

REPORT ON RF SCANNING IN A SHIELDED ENVIRONMENT

ICAACT Phase III Testing



*International Center Against
Abuse of Covert Technologies*

"injustice anywhere is a threat to justice everywhere"

— Martin Luther King Jr.

Testing was conducted in Belgium, 6. of October 2012



Acknowledgment

On behalf of ICAACT we sincerely give thanks to those who made this testing possible. We want to thank the leadership of the scientific research facility in Belgium for allowing us to use their newly constructed Faraday cage. We want to thank the local organizing group in Belgium, who established the contacts and made this testing process possible. We also want to thank the scientists and researchers who helped us in evaluating this project. Last but not least, we want to thank all the participants of this study for their support.



Fig.1 - Lars Drudgaard (Left) and Jesse Beltran (Right) inside the Faraday Cage

The testing process and this report were completed by Jesse Beltran, California, USA and Lars Drudgaard Aarhus, Denmark, technical specialist for ICAACT.ORG.



Foreword

The main mission of ICAACT is to uncover non-consensual human experimentation utilizing electronic and communication technologies. This phenomenon was brought to our attention by the number of persons contacting ICAACT.ORG with complaints of electronic terrorism. Due to the vast similarities in the signs and symptoms of those bringing forth these complaints, ICAACT developed a 3-phase testing process which would provide the victims with either circumstantial- or hard-evidence of possible crimes being committed against them. ICAACT first began utilizing frequency detectors, scanners, and counters as forensic tools approximately 2½ years ago, after an inventor by the name of Bob Boyce had discovered electronic implants in his body utilizing radio-frequency (RF) scanners. This new type of forensics has been utilized by the renowned Dr. John Hall, based in Austin, Texas, who is also the author of the book "A NEW BREED: Satellite Terrorism in America". After consulting with Dr. John Hall, ICAACT also began using this type of RF scanning, and began testing throughout the United States and Europe.

ICAACT is committed to the respect and fundamental privacy of voluntary and consenting participants in our study. ICAACT has, therefore, granted the requested anonymity of the research facility that kindly allowed us access to their facility without charge.

ICAACT had the findings reviewed by a number of different highly regarded scientists from different countries. Their anonymity is being respected at this time, at their request, mainly due to their fear of political reprisal, as the subject matter involving this phenomenon is a delicate issue and potentially a political "hot potato" that could bring about serious ramifications. ICAACT is thankful for the time they have spent reviewing our findings and giving us their opinions. We have taken note of their comments, and they are reflected in this report and brought forward as our own.

This general report highlights the findings of Mr. Magnus Olsson from Sweden. Many of the findings on the other test persons are very similar to the results of Mr. Olsson.



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Synopsis

On October 6, 2012, ICAACT conducted its Phase III testing for the first time as a follow up on Phase I and Phase II testing. The testing was done in a research facility in Belgium. Participants were from the United States, England, Sweden, Slovenia, Spain, Holland, France, Israel, Denmark, and Belgium.

A Faraday cage was utilized to conduct the testing. The shielding spectrum of the environment was rated to be effective between 9KHz and 18GHz. The Faraday cage was certified in December of 2011 and was less than a year old when the tests were conducted. The scanning equipment used by ICAACT for this Phase III testing was a laptop-based Spectrum Analyzer, two different-hand held scanners, a frequency detector (MACE-JM20Pro), and a frequency counter (ACECO-FC1003). All tests were conducted inside the shielded environment also referred to as a Faraday cage.

Testing was conducted on two groups. Group I was a randomly selected group with no complaints of signs or symptoms of electronic terrorism. Group II were individuals who were symptomatic and had undergone Phase I of the ICAACT testing process.

Scientific studies on the side effects of consented implant technology and the similarity of expressed symptoms by the participants in this study will be discussed in the conclusion.

Our intentions are to share our findings in hopes that it will lead to further investigations within the scientific, medical, and forensic communities around the world. ICAACT is willing to assist, collaborate, and share our expertise, and consult with the broader scientific community in future investigations on the correlation between specific symptoms and RF emissions emanating from specific focal points of the human body.

ICAACT is dedicated to improving the existing testing methods and the conceptualizing, development, and implementation of new testing techniques in this new frontier of forensics, specifically in electroencephalogram technologies

Along side with this report a video on the RF scanning of Mr. Magnus Olsson can be viewed on the ICAACT web-page.



Phase I Explained

Prior to the Phase III testing described in this report, Phases I and II should preferably be conclusive and correlate with one another.

ICAACT conducts preliminary RF scanning on volunteers. This is in a non-shielded environment utilizing advanced radio frequency detectors. This is referred to as Phase I testing.



Fig.2

ICAACT Phase 1 preliminary scanning in Croydon, London, UK, April 27th 2012

The image shows Mr. Magnus Olsson participation in the scanning session where he was found to emit RF (Radio Frequencies) from various specific narrow focal points.

Phase I testing can provide indications of possible RF emissions from ones person. ICAACT has previously discussed the findings of RF emitting from very narrow specific focal points of the human body with medical experts who have expertise in different medical fields (Neurologist, Anesthesiology, and all general medical practitioners), and these experts point to the current understanding in medical science, which is that the human body does not naturally produce or emit radio frequencies. They point to the fact that the human body is a bio-electrical mechanism, and does evoke static electrical potentials, but that these are very different from RF signals. Phase I testing is conducted with the frequency detector MACE-JM20pro and the ACECO-FC1003 frequency counter. Some of the possibilities for false positive in the Phase I testing consist of RF signals from an surrounding source (example a passing police car or ambulance with ongoing radio communication) that temporarily overpowers the level of background signal the MACE-JM20Pro Frequency detector is calibrated to suppress, we try to eliminate this problem by doing several test, to confirm the result. Another possibility for a false positive is reflection from surrounding walls, more specifically windows and mirrors. We try to compensate for these situations by conducting the test in at least two different positions, minimizing the same type of reflections.



Phase II Explained

Phase II testing is left to the discretion of each individual tested. It consists of acquiring medical imagery of the specific narrow focal points of the body where positive RF was detected. Imagery can be in the form of High Digital Panoramic X-rays, CT scans, MRI scans, etc., and may offer further indication of the presence of a foreign body, if it correlates with the findings in Phase I testing.

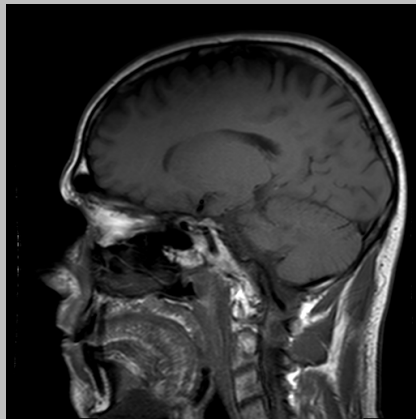


Fig.3 - Side View



Fig.4 - Top View

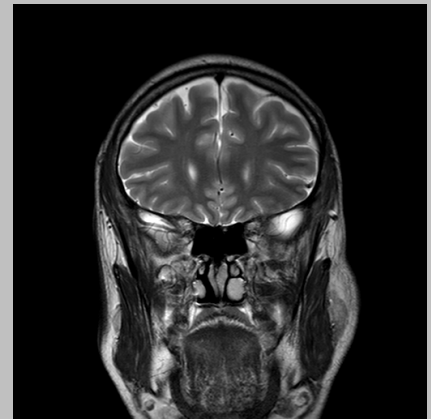


Fig.5 - Back View

Fig.3, 4 and 5 Show examples of individual slices of an MRI Brain Scan of the same person in the same session from different angles.

It is worth noting that there are different types of MRI scans that yield different resolution standards, and the resolution of the medical imagery is of great importance. Even with the best possible resolution of currently available medical imagery, there are limitations to the size of foreign bodies that can be identified. The new fiber-optic and Nano-scale electronic devices can be very difficult to detect, if not impossible, with the currently used medical imaging technology. This has precipitated the need for radio frequency testing. The abstracts' and studies in the appendix indicate that the foundation of the working process of these electronic devices function on radio frequency technologies. New breeds of synthetic biological electronic devices and organic electronics are on the horizon; and they are integrated with biological matter. These will become nearly impossible to differentiate from the organic makeup of the human body.



Phase III testing – Setup

Phase III consists of all the procedures conducted in Phase I, with the addition of having the process done within a controlled environment.

The testing was conducted in a modern Faraday cage. The size of the Faraday cage was approximately 3m x 9m in inner working area. 2/3 of the interior of the Faraday cage was covered with acoustic dampening cones of a special hard foam composition on the walls and the ceiling. The Faraday cage is designed to only shield against EMF (Electro Magnetic Frequencies) and radio frequencies.

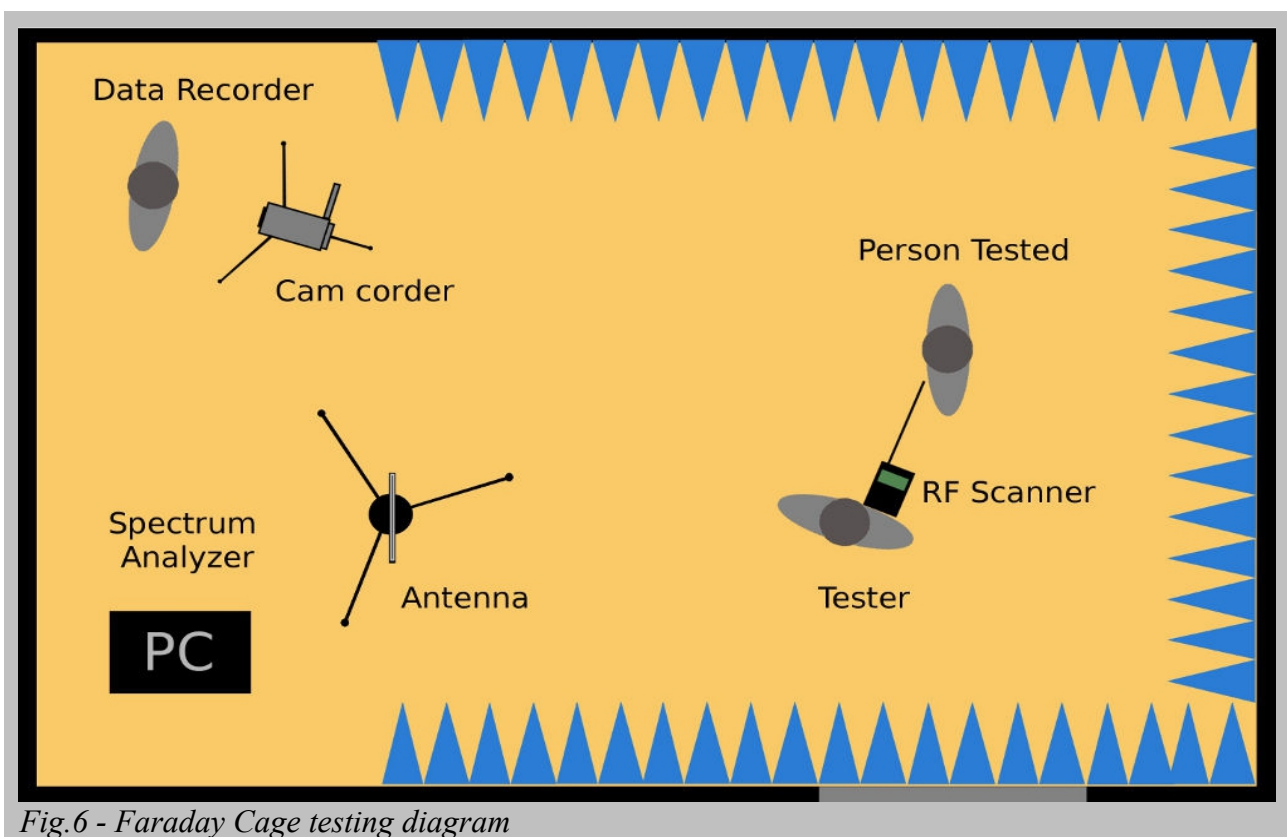


Fig.6 - Faraday Cage testing diagram

Fig.6 shows a diagram of the interior setup of the Faraday cage. It demonstrates the positioning of the test person, the tester, and the data recorder, as well as the placement of the testing equipment. The blue triangle depicted on the inner sides of the Faraday cage represent special foam cones that are intended to dampen the acoustics of the test environment. A manned camcorder on a tripod was setup in the acoustically untreated end of the Faraday cage to record and register the findings in this test. Next to the camcorder a special antenna (Appendix L) was placed on a tripod, and connected to a laptop running professional high resolution frequency spectrum analyzer software.



This spectrum analyzer setup was intended to record the entire spectrum of EMF/RF frequencies in the Faraday cage, and give indications of possible spikes, and provide a real-time overview of frequencies inside the Faraday cage, to be used in comparison between the different test subjects.

The test subject and the testing person were situated in the acoustically dampened end of the Faraday cage (see Fig. 6). The tester was equipped with two different types of hand held detectors.

