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To the
Federal Administrative Court
Simsonplatz 1
04107 Leipzig

Bielefeld, July 1, 2022

connected
Military Complaints Procedure
Here: [redacted]
BVerwG 1 WB 5.22 and 1 W-VR 3.22 wg.
Inclusion of COVID-19 vaccination in the basic vaccination schedule of the Bundeswehr

In the above-mentioned military complaints procedure, I comment on the result of the taking of evidence in the oral hearing on June 7th/8th, 2022 as follows:

I. How dangerous is the disease COVID-19?

1. To spread COVID-19

During the oral hearing on May 2nd, 2022, senior physician Prof. Dr. Wölfel, with SARS CoV-2 there was no cross-immunity with other respiratory viruses; rather, billions of people have contracted COVID-19. Apparently he equates "sick" with "tested positive", as can be seen from his reply to the lecture by Prof. Dr. Ulrike Kämmerer on June 7th, 2022: In it he defends the thesis that a positive test is equivalent to a COVID-19 disease, because a positive test result allows "inferences" to be drawn about a contagious infection. In doing so, he assumes that every positive test result was obtained in the proper application of laboratory diagnostic standards. Laboratories have every reason to be clean as they are subject to strict inspections and act illegally,

With these objections, Mr. Wölfel was not able to refute Ulrike Kämmerer's convincing statements. If numerous tests are carried out in a PCR test device in one day, there is a great risk that the desideratum "quality" will be sacrificed for the desideratum "speed". Therefore, Ulrike Kämmerer's assessment that the standards are often not complied with is plausible. I refer to the 41-page report by Ulrike Kämmer on this and other sources of error in purely PCR-based diagnostics, which the attorney-in-fact Wilfried Schmitz submitted to the case files.

And if Mr. Wölfel thinks that a positive test result allows "conclusions", he misjudges the difference between an infection (§ 2 No. 2 IfSG) and a suspicion of infection (§ 2 No. 7 IfSG). In a systematic comparison of these two regulations, an infection is *proof* to demand a reproductive pathogen.

In addition, not even the RKI believes in such proof. In my brief dated June 3, 2022 (page 7 f.) I referred to an article in the Epidemiological Bulletin of the RKI No. 39/2020, in which the President of the RKI, Prof. Dr. Lothar Wieler, is involved as an author. It proves that a positive test is also a *survived*, can no longer detect active infection in which the pathogen no longer multiplies, and that in vitro data indicate that 1% to a maximum of 10% of all positive swab samples actually contain infectious virus. Against this background, a positive test can only indicate contagion, if at all *suspect* justify, and the *proof* can only be carried out if reproducible virus can be isolated and cultured from the swab sample. Colonel Dr. Kehe had stated on May 2, 2022 that the Bundeswehr had its own laboratory that could carry out such cultivation. To this day it is unclear in how many cases – be it in the Bundeswehr or in the general civilian population – such cultivation is attempted and how often *this* produces a positive result.

It follows from all of the above: The extent of the danger posed by SARS CoV-2 has been artificially inflated by the mass testing of symptom-free people. The real extent of the risk can be seen by using the RKI-SOEP study

(available under https://www.rki.de/DE/Content/Gesundheitsmonitoring/Studien/lid/Fachinformationen/

Specialist information_node.html). Thereafter, the seroprevalence of SARS CoV-2 in the general population until November 2020 - mind you in the allegedly worst pandemic of all time - was a negligible 1.3%.

In the oral hearing on June 7th, 2022, when questioning PD Dr. Ole Wichmann pointed out the results of the influenza working group at the RKI, in whose sentinel analyzes (§ 13 Para. 2 IfSG) SARS CoV-2 plays a permanently subordinate role compared to other respiratory pathogens. Between the 16th and the 38th calendar week 2020 was in the Sentinel*not a single case*SARS CoV-2 has been reported (see report of the influenza working group on week 37-39, available at https:// influenza.rki.de/Wochenberichte/2019_2020/2020-39.pdf). And even in the period that followed, the proportion of SARS CoV-2 remained comparatively low (see, for example, the weekly report for week 47, available at https://influenza.rki.de/ Wochenberichte/2021_2022/2021-47.pdf : SARS CoV-2 just 9%). In the meantime, however, the proportion of SARS CoV-2 in the Sentinel samples has increased significantly. In the weekly report for week 24 (available at https://influenza.rki.de/ Wochenberichte/2021_2022/2022-24.pdf) SARS CoV-2 is even number 1. I definitely imagine a success of the vaccination campaign in a different way.

I can state: When COVID injections did not exist yet, SARS CoV-2 played an almost negligible role in the overall respiratory infection process. Apparently, the booster campaign in particular has changed the actual conditions - in terms of an increase in COVID-19 diseases. It seems that the vaccination campaign of the*quantitative* Massively fueled the spread of COVID-19. We will come back to this under II. when it comes to the effectiveness of the COVID injections.

Mr. PD Dr. Incidentally, Ole Wichmann replied to my question as to whether STIKO took the results of the influenza working group into account in its recommendations that he was aware of these results. He could not or did not want to explain what significance this has for the work of STIKO; he only said that the vaccinations against COVID-19 and against influenza were not compared with each other (which was not the core of my question - it was about the danger of the disease, not about the effectiveness of the vaccine!). But if Mr. Wichmann the results of the working group influenza*knows*, is he also able

to bring them into the consultations of the STIKO. It is surprising that STIKO does not seem to draw any conclusions from the developments presented.

2. The possibility of a serious or fatal outcome

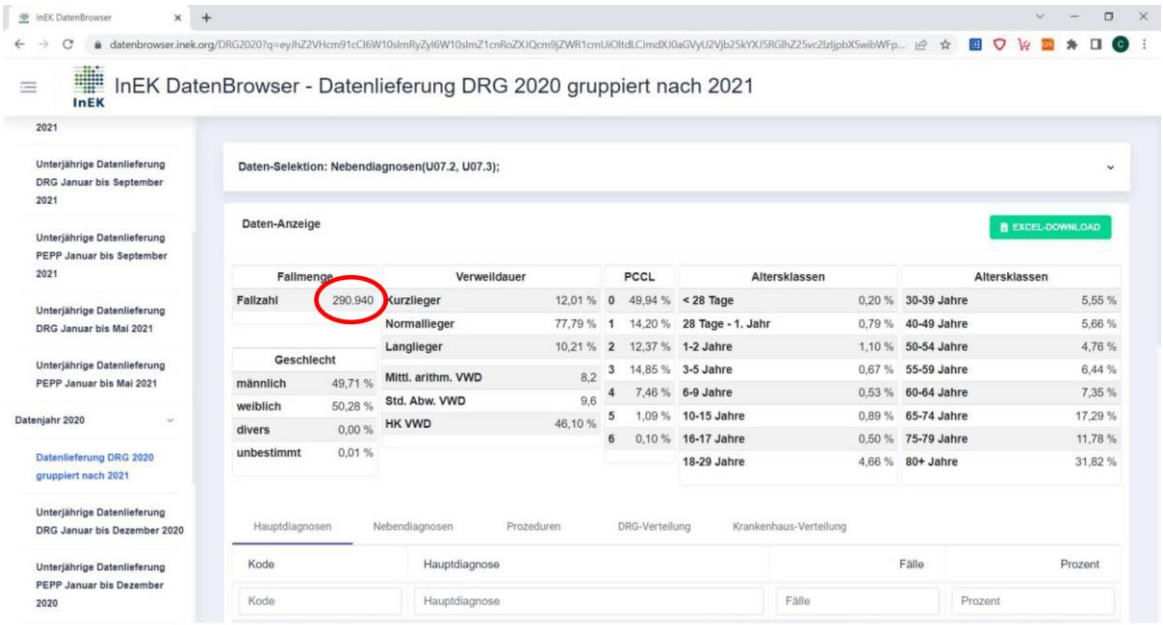
This is not to deny that COVID-19 can be severe or fatal. Prof. Dr. However, Ulrike Kämmerer pointed out a therapy option here that I had already mentioned in my brief of April 14, 2022 (page 30 with attachment BF-MS 65): On the 8th day after the onset of symptoms, an overreaction of the immune system through the administration of cortisone and antihistamines prevented and an impending thrombosis counteracted by administering blood thinners. The South African doctor Dr. Shankara Chetty has used it to successfully treat thousands of COVID-19 patients.

In this context, I would like to remind you once again that a good vitamin D level already drastically reduces the risk of severe COVID progression (see my brief of April 14, 2022, p. 29 f.). And a book was recently published that describes the treatment protocols of two US doctors who were able to prevent severe and fatal courses with simple and conventional medication (Fareed/Tyson, Covid-19 - curable since 2020", ISBN: 979-8-9855583 -3-3, review on this at reitschuster.de from 6/30/2022,https://reitschuster.de/post/gewinn-bei-12- 000-patienten-niemand-muss-an-covid-19-die/).

On May 27, 2022, the blog transparenztest.de drew attention to an inconsistency in the RKI data: The SARS CoV-2 weekly reports listed significantly fewer COVID-19 deaths than an Excel table in which the COVID- 19 dead are listed sorted by age groups. Against this background, I asked Mr. Wichmann the following question: How is it that the weekly report of April 28, 2022 (data status April 26, 2022) lists 201 COVID-19 deaths (for weeks 13-16), but in the Excel spreadsheet for same period over 5,000 (data as of June 2nd, 2022)? The answer from Mr. Wichmann was initially that one still had to calculate those cases from the Excel spreadsheet in which there were no symptoms and no laboratory confirmation. Only when I asked how it could be that one died of COVID-19 without any symptoms, Mr. Wichmann had to admit that this was rather unlikely. You can also put it like this: Mr

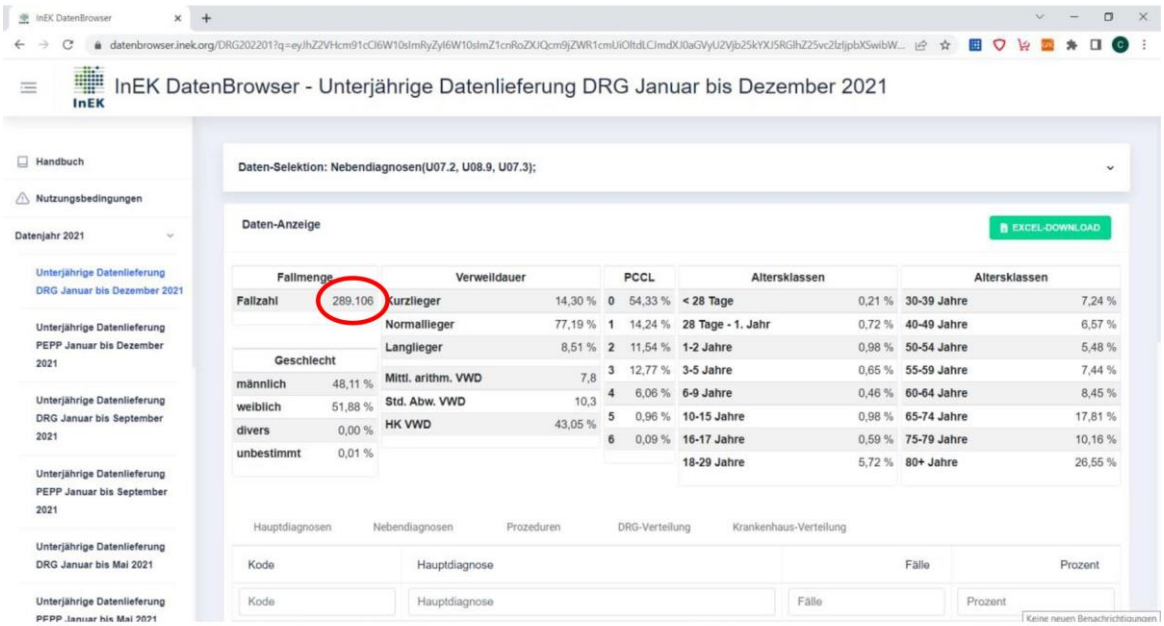
Wichmann has no conclusive explanation for the inconsistent and non-transparent numbers at the RKI.

