Tab 1

Did the mRNA COVID vaccine kill more people than it saved in the US before Jan 2023?

During the pandemic, we witnessed numerous occasions that cast doubt on the reliability and quality of the peer-review process.

In the early days of the pandemic, the Surgisphere scandal exposed *The Lancet*—one of the world's highest-impact-factor journals - for publishing an entirely fraudulent study based on fabricated data[1]. This incident highlights the need for observational studies—and, more broadly, the entire body of scientific literature - to be held to strict standards of scrutiny and transparency.

Regarding the approval of COVID-19 vaccines, these were fast-tracked to Emergency Use Authorization (EUA) in a deeply politicized context, raising concerns about their alleged efficacy. For instance, Pfizer, while publicly asserting that it was acting to save lives, delayed announcing its vaccine efficacy results until November 9, 2020 - coincidentally just after the U.S. presidential election - despite having data available on October 22, 2020[2]. This delay has fueled skepticism about the motivations behind the timing. Moreover, whistleblower Brook Jackson reported significant Good Clinical Practice (GCP) violations during the Pfizer trials to the FDA and was subsequently fired[3]. Similarly, Augusto Roux, a trial participant, testified to the horrendous treatment of individuals who suffered severe adverse effects after receiving the trial product[4] [5].

Additionally, the manufacturing process authorized for Pfizer's vaccine was tested on only 252 participants due to a protocol flaw stating that testing would occur in "lots of 250 subjects" without specifying the number of lots to be tested (Levi, Guetzkow[6]). Ultimately, only one lot was tested. The EMA leaks revealed **severe batch-to-batch variability**, which violates Good Clinical Practice requirements that a product must remain consistent[7]. A Freedom of Information (FOI) request filed by Nick Hunt confirmed that the comparative analysis between manufacturing processes 1 and 2 was later canceled[8]. Reanalysis of Pfizer's trial data, released under a court

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[1] https://www.theguardian.com/world/2020/jun/03/covid-19-surgisphere-who-world-health-organization-hydroxychloroquine

[2] https://openvaet.substack.com/i/144275433/inconsistencies-in-interim-efficacy-analyses-announcement-dates-and-non-compatible-subject - Points 52 to 54.

[3] https://www.bmj.com/content/bmj/375/bmj.n2635.full.pdf

[4] https://content.iospress.com/articles/international-journal-of-risk-and-safety-in-medicine/jrs220043

[5] https://davidhealy.org/disappeared-in-argentina/

[6] https://www.bmj.com/content/378/bmj.o1731/rr-2

[7] https://www.bmj.com/content/372/bmj.n627

[8] https://openvaet.substack.com/p/pfizerbiontech-c4591001-trial-audit - Reference 116, Page 4.

order, demonstrated that Process 2 was **highly variable**, with significantly increased rates of adverse effects such as lymphadenopathy and menorrhagia[9].

Lastly, observational studies, commonly used to claim a favorable benefit-risk ratio in the absence of convincing trial results, are **prone to numerous biases**. Medical journals often exhibit bias against publishing high-quality studies that challenge widely held beliefs, and real-world data is frequently non-auditable and affected by errors such as misclassification (Fraiman, 2024[10]).

Below I will show evidence supporting my assertion that the vaccines **increased**:

1. the risk of being infected with COVID (by as much as 3.6X per a recent CDC study) which is consistent with the reanalysis of the infection rate based on the number of doses administered in Israel[11].
2. the risk of dying from COVID once infected (e.g., that it increased the COVID case fatality rate (CFR) by 2.6X in my own county, and as high as 30X at Apple Valley Village nursing home per Medicare records)
3. non-COVID all-cause mortality (ranging from 1 per 1,000 in healthy populations (FDNY) to 26 per 1,000 in a large geriatric practice (Tidewater))
4. overall all-cause mortality (sum of 2 and 3).

Additionally:

5. Real-world evidence that can be independently collected and verified, including specific medical clinic mortality statistics, are consistent with the points above and **would have been statistically impossible to have been observed if the vaccines were beneficial.**

Summary: The increase in all-cause mortality was likely at least 22X or more higher than the most optimistic COVID mortality benefit from the vaccines.

Keep in mind the following points:

1. **Biased peer-reviewed literature:** The medical journals are biased against publishing high-quality studies that were not consistent with widely held beliefs. See Fraiman (2024).
2. **Abundance of flawed studies:** Many studies of the COVID vaccine are of poor quality and can't be replicated, but get published anyway, despite the lack of scientific rigor. Fraiman (2024) enumerates the issues with these studies. He's become convinced over time that the vaccines killed more people than they've saved.

   One of the most common mistakes is not realizing that people who choose to vaccinate

[9] https://openvaet.substack.com/p/pfizerbiontech-c4591001-trial-audit - Points 82 to 112, Points 116 to 118.
[10] https://brownstone.org/articles/a-critical-analysis-of-covid-19-vaccine-impact-claims/
[11] https://x.com/Jikkyleaks/status/1870708191367254095

may die at a much lower rate than the unvaccinated (e.g., 2x or more). This can be seen in Pfizer's own confidential study (Table 16, Deaths any causes) and in the stats of Xu (2023) among others. This is why many observational studies can erroneously show a mortality benefit for those who got the vaccine because they fail to account for this effect.

In one of the most important revelations of the pandemic, Høeg et al. (2024) pointed out that in Arbel, 2021, the non-COVID mortality (NCACM) differences completely accounted for the 90% lower mortality benefit claimed in the study, i.e., **the vaccine didn't reduce mortality at all; it was all a mirage.** In their reply, Arbel et al. acknowledged the failure, and then tried unsuccessfully to rescue their result with a ridiculous new analysis. An organization in Israel sued Clalit Health Services to release the data used by Arbel, but they lost. So **Arbel's methods and data remain secret**. The Høeg authors are expecting their reply to be published in a month.

Similarly, Bourdon (2024) found that the FDA's risk-benefit analysis of Moderna was deeply flawed. Looking at **just one adverse event**, they found that vaccination of 18-25-year-old males generated between **16% and 63% more hospitalizations** from vaccine-attributable myocarditis/pericarditis alone compared to COVID **hospitalizations prevented.**

And then there is miscategorization bias. Engler (2024) points out that every single study with the words (covid, vaccine, efficacy, safety) that Neil and Fenton (2024) could locate had one or more types of miscategorization errors. Fenton, Neil, McLachlan and Craig also managed to successfully demonstrate to the UK Office of the Statistics Regulator that these miscategorisation processes meant **official statistics in the UK could not be relied upon when used to support arguments of Covid-19 vaccine effectiveness** (link) supporting our contention that state-level results are always inconsistent with the results announced by their record-level data - when such data is exceptionally published as it was in the UK.

This is why I like to compare the one year mortality of different BRANDS of vaccines against each other because that's closer to a randomized trial. When you do that, the results are devastating which is why you don't see it being done anywhere comparing the RAW data by brand for the 1 year mortality rate since the shot.

3. **Mathematical models are poor substitutes for measuring efficacy:** Models are easy to manipulate. It is much better to directly measure what was occurring shortly before vs. shortly after an intervention. With all the direct data we have, there should be no need to reference predictive mathematical models to figure out what is going on.
4. **Longitudinal studies looking at raw data shortly before and after vaccination can** give us the most realistic assessment of the impact of the intervention. For example, looking at the case fatality rate (CFR) before the shots rolled out vs. shortly after should tell us if the intervention reduced deaths. However, looking at COVID case rates, before vs. after an intervention, can be extremely misleading because COVID comes in waves.

5. **The CDC lies to the public with no evidentiary basis to support their beliefs.** For example, they make a claim about COVID vaccine ingredients being perfectly safe but a FOIA request revealed they have absolutely no evidence to support their claim.
6. **The highest quality evidence we have is very seriously flawed.** The Phase 3 DB-RCTs are supposed to be definitive. Yet I easily identified over a dozen things wrong with the Pfizer trial that caused us to cast doubt on both the safety and efficacy claims. Eight authors collaborated to produce this very comprehensive report describing over 100 serious problems with the Pfizer trial that need to be investigated. **There have been no investigations into any of the allegations.**

7. **Record-level data (showing a record for each person of the date(s) of all vaccinations and date of death) is the most definitive "ground truth" data we have, yet mainstream scientists have all ignored it.**

   We have record-level data publicly available for only two countries: New Zealand and Czech Republic.

The Czech Republic data enables us to compare vaccine brands, which were distributed without any systemic or systematic bias.

Remarkably, there hasn't been a single peer-reviewed study on either of these datasets to show that the observed data is consistent with the "safe and effective" narrative.

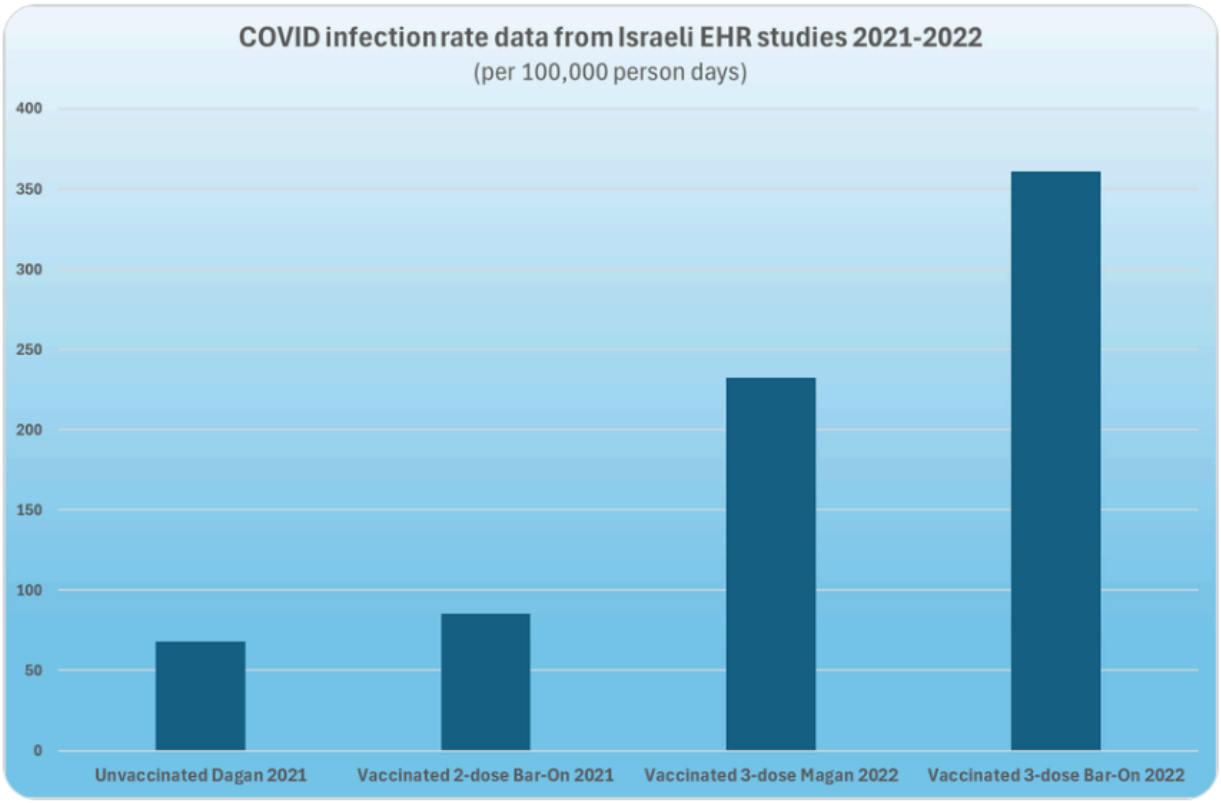
NZ Epidemiologists Paynter and Petousis-Harris have had the NZ record-level data for over a year, yet their promised analyses never materialized.

1. Infection risk

a. Pfizer's own DB-RCT Phase 3 post-hoc trial results had a hidden outcome that Pfizer privately admitted to the FDA that **those who got the shots were twice as likely to get COVID** (if you do the math correctly since one group was vaccinated for half the time)! And 100% of the severe COVID cases only happened i**n the people who were vaccinated.** So Pfizer's own post-hoc trial results showed the vaccines were making things worse, not better.

b. This just-published study done by the **CDC** shows in Table 2 that the Pfizer vaccine given to COVID-naive kids **increases the risk of symptomatic COVID infection: HR 3.57 (1.10, 11.63)**. Since, by the CDC's own study, the vaccine **increases** the odds of a symptomatic COVID infection by an estimated 3.57 in healthy kids under 4, what do you think it will do to the elderly? It is highly unlikely for a vaccine to simultaneously **increase the risk of infection in one age group** (e.g., children under 4) while **reducing it in another age group** (e.g., adults). There are **NO well-documented examples** where a vaccine increased infection risk in one demographic while reducing it in another. Show me the counterexample if you think I'm wrong. Otherwise, we're done with this category. Since even the CDC admits they were wrong (i.e., their own paper shows vaccines **increased** risk).

c. [Re-analysis of 4 Israeli papers](#) shows vaccines **increase** your risk of infection:

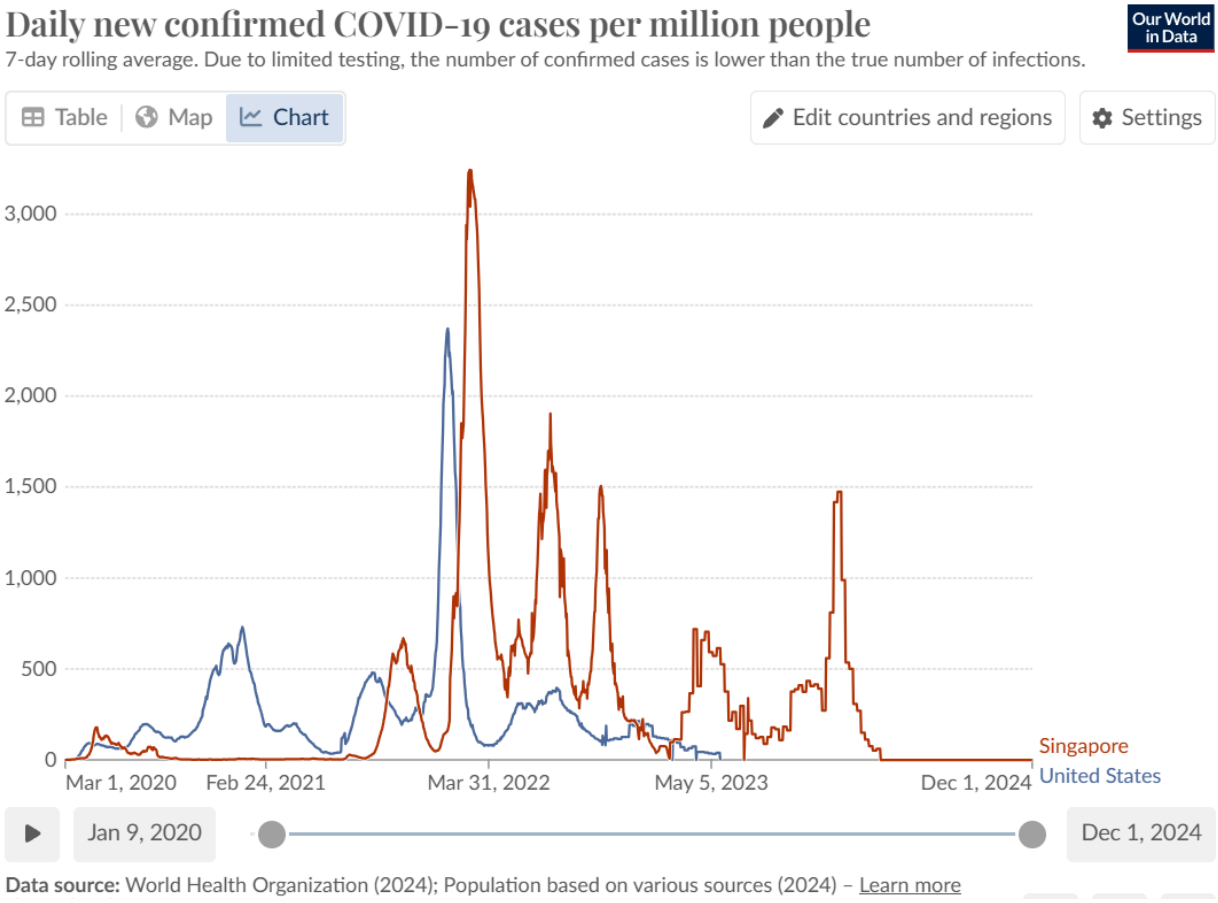


d. Worldwide COVID case numbers reported by OWID and [accessible from this page](#) show that highly vaxxed countries have higher cases per million (see [The Aarstad paper](#) below). For example, Singapore has one of the highest vaccination rates in the world and everyone was vaxxed before they opened the country to foreigners. So Singapore should be a “best possible” comparison scenario. So why do they have more cases per capita than the US? If the vaccine reduced infection as claimed, Singapore should be knocking it out of the park due to 1) heavy vaccination and 2) incredibly high herd immunity (due to the high vaccination rate), and 3) compliance with health directives which, if the authorities were right, makes it impossible for the virus to spread. Yet from an infection rate, they did much worse than the US. How is that possible?

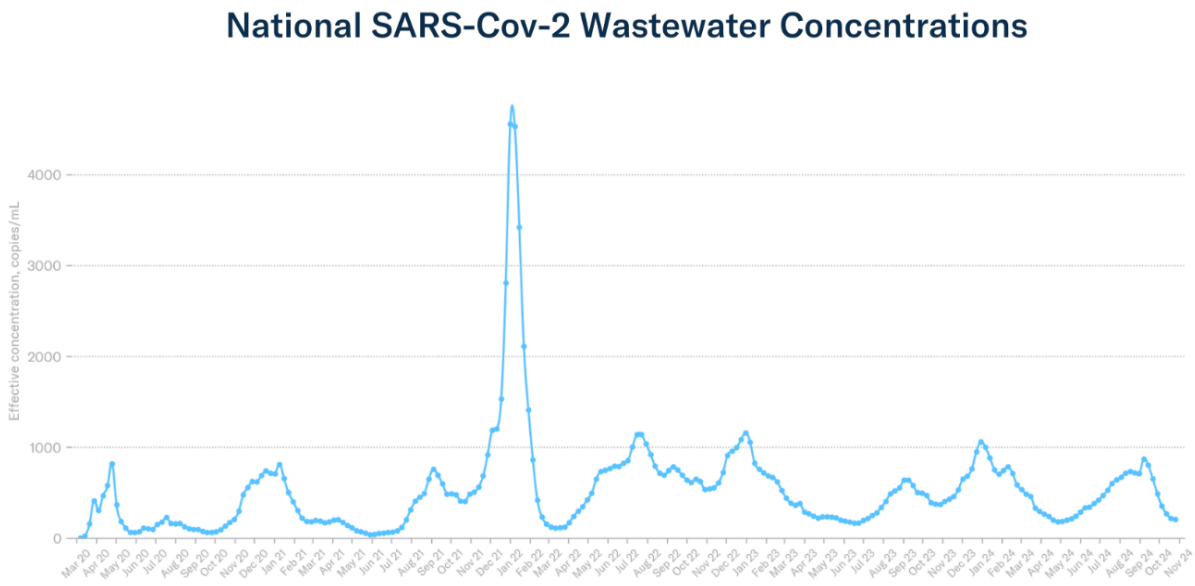
   It’s not country-specific differences because these would be the same over a period of a few years since societies change very slowly. We see greater disparities in COVID rates between the countries over very short timeframes.

   The example was hardly “cherry picked”; you can see similar curves for Australia and New Zealand for example. All of these countries keep very accurate statistics and should have done much better than the US since everyone was vaccinated

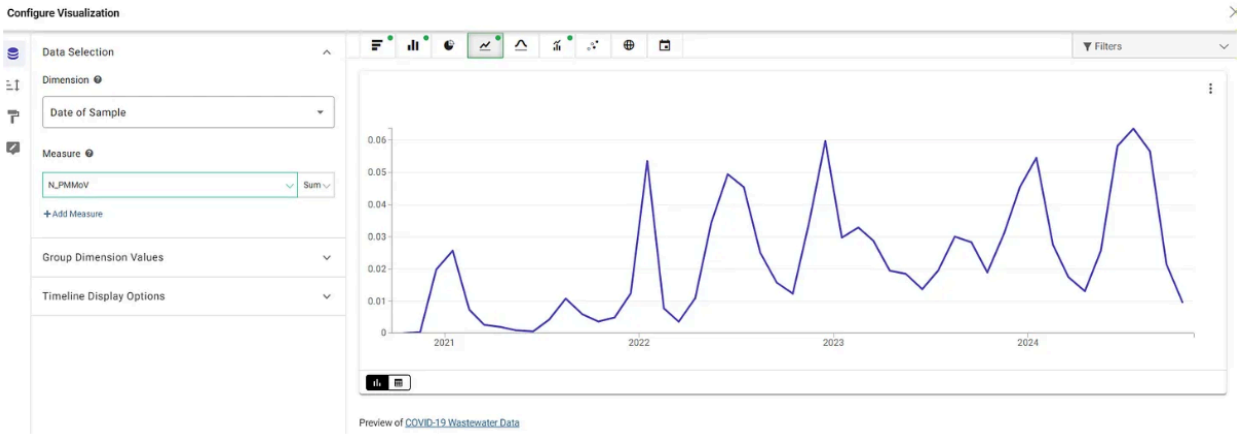
before they opened the borders.



e. US Wastewater. Look at the graph “National Wastewater Concentration.” The peaks are higher after the vaccine was rolled out! (see also the graph in the next bullet) If the vaccine worked, the peaks should have plummeted, You cannot tell by looking at the graph when the vaccine rolled out!



f. Santa Clara County (SCC) wastewater.



You can clearly see SCC did worse than the country, but **SCC is HIGHLY vaccinated**.

In SCC, every single viral peak after the vaccines rolled out is higher than the peak before the vaccines rolled out. In short, in this highly vaccinated county, you were *more* likely to be infected *after* the vaccine rollout.

Could this be because the variants were more contagious?

No. When we compare with the **national** wastewater concentrations, we see that Omicron was about 5X more contagious than any other variant, but you wouldn't know it in SCC where the peaks just kept getting higher.

g. Santa Clara County FOIA shows that the % of COVID cases who were vaccinated (98%) is much higher than the 86% of people who were vaccinated in Jan 2022. It's supposed to be the other way around if the vaccine worked. The health authority was officially asked both by the County Executive and a member of the Board of Supervisors to explain this data and they said "No comment." Why would they say that if there is a simple explanation?

h. IgA is critical to prevent the risk of infection of respiratory viruses which happen on the **outside** of the body. But this Nature paper on COVID vaccine-induced antibodies shows that the mean IgA against the RBD concentration (black line) drops to **unmeasurable values** (below that horizontal line on the graph in the paper which represents undetectable levels) after the second vaccine dose in Fig. 1h. How can eliminating your RBD IgA response reduce your risk of infection? My colleagues and I agree with ChatGPT: "Antibodies against the **RBD** are more critical for directly reducing infection risk because they specifically block the virus's ability to attach to and enter cells."

i. A huge study involving 170 million episodes of care and 7.6 million all-cause deaths during flu season (Anderson, 2020) found definitively that the **INFLUENZA vaccine does NOT reduce the risk of hospitalization or**

mortality. This very clever paper is better than anything ever done on the subject (and they note that in the paper), because it used a novel method: there is a HUGE increase (20% to 30%) in the vax rate at age 65 due because flu shots are free when you turn 65. The paper found **no decrease** in the hospitalization or death rate during flu seasons.

So if the flu vaccines don't work against the flu after over 75 YEARS of research, what new scientific mechanism of action is there that would lead us to expect that a quickly-produced COVID vaccine would reduce mortality in a different respiratory virus?

Flu and COVID are both single-stranded RNA respiratory viruses. The claim of higher efficacy for the COVID vaccine is solely based on precise targeting of telltale proteins with the novel mRNA technology.

But we note that Moderna's mRNA-based RSV trials (of their mRNA-1345 vaccine which precisely target the pre-F protein in RSV) were halted because it dramatically **INCREASED** the risk of kids getting RSV (HR=2.5).

Among those who developed symptomatic RSV, 26.3% of vaccinated participants progressed to severe illness, sharply contrasting with the 8.3% in the placebo group. This is an HR=3.2 of getting severe illness if you were vaccinated.

Why should we expect the mRNA technology to reduce risk for COVID, when it dramatically increases the risk for RSV?

j. The two Cleveland Clinic studies showed more vaccines → more likely to be infected. The difference was so stark that the confidence intervals per jab didn't overlap. They did the research twice which showed that the observed effect was not an effect of testing likelihood or time since infection. Both papers are published in peer-reviewed journals. Nobody's been able to attack this study with evidence that explains the effect, just speculation. Here's the graph from the first paper showing the more vaccinated you were, the MORE likely you were to be infected with COVID over time.

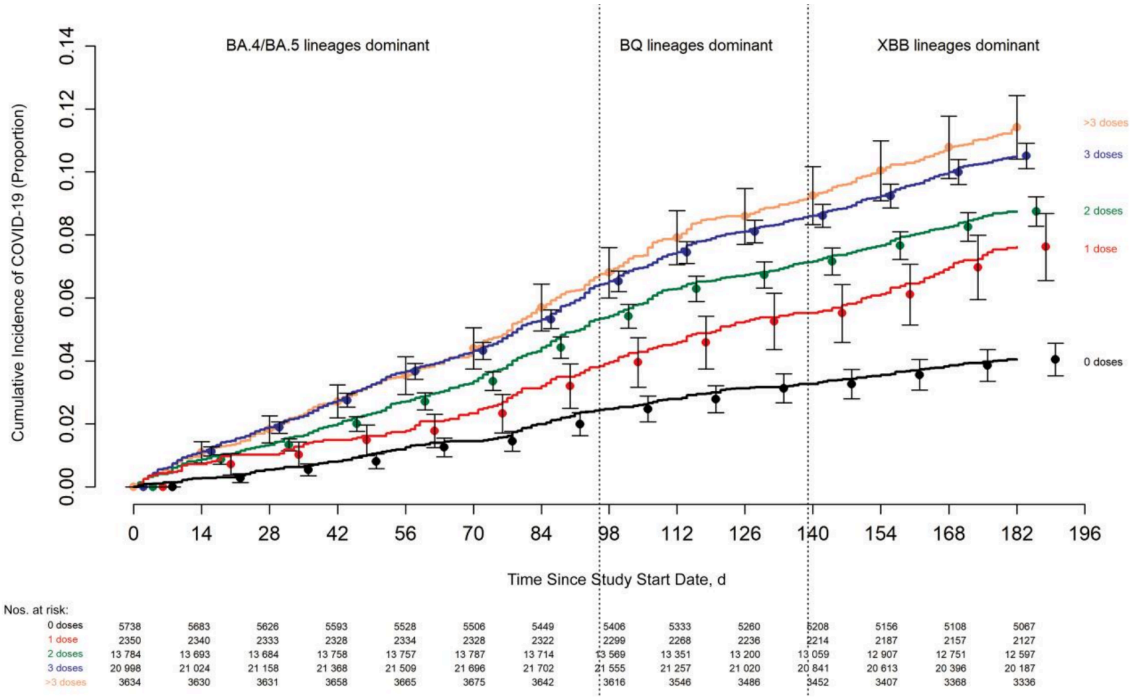


Figure 2. Cumulative incidence of coronavirus disease 2019 (COVID-19) for study participants stratified by the number of COVID-19 vaccine doses previously received. Day 0 was 12 September 2022, the date the bivalent vaccine was first offered to employees. Point estimates and 95% confidence intervals are jittered along the x-axis to improve visibility.

k. It's now so obvious to everyone that the vaccines don't reduce infection risk that even the authorities who touted the COVID vaccines are now backpedaling. For example, Dr. Birx admitted it doesn't protect against infection. Former CDC Director Robert Redfield also admitted they don't stop infections. It's one of the few things both sides agree on! The data clearly shows the vaccine increased your risk of infection.

l. Finally, even Fauci admitted in Morens (2023) that injectable vaccines have never worked against respiratory viruses and we need mucosal respiratory vaccines. We agree. The reason is simple: respiratory viruses incubate and multiply on externally-exposed body surfaces. Most people don't realize that the PCR test is, in most cases, simply measuring remnant RNA and all the action is happening outside the body.