First, the test subject was scanned with the Mace-JM20Pro, a frequency detector that is designed to locate the physical position of an emitting RF source/transmitter. A complete sweep of the test subject's body was conducted several times with a telescopic antenna in two different extended positions, to facilitate maximum sensitivity to both the upper and lower frequency range of the device's specified detection range. The second hand-held testing device that was used was the ACECO-FC1003 frequency counter. This device has a digital readout and can determine the specific frequency at a given location. Its wand is rated at an accuracy of 1 part per million. As RF signals transmit through the air, its signal strength decreases with square to the distance of the emitting source. This means that even a very weak signal transmitter is stronger than the RF signals we are surrounded by, if the proximity to the transmitter is close enough. The ACECO-FC1003 was used to detect the frequencies in close proximity at the specific narrow focal point of the body that were detected in the individual with the Mace-JM20-Pro testing outside the Faraday cage in Phase I. Through completing many scans with Phase I testing in Europe and in the US, we have discovered a number of specific narrow focal points of the body that are common with the symptomatic test persons in respect to the symptoms they experience. One of these specific points is the TMJ (temporomandibular joint) area, the juncture between the upper and lower jaw. The comparison of symptomatic- and non-symptomatic test persons was based on these common points previously established by ICAACT.



Phase III testing – Testing

Mr. Magnus Olsson, who previously had been scanned by ICAACT in Croydon, England, with Phase I scanning and has gone through Phase II, providing medical imagery in the form of MRI scans, was tested on the 6th of October, 2012, in the science laboratory Faraday cage in Belgium. First, Mr. Olsson was tested with the Mace-JM20pro, but these test results were subsequently discarded because of the discovery of an aberrant signal found to be transmitting inside the testing environment. This signal was transmitted at fixed intervals 30 seconds apart and for a duration of 5 seconds in length. This was an atypical finding. This source was located utilizing the JM20 Pro and was found to be emitting from the spectrum analyzer. The spectrum analyzer was disabled and removed from the testing procedure.

Then Mr. Olsson was tested with the ACECO-FC1003 Frequency counter, at the specific narrow focal points of his body that were established in the Phase I testing in Croydon, England.



Fig.7 - Testing of left TMJ, perspective



Fig.8 - Testing of left TMJ, closeup

Testing of Left TMJ

Mr. Magnus Olsson was found to emit RF signals from the left TMJ area as seen on Fig. 7 and Fig. 8. The ACECO-FC1003 clearly detected a RF frequency, as can be seen on the numerical readout on Fig. 8. This correlated with the finding in the Phase I testing.



Fig.9 - Testing of right TMJ, perspectiv



Fig.10 - Testing of right TMJ, closeup



Testing of Right TMJ

Mr. Magnus Olsson was found to emit RF signals from the right TMJ area, as seen on Fig.9 and Fig.10. The ACECO-FC1003 clearly detected a RF frequency, as can be seen on the numerical readout on Fig. 10. This correlated with the finding in the Phase I testing.



Fig.11 - Testing of forehead, perspective



Fig.12 - Testing of forehead, Readout

Testing of Forehead

Mr. Magnus Olsson was found to emit RF signals from the forehead, as seen on Fig.11 and Fig.12. The ACECO-FC1003 clearly detected a RF frequency, as can be seen on the numerical readout on Fig.12. This correlated with the finding in the Phase I testing.

Summary

Mr. Olsson was found to emit RF from 3 different specific narrow focal points of his body. These findings correlate with the findings in the initial Phase I testing, where the same three points were tested positive for RF emissions.

Mr. Olsson had positive frequency scans to the left and right temporal mandibular area. In addition he had a positive frequency reading to the anterior frontal region of the cranium just superior to the mid line sinus cavity.

Mr. Olsson is one of sixteen individuals who were tested in Belgium. Fourteen of the individuals tested would be classified as symptomatic. A symptomatic classification would be defined as those individuals who participated in Phase I with documented complaints and had a positive preliminary radio frequency scan. Phase I testing was conducted in an uncontrolled environment. Two participants were utilized as a controlled group. These participants were chosen at random and had no expressed complaints or signs or symptoms that correlated with or had any congruency as that of the symptomatic group. This is a general report that reflects the objective findings of the testing proceedings that were conducted within a controlled environment.



Findings in the Phase III testing conclude that frequencies were detected from the symptomatic group within the controlled environment. The frequency range was within the 9khz to 18ghz range that the faraday cage was certified to shield. The patterns were similar and consistent from phase I and duplicated in phase III. Consistency is explained and defined that participant participated in phase I and had a positive radio frequency scan at a specific focal point. Those focal points were then retested within the faraday cage and were positive for frequency detection..

These emissions were detected with the ACECO-FC1003 frequency counter. This is regarded as a significant finding as the testing environment specifications were rated to shield against frequencies from an outside source, and the respective lower and higher end of the effective shielding range was better than that of the specifications of the scanner. The same test that was conducted on Mr. Magnus Olsson was also conducted on Group II, the "Control Group" that did not experience any symptoms. This points to a correlation between the experienced symptoms and the emission of RF signals, with a yet unknown transmitter source. The finding in the tests of the symptomatic group confirms the findings in the previous tests done by ICAACT in Phases I and II.



Phase III testing – Control group testing

The symptomatic test subjects are tested with the ACECO FC1003 device, which is a high resolution frequency counter in the specific narrow focal points of the body where RF signals have been detected in prior scanning in Phase I. The non-symptomatic test subjects are tested in the same specific narrow focal points.

A control group was used. The control group consisted of two volunteers who do not exhibit signs, symptoms, or complaints of being a victim of electronic terrorism (see appendix A - Symptomatic VS non-symptomatic).

The reason for the testing of non-symptomatic test-persons was to rule out the possibility that any positive findings in the symptomatic group could be interpreted as being a new discovery of a new phenomenon, unknown by the scientific and medical communities, and to determine whether any difference in findings between symptomatic and non-symptomatic test persons can be attributed to the causation of the symptoms experienced by the symptomatic group.

The two control group participants, one male and one female, were tested together with a symptomatic person, in the same physical location, inside of the Faraday Cage. This insured objectivity.

The control group testing was done with the Mace-JM20pro (complete body scan) and the ACECO-FC1003, on specific narrow focal points of their bodies that we determined to be common to most participants of this testing, the left and right TMJ.

Identical tests were conducted with a symptomatic person against a non-symptomatic control group. For reasons of respect for privacy, the symptomatic test person will also remain anonymous in other participant's reports.

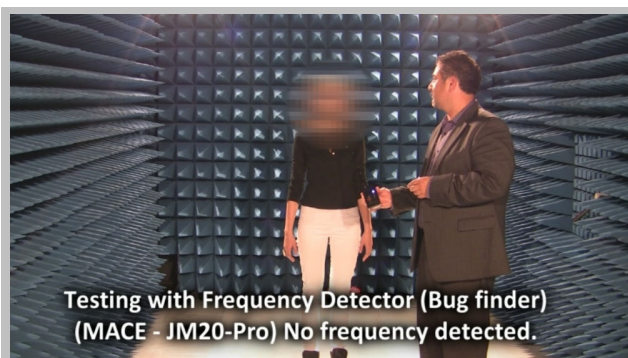


Fig.13 – F. Control Person - JM20pro

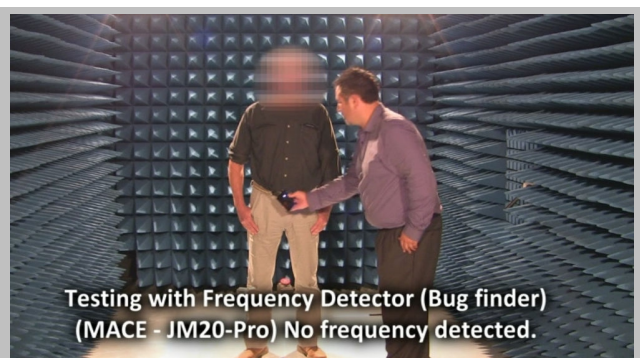


Fig.14 – M. Control Person - JM20pro

The two non-symptomatic control test persons were subjected to a thorough full body scan with the Frequency Detector Mace-JM20pro. No signals were registered on either of the two control subjects (see Fig.13 & Fig.14 and section on discarded test results)

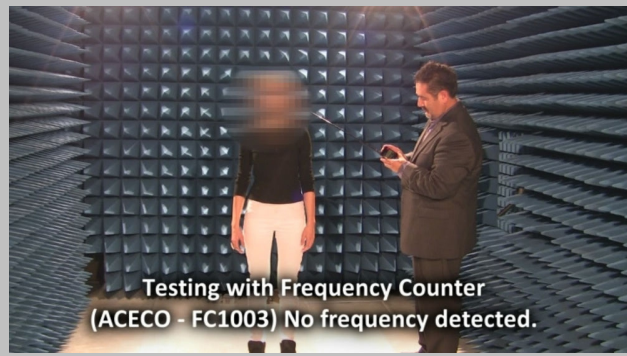


Fig.15 – F. Control person, overview

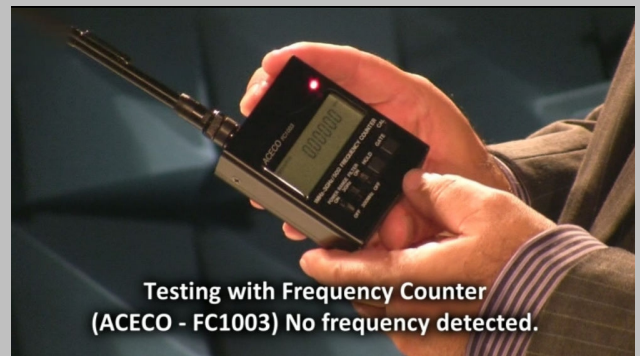


Fig.16 – F. Control person, Readout

The non-symptomatic female test person was tested for frequency emissions on her left and right TMJ with the ACECO FC1003 Frequency Counter (see Fig.15). A close-up of the numerical display (see Fig.16) shows no indications of the presence of RF signals. No radio frequency signals could be registered in close proximity of her body, with either of the hand held frequency detection devices.

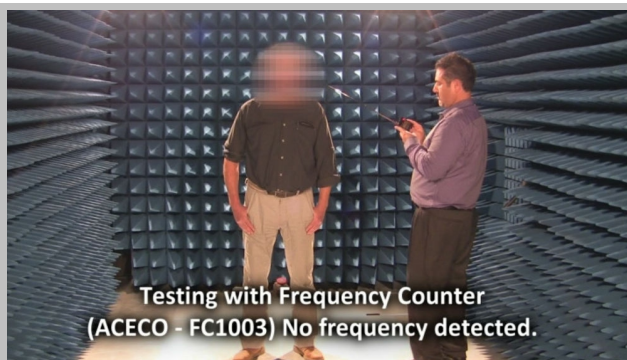


Fig.17 – M. Control person, Left TMJ, Overview

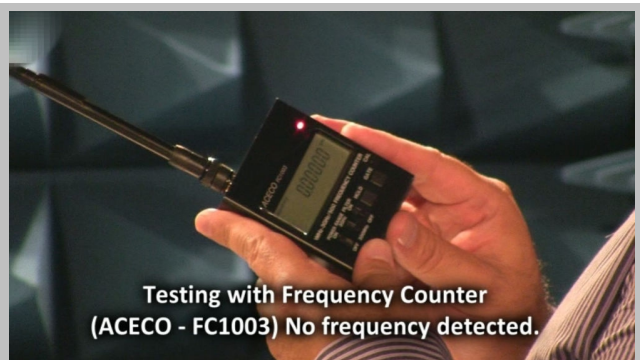


Fig.18 – M. Control person, Left TMJ, Readout

The non-symptomatic male test person was tested for frequency emissions in close proximity of his left TMJ with the ACECO FC1003 Frequency Counter (see Fig.17). A close-up of the numerical display (see Fig.18) shows no indication of the presence of RF signals.

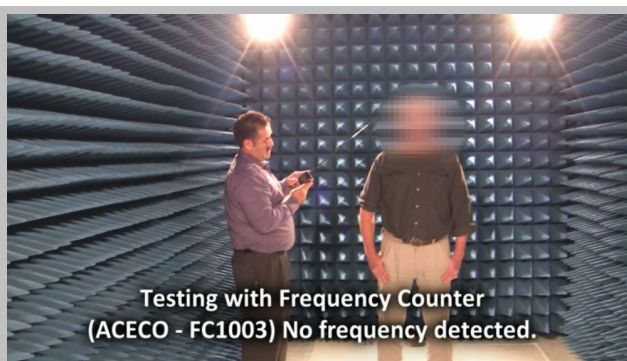


Fig.19 – M. Control person, Right TMJ, Overview



Fig.20 – M. Control person, Right TMJ, Readout

The non-symptomatic male test person was tested for frequency emissions in close proximity of his right TMJ with the ACECO FC1003 Frequency Counter (see Fig.19). A close-up of the numerical display (see Fig.20) shows no indication of the



presence of RF signals. No radio frequency signals could be registered in close proximity of his body, with either of the hand held frequency detection devices. To insure the validity of these findings and the apparent differences in the findings between symptomatic and non-symptomatic test persons, and to rule out any type of device malfunction or failure, we decided to repeat the testing with the frequency counter ACECO FC1003. This time we placed a symptomatic test person, who had tested positive for RF emissions earlier in the day and a non-symptomatic test person side by side inside the Faraday cage and asked them to exchange positions during this scan.



