ACIP Comments June 20, 2025.

The UNIQUE property of COVID-19 spike mRNA gene therapy products causing high levels of persistent spike IgG1 and IgG3 in the Upper Respiratory Tract (URT) likely contributed to increased pathology and sudden deaths related to microclotting and/or myocarditis following the transmission of these deadly IgG1/3 antibodies that bind complement (and initiate clotting) with SARS-CoV-2 variants and with shed spike mRNA gene therapy exosomes from the upper respiratory tract (URT).

From

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Synopsis

Whether or not you believe in spike mRNA shedding, shedding causing deaths or shedding causing many deaths; or understand how the shedding of unadulterated HERV-K102 protector particles from the upper respiratory tract (URT) likely generates and spreads herd immunity; the critical point that the ACIP must acknowledge and act upon, is the undeniable truth that the COVID-19 spike mRNA gene therapy technology uniquely caused the high production of spike IgG1 and IgG3 antibodies in the URT after the second dose. These IgG subclasses are excellent at binding complement and can drive clotting when bound to cognate antigen. SARS-CoV-2 virions transmitted from the URT of persons who received two or more doses of the spike mRNA shots, would exhibit a higher probability of inducing myocarditis and microclotting symptoms including death than SARS-CoV-2 virions transmitted before the mRNA vaccinations were introduced.

Evidence from Bowe B et al., [Nature Medicine, 2022] CONCERNING 5.8 MILLION VETERANS, indicated that the 30 DAY reinfection risk of **death was 1/100,** of **hospitalization was 1/14.3** and of suffering a long term **health sequela was ¼.** One could argue that these INCREASED RISKS that involved primarily microclotting type sequalae pertained to the probability of the co-transmission of the deadly spike IgG1/3 antibodies with the newly selected SARS-CoV-2 virions and/or with spike mRNA commandeered HERV-K102 particles (shedding of spike mRNA gene therapy products). Accordingly, with these extraordinary odds, the ACIP must conclude any technology like spike mRNA gene therapy that produces high persistent levels of complement binding spike antibodies in the URT must be avoided and hereby banned for use in humans and animals.

ACIP with NIH needs to prioritize the study of HERV-K102 protector particle shedding creating trained (innate) immunity in M1-like foamy macrophages, its apparent role in generating herd immunity, and the role of the spike mRNA LNPs in converting the protector HERV-K102 particles into bioweapons. Also since HERV-K102 particles contain functional reverse transcriptase and integrase, the contamination of these particles in the sebocytes in the URT by spike mRNA could greatly increase the risk of spike mRNA integration when transmitted to humans or their microflora.

In retrospect the use of mRNA gene therapy technology was a disaster which could have been mitigated in part by following the FDA 2015 guidance for extended shedding and integration studies prior to the marketing of any mRNA gene therapy

products.[1,2] It would have also significantly helped if these shots were not mandated given that it unconstitutional to mandate any medical intervention, and more specifically the FDA forbids the mandating of any product or medical intervention that has not met the standard for safety assessment such as products placed on the market by Emergency Use Authorization. Finally, the failure to properly monitor and/or report adverse events and deaths in a timely manner to inform vaccine candidates of the real risks, when combined with the focus by the previous White House Administration in quelling the truth about the lack of safety of the mRNA gene therapy shots, are thought to be main reasons for the extent of injuries and deaths over the past 4 years. As a minimal requirement, the vaccination record should have been linked to the mortality database to determine the amount of iatrogenic deaths linked to vaccination including shedding deaths as was performed for England [1] and made available in real time. Why the previous ACIP panel did not absolutely require this data to be collected and provided publicly in real time is beyond belief.

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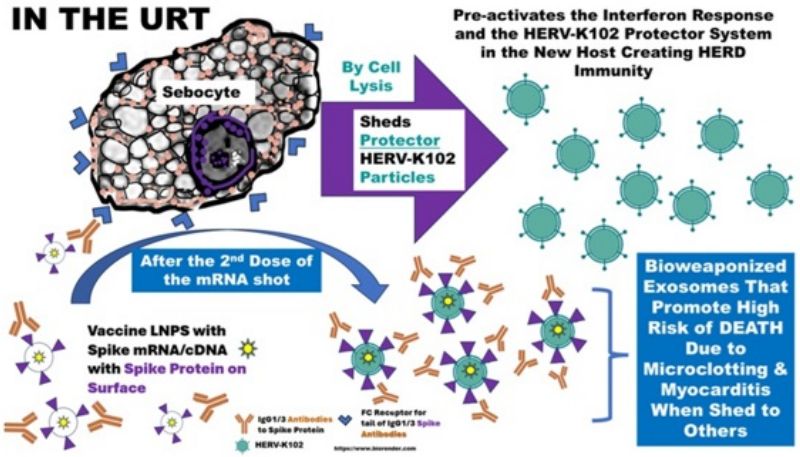
[1] https://www.fda.gov/files/vaccines%2C%20blood%20%26%20biologics/published/Design-and-Analysis-of-Shedding-Studies-for-Virus-or-Bacteria-Based-Gene-Therapy-and-Oncolytic-Products--Guidance-for-Industry.pdf

