

Eleven Sets of Serious Problems with the New York City Mass Casualty Event of Spring 2020

Jessica Hockett, PhD

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In the spring of 2020, New York City claimed that roughly 26,000-27,000 more people died than expected over an eleven-week period.¹ This claim was used to justify a pandemic declaration and sweeping, sustained emergency actions. The outrageous all-cause death spike (figure 1) has never been verified, fully explained, or reasonably substantiated by officials, even with basic records, and therefore demands immediate attention from public officials and citizens alike.

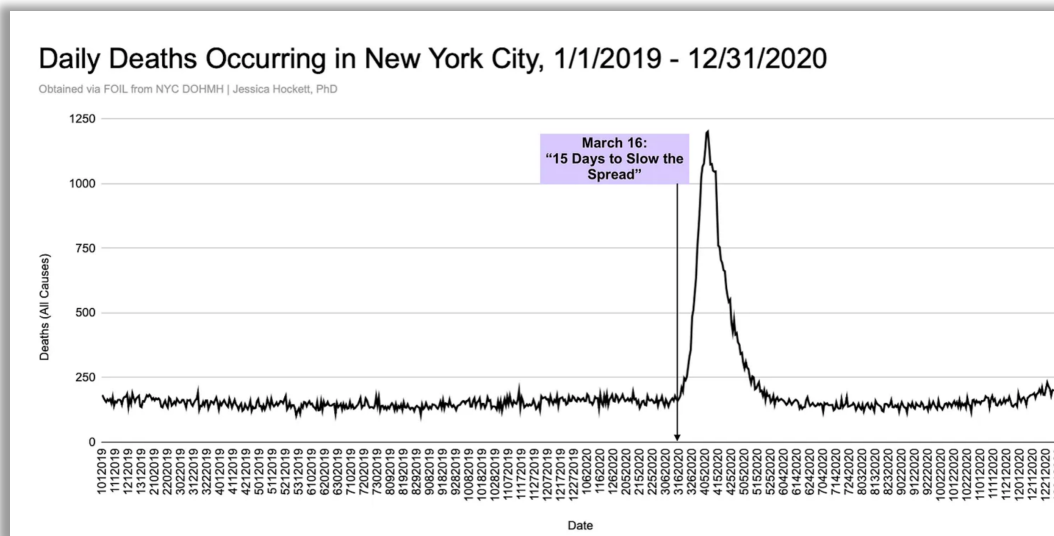


Figure 1. Daily deaths occurring in New York City, 1/1/2019-12/31/2020, with federal “15 Days to Slow the Spread” announcement on 3/16/2020 marked.

¹ New York City mortality, weeks 12-22, 2019 versus 2020: A comparison of federal and city sources

Source	Week 12-22, 2019	Week 12-22, 2020	Simple increase
CDC WONDER: County of Residence, 5 boroughs	11,140	38,155	27,015
CDC WONDER – County of Occurrence, 5 boroughs	11,097	37,175	26,078
NYC DOH – Residents of the 5 boroughs (exclusive of people living in NYC who have not established residency)	10,268	35,715	25,447
NYC DOH – Deaths Occurring in the 5 boroughs	11,235	37,309	26,074

This paper outlines *some* of the more serious problems that emerge when the New York City spring 2020 mass casualty event is examined using various kinds of timeseries data and qualitative evidence.² Each “set” is framed as a question, reflecting unknowns or variables that remain undisclosed, unexamined, or unaccounted for.

They are “serious problems” not only because they suggest Americans don’t know what really happened, but also because they show that *what we are told happened cannot plausibly account for the observed data*. They raise numerous questions and, more importantly, point to *systematic incoherence and incongruity across independent domains and variables that we would expect to exhibit more interdependence and consilience in a mass death event involving systematic failure per se*.

The problems identified are not limited to disputes over cause-of-death coding or the number of deaths labeled “COVID.” They involve the timing, speed, and shape of the daily mortality curve itself; age and place-of-death patterns; hospital and ambulance activity; body handling; and the persistent refusal of public agencies to release basic records.

For whom, exactly, are these things “serious problems”? For those who support the official narrative about a novel spreading pathogen *and* those who believe all or some portion of the New York City death spike is iatrogenic and/or wrought by democidal policies (be those intentional or unintentional).

There was a virus. There was no virus. Viruses don’t exist. None of these assertions explains the New York event – or needs to be either accepted or rejected in order put pressure on authorities to verify that the spike is entirely real. Until the daily death curve is supported by the best possible public proof, the New York City event should be regarded with skepticism by anyone with an interest in eventual disclosure of the truth about COVID-19 and regarded as unsubstantiated.

1. No Signals?

There was no clear sign or signal of a spreading pathogen adding risk of severe illness or death in New York until the federal government announced, “15 Days to Slow the Spread” and the rapid expansion of mass testing for SARS-CoV-2. [1, 2]

Researchers from metro-area Northwell Health system acknowledged this temporal mismatch in an early study, writing, “Our [testing] data reveal that SARS-CoV-2 incidence emerged rapidly and almost simultaneously across a broad demographic population in the region. These findings support the premise that SARS-CoV-2 infection was widely distributed prior to virus testing availability.” [3] Viral genomic sequencing and antibody studies similarly concluded that the entity named SARS-CoV-2 was already prevalent in early February 2020, if not much sooner [4, 5]

Taken together, these studies and raw data showing the number of deaths occurring daily (figure 2) indicate that whatever was being detected by the new tests was already widespread well before any emergency was alleged. There is no getting around the fact that the “ubiquity” of the viral agent was

² as of when this summary was first published in September 2024

not accompanied by a corresponding increase in mortality. Winter deaths in New York were unremarkable, and lower than during the 2017–2018 influenza season and already past the normal seasonal peak, prior to the World Health Organization’s pandemic declaration on 11 March 2020.

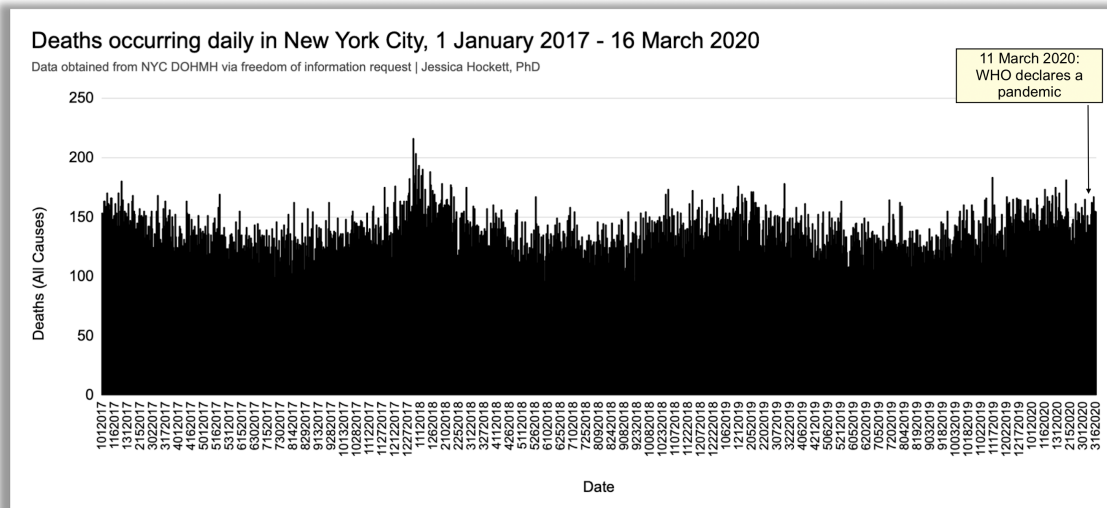


Figure 2. Daily deaths occurring in New York City, 1 January 2017- 16 March 2020.

Why such an allegedly-deadly-for-some virus wasn’t manifesting itself in mortality *prior* to international and national decrees has not been scientifically explained in a satisfactory manner by those who believe a novel pathogen akin to a “bad flu” suddenly appeared. The implication that officials somehow had the prescience to time their “lockdown” decisions with virus arrival is preposterous.

In theory, a respiratory disease like the one that coronavirus disease 2019 (COVID-19) is purported to be should first impact the elderly infirm in settings where the most-vulnerable populations are present and do so more gradually. Instead, we see simultaneous jumps in deaths across age groups, which makes little sense with initial or subsequent infection fatality ratios for the disease [6, 7].

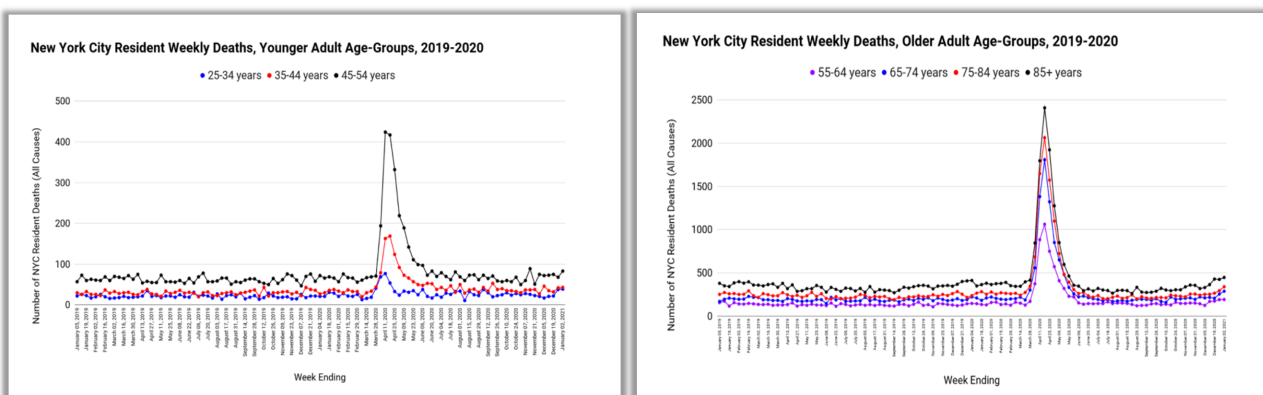


Figure 3: Weekly NYC all-cause mortality by age group. Source: CDC WONDER, County of Residence ([Verduyn, Hockett, Engler, Kenyon, & Neil, 2023](#))

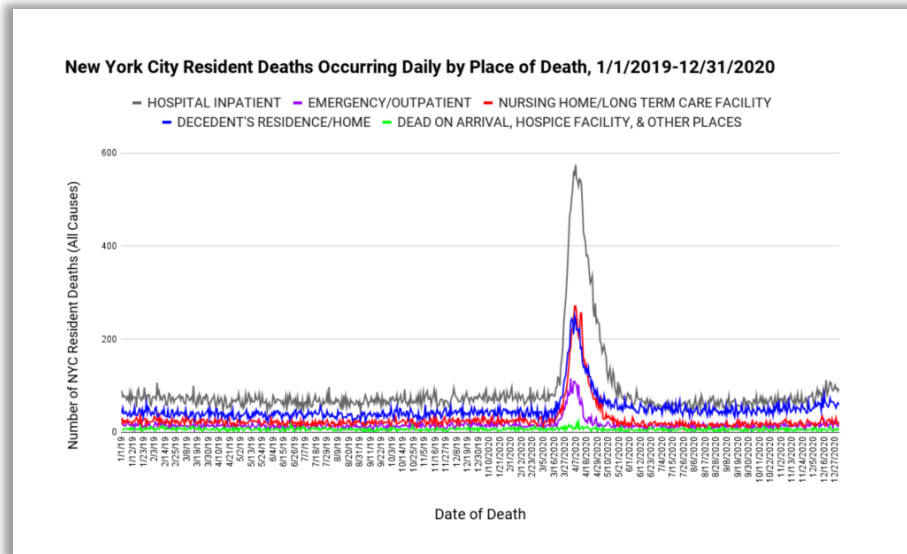


Figure 4: NYC all-cause mortality by place of death. Data obtained via FOIL. Requested from NYC DOHMH on 15 June 15 2023 by Jessica Hockett. Records received on 26 July 2023 | Values under 5 were censored and replaced with 3 in ED/Outpatient only. ([Verduyn, et al, 2023](#))

Similar synchronicity is evident in place-of-death data (figure 4, above) – specifically, deaths occurring in hospital, nursing homes, and personal residences, none of which rose until the federal government took drastic actions. In the event of a spreading illness, we would expect deaths in emergency departments/outpatient or long-term care facilities to rise first, yet we don't.

