# How to access and read Official Government Data:
# A guide for people who want to assess the risks involved in the current situation

**Here we will examine the following:**

- **The known severity of the situation and thus what solutions it might require**
- **The known risk to individuals in different population groups**
- **The known safety of the vaccines**
- **The effectiveness of the vaccines**
- **Personal, social and moral perspectives and implications**
- **Looking ahead according to stated intentions by governing bodies**

**We will examine ONLY data and documents from the UK Government, the NHS, the US Government, official regulatory and advisory bodies such as the WHO, and the vaccine manufacturers. Readers can then derive their own conclusions ONLY from the available official data and not from external influences.**

## Pre-amble:

**- Does the situation require this solution? In 2020 the mortality rate was slightly lower than in 2003-2001**, and lower than in all years of all previous decades; it was only very slightly higher than 2004 - 2019, but with a population in England and Wales of nearly 60,000,000 and in the UK of 67,000,000, that is where the "excess deaths" were gleaned from. 2004 - 2019 were the only years in our history when the death rates dropped below 1,000 per 100,000, and so *that* is the abnormality. There are lots of factors which one could look at that could show why the preceding years were different and what may have happened differently in 2020, so we will just look them briefly to see where you can find official data if you want to, but the point is that the shift back to the figures of 2020 should be no shock, despite everything. It is because of that mortality rate, and the fact that on 19th March 2020 the government no longer considered Sars-Cov2 to be a high-consequence infectious disease, that the state of emergency was declared during which the covid vaccines, which are still in trial phases until 2023, were given temporary approval for use.

**- How much are you at risk?** If you are, for example, a healthy 44 year-old you have a 0.009% probability, or less than a **1 in 100 thousand chance, of dying from covid**. In fact, **you are 3 times more likely to die in a road accident, as any form of road user, than die of covid**. So, if you are going to get vaccinated, presumably you are not going to leave your house ever again either. The risk, depending on health, for **10-19 year-olds dying from covid is between 0.0002% and 0.00002%, or a 1 in 5 million chance. 10-19 year olds are 200 times more likely to die from suicide.**

**- How safe are the vaccines?** They are approved for emergency use only (no mRNA or adenovirus vaccine, citing government publications, has ever been approved for normal use), and so may only be used whilst the emergency is ongoing; the vaccines are still in trial phases until 2023. For example, **if you are 44 years old and in good health, you are at least 3 and a half times more likely to die immediately from the vaccine than from covid,** and could be **between 600 and 3,500 more times likely to suffer from a debilitating condition, and perhaps a later death, as a result from the vaccine than you are of dying from covid.** For children of secondary school age and young people at FE college**, a healthy 10-19 year old is 150 times more likely to die from the covid vaccine than from the disease.** In terms of immediate risk, data shows that ***the covid vaccines are around 2,184 times more dangerous than the average vaccine*.** That is the immediate risk; they may be taken as indications as to what the long-term risks may be, considering that these kinds of vaccines work in a new way, using genetic technology, that others before have not used.

**- How effective are the vaccines, and how much will you protect others, if that is what you want?** The efficacy ratings published are only relative ones, because they were obtained during test with a population that does not necessarily reflect the total population, therefore the results are not absolute; furthermore, **as UK Government documents state,** the duration of protection is not officially known, and the vaccine may not be as effective with other variants of the virus, as is the case with other coronaviruses which mutate such as the flu, so are you going to keep taking boosters of vaccines which may be dangerous?

**- Do you want to do help end the ongoing situation?** The last stage of the argument is philosophical and moral: after seeing the evidence of whether or not this is an emergency and requires a vaccine, and how safe such vaccines are and whether their benefits outweigh their risks, if it is about doing your part to end this situation, **is that something you freely want to do, or would you be conceding, under coercion, your sovereign right over your body to protect it under any situation, and are you using your own mind, over which you have sovereign rights, or would you be conceding the responsibility to others to do your decision-making for you?** Furthermore, if you look at the publications of organisations such as the WHO, which advise our government, you will see that the measures will not stop with vaccination, because the **WHO regard vaccines as only one of the tools in the toolbox, along with continued surveillance, tracking and quarantining.**

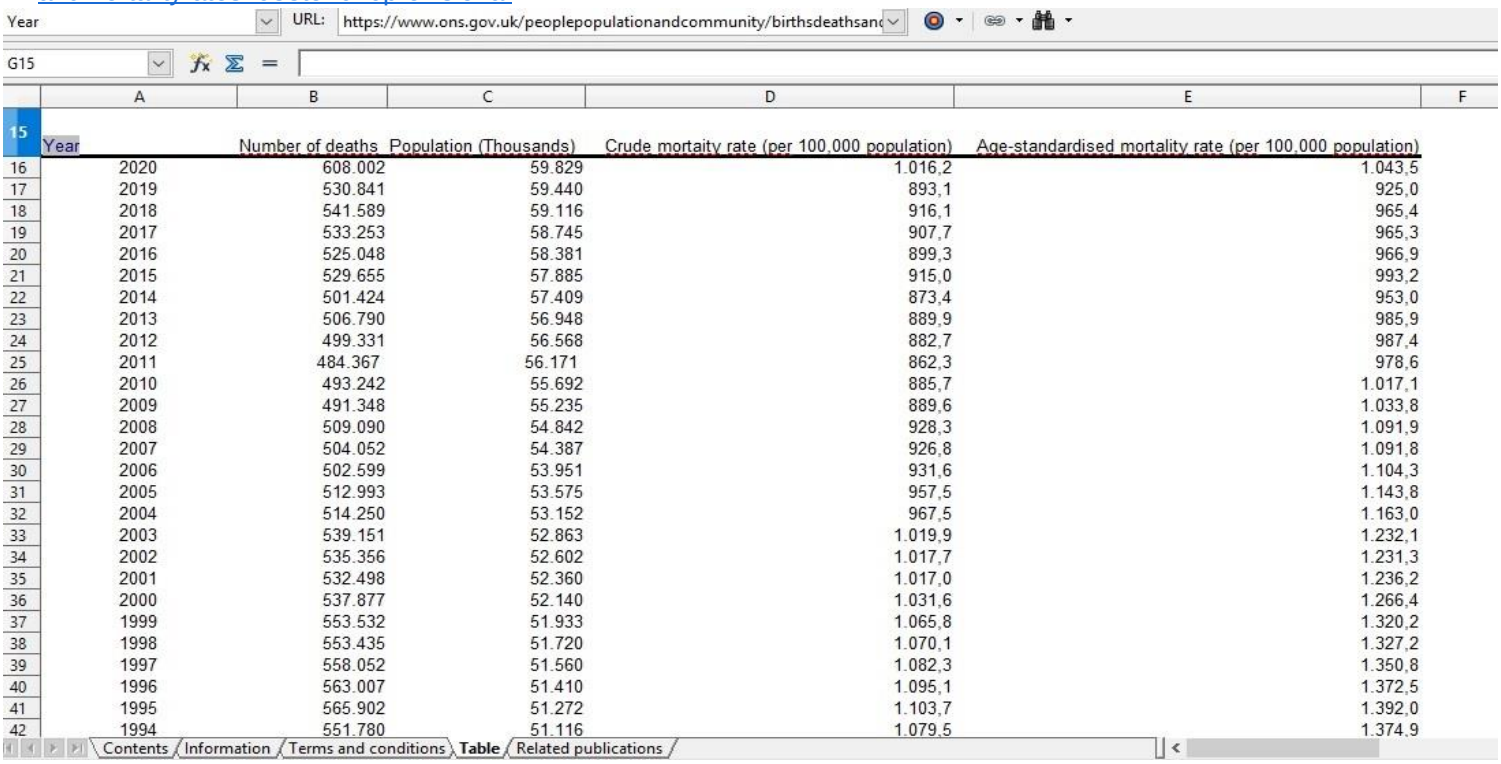
**- Lastly but not least, all of the vaccines made available to the public have been created using the cells of aborted fetuses.** Therefore, those taking the vaccine will be seeking a personal benefit derived from the termination of the life of a human being who did not consent to that act being committed on him or her.

**Remember, if you decide to take the vaccine, it is a decision you will never be able to reverse**; please read the information with the official documentation below before making that decision, so that you that you make an informed choice and if you do decide to take it you do so because you do really think it is the best course of action to take. If you become unsure, then the vaccine will always be there, as long as there is an emergency declared (until 2023), so you have plenty of time to see what happens with it and then take it if really you judge it acceptable and worthwhile, and if there is no longer an emergency then you will not need to ask yourself whether you need it anyway. Furthermore, other treatments for diseases with covid symptoms such as respiratory disorders, such as Ivermectin, have been made re-available, have been used successfully in the past for similar diseases and some doctors are now using them to treated suspected cases of covid. Further alternative treatments are currently being studied by the FDA.

