A critical rethink: Real Efficacy of Covid Vaccines depends fully on accuracy of Reporting side effects

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Background

SARS CoV-2 has ravaged the world in many ways. Vaccines were supposed to be the way out of the pandemic.

Traditional vaccines provide immunity. They were trialed for efficacy and safety for many years through extensive phase trials first in vitro then in vivo (on animals) and then in long term community trials. Determination of vaccine efficacy and safety was achieved by comparing the side-effects of the vaccines with the effects of the relevant disease be it measles, hepatitis, meningitis etc. If the efficacy and safety of these traditional vaccines was acceptable, they were considered for Market Authorization by FDA, EMA etc. If a certain number of fatalities or serious side-effects occurred, the vaccine trials were stopped and market authorization would not be submitted such as for example for the Rotavirus vaccines in 1995 (ref 10).

With the SARS CoV2 vaccines from Pfizer, Astra Zeneca, Moderna and Johnson&Johnson the trials are currently ongoing and unfortunately we see many breakthrough cases which suggests immunity is not obtained. In such a situation the side-effects of the vaccines need to be added to the breakthrough cases rather than comparing them only to the disease SARS CoV2. In this study I suggest that the vaccine efficacy and safety is negative for the Delta variant and that therefore all vaccination globally should be stopped until the pandemic is over to try to develop a vaccine which provides immunity.

Method

Data from Public Health England (Technical Briefing 23) was used to analyze the VE (Vaccine Efficacy) based on some 573.000 Delta cases sequenced and genotyped in a laboratory. Efficacy against infection, hospitalization and death was studied. These data were then added to the side-effects cases reported to the Yellow Card system of NHS. Hypothetical percentages were consequently added based on the Lazarus report from the US Government from 2010. Also VASE from the EMA data-site were analyzed. A comparison is made to the AZ Phase III trials.

Results

When adding the side-effects to the breakthrough cases for infection, hospitalization and death negative efficacy was reached at factor 0,83 of side-effects for infection overall, factor 0.27 for infection for the over 50 and factor 0.7% for the under 50.

Negative efficacy was reached for hospitalization at factor 1 overall, factor 3.4 for the over-50 and factor 2.3 for the under-50.

Overall the vaccines have a negative efficacy of 45% against death without adding any side-effects. For the over-50 negative efficacy is achieved at factor 4.7 and for the under-50 it is achieved at factor 0.4.

Conclusion

When adding the adverse vaccine side-effects (VASE) reported at Yellow Card website to the breakthrough cases the VE becomes negative for infection regardless of age. When adding to the hospitalization and death rates, none or only minimal factors are needed to achieve negative VE regardless of age. As more side-effects shall be reported over time when long-term side-effects are added such as ADE, auto-immune disorders, learning disabilities, chronic sleep disorders (as we saw with the Mexican flu vaccine) and further breakthroughs due to waning efficacy, the required factor for negative efficacy shall only become lower and the threshold for efficacy disappears altogether eventually.

Considering the largest study ever undertaken suggests that adverse vaccine side-effects are under reported by 99%, the accuracy of the reporting of adverse side-effects fully determines the accuracy of the SARS CoV2 vaccines. Even very limited under-reporting or moderate long-term effects will push the SARS CoV2 vaccines in the negative range.

Since minimal 50% efficacy is required for Emergency Market Authorization and this is not obtained in any case when VASE are added to the breakthrough cases, all vaccination programs against SARS CoV2 should be stopped as well as all vaccine related measures such as the heavily debated health-pass.

