My document is in support of Aly Cook's submission to the petitions committee requesting that the House of Representatives call for a Royal Commission of Inquiry into the safety and efficacy of Covid-19 vaccine use in New Zealand and for those in parliament who may read it. I give my full permission for my story to be shared publicly as part of Aly's submission to be eventually posted on the NZ Parliament Petitions website.

I am Hilary Butler, the mother-in-law of Maree B, who was **mandated to receive the Comirnaty injection by her workplace under orders from the Government**.

Immediately after her first injection, she experienced distressing symptoms. Her documentation included in Aly's submission, is skeletal regarding the severity of her experience.

Hospital experiences.

Maree had many interactions with the medical system at the time, none of which were satisfactory. My son accompanied her, and was disgusted by what happened. Some of the gas-lighting interchanges were videoed without the knowledge of the hospital and revealed to me, so I can validate their experience.

A junior cardiologist was very concerned and ordered tests, but they were cancelled from higher up. Both Maree and her husband asked for a treadmill test because they knew that walking and any exercise, caused her heart to flutter with crushing chest pain, and destabilised her breathing. She would have failed that test, but the hospital wouldn't sanction it.

Her symptoms had all the classical hallmarks of significant heart involvement, but the medical staff would not listen, conduct appropriate tests, nor report her reactions.

This scenario has been repeated innumerable times, with many New Zealanders learning the hard way that "doing the right thing" can jeopardize their health, if not their life.

Parliamentarians need to consider some key issues, which are currently buried in a pond with a 'no fishing' sign over the top. **The first being that "You were not mandated, nor required to be vaccinated, and therefore not penalised for not doing so."** A source revealed that ACC has had to employ huge numbers of staff to process Comirnaty reactions, and as a result of what they have seen, new ACC workers were not mandated either. If true, it's fascinating.

A summary of the medical literature shows that with infection, the SPIKE is the primary pathogen and that the ***spike alone is toxic***. The medical literature also shows that:

- Comirnaty is not a vaccine, but a prodrug which should have been regulated differently.
- Comirnaty mRNA makes a totally different spike to the spike of the infection.
- Comirnaty spike is more dangerous than the infection spike.
- Comirnaty causes significant long term immune down-regulation.
- Comirnaty causes a multitude of thrombotic disorders, including several forms of "carditis".
- Comirnaty spike has been found all throughout bodies in autopsies.
- Comirnaty spike easily accesses the brain, spinal fluid and nerve tissue.
- Comirnaty contains serious contaminants described later in this document.
- Comirnaty does not prevent transmission, infection, hospitalisation or death.
- Comirnaty does not create herd immunity.

- Comirnaty results in many different pathogenic responses, the list of which increases daily.
- Comirnaty should never have been approved, and will result in significant and undeniable social upheaval in the coming years far beyond that of the infection.
- Comirnaty does NOT give superior protection against infection. In fact, it gives defective immunity resulting in repeated infections, as more boosters further skew the immune system through both antibody dependant enhancement and original antigenic sin (explained later).
- The advice that previously infected people should be vaccinated after infection was a deliberate and cynical attempt to hide the clinical proof that natural immunity is, and always has been, vastly superior for any viral infection as per ALL medical literature prior to 2020.

I have detailed all the above and more within this document, but would like to poignantly note:

I started studying medical literature in 1981, and have not stopped since. When I started, I was researching literature from the 1950's and 60's in order to provide medical and historical context for literature relating to the 1980s. Scientists of old would say that the medical literature was primarily for discussion amongst their peers, and not for lay people.

Since about 2000, there has been a progressive shift away from honest discourse both publicly and in the medical literature. From 2020, there was a significantly shift away from accurate bench science towards a torrent of expedient propaganda which was plainly orchestrated.

However many scientists and doctors have pushed back and published peer reviewed medical articles exposing that the current political covid narrative is unscientific, and that other forces are at play, within political, medical and regulatory spheres. That has been accompanied by a retaliatory snow storm of industry written pap designed to obfuscate that truth.

The response of the medical system to the doctors who initially spoke out has been very severe, as a warning to anyone else who wishes to step up and openly reveal what they see.

Two notable examples are the cardiologists, Dr Aseem Malhotra and Dr Peter McCullough, who have both seen and described disastrous consequences in their practices. Both are now publicly ostracised by those perpetuating false narratives. However, other cardiologists who have remained silent publicly, are now publishing medical literature revealing their anger at how certain stakeholders have twisted science and put them in very difficult clinical positions.

Many more scientists who have publicly remained quiet after seeing colleagues effectively euthanized for speaking out, are still being backed into a corner, similar to the one that Lenin backed his people into. To stay onside with Lenin, everything said, written or done had to come from the foundation of:

1) Lenin is God.
2) See number 1.

Publishing scientists have reached that point. In order to get anything published in any medical journal financially controlled by narrative stakeholders, they must start and conclude their study with;

1) The only way to safely and effectively prevent the pandemic continuing is injecting and boosting continually with Comirnaty.
2) See Number 1.

So long as those two things are in the abstract, introduction and conclusion (A, I and C), the paper will invariably be published. So many papers are being published daily that few people read anything but the AIC, giving the impression than Comirnaty is the only solution because the consensus indicates that the benefits outweigh the risks.

That statement is a carefully contrived and misleading narrative.

Those who read between the lines know that truth will be found buried in the body of the articles. When you find accurate science and use PubMed to find out who cited such articles, you can ignore most of the stakeholder financed narrative articles which whitewash over the most significant information.

This submission presents parliament with science from a fraction of the needles buried in the haystack. Those "needles" are becoming increasingly more common as clinicians note the escalating consequences of mRNA injections first hand. They are then faced with an option. Remain silent, or publish their concerns to alert others. They recognise that silence is tantamount to deceiving their clientele.

Not only are the narratives driven by politicians dividing society, but they are also dividing the medical community.

Hopefully the time will come when the ongoing effects of Comirnaty become so apparent that people will realise that they were either duped, or choose to be wilfully ignorant. In reality, most people haven't a clue as to how to analyse scientific documentation, and a lot of what has been sanctioned ignores Medsafe's recommendations, as well as the Department of Justice's warnings that mandating, coercion etc., is against the Bill of Rights.

Morally, that is totally unacceptable, and it is time to correct this situation.

The medical information presented here is vital and has wider ramifications for the wider public.

Hilary Butler, 25 Harrisville Road, Tuakau 2121.

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What broad safety issues should parliament seriously consider?

The core of analysing safety is to balance effectiveness with the risk of infection. If a product functions effectively by providing protection from infection, then higher risks of an intervention product may be considered worthwhile.

The Ministry of Health's own data[1] starting with their analysis of Comirnaty, that the promise that Comirnaty was effective, was and still is, a mirage. Many New Zealanders questioned the rhetoric of what was said and promised, and predicted what we are seeing now. We were dismissed as conspiracy theorists, but what we said has been proven to be true. With the benefit of three years hindsight, Parliament needs to reconsider these questions.

[1] https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-current-cases
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"Is Comirnaty safe?"

Most people who chose to be vaccinated probably thought, "Well, it's just like any other vaccine, therefore it will work."

In order for Parliament to reconsider Comirnaty's safety, foundational issues need to be revisited.

1) ***the definition of a vaccine*** in the context of the past and present.
2) ***the risks of the Comirnaty compared to the risks of the infection, and factors that might affect those risks.***

Definition of vaccine.

Up until 2020, the definition of "vaccine" did not align with mRNA technology. To accommodate mRNA technology, the FDA had to make the definition very vague . . . the definition of a classical vaccine[2] was "***any preparation of weakened or killed bacteria or viruses introduced into the body to prevent a disease by stimulating antibodies against it***."

A 1985 National Institute of Health[3] book stipulated that a vaccine: "… ***involves the administration of a modified pathogenic agent, or a component of a pathogen, to stimulate the recipient's immune mechanisms to produce long-lasting protection without causing the clinical manifestations or other consequences of disease.***

Three major types of preparations are employed to produce active immunity. The first consists of vaccines made from whole, inactivated (killed) pathogens or components of a pathogen….

Toxoids are the second type of active immunogen. The diphtheria and tetanus vaccines are good examples. Toxoids are toxins that have been treated by physical or chemical means until they no longer produce clinical disease, but retain the capacity to induce immunity….

Attenuated infectious vaccines are the third type. Virus vaccines in this group are derived from the offending organism after it has undergone repeated passages in the laboratory in culture; it remains infectious for man but loses the ability to induce clinical disease…"

All three classes of vaccines were factory produced, and the final end product of a manufacturing process, which had been regulated, quantified and clearly defined.

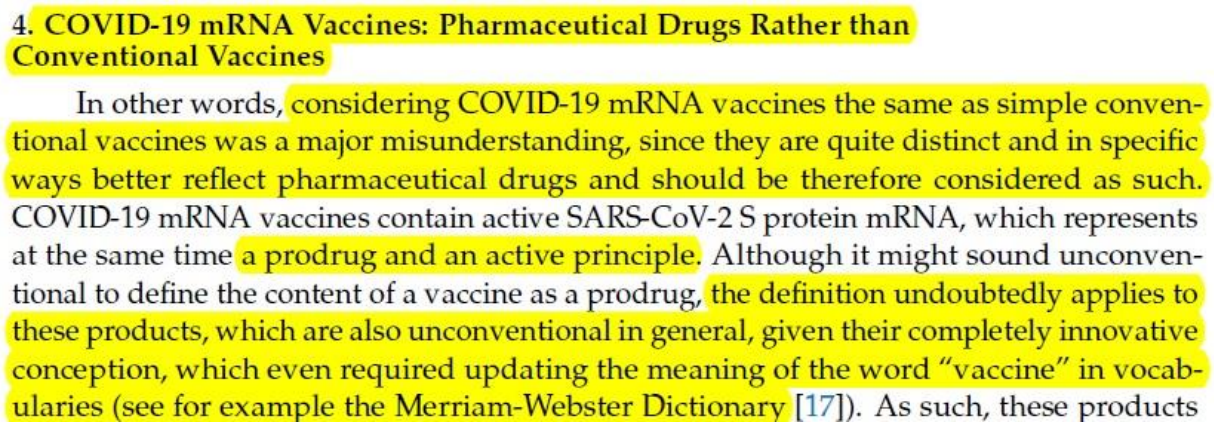
In order to include the mRNA technology, the CDC[4] definition of a vaccine was changed to:

"A preparation that is used to stimulate the body's immune response against diseases. Vaccines are usually administered through needle injections, but some can be administered by mouth or sprayed into the nose."

This change needs to be reconsidered because there is a significant difference between the old vaccines and mRNA sanctioned prodrugs.

[2] https://languagelog.ldc.upenn.edu/nll/?p=50886 (also discusses new definition.)
[3] https://www.ncbi.nlm.nih.gov/books/NBK216821/
[4] https://www.cdc.gov/vaccines/vac-gen/imz-basics.htm

One scientist, details why ***Comirnaty is a PRO-DRUG[5], not a vaccine,*** which is why the trials and testing should have been far more expansive and rigorous.



4. COVID-19 mRNA Vaccines: Pharmaceutical Drugs Rather than Conventional Vaccines

In other words, considering COVID-19 mRNA vaccines the same as simple conventional vaccines was a major misunderstanding, since they are quite distinct and in specific ways better reflect pharmaceutical drugs and should be therefore considered as such. COVID-19 mRNA vaccines contain active SARS-CoV-2 S protein mRNA, which represents at the same time a prodrug and an active principle. Although it might sound unconventional to define the content of a vaccine as a prodrug, the definition undoubtedly applies to these products, which are also unconventional in general, given their completely innovative conception, which even required updating the meaning of the word "vaccine" in vocabularies (see for example the Merriam-Webster Dictionary [17]). As such, these products

Another part of your consideration of safety issues, involves revising what Jacinda Ardern reported daily in accordance with her advisors' instructions:

- Comirnaty is just like any other vaccine.
- Comirnaty will end the covid pandemic.
- Comirnaty is effective.
- Comirnaty injections will stop you, loved ones, and the whole community from getting covid.
- Comirnaty will mean you can't spread it to others.
- Comirnaty will prevent illness, hospitalisation and death.
- Comirnaty will prevent the hospital system being overwhelmed.
- Comirnaty will mean we can enjoy summer.
- Comirnaty will not be mandated or made compulsory.
- There will be no penalty for anyone declining Comirnaty.
- Comirnaty has been fully tested with no short cuts.
- Comirnaty will stay in the arm muscle and only survives for a few minutes before it's gone.
- Comirnaty mRNA cannot integrate into chromosomes in the nucleus.

A major problem with the current narrative, is that an increasing number of genomic scientists disagree with the information disseminated to the public, such as whether or not mRNA could affect genes.

One scientist noted that all mRNA prodrugs, can integrate[6]:

[5] Cosentino 2022 https://pubmed.ncbi.nlm.nih.gov/36142792/
[6] Domazet-Loso 2022 https://pubmed.ncbi.nlm.nih.gov/35627104/

basic comparisons, I show that the sequence features of mRNA vaccines meet all known requirements for retroposition using L1 elements—the most abundant autonomously active retrotransposons in the human genome. In fact, many factors associated with mRNA vaccines increase the possibility of their L1-mediated retroposition. I conclude that is unfounded to a priori assume that mRNA-based therapeutics do not impact genomes and that the route to genome integration of vaccine mRNAs via endogenous L1 retroelements is easily conceivable. This implies that we urgently need experimental studies that would rigorously test for the potential retroposition of vaccine mRNAs. At present, the insertional mutagenesis safety of mRNA-based vaccines should be considered unresolved.

(C) Hypothetical L1-mediated retroposition of vaccine mRNA. Vaccine mRNA formulated in lipid nanoparticles (LNPs) enter the cell via endocytosis [1,2,6,10,56]. A fraction of the vaccine mRNA enters the cytosol via endosomal escape, while the rest of the vaccine mRNA undergoes degradation in endosomes [56] or is repackaged in multivesicular endosomes into extracellular vesicles (EVs) and secreted back into the extracellular space [57]. The neighboring or distant cells can uptake vaccine mRNA from these EVs [57,58]. L1 proteins (ORF1p and ORF2p) interact with vaccine mRNA via a process termed *trans*-association to form a vaccine mRNA ribonucleoprotein particle (vaccine mRNA RNP) [36,45,46,49]. Like L1 and parental gene RNPs, a vaccine mRNA RNP enters the nucleus where the vaccine mRNA, through TPRT, is reverse-transcribed and integrated into the genome. The poly-A tail of vaccine mRNA plays a crucial role in this process [36,50–52].

And before considering possible DNA contamination bear in mind that the public was repeated informed:

- that Comirnaty is very safe.
- that Comirnaty stays in the arm and is gone in a couple of days

Another scientist[7], who tries to dispel this information, recaps what was being publicised:

enzyme 2 (ACE2). These products were presented from the outset as intrinsically safe, since it was believed that, similar to conventional vaccines, after intramuscular injection, most of the dose would remain in the muscle and the rest would drain through the lymphatic system, being eventually captured by antigen-presenting cells and B cells and undergoing complete elimination in a few tens of hours at the most [3,4]. On this basis, the public

Free-floating Comirnaty mRNA can be found in most body fluids, so let's start with blood, since the deltoid muscle is the place injections are given, precisely because that muscle is replete with blood vessels.

Comirnaty mRNA is found in the blood, 15 days after injection[8].....

Later, a new pulpit pronouncement was made:

- Comirnaty will lessen infection symptoms, prevent hospitalisation and death.

Really?

[7] Cosentino 2022 https://pubmed.ncbi.nlm.nih.gov/36142792/
[8] Fertig 2022 https://pubmed.ncbi.nlm.nih.gov/35884842/

On 15 May, 2023, I finally received an answer to an OIA:

Tēnā koe Hilary

You request for Official information, reference: HNZ00014159

Thank you for your email on 21 March 2023 asking for the following which has been considered under the Official Information Act 1982 (the Act):

- *"Could you please tell me how many deaths there have been from covid INFECTION in people in eligible age groups, who have never received any Covid vaccines injected.*

Te Whatu Ora is unable to separate the number of deaths per age group due to privacy reasons. Where the number is low, or can be calculated, and demographic information provided may result in identification, we would withhold this information in accordance with section 9(2)(a) of the Act, in order to protect the privacy of the individuals.

We can provide you with the total number of deaths of people over the age of 5, who have not received any COVID vaccinations. There has been a total of 316 deaths.

The Ministry of health database[9] has the following **23 May 2023** graph:

Age and vaccination status of deaths within 28 days of being reported as a case

Age group	Not fully vaccinated	Fully vaccinated	Received booster	Total
0 to 59	91	119	169	379
60 to 69	56	92	245	393
70 to 79	111	124	664	899
80 to 89	157	169	1218	1544
90+	118	108	905	1131
Total	533	612	3201	4346

Simple maths will show you the following.

Never vaccinated deaths……316.

- **1 – 2 injection – deaths …….. 217**
- **Fully vaccinated deaths …….. 612**
- **Boostered …….. 3,201**

TOTAL DEATHS …….. 4,346 people.

Those who observed that no previous coronavirus vaccine had ever passed animal trials, nor functioned effectively, and detrimentally affected the immune system as well as having significant side effects, were chastised.

Interestingly, some of the scientists involved in previous SARS vaccine research wavered in their initial assertions, then declared the mRNA injections to be wonderful, safe, and would stop the pandemic.

[9] https://www.health.govt.nz/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-case-demographics

EMA documentation shows that the safety trial product used to justify approving Comirnaty, was a prototype made using a radically different process to the commercial product later injected into New Zealanders.

It was intimated from the outset, that only a couple of jabs would suffice, yet now booster injections are repetitively promoted along with resurrection of the admonition to continue wearing a mask.

Scientists know that coronaviruses mutate exponentially, and that if Comirnaty caused either ADE (antibody dependant enhancement) or OAS (original antigenic sin) then the immune system would not prevent infection from new variants. Frasca[10] isn't the only scientist saying this in peer reviewed literature:

variants. We debate here the safety aspect, with a final section on the discussion of the mechanisms of escape of mutant viruses, and the ADE phenomenon (antibody-dependent enhancement, see below), which is an additional unwanted side effect of these vaccines. The latter effect, as well as the variability of the virus, which impairs the durability of the protection of COVID-19 vaccines from death or severe disease, is also the object of the present review.