## Here is the evidence:

**- Is the situation an emergency, requiring this solution?**

Here is a table of data from the UK Government Office for National Statistics, showing mortality rates in the population of England and Wales every year from the 19th Century to 2020 (you have to download the table): https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/12735annualdeathsandmortalityrates1938to2020provisional



Year | URL: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsanc

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| Year | Number of deaths | Population (Thousands) | Crude mortaity rate (per 100,000 population) | Age-standardised mortality rate (per 100,000 population) |
|---|---|---|---|---|
| 2020 | 608.002 | 59.829 | 1.016,2 | 1.043,5 |
| 2019 | 530.841 | 59.440 | 893,1 | 925,0 |
| 2018 | 541.589 | 59.116 | 916,1 | 965,4 |
| 2017 | 533.253 | 58.745 | 907,7 | 965,3 |
| 2016 | 525.048 | 58.381 | 899,3 | 966,9 |
| 2015 | 529.655 | 57.885 | 915,0 | 993,2 |
| 2014 | 501.424 | 57.409 | 873,4 | 953,0 |
| 2013 | 506.790 | 56.948 | 889,9 | 985,9 |
| 2012 | 499.331 | 56.568 | 882,7 | 987,4 |
| 2011 | 484.367 | 56.171 | 862,3 | 978,6 |
| 2010 | 493.242 | 55.692 | 885,7 | 1.017,1 |
| 2009 | 491.348 | 55.235 | 889,6 | 1.033,8 |
| 2008 | 509.090 | 54.842 | 928,3 | 1.091,9 |
| 2007 | 504.052 | 54.387 | 926,8 | 1.091,8 |
| 2006 | 502.599 | 53.951 | 931,6 | 1.104,3 |
| 2005 | 512.993 | 53.575 | 957,5 | 1.143,8 |
| 2004 | 514.250 | 53.152 | 967,5 | 1.163,0 |
| 2003 | 539.151 | 52.863 | 1.019,9 | 1.232,1 |
| 2002 | 535.356 | 52.602 | 1.017,7 | 1.231,3 |
| 2001 | 532.498 | 52.360 | 1.017,0 | 1.236,2 |
| 2000 | 537.877 | 52.140 | 1.031,6 | 1.266,4 |
| 1999 | 553.532 | 51.933 | 1.065,8 | 1.320,2 |
| 1998 | 553.435 | 51.720 | 1.070,1 | 1.327,2 |
| 1997 | 558.052 | 51.560 | 1.082,3 | 1.350,8 |
| 1996 | 563.007 | 51.410 | 1.095,1 | 1.372,5 |
| 1995 | 565.902 | 51.272 | 1.103,7 | 1.392,0 |
| 1994 | 551.780 | 51.116 | 1.079,5 | 1.374,9 |

Contents | Information | Terms and conditions | Table | Related publications

You can see that, although the mortality rate in 2020 (1016.2 per 100,000 or 1.016%) is marginally higher than that of 2019 (893.1 per 100,000 or 0.893%) and of 2018 (916.1 per 100,000 or 0.916%) and so on to 2004 (967.5 per 100,000 or 0.97%), **2020 is equal to or even slightly less in some cases than the death rates of the years from 2003 - 2001** (1019.9 per 100,000 or 1.02% for 2003; 1,017.7, 1,017.0 and 1,031.6 respectively for 2002-0), and also earlier, to the 1990s when the death rates were even higher (around 1.1%) and the 1980s and 1970s when it was even higher (1.15% to 1.2%). In fact, the average mortality rate for the last half-century, 1970-2019, so we miss out the world wars and 1918 'flu, and when we can say we have all been living in an era of prosperity and good standard of living in general, is 1,060 per 100,000; **2020 had a lower than average mortality rate for the last 50 years**.

Several factors could explain lower previous death rates and a return to earlier ones: it may be time-consuming to untangle them, so they are mentioned briefly here should you wish to look them up:
A significant drop in work and family visa and asylum grants and EEA resident registrations in 2020 that could reflect a change in trend in previous years: https://www.gov.uk/government/statistics/immigration-statistics-year-ending-december-2020/summary-of-latest-statistics
Lower hospital bed occupancy and increased deaths at home, raw data: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/latest#deaths-registered-by-place-of-occurrence ; and an overview: https://www.nuffieldtrust.org.uk/resource/hospital-bed-occupancy
Cancelled appointments and operations: https://www.nuffieldtrust.org.uk/resource/cancelled-operations#background
An increase in deaths in homes (see section 4) and also the care home (Section 6): https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredweeklyinenglandandwalesprovisional/latest#deaths-registered-by-place-of-occurrence
The average life expectancy increasing, which may have decreased deaths which may have been abruptly interrupted by the deaths in care homes (data 2001-2018): https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/datasets/averageageatdeathbysexuk
At the same time, during this first part of the 21st century the birth rate has been gradually dropping which will have left an aging population, which at one time would have to become reflected in a higher death rate: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/vitalstatisticspopulationandhealthreferencetables

Furthermore, we can see that the slightly greater mortality in 2020 compared to 2019 is not necessarily because of events lasting a whole year: The higher mortality can be minimised by removing the factor of the higher deaths in one month, April 2020, which were 88,153, and substituting it for death-count of April 2019, which was 44,121, changing the death-count of 2020 from 1,016.2 per 100,000 to 942.5 per 100,000 or 0.94%, making it on par with the mortality rates of 2004-2019 which were below 1% or 1,000 per 100,000; thus 2020 would have a mortality rate practically the same as average mortality rate of the 21st Century so far, 931.2 per 100,000 or 0.93%. Therefore, the only significant rise in deaths was in one month only and the statistical rise in mortality rate over the some of the preceding years attributable to one month only. In fact, the numbers of deaths in July and August were slightly lower in 2020 than in 2019; 40,780 and 37,187 respectively in 2020 compared to 42,308 and 38,843 in 2019. and taking into account the 0.65% increase in population, those months in 2020 showed had an average death rate of 0.065% compared to 0.068% in 2019. In other words, **the situation deemed an emergency, if it were so, was confined to one month, and therefore was not or is not on-going.** ONS deaths registered monthly, by year: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/monthlyfiguresondeathsregisteredbyareaofusualresidence

| | A | B | C | D | E | F | G | H | I | J | K | L | M | N |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Contents | | | 1st Q | 180.466 (2021) | | | | | | | | | |
| 2 | Monthly provisional figures on deaths registered by area of usual residence, 2020 | | | is + 18% from | | | | | | | | | England and Wales | |
| 3 | | | | 1st Q | 152.793 (2020) | | | | | | | | | |
| 4 | Area of usual residence | | Jan-20[3] | Feb-20[3] | Mar-20[3] | Apr-20[3] | May-20[3] | Jun-20[3] | Jul-20[3] | Aug-20[3] | Sep-20[3] | Oct-20[3] | Nov-20[3] | Dec-20[3] |
| 5 | | | | | | | | | | | | | | |
| 6 | K04000001, J99000001 | ENGLAND, WALES AND ELSEWHERE [1] | 56.706 | 43.653 | 49.723 | 88.153 | 52.374 | 42.624 | 40.780 | 37.187 | 42.500 | 46.296 | 51.330 | 56.690 |
| 7 | | | | | | | | | | | | | | |
| 8 | K04000001 | ENGLAND AND WALES | 56.597 | 43.555 | 49.641 | 88.049 | 52.315 | 42.577 | 40.731 | 37.129 | 42.432 | 46.255 | 51.274 | 56.614 |

**Monthly figures on deaths registered by area of usual residence, 2019** **England and Wales**

| Area of usual residence | | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Nov-19 | Dec-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| K04000001, J99000001 | ENGLAND, WALES AND ELSEWHERE [1] | 53,910 | 45,795 | 43,944 | 44,121 | 44,389 | 38,603 | 42,308 | 38,843 | 40,011 | 46,238 | 45,219 | 47,460 |
| K04000001 | ENGLAND AND WALES | 53,774 | 45,695 | 43,817 | 44,005 | 44,292 | 38,511 | 42,192 | 38,721 | 39,915 | 46,131 | 45,124 | 47,376 |

**In other words, 2020 still had a normal death rate for the 2000s, a lower death rate than in the 1990s and a lower than average death rate for the last half century!**

In addition to that, on the 19th March, 2020, **the UK Government no longer considered the SARS-Cov2 virus to be a High-Consequence Infectious Disease** (HCID):
https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid

So, would one say that is an "emergency"?

**- Are you at risk?**

Furthermore, within whatever you may call this situation, are you in an "at risk" category? Here is the UK Government data on the ONS site for covid 19 deaths (remembering that such a death is someone who has been diagnosed with covid symptoms, which are many and varied and similar to those of other diseases such as ´flu or pneumonia, before dying or tested positive, and consider the reliability of the tests, for covid):
https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/covid19deathsbynhsagebands
In 2020 the government says that in England and Wales there were 80,830 deaths "involving covid"; the ONS measured the population of England and Wales at 59,829,000 in 2020, which means that the overall death rate for people with covid on their death certificates (which means dying whilst having a flu-like or pulmonary disorder that could be given a diagnosis of covid, or having had a positive PCR/LAMP test within the previous 28 days, whilst possibly having other contributing illnesses) was 0.14%.

However, the ONS gives a figure of only 8.9% during 2020 of deaths certified to involve covid but with no other underlying conditions, which leaves a figure of 7,194 deaths:
https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/ukcovid19deathsbyagewithnounderlyingconditions
That means the overall rate of deaths attributable only to covid (dying whilst only having a flu-like or pulmonary disorder that could be given a diagnosis of covid, or having had a positive PCR/LAMP test within 28 days), was 0,012%.

The age-group covid death data shows differences of mortality rates between age-groups, showing that the older people are the more at risk they are. For example, in the 30-34 age-group there were 117 such deaths, which is 0.14% of the total. 72,647, or 89.9%, of the deaths were in the 65+ age group, and 49,352, or 61%, of the deaths were in the 80+ age group (82 for men and 84 for women are the average ages of death).

