Coronavirus

# Why Is There A Correlation Between The Vaccine Rollout And Increased COVID–19 Mortality?

by Iain Davis

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A number of unusual death events have been reported in care homes across the country since the beginning of the vaccine rollout. Officially, any connection to the vaccines has been denied and they have all been taken as evidence of the spread of new variant COVID–19.

The new Coronavirus variant tale, commonly offered by the mainstream media, asserts that SARS–CoV–2 consistently evolves into an ever more dangerous iteration of itself. If that were true, it would turn decades of virology, immunology and epidemiology on its head, and in any case, as we shall see, any such claim is unsupported by the the statistics.

The so called *British variant* was first discovered in September 2020o we can look at four distinct periods to see if we can observe its effect. Let's look at the period from

the start of the alleged global pandemic to the end of the first hard lockdown.

Until 10 May 2020, the UK state tested 1,655,281 people. From this, they identified 210,500 so called *cases* (a positive test result). This resulted in 98,799 COVID–19 hospital admissions. There were 32,960 claimed COVID–19 deaths during the same period.

Therefore, the percentage chance of a test discovering an alleged *"case"* of COVID–19 was 12.7%. The claimed chance of one of these *"cases"* leading to hospitalisation was 46.9%, and the confirmed *"case"* risk of dying (Case Fatality Rate — CFR) was a staggering, and frankly unbelievable, 15.6%.

Next, we can consider the period from 11 May 2020 to 30 September 2020. During the summer months, you would expect the raw numbers for any respiratory illness to be much lower. This period takes us up the point where the new *"variants of concern"* were well established.

There were 20,738,550 tests given, resulting in 235,334 cases and 43,926 hospitalisations. A total of 9,046 people died during this period. The percentage chance of a test finding a case was 1.1%, with an 18.7% chance of subsequent hospitalisation. The CFR had dropped to 3.8%.

Now, let's look at the period of *new variant* activity up to the start of the vaccine rollout. As we were heading towards winter here, we might expect a general increase in disease contagion and severity.

Between 1 October and 9 December 2020, there were 21,218,805 tests carried out, finding 1,315,529 cases. Of these, 92,999 people were hospitalised and 21,674 died. The case discovery rate was 6.2%, the hospitalisation rate was 7.1% and the CFR was 1.6%.

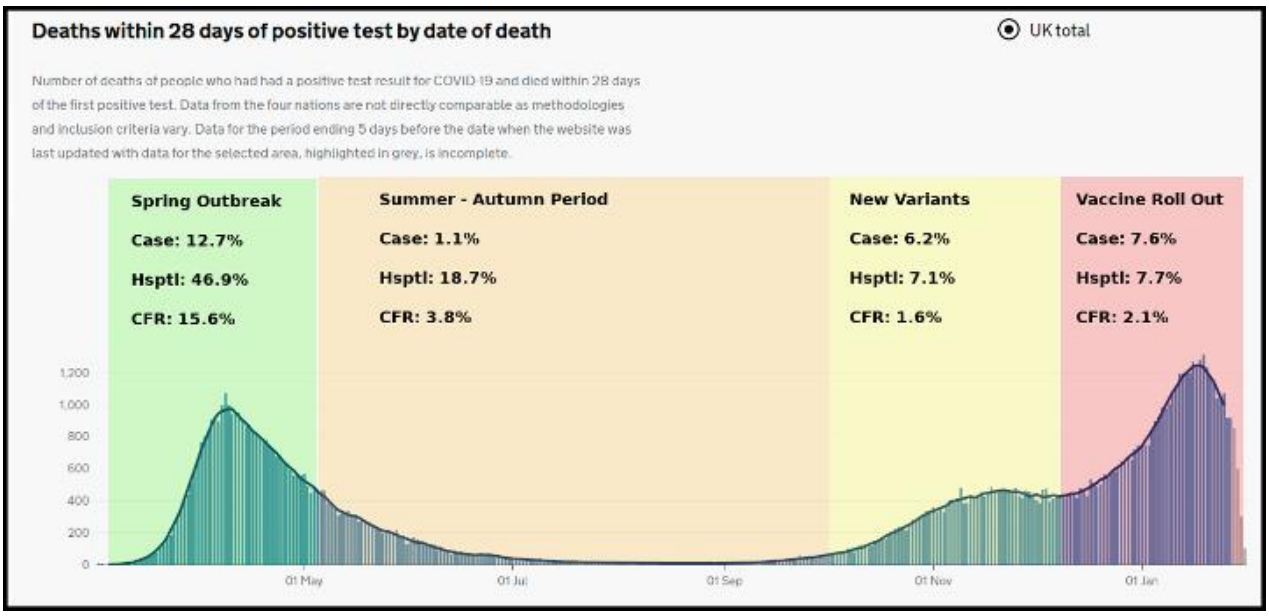
The chances of a positive test had increased, suggesting a more contagious COVID–19 variant than seen during the summer. However, the *new variants* of SARS–CoV–2 were nearly 7 times less transmissible than observed during the initial spring outbreak. The chance of hospitalisation was lower, and they were also less than half as deadly as the summer variants and nearly ten times less lethal than the spring variants.

