

200 Park Avenue, 17th Floor, New York, NY 10166
sirillp.com | P: (212) 532-1091 | F: (646) 417-5967

March 6, 2023

VIA FEDEX AND EMAIL

Lawrence A. Tabak, D.D.S., Ph.D.
Director, National Institutes of Health
9000 Rockville Pike
Bethesda, Maryland 20892
Lawrence.Tabak@nih.hhs.gov

Robert M. Califf, MD
Commissioner, Food and Drug Administration
10903 New Hampshire Ave.
Silver Spring, MD 20993-0002
Commissioner@fda.hhs.gov

Rochelle P. Walensky, MD, MPH
Director, Centers for Disease Control and
Prevention
Roybal Bldg. 21, Rm 12000
1600 Clifton Road
Atlanta, GA 30333
Aux7@cdc.gov

Janet Woodcock, MD
Principal Deputy Commissioner,
Food and Drug Administration
10903 New Hampshire Ave.
Silver Spring, MD 20993
Janet.Woodcock@fda.hhs.gov

Re: *Alarming Rise in Deaths Among Young-Middle Age Groups in the United States –
Call to Investigatory Action*

Dear Dr. Tabak, Dr. Califf, Dr. Walensky, and Dr. Woodcock:

We write on behalf of Informed Consent Action Network (“ICAN”) regarding a very concerning and increasing trend in mortality rates among the young and middle-aged groups over the past 1-2 years. This alarming effect is seen across numerous countries globally and does not appear to be decelerating or reversing, and the lack of attention afforded to it is equally concerning. There is a critical need for the FDA, NIH and CDC to carefully examine this issue, and the data points presented herein, investigate the possible causes, and publish their findings forthwith.

I. ALL-CAUSE MORTALITY – A BIAS-FREE INDICATOR WHICH CAN DETECT IMPORTANT TRENDS IN POPULATION LEVEL DEATHS

Determining the cause of death can often be both difficult and contaminated by various biases, including physician bias resulting from preconceived notions, ideology and even from media exposure. For example, William Farr, one of the founders of medical statistics, was quoted¹ as stating, “there is a strong disposition among some English practitioners not only to localize

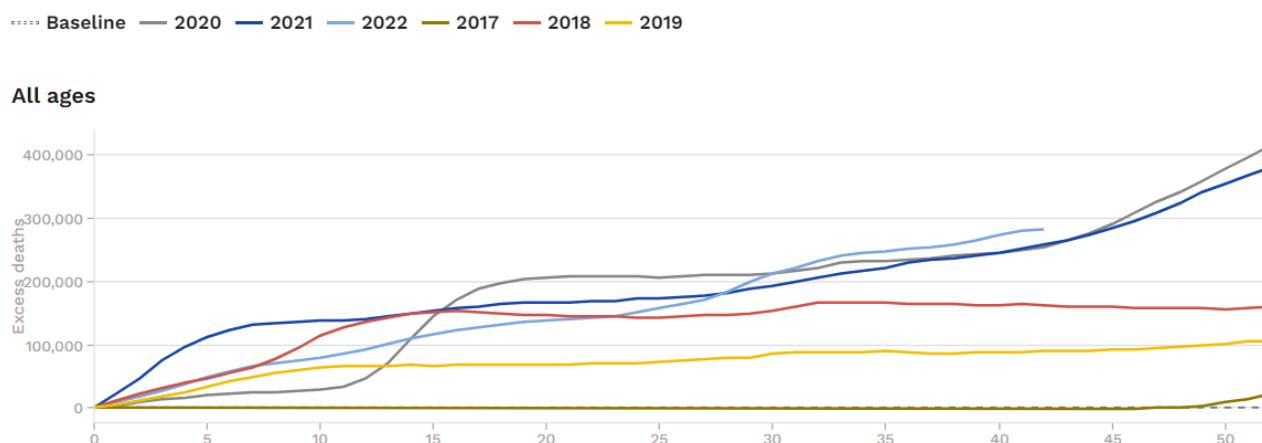
¹ Alexander Langmuir, *William Farr: Founder of Modern Concepts of Surveillance*, International Journal of Epidemiology (Mar. 1, 1976), <https://academic.oup.com/ije/article-abstract/5/1/13/769732?redirectedFrom=fulltext>.

disease but to see nothing but the local disease.”² These biases are frequently intentionally or unintentionally inserted into the death categorization process. This is why all-cause mortality – the total of all deaths without attribution to cause – is one of the best indicators in assessing population-level epidemiological events.³

If there is a significant population-level mortality event, whether increasing or decreasing, all-cause mortality should effectively detect it. All-cause mortality is thus an objective datapoint. It removes the bias associated with determining cause of death.

II. A SIGNIFICANT RISE IN ALL-CAUSE MORTALITY IS OCCURRING IN THOSE YOUNG TO MIDDLE-AGED

All-cause mortality is calculated and monitored, and is rising, in numerous countries. The below figure shows excess mortality (that is, the number of all-cause deaths exceeding the baseline) for all age groups in Europe.⁴ As seen in the official European government data chart, the all-cause mortality in 2022 exceeds even that of 2020 during the height of the Covid-19 pandemic before there was any authorized or licensed Covid-19 vaccines.⁵



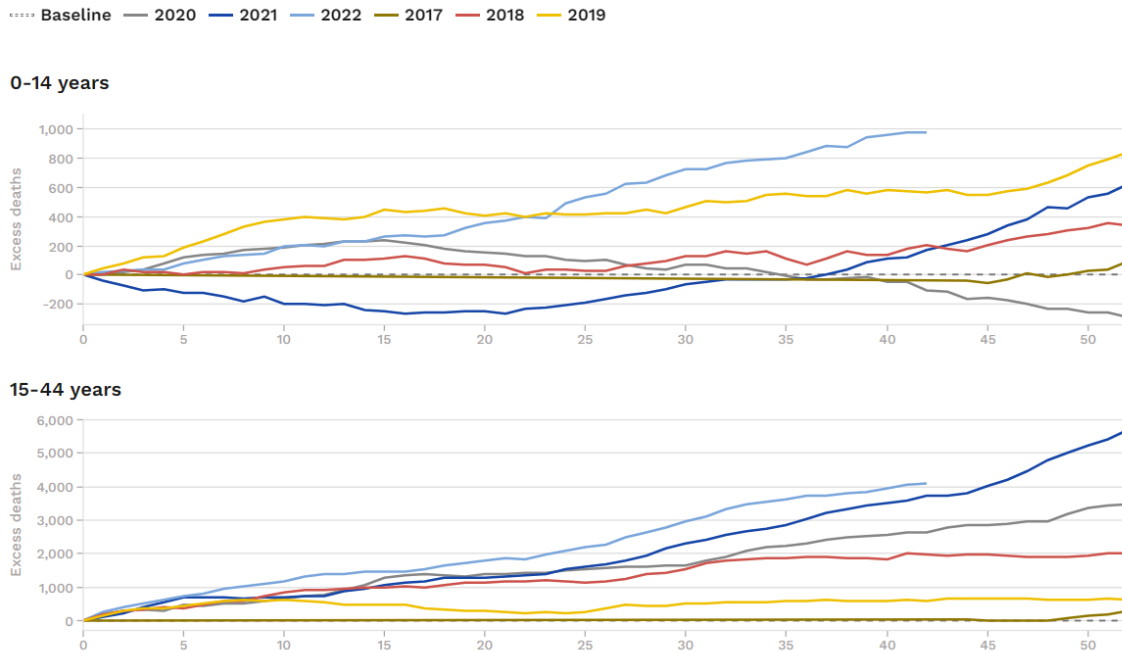
² Similarly, the bias attendant in death assignment is discussed in a study by leading epidemiologists, in which they noted, using influenza as his example: “the decision to classify deaths into “pneumonia and influenza” [P&I] is subjective and potentially inconsistent. On one hand, the effect of influenza or influenza-related pneumonia may be underestimated because underlying chronic diseases, particularly in the elderly, are usually noted as the cause of death on the death certificate. On the other hand, after influenza activity has been publicly reported there may be an increased tendency to classify deaths as due to “pneumonia and influenza,” thereby amplifying the rate of increase in P&I deaths or, when a decline in influenza activity is reported, a bias toward decreasing the classification of deaths related to pneumonia and influenza may result. Surveys to evaluate these possibilities have not been done.” K J Lui & A P Kendal, *Impact of influenza epidemics on mortality in the United States from October 1972 to May 1985*, *Am J Public Health* (June 1987), <https://pubmed.ncbi.nlm.nih.gov/3578619/>.