Statistically, a person in the 30-34 age-group has a 0.0029% probability or approximately a 1 in 35,000 chance of dying whilst having a flu-like or pulmonary disorder that could be given a diagnosis of covid, or having had a positive PCR/LAMP test within the previous 28 days. However, a healthy person would not be grouped with those having conditions which may be hereditary or habit-formed, such as obesity and diabetes, which are increasingly common in our society and in young adults, so a healthy person would have only 8.9% of that chance of dying, which means **a healthy 30-34 year old has a 1 in 385,000 chance of dying with covid symptoms or a positive covid test.**

With regards to secondary school children and FE college age young people, from 10-19 years of age, there were 16 deaths amongst a population of 6,909,000. If 8.9% of those 16 deaths were of healthy individuals, then **a healthy young person aged 10-19 has a 0.00002% probability or a 1 in 5 million chance of dying with covid symptoms or a positive covid test.**

We can compare the risk of death from covid to other risks of death, to help assess whether we should consider taking measures:

The following tables show an assessment of risk, as found using this data on covid related deaths, comparing it to the data given by the UK Government in other scenarios, such as suicide, road deaths, influenza and pneumonia and reported covid vaccine related deaths. *The death rates for covid with no other underlying conditions were not available for age groups, so the 8.9% proportion given in the aforementioned documentation was used across the age rages to give an indication, though one would expect the proportion of other underlying causes would be greater with age. The deaths were recorded from the first week of January 2020 to the week beginning 1st January 2021.*

| Age Group | Age group population in England and Wales (UK ONS) | Deaths with covid on the death certi-ficate in age group in E&W (NHS ONS) | Percentage mortality with covid on death certificate of age group (NHS ONS) | Percentage mortality of designated covid deaths of otherwise healthy individuals (8.9%) of age group (NHS ONS) | Expression of chance of dying from covid for healthy individuals in age group *(for people with underlying conditions multiply by 11, or 10 for an approximation,, e.g. figure 11 instead of 1 in …, or remove a 0 from "in …." number)* | Comparison to covid mortality in healthy individuals (roughly figure 10 or 11 times less for people with underlying conditions): | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Suicide rate in age group (UK ONS) | Risk of death in Great Britain from a road accident (UK ONS): **0.0026% or 1 chance in 38,000** | Known vaccine risk 1 1/3 doses<br>Reported (UK MRHA) risk of immediate death (long term unknown) from covid vaccines: **0,003% or 1 chance in 32,000** | Vaccine risk assessments<br>C = covid death more likely<br>V = vaccine death more likely | | |
| | | | | | | | | | A probable | **B likely** | C possible |
| 0-4 | 3,416,000 | 3 | 0.000088% | 0.0000078% | 1 in 13 million | - | RA x 340 | Vax x 394 | V | **V** | V |
| 5-9 | 3,727,000 | 1 | 0.000027% | 0.0000024% | 1 in 42 million | - | RA x 1100 | Vax x 1273 | V | **V** | V |
| 10-14 | 3,625,000 | 5 | 0.00014% | 0.000012% | 1 in 8 ½ million | 0.0004% | RA x 220 | Vax x 256 | V | **V** | V |
| 15-19 | 3,284,000 | 11 | 0.00033% | 0.00003% | 1 in 3 ½ million | 0.0067% | RA x 92 | Vax x 100 | V | **V** | V |
| 20-24 | 3,663,000 | 34 | 0.00093% | 0.000083% | 1 in 1.2 million | 0.011% | RA x 32 | Vax x 36 | V | **V** | V |
| 25-29 | 3,992,000 | 70 | 0.0018% | 0.00016% | 1 in 625,000 | 0.012% | RA x 16 | Vax x 19 | V | **V** | V |
| 30-34 | 4,035,000 | 117 | 0.0029% | 0.00026% | 1 in 385,000 | 0.013% | RA x 10 | Vax x 12 | V | **V** | V |
| 35-39 | 3,938,000 | 195 | 0.0049% | 0.00044% | 1 in 227,000 | 0.013% | RA x 6 | Vax x 7 | V | **V** | V |
| 40-44 | 3,657,000 | 369 | 0.01% | 0.0009% | 1 in 111,000 | 0.015% | RA x 3 | Vax x 3 ½ | V | **V** | V |
| 45-49 | 3,839,000 | 694 | 0,018% | 0.0016% | 1 in 63,000 | 0.018% | RA x 1.7 | Vax x 2 | V | **V** | V |
| 50-54 | 4,094,000 | 1,284 | 0.031% | 0.0028% | 1 in 36,000 | 0.015% | CV = RA | Vax x 1.12 | V | **V** | V |
| 55-59 | 3,987,000 | 2,186 | 0.055% | 0.0049% | 1 in 20,000 | 0.012% | CV x 1.9 | CV x 1.65 | = | **V** | V |
| 60-64 | 3,400,000 | 3,241 | 0.095% | 0.0085% | 1 in 12,000 | 0.011% | CV x 3 | CV x 2.75 | C | **V** | V |
| 65-69 | 2,971,000 | 4,596 | 0.15% | 0.014% | 1 in 7,000 | 0.0086% | CV x 5 | CV x 4.7 | C | **V** | V |
| 70-74 | 3,001,000 | 7,633 | 0.25% | 0.022% | 1 in 4,500 | 0.007% | CV x 8 | CV x 7 | C | **V** | V |
| 75-79 | 2,149,000 | 11,066 | 0.5% | 0.046% | 1 in 2,200 | 0.008% | CV x 17 | CV x 15 | C | **C** | = |
| 80-84* | 1,550,000 | 15,374 | 0.99% | 0.088% | 1 in 1,100 | 0.009% | CV x 35 | CV x 30 | C | **C** | C |
| 85-89** | 948,000 | 16,574 | 1.75% | 0.16% | 1 in 625 | 0.011% | CV x 60 | CV x 53 | C | **C** | C |
| 90+** | 544,000 | 17,404 | 3.2% | 0.28% | 1 in 357 | 0.01% | CV x 106 | CV x 92 | C | **C** | C |
| ALL | 59,829,000 | 80,830 | 0.14% | 0.012% | 1 in 8,300 | 0.011% | CV x 4.5 | CV x 4 | C | **V** | V |

*At average life expectancy **Above average life expectancy ***Under average life expectancy

*Guide to possible vaccine risks:*

***A)*** ***Probable:*** *Risk assessment taking into account that at the time of analysing the data: one third of the individuals vaccinated (33,300,000 first doses) had two doses (11,200,000), so an assessment of a treatment consisting of two doses would be made multiplying the existing events by 1.67* ***= 0.0045% or 1 in 22,000 chance***

***B)*** ***Likely:*** *Risk assessment adjusting reported deaths (MHRA AER 0.6%, only 1/3 of people had received two doses so remove 1/4 of percentage representing second dose) to incidence of CDC reported events in trials after 1 dose (AER 2.8%): 2.8/0.45 = 6 x higher per dose, so 6 x A)* ***= 0.027% or 1 in 3,700 chance*** https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-12/slides-12-19/05-COVID-Clark-508.pdf

*C)* ***Possible:*** *Worst case scenario, adjusting risk assessment A using MHRA estimates: "It is estimated that only 10% of serious reactions and between 2 and 4% of non-serious reactions are reported"* https://www.gov.uk/drug-safety-update/yellow-card-please-help-to-reverse-the-decline-in-reporting-of-suspected-adverse-drug-reactions *=* ***0.045% or 1 in 2,200 chance***

*"C" = most at risk from covid; "V" = most at risk from vaccine*

Covid deaths: https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/covid19deathsbynhsagebands
No underlying conditions:https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/ukcovid19deathsbyagewithnounderlyingconditions
Age-group populations:
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/tablea23principalprojectionenglandandwalespopulationinagegroups
Age-group deaths: https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/ukcovid19deathsbyagewithnounderlyingconditions
Suicide rates: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations#suicide-patterns-by-age
Road deaths: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/922717/reported-road-casualties-annual-report-2019.pdf
Vaccine AER: https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting

| Influenza and pneumonia compared to covid | |
|---|---|
| Deaths involving covid, 2020 | 80,830 |
| Deaths involving influenza and pneumonia, 2020 | 111,957 |
| **Difference of deaths inolving influenza and pneumonia over deaths involving covid** | In&Pn **38.5% more** than Cov |
| Deaths of covid with no other underlying causes, 2020 | 7,194 |
| Deaths due to influenza and pneumonia with no other underlying causes, 2020 | 20,523 |
| **Difference of deaths due to influenza and pneumonia over deaths due to covid** | In&Pn **185% more** than Cov |
| Deaths of covid with no other underlying causes, 2020 | 7,194<br>0.012% of 59829000 |
| Deaths due to influenza and pneumonia with no other underlying causes, 2015-2019 yearly average | 28,188<br>0.048% of 58713000 |
| **Difference of deaths due to influenza and pneumonia over deaths due to covid** | In&Pn **300% more (4 times)** than covid |
| ***https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/influenzadeathsfrom1999to2021***<br>***https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/12267numberofdeathswhereinfluenzaandpneumoniawheretheunderlyingcauseofdeath2015to2019englandandwales*** | |

In England and Wales there were 111,957 deaths “involving Influenza and pneumonia” 2020, which was 38.5% more than the 80,830 deaths involving covid, recorded on the death certificate; in the same period there were 20,523 deaths “due to influenza and pneumonia”, or where “influenza and pneumonia were recorded as the underlying cause”, which is 185% more than the 7,194 deaths from covid where the patients had no underlying conditions.
https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/influenzadeathsfrom1999to2021

The numbers of deaths in England and Wales where Influenza and pneumonia underlying causes in the previous five years were: 29885 in 2015, 27504 in 2016, 27639 in 2017, 29516 in 2018, and 26398 in 2019; the 5 year average was 28188 deaths
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/12267numberofdeathswhereinfluenzaandpneumoniawheretheunderlyingcauseofdeath2015to2019englandandwales
The averge population of the 5 year period (see previous ONS data sheet on yearly mortality rates) was 58,713,000, giving a death rate of 0.048% where influenza and pneumonia were the underlying cause; compared to a rate of 0.012% where deaths were recorded with covid as the underlying cause, we can see **historically 4 times as many people died of influenza and pneumonia than died with covid** as the recorded underlying cause of death in 2020.

