



National Citizens Inquiry (NCI | CeNC) ☀
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...

The National Citizens Inquiry is pleased to welcome **Dr. Marian Laderoute** as an *Expert Witness* at our upcoming hearings in Regina, Saskatchewan on **Saturday, June 1st at 11:30 AM, CST.**

Dr. Laderoute has a Ph.D. in Medical Sciences-Immunology from the University of Alberta and has had a career in pandemic and infectious disease prevention since 1996 at Health Canada and the Public Health Agency of Canada.

Join us in Regina:national-citizens-inquiry.ticketleap.com/nci-regina-202.....Or watch our live-stream of the event at:
nationalcitizensinquiry.ca/live/

@hervk102

The National Citizens Inquiry
is pleased to welcome

DR. MARIAN LADERROUTE
Ph.D. in Medical Sciences - Immunology

as an Expert Witness

Saturday, June 1st - 11:30 am CST
Regina, Saskatchewan

Live-streaming:
nationalcitizensinquiry.ca/live/

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<https://rumble.com/v51idm2-dr.-marian-laderoute-jun-01-2024-regina-saskatchewan.html>

Potential
Mechanisms

MORTALITY
Outcomes

Dr. Marian P. Laderoute
Ph.D. Medical Sciences-
Immunology

Shedding of Spike mRNA “Gene Therapy” Products

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2024 06-01

I am bringing you my testimony based on
a career in
pandemic and infectious disease prevention
for Canadians since 1996.

I was hired into the **Blood & Tissues Division** in the Bureau of Biologics at Health Canada in 1996 in direct response to the interim report of the **Krever Inquiry into the HIV-1** (over 1000 infections) and Hepatitis C (over 28,000 infections) **Tainted Blood Scandal** of the 80's and 90's.

Efforts here led to expert and public consultations¹ which resulted in the establishment of a ‘voluntary moratorium’ on xenotransplantation; the implantation of animal tissues into humans. In this way the issue of xenozoonotic infections causing a pandemic in Canada was alleviated.

¹. Laderoute MP. Editor/Producer of “Report of the National Forum on Xenotransplantation: Clinical, Ethical and Regulatory Issues, November 1997”.

<https://publications.gc.ca/cnt/pgr/0-686126/publication.html>

- Then I was hired as the Research Manager of the Blood Zoonotics Unit by the Laboratory Centre for Disease Control and tasked with the development of risk mitigation measures against emerging zoonotic diseases including the development of a blood donor screening test for unknown zoonotic diseases.
- So, in our quest to examine the impact of “xenozoonoses” on the human immune system my research team identified the activation of the (elusive) foamy retrovirus of humans (HERV-K102) which generated foamy macrophages in response to viral infections.
- Public Health Agency of Canada (PHAC) then issued patent applications worldwide for these blood donor screening tests and for the exploitation of HERV-K102 activation for pandemic preparedness.
- We showed HERV-K102 was replication competent *in vivo* and *in vitro* and generated **foamy macrophages** that we now know mediate ‘trained (innate) immunity (TI)’.
- TI provides more rapid-onset non-antigen-specific (heterologous) protection against pathogens and cancers which includes pathogen neutralizing INNATE antibodies and innate T cells that recognize surrogate markers: HERV-K102 envelope proteins on infected cells and which are captured on viruses as they bud from the infected cells. Moreover, it is believed that the HERV-K102 particles kill virus-infected cells and tumor cells by undergoing lytic infections. In contrast, in normal cells, HERV-K102 merely integrates and waits at the ready to pounce if the intruder (pathogen) enters the cells.

HERV-K102 particle entry into cells is able to provide an alternative means to not only activate but to quickly amplify the critical Type 1 interferon response needed for COVID-19 recovery [1-3] and explains how in a humanized mouse model of mild COVID-19 disease that ‘macrophages’ were somehow able to achieve this [4].

Evaluation only.

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1. Russ E, Mikhalkovich N, Iordanskiy S. Expression of human endogenous retrovirus group K (HERV-K) HML-2 correlates with immune activation of macrophages and type I interferon response. Microbiol Spectr. 2023 Mar 2;11(2):e0443822. doi: 10.1128/spectrum.04438-22.
2. Russ E, Iordanskiy S. Endogenous retroviruses as modulators of innate immunity. Pathogens. 2023 Jan 19;12(2):162. doi: 10.3390/pathogens12020162.
3. Guo Y, Yang C, Liu Y, et al. High expression of HERV-K (HML-2) might stimulate interferon in COVID-19 patients. Viruses 2022, 14, 996. <https://doi.org/10.3390/v14050996>.
4. Kenney DJ, O'Connell AK, Turcinovic J, et al. Humanized mice reveal a macrophage-enriched gene signature defining human lung tissue protection during SARS-CoV-2 infection. Cell Rep. 2022 Apr 19;39(3):110714. doi: 10.1016/j.celrep.2022.110714.

- The most important evidence to indicate the HERV-K102 particles involved a protective response was; we discovered that a cohort of individuals resistant to HIV-1 acquisition had a five-fold increased HERV-K102 pro-viral copy number in their genomic DNA [the late Dr. Frank Plummer's HESN; Commercial Sextrade Workers (CSW) of Nairobi, Kenya]. This argued that **high HERV-K102 replication/pre-activation may strongly protect against HIV-1 infection where HIV-1 is a pandemic RNA virus.**
- Now, in the paper below¹ it is overwhelmingly suggested that foamy macrophages and HERV-K102 replication are key to the recovery from COVID-19, the disease caused by SARS-CoV-2, a second pandemic RNA virus.
- Indeed, HERV-K102 at 1g22 may have helped ensure the survival of the human species from RNA epidemics prevalent at the time of encounters with other hominins who subsequently went extinct.¹

So HERV-K102 appears to be THE crucial host defence mechanism of macrophages promoting survival against pandemic RNA viruses.

¹. Laderoute, M. Antibody Dependent Enhancement (ADE) of Infection into Macrophages Validates the Importance of HERV-K102 Particle Production for Pandemic Preparedness. *Preprints* 2023, 2023120185.

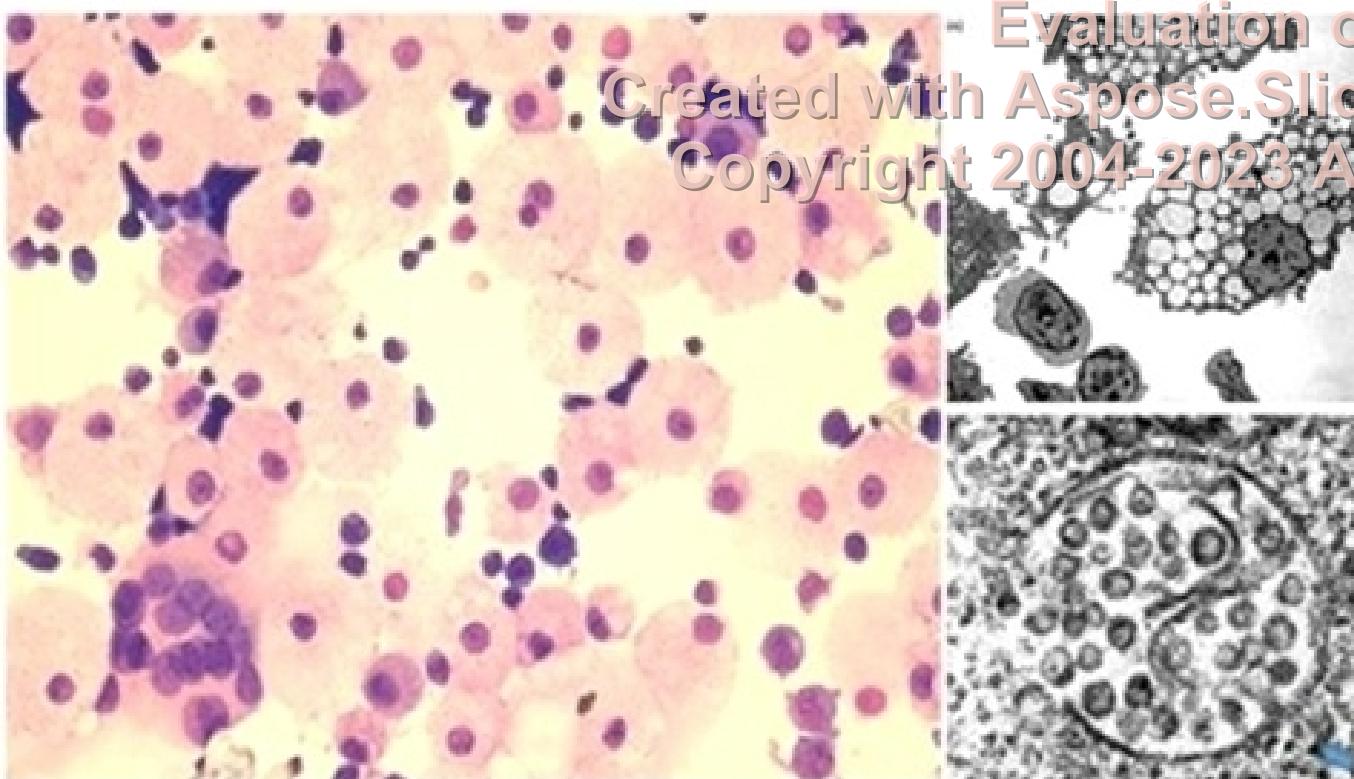
DOI: 10.20944/preprints202312.0185.v2.

Laderoute MP, Larocque LJ, Giulivi A, Diaz-Mitoma F. Further evidence that human endogenous retrovirus K102 is a replication competent foamy virus that may antagonize HIV-1 replication. Open AIDS J. 2015 Dec 7;9:112-22. doi: 10.2174/1874613601509010112.

Laderoute MP, Giulivi A, Larocque L, et al. The replicative activity of human endogenous retrovirus K102 (HERV-K102) with HIV viremia. AIDS. 2007 Nov 30;21(18):2417-24. doi: 10.1097/QAD.0b013e3282f14d64.

HERV-K102 is the elusive foamy retrovirus of humans.

Particles are produced in M1-like foamy macrophages where release is by lysis on day 6/7.



Russ E et al., Microbiol Spectr 2023.

Produced by budding through the golgi creating vacuoles) and accumulate hundreds of particles per vacuole and hundreds of vacuoles in the M1-like foamy macrophages.

- Requires lots of lysine and cholesterol to produce
- Release of particles is by a **novel cytosol-initiated Novel DNase-2 mechanism for apoptosis** [Fischer H, et al. Holocrine secretion of sebum is a unique DNase2-dependent mode of programmed cell death. J Invest Dermatol. 2017 Mar;137(3):587-594. doi: 10.1016/j.jid.2016.10.017.]

