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To the
Federal Administrative Court
Simsonplatz 1
04107 Leipzig

Bielefeld, June 3rd, 2022

Associated military complaints procedures
Here…
BVerwG 1 WB 5.22 and 1 W-VR 3.22
according to Recording COVID-19 vaccination
in the basic vaccination schedule of the Bundeswehr

In the above-mentioned defense complaint proceedings, I comment as follows on the Respondent's submissions in the oral hearing and on the Respondent's written submissions since then:

I. Oral hearing on May 2nd, 2022

The impressions from the oral submissions of the Respondent can be summed up in one sentence: The Respondent is stonewalling the data and getting caught up in contradictions!

1. Purpose of the mandatory COVID injections

According to § 17a Section 2 Sentence 1 No. 1 of the Soldiers' Act, a soldier must tolerate medical measures if they serve to prevent or combat communicable diseases. As already stated in a brief dated April 14, 2022, the COVID injections are not “medical measures” and, moreover, they do not “serve” the purpose just described, as long as it is not determined individually for each individual soldier the extent to which he already has immunity.

When we repeated this during the oral hearing, a representative of the Federal Ministry of Defense (Colonel Bullwinkel) replied that the vaccination scheme serves overall (!), i.e. without specifically emphasizing COVID-19, to maintain health. The Federal Ministry of Defense thus evaded our objection: the subject of the dispute is precisely whether the inclusion of the COVID injections specifically serves this purpose!

2. Danger of COVID-19

When the court addressed the question of how dangerous the disease COVID-19 really is, we argued that this disease predominantly affects older and previously ill people. Senior Physician Prof. Dr. Kehe replied that every human life was important to him.

This provokes the question of whether Mr. Kehe also cares about the lives of those soldiers who will potentially die from the vaccination. What Mr. Kehe said about the side effects of the vaccination was revealing - at a much later point in time in the hearing: With 360,000 injections administered, the Bundeswehr reported only 47 cases as a side effect of the vaccination, including one fatality: atrial fibrillation after Moderna injection. The written presentation of the respondent is now: 54 reported cases of vaccination side effects with 480,000 administered injections. The question as to whether the deceased soldier had been autopsied was answered in the negative by Mr. Kehe during the oral hearing.

I definitely imagine a credible interest in the cause of death being different. The life of the soldiers doesn't seem so terribly important to Mr. Kehe after all.

3. Monitoring of vaccination side effects

This lack of interest on the part of the Federal Ministry of Defense is also evident elsewhere: Another representative of the Federal Ministry of Defense, Colonel Prof. Dr. Steinestel explained that thrombosis is a well-known side effect of vaccination and that the Bundeswehr monitors it.

> **I hereby ask the Respondent**what this monitoring looks like: Are blood coagulation values (D-dimers) measured for each soldier immediately before and 4-7 days after the injection? And documented? And the results recorded centrally?

4. Determination of infection, disease and causes of death

The Federal Ministry of Defense presented figures. According to information from Prof. Dr. Kehe, since COVID-19 became known as a disease, 59,529 soldiers have contracted it; 6,590 cases are currently counted. The diagnosis is made by RT-PCR. The Bundeswehr has its own laboratory that is able to grow the virus. So there is an infection, namely by SARS CoV-2.

At first it sounded as if a virus capable of replication had been found in all cases documented in the Bundeswehr. This information prompted a need for clarification. Here, too, the Respondent failed to provide any coherent argument:

a) Died of or with Corona?

At a later point, Colonel Physician Prof. Dr. Steinestel states that he treats COVID patients himself, and that 84% of the deceased died from Corona. This statement contradicts media reports that show that a large percentage of those who are listed as corona patients after a positive PCR test actually sought inpatient treatment in a clinic for completely different reasons; the WELT reported on this on March 18, 2022:https://www.welt.de/debatte/kommentare/plus237618105/Corona-Politik-Deutschlands-post-faktischer-Umgang-mit-dem-Virus.htmland on March 24th, 2022:https://www.welt.de/vermischtes/plus237758181/Helios-Kliniken-Grossteil-der-Covid-patients-not-because-of-Covid-hospitalisiert.html.

1. Accumulation of positive cases in winter 2021/2022?

It seems striking that the Corona crisis has now lasted for more than two years and the current 6,590 cases account for at least 11% of the total of 59,529 cases recorded since the outbreak of the Corona crisis.

> **I hereby ask the Respondent**, how many of these 6,590 cases were symptomatic, how many only tested positive and how many were only quarantined as contact persons.

If the 6,590 soldiers who are currently absent due to Corona actually all fell ill with COVID-19 and were not just sent to quarantine in good health, the question arises how such a high incidence can be explained now that the troops are 94% vaccinated can. During the oral hearing I had already asked whether more or less than 6,196 soldiers (that is 94% of 6,590) received this injection. The only answer I got was that since most of the soldiers were vaccinated overall, the number of vaccinated soldiers would outweigh those who were currently ill.

Exact numbers were not given. This is to be regretted. After all, reliable data could have provided an indication of positive or negative vaccination effectiveness. If more than 94% of those currently ill were vaccinated, this would indicate that the vaccination campaign in the Bundeswehr not only brought nothing, but actually did more harm than good. Doesn't the Bundeswehr care about the effectiveness of the COVID injections?

So I'm also wondering where Colonel Dr. Steinestel accepts his statement that since the vaccinations the incidence within the Bundeswehr has fallen by 50%. This is what he said at the hearing. So why are so many soldiers sick with COVID right now? And how is it that up to October 15, 2021 only a total of 9,000 cases were documented (Respondent’s brief dated May 22, 2022, p. 13), so there were few cases for a year and a half, but this number was up to April 29, 2022 jumped to 59,529 cases? Can that really speak for the supposedly high immunization effect of the COVID injections within the Bundeswehr? How does Mr. Steinestel's oral statement fit in with the incidence figures listed in the Respondent's brief of May 22, 2022 on p. 7?

> **I hereby ask the Respondent again**, the proportion of Bundeswehr soldiers currently suffering from COVID-19 who have been vaccinated against COVID-19 (please break down: how many have received one dose of vaccine, how many

> have received two doses of vaccine, how many have received three doses of vaccine, how many have received four or more doses of vaccine?) . The Respondent's assertion that there is no breakdown between vaccinated and non-vaccinated soldiers because these numbers are not recorded (briefing of May 22, 2022, p. 17) seems hardly credible: Doesn't the Bundeswehr have to be interested in these numbers in both Record cohorts separately to monitor vaccination effectiveness in the force?

In the brief dated May 11, 2022, p. 23, the Respondent assumes that all soldiers who have undergone the COVID injection have received a total of three doses of vaccine so far. In view of the fact that many soldiers initially refused the injection and were forced to inject by disciplinary means, this account does not seem immediately credible.

2. risk factors

Prof. Dr. Susanne Wagner, who was heard as an expert at our request, explained that the risk factors obesity and anxiety disorders play a particularly important role in a severe course. Senior Physician Prof. Dr. Roman Wölfel replied that he also knows COVID patients who do not have these risk factors.

That may be all - but it does not refute the statement by Susanne Wagner! Reliable data would also be helpful here.

> **I therefore ask the Respondent**: What anamnesis does the Bundeswehr arrange for COVID patients? Are there certain physical conditions that statistically favor COVID-19 disease in Bundeswehr soldiers?

This question is all the more pressing as the Respondent on p. Arne Burkhardt on the grounds that an anamnesis of a large number of previous illnesses, which are listed individually by the respondent, would be helpful for the evaluation of this data. How exactly does the Respondent take the need for an anamnesis in her own soldiers?

3. Severe courses of COVID-19

The Respondent was unable to provide any data when asked by the court about the severe course of COVID-19! Senior Physician Prof. Dr. Steinestel later explained that the number of long-COVID patients had fallen significantly as a result of the vaccination. He also hopes that the vaccination will reduce the number of severe cases. In this context, however, he conceded that the Bundeswehr's database was not good.

That provoked the question, why then but Prof. Dr. Kehe asserted in a tone of conviction that the side effects of the vaccination had been fully recorded by the Bundeswehr: Where does the Federal Ministry of Defense draw this confidence from? Answer from Mr. Kehe: In contrast to a severe course, a soldier is obliged to report

vaccination damage to his office, and it is in his own interest to report this. After all, he could hope for benefits because of military service impairment.