These and nearly every time-series dataset of any kind reviewed in-depth is unremarkable or within normal variation until mid-March. After that point, sharp spikes or drops occur, as though someone pulled a trigger or commenced a drill and then called it off.³ It is *extremely* unlikely that natural and/or man-made incidents or "reactions" could generate the simultaneity and shapes observed across data of different types. The fact that no analysts or academics (including esteemed epidemiologists) have been able to explain these and similar anomalies as the work of a novel coronavirus – and that few have even tried – is a testament to the implausible nature of the proposition.

2. (Almost) No Peers?

The speed and magnitude of the New York City event is almost peerless and exceeded in speed and percent-increase over baseline only by smaller and less population-dense provinces in Northern Italy [8], including Bergamo. Madrid, London and Manaus (Brazil) also reported suspiciously high and fast death events. None appear to bear the characteristics of New York's

³ It could be argued that the staggered return to baseline across settings – with emergency department deaths normalizing before hospital inpatient, nursing home, and residential deaths – points to the activation and subsequent deactivation of specific exercises.

curve; data in daily increments for these and other cities with comparable increases should be obtained and analyzed more closely.

The counter examples are informative too: Berlin, Tokyo, and Sydney saw little to no substantive increase in deaths during spring 2020.⁴ Domestically, New Orleans and Detroit did; Houston and Atlanta did not. Explanations like viral behavior, population density, weather, and time of year neither explain the differences between these locations nor help explain New York.

The city and surrounding area's overall "performance" was also unparalleled in the 50 states. Figure 5 (below) shows that the NYC metro/Tri-State corridor comprised a disproportionate, outsize contribution to U.S. excess death in the weeks after the pandemic declaration. [9] Thirteen counties are home to 4.5% of the country's population (15.6 million/342 million) yet comprised 24% of the spring 2020 excess death toll.⁵ In other words, a small cluster of counties accounted for an extreme share of U.S. excess mortality.

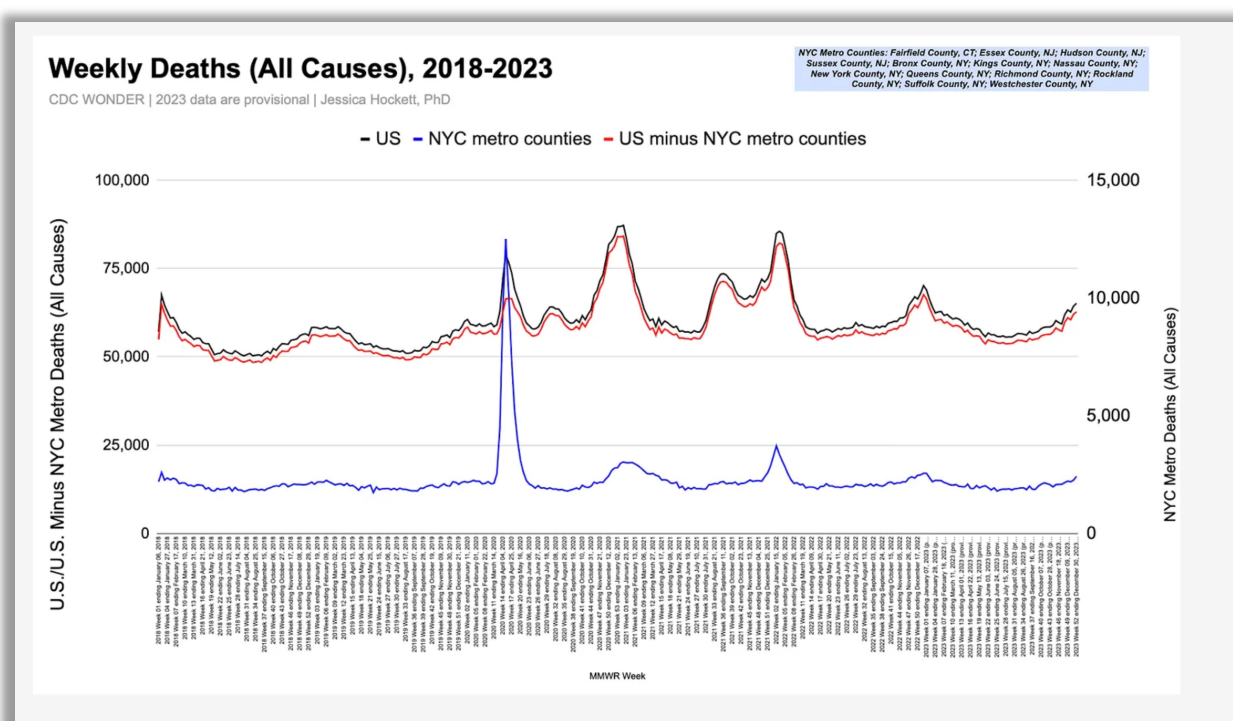


Figure 5: Weekly US deaths (all causes) with and without New York City metro area counties, January 2018 – December 2022. (Fairfield County, CT; Essex County, NJ; Hudson County, NJ; Sussex County, NJ; Bronx County, NY; Kings County, NY; Nassau County, NY; New York County, NY; Queens County, NY; Richmond County, NY; Rockland County, NY; Suffolk County, NY; Westchester County, NY) | Source: CDC WONDER, County of Residence

⁴ These locations challenge the position that “lockdowns” are inherently deadly and/or necessarily create excess death.

⁵ U.S. mortality, weeks 12-22, 2019 = 601,452; weeks 12-22, 2020=744,944 | NYC Metro mortality, weeks 12-22, 2019: 18,793; weeks 12-22, 2020=52,588 | U.S. increase divided by Metro increase = 143,492/33,795 = 24% | Source: CDC WONDER

Compared to selected, high-population metropolitan areas beyond the NYC metro area, excess mortality in the five boroughs was up to 14 times higher (figure 6).⁶

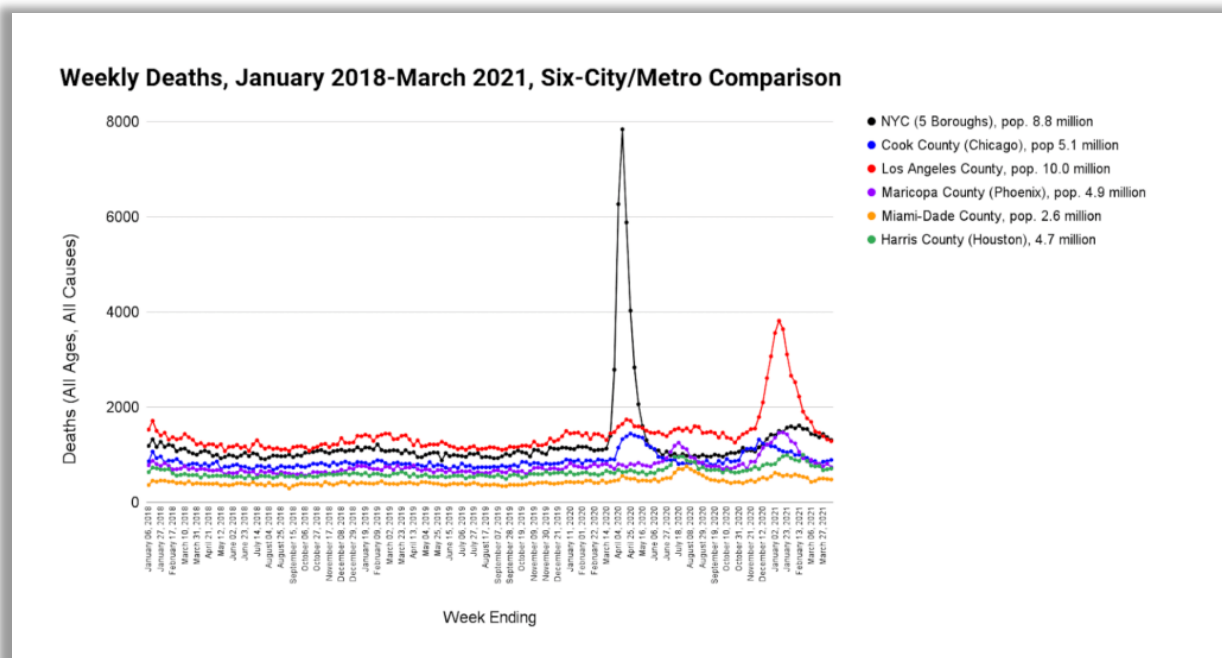


Figure 6. Weekly deaths (all ages, all causes) for NYC (5 boroughs combined) compared to 5 other large metropolitan regions: Cook County (Chicago), Los Angeles County, Maricopa County (Phoenix), Miami-Dade County (Florida), and Harris County (Houston). Source: CDC WONDER, County of Occurrence ([Verduyn, et al, 2023](#))

Simply put, nothing remarkable happened in most of America. Without the New York event, it's hard to imagine the illusion of a pandemic pathogen attacking the country would have been possible.

3. No Precedent?

The all-cause death rate, peak, and duration of the spring 2020 event exceeded that of New York's "Spanish flu" episode in autumn 1918. A comparison of daily death curves shows that deaths per million in spring 2020 were twice the rate (figure 7; peak rate of 218 per million versus 114 per million,).

Notably, both events occurred "off-season" from normal winter respiratory illness peaks in northern latitudes (figure 8). This raises the question of how "accused" viral pathogens know to strike when their sudden appearance (presumably) can't be hidden, i.e., just before or after colder-weather factors are in the mix.

⁶ Los Angeles County's late 2020/early 2021 death spike is also anomalous. How it managed to "escape" a spring 2020 cataclysm – or "learn from" New York is a mystery. <https://woodhouse76.com/2025/03/08/lo-l-la-la-land/>

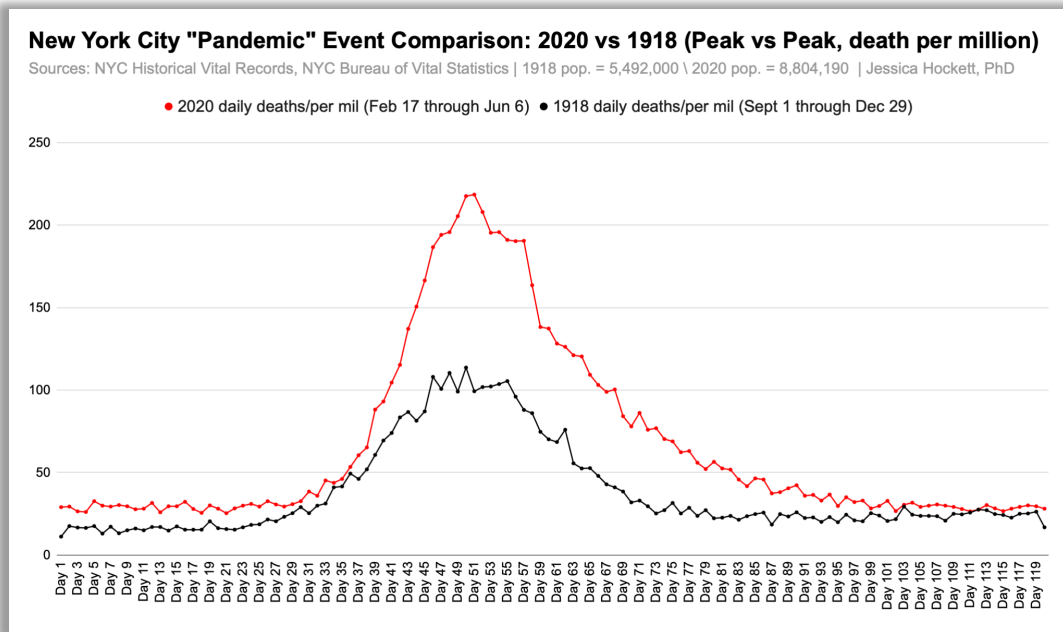


Figure 7: Comparison of New York City “pandemic” events.
Daily death rate per million in spring 2020 versus autumn 1918.

