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Sir Simon Stevens
Chief Executive Officer
NHS England

2 July 2021

Dear Mr Stevens

Re: My Client: Dr Sam White

I am instructed by Dr Sam White, a GP.

Dr Sam White has had his licence to practise within the NHS suspended by letter from the NHS dated 26 June 2021.

Please treat this letter as a public interest disclosure or whistle blow in that it raises allegations of alleged criminal conduct and breach of legal obligations by those leading the covid response.

The reasons given for my client's suspension have been inconsistent. My client has been told one thing verbally and another in writing.

What my client has been told in writing is he has been suspended on the basis of his social media output.

My client's social media output does not differ in any material extent to other clinicians also with an online presence who have not been suspended.

My client raised concerns during his NHS five year revalidation appraisal process with the NHS in November 2020.

All of these concerns were raised during the revalidation appraisal process and overlap with what is in my client's social media content.

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The NHS took no action on either the substance of the concerns raised in my client's appraisal nor did the NHS take any action against my client for raising those concerns during his appraisal. My client's appraisal was signed off by the NHS Responsible Person. The same Responsible Person who later suspended my client.

It would appear that the reason the NHS took the action they did of suspending my client from practice in the NHS was the fact that the contents of Dr White's video went viral clocking up over a million views in June 2021.

The NHS appears to have taken umbrage at my client letting the cat out of the bag. The NHS appear to have acted in the way they did because my client pointed out that there are a number of elephants in the room. My client is entitled to point out alleged wrongdoing and is also entitled not to be victimised for so doing.

My client's social media output sets out two main propositions which are further developed here:

1. The vaccine programme has been rolled out in breach of the legal requirements for clinicians to obtain the free and informed consent of those being vaccinated.
2. That the requirement to wear face coverings in an NHS setting is in breach of common law obligations not to cause harm and breaches statutory obligations in relation to provision of PPE.

My client has instructed me to write to you setting out the complaint that he has been victimised and harassed for telling the truth by the organisation you head.

Clinicians should feel able to voice genuine concerns relating to alleged malpractice without fear for their ability to practice within the NHS being suspended.

The truth that Dr White is telling may be uncomfortable for you to hear. But hear it you must.

I am instructed to copy this letter to the relevant regulators as well as law enforcement.

I am also instructed by my client to publish this letter on social media as the public has the right to know what is happening and how truth is being suppressed.

The allegations are that the following groups of people have committed unlawful and potentially criminal acts in breach of their common law obligations to act in the best interests of the public as well as in breach of their common law obligation of doing no harm to the public.

The Nolan Principles of Standards in Public Life are alleged to have been breached.

The groups of people who my client alleges have breached common law obligations are:

1. HM Government.
2. The Executive Board of the NHS.
3. SAGE.
4. Senior public office holders within the civil service.
5. The Executive Board of the MHRA.

In relation to the MHRA they have failed to ensure that the vaccine advertising programme meets their common law obligations as well as their statutory obligations.

The MHRA in granting emergency use authorisation for the vaccines has failed in their obligation to consider whether there are safe and effective medicines available as an alternative to vaccination.

The MHRA is failing in its obligations in failing either to instruct a bio-distribution study is conducted on those who have been vaccinated or in failing to publish the findings of such a bio-distribution study. A bio-distribution study is a study of what happens to the vaccine after it is injected into the body.

I am instructed to set out the factual allegations in a comprehensible way, free of jargon, so the general public can follow what is being said.

To assist my client has provided source material to back up every single one of his principal facts and that source material will be referenced via footnotes or endnotes.

The Vaccination Roll Out:

Clinicians practising within the NHS are obliged to do two things when administering a vaccine:

1. To do no harm.
2. To obtain the free and informed consent of those being vaccinated.

The law on free and informed consent is set out in the case of Montgomery.

Montgomery's case which went to the Supreme Court laid down the principles for what amounts to free and informed consent.

1. That the patient is given **sufficient information – to allow individuals to make choices that will affect their health and well being on proper information.**[1]
2. Sufficient information means informing the patient of the **availability of other treatments**.[2]
3. That the patient is informed **of the material risks** of taking the vaccine and the **material risks** of declining the vaccine.

The Montgomery principles are in line with Article 6 of the Unesco Declaration of Bio-Ethics and Human Rights, the right to decline any medical treatment without being penalised is enshrined in International Law.[3]

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[1] Per Lord Justice Simon in Webster v Burton Hospitals NHS Foundation Trust [2017] EWCA Civ 62

[2] Montgomery v Lanarkshire Health Board [2015] UKSC 11

[3] http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html

Breach of these principles on free and informed consent is professional gross misconduct at an individual level.

At an organisational level if the NHS does not have clear evidence that every person being vaccinated has given free and informed consent it will render those holding executive office within the NHS as legally liable for those institutional failings.

The Government has set the vaccination strategy. The NHS has led the roll out. The strategy and roll out has included the provision of information to the public.

Much of the information has been inadequate or misleading.

1. **Montgomery Guideline 1: Sufficiency of Information**:

The provision of information has been inadequate. The principal source of information to the public has been the following:

1. The Daily Press Conferences.
2. The NHS badged advertisements.
3. The Patient Information Leaflet.

The information presented has not informed the public of the following material risks:

1. The material risk of being infected with the coronavirus.
2. The material risk if infected of being hospitalised by the coronavirus.
3. The material risk if infected of not being hospitalised by the coronavirus.
4. The material risk of dying from the coronavirus infection.
5. The material chance of recovering from the coronavirus infection.
6. The material chance of having an asymptomatic infection.
7. The numbers of people with existing antibody immunity or memorised T cell response.

Before we come to what information has been presented to the public it should be noted that those presenting the information have not publicly declared at the press conferences their financial links to the vaccine industry. Public Office Holders should

act with integrity and transparency when presenting information to the public, particularly information relating to public health.

Those financial links include direct investment in the vaccine industry as well as financial assistance with grants from charitable foundations set up by those with investments in the vaccine industry.[4]

It should be noted that Moderna's share price has risen from $10 to over $200 [5] in the space of eighteen months. Bill Gates and his charitable foundation are significant investors in Moderna[6], one of the companies supplying a vaccine. It should also be noted that Bill Gates has a known association with Geoffrey Epstein.[7]

Many of those presenting the information to the public are associated with or employed directly or indirectly by organisations who have been financially funded by the Gates Foundation.

The MHRA, the UK regulatory body approving the vaccines, has itself been funded by the Gates Foundation.[8]

Finally the former secretary of state did not declare to the public that he had a girlfriend and he did not declare that that girlfriend had financial links through her business with PPE and other contracts[9] over which Matt Hancock had responsibility.

When presenting information on a public health matter the Nolan Principles require transparency.

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[4] https://www.conservativewoman.co.uk/sages-covert-coup

[5] https://tinyurl.com/c89nke49

[6] https://www.modernatx.com/ecosystem/strategic-collaborators/foundations-advancing-mRNA-science-and-research

[7] https://www.nytimes.com/2019/10/12/business/jeffrey-epstein-bill-gates.html

[8] https://www.gov.uk/government/news/mhra-awarded-over-980000-for-collaboration-with-the-bill-and-melinda-gates-foundation-and-the-world-health-organisation

[9] https://www.prweek.com/article/1700784/hancock-faces-questions-luther-pendragon-shareholder-hired-advisory-role

The Nolan Principles requires those presenting the information to declare any interests publicly so that those receiving the information can determine whether the information has been presented in an objective way or in a way that lacks balance and may favour any undeclared interests.

How many people know for example that our Chief Medical Officer has been or is involved in Vaccine organisations which have been substantially funded by the Gates Foundation as well as other vaccine businesses?[10]

How many people know that our Chief Scientific Officer has substantial investments in Astra Zeneca?

Dominic Cummings talked about Mr Gates' influence in government during his session in select committee.

If a Public Office Holder is presenting information about public health to the public, those people should be upfront and transparent about their interests and who has funded those interests as they might have a bias towards vaccination when other more optimal routes may be available. Vaccination should not be presented as the only route out of the declared pandemic when there are other routes that can be run in tandem. The Officials should level with the public.

It seems from day one the Public have been informed via press conferences that there was only one medical route out of the pandemic and that was via vaccination. That route is not the only available route. Quicker, cheaper and less risky routes are also available as an alternative to those who have no need or desire to be vaccinated and these routes have been known about for many months.

Taking each risk in turn:

The material risk of being infected:

[10] https://www.gavi.org/investing-gavi/funding/donor-profiles

1. The Government and the NHS has supplied information to the public information on the number of infections.
2. That information does not differentiate between:
    a. Those individuals testing positive without a Doctor or nurse diagnosing that individual and confirming that they are infected and or are ill with covid.
    b. Those individuals testing positive where a Doctor or nurse has diagnosed infection in that individual and has diagnosed that they are ill with covid.
3. The principal diagnosis tools have been:
    a. The lateral flow test.
    b. The PCR test.
4. Primary Care in the form of General Practice Doctors have by and large been kept out of the diagnostic loop.
5. The NHS's internal leaflet says that a positive test should not be relied on alone but a clinician, a Doctor or nurse, should confirm the fact of infection by clinical diagnosis.
6. The tests have been subject to major criticism for being unreliable and producing false positives. [11] The writer of this letter has a letter from his MP stating that the tests used can test for any Winter virus. It is probable therefore that the data presented by the government as infections with coronavirus also includes individuals who have tested positive but the test has failed to distinguish what sort of virus is present and whether that virus is old or recent.
7. Dr Fauci admitted that PCR tests do not test for infectiousness.[12]
8. Reports of schoolchildren testing positive using lemon juice show how unreliable these tests are. [13]
9. The inventor of the PCR test has also stated that the PCR test should not be used as a diagnosis tool.

[11] https://cormandrostenreview.com/report/
[12] https://www.youtube.com/watch?v=a_Vy6fgaBPE
[13] https://inews.co.uk/news/technology/tiktok-fake-covid-positive-test-schools-1079693

10. The Portuguese Court of Appeal said it is contrary to international law for a positive test result alone to be used without a Doctor or nurse also seeing the person with that test result and diagnosing an infection.[14]
11. The public do not know how many people have been classed as an infection on test alone or on test and clinical diagnosis. That is a major failing in gathering data and presenting data.
12. The cycle threshold at which the PCR test has been set is too high to give reliable data on infection.
13. The WHO suggested re-setting the cycle rate on the PCR test in January 2021 it is unknown whether the NHS has adopted that advice.[15]
14. The press conferences have heightened the public's sense of the material risk as the information presented has in my client's view exaggerated the numbers in a material way.
15. There has been no publicity at all at the press conferences that covid is not a High Consequence Infectious Disease.[16]

The material risk of being hospitalised with covid:

1. The numbers of hospitalisations of people with covid has been presented to the public at the press conference and then disseminated via news broadcasts.
2. That information has not differentiated between:
    a. Those presenting in hospital with covid illness.
    b. Those presenting in hospital with another condition who have subsequently been tested positive for coronavirus.
    c. Whether those hospitalised with coronavirus have caught the infection in hospital.
3. The information presented to the public has also not set out the numbers of people who have recovered from covid.
4. In assessing material risk the public need to have adequate information.

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[14] https://translate.google.com/translate?hl=&sl=pt&tl=en&u=http%3A%2F%2Fwww.dgsi.pt%2Fjtrl.nsf%2F33182fc732316039802565fa00497eec%2F79d6ba338dcbe5e28025861f003e7b30

[15] https://www.who.int/news/item/20-01-2021-who-information-notice-for-ivd-users-2020-05

[16] https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid

5. **The allegation is that the information has been presented in such a way to make the public think that the material risks are greater than they are**. This has either been intentional or grossly negligent.
6. Presenting information in a distorted way affects the public's ability to weigh up the material risk that coronavirus presents.
7. The public are unable to give proper informed consent to vaccination if the material risks have been exaggerated or distorted.

The material risks of dying from covid:

1. The information presented to the public does not differentiate between:
    a. Those dying from covid.
    b. Those dying from another condition but who have tested positive within 28 days of death.
    c. Those dying from another condition but who have tested positive after death.
    d. The death certificates are allowed to be signed by Doctors who may not have seen the individual who has died before death.
    e. Anyone who has died within 28 days of a positive test is recorded as a covid death.
2. The public is unable to determine what their material risk is of dying from covid as the numbers of deaths from covid have been exaggerated and are unreliable. The CDC in the USA has recently presented its information in a different way to enable any individual to find out how many people have died from covid alone without having any other medical condition or co-morbidity.[17]
3. A Portuguese Court has recently found that the numbers of people said to have died from covid has been exaggerated.[18]

[17] https://www.the-scientist.com/news-opinion/no-the-cdc-has-not-quietly-updated-covid-19-death-estimates-67902
[18] https://www.expatica.com/pt/news/lisbon-court-rules-only-0-9-of-verified-cases-actually-died-of-covid-100196/

4. The data about risk of dying has also been confused by the fact that Do Not Resuscitate Notices have been used unilaterally without consent and the widespread use of Midazolam during the pandemic in care home settings.[19] [20]
5. The information that has been presented shows that the distribution of risk is uneven.
6. Those under 75 who are healthy are unlikely to die from covid.
7. The risk is asymmetrical.
8. The vaccination roll out has been symmetrical.
9. The government's communication on vaccination has been inconsistent.
10. The Prime Minister of the country in January 2021 described the vaccination roll out as an immunisation programme. That communication gave the public the impression that vaccines would provide immunity.
11. The vaccine trials have been set up have as their trial design and trial protocol to reduce symptoms[21]. The Prime Minister was at best sloppy with his language as the vaccine trial protocols was to test for efficacy of symptom reduction.
12. It should also be noted that the vaccine protocols also refer to the use of PCR tests in the clinical trials, despite those tests' known unreliability.[22]
13. None of the vaccines provide immunity. None of the vaccines stop transmission.
14. Initially the government said that only those identified as vulnerable should be vaccinated. That then changed. Mr Gates met with the PM before the change in policy, this meeting with Mr Gates was to discuss a global vaccine strategy.[23]
15. Initially the government said that children would not be vaccinated. That then changed.
16. Initially government said restrictions would be released when 15 million people had been vaccinated, that then changed.
17. Initially government said it had no plans for vaccination passports, that then changed.