The inconsistencies become even clearer if you add the InEK data. The abbreviation "InEK" stands for "Institute for the remuneration system in hospitals". In the years 2020 and 2021, almost 300,000 hospitalized patients were billed as corona cases for which there was never a laboratory confirmation. This can be illustrated by the graphic below, which shows the following numbers for the clearly defined ICD-10 codes U07.2 and U07.3, both of which do not require laboratory confirmation for the COVID-19 diagnosis (available athttps://datenbrowser.inek.org/):



Erklärung:
U07.2 = COVID-19, Virus nicht nachgewiesen
U07.3 = COVID-19 in der Eigenanamnese, nicht näher bezeichnet

⇨ 290.940 Hospitalisierungen, die als COVID-Fälle abgerechnet wurden, jedoch keinen laborbestätigten PCR hatten.



Erklärung:
U07.2 = COVID-19, Virus nicht nachgewiesen
U07.3 = (falsch codiert?)
U08.9 = COVID-19 in der Eigenanamnese, nicht näher bezeichnet

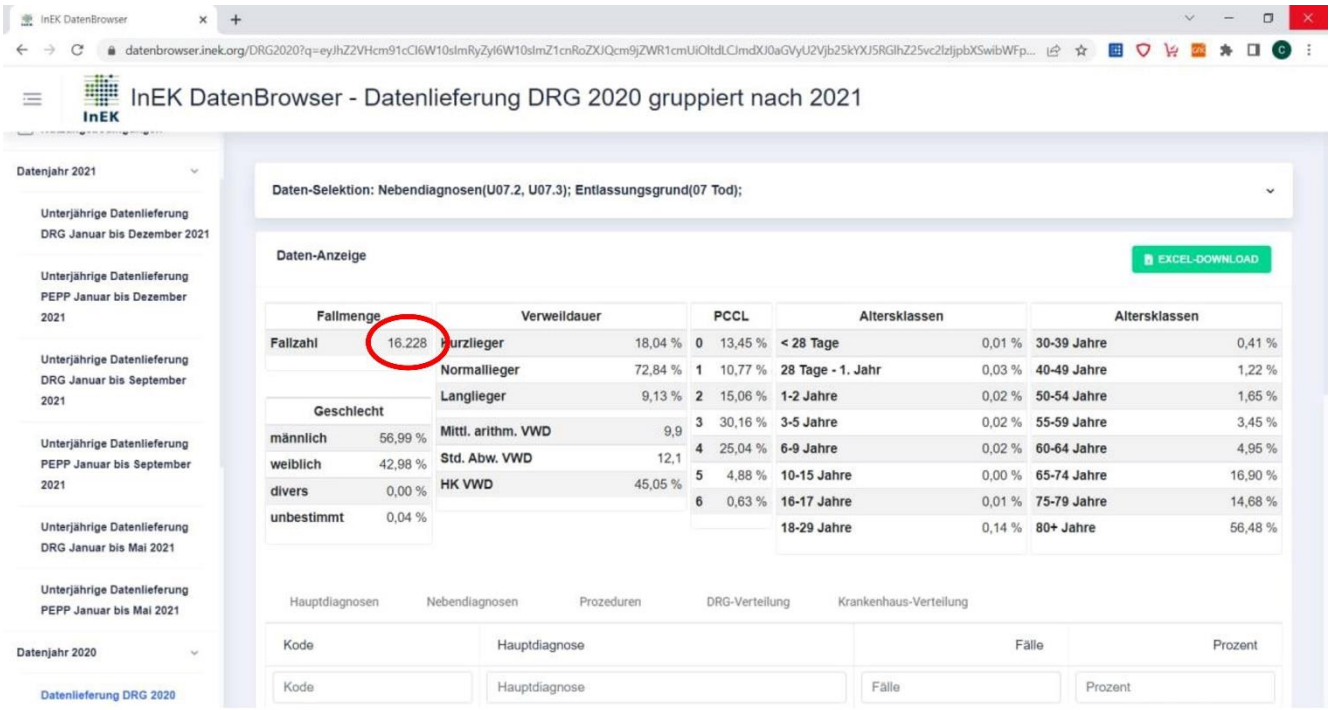
⇨ 289.106 Hospitalisierungen, die als COVID-Fälle abgerechnet wurden, jedoch keinen laborbestätigten PCR hatten.

It is doubtful whether we are really dealing with 300,000 COVID-19 cases in this category. The hypothesis that the threshold of shame in the clinics is very low when it comes to the billing of charges is much more likely. But be that as it may: If about the spread

If such contradictory information about SARS CoV-2 is circulating, neither a vaccination recommendation nor even a vaccination obligation can be based on this information.

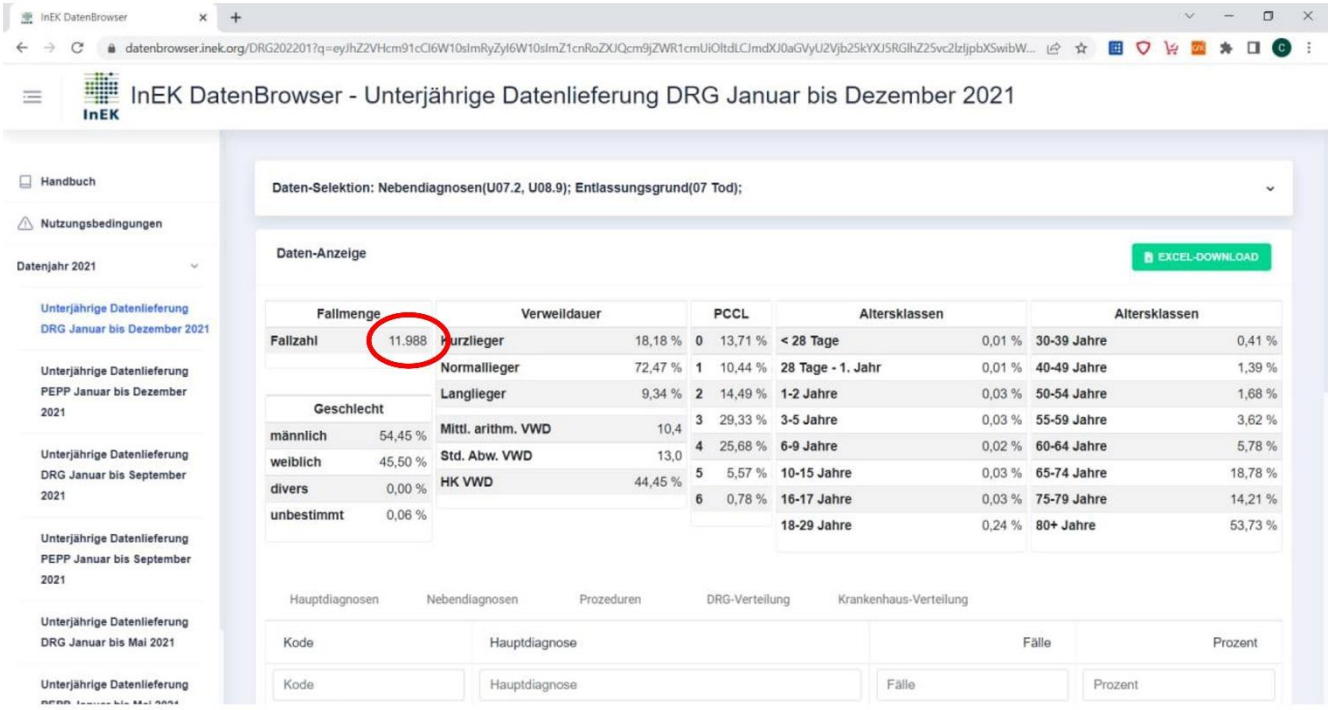
Mr. Wichmann's answer to the question of whether he could rule out the possibility that all the deceased who were listed as COVID-19 dead were really vague also remained vague*on*and not only*With*Corona have died. Herr Wichmann replied that yes, he could rule that out. There are "a few" who only*With*Corona have died. Reporting data is not perfect data. Media reports that meanwhile only a minority of the "corona patients"*because*COVID-19 are hospitalized (see WELT from 24.3.2022, https://www.welt.de/vermischtes/plus237758181/Helios-Kliniken-Grossteil-der-Covid-patients-not-because-of-Covid-hospitalisiert.html ?), Mr. Wichmann does not seem to notice.

So let's let the InEK data speak again, which apparently also did not reach Mr Wichmann's threshold of perception. According to this, an impressive number of people who died in the hospitals only died with and not from Corona (see again https://datenbrowser.inek.org/). We see the cases of deceased patients whose alleged COVID-19 disease was never confirmed by a laboratory test, but who were listed as COVID-19 dead, reaching five figures for 2020 and 2021 respectively:



Erklärung:
U07.2 = COVID-19, Virus nicht nachgewiesen
U07.3 = COVID-19 in der Eigenanamnese, nicht näher bezeichnet

⇨ 16.228 Todesfälle, die als COVID-Fälle abgerechnet wurden, jedoch keinen laborbestätigten PCR hatten.



Erklärung:
U07.2 = COVID-19, Virus nicht nachgewiesen
U07.3 = (falsch codiert?)
U08.9 = COVID-19 in der Eigenanamnese, nicht näher bezeichnet

⇨ 11.988 Todesfälle, die als COVID-Fälle abgerechnet wurden, jedoch keinen laborbestätigten PCR hatten.

3. For comparison: omicron-COVID versus influenza

Mr. Wichmann was asked how dangerous he considered COVID-19 under the rule of the omicron variant of SARS CoV-2 compared to seasonal flu (influenza). He replied that the comparison was flawed, one had to pay attention to the age group. Especially with Corona there are aspects that we do not yet fully understand, e.g. Long COVID in children. Even healthy people can become seriously ill. However, it is not yet known how often this occurs. When asked by the recognized Senate which risk factors could be identified in the 18-59 age group, Mr. Wichmann answered as follows: These risk factors did not differ from those in the first phase of the Corona crisis. Only the probabilities could have changed. He does not have current figures; you can't remember everything.

This statement from an expert who is helping to prepare the STIKO recommendations is remarkable: Apparently, the RKI and STIKO do not even get a consistent picture of the extent of the threat posed by SARS CoV-2 before recommending a vaccination . So here are some facts and figures:

- The recently published study Lewnard et al, Clinical outcomes associated with SARS-CoV-2 Omicron (B.1.1.529) variant and BA.1/BA.1.1 or BA.2 subvariant infection in southern California, provides information. https://doi.org/10.1038/s41591-022-01887-z (2021) . It describes that the risk of contracting SARS CoV-2 is significantly lower under Omikron than under Delta - and that it is precisely those who have not been vaccinated who benefit most from this risk reduction. The analysis by Thomas Oysmüller from June 14, 2022 is worth
- reading https://tkp.at/2022/06/14/eindeutige-verstaetigung-omikron-erheblich-milderals-grippe/ . He interprets the study to mean that case mortality (not to be confused with infection mortality!) under omicrons is only 0.007% - which is far below the case mortality of normal flu.

- An Excel table, which can be accessed at the RKI, shows that the COVID-19 case mortality in Germany is only 0.02% (see the

equestrian "Clinical aspects"; the tabel is available under https://www.rki.de/SiteGlobals/Forms/Suche/serviceSucheForm.html;jsessionid=08F14779B901290C172E10D4BEDD1143.internet111?nn=2725444&input_=2725444>s=2725442_list%253DdateOfIssue_dt%252Bdesc&resourceId=2390936&submit.x=0&submit.y=0&searchEngineQueryString= age median+todesf%C3%A4lle+covid-19&pageLocale=de , as of June 23, 2022); that is significantly less than a light (!) Influenza wave.

- Klaus Cichutek, President of the PEI, therefore recently rejected the proposal by BioNTech boss Ugur Sahin to refrain from clinical studies on humans when approving new COVID vaccines: This can be done in an emergency; but this is currently not available (WELT from 25.6.2022,https://www.welt.de/politik/deutschland/plus239550429/Neuer-Vaccine-PEI-Chef-lehnt-Biontech-Vorstoss-ab.html).

Conclusion: If SARS CoV-2 ever represented a significant threat to humanity, this is definitely no longer the case under the rule of the omicron variant! After all, Mr. Wichmann admitted that the omicron subvariant BA.5, which is currently on the advance, does not cause more severe diseases than the subvariants BA.1 and BA.2. It is becoming increasingly incomprehensible why vaccination against such a pathogen is still recommended at all.