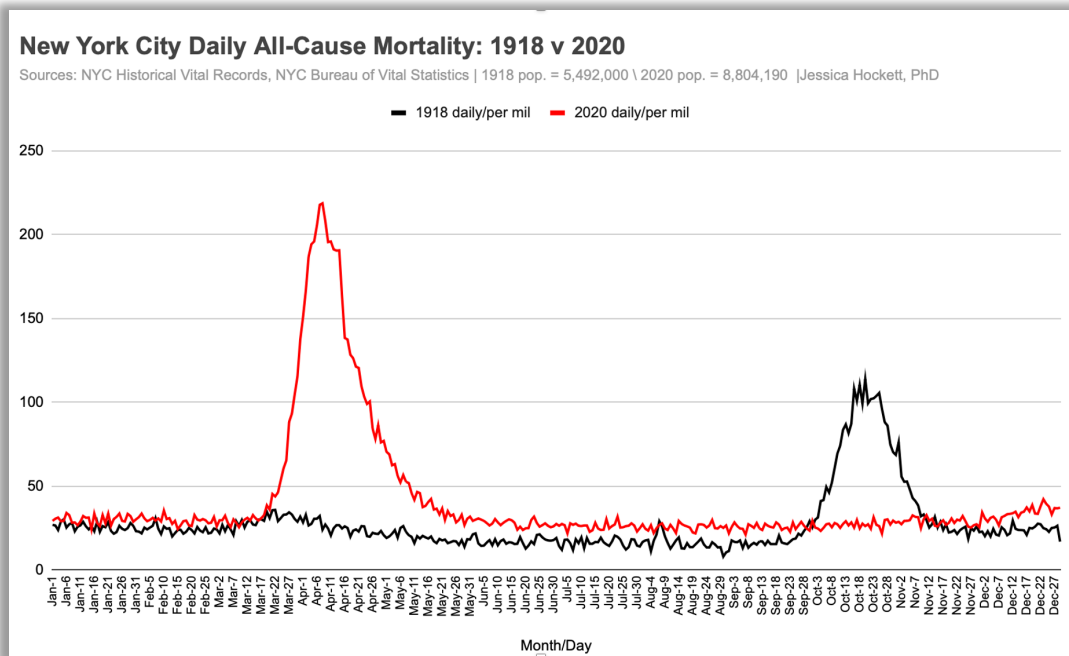


Figure 8: Daily all-cause mortality (rate per million) in New York City,
spring 2020 versus autumn 1918, annual view

The New York City Department of Health’s *Summary of Vital Statistics 2020* reported greater excess mortality in 2020 than in 1918 [10]. Although no comparison was made to the 1890 “Russian flu,” later attributed to a coronavirus, reported respiratory disease deaths in the 2020 event exceeded those reported during that episode as well (figure 9), implicitly suggesting either a deadlier pathogen or more harmful “treatments.”

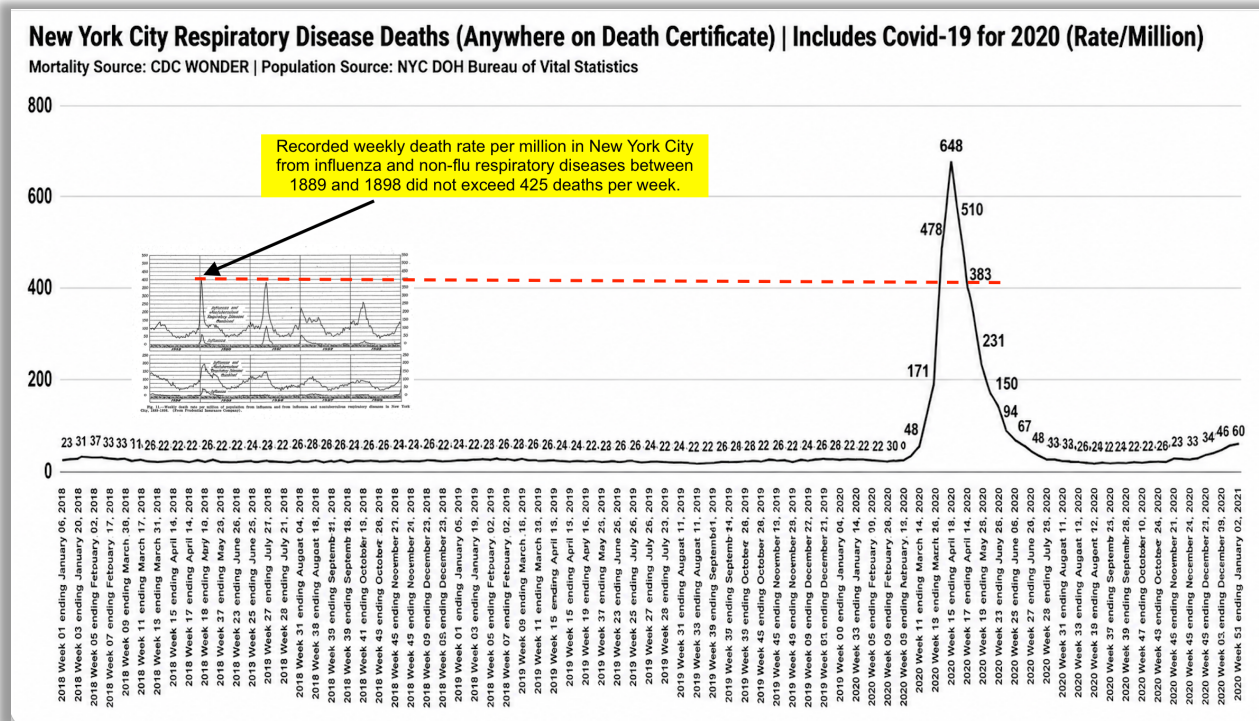


Figure 9: New York City weekly deaths with any respiratory disease (including COVID-19) on the death certificate, from 2018-2020 (Source: CDC WONDER) | Embedded/Comparison graph: Weekly death rate per million from influenza & non-tuberculosis respiratory diseases in NYC 1889-1893 (Source: [Epidemic Influenza: A Survey, Edwin O. Jordan](#), p. 39)

Even if tales about foreign-born flus hold true, a “silent” biological or epidemiological mechanism cannot possibly account for producing nearly ten times the number of deaths as the World Trade Center disaster. [11] Outside of a Hollywood film script, there is no reason to believe such a huge loss of life could occur from a pathogen spreading from person to person, regardless of “origin” – and many reasons to wonder whether any combination of unobserved factors could even do so or would result in such a shape like the one presented.

On the rise especially, the curve lacks the stochastic properties of expected and observed death patterns, including factors involving days of the week, seasonal waves influenced by respiratory illness and other phenomena or incidents known to impact the number of deaths over more than one day in a specific location (e.g., earthquakes, hurricanes, heat waves, power outages).⁷ Seventeen days of consecutive increases in *daily* deaths (figure 10) defies credulity, may be a

⁷ Paris, France, during the 2003 heat wave is not an exception. See Figure 1 in [“Mortality in 13 French cities during the August 2003 heat wave”](#) (Vandentorren, et al, 2004).

previously unobserved phenomenon in modern death-recording, and is by itself grounds for an audit.

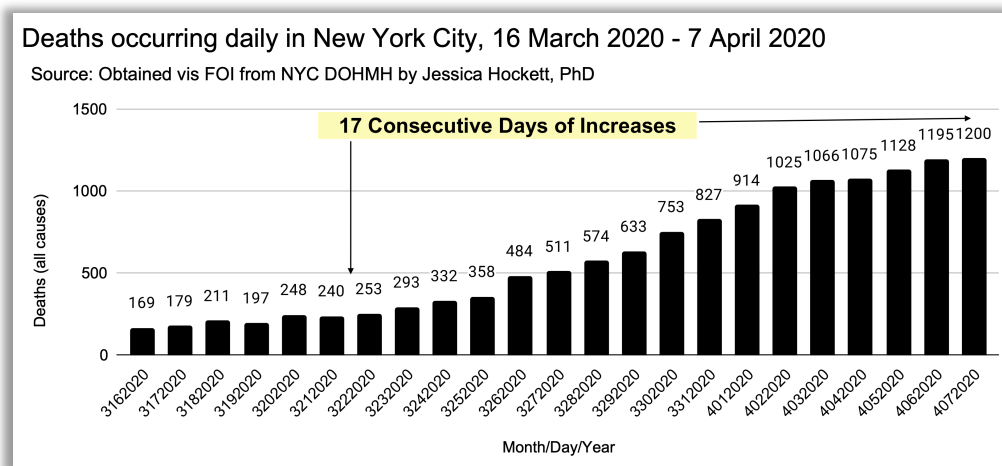


Figure 10: Deaths occurring daily in New York City, 16 March 2020 -7 April 2020
(Note: 17 days of consecutive increases is unexpected and manifests a shocking lack of stochasticity.)

The compressed timeframe of the New York event is also incongruent with the duration and nature of policies implemented. [12] Like Bergamo, the increase is simply too fast, the peak too high, the return to normal too abrupt, and the failure to rise again appreciably for the rest of the calendar year too absurd to be believed and accepted. The fact that the New York and Bergamo curves look so similar (image 1) is not evidence of same viral pathogen attacking both locations with the same fervor [13]. Whether such curves *can* result from implementing the similar iatrogenic measures *without assistance from data-engineering feats* is a critical, unresolved question.⁸

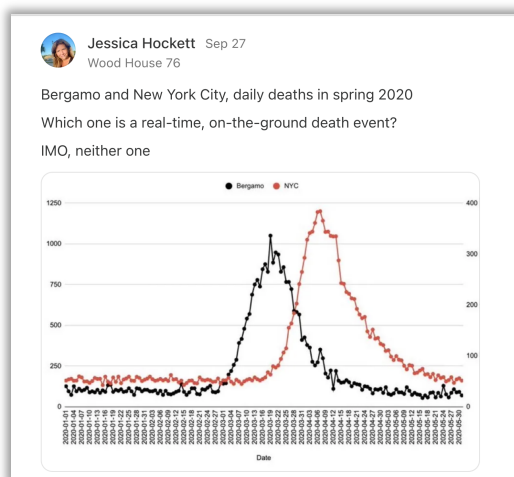


Image 1: Substack note posted on 27 September 2024 by Jessica Hockett, Wood House 76, drawing attention to the similarity and artificiality of the Bergamo province and New York City spring 2020 death curves.

New York's obvious "outlier" status should make its mass casualty event (and any like it) the object of intrigue and in-depth study by the most prominent scholars from multiple disciplines — not to mention hundreds of journalists and documentary filmmakers. Yet interest remains low, especially among U.S. officials and analysts. This is curious, and unsettling, given the scale and impact.

4. No Proof?

There is no basic proof in the form of names or death records substantiating the claim that approximately 38,000 city residents died in two and a half months (versus 11,000 or so in 2019). State and local laws don't permit death certificates or a death registry to be obtained via freedom of information request, nor are medical examiner's determinations subject to public disclosure or scrutiny, like they are in other states.

Proxies fall short. Names published by [The New York Times](#), [The City](#), and [HartIsland.net](#) comprise less than 10% of the 11-week total. FEMA COVID-19 Funeral Assistance for New York City resident deaths also fails to substantiate the toll. Less than 50% of COVID deaths in the spring are connected to an application; just over a third received funds. [14] Such proportions, shown in figure 11 below, seem strikingly low for a high-profile disaster and disaster-relief program.

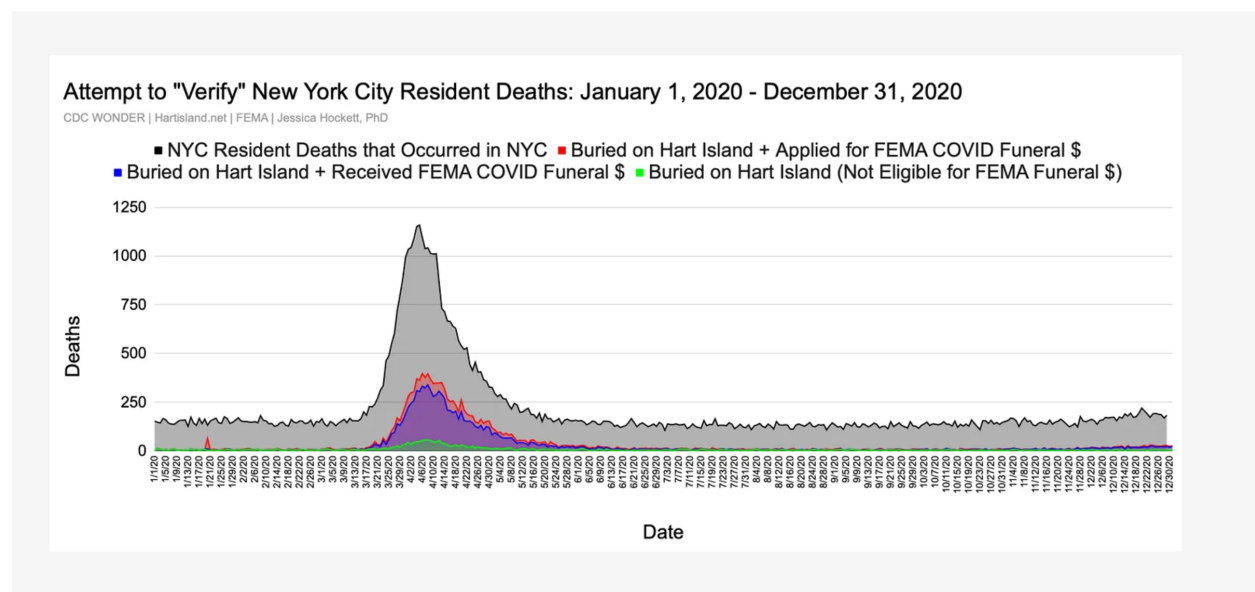


Figure 11: Number of New York City resident daily deaths in 2020 that are verified or substantiated by public burial records and FEMA COVID funeral assistance application and receipt of funds

Given that basic death records for city burials on Hart Island are public (including decedent names), there is no reason the same information cannot be released for every decedent. The dead do not have the same right to privacy as the living. Basic facts about a death are a matter of public interest and accountability for proper stewardship of vital records.

