

Estimating the number of COVID vaccine deaths in America

By Steve Kirsch, Jessica Rose, Mathew Crawford

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.

Our estimate is validated in 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!**”

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

“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: the URL to this will be added by Sep 29..due to a typesetting delay at the journal]

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 vax - # 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 URF by using a known significant adverse event rate
2. Determine the number of US deaths reported into VAERS
3. Determine the 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” people fully vaccinated. 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.

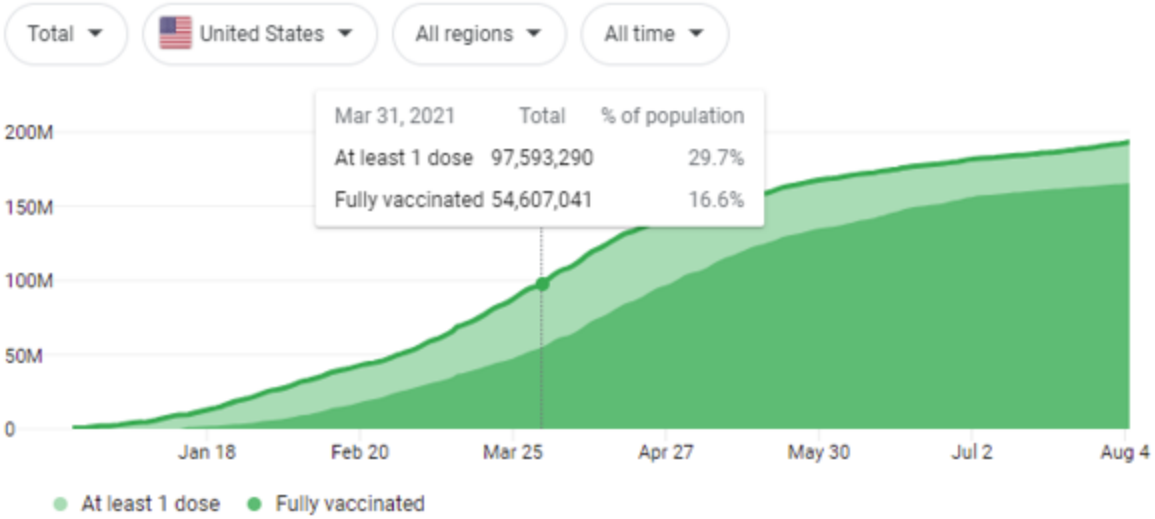
However, after the MGH study was published, one doctor pointed out that doctors were more careful to avoid anaphylaxis; **there was more careful screening of people likely to have anaphylaxis**, and they were advised to see their allergist and take more precautions prior to vaccination. This sort of 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 their [anaphylaxis warning letter](#)).

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%
TOTAL	† 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 suggests that the under-reporting factor (URF) is 41X.**

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 estimate is to use myopericarditis. There are 2,888 reports in VAERS after 200M vaccinations. The rate of myopericarditis across all age groups is 1 in 1,000 people vaccinated (see [mRNA COVID-19 Vaccination and Development of CMR-confirmed Myopericarditis](#)).

This leads to an $UFR=200/2.888=69$. This makes total sense since myopericarditis isn't as serious as anaphylaxis, so the UFR would be much higher than for anaphylaxis.

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.

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.

For example some people think that the PTR is 10 this year (i.e., that people are reporting 10 times more frequently than last year) and that it is simply a PTR issue resulting in all of the reports.

It may surprise you to learn that the PTR this year is estimated to be 0.25 which will be explained later.

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.](#)

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.

This is 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 this claim violates the data. The data also confirms the idea of less frequent filing of reports to VAERS by physicians based on the fact that many believe that these products are safe.

The paradox though is 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 16 times more dangerous than previous vaccines with regards to the number of people seeing their doctors, we’d expect a reporting rate of 10 events in the reference year to be 40 in the current year since $10 * 0.25 * 16 = 4$ (i.e., $10 * PTR * (\text{elevation in the number of unique victims})$).

The bottom line is an event that is 10 in 2019 could be 40 in 2021 and that would just be considered a “flat” event.