At this point, reference is once again made to the investigations regarding the vulnerable groups as part of the so-called "Gangelt study", where it was already possible to determine from the first SARS CoV-2 variants that the actual vulnerable group are the multimorbid above all people with obesity, diabetes and anxiety disorders (Dreher et al., characteristics of 50 hospitalized COVID-19 patients with and without ARDS,DOI: 10.3238/arztebl.2020.0271 ; https://www.aerzteblatt.de/archiv/213454/kennistik-von-50-hospitalisiert-COVID-19-patienten-mit-und-ohne-ARDS). This has also been demonstrated by foreign authorities, for example the US Center for Disease Control - CDC (https://www.cdc.gov/pcd/issues/2021/21_0123.htm) confirmed, which evaluated about 5 million corona hospital cases in the USA. It cannot be assumed that this vulnerable group is serving in the Bundeswehr. For the soldiers of

Bundeswehr, the thought of vaccination against SARS CoV-2 is even less obvious than for the general population.

II. How effective is the vaccination?

In the oral hearing on June 7th, 2022, the topic of proof of the effectiveness of the COVID vaccines was called up in the morning. The expert interviewed by the RKI. Mr. PD Dr. Ole Wichmann was unable to prove the effectiveness of the vaccines.

1. Basic questions

The active principle of conventional vaccines has always been designed in such a way that the pathogen, i.e. the pathogen, is presented to the human immune system in a weakened (attenuated) or killed form, with its entire genome. The confrontation with the pathogen prepared in this way should configure the human immune memory in such a way that the human body is already prepared for the encounter with the real pathogen and can fight it off without consequences, ideally even without becoming ill.

With COVID injections, however, the situation is completely different. The human body is enabled by their active ingredients and mechanisms of action to form the pathogen itself, namely the spike protein -*without* that it would be weakened. The human body is therefore immediately confronted with the “focused” pathogen. And we know that the spike protein is responsible for the severe course of COVID (see my brief of April 14, 2022, page 3 f. with further evidence). The remaining parts (so-called epitopes) of the virus genome are not even presented to the human immune system and therefore cannot be stored by the human immune memory.

With this in mind, the highest level of evidence must be demanded of anyone who claims the effectiveness of the COVID vaccines. Because one *theoretical* So far, no one has been able to answer the question of how a vaccination should work that is not adapted to mutations, in which the pathogen is not weakened and in which not all epitopes of the pathogen can enter the human immune memory.

2. For the questioning of Mr. PD Dr. Ole Wichmann

The required maximum amount of evidence can therefore at best be drawn from convincing data from real life. However, Mr. Wichmann was not able to provide this during his interrogation - and what is more: he is responsible for the effectiveness of the COVID injections*None at all*can provide evidence.

a) No information on vaccination effectiveness in the weekly reports after April 28, 2022

Mr. Wichmann was unable to give a conclusive answer to the pertinent question of the senate, why the RKI has not published any information on vaccination effectiveness in the weekly reports since May 5th, 2022. The admission that the report was intended to be streamlined is in no way plausible. The shortening of texts can always be a worthwhile concern - but please not at the expense of the substance of the content in an issue that is so eminently important for the general public such as vaccination effectiveness! The further answer from Mr. Wichmann, that there were many "misunderstandings" about this vaccination effectiveness, is even less plausible: The weekly report of April 28, 2022 showed a vaccination effectiveness of *zero*out. With this sobering insight there was no room for misunderstandings!

Finally, Mr. Wichmann referred to errors after changing the reporting software; the RKI is currently investigating this. Depending on the reporting software, there are differences in the information. All of this cannot be verified. This statement reminds me more of possible train announcements: "Due to a disruption in the operational process, our train is currently delayed by 15 minutes". The train is late because it is late.

When asked by the Senate, Mr. Wichmann gave a plausible, but at the same time sobering explanation: he explained that the fact that the effectiveness of the vaccination was falling was due to the fact that the vaccination campaign was stagnating. Most booster shots were given in late 2021/early 2022. The protection provided by the vaccination decreases significantly 3-5 months after vaccination. However, this is a clear admission that vaccination is in reality*Not*works : What do I have to think of a “vaccine” that is not even at a distance

must be sprayed again every six months so that protection is guaranteed at all?

And does this not support the thesis already put forward in my brief of April 14, 2022, page 20 et seq. that the COVID injections are gradually destroying the human immune system? I confronted Mr. Wichmann with the study Seneff et al., Innate Immune Suppression by SARS-CoV-2 mRNA Vaccinations: The role of Gquadruplexes, exosomes and microRNAs,https://doi.org/10.1016/j.fct.2022.113008 . According to Mr. Wichmann, he was aware of this study; However, there is no evidence that the effect after the 4th vaccination is worse than after the 3rd vaccination. Oh yes, these clues are there! I refer to the Israeli study Regev-Yochay et al., Efficacy of a Fourth Dose of Covd-19 mRNA Vaccine against Omicron, DOI: 10.1056/NEJMc2202542, https://www.nejm.org/doi/full/10.1056/NEJMc2202542 , which relates to the effectiveness of the fourth vaccine in young healthcare workers and concludes:

Thus, a fourth vaccination of healthy young health care workers may have only marginal benefits.

In his brief, attorney-in-fact Tobias Ulbrich has already referred to another study that proves massive disruption of the human immune system by COVID injections: Liu et al., Comprehensive investigations revealed consistent pathophysiological alterations after vaccination with COVID-19 vaccines,https://doi.org/10.1038/s41421-021-00329-3 . Studies like those by Liu et al. and Seneff et al. only prove one thing: the COVID injections were completely insufficiently researched and equally insufficiently tested before they were approved as vaccines in the EU. It would actually have been the task of the manufacturers to carry out studies of this type. However, the opposite is the case: In the approval process, the manufacturers even let it go that no preclinical safety studies on the two mandatory animals (old male golden hamster before use on humans and pregnant rabbit before use on pregnant women) were presented.

Now one may take the position with the Senate that the legality of the admission decision is not to be examined in the current procedure

is: The subject of the approval process was whether the COVID injections will be marketed as vaccines*allowed to*; The subject of the current proceedings is whether they will be tolerated by the soldiers*have to*. However, anyone who declares a vaccination to be mandatory for which the manufacturer has been permitted to refrain from certain examinations and tests must carry out these examinations themselves. Section 17a (2) sentence 1 no. 1 SG does not provide a legal basis for rolling out a vaccination experiment on soldiers.

However, the RKI's SARS CoV-2 weekly report of June 2nd, 2022 contains other interesting information, namely regarding the occupancy of the intensive care units

(https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Situationsberichte/Wochenbericht/Wochenbericht_2022-06-02.pdf?__blob=publicationFile):

"For the period from 05/02/2022 to 05/29/2022 (week 18 - week 21/2022) the vaccination status of 1,813 COVID-19 admissions was reported, which corresponds to about 66.7% of the cases reported for this period (2,720). 15.8% (286 cases) of all COVID-19 admissions with known vaccination status were unvaccinated. Around 7.7% (139 cases) showed incomplete immune protection (recovery without vaccination or partial immunization). 76.6% (1,388 cases) had full vaccination protection (primary immunization or booster), the proportion with a booster vaccination was around 51.6% (936 cases)."

So 15.8% of the COVID-19 cases treated in intensive care are without vaccination. We now compare this with the information on the vaccination rate:

“The vaccination rate has now remained almost unchanged for several weeks: as of May 31, 2022, a total of 78% of the population had been vaccinated at least once and 76% had been fully vaccinated; 60% of the population received a first booster and 6% a second booster.”

22% of the German population is unvaccinated overall, but only 15.8% of COVID cases in intensive care units. For the sake of honesty, one would even have to subtract from this number those who, by definition, still receive the status “unvaccinated” in the first 14 days after the COVID vaccination. But be that as it may: These numbers clearly indicate that the COVID injections do not prevent a severe course, but on the contrary fuel it.

b) More vaccinations - higher incidence

The former legal representative Beate Bahner had forced the respondent to admit that since the start of vaccination in the Bundeswehr, the incidence there has increased massively - after Colonel Dr. Konrad Steinestel had claimed in the oral hearing on May 2nd, 2022 that compared to the time when no soldier had been vaccinated, the incidence had fallen by 50%. I hereby refer to Beate Bahner's pleading of June 3, 2022, in which she aptly commented on the incidence figures presented by the respondent:

“But what is amazing here is the increase from November 2021 to January 2022 to an average of 786 infected soldiers per month and then an explosion in the infected from February to April 2022 to 3,434 infected soldiers per month!

Here, too, we see a 27-fold increase in the number of infected, an increase of 2,700 percent!

And this despite or because of the "vaccination" against Corona?

Please use these numbers to justify the vaccination from the RKI.”

I refer to the table created by Beate Bahner - based on the respondent's pleading of June 3, 2022 - which I reproduce here for the sake of simplicity:

5.5 Übersicht der Infektionen bei 200.000 Soldaten

Zahlen gemäß Schriftsatz Bundeswehr v. 22.5.2022
Seite 6, Punkt 3: Entwicklung 7-Tage-Inzidenz Bundeswehr
April 2020 - April 2022 (insgesamt 25 Monate)

Monate	Jahr Monat	Mittelwert	Multipliziert mit 2 (Hochrechnung auf ca. 200.000 Soldaten)	Mittelwert
1	Apr 20	29	57	
2	Mai 20	6	12	
3	Jun 20	1	2	
4	Jul 20	4	8	
5	Aug 20	11	22	
6	Sep 20	18	36	
7	Okt 20	57	113	
8	Nov 20	117	235	
9	Dez 20	145	290	
10	Jan 21	141	282	
11	Feb 21	85	170	126
12	Mrz 21	131	261	
13	Apr 21	172	345	
14	Mai 21	114	228	
15	Jun 21	20	39	
16	Jul 21	12	23	
17	Aug 21	25	51	
18	Sep 21	49	97	
19	Okt 21	63	126	
April 2020- Okt. 2021 19 Monate		1.199	**2.397**	
20	Nov 21	256	511	
21	Dez 21	302	603	
22	Jan 22	621	1242	786
Nov. 21 - Jan. 22 3 Monate		1.178	**2.357**	
23	Feb 22	1.587	3173	
24	Mrz 22	1.961	3922	
25	Apr 22	1.604	3209	3434
Febr. 22 - April 22 3 Monate		5.152	**10.303**	

These frightening numbers had to provoke critical questions to Mr. Wichmann: How can it be that the incidence increases so sharply when the troops are 94% vaccinated? And how do the Bundeswehr numbers compare with the incidence in the general population among 18 to 59 year olds? Mr. Wichmann could only present evasive answers: The infection process is influenced "multifactorially", as is its perception. So it could be that the Bundeswehr is looked at more closely than the general population. In any case, there is no reason to assume that vaccination in the Bundeswehr is less effective than in the rest of the population. You can't compare the numbers from 2020 with today's either, especially not the incidence values. The virus changes the behavior of the population changes. In 2020 there were many more deaths, but in 2022 there was a huge omicron wave with hardly any deaths.

With the sentence last quoted, Mr. Wichmann confirms one thing above all: The vaccination is not necessary because the severity of the courses has decreased dramatically! In any case, this appreciation is necessary if one accepts the premise set by Mr. Wichmann that the virus actually caused as many deaths in 2020 as it claims, i.e. if one ignores other causes of death (e.g. wrong medication? premature invasive ventilation? Premature determination of SARS CoV-2 as the relevant pathogen, although a PCR test is also positive for other pathogens?). Incidentally, the question of whether vaccination in the Bundeswehr is less effective than in the general population does not go to the heart of the problem. The question is rather whether the vaccination*at all*works and whether its effect maybe even*negative*is.

In this context, Mr. Wichmann said that it is not known whether the COVID vaccinations would not have prevented an even higher incidence. However, the RKI data indicate a clear correlation: the higher the vaccination rate, the higher the 7-day incidence (see Peter F. Mayer of June 4, 2022,https://tkp.at/2022/06/04/rkidaten-show-je-mehr-geimpft-desto-hoeher-die-inzidenz/)! Something similar also emerges from a list that IAnnex BF-MS 67 attach. Now you may object that in my previous presentation I did not attach any significance to the PCR test results from which the incidence value is fed. But even then no argument in favor of the Respondent could be derived from it. Because either the incidence value says something about the infection process - then it correlates positively with the vaccination rate with the result that a negative vaccination effectiveness is indicated. Or it says nothing about the infection process - then the entire pandemic story has to be put to the test, which is why the vaccination campaign was rolled out in the first place.

