Contents

Executive Summary

Scope and Expert Opinion

Based on my review of primary regulatory documents, leaked Pfizer's Chemistry-Manufacturing-Control (CMC) files, relevant legislation in the U.S. and EU, and other publicly available documentation, it is my expert opinion that the Covid-19 mRNA injections were deployed under military 'medical-countermeasure' rules that bypassed standard pharmaceutical safeguards, rendering them legally and functionally indistinguishable from a potential bio-chemical weapon.

1. The Dual-Use Nature of mRNA/DNA Platforms

Established "dual-use" designation – Since at least 1997, U.S. defense advisors (JASON group) and later the U.S. National Academies have listed gene-therapy platforms, including lipid-nanoparticle (LNP) mRNA systems utilized as vaccines, as technologies that can be weaponized (e.g., by delivering toxins, oncogenes, or immune-suppressive micro-RNAs).

Ease of weaponization – The same attributes that make mRNA attractive for therapy (cell entry, high expression) make it attractive for hostile use; even fragmented RNA (shRNA, miRNA) can dysregulate host gene expression without coding for proteins.

2. "Bait and Switch": Consumers Worldwide Were Misled About the Legal Status of Covid-19 Products as Countermeasures – Medicines Used for Non-Medicinal Purposes, i.e. as Weapons.

Safeguard normally in force	How it was removed for Covid-19 mRNA products
Investigational New Drug Regulations/ IRB oversight	Products formerly developed as gene therapies were reclassified as "vaccines/countermeasures" based solely on declared intended use; safety-pharmacology, carcinogenicity, and mutagenicity packages were waived; emergency declarations and non-investigational status of countermeasures removed enforceability of all pharmaceutical regulations.
Current Good Manufacturing Practice (cGMP) inspections	PREP Act (U.S.) and EU Emergency Support Regulation 2016/369 (as amended 2020) allow the Secretary/Commission to waive cGMP entirely during a declared CBRN emergency.
Import-export regulations and manufacturer liability	Waived via EU supply agreements with pharmaceutical companies. Thorough indemnification of pharmas for any injury or death resulting from unsafe product, except in case of narrowly defined "willful misconduct" – parallels the US PREP Act in EU contract.
Independent batch testing in the EU	FDA-EMA Mutual Recognition Agreement (fully operational July 2019) lets EU Qualified Persons accept U.S. batch data sight-unseen.
Facility inspections every two years (21 CFR 600.21)	April 2019 FDA rule deleted inspection frequency and penalties; Covid travel bans then halted inspections outright.

Documentary Evidence of Non-Compliance with Good Manufacturing Practices and Product Adulteration (Potential Weaponization)

EMA leaks (Nov 2020) – ~1,000 pages show major objections: (i) non-existent cGMP packages; (ii) ≤50 % intact mRNA (specification quietly lowered from ≥70 %); (iii) missing analytical-method validation; (iv) unreviewed manufacturing changes.

Rentschler 2022 FDA Form 483 – Post-deployment inspection of Pfizer's EU contractor documented cGMP violations, confirming earlier warnings. No enforcement actions taken.

Legal shield – 21USC§360bbb-3a(c) explicitly states that even if a product would be "adulterated or misbranded," it cannot be treated as such once designated an EUA countermeasure. Same regulation- and liability-free conditions were implemented in EU via predatory purchasing contracts.

3. Evidence that Covid Response Was Not a Public Health Response, but a Classified Military Operation Utilizing Medicines as Weapons

All Covid-19 countermeasures, including bio-chemical substances marketed as "safe and effective vaccines", were ordered by the DoD as a "large scale manufacturing demonstration" via Other Transactions Authority contracts. According to Operation Warp Speed/HHS Assistant Secretary for Preparedness and Response (ASPR) reports, the US Department of Defense (DoD) ordered and oversaw the development, manufacture, and distribution of all countermeasures.

The Covid Dossier (Exhibit 1) is a compilation of the evidence from many countries and regions of the world demonstrating that:

Covid was not a public health event, although it was presented as such to the world's population. It was a global operation, coordinated through public-private intelligence and military alliances and invoking laws designed for CBRN (chemical, biological, radiological, nuclear) weapons attacks.

The Dossier contains information regarding the military/intelligence coordination of the Covid biodefense response in the U.S., U.K., Australia, Canada, the Netherlands, Germany, Italy, and many more locations. For as many countries as possible, the Dossier lists the military/intelligence agencies in charge of their country's Covid response; dates on which emergency declarations were made in each country; military/intelligence-related agencies and bodies in charge of censorship/propaganda; and top people with military/intelligence

jobs who were known or reported to hold leadership positions in the response. The Dossier also lists connections to global governing bodies, including the EU and UN/WHO, through which the response was coordinated, and provides a listing of the military/intelligence/biodefense alliances that provided multinational frameworks for responding to a bioterror/bioweapons attack.

4. Covid-19 mRNA Injections are Indistinguishable from Bio-Chemical Weapons.

- **Covid-19 mRNA injections meet the statutory definition of "biological product" used as a countermeasure** for non-medicinal unapproved purposes, simultaneously exempt from drug-safety law and manufacturers' liability.
- **Potential qualification as a "biological weapon"** under 18 U.S.C. § 175 et seq. (possession or delivery of any agent "not reasonably justified by a prophylactic or protective purpose") given the evidence of systematic adulteration and misbranding.
- **Foreseeability of harm** – Regulatory guidance for gene therapies and extensive scientific literature lists insertional mutagenesis, autoimmunity, and persistent expression as known risks; these were neither tested nor disclosed. Lack of cGMP compliance, evidence of adulteration and contamination, and large gaps in manufacturing process characterization at the time of the global launch demonstrate depraved indifference of the state and health authorities, intentionally putting millions of people at risk of death and severe injury.
- **Vicarious liability** – Defendants knew or should have known that no lawful pharmaceutical authorization existed for Covid-19 mRNA injections, that millions of people were exposed to foreseeable harm. Yet, they proceeded to lie to the public and implement coercive measures to increase the uptake of these shots.

Conclusions

- **Scientific** – The intrinsic dual-use danger of LNP-mRNA platforms demands the highest manufacturing and regulatory scrutiny; the opposite has occurred.
- **Regulatory** – Through a concerted global strategy (PREP Act, countermeasures, EU emergency regulations, MRAs), customary drug-safety law was suspended, enabling unchecked adulteration.

- **Forensic** – Leaked EMA files and later FDA inspection findings document objective manufacturing failures consistent with weaponization pathways described in U.S. biodefence literature.
- **Legal** – Under U.S. and international law, a product delivered under the color of medicine but meeting the functional test of a bio-chemical weapon triggers potential criminal liability for all actors in the supply chain.

Prepared for counsel as foundational narrative; detailed citations, exhibits, and curriculum vitae available on request.

1. The Dual Use Nature of mRNA/DNA Platforms

Biological and bio-chemical weapons are both naturally derived and man-made materials designed to induce disease through the introduction of toxins and microorganisms. The method through which a bio-chemical weapon is deployed depends on the agent itself, its preparation, its durability, and the route of administration. Attackers may disperse these agents through aerosols or food and water supplies[1]. In addition to externally dispersing such agents, introduction of bio-chemical agents via other means is described in literature dealing with bio-chemical weapons and terrorism. Specifically, use in consumer products, medicines, or even pet food and other products has been described as possible vectors of attack.[2]

In politics, diplomacy, and export control "dual use" refers to technology that can be used for both peaceful and military aims. mRNA/DNA technology, including embodiments as injectable drugs or vaccine products, has long been identified as a dual-use, potentially weaponizable technology[3],[4],[5]. The "dual use dilemma" was first noted with the discovery of the process for synthesizing and mass-producing ammonia, which revolutionized agriculture with modern fertilizers but also led to the creation of chemical weapons during World War I. The dilemma has long been recognized in chemistry and physics, leading to international conventions and treaties, including the Chemical Weapons Convention and the Treaty on the Non-Proliferation of Nuclear Weapons.

In 1997 the JASON group[6], an advisory committee to the US President on scientific matters pertaining to war technologies identified potential for genetically engineered pathogens in the following six groups:

- Binary biological weapons
- Designer genes
- **Gene therapy as a weapon**

[1] https://en.m.wikipedia.org/wiki/List_of_U.S._biological_weapons_topics
[2] https://www.ncbi.nlm.nih.gov/books/NBK535870/
[3] https://sites.dartmouth.edu/dujs/2013/03/10/genetically-engineered-bioweapons-a-new-breed-of-weapons-for-modern-warfare/
[4] https://www.ncbi.nlm.nih.gov/books/NBK535887/
[5] https://irp.fas.org/threat/cbw/nextgen.pdf
[6] https://isgp-studies.com/jason-group-national-security-science

- Stealth viruses
- Host swapping diseases
- Designer diseases

To date, both awareness and control systems for detecting and preventing potential subversion and misuse remain woefully inadequate. Despite the obvious threat introduced by advanced synthetic biology products, if misused as weapons, little to no control measures exist today beyond a handful of guidance documents for scientists and research institutions. These self-reporting requirements are largely ignored, and as evidenced by the NIH grants to Wuhan Institute of Virology, research that is likely to raise objections is offshored.

1.1. Methods for weaponization of mRNA/DNA technologies and products:

In principle, any drug or injectable medical product can be weaponized, i.e., used as a poison instead of medicine. This is because the consumer or healthcare provider cannot directly assess the product and its ingredients and must rely on regulators enforcing pharmaceutical law/regulations to ensure compliance and safety as the product travels through the manufacturing supply chain and distribution. Pharmaceutical substances contain potentially dangerous chemicals, and typically, the difference between a drug and a poison/lethal weapon is the precise dosage, which the pharmaceutical regulations are designed to keep tightly controlled. As an example, consider opioids for legitimate use - pain management vs. their potential for lethal overdose. A mislabeled opioid product with an incorrect specification for dosage would be an example of a weaponized medicine.

According to the literature on bioweapons, weaponization of gene therapy/mRNA technology or another DNA/RNA platform technology can be accomplished in numerous ways. Synthetic mRNA is a large molecule (~3000+ base pairs). It is unstable and fragile, breaking into smaller segments during manufacture, storage, and transportation. It has been demonstrated that segments of RNA, such as short hairpin RNAs (shRNAs) or micro RNAs (miRNAs), can be exploited as weapons, and do not need to be precisely made, nor do they need to "code" for anything specific.

The following paragraph is found in Chapter 6 of the 2018 edition of the textbook **"Biodefense in the Age of Synthetic Biology"**[7]:

[7] https://www.ncbi.nlm.nih.gov/books/NBK535870/

> *"Small RNAs are an example of functional genetic information that could be horizontally transferred. Small RNAs, although not a genome modification per se, are important because they may prove capable of modifying gene expression and bringing about phenotypic change. The large number of small interfering RNA (siRNA), short hairpin RNA (shRNA), micro RNA (miRNA) (Zhang et al., 2007; Huang et al., 2008), and other small-RNA library studies in a variety of species and cells from different species, including human, provides a potential roadmap of what sequences may lead to what disease states or to modulation of defenses against disease. {…}*
>
> *One reason that RNA delivery is potentially a viable biological threat is that even a small initial skew in gene expression (such as the changes in gene expression normally caused by miRNAs) could greatly alter the probability of an initial cellular alteration. Even small amounts of a targeted RNA would not modify the genome per se, but might allow or encourage cells to begin the process of self-transformation to tumors, as evidenced by the fact that a large number of pro-oncogenic miRNAs have already been discovered (O'Bryan et al., 2017). In addition to RNAs produced by viruses, bacteria produce numerous small regulatory RNAs; introduction of these into the endogenous microbiome could lead to dysbiosis. Larger mRNAs can also be delivered via liposomes and nanoparticles or by RNA replication strategies being developed for vaccine production (see Chapter 8, Rapid Development of Self-Amplifying mRNA Vaccines); these methods could potentially be used to express deleterious cargo such as toxins or oncogenes, similar to threats related to DNA vectors."*

Clearly, both small and larger RNA sequences can be introduced into the human body for nefarious purposes, including the promotion of cancer, dysbiosis, immune system suppression, and organ damage. This can be accomplished with and without incorporation of the weaponized RNA code into the host genome and by RNA sequences that do not need to encode any protein.

