Aan : Griffie Tweede kamer der Staten Generaal
Lange Poten 4,
2511 CL Den Haag

Van : J.E. van Kalker
St. andreasstraat 7
6074 BJ Melick

Plaats/ Datum : Melick, 5 november 2020
Onderwerp : Bezwaar tijdelijke wet maatregelen Covid 19

Geachte Griffier,

Bij deze wil ik **bezwaar** indienen tegen de wet

Tijdelijke wet maatregelen covid-19.

Tot op heden is er geen enkel bewijs dat het COVID 19 virus als zodanig bestaat
Geen enkel laboratorium ter wereld is in staat geweest het virus te isoleren in enig meetbare hoeveelheid.

fda.gov/media/134922/download

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are maintained until otherwise notified by FDA. Such records will be made available to FDA for inspection upon request.

Performance Characteristics

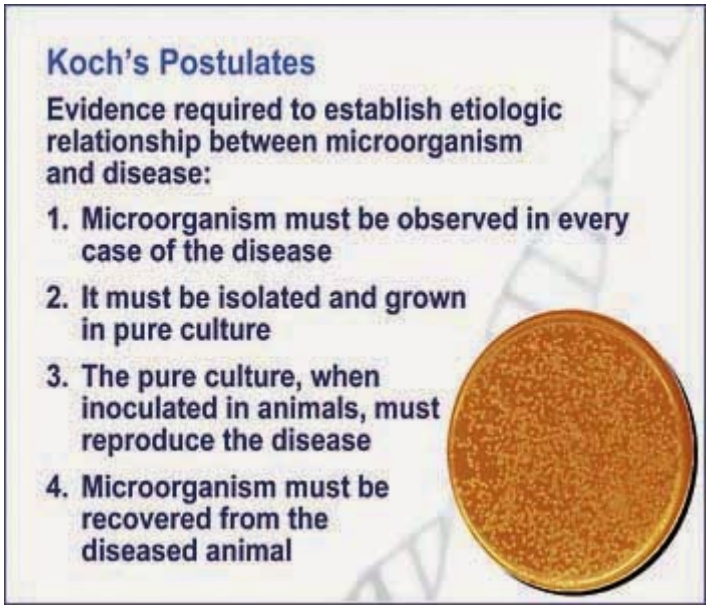
Analytical Performance:

Limit of Detection (LoD):

LoD studies determine the lowest detectable concentration of 2019-nCoV at which approximately 95% of all (true positive) replicates test positive. The LoD was determined by limiting dilution studies using characterized samples.

The analytical sensitivity of the rRT-PCR assays contained in the CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel were determined in Limit of Detection studies. Since no quantified virus isolates of the 2019-nCoV are currently available, assays designed for detection of the 2019-nCoV RNA were tested with characterized stocks of in vitro transcribed full length RNA (N gene; GenBank accession: MN908947.2) of known titer (RNA copies/µL) spiked into a diluent consisting of a suspension of human A549 cells and viral transport medium (VTM) to mimic clinical specimen. Samples were extracted using the QIAGEN EZ1 Advanced XL instrument and EZ1 DSP Virus Kit (Cat# 62724) and manually with the QIAGEN DSP Viral RNA Mini Kit (Cat# 61904). Real-Time RT-PCR assays were performed using the ThemoFisher Scientific TaqPath™ 1-Step RT-qPCR Master Mix, CG (Cat# A15299) on the Applied Biosystems™ 7500 Fast Dx Real-Time PCR Instrument according to the CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel instructions for use.

Tevens is geen enkel wetenschapper dan wel laboratorium ter wereld instaat geweest het virus te reproduceren volgens de algemeen wetenschappelijk aanvaarde methode van de Koch postulates



StandUpX • Science Committee 22nd June 2020

Dear Prime Minister,

CHALLENGE TO PUBLIC HEALTH ENGLAND THAT THEY MUST SHOW PROOF THAT A VIRUS EXISTS WHICH CAUSES COVID-19 OR DECLARE THERE IS NO VIRUS AND END THE VAX AND TRAX PROGRAMMES

We understand that the World Health Organisation has advised Public Health England not to isolate and purify a 'virus' said to cause the disease 'Covid-19.'