The data shows that the new variants discovered in the autumn of 2020 were both less contagious and less lethal than the variants encountered in the initial spring outbreak. They were notably more contagious than the variants that persisted during the summer, but were far less dangerous.

Finally, let's look at the recent period since the rollout of the vaccine. From 10 December 2020 to 31 January 2021, there were 25,982,406 tests, which discovered

1,995,048 cases. This led to 154,019 hospitalisations and 42,038 so called COVID–19 deaths.

The case rate rose from 6.2% to 7.6%, continuing the trend of increasing transmission with the new prevalent variants, though it remained much lower than during the spring. Yet strangely, hospitalisation rose to 7.7% and the CFR jumped from 1.6% to 2.1%.




*UK Government - Daily COVID-19 Mortality*

These figures are very difficult to reconcile from a *new variant* perspective. During October, November and early December, the new variants had accounted for an increased rate of transmission — but significantly lower rates of hospitalisation and mortality. The disease risk trend continued to *decline*, even in comparison to former summer variants.

During the vaccine rollout, despite continued falling mortality rates in early December, the new COVID–19 variants suddenly changed behaviour. Hospitalisation rates increased by more than 8% and the mortality risk shot up by over 31%.

Harsher winter conditions are expected to account for more numbers of hospitalisations and deaths, but not to *fundamentally change the characteristics* of the resultant disease. Some other factor must have been at work during the vaccine rollout.

## Less Lethal

Viruses are effectively parasites; there is no evolutionary advantage for them to kill their hosts. Consequently, virus variants lead to new predominant strains which

infect more hosts while killing fewer of them. More lethal variants tend to lose out to less lethal ones. This is why some form of coronavirus accounts for approximately 30% of common colds.

Up until the vaccine rollout, the reduction in lethality is clearly identifiable in the statistics. So where has all the fear and alarm come from about the British, Brazilian, South African, Kent, and who knows how many more *variants*?

Once again the UK government were reliant upon their *preferred experts* at Imperial College London (ICL) for their *new variant* alarm. ICL came up with another computer simulation, showing some scary predictions about the B.1.1.7 "*global lineage variant.*"

ICL said the sub-variant of B.1.1.7 (N501Y) was up to 70% more transmissible. They were wrong again, or as usual, but the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) used ICL's *"science"* to provide some legitimacy to the governments claim that the COVID–19 pandemic was still raging.

ICL and NERVTAG designated N501Y as a *Variant of Concern (VoC)*. Amid all the panic, few seemed to notice that there wasn't any evidence that these scary variants presented any additional risk.

Writing about the newly discovered *British variant* in December, physicians from Johns Hopkins Medical Centre explained why there was no reason to panic:

> *Mutations in viruses … are neither new nor unexpected … This particular strain was detected in southeastern England in September 2020. In December, it became the most common version of the coronavirus, accounting for about 60 percent of new COVID–19 cases … We are not seeing any indication that the new strain is more virulent or dangerous in terms of causing more severe COVID–19 disease.*

Professor Michael Yeadon also observed that the notion of greater risk from variants of SARS–CoV–2 took no account of existing human immunity. Even if a variant spread more readily, it could only do so among an ever dwindling number of potential hosts.