This answer is not convincing. How is it possible that the Respondent does not notice when a soldier is being treated in hospital for pneumonia caused by COVID-19 and is absent for a longer period of time? Even if the soldier is being treated in a civilian hospital, doesn't someone in the Bundeswehr ask about it at some point? And how can the leadership of the Bundeswehr declare a COVID injection to be tolerated if they do not know how great the risk of a severe course is?

4. From the subjective feeling of a vaccination reaction to the reported suspected case

If the Bundeswehr actually only reported 47 (or currently 54) cases of vaccine side effects, the question arises as to how many soldiers went to their unit doctors with the subjective feeling that they might have suffered vaccine damage.

> **I hereby ask the Respondent**: How many soldiers who felt physically impaired beyond the usual level after vaccination were not reported as suspected cases?

This question is essential. Because there are increasing media reports that patients with complaints that they attribute to the COVID injections are not being taken seriously by doctors. In my brief of April 14, 2022, I had already mentioned some of these media reports. In addition, I refer to SWR from May 10, 2022,https://www.swr.de/swr2/wissen/verdraengte-corona-impfschaeden-schwere-einzelfaelle-wenig-forschung-swr2-wissen-2022-05-11-100.html; Bayerischer Rundfunk from May 18, 2022,https://www.br.de/nachrichten/wissen/corona-impfung-mit-den-side-effects-alone-left,T6AzlmY. The Respondent has not yet presented any figures on this.

II. Written statement by the Respondent dated May 11, 2022

The passage on the alleged refutation of the statements by Prof. Dr. According to the title on p. Roman Wolfel.

1. Core elements of the pandemic narrative

In the oral hearing on May 2, 2022, Mr. Wölfel commented on some core elements of the pandemic narrative. It is important to record this here because it is important for assessing the credibility of Mr. Wölfel as an expert and for evaluating the factual statements in the Respondent's pleading of May 11, 2022. In detail, Mr. Wölfel stated the following:

- SARS CoV-2 can also be transmitted by someone who has no symptoms.

- There is no cross-immunity with SARS CoV-2. This is shown by the fact that billions of people around the world have contracted COVID-19. Mr. Wölfel apparently equates the masses of positive PCR tests that were carried out all over the world with illnesses.

Before Mr. Wölfel's statements about Mr. Bhakdi can be discussed in detail, the following can be countered:

a) Symptomless infection?

A Chinese businesswoman was presented as the alleged first COVID-19 case in Germany in a letter to the editors of the New England Journal of Medicine, who – allegedly without symptoms – attended a meeting in a Munich company and infected the other participants in the meeting have; the COVID-19 diagnosis was only made after her return to China. Mr. Wölfel and also Prof. Dr. med. Christian Drosten involved.

> **Proof:**Rothe et al., Transmission of 2019-nCoV Infection from an Asymptomatic Contact in Germany,https://pubmed.ncbi.nlm.nih.gov/32003551/DOI: 10.1056/NEJMc2001468.

However, on February 3rd, 2020, more than a month before this letter appeared in the New England Journal of Medicine, it had become known that the Chinese businesswoman did have symptoms and was taking an antipyretic drug in order to be able to attend the meeting at all. This came out after the RKI had carried out appropriate investigations.

> **Proof:**Kai Kupferschmidt in an article from February 3rd, 2020https://www.sciencemag.org/news/2020/02/paper-non-symptomatic-patient-transmitting-coronavirus-wrong.

However, this realization did not in any way prompt the team of authors – and thus also Messrs. Wölfel and Drosten – to withdraw the letter. Rather, they allowed the letter to be printed, even though the alleged added value, namely the alleged proof of a symptom-free transmissibility of SARS CoV-2, had finally been destroyed. In a follow-up study, in which Messrs. Wölfel and Drosten were also involved, the reader then learned that the Chinese businesswoman had been in contact with her parents in Wuhan, who were suffering from COVID-19, shortly before she left for Germany - information that was definitely would have been of interest in the letter in the New England Journal of Medicine.

> **Proof:**Böhmer et al., Investigation of a COVID-19 outbreak in Germany resulting from a single travel-associated primary case: a case series,https://doi.org/10.1016/S1473-3099(20)30314-5.

First of all, this proves that Colonel Prof. Dr. Roman Wölfel brought an essential core element of the pandemic narrative, namely the thesis of the alleged symptom-free contagiousness of SARS CoV-2, with the help of blatant scientific misconduct into the

world. The misconduct consists in the fact that Mr. Wölfel, together with the other authors, knowingly presented a case as proof of the alleged symptom-free contagiousness, which was obviously not suitable to prove this thesis.

This finding massively shakes the credibility of the Respondent's submission in its brief of May 11, 2022, insofar as it relates to Mr Wölfel's dispute with Mr Bhakdi. Mr. Wölfel obviously doesn't take scientific honesty very seriously.

b) PCR test as proof of infection

§ 2 No. 2 IfSG defines the infection as the absorption of a pathogen and its multiplication in the human body. However, a PCR test cannot prove precisely this characteristic of the infection, the multiplication of the pathogen. Let's read an essay entitled "Weighing the duration of quarantine and isolation in COVID-19", which was published in the Epidemiological Bulletin of the RKI No. 39/2020, pp. 3-11 and in which Prof. Dr. Lothar Wieler, President of the RKI is involved. There it says first on page 5, bottom right column (quote without footnotes):

"In contrast to a virus capable of replication, the RNA of SARS CoV-2 can still be detected in many patients weeks after the onset of symptoms using a PCR test. The fact that these positive PCR results in recovered patients are not to be equated [correct: are] with contagiousness was shown in several analyzes in which SARS CoV-2 was cultivated in cell cultures parallel to the PCR examination".

So: the positive test may not indicate an active, contagious infection, but a past, survived infection - for which the Infection Protection Act is no longer interested because it no longer poses any danger.

On page 8, right column top/middle, the PCR test is praised as the gold standard for detecting a COVID-19 infection. Immediately afterwards, however, the reader of the article is given the following information:

“However, the detection of the SARS-CoV-2 genome does not provide direct evidence of a patient’s contagiousness, since not every genome is representative of an infectious virus particle. In vitro data indicate a ratio of 10:1 to 100:1 between genomic RNA and infectious virus particles.”

In plain language: In the most favorable (!) case, 10% of the positively tested swab samples contain contagious virus. And the RKI knows that. The incidence values, which are transmitted day by day and which are based on the legal element of "new infections" (§ 28a Para. 3 IfSG), must be divided by at least the divisor 10 against the background of the statements just quoted, if not even be divided by the divisor 100. And this does not take into account all possible sources of error that can stand in the way of evaluating a positive test result as an "infection":

a) On January 13, 2021, the WHO recommended taking another swab sample from people who tested positive but asymptomatic and testing it before the case

was considered an infection. There is no guarantee that this will happen consistently.

b) It is possible that a positive test result from a person who has previously tested positive within the past 6 weeks will be registered as a new case, although it is still the same infection (duplicate testing problem).
c) It is possible that the test results are influenced by cross-contamination, i.e. by sample residues from previous swab samples, especially in the case of conspicuous accumulations of positive test results.
d) It is possible that swab samples that are contaminated (particularly by blood) and therefore cannot be used for diagnostics, are nevertheless used.
e) On December 7, 2021, the US CDC withdrew the PCR test's emergency use diagnostic approval after finding that the tests could not distinguish between corona and influenza viruses (https://www.cdc.gov/csels/dls/locs/2021/07-21-2021-lab-alert-Changes_CDC_RT-PCR_SARS-CoV-2_Testing_1.html).

At the same time, it is clear that it is not (as Mr. Wölfel believes) that billions of people have contracted COVID-19, but at most billions of people have tested positive and that these test results mean nothing.

For this reason, the description in the Respondent's brief, according to which people who test positive, even if they have no symptoms, replicate measurable viruses and are therefore "sick" by definition, is simply wrong. This assertion by the Respondent is completely refuted by the insights from Epidemiological Bulletin No. 39/2020. Contrary to the Respondent's view, people who do not show any clinical symptoms are healthy, regardless of the PCR test result.

