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An das

Bundesverwaltungsgericht
Geschäftsstelle 1. Wehrdienstsenat

04107 Leipzig

Zustellung über das beA

Bei Zahlungen bitte stets angeben:
Rechn.-Nr.:

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Aktenzeichen: 37 + 58 / 2022

Selfkant, den 26.5.2022

In the military appeal proceedings
of Mr. ...
AZ. ...
and
of ...
AZ. ...

we have to ask the respondent, the PEI and the company BioNTech in particular also the following questions, whereby further questions are expressly reserved and can be asked if necessary only in the date.

A)

Questions to the respondent:

We still need the following information, also so that the expert Prof. Dr. Ulrike Kämmerer can prepare her presentation appropriately:

Which test systems exactly does the Bundeswehr use and under which conditions?

What are the SOPs (SOP = Standard Operation Procedure) for testing?

How qualified are the laboratory personnel?

What contamination controls are performed and how are they documented?

Responses to this should specifically detail:

Manufacturing company, kit name, which target genes, how many genes are tested, which primers (if known) and with which CT at how many genes is the test result considered "positive" and which controls for viral load determination are taken in each case and which genome copy number does the CT at the borderline to positive correspond to?

Is the PCR matched with symptoms? And if so, what counts as symptoms of the disease?

So if the original WHO protocol is no longer used: What is the testing strategy since the beginning? And if this has been changed: When and why and what systems were replaced?

B)

Questions for PEI:

Even if these defense appeal proceedings are factually about a direct "vaccination" obligation and thus a different constellation than the one referred to in the BVerfG's case law on the institution- and company-related obligation to provide evidence (BVerfG, decision of 27.4.2022 - 1 BvR 2649/21), it should be pointed out most emphatically as a precaution that this case law of the BVerfG is based on false assumptions in central respects.

In this decision, the BVerfG also assumed, among other things, that the legislature "could trust in the resilience of the data material collected and evaluated by the Robert Koch Institute and the Permanent Vaccination Commission." (ibid. para. 160).

We should have already thoroughly shaken this assertion with the previous presentation. And the transmission and answering of all questions to the RKI are still pending.

The BVerfG further erroneously assumed that a PCR test is a suitable instrument for assessing the occurrence of an infection, especially since it can indicate "an infection at an early stage of infection" (ibid., marginal no. 194).

But after all, it is also stated there in margin no. 235_.

"Nevertheless, an initially constitutional regulation may later become unconstitutional with effect for the future if original assumptions of the legislature are no longer supported (cf. BVerfG, Decision of the First Senate of November 19, 2021 - 1 BvR 781/21 et al. -, marginal no. 186 with further references) because they are shaken by subsequent findings or developments (cf. also BVerfGE 68, 287 <309>)."

Source:

https://www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/DE/2022/04/rs20220427_1bvr264921.html

This is precisely the case. The original assumptions of the legislator are no longer valid, nor are those of the BVerfG, because they have not only been shaken by "subsequent" findings, but have already been refuted many months ago by numerous findings that were simply not taken into account by the legislator and the BVerfG.

We will therefore question in depth here whether significant statements and assessments of the PEI - and also of the RKI and the STIKO - are really based on serious, scientifically sound methods or whether these statements and assessments are reminiscent of methods that have more in common with manipulative and misleading card player tricks.

Question block I

1.
How often are adverse drug reaction (ADR) reports classified as "unrelated" or "insufficient" or similar, so that they are not counted as adverse drug reactions. (Absolute numbers and percentage of all events reported).
1.1.

How often did this occur previously (years 2000 - 2020), how often since 2021?

1.2.

Conversely: How many of the reported adverse events were included in the revision of the SmPC?

2.

What is the distribution of subgroups among 14 days, 2 months, 6 months, more?

3.

How often in total and in % were adverse events not counted when **reported by patients** and in comparison when reported by **physicians.**

4.

What is the average processing time of adverse event reports (past and present)?

4.1.

How many have not yet been processed? (Absolute and percentage)

4.2

How long (days/weeks) is the processing backlog?

4.3.

For how many reports was personal contact made with the reporter (past and present)?

4.4.

How many more staff have been hired to process current adverse event reports since 2020?

4.5.

What are the qualifications of the staff who assess NW reports. Do the qualifications of long-time and new employees differ?

5.

For what reasons are adverse event reports classified as "unrelated"?

6.

Under what circumstances can adverse events occurring after 6 months also be classified as related, and how can this be assessed at all, given that in the clinical trials the comparison group was discontinued after 6 months?

7.

Since we know that the spike protein can be expressed in the body for months (at least up to 9 months): How does this apply to adverse event assessment as opposed to previous inactivated vaccines or live vaccines?

7.1.
What was the longest follow-up of study subjects after vaccinations were completed?

8.