We can make comparisons with other life events. For example, there were 1,752 reported road deaths for all kinds of road users in 2019:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/922717/reported-road-casualties-annual-report-2019.pdf
In 2019 the official estimate of the population for the whole of Great Britain was 66,796,807.
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2019estimates
This means a person has a 0.0026% chance of dying in a road accident, as a driver, passenger, cyclist or pedestrian, or a 26 in a million chance or 1 chance in 38,000 of it. So, with a 1 in 385,000 chance of dying of covid, a healthy 30-35 year old is **10 times more likely to die in a road accident than die of covid**.

For children and young people, the suicide rate in the UK for 10-14 year-olds in 2018 was 0.0004%, and for 15-19 year-olds it was 0.0067%. Assuming proportions in England and Wales are similar to the UK, there are 1.1 10-14 year-olds to 15-19 year-olds, so the suicide rate of the secondary school and FE college age-group, 10-19 years old is 0.004%; compared to a 0.00002% probability or a 1 in 5 million chance of dying with a covid diagnosis, **children and young people aged 10-19 are 200 times more at risk of suicide than covid:**
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations#suicide-patterns-by-age

**- What is the vaccine?**

Against that situation assessment, one would need to look at what the risks of taking the vaccine might be, in order to decide whether it is worth it in terms of the possible benefits outweighing the known risks. Before looking at data to tell us that, we will look at what kind of vaccines these are, in order to assess how suitable they might be for the situation.

First of all, the vaccines are still in trial stages of development, and will be so until 2023:
mRNA vaccines e.g. Pfizer, Study details - para2 Study Design **"Estimated study completion date 6th April 2023"**:
https://clinicaltrials.gov/ct2/show/NCT04368728
Astra-Zeneca vaccine, Study details - para2 Study Design **"Estimated study completion date 4th February 2023":**
https://clinicaltrials.gov/ct2/show/NCT04516746#contacts
These are the US government websites - Astrazeneca is a US company though it was developed in Oxford, and currently it and all other adenovirus vaccines do not have any form of approval, not even for emergency use, in the US.

The US FDA has given the vaccines an EUA (Emergency Use Authorisation), about which it says “The issuance of an EUA is different than an FDA approval (licensure) of a vaccine” and that “FDA approval of a drug means that the agency has determined, based on substantial evidence, that the drug is effective for its intended use, and that the benefits of the drug outweigh its risks when used according to the product’s approved labelling. The drug approval process takes place within a structured framework that includes collecting clinical data and submitting an application to the FDA.” In other words, the vaccines have not been through that process or assessment.
https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-frequently-asked-questions

The Astra-Zeneca Covid 19 vaccine information for users on the UK Government website:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/978194/uk-HCP-covid-19-vaccine-astrazeneca-reg174_proposed_14_Apr_2021.pdf
P2: "This medicinal product has been given **authorisation for *temporary supply*** by the UK Department of Health and Social Care and the Medicines & Healthcare products Regulatory Agency..... this *temporary authorisation* grants permission for the medicine to be used for active immunisation of individuals aged 18 years and older....."
It is temporary because it has still not passed the trial period, which is due to end in 2023. Other statements of note:
p4: "Duration and level of protection: **The duration of protection has not yet been established**"
" No interaction studies have been performed."
p10: **"Animal studies into potential toxicity to reproduction and development have not yet been completed."**
Also, look at the adverse side effects listed on p5.

Similarly, the Pfizer vaccine has been given “authorisation” for "temporary supply during the covid pandemic" (p3), and the "COVID-19 mRNA Vaccine BNT162b2 remains under review" by the MHRA (p6)::
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/944544/COVID-19_mRNA_Vaccine_BNT162b2__UKPAR___PFIZER_BIONTECH__15Dec2020.pdf

It is the same for all the other vaccines. Information on them from the UK Government can be found here:
https://www.gov.uk/health-and-social-care/pharmacy (scroll for the regulatory approval documents for each vaccine)

The statement on the NHS website is misleading, therefore, because it says that the vaccines have been "approved" and not "temporarily authorised" for emergency use:
https://www.nhs.uk/conditions/coronavirus-covid-19/coronavirus-vaccination/coronavirus-vaccine/?utm_campaign=coronavirus_grants&utm_medium=paid_searchl&utm_source=google&utm_content=keyword&gclid=EAIaIQobChMIy7HMouyq8AIVO4BQBh1jfgL7EAMYASAAEgLF-fD_BwE
The absolute statement it makes that the vaccines are safe can also be said to not be true, given there are a percentage of injuries and deaths, and, as the official documentation above says, there is no long-term safety data.

So, the vaccines may only legally be offered for emergency use, the emergency being the one as described above, when death rates were the same as in 2004 to 2001 and lower than preceding years.

In the Astra-Zeneca vaccine Regulatory Approval Conditions, points, 8, 9 and 20 refer to sharing information with the MHRA on vaccinated patients, 22-25 refer to reporting to the MHRA on the clinical trials, and point 25 makes reference to the clinical trials in accordance with the regulation under which the temporary supply is authorised (174A).
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/963841/AZ_Conditions_for_Authorisation_final_23.02.21.pdf

Regulation 174A was made in 2020; it was made to address the covid 19 situation:
https://www.legislation.gov.uk/uksi/2020/1125/regulation/6/made

This UK Government (Department for Business, Energy and Industrial Strategy) document on the development of vaccines makes statements on the issues involved in developing a vaccine safe and effective vaccine for this situation:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/937596/vaccines-task-force-falk-group-21-oct-redacted.pdf
On page 2 you can read:
**"Development of vaccines against Covid 19 is uncertain.....**
**…...Covid 19 has traits which are not yet understood....**
**…...no vaccine was approved for Sars1**....
**…...viruses mutate e.g. flu, herd immunity may never be possible....**
**…...unknown durability of protection.....**
**…...the most advanced clinical vaccine modalities have never been approved by regulators - adenovirus vaccines (Oxford) and mRNA vaccines (Pfizer, Moderna), no long-term experience or safety data....."**

On the next page, however, it goes on to say that despite all that the government aims to vaccinate everybody. The UK gov has been secretive about ages of people dying with a diagnosis or positive test of covid, but on p7 says that in the US 78% of such deaths are in the over 65s. Again, how much of an emergency is it and how much does a person under 65 years of age need it?

So, if you take this vaccine **you will officially be a participant in an experiment.**

When something is in trial stages it is the same as saying it is experimental. The Nuremberg Code, written after WWII so that the practices of the Nazis could not be repeated, states that people may not be subjected to experimentation without their consent; the Government covers itself with that small print in a long document, and the user´s signature. Even if they do understand what they are doing, the coercive nature of the situation (vaccine passports, "no jab, no job" in discussion, media messages that lockdowns can end when everyone is vaccinated but will not if they are not) brings us into a grey area where the Nuremberg Code could be said to be violated, so consider the legal implications of what a person taking the vaccine might be participating in.
https://committees.parliament.uk/writtenevidence/2267/pdf/
Children will not be able to understand the implications of participating in such a medical experiment, so giving them these vaccines may an even clearer violation of the Nuremburg Code.