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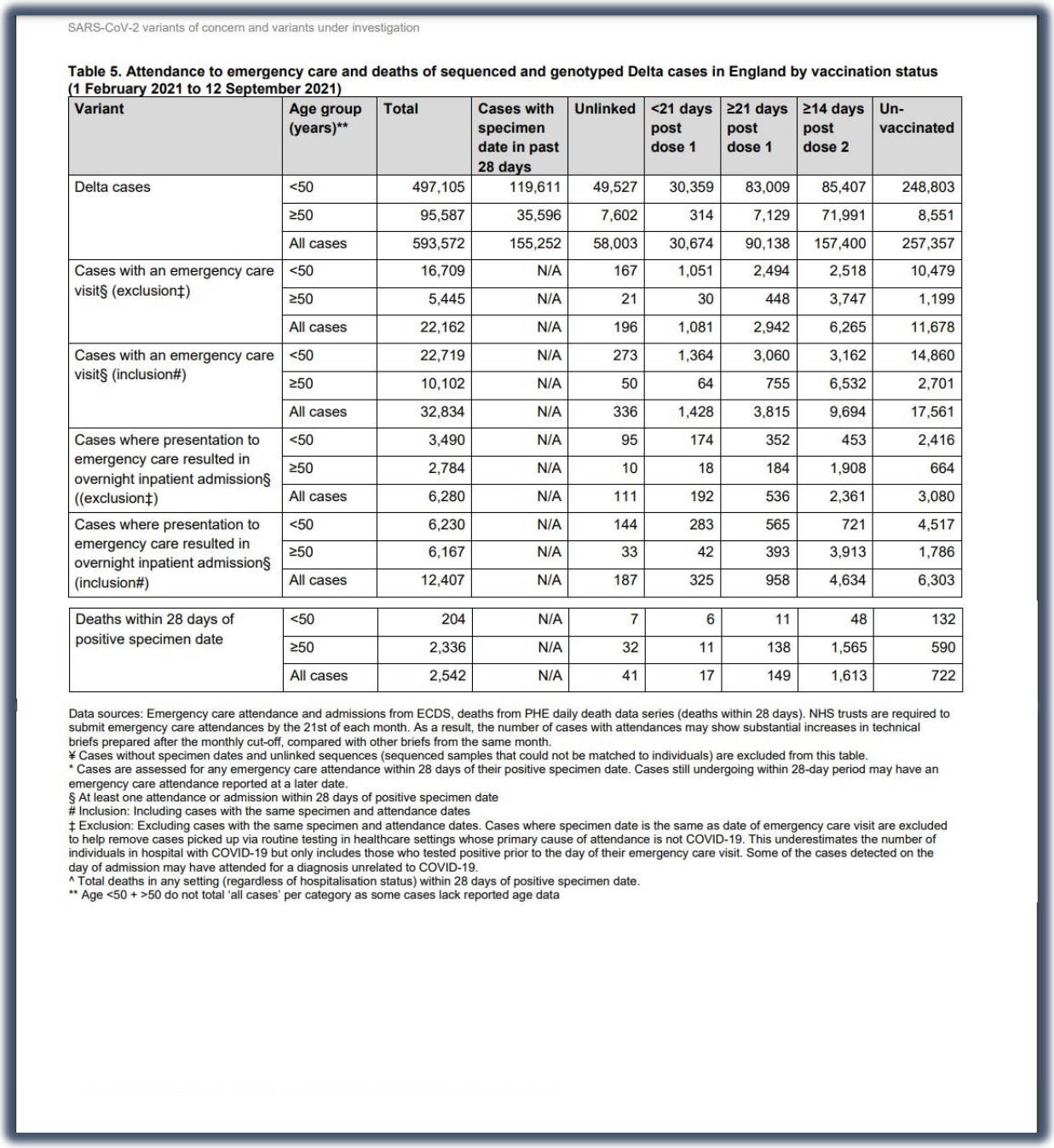
Firstly it is very important to understand that the SARS CoV2 vaccines were developed based on the genetic code for the original wild-type Chinese variant. Eventually after about 12 months this variant disappeared as it mutated into the Alpha variant (the British variant). The Alpha variant which was less lethal than the Chinese variant was completely replaced in England by the Delta variant within 6 months. Already very soon it became clear that the Delta variant was more transmissible but substantially less virulent (sickening or lethal) than the Alpha variant. Currently it appears to be 5 to 10 times less lethal than Alpha. In my previous paper “Alpha Delta Over” I explained that vaccination cannot explain the dramatic drop in CFR as both variants were equally dominant for a period of 6 weeks from early June to mid-July 2021 yet the patients infected with the Alpha variant had a 10 times higher chance of dying than patients infected with the Delta variant (see PHE technical briefings 15 to 20).

Secondly it is imperative to determine the most reliable data from the most reliable sources. In my view these are the PHE technical briefings as they are the only data which use genotyped and sequenced PCR positives (meaning these are symptomatic samples confirmed in a laboratory) and they differentiate between patients whom tested positive the day(s) before A&R visit and hospitalizations which eliminates many – but not all - patients coming in for other reasons than Covid who test positive. This is why we use them here.

"PHE Technical Briefing 23 – Table 5"



SARS-CoV-2 variants of concern and variants under investigation

Table 5. Attendance to emergency care and deaths of sequenced and genotyped Delta cases in England by vaccination status (1 February 2021 to 12 September 2021)

Variant	Age group (years)**	Total	Cases with specimen date in past 28 days	Unlinked	<21 days post dose 1	≥21 days post dose 1	≥14 days post dose 2	Un-vaccinated
Delta cases	<50	497,105	119,611	49,527	30,359	83,009	85,407	248,803
	≥50	95,587	35,596	7,602	314	7,129	71,991	8,551
	All cases	593,572	155,252	58,003	30,674	90,138	157,400	257,357
Cases with an emergency care visit§ (exclusion‡)	<50	16,709	N/A	167	1,051	2,494	2,518	10,479
	≥50	5,445	N/A	21	30	448	3,747	1,199
	All cases	22,162	N/A	196	1,081	2,942	6,265	11,678
Cases with an emergency care visit§ (inclusion#)	<50	22,719	N/A	273	1,364	3,060	3,162	14,860
	≥50	10,102	N/A	50	64	755	6,532	2,701
	All cases	32,834	N/A	336	1,428	3,815	9,694	17,561
Cases where presentation to emergency care resulted in overnight inpatient admission§ ((exclusion‡)	<50	3,490	N/A	95	174	352	453	2,416
	≥50	2,784	N/A	10	18	184	1,908	664
	All cases	6,280	N/A	111	192	536	2,361	3,080
Cases where presentation to emergency care resulted in overnight inpatient admission§ (inclusion#)	<50	6,230	N/A	144	283	565	721	4,517
	≥50	6,167	N/A	33	42	393	3,913	1,786
	All cases	12,407	N/A	187	325	958	4,634	6,303
Deaths within 28 days of positive specimen date	<50	204	N/A	7	6	11	48	132
	≥50	2,336	N/A	32	11	138	1,565	590
	All cases	2,542	N/A	41	17	149	1,613	722

Data sources: Emergency care attendance and admissions from ECDS, deaths from PHE daily death data series (deaths within 28 days). NHS trusts are required to submit emergency care attendances by the 21st of each month. As a result, the number of cases with attendances may show substantial increases in technical briefs prepared after the monthly cut-off, compared with other briefs from the same month.
¥ Cases without specimen dates and unlinked sequences (sequenced samples that could not be matched to individuals) are excluded from this table.
* Cases are assessed for any emergency care attendance within 28 days of their positive specimen date. Cases still undergoing within 28-day period may have an emergency care attendance reported at a later date.
§ At least one attendance or admission within 28 days of positive specimen date
# Inclusion: Including cases with the same specimen and attendance dates
‡ Exclusion: Excluding cases with the same specimen and attendance dates. Cases where specimen date is the same as date of emergency care visit are excluded to help remove cases picked up via routine testing in healthcare settings whose primary cause of attendance is not COVID-19. This underestimates the number of individuals in hospital with COVID-19 but only includes those who tested positive prior to the day of their emergency care visit. Some of the cases detected on the day of admission may have attended for a diagnosis unrelated to COVID-19.
^ Total deaths in any setting (regardless of hospitalisation status) within 28 days of positive specimen date.
** Age <50 + >50 do not total 'all cases' per category as some cases lack reported age data

Any report or data set based on PCR tests only cannot be used to determine vaccine efficacy even remotely as according to NHS 95% of all Covid deaths since March 2020 had underlying conditions (table 1 – NHS)

This is evidenced among others by the fact that the PHE technical briefings work with some 573.000 samples collected over 18 weeks.