Moreover the SARS–CoV–2 genome is vast in comparison to the tiny genetic variations that are allegedly so lethal. A recent study of T-cell immunity by Californian scientists demonstrated how the human immune system is able to adapt to the new SARS–CoV–2 variants. The scientists found:

> *By attacking the virus from many angles, the body has the tools to potentially recognise different SARS–CoV–2 variants.*

The human immune system normally defends itself against the *whole virus*, not just one specific genetic component. It does this by breaking the complete virus down into its constituent nucleotide sequences. Prepared to resist each and every one of these genetic signals, it won't be fooled by any minor genetic mutation in one spike protein. Professor Yeadon stated:

> *What is happening in the name of saving lives simply doesn't stand up to scientific scrutiny.*

It is difficult to understand how the experts at ICL couldn't work this out for themselves. The ICL team were led by Prof. Erik Volz. Just as they did after releasing their wildly inaccurate COVID–19 models in the spring, they immediately started backpedaling on their claims that the new variant was up to 70% more transmissible.

The claim of 70% increased transmission came from a comparison made between *models* for N501Y and A222V. Speaking to the COVID–19 Genomics UK (COG-UK) consortium about how these *models* worked, Volz said:

> *[The] model fit is not particularly good … there are lots of outliers early on and there are lots of outliers quite late … we wouldn't expect that a logistical growth model is necessarily appropriate in this case.*

Volz and the ICL team then used a model that was *"not particularly good"* to make the comparison anyway, adding that their simulations had to work with *"very noisy sampling."* Volz pointed out that data was limited and the *inappropriate* datasets were incomplete. He said it was too early to tell with any accuracy what the impact of N501Y might be.

None of this prevented the UK Prime Minister from using ICL's *"not particularly good"* science to allege the new variants were up to 70% more transmissible.

A media feeding frenzy ensued, with an ever growing list of variants being flung around. Perhaps emboldened by this, Boris Johnson then said the new variants were 30% more deadly too. Even the mainstream media reported the scientific objections to that one. NERVTAG stepped in to defend the Prime Minister.

While NERVTAG chair Prof. Peter Horby acknowledged there was no data to back up Mr Johnson's claim and that the risk of him being right was *"very, very small,"* he offered a weird defence on Boris's behalf.

Horby hypothesised that if the government ***hadn't*** made a baseless claim which later, by some miraculous chance, turned out to be true, they could be *accused of a cover-up*.

Notwithstanding this unfathomable argument, at the most basic epidemiological level, the *new variant* narrative was wrong. The statistics prove it. They also show that the sharp increase in mortality which correlates precisely with the COVID–19 vaccine rollout cannot easily be explained by blaming *new variants*.

## Correlation In A Data Vacuum

Correlation does not prove causation but it is reason for investigation. So perhaps we can anticipate a report from the UK Medicines and Healthcare Products Regulatory Agency (MHRA) in the coming days and weeks.

The MHRA were certainly anticipating significant numbers of adverse drug reactions (ADRs) from the COVID–19 vaccines. They tendered for an AI software solution to meet the projected need. The MHRA stated:

> *The MHRA urgently seeks an Artificial Intelligence (AI) software tool to process the expected high volume of Covid–19 vaccine Adverse Drug Reaction (ADRs) … it is not possible to retrofit the MHRA's legacy systems to handle the volume of ADRs that will be generated by a Covid–19 vaccine.*

A £1.5m contract was awarded to Genpac UK to augment the MHRA's *"Yellow Card"* vaccine ADR monitoring system. The contract was signed in early November 2020, providing Genpac UK the opportunity to upgrade the Yellow Card software in time for Phase One rollout of the COVID–19 vaccines.