Fig.21 - Symptomatic, Overview



Fig.22 - Symptomatic, Readout

First we tested the symptomatic test person, and again the frequency detector came up with a positive result for RF emission (see Fig.21). A close-up of the numerical display (see Fig.22) shows the presence of RF signals.



Fig.23 - Non-Symptomatic-female, Overview



Fig.24 - Non-Symptomatic-female, Readout

Next we conducted the same test with the non-symptomatic test person in the exact same physical location of the Faraday cage as before (see Fig.23). A close-up of the numerical display (see Fig.24) shows no indication of the presence of RF signals. We find the results of the comparative study between symptomatic and non-symptomatic test persons to be of great significance. It establishes the presence of an unusual new finding that clearly points towards certain experienced symptoms, being accompanied by the emission of RF signals. This finding requires further investigation in the causation of this phenomenon, whether this is a new finding of biological principals or the possibility of the presence of foreign bodies transmitting the found emissions.



Phase III testing- Subjective testing on acoustic perception

The Faraday cage, in addition to being shielded for electromagnetic frequencies, also had some acoustic dampening features. The chamber was not dampened evenly throughout the chamber and the dampening was not to the extent of being an anechoic chamber (completely sound proof and sound dampened testing environment). Several of the symptomatic test subjects fall into the category of experiencing auditory effect symptoms (Appendix A). From the participants tested with auditory symptoms, we learned that the chamber did not block these to the full extent, but merely dampened the expressed signals. So we decided to do additional subjective testing of several symptomatic participants. We asked them to position themselves in several different locations inside the Faraday cage (see Fig.25), and to describe their experience for several minutes.

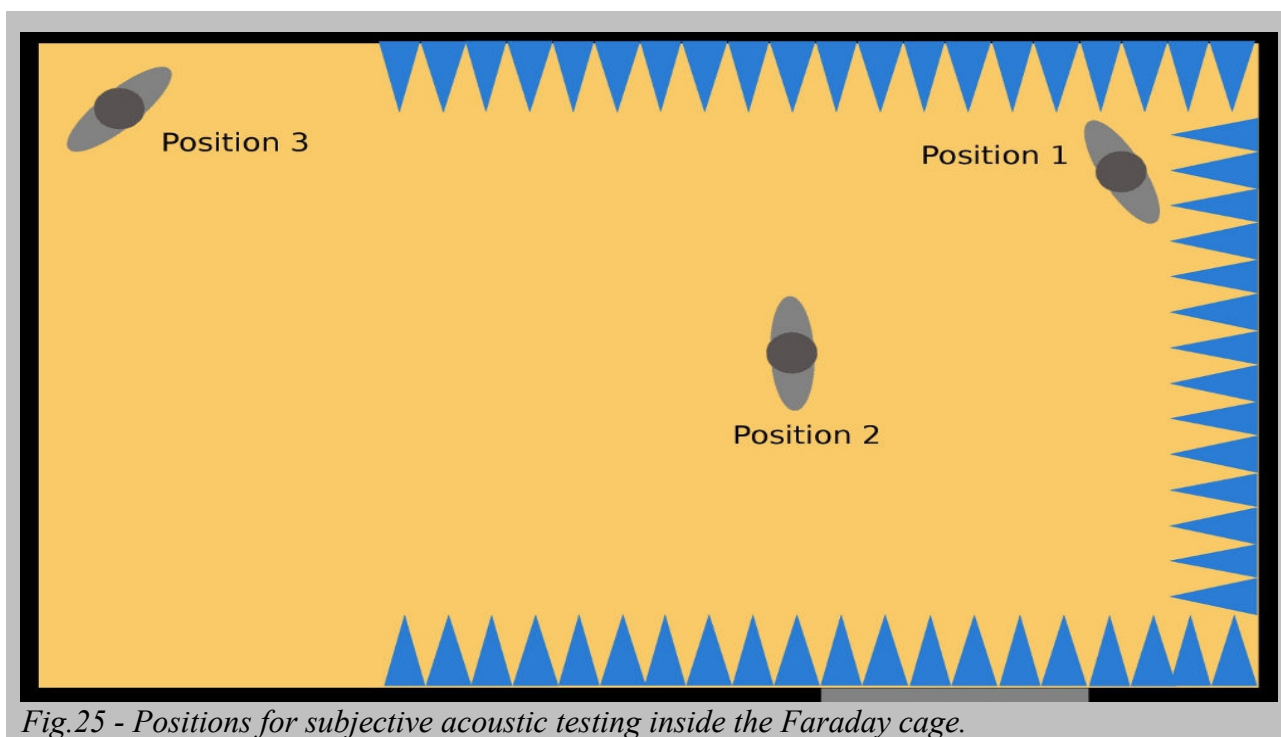


Fig.25 - Positions for subjective acoustic testing inside the Faraday cage.

After having spent several minutes in each location, with complete silence in the chamber, we interviewed the participants on their experience and their impression. All participants reported that certain areas of the chamber significantly dampened the auditory effects in comparison to other areas. We regard this finding as being highly significant. ICAACT will investigate this further in future testing scenarios, at present we do not have a conclusive theory on the finding, except that it points to the participants being sensitive to certain very low level audio signals, and depending on which location in the Faraday cage they were standing, a decrease in the intensity of the expressed signal was described. Position 2 was the most prominent in the dampening effect. It will be necessary to rule in or out the possibility of electromagnetic low frequency or different wave types being one of the possibilities for this phenomenon. ICAACT will consult with experts and research credible modalities to verify or disprove this possibility in future testing.



Discussion on the elimination of aberrant RF signal within the Faraday cage and the exclusion of data obtained during simultaneous testing.

In the initial testing setup we included a frequency spectrum analyzer. This device was made up of a highly sensitive antenna on a tripod that was connected to a laptop computer running sophisticated high resolution analyzing software (see Appendix L). The intention was to test for possible penetration of the shielded testing environment (Faraday Cage) by signals originating from outside the environment and, at the same time, to record all frequencies in the testing environment in time domain. This setup was intended to run in the background while conducting the actual testing with the hand held, close proximity, scanners.



Fig.26 – MACE-JM20pro (RF Detector)



Fig.27 – ACECO-FC1003 (Frequency Counter)

The first type of scanning we conducted was done with the frequency detector MACE-JM20Pro. Initially we did get some positive indications on several symptomatic test persons, but the positive signals were atypical from previous preliminary testing. After having conducted several tests, we began to notice that the positive findings of signals appeared to show up in fixed timed intervals. We found this to be strange and decided to temporarily break of the testing and investigate this further. During this investigation we found that these burst-like RF signals originated from the spectrum analyzer setup. We isolated the source and disabled the spectrum analyzer. The aberrant signals were no longer detected. The previous test results done with the MACE-JM20Pro were then discarded. In subsequent testing we had no further positive finding from the MACE-JM20Pro.

The difference in detection of frequencies between the MACE-JM20Pro and the ACECO FC1003 is most likely due to differences in the device sensitivity. Even though the MACE-JM20Pro is generally regarded to be very sensitive, it primarily



relies on the physical facts that RF signals decrease in signal strength with the square to the distance. This means that even a very weak signal gets relatively strong in close proximity, which is the principal it utilizes to locate the source of the transmitter.

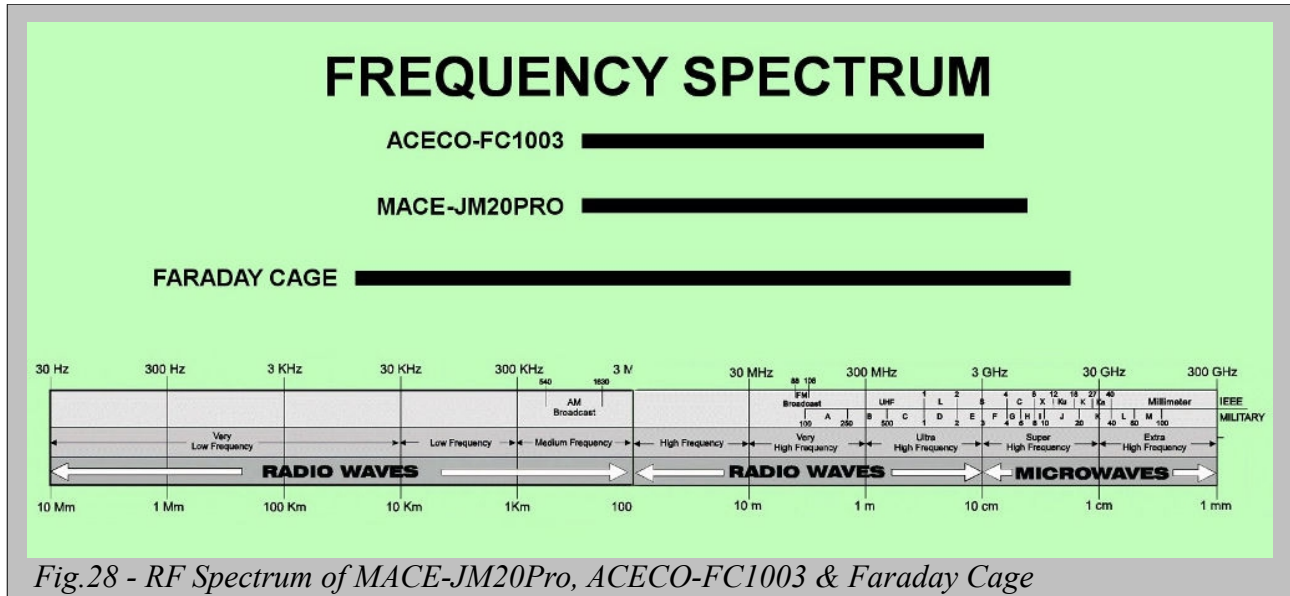


Fig.28 - RF Spectrum of MACE-JM20Pro, ACECO-FC1003 & Faraday Cage

As mentioned in this report, we did consult with several renowned scientists and experts to evaluate our findings. We want to thank them for their responses and their help in pointing out some of their observations in the testing scenario, as well as their suggestions for improvement in future testing techniques.

These scientists and experts agree with our reasoning that the difference in detection with the two types of hand held devices is most likely to contribute to the devices having different sensitivity to RF signals. It appears that the ACECO-FC1003 frequency counter is more sensitive than the MACE-JM20pro. It would be beneficial to have a specified sensitivity rating listed by each manufacturer.

The Faraday cage is rated to shield from 9KHz at the lower end to 18GHz on the upper end. Frequencies below the 9KHz range and higher than the 18GHz range are not shielded. Ideally the test environment should shield from 0Hz at the lower end to 300GHz at the higher end of the frequency scale for these types of tests.

There is a gap between the ratings of the Faraday cage and the hand held testing devices, most notably in the lower range. Both the MACE-JM20pro and the ACECO-FC1003 are specified to work from 1MHz at the lower end and respectively up to 3GHZ for the ACECO-FC1003 and 6GHZ for the MACE-JM20pro at the higher end of the spectrum. This means that the two types of hand held devices are unable to cover the entire RF range, and the possibility of missing RF sources is therefore possible.



Conclusion

The use of electronic implant technology is becoming common practice in the medical and scientific community and will grow towards being the main diagnostic and interactive tool with the human body. The use of implant technology has in recent years also gained interest outside the medical and scientific community and has now become tools of interest in many newly emerging commercial fields for many different applications. Because of the lack of current public knowledge about these rapidly growing uses of these technologies we will start out with a brief historical and contemporary context, as a background for understanding the importance of our findings.

Historical Context

Human electronic implant technologies are not new, they have been in existence since the early 50's. Some of the earliest research and developments into electronic implant technology for use in the human body was done by the military and intelligence community, as is the case with many new technologies. These are by the nature of the secrecy surrounding new military and intelligence applications not very well documented in the public domain, and to a great extent these developments and their specific applications remain elusive and secret. However, some facts have emerged in the early days of human implant technology. In a FOIA request for the remaining MKULTRA documents, it was revealed that MKULTRA was in fact an umbrella program with 149 sub programs. Electronic implant technology is mentioned in a couple of them. In one of the documents from sub project 142, dating back to 1962 (51 years ago), a previously developed electronic implant device for eavesdrop applications is mentioned.(ref.1)

Early pioneers working in the field of brain implant technology from the 50's and early 60's have documented their work. A Norwegian government report is available (ref.2) covering some of the work of Sem-Jacobsen, who also collaborated with professor Jose Delgado, who has published books on his work (ref.3). Delgado became famous for showing how he could remote control an angry bullfighting bull in 1963 with a hand held radio device (ref.4).