[2] https://www.fda.gov/regulatory-information/search-fda-guidance-documents/determining-need-and-content-environmental-assessments-gene-therapies-vectored-vaccines-and-related



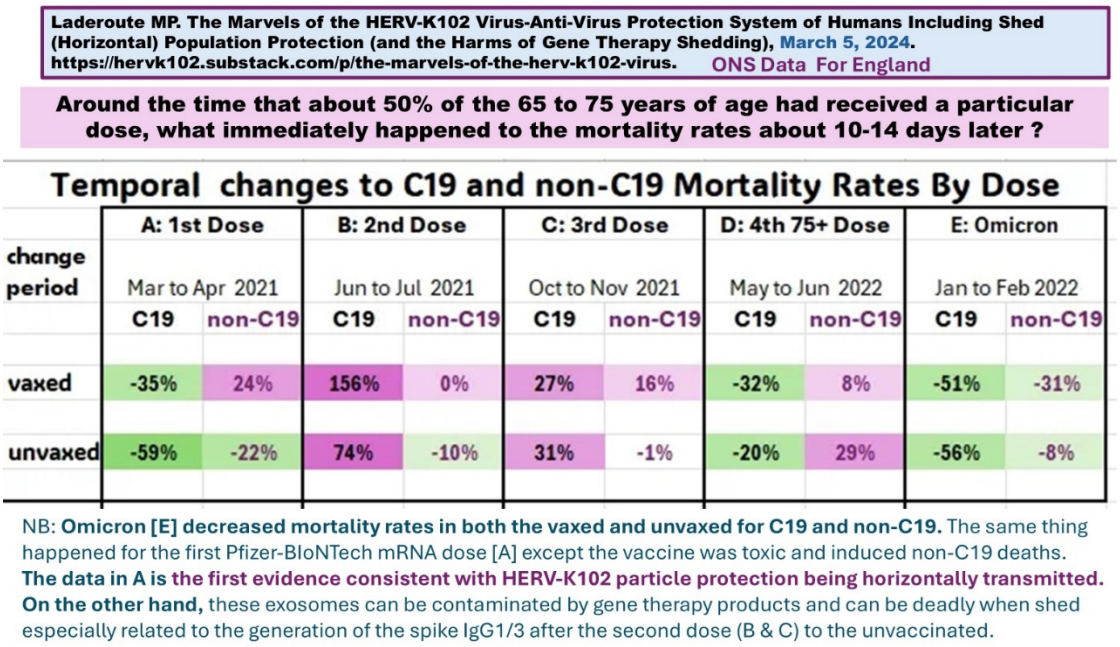
Putatively How the mRNA Gene Therapy Products May Convert **HERV-K102 Protector Particles that Provide HERD Immunity** to Bioweaponized Exosomes Expressing Spike Protein That May Cause Death from the Activation of Complement, Coagulation (Microclotting) and/or Myocarditis

Image 1. From reference [1].

HERV-K102, the protector foamy retrovirus of humans encoded in the human genome at 1q22, becomes activated by viruses [2] to produce high levels of the protector HERV-K102 particles in M1 foamy macrophages that are subsequently released by cell lysis [3]. In the upper respiratory tract (URT) there are highly specialized M1-like foamy macrophages that constitutively produce HERV-K102 particles and release them as a waxy substance called sebum [4,5]. These are the sebocytes, the cells with identical morphology to M1-like foamy macrophages found in the sebaceous glands that line the mucosa such as the URT.

However, when dirty process 2 lipid nanoparticles (LNPs) containing mRNA produced in *E. coli* are used for mass inoculation, this is proposed to result in the targeting of the spike laden LNPs to the sebocytes in the URT via antibody dependent enhancement (ADE) of infection into macrophages after the second dose of spike mRNA gene therapy products. The high levels of **spike IgG1 and IgG3 are first produced in the URT upon the second dose of spike mRNA** and **is uniquely a property of the spike mRNA gene therapy products** but not cDNA gene therapy products (adenovirus-based vaccines) or natural infections [6]. From work of Bansal et al, 2021 [7], these CD9 exosomes (meaning they come from M1-like foamy macrophages [8] and thus likely represent HERV-K102 particles [3]), become contaminated with spike protein and they

are made for about for 3-4 months after the second dose [7]. This mechanism shown in Image 1, helps to explain how the shed compromised HERV-K102 particles from the URT when complexed to the spike IgG1 and IgG3 antibodies could result in sudden or unexpected deaths relating to microclotting and/or myocarditis in the recipient. See Image 2 population data from England for evidence consistent with this notion.



