24 January 2022

**Letter from the UK Medical Freedom Alliance to:**

- Richard Pebody – Corresponding Author

**Re: Rapid Communication in Eurosurveillance "Estimated number of deaths directly averted in people 60 years and older as a result of COVID-19 vaccination in the WHO European Region, December 2020 to November 2021"**

The UK Medical Freedom Alliance is an alliance of medical professionals, scientists and lawyers who are campaigning for Informed Consent, Medical Freedom and Bodily Autonomy to be protected and preserved.

We are writing to you as the lead and corresponding author of the recent Rapid Communication in Eurosurveillance entitled "Estimated number of deaths directly averted in people 60 years and older as a result of COVID-19 vaccination in the WHO European Region, December 2020 to November 2021" [i].

The figures presented in this communication regarding the number of deaths averted by COVID-19 vaccinations, are quoted widely to further support the promotion of the COVID-19 vaccine program. **We argue that the data you have presented does not allow your conclusions, due to serious errors in your methodology.**

**The purpose of this letter is therefore to request an immediate retraction of this communication.**

Below, we outline the specific issues leading to your incorrect conclusions:

1) **The analysis is founded on an incorrect assumption of vaccine effectiveness**

   a. The study clearly states that it provides an "*estimate*" of the "*number of deaths averted*". In order to arrive at the estimate, an assumption is made about vaccine effectiveness (first dose 60% / second dose 95%), and all subsequent calculations are based on that assumption.

   b. In the clinical regulatory trials, **vaccine effectiveness was not defined by numbers of deaths averted**. The clinical trials were not set up to assess vaccine effectiveness with regards to death or even hospitalization[ii] [iii]. Instead, vaccine effectiveness was defined by the reduction of symptoms[iv]. Whilst numbers needed to vaccinate (NNTV) to prevent a symptomatic case may be 490, the NNTV for prevention of a death will be as much as 53 times higher (25,940)[v].

   c. The quoted rate of 95 % vaccine effectiveness in the regulatory trials was pertaining to relative risk reduction. This does not relate to the reduction of any particular outcome (illness/ hospitalization / death) in an individual, which is defined as absolute risk reduction. **The absolute risk reduction regarding the development of symptoms (not death) for an individual has been shown to be in the range of 1%** [vi]. Some population groups, including the elderly, were also not adequately represented in the clinical trials, and therefore statistical significance of outcomes may not even apply to them[vii].

**2) <u>Figures resulting from this incorrect assumption are in stark incongruence with observed data</u>**

As your analysis is clearly based on false assumptions, the data cannot be expected to be correct. This is confounded by an assessment of actually occurring mortality, and we elaborate on this incongruence showing data from Scotland / UK as an example.

a. The study suggests that the expected mortality per 100,000 for the age groups 60 years or older related to COVID-19 would have been 2,343.8 in Scotland for the weeks 51/2020 to 45/2021 whilst the observed COVID-19 related mortality was 333.3, concluding that 86% of deaths were averted by vaccination.

**Assessing Scottish all-cause mortality rates from the last 20 years for this age group, it has never been even close to the proposed expected figure of 5961 per 100,000** (Fig 1).

The average annual number of deaths occurring in this age group has been 49,146 in the last 22 years. It was 56,553 in 2020 and 55,131 in 2021. **There is absolutely no scientific basis for the assumption of the modelled expected COVID-19 related mortality rate or the assumption that without vaccination the death rate for those aged 60 or older in Scotland would have been 50% higher than observed**. The conclusion that over 27,000 deaths have been averted is therefore a completely unreasonable speculation and can only be described as false.

