
Jeanne Translation

Grand Jury - Session 31

February 13, 2022

A group of international lawyers and a judge are conducting a criminal investigation modeled after the U.S. Grand Jury proceedings to present to the public all available evidence of crimes against humanity committed under the cover of covid-19. To date, this investigation is being conducted against the "leaders, organizers, instigators and accomplices" who aided, abetted or actively participated in the formulation and execution of a common plan for a pandemic. This investigation is being conducted by the people, with the people, and for the people, so you can be on the jury.

By showing a complete picture of what we are facing [including the geopolitical and historical backdrop] the procedure aims to create an awareness of the real collapse of the current system and its institutions and, therefore the need for the peoples themselves to regain their sovereignty and the need to first stop the measures of this pandemic by refusing to comply with them and the need to launch their own new system of health care, education, economy and justice, in order to re-establish democracy and the rule of law on the basis of our constitutions.

The Stakeholders

Reiner	Fuellmich	Germany	and
USA - Lawyer	Rui Fonseca e Castro	Portugal	- Judge
8m	Introduction		
Astrid	Stuckelberger	Switzerland	- International Health Scientist and Researcher
37m	Conflict of interest (PCR test) between Drosten, Berlin Charité, gavi,		
who	Virginia de Araujo	Recchia	France - Lawyer
	Ana Garner	USA	- Geneticist, lawyer, prosecutor (New
Mexico)	Mike	Yeadon	Great Britain - former scientific director Pfizer
2011	Dexter L.-J. Ryneveldt	South Africa	- Lawyer
	Ulrike Kämmerer	Germany	- Virologist, immunologist (human biology)
48m	Function and exact role of the PCR test		
Viviane	Fischer	Germany	- Lawyer
Dolores	Cahill	Ireland	- Molecular Biologist
Sonia	Pekova	Czech Republic	- Molecular biologist
42m	Different virus genomes		
	Ban on using own covid tests in Czech Republic Traffic		
	in results		
Bryan	Ardis	USA	- Physician, holistic practitioner, CEO of ArdisLab.
66m	Remdesivir, how hospitals literally killed people		
	with a treatment that is supposed to save them		
John	O'Looney	United Kingdom	- Funeral Director
25m	No excess mortality before injections begin		
	After the campaign, it increased by 300%.		
	Testimony of his stay in the hospital where they tried to kill		
him	Shankara Chetty	South Africa	-
General practitioner			
120m	Experience of a general practitioner		
	Omerta on real treatments		
Thomas	Binder	Switzerland	- Cardiologist



Good morning and good evening to all of you who are following this third day of the Court of Public Opinion's grand jury inquiry into the coronavirus problem.

Yesterday we heard from a panel of experts who explained the geopolitical and historical background of what we are dealing with and what some of us are suffering from now.

Today, we're going to take a closer look at the PCR test that underlies everything we see. But before we begin today's session, Judge Rui will give a summary of what we learned yesterday.



Thank you, Reiner. This is the summary of the second day of the grand jury investigation of the court of public opinion. Yesterday, February 12, 2022, this court, with the help of some experts, was examining the context in which

is unfolding the coronavirus pandemic. Three experts from the UK, Alex Thompson and Brian Gerrish, both former employees of the British secret service, have explained, along with Debi Evans, that the real center of power behind everything that is going on is totally independent of England, of London, of the city² of London and the criminal financial industry that has emerged there and is now spreading around the world. Everything emanates from the fifth column, Wall Street in the United States.

This financial mafia was responsible for the first and second world wars³. In each case, they financed both sides of the conflict. Terrorism and drug trafficking were also invented by the financial mafia in the city of London and also profit from it. This financial mafia is run by a small group of families, through criminal organizations, other private parties including the Gates Foundation by taking control of health care first in England and then worldwide. Health care is used as a lever by this caste.

With the help of one of the most important platforms of this group, the wef⁴ and the politicians raised by the wef's young global leaders⁵ program, they are striving for total power and control over the entire world population. For in this anti-social and anti-human vision of the world population, human beings are no longer relevant to them.

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- 2 The City of London, or "square mile", is a city and ceremonial county within Greater London. The mode of administration is unique in England. The city is home to the headquarters of many banks, insurance companies and large multinational corporations.
 - 3 Wars are monstrous: however, why capitalize them? We reserve the same fate for the city of London, the Gates foundation, the wef (Davos forum), the ygl, young global leaders...
 - 4 The World Economic Forum (WEF), founded by Klaus Schwab in 1971 and often referred to as the Davos Forum, is a non-profit foundation and lobbying organization based in Geneva. The forum brings together paying members, business leaders, politicians from all over the world as well as intellectuals and journalists to discuss the world's most pressing issues.
 - 5 The young global leaders is an independent, non-profit organization managed from Geneva, Switzerland, under the supervision of the Swiss government. Launched in 2005 by Klaus Schwab, the ygl is governed by a board of twelve world and industry leaders. ygl members include Gabriel Attal, Leonardo DiCaprio, Alexander De Croo, Macron, Michael Schumacher, Zuckerberg...

Matthew Ehret of Canada and Whitney Webb of the United States explained that Canada is still completely under the control of the British crown. This explains why Justin Trudeau of the wef's ygl program took office explicitly swearing allegiance to the British crown, namely Queen Elizabeth.

In the United States, however, there seems to be a difference. Their domination of the Anglo-American world, envisioned by the City of London for the London financial market, has not taken. There are two systems that now exist in the United States.

One is the system of those who want to separate themselves from the European plunderers, especially the City of London. The other is the so-called Deep State⁶ led by Henry Kissinger, among others, which continues to pursue precisely this global domination. The role of the Chinese leadership will be to expand the social credit system. First in China, then worldwide.

James Bush, a retired U.S. Army lieutenant colonel, includes oversight of the Level 3 and 4 laboratories in the United States. He talks about Operation Dark Winter⁷, in which he himself participated in 2001, Lockstep⁸ by the Rockefeller Foundation and finally Event ²⁰¹⁹ in October 2019, to explain that the financial mafia has been planning for at least 20 years to use healthcare to stage the epidemic panic. Precisely what was done in October 2019, as a dress rehearsal, has been implemented since early 2020.

Silvia Behrendt and Astrid Stuckelberger, who both worked at who, explained to us that this financial mafia has now taken extensive control not only of who, but also of the un, through who rules and regulations that have no democratic legitimacy and through its own constitution that has no democratic legitimacy either. The real legal regulations and national constitutions are effectively suspended, or will be soon.

In fact, only private parties, especially the Gates Foundation, determine the course of who. In January 2020, there were virtually no cases when the long-anticipated corona pandemic began. This is what they needed to declare a public health emergency of international concern. Because that is the only basis on which new drugs can be used that have not been tested on humans. So they created these cases artificially with the help of the PCR tests of a certain Christian Drosten, from the Charité hospital in Berlin.

The many people in this financial mafia have infiltrated what they believe to be important strategic positions in politics, the media and the judiciary, and of course medicine around the world. So that was a summary of what happened at the second session of the People's Court of Public Opinion. Thank you.

7:37 Reiner Fuellmich

Thank you, Judge Rui de Castro.

This leads us directly to the discussion of the PCR test, as it is the basis for all measurements, as we will soon discover. We will start by looking at the significance of the PCR test in the World Health Organization system. Dr. Stuckelberger will explain some of the details.

8:07 Astrid Stuckelberger



Yes, thank you Reiner. I want to start by saying that who has never used PCR in the 2005 international health regulations, until swine flu when Drosten stepped in and tried his hand at it. PCR is a technology that replaces the physician and you can compare, which is what I often do, what happened with SARS-CoV-1 versus SARS-CoV-2. SARS-CoV-1 was not managed by technology at all, it was symptomatology that mattered, physicians were at the center of the validation process. This is what has completely disappeared with SARS-CoV-2.

6 The deep state, a transcription of the American deep state, is a political concept that designates a parallel hierarchy or informal entity within a state that secretly holds the decision-making power over society and all political decisions in a democracy.

7 Operation Dark Winter is a simulation of a bio-terrorist attack in 2001.

8 Operation Lockstep is a simulation of a viral epidemic in 2010.

9 Event 201 is a simulated epidemic in October 2019.

The other thing, which is very different, is that in the International Health Regulations Implementation Training, which we did between 2009 and 2013, we had guidance on how to validate and identify, this is a very important process. When you have an outbreak... what is an outbreak? The who has an emergency room, it's called "shock". It's a strategic health operating room. Every morning they look at the messages, they look to see if anything is suspicious, not just coronavirus, which is a common flu. From there, they have to have a validation process, not only if it's a biological infection, but also a zoonotic infection, a foodborne infection, or chemical, radio-nuclear, or radiation.

We had the guideline. We see how different it is with this RCP. It was validated by all the who experts. I was leading the case study exercise for the typologies. It is, first, to describe the circumstances, and then, second, to identify and characterize the chemicals, infectious or toxic agents that pose a public health problem internationally. Third, describe how people come into contact with a chemical, infectious toxic agent, the timing of toxicity, the effects on humans, validated several times, the nature of animal life, water, food, environment. The fourth thing to do is to characterize the health risk.

It's called risk assessment. There's a lot of literature on this, related to exposure, how long, with the first strain of the common flu, I'm getting to that... as well as the duration, what treatment eventually, what is the risk of it spreading internationally and becoming a public health emergency of international concern. It doesn't happen overnight. From January 22 to March 16... when Fauci received an email asking him to contain everything, everything is documented.

That's the first thing. We had a process, I have a kind of sketch for decision making. There's an annex 2 of the international health regulations, which everybody has to look at. But before that, they have to have a zero case.

With Ebola¹⁰, you can watch a lot of movies like "Alert!" with Dustin Hoffman, that was an exercise we did with the students. There is always a zero case. With covid-19, where is the first case? Where exactly is the zero case description? People need to think about that. No, it did not happen, there is always a doubt. Today we know that it was man-made. It took a long time to verify it. It is essential!

Then you have to go through a procedure that is very well known in science called Koch's postulate, which has to be validated at the international level, if we want to use it at the international level, like being able to say that this is the covid-19 virus. The Chinese claim to have done this. But there has been a lot of criticism from many academic institutions that two parameters have never really been analyzed.

This needs to be analyzed over and over again, not just in China, but every country should. It is about contagiousness and causality. Causality is very important in science, it should be done again and again. It's not just a PCR test that decides the future of humanity. It's completely crazy compared to the international health science process and procedure of identifying, detecting and validating and verifying each time, over and over again.

So that's really the first parameter. The second is that this PCR test, in the laboratory there are guidelines and directives that were posted, early 2020, as to exactly how to proceed with a PCR test. Already at that time, there was the option of doing the ELISA¹¹ test and it was recommended that the physician validate that PCR.

Then as time went on from January 2020, also the CDC had already warned, (I have the document), that the PCR test does not work, it is not there to monitor an outbreak, nor to validate an infectious disease, clearly. What the WHO has done is that they have made a warning product: the PCR test is to be looked at with caution. But it was hidden on the who website. There was an alert in December 2020, it was, I think.

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- 10 The Ebola virus is the infectious agent that causes hemorrhagic fevers in humans and other primates (Ebola virus disease), which have caused historical epidemics of great scope and severity.
- 11 The Enzyme-Linked Immuno Assay (ELISA) is an immunoassay that allows the detection or determination of molecules in a biological sample. It was conceptualized and developed by Swedish scientists, Peter Perlmann and Eva Engvall in 1971.

The third or fourth alert, and another in 2021. It stated that each country using the PCR test, should clearly indicate on the result the amplification cycle. However, they were very vague about the validity of this information.

So this is for the procedure. I complete that it has nothing to do with the obligations in the international health regulations. Each state that followed our trainings was sovereign in the way it managed its epidemic. It is an epidemic and then a pandemic. It is not clear when it is a pandemic.

In the case of SARS-CoV-1, as a reminder, it was a common flu that disappeared after eight months. 24 countries were affected. 787 people died from this coronavirus and 8,000... 6,000 were sickened.

When you compare SARS-CoV-1 and SARS-CoV-2, there is something totally wrong. Since SARS-CoV-1, international experts and scientific teams have been trying to develop a vaccine, without success for 20 years. How is it that suddenly we see the development of a vaxxin, an experimental, synthetic vaxxination? When all vaccine developments against coronaviruses have failed. They have failed because the coronavirus mutates all the time. You can't make a vaccine when something mutates.

So I want to emphasize that who has never been a seller of vaxxins or drugs. That was against the purpose of who, not the world disease management organization. So who has changed, we can see it in a very different light today. I'm going to close by saying that I found something very interesting for you.

First, something else. The PCR test is not just the test. It's also how you apply it. That should be made obvious. What are the reasons for sticking it so deep into the nose, cracking the most sensitive part of the pre-brain and the layer between the brain and the nasal cavity? A clue!

The PCR test allows to vaxxinate people. Apparently the Egyptians were already doing this. This is how veterinarians vaxx animals by putting a swab very deep into the animal's nose. You can ask the vets.

We can therefore ask ~~you~~ about the procedure, the quality control of this procedure. We now know that these swabs are not neutral. They contain nanoparticles. I'm sure the experts will talk about that. A lot of toxic stuff doesn't belong there. In fact, the test doesn't need to go in the nose. Why did Drosten decide to do this?

One final scoop I bring is the conflict of interest of Berlin's La Charité¹² hospital with the vaxxin world. We discovered three gavi¹³ payments to La Charité between 2018 and 2020.

October 2018. The grant topic speaks to global health and development, public awareness and analysis, for 14 months beginning in October 2018. 550,000, to Global Policy and Advocacy at Charity, Berlin. Another was in December 2019. The Division of Global Health at La Charité University, Berlin, received \$86,000 for a grant topic on pneumonia (four months). The last one in March 2020. There could be more. This was to support innovative technology solutions.

Since March 2020, they have gotten \$249,550 for 14 months. So there is clearly a conflict of interest, as with Imperial College who also got \$79 million for the malaria program. This is in the same file. We can see here that there is a big conflict of interest with Drosten, with Gavi. Just follow the money. That's where it's going.

The last thing I discovered was what Drosten is doing right now. He is involved in the This is a "world health summit". This usually takes place in Germany for three days. There, the people in charge of La Charité and those behind it meet with who and with gavi. Drosten is there, the University of Geneva is there.

12 The Charité University Hospital, founded in 1710 as a nursing home for plague patients, is the oldest hospital in Berlin. With more than 3,000 beds, it is one of the first university hospitals in the world.

13 The vaccine alliance, gavi, is an international organization created in 2000 as a public-private partnership for immunization. It aims to accelerate progress in poor countries in increasing children's access to immunization and the range of vaccines available.

The hospital university [Ilona Kickbusch is retired but still illegally active at the University of Geneva], is preparing the who pandemic treaty, mentioned yesterday, which wants to take over from the who constitution, implementing a global constitution because we have such a terrible pandemic. They were preparing this new governance at the who special assembly in november and december [the 75th, the second special assembly in the history of who]. They also discussed it at the executive board and are planning a new world health assembly in the third week of May 2022 to discuss it and perhaps make it a reality.

It is good that we are here together. I should point out, because people are listening, that this pandemic treaty will disenfranchise citizens. The Constitution will no longer work. A Russian NGO and a citizens' association have already written to who and, I hope, to their health minister to say that they do not agree with this pandemic treaty.

21:48 Reiner Fuellmich

Thank you. The first question is from Virginie,

21:53 Virginie de Araujo



Yes, thank you. Thank you again, Dr. Stuckelberger, for these important points. We would like to know if at least one country has been able to question the quality, the validity of these PCR tests that have been

developed very quickly. It seems that no one has tried to challenge this product.

22:19 Astrid Stuckelberger

This is a very good question. Normally, Member States can of course question products. In the International Health Regulations, sovereignty was respected in that only two countries had reservations.

There are legal articles in this international sanitary regulation that is set for all member states. Let's make reservations, there is a procedure and a timetable for this.

It seems that if this happened, we don't know. What I do know is that there is a connection with Dr. Fauci¹⁴. He, in one of his many emails, received a proposal to replace the PCR test. I have people following me and helping me. One of them, Nadia, just sent me this. This is Anita Gael writing to Anthony Fauci on February 26, 2020, proposing a much more effective detector diagnostic tool called the Mobile Genetic Radar Platform. It was rejected by Fauci. Apparently they hid all the data from it.

I think there have been attempts, on a personal level. It seems like it's a much bigger network that wants to govern than just who. Frankly, I don't think Director General Tedros is really running it. Normally, when there is a pandemic, there is a pandemic team that goes to the media. Today, it's just Tedros and a few media figures who are involved.

So we don't really know the reality, if any countries have resisted. I know that Madagascar has tried to withdraw from who several times. So they could do that, of course, under international regulations. But what we discussed yesterday is that if they have an epidemic law, or if the country has changed its constitution, or if the country is registered as a corporation, which we've seen with many countries... things would be totally different.

People don't know these facts, and people don't know that they can refuse or that their government would protect them.

Maybe the key question is that today people know, they can react and we will help them, I hope, to resist this PCR test that is still used and promoted by this international atomic energy agency. This one, I remind you, is a very powerful agency because it manages all the radio nuclear events, even before the WHO. It has a contract with many un agencies, I looked at this morning. Not only who, but also unesco, fao (food administration organization) and many others. So we really need to react to all these political Ponzi schemes, which are designed to take away our freedoms.

¹⁴ Anthony Stephen Fauci, 81, advises American presidents. He has directed the National Institute of Allergy and Infectious Diseases since 1984. The niaid is a research center of the US Department of Health.

25:45 Reiner Fuellmich

Thank you, Astrid. Is there a follow-up question? Is Ana next?

25:56 Ana Garner

I think this is mine, thank you. Dr. Stuckelberger, that was very good, thank you. Did you know that the Prime Minister of Tanzania had asked the WHO to leave his country after testing various non-human objects with

PCR tests? [A papaya, a goat, oil](#), that sort of thing. He had found that the test was positive. He immediately denounced the PCR test. He died under mysterious circumstances. Were you aware of this story?

26:45 Astrid Stuckelberger

I am aware that a few presidents have resisted and died. Yes, I think he is not the only one. I don't know the whole story behind the RCP. There's probably more than just the RCP, because everyone who resisted that band of pirates is gone. Even Kary Mullis. So yeah, I don't know much about it, but it's a good example.

27:15 Ana Garner

I also have a follow-up question. Of course, Kary Mullis was the one who invented the PCR test to begin with, in terms of being able to multiply tiny amounts of DNA to detect it, by amplifying it. It was used primarily in forensics, if I'm not mistaken, is that correct?

27:37 Astrid Stuckelberger

Kary Mullis was a researcher. He said it was a very interesting tool for laboratory research, because you know what you are studying. So you look for what you know, but you look a little bit deeper. But he said under no circumstances can it be amplified. Ulrike may have put that in his first page. In no way can we diagnose anything, it's like a big soup. It is not a diagnostic tool. He has discussed this many times with Dr. Fauci to resist, already with HIV/AIDS.

28:17 Ana Garner

My final question: do you have or know of any evidence, direct or circumstantial, that would show that Drosten¹⁵ was aware of the fraudulent nature of the covid-19 PCR test?

28:36 Astrid Stuckelberger

No, I don't see anything that would incriminate him. I see that he has links with gavi from the beginning. Since gavi was the big organizer of this whole global vaccination campaign that is killing people and making them sick, I guess that's the link I would really look into, to prove that he knew.

29:08 Ana Garner

All right, thank you. I will ask the other experts what they think. Thank you very much.

29:14 Virginie de Araujo

If I may add, I think Dr. Drosten knew it was not a good tool since at least 2014, because there was a journal article about it. When he was working on Mers-Cov, he had already stated that PCR tests were too sensitive and not a way to track a virus. It was really too sensitive and exposed by the media already in 2014.

29:58 Reiner Fuellmich

Yes, in this article, he explains that a positive result means nothing because this test, it tests positive on perfectly healthy people. He was talking about a nurse at the time. I'm sorry, Mike, I didn't mean to interrupt.

30:14 Mike Yeadon

Yes, I was going to make the same point you just made. He used a phrase like: "this technique can show a positive result, even if only one copy of the virus was passed on the respiratory mucosa of a nurse."

He used a phrase like that. So that's important. Did he know that? Well, he co-authored the fundamental test, which we call the Corman-Drosten test. So he came up with a test, which the who then came up with in their famous test-test-test speech, that was the test that he was talking about.

¹⁵ Christian Drosten, 48, is head of the Department of Virology at the Charité University Hospital in Berlin. He is a member of the German Bundestag and since mid-January he has become one of the most sought-after and referenced figures in the country.

We're certainly going to talk about this, but Drosten is the co-author of the test whose variants have been used around the world. He knew, as we just mentioned, that if used with improper amplification stress, it can give positive results when people are not sick and are not infectious. It should also be said, perhaps a colleague will say this in the abstract, that the inappropriate use of PCR and asymptomatic transmission, the idea that people without symptoms can infect other people [which is not true], that is epidemiologically rare and irrelevant.

Drosten was also in Europe the absolute center of the promotion of this idea, which seems a remarkable coincidence, because he is the author of a technique now used worldwide, which he knew was not appropriate. PCR. He is also the greatest expert on television, telling us about this asymptomatic transmission. So you can decide for yourself, but for this same expert, an advisor to Angela Merkel for years, he happens to be the center of two of the absolutely crucial parts of these lies, the lies about this whole pandemic, seems to me more than a coincidence.

32:18 Reiner Fuellmich

Absolutely. Dexter, do you have your hand up?

32:24 Dexter Ryneveldt



Hello, Dr. Stuckelberger. Thank you very much for your testimony. What I am going to offer you now, since we are talking about crimes against humanity, is the evidence that you have just given. Can you please

How can we tell if it is correct? When you compare the regulatory procedures between SARS-CoV-1 and SARS-CoV-2, it is clear that there are huge discrepancies. You mentioned something important with respect to SARS-CoV-1, there is some terminology itself, which was

not a prerequisite when testing for SARS-CoV-2. Why not? Because the regulatory procedures have changed. So, I ask you, Dr. Stuckelberger, can we clearly say that they have demonstrated criminal intent on the part of who and all the specific parties behind it? Do you agree with me?

33:49 Astrid Stuckelberger

I wrote a scientific paper in May 2020, *Acta Biomedica*, on international health regulation and uncertainties. At that time, I already had doubts. Now I think we need to add this injection. I agree. Because the end game for them is to inject toxicity containing a chemical level and maybe a radiation level and not just mRNA, etc.

So, yes, the real crime is that people are dying, not because of something that we haven't identified very clearly, that a PCR has misidentified cases that are asymptomatic, which is already criminal. The problem is that their goal now is to modify and edit the genome. They are very clear about that. The who, before this treaty came out in July, recommends genome editing, it's much more than CRISPR16, it's the modification of our identity. It goes against the Oviedo convention17, it goes against medicine, it goes against the whole Declaration of Helsinki18, it goes against all the ethics and regulations about preserving our heritage intact. In this sense, it is definitely a crime against humanity that we are witnessing.

35:26

Dexter

Ryneveldt

Thank you very much. One more question. I would like the jury to think about this because I think it's at the root of these crimes against humanity. We have SARS-CoV-1. There is a precedent to work from. Now we have SARS-CoV-2. In all respects, you have extensive knowledge, you have worked with who. What about the regulatory procedures for SARS-CoV-2? Do you see the need for who to radically change the regulatory procedures for SARS-CoV-1?

16 In genetics, CRISPRs (Clustered Regularly Interspaced Short Palindromic Repeats) are families of repeated sequences in DNA that are characterized by series of direct short repeats regularly spaced by sequences called "spacer", usually unique, of 20 to 40 base pairs.

17 The European International Convention of Oviedo (Protection of Human Rights, Dignity of the Human Being with regard to the Application of Biology and Medicine - 1997) entered into force on 1st December 1999.

18^{The} Declaration of Helsinki is an official document of the World Medical Association, representing physicians worldwide. It was adopted in 1964 in Helsinki, Finland, and has been revised several times.

Logically, it doesn't make sense. We have something that we can relate to, which means that if we have to change something, it will be something very, very minor. So I would like you to tell the jury, based on your expertise, your experience, your inside knowledge as well, whether there was really a need to change this regulatory procedure compared to SARS-CoV-1. Thank you.

36:50 Astrid Stuckelberger

Thank you, this gives me the opportunity to explain a little bit more in depth. The important way for a country to identify that they have something to notify, to the country or to the Centers for Disease Control and Prevention, is that they have developed an algorithm in Annex 2 of the International Health Regulations. Anyone can look up Annex 2 on the web. A PDF document, translated into about 10 languages. There are four main questions in this Annex 2. I taught this in college, in summer school, to American schools. So it's really very important. Anybody can do it.

The first one, they have three boxes and then another box. If it's a disease, is it a disease? They list the diseases: Poliomyelitis, etc. They have SARS, acute respiratory syndrome. So if it's there, that means it's known. So that's the first question. Is it known? Yes, it is known, we have SARS-CoV-1.

So the second one, is this unusual, or is there a different morbidity and mortality, etc.? The answer is no because we know now that in 2020, Professor John Ioannidis, the most quoted, even published on the who bulletin, it was in there, that there was no more mortality in 2020. So no, we know that now.

The third question is: is there a risk of international spread? You see that SARS-CoV-1 only affected 24 countries in eight months. So if you compare, we had total containment in 196 countries in 1 month and SARS-CoV-1 lasted 8 months. So no, the international spread was slow. It was not rapid. They claimed it was fast. But it's very worrying for them.