Laderoute MP. The Marvels of the HERV-K102 Virus-Anti-Virus Protection System of Humans Including Shed (Horizontal) Population Protection (and the Harms of Gene Therapy Shedding), March 5, 2024.
https://hervk102.substack.com/p/the-marvels-of-the-herv-k102-virus. ONS Data For England

Around the time that about 50% of the 65 to 75 years of age had received a particular dose, what immediately happened to the mortality rates about 10-14 days later ?

Temporal changes to C19 and non-C19 Mortality Rates By Dose

change period	A: 1st Dose Mar to Apr 2021		B: 2nd Dose Jun to Jul 2021		C: 3rd Dose Oct to Nov 2021		D: 4th 75+ Dose May to Jun 2022		E: Omicron Jan to Feb 2022	
	C19	non-C19	C19	non-C19	C19	non-C19	C19	non-C19	C19	non-C19
vaxed	-35%	24%	156%	0%	27%	16%	-32%	8%	-51%	-31%
unvaxed	-59%	-22%	74%	-10%	31%	-1%	-20%	29%	-56%	-8%

NB: **Omicron [E] decreased mortality rates in both the vaxed and unvaxed for C19 and non-C19.** The same thing happened for the first Pfizer-BIoNTech mRNA dose [A] except the vaccine was toxic and induced non-C19 deaths. **The data in A is the first evidence consistent with HERV-K102 particle protection being horizontally transmitted. On the other hand,** these exosomes can be contaminated by gene therapy products and can be deadly when shed especially related to the generation of the spike IgG1/3 after the second dose (B & C) to the unvaccinated.

Image 2. Population-Based Data From England and Changes to Mortality Rates by Vaccination Status and Dose in 65 to 75 Year Olds [1].

A positive control for the diminishing of mortality rates is shown in E: Omicron Era which infected the non-vaccinated and the vaccinated. Following the first dose [A], which is known to generate trained innate immunity which provides heterologous protection against all-cause mortality [9] and in consideration that trained innate immunity is generated by HERV-K102 particle production in the M1-like foamy macrophages [4,5], the results in A indicate (with the exception of non-COVID-19 deaths due to Pfizer spike mRNA direct toxicity) that the shed HERV-K102 protector particles diminished COVID-19 deaths in both the vaccinated and unvaccinated. However, with subsequent doses the level of protection by the putative shed HERV-K102 particles on non-C19 deaths in the unvaccinated dropped (-22%, -10 %, -1 %) such that by the 4th dose there was an increase in non-C19 deaths (plus 29%). This data implied that with each Pfizer spike mRNA dose more and more of the HERV-K102 protector particles shed from the URT were being compromised by the dirty LNPs and turned into bioweapons (see Image 1).