³ Denis Rancourt, *All-cause mortality during COVID-19: No plague and a likely signature of mass homicide by government response*, ResearchGate (June 2, 2020), https://denisrancourt.ca/uploads_entries/1626793454013_All-cause%20mortality%20during%20COVID-19----3.pdf.

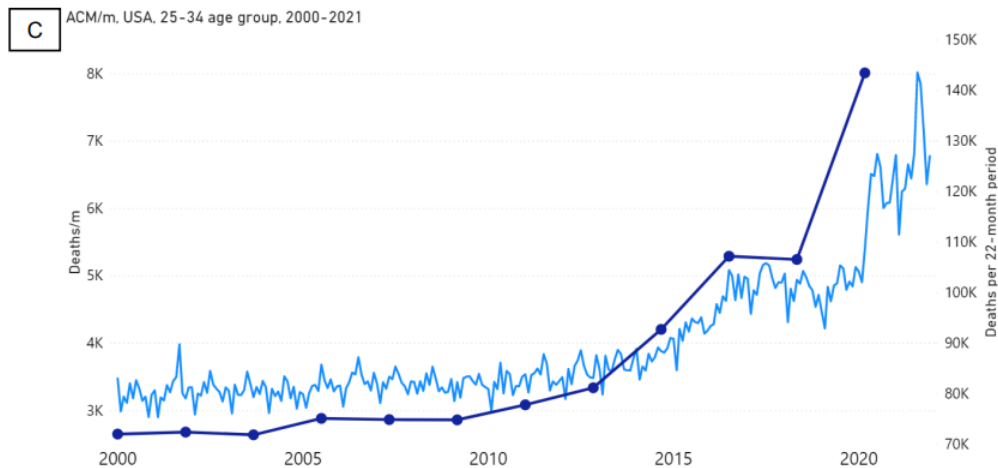
⁴ EUROMOMO (Last accessed Nov. 2, 2022), <https://www.euromomo.eu/graphs-and-maps#excess-mortality>.

⁵ *Id.*

The European excess mortality is highest in the 0-14 and 15-44 age groups, as seen in the following chart, which should cause serious concern as this significant rise in all-cause mortality among children is occurring without explanation:⁶



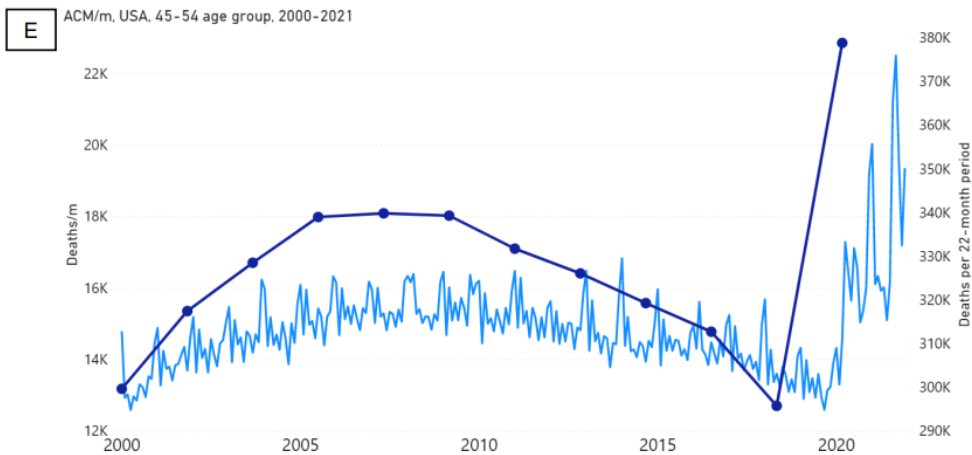
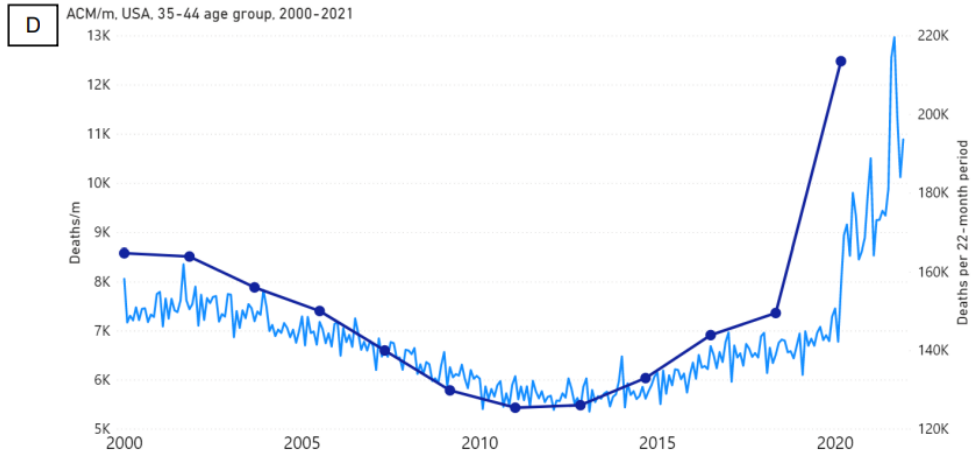
Turning to the United States, all-cause mortality data suggests a significant upward trend initiated in approximately 2020 which has not yet decelerated.⁷ The following figures show all-cause mortality for the 25-35, 35-44, and 44-54-year-old age groups, respectively.⁸



⁶ *Id.*

⁷ Denis Rancourt, *et al.*, *COVID-Period Mass Vaccination Campaign and Public Health Disaster in the USA* (Aug. 2, 2022), https://www.researchgate.net/publication/362427136_COVID-Period_Mass_Vaccination_Campaign_and_Public_Health_Disaster_in_the_USA_From_agestate-resolved_all-cause_mortality_by_time_age-resolved_vaccine_delivery_by_time_and_socio-geo-economic_data.

⁸ *Id.*



Other studies have examined these data and determined statistically significant trends in all-cause mortality. The following data is further evidence of this ongoing phenomenon.⁹ In the below table, odds ratios between the total mortality risk during 2021 and the total mortality risk for 2015-2019 are denoted for all age groups. In practical terms, cells in bold are suggestive of odds ratios over 1 and p-values under 0.001, which equates to a statistically significant increase in deaths in 2021 versus the 2015-2019 baseline period.¹⁰ The highest odds ratios (most significant increase in deaths) occurred in the age 25-44 range (men 35-44 years of age featured the greatest odds ratio of any age/sex subcategory); however, all results in bold are statistically significant. Since the p-values for the bolded are less than 0.001, this suggests there is a genuine, legitimate signal (unlikely due to chance) for significantly increased mortality in 2021 versus the baseline average. Moreover, the “NC” label in the below table’s header represents “Non-Covid” deaths. As

⁹ Ian Ludden, *et al.*, *Excess deaths by sex and Age Group in the first two years of the COVID-19 pandemic in the United States*, Health Care Manag Sci. (Aug. 23, 2022), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9395936/>.

