NATIONAL CITIZENS INQUIRY

Regina, SK **Day 3**

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EVIDENCE

Witness 2: Dr. Marian Laderoute
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Kassy Baker
Welcome back to day three of the National Citizens Inquiry in Regina. We have with us our next witness and we're pleased to welcome Dr. Marian Laderoute. She will be speaking to us regarding her research on shedding, vaccine shedding. And just by way of a very brief introduction, she will of course be taking us through her experience in some detail. But just as we prepare to hear from her, I'll let you know that she has a PhD in medical sciences immunology from the University of Alberta. And she has had a career in pandemic and infectious disease prevention since 1996, working with both Health Canada and Public Health Agency of Canada. Can you hear me, Dr. Laderoute?

Dr. Marian Laderoute
I can. Can you hear me?

Kassy Baker
We can. Can you please just begin by stating and spelling your name for the record, please.

Dr. Marian Laderoute
My name is Marian Laderoute. Marian is spelled M-A-R-I-A-N. Laderoute is L-A-D-E-R-O-U-T-E.

Kassy Baker
Thank you very much. I understand that we have a presentation. Are we able to put this up on the screen?

Dr. Marian Laderoute
Okay, I'll just open it and—just a moment here.

Kassy Baker
No problem.

Dr. Marian Laderoute
Okay, now do you see it?

Kassy Baker
Not yet.

Dr. Marian Laderoute
Okay, just a moment. I'll go back.

Kassy Baker
Thank you.

Dr. Marian Laderoute
Just a moment here. I'll go back. And I think I have to share my screen first, so. Okay, I'm pressing the share button. Can you see it now?

Kassy Baker
Not yet, no.

Dr. Marian Laderoute
Okay, well then how about this? Do you see that?

Kassy Baker
We can see that, I believe.

Dr. Marian Laderoute
Okay, so I'll go to the beginning. All right, so I'm set.

Kassy Baker
I think we're ready. I'll let you take it from here.

Commissioner Drysdale
Just a moment.

Kassy Baker
Oh, one moment. My apologies, I forgot to have you swear in. Thank you very much Commissioner Drysdale. Dr. Marion Laderoute, do you promise to tell the truth at these proceedings herein?

Dr. Marian Laderoute
I most certainly do.

Kassy Baker
Very good. Thank you.

Dr. Marian Laderoute
Okay, my talk today is about shedding of the spike mRNA gene therapy products. And I'll be looking at the mechanisms, and I'll be focusing mostly on mortality outcomes.

So there is a high likelihood of a causal link between the injections of the mRNA COVID gene therapy shots and sudden early death involving myocarditis, which on average occurs six days with a median of three days after the last shot. The rate of myocarditis has increased by 2300% in 2021, of which 3% resulted in deaths. These are the reports to the VAERS database. And there have been many calls for the halting of the use of these mRNA shots because of the problems of micro clotting and myocarditis.

However, others like myself are of the opinion that the mRNA gene therapy vaccine approach is so dangerous as a stealth bioweapon, that it and vaccine mandates should be banned forever, and this immediately written into the Canadian Constitution. And I hope to convince you of this by the end of my testimony today.

So I'm bringing you my testimony based on a career in pandemic and infectious disease prevention for Canadians since 1996. So I was actually hired in direct response to the interim report of the Krever Inquiry into the tainted blood scandal of the eighties and nineties. So I was hired into the Blood & Tissues Division in the Bureau of Biologics at Health Canada. The efforts here led to expert and public consultations which resulted in the establishment of a voluntary moratorium on xenotransplantation, which is the implantation of animal tissues into humans. In this way, the issue of xenozoonotic infections causing a pandemic in Canada was alleviated. And I welcome you to download and have a look at this report, which has received many praises internationally.

After this, I was hired by the LCDC [Laboratory Centre for Disease Control] to develop risk mitigation measures against emerging zoonotic diseases, including the development of a blood donor—sorry, my picture is in the way—of a blood donor screening test. 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 that we identified as HERV-K102 [human endogenous retrovirus K] on chromosome 1q22, which generated these foamy macrophages in response to viral infections.

So the Public Health Agency of Canada 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, both in the body and in the test tube, and that it generated these foaming macrophages. We now know that these foamy macrophages provide this important trained innate immunity.

So trained innate immunity actually provides what we call heterologous, or nonspecific protection against pathogens and cancers. And it actually includes pathogen neutralizing innate antibodies, as well as the innate T-cells that recognize surrogate markers—in this case, the HERV-K102 envelope protein that is expressed on cells that are infected with

viruses, and which are actually also captured on the viruses as they bud from the infected cells.

Finally, it's believed that the HERV-K102 particles themselves can kill virus-infected cells in tumour cells by undergoing lytic infections. In contrast, in the normal cells, the HERV-K102 simply integrates and waits at the ready to pounce if the intruder enters the cells.

Now, what's really important to understand is that HERV-K102 particle entry into cells is able to provide an alternative means to not only activate, but to quickly amplify the critical type I interferon response needed for COVID recovery. And in fact, it explains how, in a humanized mouse model of mild COVID-19 disease, that macrophages were somehow able to achieve this.

The most important evidence, however, to date is that there is evidence of HERV-K102 increased integration in a cohort of individuals that are known to be resistant to HIV acquisition. And this is the famous cohort of the HIV-exposed seronegative cohort from Nairobi, Kenya. So this actually argues that high HERV-K replication pre-activation may strongly protect against HIV infection, and where HIV-1 is considered pandemic virus.

Now in the paper below—this is a preprint available since December of 2023—it is suggested that foamy macrophages and the HERV-K102 replication are key also to the recovery from COVID-19, the disease caused by SARS-CoV-2 which represents a second pandemic virus. Indeed, HERV-K102 at [chromosome] 1q22 may have helped ensure the survival of the human species from RNA epidemics that would have been prevalent at the time of encounters with other hominins who subsequently went extinct. Taking all this evidence together, it appears the crucial host defence mechanism of macrophages promotes survival against pandemic RNA viruses.