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:

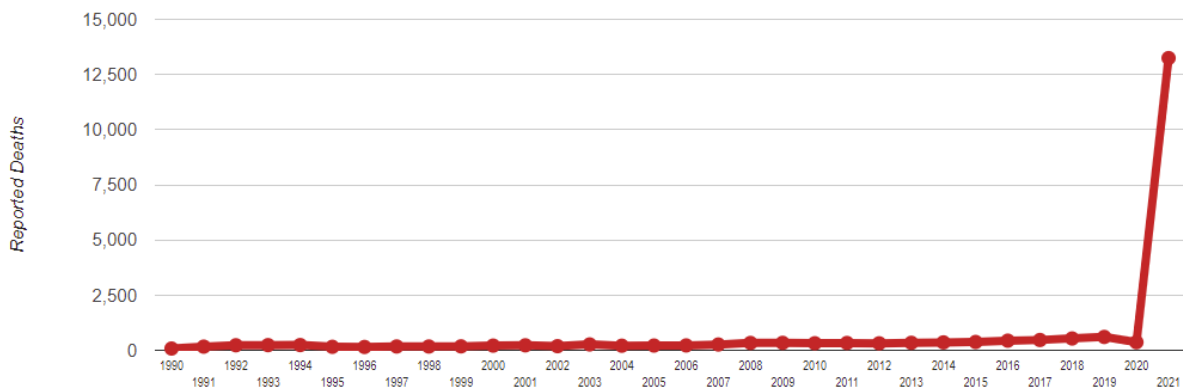
1. VAERS is over-reported this year for COVID19 events so all the deaths are simply background deaths. The vaccine has caused zero deaths. This is the FDA/CDC claim.
2. VAERS is reported this year at the same rate as previous years. All the excess deaths relative to previous years are due to the vaccine.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

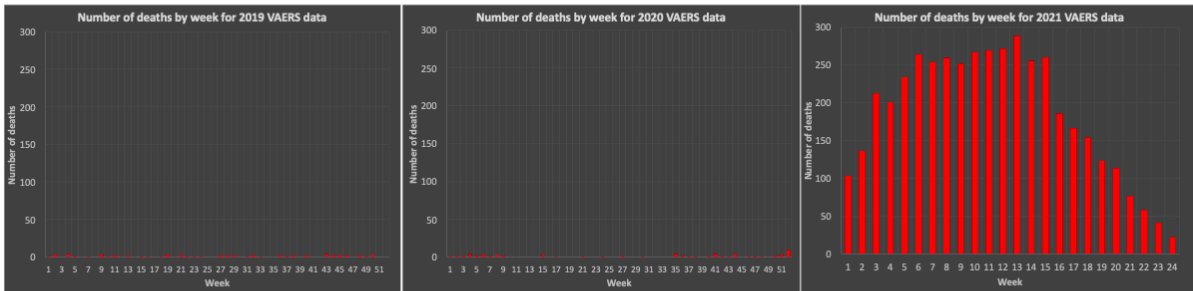


Figure 1: Bar plots showing the number of VAERS reported deaths per week for 2019, 2020 and 2021.