Israel's data for instance (the other most vaccinated country) are not reliable as Israel is "Pfizer's laboratory" (Pfizer's own words). I have to state here that the PHE data are also not 100% unbiased but they are the best we have.

Table 1:

Note: Data in this sheet are updated weekly

Title: COVID-19 deaths by age group and pre-existing condition

Summary: This file contains information on the deaths of patients who have died in hospitals in England and have tested positive for Covid-19. All deaths were reported during the period specified below.

Period: All data up to 4pm 25 August 2021
Source: COVID-19 Patient Notification System
Basis: Provider
Published: 26 August 2021
Revised: -
Status: Published
Contact: england.covid19dailydeaths@nhs.net

Breakdown by pre existing condition

	Pre existing condition			
Age group	Yes	No	Unknown presence of pre-existing condition	Total
Total	86,315	3,832	0	90,147
0 - 19 yrs	39	9	0	48
20 - 39	595	108	0	703
40 - 59	6,002	691	0	6,693
60 - 79	32,992	1,594	0	34,586
80+	46,687	1,429	0	48,116
Unknown age	0	1	0	1

Any scientific study which is directly or indirectly funded or "supported" by pharmaceuticals or their supporters/funders (like Wellcome or EcoHealth) is dismissed immediately for Bias. Any person with deeper knowledge of statistics would be aware of John Ioannidis' paper of 2005 "Why Most Published Research Findings Are False", the most cited scientific paper in the history of the Library of Science (ref 1). My study follows John Ioannidis' guidelines as far as possible. In his January 2021 paper Ioannidis states that he estimates the IFR for Covid could drop below 0,1% and that Common Cold viruses can have IFR's as high as 10% in nursing homes (ref 2).

Further we must consider England's Yellow Card system (ref 3). According to latest data from Gov.uk some 1.612 people have died shortly after taking the vaccine and some 356.895 reports of side effects have been made. Tens of thousands serious side-effects have been reported in England.

It is extremely difficult to determine the real number of (serious) side-effects and deaths from vaccine uptake. In 2011, over 20 years after the establishment of the VAERS system, the Agency for Healthcare Research and Quality (AHRQ) of the U.S. Department of Health and Human Services undertook the largest study ever in regard to VAERS reporting with some 715.000 patients with 1.4 million doses given to 376.452 individuals over a period of 3 years named the Lazarus report. A massive study. This report was reviewed and approved by the CDC including the CDC's Clinical Immunization Safety Assessment (CISA) Network (ref 4).

The results were: "Adverse events from drugs and vaccines are common but underreported. Although 25% of ambulatory patients experience an adverse drug event, less than 0.3% of all adverse drug events and 1-13% of serious events are reported to the Food and Drug Administration (FDA). Likewise, fewer than 1% of vaccine adverse events are reported. "

Note: until 2018 annually some 30.000 VAERS events were reported with 10-15% serious events.

These are very important data to consider efficacy of Covid vaccines because the patients reporting to A&E, hospital admission and death must be added to the breakthrough cases to calculate the real vaccine efficacy. Afterall: no vaccine uptake, no vaccine side effects.

In 1999 the vaccine for Rotavirus (RotaShield) was withdrawn after intussusception was reported in 1 to 2 children per 10.000 vaccinated. CDC gave the reason for withdrawal as follows (Ref 10):

"A primary goal of CDC is to protect the health and safety of the general public in the United States. One of the most effective ways to prevent disease is through vaccination. However, when a vaccine is discovered to have a serious side effect, a recommendation to continue using the vaccine will be

reconsidered and the vaccine may be withdrawn, in spite of the beneficial effect of the vaccine to prevent disease.

The vaccine safety monitoring systems worked to detect an uncommon side effect. Rotavirus vaccination was promptly suspended and new cases of intussusception were prevented."

In order to determine vaccine efficacy and safety the vaccine makers during Phase III trials compare the number of reported side-effects to the number of Covid cases. A catastrophic flaw in this case considering vaccination does not provide immunity. It would be an acceptable approach if vaccination would provide 100% or close immunity. The breakthrough cases need to be added to the reported vaccine related adverse side effects (VASE). Only then shall real efficacy become apparent.

A further important study to consider is the AstraZeneca Phase II trial study which stated overall efficacy 55-70% which is OK one would think (ref 5). The devil as always is in the details. The seriously underpowered study states under results (for safety): "175 severe adverse events occurred in 168 participants, 84 events in the ChAdOx1 nCoV-19 group and 91 in the control group.". On first sight one would assume that this is acceptable because the control group (placebo) has more serious side-effects than the vaccinated group. This would be true if the control group was given a saline-solution (saltwater) as is common in vaccine or medication trials.

The control group however was given the meningococcal vaccine, a vaccine which in adults can cause very nasty side-effects if injected at an older age. Using another vaccine as control group is an acceptable method however in this case should never have been used as safety couldn't be measured properly as one had to compare to "no vaccine" instead of "other vaccine". Only young healthy persons aged 18 to 55 were injected. A very important point as efficacy was determined based on an "OVERALL" outcome without age-adjusting (data for elderly was not available). It will become apparent later in this study how this is a critical flaw.

