

# Estimating the number of COVID vaccine deaths in America

By Steve Kirsch, Jessica Rose, Mathew Crawford

Last update: December 24, 2021: Added excess death study so there are 9 ways to get to >150K Americans killed by the COVID vaccines

*Abstract: Analysis of the Vaccine Adverse Event Reporting System (VAERS) database can be used to estimate the number of excess deaths caused by the COVID vaccines. A simple analysis shows that it is likely that over 150,000 Americans have been killed by the current COVID vaccines as of Aug 28, 2021.*

At this point, two separate stopping conditions have been satisfied:

1. The vaccines kill more people than they save
2. The vaccines have killed over 150,000 Americans so far.

## This is an engineering estimate

This is an engineering analysis, not a strict scientific analysis.

What I mean by this is that our objective is to use all the available data and our own expert judgement in interpreting that data in a reasonable way in an attempt to get an accurate estimate.

For example, one analysis we reference said that up to 86% of VAERS deaths could be caused by the vaccine and 14% could not be. However, we know more about the causes of death after vaccination than someone who doesn't understand the mechanisms of action of the vaccine and common side effects reported by victims. So we took the high end of the estimate as being closer to the truth.

Similarly, critics delight in saying that the English translation of the Schirmacher article says he estimated that between 30% to 40% of the bodies he examined died from the vaccine. However, we know from personal contacts that the 30% to 40% is a floor.

Similarly, using anaphylaxis as a proxy for the URF was chosen because in our judgement, anaphylaxis should always be reported at a higher rate than deaths. It's the best-case adverse event. So calculating a URF from anaphylaxis yields a value that should always underestimate the number of actual events when applied to any event (such as death). **Nobody who has**

**disputed this choice has produced any data at all that supports their hypothesis that our assumption wasn't correct; they just use hand-waving arguments.**

So all this extra knowledge is included in interpreting the data.

Because we validated our death estimates against the analysis of different datasets done by different people, we have high confidence our estimates are reasonable.

It is easy to criticize every single method and to tell us "you can't do that" or "you have to use DB-RCT data" or other objections.

More constructive would be for our critics to come up with their estimate and provide the 7 independent ways they validated that their estimates were valid. And then show that all 8 of our methods are flawed. Then we can simply compare which analysis better fits the observed data.

Nobody seems to want to do that for some odd reason. We can't fathom why...

## Our research is supported by the peer reviewed literature

Our estimate is supported by multiple papers in the peer-reviewed scientific literature including:

[Why are we vaccinating children against COVID-19?](#) by Ron Kostoff

"Compared with the 28,000 deaths the CDC stated were due to COVID-19 and not associated morbidities for the 65+ age range, the **inoculation-based deaths are an order-of-magnitude greater than the COVID-19 deaths!**"

The [Walach paper](#) found the same thing: that the vaccines harm more people than they save. It has now been re-published in [Science, Public Health Policy and the Law](#) which is a peer-reviewed medical journal. The Walach paper appears in [this issue](#) along with a scathing editorial by the journal editor talking about how the paper authors were mistreated by the scientific community.

[Critical Appraisal of VAERS Pharmacovigilance: Is the U.S. Vaccine Adverse Events Reporting System \(VAERS\) a Functioning Pharmacovigilance System?](#) By

Jessica Rose. "Using this URF for all VAERS-classified SAEs, estimates to date are as follows: **205,809 dead**, 818,462 hospitalizations, 1,830,891 ER visits, 230,113 life-threatening events, 212,691 disabled and 7,998 birth defects to date [39]."

Note that in this paper, the 205,809 deaths were not categorized into background deaths and excess deaths. We do that calculation in this paper. The point of this paper is she determined a URF of 31 using a very conservative method which determines a lower bound on the URF. Even with a URF of 31, the death toll is horrendous, and as we show

in [Risk benefit by age of the COVID vaccines](#), virtually all these deaths are “excess” deaths.

And other independent studies such as:

[Vaccine death report](#)

The VAERS database is the only pharmacovigilance database used by FDA and CDC that is accessible to the public. It is the only database to which the public can voluntarily report injuries or deaths following vaccinations. Medical professionals and pharmaceutical manufacturers are mandated to report serious injuries or deaths to VAERS following vaccinations when they are made aware of them. It is a “passive” system with uncertain reporting rates. VAERS is called the “early warning system” because it is intended to reveal early signals of problems, which can then be evaluated carefully by using an “active” surveillance system.

Those who believe the [FDA mantra that you cannot use VAERS to determine causality](#), should start by reading this editorial: [If Vaccine Adverse Events Tracking Systems Do Not Support Causal Inference, then “Pharmacovigilance” Does Not Exist.](#)

There are effectively two separate determinations:

1. What is the number of “excess deaths” which is the total # of deaths from this vac - # of deaths normally expected from the typical vaccine. Causality plays no role whatsoever in determining this number.
2. Ascribing a cause to the excess deaths. Were these excess deaths caused by the vaccine or by something else?

The detailed steps are:

1. Determine the under-reporting factor (URF) by using a known significant adverse event rate
2. Determine the number of US deaths reported into VAERS
3. Determine the propensity to report (PTR) significant adverse events this year
4. Estimate the number of excess deaths using these numbers
5. Validate the result using independent methods

## Determining the VAERS under-reporting factor (URF)

One method to discover the VAERS under-reporting analysis can be done using a specific serious adverse event that should always be reported, data from the CDC, and a study published in JAMA.

Anaphylaxis after COVID-19 vaccination is rare and occurs in approximately 2 to 5 people per million vaccinated in the United States based on events reported to VAERS [according to the CDC report](#) on Selected Adverse Events Reported after COVID-19 Vaccination.

Anaphylaxis is a well known side effect and doctors are required to report it (see [FDA Fact Sheet](#) at the top of page 10) because it is considered a “severe adverse reaction.” It occurs right after the shot. You can’t miss it. It should always be reported.

[A study at Mass General Brigham \(MGM\) that assessed anaphylaxis in a clinical setting after the administration of COVID-19 vaccines](#) published in JAMA on March 8, 2021, found “severe reactions consistent with anaphylaxis occurred at a rate of 2.47 per 10,000 vaccinations.” This rate is based on reactions occurring within 2 hours of vaccination, the mean time was 17 minutes after vaccination. This study used “active” surveillance and tried not to miss any cases.

When asked about this, both the **CDC and FDA sidestepped answering the question.** [Here’s the proof at the CDC](#) (see page 1 which incorporates the CDC response to the original letter on pages 2 and 3).

[As noted in the letter](#), this implies that VAERS is under-reporting anaphylaxis by 50X to 123X. **The CDC chose not to respond to the letter.**

Is the anaphylaxis under reporting rate a good proxy for reporting fatalities? Since anaphylaxis is such an obvious association, one could argue that the rate would be a lower bound. Others would argue that deaths are more important and would be more reported than anaphylaxis.

We don’t know, but it doesn’t matter because this is just an estimate to get to a ballpark figure. Since there are 5 other estimates, if we are wrong, we’ll know pretty quickly. Lacking a more definitive method, we go with this as our “best guess” in the meantime. We are working on a clever way to determine the fatality URF directly which will be a good “double check” on our estimate.

In general, most of us think It is therefore entirely reasonable to assert that deaths are reported even less frequently than anaphylaxis since deaths are not as temporally proximal to the injection event.

The MGH study used practically identical criteria as CDC used in its study to define a case of anaphylaxis.

We ran the numbers ourselves and confirmed this. Therefore, a conservative estimate (giving the government the greatest benefit of the doubt) would use 50X as the under-reporting rate.

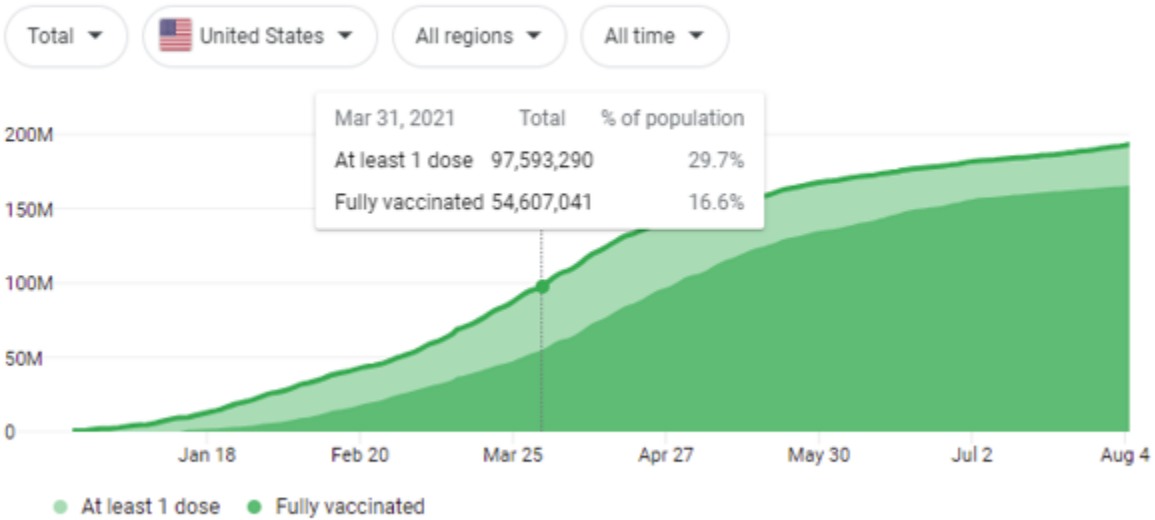
However, after the MGH study was published, one doctor pointed out that doctors were more careful to avoid anaphylaxis; **there was more careful screening of people likely to have anaphylaxis**, and they were advised to see their allergist and take more precautions prior to vaccination. This sort of thing would overstate the numbers above.

So we ran the numbers BEFORE the JAMA study appeared and got a more conservative estimate (and AFTER the FDA had issued an anaphylaxis warning in their [January 2021 fact sheet](#)).

Here's the data from Google (which uses World In Data):

## Vaccinations

From [Our World in Data](#) · Last updated: 2 days ago



This data shows how many people have received at least 1 dose of a vaccine. People who are fully vaccinated may have received more than 1 dose. · [About this data](#)



## Search Results

From the 7/30/2021 release of VAERS data:

**Found 583 cases where Location is U.S. States or Unknown and Onset Interval is 0 and Vaccine is COVID19 and Vaccine Dose is '1' and Symptom is Anaphylactic reaction or Anaphylactic shock and Vaccination Date on/before '2021-03-31'**

Table

↓	↑ ↓	↓
Event Outcome	Count	Percent
Death	2	0.34%
Permanent Disability	3	0.51%
Office Visit	111	19.04%
Emergency Doctor/Room	388	66.55%
Hospitalized	71	12.18%
Recovered	308	52.83%
Life Threatening	112	19.21%
Not Serious	51	8.75%
<b>TOTAL</b>	† 1,046	† 179.42%
† Because some cases have multiple vaccinations and symptoms, a single case can account for multiple entries in this table. This is the reason why the Total Count is greater than 583 (the number of cases found), and the Total Percentage is greater than 100.		

We've vaccinated 97.5M people from the start thru March 2021 and there were 583 reports in VAERS who had an anaphylaxis reaction on their first dose. This is a VAERS rate of 5.97 per million doses which is nearly half the rate found by the [CDC using VAERS \(11.1 cases per million\)](#) posted on January 6, 2021. This makes sense because after that CDC report, doctors were made aware of the problem. A [paper published in JAMA on August 31, 2021](#), confirmed the lower number, and reported "an updated reported anaphylaxis rate of 4.7 cases per 1 million doses" into the VAERS system which is lower than our number.

Using the MGH numbers with our own VAERS queries, we have 247 cases per million doses from the MGH study divided by 5.97 cases per million doses from VAERS.  $247/5.97 = 41$ .

**This suggests that the VAERS under-reporting factor (URF) is 41X.**

There was also [a Japanese study of Japanese healthcare](#) workers that found an anaphylaxis rate of “204.2 cases per million doses administered” which is 17% lower than the MGH number. So we could also use that number and take the more recent CDC number for the event rate in VAERS (4.7 anaphylaxis reports per million doses) and we’d get  $204.2/4.7 = 43X$ .

Note: Even though 41% of the cases analyzed were deemed to have satisfied Brighton criteria 1,2,3, this may simply be due to lack of sufficient data that was recorded in the record. What is more important is what the institutions themselves believed were anaphylaxis cases since that is what is important to the VAERS URF; all of those cases should have been reported to VAERS.

So the URF=43 is based on 1) the official CDC count of VAERS anaphylaxis reports published in JAMA and 2) measured anaphylaxis rates in Japan which were even lower than the US numbers. So that’s a very conservative approach: I’m using the latest CDC number and the more conservative anaphylaxis numbers.

We’ll go with the lower 41X number for the rest of this analysis to be even more conservative (since we wouldn’t want any fact checker to criticize us for “inflating” the numbers).

Other estimates such as [How Underreported Are Post-Vaccination Serious Injuries and Deaths in VAERS?](#) suggests UFR=30 factor based on VAERS. However, this used a serious adverse event rate from the Pfizer Phase 3 study which we believe under-reported these events for three reasons: 1) the patients were much healthier than average with a 10X lower rate of cardiac arrest than the general public (for example), 2) it was hard to report adverse events if you were in the trial (the evidence of this was unfortunately deleted when Facebook removed the vaccine side effect groups), and 3) there was known malfeasance in the reporting of adverse events in the 12-15 year old trial where the paralysis of 12-year-old Maddie de Garay was never included in the trial results and the FDA and CDC refused to investigate and the mainstream media would not report on it.

Another way to estimate the URF is to use myocarditis, but we don’t have a good reference for a fully reported number that we trust. The CDC trusts VSD, but that is a huge mistake since it is as underreported as VAERS (sometimes more, sometimes less).

The point of this paper is not to find the exact number of deaths, but merely to find the most credible estimate for deaths. We think that anaphylaxis is an excellent proxy for a serious adverse event that, like a death, should always be reported so we think 41X is the most accurate number.

Our hypothesis is that this number will be applicable to deaths as well. In order to confirm our hypothesis, we must derive the death count in different ways and see if we come up with the same answer.

When used for less serious events, such as a headache, it's likely that 41X is going to be low since such events are less likely to be reported.

In summary, others estimated the URF of:

Reference	URF
<a href="#">Aaron Siri using anaphylaxis</a>	50
<a href="#">Rose using serious adverse events</a>	30
<a href="#">Vaersanalysis using CMS data</a>	44.6

So our hypothesis is that 41X is a safe, conservative factor useful for all types of events.

## Determining the number of US deaths

As of August 27th, 2021, a search of the VAERS database shows that there are 7,149 domestic deaths in the VAERS database (US/Territories/Unknown).

## Estimate the Propensity To Report (PTR) for 2021

The PTR is a number that allows us to compare reporting rates between years. It is expressed as a number relative to the average URF:

$$\text{PTR} = (\text{Average URF}) / (\text{current URF})$$

The higher the PTR, the more likely people are to file reports.

You could measure PTR from year to year and derive the URF from that.

Or you can calculate the URF each year and derive the PTR from that.

Ideally, you do both as a double check.

Of course, the CDC and FDA apparently do neither [as clearly pointed out in my video](#).



For example, the CDC determined the URF is 10 in previous years, and based on their behavior, they think the URF is 1 this year, so the PTR would be 10 and so they think they can write off the increased events being reported as just background over reporting.

How do we know what the PTR is? We know the URF for the COVID vaccines is 41 and the URF for previous years was around 10 from CDC papers (which we know are always “right”), for example, [The reporting sensitivity of the Vaccine Adverse Event Reporting System \(VAERS\) for anaphylaxis and for Guillain-Barré syndrome | Request PDF](#) which was written by 5 CDC authors. Here is the full paper written by five CDC authors: [The reporting sensitivity of the Vaccine Adverse Event Reporting System \(VAERS\) for anaphylaxis and for Guillain-Barré syndrome](#).

So  $10/41 = 0.25$ .

So if we have 1 event reported this year it is comparable to 4 events reported last year. If we have 25 times higher reporting frequency last year, then in reality it is 100X higher than last year!

