# World Gone Crazy

## Global False Alarm Was Triggered By The Most Exaggerated Health Threat In History

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World Gone Crazy:
Global False Alarm Was Triggered By The
Most Exaggerated Health Threat In History



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Front and back cover image, Covid-19 red array (cdc.gov)

Dedicated to Sofiya and Anamaria
for inspiring this book to be written.

Acknowledgment is given to
Aleksandr Lukashenko
for having the strength of character to
publicly identify in March 2020 the
wildly exaggerated reaction to COVID-19
as a psychosis, and providing
an oasis of rationality in Belarus
from coronavirus insanity
that gripped most of the world.

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# Introduction

World Gone Crazy is based on an intensive investigation of official data, scientific studies, and the critical analysis of experts regarding the COVID-19 outbreak of 2019/2020. That investigation resulted in discovery of information leading to conclusions that include:

- By March 2020 it was known COVID-19 is not a widespread threat to the population, with healthy people of any age – and especially the young – affected by it similar to or less than the seasonal flu.

- Wuhan Flu was the name for the virus after the first cases were diagnosed in Wuhan, China, however, based on the assertion it was culturally offensive to call it Wuhan Flu, it began to be referred to by the politically correct name COVID-19.[1]

- COVID-19 is not even in the top six of worldwide flu outbreaks and life went on as normal with no shutdown of society due to them: 1830 Chinese Flu killed five times more people; 1889 Russian Flu killed five times more people; 1918 Spanish Flu killed 80 times more people; 1957 Asian Flu killed five times more people; 1968 Hong Kong Flu killed twice as many people; and 1977 Russian Flu killed 20% more people.[2]

- Unhealthy people with underlying health conditions – and particularly the elderly – are the demographic most vulnerable to become ill, need hospitalization in a serious case, or at worst die as a consequence of the COVID-19 – that is opportunistically most dangerous for people with relatively low life expectancy.

- CDC and WHO data supports COVID-19 was never a danger for the public at large – with 97% of C-19 deaths in the U.S. of unhealthy people suffering from one or more comorbidities, and 99% in Italy.[3]

- Reasonably healthy people of any age and particularly those under 65, typically have a benign experience from a COVID-19 infection, with a very high asymptomatic percentage and a mortality rate less than or comparable to the flu.

- K-12 students are a natural barrier against transmission of COVID-19 because they effectively do not transmit it to each other or to adults, and with a fatality rate approaching zero it is less of a health threat to them than the seasonal flu.

- The media, political, and medical establishment have done everything possible to obscure the fundamental fact COVID-19 is such an insignificant health event for society as a whole that few people know anyone who has gotten ill from it, even less people know anyone who

has been hospitalized, and only a small fraction of people know anyone who has died from it.

● The majority of people wouldn't even know COVID-19 existed if it wasn't drummed into their heads 24/7 by the legacy and social media that they need to be terrified of it.

● COVID-19 is the greatest health related exaggeration in world history.[4]

● The greatest media disinformation campaign in world history spun COVID-19 as a global menace.

● The lemming like response by government officials globally to the alleged menace of COVID-19 is the greatest political over-reaction in world history.

● Computer models based on guesstimates disassociated from the reality of COVID-19's actual effect on the population, falsely portrayed it as the second-coming of the Spanish Flu.

● People related to the medical industry seized on spewing hysterical suppositions about the menace of COVID-19 as a sure fire way to have a lingering 15-minutes of fame and media attention.

● Medical/health related organizations and businesses used COVID-19 to milk money hand over fist from governments.

● COVID-19 was a godsend to billionaires worldwide by opening the floodgates to an unprecedented orgy of their wealth being increased by at least $1.5 trillion – with an $845 billion increase in the wealth of U.S. billionaires from mid-March 2020 to mid-September, and an increase of $655 billion by non-American billionaires during the same period of time, with the biggest "winners" Jeff Bezos (Amazon, +$73.2 billion); Elon Musk (Tesla, +$67.4 billion); Larry Ellison (Oracle, +20.2 billion); Steve Ballmer (Microsoft, +$18.7 billion); and Bill Gates (Microsoft, +$18.3 billion), with many more increasing their wealth by billions – while the U.S. economy as a whole shrank 8% and hourly workers with no job security were hit the hardest.[5]

● Knowledgeable people with rational fact-based criticisms of the non-science based hysteria that COVID-19 is a threat to mankind have been ignored by politicians, marginalized and silenced by the legacy media, and systematically ridiculed and muted by social media.

● The undisclosed political and economic agendas pushing COVID-19 as an end-of-the-world virus are epitomized by the WHO repeatedly pressuring Belarus' President Aleksandr Lukashenko to impose highly restrictive COVID-19 policies similar to those of neighboring countries, and the IMF's effort to bribe him with the promise of a large loan if he would impose those policies – but he rejected all outside agendas and

kept Belarus operating normally, even saying in a speech on August 7, 2020 to Belarusian healthcare workers the coronavirus involves "political and economic warfare," and is not just a disease outbreak.[6]

● Hospitals and health facilities in the U.S. and other countries operated very significantly under-capacity with COVID-19 patients during the height of the outbreak – when the claim they would be overwhelmed was the stated political justification for shutting down society.[7]

● More people were hospitalized during the six months of the 2019-2020 seasonal flu outbreak than were hospitalized during the first nine months of the COVID-19 outbreak.[8]

● The fact-deficient emotional based response by governments to COVID-19 that was aided by a media hypnotized public, resulted in the greatest widespread societal damage in world history unrelated to a war or revolution – with the possible exception the 14th-century Black Death.[9]

● Many more people have died and multiple times more life-years have been lost as a result of the exaggerated response by governments around the world to COVID-19, than if the virus had been treated the same as the seasonal flu or a typical cold virus.

● COVID-19 is not particularly virulent or unusually contagious compared to the seasonal flu.

● The public was misled to think a coronavirus is novel or unique, when there are multiple strains that infect humans, and it is a common cause of upper-respiratory tract illnesses that includes the common cold.[10]

● National and state shutdowns of commerce, education and social activities caused infinitely more economic, societal and public health harm than if the response to COVID-19 had been the same as for the seasonal flu: Let it run its natural course and dissipate.

● Not a single state conducted the cost-benefit analysis set-forth under CDC guidelines to determine the negative economic and societal consequences *before* it instituted COVID-19 mitigation measures such as shutting-down businesses and schools, mandating social distancing, etc.

● No nation based its decision to institute a COVID-19 shutdown or other severe restrictions on a cost-benefit analysis that determined they would cause less harm than alternatives, including doing nothing.

● Government officials used psychological terror tactics to manipulate and scare the general population into being guinea pigs by complying with arbitrary behavior controls ostensibly declared to protect and preserve the public health, but which were without a scientific or historical foundation.

● National and state shutdowns resulted in lower population immunity to COVID-19, and higher cumulative deaths than if the virus had been allowed to run its course naturally.

● U.S. states *without* statewide stay-at-home orders had COVID-19 death rates *67% lower* than states with harsh stay-at-home orders.

● Countries *without* nationwide lockdowns overall had COVID-19 death rates *80% lower* than countries with lockdowns.

● "Temporary" state of emergencies imposed by state governors for what was expected to be the two-week infection cycle of COVID-19 were inexplicably transformed into months-long quasi-permanent intrusions into the lives of people and the operation of businesses.

● The number of cases recorded by WHO and the CDC were wildly over-inflated because 90%+ of positive results from PCR testing worldwide were reactions to artifacts from a previous coronavirus infection or false positives, and did not indicate the presence of an active/infectious COVID-19 virus.

● Death recording guidelines adopted special for COVID-19 are estimated to have inflated the reported fatality total by more than 1,000% above its actual number.

● Even with inflated fatality numbers COVID-19 may not rank in 2020's top 10 causes of death world-wide.[11]

● CDC data establishes COVID-19 is less lethal for people under 85 than pneumonia.[12]

● CDC data shows that in 2020 only 0.3% of U.S. deaths were solely attributable to COVID-19 – less than one in 326 deaths nationwide.[13]

● The radical overreaction to COVID-19 by health officials in the U.S. was due to replacement in 2017 of the CDC's 2007 influenza response guidelines under which COVID-19 is classified as a mid-level Category 2 (out of 5) outbreak, with the *recommended* response of "Voluntary isolation of ill at home."