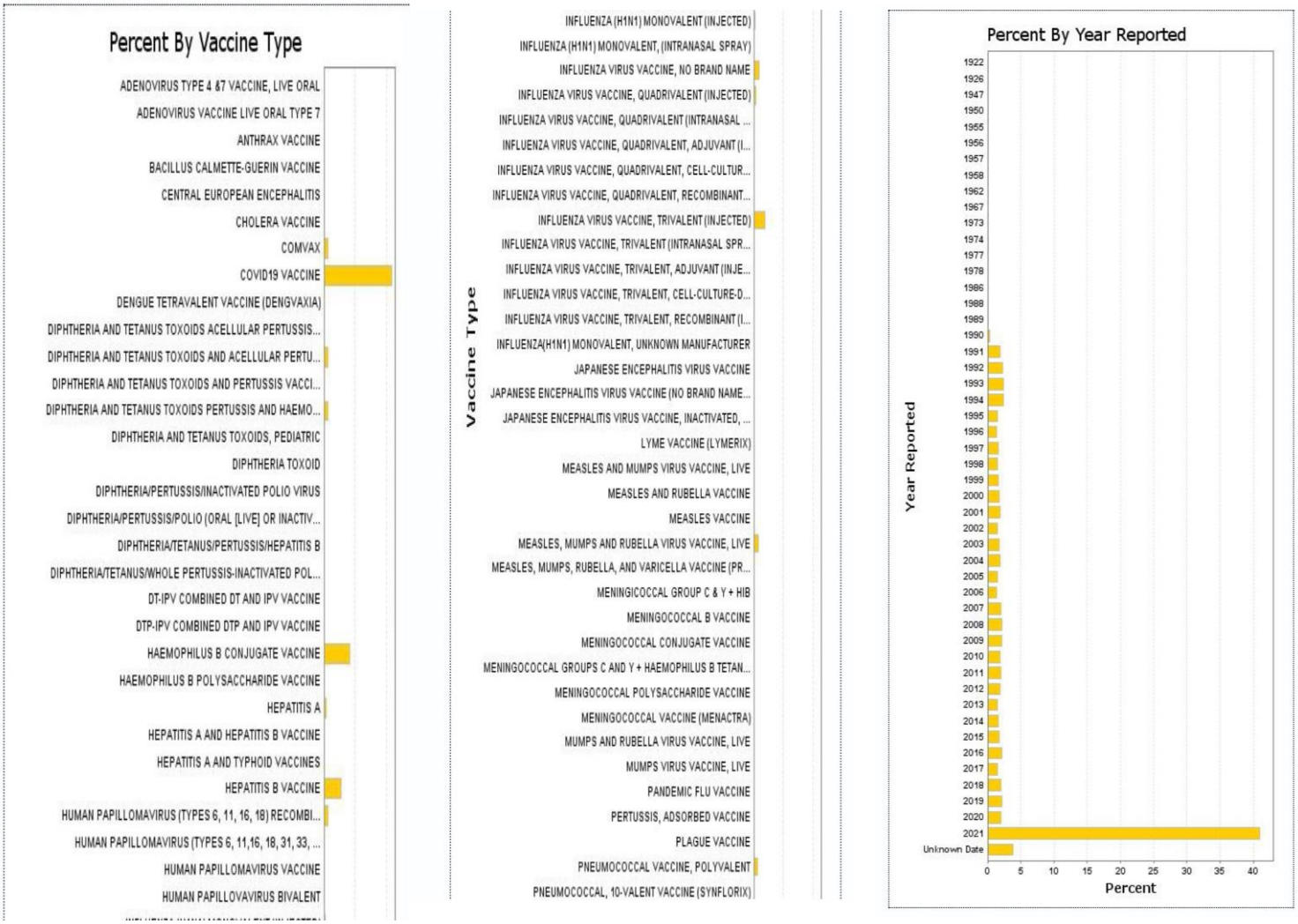
**- Now, what might the level of immediate risk be?**

If you look at the data from VAERS (the US Government Vaccine Accident and Event Reporting System which started report on vaccine events in 1990), you can see **43% of all deaths from all vaccines since 1990 have been from the covid 19 vaccines:** https://wonder.cdc.gov/vaers.html
A viewer has to request a list of data or a chart by inputting requirements as below
Click "I agree" - request form - 1) choose "vaccine type" - 2,3,4) no change - 5) select "death" and leave the rest as they are, 6 onwards) no change - press "send" then choose "chart".

*(The charts were requested at the beginning of May; at the time of revising this document the percentage in the first has risen to 47%, and in the second increased correspondingly)*

This is corroborated by the fact that **42% of all vaccine deaths since 1990 have been reported in the first four months of 2021, which is 15% of the time** (on step 1) choose "year reported"

The data of the first chart shows that from 1990 to 2021 there have been a total of 3,607 reported deaths from the covid vaccines, out of a total of 14,025 deaths for a total of 70 vaccines. That means that the average vaccine of the other 69 has caused 151 deaths. That means that the covid vaccines have caused 24 times the amount of deaths than the others. However, the covid vaccines have done that in 4 months, whilst the others have done that in 364 months, 91 times the amount of time.




So, **the covid vaccines are 2,184 times more dangerous than the average vaccine.** The other vaccines may not have been present throughout the whole time, so this is an indication, but also most other vaccines are given to a larger part of the population, especially during childhood, whereas the covid vaccines have not been taken by all adults, approximately half, so in fact the covid vaccine may be even more dangerous!

The first human test results for the AZ vaccine in December 2019, recorded by **the US CDC, showed a 2.8% rate of accidents or adverse events immediately after taking the vaccine requiring admittance to hospital and not being able to go to work:**
https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-12/slides-12-19/05-COVID-CLARK.pdf
or https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-12/slides-12-19/05-COVID-Clark-508.pdf
That is much higher than with normally approved vaccines, and only the immediate effects; long-term ones are not known.

That is in the US; the UK data via the Government Yellow Card system is a bit more time-consuming to sift through. Here is the data from the UK MHRA Yellow Card for up to 21st April 2021:
https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting
Cumulatively 19 weeks for Pfizer (approx 18 million doses) and 15 weeks for Astrazeneca (approx 26.4 million doses) and 2 weeks for Moderna (approx 0.1 million doses).
33.3 million unique people received one or two doses (33,300,000 first doses and 11,200,000 second doses)
205,997 unique reports filed with Yellow Card, that is **0.6% accident or adverse event rate; 1,047 were fatalities.**
Bear in mind that not all events are reported on Yellow Card, nor to VAERS in the US, and reports take time to be processed and published, as will be discussed.

According to this exact data only, **a user has a 0,003% probability or a 1 in 32,000 chance of dying from the vaccine.**

However, the vaccine treatment is of two doses, so if these figures came when only one-third of users had taken a second dose, then figures would need to be multiplied by 3/2 to obtain a figure which would reflect accident rates after two doses; **so, a user would have a 0,0045% probability or a 1 in 22,000 chance of dying from the vaccine.**

The test data from the Pfizer vaccine prospectus from the UK Government above shows on p40 that **amongst 37,586 participants, 21 had life-threatening adverse reactions, which is a 0.06% or 1 in 1,800 risk, and 2 died, which is a 0.005% risk or a 1 in 18,800 risk.** This is a similar figure to that obtained from the actual data, adjusted to the risk the CDC test data shows.

Remember that the tests recorded a 2.8% accident rate, compared to users filling a Yellow Card at 0.6% adverse event rate; that means that in reality the accident rate could be much higher. The CDC tests showed events after a first dose; so, after a second (for a two-dose treatment), the accident rate could be 5.6%, which is 12 times higher than 0.45%, which is three-quarters of the reported rate of 0.6% after removing the proportion of the figure that corresponds to the amount of second doses. This means we can multiply the existing MHRA figures by a factor of 9, **so a user could have a 0.027% probability or a 1 in 3,700 chance of dying as an immediate result of taking the vaccine.**

This calculation is not far from the MHRA's estimate that only around 10% of adverse vaccine events are reported, the real risk of death could be 10 times, which would mean **a user might even have a 0,045% probability or a 1 in 2,200 chance of dying as an immediate result of taking the vaccine.**

*We might consider the previous calculation of a **1 in 3,700 chance to be the most accurate** or likely, whilst the most conservative, given its adjustment to known data specific to the vaccine.*

Remember, a healthy 45 year-old has a 0.009% or 1 in 100 thousand chance of dying from covid, **so statistically a healthy middle-aged person is known to be at least 4.5 times but likely 27 times more at risk of dying from the vaccine than from covid.**

With a 0.00002% probability or 1 chance in 5 million from dying of covid, **a healthy child or young person aged from 10-19 is known to be at least 227 times but likely 1,350 times more at risk of dying immediately from the vaccine than from covid.**

A person will also have a 5.4% chance of having and serious adverse reaction, according to the CDC test results, as on the list of Yellow Card events or described in the CDC document as requiring medical attention and not being able to go to work.

We can see risk of accidents recorded by the MHRA from the number of users, 33,300,000 (we do this as with deaths, rather out of number of doses assuming that if a person has a serious reaction with the first dose that person will not take a second dose) and multiply the risk by 9 according to the two-dose (x 3/2) x CDC test results (x 6) factor:

| Disorder | Number of users suffering | Percentage of users suffering | **Likely 2-dose risk calculation using CDC test data** |
|---|---|---|---|
| Psychiatric disorders | 13,259 | 0.04% | **0.36%** |
| Blood disorders | 9751 | 0.029% | **0.26%** |
| Acute cardiac events | 7721 | 0.023% | **0.21%** |
| Strokes | 1240 | 0.0037% | **0.033%** |
| Blindness | 166 | 0.0005% | **0.0045%** |

*(Here is the list of MHRA Yellow Card results from the above documentation)*

*Reactions - 149,082 (Pfizer) + 573,650 (AZ) + 660 (Moderna) + 1687 (Unknown) = 725,079*

*Reports - 52,130 (Pfizer) + 153,098 (AZ) + 228 (Moderna) + 541 (Unknown) = 205,997*

***Fatal - 347 (Pfizer) + 685 (AZ) + 2 (Moderna) + 13 (Unknown) = 1047***

***(Update 12th May 374 (P) + 786 (AZ) + 4 (M) + 16 (U) = 1,180 out of** 35,906,671 people with at least 1 dose = 0.003% still)*

*Acute Cardiac - 1901 (Pfizer) + 5798 (AZ) + 7 (Moderna) + 15 (Unknown) = 7721*

*Chest Pain - 871 (Pfizer) + 3182 (AZ) + 3 (Moderna) + 9 (Unknown) = 4065*

*Anaphylaxis - 275 (Pfizer) + 562 (AZ) + 1 (Moderna) = 838*

*Blood Disorders - 5071 (Pfizer) + 4652 (AZ) + 9 (Moderna) + 19 (Unknown) = 9751*

*Infections - 3545 (Pfizer) + 11,621 (AZ) + 12 (Moderna) + 37 (Unknown) = 15,215*

