Coronavirus

Why We Must Question Vaccine Efficacy And Safety Claims

by IAIN DAVIS

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The BBC claims that vaccines have reduced mortality by 95%. They state:

> But the actual number of people dying would be much lower - a 20th as many as if no-one was vaccinated, according to PHE estimates.

They add the Public Health England (PHE) *"estimate"* that 27,000 lives have been saved. Politicians, for example the New Health Secretary Sajid Javid, have made similar claims. They assert that vaccines efficacy is proven and that they are known to be safe.

All claims, no matter who makes them, must be supported by evidence.

In this case, when we look at the evidence allegedly *"proving"* vaccine efficacy and safety, there are many unresolved questions. It seems these claims cannot be *trusted*. There are reasons for doubt.

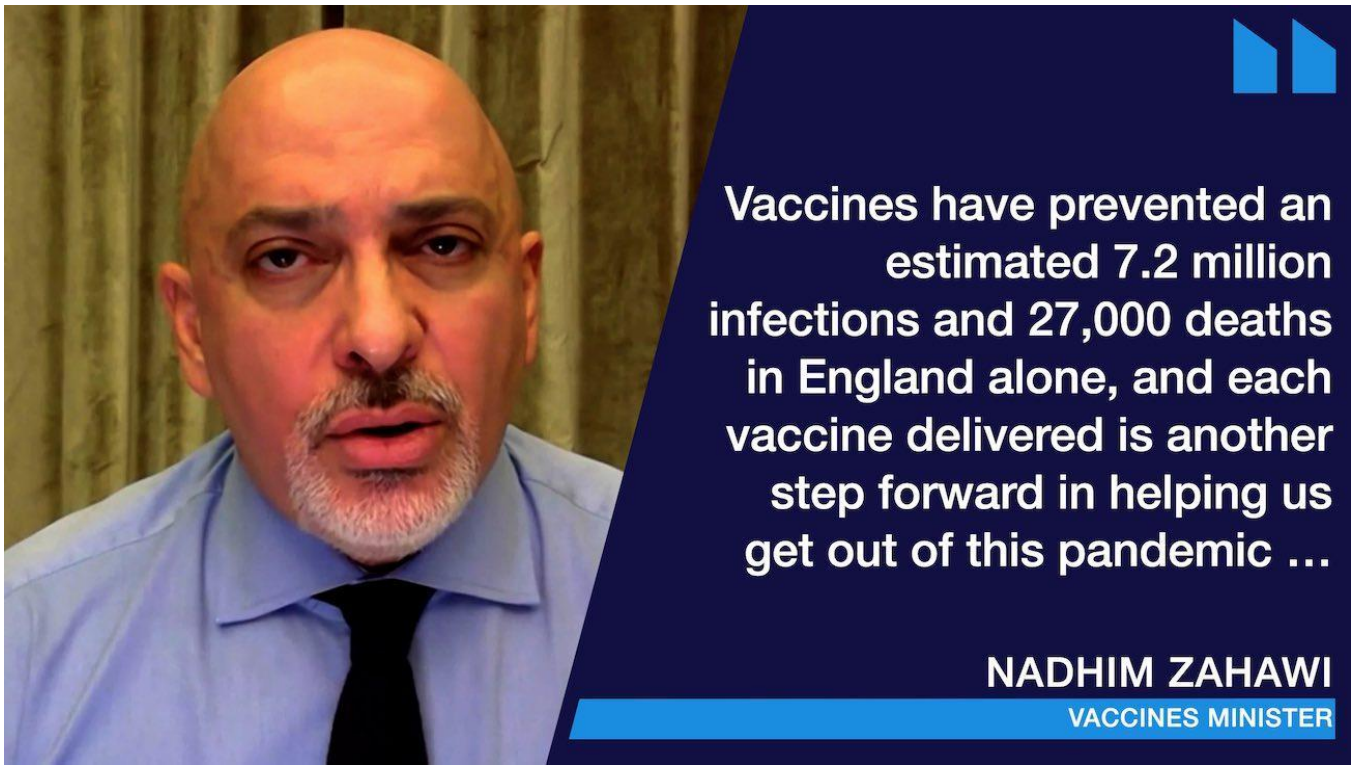
The BBC proclamation is based upon the models of the PHE and MRC Biostatistics Unit's COVID-19 working group (PHE/MRC).