● As reported fatality rates dropped to levels well below those of vehicle related accidents, the flames of COVID-19 hysteria were fanned by the media, politicians, and health officials switching to emphasizing *positive test* rates – while ignoring those are of little importance because a very small percentage of people who test positive become ill enough to even require hospitalization.

● To avoid COVID-19 hysteria from dying a natural death after the "flatten the curve" mantra was proven to be hyperbole, governments around the world did a bait-and-switch to hyping eradication of the virus with a vaccine.

- Governments around the world are taking advantage of COVID-19 to tout administration of a vaccine as necessary to ensure safe interaction within a country and internationally.

Before any U.S. state imposed a lockdown and before European countries began *en masse* imposing lockdowns – it was known by early March 2020 from the experience of the Diamond Princess cruise ship, China, South Korea, Japan and other countries with early outbreaks, that for society overall COVID-19 is a milder virus than the seasonal flu.

It is also known a high percentage of the healthy population is immune to infection from COVID-19 – possibly from exposure to other coronaviruses circulating worldwide for several decades – and a very high percentage of healthy people who become infected are asymptomatic.

Just like the flu or pneumonia, the most at risk group for fatalities from COVID-19 are people already at, or rapidly approaching, deaths door. The general frailty or compromised health condition of elderly people makes them a prime group vulnerable to any illness. However, data shows COVID-19 is not any more of a health threat to elderly people than pneumonia.

The legacy media's insatiable hunger for hits, clicks and views drove their narrative COVID-19 is the second coming of the Spanish Flu of 1918/19.[14] That storyline deliberately disregards the fact that for the overwhelming majority of the population COVID-19 is a relatively benign respiratory virus.

The obsession for 15 minutes of fame by medical talking heads fed the media flames by adding an air of respectability to the misinformation spewed non-stop about COVID-19's supposed dangerousness.

Social media's hunger for likes and retweets/repostings threw gasoline on the legacy media's false characterization COVID-19 posed an imminent danger for the general public.

COVID-19 became an out of control conflagration in the media and the Internet world, and they fueled irresponsible fact-free hysteria by portraying it as bad as possible. The story had legs, so they kept adding fuel to keep the hysteria going … for months and months. Distortions of the truth or its absence didn't matter if it added to the "end of the world" as we know it narrative.

COVID-19 transmuted to not only have a physical form – but it also became phantasmic. COVID-19 evolved into a mind virus systematically injected into the brains of people throughout the world by every known information transmission method. People who watched, read or listened to the legacy media, and were exposed to the drumbeating on social media, became fearful the boogie-virus was lurking on a countertop or the breath of strangers waiting for the chance to infect and strike them dead.

Countries descended into coronavirus madness as if faced with a zombie apocalypse threatening to overwhelm the world.

Politicians and bureaucrats throughout the world had knee-jerk reactions to the media wave, and restrictions of varying degrees were decreed in most countries. Those restrictions were imposed without any cost-benefit analysis of how society would be better off from them compared with their negative financial, social, medical, physical, and psychological effect on people. Public policy was driven by pandering to media whipped hysteria and not rational deliberation and thoughtful analysis of what could positively be justified as beneficial to the public.

COVID-19 was incessantly promoted as a pandemic. The legacy media and social media spewed out endless doomsday scenarios. Publicizing the truth that COVID-19 is no more a threat to the survival of mankind than the common cold wouldn't generate hits, clicks, views, and advertising revenue.

The real crisis was the unreasonable reaction of politicians, government officials, and compromised people in the health care industry to COVID-19. They contributed to mass infection of the general population with an attitude of extreme fear regarding it. It was obscured that COVID-19 is far less harmful as a physical virus than it is as a manufactured mental virus stoking irrational fear in people.

In retrospect China radically over-reacted initially to the Wuhan Flu (COVID-19). When it was first detected they didn't know what they were dealing with. So Hubei Province – and in particular the very large city of Wuhan where it was first detected – was isolated.[15] However, China quickly learned the effects of COVID-19 were either undetectable or very minor in the vast majority of people who were infected with it, and the number of fatalities as a percentage of the population was extraordinarily low.[16] It was also learned the overwhelming percentage of fatalities were of elderly people with one or more serious underlying medical conditions that by themselves could be a cause of the persons death, e.g., diabetes, heart disease, cancer, etc.

China's initial over-reaction set the stage for what many other countries did after infections were detected. With the medical, media, political complex hysterically pushing the narrative COVID-19 was an out of control killer virus, countries around the world disregarded the evidence there was nothing to worry about because it was no more fearful than the seasonal flu.

Disregarding the information learned from China's experience, national governments and states widely adopted China's initial strategy that "flattening the curve" of infections and hospitalizations was the only way to keep the natural transmission of COVID-19 from overwhelming the capacity of hospitals.

Worse, China's mistaken overreaction was copied without any cause-effect/harm-mitigation analysis being conducted to legitimize the radical "flatten the curve" restrictions imposed by governments worldwide.

The "flatten the curve" mantra somnambulistically repeated by people

around the world has been played out. It inspired policies that artificially extended the life-cycle of the COVID-19 outbreak and likely resulted in substantially more deaths than would have occurred naturally. However, "flatten the curve" was useful to cultivate the coronavirus psychosis relied on to convince people they can only be protected from the scourge of COVID-19 by a vaccine. Government officials are now considering public policies that would require a COVID-19 "passport" proving inoculation before a person would be allowed on public transportation, airplanes, trains, or possibly even being admitted to one's workplace. It is unreasonable to think the pro-vaccinators aren't aware flu vaccines are notoriously ineffective and there is no viable cold vaccine after decades of research, so there is reason to be suspicious of what is driving vaccination fever.

This is not being written in hindsight after the COVID-19 hysteria has died down, but as the author is experiencing in real-time the economic and social effects of political and bureaucratic edicts, and the feverish efforts of the medical establishment, legacy media, and Internet social media to keep alive for as long as possible the narrative we all must be constantly afraid of the stalking killer virus.

The information in this book is an antidote to overcome the artificial deaf, dumb and blindness induced in a large segment of the population by people benefiting in one way or another from coronapsychosis.

This book clearly explains with data from health organizations around the world that COVID-19 is less of a threat to the health and welfare of the general public than the seasonal flu. It also explains the media's narrative it is a deadly menace to mankind contributes to COVID-19 being both the greatest medical exaggeration and the most widespread political over-reaction in world history. The result has been catastrophically negative social, economic, and human rights consequences.

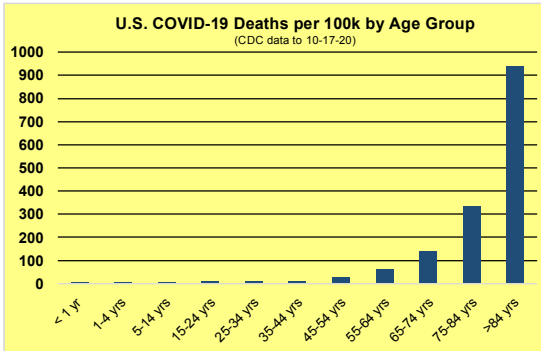
There doesn't seem to have been a single governmental official in a position of authority in the countries that instituted a shut-down/lockdown, who took the reasonable step of evaluating the costs versus the benefits of taking that action. And worse, there was an almost psychotic like worship of the sunk-cost fallacy: those shut-down/lockdowns were continued or other measures imposed (masks, etc.) when the absence of scientific justifications for them became ever more apparent.

If someone was to awaken from a coma and be told about 2020's world-wide COVID-19 hysteria he would think almost all the world's political leaders had gone completely mad or been infected with a virus that caused stupid, cowardly, or power grabbing behavior. The absurdity of their conduct is exposed by the handful of political leaders who didn't drink the COVID-19 Kool-Aid and acted rationally and with courage to protect their country or

state from unnecessary economic, medical, and psychological carnage.

It is positively known from data around the world that COVID-19 is not an abnormal health threat to society, and it is just as positively known the response to it by government and medical authorities manufactured from nothing more than irrational fear a very real economic and societal crisis that is divorced from reality.