- **100 nm immature particles (no condensed cores)**
- **Have envelope spikes on surface**
- **Density of 1.10 to 1.20 g/ml (iodixanol gradients)**
- **Carry and use reverse transcriptase and integrase for replication *in vivo* and *in vitro***
- **Replication competent (functional REVERSE TRANSCRIPTASE and INTEGRASE**

**One needs to understand
“Antibody Dependent Enhancement (ADE) of Infection
into Macrophages” in order to understand what shedding
is and
the role of spike IgG1/3 antibody in generating
more lethal COVID-19 outcomes.**

During natural infection, PROGRESSION to severe COVID-19 is associated with the ‘early’ onset of spike protein ANTIBODIES (as part of the B cell response of ADAPTIVE immunity) that occurs before the innate system has cleared/inactivated SARS-CoV-2 [1].

In other words, the spike IgG1/3 antibodies cause progression to severe COVID-19 when the SARS-CoV-2 virus is present and does not prevent disease.

So this raised a red flag as to why the COVID-19 vaccines would be designed to produce

Production for Pandemic Preparedness. *Preprints* 2023, 2023120185. DOI: 10.20944/preprints202312.0185.v2.

Monocytes/ macrophages do Not express ACE2 and thus, entry of SARS-CoV-2 into macrophages is via ADE.

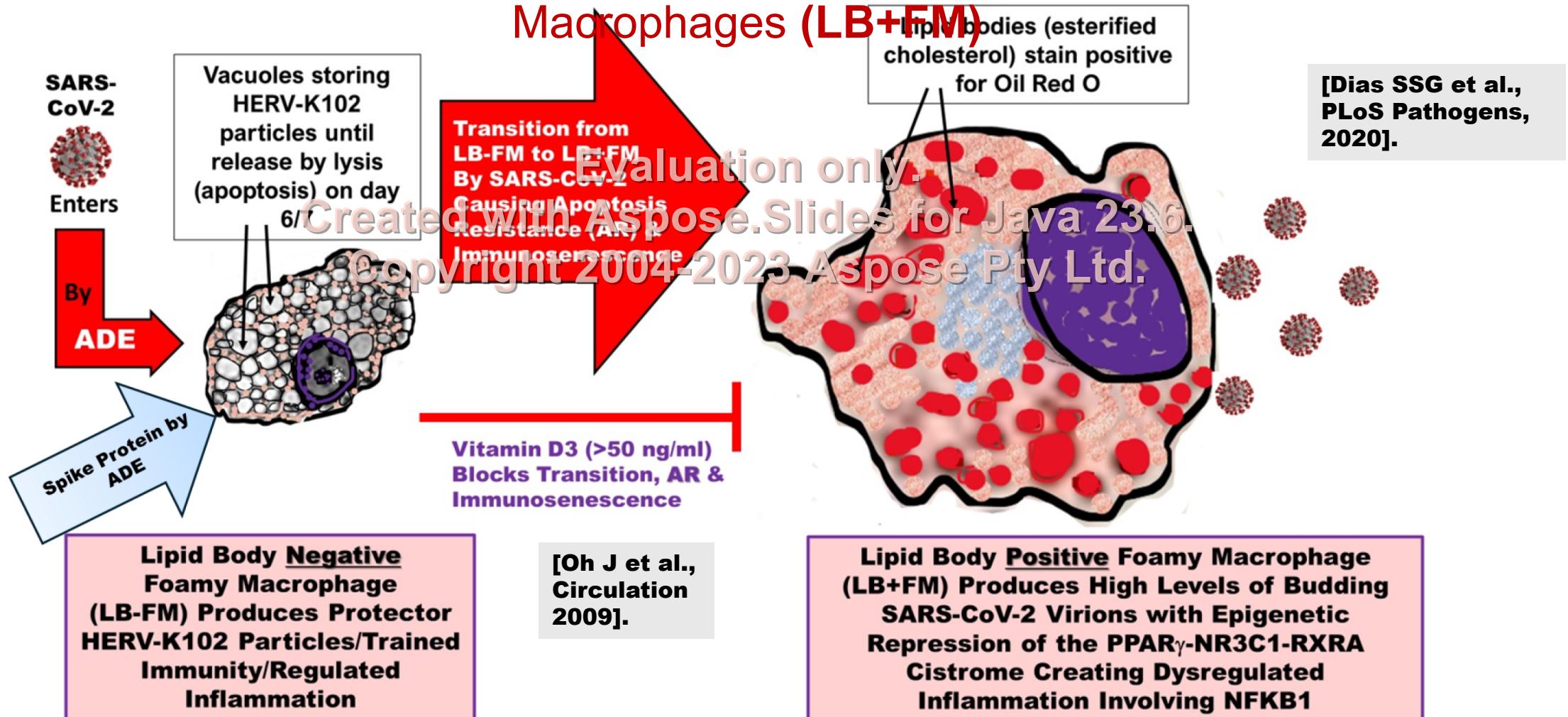
Upon the entry of SARS-CoV-2 into macrophages by ADE, this blocks the critical launch of the HERV-K102 protector system in macrophages needed for recovery/survival.

Evaluation only.

This is why the IgG1/3 antibodies to spike protein and ADE are so dangerous. It also explains how the COVID-19 vaccines were doomed not only to failure but to **increased risks of death upon subsequent exposures to SARS-CoV-2.**

NO adaptive immunity vaccine that generates antibodies to the RNA spike protein to an emerging pathogen can be considered safe due to the well-known problems of ADE.

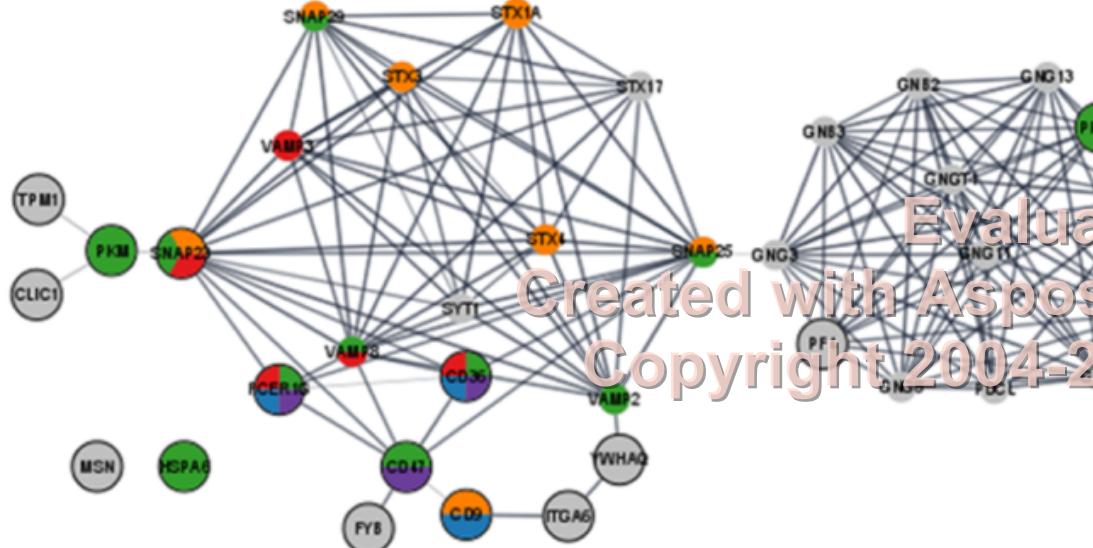
Vitamin D3 essentially downregulates adaptive immunity & favors innate immunity including the activation of HERV-K102 expression. Vit D3 blocks the ability of SARS-CoV-2 to convert the **Protector FOAMY MACROPHAGES (LB-FM)** into the **DISEASE Progression Causing Foamy Macrophages (LB+FM)**



MOST EXOSOMES In Plasma From COVID-19 Patients are from Macrophages (CD9 positive)

Pesce E, Manfrini N, Cordiglieri C, Santi S, Bandera A, Gobbini A, Gruarin P, Favalli A, Bombaci M, Cuomo A, Collino F, Cricri G, Ungaro R, Lombardi A, Mangioni D, Muscatello A, Aliberti S, Blasi F, Gori A, Abrignani S, De Francesco R, Biffo S, Grifantini R. Exosomes Recovered From the Plasma of COVID-19 Patients Expose SARS-CoV-2 Spike-Derived Fragments and Contribute to the Adaptive Immune Response. *Front Immunol.* 2022 Jan 17;12:785941. doi: 10.3389/fimmu.2021.785941.

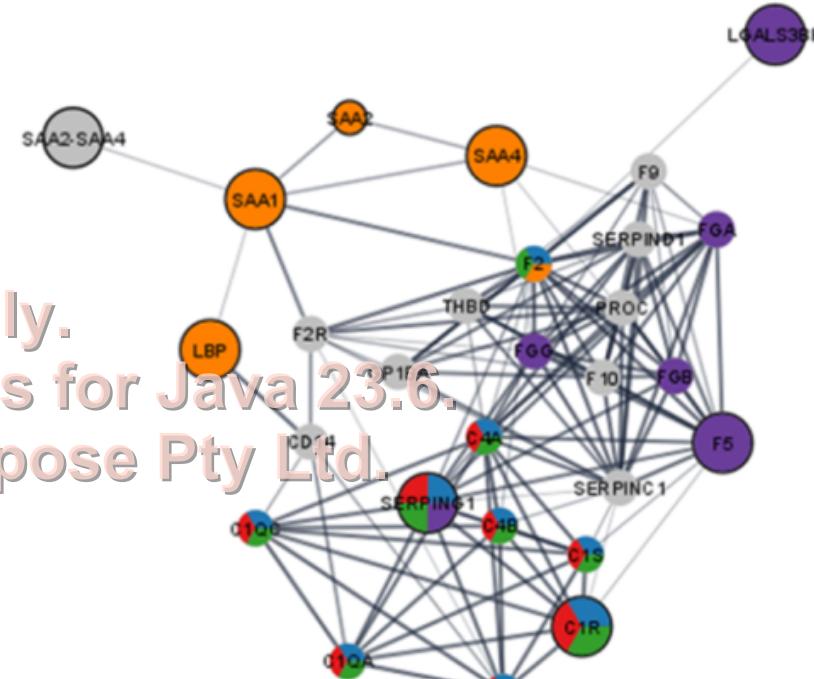
PPI analysis on enriched proteins in COVID-19 MILD



#term ID	term description	Colour Legend
GO:0045026	plasma membrane fusion	
GO:0042590	antigen processing and presentation of exogenous peptide	
GO:0071404	cellular response to low-density lipoprotein particle stimulus	
GO:0002275	myeloid cell activation involved in immune response	
GO:0050766	positive regulation of phagocytosis	

CD9 Positive Exosomes (HERV-K102) from LB-Foamy Macrophages (decrease by 75% with transition to Severe C19)

PPI analysis on enriched proteins in COVID-19 SEVERE



#term ID	term description	Colour Legend
GO:0006953	acute-phase response	Orange
GO:0006958	complement activation, classical pathway	Red
GO:0030449	regulation of complement activation	Blue
GO:0002673	regulation of acute inflammatory response	Green
GO:0002576	platelet degranulation	Purple

CD9 Positive Exosomes from LB+ Foamy Macrophages (Provoking Microclotting, Complement Activation & Dysregulated Inflammation)

Shedding in the donor URT probably lasts up to 3 months after vaccination

Bansal S, Perincheri S, Fleming T, Poulson C, Tiffany B, Bremner RM, Mohanakumar T. Cutting Edge: Circulating Exosomes with COVID Spike Protein Are Induced by BNT162b2 (Pfizer-BioNTech) Vaccination prior to Development of Antibodies: A Novel Mechanism for Immune Activation by mRNA Vaccines. *J Immunol.* 2021 Nov 15;207(10):2405-2410. doi: 10.4049/jimmunol.2100637.