Furthermore, the same textbook states that vaccine platforms are recognized a potential vehicle for weaponization:

> **"*Larger mRNAs can also be delivered via liposomes and nanoparticles or by RNA replication strategies being developed for vaccine production* [referring to self-amplifying mRNA vaccine platform] ...*these methods could potentially be used to express deleterious cargo such as toxins or oncogenes.*"**

Therefore, the mRNA/DNA products marketed as “vaccines” are, in principle, open to adulteration, whether intentional or due to a lack of proper manufacturing process controls and purity characterization. Technical capabilities that are required to reliably characterize and control these substances at the point of manufacture, in distribution, and administration, are nascent today and had not been routinely established by the manufacturers nor by the regulators in 2020-2021 when these substances were mass deployed worldwide.

2. “Bait and Switch”: Consumers Worldwide Were Misled About the Legal Status of Covid-19 Products as Countermeasures – Medicines Used for Non-Medicinal Purposes, i.e. as Weapons.

2.1. Summary of legal requirements under US and EU law for marketing pharmaceuticals as “safe and effective”.

In both the United States and the European Union, pharmaceutical regulations are designed to ensure that medicines are safe, effective, and of high quality before they reach the public. While there are many similarities between the U.S. and EU systems—especially in their reliance on scientific evidence—each has its own regulatory bodies and procedures for evaluating drugs and approving claims about safety and efficacy.

In the United States, the Food and Drug Administration (FDA), through its Center for Drug Evaluation and Research (CDER) and the Center for Biologics Evaluation and Research (CBER), is the primary authority responsible for approving pharmaceutical products. Before a new drug can be marketed, the sponsor must submit a New Drug Application (NDA) or Biologics License Application (BLA) that includes robust data from preclinical studies and clinical trials demonstrating the product's safety and efficacy for its intended use. The clinical trial process requires investigational status of the product under Investigational Drug Exemption and follows a structured progression through Phases I–III, with formal oversight by an independent Investigational Review Board (IRB) ensuring protection of human subjects and execution of valid informed consent procedures. Only after this thorough process—culminating in a favorable risk-benefit assessment—can safety and efficacy claims be made. The FDA also reviews the manufacturer’s compliance with current Good Manufacturing and Clinical Practices (cGxP), assuring the product’s fidelity to

the precise quantities of ingredients and labeling to ensure that all claims are substantiated and not misleading.

In the European Union, the regulatory landscape is governed by the European Medicines Agency (EMA) for centralized approvals, while national competent authorities (such as Germany's BfArM, France's ANSM or CBG/MEB in the Netherlands) handle decentralized or mutual recognition procedures. For most innovative drugs, especially those involving biotechnology or affecting multiple EU member states, the centralized procedure is mandatory. This involves submitting a Marketing Authorization Application (MAA), which must contain comprehensive data similar to what the FDA requires, including clinical and non-clinical findings. Safety and efficacy claims are scrutinized by the EMA's Committee for Medicinal Products for Human Use (CHMP) before an opinion is issued and authorization is granted by the European Commission.

In both jurisdictions, post-marketing surveillance is essential. Companies are required to conduct pharmacovigilance activities and may be asked to perform additional studies (Phase IV trials) to monitor long-term safety and effectiveness. Any promotional material or advertising must strictly reflect the approved labeling and claims; unsubstantiated or misleading claims can lead to regulatory action. Additionally, there are stringent requirements for transparency, including public disclosure of clinical trial data.

While the U.S. and EU systems have distinct regulatory structures and processes, there is significant harmonization through international initiatives, such as the International Council for Harmonization of Technical Requirements for Pharmaceuticals for Human Use (ICH) and Mutual Recognition Agreements (discussed further in this testimony).

The pharmaceutical regulator in the Netherlands is the Medicines Evaluation Board (CBG/MEB). The CBG is responsible for assessing and monitoring the safety, efficacy, and quality of human and veterinary medicines in the Netherlands. It evaluates marketing authorization applications (MAAs) for new drugs and ensures that product information and claims are accurate, evidence-based, and compliant with regulatory requirements. The agency also participates in the European regulatory network, working closely with the European Medicines Agency (EMA) and other national authorities in the EU.

CBG's responsibilities include:

- Granting national marketing authorizations for medicines in the Netherlands.
- Participating in decentralized and mutual recognition procedures for drug approvals within the EU.
- Contributing to centralized EMA procedures, including involvement in scientific assessments through experts on committees like the CHMP.

- Monitoring pharmacovigilance and ensuring that medicines remain safe and effective post-approval.

The CBG operates under the Dutch Ministry of Health, Welfare and Sport and collaborates with the Health and Youth Care Inspectorate (IGJ), which enforces compliance with pharmaceutical laws and inspects manufacturers and healthcare providers.

2.2. Mutual Recognition Agreements between US FDA and EU EMA:

The actions of the US FDA are directly related to those of the EMA due to the Mutual Recognition Agreements that national food and drug regulators signed in the years leading up to 2020. These agreements are contracts that allow one regulator to accept, without further review, what another regulator in a different country or region has presumably examined and approved. This legal framework was created to promote harmonization and efficiency. However, during the orchestrated global COVID event, this structure was exploited by the perpetrators for malicious purposes, enabling a false facade of regulation by the FDA and allowing other regulatory agencies to simply accept FDA's statements without conducting mandatory independent reviews of the data.

Here is one MRA as an example, between the FDA and EMA.[8] This US-EU MRA was entered into force on 1 November 2017 for human medicines and 30 May 2023 for veterinary products. It became fully operational for human medicines as of 11 July 2019:

> *"qualified persons in the EU Member States **do not need to batch test** human medicines covered by the MRA, provided that they have verified that these controls have been carried out in the United States for products manufactured in and imported from the United States."*

Most, if not all, other national food and drug regulatory systems now rely on the FDA regulations and their compliance/cGMP monitoring, without conducting any of their own reviews, regulation, batch testing, or other cGMP procedures.

[8] https://www.ema.europa.eu/en/human-regulatory-overview/research-and-development/compliance-research-and-development/good-manufacturing-practice/mutual-recognition-agreements-mra

2.3. Covid-19 mRNA injections were deployed as Medical Countermeasures, while being falsely promoted to the public as normally regulated pharmaceutical products.

While the Covid-19 mRNA injections were broadly marketed as "safe and effective vaccines," all Covid products and protocols entered the global markets without following the usual pharmaceutical manufacturing and distribution compliance standards for regulated drugs, due to their legal status as "countermeasures under a public health emergency." In other words, they are considered non-medicinal. This status is managed by a completely different, militarized governance framework and a separate set of laws, originally designed to respond to time- and location-specific attacks involving Chemical, Biological, Radiological, and Nuclear (CBRN) weapons. The defendants were aware of this. The public has not been informed of the true legal status of these injections or their permitted use.

US FDA provides the following definition of medical countermeasures:

> "Medical countermeasures (MCMs) are FDA-regulated products such as biologics, drugs, and devices that may be used in public health emergencies to diagnose, prevent, or treat diseases or conditions caused by CBRN threats or emerging infectious diseases."[9]

While the statement on the FDA website claims that MCMs are "FDA-regulated", this statement is misleading because it omits the fact that MCMs are not regulated like typical pharmaceutical products, as expected by consumers and healthcare providers.

Under U.S. federal law and EU law, for medicinal uses of medicinal products, FDA/EMA must formally approve any new investigational drug before a manufacturer can introduce it into interstate commerce.

This process requires the manufacturer to submit an Investigational New Drug application and obtain approval from the FDA/EMA for its use in regulated clinical research (trials). This regulated process is therefore called an "investigational" regulatory pathway. It mandates that a manufacturer conduct regulated clinical research trials, obtain Institutional Review Board's (IRB) approval for clinical trial protocols, ensure independent safety monitoring, and secure informed consent from clinical trial volunteers. Additionally, the manufacture of drugs and biologics under investigational status must strictly comply with current Good Manufacturing Practices (cGMP) and broader cGxP regulations.

[9] https://www.fda.gov/emergency-preparedness-and-response/about-mcmi/medical-countermeasures

CMs can include both previously FDA/EMA approved medical products (e.g. opioids, ventilators, antibiotics, masks, swabs, etc), and new unapproved products (e.g. mRNA/DNA injections). However, the key distinction between MCMs and normally regulated medicines is the **statutory non-investigational categorization of MCMs**. Specifically, in US law, use of Emergency Use Authorized (EUA) covered countermeasures under a declared Public Health Emergency **cannot constitute a clinical investigation** (21 USC 360bbb-3(k)), therefore countermeasures cannot be tested for safety or efficacy in accordance with US law (21 CFR 312 and 21 CFR 601), nor can compliance with current Good Manufacturing Practices (cGMP) or Good Distribution Practices (GxP in general) be enforced by the FDA.

This re-categorization of previously approved and unapproved medical products deploys MCMs for "unapproved uses". Together with the non-investigational status, this re-categorization precludes the use of MCMs as medicines, and, by removing consumer safeguards, leaves MCMs entirely open to weaponization.

The laws that enable the removal of all consumer safeguards and manufacturers' liability include the PREP Act (2005)[10], Sec 564 of the Food, Drug and Cosmetics Act (FDCA)[11] in the US and a set of EU provisions for "pandemic preparedness" and "medical countermeasures" (discussed in Section 2.5). The PREP Act and corresponding EU provisions for countermeasures waive enforcement of pharmaceutical law for products declared countermeasures under an existing emergency declaration and provide liability immunity to covered persons (except narrowly defined willful misconduct). The PREP Act law is subject to legal controversy, and a proposal for its repeal is currently pending in the US Congress[12].

Due to the declared non-investigational status of MCMs, while the manufacturers may choose and the FDA/EMA may ask to undertake some of the activities typically expected from an investigational clinical trial and manufacturing validation process, none of the typical pharmaceutical regulatory standards are applicable in an enforceable way. In general, any activities claimed as regulated investigational tests and processes for medical countermeasures should be deemed deceptive practices designed to manufacture a veneer of consumer protection where none exists, nor intended to exist.

FDA has the discretion to issue an EUA if, in the sole opinion of the HHS secretary, the product "may be effective" in treating the relevant disease or condition[13]. No other criteria

[10] https://aspr.hhs.gov/legal/PREPact/pages/default.aspx
[11] https://www.fda.gov/regulatory-information/federal-food-drug-and-cosmetic-act-fdc-act/fdc-act-chapter-v-drugs-and-devices
[12] https://massie.house.gov/news/documentsingle.aspx?DocumentID=395737
13 21 U.S.C. § 360bbb-3(c)(2)(A)

for approval apply in an enforceable way. There is no strict legal requirement to conduct clinical trials prior to authorization and no lawful human subject-protected clinical trials are possible due to statutory "non-investigational" status of countermeasures.

FDA will approve EUA countermeasures on incomplete/non-existent information based on an opinion of the HHS Secretary that "known and potential benefit of the product" may "outweigh the known and potential risks"[14] and considers it unlikely that "comprehensive effectiveness data" will be available before an EUA grant. In contrast, for an investigational drug (under normal regulatory approval process) the FDA "shall" deny approval if the applicant "do[es] not show that such drug is safe."[15]

There is no strict requirement for an Investigational New Drug exemption (IND), nor institutional review board (IRB) approval of a clinical trial protocol and informed consent forms. Therefore, the EUA status of a medical countermeasure precludes collection of the regulated clinical trial data and thus precludes reliable, valid scientific knowledge of risks and benefits associated with the EUA Countermeasure while it remains non-investigational.

Furthermore, there are no required standards for quality-control in manufacturing; no inspections of manufacturing procedures; no lot-release testing and no prohibition on wide variability among lots; no prohibition on adulteration; and no required compliance with Current Good Manufacturing Practices. EUA products, even though unregulated and non-standardized, "shall not be deemed adulterated or misbranded."[16]

The EUA pathway for medical countermeasures is used only when the United States Secretary of Health and Human Services or Minister of Health in EU Member State(s) declares an emergency[17]. In the United States, the PREP Act emergency declarations for covid have been extended 12 times to last until end of 2029[18], preventing enforceable regulations and extending the liability shield for deaths and injuries caused by the countermeasures.

In the Netherlands, the government formally classified COVID-19 as a Category A infectious disease under its national Public Health Act (Wet publieke gezondheid) on January 27, 2020. This classification — announced by Health Minister Bruno Bruins — activated a range of emergency measures. This step is effectively the national declaration

14 21 U.S.C. § 360bbb3(c)(2)(B)
15 21 U.S.C. § 355(d)(2); See also 42 U.S.C. § 262(a)(2)(RB) (biologic approved only if it actually "is . . . safe").
16 21 USC 360bbb-3a(c).
17 21 U.S.C. § 360bbb-3(a)(1), (b).
18 https://public-inspection.federalregister.gov/2024-29108.pdf

of a public health emergency, empowering authorities under the Public Health Act. These powers enabled nationwide responses—such as lockdowns—without declaring a formal emergency status. The Netherlands never invoked a formal national "public health emergency" declaration; therefore, there's no emergency status to formally end.

