April 14, 2021

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Recipient:
Dr. Anthony S. Fauci, NIAID
5601 Fishers Lane
NIAID
ROCKVILLE, MD, US, 20852

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Paul V. Sheridan, DDM Consulting
22357 Columbia Street
DDM Consulting
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12 April 2021 VIA FEDEX AIRBILL 773420981392 (Received 14 April 2021)

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
5601 Fishers Lane
Rockville, MD 20852
301-496-2263 / anthony.fauci@nih.gov

Subject 1: **Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremberg Code**
Subject 2: **Connections of Dr. Anthony Fauci to the Nursing Homes Deaths**
Reference 1: **My Letter to You of 21 July 2020**
Reference 2: **My Letter to You of 21 December 2020**
Reference 3: **My Letter to the Presidents of the Ivy League of 6 March 2021**

Courtesy Copy List

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Senator Rand Paul
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Washington DC, 20510
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Shipper tracking 773434964878

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Department of Defense
The Pentagon
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703–545–6700
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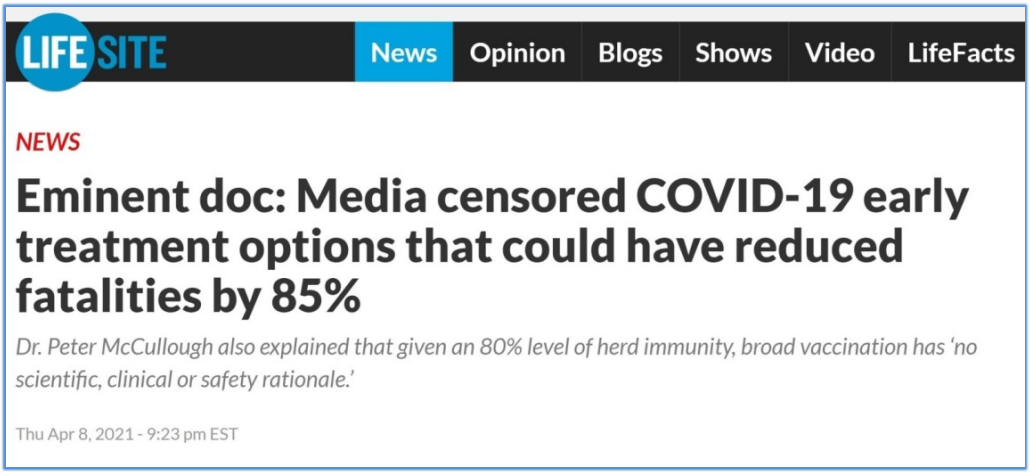
LIFESITE News Opinion Blogs Shows Video LifeFacts

NEWS

Eminent doc: Media censored COVID-19 early treatment options that could have reduced fatalities by 85%

Dr. Peter McCullough also explained that given an 80% level of herd immunity, broad vaccination has 'no scientific, clinical or safety rationale.'

Thu Apr 8, 2021 - 9:23 pm EST

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Dearborn, MI 48124-3431
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12 April 2021 VIA FEDEX AIRBILL 773420981392

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
5601 Fishers Lane
Rockville, MD 20852
301-496-2263 / anthony.fauci@nih.gov

Subject 1: **Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremberg Code**
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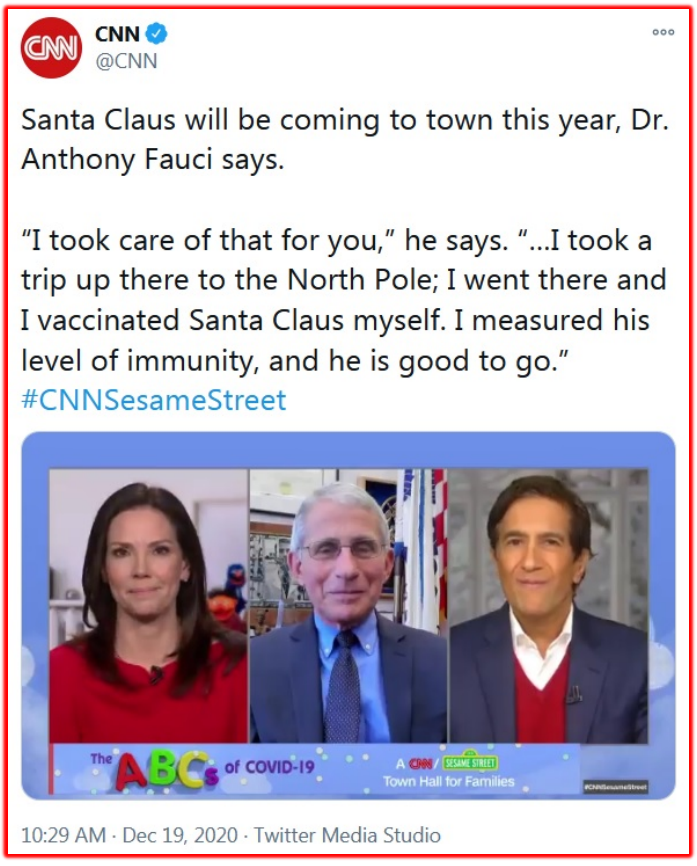
Dear Dr. Fauci:

Certainly, a person of such notoriety has the time to defend in open-court your many statements and recommendations; all central to global human health with-respect-to COVID-19, and the identification of its cause in Wuhan China, SARS-CoV-2, the coronavirus labeled as "novel."

A person that uses taxpayer-funded time on sales & marketing schemes that promote his "vaccine" to children, and also targets by racial group, may not wish to be placed-under-oath, especially regarding his denunciation of these documents: **The United States Constitution of July 1789, The Nuremberg Code of August 1947, The Helsinki Declaration of June 1964, The Civil Rights Act of July 1964.**



Context for Subjects 1 and 2 : Medicalization

The broad context is *your* efforts (and those of the global conglomerate of which you are a key member) to severely limit if not eradicate human freedom under the guise of making us "safe." This effort is blatantly **coercive and therefore characteristically steeped in fraud**; an approach to global tyranny premised on profiteering and population control, with an operative identified as "medicalization."

These characterizations are not some "conspiracy theory." There is nothing theoretical about any of this; racketeering of such type has already been declared. A sample of two associates that have openly promoted The Great Reset and the true purpose of medicalization, Mr. Klaus Schwab and Mr. Bill Gates:

Subject 1 Conclusion:
Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremberg Code

Relating to the four documents on Page 1, I am recommending to plaintiff firms that they subpoena **you** as a key witness at litigations wherein hundreds-of-years of precepts of human freedom and human dignity are under direct attack by medicalization, especially where mandatory vaccinations and the vileness of "vaccine passports" are being dictated. I have recommended that examination under-oath be conducted on your many medical and biological and immunological claims relative to COVID-19. Pursuant to well-established legal discovery/protocol, your "expertise" will endure scrutiny under the rigors of not just factual competence but veracity; the latter enforced by the consequences of perjury (Tabs 1, 2, 3, and 4).

Context for Subjects 1 and 2 : The Underbelly of Medicalization

But the underbelly of your medicalizations needs to be exposed, which in-turn exposes the fraud and exploitations perpetrated upon the trusting staff and students at the Ivy League. Cornell University's Ms. Martha Pollack, Mr. Michael Kotlikoff and Ms. Madelyn Wessel have spewed the following **falsehood** regarding the so-called COVID-19 vaccine:



"At this time, Cornell is not requiring our employees or students to be vaccinated; however, we strongly encourage each of you to be vaccinated when you become eligible. Vaccination is key to the resolution of this global pandemic, and we hope that you all take this opportunity to protect yourselves, as well as our community".

I discussed in Reference 2, your testimony in criminal proceedings regarding the K-12 suicide deaths (two thousand), connectable to your **pre-planned medicalization-premised** lockdowns of early 2020.

Court settings do not offer the cozy ambience, orchestrated by your media comrades at CNN or Politico or the Financial Times; the Fauci protestations with the latter of 10 July 2020:

> *" I have a reputation, as you probably have figured out, of speaking the truth at all times and not sugar-coating things. And that may be one of the reasons why I haven't been on television very much lately."*

Certainly a person of such noble motivations, *"speaking the truth at all times,"* would not hesitate to be sworn-in to defend his many medical, biological and immunological claims relative to COVID-19. What is now needed is exposure of **the underbelly of your medicalizations:**

It is your well-documented historical practice of deriding and discarding, at every opportunity, the merits of non-vaccine based treatments and cures for a variety of health issues. You have dictated that "vaccination is key" to disease mitigation. Vaccination is Fauci's priority; especially the experimental. You have a long record of discrediting and subverting the use of now-inexpensive, proven/safe treatments, and health/immune system enhancement protocols. You have a long record of orchestrating **investment-intensive, taxpayer-funded,** corporate pharmaceutical, shareholder promoted, university Development Office prospect endorsed, globally-scaled **vaccine** development and deployment. Those that question your methods are ridiculed, their employment terminated, and reputations publically tarnished.

Context for Subjects 1 and 2: The Underbelly of Medicalization – conclusion

"Sometimes you get the feeling that there is a whole industry almost waiting for a pandemic to occur!"

Dr. Tom Jefferson, Epidemiologist, Cochrane Group Researcher, Rome, Italy

But let me offer the lay person, especially the Ivy League law school deans, evidentiary connection. Am I alone, thinking that the underbelly as described has historical, legal and evidentiary merit?

In the context of your claims of *"speaking the truth at all times,"* certainly you would review, **under oath**, your record on prior health issues ("HIV = AIDS"). Examination at-trial would provide the opportunity to rebut the ***'this has gone on before'*** and ***'seventeen thousand people died because of Dr. Fauci'*** statements made by Yale University Professor of Epidemiology, Dr. Harvey Risch:

"Somehow we have let politics overrule science, and it is an absurd situation that people have compared to '1984' and 'The Ministry of Truth' and so on; that is limiting what people can say on objective facts, it is beyond belief ! . . . I think 'they' know the (hydroxychloroquine) treatment works. I think that basically they are afraid to even let it be tried, because letting it be tried would show that it works. So the message has to be shut at all costs, because anything will leak out, and in fact it is leaking out, and you see across the country, people who started to speak up, who become almost deathly ill, and have been turned around in three days or sooner even, and these are now public figures who are speaking up, who have said that the medicine hydroxychloroquine saved their life. And it is very difficult to, you know, close all the leaks in that dike that are being suppressed by the media that are trying to do that."

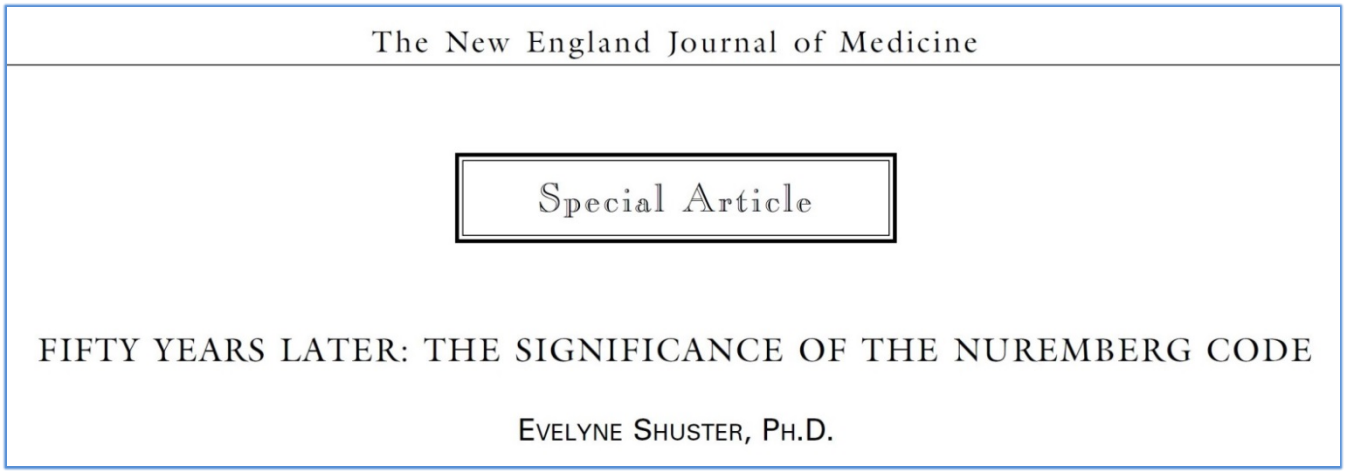
This has gone on before *. . . now we have Dr. Fauci denying that any evidence exists of benefit, and that has pervaded the FDA. The FDA has relied on Dr. Fauci and his NIH advisory groups to make the statement saying that there is no benefit of using hydroxychloroquine in outpatients, and this is counter to the facts of the case. The (positive) evidence is overwhelming. The FDA has also said that there is harm in using these medications in outpatients (that) overweighs the benefits. Ninety per cent of the COVID cases have occurred since the FDA restricted (hydroxychloroquine usage) to inpatients-only. Dr. Fauci and the FDA are doing the same thing that was done in 1987, and that has led to the (COVID-19) deaths of hundreds of thousands of Americans that could have been saved by usage of this drug.*

This was started most noticeably in 1987 . . . ***Seventeen-thousand people died because of Dr. Fauci's*** *insistence on not allowing even a statement supporting consideration of the use (of Bactrim vs. AIDS)."*

COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent'

In Reference 3, I presented a similar section (Pages 4/5 of 17). This needs to be updated, and extended to the Ivy League law school deans. That I am compelled to lecture the law schools about the conspiratorial attacks upon the United States Constitution, specifically its First Amendment, decries of a hypocrisy that only the most obtuse would deny: Without the U.S. Constitution and the First Amendment, the Ivy League will cease to exist, let-alone flourish.

In Reference 3, dated 6 March 2021, I mention the term 'Nuremberg' **not less than three times**. Under instant Tab 5 you find the **1997** Special Article in the New England Journal of Medicine:



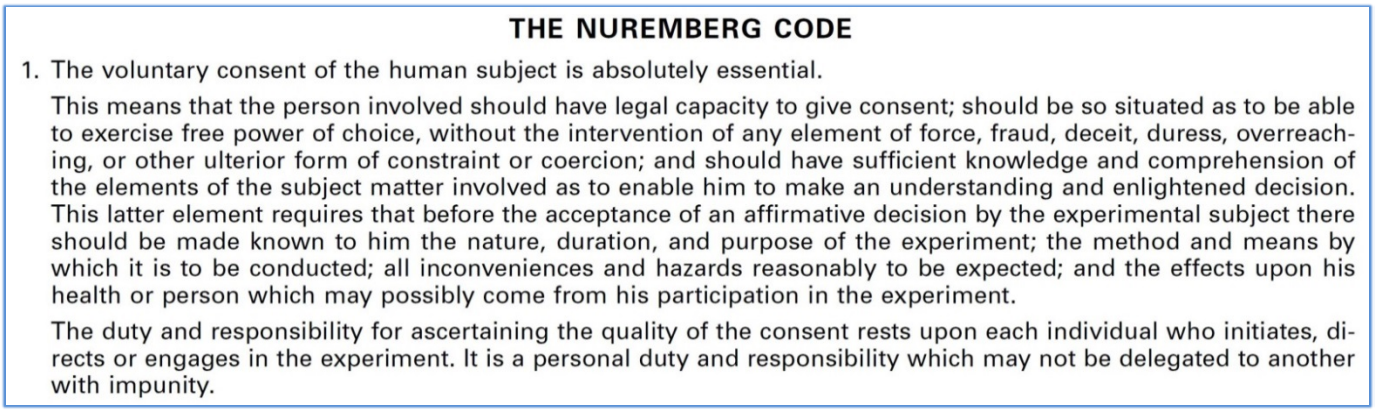
The New England Journal of Medicine

Special Article

FIFTY YEARS LATER: THE SIGNIFICANCE OF THE NUREMBERG CODE

EVELYNE SHUSTER, PH.D.

Their first page displays the ten concepts that define the Nuremberg Code; we emphasize Paragraph 1 :



THE NUREMBERG CODE

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.

Equally ironic, **to the point of being treasonous**, tens-of-thousands of American military personnel lost their lives or limbs during World War Two, just prior to the medical codifications at the Nuremberg Tribunal. The Secretary of Defense, Mr. Lloyd Austin III, now intends to renege on the portent of Arlington Cemetery, deploying bureaucratic **coercion** to force "COVID-19 vaccination" upon our military personnel . . . this speaks to the primitive global social condition; a condition partially the result of 'social media.'

We now review the relation between (1) the Nuremberg Code, (2) the emasculation of the First Amendment by Big Tech and social media, and (3) **the impossibility of 'informed consent.'**

We will see, especially in the context of medicalization (operative of The Great Reset), that Item 3 is relied upon, actively promoted, and then coyly practiced . . . by "America's Doctor."

COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent' – con't

Tab 6 is the March 26, 2021 letter sent by someone very familiar to your comrade Bill Gates.

Mr. Robert Kennedy, Jr. (whose social media accounts, Instagram, Twitter, YouTube, etc. have been censored or terminated) sent a polite warning to the fumbling, bumbling, mumbling president of Rutgers University. Mr. Kennedy discusses prior failed attempts to use our military personnel as "guinea pigs." In the context of Nuremberg; he states:

"Consent of the individual is 'absolutely essential.' "

Yes . . . but what *type* of consent?! The type encouraged by Ivy League presidents, Ivy League law schools, and Dr. Fauci . . . a consent where ignorance is key? Paragraph 1 of Nuremberg specifies:

> *"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****."*

Enlightened decision? As "health authorities," Ivy League presidents, law school deans, Bill Gates and as **you** are actively aware, the current social condition obviates any chance of meaningful 'informed consent.'

This criminality is not inadvertent. The mechanisms by which the social conditions exist include direct participation by, once again, "health authorities," Ivy League presidents, law school deans, Bill Gates and **you**; a person claiming adherence to the Hippocratic Oath. The mechanisms subvert everything from democracy *per se*, to the Nuremberg Code, to the rule of law, to human dignity. In the current scenario, Kennedy's "absolutely essential" amounts to rhetoric.

There are at-least three active social **modes** that make 'informed' consent' impossible:

A. Censorship *and derision* of the truth, especially after attempts to share have been made by respected and credentialed persons with direct knowledge and relevant real-world expertise.

B. Through deployment of elaborate media / political stunts, the socialization and *enforced acceptance of persons;* persons who happily declare ignorance, encourage others to remain ignorant, and then demand endorsement of the tyrannical theme that complicity is a rewarding social-psychological state for the individual citizen. The directives of Marx, Lenin, Dzhugashvili, and the <u>current</u> Ivy League presidents and their legal counsels come to mind.

C. Diversions, lies-by-omission, and bold-faced lies by Dr. Anthony Fauci, the person The Great Reset gushes as "America's doctor."

These three modes are samples. The plaintiffs' bar would have a proverbial field day in a court of law when this evidence of malfeasance, and *knowledge* of the malfeasance, is assigned against those **not** legally immune by virtue of 'liability immunity,'

We review the three modes (A, B, and C) that obviate 'informed consent' by individual citizens who are trying to decide whether your mRNA gene modification is "safe" . . . or even necessary.

Mode A: COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent'

Mode A: Censorship *and derision* of the truth, especially after attempts to share have been made by respected and credentialed persons with direct knowledge and relevant real-world expertise.

On the Left, a person with education in economics gets assigned to your health, dictating what information you are allowed to access, know or utilize. This gatekeeper has no medical, biological or immunological expertise whatsoever, but has deep political ties to persons who will continue to benefit (politically) from the Fauci lockdowns and his intention to **coerce** COVID-19 "vaccinations." This politically protected gatekeeper has never been responsible-for and has **zero** experience with patient care. Like Fauci, this social media thug has an open fetish for and deep political ties to "Candidate H."

On the Right is a medical doctor with both pre-med education, and a Doctor of Medicine degree from the University of Texas (Austin). He has DECADES of responsibility-for and DECADES of experience treating thousands; real flesh & blood patients, not theoretical simulations or "pandemic models." He has written several books on medicine and health, which have been endorsed by MD professionals nationwide. The man at Right has conducted innumerable seminars on health & well-being, and has been the guest on innumerable national and local television shows regarding his work on the human immune and endocrine systems. He founded and directs a highly regarded Health & Wellness Center in Houston since 1989, and hosted his own call-in radio show.

The crucial implied difference between the man on the Right versus the woman on the Left, is that she also has ties to Bill Gates. Possibly for the same reasons as Gates, she pushes profitable COVID-19 "vaccines."

The man on the Right practices the opposite; he has no connection to computers and networks that profit from Fauci lockdowns, but he does promote the use of natural remedies and vitamin supplementation; only using pharmaceuticals and drugs when his patient expertise deems it necessary.

Mode A: COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent'

What happened to a video Dr. Steven Hotze uploaded to Ms. Susan Wojcicki's YouTube? A video merely factual about the "COVID-19 pandemic"? A video that is factual about the true physiological strategy of the mRNA gene modification concoction that fills the Fauci/Gates/WHO needles? Wojcicki's sputum:

COVID-19 medical misinformation policy

The safety of our creators, viewers, and partners is our highest priority. We look to each of you to help us protect this unique and vibrant community. It's important you understand our Community Guidelines, and the role they play in our shared responsibility to keep YouTube safe. **Take the time to carefully read the policy below**. You can also check out this page for a full list of our guidelines.

YouTube doesn't allow content about COVID-19 that poses a serious risk of egregious harm.

YouTube doesn't allow content that spreads medical misinformation that contradicts local health authorities' or the World Health Organization's (WHO) medical information about COVID-19. This is limited to content that contradicts WHO or local health authorities' guidance on:

- Treatment
- Prevention
- Diagnostic
- Transmission
- Social distancing and self isolation guidelines
- The existence of COVID-19

Note: YouTube's policies on COVID-19 are subject to change in response to changes to global or local health authorities' guidance on the virus. This policy was published on May 20, 2020.

Contrary to Wojcicki's censorship, there is **no connection** between her rantings such as *"serious risk of egregious harm,"* and someone like Dr. Stephen Hotze . . . **or anyone like him.**

Alternatively, what of the motivations of Mr. Klaus Schwab and The Great Reset? Medicalization? Ivy League presidents and their lawyers? Mr. Bruce Aylward? Dr. Tedros Ghebreyesus? Mr. Bill Gates?

Mode A: COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent'

Do we need to specify that Anthony Fauci has endorsed the Wojcicki censorships which also resulted in the following sequence levied against the hard-fact presentations of Mr. Nick Hudson?

And that "half a million views"? . . . That occurred in less than 48 hours!

Mode A: COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent'

That Wojcicki rant *"serious risk of egregious harm"* ? In the opposite sense, what harm has already resulted from her censorship? What motivates Anthony Fauci to endorse that censorship?

> **Specifically, how does the Anthony Fauci complicity if-not outright endorsement of censorship connect him to the tens-of-thousands that died in the nursing homes?**

Also, what is the **source** of the "YouTube Community" **empowerment?** An open subversion of the US Constitution; subversion that thwarts the expertise of MDs such as Dr. Harvey Risch, Dr. Richard Bartlett, Dr. Vladimir Zelenko, Dr. Simone Gold, Dr. Pierre Kory, Dr. Ryan Cole . . . **to name just a few.**

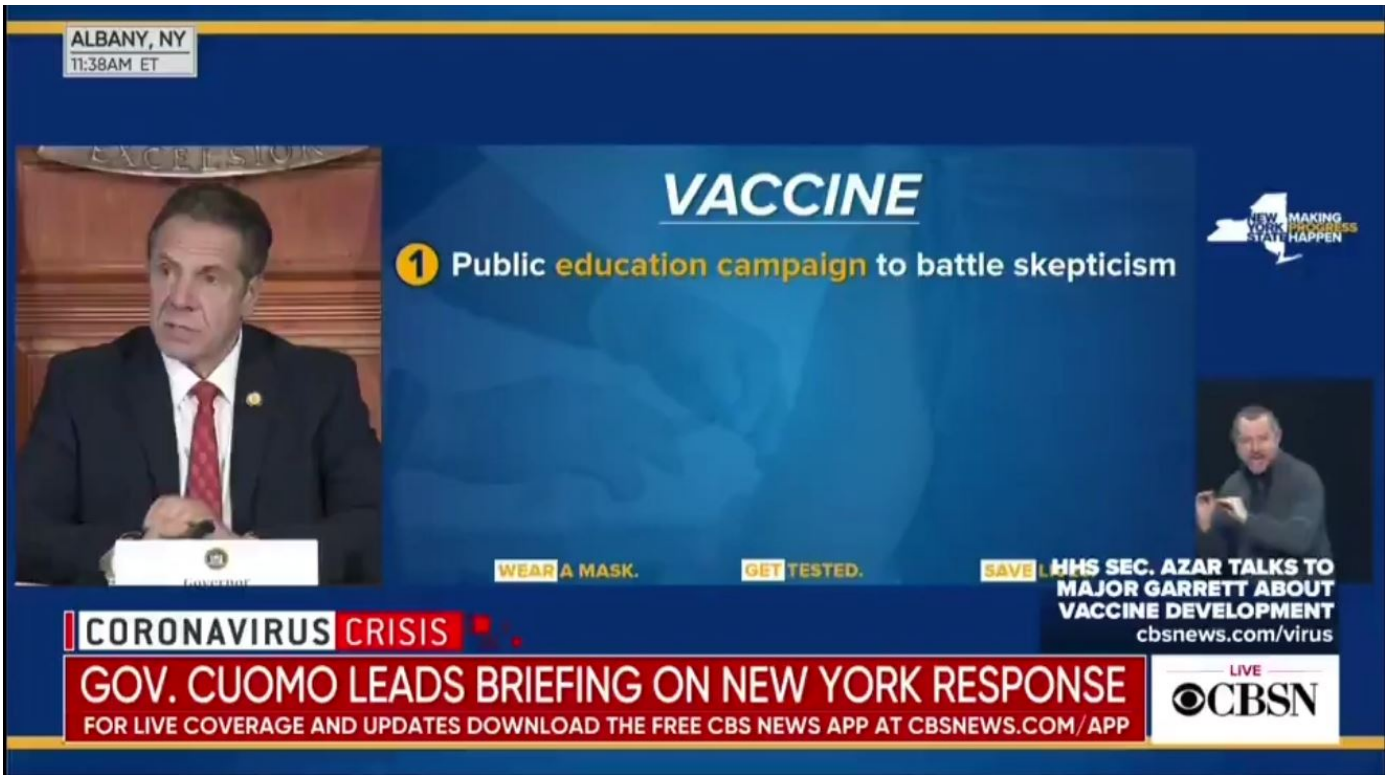
. . . a medical expertise derived from real-world practices that defined and dispensed non-vaccine protocols that had proven safety and continue to **obliterate the need for Fauci's mRNA gene modification . . . but most importantly . . . if that expertise had not been censored on a global basis it would have saved hundreds of thousands of lives . . . especially those in the nursing homes.**

Mode B: COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent'

> **Mode B:** Through deployment of elaborate media / political stunts, the socialization *and enforced acceptance of persons;* persons who happily declare ignorance, encourage others to remain ignorant, and then demand endorsement of the tyrannical theme that complicity is a rewarding social-psychological state for the individual citizen. The directives of Marx, Lenin, Dzhugashvili, and the current Ivy League presidents and their legal counsels come to mind.

The Emmy Award winning comrade, the person that has almost succeeded in the destruction of my birth/home state of New York, a person associated with more COVID-19 deaths than most nations; Governor Andrew Cuomo recently orchestrated a "news conference" that was focused upon, and deployed *against* the free will and free thinking of black people.

In the context of Nuremberg, I am confident the trendy Ivy League presidents overlooked the deep irony of Cuomo's **"education campaign."** Deployment of *his* elaborate media / political stunt begins with:



Whose skepticism?! Cuomo's elaborate media stunt was a precursor to *your* follow-up exploitations a few weeks later. Cuomo exploited the deep ignorance of a black woman who, paraphrasing Mode B:

> ' . . . happily declared her own ignorance, encouraged others to remain ignorant, and also demanded endorsement of the tyrannical notion that complicity through deep ignorance is a far more rewarding social-psychological state for the individual (black) citizen.'

Mode B: COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent'

With the Emmy Award winning Governor smirking beneath his harmful face mask, the woman declared:

"We must take the vaccine."

"I am not asking what is in the infusion."

"I am not looking up all of the ingredients in the infusion."

"I am sticking out my arm, and I am taking the infusion."

Mode C: COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent'

Mode C: Diversions, lies-by-omission, and bold-faced lies by Dr. Anthony Fauci, the person The Great Reset gushes as "America's doctor."

I have emailed you many times, but you have declined to respond. In some I posed questions related to non-vaccine treatments. As I discuss below, Subject 2 is the crux of your reticence.

So, while you claim to be too busy to respond to an American taxpayer, you did find the time to do a sales & marketing interview with Mexico (?!).

Your interview with Eugenio Derdez confirmed, once again, that you cannot be trusted. It also serves as the most recent demonstration of Mode C.

Eugenio asks, *"Which of the COVID-19 vaccines have been officially approved by the FDA?"*

An honest person would have immediately responded, None. Instead you diverted and back-pedaled with:

"Three of them. One from Moderna, which is the mRNA vaccine. One from Pfizer which is another mRNA vaccine. And the other is from J&J, Johnson & Johnson, which is a little bit different, it gives the same kind of response, but it's a little bit different. So there are three vaccines that have gotten emergency use authorization from the FDA so far."

Eugenio did not ask you about EUA, he asked you about "officially approved." True to form, when cornered, you babbled about "logistics." But then you lied when making the claim that EUA is the "first step" in the approval process . . . So . . . tell us Dr. Fauci, which prior vaccine underwent the "logistics" of EUA as its "first step"? The SARS-Cov-1 vaccine? The MERS vaccine? The AIDS vaccine?

But then the most insidious, your outright diversions and lies regarding the essence of *Reference 3: My Letter to the Presidents of the Ivy League of 6 March 2021* . . . **the secret orchestration <u>BY YOU</u> of 'liability immunity' for Big Pharma (vaccine manufacturers in-particular).**

> Eugenio asks, "What is the medical and legal responsibility of the companies that are making the vaccine? What happens if secondary effects are seen in five or ten years? Can I sue the manufacturer of the product if it hurts me? Or if there is long-term effects, years down the road?"

Informed consent? Your response to Eugenio's "legal responsibility" question was adolescent ***crap***. I have no intention of dignifying it. A more accurate response from "America's Doctor" would have been:

Mode C: COVID-19 "Vaccines," the Nuremberg Code and the Impossibility of 'Informed Consent'

"Well . . . you can sue . . . sorta. You cannot sue successfully.

As a matter of fact I am the errand boy that submitted to the massive lobbying onslaught by Big Pharma, who were whining like stuck-pigs about the plaintiff's bar, and the success they had, and would continue to have. Those darn Ivy League law school graduates, those attorneys, rather than helping us with our arm-waving media promotions and scripted questions, they get our internal documents, they get to ask detailed questions, and worst of all . . . they place our researchers and our multi-million-dollar income executives under oath !

So . . . no matter what happens to the patient, no matter how flawed the vaccine, no matter how defective the vaccine is or how liable the manufacturer, I pushed a secret ***'liability immunity'*** *gizmo, which no other industry has (at least not yet). I began working on this thuggery way back in 1986 . . . it gets my Big Pharma pals off the hook.*

Besides, my special buddy Bill Gates is a major shareholder in these big vaccine companies. The last thing we want is for our stock values to nose-dive after a scandal is exposed in open court, and the result is a huge jury verdict.

So, instead of all that responsibility, ***and this is the really funny part,*** *we wanted these legal shenanigans to 'look good' for the average unsuspecting person, ya know, the citizen dupes that trust us. So we set up a 'fund' that is run by . . . get this . . . a bunch of government gatekeepers, running-cover for the very industry they're supposed to be regulating!! But this gets even funnier . . . the fund? It's the US Treasury . . . That's right, the dupes that have suffered horribly due to our needles get to pay themselves with their own tax dollars . . . but only if the gatekeepers let them !!*

Remember, everyone else in the COVID-19 vaccine circus is still liable. They do ***not*** *have 'liability immunity.' Everyone from Ivy League presidents, to nurses, the doctors, the health clinics, even state and local officials that are connected to the injury or death of a patient caused by our needles . . . they're all still on-the-hook.* ***Unless they are in Florida, where Governor Ron DeSantis now requires vaccine victims to sign a liability wavier form.***

One final point . . . unlike the innuendo I fed Mexico, you can sue the vaccine manufacturer, but it will be a waste of time and money; the judge will take one look at the 'liability immunity' status, and dismiss the plaintiff's lawsuit as frivolous. "

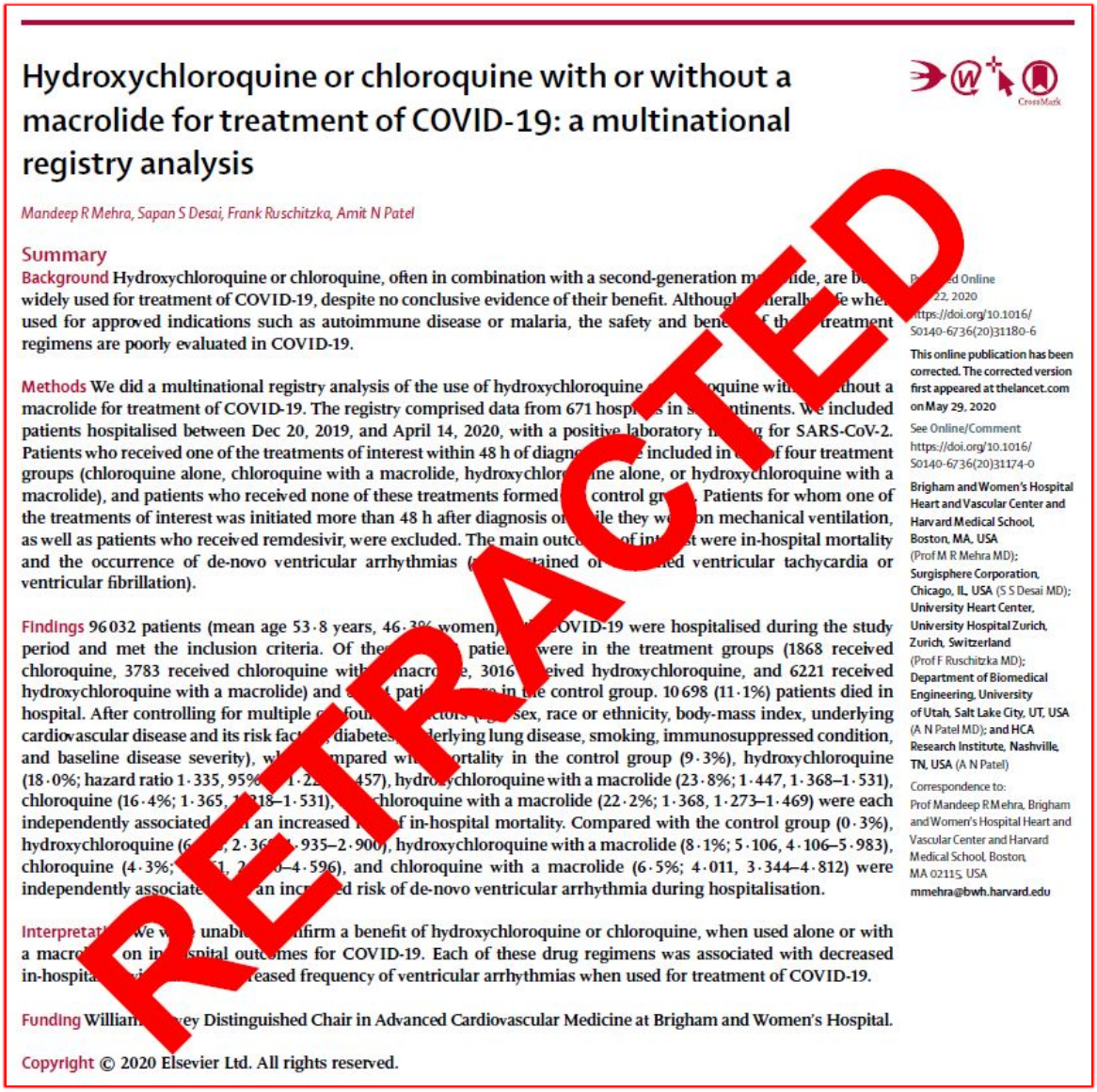
Conclusion – COVID-19 "Vaccines," Nuremberg Code, the Impossibility of 'Informed Consent'

The four hallowed documents on Page 1 protect global citizenry from a putrid future that now proposes mandatory vaccinations and **coercion** implicit to "vaccine passports." The crux of this putrid future, and its birthrights, The Great Reset and medicalization, is (a) censorship-derived ignorance, (b) subsequent fear-based intimidation, and (c) submission to police force. **Such is the true legacy of "America's Doctor."**

Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths

In Reference 1, I discussed *'Censorship-of and Outright Threats Against Those Associated with Hydroxychloroquine.'*

Your collusion-with the pro-vaccine company Surgisphere, its **fraudulent** hydroxychloroquine "research," and your hurried May 27, 2020 interview with Politico, are just the beginning of the criminal evidence.



RETRACTED

Hydroxychloroquine or chloroquine with or without a macrolide for treatment of COVID-19: a multinational registry analysis

Mandeep R Mehra, Sapan S Desai, Frank Ruschitzka, Amit N Patel

Summary

Background Hydroxychloroquine or chloroquine, often in combination with a second-generation m[illegible]ide, are b[illegible] widely used for treatment of COVID-19, despite no conclusive evidence of their benefit. Although [illegible]enerally safe whe[illegible] used for approved indications such as autoimmune disease or malaria, the safety and bene[illegible] of th[illegible]treatment regimens are poorly evaluated in COVID-19.