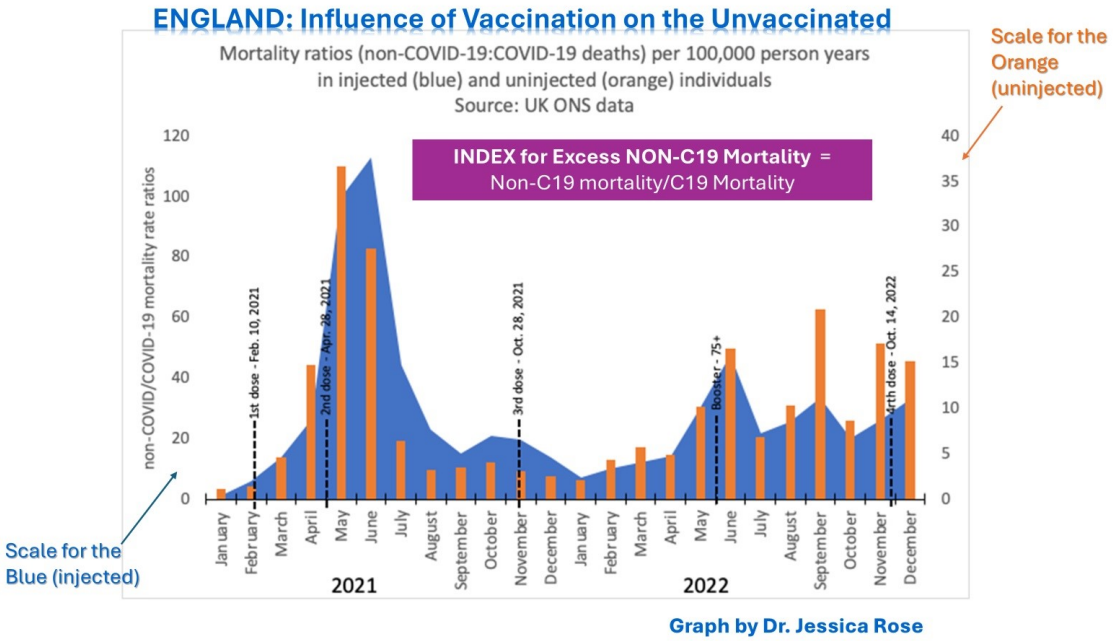


Image 3. The highest peak of putative shedding of compromised HERV-K102 particles (ie, converted to bioweapons) occurred in June/July 2021 in England [1] Also shedding seemed to cause deaths in the unvaccinated albeit at levels about 3-fold less.

Note that as expected the highest peaks were associated with the second dose of the Pfizer mRNA gene therapy shot and each round of shedding following the administration of the Pfizer mRNA gene therapy shots typically lasted 3 to 4 months as expected based on the work of Bansal et al, 2021 [7]. Later after the 4th dose in the 75+ (and other high risk groups) we see a relative increase in mortality in the unvaccinated compared with the vaccinated in fall 2022. It is tempting to speculate that the relative decrease in deaths in the vaccinated during this time could have been due to vaccinated individuals converting their spike IgG1/3 in the blood to the IgG4 which does not bind complement [6] and thus placed them at reduced risks.

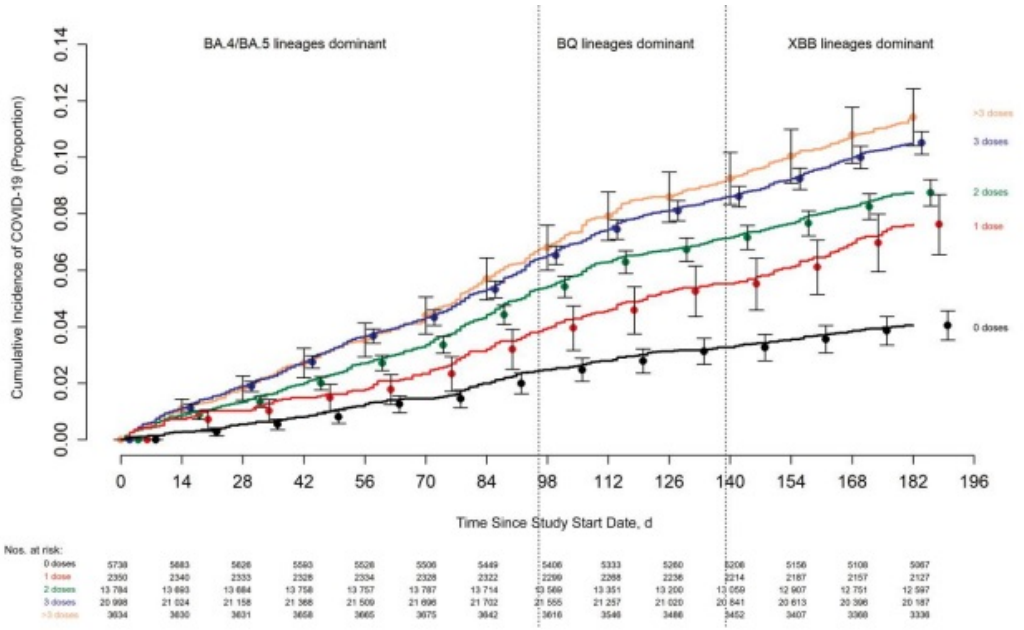


Figure 2. Cumulative incidence of coronavirus disease 2019 (COVID-19) for study participants stratified by the number of COVID-19 vaccine doses previously received. Day 0 was 12 September 2022, the date the bivalent vaccine was first offered to employees. Point estimates and 95% confidence intervals are jittered along the x-axis to improve visibility.

Image 4. The infamous Cleveland Clinic data [10] supports the contention that the spike IgG1/3 antibodies in the URT never get converted to IgG4 **although this needs to be directly examined.**

This means that the transmission of SARS-CoV-2 from the URT of a person who has had two doses of the spike mRNA shots, most likely occurs in a complex with high levels of spike antibodies that bind complement and thus, this complex can easily initiate complement binding in the new host when it enters the blood in the microcirculation deep in the lungs. That antibodies to spike protein can be transmitted by exhalation has been shown [11].