CIA Brain Experiments Pursued in Veterans' Suit

If military veterans have their way in a California law suit, the spy agency's quest to turn humans into robot-like assassins via electrodes planted in their brains will get far more exposure than the drugs the CIA tested on subjects ranging from soldiers to unwitting bar patrons and the clients of prostitutes. It's not just science fiction -- or the imaginings of the mentally ill. U.S. Magistrate Judge John Larsen's Nov. 17 2010 order exempted the agency from having to testify about electrode tests on humans, but Gordon P. Erspamer, lead attorney for the veterans, says "we are pursuing this as well." "We believe that one of our plaintiffs was given a septal implant at Edgewood Arsenal" he said, based on an MRI he has "showing a 'foreign



body' on the border between the septum and the frontal lobe." The CIA claims that at least some of the documents should remain classified as "state secrets." But Magistrate Larson told the agency to come back with a better rationale on why the documents should be protected after all these years. (ref.5)

In 2012 ICAACT conducted an interview with the former British microwave weapons expert and agent Mr. Barrie Trower. Mr. Trower pointed out that the use of microelectronic human implant technologies were not even secret and were spoken open about in the intelligence community until the mid-seventies, when it became classified (ref.6). His testimony is collaborated by a public proposal made 40 years ago. In 1973, then governor of California, Ronald Reagan (ref.7) proposed to use the brain implant technology with the abilities of that time to control the sexuality of the prison inmates, to use real- time wireless monitoring of electro-encephalogram (EEG), to be able to incapacitate inmates by remote control, and to further be able to track and locate them in case a successful escape from the correction facility. The program was stopped due to public outcry.

Present Day Context

Electronic implant technology for use in the human body is now 60 years after its first inception on the verge to become the everyday common tools in many fields. A report from the Swiss university of Neuchatel published back in 2007 (Appendix B - *Microsystem technologies for implantable applications*) discusses many of the commercially available micro-electronic devices on the market and in uses, it mainly covers implant technology for medical and scientific use.

Besides the many different applications in the medical field, implant technology is gaining popularity in the broader field of science where they can provide real-time data from real life scenarios, rather than from the restrictive and in many cases limiting artificial scenarios that can be recreated in laboratory and clinical settings. Some of the science fields that utilize implant technology are computer science, robotics science, and the communications sciences and industry. There is a ongoing boom in commercially driven neuroscience research like marketing and consumer behavior. The social sciences and especially the behavioral sciences are having a "field day" (literally).

A series of commercialized microchip implants for various purposes that have attracted some controversy in the alternative media, was launched by the company Applied Digital Solutions. Their products received United States FDA approval in 2004 and were launched under the trademark Verichip. The initial product range had four cornerstones VeriPay for ID and financial transactions purposes, VeriMed for healthcare purposes containing ID and online medical information, VeriGuard for ID type chips for access to facilities that require security clearance and Corrections for use in correction facilities and tracking legal offenders. VeriChip also advertized implants containing GPS tracking capabilities for individuals that could become subject to kidnapping. The company CEO publicly proposed its use in Children for parental control. This was rightfully criticized after it was revealed that the VeriChip's lack of security features made it susceptible to cloning and hacking,



which could present a risk of identity theft. This would also pose a serious risk to the implanted children as they could become easy prey for sex offenders, who would be able to locate them anywhere. VeriChip was re-branded to Positive ID in 2010.

The use of brain implants on the prison population for tracking and behavior control, was first publicly proposed 40 years ago and subsequently stopped because of public outcry. The same proposals in recent years have not met the same opposition, and have to a large extent not been discussed in the mainstream media. Many of the new and unexpected applications of implant technology and its use today is pointed out and discussed in a report from the Australian University of Wollongong (Appendix D - *The Future Prospects of Embedded Microchips in Humans as Unique Identifiers*). The report also covers a lot of the present and some future ethics problems that arise from these implant technologies, from their commercialization, and extensive use in science today. Most of these ethical and legal implications are as yet unsolved, and need urgent attention. These implications pertain to tampering with the innermost sacred sanctum of a human being, the mind.

Driven by the prospect of prosperity, and in a worldwide race and quest for global dominance in these new fields, both the EU and the US have billion Dollar/Euro initiatives to decode and emulate the human brain, these project encompass many different fields of science. The European project "The Human Brain Project" (ref.8) involves more than 80 universities and institutions. The US counterpart project "BRAIN" (ref.8) is spearheaded by DARPA and NIH, together with a variety of government and private institutions. The stated goal of both projects is to emulate the human brain, and recreate artificial ones. The European project also takes advantage of new developments in synthetic biology, DNA -modification, and nano-technology. US president Barack Obama stated that one of the additional goals in the US program is to create thought based communications system both between man and machine and ultimately also between human beings. The term for these communications interfaces is BCI (Brain Computer Interface).

The spear heading of these science fields by a military organization like DARPA is troublesome. A report from 2012 by the Royal Society with the title "Neuroscience, conflict and security" gives specific warnings about the implications of the militarization of these new neuroscience frontiers (ref.10). Similar warnings have been brought forward by US professor Jonathan Moreno in his books "Undue Risk" (ref.11) and "Mind Wars" (ref.12) where he outlines the military as the main economic financier behind most new neuroscience developments, and its many military applications.

A 2007 report from the University of Tilburg in the Netherlands (Appendix C - *Did My Brain Implant Make Me Do It?*), point out many of the ethical and legal dilemmas involved with human brain implants, even in the best circumstances with full oversight and full and informed consent many legal and ethical dilemmas arise. It can be expected that many field tests using these types of devices are required in



order to fine-tune their uses, testing for long-term effects and long-term stability in real life environments. With a historical poor track record for both government institutions, as well as private companies when it comes to the well-being and privacy of citizens and with a notorious total disregard for full and informed consent and basic human rights. It has become political correct to establish Bio-ethical watchdog agencies to oversee publicly funded research. However in a recently published article it was pointed out that these measures merely fulfill the role of blue-stamping projects as part of a whitewashing program (ref.13).

ICAACT is mainly concerned with the abuse of these types of technology being used on people without their knowledge and without full and informed consent.

The Phase III Testing and Our Findings

On October 6, 2012, ICAACT conducted its Phase III testing for the first time as a follow-up to Phases I and II. The testing was done in a research facility in Belgium. Participants were from the United States, England, Sweden, Slovenia, Spain, Holland, France, Israel, Denmark and Belgium.

We anticipate some criticism due to the anonymity of the research facility that granted us free access to their Faraday cage, our control test persons, and the experts and scientist who helped us to evaluate the test data. Without them, however, the project would not have been possible at all. Therefore, on behalf of ICAACT, we want to thank them sincerely.

A Faraday cage was utilized in which to conduct the testing. The shielding spectrum of the environment was rated to be effective between 9KHz and 18GHz. The Faraday cage was certified in December of 2011 and was less than a year old when the tests were conducted. The first test conducted within the Faraday cage was frequency detection with a frequency analyzer for broad spectrum analysis of the entire testing environment simultaneously with the hand held frequency detector MACE-JM20pro.

The second test we conducted was done using with the ACECO-FC1003 without the frequency analyzer to test the environment. This test was then done in the specific narrow focal points of the body that had been tested positive for RF emission in the Phase I testing. Those focal points from the symptomatic group were found to emit RF signals from these specific narrow focal points, to be specific, from the left and right temporomandibular area, in addition to his anterior facial area. These emissions were detected with the ACECO-FC1003 frequency counter with a numeric display to indicate the frequencies. This is a significant finding as the testing environment specifications were rated to shield against frequencies from an outside source, and the respective lower and higher end of the effective shielding range was better than that of the specifications of the scanner, which excludes the possibility that the signals could originate from an external transmitter source.



The same test that was conducted on the symptomatic group was also conducted on 2 control persons that did not experience symptoms. This points to a correlation between the experienced symptoms and the emission of RF signal, with an as yet unknown and unspecified transmitter source. The difference in test results between the symptomatic and non-symptomatic test group, is highly significant, not least because the findings showed emissions of RF signals from all 14 symptomatic persons tested and no RF signals from the two non-symptomatic control persons tested.

Several scientific reports are published regarding the known side effects of electronic implants for medical use (Appendix E, Appendix F, Appendix G). There are some interesting correlations between the findings in the medical community and the ICAACT test group. There appears to be significant congruence between the side effects described in the medical reports and the symptoms reported by the symptomatic test group in the ICAACT testing. To give a concrete example from an actual patient experiencing side effects from medical implant technology, see Appendix E - *Acute psychosis and EEG normalization after vagus nerve stimulation*.

...."The case of a patient with medically intractable epilepsy who developed a schizophrenia-like psychosis when control of seizures and scalp EEG normalization were achieved through vagus nerve stimulation is presented"....

...."at the same time the family had noted a change in the patient's behavior. Psychiatric evaluation disclosed a schizophrenia-like syndrome with auditory hallucinations, delusions of persecution, thought broadcasting, psycho-motor agitation, and complete lack of insight"....

Additional case reports from Appendices F & G mention symptoms such as:

...He continued to experience vivid dreams, but not waking hallucinations....

...such as the conviction that a perceived injury to his left arm "was growing from the inside towards the outside"....

The symptoms described in the actual cases above parallel with those who experience electronic terrorism, as we have come across similar stories among the participants as we conducted the Phase I testing in the United States and in Europe.

The general overlap of side effects in the medical reports versus the expressed symptoms of ICAACT participants, together with familiar descriptions like the one above, in addition to the ICAACT findings of RF signals emanating from specific focal point of the body of the symptomatic test group, points to the strong possibility of the participants being victims of electronic implant technology. In fact we should point out that it is highly likely that the participating group are victims of non-consented electronic implant technology.



Acoustic Findings

Mr. Magnus Olsson also participated in an additional subjective test on the perception of acoustics in reference to his symptoms, and this revealed some interesting findings that will need future investigation by ICAACT.

The subjective acoustic testing was performed within the Faraday cage, which was treated with sound absorbing defusing material, in the form of special foam cones on the walls and on the ceiling of the internal work space. The acoustic dampening of the Faraday cage was uneven. One end of the cage was untreated. This allowed for positioning of test persons in 3 test positions, and after several minutes of complete silence, the test subjects reported on their impressions while in the different positions and what differences they perceived. Of the selected 5 test persons (all symptomatic of auditory effects), the same results emerged. The acoustically treated areas of the Faraday cage seem to dampen the auditory effect in reference to the untreated section. This leads to the conclusion that these symptoms are based on a physical external signal. ICAACT finds this to be of great interest but we have not reached any final conclusions to the exact signal type and the physics involved. One explanation could be low levels ELF transmissions as used in submarine communications. This could explain the perceived differences in signal strength due to difference in acoustic dampening. Another possible cause are alternative types of wave communication, as these are also capable of penetrating the shielded Faraday cage and naturally occurs within the human body, as pointed out in Professor Dr. Konstantin Meyl's work on DNA and cell communication.

Future Improvement of Testing Should Include EEG Testing

ICAACT affiliates have conducted early preliminary tests with EEG. This could be an alternative or supplementary type of test to verify or dismiss claims of unknown external communication signals. We find it interesting that some of the studies addressing implant side-effects (Appendix G) have measured unexplained 10hz (alpha brainwave range) signals in the test subjects who have expressed experiencing side effects of implant technology. Several studies and reports (Appendix H) agree that brain wave activity in the upper alpha range of 10Hz relate to auditory experiences, attention, and memory processes. This becomes even more interesting, seen in the light of the David A. Larson report (Appendix I) that makes a very compelling case that covert implant technology may have many more applications and capabilities than are revealed to the those entities who grant permission to use them in human beings. Chinese Universities have been doing some pioneering work in this area, which could inspire a new type of communications forensics testing. We are remaining informed on these developments and hope to bring EEG technology into our arsenal of forensics testing in the near future.



International Center Against Abuse of Covert Technologies

"Injustice anywhere is a threat to justice everywhere" - Martin Luther King Jr.

Intent

We sincerely hope that our findings will lead to further investigations within the scientific, medical, and forensic communities around the world. ICAACT will be more than happy to collaborate and share our expertise and consult with the broader scientific community in future investigations on the correlation between specific symptoms and RF emissions from specific narrow focal points of the human body.

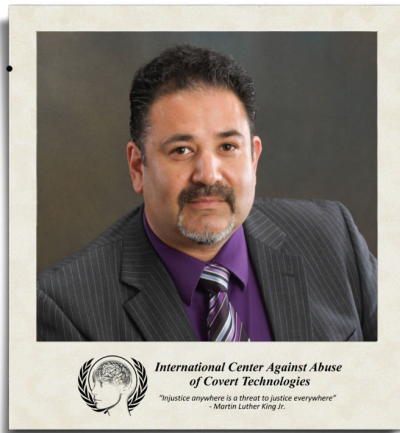
ICAACT is dedicated to improving the existing testing methods and the conceptualizing, development and implementation of new testing techniques in this new frontier of forensics, in an age where high-tech crimes are on the rise.



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The testing process and this report were completed by Jesse Beltran, California, USA, and Lars Drudgaard, Aarhus, Denmark, for ICAACT International.