U.S. federal and state officials and foreign governments used COVID-19 as medical terrorism against their own people to discourage skepticism and compel compliance with directives no less preposterous than requiring: public acknowledgment a King parading naked down the street is wearing clothes; or mandating belief the Earth is flat and the Sun revolves around it.




The chart of deaths by age group exposes the magnitude of the lie the public has been sold about the purported health menace of COVID-19.[17] People 75 and older are the high risk age group for fatalities because in general they are more frail and less healthy than younger people. The mortality risk very rapidly decreases by age to the point it is close to nil for K-12 and university aged students. Data from the U.S. and other countries is crystal clear that no healthy non-obese person under 65 has any reason to be more concerned about COVID-19 than they are about the seasonal flu. The common cold can cause more inconvenience.

You don't have to have a medical degree or be an expert epidemiologist or virologist to understand the data and studies that demonstrate COVID-19 is not the killer threat to mankind it has been portrayed to be by the legacy and social media, medical organizations and experts, and politicians. The voluminous evidence COVID-19 is an ordinary disease is plain enough to be understood by a ten-year-old, and written about in plain language by a knowledgeable layperson.

COVID-19 is a global false alarm. There has been an avalanche of lies, half-truths, and speculations spewed out for months by the media, the medical establishment, and politicians "crying wolf" promoting a non-existent contrived health emergency. Hopefully that psychological terror campaign hasn't jaded large numbers of people to be unable to recognize a genuine widespread health threat in the future.

Hans Sherrer
October 28, 2020

# 1. Timeline Of Significant COVID-19 Events

**October 6, 2019**: "Phylogenetic estimates supports that the COVID-19 pandemic started sometimes around 6 October 2019 – 11 December 2019. … The genomic diversity of the global SARS-CoV-2 population being recapitulated in multiple countries points to extensive worldwide transmission of COVID-19, likely from extremely early on in the pandemic."[18]

**November 12, 2019**: An individual in Pike County, Ohio had a positive antibody test in July 2020, but his COVID-19 symptom onset was in Nov. 2019. The person had recently travelled out-of-state.[19]

**November 17, 2019**. First person in China known to have suffered from COVID-19 infection traced to first experiencing symptoms on November 17 in Hubei.[20]

**December 11,** 2019. First positive test for COVID-19 was of a woman who lived near the fish market in Wuhan, China.[21]

**December 2019**: At least 26 people in Florida started showing symptoms of COVID-19 in late December-early January 2020 who later tested positive. At least eight of the people both had not traveled outside Florida and had no contact with another person known to have been infected with the virus. (This was reported on May 5, 2020.)[22]

**December 2019**: A man coughing up blood arrived at a hospital near Paris, France in late December. His blood sample later tested positive for COVID-19.[23]

**December 31, 2019**: "Wuhan Municipal Health Commission, China, reported a cluster of cases of pneumonia in Wuhan, Hubei Province."[24]

**January 1, 2019**: Wuhan seafood market was closed by Chinese authorities.

**January 4, 2020**: "WHO reported on social media that there was a cluster of pneumonia cases – with no deaths – in Wuhan, Hubei province."[25]

**January 5, 2020**: WHO published its first Disease Outbreak News on the new virus.[26]

**January 9, 2020**: "WHO reported that Chinese authorities have determined that the outbreak is caused by a novel coronavirus."[27]

**January 12, 2020**: "China publicly shared the genetic sequence of coronavirus."[28]

**January 13, 2020**: "Officials confirm a case of coronavirus in Thailand, the first recorded case outside of China."[29]

**January 14, 2020**: Limited human to human transmission of COVID-19 – "mainly through family member" -- was suggested during WHO press briefing.[30]

**January 17, 2020**: U.S. Center for Disease Control began screening passengers at New York and San Francisco, the only two cities that received direct flights from Wuhan, and at Los Angeles where passengers arrived in the U.S. on connecting flights. [31]

**January 20, 2020**: First confirmed case in U.S. was a man in Snohomish County, Washington (north of Seattle) who had returned on January 15 from Wuhan, where he visited family members.[32]

**January 21, 2020**: "WHO/WPRO tweeted that it was now very clear from the latest information that there was "at least some human-to-human transmission", and that infections among health care workers strengthened the evidence for this."[33]

**January 24, 2020**: France informed WHO of three coronavirus cases, all who had travelled from Wuhan. These were the first confirmed European cases.[34]

**January 24, 2020**: First reported case in Australia.[35]

**January 30, 2020**: 7,818 cases reported world-wide., with all cases in China except for 82 cases reported in 18 other countries[36]

**January 31, 2020**: First reported case in Russia.[37]

**February 11, 2020:** International Committee on Taxonomy of Viruses (ICTV) named the new virus SARS-CoV-2 because it was genetically related to the coronavirus responsible for the 2003 outbreak of SARS (Severe Acute Respiratory Syndrome CoronaVirus).[38]

**February 11, 2020**: "WHO announced that the disease caused by the novel coronavirus would be named COVID-19."[39]

**February 14, 2020**: First reported case in Africa (Egypt).[40]

**February 26, 2020**: First reported case in South America (Brazil).[41]

**February 27, 2020**: "WHO published guidance on the rational use of personal protective equipment:

- performing hand hygiene frequently with an alcohol-based hand rub if your hands are not visibly dirty or with soap and water if hands are dirty;
- avoiding touching your eyes, nose and mouth;
- practicing respiratory hygiene by coughing or sneezing into a bent elbow or tissue and then immediately disposing of the tissue;

- wearing a medical mask if you have respiratory symptoms and performing hand hygiene after disposing of the mask;
- maintaining social distance (a minimum of 1 m) from individuals with respiratory symptoms.[42]

**March 8, 2020**: Italy adopted a nationwide lockdown.[43]

**March 11, 2020**: "WHO made the assessment that COVID-19 could be characterized as a pandemic."[44]

**March 13, 2020**: Actor Tom Hanks and his wife Rita Wilson reported testing positive for COVID-19 in Australia, when there were 92 confirmed cases in the entire country. Hanks was working on a movie about Elvis Presley and no one else on the movie set was reported to have tested positive.[45]

**March 13, 2020**: U.S. President Donald Trump declared a COVID-19 National Emergency.

**March 13, 2020**: Governors in a number of U.S. states, including Washington Gov. Jay Inslee, issued Executive Proclamations (Order) closing all public and private schools.

**March 23, 2020**: Washington Gov. Jay Inslee issued Executive Proclamations (Order) prohibiting all people in Washington State from leaving their homes or participating in social, spiritual and recreational gatherings of any kind regardless of the number of participants, and all non-essential businesses in Washington State from conducting business." Similar orders were issued in all but eight states.[46]

**March 23, 2020**: COVID-19 related hospitalizations and deaths peaked in Washington State– and declined thereafter.

**March 23, 2020**: United Kingdom Prime Minister Boris Johnson ordered the closing of all non-essential businesses and for everyone to stay-at-home unless they need to go out for essential services.

**March 24, 2020**: The CDC adopted new data collection and fatality reporting guidelines unique to COVID-19. COVID-19 was to be coded on a death certificate as a cause of death when without confirmation it was "*assumed* to have caused or contributed to death," with the result it was expected to be "the underlying cause more often than not."[47]

**April 2, 2020**: "WHO reported on evidence of transmission from symptomatic, pre-symptomatic and asymptomatic people infected with COVID-19, noting that transmission from a pre-symptomatic case can occur before symptom onset."[48]

**April 4, 2020**: "WHO reported that over 1 million cases of COVID-19 had been confirmed worldwide."[49]

**April 6, 2020**: "WHO issued updated guidance on masks." ("However, there is currently no evidence that wearing a mask … by healthy persons in the wider community setting, including universal community masking, can prevent them from infection with respiratory viruses, including COVID-19.")[50]

**April 14 2020**: CDC adopts the Council of State and Territorial Epidemiologists (CSTE)'s unique COVID-19 data collection guidelines that allow reporting of "probable" cases, hospitalizations, and fatalities.[51]

**April 24, 2020**: "WHO issued a Scientific Brief on 'immunity passports' in the context of COVID-19. … there was not enough evidence about the effectiveness of antibody-mediated immunity to guarantee the accuracy of an 'immunity passport' … may therefore increase the risks of continued transmission."[52]

**May 5, 2020:** Neil Ferguson – whose Imperial College Report 9 had resulted in the U.K.'s lockdown – resigned from the U.K. government's Scientific Advisory Group for Emergencies (Sage), after it was reported he had broken England's social distancing guidelines by having multiple liaisons with his married lover who travelled to his home.