The last question is: is there an international risk of travel and trade being stopped? Because the international health regulations have been

set up precisely to prevent restrictions on trade and travel. Here we have the exact opposite. That's the only question we could answer in the affirmative, it happened because they put a lot of fear into their messaging and communication, which is counter to the international health regulation training that we received.

We had an anchor from CNN during the course. I was in charge of that. You have to have ethical communication, be nice, reassure people, say you're looking, you haven't found, you're still looking.

I don't know if you remember, in Germany in 2011, there was the Koch Institute that came out with the killer cucumber, it was the Escherichia Coli epidemic emergency, because there were three deaths. They were saying every day, "we don't know we are looking", they blamed a cucumber that had Escherichia Coli in Spain and they stopped the whole production of cucumbers in Spain, in the European Union. Actually, it wasn't that, it was from a fenugreek market in Egypt and it came to Denmark. People lost all that money. Because it was an announcement that was false by scientists who were very careful. What happened was that the European Union reimbursed all the farmers who lost money, because the announcement was false.

This is one of the examples I've taken in my classes, because every situation is different. But here, they did a communication of fear and lies. That's how they got people to believe that this coronavirus, which was totally ruled out and didn't even exist in the fall [Professor Raoult looked at this very carefully, I really watched how he sequenced the genome, ~~th~~ another way of looking at it, although not enough]. It was part of the international effort on the human covid-19 genome. It was very scientific, but we definitely can't say that it was handled the way it should have been.

41:30 Dexter Ryneveldt

Thank you very much. Dr. Stuckelberger, just to conclude, from the standpoint of the evidence and the safety of the grand jury investigation, it all comes down to Drosten's RCP. So based on the evidence that was listed yesterday by Dr. Behrendt and the evidence that you

also just mentioned, the only reason why who could have declared a pandemic is simply because right now we are talking about spread that has a direct link to Drosten's fake PCRs. So basically, tell me if you agree with the following statement: Drosten should be held accountable, because it is as a result of his faulty PCR [which they needed for a spread transmission], that we are currently with a

pandemic. Do you agree with this statement, Dr. Stuckelberger?

42:48 Astrid Stuckelberger

Yes, I think he is a piece of the puzzle. It's him and La Charité University in Berlin, because the whole institution is behind him. I know from other universities, it's a system, a health system. So yes, I agree. But I would take the whole institution. Not everybody in the institution, but we can't continue to have universities that lie and create science that is false.

43:23 Reiner Fuellmich

This is a political question. But Dexter's question specifically asks if he is, as he is one of the putative defendants in this proceeding here, do you think he should be held accountable? As we have learned from your statements and also from Dr. Mike Yeadon's statements, should he be held responsible, because he is the one who invented the test, knowing that it would give positive results on perfectly healthy people?

43:56 Astrid Stuckelberger

Yes, definitely. Yes. We have the evidence for that, I don't have the details, etc. But yes, of course, given the evidence.

44:05 Reiner Fuellmich

Thank you very much. Now let's take a closer look at the PCR test itself. What can it do and what can't it do? Thank you, Astrid. Professor Kämmerer, please tell us what this test can do? Can it really tell us about the infection or not?

44:25 Ulrike Kämmerer



I am trying to share my screen. I have prepared some slides to give you some information about the basic principle of RT-qPCR. First a definition, because not many people know what it means. The system

The test used for the detection of the SARS-CoV-2 genome is called RT-qPCR. It is a quantitative reverse transcriptase polymerase chain reaction.

Some basic aspects of the RT-qPCR as principal point of the "pandemic" situation

RT-qPCR: reverse transcriptase quantitative polymerase chain reaction

The RT-qPCR for the detection of the SARS-CoV-2 RNA

- is technically not able to decide if a sample, which is found positive, is indicative of an infectious (contagious) person
- even if performed under perfect conditions, this technique can not be used as „gold standard“ and basis for the non medical actions intended to stop spread of a virus. Especially, mass testing without clear controlled standard operating procedures must result in inaccurate test results.
- especially the first WHO protocol (responsible C. Drosten, Charité) is very poor in technique, faulty and highly prone to the production of false positive results

The main arguments are that RT-qPCR for SARS-CoV-2 RNA detection is technically not capable of deciding whether a sample that has been found positive is indicative of an infectious or contagious person. I'll come back to that...

Even if it is done under perfect conditions, it means that everything I do is perfectly designed. So, the primers are correct, the temperature is correct, the lab performance and the technique are perfect. This technique cannot be used as a reference as it is designed. As a basis for non-medical action to stop the spread of a virus. Especially mass testing without clear control of standard operating procedures that are still lacking in most laboratories inevitably leads to inaccurate test results.

In particular the first WHO protocol [Drosten's name has been mentioned several times today, he is responsible for this first WHO protocol]. It is very bad in its technical aspects, it is flawed and it is very prone to produce false positive results.

19 Ulrike Kämmerer is a professor and doctor of human biology. Together with her team at the University Hospital for Women in Würzburg, she conducts research in immunology in the fields of reproductive and tumor biology.

So the definition of PCR is that it is a perfect laboratory method, if you want to amplify a specific section of RNA from a small sample to a detectable and characterizable amount, for example, to do sequencing. It's used worldwide in almost every life science lab for expression analysis and research. So this technique is very widespread in the world and every molecular biologist, [you don't have to be a biologist or anything, because anyone who works with this technique knows that it is limited and that its current use for mass testing is absolutely not a good idea].

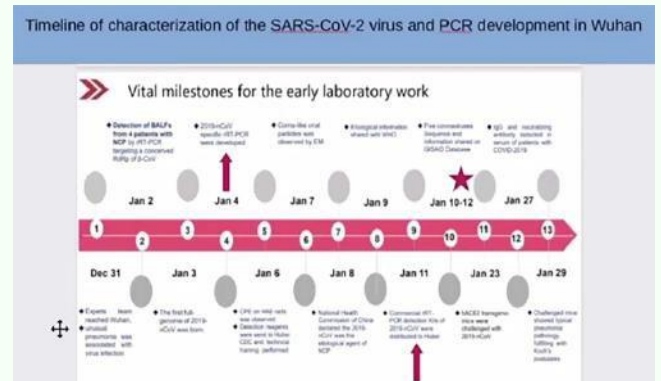
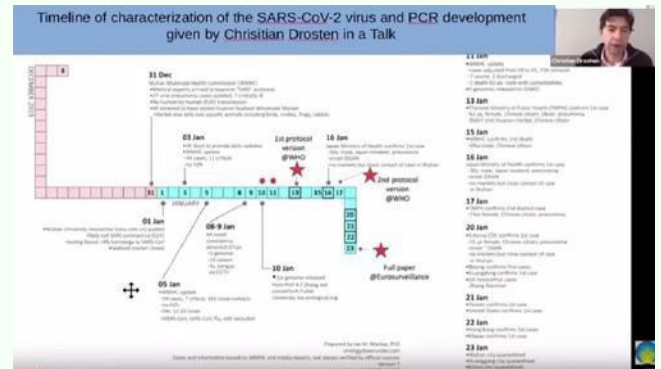
Thus, the "q" is the quantitative version of RT PCR, which defines a modified technique that controls the amplification steps. Each step is controlled by a light signal produced in each amplification cycle. However, the problem is that this does not allow for subsequent characterization of the PCR product, such as sequencing. It requires very careful development and appropriate controls in each step. This is often lacking in laboratories that perform mass testing for the public.

RT-PCR, so the "normal" one, is commonly used in almost every life science lab. PCR [DNA amplification], is a basic method designed by Kary Mullis. Nowadays, it is mainly used in laboratories for forensic diagnosis. For example, to establish the genetic framework of fingerprints at crime scenes to identify the culprit.

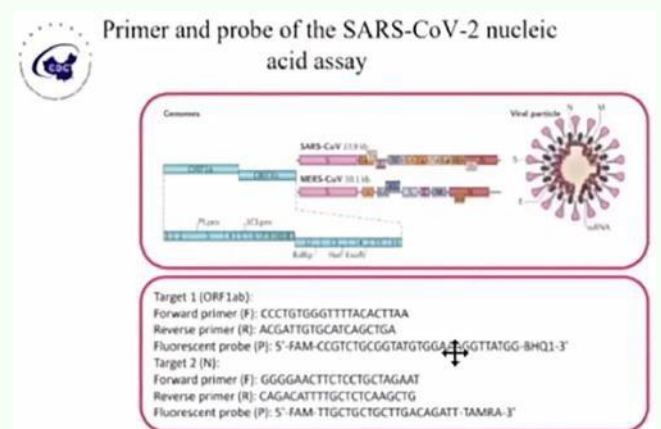
Before I get to the technical point, I think what is most important in the question of who is responsible for the misuse of PCR, what is the timeline. Because the main question is why did who wait for Drosten's PCR protocol and promote it, when the scientists in Wuhan had everything by the end of 2019. They had shared information with who before the first version of Drosten's protocol.

So this is a timeline that Drosten gave in a lecture, it's official, with his own photo. He wrote his remarks. So on January 1 the first version of the protocol was sent to who, the second modified version of the protocol was sent on January 17 and his full article in euro surveillance was published on January 23.

If we compare this chronology, the work of the Wuhan scientists is not mentioned anywhere.



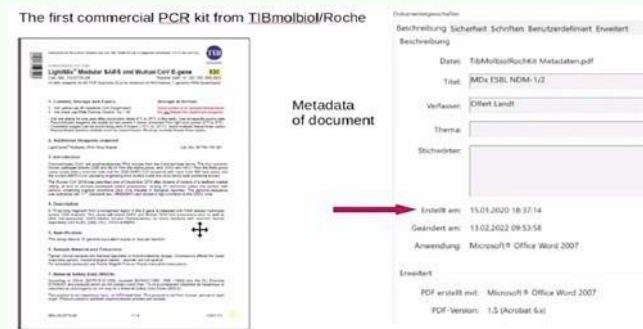
If you compare this timeline to a presentation from the Chinese CDC in Wuhan, you can see that they identified the first complete genome of the new virus as early as January 3. They mentioned that the specific RT PCR was developed on January 4. On January 11, you notice that they have a commercial RT PCR detection kit, which is distributed to Hubei Province [of which Wuhan is the capital]. The red star indicates when Drosten provided its first protocols to who. On January 1, Chinese scientists had a complete PCR and informed who on January 9. So why did they wait for Drosten to come on the scene?



So here is a PCR performed by the Wuhan scientists. It differs by two genes from Drosten's later published protocol, but it works very well. It is the same principle of quantitative RT PCR.

At the same time, another interesting aspect is this quote from a publication from Slovenia, because they quoted in their publication **"After a thorough evaluation, our laboratory implemented the LightMix-based SARS-CoV-2 test on January 17."**

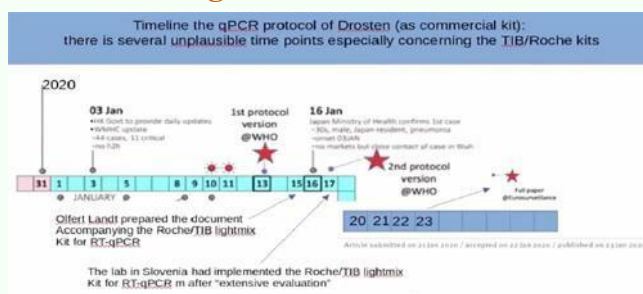
How is it that a Slovenian laboratory has a commercial test kit, based on the What is the meaning of "Drosten's primers" and this data sheet?



This is an original data sheet accompanying the commercial kits of the company Tib Molbiol, which are sold exclusively via the Roche company working through Roche platforms.

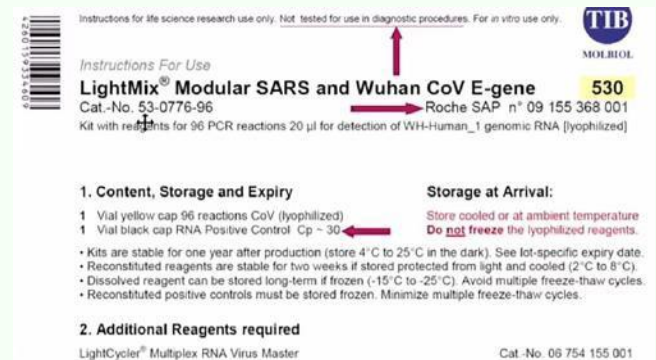
If we go into the metadata, this card is produced by Olfert Landt, the president of Tib Molbiol. It is produced on January 15, 2020. So the whole commercial kit was ready, it seems, by January 15, even after the first version of the who protocol. So this is a remarkable timeline, which normally, especially for this Roche SAP issue, is very unusual.

So, if we change Drosten's timeline. We are on January 15. Officially, Olfert Landt prepared the document that I showed you and on January 17, the laboratory in Slovenia implemented, made a complete commercial product and mentioned **"after a thorough evaluation"**.

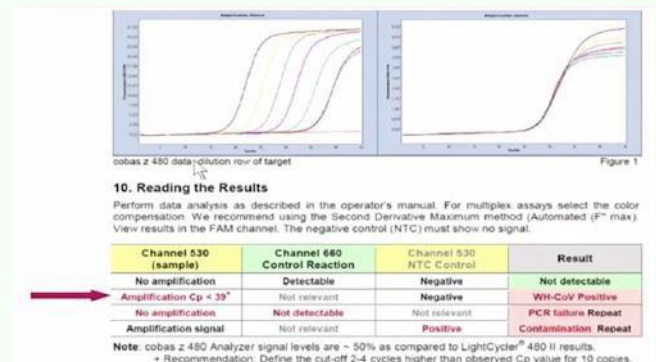


A thorough evaluation cannot be done in two days. So they must have the commercial kit somewhere else. But there is no documentation as to why a commercial kit was available so early, even before there was any international concern.

So here is Drosten's paper, which he published after his primers were already in the commercial kit. This is scientific misconduct, a collateral effect.



So this first test, it's one of three genes, not tested for diagnostic procedures. But it was used for diagnostic procedures. It's a SAP number, normally it uses a large amount of tests to get into the system. One important point is that he correctly added a positive control and in the design there must be a CT that is corresponding to the cycle thresholds, a CT of about 30. So at this point, 30 should be the cutoff for the PCR.



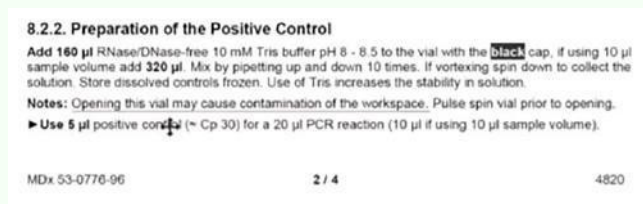
However, the amplification of the Cp [or CT, it's the same thing], up to 39 is the positive evaluation. So they had in this protocol a CT that was already way too high.

Regardless of each PCR, whether it's a Charity protocol or a CDC protocol, a protocol from any other institution, the main problem is false positives.

To give some points, false positives can be triggered by poor PCR design, which is the case for the Charity PCR, the Corman-Drosten protocol. They contain non-specific primer pairs and probes, these are poor conditions for the reaction itself. The temperatures, especially in the Corman-Drosten protocol, are not appropriate.

In the case of quantitative PCR, the CT is too high. Thus, the design, in this case, produces false positives.

But there are handling problems in the independent laboratories that perform this technique and the most problematic [anyone working with PCR knows] is contamination of materials with PCR positive control samples: this is the most common. Cross-contamination from positive patient samples to negative samples due to non-pure pipetting techniques or aerosol generation is also very common.

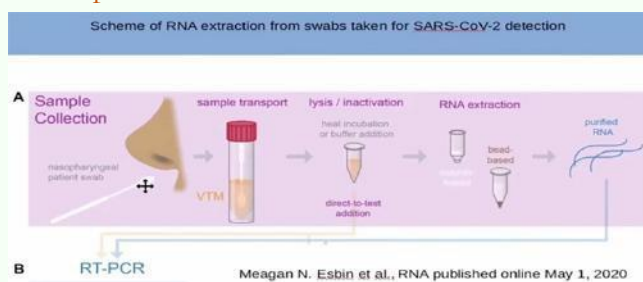


So, in the first protocol data sheet, there is a note: "opening this vial may result in workspace contamination" and once you contaminate your workspace, almost all samples become positive at random when one of those positive samples enters the reaction chain.

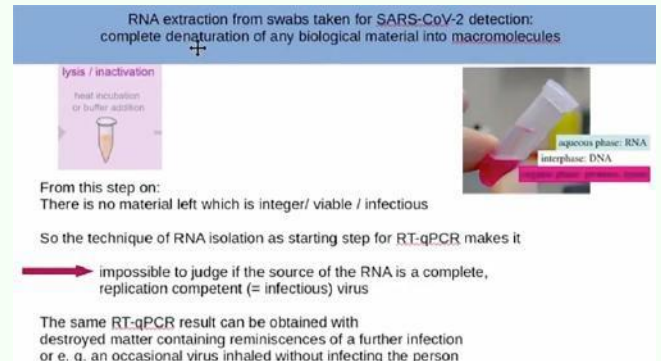
The last point to give a brief overview is a question. Can a properly performed RT-qPCR [so if everything works well, if the design is correct, if the handling is correct], can a properly performed and positive RT-qPCR indicate infectivity?

In principle, neither PCR, RT-PCR nor RT-qPCR is technically capable of deciding whether a sample that is found positive indicates an infectious or contagious person.

Why is that? The problem comes from the sample preparation technique. It requires the destruction of all biological structures in order to separate the nucleic acid [in the case of SARS-CoV-2 its RNA], to make it accessible to the enzymes that perform the amplification.



This diagram, from a publication, shows the extraction of SARS-CoV-2 RNA, to make it available for amplification in PCR. You have your swab, then you dilute the swab in this solution and this solution is *lysis/inactivation*, in title. From that point on, all the active material is destroyed, inactivated.



When you extract RNA from the swab, you must absolutely complete the denaturation of any biological material into macromolecules. We go from the pink step on the left of the diagram to the one on the right. You have a combination of RNA from the genome, DNA for example, from the cells you have from the swab, proteins and lipids.

In this situation, you have beautiful intact mucous membrane cells. No bacteria or fungi that are still in your nose and throat, no viruses. You can't have any virus particles. There is no material left that is whole, viable or infectious. The RNA isolation technique is the starting step for the RT- qPCR that is used for the so-called SARS-CoV-2 virus detection.

It is impossible to judge whether the source of this RNA is a complete replication is infectious in the case of a virus. The same RT-qPCR result can be obtained from a positive result with destroyed material containing reminiscence of a later infection or a casual virus as Michael Yeadon said, virus inhaled via a patient's mucosa.

So the main problem is the isolation of the nucleic acid for amplification. Everybody, including Christian Drosten who works with this technique, as well as all the companies that prepare and advertise these kits, all the people who advertise this RT-PCR or even RT-qPCR technique for detection of infectious individuals, should know that they are not capable of doing this.

01:01:12 Reiner Fuellmich

I am shocked.

01:01:18 Viviana Fischer

I have a question. Dr. Stuckelberger and Prof. Kämmerer. Yesterday I think it was mentioned that who, in the first attempt to declare a pandemic, only counted 500 cases and that it went nowhere. Then they waited 10 days and all of a sudden there were 14 times more cases. Could you put that in a timely perspective with respect to the developments that have happened with Drosten's test?

01:02:00 Astrid Stuckelberger

I think it was Silvia who had all the numbers yesterday, the information. I don't know them by heart. I'm sorry.

01:02:09 Reiner Fuellmich

I think she said about 500 cases, which is...

01:02:13 Viviana Fischer

But we don't know the exact date yet...

01:02:16 Ulrike Kämmerer

There was something in the timeline slide given by Drosten. There

here was exactly an alignment of the actual cases when he did his PCR. One of which was in China, one in South Korea. There were very few cases. Even the first case, the official cases in Wuhan, they are published by Li-Li Ren (see here) and by other Chinese scientists. The first five patients in Wuhan, only one of them died. This one was in a serious condition because he had

metastatic cancer. From the beginning, it was clear that this virus was not a killer virus as we had been told.

01:03:15 Astrid Stuckelberger

Yes, I remember it was 24, the first number that Silvia mentioned yesterday, in January, which is normal at who, you move increasingly to a larger number, but you don't go straight to numbers everywhere.

01:03:33 Reiner Fuellmich

I have four questions. The first is a clarification. You showed us in your timeline, that the Corman-Drosten paper, or the protocol that was recommended to the world by who [Tedros], as the gold standard for covid-19 screening. Before

even before it was published, the test kits that were produced by Drosten's business partner, Olfert Landt, with his company Tib Molbiol which is now under the control of Roche because I think they bought it. But even before they published the article, they sold their test kits to the world, is that correct?

01:04:30 Ulrike Kämmerer

Not to the whole world, but almost. Many test kits have been sent out, Olfert Landt even mentioned this in several interviews. We know from other work that Roche, in collaboration with Tib Molbiol, started training laboratory staff in Africa and Asia in the use of this test at the beginning of January.

01:05:00 Reiner Fuellmich

Isn't this a clear violation? Don't we see a clear conflict of interest here? I mean, first you sell the product you invented and then you go out and publish something that calls for buying your product. Isn't that, I mean...it's not just non-scientific, isn't that a blatant conflict of interest that we're seeing here?

01:05:27 Ulrike Kämmerer

That's for sure. In addition, they did this test in what's called Labor Berlin of which Christian Drosten is the director. It's the largest laboratory in Germany. In the beginning, they did almost all the PCR tests, because they had the advantage of having been installed very early, before all the others could start. So there are at least two conflicts of interest, in my opinion.

01:05:59 Reiner Fuellmich

Another question for clarification. Is it true that no matter how you run a PCR test, it can never tell you anything about infections? First, it cannot distinguish between [I'm not speaking from a scientific point of view, of course], dead matter and living matter. Secondly, since the actual virus is completely destroyed, before you put that swab into the machine. The only way you can have an infection is by a complete virus entering the cells and starting to replicate. Is it true that it is totally impossible, no matter how you apply a PCR test, that this PCR test can tell us anything about infections?

01:06:49 Ulrike Kämmerer

Well, it's a matter of definition, I think we should... It's possible that if the PCR is done correctly and the threshold is very low, then there could be a large number of viruses in that person. If you compare it to a baseline, which is a cell culture, then you are comparing it to an infection.

But you can never judge whether the person is infectious, so whether he or she can transfer the replicable virus to another person. PCR is not able to identify people who, as super propagators, transfer the virus. This is an important point in a pandemic. You have to identify the people who are infecting others. PCR is certainly not the technique for that.

I forgot the first question.

01:07:59 Reiner Fuellmich

So what this means is that we need to be very clear about what we are talking about. WHO needed cases in order to declare a public health emergency of international concern. Now, everyone thinks that a case means someone who is infected, that is, contagious to other people. But that's not what this test can show. No matter how you apply it, it can show that there may be some probability that a person has a significant load of this virus.

But even if that person is, I'm going to say infected [because that's what the test finds], it still doesn't mean that that virus has entered the cells and is replicating so that the person becomes infectious, that is, contagious to other people. If that is the definition, then contagiousness can never be detected by this test.

01:09:08 Ulrike Kämmerer

Exactly. The test can't determine the disease, so the symptoms. Because, especially in the case of respiratory viruses, it is normally a combination of different viruses. If you look for the flu virus alone, for example, the flu is called Influenza. If you're looking for rhinovirus, it's rhinovirus disease. And if you're looking for coronavirus, then it's coronavirus disease. So normally, the doctor has to conceive that the person has a disease and if they want to know what

pathogen is producing the symptoms then you can do a test like a PCR. But normally the doctor has to start with the symptoms and then if you do, for example, a multiplex PCR, you can see that there is a lot of virus.

Even though the PCR may show that you have a high load of this special RNA from this special virus, it doesn't tell you that the disease can't be from another virus. Especially for example, in Wuhan, they published that the most severe cases were always a dual infection of SARS-CoV-2 and influenza B. This is already known. So you have three to four viruses often in parallel. PCR can't say that your illness is caused by this virus or that you can transfer this virus to another person.

01:10:48 Reiner Fuellmich

Okay. So when someone tests positive, it only means that they are infected. There can be a huge load even of that particular coronavirus because that's the only thing it tests for. It looks for coronavirus, so that's the only thing it finds. However, he can't tell us if this particular person is infectious in the sense of contagious to other people. That's a possibility, but he can't say whether that particular positive test means that the person is infectious with covid-19.

The only way to find out what caused the symptoms, I guess it doesn't make sense to test people without symptoms, the only way to find out what caused the symptoms is to do differential diagnoses. Is that correct?

01:11:49 Ulrike Kämmerer

That's right. That's what the normal job of physicians should be. So I think this is the first time in history that a molecular laboratory test has made a diagnosis and not every doctor is doing their normal job to make that diagnosis. This test can't do that.

01:12:15 Reiner Fuellmich

Here's the last question I have. You said that the Corman-Drosten protocol is very unscientific. I'm really trying to hold back the anger that I have. Is it so poorly designed? Because all the people who have worked on this protocol don't know what they are doing, or...? What does it mean?

01:12:48 Ulrike Kämmerer

That's a good question. So I thought they really didn't know what they were doing. But that's not possible because it's a very common and simple technique. So they should know what they are doing. Especially as high level scientific experts and big shots. It's not just Corman-Drosten; even Olfer Landt in his publication and his job is to produce the RT-PCR for the commercial kits. So they all know exactly what they're doing, because everyone in this position can't ignore that there are huge problems with the design of this test. So it must be intentional.