Because numbers and unverified images from New York were used to extend shutdowns and sell the world on a new "vaccine," it *must* be shown that the number of people who are claimed to

have died on each day actually died on those days, in the places claimed, irrespective of whether COVID-19 is blamed. The ongoing failure to allow the public to verify the toll is itself reason enough for all statistics related to the event to be treated as potentially manipulated and/or partially fabricated. [15]

Illegal decrees, mandates, and coercion aside, it is also *indefensible* for one of the biggest mass casualty events in a U.S. city's history to be proclaimed as a matter of irrefutable fact by way of digits on a screen. The onus is on *state and federal authorities* to back up their claims with actual records. This is especially important because city and federal data do not agree as to the total number of deaths in the excess timeframe (see footnote 1).

5. No Corroboration of Hospital Event?

Not only did New York City report what almost certainly must be the most cataclysmic death event in a city hospital system anywhere *ever*, they did so during a period of *decreased* hospital activity and patient volume. More than 22,000 hospital deaths reportedly occurred in a period that saw 5,800 deaths in the previous year (+280%).⁹ Emergency department visits dropped in half simultaneous to a 700% base-to-peak increase in ED/outpatient deaths systemwide (figure 12) – as though treatments being using in ERs and urgent care centers were either withheld or inappropriately applied.

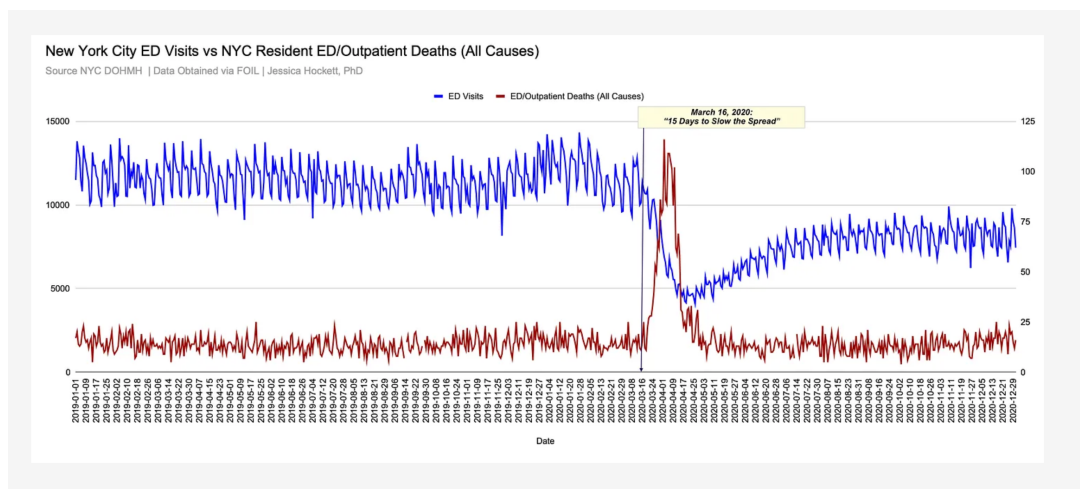


Figure 12: Daily number of visits to New York City emergency departments versus daily deaths in NYC emergency departments and outpatient facilities, 1 January 2019- 31 December 2020. (Reported in [Hockett, 2023](#))

Both the state and city health departments say they do not have daily admission data, which (if true) is unacceptable for publicly funded entities. Records showing when patients who died during the spike were admitted to hospitals have not been released [16], but a decline monthly in admissions concurrent with record numbers of in-hospital deaths (figure 13) raises serious questions warranting federal inquiry, especially given that there was military presence in some facilities.

⁹ CDC WONDER

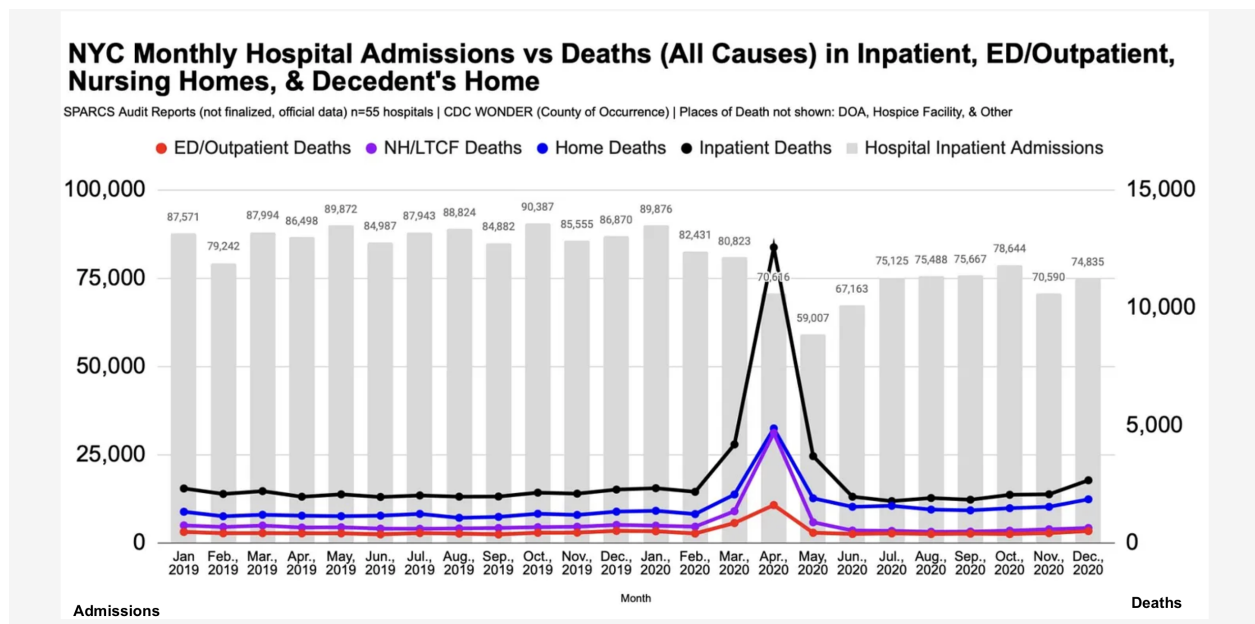


Figure 13: New York City hospital monthly admissions from SPARCS audit reports versus monthly deaths in hospital inpatient, ED/outpatient, nursing homes/care facilities, and personal homes.

Another reason to care about date of admission for New York’s hospital deaths is that mortality there appears to have risen faster and higher than anywhere else in the United States, wildly out of proportion to the number of hospital inpatient beds.¹⁰ This pattern is difficult to explain without a substantial number of existing inpatients dying. The number of patients already hospitalized before the national emergency declaration on 13 March 2020 has never been disclosed. Absent clear evidence of widespread community transmission beforehand, a sudden, massive loss of life from nosocomial spread alone is implausible.

As shown in Tables 1 and 2 below, during weeks 12–22 of 2019, the five boroughs accounted for 2.8% of all U.S. inpatient hospital deaths, closely matching New York City’s share of the national population. During the same weeks in 2020, following the “15 Days to Slow the Spread” announcement, that share surged to 16%, before returning to baseline by late May. When U.S. inpatient deaths are viewed alongside how much of the increase came from New York alone, the city’s outsized role in driving the national shutdown narrative becomes difficult to ignore.

¹⁰ ~20,000

MMWR Week (mid-March - end of May)	U.S. 2019 Hospital Inpatient Deaths	NYC 2019 Hospital Inpatient Deaths	NYC as % of U.S.	MMWR Week	U.S. 2020 Hospital Inpatient Deaths	NYC 2020 Hospital Inpatient Deaths	NYC as % of U.S.
Week 12	16,766	430	2.56%	Week 12	16,781	634	3.78%
Week 13	16,486	479	2.91%	Week 13	17,739	1,346	7.59%
Week 14	16,387	438	2.67%	Week 14	22,357	3,148	14.08%
Week 15	16,011	446	2.79%	Week 15	24,784	3,966	16.00%
Week 16	15,608	390	2.50%	Week 16	24,179	3,344	13.83%
Week 17	15,518	418	2.69%	Week 17	22,718	2,447	10.77%
Week 18	15,558	453	2.91%	Week 18	20,961	1,737	8.29%
Week 19	15,407	471	3.06%	Week 19	19,576	1,217	6.22%
Week 20	15,284	464	3.04%	Week 20	18,452	843	4.57%
Week 21	15,294	452	2.96%	Week 21	17,347	650	3.75%
Week 22	15,096	396	2.62%	Week 22	16,586	495	2.98%
TOTAL	173,415	4,837	2.79%	TOTALS	221,480	19,827	8.95%

Source: CDC WONDER

Table 1. New York City 2019 hospital inpatient deaths as a ratio of U.S. 2019 hospital inpatient deaths.

Table 2. New York City 2020 hospital inpatient deaths as a ratio of U.S. 2020 hospital inpatient deaths.

The fact that *virtually no one* has called for such an inquiry of hospitals is deeply disturbing, especially when hospitals were financially incentivized to test for and code hospitalizations and deaths as being due to a new disease the WHO called COVID-19. Instead, the main focus has been on nursing homes, which reported fewer COVID deaths and a lower proportion of death than hospitals did, and yet were an emphasis of a [U.S. congressional committee](#) that directed attention away from any federal role or responsibility for what happened in New York and toward state and local officials in charge at the time.

Also concerning: The state's "[HERDS](#)" dataset is incomplete and starts the day after the CARES Act was passed, with no earlier data available (figure 14).

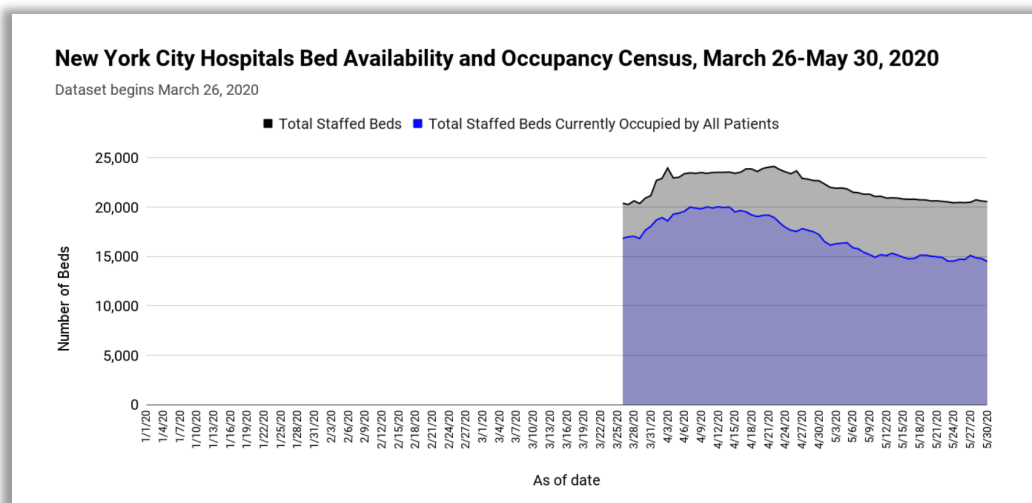


Figure 14: New York City hospital bed census – total daily number of staffed beds versus staffed beds occupied, 26 March 2020 – 30 May 2020. Source: New York State Department of Health

The gall of a state agency to hide or pretend it is impossible to get baseline hospitalization data is reason enough to believe the New York City **overwhelmed hospitals** fervor was a hyperreality TV show.