¹⁰ *Id.*

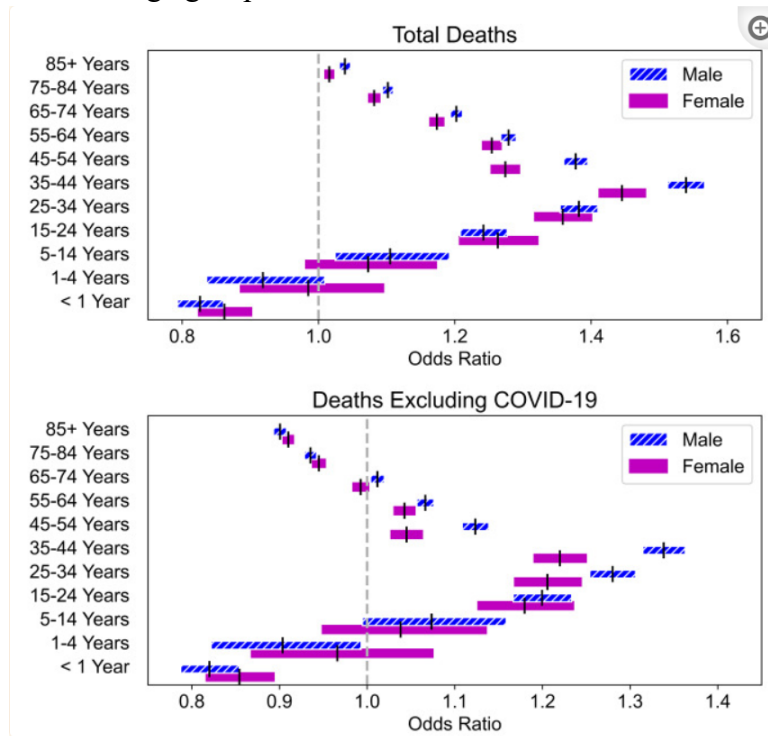
such, 2021's non-COVID deaths were also statistically significantly higher than 2015-2019 for most age groups.¹¹

Odds Ratio 99.8% Confidence Intervals for 2021 vs. 2015-2019 Mortality Risks

Ages	Male, Total	p value	Female, Total	p value	Male, NC†	p value	Female, NC†	p value
< 1	(0.793, 0.86)	< 0.001	(0.824, 0.902)	< 0.001	(0.787, 0.854)	< 0.001	(0.816, 0.894)	< 0.001
1-4	(0.836, 1.009)	0.005	(0.886, 1.096)	0.66	(0.822, 0.993)	< 0.001	(0.868, 1.075)	0.317
5-14	(1.024, 1.192)	< 0.001	(0.981, 1.173)	0.015	(0.995, 1.159)	0.004	(0.949, 1.136)	0.198
15-24	(1.208, 1.277)	< 0.001	(1.207, 1.322)	< 0.001	(1.167, 1.233)	< 0.001	(1.126, 1.235)	< 0.001
25-34	(1.354, 1.41)	< 0.001	(1.317, 1.401)	< 0.001	(1.254, 1.306)	< 0.001	(1.168, 1.244)	< 0.001
35-44	(1.512, 1.566)	< 0.001	(1.412, 1.48)	< 0.001	(1.314, 1.363)	< 0.001	(1.191, 1.25)	< 0.001
45-54	(1.36, 1.395)	< 0.001	(1.253, 1.295)	< 0.001	(1.109, 1.139)	< 0.001	(1.027, 1.063)	< 0.001
55-64	(1.268, 1.29)	< 0.001	(1.241, 1.268)	< 0.001	(1.057, 1.076)	< 0.001	(1.031, 1.054)	< 0.001
65-74	(1.193, 1.211)	< 0.001	(1.164, 1.184)	< 0.001	(1.004, 1.02)	< 0.001	(0.984, 1.002)	0.011
75-84	(1.094, 1.11)	< 0.001	(1.074, 1.09)	< 0.001	<i>(0.928, 0.942)</i>	< 0.001	<i>(0.938, 0.952)</i>	< 0.001
85+	(1.031, 1.047)	< 0.001	(1.009, 1.022)	< 0.001	<i>(0.893, 0.908)</i>	< 0.001	<i>(0.904, 0.916)</i>	< 0.001

†NC denotes non-COVID-19, i.e., excluding deaths involving COVID-19

The same odds ratios are shown in graphical form below for 2021 versus 2015-2019.¹² Note that deaths in 2021 are statistically significantly higher for both non-COVID deaths and COVID deaths for most age groups.



¹¹ *Id.*

¹² *Id.*

The increase in all-cause mortality did not slow down in 2021 for many age groups; in fact, when comparing April 2021 - March 2022 with April 2020 - April 2021, there was a statistically significant *uptick* in mortality for many of the same age groups as described in the 2021 versus 2015-2019 comparison:¹³

Odds Ratio 99.8% Confidence Intervals for Year 2 vs. Year 1 Mortality Risks

Ages	Male, Total	p value	Female, Total	p value	Male, NC†	p value	Female, NC†	p value
< 1	(0.962, 1.047)	0.808	(0.975, 1.071)	0.154	(0.955, 1.04)	0.802	(0.967, 1.062)	0.379
1-4	(1.03, 1.249)	< 0.001	(1.041, 1.298)	< 0.001	(1.016, 1.235)	< 0.001	(1.017, 1.27)	< 0.001
5-14	(0.966, 1.121)	0.099	(1.006, 1.203)	0.001	(0.947, 1.101)	0.392	(0.979, 1.174)	0.018
15-24	(0.984, 1.037)	0.253	(1.014, 1.106)	< 0.001	(0.965, 1.018)	0.298	(0.976, 1.067)	0.163
25-34	(1.039, 1.078)	< 0.001	(1.052, 1.113)	< 0.001	(1.002, 1.041)	< 0.001	(0.986, 1.046)	0.108
35-44	(1.095, 1.131)	< 0.001	(1.104, 1.152)	< 0.001	(1.039, 1.074)	< 0.001	(1.014, 1.062)	< 0.001
45-54	(1.055, 1.081)	< 0.001	(1.062, 1.096)	< 0.001	(1.001, 1.028)	0.001	(0.985, 1.019)	0.778
55-64	(1.01, 1.027)	< 0.001	(1.048, 1.07)	< 0.001	(0.999, 1.017)	0.006	(1.013, 1.036)	< 0.001
65-74	<i>(0.955, 0.969)</i>	<i>< 0.001</i>	(0.985, 1.001)	0.006	(0.997, 1.012)	0.042	(1.001, 1.018)	< 0.001
75-84	<i>(0.918, 0.93)</i>	<i>< 0.001</i>	<i>(0.936, 0.95)</i>	<i>< 0.001</i>	(0.992, 1.007)	0.783	(0.997, 1.012)	0.048
85+	<i>(0.867, 0.88)</i>	<i>< 0.001</i>	<i>(0.861, 0.872)</i>	<i>< 0.001</i>	<i>(0.958, 0.973)</i>	<i>< 0.001</i>	<i>(0.953, 0.965)</i>	<i>< 0.001</i>

†NC denotes non-COVID-19, i.e., excluding deaths involving COVID-19

Intriguingly, non-COVID deaths in year 2 (April 2021 - March 2022) were statistically significantly higher for a number of groups, especially the 25–44-year-old males. Again, this effect is both genuine, due to the statistical significance, and surprising given the apparent disconnect between the highest COVID-19 fatality rates established to occur in the oldest age groups and the greatest increase in all-cause mortality seen in young-middle aged groups.