Methods We did a multinational registry analysis of the use of hydroxychloroquine [illegible]oquine wit[illegible]thout a macrolide for treatment of COVID-19. The registry comprised data from 671 hosp[illegible]s in s[illegible]ntinents. We included patients hospitalised between Dec 20, 2019, and April 14, 2020, with a positive laboratory [illegible]g for SARS-CoV-2. Patients who received one of the treatments of interest within 48 h of diagn[illegible]e included in [illegible]f four treatment groups (chloroquine alone, chloroquine with a macrolide, hydroxychlor[illegible]ine alone, or hydroxychloroquine with a macrolide), and patients who received none of these treatments formed [illegible] control gr[illegible]. Patients for whom one of the treatments of interest was initiated more than 48 h after diagnosis o[illegible]ile they w[illegible]on mechanical ventilation, as well as patients who received remdesivir, were excluded. The main outc[illegible] of int[illegible]st were in-hospital mortality and the occurrence of de-novo ventricular arrhythmias ([illegible]tained o[illegible]ed ventricular tachycardia or ventricular fibrillation).

Findings 96 032 patients (mean age 53·8 years, 46·3% women) [illegible]OVID-19 were hospitalised during the study period and met the inclusion criteria. Of the[illegible] patie[illegible]were in the treatment groups (1868 received chloroquine, 3783 received chloroquine with [illegible]macro[illegible]e, 3016 [illegible]eived hydroxychloroquine, and 6221 received hydroxychloroquine with a macrolide) and [illegible] pati[illegible]e in the control group. 10 698 (11·1%) patients died in hospital. After controlling for multiple [illegible]fou[illegible]ctors ([illegible] sex, race or ethnicity, body-mass index, underlying cardiovascular disease and its risk fac[illegible], diabetes[illegible]derlying lung disease, smoking, immunosuppressed condition, and baseline disease severity), w[illegible]mpared wi[illegible]ortality in the control group (9·3%), hydroxychloroquine (18·0%; hazard ratio 1·335, 95%[illegible]1·22[illegible]457), hydr[illegible]ychloroquine with a macrolide (23·8%; 1·447, 1·368–1·531), chloroquine (16·4%; 1·365, [illegible]218–1·531), [illegible]chloroquine with a macrolide (22·2%; 1·368, 1·273–1·469) were each independently associated [illegible] an increased [illegible]f in-hospital mortality. Compared with the control group (0·3%), hydroxychloroquine (6[illegible], 2·36[illegible]·935–2·906), hydroxychloroquine with a macrolide (8·1%; 5·106, 4·106–5·983), chloroquine (4·3%; [illegible]1, 2[illegible]0–4·596), and chloroquine with a macrolide (6·5%; 4·011, 3·344–4·812) were independently associate[illegible] an incr[illegible]ed risk of de-novo ventricular arrhythmia during hospitalisation.

Interpretati[illegible] We w[illegible] unabl[illegible]nfirm a benefit of hydroxychloroquine or chloroquine, when used alone or with a macro[illegible] on in[illegible]spital outcomes for COVID-19. Each of these drug regimens was associated with decreased in-hospita[illegible]i[illegible]reased frequency of ventricular arrhythmias when used for treatment of COVID-19.

Funding William[illegible]ey Distinguished Chair in Advanced Cardiovascular Medicine at Brigham and Women's Hospital.

P[illegible]ed Online
[illegible]22, 2020
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This online publication has been corrected. The corrected version first appeared at thelancet.com on May 29, 2020

See Online/Comment
https://doi.org/10.1016/S0140-6736(20)31174-0

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Correspondence to:
Prof Mandeep R Mehra, Brigham and Women's Hospital Heart and Vascular Center and Harvard Medical School, Boston, MA 02115, USA
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Although you took time for sales stunts with Politico, you did not respond to Reference 1, quote:

> **"Dr. Vladimir Zelenko has had a 99.7% survival rate using hydroxychloroquine-based treatment of patients . . . and he has had zero heart-related 'side effects.' "**

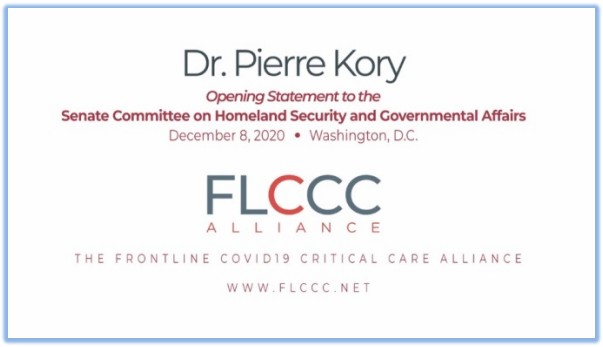
Was this general **type** of information in-any-way useful to the life-saving treatment of residents in the nursing homes? Yes. Since it was, what is the legal status of those in responsible positions; those that ignored, or suppressed, or actively subverted this information and the associated life-saving protocols?

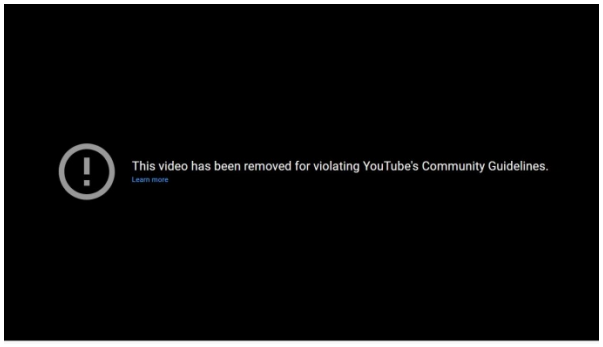
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths – con't

In Reference 2, I elaborated further upon hydroxychloroquine by quoting the Mark Levine interview with Yale Professor of Epidemiology, Dr. Harvey Risch:

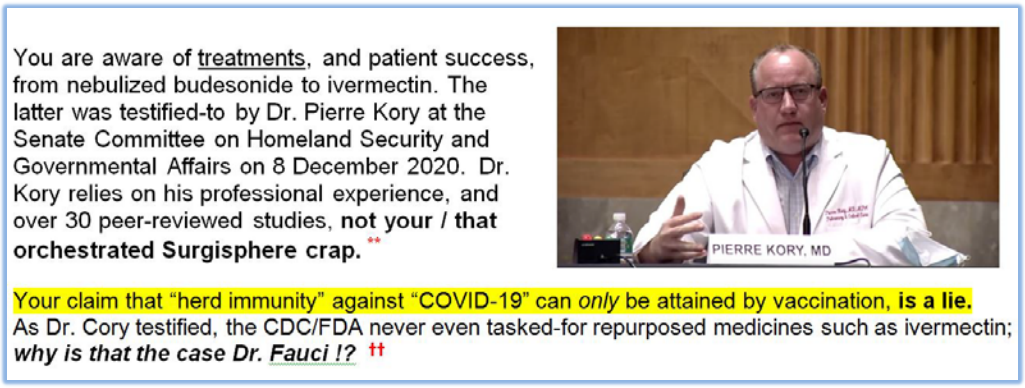
*"**This has gone on before** . . . now we have Dr. Fauci denying that any evidence exists of benefit (use of hydroxychloroquine), and that has pervaded the FDA. The FDA has relied on Dr. Fauci and his NIH advisory groups to make the statement saying that there is no benefit of using hydroxychloroquine in outpatients, and this is counter to the facts of the case. The (positive) evidence is overwhelming. The FDA has also said that there is harm in using these medications in outpatients (that) overweighs the benefits. Ninety per cent of the COVID cases have occurred since the FDA restricted (hydroxychloroquine usage) to inpatients-only. Dr. Fauci and the FDA are doing the same thing that was done in 1987, **and that has led to the (COVID-19) deaths of hundreds of thousands of Americans that could have been saved by usage of this drug."***

On Page 3 of Reference 2, I extended thematically into another treatment, Ivermectin. I reviewed the US Senate testimony of Dr. Pierre Kory. Dr. Kory testified to the overwhelming COVID-19 benefits of that inexpensive and decades-safe medication. As you are fully aware, and endorsed, that sworn testimony was censored by your comrade Susan Wojcicki of YouTube:





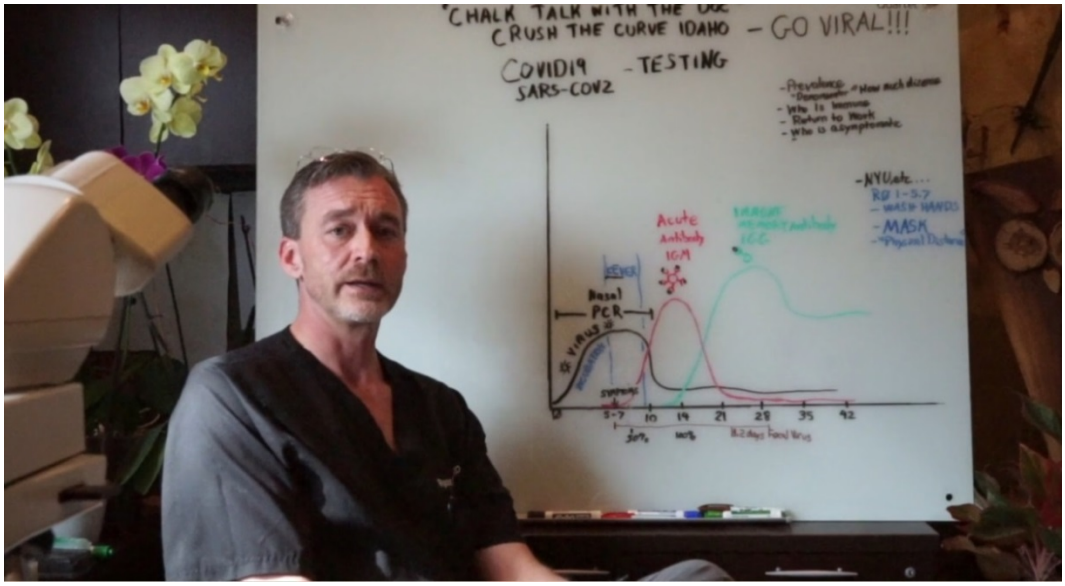
A screenshot from Page 3 of Reference 2, received at your office on 23 December 2020:



Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths – con't

The agenda of Klaus Schwab and his Great Reset has nothing to do with human dignity, let-alone health. Medicalization implies the tyranny of mandatory COVID-19 "vaccination." The Great Reset addresses the ***'Why is that the case'*** question I posed regarding Ivermectin (Reference 2, screenshot Page 16 above).

We sample *another* practicing medical doctor. The sole agenda of Dr. Ryan N. Cole is a dedication-to and experience-with maintaining patient health:



Dr. Cole has treated 350,000 patients; last year he tested and treated over 100,000 COVID-19 patients.

Regarding the latter, those Idaho patients are **victims** of the Gain of Function (GOF) research that you illegally funded, during a global moratorium, at the Wuhan Laboratory of Virology in Communist China. Your direct involvement, and leading role in that Wuhan GOF research criminality and its global tyrannical CCP-styled aftermath is not disputable; documents disclosed by a Freedom of Information Act (FOIA) demand by Mr. Tom Fitton of Judicial Watch are plain. Your direct endorsement of the CCP lockdown fabrications and promotions, which you later "recommended" to President Donald Trump, is clear.

Mr. Fitton was a recipient of References 1 and 2.

Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths – con't

Dr. Cole has never made closed-door announcements such as:

"There will be a challenge (for) the coming Administration in the arena of infectious diseases, both chronic infectious diseases in the sense of already ongoing disease, and we have certainly a large burden of that, but also there will be a surprise outbreak."

(Please confer with Mr. Fauci for the exact date, approx January 2017.)

Dedicated practicing physicians such as Dr. Cole have, and continue to do the exact opposite, especially with respect to the true purpose and expectations of your "surprise outbreak."

In his March 2021 presentation at the Idaho State Capitol, to Lieutenant Governor Janice McGeachin, her staff, and the state legislature, Dr. Cole commented on his experiences and detailed knowledge-of at least three key areas relating to the use of non-vaccination oriented, disease mitigating protocols:

Efficacy of **Hydroxychloroquine**

The winter months and the northern 35th Parallel, **Vitamin D** production by exposure of the epidermis to sunlight, with an emphasis on a lower production for all, **but especially dark skinned people.**

The crucial role of Vitamin D to the functioning of the human immune system, prompting a quote from "America's doctor" regarding ***his*** daily intake of "8000 to 9,000 IUs per day." (225 mcg)

Efficacy of **Ivermectin**

Immediately, fact checkers ridiculed, slandered and libeled Dr. Cole. Perhaps the most indicative diatribe was the claim that Dr. Cole is an **"anti-vaxxer."** I reviewed the labeling routine multiple times with the Ivy League (Reference 3, Page 5). But . . . get this . . . the buffoons that labeled Dr. Cole **were fully aware** that he, his wife and children were already "vaccinated"!

In the context medicalization and The Great Reset, hard truth has no relevance; and those that violate edicts *in any way* will be vilified. **Such is the true legacy of "America's Doctor."**

Like abuse rendered against Nobel Prize winner Dr. Kary Mullis (and his PCR process) by Anthony Fauci, we now review **the Idaho buffoons who also abused a Nobel Prize winner, while libeling Dr. Cole.**

Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths – con't

At left is a typical media buffoon, Brian Holmes. At right, an even more dishonest charlatan Dr. Jim Souza; the type of people that support medicalization and "America's doctor."

After the Dr. Cole presentation, these two buffoons did 'fact checking' which is typified by the following:

KTVB7 News Weather Sports Connect Watch

Cole also told lawmakers that ivermectin, a medication used in horses to treat parasites, killed the coronavirus in 99.9% of petri dish studies. Souza said while this statement is true, it would have to be given to humans in a dose 100 times the size used in studies, which would be unsafe for humans.

"When you actually go to the studies, the truth is, it's a mixed bag so we should talk about the entire bag and not just the positive sides of the bag," Souza said. "I understand the desire to reach for solutions that are easy, but I find it interesting that people might be more interested in putting an animal, anti-parasite, chemical medication into their body to prevent something that we already know we can prevent non invasively by wearing a mask and spacing out."

Author: Brian Holmes
Published: 6:09 PM MDT March 16, 2021
Updated: 1:42 PM MDT April 2, 2021

Horses?! Holmes? With a degree in Television Production, he has no idea what he is "reporting," instead bowing to the fraudulent conflations and the outright lies of Dr. Souza.

Background . . . according to Fauci there is no evidence that SARS-CoV-2 originated from GOF research conducted in a Wuhan Laboratory. You have promoted that its origin is a bat, or some mammal, sold in a "fish market" (?!) . . . and that SARS-CoV-2 was later transmitted to another mammal . . . a human.

Even if we disbelieve the Fauci/SARS-Cov-2 origins ***goo***, we do agree that horses are mammals . . . as are the humans of Africa for whose benefit Ivermectin was originally dispensed.

Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths – con't

In the 1970s Africans suffered terribly from the disease Onchocerciasis, or river blindness. A brilliant Japanese biochemist, Dr. Satoshi Ōmura discovered that river blindness was caused by a parasite. It was Dr. Ōmura who was credited with real-world discoveries that *led* to the development of Ivermectin, which when dispensed in the 1980s in South America and many other locations **effected immediate and greatly improved health for our fellow humans in Africa**.

For his great work, and dedication, and specifically for his contributions to Ivermectin, Dr. Satoshi Ōmura shared the Nobel Peace Prize for Medicine in 2015:

Horses' asses like Dr. Souza were not involved in the original research that led to the miraculous benefits of Ivermectin. The original focus was the health needs of our fellow humans in Africa.

`Not in the Holmes/Souza 'fact check,' Ivermectin is a medication focused on mammalian physiology. As Dr. Souza is fully aware, the formulation used in non-human mammals is Ivomec. This variant of Ivermectin has been dispensed for a variety of ailments and species; cattle, swine, sheep, goats, dogs, cats and horses. Those animal benefits were the direct result of re-purposing. This buffoon then diverts to an FDA recommendation that he knows has no connection whatsoever to COVID-19, as he feigns concern about *"a dose 100 times,"* but Souza never blinks with the fact that **Fauci routinely takes over 10 times the FDA daily allowance for Vitamin D.** Souza's behavior is called 'lying by omission.'

For Dr. Souza to spew the **lie** that practitioners (Dr. Pierre Kory, Dr. Ryan Cole, etc.) are recommending that animal formulations be used in humans, for use in COVID-19, is not merely misinformation; **Dr. Souza's public sputum confirms that he is a bold-faced liar.** Holmes? He's just *another* media twit.

The point? Such is the type of people that support and endorse "America's doctor."

Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths – con't

Ivermectin has been re-tasked (beyond Onchocerciasis) for other ailments **in humans**, has met overwhelming success, and **has been safely dispensed for decades *to BILLIONS* worldwide.** Also known, and subverted by you, innumerable requests were made to the NIH, NIAID, CDC and the FDA to study the re-purposing of Ivermectin for COVID-19. Again Page 3 of Reference 2:

You are aware of treatments, and patient success, from nebulized budesonide to ivermectin. The latter was testified-to by Dr. Pierre Kory at the Senate Committee on Homeland Security and Governmental Affairs on 8 December 2020. Dr. Kory relies on his professional experience, and over 30 peer-reviewed studies, **not your / that orchestrated Surgisphere crap.** **

Your claim that "herd immunity" against "COVID-19" can *only* be attained by vaccination, **is a lie.** As Dr. Cory testified, the CDC/FDA never even tasked-for repurposed medicines such as ivermectin; ***why is that the case Dr. Fauci !?*** ††

In the context of the nursing homes deaths, your profiteering-based assault against hydroxychloroquine, which occurred not-later-than May 27, 2020 is, at the very least, **malfeasance**. Reference 1, page 7 :

Your May 27 Politico interview occurred **a mere 5 days after the thelancet.com publication of Surgisphere's "investigation."**

In that globally distributed interview, contextualized-by and based-upon the Surgisphere "investigation," you bold-facedly declared:

> "I'm not so sure it (hydroxychloroquine), should be banned, but clearly the scientific data is really quite evident now about the lack of efficacy for it, and even the possibility that there could be, not could be but there is, you know, likelihood that under certain circumstances, might be rare but you'd see it, adverse events particularly with regard to cardiovascular and the arrhythmias that might be associated with it (hydroxychloroquine), I mean there was suspicion of that for a while, but as data comes in it becomes more clear. So I'm not so sure that you'd want to ban it, but certainly the data are clear right now."

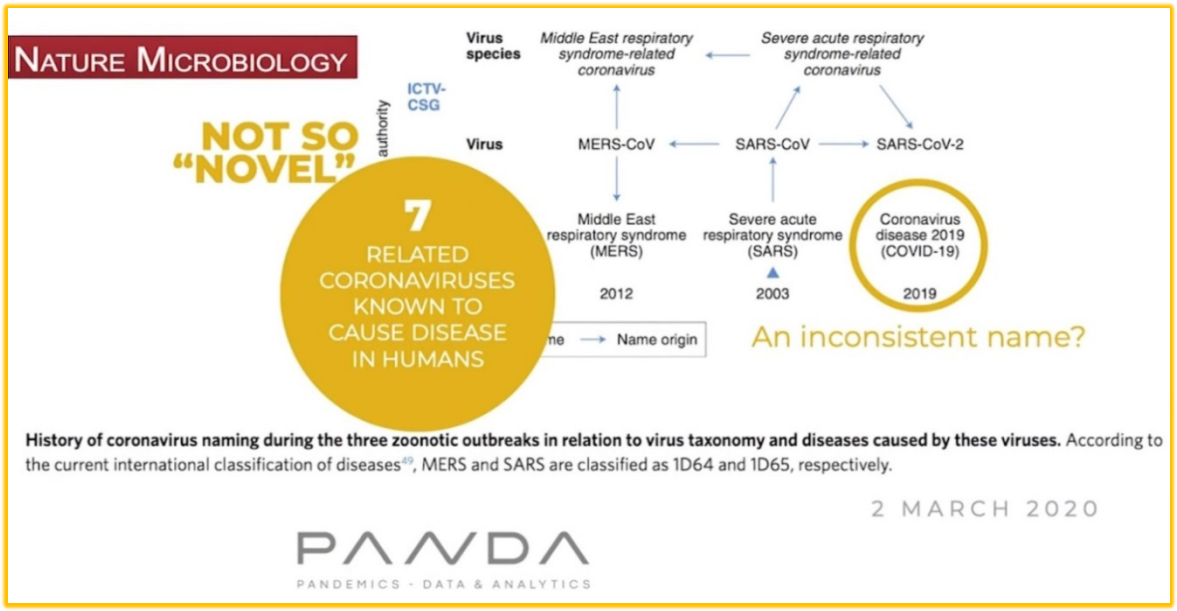
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths – con't

As if written or approved by you, the ongoing letters written ***from*** the FDA ***to*** Big Pharma **continue** to spew the following sales & marketing ***crap*** (screenshot):

> 3. There is no adequate, approved, and available alternative to the emergency use of Pfizer-BioNTech COVID-19 Vaccine to prevent COVID-19.[4]

One could easily interpret that this ***crap*** was written by Pfizer's public relations staff. Officially this sputum comes from Dr. Denise Hinton of the FDA.

But what is the key <u>global</u> propaganda that underscores the Dr. Hinton lie; a lie abusing the innocence of the trusting people your profession is tasked to <u>serve</u>? What is the long-term purpose of that propaganda?



The vigorously promoted propaganda, especially from a disease treatment perspective, is that SARS-CoV-2 is "novel." You, Dr. Tedros Adhanom Ghebreyesus, and many more, have deceived the entire globe**.**

That SARS-CoV-2 is "novel" is the scam used to justify the Hinton lie. It is meant to bolster the ongoing profiteering of Big Pharma. The "novel" label facilitated **distinction** relative to prior, failed attempts at mRNA gene modification applications to SARS-CoV. The label allows the results of 'Operation Warp Speed' to be promoted as a unique, first-of-its-kind "vaccine" that is a marvel of technology. This marvel allegedly defined "**the (only) path forward."** As Hinton's marketing crap demands, the Fauci needle **is the only "alternative."**

The truth is, this scheme is ***not*** the only alternative; **proven alternatives existed prior to this pandemic.** But those that promoted or used non-vaccine treatments, such as hydroxychloroquine, ivermectin and Vitamin D, have been ostracized. The "novel" lie, and those affiliated with that lie who used it to subvert or delay the non-vaccine alternatives, are legally connectable to the nursing home deaths.

Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths – con't

"This has gone on before! Seventeen-thousand people died because of Dr. Fauci's insistence on not allowing even a statement supporting consideration of the use of (non-vaccine COVID-19 treatments)**."**

Assigning culpability for the nursing home deaths involves (i) updating the death statistics (to higher levels), (ii) revising the "consideration of use" to COVID-19 related non-vaccine treatments, and then (iii) factually connecting these updates to the horrors that you and your comrades caused in the nursing homes.

Factual Consluson to Subject 2

1. By encouraging ignorance through social media and MSM censorship, and therefore making the Nuremberg levels of 'informed consent' impossible,

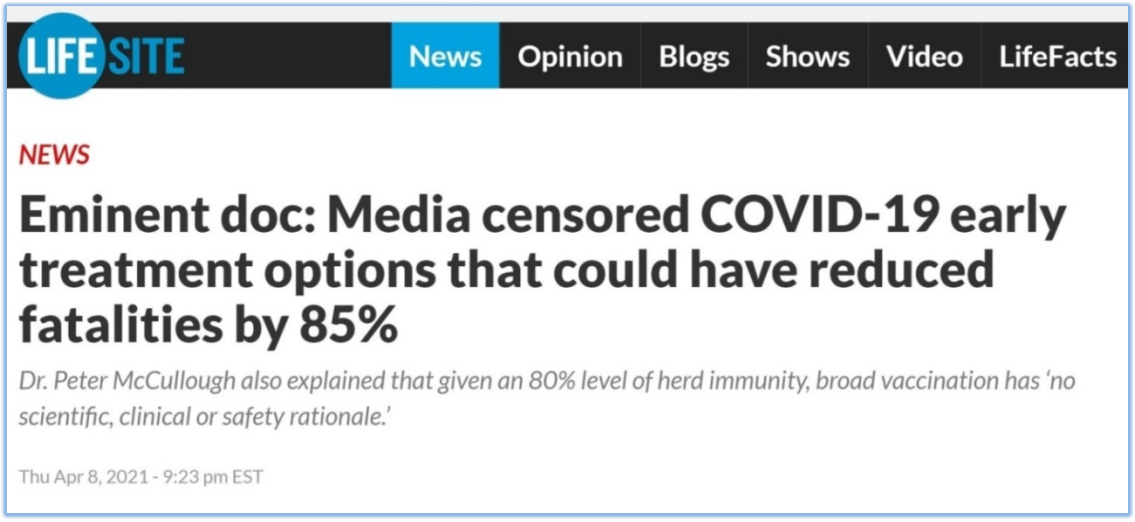
2. By discouraging, subverting and delaying through intimidation and **coercion** the prescriptive and prophylactic use of non-vaccine disease mitigating treatments,

3. By misleading the global citizenry and the global officialdom with the "novel" scam, and using that sleight-of-hand to codify the mRNA gene modification results of 'Operation Warp Speed,'

4. By approving and loudly promoting, and then demanding submission to the portent of Dr. Denise Hinton's "no alternative" profiteering . . . **you are connectable to the death of tens-of-thousands of elderly, trusting and socially/politically vulnerable human beings in the nursing homes:**

To avert your anticipated diversion that assessment of your historical record by renown Yale Professor Dr. Harvey Risch (in red font above) is an outlier, we now review the sworn testimony of Dr. Peter McCullough at the Texas State Senate's Health and Human Service Committee; **testimony that occurred this past Thursday, 8 April 2021, *while* I was drafting this letter** (Tab 7).

Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths – con't


LIFESITE News Opinion Blogs Shows Video LifeFacts

NEWS

Eminent doc: Media censored COVID-19 early treatment options that could have reduced fatalities by 85%

Dr. Peter McCullough also explained that given an 80% level of herd immunity, broad vaccination has 'no scientific, clinical or safety rationale.'

Thu Apr 8, 2021 - 9:23 pm EST

Note that Dr. McCullough did not testify about 5% . . . *he stated 85% !* Of the "500,000 COVID deaths," the national number that you constantly claim, **up to 425,000 would still be alive! Of the 15,430 that died in Governor Cuomo's nursing homes, over 13,115 could still be alive!**

As background, in your sales & marketing presentation to Howard University President Wayne Frederick, of 8 December 2020, Dr. Fauci essentially declared *his* protocol:

> "If a victim of my GOF research has COVID-19 symptoms, do <u>not</u> treat them. Send them home and let them get worse and worse and worse; wait about '28 days' until they are near death before you accept hospitalization, where we get to control the statistics for later use with our media friends and the hapless cowards in Congress, then stick a big ventilator on the victim's face, and pump them full of expensive drugs that we know don't work. If they die we'll say, 'Oh well, we tried!'"

By stark contrast, citing an August 2020 paper co-authored by Dr. Harvey Risch *(Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 Infection),* Dr. McCullough testified as follows:

> "Let's take the White House: How come we didn't have a panel of doctors assigned to put all their efforts to stop these hospitalizations? Why don't we have doctors who actually treated patients get together in a group and every week and give us an update? Why don't we have any reports about how many patients were treated, and spared hospitalizations? This is a complete and total travesty to have a fatal disease, and not treat it . . .
>
> "The calculations in Texas on herd immunity . . . right now with no vaccine effect is 80 percent. And more people are developing COVID today. They're going to become immune as well. People who develop COVID have complete and durable immunity. And that's a very important principle: complete and durable. You can't beat natural immunity. You can't vaccinate on top of it and make it better. There's no scientific, clinical or safety rationale for ever vaccinating a COVID-recovered patient. There's no rationale for ever testing a COVID-recovered patient."

I am confident that the defense attorneys for Governor Cuomo will seek testimony from innumerable practicing MDs, worldwide, that <u>know</u> that your mRNA gene modification therapy is <u>not</u> and has <u>never</u> been "the only alternative" during this COVID-19 pandemic, which officially commenced on 31 January 2020 . . . Your "only alternative" vaccine <u>coercions</u> are not only falsely premised, but such is criminal under every law from the Nuremberg Code to the Civil Rights Act.

General Consluson to Subject 2, and the Issue of 'Depraved Indifference'

This Conclusion is not restricted to the Marxist-styled parasite in Albany, New York (pages 11/12). The following governors are also in focus: Gretchen Whitmer (Michigan), Thomas Wolf (Pennsylvania), Thomas Murphy (New Jersey), Gavin Newsom (California), Jay Pritzker (Illinois), Mike DeWine (Ohio), Charles Baker (Massachusetts), and Greg Abbott (Texas).

In the nursing home death litigations, the defense lawyers for governors and staffs will point to "health authorities" and the "guidance" relied upon during implementation of state policies that contributed to the deaths.

In Reference 1, way back in July 2020, I declared the *'Horrific Avoidable Deaths of Elders in Nursing Homes, and the Deafening Silence of Dr. Anthony S. Fauci.*' The correct legal descriptor is **'depraved indifference.'** I will continue to recommend to the governors' defense attorneys that a priority be placed upon having Dr. Anthony S. Fauci as a key witness.

Conclusion to this Memorandum

Throughout your pitch to Howard University you spewed ***ad nauseam*** "Safe! Safe! Safe!" But you never mentioned the term 'liability immunity.' But last Wednesday, 7 April 2021, an interview with the former Pfizer Vice President and Chief Scientist **of 32 years**, Dr. Michael Yeadon, headlined as follows (Tab 8):

EXCLUSIVE - Former Pfizer VP: 'Your government is lying to you in a way that could lead to your death.'

'Look out the window, and think, "why is my government lying to me about something so fundamental?" Because, I think the answer is, they are going to kill you using this method. They're going to kill you and your family.'

Wed Apr 7, 2021 - 8:47 am EST

The true legacy of "America's Doctor" will be the permanent tarnishing and diminished stature of the medical profession in-general. The COVID-19 situation you administered is so egregious, that soon even Ivy League law school deans will distance themselves from this ongoing tragedy. The legal portion of this situation is detailed further under Tabs 9 and 10.

Cordially,

Paul V. Sheridan

Enclosures

ADDENDUM

Listed as Reference 3, the enclosed 1" binder is an exact duplicate of that previously received by the eight Ivy League presidents; the only addition contained in the front inner sleeve, the eight shipper SPODs. The relevant hyperlinks are here:

http://pvsheridan.com/SPODs-Ivy_League-1.pdf

http://pvsheridan.com/sheridan2ivyleague-1-6march2021.pdf

http://pvsheridan.com/sheridan2ivyleague-1-6march2021-enclosure.pdf

http://pvsheridan.com/sheridan2fauci-2-21december2020.pdf

http://pvsheridan.com/sheridan2fauci-1-21july2020.pdf

Attachment Tabs to Instant Memorandum

California Educators for Medical Freedom vs. Los Angeles Unified School District	Tab 1
Isaac Legaretta vs. Dona Ana County	Tab 2
Violation of the Nuremberg Code by Israel	Tab 3
9 March 2021 Letter from Paul V. Sheridan to Dr. Harvey Risch	Tab 4
NEJM Article - Fifty Years Later: The Significance of the Nuremberg Code	Tab 5
26 March 2021: Letter from Robert F. Kennedy Jr. to Rutgers University	Tab 6
8 April 2021: Media Censored COVID-19 Early Treatment Options That Could Have Reduced Fatality by 85%	Tab 7
7 April 2021: Former Pfizer Vice President of Research: Your Government is Lying to You in a Way That Could Lead to Your Death	Tab 8
June 2020: All-cause Mortality During COVID-19: No plague and a Likely Signature of Mass Homicide by Government Response	Tab 9
The Fauci / COVID-19 Dossier by Dr. David E. Martin	Tab 10

Instant Memorandum dated 12 April 2021 hyperlink:

http://pvsheridan.com/sheridan2fauci-3-12april2021.pdf

Tab 1

21 Pages

12 April 2021

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
5601 Fishers Lane
Rockville, MD 20852
301-496-2263
anthony.fauci@nih.gov

Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths
Reference 1: My Letter to You of 21 July 2020
Reference 2: My Letter to You of 21 December 2020
Reference 3: My Letter to the Presidents of the Ivy League of 6 March 2021

California Educators for Medical Freedom vs. Los Angeles Unified School District

21 Pages (abridged)

Complete 104 Page Document Available Here:

http://pvsheridan.com/cemf-versus-lausd.pdf

John W. Howard (SBN 80200)
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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

WESTERN DIVISION

CALIFORNIA EDUCATORS FOR MEDICAL FREEDOM, ARTEMIO QUINTERO, MIGUEL SOTELO, JANET PHYLLIS BREGMAN, CEDRIC JOHNSON, MISANON (SONI) LLOYD, HEATHER POUNDSTONE, and THERESA D. SANFORD,

Plaintiffs,

v.

THE LOS ANGELES UNIFIED SCHOOL DISTRICT, AUSTIN BEUTNER, in his official capacity as Superintendent of the Los Angeles Unified School District, and LINDA DEL CUETO, in her official capacity as the Director of Human Resources for the Los Angeles Unified School District,

Defendants.

Case No.: 21-cv-02388

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

DEMAND FOR JURY TRIAL

Plaintiffs, CALIFORNIA EDUCATORS FOR MEDICAL FREEDOM ("CEMF"), ARTEMIO QUINTERO, MIGUEL SOTELO, JANET PHYLLIS BREGMAN, CEDRIC JOHNSON, MISANON (SONI) LLOYD, HEATHER

POUNDSTONE, AND THERESA D. SANFORD, by and through their undersigned counsel, sue Defendants, the LOS ANGELES UNIFIED SCHOOL DISTRICT ("LAUSD"), AUSTIN BEUTNER, in his official capacity as the Superintendent of the LAUSD, and LINDA DEL CUETO, in her official capacity as the Director of Human Resources for the LAUSD, and allege as follows:

INTRODUCTION

1. Plaintiffs are informed and believe and thereon allege that Defendants have implemented a policy mandating that all employees of LAUSD be vaccinated against the virus known as SARS-CoV-2, which causes the corona virus disease known as COVID-19 (together "COVID-19") by the use of vaccine materials that have not, as yet, been finally approved by the relevant federal agencies, as a condition of their continuing employment (hereinafter, the "Mandate").

2. None of the currently available vaccines for COVID-19 (the "COVID Vaccines") has received final approval from the Food and Drug Administration (the "FDA"). Rather, each one of the COVID Vaccines is an *unapproved product* that has been authorized for emergency use under a series of Emergency Use Authorizations ("EUAs"). The statute granting the FDA the power to authorize a medical product for emergency use requires that the person being administered the unapproved product be advised of his or her right to refuse administration of the product. *See* 21 U.S.C. § 360bbb-3(e)(1)(A) ("Section 360bbb-3").

3. For its part, the FDA refers to the COVID Vaccines as "*investigational products*" – i.e., they remain experimental. In accordance with the governing statute, the FDA requires that patients and caregivers be informed of their right to refuse administration of the product. As well, the FDA has held that the terms and conditions of the EUAs preempt state and local laws that would impose obligations that are inconsistent with those terms and conditions.

4. Section 360bbb-3 reflects a fundamental, public policy goal of striking a balance between giving people the option of having access to experimental medical

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products during public emergencies, while also assuring that no one is forced to accept administration of such an experimental medical product. The Mandate effectively usurps that public policy objective and stands in violation of clear federal statutory authority and guidelines.

5. Section 360bbb-3 further recognizes the well-settled doctrine that medical experiments, better known in modern parlance as "clinical research", may not be performed on human subjects without the express, informed consent of the individual receiving treatment.

6. This right to avoid the imposition of human experimentation is fundamental, and has its roots in the Nuremberg Code of 1947 and has been ratified by the 1964 Declaration of Helsinki, and further codified in the United States Code of Federal Regulations. The standard is indeed so universally recognized that it constitutes a *jus cogens* norm under international law.

7. The Nuremberg principles have been adopted by the California Legislature, and no person subject to this State's jurisdiction may be forced to undergo the administration of experimental medicine without that person's informed consent. The Mandate is therefore contrary to the law of this State.

8. There is no "pandemic exception" to the law or the Constitution. Plaintiffs ask that the Court intervene to protect their rights before it is too late.

PARTIES

9. Plaintiff CEMF is a voluntary, unincorporated association of LAUSD employees whose purpose is to advocate for medical choice and bodily autonomy on behalf of its members, vis a vis the Mandate. CEMF's members are directly affected by the Mandate, and therefore would have standing in their own right to bring this action. As well, the interests at stake in this case are germane to CEMF's purpose, and neither the claims asserted nor the relief requested requires the individual participation of its members.

10. Plaintiff ARTEMIO QUINTERO is a citizen of Los Angeles County, and

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is employed by LAUSD as a Carpenter.

11. Plaintiff MIGUEL SOTELO is a citizen of Los Angeles County, and is employed by LAUSD as an Electrician.

12. Plaintiff JANET PHYLLIS BREGMAN is a citizen of Los Angeles County, and is employed by LAUSD as a Teacher.

13. Plaintiff CEDRIC JOHNSON is a citizen of Los Angeles County, and is employed by LAUSD as a SSS PSA Counselor.

14. Plaintiff MIDSANON (SONI) LLOYD is a citizen of Los Angeles County, and is employed by LAUSD as a Teacher.

15. Plaintiff HEATHER POUNDSTONE is a citizen of Los Angeles County, and is employed by LAUSD as a Teacher and Librarian.