So we are using CDC data to show that things are even more under-reported this year.

This is exactly the OPPOSITE of what the FDA had claimed. Their claim is that VAERS is vastly over-reported which explains the huge number of events for 2021. But they never provide any evidence of this, just a hand waving argument (just like [Jeffrey Morris does](#)). What we’ve found from all the reports we’ve received (no cherry picking) is the less frequent filing of reports to VAERS by physicians based on the fact that many believe that these products are safe.

We find that “neutral events” such as otitis media aren’t affected much by the vaccine are actually elevated in the COVID search, rather than reduced. Why is that?

The answer is that these vaccines are not safe for use in humans. Thus, more people are coming in to see their doctors. When they do, they bring their ear aches with them. So if this vaccine is, for example, 5 times more dangerous than previous vaccines with regards to the total number of people seeing their doctors, we’d expect a reporting rate of unrelated background events to be similarly elevated since there are more severe events being reported. So there is correlation here, not causality, for ear infections..

The bottom line is an event that has 10 reports in 2019 could be 50 in 2021 and that would just be considered a “flat” event.

For otitis media, there are 52 reports in VAERS for the COVID vaccines excluding foreign (as of 10/13/21), and 67 over a 5-year period. This means we are getting  $52/67*5=3.9$  times as many reports this year as in a typical year.

Therefore, a symptom elevation of 3.9X from a previous year shouldn't necessarily trigger any alarms since there are simply many more people reporting (about  $593K/35K=16.9$  times as many people reporting which is taken from the # of reporters this year divided by the average number of reporters in previous years).

This means that the PTR derived from actual data is  $3.9/16.9=.23$  which is interesting since it matches the derivation from the CDC URF vs. our URF for this year.

So once again, no matter which derivation you prefer to use, we are under-reporting this year, which means these huge spikes are not just "over-reporting" of background events. They are actual spikes in events (i.e., excess events) and they are even more extreme than anyone ever thought (since at worst people thought that the PTR was the same as previous years which it clearly is not).

But death is special since it never piggybacks on other symptoms. It's the final symptom, the "buck stops here" symptom. So an elevated death count this year is not simply due to the patient coming in for some other reason like a sore arm.

So for death, any increase over the previous year is considered "excess" since there is no evidence of a higher propensity to report this year based on the actual data (our 3.9X should have been 16.9X), physician surveys, or logical arguments based on observed behaviors.



Search Results

From the 10/1/2021 release of VAERS data:

**Found 52 cases where Location is U.S., Territories, or Unknown and Vaccine is COVID19 and Symptom is Otitis media**

Table

↓	↑ ↓	
Age	Count	Percent
17-44 Years	20	38.46%
44-65 Years	22	42.31%
65-75 Years	7	13.46%
75+ Years	3	5.77%
TOTAL	52	100%



Search Results

From the 10/1/2021 release of VAERS data:

**Found 67 cases where Location is U.S., Territories, or Unknown and Symptom is Otitis media and Vaccination Date from '2015-01-01' to '2019-12-31'**

Table

↓	↑ ↓	
Age	Count	Percent
< 3 Years	51	76.12%
3-6 Years	3	4.48%
17-44 Years	5	7.46%
44-65 Years	2	2.99%
65-75 Years	3	4.48%
75+ Years	1	1.49%
Unknown	2	2.99%
<b>TOTAL</b>	<b>67</b>	<b>100%</b>

However, I don't believe that the PTR is .25 because I think the CDC's URF for previous years is a garbage number because it was derived from VSD which is as under-reported as VAERS.

A safer assumption is that the PTR=1, i.e., people are as likely to report this year as they did in previous years. I think it is somewhat less than 1, so using 1 is a safe bet. This is primarily for two reasons:

1. because there are so many events this year that doctors with a lot of events are simply going to give up.
2. Doctors have been brainwashed into believing the vaccines are safe, so they won't waste time reporting an event that "obviously" couldn't be caused by the vaccine; that wastes the doctor's time, wastes the government's time, and increases vaccine hesitancy which is bad for the country. So the patriotic thing to do is not report since they falsely believe that the vaccine is our only hope to save America.
3. The healthcare systems frown upon making VAERS reports [as all saw firsthand in the Project Veritas under-cover story #1](#).

Healthcare providers have been required by [law to report serious adverse events in VAERS](#) with passage of the [National Childhood Vaccine Injury Act \(NCVIA\)](#) in 1986.

Therefore, nothing has changed this year vs. previous years:

1. no new legal requirements,
2. no noticeable promotion or incentives to report into VAERS.

Some people claim that more than 10 times as many doctors are reporting because of the scale of the COVID vaccination program. This claim requires corroboration..

To make things simple, there are basically two hypotheses:

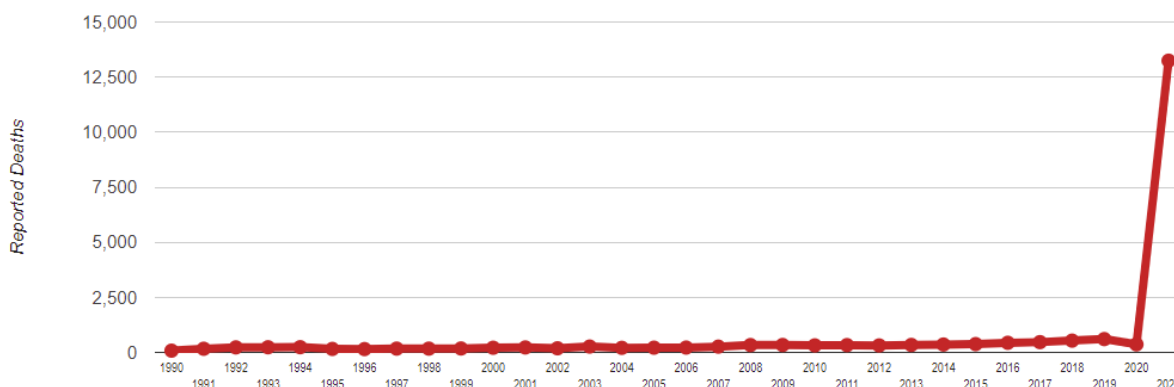
1. VAERS is over-reported this year for COVID19 events so all the deaths are simply background deaths. The vaccine has caused zero deaths. This is the FDA/CDC claim.
2. VAERS is reported this year at the same rate as previous years. All the excess deaths relative to previous years are due to the vaccine. This is our hypothesis.

Now, let's look at the evidence/arguments. We leave it up to the reader to decide for themselves which hypothesis better reflects the data.

Even when there are strong promotions to report adverse events as there was [with H1N1 in 2009 where there were serious campaigns to raise the visibility of reporting](#), this didn't impact the background fatality event reporting: **it didn't go up at all in 2009 and 2010** as can be seen from the graph below.

In short, it is extremely difficult to materially change the PTR serious adverse events into the VAERS system; it is remarkably consistent from year to year. This makes sense: old habits die hard... behaviors are hard to change. And there was nothing "new" this year to incentivize a massive change in behavior.

## All Deaths Reported to VAERS by Year



**Method #1:** Look at the weekly data below. The massive increase in reporting pretty much happened almost instantaneously as soon as the vaccines started rolling out. And it was proportional to the rollout. That is not how behavioral change works... behavioral change would happen very slowly over time; especially if you are trying to get doctors to change their long term behaviors. The reporting basically followed the roll out of the vaccine. Doctors were more likely to report to VAERS this year because there were simply more events to report. We have verified that by talking directly to the doctors as the reason they are reporting more for these vaccines.

### Results

#### 1.1 General information

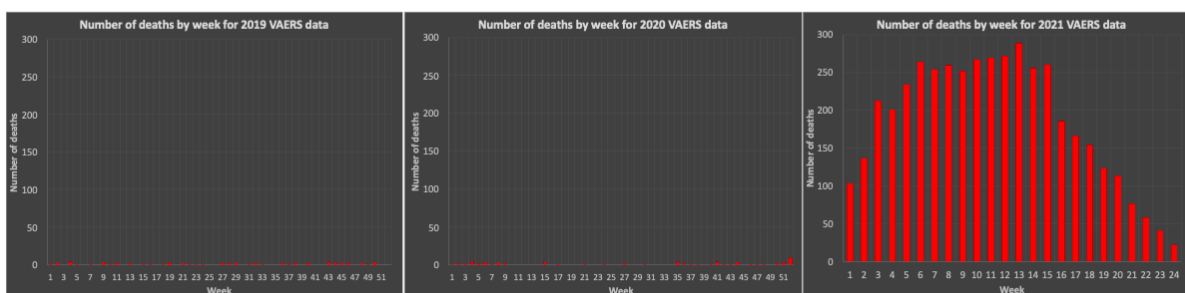


Figure 1: Bar plots showing the number of VAERS reported deaths per week for 2019, 2020 and 2021. Analysis: Dr. Jessica Rose

**Method #2:** To double check our hypothesis that the PTR is unchanged this year, we ran VAERS queries using symptoms unrelated to those impacted by the vaccines. We ruled out any known co-morbidities like diabetes and obesity since these would likely be elevated since there are more adverse events.

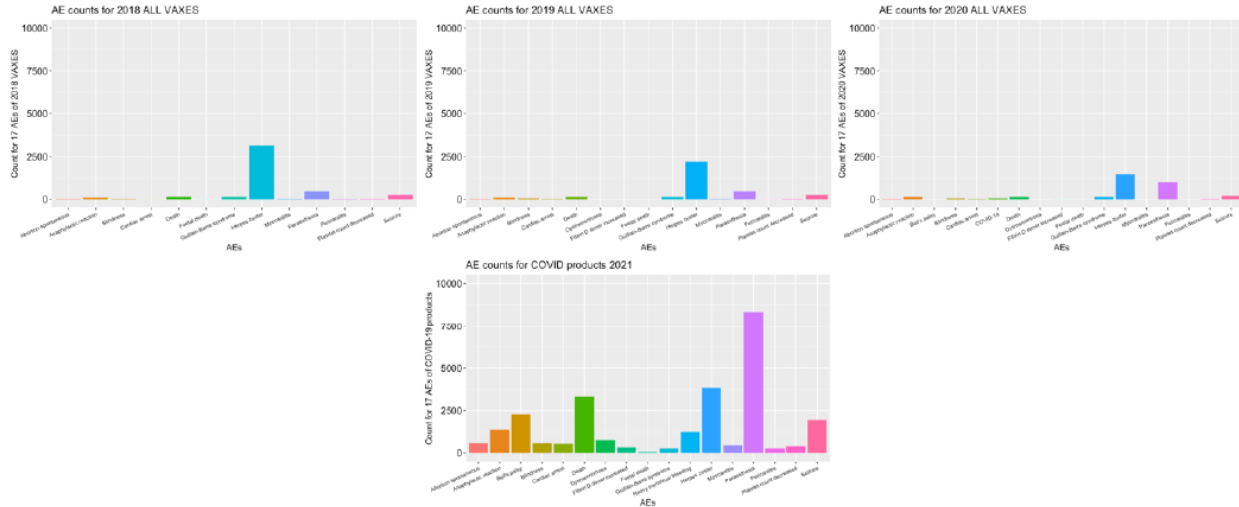
We found that the reporting rates for these unrelated events (listed in the table below) are no different this year than in previous years and for some of these events, the reporting rate is

dramatically lower. Note that the number in the 2015-2019 column is the total for the 5 years, not an average annual amount. The Rate Increase is an X factor (i.e., A/B\*5)

Symptom	2021	2015-2019	Rate increase
Metal poisoning	2	47	0.22
Otitis media	48	255	0.94
Hepatitis	331	1457	1.13
Wart	1	7	0.71
Cancer	31	132	1.17
Breech delivery	0	3	0

However, the rate of other events may be elevated by a factor of 30 or so just because they go along with the patient. For example, suppose 10% of the population has earaches at any time. You then give people a vaccine that has 30 times more people giving reports. The number of earaches will be increased by 30 times, but there isn't causality here. To establish causality, we'd want to either see dose dependency (e.g., the rate after dose 1 != the rate after dose 2) or a significantly higher rate of the adverse event than would be predicted by the number of additional reports. Note that this 30X increase is not due to reporting bias at all.

**Method #3:** Another way to show that 2021 isn't simply over-reporting normal background adverse events is to look at the "adverse event (AE) footprint" of the vaccine. You do that by listing adverse events on the X-axis and AE counts on the Y-axis. If there is over-reporting this year, the overall outline of the boxes will be exactly the same as previous years, and they will just be higher due to the higher PTR of the same types of events. As you can see, that is not the case here. This vaccine is definitely causing a completely different "shape" of severe adverse events. Here we show 2018, 2019, 2020, and 2021. Clearly, there is something going on since the overall shape is not the same in 2021 compared to previous years.



For a more detailed set of vaccine fingerprints (COVID vs. other vaccines), see [these charts](#) from Jessica Rose.

**Method #4:** Another way to confirm there wasn't over-reporting is through informal physician surveys. In our informal physician surveys we saw a bias to under-report serious adverse events in order to make the vaccines look as safe as possible to the American public since most physicians believe they are hurting society if they do anything to create vaccine hesitancy. Secondly, we'd estimate that at least 95% of physicians have completely bought into the "safe and effective" narrative and thus any event that they observe they deem as simply anecdotal and don't bother to report it since it couldn't have been caused by such a safe vaccine that appeared to do so well in the Phase 3 trials. The physicians who are clued into the danger of the vaccines say there is more reporting this year because there are more events. Our neurologist for example had 2,000 events to report this year, but had 0 in all 11 years she's been in practice.

**Method #5:** A fifth way is to simply look at the reporting curve relative to vaccination date. As you can see from the chart below, the curve is flat for a safe vaccine and peaks at Day 1 for this vaccine with a very strong peak in the first few days:

**Method #6:** The [Scott Mclachlan paper](#) determined that 86% of the deaths could have been caused by the vaccine

**Method #7:** The [CDC VAERS review of the 12-17 year old data](#) shows these kids didn't die from normal causes. More below.

**Method #8:** The [German pathologist who determined that at least 30 to 40% of the deaths after vaccination were due to the vaccine](#).

None of these is definitive proof but the evidence is mounting and corroborative. These points are consistent with the hypothesis that there are a significant number of excess deaths and thus



the PTR hasn't changed much, if at all. The FDA must provide clear evidence that the deaths associated with the COVID-19 products are not caused by them.