What "inclusion criteria" resulted in patients being excluded from the study even after "vaccination" (both first and second) (e.g., developing immune disease)?

8.1.

How should such a subsequent exclusion of subjects in a pivotal study be assessed?

9.

Apart from the fact that it is a protein expressed in the body for a long time after "vaccination" with characteristics such as increased coagulation, blood mobility by release into the blood (furin cleavage site), nerve mobility, nerve toxicity, immune cell targeting: What studies had to be submitted for approval that go beyond the requirements for an inactivated or live vaccine?

10.

Are there data on what effects the additives or modRNA have on fertility of the offspring of vaccinated humans/animals?

11.

Most important point Efficacy: in addition to a positive PCR test, what clinical symptoms were sufficient for 8 or 162 patients to be counted as having Corona in the pivotal study (antibody rise, cough?)?

Which criteria were the basis for this assessment?

11.1.

Does this mean that a positive PCR test (please specify the test criteria) and an increase in antibodies in the unvaccinated group was sufficient to detect infection/disease? Was an additional clinical symptom necessary to establish disease?

12.

How many batches in the first year of production met the final approved batch release criteria?

Question Block II

To understand the scope of the questions that follow, a few introductory remarks are necessary here.

These further questions concern the alleged safety of the vaccines according to PEI safety reports. This is a central point of attack because the respondent and basically also the BVerfG argue as follows:

"There are also no disproportionately high vaccination risks associated with vaccination. The use of the vaccine is continuously monitored by the competent European authorities and the Paul Ehrlich Institute. The latter comes to the conclusion in its safety report that serious side effects occur very rarely and would not change the positive benefit-risk ratio of the vaccination."

So it is not only central to this trial that there is every indication that the safety analyses reported in the PEI safety reports are methodologically misapplied, in such a way that, for example, even in the case of an extremely high number of vaccine-related deaths, no risk signal would show up. And this is easily recognizable even to non-specialist experts.

Thus, the PEI negligently creates the illusion of "safety", which in reality may not exist.

Legislators and also the BVerfG thus assume, on the basis of the PEI's faulty analyses, a supposed safety of the vaccines, which in reality is not validly proven. A more detailed

evaluation of the available data suggests rather that these gene-based injections pose an unprecedented risk to life and limb compared to other vaccines (which deserve this name), which has unfortunately already been realized in thousands of cases.

1.

Faulty Observed-Versus-Expected Analysis

To monitor vaccine-related deaths, PEI uses what is actually an established method for detecting risk signals, a so-called "observed-versus-expected analysis." Such an analysis examines whether more people die than statistically expected in a given period after vaccination (e.g., 30 days).

For this purpose, the number of people who would normally die within 30 days ("expected") is determined, initially based on the composition of the vaccinated group of people. For example, in the safety report of 19.8.2021 (where the procedure is presented once in more detail), the PEI calculates that in relation to the group of people vaccinated with the BioNTech vaccine at that time, 75,284 deaths can normally be expected within a period of 30 days.

This number is then compared to the number of people who died in the vaccinated group of people within 30 days of vaccination ("Observed"). A risk signal would result if the number of persons who died in the vaccinated group of persons is statistically significantly higher than the statistically expected number of persons who died - in this case 75,284.

There is one key requirement for such an analysis to yield meaningful values, and it is easy for even medical laypersons to see: Since the standard of comparison is, after all, the number of deaths that normally occur, one must, of course, include as "observed" all deaths that occurred in the vaccinated group of persons in the analysis - that is, both those who died from the normally occurring causes of death and those who died for which a connection with the vaccination is suspected.

If only the number of deaths suspected to be related to vaccination were included in the analysis, a safety signal would only show up if the number of presumed vaccine-related deaths was higher (or from me: would be nearly as high) than the number of deaths due to all other causes of death combined - **which would be completely absurd.**

But that is exactly what is done in the PEI safety analyses.

It may be hard to believe, but PEI actually compares the number of statistically expected deaths - i.e. 75,284 in the above case - with the number of suspected deaths reported to PEI. This was 926 in the above safety report for the group of people vaccinated with the BioNTech vaccine. And then the PEI actually concludes from the fact that the number 926 is smaller than the number 75,284 that there is no risk signal. Specifically, for example, the PEI still writes in the current safety report:

"A comparison of the number of reported suspected cases of adverse reactions with fatal outcomes at intervals of one day to 30 days after COVID-19 vaccination with the number of deaths that could be statistically expected by chance in the same period (data from the

Federal Statistical Office) showed no risk signal for any of the five approved COVID-19 vaccines."

Thus, such a methodologically misapplied safety analysis would create the illusion of a supposedly safe vaccine even with an extremely high number of vaccine-related deaths.