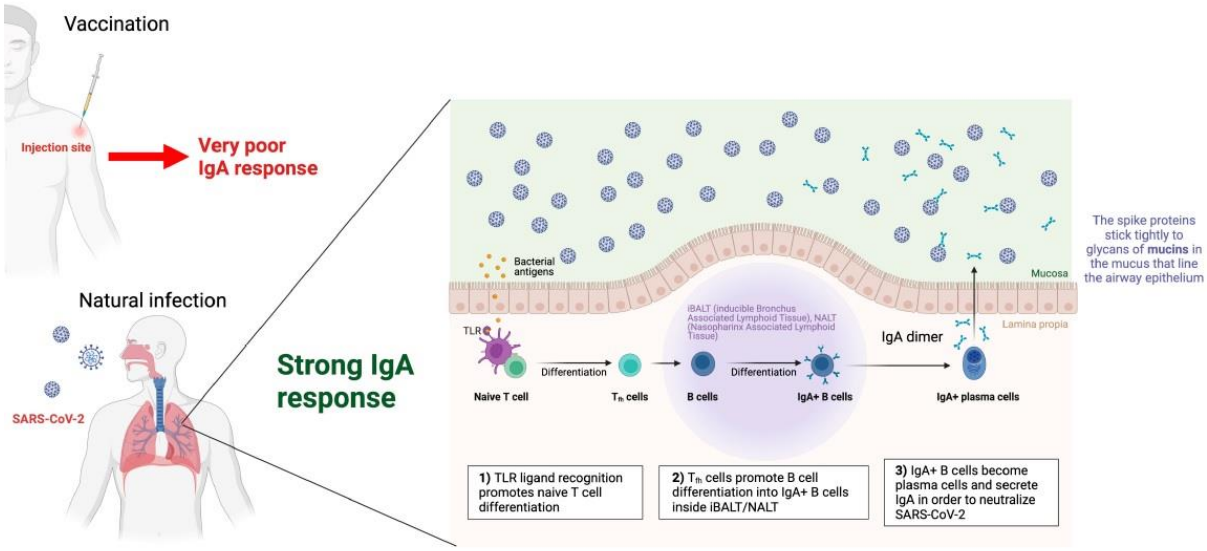
When it was suggested that antibody-dependant enhancement could result in the vaccinated being more susceptible to infection after mRNA injections, than those naturally immune, that assertion was vehemently disputed.

Yet a study[11] published six months ago, again proves the assertion to be correct:

In a large epidemiologic study [19] 39,086 specimens were collected nationwide (USA) and the seropositivity rate was analyzed. This study was performed through the access to a large database of longitudinal data regarding patients recovered from COVD-19. The authors demonstrated the presence of both anti-S and anti-N IgG in the blood samples, and this finding was evident also 300 days post-infection. More specifically, there was an average seropositivity for N-protein in 68% of the subjects after 293 days and a 87% seropositivity of antibodies to S-protein at 300 days. Furthermore, the authors demonstrated that the subjects under the age of 65 had a higher antibody seropositivity.

included. It was highlighted that the vast majority of the individuals after suffering from COVID-19 develop a natural immunity both of cell-mediated and humoral type, which is effective over time and provides protection against both reinfection and serious illness. Vaccine-induced immunity was shown to decay faster than natural immunity. In general, the severity of the symptoms of reinfection is significantly lower than in the primary infection, with a lower degree of hospitalizations (0.06%) and an extremely low mortality. Conclusions: this extensive narrative review regarding a vast number of articles highlighted the valuable protection induced by the natural immunity after COVID-19, which seems comparable or superior to the one induced by anti-SARS-CoV-2 vaccination. Consequently, vaccination of the unvaccinated COVID-19-recovered subjects may not be indicated. Further research

[10] Frasca 2022 https://pubmed.ncbi.nlm.nih.gov/36839505/
[11] Diani 2022 https://pubmed.ncbi.nlm.nih.gov/36362500/



That is only a fraction of what the Diani study showed. You should read it all.

These concepts have been verified and underpin core concepts relating to both efficacy and safety of Comirnaty. They are the same problems which lead to scientists agreeing that the original coronavirus vaccines should not be developed commercially.

Up until 2020, a fundamental tenet of immunology was that the most effective immunity was natural immunity as a result of infection. Suddenly, the public was told that covid infection didn't create immunity, so a few weeks after an infection, you should receive all doses of Comirnaty to protect you.

Then the public was also told that covid infections after two or more Comirnaty injections didn't mean that this prodrug wasn't working, because,

- regular boosters would prevent serious infection, hospitalisation and deaths.

The Ministry of Health death data, proves the statement above to be incorrect.

Influenza is an RNA virus, which also mutates but not as quickly as coronaviruses. Every year, the influenza vaccines are changed to "update" the vaccine to contain something akin to the predicted variants developing each year. Often the vaccine does not match the circulating strains.

The 2019 flu vaccine will not be used in 2023. However, the "new" Comirnaty bivalent boosters contain the long extinct Wuhan strain, and the 2021 Omicron strain which has vastly diverged from the 2023 variant.

The current variant is XBB.1.16, nicknamed "Arcturus"[12] which has as its main symptom. . . conjunctivitis.

New Zealanders are being injected with an outdated, irrelevant product containing extinct 2019 and 2021 variants.

The above facts negate any "infection moderation benefit".

[12] Arcturus https://www.theguardian.com/world/2023/may/09/covid-variant-arcturus-conjunctivitis

However, when analysing efficacy, another question arises:

Can the infection be treated?

If an infection can be successfully treated, there should be no need for any vaccine of any description.

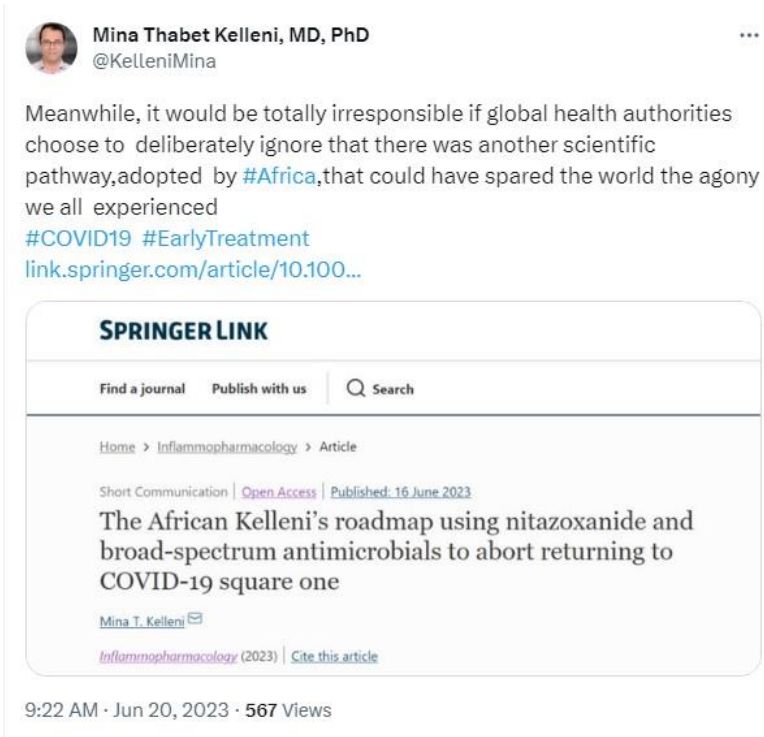
It is hoped that Parliamentarians realise that the previous statement is not the basis for approving a product under Emergency Use Authorisation, as it is called in America, or Provisional Authorisation, which is how Medsafe defines the same concept.

By March 2020, the Ministry of Health had already motioned to remove compounds from the shelves which had the potential to treat covid. Doctors like Dr. Zelenko stated that these compounds could reduce the severity of the infection.

Progressively, the Ministry of Health reduced the allowed usage of hydroxychloroquine except for people who had auto-immune conditions.

Ivermectin was effectively banned, as were other drugs proven to be safe and effective in treating coronavirus infections. The banning of Ivermectin was ironic, considering the American CDC established in 2005[13] that Ivermectin stopped SARS Cov-1 in its tracks. Nitazoxanide, which is similar to Ivermectin, also stops the virus replicating as well, but with a different biochemical action.

Africa's Dr Kelleni[14] was at the forefront of a cheap, safe and effective protocol which was highly successful in Africa. Dr Shankar Chetty used a similar protocol:



From 2021, medical science changed tack by running trials, many of which were later retracted, as Ivermectin doses used proved to be toxic. Even after fraudulent medical articles of different compounds were retracted, the "useless and dangerous" trope was traipsed out ad nauseum by the media.

To this day, scientific narratives still consider Ivermectin to be ineffective.

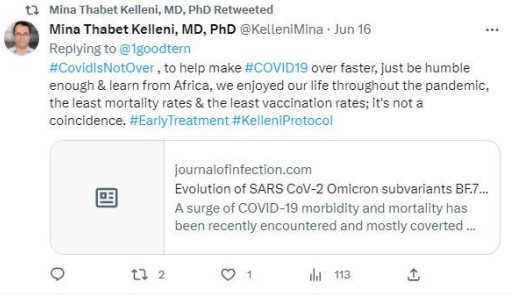
Meanwhile, doctors on the front-lines in USA and elsewhere, were being persecuted for using these and other drugs to save the lives of people infected with Sars Cov-2.

[13] Vincent 2005 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1232869/
[14] Kelleni Twitter https://twitter.com/KelleniMina/status/1670904808746762240

Strangely, the death rates from coronavirus infections in Africa are far lower than in western countries, even though their vaccination rates are ridiculously low. The reason for their low death rates and limited numbers of serious covid infections and deaths throughout Africa, is because a very large percentage of the population regularly uses ivermectin and hydroxychloroquine for parasites and malaria, and their doctors had unrestricted access to cheap repurposed drugs.

Their protocols include simple cheap pharmaceutical solutions still not available to New Zealanders.[15] Africa used Ivermectin, and hydroxychloroquine along with Nitazoxanide (which Kelleni preferred over Ivermectin), another drug not available to New Zealanders. Nitazoxanide worked well in Africa in combination with aspirin, nsaids, zinc, resveratrol, ivermectin, zinc, and antimicrobials. These are cheap drugs which also work well for all other respiratory viral infections.

Many New Zealanders would have loved to be the patients of overseas doctors like Pierre Kory, Shankar Chetty, or Mina T Kelleni, whose peer-reviewed published clinical results prove that the current methods of non-treatment elsewhere in the world, are responsible for needless deaths, something that Dr Kelleni and others have repeatedly stated from 2020.



By March 2020 Egyptian doctors[16] were also noting that similar treatment protocols cleared the virus when used in the early stages:

Effect of a combination of nitazoxanide, ribavirin, and ivermectin plus zinc supplement (MANS.NRIZ study) on the clearance of mild COVID-19

That fact that hydroxychloroquine is beneficial in reducing severity of infection, hasn't escaped the attention of unvaccinated New Zealanders with autoimmunity, who use hydroxychloroquine daily. Most noticed that when they eventually got Covid, it was insignificant, despite being told that their own health issues put them at high risk of serious infection and death.

For the first time in history, doctors were instructed not to prescribe either mentioned or unmentioned off-label drugs. Who issued that order?

Instead, New Zealanders were advised to stay at home until they experienced respiratory problems and then go to hospital where they could be ventilated (which has around a 50% death rate from hospital acquired secondary ventilator associated pneumonia) and put on Remdesivir, which has a 30% mortality for people without Covid.

[15] Kelleni 2023 The African roadmap… https://pubmed.ncbi.nlm.nih.gov/37326756/
[16] Elalfy 2021 https://pubmed.ncbi.nlm.nih.gov/33590901/

The banning of effective drugs by Medsafe led to no home treatments, and no front line treatment of infections within medical facilities which increased the risk of serious infection, hospitalisation rates and the number of deaths.

This placed doctors in an unprecedented and unethical position of non-treatment, and it should be noted that it has paved the way for such unethical practices to be replicated.

By purposefully restricting doctors, the rate of infection became more virulent, and the risks and benefit analysis were skewed in favour of a Pfizer prodrug, of which few New Zealanders know anything, and still assume Comirnaty to be safe and effective.

Benefit/risk equations are not just based on risk of **infection vs efficacy** of any vaccine. The key component is always PRODUCT safety, because it is injected into healthy people.

Comirnaty is NOT an old-style vaccine. Comirnaty converts the body into a factory that has to perform unregulated functions, producing an unknown quantity of spike antigen, in unknown places for unknown lengths of time.

The consequence of the incorrect definition change is described in a 2022 medical article[17] aptly titled "Playing dice with spike".

> The complex pharmacological profile of both the SARS-CoV-2 S protein mRNA contained in COVID-19 vaccines and the resulting S protein, together with the evidence of their systemic disposition, would better fit with the comprehensive assessment recommended for pharmaceuticals, in comparison to the assessment focused on immunogenic properties required for conventional vaccines. Unfortunately, the latter was chosen as a reference for COVID-19 mRNA vaccines, as explicitly indicated in the EMA assessment reports [1,2]. As a consequence, preclinical assessment of these products did not include any secondary pharmacodynamic studies, safety pharmacology studies, pharmacodynamic drug interaction studies, traditional pharmacokinetic or biodistribution studies and/or genotoxicity studies, and all these omissions are defined as acceptable/agreeable by the EMA Committee for Medicinal Products for Human Use (CHMP). Specifically, the EMA assessment reports never mention any pharmacological and functional properties of the SARS-CoV-2 S protein mRNA and/or of the S protein that are described above in Section 4.

4. COVID-19 mRNA Vaccines: Pharmaceutical Drugs Rather than Conventional Vaccines

> In other words, considering COVID-19 mRNA vaccines the same as simple conventional vaccines was a major misunderstanding, since they are quite distinct and in specific ways better reflect pharmaceutical drugs and should be therefore considered as such. COVID-19 mRNA vaccines contain active SARS-CoV-2 S protein mRNA, which represents at the same time a prodrug and an active principle. Although it might sound unconventional to define the content of a vaccine as a prodrug, the definition undoubtedly applies to these products, which are also unconventional in general, given their completely innovative conception, which even required updating the meaning of the word "vaccine" in vocabularies (see for example the Merriam-Webster Dictionary [17]). As such, these products urgently need a proper conceptualization. Conventional vaccines contain antigen(s), which represent their active component, in turn exerting their effect by acting on endogenous

[17] Cosentino 2022 https://pubmed.ncbi.nlm.nih.gov/36142792/

targets (the immune system cells). On the contrary, mRNA vaccines do contain a molecule (the mRNA) which is unable to trigger any anti-SARS-CoV-2 immune response unless it is translated by endogenous cell metabolism into an active moiety, which is the viral S protein. In other terms, mRNAs contained in vaccines fully meet the definition of a "prodrug" as reported, for example, in the Merriam-Webster Dictionary: *"a pharmacologically inactive substance that is converted in the body (as by enzymatic action) into a pharmacologically active drug"* [18], which is the case for vaccine-derived mRNA, converted into active S protein by ribosomes through their catalytic peptidyl transferase activity that links amino acids together, leading to protein synthesis. According to the conventional classification of pro-drugs [19], COVID-19 mRNA vaccines could be classified as type I prodrugs since they undergo intracellular conversion. The tissue location where conversion occurs is, however, uncertain, since the catalytic mechanism leading to protein synthesis is common to all the cells in any tissues and organs, with the notable exception of erythrocytes, which do not have ribosomes, but including, for example, platelets, which maintain the ability to synthesize proteins thanks to a small pool of ribosomes inherited from their precursor megakaryocytes [20]. Translation of the SARS-CoV-2 S protein mRNA into active S proteins could therefore in principle occur anywhere in the body, as also suggested by the ability of the lipid nanoparticle–mRNA formulations of both BioNTech–Pfizer and Moderna preparations to reach virtually any organ and tissue in preclinical biodistribution studies in rodents [1,2].

Prodrugs lack the pharmacological activity of their active moieties; however, they may contribute to the overall safety and toxicity profile of the drug product, and therefore their evaluation is usually included in the overall assessment of new preparations [19].

Comirnaty's unregulated unpredictability severely changes the safety aspect.

Furthermore, the known concepts found in previous coronavirus vaccine trials which stopped them from being marketed should also be taken into consideration.

For example;

- Original antigenic **sin**.
- Antibody dependant Enhancement

These problems followed the use of early coronavirus vaccines, and also plague influenza vaccines. These assertions are verified by a scientist in the following article by Scholkmann.[18]

Scholkmann and many others experts are increasingly speaking out about the blatant lack of science displayed in the last three years, albeit cautiously.

[18]Scholkmann 2023 https://pubmed.ncbi.nlm.nih.gov/37192595/

multifactorial nature and multiple pathophysiological factors at play" [19] and is a "multisystemic illness encompassing ME/CFS [myalgic encephalomyelitis/chronic fatigue syndrome], dysautonomia, impacts on multiple organ systems, and vascular and clotting abnormalities" [20] whereby specific types of PACS can be defined depending, for example, on the type of symptoms [21–24], severity of symptoms [25] or the timeline of the symptoms' appearance [26,27]. The probability of developing PACS depends on many factors, including the type of SARS-CoV-2 variant infected with. For example, the odds of PACS development is reduced with the SARS-CoV-2 omicron variant, compared to the delta variant [28]. According to data from the UK (December 2021 to March 2022, n = 56003 adults), 4.5% people experienced PACS (after infection with the Omicron variant), and 10.8% (after infection with the Delta variant) [28].

While according to the WHO more than 350 COVID-19 vaccines are currently in preclinical or clinical development (January 2023), ten have already been approved by the WHO for global use. The vaccines can be divided into four different types: "inactivated virus vaccines (Sinopharm's Covilo, Sinovac's CoronaVac, and Bharat Biotech's Covaxin), messenger RNA (mRNA) vaccines (Moderna's Spikevax mRNA-1273 and Pfizer–BioNTech's Comirnaty BNT162b2), adenovirus vector–based vaccines (AstraZeneca's Vaxzevria and Covishield ChAdOx1 and Johnson & Johnson–Janssen's Ad26. COV2. S), and adjuvanted protein vaccines (Novavax's Nuvaxovid and Covovax NVX-CoV2373)." [29]. In addition, there are other vaccines in use that have been approved by other regulatory authorities (e.g. the self-amplifying COVID-19 mRNA vaccine GEMCOVAC-19 and the DNA plasmid based COVID-19 vaccine, both approved for emergency use in India).

The global COVID-19 vaccination campaign started in December 2020 and is ongoing. Currently the global COVID-19 vaccine campaign faces two challenges: a decrease in the vaccine's efficacy in preventing a more severe COVID-19 disease course and/or death, and in parallel an increased recognition and awareness in relation to possible problems with the vaccine's safety.