## Determining the number of excess deaths caused by the COVID vaccines

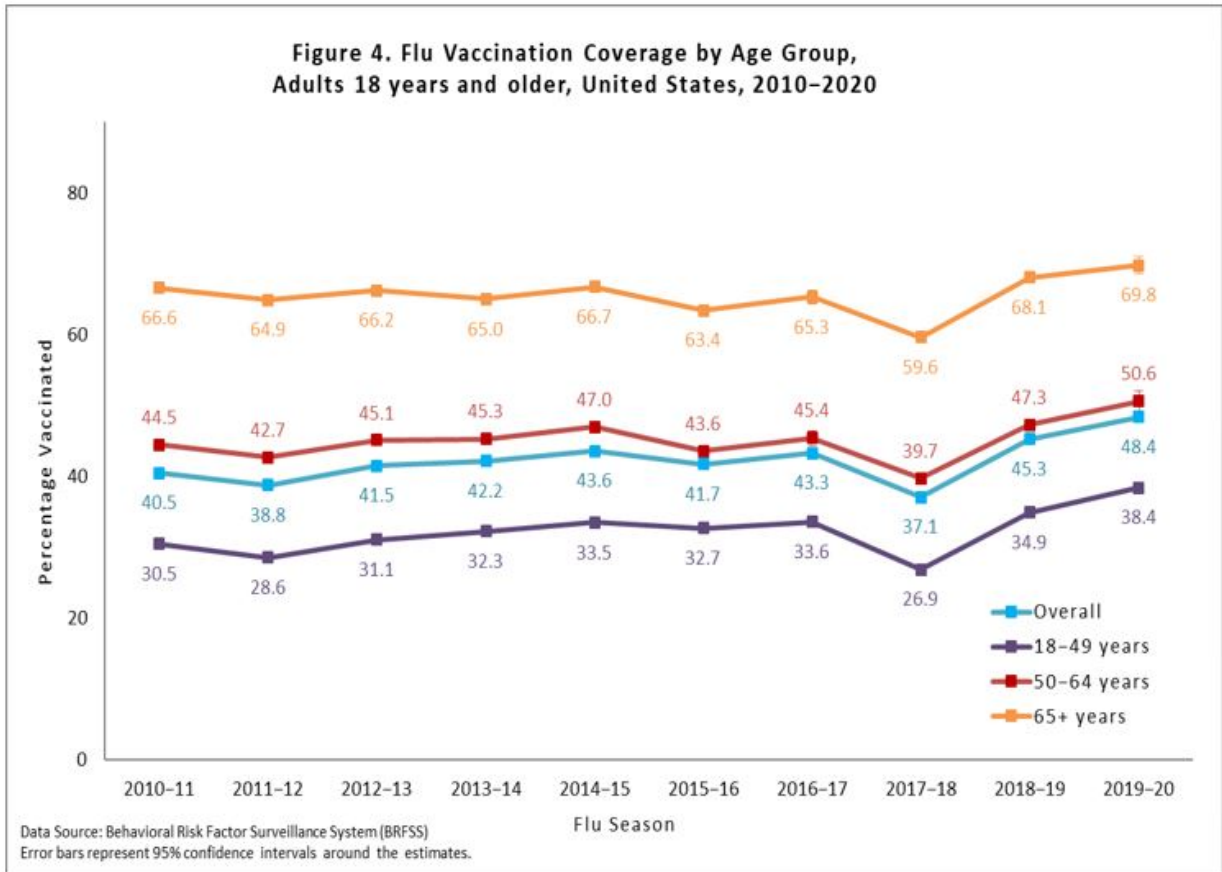
There are three ways to estimate the number of excess deaths caused by the vaccine. Using these methods we can estimate the low and high likely bounds for the number of excess deaths caused by the vaccine:

1. Subtract the average number of background deaths in previous years
2. Use 86% based on the analysis in the [Mclachlan study](#)
3. Use 40% based on the [estimate of Dr. Peter Schirmacher](#)
4. Use 99% based on [this risk-benefit analysis](#)

Here are the results that we obtain from these four methods:

Method	
Subtract average background deaths	$(7149-1000)*41 = 252,109$
<a href="#">Mclachlan</a> case analysis	$.86 * 41 * 7149 = 252,073$
Pathologist estimate	$.60 * 41 * 7149 = 175,865$
Risk-benefit analysis	$.99 * 41 * 7149 = 290,177$

In the first method, we used 500 background deaths as normal for a year since the PTR is the same this year as in previous years as shown earlier. However, we should assume that the age cohort is older this year than previous years. For example, [here are the vaccination rates shown in a CDC report](#) for influenza:



Also, from [an Alex Berenson article](#), “The number of covid shots [in the US] administered so far in 2021 (309 million) is **roughly the same as all other vaccines administered in 2020** (316 million). But a shocking 36-times more deaths were reported this year from the covid shots than were reported last year from all other vaccines.”

So a conservative estimate is to take the <500 deaths per year and increase it by 50% to more than account for a shift to higher ages so subtract 750 background deaths.

In the second method, [Mclachlan](#) examined 250 VAERS reports in detail and concluded that up to 86% of the deaths were consistent with the vaccine being causal for the death. We use the higher number, because using a lower number makes no sense since it leads to a background death rate that would be excessive compared to previous years ( $.14 \times 7149 = 1,000$  which is already higher than the 500/yr background death rate).

The third method uses estimates made by [Dr. Peter Schirmacher, one of the world's top pathologists](#), for the % of deaths examined by autopsy within 2 weeks of the vaccine that were clearly caused by the vaccine. The range was from **30% to 40%** and we used the high end of the range since we believed that in making a potentially career-ending revelation such as this

that Dr. Schirmacher was being extremely conservative and only estimating what he was 100% certain of proving. 40% is likely very conservative since Norway was under no such reputational pressure and in the the first 13 bodies they assessed, 100% of the deaths were found to be caused by the vaccine (see [Norwegian Medicines Agency links 13 deaths to vaccine side effects](#)). Therefore using a 60% number seems relatively conservative (less than the 65% average of 30 and 100).

Therefore we have a range of death estimates from **148,000 to 216,000** deaths which averages to 182,000 deaths.

## Sanity check using 11 other methods

In order to validate that our estimates are reasonable (or simply that the evidence was more likely consistent with the hypothesis that the vaccine does more harm than good), we looked at seven different quantitative methods from very small to very large and summarized their estimates in the table below.

The most credible analysis in the table are the two done by Crawford.

We didn't rely on ANY of these analyses. All can have flaws. But now we have 8 different methods that are disjoint and they all come to the same conclusion.

It is hard to explain that the CDC's analysis that there have been no excess deaths caused by the vaccine is consistent with any of these methods.

	<b>Method</b>	<b>Estimate of US excess vaccine deaths</b>
1	<a href="#">Excess CFR analysis</a> done in Europe determines 200-500 D/M doses	72,000 - 180,000
2	<a href="#">Excess death analysis</a> done in 23 nations (comprising 25% of world population) which includes 2 Europe nations in the CFR analysis which determined a 411 D/M doses.  Together, the two analyses cover 35% of the global population	147,960 (411 D/M)
3	<a href="#">Small island study done by Marc Girardot</a>	171,000
4	By mid-January, Norway had vaccinated around 40,000 people. They had <a href="#">23 reported deaths</a> , so 1 in 1700 (maybe more because it's hard to know when such statements are formulated relative to a program	150,000

	that was vaccinating several thousand per day). That scales to 575/M, and assuming a 2:1 ratio for 1st:2nd dose puts the U.S. in the ballpark of 150k deaths.	
5	<a href="#">Professional pollster analysis #1</a> (311 people) Few people attribute death to the vaccine (including doctors); it just looks like “bad luck.” So “death caused by the vaccines” is likely to be under-reported in the surveys. Even with that, the estimated death count is staggering.	174,000
6	<a href="#">Professional pollster analysis #2</a> Larger poll (1,000 people surveyed)	146,863
7	Asking my doctor friends who are “clued in” that the vaccines can cause death. Charles Hoffe found 1 death in 1,000. Ira Bernstein had two deaths in 700. George Fareed had 3 deaths in 3,000 patients. A lot of docs simply don’t know the answer since they don’t track it unfortunately, so it is hard to get good data points. I wish I had more data on this, but this was not cherry picked and this is the weakest item on this list, but what we found was a consistent 1 in 1,000 death rate approximately.	~ 200,000
8	Pilot data Pilot deaths are rare. British Airways lost 4 pilots in ~1 month after the jabs rolled out. The vaccination status of each pilot was officially “unknown.” They each died from a different cause, but each cause was verified elevated by the vaccine. It is statistically unlikely this happened by chance (1 in 525,000). We’ll assume one death was just bad luck. That leaves 3 deaths out of an estimated 3,000 jabbed pilots (75%) which is 1 in 1,000	~ 200,000
9	Scotland data See below.	192,000 (480 D/M)
10	<a href="#">Excess death analysis shows a VAERS URF of 20 and VFR of 0.04%</a> (Paper by Pantazatos and Seligmann of Columbia University)	146K to 187K (February and August, 2021).

11	<a href="#">Indiana excess mortality data implies a VAERS URF of over 80</a> . See the article.	> 500K
12	<a href="#">Pfizer trial</a> showed 21 vs. 17. But two COVID deaths in placebo implies 15 natural deaths in the cohort. So an estimate of 5 excess vaccine deaths in the vaccine group, possibly caused by the vaccine. At a scale of 220M fully vaccinated, this would be 50,000 deaths. But the trial cohorts didn't die at a normal rate (which is .87% per year on average), so we expected 95 natural deaths over 6 months, yet there were only 15 natural deaths in the placebo group (there were 2 COVID deaths which don't count) suggesting we use a 6.3 correction factor due to biased selection of healthier patients.	315K

Here's the scoop regarding the Scotland number which was too large to fit in the table.

As far as I know there is only ONE government in the world that has OFFICIALLY released the death figures following vaccination. Public Health Scotland. They did it only once, in one report and never updated the figures.

<https://publichealthscotland.scot/publications/covid-19-statistical-report/covid-19-statistical-report-23-june-2021/>

Page 29 gives the death figures totalling 5522. They do try to claim that they are the number of deaths they would have expected without the vaccines but as they are happy to use a blanket unfiltered 28 days when exaggerating the deaths from Covid I believe it is reasonable to apply the same standard to vaccine deaths.

Page 30 shows the number of vaccinations as 2.3million.

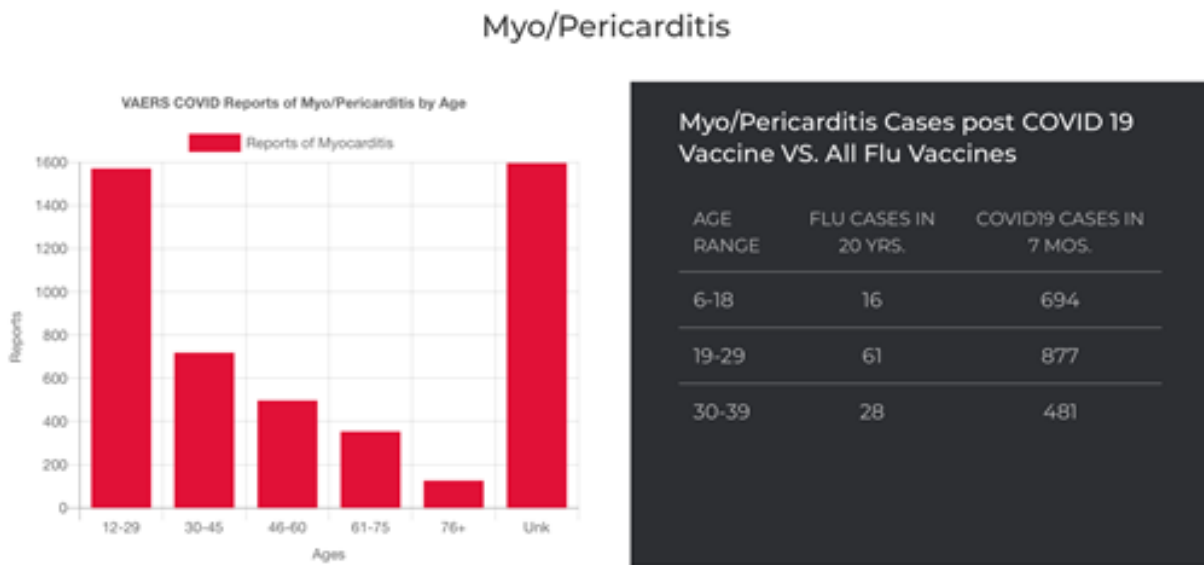
2.3m fully vaccinated / 5522 deaths means 1 death within 28 days for every 416.5 people fully vaccinated. Obviously the earlier vaccinations were of the elderly so this figure may contain deaths from other causes, we can never know whether the vaccinations have accelerated deaths among those already weak.

Note: 5,522 is roughly 0.1% of the entire Scottish population.

Now, let's conservatively assume that only 40% of those deaths were due to the vaccine (based on Schirmacher).  $2.3M / (.4 * 5522)$  is 1 death per 1041 fully vaccinated or essentially 1 death per 2082 doses or  $1/2082 * 1000000 = 480$  deaths per million doses. So for 400M doses, it would be 192,000 people killed.

There are additional qualitative methods that show a large number of deaths. The point of these methods is to show that the FDA assumption that “the vaccines are safe and all of the reports in VAERS are background events” is not even close to being true.

**Example 5:** The pericarditis data below shows that the number of events for these vaccines are anything but safe: they generate myocarditis/pericarditis at **860 times the rate of the typical flu vaccine in a year.**



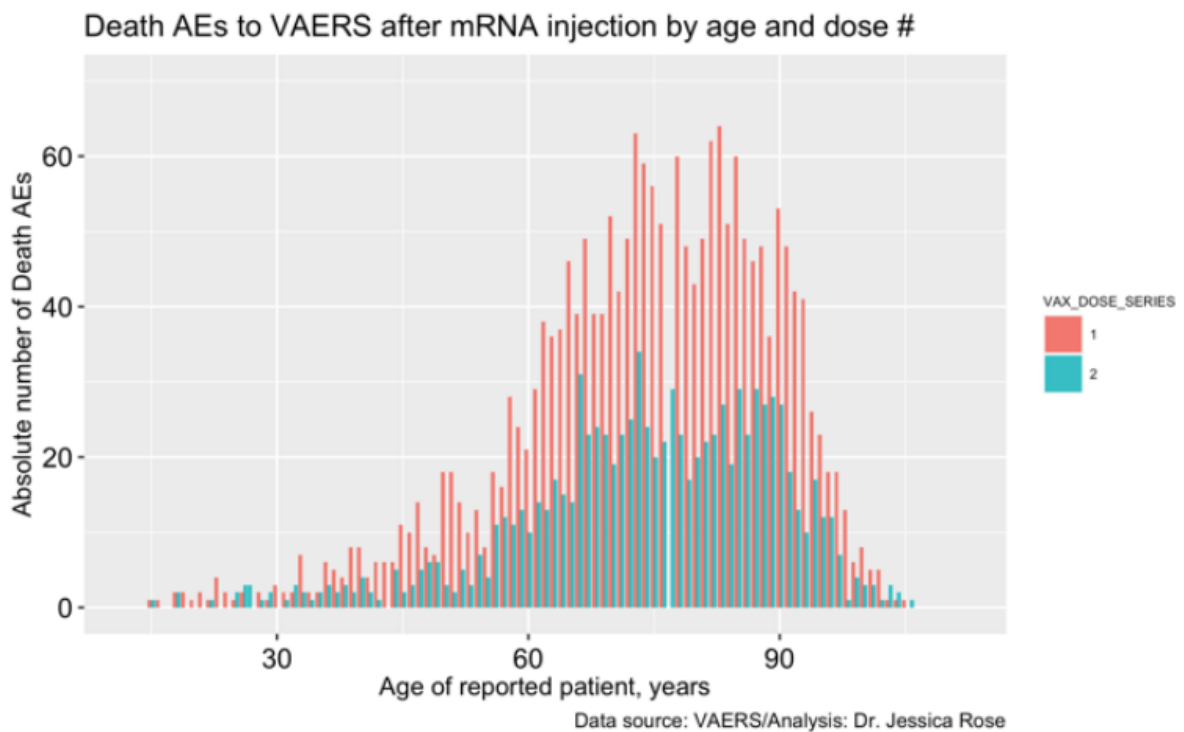
A friend of ours got pericarditis right after getting the influenza vaccine when she was 30 years old. It took her two years to recover. The heart muscle never really regenerates like other organs unfortunately.

**Example 6:** A total of 23 deaths have been reported in connection with the corona vaccination to the Norwegian Medicines Agency. Of those, 13 deaths were linked to the vaccine’s side effects. The other 10 haven’t been evaluated yet. Thus, 100% of the reported deaths have been deemed to be caused by the vaccine. If the vaccine is perfectly safe and has killed no one, then this is statistically impossible. Someone is lying. The fact that there are no autopsies being done in the US in public view suggests that it is more likely that the CDC is lying than the Norwegian Medicines Agency.

**Example #7:** An [analysis of excess deaths in Israel, especially among young people, that was done by Dr. Steven Ohana](#), clearly shows a huge rise in excess deaths that have no explanation other than the rollout of a mass vaccination program.

**Example #8:** A published analysis of VAERS data by Dr. Jessica Rose (Rose, J. 2021. A report on US Vaccine Adverse Events Reporting System (VAERS) of the COVID-19 messenger ribonucleic acid (mRNA) biologicals. Science, Public Health Policy & the Law. 2:59-80/[VAERS UPDATE for CCCA \(Canadian COVID Care Alliance\)](#)) and a more recent [analysis of VAERS data done by Christine Cotton](#) show massive numbers of cardiovascular and neurological adverse events occurring within temporal proximity to the injection date.

**Example #9:** Causality of these adverse events is confirmed using [Dose 1 and Dose 2 studies](#) done by Dr. Jessica Rose.