This leads to the following caution and question for PEI:

Caution on this:
PEI uses an "observed-versus-expected analysis" to monitor vaccine-related deaths, which compares the number of deaths that normally occur in the vaccinated population ("expected") to the number of suspected vaccine-related deaths reported to PEI ("observed"). For example, in the 8/19/2021 Safety Report, PEI calculates that 75,284 deaths are normally expected to occur in a 30-day period with respect to the group of people then vaccinated with the BioNTech vaccine. PEI then compared this number to the number of reported suspected deaths related to the BioNTech vaccine, which was 926 at that time. Based on the fact that the number of suspected deaths - i.e., 926 - is smaller than the number of total expected deaths - i.e., 75,284 - PEI then concludes that there would be no risk signal. Such a safety analysis would only result in a risk signal if the number of reported suspected deaths is greater than the number of deaths due to all other causes of death combined - so there may not be a risk signal even if the number of suspected deaths is extremely high.

The question regarding this is:

Why does PEI use such a methodologically questionable safety analysis, which in reality masks even strong risks and thus lulls the public and policymakers into a sense of security that may not exist?

2.

Misleading presentation of the examination of the causal relationship with vaccinations in the reported suspected deaths.

PEI reports the results of testing the causal relationship with vaccinations in reported suspected deaths in the safety reports as follows (example from the current safety report:

"In approximately one percent of the suspected case reports (n = 2,810 cases), a fatal outcome was reported in varying temporal relation to COVID-19 vaccination. 116 cases were assessed by the Paul Ehrlich Institute as consistent with a causal relationship with the respective COVID-19 vaccination (synonymous: probable or possible causal relationship)."

This kind of presentation gives the impression that only 4 percent of the reported suspected deaths were really causally related to the vaccinations. But this need not be so; in fact, this is also a misleading way of reporting from which no valid conclusions can be drawn. For example, it is not reported how many of the reported suspected deaths were even investigated by the PEI. Thus, it is not known whether a causal relationship was ruled out for the other 96 percent, or whether instead many cases could not be

reviewed, for example, due to a lack of data. Furthermore, it remains completely open in what way - for example, through autopsies - it was proven or excluded that a suspected death was due to a causal relationship with the vaccinations.

That the portion of the causally at the inoculations deceased suspicion deaths lies in reality around a multiple larger, suggest - as already one submitted - among other things also the autopsy results of the renowned pathologist Professor Dr. med. Peter Schirmacher, director of the pathological institute at the university clinic Heidelberg, and also the observation study of Professor Dr. med. Harald Matthes of the Charité in Berlin.

Caution on this:

In its safety reports, the PEI always reports the number of suspected deaths in which a causal relationship with the vaccinations is actually probable. The way it is presented gives the impression that this is the case for only four percent. However, it is not reported how many of the reported suspected deaths could actually be investigated and in how many a link could actually be ruled out. Furthermore, it is not reported on the basis of which methods such conclusions were drawn. That the proportion of suspected deaths that actually died as a result of vaccinations could be significantly higher is suggested, for example, by the autopsy results of the renowned pathologist Prof. Peter Schirmacher, director of the Institute of Pathology at Heidelberg University Hospital, who arrives at a proportion of 30-40 percent in the suspected deaths he investigated.

Related questions:

How high does the PEI estimate the proportion of suspected deaths that actually died as a result of vaccinations in reality?

And on what methods is such an estimate based?

3.

Justification of the statement that severe side effects are very rare?

As described, the safety analyses of the PEI are not suitable to validly estimate the risk of the vaccines. In particular, a closer look at the available data shows that in reality there are risk signals that reach an extent never known before for vaccines.

According to the current safety report, 2,810 deaths have been reported to the PEI since the start of vaccinations, in which there is a suspicion of a connection with the vaccinations. This number is - as has already been stated - much higher than it is - related to a much longer period - for all other vaccines together the case.

For example, according to a peer-reviewed publication, the number of suspected deaths reported in the European surveillance database EudraVigilance is **42.5 times higher** for the COVID vaccines than for the influenza vaccines, which are also commonly given to the elderly.

Source:

https://www.frontiersin.org/articles/10.3389/fpubh.2021.756633/full

With regard to the vaccinations recorded in the current safety report, one suspected death was reported for every 23,000 persons vaccinated at least once.

However, this does not take into account that there is probably a higher number of unreported suspected deaths. If only 20% of the actual suspected deaths were reported, one would arrive at a value of 1 suspected death per 4,585 vaccinated persons, if only 10% of the actual suspected deaths were reported, one would arrive at a value of 1 suspected death per 2,293 vaccinated persons, if only 5% of the actual suspected deaths were reported, one would arrive at a value of 1 suspected death per 1,146 vaccinated persons.