2. Case fatality rate (CFR)

a. The CFR estimated from the Pfizer Phase 3 trial data was more than 10X higher for the vaccinated than the unvaccinated. The result wasn't statistically significant. **This should have been a HUGE red flag**, but they were all focused on reducing infections and ignoring everything else including mortality.

b. Despite being highly biased to make the product look as good as possible, the only mortality benefit Pfizer/BioNTech could find during their clinical trial was one COVID life saved in the trial, during the blinded period of July to mid-November (see Table S4 in the Appendix page 11). So **at best they can claim "1 life saved from COVID"**

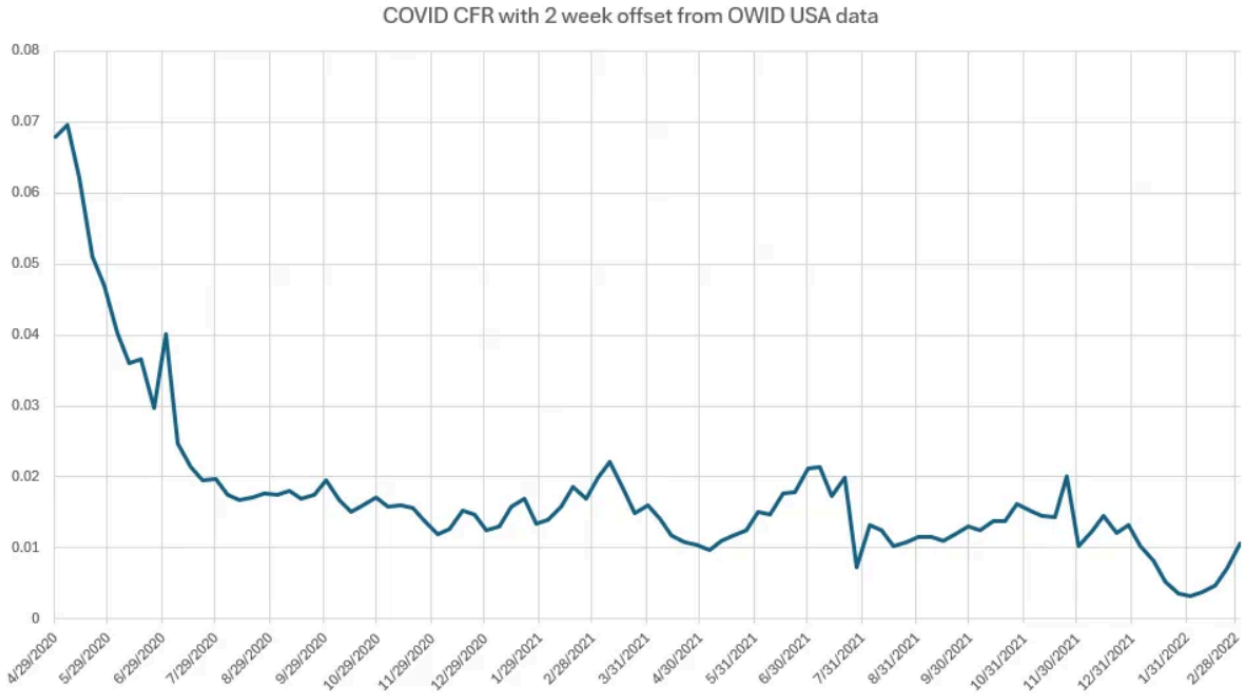
per 22,000 fully vaccinated.

Extrapolate that out to 270M people in the US who were injected. So the very best case is that the COVID vaccines saved on the order of 12,000 lives under ideal conditions. I don't believe it is anywhere close to that, but if you claim more than this number, it means you are saying the "gold-standard trials" are wrong and if the gold-standard DB-RCT trials are wrong, then everything else should be highly suspect.

So all I have to do is show the vaccines killed more than .05 people per 1,000.

Of course, the Pfizer trial also showed that more people died in the vaccinated cohort than the unvaccinated cohort (15 vs. 14 in the paper), so from an all-cause mortality point of view, the Pfizer trial results are consistent with my position, but the trial results were not statistically significant.

c. CFR calculated from COVID cases and COVID deaths in the US. I did the analysis and posted it here for all to see. The CFR doesn't drop consistently below the pre-vaccination level until the variants become less deadly. If the vaccine reduced the CFR, you would be able to, without looking at the x-axis date, tell exactly when the vaccine rolled out because the points would start moving lower from the date of first vaccination onward. So the downward slope would have increased. Can you?

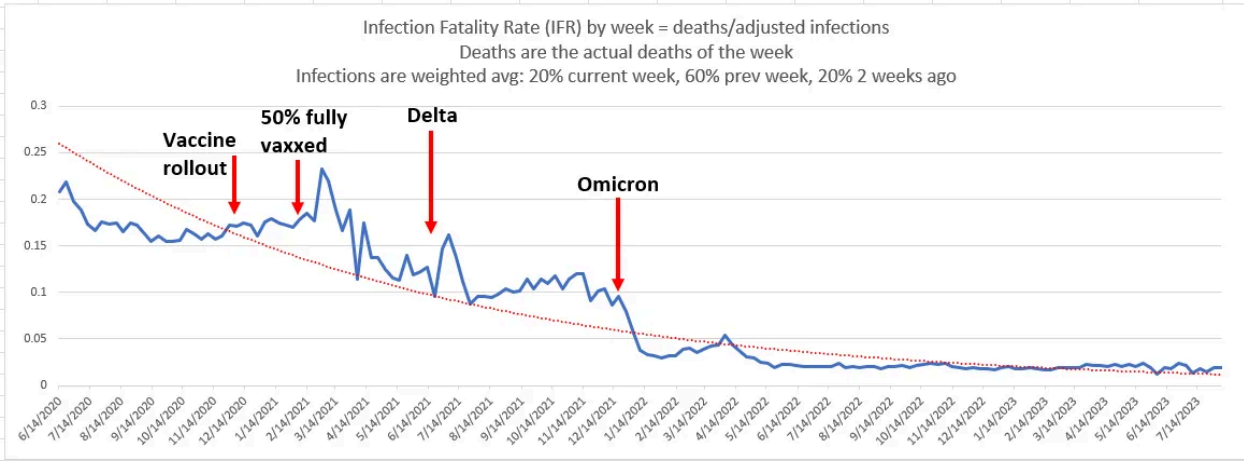


CFR with OWID data = Deaths/Cases from 2 weeks earlier. The .012 level seen pre-vax rollout isn't consistently breached until Omicron launches in 2022.

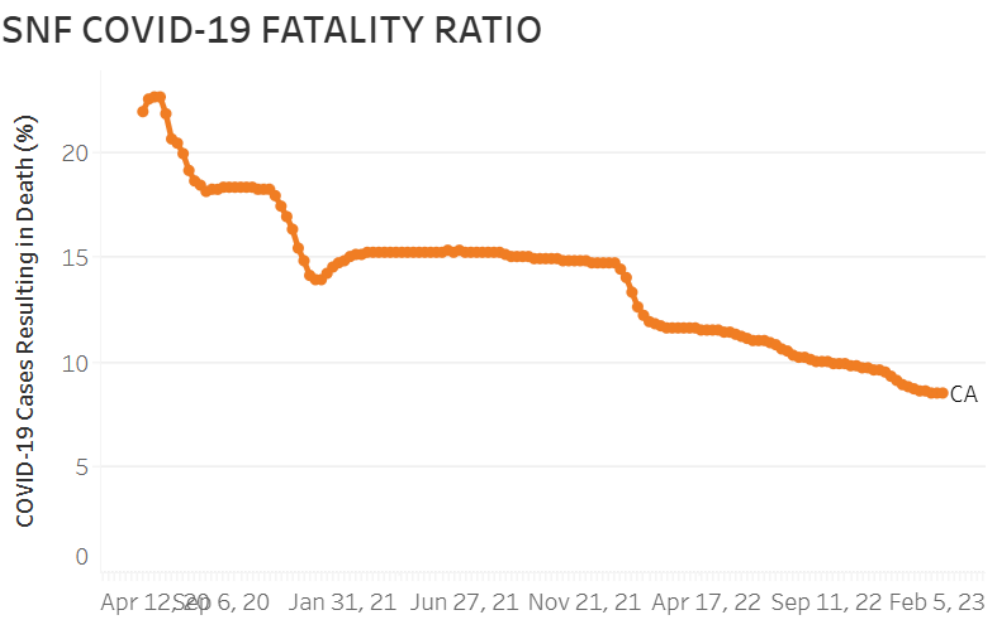
d. The US nursing home COVID data published by CMS. Reducing the death rate of the elderly in nursing homes was the #1 goal of the vaccines. We plot the CFR over time below from the official US Nursing home data obtained from the CMS website. See analysis and further analysis which show the CFR went up after half the elderly were fully vaccinated as you can see from the chart below. But it was supposed to go down if the vaccines worked, not up.

   The graphs show the CFR went down only when Omicron rolled out, **exactly as expected**.

   How can the CFR increase on the same variant when nature acts to monotonically reduce the CFR over time for the same variant (because the most susceptible people succumb early).



e. The official COVID fatality ratio graph from the California Department of Public Health (CDPH) website for Skilled Nursing Facilities (SNF) shows below that the vaccines simply didn't move the needle on the CFR. **For a given variant, it would have naturally fallen if we had let nature take its course.** It was falling and then they rolled out the vaccines and it reversed course and then flatlined until Omicron arrived and then the vaccines suddenly started working INSTANTLY in 30 days with a big drop coinciding with Omicron. It was the weaker variants, not the vaccine. The drop starts Dec 26, 2021 (14.7%) and ends almost exactly 30 days later on Feb 6, 2022 (11.9%).



Vaccines don't suddenly start working a year after they are given and all go into effect at a certain calendar date regardless of vaccination date. The drop was Omicron. If we had an effective vaccine, we'd have seen a drop like the Omicron drop. We saw nothing like that. We saw a declining FR that bottomed out on December 27, 2020, which turns out to be the same time that the COVID vaccines were being rolled out to SNFs. Something turned the FR around and reversed it. The evidence points to the vaccine. What other intervention was introduced at the end of December 2020 that could have spiked the FR? I know of none.

Thanks to a Sacramento Supervisor, I was able to ask the CDPH why the CFR increased post vaccine. Their response: "It was a COVID surge."

But their explanation doesn't fit the facts: 1) surges don't raise the CFR and 2) the surge ended Jan 6, 2021. See this article for all the details.

Most importantly, **the CFR never dropped below pre-vaccine baseline until MORE THAN A YEAR LATER on Jan 16, 2022** due to Omicron being less fatal.

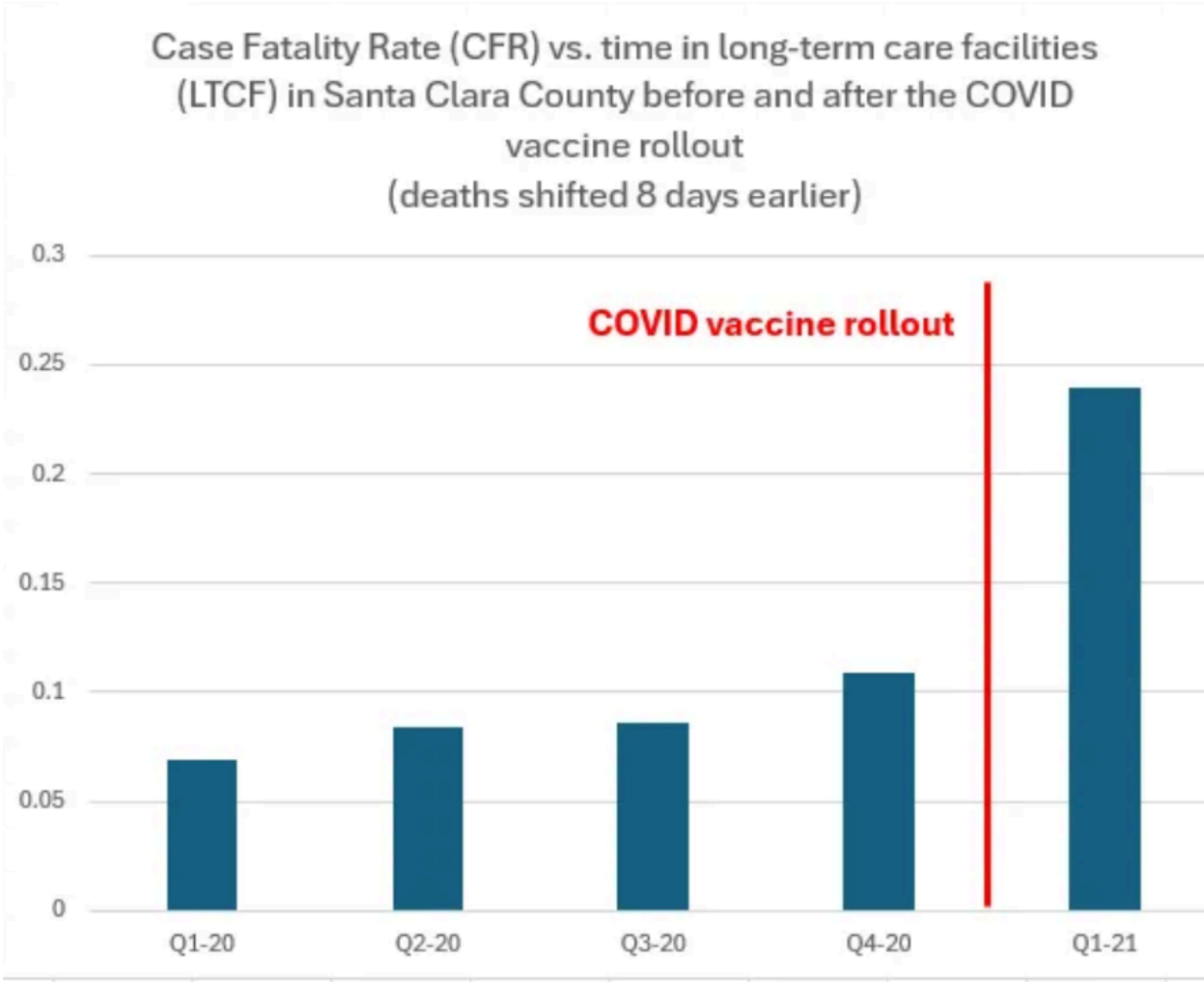
I like this data because this is raw data, with no statistical manipulation and no chance for misclassification errors or immortal time bias. It's the same group of people before and after the shots and the same variant.