**June 2, 2020:** Neil Ferguson testified before the House of Lords' science and technology committee that Sweden had achieved similar suppression of COVID-19 as the U.K. While the U.K. imposed a harsh nationwide lockdown, Sweden had primarily relied on voluntary social distancing and herd immunity. Sweden had significantly lower infection and death rates per 100k population than the U.K.

**June 5, 2020**: WHO's updated its mask recommendation (updated June 5):

> "2) Advice to decision makers on the use of masks for the general public
> Many countries have recommended the use of fabric masks/face coverings for the general public. *At the present time, the widespread use of masks by healthy people in the community setting is not yet supported by high quality or direct scientific evidence*."[53]

**June 30, 2020**: Czech Republic became first country in Europe to completely end COVID-19 related restrictions.[54]

**July 2020**: Mandates for mask wearing in public indoors began being declared in U.S. states.

**August 11, 2020**: Russia became the first country to approve a vaccine, named Sputnik V, against SARS-CoV-2.

**August 31, 2020**: Lawsuit filed in U.S. District Court in Ohio alleging the State of Ohio, and the governor and state health director were violating the constitutional rights of Ohio residents by imposing lockdowns and other restrictions, invading privacy, and taking property "under the guise of a

health emergency that is roughly as dangerous as a seasonal influenza outbreak."[55]

**September 14, 2020**: U.S. District Judge William Stickman IV ruled that the COVID-19 restrictions ordered by Pennsylvania Gov. Tom Wolf – that include stay-at-home orders and closure of non-essential businesses – are unconstitutional and void.[56]

**October 2, 2020**: President Donald Trump and First Lady Melania were revealed to have tested positive for COVID-19, with both saying they "are feeling good." As a precaution Trump, 74, went to the Walter Reed National Military Medical Center to have his infection monitored, while Melania, 50, self-quarantined at the White House.[57]

**October 5, 2020**: President Trump was released from Walter Reed after three days of having his health status monitored, and he wasn't showing any signs of an active infection.

**October 10, 2020**: President Trump held his first campaign event after testing positive for COVID-19, and he resumed holding multiple campaign rallies daily around the U.S..

**October 14, 2020**: Barron Trump, 14, the son of President Trump and Melania Trump, was reported to have tested positive for COVID-19 but he was asymptomatic.[58]

**October 17, 2020**: *Zero* COVID-19 deaths of anyone under 35 years old in the United States the week ending Oct. 17 week, and only 14 deaths in the entire country of people 35-54 according to CDC data.[59]

**October 24, 2020**: CDC reported that from Feb. 1 to October 24, 2020 pneumonia caused more deaths in the U.S. – 215,941 – than COVID-19 – 210,545 – yet COVID-19 continued to be described by the CDC, the media, and government officials as a pandemic, while pneumonia deaths were ignored with a yawn as business as usual.[60]

# 2. Covid-19 Is An Epidemic, But A Phony Pandemic

COVID-19 can genuinely be described as an epidemic in some specific areas of the world. However, it can just as genuinely be described as a phony pandemic, because it isn't a real pandemic – only mistakenly called one.

Word definitions are critical because it is the only way people can intelligently communicate. The more serious the discussion, the more important it is that the words used to describe the central event is understood. Any discussion of COVID-19 is important because of the reaction to it in countries around the world.

The *Oxford English Dictionary* is the world's most authoritative English language dictionary. The *OED* defines Epidemic as:

> 1. a. Of a disease: 'Prevalent among a people or a community at a special time, and produced by some special causes not generally present in the affected locality.'[61]

COVID-19 is clearly an epidemic because it meets the definition's two criteria by being 1) Being prevalent among people or a community at a special time period; and, 2) It is a new type of coronavirus so it is not generally present in the areas affected by it.

The *OED* defines Pandemic as:

> 2. Of a disease: epidemic over a very large area; affecting a large proportion of a population. Also: of or relating to such a disease.[62]

COVID-19 is definitely not a pandemic because while it meets the definition's first criteria of being an epidemic, it doesn't meet the definitions second criteria because it doesn't "affect[] a large proportion of a population." The proportion of people affected by COVID-19 in even the most infected areas is a relatively small proportion of the population.

*A Dictionary of Epidemiology* is the world's most respected dictionary of epidemiological words. The ADA defines Epidemic as:

> "The occurrence in a community or region of cases of an illness, specific health-related behavior, or other health-related events clearly in excess of normal expectancy."[63]

COVID-19 is clearly an epidemic because it meets the definition's two criteria by being 1) An illness occurring in a community or region; and, 2) It is a health-related event in excess of normal expectancy.

The ADE defines Pandemic as:

> "An epidemic occurring worldwide or over a very wide area, crossing international boundaries, and usually affecting a large number of people."[64]

COVID-19 is definitely not a pandemic because while it meets the definition's first criteria of being an epidemic, it doesn't meet the definitions second criteria because it doesn't "affect[] a large number of people." And most certainly not as a proportion of a population, because in even the most infected areas COVID-19 affects a relatively small percentage of the population.

So both the historical general definition and the epidemiological definition include virulence as a prerequisite for the outbreak of an illness to be considered a pandemic.

However, the World Health Organization has a very watered down definition of pandemic that omits ***any*** consideration of the severity of an illness outbreak: "A pandemic is the worldwide spread of a new disease." [65]

A relatively benign illness that spreads worldwide – which can easily occur in the modern age of airline travel – will be considered a pandemic by WHO. There is now pandemic inflation by the WHO.

That wasn't always the case. Prior to May 2009 WHO's definition of "pandemic" included the severity criteria that it was an illness "resulting in several simultaneous epidemics worldwide with enormous numbers of deaths and illness."[66]

What happened was the H1N1 influenza outbreak in 2009 was much less lethal than had been predicted, and it could not legitimately be labeled a pandemic under the WHO's prevailing definition. For WHO to justify calling it a pandemic, the definition was changed by removing the requirement that it was "several simultaneous epidemics worldwide with enormous numbers of deaths and illness."[67]

Consequently, it is now recognized that with no consideration of seriousness by WHO: "Simultaneous worldwide transmission of influenza is sufficient to *define* an influenza pandemic."[68]

The CDC has followed the lead of WHO: "An influenza pandemic is a global outbreak of a new influenza A virus." A new flu virus affection people in a number of countries would be considered a pandemic by the CDC, even though it resulted in fewer fatalities than the seasonal flu that wouldn't be considered as either an epidemic or a pandemic.[69]

Consequently COVID-19 is called a pandemic by both WHO and the CDC with no consideration whatsoever to its lethality. While it is not considered a pandemic by either the general or the professional definitions because it doesn't affect a large number of people.

Both WHO and the CDC now have a lack of discrimination in classifying a widespread illness outbreak as a pandemic. It effectively renders pandemic to having no useful meaning to inflate it definition to include disease outbreaks regardless of their severity or scope. There is obviously a very significant difference between a widespread illness outbreak that kills enormous numbers of people proportionate to the population as a whole, and one that kills a moderate number of people, and one that kills relatively few people. The Black Death was magnitudes worse than the Spanish Flu, which was many times worse than COVID-19. Yet under current WHO and CDC guidelines all three would be classified as pandemics. That is plainly ridiculous and uninformative.

While COVID-19 can genuinely be described as epidemic, due to its lack of severity it can in all honestly be described as a phony pandemic.