The PHE/MRC have created the PHE/Cambridge real-time pandemic surveillance model. Using this model they claim the vaccination programme has prevented between 6.4 and 7.9 million infections

and 26,100 and 28,400 deaths in England alone. The PHE/MRC add:

> The total was calculated by comparing the estimated impact of vaccination on infection and mortality against a worst-case scenario where no vaccines were in place to reduce infections and mortality.. Vaccination rates in the model are based on the actual number of doses administered, and the vaccine is assumed to reduce susceptibility to COVID-19 as well as mortality once infected.

This is an estimate, based upon assumptions, compared to a model of a worst case scenario. So the question is, what are the assumptions informing the *"worst case scenario"* and the subsequent claims about lives saved? Are these assumptions reliable and is there clear clinical evidence to substantiate them?



The PHE/MRC have created their Nowcast and Forecast model. This is where we find the initial assumption:

> Vaccine efficacy is assumed against both infection and death, using values for the efficacy in agreement with those found here [PHE Covid-19 Vaccine Surveillance Reports]

This assumption is based upon Public Health England's Covid-19 Vaccine Surveillance Reports.

In these reports PHE state that they work with the Medicines and Healthcare Regulatory Agency (MHRA), NHS England and other government and academic partners. They claim the safety of the Covid-19 vaccines is continually monitored by the MHRA who have judged that the benefits of the vaccine outweigh the potential risks. This judgment has been made in keeping with the Covid-19: Vaccine Surveillance Strategy.

In the PHE report, Public Health England claim:

> Several studies of vaccine effectiveness have been conducted in the UK which indicate that a single dose of either vaccine is between 55 and 70% effective against symptomatic disease, with higher levels of protection against severe disease including hospitalisation and death. Additional protection is seen after a second dose. There is now also evidence from a number of studies that the vaccines are effective at protecting against infection and transmission.

PHE introduce vaccine effectiveness by stating:

> Large clinical trials have been undertaken for each of the COVID-19 vaccines approved in the UK which found that they are highly efficacious at preventing symptomatic disease in the populations that were studied.

They don't link to these *large clinical trials* in the surveillance report, so we are left uncertain. Presumably, PHE are referring the vaccine clinical trials. It seems odd that they don't cite them.

The clinical trials for the vaccine include the Pfizer and BioNTech trial of BNT162b2 (NCT04368728), which is still in the recruitment phase, AstraZeneca's AZD1222 (or ChAdOx1-S) trial (NCT04516746), due to be completed in February 2023, Moderna's mRNA vaccine phase III trial (NCT04470427), which should be concluded by October 2022 and Johnson & Johnson's *Janssen* trial (NCT04614948), which will hopefully near completion in May 2023.

No Results, No Control

There are no results posted for any of these trials, so it is difficult to understand how PHE can possibly know that the vaccines are *"highly efficacious."* Similarly, without completed clinical trials for the vaccines, and no published clinical trial data, it is also a mystery how the MHRA have been able to judge that they are safe.

The British Medical Journal were among those who recognised that the vaccine trials were, in any invent, incapable of assessing either efficacy or safety. Some interim trial results are available but the Lancet reported that these suffered from selective use of data, inconsistent disease definition, evident bias and the trial protocols differed between vaccines, even changing mid trial in some instances. With mixed endpoints, it wasn't clear from these interim analysis who were the primary beneficiaries of the claimed *efficacy*.