Note: My children are vaccinated against meningococcal and other child diseases and I still support our decision to have them vaccinated. I am not "anti-vax" whatever that means.

Now to my analysis of the PHE Technical Briefing 23 (table 5 pages 21&22) and how this determines the real efficacy of vaccination in England (ref 6)

We need to consider some overall data as of 12 September 2021:

- Total 593.572 cases:
- 257.357 unvaccinated (0vax) cases
- 157.400 double vaccinated cases (2vaxx)
- 278.212 vaccinated cases (allvax)
- In England, 65% of the population is 2xvax and thus 35% 0vax or 1xvax
- In numbers: 56 mil inhabitants thus 36 mil 2xvax and 20 mil 0vax/1xvax
- 2xvax 18-50 16,106,700
- 0xvax 18-50 5,812,300
- 2xvax >50 19,917,047
- 0xvax>50 1,403,953

Yellow card cases to 8 September 2021

- yellow card cases • 356,895
- yellow card cases hospital • 2,991
- yellow card death • 1,612

I analyzed the data as per the below three spreadsheets (graph 2). In the first three rows you will find the benchmarks.

I started these calculations early to mid-September 2021 put them in a simplified tweet-thread on 8 September. On 5 September REACT-1 (Imperial College and University of Oxford) published a paper with regard to efficacy of the vaccines (ref 7). They conclude among others as follows:

"However, in round 13, 44% of infections occurred in fully vaccinated individuals, reflecting imperfect vaccine effectiveness against infection despite high overall levels of vaccination. Using self-reported vaccination status, we estimated adjusted vaccine effectiveness against infection in round 13 of 49% (22%, 67%) among participants aged 18 to 64 years"

I believe these findings put some weight to my own findings.

From row four you will find the absolute numbers, relevance to their cohort and the consequent efficacy. Row 4 to 6 show the efficacies as per the PHE TB23.

In bold from row 7 onwards I added the VASE (vaccine adverse side effects) as reported by the yellow card system but considering also the Lazarus report which implies that the reports in the yellow card system would only be 1% of the total side effects.

I suggest three scenario's:

- Adding the actual reported VASE (basis 1%)
- Adding VASE basis 2% eg assuming that the VASE are under-reported by a factor 2
- Adding VASE basis 10% assuming that the VASE are under-reported by a factor 10

"CASES" (graph 2)

cases	cases	% fm population/cohort	Efficacy % cohort
1) 0vax <50	248,803	1.300	
2) 0vax >50	8,551	0.609	
3) 0vax ttl	257,357	1.253	
4) 2xvax<50	85,407	0.446	**65.7**
5) 2xvax>50	71,991	0.361	**40.7**
6) 2xvax ttl	157,400	0.437	**65.1**
7) 2xvaxx incl VASE1%	**514,295**	**1.428**	**12.3**
8) 2xvaxx incl VASE2%	**871,190**	**2.418**	**48.2**
9) 2xvaxx + VASE10%	**3,726,350**	**10.344**	**87.9**
10) 2xvaxx incl VASE 0.83%	**453,623**	**1.259**	**0.5**
11) 2xvaxx>50 incl VASE1%* (50%)	**250,439**	**1.257**	**51.6**
12) 2xvaxx>50 incl VASE2%* (50%)	**428,886**	**2.153**	**71.7**
13) 2xvaxx>50 incl VASE10%* (50%)	**1,856,466**	**9.321**	**93.5**
14) 2xvaxx>50 incl VASE 0.27%* (50%)	**120,172**	**0.603**	**0.9**
2xvaxx<50 incl VASE1%* (50%)	**263,855**	**1.638**	**20.6**
2xvaxx<50 incl VASE2% (50%)	**442,302**	**2.746**	**52.7**
2xvaxx<50 incl VASE10% (50%)	**1,869,882**	**11.609**	**88.8**
2xvaxx<50 incl VASE 0.7%* (50%)	**210,320**	**1.306**	**0.5**

I consider a "case" in the yellow case reporting as a "Covid case". As we know over 90% of Covid cases are mild and require no medical attention. I assume the same for VASE cases. Mild Covid cases equal mild VASE cases.

The same applies for hospitalization and death. Since I only calculated the four main reasons of serious side effects (myocarditis, anaphylactic shock, TTS and GBS) this number in itself is already heavily under-reported.

From experience with my vaccinated acquaintances, friends and family I know that all of them have had mild to severe side effects, some had to go to the emergency rooms, others see their GP and others have been sick for days unable to work. There is even an example of a young healthy female friend in her thirties developing Glandular Fever within one week from the second dose. None of them have reported their side-effects. Not a single person. I believe many readers will have similar experiences. Some of our relatives and friends also are a bit ashamed to admit they were sick. Medical practitioners and nurses may have fear of legal consequences, the reporting agencies may be understaffed to cope with the large extend of the VASE reporting and others may not realize that the side-effects are from the vaccines or they may be unable to

operate a computer. Is it then really so strange to assume that the side effects are under-reported by a factor two or ten or even 100 as the Lazarus report suggests? I think not.

On the other hand, nearly every Covid case is recorded.

So what happens when we apply the VASE to the breakthrough cases? Only 83% of the VASE cases need to be added for the efficacy to be negative for all vaccinated cases.