# 3. Flu Annually Kills Half-Million & Afflicts Tens Of Millions Worldwide

Seasonal influenza (flu) afflicts people in countries around the world. It is as ubiquitous as the common cold, but generally with more serious health implications. The World Health Organization describes "Seasonal influenza is an acute respiratory infection caused by influenza viruses which circulate in all parts of the world."[70]

There are three types of influenza viruses that infect people: Type A, B, and C. Only type A viruses can be transmitted from animals to humans, and they are only known to have caused pandemics.[71]

Influenza A viruses can be transmitted from animals to humans in two ways:

- Directly from birds or from avian influenza A virus-contaminated environments to people.
- Through an intermediate host, such as a pig. [72]

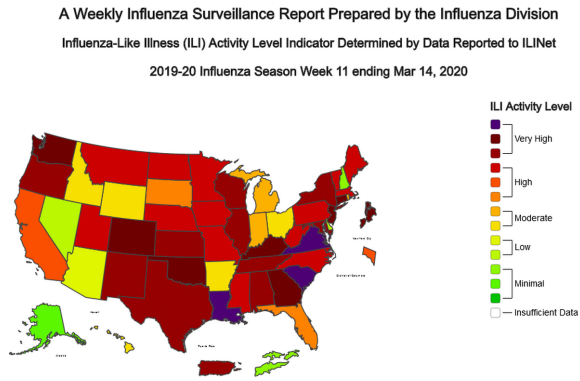
The WHO's website states about influenza:

> "In terms of transmission, seasonal influenza spreads easily, with rapid transmission in crowded areas including schools and nursing homes. When an infected person coughs or sneezes, droplets containing viruses (infectious droplets) are dispersed into the air and can spread up to one meter, and infect persons in close proximity who breathe these droplets in. The virus can also be spread by hands contaminated with influenza viruses. To prevent transmission, people should cover their mouth and nose with a tissue when coughing, and wash their hands regularly."[73]

The World Health Organization estimates that worldwide there are 3 to 5 million severe (hospitalization quality) cases of influenza annually, and from 290,000 to 650,00 deaths: with a mean of 470,000.[74] Those are numbers for a normal year.

It is *expected* that up to 650,000 people will die from the flu each year, and when that happens it isn't considered a flu epidemic or pandemic – but the norm.

For the last eight years there has been an average of 41,389 flu deaths annually in the U.S. Deaths exceeded 60,000 in 2017/2018, and the CDC estimates there have been up to 62,000 flu deaths this year (2019/2020). (All data is in the tables below)




The CDC map shows flu infections for each state at the time President Donald Trump proclaimed a COVID-19 National Emergency on March 13, 2020. Flu infections were prevalent throughout the U.S. There was maximum flu activity in Louisiana, South Carolina, and Virginia, with very high infections in a number of other states. Thirty-nine states had High or Very High Influenza-Like Illness activity, and only eleven had Low or Minimal activity.

For the last eight flu seasons (which begins in the fall and continues into the spring of the next year) the CDC's figures are:

2012-2013 – 42,570 deaths
– 33.7 million illnesses
– 15.8 million medical visits
– 571,382 hospitalizations[75]

2013-2014 – 37,930 deaths
– 29.7 million illnesses
– 13.2 million medical visits
– 346,912 hospitalizations[76]

2014-2015 – 51,376 deaths
– 30.2 million illnesses
– 14.4 million medical visits
– 590,869 hospitalizations[77]

2015-2016 – 22,705 deaths
– 23.5 million illnesses
– 10.7 million medical visits
– 276,198 hospitalizations[78]

2016-2017 – 38,230 deaths
– 29.2 million illnesses
– 13.6 million medical visits
– 496,912 hospitalizations[79]

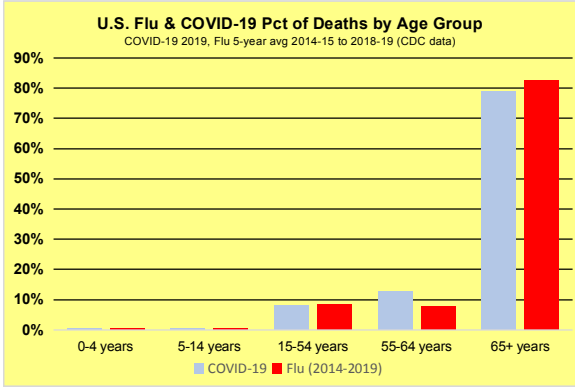
2017-2018 – 61,099 deaths
– 44.8 million illnesses
– 20.7 million medical visits
– 808,129 hospitalizations[80]

2018-2019 – 34,200 deaths
– 35.5 million illnesses
– 16.5 million medical visits
– 490,600 hospitalizations[81]

2019-2020 – 43,000 deaths[82]
– 47.5 million illnesses[83]
– 22 million medical visits[84]
– 575,000 hospitalizations[85]

The averages for the last eight years are:

2012-2020 – 41,389 deaths
– 34.3 million illnesses
– 15.9 million medical visits
– 519,500 hospitalizations




The 2019/2020 numbers that are greater than some years and less than others aren't considered a flu epidemic or pandemic in the U.S. The chart shows the seasonal flu and the Wuhan flu (COVID-19) affect age groups very similarly. The most seriously affected age group, people 55 and older, account for 91.6% of COVID-19 deaths and 90.5% of flu deaths.

The widespread prevalence of the seasonal flu in the U.S. every year is not considered an epidemic, much less a pandemic by either the CDC or WHO – precisely because it is recognized as normal and not a new flu virus.

Whether it is called an outbreak, epidemic, or pandemic, influenza has a cyclic propensity to capture the world's attention and to generate large public health responses. However, with the exception of the 1918 pandemic, which all agree was catastrophically severe, the impact of more recent outbreaks carrying the "pandemic" label is difficult to gauge, as their divergent descriptions suggest.

The following news story warned about circulation in America of a "dangerous strain" of the flu virus "which can lead to deadly complications in the elderly." It was called the "Wuhan virus." A spokeswoman for the CDC's National Center for Infectious Diseases ominously warned: "The more viruses like Wuhan, the more people die." The CDC also cautioned: "A strain similar to Wuhan caused 38 percent of all cases of the flu in the United States last year. If the elderly or others who are chronically ill get the harsh Wuhan strain, they are more likely to get pneumonia or other life-threatening illnesses."

That new deadly Wuhan flu virus was in 1996.

The more things change the more they stay the same.

THE SPOKESMAN-REVIEW

Nation World

NEWS > NATION/WORLD

## Flu Virus More Potent, Can Be Deadly

Fri., Sept. 27, 1996

**Associated Press**

It's ah, ah, ahchoo ... flu season again, and a more dangerous strain of the virus than those seen last year will be circulating this time.

The Type A-Wuhan virus, which can lead to deadly complications in the elderly, is the most dangerous of three viruses expected around the nation. The others are Type A-Texas and Type B, the Centers for Disease Control and Prevention said Thursday.

How bad the flu season will be is hard to predict, said Nancy Arden of the CDC's National Center for Infectious Diseases. But she warned: "The more viruses like Wuhan, the more people die."

The good news is that the current flu vaccine counteracts all three.

Flu contributes to the deaths of about 20,000 people a year in the United States.

A strain similar to Wuhan caused 38 percent of all cases of the flu in the United States last year. If the elderly or others who are chronically ill get the harsh Wuhan strain, they are more likely to get pneumonia or other life-threatening illnesses, Arden said.

The CDC recommends vaccinations for people 65 and older, people in nursing homes, children with asthma and anyone with a chronic illness.

# 4. Influenza Epidemics In History

The first known writings that may have describe an influenza outbreak are from Greece in 412 BC. However, to identify an outbreak/epidemic medical historians have to look for known signs and symptoms of influenza infection because the virus wasn't isolated until the 20th century.

There is believed to have been an outbreak in 1173, but it wasn't widespread enough to be considered a pandemic. There were suspected influenza outbreaks in 1510 in North Africa and Europe, and another in 1557.