Consistent with the above findings, another study established, when comparing all-cause mortality for March 2020 through February 28, 2022 with 2014-2019 averages: “the largest relative increase in all-cause mortality was 27% among adults ages 18-49 years. Males comprised most of the excess mortality (57%), but this predominance declined with age.”¹⁴ Furthermore, it is important to underscore that both the greatest excess mortality and steepest increase in same occurred in *the second half of 2021 for ages 18-49*, not in the year 2020 during the height of the COVID-19 pandemic.¹⁵

Accordingly, thus far, this data, collectively, has affirmatively established that a statistically significant increase in all-cause mortality occurred and is occurring. While this increase is apparent for the “all-ages” composite, it is most pronounced in the young adult and

¹³ *Id.*

¹⁴ Jeremy Faust, et al., *Two years of COVID-19: Excess mortality by age, region, gender, and race/ethnicity in the United States during the COVID-19 pandemic, March 1, 2020, through February 28, 2022*, medRxiv (Sep. 26, 2022), <https://www.medrxiv.org/content/10.1101/2022.08.16.22278800v2.full-text#T1>.

¹⁵ *Id.*, Figure 2C.

middle-aged subpopulations. Moreover, excess deaths were higher in 2021 than 2020, and, in numerous age groups, were statistically significantly higher in 2021-2022 compared to 2020-2021.

III. POSSIBLE CAUSES – ALARMING INCREASE CANNOT EXCLUSIVELY BE DUE TO COVID-19

The following is evident:

- All-cause mortality increased substantially and in a statistically significant way across numerous age groups in the United States for the period 2020-2022 versus the baseline period 2014-2019.
- This heightened all-cause mortality effect is present across numerous countries, as evidenced by higher excess deaths in 2021 and 2022 versus the baseline period for the European continent (see graph in Section II). 2022 featured the greatest excess deaths in Europe, even higher than 2021.
- The subpopulations most impacted by the heightened all-cause mortality are the young and middle-aged groups, especially ages 25-45, and the effect is somewhat more robust in men versus women.
- The infection fatality rate due to COVID-19 was mostly concentrated in the oldest subpopulations¹⁶ from the outset of the pandemic (ages 70+), and that effect has not altered, even considering the declining viral virulence with new variants such as the currently predominating Omicron variant.¹⁷
- Accordingly, the established COVID-19 fatality risk by age distribution and the pattern of the all-cause mortality present across many regions and in similar time periods is such that there must be another variable significantly contributing to the rise in deaths aside from COVID-19. The excess deaths are mainly occurring in those age subpopulations at lower risk of fatality from COVID-19, and additionally, deaths have continued to increase since 2020 rather than decrease. COVID-19 declining virulence since 2020 would suggest that all-cause mortality should have decreased with time, but it has not. Instead, and alarmingly, the opposite has occurred.

What is the primary factor involved in the excess death increase if not COVID-19? To further investigate this phenomenon, it is necessary to identify a factor common to all regions

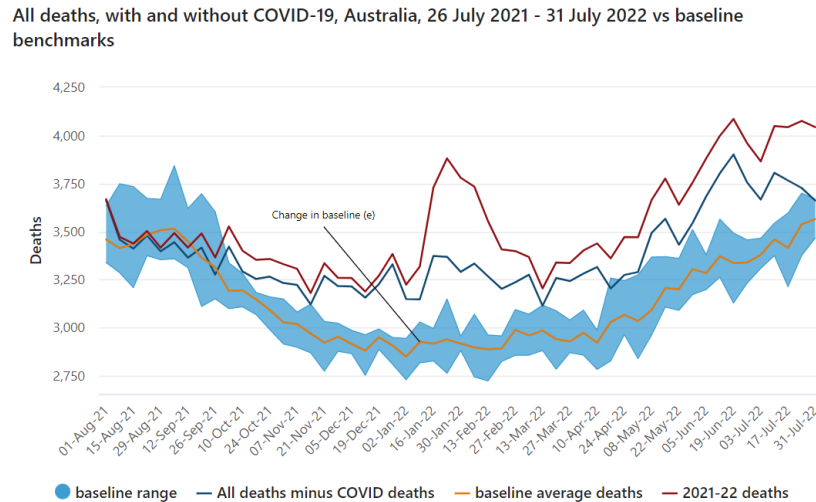
¹⁶ COVID-19 Forecasting Team, *Variation in the COVID-19 infection-fatality ratio by age, time, and geography during the pre-vaccine era: a systematic analysis*, *The Lancet* (Feb. 24, 2022), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)02867-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02867-1/fulltext).

¹⁷ Centers for Disease Control and Prevention, *COVID Data Tracker – Variant Proportions*, <https://covid.cdc.gov/covid-data-tracker/#variant-proportions>. (Last accessed Oct. 26, 2022); Blas J. Larrauri, *et al.*, *Omicron and vaccines: An analysis on the decline in COVID-19 mortality*, medRxiv (May 23, 2022), <https://www.medrxiv.org/content/10.1101/2022.05.20.22275396v1>.

experiencing the same/similar excess mortality event.

A. AUSTRALIA

The following figure, from the Australian Bureau of Statistics, shows all-cause mortality in Australia from mid-2021 through end of July 2022.¹⁸



Note that the 2021-22 deaths (red line) and “all deaths minus COVID deaths” (blue line) rise significantly above the baseline range deaths (blue shading) in the second half of 2021, beginning around September 2021. These excess deaths were outside of the blue denoted “baseline range,” and importantly, Australia did not experience its first substantial wave of COVID-19 infections until after that - the beginning of 2022 (see below graph).¹⁹

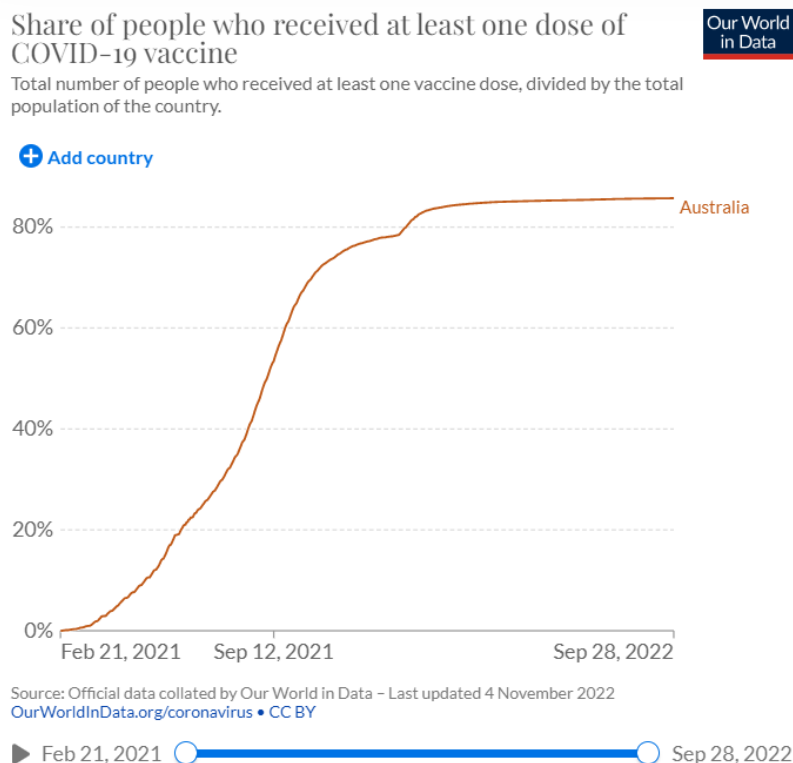


The significant increase in total deaths (2021) occurred **prior to** the exponential rise in COVID-19 infections (early 2022).