16. Plaintiff THERESA D. SANFORD is a citizen of Los Angeles County, and is employed by LAUSD as a Teacher.

17. Allegations regarding "Plaintiffs" hereinbelow shall be deemed to include the individual Plaintiffs and the members of Plaintiff CEMF.

18. Defendant LAUSD is an independent subdivision of the State of California, and has responsibility for governance of all public schools in the geographical boundaries defined in its governing documents. LAUSD has enacted policies, whether express or implied, that deprive or threaten to deprive Plaintiffs of certain rights, privileges, and immunities under the laws and Constitution of the United States and under the laws and Constitution of the State of California.

19. Defendant AUSTIN BEUTNER is the Superintendent of LAUSD, and is *sui juris*. Mr. Beutner is ultimately charged with, *inter alia*, enforcing all employment policies of the LAUSD. He is being sued in his official capacity.

20. Defendant LINDA DEL CUETO is the Director of Human Resources for LAUSD, and is *sui juris*. On information and belief, Ms. Del Cueto is charged with developing and enforcing employment policies of LAUSD. She is named as a defendant herein in her official capacity.

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21. Defendants Beutner and Del Cueto have personally undertaken actions under color of law that deprive or imminently threaten to deprive Plaintiffs of certain rights, privileges, and immunities under the laws and Constitution of the United States, and under the laws and Constitution of the State of California.

22. Defendants are all state actors unprotected by sovereign immunity for purposes of this action.

JURISDICTION AND VENUE

23. This Court has jurisdiction to hear this case under 28 U.S.C. § 1331, which confers original jurisdiction on federal district courts to hear suits arising under the laws and Constitution of the United States, as well as under 42 U.S.C. § 1983 in relation to Defendants' intent to deprive Plaintiffs of certain rights, privileges, and immunities as detailed herein.

24. This Court has jurisdiction over the claims asserting violations of the laws and Constitution of the State of California through its supplemental jurisdiction under 28 U.S.C. § 1367(a), as those claims are so closely related to the Plaintiffs' federal question and Section 1983 claims that they form part of the same case or controversy under Article III of the United States Constitution.

25. This Court has the authority to award the requested declaratory relief under 28 U.S.C. § 2201; the requested injunctive relief under 28 U.S.C. § 1343(a), and attorneys' fees and costs under 42 U.S.C. § 1988.

26. The Central District of California, Western Division is the appropriate venue for this action pursuant to 28 U.S.C. § 1391(b)(1) and (2) because it is the District in which Defendants reside, exercise their authority in their official capacities, and/or have threatened to deprive Plaintiffs of the rights and liberties under the laws and Constitution of the United States, and in addition thereto to violate the laws and Constitution of the State of California, as further alleged herein. It is also the District in which a substantial part of the events giving rise to Plaintiffs' claims have occurred and continue to occur.

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FACTUAL BACKGROUND

The Universal Prohibition on Human Experimentation Without Consent

27. Among the horrors that emerged from the rubble of World War II were stories of barbaric medical experiments performed on unwilling victims of Nazi Germany's concentration camps.

28. On August 8, 1945, the prevailing Allies established an International Military Tribunal (the "IMT"). Under the aegis of the IMT, the law authorized the creation of U.S. military tribunals for the trial of "lower-level" war criminals, such as doctors accused of conducting medical experiments without the subjects' consent.[1]

29. A U.S. military tribunal subsequently found 15 doctors guilty of conducting nonconsensual experiments, which included the testing of drugs for immunization against malaria, epidemic jaundice, smallpox, and cholera. "In every single instance appearing in the record," the tribunal concluded, "subjects were used who did not consent to the experiments. . . ." The tribunal sentenced seven of the doctors to death, and the remaining eight to life in prison.

30. As part of its final judgment, the tribunal promulgated the Nuremberg Code on Permissible Medical Experiments. Point One of the Nuremberg Code states: "**The voluntary consent of the human subject is absolutely essential**."

31. This standard has since been repeatedly ratified and adopted around the globe, in laws, treaties, regulations, and ethical guidelines for medical research. For example, in 1964, the World Medical Association adopted the Declaration of Helsinki, which provides that human subjects "must be volunteers and informed participants in the research project." Declaration of Helsinki at Art. 20.

32. Although themselves non-binding, the principles underlying the

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[1] Sources for the historical facts set forth herein can be found in *Abdullahi v. Pfizer, Inc.*, 562 F.3d 163 (2d Cir. 2009), which explains in detail the history and reasons why the prohibition against nonconsensual human experimentation should be regarded as a *jus cogens* norm.

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Declaration of Helsinki and the Nuremberg Code have been incorporated into international conventions, as well as the laws and regulations of countries around the world, including the United States of America.

33. The International Covenant on Civil and Political Rights of the United Nations, which went into effect in 1976, provides in Article I that "[a]ll peoples have the right of self determination" and in Article 7 that "no one shall be subjected without his free consent to medical or scientific experimentation."

34. The informed consent principles of the Declaration of Helsinki were also incorporated by a 2001 Directive passed by the European Parliament and the Council of the European Union.

35. In addition, 35 members of the Council of Europe have signed the Convention on Human Rights and Biomedicine, which provides that informed consent is required for a subject's involvement in medical research.

36. In 2005, the General Conference of UNESCO adopted the Universal Declaration on Bioethics and Human Rights, requiring free and informed consent for participation in medical research-oriented treatments.

37. On December 1, 2020, the High Court of Justice, Queen's Bench Division, Administrative Court in the United Kingdom concluded that minors lack the ability to give informed consent to the administration of puberty blockers to treat gender dysphoria because the procedure remains experimental.[2]

38. These principles have been adopted by statutes and regulations in the United States.

39. In 1979, the Department of Health, Education and Welfare issued the

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[2] *See Bell v. The Tavistock and Portman NHS Foundation Trust*, Case No. CO/60/2020, [2020] EWHC 3274 (Admin) (Engl. & Wales) https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf.

Belmont Report, which addressed the issue of informed consent in the human experimentation setting. The Report identified respect for self-determination by "autonomous persons" as the first of three "basic ethical principles" which "demands that subjects enter into the research voluntarily and with adequate information."

40. Ultimately, the principles of the Belmont Report, which itself was guided by the Nuremberg Code and the Declaration of Helsinki, were adopted by the FDA in its regulations requiring the informed consent of human subjects for medical research. *See* 21 C.F.R. § 50.20.[3] The Department of Health and Human Services has similarly adopted this standard in its regulations governing grants for medical research. *See* 45 C.F.R. § 46.116. The United States clearly regards itself as bound by the provisions of the Nuremberg Code and the Declaration of Helsinki.

41. The Nuremberg principles have also been adopted by this State. *See* Cal. Health & Saf. Code § 24170, *et. seq*. (requiring informed consent for human trial subjects).[4]

42. For these and other reasons, the prohibition against nonconsensual human experimentation must be regarded not only as established by U.S. law and regulations, but also as so broadly recognized by all nations as to constitute a *jus cogens* norm under international law.

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[3] The exceptions to this standard are extremely narrow, and require certification by a researcher and an independent physician that, for example, "[t]he human subject is confronted with a life-threatening situation necessitating the use of the test article"; informed consent cannot be obtained from the subject; time does not permit obtaining informed consent from the subject's legal representative; and "there is available no alternative method of approved or generally recognized therapy that provides an equal or greater likelihood of saving the life of the subject." 21 C.F.R. § 50.23. *See also* 21 C.F.R. § 50.24 (providing a similarly narrow exception to informed consent requirements for emergency research).

[4] California is not the only state to encode the Nuremberg principles. *See, e.g.*, Pub NY Health Ch. 45, Art. 24-a (mandating informed consent in human research); VA Code Ann. § 32.1-162.18 (same).

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Operation Warp Speed

43. On January 30, 2020, the World Health Organization ("WHO") declared a "public health emergency of international concern over the global outbreak" of COVID-19. Among other recommendations, the WHO called for accelerated development of "vaccines, therapeutics and diagnostics."

44. The following day, U.S. Health and Human Services ("HHS") Secretary Alex Azar declared a national Public Health Emergency ("PHE"), retroactive to January 27, 2020, "to aid the nation's healthcare community in responding" to COVID-19. By then, HHS was already collaborating with the pharmaceutical industry regarding the development of vaccines.

45. In April 2020, the national Administration announced Operation Warp Speed ("OWS") – a public/private partnership to develop and distribute a vaccine for COVID-19 by the end of 2020 or early 2021.

46. The process for developing a vaccine normally takes place in several phases, over a period of years.

47. The general stages of the development cycle for a vaccine are:

a. Exploratory stage;

b. Pre-clinical stage (animal testing);

c. Clinical development (human trials – *see* below);

d. Regulatory review and approval;

e. Manufacturing; and

f. Quality control.[5]

48. The third stage, clinical development, is itself a three-phase process:

a. During Phase I, small groups of people receive the trial vaccine.

b. In Phase II, the clinical study is expanded and vaccine is given to people who have characteristics (such as age and physical health) similar to

[5] https://www.cdc.gov/vaccines/basics/test-approve.html.

those for whom the new vaccine is intended.

c. In Phase III, the vaccine is given to thousands of people and tested for efficacy and safety.

49. Phase III itself normally occurs over a course of years. That is because it can take years for the side effects of a new vaccine to manifest themselves.

50. Phase III must be followed by a period of regulatory review and approval. During this stage, data and outcomes are reviewed by peers and by the FDA.

51. Finally, the manufacturer must demonstrate that the vaccine can be manufactured under conditions that assure adequate quality control.

52. The timeline set by OWS telescoped what would normally take years of research into a matter of months.

53. Commercial vaccine manufacturers and other entities proceeded with development of COVID-19 vaccine candidates using different technologies including RNA, DNA, protein, and viral vectored vaccines.

54. Two potential vaccines emerged early on as likely candidates: one developed by Moderna (the "Moderna Vaccine"), the other by Pfizer (the "Pfizer Vaccine"), with both announcing Phase III trial results in November 2020.

55. In early 2021, Janssen Biotech, Inc. submitted Phase III trial results for its adenovirus vector vaccine (the "Janssen Vaccine").

The EUAs

56. Congress enacted Title 21, Section 360bbb-3 of the Federal Food, Drug, and Cosmetic Act (the "FFDCA") to vest the Secretary of Health and Human Services with permissive authority to "authorize the introduction into interstate commerce, during the effective period of a declaration [of emergency], of a drug, device, or biological product intended for use in an actual or potential emergency. . . ." 21 U.S.C. § 360bbb-3(a)(1).

57. The statute provides for the authorization of both unapproved products and unapproved uses of an approved product. *See* 21 U.S.C. § 360bbb-3(a)(2). The

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Vaccines fall under the former category, as they have not been previously approved for any use, nor have they been approved to date.

58. Section 360bbb-3 mandates the following conditions for authorization of an unapproved product:

> . . . [T]he Secretary, to the extent practicable given the applicable circumstances described in subsection (b)(1), ***shall***, for a person who carries out any activity for which the authorization is issued, establish such conditions on an authorization under this section as the Secretary finds necessary or appropriate to protect the public health, including the following:
>
> **. . . (ii)** Appropriate conditions ***designed to ensure*** that ***individuals to whom the product is administered are informed***—
>
> **. . . (III)** ***of the option to accept or refuse administration of the product***. . . .

21 U.S.C. § 360bbb-3(e)(1)(A)(ii) (emphasis added).

59. Pfizer and Moderna applied for EUAs under Section 360bbb-3 in November-December 2020. Janssen applied for an EUA in early 2021.

60. On December 11, 2020, the FDA granted an EUA for the Pfizer Vaccine. An updated version of the EUA Letter to Pfizer is attached hereto as Exhibit "A".

61. The FDA granted an EUA for the Moderna Vaccine on December 18, 2020. The EUA Letter to Moderna is attached hereto as Exhibit "B".

62. The FDA granted an EUA for the Janssen Vaccine on February 27, 2021. The EUA Letter to Janssen is attached hereto as Exhibit "C".

63. Each of the EUA Letters provides details regarding the reasoning for the EUAs, and dictating strict conditions for, among other things, administering the Vaccines.

64. Under "Conditions of Authorization," each of the EUA letters directs that the manufacturers:

> and authorized distributor(s) will ensure that the authorized [] COVID-19 Vaccine is distributed, as directed by the U.S. government, including CDC and/or other designee, and the authorized labeling (i.e., Fact Sheets) will be made available to vaccination providers, recipients, and caregivers consistent with the terms of this letter.

See, e.g., Ex. "C" at 5, ¶A.

65. Each EUA Letter is accompanied by a Fact Sheet for Health Care Providers and a Fact Sheet for Patients and Caregivers. The Fact Sheets to Providers mandate, among other things, that a provider must communicate, to the recipient or the caregiver, information consistent with the "Fact Sheet for Recipients and Caregivers" prior to administering the vaccine, including information that "*the recipient or their caregiver has the option to accept or refuse*" the vaccine. *See* Pfizer Fact Sheet for Health Care Providers, attached as Exhibit "D" (emphasis added).

66. The Fact Sheets for Recipients and Caregivers likewise contain the following advice:

> **WHAT IF I DECIDE NOT TO GET THE [] COVID-19 VACCINE?**
>
> ***It is your choice*** *to receive or not receive the [] COVID-19 Vaccine*. Should you decide not to receive it, it will not change your standard medical care.

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See Moderna Fact Sheet for Recipients and Caregivers, attached as Exhibit "E" (emphasis added).

67. Consistent with its mandate under Section 360bbb-3, the FDA continues to refer to the Vaccines as "unapproved" or "investigational" products. *See, e.g.*, Ex. "D" at 8 (referring to Pfizer Vaccine as an "*unapproved* product") (emphasis added); Ex. "B" at 1 (noting that the Moderna Vaccine "is an *investigational* vaccine *not licensed* for any indication") (emphasis added).

68. In other words, as a legal matter and as a matter of FDA policy and guidance, the Vaccines remain experimental.[6]

69. Separate and apart from the requirements of Section 360bbb-3 and the FDA's guidance thereunder, Plaintiffs have a reasonable apprehension that the technology underlying the Moderna Vaccine (the vaccine being acquired by LAUSD) is experimental.

70. As noted above, the Moderna Vaccine uses messenger RNA ("mRNA"). Before last year, no mRNA-based vaccine had ever made it to human trials, because when injected in sufficiently high doses to render the desired effect, it triggered dangerous immune reactions, even resulting in death, in animal subjects, making it too dangerous to test on humans. Even if that problem has been solved, given the severely telescoped timeline for development, no one knows at this time what will be the long-term effects of mRNA vaccine technology. It is, by definition, experimental medicine.

The Mandate

71. On or about March 16, 2020, LAUSD closed all schools in Los Angeles County to in-person instruction.

72. Since that time, LAUSD has struggled to come up with a plan for

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[6] Only one vaccine, against inhaled anthrax, has ever previously been approved for emergency use. A district court found that it was an investigational drug and enjoined its forced administration to military servicemembers without their informed consent. *See Doe v. Rumsfeld*, 297 F. Supp. 2d 119 (D.D.C. 2003).

reopening for in-classroom instruction.[7]

73. In or about February 2021, Plaintiffs began to receive communications from Defendant Beutner, and other representatives of LAUSD, instructing them to make appointments to get vaccinated. None of these communications have included the Fact Sheet information required by the FDA to be disseminated to recipients under the EUAs.

74. On March 4, 2021, Defendant Del Cueto distributed an interoffice memorandum to the local district superintendents regarding "Human Resources COVID-19 Employee Vaccination Information and Resources," a true and correct copy of which is attached hereto as Exhibit "F".

75. The memorandum includes as "ATTACHMENT 1" Defendants' "VACCINATION GUIDANCE FOR EMPLOYEES" (the "Guidance"). The Guidance states, *inter alia*, that:

a. The Moderna vaccine is currently being administered by Los Angeles Unified nurses and other licensed healthcare professionals to Los Angeles Unified employees.

b. You *will* schedule your appointment . . . .

c. You *will* provide proof of vaccination via the DailyPass for time reporting purposes.

Ex. "F" (emphasis added).

76. ATTACHMENT 2 provides guidance for supervisors, and contains essentially the same language.

77. The Guidance clearly indicates that vaccination is mandatory.

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[7] This has been despite growing evidence that large public schools have, since the fall semester of 2020, reopened safely for in-classroom instruction, with positivity rates for COVID-19 well below those for their surrounding communities. *See* https://www.cnn.com/2021/01/11/us/miami-dade-schools-open-coronavirus-wellness/index.html.

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78. As well, Defendant Del Cueto made a verbal statement in the presence of Plaintiff Quintero to the effect that the vaccine is mandatory, and that any refusal by an employee to get vaccinated will trigger disciplinary action.

79. A representative of Teamsters Local 572 informed employees of LAUSD's Operations department via email of the results of a "Q&A" session with representatives of LAUSD. *See* Exhibit "G", attached hereto. The email states that, in response to a question as to whether vaccinations will be mandatory, LAUSD representatives answered: "***All District employees will be required to be vaccinated. No exceptions have been made. . . .***" (emphasis in original). *Id*.

80. The foregoing communications, as well as other statements made to Plaintiffs by supervisors and union representatives, all indicate that Defendants have formed an express or *de facto* policy, referred to herein as the Mandate, that requires vaccination as a condition of Plaintiffs' continuing employment unhindered by disciplinary action.

81. Plaintiffs have further been informed that any refusal to be vaccinated by April 2021 will result in a job detriment, up to and including termination from employment.

82. LAUSD is a political subdivision of the State of California with a governing board publicly elected by residents of Los Angeles County and Defendants Beutner and Del Cueto are employees of LAUSD. The Mandate therefore constitutes "state action" taken "under color of law."

PLAINTIFFS' CONCERNS AND STANDING TO SEEK DECLARATORY RELIEF

83. Plaintiffs are all employees of LAUSD who are directly affected by the Mandate.

84. The conditions of the EUAs prohibit any person from administering the Vaccines without the consent of the patient, as particularly described hereinabove and governmental agencies from requiring non-consensual administration of same.

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85. More broadly, Plaintiffs have a universally recognized, fundamental right to be free from human medical experimentation, a right that is protected by recognized international legal standards, international treaties to which the United States is a member, the laws and regulations of the United States, and the Due Process Clause of the Fourteenth Amendment.

86. Plaintiffs do not consent to being administered the COVID Vaccines.

87. Because Defendants have indicated that administration of the COVID Vaccine will be a condition of their ongoing employment, Plaintiffs are uncertain of their rights, and seek declaratory relief in order to have clarity as to their rights. A real and concrete controversy exists between Plaintiffs and Defendants in that Defendants contend that they have the right, power and authority to require involuntary vaccination as a condition of continuing employment at a public, governmental agency and Plaintiffs contend that they have the right under international treaties and protocols, the Constitution and laws of the United States of America, and the Constitution and laws of the State of California to refuse vaccination without discipline or impairment of their employment status with LAUSD.

88. All conditions precedent to this action have been performed, excused, and/or waived.

FIRST CLAIM

(All Defendants)

FEDERAL PREEMPTION

89. Plaintiffs reallege and incorporate by reference their allegations in Paragraphs 1 – 88, as if fully alleged herein, and further allege:

90. Federal laws and regulations governing the administration of medical products such as vaccines, including Section 360bbb-3 and the FDA's regulations, protocols, and guidance thereunder, fully occupy the field and explicitly and completely preempt any and all contrary or inconsistent laws of the States and/or local governments.

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91. The clear intent of Section 360bbb-3 and of the FDA's guidance and regulations implementing the statute is to allow, in the course of a medical crisis, *voluntary* access to *unapproved* – i.e., *experimental* – medical products. It was plainly not the intent of Congress to shortcut the formal approval process for medical products such as vaccines.

92. By mandating that all employees of LAUSD be administered the COVID Vaccine, Defendants usurp and frustrate the intent of Congress, and the mission of the FDA in carrying out that intent.

93. Because the COVID Vaccines are investigational products, authorized – not approved – for use under an Emergency Use Authorization, the laws and regulations of the United States prohibit their administration to any person who does not consent.

94. Plaintiffs do not consent to being administered the COVID Vaccines.

95. The Mandate is therefore patently contrary to United States law, and thus preempted and invalid.

96. As well, Title 21, Part 50 of the Code of Federal Regulations governs the protection of human subjects in the conduct of all clinical investigations regulated by the U.S. Food and Drug Administration.

97. 21 C.F.R. § 50.20 provides that, "[e]xcept as provided in §§ 50.23 and 50.24, no investigator may involve a human being as a subject in research covered by these regulations unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative."

98. None of the exemptions provided in sections 50.23 and 50.24 would apply to Plaintiffs.

99. Accordingly, the Mandate at issue violates federal regulations governing the administration of experimental medicine, and is thus preempted.

100. A real and immediate controversy exists between the parties requiring the intervention of this Court by way of declaratory relief to determine the respective rights and powers of the respective parties. In addition, Plaintiffs have no adequate remedy at

law available against Defendants for the injuries and the irreparable harm they will imminently suffer as a direct result of the Mandate.

SECOND CLAIM

(All Defendants)

SUBSTANTIVE DUE PROCESS – MEDICAL EXPERIMENTATION

42 U.S.C. §1983

101. Plaintiffs reallege and incorporate by reference their allegations in Paragraphs 1 – 88, as if fully alleged herein, and further allege:

102. As set forth above, the COVID Vaccines are experimental.

103. Plaintiffs have a protected liberty interest, secured by the Due Process Clause of the United States Constitution, international protocols and international treaties adopted by and entered into by the United States of America, and by the laws and regulations of the United States, to be free from forced medical experimentation.

104. This right is further recognized as a *jus cogens* norm under the law of nations, which prohibits human medical experimentation without informed consent.

105. Plaintiffs do not consent to being administered the COVID Vaccines.

106. Defendants have instituted a District-wide Mandate requiring that all employees of LAUSD be vaccinated against COVID-19.

107. The Mandate constitutes the official or *de facto* policy of LAUSD, such that LAUSD is a "person" for purposes of Section 1983.

108. Defendants are state actors, and have instituted or imminently intend to institute the Mandate under color of law.

109. The forcible administration of the COVID Vaccines, on pain of termination from employment, would deprive Plaintiffs of their substantive due process rights and constitute a violation of their property rights under *Skelly v. State Personnel Board* (1974) 15 Cal.3rd 194.

110. The harm to Plaintiffs cannot be adequately redressed in the event that the Mandate is carried out.

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THIRD CLAIM

(All Defendants)

VIOLATION OF CALIFORNIA'S PROTECTION OF HUMAN SUBJECTS IN MEDICAL EXPERIMENTATION ACT, CAL. HEALTH & SAFETY CODE § 24170, *et. seq*.

111. Plaintiffs reallege and incorporate by reference their allegations in Paragraphs 1 – 88, as if fully alleged herein, and further allege:

112. Plaintiffs invoke the Court's supplemental jurisdiction to claim that the Mandate violates the law of this State governing human medical experimentation.

113. The Protection of Human Subjects in Medical Experimentation Act (the "Act") adopts the Belmont principles by prohibiting medical experimentation on human subjects without their informed consent. Cal. Health & Saf. Code § 24170, *et. seq*.

114. The COVID Vaccines are experimental, as further alleged hereinabove.

115. The Mandate is therefore facially void, as a matter of law.

116. Even if the Mandate is not void, Plaintiffs do not consent to being administered the COVID Vaccines.

117. Plaintiffs reserve their rights to seek damages and other relief as the Court may deem just, pursuant to Section 24176 of the Act.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for judgment in its favor and against Defendants, and each of them, as follows:

FIRST CLAIM

1. For declaratory judgment that Defendants' Mandate requiring administration of the COVID Vaccines to each of them violates and is preempted by the laws and regulations of the United States governing the administration of investigational medical products, for an injunction prohibiting enforcement of the Mandate; and
2. For attorneys' fees and costs pursuant to 42 U.S.C. § 1988.

/ / /

SECOND CLAIM

1. For declaratory judgment that Defendants' Mandate requiring administration of the COVID Vaccines to each of them violates their rights to substantive due process and/or their liberty and property interests under the Fourteenth Amendment to the Constitution of the United States and the laws and Constitution of the State of California, that Defendants be enjoined from administering any COVID Vaccines to any Plaintiff without that Plaintiff's express informed consent; and
2. For attorneys' fees and costs as provided in 42 U.S.C. § 1988.

THIRD CLAIM

1. For declaratory judgment that Defendants' Mandate Violates California Health and Safety Code §§ 24170, *et. seq*., and that the Court enjoin Defendants from enforcing the Mandate.

ALL CLAIMS

1. For judgment in favor of Plaintiffs;
2. For costs of suit herein; and
3. For such other and further relief as the Court deems just and proper.

Dated: March 17, 2021

JW HOWARD/ATTORNEYS

/s/ John W. Howard
John W. Howard
Attorney for Plaintiffs

JW HOWARD/ ATTORNEYS, LTD.
701 B Street, Suite 1725
San Diego, California 92101

DEMAND FOR JURY TRIAL

Plaintiffs demand a right to a jury trial for all matters so triable.

Dated: March 17, 2021

JW HOWARD/ATTORNEYS

/s/ John W. Howard
John W. Howard
Attorney for Plaintiffs

JW HOWARD/ ATTORNEYS, LTD.
701 B Street, Suite 1725
San Diego, California 92101

Tab 2

10 Pages

12 April 2021

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
5601 Fishers Lane
Rockville, MD 20852
301-496-2263
anthony.fauci@nih.gov

Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths
Reference 1: My Letter to You of 21 July 2020
Reference 2: My Letter to You of 21 December 2020
Reference 3: My Letter to the Presidents of the Ivy League of 6 March 2021

Isaac Legaretta vs. Dona Ana County

10 Pages (abridged)

Complete 23 Page Document Available Here:

http://pvsheridan.com/legaretta-versus-donaanacounty.pdf

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF NEW MEXICO

ISAAC LEGARETTA, and JOHN or JANE DOES 1-20, Plaintiffs, vs. FERNANDO MACIAS, Dona Ana County Manager, DIRECTOR BRYAN BAKER, an Official with the Dona Ana County Detention Center, CAPTAIN BEN MENDOZA, an official with the Dona Ana County Detention Center, CAPTAIN JOSHUA FLEMING, an official with the Dona Ana County Detention Center, and JOHN or JANE DOES 1-20, Defendants.	)	Case No.: _____ COMPLAINT

COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

The Plaintiff states:

GENERAL ALLEGATIONS

1. He is a resident of the state of New Mexico, County of Dona Ana, City of Las Cruces. Defendant Fernando Macias is a governmental official within the state of New Mexico. Defendants Director Bryan Baker, Captain Ben Mendoza and Captain Joshua Fleming are supervisors to Plaintiff, any of which have the authority from Defendant Macias to terminate Plaintiff from his employment or otherwise enforce the illegal mandate for compulsory injection.

2. This Court has jurisdiction under Article III because the Plaintiff alleges that Defendant Macias has violated Plaintiff's rights by issuing a mandate requiring him to take a vaccine for COVID-

19 which mandate is in direct conflict with federal law which states that the unapproved vaccine cannot be mandatory.

3. The Plaintiff is an employee at the Dona Ana Detention Center which is administered by the Defendants. On or about February 1, 2021, County Manager Fernando Macias issued a "Mandatory COVID-19 Vaccination Directive," requiring first-responders in Dona Ana County to receive COVID-19 vaccination as a condition of ongoing employment. **Exhibit A.**

4. On or about February 18, 2021, Plaintiff received a 5 day notice to comply with the mandate to receive the COVID vaccine. Plaintiff has received a "coaching and counseling" write up for not complying with the directive. **Exhibit B.**

5. Plaintiff is in imminent danger of being terminated from his job for refusing to accept the vaccine.

6. The Mandatory COVID-19 Vaccination Directive issued by Defendant Macias is in direct violation of Federal law, specifically 21 U.S. Code § 360bbb–3 - *Authorization for medical products for use in emergencies*. That law states that where a medical product is "unapproved" then no one may be mandated to take it. At Section (e)(1)(A) of the aforementioned statute it states:

> "With respect to the emergency use of an unapproved product, the Secretary, to the extent practicable given the applicable circumstances described in subsection (b)(1), shall, for a person who carries out any activity for which the authorization is issued, establish such conditions on an authorization under this section as the Secretary finds necessary or appropriate to protect the public health, including the following:
>
> (i) Appropriate conditions designed to ensure that health care professionals administering the product are informed--
>
> (I) that the Secretary has authorized the emergency use of the product;
>
> (II) of the significant known and potential benefits and risks of the emergency use of the product, and of the extent to which such benefits and risks are unknown; and
>
> (III) of the alternatives to the product that are available, and of their benefits and risks.
>
> (ii) Appropriate conditions designed to ensure that individuals to whom the product is administered are informed--

(I) that the Secretary has authorized the emergency use of the product;

(II) of the significant known and potential benefits and risks of such use, and of the extent to which such benefits and risks are unknown; and

(III) **of the option to accept or refuse administration of the product,** of the consequences, if any, of refusing administration of the product, and of the alternatives to the product that are available and of their benefits and risks. (emphasis added)

7. The Defendants have violated the last two quoted sections (II and III). They did not advise Plaintiff of the "known and potential benefits and risks of such use, and of the extent to which such benefits and risks are unknown" of the COVID-19 vaccine.

8. Most importantly for purposes of the injunctive and declaratory relief requested, the Defendants did not inform Plaintiff that he had an option to refuse the vaccine. Quite the opposite, he was advised that he would be fired if he did so.

9. That the vaccine being forced upon Plaintiff is "unapproved" cannot be disputed. Even though the FDA granted emergency use authorizations for the Pfizer/BioNTech and Moderna vaccines in December, 2020, the clinical trials the FDA will rely upon to ultimately decide whether to license these vaccines are still underway and are designed to last for approximately two years to collect adequate data to establish if these vaccines are safe and effective enough for the FDA to license. The abbreviated timelines for the emergency use applications and authorizations means there is much the FDA does not know about these products even as it authorizes them for emergency use, including their effectiveness against infection, death, and transmission of SARS-CoV-2, the virus that is allegedly the cause of the COVID disease. Given the uncertainty about the two vaccines, their EUAs (emergency use authorizations) are explicit that each is "an investigational vaccine not licensed for any indication" and require that all "promotional material relating to the Covid-19 Vaccine clearly and conspicuously ... state that this product has not been approved or licensed by the FDA, but has been authorized for emergency use by FDA". See **Exhibit C, EUA letter for Pfizer.**

10. The FDA on their website has stated the following:

> FDA believes that the terms and conditions of an EUA issued under section 564 preempt state or local law, both legislative requirements and common-law duties, that impose different or additional requirements on the medical product for which the EUA was issued in the context of the emergency declared under section 564 … In an emergency, it is critical that the conditions that are part of the EUA or an order or waiver issued pursuant to section 564A — those that FDA has determined to be necessary or appropriate to protect the public health—be strictly followed, and that no additional conditions be imposed."

11. On August, 2020 at a Centers for Disease Control and Prevention published meeting of the Advisory Committee on Immunization Practices the Committee's Executive Secretary and Chief Medical Officer of the National Center for Immunizations and Respiratory Diseases, Dr. Amanda Cohn stated (@1:14:40):

> "I just wanted to add that, just wanted to remind everybody, that under an Emergency Use Authorization, an EUA, vaccines are not allowed to be mandatory. So, early in this vaccination phase, individuals will have to be consented and they won't be able to be mandated."

FEDERAL PREEMPTION

12. The Supremacy Clause of the United States Constitution, Art. VI, which is the basis of the federal preemption doctrine, states:

> "This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the judges in every state shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding."

A federal requirement preempts a state requirement if the state requirement actually conflicts with the federal requirement because compliance with both is impossible. *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-143 (1963). Preemption will also be applicable if the state requirement "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress," *Hines v. Davidowitz*, 312 U.S. 52, 67, 61 S.Ct. 399, 404, 85 L.Ed. 581 (1941). Finally, federal exemption applies if a scheme of federal regulation is "so pervasive as to make reasonable the inference that Congress left no room for the States to supplement it." *Rice v. Santa Fe Elevator Corp*., 331 U.S. 218, 230 (1947).

A more attenuated analysis of the doctrine of federal preemption including express and implied preemption is succinctly articulated in *Frei v. Taro Pharm. United Statesa*, Inc., 443 F.Supp.3d 456 (S.D. N.Y. 2020):

> "Express preemption is present when Congress's intent to preempt state law is explicitly stated in the statute's language." In re PepsiCo., Inc., Bottled Water Mktg. & Sales Practices Litig., 588 F. Supp. 2d 527, 530 (S.D.N.Y. 2008). "Implied preemption arises when, in the absence of explicit statutory language, ... Congress intended the Federal Government to occupy a field exclusively, or when state law actually conflicts with federal law." Air Trans. Ass'n of Am., Inc. v. Cuomo, 520 F.3d 218, 220 (2d Cir. 2008) (citing English v. Gen. Elec. Co., 496 U.S. 72, 79, 110 S.Ct. 2270, 110 L.Ed.2d 65 (1990)).
>
> The latter type of implied preemption, called "conflict preemption," "comes in two forms—impossibility preemption and obstacle preemption." McDaniel v. Upsher-Smith Labs., Inc., 893 F.3d 941, 944 (6th Cir. 2018). The first, impossibility preemption, arises as its title suggests: when compliance with both federal and state law is impossible. Gade v. Nat'l Solid Wastes Mgmt. Ass'n, 505 U.S. 88, 98, 112 S.Ct. 2374, 120 L.Ed.2d 73 (1992). "The proper question for impossibility analysis is whether the private party could independently do under federal law what state law requires of it." PLIVA, Inc. v. Mensing, 564 U.S. at 620, 131 S.Ct. 2567. The second form, obstacle preemption, exists "when a state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." Wis. Pub. Intervenor v. Mortier, 501 U.S. 597, 605, 111 S.Ct. 2476, 115 L.Ed.2d 532 (1991).

Frei v. Taro at 465-466

13. It is evident that the federal law at issue in this case preempts the Defendants' directive which completely disregards it, because compliance with both is impossible. In addition, Defendants' failure to comply with the federal law clearly is an obstacle to the purpose of the federal law which to allow people to not be compelled to take an unapproved drug or vaccine. Moreover, Plaintiff contends that the FDA, an agent of the Department of Health and Human Services, intends to exclusively occupy the field of approval of drugs and the manner in which unapproved drugs may be administered. This would seem to be self-evident. States simply do not venture into the area of drug approval. This is the FDA's field. The Defendants deciding to violate federal law by not giving employees the right to not take the vaccination clearly violates the doctrine of federal preemption. *See generally, Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525, 570-71 (2001) (overturning a state public health law because it was already the subject of a comprehensive federal scheme to manage public health).

RELIEF REQUESTED

COUNT ONE – DECLARATORY RELIEF

14. Plaintiff requests the Court issue declaratory relief that:

(a.) 21 U.S. Code § 360bbb–3, Section (e)(1)(A) does not permit Defendants to coerce an employee to accept an unapproved vaccine on penalty of termination or other sanctions.

(b.) The doctrine of federal preemption invalidates and voids the "Mandatory COVID-19 Vaccination Directive" of Defendant Macias.

COUNT TWO – INJUNCTIVE RELIEF

15. Plaintiff has been threatened with termination for choosing not to take an unapproved vaccine which federal law states cannot be mandated because insufficient trials have been conducted and its long-term effects are not known. Already there are many news reports of adverse effects and even deaths resulting from the vaccine. If Plaintiff were to be terminated for refusing a vaccine which federal law requires *not* to be mandated, it would be a retaliatory discharge under New Mexico law. The New Mexico Supreme Court has defined a retaliatory discharge as follows:

"For an employee to recover under this new cause of action, he must demonstrate that he was discharged because he performed an act that public policy has authorized or would encourage, or because he refused to do something required of him by his employer that public policy would condemn."

Shovelin v. Central New Mexico Elec. Co-op., Inc., 850 P.2d 996, 115 N.M. 293, 1993 NMSC 15 (N.M. 1993)

16. Plaintiff could not sue for damages for the tort of retaliatory discharge because New Mexico's sovereign immunity would not allow it and such immunity for a retaliatory discharge has not been waived in the New Mexico Tort Claims Act. New Mexico's sovereign immunity protects Defendants from suits for monetary damages but not suits for injunctions. Lacking the ability to sue for damages for retaliatory discharge, Plaintiff will be irreparably harmed absent injunctive relief.

17. If the Defendants were to terminate Plaintiff for refusing to take a vaccine it would be a

violation of his due process right to life and liberty under the 14th Amendment and an invasion of the zone of privacy and right to bodily integrity which have been held to emanate from various Bill of Rights amendments, including the first, fourth and fifth as well as the ninth amendment which speaks of essential but unenumerated rights. The constitutionally protected zone of privacy and right to bodily integrity have been articulated is many Supreme Court cases, including *Mapp v. Ohio*, 367 U.S. 643 (1961), *Griswold v. State of Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965); *Roe v. Wade,* 410 US 113 (1973).