There are major questions over the validity of the testing procedures being used to determine the presence in the UK population of the putative 'Covid19 virus' specifically relating to the throat swab (RT-PCR test) and evidence of previous infection using antibody tests.

The disease-causing effects of any virus are scientifically verified using Koch's Postulates of which four conditions must be met. Currently the virus thought to cause Covid-19 does not meet any of them.

Fulfillment of Koch's Postulates requires that the so-called Covid-19 virus must be isolated and purified. This ***has not been done*** – therefore the accuracy of the tests authorized by Public Health England is unknown.

In summary, the tests for the Covid-19 virus are of unknown accuracy, scientific procedures for viral isolation and purification have not been followed and neither have any of the Koch methods for determining any disease causing effects.

Therefore, we demand that by July 22nd 2020, Public Health England must:

1. Produce independently peer reviewed scientific evidence proving that the Covid-19 virus has been isolated and purified in the reference laboratories run by Public Health England under the leadership of Professor Zambon (Imperial College London/SAGE member) ignoring the instructions not to do so issued by the World Health Organisation.

2. Produce independently peer reviewed scientific evidence proving that Covid-19 virus causes disease using all of the Koch Postulates.

If the United Kingdom Government's own health agency - Public Health England – CANNOT show independent and peer-reviewed proof that a virus exists which causes COVID-19 then the Government must DECLARE THERE IS NO SUCH VIRUS AND CEASE MEASURES AGAINST SOMETHING WHICH DOES NOT EXIST, including producing a vaccine and the Government's Track+Trace policy.

Yours faithfully

Dr Kevin P. Corbett BA (Art) University of Reading, Higher Diploma (Fine Art) Slade School of Fine Art University College London, MSc (Nursing) Kings College London, PGCE (Health Professions) University of Greenwich, PhD (Social Sciences) London South Bank University. 37-years nursing experience. UK-based visual artist; clinical nurse researcher specialised in acute, palliative & primary medical care, forensics, respiratory/infectious diseases (STIs, HIV & AIDS), medical screening and testing; Director KPC Research and Consultancy Ltd (management consultancy); extensive research publications on patient & citizen experience of medical science; international speaker at academic research meetings and conferences.

Piers Corbyn Royal Scholar Imperial College, BSc (1st class) Imperial College, ARCS, MSc (Astrophysics, QMC), first democratically elected President Imperial College Students Union, Convenor Institute of Evidence-based Science; Founder and Director WeatherAction unique Solar-based long-range weather forecasters & CEO of former listed WeatherAction Holdings PLC, elected Fellow Royal Astronomical Society, elected corporate member (WeatherAction Holdings) Royal Meteorological Society, wide-ranging publications including on Meteorological Instrumentation, astronomy and coastline physics (pre-university), Cosmology and galaxy formation; Rights Campaigner, accomplished (with prizes) international presenter at Commercial, Agricultural and academic research conferences.

David Crowe BSc (1st class Mathematics and Biology) Canadian software engineer, expert witness, independent researcher of infectious disease models, host of a weekly radio programme called The Infectious Myth from US (New York) on PRN.FM **http://theinfectiousmyth.com?** President of Rethinking AIDS, wide-ranging publications and international speaker.