While a recent mathematical modelling study estimated that the global COVID-19 vaccination campaign prevented 14.4 million deaths from COVID-19 in 185 countries and territories [30] (but see also a critical evaluation of the methodology of this study [31]), the efficacy of the available COVID-19 vaccines is declining as novel SARS-CoV-2 variants emerge [32,33]. The current use of a bivalent booster for the two available mRNA COVID-19 vaccines (including the wild-type (Wuhan-Hu-1) and Omicron (BA.1) SARS-CoV-2 spike messenger RNAs) "likely only represents a temporizing measure until variants emerge", and the "need to repeatedly vaccinate at-risk populations, combined with the documented emergence of a new dominant SARS-CoV-2 variant approximately every 3–4 months, presents a public health dilemma." [34]. In addition, the "long-term consequences of ongoing, repeated vaccination campaigns against COVID-19 for viral ecology and viral mutations inducing vaccine resistance" is seen as a potential problem, and there is also the serious concern of the risk of "repeated vaccination to cause vaccine exhaustion and, consequently, reduce protection against microbial infection" [35]. Repeated vaccination with the same antigen has been shown to induce overstimulation of $CD4^+$ T cells and subsequent development of autoantibody-inducing $CD4^+$ T cells [36].

The protection gained from a COVID-19 vaccination booster dose diminishes with increasing number of booster doses received, as recently found [37]. Repeated vaccination and confrontation with novel antigen variants are associated with the immune memory phenomenon of "original antigenic sin" (leading to less efficient immune responses in comparison to the original antigen variant) and "immune imprinting" (leading to a progressively narrowed immune response towards a new antigen variant) [38]. That the "vaccine-induced immune imprinting against the S [spike] protein partially inhibits the response against the N [nucleocapsid] protein after SARS-CoV-2 infection" has been shown already [39], and a recent study came to the conclusion that "protective effects from the humoral immunity and cellular immunity established by the conventional immunization were both profoundly impaired during the extended vaccination course." [40]. Immune imprinting was also concluded to be the reason for the unexpectedly reduced efficacy of the novel bivalent COVID-19 vaccines since the "immune systems of people immunized with the bivalent vaccine, all of whom had previously been vaccinated, were primed to respond to the ancestral strain of SARS-CoV-2" [41]. Also the "antibody dependent enhancement" (ADE) mechanism becomes relevant, as demonstrated by new results showing the "possible emergence of adverse effects caused by these [antibodies] in addition to the therapeutic or preventive effect"; some sera of mRNA-vaccinated individuals were observed to "gradually exhibited dominance of ADE activity in a time-dependent manner" [42]. The recent documentation of an immunoglobulin G4 (IgG4) dominated immune response after three doses of the Pfizer BNT162b2 COVID-19 vaccine [43], possibly inducing immune tolerance [44], must also be considered in this context.

With regard to the safety of the vaccines, adverse effects following COVID-19 vaccination are increasingly being noticed and studied, including cardiovascular [45–49], neurological [50–53] as well as autoimmune and inflammatory [54–59] disorders.

Researchers and doctors around the world are confronted with patients with various symptoms after SARS-CoV-2 infection and/or COVID-19 vaccination. In the work presented here, we address the current need for appropriate medical terminology that classifies the syndromes associated with SARS-CoV-2 infection and COVID-19 vaccination, based on specific similarities and differences of these conditions.

2. The need for a new unified medical terminology: COVID-19, PACS, PCVS, ACVS and PACVS

Based on the facts summarised so far in the introduction, we hypothesise that (i) the COVID-19 vaccination side effects have specific similarities and differences to acute COVID-19 and PACS, that (ii) a new term should be used to refer to these side effects (post-COVID-19 vaccination syndrome, PCVS, colloquially "post-COVIDvac-syndrome"), and that (iii) there is a need to distinguish between an acute COVID-19 vaccination syndrome (ACVS) and a post-acute COVID-19 vaccination syndrome (PACVS) – in analogy to acute COVID-19 and PACS ("long COVID").

Fig. 1 visualises the definition of the terms. Based on this concept, the syndromes can be classified according to their cause (infection/vaccination) and according to their general temporal manifestation (acute/chronic). The transition from the acute to the chronic phase is fluid and not abrupt.

Fig. 2 visualises our concept, according to which the acute phases (COVID-19, ACVS) and the chronic phases (PACS, PACVS) of both syndrome types (infection-related and vaccination-related) show

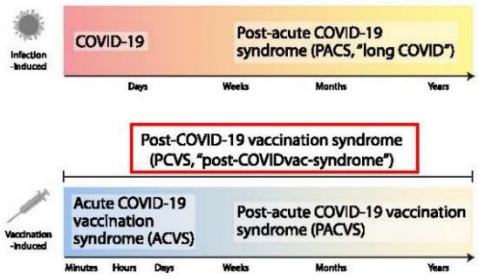


Fig. 1. Definition of the terminology of syndromes with respect to the causative factor (infection/vaccination) und their general temporal manifestation. The colour gradient shows that it is a spectrum where the initial syndrome can change to the following syndrome.

Reactions must be reported in order for Comirnaty risk to be analysed.

What we experienced as a family (refusal to both acknowledge a reaction, or report it) has become a dominant theme of discussion amongst many mRNA damaged patients worldwide.

Serious reactions are seldom or reluctantly reported by doctors. Cosentino [19] also discusses the consequences of what he sees as extreme underreporting of all adverse events:

pregnancy, most of the post-marketing safety assessment is essentially based on activities related to the receipt and review of individual spontaneous adverse event reports sent by physicians, other health care workers and by the general public [60,61].

This approach suffers from two major limitations. The first one is the well-known underreporting, which in "normal" times has been estimated in the order of 82–98% of all adverse events, and even higher for serious/severe events [62]. In the case of COVID-19 vaccines, such underreporting may be, however, even more dramatic and extreme. Let us look at the latest Italian report on the surveillance of COVID-19 vaccines [63], which summarizes about a year and a half of monitoring. The report apparently includes 93% spontaneous reporting and an additional 7% reports coming from "active pharmacovigilance" unspecified studies, possibly the additional studies mentioned by the EMA in its abovementioned risk management plans. The key issue is, however, that, while AIFA reports about 100 suspect adverse events per 100,000 doses administered, over the same period, the USA active surveillance system v-safe recorded about 68,600 local reactions and 52,700 systemic reactions per 100,000 doses after the first dose, and 71,700 local reactions and 70,800 systemic reactions per 100,000 doses after the second dose, which is 70,300 per 100,000 local reactions and 61,750 per 100,000 systemic reactions [64]. Taking the v-safe data as a standard reference, the AIFA spontaneous reporting system suffers from a rate of about 99.92%; that is, less than 1 in 1000 adverse events are reported to the system. Underreporting is even higher in the case of severe adverse events (i.e., those events which require intervention to prevent permanent impairment or damage, result in disability or permanent damage, require or prolong hospitalization, result in congenital anomalies/birth defects, result in death), as AIFA reports 3.8 severe events per 100,000 doses and v-safe reports 17,700 per 100,000 doses, that is, 4650 reports in v-safe per each report in AIFA. Thus, despite the EMA additional monitoring, taking Italy as a reference (and indeed it is, since it is constantly among the countries with the highest absolute number of COVID-19-vaccine-related reports included in the EudraVigilance system—https://www.adrreports.eu/—accessed on 8 September 2022), the pharmacovigilance systems for these products are likely missing more than 999 adverse events of any severity per 1000 events, and more than 4998 severe adverse events per 5000 events.

Another problem many vaccinated people have discovered is that when they ask to see a copy of the reaction report, it doesn't detail their experience or what they were told.

Letters sent to all New Zealand health professionals at the outset of the vaccination campaign warning them that if they said anything which deviated from the political narrative, or discussed information which might hinder the uptake of Comirnaty, they would be subject to investigation by the Medical Council. Because that was unprecedented, some medical professionals realised that Covid was not about science. Even worse, after serious Comirnaty reactions, medical exemptions were denied.

Since then, health professionals who shared peer reviewed medical articles with proof, contrary to authorisation, have been disciplined for "spreading disinformation and misinformation". It is not even possible to give information enabling "informed consent".

[19] Cosentino 2022 https://pubmed. ncbi.nlm.nih.gov/36142792/

After Maree's reaction, she was constantly lied to by hospital staff because of gag orders. They were not allowed to say anything beyond a short paragraph provided to them in writing which has been confirmed by medical professionals on condition of anonymity.

Instructions to Health professionals prevent them from acting in accordance with the Hippocratic oath, by not being able to diagnose or report reactions to Comirnaty which also breaches the Health and Disability code of rights. On a recent visit to Middlemore hospital, the absence of H&DC posters was conspicuous.

Safety is assessed by analysing data on reactions.

In the past, all vaccine reactions have been reported to the Centre for Adverse Reactions Monitoring[20] at Otago University. For whatever reason, CARM was side lined from the Comirnaty reaction process. Reports sent to them, are forwarded to the new system[21] under Medsafe.

Though reporting is avoided, there have been considerable numbers reported despite the contents of reports not always being accurate, and the severity being downgraded.

Furthermore, the reporting system uses a numbering system which is constantly changed, making cross-checking impossible. There is also a backlog of reactions yet to be processed. The system has since changed over to the SMARS database, and yet again, the new numbers make no sense.

Most people with reactions are told that their health issues are coincidental by medical workers, and health providers often refuse to report them. Worse, deaths are routinely considered as coincidental and autopsies are refused.

Only 40% (1,541) of cases (3,818) sent for ACC compensation have been accepted as of April 2023[22], at a cost of $5,658,510.

Therefore the existing information on reactions is useless to assess safety.

What clinical and evaluation information did Medsafe consider, in order to assess the Cominarty's safety?

One of the earliest Medsafe documents available, was 3rd February, 2021 Gazette Notice[23], which asked 58 questions.

I had already carefully dissected the European Medical Agency's first assessment of Comirnaty[24] which was first published on their website on 23rd December 2020, so it was obvious from Medsafe questions and required dates of answers to the questions, that the EMA document was the source of the 58 questions.

Seemingly Medsafe did not keep their finger on the pulse of the EMA documents, because many of

[20] https://nzphvc.otago.ac.nz/reporting/
[21] https://www.medsafe.govt.nz/COVID-19/adverse-event-reporting-form.asp
[22] ACC https://www.acc.co.nz/assets/covid-19-vaccination-claims-refresh-April-2023-IPA-11582.pdf
[23] https://gazette.govt.nz/notice/id/2021-go338
[24] https://www.ema.europa.eu/en/documents/assessment-report/comirnaty-epar-public-assessment-report_en.pdf

those crucial questions asked of Pfizer, ***have still not been satisfactorily answered by authorities, or to the public.***

Some answers were given to EMA, TGA or FDA, but all three agencies chose NOT to put those documents on their regulatory websites at the time.

Two years after the fact, those regulatory documents are being provided to citizens who tabled freedom of information requests. Two years after the fact, is two years too late.

In terms of New Zealand, in my experience, these three years have been the first time that getting an answer to an OIA is like trying to catch a creek eel with bare hands while blindfolded and ankle tied.

Why is it that the public is only seeing the truth through ***internationally*** released freedom of information requests?

Prior to the 23rd December 2020 EMA document, there was another EMA document dated 19th November 2020, which for whatever reason, was never put on the EMA website, but was recently leaked to the European Parliament by someone with a conscience. A copy of it can be found here[25]:

TWO of the key safety issues discussed in this leaked report, were the two very different manufacturing processes used in the Phase 1 Comirnaty Safety Trial, as compared with the subsequent process utilised to make Comirnaty injected into New Zealanders.

The safety trial product (page 137) used **process 1**, where the mRNA was made on a PCR template and magnetic beads were used to purify the mRNA. This process was too time consuming and can only be made in small amounts. But it's a much safer product.

The product injected into New Zealanders was **process 2** involving a very fast linearized plasmid DNA process grown in E.coli bacteria along with antibiotic resistance genes, and a genetic sequence called SV40 mammalian gene expression promotor, as well as other listed components. This product required a much more rigorous decontamination using various enzymes etc.

EMA, assumed that because Pfizer **said** that ***the end product was identical to the trial Comirnaty, that therefore***, safety outcomes would also be the same.

But there were early indications in a later 19th February 2021 EMA document[26], that the up scaled new commercial "process 2" had mRNA plasmid problems not present in "process 1".

EMA said,

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Specifications for the circular plasmid DNA as well as for the DNA linear template are provided. Process- and product-related impurities including host cell genomic DNA, RNA, proteins, endotoxins, bioburden and plasmid isoforms, for the plasmid DNA, are routinely quantified. The reference material is described. Implementation of any changes in the manufacture of the linear DNA template should be applied for in a variation application.

[25] https://mega.nz/file/tQgzBYIS#KZLmkCVKJljv2IotP8hnQNXPhEj-sZYos2mSv8o7fYE

[26] EMA 19th February 2021 https://www.ema.europa.eu/en/documents/assessment-report/comirnaty-epar-public-assessment-report_en.pdf

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Biodistribution: Several literature reports indicate that LNP-formulated RNAs can distribute rather non-specifically to several organs such as spleen, heart, kidney, lung and brain.

In line with this, results from the newly transmitted study 185350, indicate a broader biodistribution pattern with low and measurable radioactivity in the ovaries and testes. Given the current absence of

Medsafe led the public to believe that the hundreds of pages of regulatory gobbledegook, from overseas regulatory agencies, which most people never read, guaranteed safety, efficacy and purity. Yet the above quotes were ***a warning of things to come***.

BIODISTRIBUTION. Where does Comirnaty go?

Helen Petoussis-Harris was reported on News hub as saying[27]:

"People often imagine the components of vaccines charging around the body via the bloodstream - but that is not actually what happens," said Dr Petousis-Harris.

"When the injection is given, into the muscle of the arm, not the blood, the cells in the area as well as specialised immune cells basically inhale the vaccine material. The spike protein is produced in these cells and it actually gets broken down into bits in the same cells. These bits get coupled to special molecules and then the who package is presented to the immune system. There is no rush of spike proteins.

Real science shows, and real scientists know that the mRNA does not stay in the arm, and so did all the regulatory agencies including Medsafe, EMA, TGA, FDA and the CDC.

Bio distribution (where any drug or vaccine goes after it is injected) is crucial. New Zealand citizens repeatedly asked Medsafe, what happened to the mRNA after injection, and New Zealanders were repeatedly told by Helen Petoussis Harris, doctors, and media Key Opinion Parrots, that the mRNA stayed in the arm and disappeared very quickly.

Ashley Bloomfield repeatedly stated that they were consulting with EMA, TGA and FDA.

Were that really the case, they would have known from EMA, TGA and FDA documents, that Comirnaty wouldn't just stay in the arm. The TGA[28] knew by January 2021 that mRNA left the deltoid muscle and was distributed throughout the whole body. There is no place that Comirnaty cannot go, and even the brain has a wide open door because lipid nanoparticles open the blood brain barrier.

The 23rd December 2020 EMA document specifically mentioned on page 54, "***newly transmitted study 185350***," (which was completed in June 2020) and another phrase was, "***In study PF-07302048_06Jul20_072424, the applicant has used a qualified LC-MS/MS method***." Little

[27] 5 May 2021 https://www.newshub.co.nz/home/world/2021/05/coronavirus-covid-19-uses-spikes-to-damage-blood-vessels-study-finds-sparking-new-vaccine-conspiracy-theories.html

[28] https://www.tga.gov.au/sites/default/files/foi-2389-06.pdf page 45 FOIA request

was repeated as to what those studies showed.

Putting those words in Google, brought up the ***PF-07302048*** study (in Japanese) on the Japanese Department of health[29] website, along with three other toxicity studies, which were also a concern to me. All four documents have since been removed, but if you have the URLs as I do, the "way back machine" brings them up.

Those studies were also requested by a Canadian immunologist and vaccine developer, Dr Byram Bridle, through a FOIA request but only one of the four documents was provided to him. I gave him the other three.

Like all other questioners, Dr Bridle has been treated as a pariah of society after speaking out about these bio distribution studies.

Another American FOIA request, shows that the FDA knew by 1 July 2020[30], that lipid nanoparticles alone, would not stay in the arm, and in animals resulted in enlarged spleens, enlarged adrenal glands, enlarged lymph nodes, kidney and liver congestion and increased fibrinogen concentration, along with other significant abnormalities which were thoughtlessly dismissed as the result of normal immune system activation.

An Australian FOIA request turned up the fact that on January 10th 2021[31], Australia's TGA knew that bio distribution studies had been done, mentioning it with little detail on page 10.

Judicial watch[32] in USA then obtained different FDA documents relating to bio distribution 185350 study. This compilation of three documents in one, [33] dated 8th February 2021, 21 January 2021, 9 November 2020 confirmed ***that LNPs radioactively labelled*** to be traced and tracked, were used as a proxy for everything in the vial, and that the contents did indeed go **everywhere.**

Lest anyone tell you that lipid nanoparticles used as a proxy is not the same as Comirnaty, the FDA specifically said that LNPs alone are an accurate proxy for all ingredients inside the injected lipid nanoparticles.

29 https://www.pmda.go.jp/drugs/2021/P20210212001/672212000_30300AMX00231_I100_1.pdf#page=11 FOIA request

30 https://icandecide.org/wp-content/uploads/2023/03/125742_S1_M4_4.2.3.2-38166.pdf FOIA request

31 https://www.tga.gov.au/sites/default/files/foi-2389-06.pdf

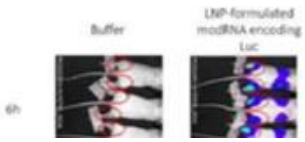
32 https://www.judicialwatch.org/nanoparticles-materials-outside-injection-site/

33 https://www.judicialwatch.org/documents/jw-v-hhs-fda-pfizer-biontech-vaccine-prod-3-02418/#

: 08-Feb-2021 15:26 (GMT)

The biodistribution of the antigen encoded by the RNA component of BNT162b2 is expected to be dependent on the LNP distribution and the results presented should be representative for the vaccine RNA platform, as the LNP-formulated luciferase-encoding modRNA had the same lipid composition.

Figure 2.4.3-2. Bioluminescence Emission in BALB/c Mice after IM Injection of an LNP Formulation of modRNA Encoding Luciferase



Graphs on page 55 and 56 of the Judicial Watch document show ***distribution throughout the WHOLE body.*** Using the word "radioactivity" in a search function will quickly show you the full discussion that LNP distribution is everywhere.

So, the EMA knew, FDA knew, TGA knew, Japan knew that mRNA injections, both Moderna and Pfizer's Comirnaty, went everywhere in the body.

Therefore Ashley Bloomfield and Helen Petoussis Harris must also have known that what was said by their single source of truth, was a lie.