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[19] https://www.dailymail.co.uk/news/article-9374291/Scandal-500-care-home-patients-given-DNR-orders-without-consent.html

[20] https://www.dailymail.co.uk/news/article-8514081/Number-prescriptions-drug-midazolam-doubled-height-pandemic.html

[21] https://cdn.pfizer.com/pfizercom/2020-11/C4591001_Clinical_Protocol_Nov2020.pdf

[22] https://cdn.pfizer.com/pfizercom/2020-11/C4591001_Clinical_Protocol_Nov2020.pdf

[23] https://www.gov.uk/government/news/pm-hails-herculean-effort-of-life-science-companies-to-defeat-coronavirus

18. Providing inconsistent and changing information does not enable the public to have adequate information to give informed consent.

The Patient Information Leaflet:

The NHS has provided the Patient Information Leaflet to some patients who are being vaccinated.

That Patient Information Leaflet does not present the material risks and the material benefits of the vaccination in an adequate way:

1. The Patient Information Leaflet does not make clear that the vaccines are still in clinical trial.
2. The Patient Information Leaflet does not make any reference to alternatives to vaccination.
3. The Patient Information Leaflet does not make clear that the mRNA vaccines are experimental in that these vaccines have never been used before and there is no data on medium term to long term safety. mRNA vaccines are described by the FDA as gene therapy.[24]
4. The Patient Information Leaflet does not make clear that the clinical trials being run to show the safety and efficacy of the vaccine did not include particular cohorts of people including pregnant women and the very elderly. There is therefore no evidence available to show that they are safe and efficacious for those cohorts.
5. The Patient Information Leaflet does not make clear that the clinical trials are only using people who have not been infected with covid. There is therefore no data on safety and efficacy for vaccination of those who have been infected. Many people who have been infected with coronavirus are also being vaccinated.
6. The Patient Information Leaflet does not set out the difference between the absolute risk and the relative risk from coronavirus infection.

[24] https://www.sec.gov/Archives/edgar/data/1682852/000168285220000017/mRNA-20200630.htm

7. By being vaccinated each individual is reducing their absolute risk of being infected and dying from covid by 1%. [25]

Advertising of the vaccine:

The NHS allowed its logo on a series of adverts using celebrities to promote vaccination.

It is also alleged that a number of celebrities have been paid to promote the vaccine via their social media.

1. None of the vaccines have received marketing authorisation from the MHRA[26]. So there is a question mark as to whether an emergency use authorised vaccination should be advertised at all as there is very limited number of vaccines to choose from.

2. Advertising of licensed medicines is strictly regulated. The Human Medicines Regulations 2012[27] make it a criminal offence for licensed medicines to be advertised by celebrities and any advert should notify the viewer what the active ingredient is in the vaccine if there is only one active ingredient. These adverts breach the law in my client's view.

3. The NHS has taken no steps to distance itself from HM Government's attempt to fetter every UK citizen's right to decline any medical intervention.

4. The advertising campaign has placed pressure on people to have a vaccination. In the advertisement it is suggested that vaccination protects other members of a family including the elderly. However free and informed consent

[25] https://pubmed.ncbi.nlm.nih.gov/33652582/

[26] https://www.gov.uk/government/publications/regulatory-approval-of-pfizer-biontech-vaccine-for-covid-19/conditions-of-authorisation-for-pfizerbiontech-covid-19-vaccine

[27] https://www.legislation.gov.uk/uksi/2012/1916/part/11/crossheading/enforcement/made

means that no one should be under any pressure from any family member to have a vaccination or indeed any medical treatment. The NHS website even states that in its section on informed consent.[28]

5. The vaccination adverts give the impression that the vaccines have been licensed rather than the true position which is that they have been emergency use authorised which is a lower regulatory threshold than licensing.

6. The advertisements infer that the vaccines are safe. Safety is about risks. The adverts make no reference to the risk, however small, of serious adverse events.

Information on Vaccine Passports:

7. HM Government has linked vaccination with the ability to travel using a vaccination passport. [29]

8. Many UK citizens know at least one person whose only reason for being vaccinated is to go on holiday.

9. HM Government has been coercive in linking release of restrictions to vaccination.

10. A publicly funded National Health Service is breaching its obligations to its patients in not distancing itself and calling out such unlawful government coercion. NHS clinicians should be not be used as conduits for government policy. That politicises health.

11. The NHS should make it clear that it does not endorse coercion or any fettering of an individual's right to consent or decline any medical intervention.

[28] https://www.nhs.uk/conditions/consent-to-treatment/
[29] https://www.dailymail.co.uk/news/article-9744557/Double-jabbed-Brits-able-travel-quarantine-free-July-26.html

2. Montgomery Guideline 2: Availability of other treatments:

1. The NHS has published no information in its Patient Information Leaflet on the efficacy of other available treatments available to combat coronavirus infection or the disease of covid.
2. The body has an incredible way of treating itself if it is infected.
3. It's called the immune system.
4. The NHS should not be proposing a medical intervention when most people have a readily available treatment system to combat the infection and disease namely their immune system.

5. The immune system for most people will fight off the infection by the production of antibodies.

6. Further that immune response will be memorised by the T cells and B cells and will provide long lasting protection.

7. It is proven from SARS Coronavirus 1 in 2002 that T cells and B cells memorise the antibody response for many years.[3031]

8. There has been very little information to the public on the efficacy of the immune system to fight off any covid infection. The immune system is the first line of defence yet has been ignored by our NHS and by the government and SAGE.

9. It is accepted that the thymus gland which produces T cells and B cells gets less efficient over the age of 70 or if a person is immune compromised.

10. Taking vitamin D will enhance the immune system. These have only been provided as supplements.

11. At no time during any of the press conferences has the government and its advisers stressed the importance of the immune system and how to take care of

[30] https://www.nature.com/articles/s41467-021-23333-3
[31] https://www.nature.com/articles/s41467-021-24377-1

it as a first line of defence against coronavirus. It's only ever been about the vaccine. The failure to provide adequate information of the role of the immune system is an egregious breach of Montgomery.

12. Immunity gained via infection is better than any immunity enhancement from vaccination.[32]

13. Professor Whitty, to be fair, did say that for most people covid will be a mild illness. He therefore implied, without expressly stating it, that most people's immune system will fight off the illness arising from a coronavirus infection.

14. There is now ample data that there are a number of therapeutics that will work to prevent infection, and prevent hospitalisation and death.

15. Those therapeutics are:

    1. Ivermectin. There are numerous studies showing the efficacy of Ivermectin, it is also proven safe.[33] [34]Courts have ordered the use of Ivermectin in some jurisdictions.[35]
    2. HCQ and Zinc.[36]
    3. Budoneside or anti-inflammatory respiratory inhalers[37].[38]

16. The evidence has been available for some time that all these work to prevent infection, to prevent, hospitalisation and to prevent death.

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[32] https://www.medrxiv.org/content/10.1101/2021.04.20.21255670v1.full.pdf

[33] https://journals.lww.com/americantherapeutics/Abstract/9000/Ivermectin_for_Prevention_and_Treatment_of.98040.aspx

[34] Published Ahead-of-Print : American Journal of Therapeutics (lww.com)

[35] https://www.webmd.com/lung/news/20210506/covid-patient-in-coma-gets-ivermectin-after-court-order

[36] https://vladimirzelenkomd.com/zelenko-prophylaxis-protocol/

[37] https://www.bmj.com/content/373/bmj.n957

[38] https://www.ox.ac.uk/news/2021-04-12-asthma-drug-budesonide-shortens-recovery-time-non-hospitalised-patients-covid-19

17. There is limited or no information in the Patient Information Leaflet on available treatments other than vaccination.

18. Why haven't these medicines been made available? These medicines have been successful in a number of other countries and have prevented death and hospitalisation.

19. Why hasn't the MHRA investigated these other available and cheaper alternatives before granting emergency use authorisation to vaccines with no proven long term safety record?

20. My client cannot understand why the NHS does not make available safe and effective medicines. This is grossly negligent.

21. These safe and effective medicines and the immune system are the elephant in the room. The NHS does not want to look at them. The regulator does not want to look at them. SAGE does not want to look at them. The government does not want to look at them. Who's pulling the strings?

22. The question is why isn't the public being given a choice? Do commercial considerations and political agendas take precedence over public health? If so that's an extremely serious matter.

23. The NHS and the government appear to be very quick to vaccinate the population but very slow to consider and make available cheaper, safer and effective alternatives, to give the people an option. Why is that?

3.**Montgomery Guidelines: Risks of Vaccination**:

1. At none of the press conferences have the risks of vaccination been presented.
2. The advertising campaigns infer that the vaccines are safe.

3. The mRNA method of vaccination is considered a gene therapy product according to the US FDA.[39]
4. Serious adverse event data is being collected by the MHRA. But is not being disseminated to news outlets or via the press conferences[40]
5. That serious adverse event data is not being presented by Government or the NHS in its Patient Information Leaflet.
6. Data from deaths falling within 28 days of vaccination is not being collected, let alone communicated.
7. The Salk Institute has found that the spike protein, a constituent component in the vaccine or the vaccine's mode of action, is a toxin.[41]
8. The Japanese medicine regulator has found that those who have been vaccinated have a concentration of spike proteins in every organ of their body, in particular the ovaries[42]. This study is a called a bio-distribution study.
9. The NHS does not appear to have done any bio-distribution study of those who have been vaccinated.
10. The MHRA has not required a bio-distribution study to be conducted to check the safety of vaccination and if there has been a bio-distribution study conducted it has not been communicated to the public.
11. A number of regulators around the world have required health authorities to stop using the vaccine on health grounds.
12. The last UK emergency vaccine after swine flu was also suspended on safety grounds after 50 deaths.
13. The material risks from vaccination known to date are:
    a. Death in extreme cases. Over 1300 deaths reported on the yellow card system.[43]
    b. Bells Palsy.
    c. Thrombo-embolic events with low platelets.
    d. Capillary Leak Syndrome.

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[39] https://www.sec.gov/Archives/edgar/data/1682852/000168285220000017/mRNA-20200630.htm

[40] https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting

[41] https://www.salk.edu/news-release/the-novel-coronavirus-spike-protein-plays-additional-key-role-in-illness/

[42] https://regenerativemc.com/biodistribution-of-pfizer-covid-19-vaccine/

[43] https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting

e. Menstrual disorder and extreme bleeding.
f. Myocarditis and Pericarditis.
g. Antibody dependant enhancement.

14. The public is not able to give informed consent to vaccination as the data on the material risks on vaccination is being inadequately collated and the data that is collected is then not communicated to the public at any Press Conference.
15. The public is being informed that the vaccination is a public health benefit, the risks of vaccination are not being communicated in as systematic way as coronavirus infections and deaths are communicated.
16. It is up to individuals to decide whether they want to take material risks, however low the likelihood of the risk materialising, yet no or inadequate information is being presented on those risks.
17. Adults may shortly be asked to give consent to vaccination for their children when the risks of coronavirus to children is exceptionally low. This is one of the reasons my client did not want any involvement in the vaccination programme.
18. Every clinician vaccinating any individual must tell the individual of **the risk of a serious adverse event**, however small that risk is. This requirement does not appear to be built into the vaccine roll out in any systematic way.

My client is raising these concerns in this letter and these concerns are consistent with his obligation as a professional to act in accordance with the law and with professional ethics. The public who paid his wages up until recently deserve nothing less.

The second issue is the requirement for the public to wear masks in the NHS setting.

1. The requirement to wear a mask in an NHS setting is unlawful for the following reasons:
    a. The requirement is for the public and clinicians to wear masks on NHS facilities.
    b. The mask is not defined.
    c. If the mask is a piece of PPE, the 1992 PPE Regulations are engaged.[44]

[44] https://www.legislation.gov.uk/uksi/1992/2966/contents/made

d. The employer is obliged under regulation 6 to evaluate both the risks and the suitability of the PPE.[45]
e. Any evaluation of the risks would have to pose three questions:
    i. What are the risks of asymptomatic infection?
    ii. What are the risks of symptomatic infection?
    iii. How are those risks best mitigated?
f. To answer the first question the risk of asymptomatic infection is low.[46] Dr Fauci said that asymptomatic infection has never been the driver of any respiratory virus.
g. The risks of symptomatic transmission are higher.
h. What is the best way to mitigate the risks?
i. To provide category 3 PPE masks is the answer as they show efficacy in reducing transmission. These have not been provided or indeed mandated by the Health Secretary.

j. PPE Regulations require all masks to meet EC standards and to be category three in the case of the risk posed by biological agents.[47]
k. The masks provided to NHS clinicians are not category three. It is against the law to provide unsuitable PPE. It is also mandatory to follow the PPE regulations. [48]
l. The NHS has issued guidance that any person on NHS facilities must wear a mask. There is however no requirement for the public to wear a category three mask.
m. The requirement for the public to wear any mask in any NHS facility does not provide any benefit to the public.[49] [50]

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[45] https://www.lawgazette.co.uk/law/suitability-of-personal-protective-equipment/58160.article
[46] https://www.bmj.com/content/371/bmj.m4851.full
[47] https://www.legislation.gov.uk/eur/2016/425/annex/I/division/3
[48] https://www.legislation.gov.uk/eur/2016/425/annex/II/division/n1
[49] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006207.pub5/full
[50] https://www.acpjournals.org/doi/10.7326/m20-6817

n. The requirement for the public to wear a mask in any NHS facility poses a material risk. The risks of mask wearing is of bacterial infection plus a risk of hypoxia for prolonged use. [51]
o. There is also the risk posed by CO2 and a RCT reported in JEMA found 6 times the safe level of CO2 in children wearing masks. [52]
p. Anything other than a Category 3 mask is inadequate as PPE for the risk of infection posed by a biological agent.
q. The NHS has a policy that any patient or relative must wear a mask as must any clinician.
r. However there is no requirement that the masks have to be PPE. The masks therefore pose more risk than benefit.
s. The masks that are being worn by the public are unregulated.
t. Some of the masks have been manufactured in China and contain toxins.[53]
u. The NHS has failed the public in its guidance as unregulated masks pose more risks than benefits.
v. The NHS has failed its staff by requiring all staff to wear masks which pose more risks than benefits.

The issues raised by my client and other clinicians who have not been suspended raise issues about the integrity of those leading the Covid response. They raise issues about whether the information that has been provided to the public has been collected and presented fairly. They raise issues of breaches of the law and accepted standards in public life. They raise issues of whether private individuals with charitable foundations have too much influence on policy direction and whether the financial support offered by those individuals and foundations is healthy in a transparent democracy.

How can the National **Health** Service be endorsing the government policy of vaccine passports when that policy:

[51] https://www.sciencedirect.com/science/article/pii/S2214031X18300809
[52] https://jamanetwork.com/journals/jamapediatrics/fullarticle/2781743
[53] https://www.politico.eu/article/free-masks-distributed-by-belgian-government-contain-toxic-articles/

1. Makes those who wish to rely on their own immune system second class citizens.
2. That policy gives privileges to citizens who take a medical intervention, vaccination.