The MHRA report the ADR notifications they receive through their *interactive Drug Analysis Profiles* (iDAP) system. To date, and for some unknown reason, there are no available iDAP reports for any of the COVID–19 vaccines. The MHRA state:

> *Information regarding suspected adverse reactions to vaccines is not currently available via the iDAPs but is available upon request.*

Despite numerous requests for this data, the MHRA have yet to release any information. Given the apparent correlation between increased mortality and the vaccine rollout, this is inexplicable. Clearly, the MHRA *were* anticipating a possible correlation: they invested in bespoke software to deal with the eventuality.

The MHRA informed the Financial Times that the COVID–19 vaccines had undergone *rigorous testing*. This was a disingenuous statement. None of the COVID–19 vaccine are close to completing any clinical trials. They are not licensed by the MHRA and do not have marketing authorisation.

They have been distributed in the UK thanks to legislative changes to Regulation 174 of the Human Medicine Regulations 2012 (as amended). These changes included the removal of all liability from manufacturers and distributors.

This came as a great relief to pharmaceutical corporation executives. As Gary Nabel, chief scientific officer at Sanofi, highlighted:

> *You're talking about vaccines that have potential liabilities, it's an unknown unknown. As big as a 30,000-person trial is, when these go out into the world of millions of people, things will happen.*

Mr Nabel fondly recalled the wise words of the famous vaccine developer Maurice Hilleman:

> *Every time I launch a new vaccine, I hold my breath for the first 30 million doses.*

On 8 December, Margaret Keenan became the first woman in the world to receive a COVID–19 vaccine. The UK government stated that it would take a few days to get Phase One of the vaccine rollout up and running nationally. They started publishing data on numbers of vaccinated people from 11 January 2021.

The BBC reported that all care homes in England had been offered the vaccine by the end of January. This was in keeping with a report on 27 January 2021 from the National Care Forum (NCF) that 95% of English care homes had received the vaccine. BBC Scotland reported that well over half of the care homes in Scotland had been vaccinated by 7 January. A completed care home vaccine program in Scotland also seems highly likely.

Up to 10 January 2021, the UK governments reported that 2,286,572 people *had received* their first dose inoculations. The Health Secretary Matt Hancock confirmed this figure and highlighted the government's newly published Vaccine Delivery Plan.

The Vaccine Delivery Plan was based upon the advice of the Joint Committee for Vaccination and Immunisation (JCVI). Their stated priority for the vaccine rollout in the UK was set in early December 2020, before distribution began. Care home residents and staff were the first to be vaccinated. The JCVI advised:

> *For both Pfizer/BioNTech and Oxford/AstraZeneca, the vaccine should first be given to residents in a care home for older adults and their carers, then to those over 80 years old as well as frontline health and social care workers, then to the rest of the population in order of age and clinical risk factors.*

A 2017 report from the Competition and Markets Authority estimated that there were 410,000 care home residents in the UK. Unfortunately, due to the disparate nature of mixed public and private provision, there is no official data for the

number of older care home residents. However, it is reasonable to estimate 450,000 or fewer care home residents in the UK in 2020.

Clearly the Phase One priority groups were first and foremost older residents in a care homes followed by all those aged 80 years of age or older. With nearly 2,300,000 people vaccinated by 10 January, this would seem to easily account for the 450,000 care home residents in the UK.

## The COVID–19 Vaccine Mortality Correlation

We know that 2,300,000 people had been vaccinated by 10 January in the UK. We also know that there are approximately 450,000 UK care home residents and that they were the priority for the vaccine. We also have reports of high level of vaccine coverage by the last week of January 2021.

With a vaccine rollout commencing on 8 December and first phase completion by late January, it is reasonable to surmise that the majority of care home residents had been vaccinated by mid-January. The precise extent of the coverage in a region would appear to have been largely dependent upon when the local vaccination programme began.

The Office of National Statistics estimated the UK population of over-80s to be 3,362,599 in 2019. The vaccine priority group of over-80s who live in care homes represents approximately 13.4% of the national population of over-80s.

The UK COVID–19 Vaccine Monitoring Report records the percentage of all those over 80 years old who received a COVID–19 vaccine between 8 December 2020 and 10 January 2021. By 10 January, the lowest vaccine rollout completion in England was 27.9% in the South East region, and the highest was 43.8% in the North East and Yorkshire. Again, this would appear to be more than sufficient to have completed a high proportion of care home vaccinations.