01:13:30 Reiner Fuellmich

So you agree. Since this test is so poorly designed... If you look at the totality of the evidence, we have a very poorly designed test, we have no cases before the test is published. Then, after the test is published, all of a sudden we have cases that are used by who as a basis for declaring a public health emergency of international concern, which is then used as a basis for the use of drugs not tested on humans. Would you agree that this is very strong evidence that this has been used to create cases, to artificially create cases out of thin air? That's what I believe. Would you agree with that, or does it not make sense?

01:14:27 Ulrike Kämmerer

No, it makes perfect sense, because there is no other way to look at it.

01:14:34 Viviana Fischer

May I add something? Drosten was a witness or expert, he was questioned at a hearing in the German county of Brandenburg in the summer of last year. He was asked what kind of threshold he would consider reliable with regard to the PCR test. He said it was around 26 [we have this in writing because we had a witness at the hearing]. Yet in his paper he had suggested that the threshold should be 43.

So why did he never correct his article? Or did he not make this public and insist, as a government advisor, that the threshold should be changed? Because we can see that many of the PCR tests done were still in a very high range. Up to 40 amplifications. All this caused all these false

results, these false positives and led to a lot of suffering and damage, with people being quarantined for no reason. What can you say to that?

01:15:53 Reiner Fuellmich

As a scientist, would you correct yourself once you realized you made a mistake?

01:15:59 Ulrike Kämmerer

Normally, yes! Especially in this case, we wrote a first letter and then a very long review in a specialized journal where this fraudulent publication was located. We asked for the retraction of this publication, which is normally a scientific procedure. Even then, the retraction of the protocol was refused.

So yes, the reasons behind it, nobody knows. We can only speculate. But normally we would ask Christian Drosten why he works in such an unscientific way, not correcting his fraudulent PCR protocol.

01:16:48 Viviana Fischer

I don't know. I think you haven't mentioned it yet, but the article went through the peer review process in a very short time. Can you maybe comment on that?

01:17:05 Ulrike Kämmerer

Yes, we analyzed it in detail, it couldn't have been more than 24 hours, which is very unusual for a scientific review process of a full research article. In an emergency or for their excellent publications, it could be that the editor of a journal got the manuscript, agreed, and said, "*Oh, this is an excellent manuscript.*" But even then, that very short 24-hour delay between submission to the review process and publication of the article. That's, shall we say, pretty unique in the world.

01:17:51 Viviana Fischer

I remember you identified a lot of, I think it was nine big mistakes or so, in that article. Some of them, such as the threshold issue, would have been, I imagine, so obvious that peer reviewers would have immediately, even within 24 hours, had to jump on it and say, "*Well, maybe that's not a really scientific or relevant approach in this essay.*", is that right?

01:18:26 Ulrike Kämmerer

Yes, in addition, one of the main points is that they mentioned that they needed to quickly design a robust diagnostic tool, PCR, because it was an emergency case, without having information about the virus. But they had the virus, because they had the Wuhan sequences. If it was so necessary to have a good PCR, these controls and sequencing, they should have asked the Chinese colleagues. Because they had everything and so there was certainly no need for this publication and this protocol.

01:19:11 Reiner Fuellmich

Mike. Is there anything you would like to add to that? I mean, it's very disturbing to see someone working in a way that is not only unscientific, but almost criminal. Would you also agree that this looks like a test designed to produce cases that mean false positives?

01:19:45 Mike Yeadon

Yes, Dr. Kämmerer did a better job than I could do. But I think she didn't approach some aspects in her introduction. This test was set up very quickly using the sequence that was provided by Wuhan to their lab. They had to work, night and day.

So, ostensibly, they had to consider: here is a potential virus that can cause a serious pandemic. Let's put a test in place to help the world identify who is infected and therefore sick, who might be infectious and should quarantine themselves. They knew exactly what the context was. It wasn't an academic or esoteric idea. They knew they were facing a potential pandemic and they developed, as far as possible and as quickly as possible, a test that could be applied.

If I were in their shoes, I would know that the people who are going to use these tests around the world, will at best be able to handle pipettes and follow formulas. They won't be labs like mine, if I were Professor Drosten. So I would say to myself that this system has to be impeccable, so that it doesn't produce a lot of false positives. But that's not what they did.

It seems to me that they have established conditions such that even if a laboratory like his applied this recipe, he would have a high probability of obtaining

positive results from clinical specimens. This would not mean that the person was ill from the virus or infectious from the material detected.

Moreover, as a senior advisor to the German government for many years and as an intelligent scientist, he knew all these things. So he spread around the world a technique which, used as it was by barely trained people, could only, as Dr. Kämmerer said, produce results that I would say at best, were uninterpretable.

01:22:14 Reiner Fuellmich

Dexter, you wanted to ask a question?

01:22:18 Dexter Ryneveldt

Yes, thank you very much. Thank you for your testimony, Professor Kämmerer. With your testimony, you have raised a very important point. That point is that everyone who uses PCR, it's in every country, specifically, we look at the health regulatory authorities who have approved it and have confined every country. Your evidence is that they were supposed to know that there was no way that this could be used as a diagnostic tool. I would just like you to answer yes or no, just to confirm that and be able to list it.

01:23:01 Ulrike Kämmerer

It cannot be used as a diagnostic tool to assess contagiousness. Yes.

01:22:18

Dexter

Ryneveldt Okay. So contagiousness, in light of the evidence that was presented yesterday by Dr. Behrendt and even by Dr. Stuckelberger, the only way they, the who, could declare a public health emergency of international concern was if the conditions for transmission were met, and transmission comes down to contagiousness. Is this correct? Three speakers nodded: Dr. Kämmerer, Shankara Chetty and xxx.

Okay, I'm going to read you the following that I would like you to comment on. What I'm going to read is a statement by Professor Christian Drosten in a 2014 article. I got it from your peer review that you co-authored. It is the Corman-Drosten peer review. I read this so I can include it in this panel. This is what he said in the article in 2014.

"The method is so sensitive that it cannot detect a single genetic molecule of the virus. If, for example, such a pathogen flies over a nurse's nasal mucosa for a day, without getting sick, or without noticing anything, it is suddenly a case of MERS. Whereas previously terminally ill patients were reported, suddenly mild cases and people who are actually very healthy are now included in the reporting statistics." I want us to focus on the word statistics. "This could also explain the explosion of cases in Saudi Arabia" Article 2014.

Do you have a comment on this, specifically in relation to the evidence you have actually presented so far?

01:25:25 Ulrike Kämmerer

Yes, in 2014, he described exactly that the problem is PCR. Therefore, he knows exactly that there is a misuse of this technique in the SARS-CoV-2 situation. In the current situation, it produces exactly the same problems that he described in 2014. So he certainly must have known that he was promoting a technique to the world that produces a lot of false positives, a lot of problems, and a lot of statistical false cases. So he must have known that and he must have pronounced it against his own knowledge. For what reason, I don't know!

01:26:20 Dexter Ryneveldt

Right. The next question is, you mentioned very clearly the evidence. It's basically based on what you said, from 2014, to 2020, between the time period of January 22, 2020 and ultimately the second meeting of the who on January 30, 2020. Is it accurate to say that nothing has changed in terms of the very basics of PCR testing? Maybe he could say, "you know what, this is a statement I made in 2014, we're talking about 2020, this is what's  and so I'm justifying that we can use it." Has anything changed scientifically, professor?

01:27:17 Ulrike Kämmerer

No, as I showed you, this technique is a basic technique, there are only minor combinations that change, like the primers, but the basic technique and everything you can say, it's exactly the same since it was

invented by Kary Mullis and then improved by adding this quantitative version. So it's the same problem that was in 2014 that is now in the situation we are in.

01:27:49 Dexter Ryneveldt

So now we're going to go back before 2014, we're going to go back to 2007 with this New York Times article. Again, I read it from your peer review, the Corman-Drosten peer review. I'll quickly quote what he said. Quote:

"I felt at the time that this gave us the shadow of a clue as to what a flu epidemic might be. Yet, according to epidemiologists, one of the most troubling aspects of this pseudo-epidemic is that all the decisions seemed so right at the time."

This is 2007. This is a New York Times article that basically referred to a pseudo-epidemic, also based on the PCR test. We have 2014, we have 2020, 2021, 2022 where we are now.

You will agree that nothing has changed. So what is applicable in 2007, 2014 and 2020, 21, 22, is exactly the same, do you agree with that?

01:29:12

Ulrike

Kämmerer

Exactly. Because it's a technique that produces problems.

01:29:18 Dexter Ryneveldt

Okay, thank you very much, Professor.

01:29:21 Reiner Fuellmich

Professor Dolores Cahill. We've talked together before. Is there anything that... Do you see this differently? Or do you agree Dolores?

01:29:32 Dolores Cahill



I agree completely. I did hundreds of thousands of PCRs in the 80s and 90s at the Max Planck Institute for Molecular Genetics in Berlin, it is a very similar technique.

Perhaps the only thing I would add is that we should ask, in all our countries, we have virology labs and regulatory labs. We have regulatory authorities that should also oversee the companies that produce these tests as commercial products and ask them for their positive and negative controls.

Also, physicians in a way, just to follow up on what was said, need to make a differential diagnosis. So they need to and should use a technique called sequencing or Sanger sequencing of these so-called positive tests to confirm that it is SARS-CoV-2. Because if it's not, physicians have an obligation to look for other infectious agents or agents that can cause the symptoms. If it's an infectious agent that calls for pneumonia, or if it's the flu virus, or the rhinovirus.

As you all know, I've been studying the law for maybe 20 years, the immediate question is what is the legal basis for a specific diagnosis and then who is responsible. I would say that the people who are responsible are the people who give these approvals for these tests.

They should look for positive controls, negative controls, and also check patient samples to validate the presence of infectious agents by other methods, including directly from saliva or mucous membranes. They should also sequence the tests and review the positive and negative controls to confirm the diagnosis.

Then physicians should say, if the test is negative and my patient has symptoms, there should be a series of tests, a follow-up investigation to identify the causative agent, so that antibiotics or other preventions and treatments can be given to the patient.

01:31:44 Reiner Fuellmich

Thank you, Dolores. That brings us directly to the question of sequencing. To that end, I would like to ask Dr. Sonia Pekova, because we did an interview a few days ago. In that interview, you told us that you found something very strange, which seems to me, to confirm that something is wrong with the Drosten test, which tends to confirm that criminal activity has taken place.

You didn't do Sanger sequencing, Sonia. You did a next generation sequencing, is that correct?

01:32:27 Sonia Pekova



Yes, that's right. I'll answer your question first. And then I'd like to go back to the issues that were discussed ~~at~~ because I'd like to offer some comments on that.

As far as sequencing is concerned, when the first wave started in the Czech Republic in March 2020, it was a small wave. It would have gone unnoticed if the media and journalists hadn't made a fuss about it. Then the summer was completely free of the virus. It started up again abruptly in September 2020. It was followed by another wave in November 2020. Finally, it was followed by a wave that started in December 2020 and continued until March 2021. Each of these waves behaves differently clinically.

The first, in March, was benign. The second one, in September 2020, was also mild. The next one in November and December was really severe, a lot of people were sick and a lot of people, unfortunately, died. But maybe not all the time because of the virus, also because of the mismanagement of the care by the general practitioners, because there was almost no contact at that time. Everybody was afraid of the virus and the doctors just closed their services, the outpatient services. People didn't get proper care.

When we started to characterize the waves individually, we discovered the original virus, from Wuhan: we had the reference sequence, given by the Chinese scientists, at the end of January 2020. That was the March 2020 wave. The second wave, in September, was slightly different genomically. It contained many mutations throughout the genome. It was only possible to identify these mutations by using next-generation sequencing, because it allows you to sequence the entire genome from start to finish.

We have sequenced all of our positive samples and it must be said that we have analyzed close to 30,000 individuals. All of the positives were sequenced by our laboratory, either by Sanger sequencing or by next-generation sequencing. The next-generation sequencing was used for a complete characterization of the individual waves and the individual viruses, which make up the individual waves. We found that not only was each wave, at least in the Czech Republic, created by a different strain, but also that the strains were not directly related to each other.

So the wave that started in September 2020 was carrying or had a certain mutation pattern. We use that mutation pattern to track the circulation of the virus in the country. At certain points, starting in November 2020, the mutation pattern changed. The wave that circulated in our country in November and December 2020 was genomically different. Interestingly, it lost many mutations from the previous wave, which is not possible. So it's not possible from an evolutionary standpoint.

So, if you have a confined area, as our country was, at that time, because the country was confined, everyone was wearing face masks, the social distancing was in place in society. We didn't see any respiratory illnesses, with the exception of SARS-CoV-2, which really created three major waves, all through the fall of 2020. So the next wave was not the direct offspring of the previous one, which is not possible in a confined population.

Which raises this question. What was the source? Where is the source of the individual strains? Without next-generation sequencing, you wouldn't be able to identify the diversity, the genetic diversity between the individual waves.

At the beginning, the narrative was constantly: this is the Wuhan virus, it appears and disappears. Everybody was surprised, it was really amazing, because it was about creating fear in the population with a virus, which appears and disappears and nobody knows when. Then we discovered that it was not the same virus. Each time it was something different. Even though it was different in the sense that you have a wave and it has a certain mutation pattern,

because the virus accumulates mutations over time, it would be perfectly logical and possible. Then you would expect the next wave, which would carry the mutations of the previous wave and might only add a few more mutations, because that is normal evolution.

But this was not the case. The previous wave had mutations, and the immediate wave that followed only erased many of those mutations. The virus is not able to erase the mutations and return to the original plan, it does not know what the original Wuhan sequence was.

So, to me, that implies that all the individual waves are not directly interdependent. As I said, I didn't know where the source of this could be. It was a kind of orchestrated chaos that was created. Using next-generation sequencing, we are able to identify this trick.

Omicron, for example, is the virus that is circulating right now. It's really benign. Omicron, I found it in the mainstream media, it means what it means if you find news in the mainstream media. They said there is no direct predecessor to Omicron because it is so different from anything we have seen so far, they don't know what the origin of Omicron is.

Again, you can speculate that it came from a lab because to me, it did come from a lab and it was done on purpose.

Originally, I thought maybe it was intentional or some kind of danger or whatever. But now it seems that all the evidence points to it being intentional and that the individual waves don't look like normal evolution in a confined closed area, because you'd see one wave with a certain pattern of mutation, and then another one rising from the previous one, containing the same pattern of mutation plus a few more mutations, until it dies.

With Omicron, because it is so highly mutated, I expect that the creators of this pandemic already know that we are able to sequence the strains and characterize the waves genomically.

So they know that after Omicron, if another strain appears, it will be more mutated than Omicron. Because that's the normal evolution of the virus, until it dies, until it's full of mutations, it's also infested with mutations and the mutations eventually kill the virus.

So either Omicron is the last one. Or if something happens, it must be more mutated than Omicron. If Omicron is benign, the next one, if it happens, must be even more benign, almost unrecognizable. If we don't have to do PCR tests like crazy all the time, because that's exactly what our governments want us to do.

01:41:50 Viviana Fischer

When you say it's so distinctive, how is it that the PCR test, as I understand it, has not been adapted to the versions that are circulating, so how is it that it can detect this kind of variety of versions of the virus and still be basically the old SARS-CoV-2? I mean, was it designed that way from the beginning, sort of, what is your opinion?

01:42:26 Sonia Pekova

That's a fantastic question. I appreciate that. As we discussed on Friday when we first met, I pointed out an interesting and strange thing about Drosten's design, which targeted three parts of the SARS-CoV-2 genome early on.

Since 2006, my job is to design real-time PCR assays and real-time quantitative PCR assays for any pathogen, because our lab is a large diagnostic lab. We focus on human and veterinary molecular microbiology and 99% of the tests we have, it's a real-time quantitative PCR assay, whether it's single or oral duplex, that's my job.

I am the designer of these tests. I have been doing it since 2006. It's my regular job. Always, when I design a new test for a new pathogen, I use bioinformatics tools and I align the genome of the pathogen that I'm about to test for and I align the genome to all the genomes in the database, the National Biotechnology Information Center's global database. I look for the most specific part of the pathogen's genome, if

specific and so unique, that no other germ or pathogen in the world, dog, cat, human, or any other organism, has that strand of DNA or RNA. I can't recall a single assay in our lab, and we have hundreds, covering both veterinary and human pathogens, where we have used more than a single unique target in the genome of a given pathogen.

So when I saw Drosten's project at the very beginning of the pandemic in March 2020, I didn't understand why he chose three targets. Because he could only pick one in the course of his normal work. If you want to investigate, I don't know, hepatitis C, you only have one PCR targeting a specific part of the hepatitis C virus. If you're investigating HIV, the same thing, one specific question, because the PCR has to be specific and has to be able to extract only the target you're looking for.

Drosten decided to go with three individual targets, which made no sense to me at the time. But now I understand why he probably did, because as we see each individual wave was created by a different strain of the virus. It seems to me that he could have, at the very beginning, expected this heterogeneity, in the SARS-CoV-2 family - we know that the coronavirus has mutated, the speed at which SARS-CoV-2 mutates, is unprecedented, never seen, never heard of.

If you only target part of the N or E gene or the polymerase gene, you can easily miss a strain that might occur at some point during a wave in a particular country. So you need more security...

If your task at the beginning was to create or design a test that will not miss anything, even if it mutates, do it this way, you will not miss anything. We need numbers and we need to track each individual wave in each individual country. If I were asked to write an assay for this task, I would certainly pick three individual targets in the genome, maybe four and make it very complicated. So we wouldn't miss anything.

For example, in our country, because we do a lot of veterinary microbiology, we study coronavirus in cats, dogs, parrots, horses and every species

individual has its own coronavirus. We have been testing for years. We never had the idea to change them or redesign them because they are perfect... Although the coronavirus mutates, it is not so particular, it is not more complicated, anything that could interfere with the diagnostics.

So normally, even if you're investigating parrot coronavirus, you've had the same test for 20 years you're perfectly happy with. But for sars cov-2, you needed many different assays to be able to catch all the individual strains of the virus.

Also, I remember a notice from our government that when the British strain came out, they said, "Don't use this or that commercial kit because it is not capable of identifying the British or alpha variant."

When Drosten designed his test in such a complicated way, to me that implies, because I'm a designer myself and I've been doing this for almost 20 years, to me that means that his task was to make it totally applicable to everything, no matter if you identify something that's not SARS-CoV-2, if you have a huge experience, there are a lot of false positives and so on. Because the question or the task was not to make a PCR test that was specific. It was to make a PCR test that produces numbers. That was the question and the task.

if I can develop that idea. I think Attorney Dexter may have asked a question about this. What was the difference between SARS-CoV- 1 and SARS-CoV-2 in terms of official regulation? In Europe and in the United States, because I have traveled or spent a lot of time in the United States and I know the type of regulations there. We have something similar here in Europe. In 2008 or so, a process called laboratory accreditation was started. Accreditation means that you have in Europe, what's called ISO 15,189 and it has to show the quality of sample processing in the laboratory and the quality of the overall management of the laboratory.

But it also means that the laboratory should preferably use CIBD certified kits and not so-called laboratory kits, like some in-house kits.

When we started working on this pandemic in March 2020, we developed our own PCR assay, because I was absolutely not satisfied with Drosten's design.

I've said it openly to our government: we will not use the Drosten test because it looks dangerous. It will probably produce a lot of false positives, it will probably have a high fluorescence intensity and we have developed our own test, we always target and do five primary UTRs of a virus, which I think is so unique that it means it comes from a laboratory.

The majority of teaching hospitals in our country and also in Europe, because they apply the ISO 15 189 accreditation system, always tend to choose an ISO accredited kit. Here I can show you, this is a box. It comes into your lab, it has a label on it that says CIBD, ~~is~~ like a mantra to you, saying that somebody has thoroughly validated the test in front of hundreds of samples, because to get the CIBD label, you have to follow ISO 13,485, which is an ISO standard for the production of diagnostic kits. You have to validate sensitivity, specificity, variability around hundreds of samples for cross-reactivity and blah, blah, blah. Once you have a box, which has the CIBD mark on it, it means to the lab that if they use the chemicals in the box, even if there are diagnostic errors, the fault lies with the kit producer, not the lab.

This argument is massively invoked in faculties, hospitals, large hospitals in our country and in Europe more widely. But imagine a kind of black box, you don't know what it contains, you just get it from the manufacturer.

In this case, it is from Life River, based in Shanghai, China. If there is a problem with one of these boxes, will you file a claim against someone in China? Will you be able to demand accountability and negotiate anything? You receive a box that contains a brand new SARS-COV2 enzyme mixture that has passed an internal control, a negative control and a positive control, along with instructions on how to mix the components together and how to conduct the test. Since you do not know the components of the diagnostic kit, you have no choice but to rely on its reliability.

If it contained fraudulent chemicals, all kits or the overwhelming majority of them being based on the Drosten model, at least initially. So you buy this kit anyway, because you want to protect your business, you're ISO certified, and you only want to use CIPD certified kits to be in good standing with your government. So if you generate false positives, first of all, you're not responsible. Secondly, you cannot say that you are generating false positives in a predictable way, because you are unable to verify whether the positivity you get is correct or incorrect. You can't sequence it, because you don't know the sequences of the primers and receptors used.

So, because most employees are locked into their routine, they just take the box, the samples and they do the test. Therefore, I think they abuse that, they abuse the situation in the developed countries in Europe and in the United States, where everybody relies on CLIA, CIBD or FDA certified kits, in all cases. They don't check the quality of the diagnostics, they just look to see if it has the CIPD logo, or the "Approved by the fda". If the instigators of this plague had wanted to confuse everyone to the core, they would have done nothing but produce diagnostic kits in countries like China. In Wuhan province, you would be unable to report problems with your diagnoses, because of the language barrier or whatever. But it would produce cases.

When we launched our own 5'-UTR test in our country, we were under terrible pressure, with threats to close our laboratory. They raised so many objections against us, questioned our honesty, discredited me. I didn't understand what was going on, because the 5'-UTR tests are perfectly specific, they are beyond doubt and do not produce false positives. I offered the test for free to anyone who needed it. Hundreds of competent authorities around the world were asking for it, so I published the principle of the test on the Internet, free of charge. The government gave us a hard time, they told us to use the Drosten protocol, I said "We don't use it because it produces false positives. In Europe and the USA.

01:55:54 Reiner Fuellmich

Just a second, Sonia, were you told not to use this test that you designed, but rather the Drosten Corman test?

01:56:03 Dr. Sona Pekova

Absolutely, from the beginning, the absolute recommendation of our authorities was to use the excellent Drosten test, highly recommended by the CDC and who. So initially we bought the reagents, we bought a kit. We did that because I didn't want to become a heretic in my country. I realized that the Drosten test is so... can I say the word "What is 'crap'"?

01:56:34 Reiner Fuellmich

I guess that describes it best, after hearing all the testimonials from your colleagues...

01:56:41 Dr. Sona Pekova

This test is so bad, to put it mildly. So I totally refused to use it. We immediately replaced it with the 5'-UTR test we designed, which was subsequently certified by external quality control, first nationally, then internationally.

Once it received validation from this external quality control, our authorities stopped bashing us, to keep it euphemistic once again. Since then... excuse me, it's Omicron... since then, we have continued to use our 5'-UTR test. We have screened close to 30,000 people, unequivocally. It works, it's excellent, it's reliable, and it meets all the requirements of ISO 13 485, because we designed it to be evaluated according to that European procedure. So I didn't understand and I still don't understand why the authorities always favor a test that is not reliable. Unless you accept the assumption that the main objective is not to be reliable and accurate, but to keep generating cases.

01:58:18 Reiner Fuellmich

In conclusion, having listened to your colleagues and given the conclusions you yourself have reached through your own research, would you validate the statement that there seems to be absolutely no basis for any corona measures and in particular vaccinations?

01:58:43 Dr. Sona Pekova

Absolutely. The very first corona measures, whether in our country, in other European countries, in America and all over the world, were to introduce draconian anti-epidemic measures, such as wearing masks, social distancing, quarantine, children not being allowed to go to school, etc. In spite of all these drastic measures, while other respiratory diseases have disappeared, nobody has come across influenza A, influenza B or respiratory syncytial virus, which are normally present in autumn or early spring...

In spite of all these drastic measures, the fact of having locked up everyone at home, etc., three waves of coronavirus still appeared, disappeared, appeared, disappeared, appeared, disappeared, in spite of all the measures.

In my opinion, if the objective was to fight influenza A, then indeed it was the best way, it really made sense to introduce respirators or face masks. But as far as SARS- CoV-2 is concerned, nothing worked. Whatever the measures, the waves have always washed over the country, in an obviously orchestrated way. Indeed, they were announced several months before they occurred. This is extremely disturbing.

How could a government official know this, even though the virus had completely disappeared in the summer of 2020? How could he know that, based on some data, nonexistent data at all. How could he predict that there would be a massive wave in September?

My expertise as a microbiologist [I'm a physician trained in molecular biology, genetics, and microbiology], given my knowledge, leads me to say that contracting a respiratory disease, whether severe, normal, common, natural, naturally occurring, at the end of August, is impossible, we've never seen that. We see the onset of respiratory illnesses typically in October or November, when it's raining, when the weather is bad, but never in a beautiful sunny summer. This too was troubling. Not only was it predicted in advance, but it happened at an unusual time. The waves appeared as predicted.