The vaccine's clinical trials were all designed to be randomised control trials (RCTs). Safety and efficacy was meant to be measured by comparing the outcomes of the vaccinated cohort against those of a control group, who did not receive the vaccine. All of the various vaccine trial protocols were designed to assess these outcomes over a two to three year period.

However, long before they were due for completion, the studies were apparently *unblinded*. The pharmaceutical corporations have seemingly administered the vaccine to their placebo control groups. This means that none of the current Covid-19 vaccines are subject to randomised control trials as claimed. The British Medical Journal stated:

> The BMJ asked Moderna, Pfizer, and Janssen (Johnson and Johnson) what proportion of trial participants were now formally unblinded, and how many originally allocated to placebo have

> participants were now formally unblinded, and how many originally allocated to placebo have now received a vaccine. Pfizer declined to say, but Moderna announced that 'as of April 13, all placebo participants have been offered the Moderna covid-19 vaccine and 98% of those have
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> received the vaccine.' In other words, the trial is unblinded, and the placebo group no longer exists. Janssen ... confirmed it was implementing an amended protocol across all countries to unblind all participants in its two phase III trials.

PHE claims of *between 55 and 70%* efficacy cannot be based upon the vaccine clinical trial data, as there isn't any, and the available interim analysis is pretty shoddy stuff. So what is the basis for this conclusion? For this they cite some observational studies and their own surveillance reports. In other words the PHE claims are largely based upon their own, self referenced, reports.

For example, Public Health England's own study considered observations of the effectiveness of the Pfizer-BioNTech and Oxford-AstraZeneca vaccines on symptoms, hospital admissions, and mortality in older adults in England. The researchers pointed out that those initially vaccinated with the Pfizer vaccine faced *"higher odds of testing positive for covid-19 in the first nine days after vaccination"* than the unvaccinated.

The researchers assessed that this was because the early adopters were those most at risk from Covid-19. They considered those who later received the AstraZeneca vaccine to be at marginally less risk as they weren't as *vulnerable* as the initial Pfizer recipients. They therefore adopted a *"stratified approach"* for their analysis of the vaccinated.

They then studied hospitalisation within 14 days of a positive test result. For the vaccinated they calculated the hazard ratio. This broadly indicated the different degree of the risk faced by the subject under study.

According to the PHE study, the lowest hazard ratio for Pfizer was 0.48 but for Atrazeneca it was 0.41. The researchers then inferred additional hazard protection for the vaccine recipients, based upon these ratios. However, they didn't undertake any hazard ratio analysis for the unvaccinated so these comparisons were meaningless.

Those over 80 who were unvaccinated had a 15.35% chance of hospitalisation, the Pfizer recipients, who had been vaccinated in the last 14 days, had 14.06% chance and the AstraZeneca subjects a 11.06% chance. For those who had been vaccinated more than 14 days before a positive test with Pfizer, hospitalisation chances dropped to 9.14%, and for AstraZeneca it was 7.14%.

This appears to be one source for the *"55 - 70% efficacy"* claimed by PHE. However, it is an observational study, not a clinical trial, so this cannot be the *large clinical trial* which shows the vaccines to be "*highly efficacious.*"

The study also compared mortality within 21 days of a *"positive COVID - 19 test."* For the unvaccinated over 80's this was said to be 13.3%, for the Pfizer vaccine it was 10.4%, within 14 days of vaccination, and 6.8% more than 14 days after vaccination.

PHE's observational study appears to show hospitalisation and mortality efficacy for those vaccinated with both the first and second doses of Pfizer jab and hospitalisation efficacy for the first AstraZeneca dose. However, as the Astrazeneca roll out occurred later than distribution of the Pfizer jab, researchers did not have time to assess the impact of the Astrazeneca second dose on mortality. There are some major, additional caveats.

Risky PCR

As we do not know the hazard ratio for the unvaccinated, it wasn't clear if the PHE study compared like with like, in terms of risk. More importantly the study relied upon a definition of a Covid-19 *"case"* based upon positive RT-PCR tests.