In summary, in both US and EU, legal status of a product, service, procedure or action designated as "countermeasure" is equivalent to that of a potential weapon. Medicinal products or potential medicinal products (unapproved drugs), when designated as "countermeasures" under real or fabricated emergency, are legally permitted to be used for non-medicinal purposes. The non-medicinal purposes include use as a weapon or an illegal human experiment. Misrepresentations of safety, efficacy, or contents of EUA products are allowed by the applicable law. The defendants knew or should have known this, yet they concealed this from the public and propagated monstrous lies and coercion to achieve the maximum scope of deployment of these pretend medicines, which are in fact bio-chemical weapons.

2.4. Legal Provisions for Countermeasures in EU.

While the relevant laws between US and EU are not identical, there are several EU provisions corresponding with the provisions in US in relation to "medical countermeasures".

In the European Union (EU), medical countermeasures (MCMs) are regulated primarily through a framework of EU pharmaceutical, medical device, and public health laws, especially as they relate to preparedness for serious cross-border health threats. While the EU doesn't use the term "medical countermeasure" as explicitly as the U.S. FDA does, the legal infrastructure supports the development, authorization, stockpiling, and deployment of such products in public health emergencies.

Key EU Laws and Regulations Governing Medical Countermeasures:

1. Regulation (EU) 2022/2371 "On serious cross-border threats to health"

- Adopted: 2022
- Establishes:
    - A Health Crisis and Pandemic Preparedness Plan
    - EU-level coordination of medical countermeasures

- The Health Emergency Preparedness and Response Authority (HERA)

2. Regulation (EU) 2022/123 "On a reinforced role for the European Medicines Agency (EMA)"

- Adopted: January 2022
- Purpose: Expands EMA's role in monitoring, coordinating, and facilitating the development and availability of medicines and medical devices during public health emergencies.
- Creates the Medicines Shortages Steering Group (MSSG) and Emergency Task Force (ETF).
- Legal basis for emergency use authorizations of MCMs in the EU.
- Legal reference:
  Regulation (EU) 2022/123

3. Joint Procurement Agreement (JPA) under Article 5 of Decision 1082/2013/EU

- Enables EU Member States to jointly procure **vaccines**, **antivirals**, **PPE**, and other MCMs.
- Still operational as a **coordinated procurement tool** post-COVID under HERA.

4. In 2016 the EU enacted a Regulation (EU) 2016/369, https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32016R0369&from=EN , which provides for emergency support within the European Union. Emergency support *"may be awarded through specific measures appropriate to the economic situation in the event of an ongoing or potential natural or man-made disaster*." (Art. 1 (1)) Based on a decision of the Council according to Art. 2 of Regulation 2016/369/EU "*to activate the emergency support*" under this Regulation, after proposal submitted by the EU Commission, the stage has been set for financing "*specific measures*" against threat emerging from "*human made or natural disasters*".

On 14 April 2020 this Regulation was amended by Regulation (EU) 2020/521[19] with **retroactive effect as of 1 February 2020**, in order to extend the application of this Regulation to emergency support during Covid-19 crisis.

In its Art. 1 the "*emergency support under Council Regulation (EU) 2016/369*" is activated.

This Regulation provides for an Annex of Regulation 2016/369/EU in which it enumerates the eligible measures which may be funded in case of emergency situations. It says that the **enumeration is not exhaustive,** and it reads:

> *"The following actions may **be financed in case of pandemics with large-scale effect**:*
>
> *(a) temporary reinforcement of the medical workforce, exchange of medical professionals, hosting foreign patients or other type of mutual support;*
>
> *(b) deployment of temporary healthcare facilities and temporary extension of existing healthcare facilities to relieve pressure on existing structures and increase overall healthcare capacity;*
>
> *(c) activities to support the administration of large-scale application of medical tests and prepare the necessary scientific testing strategies and protocols;*
>
> *(d) setting up temporary **quarantine facilities** and other appropriate measures **at the Union borders**;*
>
> ***(e) development, production or purchase and distribution of medical products;***
>
> ***(f) increases and conversions of production capacities for medical products as referred to in point (e) to address supply shortages;***
>
> *(g) maintenance of the stock of medical products as referred to in point (e) and their disposal;*
>
> ***(h) actions to support the necessary steps to obtain approval for the use of the medical products as referred to in point (e) if required;***
>
> *(i) actions to develop appropriate methods to track the development of the pandemic and the results of measures implemented to address it;*

[19] https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32020R0521&from=EN

(j) organisation of ad-hoc clinical trials of potential therapies or diagnostics according to trial standards agreed at Union level;

(k) scientific validation of medical products, including potential new testing methods.

The above list is not exhaustive.'

Thus, (h) enables any actions asserted necessary to achieve the approval for the use of medical products. It enables avoiding any provisions applicable to medicinal products /drugs and medical devices.

Lit (j) shows that for "ad-hoc" clinical trials GCP (Good Clinical/ Good Manufacturing Practice laws) can be waived and replaced with rather vaguely defined "trial standards agreed at Union level", meaning the rules agreed upon by unelected bureaucrats, rather the pharmaceutical regulations spelled out in the law that governs consumer safety in medical products.

2.5. Conditional Marketing Authorization (CMA) Pathway in EU Was Utilized to Deliver Countermeasures Under Color of Medicines

Extensive evidence of public deception by pharmaceutical companies acting in concert with the regulators became available in late November 2020, when approximately 1000 pages of Chemistry Manufacturing Controls (CMC) documentation and a set of internal email exchanges were leaked from EMA[20]. The full set of leaked pages and emails is included in the Attachment to this affidavit. These documents demonstrated that public health officials in the European Union committed fraud on all citizens, giving the impression that they evaluated and approved the covid injections according to existing standards for medicinal products, at least based on conditional marketing authorizations (CMA). The documents revealed that behind the scenes regulators were concerned solely with the timing of the launch, even before any data was reviewed, and waiving or making up greatly reduced quality standards to help Pfizer "meet" those standards, based on Pfizer's say-so and no scientific basis whatsoever. This deceptive "bait and switch" scheme was coordinated globally among the regulatory agencies – the FDA, EMA, MHRA, TGA, Health Canada and many others.

In the EU, the same net effect – absence of any enforceable compliance with pharmaceutical cGxP regulations and other relevant pharmaceutical law - has been

[20] https://www.bmj.com/content/372/bmj.n627

accomplished by forcing all Member States to sign EU-orchestrated predatory purchasing contracts with pharmaceutical manufacturers that waived all relevant pharmaceutical regulations and obligated national governments to indemnify the manufacturers in case of successful liability suits against pharma companies in the Member States. This indemnification included waiver of sovereign immunity (see p.32 of Pfizer Advanced Purchase Agreement with EU[21]). These contracts effectively prevented the Member States from exercising sovereign legislative powers with respect to pharmaceutical liability for these products in their countries. These contracts have been allegedly negotiated by Ursula von den Leyen by text messages. There is an ongoing investigation by the European Public Prosecutor's Office (EPPO) into the acquisition of COVID-19 vaccines in the European Union[22]. The defendants who acted as corresponding health authorities in the Netherlands knew or should have known that these contract clauses were predatory, violate the respective state's Constitution, and thus are unacceptable for a sovereign government, and would result in mass injuries among the citizens these public health officials had sworn the oath to protect.

One of the critical mechanisms of deception was tying all 27 EU Member States into one (blind) deal by promising that the vaccines in Europe will go through the Conditional Marketing Approval (CMA) regulatory pathway as opposed to the Emergency Authorization, i.e. the issue of Art 5(2) vs CMA. This is discussed in several emails included in the EMA documentation leak. For example:

[21] https://dn721909.ca.archive.org/0/items/contract_03/Contract%203_text.pdf
[22] https://www.eppo.europa.eu/en/media/news/ongoing-eppo-investigation-acquisition-covid-19-vaccines-eu

From: Boone Hilde <Hilde.Boone@ema.europa.eu>
Sent: Thursday, November 12, 2020 3:57 PM
To: SOLOMON Olga (SANTE) <Olga.Solomon@ec.europa.eu>; SCHMIDT Florian (SANTE) <Florian.SCHMIDT@ec.europa.eu>
Cc: GIRARD Thomas (EMA) <Thomas.Girard@ema.europa.eu>; CAVALERI Marco (EMA) <Marco.Cavaleri@ema.europa.eu>; WATHION Noel (EMA) <Noel.Wathion@ema.europa.eu>
Subject: Art 5(2) vs CMA

Dear Olga & Florian

Just a heads-up: we just finished the TC between the Commissioner and ECDC/EMA in which the Commissioner asked questions about the expected approval of the Pfizer vaccine, and timing of FDA vs EU approval. So, automatically the issue of national Art 5(2) vs CMA came up, which Noel explained in detail and also how we plan to further discuss it with the NCAs next week and in HMA. Guido also suggested to consider raising it with the Health Ministers at EPSCO.

Sandra and Giorgios said that they would further discuss also within SANTE, so, hence my email to you.

(Andrzej was also present)

Also of note:
The Commissioner said that, since EC made a commitment to the MSs and EP that the vaccines will be available to all MSs at the same time – and that therefore it will be important that MSs will not be 'forced' to use that national route due to "delays" in the formal approval procedure.

She also said that she will be prepared to call relevant health ministers personally to avoid the use of Art 5(2).

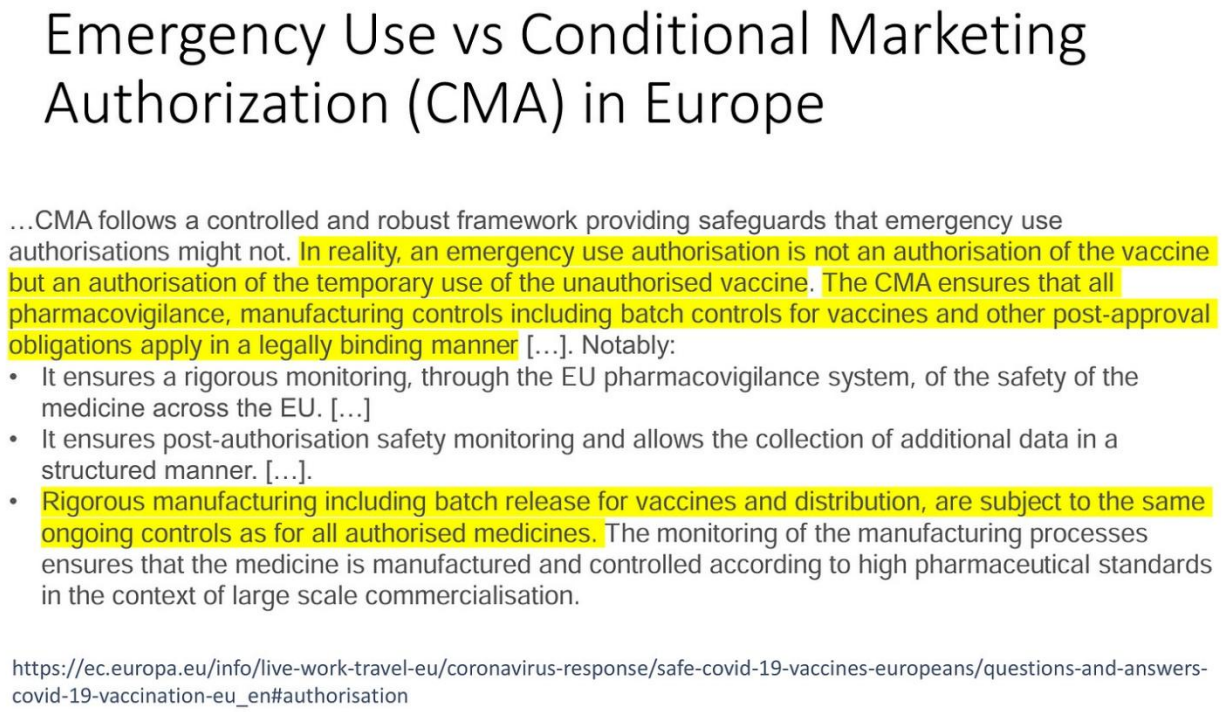
Best regards,

Hilde

The Art 5(2) is an Emergency Authorization mechanism available individually to the Member States. This authorization is issued for one year only, it is issued by each state and each state can revoke it independently. The CMA is a pan-EU mechanism in which the individual states have no say. The CMA in EU, however, is a **non-emergency investigational** pathway which, prior to 2020, had only been used for oncology drugs as a "right to try" or "compassionate use" for terminally ill patients. It is similar to the Expanded Access Use[23] (EAU, not to be confused with the EUA) in the US. Both CMA and EAU pathways however are investigational, meaning legally designated as medicinal use and purpose of the product. However, as discussed above, the "countermeasures" are non-investigational substances designated for non-medicinal purposes, thus coloring them as CMA or "BLA" is fraud and deception associated with their use as weapons.