02:01:34 Reiner Fuellmich

So we can conclude, if I understand correctly, that there is no corona pandemic, but rather a PCR testing pandemic...

02:01:45 Dr. Sonia Pekova

Absolutely. Reiner, you were talking about vaccination. We have to remember that, that's a really important point. When we started to analyze these waves, we identified that each one was something different. I didn't hesitate to announce openly to our authorities, to our government, what was going on. As for the so-called experts, those who advise our governments, they are not good advice. These experts live in a world apart, these experts in immunology, vaccinology, etc.

Any immunologist or vaccinologist should know from their studies, from the literature, that if your target, the virus, mutates very frequently, then it is not possible, it is contraindicated, to rely on a vaccine designed against the virus that escaped from Wuhan and is no longer circulating. You end up with a heterologous vaccine [different from the surrounding tissue], and viruses that are themselves heterologous. If you create heterologous vaccines for heterologous viruses, then you can end up with antibody-dependent enhancement, which can actually result in the death of the individual who was vaccinated with that heterologous vaccine.

To date, we have no long-term follow-up data on vaccines. They have been introduced for one year. We don't have 5 years, 8 years, or 10 years of follow-up on these vaccines. We have computer predictive models of how much damage a vaccine could do and how dangerous it could prove to be. Even if they are just computer predictions, even if you doubt the lab that makes them, even if you don't believe them, you have a vaccine that doesn't match the variants that are circulating. This is an established fact that they absolutely cannot ignore. If this is not the case, then I don't know what kind of experts they are. Knowing that each variant is different and that vaccine is heterologous, heterogeneous, they should have stopped vaccination immediately, for safety reasons, instead of making it compulsory, encouraging it, offering money to get vaccinated, or even iPhones, pairs of sneakers...

02:04:44 Reiner Fuellmich

I'm sorry to interrupt, but we will address the issue of so-called vaxxins with another panel. So to conclude again, there is no justification for vaxxinations, because corona measurements are not based on anything, because PCR tests do not reflect infections at all. Is this correct?

02:05:10 Dr. Sonia Pekova

Quantitative PCR tests can give you an indication when the patient actually has SARS-CoV-2 disease.

02:05:28 Reiner Fuellmich

You say it can give you an indication, but it can't tell you if the patient is really contagious, because even if the virus has infected his cells. Because as Ulrike explained to us, it doesn't exist in its complete form when the swab enters the machine, does it?

02:05:48 Dr. Sona Pekova

Yes, absolutely. Whatever the laboratory tests are, the data are only indicative. They should be helpful and only the patient's clinical condition should be taken as a guide...

02:06:06 Reiner Fuellmich

In other words, by itself, the PCR test is not sufficient to affirm whether or not someone is infected and contagious with covid-19.

02:06:21 Dr. Sona Pekova

Absolutely.

02:06:23 Reiner Fuellmich

Very well, thank you very much Sonia. We're a little bit pressed for time. I don't want to cut anybody off. So if any of you, Ana, Dexter, Virginia, Dipali, have any questions, please go ahead.

02:06:41 Dexter L-J Ryneveldt

Dr. Sonia, thank you very much for your testimony. I think what is very important for the jury to remember is that as has been the case since the beginning of this pandemic [we call it a "plandemy"], we need to continue to pay attention to the statistics.

By now, we have detected so many positive cases, that in the end, it ends up

The purpose is to shape people's minds, to make them think that their government seems to be working in their interests after all. Therefore, confinements are necessary, they must be complied with, masks must be worn, and above all, the circus of social distancing must be consented to.

The question I would like to ask you, which is relatively crucial, is about the statistical data from these Drosten PCR tests. Before this committee, Dr. Sonia, would you say that all this statistical data that has been provided to the public and that the jury has been bombarded with on a daily basis, **"positive cases, positive cases, positive cases,"** is that statistical data wrong? Is it possible that a public regulatory body in a country could have used them to justify containment? Thank you.

02:08:10 Dr. Sonia Pekova

Indeed, we have been bombarded with figures. Every day in the newspapers, we could read that the laboratories have detected such and such a number of positive cases, that it is more than yesterday, etc. A real campaign of terror continues to be waged on the population. Moreover, since a positive PCR represented a bonus for the hospitals.

If they had a patient who might be positive, even just a suspicion, then they would get a much higher reimbursement from the insurance. Whether it's hospitals or doctors, there is such a level of corruption, it's terrible! There was no pressure, either from the hospitals or the doctors, to get accurate results. When they had a PCR-positive individual, [let's not call him a patient], then they were getting three times as much money for him as if the individual was SARS-CoV-2 negative. In the end, they were pretty happy, because they were making more money. The patients were more profitable for them. They were getting more reimbursement from insurance. There was no pressure from the medical staff to ask for reliable data, because they benefited from the influx of SARS-CoV-2 positive cases. It didn't matter if they were false positive or true positive. As long as the patient was SARS-CoV-2 positive, it didn't matter how many TCs they had, they were much better reimbursed by insurance. This situation was not specific to our country, it was repeated in many, many countries around the world. So... but maybe I digressed a bit on your question...

02:10:13 Dexter L-J Ryneveldt

The most important thing about these statistics that are published on a daily basis, which the jury was bombarded with every day, is that they are actually not trustworthy. In fact, I would argue that the public health authorities, the public health decision makers in the countries, should not have used them in any way to justify all the confinements. To summarize, first, these statistics are not reliable. Second, public health policy makers should never have used them to justify anything they put in place. True or false, Dr. Sonia?

02:10:56 Dr. Sonia Pekova

Indeed, the statistics from PCR tests are not reliable at all. Because even in the case of a patient run over by a truck, if he was positive for SARS-CoV-2, he was counted in the statistics as positive for SARS-CoV-2. There was a big debate in the Czech Republic about whether it was a patient who died with covid or died of covid. Any person who was positive for SARS-CoV-2 was counted in the statistics as a case.

These statistics cannot be trusted at all. They have only served as a pretext for the government to put in place powerful tools to control society and to institute draconian measures, confinements, draconian laws and ultimately restrict the rights of the people. All of this is done with these tools, with these false numbers and false statistics, completely doctored and fraudulent. They use them to control society. For example, to close down small and medium-sized businesses, to close down schools.

They have caused damage to many, many people in society. In my opinion, and no one has changed my mind, the SARS-CoV-2 virus is nothing more than a tool to control society, to take it in a desired, or planned direction. The first objective was to impose the vaxxins, to inject everyone, whatever these vaxxins or products are, in order to implement even more draconian measures. All that energy...

02:12:47 Reiner Fuellmich

One second, he asked you a specific question: we can't trust the numbers from the PCR tests...

02:12:53 Dr. Sonia Pekova

No, we can't trust these numbers. Most of these statistics have been doctored on purpose.

02:13:02 Reiner Fuellmich

Okay, thank you very much.

02:13:03 Dexter L-J Ryneveldt

One last quick question. You can just answer yes or no, that will be more than enough, given the consistency of the evidence you have provided. The final question about this PCR testing pandemic that we're talking about, is this science or not, Doctor?

02:13:23 Dr. Sonia Pekova

Yes, it's a PCR testing pandemic.

02:13:24 Dexter L-J Ryneveldt

Thank you very much. No further questions.

02:13:29 Reiner Fuellmich

Thank you very much, Sonia. Let's take a closer look at how the world is actually dealing with this pandemic, which has no basis in fact. First of all I would like to draw attention to those who claim that many people are dying, in Bergamo, in New York... Let's start by looking at the causes. Then we will ask ourselves how it could have been handled otherwise. We all know there's a virus out there, but how can it be treated? Let's first look at the question: why is this happening? Bryan Ardis has joined us. Dr. Bryan Ardis, from Texas. How do you explain the fact that so many people seem to have died, in New York in particular, from coronavirus?

02:14:31 Dr. Bryan Ardis



This is an excellent question. As early as the beginning of May 2020, I asked myself that question, because in March and April 2020, there were incessant stories in the media from physicians and administra-

hospital workers in New York City, who lamented and reported the same scenario. Every time they were asked by the media, "What do you see in the patients you treat for covid- 19 in New York City hospitals?"

They all answered the same thing. All of them, without exception. **"We have never seen a respiratory virus do this before. From the time we start treating this respiratory virus, around days 3, 4, and 5 of treatment, the virus leaves the lungs and it starts attacking the kidneys and causing acute renal failure, something we have never seen before."** They kept repeating, **"We're not only running out of respirators here in New York, but we're also running out of dialysis machines."**

It intrigued me greatly. I had just experienced a similar scenario just three months earlier, compared to May 2020 when I was seeing all these interventions in the media. My own father-in-law passed away in the hospital due to a poor care protocol in early February 2020. My wife and I received a phone call on the third day of his flu treatment that he was suffering from acute renal failure, only to find out that it was due to a drug he was prescribed that was not recommended for the flu, as it was known to cause acute renal failure.

Regardless of covid, three months later, I read a memo from Anthony Fauci of nih²⁰, because I was trying to figure out why all these doctors, nurses, hospital administrators in New York kept reporting the same thing I had experienced: on days 3, 4, and 5 of the treatment for the so-called virus in New York, covid-19, they were seeing many cases of acute renal failure. I went to cdc.gov.

There was no protocol regarding inpatient treatment for covid-19, but a reference to a nih protocol for covid-19. In this memo, attached to nih.gov, Anthony Fauci published his instructions to the world. This was in mid-May 2020. He announced that there was one and only one drug allowed in all hospitals in America, for Americans hospitalized with covid-19 and that experimental antiviral drug is called

Remdesivir. In the two studies promoting its use, it was deemed safe and effective against Ebola a year earlier in Africa. Then he said it was deemed safe and effective in a trial in March 2020, just two months earlier, a trial conducted by Remdesivir's manufacturer, Gilead Sciences.

In that same memo, Fauci stated that there were two banned drugs. They had been found to have toxic effects on the heart, resulting in the death of patients treated for covid. These two drugs were Hcq and chloroquine. I didn't look into that at the time. I looked into Remdesivir instead, because I had never heard of it.

I learned that it was still experimental at this point and had never been approved by the fda²¹. So I dug into what Dr. Anthony Fauci was stating on nih.gov. What was his reason for selecting this one and only drug. The first link was to the New England Journal of Medicine study about Ebola. Then I read the second study as well. I couldn't believe what I had discovered.

I learned that Remdesivir had not been shown to be safe and effective against Ebola. In fact, it turned out to be the least effective and most deadly drug in the trial. The trial's monitoring committee suspended its use for the remainder of the study. No one could receive it anymore, as it was the only drug of the four in the published trial to have a mortality rate of more than 50%. Only Remdesivir was in this case, the reason for the withdrawal by the monitoring committee.

This kind of information made me realize that Anthony Fauci was lying about this drug. In the second study conducted by Gilead Sciences, they gave Remdesivir for 10 days to covid-19 patients, to 53 people in March 2020. The findings reported that for 31% of the participants who received this drug, between days 5 and 10 of treatment and that was limited to 10 days, 31% of the people who received this drug who were covid-19 positive, actually suffered various organ failures, including

20 nih: the national institutes of health are U.S. government institutions that conduct medical and biomedical research. They are part of the U.S. Department of Health and Human Services. Like many other organizations, we give them the tiny bits they deserve until they start taking care of people!

21 fda: The food and drug administration is the American food and drug administration. This organization has, among other things, the mandate to authorize the marketing of drugs on the territory of the USA.

acute renal failure, which was what all the media were reporting. I realized right away that the doctors were being honest in their statements that they had never seen a respiratory virus in New York that, when they started treating covid- 19 patients, caused so many acute kidney failures. It was simply because they had never used the drug Remdesivir before. They didn't realize that the drug they were injecting was causing acute renal failure, liver failure, and heart failure, which are now all recognized side effects of Remdesivir.

The most heartbreaking part of all of this... I wish the whole world knew about it. Anthony Fauci in May 2020 asked our U.S. federal government to purchase the entire stock of this experimental, failed, deadly drug and he asked the U.S. federal government to export it to other countries until the end of 2020.

This is not trivial! Whether at the end of 2020, or today, February 2022, America has the highest death rate of any country in the world, regarding covid-19 treatment. To all American citizens affected by covid-19, no other country has recorded more deaths than we do.

I attribute this to the hospital protocols initiated early on by Dr. Anthony Fauci. If I may, I will show you all the evidence that supports my suspicions about this drug. Because now, not only the United States of America is the only country with more than 900,000 deaths from covid-19, but Brazil is in second place, with more than 630,000 deaths. Brazil, since the beginning of March 2021, uses Remdesivir exclusively in all its hospitals.

The correlation of the published fatal side effects, the fatal side effects of Remdesivir in my opinion, based on the data I can show you, shows that the hospital protocols that include Remdesivir, for the last two years, with its recognized combined side effects, are the leading cause of death in all people

hospitalized for covid-19, all over the world. So now it appears [everyone should know] that from the beginning, I even heard the term mentioned by the judge, that this is indeed a **"plandemy"**.

From the beginning, even before March and April 2020, New York City was allowed to experiment on all New York patients with a drug called Remdesivir, with the aim of killing some of them by causing acute kidney failure, deaths from pulmonary edema, which occurs when you cause acute kidney failure.

On the other side of the Atlantic Ocean, in the United Kingdom, there is an organization called nice²² that, in conjunction with the British Parliament and the mhra²³, promoted what was called end-of-life care. They set up this protocol to introduce morphine and [Midazolam](#), in nursing homes across the UK. In March 2020, they put this drug into nursing homes and killed 18,000 people in March 2020, 25,000 in April 2020: all counted as covid-19 deaths.

I think both for Remdesivir here in the US and for the Midazolam/morphine protocols or end of life care in the UK, everyone should refer to the work of Claire Wills Harrison, a lawyer in the UK, who has done a great job of tying these things together as well as John O'Looney in his witness panel. He can testify, as a funeral director, to these so many deaths in March and April 2020 attributed to covid-19, even though none of these people had covid-19 in March and April 2020 in the UK.

I believe there was a huge operation, to mass murder many people, using drugs and care protocols recommended and selected by health authorities and by our governments, to generate a large number of deaths, and then make the world believe that it was a virus that killed all these people. I said from the beginning of May 2020 that they were going to use these

22 nice, the national institute for clinical excellence in the UK, is the independent body responsible for providing national advice on treatment and care for people using nhs in England and Wales. Its advice is aimed at health professionals, patients and their careers to help them make decisions about treatment and care.

23 The mhra (Medicines and Healthcare products Regulatory Agency) is a government agency that licenses all medicines and medical devices in the UK.

mortality figures in hospitals and nursing homes, that they were going to designate them as deaths from a virus called covid-19, that they were going to take those figures and sell them to the media and to all the businesses in America and the United Kingdom, claiming that there is a deadly virus circulating all around the world and that you need to sign up for our upcoming vaccination program, which we'll be talking about later in this trial.

The vaxxins were the ultimate goal from the beginning. They had to murder many people to convince others that it was a deadly virus. Would you like me to present the evidence?

02:23:44 Reiner Fuellmich

Yes, please.

02:23:45

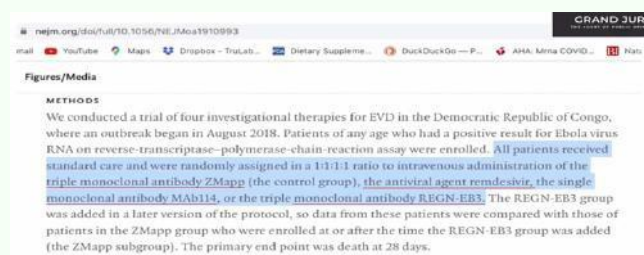
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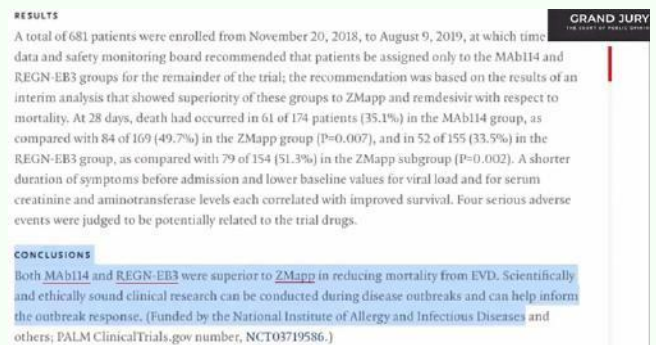
Anthony Fauci said that in May 2020, an Ebola trial established that Remdesivir was safe and effective against Ebola. Really?



This is the actual trial that is still in the New England Journal of Medicine. You can see on the right side of the page, it was published on December 12, 2019. This study had started in November 2018.



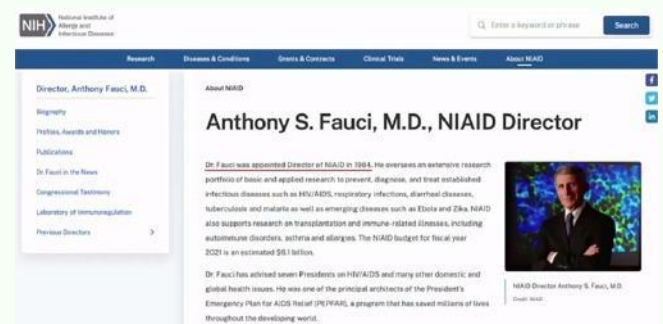
Here's what they did, they took four experimental drugs. All the patients were treated. See the names **ZMapp**, a triple monoclonal antibody, an antiviral agent called **remdesivir**, a single monoclonal antibody, **MAb114**, and then a triple monoclonal antibody that the world now knows, **Regeneron**, REGN-EB3 for short. That was the real study. We're going to go to four regions in Africa and give four different drugs to patients with Ebola.



The conclusions, right off the bat, when you look at any study, they give you a summary and then they show you the conclusions. It's really abominable. Everybody needs to see that.

From the outset, the conclusions are that MAb114 and Regeneron are superior to ZMapp in reducing Ebola mortality. Item.

Okay, I want to draw your attention to this. It's published in the New England Journal of Medicine. Notice that the conclusion only cites three drugs. There were four in the study. Interesting! They mentioned remdesivir. Let's see why they didn't want to show it in the conclusions at the beginning of the study. To draw attention, let's look in parentheses under the conclusions: the study is funded by the national institute of allergy and infectious diseases (niaid). It is the one that funded this study on Ebola in Africa in 2018 and 19. Who is the head of the national institutes of allergy and infectious diseases?



I just want to make sure it's recorded. The director of the nih department that funded the Ebola trial, niaid, is Dr. Anthony Fauci. The first statement is, "Dr. Anthony Fauci has been director since 1984." So he was the director during this study from 2018 to 2019. How did they screen these people for Ebola? Just listen to Dr. Sonia. "For all the patients in the Ebola trial, they used the PCR test to determine if they had Ebola. Disgustingly, they accepted pregnant women with a positive PCR test for Ebola, they allowed pregnant women."

SCREENING AND RANDOMIZATION

Patients were assessed for eligibility on the basis of a reverse-transcriptase-polymerase-chain-reaction (RT-PCR) assay to detect the RNA of the nucleoprotein of Ebola virus (EBOV). Patients of any age, including pregnant women, were eligible if they had a positive result on RT-PCR within 3 days before screening and if they had not received other investigational agents (except experimental vaccines) within the previous 30 days. Neonates who were 7 days of age or younger were eligible if the mother had documented EVD. Randomization was stratified according to baseline nucleoprotein cycle-threshold (Ct) value (≤ 22.0 or > 22.0 , corresponding to higher and lower viral loads, respectively, as determined by quantitative RT-PCR) and Ebola treatment center. Trial-group assignments were placed in sequentially numbered envelopes, which were distributed to trial sites to be opened at the time of enrollment. Data were recorded on bar-coded paper case-report forms that were transmitted from the site to a server, where they were digitally sorted into electronic patient folders with the use of software developed by the University of Minnesota and were then entered by trial staff at the Institut National de Recherche Biomédicale (INRB) Coordinating Center (Kinshasa, DRC) and NIAID (Bethesda, MD) into the Web-based REDCap database.

Look at the last highlighted passage. Even newborns seven days old or younger were included in this experimental drug trial in Africa, if the mother was labeled positive, Ebola.

I find it pretty disgusting that an experimental drug trial would include children seven days old and younger, with no symptoms, just because the mother tested positive.

In the mortality section of this Ebola in Africa study, **"...on August 9, 2019, when 681 patients had been enrolled, the data and safety monitoring board conducted an interim analysis of data from 499 patients. Based on two observations, in August 2019, they recommended discontinuing random assignment of ZMapp and Remdesivir."**

The safety board found two problems with ZMapp and Remdesivir and discontinued their use for the rest of this trial. What was so worrisome?

This is Table 2 from that study. Let's look at the title of Table 2, **"Comparison of Deaths at 28 Days by Treatment Group,"** you have the population column on the left and then the four drugs listed ZMapp, Remdesivir, MAb114. Regeneron is noted as REGN-EB3. The first statistic listed under each one is the mortality rate, what percentage of people who received this drug in this trial died?

Table 2. Comparison of Death at 28 Days According to Treatment Group.

Population	ZMapp	Remdesivir	Difference, Remdesivir vs. ZMapp	MAb114	Difference, MAb114 vs. ZMapp	REGN-EB3	ZMapp Subgroup	Difference, REGN-EB3 vs. ZMapp Subgroup
	no. of deaths/total no. (%)	no. of deaths/total no. (%)	percentage points (95% CI)	no. of deaths/total no. (%)	percentage points (95% CI)	no. of deaths/total no. (%)	no. of deaths/total no. (%)	percentage points (95% CI)
Overall	84/168 (49.7)	88/170 (51.7)	3.4 (-2.2 to 14.0)	81/134 (60.1)	-14.8 (-25.2 to -3.7)*	52/103 (50.5)	79/154 (51.3)	-17.8 (-28.9 to -6.9)*
Patients with high viral load	40/71 (56.3)	64/75 (85.3)	0.8 (-15.3 to 17.2)	31/77 (39.9)	-14.8 (-33.0 to 3.3)	42/66 (63.6)	56/65 (86.2)	-22.5 (-41.8 to -3.1)
Patients with low viral load	24/98 (24.5)	24/95 (25.3)	4.5 (-6.1 to 19.1)	50/57 (87.9)	-14.6 (-32.8 to 3.6)	10/39 (25.6)	23/39 (59.0)	-14.6 (-32.8 to 3.6)

* The result is significant according to the criterion stopping boundary of $P < 0.05$ for the MAb114 group and $P < 0.028$ for the REGN-EB3 group.
 † Patients with a high viral load had an EBOV nucleoprotein Ct value of 22.0 or less. Patients with a low viral load had an EBOV nucleoprotein Ct value of more than 22.0. The total number is the total number of patients in this category for each group.

ZMapp had a mortality rate of 49.7%, you will see this in parentheses just below the name ZMapp in the highlighted area labeled "Overall (global)", so of all those who received ZMapp 49.7% died, Remdesivir with a percentage loss of 53.1%. MAb114 35.1% died, Regeneron 33.5%.

Based on this information, the safety board found that remdesivir had the highest mortality rate and was the least effective in the trial. Therefore, they decided to withdraw it from the trial along with ZMapp. I would like to propose this to the jury.

If you were Anthony Fauci and you had this study that you funded and you had to pick one drug, one drug that would be the only drug injected against covid-19 to all innocent American citizens... Knowing what the safety board had withdrawn remdesivir when they saw that it was the only drug that had a 53.1% mortality rate? These are the only four drugs in the world that you could choose. Which of the four would you have chosen?

Then I'd like you to ask yourself why Anthony Fauci chose remedy? When the safety board itself had doubts? I would hope and think that as a health care administrator or a department head for the whole country, you would decide to choose the one with the lowest mortality rate, like Regeneron, in this case. Just to get your attention, at the end of the study, the niaid and contributing authors are listed.

After seeing this study on the Ebola trial, I knew that Anthony Fauci was grossly lying, that it had not been improved to be safe and effective against Ebola. Yet that is what he claimed. The Ebola trial itself had been published in December 2019. Just one month later, in January 2020, Gilead was given the opportunity to conduct a study with Remdesivir on covid- patients.

19. The Gilead study took place between January and March 2020. It was published on June 11. It was their own study.

The Ebola trial was 28 days of treatment per patient. In January 2020, Gilead got smart and announced that covid-19 patients would only be given the drug for 10 days.

Here are the results published by Gilead of their 10-day remdesivir poisoning in covid-19 patients. 23% of them experienced serious adverse events between days 5 and 10. The most common serious adverse events were multi-organ failure, septic shock, acute kidney injury and hypotension. Just under 8% discontinued the treatment prematurely because of the risks, they did not even last the whole period.

A study was conducted at exactly the same time in France, in Paris, with five covid-19 positive patients, including one from Wuhan. They had established a treatment duration of 14 days with Remdesivir. What did they discover?

Remdesivir was discontinued earlier than originally planned in four of the five patients because of elevations of alanine aminotransferase, an increase in liver toxicity enzymes in the blood, abbreviated as ALT in most blood tests. Liver toxicity was three to five times greater than normal during these 14 days. Two cases required renal transplantation. Only one survived the 14 days of treatment. Two of the five patients died as a result of remdesivir treatment. This study was conducted and finalized in March 2020.