So these two papers represent our data showing that this virus replicates both in the body and in the test tube. So we—in the first paper up here at the top, the 2015 paper—we're claiming that HERV-K102 is the elusive foamy retrovirus of humans. Now, we don't really understand foamy retroviruses very much, except to say we know that they're non-pathogenic, they like to replicate in the sebocytes and sebaceous glands, and that they're known to co-evolve with the host. So the latter suggests that it plays a role in human survival.

Now when the macrophages start producing the HERV-K102 particles, they take on this foamy appearance, which is shown here by electron microscopy. And these vacuoles contain hundreds and thousands of these particles that are 100 nanometer in size on average. And all their physical characteristics are identical to the CD9 exosomes that are known to be released from macrophages.

Kassy Baker
Sorry, Dr. Laderoute. I'm just hoping that we can pause here for a moment and just clarify what you've told us up until this point. So please do correct me if I'm wrong, but I think what you've told us is that through your research, you have identified particles that essentially—or cells perhaps is the better word—that bestow particular immunity against viruses. And you've identified them as these foamy microphages, is that correct?

Dr. Marian Laderoute

We know that macrophages are protecting against pandemic diseases, and nobody really knew why. And what I'm saying here is what we discovered at the Public Health Agency of Canada is that these macrophages, these foamy ones, actually express the HERV-K102 particles. So after day six or seven, they will actually lyse and release the particles. And I just have to say that Russ et al. recently confirmed our findings. Does that help?

Kassy Baker
I believe so.

Dr. Marian Laderoute
Okay. So in order to really understand what shedding is all about, you have to understand what antibody-dependent enhancement of infection into macrophages really is. So we call that ADE. So during natural infection, progression to severe COVID-19 is associated with the early onset of these spike protein antibodies. This is all part of the adaptive immunity that occurs before the innate system has cleared or inactivated SARS-CoV-2.

So in other words, the spike antibodies cause progression to severe COVID-19 when the SARS-CoV-2 virus is present. It doesn't prevent disease. So this raised a red flag as to: Why would you use COVID-19 vaccines designed to produce antibodies to the spike protein of SARS-CoV-2, as this would cause harm and not protect the host?

So the monocytes and the macrophages do not express ACE-2. So the only way that SARS-CoV-2 can get inside the macrophages is through this antibody-mediated dependence on the spike antibodies. So when SARS-CoV-2 enters into these macrophages by ADE, this will actually block the critical launch of the HERV-K102 protector system, which we need for recovery and for survival.

So this is why the IgG1 and 3 [IgG1/3] antibodies to spike protein and ADE are so dangerous. It also explains how it is the COVID-19 vaccines were doomed not only to failure, but to increase risks of death upon subsequent exposures to the SARS-CoV-2 virus.

I would like people to understand that there's no adaptive immunity vaccine that generates antibodies to the RNA spike protein of any emerging pathogen that can be considered safe, due to the well known and experienced problems of ADE.

So in this slide, I'm just trying to show you a picture of what this kind of looks like. So down here below, I have these protector foamy macrophages that are producing the HERV-K102 particles. And this blue V is actually representative of the Fc receptor for the tail of the IgG spike antibodies. And once the antibody binds to the antigen, it enters the cells.

So it's through this mechanism, this ADE, that SARS-CoV-2 enters inside the protector cells and converts them to a disease-causing cell which actually produces tons of the SARS-CoV virus, rather than the protector one.

And what I'm trying to illustrate here on this slide is that it doesn't have to be restricted just to the SARS-CoV-2 virus. It could be the actual free spike protein. It could be the vaccine lipid nanoparticles that have the spike protein on it. And it can even be, as I will discuss later, the HERV-K102 particles that become contaminated with spike protein. These, too, can also enter into these cells and convert them to the bad, or the disease-causing cell types. So in my opinion, this is what really is going on with shedding.

Now we heard from Dr. Kory this morning the different methods of shedding, but most people believe it's through the exosomes from the upper respiratory tract. So these are the sebocytes. Now sebocytes are the cells of the sebaceous glands found in skin and in all the mucosal tissues. And under normal circumstances, they actually just produce the HERV-K102 particles and release them by cell lysis on day seven.

So as shown here in the green are these protector HERV-K102 particles that when shed to the new person induces the critical interferon response as well as the HERV-K102 protector system. And this is what generates the herd immunity.

Now in people who have received the second dose of the mRNA vaccine, the lipid nanoparticles that they've been injected with contain the spike protein. So this then, through ADE, allows the contamination of the HERV-K102 particles into these—it transforms them into these bioweaponized exosomes that promote high risk of deaths due to micro clotting and myocarditis when shed to others. And the most important thing to realize about these exosomes is that it actually represents antigen antibody interaction, which, unfortunately, when it is IgG1/3 will cause complement activation and really initiate that dangerous coagulation cascade.

Kassy Baker
Dr. Laderoute, if I can just make one more clarification at this point. I just want to be sure that I understand and that our viewers of course understand as well. I believe what you've said, and again please do correct me if I've misunderstood, is that the spike protein—whether through natural infection or through a vaccine—when it enters the body, it can essentially transform healthy cells that would normally help us fight infection and turn them into dangerous infecting cells. Is that sort of more or less accurate to say?

Dr. Marian Laderoute
Yes, I think you've got it, Ashley. But may I continue, because this slide also deals with something similar. So most people listening today know that Vitamin D3 actually protects against the onset of severe COVID. It actually protects against many all-cause mortality, but let's just focus on COVID for today. So what it does is it essentially downregulates the adaptive immune system and favours the innate immune system, including the activation of the HERV-K102 particles in these cells.