Occupancy data for the “star” of that show – “epicenter of the epicenter” Elmhurst Hospital in Queens – contradicts reports from media and elected officials about the facility being overwhelmed by sick patients. [17, 18] Moreover, a comparison of the Elmhurst bed occupancy data reported in the HERDS file and data provided via FOI requests shows a severe discrepancy between the number beds occupied (figure 15). Both datasets are sourced from the same agency but cannot both be “true.” [19]

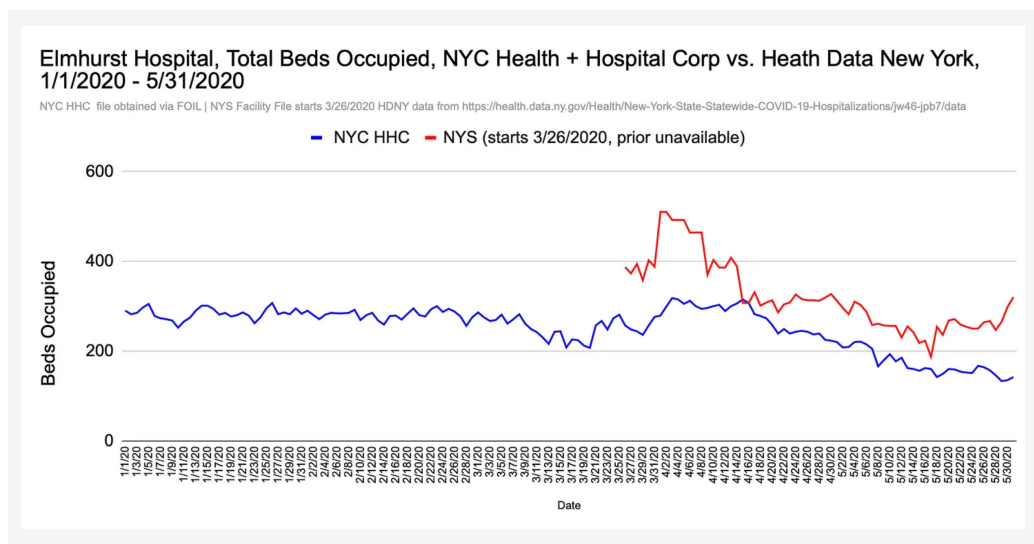


Figure 15: Total Beds Occupied Daily (Census) at Elmhurst Hospital, Queens, NYC, 1 January 2020 – 30 May 2020, Health + Hospitals Corporation (HHC) versus NYS HERDS dataset.

Such differences exemplify why *daily* occupancy, admissions, emergency department, and deaths for *every* NYC hospital going back to 1999 should be released immediately. The public needs to see how busy and full the city’s hospitals really were (or weren’t), in proper historical context.

Finally, despite much attention on ventilators as a “weapon” in a “war” against a “silent killer” [20] – and various reports on the use/misuse of the devices – no public dataset discloses how many patients total were placed on ventilators, or how many of those patients died. [21] The peak number of COVID patients on the machines in ICU was approximately 2,700. Presumably, a portion of ventilated patients were *not* designated “COVID,” but the state does not report what portion.

There is no excuse for withholding such numbers when the entire nation (if not the world) was subjected to press conferences and headlines about New York’s crisis-level “need” for the devices, which played an outsize role in scaring the world into submitting to a shutdown.

6. No Bodies?

The total number of bodies needing to be managed during the 11-week timeframe of the NYC event is hard to believe. Ranking of the most deaths per day going back to 1999 (figure 16) makes clear the city had no prior experience in recent decades (if ever) handling the number of bodies it claims to have handled in late March and April 2020.

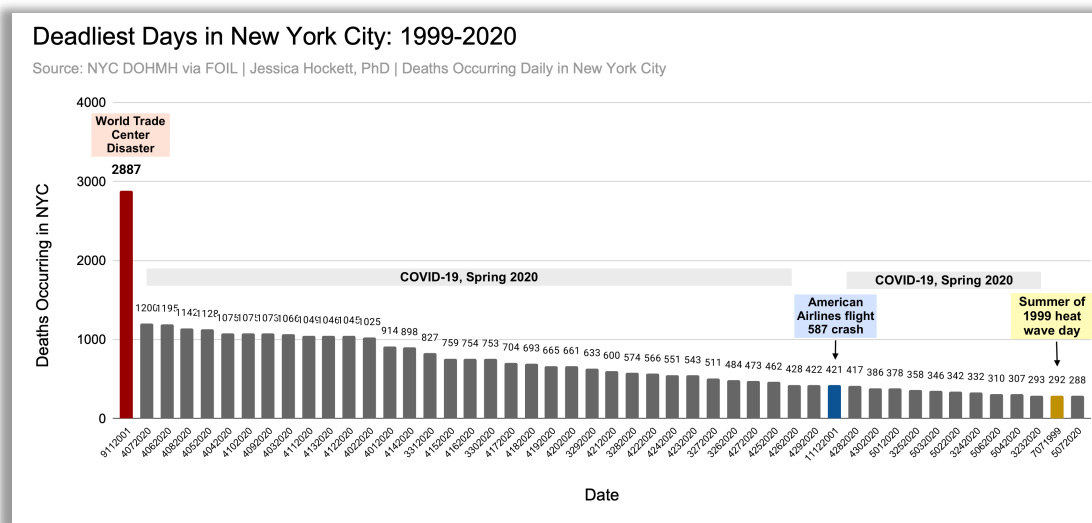


Figure 16: Deadliest days in New York City, 1999-2020, rank-ordered. All causes, New York City as place of death occurrence, resident and non-resident.

The World Trade Center disaster remains the highest magnitude single-day mass casualty event in city history but did not require managing decedent “turnover” as in hospitals or nursing homes.

While “pandemic influenza” mass fatality planning guidance *anticipated* handling 27,000-85,000 deaths in such an event, the estimates appear aggrandized [22]. The lower bound was hypothetical and, possibly, based on the number of 1918 flu deaths reported for New York *state*, as reported by a department of health report published the following year. [23] It's also possible that “influenza pandemic” was euphemistic for devoting preparedness efforts and resources toward any highly unlikely, worst-case-scenario event (e.g., asteroid assault, alien invasion).

From a practical standpoint, the movement of 5-6 million pounds of bodies (3-4 million more pounds than normal) would be hard to hide from public view. Many New Yorkers have cameras on their phones, yet no pictures and videos on social, mainstream, or independent media depict anything that corroborates the existence of a mass fatality emergency or scale of the death toll. Instead, images and footage of unremarkable incidents (moving a body or two), “props” (refrigerated trailers), and unverified or decontextualized “scenes” like those captured by drones flying over burial trenches were used as propaganda to prove “something” was happening.

A reason the body management task in hospitals is difficult to envision because documentation is scant or in conflict with a mass casualty event of the magnitude purported. Total morgue capacity in NYC hospitals is reportedly 800-900 decedents [24]. This would make the normal daily death rate 10%-12% of capacity, with increases to 25-85% for 45 consecutive days during the spring spike.

That kind of escalation in the absence corresponding testimonies from staff or film and news crews is suspicious. An ER doctor giving an interview during the greatest loss of life that he or the hospital has ever experienced makes little sense.¹¹ Photos and press releases involving military personnel in hospitals are too anodyne and upbeat to be from a high-casualty event on the order of what public data purport.¹²

The total number of bodies placed into storage units sent to hospitals by the New York City Emergency Management agency is undisclosed. Records obtained via freedom of information request show that refrigerator trucks sent by FEMA were underutilized as morgue storage and account for only 5% of the total number of hospital deaths. [25] Even with additional storage, a monumental hospital casualty event was reported and must be publicly audited, not only for accountability purposes but so that hospital systems around world can verify and learn from what New York's facilities claim to have experienced.

Oddly, there is no single detailed report showing exactly how (and how many) decedents were managed and transported by medical examiner staff and National Guard and U.S. Army units sent to assist the city. Data obtained from the city medical examiner's office shows a three-day 11,000-death processing event at the end of April, with no explanation of why or how that magnitude of processing occurred and resistance to disclosing corroborating or descriptive records. [26] The New York City medical examiner's office appears to be entirely unaccountable with regard to the spring 2020 event – or operating under federal direction – and obstructing the truth.

7. No Explanation for Young Deaths?

There was an astounding 200% increase in deaths among younger, working-age adults during the 11-week excess period (table 3) much of which attributed COVID-19 as underlying cause and occurred in hospitals (figure 17).

Age Group	2019 Deaths	2020 Deaths	Absolute Increase	% Increase
25–29	99	176	+77	+77.8%
30–34	140	266	+126	+90.0%
35–39	138	419	+281	+203.6%
40–44	187	546	+359	+192.0%
45–49	247	886	+639	+258.7%
50–54	416	1,409	+993	+238.7%
Total (25–54)	1,227	3,702	+2,475	+201.8%

Table 3. New York City All-Cause Mortality by working-age adult groups, 25-54, weeks 12-22, 2019 versus 2020.

¹¹ <https://nymag.com/intelligencer/2020/04/elmhurst-hospital-emergency-room-doctor.html>

¹² e.g., <https://www.nationalguard.mil/News/Article-View/Article/2206664/new-york-national-guard-paramedics-aid-queens-hospital/>

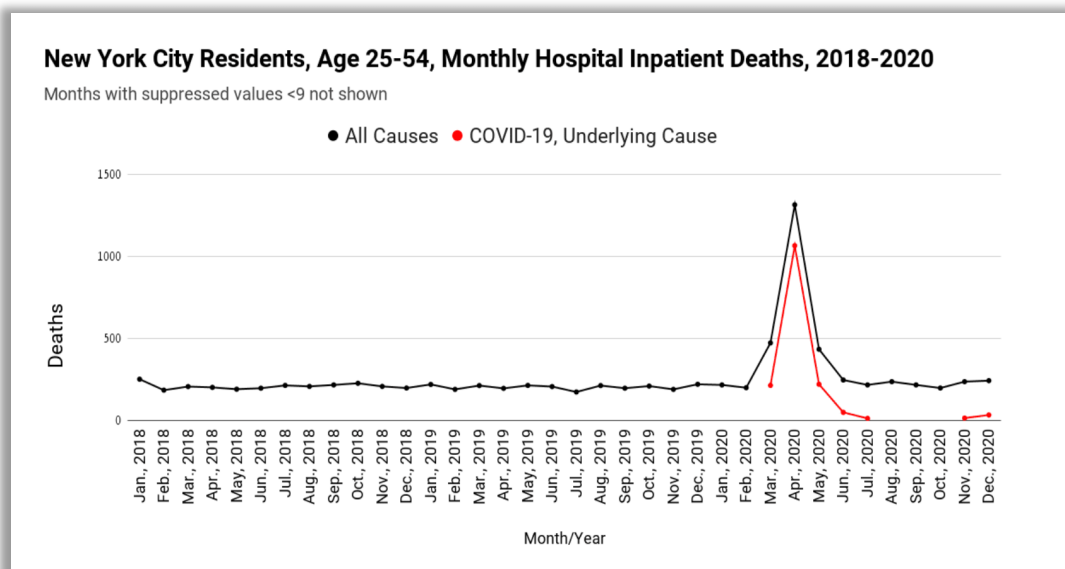


Figure 17: New York City residents, age 25-54, monthly hospital inpatient deaths, 2018-2020, all causes versus COVID-19 as underlying cause. Source: CDC WONDER.

This is especially troubling because

- a full 25% of all U.S. COVID deaths in the age group at that time were in New York City (table 4)
- the incidence of COVID-attributed deaths in adults under age 69 is recognized as very low [6], and
- no other city in the world appears to have experienced a similar magnitude of younger-adult deaths in the timeframe or thereafter.

Location	Pop aged 25-54	Percent	Covid Deaths aged 25-54	Percent of total U.S. Covid deaths aged 25-54
NYC	3,838,849 [10]	3%	1,937	25.4%
Rest of U.S.	122,421,151 [11]	97%	5,704	74.6%
Total	126,260,000	100%	7,641	100.0%

Table 4: Deaths attributed to COVID in NYC and the rest of the U.S. for those aged 25 to 54: March to May 2020. Source: US Census Bureau, CDC WONDER, NYC Department of Health (Verduyn, et al, 2023)

Younger-adult deaths in NYC – and the myth of ‘asymptomatic transmission’ – were used as propaganda to sell Americans on the threat posed by a spreading pathogen. [27] It is

highly unlikely that any generation under age 65 would have obeyed “stay home” orders, or been persuaded to receive a vaccine for, a non-transmissible illness affecting only the elderly.

The fact that no study or separate investigation has been conducted on why the city reported so many young deaths is bizarre. Dr. Pierre Kory, who arrived at a New York City hospital from Madison, Wisconsin in late April, after the death-spike peak, testified to a Senate committee in May 2020 that witnessed younger adults suffering from COVID-19. [28] Responding later to questions about his experience, Dr. Kory said he didn’t think an investigation of city hospitals was warranted on that basis alone. [29] Such an attitude is perplexing and another sign (one of *many*) that something very unusual occurred and a full review of patient records desperately needed.