By endorsing the vaccine passport policy the National Health Service is not only endorsing a breach of international law which makes sacrosanct an individual's right to decline any medical intervention without any repercussion but also breaches the UK law on informed consent. Since when did the National Health Service morph into the National Pharmaceutical Distribution Service?

The writer of this letter has a backlog of whistle blowers to advise with examples of pressure being placed on employees within care and NHS settings during the covid pandemic, including exaggeration of covid bed occupancy and hospitalisation, such pressure is unethical and contrary to the standards the public expect in public health settings.

Please feel free to contact me directly for any further clarification, in the meantime we have copied in the relevant regulators who no doubt will conduct a full and independent and robust enquiry into the issues raised in this letter.

I look forward to hearing from you with a full response to the points raised.

Yours sincerely

Philip Hyland
Principal
PJH Law
Solicitors

Cc Cressida Dick, Metropolitan Police

Cc Charlie Massey Chief Executive GMC

Cc Kathryn Stone OBE, Commissioner for Parliamentary Standards

Cc Lindsay Hoyle, Speaker of The House of Commons

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The Right Hon Boris Johnson MP
10 Downing Street
Westminster
SW1A 2AA

014/PH/2477/
4 August 2021

Dear Mr Johnson

Re: Dr Sam White

I am instructed by Dr Sam White.

You will be aware of his case from my letter to Sir Simon Stevens dated 2 July 2021.

The General Medical Council [GMC] is now bringing a case before the Medical Practitioner's Tribunal Service [MPTS].

There is an Interim Order's Tribunal [IOT] listed for 17 August 2021. The IOT has the power to suspend my client.

Part of the GMC's case is that my client was spreading disinformation regarding the vaccination programme.

My client's position is that there were issues with informed consent to vaccination given the non-availability of effective pharmaceuticals such as Ivermectin. My client had a duty to bring those concerns to the attention of the NHS and others.

My client notes that American Front Line Doctors has a report regarding the contracts entered into between Pfizer and national governments. These reports suggest that effective but competing therapeutics might be the subject of a contractual term.

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I am sure you will agree that any MPTS that is determining the fate of a Doctor should have all the available evidence before it to enable it to come to a fair and fully informed decision.

The UK's contract with Pfizer was announced by the government with some fanfare in July 2020.

In the circumstances I would invite you to publish the full unredacted version of the contract or contracts entered into with Pfizer on the Number Ten website within the next five days. By contracts we mean any contracts for development and or supply of the Pfizer vaccine.

No doubt you and your colleagues in government will have driven a hard bargain for the British public ensuring that any devil in the detail is in the UK's favour rather than Pfizer's.

Publication of the contract is in the public interest, as well as the interests of justice given the imminent IOT. Transparency and openness is a key Nolan principle of public life.

I look forward to your response.

Yours sincerely

Philip Hyland
Principal

Cc: The Parliamentary Commissioner for Standards
Cc: MHRA

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The Right Hon Savid Javid MP
Minister for Health and Social Care
Ministerial Correspondence and Public Enquiries Unit
Department of Health and Social Care
39 Victoria Street
London
SW1H 0EU
United Kingdom

014/PH/2477/
5 August 2021

Dear Mr Javid

Re: Dr Sam White

I am instructed by Dr Sam White.

You will be aware of his case from my letter to Sir Simon Stevens dated 2 July 2021.

My client has a case currently before the GMC, part of which relates to comments my client made around the vaccination roll out and free and informed consent, part of it relates to guidance on wearing face coverings in a clinical setting.

My client has a number of concerns relating to the Guidance on vaccination of care home staff and visitors which was published by the Department of Health and Social Care on 4 August 2021.

I trust that legal advice was taken before publishing the Guidance. In the interests of transparency it may be helpful if that legal advice was published, given that such advice was paid for by the tax payer.

The Guidance does not reflect the following common law and or statutory and or other legal rights of care home workers. In particular, but not exclusively, the:

1. Right of every care home worker to free and informed consent, including the right to decline treatment.
2. Right of every care home worker to choose any safe and effective treatment including their immune system.
3. Right to data privacy including medical records.
4. Right not to be discriminated against under the Equality Act 2010.
5. Right to have fundamental human rights respected, all and any rights which are laid down in International Conventions and under International Law.
6. Right not to be subject to an experimental vaccine and run the material risk of harm via coerced medical treatment.

No doubt you will review the Guidance carefully and issue an amended version so that the Guidance does not conflict with the law and the hard won and long established legal rights of care home workers.

In the meantime can you confirm in writing to both care home workers and care home owners and managers that in the event of a conflict between the law and the Guidance, the law should be followed by all, including the NHS and the Department for which you are minister.

I look forward to hearing from you within seven days.

Yours sincerely

Philip Hyland

Principal

Cc: All MPs, House of Commons via email
Cc: NHS England
Cc: NHS Improvement
Cc: GMC
Cc: BMA

Dear Sir/Madam:

Re: Vaccination of Care Home Staff

I write to you in connection with the proposal to require [insert name] to show proof of his/her vaccination status as a condition of continued employment. This condition is met by a self declared exemption for reasons set out below.

I understand as an employer you are relying on the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 [the Regulations].

The particular regulation on which you are relying is 5 (2):

> *B has provided A with **evidence that satisfies** A that either—*
>
> *(i)B has been vaccinated with the complete course of doses of an authorised vaccine; or*
>
> *(ii)that **for clinical reasons B should not be vaccinated** with any authorised vaccine*;

Leaving aside any argument about the legal validity of the Regulations, regulation 5 (2) must be interpreted in a way that is consistent with the language used.

The word “satisfies” means satisfies in a legally compliant way.

The words “for **clinical** reasons **should** not be vaccinated” must be interpreted in accordance with the existing law and in a legally compliant way.

A clinician **cannot and should not** vaccinate any care home worker either:

1. where the care home worker does not want a vaccine. Declining treatment amounts to a clinical reason under Montgomery, and the earlier case of Heart of England NHS Foundation Trust v JB [2014].
   or
2. who is being vaccinated through third party pressure. Coercion or pressure invalidates any consent leaving the clinician potentially liable for the tort of battery.

The right to decline treatment is a human right of bodily autonomy which no person including the government can trespass on without there being exceptional circumstances relating to a lack of capacity. No such circumstances exist. There are many different reasons why a care home worker may not want a vaccine.

The right to decline treatment is recognised as a long established common law right. A clinician has to accept that any patient with mental capacity has the right to decline any treatment. A clinician should not vaccinate where an individual declines treatment. **Declining vaccination amounts to a clinical reason why a care home worker should not be vaccinated.**

Under Regulation 5 (2) (b) all the care worker needs to do is provide satisfactory evidence of clinical reasons that the care worker should not be vaccinated.

My client requires you to accept a self-exemption as satisfactory evidence under regulation 5 (2) (b).

The NHS supports this interpretation of the Regulations, albeit in relation to their own application the covid pass.

The covid pass describes itself as:

> *The NHS COVID Pass lets individuals share their **coronavirus (COVID-19) vaccination** and test results in a secure way*.

The website states as follows under exemptions:

> *There will also be a small number of exemptions for individuals who have a **medical reason** which means they cannot vaccinate or test. **These individuals will need to self-declare their medical exemption directly with you**…*
>
> *Please ask your customer if they can demonstrate their COVID-19 status using the NHS COVID Pass.. **This allows your customer to respond with information about a self declared medical exemption**.*
>
> ***If your customer confirms that they have a self declared exemption, but is unable to show any evidence, you should allow them access to your venue or event. You must not ask for proof of their medical exemption and it is not essential they show any form of exemption card at any point**.*

The Regulations specifically state at regulation 5 (5) that:

> (*5) Nothing in this regulation authorises the processing of personal data in a manner inconsistent with any provision of data protection legislation.*

The data protection legislation requires consent for medical information to be given to a third party such as an employer. A care home worker is entitled to withhold consent.

The issue therefore is consent.

A care home worker is entitled to withhold consent to vaccination. A care home worker is entitled not to share his or her medical records with their employer.

A self-declared exemption is satisfactory evidence of the clinical reasons why a care home worker should not be vaccinated.

This interpretation is in line with section 45 E of the Public Health (Control of Disease) Act 1984 [the 1984 Act] which states as follows:

> *"Medical treatment*
> *(1) Regulations under section 45B or 45C may not include provision* ***requiring a person to undergo medical treatment.***
> ***(2) "Medical treatment" includes vaccination and other prophylactic treatment****."* The Regulations must be interpreted to be consistent with the 1984 Act.

Should you not agree with that analysis, you will need to set out in full why this interpretation is incorrect. Please do not quote the care worker's guidance as the law should be followed not the guidance, where there is a conflict.

If you proceed to require more than a self-declared exemption you will find your organisation and potentially individuals within the organisation facing the following risks.

How the regulations breach common law rights if interpreted to not allow self declared exemptions:

Vaccination is a medical intervention. It requires the consent of the individual before its administration.

Vaccination without consent is assault and battery. Putting someone in fear of violence can itself be a criminal offence of assault.

An individual who has been threatened with the loss of their job if they are not vaccinated, or show proof of vaccination cannot give valid consent if that is the reason for vaccination.

The NHS defines valid consent as follows:

> *"For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.*
>
> *The meaning of these terms are:*

1. *voluntary – the decision to either consent or not to consent to treatment must be made by the person, and must not be influenced by pressure from medical staff, friends or family*
2. *informed – the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead*
3. *capacity – the person must be capable of giving consent, which means they understand the information given to them and can use it to make an informed decision."*

Here, the relevant factor is 'voluntary'.

An individual undergoing medical treatment for the sole reason that if they do not, they will lose their job, has not given the degree of consent required to describe the procedure as "voluntary". No valid consent can be given in these circumstances.

As per the above definition, the "*decision to either consent or not to consent to treatment must be made by the person and not influenced by pressure*". Decisions made to receive medical interventions under pressure are therefore invalid. Such ostensible consent is not real.

It follows that any consent given on pain of losing one's job is vitiated. The individual who has administered the medical intervention, their employer, and the employer who has required their staff to be vaccinated, may be liable in tort under the following heads of claim:

Assault and Battery:

The definition of assault is an act which causes another person to apprehend the infliction of immediate unlawful force on his person. A vaccination administered without proper consent is unlawful personal force and therefore the apprehension of such is the apprehension of immediate unlawful force.

The definition of battery is the actual infliction of that unlawful force on another person. The administration of a vaccine without proper consent is the infliction of unlawful force. Both

torts are actionable per se, so no loss must be shown. It is enough that the tort occurred.

Inducement as to Assault and Battery. The individual or organisation that has induced the Assault and Battery may be liable under this head of claim. It is also actionable per se. Organisations may argue they are acting under statutory authority (the abovementioned regulations), but it is well established law that acting under statutory authority is no defence to an assault or battery for example the case of Wilkinson .

Intimidation. The organisation who has induced the battery (the employer) could also be liable for the tort of intimidation or coercive behaviour to induce a battery.

The potential criminal offences are as follows:

> "Technically, the offences of assault and battery are separate summary offences. An assault is committed when the defendant intentionally or recklessly causes another to apprehend immediate and unlawful violence and battery is committed when a defendant intentionally or recklessly inflicts unlawful force. Although battery may follow an assault that is not always the case."

You will need to take independent legal advice as to whether the approach adopted by your organisation meets the threshold of assault if any care home worker apprehends that his or her job depends on immediate and unlawful violence of a forced vaccination. The question is whether the misinterpretation of the law is reckless or not.

Statutory liability

The requirement that an individual be vaccinated, on pain of their job, is contrary to several statutory provisions.

The Equality Act 2010 outlaws various forms of discrimination.

The requirement for staff to be vaccinated, on pain of their jobs, is discriminatory in several respects:

1. Requiring care home workers to disclose their disability and any exemption discriminates directly and indirectly against disabled care workers and puts such care workers at a substantial disadvantage. The Assessment acknowledged 22% of care workers are disabled. Care workers have the right not to disclose their disability to their employer.
2. Indirectly discriminating against care workers who as an occupational group are mainly women. Women have greater vaccine hesitancy than men.
3. Directly or indirectly discriminating against pregnant women in that the requirement to

vaccinate also puts pregnant care workers at a substantial disadvantage as none of the clinical trials for the vaccines included any pregnant women see 10.4.2 of Pfizer trial. Women who were breastfeeding were also excluded.

4. Indirectly discriminating against care workers who do not have English as a first language.

5. Discriminating against those care workers who hold philosophical beliefs that government should not determine what medical treatment a care worker has. 6. Discriminating against those care workers who have philosophical beliefs based on natural remedies and or the non-use of animals in clinical trials. It is to be noted that

the Equality Impact Assessment did not include the risk of discrimination against care workers holding particular philosophical beliefs.

7. Discriminating against those care workers who have a religious belief relating to the constituent materials from which some vaccines are made.
8. Indirectly discriminating against members of BAME communities who have vaccine hesitancy based on past injustice relating to medical treatment. The Equality Impact Assessment acknowledges the BAME community's loss of trust in authority. It is alleged that the covid response has not rebuilt that loss of trust.
9. Directly or indirectly discriminating against younger care workers who face less risk from covid infection but risk a serious adverse event from the vaccination which is disproportionate to the risk being mitigated. It is to be noted that care home residents have their right to decline vaccines respected. It is also to be noted that only 10% of residents have not been vaccinated. The Equality Impact Assessment acknowledges that younger female care workers have concerns over whether the vaccine may impact fertility. Those concerns are cogent as there is no long term evidence of fertility impact yet reports of adverse events from vaccination include heavier menstruation. It is also to be noted that the bio-distribution study Pfizer supplied to Japan may have found a build up of the spike protein in the ovaries together with concerns over breast feeding mothers. The relevant extract is here. Canadians have raised concerns on this issue. In particular where uncertainties exist on toxicity that the precautionary principle should be applied. In 2021 every person should have their right to bodily autonomy respected and those who wish to adopt a wait and see policy with regards to vaccination should not be penalised for that choice. That's their right and a right that should be respected. The generations that came before fought for that right.

Any provision, criterion or practice [PCP] which cannot be objectively justified is unlawful discrimination if it can be shown to have an adverse impact on those with a particular

characteristic.