So it turns out that Vitamin D3, when it's optimal—greater than 50 nanograms per mill [mL]—this blocks the ability of the SARS-CoV-2 to convert the protector lipid body negative foaming macrophages to the lipid body positive dangerous ones that are actually producing the SARS virus. So the Vitamin D is preventing this apoptosis resistance and is preventing the onset of immunosenescence, which we know causes chronic illness.

So if we look at the exosomes in plasma from patients that are infected with COVID-19, first of all most of the exosomes are coming from macrophages, and these are CD9 positive. If we look at the ones that are derived from mild patients, we see they have these expression of proteins that are involved in these functions, which indicate to me that these exosomes are probably HERV-K102 coming from the lipid body negative foamy macrophages.

In contrast, when we go to the more severe forms of COVID-19, we see different types of proteins that are being captured as exosomes. And these appear to be coming from the lipid body positive, the dangerous disease-causing foaming macrophages, which here it's very

clear that they're provoking microclotting, complement activation, and dysregulated inflammation.

Now it turns out, when there's a transition from mild COVID to severe, we lose about 75% of the beneficial exosomes. And in fact we get about a 75% drop in the green, which is your CD9, the macrophage-type exosomes, whereas these purple ones are the CD41a, which is coming from the platelets.

So in addition to that, Bansal et al. had studied the production of the exosomes following the Pfizer vaccination. So it turns out they couldn't demonstrate any exosomes at all until day seven, which fits with the known history of the HERV-K102 particles. They're released on day seven. But on day seven, they could not detect any spike protein in these exosomes.

Now these exosomes are CD9, telling you they're coming from macrophages. However, by the 14th day after the first dose, they did see some very, very weak signal of spike protein contaminating these exosomes. However, 14 days after the second dose, they showed a very, very strong signal, as shown here. And this tells me that first of all, the lipid nanoparticles, they do have the spike protein on the particle surface. And secondly, it tells me that these antibodies, these IgG1/3 to the spike protein, are actually focusing the lipid nanoparticles to the macrophages and sebocytes.

Now this group also showed that by four months, neither the IgG1 or 3 antibodies or the exosomes were detectable. So if we extrapolate that information to the upper respiratory tract, we can say that it looks like shedding can last up to three months after vaccination. Now in this other paper quoted here, they provided evidence that the antibodies themselves were also aerosolized from the upper respiratory tract and transferred to third parties, such as in this case, captured on their masks.

So I just wanted to reiterate that the sebocytes, these are the main cell types of the sebaceous glands that are found in skin and the mucosa. They can be with or without hairs. And we know now that these sebocytes, they have the identical morphology of the lipid body negative foamy macrophages. And we know that they do express HERV-K102 because Nelson et al. showed it both in vivo and in vitro.

And it turns out sebocytes can become activated like the normal macrophages. And once they're activated, they can be infected by SARS-CoV-2 through the classical ADE mechanisms, which involves this Fc receptor for IgG. And it's called the R2A receptor, which is CD32. And this issue of the activation of the sebocytes indicates the contamination of the lipid nanoparticles with endotoxin could be playing a role in helping to promote the bioweaponization of the exosomes.

So this is the famous Cleveland Clinic data, which shows that depending on how many doses you've had, it determines how likely you're going to be infected with SARS-CoV-2. Now what I find interesting about this is that, to me, it implies that the spike IgG1/3 in the upper respiratory tract is not being converted to IgG4, even after multiple boosters. So the problem with the vaccine is that it contains the spike protein apparently on the outside of these lipid nanoparticles. And the spike protein is very toxic. And worse, it causes abnormal micro clotting, which involves a slightly different confirmation of the fibrin clot. And what's kind of interesting too, is endotoxin or lipid polysaccharide also can do this.

Now, there have been numerous reports of symptoms in pathologies that are identical to the adverse effects of the mRNA vaccines. But this has been observed in people who were not vaccinated but who were recently in contact with people who were recently vaccinated.

So has there been any evidence for excess deaths or sudden unexpected deaths? And I think we need to acknowledge that Edward Dowd was one of the first to approach this problem. And he reported that there was excess non-COVID deaths amongst younger people, and many of these involved these sudden deaths, so the SADS [Sudden Adult Death Syndrome]. So this is where the concept of SADS and the vaccines came to be.

Now, more recently in a FLCCC webinar, Mary Pat Campbell provided this data which shows in the 16+ who were vaccinated, you got this excess all-cause mortality, particularly in 2021. Now also reported by Edward Dowd was that this really happened quite a lot, very strongly in the third quarter of 2021, and persisted into the fourth quarter.

But what I find really interesting about her studies was that she provided an average by age group. And we can see here for the 0 to 24 age group, there was a 12% increase in all-cause mortality over this time. Three per cent of this were due to COVID deaths, and 9% were due to non-COVID.

And so if we look at the next age group, it was 31%, where there was 10% COVID deaths and 21% non-COVID deaths. So if you take this non-COVID percentage and as a ratio over the COVID-19 percentage, you end up with these non-COVID-19 to COVID-19 death ratios, which in my mind provides a lovely index of the issue of the unexpected and excess non-COVID deaths. So I use this index to examine as a proxy for shedding.

Now I have to qualify the data before I can show it to you. And that is to say, this data is the data from the UK ONS, which stands for the Office for National Statistics. And they claim right in their bulletin that deaths that occurred on the day of vaccination count as vaccination-associated deaths. Now Professor Norman Fenton and colleagues indicated that the ever-vaccinated totals that were provided by the ONS in these documents appear to have been manipulated to essentially discount the deaths that occurred in the first 14 days following the vaccination.

But when I saw the data, I saw that the problem was easily overcome by manually adding up all the individual age standardized mortality rates for each vaccination category, as shown in this slide. So this is the all-cause mortality, and this is the actual per 100,000 patient years. And this is the actual rate provided by the ONS for the unvaccinated—so for the first 17 months of the vaccine rollout.