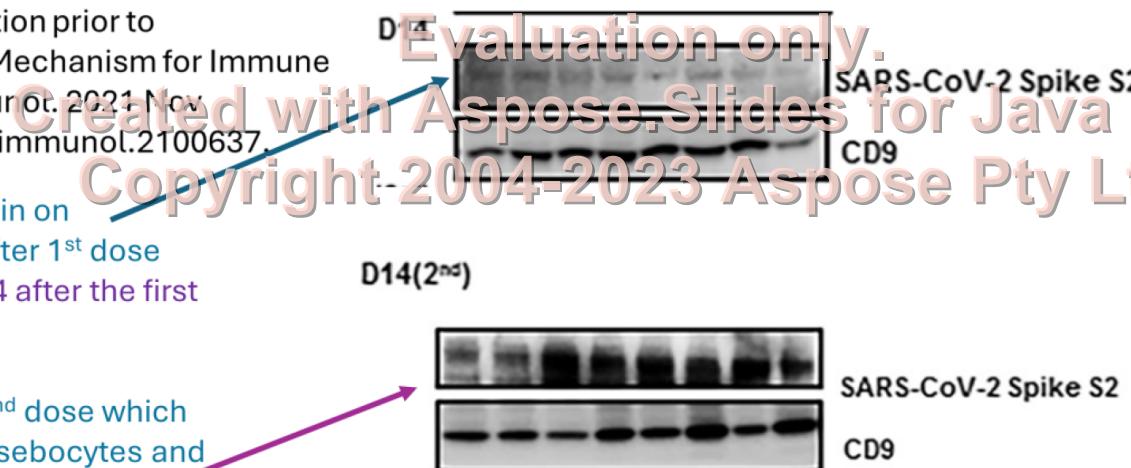
In BNT162b2 mRNA vaxed saw S2 protein on exosomes (**about 120 nm**) at 14 days after 1st dose but not at d7 (**very weak signal by day 14 after the first dose**).

Antibodies peaked at day 14 after the 2nd dose which targeted the LNPs to the macrophages/sebocytes and much higher concentration of spike S2 protein on the exosomes (**very strong signal (100 fold?)**).

By 4 months neither the IgG1/3 antibodies nor the exosomes were detectable.

Didn't discuss where was S1

Kedl RM, Hsieh EWY, Morrison TE, Samayoa-Reyes G, Flaherty S, Jackson CL, Rochford R. **Evidence for Aerosol Transfer of SARS-CoV-2-Specific Humoral Immunity.** *Immunohorizons.* 2023 May 1;7(5):307-309. doi: 10.4049/immunohorizons.2300027.

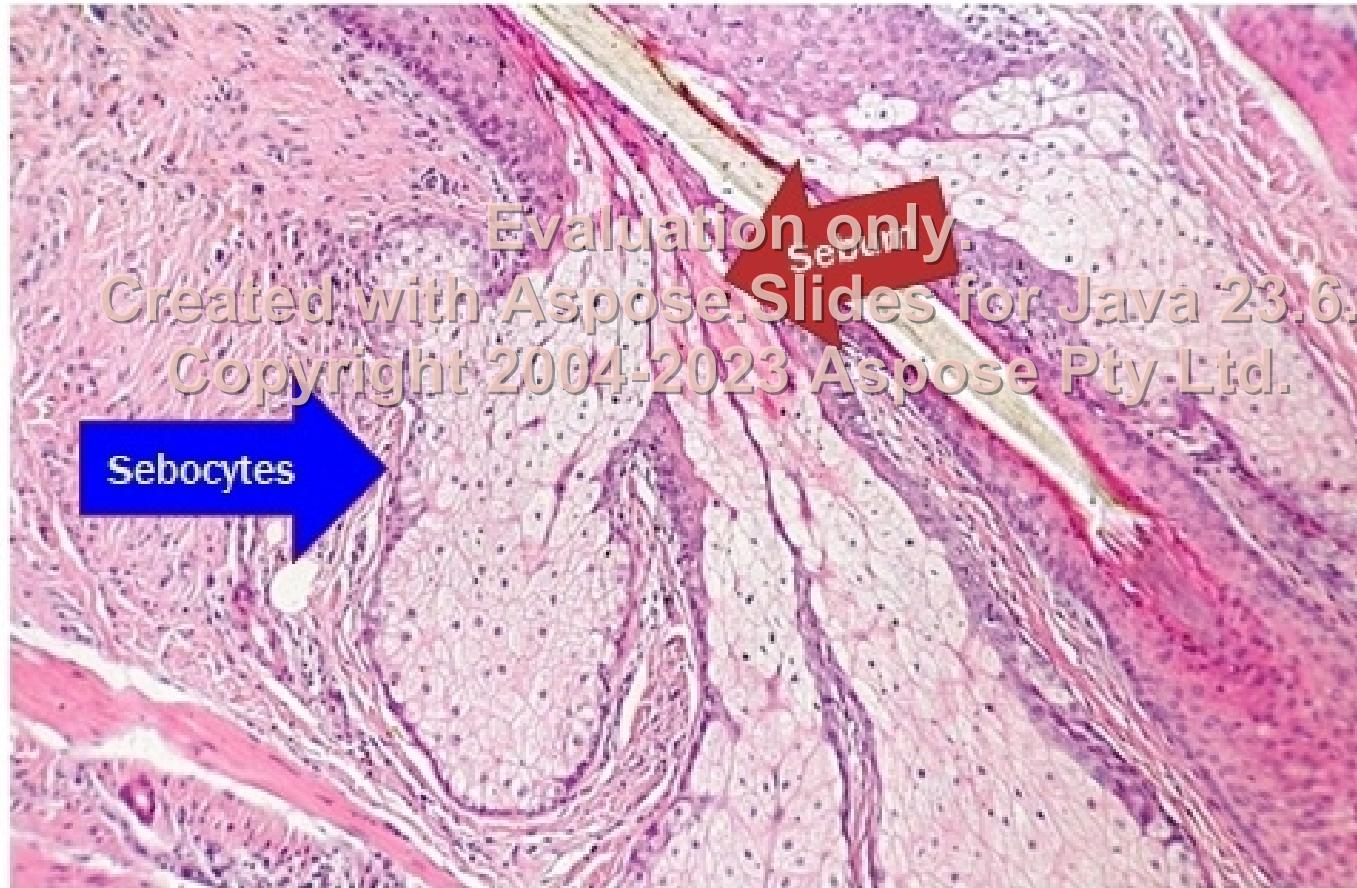


In 2021 letter to editor found S2 and N on exosomes

Bansal S, Tokman S, Fleming T, Maine GN, Sanborn K, Hachem R, Bharat A, Smith MA, Bremner RM, Mohanakumar T. SARS-CoV-2 infection in lung transplant recipients induces circulating exosomes with SARS-CoV-2 spike protein S2. *Clin Transl Med.* 2021 Nov;11(11):e576. doi: 10.1002/ctm2.576.

SEBOCYTES are specialized lipid body negative foamy macrophages (LB-FMs)
releasing HERV-K102 particles
by lysis (novel Lysosomal DNase2 apoptosis mechanism [Fischer H et al., 2017])
producing **SEBUM** that coats the mucosa

Constitutive Production of the Protector HERV-K102 Particles in SEBOCYTES
[Nelson AM et al., 2008; 2009]

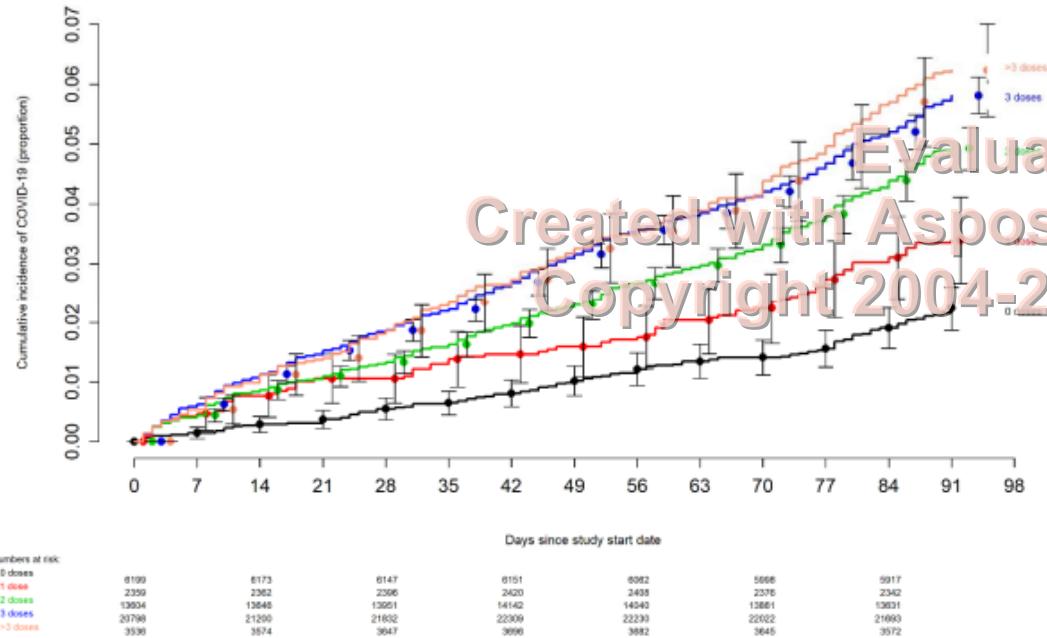


https://commons.wikimedia.org/wiki/File:Insertion_of_sebaceous_glands_into_hair_shaft_x10.jpg

Sebocytes can become activated like LB-FMs [Torosik D et al., 2018] and once activated can be infected by SARS-CoV-2 through classical ADE involving FCGR2A [Ziegler CGK et al., 2021].