¹⁸ Australian Bureau of Statistics (Last Accessed Nov. 4, 2022), <https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/latest-release>.

¹⁹ Our World in Data (Last Accessed Nov. 9, 2022), <https://ourworldindata.org/covid-cases>.

A possible variable of causative interest is the mass COVID-19 vaccination program which initiated in early 2021 in Australia. Vaccination rates increased exponentially through 2021 such that the population vaccination rate was 50% by early September 2021, and over 80% by the end of 2022 (see below figure).²⁰ As such, the exponential increase in vaccination rates throughout 2021 was simultaneous with the increase in excess mortality, all prior to the onset of the COVID-19 infection wave in early 2022.



Accordingly, since the all-cause mortality divergence from baseline averages in 2021 occurred prior to the substantial increase in COVID-19, attribution to COVID-19 alone is implausible.

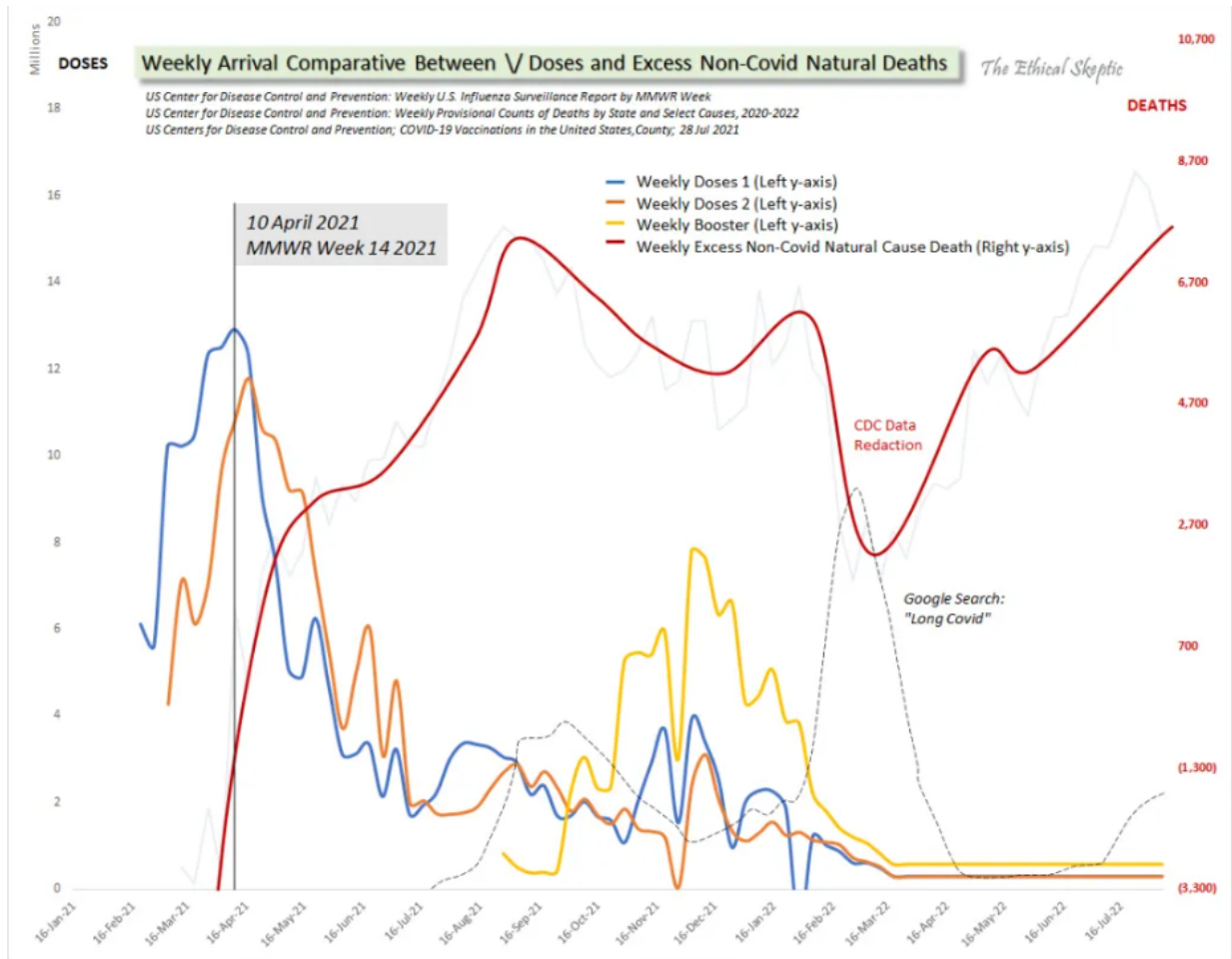
B. UNITED STATES

Like Australia, the United States data depicted below portrays COVID-19 vaccination rates (doses per million on Y axis) overlaid by excess non-COVID natural deaths.²¹ The exponential increase in doses administered (February through April 2021) immediately preceded the exponential rise in non-COVID natural deaths (April through September 2021). Thus, the temporal correlation holds here as well. Note the following in the below graph: 1) the orange and blue lines showing vaccine doses rapidly increasing in the first half of 2021, and 2) the red line, which

²⁰ Our World in Data (Last Accessed Nov. 4, 2022), <https://ourworldindata.org/coronavirus/country/palestine#what-share-of-the-population-has-received-at-least-one-dose-of-the-covid-19-vaccine>.

²¹ The Ethical Skeptic, Houston, We Have a Problem (Aug. 20, 2022), <https://theethicalskeptic.com/2022/08/20/houston-we-have-a-problem-part-1-of-3/>.

represents non-COVID deaths, significantly and quickly increasing shortly after spike in vaccine doses.



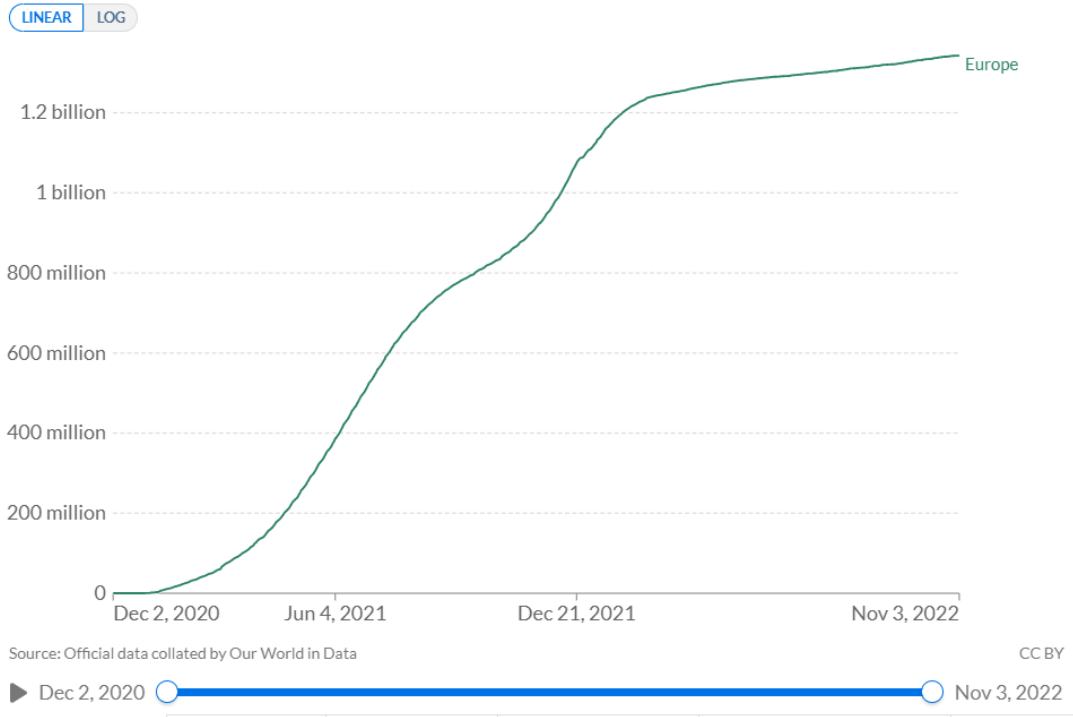
C. EUROPE

The temporal relationship between the mass vaccination program and the significant increase in excess deaths exists for Europe as well. The following figure shows cumulative COVID-19 vaccine doses administered in Europe; note the exponential curve throughout Jan-Dec 2021.²²