Worse still, a recent analysis has found that there is a highly striking positive correlation between vaccination coverage and all-cause mortality, and a still weak positive correlation between vaccination coverage and COVID-19 mortality (https://coronablog.net/2022/06/18/gesamtsterbefallzahl-korreliert-hochsignifikant-positiv-mitimpfquote-beim-vergleich-aller-deutscher-bundeslaender/). The former indicates a massive number of potential deaths from vaccination, the latter a complete (at best) uselessness of vaccination in combating

SARS-CoV-2. In particular, one can then no longer claim that the COVID injections prevented severe COVID-19 courses. In any case, the numbers speak for themselves *versus* Mr. Wichmann's attempt at justification. It's possible *Not* show that vaccination prevented an even higher incidence. Rather, they obviously fuel this incidence.

c) Exclusion of “another” vaccinated persons from the statistics

Mr. Wichmann was confronted with the question of why COVID patients are counted as unvaccinated COVID patients when measuring vaccination effectiveness between the first and 14 days after the second injection and are not recorded in a separate category. The question is more than obvious: Because it is precisely during this period that the immune system is particularly stressed by the COVID injections. Mr. Wichmann only replied that such a recording would falsify the data situation, but without explaining this in more detail. In reality, a separate recording of people who have started the vaccination but not yet completed it would bring revealing insights to light - but in all likelihood those that the RKI would not like because they cast a bad light on the vaccination campaign would.

d) household studies

The RKI reports on its website under the heading "How effective are the COVID-19 vaccines?" (RKI - Vaccination - COVID-19 and Vaccination: Answers to Frequently Asked Questions (FAQ)) the following:

*"About the **Transmission below omicron** there is not enough data yet; it appears to continue to be reduced in vaccinated individuals, although the extent of the reduction is not fully understood Norway and Denmark show that vaccination reverses transmissibility even under predominant circulation of the omicron variant **approx.** Reduced by 6-21% after primary vaccination and by another 5-20% after booster vaccination.”*

The studies are from the following sources:

Norway: Jalali et al., Increased household transmission and immune escape of the SARS-CoV-2 Omicron variant compared to the Delta variant: evidence from Norwegiancontacttracingandvaccinationdata, https://doi.org/10.1101/2022.01.28.22270044 .

Denmark: Lyngse et al., Transmission of SARS-CoV-2 Omicron VOC subvariants BA.1andBA.2: Evidence from Danish Households, https://doi.org/10.1101/2022.01.28.22270044 .

Both studies have been made available to the public as preliminary versions (so-called preprints), so they have not yet gone through a peer review. This in itself does not have to speak against using the results of these studies now. I am only emphasizing this point at this point because the senate hearing the hearing we requested from Prof. Dr. Harald Matthes, inter alia, refused on the grounds that any research results could only be included in the proceedings here if they had been published and externally assessed.

The statements by Mr. Wichmann that the vaccination still offers 36% protection against the transmission of the pathogen even after a long period of time does not match the information just quoted on the RKI website. However, the Danish study in particular also has methodological weaknesses that are worth taking a closer look at:

- What the authors call the "study" is not a study, but a retrospective analysis of positive PCR and antigen tests from individuals matched to households based on their personal identification number and whose vaccination and test status is derived from the personal identification number.

- With this study, they wanted to determine transmission within the households with those who tested positive. To do this, they chose the period from Christmas to New Year as the analysis period. The authors themselves admit that this is a weak point of the study, since it can be assumed that intensive contact outside the household also took place during this period, despite corresponding government recommendations. The time period alone was therefore in no way suitable for analyzing transmission of Omicron within a household.

Some limitations apply to this study. The study period runs over Christmas 2021 and New Year's Eve 2021/22, which are public holidays in Denmark. Despite government advice to limit social activity, it is likely that there has been considerable social mixing with family and friends outside the households during this period. Social mixing over the holidays in conjunction with the high incidence levels in Denmark during this period likely means that some secondary cases in this study are actually misclassified co-primary cases, i.e. infections picked up outside the household and testing positive after each other. However, this potential bias would be applicable to both subvariants. Moreover, our estimates were robust when only including primary cases from 5-11 January 2022 (appendix Table 12, model II) and when only including secondary cases found on day 2-7 or 3-7 (appendix Table 13, model VII and VIII).

- The analysis does not take into account the different subjective test behavior of people. Only the first positive test in a household was chosen as a starting point and then it was checked whether further positive tests were recorded for this household. The way of life of the people was not taken into account in any way.

A primary case was defined as the first individual in a household testing positive with an RT-PCR test within the study period and being identified with the Omicron VOC BA.1 or BA.2 by WGS. We followed all tests of other household members in the follow-up period. A positive secondary case was defined by either a positive RT-PCR test or a positive antigen test (Jakobsen et al., 2021). Households were categorized as BA.1 or BA.2 households depending on the WGS result of the sample from the primary case.

- Simply vaccinated are also classified as unvaccinated. This distorts the picture enormously! It is noticeable that Mr. Wichmann just *here*, where it would have been appropriate *Not* allegations of data corruption.

The vaccination status of all individuals was classified into three groups following Lyngse et al. (2021b): i) unvaccinated (including partially vaccinated individuals); ii) fully vaccinated (defined by the vaccine used, Comirnaty (Pfizer/BioNTech): 7 days after second dose; Vaxzevria (AstraZeneca): 15 days after second dose; Spikevax (Moderna): 14 days after second dose; Janssen (Johnson & Johnson): 14 days after vaccination, and 14 days after the second dose for cross vaccinated individuals) or 14 days after previous infection; or iii) booster-vaccinated, defined by 7 days after the booster vaccination, (Pfizer, 2021; Bomze et al., 2021). By 22 December 2021, of all vaccinated individuals in Denmark, 85% were vaccinated with Comirnaty, 14% with Spikevax, 1% with Janssen, and approximately 0% with AstraZeneca (SSI, 2021).

- The analysis is therefore anything but meaningful with regard to a statement on the transmissibility of Omicron by the unvaccinated, vaccinated and boosted. In addition, a PCR test is unsuitable for detecting an infection. It is a retrospective analysis of data from which one does not know how they came about.

But back to the information on the RKI website: If the vaccination effectiveness has dropped to around 20%, the question arises with all vigor as to whether a vaccine with such a low effectiveness would ever have a chance of being re-approved . If you say no to this question, the question of a duty to tolerate is also resolved. Even assuming that the COVID injections are currently being used in a legitimate manner to combat the omicron variant, one cannot make the toleration of these injections mandatory given their weak effectiveness.

e) Data from England, Portugal and Israel

During his interrogation, Mr Wichmann also referred to data from England to support his claim that the COVID injections reduced transmission of SARS CoV-2. When looking at the total population there in close proximity to the previous vaccination, the reduction is 94%, later 88%. Among the 18-64 year olds it was initially 97%, later 76%.

Where Mr. Wichmann gets this data from remains unclear. On the blog tkp.at from March 24, 2022, Waldo Holz analyzed the data from the British Ministry of Health for the period from February 14, 2022 to March 13, 2022 (https://tkp.at/2022/03/24/uk-desaster-92- percent-der-covid-toten-geimpft/). The tables from the UK COVID-19 Surveillance Report for calendar week 11 are accurately reproduced in this analysis

(please refer

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1061532/Vaccine_surveillance_report_-_week_11.pdf , p. 43)
The devastating result of this analysis is: Of 1,584 COVID-19 deaths, 1,230 were triple and 220 were double vaccinated. 1,450 of 1,584 = 91.5% of the deceased had what, according to the (German) nomenclature of the time, was a complete

called immunization. A success of the vaccination campaign definitely looks different.

The same picture emerges in Israel (see Peter F. Mayer of June 19, 2022, https://tkp.at/2022/06/19/daten-aus-israel-showing-effectiveness-of-mrna-vaccines/): By far the most COVID-19 cases can be attributed to the group that appears in the graphics of the Israeli Ministry of Health in the section *vaccinated without validity*are listed - those people who originally had the COVID injections given but then refused to agree to the vaccination subscription sought by the Israeli government.

Even in Portugal, which is considered the European vaccination champion, a high vaccination rate was not able to prevent high numbers of cases (Peter F. Mayer from May 23, 2022, https://tkp.at/2022/05/23/portugal-mit-weltweit-highest-vaccination-rate-and-permanently-high-case-numbers/). During his interrogation, Mr. Wichmann tried to put the development in Portugal into perspective: These are not serious cases, but mild courses, and the current increase in cases can possibly be explained by the omission of the mask requirement. However, the latter is speculative, since such an explanation would first require proof that masks can counteract the transmission of SARS CoV-2. Above all, however, the graph in the article by Peter F. Mayer just cited shows that despite (or perhaps because of?) the high vaccination rate, much larger numbers of cases were recorded at the turn of the year 2021/2022.

f) Studies versus surveillance data

Mr. Wichmann made a remarkable statement when it came to the question of how the data on vaccination effectiveness came about. Mr. Wichmann defended himself against assumptions that the RKI was manipulating the data. The assessment of vaccination effectiveness is based on an overall view of hundreds of studies carried out by thousands of scientists. The data on which these studies are based are more meaningful than our own surveillance data. Because the RKI does not investigate each individual case, but only collects its own data passively. The manner in which surveillance data is collected is up to the local actors. I

understand that the advantage of the study data should be that they are proactively collected by the researchers.

I will return to this statement when discussing the safety of the COVID vaccines. Because the PEI bases its security report on passively collected surveillance data! If this is seen as a weakness in vaccine effectiveness, the same must be true of vaccine safety.

However, if one gives preference to studies, it would be helpful if the RKI and STIKO would also take note of the research work that *versus* support the assumption that the COVID injections offer protection against COVID-19 disease. I refer to a study that observed an extremely large cohort—populations in 68 countries and 2,947 US counties (Subramanian/Kumar, Increases in COVID-19 are unrelated to levels of

vaccination across 68 countries and 2947 counties in the United States, https://doi.org/10.1007/s10654-021-00808-7). The result of this study is simple: If the vaccination has any effect on the course of infection at all, then at most it is that where more vaccinations are given, there tends to be a (albeit slightly) increased risk of contracting CIOVID-19 . In plain language: The COVID-19 vaccination brings *nothing at all*!

g) Clinical registration studies

According to Mr. Wichmann, the approval studies are used to evaluate the effectiveness. It is doubtful, however, that the RKI and the STIKO also take note of critical analyzes of these studies. A recent media report shows that according to the Pfizer documents, 800 subjects did not complete the study, partly because they died during the study (The Exposé of 6/15/2022:

https://expose-news.com/2022/06/15/pfizer-documents-800-people-never-finished-trial/). Apparently, the authorities are not even asking about the cause of death. A British group of experts used the Pfizer documents, the release of which was legally enforced in the USA, to determine that the assertion in the Pfizer approval study that only 8 test persons in the group of vaccinated people were infected cannot be correct; a significantly higher number of the vaccinated subjects (namely 75) had been shown to have antibodies

formed against SARS CoV-2. In addition, some test persons who were symptomatic of COVID-19 were simply excluded (for details see the report by Peter F. Mayer of June 20, 2022,https://tkp.at/2022/06/20/ausanalyse-der-pfizerzulassungsstudie-durch-hart-group-efficacy-null/).

3. Conclusion

During his interrogation, Mr. Wichmann was unable to prove the effectiveness of the COVID vaccinations. His answers to critical questions remained vague and sometimes contradict the actual circumstances, even the announcements on the RKI website.

III. How safe is the vaccination?

Furthermore, the statements by Dr. Dirk Mentzer (PEI) on the safety of the COVID vaccines.

1. The distribution of the active substance in the human body

A very important argument to allay any concerns about the safety of COVID injections is the claim that the active ingredient in COVID injections remains at the injection site. This thesis has always been very daring. Because the assessment reports state that there are no studies on the pharmacokinetics of the finished substances. Here is an excerpt from the Comirnaty report as an example:

2.3.2. Pharmacokinetics

The applicant has determined the pharmacokinetics of the two novel LNP excipients ALC-0315 (aminolipid) and ALC-0159 (PEG-lipid) in plasma and liver as well as their elimination and metabolism in rats. Furthermore, the Applicant has studied the biodistribution of the two novel lipids (in rats) and the biodistribution of a LNP-formulated surrogate luciferase RNA in mice (IV), as well as the biodistribution of a [^{3}H]-Labelled Lipid Nanoparticle-mRNA Formulation in rats (IM).

