Denis Rancourt (and team's) new report on vaccine dose fatality rate (vDFR) - in a nutshell

...and what it means for the URF in VAERS

Jessica Rose
11 hr ago

Update: A reader brought it to my attention that the ResearchGate link to the study leads no-wheres-ville. I believe they might be gearing up to dismiss Denis from ResearchGate. So here's a link to his website and a pdf of the study so his work gets even more attention. :)

I will be interviewing Denis Rancourt soon (we are trying to settle on a date) but in the meantime, here is my synopsis of his and his team's latest work entitled "Age-stratified COVID-19 vaccine-dose fatality rate for Israel and Australia" - Brief Report published February 9, 2023 on ResearchGate. [1]

This report is important because it shows with empirical evidence that the prioritization of injecting the elderly with COVID-19 products was the wrong way to go. Furthermore, it wasn't really based on any data. It was just, 'a hope'. Right Walensky? Well, your hopes and dreams killed a lot of people.

The authors calculated what they refer to as the **vaccine-dose fatality rate** (vDFR) which very simply equates to the number of injection-induced deaths over the number of doses administered.

$$vDFR = \frac{number\ of\ injection\ induced\ deaths}{number\ of\ doses\ administered}$$

In this report, they perform empirical evaluations of vDFRs stratified by age, using all-cause mortality and vaccine rollout data, specifically for Israel and Australia.

Thankfully, they plan to expand the search to other countries so stay tuned for these follow-up studies.

What they found is that older individuals have much higher vDFRs - peaking at 0.93% in individuals 85 years and older in Australia - and doubling times obtained by fitting an exponential function to the age-stratified vDFR calculations (for the 5 and 8 data points for Australia and Israel, respectively) at 5.4 and 4.9 years. The doubling times in this case are calculated based on age, so basically the risk of dying doubles every 5 years, per injection, and therefore, it is precisely the elderly who should NOT have gotten these shots first, **if at all**.

By the way, this report only considers death - it does not consider disabilities in the form of neurological or cardiovascular injuries sustained, for example. Reports of adverse events of these types in VAERS are in the hundreds of thousands. Disability reports are at 63,065, no under-reporting factor (URF) considered. If we consider an URF of 31, this becomes 1,955,015 disabled in association with these COVID injections in the U.S. alone.

Below is a summary of the fits of the calculated vDFRs per age group for Australia and Israel along with the respective doubling time calculations (T2).