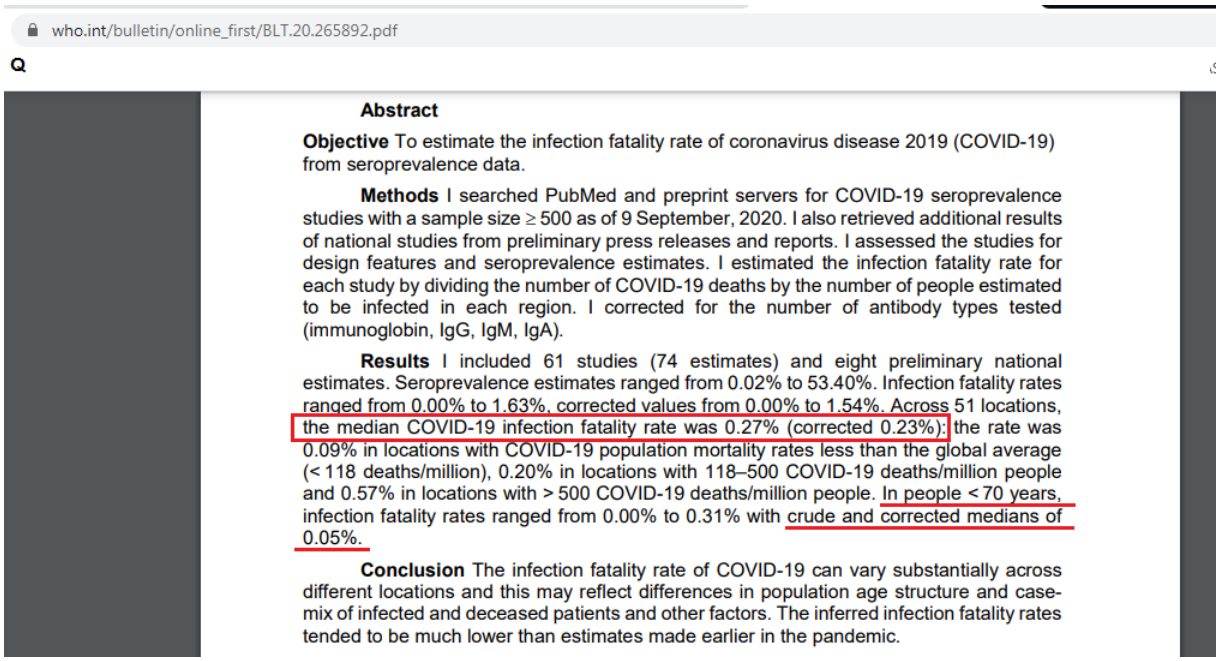
Dr Andrew R. Kaufman BS (Molecular Biology), MD (Medicine) U.S. Forensic Psychiatrist, Natural Healing Consultant, and Independent Researcher. Former Assistant Professor of Psychiatry at SUNY Upstate Medical University, Medical Director Psychiatry Department, Research Committee Chair for American Academy of Psychiatry and the Law, Certified Expert Witness in local, state and federal courts, Founder and CEO of medical device start-up company (Zinnia Safety Systems), Holds two patents for medical devices, published several peer reviewed scientific papers and a medical textbook chapter.

Dr David Rasnick BS (Biology), BS (Chemistry), PhD (Biochemistry) U.S. independent scientist, Chromosomal Imbalance (Aneuploidy) Cancer Theorist, inventor **DATE Analysis.pdf**, former Chief Science Officer of the Office of Medical and Scientific Justice, former Member of The Presidential AIDS Advisory Panel of South Africa initiated by President Thabo Mbeki, former President of Rethinking AIDS, synthesizer of the first peptidyl-fluoromethanes, founder of biotechnology companies and wide-ranging publications and international speaker.

Professor Roger Watson BSc (Biological Sciences), PhD (Biochemistry), FRCP Edinburgh, UK Editor-in-Chief of Journal of Advanced Nursing and Editor of Nursing Open, Professor of Nursing University of Hull UK, member of the UK 2014 Research Excellence Framework sub-panel for Allied Health Professions, Dentistry, Nursing & Pharmacy, Sigma Theta Tau International Nurse Researcher Hall of Fame and wide-ranging publications and international speaker.

Bovendien heeft het griepvirus covid 19 volgens de WHO een gemiddelde IFR van 0,23 %