*Herpes - 689 (Pfizer) + 1175 (AZ) + 2 (Moderna) + 7 (Unknown) = 1873*

*Headaches - 13,107 (Pfizer) + 63,589 (AZ) + 45 (Moderna) + 155 (Unknown) = 76,896*

*Migraine - 1181 (Pfizer) + 5474 (AZ) + 1 (Moderna) + 13 (Unknown) = 6669*

*Amnesia + Memory Loss - 102 (Pfizer) + 330 (AZ) + 2 (Unknown) = 434*

*Eye Disorders - 2322 (Pfizer) + 8311 (AZ) + 8 (Moderna) + 26 (Unknown) = 10,667*

*Eye Pain - 406 (Pfizer) + 2455 (AZ) + 2 (Unknown) = 2863*

*Blindness - 31 (Pfizer) + 134 (AZ) + 1 (Unknown) = 166*

*Hearing Loss - 156 (Pfizer) + 333 (AZ) + 3 (Moderna) + 1 (Unknown) = 193*

*Psychiatric Disorders - 2417 (Pfizer) + 10,792 (AZ) + 13 (Moderna) + 37 (Unknown) = 13,259*

*Skin Disorders - 10,937 (Pfizer) + 34,074 (AZ) + 68 (Moderna) + 103 (Unknown) = 45,182*

*Spontaneous Abortions - 57 + 4 stillbirth/foetal death (Pfizer) + 30 + 3 stillbirth (AZ) = 94 + 7*

*Vomiting - 1831 (Pfizer) + 8897 (AZ) + 4 (Moderna) + 30 (Unknown) = 10,762*

*Abdominal Pain - 1337 (Pfizer) + 7238 (AZ) + 4 (Moderna) + 11 (Unknown) = 8590*

*Facial Paralysis - 341 (Pfizer) + 376 (AZ) + 1 (Moderna) + 2 (Unknown) = 720*

*Nervous System Disorders - 27,949 (Pfizer) + 124,324 (AZ) + 128 (Moderna) + 346 (Unknown) = 152,747*

*Disturbances in Consciousness - 2161 (Pfizer) + 7327 (AZ) + 9 (Moderna) + 29 (Unknown) = 9526*

*Dizziness - 4159 (Pfizer) + 17,444 (AZ) + 28 (Moderna) + 48 (Unknown) = 21,679*

*Fatigue & Malaise - 11,951 (Pfizer) + 45,942 (AZ) + 42 (Moderna) + 134 (Unknown) = 58,069*

*Crying, Moaning & Screaming - 43 (Pfizer) + 205 (AZ) + 1 (Moderna) + 1 (Unknown) = 250*

*Strokes and CNS haemorrhages - 271 (Pfizer) + 964 (AZ) + 1 (Moderna) + 4 (Unknown) = 1240*

*Thrombosis & Embolism (All types) - 419 (Pfizer) + 2638 (AZ) + 16 (Unknown) = 3073*

*Respiratory Disorders - 6271 (Pfizer) + 17,755 (AZ) + 22 (Moderna) + 48 (Unknown) = 24,096*

*Seizures - 315 (Pfizer) + 1155 (AZ) + 3 (Moderna) + 5 (Unknown) = 1478*

*Paralysis - 128 (Pfizer) + 432 (AZ) + 1 (Moderna) + 3 (Unknown) = 564*

*Haemorrhage (All types) - 440 (Pfizer) + 1480 (AZ) + 4 (Moderna) + 4 (Unknown) = 1928*

*Nosebleeds - 352 (Pfizer) + 1197 (AZ) + 4 (Moderna) + 2 (Unknown) = 1555*

*Inner Ear incl Vertigo/Tinnitis - 1108 (Pfizer) + 2993 (AZ) + 7 (Moderna) + 11 (Unknown) = 4119*

*Reproductive/Breast - 1012 (Pfizer) + 2401 (AZ) + 7 (Moderna) + 6 (Unknown) = 3426*

If only 8.9% of the 80,830 deaths in 2020 involving covid were only of a covid diagnosis or positive test result and no other co-morbidities, then that gives a figure of 7,194 people dying only from covid. The above UK Government document/webpage states that " 11.2 million first doses of the Pfizer/BioNTech vaccine and 22 million first doses of the Oxford University/AstraZeneca vaccine had been administered .... 0.1 million first doses of the Moderna vaccine have also now been administered. .....around 6.8 million and 4.4 million second doses of the Pfizer/BioNTech vaccine and Oxford University/AstraZeneca vaccine respectively....." so that is 33,300,000 first doses and 11,200,000 second doses. The population of the whole of the UK is estimated at 68,183,590 in 2021 (https://www.worldometers.info/world-population/uk-population/ ) (it was estimated at 66.8 million by the ONS in 2019: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/january2021 ). This means that 44,500,000 doses out of 136,367,180, if everyone in the UK is to receive two doses, have been given, meaning that dosage will need to increase 3.06 times, or by 306%, for every one to be fully vaccinated; that means there will be 3,208 immediate deaths in England and Wales reported as a result, but likely up to 28,872 estimating from the CDC test results or possibly up to 32,080 from MHRA Yellow Card estimates. From the whole population of England and Wales in one year 80,830 deaths were registered with covid as a cause, amongst healthy people and people with underlying conditions, which is only around two-and-a-half times the amount that would likely die as an immediate result of vaccination, and in the longer term it is not known how many more would likely be affected.

In the future this year, on page 10 of this recent Government document, the Government anticipates that "The resurgence in both hospitalisations and deaths is dominated by those that have received two doses of the vaccine, comprising around 60% and 70% of the wave respectively. This can be attributed to the high levels of uptake in the most at-risk age groups, such that **immunisation failures account for more serious illness than unvaccinated individuals**":https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/975909/S1182_SPI-M-O_Summary_of_modelling_of_easing_roadmap_step_2_restrictions.pdf
So, if you are old or at risk then then perhaps you should not take it, but if you are young and healthy as we have seen you should not take it either.....

## ***Conclusion of immediate risk:***

- The population as a whole is likely more at risk of dying from the vaccine than from covid, according to available data and CDC test results.
- If you are a healthy person under 55 you are definitely more likely to die from the vaccine than from covid, according to available data.
- If you are healthy person from 75 - 55 years of age you are more likely to die from two doses of the vaccine than from covid, according to available data and the vaccine test data
- If you are a healthy person the age of 80 – 75 years of age it is possible you are more at risk of dying from the vaccine than from covid
- You are only certainly more likely to die from covid than the vaccine, in the short term, if you are over the average life expectancy, according to data, but then you may expect to die at any time anyway.
- You are, in general, always more at risk of dying from influenza and pneumonia than covid
- If you are a healthy person under 50 you are more likely to die in a road accident or by suicide, as well as from the vaccine, than of covid, according to data
- If you are a healthy person under 65 you are more likely to die by suicide, as well as from two doses of the vaccine, than of covid, according to data
- For children and young adults the risk of dying from the vaccine, road accidents and suicide is far greater than that of dying from covid.
- CONCLUSION: It is only worth taking the vaccine if you are over 80 years old, though no long-term risk data is available, and you still run a 5.6% probability of having a serious adverse reaction

It is also worthwhile to look at the hospitalisation rates now, since the vaccine roll-out started in 2021: https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-covid-19-and-increasing-pressure-on-nhs-critical-care-beds (The raw NHS data is here: https://www.england.nhs.uk/statistics/statistical-work-areas/uec-sitrep/ )

**- Moral Questions:**

Finally in the list of risk, but with primary significance, is the fact that **all the vaccines available in this country have been developed using the cells of aborted fetuses**; this is unviable for a Christian, an abhorrence to God and is against Christian teaching and Catholic doctrine and catechism. It may also be against the beliefs of other faiths, and those of anybody who believes in the sanctity of life and that human life begins at conception.

We can see the composition of the Astra-Zeneca Covid 19 vaccine in the link to the prospectus we have already seen on the UK Government website:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/978194/uk-HCP-covid-19-vaccine-astrazeneca-reg174_proposed_14_Apr_2021.pdf
On page 2 in paragraph 2 it lists as part of the vaccine composition "Produced in genetically modified human embryonic kidney (HEK) 293 cells".

We can see the composition of the Pfizer Covid 19 vaccine via the link to the public information report we have already seen on the government website:
https://www.gov.uk/government/publications/regulatory-approval-of-pfizer-biontech-vaccine-for-covid-19/summary-public-assessment-report-for-pfizerbiontech-covid-19-vaccine
It states that development and testing of it used HEK 293 cells, which are from an aborted human embryo.

The Janssen / Johnson & Johnson Covid 19 vaccine is less used in the UK but here is a report on it by the European Union´s European Medicines Agency:
https://www.ema.europa.eu/en/documents/assessment-report/covid-19-vaccine-janssen-epar-public-assessment-report_en.pdf It states on page 19 that the vaccine was produced in HEK 293 cells.

The Moderna vaccine is the same.

Here is a vaccine information page from Oxford University that explains what the HEK 293 cell is:
https://vk.ovg.ox.ac.uk/vk/vaccine-ingredients#Human%20cell%20strains
It says **HEK means "Human Embryonic Kidney**": "HEK-293 is the name given to a specific line of cells used in various scientific applications. **The original cells were taken from the kidney of a legally aborted foetus** in 1973. HEK-293 cells used nowadays are clones of those original cells..."