No traditional pharmacokinetic or biodistribution studies have been performed with the vaccine candidate BNT162b2.

In study PF-07302048_06Jul20_072424, the applicant has used a qualified LC-MS/MS method to support quantitation of the two novel LNP excipients. The bioanalysis methods appear to be adequately characterized and validated for use in the GLP studies.

PK studies with the two novel LNP-excipients ALC-0315 and ALC-0159:

Wistar Han rats were IV bolus injected with LNP formulated luciferase-encoding RNA at 1 mg/kg and ALC-0315 and ALC-0159 concentrations at 15,3 mg/kg and 1,96 mg/kg respectively. ALC-0315 and

The interpretation of this information is in German: We do not know how the substance is absorbed by the body (absorption). We do not know whether and, if so, how the substance is distributed in the body (distribution). We do not know how the substance is incorporated / metabolized in the body and what exactly it does in the body (metabolization). We do not know whether and, if so, how the substance is eliminated from the body (excretion).

In addition, this assumption by Mr. Mentzer has now been completely refuted:

- In my brief dated June 3rd, 2022, page 25, I pointed out that even according to the own documents of Comirnaty manufacturer Pfizer, the lipid nanoparticles, i.e. the carrier substance of the active ingredient, are distributed in numerous places in the body.
- A case report has now been published describing a patient who died from the COVID vaccination (Mörz, A Case Report: Multifocal Necrotizing Encephalitis and Myocarditis after BNT162b2 mRNA Vaccination against Covid-19, doi: 10.20944/preprints202206.0308.v1 , https://www.preprints.org/manuscript/202206.0308/v1). This report describes that the spike proteins were found at autopsy in many places in the body, including the brain and heart (see also report24 of 27 June 2022 for this case report,https://report24.news/manndied-after-booster-autopsy-spike-protein-in-brain-and-heart-proven/?feed_id=18137). The vaccine spike proteins thus overcome the blood-brain barrier!
- In another study (Ogata et al., Circulating Severe Acute Respiratory Syndrome Coronavirus 2 (SARSCoV-2) Vaccine Antigen Detected in the PlasmaofmRNA-1273VaccineRecipients, https://doi.org/10.1093/cid/ciab465 The vaccine mRNA of the Moderna vaccine was found in the blood of patients who had been vaccinated with it.
- BioNTech boss Ugur Sahin commented on this as follows: “For the Covid-19 candidate vaccine, we chose lipid nanoparticles that promote migration from the muscle cells into the lymph nodes. Dendritic (antigen presenting) cells then present the resulting S protein to the immune system” (see Peter F. Mayer of June 7th, 2022,

https://tkp.at/2021/06/07/schaedigung-der-zellen-due-planned-distribution-of-mrna-vaccines-in-the-body/).

2. The importance of enhanced pharmacovigilance in legislative materials

However, if the active ingredient settles everywhere in the body, completely convincing evidence must be provided that the ingredients - specifically the lipid nanoparticles and the vaccine mRNA - do not cause any damage where they go. Maximum efforts must be expected from the supervisory authorities to meticulously get to the bottom of possible adverse vaccination complications. This requirement has also found its way into the legislative materials for the 3rd Civil Protection Act. In the printed matter 19/14)245.1 of the Committee on Health in the German Bundestag it says verbatim:

"In view of an accelerated development and currently not yet comprehensive data on the clinical effectiveness and side effect profile of the COVID-19 vaccines, particularly strict requirements for the vaccination rate monitoring and the monitoring of effectiveness and safety (surveillance) are already in phase 1 of the central vaccination in vaccination centers and by means of mobile teams."

This requirement has led to an important change in Section 13 (5) IfSG, which is also significant for the present proceedings; this will still have to be dealt with.

3. Risk signals

Stricter pharmacovigilance means, among other things, that the PEI, as the supervisory authority, perceives risk signals and actively searches for such signals.

a) Years of life lost?

It is known that the median age of patients dying from COVID-19 levels off at +/- 80 years with slight fluctuations (https://de.statista.com/statistics/data/studie/1241071/umfrage/alter-bei-

corona infections-hospitalizations-and-deaths-in-germany/ , 06/08/2022; see also Understanding RKI Excel spreadsheet, “Alter_Median_Mittelwert” tab, status 22.6.2022, https://www.rki.de/SiteGlobals/Forms/Suche/serviceSucheForm.html;jsessionid=08F14779B901290C172E10D4BEDD1143.internet111?nn=2725444&input_=2725444&gts=2725442_list%253DdateOfIssue_dt%252Bdesc&resourceId=2390936&submit.x=0&submit.y=0&searchEngineQueryString= median age+death%C3%A4lle+covid-19&pageLocale=de) and is thus about the same, if not even higher, than the median age in the general population (another indication that this disease is not nearly as dangerous as is widely claimed). A monitoring agency that is serious about its job would now be proactive in asking about the median age of people dying with COVID vaccination (and not just a full one!). If there is a significantly lower median age, this would be a reason to investigate the causes. Years of life lost in vaccinated people would certainly be a risk signal!

Consequently, Mr. Mentzer was confronted with the question of whether the PEI knew the median age of the patients who died from or with the vaccination. His answer: The PEI has not yet calculated this median age. There is a risk of distortion. Regrettably, Mr. Mentzer did not explain exactly what threatens to be distorted and how.

The inactivity of the PEI at this point is to be regretted. After all, excess mortality in young and middle-aged groups is definitely detectable. This becomes clear when one studies media reports on the recent increase in life insurers' death benefits (see Peter F. Mayer of 17.6.2022, https://tkp.at/2022/06/17/wieder-enorme-verluste-due-vermehrte-todesfaelle-undmedizin-bei-us-lebensversicherung/ as well as the report in The Center Square of January 1, 2022,Appendix BF-MS 68).

b) Increase in all-cause mortality over time with the increase in the number of vaccine doses administered

Prof. Dr. Christof Kuhbandner, who was also present on the two days of the hearing on June 7th and 8th, 2022, had pointed out another risk signal to the PEI - namely an increase in overall mortality in temporal relation to the increase in the number of vaccine doses administered (I had the document as a Attachment BF-MS 60 to my brief of April 14, 2022). I asked Mr. Mentzer whether he knew Christof Kuhbandner's letter; he denied that. This answer is more than worrying. Apparently it is not enough that the PEI refuses to proactively identify risk signals. What's more, it doesn't even take action when it receives such a signal on a silver platter!

From Dr. Personally, I would have hoped for Mentzer to be informed as to whether he was aware that within the framework of the GCP regulation or, since January 31, 2022, the VO EU 536/2004 (OJ EU No. L 158 of May 27, 2014 , p. 1) as part of a clinical phase IV approval study (we are currently in this phase) all SUSARs (suspected unexpected severe adverse reactions) are at the expense of the pharmaceutical company and the sponsor, i.e. all suspected reports are to be equated with an actual side effect, until proven otherwise. The PEI cannot content itself with the statement that the causality of the vaccination for the subsequent physical impairment has not been proven. Rather, it must be able to rule out with certainty that causality before shelving the case in question as irrelevant to pharmacovigilance. This would certainly have required the ordering of autopsies.

Of interest in this context is Mr Mentzer's – in this respect credible – statement that 90% of all reported suspected cases are not reported by doctors but by the affected persons themselves or their relatives. In the oral hearing on June 7th, 2022, Mr. Wölfel tried to interpret this as meaning that the doctors would have ruled out a suspected case due to their superior professional assessment and that reports from non-medical professionals are therefore of no comparable importance for the monitoring of the COVID vaccines. However, this appraisal falls short of the mark. the

The reluctance of doctors to report vaccination side effects can be explained by the fact that the admission that the COVID injections could cause damage would shake an entire worldview, especially among doctors (see my brief of April 14, 2022, page 24 ff.).

c) Observed versus Expected Analysis

Mr. Mentzer's statements on the determination of the so-called standard mortality ratio based on an observed-versus-expected analysis were in no way convincing. The attorney-in-fact Wilfried Schmitz has already presented this in detail. The crucial error of the PEI is that the cohort "observed" is not identical to the cohort "expected": If the *expected* Mortality is related to the total population and thus to all conceivable causes of death, one must not at the same time *watched* Mortality refers only to those who died in connection with the COVID vaccination. By proceeding in this way, the PEI is comparing apples and oranges.

In this context, Mr. Mentzer was confronted with the question of how the frequency of vaccination complications with the COVID vaccines differs from that with other vaccines. Mr. Mentzer was unable to understand the figures we presented, but said anyway that such a comparison does not represent a normal calculation and cannot convey any risk signal. It is unfortunate that the PEI again misses the opportunity to get to the bottom of possible safety concerns about the COVID injections.

d) How many people must die?

It was with great astonishment that I heard Mr. Mentzer's answer to the question of how many people he believes have to die before the PEI recognizes a risk signal and, if necessary, the COVID injections as a questionable drug within the meaning of $ 5 para. 1 AMG classified. Mr. Mentzer was not able to name a specific threshold value! He just said that vaccination-related death does not necessarily mean vaccination-related death; he is obviously not aware of the above-mentioned reversal of the burden of proof to the detriment of the manufacturer. The PEI researches every suspected case

after. He, Mr. Mentzer, does his own research into the deaths of children. There were no new findings on children for the last safety report. He does not know how many children have been vaccinated since December 31, 2021. When asked how likely it is that*no*another child died, Mr. Mentzer replied that he could not say that, in any case no further case of a child dying after vaccination had been reported. He concluded with the words: "You are welcome to ask the PEI."

The statement last quoted is surprising: wasn't it Mr Mentzer who represented the PEI in the hearing on June 7th, 2022? Above all, however, the statement that no other child has died after the vaccination since the beginning of 2022 does not correspond to reality. Rather, the truth is that the number of children who died after vaccination (note only those who were reported!) has meanwhile increased from 8 to 9 (Report24 of June 9, 2022,https://report24.news/paul-ehrlichinstitut-packt-aus-official-9-dead-and-1-208-damaged-children-after-vaccination/?feed_id=17256). Since Mr. Mentzer says he researches the children's cases himself, it is difficult to explain the misinformation he gave in the oral hearing on June 7, 2022 regarding the number of children who died with gaps in memory.

The current safety report shows a significant number of people who died on the day of vaccination or the day after.

Bundesinstitut für Impfstoffe und biomedizinische Arzneimittel
Federal Institute for Vaccines and Biomedicines

Paul-Ehrlich-Institut

Tabelle 2: Observed-versus-Expected-Analyse zu den dem Paul-Ehrlich-Institut berichteten Todesfällen in unterschiedlichem zeitlichen Abstand zur Impfung gegen COVID-19

Eingeschlossen wurden gemeldete Fälle, die sich auf eine COVID-19-Impfung bis zum 31.03.2022 bezogen und bei denen das Zeitintervall zwischen Impfung und Symptombeginn bekannt ist. Die Hintergrundinzidenz beträgt laut Statistischem Bundesamt 1.240,97 Todesfälle pro 100.000 Personen/ Jahr[1].