2. Roman Woelfel vs. Sucharit Bhakdi

In the Respondent's pleading of May 11, 2022, Mr. Wölfel deals with the presentation of Mr. Bhakdi in the oral hearing of May 2, 2022 - and in the process gets himself entangled in contradictions.

In the said brief on p. 6 below, it is described as a deficiency in the Marking et al. study. considered that high RNA values in an RT-qPCR indirectly indicate a high level of infectivity in the people included in the study. However, own measurements of the infectivity of the detected viruses were not carried out.

Mr. Wölfel thus admits that a PCR test does not detect an infection. This contradicts his statement in the oral hearing on May 2, 2022 that billions of people have contracted COVID-19. Because with "sick" Mr. Wölfel can only have meant "tested positive" at this magnitude. There is also a contradiction to the presentation on p. asymptomatic) disease is equated.

On p. 8 of the pleading of May 11, 2022, Mr. Wölfel tries to put Mr. Bhakdi's concerns about the lipid nanoparticles as a protective cover for the mRNA into perspective. The authors of the study Ndeupen et al. have themselves pointed out that the doses and

volumes of vaccine administered in rodents are much higher than in humans (why not?) and that detailed dose/volume response studies are therefore required.

If this is true, one asks oneself with all emphasis, why then the mRNA injections are already being injected widely as a vaccine without these detailed studies having been carried out so far. Mr. Wölfel thus confirms the statement in my brief of April 14, 2022 that the manufacturers of the COVID injections are currently carrying out a dose-finding study on all of humanity and that therefore everyone who has these injections administered or who is forcibly administered them - so too the soldiers of the Bundeswehr - take part in a global vaccination experiment without ever having been asked whether they are available as subjects for an experimental scientific study.

3. Konrad Steinestel vs. Sucharit Bhakdi and Arne Burkhardt

a) benefit-risk ratio

On p. 8 below in the Respondent's brief of May 11, 2022, Mr. Steinestel counters Mr. Bhakdi's thesis that the risk-benefit ratio of the COVID injections is zero and the risk-benefit ratio is infinite. In order to refute this thesis, Mr. Steinestel cites the study Barda et al., Safety of the BNT162b2 mRNA Covid-19 Vaccine in a Nationwide Setting, DOI: 10.1056/NEJMoa2110475, where a study population of 885,000 people showed that the risk of numerous side effects, which Mr. Steinestel lists in detail, is significantly higher after a COVID-19 infection than after a COVID injection with the BioNTech active ingredient.

This study was funded with third-party funds. The third-party funder is the Ivan and Francesca Berkowitz Family Living Laboratory Collaboration. Their destinations are displayed on the Internet (https://www.berkowitzlivinglaboratory.org/about) as follows (emphasis not in the original):

"As early as the 19th century, Sir William Osler, one of the founders of modern medicine, cautioned that while the good physician treats the disease, the great physician treats the patient with the disease. New insights into human biology, genetics, genomics, big-data science, clinical medicine, and computation have given Osler's words new meaning and brought precision medicine ever closer to reality.

Untangling the precise factors that underlie modern medical mysteries can illuminate individualized treatments based on a person's genetic predispositions, immune profile, health history, and lifestyle. Such insights can propel the science and practice of precision medicine forward and have a profound effect on human health.

Made possible by a generous philanthropic gift by Ivan and Francesca Berkowitz and Family, the Ivan and Francesca Berkowitz Family Living

Laboratory Collaboration is a collaboration between Harvard Medical School and Clalit Research Institute. These two institutions are uniquely positioned to accelerate the generation of valuable biomedical knowledge that will have the power to inform better treatments, care, and prevention, and improving the health and wellbeing of generations to come. Together, we will create an unparalleled Living Laboratory environment in which world-class biomedical researchers, clinicians, and data scientists will investigate important questions in the fields of precision medicine and predictive health.

The research mission of this collaboration is to leverage this unparalleled living laboratory environment to investigate important biomedical questions in precision medicine and predictive health.

The educational mission of this collaboration is to train the next generation of leaders in translational biomedical informatics, computational biology, and precision medicine research and practice.

As a separate clinical effort, Clalit Health Services will establish The Ivan and Francesca Berkowitz Family Precision Medicine Clinic, also funded by a philanthropic gift by Ivan and Francesca Berkowitz and Family."

German translation (with www.DeepL.com/Translator):

"As early as the 19th century, Sir William Osler, one of the founders of modern medicine, warned that the good doctor treats the disease, but the great doctor treats the patient with the disease. New discoveries in human biology, genetics, genomics, Big data science, clinical medicine and computer engineering have given new meaning to Osler's words and brought precision medicine ever closer to reality.

Unraveling the precise factors underlying modern medical mysteries may enable individualized treatments based on a person's genetic predispositions, immune profile, health history and lifestyle. Such insights can advance the science and practice of precision medicine and have profound implications for human health.

The Ivan and Francesca Berkowitz Family Living Laboratory Collaboration is made possible by a generous donation from Ivan and Francesca Berkowitz and family and is a collaboration between Harvard Medical School and the Clalit Research Institute. These two institutions are uniquely positioned to accelerate the generation of valuable biomedical insights that form the basis for better treatments, care and prevention, and improve the health and well-being of future generations. Together we will create a unique Living Laboratory environment where world-class biomedical researchers, clinicians and data scientists will explore critical questions in the fields of precision medicine and predictive health.

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This self-perception of the third-party funder does not give the impression that they are enthusiastic about research results that certify the failure of the gene injections that are currently being administered as vaccines.

The authors of the study, as they expressly admit, are unable to disclose the raw data of the study for reasons of data protection. The study is therefore not intersubjectively verifiable. The vaccinated cohort was observed for 21 days following the first dose and 21 days following the second dose. The unvaccinated cohort was followed for 42 days following diagnosis. Only people who had never been infected with SARS CoV-2 before were included in the study. On this basis, the authors calculate (eg) an increased risk of myocarditis after vaccination, but a significantly higher risk of myocarditis after infection.

However, to conclude that the COVID injections had a positive risk-benefit ratio is based on several misconceptions:

- The study was designed so that the people involved were either infected or vaccinated. However, we know today - not least from the SARS CoV-2 weekly reports of the RKI, namely from that of April 28, 2022 - that infection and vaccination are not mutually exclusive alternatives in practice: You can have both, vaccination and subsequent ones Infection, and many people obviously contracted SARS CoV-2 after COVID vaccination!
- Those who have the mRNA injections administered are certainly exposed to the increased risk of side effects of the vaccination – also identified in the study – even if they don’t also go through a (breakthrough) infection afterwards. Anyone who does not have the mRNA injection administered is not automatically exposed to the increased risk that is said to result from the COVID-19 infection, but only if they become infected. But who says that all people who do not get vaccinated will automatically become infected? And what is the probability of getting infected at all?

In order to answer the second question specifically for the Bundeswehr, I use the figures presented by the respondent on May 2, 2022 in the oral hearing. As of April 29, 2022, 59,529 cases had been registered among 180,000 soldiers. I don't know exactly what these cases are (that's why I asked about them above); but the most likely version

is that there were 59,529 positive PCR tests. This is also how I understand the information on p. 17 of the Respondent's pleading of May 22, 2022, where 64,878 patients are given as of May 17, 2022 (which would mean, however, that since April 29, 2022, i.e. within less than three weeks, more than 5,000 patients must have been added - can that really be?).

If one now assumes that these positive tests are attributable to 59,529 or 64,878 different people, i.e. that each of these people only tested positive once, on April 29, 2022, i.e. after more than 2 years of the corona crisis, almost exactly 33% of the Troupe tested positive at some point. With the numbers from May 17th, 2022 it would be 36%.

However, that does not mean that 33% (as of April 29, 2022) or 36% (as of May 17, 2022) of the soldiers were also infected with SARS CoV-2. Rather, the insights already given from the Epidemiological Bulletin No. 39/2020 are now coming into play: Only 1% to 10% of the swab samples that tested positive contain infectious virus. In the "best" case - from the point of view of the Respondent - 3.3% or 3.6% of the troops had been infected with SARS CoV-2 in the last two years. And this number does not even include all the other sources of error that can stand in the way of evaluating a positive PCR test as a COVID-19 infection.