The Vatican does acknowledge this fact, and approves their use, saying that "*it is morally acceptable to receive Covid-19 vaccines that have used cell lines from aborted fetuses in their research and production process.":*
http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20201221_nota-vaccini-anticovid_en.html
It explains this by saying that those taking the vaccine are only participating passively in an evil act and not actively, because they did not cause the abortions to occur.

However, the opinion or a statement made by any member of the church does not replace Christian teaching, as given in the Bible, or replace or modify doctrine or catechism; those are eternal and permanent laws which are the foundation of the church about which the church or church members may make commentaries so followers may be able to understand them, or they may, as they have done, guide followers through rites in order to be able to embrace them; indeed, if those laws were changed them the foundation of the church would be moved and the church as such cease to exist, in which case without a church there would be no church leaders to make such statements. This is not a matter in which only clergy are permitted to be involved but one which every member of the church down to the lay followers may understand and defend without needing permission.

**- How effective is the vaccine, and how much would taking it protect others?**

If a person considers it his or her social duty to undergo such risks not for the benefit of self but to protect others, then he or she should consider several things:

Firstly, the risks presented above involve being hospitalised and putting pressure on the healthcare system, as well as depriving families of a loved one, a provider or a parent, as well as a useful person in society.

As discussed, covid-symptom illness is not a threat for anyone who is not elderly; one will not be putting one´s family at risk by not vaccinating oneself, and if elderly relatives feel at risk they can feasibly protect themselves or one can avoid contact with them.

As the UK Government Astra-Zeneca vaccine information above states on p4 **"The duration of protection has not yet been established. As with any vaccine, vaccination with COVID-19 Vaccine AstraZeneca may not protect all vaccine recipients."**

There are different ways to view the efficacy of vaccines, and the British Medical Journal describes how to calculate them: https://bestpractice.bmj.com/info/toolkit/learn-ebm/how-to-calculate-risk/
Relative Risk Reduction assumes that without the treatment the patient will definitely be affected by the disease, whilst Absolute Risk Reduction takes into account the probability of contracting the disease in the first place and then measuring by how much that risk would be reduced by taking the treatment. The vaccine test results were obtained by seeing whether any of the people given vaccines or placebos developed covid symptoms or returned a positive PCR test after a certain period of time, and then compared the proportions of declared infections; this poses the problem of waiting for people to catch SARS-Cov2, and secondly the reliability of PCR tests: the British Medical Journal cites them as having a 30% inaccuracy rate: https://www.bmj.com/content/372/bmj.n287/rr

On p9 of the Astra-Zeneca vaccine document seen above, the test phase for the second dose after 12 weeks showed the following results: 15 out of 2,038 (0.7%) participants taking the vaccine tested positive for covid; 76 out of 2,093 (3.6%) participants taking the placebo tested positive:
Absolute Risk in Control Group (ARC) = 76 / 2093 = 0.036
Absolute Risk in Test Group (ART) = 15 / 2038 = 0.007
RRR (relative risk reduction) = (ARC – ART) / ARC = (0.036 – 0.007) / 0.036 = 0.8 = 80%
ARR (absolute risk reduction) = ARC – ART = 0.036 – 0.007 = 0.029 = 2.9%
NNT (number needed to treat) = 1 / ARR = 34 people to prevent 1 infection

The vaccine document and the Public Health England report below cite this relative risk reduction of 80% as being the vaccine efficiency of preventing infection:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/989360/PHE_COVID-19_vaccine_effectiveness_report_March_2021_v2.pdf
However, a risk reduction of 80% would only mean that a person taking the Astra-Zeneca vaccine was 80% less likely to become infected or had a 20% chance of becoming infected if the probability of becoming infected without the vaccine was 100%. The real risk of becoming infected with covid is obviously much lower, **so the real difference it will make to a person becoming infected by taking the vaccine is 2.9%:** assuming that covid is highly contagious and the whole population will inevitably get exposed to it at some time or another, that would change a vulnerable 80 year-old's risk of having symptoms and dying from covid from 0.5% to 0.485%, but with the added risk of taking the vaccine the person would run a definite risk of 0.49% and a likely risk of 0.52% of dying in the short term, with long-term chances unknown.

**So, a person must weigh the risks above with a 2.9% probability gain against infection from covid.**

Some publications claim a 95% efficacy for the vaccines, the RRR, and a lower ARR of 1%, which may be from further tests with a larger test group of people; the results from the official vaccine documents are used here though.

As we are being told, new variants of the virus are emerging; we have always been told that viruses mutate, and that coronaviruses, to which the flu and common cold belong. and the UK Government (see the above document on resurgence in hospitalisations, p9) says there is **"known reduced protection against mild to moderate disease from some vaccines" against a new strain.** Thus, booster vaccines and the development of further vaccines from the existing ones, as with the flu vaccines, are being discussed; should one multiply the aforementioned risks to oneself of taking more such vaccines after this one, to keep up with the programme if it requires them?

**- What could the long-term risks be?**

Firstly, the data we are receiving of vaccine accidents is the very short term, and we do not yet know whether similar accidents may continue to occur in the middle term, for example over the course of several months or a year or two years.

We may, however, wish to also think of much longer-term effects that may not be known currently, due to the vaccines being of a new kind.

This may concern the nature of the vaccines, being mRNA or Adenovirus in type, as described in the UK Government vaccine documentation here above, not used in a human population before, rather than the traditional type; the Government advisors, doctors and scientists developing the vaccines vouch for their safety. There have been other professionals, qualified doctors and scientists who warn of hazards such as the unwanted damage or modification of the users´ immune systems which may result in it over or under-reacting or something else.

We have no objective ourselves way of knowing who is right and which statements are true, but it may be reasonable to suppose that the kinds of side-effects or accidents that could occur with these vaccines may be different to those that could happen with traditional vaccines.

Indeed, scientists have been developing mRNA and adenovirus vaccines for around twenty years, but it is worthy of asking why **none have been approved so far** (see the previous document from the UK Department for Business, Energy and Industrial Strategy). These treatments are denominated vaccines by the governments and regulatory bodies, though as stated in the official; vaccine documents employ new techniques using genetic coding; mRNA delivered in nano lipid particles or delivering genetic material into cells through viral vectors in the case of adenoviruses.

The Astra-Zeneca website tells us that in the phase 3 trials (ongoing) the treatment uses “a replication-deficient chimpanzee viral vector based on a weakened version of a common cold virus (adenovirus) that causes infections in chimpanzees and contains the genetic material of the SARS-CoV-2 virus spike protein. After vaccination, the surface spike protein is produced, priming the immune system to attack the SARS-CoV-2 virus if it later infects the body”:
https://www.astrazeneca.com/media-centre/press-releases/2020/azd1222hlr.html

Page 7 of the UK Government Astra-Zeneca vaccine document states that the COVID-19 Vaccine AstraZeneca is a monovalent vaccine composed of a single recombinant, replication-deficient chimpanzee adenovirus (ChAdOx1) vector:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/978194/uk-HCP-covid-19-vaccine-astrazeneca-reg174_proposed_14_Apr_2021.pdf

The FDA includes viral vectors in its description of forms of gene therapy:
https://www.fda.gov/vaccines-blood-biologics/cellular-gene-therapy-products/what-gene-therapy

In this document on the risk of gene therapies the FDA makes references to vectors and on p3 states risk may include “undesirable changes in the genoma with the risk of malignancies, impairment of gene function ……. have the potential to establish persistent infections in immunocompromised patients leading to the risk of developing a delayed but serious infection”:
https://www.fda.gov/media/113768/download

Therefore, we must make up our own minds as to whether this technology may or may not be safe for us.

**- Making a decision looking ahead:**

Then, if the situation is not really an emergency, and without saying whether that might be because of a conspiracy or governmental blunder, taking the vaccine just so the government lets everybody out of lockdowns is not taking it for the right reason, for protecting health. Statements from persons in positions of authority and the press that everybody should get vaccinated in order for society to get back to normal, and that the public may not have its freedoms because of a group of the population who do not take the vaccine, is coercion.

The Cambridge dictionary defines coercion as "the use of force to persuade someone to do something that they are unwilling to do" : https://dictionary.cambridge.org/dictionary/english/coercion
This legal dictionary ( https://legal-dictionary.thefreedictionary.com/Coercion ) defines it as:
"The intimidation of a victim to compel the individual to do some act against his or her will by the use of psychological pressure, physical force, or threats. The crime of intentionally and unlawfully restraining another's freedom by threatening to commit a crime".
The UK law on the crime of "controlling or coercive" behaviour, though targeting domestic abuse, is described thus:
"Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim;
Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour"
https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship#:~:text=Coercive%20behaviour%20is%20an%20act,punish%2C%20or%20frighten%20their%20victim
It refers to the acts of one individual toward another, but if an employer, body of people or organisation placed individuals in a position where if they did not take a vaccine then they would have their movements restricted or not be able to be employed and thus deprived of a livelihood, then it could be argued that they are being forced to act against their will. That action would be to take an experimental and unproven substance, possibly for a reason that does not affect them in the first place, according to age and health. As discussed, this possibly violates the Nuremburg Code.

Furthermore, as we all have the same basic biology, true social responsibility would mean that if a person does not wish to take the vaccine thinking it is unsafe then the most responsible thing towards others is to act accordingly and not take it, passing on that same message to others. A society that is made up of people who are not able to follow their own conscience and preserve the sovereignty of their own minds and bodies is a society, one would imagine, not worth living in, so to exercise own conscience and sovereignty of one's mind and body is to defend society.