Analysis: Dr. Jessica Rose

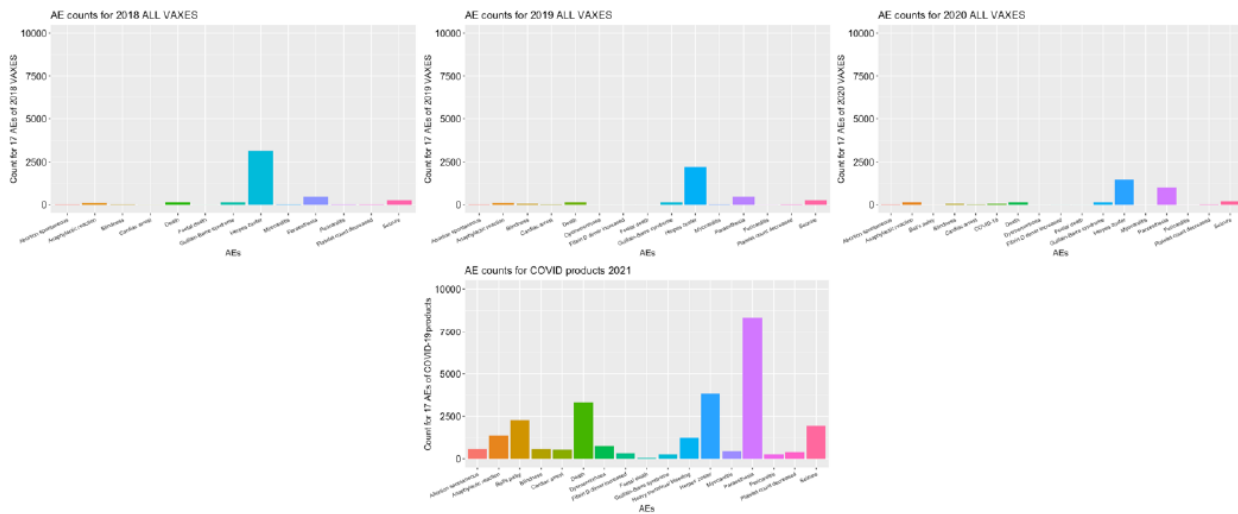
Method #2: To double check our hypothesis that the PRT is unchanged this year, we ran VAERS queries using symptoms unrelated to those impacted by the vaccines. We ruled out any known co-morbidities like diabetes and obesity since these would likely be elevated since there are more adverse events.

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

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 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.



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

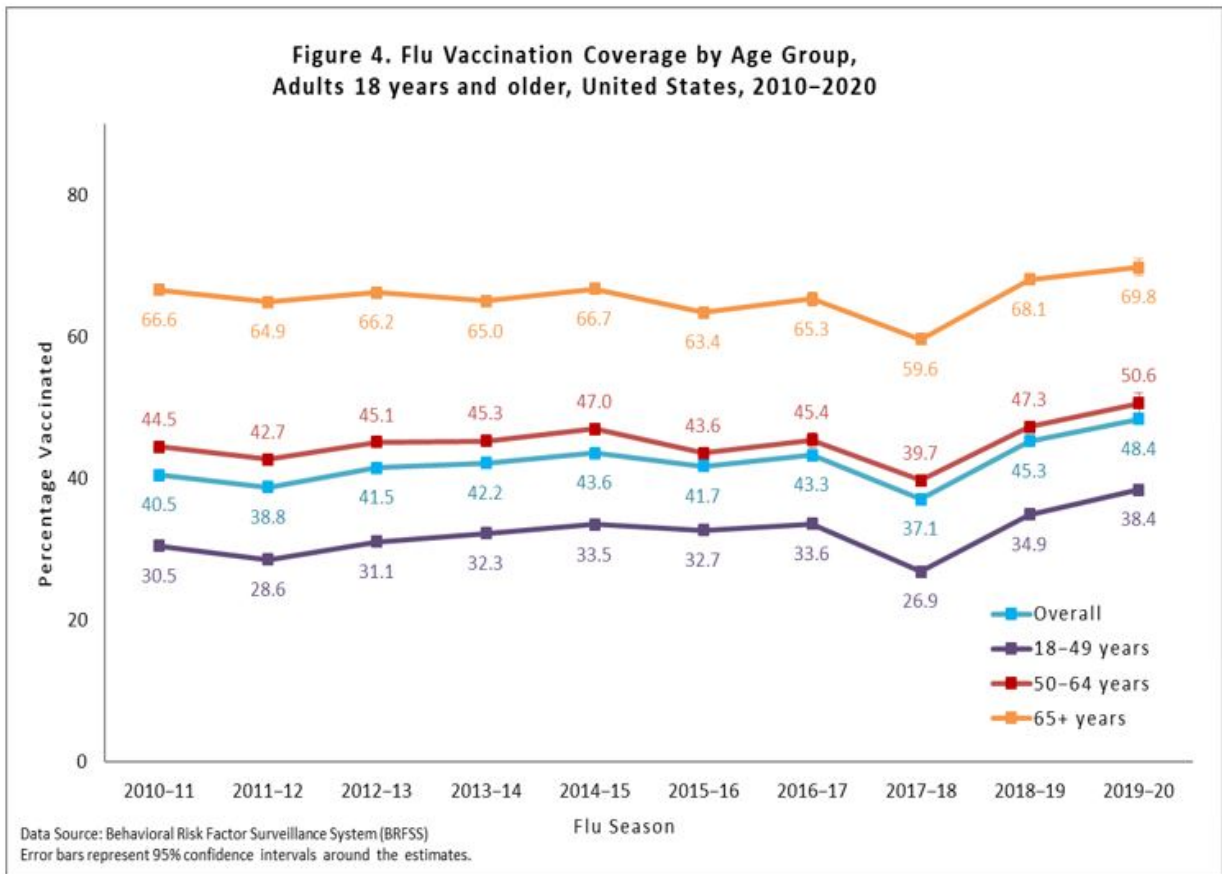
There are three ways to estimate the number of excess deaths caused by the vaccine. Using these three methods we can estimate the low and high likely bounds for the number of excess deaths caused by the vaccine:

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](#)

Here are the results that we obtain these three methods:

Method	
Subtract average background deaths	$(7149-1000)*41 = 252,109$
Mclachlan case analysis	$.86 * 41 * 7149 = 252,073$
Pathologist estimate	$.60 * 41 * 7149 = 175,865$

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:



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 seven 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.

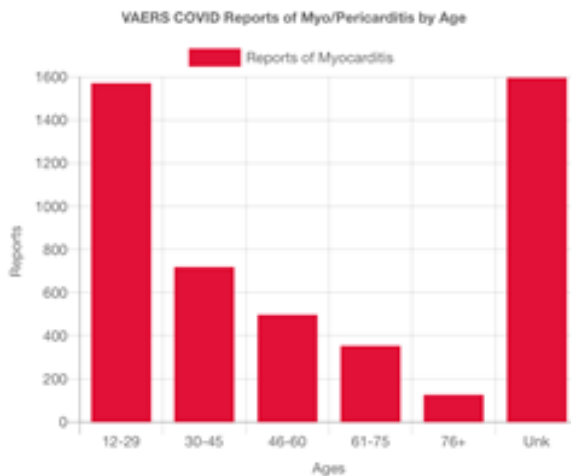
Method	Estimate of US excess vaccine deaths
Excess CFR analysis done in Europe determines 200-500 D/M doses	72,000 - 180,000
Excess death analysis done in 23 nations (comprising 25% of world population) which includes 2 Europe nations in the CFR analysis which determined a 411 D/M doses. Together, the two analyses cover 35% of the global population	147,960
Small island study done by Marc Girardot	171,000
By mid-January, Norway had vaccinated around 40,000 people. They had 23 reported deaths , so 1 in 1700 (maybe more because it's hard to know when such statements are formulated relative to a program 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.	150,000
Professional pollster analysis Few people attribute death to the vaccine	174,000

<p>(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.</p>	
<p>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 consistent.</p>	<p>~ 200,000</p>
<p>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</p>	<p>~ 200,000</p>