Table 1. Trends in Case Fatality Rates[a] Involving SARS-CoV-2 Delta Variant in England from June 21 to September 12, 2021 by Vaccination Status and Stratified by Age (Delta Variant Cumulative Cases Since February 1, 2021)

AGE Category (years)	TB # * (issue date in 2021)	Unvaccinated	Two Doses (>13 days)	One Dose (>20 days)	n one dose/two doses
>/= 50	23 (Sept 17)	6.90 %	2.17 %	1.90 %	7129/71991
	20 (Aug 6)	5.96 %	1.81 %	1.15 %	5640/21472
	18 (July 9) +	5.60 %	2.22 % +	0.90 %	4542/5234
	17(Jun 25) +	3.89 %	1.41 %	0.43 %	3865/3546
< 50	23 (Sept 17)	0.053 %	0.056 %	0.0130 %	83009/85407
	20 (Aug 6)	0.033 %	0.051 %	0.0099 %	40449/25536
	18 (July 9) +	0.030 %	0.036 %	0.0022 %	13391/5600
	17(Jun 25) +	0.011 %	0	0.0020 %	9850/3689

a) Death within 28 days of the first positive specimen (hospitalized or not).
* TB # = Technical Briefing Number. SARS-CoV-2 variants of concern and variants under investigation in England: Technical Briefings. https://www.gov.uk/government/publications/investigation-of-novel-sars-cov-2-variant-variant-of-concern-20201201
+ Both the TB #17 and #18 reported on cases up to June 21, 2021,. The extra data in the July 9 2021 report might potentially explain the increased CFR for two doses at 2.22% for the over or equal to 50 years of age.

Table 2. Trends in Hospitalizations[a] Involving SARS-CoV-2 Delta Variant in England from June 21 to September 12, 2021 by Vaccination Status and Stratified by Age (Delta Variant Cumulative Cases Since February 1, 2021)

AGE Category (years)	TB # * (issue date in 2021)	Unvaccinated	Two Doses (>13 days)	One Dose (>20 days)	Proportion of Hospitalized Cases by Age Category
>/= 50	23 (Sept 17)	20.9 %	5.43 %	5.51 %	49.7 %
	20 (Aug 6)	19.5 %	5.27 %	4.08 %	40.2 %
	18 (July 9) +	15.4 %	5.06 %	3.08 %	32.3 %
	17(Jun 25) +	13.9 %	4.60 %	2.69 %	31.6 %
< 50	23 (Sept 17)	1.82 %	0.84 %	0.68 %	50.2 %
	20 (Aug 6)	1.55 %	0.88 %	0.74 %	60.0 %
	18 (July 9) +	1.40 %	0.86 %	0.88 % +	67.4 %
	17(Jun 25) +	1.32 %	0.73 %	0.86 %	68.3 %

a) Hospitalized even with a positive PCR result on the day of admission ie., includes those hospitalized for some other reason than the classical signs and symptoms of COVID-19 but positive for SARS-CoV-2.
* TB # = Technical Briefing Number. SARS-CoV-2 variants of concern and variants under investigation in England: Technical Briefings. https://www.gov.uk/government/publications/investigation-of-novel-sars-cov-2-variant-variant-of-concern-20201201
+ Both the TB #17 and #18 reported on cases up to June 21, 2021. The extra data in the July 9 2021 report might potentially explain the increased hospitalizations for one dose at 0.88 % for the < 50 years of age.

Image 5. Early Data Warning of High Lethality of Transmitted DELTA Variants In England in June/July 2021 but which disappeared by September 2021.

I posted this data in late September 2021 on LinkedIN, and I was subsequently banned by October 23, 2021 for releasing data implicating the dangers of the Pfizer spike mRNA second shot particularly when compared with those who got only one dose. In fact, the data implicated for the 50+ age group that the COVID-19 spike mRNA was killing about 1 % of the people who got the second shot (top panel) and that there was about a 50% mortality in hospitalized delta cases that had had delta transmitted to them

in June/July 2021. Again with time, these risks abated by September 2021. However, since the data pertained to delta infections only, this means the enhanced mortality was likely caused by SARS-CoV-2 being transmitted with high levels of complement binding IgG1 and IgG3. The levels of antibody in the URT would naturally diminish with time, at least until the next shot or infection.

TABLE 1. UK Office for National Statistics (ONS) England Monthly Age-Standardized Mortality Rates (ASMRs) per 100,000 Person-Years and Vaccinated (Vax) to Unvaccinated (Unvax) Rate Ratios for January 1, 2021 to May 31, 2022 for Both Sexes and All Ages 10+ *