Now, what they claimed for the Ever Vax—and Ever Vax means people who received at least one dose of the vaccine—here we see that in every case, they're claiming the rates were much lower. But if you actually go into the database and pull out the actual numbers for each subcategory of vaccination, you see that, in fact, the numbers were much higher for all the vaccinations, with the exception of February. So from this, I was able to recompile the data so that you actually have the actual rate for the Ever Vax by all-cause COVID-19 and non-COVID-19 mortality.

So when you have this ratio of Vax to Unvax, it means when this number is over one, it means that the rate in the Ever Vax was much higher than in the Unvax. So for the most part, we see here it's always over one. So that's telling you that the vaccines are basically killing, or there's higher risk of death if you were vaccinated.

Now, a very important point is that for 2021, had the ONS revealed the true data—so across the board for these numbers—in my view as a previous regulator for Health Canada, it means nobody would have continued to use the COVID vaccines worldwide had they

published this data. The second thing you would notice is, for all-cause mortality there is only one month where there was some evidence for benefit.

And in this particular month, what happened was 95% of the people who were immunized—these are mostly older people—95% only received the first dose. So you're actually seeing the benefits of trained innate immunity, which actually decreases all-cause mortality. So it was quite significant for COVID-19, but perhaps not as powerful for non-COVID mortality.

So if you look at the COVID-19 mortality, you can see that, as we all expected, with time there would be a higher risk of death with time, which represents this problem of ADE. And in the non-COVID mortality, you can see that there's onset is occurring sooner, faster, and at much higher levels. And this increased risk of death for non-COVID-19 mortality relates to the vaccination-associated deaths—so both the early and the later, which I'm calling shedding. I will talk about these 71,000 vaccination-associated deaths that were excluded from this analysis in a later slide.

So I'd like to acknowledge that Dr. Jessica Rose was able to plot my data, and it's given here. So this is that index that I told you was probably a good marker for shedding. So this is the non-COVID-19 mortality over the COVID-19 mortality. In blue is the vaccinated and in the orange is the unvaccinated. So following the first dose, there's not much difference. But when the second dose was being administered, you can see that there was a huge increase in this index, and it actually lasted about three months which is consistent with shedding.

And there is a corresponding mirror image of: what is happening in the vaccinated is actually being reflected in the unvaccinated. So when the risk goes down, it also goes down in the unvaccinated. So overall, when you consider this data, the only real way you can explain this is through shedding.

So there were two key periods when negative excess all-cause mortality was observed in the UK. And when you get this negative excess, it's because of the heterologous protection by trained innate immunity. So Omicron, which was kind of like an attenuated virus, induced a little bit of it and we really saw quite a lot of it following the first dose, as I already mentioned.

Now in this slide, I'm trying to illustrate the temporal changes to the COVID-19 and non-COVID-19 mortality rates in the unvaccinated by the dosage of the vaccinated. So to make it more understandable, I'm going to start with E, which is Omicron from January to February. So with the onset of Omicron, which infected both the vaxxed and unvaccinated, they had a significant reduction in the COVID-19 as well as the non-COVID-19.

If you now look at the first dose of the vaccine, which was only given to the vaccinated, we basically see the same picture as we did with Omicron. But now the vaccine is causing death, non-COVID deaths in the vaccinated, but of course not the unvaccinated because they're not receiving the vaccine. So I would submit to you that in A is the first evidence ever that is consistent with HERV-K102 particle protection being horizontally transmitted to third parties to give you your herd immunity.

Now in B, after the second dose when we know those dangerous IgG1 and 3 antibodies to spike protein BMA, we can see this whopping increase in COVID-19 mortality in both the vaccinated and unvaccinated. So this suggests to me that these are the protective particles after the first dose, and they are being converted to these deadly exosomes after the second dose. If you look at the non-COVID-19 for the unvaccinated results, here you can see over

time there is a sequential decrease, apparently, in the number of protector HERV-K102 particles that are being transmitted—to the point where by the fourth dose, from May to June of 2022, we're now seeing most of those exosomes are actually dangerous.

So in this slide, I'm showing that it's extremely rare for a traditional vaccine to show deaths beyond 60 days. So this data covered 2015 to 2023 for all vaccines reported to the VAERS reporting system in the United States. So you can see here that in contrast to the rarity of cases where there's deaths that occur beyond 60 days, we see it's very common in the COVID-19.

Now it turns out for the COVID-19, a lot of these actually involved SARS-CoV-2 breakthrough infections, which is not found for traditional vaccines. So in reality, these late onset deaths that occur beyond 63 days could be due to SARS-CoV-2 infection shedding, or both. But fortunately, when we look at the ONS database, we can see that any case where it was revealed that the person was SARS-CoV-2 infected, this no longer is captured under the non-COVID deaths. It would be captured under the COVID-19 deaths.

So there were two tables of data from the ONS that provided raw death counts. And the first one is table eight, where they provided the death counts by age group. And they provided the all-cause mortality rates, the deaths numbers, and the COVID-19. And so I had to, in purple, calculate the non-COVID-19 deaths for each of the age groups and across the board. So what you can see here highlighted in the yellow, is that there were notable peaks that occurred in July and October of 2021. And July was when we had the onset of the second dose to the elderly, and October 2021 was the third dose to the elderly.

So by just taking the data provided by the ONS for the months January 2021 to May of 2022, these were the non-COVID total deaths that occurred. The lowest month was May of 2022. So I chose that as the background and subtracted it from these numbers, which gave me these numbers for the excess non-COVID-19. And it turned out for the shedding deaths for the unvaccinated, it was over 72,000. At the same time, the C19 or the COVID-19 deaths only amounted to 46,000. So the shedding was much higher in the unvaccinated.