RT-PCR is a test for nucleotide sequences specified in the WHO Protocols for RT-PCR testing, with the relevant sequences identified in a January 2020 paper by *Cormen - Drosten et al*. These nucleotide sequences are said to be unique to the SARS-CoV-2 viral genome. Yet research by the Spanish medical journal D-Salud showed that the *Cormen - Droston* sequences (primers and probes), stipulated in the WHO protocols, did not appear to be unique to the SARS-CoV-2 published genome.

Scientists have issued a formal request that the Cormen - Drosten paper be withdrawn pending genuine scientific validation. The *Corman-Drosten Review Report* found seven serious scientific flaws in the study.

The primers were inaccurate, non specific and inadequate; the binding (annealing) temperature used in the study was too high, again giving non-specific results; the study used 45 PCR amplification cycles, meaning the RT-PCR identified nothing but genetic background noise; there was no bio-molecular verification of the results and no controls applied to viral detection; no standardised operating procedures were described to enable others to repeat the experiment and the study design was imprecise, greatly increasing the chances of false results.

The Corman-Droston paper was submitted for review on 21st January 2020, accepted on the 22nd and published on the 23rd. Proper peer review did not seem possible. The paper was first published in Eurosurveillance and two of the study's lead authors, Christian Drosten and Chantal Reusken, were members of the Eurosurveillance editorial board.

Currently the UK government claim they have conducted 209 million PCR tests from which 4.8 million were *positive*, representing 2.3% of tests. The UK Scientific Advisory Group for Emergencies (SAGE) estimated the RT-PCR false positive to vary between 0.8% - 4.0% with a mean false positive rate of 2.3%.

Therefore, at the lower estimate, 1.7 million of the alleged 4.8 million *"cases"* could be false positives. As we approach the mean, it is possible that none of the claimed *cases* are based upon genuine positives.

It isn't quite that straightforward because the government state that their test numbers include multiple tests of the same individuals and, latterly, they have also included lateral flow tests.

So the 4.8 million positives almost certainly accounts for a higher percentage of *"individuals tested."* Unfortunately the government have not said how many duplicate tests there are and so we don't know the full *false positive* picture. Nonetheless, it is significant and this has massive implications for observational studies, such as those cited by PHE, which base their assumptions of *"case numbers"* upon RT-PCR tests.

Most importantly, an RT-PCR test is not a test for a disease. The degree to which it can be said to accurately identify the presence of the virus is highly dubious, but it absolutely cannot identify the subsequent disease of Covid-19. In no way can you claim, as PHE have, that a positive RT-PCR test *"confirms"* a *"case"* of Covid-19. Their claim of 55 - 70% effective is looking increasingly dubious.

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Another paper PHE referenced was based upon the UK Covid-19 Infection Survey (CIS). The CIS attempts to measure the prevalence of SARS-CoV-2 antibody responses in the population. PHE cited one of two comparative studies, which used CIS data, to compare the antibody response elicited by

the Pfizer and AstraZeneca vaccines to those following infection without the vaccines. The findings, reported by the BMJ, revealed:

> 21 days after a single dose of either the AstraZeneca or the Pfizer vaccine the rates of all new SARS-CoV-2 infections had fallen by 65%...Among people who had a second dose of the Pfizer vaccine, infections were 70% lower and symptomatic infections 90%, similar to the effects in people who had previously been infected naturally (70% and 87% reductions, respectively).

This indicated that there was no appreciable difference to SARS-CoV-2 *immunity* between those vaccinated and those who had been naturally infected with the SARS-CoV-2 virus. The difference was that those who were naturally infected faced the risk from the disease (Covid-19). These were seemingly reduced, but not eliminated, by vaccination. However the vaccinated also faced the additional risk from the vaccine.