8. No Nursing Home Resident Death Total?

Multiple investigations and hearings around the Cuomo administration’s so-called “nursing home policy” have come and gone without reporting the total number of facility residents that died during the NYC event, irrespective of place or cause of death. [30]

The much-repeated “9,000” admissions/readmissions from hospitals to nursing homes cited by *AP News* in February 2021 is a *statewide aggregate* number and is divorced from a baseline. [31] It made for a good soundbite but means very little without context or a sense of what’s normal and does not itself establish a causal link between those admissions and the number of nursing home residents who died. Without a daily time-series (or county/borough-specific time-series) it is impossible to see the “mechanics” of what occurred.

Discharges from city hospitals to skilled nursing facilities *dropped* 20% in 2020 (figure 18), and the raw-number decrease is curiously close to the increase hospital inpatient deaths during the spring death spike. This suggests many nursing home residents who went into hospitals didn’t make it out alive **or** that a high number of hospitalized people who would have normally been sent to a nursing home afterward died.

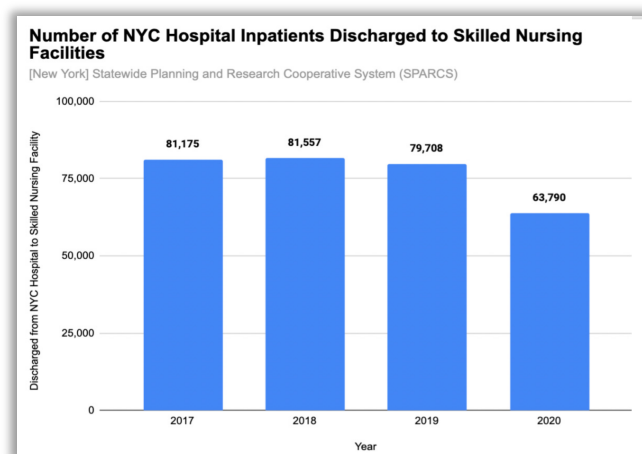


Figure 18: Number of New York City Hospital Inpatients discharged to skilled nursing home facilities, 2019-2020. New York Statewide Planning and Research Cooperative System (SPARCS).

Why officials are continuing to ignore or hide how many nursing home residents perished in the city's spring death spike (and who else died in hospitals) is unclear and inexcusable.

9. No In-Depth Study of Home Death Event?

There was a shocking six-week, 250% increase in deaths occurring at Home, driven by an unprecedented, under-investigated, and largely unexplained cardiac arrest event (figure 19).¹³

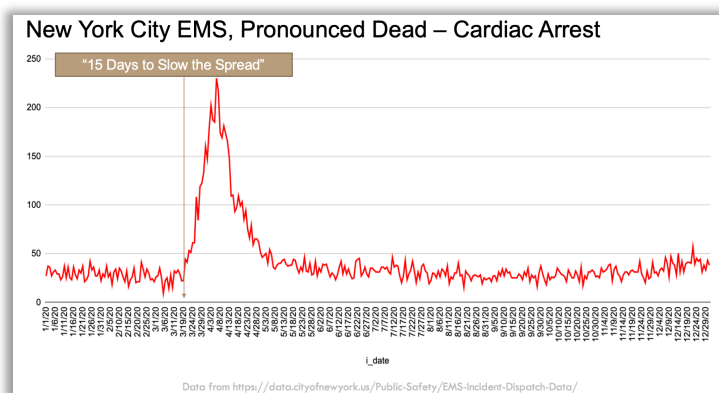


Figure 19: New York City ambulance dispatches ending in patient Pronounced Dead-Cardiac Arrest, January 2020 – 31 December 2020. Source: City of New York EMS incident dispatch data

Media and officials reported that people were staying away from hospitals and did not seek medical care, yet 9-1-1 call and ambulance dispatch data show a 25% increase in calls for medical help during the first weeks of the emergency period (figure 20).¹⁴

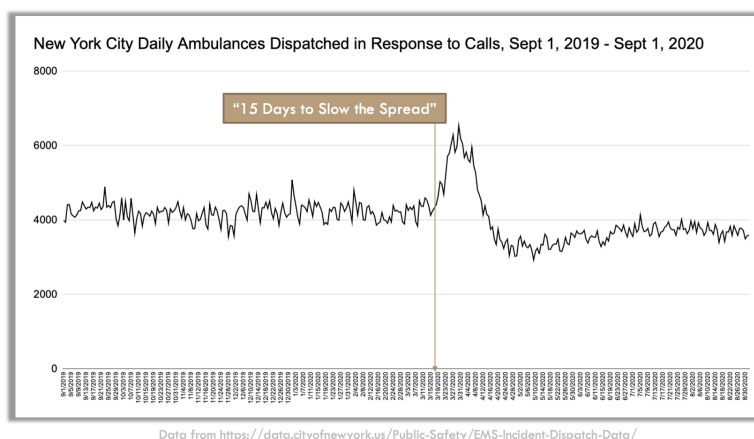


Figure 20. New York City daily ambulances dispatched in response to 9-1-1 calls, 1 September 2019 -1 Sept 2020. Source: City of New York EMS incident dispatch data

¹³ Significant OHCA events in [London](#), [Paris](#), [Lombardy](#), and [Detroit](#) in spring 2020 were also reported and should be investigated – especially because most other major, population-dense cities and regions did not experience such events.

¹⁴ Exception: Manhattan. See figure 28.

The demographically comparable Cook County (Chicago) did *not* experience the same magnitude of heart-related deaths at home (figure 21), or an increase in calls to 911 (figure 22).

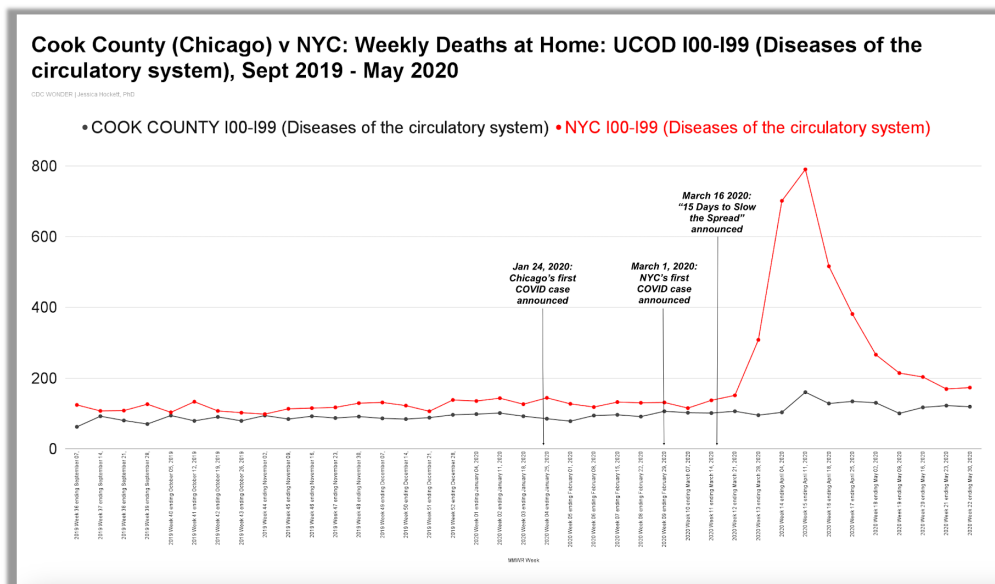


Figure 21. Weekly deaths at home, underlying cause disease of the circulatory system, Cook County versus New York City (5 boroughs), September 2019 – May 2020. Source: CDC WONDER.

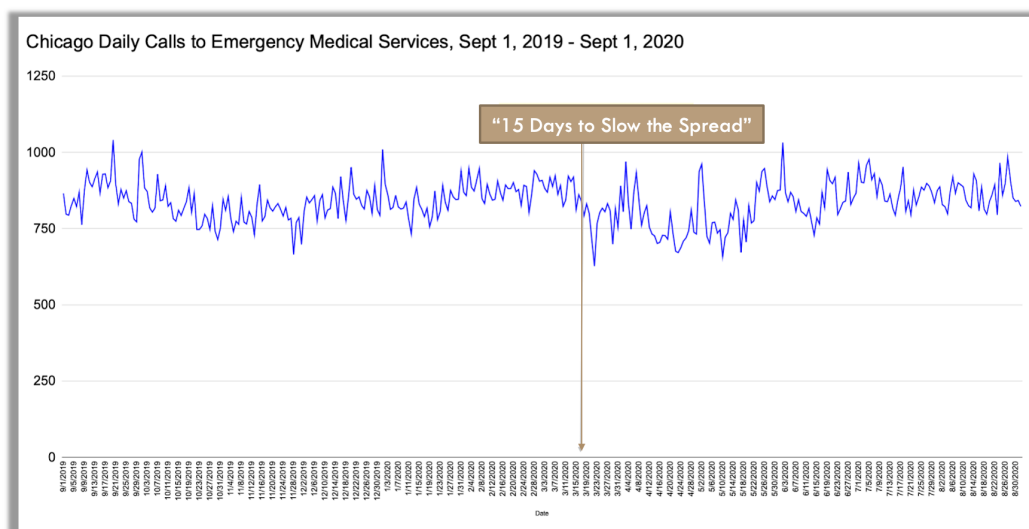


Figure 22: Daily Calls to EMS in the city of Chicago, 1 Sept 2019 to 1 Sept 2020. Data obtained via Freedom of Information request from Chicago Emergency Management & Communications Department by Jessica Hockett.

While the data could be manipulated, some calls simulated, and a portion of dispatches sent out merely to blare sirens and scare people, the rise contradicts the claim that people were afraid to go to the hospital, since those calling 9-1-1 *want* medical help.

“Worried well” calling for paramedics doesn’t explain the cardiac event, nor does the catch-all explanation “panic,” especially given the following:

- a 183% increase in dead on ambulance arrival cardiac calls;
- the cardiac arrests manifested characteristics not necessarily associated with basic anxiety;¹⁵ [32]
- the spike happened alongside changes to calls directed to the Fire Department of New York (FDNY) and deadly protocols issued to emergency medical services. (Summary shown below in the context of other events and decisions.)¹⁶

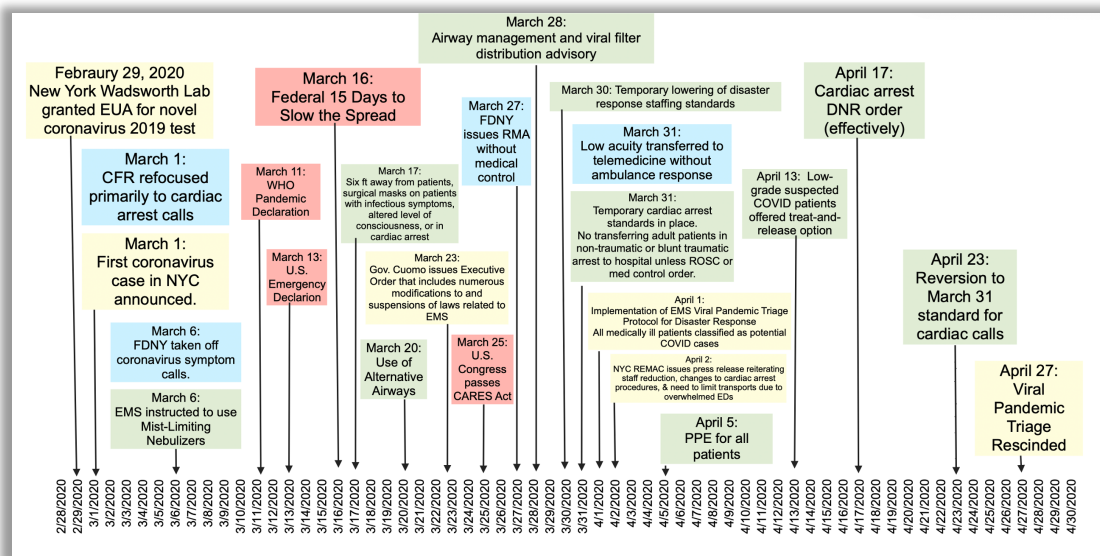


Figure 23. Timeline of orders given to FDNY and EMS between 1 March 2020 and 30 April 2020, in the context of other events and decisions.

The Home-death event is partly blamed on COVID-19, with the “new disease” being the second-leading cause of NYC Home deaths. As if people suddenly dying at Home of a respiratory virus weren’t ridiculous enough, a full 40 percent of Home deaths in the entire U.S. that attributed COVID-19 as underlying cause in April 2020 were in New York City, where less than 3% of the country’s population lives (figure 24).