		Zeitintervall zwischen Impfung und Symptombeginn			
Todesfälle Gesamt		**1 Tag**	**7 Tage**	**14 Tage**	**30 Tage**
Comirnaty	Anzahl Fälle	422	922	1165	1369
	SMR (95% CI)	0,098 (0,089-0,108)	0,031 (0,029-0,033)	0,019 (0,018-0,021)	0,011 (0,010-0,011)
Spikevax	Anzahl Fälle	55	103	121	136
	SMR (95% CI)	0,055 (0,041-0,072)	0,015 (0,012-0,018)	0,009 (0,007-0,010)	0,0045 (0,0038-0,0054)
Vaxzevria	Anzahl Fälle	57	131	180	230
	SMR (95% CI)	0,132 (0,100-0,170)	0,042 (0,036-0,051)	0,030 (0,025-0,034)	0,018 (0,015-0,020)
Jcovden (COVID-19 Vaccine Janssen)	Anzahl Fälle	14	26	35	39
	SMR (95% CI)	0,114 (0,062-0,191)	0,030 (0,020-0,044)	0,020 (0,014-0,028)	0,011 (0,007-0,014)
		Zeitintervall zwischen Impfung und Symptombeginn			
Todesfälle nach Auffrischimpfungen		**1 Tag**	**7 Tage**	**14 Tage**	**30 Tage**
Comirnaty	Anzahl Fälle	51	101	114	128
	SMR (95% CI)	0,049 (0,036-0,064)	0,014 (0,011-0,017)	0,008 (0,006-0,009)	0,004 (0,003-0,005)
Spikevax	Anzahl Fälle	9	23	26	29
	SMR (95% CI)	0,015 (0,007-0,028)	0,005 (0,003-0,008)	0,003 (0,002-0,004)	0,0016 (0,0011-0,0023)
Vaxzevria	Anzahl Fälle	-	-	-	-
	SMR (95% CI)	-	-	-	-
Jcovden (COVID-19 Vaccine Janssen)	Anzahl Fälle	0	0	0	1
	SMR (95% CI)	-	-	-	1,66 (0,04-9,28)

[1] Daten des Statistischen Bundesamts (abgerufen am 19.01.2022): 982.792 Sterbefälle im Alter von 5 Jahren und älter im Jahr 2020; Bevölkerungsstand (Altersgruppen: 5 Jahre und älter im Jahr 2020): 79.195.618,
CI: Konfidenzintervall
SMR: Standard Mortality Ratio (SMR) bezeichnet das Verhältnis zwischen der Zahl der in einer Population in einem bestimmten Zeitraum beobachteten Todesfälle und der Zahl, die im gleichen Zeitraum zu erwarten wäre, wenn die Studienpopulation dieselben altersspezifischen Raten hätte wie die Standardpopulation.

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This finding alone should actually be seen as a risk signal!

4. The problem of underreporting of vaccination complications

a) Statements in the legislative materials

It has been known for a long time that not all side effects of drugs that actually have to be reported according to § 6 paragraph 1 IfSG are actually reported. This has not escaped the attention of the legislature either. I quote from BT printed paper 19/23944, p. 28 (in connection with the amendment of Section 13 (5) IfSG):

"However, the data collected by the Paul-Ehrlich-Institut since the IfSG came into force shows that not all vaccination complications are recognized or reported and that under-surveying can be assumed."

And it is just as clear to the legislator that a key weakness is the purely passive character of the reporting system. I quote further:

"Until now, the Paul-Ehrlich-Institut had to rely on purchasing health data on a case-by-case basis from health insurance companies or the European Medicines Agency for long-term, comparative pharmacovigilance studies on the basis of Section 75 of the Social Code Book X. Regular active pharmacovigilance, which has long been the standard in the USA or other EU countries, was only possible to a limited extent."

Let's remember: Mr. Wichmann, who was questioned on June 7th, 2022 as an expert of the RKI, prefers to rely on study data than on passively collected surveillance data for the assessment of vaccination effectiveness - precisely because the study data is not only passively received, but actively collected . We must therefore examine the data basis on which the assessment of vaccine safety is based all the more critically.

b) The interrogation of Dr. Mentzer on the issue of underreporting

During his interrogation, Mr. Mentzer was asked how he assessed the underreporting. His answer: he was aware that the PEI had too few reports

get. The PEI is the recipient, not the collector of the data. The reporting platform is designed to be low-threshold, the PEI cannot do more. In the worst case, the PEI assumes 50% underreporting. In the case of myocarditis, there is even over-reporting.

Mr. Mentzer went into more detail about the reporting procedure. There is a standardized reporting form as a fillable pdf. The PEI also accepts reports that do not use the form. Forms are often sent to the PEI that are filled out with illegible writing. He, Herr Mentzer, manages to fill out the form in 10 minutes. I would like to remind you that doctors assume that it will take 20 to 30 minutes for each case to be reported (see the evidence in my brief of April 14, 2022, page 23 f.).

When asked about the incendiary letter from the former BKK-Pro-Vita boss Andreas Schöfbeck, which had also been reported in the media, Mr. Mentzer replied: He had arranged a meeting with Mr. Schöfbeck. However, this was not approved by the BKK board. He, Mr. Mentzer, approached Mr. Schöfbeck proactively. The PEI was very open to its analyses. I want to emphasize that I*this*consider the statement to be credible.

On the other hand, Mr. Mentzer's statement on how to deal with vaccination complications reported from clinics was not very convincing. Mr. Mentzer was obviously of the opinion that the PEI was entitled to make a differentiation according to the degree of severity when classifying vaccination complications: If only fever is reported in the affected patient, the vaccination complication should not be classified as serious. According to the opinion represented here, this is not tenable, because on the one hand this would only affect fever below 39.5°C, on the other hand it applies to hospitalized patients*all*vaccination complications to qualify as serious. After all, there is a reason why the patient and his doctors decided to stay in hospital. The burden of proof rule, which has already been emphasized here several times, has an effect again: Only when the vaccination can be ruled out beyond a reasonable doubt as the cause of hospitalization can the case be assessed differently - and then it is not just a question of no serious complication, but of no vaccination complication at all . But as long as only the suspicion of causality between vaccination and the physical

impairment of the patient is in the room, the case must be recorded as a serious vaccination complication.

In response to the problem of under-reporting, the legislature had amended Section 13 (5) IfSG, obliging the Associations of Statutory Health Insurance Physicians to transmit billing data to the PEI. According to Mr. Mentzer during his interrogation, this data is not part of the safety report. The problem lies in the fact that the Associations of Statutory Health Insurance Physicians apparently have problems pseudonymising the billing data and therefore do not cooperate with the PEI.

However, there seem to be different perceptions as to whether the PEI has even spoken to the Associations of Statutory Health Insurance Physicians. Tom Lausen, who testified as an expert in the present proceedings and also asked Mr Mentzer himself, in an interview with Epoch Tims on June 28, 2022:

"There is a question from a member of parliament to the federal government who wanted to know: Was that really not reported? Did the Associations of Statutory Health Insurance Physicians really not talk to the PEI about this data? The Federal Government then said: No, for two years they have not spoken to each other about the side effect data that is to be transmitted by law. Before the Federal Administrative Court, Dr. Mentzer, however, responded to my question that they had probably spoken to the associations of statutory health insurance physicians. So there is a discrepancy between the information from the Federal Ministry of Health and the statement from the head of pharmacovigilance at the PEI."

I suggest that the recognized Senate clarify these inconsistencies. A written statement from Mr. Mentzer would suffice for me; In my view, he does not need to be summoned again specifically for this purpose.

c) Lack of organizational precautions

When asked, Mr. Mentzer explained that the PEI employs a total of 13 people to record vaccination complications. These are often working students. This means that the department for recording suspected cases is not only clearly understaffed in terms of quantity; rather, it is also to be feared that the

The professional qualification of the staff is not sufficient to be able to correctly classify the suspected cases.

Mr. Mentzer also explained that the PEI and RKI are currently conducting a clinical study in order to one day compare the findings obtained with the data from the health insurance companies. A total of 57,000 study participants would be observed for a whole year. That can only mean: *The PEI itself does not know whether the vaccines are safe*. Otherwise there would be no need for such a study.

Incidentally, the federal and state governments show an almost shameful disinterest in the underreporting of vaccine side effects. This comes from a revealing report in The Epoch Times 6/15/2022 (https://www.epochtimes.de/politik/deutschland/nebeneffekten-untererathert-undniemand-will-es-wissen-a3861395.html?telegram=1). Apparently, the top German executive doesn't think much of their commitment to the law. Because once again: In the course of the amendment of § 13 Para. 5 IfSG, the legislator had called for extreme care in pharmacovigilance!

d) Current data from the National Association of Statutory

Health Insurance Physicians

The current accounting data published by the National Association of Statutory Health Insurance Physicians (KBV) shows 2.487 million vaccine side effects coded by doctors. In media comments, this is rightly seen as a strong indication of massive underreporting of vaccination complications (Epoch Times of June 23, 2022,https://www.epochtimes.de/politik/deutschland/kbv-papierenthuellt-25-mio-patienten-mit-impfnebeneffekten-afd-will-konequencena3870369.html ; Report24 from June 24th, 2022https://report24.news/daten-deutscherkrankenkassen-behaben-only-10-of-25-million-side-effects-reported/). However, the KBV then also provided its own interpretation of this data (which it was not even asked about): Such a number was to be expected, since the COVID vaccines in particular are being looked at particularly closely.

The KBV takes the total number of vaccine doses administered from the PEI safety report of May 4, 2022, which refers to the period from the start of vaccination to March 31, 2022. In this way, the KBV tries to put the number of side effects of vaccinations in relation to the total number of vaccine doses administered. Meanwhile: The*vaccination side effects*, which are documented in the KBV report, only affect the accounting figures up to December 31, 2021. The number of vaccine side effects must therefore be divided by a much smaller divisor, namely the total number of vaccine doses administered by December 31, 2021 (!). This was immediately noticed in the critical media reporting (Epoch Times of June 23, 2022 https://www.epochtimes.de/politik/deutschland/peibetaeigt-kbv-hantätt-mit-falschen-zahlen-a3871776.html).

The KBV's own interpretation of the data is in no way convincing. After all, those affected felt so bad that they went to see a doctor. And as I have already explained in more detail in my brief of April 14, 2022, page 24 ff., to this day numerous doctors are not able to open themselves to the idea that the vaccination that they may receive themselves and also in more or a smaller number have given their patients, could cause such damage: For them, their worldview would collapse if the promise of salvation of vaccination were to prove to be a fallacy. In reality, we must therefore assume that there will be a much larger number of adverse vaccination complications. Another possible reason for the underreporting of vaccination side effects is shown in a report by Just Now News dated June 27th.https://just-now.news/de/deutschland/jeder-der-impfschaden-reports-will-be-dismissed-verkehrspiloten-starten-sich-to-defend/): Employers put pressure on their workforces by threatening to fire anyone who reports vaccine damage (probably meaning a vaccination complication, because vaccine damage is not reported to the PEI but to the pension office).

If, in view of this new development, we return to Mr. Mentzer's statements, the question immediately arises as to how the PEI, with its - as shown - weakly staffed department for recording suspected cases, can handle such a large number of suspected cases if they are all covered by Section 6 Para. 1 sentence 1 no. 3 IfSG would be reported, could manage at all. It would also be interesting to find out

whether the risk assessment of the PEI changes if 10 to 11 times as many vaccination side effects are coded as reported?

Tom Lausen, who testified as an expert in the present proceedings, summarizes the problem as follows (https://www.epochtimes.de/politik/deutschland/wirmuessen-von-einer-serious-versagen-der-behoerden-ausgehen-tomlausen-a3867788.html):

“This will that this cannot come from vaccination is expressed everywhere. If the data is acknowledged in such a way that a board member is dismissed after 21 years, or a study is confiscated, or the associations of statutory health insurance physicians do not hand over data, then we all have to worry. Then it's not honest anymore."

e) What I don't know doesn't bother me?

Overall, the questioning of Mr. Mentzer revealed the blatant weaknesses of the current reporting system in all sharpness. Tom Lausen, who testified as an expert in the proceedings here, describes this in an interview with the Epoch Times on June 28, 2022https://www.epochtimes.de/politik/deutschland/wirmuessen-von-einer-serious-versagen-der-behoerden-ausgehen-tomlausen-a3867788.html) as follows:

"Dr. Mentzer, who has been the head of pharmacovigilance at the PEI since 2004 and is responsible for ensuring that the PEI safety reports are complete and correct, explained when I asked whether all available side effects were really being recorded: No, they are not. So the PEI only takes care of the vaccination side effects that are brought to their attention. So if a patient goes to a hospital with a side effect of a vaccination and this has not been reported to the health department, this side effect of the vaccination is definitely not included in the PEI - even if the doctor codes his treatment as a side effect of the vaccination and bills it to the health insurance company. This is a purely passive reporting system and that is of course frightening.”

The Italian province of Apulia showed that things could be done differently in 2020 as part of the Italian measles vaccination requirement by publishing the following: Parents of 2,500 children were asked to stay for three weeks

MMRV (measles, mumps, rubella, chickenpox) vaccination diary. After that, they were called by researchers from the university and the Ministry of Health. 992 of 2149 children (that's how many returns there were) showed undesirable side effects, which corresponds to a rate of 462 per 1000 vaccinated children (46.2%). Of these 992 adverse reactions, 109 (11%) met the WHO criteria for being a 'serious' adverse reaction, meaning they were life-threatening or fatal, required intervention or hospitalization, or caused ongoing disability or disability. In Apulia there were 38 serious, undesirable side effects per 1000 vaccinated children - and that "only" with the measles vaccination, not with Corona, for example, which we all subjectively perceive as "having even more side effects". Adverse events following measles-mumps-rubella-varicella vaccine: an independent perspective on Italian pharmacovigilance data, https://doi.org/10.12688/f1000research.26523.2).