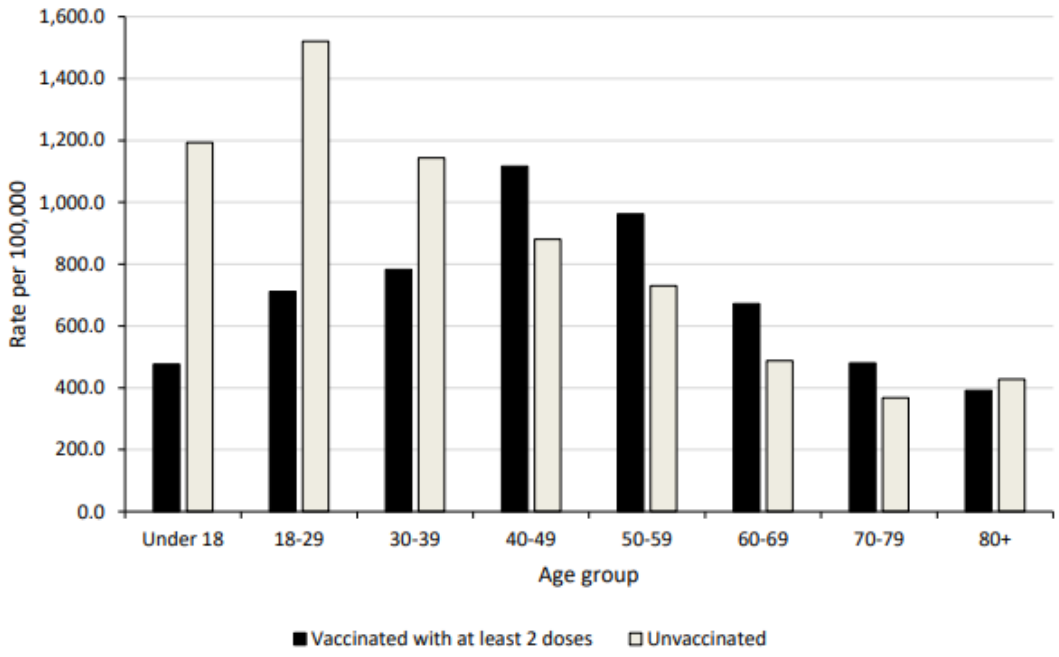
For the >50 we assume 50% of all VASE-cases. Result: only 27% of the VASE need to be added for the vaccines to be ineffective. If we add the full 1% or even 2% and 10% the efficacy becomes catastrophic.

For the <50 only 70% of 50% of the cases needs to be added for negative efficacy. At 1% it is negative 20.6 and for 2% it is negative 52.7%. At 10% the efficacy goes to negative 88.8%. In other words if there were 714.000 reported cases (2%) out of 36 million vaccinated instead of 356.000 (1%) the efficacy drops well into negative in every single group.

Disturbing in this context is figure 2 on page 18 of the VSR (Vaccine Surveillance Report also issued by PHE):

Figure 2. Rates (per 100,000) by vaccination status from week 32 to week 35 2021

(a) COVID-19 cases



Contradicting their own Technical Briefing 23 according to the VSR, above 40 years the chance of being infected for the double vaccinated appears to be 20% higher (already **negative efficacy of 20%)** instead of 49% lower. It just demonstrates how contradicting the PHE datasets in the VSR are If we would run the VASE numbers based on these rates, the efficacy would be even more catastrophic. For now we won't go that far.

Remember the outcome of the Phase 3 trials for Astra Zeneca based on which they obtained EUA:

“A further analysis of the efficacy regimens showed that when the vaccine was given as two full doses, vaccine efficacy was 62.1% (n=8,895; CI 41.0% to 75.7%), and 90.0% (n=2,741; CI 67.4% to 97.0%) in participants who received a half dose followed by a full dose. ”

Here the 62,1% and 90% were based on OVERALL efficacy for people aged 18-64. If we use the OVERALL data from PH, as opposed to the age-stratified data, the efficacy is very negative if we add the VASE in all cases but for mortality adding the VASE is not even necessary to obtain 44.8 negative efficacy. A remarkable fact.

It should be noted that AZ's study was based on approximately 44,000 participants during the wildlife virus variant, while PHE's data is about 573,000 confirmed Delta cases.

Hospitalization:

In this section the <50 make up 75% of the cases according to the PHE TB23 so we adjust accordingly. Overall if we add the VASE it becomes a negative scenario for the vaccine efficacy. Above 50 the break-off sits at 3.4% whereas under 50 only 2.3% is needed to achieve negative efficacy. If out of the 16.1 million double vaccinated 18-50 year olds 0,013% instead of 0,002% reported VASE or if the long term VASE eventually amount to this percentage , then the vaccine efficacy would be negative. If we add the VASE to the breakthroughs as we should, efficacy already drops to approx 50%. Long term VASE will drop this to unacceptable levels so would 1% under-reporting be.

Hospital	cases	% fm population/cohort	Efficacy % population/cohort
0vax <50	2,416	0.013	
0vax >50	664	0.047	
0vax ttl	3,080	0.015	
2xvax<50	453	0.002	**81.3**
2xvax>50	1,908	0.010	**79.7**
2xvax ttl	2,361	0.007	**56.3**
2xvaxx incl VASE1%	**5,352**	**0.015**	**0.9**
2xvaxx incl VASE2%	**8,343**	**0.023**	**35.3**
2xvaxx incl VASE10%	**32,271**	**0.447**	**96.6**
2xvax>50 incl Vase1% (75%)	**4,151**	**0.021**	**55.9**
2xvax>50 incl Vase2% (75%)	**6,395**	**0.032**	**32.1**
2xvax>50 incl Vase10% (75%)	**24,341**	**0.419**	**97.0**
2xvax>50 incl Vase% 3.4 (75%)	**9,535**	**0.048**	**1.2**
2xvax<50 incl Vase1% (25%)	**1,201**	**0.006**	**52.2**
2xvax<50 incl Vase2% (25%)	**1,949**	**0.010**	**22.5**
2xvax<50 incl Vase25% (25%)	**7,931**	**0.040**	**68.3**
2xvax<50 incl Vase 2.3% (25%)	**2,173**	**0.013**	**-6.9**