In *Griswold,* the Court said:

> The foregoing cases suggest that specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. See Poe v. Ullman, 367 U.S. 497, 516—522, 81 S.Ct. 1752, 6 L.Ed.2d 989 (dissenting opinion). Various guarantees create zones of privacy. The right of association contained in the penumbra of the First Amendment is one, as we have seen. The Third Amendment in its prohibition against the quartering of soldiers 'in any house' in time of peace without the consent of the owner is another facet of that privacy. The Fourth Amendment explicitly affirms the 'right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures.' The Fifth Amendment in its Self-Incrimination Clause enables the citizen to create a zone of privacy which government may not force him to surrender to his detriment. The Ninth Amendment provides: 'The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.'
>
> The Fourth and Fifth Amendments were described in Boyd v. United States, 116 U.S. 616, 630, 6 S.Ct. 524, 532, 29 L.Ed. 746, as protection against all governmental invasions 'of the sanctity of a man's home and the privacies of life.'* We recently referred in Mapp v. Ohio, 367 U.S. 643, 656, 81 S.Ct. 1684 1692, 6 L.Ed.2d 1081, to the Fourth Amendment as creating a 'right to privacy, no less important than any other right carefully and particularly reserved to the people.' See Beaney, The Constitutional Right to Privacy, 1962 Sup.Ct.Rev. 212; Griswold, The Right to be Let Alone, 55 Nw.U.L.Rev. 216 (1960).
>
> More recently in *Planned Parenthood v. Casey,* 505 U.S. 833(1992), referencing the Roe v. Wade decision the Court states stated:
>
> *Roe*, however, may be seen not only as an exemplar of *Griswold* liberty but as a rule (whether or not mistaken) of personal autonomy and bodily integrity, ***with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection. If so, our cases since Roe accord with Roe's view that a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims***. *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 278, 111 L. Ed. 2d 224, 110 S. Ct. 2841 (1990); cf., *e. g., Riggins v. Nevada*, 504 U.S. 127, 135, 118 L. Ed. 2d 479, 112 S. Ct. 1810

(1992); *Washington v. Harper*, 494 U.S. 210, 108 L. Ed. 2D 178, 110 S. Ct. 1028 (1990); see also, *e. g., Rochin v. California*, 342 U.S. 165, 96 L. Ed. 183, 72 S. Ct. 205 (1952); *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30, 49 L. Ed. 643, 25 S. Ct. 358 (1905). (emphasis added)

18. It is worth noting that in *Planned Parenthood, supra*, the Court includes *Jacobson v. Massachusetts* as a case "*recognizing limits on governmental power to mandate medical treatment or to bar its rejection."* because *Jacobsen* has often been cited for the opposite proposition since its holding was that a state law requiring vaccination was valid. However, the Jacobsen court said: "Before closing this opinion, we deem it appropriate, in order to prevent misapprehension as to our views, to observe -- perhaps to repeat a thought already sufficiently expressed, namely -- that the police power of a State, whether exercised by the legislature or by a local body acting under its authority, may be exerted in such circumstances or by regulations so arbitrary and oppressive in particular cases as to justify the interference of the courts to prevent wrong and oppression." (*Id*, 197 US 38).

Moreover, *Jacobsen* was decided 116 years ago when many of our most sacred and fundamental rights were still being sorted out. Suffrage had not yet occurred, civil rights barely existed, critical cases on fundamental rights such as interstate travel and bodily privacy had not come into play and the administrative state that we live in today simply did not exist. Since *Jacobsen* the court has decided many critical cases which expanded the conceptual and practical reach of the Bill of Rights as outlined in the preceding paragraphs.

19. Plaintiff contends that in light of the facts and the law hereinabove, success on the merits is likely, the balance of equities argues for granting injunctive relief and the public interest will not be harmed by the injunctive relief requested.

20. There is no need for a bond since Defendants will not suffer economic harm from injunctive relief.

COUNT THREE – INJUNCTION OR MANDAMUS REQUIRING DEFENDANTS TO REINSTATE PLAINTIFF

21. Plaintiff fears that the Defendants may, by the time this Complaint is filed and the Court can enter injunctive relief preventing termination of his employment, have already terminated him.

22. If such does occur, Plaintiff requests that the Court issue an affirmative injunction or Writ of Mandamus requiring the Defendants to reinstate him.

WHEREFORE, Plaintiff respectfully requests that the Court:

1. Enter declaratory relief as requested in Count One.

2. Enter an immediate TRO and a preliminary injunction enjoining the Defendants from terminating, demoting, or taking any negative action against Plaintiff for refusing to take a non-mandatory unapproved vaccine.

3. If need be, enter an injunction or Writ of Mandamus requiring Defendants to reinstate Plaintiff to his position of employment.

4. Order any other appropriate relief.

Respectfully submitted,

/s/ N. Ana Garner

N. Ana Garner
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and

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DECLARATION UNDER PENALTY OF PERJURY

The undersigned declares under penalty of perjury that he is the Plaintiff in the above action, that he has read the Complaint and hat the information contained therein is true and correct. 28 U.S.C. §1746. 18 U.S.C. 1621.

Executed at Las Cruces, New Mexico on February 26, 2021.

Isaac Legarreta

Tab 3

5 Pages

12 April 2021

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
5601 Fishers Lane
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301-496-2263
anthony.fauci@nih.gov

Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
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Violation of the Nuremburg Code by Israel

5 Pages

א. סוכובולסקי ושות'
משרד עורכי-דין ונוטריון
A. SUCHOVOLSKY & Co.
LAW-OFFICES & Notary

ABRAHAM SUCHOVOLSKY 1931- 1995	אברהם ואביבה סוכובולסקי ז"ל	15, YAVNE ST.		רח' יבנה 15,
ARIE SUCHOVOLSKY, B.A.,LL.B	אריה סוכובולסקי	Tel-Aviv	6579119	תל-אביב
ISHAY BEINART, LL.M	ישי ביינרט	TEL:	03-5663222	טל':
NURIT SUCHOVOLSKY, LL.B	נורית סוכובולסקי	FAX:	03-5604914	פקס':
		E-Mail:	as@suchov.co.il	אי-מייל:
		DATE:	01/03/21	תאריך:

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

BEFORE THE INTERNATIONAL CRIMINAL COURT
(TREATY OF ROME, ART. 15.1 AND 53)
IN THE MATTER OF CRIMES AGAINST HUMANITY

Subject of complain: **Violation of the Nuremberg Code by the Government of Israel and additional factors**

We address you in the name of the "Anshei Emet" Fellowship, a fellowship under establishment, in which the members are attorneys, physicians, public and general activists, who made a choice to exercise their democratic right not to receive the experimental medical treatment (Corona Immunization), and who feel that great pressures, hard and illegal, are exerted upon them on behalf of the Government of Israel, members of the Knesset, ministers, senior public elected representatives, heads of cities and more.

We wish to begin with basic knowledge on the subject matter:

The Corona Virus is an innovative medical treatment, which has only recently obtained **FDA approval in the United States (in an emergency procedure only)**, an approval that is not final, and with details of 22 side effects to the vaccine. Additionally, it is clear to all the medical factors that the subject of the long-range influence of the treatment was not scientifically tested (testing and research), and the long-range effect and safety of the treatment on its recipients are unknown. T is important to state that never until now were administered in the

entire world immunizations by this medical technology of introduction of a synthetic M-RNA to the body, and all the previous immunizations operated in a totally different manner, by the introduction of a deactivated or weakened virus and natural arousal of the immunity system against it. As detailed by a senior virologist, the risks anticipated by this innovative medical treatment are hereby enclosed **as Appendix 1** to my letter.

"Nuremberg Code" – A medical ethics code issued based on laws under which the Nazi criminals were judged for conducting horrible medical experiments during the Second World War, in the physicians' trial known by the name Nuremberg Trials. The Nuremberg Code later constituted the base for the Helsinki Declaration Legislation as well as the base for the Patient's Rights Law in Israel.
It is our intention to present to you and detail how in the State of Israel this year, the Government of Israel with its ministers and its Knesset members, heads of cities, and additional senior factors, violate the Nuremberg Code in an unlawful manner, blatant and extreme, and to our regret, not only in a single aspect but many, too many!

,

a. Informed consent to participate in a medical experiment – **a first principle** of the Nuremberg Code is **a willingness and informed consent by the person** to receive treatment and participate in an experiment. The person is supposed to activate freedom of choice without the intervention of a factor employing force, deceit, fraud, threat, solicitation, or any other type of binding or coercion.
When the heads of the Ministry of Health as well as the Prime Minister presented the vaccine in Israel and began the vaccination of Israeli residents, the vaccinated were not advised, that in practice, they are taking part in a **medical experiment** and that their consent is required for this under the Nuremberg Code, and only when it became apparent that indeed the Prime Minister signed an agreement with the Pfizer Company (the manufacturer), it was first published and also stated by the Prime Minister, that it is indeed a medical experiment, and that this was the essence of the agreement. This, as a matter of fact, is **a genetic medical experiment** on human beings, performed without informed consent and under a severe and blatant offense of the Nuremberg Code.
b. **The Bibi-Pfizer Agreement.** Post factum it became clear that the Prime Minister of Israel signed an agreement with the Pfizer Company (the manufacturing company), under which he will receive a huge quantity of millions of vaccine portions, and with a preference over other countries, and in consideration, the vaccinated (residents of Israel) will serve as "**Experimenters**" for the pharmaceutical company. It was agreed that the pharmaceutical company would receive from Israel all their medical, personal secret information without their knowledge or consent in advance. Additionally, we must state that until this moment, the contents of the agreement related to most of the State of Israel residents, was not published, which is the transparency obligating under the law, and it was published with "blackout" / concealment of a great deal of information included in this agreement. It is worthy to state and recall that we do not live in a

dictatorship country so that clearly, such an agreement must be subject to total transparency towards the wide public.

c. **Alternative treatments** – On the subject of informed consent for medical treatment, and based on the Nuremberg Code principles, an obligation exists to detail and suggest to a patient several treatment alternatives, detailing the medical process (and all that is included in it) as well as the advantages and the disadvantages/benefits and risks, existing in every treatment, to enable him **to make an intelligent personal decision** regarding the treatment he prefers. As stated, this must be done without exerting any pressures and freely, as a free person. Despite all the above-stated, the State of Israel and the Ministry of Health fail to present to the citizens of Israel the currently existing alternatives for treating the Corona disease, proven to be efficient and with few side effects, and not dangerous. They solicit the citizens and pressuring them (while blatantly violating the informed consent process), concealing the information regarding the immunizations, and creating a severe atmosphere of fear and coercion.

d. **A fourth principle is that the experiment will be conducted to prevent suffering or physical injury.** It is known that the treatment caused the death of many, injury, and severe damages (including disablement and paralysis) after the vaccine was administered. Despite this fact, the Government did not instruct the initiation of an investigation on the matter. **It is of interest to state that the Ministry of Health openly admitted that 41% of police persons, military, education, and medical personnel, who were vaccinated, suffered severe side effects and life-endangering**. It is also a wonder that there are no full reports of the numbers of dead or injured, as may be expected in such a medical process for the benefit of the participating public in the experiment.

e. **A fifth principle states that the experiment must not be conducted when there is reason to assume that death or real injury will occur**. Regarding the violation of this principle, see above. As stated, regarding the data on cases of death, we the citizens hear only by word of mouth on the social networks (by friends, neighbors, or relatives) and not on the central media.

f. **An additional principle is that the experiment's responsible factor will be ready to stop it at any stage if there is a reasonable cause to assume that it will cause injury, disability, or death of the experiment participant. It has already been proven that many and good died from the treatment, were injured, became disabled, and paralyzed; however, the Government of Israel continues to compel this dangerous experiment on Israel's citizens.**

g. The following are recent publications, which demonstrate the blatant and criminal violations of the Nuremberg Code on behalf of the Government, the Ministers and the Members of the Knesset, heads of cities, and senior public factors, as well as employers:

Below are some examples (out of many) of the Nuremberg Code violations (As shall be enclosed **as Appendix 2** of my letter).

Exert economic pressure:

1. The Manufacturers' Association, backed by a legal opinion, **threatens** to send on unpaid leave every employee who will not be vaccinated.
2. The Minister of Health, Yuli Edelstein, wishes to enact a law that will **prevent the arrival** of unimmunized to a place of work.
3. **A threat** to deny unemployment fees

The exertion of social pressure:

1. **A Threat** to prevent entrance to entertainment, leisure, and receipt of services from the community
2. Artists, opinion leaders, and public representatives, who in every corner elect to make propaganda, and aggressively and insulting manner even propose punishment and sanctions. (Member of Knesset Ayelet Shaked, member of Knesset Smotrich, the Minister of Health Edelstein, Member of Knesset Benet, Avri Gilad morning program host, the singer Yoram Gaon, Judy Nir Moses and others)
3. Vehicles with public address systems roaming on the streets urging people to arrive for vaccinations, conversations and **aggressive** notices by the health insurance companies, and even setting appointments for vaccinations without the insurants' wish, and more.

Forbidden incentives for the vaccinated:

1. Receiving a free night in a hotel, vacation days, and more, offered by various companies' owners to their employees.
2. Discounts in various business establishments, private and public, as well as a benefits card promoted by the Government

The Prime Minister of Israel stated more than once that **the Israeli citizens take part in that innovative medical experiment** for the benefit of all world citizens, who for some reason do not rush to obtain the above-stated medical treatment, and they are looking forwards to see the Israeli experimenters. The same is true regarding the agreement signed by the Government with the Pfizer Company, blacked-out in many places, raising questions regarding the agreements reached by the Government with the Pfizer Company.
It shall be hereby emphasized that the means currently activated against citizens, including legislation proposal against whoever was not vaccinated, contradict not only the Nuremberg Code and the **individual's autonomy over his body** but also the **existing legislation in Israel,** including the Persons Dignity and Freedom Basic Law, the Freedom of Occupation Law, the Patient's Rights Law, the Work Equal Opportunities Law, the Prohibition of Discrimination in Products, Services, and Entrance to Entertainment and Public Places Law, and other laws.

Therefore, and considering the stated above, we address your honor with two main demands:

1. **To discontinue the medical experiment and the administration of vaccinations to the public of Israeli citizens immediately.**

2. **To instruct the Government to step all the legislative proceedings which infringe on the principle of Informed Consent by a person to receive the above-described medical treatment, and which negates the legal status in Israel and the Israeli democracy, including the avoidance to legislate the Green Passport, delivery of names of those who are not vaccinated to the local authorities, or any other harming legislature.**
3. **To act in the most required severity against any public/business/employment entity, which violates the laws of the State on subjects of employment or the other subjects required to prevent compulsion, coercion or solicitation to vaccinate, as well as the subject of discrimination, against those who made a choice not to receive the above-stated innovative medical treatment.**
4. **We ask to bring to your attention that a copy of this document will also be forwarded to the media channels worldwide because the Nuremberg Code violation is relevant in all countries of the free world.**
5. And as a final note, it shall be stated that only recently a **decision was reached** in the **European Parliament** on 77/1/21, instructing all the authorities **not to activate any pressure or solicitation on persons to take the Corona vaccine in any way.** Therefore, **whatever is good for the advanced European States, certainly is also good for Israel – and the balance is self-explanatory.**

Legal representation and election of domicile
The applicants will be represented for the purposes of this procedure by

Respectfully

Ruth Machnes

Ruth Machnes, Adv.

A. Suchovolsky

Arie Suchovolsky, Adv.

Consequently, all subsequent correspondence should be sent only to the mailing and/or e-mail addresses given above. Any notification within the meaning of the Statute of the Court addressed in this way will be considered valid.
ONCE FILED AND PROCESSED

Tab 4

3 Pages

12 April 2021

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
5601 Fishers Lane
Rockville, MD 20852
301-496-2263
anthony.fauci@nih.gov

Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths
Reference 1: My Letter to You of 21 July 2020
Reference 2: My Letter to You of 21 December 2020
Reference 3: My Letter to the Presidents of the Ivy League of 6 March 2021

9 March 2021 letter from Paul V. Sheridan to Dr. Harvey Risch

3 Pages

9 March 2021

Dr. Risch:

First the courtesy, and then a personal ‘thank you.’

As a heads-up, the letter to **Yale President Peter Salovey** was signed-for this AM; please see enclosed SPODs. As a courtesy to you I am sharing a copy of my letter entitled:

Subject: **Ensuring Liability Immunity for Ivy League University Presidents and Staffs – Student Signature / Consent Requirements for COVID-19 “Vaccine”**

Reference: **Plan by Ivy League Universities to Make COVID-19 “Vaccinations” Mandatory**

Your comments on the letter are welcome.

The ‘thank you’ involves your good interview with Laura Ingraham of 8 March 2021 (along with Stanford University professor Dr. Jay Bhattacharya):

But the ‘thank you’ goes further . . . you should know that at-least three weeks ago, when I began drafting my letter to the Ivy League presidents; **that original edition had the word ‘Nuremburg’ as part of the draft THREE TIMES.** That word and frequency survived to the final edition, which was on-its-way as you spoke last night.

So, when **you** explained that the Nuremburg tribunal was relevant, I was immediately compelled to share this courtesy and this ‘thank you.’ Again, your comments on the letter are welcome.

Paul V. Sheridan

cc: Laura Ingraham

March 10, 2021

Dear Customer,

The following is the proof-of-delivery for tracking number: 773114584217

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		Delivery date:	Mar 10, 2021 10:05

Shipping Information:

Tracking number:	773114584217	**Ship Date:**	Mar 9, 2021
		Weight:	0.5 LB/0.23 KG

Recipient:
Dr. Harvey Risch, Yale University
60 College Street
Suite LEPH 413
NEW HAVEN, CT, US, 06510

Shipper:
Paul V. Sheridan, DDM Consulting
22357 Columbia Street
DDM Consulting
Dearborn, MI, US, 48124

Reference Letter to Ivy League

Thank you for choosing FedEx

March 12, 2021

Dear Customer,

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Special Handling:	Deliver Weekday; Residential Delivery		WASHINGTON, DC, 20001
		Delivery date:	Mar 12, 2021 11:38

Shipping Information:

Tracking number:	773114634042	**Ship Date:**	Mar 9, 2021
		Weight:	0.5 LB/0.23 KG

Recipient:
Ms. Laura Ingraham,
400 North Capitol St NW
Fox News Washington
WASHINGTON, DC, US, 20001

Shipper:
Paul V. Sheridan, DDM Consulting
22357 Columbia Street
DDM Consulting
Dearborn, MI, US, 48124

Reference Ltr to Ivy League and Dr Risch

Proof-of-delivery details appear below; however, no signature is available for this FedEx Express shipment because a signature was not required.

Thank you for choosing FedEx

Tab 5

5 Pages

12 April 2021

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
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anthony.fauci@nih.gov

Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths
Reference 1: My Letter to You of 21 July 2020
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NEJM Article - Fifty Years Later: The Significance of the Nuremburg Code

5 Pages

Special Article

FIFTY YEARS LATER: THE SIGNIFICANCE OF THE NUREMBERG CODE

EVELYNE SHUSTER, PH.D.

THE Nuremberg Code is the most important document in the history of the ethics of medical research.[1-6] The Code was formulated 50 years ago, in August 1947, in Nuremberg, Germany, by American judges sitting in judgment of Nazi doctors accused of conducting murderous and torturous human experiments in the concentration camps (the so-called Doctors' Trial).[7] It served as a blueprint for today's principles that ensure the rights of subjects in medical research. Because of its link with the horrors of World War II and the use of prisoners in Nazi concentration camps for medical experimentation, debate continues today about the authority of the Code, its applicability to modern medical research, and even its authorship.[1,2,4,5,8] The chief prosecutor at the Doctors' Trial, General Telford Taylor, believed that one of the three U.S. judges, Harold Sebring, was the author of the Code.[2] Two American physicians who helped prosecute the Nazi doctors at Nuremberg, Leo Alexander and Andrew Ivy, have each been identified as the Code's author.[5,8-11] A careful reading

From the Veterans Affairs Medical Center, University and Woodland Ave., Philadelphia, PA 19104, where reprint requests should be addressed to Dr. Shuster.

THE NUREMBERG CODE

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 will 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.

of the transcript of the Doctors' Trial, background documents, and the final judgment reveals that authorship was shared and that the famous 10 principles of the Code grew out of the trial itself.

In this article I will explain the important role that physicians had in the prosecution of the Nazi doctors and in the formulation of the Nuremberg Code and summarize how medical researchers have used the Code as a guide over the past five decades.

THE DOCTORS' TRIAL

The main trial at Nuremberg after World War II was conducted by the International Military Tribunal. The tribunal was made up of judges from the four allied powers (the United States, Britain, France, and the former Soviet Union) and was charged with trying Germany's major war criminals. After this first-of-its-kind international trial, the United States conducted 12 additional trials of representative Nazis from various sectors of the Third Reich, including law, finance, ministry, and manufacturing, before American Military Tribunals, also at Nuremberg. The first of these trials, the Doctors' Trial, involved 23 defendants, all but 3 of whom were physicians accused of murder and torture in the conduct of medical experiments on concentration-camp inmates.[7]

The indictment of the defendants was filed on October 25, 1946, 25 days after the conclusion of the first Nuremberg trial by the International Military Tribunal. The Doctors' Trial began on December 9, 1946, and ended on July 19, 1947. The case was heard by three judges and one alternate. Thirty-two prosecution witnesses and 53 defense witnesses, including the 23 defendants, testified. A total of 1471 documents were introduced into the record. Sixteen of the 23 defendants were found guilty; 7 of them were sentenced to death by hanging, 5 to life imprisonment, 2 to imprisonment for 25 years, 1 to imprisonment for 15 years, and 1 to imprisonment for 10 years. Seven were acquitted. The sentences were confirmed by the military governor, and, after the U.S. Supreme Court declined to review the case, the executions were carried out at the Landsberg prison.

For the United States and its chief prosecutor, Telford Taylor, the trial was a murder trial (and murder had been identified by the International Military Tribunal as a crime against humanity). Nonetheless, as Taylor pointed out in his opening statement, this was "no mere murder trial," because the defendants were physicians who had sworn to "do no harm" and to abide by the Hippocratic Oath.[12] He told the judges that the people of the world needed to know "with conspicuous clarity" the ideas and motives that moved these doctors "to treat their fellow human beings as less than beasts," and that "brought about such savageries" so that they could be "cut out and exposed before they become a spreading cancer in the breast of humanity."[12] One recurring theme was the relevance of Hippocratic ethics to human experimentation and whether Hippocratic moral ideals could be an exclusive guide to the ethics of research without risk to the human rights of subjects. In the trial's exploration of ideas that shaped medical-research ethics, three physicians had central roles: Leo Alexander, an American neuropsychiatrist, Werner Leibbrand, a German psychiatrist and medical historian, and Andrew Ivy, a renowned American physiologist.

Leo Alexander

Leo Alexander, a Viennese-born American physician, had joined the U.S. Army Medical Corps in 1942, before being stationed in England at the American Eighth Air Force base. At the end of the war, Alexander was sent on a special mission under the Combined Intelligence Objectives Sub-Committee, an intelligence organization with members from several nations, and charged by orders from Supreme Headquarters of Allied Expeditionary Forces to gather evidence for the Nuremberg trials. Two days before the opening of the Doctors' Trial, Alexander gave Taylor a memorandum entitled "Ethical and Non-Ethical Experimentation on Human Beings," in which he identified three ethical, legal, and scientific requirements for the conduct of human experimentation.[9] The first requirement established the right of the competent experimental subject to consent or refuse to participate in these terms: "the subject should be willing to undergo the experiment of his own free will. . . ." The second focused on the duty of physicians as expressed in the Hippocratic Oath, which Alexander restated in research terms: "the medical Hippocratic attitude prohibits an experiment if the foregone conclusion, probability or a priori reason to believe exists that death or disabling injury of the experimental subject will occur." The third characterized good research practices.

On April 15, 1947, Alexander gave Taylor a second memorandum.[9,11] In it he set forth in greater detail six specific conditions for ethically and legally permissible experiments on human beings. The first stated that

> the legally valid voluntary consent of the experimental subject is essential. This requires specifically the absence of duress, sufficient disclosure on the part of the experimenter and sufficient understanding on the part of the experimental subject of the exact nature and consequences of the experiment for which he volunteers, to permit an enlightened consent.

The five other conditions established the humanitarian nature and purpose of the experiment and the scientific integrity and obligations of the investigator to the welfare of the subject.

Werner Leibbrand

On January 27, 1947, Werner Leibbrand, a German psychiatrist and medical historian at Erlangen University, opened the debate on medical ethics at Nuremberg.[12] He explained to the court that German physicians at the beginning of the 20th century had adopted a "biologic thinking" according to which a patient was a series of biologic events, and nothing more than "a mere object, like a mail package."[12] Leibbrand insisted that such a view precluded any human relation between physicians and their patients and that it represented a perversion of Hippocratic ethics and "a lack of morality and reverence for human life."[12] He strongly condemned physicians who conducted experiments on subjects without their consent, and testified that this was also the result of biologic thinking.

During cross-examination, defense lawyers asserted that "civilized" nations such as France, the Netherlands, Britain, and the United States had performed dangerous medical experiments on prisoners, often without their consent. They cited American malaria experiments[12-14] to argue that Nazi physicians had followed common research practices. Leibbrand replied that this American research also was wrong because "prisoners were in a forced situation and could not be volunteers."[12] Leibbrand insisted that "the morality of a physician is to hold back his natural research urge which may result in doing harm, in order to maintain his basic medical attitude that is laid down in the Oath of Hippocrates."[12] This strong accusation of American research by the prosecution's first medical-ethics witness created major unanticipated problems for the prosecution. It therefore became necessary to broaden the scope of the trial by defining the conditions under which risky human experimentation is ethically permissible.

Defense lawyers explained that Nazi doctors were ordered by the state to conduct such experiments as the high-altitude, hypothermia, and seawater experiments on inmates at the Dachau concentration camp to determine how best to protect and treat German fliers and soldiers. They contended that these experiments were necessary and that the "good of the state" takes precedence over that of the individual.[12] Leibbrand replied that "the state could order deadly experiments on human subjects, but the physicians remained responsible for [not] carrying them out."[12] Once these physiologic experiments became the centerpiece of the trial, reliance on psychiatrists alone was not possible. The prosecution needed a prestigious medical scientist who was an authority on research physiology and whose wartime scientific interests corresponded to those of the Nazi doctor defendants. This expert was Andrew Ivy.

Andrew Ivy

Andrew Ivy was an internationally known physiologist and a noted scientist. He also had first-hand knowledge of the Stateville Penitentiary experiments on malaria[12,13] in his home state of Illinois, which the Nazi defendants attempted to liken to those performed on concentration-camp inmates. When the secretary of war, through the surgeon general of the army, asked the board of trustees of the American Medical Association to nominate a medical advisor to the Nuremberg prosecution, Ivy emerged as the natural nominee. On June 12, 1947, Ivy came to Nuremberg for the third time, this time to testify in rebuttal for the prosecution. His testimony, the longest of the trial, lasted four days.[12]

In direct examination, Ivy presented to the judges three research principles that he had formulated at the request of the American Medical Association and which, he said, reflected common research practices.[12] His document entitled "Principles of Ethics Concerning Experimentation with Human Beings," adopted by the American Medical Association House of Delegates in December 1946, read in part:

> 1. Consent of the human subject must be obtained. All subjects have been volunteers in the absence of coercion in any form. Before volunteering, subjects have been informed of the hazards, if any. Small rewards in various forms have been provided as a rule.
> 2. The experiment to be performed must be based on the results of animal experimentation and on a knowledge of the natural history of the disease under study, and must be so designed that the anticipated results will justify the performance of the experiment. The experiment must be such as to yield results for the good of society, unprocurable by other methods of study, and must not be random and unnecessary in nature.
> 3. The experiment must be conducted only by scientifically qualified persons and so as to avoid all unnecessary physical and mental suffering and injury and only after the results of adequate animal experimentation have eliminated any *a priori* reason to believe that death or disabling injury will occur. . . .[15]

Ivy explained that these common-sense principles mirrored the understanding shared by everyone in practice in the medical community.[12] The first principle was that a physician would never do anything to a patient or subject before obtaining his or her consent. Ivy also asserted that, unlike Leibbrand, he did not consider prisoners to be in an inherently coercive situation and thus unable to give consent, because in democratic countries where the rights of individuals are respected, prisoners can always say yes or no without fear of being punished.[12] He testified:

> The American malaria experiments with 800 or more prisoners were absolutely justified, scientifically, legally and ethically even if they bring with them danger to human life. To treat malaria was an important scientific problem,

and so long as the subjects volunteer and are explained the hazards of the experiments, there is no ethical reason against it. . . . If prisoners condemned to death are volunteers, then it was ethical to do just that.[12]

During cross-examination, Ivy acknowledged that there were no written principles of research in the United States or elsewhere before December 1946 and that the principles adopted by the American Medical Association were expressly formulated for the Doctors' Trial.[12] Ivy also recognized that the right of the research subject to withdraw from an experiment may not always exist, as in the malaria experiments in which the subjects had already been infected, or in dangerous experiments in which the subjects could be severely injured or fatally harmed. Ivy agreed with Leibbrand that researchers must refuse to conduct experiments on human beings when ordered by the state in order "to save lives," because in such cases subjects would not be volunteers. He declared that "[t]here is no justification in killing five people in order to save the lives of five hundred" and that "no state or politician under the sun could force [him] to perform a medical experiment which [he] thought was morally unjustified."[12] Ivy also stressed that the state may not assume the moral responsibility of physicians to their patients or research subjects, arguing that "[E]very physician should be acquainted with the Hippocratic Oath [which] represents the Golden Rule of the medical profession in the United States, and, to [his] knowledge, throughout the world."[12] When, finally, defense counsel asked Ivy to reconcile the Hippocratic moral maxim that forbids physicians to "administer a poison to anyone even when asked to do so" with conducting potentially lethal experimental interventions on volunteer subjects, Ivy replied, "I believe this Hippocratic commandment refers to the function of the physician as a therapist, not as an experimentalist, and what refers to the Hippocratic Oath is that he must have respect for life and the human rights of his experimental patient."[12]

MEDICAL ETHICS AND HUMAN RIGHTS

The judges at Nuremberg, although they realized the importance of Hippocratic ethics and the maxim *primum non nocere,* recognized that more was necessary to protect human research subjects. Accordingly, the judges articulated a sophisticated set of 10 research principles centered not on the physician but on the research subject. These principles, which we know as the Nuremberg Code, included a new, comprehensive, and absolute requirement of informed consent (principle 1), and a new right of the subject to withdraw from participation in an experiment (principle 9). The judges adopted much of the language proposed by Alexander and Ivy but were more emphatic about the necessity and attributes of the subject's consent and explicitly added the subject's right to withdraw.

In the traditional Hippocratic doctor–patient relationship, the patient is silent and dutifully obedient to the beneficent and trusted physician.[16-18] Obviously, the patient must seek the physician's help and initiate the therapeutic relationship with the physician.[17] But once patients agree to be treated, they trust that the physician will act in their interest, or at least will do no harm.[17,18] In research, which is outside the beneficent context of the physician–patient relationship, this trust may be misplaced, because the physician's primary goal is not to treat; rather, it is to test a scientific hypothesis by following a protocol, regardless of the patient-subject's best interest. It is therefore only through a conflation of treatment and research that Alexander and Ivy believed they could expand on Hippocratic ethics to protect the rights of subjects in human experimentation.[19,20] Their Hippocratic view of medical research may have prevented them from adequately appreciating the risks to research subjects, which are many times greater than the risks to patients who are merely being treated.[21] Hippocratic ethics, even when supplemented with informed consent, tend to submerge the subject's autonomy into what the physician-investigator thinks is best for the subject.

Informed consent, the core of the Nuremberg Code, has rightly been viewed as the protection of subjects' human rights. The key contribution of Nuremberg was to merge Hippocratic ethics and the protection of human rights into a single code. The Nuremberg Code not only requires that physician-researchers protect the best interests of their subjects (principles 2 through 8 and 10) but also proclaims that subjects can actively protect themselves as well (principles 1 and 9). Most strikingly, for example, in Hippocratic ethics the subject relies on the physician to determine when it is in the subject's best interest to end his or her participation in an experiment. In the Nuremberg Code, the judges gave the subject as much authority as the physician-researcher to end the experiment before its conclusion (principle 9).

50 YEARS AFTER NUREMBERG

The Nuremberg Code has not been officially adopted in its entirety as law by any nation or as ethics by any major medical association. Nonetheless, its influence on global human-rights law and medical ethics has been profound.[6] Its basic requirement of informed consent, for example, has been universally accepted and is articulated in international law in Article 7 of the United Nations International Covenant on Civil and Political Rights (1966).[6,22] Informed consent, with specific reliance on the Nuremberg Code, is also the basis of the International Ethical Guidelines for Biomedical Research Involving Human Subjects, the most recent guidelines

promulgated by the World Health Organization and the Council for International Organizations of Medical Sciences (1993).[23]

The World Medical Association, established during World War II, has been accused of purposely trying to undermine Nuremberg in order to distance physicians from Nazi medical crimes.[24] The election of a former Nazi physician and SS member, Hans-Joachim Sewering, to the presidency of that organization in 1992 added credibility to that accusation.[24] (Because of public criticism, Sewering later withdrew.) Nonetheless, the various versions of the Declaration of Helsinki promulgated by the World Medical Association since 1964, although attempting to have peer review supplement informed consent and even supplant it as their central principle in the context of "therapeutic research," all implicitly acknowledge Nuremberg's authority. Both the Nuremberg Code and the Declaration of Helsinki served as models for the current U.S. federal research regulations, which require not only the informed consent of the research subject (with proxy consent sometimes acceptable, as for young children), but also prior peer review of research protocols by a committee (the institutional review board of the hospital or research institution) that includes a representative of the community.[25]

The Nuremberg Code focuses on the human rights of research subjects, the Declaration of Helsinki focuses on the obligations of physician-investigators to research subjects, and the federal regulations emphasize the obligations of research institutions that receive federal funds. Nonetheless, by insisting that medical investigators alone cannot set the rules for the ethical conduct of research, even when guided by beneficence and Hippocratic ethics, and by adopting a human-rights perspective that acknowledges the centrality of informed consent and the right of the subject to withdraw, the Nuremberg Code has changed forever the way both physicians and the public view the proper conduct of medical research on human subjects. Fifty years after Nuremberg, we recognize the human-rights legacy of the Nuremberg Code and are better able to face the critical challenge of applying the Code in its entirety and enforcing its human-rights provisions.

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Tab 6

4 Pages

12 April 2021

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anthony.fauci@nih.gov

Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths
Reference 1: My Letter to You of 21 July 2020
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Reference 3: My Letter to the Presidents of the Ivy League of 6 March 2021

26 March 2021: Letter from Robert F. Kennedy Jr. to Rutgers University

4 Pages

Children's Health Defense

President Jonathan Holloway
Rutgers, The State University of New Jersey
7 College Avenue, 2nd Floor
New Brunswick, NJ 08901
VIA FEDEX

March 26, 2021

Dear President Holloway,

Your plans to modify Rutgers' vaccination policy has gained national attention. So much so, that your March 25, " Our Path Forward – COVID-19 Vaccination and the Fall Term" letter made its way to my desk.

I have worn many hats throughout my life. Right now, the health and medical freedom movement consumes most of my attention because bodily integrity and personal liberty are under attack. I firmly believe that leaders and individual citizens must not become unwitting pawns in schemes cloaked in liberty that actually impose totalitarian and tyrannical policies.

Your letter states, "the University will be updating its Immunization Requirements for Students to include the COVID-19 vaccine." Before you implement such a plan, I'd like you to consider that even though many university vaccination requirements for licensed and approved vaccines have been upheld in court, no court has ever upheld a mandate for an Emergency Use Authorization (EUA) vaccine, which all COVID vaccines are at present. In fact, a federal court has held that EUA vaccines cannot be mandated to soldiers in the U.S. military, who enjoy far fewer rights than civilians, *Doe #1 v. Rumsfeld*, 297 F.Supp.2d 119 (2003). That court remarkablly held "….the United States cannot demand that members of the armed forces also serve as guinea pigs for experimental drugs." Id. at 135.

Federal law 21 U.S.C. § 360bbb-3(e)(1)(A)(ii)(III) requires that the person to whom an EUA vaccine is administered be advised, "of the option to accept **or refuse** administration of the product, of the consequences, if any, of refusing administration of the product, and of the alternatives to the product that are available and of their benefits and risks." The reason for the right of refusal stems from the fact that EUA products are by definition experimental. Under the Nuremberg Code, no one may be coerced to participate in a medical experiment. Consent of the individual is "absolutely essential." The liability for forced participation in a medical experiment, not to mention injury from such coerced medical intervention, may be incalculable. The consequences described in the statute mean medical consequences, not termination of employment or denial of in-person learning, as Rutgers contemplates.

I recently filed civil complaints on behalf of CHD and others regarding EUA products. I am swamped already with calls and emails to bring an action against your intended program. Since nothing has been finalized and no one has yet been harmed, now is not that time.

It is my sincere hope that you will reconsider your decision in light of the above facts.

Sincerely yours,

Robert F. Kennedy, Jr.

1227 North Peachtree Parkway, Suite 202. Peachtree City, GA 30269
www.childrenshealthdefense.org

RUTGERS TODAY

Rutgers to Require COVID-19 Vaccine for Students

The university will require all students to be vaccinated before arriving on campus in the fall

Rutgers University will require the COVID-19 vaccine for students who are enrolled for the 2021 fall semester.

Assurances from the federal government that vaccines will be available for all Americans by the end of May and assessments by public health experts prompted university leaders to adjust the vaccine requirements for the fall semester.

"We are committed to health and safety for all members of our community, and adding COVID-19 vaccination to our student immunization requirements will help provide a safer and more robust college experience for our students," said Rutgers President Jonathan Holloway.