Fast forward to November 2020. Remdesivir advised against by who: **"The antiviral Remdesivir should not be used as a treatment for hospitalized patients covid-19,"** said who, just one month after the fda

Gilead reported this information and data collection by the WHO and even stated that remdesivir had potential kidney side effects, which they reported to the European Medicines Agency (November 2020).

I'd like you to read the beginning of this summary. This is two months after Anthony Fauci got Gilead, the maker of remdesivir, to be the only pharmaceutical company to get the only contract for the one drug to treat all hospitalized patients with covid-19 throughout the United States.

I received this article two months after Gilead Sciences was approved to be the only drug manufacturer to provide a solution to all patients hospitalized for covid-19. As I read the article, I already knew that the virus itself was not the primary cause of acute kidney injury. It was the Remdesivir. The toxicity to the liver, according to Nature Medicine in July 2020, comes exclusively from this new virus that causes these problems in the body.

In China, the incidence of acute kidney injury in patients hospitalized for covid ranges from 0.5 to 29%. These injuries occurred on average within 7 to 14 days of hospital admission.

US studies have reported much higher rates of acute kidney injury. In a study of nearly 5,500 patients admitted for covid-19 in a New York City hospital system, 37% of patients developed acute kidney injury. 14% of them requiring dialysis. Remember, they all said they didn't have enough dialysis spots... About one in three patients in the study was diagnosed with acute kidney injury within 24 hours of admission. The only drug used in this study in New York City hospitals in March and April 2020 was Remdesivir. That's the only difference between what China was doing and what we were doing.

02:38:12

I couldn't believe it. In the Nature Medicine publication's ethics statement for the world on what the virus does and how doctors should treat it everywhere.

We want you to recognize that the SARS-COV-2 virus, covid-19 causes all these problems in other organs of the body. In the ethics statements, you must list those who are contributing to the study data. You must answer **"Do you possibly have a conflict of interest to be allowed to participate in contributing data?"** For the panel, a woman named Joan, J. M. B brings in an honorarium for her participation in a grant review committee for Gilead Biosciences.

Why would someone paid by Gilead be allowed to contribute? When they are the only pharmaceutical company providing the only inpatient drug for covid-19? Why would someone from Gilead be allowed to contribute to defining the side effects of the virus that you are treating, when in fact I will show you. This is actually all the side effects, all of these [here](#) and [here](#). These side effects that are listed [here](#) are actually side effects of Remdesivir. We can prove it.

So Remdesivir, in April 2021. There is an analysis of the global health security database. They want to compare what's going on around the world. Four main drugs are used to treat all patients with covid-19, this is April 2021. They want to see if it is true that the virus that causes covid-19 causes acute kidney injury in the majority of people, that it is a side effect of the virus. We go to the who database and compare four drugs that treat covid-19 patients around the world: remdesivir, Hcq (Hcq), lopinavir and a drug that is a monoclonal antibody called Tocilizumab. This is what they found.

Safety Signal From Disproportionality Analysis of the WHO Safety Database

Alexandre O Gérard ^{1, 2}, Audrey Laurain ¹, Audrey Fresse ², Nadège Parassol ², Marine Muzzzone ², Fanny Rocher ², Vincent L M Esnault ¹, Milou-Daniel Ricci ²

Affiliations + expand
PMID: 33340409 DOI: 10.1002/cpt.2145

Abstract

Remdesivir is approved for emergency use by the US Food and Drug Administration (FDA) and authorized conditionally by the European Medicines Agency (EMA) for patients with coronavirus disease 2019 (COVID-19). Its benefit-risk ratio is still being explored because data in the field are rather scant. A decrease of the creatinine clearance associated with remdesivir has been instantaneously reported in clinical trials with unclear relevance. Despite these uncertainties, we searched for a potential signal of acute renal failure (ARF) in pharmacovigilance postmarketing data. An analysis of the international pharmacovigilance postmarketing databases (Vigilbase) of the World Health Organization (WHO) was performed, using two disproportionality methods. Reporting odds ratio (ROR) compared the number of ARF cases reported with remdesivir, with those reported with other drugs prescribed in comparable situations of COVID-19 (hydroxychloroquine, tocilizumab, and lopinavir/ritonavir). The combination of the terms "acute renal failure" and "remdesivir" yielded a statistically significant disproportionality signal with 138 observed cases instead of the 9 expected. ROR of ARF with remdesivir was 20-fold (20.3; confidence interval 0.95).

Read the highlighted part **"The odds ratio25 compares the number of cases of acute renal failure reported with remdesivir, with those reported with other drugs prescribed in comparable covid-19 situations."** That's the most important part of this whole thing. They prescribed these four drugs in comparable covid-19 situations. In the Nature Medicine publication, they said it causes acute kidney injury. They are comparing and looking to see if that is true. Do all these covid-19 positive patients in the world all develop acute renal failure on the same scale? Four different drugs: Remdesivir, Hcq, Tocilizumab and Lopinavir. What did they find?

First, the odds ratio of acute renal failure with remdesivir was 20 times higher than with the drugs compared. Twenty times higher. Remdesivir is known to cause acute renal failure, absolutely. Now let's come full circle to October 2021, five months after April, in the Journal of Cardiovascular Toxicology.

25 The odds ratio, also known as the odds ratio, odds ratio or close relative risk, is a statistical measure, often used in epidemiology, expressing the degree of dependence between qualitative random variables. It is used in Bayesian inference and logistic regression to measure the effect of a factor.

The headline, **"Potential Cardiotoxic Effects of Remdesivir on the Cardiovascular System."** Read below. **"Remdesivir can also induce significant cytotoxic or cellular toxic effects on cardiomyocytes, the heart cells, which is far more serious than the cardiotoxic effects of Chloroquine. Remdesivir-induced toxicity is due to its binding to mitochondria and RNA polymerase."**

In May 2020, Anthony Fauci said, **"You can't use Chloroquine. You can't use Hcq with these covid-19 patients because Chloroquine has been found to cause heart disease and death in patients treated for covid-19. So we're only going to use Remdesivir."**

Review > [Cardiovasc Toxicol.](#) 2021 Oct 13;1-5. doi: 10.1007/s12012-021-09703-9. Online ahead of print.

Potential Cardiotoxic Effects of Remdesivir on Cardiovascular System: A Literature Review

Maryam Nabati ¹, Homa Parsaee ²

Affiliations + expand
PMID: 34643857 PMCID: PMC8511861 DOI: 10.1007/s12012-021-09703-9
[Free PMC article](#)

Abstract

Corona disease 2019 (COVID-19) pandemic continues to spread around the world with no efficacious treatment. Intravenous remdesivir is the only authorized drug for treatment of COVID-19 disease under an Emergency Use Authorization. Remdesivir is a 1'-cyano-substituted adenosine nucleotide prodrug which inhibits viral RNA synthesis. This metabolite is an adenosine analog but with a significantly longer half-life than adenosine. Adenosine is a powerful vasodilator that can cause profound hypotension which is followed by the compensatory release of catecholamines. It can also shorten atrial action potential and refractoriness and lead to atrial fibrillation (AF). These effects may also occur in ventricular cells and predispose patients to ventricular fibrillation. **Remdesivir can also induce significant cytotoxic effects in cardiomyocytes that is considerably worse than chloroquine cardiotoxic effects. Remdesivir-induced cardiotoxicity is due to its binding to human mitochondrial RNA polymerase.** On the other hand, remdesivir can increase field potential

In October 2021. You can see the data at the top, the log is on the left. In the highlighted part, **"Remdesivir can also induce significant cytotoxic effects on cardiomyocytes, which is much worse than the cardiotoxic effects of chloroquine."**

NCBI Resources How To

PMC US National Library of Medicine National Institutes of Health

Journal List > Nature Public Health Emergency Collection > PMC7256923

Nature Public Health Emergency Collection

Public Health Emergency COVID-19 Initiative

Reactions Weekly, 2020; 1806(1): 1. PMID: PMC7256923
Published online 2020 May 30 doi: [10.1007/s40278-020-79019-x](#)

Chloroquine and hydroxychloroquine increase risk of death in COVID-19

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Treatment with chloroquine or hydroxychloroquine, with or without a macrolide, appears to increase the risk of death in patients with COVID-19, according to findings of a multinational registry analysis published in *The Lancet*.¹

Registry data from 671 hospitals in six continents were used to evaluate the safety and benefit of chloroquine or hydroxychloroquine, with or without a macrolide, in a total of 96 032 patients hospitalised with COVID-19 between December 2019 and April 2020. Patients received chloroquine (n=1868), hydroxychloroquine (3016), chloroquine plus a macrolide (3783), hydroxychloroquine plus a macrolide (6221), or none of these treatment regimens (81 144; controls).

Overall, 11.1% of patients died during hospitalisation.

This is a study from 2020, cited by Anthony Fauci that said, **"Chloroquine and Hydroxychloroquine increase the risk of death in patients with covid-19."**

In this study they say that **"all four treatments were also independently associated with an increased risk of newly developed tachycardia or ventricular fibrillation."** So this study found toxic cardiac effects due to Chloroquine and Hcq, which increase [read the title], the risk of death from covid-19. However, the Journal of Cardiovascular Toxicology, just a few months ago claimed, **"Remdesivir causes much worse cardiotoxic effects than Chloroquine."**

Good! What other cardiotoxic effects have been published? There are reports of sinus bradycardia, hypotension, T wave abnormalities, atrial fibrillation, which are arrhythmic problems. Remember that Nature Medicine said that **"arrhythmias are a side effect of the virus."** It is a novel side effect of the one and only drug infused into your veins. A prolongation of the QT interval that creates that lethargy and fatigue and a few cases of cardiac arrest after Remdesivir infusion. Why is this important?

In 2005, Anthony Fauci knew that Chloroquine had been shown to be a potent inhibitor of the SARS-CoV-1 coronavirus. Why did we publish this? The conclusion of the study in 2005:

"Chloroquine, a relatively safe, effective, and inexpensive drug used to treat many human diseases, including malaria, amebiasis, and human immunodeficiency virus (HIV), is effective in inhibiting the infection and spread of SARS-COV-1 in cell culture." We have known this for 15 years now. This is important.

The nih has just updated these tables. This is actually table 2e. on nih.gov. Last updated July 8, 2021. Note that the adverse effects of Remdesivir are listed. In the second column, the fifth bullet under the adverse effects of Remdesivir could not be clearer. It says that the drug's vehicle, SBECN for short, has been associated with renal and liver toxicity.

Table 2e. Characteristics of Antiviral Agents That Are Approved or Under Evaluation for the Treatment of COVID-19
Last updated: **July 20, 2021**

Dosing Regimens	Adverse Events	Monitoring Parameters	Drug-Drug Interaction Potential	Comments and Links to Clinical Trials
Remdesivir The doses and indications listed below come from the FDA product information. Please see Therapeutic Management of Hospitalized Adults With COVID-19 for the Panel's recommendations on when to use RDV for hospitalized adults and children (aged ≥12 years and weighing ≥40 kg). For patients who are not mechanically ventilated and/or on ECMO: • RDV 200 mg IV on Day 1, then RDV	- Nausea - ALT and AST elevations - Hypersensitivity - Increases in prothrombin time - Drug safety is SEVERE, which has been associated with death and low toxicity. SEVERE information may occur in patients with moderate or severe renal impairment. - Each 100 mg vial of RDV (single-dose powder) contains 3 g	- Infection reactions - Renal function and hepatic function should be monitored before and during treatment as clinically indicated. - In the FDA product information, RDV is not recommended when eGFR is <30 mL/min. See the Remdesivir section for a discussion on using RDV in patients with renal insufficiency. - RDV may need to be	- Clinical drug-drug interaction studies of RDV have not been conducted. - In vitro, RDV is a substrate of CYP3A4, GATP1B, and P-gp and an inhibitor of CYP3A4, GATP1B, GATP1B, and MATE1. - Minimal to no induction in RDV exposure is expected when RDV is coadministered with dexamethasone (dexamethasone [dexamethasone]).	- RDV should be administered in a hospital or a health-care setting that can provide a similar level of care to an inpatient hospital. - RDV is approved by the FDA for the treatment of COVID-19 in hospitalized adult and pediatric patients (aged ≥12 years and weighing ≥40 kg).
Ivermectin The doses and indications listed below come from the FDA product information. Please see Therapeutic Management of Hospitalized Adults With COVID-19 for the Panel's recommendations on when to use ivermectin for hospitalized adults and children (aged ≥12 years and weighing ≥40 kg). For patients who are not mechanically ventilated and/or on ECMO: • Ivermectin 0.6 mg/kg IV on Day 1, then ivermectin	- Generally well tolerated - Diarrhea - Pruritus - GI effects (e.g., nausea, diarrhea) - Neurological AEs have been reported when ivermectin has been used to treat parasitic diseases, but it is not clear whether these AEs were caused by ivermectin or the underlying conditions.	Monitor for potential AEs.	- Minor CYP3A4 substrate - P-gp substrate	- Generally given on an empty stomach with water; however, administering ivermectin with food with food increases its bioavailability.³ - A list of clinical trials is available from Accession.
Nitazoxanide The doses and indications listed below come from the FDA product information. Please see Therapeutic Management of Hospitalized Adults With COVID-19 for the Panel's recommendations on when to use nitazoxanide for hospitalized adults and children (aged ≥12 years and weighing ≥40 kg). For patients who are not mechanically ventilated and/or on ECMO: • Nitazoxanide 500 mg PO 3 times daily for 3 to 5 days	- Generally well tolerated - Abdominal pain - Diarrhea - Headache - Nausea - Vomiting	Monitor for potential AEs.	- Drug-drug interactions may occur if NTZ is administered concomitantly with other highly plasma protein-bound drugs due to competition for binding sites.³ - NTZ is a substrate of CYP3A4 and CYP2C8.	- NTZ should be taken with food. - The oral suspension is not bioequivalent to the tablet formulation. - A list of clinical trials is available from Accession.

We know this, as it is even published as a known side effect of the drug. On this chart dated July 2021, entitled **"Characteristics of Antiviral Agents Approved or Under Evaluation for the Treatment of Covid-19."**

In this table, three drugs are listed as approved or under evaluation by the nih. The second was ivermectin. It gives you the doses to use in hospitalized patients. The very first item in the second column under adverse events or side effects, **"generally well tolerated".**

NIA COVID-19 Treatment Guidelines
About the Guidelines Overview Management Therapies Special Populations

Home Therapies Antiviral Therapy Table Characteristics of Antiviral Agents Table 2f Characteristics of Antiviral Agents

Table 2f. Characteristics of Antiviral Agents
Last updated: December 16, 2021

Remdesivir
The doses and indications listed below come from the FDA product information. Please see [Therapeutic Management of Hospitalized Adults With COVID-19](#) for the Panel's recommendations on when to use RDV for hospitalized adults and children (aged ≥12 years and weighing ≥40 kg). For patients who are not mechanically ventilated and/or on ECMO:
• RDV 200 mg IV on Day 1, then RDV

Ivermectin
The doses and indications listed below come from the FDA product information. Please see [Therapeutic Management of Hospitalized Adults With COVID-19](#) for the Panel's recommendations on when to use ivermectin for hospitalized adults and children (aged ≥12 years and weighing ≥40 kg). For patients who are not mechanically ventilated and/or on ECMO:
• Ivermectin 0.6 mg/kg IV on Day 1, then ivermectin

Nitazoxanide
The doses and indications listed below come from the FDA product information. Please see [Therapeutic Management of Hospitalized Adults With COVID-19](#) for the Panel's recommendations on when to use nitazoxanide for hospitalized adults and children (aged ≥12 years and weighing ≥40 kg). For patients who are not mechanically ventilated and/or on ECMO:
• Nitazoxanide 500 mg PO 3 times daily for 3 to 5 days

I would like to draw attention to this: they have updated this table on December 16, 2021: table 2f. In it, they list Remdesivir as the only fda-approved drug on this list.

I call attention to Ivermectin which is not approved by the fda and it is not recommended by the expert panel. In the side effects box for ivermectin [I pointed this out to legislators around the country and the world], they removed the first sentence that said

"They don't want you to know that it's generally well-tolerated. They don't want you to know that it's generally well tolerated."

Okay, so I want you to know that this nih chart has 6 or 7 drugs, Remdesivir is the only one that was approved in December 2021. It's still the only drug approved by the fda to treat, Remdesivir. After it was published that it causes liver failure, acute kidney failure and now the heart failure we know and heart defects.

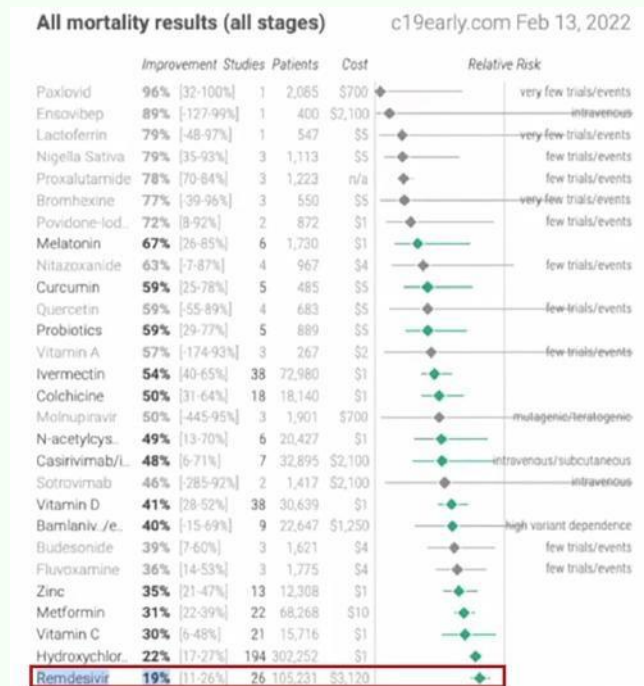
The Centers for Medicare Medicaid Services in the United States, Medicare covers all elderly, poor and disabled people. Medicaid currently offers additional payments for covid-19 treatment, according to the Cares Act. The jury should be out on this.

If it is true that Remdesivir causes acute renal failure, liver failure and heart failure, everyone should debate the fact that Medicare CMS bribes all hospitals with a 20% bonus if they use Remdesivir. This bonus applies to the entire bill for patients treated for covid-19. You can read here, in the highlighted section, that **"NCTAP (Ncovid-19 Treatments Add-On Payment) claims that those that are eligible for the 20% bonus add-on payment under CARES section 3710."**

Bonuses of 20% are distributed to all hospitals in America in 2 cases for patients 65 years and older. First, the ICD-10-CM diagnosis code U07 is covid-19 positive, which is the diagnosis code for which they receive a 20% bonus. Second, the ICD-10-PCS code for Remdesivir.

Then below that, you'll see the chart where they say to hospitals, if you enter these two codes, those first two codes in the chart will give you a 20% bonus if you choose Remdesivir, a drug known to be toxic and deadly, proven to be so.

Now I draw your attention to this. Why does Medicare continue to bribe hospitals? When in fact, look at this chart, look at the date at the top right. It's via c19early.com. Today is February 13, 2022. Notice that these are all mortality results. They're taking research studies from around the world used to treat hospitalized patients with covid-19 and they want to know which of these drugs produces the greatest improvement and survival rates.



This chart is from this morning. Look at the bottom of the chart. That's where Remedivir is. The second column is the improvement section. The percentages of all the people in the research studies who see improvement and don't die. Remdesivir is at 19% improvement and look at the number of studies and the number of patients in those studies and then look at the cost of this drug which is a failure. It's over \$3,100 per treatment, which is a five-day treatment period. Almost anything above that works better than Remdesivir. These are global studies.

My question is: two years later, why are we still supporting a drug that has clearly failed against more than 30 other products, including nutrients? Ivermectin alone has a 54% success rate. That's easily double the effectiveness of Remdesivir on mortality and improved mortality outcomes. Quercetin... Povidone-iodine at 72%. It's a nasal wash and throat gargle that costs \$1.

Why promote Remdesivir? It is the most expensive drug on this list and one of the most unsuccessful.

The fda just issued an update on January 24, just a few weeks ago, because of the Omicron variant. We are discontinuing the use of Regeneron in every clinic in the country, in every state, every territory, every jurisdiction. They're actually saying that Omicron is not responding to these monoclonal antibody treatments that were being used.

Because of this data, they are now suspending its use. It is important to note that several other treatments, Paxlovid, Sotrovimab, remdesivir, called Veklury, and Molnupiravir, a drug from Merck, are supposed to work against the Omicron variant. These are the only ones that are licensed or approved to treat patients with mild to moderate covid-19, both in and out of hospital, with the Omicron variant.

They listed four drugs: Paxlovid, Sotrovimab, Veklury (*Remdesivir*) and Molnupiravir. In the February 13 chart, Paxlovid is at the top [a Pfizer-created drug], which has only been studied in one study of 2,000 patients and has an average cost of \$700. Sotrovimab [the tenth from the bottom, just above vitamin D], 46% effective, is the second drug they suggest. Two studies with 1,400 cases at \$2,100. Molnupiravir is three lines above Sotrovimab with a 50% success rate, three studies of 1,900 people at \$700. These are the most expensive, including Remdesivir which was the fourth drug. So many others are cheaper and more effective. People should refer to them.

Three days before the fda says Remdesivir, Sotrovimab, Paxlovid and that other expensive drug, Molnupiravir, should be used, the fda just expanded the use of Remdesivir on January 21. The **"Fact Sheet for Healthcare Providers (EUA)"** authorizes the emergency use of Veklury (*Remdesivir*) for the treatment of covid-19 in pediatric patients weighing at least 3.5 kilograms.

They now allow Remdesivir to be injected into the veins of all newborns weighing 3.5kg or more and everyone in between. They are doing PCR tests on babies in hospitals as soon as they are born to see if they are positive.

They will take them and inject Remdesivir intravenously, a drug known to destroy heart cells, causing cardiomyocytes, liver failure and kidney failure.

I draw the attention of the jury, the judges in the world to this document. It stipulates positive tests in and out of hospitals. Under the emergency use authorization issued by the fda for pediatrics, the parent and caregiver have the option to accept or decline the Veklury. As noted on the EUA, all parents have the right to refuse. According to the third point of the EUA, health care professionals must provide information about available alternative treatments and the risks and benefits of those alternatives. They must inform you about the alternative treatments available for your child or baby. But...

But the rest of the document talks about **"approved and available alternatives."** On page 10 of the same document, it states that there are no approved and available alternatives for the treatment of covid-19 in pediatric patients.

Wait a minute! They just said in point three that doctors and health care providers must provide information about available alternative treatments and further on, the document tells you that there are no approved alternatives: only Remdesivir. The document says what providers should do if they ever give you Remdesivir. Let's look at statement 7. It says that within seven calendar days, a health care provider must provide, on fda form 3500, all serious adverse events reported in babies receiving Remdesivir. What are the serious adverse events that could happen with Remdesivir that they want you to report and hold you accountable for?

In #8, serious adverse events defined are death, a life-threatening adverse event, hospitalization or prolongation of an existing hospitalization, a congenital anomaly or birth defect, persistent or significant disability or substantial impairment of the ability to carry out normal life functions, medical or surgical intervention to prevent death, a life-threatening event.

What else do you need to know? The fda has issued an EUA for remdesivir in babies. It says that the fda issued it at the request of Gilead, the manufacturer of Remdesivir. Based on the data submitted.

Why don't we have the other companies that make ivermectin, Hcq, budesonide? They need to approach the fda and ask for emergency approval. It looks like Gilead can do that. Based on the data they submitted, I'll show you the data that Gilead provided to the fda to say that it can now be used in pediatric patients.

11.3 Pediatric Use

The safety and effectiveness of VEKLURY have not been established in pediatric patients weighing 3.5 kg to less than 40 kg or pediatric patients less than 12 years of age weighing at least 3.5 kg, with positive results of direct SARS-CoV-2 viral testing, and who are:

- Hospitalized, or
- Not hospitalized and have mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death.

VEKLURY for injection (supplied as 100 mg lyophilized powder in vial) [see Dosage and Administration (2.2, 2.3, 2.4, 2.5)] is the only authorized dosage form of VEKLURY for pediatric patients in this age group.

Use in this age group is based on extrapolation of pediatric efficacy from adequate and well-controlled studies in adults [see Overall Safety Summary (6), Clinical Pharmacology (14), Clinical Trial Results and Supporting Data for EUA (18)].

"11.3 All data for pediatric use. The safety and efficacy of VEKLURY (remdesivir) have not been established in pediatric patients weighing 3.5 kg to less than 40 kg." Below that there are 2 bullet points: hospitalized or not. So I would like to know what data the fda has if the safety and efficacy of the product has not been proven in pediatric patients. What data has Gilead given you?

When in fact Remdesivir has consistently proven to be the least effective and most dangerous of almost all the drugs on this list. I leave it to the jury to find out why they use this drug and continue to use it when it has been proven to cause more deaths and side effects than many other drugs.

32:52 Viviana Fisher

Could you just re-present the slide because I think in the note at the bottom it says that it extrapolates from the information received from the adult studies. But, they were negative. So...

02:57:02 Bryan Ardis

Yes, it's right there. I'll share it with you again, just wait.

What amazes me is all the literature on Remdesivir and its failed publications and studies. You can see it on the screen.

"Use in this age group is based on extrapolation of pediatric efficacy from adequate and well-controlled studies in adults." I am sharing a document with you so the world can see this, because they need to see it. This is the nih table 2f. that was just updated in December. I am scrolling through it. It lists the Remdesivir approved by the fda for the treatment of patients hospitalized with covid-19 :

"Approved by the fda," I'll scroll down here so you can see the list. Interferon alpha is now added **"not approved"**. Interferon beta **"not approved"**. Interferon lambda **"not approved"**. Ivermectin **"not approved"**. Nitazoxanide, **"not approved"** and you come to the end.