En voor mensen onder de 70 zelfs 0,05 %



who.int/bulletin/online_first/BLT.20.265892.pdf

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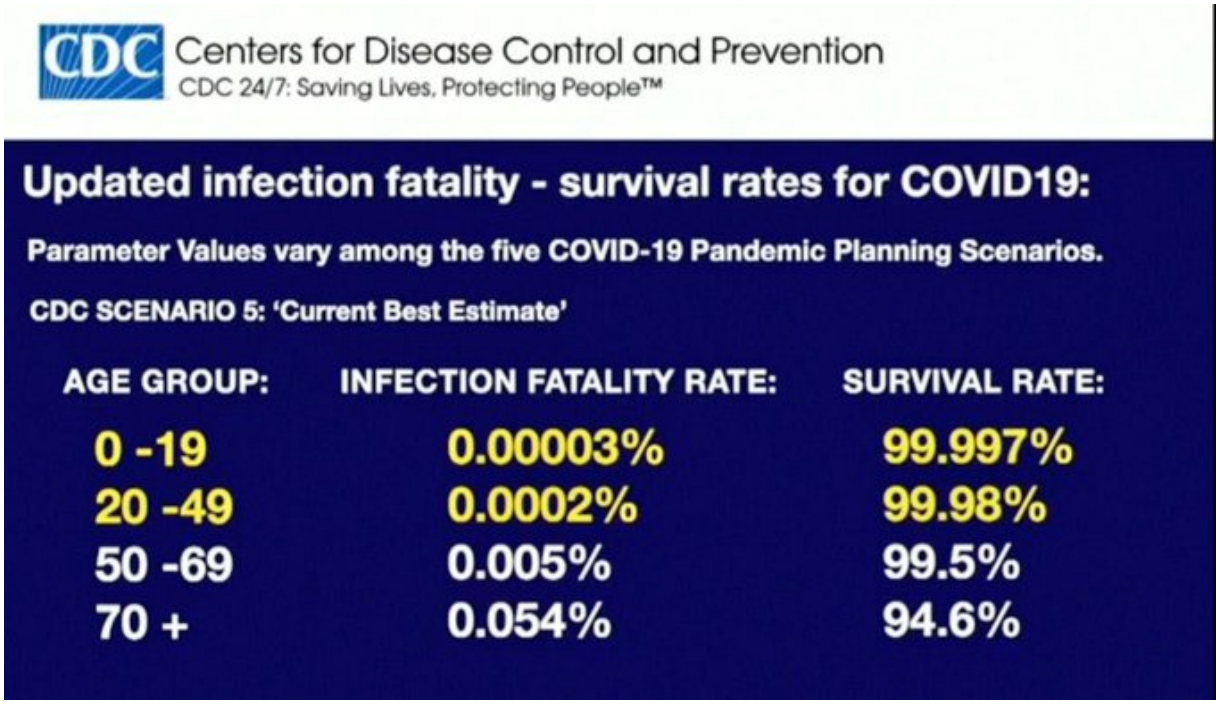
Abstract

Objective To estimate the infection fatality rate of coronavirus disease 2019 (COVID-19) from seroprevalence data.

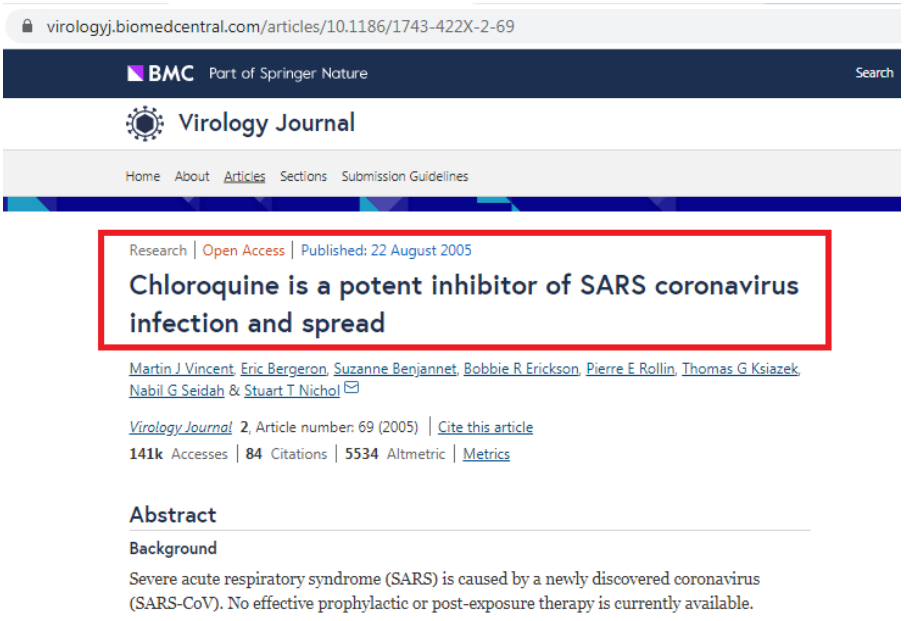
Methods I searched PubMed and preprint servers for COVID-19 seroprevalence studies with a sample size ≥ 500 as of 9 September, 2020. I also retrieved additional results of national studies from preliminary press releases and reports. I assessed the studies for design features and seroprevalence estimates. I estimated the infection fatality rate for each study by dividing the number of COVID-19 deaths by the number of people estimated to be infected in each region. I corrected for the number of antibody types tested (immunoglobin, IgG, IgM, IgA).