Endotoxin-LPS Role Promoting Bioweapon Exosomes

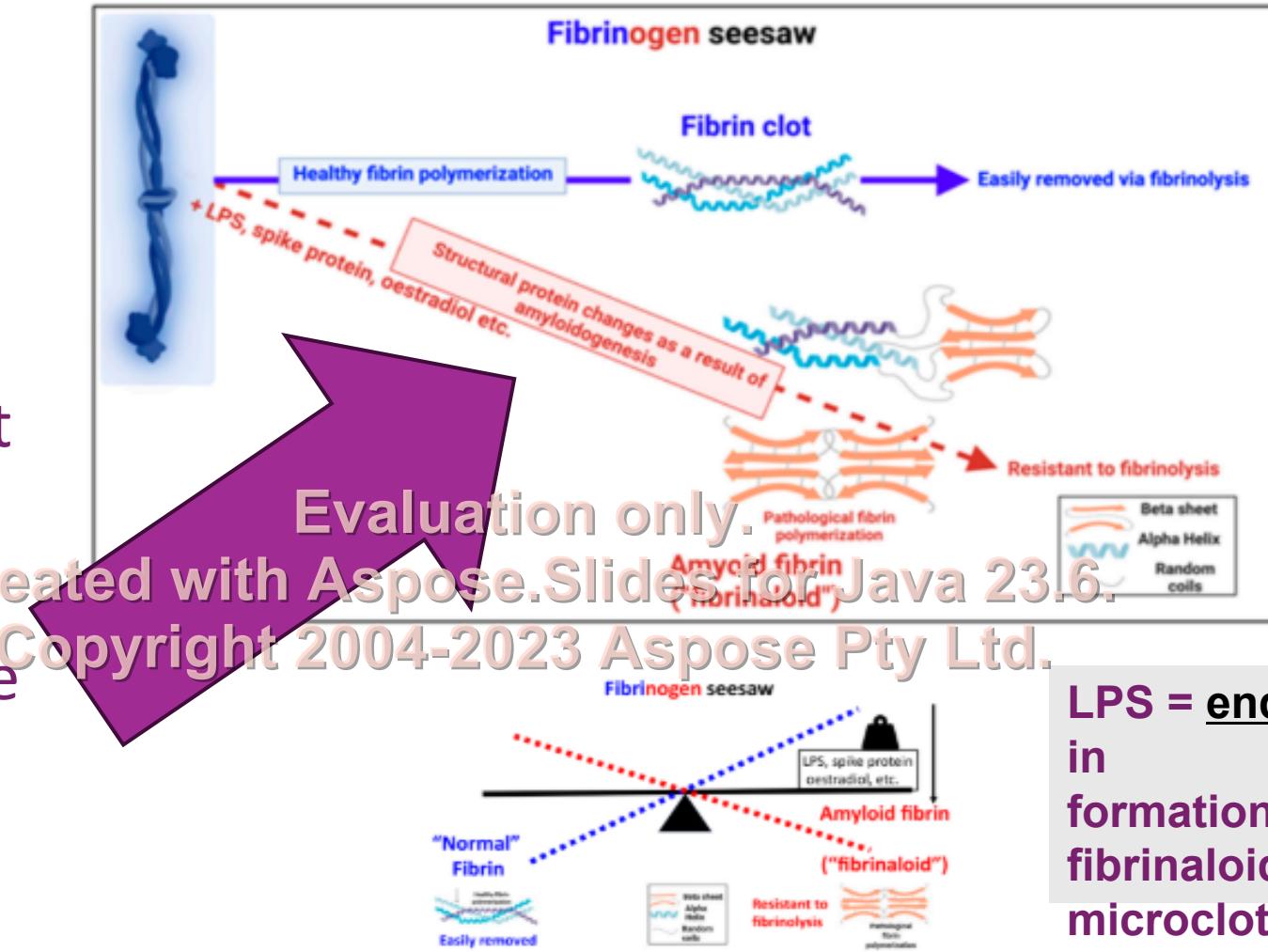
Shrestha NK, Shrestha P, Burke PC, Nowacki AS, Terpeluk P, Gordon SM. Coronavirus Disease 2019 Vaccine Boosting in Previously Infected or Vaccinated Individuals. Clin Infect Dis. 2022 Dec 19;75(12):2169-2177. doi: 10.1093/cid/ciac327.



The famous Cleveland Clinic data implies that the spike IgG1/3 in the URT is not converted to IgG4 even after multiple boosters.

Figure 2. Simon-Makuch plot comparing the cumulative incidence of COVID-19 for subjects stratified by the number of COVID-19 vaccine doses previously received. Day zero was 12 September 2022, the day the bivalent vaccine began to be offered to employees. Point estimates and 95% confidence intervals are jittered along the x-axis to improve visibility.

The clotting caused by the Wuhan spike protein involves abnormal “microclotting” that is made more dangerous due to the clot’s resistance to fibrinolysis.



LPS = endotoxin also a role in formation of the white fibrinaloid clots and microclots.

Figure 6. Cartoon illustrating the ability of fibrinogen to polymerise either to its α -helix-rich normal form or its crossed- β -sheet amyloid ‘fibrinaloid’ form, depending on the presence of various small-molecule triggers. Glyphs taken from the CC-BY Open Access publication [118]. Created with BioRender.com.

There are numerous reports of symptoms and pathologies **identical to the adverse effects of mRNA vaccines** in unvaccinated persons in contact with freshly vaccinated persons.

Evaluation only.

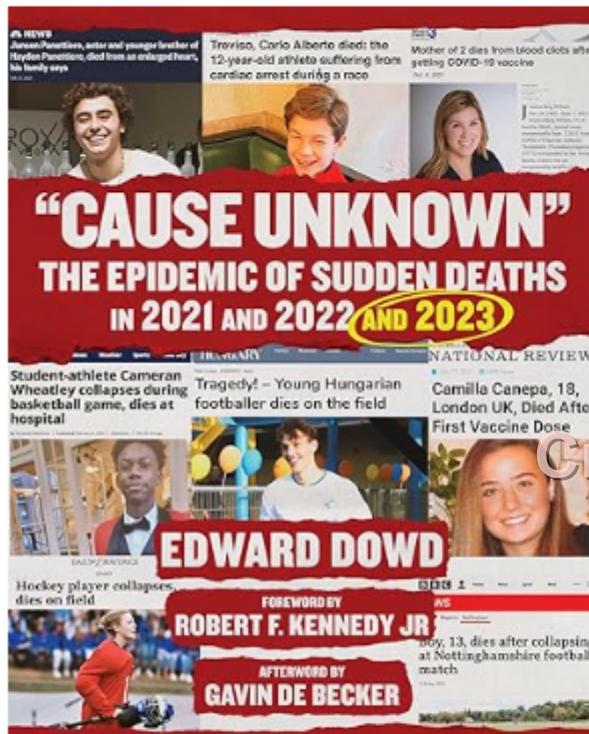
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Hélène Banoun. Current state of knowledge on the excretion of mRNA and spike produced by anti-COVID-19 mRNA vaccines; possibility of contamination of the entourage of those vaccinated by these products. *Infectious Diseases Research*, 2022, 3 (4), pp.22. 10.53388/IDR20221125022 . hal-03891682

Is there any evidence that shedding has
caused excess deaths

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or any evidence for
sudden unexpected deaths?



"Cause Unknown": The Epidemic of Sudden Deaths in 2021 & 2022 & 2023 (Children's Health Defense) Hardcover – March 5, 2024

by Ed Dowd (Author), Gavin de Becker (Afterword), Robert F. Kennedy Jr. (Foreword)

5.0 7 ratings

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100+ bought or read in past month

What is killing healthy young Americans?

2020 saw a spike in deaths in America, smaller than you might imagine during a pandemic, some of which could be attributed to COVID and other treatment strategies that were not effective. But then, in 2021, the stats people expected went off the rails. The CEO of the One America insurance company publicly disclosed that during the third and fourth quarters of 2021, death in people of working age (18-64) was 40 percent higher than it was before the pandemic. Significantly, the majority of the deaths were not attributed to COVID.

A 40 percent increase in deaths is literally earth-shaking. Even a 10 percent increase in excess deaths would have been a 1-in-200-year event. But this was 40 percent.

- What has caused this historic spike in deaths among younger people?
- What has caused the shift from old people, who are expected to die, to younger people, who are expected to keep living?



Ed Dowd

[FOLLOW](#)

Sudden Adult Death Syndrome (SADS)

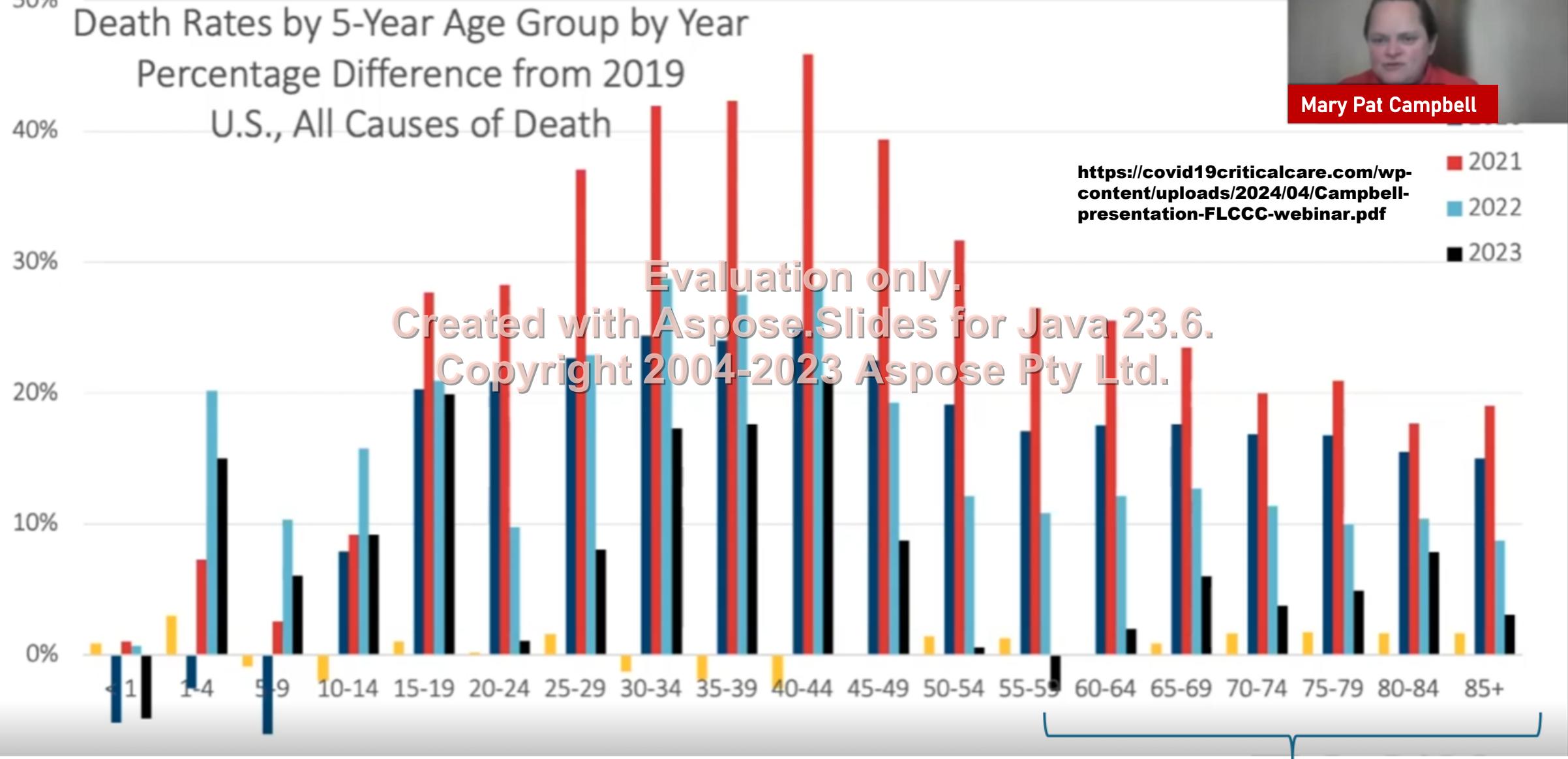
216 pages

English

Childrens Health
Defense Books

March 5, 2024

8 x 0.8 x 10 inches



Especially the 25 to 54 year olds, exhibited >30 % increase in excess deaths in 2021.
Some of this was the direct toxicity of the COVID-19 mRNA vaccines. Could shedding be involved?
82% of all deaths