¹⁵ A study of the OHCA event [32] reported cardiac arrests between March 1 and April 25 were “3.5 times more likely to present in asystole (OR, 3.50; 95% CI, 2.53–4.84; $P < .001$) and twice as likely to present in pulseless electrical activity (OR, 1.99; 95% CI, 1.31–3.02; $P = .001$) than in ventricular rhythms (ventricular fibrillation or ventricular tachycardia).” [32] The authors also reported a 183% increase in arrest call patients who were dead upon ambulance arrival, a lower success rate for resuscitation, and lower use of naloxone (opioid overdose-several drug), as compared to the same weeks in 2019. The lead author, David Prezant, refused my request for underlying data from the study.

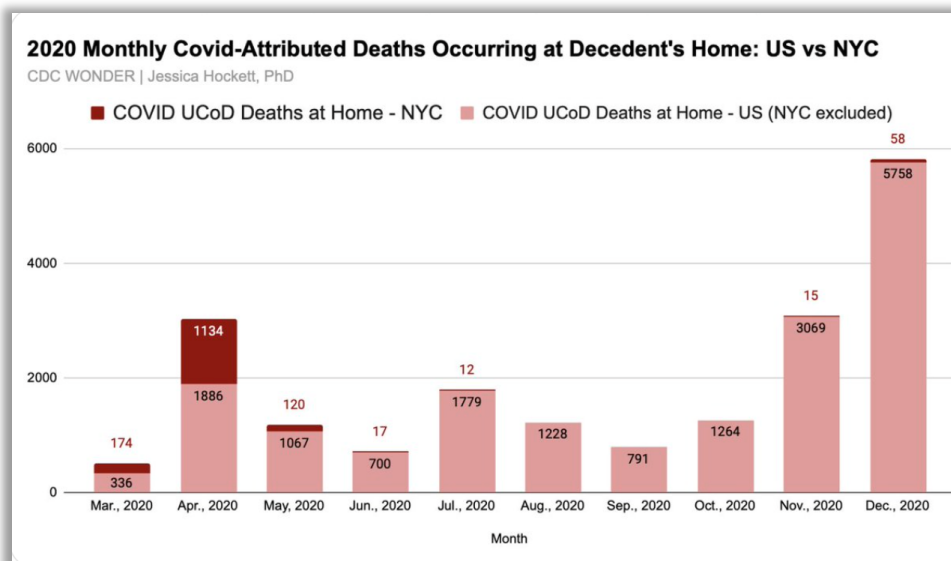


Figure 24: 2020 Monthly COVID-attributed deaths occurring at decedent's home: New York City versus United States minus New York City. Source: CDC WONDER.

The trajectory and shape of the Home COVID death curve mirrors that of the Home heart-related death curve (figure 25). This raises the possibility that COVID deaths are deaths from other causes but for which there was record of a positive SARS-CoV-2 test result, qualifying the death as a “COVID death” per WHO and CDC coding guidance.

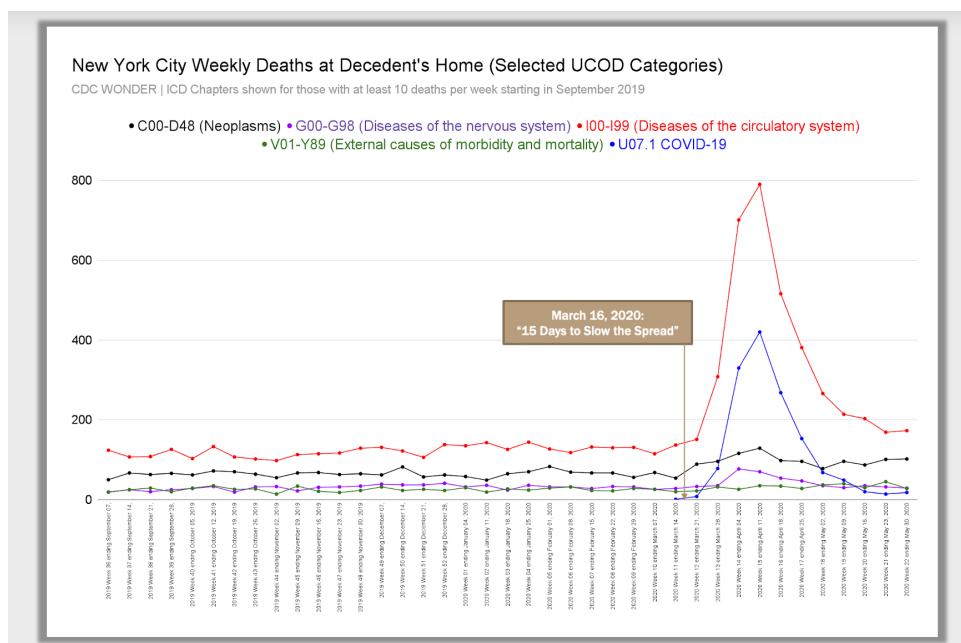


Figure 25. New York City weekly deaths at the decedent's home, selected Underlying Cause of Death categories (neoplasms, nervous system, circulatory system, external causes, COVID-19), Sept 2019 – May 2020

Because deaths at Home are normally the most-autopsied, associated autopsy records are a potential source for verifying or refuting the idea of a coronavirus contributing to the Home death event. Unfortunately, federal data reveal that autopsies conducted on NYC home deaths fell 67% during the spike. [33]

It's hard to blame the decrease on staff shortages when records obtained via freedom of information request show OCME hired additional positions and received assistance from the U.S. Army and National Guard *and* Cook County (Chicago) showed no such decline. If nothing else, a failure to perform a normal number of autopsies has the appearance of trying to cover up undisclosed factors involved in a highly unusual surge in deaths at home.

It's possible the home-death data reflect an altered or expanded definition of where people died. "Home" refers to a decedent's personal, private residence; however, undisclosed guidelines could have been applied during or *ex post facto* of the spring event to deaths in congregate settings for younger adults, or care facilities that are not skilled nursing homes per se. If that's the case, the presentation of the home death event is not entirely genuine and death records need to be reviewed and corrected. Reports about the National Guard picking up decedents at "private residences and nursing homes" [34, 35] hint at this possibility, as does Andrew Cuomo's infamous rhetorical question, "Who cares [if they] died in the hospital, died in a nursing home? They died!" [36]

A veteran, now retired, NYPD detective I spoke with in 2024 about his experiences in spring of 2020 said his DOA unit did *not* see a dramatic increase in calls during the event, but that most every death was "determined" or proclaimed on the scene to be a COVID death, irrespective of what the cause actually was or appeared to be.¹⁷ He also shared that his unit responded to an unusual number of calls involving drug overdose deaths in the same building in January of 2020. Based on the location provided, I attempted to secure corresponding police reports but was unsuccessful. NYPD has ignored my freedom of information requests for DOA call data.

10. No Accountability for Ambulance Activity & Protocols?

What happened with ambulances during the first 6-8 weeks of the New York death spike might be the most under-discussed aspect of the entire event. A full treatment of issues and questions is beyond the scope of this summary.¹⁸ Suffice to say, ambulance activity shows disturbing patterns that contradict or don't mesh well with media reports and studies about what happened with emergency calls and medical services, and why (figure 26). Dispatches rise, as do refusals of medical aid and patients pronounced dead on the scene of pick up, as patient transports drop.

¹⁷ I recorded notes for this interview, which was conducted "on background," but wasn't able to get expressed permission to write a profile or directly quote and attribute by name.

¹⁸ See <https://rumble.com/v4ifmhr-jessica-hockett-woodhouse76-deaths-at-home-new-york-city-april-2020-covid-e.html> and accompanying visuals for fuller discussion.

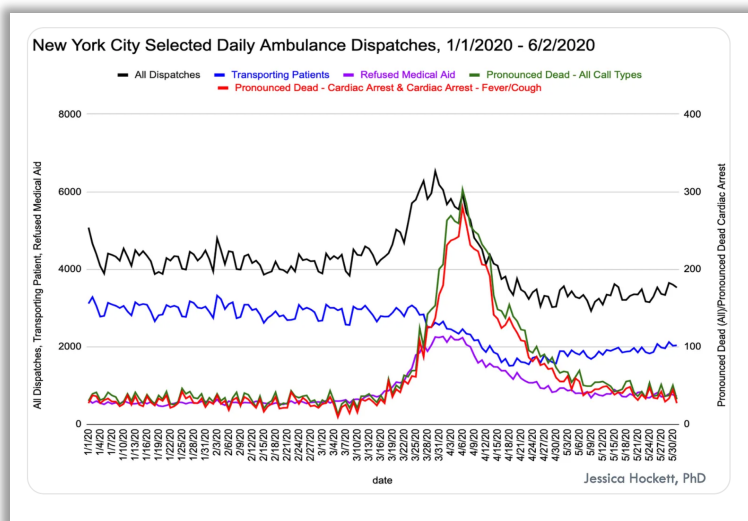


Figure 26. New York City, selected ambulance dispatch codes, 1 January 2020 – 2 June 2020.
Source: City of New York EMS incident dispatch data

Further information on troubling dispatch trends during the emergency period follows:

1. Dispatches resulting in patient transport (e.g., to hospitals) *did not* rise in tandem with the surge in EMS calls. Instead, transport volumes were initially within normal ranges and then declined, rather than increased (figure 27). During this period, EMTs were instructed to avoid transporting certain patients to hospitals “due to the tremendous volume of patients in our Emergency Departments [37]. In March 2021, the American Rescue Plan Act retroactively authorized reimbursement to ambulance providers for services involving COVID-19 patients even when no transport occurred;¹⁹ notice that such reimbursement would be available had already been issued in April 2020 [38].

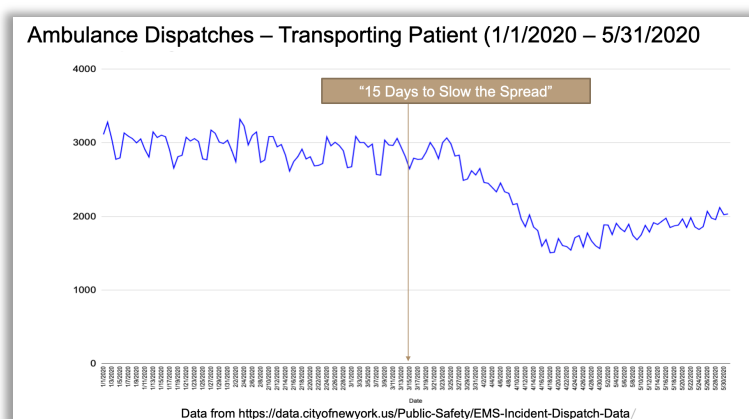


Figure 27. New York City ambulance dispatches coded Transporting Patient (from point of pick-up to another location), 1 January 2020 – 31 May 2020. Source: City of New York EMS incident dispatch data

¹⁹ American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9832 (Mar. 11, 2021)

Unlike the other four boroughs, dispatches in Manhattan *did not* increase (and dropped slightly) with the federal “15 Days to Slow the Spread” announcement (figure 28). Reasonable explanations include Manhattan residents departing the city for other places during the shutdown [39], and the impact of “stay home” directives and travel restrictions on workday commuters, evening activities, and tourism.²⁰ Arguably, if ambulance dispatches in Manhattan are normally driven by those populations and activities, the relative absence of those groups should have resulted in a more significant drop than the one observed.

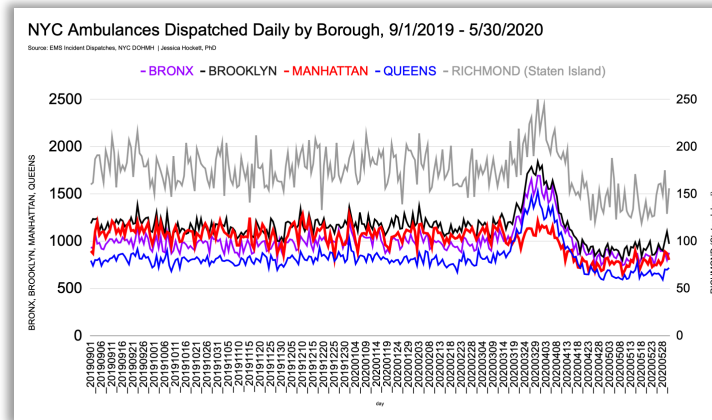


Figure 28. New York City ambulance dispatches by borough. 1 September 2019 – 30 May 2020. Source: City of New York EMS incident dispatch data.

2. There was a 300% increase (base to peak) in dispatches ending in refused medical aid (RMA) (figure 29). Analysis of calls by type and severity level suggests some RMAs were people unwell enough to go to the hospital; however, nearly 20,000 of the RMA calls were coded as severe in nature (severity code 1 or 2). It makes little sense that New Yorkers with severe medical issues – or their loved ones or bystanders – called 9-1-1 and then refused treatment and transportation to a hospital.