Now, in the vaccinated, I did the same things, except January 2021 was when the lowest point was achieved. So I subtracted that number from all of these numbers, which gave me, in purple, the excess non-COVID deaths, which I'm calling our shedding deaths. So according to this, there was 430,855 case deaths that were potentially related to shedding at the same time in the COVID-19 deaths, for only 41,112, which represents about a ten-fold increase rate in the shedding deaths over the COVID-19.

Now, from the ONS table nine, it listed the deaths by onset interval. So it was very easy to count the number of deaths that occurred under 21 days, and that totaled 43,088. And for the deaths that occurred beyond 63 days, it was 420,194. The fact that these two numbers, the 430 and the 420, they're within 4% of each other, so it gave me confidence in the data.

If we look from all the totals, it turns out in England for those first 17 months, there were 5,248 lives that were saved by the vaccine. And I would submit to you that these were all due to after the first dose, which involved the trained innate immunity. At any rate, for every life that was saved by the vaccine, the vaccination process caused 103 deaths, which from a regulatory standard is obscene, actually, and it's certainly not acceptable. So if you look at the percentage of the actual non-COVID deaths that were due to shedding, you'll see that in the unvaccinated it was 75% and it was 75% in the vaxxed.

Now, I'm not sure if those two things are connected, but if you recall, I mentioned earlier that there was 71,000 deaths that were excluded from this analysis. So if we assume that those 75% were shedding deaths, then instead of having a total of just under half a million shedding deaths, it turns out it's over half a million shedding deaths in England over the first 17 months of the rollout. And if we add in the 43,000 and some odd early vaccination deaths, we get almost 600,000 iatrogenic deaths. Iatrogenic, meaning it was man-made, it was not naturally occurring.

Now there's a Dr. Wilson Sy of Australia who found that 74% of the excess deaths in Australia were caused by the COVID-19 mRNA vaccines. So he says Australia did not suffer a COVID-19 pandemic, but has suffered a man-made pandemic relating to the use of gene therapy products inappropriately as vaccines.

Now, it turns out that Sakura recently published data showing that 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 covering the years 2021 to 2023. So I attempted to estimate for Canada what the numbers would be. I came up with an average of 40,281 COVID-19 deaths for the three years from 2021 to 2023. There were approximately 85,490 excess non-COVID deaths, of which 7,865 would have been these early direct vaccination deaths, based on what we found for England at 9.2%. And the shedding deaths representing about 90% would have been about 77,645 people that suddenly—met their maker, I guess.

So we have to appreciate that the shedders of the bioweapons are only those who have had at least two doses of the mRNA vaccines. And only the mRNA or the adenovirus DNA vaccines induce the deadly IgG1/3 spike antibodies in the upper respiratory tract. So in the blood we get the conversion of this dangerous IgG1/3 to tolerogenic IgG4 at six months after the second dose, or with the third dose. However, this conversion to the IgG4 is not the case with the adenovirus vaccine. So this would help to explain the higher risk of micro clotting/myocarditis, for the adenovirus COVID-19 vaccines, and why they were sequentially pulled from the market. And then, in fact, they are no longer being produced.

Now, the people who are at the highest risk of shedding are those who were infected before receiving the COVID-19 mRNA gene therapy shots, because in the blood these people do not switch to the dangerous spike; they do not switch the dangerous spike IgG1/3 to IgG4. So the younger one is, the more likely they were not vaccinated until after they were naturally infected. So a higher proportion of the younger population may have been at increased risk of early vaccination injury as well as shedding deaths due to the persistence of these complement binding IgG1/3 antibodies to the spike protein.

So in order to mitigate the risk of emerging or pandemic RNA viruses—and I have to say these are recommendations, are not medical advice, but general scientific opinions—is first of all, keep your vitamin D3 levels optimal. And you should be tested once or twice a year. Adopt a healthy lifestyle weight and maintain a healthy blood pressure. Where required, such as those with comorbidities including hypertension, reverse and prevent the immunosenescence of macrophages with alpha-fetoprotein [AFP] antagonists such as daily zinc, genistein, 7 keto-DHEA, which is legal in the United States but not in Canada, ivermectin—I published an article indicating that ivermectin is also an AFP antagonist. And there's other things like near-infrared that you can do to help improve your situation.

But most of all, you should avoid any adaptive immunity vaccines that would generate IgG1 and 3 spike antibodies to the RNA virus, whichever is causing the emerging pandemic, because it would cause the ADE infection of the macrophages, which turns out to abolish

the HERV-K102 trained innate immunity that you need for survival. But most of all, in my opinion, never accept an mRNA gene therapy product as a vaccine.

So in summary, the evidence is provided that suggests that there is shedding that causes deaths and it relates to the bioweaponized HERV-K102 exosomes from sebaceous glands in the URT [Upper Respiratory Tract]. And this may have been the most important cause of deaths during the years 2021, ’22 and ’23. And these iatrogenic deaths, or man-made deaths, are associated with vaccination, which includes the early direct vaccination deaths and the later onset shedding deaths.

Now these were stealth deaths involving a bioweaponized gene therapy shot that was inappropriately used as a vaccine. So many of these people would not realize what was happening and would have died suddenly or at least unexpectedly, because 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 the two doses of the mRNA vaccines. So this helps to explain that excess risk of death in all age groups, including the higher propensity for the younger adults.

So in addition to workers dropping out of the medical professions due to vaccine mandates and censorship, iatrogenic injuries and deaths may have contributed to the current shortages of nurses and doctors, because they too were likely infected prior to the RNA vaccination, which placed them at higher risk. So based on my expertise, I would make the following recommendations that all countries pull out the COVID-19 vaccination record and link it to the mortality rates and raw death counts to actually determine the true risk versus the benefits of the COVID-19 vaccines.

In my opinion, the alleged fraud of Pfizer regarding the use of the clean lipid nanoparticles for the clinical trials that use process 1 and the dirty ones for the mass vaccination that used process 2, I think this could be further pursued in the courts with the purpose of recovery of the taxpayers’ dollars to help deal with the compensation to the vaccination injured or killed.