It should be of concern to Parliament that the EMA, TGA and FDA did not put those reports onto their regulatory websites, and neither did Medsafe discuss the answers to the questions, which were found in those undisclosed reports.

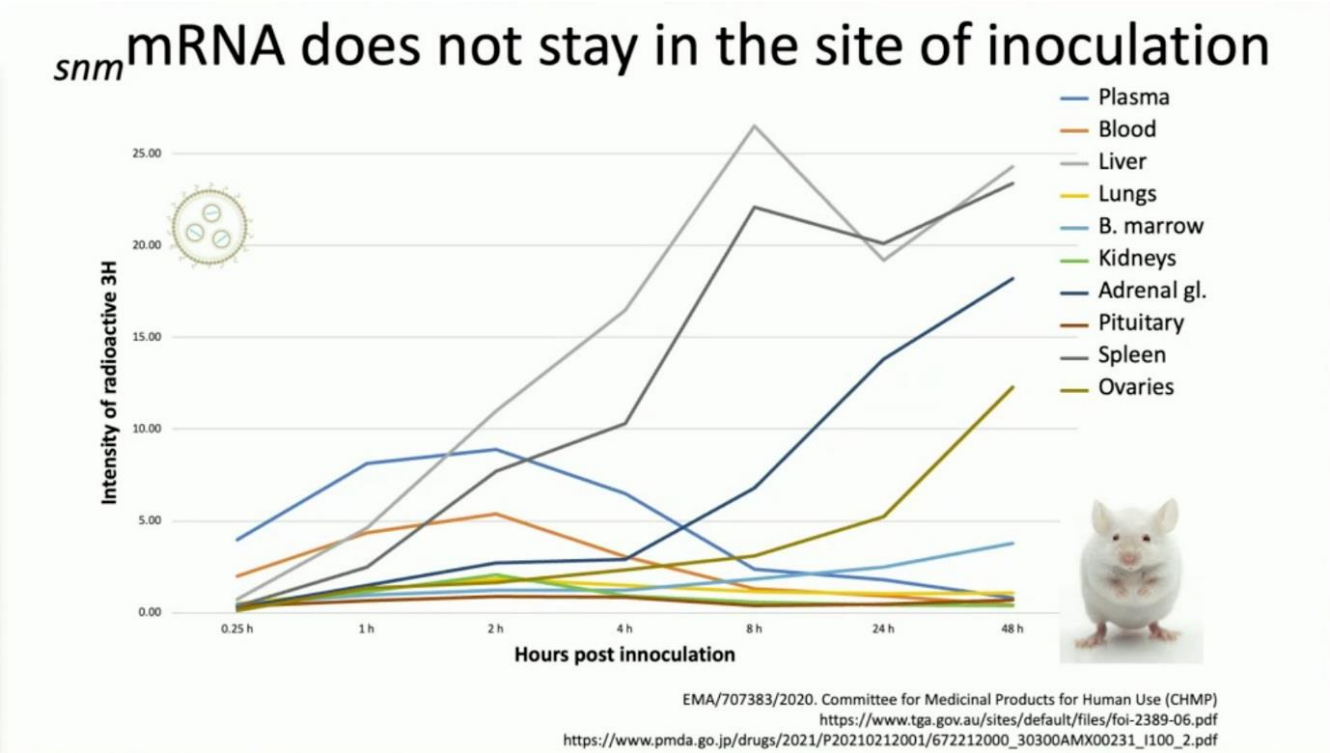
What do we gain from the information that was deliberately hid from sight?

Who ordered those reports to be hidden?

While Japan did put four very detailed reports in Japanese onto their Department of Health website, they perhaps believed no-one would look for them, or translate them.

- Recap: Overseas FOIA released official documents, show us that what we were told by many different people including Bloomfield and all the medical experts – that Comirnaty would stay in the arm and be gone at the latest, by two days – was untrue, and that **all regulatory authorities knew that**.

The bio distribution studies only tracked where the LNPs went for 48 hours. In many parts of the body, the concentrations were still increasing at the 48 hour cut off point, so we have no idea the accumulation status beyond 48 hours, OR the combined accumulation after repeated doses.



That raises the next important safety question:

If Comirnaty goes everywhere in the body because the lipid nanoparticles guarantee unrestricted access to every cell in the body, what might the dangers be, to the recipient?

The official answers were again of the "Not a problem" ilk.

"Comirnaty only contains mRNA and just makes antibodies."

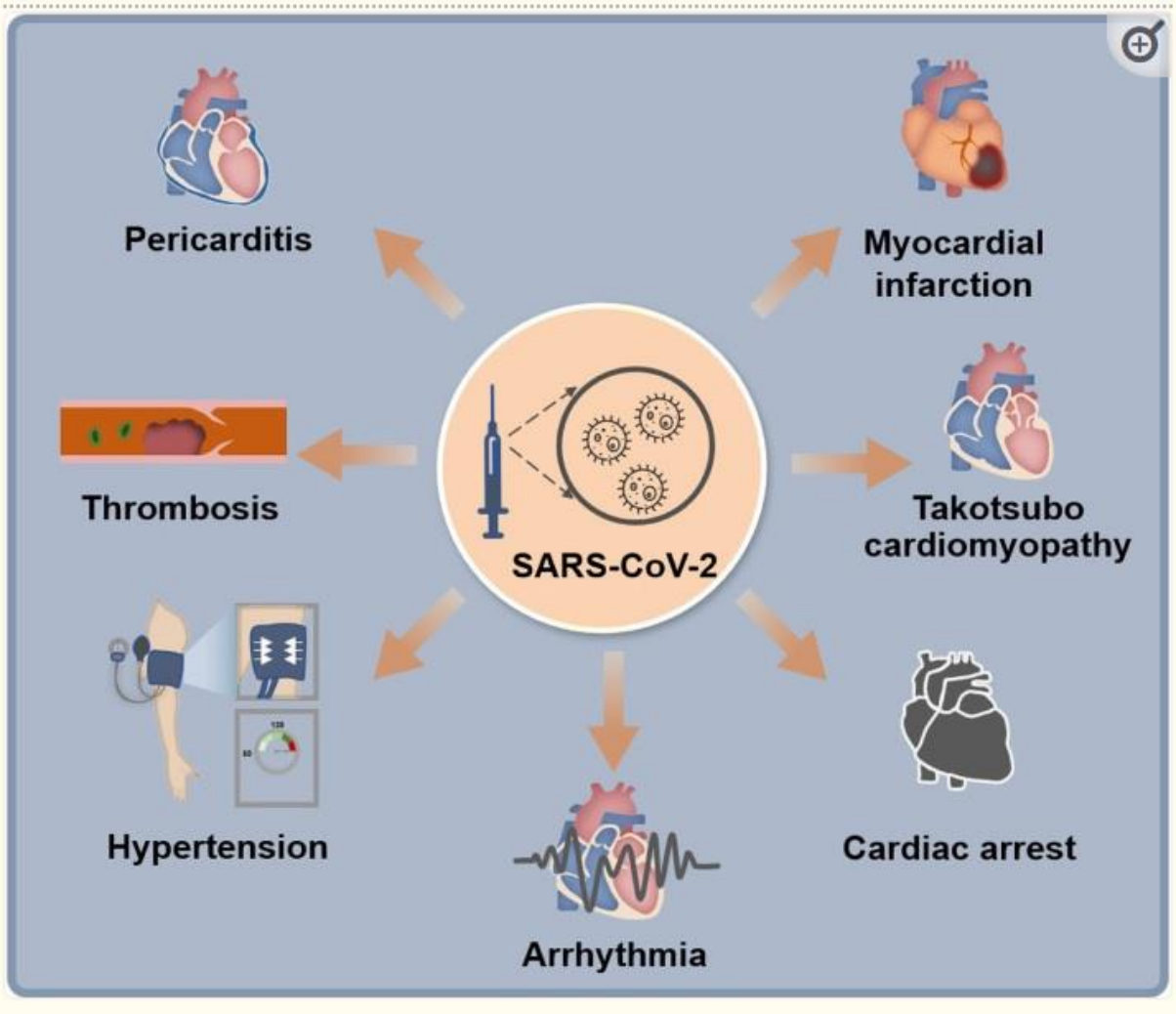
What else were we not told?

The fact that Comirnaty mRNA is found in breastmilk[34], as well as in the blood, means that it can go everywhere in all body fluids. It also means that mRNA can set up anywhere in the body and manufacture spike wherever that location happens to be.

What happens in all the different places?

[34] Hanna 2022 https://pubmed.ncbi.nlm.nih.gov/36156636/

Here are just a few of the heart problems cardiologists discuss:



Just recently, another very angry Japanese cardiologist had this[35] to say about the desecration he sees in his hospital and what he thinks about it all[36]:

to become more apparent. It has been hypothesized that there will be an increase in cardiovascular diseases, especially acute coronary syndromes, caused by the spike proteins in genetic vaccines [18, 19]. Besides the risk of infections owing to lowered immune functions, there is a possible risk of unknown organ damage caused by the vaccine that has remained hidden without apparent clinical presentations, mainly in the circulatory system. Therefore, careful risk assessments prior

[35] Yamamoto 2022 https://pubmed.ncbi.nlm.nih.gov/35659687/
[36] Yamamoto 2022 https://pubmed.ncbi.nlm.nih.gov/35659687/

Some studies suggest a link between COVID-19 vaccines and reactivation of the virus that causes shingles [12, 13]. This condition is sometimes referred to as vaccine-acquired immunodeficiency syndrome [14]. Since December 2021, besides COVID-19, Department of Cardiovascular Surgery, Okamura Memorial Hospital, Shizuoka, Japan (hereinafter referred to as "the institute") has encountered cases of infections that are difficult to control. For example, there were several cases of suspected infections due to inflammation after open-heart surgery, which could not be controlled even after several weeks of use of multiple antibiotics. The patients showed signs of being immunocompromised, and there were a few deaths. The risk of infection may increase. Various medical algorithms for evaluating postoperative prognosis may have to be revised in the future. The media have so far concealed the adverse events of vaccine administration, such as vaccine-induced immune thrombotic thrombocytopenia (VITT), owing to biased propaganda. The institute encounters many cases in which this cause is recognized. These situations have occurred in waves; however, they are yet to be resolved despite the measures implemented to routinely screen patients admitted for surgery for heparin-induced thrombocytopenia (HIT) antibodies. Four HIT antibody-positive cases have been confirmed at the institute since the start of vaccination; this frequency of HIT antibody-positive cases has rarely been observed before. Fatal cases due to VITT following the administration of COVID-19 vaccines have also been reported [15].

On March 29, 2020 George and Victor Tetz posted a preprint describing the fact that the SARS Cov-2 is the ONLY coronavirus to ever have PRION sequences in the receptor binding domain of the spike, which enable the spike to bind very tightly to the ACE2 receptor, increasing infectivity and prion forming potential. That study[37] was finally published in February 2022. Why did it take two years to get published?

The medical literature has many cases of prion-provoked amyloid brain infections **after covid infections**, which usually start quite quickly after infection.

Both infection and injection can result in very unusual micro clots[38] which on investigation, are amyloid in composition, which can only be from the unusual prion inserts in the receptor binding domain of the spike.

I watched a presentation by a neurologist whose discussion was the huge increase in brain disorders which start very quickly after serious infection, or the spike made from the injection. It was pointed out that both routes of brain penetration are the same, ***but that degeneration after injection was much faster and subsequent injections spiralled the disorder out of control***.

- S1 causes amyloid to form (Nystrom S et al 2022)
- S1 protein binds to heparin and the heparin binding domain which accelerates amyloid in the brain. This may advance neurodegeneration (Idrees D 2021)
- S1 and other viral fragments drive senescence and block autophagy (Meyer K et al 2021)

- In a study they by Shen et al, they looked at 17 COVID-19 vs 17 non-COVID-19 human brains (most with no h/o NDG disease)
- SARS-CoV-2 RNA, nucleocapsid, and spike proteins are present in neurons of the cognitive centers of all COVID-19 patients (no whole virus)
- These viral fragments activate microglia, causes neuroinflammation and induces Aβ and p-tau deposits in **non-Alzheimer's patients too**
- SARS-CoV-2 triggers AD-like gene programs in **healthy** neurons and exacerbates AD neuropathology
- The 2002 and 2012 SARS and MERS epidemics caused memory impairment in many recovered patients but not like we are seeing now

SARS-CoV-2 invades cognitive centers of the brain and induces Alzheimer's-like neuropathology Shen W et al bioRxIV Sept 2022

[37] Tetz 22 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8878784/
[38] Kruger 2022 https://pubmed.ncbi.nlm.nih.gov/36131342/

- Many neurodegenerative diseases such as Alzheimer's, Parkinson's, Huntington's and ALS and even MS are now thought to be a result of prion-like activity
- Prions travel from cell to cell and self propagate causing more proteins to misfold & promote neuroinflammation and death of neurons
- SARS-CoV-2 is the only coronavirus with a prion-like domain found in the receptor-binding domain of the S1 region of the spike protein (Tetz G 2020)

Misfolding of Brain Proteins Triggering Neurodegenerative Diseases Westaway D : Biology, Health and Medicine Dec 2021

Is MS a Transmissible Protein Misfolding Disorder? ACTRIMS 2018 Tsutsui S University of Calgary

- Micro-clots contain amyloid and are very resistant to breakdown and these clots can propagate which suggests S1 amyloidogenic properties (Kreuger A 2022)
- Codon optimization and mistranslation w mRNA can result in protein misfolding (Seneff S 2022 & Smith K et al 2022)
- When amyloid fibrils aggregate, they nucleate and once nucleated AMYLOID AGGREGATES SELF-PROPOGATE

The neurologist had this to say on some slides:

At autopsy no virus or mRNA was found. The damage stems solely from SPIKE:

"S1 binding to vessel walls induces a pro-inflammatory microenvironment, damages the BBB, activates microglia and creates a hypercoagulable state stressing the dysfunctional neurons (this was 5-10X worse in those with dementia) targeting vulnerable areas. Molecular changes in protein expression fuel neurodegeneration."

When overseas doctors said that the spike (which the original Wuhan strain infection and the current injections make) are toxic, we were told that was untrue. Frasca et al[39] state the case clearly:

produced after vaccine inoculation. Does this Spike interfere with the natural physiology of the vaccinated person, contributing to tissue/organ damage and, ultimately, in the worse scenario, to death? Indeed, one should consider that the Spike antigen (and the modified mRNA itself) is not a biologically inactive factor but can enter into a number of molecular pathways occurring in an organism, including pathways driven by anti-oncogenes [102]. The administration to animals of the sole Spike protein recapitulated the majority of the features of the first COVID-19 disease, suggesting that Spike exerts a consistent part of the toxic effects of SARS-CoV-2 [131]. The effect of Spike of SARS-CoV-2 has been studied

There is a simple test which will distinguish between an infection and injection problem.

That is the test for antibodies against the nucleocapsid proteins.

People who have only had the injection but NOT the infection, will **never have anti-nucleocapsid antibodies** because the current injections do not allow the body to make antibodies to that part of SARS Cov-2.

It is notable that the new generation covid injections are looking to add in the nucleocapsid portion on the theory that that might provide "better" protection. Such a move would deprive pathologists and scientists of their only diagnostic test with the ability to separate the consequences of Comirnaty, from consequences of an infection.

At the moment, an autopsy[40] can define whether the infection or the INJECTION was the cause.

[39] Frasca 2023 https://pubmed.ncbi.nlm.nih.gov/36839505/
[40] Morz 2022 https://pubmed.ncbi.nlm.nih.gov/36298516/

histopathological analyses of the brain uncovered previously unsuspected findings, including acute vasculitis (predominantly lymphocytic) as well as multifocal necrotizing encephalitis of unknown etiology with pronounced inflammation including glial and lymphocytic reaction. In the heart, signs of chronic cardiomyopathy as well as mild acute lympho-histiocytic myocarditis and vasculitis were present. Although there was no history of COVID-19 for this patient, immunohistochemistry for SARS-CoV-2 antigens (spike and nucleocapsid proteins) was performed. Surprisingly, only spike protein but no nucleocapsid protein could be detected within the foci of inflammation in both the brain and the heart, particularly in the endothelial cells of small blood vessels. Since no nucleocapsid protein could be detected, the presence of spike protein must be ascribed to vaccination rather than to viral infection. The findings corroborate previous reports of encephalitis and myocarditis caused by gene-based COVID-19 vaccines.

MORZ 2022 PMID: 36298516

The question must be asked, "Why have autopsies been refused in this country and why is the test for antibodies against the nucleocapsid proteins not being utilised to answer the questions asked by family members of those who died?"

What else is in Comirnaty other than lipid nanopartlcle-enclosed mRNA?

EMA stated this in the public assessment report dated 23rd December, 2020:

the formulation buffer of FP, is free from contaminating RNases **(REC2).** The description of synthesis of 5'cap and its related impurities were requested during the procedure. Appropriate information was given. The applicant should implement in-house functional activity analytical methods for release testing of enzymes used in the manufacturing process at all relevant manufacturing sites, by Q1 2021 **(REC3)**.

The BNT162b2 active substance is manufactured by in vitro transcription using a linear DNA template, produced via plasmid DNA from transformed *Escherichia coli* cells.

pg 16

and…

Process-related and product-related impurities as well as potential contaminants are described. A number of batches were evaluated for impurities, i.e. clinical, initial emergency supply and PPQ batches from both manufacturing sites.

The sole product-related impurity addressed is double-stranded RNA, derived from the in-vitro transcription reaction. Results from the active substance batches demonstrate that the level of double stranded RNA is low, acceptable and consistent.