There are no other drugs that nih and Anthony Fauci say are licensed or approved for treatment. Yet it says here that Remdesivir causes acute renal failure. I don't know if you noticed that in the monitoring parameters for Remdesivir, it says

"See the section on Remdesivir for information on the use of Remdesivir in people with renal impairment."

The monitoring parameters indicate that if you give Remdesivir to someone in America, you can monitor liver enzyme activities, right here, ALT and AST elevations. They say if you see ALT increase, as we found in the French study. In the French study, Remdesivir was withdrawn when the ALT level in the liver increased by three to five times normal, it was considered toxic and lethal.

America and the nih consider acceptable levels of ALT elevation, it is in the EUA of Remdesivir; they allow elevation of ALT toxic liver enzymes to 10 times normal. Is this acceptable?

For those of you who want to see it, I'll show it to you because it disgusts me. I'll show you. It bothered France and they withdrew it. Increased risk -page 7 of the EUA for Remdesivir. Increased risk of elevated transaminases. I want you to look at the first bullet point at the bottom of the page.

It says right above, **"Perform liver laboratory tests for all patients before starting Remdesivir and during treatment."** First point, **"consider stopping Remdesivir if ALT levels increase to more than 10 times the upper limit of normal."**

I would like to know why our nih is okay with liver poisoning when the French physician scientists withdrew the drug knowing it was deadly and toxic and inflamed the liver with ALT levels three to five times the normal level that they consider life threatening? For what reason is our NIH, Anthony Fauci and these protocols, why are they okay with giving them this drug? Just below that accepted 10-fold level for ALT elevations, liver toxicity. Just below that it says:

"Risk of reduced antiviral activity when co-administered with chloroquine phosphate or hcq sulfate". You should know... oh, I know what I wanted to show you. Wait a minute.

Number four, as already mentioned, **"you must perform liver laboratory tests in all patients before starting Veklury."**

Number five, **"you should determine the prothrombin time in all patients before starting Veklury and monitor it during treatment if clinically appropriate."**

By definition, prothrombin time is a blood clotting factor. If it goes up, it means your blood is taking longer to clot, putting you at risk for internal bleeding. If the prothrombin time is shortened, it means you have blood clotting problems. So for this drug, they know to check two things: liver function before and during treatment. According to the EUA, you need to determine the blood clotting time before and during treatment. I would like to know if everyone in the world does this. I would demand that all health care professionals do it because there is evidence that this drug causes cardiovascular toxicities, including, as we showed you in Nature Medicine, thrombotic events, blood clotting events due to the virus, when in fact, remember, Gilead was allowed to participate in the publication of the side effects of the drug.

This drug should be withdrawn from circulation. There is a lot of other information about this drug. I believe this drug has been used as a sedative and it is not the only one.

Remdesivir targets and kills the elderly. It complicates liver failure, kidney failure and heart failure. But there are sedative drugs used around the world, like morphine, midazolam, currently in America and Canada... They use such drugs to intubate these people brought in with multi-organ failure, which forces them to be put on a ventilator because they can't breathe. These drugs are midazolam, morphine, lorazepam, precedex. These drugs suppress the nervous system's ability to control your ability to breathe. They inhibit breathing. They are also known to paralyze the central nervous system and stop the heart from beating. This is my opinion.

They use them as euthanasia agents and protocols to speed up death in hospitals. They are targeting the elderly all over the world and have been since the beginning. We see that they are now targeting the young, everyone. If you don't mind, I'll show you another thing: they are targeting the hearts of all these people with these sedation drugs, with Remdesivir as proven in these studies.

There's one other thing I'd like to show the world before it even comes out, I may not even be a part of it. In its November 8, 2021 Circulation journal, the American Heart Association states that there is an affirmed attack on the heart muscle using Remdesivir, spike proteins and vaxxins. This is in line with the proven effects of Remdesivir. The article is entitled

"Covid mRNA vaxxins dramatically increase markers of endothelial inflammation and the risk of acute coronary syndrome as measured by the PULS cardiac test. This is a warning.

At the bottom of the article, **"At the time of writing, the changes in the heart persist for at least 2.5 months after the second dose of vaxxin mRNA. We conclude that vaxxin mRNAs significantly increase endothelial inflammation and T-cell infiltration in the**

cardiac muscle and may explain the observations of increased thrombosis, blood clotting disorders, cardiomyopathy and other vascular events following vaxxin."

I'm only bringing this up now because this is the part of the jury trial where they tell you about the side effects of vaxxins. They're now finding out that the ingredients in vaxxins target the heart muscles, the blood clotting problems in the heart. They cause strokes, heart attacks.

The American Heart Association publishes these findings in November. One month after the Journal of Cardiovascular Toxicology published that Remdesivir causes thrombotic problems, cardiomyopathy and heart cell death. I believe there is a technological onslaught to create targeted drug therapies, poisons that directly target the hearts of innocent people around the world.

They call it covid-19 deaths using falsified tests, like the PCR we've already heard about. That's my reasoning. When in fact, we know that there are 150 studies right now promoting natural immunity and showing that natural immunity, following covid or other infections, actually provides robust and longer lasting immunity than any of the current vaxxins that are currently being pushed on the general public.

03:06:41 Viviane Fisher

May I ask if there is any evidence of conflict of interest or financial interest of Fauci in what is happening?

03:06:51 Bryan Ardis

Yes, there was a meeting where Anthony Fauci discussed the drugs they were going to use as a solution to the pandemic. That was in March; Dr. Peter Breggin did a great job in his book subtitled **"We Are the Prey."**

Anthony Fauci held a meeting with 17 other representatives, nine of whom worked at Gilead Sciences. Is that amazing? This book is a great reference: 2,000 citations to this in his book that will also tell you that there are links between Anthony Fauci and Gilead Sciences. I've already heard references in this trial today.

Let's look at Gilead Sciences' ties to Genentech and Roche and Pacbio with the PCR test. There's a lot of collusion behind a lot of what they've been doing all along. It's been orchestrated since 2014-2015. That's part of this whole plandemy. Yes, with Anthony Fauci and with the companies that own Gilead, [primarily Vanguard and BlackRock]. There are tons of connections with Gilead, Anthony Fauci and others.

The choice, the support for the use of Remdesivir in my mind is always to target the heart, the liver, the kidneys of individuals, they know it is toxic. The reason I believe they are putting Remdesivir as of January 21, with the EUA, as the only drug allowed to be injected into the veins of children, with no other alternatives, is because they need babies to start dying.

Because February 15 was the fda meeting that was supposed to take place to vote to give these vaxxins from newborns to five year olds, these Pfizer vaxxins. So I think they're putting everything in place, step by step, to create more carnage, more deaths, more trauma, blaming a virus like this Omicron variant that's almost the common cold.

But they really want to put this virus out there that is deadly even in the pediatric demographic. So they can sell the parents, the grandparents that they need to get vaxxed too. That's the only reason they would do it. I can't think of any other reason why you would do it. Even the c19early.com mortality results document, which is updated daily, shows the effectiveness of Remdesivir in actually preserving the lives of people with covid-19. That's 19%, according to research studies around the world, two years later, 19%.

I would like to ask the jury why this one and only drug is still being promoted. It is now approved for use in all nursing homes in America, outside of hospitals, since the January 24 fda update. So just as midazolam and morphine are being used in the UK to kill innocent elderly people, by incriminating covid-19, they are now setting the stage to do it here with Remdesivir. With the published documentation I have given you, there is no reason in the world to consider Remdesivir safe

to be administered to the elderly. When in fact, at this very moment, February 13, 2022, less than 1% of the world's population that has contracted this virus and been infected that has died, less than 1%.

We pulled data from CMS whistleblowers with attorney Thomas Renz, for all of New York State. When I say they are targeting the elderly, they know these drugs are going to be toxic to them. Why would you use a drug that has failed so badly, continue it two years later, unless there is an attempt at genocide, and then sell to the world that they need vaxxins that are clearly a failure?

03:10:56 Viviane Fisher

Is it only... a prescription drug? Or can you use it... can you also administer it yourself. Do people do it?

03:11:06 Bryan Ardis

Remdesivir is only approved to be given intravenously, either in the hospital or in a nursing home. They administer it through an IV needle, it's not a pill. That said, it was also approved for use in outpatient infusion centers outside of hospitals, where they were using monoclonal antibodies like Regeneron, which have been very successful. They are now allowing Remdesivir to be used in those facilities. These drugs were also administered intravenously.

03:11:34 Reiner Fuellmich

Now, at the risk of making a fool of myself, is that a fair conclusion, after looking at everything, all the evidence we've heard tonight, including yours.

Is it a fair conclusion to say that,

- one: we only have an illusion of a pandemic created by a faulty PCR test.
- two: they use this illusion to use drugs that kill people, which is then,
- three: the reason why people are made to believe that it is caused by the virus, the illusion and finally
- four: using vaxxins that are just as deadly as Remdesivir and other drugs?

03:12:18 Bryan Ardis

That is the illusion, absolutely. However, corruption cannot be underestimated. Dr. Pierre Kory continues to say that this is an obvious and ongoing attempt to cause death and harm. The PCR test does not determine if you have SARS-CoV-2 or covid-19, or any other respiratory virus, for that matter. It is a flawed test, a bad cycle set up to create an exaggeration of covid-19 cases.

In March 2020, our CDC released documents for hospitals across the country. Thomas Renz filed a lawsuit. They said that in March 2020, any hospital that received a patient that tested positive for influenza A or B, but negative for pneumonia and negative for covid-19 PCR test [this is in their own paperwork, if you look at the admission form and home address], or if you heard of a covid-19 positive case, you can call that a covid-19 positive case documented as such, that will give you an additional 20% bonus for that diagnosis instead of the actual tested influenza confirmation diagnosis.

They did the same thing for pneumonia. So, starting in March 2020, they started encouraging hospitals and clinicians to make false diagnoses of covid-19, even if they weren't PCR positive. They incentivized them all to do that. So yes, this is an illusion orchestrated by our federal health agencies to exaggerate covid cases, to exaggerate the causes of death from covid. They call them complications of covid.

I would certainly appeal to as many complainants as possible whose loved ones died in hospitals around the world after being treated with Remdesivir. I would ask them to look at their death certificates. They died of complications from covid-19.

They diagnosed, secondarily, acute renal failure and they died from complications of pneumonia secondary to covid. It's not covid secondary pneumonia, when you block the kidneys and you put an IV bag that floods someone's veins with water and they can't excrete the water from their blocked kidneys. You flood his abdomen with water, it then floods the heart and then seeps into the lungs and you drown them. This is called pulmonary edema.

So I'm calling for pushing as many people as possible to share this information. We know that's what drugs do. Yes, we have the illusion that they are dying of a virus. They are being poisoned to death by inappropriate protocols. Absolutely.

They are also incentivized to artificially exaggerate the positive cases and give diagnoses for that. I just showed you that Medicaid in America incentivizes hospitals with a 20% bonus and code if you give us a positive diagnosis covid-19 to all patients 65 years and older, really.

I would like to ask you, jury, judge, if as I showed you on the NIH chart, there is only one drug, as of December 16, that is approved by the fda to treat inpatients for covid-19, why is Medicaid bribing all the hospitals to use that one and only one drug if there is only one approved drug that is usable anyway? Why should Medicaid bribe them with a 20% bonus to use this one and only drug?

There is only one nefarious reason why they are bribing all the hospitals to use this one drug that is proven to cause acute renal failure, liver failure and heart failure. All along, we knew this was the case. You have all been lied to.

03:16:12 Reiner Fuellmich

[It looks like it.](#)

03:12:14 Dexter Ryneveldt

Dr. Ardis, thank you very much for your testimony, I have to say that you have given the jury an accurate picture of what we are dealing with. We are dealing with a textbook scenario of medical error. We see it in the United States and also in every country in the world.

With respect to this grand jury as well, can you confirm that every hospital, every doctor who prescribes Remdesivir, who prescribes all the other drugs you mentioned, Midozalam, is committing deadly malpractice, medical malpractice, without a doubt? Do you agree with that?

This is consistent with your statement and the testimony you just gave, namely

that you motivate every citizen, the jury in fact, around the world, that once they understand that these drugs have been prescribed, they will take the necessary action.

So, really and to me, based on the evidence you've given, this is a textbook scenario of medical malpractice. At the heart of this medical malpractice, without a shadow of a doubt, is a financial game. The parties you mentioned when it comes to financial gain are BlackRock and also all the other investors, I believe.

So would you agree that yes, we are now talking about a scenario with regard to this prescribed drug? It is also used both to increase statistics and to instill or instill fear in the world population. Do you agree with that?

03:18:23 **Bryan** **Ardis**

Absolutely. A 100%. I would confirm, I would also just like to say that it's actually a eugenics manual.

03:18:32 Dexter Ryneveldt

I think you're absolutely right, because when you look at the intent and you've made the intent very clear, in the way that you've actually led the jury to look at each of the documents. To me, it also comes down to eugenics. It is clear criminal intent and I don't see how any of these perpetrators will get away with it. So I thank you for making that clear. Thank you very much for your evidence.

Thank you for taking the time, step by step, to show the jury, every citizen of the world, what we are dealing with. Thank you, Dr. Ardis.

03:19:15 **Bryan** **Ardis**

Please. I can't thank Dr. Reiner Fuellmich and your team enough. Thank you to all of you who are here for standing up for humanity when so many people don't care and don't want to do the right thing. So thank you to all of you.

My intention from the beginning was to try to educate, to warn, to inspire as many people as possible about what is going on. You have done a great job in bringing together a great group of people that I continue to call my colleagues and friends, thank you on behalf of humanity.

03:19:43 Reiner Fuellmich

Thanks Brian.

03:19:45 Dexter Ryneveldt

Thank you very much, Dr.

03:19:47 Reiner Fuellmich

We care, we all care. Pffff...

Please, John O'Looney, even though this is extremely disturbing, I think this is a good time for you to explain what happened in the UK because it kind of mirrors what Dr. Bryan Ardis just told us. What happened in the UK? How did you find out?

03:20:32 John O'Looney



As a funeral director, initially, of course, when covid came along, I was convinced, I had no reason not to be convinced, and I had absolutely no idea that the business was going to be so

serious. You know, plandemic is the word that was used to describe it. A number of things alarmed me, the first was the mortality rate in 2020. Despite all the efforts in the nursing homes between March and April, the mortality rate did not increase ...

What we saw on the news, we were told about this deadly pandemic, people falling left, right and center. That was not the case. The death rate was not there. I washed and dressed suspected covid victims throughout 2020. It's very interesting to hear the doctor talk about lung edema. Because when we embalm someone, the process is quite invasive. We have an instrument called a trocar. We insert it into the abdomen and into the lungs. We were encountering a lot of edema in the patients that were referred to us. It was so obvious, like a clear yellow liquid when we emptied the lungs, it was always full.

I also had a pandemic guy who introduced himself as John. He called me in early 2020. He said he was sponsored by the government to call all the funeral directors in the area.

His task was to collect the deaths and the covid numbers. He asked me what my capacity was as a funeral director, how many deceased I could accommodate in my establishment, how many deceased I had collected that week, how many had died from the covid and where they came from. It wasn't very long.

Right away, he started staring at me. I would say to him, for example, **"I went to pick up a gentleman in a nursing home, he had the beginnings of dementia, I talked to the family, he had been there for years. No doctor was present at the time of his death. No covid test done at the time of his death."**

Yet this guy insisted that all the deaths were due to covid. When I questioned him, he said, **"We were told that there was covid in this facility, in this nursing home. We were told that we had to label all of them as covid deaths."** These people did not have covid.

Same scenario with cancer patients. Basically anyone they could label as dead from covid... Even a guy who had died crushed, with tire tracks from hip to chest, that was a dead from covid. This happened throughout 2020. At the cost of great effort.

Then, shortly before the end of 2020, when it was announced that the vaxxins were coming and everyone wanted one because there were so many covid deaths, he called to tell me that he would no longer be calling. So clearly this pandemic guy didn't need to call me anymore.

It was obvious what he was doing and it was towards the end of 2020 that I realized what was going on. Obviously, it's very troubling. I saw these people coming and it's always hard to be a funeral director anyway, when you're dealing with a number of tragic deaths, but when you're dealing with people who are killed illegally, it's even more heartbreaking. Some families are blissfully unaware, others are very aware and no one listens. Since I've spoken out publicly, I've been contacted by a lot of people.

People from the nhs environment, blew me information and victims told me their story. I also found myself

in the unique position of being in the hospital as a covid patient, to see things firsthand. I saw it as an opportunity to get as much information and gather as much evidence as I could while I was there and it was very productive, I can tell you.

So the year 2020 passed and they announced that they were going to start vaxxing on January 6, 2021. I had an idea at that point, in fact, I mentioned to a number of people that I suspected that the mortality rate was finally going to go up because it hadn't been there before, at the time they were putting needles in the arms and that's what happened.

It exploded I would say by about 300% of the normal mortality rate, from the time they started vaxxing. It was horrible. Horrific. That's the only time in that whole two-year period that I call it a pandemic death rate as a mortician. It went on for 12 weeks, more or less, before it almost stopped and the batch was exhausted; it stopped completely and it got very, very quiet.

What we are seeing now is the number of deaths from thrombosis, that is, from an aneurysm, a stroke, or a heart attack. What is most disturbing is that these are people of all ages. The youngest people I've cared for are 23, 28, 32, 33, an age when you don't usually die of thrombosis or in large numbers.

Among the key calls I took from those who contacted me, one was a morgue director, Nick who has worked at a large hospital for almost 30 years. He was going to lose his job in April, because they were blackmailing people, if they didn't do the injection, no more work, hopefully he got that reversed. They backed out.

They don't want 80,000 key witnesses, do they? He told me he was putting the numbers together. That said, he had to be careful because of the GDPR [General Data Protection Regulation]. These laws they passed recently, he could only keep a limited amount of information. But as a morgue director, he was collecting that information. He told me he saw a 600% increase in thrombosis deaths exclusively in vaxxed people this year. That's very consistent with what I've seen. I saw more thrombosis deaths this year.

When I worked for a large cooperative with a 60% market share of the funeral industry in the UK, a very large group, I rarely saw 20 year olds being handed over to us; I saw more this year than I have ever seen in my entire career. All died suddenly. Think about how many soccer players, fit athletes have died suddenly on national television because of heart problems. It's unprecedented and no one seems to want to acknowledge it.

I was so concerned that I wrote to the Chief Coroner of England, because my job as a funeral director is to raise issues if I have concerns about a death or deaths per se. I've written to many people, some of whom are in this room, including Dolores, and I've said, "Look, I know you're aware of these deaths, this sharp increase in thrombosis deaths. What's going on?" I never got an answer.

I let three or four weeks go by and then I emailed again and finally got a response from the secretary who said **"we follow government policy."** So they correctly diagnose these deaths as thrombosis deaths and quite often these people come in and are cut from the ankle to the hip, where they looked for thrombosis in the femoral artery and places like that, I guess.

But that's as far as they go in linking it to a vaccination done perhaps two weeks earlier. In one case, a 28-year-old woman died 90 minutes after being vaxxed in the hospital bed she was in: her parents are obviously furious. No one wants to know, they said it was death by thrombosis.

That's unheard of, right? But is it as common as what's happening? Does it happen right after a gene therapy injection? No... So this girl's story... her family won't mind me telling you. She was admitted to the hospital for a minor procedure. They forced her to do it by telling her she was at great risk because ~~there~~ were covid patients there. She reluctantly accepted a vaxxin only to die of thrombosis 90 minutes later in her hospital bed. So the cause of death is pretty obvious. Indeed, she arrived cut from the ankle to the hip, where they looked for these thromboses.

Just before Christmas 2022, I was out; I had a cold that got worse. My wife had it too. We both went to bed because we were feeling bad. I started to get a little short of breath. So I had an ambulance come. It had three staff members, two big guys who were really nice. One woman who started berating me almost instantly saying I was being selfish. That's a story I've heard from several people.

They do that, they start berating you for your medical choices. Anyway, they took me to the hospital, I went to triage initially. They did three rapid tests there. All negative. I was transferred to one of the wards where early in the morning a consultant came to see me. He sat on the bed and said, **"Okay, we're going to put you on Remdesivir."** I said, **"Thanks, but no, thanks."** He said, **"Well, why?"** and I said something like, **"Well, because we're going to take a look at the clinical reasoning behind it then,"** and he left. He wouldn't even engage with me on any level. He knew what I was talking about. Two staff members came up to me and quietly thanked me for what I was doing.

You know, this is not a joke exchange. These people know what's going on. That afternoon a young woman came up to my bedside, she sat on the edge of the bed and said, **"I'm, whatever her name is, from Oxford University,"** okay, that's unusual, that's not normal hospital practice. She told me, **"I'm here to offer you some trial drugs, we're trying to save lives, I think you might die without them."** She told me that and one of them was baricitinib. the other was tocilizumab. So again, I looked up the names of these drugs. I said, **"Well, let's think about this. Can you give that assessment?"** a basic Google search for side effects tells you what you need to know. I said, **"Why would you want to give this product to someone with breathing problems?"** again, she couldn't look me in the eye, she was looking at everything but me, like a child caught with her hand in the cookie jar. She left the bed saying, **"I'll come back tomorrow, then."** The two guys across from me were covid patients who had both accepted these treatments.

I stayed up all night listening to these guys on CPAP [continuous positive airway pressure], high pressure ventilation, coughing and hiccupping. Every once in a while the nurse would come out and give one of them morphine. Which, again, was really, really bad. You know, I'm a mortician. I'm not a doctor. But I'm sensible and educated enough to know that this is not a healing treatment. I heard these guys coughing and hiccupping and dying and it became obvious, so, I knew I had to get out. Because they knew who I was and they offered me three of the most toxic drugs, when my stats were at 78%. I was on antibiotics and steroids for a few days. I recovered enough to try to get out.

What followed was a three hour battle, they wouldn't let me out, they even called security and said they would have me arrested as a public health threat. Three ridiculous hours of fighting. In the end, they knew I wasn't going to give in, I was going to be stubborn. They called my wife, a guy called, I have his name and a recording of the conversation. He was a pulmonary consultant and he said to my wife.

"John will die in minutes if he leaves the ward," to try to keep me and finish me off. I know that's what it was. I'm not stupid. So it was really chilling.

When I left the hospital, actually, I was very lucky and I made some very good friends. I was going to say contacts, but they're more than that now. Friends, they came to the hospital, Mark Sexton came and a guy, Dr. Chan. They saved me, they helped facilitate my release, it was really that.

I didn't need oxygen, they were giving me oxygen that I didn't need, they were desperately trying to put me on CPAP even in the ambulance on the way to the hospital, they were trying to ventilate me to persuade me that ventilation was the answer when I got to the hospital. I kind of said, no, no and I was traumatized because I knew what was going on. There's nothing worse than going to the hospital and you're not well. There are people there that you're supposed to be able to trust trying to kill you. That is the reality.

I have a very good friend, I took care of her mother. This friend had the exact same experience almost word for word, where she was

monitored, they were aggressive in the ambulance, her test was negative at the time, they then tried to hide something to get her to take the same meds and she ended up being released. They're pretty quick to release you when they realize you're not going to take those drugs.

With me, they tried to hold me back, they were actually quite intimidating and aggressive and it's only because I'm actually a solid guy and I'm well aware of what these drugs do and what their purpose is that I survived because I watched these two guys in front of me die, they who had trusted them.

Yes, it was chilling, the whole thing was horrible. I have absolutely no desire to go back, I can tell you I would rather die at home, I think. So that's where we are. I've been back at work for about four weeks now. I've recovered pretty well, the lawyers that I had, or have, kind of guided me with the ivermectin and different pills. Really. one of the hardest things to deal with was the brain fog. This Dr. Chan made me a list of everything I needed to take, my wife put everything in little jars for morning, noon and night. I was treated, I am very lucky.

When I left the hospital, I felt a kind of survivor's guilt, because it's kind of like leaving a burning house, people are still there and will die. I couldn't do anything for them. It's going to haunt me forever, that I couldn't save them. That's pretty much where I'm at.

03:36:41 Reiner Fuellmich

[What you describe sounds like a horror movie, but it is reality.](#)

03:36:46 John O'Looney

It was a horror movie. It was horrible, no doubt about it. I have a pretty strong will. But I think it affected me mentally, I was stressed and I stayed up 72 hours, I was too afraid to fall asleep, just in case one of them injected me with something. You will never understand unless you are in that position and isolated. They don't let family or advocates support you. Then I had to fight for three hours gasping to get out. Knowing that if I didn't, I would probably die. Yes, it was horrible. Really horrible.

03:37:26 Reiner Fuellmich

My God. From what you have seen, the conclusion you can draw after hearing all these testimonies, do you also believe that this is an intentional mass murder?

03:37:46 John O'

Looney 100%. Certainly not at the staff level, some of the staff and I saw this as an opportunity to gather evidence while I was there. Some of the staff have disassociated themselves, some of the staff are aware of what's going on and they've bought into it thinking it's okay because they're doing what they're told to do. Other staff are broken.