Students may request an exemption from vaccination for medical or religious reasons. Students enrolled in fully remote online degree programs and individuals participating in online-only continuing education programs will not be required to be vaccinated.

"Since the start of the pandemic, we have said that the safety of the Rutgers community is a shared responsibility," said Antonio Calcado, executive vice president and chief operating officer at Rutgers. "An effective vaccination program is a continuation of Rutgers' commitment to health and safety for all members of our community of more than 71,000 students, the cities we are in and the communities we serve throughout New Jersey."

As vaccine supplies are made available to the wider population, faculty and staff are strongly urged to receive the vaccine, Calcado said.

"The COVID-19 vaccines have proven to be safe and effective in preventing serious illness, hospitalization and death," said Brian Strom, chancellor of Rutgers Biomedical and Health Sciences and executive vice president for health affairs at Rutgers. "Vaccination is key to stopping the current pandemic and to the return of campus instruction and activities closer to what we were accustomed to before the pandemic drastically changed life at Rutgers."

Students enrolling at Rutgers who are under age 18 will be advised to receive the Pfizer vaccine, the only one of three vaccines currently approved in the United States that may be administered to 16- and 17-year-olds. Pfizer, Moderna and Johnson & Johnson vaccines are approved for those 18 years and older.

In a message to the Rutgers community, President Jonathan Holloway, Calcado, and Prabhas Moghe, executive vice president for academic affairs, noted widespread vaccination will accelerate the return to a pre-pandemic normal on the university's campuses, including increased in-person course offerings, more on-campus events and activities and more collaboration in instructional and research projects.

Rutgers has received approval from the State of New Jersey to administer vaccines on campus to faculty, staff and students once vaccine supplies are available to the university. More information will be forthcoming on vaccination clinic sites. However, faculty, staff and students are urged to not wait to sign up for vaccines at a Rutgers site.

"We urge all members of our community to pre-register for the vaccine on the state COVID-19 website to get vaccinated at the earliest opportunity and the first available location," Strom said.

Our Path Forward – COVID-19 Vaccination and the Fall Term

March 25, 2021

Members of the Rutgers Community:

We write to share news of our plans to welcome back all members of our community to our campuses this fall. The anticipated additional availability of the COVID-19 vaccine is enabling Rutgers to take steps to protect the health of our academic community and to move toward a full return to our pre-pandemic normal as a vibrant institution in Fall 2021.

President Biden recently announced that he is encouraging all states to open their COVID-19 vaccine eligibility requirements to include all adults and, further, that he expects that all adults could have access to at least one inoculation dose by the early summer. The Federal Centers for Disease Control and Prevention (CDC) also recently issued helpful guidance for those individuals who have been fully vaccinated. These announcements have provided us with the opportunity to clarify what our path forward will entail as we plan for the Fall 2021 academic semester.

In support of Rutgers' commitment to health and safety for all members of its community, the University will be updating its Immunization Requirements for Students to include the COVID-19 vaccine. **This health policy update means that, with limited exceptions, all students planning to attend in the Fall 2021 semester must be fully vaccinated.** In parallel, we continue to strongly urge all Rutgers faculty and staff to get immunized against COVID-19 at the earliest opportunity.

The benefits of COVID-19 vaccination include prevention of serious illness, hospitalization, and death from the virus. Broad immunization is critical to help stop the current pandemic and to protect our University community. Benefits specific to the Rutgers community include:

An expedited return to pre-pandemic normal

Additional face-to-face course offerings and academic experiences

Opportunities for a wider range of events and activities offered at our campuses

Expanded dining and recreation options at Rutgers

Greater interpersonal collaboration among faculty, students, and researchers

Most importantly, a safer Rutgers community supports a safer New Jersey for our families, our friends, and our neighbors across the state.

The University has also been approved by the State to offer Rutgers clinics for on-campus administration of vaccines to faculty, staff, and students when vaccine supplies become available. However, we have not yet been given vaccine to administer. Thus, the University urges all members of its community currently eligible to receive a vaccine not to wait and to register with the State (https://covidvaccine.nj.gov/) in order to get vaccinated as soon as possible, wherever you can, if you have not done so already.

Proof of vaccination will be required for all students planning to attend this fall. Any vaccine authorized for use in the U.S. (currently Moderna, Pfizer, and Johnson & Johnson) is acceptable. It is understood that some incoming students may be 17 years old, and may be only eligible for the Pfizer vaccine.

Students planning to attend the fall 2021 semester may request an exemption from the vaccination requirement for medical or religious reasons. Students enrolled in fully online degree programs (typically defined as having no access to on-campus facilities), as well as individuals participating in fully online or off-campus Continuing Education programs, will not need to provide proof of vaccination.

Should you have any questions about the vaccination program or Rutgers' requirements, please see the FAQs at https://coronavirus.rutgers.edu/covid-19-vaccine/#forStudents (https://coronavirus.rutgers.edu/covid-19-vaccine/#forStudents). For general questions about COVID-19 vaccines, please visit https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html) and https://covid19.nj.gov/pages/vaccine (https://covid19.nj.gov/pages/vaccine).

From the onset of the pandemic, the safety of the broader Rutgers community has been our shared responsibility. This has never been more true. The importance of an effective vaccination program to make our community safer for all cannot be overstated.

Please look for additional information and instructions regarding Rutgers vaccine clinics and exemptions in the coming days from Brian Strom, Executive Vice President for Health Affairs. Chancellors and their staffs will follow with additional information about fall planning as well.

We appreciate your patience, understanding, and commitment to health and safety during these challenging times, and we look forward to seeing you on campus this fall.

Sincerely,

Jonathan Holloway
President and University Professor

Prabhas V. Moghe
Executive Vice President for Academic Affairs
Distinguished Professor

Tab 7

4 Pages

12 April 2021

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
5601 Fishers Lane
Rockville, MD 20852
301-496-2263
anthony.fauci@nih.gov

Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths
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8 April 2021: Media Censored COVID-19

Early Treatment Options That Could Have Reduced Fatality by 85%

4 Pages

NEWS

Eminent doc: Media censored COVID-19 early treatment options that could have reduced fatalities by 85%

Dr. Peter McCullough also explained that given an 80% level of herd immunity, broad vaccination has 'no scientific, clinical or safety rationale.'

Thu Apr 8, 2021 - 9:23 pm EST

Dr. Peter McCullough, MD addresses the Texas State Senate Health and Human Service Committee. YouTube screenshot

By Patrick Delaney

LifeSiteNews has produced an extensive COVID-19 vaccines resources page. View it here.

AUSTIN, Texas, April 8, 2021 (LifeSiteNews) — An exceedingly well-qualified physician, who was censored by YouTube last year, addressed the Texas State Senate Health and Human Service Committee

last month providing thorough information on successful treatments of COVID-19, the present high-level of herd immunity from the disease, the very limited potential of "vaccines," and the data that shows early treatment could have saved up to 85 percent of the "over 500,000 deaths in the United States."

Dr. Peter McCullough, MD is an internist and cardiologist, along with being a professor of medicine at Texas A&M University Health Sciences Center. He is distinguished as the most published person in history in his field and an editor of two major medical journals.

McCullough explained that from the beginning of the pandemic, he refused to let his patients "languish at home with no treatment and then be hospitalized when it was too late," which was the typical treatment protocol being discussed, promoted and offered across the west.

He thus "put together a team of doctors" to study "appropriately prescribed off-label use of conventional medicine" to treat the illness and they published their findings in the *American Journal of Medicine*.

"The interesting thing was, (that while) there were 50,000 papers in the peer-reviewed literature on COVID, not a single one told the doctor how to treat it," he said. "When does that happen? I was absolutely stunned! And when this paper was published … it became … the most cited paper in basically all of medicine at that time the world."

With the help of his daughter, Dr. McCullough recorded a YouTube video incorporating four slides from the "peer-reviewed paper published in one of the best medical journals in the world" discussing early treatments for COVID-19. The video quickly "went absolutely viral. And within about a week YouTube said 'you violated the terms of the community'" and they pulled it down.

Due to the "near total block on any information of treatment to patients," Sen. Bob Johnson hosted a November hearing on this important topic where McCullough was the lead witness.

With such an aggressive suppression of information on early treatments, and the default policy in COVID-19 testing centers to not offer any such resources to those who test positive for the infection, McCullough said, "No wonder we have had 45,000 deaths in Texas. The average person in Texas thinks there's no treatment!"

And the blackout of such vital information goes well beyond the blatant censorship of big tech companies. McCullough said, "What has gone on has been beyond belief! How many of you have turned on a local news station, or a national cable news station, and ever gotten an update on treatment at home? How many of you have ever gotten a single word about what to do when you get handed the diagnosis of COVID-19? That is a complete and total failure at every level!"

— Article continues below Petition —

"Let's take the White House: How come we didn't have a panel of doctors assigned to put all their efforts to stop these hospitalizations? Why don't we have doctors who actually treated patients get together in a group and every week give us an update? … Why don't we have any reports about how many patients were treated, and spared hospitalizations? … This is a complete and total travesty to have a fatal disease, and not treat it," he said.

“So what can be done right here, right now?” McCullough proposed to the legislators. “How about tomorrow, let’s have a law that says there’s not a single (test) result given out without a treatment guide, and without a hotline of how to get into research. Let’s put a staffer on this and find out all the research available in Texas, and let’s not have a single person go home with a test result with their fatal diagnosis, sitting at home going into two weeks of despair before they succumb to hospitalization and death. It is unimaginable in America that we can have such a complete and total blind spot.”

In reference to early treatments that have been widely used outside the west with great success (with around 1 percent to 10 percent of the death rates of the first world), McCullough turned his attention to broad media suppression of information once again asking, “When was the last time you turned on the news and ever got a window to the outside world? When did you ever get an update about how the rest of the world is handling COVID? Never. What's happened in this pandemic is the world has closed in on us.

“There's only one doctor whose face is on TV now. One. Not a panel. (As) doctors, we always work in groups, we always have different opinions. There's not a single media doctor on TV who's ever treated a COVID patient. Not a single one. There's not a single person in the White House Task Force who has ever treated a patient,” he said.

“Why don’t we do something bold. Why don’t we put together a panel of doctors that have actually treated outpatients of COVID-19, and get them together for a meeting. And why don’t we exchange ideas, and why don’t we say how we can finish the pandemic strongly.”

“Isn’t it amazing?! Think about this. Think about the complete and total blind spot (regarding home treatments),” he said.

Herd immunity and vaccination

“The calculations in Texas on herd immunity … right now with no vaccine effect (is) 80 percent,” McCullough said. “And more people are developing COVID today. They're going to become immune (as well).”

“People who develop COVID *have complete and durable immunity*. And (that’s) a very important principle: *complete and durable*. You can't beat natural immunity. You can't vaccinate on top of it and make it better. There's no scientific, clinical or safety rationale for ever vaccinating a COVID-recovered patient. There's no rationale for ever testing a COVID-recovered patient,” he continued.

“My wife and I are COVID-recovered. Why do we go through the testing outside? There's absolutely no rationale (for such testing).”

Given the high levels of herd immunity, McCullough said any impact from broad vaccination in preventing COVID-19 can only be minimal at best.

“There's plenty of COVID-recovered patients. Let them forgo the vaccine and let people who are clamoring for it get it. But at 80 percent herd immunity, in the vaccine trials fewer than one percent … in the placebo actually get COVID. Fewer than one percent. The vaccine is going to have a one percent public health impact. That's what the data says. It's not going to save us, we’re already 80 percent herd immune,” he said.

“If we're strategically targeted we can actually close out the pandemic very well with the vaccine,” the cardiologist stated. “But strategically targeted. (For) people under 50 who fundamentally have no health risks, there's no scientific rationale for them to ever become vaccinated.”

Addressing the broad “misinformation” of asymptomatic transfer of COVID-19, which has supported the need for lockdowns due to the notion that the virus can be unintentionally spread by infectious, asymptomatic people, the medical professor said, “One of the mistakes I heard today as a rationale for vaccination is asymptomatic spread. And I want to be very clear about this: My opinion is there is a low degree, if any, of asymptomatic spread. Sick person gives it to sick person. The Chinese have published a study … [of] 11 million people. They tried to find [evidence of] asymptomatic spread. You can't find it. And that's been, you know, one of important pieces of misinformation.”

Finally, McCullough highlighted the impact of suppressing information on effective and safe early treatments during this last year. Citing two “very large” studies, he said “when doctors treat patients early who are over age 50 with medical problems, with a sequence multi-drug approach … there's an *85 percent reduction in hospitalizations and death*.”

“We have over 500,000 deaths in the United States. The preventable fraction could have been as high as 85 percent (425,000) if our pandemic response would have been laser-focused on the problem: the sick patient right in front of us,” he concluded.

RELATED:

Outpatient Early Treatment Algorithm for COVID-19 - a Webinar with Dr Peter A. McCullough – This Oct. 2020 webinar includes a great deal of additional information, many incredibly useful slides from Dr. McCullough as well as some participation from Dr. Brian Tyson.

‘Only a one in 17 billion chance hydroxychloroquine doesn’t work’: medical professor

Frontline Doctors: Experimental vaccines are ‘not safer’ than COVID-19

EXCLUSIVE - Former Pfizer VP: ‘Your government is lying to you in a way that could lead to your death.’

It’s ‘entirely possible’ vaccine campaigns ‘will be used for massive-scale depopulation’: Former Pfizer VP

Asymptomatic transmission of COVID-19 didn’t occur at all, study of 10 million finds

The anti-hydroxychloroquine campaign was based in politics, not science: biologist

Tab 8

8 Pages

12 April 2021

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
5601 Fishers Lane
Rockville, MD 20852
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anthony.fauci@nih.gov

Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
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7 April 2021: Former Pfizer Vice President of Research: Your Government is Lying

to You in a Way That Could Lead to Your Death

8 Pages

NEWS

EXCLUSIVE - Former Pfizer VP: 'Your government is lying to you in a way that could lead to your death.'

'Look out the window, and think, "why is my government lying to me about something so fundamental?" Because, I think the answer is, they are going to kill you using this method. They're going to kill you and your family.'

Wed Apr 7, 2021 - 8:47 am EST

Dr. Mike Yeadon Arshad Ebrahim / YouTube

By Patrick Delaney

LifeSiteNews has been permanently banned on YouTube. Click HERE to sign up to receive emails when we add to our video library.

April 7, 2021 (LifeSiteNews) — Dr. Michael Yeadon, Pfizer's former Vice President and Chief Scientist for Allergy & Respiratory who spent 32 years in the industry leading new medicines research and retired from the pharmaceutical giant with "the most senior research position" in his field, spoke with LifeSiteNews.

He addressed the "demonstrably false" propaganda from governments in response to COVID-19, including the "lie" of dangerous variants, the totalitarian potential for "vaccine passports," and the strong possibility we are dealing with a "conspiracy" which could lead to something far beyond the carnage experienced in the wars and massacres of the 20th century.

His main points included:

1. There is "no possibility" current variants of COVID-19 will escape immunity. It is "just a lie."

2. Yet, governments around the world are repeating this lie, indicating that we are witnessing not just "convergent opportunism," but a "conspiracy." Meanwhile media outlets and Big Tech platforms are committed to the same propaganda and the censorship of the truth.

3. Pharmaceutical companies have already begun to develop unneeded "top-up" ("booster") vaccines for the "variants." The companies are planning to manufacture billions of vials, in addition to the current experimental COVID-19 "vaccine" campaign.

4. Regulatory agencies like the U.S. Food and Drug Administration and the European Medicines Agency, have announced that since these "top-up" vaccines will be so similar to the prior injections which were approved for emergency use authorization, drug companies will not be required to "perform any clinical safety studies."

5. Thus, this virtually means that design and implementation of repeated and coerced mRNA vaccines "go from the computer screen of a pharmaceutical company into the arms of hundreds of millions of people, [injecting] some superfluous genetic sequence for which there is absolutely no need or justification."

6. Why are they doing this? Since no benign reason is apparent, the use of vaccine passports along with a "banking reset" could issue in a totalitarianism unlike the world has ever seen. Recalling the evil of Stalin, Mao, and Hitler, "mass depopulation" remains a logical outcome.

7. The fact that this at least *could be* true means everyone must "*fight like crazy to make sure that system never forms*."

Dr. Yeadon began identifying himself as merely a "boring guy" who went "to work for a big drug company … listening to the main national broadcast and reading the broad sheet newspapers."

Continuing, he said: "But in the last year I have realized that my government and its advisers are lying in the faces of the British people about everything to do with this coronavirus. *Absolutely everything*. It's a fallacy this idea of asymptomatic transmission and that you don't have symptoms, but you are a source of a virus. That lockdowns work, that masks have a protective value obviously for you or someone else, and that variants are scary things and we even need to close international borders in

case some of these nasty foreign variants get in.

“Or, by the way, on top of the current list of gene-based vaccines that we have miraculously made, there will be some ‘top-up’ vaccines to cope with the immune escape variants.

“Everything I have told you, every single one of those things is demonstrably false. But our entire national policy is based on these all being broadly right, but they are all wrong.”

‘Conspiracy’ and not just ‘convergent opportunism’

“But what I would like to do is talk about immune escape because I think that’s probably going to be the end game for this whole event, which I think is probably a conspiracy. Last year I thought it was what I called ‘convergent opportunism,’ that is a bunch of different stakeholder groups have managed to pounce on a world in chaos to push us in a particular direction. So it *looked* like it was *kind o*f linked, but I was prepared to say it was just convergence.”

“I [now] think that’s naïve. There is no question in my mind that very significant powerbrokers around the world have either planned to take advantage of the next pandemic or created the pandemic. One of those two things is true because the reason it must be true is that dozens and dozens of governments are all saying the same lies and doing the same inefficacious things that demonstrably cost lives.

“And they are talking the same sort of future script which is, ‘We don’t want you to move around because of these pesky varmints, these “variants”’— which I call ‘samiants’ by the way, because they are pretty much the same — but they’re all saying this and they are all saying ‘don’t worry, there will be “top-up” vaccines that will cope with the potential escapees.’ They’re all saying this when it is obviously nonsense.”

Possible end game: vaccine ‘passports’ tied to spending allowances, thorough control

“I think the end game is going to be, ‘everyone receives a vaccine’… Everyone on the planet is going to find themselves persuaded, cajoled, not quite mandated, hemmed-in to take a jab.

“When they do that every single individual on the planet will have a name, or unique digital ID and a health status flag which will be ‘vaccinated,’ or not … and whoever possesses that, sort of single database, operable centrally, applicable everywhere to control, to provide as it were, a privilege, you can either cross this particular threshold or conduct this particular transaction or not depending on [what] the controllers of that one human population database decide. And I think that’s what this is all about because once you’ve got that, we become playthings and the world can be as the controllers of that database want it.

“For example, you might find that after a banking reset that you can only spend through using an app that actually feeds off this [database], your ID, your name, [and] your health status flag.”

“And, yes, certainly crossing an international border is the most obvious use for these vaccine passports, as they are called, but I’ve heard talk of them already that they could be necessary for you to get into public spaces, enclosed public spaces. I expect that if they wanted to, you would not be able

to leave your house in the future without the appropriate privilege on your app.

"But even if that's not [the] true [intent of the vaccine campaign], it doesn't matter, *the fact that it could be true* means everyone [reading] this should *fight like crazy to make sure that [vaccine passport] system never forms*."

"[With such a system], here is an example of what they could make you do, and I think this is what they're going to make [people] do.

"You could invent a story that is about a virus and its variations, its mutations over time. You could invent the story and make sure you embed it through the captive media, make sure that no one can counter it by censoring alternative sources, then people are now familiar with this idea that this virus mutates, which it does, and that it produces variants, which is true [as well], which could *escape your immune system*, and *that's a lie*.

"But, nevertheless, we're going to tell you it's true, and then when we tell you that it's true and we say 'but we've got the cure, here's a top-up vaccine,' you'll get a message, based on this one global, this one ID system: 'Bing!' it will come up and say 'Dr. Yeadon, time for your top-up vaccine. And, by the way,' it will say 'your existing immune privileges remain valid for four weeks. But if you don't get your top-up vaccine in that time, you will unfortunately detrimentally be an "out person," and you don't want that, do you?' So, that's how it'll work, and people will just walk up and they'll get their top-up vaccine."

Gov't lies, Big Pharma moves forward, medicine regulators get out of the way, and possible 'mass-depopulation'

"But I will take you through this, Patrick, because I am qualified to comment. I don't know what Vanden Bossche is about. There was no possibility *at all*, based on all of the variants that are in the public domain, 4000 or so of them, none of them are going to escape immunity [i.e. become more dangerous].

"Nevertheless, politicians and health advisers (to loads of governments) are saying that they are. They're lying. Well, why would you do that?

"Here's the other thing, in parallel, pharmaceutical companies have said, several of them, it will be quite easy for us to adjust our gene-based vaccines, and we can hasten them through development, and we can help you.

"And here's the real scary part, global medicines regulators like [the U.S. Food and Drug Administration] FDA, the Japanese medicines agency, the European Medicines Agency, have gotten together and announced … since top-up vaccines will be considered so similar to the ones that we have already approved for emergency use authorization, we are not going to require the drug companies to perform any clinical safety studies.

"So, you've got on the one hand, governments and their advisers that are lying to you that variants are different enough from the current virus that, even if you're immune from natural exposure or vaccination, you're a risk and you need to come and get this top-up vaccine. So, I think neither of

those are true. So why is the drug company making the top-up vaccines? And [with] the regulators having got out of the way — and if Yeadon is right, and I'm sure I am or I wouldn't be telling you this — *you go from the computer screen of a pharmaceutical company into the arms of hundreds of millions of people, some superfluous genetic sequence for which there is absolutely no need or justification.*

"And if you wanted to introduce a characteristic which could be harmful and could even be lethal, and you can even tune it to say 'let's put it in some gene that will cause liver injury over a nine-month period,' or, cause your kidneys to fail but not until you encounter this kind of organism [that would be quite possible]. *Biotechnology provides you with limitless ways, frankly, to injure or kill billions of people.*

"And since I can't think of a benign explanation for any of the steps: variants, top-up vaccines, no regulatory studies… it's not only that I cannot think of a benign explanation, the steps described, and the scenario described, and the necessary sort of resolution to this false problem is going to allow what I just described: unknown, and unnecessary gene sequences injected into the arms of potentially billions of people for no reason.

"I'm very worried … that pathway will be used for mass depopulation, because I can't think of any benign explanation."

— Article continues below Petition —

'Absurdly impossible' variants will escape immunity, 'just a lie'

"If I can show you that one major thing that governments around the world are telling the people is a lie, you should take my 32 years of experienced opinion that says, most of it, if not all of it, is a lie."

"The most different variant is only 0.3% different from the original sequence as emailed out of Wuhan in … January 2020. 0.3% [is] the one [variant] that is the *most* different on the planet so far. And now another way of saying it is, 'all of the variants are not less than 99.7% identical to each other.'

"Now, you might be thinking, 'hmm, .3%, is that enough [to escape immunity and become more dangerous]?' The answer is *no*. Get away, ya know, get out of here …

"The human immune system is a thing of wonder. What it does is when it faces a new pathogen like this, you've got professional cells, they're called professional antigen-presenting cells —they're kind of rough tough things that tend not to succumb to viruses. And their job is to grab foreign things in the near environment and tear them limb from limb [inside the cell]. They really cut them up into hundreds of pieces. And then they present these pieces on the surfaces of their cell to other bits of your immune system, and amazingly, because of the variability that God and nature gave you, huge variability to recognize foreign things, and your body ends up using 15 to 20 different specific motifs that it spots about this virus. They're called epitopes, basically they're just like little photographs of the details about this virus. That's what they do. And that is what is called your repertoire, your immune repertoire is like 20 different accurate photographs, close-ups, of different bits of this virus.

"Now, if a tiny piece of the virus changes, like the .3% I've just described, if you are reinfected by that variant, your professional cells tear into that virus and cut it into pieces, present them again, and lo

and behold, most of the pieces that you have already seen and recognized, are still there in the variants.

"There is absolutely no chance that all of them will fail to be recognized and that is what is required for immune escape, to escape your immunity. It must present to you as a new pathogen. It must be sufficiently different that, when it is cut up by your professional checker cells, it won't find mostly the same thing it has seen before. *And that is just absurdly impossible when you have only varied .3%, so it is 99.7% (similar).*

"You can go and check that by looking at papers by a person called Alison Tarke. There is also Shane Crotty, and all of the other co-authors.

"And before them, coming from my theoretical understanding of multi-locus immunity, which is what I just badly tried to describe, to what actually happens … If your [immune system] is presented with something that contains even half of those similar pieces, there is no way your body will say, 'that's a new pathogen.'

"And, so, the idea that 0.3% could even have a chance of getting around immunity is just a lie. It's not [even] like an opinion difference.

"I don't think 3% would be enough. That's 10 times more variation than has occurred in 16 months [with this virus]. I don't even think 30% difference would be enough. So, I'm saying that 100 times more variation than has actually happened, would still leave me putting *a big bet on the human immune system not being fooled that these are new pathogens*.

"I've chatted this over with several professors of immunology and they agreed with me, it's like, 'why are you asking me this?'

"So, I think that what I've just said is that governments and their advisors in multiple countries are lying about variants. That's a massive thing! You should check it out. Your readers should check it out. If it's true, don't you think it's terrifying?! It was when I realized it.

"So, they're lying about variants, and then, of course, since [the variants] are not really different, you do not need a 'top-up' vaccine. *Now you should be getting the hairs on the back of your neck up*, because they are making them right now!"

"They are making billions of vials of it. And they will be available by the end of the year.

"And I think they'll require people to first, be on the vaccine passport one-world database, and then it will roll up into the top-ups, and if it takes a bit longer it will take a bit longer.

"But this is not going away. It won't go away until enough people, if they ever do, say 'you're a bunch of frauds and we are taking our freedoms back, so you can just stop doing this.'

"Because one person shouting into the wilderness and all of the other academics looking the other way, will have us just going down this pipe maybe a week later than if I hadn't said anything, but we're still going down *to hell*.

“So, that’s why I’m frightened.

“The variants aren’t different. I call them ‘samiants’… they’re pretty much the same. They’re not different. Therefore, you don’t need a top-up vaccine, so don’t go near any of them.”

‘Why is my government lying to me?’ Because ‘they are going to kill you.’

“[And if you recognize that our governments are involved in a major verifiable lie], don’t just turn your computer off and go to supper. Stop. Look out the window, and think, ‘why is my government lying to me about something so fundamental?’ Because, I think the answer is, *they are going to kill you using this method. They’re going to kill you and your family*.

“The eugenicists have got hold of the levers of power and this is a really artful way of getting you to line-up and receive some unspecified thing that will damage you. I have no idea what it will actually be, but it won’t be a vaccine because you don’t need one. And it won’t kill you on the end of the needle because you would spot that.

“It could be something that will produce normal pathology, it will be at various times between vaccination and the event, it will be plausibly deniable because there will be something else going on in the world at that time, in the context of which your demise, or that of your children will look normal.

“That’s what I would do if I wanted to get rid of 90 or 95% of the world’s population. And I think that’s what they’re doing.”

“Now I don’t know [for certain] that they’re going to use that [system] to kill you, but I can’t think of a benign reason, and with that power they certainly could harm you, or control you, so you should object [and strenuously oppose it].”

People can’t deal with this level of evil, but Soviets, Hitler, Mao show its possibility

“It’s become absolutely clear to me, even when I talk to intelligent people, friends, acquaintances … and they can tell I’m telling them something important, but they get to the point [where I say] ‘your government is lying to you in a way that could lead to your death and that of your children,’ and they can’t begin to engage with it. And I think maybe 10% of them understand what I said, and 90% of those blank their understanding of it because it is too difficult. And my concern is, we are going to lose this, because people will not deal with the possibility that anyone is so evil…

“But I remind you of what happened in Russia in the 20th Century, what happened in 1933 to 1945, what happened in, you know, Southeast Asia in some of the most awful times in the post-war era. And, what happened in China with Mao and so on.

“We’ve only got to look back two or three generations. All around us there are people who are as bad as the people doing this. They’re all around us. So, I say to folks, the only thing that really marks this one out, is its *scale*.

“But actually, this is probably less bloody, it’s less personal, isn’t it? The people who are steering this

… it's going to be much easier for them. They don't have to shoot anyone in the face. They don't have to beat someone to death with a baseball bat, or freeze them, starve them, make them work until they die. All of those things did happen two or three generations back and our grandparents or great grandparents were either victims of this, or they were actually members of it, or at least they witnessed it from overseas. That's how close we are.

"And all I'm saying is, some shifts like that are happening again, but now they are using molecular biology.

"And the people going along with it, I think they would probably say, 'I was only following orders,' which we have heard before.

"But I know, because I have talked to lots of people, and some of them have said 'I don't want to believe that you are right, so I'm going to just put it away because if it is true, I can't handle it.' And I think … all you need to do is find a good reason to tell people, 'Don't take the vaccine unless you're a medical risk of dying from the virus!' That seems to me a pretty good line!"

Towards a solution – 'We need God'

"I'm a scientist, and I can tell you, talking to non-scientists, using science as a tool, will not work. It will fail.

"So, we need philosophers, people who understand logic, religion, something like that, [they have] got to wrestle with this, and start talking in a language people will understand. Because if we leave it with scientists, people like me, even though I'm well-intentioned, I'm a gabbling alien as far as most people in the street are concerned. They won't believe the government will lie to them, they don't believe the government would ever do anything that will harm them, but they are [doing such things]."

Finally, in an email correspondence, Dr. Yeadon concluded, "I have latest taken to signing off with 'May God save us', because I think we need God now more than at any time since WW2."

LifeSiteNews has produced an extensive COVID-19 vaccines resources page. View it here.

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Tab 9

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Dr. Anthony S. Fauci, Director
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Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
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Technical Report · June 2020

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All-cause mortality during COVID-19: No plague and a likely signature of mass homicide by government response

Denis G. Rancourt, PhD
Researcher, Ontario Civil Liberties Association (ocla.ca)

Working report (not submitted for journal publication), published at Research Gate (https://www.researchgate.net/profile/D_Rancourt)

2 June 2020

Summary / Abstract

The latest data of all-cause mortality by week does not show a winter-burden mortality that is statistically larger than for past winters. There was no plague. However, a sharp "COVID peak" is present in the data, for several jurisdictions in Europe and the USA.

This all-cause-mortality "COVID peak" has unique characteristics:

- Its sharpness, with a full-width at half-maximum of only approximately 4 weeks;
- Its lateness in the infectious-season cycle, surging after week-11 of 2020, which is unprecedented for any large sharp-peak feature;
- The synchronicity of the onset of its surge, across continents, and immediately following the WHO declaration of the pandemic; and
- Its USA state-to-state absence or presence for the same viral ecology on the same territory, being correlated with nursing home events and government actions rather than any known viral strain discernment.

These "COVID peak" characteristics, and a review of the epidemiological history, and of relevant knowledge about viral respiratory diseases, lead me to postulate that the "COVID peak" results from an accelerated mass homicide of immune-vulnerable individuals, and individuals made more immune-vulnerable, by government and institutional actions, rather than being an epidemiological signature of a novel virus, irrespective of the degree to which the virus is novel from the perspective of viral speciation.

The paper is organized into the following sections:

- Cause-of-death-attribution data is intrinsically unreliable
- Year-to-year winter-burden mortality in mid-latitude nations is robustly regular
- Why is the winter-burden pattern of mortality so regular and persistent?
- A simple model of viral respiratory disease *de facto* virulence
- All-cause mortality analysis of COVID-19
- Interpreting the all-cause mortality "COVID peak"

Cause-of-death-attribution data is intrinsically unreliable

Assignment of cause of death, with infectious diseases and comorbidity, is not only technically difficult (e.g., Simonsen et al., 1997; Marti-Soler et al., 2014) but also contaminated by physician-bias, politics and news media.

This has been known since modern epidemiology was first practiced. Here is Langmuir (1976) quoting the renowned pioneer William Farr, regarding the influenza epidemic of 1847:

> Farr uses this epidemic to chide physicians mildly on their narrow views pointing out that sharp increases were observed not only in influenza itself but in bronchitis, pneumonia and asthma and many other non-respiratory causes, he states:
>
> > '… there is a strong disposition among some English practitioners not only to localize disease but to see nothing but the local disease. Hence, although it is certain that the high mortality on record was the immediate result of the epidemic of influenza, the deaths referred to that cause are only 1,157.'

And, such bias is generally recognized by leading epidemiologists (Lui and Kendal, 1987):

> … the decision to classify deaths into "pneumonia and influenza" is subjective and potentially inconsistent. On one hand, the effect of influenza or influenza-related pneumonia may be underestimated because underlying chronic diseases, particularly in the elderly, are usually noted as the cause of death on the death certificate. On the other hand, after influenza activity has been publicly reported there may be an increased tendency to classify deaths as due to "pneumonia and influenza," thereby amplifying the rate of increase in P&I deaths or, when a decline in influenza activity is reported, a bias toward decreasing the classification of deaths related to "pneumonia and influenza" may result. Surveys to evaluate these possibilities have not been done.

One can reasonably expect that in the current world of social media, with a World-Health-Organization-declared (WHO-declared) “pandemic”, such bias will only be greater compared to its presence in past viral respiratory disease epidemics.

For example, it is difficult to interpret the synchronicity of the WHO declaration of COVID-19 as a pandemic and the onset of the observed surge in reported COVID-19 cases and deaths as being the product of either coincidence or extraordinary forecasting ability of the global health-monitoring system:

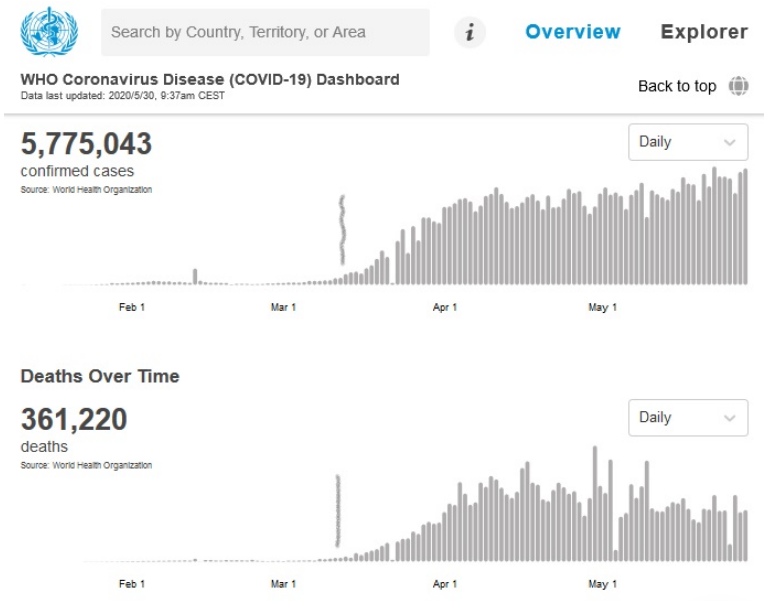


Figure 1: Globally reported COVID-19 cases, and reported COVID-19-assigned deaths, by day. WHO data was accessed on 30 May 2020. The vertical lines in pencil indicate the date at which the WHO declared the pandemic.

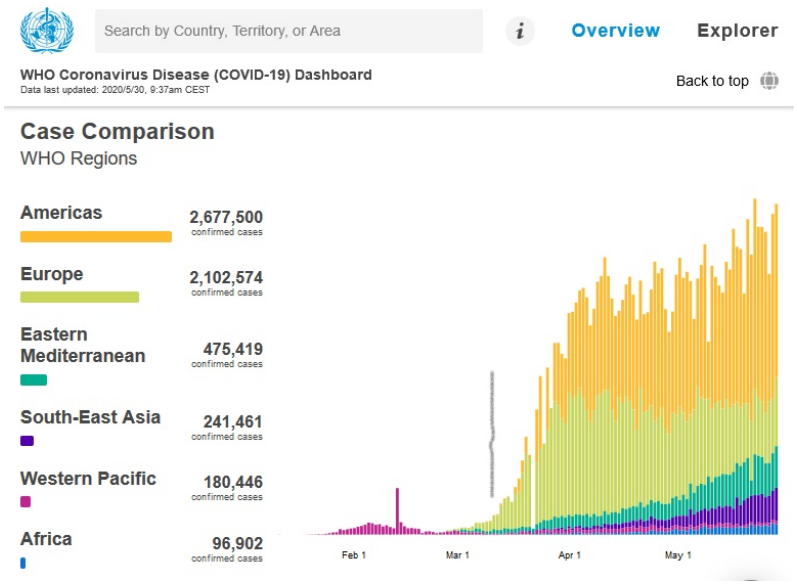


Figure 2: Globally reported new COVID-19 cases per day, discerning the continents. WHO data was accessed on 30 May 2020. The vertical line in pencil indicates the date at which the WHO declared the pandemic.

Instead, in light of past epidemics, it is more likely that this remarkable synchronicity phenomenon arises from biased reporting, in the flexible context of using urgently manufactured laboratory tests that are not validated, clinical assessments of a generic array of symptoms, and tentative cause-of-death assignations of complex comorbidity circumstances.

That is why rigorous epidemiological studies rely instead on all-cause mortality data, which cannot be altered by observational or reporting bias (as discussed in Simonsen et al., 1997; and see Marti-Soler et al., 2014). A death is a death is a death.

Year-to-year winter-burden mortality in mid-latitude nations is robustly regular

Modern human mortality in mid-latitude temperate-climate regions is robustly seasonal. Graphs of number of all-cause deaths per unit of time (month, week, day), in given regions, have a yearly pattern, with a peak-to-trough amplitude of typically 10% to 30% of the trough-baseline value, largely irrespective of the specific pathogens that populate the specific seasons. High mortality occurs in winter, and is thus inverted in the Northern and Southern hemispheres (e.g., Marti-Soler et al., 2014).