**Example #10:** If the vaccine is perfectly safe, the number of deaths would be equally likely after the first dose vs. the second dose since both are effectively “non-events.” Because there are 15% fewer people who get the second dose than the first dose, we should expect the blue bars to be uniformly 15% lower than the red bars. This is not the case here. If the vaccine kills 50% of the 1% most vulnerable people each time it is administered, this can explain the dramatic drop off in events.

Another explanation is that the vulnerable population experienced severe adverse events following Dose 1 and thus chose not to get a second Dose despite the societal pressure (vaccine mandates, peer pressure, etc) to do so. It is likely a combination of both effects. Here is an example of this from a comment posted to TrialSiteNews on [A New Low For the FDA](#):

KatieZ2

August 23, 2021

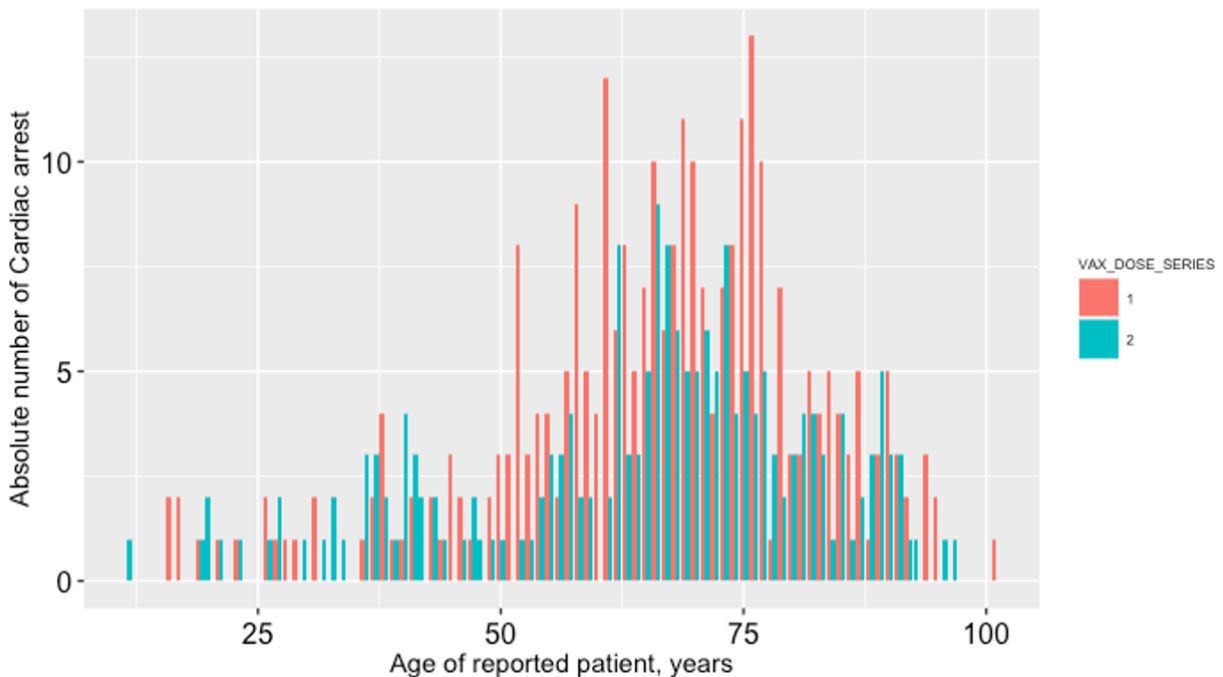
As someone who suffered one of these adverse effects, all I can say is shame on the FDA. I am on the Liberal side of the fence, and would not typically see myself on something like TrialSiteNews, but I am being shunned by my own camp any time I say anything about my story or the safety of these vaccines. I was very excited to get my vaccine but had so many symptoms post dose #1, including heart involvement, that I was unable to get dose #2. More than one VAERS report in – doctor completed a VAERS. Absolutely no follow-through by anyone. It's also correct that no one gets back to you – Senators or Congressmen. It has taken months to get better. The Ivy drug that shall not be named has helped me. There are docs using the Ivy med trying to help both long haul covid and post vax patients. Except for a few brave docs, all the injured are just being ignored. I can't believe it. I just can't fathom it.

Reply Edit

Whatever the cause, evidence to support the arisal and reporting of multiple severe adverse events that are dose-related is a very strong safety signal that requires investigation.

**Example #11:** The same commentary as before applies for cardiac arrest; a safe vaccine should have blue bars on average 15% below the red bars.

Cardiac arrest in VAERS after mRNA injection by age and dose #



Data source: VAERS/Analysis: Dr. Jessica Rose



**Example 12:** Absolute numbers of VAERS reports plotted according to “time to death” is very revealing. We don’t know what the exact distribution of timing looks like because this was never measured. But we speculate that maximum accumulation of spike protein is achieved around 24 hours or so after injection and then it plateaus after that point as the mRNA disintegrates. Therefore, we would expect to see a death peak more than 24 hours after injection, i.e., on Day 1 and not on Day 0. This is exactly what happens in practice:

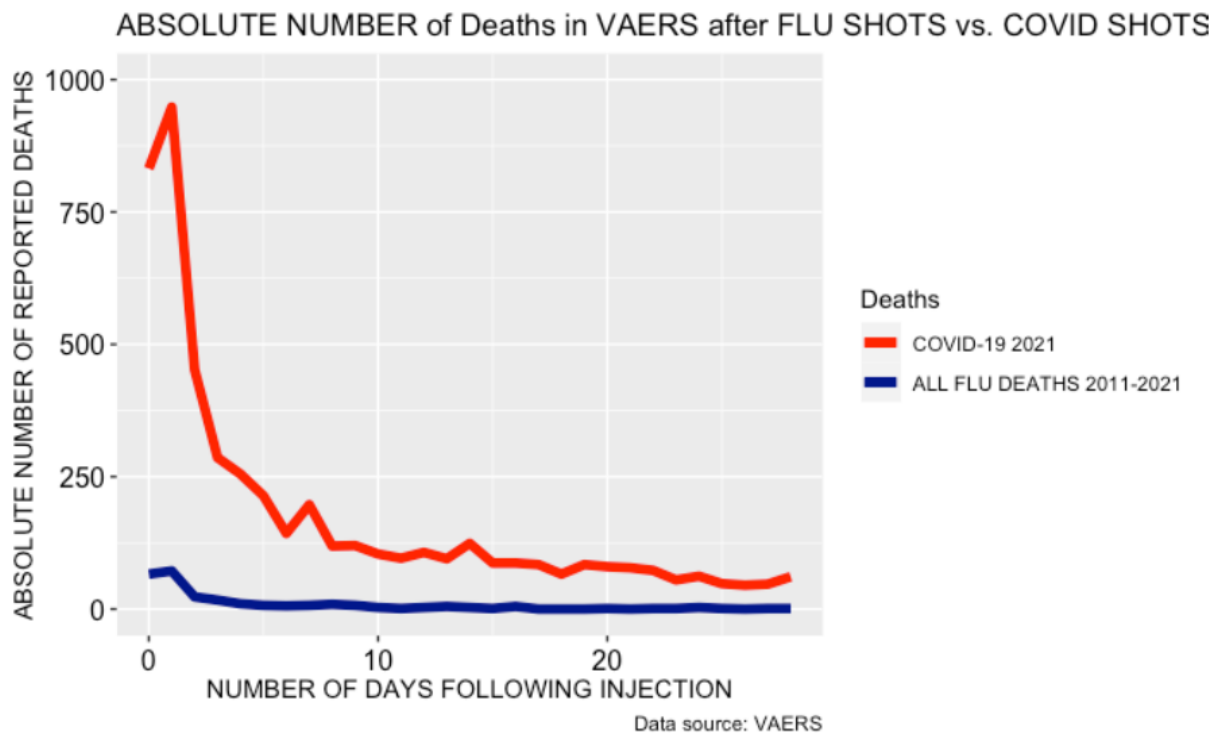


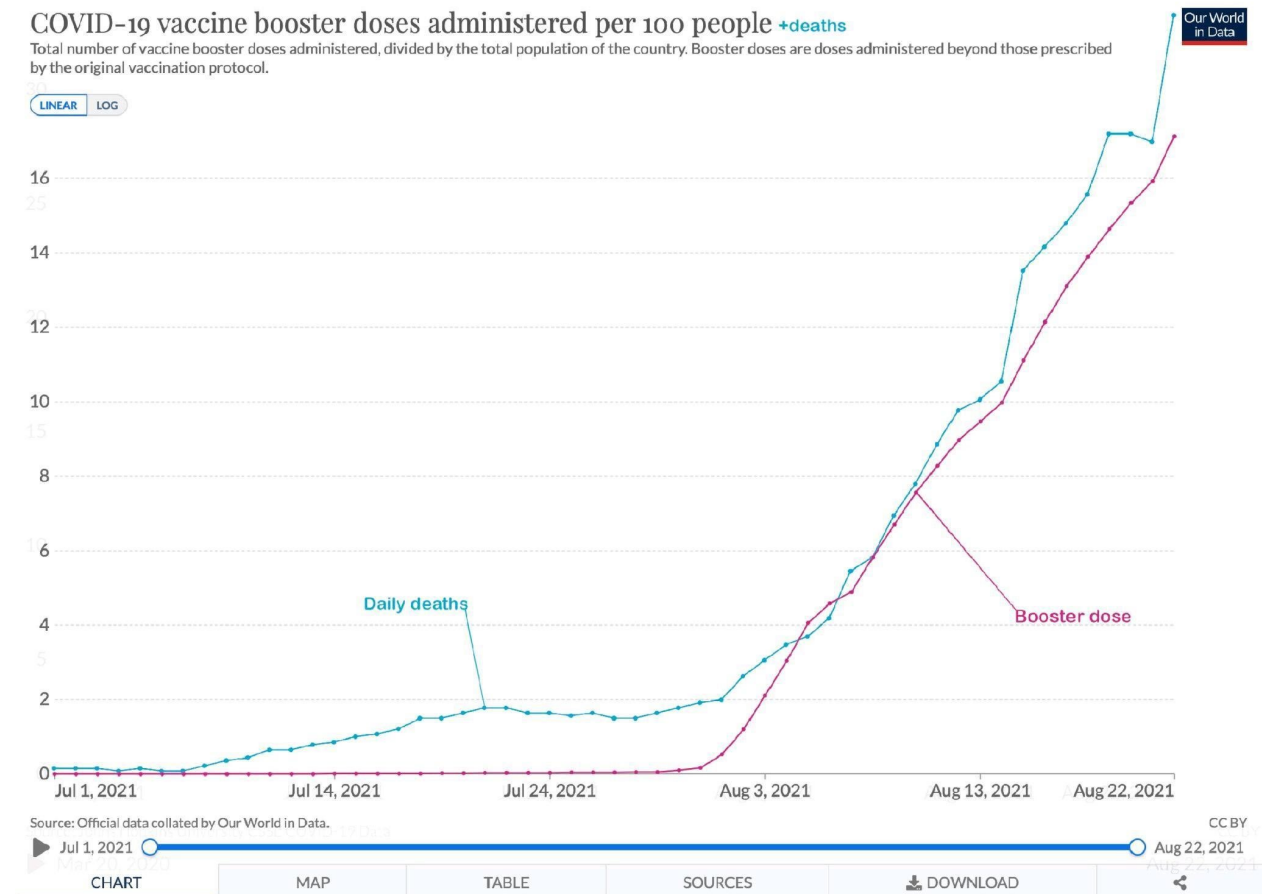
Figure 5: Absolute number of reported deaths for all COVID-19 deaths and all FLU deaths reported to VAERS with respect to time elapsed between injection date and AE onset.

If these were simply random background deaths, we would expect to see a peak on the first day since that has the highest PTR, and it would drop from there; it would never peak on Day 1. In the graph above, we plot 8 months of the COVID19 vaccine reports compared to all death reports from all influenza vaccines for the past 10 years combined. The blue line at 0 is 20 years of death reports, it is **not** an annual average. In short, the killing power of this vaccine is at least 200X greater than the influenza vaccine and probably a lot more than that since background deaths are included in both red and blue bars.

Furthermore, the shape of the two curves is completely different. The combined flu deaths are relatively flat with a slight rise in the first few days. The COVID vaccine generally kills people very quickly, and then gradually over time from there.

**Example 13:** A visual way to show that excess deaths are likely caused by the vaccine is to plot vaccinations and deaths on the same axis using [data from the COVID-19 data explorer](#). For

Israel we get this chart which shows a correlation between vaccine booster doses given (cumulative booster doses per 100 people) and average daily deaths per million: they track almost in lock step. This is hard to explain any other way.



**Example 14:** I did an analysis of random countries that had little to no incidence of covid cases for more than a year after the initial known outbreak in late 2019. In every case, the death rate skyrocketed within a few weeks of the vaccine rollout. Charts here:

<https://twitter.com/milehijules/status/1425591290155225104?s=20>

So if it wasn't the vaccine that caused these deaths after vax rollout, what did?

In summary, the qualitative and quantitative confirmation techniques we used were all independent of each other and of our main method, yet all were consistent with the hypothesis that the vaccines cause large numbers of serious adverse events and excess deaths and are inconsistent with the null hypothesis that the vaccines have no effect on mortality and have a safety profile comparable to that of other vaccines.

We were not able to find a single piece of evidence that supported the FDA and CDC position that all the excess deaths were simply over-reporting of natural cause deaths.

# Serious adverse events elevated by the COVID vaccines

To isolate events caused by the vaccine, we can compare reporting rates between years (corrected using the PTR) and then look for elevated signals.

But the problem with that is that the reported events could be:

1. Directly caused by the vax (e.g., death, myocarditis, etc)
2. Indirectly caused by the vax (e.g., fracture could be caused by having a stroke while driven)
3. A co-morbidity like diabetes (association not causation)
4. Unrelated (such as metal poisoning).

In general, the higher the ratio of event rates between adjacent years, the more likely we are to have causality.

The tables below were made using uncorrected event rates (no PTR correction), so the absolute numbers are currently wrong, but the relative numbers are unchanged. Anything with a value of 16 or more would be considered very troubling.

We made a table comparing the rate of adverse events this year relative to the annual VAERS incidence rate reported for all vaccines over the period from 2015-2019 for ages 20 to 60. We limited the age range to show that these events are affecting young people and not just the elderly. Also, the signal to noise ratio is much stronger in this younger age group since they are less likely to suffer “background” adverse events. A value of 473 means the rate reported in VAERS for the COVID19 vaccines in 2021 was 473 times higher than what is typical for all vaccines combined in the typical average year.

Nearly all serious adverse events we examined were strongly elevated compared to the expected normal baseline event rate. This table is useful when assessing whether the vaccine may have been involved in causing death in particular cases. The symptoms listed here are consistent with the presumed mechanism of action for how these vaccines systematically disrupt normal human physiological functioning (producing spike protein throughout the body that cause inflammation, scarring, and blood clots).

Surprisingly, [only some of these adverse events are listed in the labeling of the recently approved Pfizer vaccine](#). Thus, this table is important and timely.

<b>Symptom</b>	<b>Incidence rate elevation over normal (X factor)</b>
Pulmonary embolism	473
Stroke	326
Deep vein thrombosis	264.3
Thrombosis	250.5
Fibrin D dimer increased	220.8
Appendicitis	145.5
Tinnitus	97.3
Cardiac arrest	75
Death	58.1
Parkinson's disease	55
Slow speech	54.3
Aphasia (inability to talk)	52.3
Fatigue	50.9
Pericardial effusion	50.5
Headache	46.4
Chills	45.6
Pericarditis	44.9
Deafness	44.7
Myocarditis	43.2
Haemorrhage intracranial	42.5
Abortion Spontaneous	41.3
Cough	38.5
Bell's Palsy	36.6
Paraesthesia	29.5
Blindness	29.1

Dyspnea (difficulty breathing)	28.4
Myalgia	28.4
Dysstasia (difficulty standing)	27.8
Seizure	27
Thrombocytopenia	25
Anaphylactic Reaction	21
Suicide	18.3
Speech disorder	17.2
Convulsion	16.3
Thrombotic thrombocytopenic purpura (TTP)	16.3
Paralysis	16
Swelling	14.3
Diarrhoea	11.9
Neuropathy	11.2
Multiple organ dysfunction syndrome	11.1
Depression	8.9

## Child deaths are consistent with symptoms elevated by the COVID vaccines

Perhaps most troubling of all are child deaths.