Understanding the Risk

It is therefore vital to understand the risk from the vaccine to calculate the relative risk/benefit profile of the vaccines compared to natural infection. None of the studies cited by PHE considered this risk. They assume that the MHRA's judgement that the vaccines were safe was based upon a thorough evaluation. As we shall see, it was not.

On April 30th 2021 the UK government launched a committee review of the evidence surrounding the proposed vaccine passports. In the corresponding press release they stated:

> Vaccine certificates' would provide proof of vaccination to confirm an individual is at lower risk of suffering severe covid symptoms. However it is not yet known what effect the vaccine has on transmission.

Five months into their vaccine roll out the UK government still had no idea what the effect the vaccines had on transmission. The reason they didn't know was because there are no completed clinical trials for the vaccines.

PHE's description of how they calculated the impact of the vaccines on infections and transmission leave many questions unanswered. Speaking about infections they state:

> Although individuals may not develop symptoms of COVID-19 after vaccination, it is possible that they could still be infected with the virus and could transmit to others ... In order to estimate vaccine effectiveness against infection, repeat asymptomatic testing of a defined cohort of individuals is required.

PHE are referencing so called *asymptomatic* transmission. This is something they *assume* to be real in their observational studies and models.

The Myth of Asymptomatic Spread

The Wuhan University of Science and Technology carried out screening on nearly 10 million Chinese

The Wuhan University of Science and Technology carried out screening on nearly 10 million Chinese citizens in Wuhan. Of the of the 9,865,404 participants without any previous history of COVID-19, a mere 300 were identified as being positive and *asymptomatic*. 1,174 close contacts of the

asymptomatic positive cases were tracked and traced. None of them tested positive. The scientists concluded:

> There was no evidence of transmission from asymptomatic positive persons to traced close contacts. There were no asymptomatic positive cases in 96.4% of the residential communities.

Of the 34,424 people previously diagnosed with COVID-19, 107 (0.310%) subsequently tested positive again, but all of them were *asymptomatic*. All of the asymptomatic cases, with an age range between 10 and 89, had low viral loads. There was no reason or evidence to suggest they would infect anyone or redevelop symptoms of Covid-19.

A study conducted in the Republic of Ireland, published in May 2020, found no evidence of secondary transmission of Covid-19 from children attending school in Ireland. A meta-analysis of studies looking at SARS-CoV-2 transmission in and between households, conducted by the Department of Biostatistics at Florida State University, also found extremely limited evidence of *asymptomatic* transmission among all age ranges. They considered 54 transmission studies collectively analysing 77,758 *"cases."*

From these they calculated the secondary attack rate (SAR). This is the likelihood of infection occurring within specific group under a defined set of circumstances, in this case households living in overcrowded conditions. The Florida researchers found the following:

> Estimated mean household secondary attack rate from symptomatic index cases (18.0%...) was significantly higher than from asymptomatic or presymptomatic index cases (0.7%) ... These findings are consistent with other household studies reporting asymptomatic index cases as having limited role in household transmission ... The lack of substantial transmission from observed asymptomatic index cases is notable.

The 0.7% chance of *asymptomatic transmission* was negligible. This figure was for both *asymptomatic* (low viral load) and *presymptomatic* (higher viral load) infections combined.

An analysis of 73 studies, collectively evaluating 5,340 test subjects, ascertained that viable viral shedding (transmission of the virus in high enough load to infect someone else) was short lived among people with symptoms. The researchers stated:

> Duration of viable virus is relatively short-lived. SARS-CoV-2 titres in the upper respiratory tract peak in the first week of illness.

Professor Michael Yeadon explained what this meant:

> In order to be a good source of infection, you need to have a lot of virus in your airway.. If you only have a little bit of virus ... the chances that you are going to infect someone else are very low.. Here is the critical point. People with lots of virus in their airway will have symptoms. No question, no arguments.. That's because the virus is attacking the lining of your lungs.. People without symptoms can't have much virus.. People without symptoms can't infect other people.