The only way the virus can have a HIGHER CFR is through human intervention. And the CDPH was unable to come up with an explanation

that made any sense at all.

f. The COVID CFR in Long-Term Care Facilities (LTCF) in highly vaccinated Santa Clara County. In the quarter after the vaccine was rolled out, the CFR **skyrocketed by 2.6X** from the CFR in the previous quarter. The effect was **highly statistically significant**: 95% CI was 2.1 to 3.1). See the analysis here. All from official data posted on the SCC website. When asked to explain this, they said "No comment."

There is silence at the Board of Supervisors meetings when I bring this up. **There is no interest in investigating.**



OR=2.6 (95% CI 2.1-3.1) for Q1-21 vs. Q4-20.

g. The COVID vaccines **didn't even reduce the risk of COVID hospitalization** as can be derived from a study in JAMA on VA hospitalization which revealed the vaccination status (for both flu and covid vaccines) for those hospitalized for either condition. Since these are both respiratory viruses and the vaccines are

specific to the virus, I thought it would be revealing to use the opposite group's vaccination breakdown as a control. If the COVID vaccines worked, there should be a dramatic reduction in the percentage of people who are COVID vaccinated who were hospitalized for COVID compared to the % COVID vaccines among those hostpitalized for the flu. The analysis makes the very reasonable assumption that the COVID vaccine should do a better job protecting people from being hospitalized from COVID than from the flu among a group of people with homogeneous demographics (the VA members). When you do a Fisher Exact test on the data from the study, both the raw and propensity adjusted data showed no effect from either vaccine on hospitalization rate using the other cohort as the control. When I asked the author to explain why there was no statistically significant benefit, he stopped talking to me.

Here's the propensity matched data and **the reduction in the risk of hospitalization. It was not statistically significant for any vaccine in any dose**, despite large numbers in the study. **The flu vaccine acted as a negative control in our calculations since we know that doesn't work at all; the OR was .98 and the CI's were wide, exactly as expected which validates our methodology.**

	CONTROL (count for the opposite infection)			EXPERIMENT (count for this inf	sum			95% CI	
Intervention	**# not vaxxed with that do**	**# vaxxed with that dose**	**sum**	**# not vaxxed with tl**	**# vaxxed with that dose**		**OR**	Low	High
flu vaccine	3253	5743	8996	879	1524	2403	0.98	0.894746	1.078725
COVID shot #1	2291	112	2403	8612	384	8996	0.91	0.732631	1.12655
COVID shot #2	1873	530	2403	7155	1841	8996	0.91	0.814807	1.013666
COVID booster	1071	1332	2403	4090	4906	8996	0.96	0.881196	1.056074

h. This OSU paper (Adhikari, 2024) was published in *Frontiers* and found the vaccinated had lower non-COVID mortality (due the selection bias) but **higher COVID mortality** (n=152 total patients):

Results: While mortality rates were 36% (n=25) and 27% (n=15) for non-COVID-19 NVax and Vax patients, respectively, in COVID-19 patients mortality rates were 37% (NVax, n=89) and 70% (Vax, n=23). Among COVID-19 patients, mortality rate was significantly higher among Vax vs. NVax patients (p=0.002).

In plain English, people who were hospitalized for Acute Respiratory Failure (ARF) conditions ***excluding*** COVID were 54% more likely to die (OR 1.54) if they were unvaccinated relative to the vaccinated. That makes total sense due to selection bias. **But those hospitalized for COVID-19 were MUCH more likely to die if they were vaccinated (OR=3.9, 95% CI: 1.3-12.2)**. In short, the unvaccinated are generally less healthy, but when it comes to COVID 19, if you got the shots and were hospitalized **for COVID**, then you were much more likely to die. **In short,**

the vaccine did exactly the opposite of what was promised: it made you *more* likely to die from COVID.

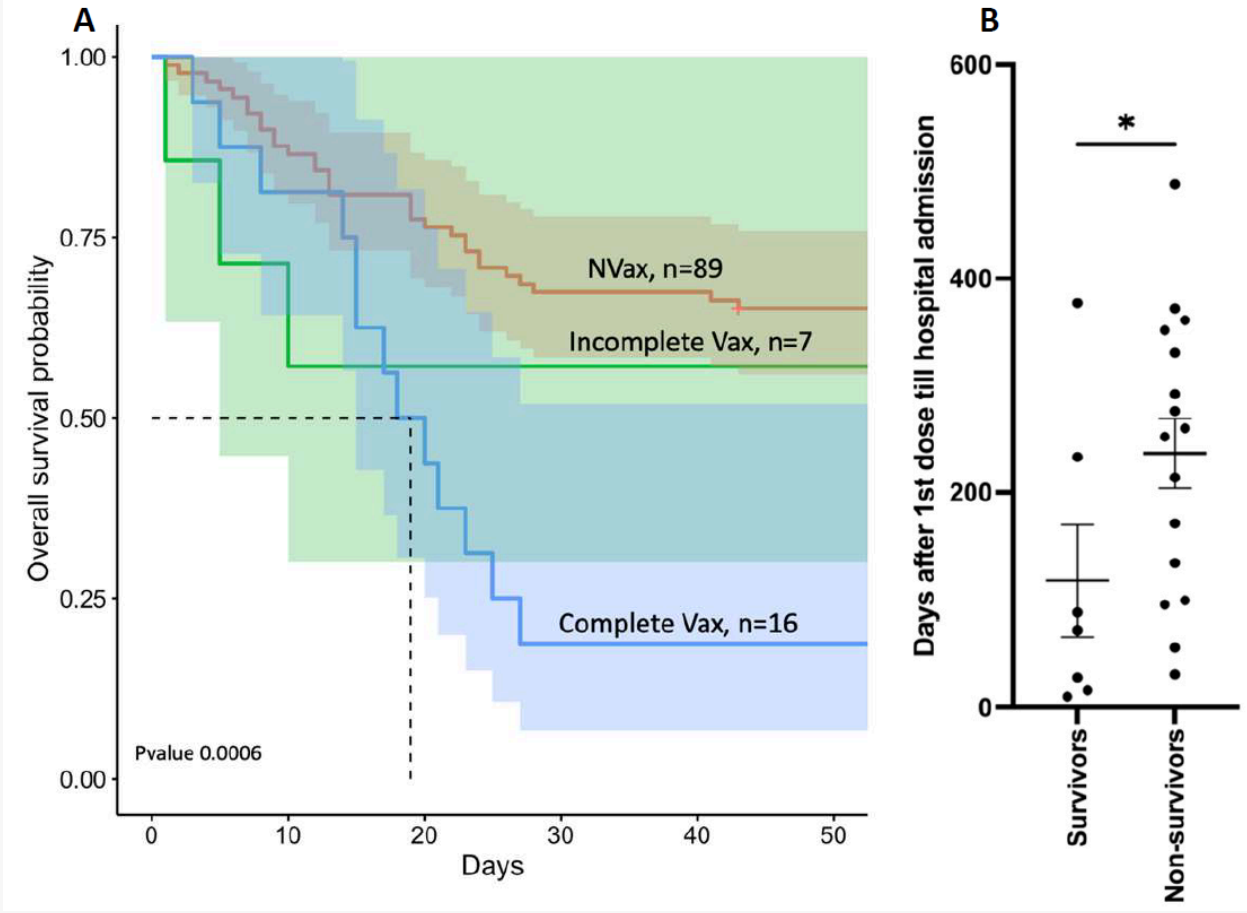
The paper even showed the effect could NOT be explained by higher comorbidities because the effect was STILL there AFTER adjusting for comorbidities.

Here is the OR calculation based on the numbers in the study:

```
Frontiers Adhikari paper; Odds of dying from COVID if you were
vaccinated
Fisher values = 56 7 33 16 89 23 112
One-sided p-value 0.005
Max likelihood estimate of the Odds ratio= 3.83
95% ConfidenceInterval(low=1.3, high=12.2)
```

There is more in the supplementary material **Figure 1** Overall survival probability of the Vax (incomplete and complete vax series) and NVax SARS-CoV-2-infected patients (A) and average time post-first vaccine dose to hospitalization among Vax survivors and non-survivors

(B).



You are more likely to die if you got the full vax series! This is confirmation of the effect because it shows that **the more vaccinated you were, the more likely you were to die of COVID**.

There is nothing like dose dependency to prove causality. T

And then there's one more thing most people would miss. All those dots on the right graph. Look at that black bar. That's the mean days after the shot for the survivors vs. the people who died.

What it means is that the longer the vaccine has had to do its dirty work on you, the more likely you were to die. A safe vaccine would have had the same mean, not a radically different mean.

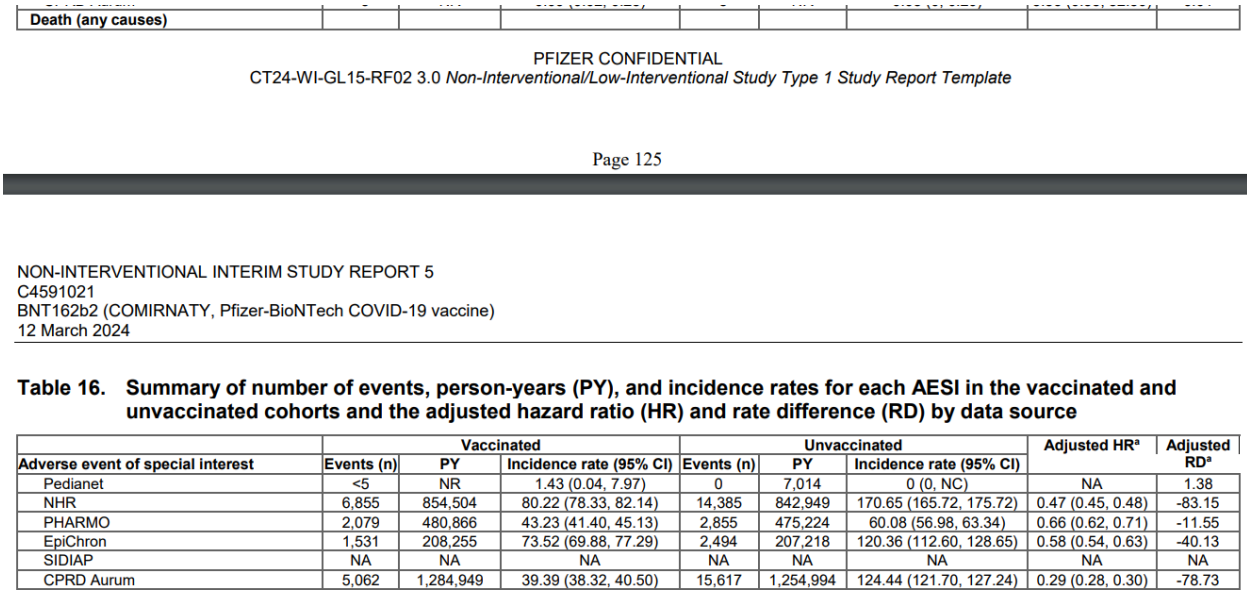
So in this paper, we have triple confirmation the vaccine made things worse:

1. Vaccinated died at higher rate from COVID than unvaccinated

2. The effect was there even after adjusting for comorbidities
3. The more vaccinated you were, the less likely you were to survive
4. The longer the vaccine has been in you, the more likely you were to die

The authors told me that nobody has found an error in this paper or the methodology.

i. Pfizer's own post-marketing safety study shows that **overall people who opt for vaccines are 2X to 3X LESS likely to die of all-causes**. This is well known and seen in other countries. It is because the vaccinated have higher socioeconomic status and take better care of their health (have access to better medical care). Here it is from Table 16 (the page break was a little unfortunate). Click the image to see the full table in the FOIA document:



Death (any causes)								

PFIZER CONFIDENTIAL
CT24-WI-GL15-RF02 3.0 *Non-Interventional/Low-Interventional Study Type 1 Study Report Template*

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NON-INTERVENTIONAL INTERIM STUDY REPORT 5
C4591021
BNT162b2 (COMIRNATY, Pfizer-BioNTech COVID-19 vaccine)
12 March 2024

Table 16. Summary of number of events, person-years (PY), and incidence rates for each AESI in the vaccinated and unvaccinated cohorts and the adjusted hazard ratio (HR) and rate difference (RD) by data source

	Vaccinated			Unvaccinated			Adjusted HR[a]	Adjusted RD[a]
Adverse event of special interest	**Events (n)**	**PY**	**Incidence rate (95% CI)**	**Events (n)**	**PY**	**Incidence rate (95% CI)**		
Pedianet	<5	NR	1.43 (0.04, 7.97)	0	7,014	0 (0, NC)	NA	1.38
NHR	6,855	854,504	80.22 (78.33, 82.14)	14,385	842,949	170.65 (165.72, 175.72)	0.47 (0.45, 0.48)	-83.15
PHARMO	2,079	480,866	43.23 (41.40, 45.13)	2,855	475,224	60.08 (56.98, 63.34)	0.66 (0.62, 0.71)	-11.55
EpiChron	1,531	208,255	73.52 (69.88, 77.29)	2,494	207,218	120.36 (112.60, 128.65)	0.58 (0.54, 0.63)	-40.13
SIDIAP	NA	NA	NA	NA	NA	NA	NA	NA
CPRD Aurum	5,062	1,284,949	39.39 (38.32, 40.50)	15,617	1,254,994	124.44 (121.70, 127.24)	0.29 (0.28, 0.30)	-78.73

j. The Pfizer paper says the vaxxed die 2X less, the Czech data confirmed it, and here's another paper, a study done on the Vaccine Safety Datalink (VSD) data showing that YOUNG COVID vaccinated people die at a rate 78% lower than their unvaccinated peers. The stunning part: That's non-COVID ACM!!! Come on. If the paper were true, they'd be marketing the vaccine as a fountain of youth. **It's all cohort selection bias as well as miscategorization bias.** Former FDA Commissioner Janet Woodcock first brought this paper to my attention, and she knew it was phony too. But this is how studies get a huge mortality benefit from the vaccine. It's not from the vaccine at all. The vaccine can't reduce non-COVID ACM. No possible mechanism of action for that exists. If it were true, there would be TONS of papers about this remarkable fringe benefit!