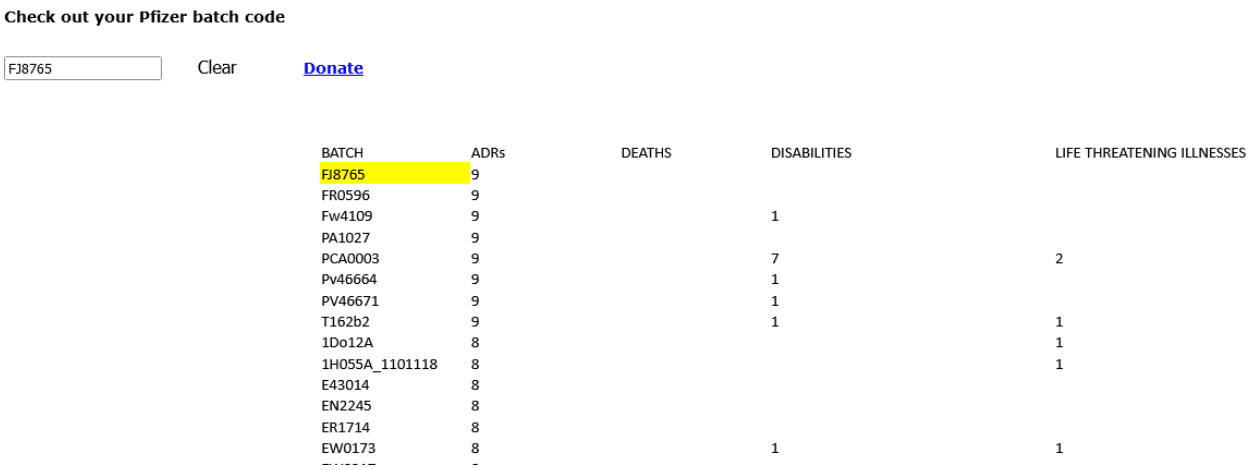
If pharmacovigilance in Germany were to be carried out proactively in the same way with the COVID vaccines as was done with the measles vaccination in Puglia: What results could we then expect?

5. How bad is your batch?

In my brief of April 14, 2022, page 6, I had already pointed out that, according to the US database for recording vaccination complications, a few batches of injections from Moderna, BioNTech and Johnson & Johnson are responsible for the majority of the serious vaccination side effects. I had to refer to a media report (https://2020news.de/how-bad-is-your-charge/) as well as to a website where anyone who has received the vaccination can check whether the batch they have been given is one of the particularly high-risk (https://www.howbadismybatch.com/). For the manufacturers Pfizer/BioNTech and Johnson & Johnson, this website also records batches that were administered outside the USA.

For example, suppose someone has been vaccinated with Comirnaty, batch FJ8765, manufactured by Pfizer/BioNTech. Then the person vaccinated in this way can climb onto the underside https://www.howbadismybatch.com/pfizerforeigndeaths.html navigate and the

Write down the batch number in an input field at the top left of the screen and then press the Enter key. Then this picture appears:



Check out your Pfizer batch code

FJ8765 Clear **Donate**

BATCH	ADRs	DEATHS	DISABILITIES	LIFE THREATENING ILLNESSES
FJ8765	9			
FR0596	9			
Fw4109	9		1	
PA1027	9			
PCA0003	9		7	2
Pv46664	9		1	
PV46671	9		1	
T162b2	9		1	1
1Do12A	8			1
1H055A_1101118	8			1
E43014	8			
EN2245	8			
ER1714	8			
EW0173	8		1	1

The person in question was obviously lucky: there were 9 ADRs (adverse drug reactions, i.e. vaccination complications) in this batch, but no deaths, no disabilities and no life-threatening illness.

I confronted Mr. Mentzer with the question of whether he was aware of this website and whether the PEI had noticed during the batch test that certain batches were responsible for a particularly large number of side effects. He denied this. However, it would be helpful if he and his team would take a look at this website. Because it may also provide insightful insights for Europe.

6. Especially myocarditis and pericarditis

One the probably most famous vaccination side effects are myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the sac around the heart). Mr. Mentzer was asked specifically about these vaccination complications for his assessment and answered the following: According to the findings of the PEI, the probability of getting one of these two symptoms after the vaccination is 1:10,000. This coincides with the results of studies from Israel and Scandinavia. The symptoms appeared shortly after the vaccination and usually healed after 1-5 days without any consequences. Men get it more often than women. It is most common in men under 30. Mr. Mentzer also emphasized that

which the Respondent had already submitted: the risk of heart muscle inflammation is significantly greater after COVID infection than after vaccination.

In a brief dated June 3rd, 2022, page 12, I had qualified this derivation as a fallacy: whoever gets vaccinated and then gets vaccinated*also* infected, carries *either* the risk of myocarditis from vaccination*as well as* that by the infection. And by no means all people become infected with SARS CoV-2. I confronted Mr. Mentzer with these objections. He replied that someone could have contact with both SARS CoV-2 and the vaccine antigen (spike) at the same time. Then it is difficult to determine which of the two caused the myocarditis. With that, however, Mr Mentzer avoided my question. My question was aimed at making it clear that one cannot develop myocarditis either through vaccination or through infection, but that the risk of myocarditis through vaccination is increased*accumulated* will because *either* vaccination*as well as* possible infection as a risk factor. Mr. Mentzer did not get to the heart of my question.

However, it is fundamentally questionable whether it is true that the risk of myocarditis and pericarditis is lower after vaccination than after infection. A recent study (Le Vu et al Age and sex-specific risks of myocarditis and pericarditis following Covid-19 messenger RNA vaccines, https://doi.org/10.1038/s41467-022-31401-5) shows – once again – a significantly increased risk of these two diseases as a result of COVID-19 vaccinations, with the Moderna injections (risk increase on average 30%) performing significantly worse than the BioNTech injections (risk increase on average 8%). This risk increase was measured by comparing it with a non-vaccinated control group (on this study, see also Epoch Times of June 28, 2022,

https://www.theepochtimes.com/moderna-vaccine-increasesmyocarditis-risk-by-44-times-in-young-adults-peer-reviewed-study_4561018.html?utm_source=newsnoe&utm_campaign=breaking-2022-06-29-2&utm_medium=email&est=zkXE7o02WIedxUWivp7mWclqex%2BGvF14oNRinrM0SV39J.SYP).

That vaccination*As a general rule*, so that*entire* A recent study (Fraiman et al., Serious Adverse Events of Special Interest Following mRNA

vaccination in Randomized trials, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4125239 .), which has received wide media coverage (see The Exposé of June 23, 2022,https://exposenews.com/2022/06/23/who-study-risks-outweigh-benefits-covid-vaccination/ ; Thomas Oysmüller from June 2nd, 2022,https://tkp.at/2022/06/22/hochbrisante-studie-aususa-impfung-riskanter-als-infection/ ; Peter F. Mayer from June 26, 2022, https://tkp.at/2022/06/26/neue-studie-shows-high-rate-of-side-effects-in-denmrna-vaccinations/ ; TCW from 25.6.2022,https://www.conservativewoman.co.uk/covidvaccines-more-likely-to-put-you-in-hospital-than-keep-you-out-bmj-editors-analysisof-pfizer-and-moderna-trial- data finds/). This study has not yet gone through a peer review; but let me remind you that the RKI does not hesitate to refer to research work that has already been presented to the public as a preprint but has not yet been externally reviewed.

The way in which Mr. Mentzer downplayed the risk of heart muscle inflammation (myocarditis) during his interrogation must be emphatically contradicted. In some cases it may actually be the case that the disease heals after 1-5 days without consequences. However, one reads, for example, in the yellow list, the pharmaceutical index: “Acute myocarditis has a high mortality rate despite treatment. Focal borderline myocarditis often heals spontaneously if there is no significant cardiac insufficiency initially. Fulminant lymphocytic myocarditis has a mortality rate of over 40% in the first four weeks. Undetected and untreated, granulomatous-necrotizing myocarditis is fatal. Untreated giant cell or eosinophilic myocarditis also has a 4-year survival rate of < 20% have an extremely poor prognosis. Non-fulminant active myocarditis is associated with a mortality rate of 25 to 56% within three to ten years due to progressive cardiac insufficiency and sudden cardiac death.” (https://www.gelbe-liste.de/diseases/myocarditis). In 20% of cases, myocarditis also leads to a chronic disease (cardiomyopathy, see Deutsche Herzstiftung, Offprint Myocarditis, p. 17, 19, available

under https://www.herzstiftung.de/infos-zu-heart disease/inflammation of the heart muscle).

7. On the question of the completeness of the safety reports

In the oral hearing on June 7th, 2022, the Senate addressed an extremely important question to Mr. Mentzer: If a specific risk of the vaccination does not appear in the safety report - can the population then assume that the risk in question does not actually exist? Mr. Mentzer replied that the PEI is following 240 possible vaccination complications. But nobody would read a report about so many side effects; that would be too boring.

I hope I get the appreciative Senate*Not*I am bored when I list below some vaccine complications that are either not listed at all or are of marginal importance in the current safety report. In addition to the following description, I refer again to Annex BF-MS 66 to my brief of June 28, 2022, where the wide variety of vaccination side effects is also described and documented in detail with relevant studies.

Hives (urticaria) are reported as a vaccination complication in children, but not in adults, although this vaccination complication also clearly occurs in real life in adults and is also taken up in media reports (see reitschuster.de of June 19, 2020, https://reitschuster.de/post/impfnebeneffekt-nesselsucht-fuer-das-paul-ehrlichinstitut-kein-thema/ ;https://www.welt.de/gesundheit/plus239073909/Urtikaria-Mit-der-Covid-Impfung-kam-der-rash-und-went-not-more-away.html).

There is not a word about inflammation of the thyroid, although this vaccination complication has even been described in a clinical study (Pascho et al., Patients With Autoimmune Thyroiditis Present Similar Immunological Response to COVID-19 BNT162b2 mRNA Vaccine With Healthy Subjects, While Vaccination May Affect Thyroid Function: A Clinical Study, https://doi.org/10.3389/fendo.2022.840668). The same applies to inflammation of the pituitary gland (see Ankiredypalli et al., A case of hypophysitis associated with SARS-CoV2 vaccination,https://doi.org/10.1016/j.aace.2022.06.001).

Tumor diseases are only mentioned in one place in the safety report, namely as a possible alternative cause for immune thrombocytopenia, which is known to be a possible vaccination complication. However, tumor diseases in turn are a *Consequence of the COVID injections*can be, is in the current safety report

Completely hidden - although there are already clear signals in this direction. In my brief dated June 3, 2022, I had already presented a study on p. 20 f. that described lymphoma as a possible consequence of the vaccination. Recently, increasing cases of cancer at the injection site have been reported (Peter F. Mayer of June 12, 2022, https://tkp.at/2022/06/12/immer-frequenteres-vorfallen-vonkrebs-an-der-einstichstelle-und-im-ganzen-koerper/).

The fact that the vaccination can have a negative effect on human reproduction is at least indicated in the current safety report by reporting on a case of a newborn child who died as a result of a placenta detachment on the day of birth. Scientist Peter Mc Collough describes the devastating effects of lipid nanoparticles, polyethylene glycol, and vaccine mRNA on conception, pregnancy, and the birth process in America Out Loud, 6/25/2022 (https://www.americaoutloud.com/lipid-nanoparticles-mrna-peg-assault-naturalconception-gestation-and-birth/). Male fertility may be temporarily impaired as a result of vaccination (see Gat et al., Covid-19 vaccination BNT162b2 temporarily impairs semen concentration and total motile countamongsemendonors,DOI:10.1111/andr.13209, https://onlinelibrary.wiley.com/doi/epdf/10.1111/andr.13209

and to https://worldcouncilforhealth.org/news/2022/06/study-confirms-experimental-covid-19-vaccines-impact-male-fertility/77993/).