During a June 2020 press briefing, Maria Van Kerkhove, the WHO's technical lead for the COVID-19 pandemic, made it abundantly clear that asymptomatic transmission was very rare:

> We have a number of reports from countries who are doing very detailed contact tracing. They're following asymptomatic cases, they're following contacts, and they're not finding secondary transmission.. it's very rare, and much of that is not published in the literature.

Just one day later, Dr. Mike Ryan, executive director of the WHO's emergencies program, back-pedalled swiftly claiming that Van Kerkhove's statement was *"misinterpreted."* For her part, Dr. Van Kerkhove was clear about what she meant. She responded to the comments of Dr Ryan by conceding that the *"models"* show asymptomatic spread but that real world data did not.

The Sound of a SIREN

The PHE/MRC *Nowcast and Forecast* model assumes that the PHE surveillance figures for reduced infection and transmission, are correct. PHE surveillance also cites the SIREN study. This said nothing at all about transmission of the virus but claimed more than a 70% reduction in infection rates following two doses of the Pfizer vaccine. Again, this appears to be a source for the PHE claim of up to 70% effectiveness.

SIREN allegedly evaluated infections among 20,641 vaccinated and 2,683 unvaccinated health workers. They monitored each group at two-week intervals for a number of months. They then calculated the total accumulated number of days each cohort had been monitored, divided that by the number of positive RT-PCR results per cohort, to derive a figure of incidents per 10,000 days cumulative monitoring.

For the unvaccinated this was said to be 14 incidents per 10,000 days and for the vaccinated this dropped to 4 incidents per 10,000 days, following the second dose. Subsequently the SIREN scientists reported:

> Our study demonstrates that the BNT162b2 vaccine effectively prevents both symptomatic and asymptomatic infection in working age adults; this cohort was vaccinated when the dominant variant in circulation was B1.1.7 and demonstrates effectiveness against this variant.

The problem with the SIREN study is that they did not appear to monitor both groups using the same method. The study stated that they would follow up the vaccinated cohorts for 59 days post first dose and 39 days post second dose: the periods where the vaccinated were effectively at risk of possible infection.

In order to make a meaningful comparison with the *unvaccinated*, the amount of time they were exposed to potential infection, hazard and risk would need to be the same.

However, the data reported in the study does not seem to correspond to the proposed study design. The 2,683 unvaccinated subjects were monitored for a total of 710,587 cumulative days, which appears to equate to approximately 265 days per unvaccinated study subject.

The study seems to show they monitored the 20,641 vaccinated subjects for a total of 108,256 days,

equating to 5.25 days per vaccinated study subject.

It appears that the unvaccinated were exposed to potential infection, health hazards and risks far longer than the vaccinated cohort. The unvaccinated were seemingly monitored continuously throughout the entire trial and the vaccinated were monitored in specific monitoring windows.

The SIREN study was assessing health workers. This apparent disparity in the duration of monitoring suggests that the unvaccinated were more likely to come into contact with SARS-CoV-2 positive patients, had a higher risk overall than the vaccinated cohort and faced additional health hazard. Consequently the chances of the unvaccinated group returning positive test results or falling ill were considerably higher than for the vaccinated group.

This requires explanation. If this was the case, as the data suggests, then the results from the SIREN study for the Pfizer vaccine were *"null."* No conclusion can be drawn, suggesting that the SIREN scientists' claim that vaccines reduced infection rates were unfounded.

What About Antibodies?

PHE report that:

> Based on antibody testing of blood donors, 79.1% of the adult population now have antibodies to COVID-19 from either infection or vaccination compared to 14.8% that have antibodies from infection alone. Over 98% of adults aged 50 or older have antibodies from either infection or vaccination.

There is no distinction here between antibodies gleaned from vaccination or from natural infection. Consequently the PHE assessment of vaccine effectiveness in reducing transmission is unusual:

> As described above, several studies have provided evidence that vaccines are effective at preventing infection. Uninfected individuals cannot transmit; therefore, the vaccines are also effective at preventing transmission.