At least 96.7% or 96.4% of the troops have either never had contact with SARS CoV-2 or (and much more likely) they have reacted to the contact as a person with an intact immune system would: The virus did not even penetrate the body cells and was therefore not able to multiply in the body at all, because it had already failed due to the immune cells and antibodies in the mucous membranes of the nasopharynx. This is exactly how I imagine the immune system in a troop made up of men and women who are physically above average. I already pointed out the importance of the mucous membranes for the human immune system in my brief of April 14, 2022. These 96.7% are apparently not at risk at all, myocarditis, suffer a pulmonary embolism or heart attack after COVID infection. For them, the risk-benefit ratio is zero and the risk-benefit ratio is infinite - just as Mr. Bhakdi pointed out.

b) Case report Sawatari et al.

Mr. Steinestel relativizes the importance of the case report by Sawatari et al., which described deep vein thrombosis and pulmonary artery embolism after vaccination. The words that Mr. Steinestel chooses are revealing: It is a known and potentially life-threatening complication after COVID infection and after mRNA vaccination. The data are known and flow into the risk assessment.

You have to let that melt in your mouth: The respondent knows that the COVID vaccination can be life-threatening. However, that does not stop them from declaring the COVID injection to be subject to tolerance. The fact that comparable complaints, as Mr. Steinestel claims, occur statistically significantly more frequently after infection but not after vaccination (even if it should be true, which is hereby disputed) is not sufficient, contrary to the opinion of the Respondent, to certify the legal harmlessness

of the obligation to tolerate . Because once again the question arises as to how great the risk is of becoming infected with SARS CoV-2 at all.

c) Case report Maung et al.

Mr. Steinestel relativizes the importance of the case report by Maung et al., which describes post-vaccination hepatitis. Here, too, the data are known and are included in the risk assessment. Once again, the Respondent knows that she may inflict liver inflammation (autoimmune hepatitis) on her soldiers by means of the duty of acquiescence, but nevertheless does not shy away from the duty of acquiescence.

Mr. Steinestel also argues that blood is taken to determine liver values as part of regular fitness examinations; there is therefore a monitoring for hepatitis after vaccination. This lecture is not even remotely convincing. A monitoring worthy of the name is not content with a regular measurement of the liver values, but strives for a measurement immediately before and a certain time after the injection - whereby the period of time that has to be waited after the injection has to be based on this the time window in which the relevant side effect is expected to occur.

> **I ask the respondent**which liver values she has regularly measured, whether this happens before and after the COVID vaccination (and if so, how long before and how long after the vaccination) and, if not, why the Respondent considers the regular measurement of liver values to be sufficient to To be able to reliably follow up on hepatitis following the vaccination. What diagnostics does the Respondent use to determine the presence of autoimmune hepatitis?

The Respondent's stereotypical presentation "The data are known and are included in the risk assessment" (which is repeated more often, see the Respondent's brief of May 11, 2022, p. 11 on Karlstad et al., p. 12 on Roncati et al . and Boettler et al.) also provokes fundamental criticism. The Respondent cannot even be aware of the data because we have to assume that the side effects of vaccination are massively underreported; we gave a written, extensive lecture on this. Incidentally, the Respondent's argument just reproduced boils down to the following sentence: "Dear soldier, we know that you can get hepatitis or a pulmonary embolism as a result of the vaccination. We know it. But we still oblige you to take the injection. Because otherwise you might die as a result of an infection from a pulmonary embolism or you might suffer from hepatitis as a result of an infection." The Respondent thus relies on a hypothetical causal course, i.e. a reserve cause. With this objection, however, the Respondent is not heard according to the recognized principles of attribution of success in criminal law and civil tort law. We must therefore state: The Respondent accepts with approval that a causal process is set in motion which, if the injury or death that is considered possible as a result of the vaccination occurs, fulfills the elements of an intentional completed bodily injury or an intentional completed manslaughter.

d) Study Alden et al.

According to the study by Aldén et al, the COVID injections can cause the mRNA from those injections to be reverse-transcribed into human DNA and thus integrated into the human genome. Mr. Steinestel attests methodological errors in this study and is surprised that Mr. Bhakdi was not aware of the limitations of the study. In the end, Mr. Steinestel says the study only shows that a protein that is common in liver cancer cells and can unselectively convert mRNA into DNA also does the same with the vaccine mRNA. However, they show no influence on the human genome.

Assuming that Mr. Steinestel's objections are valid, this only means that the integration of the vaccine mRNA into the human genome has not been proven. However, this does not mean that such an integration is impossible. However, if the Respondent believes that it can emerge victorious from the current proceedings in a non-liquet on the genotoxicity of the COVID injections, it is wrong.

As the legal representative Brigitte Röhrig, to whose entire written presentation I hereby refer in full, already explained and convincingly demonstrated in a written pleading of March 28, 2022, the manufacturers Pfizer/BioNTech and Moderna have not carried out any studies on the genotoxicity of the COVID injections they sell carried out and the EMA did not request such studies. We simply don't know if the COVID injections are altering the human genome. But it may very well be that they do; Dutch researcher and microbiologist Dr. Peter Borger explained this very clearly in a video (his technically well-founded lecture begins at 6:20 p.m.).

> **Proof:** Video Peter Borger from January 15, 2022, https://www.youtube.com/watch?v=046UL8FEI1g.

This video is discussed in more detail below IV. But it is already justified to state that the Respondent is making things far too easy for itself when it withdraws from the position that the effect of the vaccine mRNA on the human genome has not been proven. The Respondent has no right to carry out a vaccination experiment on her soldiers! If the Respondent wants to make it mandatory to tolerate the injection of an active substance whose manufacturer has been exempted from the need for certain tests, she should kindly carry out these tests herself before forcing her soldiers to have the COVID injections carried out on her.

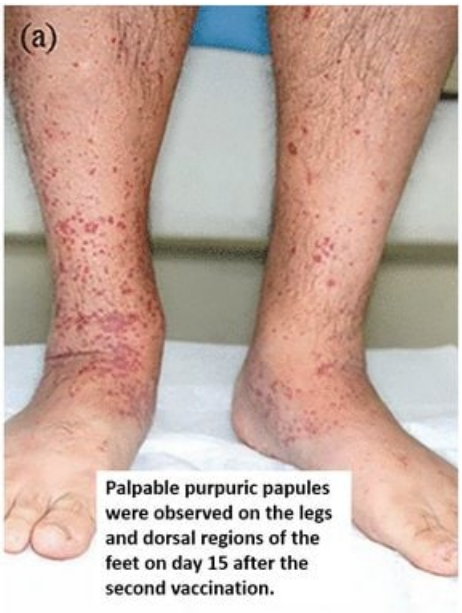
e) Case study Roncati et al.

Mr. Steinestel explains that blood clots are known to be a rare complication of vaccination; this is included in the risk assessment. However, Mr. Steinestel has no way of knowing how rare such clots occur if blood coagulation values (especially D-dimers) are not systematically measured immediately before and 4-7 days after the COVID injection. It is all the more important that the Respondent answers the question I have already asked about this.

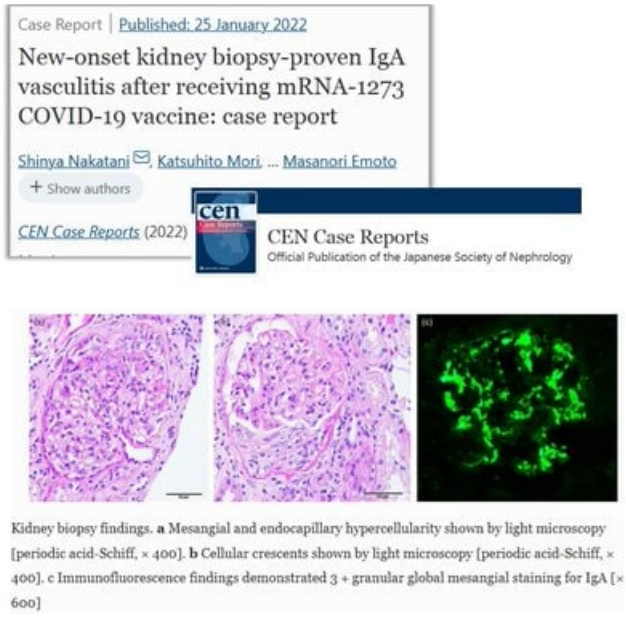
f) Anecdotal character of case reports

In connection with the case reports Sawatari et al. and Maung et al. the Respondent points out that no further conclusions can be drawn from anecdotal case reports and the results of such reports cannot therefore be applied uncritically to clinical practice. This prompts me to share a few more "anecdotes" - all published in peer-reviewed journals. What follows is a selection from a wealth of similar reports. In making this selection, I limited myself to the mRNA injections, since the vector vaccines approved in the EU, if I understood the respondent correctly, no longer play a role anyway.

