

Subject: 21SE9_Your Kinexus SARS-CoV-2 antibody testing results

From: Steven Pelech <spelech@shaw.ca>

Date: 2021-09-09, 2:42 a.m.

To: [REDACTED]

Klahowya D [REDACTED], M [REDACTED]

Thank you for participating in our clinical study to identify the parts of SARS-CoV-2 proteins that are the most immunogenic in people who become infected with this virus. This information is helping us to develop a more sensitive, accurate, and cheaper serological test for detection of past infection with SARS-CoV-2 and possible immunity against future infections with this virus and related mutant strains.

To analyze your blood sample, we have used our CCS SARS-CoV-2 Antibody Test, which tracks 41 of the best markers that we have identified, with coverage of 10 of the 26 viral protein encoded by the SARS-CoV-2 genome. These 41 markers were amongst the most immunogenic peptide fragments from the virus's proteins that we have identified out of the original 8000 tested, which were tested on much larger SPOT peptide arrays. If a person possesses a specific antibody that recognizes one of these immunogenic peptides, a strong signal appearing as a dark spot will be generated on the array. The darker the peptide spot, the higher the level of antibody in the serum against that specific peptide sequence. Spot F7 is a control peptide that binds to the secondary detection anti-human IgG antibody used in our test. It ensures that this step of our assay is working. The spots in the top 3 rows A-C correspond to fragments of the SARS-CoV-2 spike protein. This is the virus protein that is made with the current RNA (Pfizer and Moderna) and adenovirus (Johnson & Johnson and AstraZeneca) COVID-19 vaccines. Locations of antibodies that are directed against the other SARS-CoV-2 proteins that are tracked are also shown on the attached jpg figure. Other serological tests monitor only antibodies against the spike and/or nucleocapsid proteins. The vaccines that are currently being used will specifically induce immunoreactivity towards the spike protein, but unfortunately none of the other SARS-CoV-2 proteins. Actual infection by the virus itself actually confers the best protection against future infections by other SARS-CoV2 mutant strains and related viruses.

It should be appreciated that our tests do not demonstrate that you are necessarily immune to future SARS-CoV-2 infections and development of COVID-19. No commercial test can actually show this. However, the larger your antibody response, the more likely that you are protected. Our test would unlikely be accepted by those organizations that are trying to impose mandatory vaccination for travel or access to public events. They should be used for your personal decision making, in the context of your own unique situation and risks from COVID-19 and the vaccinations. Interestingly, the RNA and likely adenovirus COVID-19 vaccines appear to work poorly against the Delta variant of SARS-CoV-2 according to recent data from the Israel, Iceland and the US, so the long term efficacy of these vaccines has been seriously called into question. Our data seems to indicate the mutations associated with the common variants of concern, including delta, are irrelevant to immunity, because 1) the parts of the SARS-CoV-2 spike proteins that are the most immunogenic (i.e., antibody producing) are different from the parts with the mutations, and 2) many different parts of the viruses elicit antibodies as you will see in the examples provided. Note that we are only tracking 41 of the possible targets for antibodies. A person with COVID-19 will make hundreds of different antibodies simultaneously.

In the attached jpg, I have provided images of the results of 12 of the tests that we have performed with blood samples from several COVID-19 patients that have been confirmed with the PCR genetic test for SARS-CoV-2. As you can see in these control images of our immunoblots, the actual pattern of antibody immunoreactivities varies dramatically between different people that have been infected with the same virus. Such differences are also evident with serum samples from COVID-19 vaccine immunized individuals. Remarkably, we have observed that for people that have had COVID-19, the individual patterns are generally very stable when measured a year after their initial infection. Our studies have demonstrated that natural immunity persists for at least 18 months. Normally, antibody levels will wane after a few months, but the persistence of the antibody levels could reflect ongoing re-exposures to the SARS-CoV-2 virus, which act like booster shots.

In fact, many of the people in B.C. that we have tested that are healthy and have no prior indication of infection with SARS-CoV-2 actually already have antibodies that will recognize the virus. It should be appreciated that the BC Ministry of Health and the BC Centre for Disease Control believe that only a tiny portion (less than 5%) of the BC population that is not vaccinated, have protective antibodies against the virus. However, our collaborative studies seem to indicate that these healthy people that have antibodies with our tests also confer protection from infection by SARS-CoV-2.