		All-Cause Mortality				COVID-19 Mortality				Non-C19 Mortality			
		RATE Unvax	Actual RATE Ever Vax	Ratio of Vax/ Unvax Rates	p values	RATE Unvax	Actual RATE Ever Vax	Ratio of Vax/ Unvax Rates	p values	RATE Unvax	Actual RATE Ever Vax	Ratio of Vax/ Unvax Rates	p values
2021	Jan	2507.6	3483.5	1.39		1187	1526	1.29		1320	1958	1.48	
	Feb	5261.5	3205.4	0.61		2174	456.8	0.21		3087	2689	0.87	
	Mar	3307.8	4192.7	1.27		591.9	283.9	0.48		2716	3909	1.44	
	April	2298.4	5039.7	2.19		145.8	184	1.26		2153	4855	2.25	
	May	1718.8	8582.6	4.99		45.5	84.5	1.86		1673	8426	5.04	
	June	1589.7	10060	6.33		55.6	87.7	1.58		1534	9916	6.46	
	July	1610.7	10307.1	6.40		218.2	224.9	1.03		1392	9960	7.16	
	Aug	1711.6	10340.7	6.04		404.2	402.9	1.00		1307	9266	7.09	
	Sept	1664.5	8639	5.19		367.8	520.2	1.41		1297	7884	6.08	
	Oct	1623.7	12456.3	7.67		322.3	568.6	1.76		1302	11845	9.10	
	Nov	1708	15546.6	9.10		421.3	721	1.71		1287	14155	11.00	
	Dec	1878.5	16974.3	9.04		520.5	1121.9	2.16		1358	15501	11.41	
2022	Jan	1812	19997.9	11.04		584.6	2310.9	3.95		1227	16417	13.38	
	Feb	1384.5	12474.4	9.01		258.7	1128.4	4.36		1126	11346	10.08	
	Mar	1231.7	10257.2	8.33		183.5	763.6	4.16		1048	9445	9.01	
	April	1204.6	12423.2	10.31		204.7	800.8	3.91		1000	11622.4	11.62	
	May	872.9	8246	9.45		77.6	261.8	3.37		795	7914	9.95	
average		1964	10131	6.37	0.0001	457	673	2.09	NS (0.8)	1507	9242	7.26	0.0001
						Oct 1 2021-May 31, 2022		3.17	0.01				

The **"Actual Rate Ever Vax"** refers to recompiled data where all the ASMRs in the different categories of vaccination were manually added up to yield a total, because **the 'Ever vaccinated' totals provided by the ONS were *manipulated/wrong***.

NB: There were 71,318 vaccination cases that were excluded due to incomplete records. There were 1,436 vaccination deaths that were excluded because the vaccination details were only entered after they died and this was NOT updated. #

#https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19byvaccinationstatusengland/previousReleases

***https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsbyvaccinationstatusengland**

Image 6. Mortality rates per 100,000 person years by vaccination status for England [1].

The CDC and in Canada PHAC, should have linked the vaccination record to the mortality database to derive the monthly estimates for mortality and delivered this data in real time. Here we see convincing evidence that the spike mRNA shots should have been halted by the first week in February 2021 in England.

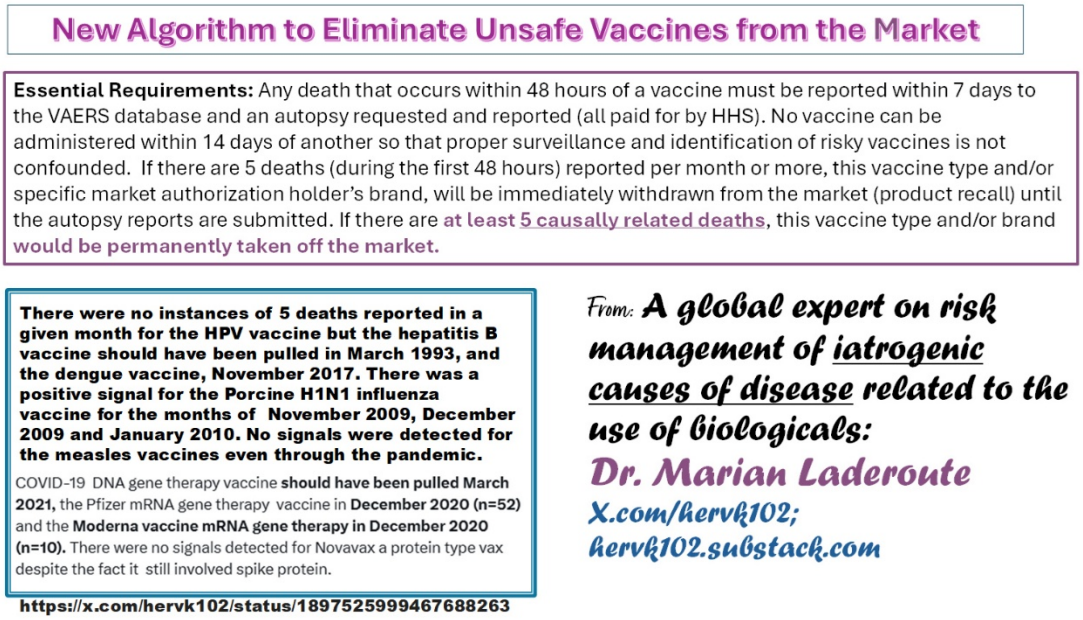
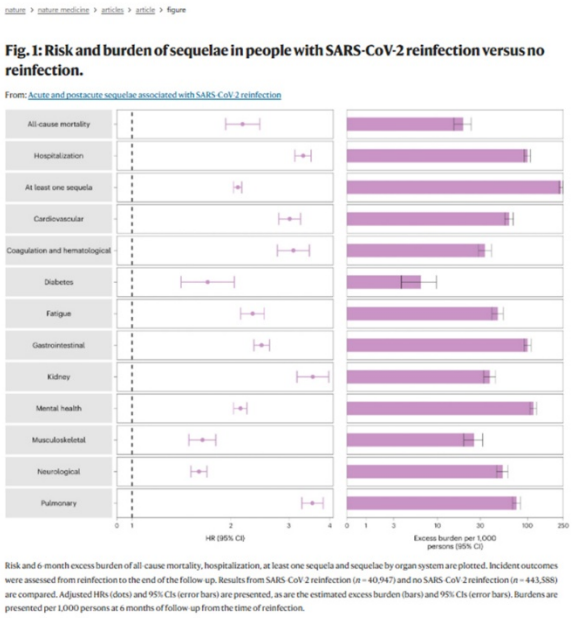