For the USA, the phenomenon is well illustrated in this figure from Simonsen et al. (1997):

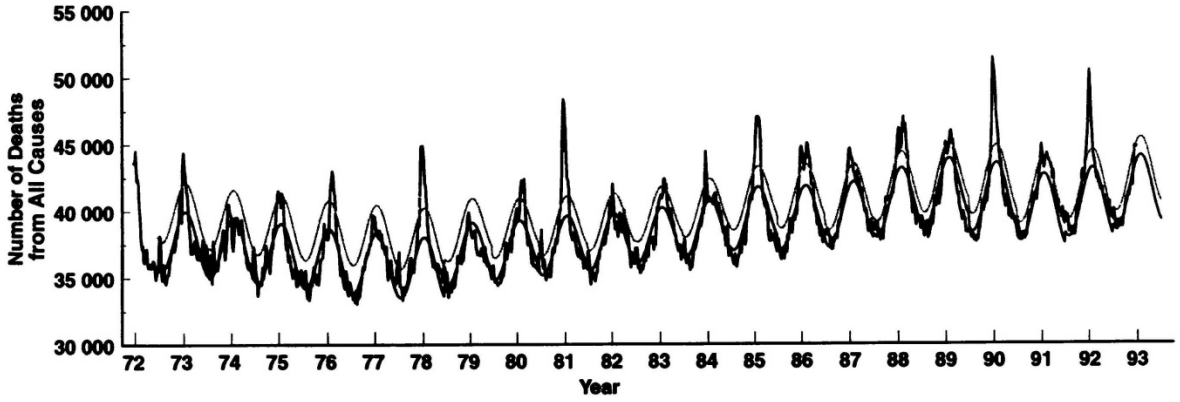


Figure 3: All-cause mortality, by week, for the USA, 1972 to 1993 (Simonsen et al., 1997; from their Fig. 1).

In such a graph, the area under a peak, to its trough-level baseline, is the total number of yearly winter-burden deaths above the trough baseline. The thus calculated yearly "excess" number of deaths, here (in the era 1972-1993), is always approximately 8% to 11% of the total yearly trough-baseline-level deaths, also approximately 8% to 11% of the yearly all-cause mortality.

This regular and seasonal "excess" mortality, or winter burden, has been an epidemiological challenge to understand, although, starting with Farr, many epidemiologists originally attributed it almost entirely to the seasonal influenza-like viral respiratory diseases.

Nonetheless, the agonizing difficulty to understand the cause(s) of this remarkably regular and global (both hemispheres, but inverted) pattern persists, as illustrated in the words of Marti-Soler et al. (2014) (references omitted):

> Given that mortality from cancer showed virtually no seasonality pattern, the seasonality of overall mortality is driven mostly by seasonality of both CVD [cardiovascular diseases] and non-CVD/non-cancer mortality. For these conditions, and particularly for CVD, exposure to cold is a plausible explanation for the observed seasonality, given relationship of cold climate with latitude. Several longitudinal studies have demonstrated that a decrease in outdoor temperature was associated with a rise in all cause mortality. However, other latitude-dependent factors, such as dietary habits, sun exposure (vitamin D levels) and human parasitic and infectious agents might also play a role. The magnitude of the seasonal pattern for CVD mortality was highest than that for all cause mortality. The seasonality of CVD mortality might be partly due to the joint seasonality of several known CVD risk factors, as described previously. Similarly, lifestyle factors such as diet and physical activity also tend to differ during summer and winter months. Moreover, exposure to cold increases energy expenditure, peripheral vasoconstriction and cardiac afterload, thus potentially triggering myocardial ischemia

and stroke. Finally, winter prone influenza infection might also be a trigger for CVD deaths by exacerbating CVD conditions or due to secondary complications. This is likely to be the case of concentration of air pollutants.

The seasonality of non-CVD/non-cancer mortality can relate to the facts that chronic obstructive pulmonary disease and pneumonia are frequent diseases in this category and that these disease are exacerbated by influenza, other influenza-like infections and concentrations of air pollutants, which are all more frequent in winter. A few other diseases in the non-CVD/non-cancer category also present a seasonal pattern, e.g. depression, suicide, and oesophageal variceal bleeding.

Why is the winter-burden pattern of mortality so regular and persistent?

Even the seasonality of the pneumonia and influenza ("P&I") part *alone* (which is a large part of what Marti-Soler et al. quantify as "non-CVD/non-cancer mortality") was not understood until a decade ago. Until recently, it was debated whether the P&I yearly pattern arose primarily because of seasonal change in virulence of the pathogens, or because of seasonal change in susceptibility of the host (such as from dry air causing tissue irritation, or diminished daylight causing vitamin deficiency or hormonal stress). For example, see Dowell (2001). In a sense, the answer is "neither".

In a landmark study, Shaman et al. (2010) showed that the seasonal pattern of respiratory-disease (P&I) excess mortality can be explained quantitatively on the sole basis of absolute humidity, and its direct controlling impact on transmission of airborne pathogens.

Lowen et al. (2007) demonstrated the phenomenon of humidity-dependent airborne-virus contagiousness in actual disease transmission between guinea pigs, and discussed potential underlying mechanisms for the measured controlling effect of humidity.

The underlying mechanism is that the pathogen-laden aerosol particles or aerosol-size droplets are neutralized within a half-life that monotonically and significantly decreases with increasing ambient absolute humidity. This is based on the seminal work of Harper (1961). Harper experimentally showed that viral-pathogen-carrying droplets were inactivated within shorter and shorter times, as ambient absolute humidity was increased.

Harper argued that the viruses themselves were made inoperative by the humidity ("viable decay"), however, he admitted that the effect could be from humidity-enhanced physical removal or gravitational sedimentation of the droplets ("physical loss"): "Aerosol viabilities reported in this paper are based on the ratio of virus titre to radioactive count in suspension and cloud samples, and can be criticized on the ground that test and tracer materials were not physically identical."

The latter ("physical loss") seems more plausible to me, since absolute humidity would have a universal physical effect of causing particle/droplet growth-by-condensation and gravitational sedimentation (and, conversely, loss-by-evaporation and aerosolization), and all tested viral pathogens have essentially the same humidity-driven "decay". Furthermore, it is difficult to understand how a virion (of any virus type) in a droplet would be molecularly or structurally attacked or damaged by an increase in ambient humidity. A "virion" is the complete, infective form of a virus outside a host cell, with a core of RNA or DNA and a capsid. No actual molecular or other mechanism of the humidity-driven intra-droplet "viable decay" of a virion postulated by Harper (1961) has, to date, been explained or studied, whereas gravitational sedimentation ("physical loss") is well understood.

In any case, the explanation and model of Shaman et al. (2010) is not dependant on the particular mechanism of the absolute-humidity-driven decay of virions in aerosol/droplets. Shaman's quantitatively demonstrated model of seasonal regional viral epidemiology is valid for either mechanism (or combination of mechanisms), whether "viable decay" or "physical loss".

The breakthrough achieved by Shaman et al. is not merely some academic point. Rather, it has profound health-policy implications, which have been entirely ignored or overlooked in the current coronavirus pandemic:

- It means that the seasonality of P&I mortality is directly driven by absolute-humidity-controlled contagiousness of the viral respiratory diseases.

If my view of the mechanism is correct (i.e., "physical loss" rather than "viable decay"), then:

- It additionally implies that the transmission vector must be small aerosol particles in fluid suspension in air, breathed deeply into the lungs, indoors; not hypothesized routs such as actual fluid or fomite contact, and not large droplets and spit (that are quickly gravitationally removed from the air, or captured in the mouth and digestive system).
- And it means that social distancing, masks, and hand washing can have little effect in the actual epidemic spread during the winter season (see: Rancourt, 2020).

On the epidemiology modelling side, Shaman's work implies that, rather than being a fixed number (dependent solely on the spatial-temporal structure of social interactions in a completely and variably susceptible population, and on the viral strain), the epidemic's basic reproduction number (R0) is predominantly dependent on ambient absolute humidity. For a definition of R0, see HealthKnowlege-UK (2020): R0 is "the average number of secondary infections produced by a typical case of an infection in a population where everyone is susceptible."

Shaman et al. showed that R0 must be understood to vary seasonally between humid-summer values of just larger than "1" and dry-winter values typically as large as "4" (for example, see their Table 2). In other words, the seasonal infectious viral respiratory diseases that plague temperate-climate regions every year go from being intrinsically mildly contagious to virulently

contagious, due simply to the bio-physical mode of transmission controlled by atmospheric absolute humidity, largely irrespective of any other consideration.

Furthermore, indoor airborne virus concentrations have been shown to exist (in day-care facilities, health centres, and onboard airplanes) primarily as aerosol particles of diameters *smaller than* 2.5 μm, such as in the work of Yang et al. (2011):

> "Half of the 16 samples were positive, and their total virus concentrations ranged from 5800 to 37 000 genome copies m^{-3}. On average, 64 per cent of the viral genome copies were associated with fine particles smaller than 2.5 μm, which can remain suspended for hours. Modelling of virus concentrations indoors suggested a source strength of $1.6 \pm 1.2 \times 10^5$ genome copies m^{-3} air h^{-1} and a deposition flux onto surfaces of 13 ± 7 genome copies m^{-2} h^{-1} by Brownian motion. Over 1 hour, the inhalation dose was estimated to be 30 ± 18 median tissue culture infectious dose ($TCID_{50}$), adequate to induce infection. These results provide quantitative support for the idea that the aerosol route could be an important mode of influenza transmission."

Such small particles (*smaller than* 2.5 μm) are part of air fluidity, are not subject to gravitational sedimentation, and can therefore be breathed deeply into the lungs.

The next question is: How many such pathogen-laden particles are needed to cause infection in a person of average immune-response capacity?

Yezli and Otter (2011), in their review of the minimal infective dose (MID), point out relevant features:

- most respiratory viruses are as infective in humans as in tissue culture having optimal laboratory susceptibility
- the 50%-probability MID ("$TCID_{50}$") has variably been found to be in the range 100−1000 virions
- there are typically 10^3–10^7 virions per aerolized influenza droplet with diameter 1 μm − 10 μm
- the 50%-probability MID easily fits into a single (one) aerolized droplet

For further background:

- A classic description of dose-response assessment is provided by Haas (1993).
- Zwart et al. (2009) provided the first laboratory proof, in a virus-insect system, that the action of a single virion can be sufficient to cause disease.
- Baccam et al. (2006) calculated from empirical data that, with influenza A in humans, "we estimate that after a delay of ~6 h, infected cells begin producing influenza virus

and continue to do so for ~5 h. The average lifetime of infected cells is ~11 h, and the half-life of free infectious virus is ~3 h. We calculated the [in-body] basic reproductive number, R_0, which indicated that a single infected cell could produce ~22 new productive infections."

- Brooke et al. (2013) showed that, contrary to prior modeling assumptions, although not all influenza-A-infected cells in the human body produce infectious progeny (virions), nonetheless, 90% of infected cell are significantly impacted, rather than simply surviving unharmed.

The above review means that all the viral respiratory diseases that seasonally plague temporal-climate populations every year are extremely contagious for two reasons: (1) they are transmitted by small aerosol particles that are part of the fluid air and fill virtually all enclosed air spaces occupied by humans, and (2) a single such aerosol particle carries the minimal infective dose (MID) sufficient to cause infection in a person, if breathed into the lungs, where the infection is initiated.

This is why the pattern of all-cause mortality is so robustly stable and distributed globally, if we admit that the majority of the burden is induced by viral respiratory diseases, while being relatively insensitive to the particular seasonal viral ecology for this operational class of viruses. This also explains why the pattern is inverted between the Northern and Southern hemispheres, irrespective of tourist and business air travel and so one.

Virologists and geneticists see viral strains, mutations, and species (Alimpiev, 2019), like a man with a hammer sees nails. Likewise, there are professional rewards for identifying new viral pathogens and describing new diseases. For these reasons, scientists have not seen the forest for the trees.

But the data shows that there is a persistent and regular pattern of winter-burden mortality that is independent of the details, and that has a well constrained distribution of year to year number of excess deaths (approximately 8% to 11% of the total yearly mortality, in the USA, 1972 through 1993). Despite all the talk of epidemics and pandemics and novel viruses, the pattern is robustly constant.

An anomaly worthy of panic, and of harmful global socio-economic engineering, would need to consist of a naturally caused yearly winter-burden mortality that is statistically greater than the norm. That has not occurred since the unique flu pandemic of 1918 (Hsieh et al., 2006).

The three recent epidemics assigned as pandemics, the H2N2 pandemic of 1957, the H3N2 pandemic of 1968, and the H1N1 pandemic of 2009, were not more virulent (in terms of yearly winter-burden mortality) than the regular seasonal epidemics (Viboud et al., 2010; Viboud et al., 2006; Viboud et al., 2005). In fact, the epidemic of 1951 was concluded to be more deadly, on the basis of P&I data, in England, Wales and Canada, than the pandemics of 1957 and 1968 (Viboud et al., 2006).

A simple model of viral respiratory disease *de facto* virulence

In the face of the persistent and regular pattern of winter-burden mortality, one is tempted to propose that the specific (structural, molecular, and binding) properties of the particular respiratory disease viral pathogen are not as determinative of mortality as virologists suggest. Instead, it is possible that mortality, in a given population exposed to these highly contagious viral pathogens that invade the lungs, is predominantly controlled by the population's distribution of immune-system capacity and preparedness.

A viral load enters the lungs. Once the viral antigen is recognized, an immune response is mounted.[1] A dynamic "war" ensues between the virus reproducing and spreading by infecting cells on the lining of the lungs, and the immune system doing everything it can to identify, locate and destroy infected cells before the said infected cells successfully can be productive of the virus.

The immune response is extraordinarily demanding of the body's metabolic energy resources (which is why you "feed a cold", "rest", and "stay warm"). The demand in metabolic energy is prioritized, and can compete with the demands of essential bodily functions and immune responses to other pathogens. This is why individuals with "aging" diseases and comorbidity conditions are particularly at risk: their rate of metabolic energy supply to the immune-system is limited by their co-conditions, and the demand is not met at a sufficiently high rate to win the "war". See: Straub (2017); Bajgar et al. (2015).

In a simple view of the infection (which I propose for illustration), a given individual, having a given state of health, can only provide metabolic energy to the immune system up to some maximum rate of supply, during the crucial stage of the "war". Call this "rate of energy supply for the immune response": RS. RS is in units of energy per unit time, J/s, or calories per second. If RS is sufficient to "win the war", and is sustained long enough, then the individual recovers from the infection, and the immune system stores a molecular memory of the viral antigen, which greatly reduces energy demand for future immune responses to attacks from the same or sufficiently similar virus. If RS is insufficient then the individual succumbs to the virus and dies.

Therefore, the seasonal virus can be characterized as having a virus-specific value of RS, RSv, which is the RS threshold for survival of the infected person. If RS > RSv, then the person recovers. If RS < RSv, then the person dies. The larger the RSv, the more virulent is the virus, and vice versa.

---

[1] See: "The immune system: Cells, tissues, function, and disease", medically reviewed by Daniel Murrell, MD on January 11, 2018 — Written by Tim Newman, at *medicalnewstoday.com*, accessed on 1 June, 2020. https://www.medicalnewstoday.com/articles/320101

A given human population (national or regional) will have a given distribution of RS values associated with the individual members of the population.

Mathematically, this distribution can be represented as a probability density of RS values. A probability-density value has units of number of persons per unit interval of RS. The total area under the probability density curve is the population, of the nation or region.

Figure 4 illustrates three hypothetical distributions of RS values, in three different populations of equal size. Here: “Germany” (solid-blue line) is for a current Western population, not having a particularly large elderly population; “Italy” (dashed-blue line) is for a current Western population having a large elderly population; and “Stressed” (solid-red line) is for a population of individuals subjected to high metabolic (or health) stress, such as might have been the case in 1918 England.

Such health stress can arise from nutritional deficiency, essential nutrient or vitamin efficiency, high levels of environmental stressor-agents, toxins, or pathogens, shelter deficiency (“fuel poverty”), oppressive working conditions, social-dominance oppression, substance abuse causing organ damage, and so on. There is a vast literature on these factors. As one anchor point, see: Sapolsky (2015); Sapolsky (2005).

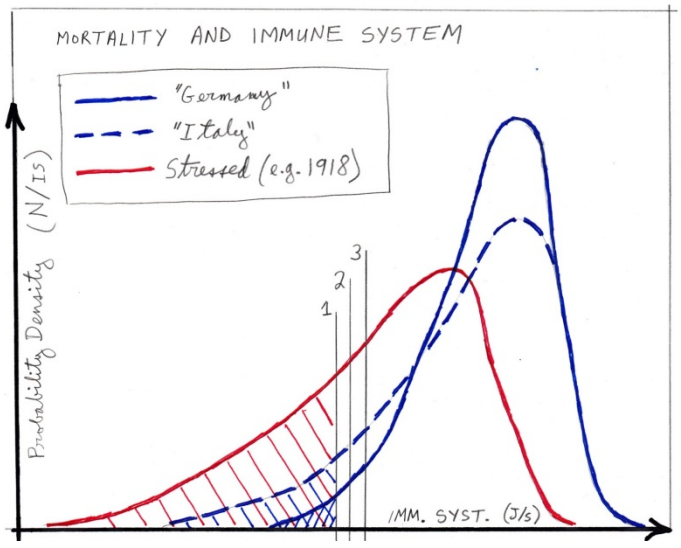


Figure 4: Probability densities of RS values, for three populations of equal size but differing in health-stress levels and health vulnerabilities, as explained in the text. The three vertical lines, drawn in pencil and labelled “1”, “2” and “3”, show three different virus-specific values of RSv, as explained in the text. The hatched areas are the fractions (of total area) representing the mortality fractions for the less virulent virus having RSv value labelled “1”.

In this model, therefore, comparative mortality between populations, for a given viral pathogen, is determined by the different health states (distributions of RS values of the individuals) of the compared infected populations.

This is for the full cycle of infection and recovery. It says little about both the death rates on a daily basis and age distributions, which depend on the natural or forced spread of the infection, which in turn is not necessarily uniform in time and space but rather can target particular segments of the population, such as people confined in institutions.

Furthermore, the distribution of RS values for a given population can change significantly during the course of an epidemic, if vulnerable segments are subjected to additional health stressors, for example.

All-cause mortality analysis of COVID-19

In light of the above background and conceptual tools, we can now examine data for COVID-19, to date. For good reason (as per above), we ignore death-attributed data and model deconvolutions of P&I deaths versus other deaths deemed to be seasonal for reasons unrelated to the seasonal viral pathogens. We concentrate on all-cause mortality, by week.

All-cause mortality is not susceptible to bias, and is currently available for several jurisdictions. We use the raw data without any manipulation, and we do not modify the data to "correct" for changes in total population, or for changes in age structure of a population.

For the data, we rely on the CDC (USA), national institute data for England and Wales, and the graphical compilations of the EuroMOMO hub. We use only the latest weeks that are reported as complete (">100%", CDC) or reported to be of sufficient quality to publish. Unfortunately, some jurisdictions such as Canada can be characterized as slow and refractory to requests.

Figure 5 shows all-cause mortality by week for England and Wales, starting in 2010. The sudden single-week drops are book-keeping and death-certification-delay inconsistencies, which are counted in the following week(s). The red vertical line indicates the date at which the WHO declared the pandemic.

In declaring the pandemic, the WHO Director-General, Tedros Adhanom, put it this way, among other things:[2]

[2] "WHO Director-General's opening remarks at the media briefing on COVID-19 - 11 March 2020", https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020

> […] In the days and weeks ahead, we expect to see the number of cases, the number of deaths, and the number of affected countries climb even higher. […] And we have called every day for countries to take urgent and aggressive action. We have rung the alarm bell loud and clear. […]
> This is not just a public health crisis, it is a crisis that will touch every sector – so every sector and every individual must be involved in the fight.
> I have said from the beginning that countries must take a whole-of-government, whole-of-society approach, built around a comprehensive strategy to prevent infections, save lives and minimize impact. […]
> I remind all countries that we are calling on you to activate and scale up your emergency response mechanisms; Communicate with your people about the risks and how they can protect themselves – this is everybody's business; Find, isolate, test and treat every case and trace every contact; Ready your hospitals;
> […] [my emphasis]

Adhanom's words either were the most remarkable public health forecast ever made for England and Wales (and many jurisdictions in the world, see below), or something else might explain the sharp peak in all-cause mortality that immediately followed his declaration.

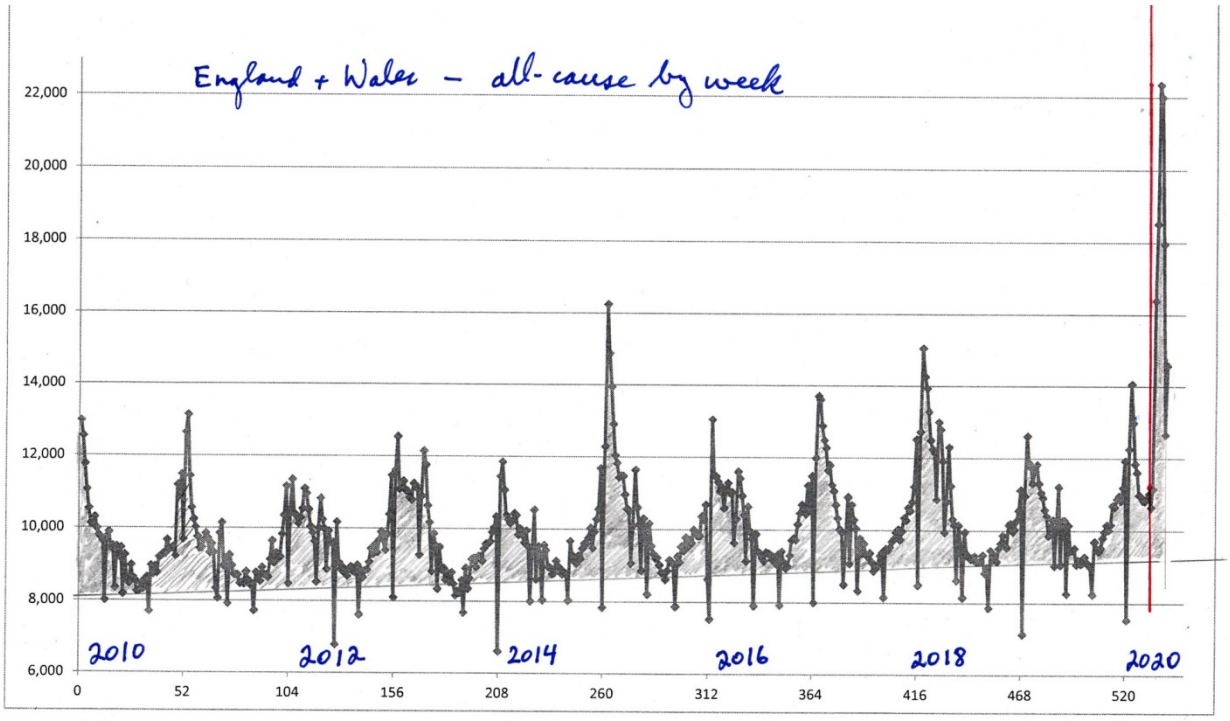


Figure 5: All-cause mortality by week for England and Wales, starting in 2010. The sudden single-week drops are book-keeping and death-certification-delay inconsistencies, which are counted in the following week(s). The red vertical line indicates the date at which the WHO declared the COVID-19 pandemic.

Importantly, the total number of winter-burden all-cause "excess" deaths for the season ending in 2020 (area above the summer baseline) is not statistically larger than for past years, and it remains to be seen how low the summer 2020 trough will be.

What can be called "the COVID peak" is a narrow feature (Figure 5). Relative to the summer baseline, the full-width at half-maximum of the peak is approximately 5 weeks. It has the distinction of being late in the infectious season, and of climbing far above the broader winter-burden hump.

This "COVID peak" is a unique event in the epidemiological history of England and Wales. Does this unique feature arise from an unusually novel viral pathogen, or does it arise from the unique, unprecedented and massive government response to the WHO declaration of a pandemic?

Note that such a "COVID peak" does not imply intrinsic virulence of the virus. It only means that the deaths of vulnerable persons, or persons made vulnerable, occurred in a short time span. For example, those who would have died in the next few or more weeks or months can have their deaths accelerated by human intervention, or those who are still recovering from a viral infection can be thrust into more precarious and stressful living conditions.

An analogous "COVID peak" occurred in the EuroMOMO hub data for Europe (Figure 6). Here again, the total number of winter-burden all-cause excess deaths for the season ending in 2020 (area above the summer baseline) is not statistically larger than for past years, and the date of declaration of the pandemic is shown by a vertical red line.

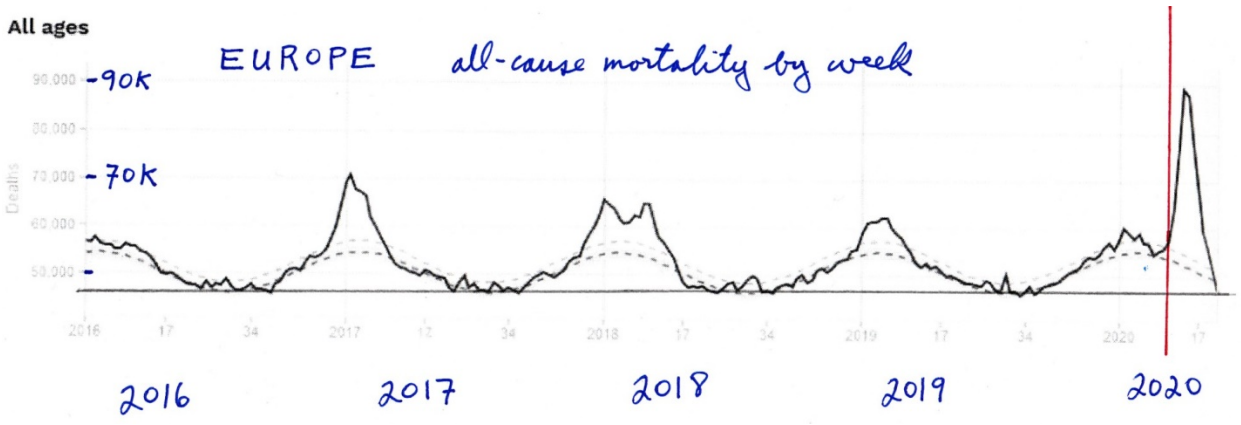


Figure 6: All-cause mortality by week EuroMOMO hub data for Europe, accessed on 1 June 2020. The date of declaration of the pandemic is shown by a vertical red line.

What looked like a concluding and "mild" 2020 season turned into a "COVID peak" immediately after the WHO declared the pandemic.

Let us next move to the USA, where both national and state-by-state current data is readily available, thanks to the CDC.

Figure 7 shows all-cause mortality by week for the USA, starting in 2014. Here the summer baseline is at approximately 46 K to 52 K deaths per week, increasing with the increase in total population. The red vertical line indicates the date at which the WHO declared the COVID-19 pandemic.

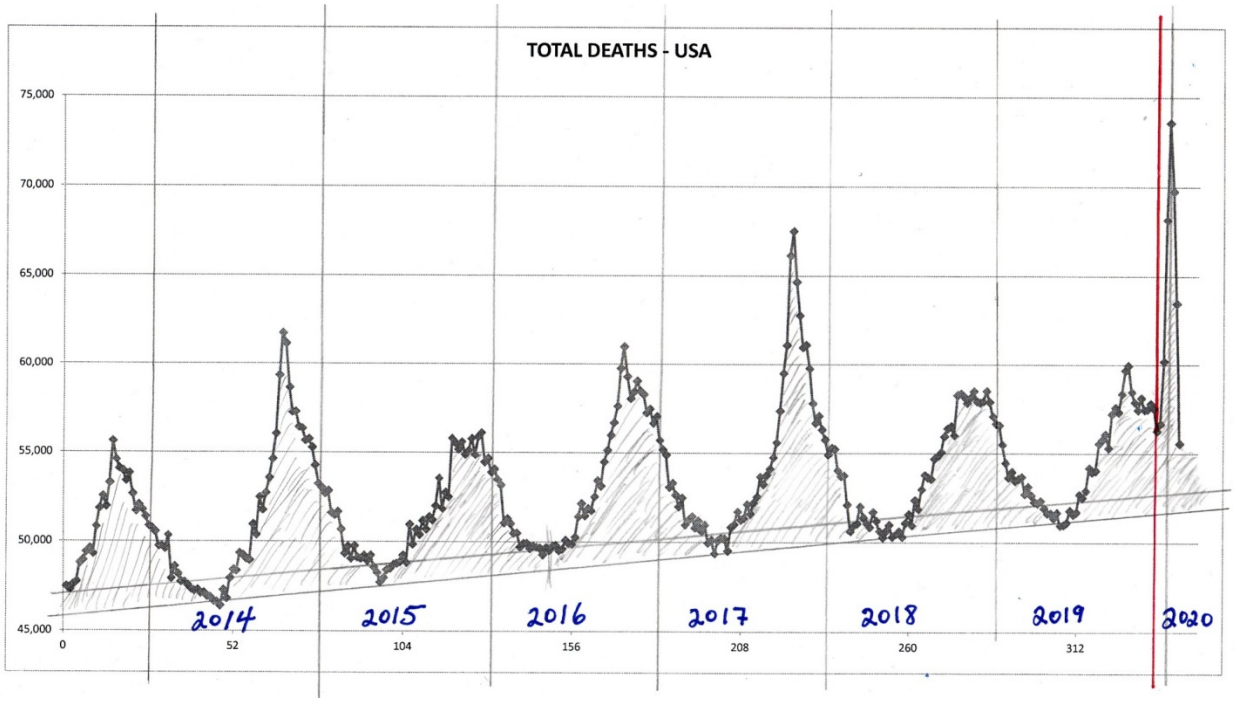


Figure 7: All-cause mortality by week for the USA, starting in 2014. The red vertical line indicates the date at which the WHO declared the COVID-19 pandemic. The hatched or gray-fill areas represent the all-cause winter-burden deaths for each year.

Here, again, we see that the total number of winter-burden all-cause deaths for the season ending in 2020 (area above the summer baseline) is not statistically larger than for past recent years. There is no evidence, purely in terms of number of seasonal deaths, to suggest any catastrophic event or exceptionally virulent pathogen. There was no “plague”. The winter burden, in these years, is consistently in the range of approximately 6% to 9% of total yearly all-cause mortality, and the year to year variations are typical of historic variations.

On the other hand, there is again a “COVID peak”, which has the following unique features:

- It is remarkably sharp or narrow, having a full-width at half-maximum of the peak, relative to the summer baseline, of approximately only 4 weeks. By comparison, the sharp peaks in the infectious seasons ending in 2015 and 2018 have such full-widths of 14 and 9 weeks, respectively.

- It occurs later in the infectious season than any other large sharp peak ever seen for the USA, surging after week-11 of 2020.

- Its surge occurs immediately after the WHO declared the pandemic, in perfect synchronicity, as seen in both Europe, and England and Wales, which are an ocean apart from the USA.

The “COVID peak” in the USA data arises from “hot spots”, such as New York City (NYC). Figure 8 shows the all-cause mortality by week for NYC, starting in 2013. The red vertical line indicates the date at which the WHO declared the COVID-19 pandemic.

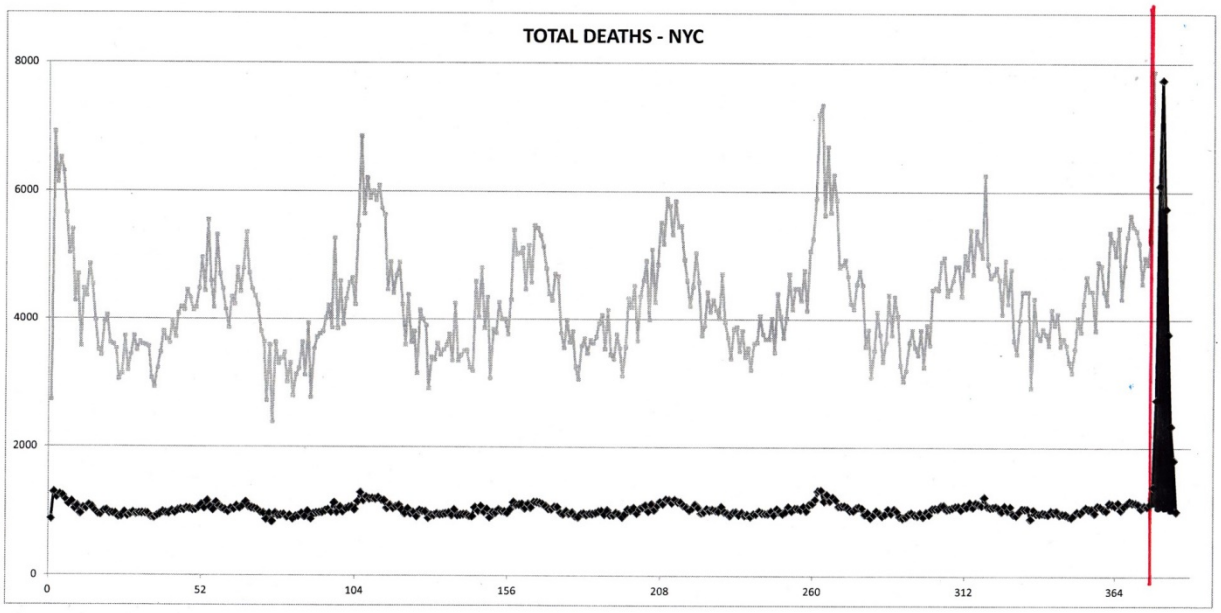


Figure 8: All-cause mortality by week for NYC, starting in 2013, in black. The red vertical line indicates the date at which the WHO declared the COVID-19 pandemic. The grey line is simply the same data on a vertically expanded and shifted scale, for visualization.

The NYC data makes no epidemiological sense whatsoever. The “COVID peak” here, on its face, cannot be interpreted as a normal viral respiratory disease process in a susceptible population. Local effects, such as importing patients from other jurisdictions or high densities of institutionalized or housed vulnerable people, must be in play, at least.

What is also striking is that some of the largest-population states in the USA, having large numbers of measured and reported cases, and large numbers of individuals with the antibodies, do not show a “COVID peak”. (Characteristic antibodies are produced and stored in the bodies of individuals who were infected and recovered following their immune responses. For example, see the antibody field study for California done by Bendavid et al., 2020).

This is shown for California in Figure 9, and for Texas in Figure 10.

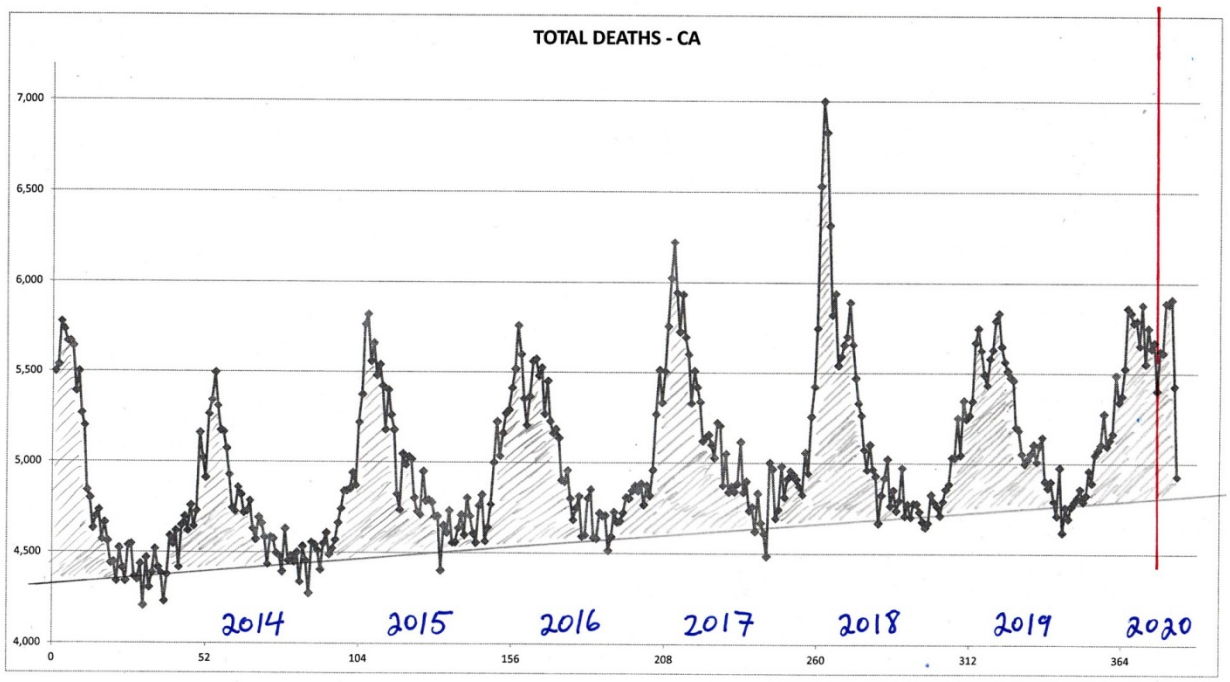


Figure 9: All-cause mortality by week for California, starting in 2013. The red vertical line indicates the date at which the WHO declared the COVID-19 pandemic. The hatched or gray-fill areas represent the all-cause winter-burden deaths for each year.