[23] https://www.fda.gov/news-events/public-health-focus/expanded-access

As it is spelled out in law, the CMA sounds like a much stronger regulation and compliance mechanism vs Art5(2):



Emergency Use vs Conditional Marketing Authorization (CMA) in Europe

…CMA follows a controlled and robust framework providing safeguards that emergency use authorisations might not. In reality, an emergency use authorisation is not an authorisation of the vaccine but an authorisation of the temporary use of the unauthorised vaccine. The CMA ensures that all pharmacovigilance, manufacturing controls including batch controls for vaccines and other post-approval obligations apply in a legally binding manner […]. Notably:

- It ensures a rigorous monitoring, through the EU pharmacovigilance system, of the safety of the medicine across the EU. […]
- It ensures post-authorisation safety monitoring and allows the collection of additional data in a structured manner. […].
- Rigorous manufacturing including batch release for vaccines and distribution, are subject to the same ongoing controls as for all authorised medicines. The monitoring of the manufacturing processes ensures that the medicine is manufactured and controlled according to high pharmaceutical standards in the context of large scale commercialisation.

https://ec.europa.eu/info/live-work-travel-eu/coronavirus-response/safe-covid-19-vaccines-europeans/questions-and-answers-covid-19-vaccination-eu_en#authorisation

The important difference between Art 5(2) and CMA is that it puts liability onto the manufacturer, and that's what was promised to be enforced via the use of the pan-EU CMA authorization:

However, in a classic bait-and-switch fraudulent inducement scheme the public health authorities in the EU and the Netherlands never meant to hold the pharmas to any of those promised CMA standards. The EU supply contracts with pharmaceutical companies waived all the relevant consumer safety enforcement regulations and laws in their countries. In effect, this removed any meaning from the CMA standards for consumer safety and manufacturer liability, because no enforcement = no law!

For example, see the EU supply agreement with Pfizer[24] wrt Indemnification:

In summary, the net effect of the PREP Act (i.e. removal of all relevant pharmaceutical regulations and manufacturers' liability) was accomplished in EU via centralizing supply agreements under the pan-EU fraudulent scheme designed to pass military countermeasures onto the consumers under the color of CMA-authorized and later "fully approved" vaccines.

[24] https://dn721909.ca.archive.org/0/items/contract_03/Contract%203_text.pdf

2.6. Direct evidence of noncompliance of the covid mRNA/DNA injections with normal pharmaceutical regulations, expected by the consumers and healthcare providers.

Approximately 1000 pages of Pfizer's manufacturing documentation were leaked from the European Medicines Agency (EMA) at the end of 2020 showing absence of the Good Manufacturing Practice (cGMP) compliance less than 2 weeks before the product was deployed onto billions of consumers worldwide. The leak of the documents was authenticated by the British Medical Journal. The EMA did not deny the authenticity of the documents. In addition to the manufacturing documentation, the EMA files also contain 14 screenshots of emails dating from mid to late November 2020. The email exchanges are between the EMA staff and senior executives at the agency and their correspondence with the FDA and MHRA (the UK regulator). These emails demonstrate that the EMA reviewers were under massive political pressure to invent new ways of approving the inherently non-approvable dangerous products. It is evident from the emails, comments and objections raised by the EMA review staff that they were not aware of the legal status of the Covid-19 injections as countermeasures, nor that the regulatory review of the data was not material to their deployment.

It is also evident that the EMA leadership were concerned primarily with coordinating the launch dates, and the "authorization" of these shots for all EU Member States was a forgone conclusion. The pressure to overlook all regulatory deficiencies was emanating from the very top of the US, UK and EU governments.

There were severe and unresolvable - given the purposefully unrealistic timeline - issues with the quality of the product the EMA staff were pressured to ok. The manufacturing process was woefully out of compliance. The EMA reviewers raised more than 100 objections to approval, including several Major Objections. Specifically, Major Objections included

1) lack of cGMP compliance;

2) lack of mRNA integrity and large amounts of mRNA fragments (**some of which can be characterized as miRNA, siRNA and shRNA - all potential weaponization components as described above**);

3) many significant gaps in manufacturing documentation making it impossible to determine if the product could be made as described.

Emails leaked from EMA also demonstrate that the EU regulators were only concerned with the dates of product launch and were not going to review the necessary data prior to

launch. The process was highly political and not scientific. The EMA regulators took verbal assurances from the FDA officials instead of reviewing the data. As stated above, the EMA staff reviewers objected to the data, but the high-ranking officials ignored and over-ruled their concerns.

Lack of cGMP compliance means that no assurances can be made that the products contain specific ingredients in specific amounts in the units dispensed to the patients. Therefore, in addition to the product being dangerous, no informed consent is possible.

One of the key elements guaranteeing the quality of the drug substance is a product specification based on the current state of product development as well as science and technology. For this, the framework is set by International Conference on Harmonization (ICH) guideline Q6A "Test procedures and acceptance criteria for new drug substances and new drug products: chemical substances"[25]. The specification defines a list of tests along with references to analytical procedures and appropriate acceptance criteria for the quality assessment of the respective product regarding identity, assay/quantity, purity/impurities, and potency/ biological activity.

All analytical procedures must be fully validated, which means that either standard, previously validated methods are used, or if proprietary/novel – then the manufacturer must invent and fully validate the assays that are used for novel techniques. This requires, among other things, definitive tests with positive and negative controls as well as full and traceable documentation "audit trail" for every test. Commercial secrecy is not an excuse for failure to comply with these requirements. Even if the manufacturer does not wish to publicly disclose their analytical procedures, they still must submit full transparent documentation to the FDA who holds it on file (and this fact is formally communicated to purchasers of the product for their own GxP compliance).

In Pfizer's CMC documentation leaked at the end of 2020, the reviewers from EMA noted that there was no description of the "non-compendial", i.e. Pfizer's own developed proprietary methods for analytical procedures. This made it impossible to evaluate the scientific accuracy of the proprietary methods used by Pfizer to control the quality of produced injections.

Numerous product and process control parameters were proprietary, not well defined, some were not yet invented, and none were scientifically validated. For example, the test used for the **mRNA identity** testing was chosen RT-PCR (real-time PCR). However, the mRNA is a highly unstable and fragile substance, which, while manipulated and chemically

[25] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/q6a-specifications-test-procedures-and-acceptance-criteria-new-drug-substances-and-new-drug-products

"optimized" for stability, still has shown a great degree of fragility. As a result, the integrity of the mRNA has been problematic, especially with the scale up of manufacturing.

One of the Major Objections (MO) from the EMA reviewers stated in the leaked Pfizer CMC documentation was lack of mRNA integrity, i.e. low % of RNA in the vial conforming to the specification and a very high % of broken RNA pieces:

From: Jekerle Veronika <Veronika.Jekerle@ema.europa.eu>
Sent: 24 November 2020 12:02
To: Korakianiti Evdokia <Evdokia.Korakianiti@ema.europa.eu>
Cc: Facchini Claudio <claudio.facchini@ema.europa.eu>; Moseley Jane <Jane.Moseley@ema.europa.eu>; van der Stappen Ton <ton.vanderstappen@ema.europa.eu>; Dooley Brian <Brian.Dooley@ema.europa.eu>; Rager Irene <Irene.Rager@ema.europa.eu>; Seguin Vanessa <Vanessa.Seguin@ema.europa.eu>
Subject: update from BWP meeting on BioNTech

Dear Evdokia,

The BWP has just discussed the BioNTech BWP and below you will find the main conclusions:

The Dossier is generally of good quality considering the speed in development and compilation.

- 3 major objections are agreed:

- **MO1**: GMP distant assessments for US manufacturing sites (Note: Distance assessment on the Wyeth, Andover site (DS, QC DS, QC DP) and on the Pfizer, Chesterfield site (QC DS, QC DP) are ongoing → interim reports expected 11 Dec 2020, MO reworded to allow statement of GMP)
- **MO2**: Differences in the level of mRNA integrity; comparability between clinical and commercial material, DS and DP is questioned (Note: root cause analysis ongoing an 2 additional PPQ batches manufactured with a slightly adjusted process – waiting for results, if RNA integrity is improved back to initial levels this could be accepted / characterisation data requested to understand protein variability from mRNA fragments → potential impact on safety).
- **MO3**: Pending PPQ-batches for DP: comparability, process validation and stability (Note: as above: 2 PPQ batches manufactured and currently undergoing testing).
- Note that full information on two novel excipients (lipid in the nanoparticles) is not yet provided. This data is expected in the next CMC wave.

Conclusions: a number of major concerns remain that impact the benefit/risk of the vaccine (efficacy/safety) most notably the comparability issue around % mRNA integrity. These concerns are shared by most member states. **An approval by the end of the year could potentially be possible, if these concerns + GMP will be resolved**. Any remaining Quality issues will need to be considered in the context of overall B/R (& could potentially be addressed via specific obligations/Annex II conditions/recommendations).

The BWP report reflecting these conclusions is undergoing written adoption today.

With thanks to Ton, Brian and Claudio,

Kind regards,

Veronika

Veronika Jekerle, PhD
Head of Pharmaceutical Quality Office
Quality and Safety of Medicines
Office: 09-N-02
Extension: 8438

The large amount of non-conforming RNA was deemed impurity by the EMA reviewers. It is, indeed, a major problem - the entire claimed efficacy of the product allegedly depended on the "correct code" to produce the "Wuhan spike protein" using the cellular machinery of the injected individuals. Here we have evidence of the regulators objecting to approval due to the fact that many other things besides the "Wuhan spike protein" can happen in the cells bombarded with broke RNA pieces, **which is a known weaponization method for mRNA vaccines as discussed above**.

Instead of stopping the approval and demanding that the mRNA integrity is resolved, the regulators simply arbitrarily moved the acceptance criterium for the %mRNA integrity from the previous standard of 70%+ to just greater than 50%.

That means that a large portion of drug substance is allowed to contain "junk" RNA material, fragments, and uncharacterized pieces, some of them large enough to code for unknown and possibly aberrant proteins, and most of them falling into the category of micro RNAs (miRNAs). These short sequences, while non-coding, are known to interfere with cellular processes and are implicated in cancer pathways[26].

Ultimately, the regulatory review itself and the objections raised by the EMA reviewers did not matter - the product was going to be pushed on the market regardless of the regulatory objections due to the military CBRN response that was invoked globally, in secret from the public.

2.7. Removal of requirements for biologics manufacturing facility inspections:

Neither the FDA nor EMA conducted the manufacturing facilities inspections for Pfizer and its suppliers in 2020, citing covid emergency. When the manufacturing facility inspections resumed in 2022, Pfizer's major European contractor, Rentschler, was found in violation of cGMP (form 483 issued). This means the supply chain for Pfizer in Europe was not in compliance between 2020 and 2022. No enforcement action was taken by the regulators, as per EUA law there is no enforcement possible.

It is also worth noting that in 2019, evidently in preparation for the Covid-19 operation, then US FDA Commissioner Scott Gottlieb changed the federal regulations governing inspection of licensed facilities manufacturing **all biological products including 'vaccines'**, from at least every two years to unspecified times; eliminated enforcement provisions if a licensed

[26] https://www.nature.com/articles/sigtrans20154

facility failed an inspection; and eliminated all inspection duties for FDA inspectors. Prior to the rule change, 21 CFR 600.21, Time of inspection, read:

"The inspection of an establishment for which a biologics license application is pending need not be made until the establishment is in operation and is manufacturing the complete product for which a biologics license is desired.

In case the license is denied following inspection for the original license, no reinspection need be made until assurance has been received that the faulty conditions which were the basis of the denial have been corrected. An inspection of each licensed establishment and its additional location(s) shall be made at least once every 2 years. Inspections may be made with or without notice, and shall be made during regular business hours unless otherwise directed."

Effective May 2, 2019, the last three sentences of 21 CFR 600.21 were removed.

There is currently no legal requirement for an initial FDA inspection; no minimum interval for subsequent FDA inspections, and there are no legal consequences for compliance failures, such as establishment or product license denial or revocation.