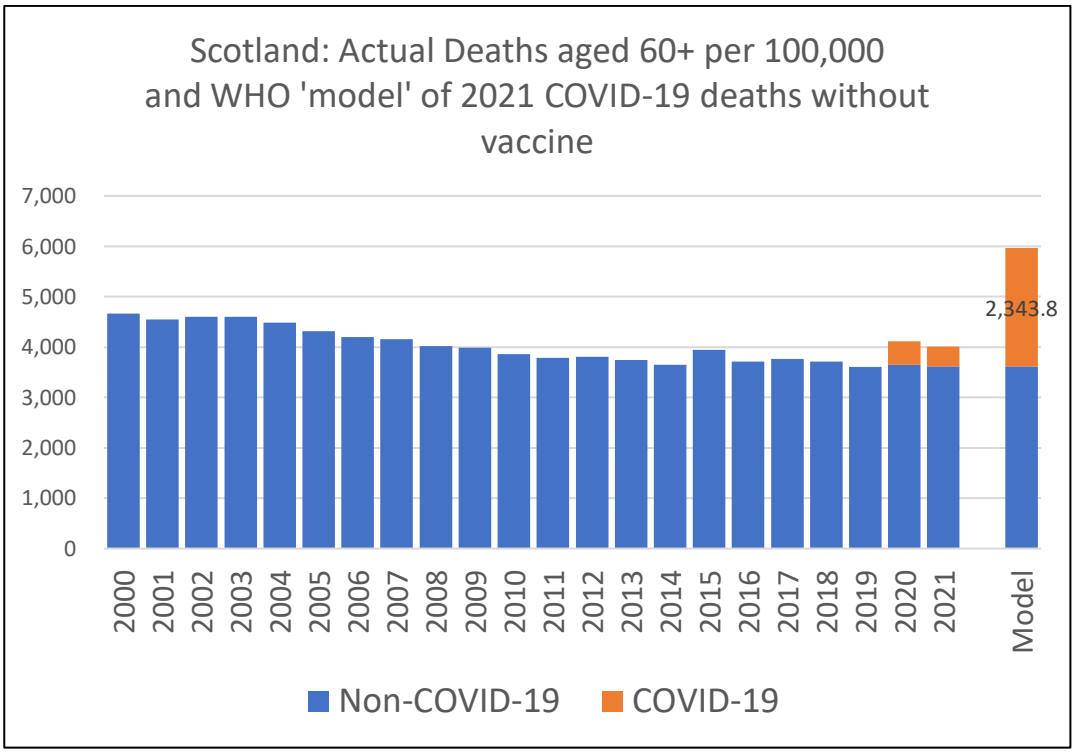


Fig 1 <u>All-cause annual mortality rates per 100,000 in Scotland for age groups 60 and older</u>

b. The suggestion in the proposed model is that 39% of mortality would have been related to COVID-19. **COVID-19 related deaths have not constituted a major proportion of all-cause mortality, and it is therefore entirely implausible to assume it may have contributed to as many as 39% of the deaths in 2021** (Fig 2). With the natural course of the pandemic (as seen in all previous pandemics) deaths due to the disease would have been expected to diminish even without vaccination, as people increasingly acquire broad-based natural immunity, effective also against naturally occurring variants[viii] [ix].

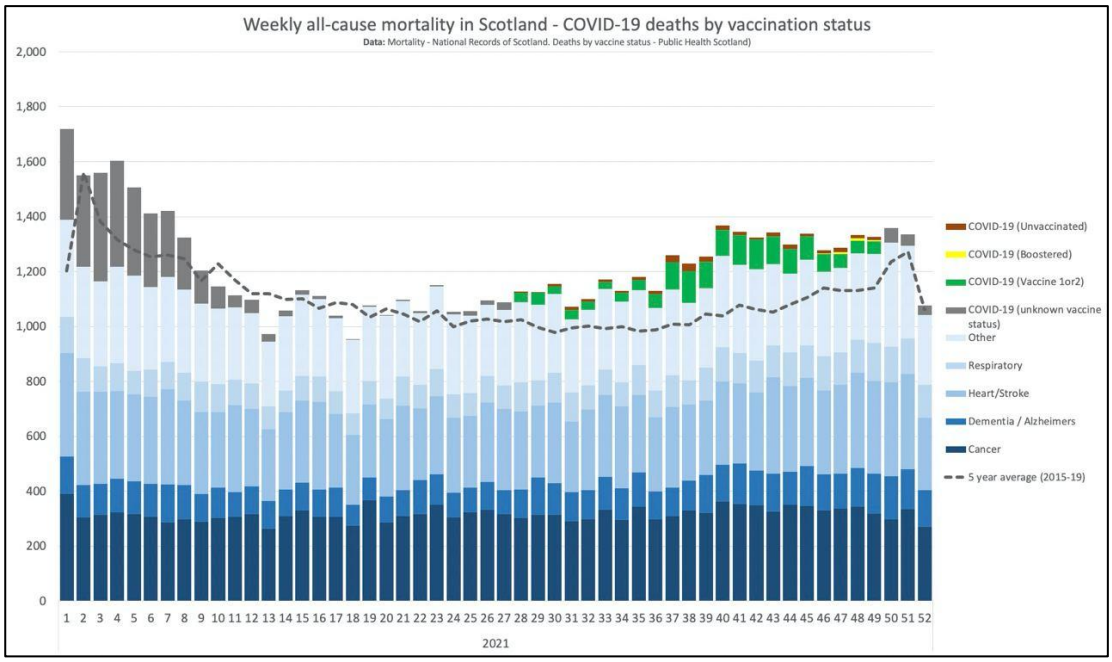


Fig 2 Weekly all-cause mortality in Scotland (NRS data)
Vaccination Status Data from Public Health Scotland (PHS)

c. Contrary to your conclusion that lives have been saved, there has been a significant increase in excess mortality in Scotland. This is also demonstrated in Figures 2 and 3.