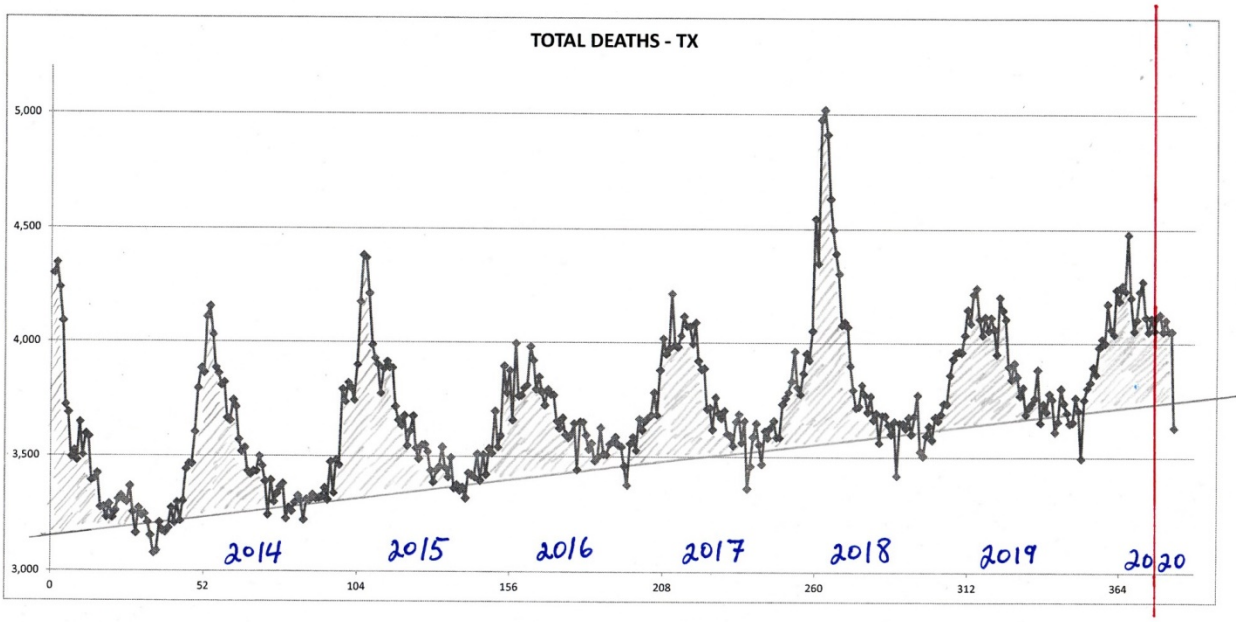
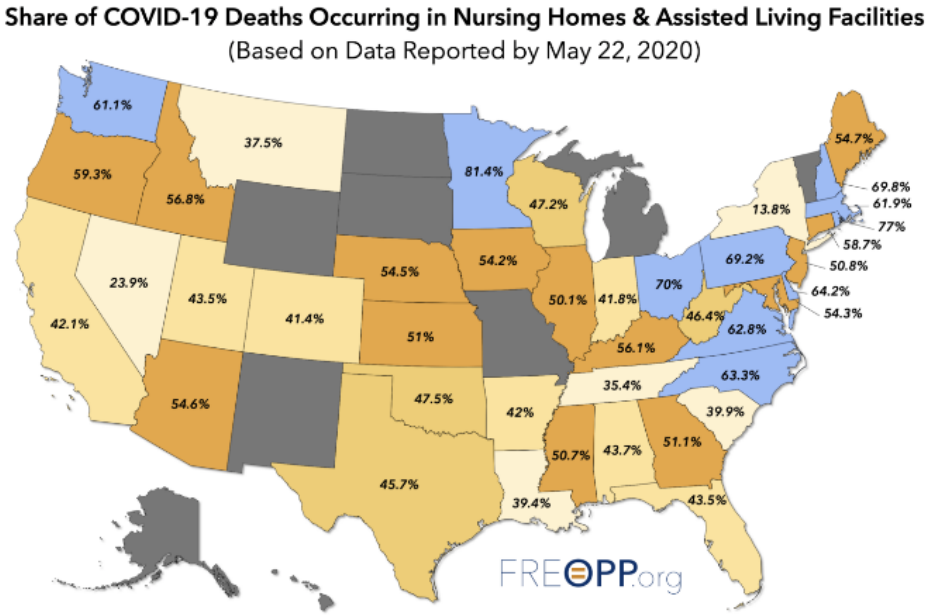


Figure 10: All-cause mortality by week for Texas, starting in 2013. The red vertical line indicates the date at which the WHO declared the COVID-19 pandemic. The hatched or gray-fill areas represent the all-cause winter-burden deaths for each year.

Also, none of the seven states that did not impose a lockdown (Iowa, Nebraska, North Dakota, South Dakota, Utah, Wyoming, and Arkansas) have a "COVID peak".

The presence of a "COVID peak" is positively correlated with the share of COVID-19-assigned deaths occurring in nursing homes and assisted living facilities, as per this map:



Interpreting the all-cause mortality "COVID peak"

Given the uniqueness of the all-cause mortality "COVID peak":

- Its sharpness, with a full-width at half-maximum of only approximately 4 weeks;
- Its lateness in the infectious-season cycle, surging after week-11 of 2020, which is unprecedented for any large sharp-peak feature;
- The synchronicity of the onset of its surge, across continents, and immediately following the WHO declaration of the pandemic; and
- Its USA state-to-state absence or presence for the same viral ecology on the same territory, being correlated with nursing home events and government actions rather than any known viral strain discernment.

Given the above review of knowledge about seasonal viral respiratory diseases:

- The robustly persistent and regular winter-burden patterns of all-cause mortality, across the modern era of epidemiology, and across nations in two hemispheres;
- The newfound (2010) understanding that transmissivity is controlled by absolute humidity, and that the transmission vector is small aerosol particles taken deeply into the lungs;
- The increasing recognition of metabolic energy budgeting as the paradigm for understanding death from infectious diseases with comorbidity conditions, while recognizing that the immune system has hierarchical control over metabolic energy budgeting, second only to cognition of external imminent danger; and
- The increasing understanding of the dominant role of metabolic stress (including stress cognition, perceived stress) in depressing immune system response capacity.

I postulate that the "COVID peak" represents an accelerated mass homicide of immune-vulnerable individuals, and individuals made more immune-vulnerable, by government and institutional actions, rather than being an epidemiological signature of a novel virus, irrespective of the degree to which the virus is novel from the perspective of viral speciation.

Finally, my interpretation of the "COVID peak" as being a signature of mass homicide by government response is supported by several institutional documents, media reports, and scientific articles, such as the following examples.

Two scientific articles are on-point:

- Hawryluck et al. (2004), on posttraumatic stress disorder (PTSD) arising from medical quarantine.

- Richardson et al. (2020), on statistical proof that mechanical ventilators killed critical COVID-19 patients.

Media articles and institutional memos include:

- "New study finds nearly all coronavirus patients put on ventilators died", *News Break* | *The Hill* 04-23, 23 April 2020.

https://www.newsbreak.com/news/0Oq9qI1z/new-study-finds-nearly-all-coronavirus-patients-put-on-ventilators-died

"New health care data suggests that almost half of all coronavirus patients placed on ventilators die, first reported by CNN. The data was gathered at Northwell Health, New York state's largest hospital system. It revealed that about 20 percent of COVID-19 patients passed away, and 88 percent of those placed on ventilators died."

- "Daughter blames 'chaos' of COVID-19 pandemic for mother's rapid decline", by Arthur White-Crummey, *Regina Leader-Post*, 29 May 2020.

https://thestarphoenix.com/news/saskatchewan/daughter-blames-chaos-of-covid-19-pandemic-for-mothers-rapid-decline/

"Sue Nimegeers's mother never had COVID-19, but she still counts her as a victim of the disease. "She never tested positive, but the chaos of the pandemic itself around us, we feel, took her from us just way too soon," Nimegeers told the board of the Saskatchewan Health Authority (SHA) on Friday."

- " 'Deeply disturbing' report into Ontario care homes released", *BBC*, 27 May 2020.

https://www.bbc.com/news/world-us-canada-52814435

"Mr Ford said a full investigation has been launched into the allegations, which included claims that facilities smelt of rotten food, infested with cockroaches and flies, and that elderly people were left for hours "crying for help with staff not responding"."

- "Nothing can justify this destruction of people's lives", Yoram Lass, former director of Israel's Health Ministry, on the hysteria around Covid-19, *sp!ked*, 22 May 2020.

https://www.spiked-online.com/2020/05/22/nothing-can-justify-this-destruction-of-peoples-lives/

"Yoram Lass: It is the first epidemic in history which is accompanied by another epidemic – the virus of the social networks. These new media have brainwashed entire populations. What you get is fear and anxiety, and an inability to look at real data. And therefore you have all the ingredients for monstrous hysteria.
It is what is known in science as positive feedback or a snowball effect. The government is afraid of its constituents. Therefore, it implements draconian measures. The constituents look at the draconian measures and become even more hysterical."

- "Cuomo downplays calls for federal probe into nursing home coronavirus deaths: 'Ask President Trump' ", by Andrew O'Reilly | *Fox News*, 20 May 2020.

https://www.foxnews.com/politics/cuomo-probe-into-nursing-home-coronavirus-deaths-ask-president-trump

"New York Gov. Andrew Cuomo on Wednesday brushed off calls for the Department of Justice to open an investigation into the massive number of deaths in the state's nursing homes during the coronavirus pandemic – claiming he was only following guidelines from the Trump administration and Centers for Disease Control and Prevention.
While no formal probe has been announced, the speculation comes amid scrutiny of his March 25 directive that required nursing homes to take on new patients infected with COVID-19."

- DATE: March 25, 2020

TO: Nursing Home Administrators, Directors of Nursing, and Hospital Discharge Planners
FROM: New York State Department of Health
Advisory: Hospital Discharges and Admissions to Nursing Homes
(Removed from:
https://coronavirus.health.ny.gov/system/files/documents/2020/03/doh_covid19-_nhadmissionsreadmissions_-032520.pdf)

"During this global health emergency, all NHs must comply with the expedited receipt of residents returning from hospitals to NHs. Residents are deemed appropriate for return to a NH upon a determination by the hospital physician or designee that the resident is medically stable for return. […]
No resident shall be denied re-admission or admission to the NH solely based on a confmned or suspected diagnosis ofCOVID-19. NHs are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or readmission."

- "Nursing Homes & Assisted Living Facilities Account for 42% of COVID-19 Deaths: A startling statistic has profound implications for the way we've managed the coronavirus pandemic", by Gregg Girvan, *FREOPP*, 7 May 2020.

https://freopp.org/the-covid-19-nursing-home-crisis-by-the-numbers-3a47433c3f70

"Based on a new analysis of state-by-state COVID-19 fatality reports, it is clear that the most underappreciated aspect of the novel coronavirus pandemic is its effect on a specific population of Americans: those living in nursing homes and assisted living facilities."

- "Guilty - Of Breathing", by Tony Heller, *Tony Heller YouTube Channel*, 24 May 2020.
https://www.youtube.com/watch?v=4sjNQ4YTUM4

  "Lockdowns were sold months ago on the idea of "flattening the curve." In most places there never was much of a curve to flatten, yet the lockdowns are still in place. Tens of millions are now having their lives destroyed - for the crime of breathing."

- "The 'massacre' of Italy's elderly nursing home residents: Covid-19 patients in Italy's virus epicentre of Lombardy were transferred to nursing homes by an official resolution with catastrophic consequences", by Maria Tavernini and Alessandro Di Rienzo, *TRT World*, 20 April 2020.
https://www.trtworld.com/magazine/the-massacre-of-italy-s-elderly-nursing-home-residents-35575

  "Hosting Covid-19 patients in nursing homes was like lighting a match in a haystack."

- "Coronavirus Update: How shoring up hospitals for COVID-19 contributed to Canada's long-term care crisis", by Jessie Willms and Hailey Montgomery, *Globe & Mail*, 20 May 2020.
https://www.theglobeandmail.com/canada/article-coronavirus-update-how-shoring-up-hospitals-for-covid-19-contributed/

  "Most of the nursing- and retirement-home residents who have succumbed to COVID-19 in Canada died inside the virus-stricken, understaffed facilities as hospital beds sat empty."

- "There Is No Evidence Lockdowns Saved Lives. It Is Indisputable They Caused Great Harm", by Briggs, *wmbriggs.com*, 14 May 2020.
https://wmbriggs.com/post/30833/

  "In the end, it does not come down to country- or even city-level statistics. It comes down to people. Each individual catches the bug or not, lives or dies. Not because of their country, but because of themselves, their health, their circumstances. Any given individual might have benefited from self-quarantine and loss of job. Just as any given individual might have come to a bad end from a lockdown."

- "Hospitals get paid more to list patients as COVID-19", by Tom Kertscher, *POLITIFACT*, 21 April 2020.
https://www.politifact.com/factchecks/2020/apr/21/facebook-posts/Fact-check-Hospitals-COVID-19-payments/

  "It's standard for Medicare to pay a hospital roughly three times as much for a patient who goes on a ventilator, as for one who doesn't. Medicare is paying a 20% add-on to its regular hospital payments for the treatment of COVID-19 victims. That's a result of a federal stimulus law."

- "CDC: 80,000 people died of flu last winter in U.S., highest death toll in 40 years", by Associated Press, *STAT News*, 26 September 2018.

https://www.statnews.com/2018/09/26/cdc-us-flu-deaths-winter/

"An estimated 80,000 Americans died of flu and its complications last winter — the disease's highest death toll in at least four decades. The director of the Centers for Disease Control and Prevention, Dr. Robert Redfield, revealed the total in an interview Tuesday night with The Associated Press."

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Tab 10

26 Pages

12 April 2021

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Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths
Reference 1: My Letter to You of 21 July 2020
Reference 2: My Letter to You of 21 December 2020
Reference 3: My Letter to the Presidents of the Ivy League of 6 March 2021

The Fauci / COVID-19 Dossier by Dr. David E. Martin

26 Pages (abridged)

The complete 205 page document available here:

http://pvsheridan.com/The_Fauci_COVID-19_Dossier.pdf

The Fauci/COVID-19 Dossier

This document is prepared for humanity by Dr. David E. Martin.

The Fauci/COVID-19 Dossier

This document is prepared for humanity by Dr. David E. Martin.

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Background:

Over the past two decades, my company – M·CAM – has been monitoring possible violations of the 1925 Protocol for the Prohibition of the Use in War of Asphyxiating, Poisonous, or other Gases, and of Bacteriological Methods of Warfare (the Geneva Protocol) 1972 Convention on the Prohibition of the Development, Production, and Stockpiling of Bacteriological and Toxin Weapons and Their Destruction (the BTWC). In our 2003-2004 ***Global Technology Assessment: Vector Weaponization*** M·CAM highlighted China's growing involvement in Polymerase Chain Reaction (PCR) technology with respect to joining the world stage in chimeric construction of viral vectors. Since that time, on a weekly basis, we have monitored the development of research and commercial efforts in this field, including, but not limited to, the research synergies forming between the United States Centers for Disease Control and Prevention (CDC), the National Institutes for Allergies and Infectious Diseases (NIAID), the University of North Carolina at Chapel Hill (UNC), Harvard University, Emory University, Vanderbilt University, Tsinghua University, University of Pennsylvania, many other research institutions, and their commercial affiliations.

The National Institute of Health's grant AI23946-08 issued to Dr. Ralph Baric at the University of North Carolina at Chapel Hill (officially classified as affiliated with Dr. Anthony Fauci's NIAID by at least 2003) began the work on synthetically altering the *Coronaviridae* (the coronavirus family) for the express purpose of general research, pathogenic enhancement, detection, manipulation, and potential therapeutic interventions targeting the same. As early as May 21, 2000, Dr. Baric and UNC sought to patent critical sections of the coronavirus family for their commercial benefit.[1] In one of the several papers derived from work sponsored by this grant, Dr. Baric published what he reported to be the full length cDNA of SARS CoV in which it was clearly stated that SAR CoV was based on a composite of DNA segments.

> *"Using a panel of contiguous cDNAs that span the entire genome, we have assembled a full-length cDNA of the SARS-CoV Urbani strain, and have rescued molecularly cloned SARS viruses (infectious clone SARS-CoV) that contained the expected marker mutations inserted into the component clones."*[2]

On April 19, 2002 – the Spring before the first SARS outbreak in Asia – Christopher M. Curtis, Boyd Yount, and Ralph Baric filed an application for U.S. Patent 7,279,372 for a method of producing recombinant coronavirus. In the first public record of the claims, they sought to patent a means of producing, "an infectious, replication defective, coronavirus." This work was supported by the NIH grant referenced above and GM63228. In short, the U.S. Department of Health and Human Services was involved in the funding of amplifying the infectious nature of coronavirus between 1999 and 2002 ***before SARS*** was ever detected in humans.

[1] U.S. Provisional Application No. 60/206,537, filed May 21, 2000

[2] https://www.pnas.org/content/100/22/12995

Against this backdrop, we noted the unusual patent prosecution efforts of the CDC, when on April 25, 2003 they sought to patent the SARS coronavirus isolated from humans that had reportedly transferred to humans during the 2002-2003 SARS outbreak in Asia. 35 U.S.C. §101 prohibits patenting nature. This legality did not deter CDC in their efforts. Their application, updated in 2007, ultimately issued as U.S. Patent 7,220,852 and constrained anyone not licensed by their patent from manipulating SARS CoV, developing tests or kits to measure SARS coronavirus in humans or working with their patented virus for therapeutic use. Work associated with this virus by their select collaborators included considerable amounts of chimeric engineering, gain-of-function studies, viral characterization, detection, treatment (both vaccine and therapeutic intervention), and weaponization inquiries.

In short, with Baric's U.S. Patent 6,593,111 (Claims 1 and 5) and CDC's '852 patent (Claim 1), no research in the United States could be conducted without permission or infringement.

We noted that gain-of-function specialist, Dr. Ralph Baric, was both the recipient of millions of dollars of U.S. research grants from several federal agencies but also sat on the World Health Organization's International Committee on Taxonomy of Viruses (ICTV) and the *Coronaviridae* Study Group (CSG). In this capacity, he was both responsible for determining "novelty" of clades of virus species but directly benefitted from determining declarations of novelty in the form of new research funding authorizations and associated patenting and commercial collaboration. Together with CDC, NIAID, WHO, academic and commercial parties (including Johnson & Johnson; Sanofi and their several coronavirus patent holding biotech companies; Moderna; Ridgeback; Gilead; Sherlock Biosciences; and, others), a powerful group of interests constituted what we would suggest are "interlocking directorates" under U.S. anti-trust laws.

These entities also were affiliated with the WHO's Global Preparedness Monitoring Board (GPMB) whose members were instrumental in the Open Philanthropy-funded global coronavirus pandemic "desk-top" exercise EVENT 201 in October 2019. This event, funded by the principal investor in Sherlock Biosciences and linking interlocking funding partner, the Bill and Melinda Gates Foundation into the GPMB mandate for a respiratory disease global preparedness exercise to be completed by September 2020 alerted us to anticipate an "epidemic" scenario. We expected to see such a scenario emerge from Wuhan or Guangdong China, northern Italy, Seattle, New York or a combination thereof, as Dr. Zhengli Shi and Dr. Baric's work on zoonotic transmission of coronavirus identified overlapping mutations in coronavirus in bat populations located in these areas.

This dossier is by no means exhaustive. It is, however, indicative the numerous criminal violations that may be associated with the COVID-19 terrorism. All source materials are referenced herein. An additional detailed breakdown of all the of individuals, research institutions, foundations, funding sources, and commercial enterprises can be accessed upon request.

Contents

35 U.S.C. § 101

From Justice Clarence Thomas' opinion for the majority

Section 101 of the Patent Act provides: "Whoever invents or discovers any new and useful ... composition of matter, or any new and useful improvement thereof, may obtain a patent therefor, subject to the conditions and requirements of this title." 35 U.S.C. § 101.

We have "long held that this provision contains an important implicit exception[:] Laws of nature, natural phenomena, and abstract ideas are not patentable." Mayo, 566 U.S., at ___, 132 S.Ct., at 1293 (internal quotation marks and brackets omitted). Rather, "`they are the basic tools of scientific and technological work'" that lie beyond the domain of patent protection. Id., at ___, 132 S.Ct., at 1293. As the Court has explained, without this exception, there would be considerable danger that the grant of patents would "tie up" the use of such tools and thereby "inhibit future innovation premised upon them." Id., at ___, 132 S.Ct., at 1301. This would be at odds with the very point of patents, which exist to promote creation. Diamond v. Chakrabarty, 447 U.S. 303, 309, 100 S.Ct. 2204, 65 L.Ed.2d 144 (1980) (Products of nature are not created, and "`manifestations... of nature [are] free to all men and reserved exclusively to none'").[3]

In their majority opinion in 2013, the U.S. Supreme Court made it abundantly clear that the Court had "long held" that nature was not patentable. Merely isolating DNA does not constitute patentable subject matter. In their patent, the CDC made false and misleading claims to the United States Patent & Trademark Office by stating that, "A newly isolated human coronavirus has been identified as the causative agent of SARS, and is termed SARS-CoV."[4] No "causal" data was provided for this statement.

When they filed their patent application on April 25, 2003 their first claim (and the only one that survived to ultimate issuance over the objection of the patent examiner in 2006 and 2007) was the genome for SARS CoV.

While this patent is clearly illegal under 35 U.S.C. §101, not only did the CDC insist on its granting over non-final and final rejections, but they also continued to pay maintenance fees on the patent after the 2013 Supreme Court decision confirmed that it was illegal.

In addition, the CDC patented the detection of SARS CoV using a number of methods including reverse transcription polymerase chain reaction (RT-PCR). With this patent, they precluded anyone outside of their licensed or conspiring interest from legally engaging in independent verification of their claim that they had isolated a virus, that it was a causative agent for SARS, or that any therapy could be effective against the reported pathogen.

It is important to note that the CDC's patent applications were also rejected in non-final and final rejections for ineligibility under 35 U.S.C. § 102 for being publicly disclosed prior to their own filing. In the first non-final rejection, the USPTO stated that the CDC's genome was published in four Genbank accession entries on April 14, 18, and 21, 2003 with identity ranging from 96.8% to 99.9% identical sequences.[5] Dr. Fauci knew, and failed to disclose evidence that the CDC patent was illegal, based on work he had funded in the years leading up to the SARS outbreak.

After seeking an illegal patent, petitioning to override the decision of an examiner to reject it, and ultimately prevailing with the patent's grant, the CDC lied to the public by stating they were controlling the patent so that it would be "publicly available".[6] Tragically, this public statement is falsified by the simple fact that their own publication in

[3] ***Association for Molecular Pathology v. Myriad Genetics, Inc.***, 569 U.S. 576 (2013)
[4] U.S. Patent 7,220,852
[5] USPTO Non-Final Rejection File #10822904, September 7, 2006, page 4.
[6] https://apnews.com/article/145b4e8d156cddc93e996ae52dc24ec0

Genbank had, in fact, made it public domain and thereby unpatentable. This fact, confirmed by patent examiners, was overridden by CDC in a paid solicitation to override the law.

While not covered under 35 U.S.C. §101, Dr. Fauci's abuse of the patent law is detailed below. Of note, however, is his willful and deceptive use of the term "vaccine" in patents and public pronouncements to pervert the meaning of the term for the manipulation of the public.

In the 1905 Jacobson v. Mass case, the court was clear that a PUBLIC BENEFIT was required for a vaccine to be mandated. Neither Pfizer nor Moderna have proved a disruption of transmission. In Jacobson v. Massachusetts, 197 U.S. 11 (1905), the court held that the context for their opinion rested on the following principle:

"This court has more than once recognized it as a fundamental principle that 'persons and property are subjected to all kinds of restraints and burdens in order to secure the general comfort, health, and prosperity of the state…"

The Moderna and Pfizer "alleged vaccine" trials have explicitly acknowledged that their gene therapy technology has no impact on viral infection or transmission whatsoever and merely conveys to the recipient the capacity to produce an S1 spike protein endogenously by the introduction of a synthetic mRNA sequence. Therefore, the basis for the Massachusetts statute and the Supreme Court's determination is moot in this case.
Further, the USPTO, in its REJECTION of Anthony Fauci's HIV vaccine made the following statement supporting their rejection of his bogus "invention"

Application/Control Number: 09/869,003 Page 5
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These arguments are persuasive to the extent that an antigenic peptide stimulates an immune response that may produce antibodies that bind to a specific peptide or protein but is not persuasive in regards to a vaccine. The immune response produced by a vaccine must be more than merely some immune response but must be protective. As noted in the previous Office Action, the art recognizes the term "vaccine" to be a compound which prevents infection. Applicant has not demonstrated that the instantly claimed vaccine meets even the lower standard set forth in the specification, let alone the standard art definition, for being operative in this regards. Therefore, claims 5, 7, and 9 are not operative as an anti-HIV-1 vaccine and therefore lack patentable utility.

18 U.S.C. §2339 C *et seq*. – Funding and Conspiring to Commit Acts of Terror

Indirectly, unlawfully and willfully provides or collects funds with the intention that such funds be used, or with the knowledge that such funds are to be used, in full or in part, in order to carry out—

> **(A) an act which constitutes an offense within the scope of a treaty specified in subsection (e)(7), as implemented by the United States, or**
>
> **(B) any other act intended to cause death or serious bodily injury to a civilian, or to any other person not taking an active part in the hostilities in a situation of armed conflict, when the purpose of such act, by its nature or context, is to intimidate a population, or to compel a government or an international organization to do or to abstain from doing any act….**

By no later than April 11, 2005, Dr. Anthony Fauci was publicly acknowledging the association of SARS with bioterror potential. Leveraging the fear of the anthrax bioterrorism of 2001, he publicly celebrated the economic boon that domestic terror had directed towards his budget. He specifically stated that NIAID was actively funding research on a "SARS Chip" DNA microarray to rapidly detect SARS (something that was not made available during the current "pandemic") and two candidate vaccines focused on the SARS CoV spike protein.[7] Led by three Chinese researchers under his employment – Zhi-yong Yang, Wing-pui Kong, and Yue Huang – Fauci had at least one DNA vaccine in animal trials by 2004.[8] This team, part of the Vaccine Research Center at NIAID, was primarily focused on HIV vaccine development but was tasked to identify SARS vaccine candidates as well. Working in collaboration with Sanofi, Scripps Institute, Harvard, MIT and NIH, Dr. Fauci's decision to unilaterally promote vaccines as a primary intervention for several designated "infectious diseases" precluded ***proven therapies*** from being applied to the sick and dying.[9]

The CDC and NIAID led by Anthony Fauci entered into trade among States (including, but not limited to working with EcoHealth Alliance Inc.) and with foreign nations (specifically, the Wuhan Institute of Virology and the Chinese Academy of Sciences) through the 2014 *et seq* National Institutes of Health Grant R01AI110964 to exploit their patent rights. This research was known to involve surface proteins in coronavirus that had the capacity to directly infect human respiratory systems. In flagrant violation of the NIH moratorium on gain of function research, NIAID and Ralph Baric persisted in working with chimeric coronavirus components specifically to amplify the pathogenicity of the biologic material.

By October 2013, the Wuhan Institute of Virology 1 coronavirus S1 spike protein was described in NIAID's funded work in China. This work involved NIAID, USAID, and Peter Daszak, the head of EcoHealth Alliance. This work, funded under R01AI079231, was pivotal in isolating and manipulating viral fragments selected from sites across China which contained high risk for severe human response.[10]

By March 2015, both the virulence of the S1 spike protein and the ACE II receptor was known to present a considerable risk to human health. NIAID, EcoHealth Alliance and numerous researchers lamented the fact that the public was not sufficiently concerned about coronavirus to adequately fund their desired research.[11]

Dr. Peter Daszak of EcoHealth Alliance offered the following assessment:

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[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3320336/

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7095382/

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1232869/

[10] Ge, XY., Li, JL., Yang, XL. *et al.* Isolation and characterization of a bat SARS-like coronavirus that uses the ACE2 receptor. *Nature* **503,** 535–538 (2013).

[11] Forum on Medical and Public Health Preparedness for Catastrophic Events; Forum on Drug Discovery, Development, and Translation; Forum on Microbial Threats; Board on Health Sciences Policy; Board on Global Health; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine. Rapid Medical Countermeasure Response to Infectious Diseases: Enabling Sustainable Capabilities Through Ongoing Public- and Private-Sector Partnerships: Workshop Summary. Washington (DC): National Academies Press (US); 2016 Feb 12. 6, Developing MCMs for Coronaviruses. Available from: https://www.ncbi.nlm.nih.gov/books/NBK349040/

"*Daszak reiterated that, until an infectious disease crisis is very real, present, and at an emergency threshold, it is often largely ignored. To sustain the funding base beyond the crisis, he said, we need to increase public understanding of the need for MCMs such as a pan-influenza or pan-coronavirus vaccine. A key driver is the media, and the economics follow the hype. We need to use that hype to our advantage to get to the real issues. Investors will respond if they see profit at the end of process, Daszak stated*."[12]

Economics will follow the hype.

The CDC and NIAID entered into trade among States (including, but not limited to working with University of North Carolina, Chapel Hill) and with foreign nations (specifically, the Wuhan Institute of Virology and the Chinese Academy of Sciences represented by Zheng-Li Shi) through U19AI109761 (Ralph S. Baric), U19AI107810 (Ralph S. Baric), and National Natural Science Foundation of China Award 81290341 (Zheng-Li Shi) et al. 2015-2016. These projects took place during a time when the work being performed was prohibited by the United States National Institutes of Health.

The public was clearly advised of the dangers being presented by NIAID-funded research by 2015 and 2016 when the Wuhan Institute of Virology material was being manipulated at UNC in Ralph Baric's lab.

"The only impact of this work is the creation, in a lab, of a new, non-natural risk," agrees Richard Ebright, a molecular biologist and biodefence expert at Rutgers University in Piscataway, New Jersey. Both Ebright and Wain-Hobson are long-standing critics of gain-of-function research.

In their paper, the study authors also concede that funders may think twice about allowing such experiments in the future. "Scientific review panels may deem similar studies building chimeric viruses based on circulating strains too risky to pursue," they write, adding that discussion is needed as to "whether these types of chimeric virus studies warrant further investigation versus the inherent risks involved".

But Baric and others say the research did have benefits. The study findings "move this virus from a candidate emerging pathogen to a clear and present danger", says Peter Daszak, who co-authored the 2013 paper. Daszak is president of the EcoHealth Alliance, an international network of scientists, headquartered in New York City, that samples viruses from animals and people in emerging-diseases hotspots across the globe.

Studies testing hybrid viruses in human cell culture and animal models are limited in what they can say about the threat posed by a wild virus, Daszak agrees. But he argues that they can help indicate which pathogens should be prioritized for further research attention."[13]

Knowing that the U.S. Department of Health and Human Services (through CDC, NIH, NIAID, and their funded laboratories and commercial partners) had patents on each proposed element of medical counter measures and their funding, Dr. Fauci, Dr. Gao (China CDC), and Dr. Elias (Bill and Melinda Gates Foundation) conspired to commit acts of terror on the global population – including the citizens of the United States – when, in September 2019, they published the following mandate:

"Countries, donors and multilateral institutions must be prepared for the worst. A rapidly spreading pandemic due to a lethal respiratory pathogen (whether naturally emergent or accidentally or deliberately released) poses additional preparedness requirements. Donors and multilateral institutions must ensure adequate investment in developing innovative vaccines and therapeutics, surge manufacturing capacity, broad-spectrum antivirals and appropriate non-pharmaceutical interventions. All countries must develop a system for immediately sharing genome sequences of any

[12] *Ibid.*

[13] https://www.nature.com/news/engineered-bat-virus-stirs-debate-over-risky-research-%201.18787

new pathogen for public health purposes along with the means to share limited medical countermeasures across countries.

Progress indicator(s) by September 2020

> *• Donors and countries commit and identify timelines for: financing and development of a universal influenza vaccine, broad spectrum antivirals, and targeted therapeutics. WHO and its Member States develop options for standard procedures and timelines for sharing of sequence data, specimens, and medical countermeasures for pathogens other than influenza.*
>
> *• Donors, countries and multilateral institutions develop a multi-year plan and approach for strengthening R&D research capacity, in advance of and during an epidemic.*
>
> *• WHO, the United Nations Children's Fund, the International Federation of Red Cross and Red Crescent Societies, academic and other partners identify strategies for increasing capacity and integration of social science approaches and researchers across the entire preparedness/response continuum."*[14]

As if to confirm the utility of the September 2019 demand for "financing and development of" vaccine and the fortuitous SARS CoV-2 alleged outbreak in December of 2019, Dr. Fauci began gloating that his fortunes for additional funding were likely changing for the better. In a February 2020 interview in ***STAT***, he was quoted as follows:

""*The emergence of the new virus is going to change that figure, likely considerably, Fauci said. "I don't know how much it's going to be. But I think it's going to generate more sustained interest in coronaviruses because it's very clear that coronaviruses can do really interesting things*.""[15]

[14] https://apps.who.int/gpmb/assets/annual_report/GPMB_annualreport_2019.pdf (page 8)

[15] https://www.statnews.com/2020/02/10/fluctuating-funding-and-flagging-interest-hurt-coronavirus-research/

18 U.S.C. § 2331 §§ 802 – Acts of Domestic Terrorism resulting in death of American Citizens

Section 802 of the USA PATRIOT Act (Pub. L. No. 107-52) expanded the definition of terrorism to cover "domestic," as opposed to international, terrorism. A person engages in domestic terrorism if they do an act "dangerous to human life" that is a violation of the criminal laws of a state or the United States, if the act appears to be intended to: (i) intimidate or coerce a civilian population; (ii) influence the policy of a government by intimidation or coercion;

Dr. Anthony Fauci has intimidated and coerced a civilian population and sought to influence the policy of a government by intimidation and coercion.

With no corroboration, Dr. Anthony Fauci promoted[16] Professor Neil Ferguson's computer simulation derived claims that,

"The world is facing the most serious public health crisis in generations. Here we provide concrete estimates of the scale of the threat countries now face.

"We use the latest estimates of severity to show that policy strategies which aim to mitigate the epidemic might halve deaths and reduce peak healthcare demand by two-thirds, but that this will not be enough to prevent health systems being overwhelmed. More intensive, and socially disruptive interventions will therefore be required to suppress transmission to low levels. It is likely such measures – most notably, large scale social distancing – will need to be in place for many months, perhaps until a vaccine becomes available." [17]

Reporting to the President that as many as 2.2 million deaths may result from a pathogen that had not yet been isolated and could not be measured with any accuracy, Dr. Fauci intimidated and coerced the population and the government into reckless, untested, and harmful acts creating irreparable harm to lives and livelihoods.[18] Neither the Imperial College nor the "independent" Institute for Health Metrics and Evaluation (principally funded by the Bill and Melinda Gates Foundation)[19] had any evidence of success in estimating previous burdens from coronavirus but, without consultation or peer-review, Dr. Fauci adopted their terrifying estimates as the basis for interventions that are explicitly against medical advice.

- The imposition of social distancing was based on computer simulation and environmental models with NO disease transmission evidence whatsoever.
- The imposition of face mask wearing was directly against controlled clinical trial evidence and against the written policy in the Journal of the American Medical Association.

  > *"Face masks should not be worn by healthy individuals to protect themselves from acquiring respiratory infection because there is no evidence to suggest that face masks worn by healthy individuals are effective in preventing people from becoming ill."*[20]

- In both the Imperial College and the IHME simulations, ***quarantines were modeled for the sick, not the healthy.***

[16] https://www.cato.org/blog/did-mitigation-save-two-million-lives
[17] https://www.imperial.ac.uk/news/196234/covid-19-imperial-researchers-model-likely-impact/
[18] https://www.npr.org/2020/03/31/823916343/coronavirus-task-force-set-to-detail-the-data-that-led-to-extension-of-guideline
[19] https://www.gatesfoundation.org/Media-Center/Press-Releases/2017/01/IHME-Announcement
[20] https://jamanetwork.com/journals/jama/fullarticle/2762694?fbclid=IwAR2RE-c4V-fhUodui0JQRbiHRcgEJuDKG_21N4oL5zAfciQfWCyHAsetJmo

Insisting on vaccines while blockading the emergency use of proven pharmaceutical interventions may have contributed to the death of many patients and otherwise healthy individuals.[21]

Using the power of NIAID during the alleged pandemic, Dr. Anthony Fauci actively suppressed proven medical countermeasures used by, and validated in scientific proceedings, that offered alternatives to the products funded by his conspiring entities for which he had provided direct funding and for whom he would receive tangible and intangible benefit.

[21] https://www.reuters.com/investigates/special-report/health-coronavirus-usa-cost/

18 U.S.C. § 1001 – Lying to Congress

(a)Except as otherwise provided in this section, whoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully—

(1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact;

(2) makes any materially false, fictitious, or fraudulent statement or representation; or

(3) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry;

shall be fined under this title, imprisoned not more than 5 years or, if the offense involves international or domestic terrorism (as defined in section 2331), imprisoned not more than 8 years, or both. If the matter relates to an offense under chapter 109A, 109B, 110, or 117, or section 1591, then the term of imprisonment imposed under this section shall be not more than 8 years.