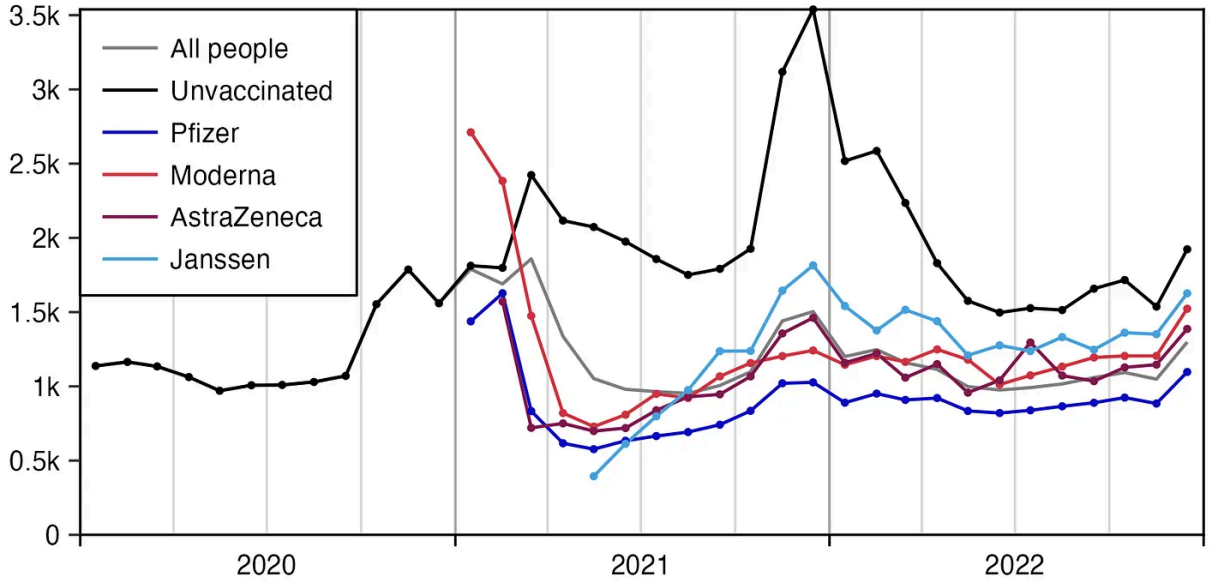
k. So we now have a complete explanation. People thought the vaccinated died less because of the vaccine, but this was a mirage. It was all selection and miscategorization bias. The Adhikari (2024) paper showed this effect as well for

non-COVID hospitalizations where the COVID vaccinated patients died less for NON-COVID deaths, but died more for COVID deaths.

The Czech Republic data (record-level data obtained under FOIA) showed this as well because the mortality rate for those opting for the vaccine INSTANTLY dropped in half as soon as the groups split. For details, see A summary of why the Czech Republic data is so devastating to the "safe and effective" narrative. Note that this Henjin-produced graph is seriously flawed as explained in great detail here, but it illustrates the bias problem.

Czech record-level data: ASMR by month and type of first vaccine dose

People are kept included under the first dose after subsequent doses. The standard population is the estimated resident population in the 2021 census by 5-year age groups.



3. Non-COVID ACM:

a. The Pfizer Phase 3 trial had more deaths in the treatment group than the placebo group. The researchers determined it wasn't the drug that caused any of the deaths, but this was based on speculation because **they never did any of the required tests (**documented in Schwab 2022**) to rule out the drug causing ANY the deaths.** They also didn't disclose the cardiac deaths in the treatment group that they knew about at EUA time.

It is also notable that when a female subject died from cardiac arrest in her sleep 72 days post-vaccine, there **wasn't even an autopsy** to determine if it was drug related. Pfizer simply concluded there "was no reasonable possibility" that the death was study drug related. This is simply willful blindness especially in light of the findings of Schwab 2022.

b. **We know for a fact that they expunged adverse events in the trials.** For example, Maddie DeGaray who was in the Pfizer kids trial, is a paraplegic for life due to the Pfizer vaccine. But her injuries, which should have kept the drug from the market, were illegally expunged from the trial results so that the drug would move forward. Augusto Roux is another well-documented case of misclassified serious adverse events.

c. COVID-19 'vaccines' now have **375,340% more associated death reports than the disastrous Cutter Polio Vaccine Incident of 1955, which led to immediate market withdrawal after only 10 deaths**.

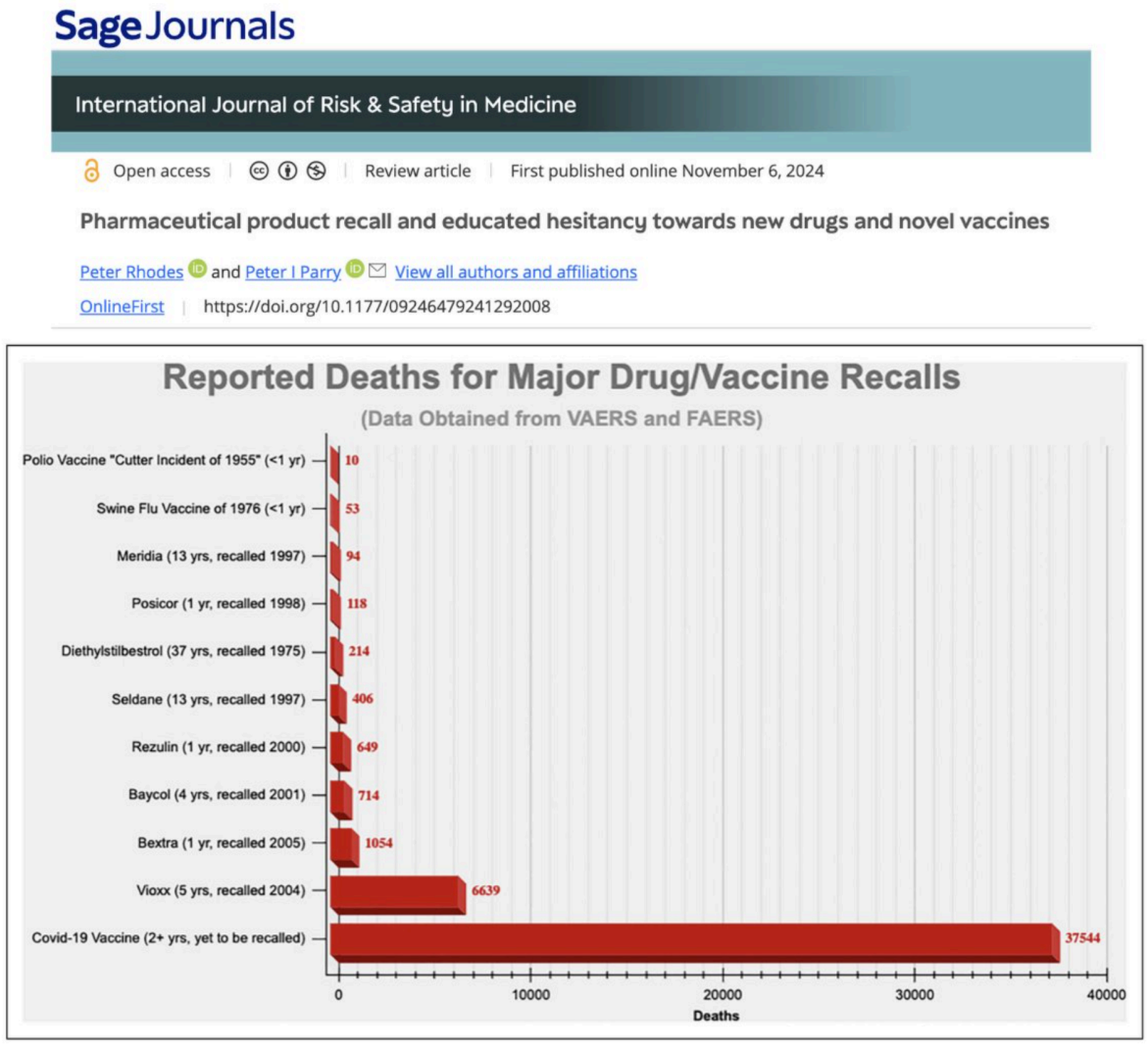


Figure 4. Reported suspected deaths for major drug/vaccine recalls versus COVID-19 vaccine reported suspected deaths. From VAERS Analysis[43] (with permission).

d. The v-Safe data showed that 8% of people had to seek professional medical help after getting their shots (783K out of 10.1M reporting). **8% seeking medical attention after a vaccine is a train wreck.** This should be a red flag that the vaccines are not safe. If just 1% of these medical cases resulted in a death, that

is a .08% death rate which is comparable to the minimum of 1 death per 1,000 vaccinated estimated in this document. Note: people signed up for v-safe at the time they got their shot; they were given a pamphlet to sign up for v-safe along with their vaccination card.

e. In Germany, even the regulator who promoted the vaccines admitted that 1 in 5,000 suffer from serious side effects. So that's a start, but the injury numbers are far higher than 1 in 5,000. This is just a perfect example of how officials are underreporting the true rate of harm, but at least acknowledging it.

f. Even the "gold standard" clinical trials (which I claim were rigged but that's a separate debate) showed an overall 16% higher risk of serious adverse events vs. placebo (Fraiman, 2022).

g. Look at the FRED US disability numbers after the shots rolled out. We very quickly added **5M people** to the disability rolls (from 30M to 35M). If you go to the site, you can see dates and counts by mousing over the graph. The FRED data suggests a **2% rate of serious injury**, not 1 in 5,000.

The US data was replicated in the UK where the PIP (UK disability equivalent) **where onflow (people applying to the system) more than DOUBLED from pre-vax levels** (See Chart F).

h. The actual injury numbers are of course **MUCH higher than the German regulator admits** because we know from the myocarditis study conducted in Thailand that found a 3.5% rate of myo/pericarditis in teenagers, but **Swiss researchers found a 2.8% rate of myo/pericarditis over a much larger study**

population (777 people). See my article for links to the research.

Tracy Høeg, MD, PhD
@TracyBethHoeg

Stunning prospective study from Thailand
Of 301 13-18 year olds following dose 2 pfizer

18% had abnormal EKG post vax

3.5% (7/202) males & 0 females developed myoperi/peri or subclinical myocarditis, 2 were hospitalized w/1 being observed in the ICU
preprints.org/manuscript/202...

Table 3. Characteristic of patients with elevated level of biomarkers or positive lab assessments.

Demographic						Clinical presentation								Echocardiography				
						CK-MB level (ng/mL)				Troponin-T (pg/mL)				LVEF%				
No.	Age (y)	Sex	Classification	Peak CRP (mg/L)	Peak ESR (mm/hr)	1	2	3	4	1	2	3	4	1	2	3	4	Pericardial effusion
1	16	Male	Myopericarditis	86.6	19	1.25	109.6	2.36	1.67	3.18	593	37.2	10.9	75.3	73.7	77.2	84.7	Yes
2	15	Male	Pericarditis	1.3	7	1.11	1.34	1.52	1.46	2.58	3.77	6.04	3.93	61.5	60.2	74.1	70.7	Yes
3	17	Male	Pericarditis	10.5	8	1.99	1.87	1.72	2.71	4.54	8.03	7.87	6.75	78.9	77.5	61.0	67.2	Yes
4	13	Male	Subclinical myocarditis	0.3	-	1.39	1.72	2.28	-	8.56	10.3	34.94	-	58.6	59.2	75.4	-	No
5	14	Male	Subclinical myocarditis	0.5	-	3.00	2.06	3.06	-	3.73	28.6	38.68	-	79.6	60.1	76.2	-	No
6	13	Male	Subclinical myocarditis	0.9	-	3.90	3.67	5.10	-	5.35	14.87	16.81	-	64.3	76.2	78.9	-	No
7	17	Male	Subclinical myocarditis	4.3	-	2.25	2.32	2.41	-	3.12	13.06	15.44	-	70.8	52.4	53.8	-	No

CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; CK-MB, creatine kinase-myocardial band; LVEF, left ventricular ejection fraction.

9:23 AM · Aug 9, 2022 · Twitter Web App

2,083 Retweets **294** Quote Tweets **3,887** Likes

i. The CDC acknowledged 770 safety signals were triggered in VAERS. A safe vaccine would have triggered none. These are 770 different adverse event types. **This is unprecedented for any vaccine**.
j. The US has an official “vaccine monitoring safety system” called VAERS. It’s self-reported. It should be a system where people are enrolled and we have a

numerator and denominator. From Scott McLachlan's work, we know around 70% of VAERS reports are completed by a medical professional. We also know from several studies that the under-reporting factor is around 40, i.e., only around 2.5% of people report. There were **17,972 deaths in the first 2 years**. We know from VAERS that, if all other vaccines are safe, we'd see fewer than 500 death reports a year. So that leaves us with approximately 17,000 "excess" deaths that were unexpected. Multiply that by 40 and you get **680,000 excess deaths over the first two years** of the vax rollout.