Results I included 61 studies (74 estimates) and eight preliminary national estimates. Seroprevalence estimates ranged from 0.02% to 53.40%. Infection fatality rates ranged from 0.00% to 1.63%, corrected values from 0.00% to 1.54%. Across 51 locations, the median COVID-19 infection fatality rate was 0.27% (corrected 0.23%): the rate was 0.09% in locations with COVID-19 population mortality rates less than the global average (< 118 deaths/million), 0.20% in locations with 118–500 COVID-19 deaths/million people and 0.57% in locations with > 500 COVID-19 deaths/million people. In people < 70 years, infection fatality rates ranged from 0.00% to 0.31% with crude and corrected medians of 0.05%.

Conclusion The infection fatality rate of COVID-19 can vary substantially across different locations and this may reflect differences in population age structure and case-mix of infected and deceased patients and other factors. The inferred infection fatality rates tended to be much lower than estimates made earlier in the pandemic.



De door de tweede kamer der statengeneraal voorgestelde maatregelen zijn buiten proportioneel en een misdaad tegen de menselijkheid onder o.a. de Neurenberger code, vooral omdat er een prima goedkoop geneesmiddel voorhanden is nl HCQ



virologyj.biomedcentral.com/articles/10.1186/1743-422X-2-69

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Research | Open Access | Published: 22 August 2005

Chloroquine is a potent inhibitor of SARS coronavirus infection and spread

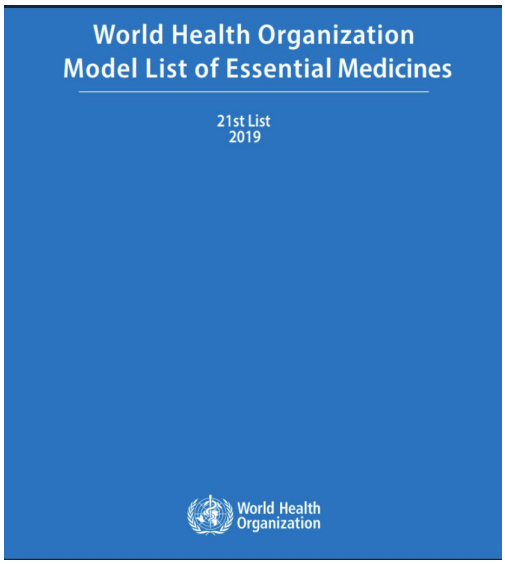
Martin J Vincent, Eric Bergeron, Suzanne Benjannet, Bobbie R Erickson, Pierre E Rollin, Thomas G Ksiazek, Nabil G Seidah & Stuart T Nichol

Virology Journal 2, Article number: 69 (2005) | Cite this article

Abstract

Background

Severe acute respiratory syndrome (SARS) is caused by a newly discovered coronavirus (SARS-CoV). No effective prophylactic or post-exposure therapy is currently available.