(1) A 47-year-old man was diagnosed with vasculitis (inflammation of blood vessels) after the first Moderna injection, which initially went away but returned after the second injection. The external characteristics of this inflammation are unmistakable:



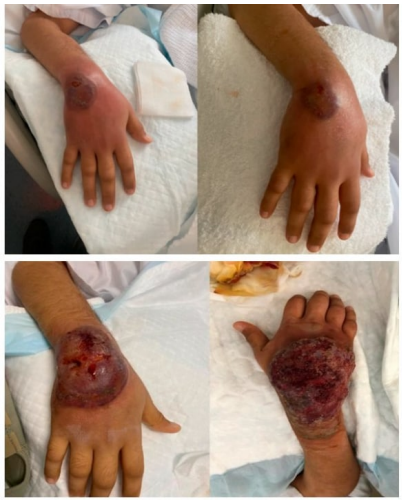
Palpable purpuric papules were observed on the legs and dorsal regions of the feet on day 15 after the second vaccination.



Kidney biopsy findings. **a** Mesangial and endocapillary hypercellularity shown by light microscopy [periodic acid-Schiff, × 400]. **b** Cellular crescents shown by light microscopy [periodic acid-Schiff, × 400]. c Immunofluorescence findings demonstrated 3 + granular global mesangial staining for IgA [× 600]

Proof: Nakatani et al., Newonset kidney biopsyproven IgA vasculitis after receiving mRNA1273 COVID19 vaccine: case report,https://doi.org/10.1007/s13730-021-00677-9.

(2) A 27-year-old man presented with painful swelling that reached dramatic proportions 24 hours after the first dose of BioNTech:



Right hand swelling with eschar on the dorsum that developed in hospital.

Progression and ulceration of lesion two days after appearance.

Pyoderma Gangrenosum Induced by BNT162b2 COVID-19 Vaccine in a Healthy Adult

by **Mazin Barry** [1,*], **Abdulaziz AlRajhi** [1] and **Khaldoon Aljerian** [2]

[1] Division of Infectious Diseases, Department of Internal Medicine, College of Medicine, King Saud University, Riyadh 11451, Saudi Arabia
[2] Department of Pathology, College of Medicine, King Saud University, Riyadh 11451, Saudi Arabia
* Author to whom correspondence should be addressed.

Academic Editor: Silvio Tafuri

Vaccines **2022**, *10*(1), 87; **https://doi.org/10.3390/vaccines10010087**

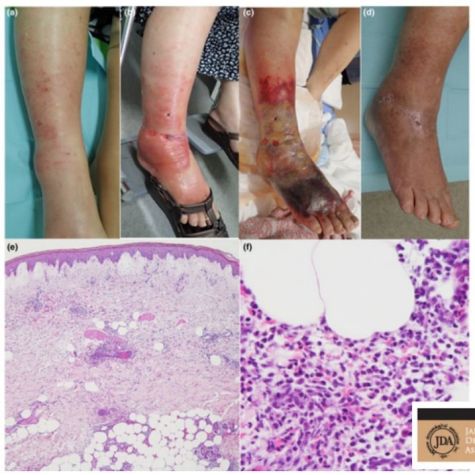
vaccines

Incidentally, the authors of this study do not limit themselves to emphasizing the anecdotal character of such horrifying vaccine damage. Rather, under “Conclusions” it says:

"With the increasing uptake of mRNA-based vaccines, clinicians should be aware of the diversity of adverse events that may be encountered, including unusual skin manifestations."

Proof: Barry et al., Pyoderma Gangrenosum Induced by BNT162b2 COVID-19 Vaccine in a Healthy Adult,https://doi.org/10.3390/vaccines10010087.

(3) An 87-year-old woman presented with the following symptoms after the first BioNTech injection (fortunately she refrained from a second one), which took a full 8 weeks to resolve:



Clinical appearance. (a) Slightly edematous swelling with patchy erythema and reddish papules 6 days after inoculation. (b) Worsening of the swelling, with vesicles and bulla formation. (c) Purpura and hemorrhagic bulla formation 12 days after inoculation. (d) Largely improved lesions with small ulcers 3 months after inoculation. (e,f) Histopathological findings. (e) Marked edema in the papillary dermis with perivascular and interstitial infiltrates of inflammatory cells (hematoxylin–eosin [HE], original magnification × 40). (f) Dense neutrophil and lymphocyte infiltration with erythrocyte extravasation in the lobular adipose tissue (HE, × 400).

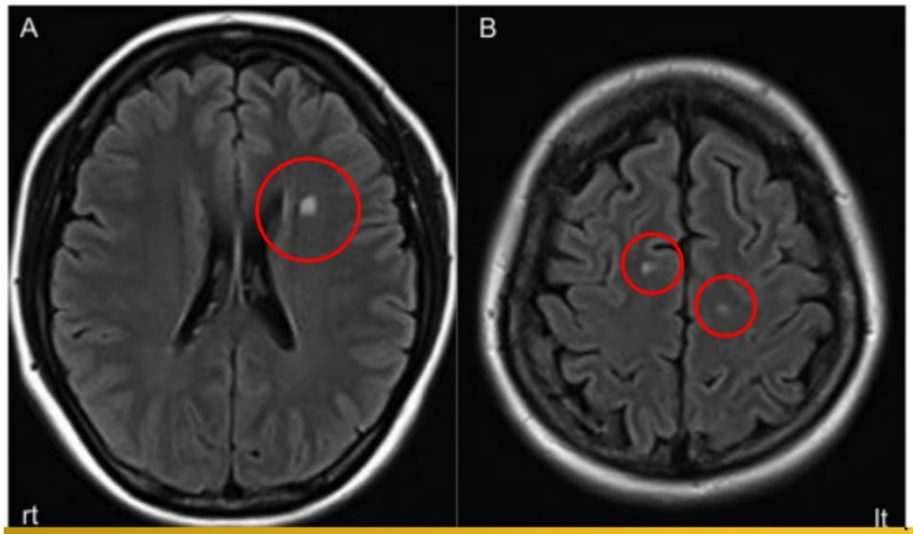
Sweet syndrome after severe acute respiratory syndrome coronavirus 2 mRNA vaccine: A case report and literature review

Daichi Hoshina ✉ Akihiro Orita

JDA Japanese Dermatological Association — The Journal of Dermatology

Proof: Hoshina/Orita,Sweet syndrome after severe acute respiratory syndrome coronavirus 2 mRNA vaccine: A case report and literature review,https://pubmed.ncbi.nlm.nih.gov/35037288/, DOI: 10.1111/1346-8138.16309.

(4) A 40-year-old woman presented with a BioNTech injection with symptoms that were differentially diagnosed as vaccine-induced multiple sclerosis:



Axial fluid-attenuated inversion recovery (FLAIR) imaging (A, B) (TR, 9000 ms; TE, 111 ms) MRI scan of the head on admission revealed left periventricular and bilateral frontal subcortical high-intensity lesions.

Initial clinical manifestation of multiple sclerosis after immunization with the Pfizer-BioNTech COVID-19 vaccine

Juichi Fujimori • Kouichi Miyazawa • Ichiro Nakashima

Journal of Neuroimmunology

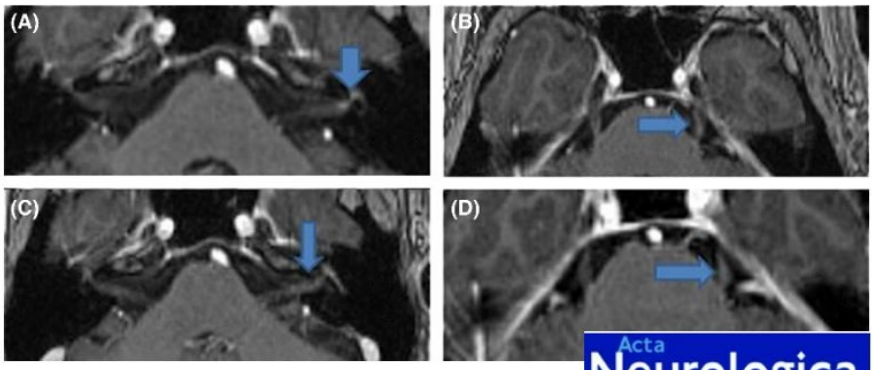
Proof: Fujimori et al., Initial clinical manifestation of multiple sclerosis after immunization with the Pfizer-BioNTech COVID-19 vaccine,https://doi.org/10.1016/j.jneuroim.2021.577755.