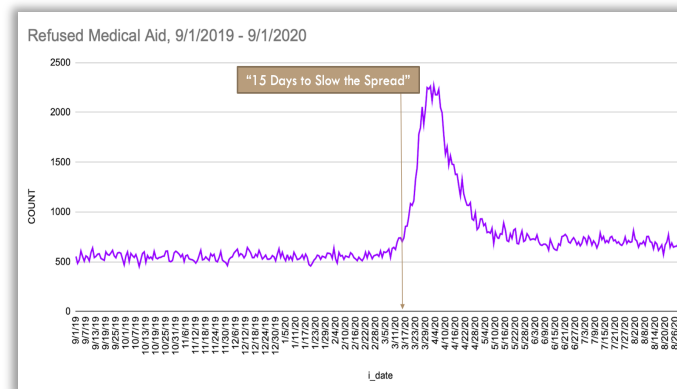


Figure 29. New York City ambulance dispatches coded Refused Medical Aid. 1 September 2019 – 30 May 2020. Source: City of New York EMS incident dispatch data

²⁰ Ridership data ([accessible here](#)) reveal that, by late March 2020, Manhattan effectively lost its daytime population. Official MTA ridership data show that on the order of 3-4 million daily commuter trips into Manhattan disappeared within weeks, driven by a ~90–95% collapse in subway ridership and a parallel collapse in commuter rail traffic.

- Refusals in RMAs are usually on the part of the patient, but orders issued during the timeframe show that the person doing the refusing, and the medical aid being offered, could have been involved in the RMA spike. For instance, if a patient refused a breath-actuated nebulizer (March 6) or surgical mask (March 17) or resisted use of an alternative airway (March 20), it may have been grounds to code the dispatch as RMA.

A 27 March 2020 FDNY bulletin loosened oversight for RMAs, including in instances where the patient had received medication or was at high risk of severe outcome (image 2). Such an allowance being made for patients in need of a hospital during an emergency is troubling.

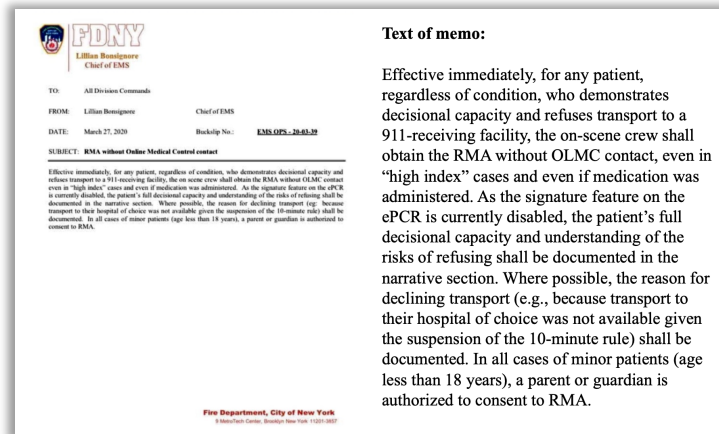


Image 2. Fire Department of the City of New York, Emergency Medical Services. “RMA without Online Medical Control Contact,” Buckslip EMS OPS-20-03-29, March 27, 2020. Sourced from <https://twitter.com/NYCEMSwatch/status/1243746310882197506>

Some anecdotal evidence raises the question of whether (in some cases) it was the First Responders who refused medical aid when it should have been given. Not far from the city, in northern New Jersey, paramedics reportedly refused to take a man with a liver condition to the hospital and relented under pressure from the man’s wife when they came back a second time. [40] Similar instances were documented nearby. [41]

- Thousands of New Yorkers, including those I’ve spoken to directly, testify to the incessant sound of sirens in the first weeks of the shutdown. The overall increase in dispatches corroborates their memories, as does the city being shut down and residents perhaps more attuned to the sound amidst the relative quiet. Some have said ambulances were driving around the city empty, on purpose, with sirens and lights on, to make people afraid and/or convey the “emergency” situation. Though they comprise a low number of the total rise in dispatches (figure 30), the sudden and brief increase in *uncoded* ambulance dispatches (null value) *may* help support the “empty ambulance hypothesis”.²¹

²¹ The role of sound, or its conspicuous absence, during the event warrants further investigation. Research on how repetitive, wave-like auditory patterns (including ambulance sirens, mass notification tones, or even naturally occurring phenomena such as cicada broods) can induce stress, anxiety, or heightened alertness in some individuals may be relevant. Also of interest is the extent to which military and intelligence agencies have studied, tested, or deployed sound and frequency-based stimuli in experimental, emergency, or operational contexts.

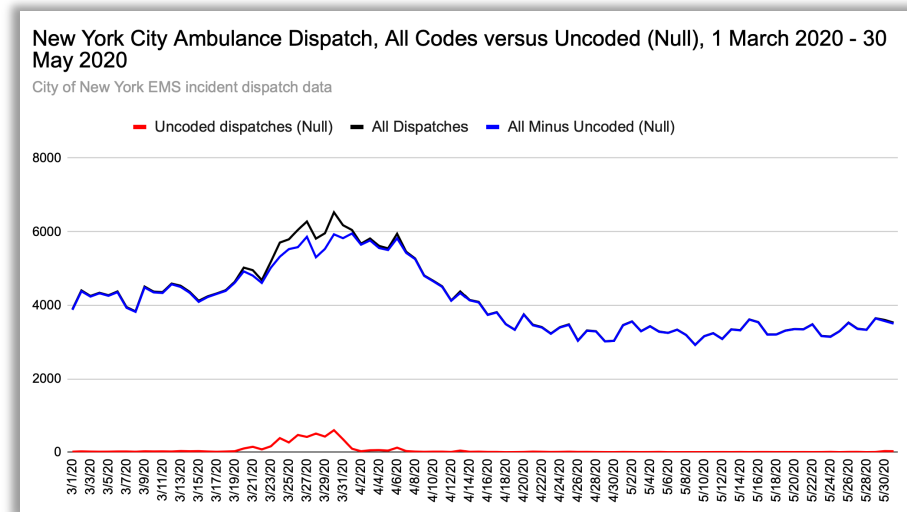


Figure 30. New York City ambulance dispatches, all codes versus uncoded (null), 1 March 2020– 30 May 2020.
Source: City of New York EMS incident dispatch data

The ambulance dispatch datasets are extremely complex and warrant forensic investigation by qualified auditors and computer scientists. Ideally, this would involve multiple credentialed parties who have no political, professional, or personal ties to any New York or federal agency, workers' union, or official conducting analysis independently.²² In addition, all call recordings, transcripts, and dispatch reports should be analyzed and verified as authentic and having occurred on the date claimed.

11. No Records, No Response?

Public agencies and researchers have resisted, refused, or exercised reticence toward releasing or providing taxpayer-funded data in response to requests and, in some cases, have done so in a manner suggestive of fear or secrecy. Examples **as of late September 2024** follow:²³

- Request to New York City Health + Hospitals Corporation (HHC) for daily death and blood culture data between 2017-2020: Delayed six months with a final response granting records for 2020 only; appeal denied.
- Inquiry to HHC COVID Research Committee regarding a discrepancy between data supplied to researchers and data reported to HDNY: Ignored. (Inquiries to the researchers also went unanswered.)
- Requests to HHC employees for data in two studies that report taxpayer-funded data were ignored after authors initially said they would supply it.
- Requests to HHC for medication and intubation data and emergency department visits were 1-3 months overdue.

²² Downloads of the data over the past few years show signs of tampering. I am not in the position to *prove* such adulteration has occurred but would be happy to speak to anyone acting in an official capacity about some of the changes observed.

²³ Documentation of all FOI-related interactions are on file with and available from the author.

- Request to the Office of the Medical Examiner for records related to anomalous processing event: Submitted in December 2023 and delayed until October 2024 (still outstanding)
- Request to FDNY Chief Medical Officer for 911 call data in a publicly-funded study he co-authored: Denied (“At this time, we cannot provide this.”)
- FDNY suddenly closed a request for ambulance transfer data, following a 14-month saga. Appeal submitted; no response to appeal to date.
- Request to NYPD for daily dead-on-arrival (DOA) calls: Submitted March 2024, delayed until August 2024; no response to recent email asking for status update.

In my advocacy efforts and policy work, I’ve submitted records requests to entities in nearly every state in the U.S., including to many big-city and federal agencies. Public employees in a large city ignoring or circumventing records requests is unsurprising and, in some ways, par for the course.

The pattern of recalcitrance I’ve experienced in the past two-plus years actively investigating the New York event, however, involves data most critical to verifying official and media claims about the event itself – and points to a culture of, or preference for, self-protection, rather than transparency around what did or did not happen. I’m left with the impression that *conceal, don’t reveal* is a guiding principle for some entities and individuals when it comes to the spring 2020 spike.

Conclusion

The specter of death and doom in New York City was used to justify a pandemic declaration, upend life as We the People knew it, and usher in months and years of harms against children and adults around the world. Desiring and demanding the truth about the event is not only the responsibility of the 8 million people who live in the five boroughs, but of all Americans who want the truth about what occurred, why, and how. The daily death curve must be substantiated by city, state, and federal agencies with records that show the names, dates, and places of death of all decedents. “Burden of proof” lies not with affiliated or academic researchers but with the officials who have made the claim.

The eleven sets of problems summarized in this paper describe anomalies and contradictions across timing, geography, age distribution, place-of-death patterns, hospital activity, emergency medical services, body management, and public-record disclosure. Taken together, they are not well explained by ordinary or presumed epidemiological mechanisms or by a naturally spreading respiratory pathogen acting alone. A ‘novel virus’ notwithstanding, whether and to what extent New York City’s all-cause daily death curve is a feat attainable via iatrogenic measures alone, sans data engineering, is an open question. Analysts with different backgrounds and perspectives should be able to agree that the event warrants an independent audit with full release of the underlying records required to verify the names and number of people who are claimed to have died on each day.

If the New York curve is allowed to stand, unscrutinized, it sends a strong message to authorities: *go ahead: assert whatever mass-casualty claim you’d like, without verification. We,*

the public, will simply believe. Both average citizens and experts alike should be concerned about impossible death events “feeding” future models and predictions that can be leveraged to introduce or perpetuate harmful policies and increase officials’ power far beyond Constitutional bounds.

What to Do

New York residents and legislators with an interest in holding leaders accountable for the “pandemic response” are well-positioned to

- demand a full and public release of death certificates with names, dates of death, places of death, and attributed causes as a first step to substantiating the mortality curve,
- pressure public agencies to stop withholding data and delaying requests for public records,
- contact members of the [U.S. House Select Subcommittee on the Coronavirus Pandemic](#) and urge them understand what data regarding nursing homes has been suppressed and to open a separate inquiry into the New York City death spike. (This is also something any American can do.)
- send this article to elected officials, activists, and other New Yorkers and let them know “Cuomo sending COVID-positive people into nursing homes” does *NOT* sufficiently explain or substantiate the city’s spring 2020 death event.

Author’s Note on 30 December 2025 revision

This summary was originally published on 24 September 2024 with links to cited material and, to aid readability on the Substack platform, no figures embedded. The revised and expanded (“amplified”) version presented here incorporates the relevant figures, tables, and images, replaces most embedded hyperlinks with in-text citations (IEEE style), and includes corresponding reference list.

Several points have been elaborated or clarified since the original publication. Edits and revisions to language and style have been made to formalize the paper. In some cases, material previously presented as footnotes has been relocated to, or integrated directly into, the body of the article. There is also a more substantive introduction and conclusion.

“Eleven Problems” was initially written in advance of (and with an eye toward supporting) the narrative overview of my independent investigation into the New York City mass-casualty event, [“New York City Spring 2020: An unsubstantiated mass casualty event that appears fraudulent and staged.”](#)

The revision intentionally excludes evidence, findings, records, analysis, or conclusions amassed, executed, or developed after September 2024. However, nothing I’ve obtained or learned since then refutes or conflicts with the points I’ve made; on the contrary, most of what I continue to gather and have written about the New York and Bergamo, Italy events strengthens the argument that the death curves may be false and, even if they are “true,” require validation.

Corrections made on 30 August 2026: The title of Table 2 was corrected from 2019 to 2020. Figure 9 and the accompanying prose were revised to clarify the comparison and ensure that the description corresponds to the

figure. The graphs show deaths recorded as due to respiratory disease, not deaths from all causes. The link to E. Jordan's book now goes directly to the relevant graph.

Reference link updates made on 25 March 2026.

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