The [CDC VAERS review of the 12-17 year old data](#) released on July 30, 2021 showed that there were [345 cases of myocarditis](#) and [14 deaths](#). The death rate associated with children is very different from the death rate associated with the elderly. We can all agree on this.

Using the table above and investigating each death, sufficient details described in the death reports showed that the deaths involved one or more of the symptoms listed in the elevated adverse event table.

14\*41 = 574 deaths

There are fewer total child deaths for 17 and under (which is a much wider age range than above) in the entire pandemic.

### **PEDIATRIC MORTALITY**

#### **Pediatric Deaths of Ages 17 and Under, COVID-19 vs. Recent Flu Outbreaks**

<b>H1N1 April 12, 2009 - April 10, 2010 (1)</b>	<b>COVID-19 Jan. 1, 2020 - Aug. 14, 2021 (3)</b>
1,282	361
<b>2012-13 Flu Season (2)</b>	<b>2010-11 Flu Season</b>
1,161	352
<b>2014-15 Flu Season</b>	<b>2015-16 Flu Season</b>
803	266
<b>2017-18 Flu Season</b>	<b>2016-17 Flu Season</b>
643	251
<b>2018-19 Flu Season</b>	<b>2013-14 Flu Season</b>
477	130
<b>2019-20 Flu Season</b>	(2011-12 estimate unavailable)
434	

(1) Clinical Infectious Diseases journal, Vol. 52, published January 2011

[https://academic.oup.com/cid/article/52/suppl\\_1/S75/499147](https://academic.oup.com/cid/article/52/suppl_1/S75/499147)

(2) CDC, Past Seasons Estimated Influenza Disease Burden for 2010-11 through 2019-20

<https://www.cdc.gov/flu/about/burden/past-seasons.html>

(3) CDC Provisional COVID-19 Deaths by Sex and Age

<https://data.cdc.gov/NCHS/Provisional-COVID-19-Deaths-by-Sex-and-Age/9bhg-hcku/data>

Therefore, the cost benefit case for children isn't there.

## Lack of a stopping condition

In [1976, they halted the H1N1 vaccine after 500 GBS cases](#) and 32 people died.

However, there is no stopping mortality condition for these vaccines. We are likely at 150,000 deaths and counting and nobody in the mainstream medical establishment, mainstream media, or Congress is raising any concerns.

**No member of the medical community, the policy makers, the FDA or the CDC is calling for any stopping condition nor autopsies. We find this troubling.**

## Negative efficacy

[This paper](#) shows that the vaccines we received may well shortly become **completely useless to protect us** and, to make matters worse, might **enhance the ability of future variants to infect us** due to vaccine enhanced infectivity/replication, rather than “classical” ADE.

In short, even if the vaccine were perfectly safe and killed no one, it’s rapidly becoming a net negative based on efficacy alone.

We are starting to see evidence of this today. [UK data destroys the entire premise for vaccine push](#). August 21. 2021. “Again, 402 deaths out of 47,008 cases or 0.855% CFR in fully vaccinated, and; 253 deaths out of 151,054 cases or 0.17% CFR in unvaccinated. If you get Covid having been fully vaccinated, according to this UK data, **you are five (5) times more likely to die than if you were not vaccinated!**”

## All-cause mortality is the single most important thing to focus on and it’s not there

Today, most people focus on the relative risk reduction of the vaccines against infection, and hospitalization death from COVID. They pay less attention to the absolute risk reduction from COVID. And they pay no attention at all to the absolute all-cause mortality benefit.

We should be focusing on these in the opposite order that how they are listed here, however.

**All-cause mortality is key. If there is no improvement in all-cause mortality, nothing else matters.**

In short, if a vaccine reduces the risk of dying from COVID by 2X, but it comes with a cost, e.g., increasing your risk of dying from a heart attack by 4X, both events are equally likely, then the risk/benefit ratio is skewed away from a beneficial outcome: you’re more likely to die if you took the vaccine.

Here are the results from the [Pfizer 6-month study](#):

Phase	Vaccine deaths	Placebo deaths
Pre-unblinding	15	14
Post-unblinding	5	0

Discussion of these results is quite a bit more complex than we have space to go into here, but these are the basic stats. For more information, see the 10-page discussion of the Pfizer 6 month trial at [Why so many Americans are refusing to get vaccinated](#).

All the all-cause mortality numbers are negative from the 6 month Pfizer study. This is not a surprise: it is caused by the high rates of adverse events we've already discussed.

**There is no evidence of statistically-significant mortality improvement.**

If there was the CDC, FDA, and NIH would certainly let us know. But just the opposite happened: when the Pfizer 6 month study came out, the mainstream media and mainstream medical scientists were silent on the lack of all-cause mortality evidence. It didn't even make it into the abstract. The fact that 4 times as many people were killed by cardiac arrest wasn't even mentioned.

When you combine (1) the negative efficacy of the vaccine with (2) the negative all-cause mortality benefit, it's impossible to justify vaccination. Either alone is sufficient to kill the benefit; both of them together makes things even more difficult for recommending vaccination.

The bottom line is clear: If you got the vaccine you were simply more likely to die. The younger you are, the greater the disparity.

## Early treatment using repurposed drugs has always been the safer and easier way to treat COVID infections

Early treatment protocols such as those used by Fareed and Tyson have been shown to provide more than a 99% relative risk reduction, work for all variants, and the drugs don't maim or harm the recipients. It is baffling that we are ignoring these treatments and waiting for more evidence when we have a vaccine which appears to kill more people than it saves, soon will be



completely useless against future variants, and is likely going to make things worse for the recipient by enhancing replication and/or infectivity.

There are also a variety of prophylaxis techniques that are simple, safe, and highly effective including. The precautionary principle suggests that if there is evidence from a credible source of the benefits of these treatments (which there are), that doctors should discuss these treatments with patients in a shared decision-making process.

Because early treatments using repurposed drugs don't create a measurable risk of death, the all-cause mortality for early treatments is always positive.

Many people assume that vaccination is the only path forward. It isn't. Allowing people to be infected and develop recovered immunity leads to immunity which is broader against variants and lasts longer. See "Recovered immunity is broader and longer lasting" in [this document](#).

It is instructive to compare Israel with India.

Israel is one of the most vaccinated countries on Earth with [80 percent of citizens above the age of 12 fully inoculated](#). As of Aug 24, 2021, Israel reported 9,831 new diagnosed cases on Tuesday, a hairbreadth away from the worst daily figure ever recorded in the country—10,000—at the peak of the third wave.

At the same time, India recorded 354 deaths in a day, Israel was reporting 26 deaths and [record high cases](#). Here's how they stack up:

Country	Population (M)	Vaccination rate	Covid deaths per million
India	1395	9.5%	0.25
Israel	8.7	80%	2.9

Obviously, India has 11.6X lower deaths per capita than Israel.

The conclusion is clear, vaccination is not the only solution nor the best solution.

## What is the Bradford-Hill test for causality?

Our symptoms meet all nine of the Bradford-Hill criteria for evidence of causality. 5 are listed below that are appropriate for vaccines ([per WHO guidance](#)).

You cannot infer causality from data unless you satisfy all these conditions (known as the [Bradford-Hill criteria](#)):

1. **Temporal relation:** the patient did not have the condition BEFORE the injection and the condition is new AFTER the injection. Note the condition could be an exacerbation of an existing condition, e.g., worsening of insulin resistance.
2. **Strength of association:** the rates should be higher than normal and the absolute numbers are large enough that it wasn't just random small numbers chance
3. **Consistency:** The results are consistent (e.g., it isn't just from one region or reports all from the same doctor or one batch of drug or happened in the first week and not any other week)
4. **Specificity:** The event shouldn't occur on its own or as a result of just the action of getting an injection or visiting the doctor, e.g., anxiety could be associated with the vaccination itself and would thus be not specific to the injection. So it should be a reaction that is specific to getting vaccinated such as a severe headache that starts within hours after the injection
5. **Biological plausibility:** The mechanism of action of the vaccine for how it harms patients should be able to explain the outcome. For example, warts aren't caused by vaccines. However, a wide range of neurological and cardiovascular events are within scope as are organ failures including multiple organ failure. Dysfunction of the brain, heart, and lungs, especially are suspect. Suicides can be triggered by vaccines.

## Countering the “fact checker” arguments

Let's take a look at the so-called “fact check” on FactCheck.org disputing the VAERS data.

[Viral Posts Misuse VAERS Data to Make False Claims About COVID-19 Vaccines](#)

It was written by [Catalina Jaramillo](#) and uses [Susan S. Ellenberg, PhD](#) as a source. I reached out to Catalina via LinkedIn InMail and to Susan via email on Sep 22, 2021. Susan said we were wrong and we should try to publish our results in the medical literature. So we did that (Kostoff's article). Then she stopped responding to further emails.

Let's address the false claims in the fact check, claims which are common in such articles. Here are some examples of what the “fact checkers” will claim is true:

1. **Improperly cite:** Yet over and over [websites and social media posts improperly cite unverified raw data from VAERS](#)
2. **Data may be inaccurate, incomplete, fraudulent, etc:** All reports are accepted into the database without determining whether the event was caused by a particular vaccine, and therefore, as a [disclaimer warns](#), submissions “may include incomplete, inaccurate, coincidental and unverified information.” Another issue, Ellenberg said, is the accuracy and completeness of the data because anything that anybody reports

goes into the database. A person could file a report omitting important details, such as which vaccine they got. Or someone could even report a false event, or report an event without having received a vaccine in the first place — although filing a false VAERS report intentionally [is a violation of federal law](#) punishable by fine and imprisonment.

3. **You can't determine causality:** Except, as the VAERS [website warns](#), any report submitted to the database “is not documentation that a vaccine caused the event.” As [we've explained before](#), anyone can submit a report of an event to VAERS, even if it's not clear that a vaccine caused the problem. “One of the main limitations of VAERS data is that it cannot determine if the vaccine caused the reported adverse event,” reads its [website](#). “This limitation has caused confusion in the publicly available data from VAERS WONDER, specifically regarding the number of reported deaths. There have been instances where people have misinterpreted reports of deaths following vaccination as deaths caused by the vaccines; that is not accurate.” So when VAERS says it has received [2,509 reports of death](#) among people who received a COVID-19 vaccine as of March 29, that does not mean that those deaths were caused by the vaccine. “The biggest limitation is it usually cannot help us assess causation, it provides signals,” Orenstein said. “Just because somebody reports death doesn't mean that the vaccine caused the death. So we don't use VAERS to determine death rates or anything concerning death,” a CDC spokesperson [told us previously](#). “People die, unfortunately, without vaccination,” Orenstein told us. “The issue is to determine where the vaccine enhances that risk of death and not, and that's why we have this very careful system.” He [Orenstein] said **the fact that VAERS doesn't determine causation is difficult for people to understand**, despite all the disclaimers on its website and brochures.
4. **No control group:** One of the major problems, she said, is that there's no control group to study because unvaccinated people do not report adverse events to VAERS. Therefore, there's no way to determine if the number of reported events is different from the number that would have been observed without vaccination. “You're going to have deaths that had nothing to do with the vaccines,” Ellenberg told us.
5. **There are no deaths:** In fact, after reviewing medical records, autopsies and death certificates for all of those cases, physicians from both the

CDC and the FDA determined that there was “no evidence that vaccination contributed to patient deaths.”

6. **Follow up shows the vaccines aren't dangerous:** Because of the urgency of the ongoing pandemic, the FDA required at least two months of follow-up data on half or more of the participants in phase 3 clinical trials for a COVID-19 vaccine to get an emergency use authorization. As [we've explained](#), full licensure requires a minimum of six months, though experts say there's little reason to think more time would uncover safety concerns.
7. **It's worthless:** “There are people who have said VAERS, and those kinds of systems are worthless, we shouldn't even bother with them,” Ellenberg said. “I don't agree with that.”

OK, let's take down each of these false and misleading arguments one at a time. However, fact checkers never read this part. They skip over it because it's uncomfortable for them to read. In fact, I haven't talked to a single fact checker so far that has made any attempt to read this document at all.

1. **Improperly cite:** Addressing the other claims disputes this one. It is possible that some people make mistakes. Assigning causality can be tricky in some instances, to really address this claim we'd have to see the specific case. There's no doubt people make mistakes. This argument doesn't affect anything here AFAIK. All we are saying in our symptom elevation claims is these are the numbers. The cause of that elevation has to be determined on a case by case basis. For example, diabetes is elevated vs. previous years. But we don't think the vaccine causes diabetes. Does it make it worse? Maybe, we haven't investigated this. Is diabetes a comorbidity? I think yes. But again, our claims are # of deaths that we are making. Anything else about elevated symptoms at this point is a distraction and we've put all our energies into the # of excess deaths.
2. **Data may be inaccurate, incomplete, fraudulent, etc:** Yup. So what? All data is noisy. Everyone knows this. There are 2 records in the 1.5M records that are fraudulent. It doesn't change the result at all. This is a smokescreen argument that people are fond of making. The purveyor of these arguments never ever shows any evidence that such mistakes affect the analysis. This is a hand waving argument without any data to back up the claim that the inaccuracies, etc. are sufficiently high as to

invalidate the analyses. They aren't. You can clearly see the myocarditis signal in the data for example. That contradicts their argument.

3. **You can't determine causality:** This is a widely held belief. People think if the CDC says it, it must be true. They ignore the peer-reviewed literature and common sense (see [If Vaccine Adverse Events Tracking Systems Do Not Support Causal Inference, then "Pharmacovigilance" Does Not Exist](#)). Let's take a simple example to disprove this. Suppose VAERS has 10 death reports every year for all vaccines. In every case, people died from strokes. No heart attacks. This year the COVID vaccine has 10,000 death reports filed against it. In every single month, the number of deaths reported is proportional to the number of doses delivered. In every case the person dies exactly 3 days after the shot, all from a heart attack. Did the vaccine cause this? If you said yes, in this (contrived scenario), it did. And you'd be right. It can't be over-reporting because the cause of death is different. Which means the CDC has been lying about this all these years about you cannot determine causality and nobody caught it. Whoops! Now in the current case, the analysis is more sophisticated, but basically we remove background deaths and when we do that we find around 200,000 excess deaths. Then we scratch our heads and say, "Wow. That's a lot of deaths. Wonder what could've caused it? Well it would have to be something new, and given to lots of people. We've never seen deaths like this before. So new and given to a lot of people and also it seems like the deaths were temporarily matching up with the vaccine rollout too.. The more vaccines the higher the death rate... so I wonder what all these people died from"
4. **No control group:** The "control group" is basically the previous years' data to see what is "normal" in a year since approximately a similar number of people are vaccinated according to the CDC data.
5. **There are no deaths that have been linked to the vaccine:** That's complete horseshit. Nobody in the world believes that. If they did, they'd jump at [my \\$1M bet](#). But there are no takers to my bet. Nobody is that stupid to believe the CDC on that whopper. How does one of the world's top pathologists do autopsies on 40 patients and determine that at least 30% of deaths within 2 weeks after the vaccine were caused by the vaccine? (See [Chief pathologist insists on more autopsies of vaccinated people](#)). Norway found a similar outcome based only on medical records of just 100 patients (see [Dødsfall i sykehjem etter covid-19-vaksine](#)). Our

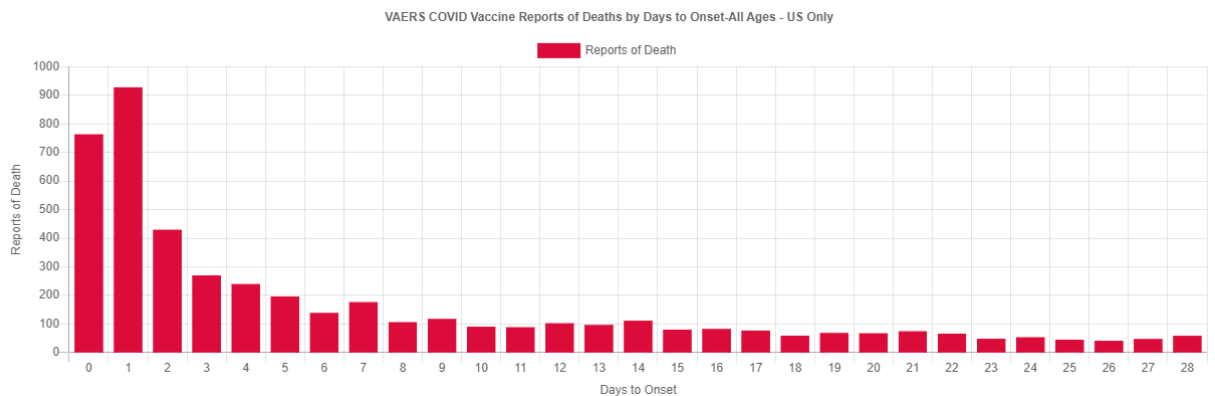
CDC found nothing after investigating [15,000 deaths](#). Are you kidding me!?!? Basically the people at the CDC looking at this stuff are bozos. I'm sorry but there is simply no excuse for the ineptitude here. There is no public report issued on the analysis. Why not? I did a video on the death analysis of the [14 kids \(aged 12-17\) who died in the CDC/ACIP analysis](#). You can [watch it on my Rumble channel](#). Or you can [read the analysis here](#) (page 57). Those kids didn't die just randomly. That is not a normal pattern of just background death. No way. These kids died to send a message to the world: these vaccines are unsafe. The world ignored it. The ACIP committee ignored it. Everyone ignored it. The 14 kids represent 574 deaths which is more than the kids killed by COVID. This sucks. Our society is truly messed up for parents to allow their kids to be vaccinated and die. Go watch [this video as well from a mother in Trinidad](#) whose child was vaccinated in the morning and he died later that night of a massive brain hemorrhage (a leading cause of death in the kids the CDC investigated). It's not normal. Or talk to our doctors who relate stories like "the 24-year-old worker in perfect health died in his sleep less than 24 hours after getting the vaccine. 24-year-olds never die in their sleep." The VAERS database is screaming out 250,000 excess deaths, but nobody is listening.