Now, it is very clear that the mRNA gene therapy technology risks well exceeded the benefits in England, and you could actually consider the use of these products on a mass scale as being akin to genocide. So I think we should consider that we need to amend the Canadian Charter of Rights and Freedoms to ban forever the use of the mRNA gene therapy products as vaccines in both humans and animals. And I even question the mandating of vaccines, because even this could be considered unconstitutional.

To keep the blood, organs and tissue supply safe, it may be useful to support the further development, evaluation, and validation of using the HERV-K102 activation methods as a screening tool to guard against emerging or unknown pathogens. And there is obviously a need to fund research on the risk of these lipid nanoparticles and the cDNA, the viral vector gene therapy products, for impact on the presumed contamination of the HERV-K102 particles.

And we need a lot more research to be done to understand how HERV-K102 protects humans against pandemic viruses. I have posted a case study that on my Substack that provides valuable insight on some of the symptoms of shedding and what might be done to minimize the risks of death.

So in conclusion, in my opinion, the mRNA gene therapy shots have converted the protector HERV-K102 particles that give you herd immunity to bioweaponized exosomes that cause

microclotting and carditis deaths. So gene therapy vaccines is an oxymoron. And I'll finish there. Thank you.

Kassy Baker
Thank you very much for your extremely interesting testimony. I have a few questions that I've made notes of as we've gone through, and I'm hoping that you can just give us a little bit more clarification. First of all, you used the term bioweaponized several times throughout your testimony. Can you explain why you've described it in this way?

Dr. Marian Laderoute
I think I'd have to say that I've been influenced by Dr. David Martin, who has explained that the genesis of the mRNA technology to be used as a vaccine actually came out of the Department of Defense from the USA. So he considers these mRNA vaccines to be bioweapons that cause death.

Kassy Baker
You also noted several times towards the end of your presentation that mRNA gene therapy, or the mRNA, what we've called vaccines—you've clarified that this is an mRNA gene therapy—should never be used for vaccines. And you underlined the word vaccines. In your opinion, are there potentially other applications for which mRNA gene therapy might be safe or effective for the treatment of humans? Or is it something that should always be avoided? Or can you answer that at this point?

Dr. Marian Laderoute
Well, there are some mRNA gene therapies that are not actually used as vaccines, and I haven't really studied the actual adverse event reporting for them, but they would tend to be less problematic. But here we're talking about pandemic and the survival of the human species. And as a vaccine, from what I can see here, if the vaccine is eliminating your only hope of survival, then it would be like a bioweapon. So my objection is primarily for uses of vaccine. But I'm also saying that if you do use it for another purpose, you have to examine what does it do to the HERV-K102 particles, and does it actually put you at risk of dying sooner due to infectious diseases or cancer?

Kassy Baker
Very good. Thank you for that explanation. I'd like to turn to the commissioners at this point to see if they have any questions for you. Commissioner Drysdale has a question.

Commissioner Drysdale
I have a couple of questions directly and perhaps indirectly, I think when you first started your talk, you talked about, was it a voluntary moratorium in Canada against the transplant of animal tissues into humans? Is that what you said?

Dr. Marian Laderoute
That's correct.

Commissioner Drysdale
Aren't they still doing that? Aren't they putting pig bells into people's hearts still in Canada?

Dr. Marian Laderoute
As far as I know, they're not. But what is very interesting is, after the first year of the vaccines that were used worldwide, the FDA actually allowed a compassionate use case of the transplantation of a pig heart into a human being. And so this would be, I think it was, yes, January 7, 2022. So this man of 57 years of age received a heart from a pig and he lasted two months, perhaps, and ended up dying because of a porcine CMV [Cytomegalovirus] infection.

So subsequent to that, there are now many, many cases of clinical trials that involve people who are brain dead being implanted. So unfortunately, what I see dangerous here is that the mRNA vaccine technology has convinced the FDA: "Oh well, we have the means to deal with any pandemic so we can go ahead with the xeno." But as far as I know in Canada we haven't allowed it yet.

Commissioner Drysdale
When did this voluntary moratorium come in, in Canada?

Dr. Marian Laderoute
I think, okay, so our forum was in 2007, and then we had a lengthy public consultation process conducted by third parties. And then it was only after that that it was formally announced. So that would be at least by 1998.

Commissioner Drysdale
Okay, thank you. I have a number of other questions here. When you're talking about in your attribution or, sorry, the way you determined or tried to estimate the deaths due to shedding or not, and we obviously, in the all-cause mortality, we see a jump in the deaths. How do we determine whether or not those deaths were either vaccine or shedding related, as opposed to we've heard testimony from other witnesses about how they were locking old people up for months on end, or people committed suicide, or all of the other things that may have been caused by the NPIs, the non-pharmaceutical interventions. Have you somehow screened out those or estimated those?

Dr. Marian Laderoute
Well, that would be part of the background that I was subtracting from the totals for each month.

Commissioner Drysdale
Okay, so that's how you tried to estimate that.

Dr. Marian Laderoute
Mm-hmm [yes].

Commissioner Drysdale
You also talked about, to some degree, multiple doses. And it appeared that in a first dose, the effect of shedding was not so great. On the second dose it was greater. I mean, we've also heard testimony of people getting five, six, seven doses of this stuff. I know you haven't studied it, but do you have any kind of an opinion as to what that might be? Is it an increasing risk? Is it a logarithmic risk? Perhaps that's not a fair question, but what are your opinions on that?

Dr. Marian Laderoute
Well, I provided you with data in that one slide where I showed that by the fourth dose, essentially everything that's being released as an exosome from the upper respiratory tract would be considered the bioweaponized exosomes. So there would be very few particles that were actually uncontaminated HERV-K102 particles to protect the host.