But for death after COVID vaccine, 40X is conservative because the 40X is derived from anaphylaxis rates and anaphylaxis MUST be reported by the law. It's both **OBVIOUS and REQUIRED**. And it's 40X underreported.

By contrast death post COVID vaccine is largely unreported if the death happens more than a few days from the shot. The reason is the lack of temporal proximity and the wide variety of causes of death makes people less likely to believe the vaccine caused the death and thus less motivated to make the report.

This is why VAERS is a poor system compared to proactively tracking on-going trial participants which the medical community is not interested in doing.

National Vaccine Information Center
Your Health. Your Family. Your Choice.

MedAlerts.org

Search Results

From the 11/29/2024 release of VAERS data:

Found 17,972 cases where Location is U.S., Territories, or Unknown and Vaccine targets COVID-19 (COVID19 or COVID19-2) and Patient Died and Date of Death on/before '2022-12-31'

Government Disclaimer on use of this data

Table

Age	Count	Percent
< 6 Months	1	0.01%
6-11 Months	1	0.01%
1-2 Years	7	0.04%
3-5 Years	2	0.01%
6-17 Years	68	0.38%
18-29 Years	202	1.12%
30-39 Years	309	1.72%
40-49 Years	544	3.03%
50-59 Years	1,272	7.08%
60-64 Years	1,262	7.02%
65-79 Years	6,313	35.13%
80+ Years	6,207	34.54%
Unknown	1,784	9.93%
TOTAL	17,972	100%

k. Skidmore (2023) used a survey methodology to estimate that **289,789 (95% CI: 229,319 – 344,319) were killed by the shots in 2021 alone**. Skidmore (2023b) has been **consistently ranked the number one article for attention received throughout the history of the journal BMC Infectious Diseases.** The journal was encouraged to retract the article (unethically since no COPE guideline was violated). Here's the story behind the article. There was no methodological flaw in what Skidmore did. In his revised version, now published in another peer-reviewed journal, he even addressed all the minor critiques that surfaced, but it didn't change the result. Where's the methodological flaw? He simply said "these are the estimated death tolls based on the survey data." His methods have now passed multiple rounds of peer-review.

l. The Skidmore estimates for 2021 are in line with our 2-years VAERS estimate above and in line with the vDFR estimated by Denis Rancourt from large scale data (vDFR=.00127 which is 1 death per 787 doses). For 600M doses given in the first two years (in the USA), this equates to 762,000 deaths. The numbers we estimated from VAERS vs. Rancourt (which didn't use VAERS) agree within 20% which is astonishing and is difficult to explain.

m. I did an investigation of what fraction of the VAERS reports since inception of VAERS 34 years ago for a variety of serious conditions were due to the the COVID vaccines. The numbers were staggering. **You can only get results like this if the COVID vaccine CAUSES these conditions**. As you can see, the COVID vaccine is causing an enormous variety of extremely serious to deadly medical conditions.

Adverse Event	**% of all VAERS reports in history of VAERS due to COVID vaccine**
Guillain-Barre	42%
Bell's palsy	98%
Appendicitis	100%
Pulmonary embolism	100%
Aortic aneurysm	100%
Atrial fibrillation	100%
Deep vein thrombosis	100%
Infertility	95%
TTS	100%
Ischaemic stroke	100%
Dementia	96%
Tinnitus	96%
Shingles	38%
Cardiac arrest	83%
Creutzfeldt-Jakob disease (CJD)	100%
Heart attacks	96%

Myocarditis cases	98%
Bleeding in the brain	85%
Glioblastoma Multiforme (GBM)	96%

Also, I asked on X if anyone could explain just one of these VAERS datapoints (ischaemic stroke)**. Nobody could explain it.**

The diverse range of pathology caused by these vaccines, combined by the constant pontificating of "safe and effective" from health authorities has led people to dismiss the association.

Doctors are reluctant to admit it was the vaccine because they are trained to look for a single symptom, not 770 elevated conditions. They are also trained to believe "experts" and "studies in the literature" which tell them these are just coincidences. So they pin the vaccine deaths on COVID side effects or bad luck. They never make the connection.

Doctors rarely do an autopsy with the proper tests to determine whether the vaccine caused the death. Vaccine deaths are easy to miss unless the autopsy is very carefully done, which is pretty much never the case (the only exception being the 5 patients in Schwab 2022). During the entire pandemic, I've only seen one paper that was published in the peer-reviewed literature that actually tested the bodies to determine whether the COVID vaccines were involved in the death. The study was led by Peter Schirmacher, one of the top pathologists in the world.

They started with 35 bodies who died within 20 days of a COVID shot, and focused **only** on 5 where no other cause of death could be ascribed. Extensive testing revealed that all 5 had similar findings consistent with a vaccine injury and inconsistent with any other known cause of death.

This suggests that at least 5/35 or **14% of people who die within 20 days of vaccination were likely killed by the vaccine**. Note that is a lower bound because they didn't investigate more than the 5 cases.

In short, in their study, they found that **100% of the unexplained deaths within 20 days of vaccination were attributed to the COVID vaccine**.

This is comparable to the McCullough study which looked autopsies of deaths happening shortly after vaccination and estimated that 74% were caused by the vaccine.

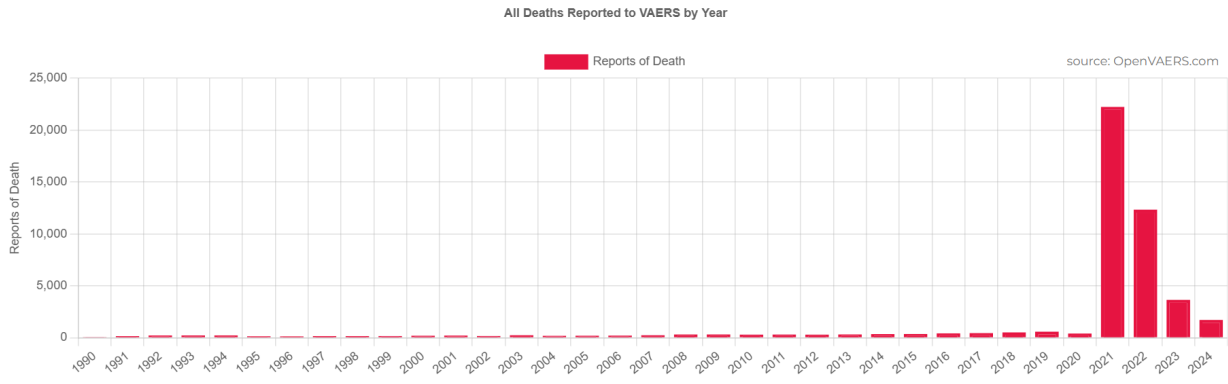
NOTE: The percentage of UNEXPLAINED deaths shortly after COVID

vaccination is a different number than the percentage of all deaths caused by the vaccine that happen within a short window after the vaccine. The former number is likely 75% or more, while the total number of deaths happening within a short time window relative to the total number of deaths caused by the vaccines is probably around 20%. The latter number is important in the context of estimating deaths from VAERS (where deaths proximate to the shot are more likely to be reported).

n. The VAERS plot of deaths over time in openVAERS (below) is staggering and unprecedented. The CDC claims this is simply over-reporting. They want us to believe that everyone found out about VAERS in 2021, instantly all at once, without any sort of ad campaign about VAERS. To show that is untrue, we computed the URF from the COVID data, and it matches URFs computed in the past for other vaccines in VAERS. So the increase was due to more events.

   I validated that with a local neurologist who said she's never had to make a VAERS report in her 15 year history as a neurologist, but after the COVID shots, she's had an estimated 2,000 reportable cases (she has 25,000 patients in her multi-physician practice) and gave up after reporting the first 2 because each report took too long to create (and kept logging her out due to timeouts). She likes being a doctor and realizes if she says anything publicly her license will be revoked.

   A safe vaccine cannot cause a **40X explosion in the number of reported VAERS deaths** like the chart below. This is simply unprecedented in the 35 year history of VAERS. It is **a crystal clear signal of a very unsafe vaccine** that has killed hundreds of thousands of innocent Americans. The medical community cannot explain the 40x increase.



o. The New Zealand record-level data released by a whistleblower shows mortality rates of a given 5 year age group were 2 to 3X higher based on the vaccine batch they got. **That is a safety disaster**. You can also do a more detailed time-series cohort analysis showing mortality rates increased post-shot

regardless of what season the shots were given. Sadly, most people never use this technique and don't understand it.

p. The Czech Republic record-level data obtained under FOIA request from the Czech government showed that people who got the Moderna vaccine were **30% more likely to die within 1 year of the shot than people who got the Pfizer vaccine.** The 30% difference appeared in all age groups where there was sufficient data and it happened during NON-COVID time periods. People tried to attack this claiming that it was due to distribution bias, but we showed that was false. The reason this is such an important study is because you cannot compare vaccinated with unvaccinated death rates due to selection bias. But in the Czech Republic, the vaccines were randomly assigned and nobody had any clue which one was safer. So there was no systematic or systemic bias. So how can the death rates be 30% higher in every age group with sufficient data? **The only way that can happen is if the Moderna vaccine is more deadly.** And in that document we show 8 different data points that are consistent with Moderna having a higher adverse event rate. We believe the higher death rate in Moderna vs. Pfizer is primarily due to the **100mcg dose vs. 30 mcg dose**. The more poison, the more death. There have been very few brand comparison studies like this and what they do is adjust the numbers to make the death differences go away because their assumption going into it is that the vaccines should have equal mortality rates so they get rid of the differences statistically. This is raw data. You can't have a 30% higher death rate in nearly all 5 year age groups over 50. That's statistically unlikely to happen. And even if Pfizer was 100% safe, **a 30% increase in ACM (over the first year from the shot) is a disaster.**

q. The official UK ASMR 21 days from dose 1 vs. Dose 2. Shows it is dose dependent. **A "safe" vaccine cannot have a dose dependent ASMR.**

r. A Systematic Review Of Autopsy Findings In Deaths After COVID-19 Vaccination shows that of the people who died after a COVID shot where an autopsy was done (which most often happens when the cause of death is not known), the **COVID vaccine was implicated in 74%** of the deaths.

Where is the paper doing the same dataset and finding a different result?

It doesn't exist. People just don't want to touch this.

s. Italian reanalysis paper shows that when you correctly analyze the data and account for immortal time bias (ITB), **the vaccine goes from saving lives to killing people** with HRs of 2.40, 1.98, using the more accurate multivariate values. Sp the first two shots increased your risk of death. Subsequent shots didn't move the needle.

t. Allen (2024), an Australian study looking at correlation between vaccination and excess deaths, Table 3 summarizes the entire argument: more vaccines → more deaths. If the vaccine worked the coefficients should have been negative.

The *** means highly statistically significant. So excess deaths are related to

Booster doses, total # vaccinated, and "recently vaccinated (RECVAC)":

Table 3: Bivariate OLS regression Analyses and Cross-Validation Tests
Part A: Bivariate OLS regression Analyses

Regression	Coefficient	Adjusted R-Square	F-Statistic	F-Statistic Residuals regression
Excess Deaths = $C_1 + \beta_1$BoostD	0.000846***	0.71	18.18***	0.010520
Excess Deaths = $C_2 + \beta_2$TotVAC	0.0000499***	0.71	15.21***	0.000319
Excess Deaths = $C_3 + \beta_3$RECVAC	0.00183491***	0.69	16.71***	0.003507
Excess Deaths = $C_4 + \beta_4$UNVAC	0.00342938	0.13	2.08	3.107021

u. Denis Rancourt 125 countries study paper (521 pages) found an overall average vDFR=.00127 which is 1 death per 787 doses which is consistent with other estimates presented here.

4. Total ACM:

a. **Mechanism of action for increasing all-cause mortality:** The pseudouridine in the vaccines makes the spike protein, a known toxin, last for an extraordinarily long time, in some cases **years** in people, as recently disclosed in the Yale Listen study. This causes a huge range of health effects (explaining the 770 AEs triggered in the VAERS monitoring at the CDC). The immune system is suppressed, especially p53 (listen to Dr. Peter McCullough more fully explain the mechanisms), as well as higher levels of IgG4, allowing the development of "turbo cancers." The normal interferon production process is also degraded.

   It is well established that mRNA vaccines specifically induce numerous short- and long-term immune impairments including lymphopenia, leukocytopenia, thrombocytopenia, leukopenia, interferon signaling impairment, and many more (see some papers below). These effects are similar to those that SARS-CoV-2 itself causes.

   i. https://www.sciencedirect.com/science/article/pii/S1521661623005259
   ii. https://www.sciencedirect.com/science/article/pii/S027869152200206X
   iii. https://onlinelibrary.wiley.com/doi/10.1002/ajh.26478
   iv. https://www.nature.com/articles/s41421-021-00329-3

b. The mechanism of action for causing sudden death is explained in this video.

c. **The undeniable rise in turbo cancers causing people to die of cancer even though the vaccine is the underlying cause.** Highly respected oncologist Dr. **Angus Dalgleish** noticed the dramatic increases in cancer in his own patients after the COVID vaccine rollout and he's been very public about the COVID vaccines being the cause.

   He told me: "My confidence is very high from my own experience alone that the COVID vaccines are causing turbo cancers. I saw 6 people in one clinic. All had

turbo cancers wanting a second opinion. None of their GPs, surgeons, or oncologists had asked about their vaccine history. I did and they had all had covid boosters within 3-9 weeks of symptoms/diagnosis. My colleague surgeon James Royle has given a great video at the stone meeting in Ireland. He is being swamped by them as are my colleagues in Australia."