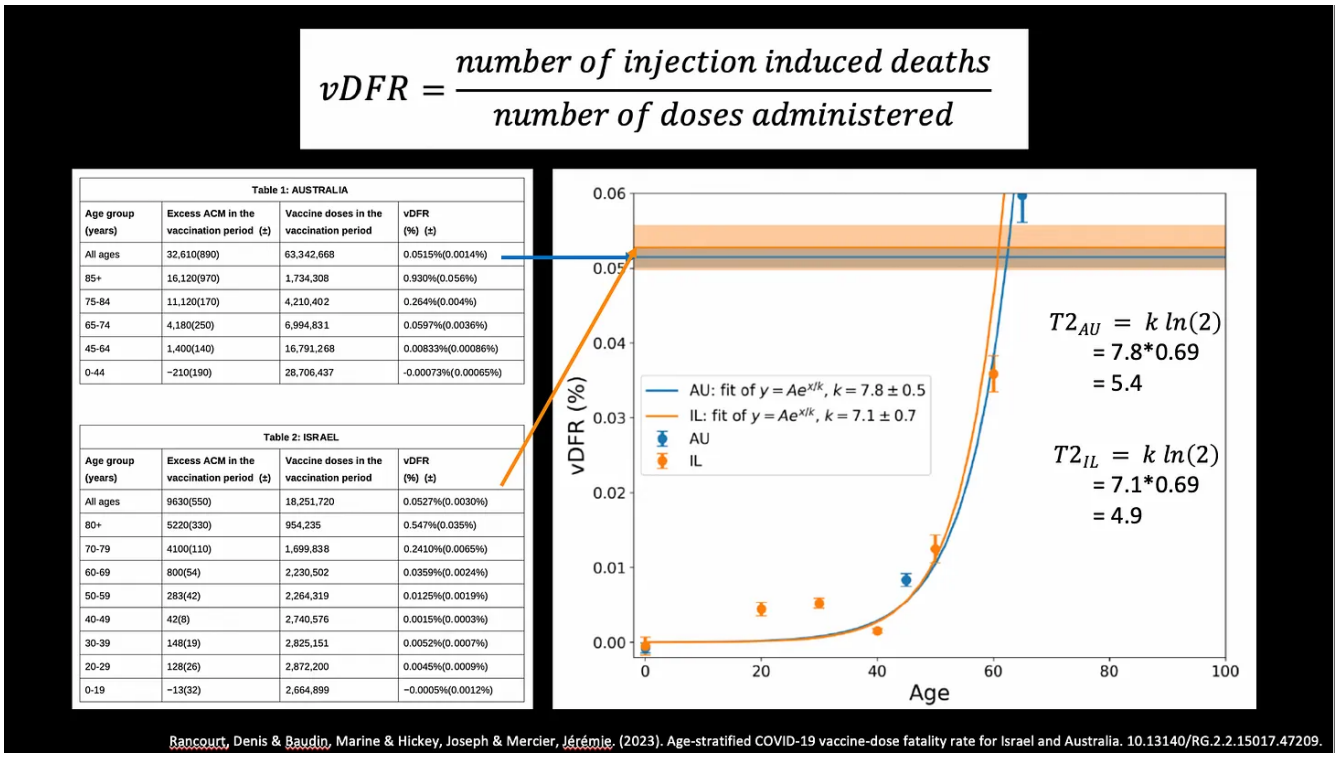

Figure 1: Summary of Figures from Rancourt et al.
DOI:10.13140/RG.2.2.15017.47209.

It is clear to see that the age data when plotted against the calculated vDFRs fit the exponential growth function y=Aexp(x/k), in both cases, even though the y-axis scale is small. I threw in the doubling time calculations as well. The all age vDFRs in the cases of both Australia and Israel is 0.05% (top row of data as per each of Table 1 and 2), and this makes a very compelling argument for extrapolation to real world data.

When the authors applied this all age vDFR to the actual numbers of people who were injected in the United States, they estimated that 334,800 people have died due to the injections based on Our World in Data's January 31, 2023 update where 669,600,000 million doses having been doled out in the U.S., up to and including that date.

Well that's interesting isn't it. We can calculate the URF using VAERS data and the all age vDFR. The number of deaths in the VAERS Domestic data set as of January 31, 2023 is 16,000, give or take a few. This means that the URF, according to the author's findings, would be 21 since the actual number of people estimated to have died in this timeframe according the all age vDFR is 334,800. This is much higher than I would have anticipated for URF for death, but I am not surprised by this. Not only that, I have confidence based on this study that it is accurate.

Steve Kirsch did his own URF calculation based on the likelihood that the vDFRs might even exceed 0.05% to be an astonishing 0.1%. The 0.1% estimate is suggested by the authors to be a more accurate estimate based on the India data and the results presented in this study. Steve found that based on the 0.1% rate that the number of dead in the U.S. is 669,600, and therefore using the same number of dead reported to VAERS as quoted above, the URF becomes 41. That's exactly the URF calculation he has reported having calculated for well over a year now based on an anaphylaxis study published by Blumenthal et al in JAMA. [2] Now, it is important to point out that the URF for death is likely going to be smaller than for many other adverse event types, but still, it is quite uncanny that the calculations match perfectly.

The results from this paper bring a sobering empirically-defined reality to the table: it was deadly to impose these injections on the elderly. And it was entirely irresponsible

to do this based on NO DATA.

Jikkyleaks has been digging into the connection to excess deaths in our elders and midazolam prescribing increases, and it is not looking good for the administrators or for all of those who had a hand in this 'operation'. Check out the Twitter post from Nick Hudson using Ben's Mortality Watch app in Figure 2 below. I don't know about you, but I do not believe in coincidences.