Jesse Beltran
Technological Specialist
President, ICAACT.ORG



Lars Drudgaard
AP. P. in Electronics Technology
ICAACT.ORG – Europe

The testing procedure and the final general report was reviewed and approved by ICAACT's medical professionals, practicing physician Dr. John R. Hall D.O and neuroscientist Dr. Edward L. Spencer MD.



Dr. John R. Hall D.O.
Practicing Physician
ICAACT - Board Member

Dr. John Hall D.O.



Dr. Edward L. Spencer MD
Neuroscientist
ICAACT - Board Member



APPENDICES



Appendix A - Symptomatic VS non-symptomatic

In this report, test subjects with one or more of the listed symptoms below are labeled "symptomatic". Test subjects with none of the symptoms listed below are labeled "non-symptomatic".

- Auditory effects, artificial
- Electric shock sensations in various extremities of the human body
- Experience of needle-sensations in specific body locations
- Frequent heat sensations in specific areas of the human body
- Frequent muscle spasms associated with electrically induced contraction
- Experience of brain stimulation

Additional symptoms experienced by some symptomatic people which are not regarded as symptoms that, on its own, will qualify to fall into the category of symptomatic test persons.

- Sensations of extreme fatigue, in addition with other symptoms.
- Sleep deprivation.
- Perceived dream manipulation.
- Heart fluttering without previous diagnosis of cardiac abnormality.
- Seizures without prior warning or apparent reason.
- Incoherent speech.
- Lack of limb coordination.



Appendix B - Microsystem technologies for implantable applications

Overview of Implantable Microsystems

An implantable medical device is considered any device that is intended to function inside the body for some time. In this paper, a microsystem is loosely defined as a device that contains at least one part that is made using IC-like fabrication technology with dimensions in the order of micrometers. The focus is also on implantable microsystems not enclosed by a hermetic metal can, although these will be briefly mentioned. An effort is made to explain the clinical need for these microsystems in just one line and to place the solution being presented in historical context. Finally there are some implantable applications of sensors for continuous long-term animal monitoring that we would like to mention. One company has a whole range of products for animal use (blood pressure, heart rate, electro-cardiogram, and EEG activity) as well as a human clinical division. A large portion of implantable clinical applications of microsystem technology deals with electrical stimulation and/or sensing and has a long history starting in the 1950s. Examples of current devices and therapies are cardiac pacemakers, cardiac resynchronization devices, implantable cardioverter defibrillators, cochlear stimulators, neurological pulse generators for spinal, deep brain or sacral nerve stimulation and there are options for other clinical areas.

Visual Cortex Stimulation

Electrical stimulation of the medial occipital cortex can produce visual sensations. One system includes a video camera, external signal processing equipment and a brain implant that gives blind people with totally non-functional retinas the ability to have some kind of vision. Research into an array of penetrating electrodes that can form the basis of a visual prosthesis centered on electrical stimulation of the visual cortex was reported in 1988 and is ongoing. The system is also being used for chronic recording of the neuronal activity in the visual cortex.

Microelectrodes for Auditory Applications

Along similar principles as applied in the ophthalmic case described above, electrical stimulation can restore 'hearing' in patients who have an intact nervous system but irreversible conduction hearing loss like damaged hair cells in the inner ear. Electrical stimulation of the auditory nerve can be applied in the cochlear nerve in the inner ear, in the midbrain or in the brain.

Microelectrodes for Brain Research

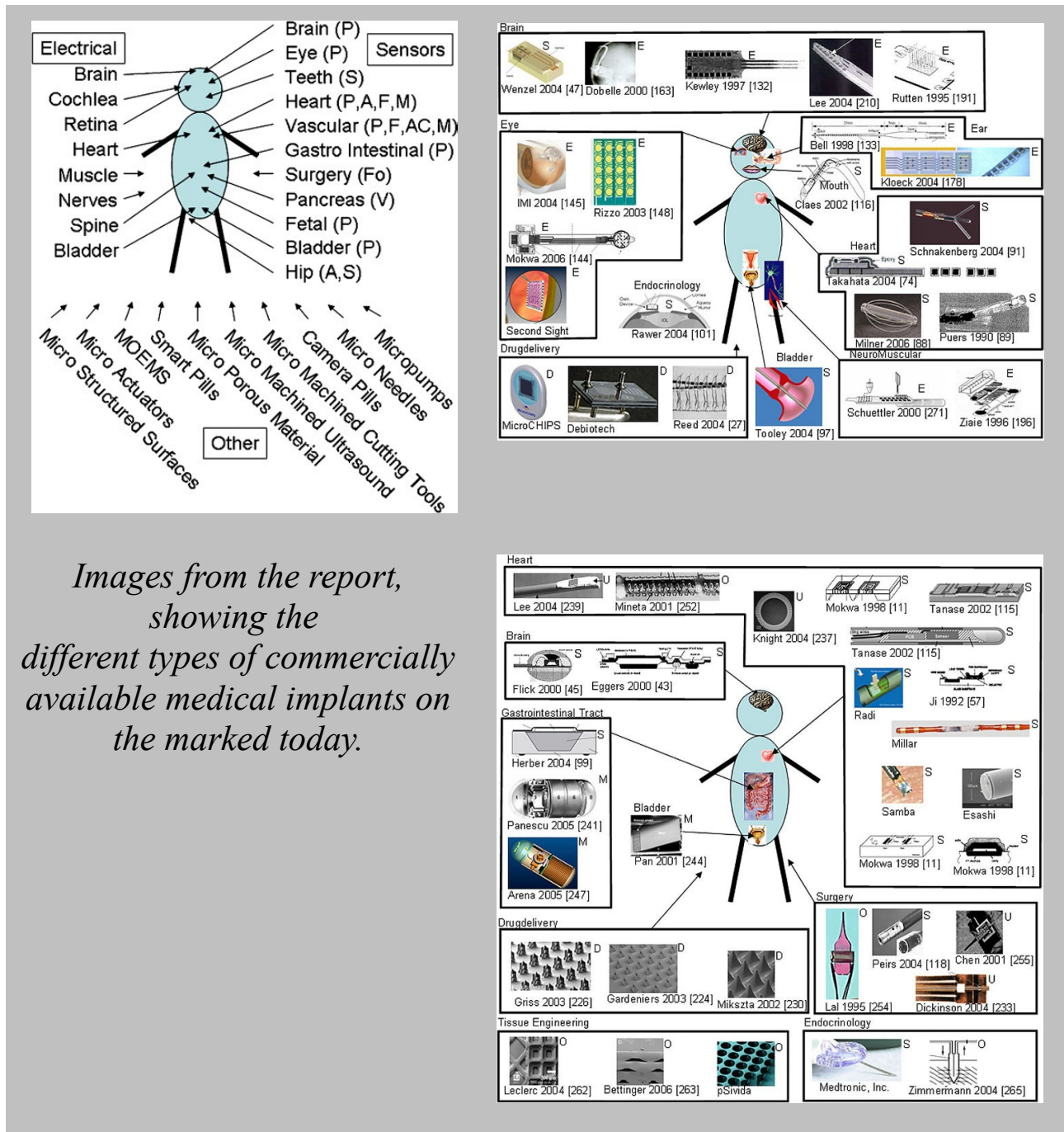
Penetrating neuro probes for recording of brain activity offer the advantage that signals can be collected from within the brain. The examples mentioned in this section are mainly used to study the functioning of the brain at a fundamental level. They enable discovering correlations between electrical activity in the central nervous system and externally applied psychophysical stimuli. Mostly, the long-term outcome of this fundamental research is targeted towards a specific clinical application. Others have proposed to treat chronic pain in a closed-loop scheme of electrical recording and stimulation in the brain. A multifunctional probe allowing both electrical and chemical recording and stimulation for fundamental brain research is being developed in the context of a European project. Microneedles have also been used for transdermal gene delivery. One technique is based on a set of oscillating solid microneedles driven by a modified tattooing device that results in plasmid DNA delivery directly to the target cells. This technique is more efficient than single injection and particle-mediated gene transfer. When these micro structures were placed in contact with DNA solution and then moved laterally over the skin they were able to breach the skin barrier.



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There is one example of a stent with micro needles covered with a nanoporous layer that contains the therapeutic agent such as DNA. Classification is based on the information available to the authors. There are 105 active and 70 commercial end items from a total of 142. The majority of the 37 passive end items are prototypes or animal research devices created by academic organizations. From the 105 active end items, 18 (13% of total number of end items) are classified as products, all made by commercial organizations. Note also that from these 18 products, there are only two for chronic use. The major technology-market combinations are sensors for cardiovascular, drug delivery for drug delivery and electrodes for neurology and ophthalmology.



Images from the report, showing the different types of commercially available medical implants on the marked today.

The full 31 page report can be downloaded from the following link: [Appendices](#)



Appendix C - Did My Brain Implant Make Me Do It?

Questions Raised by DBS Regarding Psychological Continuity, Responsibility for Action and Mental Competence

Laura Klaming • Pim Haselager

7 September 2010 © The Author(s). This article is published with open access at Springerlink.com

Abstract

Deep brain stimulation (DBS) is a well-accepted treatment for movement disorders and is currently explored as a treatment option for various neurological and psychiatric disorders. Several case studies suggest that DBS may, in some patients, influence mental states critical to personality to such an extent that it affects an individual's personal identity, i.e., the experience of psychological continuity, of persisting through time as the same person. Without questioning the usefulness of DBS as a treatment option for various serious and treatment refractory conditions, the potential of disruptions of psychological continuity raises a number of ethical and legal questions. An important question is that of legal responsibility if DBS induced changes in a patient's personality result in damage caused by undesirable or even deviant behavior. Disruptions in psychological continuity can in some cases also have an effect on an individual's mental competence. This capacity is necessary in order to obtain informed consent to start, continue or stop.

.....Taking the existing literature and the Dutch legal system as a starting point, the present paper discusses the implications of DBS induced disruptions in psychological continuity for a patient's responsibility for action and competence of decision and raises a number of questions that need further research.....

.....Although DBS has important therapeutic effects for otherwise treatment resistant conditions, there is potential for serious complications, such as hemorrhage and infections, and unexpected side effects, including cognitive and psychiatric symptoms. The most common cognitive and psychiatric problems that have been reported concern a decline in word fluency and verbal memory, depression, increased suicide tendency, anxiety, emotional hyperactivity and hypomania. Some of these side effects might also affect aspects of the patient's personality, i.e., his unique character traits, as reflected by his thoughts, desires, motivations and behavior. So far, little is known about the impact of DBS on patients' personality. Nevertheless, DBS induced changes in personality have been observed in some cases, while others have found no or little impact on personality. Alterations in mental states critical to personality could affect an individual's personal identity, i.e., the experience of psychological continuity, of persisting through time as the same person. Since there are various possible cognitive and psychiatric side effects, and effects of DBS on personality have been observed, it can be hypothesized that disruptions in psychological continuity can occur in patients undergoing DBS. So far however, there has been no *systematic* empirical research on the effect of DBS on an individual's psychological continuity and hence little is known about the influence of DBS on an individual's identity. The possibility of DBS induced changes in an individual's personality and identity entails important ethical and legal questions, for instance regarding responsibility for action and mental competence.....



.....It is not improbable that DBS may in some cases produce psychological changes leading to behavior that is morally and legally questionable. Several cases in which DBS has led to increased impulsivity and aggressiveness, or inappropriate sexual behavior, both of which could result in wrongful or even criminal behavior, have been reported in the literature. It is therefore questionable whether a patient who received DBS should be held (completely) responsible for his actions. It is currently unclear how to deal with questions of responsibility if DBS changes a patient's cognitive or emotional states and these changes cause undesirable or even deviant behavior.....

.....Several case studies however suggest that DBS can induce rather large changes in psychological continuity....

....In addition, she developed psychotic symptoms, suspecting her sons of conspiring against her, and became hostile. Although the patient in this case did not develop an alternate identity, the changes in her personality, i.e., mania and psychotic symptoms, are so severe that one may speak of disruptions in psychological continuity.....

.....The stimulation had caused serious personality changes including chaotic behavior, megalomania and mental incompetence. In this state, the patient did not suffer from motor impairments, but due to his impaired psychiatric functioning he was considered unable to live on his own. When DBS was turned off, his insight and capacity to judge returned.....

.....It is important to note that the question of responsibility is broader than described here. For instance, termination of treatment, e.g., induced by battery failure, might also cause undesirable—though probably not criminal—behavior.....

.....Furthermore, it seems obvious that there is a need for adaption of current legal rules in order to account for patients with DBS (and other neuro-technological interventions).....

.....Personality changes may, at least in some cases, be the intended outcome in psychiatric patients rather than an unwanted side effect.....

.....Could there be systematic differences regarding this conceptualization between the different people involved, i.e., the patient, the medical team, significant others, the family, friends, colleagues, neighbors? How do these changes and the way they can be conceptualized affect the person's (re-)adjustment to society, e.g., influence the roles they play within the contexts of relations, family, profession and society at large? What effect does the dependency on technology have on personal identity? Considering that with advancements in the technology and due to its successfulness DBS will most likely be expanded to various clinical populations, questions concerning the effect of DBS on an individual's personality and personal identity as well as the ethical and legal consequences thereof need much closer attention.....