If a person feels that the situation warrants taking the vaccine, decides it is safe to do so, but wants to help improve the situation for society, then this statement by the WHO, delivered by its Director-General Tedros Adhanom, former Party Leader of the Ethiopian People's Revolutionary Democratic Front, should be paid attention to:
https://www.who.int/director-general/speeches/detail/who-director-general-s-opening-remarks-on-the-executive-board-meeting-16-november-2020
"A vaccine will complement the other tools we have, not replace them. **A vaccine on its own will not end the pandemic. Surveillance will need to continue; People will still need to be tested, isolated and cared for; Contacts will still need to be traced and quarantined."**

We may speculate why, but in any case, for whatever the reason it is, the UK Government and the WHO, want as many people as possible to take the vaccines. The WHO, to promote the vaccines, has published documentation talking about how to "break barriers" and "build trust" in communities to get everyone to take the vaccines, and focus on "influencing behaviour" through creating "1 ) an enabling environment; 2) social influences; and 3) motivation" (p2) rather than presenting people with objective data: https://www.who.int/news/item/21-12-2020-behavioural-considerations-for-acceptance-and-uptake-of-covid-19-vaccines Also see the document linked on it at https://www.who.int/publications-detail-redirect/9789240016927 . In fact, that same document on p2 states that they see the problem in the following way: "In addition to the sheer magnitude of the coming vaccination effort, **the vaccines will be new and are likely to be only partially effective for a yet unknown period of time".**

Other possibilities for treating covid than the vaccines may exist at some point. If one feels that, having analised the situation that it is necessary to protect vulnerable people and so a treatment is necessary, there may be other treatments available at some point which are worth waiting for. The FDA describes the positive research results of one drug: "An in vitro study of ivermectin in SARS-CoV-2 in Australia showed a significant reduction of viral load in infected cells. Subsequently, a descriptive study of 704 critical patients with COVID-19 showed a reduction in mortality, hospitalization, and intensive care unit length-of-stay in those patients who received the drug. Unfortunately, this study was withdrawn by its authors, leaving more questions than answers."
https://clinicaltrials.gov/ct2/show/study/NCT04602507

So, one should make sure that the decision of whether to take the vaccine is made according to one's own judgement on the suitability of the vaccine only, and not to obtain or gain something else.

After 2023, the safety of the vaccine would be assessed to see if it could be approved for normal use; then if directions were made that persons must take it each person can deem whether the vaccine is beneficial to him or her or may endanger his or her life and seek protection under Article 2 of the Human Rights Act, by which the UK is bound in Article 1, of the right to life: https://www.equalityhumanrights.com/en/human-rights-act/article-2-right-life

**- Why question scientists or the Government?**

Such a situation, if one looks at it this way, inevitably makes one ask "why?" However, the important thing, for now at least, is to focus on and evaluate for ourselves the “what”; that will give us the information we need in order to be able to act accordingly to the situation, whereas the “why” may distract us. We have the information of “what” clearly here in front of us, so we can decide for ourselves now, whereas we may not have the information to work out the “why”, so we may waste time, speculate erroneously and run the risk of being led by the decisions of others and not our own.

If we see the figures not justifying the categorisation of this period in time or the measures being put in place, we can put aside discussing or trying to decide whether this is a conspiracy, a blunder or recklessness. However, we can ease our minds into being too amazed that such a thing could occur, if we consider how many times a government, an authority or scientists have made a mistake. For example:
- Asbestos was a wonder building material until it was found to cause asbestosis leading to incurable lung cancer after only small fragments had been inhaled;
- The UK Government at the beginning of the cold war made military personnel in large numbers sit on a beach, wearing sunglasses, to observe nuclear bombs being detonated in the atoll; men developed cancer and died sooner or later: https://www.gov.uk/government/publications/nuclear-weapons-test-participants-study/nuclear-weapons-test-participants-study-information-sheet

Deciding to question the scientific or political establishment does not make one a conspiracy theorist as the principle of scientific enquiry is to follow the path of observation coupled with logical reasoning and ask however many questions necessary, without taking anything for granted. Regarding the terms "conspiracy theorist" or "anti-vaxxer", if one is worried about the contents in a particular drink, does that make one "anti-drinks"? It is illogical, and dangerous, to take a position according to what group of people you follow or listen to, or what some groups of people get called; indeed, it can be a problem if society becomes divided into groups who are purported to act one way or the other.

William Pitt The Elder, Statesman and Prime Minister in the 18th Century, said that *“in every question, in which my liberty or my property were concerned, I should consult and be determined by the dictates of common sense. …. I am apt to distrust the refinements of learning, because I have seen the ablest and the most learned men equally liable to deceive themselves and to mislead others. The condition of human nature would be lamentable indeed, if nothing less than the greatest learning and talents, which fall to the share of so small a number of men, were sufficient to direct our judgment and our conduct. But providence has taken better care of our happiness, and given us, in the simplicity of common sense, a rule for our direction, by which we never shall be misled”.*
https://englishlanguageandhistory.com/?id=william-pitt-elder-common-sense
This means that we should leave our governance solely in the hands of experts, no matter how qualified they may be, to take decisions for us based on matters that we can see for ourselves. Indeed, if we do so, we surrender the sovereignty of our own minds to others, and reduce ourselves to the position almost of insects, to obey blindly the commands issued from the hive. In practical aspects, the experts may be wrong sometimes, and it is logical to presume that they are never fully right as science is something about which scientists are always learning, and on the other hand, through our powers of observation and reasoning with which are no small gift, we may be able to discern the truth. It follows that if every individual is allowed to use that gift, society will be all the stronger, whist if they are not allowed to use it then society will be weaker. If one only base one’s decisions upon one’s trust of the Government, its advisors and the press who report what they say, then one place the fallibility of the people in those institutions before one’s own powers of observation and judgement; presumably one does this because one considers one’s own powers of judgement more fallible, and the judgement of people one does not know to be less fallible or even infallible.

In fact, if a human being decides that he is unable to discern the truth himself he becomes less than human, whilst when a human being decides that he can discern the truth with the powers endowed on him then he fully becomes himself. We need to have laws about which we are able to see and understand the point, in order to act according to them through understanding and thus moral agreement; if we do not then we will be blindly obeying, without knowing why, and whilst in one case that may be the right thing to do, it could be in another that it is wrong so we will not have knowledge of it and not be able to rectify our actions, leading to harm ourselves or others.

These are obvious example of normal laws whose reasons are visible to us:
- You may know that a law which prohibits driving a car above a certain speed through a populated area is warranted because we can see that if we drive at a high speed we will not be able to react in time and may kill a pedestrian.
- Killing another person is designated the crime of murder. We can understand why because on a practical level if we allowed ourselves to do so, because we covet a possession of someone else, then society would turn anarchic and chaotic, and nobody would be able to live in it. On a more transcendental level, we can understand that another person's life belongs to that person and we have no right to take it away, no matter what we may think of the value of that person or what he or she owns and what we want.

Therefore, each individual should be able to make up his or her own mind about how to act in this situation, and that is the purpose of providing this objective information.

## SUMMARY OF OBSERVATIONS FROM THIS STUDY:

- There is no situation of an unusually high mortality rate from a high-consequence disease
- Influenza and pneumonia mortality rates have been and are higher than covid mortality rates
- People under 50 years of age are more at risk from road accidents than covid
- Physically healthy people under the age of 65 and vulnerable people under the age of 45 are more at risk from suicide than from covid
- Children are at very low risk of dying from covid and so comparatively are at a very much higher risk of dying from the vaccines; they are much more at risk from suicide than from covid which brings into question how they are being treated during the situation and through the measures put in place
- Only healthy individuals from the age of 60 upwards can likely obtain from two doses of the vaccines a 2.9% reduction in risk of dying of covid that is superior to the risk dying from the vaccines in the short term
- Only vulnerable individuals from the age of 65 upwards can likely obtain from two doses of the vaccines a reduction in risk of dying of covid that is superior to the risk dying from the vaccines in the short term
- The absolute reduction of risk afforded by the vaccine lowers the risk posed to all individuals, healthy or vulnerable and in any age-group, by covid very little, but with the added risk from the vaccine may make the overall risk of death in the short-term higher than the original risk of death from covid
- The possible short-term risks of the vaccines from estimates suggest that only individuals over the average life-expectancy (80-84 years of age) may be more at risk from covid than from the vaccine, and that the vaccine may be more dangerous for anyone below the average life-expectancy than covid
- The production of the vaccine using aborted fetal cells means it is not acceptable to any Christian, followers of other faiths and those who believe in the sanctity of life and that life begins at conception
- The long-term risks of the vaccine, which is a new form of treatment in trial phases still, are unproven
- The Absolute Risk Reduction rate is very low meaning that taking the vaccine will not greatly prevent its transmission to others, so by taking it one will not protect others much
- The measures introduced by the Government and advised by the WHO are not dependent on the acceptance of the vaccine by the population
- Being in trial phases until 2023, and being a previously unused treatment, any direction that persons must take it would be a contravention of the Nuremburg Code
- If, after 2023, the vaccine were approved for normal use, a person still has sovereignty over his or her own body so if directions were made that it must be taken each person can deem whether the vaccine is beneficial to him or her or may endanger his or her life, and if he or she does not wish to take the vaccine seek protection under international law and natural law

**With this information, obtained from official sources, the reader may draw his or her own conclusions as to what the most appropriate course of action for him or herself should be.**