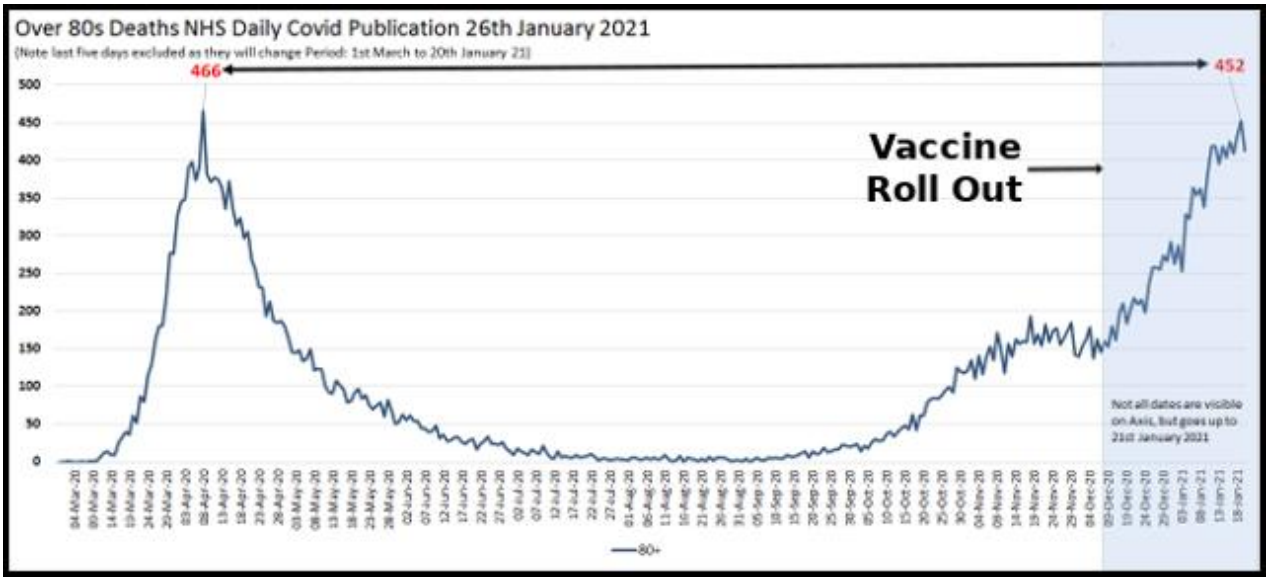
| WEEK ENDING DATE | % Vaccine uptake 80 and over (1 dose) | | | | | | |
|---|---|---|---|---|---|---|---|
| | London | South East | South West | East of England | Midlands | North East and Yorkshire | North West |
| 10/01/2021 | 29.5 | 34.82759 | 34.251966 | 27.895482 | 33.446138 | 43.808183 | 35.904141 |
| 17/01/2021 | | | | | | | |

*UK Government Vaccine Distribution for the Period 08/12/20 - 10/01/21*

By 19 January, the Care Quality Commission were reporting a 46% jump in COVID–19 care home deaths in England. They said the increase in cases was in line with the

community spread of infection. They didn't mention that it was also inline with the *community spread of vaccines*.

It is possible that some unknown *new variant* may account for this, but statistics from the NHS for mortality in the over-80s age group also reveals a clear correlation between a sharp increase in mortality and vaccine distribution. As discussed above, this increase followed a period of declining mortality in the same age group. Known variants do not explain this.




*NHS England COVID-19 Mortality 01/03/20 - 20/01/21*

On 19 January, *Vaccine Deployment Minister* Nadhim Zahawi said that the vaccine rollout was *"a race against deaths."* He claimed that half of England's care home residents were yet to receive the vaccine. He didn't mention that many vaccinated care homes had also seen an increase in mortality.