If regulation 5 (2) (b) is interpreted to require care home workers to show their vaccination status then that interpretation breaches the workers' right to keep their medical data private and confidential. That right is enshrined in the Data Protection Act 2018.

The Regulations recognise that at regulation 5 (5):

> *Nothing in this regulation authorises the processing of personal data in a manner inconsistent with any provision of data protection legislation*.

Any requirement for a care home worker to produce either their medical records or the NHS covid pass application may also be discriminatory against those who hold the philosophical

beliefs that the state has encroached too far into individual liberty when handling the declared pandemic.

An individual has the right to privacy and liberty and requiring employers to see a health pass discriminates against those who view that provision as a heavy handed and disproportionate response to the pandemic.

Any PCP that is discriminatory has to be removed.

In the circumstances can you confirm within five working days in writing that satisfactory evidence to comply with regulation 5 (2) (b) is met by a self- declared exemption without any further evidence being required.

I look forward to hearing from you as soon as possible.

Yours sincerely

[insert name]

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Amanda Pritchard
Chief Executive Officer
NHS

014/PH/2477
3 December 2021

Dear Ms Pritchard

Re: Dr Sam White:

I am instructed by Dr Sam White in connection with his treatment by the NHS since raising public interest disclosures to your predecessor, Sir Simon Stevens, by letter dated 2 July 2021.

That letter raised allegations of criminal conduct by way of gross negligence by the Executive Board of the NHS as well as those leading the NHS response in government and the regulatory agencies.

In summary the letter made the following allegations and sought to shine light on some of the darkness at the heart of the COVID-19 response:

1. That Dr White had been treated unfairly by the NHS since raising his concerns via video in early June 2021. These concerns having previously been raised at a revalidation appraisal in December 2020 which had been signed off by the responsible officer, Dr Ahmad, the same responsible officer who subsequently suspended Dr White for raising the same concerns in public.
2. The concerns are these: that the public have had their health, well being and lives put at risk by the following:
    a. The NHS adhering to government dictat by cutting the role of primary care and keeping GPs out of the loop with covid cases throughout 2020.
    That as a consequence of that decision, early diagnosis and treatment was denied to many patients and prophylactic and

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therapeutic treatments used elsewhere, to great effect, were being denied to NHS patients.

b. That the NHS was following government policy of focusing its clinical response on vaccines, vaccines developed and manufactured by companies with links to charitable foundations who had provided substantial grants to a regulator, universities, and other institutions involved in the COVID-19 response. It's a matter of record that our Prime Minister met with Bill Gates in 2020 and that vaccination policy has changed over time and the Government has ignored the advice of the JCVI.
c. That the data gathered by the NHS had exaggerated the risk posed by COVID-19 as the unfit for purpose PCR test had been used. We referred you in our ealier letter to the Drosten paper.
d. That there had been very little information on the immune system as an alternative to vaccination.
e. That the roll out of the vaccination was based on misleading and inaccurate information. That the benefits of vaccination had been overstated.
f. That the risk of vaccination had been under-reported and under stated.
g. That the NHS was complicit in working with government in rolling out a NHS COVID app which compromised NHS clinicians' ability to ensure patients were exercising free will in consenting to vaccination. Vaccination came with the benefit of traction free travel and access to events.
h. That wearing face coverings in health care settings had not been properly risk assessed. There is evidence that masks do harm, particularly to children.

The CEO of the NHS has not deigned to reply to the 2 July 2021 letter and the concerns raised. Instead the NHS has chosen to mount a campaign of targeting my client unfairly. These actions speak of a certain culture within the executive leadership of the NHS and unwillingness to act on evidenced and constructive feedback.

This letter will detail developments since 2 July 2021. The Executive Board needs to reflect on whether their inaction on Dr White's letter of 2 July 2021 and their adherence to government policy has been beneficial to service users or a dereliction of duty.

1. **Dr White's treatment by the NHS since 2 July 2021:**

    a. On 2 July 2021 the NHS forwarded the letter we had written to the GMC with the comment along the lines of "Dr White has not taken his suspension too well."
    b. My client had been previously suspended via phone by Dr Milroy from NHS Improvement where the reasons given for suspension were apparent concerns about Dr White's health. The transcript of that call is here. You will note Dr Milroy despite not being in a patient Doctor relationship with Dr White appears to diagnose my client remotely. Dr Milroy also refers to Dr White as "poppet".
    c. The original letter of suspension was dated 25 June 2021. That letter dated 25 June 2021 was signed by Dr Ahmad, the same responsible officer, who had signed off Dr White's revalidation appraisal where the same points which were the subject matter of suspension were made by Dr White. No reference was made to my client's health but a reference was made to social media posts as part of the rationale for suspension.
    d. The suspension was then lifted by Dr Ahmad on 19 July 2021. No reference is made to social media posts as either the reason for suspension or for lifting the suspension.
    e. In mid-July 2021 we received a call from the Metropolitan Police in connection with the letter dated 2 July 2021 and went through the issues.
    f. On 21 July 2021 Dr Ahmad wrote a further letter clarifying why Dr White was suspended and confirming Dr White had the right to air his views.
    g. We reached out to the GMC Investigator Gareth Eaton stating we had received all the affidavits from the USA in an application being brought in the Courts to review the EUA vaccine approval. Mr Eaton throughout his investigation did not speak to Dr White. The subject matter of the investigation was not spoken to by the investigator. You read that right.

The purpose of any GMC investigation it would appear is to gather "incriminating" evidence rather than objectively investigate whether any of Dr White's points had merit. We will return to this as we do have evidence that a complaint received by the GMC about a Doctor who makes factually inaccurate statement but who tows the government line are not investigated by the GMC. This does call into question the GMC's ability to regulate Doctors and protect patient safety. We thought you were here to protect us, not protect the government.

h. On 17 August 2021 Dr White appears before the Interim Orders Tribunal [IOT] having been referred there by the GMC. Despite having a witness statement and exhibits which backed up every point made, including expert testimony from Dr McCullough and others, as well as peer reviewed research the IOT placed as a condition of practice that Dr White was unable to post about the pandemic and associated aspects on social media. The firm sought clarification as to what the order meant and the ambit. Could Dr White stand for Parliament but not be allowed to comment on COVID-19? Could he post about discarded masks on the beach? We received no satisfactory response other than a veiled threat not to post.

i. In Dr White's statement to the IOT, he made the point that this firm has received evidence of at least one clinician breaching informed consent rules with regard to factually incorrect information given to a patient at the point of vaccination as well as a DNAR [do not attempt a resuscitation] notice being placed on an elderly patient without her consent. The GMC must be aware of the DNAR case on this point.[1] Despite having a remit to protect patient safety and investigate any clinician who poses a risk to the public, the GMC has taken no steps to contact this firm to find out what evidence we have. Why has the GMC sat on their hands when Dr White made a statement to the IOT containing allegations of at best gross negligence and at worst criminality by other clinicians?

[1] https://www.judiciary.uk/wp-content/uploads/2014/06/tracey-approved.pdf

j. On 28 August 2021 Dr White appears on Dr Reiner Fuellmich's Corona Enquiry. An enquiry set up by Dr Fuellmich, a dual qualified attorney, best known for exposing a previous testing scandal involving emissions from diesel cars.

k. On 21 September 2021 we met with Sir Graham Brady in Westminster. Sir Graham expressed an interest in Dr White's case. The letter of 2 July 2021 had reached some MPs and was acknowledged by Sir Desmond Swayne.

l. An appeal is lodged in the High Court against the IOT conditions on 7 September and the case is listed to be heard on 4 November 2021.

m. In early November 2021 the GMC make a second referral to the IOT claiming that Dr White was in breach of his conditions by having one image on Instagram and by this firm tweeting about Dr White's appearance at Dr Fuellmich's enquiry. The GMC also complained that the Crowd Justice page set up for Dr White was promoting "conspiracy theories." What conspiracies about medical regulators sitting on their hands and ignoring alleged gross negligence and criminality? Those sorts of conspiracy theories? We sought clarification on what basis the GMC had jurisdiction over a Solicitors' twitter account and we did not receive a satisfactory response. That hearing, listed for 10 November 2021, was posponed pending the High Court judgment.

n. Meantime NHS Improvement convene a Performance Advisor Group Meeting for 4 November 2021. This date is the same date when Dr White is at the High Court for his appeal. Coincidence? You be the judge if you believe in coincidences. The case manager's only attempt to contact Dr White was via an old email address from when Dr White worked in the NHS. The NHS have Dr White as a leaver on their system and Dr White has had no access to his NHS email address for many months. No attempt is made to contact Dr White on his current email address, via his website, by phone or by letter. No attempt is made to contact this firm despite NHS Improvement having our correct email details.

o. The decision of the meeting is to refer Dr White to a Performers' List Decision Panel to determine whether conditions should be imposed on Dr White for the video on social media which the NHS had previously

stated did not warrant suspension in the letter of 21 July 2021. Without any medical justification a discussion takes place about referring Dr White for an occupational health assessment.

p. On 3 December 2021 the High Court quashed the Interim Order Tribunal's finding that the GMC had erred in law in making the order. Dr White has a human right to free expression. The Judgment also finds that the Guidance relied on by the IOT made no reference to the human rights of registered Doctors who appear before the IOT.

q. Dr White is more than willing to assist the GMC if they wish us to make any evidence available to them.

r. There is evidence that a smear campaign has been started by various organisations who intend to smear Dr White and anyone associated with his case. We are conducting our own enquiries into this. We will not be distracted by bots and trolls but we will take legal action against anyone who harasses or makes defamatory statements that cause serious harm.

2. With regard to the points raised in the letter dated 2 July 2021 we refer you to facts that have come to light since the 2 July and let those facts speak for themselves. The facts below are key facts rather than all the facts. Dr White and myself have agreed to a request made by a third party to assist the UK Police in any investigation into alleged criminality regarding the government's and others' response to COVID-19. Dr White and I are also in contact with those who lodged the International Criminal Court referral in September 2021.

    a. "*The NHS adhering to government dictat by cutting primary care and keeping GPs out of the loop with covid cases throughout 2020.*"

        i. There is a huge backlog of cases and missed diagnoses of diseases such as cancer mean some patients' diagnoses have been delayed and their prognosis has worsened.[2]

        ii. There is substantial evidence accumulating that early treatment protocols for COVID-19 using a combination of anti-viral therapeutics have substantially better outcomes than waiting

[2] https://nhsproviders.org/addressing-the-care-backlog/context-the-impact-of-the-pandemic

until a patient condition worsens and then using ventilation and Remdesevir.[3] There is also evidence of patients being treated simultaneously with CPAP and midazaolam.

b. "*That The NHS was following government policy of focusing its clinical response on vaccines, vaccines developed and manufactured by companies with links to charitable foundations who had provided substantial grants to a regulator, universities, and other institutions involved in the COVID-19 response. It's a matter of record that our Prime Minister met with Bill Gates in 2020 and that vaccination policy has changed over time and the Government has ignored the advice of JCVI*."

   i. Dr David Martin a specialist in patents has gathered evidence regarding dates and timelines of patents filed by various entities from 2001 onwards which relate to both the lab creation of gain of function viruses as well as patents filed for vaccines.[4]

   ii. Full evidence of the regulatory capture by pharmaceutical companies and how that capture impacted governments' responses to the pandemic declared by WHO in March 2020 are detailed in Robert F Kennedy Jr's work "*The Real Anthony Fauci: Bill Gates, Big Pharma, and the Global War on Democracy and Public Health*" which was published on 16 November 2021. Robert F Kennedy Jr together with Dr Peter McCullough, Dr Cory, Dr Lawrie, Dr Ryan Cole, Dr Stephen Frost, Dr David Halpin, Professor Sacharit Bhakdi, Professor Dolores Cahill and other eminent clinicians and scientists have agreed to support Dr White and all have been in contact.

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[3] https://www.raps.org/news-and-articles/news-articles/2020/3/covid-19-therapeutics-tracker
https://www.who.int/publications/i/item/WHO-2019-nCoV-therapeutics-2021.3
https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html
https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/hospitalized-adults--therapeutic-management/

[4] https://www.youtube.com/watch?v=gsDlHprql-g

c. "*That the data gathered by the NHS had exaggerated the risk posed by COVID-19 as the unfit for purpose PCR test had been used*."

i. The FDA withdraw emergency use authorisation of PCR tests on 19 July 2021 effective 31 December 2021.[5]

ii. The Government has admitted that:

> "*The detection of RNA in a swab is only a proxy for viral shedding (RNA detection does not indicate the presence of live virus)*."

d. "*That there had been very little information on the immune system as an alternative to vaccination*."

i. 121 studies are summarised at the Brownstone Institute showing that immunity and infection provides longer lasting and more well rounded protection than any immunity derived via vaccination. [6]

e. "*That the roll out of the vaccination was based on misleading and inaccurate information*. "

i. The government policy was to rely on vaccination to provide immunity from COVID-19. The government has now made a highly qualified statement and admitted that:

> "*Although there is limited data to draw upon in this area, if vaccination reduces the amount of viable and transmissible virus in a person who is infected despite vaccination, there may be a reduction in transmissibility. It is also possible that vaccination reduces the duration of infectiousness in those individuals who become infected."*

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[5] https://www.cdc.gov/csels/dls/locs/2021/07-21-2021-lab-alert-Changes_CDC_RT-PCR_SARS-CoV-2_Testing_1.html

[6] https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/

ii. A whistle blower who worked in a Clinical Research Organisation has alleged that Pfizer manipulated the safety and efficacy data from the clinical trials.[7]

iii. There has been criticism that the data relied on by the government and the NHS has been misleadingly presented, particularly on what amounts to "unvaccinated" and "vaccinated" cases or hospitalisations or deaths, this was termed the "denominator problem."[8] You were accused of using misleading data in a TV broadcast.[9]

iv. Studies show that the vaccines have not been as efficacious as many had been led to believe. The vaccine has failed to prevent infection and spread against Delta.[10] That is to say studies have shown that fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts and that viral loads are no different when comparing vaccinated and unvaccinated people.[11]

v. Physicians for informed consent have produced a document showing safety and efficacy data. [12]

f. *"That the risk of vaccination had been under-reported and under stated."*

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[7] https://www.bmj.com/content/375/bmj.n2635

[8] https://fullfact.org/health/phe-ukhsa-bolsonaro/

[9] https://reaction.life/how-did-nhs-chief-get-covid-patient-numbers-so-wrong/

[10] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00648-4/fulltext

[11] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3897733.