Image 7. Proposed Algorithm for removing unsafe (grandfathered in) vaccines from the Market.

If instead the CDC had set up a special algorithm such as the one above, it is quite possible the deadly spike mRNA gene therapy shots would have been removed from the market in December 2020 sparing Americans the vast majority of injuries and deaths associated with the mRNA gene therapy technology.



nature > nature medicine > articles > article > figure

Fig. 1: Risk and burden of sequelae in people with SARS-CoV-2 reinfection versus no reinfection.

From: Acute and postacute sequelae associated with SARS-CoV-2 reinfection

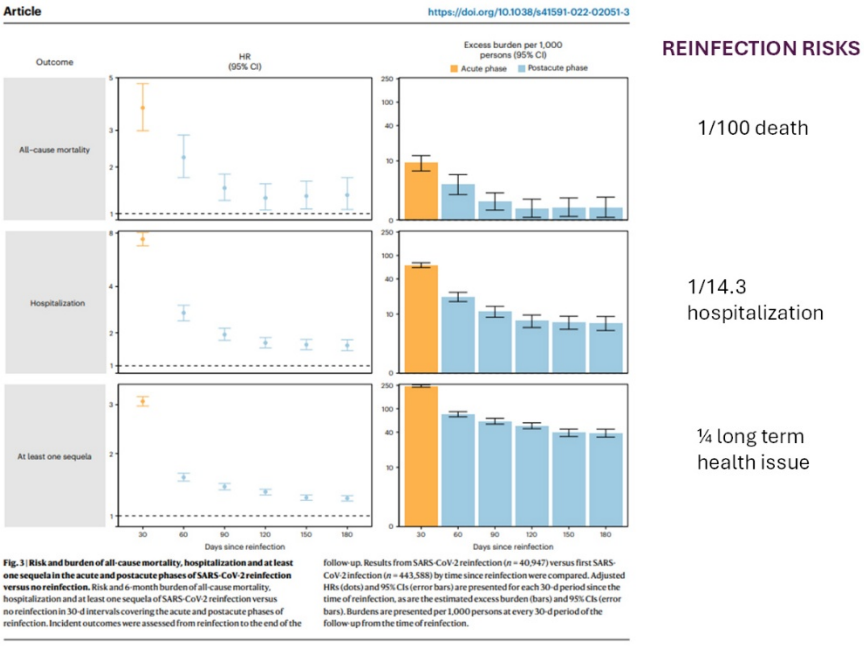
Risk and 6-month excess burden of all-cause mortality, hospitalization, at least one sequela and sequelae by organ system are plotted. Incident outcomes were assessed from reinfection to the end of the follow-up. Results from SARS-CoV-2 reinfection (n = 40,947) and no SARS-CoV-2 reinfection (n = 443,588) are compared. Adjusted HRs (dots) and 95% CIs (error bars) are presented, as are the estimated excess burden (bars) and 95% CIs (error bars). Burdens are presented per 1,000 persons at 6 months of follow-up from the time of reinfection.

Bowe B, Xie Y, Al-Aly Z. Acute and postacute sequelae associated with SARS-CoV-2 reinfection. Nat Med. 2022 Nov;28(11):2398-2405. doi: 10.1038/s41591-022-02051-3.