Neurological damage following COVID injections is noted with increasing concern in the literature. This is what one study says:

"In conclusion, safety concerns against SARS-CoV-2 vaccines are backed by an increasing number of studies reporting neurological side effects. The most frequent of them are headache, GBS, VST, and transverse myelitis. Healthcare professionals, particularly neurologists involved in the management of patients having undergone SARS-CoV-2 vaccinations, should be aware of these side effects and should stay vigilant to recognize them early and treat them adequately."

Proof:darker,Neurological side effects of SARS-CoV-2 vaccinations,https://onlinelibrary.wiley.com/doi/10.1111/ane.13550,DOI: 10.1111/ane.13550.

(5) It is therefore hardly surprising that facial paralysis is also reported. This case report concerns a 29-year-old man who was otherwise perfectly healthy.



Images were acquired by use of T1-weighted, contrast-enhanced MPRAGE TRA ISO sequences, in the axial plane. (A) Gadolinium enhancement in the intracanalicular and labyrinthic segments of the left facial nerve (blue arrow). (B) Contrast enhancement in the intracisternal length of the trigeminal nerve (blue arrow). (C) The contrast enhancement of the facial nerve persists upon repeated examination a month later (blue arrow). (D) The contrast enhancement of the trigeminal nerve persists upon repeated examination a month later (blue arrow)

Acta Neurologica Scandinavica

CLINICAL COMMENTARY | Free Access

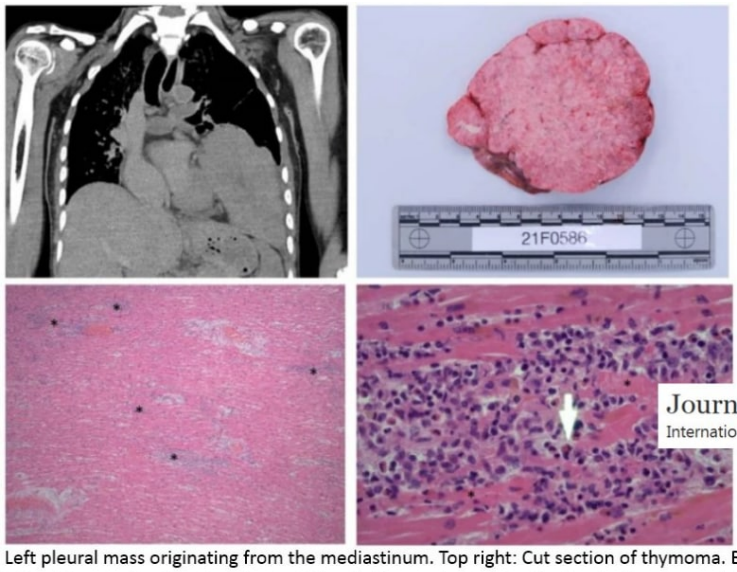
Multiple cranial nerve palsies following COVID-19 vaccination—Case report

Maria Mirabela Manea, Dorin Dragoș, Iulia Enache, Adrian George Sirbu, Sorin Tuta

First published: 02 November 2021 | https://doi.org/10.1111/ane.13548

Proof: Manea et al.,Multiple cranial nerve palsies following COVID-19 vaccination—Case report,https://pubmed.ncbi.nlm.nih.gov/34725821/DOI: 10.1111/ane.13548.

(6) It is often read that myocarditis after a COVID injection is usually mild. Things went wrong for this 57-year-old patient. She died after the first BioNTech injection.



Left pleural mass originating from the mediastinum. Top right: Cut section of thymoma. Bottom left: × 20 magnification showing multifocal inflammatory cell infiltration in the myocardium; asterisk (*) showing areas of eosinophil-rich inflammatory aggregates with myocyte necrosis. Bottom right: × 40 magnification showing an abundant eosinophilic infiltrate with myocyte necrosis. Arrow shows an eosinophil, asterisk (*) showing myocyte necrosis

Original Article | Published: 03 January 2022

First Identified Case of Fatal Fulminant Necrotizing Eosinophilic Myocarditis Following the Initial Dose of the Pfizer-BioNTech mRNA COVID-19 Vaccine (BNT162b2, Comirnaty): an Extremely Rare Idiosyncratic Hypersensitivity Reaction

Rohan Ameratunga, See-Tarn Woon, Mary N. Sheppard, Jack Garland, Benjamin Ondruschka, Christopher X. Wong, Ralph A. H. Stewart, Michael Tatley, Simon R. Stables & Rexson D. Tse

Journal of Clinical Immunology (2022) | Cite this article

Journal of Clinical Immunology
International Journal of Inborn Errors of Immunity and Related Diseases

Proof: Ameratunga et al, First Identified Case of Fatal Fulminant Necrotizing Eosinophilic Myocarditis Following the Initial Dose of the Pfizer‐BioNTech mRNA COVID‐19 Vaccine (BNT162b2, Comirnaty): an Extremely Rare Idiosyncratic Hypersensitivity Reaction,https://doi.org/10.1007/s10875-021-01187-0.

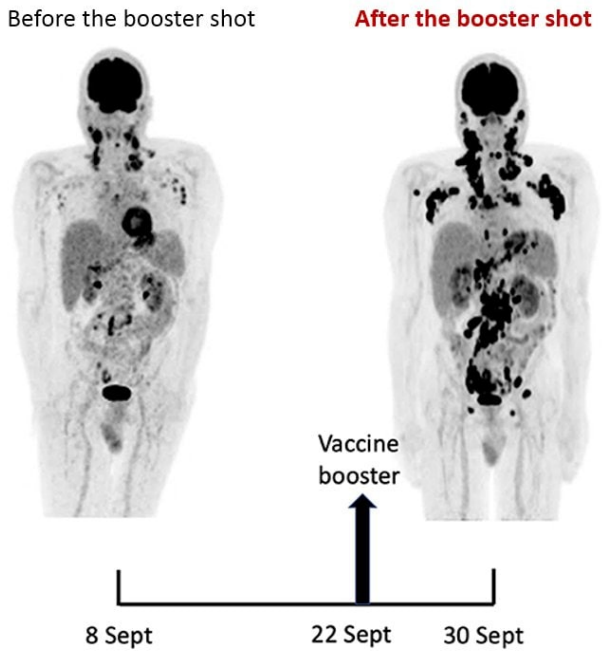
Such cases may be rare. But who guarantees a soldier forced to endure the COVID injection that he will not be the next unfortunate and extremely rare individual case?

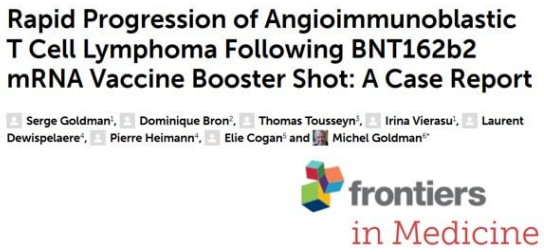
According to a recent study, vaccination-induced myocarditis can become irreversible if the patient was already infected with SARS CoV-2 before the vaccination.

> **Proof:**Khan et al., COVID-19 Vaccination-Induced Cardiomyopathy Requiring Permanent Left Ventricular Assist Device,https://www.cureus.com/articles/93217-covid-19-vaccination-induced-cardiomyopathy-requiring-permanent-left-ventricular-assist-device, DOI:10.7759/cureus.24477.

This reinforces the legitimacy of the demand made in my brief of April 14, 2022 that the immunity status of each individual soldier must be determined before any discussion about a duty to tolerate can even be discussed.