[12] https://documentcloud.adobe.com/link/review?uri=urn:aaid:scds:US:72f49401-d242-44fb-9a2b-eaacf887cb61

i. There is increasing evidence that the spike protein amounts to a toxin with the potential of causing potentially serious long term adverse effects. Dr White's concern has always been around the absence of long term safety data and the experimental nature of the mode of action of the mRNA vaccine.[13]

ii. That some of the vaccinations currently in use in the UK have been withdrawn in other jurisdictions on safety grounds.[14]

iii. That there is a higher than usual number of elite athletes having heart problems. [15]France has withdrawn Moderna's vaccine for under 30s because of the risk of heart inflammation.[16]

iv. That incidences of myocarditis and encarditis are rising. Dr White's letter dated 2 July 2021 expressly stated that there was a material risk of these conditions arising as a vaccine side effect. [17]

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[13] **https://documentcloud.adobe.com/link/review?uri=urn:aaid:scds:US:4d7d4bb8-dbaf-4731-a18f-ee27b794075e**

[14] https://www.bmj.com/content/374/bmj.n2034

https://www.bmj.com/content/375/bmj.n2477

https://www.cnbc.com/2021/10/08/nordic-countries-are-restricting-the-use-of-modernas-covid-vaccine.html

https://www.bbc.co.uk/news/health-58438669

https://www.nytimes.com/2021/04/13/us/politics/johnson-johnson-vaccine-blood-clots-fda-cdc.html

https://www.theguardian.com/world/2021/mar/30/canada-suspends-use-of-astrazeneca-covid-vaccine-for-those-under-55

https://www.bmj.com/content/373/bmj.n1053

https://www.devex.com/news/the-countries-that-don-t-want-the-covid-19-vaccine-99243

[15]

[16] https://medicalxpress.com/news/2021-11-france-moderna-under-30s-rare-heart.html

[17] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/myocarditis.html

v. Evidence of risk is being revealed daily including some evidence extracted from Pfizer via court order. [18][19]

g. *"That the NHS was complicit in working with government in rolling out a NHS COVID app which compromised NHS clinicians' ability to ensure patients were exercising free will in consenting to vaccination. Vaccination came with the benefit of traction free travel and access to events*."

i. The guidance produced for the COVID pass application has a limited number of exemptions. This application and its use is exerting undue influence on clinicans to deny exemptions to many individuals who have very good reasons (not that any are needed) not to be vaccinated.

ii. There is evidence that the CQC has allegedly unlawfully relied on the COVID pass app as the only means of evidencing exemption in their workplace. We thought the regulators, including the GMC, were independent of government, not in its pocket and pushing Government's policies.

iii. The law is that any individual has the right to make their own decision on whether to have a treatment or not. Any decision should be free from third party pressure. The NHS Covid Pass application exemption system denies individuals their lawful rights, described in the Montgomery case as a "fundamental human right," by exerting unlawful and coercive pressure by denial of exemption. This is the most serious allegation anyone could level at a health service. A health service that is complicit in denying patients their fundamental human rights and is complicit in pushing a government policy, vaccine passports, which has nothing to do with the health of the nation and

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[18] Cumulative Analysis of Post-Authorization Adverse Event Reports of PF-07302048 (BNT162B2) Received Through 28-Feb-2021 | PDF | Pharmacovigilance | Medicine (scribd.com)

https://de.scribd.com/document/543857539/CUMULATIVE-ANALYSIS-OF-POST-AUTHORIZATION-ADVERSE-EVENT-REPORTS-OF-PF-07302048-BNT162B2-RECEIVED-THROUGH-28-FEB-2021

[19] https://www.naturalnews.com/2021-12-02-smoking-gun-pfizer-document-exposes-fda-criminal-cover-up-of-vaccine-deaths.html

everything to with with the control of a nation, such control including pressuring the population into a vaccine which many patients, quite reasonably, may wish to decline for whatever reason.

h. *"That wearing face coverings in health care settings had not been properly risk assessed."*

   i. There is still no evidence that any risk assessment has been conducted on the benefits and risks of face coverings.

   ii. There is mounting evidence that face coverings cause harm and that evidence has been available for some time. Developmental and physiological harm to children is inexcusable.[20] The independent World Council of Health set up by Dr Tess Lawrie has some research you may wish to consider.[21]

Given that it has now been five months since we last wrote and evidence has been accumulating that every single one of Dr White's concerns are well founded it is incumbent on you to reply to all the points raised.

I look forward to such a response as soon as possible.

Yours sincerely

Philip Hyland
Principal
PJH Law
Solicitors

[20] https://rationalground.com/dangerous-pathogens-found-on-childrens-face-masks/

[21] https://worldcouncilforhealth.org/resources/face-masks-the-risks-vs-benefits-for-children/

Exclusively Employment Law Solicitors

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Charlie Massey
Chief Executive
GMC

011/PH/2775
7 December 2021

Via Email: Charlie.massey@gmc-uk.org

Dear Mr Massey

Re: Complaint Number: E2-7599ZL
Complaint about Dr Hilary Jones: GMC reference 2298102
Clients: Anonymous and Dr Sam White

I am instructed by a client who wishes to remain anonymous who lodged complaint number **E2-7599ZL** with the GMC on 12 August 2021.

This complaint is about a Doctor registered with the GMC, Dr Hilary Jones, who appears on Good Morning Britain [GMB].

I am also instructed by Dr White to highlight the deficiencies and discepancies in the approach the GMC took regarding the complaints made about Dr White and the approach the GMC took regarding the complaint made about Dr Jones.

The complaint made under complaint number **E2-7599ZL** was about comments made by Dr Jones on Good Morning Britain on 12 July 2021.

Under section 35C (2) of the Medical Act 1983 the GMC is legally bound to refer a registered Doctor to the Registrar for appearance at a Medical Practictioners' Tribunal Service [MPTS] if there is evidence of:

Email mail@pjhlaw.co.uk
Web www.pjhlaw.co.uk

Head office
18A Maiden Lane,
Stamford, Lincolnshire,
PE9 2AZ

Tel 01780 757589
Fax 0844 8505806

Principal
Philip Hyland

Solicitors
Liam P ke
Samantha Crombie
Joe Hyland

Trainee Solicitors
Alex McCormick
Teresa Valente

(a) Misconduct or
(b) Deficient Professional Perfromance.

By email dated 16 November 2021 the GMC decided to take no further action regarding the complaint made against Dr Jones.

The redacted email from the GMC rejecting the complaint against Dr Jones is appended.

The grounds relied upon by the GMC for taking no action were deficient and erred in law. The GMC asked and answered the wrong questions in arriving at the decision.

Rather than asking whether the complainant had presented sufficient evidence that Dr Jones posed a risk to patient safety the GMC investigator asked whether Dr Jones' comments were **offensive**.

The GMC has applied the wrong legal test. This is a gross abdication of the GMC's legal duty to protect the public from Doctors that pose a risk to patient safety. On the evidence presented to you there were sufficient grounds for an IOT referral for Dr Jones.

My anonymous client would in the first instance invite you to review your decision, correct your errors and instigate an investigation into Dr Jones.

If the public is going to have confidence in the regulation of Doctors it needs to see the regulator correct obvious mistakes.

It would also be helpful to restore public confidence if the regulator showed some insight, admitted its mistakes and complied with its duty of candour.

That's what the GMC expects from Doctors.That's the standard the GMC should be held to.

The judgment in White v GMC[1] provides helpful guidance as to the GMC's role regarding published statements made by Doctors.

In particular the Honourable Mr Justice Dove made clear what the correct approach to take was. The Interim Orders Tribunal [IOT] before they imposed any restrictions on free speech should have considered whether the free speech was such that a Fitness to Practice hearing would have more likely than not found the comments a risk to patient safety [my emphasis]:

> *"Section 12(3) makes the likelihood of success at the trial an essential element in the court's consideration of whether to make an interim order... There can be no single, rigid standard governing all applications for interim restraint orders. Rather, on its proper construction the effect of s12(3) is that the court is not to make an interim restraint order* ***unless satisfied the applicant's prospects of success at the trial are sufficiently favourable to justify such an order being made in the particular circumstances*** *of the case. As to what degree of likelihood makes the prospects of success "****sufficiently favourable****", the general approach should be that courts will be exceedingly slow to make interim restraint orders where the applicant has not satisfied the court he will probably ("more likely than not") succeed at the trial"*

The corrrect process that should have been followed by the GMC regarding the complaint made against Dr Jones was:

[1] https://www.judiciary.uk/wp-content/uploads/2021/12/White-v-GMC-judgment-031221.pdf

1. Do Dr Jones' comments pose a risk to patient safety?
2. If so, is the GMC more likely than not to succeed at a Fitness to Practice Hearing that Dr Jones made misleading and or untrue statements which posed a risk to patient safety?

Had the GMC addressed its mind properly to the issues at hand they would have answered all of the questions in accordance with the presented evidence and referred Dr Jones to an IOT for further action.

The GMC's decision not to take further action against Dr Jones contrasts with the heavy handed and unlawful approach it took in Dr White's case.

Dr White's comments were supported by a body of medical opinion, expert witness testimony and posed no risk to patients.

Instead Dr White raised serious concerns about:

1. Avoidable harm being caused to the public;
2. The lack of fully informed consent for vaccines still in clinical trial;
3. The safety of masks in non clinical settings;
4. And the continued denial of access to safe and proven therapeutics like Ivermectin.

A Doctor must be able to raise concerns about patient safety and systemic failings without being subject to regulatory investigation.

If a Doctor who is raising genuine and evidence based concerns about patient safety is muzzled by the GMC, who's the regulator protecting?

The High Court has found that there was an error of law in the approach taken by the GMC and the IOT in Dr White's case. Dr White's human rights were not taken into account.

The decision taken by the GMC to take no further action against Dr Jones is unlawful when compared to the action taken against Dr Sam White. There is a legal duty on the GMC to act consistently, fairly and equitably.

Complaints made about Dr Sam White were investigated despite not being accompanied by any supporting evidence that Dr White had breached any GMC principles.

The GMC procedure does not allow for any complainant to be identified. Dr White's video reached over 1 million views and the GMC acted upon 18 anonymised complaints of alleged 'misinformation.'

The complaints that were generated against Dr White had a very similar wording and appeared to be orchestrated against him to silence him.

The MPTS IOT imposed conditions on Dr White's practice despite the overwhelming evidence bundle submitted by Dr White to the IOT.

The IOT began proceedings by stating that they did not consider evidence, but did in fact make a decision of fact that what Dr White said was 'misinformation'- without any burden of responsibility to prove this.

The IOT was nevertheless content to contravene Dr White's human rights. More importantly the GMC's actions did not show any support for a whistleblower. Whistleblowers should have their concerns investigated.Whistleblowers should be protected as the Staffordshire enquiry made clear. Lessons that were said to be learnt by the Staffordshire enquiry need to be acted on.

In Dr White's case all Dr White's claims are and were backed up by supporting clinical and scientific evidence. This is a point made at paragraph 7 of the High Court judgment.

This is in stark contrast to Dr Jones. The complaint lodged against Dr Jones referenced evidence that contradicted Dr Jones' broadcast statements.

Dr Jones made untrue and unevidenced comments about the vaccine's safety and efficacy as well as the material risks from covid and the vaccines.

Those comments reached a far wider audience than Dr White's. Dr Jones **currently** has far greater influence than Dr White.

Dr Jones poses a risk to patient safety by making untrue statements on GMB.

Further he has damaged the reputation of Doctors by broadcasting statements that generated over 1400 complaints to Ofcom.

The complaint before you was that Dr Jones made misleading and untrue statements on GMB on 12 July 2021.

These comments constituted grounds for a misconduct or deficient professional perfomance referral to the IOT of the MPTS.

For ease I have colour coded Dr Jones' statements red.

The first of the comments that was subject to complaint was:

> *Dr Hillary: …and that's of concern. What I say to people is look: you know, of course it's your choice, it's your individual choice, it's not compulsory, I'm not going to tie you down and do it. But I think, just remember that this vaccine is not new, it's not new technology, it's been*

around for some time, it was very successfully used against SARS and MERS. (1)[2] [3]

My client, the anonymous complainant, referred to the following study to back up his contention that the first comment underlined was an untrue statement. https://ijvtpr.com/index.php/IJVTPR/article/view/23

The statement made by Dr Jones is untrue and misleading. Making untrue statements about a mode of action of a vaccine and its prior use poses a risk to patient safety.

The second comment that was subject to complaint was:

Dr Hilary: …it's something that we can absolutely understand how it works, it doesn't affect the DNA of your cells, it can't affect your fertility.(2) [4]

Here is the link on how it can be reverse transcribed into human DNA *https://documentcloud.adobe.com/link/review?uri=urn:aaid:scds:US:ecc67cba-7c65-4127-8a49-793295a20164*

My anonymous client referred to the following quotation which was referred to in the International Journal of Vaccine Studies above:

'*We finish by addressing a common point of debate, namely, whether or not these vaccines could modify the DNA of those receiving the vaccination. While there are no studies demonstrating definitively that this is happening, we provide a plausible scenario, supported by previously established pathways for transformation and transport of*

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[2] : https://ijvtpr.com/index.php/IJVTPR/article/view/23

[3] https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC7177048/

[4] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1july2021

genetic material, whereby injected mRNA could ultimately be incorporated into germ cell DNA for transgenerational transmission'

My anonymous client then backed up his complaint with the following statement:

"If the scenario of these vaccines becoming incorporated into subjects DNA is possible and not yet understood, even by respected experts in the field, due to the very short and restricted basis of the current mRNA treatment Stage 2 clinical trials, how could a medical doctor who specialises in ***Aesthetic Medicine*** *possibly be qualified to assure the viewing public that these injected fluids do not enter your DNA and he certainly cannot also categorically state that it can't affect your fertility – no one knows. These comments are currently unsubstantiated and not proven."*

The GMC should have known that the Pfizer Japanese bio-distribution study found a concentration of spike protein in the ovaries, and the semen trials are ongoing in South Africa.[5]

It is unsafe for Doctors to be broadcasting untrue and unqualified statements about a vaccine's safety and potential impact on fertility when clinical studies are ongoing.