**It is absolutely unprecedented that excess mortality rose over the summer months in 2021 and that this occurred across all age groups and across all regions in Scotland**.

Your model that has led to the claim that the COVID-19 vaccination program has saved any lives is based on false premises and assumptions. **In reality, mortality has increased significantly in Scotland in unprecedented proportions since its introduction.**

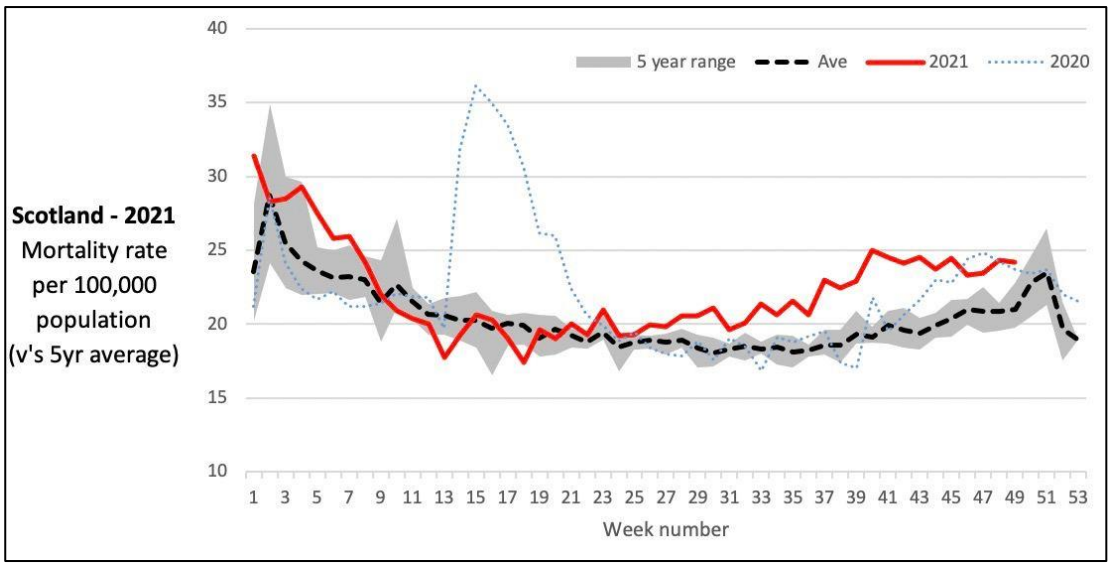


Fig 3 All-cause mortality rates in Scotland per 100,000 population (NRS data)

**In conclusion, your communication presents entirely erroneous data and we therefore hope that you come to the only possible conclusion that this paper must be retracted.**

We thank you for your time to read and consider all the points made in this letter.

We consider this to be of utmost importance in the interest of transparency and factual information regarding the COVID-19 vaccination program and its effect on public health.

We request you respond by 31 January 2022 to either confirm that:

(i) you are retracting your paper, or
(ii) you otherwise acknowledge receipt of this letter and respond to the points made therein as a matter of urgency.

We will, at this stage, not publicise this letter further, to give you time to respond and decide how you wish to proceed. However, we reserve the right to publish this letter more widely in due course, should we find that this paper remains in the public domain and continues to be used to promote the COVID-19 vaccination rollout.

Yours sincerely

UK Medical Freedom Alliance

www.ukmedfreedom.org

[i] https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2021.26.47.2101021
[ii] https://www.bmj.com/content/bmj/371/bmj.m4037.full.pdf
[iii] https://www.forbes.com/sites/williamhaseltine/2020/09/23/covid-19-vaccine-protocols-reveal-that-trials-are-designed-to-succeed/
[iv] https://www.fda.gov/media/144245/download
[v] https://mises.org/wire/what-weve-learned-israels-covid-vaccine-program
[vi] https://www.thelancet.com/pdfs/journals/lanmic/PIIS2666-5247(21)00069-0.pdf
[vii] https://www.rki.de/DE/Content/Infekt/EpidBull/Archiv/2021/Ausgaben/02_21.pdf Page 27
[viii] https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/
[ix] https://assets.website-files.com/5fa5866942937a4d73918723/6141b8500d6ede2828d82c02_UKMFA_Open_Letter_BSI.pdf