On October 22, 2020, the United States Government Accountability Office (GAO) published a report entitled: ***BIOMEDICAL RESEARCH: NIH Should Publicly Report More Information about the Licensing of Its Intellectual Property***. In this document, the authors reported that the National Institutes of Health (NIH) received, "up to $2 billion in royalties from its contributions to 34 drugs sold from 1991-2019."[22]

A casual review of the NIH Office of Technology Transfer report of active licenses[23] appears to conflict with the GAO report on several important facts. Conspicuously absent from the GAO report are over 30 patents associated with active compounds generating billions of dollars in revenue. Why would it be that the GAO and the NIH couldn't agree on something as simple as drugs generating income for NIH?

Since the passage of the Bayh Dole Act (Pub. L. 96-517, December 12, 1980), federally funded research has been an economic bonanza for U.S. universities, federal agencies, and their selected patronage. For the first decade following Bayh Dole, NIH funding doubled from $3.4 billion to $7.1 billion. A decade later, it doubled again to $15.6 billion. In the wake of September 2001, the National Institute for Allergy and Infectious Diseases (NIAID) saw its direct budget increase over 300% without accounting for DARPA funds of as much as $1.7 billion annually from 2005 forward. In 2020, NIH's budget was over $41 billion.

What has become of the $763 billion of taxpayer funds allocated to making America healthier since inventors have been commercially incentivized? Who has been enriched?

The answer, regrettably, is that no accountability exists to answer these questions.

The NIH is the named owner of at least 138 patents since 1980.

The United States Department of Health and Human Services is the named owner of at least 2,600 patents.

NIAID grants or collaboration have resulted in 2,655 patents and patent applications of which only 95 include an assignment to the Department of Health and Human Services as an owner. Most of these patents are assigned to universities thereby making the ultimate commercial beneficiaries entirely opaque. One of the largest holders is SIGA Technologies (NASDAQ: SIGA) who, while publicly reporting close affiliation with NIAID, is not referenced in the NIH GAO report. SIGA's CEO, Dr. Phillip L. Gomez spent 9 years at NIAID developing its vaccine program for HIV, SARS, Ebola, West Nile Virus, and Influenza before exiting to commercial ventures. While their technology is clearly derived from NIAID science, the company reports revenue from NIAID but no royalty or commercial payments to NIH or any of its programs.

[22] https://www.gao.gov/products/GAO-21-52

[23] https://www.ott.nih.gov/reportsstats/hhs-license-based-vaccines-therapeutics

NIAID's Director, Dr. Anthony Fauci is listed as an inventor on 8 granted U.S. patents. None of them are reported in NIAID, NIH, or GAO reports of active licensing despite the fact that Dr. Fauci reportedly was compelled to get paid for his interleukin-2 "invention" – payments he reportedly donated to an unnamed charity.[24]

Of the 21 patents listed in the U.S. Food and Drug Administration's (FDA) Orange book itemized in the GAO report, none of Dr. Anthony Fauci's patents are listed. Furthermore, none of the NIAID patents are listed despite clear evidence that Gilead Sciences and Janssen Pharmaceuticals (a division of Johnson & Johnson) have generated over $2 billion annually from sales that were the direct result of NIAID funded science. Missing from the GAO report are 2 patents for Velclade® which has been generating sales in excess of $2.18 billion annually for several years. None of the patents for Yescarta® are listed in the GAO report. None of the Lumoxiti® patents are listed in the GAO report. None of the Kepivance® patents are listed in the GAO report. In violation of 37 USC §410.10 and 35 USC §202(a), over 13 of the 21 patents in the GAO report fail to disclose government interest despite being the direct result of NIH funding.

Dr. Anthony Fauci's Own Patent Track Record:

US Patent 6,190,656 and 6,548,055 **Immunologic enhancement with intermittent interleukin-2 therapy**

A method for activating a mammalian immune system entails a series of IL-2 administrations that are effected intermittently over an extended period. Each administration of IL-2 is sufficient to allow spontaneous DNA synthesis in peripheral blood or lymph node cells of the patient to increase and peak, and each subsequent administration follows the preceding administration in the series by a period of time that is sufficient to allow IL-2 receptor expression in peripheral or lymph node blood of the patient to increase, peak and then decrease to 50% of peak value. This intermittent IL-2 therapy can be combined with another therapy which targets a specific disease state, such as an anti-retroviral therapy comprising, for example, the administration of AZT, ddI or interferon alpha. In addition, IL-2 administration can be employed to facilitate in situ transduction of T cells in the context of gene therapy. By this approach the cells are first activated in vivo via the aforementioned IL-2 therapy, and transduction then is effected by delivering a genetically engineered retroviral vector directly to the patient.

This application is a continuation of U.S. patent application Ser. No. 08/487,075, filed Jun. 7, 1995, now abandoned, which is a continuation in part of U.S. patent application Ser. No. 08/063,315, filed May 19, 1993, now issued as U.S. Pat. No. 5,419,900, and U.S. patent application Ser. No. 08/452,440, filed May 26, 1995, now issued as U.S. Pat. No. 5,696,079, which is the National Stage filed under 35 USC 371 of PCT/US94/05397, filed May 19, 1994, the contents of which are incorporated herein by reference.

Filed May 19, 1993

Issued a Final Rejection January 20, 1998. Rejected after abandonment August 14, 1998 and April 12, 1999. Reduced and modified claims granted May 8, 2000.

*This family of patents was the basis of Fauci's lie to the **British Medical Journal** in which he falsely stated:*

"Dr Anthony Fauci told the BMJ that as a government employee he was required by law to put his name on the patent for the development of interleukin 2 and was also required by law to receive part of the payment the government received for use of the patent. He said that he felt it was inappropiate (sic) to receive payment and donated the entire amount to charity."[25]

He was not "required by law" to commit fraud on the patent office and then get paid for it!

[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC545012/
[25] *Ibid.*

US Patent 6,911,527 **HIV related peptides**

This invention is the discovery of novel specific epitopes and antibodies associated with long term survival of HIV-1 infections. These epitopes and antibodies have use in preparing vaccines for preventing HIV-1 infection or for controlling progression to AIDS.

Filed May 6, 1999

Rejected as unpatentable January 22, 2003. Issued with a final rejection on July 15, 2004 after submitting reconsideration requests. Modified and restricted claims allowed September 29, 2004.

US Patent 7,368,114 **Fusion protein including of CD4**

Novel recombinant polypeptides are disclosed herein that include a CD4 polypeptide ligated at its C-terminus with a portion of an immunoglobulin comprising a hinge region and a constant domain of a mammalian immunoglobulin heavy chain. The portion or the IgG is fused at its C-terminus with a polypeptide comprising a tailpiece from the C-terminus of the heavy chain of an IgA antibody ara tailpiece from a C-terminus of the heavy chain of an IgM antibody. Also disclosed herein are methods for using these CD4 fusion proteins.

Filed October 24, 2002

Rejected as unpatentable August 18, 2006. Paid appeal to overturn examiner's findings February 15, 2007. Rejected again May 11, 2007. On October 10, 2007 applicants further narrowed the construction of what was clearly not a patent and the USPTO granted less than half the claims that had been sought in the original filing.

US Patent 9,896,509, 9,193,790 and 9,441,041 **Use of antagonists of the interaction between HIV GP120 and .alpha.4.beta.7 integrin**

Methods are provided for the treatment of a HIV infection. The methods can include administering to a subject with an HIV infection a therapeutically effective amount of an agent that interferes with the interaction of gp120 and .alpha.4 integrin, such as a .alpha.4.beta.1 or .alpha.4.beta.7 integrin antagonist, thereby treating the HIV infection. In several examples, the .alpha.4 integrin antagonist is a monoclonal antibody that specifically binds to a .alpha.4, .beta.1 or .beta.7 integrin subunit or a cyclic hexapeptide with the amino acid sequence of CWLDVC. Methods are also provided to reduce HIV replication or infection. The methods include contacting a cell with an effective amount of an agent that interferes with the interaction of gp120 and .alpha.4 integrin, such as a .alpha.4.beta.1 or .alpha.4.beta.7 integrin antagonist. Moreover, methods are provided for determining if an agent is useful to treat HIV.

Rejected May 22, 2017 as Double Patenting. In their response, the applicants acknowledge the illegal act and seek only those components of their application that extend beyond the life of the issued patents. On October 11, 2017, the limited claims were issued.

A sample of the convoluted flow of funds that evades public disclosure.

U.S. Patent 8,999,351 was issued to Tekmira Pharmaceuticals Corporation in Burnaby, British Columbia. In their patent, they disclose that their research was supported by a grant from the National Institute of Allergy and Infectious Disease (Grant HHSN266200600012C). Ironically, this $23 million grant was awarded in 2006 to Alnylam Pharmaceuticals, Inc., not to Tekmira.[26]

[26] https://www.technologynetworks.com/genomics/news/alnylam-awarded-23-million-us-government-contract-to-develop-rnai-therapeutics-186097

In 2012, Alnylam agreed to pay Tekmira $65 million to settle legal disputes including a $1 billion damages claim for "relentless and egregious" misappropriation of Tekmira's trade secrets. From the patent filing's earliest priority of November 10, 2008, there is no public record stating Tekmira as the beneficiary of this NIAID grant. Notwithstanding, the lipid nanoparticle technology developed from this grant is the technology now used in the Moderna COVID-19 intervention. In their 10-Q filing, Alnylam reports to have a license to technology from Arbutus – formerly Tekmira – which has accused Acuitas of misappropriating trade secrets and licensing them to Moderna and Pfizer's collaboration with BioNTech.

Additional references can be found at:

https://www.ott.nih.gov/nih-and-its-role-technology-transfer
https://www.accessdata.fda.gov/drugsatfda_docs/appletter/2017/206288Orig1s000TAltr.pdf
https://www.gao.gov/assets/720/710287.pdf
https://grantome.com/search?q=%22National%20Institute%20of%20Allergy%20and%20Infectious%20Diseases%22

15 U.S.C. §1-3 – Conspiring to Criminal Commercial Activity

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $100,000,000 if a corporation, or, if any other person, $1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court.

The National Institute of Health's grant AI23946-08 issued to Dr. Ralph Baric at the University of North Carolina at Chapel Hill (officially classified as affiliated with Dr. Anthony Fauci's NIAID by at least 2003) began the work on synthetically altering the *Coronaviridae* (the coronavirus family) for the express purpose of general research, pathogenic enhancement, detection, manipulation, and potential therapeutic interventions targeting the same. As early as May 21, 2000, Dr. Baric and UNC sought to patent critical sections of the coronavirus family for their commercial benefit.[27] In one of the several papers derived from work sponsored by this grant, Dr. Baric published what he reported to be the full length cDNA of SARS CoV in which it was clearly stated that SAR CoV was based on a composite of DNA segments.

> *"Using a panel of contiguous cDNAs that span the entire genome, we have assembled a full-length cDNA of the SARS-CoV Urbani strain, and have rescued molecularly cloned SARS viruses (infectious clone SARS-CoV) that contained the expected marker mutations inserted into the component clones."*[28]

On April 19, 2002 – the Spring before the first SARS outbreak in Asia – Christopher M. Curtis, Boyd Yount, and Ralph Baric filed an application for U.S. Patent 7,279,372 for a method of producing recombinant coronavirus. In the first public record of the claims, they sought to patent a means of producing, "an infectious, replication defective, coronavirus." This work was supported by the NIH grant referenced above and GM63228. In short, the U.S. Department of Health and Human Services was involved in the funding of amplifying the infectious nature of coronavirus between 1999 and 2002 ***before SARS*** was ever detected in humans.

Against this backdrop, we noted the unusual patent prosecution efforts of the CDC, when on April 25, 2003 they sought to patent the SARS coronavirus isolated from humans that had reportedly transferred to humans during the 2002-2003 SARS outbreak in Asia. 35 U.S.C. §101 prohibits patenting nature. This legality did not deter CDC in their efforts. Their application, updated in 2007, ultimately issued as U.S. Patent 7,220,852 and constrained anyone not licensed by their patent from manipulating SARS CoV, developing tests or kits to measure SARS coronavirus in humans or working with their patented virus for therapeutic use. Work associated with this virus by their select collaborators included considerable amounts of chimeric engineering, gain-of-function studies, viral characterization, detection, treatment (both vaccine and therapeutic intervention), and weaponization inquiries.

In short, with Baric's U.S. Patent 6,593,111 (Claims 1 and 5) and CDC's '852 patent (Claim 1), no research in the United States could be conducted without permission or infringement.

We noted that gain-of-function specialist, Dr. Ralph Baric, was both the recipient of millions of dollars of U.S. research grants from several federal agencies but also sat on the World Health Organization's International Committee on Taxonomy of Viruses (ICTV) and the *Coronaviridae* Study Group (CSG). In this capacity, he was both responsible for determining "novelty" of clades of virus species but directly benefitted from determining declarations of novelty in the form of new research funding authorizations and associated patenting and commercial collaboration. Together with CDC, NIAID, WHO, academic and commercial parties (including Johnson & Johnson; Sanofi and their several coronavirus patent holding biotech companies; Moderna; Ridgeback; Gilead; Sherlock Biosciences; and, others), a powerful group of interests constituted what we would suggest are "interlocking directorates" under U.S. anti-trust laws.

[27] U.S. Provisional Application No. 60/206,537, filed May 21, 2000
[28] https://www.pnas.org/content/100/22/12995

1986-1990	NIAID Grant AI 23946 leading to patent U.S. 7,279,327 "Methods for Producing Recombinant Coronavirus" Filed 2002 and issued 2007 https://patents.google.com/patent/US7279327B2/ru The paper first published from the NIAID grant is https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC7109931&blobtype=pdf
1990	Pfizer files U.S. Patent 6,372,224 on a vaccine for the *S*-protein on coronavirus November 14, 2000 which was abandoned April 2010 making it public domain.
1990s	Work focused on CoV association with cardiomyopathy (see above) Early reference to the "emergence" of CoV as a ***respiratory pathogen*** in https://link.springer.com/content/pdf/10.1007%2F978-1-4615-1899-0_91.pdf
2000	Ralph Baric AI23946 and GM63228 from the National Institutes of Health actively working recombinant CoV
2001	National Institute of Health, Allergy and Infectious diseases. "Reverse Genetics with a Coronavirus Infectious cDNA Construct." 4/1/2001-3/31/005 $1.0 million total costs/yr. RS Baric, PI
2002	Asia CoV SARS outbreak
2003	April 25, 2003 CDC Patent filed and ultimately becomes US7,220,852 (the patent on the RNA sequence) and 7,776,521 (the patent on the testing methodology. These patents give the U.S. Department of Health and Human Services the ability to control the commercial exploitation of SARS coronavirus. Dr. Anthony Fauci appointed to the Bill and Melinda Gates Foundation's Global Grand Challenges Scientific Advisory Board (served through 2010). April 28, 2003 Sequoia Pharmaceuticals $953K for pathogen response and patent US7,151,163 https://www.sbir.gov/node/305319 July 21, 2003 Ralph Baric's team (using AI23946 and GM63228) file U.S. Patent 7,618,802 which issued on November 17, 2009. https://patents.google.com/patent/US7618802B2 Dana Farber Cancer Institute files U.S. Patent 7,750,123 on a monoclonal antibody to neutralize SARS CoV. This research is supported by several NIH grants including National Institutes of Health Grants A128785, A148436, and A1053822.
2004	January 6, 2004 – ***SARS and Bioterrorism linked*** at Bioterrorism and Emerging Infectious Diseases: antimicrobials, therapeutics and immune modulators. https://tks.keystonesymposia.org/index.cfm?e=web.meeting.program&meetingid=706 ***At this conference, the term "The New Normal" was introduced by Merck*** ***FAUCI AND BARIC start making money!!!*** National Institutes of Health, Allergy and Infectious Diseases. SARS Reverse Genetics. AI059136-01. $1.7 million total costs, RS Baric, PI. 10% effort. 4/1/04- 3/31/09. The project develops a SARS-CoV full length infectious cDNA, the development of SARS-CoV replicon particles expressing heterologous genes, and seeks to adapt SARS-CoV to mice, producing a pathogenic mouse model for SARS-CoV infection.

National Institutes of Health, Allergy and Infectious Diseases. R01. Remodeling the SARS Coronavirus Genome Regulatory Network. RS Baric, PI 10% effort. 7/1/04-6/30/09. $2.1 million

November 22, 2004 University of Hong Kong patents SARS associated spike protein on CoV and pursues patent US 7,491,489

2005 DARPA gets in on the game Synthetic Coronaviruses. Biohacking: Biological Warfare Enabling Technologies, June 2005. Washington, DC. DARPA/MITRE sponsored event. Invited Speaker

Review timeline from https://www.youtube.com/watch?v=rO_EeYB0i0U and https://www.davidmartin.world/wp-content/uploads/2020/04/20APRBotWslides.pdf

2008 Biodefense Grant U54 AI057157 commences with $10,189,682 to UNC Chapel Hill https://taggs.hhs.gov/Detail/AwardDetail?arg_awardNum=U54AI057157&arg_ProgOfficeCode=104

2009 Biodefense Grant U54 AI057157 continues with $5,448,656 to UNC Chapel Hill (non-competitive grant from NIAID)

2010 Biodefense Grant U54 AI057157 continues with $8,747,142 to UNC Chapel Hill (non-competitive grant from NIAID)

Patent issuance for SARS coronavirus patents peak post the Asia outbreak at 391 issued patents.

August 6, 2010, Moderna (prior to its establishment) files U.S. Patent 9,447,164 which attracted the investment of (and "inventorship" for) venture capitalists at Flagship Ventures. This patent grew out of the work of Dr. Jason P. Schrum of Harvard Medical School supported by National Science Foundation Grant **#0434507. While the application claims priority to August 2010, the application didn't get finalized until October, 2015. On November 4, 2015, the USPTO issued a non-final rejection on this original patent rejecting all claims.** https://www.nsf.gov/awardsearch/showAward?AWD_ID=0434507 with reference to the grant funding in https://molbio.mgh.harvard.edu/szostakweb/publications/Szostak_pdfs/Schrum_et_al_JACS_2009.pdf

2011 Crucell joined the Janssen Pharmaceutical Companies of Johnson & Johnson in February taking with it all of its SARS technology.

Biodefense Grant U54 AI057157 continues with $7,344,820 to UNC Chapel Hill (non-competitive grant from NIAID)

2012 MERS isolated in Egypt

Biodefense Grant U54 AI057157 continues with $7,627,657 to UNC Chapel Hill (non-competitive grant from NIAID)

2013 Biodefense Grant U54 AI057157 continues with $7,226,237 to UNC Chapel Hill (non-competitive grant from NIAID)

2014 April 23, 2014, Moderna files patent on nucleic acid vaccine with Patents US9872900 and US10022435

2015	Moderna signs a vaccine development agreement with NIAID and executes it with the lead on the mRNA-1273 lead developer and inventor Guiseppe Ciaramella. https://www.documentcloud.org/documents/6935295-NIH-Moderna-Confidential-Agreements.html
2016	NIH through Scripps Institute and Dartmouth College file patent application WO 2018081318A1 "Prefusion Coronavirus Spike Proteins and their Use" disclosing mRNA technology that overlaps (and is used in tandem with) Moderna's technology. https://patents.google.com/patent/WO2018081318A1/en Lead Inventor Barney Scott Graham was well known to Moderna as he's the person at NIH that Moderna "e-mailed" to get the sequence for SARS CoV-2 according to Moderna's report here *("In January 2020, once it was discovered that the infection in Wuhan was caused by a novel coronavirus, Bancel quickly emailed Dr. Barney Graham, deputy director of the Vaccine Research Center at the National Institutes of Health, asking him to send the genetic sequence for the virus.")* https://www.wsws.org/en/articles/2020/05/26/vacc-m26.html In addition, co-inventor Jason McLellan worked with Graham on a vaccine patent jointly owned with the Chinese government filed in Australia in 2013 https://patents.google.com/patent/AU2014231357A1/en?inventor=Jason+MCLELLAN.
2017	August – Sanofi buys Protein Science Corp with considerable SARS patent holdings
2018	June – Sanofi buys Ablynx with considerable SARS patent holdings
2019	March, https://wyss.harvard.edu/news/sherlock-biosciences-licenses-wyss-technology-to-create-affordable-molecular-diagnostics/ funded by Open Philanthropy – the same organization that would be the financial sponsor of the Event 201 "table-top" exercise that laid out the entire "pandemic" plan in October 2019.

15 U.S.C. §8 – Market Manipulation and Allocation

Every combination, conspiracy, trust, agreement, or contract is declared to be contrary to public policy, illegal, and void when the same is made by or between two or more persons or corporations, either of whom, as agent or principal, is engaged in importing any article from any foreign country into the United States, and when such combination, conspiracy, trust, agreement, or contract is intended to operate in restraint of lawful trade, or free competition in lawful trade or commerce, or to increase the market price in any part of the United States of any article or articles imported or intended to be imported into the United States, or of any manufacture into which such imported article enters or is intended to enter. Every person who shall be engaged in the importation of goods or any commodity from any foreign country in violation of this section, or who shall combine or conspire with another to violate the same, is guilty of a misdemeanor, and on conviction thereof in any court of the United States such person shall be fined in a sum not less than $100 and not exceeding $5,000, and shall be further punished by imprisonment, in the discretion of the court, for a term not less than three months nor exceeding twelve months.

Through non-competitive grant awards to UNC Chapel Hill's Ralph Baric, to selection of the Bio-Safety Level 4 laboratory locations, to the setting of prices for Remdesivir and mRNA therapies from Moderna and Pfizer, NIAID, CDC, and the U.S. Department of Health and Human Services have been involved in allocating Federal funds to conspiring parties without independent review.

Around March 12, 2020, in an effort to enrich their own economic interests by way of securing additional funding from both Federal and Foundation actors, the CDC and NIAID's Dr Fauci elected to suspend testing and classify COVID-19 by capricious symptom presentation alone. Forcing the public to rely on The COVID Tracking Project – funded by the Bloomberg, Zuckerberg and Gates Foundation and presented by a media outlet (***The Atlantic***) – not a public health agency – Dr. Fauci used fraudulent testing technology (RT-PCR) to conflate "COVID cases" with positive PCR tests in the living while insisting that COVID deaths be counted by symptoms alone. This perpetuated a market demand for his desired vaccine agenda which was recited by him and his conspiring parties around the world until the present. Not surprisingly, this was necessitated by the apparent fall in cases that constituted Dr. Fauci's and others' criteria for depriving citizens of their 1st Amendment rights.

15 U.S.C. § 19 – Interlocking Directorates

(1) No person shall, at the same time, serve as a director or officer in any two corporations (other than banks, banking associations, and trust companies) that are—

(A) engaged in whole or in part in commerce; and

(B) by virtue of their business and location of operation, competitors, so that the elimination of competition by agreement between them would constitute a violation of any of the antitrust laws; if each of the corporations has capital, surplus, and undivided profits aggregating more than $10,000,000 as adjusted pursuant to paragraph (5) of this subsection.

Dr. Fauci is on the Leadership Council of the Bill and Malinda Gates Global Vaccine Action Plan

Dr. Fauci while controlling the economic dispensation of Federal research funding, Dr. Fauci has been, and continues to be, on the World Health Organization's Global Preparedness Monitoring Board. He is joined on this board by the conflicted donor from the Bill and Melinda Gates Foundation's Dr. Chris Elias and the State Council of China's Dr. George F. Gao of the Chinese CDC. This GPMB stipulated that all member states must take part in a global simulation of the release of a respiratory pathogen.

Dr. Baric is one of the primary beneficiaries of U.S. Federal funds, runs a BSL-4 facility and sits on the International Committee on Taxonomy of Virus *Coronaviridae* Working Group tasked to confirm the presence of absence of the pathogen for which he is directly compensated.

As referenced in the section covering violations of 18 U.S.C. § 1001 above, numerous undisclosed commercial relationships exist between funded researchers, their funding agencies, and commercial interests in which disclosed and undisclosed commercial terms exist. A complete list of all potential implicated parties is listed in the section below entitled "The Commercial Actors".

It appears that, during the period of patent enforcement and after the Supreme Court ruling confirming that patents on genetic material were illegal, the CDC and National Institute of Allergy and Infectious Diseases led by Anthony Fauci (hereinafter "NIAID" and "Dr Fauci", respectively) entered into trade among States (including, but not limited to working with Ecohealth Alliance Inc.) and with foreign nations (specifically, the Wuhan Institute of Virology and the Chinese Academy of Sciences) through the 2014 et seq National Institutes of Health Grant R01AI110964 to exploit their patent rights.

It further appears that, during the period of patent enforcement and after the Supreme Court ruling confirming that patents on genetic material was illegal, the CDC and National Institute of Allergy and Infectious Diseases (hereinafter "NIAID") entered into trade among States (including, but not limited to working with University of North Carolina, Chapel Hill) and with foreign nations (specifically, the Wuhan Institute of Virology and the Chinese Academy of Sciences represented by Zheng-Li Shi) through U19AI109761 (Ralph S. Baric), U19AI107810 (Ralph S. Baric), and National Natural Science Foundation of China Award 81290341 (Zheng-Li Shi) et al. 2015-2016.

It further appears that, during the period of patent enforcement and after the Supreme Court ruling confirming that patents on generic material was illegal, the CDC and NIAID entered into trade among States (including, but not limited to working with University of North Carolina, Chapel Hill) and with foreign nations to conduct chimeric construction of novel coronavirus material with specific virulence properties prior to, during, and following the determination made by the National Institutes for Health in October 17, 2014 that this work was not sufficiently understood for its biosecurity and safety standards.

In this inquiry, it is presumed that the CDC and its associates were: a) fully aware of the work being performed using their patented technology; b) entered into explicit or implicit agreements including licensing, or other consideration; and, c) willfully engaged one or more foreign interests to carry forward the exploitation of their proprietary technology

when the U.S. Supreme Court confirmed that such patents were illegal and when the National Institutes of Health issued a moratorium on such research.

Reportedly, in January 2018, the U.S. Embassy in China sent investigators to Wuhan Institute of Virology and found that, "During interactions with scientists at the WIV laboratory, they noted the new lab has a serious shortage of appropriately trained technicians and investigators needed to safely operate this high-containment laboratory." The Washington Post reported that this information was contained in a cable dated 19 January 2018. Over a year later, in June 2019, the CDC conducted an inspection of Fort Detrick's U.S. Army Medical Research Institute of Infectious Diseases (hereinafter "USAMRIID") and ordered it closed after alleging that their inspection found biosafety hazards. A report in the journal Nature in 2003 (423(6936): 103) reported cooperation between CDC and USAMRIID on coronavirus research followed by considerable subsequent collaboration. The CDC, for what appear to be the same type of concern identified in Wuhan, elected to continue work with the Chinese government while closing the U.S. Army facility.

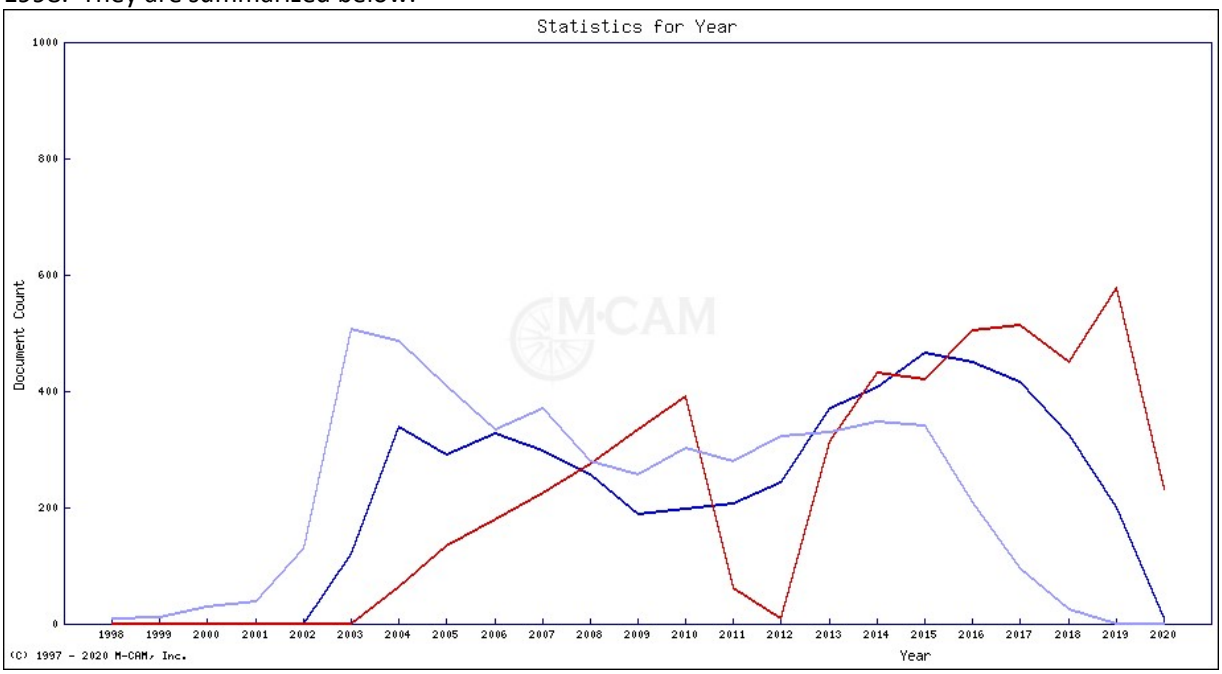
The CDC reported the first case of SARS-CoV like illness in the United States in January 2020 with the CDC's Epidemic Intelligence Service reporting 650 clinical cases and 210 tests. Given that the suspected pathogen was first implicated in official reports on December 31, 2019, one can only conclude that CDC: a) had the mechanism and wherewithal to conduct tests to confirm the existence of a "novel coronavirus"; or, b) did not have said mechanism and falsely reported the information in January. It tests credulity to suggest that the WHO or the CDC could manufacture and distribute tests for a "novel" pathogen when their own subsequent record on development and deployment of tests has been shown to be without reliability

35 U.S.C. §200 - 206 – Disclosure of Government Interest

35 U.S.C. §202 (c)(6)

An obligation on the part of the contractor, in the event a United States patent application is filed by or on its behalf or by any assignee of the contractor, to include within the specification of such application and any patent issuing thereon, a statement specifying that the invention was made with Government support and that the Government has certain rights in the invention.

Over 5000 patents and patent applications have included reference to SARS Coronavirus dating back to priority dates of 1998. They are summarized below.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020		total
file	0	0	0	0	1	120	338	290	328	297	256	188	198	207	244	371	407	466	451	416	426	199	8	file	5111
issue	0	0	0	0	0	1	63	135	179	224	275	334	391	61	8	314	431	420	504	513	449	578	231	issue	5111
priority	10	12	29	38	129	506	487	408	335	370	279	256	303	279	322	330	348	342	208	95	25	0	0	priority	5111
total	10	12	29	38	129	627	888	833	842	891	810	778	892	547	574	1015	1186	1228	1163	1024	800	777	240	total	15333

On July 23, 2020, the Patent Trial and Appeal Board of the United States Patent and Trademark Office rejected Moderna's efforts to invalidate U.S. Patent 8,058,069. This patent, owned by Arbutus Biopharma Corp (principally owned by Roivant Science Ltd), covers the lipid nanoparticle (LNP) required to deliver an mRNA vaccine. Some of the core technology was based on work originally done at the University of British Columbia and was first licensed in 1998.

mRNA-1273 – the experimental vaccine developed by Moderna for COVID-19 – uses the LNP technology that Moderna thought it had licensed from Acuitas Therapeutics Inc., a firm developed by a former principal of Arbutus' prior company Tekmira. That license did not authorize Moderna to use the technology for the COVID-19 vaccine.

M·CAM and Knowledge Ecology International have independently confirmed that Moderna has violated U.S. law in failing to disclose the U.S. government's funding interest in their patents and patent applications. While this negligence impacts all of Moderna's over 130 granted U.S. patents, it is particularly problematic for U.S. Patent 10,702,600 ('600) which is the patent relating to, "a messenger ribonucleic acid (mRNA) comprising an open reading frame encoding a betacoronavirus (BetaCoV) S protein or S protein subunit formulated in a lipid nanoparticle." The specific claims addressing the pivot to the SARS Coronavirus were patented ***on March 28, 2019 – 9 months before the SARS CoV-2***

outbreak! Both the patent and the DARPA funding for the technology were disclosed in scientific publication (*New England Journal of Medicine*) but the government funds were not acknowledged in the patent.

In 2013, the Autonomous Diagnostics to Enable Prevention and Therapeutics (ADEPT) program awarded grant funding to Moderna Therapeutics for the development of a new type of vaccine based on messenger RNA. The initial DARPA grant was W911NF-13-1-0417. ***The company used that technology to develop its COVID-19 vaccine, currently undergoing Phase I clinical trials in conjunction with NIH***.[29]

Under the Federal Acquisition Regulation (FAR) rules, contractor to the Federal Government must provide information regarding intellectual property infringement issues as part of their contract. Under FAR §27.201-1(c) and (d), the Government both requires a notice of infringement or potential infringement as well as retention of economic liability for patent infringements. Specifically, in FAR §52.227.3 (a), the "Contractor shall indemnify the Government and its officers, agents, and employees against liability, including costs for infringement of any United States Patent…". In addition to the patents cited by the USPTO in their examination of '600, M·CAM has identified fourteen other issued patents preceding the '600 patent which were used by patent examiners to limit patents arising from the same funded research including patents sought by CureVac.

In short, while Moderna enjoys hundreds of millions of dollars of funding allegiance and advocacy from Anthony Fauci and his NIAID, since its inception, it has been engaged in illegal patent activity and demonstrated contempt for U.S. Patent law. To make matters worse, the U.S. Government has given it financial backing in the face of undisclosed infringement risks potentially contributing to the very infringement for which they are indemnified.

[29] https://crsreports.congress.gov/product/pdf/IN/IN11446

21 C.F.R. § 50.24 et seq., Illegal Clinical Trial

It is unlawful to conduct medical research (even in the case of emergency) without a series of steps taken to:

a. **Establish the research with a duly authorized and independent institutional review board;**
b. **Secure informed consent of all participants including a statement of risks and benefits; and,**
c. **Engage in consultation with the community in which the study is to be conducted.**

Dr. Anthony Fauci has forced upon the healthy population of the United States an unlawful clinical trial in which the U.S. Department of Health and Human Services are extrapolating epidemiologic data. No informed consent has been sought or secured for any of the "medical countermeasures" forced upon the population and no independent review board – as defined by the statute – has been empaneled.

Through April 2020, the official recommendation by the ***Journal of the American Medical Association*** was unambiguous.

"Face masks should not be worn by healthy individuals to protect themselves from acquiring respiratory infection because there is no evidence to suggest that face masks worn by healthy individuals are effective in preventing people from becoming ill."[30]

Part of that lack of evidence in fact showed that cloth facemasks actually increased influenza-linked illness.[31]

In contravention to established science, States, municipalities, and businesses have violated the legal requirements for the promulgation of medical counter measures during a public health emergency stating a "belief" that face masks limit the spread of SARS CoV-2. To date, not a single study has confirmed that a mask prevented the transmission of, or the infection by SARS CoV-2.

All parties mandating the use of facemasks are not only willfully ignoring established science but are engaging in what amounts to a whole population clinical trial. This conclusion is reached by the fact that facemask use and COVID-19 incidence are being reported in scientific opinion pieces promoted by the United States Centers for Disease Control and Prevention and others.[32]

Social distancing of up to 6 feet has been promoted as a means of preventing person-to-person transmission of influenza-like viruses. While one study hypothesized that infection could happen in a 6 foot range, the study explicitly states that person-to-person transfer was not tested and viability of the virus at 6 feet was not even a subject of the investigation.[33] That did not stop the misrepresentation of the study to be used as the basis for an unverified medical counter measure of social distancing. To date, no study has established the efficacy of social distancing to modify the transmission of SARS CoV-2. Public health officials have referenced:

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5907354/#CR43

In contravention to established science, States, municipalities, and businesses have violated the legal requirements for the promulgation of medical counter measures during a public health emergency stating a "belief" that social distancing of a healthy population limits the spread of SARS CoV-2. To date, not a single study has confirmed that social distancing of any population prevented the transmission of, or the infection by SARS CoV-2.

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[30] https://jamanetwork.com/journals/jama/fullarticle/2762694
[31] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4420971/
[32] https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html
[33] *Werner E. Bischoff, Katrina Swett, Iris Leng, Timothy R. Peters, Exposure to Influenza Virus Aerosols During Routine Patient Care,* The Journal of Infectious Diseases*, Volume 207, Issue 7, 1 April 2013, Pages 1037–1046,* ***https://doi.org/10.1093/infdis/jis773***

It is unlawful under the FTC Act, 15 U.S.C. § 41 et seq., to advertise that a product or service can prevent, treat, or cure human disease unless you possess competent and reliable scientific evidence, including, when appropriate, well-controlled human clinical studies, substantiating that the claims are true at the time they are made. As a result, every party promoting the use of face masks is violating the FTC Act.

All of these laws have been broken. All relevant authorities in the United States must cease and desist the use of face masks until the matters above are rectified.

E N D O F D O C U M E N T

27 April 2021

Dr. Anthony S. Fauci, Director
National Institute of Allergy and Infectious Diseases
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Rockville, MD 20852
301-496-2263
anthony.fauci@nih.gov

Subject 1: Sworn Testimony of Dr. Anthony Fauci, Litigation Involving Nuremburg Code
Subject 2: Connections of Dr. Anthony Fauci to the Nursing Homes Deaths
Reference 1: My Letter to You of 21 July 2020
Reference 2: My Letter to You of 21 December 2020
Reference 3: My Letter to the Presidents of the Ivy League of 6 March 2021

Instant Memorandum dated 12 April 2021 hyperlink:

http://pvsheridan.com/sheridan2fauci-3-12april2021.pdf