We observe that there appears to be an increase in incidences of women having menstrual problems and an increase in still births.[6]

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5 https://clinicaltrials.gov/ct2/show/NCT04778033

6 https://www.rcog.org.uk/en/news/rcogfsrh-responds-to-reports-of-30000-womens-periods-affected-after-covid-19-vaccine/

The next unqualified and misleading comment made by Dr Jones which was the subject of complaint was:

> *It can only protect you: It's a win, win, win, win, win. There's nothing – there's no downsides. Yeah, about 1 in 500,000 might develop a very rare complication,(3) [7]the link still hasn't been proven yet, but 1 in 500,000 compared to quite a high risk of becoming ill. 1 million people already have suffered with long Covid and some of those people it will affect them all their lives.(4)*[8]

My anonymous client backed up his complaint about the above with the following statement:

> *As of 12/7/21 there have been almost 81 million doses of the 'vaccines' administered in the UK, so on the basis of the above comment there should have been only 164 'very rare complications' as a result – however as of 28/7/21 there have been over 1400 deaths recorded on the UK MHRA Yellow Card scheme alone, as reported by medical practitioners and coroners, which by any standard would rank as a very serious complication and certainly a lot more common than 1 in 500,000. In addition there have been over 300,000 adverse reaction cards registered ranging from fevers and aches to total blindness, coronary / neurological events and even spontaneous abortions / miscarriages.*
>
> *The current rate, according to the UK Government and MHRA of people suffering an adverse reaction to one of the 'vaccines' stands at 1 in every 142 people. It is further estimated by the MHRA that as it is a voluntary*

[7] MHRA Adverse Events https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting

[8] https://evidence.nihr.ac.uk/themedreview/living-with-covid19/

system that only 1 – 10% of adverse reactions are actually reported to the Yellow Card scheme so the rate is undoubtedly significantly higher.

There have been almost 5 times as many deaths attributed to these experimental covid 'vaccines' in 6 months than all the other vaccines authorised in the UK since 2010 added together.

Vaccines	Earliest Date Authorised since 2010	Adverse Reactions	Deaths
Tetanus	03 / 12 / 2010	3,013	15
Pneumonia	20 / 05 / 2015	8,238	38
Rabies	06 / 04 / 2017	2,387	1
Typhoid Fever	25 / 07 / 2018	309	0
Meningitis	31 / 03/ 2015	9,980	2
Anthrax	03/ 05 / 2018	294	0
Hepatitis A	24 / 12 / 2020	848	1
Influenza	06 / 02 / 2013	35,068	227
	TOTALS AS OF 08/04/21	60,137	284
Pfizer Covid-19	08 / 12 / 2020	236,555	450
Moderna Covid-19	08 / 01 / 2021 (not administered until June 2021)	22,191	6
AstraZeneca Covid-19	04 / 01 / 2021	775,940	960
Unspecified Covid-19	08 / 12 / 2020	2,690	24
	TOTALS AS OF 30/06/21	1,037,376	1,440

Dr Jones's blatant lie and unbalanced comments regarding the potential for harm to people in the wider viewing audience alone deserves his immediate suspension and investigation*.*

Dr Jones under reported the risk of vaccination by some margin. A Doctor is under a professional obligation to present accurate data on material risk. If a Doctor does not present accurate information on material risk, he is being negligent. Negligent Doctors pose a risk to patient safety.

Furthermore the data on adverse events is unreliable given the shifting definition of vaccinated and unvaccinated and the historic under-reporting of vaccine adverse events, only 1% are said to be reported according to the Harvard study cited at the High Court in Dr White's case.

The fourth comment made by Dr Jones that was subject to complaint was:

'*1 million people already have suffered with long Covid and some of those people it will affect them all their lives*'

To support his complaint that the above statement was untrue and misleading my anonymous client made the following statement:

> *The following link: https://evidence.nihr.ac.uk/themedreview/living-with-covid19/ is to an article published by the National Institute for Health Research in October 2020 discussing the occurrence and prevalence of so called 'long Covid' and it begins by stating in the opening paragraphs of the 'How many people live with ongoing Covid19?' section:*
>
> *'Covid19 began to emerge at the end of 2019* ***and as yet there is little research into the number of people at risk of developing ongoing Covid19 or the duration of their symptoms****. An unreferenced but frequently cited estimate is that most people recover from 'mild' infections within two weeks and more serious disease within three weeks.*
>
> ***We are at an early stage of understanding the disease and need to be careful not to draw conclusions prematurely****. Even in a discrete occupational group such as people serving in the defence services, the incidence is unclear with new referrals continuing to the military Covid19 rehabilitation service from people who were first unwell in March 2020.'*

There is absolutely no definitive evidence that 1 million people are suffering with 'long Covid', this is an estimate that has appeared in an Office for National Statistics survey published on 1st July 2021 here:

https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/prevalenceofongoingsymptomsfollowingcoronaviruscovid19infectionintheuk/1july2021

A highlighted caveat at the bottom of the survey description states:

'This is analysis of new, recently collected data, and our understanding of it and its quality will improve over time. Long COVID is an emerging phenomenon that is not yet fully understood. The estimates presented in this release are ***experimental****; these are series of statistics that are in the testing phase and not yet fully developed.'*

The public perception of what is true and what is false regarding statistical information surrounding Covid 19 is not advanced whatsoever by so called 'trusted' medical practitioners stating on national television estimates that are portrayed as facts.

Dr Jones made an unevidenced statement regarding long covid and exaggerated the risk posed by the condition. Dr Jones in making the statement did not qualify it in any way. Making unqualified statements about a new condition is misleading and poses a risk to patient safety.

By way of illustration of the GMC's disparate treatment, my client, Dr White, in a widely broadcast and published podcast recorded with world renowned expert

Professor Peter McCullough on 20 July 2021 discussed the three main stages of Covid-19 disease.

The first is viral replication- the stage at which early intervention in the community with both nutraceuticals and therapeutics can reduce the likelihood of progression to stage 2, namely inflammation.

Currently in the UK, patients are not offered treatment in the community. They are advised- by way of example to call back- if their shortness of breath is worsening. This is stage 3.

Covid-19 is known via the action of the toxic spike protein to be a pro-thromboembolic illness.

At this stage a patient will likely be experiencing one or multiple blood clots and decreasing oxygen saturations and have developed a full blown systemic inflammatory response.

It is then that they are ‘allowed’ treatment by dialling 999, severely impacting their chance of recovery or survival.

It is plausible that if treated early in the community at stage 1- progression to a far more serious disease and by default long covid would almost be entirely preventable.

By banning my client, Dr White, from appearing on social media the public were prevented from wider dissemination of podcasts such as the one with Peter McCullough.

However Dr Jones is free to broadcast his misleading statements to a wide audience on national television. Do you see the problem?

The following statement by Dr Jones was the subject of complaint:

Dr Hilary: So, the risk of the virus is far, far, far worse than the vaccination.(5)[9]
So think about it again.

My anonymous client substantiated the basis of his complaint by making the following statement:

> *The following link: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7524446/ is to a peer reviewed scientific paper regarding the calculation of the definitive Covid 19 Infection Fatality Rate (IFR), using data from multiple international locations published on the US National Institute of Health Library of Medicine in July 2020 and I quote from its results section:*
>
> *'After exclusions, there were 24 estimates of IFR included in the final meta-analysis, from a wide range of countries, published between February and June 2020.*
>
> *The meta-analysis demonstrated a point estimate of IFR of **0.68% (0.53%–0.82%)** with high heterogeneity (p < 0.001).'*
>
> *Even using the highest weighted IFR figure of 0.82% indicates that 99.18% people will not die from Covid 19 putting the worldwide Covid 19 death rate very similar to that of Influenza.*
>
> *As the overwhelming majority who contract Covid 19 will recover as a result of their own immune system without any experimental medical intervention, the risk of **any** adverse and potentially fatal reaction to that intervention, no matter how small, is greater than the risk of recovering from the disease. The current rate, according to the UK Government and MHRA, of people suffering an adverse reaction to one of the 'vaccines' stands at 1 in every 142 people. However the MHRA itself estimates only 1 – 10% of people actually report an adverse reaction to*

[9] : https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7524446/

the Yellow Card scheme so the rate is most likely significantly higher. On current evidence this comment is blatantly not true, is misleading and could persuade people into having the 'vaccine' when they do not need it.

I believe I have provided sufficient evidence of significant misconduct and contravention of Domain 4 of the GMC's own code of conduct that this doctor should immediately be suspended pending a detailed investigation of his actions.

Risks varies from patient to patient. For some patients the risk from vaccination outweighs the risk from covid. Material risk is not absolute. It is individual and patient centred.

In making your decision to take no further action against Dr Jones the GMC acted perversely and or inconsistently and or unfairly when benchmarked against the treatment afforded to Dr White.

The complaint made against Dr Jones had sufficient evidence to meet the threshold of a referral to the IOT.

The rationale for not taking action against Dr Jones was that the GMC considered that Dr Jones' [my emphasis]:

> *"remarks **may have caused offence**, however in general it appears the discussion surrounding the COVID-19 vaccination and the wearing of masks **have been based on medical information available at the time**."*

Had you discharged your responsibility to the general public you would have investigated Dr Jones.

Had you investigated Dr Jones you may have found that he has financial interests in the advice he is giving on air.

Dr Jones may have a conflict of interest. Dr Jones has not declared, as far as we know, any conflict of interest to his viewing public. [10]

In the GMC's dismissal of the complaint you stated erroneously that the GMC has no power to investigate conflicts of interest and in particular whether Dr Jones is receiving funding to promote the vaccine.

Yet the GMC has a guidance document stating that Doctors must be open about any interests which conflict with their advice.[11]

This firm has received some evidence that celebrities are being paid to market the vaccine despite the vaccines having no marketing approval.

It must surely be within the remit of the GMC to investigate any Doctor who it is alleged has a conflict of interest in the clinical advice he is dispensing?

A Doctor should not benefit directly or indirectly from clinical advice he gives without declaring that interest. A regulated professional should not have undeclared conflicts of interest.

Further Dr Jones broadcast has generated 1400 complaints to Ofcom.[12]

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[10] https://www.mirror.co.uk/tv/tv-news/telly-doc-hilary-jones-slammed-10806516

[11] https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors---financial-and-commercial-arrangements-and-conflicts-of-interest_-58833167.pdf

[12] https://www.dailyrecord.co.uk/news/gmb-gets-1500-ofcom-complaints-25451363

All of the comments made by Dr White were based on medical information available at the time, furthermore none of Dr White's comments were untrue or misleading.

In fact of all those comments have since been further substantiated by medical and scientific data since his video in June 2021.

Dr White's 3 December 2021 letter to the CEO of the NHS summarises the developments since Dr White's ban was imposed.[13]

As a regulatory authority you are under a legal obligation not to make mistakes involving complaints made by the public about misleading and untrue statements made by a Doctor regulated by you.

There can be no doubt that you have treated Dr Jones differently to Dr White and such a difference is an abuse of your power and a failure by you to act consistently, fairly and equally.

Dr White despite making supported and evidenced statements was subject to investigation and an Interim Orders Tribunal, he has also been subject to a smear campaign and who initiated that campaign is still being investigated. The smear campaign was highlighted as a possibility in the 3 December 2021 and began on 6 December 2021. This campaign is now subject to a Police investigation.

Dr Jones despite making unqualified, misleading and untrue statements was not investigated and the complaint was dismissed on erroneous grounds.

13

Could you come back to me within 14 days confirming that you have corrected your errors and confirming that an investigation is now taking place into Dr Jones.

Should such a confirmation not be forthcoming I am instructed to review all legal options available including a Judicial Review.

No doubt if that materialises you will have to disclose how many individuals complained about Dr Jones to you as we understand that this complaint is not unique. It may also turn out that other evidence emerges about undeclared interests. Should such evidence emerge the continuance of the GMC as a credible regulator safeguarding patient safety will be further in doubt.

We would also invite you to consider your own position as Chief Executive. You lead an organisation charged with protecting patient safety yet have taken action against Dr White who posed no risk to patient safety but who had whistle blown his concerns about patient safety. All Dr White's comments were evidence based and approved at his NHS revalidation appraisal. The GMC has taken no action against Dr Jones who has made untrue and misleading statements about the vaccine's safety and efficacy on national television as well as material risks from COVID-19.

The action that was taken against Dr White was found to have been unlawful by the High Court. That on its own should be grounds for your resignation, given Dr White was making the claim that there were safe and effective therapeutics that could have been made available to the public but were suppressed and that such suppression has led to avoidable deaths. The organisation you lead tried to silence a committed and professional Doctor with an "unblemished record" who had whistle blown about alleged criminality at the heart of the government response to the pandemic.

Robert F Kennedy Junior has made a similar claim which is fully referenced in his most recent book on Dr Fauci which details the regulatory capture by the interests of big pharma. Robert F Kennedy Junior has also been greatly supportive of Dr White's work to highlight and whistleblow severe systemic failings in the management of the pandemic. Mr Kennedy Junior has not been subject to regulatory investigation and no conditions have been placed on his practice.

Further and most damningly you have not engaged with Dr White or this firm regarding evidence we have that some clinicians are posing a risk to patient safety. You have been in receipt of Dr White's witness statement since mid August 2021 which referred to evidence of clinical malpractice. You have made no attempt to contact us for further details. It is as if you have no interest in following up evidence of malpractice in the COVID-19 vaccine roll out. Your inaction shows a casual indifference to patient safety.

You have therefore, we say, failed to discharge the legal duties that come with your office and should resign immediately. Your actions have betrayed the trust the public place in your office.

In the meantime I am instructed to make this letter an open letter as there are widespread concerns that the GMC do not act fairly, do not act consistently and disproportionately target Doctors who do not conform to political health policy, no matter how harmful that policy is to patient safety.

The GMC appears to be an enforcer of government policy rather than an independent regulator. That's a real concern when the practice of medicine has become so politicised. Despite being invited to speak at The International Covid Summit in Rome September 2021, Dr White was unable to attend because of his 'gagging order' unlawfully imposed by the MPTS. He is, however, along with thousands of other doctors, scientists and experts a signatory to the Physicians Declaration II- and a summary of the key points agreed by international

attendees calls for physicians to be physicians again; the restoration of long standing and established medical ethics; and a return to the true doctor-patient relationship, one which is free of undue politcal interference.

The GMC has also failed to uphold the human rights of doctors under investigation.

We are also in receipt of further information that suggests the GMC has not in the past played with a straight bat when it comes to dealing with other Doctors.

Now is the time for you to step aside to enable a fresh and independent pair of eyes to examine past failures.

Now more than ever the public needs confidence in the regulation of Doctors.

I look forward to hearing from you as soon as possible.

Yours sincerely

Philip Hyland
Principal
PJH Law
Solicitors

From: FPD Decisions
To: [redacted]
Subject: GMC - E2-7599ZL
Date: 16 November 2021 14:29:29

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16 November 2021

In reply please quote: E2-7599ZL

Private: for addressee only

Sent via email only:

Dear

Thank you for contacting us with your concerns about Dr Jones, we apologise for the delay in responding to your complaint. We have very carefully considered the matters you have raised, but we have decided that we will not be opening an investigation into the doctor's fitness to practise.