Mortality then:

Deaths	cases	% fm cohort	Effcy % cohort	CFR	efficy CFR
0vax <50	132	0.0007		0.05	
0vax >50	590	0.042		6.90	
0vax ttl	722	0.0035		0.28	
2xvax<50	48	0.0003	**56.8**	0.06	**17.0**
2xvax>50	1,565	0.008	**81.3**	2.17	**68.5**
2xvax ttl	**1,613**	**0.0045**	**21.5**	**1.02**	**72.6**
2xvax incl VASE1%	**3,225**	**0.009**	**60.7**	**2.05**	**86.3**
2xvax incl VASE2%	**4,837**	**0.013**	**73.8**	**3.07**	**90.9**
2xvax incl VASE10%	**17,733**	**0.049**	**92.9**	**11.27**	**97.5**
2xvax>50 incl VASE1% (90%)	**3,016**	**0.015**	**64.0**	**4.19**	**39.3**
2xvax>50 incl VASE2% (90%)	**4,515**	**0.023**	**53.9**	**6.27**	**9.1**
2xvax>50 incl VASE10% (90%)	**16,121**	**0.081**	**48.1**	**22.39**	**69.2**
2xvax>50 incl VASE4.7% (90%)	**8,384**	**0.042**	**0.2**	**11.65**	**40.8**
2xvax<50 incl VASE1% (10%)	**209**	**0.001**	**46.9**	**0.24**	**78.3**
2xvax<50 incl VASE2% (10%)	**370**	**0.002**	**70.0**	**0.43**	**87.8**
2xvax<50 incl VASE10% (10%)	**2,466**	**0.015**	**95.5**	**2.89**	**98.2**
2xvax<50 incl VASE0.4% (10%)	**112**	**0.0007**	**1.2**	**0.13**	**59.7**

The mortality table is the most significant as it shows some rather bizarre outcomes. Firstly, the CFR at 0.05% under 50 is extremely low. The Overall CFR for vaccinated is almost four times higher than the unvaccinated and although I agree that this in itself is less relevant, the EMA was issued on the basis of overall numbers (remember my comment earlier about OVERALL effectivity).

The efficacy therefore is already negative at 78.5% without adding the VASE for the Overall cases.

Vaccination Effectiveness and side-effects in the EU

For elderly a higher VASE percentage is needed to achieve negative efficacy however for elderly people the reporting is extremely low as especially over 70 and over 80 often have substantial underlying diseases. This is also evidenced by the EMA's own vaccine side-effect reporting system where the 64+ make up less than 15% of the reported side effects (ref 8) and Table 2

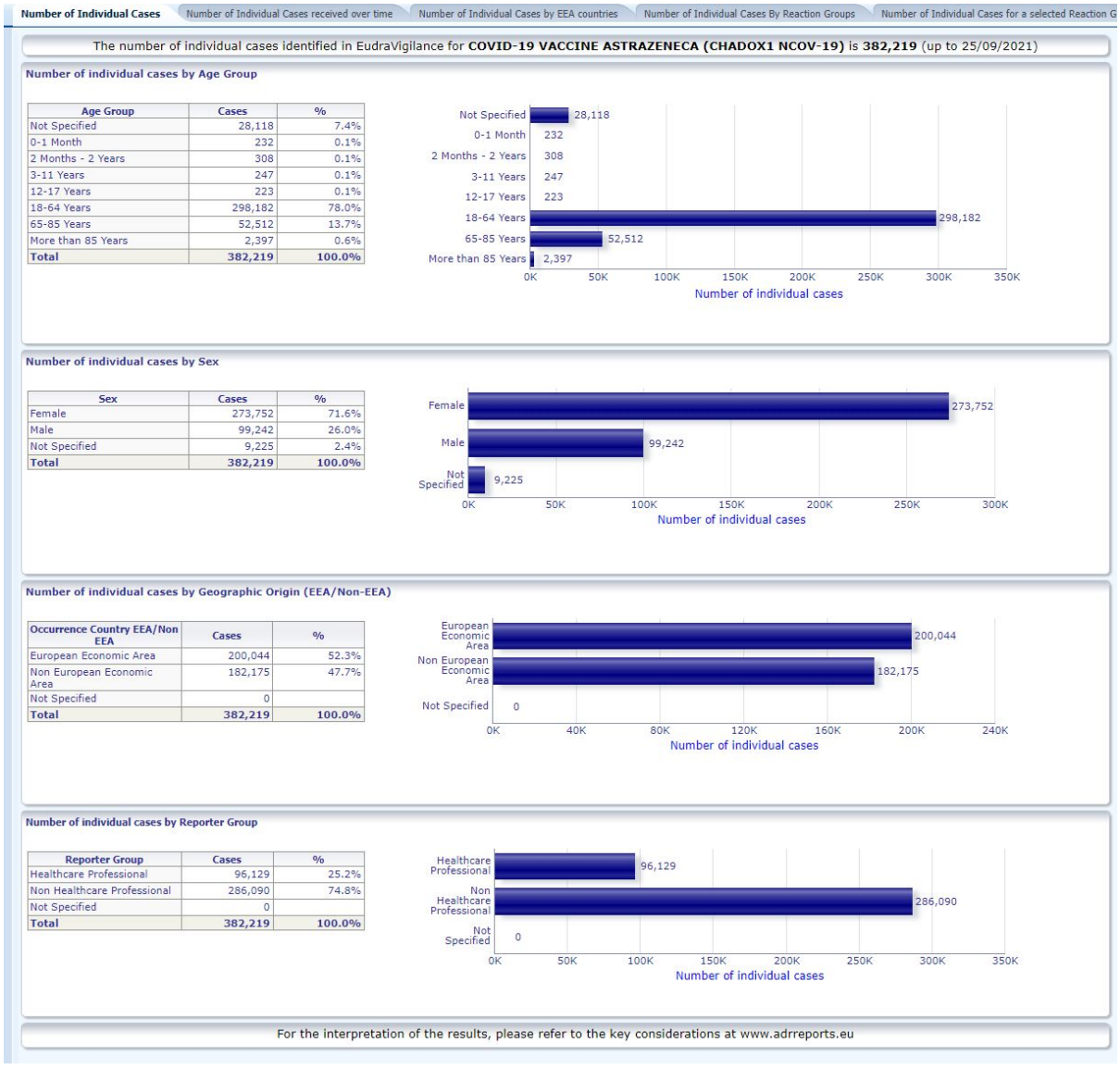
We are looking at the most recent publications of the EMA VAERS reporting via their ADR Reports website (ref 8) mentioned above. According to the ECDC European Centre for Disease Control some 61.4% of the EU population received two doses of the Covid vaccines, some 273 million people (ref 9)