There is a consensus the first definite influenza pandemic was in 1580. It "originated in Asia during the summer of that year, spread to Africa, and then to Europe along two corridors from Asia Minor and North‐West Africa. The whole of Europe was infected from south to north in a 6-month period. .. Illness rates were high; 8,000 deaths were reported from Rome, and some Spanish cities were decimated."[86]

The next influenza pandemic began in 1729. The outbreak was detected in Russia in the spring and within six months had spread to all of Europe. It lasted for three years over the known world with high death rates. There were multiple waves of infection, with the later waves more severe than the first.[87]

Fifty years later was the next pandemic. It began in China in the autumn of 1781. Within eight months it first spread to Russia, and then Europe. The infection rate was very high, particularly among young people. At its peak 30,000 people a day fell ill in St. Petersburg, and two-thirds of Rome's population became ill. The outbreak spread to Britain in the summer of 1782.[88]

| Notable Flu Outbreaks | | | |
|---|---|---|---|
| **Name** | **Year** | **Deaths** (U.S.) (Adj for 2020) | **Deaths** (Worldwide) (Adj for 2020) |
| Chinese Flu | 1830 | | 5.35 million |
| Russian Flu | 1889 | 85,000 | 5.32 million |
| Spanish Flu | 1918 | 2.158,000 | 86.7 million |
| Asian Flu | 1957 | 222,495 | 5.43 million |
| Hong Kong Flu | 1968 | 164,500 | 2.19 million |
| Russian Flu | 1977 | | 1.29 million |
| Swine Flu | 2009 | 13,400 | .412 million |

Fifty years after that was the next influenza pandemic. It began in China in the winter of 1830, and spread across Russia into Europe, and also into India, Indonesia, and the Philippines. It also spread to North America in 1831-32. There was a second wave in Europe in 1832 and 1833. The infection rate was 20-25% of the population, and although the mortality rate was low, it killed thousands during each outbreak in a location – with most deaths among the elderly during the first wave, and fewer elderly in the second wave. C. W. Potter states in *A History of Influenza*: "The pandemic of 1830–3 ranks in terms of

severity with the pandemic of 1918–20."[89] It is estimated that approximately 750,000 people died during the pandemic. That is the equivalent of 5.35 million today.[90]

There were then severe flu outbreaks in 1837 in China, and in 1847-1848 in the Mediterranean that extended into France and elsewhere in Western Europe. Those outbreaks weren't pandemics. They had very high morbidity rates of 25-50% of the population, with low mortality rates, and most of the thousands of deaths during the outbreaks were among the elderly.[91]

## I – 1889 Russian Flu

The next influenza pandemic was detected in November 1889 in Russia. It first made its way to Europe, and within four months had spread worldwide. It respected no one – infecting the czar of Russia, the king of Belgium, the king of Spain, and the emperor of Germany. The very young, elderly people, and anyone with a serious underlying health conditions was most at risk for dying, typically from pneumonia or a heart attack. Records show the infection rate in both Switzerland and Sweden was over 60%, with other countries possibly having comparable infection rates.[92]

It was reported people suffering from the Russian flu experienced "sudden chills and headaches … followed by sore throat, laryngitis and bronchitis" before typically recovering. "Overall, most infected people recovered after being "about as sick as persons with a bad cold," according to a newspaper story.[93]

The first Russian flu infection in the U.S. was in New York City, and then in other East Coast port cities where flu carriers from Europe disembarked – from which it spread throughout the U.S. *The New York Tribune* reported most of the influenza related deaths were among "Persons with weak lungs and those suffering from heart disease or kidney troubles are most seriously affected, and in many cases the influenza leads quickly to pneumonia,"[94] Most medical journals cautioned people against home remedies, and advised allowing the disease to run its course.

The Russian flu was important because it was the first outbreak in the era of bacteriology and its infection path was traced. It was learned that infection outbreaks followed major transportation routes – roads, rivers, oceans, and, railway lines (many railway lines didn't exist during the last flu epidemic in 1848.) That finding supported the theory influenza was spread by human contact, and thus stopping it would be difficult if not impossible with people readily traveling within a country and across borders.

The first death in the U.S. was on December 28, 1889 in Massachusetts, and it contributed to 13,000 deaths in the U.S. before the outbreak was basically over by early February 1890. So the initial outbreak in the U.S.

lasted less than two months. There were two or three subsequent waves (three or four total outbreaks) around the world, with mortality highest in the second wave. The Russian Flu had a very high morbidity with an estimated 300-900 million people infected, while there were an estimated 1 million deaths world-wide.[95] That is the equivalent of 5.32 million today.[96]

The mortality curve for Russian Flu by age almost perfectly tracked the mortality curve for deaths from all causes in England and Wales in 1890.[97] The chart shows that approximately 25% of all deaths in England and Wales in 1890 were related to the Russian Flu.


A study of the Russian Flu's transmission showed that it is impossible in the modern age of travel to prevent the spread of a flu virus. As explained in a *Wired* magazine article: "The rapid progression of the 1889 pandemic demonstrates that slower surface travel, even with much smaller traveler flows, sufficed to spread the pandemic across all of Europe and the United States in ~4 months. This observation supports mathematical model results, which anticipated that *restricting air transportation would have little, if any, effect*. One possible hypothesis is that *the important predictor of the speed of the pandemic is not the absolute numbers of passengers traveling between cities but the connectedness of the network of cities*."[98] The Russian Flu was the first flu epidemic to strike Europe and the U.S. after railroad lines had connected all major European and American cities.

## II – Spanish Flu

It is generally considered the first known Spanish Flu case was reported at U.S. Army Camp Funston in Kansas on March 4, 1918.[99] However, there is substantial evidence the virus originated in China. Beginning in November 1917 there were reports in China of a respiratory illness with symptoms resembling the Spanish Flu. Beginning in late 1917, 3,000 Chinese laborers transported across Canada on their way to Europe to work as laborers on the Western Front ended up in medical quarantine with flu-like symptoms.[100]

The Spanish Flu (H1N1) was genetically similar to later flu viruses known to have originated in China, and there were simultaneous outbreaks in both humans and swine.[101]

The Spanish Flu gained its name from wartime censorship rules that only allowed for reporting on the disease in neutral Spain.[102]

Wherever it originated from, it is know that infected personnel in the American Expeditionary Forces were deployed to Bordeaux, France in April 1918, and the virus quickly spread to other European countries. Eventually there were outbreaks in countries around the world.

The first wave through early summer 1918 resembled a normal flu outbreak by having relatively low mortality: In the U.S. there were only 12,000 deaths above the norm through June 1918. However, morbidity was high: three-quarters of French troops, half the British forces, and over 900,000 German soldiers became ill.[103] Infections went up sharply for a few weeks, and then just as sharply declined.

The second wave began in August 1918, and it was much more deadly than the first. In India it caused seven million deaths, and in Africa 1.5 to 2 million. In North America about 600,000 people died, and in England and Wales about 200,000 died. Unique to the Spanish Flu, a significant number of deaths were in people aged 20 to 40, as well as people over 65 who were normal flu victims.[104]

There was a third wave in 1919-20 that was also virulent.

Although the Spanish Flu was deadly to about *1 out of 50* people who were infected, the other *49 out of 50* survived. It is important to keep in mind that despite the horror stories about the Spanish Flu, "most patients experienced symptoms of typical influenza with a 3-to-5-day fever followed by complete recovery."[105]

By the time the Spanish Flu dissipated in 1920, there were 546,000 excess deaths in the U.S. and 675,000 deaths are attributed to the Spanish Flu.[106] That is the equivalent of 2,158,000 today, considering the U.S. population then was 1/3 of today.[107] It is estimated that 25-50% of the world's population became infected, and 20 to 50 million people died worldwide. That is the equivalent of 86.7 million to 216.5 million today.[108]

The Spanish Flu is now described as "the greatest medical holocaust in history," and "the pandemic ranks with the plague of Justinian and the Black Death as one of the three most destructive human epidemics."[109]

## III – Asian Flu

The Asian Flu originated in February 1957 in China's Yunnan Province. It infected large numbers of people in China before reaching Hong Kong in April, from where it spread to Singapore, Taiwan, and Japan. It then spread

into the Southern Hemisphere (Australia, Indonesia, etc.). The infection was primarily transmitted along sea lanes and six months after it began it had been seeded world-wide. There were outbreaks in North America and Europe in September with the peak in October. A second wave hit in early 1958 hit North America, Europe, the USSR, Japan, and other regions.

It is estimated that 40-50% of people were infected by the virus, with 25-30% experiencing "clinical disease." The mortality rate was approximately 1 in 4,000, predominately among the very young and the very old. Most of the deaths were "due to secondary bacterial pneumonia."[110]

The Asian Flu was caused by the H2N2 virus that was a combination of avian influenza (possibly from geese) and human influenza viruses.[111]

There was a second wave in 1958.

Deaths in the U.S. were calculated to be 116,000, and world-wide they are estimated to have exceeded 2 million. That is the equivalent of 222,495 in the U.S. and 5.43 million world-wide today.[112]

The H2N2 virus still circulates as a seasonal flu infection.