Our Role

Our role is directly related to the registration of doctors. Our responsibilities are all connected to keeping the Medical Register. We oversee medical education; we give entry to the Register for those suitably qualified; we advise on good medical practice while registered; and we remove or restrict registration in response to fitness to practise concerns where there may be a risk to patient safety.

An investigation can only be opened if the concerns raised are so serious that the doctor's fitness to practise medicine is called into question to such an extent that action may be required to stop or restrict the way in which they can work to protect future patient safety.

The purpose of an investigation is to determine if or to what extent we need to restrict the doctor from working. We are not a general complaints body and we have no legal powers to intervene in or resolve matters for patients.

Current Position

While we appreciate why you have raised concerns about the doctor's comments on television, we do not consider these issues are so serious that they indicate the doctor is unfit to work as a doctor.

It is regrettable that some of the doctor's comments may have caused offence, however in general it appears the discussion surrounding the Covid-19 vaccination

and the wearing of masks have been based on medical information available at the time.

We have received no information to support that Dr Jones is receiving funds to promote the Covid-19 vaccination. It is not our role to investigate to establish this.

We will be taking no further action at this time, but thank you for contacting us about this matter.

Yours sincerely

The Enquiries Team
On behalf of the Assistant Registrar
The General Medical Council
3 Hardman Street, Manchester, M3 3AW

Direct Dial: 0161 240 8216
Email: fpddecisions@gmc-uk.org
Website: www.gmc-uk.org

Exclusively Employment Law Solicitors

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Stephen Lightfoot
Chair
MHRA

014/PH/2477
17 December 2021

Dear Mr Lightfoot

Re: Request for Undertakings for breaches of legal obligations and breaches of duties of care.

Summary of statements of evidence prepared for an Injunction Application.

Claimants: Dr Sam White, Andrew Doyle and Debbie Webb:

I am instructed by the following claimants: Dr Sam White, Andrew Doyle and Debbie Webb in connection with your organisation's role in authorising the SARS-CoV-2 injections in the United Kingdom.

These injections are unsafe, still in clinical trial, and should be withdrawn immediately. Your failure to investigate known concerns amounts to gross negligence in office, and renders you and the executive board liable for serious misconduct in office, mal or misfeasance in public office and, or, rendering all the office holders potentially liable for corporate manslaughter in that you have been wilfully blind to the known harms of the SARS-CoV-2 injections. You have taken no action. You have a lawful duty to protect the public, and you have wilfully failed in that duty.

The claimants are:

Dr Sam White, herein after referred to as "Dr White". Dr White has evidenced concerns of the lack of safety regarding the vaccine and the suppression of safe and effective therapeutics. Dr White is unable to give his patients effective advice because the MHRA has failed to authorise safe and effective treatments other than Budesonide for use by the over 50s which was recommended as a treatment in or around April 2021[1]

[1] https://www.thelancet.com/article/S2213-2600(21)00160-0/fulltext

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Andrew Doyle, and Debbie Webb are both students at Southampton University, who are unable to go on placements by reason of the fact that they have declined consent to be injected.

Andrew Doyle, who is a second year medicine student, is facing a Fitness to Practice Hearing at Southampton University on 7 January 2022 for alleged “serious professional misconduct” for declining the injection for SARS-CoV-2. He will fail his year if he does not consent to injection. The university has given him the option of changing course and vocation.

All the claimants are owed a duty of care by you not to misconduct yourself in office.
All the claimants are owed a duty of care by you to act on concerns raised.

All the claimants are owed a duty of care by you to ensure safe and effective medicines are authorised.

All the claimants are owed a duty of care by you to suspend authorisation of the SARS-CoV-2 injections and their clinical trials on evidence of material risk.

By failing in your duty of care you have committed a tort.

All of the claimants have suffered, and are about to suffer, immediate losses as a consequence of your tortious acts.

Damages are an inadequate remedy for loss of the ability to give patients a full range of options on therapeutics.

Damages are an inadequate remedy for the loss of a vocation and career in medicine, and in Ms Webb’s case a career and vocation in podiatry.

You are in breach of your duty as you have knowingly omitted to take action to avoid the preventable, and avoidable harms of SARS-CoV-2 injections.

The known facts of the SARS-CoV-2 injections are as follows:

1. **According to expert evidence relied on by the claimants the US data shows that the SARS-CoV-2 injections are 91 times deadlier than a flu injection.**
2. **According to expert evidence relied on by the claimants 10 batches of Pfizer SARS-CoV-2 injections are responsible for over 7% of all Vaccine Adverse Event Reporting System [VAERS] reported deaths.**

3. **According to expert evidence relied on by the claimants the true level of adverse events for SARS-CoV-2 injections is likely 11 times higher than that reported by the MHRA.**

4. **According to expert evidence relied on by the claimants nine months is insufficient time to obtain approval of a regulated injection, such injections usually take twelve years from proof of concept to use. The same expert concludes that the Conditional Marketing Authorisation (CMA) used by MHRA to approve SARS-CoV-2 vaccines in the UK does not sufficiently protect patients from harm, or even death.[i] Furthermore, multiples of injections, covering a large percentage of the UK population is still ongoing and the risk could involve thousands if not millions of people.**

5. **According to expert evidence relied on by the claimants there is an abundant evidence base to support the approval of Ivermectin in early treatment protocols as set out in expert witness Doctor Peter McCullough's, Doctor Pierre Kory and Doctor Tess Lawrie's witness statement.**

6. **According to expert evidence relied on the excess deaths in young males are more likely than not to be vaccine induced.**

7. **According to expert evidence relied on the PCR tests were approved by the WHO in reliance on an academic paper written by Professor Drosten**

which was peer reviewed and found to be academic fraud. The WHO is itself in receipt of substantial funding by the Gates' Foundation.

I note the following:

a. The normal number of fatal adverse vaccine reports on Yellow Cards is 20, so 1,822 for Covid vaccines for 51 weeks is sufficient to show avoidable harm, given the known and agreed issue of under-reporting of adverse events..

b. The MHRA has an estimate that actual reports are made at the rate of 10%.

> *It is estimated that only 10% of serious reactions and between 2 and 4% of non-serious reactions are reported. Under-reporting coupled with a decline in reporting makes it especially important to report all suspicions of adverse drug reactions to the Yellow Card Scheme.*

c. The MHRA has not published any FOI replies to the internet since the end of June (several hundred are now pending). This is an egregious breach of your legal duty to provide accurate and up to date data on safety.

d. The MHRA's statement from the weekly bulletin acknowledges that the three injections in use have quite different profiles in relation to inflammatory heart disease.

> *Based on reports of suspected ADRs in the UK, the overall reporting rate across all age groups for suspected myocarditis (including viral myocarditis), after both first and second dose, is 10 reports per million doses of COVID-19 Pfizer/BioNTech Vaccine and for suspected pericarditis (including viral pericarditis and infective pericarditis) the overall reporting rate is 8 reports per million doses. For COVID-19 Vaccine Moderna, the overall reporting rate for suspected myocarditis is 38 per million doses and for suspected pericarditis is 22 per million*

doses. For COVID-19 Vaccine AstraZeneca the overall reporting rate for suspected myocarditis (including viral myocarditis and infectious myocarditis) is 3 per million doses and for suspected pericarditis (including viral pericarditis) is 4 per million doses. It should be noted that more than one event can be included in each report.

.

I write to you to request that you will confirm in writing on or before 24 December 2021 that you undertake to do the following:

1. Stop all clinical trials of the SARS-CoV-2 injections immediately.
2. Suspend the conditional marketing authorisation [CMA] for all SARS-CoV-2 injections.
3. Suspend June Raine MBE from her post and require her to disclose all her direct and indirect financial interests in all of the products she is regulating.
4. During the suspension of the CMA require all CMA holders for SARS-CoV-2 injections to disclose the following:
    a. The isolated SARS-CoV-2 purified virus sample for independent analysis with gold standards chain of custody of the evidence.
    b. All safety and efficacy raw data from the start of the clinical trials to present.
    c. Disclose any bio-distribution studies undertaken.
    d. Publish all the ingredients of the injections.
    e. Have the ingredients checked by independent researchers for toxicity with criminal standards of evidence gathering regarding chain of custody of the evidence.

5. Suspend the CMA for LFT and PCR tests.
6. During the CMA suspension authorise the use of Ivermectin and other protocols shown to be safe and effective for SARS-CoV-2.
7. Take steps to bring to the attention of NICE and all NHS Trusts concerns over any treatment protocols involving the use of Remdesivir and Midazolam in treating UK patients for SARS-CoV-2.

Should you fail to give an undertaking on the above terms in writing, I am instructed to apply to the High Court to obtain an injunction to order you to do so. Such an

undertaking should be in writing to arrive at my offices within 7 days of the date of this letter. Such an undertaking should also be announced at a special Christmas evening television broadcast by you as Chair of the MHRA, accompanied by an announcement published on your website and press-released to all media.

The legal basis for this request for an undertaking and any application to the High Court is straightforward.

1. The Chief Executive Officer, June Raine, holds public office.
2. As CEO of the MHRA she commands a substantial salary package of £250,000.00 per annum.
3. The public office she holds requires the MHRA to intervene where material risks of a regulated product are present and investigation is warranted.[2]
4. The public expects the CEO to address concerns notified to her by the public and take immediate action.
5. All the SARS-CoV-2 injections are still in clinical trial under the Clinical Trial Regulations 2002.
6. It is gross misconduct not to bring to the board's attention and/or take action on concerns on safety and efficacy of the SARS-CoV-2 injections notified by the public to the MHRA.
7. You may be liable for corporate manslaughter and/or other criminal offences for omitting to rectify concerns when they were brought to your attention.
8. It is gross misconduct not to take any action when those concerns are brought to MHRA's attention.
9. Ms Raine misconducts herself in public office as she has failed to take any action when she is on notice that preventable harm is occurring. She has been on notice throughout 2021. One such example is concern over SARS-CoV-2 injection induced deaths of unborn children brought to her organisation's attention in August 2021. We note subsequent reports of increases in still births in Scotland[3].

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[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/949131/Pharmacovigilance___how_the_MHRA_monitors_the_safety_of_medicines.pdf

[3] https://www.heraldscotland.com/news/19726487.investigation-launched-abnormal-spike-newborn-baby-deaths-scotland/

10. The MHRA and Ms Raine's legal duty is to apply the precautionary principle and investigate and prevent any avoidable harm.[4]
11. Under her contract of employment Ms Raine is required to take immediate steps to rectify any situation that is brought to her attention that causes harm.
12. A failure to act on information of avoidable harms amounts to gross negligence.
13. Throughout 2021 June Raine has been notified of serious concerns involving regulated products and has taken no action.
14. A gross dereliction of duty amounts to gross negligence which is a form of gross misconduct.
15. Adesokan v Sainsburys Supermarkets Limited in the Court of Appeal is clear on the duties of senior personnel to avoid harm and loss when brought to their attention via email or other media.[5]
16. Misconduct in public office and or gross negligence in public office amounts to a tort as well as potentially a criminal offence, and a Police report will be made on 20 December 2021.
17. The particulars of the gross negligence and or misconduct in public office are:
    a. June Raine and/or the MHRA "conditional market authorised" SARS-CoV-2 injections without:
        i. Seeing evidence of an isolated virus,
        ii. Without doing a proper consideration of safe and effective treatments which could be re-purposed such as Ivermectin. Ivermectin used with great success by Doctor Peter McCullough, world renowned physician and world leader in the practice of evidence based medicine and standards of clinical and academic research excellence. His brilliance at communicating the truth makes him a historic and heroic figure and an unimpeachable witness of truth.
        iii. Critically examining the raw safety and efficacy and quality Chemistry, Manufacturing and Controls (CMC) data.
        iv. Considering whether the use of PCR tests or equivalent Nucleic Acid Amplification Test [NAAT] to determine who participated on

[4] Regina v Dytham CACD ([1979] 1 QBD 722, (1979) 69 Crim App R 722)
[5] https://www.bailii.org/ew/cases/EWCA/Civ/2017/22.html

the clinical trial was appropriate and reliable. Failing to take and action following publication of the Corman Drosten review which described the Drosten paper and subsequent use of PCR tests as academic fraud. We have expert witness evidence from Doctor Lidya Angelova, one of the authors of the review. It should be noted that the Portuguese Court of Appeal, in upholding the fundamental human rights of their citizens, found the use of PCR tests without a Doctor overseeing the process was and is unlawful as causing harm and breaching human rights.

v. Failing to rigorously examine the toxicity tests supplied with CMA authorisation documents for all of the ingredients of the injections.

vi. Failing to publish to the public a full list of ingredients. Without information on the constituent components and or ingredients of the injections means patients do not have sufficient information on which to give informed consent. A Doctor's Hippocratic Oath includes doing no harm and not administering toxins. This point has been made by Doctor Stephen Frost. Doctor Stephen Frost also observes that post-mortems and inquests have reduced as a result of the Coronavirus Act becoming law in 2020. The rules on certifying death certificates were eased meaning certifying Doctors may have had limited knowledge of the deceased and or were relying on the results of a PCR test without further diagnosis. The increase in cremations has meant post-mortems and evidence and knowledge from pathological samples has also decreased. Mr John O'Looney, undertaker, has written to the Chief Coroner requesting that full inquests and post-mortems are immediately resumed as he has observed an increased number of deaths amongst young, previously fit and healthy, young men. We note Dr Clare Craig's expert opinion on this point. We also observe in passing the number of elite, professional athletes who have had recent publicised heart issues. Humans have an inalienable right to life and inalienable rights to bodily integrity and autonomy.

b. Ms Raine and/or the MHRA did not suspend the clinical trials and or CMA when the following avoidable harms from the CMA SARS-CoV-2 injections were brought to her attention:
    i. Death.
    ii. Serious injury including myocarditis.
    iii. Vaccine induced deaths of babies in utero.
    iv. Issues with the clinical trial data were raised by a whistle blower on 2 November 2021 from a Clinical Research Organisation.[6]
    v. Issues with batches were known from March 2021[7] and a failure to act later caused disproportionate harms.
    vi. Awareness that other jurisdictions had withdrawn authorisation of the SARS-CoV-2 injections from the market for some, if not all cohorts.
c. Ms Raine and or the MHRA continued with CMA of SARS-CoV-2 injections when she was aware of:
    i. Safe and effective alternatives.
    ii. The avoidable harms referred to at 2 (b).
d. Ms Raine and/or the MHRA gave CMA to PCR and LFT tests despite:
    i. The known unreliability of the tests.
    ii. The finding of the Corman Drosten review that found the paper to support the use of PCR tests was academic fraud, implicating the WHO and leading politicians.
    iii. A court in Portugal in December 2020 finding the tests unlawful and in breach of human rights when used without a clinical diagnosis.
    iv. Other jurisdictions withdrawing the products from market as unsafe and ineffective.
e. Failing to refer the following to NICE and or other regulators for investigation despite being aware of known issues in the treatment of SARS-CoV-2 with:
    i. Remdesivir.
    ii. Midazolam.