Due to the size and relative complexity of the reports we won't get into too much details but we can conclude that millions of side-effects have been reported. Hundreds of thousands serious side-effects have been reported by tens of thousands healthcare workers and hundreds of thousands of individuals. The data are overwhelming.

Some screenshots:

1) <u>Age (table 2)</u>

As can be seen from below graph the over 64 for Astra Zeneca are strongly under-represented in the total number of reported side-effects. It is highly questionable that persons over 64 have 85% fewer side-effects than the younger population.



Number of Individual Cases | Number of Individual Cases received over time | Number of Individual Cases by EEA countries | Number of Individual Cases By Reaction Groups | Number of Individual Cases for a selected Reaction G

The number of individual cases identified in EudraVigilance for **COVID-19 VACCINE ASTRAZENECA (CHADOX1 NCOV-19)** is **382,219** (up to 25/09/2021)

Number of individual cases by Age Group

Age Group	Cases	%
Not Specified	28,118	7.4%
0-1 Month	232	0.1%
2 Months - 2 Years	308	0.1%
3-11 Years	247	0.1%
12-17 Years	223	0.1%
18-64 Years	298,182	78.0%
65-85 Years	52,512	13.7%
More than 85 Years	2,397	0.6%
Total	**382,219**	**100.0%**

Number of individual cases by Sex

Sex	Cases	%
Female	273,752	71.6%
Male	99,242	26.0%
Not Specified	9,225	2.4%
Total	**382,219**	**100.0%**

Number of individual cases by Geographic Origin (EEA/Non-EEA)

Occurrence Country EEA/Non EEA	Cases	%
European Economic Area	200,044	52.3%
Non European Economic Area	182,175	47.7%
Not Specified	0	
Total	**382,219**	**100.0%**

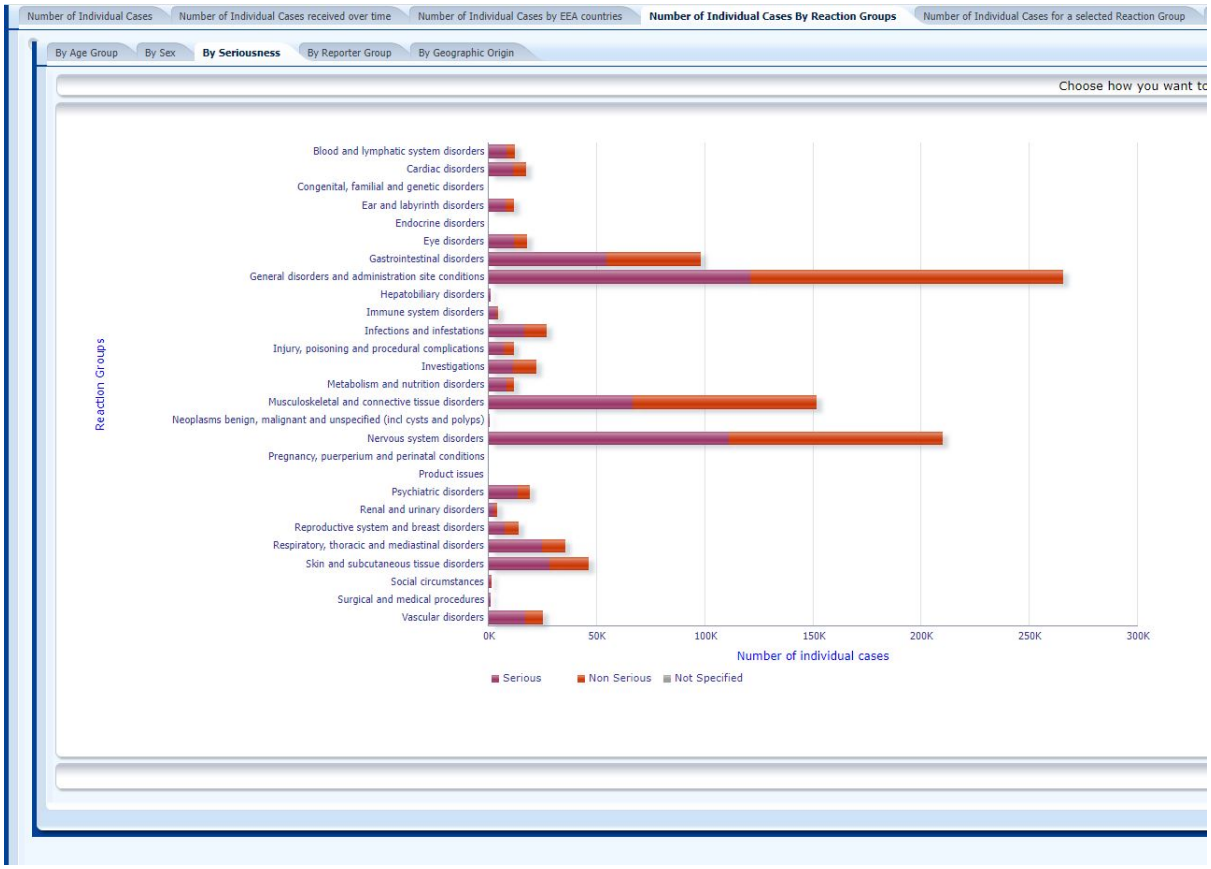
Number of individual cases by Reporter Group