## IV – Hong Kong Flu

The Hong Kong Flu was first detected in Hong Kong in early 1968. Over the next two winters it spread around the world, with very high morbidity rates. It was first detected in the U.S. in September, but people began becoming ill in December and it peaked in January 1969. There was a second wave of infections from the virus in late 1969 that lasted until March 1970, and again in the winter of 1972.[113] Mortality was concentrated in people over 65 in ill health.

It is believed many people had immunity to the Hong Kong flu because it had similarities to the Asian flu virus that circulated in 1957 and 1958. It has been suggested the first wave in the U.S. wasn't as severe as would have been expected because infections didn't begin accelerating "until near the school holidays in December. Since children were at home and did not infect one another at school, the rate of influenza illness among schoolchildren and their families declined."[114]

The Hong Kong flu was caused by the H3N2 virus that continues to circulate worldwide as a seasonal influenza.[115]

Deaths in the U.S. were about 100,000, and world-wide they are estimated to have exceeded 1 million. That is the equivalent of 164,500 in the U.S. and 2.19 million world-wide today.[116]

## V – Swine Flu

The Swine Flu in 1976 was the epidemic that never happened. In February 1976 an Army recruit at Ft. Dix, NJ became ill with the swine flu

and died. Several other soldiers also became ill. There were also two reported cases in Virginia.

Experts predicted a nationwide swine flu pandemic would hit the U.S. in the coming winter of 1976 that could result in 50 to 60 million Americans becoming infected. A crash program was undertaken to develop a swine flu vaccine. In October 1976 the federal government began a $137 million program to inoculate Americans. Around 20% of the U.S. population – about 40 million people – was inoculated with a vaccine over the next 10 weeks. More than 500 people developed Guillain-Barre syndrome from the vaccine and 25 died, so vaccinating was stopped in December. The federal government wound up paying millions of dollars in damages to the affected people or their families.[117]

The predicted pandemic was a complete bust: there were only about 200 cases nationwide and one death. So far more people contracted Guillain-Barre syndrome and died from the swine flu vaccine, than died from the swine flu itself.

Dr. Richard P. Wenzel diagnosed the two cases in Virginia in 1976. He said about the swine flu vaccine: "It was a great effort. It just had unexpected, unfortunate side effects."[118]

## VI – 1977 Russian Flu

Although it originated in May 1977 in northern China, the Russian Flu's name comes from it first attracting attention with an outbreak in the Soviet Union in November 1977. It spread rapidly and was particularly virulent among children and young adults (<23 years old). It was a form of the H1N1 virus (i.e., Spanish Flu), and older people had immunity to it from H1N1 influenza outbreaks in the 1950s. By January 1978 it had spread around the world, also primarily affecting young people 26 and younger.[119]

The first outbreak in the U.S. was in a high school in Cheyenne, Wyoming where more than 70% of students became ill – however, not a single faculty member became sick.[120]

There are credible claims the 1977 Russian Flu was not a natural outbreak, but the result of a laboratory accident. That is based on "the 1977 strain appeared to affect only those 26 years of age and younger [who were healthy]. These odd characteristics turned out to have a simple scientific explanation: the virus was not novel. The 1977 strain was virtually identical to an H1N1 influenza strain that was prevalent in the 1950s but had since dropped out of circulation. … in 1978, researchers demonstrated that an H1N1 influenza virus strain from 1950 and another strain from 1977 … were unusually closely related, although they were isolated 27 years apart"[121]

Other than people in their mid-20s and younger, The Russian Flu was generally fatal to people in ill-health over age 65.[122] The Russian Flu is credited with killing around 700,000 people world-wide, which is the equivalent of 1.29 million today.[123]

## VII – 2009 Swine Flu

In April 2009 a new influenza was first identified in Veracruz, Mexico. It was caused by the H1N1 virus that likely originated in pigs in China, and transported to Mexico. It quickly spread to the U.S., and then worldwide.

Unlike many influenzas, the Swine Flu primarily affected children and young and middle-aged adults: "80 percent of (H1N1) virus-related deaths were estimated to have occurred in people younger than 65 years of age. This differs greatly from typical seasonal influenza epidemics, during which about 70 percent to 90 percent of deaths are estimated to occur in people 65 years and older."[124]

Although the morbidity rate was very high, the mortality rate was not. In the U.S. "the CDC estimated there were 60.8 million cases [], 274,304 hospitalizations [], and 12,469 deaths."[125]

It is estimated the Swine Flu caused 363,500 deaths worldwide,[126] which is the equivalent of 412,260 today.[127] That was comparable to or even less than a normal flu season.

# 5. Historical Deadly Epidemics

There have been many deadly epidemics in world history. One way to look at them is they are nature's way of genetically strengthening humanity by culling large numbers people who lack resistance to the disease. The following chart documents 85 known epidemics over the last 2,450 years.

| Year | Event | Death toll | Disease | Location |
|---|---|---|---|---|
| 429–426 BC | Plague of Athens | 75-100k | Unknown, possibly typhus, typhoid fever | Athens[128] |
| 165-180 AD | Antonine Plague | 5-10 mil. | Unknown, possibly smallpox | Roman Empire[129] |
| 250-266 | Plague of Cyprian | 1 mil.+ | Unknown, possibly smallpox | North Africa, Italy[130] |
| 541-542 | Plague of Justinian | 25-50 mil. (13-26% of world pop.) | Bubonic plague | North Africa, Europe & West Asia[131] |
| 735-737 | Japanese smallpox epidemic | 2 mil. (1/3 of Japanese pop.) | Smallpox | Japan[132] |
| 1346-1353 | Black Death | 25 mil. (25-50% of Europe) | Bubonic plague | North Africa, Europe & Asia[133] |
| 1466 | Paris plague epidemic | 40k | Bubonic plague | Paris[134] |
| 1519-1520 | Mexico smallpox epidemic | 5-8 mi. | Smallpox | Mexico[135] |
| 1545-1548 | Cocoliztli epidemic | 5-15 mil. | Enteric fever (includes typhoid) | Mexico & Central America[136] |
| 1561-1562 | Chile smallpox epidemic | 20-25% of population | Smallpox | Chile[137] |
| 1570 | Moscow plague epidemic | 200k | Bubonic plague | Moscow[138] |
| 1572 | Lyon plague epidemic | 50k | Bubonic plague | Lyon, France[139] |
| 1576 | Venice plague epidemic | 70k | Bubonic plague | Venice, Italy |
| 1576-1580 | Cocoliztli epidemic | 2-2.5 mil. | Enteric fever (includes typhoid) | Mexico[140] |
| 1580 | First influenza pandemic | 50k+ | Influenza | Europe, Asia Minor & NW Africa[141] |
| 1596–1602 | Spain plague epidemic | 600-700k | Bubonic plague | Spain[142] |
| 1603 | London plague epidemic | 38k | Bubonic plague | London[143] |
| 1611 | Constantinople plague epidemic | 100k | Bubonic plague | Constantinople[144] |