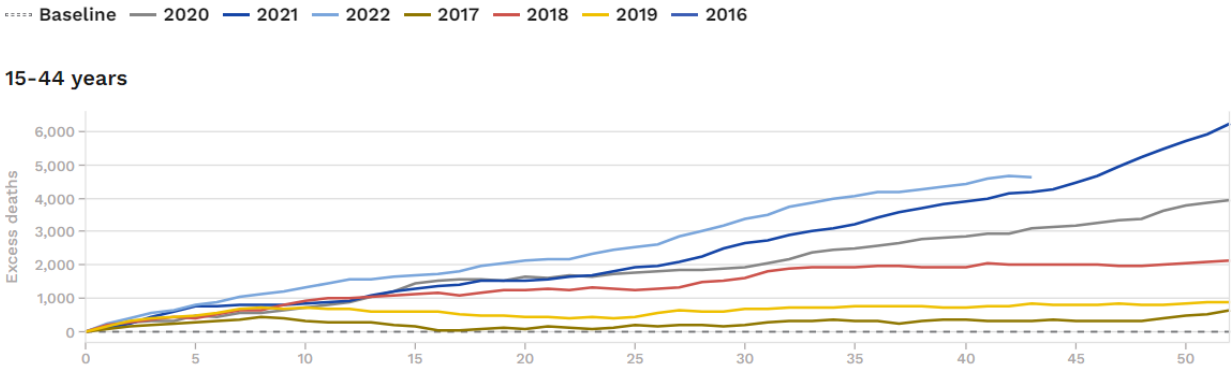
²² Our World in Data (Last Accessed Nov. 4, 2022), <https://ourworldindata.org/covid-vaccinations>.

COVID-19 vaccine doses administered

All doses, including boosters, are counted individually.



Furthermore, the next figure denotes excess deaths for the age 15-44 group in Europe. Note that 2021's excess death begins to diverge away from and higher than 2020 by the middle of the year (dark blue line), simultaneous with the above figure's exponential rise in vaccination doses administered. Excess deaths for the second half of 2021 were higher than the second half of 2020, and 2022's excess deaths are the greatest yet.²³



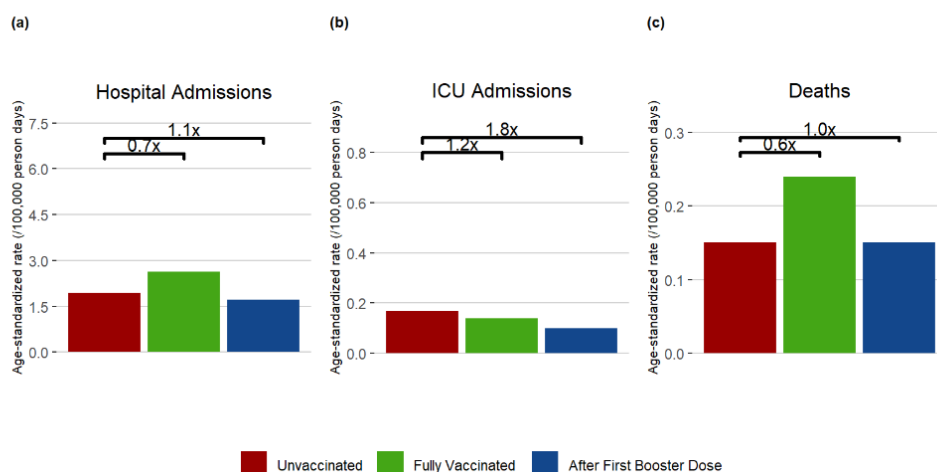
²³ See supra note 6.

The hypothesis that COVID-19 vaccines may contribute to the rise in excess deaths is not outlandish; Pfizer’s own clinical trial data indicated a 24% higher rate of mortality in the vaccinated group versus the unvaccinated.²⁴

D. CANADA

The Canadian province of Manitoba was previously publishing data indicative of the same phenomenon, namely increased mortality in vaccinated groups. The below figure depicts the rate and risk of severe outcomes associated with COVID-19 by vaccination status.²⁵ Fully vaccinated individuals were more likely to be admitted to the hospital (green bar, figure (a) on the left), and to die (green bar, figure (c) on the right) than their unvaccinated counterparts. The difference is notable and significant.

Figure 6. Age-Standardized Rate (/100,000 person days) and Risk of Severe Outcomes Associated with COVID-19 Manitoba, May 1, 2022 – May 31, 2022



Unfortunately, much like Scotland,²⁶ United Kingdom,²⁷ and British Columbia,²⁸ Manitoba joined a growing list of nations which halted release of their data depicting COVID-19

²⁴ Pfizer, Summary Basis for Regulatory Action – Comirnaty, 1, 23, (Nov. 8, 2021), <https://www.fda.gov/media/151733/download> (24% derived from a total of 38 deaths reported, 21 in the COMIRNATY group and 17 in the placebo group, hence a 24% higher rate of death in the intervention arm).

²⁵ Provincial Respiratory Surveillance Report COVID-19, (Aug. 3, 2022), https://www.gov.mb.ca/health/publichealth/surveillance/covid-19/2022/week_30/index.html.

²⁶ Public Health Scotland, Public Health Scotland COVID-19 & Winter Statistical Report, (Mar. 4, 2022), <https://publichealthscotland.scot/media/12034/22-03-02-covid19-winter-publication-report.pdf>, noting “due to the increasing risk of misinterpretation from growing complexities as the COVID-19 pandemic enters its second year, PHS has taken the decision to no longer report COVID-19 cases, hospitalizations and deaths by vaccination status on a weekly basis.”

²⁷ UK Health Security Agency, COVID-19 vaccine surveillance report – Week 14, (Apr. 7, 2022), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1067158/vaccine-surveillance-report-week-14.pdf, noting “Data on the vaccination status of COVID-19 cases, and deaths and hospitalizations with COVID-19, is no longer published.”

²⁸ Ian Holliday, *BCCDC removes data on COVID-19 infection outcomes by vaccination status from dashboard*, CTV News – Vancouver (July 30, 2022), <https://bc.ctvnews.ca/bccdc-removes-data-on-covid-19-infection-outcomes-by->

outcomes by vaccination status. While certain inferences can be drawn from the decisions to conceal the data given the highly revelatory nature of same, that is not the focus of this letter.