The Younger the Age, The More Non-COVID-19 Deaths Relative to COVID-19 Deaths Accounting for Excess All-Cause Mortality

Index

During the height of the pandemic, the Non-C19/C19 death ratio provides an index of **Excess Non-C19 Deaths**

Non-C19/ C19	2020 -Dec. 2022	COVID (%)	Non-COVID (%)	Age	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021
3.32	112%	2.8%	9.3%	0-24	124%	104%	101%	119%	128%	112%
2.13	131%	9.9%	21.1%	25-34	131%	120%	118%	132%	179%	137%
1.23	139%	17.2%	21.3%	35-44	133%	127%	129%	134%	201%	158%
0.50	130%	19.9%	10.0%	45-54	126%	129%	132%	119%	179%	151%
0.29	122%	17.4%	5.1%	55-64	122%	129%	129%	114%	152%	139%
0.11	116%	14.0%	1.5%	65-74	115%	132%	130%	108%	130%	124%
0.33	115%	11.3%	3.8%	75-84	113%	133%	123%	105%	119%	122%
-0.63	103%	8.6%	-5.5%	85+	103%	124%	111%	92%	105%	107%
0.22	116%	13.0%	2.9%	All Ages ^a	115%	128%	123%	107%	134%	126%

The cause of certain excess all-cause mortality (EACM) statistics remain baffling (July, August, September 2021).
In this presentation we will explore if shedding from the recently mRNA C19 vaccinated might be implicated.

Excess deaths SOA report, May 2023

<https://rumble.com/v4n6gmx-excess-cancer-deaths-in-young-adults-post-covid-flccc-weekly-update-april-3.html>



SOA =Society of Actuaries

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19byvaccinationstatusengland/deathsoccurringbetween1april2021and31may2023>

The individuals were then linked via NHS number to vaccination data from the National Immunisation Management Service (NIMS) and ONS death registrations. The population was restricted to people in England, alive on 1 April 2021 (**51,786,812 people ever vaccinated people**). This is 91.6% of the England population on Census Day 2021. Total population is 56,535,820 and the unvaccinated was 4,749,008.

Vaccination data

Vaccination status is based on the number of doses received (1, 2, 3 or 4 and more) and the time since that dose. From the day of vaccination, the individual will be classed as vaccinated.

The [Joint Committee on Vaccination and Immunisation \(JCVI\) advised in September 2022 an autumn booster](#) for over 50s and those more at risk because of their occupation or health. In February 2023, the JCVI advised a spring booster for over 75s and for the most vulnerable. People who are in the "at least fourth dose or extra booster" category may have received further booster doses, which are not recorded in our dataset.

People with erroneous or inconsistent vaccination data were removed from the analysis. This includes 103,142 people who have multiple entries for the same dose or who have a recorded first and third dose or booster but not a second dose, or who have a recorded first, second and fourth dose or extra booster but not a third dose or booster. This ensures that deaths are not incorrectly assigned to the wrong vaccination status. However, it also has the effect of reducing the population, therefore increasing the mortality rates for people who received a first dose.

In rare cases, a vaccination may not be recorded if the person has died soon after vaccination and before the record is entered into the system. We therefore include in our dataset an extract of people who died soon after vaccination and do not have a record in NIMS up to 28 June 2023. There were 1,484 new vaccination entries for people who linked to our 2021 Census-linked dataset who were vaccinated but not included in the NIMS data as their vaccine record was entered after they had died.

Age-standardised mortality rates (ASMRs) ASMR confidence is influenced by death occurrences and person-years in each vaccination status category. In May 2023, 49% of person-years were attributed to those who had a third dose at least 21 days ago, and 26% were attributed to those who had a fourth dose or extra booster at least 21 days ago. The remaining categories have much less confidence, which can be seen as wider, and often overlapping, confidence intervals. This is also especially true for the age breakdowns because there are even fewer deaths per status. Non-COVID-19 rates can be affected by composition effects, such as the prioritisation of younger people with comorbidities for earlier vaccination than other people in their age group. This also includes the poorer health of people who do not go on to receive subsequent vaccinations when eligible. These effects are discussed in our Deaths involving COVID-19 by vaccination status bulletin from December 2021. **Seasonal mortality and the healthy vaccinee effect may also be influencing the rates.**

The ONS data does not lump vaccine deaths up to 14 days after a dose as unvaccinated. **Deaths on the day of vaccination count as vaccination associated deaths.**

However, according to Prof. Fenton and colleagues, for the “ever vaccinated totals **provided by the ONS**”, it appears here that the data has been manipulated to essentially discount the deaths in the first 14 days following vaccination.

“Fenton N, Neil M, Craig C, McLachlan S. What the ONS mortality COVID-19 surveillance data can tell us about vaccine safety and efficacy. In: Too Many Dead - An Inquiry Into Australia’s Excess Mortality (© Australian Medical Professionals Society) Red Union Publishing, Bowen Hills QLD 4006, Australia, 2023. pp 470. [https://8630368.fs1.hubspotusercontent-na1.net/hubfs/8630368/Lite_Too-Many-Dead-PDF-with-Cover-MQ-16112023%20(2).pdf]”

However, this problem is easily overcome by manually adding up all the individual ASMRs for each vaccination category per month as shown in the next slide.

Age standardized ALL-CAUSE Mortality Rate per 100,000 person years

UK ONS Data July 6, 2022

		Unvax raw deaths	RATE unvax	vax raw deaths	claimed Evervax' d Rate	Actual RATE All Vax'd	Ratio of Vax/ Unvax Rates	Total	Differen ce	% Deaths Associated with Being Vaccinate d	1st	2nd < 6 m	2nd > 6 m	3rd< 21 d	3rd> 21 d	Mortality Rates for Individual Doses		
2021	Jan	52459	2507.6	10463	1251.8	3483.5	1.39	5991.1	975.9	16.3%	3051.9	431.6	x	x	x			
	Feb	19800	5261.5	22549	905.7	3205.4	0.61	8466.9	-2056.1	-24.3%	2045.7	1159.7	x	x	x			
	Mar	7622	3307.8	27620	901.7	4192.7	1.27	7500.5	884.9	11.8%	3066.2	1126.5	x	x	x			
	April	3850	2298.4	28006	868.3	5039.7	2.19	7338.1	2741.3	37.4%	3794.4	1245.3	x	x	x			
	May	2810	1718.8	30038	901.6	8582.6	4.03	10301.4	5863.8	66.6%	6913.6	1669	x	x	x			
	June	2339	1589.7	22843	868.5	10050.4	6.03	3151.7	8477.5	72.7%	7755	2305	x	x	x			
	July	2347	1610.7	22843	944.6	10307.1	6.40	11917.8	8696.4	73.0%	7036.6	2722.7	547.8	x	x			
	Aug	2354	1711.6	32739	942.5	10340.7	6.04	12052.3	8629.1	71.6%	7152.3	2448.4	740	x	x			
	Sept	2172	1664.5	33505	990.3	8639.0	5.19	10303.5	6974.5	67.7%	5501.7	1819.4	1095	222.9	x			
	Oct	2154	1623.7	36894	1046.7	12456.3	7.67	14080	10832.6	76.9%	6699	3076.9	1765.9	406.2	508.3			
	Nov	2147	1708.0	36713	1073.9	15546.6	9.10	17254.6	13838.6	80.2%	7392.4	4034.2	2813.4	588.8	717.8			
	Dec	2375	1878.5	39874	1126.7	16974.3	9.04	18852.8	15095.8	80.1%	6090.2	4143.2	4784.6	1103.6	852.7			
2022	Jan	2166	1812.0	38467	1084.5	19997.9	11.04	21809.9	18185.9	83.4%	7374.9	5030.3	4877.1	1779.7	935.9			
	Feb	1493	1384.5	32613	1015.7	12474.4	9.01	13858.9	11089.9	80.0%	5335.1	3727.3	3208.8	1965.4	924.6			
	Mar	1437	1231.7	35348	992.6	10257.2	8.33	11488.9	9025.5	78.6%	2402.5	2252.2	2667.1	1955.3	980.1			
	April	1349	1204.6	34835	1008.8	12423.2	10.31	13627.8	11218.6	82.3%	9076.5	5119.7	2355.6	1522.5	966.1			
	May	1017	872.9	29458	822.6	8246.0	9.45	9118.9	7373.1	80.9%	1873.4	1815.9	1703.7	2056	797			
Total		109891		53118														
		641009																

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			p values	COVID-19 Mortality			p values	Non-C19 Mortality			p values
	Rate Unvax	Actual Rate Ever Vax	Ratio of Vax/ Unvax Rates		Rate Unvax	Actual Rate Ever Vax	Ratio of Vax/ Unvax Rates		Rate Unvax	Actual Rate Ever Vax	Ratio of Vax/ Unvax Rates	
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		3187	2631	0.77	
Mar	3307.8	4192.7	1.27		591.9	283.9	0.48		2716	3909	1.44	
April	2298.4	5039.7	2.19		115.8	181.8	1.25		2153	1851	2.15	
May	1718.8	8582.6	4.99		43.5	84.5	1.80		673	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					584.6	2310.9	3.95		1227	16417	13.38	
Jan	1812	19997.9	11.04		258.7	1128.4	4.36		1126	11346	10.08	
Feb	1384.5	12474.4	9.01		183.5	763.6	4.16		1048	9445	9.01	
Mar	1231.7	10257.2	8.33		204.7	800.8	3.91		1000	11622.4	11.62	
April	1204.6	12423.2	10.31		77.6	261.8	3.37		795	7914	9.95	
May	872.9	8246	9.45									
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.