Pemberley House care home in Basingstoke suffered a lethal outbreak that coincided with their vaccination rollout. Although 22 residents died, the MHRA said the vaccines were not responsible. An unnamed spokesperson from the MHRA said:

> *We are saddened to hear about any deaths which have occurred since receiving Covid–19 vaccination. However, our surveillance does not suggest that the Covid–19 vaccines have contributed to any deaths.*

That *surveillance* is the Yellow Card system. The MHRA's *surveillance* amounts to someone reporting a suspected vaccine ADR to them. Allegedly, the MHRA then make a note of the ADR. However, unless they then launch an investigation, order a post mortem, analyse blood samples, speak to witnesses and so on, their *surveillance* amounts to next to nothing.

There is no evidence that any investigation occurred for any of the residents who died in the Pemberley care home following the vaccine rollout. Absent an investigation, the MHRA's *surveillance* based confidence is meaningless. Their

statements seem like a platitudes rather than indicating any genuine concern, or even interest.

The definition of a COVID–19 death in the UK is death from any cause where COVID–19 was mentioned on the death certificate in the last 28 days. This means the decedents tested positive for the SARS–CoV–2 virus within 28 days of death, not that they necessarily had COVID–19 disease.

Lockdown critics and those sceptical of the government's COVID–19 statistics have long argued that there is frequently no clear evidence that a death attributed to COVID–19 wasn't caused instead by other underlying comorbidities. For this, they have been accused of being heartless and uncaring, indifferent to COVID–19 deaths.

In a subsequent article reporting 24 deaths at Pemberley and another nine at Seagrave House care home, an MHRA spokesperson was quoted as saying:

> *It is not unexpected that some of these people may naturally fall ill due to their age or underlying conditions shortly after being vaccinated.*

If someone dies within 28 days of a vaccination, it is *never* considered a vaccine death. Without a post mortem, we can't know that a death was caused by a vaccine. The same could be said for COVID–19 as a cause of death. However, if the government used the same 28-day qualifying criteria for deaths following vaccines, many suspected vaccine deaths would be recorded and reported.

By 17 January, the Norwegian Medicines Agency had reported 33 fatal suspected vaccine ADRs, but none of these were related to the vaccine; the 55 post-COVID–19 vaccine fatalities reported to the U.S. Vaccine Adverse Event Reporting System (VAERS) were all unrelated to the vaccine; the deaths of two Danish vaccine recipients, were also unrelated, as was the death of a 41-year-old Portuguese nurse who died two days after her vaccine; no vaccine blame was attributed following the death of an Orange County, California, health worker after his vaccine, whose widow — remarkably — allegedly said he would take the vaccine again; when a 32-year-old Mexican doctor suffered catastrophic inflammation of the brain after receiving his vaccine, this had nothing to do with his jab; and when a Miami obstetrician became unwell after his vaccine and died soon thereafter of resultant ITP, a known vaccine side-effect, this wasn't attributable to the vaccine either.

In the U.S., the St. Anthony nursing home (Auburn, New York) reported an outbreak of COVID–19 which started on 21 December. 32 residents died, with 20 dying in one week between the 5 and 12 January. Their vaccination programme started on 22 December, though this had *nothing to do with any of the deaths*.

When twelve people died and 51 were infected in a COVID–19 outbreak at West Park Care Home in Fife in Scotland, STV news reported that this followed the residents' inoculation with the COVID–19 vaccine. NHS Fife's director of public health, Dona Milne, spoke about the *significant strides* they had made in the county to protect the *most vulnerable* with their completion of the first round of vaccinations in care homes.

Yet other media reports of the same cluster of COVID–19 deaths in the same care home made *no mention* of the vaccinations. They reported full lockdowns, emergency situations and alarming COVID–19 death tolls. They spoke to NHS teams and local public health officials — but omitted to report that all of the deceased had almost certainly been vaccinated.

How did they know the correlation was irrelevant? Why didn't they think it was in the public interest to report this?

On both sides of the Atlantic, the mainstream media are extremely reticent about even hinting at any criticism of vaccines. In order to encourage black and minority ethnic communities in the U.S. to take the vaccination, ABC News reported Baseball legend Hank Aaron's vaccination. When he sadly passed away two weeks later, the mainstream media eulogies forgot to mention his much-publicised promotion of COVID–19 vaccination. The original story from ABC News was then removed from their archives.