The full 13 page report can be downloaded from the following link: [Appendices](#)



Appendix D - The Future Prospects of Embedded Microchips in Humans as Unique Identifiers: The Risks versus the Rewards

Katina Michael and M.G. Michael, School of Information Systems and Technology, University of Wollongong

Introduction

Microchip implants for humans are not new. Placing heart pacemakers in humans for prosthesis is now considered a straightforward procedure. In more recent times we have begun to use brain pacemakers for therapeutic purposes to combat illnesses such as epilepsy, Parkinson's Disease, and severe depression. Microchips are even being placed inside prosthetic knees and hips during restorative procedures to help in the gathering of post-operative analytics that can aid rehabilitation further. While medical innovations that utilize microchips abound, over the last decade we have begun to see the potential use of microchip implants for non-medical devices in humans, namely for control, convenience and care applications. Most of these emerging applications that have been demonstrated in numerous case studies have utilized passive radiofrequency identification (RFID) tags or transponders embedded in the triceps, forearm, wrist or hand of the implantee. The RFID transponder stores a unique identifier that is triggered when the device comes into range of a reader unit.

Medical and Non-Medical Implantable Applications. When VeriChip first launched their product range, they had four cornerstone application contexts: (1) VeriPay, (2) VeriMed, (3) VeriGuard, and (4) Corrections. The VeriPay system allowed end-users the capability to perform cash and credit transactions with the embedded implant. VeriMed was a user-driven healthcare information portal whereby consumers (i.e., patients) could maintain their own personal health record (PHR) online. Hospital staff and emergency services personnel could then access that information to get patient history, as well as allergic reactions to drugs and more. The VeriGuard application was considered to be versatile secure access technology which let in authorized persons and blocked out unauthorized persons (VeriChip 9 October 2003). Finally, VeriChip's 'Corrections' product had to do with chipping people who had committed a crime, were on parole or probation, or were awaiting trial.

Human Rights

Despite the inspiration for the argument that different groups are putting forward regarding why people should or should not be implanted for commercial applications, it is important to bring diverse groups of people together to debate and discuss what the possibilities might herald, what they might mean today and well into the future. Discussions about human rights, liability and loss, and the potential for an invasion of privacy and breakdown of trust between organizations and citizens or insurmountable control of governments over citizens will have major repercussions well into the future. Are there potential detrimental effects for individuals who bear high tech devices? Privacy experts would well warn about the perils of maintaining a false sense of "freedom", "security", and "justice" based around convenience solutions which look like they are making life easier but are instead encroaching on our human rights.



Conclusion

Case studies included in this report demonstrate the successful deployment of Verichip-style devices and applications. The risks involved in non-consensual implantation of sub dermal electronic devices, if successful, could yield dividends estimated to be in hundreds of billions of dollars. Concurrently, if the risks taken are not calculated carefully in terms of the long- and short-term effects on human beings, the outcome may well be detrimental and have serious repercussions for humanity, for which there may be no turning back. One thing is clear, despite the arrival of the implantable microchips, we have not yet seen it unleashed in all its fullness. As a community of stakeholders, we have a great deal to consider but perhaps not adequate time to affect immediate change. Consumer and population control is at the heart of these technologies. With 21 states in the US having laws regarding non-consensual implantation, many are ineffective and, in some cases, are not crimes, but only a civil penalty. The reality is, by definition, these crimes are considered terrorism.

It is apparent that our political leaders, our law enforcement, our medical and scientific community must be educated in this phenomenon. It is apparent that before a stigma of a psychiatric diagnosis is falsely applied, that the possibility of non-consensual implantation or remote influencing technologies is fully ruled out.

The full 8 page report can be downloaded from the following link: [Appendices](#)



Appendix E - Acute psychosis and EEG normalization after vagus nerve stimulation

S. D. GATZONIS, E. STAMBOULIS, A. SIAFAKAS

J Neurol Neurosurg Psychiatry 2000;69:278-279 doi:10.1136/jnnp.69.2.278

Excerpt

...."The acute appearance of psychosis on achievement of seizure control and normalization of a previously abnormal EEG has long been recognized as a clinical entity termed "forced normalization".....

....."The case of a patient with medically intractable epilepsy who developed a schizophrenia-like psychosis when control of seizures and scalp EEG normalization were achieved through vagus nerve stimulation is presented".....

....."at the same time the family had noted a change in the patient's behavior. Psychiatric evaluation disclosed a schizophrenia-like syndrome with auditory hallucinations, delusions of persecution, thought broadcasting, psychomotor agitation, and complete lack of insight. An EEG recording showed a low voltage normal background activity coexisting with low voltage fast rhythms without any paroxysmal activity"....

...."Regarding the involvement of drugs as a causative factor for psychosis, all established anti epileptic drugs have been shown to precipitate psychiatric symptoms. Treatment of the patient consisted of lamotrigine and topiramate, drugs that have been implicated in the provocation of psychotic symptoms but as he had been already under the same medication for the past 10 months before the vagus nerve stimulator was implanted, the precipitation of psychosis does not seem to be pharmaceutical. Further support to the above hypothesis is provided by the fact that the psychotic symptoms appeared just when seizure control was achieved by vagus nerve stimulation"....

...."However, the absence of a history of psychosis as well as the lack of a positive family history for any major psychiatric disorder does not render support to the above possibility"....

....."Extensive brain areas seems to be involved and thereby a possible influence on behavioral mechanisms could not be excluded"....

The full 3 page report can be downloaded from the following link: [Appendices](#)



Appendix F - Psychosis from subthalamic nucleus deep brain stimulator lesion effect

Alik S. Widge, Pinky Agarwal¹, Monique Giroux², Sierra Farris², Ryan J. Kimmel, Adam O. Hebb³ -
Department of Psychiatry, University of Washington, Seattle, Surgical Neurology International

Abstract

Background: Deep brain stimulation (DBS) of the subthalamic nucleus (STN) in particular is highly effective in relieving symptoms of Parkinson's disease (PD). However, it can also have marked psychiatric side effects, including delirium, mania, and psychosis.....

....persistent hallucinations and long-term mood dysregulation, and suicides. All previously reported psychiatric complications (except delirium) occurred only after onset of chronic brain stimulation. We treated two patients who developed agitated psychosis (without mood or delirium symptoms) after bilateral STN DBS implantation. These psychoses occurred before stimulation, and we hypothesize that they arise from tissue response to electrodes in the STN|.....

Patient A

...He had no prior psychiatric history) except depression that began as a symptom of PD....
...He was a nonuser of tobacco, ethanol, or illicit drugs. He had no family history of major mental illness....Over the next 3 days, he became increasingly anxious, paranoid, and delusional....Three days after admission, his agitation progressed to requiring physical restraints after he attempted violence against staff....Psychotic symptoms, including agitation, possible hallucinations, and impulsivity, persisted for at least a week more,.....
...He continued to experience vivid dreams, but not waking hallucinations.....

Patient B

....He had no prior psychiatric problems or family history of major mental illness, had quit tobacco over 20 years earlier, and used minimal alcohol.....disclosing paranoid and grandiose delusions, although he remained fully oriented with an intact sensorium. Mr. B markedly decompensated on the third hospital day (POD 22), when he developed visual hallucinations.....Finally, some experienced practitioners have opined that bilateral STN DBS carries a higher risk of psychiatric complications

Discussion

These two patients, both of similar age and with minimal prior psychiatric history, developed a psychotic syndrome roughly 2 weeks after DBS electrode implantation, before their stimulators were active.

Conclusion

These cases describe a previously unreported post-DBS syndrome in which local tissue reaction to lead implantation produces psychosis even without electrical stimulation of subcortical circuits....

The full 7 page report can be downloaded from the following link: [Appendices](#)



Appendix G - Are psychotic symptoms related to vagus nerve stimulation in epilepsy patients?

Veerle De Herdt, Paul Boon, Kristl Vonck, Lutgard Goossens, Lotte Nieuwenhuis, Koen Paemeleire, Veronique Meire, Geert Michielsen, Frank Dewaele, Edward Baert, Dirk van Roost Reference Center for Refractory Epilepsy and Department of Neurology, Department of Neurosurgery, Ghent University Hospital, Belgium

Abstract

Four patients with refractory epilepsy presented with psychotic symptoms following treatment with vagus nerve stimulation (VNS) to control seizures. Besides its anti-epileptic effect VNS has been shown to have an effect on various cognitive and behavioural functions.

Introduction

...Psychotic symptoms commonly reported are hallucinations, delusions and prolonged euphoric states. These symptoms tend to occur particularly after markedly improved seizure control and normalization of the EEG.....VNS consists of intermittent electrical stimulation of the left vagus nerve by means of a stimulation-electrode and a programmable pulse generator that is implanted in the subclavicular area.....

Case 1

...The family history was negative for neurological or psychiatric diseases....In 1995, a routine EEG showed a background activity of 10 Hz with low voltage but without epileptiform discharges.In the following weeks, the VNS output current was gradually increased to 1.5 mA and the stimulation frequency lowered to 25 Hz because of intermittent stimulation-related hoarseness.....At this time however, the patient presented with psychotic symptoms such as tactile hallucinations and complex delusions such as the conviction that a perceived injury to his left arm "was growing from the inside towards the outside". A structured psychiatric interview confirmed the psychotic nature of the reported hallucinations and delusions.....

Case 2.

...A routine EEG recording demonstrated a low voltage background activity with isolated spikes, polyspikes and slow spike and wave activity with right hemispheric preponderance..The patient was offered treatment with VNS and he subsequently underwent the surgical implantation procedure in July 2000.....VNS was activated at 0.25 mA two weeks following the implantation procedure. Two weeks later the patient's mother reported an episode of aggressive behaviour, confusion, and visual and auditory hallucinations that seemed to be very frightening to the patient.....The stimulation output current was increased to 0.5 mA. Again, one month later, a psychotic episode with striking aggressive behaviour, hallucinations and anxiety was reported.....

Case 3

... Routine EEG showed a slow background activity.....In July 2001 she was treated with VNS.....The output current was gradually increased until 1.75 mA, without a significant change in seizure frequency....However, during the hospital admission, the patient presented extremely hostile behaviour towards medical staff and she was extremely suspicious of any medical intervention. She was diagnosed with psychosis and acute delusions for which she was transferred to the psychiatric department.....



Case 4

....The implantation was performed in December 2002 Ramping-up of the output current started 3 weeks later.....Three months after implantation and when an output current of 0.5 mA was reached, psychotic symptoms with paranoid delusions occurred. The caregivers of the patient reported hostile behaviour and at the consultation the patient was extremely suspicious and accused accompanying caregivers of lying about seizure control in the past weeks.

Discussion

.....During the ramping-up procedure of the output current, these 4 patients presented with psychotic symptoms.....Many studies have reported the increased alertness in patients treated with VNS independent from seizure control.....However, there are strong arguments from recent findings that VNS-induced effects on e.g. cognition may occur following a single VNS pulse train (Clark et al., 1999).....This seems to be in contrast with the finding in our patients who appeared to experience VNS-induced excitatory effects on the central nervous system. Most likely, the psychotic condition observed following seizure control can be induced by any kind of treatment including VNS. The finding of psychotic reactions in our patients is suggestive of an independent VNS-induced effect on central nervous system structures....

The full 6 page report can be downloaded from the following link: [Appendices](#)



Appendix H - 10HZ EEG Background Signals

Several studies and reports agree that Brain wave activity in the upper alpha range 10Hz to be exact are related to auditory experiences, attention and memory-processes.

Report 1

What goes up must come down: EEG phase modulates

Auditory perception in both directions

A precluding but not ensuring role of entrained low-frequency oscillations for auditory perception by Ng, B. S., Schroeder, T., and Kayser, C. (2012). *J. Neurosci.* 32

Recent years have seen mounting evidence that the phase of low-frequency EEG oscillations—particularly in the theta (4-8 Hz) and alpha (8-13 Hz) frequency ranges—is closely related to visual perception. In a recently published article, report, for the first time, that auditory perception also depends on the phase of theta EEG oscillations—an exciting novel finding suggesting that brain oscillations have perceptual consequences in multiple sensory modalities. This successful demonstration after previously failed attempts by other groups may be owed, in part, to the analysis of EEG oscillations that were not spontaneously produced by the brain, but rather evoked (or “entrained”) by an auditory background stimulation. In line with this idea, another recent report indicated that entrainment of brain oscillations by 10 Hz periodic transcranial electric stimulation of auditory regions induces a periodic fluctuation of auditory sensitivity at the same frequency.

Report 2

Brain Oscillations and Cognitive Processes

Christina M. Krause, Ph D, *Psychology, University of Helsinki*

Krause and colleagues were the first to examine and to report of auditory elicited brain oscillatory (ERD/ERS) responses in association with cognitive and memory processes. Funding is needed to continue this avenue of research in Finland.

EEG (and MEG signals arising from the brain consist of several simultaneous oscillations, which have traditionally been subdivided into frequency bands such as delta (1-3 Hz), theta (4-8 Hz), alpha (8-12 Hz), beta (about 14-30 Hz) and gamma (around 40 Hz) (Figure 1).