E. ADDITIONAL STATISTICALLY SIGNIFICANT RELATIONSHIPS BETWEEN VACCINE UPTAKE AND EXCESS MORTALITY SEEN IN OTHER COUNTRIES

An analysis²⁹ was performed utilizing global mortality data³⁰ and vaccine/booster uptake rates.³¹ The analysis collected mortality data in various countries, their corresponding vaccination rates, and booster rates. See the table below.³²

Country	Fully Vaxed Rate as of Mar 01	Boosters per 100 as of Jul 1	Excess Mortality Weeks 20-44
AUT	73.69	59.53	0.1168
BEL	78.28	66.36	0.0510
BGR	29.71	11.14	-0.0118
CHE	68.81	43.58	0.0839
CHL	88.42	125.38	0.2053
DEU	75.11	68.47	0.1274
DNK	81.6	62.29	0.0917
ESP	82.21	53.57	0.1836
EST	63.21	35.88	0.0946
FIN	76.27	59.92	0.0979
FRA	77.95	58.95	0.0625
GBR	72.85	59.45	0.1148
GRC	72.15	58.64	0.1709
HRV	54.93	14.65	0.0377
HUN	63.54	43.15	0.0085
ISL	78.04	67.65	0.1467
ISR	65.96	57.38	0.1143
ITA	80.15	69.33	0.1407
LTU	67.11	33.53	0.0492
LVA	69.32	28.22	0.0354
NLD	68.81	53.4	0.0865
NOR	74.46	55.95	0.1134
NZL	77.27	53.32	0.1546
POL	57.92	31.75	0.0417
PRT	85.48	65.44	0.1841
SVN	57.47	31.04	0.0633
SWE	72.42	51.96	0.0155
USA	65.48	37.44	0.1145

[vaccination-status-from-dashboard-1.6008336](#), noting that the data had become “hard to interpret” and was thus retired.

²⁹ The figures in this subsection were derived from an analysis performed by Igor Chudov, https://igorchudov.substack.com/p/association-between-vaccines-and?utm_source=post-email-title&publication_id=441185&post_id=82945844&isFreemail=true&utm_medium=email.

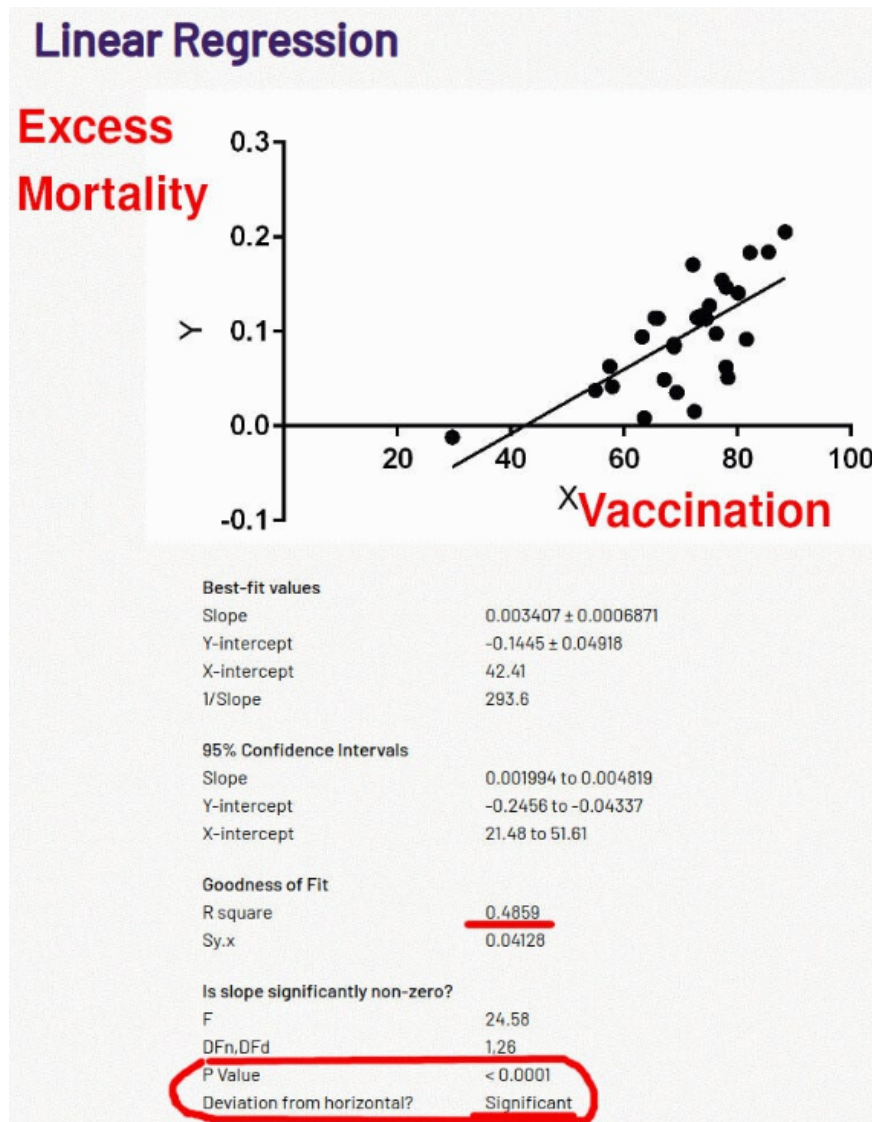
³⁰ Human Mortality Database, Short-term Mortality Fluctuations (Last Updated Nov. 7, 2022), <https://mpidr.shinyapps.io/stmortality/>.

³¹ Our World in Data, Number of people who completed the initial COVID-19 vaccination Protocol (Last Accessed Nov. 9, 2022), <https://ourworldindata.org/grapher/share-people-fully-vaccinated-covid>; Our World in Data, COVID-19 vaccine boosters administered per 100 people (Last Accessed Nov. 9, 2022), https://ourworldindata.org/grapher/covid-vaccine-booster-doses-per-capita?country=BGD~BRA~CHL~IND~ITA~PAK~RUS~SGP~USA~OWID_WRL.

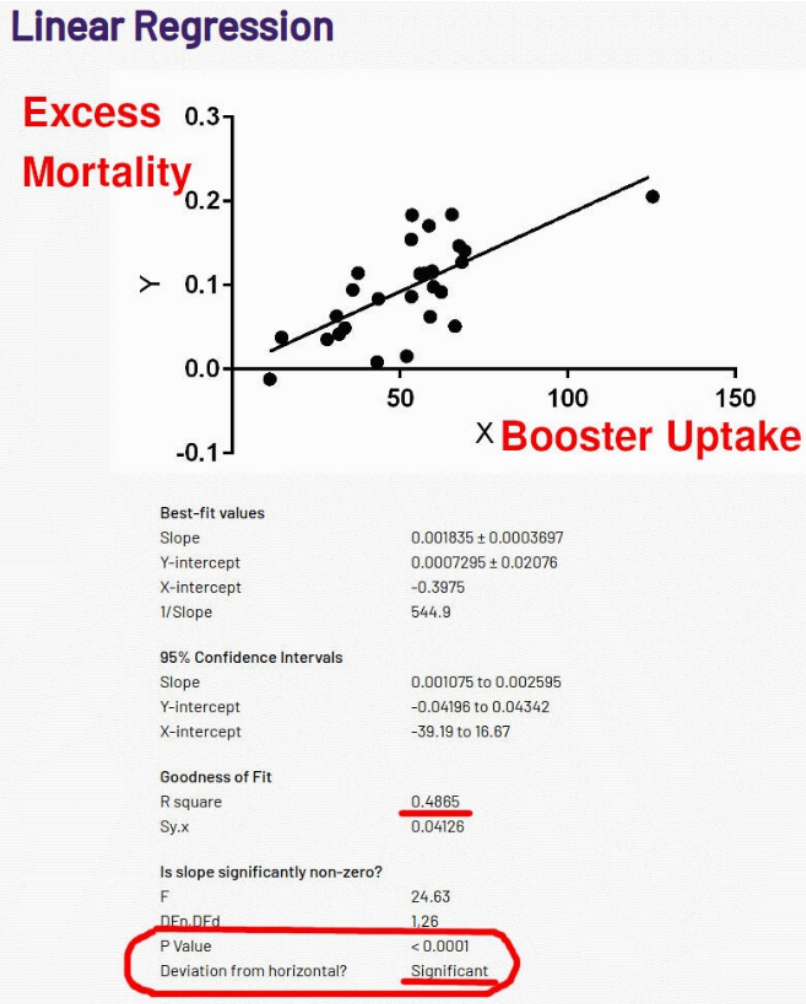
³² Igor Chudov, *Association Between Vaccines and EXCESS MORTALITY Getting Stronger – and is Discussed in UK Parliament* (Nov. 6, 2022), https://igorchudov.substack.com/p/association-between-vaccines-and?utm_source=post-email-title&publication_id=441185&post_id=82945844&isFreemail=true&utm_medium=email.