Professor Dalgleish has been doing this for more than 40 years. He went from seeing 2 cases in 40 years to as many as 6/day after the COVID shots rolled out which is a maximum rate increase of 43,800x. From a Poisson perspective, he expected to see 2/(40*365) events in a day and saw 6. The chance of that happening is 9.2e-27. What intervention could cause turbo cancer in so many people? The **only thing we know they all had in common is recent COVID vaccination**.

d. People who are vaccinated exhibit large and very unusual blood clots (white fibrous clots), never seen by embalmers before, that lead to death in many cases. One embalmer I talked to reported that at one point, 93% of the last 30 cases she embalmed died from these very unusual clots (that were never

observed prior to the COVID vaccine injections). This percentage was not sustained of course, but it shows you just how substantial the effect size was. Did she have anything to gain by revealing this? Absolutely not. After the video was made public, her business tanked. All she was doing was telling the truth about what she observed. What happened to her is why other embalmers are keeping quiet about what they observe, but embalmer surveys show 73% of embalmers are consistently seeing these novel clots since the COVID vaccine rollout. Even the scientific community has acknowledged that the COVID vaccines are causing blood clots. Blood clots in the wrong place (heart, lung, brain) can easily kill you leading to "sudden death" and "died unexpectedly."

e. Sun (2022) found a 25% increase in cardiovascular calls in those aged 16-39 during the vaccine rollout in Israel was significantly associated with the rates of 1st and 2nd vaccine doses administered to this age group but were not with COVID-19 infection rates.
f. Similarly, Hulscher (2024) looks at highly vaccinated King County. "We found a 25.7% increase in total cardiopulmonary arrests and a 25.4% increase in cardiopulmonary arrest **mortality** from 2020 to 2023. Applying our model from these data to the entire United States yielded 49,240 excess **fatal** cardiopulmonary arrests from 2021-2023" (due to the COVID vaccine). That's just **one cause** of vaccine death.
g. Aarstad (2023) found a **highly statistically significant POSITIVE association** between vax uptake in 2021 and **increased** mortality in 2022 **in the 31 EU countries where data was available.** In short, **more vaccines → more deaths**.

   They accounted for lag in deaths (COVID deaths occur days after COVID infection) and potential confounders.

   The study found that:

   i. A one percentage point increase in 2021 vaccination uptake was associated with a 0.105% monthly increase in 2022 all-cause mortality (95% CI: 0.075—0.134).
   ii. This association was statistically significant and remained robust even after controlling for alternative explanations, such as prior mortality trends (2020—2021 average relative to pre-pandemic years), life expectancy, and potential multicollinearity issues

   That's a huge negative impact. What was the error and what are the correct numbers? Where is the study, using exactly the same data, showing the correlation is negative?

h. Right after corporate America started requiring COVID vaccinations, the CEO of the OneAmerica insurance company publicly disclosed that during the **third and fourth quarters of 2021**, death in people of working age (18–64) was 40 percent higher than it was before the pandemic. **Significantly, the majority of the deaths were**

not attributed to COVID. A 40 percent increase in deaths is literally earth-shaking. Even a 10 percent increase in excess deaths would have been a 1-in-200-year event. These are **raw, unadjusted numbers**. No trickery. Same client base tracked over time. It wasn't COVID. So if it wasn't the vaccine, what could have caused such a HUGE increase?

The article said:

> We are seeing, right now, **the highest death rates we have seen in the history of this business** – not just at OneAmerica," the company's CEO Scott Davison said during an online news conference this week. "The data is consistent **across every player in that business**."
>
> OneAmerica is a $100 billion insurance company that has had its headquarters in Indianapolis since 1877. The company has approximately 2,400 employees and sells life insurance, including group life insurance to employers nationwide.

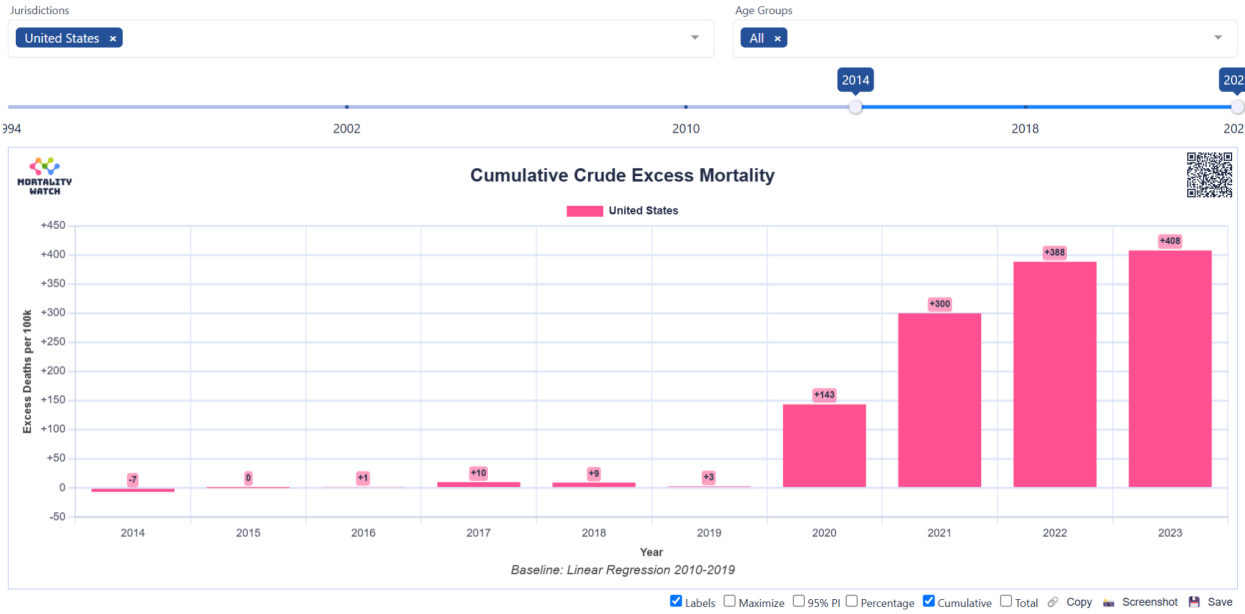
i. The OneAmerica CEO said the sudden huge rise was across every player in the business. This is confirmed in the official Society of Actuaries (SOA) 2022 report. As before, there is no statistical trickery here since none is needed; it's the same group of people before vs. after the vaccine requirement. No regression. No tricks. **It is ONLY affecting working age people.**

Table 5.7
EXCESS MORTALITY BY DETAILED AGE BAND

Age	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	4/20-3/22	% COVID	% Non-COVID	% Count
0-24	116%	124%	104%	101%	119%	127%	110%	91%	111%	3.3%	8.1%	2%
25-34	127%	132%	121%	118%	131%	178%	131%	125%	133%	13.3%	19.6%	2%
35-44	123%	134%	128%	129%	133%	200%	156%	136%	142%	23.1%	19.2%	4%
45-54	123%	127%	129%	133%	119%	180%	151%	143%	138%	27.4%	10.8%	9%
55-64	117%	123%	130%	130%	114%	153%	141%	137%	131%	24.0%	6.7%	18%
65-74	117%	115%	133%	130%	108%	131%	125%	122%	122%	18.6%	3.9%	17%
75-84	114%	114%	133%	123%	106%	119%	121%	121%	119%	14.0%	4.6%	20%
85+	112%	103%	124%	111%	92%	104%	105%	103%	107%	10.3%	-3.5%	27%
All[11]	**116%**	**115%**	**129%**	**123%**	**107%**	**134%**	**126%**	**122%**	**121%**	**17.1%**	**4.3%**	**100%**

The only thing we know of that can **selectively affect working age people** at a time when corporate America was requiring vaccination (per Biden Q3 mandate) is the COVID vaccine. Period.

j. The US cumulative excess mortality is consistent with Aarstad (2023) showing the same effect is happening in the US. With the mass introduction of vaccines in the US in 2021, we should have expected the Cumulative crude excess mortality to have reversed course, but it just kept getting worse and worse. This is a stunning chart because after such a huge mortality increase in 2020, we've "pulled forward" the deaths of the weakest so excess death rates should turn into deficit death rates and the cumulative excess mortality bars should have gone down in 2021, down further in 2022, etc. Instead, things went the wrong direction. If the vaccine was drastically reducing deaths, then how do we explain this? There is a mysterious force driving up excess deaths and it's MUCH stronger than the vaccine. What is it?



k. John Beaudoin has studied the death records in several states and has proof of massive amounts of fraud in the official death records due to misclassification (vaccine deaths are misclassified as COVID deaths). This video is a summary of his work. How big is the problem? He doesn't know. What he does know is you cannot trust the official data. **This is why, if you want to know the truth, you should not rely on the official data.**

l. The still confidential Pfizer study showed their COVID vaccines increase your risk of serious adverse events (up to 71% higher, depending on the condition).

m. The New Hampshire legislature had a bipartisan committee evaluate the COVID response. The Democrats showed up and rarely asked questions. Their conclusion was **NONE of the mitigation strategies including vaccines** made a BENEFICIAL difference. **After hearing months of testimony from expert witnesses, they found the vaccines had NO BENEFIT whatsoever, but they did increase serious adverse events (including death).**

Page 8: "It is nonetheless the case that the cumulative effects of the measures

taken by the state to slow the spread of the SARS-COV-2 virus were ineffectual. Little evidence has been presented to this committee credibly indicating that there would have been **any increase in morbidity and mortality**, or any strain of the New Hampshire healthcare system beyond capacity, **in the *absence* of these measures cumulatively**.

Page 9: "Multiple expert testimonies were received regarding both **ineffectiveness and the prevalence of serious adverse reactions** associated with vaccination."

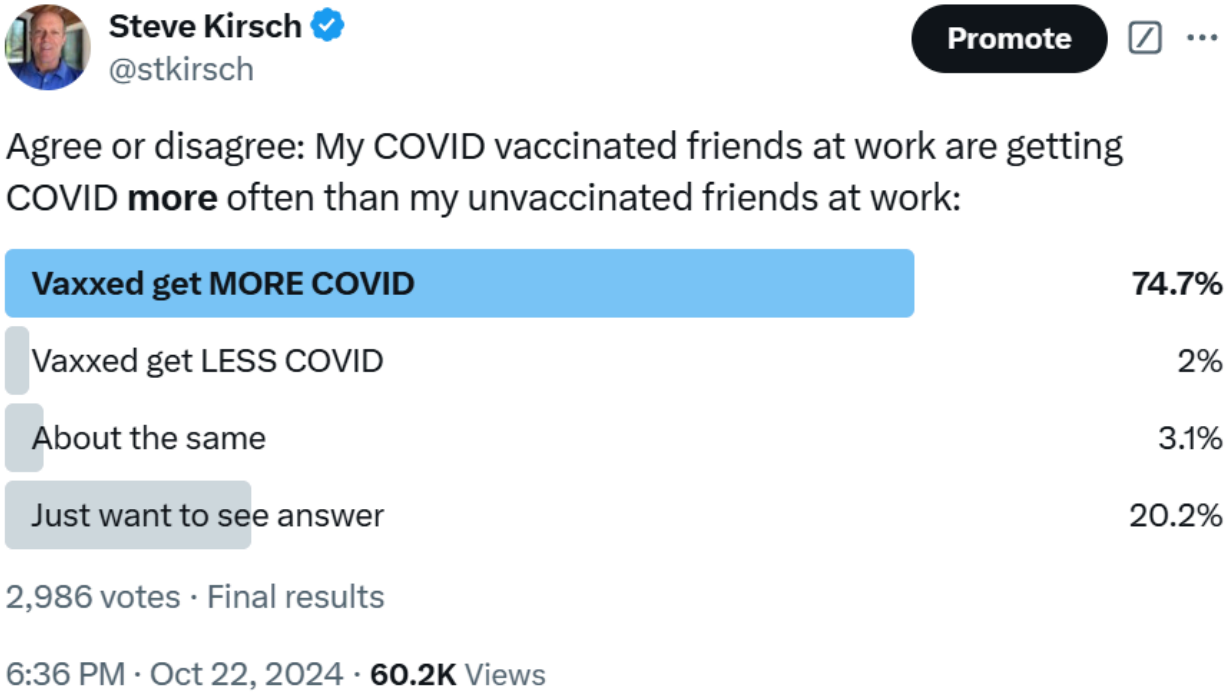
5. The data from a wide variety of real-world evidence sources is consistent with the answers above

a. These mainstream headlines are inconsistent with claims that the COVID vaccines have saved close to 20M lives:
   i. UK: the BBC headline, "Excess deaths in 2022 among **worst in 50 years**"
   ii. In 2023, the mainstream news in 98.5% vaccinated Australia reported that "A troubling new study released this week has shown Australia is experiencing its **highest excess mortality rates in over 80 years**."
b. Neil and Fenton (2022) showed that the **ONLY viable explanation** for these mortality increases was the COVID vaccine. **No one has been able to show a mistake in their analysis.**
c. Brave funeral directors have spoken out on recorded videos about how mortality has gone up dramatically after the jabs rolled out. Here (young healthy people just dropping dead, turbo cancers, "never seen so many blood clots", 2 foot clot, went from 1 baby funeral a month to 4/wk, unprecedented number of miscarriages and deformities) and here (business up 50%, many young people dying and of weird causes like dying in their sleep). They tell consistent stories.
d. In 2024, the Southwest District Health Board in Idaho voted to halt the administration of the COVID-19 vaccine in its clinics, making it the first health district in the U.S. to do so.
e. The local government of West Australian mining town Port Hedland passed a motion to demand immediate suspension of the modRNA shots due to the DNA contamination. Other councils have joined the movement.
f. An excess deaths inquiry was held to investigate Australia's excess of nearly 30,000 deaths throughout 2021-2023. The Senate Committee suppressed the majority of submissions. This raises the question: why would the government need to censor public input?
g. Former FDNY fireman O'Brian Pastrana (was injured for life by the COVID vaccine and can no longer work) testified on video that he **personally observed a 10X increase in death rate right after the vaccines rolled out**. His