Reporter Group	Cases	%
Healthcare Professional	96,129	25.2%
Non Healthcare Professional	286,090	74.8%
Not Specified	0	
Total	**382,219**	**100.0%**

For the interpretation of the results, please refer to the key considerations at www.adrreports.eu

382.000 reported side-effects for AZ alone.

2) Seriousness



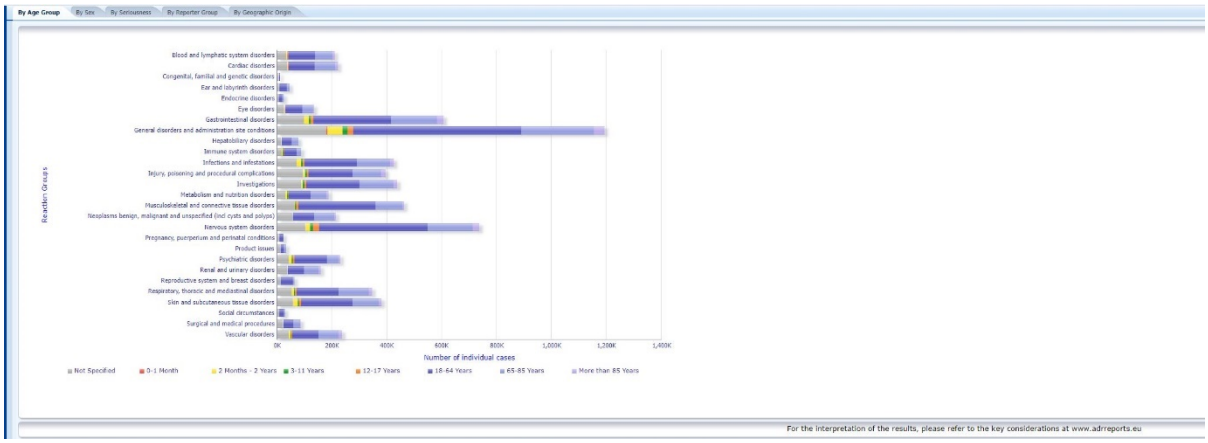
(https://dap.ema.europa.eu/analytics/saw.dll?PortalPages)

Although most reports are for younger people we see 120.000 serious nervous system reports and 110.000 serious general disorders for AZ alone. 66.000 serious Muscuskeletal disorders and 54.000 serious gastrointestinal disorders just for AZ and for 85% in the young. If we assume that 85% of the side-effects in elderly are not reported as they are misdiagnosed as underlying condition and assume only a 1% under reporting according to Lazarus then the efficacy would turn negative if we add the millions of breakthrough cases already seen in the EU already now.

These are very reasonable assumptions which require further in depth study.

Remember that RotaShield was withdrawn in 1995 because 1 to 2 out of 10.000 vaccinated developed a serious side-effect. Based on the reported cases alone in the EU 1 in 590 develops a serious side effects (about 400.000 out of 236 million) from the Covid vaccines. Were we not told these were rare side-effects?

3.) number of reported side-effects



- 1.2 million reported “general side-effects”
- 780.000 nervous system side-effects
- Over 600.000 gastrointestinal side-effects
- Millions of other reported side-effects

These are only for AstraZeneca. Pfizer’s Comirnaty sees higher numbers.

If the Lazarus report would be applied the outcome would be detrimental for the vaccine campaign in the EU. Every vaccine recipient then would have some more or less serious side-effects making them a case, creating 100% “infection” rates versus the Delta strain which shows 50% asymptomatic behavior.

The Delta variant has been diagnosed and confirmed in 593.000 symptomatic cases according to the PHE report in a 6 month period with an efficacy below 50%. One percent had to be hospitalized (6280) out of which half was partially or fully vaccinated (3.089).

65% of the population has been fully vaccinated which resulted, as a minimum in 1612 deaths and 2900 serious side-effects which we know is under-reported with a factor “X”. Based on these statistics alone, serious questions should be answered.

Unfortunately, it can only get worse as long-term side-effects and future breakthrough cases are to be included. Booster shots are unlikely to provide long term immunity yet are highly likely to create further side-effects.

Conclusion

When adding the adverse vaccine side-effects (VASE) reported at Yellow Card to the breakthrough cases, hospitalizations or death the VE becomes negative for infection regardless of age. When adding VASE to the hospitalization and death rates none or only minimal factors are needed to achieve negative VE regardless of age. As only more side-effects shall be reported when long-term side-effects are added such as ADE, auto-immune disorders and further breakthroughs due to waning efficacy, the required factor for negative efficacy shall only become lower and the threshold for efficacy disappears altogether eventually.

Considering the largest study ever undertaken in this field suggests that adverse vaccine side-effects are under reported by 99%, the accuracy of the reporting of adverse side-effects fully determines the accuracy of the SARS CoV2 vaccines. Even very limited under-reporting or moderate long-term effects will push the SARS CoV2 vaccines in the negative range.

Since minimal 50% efficacy is required for Emergency Market Authorization and this is not obtained in any case when VASE are added to the breakthrough cases, all vaccination programs against SARS CoV2 should be stopped as well as all vaccine related measures such as the heavily debated health-pass.

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27 September 2021

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