The legal mechanisms through which FDA regulation of biological product manufacturing disappeared, included a Direct Final Rule and a Proposed Rule, simultaneously issued by Federal Register notice on Feb. 26, 2018, and an April 2, 2019 Final Rule, issued by then-FDA Commissioner Scott Gottlieb.

2.8. Arbitrary reclassification of mRNA/DNA gene therapies as "Covid-19 vaccines":

Regarding the technology platform itself (mRNA in lipid nanoparticle [LNP], or DNA in adenoviral vector) - both are known as "transfection" technologies. The purpose of the product design is to deliver various bio-chemical cargo inside the cellular membranes, and often into the cell's nucleus where DNA resides. Transfection methods using a wide variety of RNA and DNA technologies are a well-established scientific reality. For example, as published in this literature review paper[27]:

[27] https://pmc.ncbi.nlm.nih.gov/articles/PMC8067914/

> *"A systematic literature search based on PRISMA guidelines (Moher et al., 2009) was established to identify relevant published studies or protocols that fit into this review's scope (Fig. 1). Databases that were employed for the literature search included Scopus, Google Scholar, and PubMed. The keywords being used during the search included "transfection", "co-transfection", "chemicals", "reagents",* ***"DNA", "siRNA", "shRNA", "miRNA", "plasmid", "oligonucleotides"****, "efficiency", "safety", "cytotoxicity", "controls" and other related key terms. An initial search returned about 5,000 articles, published protocols, or handbooks from various databases that reported the descriptions or comparisons between different transfection methods, types of transfected nucleic acids, transfection control, transfection efficiency assessment methods and transfection reagents*."

The design of the genetic therapy products is identical to that of the covid "vaccines": the LNPs will deliver the cargo attached to them into the cells, i.e. **transfect the cells**. The LNP platform or adenovirus platform are just 2 different types of "cargo trucks", the LNP being particularly effective in hacking the cells. The fact that it is a transfection technology is documented very widely in science literature and in regulatory documents. Both Moderna and BioNTech characterized their mRNA technologies as experimental, a "therapy" and in early development stages in SEC filings immediately preceding the pandemic. Moderna's 2019 Form 10-K specifically noted: "mRNA medicines are a novel and unproven approach… No mRNA immunotherapy has been approved, and none may ever be approved."

No mRNA pharmaceutical products were approved by any regulatory authorities in the world before 2020. This was due to numerous failures to meet pharmaceutical safety and compliance standards. All products in development repeatedly ran into safety issues and could not advance even into the first phase of the human testing[28],[29].

3. Covid-19 mRNA injections were financed, developed and deployed worldwide via a military campaign coordinated through military and security alliances.

[28] https://www.statnews.com/2017/01/10/moderna-trouble-mrna/
[29] https://thewashingtonstandard.com/moderna-a-company-in-need-of-a-hail-mary/

3.1. Covid-19 was not a public health event, but a global military operation:

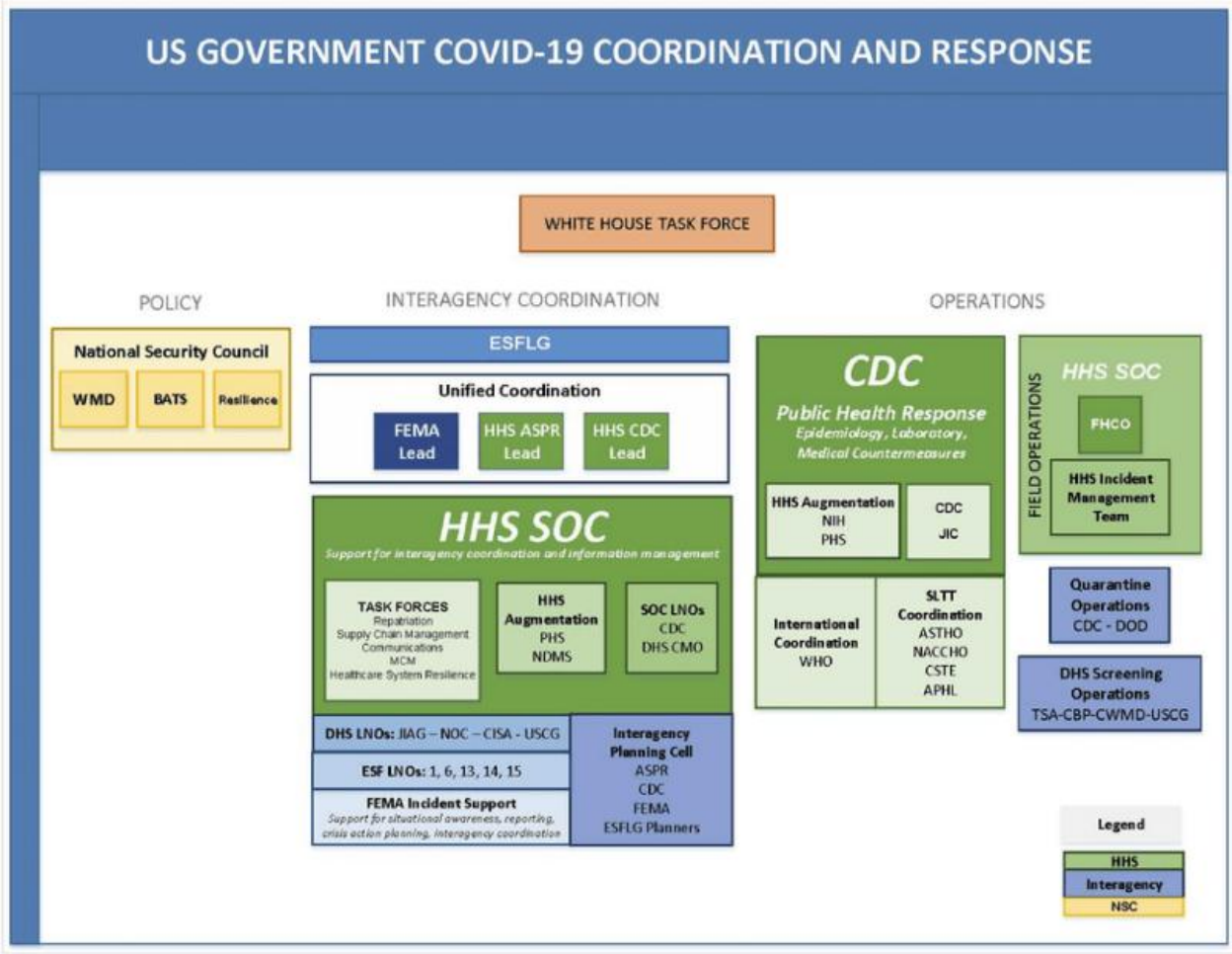
Covid operation was not a public health event, although it was presented as such to the world's population. It was a global operation, coordinated through public-private intelligence and military alliances and invoking laws designed for CBRN (chemical, biological, radiological, nuclear) weapons attacks.

In the US, the National Security Council (and not Department of Health and Human Services) is in charge of Covid policy in the US. In other countries of the world, covid campaign was coordinated via identical mechanisms, with military and intelligence apparatus leading the response policy (as in a war), and public health agencies presenting a false front of a public health emergency to the public. **See Exhibit 1 for detailed evidence of the global military campaign, including the evidence for the Netherlands and other EU countries.**

In the US, March 13, 2020: "PanCAP Adapted U.S. Government COVID-19 Response Plan" (PanCAP-A) states that United States policy in response to SARS-CoV-2 is set not by the public health agencies designated in pandemic preparedness protocols (Pandemic and All Hazards Preparedness Act,30 PPD-44,31 BIA), but rather by the National Security Council, or NSC. NSC does not have regular attendees from public health agencies and its focus is national security and foreign policy matters."

Below is the organization chart from the PanCAP-A document, p.9:

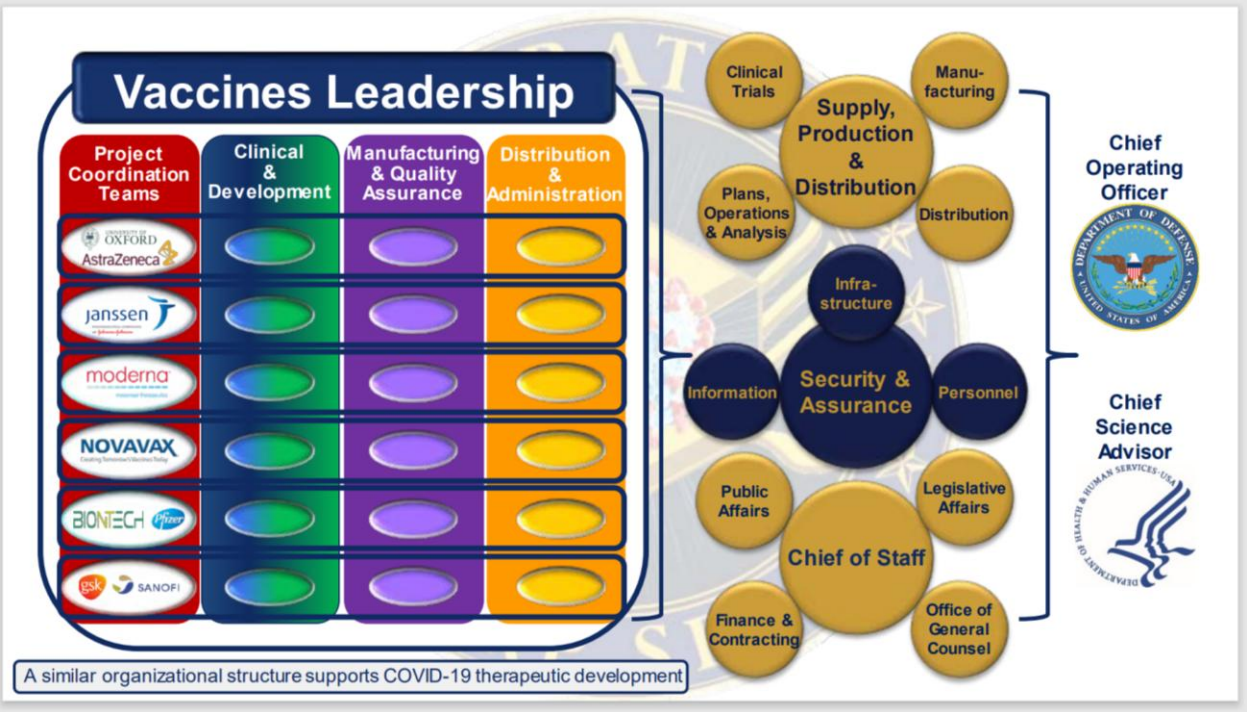
[30] https://www.govinfo.gov/content/pkg/PLAW-109publ417/pdf/PLAW-109publ417.pdf
[31] https://www.in.gov/dhs/files/FEMA-Fact-Sheet-COVID-Response-3.4.20.pdf



3.2. Operation Warp Speed Organization Structure

According to the Operation Warp Speed/ASPR reports, Operation Warp Speed was declared as a "collaborative" effort of the DOD and HHS to produce "safe and effective" Covid-19 vaccines and therapeutics. However, according to the organizational chart, the DOD was formally the Chief Operating Officer, while HHS had the Chief Science Advisor position.[32]

[32] See "VRBPAC-10.22.20-Meeting-Presentation-COVID19-Vaccine-Development-Portfolio.pdf" in Attachment



VRBPAC-10.22.20-Meeting-Presentation-COVID19-Vaccine-Development-Portfolio.pdf

Notably, the next seniormost layer of the organization is controlled by the US Government and includes all supervisory roles for manufacturing, clinical trial design and implementation, planning operations and analysis, distribution, public affairs, contracting, legal and other functions. The pharmaceutical companies are the third level down in this organization.

A report by STAT News in 2020 pointed out that roughly 60 military officials, including four generals, were involved in the leadership of Operation Warp Speed, many of them without any previous healthcare experience. Out of roughly 90 leadership positions on the organizational chart, only 29 were not employed by the DoD.[33]

The unclassified October 2020 documents from Operation Warp Speed presentations at the FDA's Vaccines and Related Biological Products Advisory Committee reveal control of the US Government over nearly all product design and implementation aspects of the development for Covid countermeasures[34].