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NB: There were **71,318** vaccination associated deaths that were excluded because details were missing for the second dose but not the first or third dose. #

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

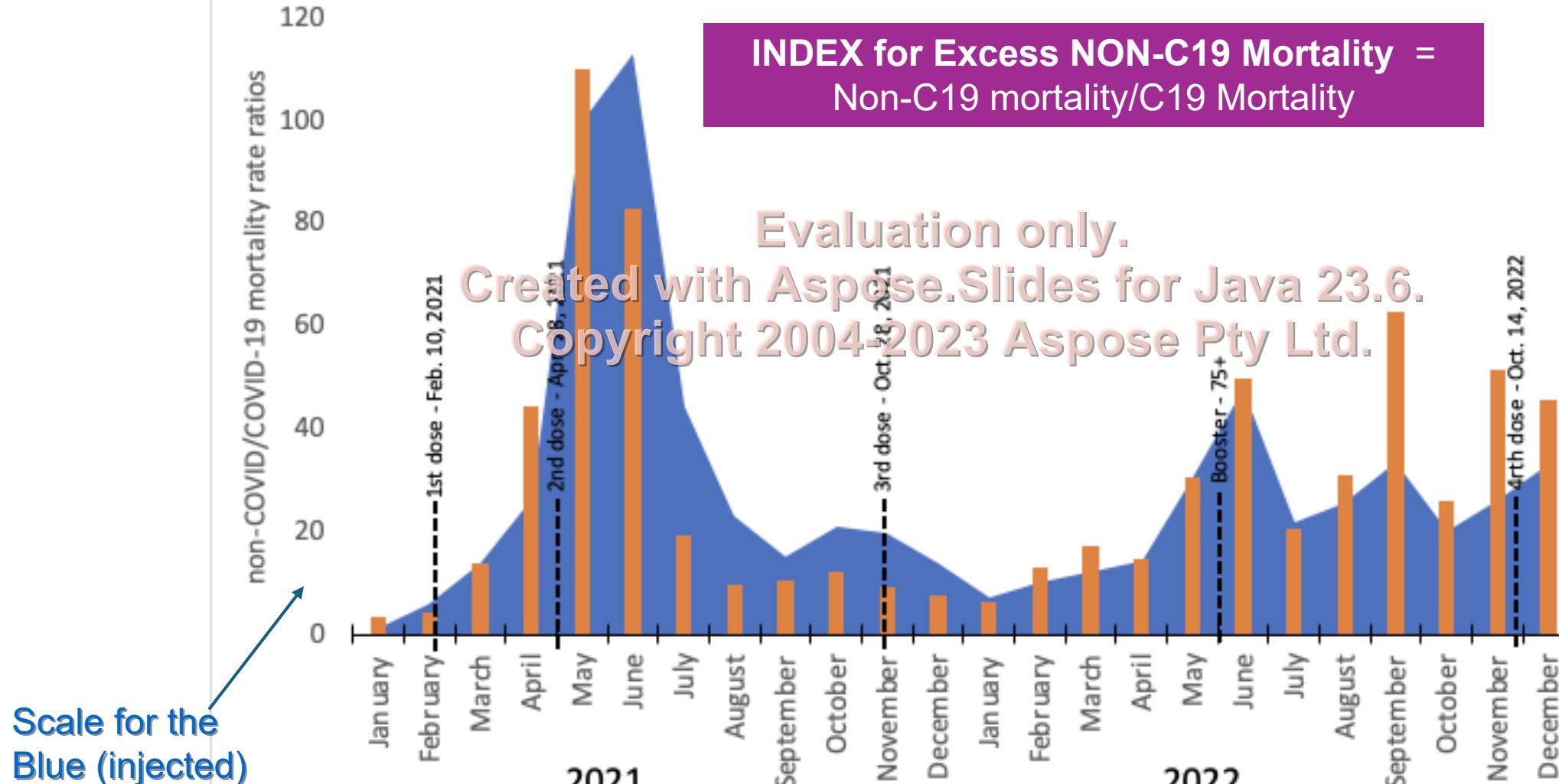
*<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/data-sets/deathsbyvaccinationstatusengland>

ENGLAND: Influence of Vaccination on the Unvaccinated

Mortality ratios (non-COVID-19:COVID-19 deaths) per 100,000 person years
in injected (blue) and uninjected (orange) individuals
Source: UK ONS data

Scale for the
Orange
(uninjected)

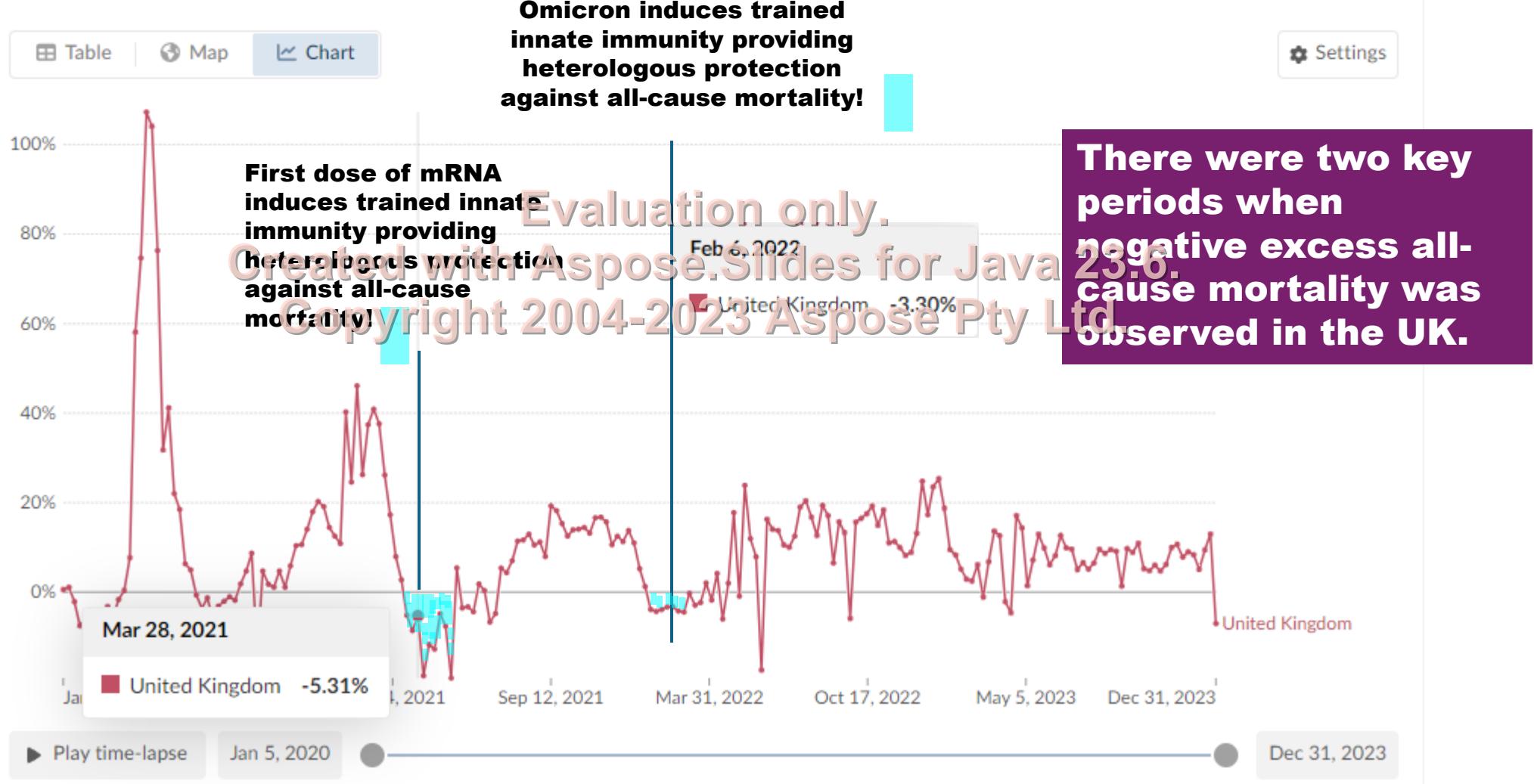
INDEX for Excess NON-C19 Mortality =
Non-C19 mortality/C19 Mortality



Scale for the
Blue (injected)

Excess mortality: Deaths from all causes compared to projection based on previous years

The percentage difference between the reported number of weekly or monthly deaths in 2020–2022 and the projected number of deaths for the same period based on previous years. The reported number might not count all deaths that occurred due to incomplete coverage and delays in reporting.



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

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

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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

Request Form Results Map Chart Report About

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Top Notes Citation Query Criteria

Messages:

- VAERS data in CDC WONDER are updated every month. Hence, results for the same query can change from month to month.
- These results are for 10,404 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine Type	Events Reported	Percent (of 10,404)
ADENOVIRUS TYPE 4 &7 VACCINE, LIVE ORAL (ADEN_4_7)	1	0.01%
CENTRAL EUROPEAN ENCEPHALITIS (CEE)	2	0.02%
COVID19 VACCINE (COVID19)	12,848	123.49%
COVID19-2 (COVID19-2)	111	1.07%
DENGUE TETRAVARIANT VACCINE (DENGVAXIA) (DF)	41	0.39%
DIPHTHERIA AND TETANUS TOXOIDS ACCELLULAR PERTUSSIS POLIOVIRUS INACTIVATED HAEMOPHILUS INFLUENZA B AND HEPATITIS B VACCINE (HEVAXA) (6VAX-F)	5	0.05%
DIPHTHERIA AND TETANUS TOXOIDS AND ACCELLULAR PERTUSSIS VACCINE (DTaP)	3	0.03%
DIPHTHERIA AND TETANUS TOXOIDS AND ACCELLULAR PERTUSSIS VACCINE + INACTIVATED POLIOVIRUS VACCINE + HAEMOPHILUS B CONJUGATE VACCINE (DTaPIPVHIB)	1	0.01%
DIPHTHERIA AND TETANUS TOXOIDS AND ACCELLULAR PERTUSSIS VACCINE + INACTIVATED POLIOVIRUS VACCINE + HAEMOPHILUS B CONJUGATE VACCINE + HEPATITIS B + (VAXELIS) (DTPIPHB)	1	0.01%
HAEMOPHILUS B CONJUGATE VACCINE (HIBV)	3	0.03%
HEPATITIS A (HEPA)	4	0.04%
HEPATITIS B VACCINE (HEP)	1	0.01%
HUMAN PAPILLOMAVIRUS (TYPES 6, 11, 16, 18) RECOMBINANT VACCINE (HPV4)	2	0.02%
HUMAN PAPILLOMAVIRUS VACCINE (HPVX)	1	0.01%
INFLUENZA VIRUS VACCINE, NO BRAND NAME (FLUX(SEASONAL))	18	0.17%
INFLUENZA VIRUS VACCINE, QUADRIVALENT (INJECTED) (FLU4(SEASONAL))	21	0.20%
INFLUENZA VIRUS VACCINE, QUADRIVALENT (INTRANASAL SPRAY) (FLUN4(SEASONAL))	1	0.01%
INFLUENZA VIRUS VACCINE, QUADRIVALENT, ADJUVANT (INJECTED) (FLUA4(SEASONAL))	11	0.11%
INFLUENZA VIRUS VACCINE, QUADRIVALENT, CELL-CULTURE-DERIVED (INJECTED) (FLUC4(SEASONAL))	2	0.02%
INFLUENZA VIRUS VACCINE, TRIVALENT, ADJUVANT (INJECTED) (FLU43(SEASONAL))	16	0.15%
MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE (MMR)	7	0.07%
MEASLES, MUMPS, RUBELLA, AND VARICELLA VACCINE (PROQUAD) (MMRV)	1	0.01%
MENINGOCOCCAL B VACCINE (MENB)	9	0.09%
MENINGOCOCCAL POLYSACCHARIDE VACCINE (MEN)	4	0.04%
MENINGOCOCCAL VACCINE (MENACTRA) (MNQ)	6	0.06%
MUMPS VIRUS VACCINE, LIVE (MU)	1	0.01%
PNEUMOCOCCAL VACCINE, POLYVALENT (PPV)	3	0.03%
PNEUMOCOCCAL, 13-VALENT VACCINE (PREVNAR13) (PNC13)	17	0.16%
POLIOVIRUS VACCINE INACTIVATED (IPV)	1	0.01%
RABIES VIRUS VACCINE (RAB)	1	0.01%
ROTAVIRUS VACCINE, LIVE, ORAL (RV1)	3	0.03%
ROTAVIRUS VACCINE, LIVE, ORAL, PENTAVALENT (RV5)	17	0.16%
RUBELLA VACCINE (RUB)	1	0.01%
TETANUS AND DIPHTHERIA TOXOIDS AND ACCELLULAR PERTUSSIS VACCINE (BOOSTRIX/ADACEL) (TDaP)	2	0.02%
TETANUS TOXOID (TTOX)	1	0.01%
VARIVAX-VARICELLA VIRUS LIVE (VARCEL)	3	0.03%
ZOSTER VACCINE (VARZOS)	13	0.12%
UNKNOWN VACCINES (UNK)	102	0.98%
Total	13,285	127.69%

It is extremely rare for a traditional vaccine to have deaths reported beyond 60 days after the last dose since shedding is not a known or common problem with vaccines that use “antigens”.