As Mrs. Bahner in particular has already pointed out, such unreported figures are likely to be very realistic, especially in view of the estimates from studies on the frequency of reporting.

That there may in fact be an extraordinary risk here is also suggested by analyses of the increase in unexpected deaths in 2021.

Similar to the observed-versus-expected analysis described above, one can compare the number of observed deaths to the number of deaths that would actually be expected based on pre-Corona pandemic death rates.

A recent publication in a peer-reviewed journal by a group led by Prof. Göran Kauermann of LMU Munich showed that there was a significantly greater increase in unexpected deaths in 2021 - the pandemic year with vaccination - than in 2020 - the pandemic year without vaccination. **Of particular concern is that the increase was not greatest in the older age groups, but in the middle age groups - which are particularly relevant for the armed forces. The strongest percentage increase of seven percent was observed in the 40-49 age group.**

Source:

https://link.springer.com/article/10.1007/s11943-022-00303-9

This age distribution makes a number of possible explanations for the high number of unexpected deaths in 2021 seem implausible.

This pattern contrasts with the risk profile for COVID-19 disease, so an explanation by COVID-related factors seems unlikely.

Other conceivable explanations such as postponed surgery or long-COVID effects are also implausible, because such effects would also and especially have to affect the older age groups.

And that there is reason to believe that behind the label "Long-Covid" in reality vaccination complication cases are hidden, we have already presented.

Clues to a possible explanation are provided by an analysis of case fatality rates over the course of the year.

Source:

https://osf.io/v62dw/download

It appears that an increased number of unexpected deaths is not observed continuously throughout the year. Instead, a massive increase in unexpected deaths is observed in April and again in October, which follows the time course of the number of vaccinations administered.

Evidence in case of dispute: Obtaining an expert opinion

Accordingly, given the high number of suspected deaths and the autopsy results, it seems likely that the high number of unexpected deaths in 2021 could be related to COVID vaccinations.

Caution on this:

According to the PEI's current safety report, which includes reported suspected cases through the end of March 2022, 2,810 suspected deaths have been reported since vaccination began through the end of March. Relative to the number of persons vaccinated at least once, one suspected death was thus reported for every 23,000 persons vaccinated. This does not take into account that there is probably a higher number of unreported suspected deaths. If only 20% of actual suspected deaths were reported, one would arrive at a rate of one suspected death per 4,585 vaccinated persons; if only 10% of actual suspected deaths were reported, one would arrive at a rate of one suspected death per 2,293 vaccinated persons. According to a peer-reviewed published study, this puts the number of reported suspected deaths for COVID vaccines 42.5 times higher than for influenza vaccines, which are also commonly given to the elderly.

The question on this:

Given these numbers, how does PEI come to the conclusion that serious adverse events would be very rare?

Further caution:

According to a recent technical publication by the CODAG group at LMU Munich led by Prof. Kauermann, there was a significant increase in excess mortality in 2021 - the pandemic year with vaccination - compared to 2020 - the pandemic year without vaccination. The largest increases occurred in the middle age groups rather than the older age groups, with the peak occurring in the 40-49 age group. The progression of excess mortality over the year followed the progression of vaccinations.

Questions:

Does PEI consider such a pattern to be a risk signal? And if not, why not?

III.

Questions for BioNTech:

Is it correct that the RNA used in Cormirnaty is not - as publicly claimed - a normal "messenger" RNA (mRNA), but is a technically highly optimized and "base-modified (mod)" RNA, the properties of which are aimed at, among other things, difficult degradation in the human body and an elimination of the immune response against this RNA?

Are there data on the distribution and half-life of modRNA in the body? If not, why not?

Are there data on the effect of mod. RNA on immune cells, especially dendritic cells?

Based on what sequence information was the base sequence selected for Cormirnaty?

Specifically: Does the resulting amino acid-based spike protein contain the 3 HIV epitopes from GP 120 described by Pradnan et al. in the Wuhan variant and confirmed in an email to Fauci dated 02.02.2020, which trigger a possible binding to CD4 T cells (and thus an HIV-like effect)?

If yes: With which intention were these left in the mod RNA of Cormirnaty or intentionally accepted, because of the suspicion of a "gain of function" effect in the spike, which makes this a dangerous toxin?

This also concerns the furin cleavage site. Is this also encoded in BioNTech's modRNa and active at the protein level?

Why did Mr. Sahin state in an interview with the BBC in the fall of 2020 that they had to make their own batch of vaccines for Biontech employees and suppliers because they could not afford any failures? After all, if the injections are safe: Why then a separate batch?

Will the soldiers of the German Armed Forces also receive this harmless batch from BioNTech employees?

These are questions of the utmost interest.

Not only the complainants, but the entire public is entitled to adequate answers.

Schmitz
Attorney