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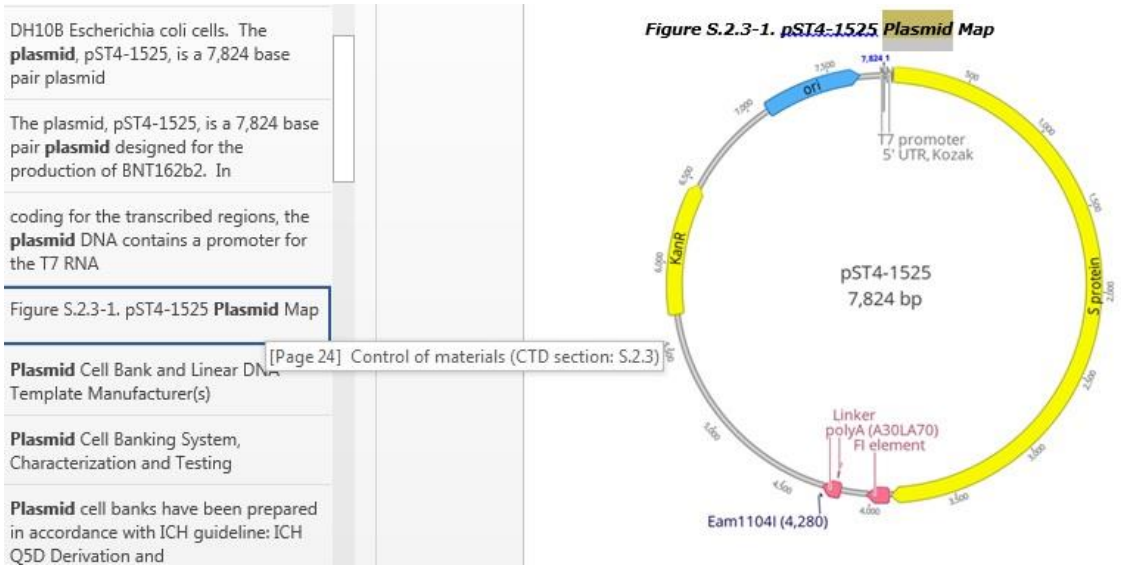
In addition to double stranded RNA, there are truncated RNA, also referred to as fragmented species. Truncated RNA is reflected in the AS specification in terms of RNA integrity. However, the characterisation of BNT162b2 AS is currently not found to be complete in relation to a specific parameter. This is especially important considering that the current AS and finished product acceptance criteria allow for a proportion of fragmented species. The Applicant should provide additional data to further characterise the truncated and modified mRNA species present in the finished product. Relevant protein/peptide characterization data for predominant species should be provided **(SO1)**.

EMA ONLY addressed double stranded and truncated RNA, **not the DNA plasmid**. Why?

Pfizer provided this diagram to the EMA[41] which looks to prove that there is nothing in there:



On 16 February 2023[42], Kevin McKernan, who was the R & D lead at the MIT Human Genome Project, and who owns his own genetics testing laboratory, started a series of 8 substack entries, detailing the results of deep sequencing of Pfizer-manufactured Bivalent Comirnaty.

On March 25th, he published the results[43] of testing Pfizer manufactured Monovalent Comirnaty, and continued to detail the methods, reagents and results of that testing over another 13 substack entries.

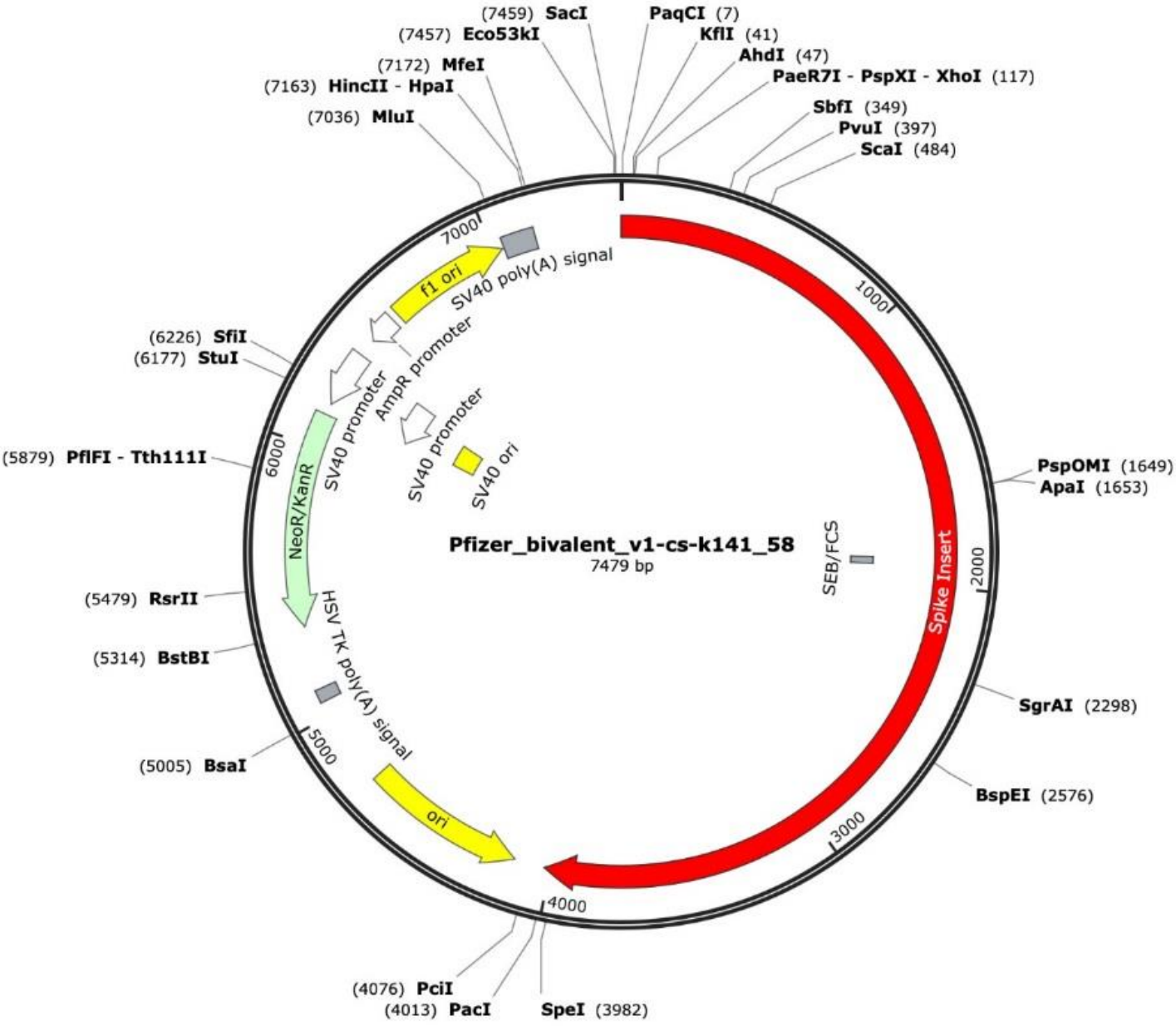
A preprint for peer review was also submitted, but because peer-review takes around 18 months, and those injured need explanations as to their problems, AND because replicating results, is the core of science, everything the laboratory has done, is detailed in over 21 substacks. Laboratories in USA and other countries are now using the same reagents and processes, and have confirmed the accuracy of his findings.

The German laboratory doing the same work, had already tested the monovalent Comirnaty before Kevin McKernan did, and found the same contaminants. They reached out to him after he publically published his results.

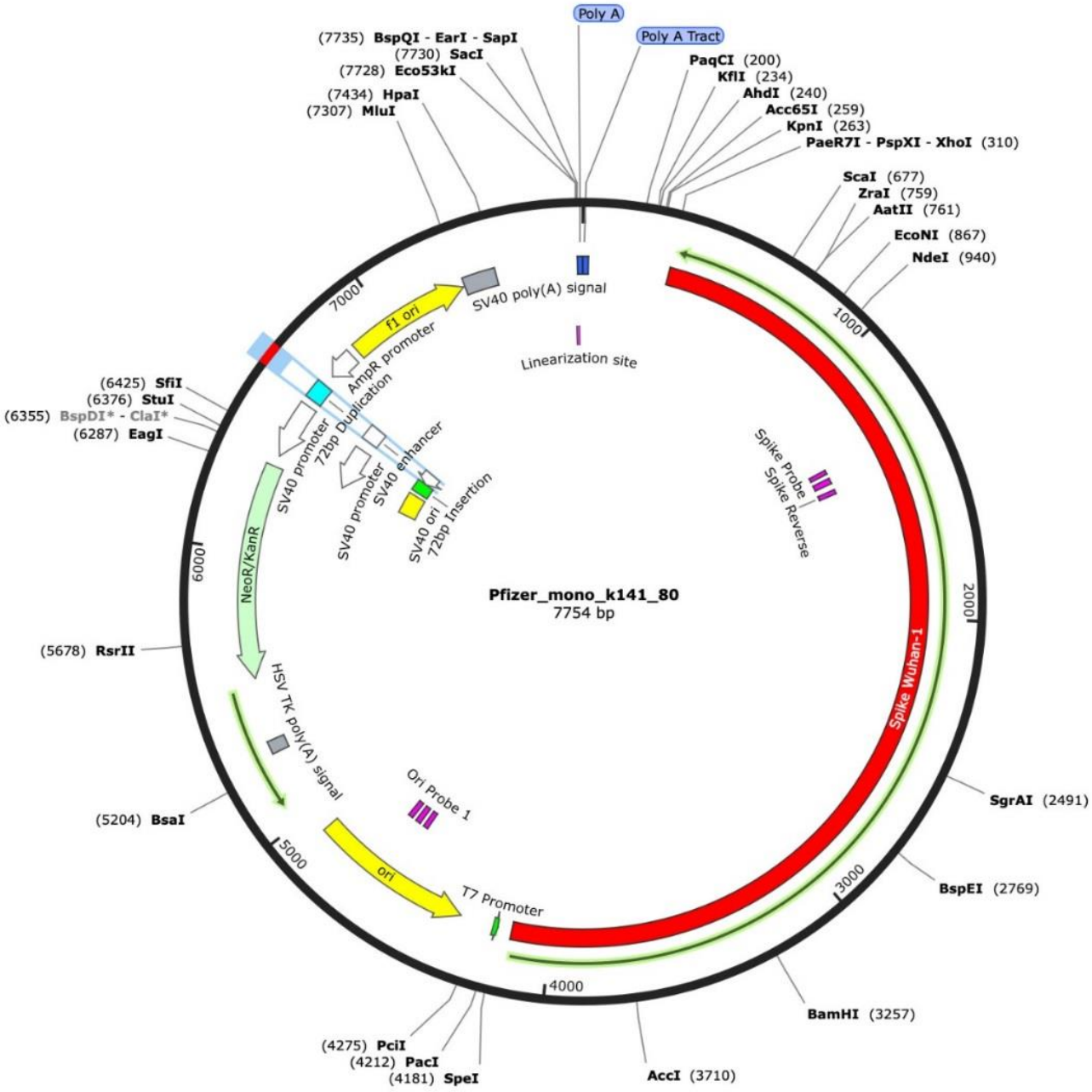
[41] Leaked EMA document
https://mega.nz/file/tQgzBYIS#KZLmkCVKJljv2IotP8hnQNXPhEj-sZYos2mSv8o7fYE

[42] https://anandamide.substack.com/p/curious-kittens
[43] https://anandamide.substack.com/p/dna-contamination-in-pfizer-monovalent

McKernan's first substack posted showed the plasmid map that the laboratory found from bivalent Comirnaty, which differs vastly from the diagram provided to EMA:



This is the plasmid map for the monovalent Comirnaty:



Inside the plasmid, using various PCRs which detect EITHER RNA or DND, McKernan genomically mapped out the contents of the plasmids in Comirnaty, which Pfizer stated had been removed from the product.

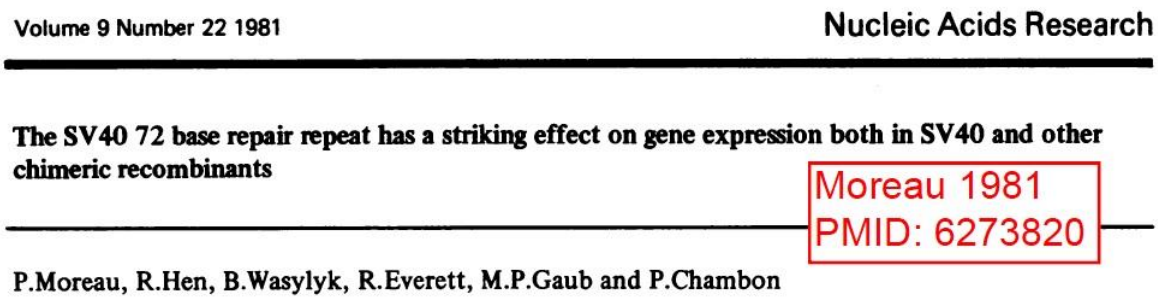
McKernan found that multiple manufacturing process contaminants **have NOT been removed** from the manufacturing process. He mapped out all the DNA, two kanamycin and neomycin antibiotic resistance genes, and the SV40 mammalian gene expression promoter, which forces the E.coli bacteria to multiply rapidly in order to make millions of plasmids very quickly, thereby turbo speeding up mRNA multiplication in plasmid production.

Further substacks and reader comments, particularly those from fellow scientists, discuss his detection methods of the plasmids, and the potential implications of these findings, as well as confirmation of these facts from other laboratories in USA, Germany and Japan (so far).

On April 13th 2023, McKernan posted his results of testing Comirnaty monovalent vials[44] but with a surprise. He stated: "***Both monovalent and bivalent Pfizer vaccines contain 2 copies of the 72 base pair Enhancer in the SV40 promoter."*** In simplistic English, that is ***turbo*** propped gene expression.

The injection of mammalian SV40 gene expression promotors into HUMANS has other implications as well. Here is a skeletal history:

The uses of and potential consequences of SV 40 mammalian gene expression promotor has been known since 1981[45]:



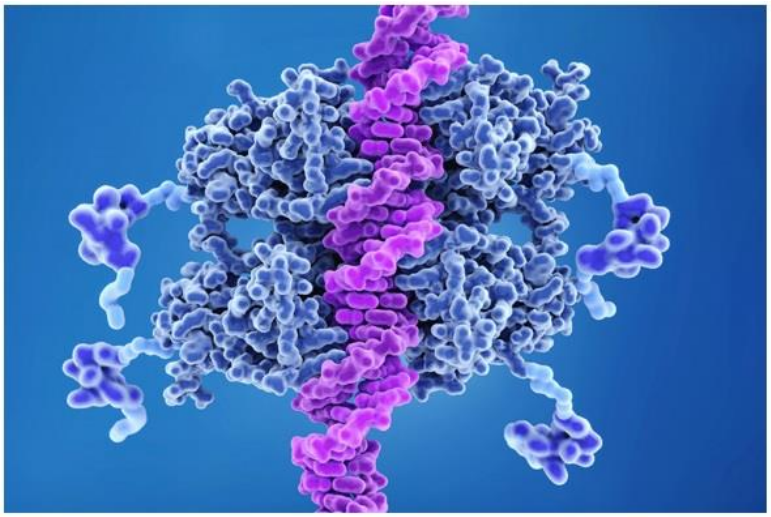
Volume 9 Number 22 1981 Nucleic Acids Research

The SV40 72 base repair repeat has a striking effect on gene expression both in SV40 and other chimeric recombinants

Moreau 1981
PMID: 6273820

P.Moreau, R.Hen, B.Wasylyk, R.Everett, M.P.Gaub and P.Chambon

SV40 was the basis of the GMO industry because it can take genetic material from two different species and splice them into nucleus DNA. SV40 can affect genes that are next to it, or integrate genetic material into DNA.



Dubbed the "guardian of the genome," the p53 protein (blue) senses damage in DNA (pink) and triggers a protective response.

All kinds of vectors have used SV40 – adenovirus vectors[46] and good old DNA plasmids[47] since 1989.

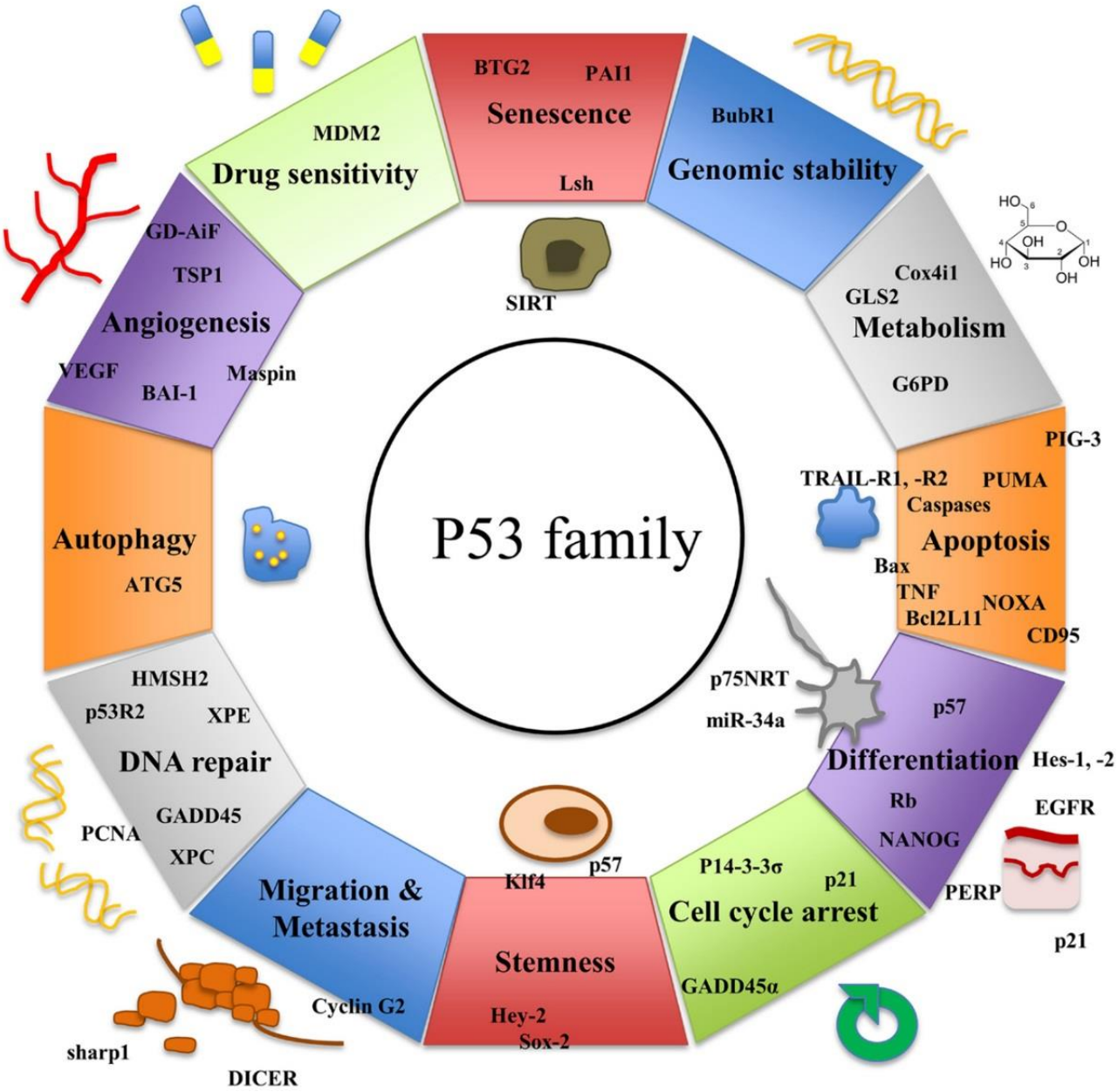
SV40 has long been known[48] to cause cancer by disabling several key cellular growth regulatory circuits.