Also some of these deaths for the COVID-19 vaccines involved SARS-CoV-2 infections indicating a problem with breakthrough infections not found for traditional vaccines.

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So late onset deaths (>63 days) could be due to SARS-CoV-2 infection, shedding, or both.

However, in the ONS database the deaths that involved SARS-CoV-2 infection are captured separately under COVID-19 deaths. Therefore, this simplified the issue and allowed me to use the > 63 days approach to gauge shedding.

ONS Death Counts for England 10+ Population Jan 1, 2021 to May 31, 2022 for Ever-Vaccinated

By Cause, All-Cause Deaths (AC), COVID-19 Deaths (C19) & Non-COVID-19 Deaths (non-C19)

Putative

Worst
Shedding
Months

Non-
C19
Totals

	10-39												40-49			50-59			60-69			70-79			80-89			90+			Putative
	AC	C19	non-C19	AC	C19	non-C19	AC	C19	non-C19	AC	C19	non-C19	AC	C19	non-C19	AC	C19	non-C19	AC	C19	non-C19	AC	C19	non-C19	Non-C19 Totals	Worst Shedding Months					
2021	jan	17	4	13	24	4	20	79	27	52	243	84	159	1350	416	934	5906	1999	3907	4189	1417	2772	7857	2021	jan						
	feb	84	10	74	136	17	119	466	63	403	1297	197	1100	5267	993	4274	10816	2481	8335	7421	1782	5639	19944		feb						
	mar	173	4	169	358	9	349	1204	64	1140	2814	181	2633	7535	429	7106	11630	805	10825	7569	528	7041	29263		mar						
	april	277	0	277	470	5	465	1625	24	1601	3368	53	3315	7649	133	7516	11360	252	11108	7181	126	7055	31337		april						
	may	263	0	263	637	0	637	1863	18	1845	3715	41	3674	8078	40	8038	12182	90	12092	7672	46	7626	34175		may						
	jun	307	5	302	647	7	640	1825	13	1812	3746	27	3719	8109	62	8047	11617	91	11526	6936	47	6889	32935		jun						
	july	446	12	434	801	35	766	2102	64	2038	4174	130	4044	9107	226	8881	12966	341	12625	8106	178	7928	36716		july						
	aug	406	21	385	723	48	675	2026	111	1915	4207	236	3971	9085	480	8605	12834	672	12162	8207	343	7864	35577		aug						
	sept	389	18	371	787	38	749	2162	129	2033	4328	310	4018	9323	689	8634	13162	849	12313	8366	436	7930	36048		sept						
	oct	388	14	374	748	39	709	2236	129	2007	4698	233	4265	10061	703	9358	14752	930	13822	9331	520	8811	39546		oct						
	nov	360	14	346	732	59	673	2236	153	2060	4619	394	4225	10028	782	9246	14503	849	13654	9514	433	9081	39308		nov						
	dec	325	21	304	722	53	669	2335	156	2171	4904	341	4513	10736	552	10184	15886	840	15076	10654	387	10267	43242		dec						
2022	jan	351	31	320	666	53	53	2150	54	1958	635	412	5211	10752	957	9150	1517	1750	13867	10417	1125	9292	39534	2022	jan						
	feb	251	8	243	539	24	515	1862	83	1779	3874	182	3692	8608	571	8037	13280	1130	12150	8875	765	8110	34526		feb						
	mar	274	18	256	563	24	530	1872	74	1790	4146	80	4006	8569	553	8541	1434	198	13146	9533	898	8635	37328		mar						
	april	244	13	231	521	25	496	1827	90	1737	4010	250	3760	9290	795	8495	14311	1506	12805	9510	1104	8406	35930		april						
	may	224	6	218	483	14	469	1645	41	1604	3586	106	3480	7815	308	7507	12236	582	11654	7608	382	7226	32158		may						
	totals	4779	199	4580	9557	454	9103	29527	1403	28124	62428	3457	58971	141754	8747	133007	217402	16335	201067	141089	10517	130572	565424								

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

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/>
Death Counts from Table 8.

Here I have highlighted the peaks in the non-C19 death counts in yellow.

There were two highest impact shedding months increasing the non-COVID-19 deaths across all ages: July 2021 (the second dose to the elderly) and October 2021 (the third dose to the elderly).

Estimation of Shedding Deaths in England for the Unvaccinated (UnVaxed) and the Vaccinated (Vaxed) for the first 17 months of the Pfizer-BioNTech Rollout

RAW DEATH Counts		ONS		Release July 6 2022		Jan 1 2021 to May 31, 2022								
10+		UnVAXED		Shedding deaths		Shedding VAXED deaths								
		Non-C19				Non-C19				Non-C19				
		ACM	C19	Non-C19	Excess Non-C19 (>1397)	ACM	C19	Non-C19	Excess Non-C19 (>7857)	VAX Death Counts <21 days	Shed Death Counts >63 days	Iatrogenic (Vax & shed)		
2021	Jan	61369	28364	33005	31608	11808	3951	7857	0					
	Feb	23938	9165	14773	13376	2487	3543	19944	12087					
	Mar	9788	1646	8142	6745	31283	2020	29263	21406					
	Apr	5212	308	904	607	31930	553	3133	22480					
	May	3949	107	3842	2445	34410	235	34175	26318					
	Jun	3343	137	3206	1309	33187	250	32935	25178					
	Jul	3439	493	2946	1549	37702	986	36716	28859					
	Aug	6884	849	6035	4638	36488	1911	34577	26720					
	Sep	3229	750	2479	1082	38517	2469	36048	28191					
	Oct	3191	663	2528	1131	42214	2668	39546	31689					
	Nov	3158	793	2365	968	41992	2684	39308	31451					
	Dec	3544	1017	2527	1130	45562	2320	43242	35385					
2022	Jan	3238	1017	2221	824	44026	4492	39534	31677					
	Feb	2192	371	1821	424	37289	2763	34526	26669					
	Mar	2198	287	1911	514	40331	3003	37328	29471					
	Apr	1954	273	1681	284	39713	3783	35930	28073					
	May	1517	120	1397	0	33597	1439	32158	24301					
		142143	46360	95783	72034	Totals	605536	41112	564424	430855		43088	420194	463282
											From ONS Table 9	From ONS Table 9		

Lowest Non-C19 death counts (to estimate background deaths).

Estimated Quantitation of Shedding Deaths In England, January 1, 2021 to May 31, 2022

	Unvaxed Deaths (n)	Vaxed Deaths (n)	Ratio Vaxed /Unvaxed	Total
ACM	142143	605536	4.26	747679
C19	46360	41112	0.89	87472
Non-C19	95783	564424	5.89	660207
Estimated Non-C19 Shedding Deaths (Excess Above Background Nadir)	72034	430855	5.98	497559
Estimated Non-C19 Shedding Deaths (Onset Interval >63 days)	N/A	420194		
Average		425525		
Estimated Direct Vaccination Non-C19 Deaths (Onset Interval <21 days)	N/A	43088		43088
Estimated Total Iatrogenic Deaths from Vaccination	72034	468613	6.51	540647
Lives Saved by Vax	-5248			
Net Outcome of Vaccination (Number of lives lost due to vaccination for every life saved)	1			-103
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarr iages/deaths/datasets/deathsbyvaccinationstatusengland				
England Population July 1, 2021 was 51,786,812				
ONS Raw Death COUNTS by Vaccination Status for All-Cause Mortality (ACM), COVID-19 (C19), & Non-COVID-19 (Non-C19) Associated Deaths				
10+ age groups				
January 1, 2021 to May 31, 2022				
Unvaxed = unvaccinated				
Vaxed= ever vaccinated with at least one dose				

The % of non-C19 deaths due to shedding was estimated in the unvaccinated at 75.2%, for the vaccinated it was 75.4% and for both it was 75.36%.

However, according to the ONS Bulletin there were an additional 71,318 vax related deaths that were excluded as the details of the first dose and 3rd were provided but not for the second dose. If we assume 75 % of these deaths were due to shedding then there were an additional 53,489 shedding deaths, for a total of

551,048 total shedding deaths in England over 17 months.

The total for iatrogenic is now 551,048 (shedding) plus 43,088 (direct vaccine deaths) for a total of **594,136 iatrogenic deaths.**

England had a 6.79-fold (594,136/87,472) increased vaccination associated deaths over COVID-19 deaths for the first 17 months of the vaccine rollout.

According to Dr. Wilson Sy of Australia, about 74% of the excess deaths in Australia were caused by the intervention, the COVID-19 mRNA vaccines. Thus, Australia did not suffer a COVID-19 pandemic but an iatrogenic pandemic relating to the use of gene therapy products inappropriately as vaccines.

[Sy, W. Australian COVID-19 pandemic: A Bradford Hill analysis of iatrogenic excess mortality. In: Too Many Dead- An Inquiry Into Australia's Excess Mortality (© Australian Medical Professionals Society) Red Union Publishing , Bowen Hills QLD 4006, Australia, 2023. pp 470.

[https://8630368.fs1.hubspotusercontent-na1.net/hubfs/8630368/Lite_Too-Many-Dead-PDF-with-Cover-MQ-16112023%20\(2\).pdf](https://8630368.fs1.hubspotusercontent-na1.net/hubfs/8630368/Lite_Too-Many-Dead-PDF-with-Cover-MQ-16112023%20(2).pdf).

Data from Our World in Data shows for 29 countries that the vaccination associated deaths on average were 1.7- fold higher than the number of deaths associated with SARS-CoV-2 infection (2021 to 2023).

Sakura K, 2024, OSFPreprints: globally, “excess deaths due to vaccination were higher than COVID-19 deaths”. [<https://doi.org/10.31219/osf.io/zv6j8>].