Consequently, we would be foolish if we didn't consider what other crucial facts may have been omitted from reports of sudden fatal outbreaks in UK care homes. Are the claims that these occurred *before vaccination programmes were underway* credible?

On 19 January 2021, the *Guardian* reported a significant cluster of deaths in a Lincolnshire care home. They stated that 18 of 27 residents at The Old Hall Care Home died *in the run-up to Christmas.* They noted that *"the deaths were so sudden [that] staff did not have the chance to administer end-of-life treatment or arrange for loved ones to say goodbye."*

Four days earlier, on 15 January, a BBC report of the same deaths stated that the Old Hall residents were anticipating receiving the *life-saving* vaccine. The *Guardian* made no mention of vaccination and the BBC were keen to stress that none of the decedents had been vaccinated. It seems there was no correlation in this case. However, the mainstream media's frequent expediency with the truth, especially when it comes to vaccines, prompts doubt.

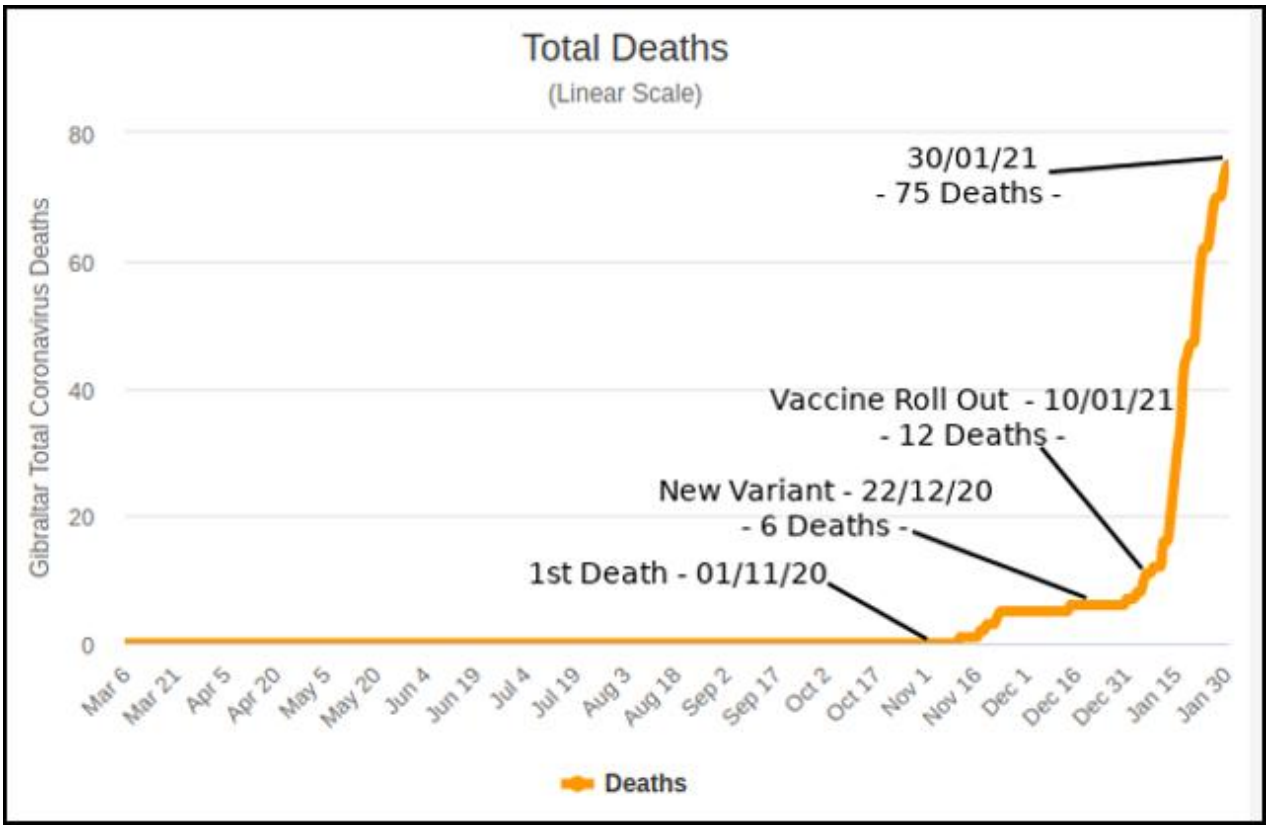
The NHS reported that Lincolnshire was one of the first counties in the UK to commence the vaccine rollout. It was an early adopter, with its programme starting