Even diabetes can be a consequence of COVID-19 vaccinations (see Science Files dated 6/6/2022, https://sciencefiles.org/2022/02/07/liver-failure-diabetes-brain-bleeding-serious-side-effects-for-the-covid-19-vaccines-are-proven-to-be-the-cause/). And since, as has already been explained several times, the COVID injections damage the human immune system, it is not surprising that these injections can even cause AIDS (see The Exposé of June 18, 2022, https://expose-news.com/2022/06/18/new-study-proves-covid-vaccines-cause-a-id-s/ ; I add another article in FOCUS from June 16, 2022 with the retrieval date asAnnex BF-MS 69 as this post has obviously been removed from the internet in the meantime).

A particularly sensitive matter is the finding, unearthed by recent studies, that the COVID-19 injections can trigger Creutzfeldt-Jakob disease (CJD) - the disease known in animals as "mad cow disease". It is a serious neurodegenerative disease that is always (!!) fatal; In the case of sporadic courses, there is still a certain, but relatively short (usually less than one year) remaining life expectancy (closer

information under *https://www.neurologienetz.de/fachliches/illnesses/neuro-muskulaereillnesses-2/template-illness-1-1-1*). A case of CJD after vaccination was already described in Turkey in December 2021 (Kuvanlik et al, Creutzfeldt-Jakob Disease After the COVID-19 Vaccination, DOI:10.4274/tybd.galenos.2021.91885). A systematic study in which the former, recently deceased Nobel laureate Luc Montagnier was also involved (Perez et al.,Towards the emergence of a new form of the neurodegenerative Creutzfeldt-Jakob disease: Twenty six cases of CJD declared a few days after a COVID-19 “vaccine” Jab), I add asAnnex BF-MS 70 because this study was deleted from the ResearchGate portal shortly after it was presented to the public as a preprint. These studies are already being picked up on in the (alternative) media (see Science Files of June 6, 2022, https://sciencefiles.org/2022/06/06/the-next-catastrophe-prion-regions-incovid-19-vaccines-and-creutzfeld-jakob-disease-as-the-result/ ; the Gateway Pundit of 06/05/2022,https://www.thegatewaypundit.com/2022/06/two-new-studies-showlink-incurable-degenerative-brain-disease-experimental-covid-19-vaccine/). The US database for vaccination complications (VAERS = Vaccine Adverse Events Reporting System) already lists 598 cases of Creutzfeldt-Jakob as of June 17, 2022

(please refer https://medalerts.org/vaersdb/findfield.php?EVENTS=ON&SYMPTOMS=Creutzfeldt-Jakob_disease_(10011384)&VAX=COVID19&DIED=Yes .).

8. Vaccination complications reflected in current media reports

But even the established media can no longer avoid the catastrophic effects of the COVID injections. More recently, I would like to mention the following reports:

- ARD magazine Plus minus from the 29.6.2022 (https://www.ardmediathek.de/video/plusminus/plusminus-vom-29-juni-2022/das-first/Y3JpZDovL2Rhc2Vyc3RlLmRlL3BsdXNtaW51cy9kYjY4OGY0Yy04YWI1LTRhMDUtYWExZC1iM2IwNzI4NmUzNTc): There it is reported that the special outpatient clinic set up at the university clinic in Marburg for the care of vaccination damage now has 3,000 patients on the waiting list and the waiting time is almost a whole year. Diagnostics and therapy must be paid for by those affected themselves!
- SPIEGEL from June 12, 2022 on post-vac syndrome. I add the post as Annex BF-MS 71 because he is hiding behind a payment barrier. The fact that DER SPIEGEL makes such a contribution is particularly noteworthy; because on December 7th, 2020 a column appeared in this same magazine, the author of which demanded that the whole republic point the finger at those who refused the COVID vaccination (https://www.spiegel.de/politik/deutschland/impfpflicht-was-denn-sonst-a-2846adb0-a468-48a9-8397-ba50fbe08a68).

- The BILD newspaper recently reported on the case of the now - after vaccination - disabled competitive athlete Eva Butzen (https://www.bild.de/video/clip/video/sportlerin-packt-aus-ich-kann-nicht-mehrleben-wie-vor-der-impfung-80449788,pAi=true.bild.html).
- In an almost 40-minute program, Radio RBB spoke to the journalist Stefanie von Wietersheim, who has been confined to a wheelchair since the third vaccination (https://rbbmediapmdp-a.akamaihd.net/content/a7/84/a784c863-dbc7-4ff0-ba0d-e6538f7d0959/80b8ac6d-23f0-426d-83f7-528e74cb5c85_5a4896cb-d208-458e-8fdb-0657b725a250.mp3). In Austria,
- heute.at and the KRONE, both on June 15, 2022, reported unanimously about a 20-year-old man who died one day after the booster (https://www.heute.at/s/20-jaehriger-geimpft-einen-tagspaeter-war-er-tot-100212511 ;https://www.krone.at/2734421).
- Celle today reported on June 27, 2022 about a man who can hardly cope with his everyday life since the vaccination; At the same time, there is criticism that the RKI is now checking the vaccination status of the COVID.19

patients concealed https://www.celleheute.de/post/das-zeug-hat-mich-broken-made-rki-no-information-about-vaccination-status-on-intensive-care-units .

From the alternative media I refer to the following sources:

- Please refer further Report24 from the 18.6.2022 (https://report24.news/impfgeschaedigte-die-nomand-sehen-want-einebefallente-paedagogin-packt-aus/?feed_id=17673) reports that the to the patient's condition, whose health has been severely impaired since the vaccination, has the label "Long COVID" stuck on it.
- General practitioner Gunter Frank can contribute a whole litany of tales of woe in the wake of the COVID injections from his medical practice; he describes a selection of them on achgut.com from 6/24/2022 (https://www.achgut.com/artikel/bericht_zur_coronalage_24.06.2022_paulehrlich-chef_feuern_lauterbach_entlassen_sofort).
- Numerous studies with moving stories of suffering after vaccination can be found in ScienceFiles from May 31, 2022 (https://sciencefiles.org/2022/05/31/covid-19-vaccines-in-the-computer-model-lives-saved-in-reality-many-lives-destroyed-180-suffering-stories-from-120-scientific-studies/).

The truth about the devastating outcome of the COVID vaccination campaign is emerging and is unstoppable.

If you don't want to wait for media reports, but want to get a more comprehensive picture, you can do so on Telegram:https://t.me/coronaimpftod . Current reports on deaths suspected of being caused by the vaccination are posted there in quick succession.

9. Would non-mRNA vaccines be an alternative?

In the oral hearing on June 7, 2022, the adjudicating Senate asked the two complainants whether other options than mRNA injections could be considered. Both complainants answered this question in the negative, and for absolutely understandable reasons:

- Novavax is not an alternative. On the contrary, the risk of myocarditis is apparently even greater there (see n.tv of June 4th, 2022,https://www.ntv.de/incoming/FDA-besorgt-wegen-posglichem-myocarditis-risk-in-novavax-vaccine-article23377351.html ; also BR from 5.6.2022,https://www.br.de/nachrichten/wissen/novavaxladenhueter-und-jetzt-auch-noch-nebeneffekten,T89KVlg .
- In the USA, vaccination with Johnson & Johnson was suspended because apparently the risk of blood clotting had increased too much (see Reuters of May 5, 2022,https://www.reuters.com/business/healthcarepharmaceuticals/us-limits-use-jjs-covid-19-vaccine-adults-blood-clot-risks-2022-05-05/).

- On June 27, 2022, a critical report on the vector vaccines (Astra Zeneca and Johnson & Johnson) was broadcast on NDR (https://www.ndr.de/nachrichten/mecklenburg-vorpommern/Studie-Vector-Vaccines-are-Urcause-fuer-Hirnvenenthrombosen-,coronavirus6684.html).

Not a single COVID vaccine on the market warrants investing in confidence in its safety.

10. Autopsy reports and histological findings

The lecture by Prof. Dr. Arne Burkhardt in the oral hearing on May 2, 2022 was massively attacked by the respondent in her brief of May 11, 2022. However, it is becoming increasingly clear that Mr. Burkhardt is not only right with his analysis, but also does a job that would have been the task of the PEI, the pharmaceutical company or the sponsor.

Already above under III.1. I referred to a shocking case report (Mörz, A Case Report: Multifocal Necrotizing Encephalitis and Myocarditis after BNT162b2mRNAVaccinationagainstCovid-19,doi: 10.20944/preprints202206.0308.v1,

https://www.preprints.org/manuscript/202206.0308/v1). This report describes that the spike proteins were found at autopsy in many places in the body, including the brain and heart. This is the result of detailed histological findings. It is important that precisely in this study *clearly*the COVID vaccination could be identified as the cause: *"Spike source*

was from vaccination not infection as no Nucleocapsid protein was detected." If the spikes found do not come from the virus but from the vaccination, this means: The vaccination spike proteins, more precisely: the lipid nanoparticles as carrier substances, *cross the blood-brain barrier*!

Another autopsy report, published in the specialist literature as early as 2021, concerns an 86-year-old man who died of acute kidney and lung failure on day 26 after vaccination, having previously tested consistently negative for SARS CoV-2 (Hansen et al., First case of postmortem study in a patient vaccinated against SARS-CoV-2, doi:10.1016/j.ijid.2021.04.053). Here, too, the indications speak very clearly for the causality of the (in this case: BioNTech) injection (see ScienceFiles of June 21, 2021, https://sciencefiles.org/2021/06/21/erste-autopsie-eines-nach-covid-19-vaccination-deceased-in-der-ärzte-zunft-herrscht-angst/).

Finally, attention should be drawn to a more recent study in which detailed tissue examinations (histology) were carried out in patients who had suffered inflammation in the heart muscle tissue after the COVID injection (Baumeier et al., Intramyocardial Inflammation after COVID-19 Vaccination: An Endomyocardial Biopsy-Proven Case Series, https://doi.org/10.3390/ijms23136940). Here, too, the causality of the vaccination could be clearly established in all cases examined. The fact that all 4 vaccines approved in the EU to date are represented in this study again speaks against the idea that the two complainants could switch to other than mRNA injections.

The analyzes published by Arne Burkhardt must therefore be taken seriously! And they speak clearly *versus* the assumption that the COVID injections are safe.

IV. Conclusion on COVID vaccination in soldiers: no benefit, high risk!

Let's summarize:

1. Vaccination is unnecessary!

Above all, it is unnecessary for soldiers who are required to have above-average physical fitness due to their job. And it is therefore also unnecessary for both complainants in the present proceedings. We're talking about a virus

- even in the tables of the RKI only listed with a case mortality of 0.02%,

- is apparently so harmless that PD Dr. Ole Wichmann (RKI) felt compelled to state during his interrogation that we had a huge wave under Omikron, but hardly any deaths,
- and is primarily only dangerous for people with significant pre-existing conditions.

The COVID vaccination can therefore make no contribution to keeping soldiers healthy. Consequently, it is not a medical measure within the meaning of Section 17 (2) sentence 1 no. 1 SG; in any case, however, it is unreasonable for the complainants within the meaning of Section 17 (4) SG.

2. The vaccination is not effective!

More precisely: It works, but in the wrong direction! There is no other explanation for the massive increase in incidence since the start of vaccination than that the COVID injections are gradually affecting the human immune system. The RKI itself is not able to prove a significant effect of the vaccination in preventing severe courses or the spread of the virus.

3. Vaccination is not safe!

The side effects of vaccination, which can go as far as death, are dramatic in their severity and still completely unclear in their extent because far too little is being done to establish a solid data basis. The only thing that is certain is that everyone who undergoes the COVID vaccination is getting involved in a game of Russian roulette: for most people, it seems (as we said, we don't know more precisely), the injection had no or only minor side effects. For many others, however, vaccination means that nothing in their lives will be the same as before.

The variety of vaccination side effects indicates that the main problem of COVID injections is the increase in autoimmune diseases (see also Peter F. Mayer of June 11, 2022,https://tkp.at/2022/06/11/autoimmune-diseases-due-to-covid-vaccinations-become-immer-more/). If the lipid nanoparticles get everywhere in the human body and the vaccine spike proteins are expressed everywhere in the body, it means that the COVID injections will attack the body's tissues wherever the vaccine spikes and the lipid nanoparticles go . The COVID injections thus become a ticking time bomb!

Prof. Dr. Martin Schwab