I talked to nurses who said they would work to try to minimize the damage caused by the clinical decisions made. They were crying on the phone. One in particular, named Michelle. A nurse for 30 years, that really speaks volumes. It was a chilling testimony. I listened to her for about 14 minutes on a phone call she made to me just before I got sick. She told me how they did it. They would take people to the hospital, x-ray their chest in bed with a mobile machine that they took everywhere. I myself had an X-ray with that machine. So I kind of understand what she means. Based on that x-ray, they were putting them in palliative care. They weren't doing any tests.

In some cases, they would lock them in a side room. When it's a geriatric case, old enough, old enough, they have no hope of surviving that. She told me that she will forever be haunted by an old man knocking on the door of her side room, locked up, begging for a cup of tea that she was unable to give him because the doctors wouldn't let, no. That guy simply starved to death.

That story, I had countless similar people, not just a nurse, dozens of people contacted me, because I'm obviously very well known, they saw me as a focal point to reach out to. It was heartbreaking!

Some of the stories you hear, some of the stories I've been told, will stay with me forever.

03:39:45 Dexter Ryneveldt

Mr. O'Looney, thank you for your testimony. You mentioned something very interesting. You sort of made a separation or a distinction between the staff who know exactly what's going on

03:40:03 John O'Looney

Yes

03:40:04 Dexter Ryneveldt

They are simply following orders.

03:40:06 John O'Looney

Yes

03:40:07 Dexter Ryneveldt

Then you mentioned the staff who know what's going on. It's these individuals, in a sense, who are pushing this version of the narrative.

03:40:16 John O'Looney

Yes

03:40:17 Dexter Ryneveldt

So in the first group, it's, "Oh, well, this is what I have to do. I know it's wrong. But I just have to do it. I don't have a choice."

03:40:24 John O'Looney

Yes.

03:40:25 Dexter Ryneveldt

So the question I want to ask you, sir, since we're talking about natural law and in terms of positive law of reference for this grand jury, it all comes down to the fact that each of us, each human being can tell right from wrong.

Would you say, then, that the only reason humanity is so involved in this eugenic journey is because our people know it is wrong. Yet they just go along for the ride. Do you agree with this statement?

Is it time for these staff members to say, "You know what, I know this is wrong, I'm not going to continue doing what I know is wrong." Because right here and now, if they can go all the way, humanity will be able to stand up to these forces that want to destroy humanity. Don't you think it's time now?

I want to refer you to the Nuremberg trials as well. One of the excuses used was, **"I was just following orders."** So, is it time for these specific staff members, in any hospital in the world to say, **"It's time to say no, this is where we draw the line."**

03:41:50 John O'Looney

À 100% ! I think it's interesting that you mentioned that, because I think a lot of the 80 to 100,000 British employees, I said it inadvertently, are on the front lines of this deadly pandemic. Yet they would rather throw away their careers than protect themselves.

Doesn't that fit with what you just said? They told us, without really saying it. They would rather lose their jobs than take this protection because they see with their own eyes people dying in front of them.

Why wouldn't we want to take that protection? 80,000 nhs employees would have preferred to give up their careers, so much so that the government backed down, because they knew they would have had 80,000 witnesses. No Zoom room is big enough for that.

03:42:38 Dexter L-J Ryneveldt

So what do you think should be done? I completely understand that you are now talking about the 82,000 people who are saying, **"No, we don't want this."** They are actually the ones who are on the right side of history. Then there are the ones you mentioned, they know what's wrong, but they keep doing what they're doing. What's going to happen to them?

03:43:02 John O'Looney

They will be held accountable. When they're held accountable for their actions and brought to court, if some of them are going to crack and start pointing fingers at others... Because that's human nature. That's what people do, right?

Perhaps since history is repeating itself, as at the Nuremberg trial, their only defense will be to say **"I did what I was told to do."** That's the reality, times change, but people don't.

03:43:32 Dexter L-J Ryneveldt

Thank you very much.

03:43:34 John O'Looney

You're welcome and thank you to all of you as well. I feel privileged to be among you.

03:43:42 Reiner Fullmich

Thank you John. That was a very powerful testimony.

03:43:42 John O'Looney

Thank you.

03:43:43 Reiner Fullmich

This will move a lot of people. I'm sure it will open their eyes.

03:43:50 John O'Looney

To be honest, my testimony is probably the greatest proof I have to offer.

03:43:57 Reiner Fullmich

You can't do better than that. Thank you.

03:44:02 John O'Looney

God bless you all, I will have to go, because I have commitments. Thank you all. God bless you. I am sure we will win. Let's hope that justice is done. God bless you all.

03:44:13 Reiner Fullmich

We will win.

03:44:13 Dexter Ryneveldt

Thank you very much, sir.

03:44:14 Reiner Fullmich

Thank you very much.

Now for the good news.

There is good news in what Dr. Shankara Chetty is going to tell us, because, as we have learned, it is an illusion.

We are not dealing with a Corona pandemic, but with a PCR pandemic. There are ways to treat this virus, which, as the figures show, is no more dangerous than the ordinary flu.

Dr. Chetty? What good news can you give us?



Thank you, Reiner. Thank you to all my colleagues on this platform. This has been a heartbreaking time for two years. I think our work is very important. I think that what I have experienced during

of the last two years will help to understand what the people before me have presented and to understand what really happened. So I think just by telling my story and my understanding of this pandemic, I can add a lot to what we are trying to accomplish.

So I'd like to start with what happened before covid arrived in South Africa. I have a background in genetics, advanced biology, microbiology and biochemistry, in addition to my work as a general practitioner. So I am a very suspicious doctor. I investigate everything. I make sure that I rely on the knowledge that I have gained in my years of graduate school. I don't believe things easily.

Before this pandemic came to South Africa, we were told that there was a virus in Wuhan, that it had spread from person to person, that it was a respiratory virus, that it seemed to be very contagious. Of course, we didn't know how this new virus was killing, how it was causing serious illness and death. But we were told that it was very contagious and that it could be the beginning of a new pandemic. The first thing I found very strange was that the Chinese sealed off Wuhan and the virus never spread to any other city in China. Yet the international borders remained open. The virus spread around the world.

So that's the first thing I found very suspicious: we're dealing with a highly contagious virus. So why hasn't it been completely contained? We weren't getting much information from China, which I expected. As a doctor, I had to anticipate the arrival of the virus in my country, to be prepared for it. The first thing that was a problem was this PCR test, developed to test the virus itself. From my scientific background, I know that a PCR test is never used as a diagnostic tool.

So I wondered why this had become the norm. Also, we started getting reports of asymptomatic spread, which was unheard of in medical science. So when these unusual things came out, I knew that a PCR test had absolutely nothing to do with infectivity. As previous speakers have pointed out, a PCR test only tests fragments of a virus. It does not test a complete infectious agent. It doesn't tell you if a person is actually infected or infectious. The only thing that tells you that a virus exists is a cell culture of the virus that proves that the virus can grow, replicate and spread. So I looked at this PCR test with suspicion.

Then this PCR test was used to evaluate or determine public health measures, sanitary measures that we saw. We were getting reports that this virus was living on surfaces for five, ten, fifteen days on different types of materials. That didn't make sense. Viruses don't live that long. They need a host to replicate and spread. There is absolutely no scientific evidence of viruses living on these surfaces for that long.

So I became very suspicious of that kind of information. Then the mask came along and I became wary of it too. As a physician, I know that the mask has limitations. Science tells us that a mask will never prevent us from contracting a respiratory virus. It's like putting a fence around your house and thinking you're protected from mosquitoes. The science doesn't add up.

So I started looking at all this evidence. Then, of course, they thought about isolation measures. They wanted people to isolate themselves for 14 days. I analyzed that and thought, **"You want people to isolate for 14 days, but you haven't really established the lifespan of the viral disease: 14 days is an arbitrary number"** So I needed to understand why they chose 14 days and not something else. So I had questions.

Also, with my studies in genetics, I was aware of the gain-of-function research being done at the time. I knew about virology and, of course, genetic warfare, the manipulation of viruses. I was aware of the research being done at

The Wuhan laboratory on coronavirus and spike protein, long before covid was created. So I knew we were dealing with the coronavirus and it seemed very strange and suspicious that a pandemic would break out after this ongoing coronavirus research. So I had good reason to think that this was a laboratory leak.

If you take it a step further, it could have been a manufactured virus. So that's something I had in mind from the beginning of this pandemic. Then the unusual things, the PCR test, the asymptomatic spread, the sanitary measures, the lockdowns, the isolation, all of those kinds of things had no scientific basis for me.

I was faced with a terrified population that had been told not to seek medical attention. They were told not to go to their doctor. We, as physicians, were told not to treat, that there was no treatment for it. That we should just do telemedicine. If a patient's condition deteriorated, they were sent to the hospital. I'm not the kind of person who gives up that easily.

So, with the knowledge I had, I decided to check it out. I needed information about this disease. Without this information about the pathology of this disease, we would never be able to solve the problem. I knew that once the virus arrived in Italy, I would get information about its symptoms. The information that came out was unusual: it allowed me to make a diagnosis without having to use a PCR test, because as doctors, we have to diagnose diseases based on symptoms.

Disease-specific symptoms tell you that you are dealing with that type of disease. The symptoms I found unusual were loss of smell and taste, which doesn't usually happen with respiratory viruses. Of course, the shortness of breath that the patients had. This shortness of breath occurred very suddenly and required very rapid ventilation. So dyspnea and loss of smell and taste became my diagnostic tool to confirm whether a patient was infected with coronavirus or not.

I observed. I needed a therapeutic toolkit to prepare me for this. We were dealing with a respiratory virus and so the first drug that came to mind was Hcq.

Hcq, or plaquenil, is well known. It has been used for decades and has broad-spectrum antiviral effects. So if I were to look for a product that could stop the spread of a virus, this would be my go-to treatment. Hcq has been used for many other diseases such as treating rheumatoid arthritis of the wrist.

So I knew I was dealing with a very safe drug that I could ethically give to my patients by evaluating its effectiveness. So I decided to get Hcq. Soon, the Lancet published an article about the toxicity of Hcq and its side effects on the heart. I thought that was absurd. I have been treating patients with Hcq for years, sometimes giving them higher doses, and I have never had any side effects from it.

So I switched to drugs that have been around for a long time, because I trust their long-term effectiveness and safety. I bought as much Hcq as I could, and two days later the South African government president took it off the shelves. Fortunately, I had a stockpile that I had prepared for my patients.

The patients came to me very concerned that I would close and not be there for them. I reassured them all that I was going to solve this problem and that I would look at each of them. I needed to understand what we were really dealing with.

When the first case of coronavirus was reported in South Africa, I decided to draw on my knowledge. I left my house to isolate myself to protect my family, my house and my practice are in the same building. I set up a tent, a true sanitation tent outside my office in the parking lot, because for me, ventilation and sunlight were the best ways to protect myself from this virus. I knew that if I disinfected my hands and didn't touch my face, I would be reasonably well protected. That way I could see all the patients.

That was my initial plan for this pandemic. But with the controversy surrounding Hcq, the PCR test being used as a diagnostic tool, the announcement of asymptomatic spread, I had well-founded suspicions about what we were being told and the so-called experts didn't seem to question it.

There was no evidence of this. Yet the government experts were telling us this story. So I started seeing my patients. I made sure to examine every patient who came into my office. I wanted to understand two things: first, the symptomatology. I also suspected coronavirus infection for every patient who came in with a sudden loss of smell and taste, which was unusual.

So I didn't want to use that PCR test. I didn't want to rely on that PCR test. I knew it would skew the numbers right off the bat and I could see the whole world going into confusion and fear.

When my patients came to me, I would first look at the symptoms and assume that those with loss of smell and taste were positive for coronavirus. I tested some of them, only the ones with loss of smell and taste, and found that they were positive. So I had proof that the loss of smell and taste was a symptom of coronavirus infection. So I didn't feel the need to test every patient. When one family member had a loss of smell and taste, and I tested him and he was positive, and the rest of the family started getting sick at about the same time and had the same kind of symptoms, I could safely assume that they had the same infection and treat them the same way.

As physicians, we are supposed to make a diagnosis by examining our patients. I was never taught to use tests as diagnostic tools. I only use tests if I have a doubt in my clinical diagnosis. A test is used to clarify. It is never used as a diagnostic tool. So I don't test patients to find out what's wrong with them. That is bad medical practice.

You're not trained for years in clinical practice to use a swab to figure out what's wrong with the patient. I started seeing all these patients with covid infections. The second thing that really interested me was shortness of breath. That's what was causing people to die. The first patients who came to me had a common flu, a respiratory infection that looked like every other respiratory infection I had seen. They had aches and pains, fever, a little sore throat

and, of course, a loss of smell and taste, an unusual symptom that made me think of a coronavirus infection. I told all the patients who came to see me that if they were short of breath in any way, I wanted them to report it to me immediately. I needed to understand exactly where the shortness of breath was coming from and why patients were ending up in the hospital.

We knew that in the hospital, patients were short of breath, their oxygen saturation was decreasing, and they were being put on ventilators. From the information provided by Italy, we knew that the progression of this breathlessness could be very variable. Some patients had mild breathlessness that did not progress and seemed to disappear. Others had a little more severe shortness of breath that lasted a very long time. Then, of course, there were those who developed very sudden shortness of breath that progressed very quickly. Within a day or two, they were on a ventilator. So I noticed that there was a strange difference in the rate of progression of that shortness of breath. I needed to understand that and also, how we got there.

Of my first 20 patients, I had the first one who was short of breath and of course I informed my patients and explained the seriousness of the situation. There was enough alarmism in the world: I was sure they would come back to me quickly. All the patients with shortness of breath came back to me the same day they noticed something was wrong. I found some very strange things in this small sample of patients who came back to me with no breath.

Remember, the majority of patients recovered without any problems, as with a normal respiratory infection. They had very few pulmonary symptoms. Most of them just had a sore throat, which would go away in two or three days, and they had absolutely no ill effects. So when patients came back to me with shortness of breath, I had to check them and figure out exactly what was going on. I noticed some very strange things.

Many of these patients who came back to me were perfectly fine the day before their shortness of breath began. They thought they had fully recovered from the disease. Some patients had a sore throat for a day, they got better, they spent the rest of the week perfectly healthy, they

practiced sports activities and then suddenly developed shortness of breath. So this shortness of breath came on very quickly. It always seemed to appear exactly one week after the first symptom.

So when a patient came to see me on a Monday, I would ask them and if the sore throat started on that Monday, I would note it as the onset of symptoms. We know that in the case of a viral infection, some viruses follow a very specific course: they replicate for a certain number of days, your immunity builds up, and then you eliminate the virus.

So, like chicken pox, measles and those kinds of viruses, they follow a specific course and last for a while. When patients would come back, I would notice that it was always on the eighth day, exactly one week after the onset of symptoms, I would think, I'm dealing with a virus that has this lifespan and then exactly one day later it starts doing something else. There's a new symptom that presents itself at that point. It doesn't affect all patients, but only a very small sample of patients.

I was seeing what was being reported from Italy: some patients would come to me with mild shortness of breath on day eight, others with more moderate shortness of breath, and others very severe. Hcq was part of my care package. I reserved it for patients who had what I thought was a higher viral load in the early days. So I would give Hcq to people who had severe pain, aches and fevers and I could see that within a day or two I could bring down the fever and get them on the road to recovery.

All the patients I saw in this first phase showed signs of healing by day five or six. Some after a day or two. The majority, by the fifth or sixth day, had signs of improvement, had regained their appetite, were feeling much better.

However, this had no bearing on what might happen on the eighth day. When I noticed that people were coming back on the eighth day with new symptoms, I informed my community of this strange difference I was observing. So I interviewed every patient who came to see me. I asked for the exact day they noticed that they were not feeling well. I used that day to

I would determine the eighth day and inform them of any new symptoms that occurred on the eighth day so that they could return to see me in time.

Second, I knew from Italy that we were dealing with a disease that responded to steroids. Doctors, we know that we should not use steroids in an infection. They should be used very carefully because they suppress your immunity and prevent you from developing a strong immune response to an infection. If you suppress immunity, you run the risk of letting that infection spread unchecked. So I had to pick a specific time in the disease when it would be appropriate to use steroids.

It was obvious that deterioration was occurring by day eight. So that's when the steroids were appropriate. With patients showing signs of healing before then, I was pretty sure that our immunity was somehow reaching the central nervous system and controlling it.

04:04:05

So I quickly put the patients on steroids when they came back on day eight with shortness of breath. By the third or fourth day on steroids, they all showed good signs of recovery. As a doctor, it's the speed of recovery that tells me something is working. I don't assume that a paracetamol pill worked if your headache takes five days to go away, for example.

The speed of recovery gives me an indication of the effectiveness of my treatment. Both give me an indication of the underlying mechanism of this disease. So if I'm treating the wrong thing, I'm not going to get that speed of cure. Looking at the first four or five patients who had presented with this shortness of breath and were put on steroids, I noticed this difference in onset, which is how quickly the second phase started. I drew on my understanding of the pathology and tried to figure out why we had this variability. The first part of the disease was unrelated to the second. Being severely ill in the first five days had no bearing on whether or not health deteriorated by day eight, because I have seen patients who were severely ill in the first five days recover and have no sequelae.

I've had patients with very mild disease who on the eighth day trigger a very severe disease. So I knew I was dealing with a non-linear disease, which went in phases. The two phases were unrelated. I was dealing with two pathologies. I had to identify the second pathology. I had patients who were diabetic, hypertensive, with a lot of co-morbidities and who had never experienced the second phase of this disease. I had had patients who were perfectly healthy, without comorbidities, who had had the second phase of the disease. So there didn't seem to be any connection with any health predisposition.

So in looking at pathology, you have to try to understand what you're dealing with, look at the facts in front of you and what makes sense. The only thing that made sense to me was that these people, on day eight, had some kind of allergic reaction to something. We had to find out what the allergic reaction was. Most people are not allergic to certain things and have no reaction after a bee sting for example. Others are mildly allergic, others moderately and others severely allergic. So that's the difference in speed of onset and severity.

Of course, if you are allergic to a bee sting, you will feel a slight itch at the sting. After a few days, the allergy will heal spontaneously and seem to go away on its own. However, if you are more moderately allergic, this sting can cause a rash all over your body. If I don't treat it, it will take a long time for that rash to go away, although it will never be life threatening. Then, finally, if you are very allergic to bee stings and I don't treat you within a day or two, you will suffer severe organ damage and end up in intensive care and probably die.

So I thought if I was dealing with this type of condition, a type 1 induced hypersensitivity reaction, then a therapeutic trial was in order. A therapeutic trial is something that every doctor does with almost every patient. When a patient comes to me, I have an idea of a diagnosis. Then I give them medication based on the diagnosis, which is a therapeutic trial. If the medication I give them is beneficial and

He's getting better, so that confirms my diagnosis and I don't have to do anything else. I don't have to give them a test to prove I was right. They are making a full recovery.

So the realization that I was dealing with a type 1 hypersensitivity reaction prompted me to improve and refine the treatment regimen I was using. At that point, it was just Hcq, symptomatic treatment and, of course, a steroid from day 8 on.

The sixth patient who came to see me was a 40-year-old woman who had developed shortness of breath the same day, when, like many others, she was perfectly fine the day before. This was actually her eighth day of illness and her sats had dropped to 80% in one day. The day before, she was fine. Being diabetic, hypertensive and obese, I was a little concerned. I knew I had to give her steroids, but I was dealing with a seriously ill patient. So I figured that if it was an allergic reaction, a few other medications would be relevant and I should add them, test them and monitor the speed of recovery. So the first thing I added to his treatment was promethazine, an older generation antihistamine used to treat severe allergic reactions. It is an essential medication approved by who. Every doctor should have it in their emergency kit.

So when a patient comes to me with a bee sting, there is nothing like a steroid and promethazine. I added a dose of promethazine to his treatment. Cautiously, I gave him a child's dose of 10 milligrams. Normally, 25 milligrams is used in adults three to four times a day. I gave him a 10-milligram tablet and told him to take it three times a day. That was just for one day, the day she came to see me. I asked my team to contact her the next day to review her healing rate and ask if she was seeing any improvement. The next day when we contacted her, she was busy washing dishes and was perfectly fine. The shortness of breath was completely gone. I had given her one dose. I expected a relapse. So I told her to be careful, I expected the shortness of breath to come back if it was an allergy and we had to inhibit that for a while. Sure enough, the very next day she was short of breath again. I gave her the antihistamine again and she recovered quickly.

That's when I realized I was dealing with a serious allergic trigger. With an allergic reaction, certain chemical mediators are released: histamine, leukotrienes, prostaglandins, prostacyclins and platelet-activating factor. To treat an allergic reaction, a high enough dose of steroids is used to turn off this inappropriate immune flow that has been activated. The second thing to do is to eliminate any mediators that have already spread.

This is where you have to act fast. The longer you let it go, the more mediators are present and the more damage is done. To eliminate these mediators, histamine is treated with antihistamines, leukotrienes with montelukast, platelet activation with anticoagulants or aspirin. As for prostaglandins and prostacyclins, these are two types of mediators that are beneficial and therefore do not need to be treated. So I added montelukast and aspirin to my protocol early on. That was my way of treating.

I was aware of the inflammation, the cytokine storm, the thrombotic events that were seen in the patients. However, I was of the opinion that it was a hypersensitivity triggered by some kind of viral debris on day eight and that this hypersensitivity trigger, if left unchecked, would lead to hyperinflammation, as we saw in the hospitals. If this hyper inflammation causing a cytokine storm was not treated appropriately, it would lead to thrombosis and therefore clot formation. That has been my approach to treatment throughout the pandemic.

The first thing I found very strange about this type of treatment was that who recommended isolating patients for 14 days. I found this to be the most disastrous advice you could give someone, especially if there was a severe allergic reaction on day 8 that could not be predicted. I had to tell them about it.

It's like a bee sting: if you get stung and you come to see me on the eighth day, I tell you I can't do anything. You have to wait and see what happens. By the time you realize that you are seriously ill, you will have damage to several of your organs. Then you will go to the hospital, but the doctor at the hospital will not know that you have been stung by a bee. He or she will have no idea

where to start your treatment. He will just try to keep you alive. So I've had remarkable recoveries right from the start. I've had patients come to me with 70% saturations. On the first dose of the treatment, that 70% rate improved to 85% within an hour to an hour and a half.

There is no other medication, other than the antihistamine, that has shown such a speed of recovery. Because I was able to reverse hypoxia so quickly in these patients, I did not need oxygen in my office. I am well aware of the so-called experts and peers who are there to dictate what we should do. That's why I've been a controversial physician all my life. I don't tend to follow the rules. I tend to follow the signs and that is controversial to me. My staff has noticed these remarkable improvements.

04:13:54

They were well aware that the rural population was dying at home and knew the mortality and morbidity associated with the lack of treatment. We were also aware that patients were dying in the hospital. I also knew that Remdesivir was being singled out, that it was toxic, that it was causing kidney failure, heart problems. I saw all these things, as the speakers before me said.

None of my patients had kidney problems, heart problems. On clinical examination of these patients, it was not covid pneumonia, it was not progressive. The patients were perfectly fine the day before. When they came to me short of breath, they were not seriously ill. They were tired. They were short of breath, but they were perfectly fine by far. When I examined them clinically, they didn't have crepitations. They didn't have any of the symptoms that you associate with pneumonia. But they were short of breath.

I felt that I was dealing with a hypersensitivity triggered on day eight in this sample of patients who were allergic to something in this virus. That hypersensitivity was causing allergic pneumonitis, which developed at different rates, depending on the propensity of the patient to be allergic. So I treated it as such. My team advised me to write an article, to send it to other doctors. I suspected from the beginning that we were dealing with a laboratory-made virus

and of course we were told that there was a dangerous coronavirus that was being transmitted to humans. The only thing that changes in a virus that moves from one species to another is its receptor.

Because the spike protein is the receptor for this virus, it was on my radar from the beginning as a possible allergen because it was new. We've been exposed to coronaviruses before this and we've never seen this type of pathological allergy. When you are exposed to a new environment, you may be allergic to something that you have never been exposed to before. So I suspected that the free spike protein was the trigger for these problems on day eight. So I published this article, hoping to inform doctors and patients and use the findings I had made to save lives.

That's when the trouble started. I shared the article with all the hospitals in my area. Before it was published, I made sure that everyone who could have an impact on this pandemic was aware of what I had discovered. Hospitals were using antivirals, I thought that was absolutely illogical. I thought the virus would disappear in five or six days. So I started looking at studies from around the world. There was no study in the world that had managed to do viral culture beyond 7 days.

Yes, the PCR test remained positive for a month in some patients. But that doesn't indicate that a virus is alive. So I was very careful about what to believe. I looked at the data and the culture results. A lot of the results showed a positive culture within the first seven days. That was consistent with what I was seeing: people had a viral infection. After seven days, there were very few, if any, positive culture results in the hospitalized patients. So I knew the virus was gone. That confirmed to me that we were clearly dealing with a distinct pathology 10 days later.

So I wrote this article and I shared it for free with our Minister of Health here in South Africa, with the President of my country, with all the stakeholders I could think of, with all the doctors I knew, but I was very careful. Because I was well aware, with the controversy around the Hcq, with the misinformation around the health measures, the isolation, the PCR tests, the masks, the

I was very cautious about getting involved with government regulators. So I was very careful before I got involved with government regulators. I didn't want my findings to go unnoticed. I thought I would share the article freely with physicians and patients. If I could teach doctors how to treat covid, how to tell patients when to seek help, then I wouldn't need anyone's permission to save lives.