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.**

Myo/Pericarditis



Myo/Pericarditis Cases post COVID 19 Vaccine VS. All Flu Vaccines

AGE RANGE	FLU CASES IN 20 YRS.	COVID19 CASES IN 7 MOS.
6-18	16	694
19-29	61	877
30-39	28	481

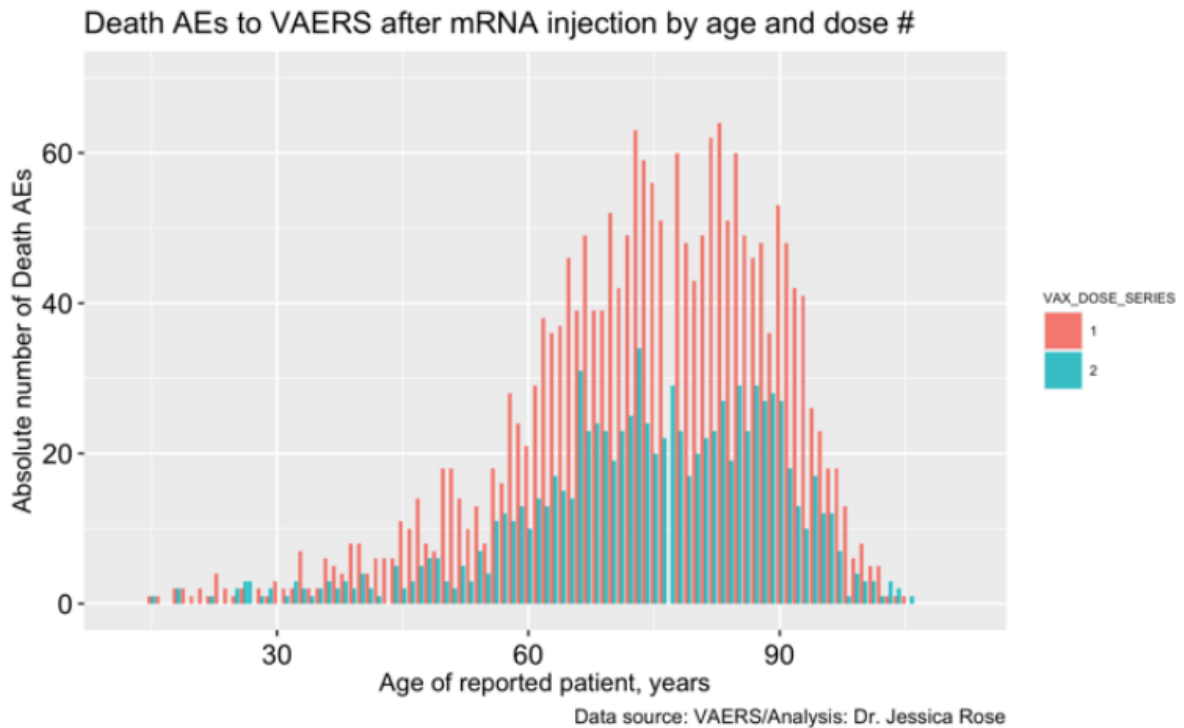
A friend of ours got pericarditis right after getting the influenza vaccine when she was 30 years old. It took her two years to recover. The heart muscle never really regenerates like other organs unfortunately.

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

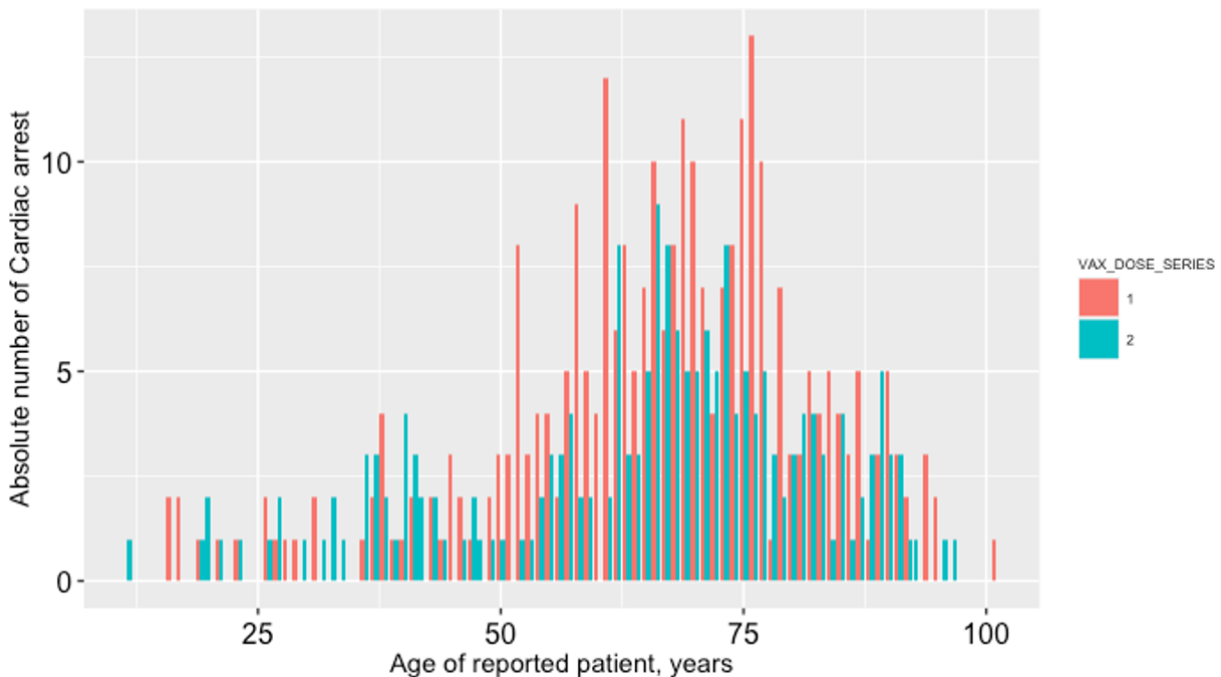
As someone who suffered one of these adverse effects, all I can say is shame on the FDA. I am on the Liberal side of the fence, and would not typically see myself on something like TrialSiteNews, but I am being shunned by my own camp any time I say anything about my story or the safety of these vaccines. 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:

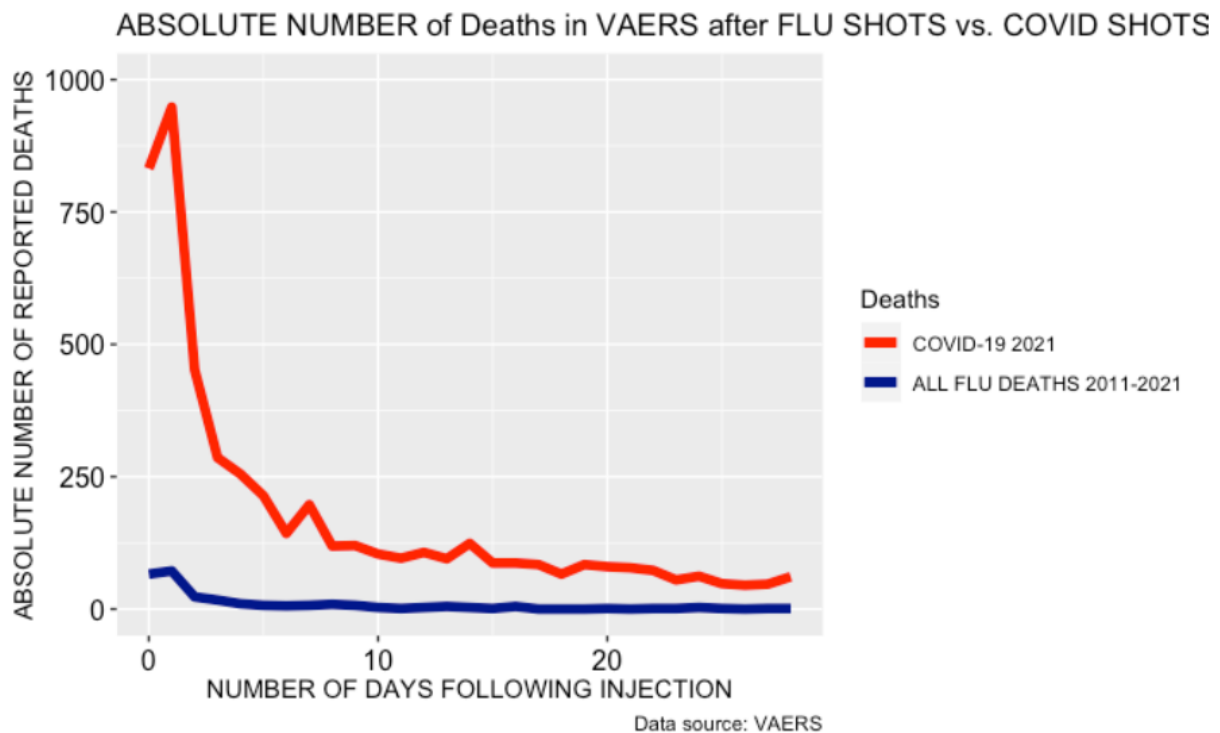


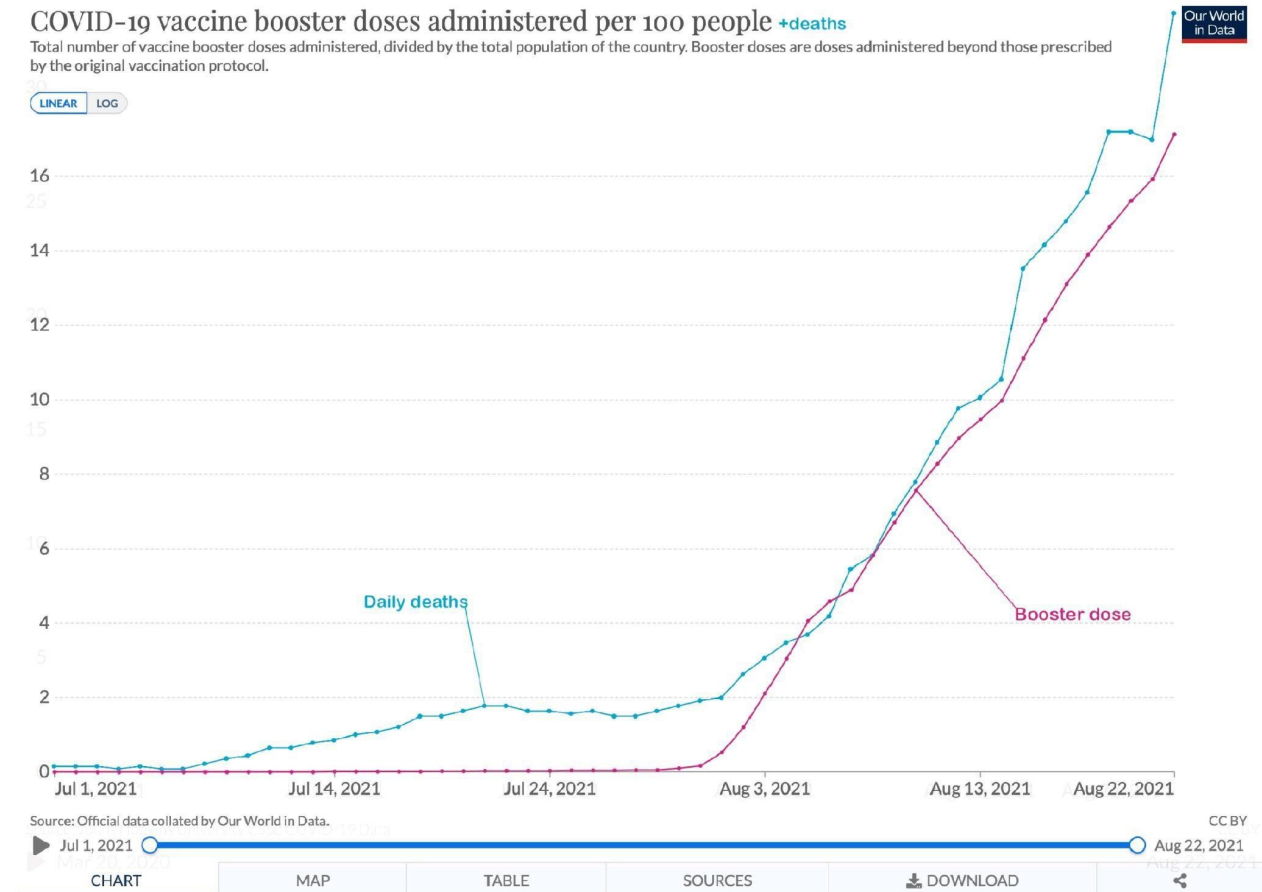
Figure 5: Absolute number of reported deaths for all COVID-19 deaths and all FLU deaths reported to VAERS with respect to time elapsed between injection date and AE onset.

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.



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.

Symptom	Incidence rate elevation over normal (X factor)
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

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

(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 hen 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
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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.

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, mercury poisoning isn'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.

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.

Let's address the false claims in the fact check, claims which are common in such articles:

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, I will 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 allows them

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:** You basically use previous years' data as a control group to see what is "normal" in a year.
5. **There are no deaths:** 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 who died in the CDC/ACIP analysis](#). You should [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 and nobody will debate me.

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. **It's 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. **There's over-reporting; there is nothing to see:** I had to ask this because 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. Lots of ways. 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](#).

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 177×4 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), 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.

\$1M bet

If you think I’m wrong, I’m willing to put my money where my mouth is. [Here are the terms of the \\$1M bet.](#)

\$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.

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 are 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.