Commissioner Drysdale
Right. But we don't know what the effect of four, five, six doses would be, whether you'd be producing more of that in greater quantities or—

Dr. Marian Laderoute
Well, if we just go based on the data I presented for the fourth dose, it clearly indicates that by the fourth dose, there's no more HERV-K102 protective particles. And I would assume, based on other evidence, that this would continue with each dose.

Commissioner Drysdale
Right. Okay, one of the other things you talked about was when you were looking at the data and how they were reporting it, I think it was in the UK, that they counted as a vaccine death, a death that occurred on the first day. And you did some mathematical or arithmetic, I suppose, manipulations or analyses to try to add to that. But, you know, we know that the effects of certain things are not known for a long time.

For instance—and we talked about this in previous commission hearings—if I tested cigarette smoking for a month or two months, I'd not know that it caused cancer. And it takes certain things, certain irritants, if you will, medical irritants, to cause cancers and something else in the long term. And so what I'm guessing here is that we have no idea what the long-term effects of these vaccines might be, one year, two years, three years out.

Dr. Marian Laderoute
Yes. And your question is?

Commissioner Drysdale
Well, the question is exactly that we have no idea what the long term effects might be. You know, they're counting vaccine deaths one day after, and you were able to perhaps project that out reasonably to whatever period of time was, days or something. But we don't know if those vaccines will be causing deaths or damage to people a year from now or two years from now or three years from now. So we're missing that part of the data in your analysis, are we not, the long term effects of these vaccines on the body?

Dr. Marian Laderoute
Yes, absolutely. I just want to make a point about the issue of the shedding versus the integration. Now, the HERV-K102 is a retrovirus, so it contains functional integrase and reverse transcriptase. If that particle is being transfected with the mRNA coming from the vaccine, it means there's a much higher likelihood that there could be reverse transcription and integration into the human genome. So I didn't address that in my talk because there's only one case of a report. Unfortunately, the data were not provided that suggested that in humans there is this integration into the peripheral blood lymphocytes. So I didn't want to really address it, because we haven't really had a chance to look closely at the issue.

But most certainly, if there is integration into the host DNA, and in particular, for example, if it's the progenitor in the bone marrow that leads to the monocytes and macrophage lineage, this person might have to be on some kind of treatment for the rest of their life. Because if it's permanently integrated into the genome of the bone marrow cells, it could last the life of the person's existence. But we don't have that information yet.

Commissioner Drysdale
Well, that's interesting. I'm glad you brought that up, because we've had a number of people, a number of experts who've talked about the unknown side to this. First, these injections were started in December of 2020, so we've had them for a few years now. We don't know if they are integrated into the DNA of a person. We don't know if it was integrated into a DNA of a person, whether that's transgenerational. We don't know, or we suspect that even if you avoided getting the vaccine, that you can still get it through shedding.

We understand that they use E. Coli to produce this in the factory, and they never purified it properly, so there's E. Coli in this. And E. Coli is in the gut of every human, every living being on this planet, as far as I understand. So what you've described, Doctor, is a Pandora's box. And we have no idea what effect this may not just have on our loved ones, but on our loved ones to come, generation and generation from now. Perhaps that sounds incredible, but I hear that from experts like yourself over and over and over again. Am I overexaggerating this, or is this a clear potential, or a possible potential?

Dr. Marian Laderoute
To me there's no clear data that it has happened so far, but it wouldn't surprise me that we will come up with the data that shows there can be permanent integration into the genome, which means these mRNA vaccines are genetically modifying humans. But as I said, we don't actually have direct evidence of that yet.

Commissioner Drysdale
Well, I'm just—sorry, when you were answering the question I was looking through my notes, and one of the experts in the last day or so had rightly talked about—we were talking at the time about pregnancy, and the witness talked about thalidomide, and the witness also talked about another medical procedure.

Dr. Marian Laderoute

DES [Diethylstilbestrol]

Commissioner Drysdale
Right. And I have to say, I'd never heard of that before, which is incredible. And from the testimony, that was generationally carried, and I believe they said two to three generations out, you would still be suffering from this.

Dr. Marian Laderoute
Yes.

Commissioner Drysdale
So with it, go ahead. Sorry.

Dr. Marian Laderoute
No, but if it gets into the germline, which is, you know, less likely, but if it does get into the germline—after all, the HERV-K102 came in to the germline, and it's just a non-pathogenic foamy retrovirus—but if it gets in the germline, it will affect all generations to come. Yes, it's scary, I think.

Commissioner Drysdale
How is it possible that someone would have opened the door on something and not only sent it out to the world, but forced people to take it? How is it possible that people, not just in one organization—you know, it's easy to point the finger and say the FDA is evil, or Ken Drysdale is evil—but you've got FDA, Health Canada, you've got the UK, the NIH, I think it's the NIH in the UK, all over the world. How did these experts from all over the world not only open the Pandora's box, but force you to put your head into it? How is it possible?

Dr. Marian Laderoute
Well, I think that's the very important question, but personally, I can't answer that. It obviously involves corruption and a lot of evil and people who are only interested in monetary gain and not about the health or viability of even the human population.

Commissioner Drysdale
Well, Doctor, you were talking about shedding, and that in my mind, that's more or less, or not necessarily so, but more or less a non–contact thing. For instance, I breathe on you or something. But what does your research potentially have to say about our blood bank and our tissue banks, and all of those things? Does this extend into the tissue bank? Do these drugs survive in a blood sample? Do you know or do we not know that?

Dr. Marian Laderoute
I would say that I'm a blood banker from my original foundation of my education, and I would have to say that there should have been measures that should have been implemented ASAP to prevent the potential transmission of the spike protein, or even the virus, of course, through the blood supply. And I don't think those measures were taken. In fact, I think in the United States they just implemented something a few weeks ago, which is

long after the storm and the horse is out of the barn. So to answer your question, I believe the answer is, yes, that these things are a threat to all of these tissues—especially the semen donors for pregnancies, but also all tissues and all blood and blood products. So I don't think people were seriously considering how dangerous these mRNA vaccines really were.