Here's your specific results. Our test does seem to indicate that you have several antibodies that can bind to different parts of the spike protein, which could support a previous infection with SARS-CoV-2. You also have immunoreactivity against some other proteins in the SARS-CoV-2 virus as well, which further strengthen this conclusion. It is possible that some of these immunoreactivities arise from pre-existing antibodies that you may have made from exposure to other related coronaviruses, including those that cause the common cold. However, in view of the number and intensity of the visible spots, it seems highly likely that you have already been infected with SARS-CoV-2.

As time passes on, reductions of these antibody signals is expected if you haven't encountered the virus more recently. This decline will actually happen faster if you have been practising social isolation and using protective measures such as constant hand washing and wearing masks. However, you should still have memory B-lymphocytic cells in your circulation that will rapidly reproduce and produce more antibodies against the virus should you become re-infected.

Some of my thoughts on COVID-19 and vaccinations are discussed in recent, lengthy interviews that I did for "What's Up Canada" that can be accessed with the following link: <https://www.facebook.com/WhatsUpCanadians/videos/1392691891123832/>
<https://rumble.com/vl0ltf-doctor-talks-the-series-panel-1-of-3-doctors-talking-variants.html>
<https://rumble.com/vllplg-doctortalks-panel-3-of-3-top-canadian-doctors-talking-vaccines.html>

I particularly recommend that you check out the Canadian Covid Care Alliance (CCCA), which recently posted their website at www.canadiancovidcarealliance.org.

One of the other initiatives that the CCCA shall be undertaking relates to the issuing of vaccine passports. It has been proposed, and even implemented in some provinces, that people that have not been vaccinated, regardless of whether they have previously developed antibodies from infection with SARS-CoV-2, should be restricted from air and train travel and other activities, or at least segregated. Our studies are already generating data that demonstrates the superiority of natural immunity over vaccination. Furthermore, most of the nearly 500 people that we have tested already have appreciable antibodies against SARS-CoV-2 and do not really need to subject themselves to the risks associated with the vaccines. These antibodies appear to be effective against the more infectious Delta SARS-CoV-2 variant, which by the way, appears to produce milder symptoms than other strains. Consequently, the imposition of vaccination is both discriminatory and

unnecessary.

I would be happy to discuss this with you further should you desire more clarification.

Best wishes from Steven Pelech.

"Klahowya" is the Chinook jargon greeting that is roughly translated "hello and how are you?" Chinook is a pidgin language that was commonly used for several hundred years as the main form of communication between West Coast natives of North America and European traders and explorers. In view of its origins from the Chinook, Nuuchanulth, French and English languages, and its historical importance, it is my preferred form of salutation in these politically correct times.

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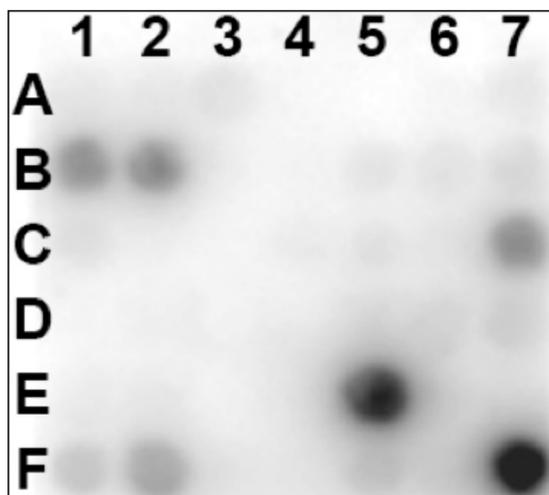
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Your SARS-CoV-2 antibodies test results are shown immediately below. Spots A4 to A6 correspond to the ACE-2 receptor binding domain of the Spike protein of the virus and antibodies against this region are suspected to be the most protective. Spots D5-D7 correspond to the SARS-CoV-2 membrane protein, which is one of our best markers for previous SARS-CoV-2 infection.



Examples of positive results obtained with serum samples from 12 COVID-19 patients (confirmed by PCR-testing) with the Kinexus CCS SARS-CoV-2 Antibody Test.

Layout of the different parts of the SARS-CoV-2 proteins that are tested.

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|------------------|------|-------|-----|----------|--------------------|-----|
| A | S1 | | | RBD | | | S1 |
| B | S1 | S2 | | | | | |
| C | S2 | | | | | | |
| D | Nucleocapsid | | | | Membrane | | |
| E | Nsp ₁ | Nsp2 | Nsp3 | | | Nsp _{8,9} | |
| F | Nsp14 | | Nsp15 | | | Orf ₃ | IgG |