[33] https://www.statnews.com/pharmalot/2020/09/28/pharmalittle-operation-warp-speed-is-more-army-than-science-jjs-covid-19-vaccine-moves-forward/

[34] See "VRBPAC-10.22.20-Meeting-Presentation-COVID19-Vaccine-Development-Portfolio.pdf" in Attachment

3.3. Review of DoD/BARDA Contracts for Covid Countermeasures

Hundreds of Covid countermeasures contracts became available via ”freedom of information” (FOIA) requests in partially redacted form.[35] Review of these contracts indicates a high degree of control by the US Government (DoD/BARDA) and specifies the scope of deliverables as “demonstrations” and “prototypes” only. Demonstration is a fake, performative activity. Medicinal products administered to people cannot be characterized as “demonstrations and prototypes” however, weapons can be ordered as prototypes. The contracts also include the removal of all liability for the manufacturers and any contractors along the supply and distribution chain under the 2005 PREP Act and related federal legislation.

While the DoD/BARDA countermeasure contracts refer to safety and efficacy requirements for vaccines and mention current Good Manufacturing Practices (cGMP) compliance, these items are explicitly carved out as not being paid (or ordered) by the US Government.

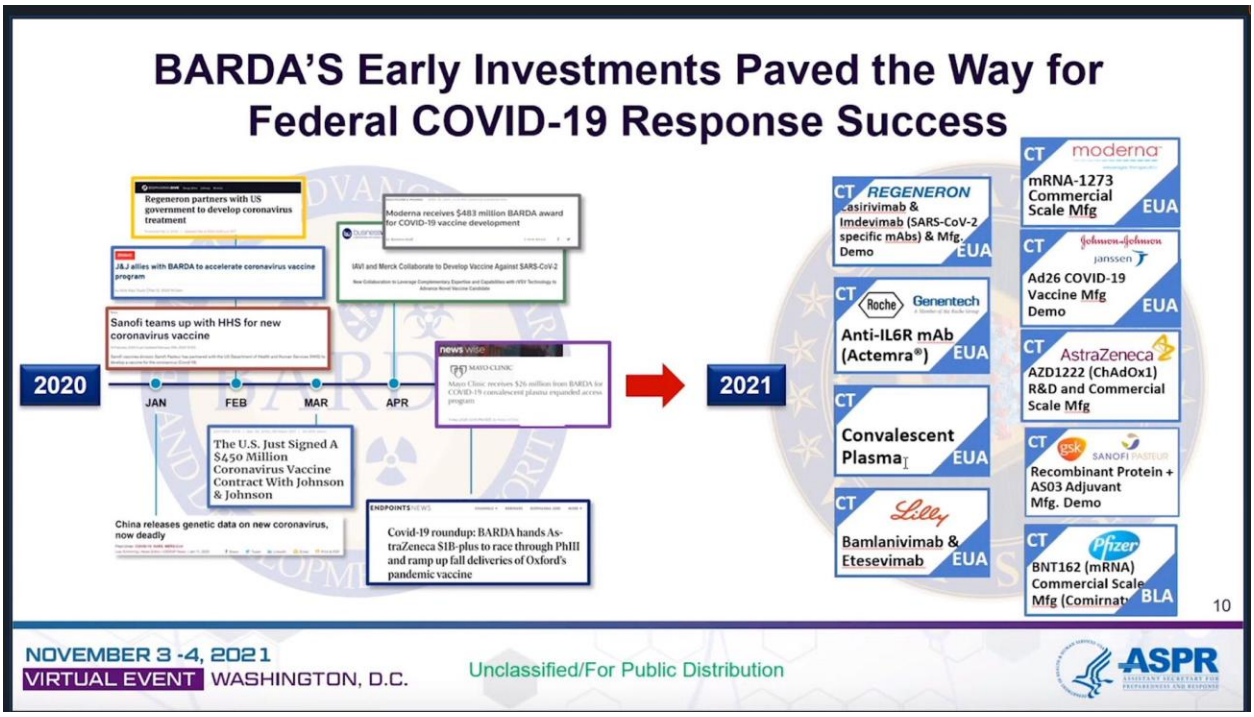
The contracts were structured under Other Transactions Authority (OTA) - a method of contracting that was utilized by the DoD and BARDA for all Covid-related countermeasures ordered from the private industry. The OTA method of contracting allows federal agencies to order otherwise-regulated products bypassing any such regulations, as well as financial accountability mechanisms that cover standard government contracting, and other laws that regulate disclosure and Intellectual Property (IP) derived from publicly funded research.[36]

“Other” is a catchall category that is not a contract, not a research grant, not a procurement, etc.: not any normally regulated/accountable government contracting.

DoD used OTA to order vaguely defined “prototypes” and “demonstrations” that are not subject to regulatory scrutiny.

BARDA’s own report, lists Covid-19 products as “demonstrations” or at best “large scale manufacturing”:

[35] https://www.keionline.org/covid-contracts
[36] https://www.keionline.org/bn-2020-3



3.4. DoD/BARDA countermeasures produced by established network of defense contractors

The DoD/BARDA contracts for "countermeasures" are managed by Advanced Technology International (ATI).[37] ATI mostly manages R&D consortia for the Department of Defense for things like weapons manufacturing, metal casting and forging, ship production and technology aimed at "countering Weapons of Mass Destruction (WMDs)." Two of these consortia related to biomedical projects.

The Medical Technology Enterprise Consortium (MTEC), operating on behalf of the U.S. Army Medical Research and Development Command, includes technology for gene-editing, nanotechnology, "telehealth solutions," artificial limbs and brain implants. MTEC is currently developing a wearable device to diagnose Covid-19 before symptoms appear.

The Medical CBRN Defense Consortium (MCDC)[38] currently includes ~300+ large and small businesses and academic entities that "support the Department of Defense's (DoD) medical pharmaceutical and diagnostic requirements to counter Chemical, Biological, Radiological and Nuclear (CBRN) threat agents" and enable "prototype technologies for

[37] https://www.ati.org/
[38] https://www.medcbrn.org/current-members/

therapeutic medical countermeasures targeting viral, bacterial and biological toxin targets of interest to the DoD," including the development of vaccines.

Through the mechanism of Other Transactions Authority, MCDC contracted with hundreds of companies to deliver Covid-related "countermeasures." Pfizer doses were ordered on July 20, 2020, through Base Agreement between Advanced Technologies Inc (ATI, a DOD vendor management company) and Pfizer, Inc., identified as MCDC Base Agreement No. 2020-532:

- July 21, 2020, MCDC Technical Direction Letter or Statement of Work (SOW) for "COVID-19 Pandemic - Large Scale Vaccine Manufacturing Demonstration" between Pfizer and DOD/Advanced Technologies Inc.[39]

The contracts specified that the product will be shipped to the DoD as sole purchaser. The delivered product is not serialized – i.e., unit doses are not barcoded and thus not traceable under normal pharmaceutical distribution rules which exist to flag any safety or quality issue in the supply chain. The product thus is open to both falsification/mislabeling and adulteration. The product was shipped to DoD and handled through a "black box" DoD distribution system, ostensibly due to the cold chain storage requirements, which were later removed, but the distribution practice via military contractors and military contracts did not change.

The product was specified as "US Government property"[40] until it is injected into a person. All persons performing any tasks along manufacturing, supply chain, distribution and administration of the shots are "covered persons" under PREP Act liability shields, as long as they follow US Government orders. Regardless of place of employment, they are deemed to be US Government employees for purposes of this work.

Importantly, the DOD contracts describe Covid countermeasures as intended for "civil and military application."

[39] https://www.keionline.org/misc-docs/DOD-ATI-Pfizer-Technical-Direction-Letter-OTA-W15QKN-16-9-1002-21July2020.pdf
[40] https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html#6-23-22

4. Conclusions and Expert Opinion:

Based on my review of primary regulatory documents, leaked Pfizer's Chemistry-Manufacturing-Control (CMC) files, relevant legislation in the U.S. and EU, and other publicly available documentation, it is my expert opinion that the Covid-19 mRNA injections were deployed under military 'medical-countermeasure' rules that bypassed standard pharmaceutical safeguards, rendering them legally and functionally indistinguishable from potential bio-chemical weapons.

Covid-19 injections were deceptively presented to the public under color of medicines, falsely advertised as "safe and effective vaccines".

Individuals who prescribed, purchased and/or administered the Covid-19 (mRNA) injections participated in war crimes and/or genocide (democide).

EXHIBIT 1: The Covid Dossier – A record of military and intelligence agencies leadership and coordination of the global Covid operation.

The dossier includes information for US, UK, Canada, Australia, Germany, the Netherlands, Italy, other EU countries, Switzerland, Turkey, Latin America and Asia.

EXECUTIVE SUMMARY

The Covid Dossier is a compilation of the evidence we have amassed over the last three years supporting the following claim:

Covid was not a public health event, although it was presented as such to the world's population. It was a global operation, coordinated through public-private intelligence and military alliances and invoking laws designed for CBRN (chemical, biological, radiological, nuclear) weapons attacks.

The Dossier contains information regarding the military/intelligence coordination of the Covid biodefense response in the U.S., U.K., Australia, Canada, the Netherlands, Germany, Italy, and many more locations. For some countries we have extensively documented information. For others, we have some documentation of military/intelligence involvement, but not all the details. For as many countries as possible, we list the military/intelligence agencies in charge of their country's Covid response; dates on which emergency declarations were made in each country; military/intelligence-related agencies and bodies in charge of censorship/propaganda; and top people with military/intelligence jobs who were known or reported to hold leadership positions in the response. We also list connections to global governing bodies, including the EU and UN/WHO, through which the response was coordinated. In the final section, we include a list of military/intelligence/biodefense alliances that provide multinational frameworks for responding to a bioterror/bioweapons attack.

On February 4th, 2020, two things happened that almost nobody knows about, but that played an important role in the course of recent world history:

1) Two declarations for CBRN (weapons of mass destruction) emergencies – EUA and PREP Act – made by the U.S. Secretary of Health and Human Services, were registered on this date. [ref][ref]

EUA stands for Emergency Use Authorization. Legally, EUA powers are intended for situations of grave, immediate emergencies involving weapons of mass destruction. They allow for the use of countermeasures against CBRN (chemical, biological, nuclear or radiological) agents without the regulatory oversight intended to ensure safety and efficacy, because the immediate threat of a CBRN attack is deemed so much greater than any potential risks caused by the countermeasures.[ref] The PREP Act is the legal indemnity granted to anyone involved in using an EUA countermeasure, because if a weapon of mass destruction is involved, the risk of the CBRN attack is so great that no one should face legal consequences for potential collateral damage caused by using unregulated countermeasures.

In order to activate EUA, the law requires "A determination by the Secretary of HHS that there is a public health emergency… that involves a CBRN agent or agents, or a disease or condition that may be attributable to such agent(s). [ref] So when the EUA was officially activated on February 4, 2020, it was in essence a declaration of a state of emergency involving weapon(s) of mass destruction.

This PREP Act Public Health Emergency declaration has been repeatedly renewed and is currently in effect through December 31, 2029.

2) A pharmaceutical executive was caught on tape saying that the U.S. Department of Defense called to inform him "that the newly discovered Sars-2 virus posed a national security threat." [ref] Also see the AstraZeneca audio file in Attachments.

It is important to note that on February 4, 2020, there were fewer than a dozen confirmed cases of the novel coronavirus disease (later called Covid-19) in the US, and zero deaths. Worldwide, the death count was fewer than 500. There was nothing about the virus, at least as it was presented publicly, that would make anyone believe it posed a threat to national security.

These two events are remarkable for several reasons:

- They indicate that the beginnings of Covid were rooted in national security machinations, not public health considerations.
- They also strongly suggest that the deployment of the EUA "medical countermeasures" under Public Health Emergency declaration was officially launched at a time when an emergency, much less a national or a global one, could

not possibly be determined. No public health parameters justifying that a novel virus posed a "threat to national security" existed at the time of the EUA and PREP Act declarations.

Thus, on this day five years ago, **a military CBRN countermeasure deployment campaign was officially launched** against a poorly defined illness that was alleged to have killed a few hundred people worldwide.

Within six weeks of this date, in order to ensure a market for the countermeasures (among other aims), the lockdown-until-vaccine response – which is a military/counterterrorism plan and has nothing to do with public health [ref] – went into effect all over the world.

It is crucially important to understand that Covid was a globally coordinated response, based on legal frameworks intended for biodefense/biowarfare situations. The attack that initiated the global Covid response could have been real, perceived or invented – regardless of the trigger, the lockdown-until-vaccine paradigm originated in the military/intelligence biodefense playbook, not in any scientifically based or epidemiologically established public health plan.[ref]

This means that nothing about the response – masking, distancing, lockdowns, vaccines – was part of a public health plan to respond to a disease outbreak. Rather, every aspect of the response was intended to induce public panic in order to gain compliance with biodefense operations, culminating with the injection of unregulated mRNA products, which were legally treated as biodefense military countermeasures (MCMs), into billions of human beings.