ABSTRACT

First infection with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is associated with increased risk of acute and postacute death and sequelae in various organ systems. Whether reinfection adds to risks incurred after first infection is unclear. Here we used the US Department of Veterans Affairs' national healthcare database to build a cohort of individuals with one SARS-CoV-2 infection (n = 443,588), reinfection (two or more infections, n = 40,947) and a noninfected control (n = 5,334,729). We used inverse probability-weighted survival models to estimate risks and 6-month burdens of death, hospitalization and incident sequelae. Compared to no reinfection, reinfection contributed additional risks of death (hazard ratio (HR) = 2.17, 95% confidence intervals (CI) 1.93–2.45), hospitalization (HR = 3.32, 95% CI 3.13–3.51) and sequelae including pulmonary, cardiovascular, hematological, diabetes, gastrointestinal, kidney, mental health, musculoskeletal and neurological disorders. The risks were evident regardless of vaccination status. The risks were most pronounced in the acute phase but persisted in the postacute phase at 6 months. Compared to noninfected controls, cumulative risks and burdens of repeat infection increased according to the number of infections. Limitations included a cohort of mostly white males. The evidence shows that reinfection further increases risks of death, hospitalization and sequelae in multiple organ systems in the acute and postacute phase. Reducing overall burden of death and disease due to SARS-CoV-2 will require strategies for reinfection prevention.

Image 8. Data on reinfection [12] compared with no reinfection (but infection in 2020) implies these deaths involved SARS-CoV-2 transmitted with the spike IgG1/3 antibodies. All cases of reinfection showed these trends essentially irrespective of vaccination status.



Article https://doi.org/10.1038/s41591-022-02051-3

Fig. 3 | Risk and burden of all-cause mortality, hospitalization and at least one sequela in the acute and postacute phases of SARS-CoV-2 reinfection versus no reinfection. Risk and 6-month burden of all-cause mortality, hospitalization and at least one sequela of SARS-CoV-2 reinfection versus no reinfection in 30-d intervals covering the acute and postacute phases of reinfection. Incident outcomes were assessed from reinfection to the end of the follow-up. Results from SARS-CoV-2 reinfection (n = 40,947) versus first SARS-CoV-2 infection (n = 443,588) by time since reinfection were compared. Adjusted HRs (dots) and 95% CIs (error bars) are presented for each 30-d period since the time of reinfection, as are the estimated excess burden (bars) and 95% CIs (error bars). Burdens are presented per 1,000 persons at every 30-d period of the follow-up from the time of reinfection.

REINFECTION RISKS

1/100 death

1/14.3 hospitalization

¼ long term health issue

Image 9. Data on reinfection [12] implied highly elevated risks of deaths (1/100), hospitalizations (1/14) and injuries (1/4).

Raw Death COUNTs for the First 17 Months of the COVID-19 Vaccine Rollout (January 1, 2021 to May 31, 2022) ONS Data Released July 6, 2022 for England. Estimates for Shedding DEATHS. 10 years of age and up.

	Total Deaths	COVID-19	Non-COVID-19	Other NonC19 but Non-iatrogenic Causes	Vaccine Iatrogenic Causes	Iatrogenic Early Vax <21 days	Average Shedding Deaths in the Vaccinated *	Estimated Shedding Deaths in the Unvaccinated *	Total Shedding Deaths	Ratio of Shedding Deaths Over COVID-19
	749,115	87,472	660,207	100,654	559,553	60,917	426,602	72,034	498,636	5.7-fold
% of Total	100%	11.6%	88.1%	13.4%	74.7%	8.1%	57.0%	9.6%	66.6%	5.7-fold

* **Two methods were used to estimate shedding deaths in the vaccinated, excess above background nadir counts of Jan 2021 (430,855) and the number of deaths that occurred >63 days (420,194) where the average was 425,525. However, there were an additional estimated 1077 shedding deaths# not captured in the ONS database for a total of 426,602. For the unvaccinated, the excess above a background nadir of May 2022 was used. See details**
https://rumble.com/v51idm2-dr.-marian-laderoute-jun-01-2024-regina-saskatchewan.html

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsbyvaccinationstatusengland **Released July 6, 2022 Covering deaths in the 10 + age group and January 1, 2021 to May 31, 2022.**

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/**bulletins**/deathsinvolvingcovid19byvaccinationstatusengland/previousReleases **# NB 1,436 vaccination deaths not included in the database for the July 6, 2022 data release. Estimated 75% of these were shedding deaths (n=1077).**

Image 10. The above data for England [1], only pertains to iatrogenic deaths that did not involve SARS-CoV-2 infections or diagnoses with COVID-19, and so we know the shedding deaths captured are independent of SARS-CoV-2. Note that the shedding deaths to COVID-19 deaths was 5.7-fold elevated implying shedding deaths more commonly lead to injuries and deaths.

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