Yet five months into the vaccine roll out the government said they didn't know what impact the vaccines had on transmission. Do they believe PHE or not?

The PHE assumption is based upon a *claimed* proof for the effective reduction of infections, not on clinical trial data. Their claims about reduced transmission are equally questionable. Perhaps this explains government hesitancy. The evidence underpinning the PHE/MRC Nowcast and Forecast model is similarly vague.

Even a casual glance at the governments own number of *"cases"* shows no difference between the reduction in cases in May 2020, without any vaccines, and the post-vaccination case reduction in February and March 2021. If anything case reduction has been slower, following vaccinations, than it was without. There certainly is no statistical evidence of vaccines reducing *"infection rates."*

With a reliance upon RT-PCR testing, nearly all of the studies referenced by PHE, including there own, have measured *"alleged"* infections. By assuming, without evidence, that asymptomatic transmission exists, PHE's claim that reduced infection rates demonstrate an inferred reduction in transmission is groundless.

Yellow Card

As mentioned above, the major problem with all these assessments of efficacy and safety, other than the absence of any clinical trials, is that they assume the risks from the vaccine are negligible and that the MHRA are monitoring the situation. The UK government claim that nearly 45 million have received at least one vaccine. However, their statistics for vaccine adverse reactions, reported via the MHRA's Yellow Card system, suggest a considerable health risk from the vaccines.

Currently just over 1 million adverse reactions, many of them serious, and 1,403 deaths have been reported to the Yellowcard system. In 2018 the MHRA, who are responsible for monitoring and supposedly investigating adverse events, revealed:

> It is estimated that only 10% of serious reactions and between 2 and 4% of non-serious reactions are reported.

There is no evidence that the MHRA have done anything to rectify this problem. This suggests the possibility of approximately 14,000 UK vaccine related deaths. Given that genuine Covid-19 mortality is a low percentage of the claimed figure, due to massive over-reporting based upon RT-PCR tests, the direct harm caused by the vaccine could be comparable to that caused by Covid-19. This possibility is simply ignored in PHE *Covid-19 Vaccine Surveillance Reports.*

Model Claims

When researchers submitted a Freedom of Information Request to PHE asking how they had arrived at their claimed efficacy and safety figures, PHE stated:

> The number of deaths averted by vaccination, can be estimated by considering vaccine effectiveness against mortality, vaccine coverage and observed deaths and through modelling using a range of parameters.

Those parameters are defined in PHE vaccine impact assessment for December 2020 to March 2021. In turn this then uses the PHE/MRC model, under discussion in this article, as the *"proof"* of efficacy and safety. PHE appear to be making claims based upon an eternal feedback loop. The *PHE/MRC Nowcast and Futurecast* model is *the evidence* upon which the model is itself based.

These claims do not appear to be born from any kind of reliable scientific method. What we have instead are assumptions, based upon estimates which are themselves produced by the self same estimates and assumptions. It is difficult to know how to describe this. All we can say is that the evidence base for these claims appears to be very weak.

Of significant concern is that the PHE vaccine impact assessment makes no assessment of vaccine harm. This is removed entirely from their models. They have no clinical trial data upon which to factor in possible vaccine harm and absolutely cannot make claims about the relative risk/benefit profile of the vaccines without this data.

The constant refrain from MHRA and vaccine manufacturers is that there is no proof determining how many deaths are caused by the Covid-19 vaccines. This is true to the extent that postmortem examinations and investigations by the regulators would be needed to clearly establish vaccine mortality. To date they have not shown any willingness to carry out those investigations. However

mortality. To date they have not shown any willingness to carry out those investigations. However they do at least concede that the Covid-19 vaccines can be lethal.