Covid Dossier: U.S.

Military/intelligence agencies in charge of pandemic response:

- **National Security Council (NSC)** [ref]
- **FEMA/Department of Homeland Security (DHS)** [ref]
- **Department of Defense (DOD)** [ref]

Dates when those agencies were known to be in charge:

- **Mid-January 2020:** NSC classified Covid meetings "starting mid-January" [ref]

- **March 13, 2020:** NSC officially in charge of pandemic policy in *Pandemic Crisis Action Plan-Adapted* – the U.S. government's Covid response plan [ref]
- **March 18, 2020:** FEMA/DHS takes over as Lead Federal Agency, replacing HHS [ref]

Dates, types and names of unprecedented emergency declarations:

- **February 4, 2020 EUA declaration** [ref]
- **February 4, 2020** [retroactive from March 17, 2020] **PREP Act declaration** [ref]
- **March 13, 2020 Stafford Act in all states simultaneously** (1st time in history) [ref]

Military/intelligence agencies involved in public communications/propaganda/censorship:

- **Government Task Force, coordinated by NSC**, controls all pandemic messaging starting February 27, 2020 [ref][ref]
- **Department of Homeland Security (DHS)** [ref]
- **Cybersecurity & Infrastructure Security Agency (CISA)** [ref]
- **Cyber Threat Intelligence League (CTIL)** (crossover US/UK) [ref]

Key figures in Covid response linked to military, IC, UN/WHO:

- Deborah Birx [ref][ref][ref][ref]
- Michael Callahan[ref] [See also *PsyWar* by Robert Malone MD MS, Kindle version p. 237]
- Richard Danzig [ref][ref]
- Richard Hatchett [ref][ref][ref][ref]
- Matt Hepburn [ref][ref][ref][ref]
- Robert Kadlec [ref][ref][ref]
- Carter Mecher [ref]
- Matt Pottinger [ref]
- Mike Ryan [ref][ref]
- Luciana Borio [ref]
- Terry Adirim [ref]

Covid Dossier: U.K.

Military/intelligence agencies in charge of pandemic response:

- **Ministry of Defense (MOD)** "Operation Rescript" [ref]
- **Covid Support Force** (MOD Report - ref)
- **Joint Biosecurity Centre (JBC)** [ref][ref][ref][ref]

Dates those agencies were publicly known to be in charge:

- **March 18, 2020:** Covid Support Force (20,000 military personnel) [ref]
- **May 2020:** (at the latest) JBC [ref][Wikipedia: "it's existence was announced"]

Dates, types and names of unprecedented emergency declarations:

- **March 13, 2020** UK Advisory Committee on Dangerous Pathogens reached a unanimous decision that Covid-19 was not a high consequence infectious disease [ref]

March 18, 2020 Public Health England announced that Covid-19 was not a high consequence infectious disease [ref]

- **March 23, 2020 national lockdown** [ref]
- **March 25, 2020 Coronavirus Act 2020** [ref]

Military/IC-affiliated groups involved in messaging/propaganda/censorship:

- **Ministry of Defense team** [ref]
- **iSAGE** [ref]
- **77th Brigade** [ref]
- **Nudge Unit** [ref from March 11 2020] / **Behavioral Insights Team** – now "fully owned by Nesta" (National Endowment for Science, Technology and the Arts) [ref]

- **RAF analysts** [ref]
- **Cyber Threat Intelligence League (CTIL)** (crossover US/UK)[ref]

Key figures in Covid response linked to military, IC, UN/WHO

- Roy Anderson [ref]
- Dominic Cummings [ref][ref]
- Jeremy Farrar [ref] [ref][ref]
- Clare Gardiner [ref]
- Richard Hatchett (crossover US/UK) [ref][ref][ref][ref]
- Tom Hurd [ref] [ref]
- Thomas Waite [ref]
- Simon Manley (UK Director-General Covid-19) [ref]

Covid Dossier: Australia

Military/intelligence agencies and special committees involved in response:

- **National Cabinet** "exempt from freedom of information laws"[ref]
- **National Security Committee of Cabinet** [ref]
- **Australian Defense Force COVID-19 Task Force** [ref]
- **National COVID-19 Commission Advisory Board (NCC)** [ref]

Dates those agencies/committees were publicly known to be in charge:

- **March 9, 2020:** Australian Defense Force COVID-19 Task Force [ref]
- **March 13, 2020:** National Cabinet established [ref]
- **March 25:** NCC [ref]

Dates, types and names of unprecedented emergency declarations:

- **March 5, 2020 National Coordination Mechanism activated** [ref]
- **March 13, 2020 National Partnership on COVID-19 Response** [ref]
- **March 18, 2020 Human Biosecurity Emergency Declaration** (first in history) [ref]

Key figures in Covid response linked to military, IC, UN/WHO:

- Lt Gen John Frewen [ref][ref]
- Jane Halton [ref][ref][ref]
- Edward Holmes [ref]
- Major General Paul Kenny [ref]

Covid Dossier: Canada

Military/intelligence agencies and special committees involved in response:

- **Canadian Armed Forces (CAF) Operation LASER** 24,000-person response force [ref]
- **CAF Operation VECTOR** (vaccine planning and distribution)[ref]
- **Cabinet Committee on COVID-19** [ref]

Dates those agencies/committees were publicly known to be in charge:

- **January 23, 2020**: first Operation LASER planning meeting [ref]
- **March 2, 2020**: Operation LASER officially launched
- **March 4, 2020:** Cabinet Committee officially announced [ref]

Dates, types and names of unprecedented emergency declarations:

In Canada, the emergency declarations were made by the provinces, as follows [ref]:

- **March 13, 2020 Quebec provincial public health emergency**
- **March 16, 2020 Prince Edward Island public health emergency**
- **March 17, 2020 British Columbia (BC) public health emergency**
- **March 17, 2020 Alberta provincial public health emergency**
- **March 17, 2020 Ontario provincial state of emergency**
- **March 18, 2020 BC state of emergency under Emergency Program Act**
- **March 18, 2020 Saskatchewan provincial state of emergency**
- **March 18, 2020 Yukon public health emergency**
- **March 19, 2020 Northwest Territories public health emergency**

- **March 19, 2020 Nunavut public health emergency**
- **March 20, 2020 Manitoba provincial state of emergency**
- **March 22, 2020 Nova Scotia provincial state of emergency**

Military/IC-affiliated groups involved in messaging/propaganda/censorship:

- **CAF** began to gather intelligence on pandemic disinformation in January 2020 [ref]
- **CAF** deployed psyop program on civilians [ref]
- **Canadian Joint Operations Command** (CJOC) [ref]
- **Canadian military intelligence unit - Precision Information Team (PiT)**[ref][ref]

Key figures in Covid response linked to military, IC, UN/WHO:

- Bill Blair [ref]
- Crystia Freeland [ref][ref]
- Brian Santarpia [ref]
- Teresa Tam [ref]
- Dr. Gary Kobinger [ref]

Covid Dossier: the Netherlands[41]

Military/intelligence agencies and alliances involved in response:

- **National Coordinator for Security and Counterterrorism (NCTV)** [ref]
- **NATO** [ref]
- **European Union** [ref]

Dates, types and names of unprecedented emergency declarations:

- **March 15, 2020**: "new additional measures to combat the COVID-19 outbreak" (closure of schools, restaurants, sports/fitness facilities)[ref]
- **March 23, 2020**: "intelligent lockdown" announcement [ref]

Military/IC-affiliated groups involved in messaging/propaganda/censorship:

- **Ministry of Defense Land Information Manoeuvre Centre (LIMC)** [ref][ref][ref][ref]
- **National Coordinator for Security and Counterterrorism (NCTV)**[ref]
- **National Core Team Crisis Communication (NKC)** (led by the NCTV)[ref]
- **Interdepartmental Working Group on Disinformation** (includes Defense, Foreign Affairs and Justice Departments, among others) [ref]

Key figures in Covid response linked to military, IC, NATO, EU:

- Marion Koopmans [ref]

[41] The Dutch government disclosed a secret obligation to comply with NATO Resilience goals (news article): https://deanderekrant.nl/kabinet-erkent-navo-is-de-baas/

- Pieter-Jaap Aalbersberg [ref]

Covid Dossier: Germany

Military/intelligence agencies, committees, and groups involved in response & dates they were announced

- **February 27/28: Corona Crisis Team (Corona-Krisenstab)** [ref] led by Ministry of Health and Ministry of the Interior (equivalent of DHS + DOJ) [ref]
- **November 2021: new Crisis Team** for vaccines (led by military)[ref]
- **NATO**[ref][ref]
- **All vaccine shipments** were delivered/distributed in Germany via a single location – a NATO military base [ref]

Key figures in Covid Response linked to NATO, UN/WHO, military, IC:

- **Major General Carsten Breuer**[ref][ref]
- **General Hans-Ulrich Holtherm**[ref][ref]
- **Christian Drosten** [ref][ref]
- **Bernhard Schwartländer** [ref]

Covid Dossier: Italy

Military/intelligence agencies, committees, and groups involved in response & dates they were announced

- **CTS (Comitato Tecnico Scientifico, or Technical Scientific Committee)** established February 5, 2020 [ref]
- **NATO Rapid Deployable Corps Italy – "**a battle-ready NATO formation that can effectively operate in support of all NATO core tasks, including collective defence, crisis management, and cooperative security through partnerships." [ref]
- The Italian **CTS (Comitato Tecnico Scientifico, or Technical Scientific Committee) was established on February 5, 2020** "with consultancy and support competence for coordination activities **to overcome the epidemiological emergency due to the spread of Coronavirus**." [ref]

Military/IC-affiliated groups involved in messaging/propaganda/censorship

- **Department of Information for Security (DIS):** The DIS intensified its monitoring and analysis activities related to pandemic-related threats, such as disinformation and potential espionage activities, starting in March 2020. [REF NEEDED]

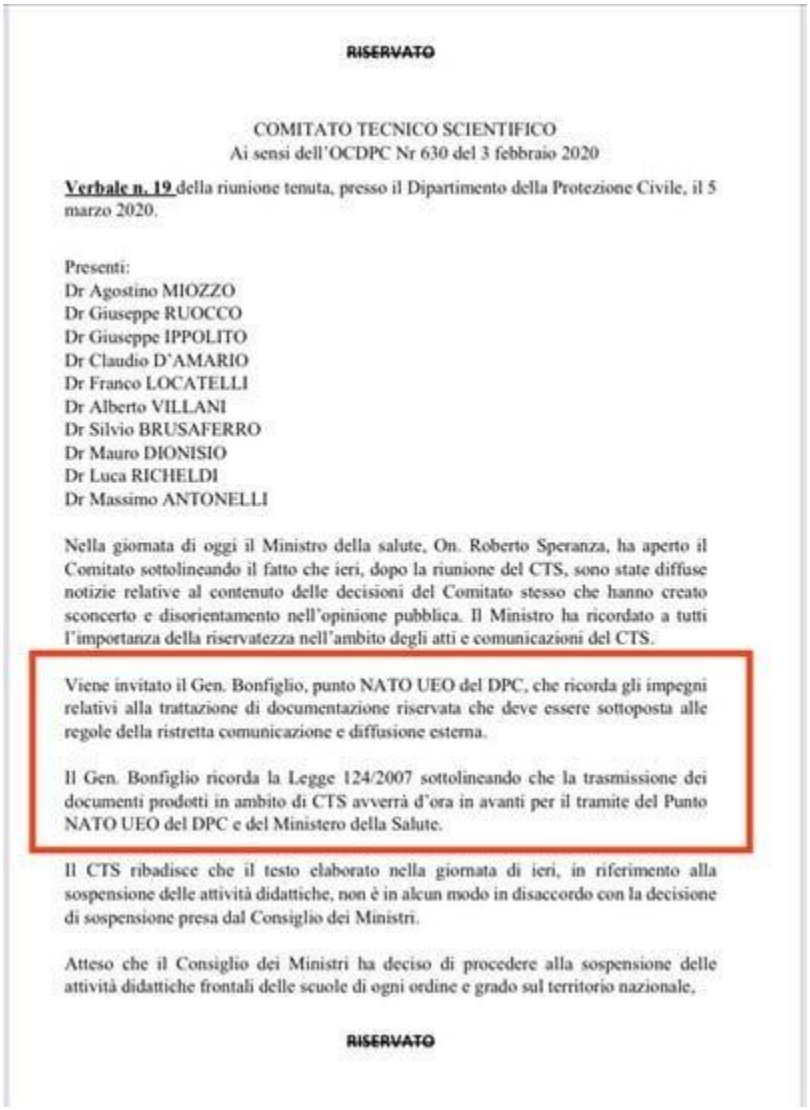
Dates, types and names of unprecedented emergency declarations

- **January 31, 2020**: Resolution of the Council of Ministers -- Declaration of a state of emergency due to the health risk associated with the emergence of diseases caused by transmissible viral agents. Duration: six months. Published in the Official Gazette No. 26 on February 1, 2020. [ref]
- **March 9, 2020:** National Lockdown [ref]

Key figures in Covid Response linked to NATO, UN/WHO, military, IC

- **General Francesco Paolo Figliuolo** [ref]
- **General Francesco Bonfiglio** [ref]
- Minutes of a CTS meeting held on March 5, 2020, obtained through FOIA [ref], include statements by General Bonfiglio, identified as belonging to the "NATO UEO point of the DPC." [ref]

Below is a screenshot of the minutes in Italian, followed by English translation:



RISERVATO

COMITATO TECNICO SCIENTIFICO
Ai sensi dell'OCDPC Nr 630 del 3 febbraio 2020

Verbale n. 19 della riunione tenuta, presso il Dipartimento della Protezione Civile, il 5 marzo 2020.