**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	559,533	426,602	72,034	498,636	5.7-fold	
100%	11.6%	88.1%	13.4%	74.7%	3.1%	57.0%	9.8%	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.-mariann-laderoute-jun-01-2024-regina-saskatchewan.html>

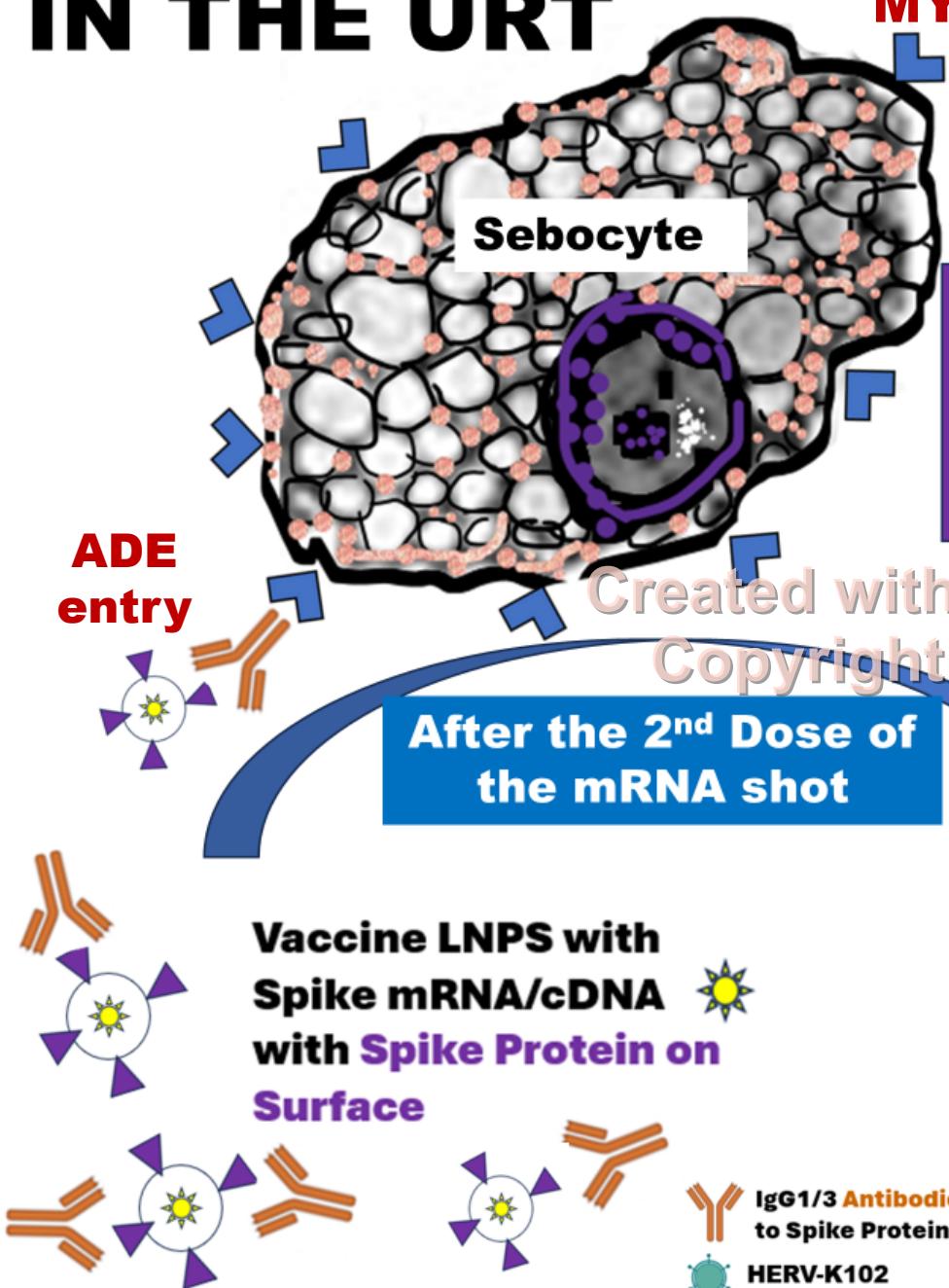
<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsbystvaccinationstatusengland> Released July 6, 2022 Covering deaths in the 10 + age group and January 1, 2021 to May 31, 2022.

<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).

Complement binding spike IgG1/3 versus non-complement binding IgG4 antibodies

- **Shedders of the bioweapons comes from those who have had at least 2 doses of the mRNA gene therapy products and shed for three months.**
- **Only the mRNA or adenovirus DNA vaccines induce the IgG1/3 spike antibodies in the URT and is very RARE during natural infection.** [Guerrieri M, et al., Dec 2021; Aksyuk AA, et al., Dec 2022.]
- In blood get conversion of dangerous spike IgG1/3 to “tolerogenic” IgG4 at **6 months after 2nd dose or with the 3rd dose**. However, the conversion to IgG4 is not the case with adenovirus (Ad) vaccines. [Irrgang P et al., Dec 2022]. This helps to explain the higher risk of microclotting/myocarditis for the adenovirus COVID-19 vaccines, why they were sequentially pulled from the market, and why they are no longer being produced.
- The Cleveland Clinic data [Shrestha NK et al., Dec 2022] appears to imply the spike IgG1/3 is NOT converted to IgG4 in the URT. Thus, shedding poses a higher risk than the direct inoculation of the mRNA gene therapy shots.
- People who may be at the **highest risk of shedding** are those who were infected before receiving the COVID-19 mRNA gene therapy shots because IN THE BLOOD they do not switch the dangerous spike IgG1/3 to IgG4 [Kiszely P et al., August 2023], such as medical personnel or those who worked in nursing homes.
- The younger one is the more likely they were not vaccinated until **after** they were naturally infected. Thus, a higher proportion of the younger population may have been at increased risk of shedding deaths **due to the persistence of complement binding spike IgG1/3 ANTIBODIES**.

IN THE URT



MY Hypothesis

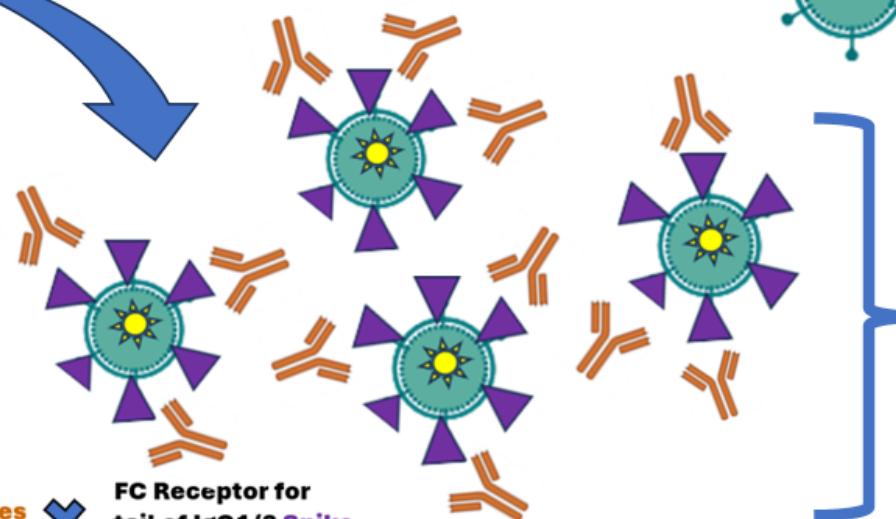
By Cell Lysis

Sheds Protector
HERV-K102
Particles

Evaluation only.

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Pre-activates the Interferon Response
and the HERV-K102 Protector System
in the New Host Creating HERD
Immunity



To help mitigate the risk of dying from emerging or pandemic RNA viruses:^{*}

1. keep your Vitamin D3 levels optimal,
2. adopt a healthy lifestyle, weight, and maintain a healthy blood pressure,
3. where required (such as those with comorbidities/hypertension), reverse & prevent immunosenescence of macrophages with alpha-fetoprotein (AFP) antagonists such as: daily zinc, genistein, 7 keto-DHEA (in USA but not legal in Canada), ivermectin [Laderoute M, Open Heart, May 10, 2021. <https://openheart.bmj.com/content/8/1/e001635.responses>], near infrared, etc.
4. AVOID adaptive immunity vaccines that generate IgG1/3 spike antibodies to the RNA virus because they cause ADE infection of macrophages and likely abolish HERV-K102 trained innate immunity needed for SURVIVAL.
5. In my opinion, NEVER ACCEPT an mRNA gene therapy product as a “vaccine”.

* These recommendations should not be viewed as medical advice but as general scientific opinions.

Summary

1. Evidence is provided that shockingly suggests shedding of bioweaponized HERV-K102 exosomes from sebaceous glands in the URT may have been the single most important cause of death during the years 2021, 2022 and 2023 in terms of pandemic/excess deaths.
2. Generally, the iatrogenic deaths associated with vaccination (early direct vaccine deaths and later onset shedding deaths) were about 1.7 fold higher than the levels of death due to COVID-19 in 2021 to 2023 worldwide.
3. These were stealth deaths involving a bioweaponized gene therapy shot that was inappropriately used as a vaccine. Many of these persons would not realize what was happening and would have died suddenly or at least unexpectedly since susceptibility was not per se related to older age or poorer health status. Rather, what mattered was whether or not, the person had been infected with SARS-CoV-2 prior to receiving at least 2 doses of the mRNA vaccines. This explained why the excess risk of death was found in all age groups (and relatively higher for the younger adults; ie., 25 to 54 age groups). Also a search of the VAERS database shows for deaths after 2 doses that occurred beyond 120 days, that many of these occurred outside of hospitals consistent with sudden or unexpected deaths.
4. In addition to workers dropping out of the medical professions due to vaccine mandates/censorship, **iatrogenic injuries and deaths** may have contributed to the **current shortage of nurses and doctors because they too were likely infected prior to mRNA vaccination which placed them at higher risk.**

Based on my expertise these would be my recommendations for consideration:

1. Governments **MUST** link the mortality rate and raw death count databases to the COVID-19 vaccination record to help determine the true risks versus benefits of the COVID-19 vaccines.
2. In my opinion the alleged fraud of Pfizer regarding the use of clean LNPs for clinical trials using process 1 and dirty ones for mass vaccination using process 2, could be further pursued in the courts with the purpose of recovery of taxpayer dollars to help deal with compensation to the vaccination injured or killed.
3. It is very clear that the risks of the mRNA gene therapy technology well exceeded the benefits in England and the use of such products on a mass scale could be considered by some as being akin to genocide. Consideration might be given to amend the Constitution to **ban forever the use of mRNA gene therapy products as "vaccines" in humans and animals.**
4. There may be a need to examine if the mandatory of vaccines and/or other medical interventions might be viewed as unconstitutional given the risks of shedding particularly to the unvaccinated.
5. **To keep the blood, organs and tissue supply safe** it may be useful to support the further development, evaluation and validation of using HERV-K102 activation (PCR and/or by serology) as a screening tool to guard against emerging or unknown pathogens (including novel toxins like the spike protein or even endotoxin) that may be transmitted via these biologics.
6. Clearly there is a need to fund research on the risk of mRNA (LNPs) and cDNA (viral vector) gene therapy products for impact on the contamination of HERV-K102 particles (regardless of purpose of the gene therapy) including the issue of the isotypes of antibodies such as spike antibodies in the URT.
7. More research is needed on the protection mechanisms of the HERV-K102 protector system: including what besides vitamin D3, vitamin C and probably ivermectin favours HERV-K102 and