The UK government's information for recipients of the AstraZeneca Covid-19 vaccine stated:

> Extremely rare cases of blood clots with low levels of platelets have been observed following vaccination with COVID-19 Vaccine AstraZeneca... Some cases were life-threatening or had a fatal outcome. It is important to remember the benefits of vaccination to give protection against COVID-19 still outweigh any potential risks.

Therefore there is certainly evidence that the vaccines pose a risk which the unvaccinated don't face. The only question is the scale of that risk. But unless the regulators actually investigate those risks it will remain completely unknown. While it is, there is no justification to any claim that the benefits of the vaccines outweigh the risks. It is untenable.

The Norwegian Health Authorities did undertake a risk assessment. Their data showed that the risks from the AstraZeneca vaccine outweighed the risk of Covid-19 for Norwegian people under 65. They halted the use of the Vaxzevria (AZD1222 brand name) vaccine.

Alas, it seems we have little hope of a similar level of scrutiny in the UK. The interim trial results for the Pfizer BioNTech trial C4591001 (NCT04368728) were cited throughout the MHRA's Authorisation for Temporary Supply for the vaccine. However, when independent researchers used freedom of information request (FOIR) to ask about why the trials didn't assess the vaccine's impact upon pregnant women the MHRA stated:

> The above trial was not conducted in the UK, the MHRA did not assess its content and are therefore not in a position to answer specific questions relating to it.

This indicates that the MHRA hadn't read the interim trial data they cited prior to granting emergency approval of the vaccine. This seeming lack of interest in the most basic regulatory oversight is exemplified by the Chief Executive of the MHRA, June Raine.

In early June 2021 Dr Tess Lawrie (MBBCh, DFSRH, PhD) was concerned enough about vaccine safety to write to the MHRA urging a halt to the vaccine roll out. Dr Lawrie is a medical researcher, public

health policy advisor and contributing research author to the prestigious Cochrane Review. She and her team analysed the adverse reaction reporting in the UK. Writing to June Raine, she stated:

> The MHRA now has more than enough evidence on the Yellow Card system to declare the COVID-19 vaccines unsafe for use in humans.. the mechanism for harms from the vaccines appears to be similar to COVID-19 itself.

On June 4th 2021 the MHRA extended the emergency Covid-19 vaccine authorisation to allow the injection of children aged between 12 - 15 years. Announcing the authorisation, June Raine said:

> We have carefully reviewed clinical trial data in children aged 12 to 15 years and have concluded that the Pfizer/BioNTech COVID-19 vaccine is safe and effective in this age group and that the benefits of this vaccine outweigh any risk.

As the risk to children from Covid-19 is zero there are no potential benefits to vaccinating them. There are clearly risks associated with the vaccines and Raine's claim that the vaccine benefit outweighed the risk was wrong. Far from having *carefully reviewed* the interim *clinical trial data,* there is good reason to suspect that the MHRA hadn't even read it.

Such as it is, this is the basis for the PHE/MRC *Nowcast and Forecast* model. Their statement that *"vaccine efficacy is assumed against both infection and death"* is reasonable because it is indeed little more than an assumption. They don't have a clue about the vaccine risks and their models are undoubtedly inaccurate. The only question is how far they deviate from reality.

They have then contrasted their assumptions with the *"worst case scenario"* to come up with claims about saving thousands of lives. This model of the *worst case* comes from the paper by Birell et al 2020. This is largely based upon assumed numbers of "cases," wrongly identified through RT-PCR, informing inaccurate reproduction numbers founded upon dubious concepts like *asymptomatic* spread.

The efficacy of the vaccines is assumed, based upon the highly questionable PHE *"science"* we have discussed, while the risks from the vaccines are ignored to produce a completely useless risk/benefit profile. This allows politicians and media outlets like the BBC to make bold claims about how wonderful the vaccines are using computer models which appear to be about as realistic as Sim City.

Iain Davis

Author, blogger, researcher and short film maker who rants at in-this-together.com.