The ERD/ERS responses of different frequencies within the EEG/MEG are functionally distinct. For example, during auditory memory encoding alpha (10-12 Hz) power typically increases whereas alpha suppression is observed during memory retrieval. In contrast, theta (4-6 Hz) synchronizes during memory encoding and becomes even more synchronized during memory retrieval.

Theoretically, alpha, theta, and beta oscillations are too slow to serve as carrier signals for cognitive processes (e.g., “online” speech perception), whereas oscillations at higher frequencies are physically appropriate to establish a rapid coupling of spatially separate cell assemblies. On the basis of previous research, it may be hypothesized that theta and alpha oscillatory networks most probably are involved in long-term information encoding and retrieval, whereas brain oscillations at higher frequencies (> 20 Hz) participate in the rapid co-ordination of multiple brain processes during information encoding and integration. Due to recent advances in signal-analysis techniques (e.g., wavelet analyses), it is now possible to examine the simultaneously occurring time-locked responses of the brain’s



oscillatory activity at different frequencies by means of Time-Frequency-Representations.

We hypothesize that brain oscillations mediate the fast information integration necessary during natural, i.e., audiovisual speech perception.

Report 3

Auditorily Elicited Event-Related Desynchronization (ERD) and Synchronization (ERS) as a Method for Studying Cortical Correlates of Cognitive Processes

Christina M. Krause, Centre for Cognitive Neuroscience, University of Turku and Department of Psychology, Abo Akademi, Finland.

Oscillations of different EEG frequencies are associated with different mental processes. Episodic memory processes seem to be reflected as oscillations in the EEG theta frequencies (~4-8 Hz). In contrast, 8-10 Hz alpha activity seems to be modulated as a function of attentional demands whereas 10-12 Hz alpha activity is modulated by stimulus-related aspects, and/or semantic memory processes

In 1994 Krause et al. (1994) reported that ERD was elicited in the lower (8-10 Hz) and the upper (10-12 Hz) alpha frequency bands during and after the presentation of short auditorily presented phrases which the subjects were instructed to memorize.

By contrast, the presentation of the probe elicited a significant ERD in both alpha frequency bands. Auditorily elicited ERD/ERS of the lower (8-10 Hz) and upper (10-12 Hz) alpha frequency bands has also been studied during an auditory memory task with synthesized instrument sounds, resembling those of different instruments, as stimuli. This finding verified that the two alpha frequency bands differ in their reactivity to stimulus type. The presentation of vowels might have activated corresponding phonetic templates, not available for tones and timbre, which in turn might have made it possible to use template matching or to use multiple cognitive strategies for the encoding/retrieval of vowels. The 10-12 Hz frequency band exhibited greater overall ERD/ERS values as compared to the lower, 8-10 Hz frequency band.

The significant interaction between frequency band and stimulus type indicated that the 8-10 Hz and 10-12 Hz frequency bands differed such that the 10-12 Hz frequency band exhibited reactivity to the presence of linguistic content while the 8-10 Hz band showed an unspecific response. The results from this study indicate that the auditorily elicited responses of the upper alpha frequency band are language-related, whereas those of the lower are not.

Report 4

Perception and imagery in EEG: Alpha band effects of task and stimulus International Journal of Psychophysiology

Rebecca S. Schaefer [a,b*](#) Rutger J. Vlek [a](#), Peter Desain [a](#)

a Donders Institute for Brain, Cognition and Behavior: Centre for Cognition, Montessorilaan 3, 6525 HE Radboud University Nijmegen, The Netherlands b Sint Maartenskliniek Research, Development and Education. Hengstdal 3, 6574 NA Ubbergen, The Netherlands

Previous work has shown that mental imagination of sound generally elicits an increase of alpha band activity (8-12 Hz) in the electroencephalogram (EEG). In addition, alpha activity has been shown to be related to aspects of music processing. In the current study, EEG signatures were investigated for perception and imagery of two different natural musical phrases. The responses are compared between tasks and between stimuli.



For all tasks and stimuli, posterior alpha band activity was seen, but differences are shown in the power of this response. As expected, imagery resulted in a significantly stronger alpha activation than perception. The comparison of the averaged responses to the stimuli also showed a difference in alpha power, although this effect is seen in different directions. These results are interpreted to indicate that both the tasks and the stimuli modulate an attentional network, which may relate to the inhibition of non-task relevant cortical areas, as well as engagement with the music.

The most commonly measured rhythm in the human electroencephalogram (EEG) is the alpha rhythm, generally referring to the frequency band spanning from 8 to 12 Hz (exceptions in other studies are noted explicitly). Early studies have related this response to internally directed attention and imagination, showing high alpha amplitudes for varying imagination task, imagining people, and sentences/arithmetics, with activity found in the left occipital and right hemispheres respectively, report a peak in activity around 10 Hz for auditory and spatial imagery in right parietal EEG channels. It has been suggested that alpha synchronization reflects an active process of inhibition, notably in areas that are task-irrelevant (possibly explaining the range of scalp distributions seen). This is also seen in modality specific attention: using an 8-14 Hz frequency band, showed that auditory expectation caused a posterior alpha increase, and an investigation of working memory for pitch, using 5 to 12 Hz) resulted in left-lateralized parieto-occipital alpha activation.

The full 3 page report can be downloaded from the following link: [Appendices](#)



Appendix I – David A. Larson Report

Criminal and Scientific Misconduct Involving Neural Prosthesis Research Funded by the NIH/NINDS/NPP and the Alfred E. Mann Foundation

David A. Larson

Excerpts:

From a research perspective, a neural prosthesis needs to remain implanted for over 40 years to effectively serve a disabled individual, and because not enough research (none in fact, except for simulations) has been done regarding this, it would make sense for Schulman and Loeb to implant a variety of devices as well as materials because the continual real-time feedback (or lack there-of) would allow them to determine which were most effective and also remained biocompatible over time

Schulman and Loeb's patents made during the time of the microstimulator contract describe much more than a typical "BION" type microstimulator and specifically address alumina, silicone and epoxy coatings instead of glass or titanium, describe how additional circuitry can upgrade a device from one which requires an external coil to one that is fully implantable,

What is defined in these systems is: Telemetry using multiple modes or frequencies so that one carrier can transmit a short distance with it being processed to another capable of longer range telemetry. Real time interaction that includes stimulation and recording from the human nervous system. Audio and video conferencing are integrated into the system that displays the EEG, EMG and other data allowing Schulman, Loeb and Troyk to simultaneously interact with the system and each other.

....a device capable of being injected into the patient's body... Wireless communication between the SCU and the other implanted devices can be implemented in various ways, e.g., via a modulated sound signal, AC magnetic field, RF signal, or electrical conduction....In accordance with a further aspect of the invention, the SCU is remotely programmable, e.g., via wireless means, to interact with the implanted devices according to a treatment regimen ...

...The microstimulator systems include external control for controlling the operation of the microstimulators. The control includes memory for programming preferred stimulation patterns for later activation by the patient or caregiver....can be implanted non-surgically by injection....upon an external command, or at predetermined intervals, power and command signals sent from controller cause the various microstimulators to emit a series of electrical current pulses (i.e., a pulse train) at the desired frequency and amplitude sufficient to cause the muscles to lift the body for the duration of the pulse train. ...

Summary Article 4: These systems allow Schulman, Loeb and Troyk to interact with the implanted devices via radio frequency, and enables this interaction from any location that allows them (Internet access) to connect to a remote server.



International Center Against Abuse of Covert Technologies

"Injustice anywhere is a threat to justice everywhere" - Martin Luther King Jr.

U.S. Provisional Applications No. 60/039,164 was filed on Feb. 26, 1997 and U.S. Provisional Application Ser. No. 60/042,447 on Mar. 27, 1997 – These patent filings pertain to the patient monitoring systems and other technology applicable to a long term human study and include methods capable of long range bi-directional telemetry.

NeuroDyne/E-Tech Press Release: August, 1999: A new Internet technology will allow a patient to carry on a face-to-face conversation with a doctor who is a few miles or even thousands of miles away while his physiological measures, such as EKG, EEG, EMG, GSR etc., are displayed in real-time on the doctor's screen for assessment...the ability for healthcare colleagues and specialists several thousand miles apart to conference concerning a patient, while interacting via audio, video and active monitoring of the patient's physiology....

Most evident however is that many of the inventions and methods involve integrating or stacking additional circuitry allowing smaller implant sizes and the ability to eliminate external components and increase the range and options for bi-directional telemetry, and also making it possible to pursue the unethical long term research involving an unwilling subject.

Individuals at the Mann Foundation have expressed a desire to create a “universal family” of microstimulators that could be used for a visual, auditory or motor prosthesis. Such a universal device would have to be much smaller than the “BION” developed under contract #N01-NS5-2325 and be flexible so as to conform and stretch in response to its implanted environment.

To get an overview of implant technology and patents also see:
Alfred E. Mann Foundation <http://www.aemf.org/>



Law Suits by David A. Larson

Larson et al v. Central Intelligence Agency et al Has Decisions

Plaintiffs: David A. Larson and Brandi Lynn Baker

Defendants: Central Intelligence Agency, Leon Panetta, Eric H. Holder, Jr., Alberto Gonzales, George W. Bush, Stephen Kappes, Joseph H. Schulman, San Bernardino County Sheriff Department, Bureau of Prisons and Alfred Mann Foundation

Case Number: 1:2010cv01774

Filed: September 27, 2010

Court: California Eastern District Court

Office: Fresno Office

County: San Bernardino

Presiding Judge: Oliver W. Wanger

Referring Judge: Jennifer L. Thurston

Nature of Suit: Other Statutes - Other Statutory Actions

Cause: 42:1983

Jurisdiction: U.S. Government Defendant

Jury Demanded By: Plaintiff

Law Suits by David A. Larson

David Larson, et al v. CIA, et al

More Sharing ServicesShare |

Defendant - Appellee,s: CENTRAL INTELLIGENCE AGENCY, LEON PANETTA, in his individual capacity as Director of the CIA, ERIC H. HOLDER, Jr., Attorney General, ALBERTO F. GONZALES, STEPHEN KAPPES, JOSEPH H. SCHULMAN, SAN BERNARDINO COUNTY SHERIFF DEPARTMENT, BUREAU OF PRISONS, ALFRED MANN FOUNDATION and GEORGE H.W. BUSH

Plaintiff - Appellant,s: DAVID A. LARSON and BRANDI LYNN BAKER

Case Number: 11-15179

Filed: January 21, 2011

Court: U.S. Court of Appeals, Ninth Circuit

Nature of Suit: Other Statutes - Other Statutory Actions

The full 46 page report can be downloaded from the following link: [Appendices](#)



Appendix J - MACE-JM 20 PRO specifications

The JM20 PRO is the highest quality personal RF Detector on the market. It uses the latest micro processor circuitry for the most accurate detection of wireless transmission. It has a built-in signal strength meter and sensitivity control. Now updated to detect RF signals from 1MHz to 6GHz. New high-gain flexible antenna covers entire frequency range, no need to switch antennas and double your work to find bugging devices! No longer can the new 4.2 and 5.8 GHz transmitting devices hide from the JM-20 PRO. The compact size and silent vibration alert enables you to conceal it on your body for private sweeping of wireless listening and video transmissions. The JM-20 PRO, with it's 5 section bar graph to detect proximity of transmitters, has also proven itself as a quality professional sweep unit. It's sturdy and durable metal case assures years of service. Powered by a rechargeable NiCad battery, unit comes complete with recharger and earphone.

Features:

- Ultra Sensitive 5 Section LED Bar Graph to show relative RF signal strength
- Silent Alert Mode, Vibration motor and earphone for silent detection
- Tone Alert
- High Frequency Coverage: 1 MHz - 6 GHz
- Earphone Included
- Flexible Antenna Included, 50 Ohms (BNC Socket)
- RF Sensitivity Adjustment
- Low power consumption
- Internal 5 x AA 600 mAH NiCd pack
- Rechargeable Power Adapter Included, Power: 9 VDC 300 mA
- Heavy Duty Metal Case, Stamped aluminum with black anodized finish
- Size: 100 mm high x 68 mm wide x 31 mm deep
- Weight: 230 g

Controls

SEN Knob - This knob turns the tracer on and adjusts sensitivity.

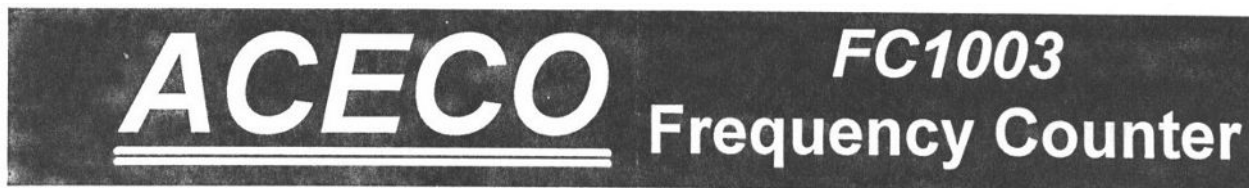
VIBRATION Switch - This switch selects the tone or vibration alert output.

