weaponization of science that is deeply dispiriting. It exposes the corruption and collusion of governments that threaten our very existence. This is an important book as it takes us towards the truth and gives us hope that many scientists, such as Dr. Fleming, are risking everything in order to bring the guilty to justice and find solutions for mankind."

—MELINDA MAYNE, attorney and barrister

Fleming

Is COVID-19 a Bioweapon?

# Is COVID-19 a Bioweapon?

## A SCIENTIFIC AND FORENSIC INVESTIGATION

**Dr. Richard M. Fleming**
PHD, MD, JD

Diseases

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## What is the true origin of COVID-19?

President Joe Biden has ordered US intelligence agencies to further investigate the origins of COVID-19. Clearly, the US government isn't decided on what really happened at the start of the pandemic. Was it truly an animal to human transmission to be blamed on a bat in a Wuhan, China wet market? Or was a much more sinister plan at work?

In 2020, Dr. Richard M. Fleming began investigating SARS-CoV-2/COVID-19. Using both his "Inflammation" Theory and patent (FMTVDM; the first method capable of measuring regional blood flow and metabolic changes occurring inside the body, which makes it possible to accurately determine what is happening inside the body as well as whether treatments prescribed for patients are working or not), he investigated COVID treatments. Simultaneously he began investigating the origins of COVID-19. This book details much of what he has found.

What he discovered will shock you.

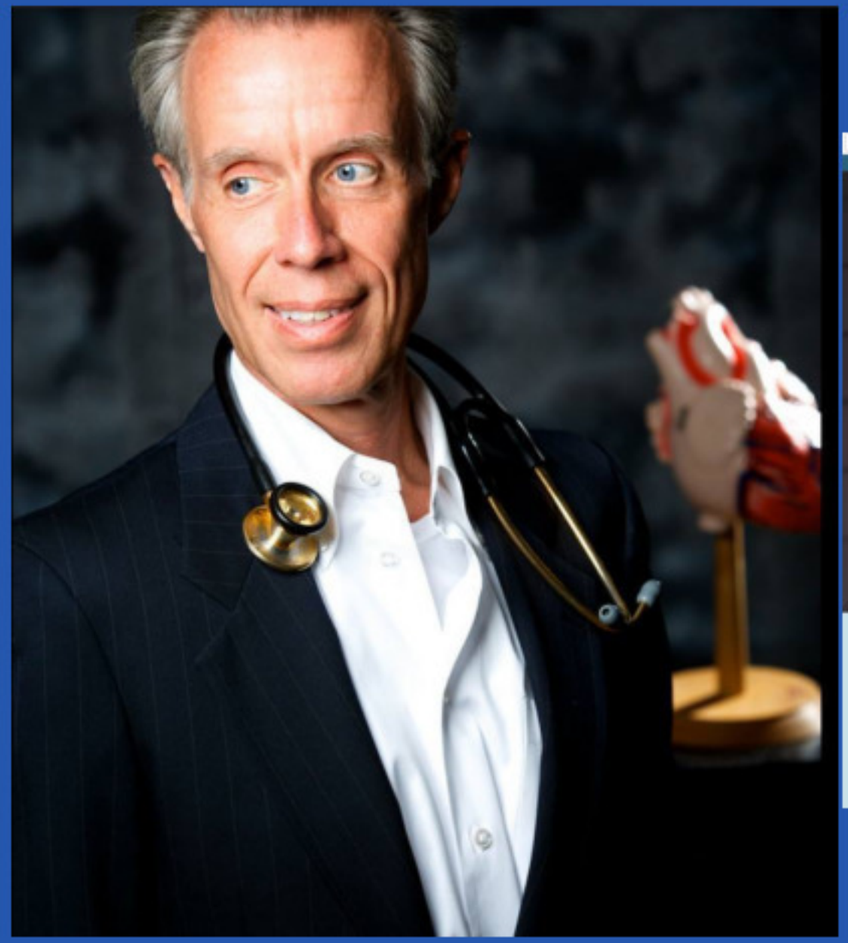
By 1999, US federal agencies began funding Gain-of-Function research—research that by its very nature is designed to increase the ability of pathogens to infect and harm people. In 2019, one of those pathogens was intentionally released upon the world in the Wuhan wet market. The key to proving and understanding this bioweapon is its spike protein, the very same spike protein now being made in millions of people after the COVID vaccines are injected into them. These vaccines are nothing more than the genetic code of this bioweapon. This book traces the publication and money trail of COVID-19; showing who is ultimately criminally responsible for the design and development of this weapon,

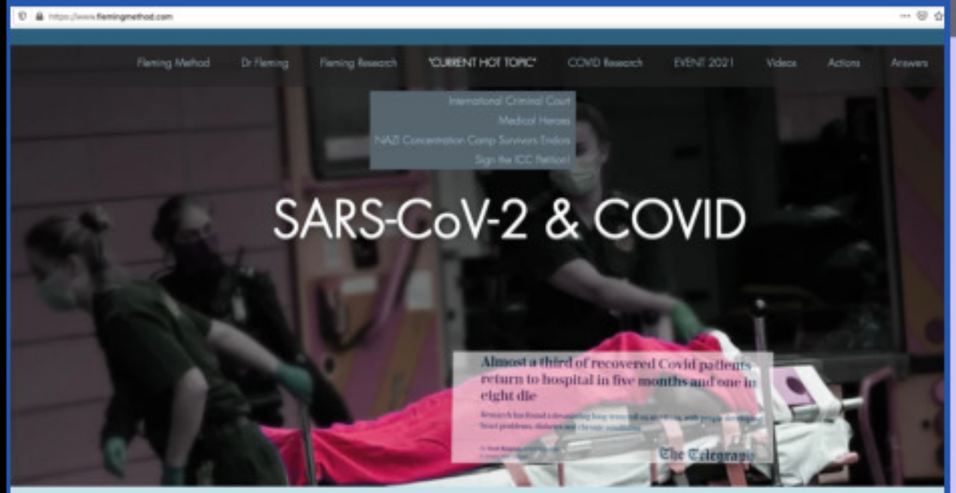
*(continued on back flap)*

https://www.barnesandnoble.com/w/is-covid-19-a-bioweapon-dr-richard-m-fleming/1139680021

# Dr Richard M Fleming

## Physicist-Nuclear Cardiologist-Attorney



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### Have Them Take Action Too!

(4) Sign the Following Petition to the International Criminal Court (ICC) calling for the ICC to Act Now to Hold These Criminals Accountable for Crimes Against Humanity.

https://www.petitions.net/investigation_and_prosecution_of_those_individuals_responsible_for_crimes_against_humanity.