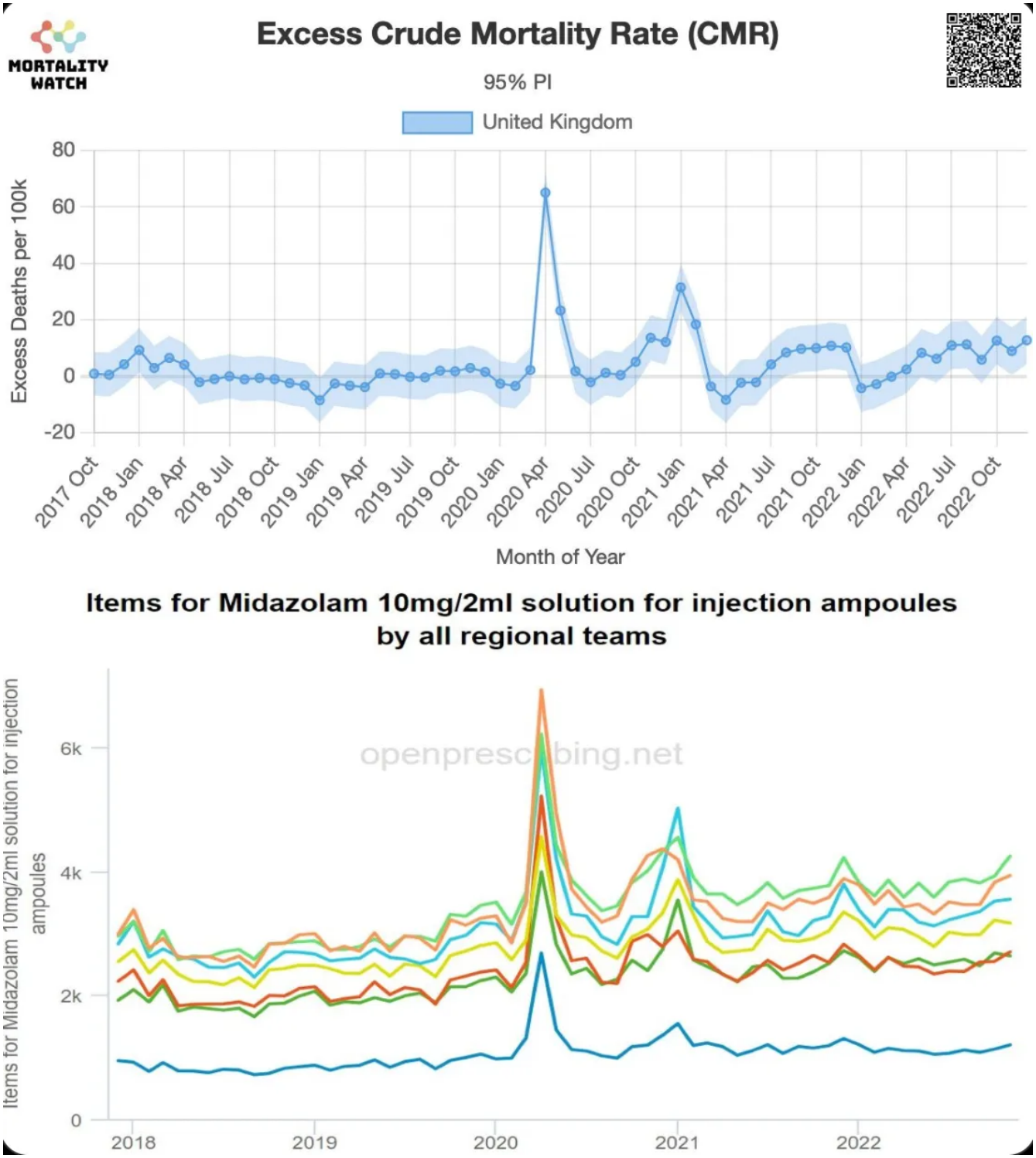

Figure 2: https://twitter.com/USMortality/status/1623394604044386309
https://openprescribing.net/analyse/#org=regional_team&numIds=0408020W0,1501041T0,0408020V0,0401010Q0&denom=nothing&selectedTab=chart
https://www.mortality.watch/?q=%7B%22c%22%3A%5B%22United+Kingdom%22%5D%2C%22cs%22%3A0%2C%22ct%22%3A5%2C%22t%22%3A3%2C%22dt%22%3A%222022+Dec%22%2C%22m%22%3A0%2C%22pi%22%3A1%2C%22sl%22%3A0%7D

To conclude this synopsis, I believe based on the charts presented by Ben and Jikky - which incidentally, you can recreate using the links in the caption under the above figure, and the data presented by the authors of this report, that what has taken place over the past few years is government-assisted termination of our elderly using such tools as the injections themselves, lethal cocktails of respiration depressing drugs upon declaration of 'COVID positive status', improper do not resuscitate (DNR) declarations and use and neglect (starvation and dehydration).

I know how horrifying that sounds. It felt awful to write as well, but one cannot ignore the data. Data does not lie; people do.

According to this report, 13 million individuals are estimated to have died in association with these injections alone, based on the 13.25 billion doses of these injectable COVID products administered to the human population as of January 24, 2023.

13 million. Think about that. What if the authors are correct?

This estimate far exceeds the number of people who were written down as having 'died from COVID'. Don't get me started on that. The COVID-19 'public health policies' pushed by bureaucrats - STILL BEING PUSHED BY BUREAUCRATS - without expertise or data to back up deployment of these policies - were, and are, **baseless.**

This report provides strong evidence of some the specifics of the baselessness with regard to the prioritization to inject our elders first and furiously, but the entire 'COVID-19 response' was, for lack of a better word: **DEGENERATE**.

Boy, am I angry.

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1 Rancourt, Denis & Baudin, Marine & Hickey, Joseph & Mercier, Jérémie. (2023). Age-stratified COVID-19 vaccine-dose fatality rate for Israel and Australia. 10.13140/RG.2.2.15017.47209.

2 Blumenthal KG, Robinson LB, Camargo CA Jr, Shenoy ES, Banerji A, Landman AB, Wickner P. Acute Allergic Reactions to mRNA COVID-19 Vaccines. JAMA. 2021 Apr 20;325(15):1562-1565. doi: 10.1001/jama.2021.3976. PMID: 33683290; PMCID: PMC7941251.