6. **Follow up shows the vaccines aren't dangerous:** That's false. The most definitive data from the gamed clinical trials were that 20 people who took the drug died vs. 14 placebo. That doesn't show the vaccines aren't dangerous. It just shows a gamed trial. See my [Pfizer analysis for details](#) starting on page 33 and the "We don't think Pfizer is trustworthy" section on page 45. So the pathologist and the Norway doctors are not just making this shit up. People are dying in droves. See the nursing home slides in [All you need to know](#) (Hawaii, Canada, Germany). Explain that one for me. That looks dangerous to me. All the docs I talk to say the death rate is 1 in 1,000. Maybe I am just talking to the wrong people. But if you TRUST the clinical trials, then the clinical trials show NO death benefit from COVID. There was only 1 net COVID life saved in the trial of 44,000 participants. Do the math. We are turning the entire world upside down for a drug whose benefit is to save 10,000 lives after 200M are vaccinated. That's insane. But that's what the (statistically insignificant) trial said that everyone believes: 2 COVID deaths Placebo, 1 COVID death in treatment: 1 life saved in 22,000 people given the drug.

7. **VAERS is worthless:** I agree with Ellenberg: the VAERS is a useful tool. It was one of 8 ways we found that over 150,000 people have died.
8. **It's just over-reporting of background events compared to last year; there is nothing to see here:** This is the FDA hand waving argument: VAERS just over-reported this year....that's why you see so many reports. This is bullshit again. We calculated the PTR above. It came in at .25. This means that VAERS is under-reported by 4x this year. So the fact we have a huge spike is mind blowing because 4X under reporting means the spike 4x larger than anyone thought it was (and it was already large as you can see from the mortality hockey stick graph). There are many other ways to tell it wasn't over-reporting: physician surveys, hard to train good habits, nobody has time to report, nobody wants to make the vaccines look unsafe, etc. The URF is great because it allows us to normalize for bad behaviors and the PTR allows us to compare numbers with previous years. The other way to tell is the distribution of symptoms... These vaccines don't look normal in VAERS. You never see facebook groups of 200,000 people on the flu vaccine.

There is also Schirmacher's study. You have to find that at least 30% of the VAERS report were causal. It's impossible that they were all background. Schirmacher's results were replicated by others.

If the deaths were all background, they would be perfectly flat over time (since they are not related to the vaccine). In other words, if it were background deaths, we'd have the same bar height for all days since the day of death would be not related to the day of the jab.



So basically, it's a nice hypothesis, but the data doesn't line up to support the hypothesis.

If anyone brings this up, you know they are not a serious scientist with a valid critique; they are someone defending their allegiance to the false narrative.

9. **“I don't know anyone who died from the vaccine but I know 10 people who died from COVID.”** That's not surprising. When you die from COVID, it has a telltale signature and progression. When you die from the vaccine, unless you know what to look for, it just looks like you died from “bad luck” since there is a huge range for the causes of death. Nobody dies “from the vaccine.” They all die from symptoms that are elevated by the vaccine including cardiovascular and neurological symptoms in general ranging from depression, suicide, multi organ failure, stroke, pulmonary embolism, cardiac arrest, intercranial haemorrhage , etc. So most people don't know what to look for. If you look at the [facebook comments here](#), you'll see that of the 200,000 respondents, most all believe the vaccine is far more dangerous than COVID. This is why we use 8 different methods to assess the number rather than relying on a few data points. If the vaccine were as safe as they said, we wouldn't have groups on Facebook with over 250,000 members talking about vaccine side effects. Of course, all those Facebook groups quickly get deleted by Facebook. Have you ever wondered, if the vaccine was as safe as they say, I wonder what those people are talking about. And if the vaccines are so safe, why not drop the liability protection? And what do you say to Maddie's mom? Or watch [this video](#) of John Looney at 15:00 for 2 minutes. Or read through this slide deck [All you need to know](#).

In addition, the fact checkers NEVER fact check the FDA/CDC by asking revealing questions like:

1. What is the PTR this year and how did you calculate it? May I see the derivation?
2. What is the URF for deaths this year and how did you calculate it? May I see the derivation?



3. You say you disagree with Kirsch's methods, but he uses the same methods you do to calculate the URF. So please explain what is specifically wrong with his methodology for calculating the URF.
4. What are the number of excess deaths showing in the VAERS system for the COVID vaccines?
5. If those excess deaths were not caused by the vaccine, then how do you explain them? Can you show me the evidence that backs that up?
6. There are doctors who never in their career had to write a single VAERS report and this year, they need to file over 2,000 for a single practice. If the vaccines are perfectly safe, then how do you explain this?
7. Why can't you supply anyone to debate Kirsch's scientific team? Discrediting his entire team in a live debate will decrease vaccine hesitancy. The public surveys show people want to see a debate on the key issues ASAP. Do you know anyone credible that would debate his team?

## Sanity checking all of this using the cost benefit data

I recently wrote another [paper on calculating the cost benefit of the vaccine broken down by age](#) looking only at mortality. This is a very important paper because it shows that the vaccines are nonsensical for every age group including the elderly. That result has been confirmed in the literature (see [Why are We Vaccinating Children against COVID-19?](#)).

What was very interesting in that paper is that the death counts in every age group were over 100X times greater if you got a COVID vaccine. It averaged 177 times greater than previous years.

So then you say, "hah! If it is only 177 times worse than previous years, and if we only kill 50 people a year in earlier years, then the vaccines have only killed 8,850 Americans! You're wrong!"

Except that argument would be misleading. Here's the correct way to state it:

In previous years, we get only 34.8 death reports in a year in the age range above 20. But the URF of those years is 10 [based on the CDC paper](#). So it's really 348 deaths. We multiply by 177 to get the deaths this year since the vaccine is 177 times worse than previous vaccines. But we must also correct for the PTR which is .25 as explained above so we have to multiply the previous year's real deaths (348) by the 708 (which is  $177 \times 4$  since the [table](#) noted that the 177 was prior to PTR adjustment).  $348 \times 708 = 246,384$ . So it all makes perfect sense and is consistent with our calculations that used just the

VAERS data exclusively from 2021. In short, we used the VAERS data both on a year-to-year relative basis as well as let's compute it solely on the 2021 data and both methods have the same result.

So basically, the average vaccine results in far more deaths of people 20 or older than people thought (350 per year) and the current vaccines are 708 times more deadly than previous vaccines if we consider all 350 deaths causal.

Here's the kicker. If we consider almost all those 350 deaths as 90% background deaths (which the FDA would claim) so that there are only 35 "real" deaths caused by the vaccine, then the story gets even worse for the government: **These vaccines are more than 7,000 times more deadly than previous vaccines** if we compare "real" excess deaths from vaccines in a typical year (35) to "real" excess deaths from COVID vaccines (250,000).

And that my friends is the inconvenient truth.

Therefore, spending any amount of time on elevated symptoms is simply rearranging deck chairs on the Titanic. The mortality rate sinks the ship. These are deadly vaccines.

## Criticisms

When people criticize this work, they never show me their "correct" analysis and point out how their analysis can be verified using 8 different methods. So these critics aren't really concerned that their hypothesis fits all the data. They are basically just interested in making points to shoot down my analysis by finding what they think is an error. It would be more constructive if they were to present the correct method.

However, in the interests of defending what I wrote, it's important to address any attacks.

I know of at least four criticisms of this work:

1. The JAMA study using VSD data shows that the  $URF \leq 1$  so you should use that and ignore everything else
2. There can't be 150,000 deaths because we'd see it in the excess deaths
3. Article by Jeffrey Morris [Evaluating claim in "peer reviewed" Toxicology Reports article vaccines kill 5 for every 1 save](#)
4. Article by Jeffrey Morris [Do Pfizer vaccines "kill" 2 people for every 1 saved? Evaluating viral social media reports](#)

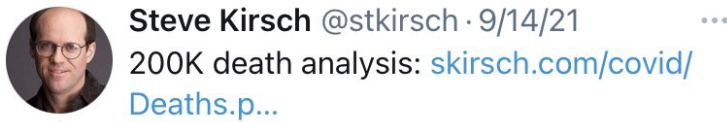
Let's address each one of these claims.

First the JAMA study.

Our critic, Matt Timberlake, claims that the JAMA VSD study proves that VAERS is actually over-reported by 15% and claims that the URF should be less than 1 (he claims  $URF=0.85$ ) in his tweet below.

This is a stunning assertion since there is nothing in the scientific literature that has ever claimed that VAERS is over-reported. Moreover, there is no evidence of that happening anywhere I'm aware of. This would mean that 15% of the reports are fabricated. We only know of 2 fabricated claims in 1.6M records. Does Matt know something we don't? Of course not.

So on it's face, we can dismiss this claim as ridiculous.



10 replies 85 retweets 228 likes



Replying to @stkirsch

Awful data. Here is ACTUAL data from hospital systems on anaphylaxis over 11.8 million doses. Not VAERS. Confirmed cases. 4.8-5.1/mil, or 497 expected cases for 97.5 mil. So  $497/583=0.85$  would suggest OVER reporting, not 41 times under reporting. [jamanetwork.com/journals/jama/...](https://jamanetwork.com/journals/jama/...)

Let's examine a more rational claim that the URF is close to 1.

Matt is referring to a [vaccine safety datalink \(VSD\) study published in JAMA on Sept 3, 2021](#) that said that "The estimated incidence rate of confirmed anaphylaxis was 4.8 (95% CI, 3.2-6.9) per million BNT162b2 doses and 5.1 (95% CI, 3.3-7.6) per million mRNA-1273 doses." This is close to the [anaphylaxis numbers reported from VSD in this ACIP presentation \(slide 27\)](#) and this [presentation](#) (slide 10).

As we mentioned earlier, a [paper from CDC authors published in JAMA on August 31, 2021](#), reported “an updated anaphylaxis reporting rate of 4.7 cases per 1 million doses” based on VAERS data.

So this suggests that VAERS is under-reporting by 5% and that the URF might be as low as  $4.8/4.7=1.02$ .

This is obviously very different from the 41 number we used in the text above. Did we make a mistake?

There are at least 9 reasons we have ignored the VSD datapoint for the derivation of the URF:

1. The Lazarus report shows that VAERS is under-reported by a factor of 10 to 100 because it is effectively a voluntary system. This is exactly what we found in our analysis:  $10 < 41 < 100$ . And the Lazarus report should know since the system they built reliably detected 10X events or more.
2. All the anecdotal evidence we have from doctors is that they are under-reporting this year compared to other years. We don't know of a single doctor who is over-reporting events and Matt didn't have one either. He's since backed off the .85 number and now claims it is fully reported. All it takes is one of my “anecdotes” to disprove that assertion (the neurologist who reported 2 out of 2,000 events).
3. Most of the public is clueless about VAERS which suggests a URF of 1 is hard to believe since the public isn't likely to make up for the under-reporting of the healthcare workers.
4. We've done surveys of people who died and looked them up in VAERS and found that in most cases they aren't reported. If the URF=1, all those cases would be found. So this again disproves Matt's claims.
5. VSD denominators are suspect, just like with VAERS because not all incidents are captured. This is why, for example, the rate of excess myocarditis/pericarditis cases found in VSD is comparable to the myocarditis/pericarditis reporting rate in VAERS for 18-24 year olds (see [slide 13 in Grace Lee's ACIP presentation](#)). So if VAERS and VSD are your only datapoints, then Matt's argument would make sense. But they are not our only datapoints because both systems are known to under-report which is why the CDC likes them (see [Historical note: Why our adverse event reporting systems all suck](#)).
6. But we know from the [Ministry of Health of Israel that the rates of excess myocarditis caused by the Pfizer vaccine is at least 1 in 12,000](#) doses. This is at least 83 cases per million doses and could be as high as 166 cases per million doses. However, VSD found only 7.5 cases per million doses ( $(14.4+.7)/2$ ). This means that VSD is under-reporting by at least 11 and more likely by at least 22. Therefore, the Israeli data shows that the assumption that VSD is a fully reported system is clearly false. Therefore, using rates of anaphylaxis from direct observation of controlled study of healthcare workers is going to be much more accurate than using VSD. And the [Mass General](#) and [Japanese](#) studies both pretty much agreed with each other on the rate they observed.
7. The [Mass General](#) and [Japanese](#) studies found more events and were published as well in peer reviewed journals. There is no reason to believe that both these studies

were simply making up cases out of thin air. Given that both studies were specifically designed to capture anaphylaxis cases, it's more reasonable to believe them.

8. The death count that follows from a URF of around 1 doesn't agree with any of the other 7 methods we used so it's unlikely to be right. This is somewhat circular but we didn't use this argument for our other methods so there isn't a positive feedback bias going on here. Matt was unable to show that any of these methods are flawed in either data or methodology. Every method has its limitations, but when you go about it 8 different ways and get the same results, it's pretty hard not to believe it. By contrast, Matt didn't show us his "correct" use of the 8 methods and show us how he got a consistent answer.
9. VSD isn't a very transparent system. Access is restricted and tightly controlled. Therefore, it is hard to verify the data that was actually used in the study. We've heard that a lot of the data used in VSD is healthcare claims data which suffer from under reporting. We have never asserted that VSD was fully reported so we've never changed our position on VSD as anything but under-reported. If VSD was fully exposed, people would realize it was under-reported, and subject to a URF of its own and thus show similar safety signals.
10. [Another paper published in JAMA using VSD](#) shows no safety signals at all in 21 symptoms monitored (which for some reason didn't include the most significant adverse event of death) which is not what VAERS shows which is further proof that VSD is not good for spotting safety events. They couldn't even spot myocarditis as a safety issue because VSD is under-reported just like VAERS. That is why there are no safety signals. They treat it like it is fully reported. It isn't.
11. And they use the rates in VSD for calibrating the VAERS under-reporting factor which explains why the [URF's they found in their paper](#) are so unrealistically low (e.g., less than 2 in the stats they cite).
12. Mathew Crawford [wrote about VSD here](#) with similar concerns.
13. See the section below [The URF for VSD](#).