So that's what I did. I sent it to every journal I could think of to see who would be willing to publish it. My wife helped me submit my paper to each journal. The response I got from them, including Nature, was either

"We need the copyright to your work," or **"We only publish articles from our subscribers."** I do not subscribe to all medical journals. So I found it very strange for journals claiming to be repositories of knowledge to sort out their sources.

So I knew immediately that I was dealing with some kind of medical collusion. After all, I had found something that could save us from this pandemic. No one seemed to want to listen to me. I also told my professor and director at the university where I studied in India, as well as my colleagues in that group. I received an immediate response from them. My director immediately wrote to thank me for my work, as did my colleagues. India was informed of my discovery very early in the pandemic. They understood my work on Hcq and the triggering of hypersensitivity.

I had also tried ivermectin. The reason I used ivermectin was because I was dealing with pulmonary hypersensitivity and ivermectin is used to clear eosinophils from the lungs. That was the reason I tried it. It worked. I told my colleagues in India about it. Ivermectin became important in the first wave. So India was the only country that supported me during the first wave of the pandemic. The other countries completely ignored me.

In August of that year, Modern Medicine, an academic journal in South Africa, contacted me to publish my article. I had insisted that it be published in its entirety and unedited, as it contained material that would have been of great

The impact and influence on the pandemic was great. Since we were dealing with a hyper-sensitive reaction, this had serious consequences and implications for the way we handled the pandemic.

First, in the first wave, we saw people over 55 die. Remember, all the deaths in this pandemic are due to the second part of the disease, not the first. The second part is an allergic reaction. So I was of the opinion that people over 55 had already been exposed to a kind of coronavirus very similar to this one and had developed the antibodies to it.

Remember, if you are allergic to something, your first exposure does not make you sick. You have to be sensitized first, so it's your second exposure that creates the problem. So I thought that people over 55 were sensitized. So they had a severe allergic reaction, for those who were allergic. That's why the deaths were in the over-55s. However, the under 55s had been sensitized in the first wave and from the second wave on, I expected them to die, to have this allergic reaction, because they were now sensitized. I expected to see younger people die. That was one of the most serious predictions in the article I wrote.

Second, we had to understand the risk: who was really at risk in this pandemic? Because we had confined the entire planet indiscriminately. Everyone had to stay home. But if we knew who was at risk, then we could have stratified the population more effectively.

To do this, we needed to find that specific IgE [Immunoglobulin E] subtype for the allergen and see who was allergic. This would have indicated the people with the highest risk of developing the second phase and with a higher risk of mortality and morbidity. So my paper covered these different aspects of the pandemic. What made my article very controversial was that I expressed an opinion, saying that if early treatment, as I had seen with my own eyes, could reduce covid mortality and morbidity, that would make a vaxxin against a hastily marketed mutagenic RNA virus totally unnecessary. I think that is the controversy that my article caused.

When we went into the second wave, I needed evidence about day eight. I needed evidence of what was going on. None of the local labs were willing to test patients with covid. You could only get tertiary care if you were hospitalized. So I had to rely on my patients' clinical improvement to adjust their medications and get them well. I was able to do that. So I contacted the local lab and told them I needed help with this work. Once the article was published in *Modern Medicine*, an academic journal, the local lab then offered me their services.

04:23:56

They were willing to give me a research grant to look into this further, but because it is a commercial lab, they did not have the capacity to develop tests for a specific IgE subtype to determine who is most at risk. The same test can tell if you are allergic to milk or wheat. It's not rocket science, you just have to figure out what the allergen is and then see who is allergic to that particular allergen.

I started checking IgE levels and doing blood tests when the second wave came back. In the first wave, another point I should mention is that of all the patients I treated, about 800, I never had a single case of long covid. So I was of the opinion that the mild cases resolved spontaneously, talking about the allergic people who presented on day 8. The moderate cases were not treated.

These are the long covid cases that were there with a moderate allergy not treated on the long term. Of course, these very severe cases needed rapid and aggressive treatment. Otherwise they ended up on a ventilator. Of course, the diagnosis of pulmonary hypersensitivity rather than covid pneumonia can give the ventilator a bad name. It's really the wrong way to treat hypersensitivity pneumonia. So I was of the opinion that the world had misdiagnosed the pandemic as covid pneumonia rather than hypersensitivity pneumonitis. All the mortality and morbidity was in the second part caused by analogy, not because of the virus.

In the second wave, we had the South African variant. Now, just so I agree on the rate later, in the first wave we had

mostly black patients, I didn't have a single Indian patient, not a single colored patient, not a white patient in the first week, they were all black. I assumed it was due to their inability to isolate themselves. They live in a community, very close to each other. I thought that was why I was seeing the disease spread in this community.

However, the second week we had what we call the famous South African variant. Looking at the genetics around this variant, the only thing that had really changed was the spike protein, the mutation caused the change in the spike protein. When we received cases, I had to look again at the symptoms and pathology to understand what was going on.

It was of course very strange that only the spike protein mutated, without anything else changing in the virus. That's not the way mutations happen naturally. So that reinforced my understanding that this was a laboratory-made virus. When you look at genetic manipulation, in addition to engineering a virus, you can also change the mutations that occur every cycle, so you can change the mutagenicity of a virus.

So in the second wave, we had the South African variant with the new spike protein. Symptomatically, we had a more contagious virus. It spread very rapidly in families, in communities, and of course that's related to the change in the spike protein which has a greater affinity for a source.

Of course, the symptomatology changed, I was seeing a lot more gastrointestinal symptoms, I wasn't seeing respiratory symptoms, the patients had a very mild sore throat that would go away in a day, but they had diarrhea, heartburn, reflux, a lot of gastrointestinal symptoms and that told me that the change in the spike protein had given an affinity for the ACE receptors in the gut, again, a change in the spike protein, a change in the affinity for the receptor. Then on day eight it stayed the same. The patients, the subsidiary subset of patients who were deteriorating on day eight, but that deterioration had changed. The patients who were deteriorating on day eight had gastrointestinal symptoms.

So I knew that on the eighth day, it was again an allergic reaction, it didn't start in the lungs as in the first wave, but in the intestines and this progression led to hyper inflammation, clotting and finally to shortness of breath. So I would see shortness of breath again, but not on the eighth day, there was a worsening of the gastrointestinal symptoms, but the shortness of breath would take two or three more days to develop. That's the allergy progressing.

I treated these patients in much the same way, spotting them on the eighth day, treating them quickly and aggressively and all cases resolved. But what caught my attention or confirmed what I thought in the second wave, I suspected that the spike protein was the culprit, because by day eight of the second wave, I was seeing much more severe allergic reactions that required a much more aggressive intervention to curb them. Once again, the speed of recovery was the measure of what I needed to do. The dose of steroids that had worked in the first week took much longer to work in the second wave and had to be increased, because the longer the tap stayed open, the worse the problem became. So in the second wave, I used a much higher dose of steroids, but the rest of my treatment stayed pretty much the same. Of course, this involved the protein spike.

This was in late 2020, during the second wave, when vaccines were going to be distributed around the world. At that point, I made it clear that the primary pathogen of covid was not the coronavirus at all. The coronavirus was a vector. It causes a transient respiratory illness and our immunity is strong enough to deal with it. But once our immunity dealt with the virus, the debris left behind caused an allergic reaction in people sensitive to spike proteins on day eight.

So people who were allergic to the spike protein had this reaction. So the spike protein became the main pathogen of the covid disease, the spike was the reason for all the mortality and morbidity. I had not had a single patient die in the first seven days of this disease. So the spike was now clearly the pathogen. Of course, being a pathogen, it was causing an allergy.

The vaxxins that were being developed at the time, the messenger RNA vaxxins, were all designed to get your body to make the spike protein. Now, the spike protein being the primary pathogen of covid disease, that was playing a dangerous game. We could have chosen many other parts of this virus that were more stable, that could have been used to make a vaxxin. For some reason, we chose the spike protein. So I was hoping that my work would draw attention to the danger of using spike to make a vaxxin.

I brought this to people's attention, but again, I was ignored. So I knew there was another motivation at play. Knowing that, that vaxxins would not be stopped, my research, understanding and efforts focused on the spike protein, without being distracted by the virus, I tried to understand what it was causing in the human body. Remember, when you have a coronavirus infection and you are exposed to the free spike protein on day eight, it is a short dose of spike protein. It will only hurt you if you are allergic to it. But if you're not, your body will eliminate it.

However, if you are given a vaxxin that causes your body to mix the protein, then you will be exposed to the spike protein for an extended period of time. So not only does the spike protein now have allergenic potential, but it will now also have a biological effect on your body.

To put that in perspective, a drug like penicillin, its biological effect on your body is that it is an antibiotic. But in order for it to have that biological effect, you have to take the full course. That said, if I gave every person on this planet a single dose of penicillin, it wouldn't have that biological effect of an antibiotic. But if I gave every person on earth, just one dose of penicillin and deprived them of medical care for 14 days, every person who was severely allergic to penicillin would die of an allergic reaction, which is what happened with the covid infection.

People were denied treatment for a simple allergic reaction. With vaxxin, they are exposed to the spike protein for a prolonged period of time, just as prolonged exposure to penicillin causes an antibiotic biological action. So I needed to understand the effects of prolonged exposure to the spike protein

on the human body. This has been the focus of my research and understanding since the spike protein was first implicated.

04:34:00

In the third wave, the same thing happened again. We found that the patients had symptoms again, the gastroenteritis was gone. So again we had patients with sore throats, the symptoms had changed and of course the spike protein had changed. On the eighth day, the patients were not short of breath, they did not have gastroenteritis. But they had a sudden onset of overwhelming fatigue. I started counseling patients about this symptom on day eight.

We saw that the third wave allergic reaction seemed to affect mostly the vessels. Patients were developing clots, embolisms. That seemed to be the trigger. We seemed to have an allergic reaction again on the eighth day, but focused on the circulatory system.

So again, the same treatment was implemented with the same results. All of the patients who arrived on day eight with overwhelming feelings of fatigue began the treatment protocol for severe allergic reaction. They all improved rapidly. This was all confirmed now that I had access to the last three results by measuring interleukin-6, CRP and D-dimer values.

I could clearly show the exponential increase in these values from day eight onwards in patients who were symptomatic, as well as the return to normal once I had treated them. The return to normal did not take long. All my patients recovered almost completely within a week, regardless of the severity of the symptoms. I've had patients, who came in by ambulance with 40% sats, on oxygen, on IVs. Within a week, I have treated them at home with 98% saturations on room air. The timeless reversal of hypoxia negates the need for supplemental oxygen.

So by the third wave, I realized that the change in the spike protein was changing the system that was affected by the allergy. Of course, I noticed something else unusual. In the second wave, it was mostly patients of

There were no more black patients in the second wave. They were all of Indian origin. Then in the third wave, there were very few black or Indian patients. It was mostly the white population and the Muslim population that were affected by this wave. I thought that was very strange, because I had assumed that the black population was affected in the first wave because of their social situation.

Then I looked at the world around me. I saw that the same thing had happened in America. The first wave affected mostly the African American population, the second wave ravaged India and I had no Indian patients here in South Africa. Then in the third wave, it affected the entire Caucasian population and the entire Muslim population.

So that drew my attention to something much more sinister. I knew I was dealing with a manufactured virus, I assumed it was a laboratory leak. But I also had the idea in the back of my mind that it could have been planned. If you had a virus, different variants that seemed to affect different systems, a propensity for different systems, respiratory for the first variant, gastrointestinal for the second and circulatory for the third, with a predisposition for certain ethnicities. This is a very bad sign. Because if it was planned, then it is a preamble to ethnic cleansing. It's an understanding of how to affect different systems and how to affect different population groups with the mutations made in a virus. so I knew then that I was probably dealing with a biological weapon.

My research all went in that direction. I pushed the researchers to stop looking at the virus and start looking at the spike protein. We had to understand what it was doing, because I knew that Pfizer and its ilk were going to expose the whole world to this biological agent. So we started looking at the long covid, the damage from the vaxxins. With long covid, when I started seeing long covid patients, I started testing IgE levels to try to prove that I was dealing with hypersensitivity. Every one of them had high levels. That confirmed hypersensitivity for me.

Subsequently, Kenneth Day and Marcos Sanchez published an article²⁶ on covid lethality, speculating that the deaths were due to hypersensitivity pneumonia and not covid pneumonia. I proved this clinically. Recently, an article was published in China on steroid use and also on the specific IgE subtype for spike protein, which means I want to look for those who are allergic to spike protein. They found a direct correlation between disease severity and spike-specific IgG levels. This proves conclusively that by day eight, we were dealing with a hypersensitivity trigger.

An uncontrolled allergic reaction caused all the loss and damage. With covid and an understanding of the side effects of vaxxins, researchers have studied the structure of the spike protein and its long-term effects on the human body. We know that it causes endothelial damage and that it will damage your blood vessels. If it damages those blood vessels, it causes clots to form in various parts of the body. People who are predisposed to vessel damage, such as diabetics and people with high blood pressure, are the most likely to have this damage become clinically significant.

The second thing we noticed is that it causes immune mediated damage in the myocardium of the heart. We've seen myocarditis in young children, clots, we've noticed these things with vaxxin. Another finding is that the spike protein in vaxxin has similarities to other pathogenic proteins that we know of, one of which is the one made during HIV, which causes immune suppression. If the spike protein caused immunosuppression, we would expect latent infections such as Epstein Barr or herpes zoster to reappear, as well as cancers in remission. We would expect a decline in immunity over time and people exposed to the spike protein would become more prone to disease. We have seen this with vaxxins. With covid, we have seen vaxxinized people be more prone to develop serious diseases. The makers of vaxxins claim that vaxxins prevent serious illness, but I find it amazing that they can make that claim.

²⁶ Article by Kenneth Day and Marcos Sanchez: [here](#)

04:42:19

They refused to accept my work on the pathogenesis of covid. I think it's because I proved that the spike protein is the primary pathogen. If you accept that the spike protein is the primary pathogen, it shows vaxxins in a very dangerous light.

That said, when you don't recognize what causes serious illness and death, how can you claim that your product can prevent it? So they have absolutely no pathological or pathophysiological evidence of how vaxxin works. We know it's not a vaccine because it doesn't prevent infection or transmission. It exposes you to the spike protein.

Clearly, if you are allergic to it, vaxxin also works as a desensitization. We do desensitization for patients who are allergic to certain allergens. We expose them to low doses of those allergens and then they become more tolerant. So vaxxin gives people who are predisposed to severe disease and death by exposure to the spike protein, which is the allergen, some tolerance for a limited period of time. Once vaxxin stops producing the spike protein, we become intolerant of that protein again and it no longer has the ability to prevent serious disease and death. We have seen this all over the world.

Similarly, the spike protein is a membrane protein. We have seen with the Japanese studies that it circulates throughout the body. Every tissue that is exposed to the spike protein and starts making it will express it on its surface, it will be recognized as foreign. This will trigger a host of autoimmune conditions, which we have also observed.

We have also seen that the spike protein passes through the nucleus of the cell, it inhibits the BRCA protein which is used to repair double stranded DNA breaks. It will therefore have an impact on the ability of DNA to repair itself. This would cause an explosion of cancers. Cells that remain viable after suffering DNA damage are the most likely to become cancerous. All of this is confirmed with the long covid and the adverse side effects of vaxxin that we have seen, the increase in all-cause mortality that we have seen worldwide since vaxxin.

If you look at the trend of this all-cause mortality, it's exactly what we predicted vaxxin would do. We've seen neuropathy, blood clots, myocarditis, emergence of latent infections, re-emergence of cancers, Alzheimer's disease, dementia, neuropathy... We're seeing all of that.

Now when we get to Omicron that started here in South Africa and everyone immediately closed their borders. I thought it was absolutely useless. It was almost a vaxxin that we could use as an attenuated vaxxin.

I also wondered if Omicron, with all the changes observed, was not a new modified vaxxinal virus. Because we suddenly had 30 new mutations in the spike protein. As the previous guests alluded to, this is not natural.

So I had in mind that this might be the Christmas present we all wanted, but that there might be a catch. So I watched Omicron very carefully. The only system that was not affected by the covid infection was the neurological system. But we saw neuropathy among the side effects of vaxxin. So I knew that the spike protein had the potential to damage nerves.

So I looked at Omicron in that light and with Omicron, the neurotoxicity became clearly evident. Many of the patients I saw had neuropathy, burning hands and feet, strange sensations in the body. Migraine-like headaches, pain radiating from the neck, it seemed to affect the C6 and C7 vertebrae, brachial plexus neuropathy. It seemed to affect the T10 and 11 vertebrae, so the diaphragm. Yes.

04:46:59 Dexter L.-J. Ryneveldt

Thank you very much for providing all this information in such an elaborate way. Actually, I'm also looking to see if we still have some witnesses with evidence.

04:47:13 Shankara Chetty

Yes, yes. Actually, I'm done. That was the last one, Omicron, that's where we are.

04:47:17 Dexter L-J. Ryneveldt

Okay, great. But the questions are actually about to conclude as well. The therapeutic trials, that's basically what you were talking about, the treatment modality and the hypersensitivity. Have you covered everything in terms of those three points?

04:47:33 Shankara Chetty

Yes.

04:47:34 Dexter L-J. Ryneveldt

Okay. So, what I want to ask you is that even the jury and the citizens of the world have seen that SARS-CoV-2 is not a death sentence, without a shadow of a doubt, it is treatable and you have very brilliantly outlined your treatment plan. So my question is, what is happening right now around the world, in every country, do you agree with me that the government is practicing medicine on the population and as a result, they are preventing doctors like you from providing proper treatment to save lives? Do you agree with this statement, sir?

04:48:25 Shankara Chetty

I completely agree with this statement. Physicians are not allowed to make the decisions they are trained to make. They are made by people who have no training.

04:48:37 Dexter L-J. Ryneveldt

So yes, we agree that the government needs to step back and trust the physicians. I mean, can you also at the same time tell us what your percentage success rate is?

04:48:54 Shankara Chetty

I myself have physically seen over 10,000 patients. I have not had a single death. I have not hospitalized a single patient. I haven't put one on oxygen. They can afford it in my practice. But four deaths have occurred because of overcautiousness on the part of family members who wanted these patients to be hospitalized. Once these patients were placed in the hospital, the doctors refused to work with me. My treatment was stopped, they were put on a hospital protocol. Those were the only four deaths I had in my practice.

04:49:35 Dexter L-J. Ryneveldt

You have stated that in terms of your plan for patients, the success rate is 100%.

04:49:41 Shankara Chetty

I would say that without a doubt and doctors from all over the world trained with the same protocol have treated with exactly the same success.

04:49:51 Dexter L-J. Ryneveldt

Thank you very much, Doctor.

04:49:55 Reiner Fuellmich

Yes, thank you very much, Shankara. That's the good news at the end of the day, so to speak.

04:50:01 Shankara Chetty

I hope this will shed some light on what's going on around us and the plan ahead, that there's more to it than meets the eye.

04:50:09 Reiner Fuellmich

I agree. Now, since it's very late. Are there any comments that you Mike, or Thomas or, Sonia, would like to add to this? Does this change any of the opinions expressed earlier? Does it confirm what you've established? Dolores, sure. So it seems that...

04:50:48 Mike Yeadon

Yes. I'm just going to say in detail that I think Dr. Chetty illustrated some of the things, I think they're worth saying. I often say this to people, don't be afraid of the virus. It's a medium severity virus, we know now that the lethality ratio of the infection, of the current strain is certainly close to the flu. If it is close to the flu, please, members of the jury, in this case we should not take unreasonable, oppressive, totalitarian measures. Not only is the mortality rate similar to the flu, but it is quite treatable. There are a variety of treatment protocols, early treatments. But what drew me into this game as an experienced research and development professional very early on in the UK was that I noticed that the government and its advisors were lying to us.

In fact, I think I gave a lot of famous interviews where I was presenting covid lies and they were telling us that this virus was much worse than it really is. They would then tell us what we should do and it wasn't

true, like masking, containment, closing borders, closing schools, mass testing. I would just like to point out to people that up until 2019, all countries had a pandemic preparedness plan that did not involve any of these things. The pandemic preparedness plan on the who website and on the UK website just said, if you are symptomatic, stay home and wash your hands more often. Nothing else, nothing else was ever used. Yet, I pointed out to people that in March 2020, every country discarded these simple, proven plans. They all adopted the same oppressive and senseless measures that, to a large extent, continue to this day and are somehow embedded in the world consciousness.

But let me tell you, none of them have been validated. Most of them have been analyzed in 2019 by scientists from who, you can find this study. They test them, they showed that masks have been tested which have no benefit whatsoever on the transmission of respiratory viruses and that school closures, border closures, business closures have not affected transmission either. That's because the only people who are good sources of transmission are symptomatic. When people are symptomatic, they usually stay home and don't circulate.

That's why I'm drawing people's attention to this, because for dozens and dozens of countries to get rid of the plans they've been using for decades all at once and adopt a set of nonsensical measures that don't work and were proven the year before not to work, the only conceivable reason for that, I'm afraid, is a supranational plan to do so.

Don't be afraid of the virus that is treatable, be afraid of the government measures that are evidence and are all passed at the same time. So these are lies. We are not going to talk about it today.

But the second risk that should scare you is not the virus, it's the vaxxins.

I fear that the third one that frightens me as much as the other two is our general passivity, as citizens of free countries. We accept these measures

when we shouldn't. I'm glad to see people, in Canada in particular, saying they've had enough, and rightly so, until we all show that we've had enough.

The people who created the global lies I mentioned at the beginning will continue to push. If you just wait for it to pass, it will never pass.

Very briefly, I gave some excellent presentations earlier on PCR. I really want to make a couple of points. The first is that there are many, many respiratory viruses, people can have a variety of symptoms that are often quite similar. So people say to me, if these covid tests, the PCR tests are not reliable, how come my grandfather died? I tell them they were symptomatic, almost certainly from something else. You can have a false positive in people who are not symptomatic at all and certainly not sick with this particular virus. You have to be aware that the normal respiratory viral infections that we've experienced in our lifetime still exist. So inserting that inaccurate PCR test, when it is positive, does not suddenly mean you have contracted covid, one can probably still have influenza, rhinoviruses, DNA viruses and coronaviruses, for that matter.

Then, to continue very briefly on the topic of bad mass testing, I happen to specialize in the British system, because that's where I lived. I struggled over and over again and I couldn't get the people involved in mass testing to admit that all tests had a false positive rate.

In hospital laboratories, you always want to know the false positive rate, the operational false positive rates, you have to know them, in the context in which you are doing it. Some of the big laboratories in the UK that do a very large number of tests, hundreds of thousands of tests a day, never admitted that a fraction of those positive tests were false. They would report all the positive results as the right number. That's how many cases there were. That means that if you have a 1% false positive rate and you tested a million people, you would get 10,000 false positives, but in reality, the net number of false positives admitted is zero.

Among the poor technique of the British laboratory and the mass laboratories, they will also recruit and this must be true all over the world. To perform these tests, they recruited people who were not properly trained as diagnosticians. They usually had a science degree and had never worked in a laboratory; they were taught how to use a pipette, as Professor Kämmerer said, with the wrong pipetting technique, you can easily contaminate your work area, even if there were a small number of true positives in these clinical samples.

Bad technique will contaminate your work area. I think that's why they deliberately hired people who didn't really know what they were doing, who had to be shown what to do, knowing that the wrong technique would increase the number of false positives.

A friend of mine actually worked in one of these labs, a very experienced PCR scientist. I asked him, "Based on the techniques you have observed, what do you think the false positive rate would be for a single bad technique?" He looked at me and said:

"Any number, 0.1, 1, 15... I don't know. It's that bad. You should totally ignore the statistics that come out of that lab." It was the biggest lab in England at the time. I probably don't have anything else to say, but I hope that if people have listened to everything I've said in the past and relate it to today, they'll realize that we're being lied to, that it's being imposed, it's being inappropriate, it's hurting the economy or society.

That we should be afraid of that and not of the virus which is quite treatable, because if we don't end up peacefully, but en masse, rising up and rejecting this oppressive regime, I don't think we will ever get our freedom back.

04:58:43 Reiner Fuellmich

Thank you. Thanks to you, Mike. I think it will have a big impact on a lot of people. Because it's a jury of the people, we think it will have an impact in the sense that they will start to rise up, because it seems to be the only solution to what we're facing right now, after everything I heard today, we must appeal to the people, the people's jury, to stop this.

Now, as it is already very late, I would like to ask you, Thomas, to save your conclusion for after the vaccination session, because that is another important thing. After that, I think it will make even more sense than it did tonight to summarize what we are witnessing, based on what we have heard tonight in particular. Is that okay with you, Thomas?

04:59:42 Thomas Binder



Yes, I will be there.

04:59:44 Reiner Fuellmich

Thank you very much. Now, unless there's something else we need to ask our experts, I suggest we adjourn this hearing until next Saturday, when we continue with the vaccinations. Is that okay with everyone?

05:00:08 Dexter Ryneveldt

That's fine by me, thank you very much.

05:00:11 Reiner Fuellmich

Thank you very much. Thank you all for joining us and contributing to this effort to stop the pandemic and to make sure that all those responsible for this pandemic are brought to justice. Thank you so much.

Various

participants Thank you. Thank you very much. Thank you very much. Thank you very much. Thank you. Thanks to you.

Reiner Fuellmich

Thank you. We will see you all next Saturday. Thank you, Dolores.

Dolores Cahill

Thank you.

Reiner Fuellmich

Goodbye.