Among these are the Rb- and p53-families of tumour suppressors. P.53 is the cellular

[44] https://anandamide.substack.com/p/sequencing-the-pfizer-monovalent
[45] Moreau 1981 https://pubmed.ncbi.nlm.nih.gov/6273820/
[46] Fang 1997 https://pubmed.ncbi.nlm.nih.gov/9398356/
[47] Menck 1989 https://pubmed.ncbi.nlm.nih.gov/2538733/
[48] Pipas 2001 https://www.sciencedirect.com/science/article/abs/pii/S1044579X00903432

gatekeeper[49] for growth and division. This is P53[50] to the blue in the graphic above. SV40 stops 53 from binding to genetic material which is precancerous, allowing cancer to form unchecked.

Here is a diagram showing the importance of p53



The whole SV40 virus, was one of 146 monkey contaminants found in both the SALK and SABIN polio vaccines used worldwide, along with another vaccine contaminant called the Mason-Pfizer Monkey

[49] Levine 1997 https://www.sciencedirect.com/science/article/pii/S0092867400818711
[50] Diagramme here: https://www.mskcc.org/news/new-findings-clarify-how-guardian-genome-works

virus, which is a monkey[51] betaretrovirus. The Mason Pfizer Monkey virus, which is a virus that creates a similar immunodeficiency to HIV, is also being used as a vector for gene therapy.

In the 1950s and 60's all the polio vaccine supplied to New Zealand was contaminated with the whole SV40 virus. It should come as no surprise to the scientifically literate that SV40 is directly implicated in many of the cancers[52] which New Zealand has high rates of, though in 2011, scientists didn't know why.

In 2019[53], new findings were from Sloan Kettering were presented about the role of p53 in the body;

"More than 50% of all cancers contain a mutation in the* p53 *gene. The protein made from this gene is critical for ridding the body of cells that have developed genetic mistakes that could lead to cancer. When it stops working, precancerous cells can slip by and a tumor may develop.

Scientists have known about the p53 protein — dubbed the "guardian of the genome" — since the 1970s. It is one of the most investigated molecules ever, the subject of more than 80,000 research papers. But despite the attention, much remains to be understood about how p53 carries out its tumor-suppressing function.

"What we found is that if you re-establish working p53 in a tumor that lost it, the tumor doesn't go away, but it reverts to a precancerous state," says Scott Lowe, Chair of the Cancer Biology and Genetics Program in SKI and one of the study's two corresponding authors. "And the way that it does this is by remodeling metabolism."

"Remodeling metabolism." That tells you how important P53 is.

It was known in 2020[54] that the **S2 subunit of the SARS Cov-2 spike alone**, already interacts with both P53 and BRCA oncogenes.

It was also known that **Covid infection with E.coli endotoxin LPS**[55] from the gut, increases systemic infection by 50%, which acts as a further cancer promoter.

Covid infection through toll receptor 4, is also a pro-cancer risk.

The way the WUHAN spike was designed, pushes the body towards a pro-cancer phenotype,

especially if any infection is left untreated and allowed to breach mucous membranes and make maximum spike throughout the body.

A ***SERIOUS untreated*** covid infection[56] can create a body wide spike inferno.

The medical literature shows that **serious** covid increases that person's probability of cancer, and also seriously impacts cancer patients whose cancer is in remission. We know that the proportion of patients across all ages developing serious infections was very low, and primarily restricted to the elderly and specific comorbidities.

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[51] Ali 2020 https://www.frontiersin.org/articles/10.3389/fmicb.2020.595410/full
[52] Qi 2011, https://pubmed.ncbi.nlm.nih.gov/21955238/
[53] Tontonoz 2019 https://www.mskcc.org/news/new-findings-clarify-how-guardian-genome-works

[54] Singh 2020 https://pubmed.ncbi.nlm.nih.gov/32619819/
[55] Petruk 2020 https://pubmed.ncbi.nlm.nih.gov/33295606/
[56] Zong 2021 httpspubmed.ncbi.nlm.nih.gov34001144

Injection with Comirnaty has a lot of unknowns[57] which will also affect cancer outcomes.

Many things about the vaccination outcome we still do not know: 1. Is the amount of S protein synthesized upon vaccination comparable with that of a natural virus infection or is it higher by many orders of magnitude? 2. How long does the Spike synthesis last following administration of mRNA? 3. How long do vaccine-derived Spike proteins remain biologically active?

It is difficult to calculate exactly the number of copies of the Spike protein that results from the administration of these vaccines, because the declared amount of mRNA is not consistent in all batches (the producer Pfizer admitted that only 30 to 70% of the mRNA in the vaccine is integer for effective translation) and because its intracellular stability may vary from cell to cell.

Thus, it is reasonable to expect a big difference in the biological effect and the immune response between the natural infection and the administration of mRNA vaccines.

This medical article describes a poor woman who had red welts (pruritic erythema) across her whole body which can be seen in photographs in the article[58]. Look at the article yourself to see where her body made spike from Comirnaty:

(mRNA) vaccine (BNT162b2). Her skin lesions spread over time and persisted for more than 3 months. Surprisingly, immunohistochemical staining of the lesion 100 days after the disease onset revealed the COVID-19 spike protein expressed by vascular endothelial cells and eccrine glands in the deep dermis. As she had no episode of COVID-19 infection, it is highly likely that the spike protein was derived from the mRNA vaccine and it might be the cause of the development and persistence of her skin lesions. Her symptoms were prolonged and intractable until oral prednisolone was given.

Autoimmunity is now another signature feature, resulting from Comirnaty[59]:

Results: We identified 31 cases of immune-mediated disease: 18 females (58%); 13 males (42%). Only 4 of them (13%) had an autoimmune background before COVID-19 vaccination. The average time between vaccination and new-onset disease symptoms was 7 days. Among all the cases in our study, 7 patients (22.5%) had new-onset vasculitis, 2 cases had IgA vasculitis and 5 cases had ANCA vasculitis, 6 cases had neurological diseases (19.3%), 4 cases (12.9%) had new-onset systemic lupus erythematosus (SLE), 3 cases (9.6%) presented with new-onset inflammatory arthritis, and one had Sjogren's syndrome (3.2%).

Conclusion: Our study is unique as it is the first study to include the largest number (31 patients) of new onsets of confirmed autoimmune diseases related to Covid-19 vaccines. Comirnaty

Keywords: autoimmune disease, SARS CoV-2, vaccine, immune-mediated disease

My daughter in law, who got all the symptoms of myocarditis and shingles after her first Comirnaty, was repeatedly told that she should have another Comirnaty injection. This is obviously international

[57] Bellavite 2023 https://pubmed.ncbi.nlm.nih.gov/36830987/

[58] Sano 2023 https://pubmed.ncbi.nlm.nih.gov/37154426/

[59] Alqatari 2023 https://pubmed.ncbi.nlm.nih.gov/36910517/

practice, because[60]…:

Case description

A 42-year-old immunocompetent man developed left ARN 12 days following first dose of Pfizer BioNTech mRNA COVID-19 vaccination. Aqueous and vitreous tap polymerase chain reaction testing was positive for VZV. Good visual outcome was achieved with combination therapy, including intravitreal foscarnet, oral valaciclovir and prednisolone, topical dexamethasone and atropine, and barrier retinal laser. Second dose of the vaccine is planned under cover of high-dose oral valaciclovir therapy.

It's not enough to get badly damaged by one injection.

This person got injected with Comirnaty, landed up with retinal Necrosis as a result, and is treated with steroids, antivirals and vitrectomy.

Then his doctors inject a second Comirnaty, which results in a repeat episode, but this time with total retinal detachment.

A Case of Acute Retinal Necrosis Associated with Reactivation of Varicella Zoster Virus after COVID-19 Vaccination

Iwai 2023 PMID: 34802376

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ABSTRACT

Purpose: To report a case of acute retinal necrosis (ARN) after receiving COVID-19 vaccination.

Methods: A case report

Results: A 78-year-old man complained of blurred vision and floaters in the right eye 2 days after receiving BNT162b2 mRNA-based COVID-19 vaccine and was referred to our hospital with worsening visual acuity after 7 days. He had no systemic symptoms and no history of systemic diseases. Ophthalmic examination revealed white-yellowish placoid lesions spreading to the entire circumference of the retina, and temporal and upper lesions extending to the posterior pole, although anterior inflammation and vitreous opacity were mild. Diagnostic and therapeutic vitrectomy was performed, and VZV-DNA was detected by comprehensive PCR using a vitreous fluid sample. The ocular inflammation subsided by systemic administration of antivirals and corticosteroids. However, total retinal detachment requiring repeat vitrectomy using silicone oil occurred after the second vaccination.

Conclusion: ARN associated with VZV reactivation may develop after SARS-CoV-2 mRNA vaccination.

ARTICLE HISTORY
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Revised 11 September 2021
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KEYWORDS
COVID-19; acute retinal necrosis; varicella zoster virus; vaccination

Will they now insist of giving this poor man three more boosters? This third case[61] was also unlucky:

[60] Lo 2022 https://pubmed.ncbi.nlm.nih.gov/35133925/

[61] Yamamoto 2022 https://onlinelibrary.wiley.com/doi/10.1002/cia2.12278

all of his skin lesions. Together, we diagnosed him with persistent, multi-dermatomal VZV as long as 3 months. Therefore, sporadic necrotic nodules and painful subcutaneous nodules were also diagnosed as VZV-related small vessel vasculitis after mRNA COVID-19 vaccination as recently reported.[6]

Since we suspected the association of his lesions with mRNA COVID-19 vaccination, which doses were given 13 days prior to and 8 days after the onset of disease, any expression of the encoded spike protein in the lesion was investigated. Surprisingly, immunostaining with anti-coronavirus spike protein (SP) antibody revealed the SP expression in the intravesicular cells in the epidermis (Figure 3A,B) and endothelial cells of the inflamed vessels in the dermis (Figure 3A,C,D). It was not specified whether VZV infected keratinocytes co-expressed the SP protein since the double staining strategy was not performed in this study. In addition, the SP was also found in the endothelial cells of venules in the subcutaneous fat tissue underlying the herpetic vasculitis lesion (Figure S1). Note that

Here the doctor details another example of Comirnaty mRNA-induced spike being made in epithelial cells, a long way away from the injected arm, again refuting what we were told.

Myocarditis.

The medical literature details a huge evolving problem affecting all age groups, with numbers and rates much higher than reported.

Many scientists and cardiologists are very angry about Comirnaty heart issues, though New Zealand public remains uninformed about the many published international studies.

An article just published[62] expresses deep concern at the vastly under-reported myocarditis, using carefully crafted language, presumably so that the publishing doctors don't lose their jobs…:

[62] Frasca 2023 https://pubmed.ncbi.nlm.nih.gov/36839505/

Review

Safety of COVID-19 Vaccines in Patients with Autoimmune Diseases, in Patients with Cardiac Issues, and in the Healthy Population

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Abstract: The coronavirus disease 2019 (COVID-19) has been a challenge for the whole world since the beginning of 2020, and COVID-19 vaccines were considered crucial for disease eradication. Instead of producing classic vaccines, some companies pointed to develop products that mainly function by inducing, into the host, the production of the antigenic protein of SARS-CoV-2 called Spike, injecting an instruction based on RNA or a DNA sequence. Here, we aim to give an overview of the safety profile and the actual known adverse effects of these products in relationship with their mechanism of action. We discuss the use and safety of these products in at-risk people, especially those with autoimmune diseases or with previously reported myocarditis, but also in the general population. We debate the real necessity of administering these products with unclear long-term effects to at-risk people with autoimmune conditions, as well as to healthy people, at the time of omicron variants. This, considering the existence of therapeutic interventions, much more clearly assessed at present compared to the past, and the relatively lower aggressive nature of the new viral variants.

Keywords: COVID-19; COVID-19 vaccines; safety; autoimmune diseases; side effects; risk/benefit ratio; myocarditis

Every Member of Parliament should read this study. It makes very sobering reading, because what they talk about, is what resulted from the mandates pushed on people like my daughter in law.

But worst of all, unlike a covid infection, Comirnaty packs all the manufacturing contaminants that shouldn't be there, with the mRNA, inside those lipid nanoparticles injected into the arm, which then travel everywhere in the body, because the lipid nanoparticles protect the contents from detection by the immune system.

Those antibiotic resistant genes, E.coli endotoxin, and the ***SV40 mammalian gene expression promoter*** don't come with the covid infection ….

Injecting all that inside the lipid nanoparticles guarantees free access everywhere, resulting in many different "recipes" for potentially disastrous side effects.

A few of those recipes include major thrombotic disorders, immune system damaging disorders through immune system downregulation, molecular mimicry and autoimmunity, AND cancer.

It comes as no surprise that when the Comirnaty-injected get their cancer diagnosis, both the patient and doctor refer to it as TURBO cancer.

An SV40 mammalian gene expression promoter is oncogenic when it integrates next to genes like p53 which suppress cancer. SV40 also has a well-documented history of silencing oncogenic genes like and including P53 that keep cancer in control.

Consider the implications of SV40 gene expression promoter amplifying the problems of a spike *that is already known* to cause blood and immune system dysfunction, and to downregulate key oncogenic genes.

Given that NZ Comirnaty programme was almost a year behind most other countries, parliament should be aware by now, that cancer rates have dramatically increased where mRNA injections have been used. Oncologists are speaking out about it, and being sacked and silenced for doing so.

In 2020, there was an in vitro study[63] showing that Comirnaty could reverse transcribe into a human liver cell line.

In 2020 the proof of existence of plasmid contaminants in Comirnaty did not exist, and criticism of the study[64] maintained that the testing methods used were scientifically incapable of evaluating Comirnaty genotoxicity, and that mRNA reverse transcribed in vitro cell lines meant nothing in real life.

The 2020 study only used reagents which pick up RNA, **not DNA.** Scientists can't know about the existence of the spike DNA inside the plasmid, inside the lipid nanoparticle along with a gene promoter, if they had assumed it's been removed, so therefore did not use the reagents to detect the plasmid DNA.

Comirnaty contamination changes everything, because theoretical Comirnaty RNA reverse transcriptase integration into the DNA is no longer even necessary, because the spike DNA is already in Comirnaty, along with the SV40 gene expression promoter which can integrate the spike DNA into the nucleus, as well as further suppress cancer genes.

Kevin McKernan also quantified[65] the **contaminating plasmid as 25 – 30% the total amount of a dose**, and that the plasmids are transformation competent in E.coli.

McKernan says, ***"The Pfizer DNA contamination ranges from 8.19-11.3 ng/ul with 23-28ng/ul of mRNA…This equates to 27.3% (9.1/33.4) of the nucleic acid in each vaccine being expression vector. This is several orders of magnitude over the the EMAs limit of 330ng/mg….*** **we demonstrate the dsDNA contamination levels are 100 fold higher, and imply trillions of DNA molecules per dose...** ***If each injection provides trillions of dsDNA contaminants, LINE-1 RT activity is not a necessary step for genome integration."*** (Please read the whole substack to understand the science of this.)

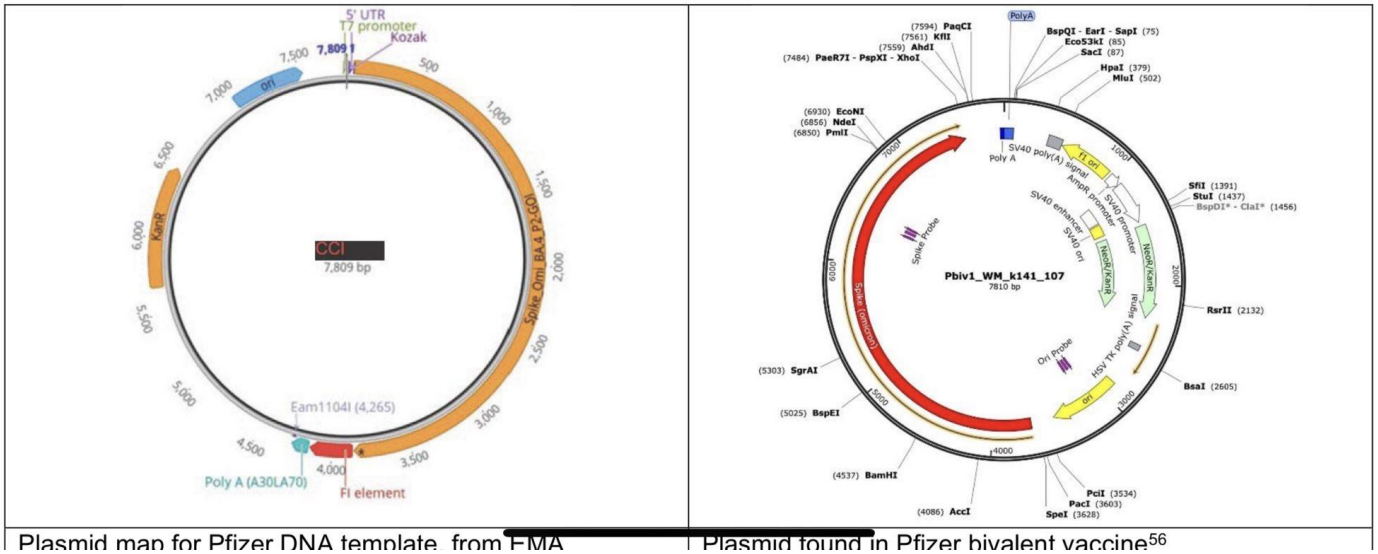
McKernan also discusses the fact that only around 50% of the mRNA could be thought to be full length while the rest is "truncated" mRNA. Again, the documents to the three agencies state that ***there is truncated mRNA*** in Comirnaty, but no-one could say what the ribosome

[63] Alden 2022 https://pubmed.ncbi.nlm.nih.gov/35723296/
[64] Merchant 2022 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9164063/
[65] https://anandamide.substack.com/p/pfizer-and-moderna-bivalent-vaccines

would make from truncated RNA, which is usually missing stop codons. It is important to compare the plasmid map given to EMA with the plasmid maps found in all the international laboratories which are now equipped to test the mRNA vials:

9.3. Plasmid maps

Compare here the plasmid maps for the Pfizer vaccine according to an EMA document and from this present investigation:



Plasmid map for Pfizer DNA template, from EMA

Plasmid found in Pfizer bivalent vaccine[56]

So when does the ribosome know when to stop churning out the micro-section of instruction from truncated mRNA? What does that micro-section of protein do in the body?