(7) Cancers can also be a consequence of the COVID injections. A remarkable case - a BioNTech injection had been administered - is described in this study:





Maximum-intensity-projection images of ^{18}F-FDG PET/CT at baseline (8 Sept) and 22 days later (30 Sept), 8 days after BNT162b2 mRNA vaccine injection in right deltoid. 8 Sept: hypermetabolic lymph nodes mainly in the supra-clavicular, cervical, and left axillary regions; restricted gastro-intestinal hypermetabolic lesions. 30 Sept: Dramatic increase in nodal and gastro-intestinal hypermetabolic lesions. Asymmetrical metabolic progression in the cervical, supra-clavicular and axillary area, more pronounced on the right side.

> **proof**: Goldman et al., Rapid Progression of Angioimmunoblastic T Cell Lymphoma Following BNT162b2 mRNA Vaccine Booster Shot: A Case Report,https://pubmed.ncbi.nlm.nih.gov/34901098/, DOI: 10.3389/fmed.2021.798095.

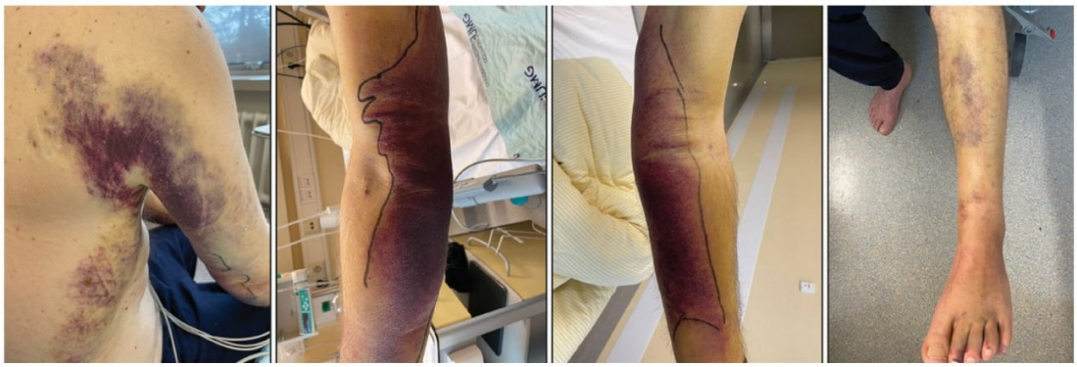
(8) In my pleading of April 14, 2022, I already presented evidence that the COVID injections damage the natural human immune system. Once the immune system is suppressed, this can stimulate the activity of herpes viruses, which were previously dormant in the human body with stable immunity. In a 74-year-old male patient, herpes zoster infection literally caught his eye after BioN-Tech injection:

Proof: You et al., A Case Report of Herpes Zoster Ophthalmicus and Meningitis After COVID-19 Vaccination,https://doi.org/10.3346/jkms.2022.37.e165.

(9) Vascular diseases after mRNA vaccinations were mentioned above. A 32-year-old woman was particularly badly hit after the second Moderna injection:

Proof: Godbe et al., Case Report: Idiopathic Subcutaneous Thrombotic Vasculopathy,https://doi.org/10.3389/fmed.2022.843793.

(10) The Moderna injection was also responsible for this skin change:



Case Report: Acquired Haemophilia A Following mRNA-1273 Booster Vaccination Against SARS-CoV-2 With Concurrent Diagnosis of Pleomorphic Dermal Sarcoma

Marlene Plüß[1], Christina Mitteldorf[2], Christoph Johannes Szuszies[3] and Björn Tampe[1*]

frontiers in Immunology

Proof: Plüß et al., Case Report: Acquired Haemophilia A Following mRNA-1273 Booster Vaccination Against SARS-CoV-2 With Concurrent Diagnosis of Pleomorphic Dermal Sarcoma,https://doi.org/10.3389/fimmu.2022.868133.

These reports, which are only an excerpt from the many case descriptions, cannot leave a person who still has a last remnant of empathy unimpressed. How many “anecdotes” of this kind do the gentlemen who sat across from us on May 2nd, 2022 and who will sit across from us again on June 7th/8th, 2022, need until they find their moral compass again?

Against the background of these case reports, the response of the respondent to the lecture by Prof. Dr. Arne Burkhardt almost cynically. In its page-long reply, the Respondent ultimately confines itself to emphasizing why the results found by Mr. Burkhardt are allegedly not scientifically valid. And if the deceased suffered from previous illnesses, it was of course these and not the vaccination that caused death (NB: if we were talking about COVID-19 deaths, the Respondent would probably not care about the previous illnesses!).

In all of this, the burden of proof is misunderstood: it is not for the soldier who is required to have a toleration to refute the harmlessness of the substance that was forcibly administered to him. Rather, the Respondent must prove the harmlessness - just as they have to prove in the approval process of the manufacturer. In any case, this applies if an active substance is to be made subject to approval that i. S. of Art. 22 Directive 2001/83/EC was only approved under certain conditions and was dispensed with when it was approved from essential requirements for the safety test.

As far as the question of an aortic dissection or rupture following an mRNA injection is concerned, the following must be stated: The aorta is the main artery. A thumb-thick high-pressure blood vessel. If a dissection (also: rupture or simply demolition) occurs here, a life-threatening situation arises because massive internal bleeding occurs. Death can occur in minutes, if not seconds. In such a case, it is more than

understandable if those involved in the management of the emergency are not primarily concerned with the scientific exploitation of the case, but with saving human life. This may explain why tears or tears in the aorta following a COVID infection or injection have so far received little attention in the scientific literature.

The Respondent should therefore prepare to rule out a connection with the vaccination for all of the cases described by Mr. Burkhardt. So far, she has not even done so in a rudimentary way, namely not in her brief of May 11, 2022.

III. Respondent's brief dated May 22, 2022

The Respondent bases the alleged effectiveness of the COVID injections on data from England, among other things. That is surprising; because data are being reported from England that speak in no way for the effectiveness of the injections. The data from March 2022 showed that 92% of all COVID-19 deaths were vaccinated - significantly more than the vaccination rate in the general population.

> Evidence: Waldo Holz in tkp.at from 24.3.2022,https://tkp.at/2022/03/24/uk-desaster-92-percent-der-covid-toten-vaccinated/.

The Danish study also used by the respondent (Lyngse et al., Transmission of SARS-CoV-2 Omicron VOC subvariants BA.1 and BA.2: Evidence from Danish Households,https://doi.org/10.1101/2022.01.28.22270044) suffers from the methodological flaw that the contagiousness was determined solely on the basis of PCR and antigen test results, which are completely unsuitable for this purpose because they are not able to determine the ability of the pathogen to reproduce. From the study Andrews et al., COVID-19 Vaccine effectiveness against the Omicron (B.1.1.529) Variant,https://www.nejm.org/doi/full/10.1056/NEJMoa2119451, DOI: 10.1056/NEJMoa2119451, it can be seen above all that the effect of the COVID injections is almost zero after just half a year. One must seriously ask oneself what to think of a "vaccination" that is losing its effectiveness at such a rapid pace. Incidentally, the study works with data from England – where, as shown, the COVID injections are obviously not able to reduce deaths, rather the opposite.

The study Sheikh et al.,Severity of omicron variant of concern and effectiveness of vaccine boosters against symptomatic disease in Scotland (EAVE II): a national cohort study with nested test-negative design,https://doi.org/10.1016/S1473-3099(22)00141-4, which claims to have found a positive effect of the booster vaccination in the Scottish population as a whole, contrasts with media reports that give devastating testimony to the Scottish vaccination campaign (see The Blaze of 21.01.2022,https://www.theblaze.com/op-ed/horowitz-the-very-concerning-data-from-scotland?utm_source=revcontent; see also Corona Transition of November 30, 2021,https://corona-transition.org/in-scotland-were-89-percent-of-the-covid-19-dead-vaccinatedas well as The Exposé from 25.11.2021,https://dailyexpose.uk/2021/11/25/pandemic-of-fully-vaccinated-89-

percent-covid-deaths-vaccinated/: 89% of COVID-19 deaths in Scotland fully vaccinated).

From the study Madewell et al., Household Secondary Attack Rates of SARS-CoV-2 by Variant and Vaccination Status,https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2791601, DOI:10.1001/jamanetworkopen.2022.9317Above all, one can conclude that the effectiveness of the COVID injections, if it ever existed, decreases dramatically, at least with the omicron variant. The authors recommend developing vaccines in step with the evolution of the virus.