[6] https://www.bmj.com/content/375/bmj.n2635
[7] https://www.independent.co.uk/news/science/covid-pfizer-vaccine-doses-uk-latest-b1815398.html

18. The claimants are suffering loss as a result of Ms Raine's torts and her failure to prevent avoidable harms of loss including injury or death. Their statements detail the loss.
19. Dr White is suffering the loss of being unable to prescribe alternative safe and effective medicines which puts Dr White's patients at risk. Dr White has had his human rights curtailed as an individual who has not been injected. It should be noted that Dr White was subject to conditions imposed on his practice following an investigation conducted by the GMC. The High Court found the conditions unlawful, in breach of Dr White's human rights. Part of the alleged disinformation which was key to the GMC's investigation was the point made by Dr White that non-clinical masks in non-clinical settings are more than likely to cause harm. Dr White saw no robust evidence to support the policy adopted. Nor could Dr White see any benign motive for the government making face coverings a requirement unless one had a reasonable excuse when no evidence existed for face coverings making any material difference to infection rates. Dr White noted the harms face coverings caused, the lack of safety data for the gene therapy injections and the ability of those injections to manipulate DNA and urged the use of the precautionary principle. These evidence based statements earnt Dr White a suspension from the NHS and investigation and prosecution by the GMC with Dr White banned from speaking on social media about the pandemic. Dr White applauds the judgement of HHJ Dove upholding Doctor White's human rights. Dr White deplores the conduct of the GMC who sought to pay no regard to patient safety and too much regard for political policy which may have been influenced by commercial interests, or worse charitable interests funded by businessmen who made system bugs a feature of their business model. Dr White was cancelled by social media for holding evidence based concerns about patient safety. For example we understand that neither the Cabinet Office or the HSE hold any risk assessments for face coverings. Dr White had censorship imposed by the GMC, his regulator, who have responsibility for regulating Doctors in accordance with their lawful duty to protect patients from unsafe Doctors. Dr White was silenced for pointing out that there was clinical data to support the use of safe and effective therapeutics for early treatment of symptoms associated with SARS-CoV2. Dr White now faces discrimination for withholding consent from one of the CMA authorised

injections, the injections that carry a material risk of death or serious injury. Dr White faces discrimination for the HMRA's unconscionable failure to authorise Ivermectin and Zinc as shown to be safe and effective by Doctor Tess Lawrie, a champion of independent scientific research and evidence based medicine and as detailed extensively in Doctor Peter McCullough's witness statement. The unlawful suppression of safe and effective alternatives to injections was a point Dr White made in his letter dated 2 July 2021 blowing the whistle on alleged criminal conduct by those leading the pandemic response, including Boris Johnson. One of the allegations made was that commercial interests were likely to be influencing public health policy and the interests of big business are not always aligned with the health interests of the public. The MHRA are paid to keep the public safe from harmful medicines. Damages are an inadequate remedy in the circumstances.

20. The other claimants are at the point of being asked to leave their clinical courses at Southampton University because they are unvaccinated. Medical student Andrew Doyle has been told by his university Southampton University that he will fail his course if he does not agree to take a SARS-CoV-2 injection which is still in clinical trial. Mr Doyle is up before a Fitness to Practice Hearing for Serious Professional Misconduct on 7 January 2022 for refusing to be injected. Podiatry student, Debbie Webb, has not been given clinical placements to enable her to pass her course. We note, in passing, Southampton University's links with the Gates Foundation.[8]

21. Damages are an inadequate remedy for all the claimants.

22. Other potential claimants from the dental profession and the NHS have asked to be joined to this action. Their statements are being prepared and attest to individuals losing a hard earnt career and being forced out of a vocation and profession for upholding their fundamental human right to decline an injection, an injection authorised by your organisation despite the known harms and material risks. No individual should have to run the material risk of death or serious injury from an injection authorised by you where safer and more effective treatments are available.

[8] https://www.gatesfoundation.org/about/committed-grants/2020/04/inv016631

23. Should an injunction be granted, a group litigation order will be sought from the court to accommodate the substantial number of individuals suffering losses as a result of the breaches of your legal obligations.

The statements which support this request and a court application are as follows:

1. Statement from principal claimant **Dr White** detailing the existence of safe and effective therapeutics including the immune system. Dr White's statement refers to his historic high court judgment lifting the restrictions imposed on his social media use. One of the points made by Doctor White is the potential for grant and sponsorship money to conflict with public health. There is clear evidence that scientific output has been tailored to meet what sponsors or governments want from the science. There is evidence that the science relied on has had errors in either the assumptions on which the computer models were based or inherent unreliability of the PCR tests used as a key data input. Data from PCR tests should only be relied on if accompanied by a clinical diagnosis. Any policy based on data drawn from PCR test data alone has been found to be unlawful by the Portuguese Appeal courts and in breach of their citizen's human rights.

2. Statements from claimants **Andrew Doyle and Debbie Webb** detailing the pressure they are under from Southampton University to take the injection or lose their university place and or vocation or career.
3. Expert statement for **Professor Sucharit Bhakdi** detailing the harms of the SARS-CoV-2 injections. In particular Professor Bhakdi states with great clarity the design of the SARS-CoV-2 injections are such that they cannot work and cause harm.
4. Expert statement from **Professor Dr Arne Burkehardt**, a pathologist, which details findings from the post mortems of 15 deceased but injected. The statement reads:

> *…Histopathological findings of similar nature were detected in organs of 14 of the 15 deceased. Most frequently afflicted were the heart (14 of 15 cases) and the lung (13 of 15 cases). Pathologic alterations were furthermore observed in the liver (2 cases), thyroid gland (Hashimoto`s Thyroiditis, 2 cases), salivary glands (Sjögren`s Syndrome; 2 cases) and brain (2 cases).*

8. A number of salient aspects dominated in all affected tissues of all cases:

• inflammatory events in small blood vessels (endothelitis), characterized by an abundance of T-lymphocytes and sequestered, dead endothelial cells within the vessel lumen;

• the extensive perivascular accumulation of T-lymphocytes;

• a massive lymphocytic infiltration of surrounding non-lymphatic organs or
tissue with T-lymphocytes,

9. Lymphocytic infiltration was occasionally with signs of intense lymphocytic activation and follicle formation. If present, this was regularly accompanied by tissue destruction (9 cases).

10. This combination of multifocal, T-lymphocyte dominated pathology that clearly reflects the process of immunological self-attack is without precedent. Because vaccination was the single common denominator between all cases, there can be no doubt that it was the trigger of self-destruction in these deceased individuals.

5. Expert statement from **Dr Pierre Kory** detailing the safe and effective clinical use of Ivermectin as well as alleged corruption of Liverpool University and or Professor Hill regarding their failure to recommend Ivermectin. Professor Hill is alleged to have agreed in a video call with Doctor Tess Lawrie that it would be difficult for Professor Hill to recommend Ivermectin as his employer and department were in receipt of funding from the Gates Foundation. A common link between the foundation and Moderna, one of the SARS-CoV-2 injections CMA injections approved by your organisation. We also observe in passing that the MHRA was itself in receipt of Gates' money. Money which can be shown to influence the academic output of Professor Hill who put the commercial pressures applied by his sponsors above what the evidence suggested was the safe and effective alternative. Dr Lawrie is alleged to have drily observed she did not know how Professor Hill could sleep.at night.
6. Expert statement from **Dr Tess Lawrie** detailing her letter to you regarding authorising Ivermectin and your failure to take any action on that letter. In that letter Dr Lawrie referred you to the meta study showing the safety and effectiveness of Ivermectin.
7. Expert statement from **Dr Peter McCullough** detailing the use of Ivermectin in clinic.

8. Expert statement from **Dr Urso** detailing the risk from the SARS-CoV-2 injection of ADE subsequently borne out by clinical data from the PHE. We observe the excess deaths in homes noted by Professor Heneghan.
9. Expert statement from **Dr Bryan Ardis** detailing the issues around Remdesivir in treatment of SARS-CoV-2 and in particular whether any symptoms previously attributed to SARS-CoV-2 are in fact attributable in full or in part to the use of Remdesivir.
10. Expert statement from **Dr Clare Craig** opining that the excess deaths seen in young adults is likely due to Pfizer SARS-CoV-2 injections.
11. Expert statement from **Professor Dolores Cahill** describing the harm, injury, adverse events and deaths reported following the SARS-CoV-2 injections in the clinical trials including those due to Immune related Adverse Events and Antibody Dependent Enhancement. Professor Cahill's opinion is that under the 'First do no Harm' and the Precautionary Principle, because of the evidence of harm, loss, adverse events, injury and death reported to men, women and children on the SARS-CoV-2 clinical trials, Professor Dolores Cahill has evoked the 'First do no Harm' and the Precautionary Principle to ask for the immediate halt to the SARS-CoV-2 injections /clinical trials.
12. Expert statement from witness identified as **Marek Pawlewski MSc** (data analytics expert) showing the SARS-CoV-2 injection is 91 times more deadly than the Flu injection in a year-on-year analysis based on reports of adverse events.
13. Expert statement from witness identified as **Jason Morphett PhD** (data analytics expert) showing that there are some Pfizer batches that account for a disproportionate number of deaths and adverse events. That in fact, 10 Lots of Pfizer/BioNTech injections account for 628 deaths. That the likelihood is that adverse events are 11 times under-reported in the UK.
14. Statement from **Professor Roger Hodgkinson** detailing his research into virulence of SARS-CoV-2.
15. Statement from **Dr Kevin Corbett** on the use of PCR both for SARS-CoV-2 and HIV.
16. Statement from **Christina Massey** on the failure to isolate the virus. Christine has submitted over 140 freedom of information requests to over 125 institutions and has no record of an isolated virus, including from Imperial College.

17. A statement from **Doctor Julian Harris** giving evidence relating to the inadequate and unsafe protocols in place at a PCR testing facility with multiple points of process where cross contamination of PCR swabs is a material risk.
18. A statement from one of the authors of peer review of the Corman Drosten review, **Dr Lidiya Angelova**. The conclusion of the review was that the PCR test and the academic paper it relied on was academic fraud implicating the WHO and other international politicians. [9]
19. A statement from two nurses employed by the NHS detailing a lack of training on serious adverse event reporting as well as giving evidence on the increases in number of admitted patients with suspected vaccine induced injuries.

20. A statement from Nick Hunt former Civil Servant on FOIs to MHRA related to his reporting to MHRA in April and August 2021 reports of alleged vaccine induced spontaneous abortion and hearing loss. The MHRA took no action.

21. A statement from a member of the public confirming that she informed the MHRA of the risk the spike protein may go beyond the injection site. The MHRA took no action.

22. A statement from a vaccine injured witness who attests to partial paralysis following a SARS-CoV2 injections, with a condition related to the spinal cord.

23. Expert Statement from **Hedley Rees** detailing the average timescale for vaccine development is 12 years. 9 months is inadequate tome to obtain full safety and efficacy data including manufacturing processes involved in biologics and the need for constant vigilance to ensure quality is controlled and maintained. There is no published data by the MHRA relating to QC audits, and random testing of finished products.

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9 https://www.researchgate.net/publication/346483715_External_peer_review_of_the_RTPCR_test_to_detect_SARS-CoV-2_reveals_10_major_scientific_flaws_at_the_molecular_and_methodological_level_consequences_for_false_positive_results

24. A statement from **Philip Hyland** summarising the evidence before the court including those not referred to above. All of the above statements are available by download and you should email me for a link.

25. Evidence from members of the public is still arriving in related to your organisation's failure to respond to concerns highlighted. These statements will be taken and presented to the court.

26. Evidence is being gathered from a specialist detailing coercive propaganda techniques methodology and language deployed by the MHRA website particularly aimed at school children and pregnant women. This expert has analysed the website against the seven Hawking Foundation Materials used to coerce children to take the vaccine in schools. The same methodology has been deployed by the MHRA in their guidance to pregnant women.

27. Evidence is being gathered from a chartered safety specialist on the usual risk analysis which should be deployed by a regulator in these circumstances, in particular regarding pregnancies and miscarriages.

28. It is possible that other expert witnesses will give statements to any hearing. Robert Malone, Mike Yeadon and Richard Fleming have been approached.

29. Statements will be taken from Doctors David Halpin and Stephen Frost as well as funeral director, John O'Looney in advance of the application for an injunction.

30. Ex-England Footballer Matt Le-Tissier has been approached for evidence of his knowledge of cardiac related issues in professional sports people and footballers in particular and any surrounding transparency issues relating to the professional football associations.

31. Statements have been prepared and substantially agreed, most are signed and some are pending signature. Please contact me for a link to the statements.

I look forward to hearing from you within 7 days and on or before 24 December 2021 at the latest, confirming you will be doing the following:

1. Suspending the CMA for all SARS-CoV-2 injections and immediately stop all clinical trials.
2. During the suspension requiring all CMA holders for SARS-CoV-2 injections to disclose the following:
    a. The isolated virus sample to allow independent analysis and approved chain of custody.
    b. All safety and efficacy raw data as well as CMC data from the start of the clinical trials to present.
    c. Disclose any bio-distribution studies undertaken.
    d. Disclosure of a full list of ingredients in the injections.
3. Suspending the CMA for LFT and PCR tests.
4. During the suspension authorising the use of Ivermectin and other protocols proven to be safe and effective.
5. Taking steps to bring to the attention of NICE and all NHS Trusts concerns over any treatment protocols involving the use of Remdesivir and Midazolam in treating UK patients for SARS-CoV-2.
6. Ensure that the withdrawal of the injections is announced via broadcast and print media and published on the MHRA's website on or before 24 December 2021.

You have an opportunity to take decisive and immediate action and prevent avoidable harm under the precautionary principle and in accordance with your legal obligations.

I look forward to receiving the written undertakings by return.

This letter will be a public letter given the importance of the issues at stake.

Yours sincerely

Philip Hyland
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