Two interesting notes about the data: 1) Bulgaria (BGR) is the least vaccinated country in the dataset, and has a negative excess mortality (-0.0118), and 2) Chile (CHL), with more boosters given than it has people (125.38), has the highest excess mortality of any nation in the dataset.

In the following linear regression figures³³ (establishes relationships between variables - here, vaccination and excess mortality, and boosters and excess mortality), notice that the r-squared values are near 0.5, and the p-values are both less than 0.0001. In statistics, p values at this very low level are indicative of robust results and imply that the relationship between vaccine rates and excess death is very unlikely to be due to chance. In other words, there is a legitimate, genuine signal here.



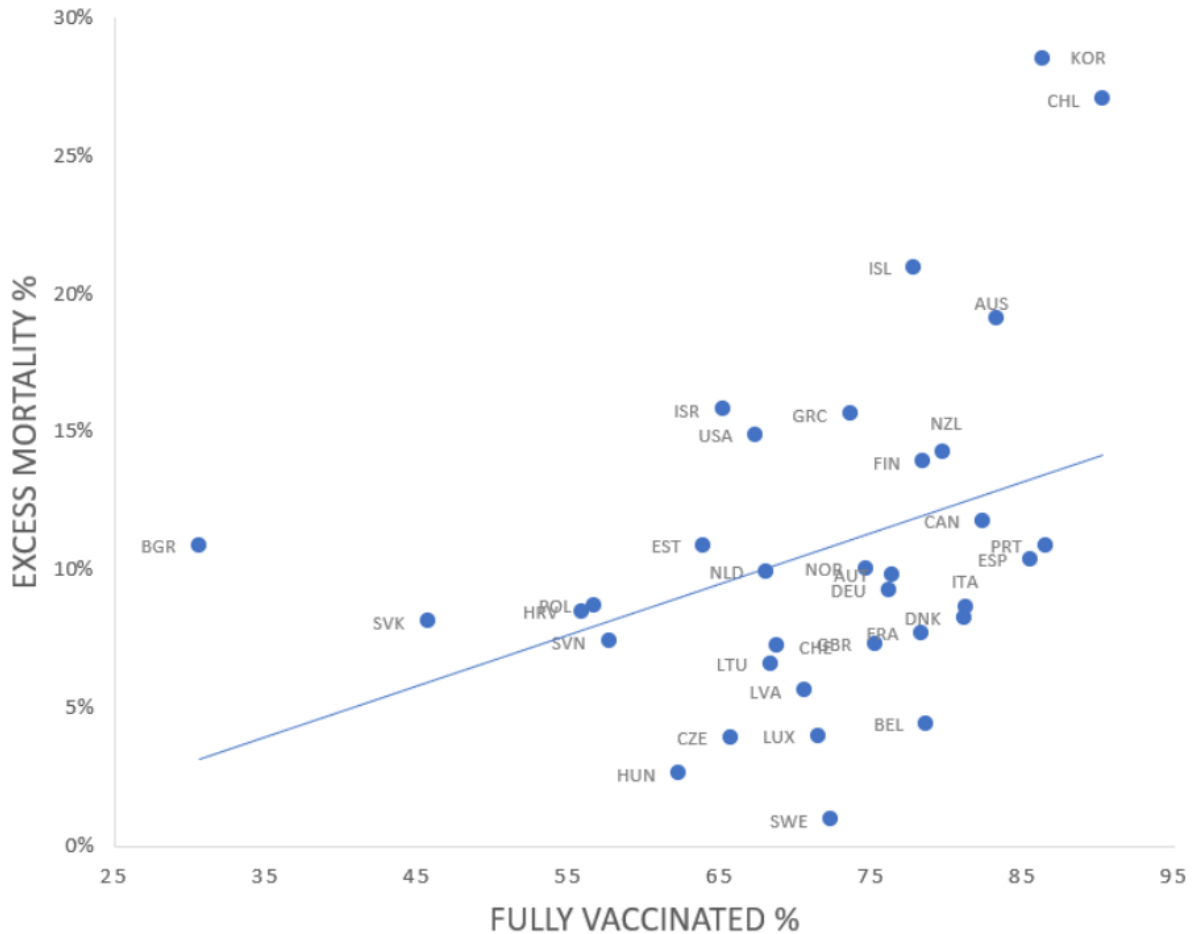
³³ *Id.*



A follow-up corroborative assessment was performed on the aforesaid analysis by Professors Fenton and Neil.³⁴ This exploratory assessment analyzed potential alternative hypotheses for the significant increase in all-cause mortality. Coefficients of determination were calculated for those hypotheses, including, COVID-19, Long-COVID, lockdown stringency, healthcare quality, and COVID vaccines. The R-squared values for all hypotheses, except COVID-19 vaccines, were statistically insignificant. However, there was a statistically significant relationship between all-cause mortality and COVID-19 vaccines, as depicted in their linear regression below.

³⁴ Norman Fenton and Martin Neil, *The Devil's Advocate: An Exploratory Analysis of 2022 Excess Mortality – What is causing excess deaths: Covid, long-covid, lockdowns, healthcare or the vaccines?* (Dec. 14, 2022), <https://wherearethenumbers.substack.com/p/the-devils-advocate-an-exploratory>.

2022 weeks 1-44



$$R^2 = 0.1354$$

P-value: 0.033 < 0.05 significant

Accordingly, their analysis concluded that all-cause mortality increase occurring in numerous jurisdictions globally is unlikely to be caused by COVID-19, lockdowns, healthcare quality, or long COVID. Rather, the COVID-19 vaccine program is at least partially culpable for the increase in all-cause mortality.

IV. CONCLUSION AND ACTION REQUEST

To summarize:

1. It is indisputable that there has been an alarming and statistically significant rise in all-cause mortality, with the increase steepening in 2021 and displaying little sign of deceleration in 2022;
2. The greatest deaths are concentrated in the young to middle-age groups;

3. The infection fatality rate by age distribution in concert with the spatial and temporal nature of these increased deaths is such that it renders COVID-19 unlikely to be the primary cause; and
4. The excess death effect is present across numerous nations.

It is self-evident that such a phenomenon must be caused by a factor common to the affected regions. One hypothesis which appears to possess strong support is the introduction of the COVID-19 vaccination program, temporally correlated and antecedent to the rise in all-cause mortality in numerous regions. This disturbing increase in deaths globally, especially within an atypical subpopulation (young/middle-age), must be further investigated.

ICAN respectfully requests a response forthwith detailing what precise steps are being taken to investigate this troubling trend of excess mortality. If none are being taken, ICAN requests an explanation as to why such an investigation is not called for.

Regards,



Aaron Siri, Esq.
Elizabeth A. Brehm, Esq.
Thomas Stavola, Esq.