Presenti:
Dr Agostino MIOZZO
Dr Giuseppe RUOCCO
Dr Giuseppe IPPOLITO
Dr Claudio D'AMARIO
Dr Franco LOCATELLI
Dr Alberto VILLANI
Dr Silvio BRUSAFERRO
Dr Mauro DIONISIO
Dr Luca RICHELDI
Dr Massimo ANTONELLI

Nella giornata di oggi il Ministro della salute, On. Roberto Speranza, ha aperto il Comitato sottolineando il fatto che ieri, dopo la riunione del CTS, sono state diffuse notizie relative al contenuto delle decisioni del Comitato stesso che hanno creato sconcerto e disorientamento nell'opinione pubblica. Il Ministro ha ricordato a tutti l'importanza della riservatezza nell'ambito degli atti e comunicazioni del CTS.

Viene invitato il Gen. Bonfiglio, punto NATO UEO del DPC, che ricorda gli impegni relativi alla trattazione di documentazione riservata che deve essere sottoposta alle regole della ristretta comunicazione e diffusione esterna.

Il Gen. Bonfiglio ricorda la Legge 124/2007 sottolineando che la trasmissione dei documenti prodotti in ambito di CTS avverrà d'ora in avanti per il tramite del Punto NATO UEO del DPC e del Ministero della Salute.

Il CTS ribadisce che il testo elaborato nella giornata di ieri, in riferimento alla sospensione delle attività didattiche, non è in alcun modo in disaccordo con la decisione di sospensione presa dal Consiglio dei Ministri.

Atteso che il Consiglio dei Ministri ha deciso di procedere alla sospensione delle attività didattiche frontali delle scuole di ogni ordine e grado sul territorio nazionale,

RISERVATO

Gen. Bonfiglio, NATO WEU Point of the Department of Civil Defense, is invited and reminds of the commitments regarding the handling of confidential documentation that must be subject to the rules of restricted external communication and dissemination.

Gen. Bonfiglio recalls Law 124/2007 emphasizing that the transmission of documents produced in CTS (Scientific Technical Committee) will henceforth be done through the NATO WEU Point of the Department of Civil Defense and the Ministry of Health.

Covid Dossier: France

Military/intelligence agencies, committees, and groups involved in response & dates they were announced

- **Conseil de Defense (Defense Council), February 29, 2020** [ref][ref]This is the equivalent of the U.S. National Security Council. After 2/29/20, it met once a week, at least 40 times. Meetings were classified top secret. Cell phones were prohibited. And all notes taken were stamped top secret. Some were kept in safes. The others were burned. [ref]

Covid Dossier: Norway

Key figures in Covid Response linked to NATO, UN/WHO, military, IC

- **Espen Rostrup Nakstad**: "In the four weeks that have passed since the strictest restrictions since World War II were introduced in Norway, Espen Rostrup Nakstad has become an important and clear spokesperson for Norwegian health authorities." [ref]
- A CBRNE (chemical, biological, radiological, nuclear and explosive) expert, Nakstad served as the Norwegian Armed Forces' Senior Consultant in CBRNE Medicine and has represented Norway in the NATO Joint Health Agriculture and Food Group (JHAFG) [ref]

Covid Dossier: Spain, Austria, Portugal, Ireland, Slovakia, Hungary, Turkey & Switzerland

For these countries, we have some information regarding military and intelligence roles in each country's pandemic response:

- **The Spanish army** was deployed in **March and April of 2020**, and again in **September**, when the army started enforcing coronavirus lockdown restrictions in Madrid. [ref] By **October 2020**, the military was tasked with track-and-trace of "cases" [ref]
- **In Austria, Major General Rudolf Striedinger was co-leader of the national Covid crisis coordination (GECKO) [ref]**
- **In Portugal, a COVID-19 Vaccination Plan Task Force** was set up by the Portuguese government on November 23, 2020, by joint order (despacho) of the **Minister of National Defense, João Gomes Cravinho**, the Minister of Internal Administration, Eduardo Cabrita, and the Minister of Health, Marta Temido. [ref] It was initially led by Francisco Ramos, former Secretary of State for Health, but he was replaced in February 2021 by **vice-admiral Henrique de Gouveia e Melo**, a naval officer who was already part of the task force. [ref]
- **In Ireland, a Joint Task Force (JTF)** was established under **Operation FORTITUDE** in March 2020 to coordinate the contribution of the Defense Forces to the whole-of-Government COVID-19 response, [ref] commanded by Brigadier General Kevin Campion. [ref]
- **In Slovakia, in October/November 2020, The Armed Forces of the Slovak Republic** was entrusted with the task of coordinating and managing operation "Joint

Responsibility," the main goal of which was to conduct nationwide testing of 5.5 million people. [ref]

- **In Hungary**, as reported in July 2020, Prime Minister Viktor Orban had put **Hungary's security forces front and centre of the fight against the novel coronavirus**, with police officials chairing daily press conferences, military commanders assigned to head major hospitals and military advisers deployed in key strategic companies to ensure their smooth running. [ref]
- **In Turkey**, as reported in 2024, the Ministry of Health worked closely with the Ministry of Interior, which oversees the **paramilitary Gendarmerie General Command**, to coordinate the implementation of measures to battle the pandemic. Externally, the Ministry of Foreign Affairs spearheaded the use of the **Turkish military**, because of its organizational capacity, to help produce, transport, and distribute aid to foreign nations. **This deployment of hard power through the quasi-military gendarmerie and the regular army allowed President Recep Tayyip Erdoğan to demonstrate his willingness to participate in alliances...** [ref]
- **In Switzerland**: Switzerland is not a NATO country, but nevertheless, its military participated and coordinated the covid and mRNA vaccine-related campaign, just like we observed in most other countries of the world. The Swiss army chief, Thomas Süssli [ref], signed some of the purchasing agreements with the "vaccine" manufacturers. But in all actuality, those were signed by Divisionär (equivalent to Major General) **Andreas Stettbacher,** Former **Chief Medical Officer of the Swiss Armed Forces** and **Federal Delegate for the Coordination of the Medical Service.** During the COVID-19 crisis, **Andreas Stettbacher** played a key role in the **national pandemic response**, including **the procurement of COVID-19 vaccines**. He was part of the federal coordination team and worked closely with various authorities on:
    - Medical logistics
    - Vaccine procurement contracts
    - Coordination with pharmaceutical companies (e.g., Pfizer, Moderna)
    - Strategic health planning during the declared "health emergency"

He was also involved in the **Swiss COVID Taskforce** and contributed to decisions on vaccine rollout and stockpiling.

The "start date" in Switzerland was March 16, 2020

On March 16, 2020, the Federal Council declared the “extraordinary situation” according to the Epidemics Act from midnight to April 19, 2020. All shops (except groceries), markets, restaurants, bars and entertainment and leisure facilities had to remain closed and a ban was in effect for private and public events. [ref]

Brigadier Raynald Droz at a media conference in Berne (capital) on March 24, 2020 (only in German) [ref]

Chronology of the pandemic from the General Swiss Military Magazine [ref]

Swiss militia soldiers get historic call up to fight coronavirus [ref]

Swiss Army Pharmacy Implements GDP-Compliant Temperature Monitoring for COVID-19 Vaccines [ref]
The brigadier Raynald Droz who played an important role and the fact that the logistics of vaccine distribution in Switzerland were also handled by the army (or the army pharmacy) could be mentioned.

Note that Divisionär (2 star general) Andreas Stettbacher, former Chief Medical Officer of the Swiss Armed Forces was removed from his position following internal controversy and public scrutiny during the COVID-19 response. However, he challenged the dismissal legally and, as a result of that process, was reinstated.

🔗 vtg.admin.ch – Andreas Stettbacher

This explains the conflicting information across various media sources and platforms — some reported his removal, while others still list him officially in position due to the reinstatement.

Covid Dossier: Latin America

- **In Brazil**, as reported in July, 2020: **General Eduardo Pazuello, "a military general with no experience, remains health minister**." Furthermore, since Pazuello took over the Ministry of Health, "**at least 25 members of the military have been appointed, most with no public health experience**. Many criticize the government for pushing technical knowledge aside by appointing military personnel." [ref]
- **In Chile, on March 18, 2020, a public state of exception [emergency] was declared**. as reported by the International Commission of Jurists (ICJ) in October 20201, "military forces have had a key and outsized role in Chile's response to the COVID-19 pandemic. The state of exception allowed the President to appoint **16 "Chiefs of National Defence"** (Jefes de la Defensa Nacional), one in each region of the country. These Chiefs, who are high-ranking military officials, had extensive powers in their designated regions, including powers more appropriately held by public health experts in the context of public health emergency such as the one brought about by COVID-19." [ref]
- **In Peru**, on April 1, 2020, with a reported total of 30 deaths and 1,065 infections attributed to the novel coronavirus, the military called up its reservists for the first time in the country's history. As reported by AP "Peru had never called up reservists, not even during the internal armed conflict with the Shining Path terrorist group between 1980 and 2000 or during the cholera outbreak in 1991." [ref]

Covid Dossier: Asia

- **Sri Lanka**, as reported in April 2023, **extensively used its military and intelligence agencies for pandemic control during the COVID-19 crisis**. [ref]
- **In the Philippines**, as reported in July 2021, **starting in March 2020 "the government adopted a militarized approach** in its fight against the COVID-19 pandemic whose **council is predominantly a group of former military officers**." [ref]
- **In Indonesia**, according to one report, the government "involved the military institution in responding to the emerging outbreak.... This therefore involved the creation of **COVID-19 task force consisting mostly of military personnel**." [ref]

Covid Dossier: military/intelligence/biodefense plans & alliances

The following plans and alliances provide frameworks for responding to a bioterror/bioweapons attack. The information provided in this Dossier suggests they may have been invoked in the global Covid response.

- **U.S. Chemical, Biological, Radiological, and Nuclear Response (9/9/2016)** This publication provides joint doctrine for military domestic or international response to minimize the effects of a chemical, biological, radiological, or nuclear incident. [ref]
- **Medical Countermeasures Consortium** - a four-nation partnership involving the Defence and Health Departments of Australia, Canada, the United Kingdom and the United States.[ref]
- **Quadripartite Medical Intelligence Committee (QMIC)** the health equivalent of the Five Eyes intelligence-sharing alliance [ref]
- **NATO - Joint Chemical, Biological, Radiological and Nuclear Defence Centre of Excellence** [ref]
- **EU - Common Security and Defence Policy (CSDP)** [ref]
- **NATO's doctrine for Chemical, Biological, Radiological, and Nuclear (CBRN) defense is outlined in documents such as AJP-3.8(A)**, Allied Joint Doctrine for Chemical, Biological, Radiological, and Nuclear Defence, which was published on March 30, 2012. This doctrine provides NATO strategic and operational commanders with fundamental principles for planning, executing, and supporting NATO operations where the threat and/or risk of intentional or accidental use of CBRN substances are assessed or exist.
- **NATO also has a Combined Joint CBRN Defence Task Force (CJ-CBRND-TF)** that is specifically trained and equipped to deal with CBRN incidents and/or attacks against NATO populations, territory, or forces. This task force includes the CBRN

Defence Battalion and the CBRN Joint Assessment Team, both of which are multinational and multifunctional teams capable of rapid deployment to participate in the full spectrum of NATO operations.

- NATO CBRN Defense Policy
- ABCANZ (American, British, Canadian, Australian, New Zealand) Force cooperation and nudge units