When I engaged in a Twitter conversation with Matt he said the URF=31 and that all of the deaths reported are all simply background deaths; that the vaccine has only killed 3 people. So the 31 would be the multiplier that gets you to the total number of background deaths reported in that time period. So this is different than the .85 number he said before. It's really hard to keep up with all the changes. And if they are all background deaths as he claims, then that means the German pathologists are all lying and kids dying in their sleep are normal. Anything is possible, but this is far fetched.

Now, let's examine the second attack: there can't be 150,000 deaths because if there was, it would show up as excess deaths.

The short summary is that there are excess deaths in 2021 and they are more than sufficient to cover our 150,000 death estimate.

Let's look at the numbers from the [CDC Weekly reports](#):

Year	Week 1-8 all cause deaths	Week 1-26 all cause deaths	Week 27-52 all cause deaths
2018		1,463,608	1,368,393
2019	465,489	1,451,714	1,394,243
2020		1,632,977	1,747,908
2021	620,659	1,673,896	

So there are 222,182 more deaths in the first 26 weeks in 2021 than in 2019, about the same number of excess deaths as in 2020. And there were 211,388 COVID deaths in the first 6 months of 2021. **In the first two months of 2021, the excess deaths were 155,170.**

By [June 16, 2021, the US had 600,000 COVID deaths.](#)

Our excess death count for the 18 months since Jan 2020 vs Jan 2018 is 5054781-4283715 = 771066. Assuming it was really 600,000 COVID deaths as the government claims, this leaves 171,066 excess deaths unaccounted for. That's a massive number of excess deaths. These could cover the 150,000 vaccine deaths. Plus, we believe that perhaps up to 100,000 of the COVID deaths (or more) could have been due to the vaccine because the [Scott Mclachlan paper](#) revealed that all the VAERS records they looked at were classified as COVID deaths even though there was no COVID in the record, so it's clear that the government has been playing games and classifying vaccine deaths as COVID deaths.

Therefore, the total numbers are plausible to support the 150K excess deaths we claim and also with respect to the timing, there were 222,182 excess deaths in the first 26 weeks of 2021 (vs. the same period 2019).

Also, the death rate is not going to be proportional to doses. The peak death rate will be in January and decline over time since it is based on when the oldest people were vaccinated. Those are the most likely to die. So the excess death curve does not follow the number of vaccine doses delivered because of this (which is why it doesn't peak in April).

# Daily COVID-19 vaccine doses administered

Number of daily doses administered (rolling 7-day average).



[LINEAR](#) [LOG](#)



Source: Official data collated by Our World in Data. For vaccines that require multiple doses, each individual dose is counted.

CC BY

## Excess mortality: deaths from all causes compared to previous years

Shown is how the number of weekly or monthly deaths in 2020–2021 differs as a percentage from the average number of deaths in the same period over the years 2015–2019. This metric is called the P-score. The reported number of deaths might not count all deaths that occurred due to incomplete coverage and delays in death reporting.



Source: Human Mortality Database (2021) and World Mortality Dataset (2021)

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Next there is Morris's article [Evaluating claim in "peer reviewed" Toxicology Reports article vaccines kill 5 for every 1 save](#)

The problem with his criticism is that even if Kostoff used a significantly less aggressive URF like 20, it's still problematic for the vaccine. With a  $URF=20$ , the deaths are easily justifiable from the excess deaths as we mentioned above, and the case for vaccination is still nonsensical.

Also, Morris as a scientist should be looking at hypotheses that fit all the data points. What happened to Schirmacher's study that 30% to 40% of deaths after vaccination are causal? And the independent validation of that? Or to the testimony from whistleblowers about high death rates and morbidity rates in nursing homes after vaccination? Or our UK mortician who said death rates in nursing homes went through the roof after they rolled out the vaccines? Well, he doesn't mention any of that. Why not? Because he can't explain it. For details, see [All you need to know](#). Morris simply cherry picks fights he can make a case for. He never attempts to show that his hypothesis is a better fit to all the data.

How about this datapoint which admits that even the clinical trials themselves showed a .1% severe adverse event rate:



← Tweet



MassimauX  
@masimauX



What is the number of Americans having experienced life threatening AEs from mRNA vaccines?

Moderna

19/15,210 = 0.13%

[nejm.org/doi/suppl/10.1...](https://nejm.org/doi/suppl/10.1...)

Pfizer

21/21,720 = 0.096%

[nejm.org/doi/suppl/10.1...](https://nejm.org/doi/suppl/10.1...)



187,000 Americans have likely experienced life threatening AEs from mRNA vaccines

Sep. 25, 2021	Moderna	Pfizer	
Fully vaccinated Americans	70,000,000	100,000,000	
% of life threatening adverse events (extracted from respective trials)	0.13%	0.096%	<b>TOTAL</b>
Estimated number of Americans experiencing life threatening adverse events from mRNA vaccines	<b>91,000</b>	<b>96,000</b>	<b>187,000</b>

10:19 AM · Sep 25, 2021 · Twitter Web App

Once you realize that the clinical trials themselves are gamed to enroll a super healthy population who die at a much lower rate than the population at large (approaching 10x lower) and you see that 187,000 people would come “close” to death in that population, it doesn’t look like we are just making this stuff up out of thin air about 150,000 actual deaths in a real population.

Finally, Morris doesn't mention the success rates of alternatives such as early treatments as a safer alternative to vaccination because he doesn't want to let anyone know that there are safer alternatives that are more effective.

← Tweet



MassimauX  
@masimauX



OK, so what do we have here? Two doctors have treated over 7,000 patients and **NOT A SINGLE DEATH** if treated within 5-7 days of symptoms.

How? Multidrug regimen based on hydroxychloroquine and ivermectin.

Wait a minute! Didn't Dr. Boulware prove in 2020 that HCQ is ineffective?

Dr. Fareed explained that patients can almost always be saved when they start the early treatment cocktail within the first five to seven days of symptoms.

"We have now treated over 7,000 patients and there has not been a single death in patients treated within the first five to seven days of the onset of symptoms. **NOT A SINGLE DEATH**. This (series) includes patients with multiple co-morbidities as well as patients in their nineties!"

- Protocol 1 uses of hydroxychloroquine an agent with antiviral reactivity against SARS-CoV-2, two antibiotics (azithromycin, doxycycline) along with aspirin and a multivitamin pack (including zinc, vitamin C, vitamin D, and others), and with selective use of one or a combination of inhaled budesonide, dexamethasone, prednisone, colchicine or other treatments deemed appropriate.
- Protocol 2 includes all of these options, plus ivermectin where deemed appropriate by physicians.

11:27 AM · Sep 20, 2021 · Twitter Web App

5 Retweets 1 Quote Tweet 6 Likes

There is another Morris criticism article by Jeffrey Morris [Do Pfizer vaccines "kill" 2 people for every 1 saved? Evaluating viral social media reports.](#)

Basically, he doesn't like the URF of 41 and thinks there is no causality and thinks that the other methods are not scientifically sound.

He won't debate us on any of this like the public wants.

What happens is long attacks, and then the other side has to write even longer defenses and the public is totally confused at the end. This is exactly what he wants to do: create confusion in people's minds. It's a very effective technique because few people have the time to go through the details. The beauty of a debate is that each side has limited time so it forces each side to choose their best arguments.

At a high level, Jeffrey is simply unhappy with the quality of the evidence used and of course he quibbles with the methodology. Sure, I'm not thrilled with the quality of the evidence either but we have to do the best we can with what we got. And we got a lot. And it's all very consistent.

Jeffrey writes:

They also cite an analysis of case fatality rate (CFR) that may be interesting for hypothesis generation, but cannot be used to draw any rigorous conclusions given its **complete dependence on national case and death rates**. Ignoring any of the many potential confounding factors, they conclude the only explanation for increasing CFR after vaccination is widespread fraudulent misclassification of vaccine deaths as COVID-19 deaths that, if true, comprises the greatest and most universal medical conspiracy in history, and leads them to infer estimates of 100k to 200k vaccine caused deaths in the USA.

Wow. He's basically saying the government statistics from all over the world are a bad data source. OK, then what are we supposed to use??? And his proof is that it can't be right because it would be too big a conspiracy. He should read RFK Jr.'s new book (not yet published as of 10/13/21, but will be out soon) which documents the conspiracy. How else are all these governments in lock-step? It's all driven by the CDC false narrative that there are no deaths. Nobody questions that. Nobody until now has even asked the FDA or CDC for the URF... I was the first one. Are you kidding me? Nobody in the medical community wants to know the URF?!? So yeah, that's proof that people have their head in the sand and aren't interested in safety signals.

The difference between Professor Morris and me is that I will take what is on the table, and spend money to do things like professional polls and physician surveys to gather more data and then do my best to analyze it.

What Morris does is the opposite. He likes to shoot down anyone's attempt to do an honest assessment of the data in front of us. When he is confronted with data he doesn't like such as the Maddie de Garay story or the dose-dependency in the VAERS data, he changes the topic.

This is why Morris won't debate us. He'd be exposed.

He never comes up with a better URF. He never proposes the "right way" to do this. He basically throws stones at anyone trying to make sense of the data. That is a tremendous disservice to America.

We would love to debate Morris but he has chickened out every time. He even refuses to do a recorded zoom call with us.

## Use of a single URF for VAERS

Because we used anaphylaxis, the event "most likely" to be reported into VAERS, the URF we calculated in this paper is a minimum URF for all adverse events. This means that it can be used to conservatively estimate any adverse event including death.

Our assumption that anaphylaxis is the "most likely to be reported" symptom is due to:

1. Obvious association with the vaccine
2. Required by law to report 100%
3. All HCW's know about VAERS

By contrast, death is less reported because:

1. no obvious association (it happens later)
2. HCW don't think they need to report (since the party dealing with the death didn't inject the vaccine)
3. The HCW handling the death may not even know about the vaccine
4. Few consumers know about VAERS (to directly report)
5. HCW reluctant to report (don't want to make vax look bad)
6. Most people, including doctors, don't think the vaccine can cause death, so why make a VAERS report that would just falsely alarm people. For example, the CDC can't find a single death caused by the vaccine. So a busy doctor is going to have less incentive to report.
7. There is no incentive for consumers to report to VAERS (it is not required, it is hard to do, and there is no reward)

Therefore, the URF for anaphylaxis should be a LOWER bound for URF of other symptoms including death and using 41 for death should provide a conservative estimate.

This is why the CDC itself uses anaphylaxis in their papers (such as their 2020 paper, [The reporting sensitivity of the Vaccine Adverse Event Reporting System \(VAERS\) for anaphylaxis](#))

[and for Guillain-Barré syndrome](#)). Note that the earlier 2015 paper, [Safety monitoring in the Vaccine Adverse Event Reporting System \(VAERS\)](#), doesn't mention this method and instead describes a more limited technique: Disproportionality analysis.

## The URF for VSD

VSD is under-reported, just like VAERS. When the CDC uses VSD as the reference to compute a URF for VAERS, they often compute URFs that are less than 2 (meaning 50% or more reporting rate as they computed in [The reporting sensitivity of the Vaccine Adverse Event Reporting System \(VAERS\) for anaphylaxis and for Guillain-Barré syndrome](#)).

Much more telling though is the myocarditis data from ACIP Chairman Grace Lee's presentation. Here's [slide 13 in Grace Lee's ACIP presentation](#):

**Myocarditis/Pericarditis – 0-7 day risk interval**

Ages (yrs)	VAERS reporting rates per million doses administered				VSD excess cases per million doses based on chart confirmed data			
	Pfizer Dose 1	Pfizer Dose 2	Moderna Dose 1	Moderna Dose 2	Pfizer Dose 1	Pfizer Dose 2	Moderna Dose 1	Moderna Dose 2
12–15	2.6	20.9			0.7	14.4	4.9	19.7
16–17	2.5	34.0						
18–24	1.1	18.5	2.7	20.2				
25–29	1.0	7.2	1.7	10.3				
30–39	0.8	3.4	1.0	4.2				

Data presented at Aug 30, 2021 ACIP Meeting 13

This chart makes it crystal clear to everyone that **VSD is as under-reported as VAERS**. In only one datapoint did VSD have a higher reporting rate. If we sum up the columns, we have 42.5 events per million for VAERS and 39.7 events per million for VSD. In other words, VSD is actually 7% under reported compared to VAERS.

Here's another slide, this time from the [Pfizer presentation at the October 26, 2021 VRBPAC meeting](#). This shows that VAERS is clearly capturing less than 20% of the cases (since Optum isn't fully reported either). Here, VSD is actually capturing more events than VAERS.

## Benefit-Risk Supports a Revision to the EUA for BNT162b2 to Include 5 to <12 Years of Age

**Model-Predicted Benefit-Risk Outcomes Based on FDA Scenario 4 and CDC Risk Scenarios per One Million Fully Vaccinated Children Ages 5 to <12 Years Over 6 Months**  
(Assumes a rate of myocarditis in 5 to <12 year-olds equal to that of 12-15 yo which may be an overestimate)

Model Scenario*	Benefits COVID-19 Outcomes Prevented				Risks Excess Myocarditis Cases		
	Cases <sup>1</sup>	Hosp. <sup>1</sup>	ICU <sup>1</sup>	Deaths <sup>1</sup>	VAERS <sup>2</sup>	VSD <sup>3</sup>	Optum <sup>1</sup>
<b>Males and Females – FDA Scenario 4</b> <i>VE=90% against cases</i> <i>VE=100% against hosp.</i>	58,851	241	77	1	22	57	106

\*FDA scenario assumes the COVID-19 incidence as of September 11, 2021.

1. FDA Briefing Document, EUA amendment request for Pfizer-BioNTech COVID-19 Vaccine for use in children 5 through 11 years of age. VRBPAC October 26, 2021.
2. Su JR. Myopericarditis following COVID-19 vaccination: Updates from the Vaccine Adverse Event Reporting System (VAERS); Slide 7 (7-day risk period post Dose 2). ACIP Meeting October 21, 2021. Available at: <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-10-20-21/07-COVID-Su-508.pdf>
3. Klein N. Myocarditis Analyses in the Vaccine Safety Datalink: Rapid Cycle Analyses and “Head-to-Head” Product Comparisons; Slide 18 (12-17 year olds; 21-day risk period post Dose 2). ACIP Meeting October 21, 2021 Available at: <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2021-10-20-21/08-COVID-Klein-508.pdf>

CC-32

## Error bars on the JAMA anaphylaxis study

The Mass General [JAMA study](#) had error bars on the rate of anaphylaxis: “Anaphylaxis was confirmed in 16 employees (0.025% [95% CI, 0.014%-0.040%])”

This means the “true” URF that we derived could range from

	URF Calculation	URF
1.4 per 10,000	140/5.97	23
2.47 per 10,000	247/5.97	41
4.0 per 10,000	400/5.97	67

But it’s highly unlikely it is 23 since that is less than the value of 31 that was calculated by [Jessica Rose in her paper](#) using the Pfizer adverse event data on a trial that was clearly gamed (in other words, the URF in a non-gamed study where the population was representative should be much larger than 31).

So in the very worst case, our estimate of deaths could be overstated by 32%, but we think that this is very unlikely.