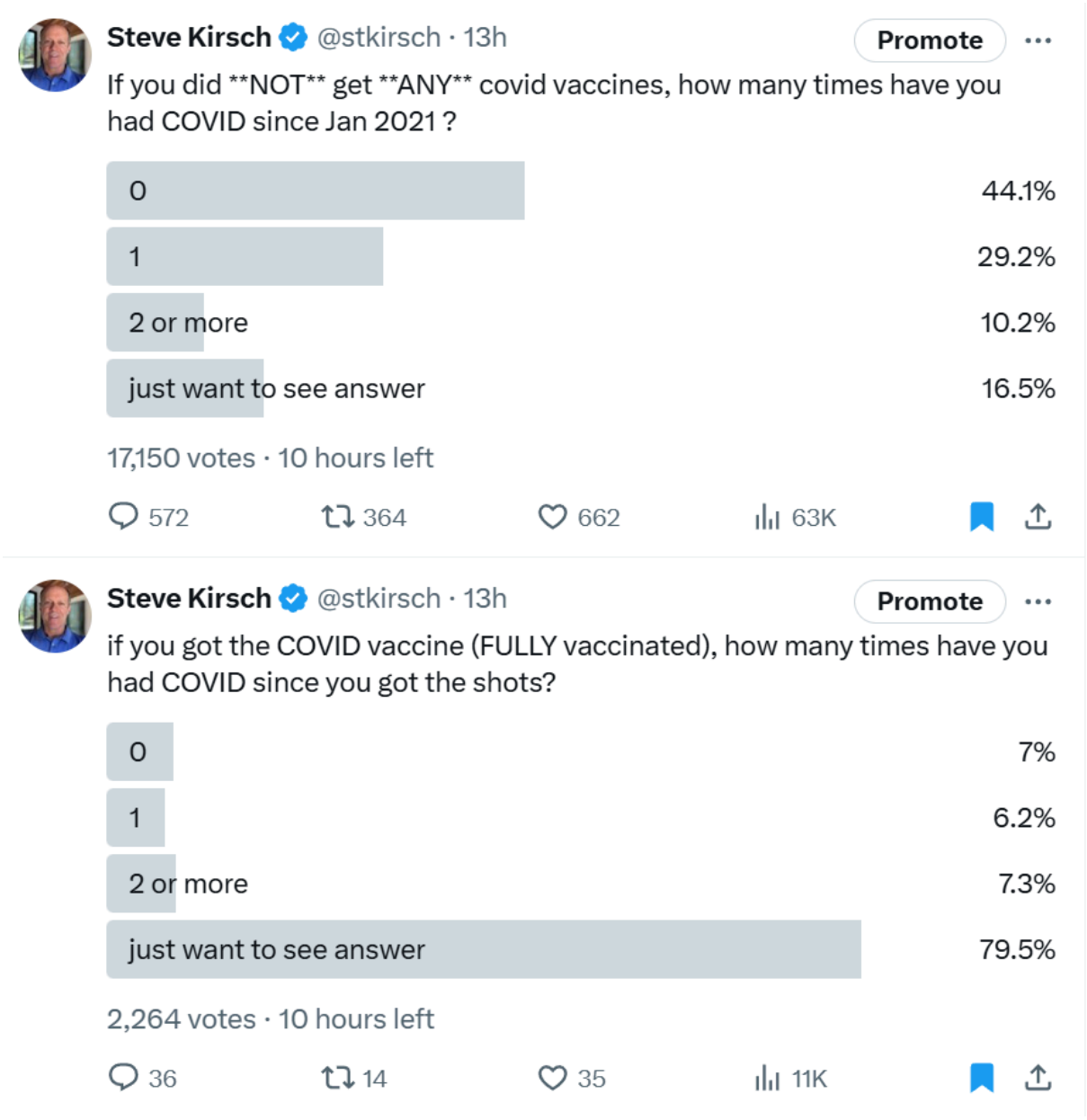
colleagues won't talk about it for fear of losing their job. He said they saw 1 to 2 deaths a week before the shots rolled out, and it shot up to 3 to 4 a day which is **an astonishing 10X increase in death rate after the COVID vaccine rollout.** This is an extreme case, but such extreme anecdotes should be statistically impossible to find if the vaccines are safe. 6.4e-14 of seeing 20 events when you're expecting 2. Which means something was causing a lot of excess deaths right after the vaccines rolled out.

h. 6 members of FDNY died within **3 months RIGHT after the COVID vaccine rollout** (Dec, Jan, Feb 2021). There were 0 deaths from COVID in active duty FDNY ever. This is unprecedented. The chance of this happening just by bad luck is 1.4e-05. Normally, they might see 1 and at most 2 deaths in a year for active duty FDNY. If you run the numbers, the chance of 6 dying in 3 months happening is between 1.4e-5 and 2.7e-7. In short, it was highly likely that a novel agent killed a whole lot of really healthy young people right after the shot rollout and if it wasn't the vaccine, what was it? It wasn't COVID and it wasn't bad luck. **THERE WERE NO COVID DEATHS.** This story is verifiable and is statistically impossible if the vaccines saved lives or were even neutral. There are nearly 11,000 active-duty FDNY. But only an estimated 45% got the shots initially. So even if we assume 1 of the 6 deaths was not from the shot, we have 5 excess deaths out of 5,000 vaccinated, so **an estimated kill rate of at least 1 per 1,000 fully vaccinated** in the healthiest people.

i. My survey on X of nearly 3,000 people strongly confirms that vaccines made people more likely to be infected. The odds were 37:1 that an observer would believe that the vaccinated were more likely to get COVID. If my poll is biased, then **where is the poll showing the opposite??**



j. I ran two polls. They show that **the vaccinated were 40% more likely to get COVID** than the unvaccinated.



k. Jay Bonnar's personal observations (which I independently validated by researching every death on Google) show he lost more than **1 friend per 1,000 vaccinated**. Jay now has 17 friends who died unexpectedly, all vaccinated. He's never had ANY of friends die unexpectedly before the COVID vax. He has about 15,000 friends in his contacts, and estimates over 75% are vaccinated (he's in King County which has a 98% vax rate, the highest in the US but only around 25% of his friends live in King County). Let's assume it is 100%. Never losing a friend unexpectedly in his life, and losing 17 friends starting AFTER the vax rollout is impossible to explain if the vaccines aren't killing people. **4 died on the same day as their shot and 3 of the 4 were under 30. Everything is**

verifiable.

So at the time he told me the story, over 25% of his friends who died unexpectedly died within 24 hours of their COVID shot.

There are few people with stats like these because most people aren't aware of deaths in their full network. Jay noted that all were previously perfectly healthy, all died within hours, days, weeks of the shot, all died with conditions consistent with other vax deaths (heart or stroke). Jay's numbers are **statistically impossible if the shots are safe** and not killing anyone (getting 17 events and expecting 1 or less is 1.1e-15 which means even if I talked to everyone in the world, I wouldn't be able to find this story).

l. Similarly, media personality Wayne Root began tracking vaxxed vs. unvaxxed friends **who died of ANY cause after the shots came out**. 34 vaccinated; 3 unvaccinated. Wayne is a Republican so only 60% of his friends took the shots. So we expected 5 deaths and got 34. The chance of that happening due to pure statistics is 4.1e-20.

m. Ed Dowd's book "Cause Unknown" documents 500 people who died unexpectedly (that was the sole criteria). They have something in common: as far as we know, only one of the 500 was unvaccinated. In a country where only 70% of the population is vaccinated, we'd expect to find 150 unvaccinated sudden deaths. We found just 1. Probability: 1e-264 by pure chance. Which means these sudden deaths are only really happening to the COVID vaccinated.

n. Statistics observed in medical practices by doctors who observed the unexpected deaths of their patients. Deanna Kline, Tidewater Family Practice, for example experienced a 4X increase in all-cause mortality in her geriatric practice after the COVID shots rolled out (from 10 deaths/yr to over 40/yr in a 3,000 patient heavily geriatric practice. That is very statistically significant (7e-13 probability by pure chance). She attributes nearly all the 78 excess deaths to the COVID vaccine. This suggests that for the elderly in this practice, the COVID shots may have **killed more than 26 per 1,000 vaccinated** and this is easily confirmed by nursing homes like Apple Valley Village where the Tidewater death rate was exceeded more than 7-fold.

o. I know what happened at Apple Valley Village because I was tipped off by an insider. Deaths started to skyrocket IMMEDIATELY after the vaccines rolled out (to the day). How can the COVID CFR go from 0 deaths in 27 COVID cases before the vaccines rolled out to over a 30% CFR after rollout (28 deaths on 90 cases) on exactly the same COVID variant? This is too large of an effect to be a statistical outlier. I reached out to them and they wouldn't talk to me, so I had a lawmaker in the state reach out and they hung up on him. This is also documented in the official Medicare records and publicly available. I just want someone to explain how that can happen after a lifesaving vaccine is rolled out. This wasn't just "bad luck" because the Poisson probability on this event is 1.2e-30 of seeing 28 deaths and expecting at most 1. They had 140 occupied

beds at the time they had 28 “COVID” deaths right **after** the shots rolled out. Based on previous COVID CFR at that facility (lets assume it was 1 per 30 cases since it was 0), there were at least 25 excess deaths per 140 vaccinated which is **178 excess deaths per 1,000 fully vaccinated**.It’s right there in the Medicare reports for anyone to see.

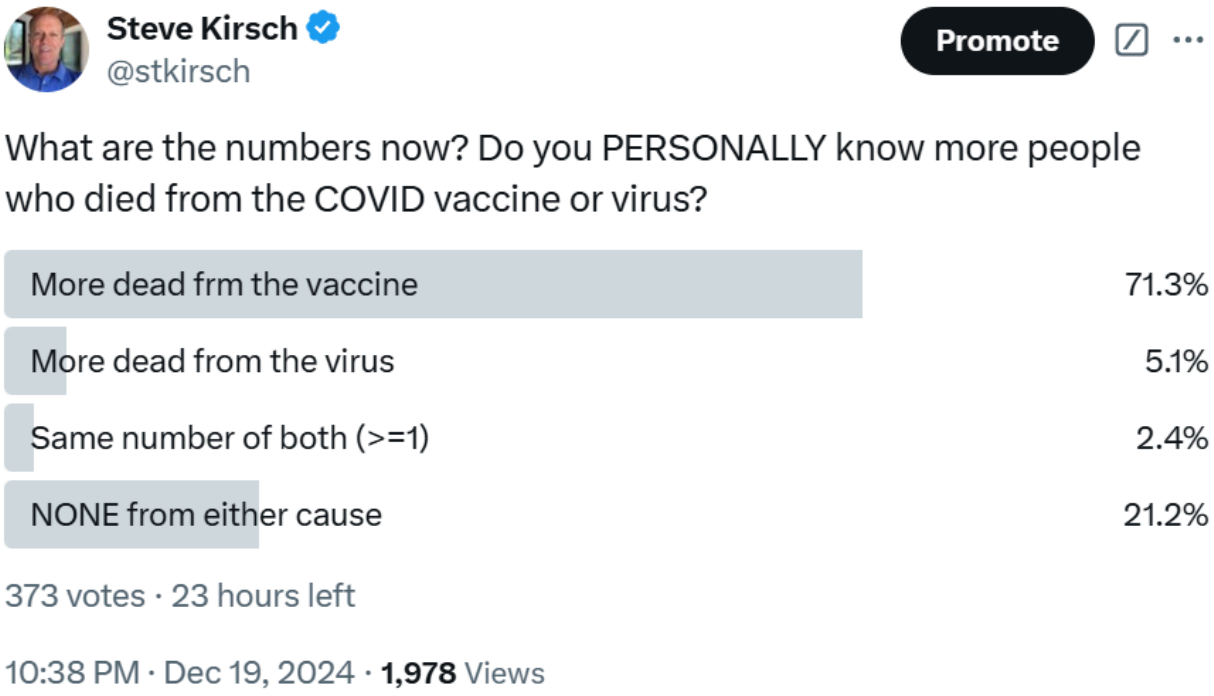
p. I was unable to find any site with a “success story” that would talk to me about it despite asking multiple times.

q. But I found plenty of stories like this one from Anen Allidnab. If the vaccines are so safe and effective, stories like these can’t exist.

> “As someone who has been working in the nursing home for the last **13 years**, **I can 💯 guarantee you that the only success that these gene editing injections brought was/were untimely, unexpected and sudden deaths of many residents**. And more and more sickness and hospitalization! **I have never ever witnessed 4-5 deaths within 5 days in my history of working in the nursing home before the vaccines were rolled out!** When I checked out our nursing home death book register it **significantly jumped up from the year 2021 onwards**.”

If the shots worked, it would have gone dramatically the other way.

r. My final piece of evidence puts it all together since the question is whether the vaccines saved more people than it killed. If it did, then it would pop up in surveys. Here’s one I just did on X:



All surveys are biased, but I’d like to believe my followers are more astute

than the average American who just believes what they are told by the government that all deaths were just coincidences. So I think this is pretty close to the actual numbers.

s. To reduce bias, we hired **a professional third-party polling firm** to survey a group of representative Americans chosen by them and we paid a **professional market research firm to draft the questions** to minimize bias.

   You still find that Americans have observed more deaths from the COVID vaccine than from the virus.

   Note that this poll is strongly biased against our position since 70% of Americans who took the shots think it is safe (or they wouldn't have taken it) so they are much less likely to report any vaccine deaths.

   So even with an audience so biased against us, the signal is so strong it is still devastating.

   Jul 4, 2022 Pollfish summary data of 1,000 households:

   Q15: 36 households with a vax death
   Q17: 13 households with a COVID death

   Bottom line: Nearly **3X as many American households reported a vax death vs. a COVID death within their own household**.

Summary

This isn't a close call. I'd estimate the vaccine likely killed at least **22X more people than it ever might have saved,** even in the most optimistic scenario.

1. **Best case saved:** The "claimed highest quality" evidence of a COVID mortality benefit was from the Pfizer clinical trials which "saved" a net **1 life saved per 22,000 fully vaccinated**. But the other data cited here from a wide variety of different data sources consistently shows **the vaccines did the opposite: increased both the risk of infection and the case fatality ratio by substantial amounts.**
2. **Likely killed:** Data from many different sources (VAERS, doctor statistics, FDNY death stats, public surveys, doctor surveys, …) show verifiable excess all-cause mortality that ranges from a low of **1 life lost per 1,000 fully vaccinated** (super healthy FDNY firefighters) and as high as **178 lives lost per 1,000 vaccinated** at Apple Valley Village nursing home.