McKernan also points out that Pfizer's own data[66] implicates their contamination.

Continual references to potential plasmid contamination are scattered through EMA documents, FDA documents, but **a generous explanation, or excuse** to explain why neither EMA, FDA or TGA understood the implications, could have been that there was NOBODY on any of these regulatory groups who understood the new technology, and therefore didn't know what to ask for in terms of proof, to confirm contamination was not there. However, such generosity is fragile.

Someone must have known the implications, because three decisions were made to NOT post that information on any regulatory website other than in Japan, and that information was only found through freedom of information requests.

When you can only obtain facts by legally demanding them, it is already obvious that someone knows that there is something to hide.

[66] https://anandamide.substack.com/p/pfizers-own-data-implicates-their

What other contaminants[67] in Comirnaty are likely to be present, when plasmids are in the injection?

include plasmid related impurities or residual DNA template.

Table S.2.6.4-1. Additional Process Related Impurities

Impurity	Source
NTP (ATP, CTP, GTP, N1-methylpseudo UTP)	In-Vitro Transcription Reaction
5'-cap	In-Vitro Transcription Reaction
DL-Dithiothreitol	10X Transcription Buffer
Spermidine	10X Transcription Buffer
Magnesium Acetate	10X Transcription Buffer
Calcium Chloride	DNase I Buffer
Ammonium Sulfate	UF/DF Buffer
Triton X-100	T7 Polymerase Storage Buffer
Tris-HCl	Enzyme Storage Buffer
Glycerol	Enzyme Storage Buffer
Sodium Chloride	Enzyme Storage Buffer
Potassium Chloride	Enzyme Storage Buffer
RNase inhibitor	In-Vitro Transcription Reaction
DNase I	DNase I Digestion
T7 RNA Polymerase	In-Vitro Transcription Reaction
Proteinase K	In-Vitro Transcription Reaction
Pyrophosphatase	In-Vitro Transcription Reaction

What could any of this, including all the above, do in any part of the body?

No-one knows, because in reality, the humans into whom this is injected, are the unfortunate real-time bio-distribution and immunological subjects who are not being studied. What Comirnaty actually does, and where the mRNA manufactures spike in the body, will vary between individuals because of unique individual bio-immunological and physical susceptibility. The injected are the Guinea pigs, and the many and varied outcomes being reported in the medical literature, are likely to be the tip of the iceberg.

McKernan is now working with international laboratories designing tests to try to identify plasmid contaminations in injured people.

But it gets worse, because as McKernan shows from both medical literature on plasmid contamination, and as is mentioned many times in the EMA documents, one of the bigger cellular risks **is the inclusion of E.coli endotoxin called lipopolysaccharide**.

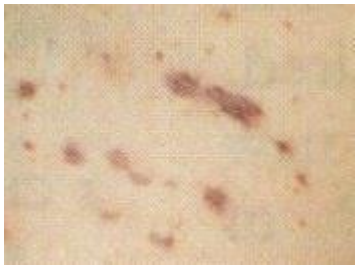
McKernan make it clear that the presence of plasmids is a proxy for E.coli endotoxin, because the plasmids were made in the E.coli.

If the plasmid is still there, the bacterial walls from E.coli are still there. Why does that matter? Endotoxin. That's why.

[67] EMA document 19th November 2020
https://mega.nz/file/tQgzBYIS#KZLmkCVKJljv2IotP8hnQNXPhEj-sZYos2mSv8o7fYE

What is E.coli endotoxin?

Put simply, it is fragments of the bacterial envelope of E.coli. Live E.coli multiplies every 20 minutes under normal body temperature, every 3 minutes at raised body temperature. As the cell divides into two (mitosis) a fragment (called curlin) of the bacterial envelope drops off. That envelope fragment is one of the most powerful bacterial toxins in the world. It is similar to the toxic bacterial envelope fragments which can result in the blackish blood haemorrhages you have seen on photographs of people with bacterial meningitis.



Those blood spots happen because there is a huge amount of bacteria in the blood dropping off curlin in the blood vessels in the body. Curlin makes the blood vessel walls leaky like a colander, and blood seeps through into tissue causing these pooled blood spots.

If someone has meningitis, one of the most dangerous times for them, is after the first lot of antibiotics, because that kills the bulk of susceptible bacteria, shredding the envelope into pieces and resulting in a huge bolus dose of bits of E.coli envelope into the body, which being highly toxic can cause toxic shock syndrome and result in death. If meningitis is diagnosed early before the rash becomes body-wide, toxic shock syndrome is less likely to happen because the bacterial load is much lower.

With Comirnaty, the situation is a bit different. The December 2020 EMA[68] report notes in several places that potential contaminants are endotoxin and "bioburden".

pg 17

Specifications for the circular plasmid DNA as well as for the DNA linear template are provided. Process- and product-related impurities including host cell genomic DNA, RNA, proteins, endotoxins, bioburden and plasmid isoforms, for the plasmid DNA, are routinely quantified. The reference material is described. Implementation of any changes in the manufacture of the linear DNA template should be applied for in a variation application.

They assert that because Pfizer guaranteed that these are tested for at all stages of manufacture and removed, that there were no concerns about them.

It would appear that EMA are mistaken in their assumption.

Kevin McKernan:

Given these vaccines exceed the EMA limits (330ng/mg DNA/RNA) with the Qubit™ 3 and Agilent data and these data also exceed the FDA limit (10ng/dose) with the more conservative qPCR standard curves, we should revisit the lipopolysaccharide (LPS) levels. Plasmid contamination from *E.coli* preps are often co-contaminated with LPS. Endotoxins contamination can lead to anaphylaxis upon injection (Zheng et al. 2021).

[68] https://www.ema.europa.eu/en/documents/assessment-report/comirnaty-epar-public-assessment-report_en.pdf

This process can lead to residual plasmid DNA being left in the vaccine mRNAs. The method can also lead to truncated mRNA synthesis as seen in many RNA integrity (RIN plots) data listed as a concern by the EMA and TGA. The presence of *E.coli* based plasmids is a canary for Lipopolysaccharide (LPS or endotoxin) contamination. Whenever you see high levels of plasmid contamination derived from gram negative bacteria like *E.coli*, you should expect high levels of endotoxin contamination. Injecting endotoxin can lead to anaphylaxis and toxic shock syndrome.

But E.coli can cause trouble in many different ways as described later.

McKernan points out that the contents of different vials are highly variable. So what you get from a Comirnaty injection is a lottery. "All vials are not the same..." is the title of a medical article in 2021[69] which comments on the lack of quality control, vial to vial.

Bottling Comirnaty fluid isn't like counting sixty linseed seeds into each vial. Huge vaccine vial variability has been seen as far back as 1985, when American researchers published their results of testing a batch of pertussis vaccine. The vials varied from almost nothing in a dose to 100 times the label specifications.

ingredients. A recent study reported that 581 people with anaphylaxis histories from previous vaccine shots did not develop anaphylaxis after receiving the Pfizer/BioNTech mRNA COVID-19 vaccine [2], suggesting that the vaccine ingredients might not always be the cause for anaphylaxis associated with this vaccine. While both active and inactive ingredients of a vaccine may be the cause of some adverse reactions, another possible cause to consider is subpar quality of the individual vial.

It is now known that when Comirnaty is thawed, there is an immediate break down of many of the lipid nanoparticles, which results in mRNA and whatever else is in lipid nanoparticles to spill into the fluid, outside of those lipid nanoparticles which stay whole. It is thought that such material isn't dangerous…but is that so?

Depending on the lottery of what is in which vial, if the contaminants have been quantified as 25 – 30% of the total dose which will include free E.coli endotoxin and other contaminants the E.coli endotoxin alone, could be enough to cause toxic shock syndrome if the needle goes into a deltoid muscle vein and straight into the blood stream. According to PubMed, vein injection is estimated at around 1% of Comirnaty injections, particularly as vaccinators are instructed not to aspirate to check if the needle is in a muscle vein—even when the recipient requests it.

[69] Yu 2021 "All vials are not the same" https://pubmed.ncbi.nlm.nih.gov/34625289/

It has previously been suggested that anaphylaxis is caused by allergy to PEG, one of the ingredients of the lipid nanoparticles. This is disputed by a 2021 study[70], which did not know that E.coli endotoxin may be in Comirnaty.

The justification for not checking whether the needle is in a deltoid vein, is that doing so means the injection takes longer and is more painful. The aim is to do it fast so that people don't complain, and time is money. New Zealand employed many inexperienced people who were not qualified to do aspirations before the injections.

The diagram above, doesn't deal with two other known factors of spike made in the body.

The first, is that ***spike from infection, disrupts coagulation both by itself, but especially if the person happens to have endotoxin in their body.***

The second is that Comirnaty by whatever mechanism, inhibits the adaptive immune responses and alters innate immune fitness[71] resulting in the reactivation of latent viruses, which ironically also appear on the list of viruses with potential to cause cancer as a result of CHRONIC infection.

Covid infection in vulnerable people can also result in reactivation of latent viruses such as Epstein-Barr, varicella virus, cytomegalovirus and other viruses, all of which have oncogenic potential if not brought back under control.

Which brings us back to **the reason why it was so important to use all possible means to treat infections**.

- **The question has to be asked as to why it was so imperative from March 2020, that the order be given to NOT treat covid infections, which was eminently doable.**

As I said before, the mRNA injections have ***all*** been implicated in reactivation of many latent oncogenic viruses.

With regard to my daughter in law, the shingles rash first appeared the day after the injection was given, as a pimply red rash in the armpit of the arm she was jabbed in. Within three days, the typical

[70] Yu 2021 All vials are not the same
[71] Qin 2022 https://pubmed.ncbi.nlm.nih.gov/36054264/

shingles bubbly swathe extended from her right armpit under the injected arm, across part of the right side of her back in classic dermatome pattern.

I also believe that my daughter in law received her Comirnaty into the vein, because her numbness, chest pain, breathing difficulties, and other symptoms started shortly after the injection.

Mouse studies in June 2022[72] showed that Comirnaty injected into a vein results in immediate myocarditis[73], and what was seen in that study is what is happening in humans, as well as mice.

We have all seen videos of children and adults dropping unconscious and some dying at public facilities where Comirnaty was injected, which would suggest E.coli endotoxin in the vials causing anaphylaxis / toxic shock syndrome.

If the injection goes into the muscle and not the vein, that leads to a different dimension to the endotoxin problem, and different myocarditis pathogenesis.

The lipid nanoparticles (LNP) take their whole cargo into the cell like a Trojan horse. So if all those contaminants inside the LNP when it fuses with the cell, are dumped into the cell, then the E.coli will have a different function, than during infection.

After the ribosomes in the cell convert the truncated and whole mRNA, the spike comes out in two ways. One is cell – cell via exosomes[74]. Bansal[75] further elaborated in answer to a comment that the detection of S2 spike sequences in exosomes after a second dose of Comirnaty **"at 4 months reflects membrane-bound S2 protein that is still present in inoculated cells. S2 is quite stable and there are reports of S2 protein present several weeks after transfection"**

The second way that spike leaves the cell is by being presented on the cell surface. These two methods also apply to infection.

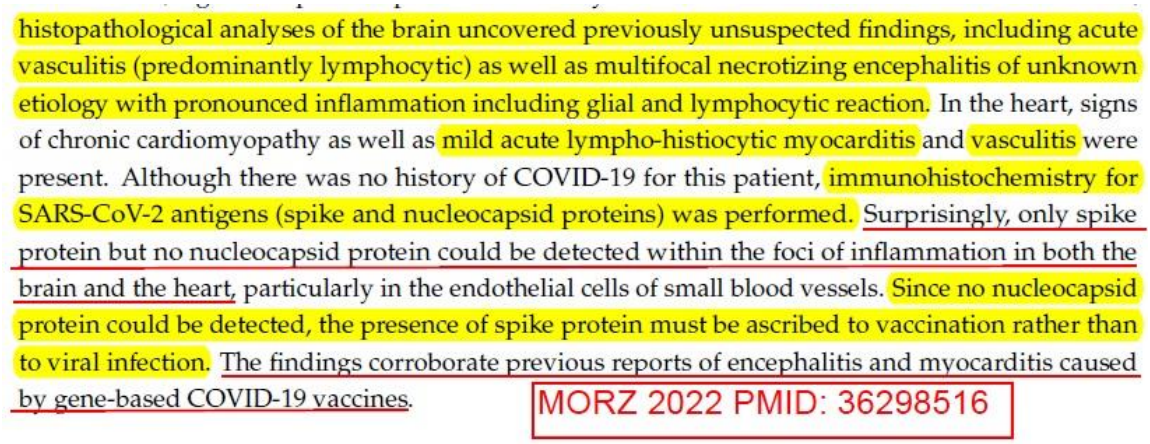
The immune system recognises spike from infection relatively and degrades it. In serious covid infection, if there is too much spike, the immune system can go into exhaustion and leave it there, resulting in organ damage. The same can happen after the vaccine, and is in fact more likely after repeatedly being injected and forcing the body to make spike time after time after time.

The mRNA-induced spike made in a person's body, is deliberately made more invisible to the immune system because Pfizer changed every uridine protein (which is quickly recognised by the immune system) and replaced uridine with a different molecule called N1-Methylpseudouridine-5'-Triphosphate which is represented by this symbol Ψ.

Pfizer didn't just change one uridine molecule. Pfizer changed out all the uridine, which results in the creation of a "stealth" spike, hidden from the immune system. The spike made by mRNA, alsohas receptors for E.coli endotoxin, so when the mRNA spike collects endotoxin on the way out of the cell, that will increase the types of responses that spike will cause in the body.

[72] Li 2022 https://pubmed.ncbi.nlm.nih.gov/34406358/
[73] Knowles 2022 https://pubmed.ncbi.nlm.nih.gov/34453510/
[74] Bansal 2022 https://pubmed.ncbi.nlm.nih.gov/34654691/
[75] Bansal 2022 https://pubmed.ncbi.nlm.nih.gov/35418502/

Spike alone, from the infection, when it attaches to ACE 2 receptors in blood vessels weakens blood vessels and causes a clotting cascade, and mRNA-induced spike does the same thing.



histopathological analyses of the brain uncovered previously unsuspected findings, including acute vasculitis (predominantly lymphocytic) as well as multifocal necrotizing encephalitis of unknown etiology with pronounced inflammation including glial and lymphocytic reaction. In the heart, signs of chronic cardiomyopathy as well as mild acute lympho-histiocytic myocarditis and vasculitis were present. Although there was no history of COVID-19 for this patient, immunohistochemistry for SARS-CoV-2 antigens (spike and nucleocapsid proteins) was performed. Surprisingly, only spike protein but no nucleocapsid protein could be detected within the foci of inflammation in both the brain and the heart, particularly in the endothelial cells of small blood vessels. Since no nucleocapsid protein could be detected, the presence of spike protein must be ascribed to vaccination rather than to viral infection. The findings corroborate previous reports of encephalitis and myocarditis caused by gene-based COVID-19 vaccines.

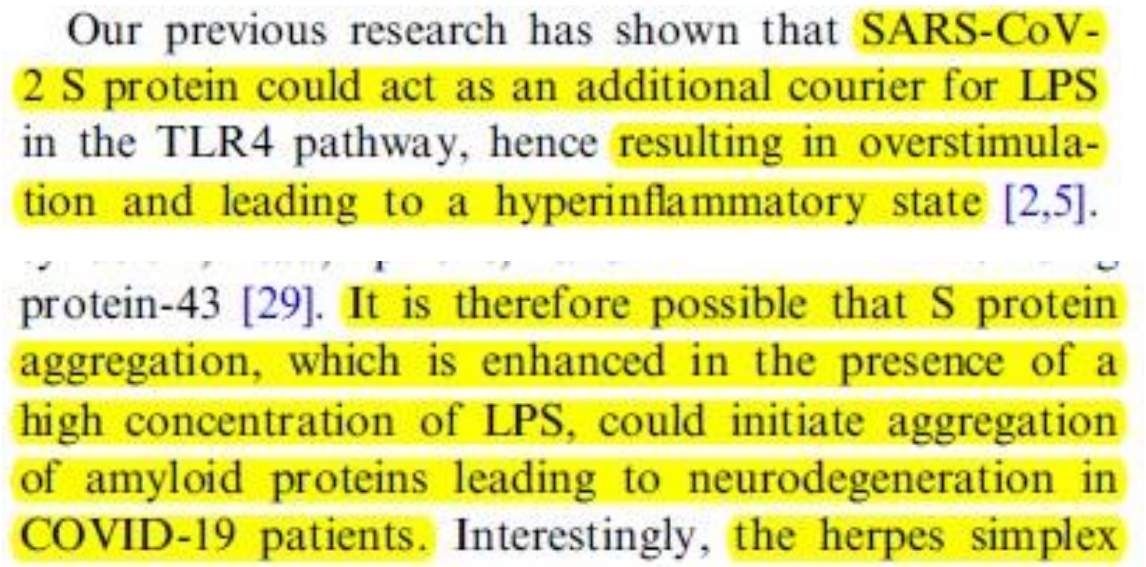
MORZ 2022 PMID: 36298516

Infection spike in serious cases where the innate immune system cannot contain it can go anywhere. Comirnaty spike by design, goes everywhere, because the lipid nanoparticles prevent it's detection by the immune system. The lipid nanoparticle then opens cell membranes on any cell, to allow entry anywhere.

During an autopsy it is possible to identify whether the spike is from Comirnaty or infection.

What happens if the injection results in intracellular spike production, and then the spike picks up endotoxin which was in the same lipid nanoparticle and the endotoxin attaches to several receptors on the outside of the spike?