IV. further remarks

1. Distribution of lipid nanoparticles in the human body

Manufacturers, politicians and the media consistently claim that the mRNA in a COVID injection remains at the injection site. This claim has since been refuted.

In the meantime, a review of the Pfizer approval documents, the publication of which was legally enforced in the USA, has shown that the lipid nanoparticles in animal experiments have spread throughout the body of the test animals used, namely in the liver:

Proof:

- Report by Peter F. Mayer,https://tkp.at/2022/04/23/verification-of-the-recently-published-pfizer-documents-by-lawyer-team/.
- Daily Clout from 13.3.2022,https://dailyclout.io/internal-pfizer-documents-prove-knowledge-that-lipid-nanoparticles-in-mice-subjects-do-not-remain-in-muscle-but-were-shown-to-be- rapidly distributed in the blood to the liver/.
- Pfizer document “Summary of Pharmacokinetic Study”; This document can be accessed in the Daily Clout source just quoted by clicking on “Continue Reading”.

The lipid nanoparticles package the mRNA. Wherever they are to be found, the mRNA is therefore not far away. Thus, the insight into the results of the animal experiments raises a completely different question: Why wasn't the approval procedure terminated at the latest after reviewing this study? Wasn't it now foreseeable that the lipid nanoparticles would also be distributed in the human body - with completely unforeseeable consequences?

Already above under III.4. I referred to a video by Dutch researcher Dr. Peter Borger from 15.1.2022 (https://www.youtube.com/watch?v=046UL8FEI1g) brought to your attention. dr In this video, Peter Borger makes it clear that the distribution of nano-lipids, which are injected into the human body to act as carriers for the active ingredients in medicines, has been researched for a long time. A study from 2013

already described how the nanolipids were distributed throughout the body of the test animals (mice) used at the time, especially in the liver and ovaries, but also in smaller amounts in the muscles and in the heart , in the brain and in the pancreas.

> **Proof:**Mérian et al., Synthetic Lipid Nanoparticles Targeting Steroid Organs, DOI: 10.2967/jnumed.113.121657,https://jnm.snmjournals.org/content/54/11/1996.

Nanoparticles have also been found elsewhere in the ovaries of experimental animals.

> **Proof:**Schädlich et al., Accumulation of nanocarriers in the ovary: A neglected toxicity risk?,https://doi.org/10.1016/j.jconrel.2012.02.012.

So the nano-lipids migrate everywhere. In all probability also in the human body. And then the vaccine mRNA also goes everywhere. But then it would have been the manufacturer's task to research where the active substance migrates to and what damage it can cause there.

The Respondent cannot therefore retreat to the position that there is currently no evidence of integration of the vaccine mRNA into human DNA. If the manufacturers of the mRNA injections were exempted from testing the genotoxicity and the investigation of long-term effects in the approval process, the Respondent may not declare the vaccination to be mandatory without having carried out these tests itself. As long as pharmacokinetics and genotoxicity have not been extensively tested, we simply do not know whether the vaccine mRNA will eventually end up in the human cell nucleus and change the human genome.

In general, the Respondent may not retreat to the point of view that there is currently no indication or evidence for certain vaccination effects. Rather, the burden of proof lies with the Respondent: It must be able to rule out that the mRNA integrates into human DNA. As long as it does not succeed in doing so, the soldiers' duty to tolerate fails at the latest due to Section 17a (4) SG, but according to the view represented here already because the facts of Section 17a (2) SG are not fulfilled: as long as the vaccines are in the experimental stage , these are not “medical measures”.

In any case, when injected intramuscularly into the deltoid muscle of the upper arm, the drug is immediately distributed into the bloodstream. This applies at least to those injections that were administered intramuscularly without prior aspiration, i.e. those injections where the person who made them did not even have the ambition to inject past the bloodstream. Because that is exactly what is being striven for with the help of aspiration: it should be prevented that the injected substance gets into the bloodstream. However, this often cannot be avoided even with aspiration: the deltoid muscle is extremely well supplied with blood, especially in athletic and physically highly capable soldiers.

The thesis that the lipid nanoparticles and the vaccine mRNA remain at the injection site is scientifically unfounded. And what we know about the distribution of these

substances in the body of laboratory animals gives reason to fear the worst for distribution in the human body.

2. malfunctions of the immune system

In my brief dated April 14, 2022, I had already stated that the COVID injections lead to incorrect reactions in the immune system. This finding is consistent with the fact that SARS CoV-2 was found in numerous body regions during an autopsy in people who received the COVID injections and died nevertheless (or precisely because of it?), i.e. it was not limited to the respiratory tract. This phenomenon occurs much less frequently in unvaccinated COVID-19 deceased.

Proof:

- Hirschbühl et al., High viral loads: what drives fatal cases of COVID-19 in vaccinees?–an autopsy study,https://doi.org/10.1038/s41379-022-01069-9.
- Analysis on this in Science Files from May 7th, 2022,https://sciencefiles.org/2022/05/07/instead-of-protection-from-death-due-to-covid-19-autopsies-show-causality-between-vaccination-and-death/.

It also fits into this picture that mRNA spike proteins could be detected in the bloodstream of people with mRNA injection.

Proof:

- Bansal et al., Cutting Edge: Circulating Exosomes with COVID Spike Protein Are Induced by BNT162b2 (Pfizer_BioNTech) Vaccination prior to Development of Antibodies: A Novel Mechanism for Immune Activation by mRNA Vaccines,www.jimmunol.org/cgi/doi/10.4049/jimmunol.2100637.
- Ogata et al., Circulating Severe Acute Respiratory Syndrome Coronavirus 2 (SARSCoV-2) Vaccine Antigen Detected in the Plasma of mRNA-1273 Vaccine Recipients,https://doi.org/10.1093/cid/ciab465.
- Analysis of these two studies in Science Files from April 25, 2022,https://sciencefiles.org/2022/04/25/four-proven-ways-on-which-covid-19-mrna-vaccines-cause-significant-health-damage/.

In earlier attempts to develop mRNA vaccines against influenza viruses, it was observed that the mRNA, which was initially injected into the test animals partly intradermally and partly intramuscularly, reached the lymph nodes and was transported to other parts of the body by means of the lymph; in the given case, the mRNA had accumulated in the spleen.

Proof: Bahl et al., Preclinical and Clinical Demonstration of Immunogenicity by mRNA Vaccines against H10N8 and H7N9 Influenza Viruses,http://dx.doi.org/10.1016/j.ymthe.2017.03.035.

It is interesting that a total of seven people who work as researchers at Moderna, the manufacturer of the COVID drug Spikevax (mRNA-1273), were involved in this study. The study praises the high ability of the influenza vaccine studied in this study to immunize its recipient. And yet the team of authors had to admit that the mRNA in the animal experiment does not remain at the injection site, but reaches other parts of the body. It is all the more surprising that the manufacturers of the COVID mRNA injections still insist on their claim that the mRNA does not leave the injection site.

In April 2022, a study was presented as a preprint that shows that people without a COVID injection produce a significantly more effective immune response to an infection with SARS CoV-2 than those who have received a COVID injection.

Proof:

- Follmann et al., Anti-nucleocapsid antibodies following SARS-CoV-2 infection in the blinded phase of the mRNA-1273 Covid-19 vaccine efficacy clinical trial,https://doi.org/10.1101/2022.04.18.22271936.
- Analysis on this by David Rosenberg in Israel National News from 24.5.2022,https://www.israelnationalnews.com/news/328102.
- Analysis on this by Alex Berenson/Robert Malone in The International Chronicles of May 26, 2022,http://www.theinternationalchronicles.com/2022/05/26/do-mrna-vaccines-hurt-long-term-immunity/. Robert Malone is known to be the inventor of mRNA technology, but he did not design it for use in vaccines.
- Analysis of this at report24 from May 28, 2022,https://report24.news/studie-covid-mrna-vaccination-hinders-formation-of-antibodies-and-impaired-immune-system/?feed_id=16727.

After all, it must be remembered that there is no legal or medical justification for the soldiers to tolerate the COVID injections.

Prof. Dr. Martin Schwab