Battery

This tracer can operate for up to eight hours from its fully charged NiCd batteries. They are charged when the unit is plugged into the supplied AC/DC adapter. Full recharge will occur over 12 to 16 hours.



Appendix K



Introduction

The Aceco FC1003 hand-held frequency counter is probably the best value ever, even advanced features such as field strength measurement are incorporated. It is compact, truly pocket sized, test instrument designed for ease of use and dependable performance. Supplied as a complete with internal NiCd pack, AC wall charger and 7 section telescopic antenna.

Specifications

Frequency range:	1 MHz - 3 GHz
Weight:	210 g
Size:	80 mm high x 68 mm wide x 31 mm deep
Impedance:	50 Ohms (BNC Socket)
Case:	Stamped aluminum with black anodized finish
Battery:	Internal 4 x AA 600 mAH NiCd pack
Power:	9 VDC 300 mA
Timebase:	Less than 1 PPM at room temperature

Features

- 10 digit Liquid Crystal Display
- Filter to prevent display of random noise
- Low power consumption (Average 6 hour battery life)
- Supplied with NiCd pack, AC wall charger and telescopic antenna
- Hold switch to lock display
- Low battery indicator
- Ultra sensitive synchronous detector 16 section bargraph to show RF signal strength
- High speed 300 MHz direct counter with 0.1 Hz resolution
- 4 selectable gate speeds

Controls

1. Power Switch - This slide switch turns the counter on and initiates a 2 second test of all the LCD segments.
2. Range Switch - This should be switched to the 300 MHz position for frequencies between 1 MHz and 300 MHz and switched to the 3 GHz position for frequencies between 10 MHz and 3 GHz.
3. Filter Switch - This slide switch turns the filter on and off.
4. Hold Button - This holds the current display and stops the counter from counting.
5. Gate Button - This selects the gate or measurement time. A longer gate time allows counting for longer period and results in higher accuracy.
6. Calibration - The calibration adjustment opening is located on the front panel of the counter. This allows access to the trimmer capacitor that provides about a 10 PPM adjustment range of the time base oscillator. This is not usually necessary but to do so read a signal of a known frequency before adjusting the trimmer for correct frequency display. If you calibrate at 4.1943 MHz or above then the counter will be more accurate.

Warranty

Aceco Electronics, Corp. guarantees the counter and accessories for one year against defects in manufacture. This warranty does not cover items that have been modified, subject to unauthorized repairs, misuse or abuse. This warranty does not cover damage caused by excessive power levels applied to the signal input. Never make any kind of connection between the counter and a transmitter.



Hints And Tips

1. NiCd Operation

This frequency counter can operate for up to six hours from its fully charged NiCd batteries. They are charged when the unit is plugged into the supplied AC/DC adapter. Full recharge will occur over 12 to 16 hours. Before recharging the batteries you should be deep cycled occasionally by allowing them to completely discharge to maintain maximum battery capacity. The NiCd batteries should last for several years. However, it is a good idea to check them every twelve months for signs of corrosion or leakage. Always replace the whole set if any one cell fails.

2. Signal Input

When using the counter with an antenna for signal pick up, random frequencies may appear on the display. This is quite normal and is caused by the high gain of the receiver circuits which amplify noise in the absence of a strong readable signal. Never get the unit too close to a transmitter as internal damage will result.

3. Antenna Selection

The supplied telescopic antenna is best for general purpose use. This is because its length can be adjusted to suit the frequency required. Usually you will want a shorter antenna for UHF and a fully extended one for VHF / HF.

4. Reception Distance From Transmitter

The distance from which you will be able to receive frequencies will depend upon the type and location of the transmitting antenna, transmitter output power and the frequency in use. Some typical distances are:

Cordless Phone	0.3 meters
Cellular Phone	3 - 20 m
CB radio	2 - 8 m
VHF Two Way Radio	3 - 30 m
UHF Two Way Radio	3 - 30 m

Input Sensitivity (Typical)

Amplifier:	50 Ohm
Impedance:	50 Ohm VSWR less than 2:1
Range:	1 MHz - 3 GHz
Sensitivity:	< 0.8 mV at 100 MHz
	< 6 mV at 300 MHz
	< 7 mV at 1.0 GHz
	< 100 mV at 2.4 GHz
Max. input:	15 dBm

RF Signal Strength Bargraph

Frequency	1st Segment	Full Scale
27 MHz	7 mV	100 mV
150 MHz	5 mV	90 mV
800 MHz	10 mV	200 mV

Frequency Display Resolution

Range	Gate Time (Seconds)	LSD	Sample Display
300 MHz	0.0625	10 Hz	300.00000 MHz
	0.25	1 Hz	300.000000 MHz
	1.0	1 Hz	300.000000 MHz
	4.0	0.1 Hz	300.0000000 MHz
3 GHz	0.0625	1000 Hz	3000.000 MHz
	0.25	100 Hz	3000.0000 MHz
	1.0	10 Hz	3000.00000 MHz
	4.0	10 Hz	3000.00000 MHz



Appendix L - Spectrum Analyzer

Software: Invisible Waves is a registered trademark of Kaltman Creations, LLC

A little bit of history about the Invisible Waves product...

In 2008 **Nuts About Nets** developed a new series of PC-based, RF spectrum analyzers — IW1800 and IW3500 — specifically designed for the professional audio and video industries. At that time these new analyzers were touted as the world's first, PC-based RF spectrum analyzers which offered automatic charting of open white space (open RF frequency) for use with wireless microphones, in-ear monitors, remote control, security, access control, etc. The product's unique features extended beyond the bounds of traditional RF analyzers. The product was licensed exclusively to Kaltman Creations, who was responsible for its promotion, marketing and sales. When the license agreement expired in 2010 both companies chose to go in different directions. The product originally developed by *Nuts About Nets* is no longer available. In the spring of 2011 *Nuts About Nets* released Pro Audio White Space Finder / RF Spectrum Analyzer [Model PAWS4400] — an RF spectrum monitoring solution that is much improved compared to our original IW1800 and IW3500 products.

The original IW1800 product won critical acclaim and received a variety of awards and much recognition. As an example, the July 2008 "InfoComm Insider" edition lists our IW1800 product as the pick of InfoComm 2008. Nominated in 2009 for the prestigious Parnelli Award for Indispensable Technology, IW800 continued to receive rave reviews. It was a great honor to be recognized in this way and considered for one of the industry's highest honors for Live Event Professionals. IW1800 did win Live Design's 2009 'Best Debuting Product Sound' product award.

General Specifications:

- IWxLIVE™ 9KHz – 1.8GHz
- IWxAV™ 9KHz – 3.5GHz
- Level Range (typical): -130dbm to 0dbm
- Filter Bandwidth: 1KHz – 50MHz
- 10PPM Frequency Stability

- Accuracy (typical): +/- 3dB
- PC Interfaces: USB Adapter 2.0
- Audio Output: Line-level, Mini stereo plug
- Antenna Interface: 50 Ohm SMA
- Receiver – DDS Based, Superheterodyne

With module and TrendNet TEW microwave antenna.



Appendix M - Faraday Cage

The shielding spectrum of the environment was between 9 KHz and 18 GHz.
The Chamber was certified in December of 2011 and is less than a year old.

The Faraday cage was produced by the highly renowned German High-tech company ROHDE & SWARTZ, that specializes in High-tech communication mainly for military purposes.

A Faraday cage, or Faraday shield, is an enclosure formed by various conducting materials. Such an enclosure blocks external static and non-static electric fields to include spectrums of radio frequency electromagnetic radiation, also known as RF shielding. The Faraday cage was developed in 1836 by a Scientist by the name of Michael Faraday. He was a physicist and bio chemist. His developments in electronic and RF shielding are still used in the majority of shielding technologies today.

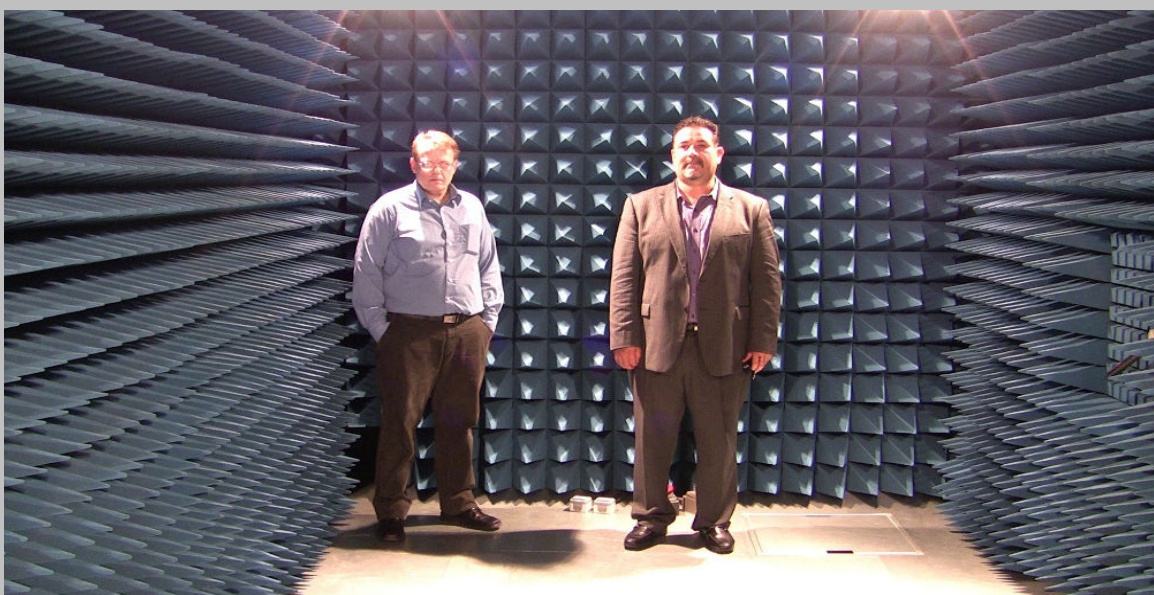
A Faraday cage was utilized to conduct the testing. The shielding spectrum of the environment was between 9KHz and 18GHz. The chamber was certified in December of 2011 and is less than a year old.



Back end of Faraday Cage – Lars Drudgaard



Back end of Faraday Cage – Jesse Beltran



Jesse & Lars inspecting the Faraday cage



Appendix N - Content of accompanying CD-ROM

Index:

- Video of Scanning in Faraday cage
- PDF version of this report.
- Appendix B - Microsystem technologies for implantable applications
- Appendix C - Did My Brain Implant Make Me Do It?
- Appendix D - The Future Prospects of Embedded Microchips in Humans as Unique
- Appendix E - Acute psychosis and EEG normalisation after vagus nerve stimulation
- Appendix F - Psychosis from subthalamic nucleus deep brain stimulator lesion effect
- Appendix G - Are psychotic symptoms related to vagus nerve stimulation in epilepsy patients ?
- Appendix H - 3 reports on 10Hz EEG and auditory function
- Appendix I – David A. Larson Report



Appendix O - Reference List

- Ref. 1 **MKULTRA Subproject 142**
<http://www.icaact.org/MKULTRA-Subproject-142.pdf>
- Ref. 2 **Norwegian government report on Sem-Jacobsen**
<http://icaact.org/articles-the-race-for-the-brain-sem-jacobsen-research.html>
- Ref. 3 **Professor Jose Delgado's book: "Physical Control of the Mind"**
http://www.amazon.com/Physical-Control-Mind-Psychocivilized-Society/dp/0060110163/ref=pd_sim_sbs_b_1/185-4327134-1522335
- Ref. 4 **Delgado implanted Bullfighting Video**
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- Ref. 13 **Bio-ethical whitewashing program**
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<https://www.youtube.com/watch?v=4DevKBcl69A>



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International Center Against Abuse of Covert Technologies

"Injustice anywhere is a threat to justice everywhere" - Martin Luther King Jr.

About this report

ICAACT is an Independent evidence gathering Non Profit Human Rights Organization. This report details the findings of the ICAACT phase III testing procedure. Testing of radio frequency emission from the human body, in a shielded environment. On October 6, 2012, ICAACT conducted its Phase III testing as a follow-up to Phases I and II. Participants were from the United States, England, Sweden, Slovenia, Spain, Holland, France, Israel, Denmark and Belgium.



Snapshots from the Phase III testing in Belgium

Context of the report

Human electronic implant technologies are not new, they have been in existence since the early 50's. The use of implant technology has in recent years also gained interest outside the medical and scientific community and has now become tools of interest in many newly emerging commercial fields. They can provide real-time data from real life scenarios, rather than from the restrictive and in many cases limiting artificial scenarios that can be recreated in laboratory and clinical settings. There is a boom in commercially driven neuroscience research like marketing and consumer behavior. The social sciences and especially the behavioral sciences are having a "Field day". The ethical and legal implications that arise from these implant technologies, and their commercialization, are as yet unsolved, and need urgent attention. These implications pertain to tampering with the innermost sacred sanctum of a human being, the mind.