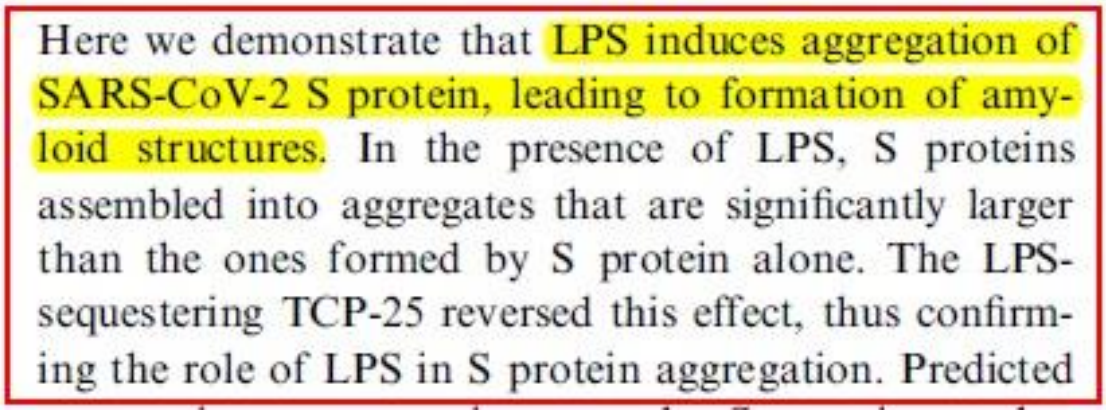
This article discusses one problem, in relation to INFECTION, not injection, but the same thing applies to Comirnaty mRNA-induced spike. Spike plus endotoxin, results in several things[76]:



Our previous research has shown that SARS-CoV-2 S protein could act as an additional courier for LPS in the TLR4 pathway, hence resulting in overstimulation and leading to a hyperinflammatory state [2,5].

protein-43 [29]. It is therefore possible that S protein aggregation, which is enhanced in the presence of a high concentration of LPS, could initiate aggregation of amyloid proteins leading to neurodegeneration in COVID-19 patients. Interestingly, the herpes simplex

[76] Petrlova 2022 https://pubmed.ncbi.nlm.nih.gov/36050806/


Here we demonstrate that LPS induces aggregation of SARS-CoV-2 S protein, leading to formation of amyloid structures. In the presence of LPS, S proteins assembled into aggregates that are significantly larger than the ones formed by S protein alone. The LPS-sequestering TCP-25 reversed this effect, thus confirming the role of LPS in S protein aggregation. Predicted

So individual spike made by injected mRNA, may be presented at the cell surface with some LPS which was also inside the lipid nanoparticles, and then become free floating in body fluid and blood.

If that spike and endotoxin attaches to Ace2 receptors on blood vessel walls, the combination is guaranteed to weaken the vessel wall and start a clotting cascade.

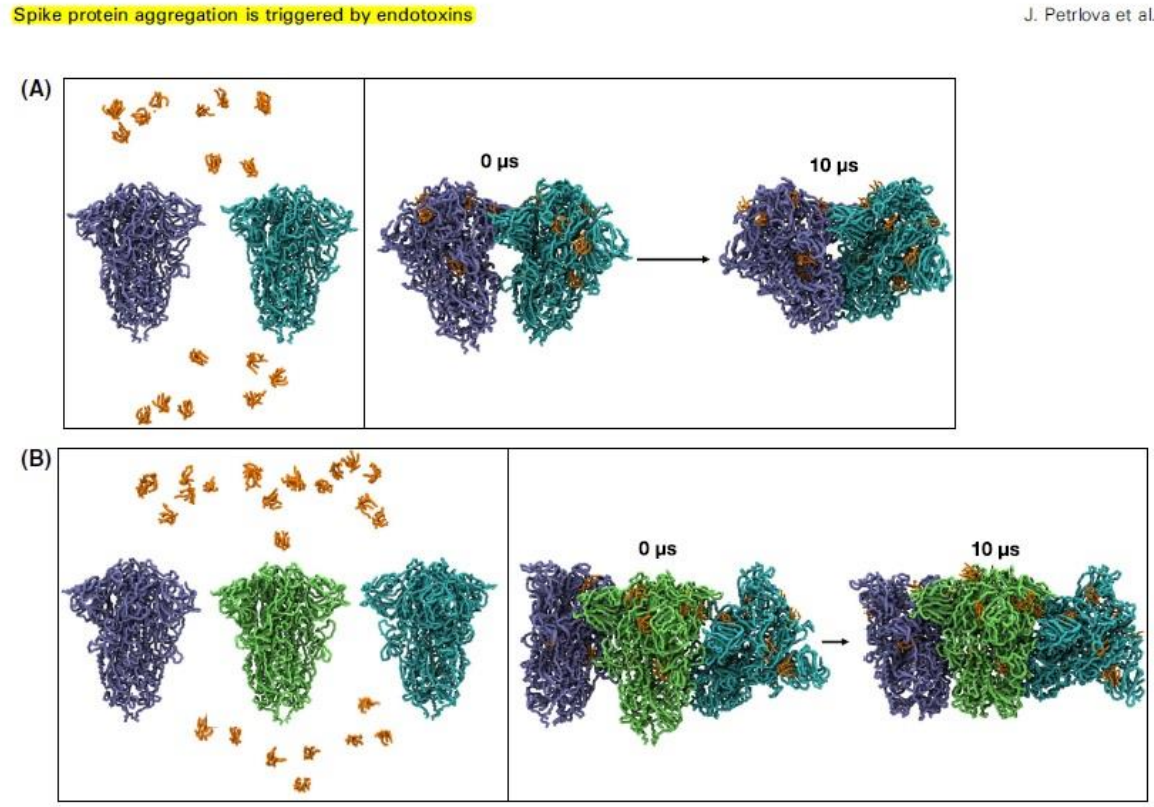
The aggregation mentioned above, can happen in the blood or in the cell. There does come a time when the cells making the spike are "seen" by the immune system as an enemy, and killer-T cells are sent in to destroy the whole cell which then spills the contents out into the blood stream, tissues, and body fluids. The results can be the development of severe inflammation and autoimmunity.

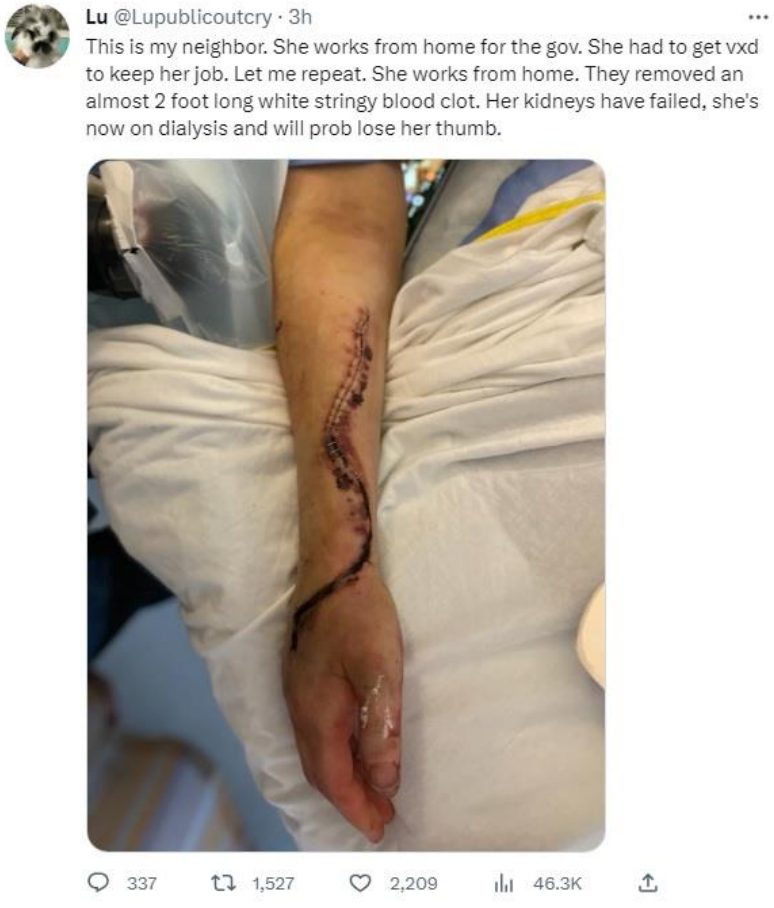
As the article said, "amyloid" structures are implicated in neurodegeneration, such as dementia, Alzheimer's etc.

What are the consequences of this for recipients of Comirnaty? What is the impact on each person's body with every subsequent injection making the body make yet more spike?

We already knew in 2020[77], that the spike itself contained amyloid genetic sequences. Add endotoxin to that in the cell which then causes aggregation, and what then?

[77] Charnley 2020 https://pubmed.ncbi.nlm.nih.gov/33295606/





There are now many pathologists worldwide, discussing the fact that the long ropey "clots" being removed at autopsy, or even in live people from veins, are not normal BLOOD clots but when washed are comprised of amyloid structures. To the left (May 15, 2023) is one of many examples from twitter[78].

There are now many descriptions from autopsies, finally being published in PubMed.

When this happens body wide, the prognosis is not good, whether it's white amyloid clots or brain degeneration.

[78] May 15 2023 https://twitter.com/Lupublicoutcry/status/1657891066161537025

One of the findings[79] from long covid is that sufferers have unique micro clots which have never been seen before, with blood samples containing anomalous (amyloid) micro clots, which are scattered throughout the body. Which is, aggregated spike plus endotoxin. I have yet to see any medical reports of long ropey clots in those who got long covid before a vaccine was available. Because the medical system asserted that vaccination could eliminate long covid, many people who have had long covid and the vaccine, now have additional health issues from the vaccine.

There is no doubt that the combination of spike and endogenous endotoxin during infection[80] stirs up the immune system to dangerous levels, and can cause immune fatigue. That usually only causes trouble in people with high levels of pre-existing endotoxin in their bodies, which usually comes from the gut. Those people usually have compromised immune systems and/or comorbidities as well, which result in pre-existing high levels of inflammation, which is tinder for the covid fire.

Again, refusing to treat that fire and the infection to put out the fire from the start of the infection, is what can result in trouble.

The combination of mRNA-manufactured spike, which already has amyloid genetic sequences in the spike itself, and endotoxin, delivered by Comirnaty lipid nanoparticles into cells bypassing the immune system, is a much worse combination than infection, because there are no immune safety nets to stop high levels of inflammation. Spike production can continue for weeks, not hours as we were told, AND every injection is a new event, with compounding possibilities.

Myocarditis can occur in different ways. One is that mRNA inside lipid nanoparticles, which has travelled from the deltoid, can make spike in the adrenal glands[81].

male(s)" or "athlete(s)." The rationale and data that supported the hypothesis were as follows: SARS-CoV-2 mRNA vaccine-induced myocarditis primarily affected young males, while the risk was not observed following COVID-19 infection; independent autopsies or biopsies of patients who presented post-SARS-CoV-2 mRNA vaccine myocarditis in different geographical regions enabled the conclusion that a primary hypercatecholaminergic state was the key trigger of these events; SARS-CoV-2 mRNA was densely present, and SARS-CoV-2 spike protein was progressively produced in adrenal medulla chromaffin cells, which are responsible for catecholamine production; the dihydroxyphenylalanine decarboxylase enzyme that converts dopamine into noradrenaline was overexpressed in the presence of SARS-CoV-2 mRNA, leading to enhanced noradrenaline activity; catecholamine responses were physiologically higher in young adults and males than in other populations; catecholamine responses and resting catecholamine production were higher in male athletes than in non-athletes; catecholamine responses to stress and its sensitivity were enhanced in the presence of androgens; and catecholamine expressions in young male athletes were already high at baseline, were higher following vaccination, and were higher than those in non-vaccinated athletes.

Researchers looking at heart samples from people with myocarditis[82] have also demonstrated that the mRNA makes spike inside the heart tissues:

[79] Pretorius 2021 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8381139/
[80] Petruk 2020 https://pubmed.ncbi.nlm.nih.gov/33295606/
[81] Cadegiani 2022 https://pubmed.ncbi.nlm.nih.gov/35971401/
[82] Stervbo 2023 https://pubmed.ncbi.nlm.nih.gov/36936235/

elusive so far. Our findings demonstrate for the first time that SARS-CoV-2 vaccine-associated myocarditis is accompanied by a substantial infiltration of the myocardium by SARS-CoV-2 specific T-cells. The reason for the SARS-CoV-2-specific T cell infiltration is not known. In general, T cell infiltration is ether antigen-driven or unspecific due to inflammatory stimuli. With respect to the antigen-induced response, an autoimmune reaction driven by antigenic mimicry has been suggested (4). Thus, it has recently been demonstrated in a mouse model that intravenous administration of the BNT162b2 leads to acute myocarditis with expression of the S-protein in the myocardium (5). This finding led to the hypothesis that SARS-CoV-2 specific T-cells might mediate vaccine-induced myocarditis. On the other hand, vaccination-caused expression of Spike protein by myocytes facing myocardium tissue as a target for Spike-specific T cells, can be another at least theoretical explanation for the accumulation of SARS-CoV-2-specific T cells in myocardium following vaccination.

Another researcher[83] doing appropriate testing on post mRNA myocarditis found that ***"markedly elevated levels of full-length spike protein (33.9±22.4 pg/mL), unbound by antibodies, were detected in the plasma of individuals with post vaccine myocarditis, whereas no free spike was detected in asymptomatic vaccinated control subjects"***

However, he was unable to locate where the free-floating full length spike protein was coming from.

Much more could be added in here, but it all repeats similar vaccine side effects, and would fill a book.

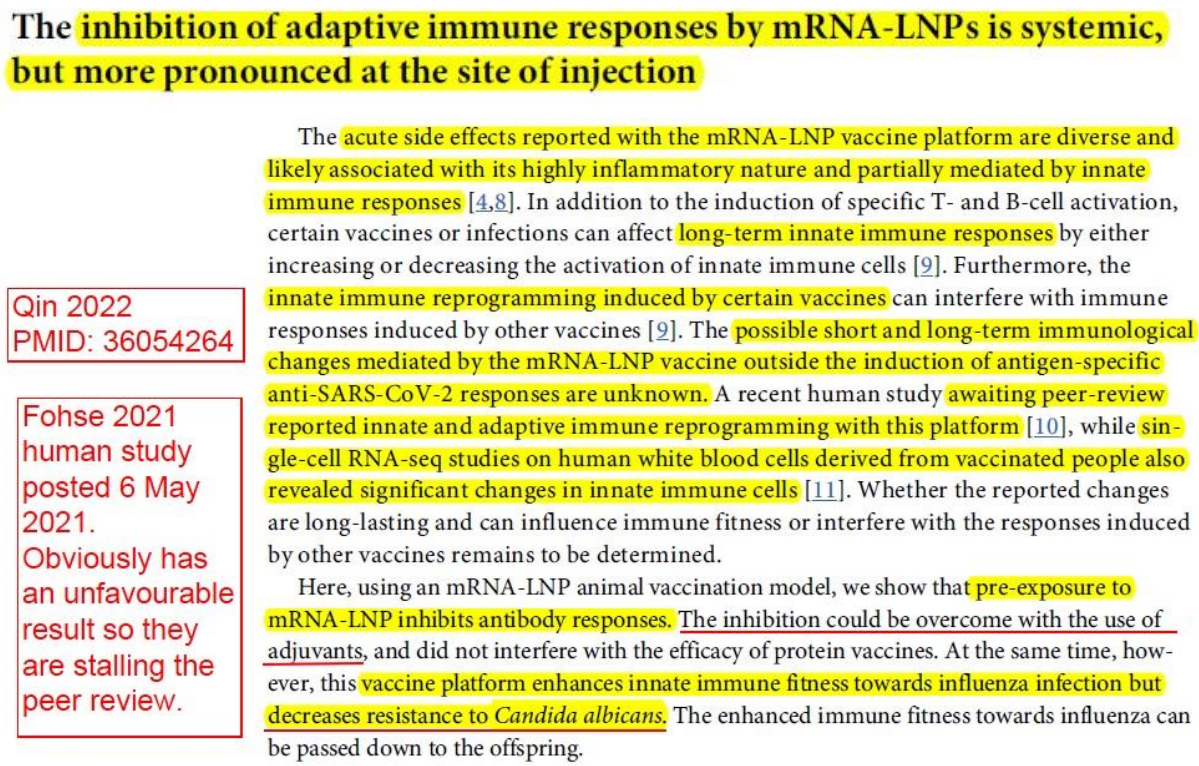
Moving back to Shingles.

Why would the Comirnaty jab result in the reactivation of latent viruses?

Comirnaty not only changes the immune system, but even more interesting, those changes, in animal studies, are handed down through three generations. Which has implications when injecting pregnant mothers with Comirnaty.

[83] Yonker 2023 https://pubmed.ncbi.nlm.nih.gov/36597886/

What are those changes[84]?



The inhibition of adaptive immune responses by mRNA-LNPs is systemic, but more pronounced at the site of injection

Qin 2022
PMID: 36054264

Fohse 2021 human study posted 6 May 2021. Obviously has an unfavourable result so they are stalling the peer review.

The acute side effects reported with the mRNA-LNP vaccine platform are diverse and likely associated with its highly inflammatory nature and partially mediated by innate immune responses [4,8]. In addition to the induction of specific T- and B-cell activation, certain vaccines or infections can affect long-term innate immune responses by either increasing or decreasing the activation of innate immune cells [9]. Furthermore, the innate immune reprogramming induced by certain vaccines can interfere with immune responses induced by other vaccines [9]. The possible short and long-term immunological changes mediated by the mRNA-LNP vaccine outside the induction of antigen-specific anti-SARS-CoV-2 responses are unknown. A recent human study awaiting peer-review reported innate and adaptive immune reprogramming with this platform [10], while single-cell RNA-seq studies on human white blood cells derived from vaccinated people also revealed significant changes in innate immune cells [11]. Whether the reported changes are long-lasting and can influence immune fitness or interfere with the responses induced by other vaccines remains to be determined.

Here, using an mRNA-LNP animal vaccination model, we show that pre-exposure to mRNA-LNP inhibits antibody responses. The inhibition could be overcome with the use of adjuvants, and did not interfere with the efficacy of protein vaccines. At the same time, however, this vaccine platform enhances innate immune fitness towards influenza infection but decreases resistance to *Candida albicans*. The enhanced immune fitness towards influenza can be passed down to the offspring.

What New Zealanders were told from the "single source of truth" does not mesh with real science and the medical literature.

- **NOTE WELL:**

- There is much, much more science which could be presented in this submission.
- The material here only pertains to safety issues, and the reactions which my daughter in law suffered, which were denied and not reported, therefore like many other New Zealanders, never became part of the Medsafe/CARM/SMARS reaction data base.

I believe it is the duty of Parliament to authorise a transparent Royal commission of enquiry into all aspects of the evaluation of safety and efficacy of Comirnaty, the contents of the injection, the many and diverse side effects suffered by New Zealanders in order to ensure that:

- joining with an internationally orchestrated abandonment of pre-existing pandemic plans and known scientific truth never happens again;
- making media into propaganda parrots by bail outs of millions of dollars never happens again;
- silencing and firing the honest members of the medical profession never happens again;
- firing employees who refused to comply with mandates, coercion and bribery never happens again;
- the accompanying tyrannical over-reach of power against New Zealand citizens never happens again;

[84] Qin 2022 https://pubmed.ncbi.nlm.nih.gov/36054264/

- and that everyone found responsible for ignoring the science and mandating Comirnaty are held legally accountable for dereliction of duty . . .

  and that such a political, scientific and medical narrative never happens again.

Hilary Butler.