Commissioner Drysdale
I asked this question of Dr. Kory earlier, and that is: If you consider shedding, and you consider the ongoing push in Canada for people and children as old as six months old to get boosters, because they're still pressing this now, have we created a self perpetuating system here? So, and what I mean by that is the CDC has reported, and Health Canada, I believe, has admitted that one of the consequences of the mRNA vaccine is an infection with COVID-19. So if you continue to get these COVID-19 shots, you're continuing to get infections, you're now shedding it to other people and causing infections, so is this a self-perpetuating closed-loop system that potentially we've created?

Dr. Marian Laderoute
Absolutely. The pandemic would have ended in May of 2021, I think it was, according to one paper, based on the natural evolution of the virus. But because they intervened with the vaccines, the vaccines were actually—and I've written about this in that paper that I published on preprints in December—that it's the actual use of a vaccine that causes IgG1 and 3 to the spike protein [that] caused the selection of variants. So every few months you got a new variant popping up because of the use of vaccine. So yes, I think it's very clear that the vaccines perpetuated the pandemic, and we wouldn't have it today. It would have naturally dissipated by May of 2021 had we not introduced the vaccines. So yes, every time someone gets immunized with these mRNA vaccines, it's probably affecting the health of many people around them.

Commissioner Drysdale
How difficult, technically difficult—given the magnitude of what you're talking about, and Dr. Kory talked about it as well—how technically difficult would it be for you to do a study or someone to do a study and select, I don't know, 100 non–vaccinated people, and take 100 vaccinated people and test both for the spike protein, or whatever other kinds of proteins you need to test for to determine exactly whether or not this is happening. And I guess, before you answer that question, I guess that doesn't necessarily say it's all shedding in the manner that you're talking about. It could be shedding through fecal matter, it could be shedding through skin transfer, but at least we would know that there's a transference between these two groups. So my question is just to reiterate, is this an impossible study to carry out? Is it impossibly expensive? Is it technically impossible? And has this been carried out?

Dr. Marian Laderoute
Well, I think Dr. Pierre Kory told us this morning that they did do such an experiment in a clinical trial, and they did find that there were 70% change in menstrual periods in the unvaccinated when they were exposed to the vaccinated women.

Commissioner Drysdale

Yeah, he did talk about that. It was only in women. So that's only, what, 50% of the population? I was just wondering how that might translate to men, considering they also reported that the vaccines affected both sexes differently. So it's not necessarily so that if a woman is affected in a certain way, then a man might not be infected in a different way.

Dr. Marian Laderoute
Yes, but there were there other studies that showed that in families when the parents were vaccinated, the children who were known never to have been exposed to the SARS-CoV-2 virus, they ended up with antibodies to the spike protein.

Commissioner Drysdale
I didn't want to hear you say that. It's also terrifying. Thank you, Doctor. I very much appreciate your time and your expertise. Thank you very much.

Dr. Marian Laderoute
Oh, you're most welcome.

Commissioner Kaikkonen
Thank you, Doctor. I'd like to go back to your roots a little bit. The Krever Inquiry, the HIV, the tainted blood scandal that so many individuals in this country died from—we saw that passage of accountability come about from the transition between the Red Cross and Canadian Blood Services as a consequence of that inquiry. Now you're suggesting that Canadian Blood Services is not putting in the protective measures that they should have, or at least being aware of the research of the potential repercussions and ramifications from their actions.

Do you see at some point in the future when—I call this the people's court, NCI—so when we get to the point of accountability for our officials, do you see another further transition from Canadian Blood Services to an organization that will be current in the research and will be protective of the people, both staff and donors, that are within the organization in the near future? Or at least in the future?

Dr. Marian Laderoute
Okay, I guess what you're asking is, would there be another COVID inquiry, another Krever Inquiry? And I think the answer would have to be, yes. But right now I'm not aware of the extent of the damage that has occurred. And some of these products are frozen for quite a period of time, so it may be a while yet before we actually know the extent of the damage done.

Commissioner Kaikkonen
So plasma is frozen for ten years. It's got ten-year term or maximum expiry date. So it might be ten years down the road before we would actually figure out what was done in the last three years?

Dr. Marian Laderoute
Yes, roughly.

Commissioner Kaikkonen
Thank you.

Kassy Baker
Are there any further questions from the commissioners?

Commissioner Robertson
Hi, I really appreciate this information, as scary as it is. We all have to realize having grandchildren. So I just want you to make sure you're saying that the more doses the vaccinated people have, the more infectious they are to the unvaccinated, and you produce more exosomes with the fourth, that are being transferred.

Dr. Marian Laderoute
Okay, well, let's not confuse the SARS-CoV-2 virus infection from the shedding infection. But in either case, actually, it turns out that most of the transmission of the virus is coming from the upper respiratory tract, and that is also where the shedding is occurring from. So, I'm sorry, what was your question again?

Commissioner Roberston
The more doses you have, the more infectious you become to the unvaccinated population.

Dr. Marian Laderoute
Yes, but I mean, even the Cleveland data show basically it falls off after the third dose. I mean, there's only a point of no return where you can't really increase the antibodies more than a certain amount. So I think that was showing that basically you reach your maximum after the third dose. But basically the data I was showing on shedding indicated that by the fourth dose, you're eliminating virtually all the protector particles that normally would be shed from the upper respiratory tract.

Commissioner Robertson
Thank you.

Kassy Baker
Are there any further questions? All right, for the record, I would like to enter Dr. Laderoute's presentation that we've just been presented with, along with her CV, and it will go into the record as Exhibit R-069. And on behalf of the National Citizens Inquiry, we would like to thank you very, very sincerely for your testimony here today. Thank you.

Dr. Marian Laderoute
Thank you very much.