WHO Model List of Essential Medicines

21st edition

darunavir	20	fluphenazine	49
dasabuvir	22	folic acid	35
dasatinib	32	*fomepizole*	5
daunorubicin	29	*fosfomycin*	15
deferoxamine	5, 35	fresh-frozen plasma	36
delamanid	17	furosemide	38, 40
dengue vaccine	46	*gemcitabine*	30
desmopressin	35	gentamicin	11, 46
dexamethasone	3, 4, 33, 41, 49	glecaprevir + pibrentasvir	22
dextran 70	36	gliclazide	43
diaphragms	48	glucagon	43
diazepam	3, 5, 50	glucose	51
diazoxide	43	glucose with sodium chloride	51
diethylcarbamazine	6	glutaral	40
digoxin	37, 38	glyceryl trinitrate	37
dihydroartemisinin + piperaquine phosphate	24	griseofulvin	18
diloxanide	23	Haemophilus influenzae type b vaccine	45
dimercaprol	5	haloperidol	3, 50
diphtheria antitoxin	44	halothane	1
diphtheria vaccine	45	heparin sodium	35
docetaxel	29	hepatitis A vaccine	46
docusate sodium	3	hepatitis B vaccine	45
dolutegravir	20	HPV vaccine	45
dolutegravir + lamivudine + tenofovir	20	hydralazine	37
dopamine	38	hydrochlorothiazide	37, 38, 40, 41
doxorubicin	29	hydrocortisone	4, 33, 39, 42, 43
doxycycline	11, 24, 25	hydroxocobalamin	35
efavirenz (EFV or EFZ)	19	*hydroxycarbamide*	30, 36
efavirenz + emtricitabine + tenofovir	20	*hydroxychloroquine*	53
efavirenz + lamivudine + tenofovir	20	hyoscine butylbromide	3
eflornithine	26	hyoscine hydrobromide	3
emtricitabine + tenofovir	21	ibuprofen	2, 26, 49
enalapril	37, 38	*ifosfamide*	30
enoxaparin	35	*imatinib*	32
entecavir	21	influenza vaccine	46
ephedrine	1	insulin injection (soluble)	43
epinephrine (adrenaline)	4, 37, 47, 51	intermediate-acting insulin	43
ergocalciferol	52	*intraperitoneal dialysis solution (of appropriate composition)*	49
ergometrine	48	iodine	52
erlotinib	32	iohexol	40
erythromycin	46	ipratropium bromide	51
erythropoiesis-stimulating agents	35	*irinotecan*	30
estradiol cypionate + medroxyprogesterone acetate	48	isoflurane	1
ethambutol	16	isoniazid	16
ethambutol + isoniazid + pyrazinamide + rifampicin	16	isoniazid + pyrazinamide + rifampicin	16
ethambutol + isoniazid + rifampicin	16	isoniazid + pyridoxine + sulfamethoxazole + trimethoprim	21
ethanol	40	isoniazid + rifampicin	16
ethinylestradiol + levonorgestrel	47	isosorbide dinitrate	37
ethinylestradiol + norethisterone	47	itraconazole	18
ethionamide	17	ivermectin	6, 26
ethosuximide	6		
etonogestrel-releasing implant	48		

Medicines for the Prevention of Malaria While Traveling
Hydroxychloroquine (Plaquenil™)

What is hydroxychloroquine?

Hydroxychloroquine (also known as hydroxychloroquine sulfate) is an arthritis medicine that also can be used to prevent malaria. It is available in the United States by prescription only. It is sold under the brand name Plaquenil and it is also sold as a generic medicine. It is available in tablets of 155mg base (200mg salt).

You should know that the 155mg base tablet is the same as the 200mg salt tablet. It is just two different ways of describing the same thing.

Hydroxychloroquine can be prescribed for either prevention or treatment of malaria.

This fact sheet provides information about its use for the prevention of malaria infection associated with travel.

Who can take hydroxychloroquine?

Hydroxychloroquine can be prescribed to adults and children of all ages. It can also be safely taken by pregnant women and nursing mothers.

Who should not take hydroxychloroquine?

People with psoriasis should not take hydroxychloroquine.

How should I take hydroxychloroquine?

Both adults and children should take one dose of hydroxychloroquine per week starting at least 1 week before traveling to the area where malaria transmission occurs. They should take one dose per week while there, and for 4 consecutive weeks after leaving.

The weekly dosage for adults is 310mg base (400mg salt).

Your doctor will have calculated the correct weekly dose for your child based on the child's weight. The child's dose should not exceed the adult dose of 310mg base (400mg salt) per week

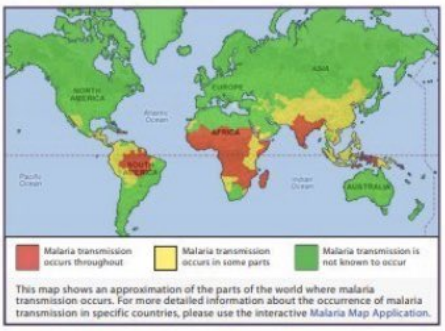
Where can I buy hydroxychloroquine?