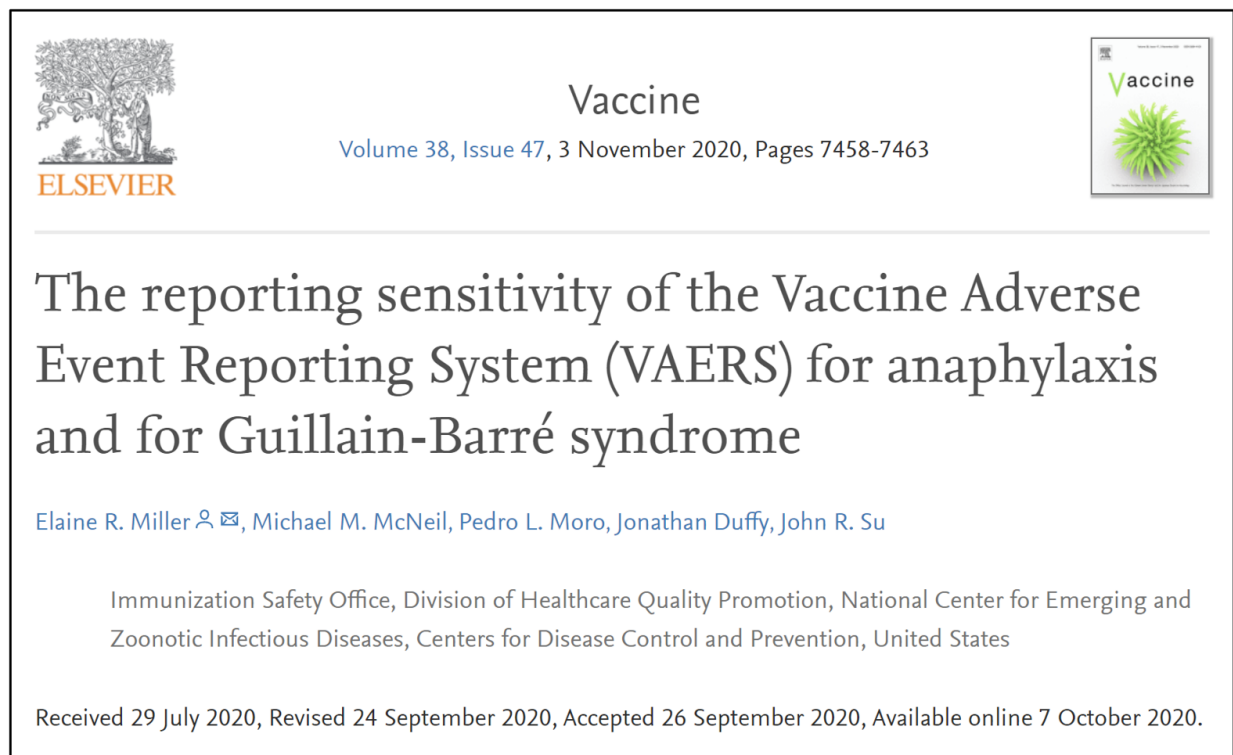
# The URF of VAERS this year


[July 19, 2021 Deborah Conrad letter to HHS](#) “Re: Underreporting to VAERS & Violation of COVID-19 Vaccine EUAs” we learned that:

1. Hospitals are preventing healthcare workers from reporting to VAERS (confirming our calculation of a high under reporting factor)
2. There are a high number of serious adverse events happening in their hospital and also in other hospitals in their area
3. Although the rate of vaccination in the community is 50%, 90% of hospital admissions are from the vaccinated suggesting [higher all-cause morbidity as the medical literature confirms](#).

## The CDC’s own paper explains how to compute the URF. We did it by the book.


There is a paper written by five CDC authors, [The reporting sensitivity of the Vaccine Adverse Event Reporting System \(VAERS\) for anaphylaxis and for Guillain-Barré syndrome](#), that was published a year ago in the peer-reviewed scientific literature.





 **ELSEVIER**

**Vaccine**

Volume 38, Issue 47, 3 November 2020, Pages 7458-7463



**The reporting sensitivity of the Vaccine Adverse Event Reporting System (VAERS) for anaphylaxis and for Guillain-Barré syndrome**

Elaine R. Miller  , Michael M. McNeil, Pedro L. Moro, Jonathan Duffy, John R. Su

Immunization Safety Office, Division of Healthcare Quality Promotion, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, United States

Received 29 July 2020, Revised 24 September 2020, Accepted 26 September 2020, Available online 7 October 2020.

The paper claims that serious adverse events in the past have been under-reported by at most a factor of 8.3 (known as the under-reporting factor (URF)).

More importantly, it describes the method for calculating the URF. We use that same method here.

## The second Blumenthal anaphylaxis paper in JAMA (Editorial)

This [Editorial](#) by Blumenthal references the original [Mass General JAMA paper by Blumenthal](#). The rates in the Editorial were based on VSD (which we know is as under reported as VAERS).

Editorial rate: 5 cases per million doses  
Research letter; 247 cases per million doses

That's quite a discrepancy by the same author! A factor of 50 less.

This of course would transform our  $URF=41$  to a new value of  $URF=.82$ . It would prove that VAERS is over reporting.

One of the Blumenthal papers must be wrong. They cannot both be right.

If you cannot figure out which Blumenthal paper is right, it's time to stop reading.

The Editorial also said, "mRNA vaccination was associated with excess risk of myocarditis/pericarditis among those aged 12 to 39 years with an estimated 6.3 (95% CI, 4.9 to 6.8) additional cases per million doses in days 0 through 7 after vaccination."

In short, it proved that the vaccines hardly move the needle on myocarditis. Seriously?!?

Bottom line: best to ignore the new study and go with the old one.

Brian S. Hooker, Ph.D., P.E., Professor of Biology at Simpson University is one of the few scientists not afraid to speak the truth (they are hard to find nowadays). Here's what he wrote on this section (emphasis mine):

You are correct in your analysis. The 2.4/10000 rate is based on all cases of anaphylaxis reported but the 5/1,000,000 is based only on inpatient hospital or emergency department visits. You can undergo anaphylaxis without being admitted into the hospital going to the emergency room. I also believe that the 5/1,000,000 applied the Brighton Collaboration criteria much too narrowly. **The second paper is just propaganda to get people vaccinated.**



# Excess background deaths aren't caused by lack of medical care during the pandemic

The problem with the theory that all the excess deaths are caused by the lack of medical care during the pandemic is that:

- 1) The deaths in VAERS are correlated with the vaccination time. Most of the deaths happen within a few days of the vaccination. If it were background deaths, they would occur at random times. The chart of deaths vs. days since vaccination would be flat. It isn't.
- 2) Dr. Schirmacher determined 30% to 40% of the deaths happening within 2 weeks of vaccination. What about those?
- 3) The event rate is related to the dose number. There isn't a stronger causal case than dose dependency. If these were all background deaths, there would be no dose dependency at all.
- 4) The causes of the children's deaths (12-17) were not "normal." Children aren't normally getting medical care to begin with. Having them then die from PE or intracranial hemorrhage could not have been caused by lack of medical care during the pandemic.
- 5) Same can be said for the causes of the deaths in adults: the "fingerprint" pattern of adverse events doesn't match normal death patterns.

In general, people who propose these "alternate hypotheses" always fail to show how their hypothesis is a better fit to the data than ours.

## Historical note: Why our adverse event reporting systems all suck

It's intentional.

The government paid for the creation of a reporting system that didn't suck (designed by the federal Agency for Health Care Research Quality (AHRQ). AHRQ proved that it could capture most vaccine injuries. AHRQ initially planned to roll out the system to all remaining HMOs, but after seeing the AHRQ's frightening results—vaccines were causing serious injuries in 1 in every 40 recipients—CDC killed the project and shelved the system.

In other words, it worked so well, **it spotted safety signals that the government didn't want people to know**. That's why they canned it.

This is why we are stuck with systems which under-report events, such as VAERS and the almost equally under-reported VSD system.

From the [Lazarus report](#) on the AHRQ project:

We had initially planned to evaluate the system by comparing adverse event findings to those in the Vaccine Safety Datalink project—a collaborative effort between CDC’s Immunization Safety Office and eight large managed care organizations. Through a randomized trial, we would also test the hypothesis that the combination of secure, computer-assisted, clinician approved, adverse event detection, and automated electronic reporting will substantially increase the number, completeness, validity, and timeliness of physician-approved case reports to VAERS compared to the existing spontaneous reporting system; however, **due to restructuring at CDC and consequent delays in terms of decision making, it became impossible to move forward with discussions regarding the evaluation of ESP:VAERS performance** in a randomized trial, and compare ESP:VAERS performance to existing VAERS and Vaccine Safety Datalink data. Therefore, the components under this particular Aim were not achieved.

The system is publicly available at [ESPHealth](#).

There was a nice paper on how well the ESP-VAERS system performed here: [Advanced Clinical Decision Support for Vaccine Adverse Event Detection and Reporting](#). This paper showed an average increase in 30X the reporting rate (30 per 100,000 vs. 1 per 100,000) and the 95% CI was that VAERS was effectively 9.52X to 95.5X under-reported. **In short, ESP-VAERS “confirmed” that a URF of 30 is very reasonable.**

So the very fact that they use VSD and VAERS instead of ESP-VAERS is basically “proof” that both systems are significantly under-reported.

## We are killing our kids, there is no doubt about it

15 year old healthy kids don’t die in their sleep... two days after vaccination

\*\*

## Sonoma County Sheriff's Office

Mark Essick, Sheriff-Coroner  
Coroner Investigations Unit  
3336 Chanate Road, Santa Rosa, CA 95404  
(707) 565-5070



### DEATH INVESTIGATION SYNOPSIS REPORT

CORONER CASE #  
21-000670

#### INCIDENT INFORMATION

LAW ENFORCEMENT AGENCY WITH JURISDICTION: <b>Santa Rosa Police Department</b>		REPRESENTATIVE TITLE AND NAME: <b>Officer Jose Andrade #568</b>	AGENCY CR #. <input type="checkbox"/> N/A <b>21-0006115</b>
MANNER OF DEATH: <b>Undetermined</b>	DATE/TIME RECEIVED: <b>06/07/2021 14:35</b>		

#### DECEDENT INFORMATION

DECEDENT'S NAME (FIRST, MIDDLE, LAST): [REDACTED]	AGE: <b>15 yrs</b>
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#### DEATH INFORMATION

PLACE OF DEATH (if facility Name or Address Location): [REDACTED]	DATE OF DEATH: <b>06/07/2021 [Found]</b>	TIME OF DEATH: <b>14:04 [Found]</b>
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#### SYNOPSIS

The decedent was found unresponsive in his bedroom after his mother was checking on his welfare long after he was supposed to wake in the morning. The decedent was pronounced dead at the scene due to obvious death. The decedent had been in good health with no medical history and had received his second Pfizer COVID-19 Vaccination approximately two days before his death.

The decedent's body was transported to the Sonoma County Morgue Facility, where he was registered for a postmortem examination by a forensic pathologist.

After extensive research, additional testing, and collaboration with numerous other entities, the cause of death was determined to be: **"STRESS CARDIOMYOPATHY WITH PERIVASCULAR CORONARY ARTERY INFLAMMATION (hours to days), due to, UNKNOWN ETIOLOGY IN SETTING OF RECENT PFIZER-BIONTECH COVID-19 VACCINATION (days)."** There were no other significant conditions contributing to the death listed.

Since the etiology of the stress cardiomyopathy with perivascular coronary artery inflammation was unknown but was in the setting of a recent Pfizer-Biontech Covid-19 vaccination, I mannered this death as **"UNDETERMINED,"** which was consistent with the circumstances and cause.

## The VAERS URF from the CDC: they won't tell us!

When asked for the URF for this year, the CDC (from 'COVID19VaxSafety') sent a copy of a 2015 saying they hope it helps.

On the same day, Oct 8, 2021, I sent this in response:

No, it's not helpful at all. That is from 2015. I want to know the URF for this year.

The CDC has calculated it for previous years for example, see: [The reporting sensitivity of the Vaccine Adverse Event Reporting System \(VAERS\) for anaphylaxis and for Guillain-Barré syndrome | Request PDF](#)

We want to know the number(s) for this year and see the calculation(s). This is very very important. Surely, you must know that.

If you don't know it for this year, then please explain how you could know it for previous years and not this year.

Also, can you send the PDF of the full paper above as I have requested it and not received it.

Also, I should call you attention to this:

When asked about this, both the **CDC and FDA sidestepped answering the question.** [Here's the proof at the CDC](#) (see page 1 which incorporates the CDC response to the original letter on pages 2 and 3).

[As noted in the letter](#), this implies that VAERS is under-reporting anaphylaxis by 50X to 123X. **The CDC chose not to respond to the letter.**

As of October 12, there is still no response from either the FDA or CDC on the URF and how it was calculated this year.

That's a long long time for a simple question that should have been calculated in early March when the [Mass General paper came out](#).

A former NY Times reporter (now working for another big newspaper) was similarly ignored when he asked the question of the FDA, so it isn't just me.

It means that neither of these agencies (and the individual members of their outside committees) really don't care to know how many people have been injured or died from the vaccines. **They simply don't give a shit.**


Re: wow. the FDA admits it has no idea of the URF !!!



Byram Bridle <bbridle@uoguelph.ca>  
To Steve Kirsch



10:29 AM

 You replied to this message on 10/12/2021 1:09 PM.  
If there are problems with how this message is displayed, [click here to view it in a web browser.](#)

Hi Steve,

How can the FDA not have some kind of estimate for the URF at this late stage of the declared pandemic?!? How have at least five international groups (incl. yours) done this and come up with #s in the same reasonable ballpark and they don't have this info. on-hand?!? ...despicable and embarrassing. Surprisingly, I have seen some people on the other side of the narrative trying to publish papers on the basis that the VAERS has captured 100% of the problems! The FDA needs to provide some leadership in this area.

Sincerely,  
Byram

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Byram W. Bridle, PhD  
Associate Professor of Viral Immunology  
Office Room #4834  
Lab Room #3808

## Putting this all in perspective

COVID vaccine mandates are necessary because the protected need to be protected from the unprotected by forcing the unprotected to use the protection that didn't protect the protected.

## \$1M bet

If you think I'm wrong about the deaths and you believe what the CDC and FDA are saying that only a few people have died from the vaccine, I'm willing to put my money where my mouth is. [Here are the terms of the \\$1M bet.](#) I've found that nobody is confident in their position to want to bet money on it. In other words, **not a single person in the world will bet money to defend the stated position of the FDA and CDC.** So why are we listening to their advice like we believe that they know what they are talking about?

## \$1M bug bounty

I'm offering a \$1M academic grant to anyone who can show the analysis is flawed by a factor of 4 or more in either direction and provide a more accurate analysis to the correct number. [See the terms here](#). No upfront cash is required for this offer.

## Solicited feedback

I tried to get feedback on my paper but nobody in mainstream medical academia could overcome their cognitive dissonance to read what I wrote.

A special mention for Professor Jeffrey Morris who reads only parts of what I write so he can critique it but he never offers any constructive feedback, like, “the better study to use is...” or “a more credible data source is ...” or a “stronger method that is practical is this...” He has never grabbed any ball I've thrown him and run with it to refine it to prove that vaccines are safe. He only seems to grab the balls that he can attempt to dispute. He calls himself a truthseeker, but that is not how truthseekers operate. He also has refused all my offers to debate him in a recorded zoom call. What is he so afraid of? That's the question he never really answers (he just says, “that's not the way it is done”; he believes we should spend years sending longer and longer documents to each other). Remarkably, Professor Morris has not spotted a single new safety signal in VAERS. Remarkably, with all the studies on ivermectin, fluvoxamine, and HCQ, he hasn't chided the medical establishment at all for not using the drug, but has instead called for “more studies.” What a guy.

And now this:



## Summary

Using the VAERS database and independent rates of anaphylaxis events from a Mass General study, we computed a 41X under-reporting factor for serious adverse events in VAERS, leading to an estimate of over 150,000 excess deaths caused by the vaccine.

The estimates were validated using multiple, independent ways.

It's interesting that General Motors recalled the Bolt battery after 3 people were injured, but the US government doesn't recall a biological product that has killed over 150,000 Americans to date.

There is no evidence that these vaccines save more lives than they cost. Our [detailed analysis](#) shows they kill twice as many people as are saved from COVID and our numbers are statistically significant. Pfizer's own study showed that adverse events consistent with the vaccine were greater than the lives saved by the vaccine to yield a net negative benefit. The result wasn't statistically significant but is troubling that there is no proven all-cause mortality benefit.

Without an overall statistically significant all-cause mortality benefit, and evidence that this optional medical intervention has likely killed over 150,000 Americans so far, the vaccine should be recalled just like the GM batteries. It is unethical to supply these vaccines to other countries.

Vaccination mandates are not justifiable and should be opposed by all members of the medical community.

[Early treatments using a cocktail of repurposed drugs](#) with proven safety profiles are a safer, more effective alternative which always improves all-cause mortality in the event of infection and there are also safe, simple, and effective protocols for prophylaxis.

## Additional resources

See [Vaccine resources](#) for a full list of my content on vaccine safety.

In particular, you definitely want to read [Cost benefit by age analysis](#) which shows that the vaccines are nonsensical for all age groups.