on 8 December 2020, the same day that Margaret Keenan received her vaccine. If the Old Hall residents had *not* been vaccinated, it seems they were among the unlucky few.

## Death on the Rock

The British overseas territory of Gibraltar provides a study in microcosm. Government of Gibraltar COVID–19 statistics show that their first case was recorded on 18 March 2020, with the first death occurring on 1 November. Total deaths had risen to six by 22 December, when the new B.1.1.7 variant was first identified. Between 22 December and 10 January, the *new variant* accounted for a further six deaths, bringing the total to 12.

Gibraltar started its vaccine rollout on 10 January 2021. By 30 January 2021, COVID–19 mortality on the Rock had risen to 75. This constituted a **525%** increase in the death rate over a twenty-day period, following nearly ten months of prior infections carrying off a handful. This order-of-magnitude increase corresponded precisely with the vaccine rollout.




*Gibraltar Mortality Statistics from virusncov.com*

Speaking on 29 January, with the death count standing at 73, the Chief Minister of Gibraltar gave a press conference. Having expressed his sorrow, and mourning *"the highest toll in lives arising from one cause"* in Gibraltar's history, the Chief Minister

encouraged the press to see this catastrophe in context. He then informed the press:

> *In Gibraltar we have now finalised the first dose inoculation of the four most at risk cohorts and the frontline … We are now starting to provide the second dose to our four priority categories … We will tomorrow receive a further delivery of the Pfizer vaccine for this purpose, once again on the wings of the RAF angels.*

The Fact-Checkers were quick to deny any link to the vaccines. They cited a statement from the Government of Gibraltar, which claimed only six vaccinated individuals died. This claim was not a fact.

The Chief Minister said their vaccination programme followed the JCVI priority. In just nineteen days, they had *finalised the first dose inoculation of the four most at risk cohorts.* That means every Gibraltarian over the age of 70 and those at high clinical risk were vaccinated.

Report after report in the local media described how the Elderly Residential Service was destroyed by the deaths that began mounting rapidly on 10 December. As just one example, on 17 January, with 13 dying in two days, the Gibraltar Chronicle reported:

> *All but three of those who died this weekend were in the care of the Elderly Residential Services. The youngest in their early 70s, the eldest in their late 90s. All were recorded as being deaths from Covid–19.*

Speaking on 26 January, Chief Minister Fabian Picardo said:

> *These Gibraltarians who are sadly losing their lives to this virus are the same people who have survived the evacuation.*

The evacuation of Gibraltar took place in the summer of 1940.

The next day, Fabien Picardo claimed that just six of the 61 people who died in the 19-day period between the start of the vaccine rollout and his wholly unbelievable statement had been vaccinated. This despite the fact that a total of *twelve* Gibraltarians had died of COVID–19 in the previous ten months.

The Fact-Checkers checked nothing, researched nothing, and simply used Picardo's spurious assertions to defend the vaccine rollout. In doing so, like the MHRA, they genuinely exhibited a callous disregard both for the truth and the lives lost. They weren't in the least bit interested.

It is possible, if unlikely, that the marked and rapid increase in mortality seen in COVID–19 affected communities around the world *may* be explained by new

variants. But it appears, wherever you look, that a dramatic mortality increase correlates with COVID–19 vaccination programmes.

The numerous anomalies and contradictions suggest we aren't being given the full story. If vaccine adverse reactions were expected, where are they?

Correlation does not prove causation — but ignoring correlation signifies denial. We should not be afraid to ask a perfectly legitimate question:

Why is there a correlation between the vaccine rollout and increased COVID–19 mortality?

*[You can read more of Iain's work at In This Together]*

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