Antimalarial drugs are available in the United States by prescription only. Medicines should be obtained at a pharmacy before travel rather than in the destination country. Buying medications abroad has its risks: the drugs could be of poor quality, contaminated, or counterfeit and not protect you against malaria.

In what parts of the world can hydroxychloroquine be used for prevention of malaria in travelers?

Hydroxychloroquine can only be used in places where chloroquine (a related medicine) is still effective. There are only a few places left in the world where hydroxychloroquine is still effective including parts of Central America and the Caribbean.

CDC keeps track of all the places in the world where malaria transmission occurs and which malaria drugs that are recommended for use in each place. This information can be found using the malaria map on the CDC website: http://www.cdc.gov/malaria/map/index.html.



This map shows an approximation of the parts of the world where malaria transmission occurs. For more detailed information about the occurrence of malaria transmission in specific countries, please use the interactive Malaria Map Application.

Center for Global Health
Division of Parasitic Diseases and Malaria

CDC

CS237187-C

Deze wet schendt tevens mijn rechten en de rechten van alle burgers
onder de volgende wetten / verdragen en overeenkomsten

art 1 GW, art 8 GW, art 9 GW, art 10 GW, art 11 GW, art. 12 GW, art 15 GW, art. 19 GW, art 20 GW,

art 8 EVRM,

art 1 UVRM, art 3 UVRM, art 4 UVRM, art 5 UVRM, art 9 UVRM , art 12 UVRM , art 13 UVRM, art 16 UVRM, art 17 UVRM, art 20 UVRM, art 22 UVRM, art 23 UVRM , art 24 UVRM, art 28 UVRM,

art 7.e Statuut van Rome inzake het Internationaal Strafhof,

Code van Neurenberg ('Artsenproces'),

https://nl.wikipedia.org/wiki/Code_van_Neurenberg

Verklaring van Helsinki ('Wet medisch-wetenschappelijk onderzoek met mensen' en 'Goede klinische praktijken')

12. Medical research involving human subjects ***must be conducted only by individuals with the appropriate ethics and scientific education, training and qualifications. Research on patients or healthy volunteers requires the supervision of a competent and appropriately qualified physician*** or other health care professional.

14. ***Physicians*** who combine medical research with medical care should involve their patients in research ***only to the extent that this is justified by its potential preventive, diagnostic or therapeutic value*** and if the physician has good reason to believe that participation in the research study will not adversely affect the health of the patients who serve as research subjects.

15**.** ***Appropriate compensation and treatment for subjects who are harmed as a result of participating in research must be ensured***. Risks, Burdens and Benefits

16. In medical practice and in medical research, most interventions involve risks and burdens. ***Medical research involving human subjects may only be conducted if the importance of the objective outweighs the risks and burdens to the research subjects.***

17. All medical research involving human subjects ***must be preceded by careful assessment of predictable risks and burdens to the individuals and groups involved in the research in comparison with foreseeable benefits to them and to other individuals or groups affected by the condition under investigation.*** Measures to minimise the risks must be implemented. The risks must be continuously monitored, assessed and documented by the researcher. 18. Physicians may not be involved in a research study involving human subjects unless the

en Internationale ethische richtlijnen voor gezondheidsgerelateerd onderzoek waarbij mensen betrokken zijn (CIOMS). o.a.

-guideline 1 “Scientific and social value cannot legitimate subjecting study participants or host communities to ***mistreatment, or injustice*.”**

- guideline 3 “ “stakeholders must ensure that the benefits and burdens of research are equitably distributed. Groups, communities and individuals invited to participate in research must be selected for scientific reasons and not because they are easy to recruit because of ***their compromised social or economic position or their ease of manipulation*.**

Ik ga dan ook niet akkoord met de invoering van deze wet
en wil graag persoonlijk gehoord worden
aangaande dit bezwaarschrift

i.o. Mw. J.E van Kalker