Memo and Draft Discovery re:
No dosing limits for EUA drugs, devices and biologics under NIH protocols, to facilitate intentional poisoning in hospitals (hospital homicide)

Analysis

Most Covid-era hospital and nursing home homicide, medical malpractice cases are dismissed long before discovery.

Hospital and nursing home defendants defend their actions through the PREP Act declarations and the classification of most of the products (drugs, devices and biological products) they used/use, as having EUA status from the HHS-FDA, to exempt themselves from medical malpractice and other civil and criminal liability.

Because the PHE-PREP+EUA system is set up, intentionally, to provide license-to-kill for "covered persons" (health care workers/nurses/doctors/pharmacists) using "covered countermeasures," my current understanding is that there is **no legal limit to the volume, concentration and/or dose of poisons** classified as EUA drugs and biological products, or volume/rate settings on ventilation machines classified as EUA devices, that may legally be administered to a targeted victim.

In other words, the public health emergency (PHE) declarations by HHS Secretary, Emergency Use Authorization (EUA) classifications by FDA Commissioner and other FDA officers (as HHS Secretary delegates) and treatment protocols promulgated by NIH, are broadly written to facilitate health care provider (HCP) use of any mixture of EUA-covered poisons, and to provide legal immunity from civil and criminal prosecution for any HCP who uses any EUA-covered poisons, even if he or she also uses non-EUA products and even if he or she administers EUA products in volumes that exceed what would, under non-emergency conditions, violate typical standards of care.

Supporting documents include:

- Aug. 8, 2022 - Blood Money in U.S. Healthcare Financial Incentives: The Use of “Covered Countermeasures (AJ DePriest, TN Liberty Network)
- Aug. 10, 2023 - Blood Money in U.S. Healthcare Financial Incentives: The Use of “Covered Countermeasures” (AJ DePriest, TN Liberty Network)
- April 21, 2020 through Feb 11, 2024 - NIH COVID-19 Treatment Guidelines (roughly 60 versions)

https://www.covid19treatmentguidelines.nih.gov/about-the-guidelines/guidelines-archive/

- April 17, 2020 - HHS Office of General Counsel Advisory Opinion [20-01] on the Public Readiness and Emergency Preparedness (PREP) Act; and the March 10, 2020 Declaration Under The Act
- May 19, 2020 - HHS-OGC Advisory Opinion 20-02 on the Public Readiness and Emergency Preparedness Act; Secretary's Declaration under the Act
- Oct. 22, 2020 - HHS-OGC Advisory Opinion 20-03 on the Public Readiness and Emergency Preparedness Act; Secretary's Declaration under the Act
- Oct. 23, 2020 - HHS-OGC Advisory Opinion 20-04 on the Public Readiness and Emergency Preparedness Act; Secretary's Declaration under the Act
- Jan. 8, 2021 - HHS-OGC Advisory Opinion 21-01 on the Public Readiness and Emergency Preparedness Act: Scope of Preemption Provision
- Jan. 12, 2021 - HHS-OGC Advisory Opinion 21-02 on the Public Readiness and Emergency Preparedness Act; Secretary's Declaration under the Act

Draft Discovery for Hospital Homicide/NIH Protocol Cases

Requests for Admission (Yes-No questions, phrased as factual statements for respondents to admit or deny)

Admit or deny:

- Under the NIH Covid-19 Treatment Guidelines in use at [name of hospital/nursing home] during the time period [date/month/year to date/month/year] when deceased was treated by [hospital] staff, there was no legal upper or lower limit to the dose volume/concentration/frequency of [each medication or device] administered to the deceased.

Note:

If the hospital/nursing home defendants were required to answer, and answered "Admit," then it would be clear to the judge that hospital employees were instructed, by NIH through hospital administrators, to continue pushing EUA poisons, while suppressing breathing and withholding water, food and non-EUA medications (i.e., vitamins, antibiotics, anti-inflammatory medications), until patients died or escaped from the hospital or nursing home.

If the hospital were required to answer, and answered "Deny," then plaintiffs would have opportunity to request further information about what those limits were, how the limits were conveyed to hospital staff, and whether the medical records for deceased show that the hospital staff gave or withheld doses outside the upper and lower limits.

Hospitals and nursing homes will likely not be required to answer the discovery questions, but there's still value in writing them, organizing them, and getting them into the hands of the general public, private lawyers, judges, lawmakers and public prosecutors, to help more people understand the death protocols and keep themselves and their loved ones away from hospitals and nursing homes where the intentional killing has been done, is still being done, and will continue to be done.

Requests for Production of Documents

- Copies of the NIH Covid-19 Treatment Guidelines in use in the hospital during hospitalization/nursing home residency of deceased [insert dates].
- Copies of all written hospital records directing hospital staff about how to use NIH Covid-19 Treatment Guidelines between Jan. 1, 2020 and the present.
- Minutes and meeting notes, slide decks, handouts, etc. for all hospital staff meetings held between Jan. 1, 2020 and the present, at which hospital staff were given instructions, directions, and/or orders pertaining to NIH Covid-19 Treatment Guidelines, including but not limited to information provided to hospital staff relating to legal exposure for medical license revocation and/or medical malpractice claims related to use or non-use of NIH Covid-19 Treatment Guidelines and/or EUA products listed in NIH Covid-19 Treatment Guidelines, and relating to financial implications for the hospital related to use or non-use of NIH Covid-19 Treatment Guidelines.
- Financial records of all HHS Centers for Medicare and Medicaid Services (CMS) payments and reimbursements received by [name of hospital or nursing home] between Jan. 1, 2020 and the present, relating to treatment of decedent and all other patients (names may be redacted) identified by ICD-10 and/or previous and/or subsequent disease classification code as Covid-19 patients.

Interrogatories

- Which version of the NIH Covid-19 Treatment Guidelines governed the treatment plans during the time that the deceased was hospitalized?
- Under non-emergency conditions, are there clinical (medical) and/or legal limits to dose volume for [medication identified by name] administered to deceased, in numerical terms? For example, milligrams per pound of body weight per time interval. [Ask the same question for each medication identified in medical records of deceased.]
- If there are clinical or legal limits to dose volume for [medication] under non-emergency conditions, what are those limits, in numerical terms? For example, milligrams per pound of body weight? [Ask the same question for each medication identified in medical records of deceased.]
- Under PHE emergency conditions, are there clinical (medical) and/or legal limits to dose volume for [medication identified by name] administered to deceased, in numerical terms? For example, milligrams per pound of body weight per time interval. [Ask the same question for each medication identified in medical records of deceased.]
- If yes, what are those limits, for each medication administered?
- Under non-emergency conditions, are there clinical (medical) or legal limits to ventilation volume and rate settings?
- If yes, what are those limits?
- Under PHE emergency conditions, are there clinical (medical) or legal limits to ventilation volume and rate settings?
- If so, what are those limits?

Other questions and document requests could be developed to elicit information about and discrepancies between standard of care, dosing, etc., for provision of water (hydration), food (nutrition), and non-EUA medications under non-emergency conditions as compared to public health emergency conditions.