| | | | | |
|---|---|---|---|---|
| 1625 | London plague epidemic | 35,417 | Bubonic plague | London[145] |
| 1647-52 | Great plague of Seville | 500k | Bubonic plague | Spain[146] |
| 1656 | Naples flu epidemic | 240k (82% of pop. died) | Influenza | Naples, Italy[147] |
| 1656-57 | Genoa flu epidemic | 80k (85% of pop. died) | Influenza | Genoa, Italy[148] |
| 1656-57 | Italian flu epidemic | 419k | Influenza | Rome, etc.[149] |
| 1663-64 | Amsterdam plague epidemic | 50k | Plague | Amsterdam[150] |
| 1665-66 | London plague epidemic | 100k (15% of London's pop) | Plague | London[151] |
| 1668 | Plague of France | 40k | Bubonic plague | France[152] |
| 1679 | Great plague of Vienna | 76k | Bubonic plague | Austria[153] |
| 1681 | Prague plague epidemic | 83k | Bubonic plague | Czechoslovakia[154] |
| 1707-09 | Iceland smallpox epidemic | 18k (36% of pop) | Smallpox | Iceland[155] |
| 1710-12 | Great Northern War plague | 164k | Bubonic plague | Denmark, Sweden, Lithuania[156] |
| 1720-22 | Great Plague of Marseille | 100k+ | Bubonic plague | France[157] |
| 1729-1731 | Russia flu epidemic | 100k | Influenza | Russia & Europe |
| 1735–1735 | Diphtheria epidemic | 20k | Diphtheria | American colonies[158] |
| 1738 | Balkans plague | 50k | Bubonic plague | Balkans[159] |
| 1738-39 | North Carolina smallpox epidemic | 7.7-11.7k | Smallpox | North Carolina |
| 1741 | Cartagena Yellow Fever | 20k | Yellow fever | Cartagena, Columbia |
| 1743 | Sicily plague epidemic | 40-50k | Bubonic plague | Sicily |
| 1770-1772 | Russian plague | 50k | Bubonic plague | Russia |
| 1772-1773 | Persian plague | 2 mil. | Bubonic plague | Persia |
| 1775-1782 | Northwest smallpox epidemic | 11k+ | Smallpox | Northwest Territory (current Ore & Wash) |
| 1781-1782 | Flu pandemic | 40k+ | Influenza | China, India, Russia, Europe & N. America[160] |
| 1793 | Philadelphia yellow fever | 5k+ | Yellow fever | Philadelphia |
| 1800-1803 | Spain yellow fever | 60k+ | Yellow fever | Spain |
| 1802-1803 | Saint Domingue yellow fever | 29k-55k | Yellow fever | Saint Domingue |
| 1812 | Russia Typhus epidemic | 300k | Typhus | Russia[161] |
| 1812-1819 | Ottoman plague epidemic | 300k+ | Bubonic plague | Ottoman Empire |
| 1813 | Caragea's plague | 60k | Bubonic plague | Romania |
| 1813-1814 | Malta plague epidemic | 4.5k | Bubonic plague | Malta |

| | | | | |
|---|---|---|---|---|
| 1817-1819 | Ireland typhus epidemic | 65k | Typhus | Ireland |
| 1817-1824 | Cholera epidemic | 100k+ | Cholera | Asia & Europe |
| 1821 | Barcelona yellow fever epidemic | 5k-20k | Yellow fever | Spain |
| 1826-1827 | Cholera epidemic | 100k+ | Cholera | Europe, Asia, NA |
| 1828-1829 | NSW smallpox epidemic | 19k | Smallpox | New South Wales, Australia |
| 1829-1833 | Malaria epidemic | 50k+ | Malaria | Northwest territory (Oregon & Wash)[162] |
| 1830-1833 | Influenza pandemic | 750k | Influenza | China, Russia & Europe[163] |
| 1836-1837 | Influenza epidemic | 50k | Influenza | China[164] |
| 1837 | Great Plains smallpox epidemic | 17k+ | Smallpox | US & Canada Great Plains |
| 1847 | Canadian typhus epidemic | 20k+ | Typhus | Canada |
| 1848-1849 | Hawaii epidemics | 10k | Measles, whooping cough, dysentery | Hawaiian Kingdom |
| 1846-1860 | Cholera epidemic | 1 mil.+ | Cholera | Russia |
| 1862-1863 | British Columbia Smallpox epidemic | 30k+ | Smallpox | British Columbia |
| 1861-1865 | U.S. Typhoid fever epidemic | 80k | Typhoid fever | United States |
| 1863-1875 | Cholera epidemic | 600k | Cholera | Middle East |
| 1871 | Buenos Aires yellow fever epidemic | 13.5k-26k | Yellow fever | Buenos Aires, Argentina |
| 1870-1875 | Europe smallpox epidemic | 500k | Smallpox | Europe |
| 1875 | Fiji measles epidemic | 40k | Measles | Fiji[165] |
| 1876 | Ottoman Empire plague epidemic | 20k | Bubonic plague | Ottoman Empire |
| 1878 | Mississippi Valley Yellow Fever | 13k | Yellow fever | Mississippi Valley, US |
| 1881-1896 | Cholera epidemic | 298k+ | Cholera | Asia, Europe, South America, Africa |
| 1889-1892 | Russian Flu pandemic | 1 million | Influenza | Russia, then worldwide[166] |
| 1896-1905 | Bombay plague epidemic | 20k+ | Bubonic plague | Bombay, India |
| 1896-1906 | Congo trypanosomiasis epidemic | 500k | African Sleeping Sickness | Congo Basin |
| 1899-1923 | Cholera epidemic | 800k | Cholera | Europe, Asia, Africa |
| 1900-1920 | Uganda trypanosomiasis epidemic | 200-300k | African Sleeping Sickness | Uganda |
| 1910-1911 | Manchuria plague | 60k | Pneumonic plague | Manchuria & Mongolia[167] |
| 1910-1912 | China plague | 40k | Bubonic plague | China |
| 1915-1926 | Encephalitis lethargica pandemic | 1.5 million | Encephalitis lethargica | Worldwide[168] |

| 1918-1922 | Russia typhus | 2.5 mil.+ | Typhus | Russia[169] |
|---|---|---|---|---|
| 1918-1920 | Spanish Flu pandemic | 20-50 mil. | Influenza H1N1 (IFR 2-3%) | Worldwide[170] |
| 1957-1958 | Asian Flu pandemic | 2 mil.+ | Influenza H2N2 (IFR <0.2%) | Worldwide[171] |
| 1960-1962 | Ethiopia yellow fever epidemic | 30k | Yellow fever | Ethiopia |
| 1968-1970 | Hong Kong Flu | 1 mil.+ | Influenza H3N2 (IFR <0.2%) | Worldwide[172] |
| 1977 | Russian Flu | 700k | Influenza H1N1 | Worldwide |
| 1981-present | HIV/AIDS | 32.7 mil.+ | HIV/AIDS | Worldwide[173] |
| 2009 | Mexican Flu | 363k[174] | Influenza H1N1 | Worldwide[175] |
| 2020 | COVID-19 | 702k[176] | SARS-CoV-2 | Worldwide[177] |
| **Year** | **Event** | **Death toll** | **Disease** | **Location** |
| | | | | |

# 6. What Is COVID-19?

The World Health Organization explains what COVID-19 is:

"Coronaviruses are a large family of viruses which may cause illness in animals or humans. In humans, several coronaviruses are known to cause respiratory infections ranging from the common cold, pneumonia and bronchitis, to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). The most recently discovered coronavirus causes coronavirus disease COVID-19.

COVID-19 is the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China, in December 2019." [178]

COVID-19 has the same symptoms as common human coronaviruses: runny nose; sore throat; headache; fever; cough; and a general feeling of being unwell.[179]

## I – WHO describes COVID-19's incubation and illness cycle

WHO describes the incubation and illness cycle of COVID-19:

"The maximum incubation period is assumed to be up to 14 days, whereas the median time from onset of symptoms to intensive care unit (ICU) admission is around 10 days. Recently, WHO reported that the time between symptom onset and death ranged from about 2 weeks to 8 weeks."[180]

The important part of the WHO's description is a symptomatic person will display signs of their infection within 14 days.

## II – WHO's describes COVID-19's symptoms and severity

WHO describes the symptoms and severity of COVID-19:

**Table 1. Symptoms and risk factors associated with COVID-19**
**Clinical presentation**

Presenting signs and symptoms of COVID-19 vary. Most persons experience fever, cough, fatigue, anorexia, shortness of breath, myalgias. Other non-specific symptoms, such as sore throat, nasal congestion, headache, diarrhoea, nausea and vomiting, have

also been reported. Loss of smell (anosmia) or loss of taste (ageusia) preceding the onset of respiratory symptoms has also been reported.

Older people and immunosuppressed patients in particular may present with atypical symptoms such as fatigue, reduced alertness, reduced mobility, diarrhoea, loss of appetite, delirium, and absence of fever.

Symptoms such as dyspnoea, fever, gastrointestinal (GI) symptoms or fatigue due to physiologic adaptations in pregnant women, adverse pregnancy events, or other diseases such as malaria, may overlap with symptoms of COVID-19.

Children might not have reported fever or cough as frequently as adults.

**Risk factors for severe disease**

Age more than 60 years (increasing with age).

Underlying noncommunicable diseases (NCDs): diabetes, hypertension, cardiac disease, chronic lung disease, cerebrovascular disease, chronic kidney disease, immunosuppression and cancer have been associated with higher mortality.

Smoking.[181]

**Table 2. COVID-19 disease severity**

**Mild disease**

Symptomatic patients (Table 1) meeting the case definition for COVID-19 without evidence of viral pneumonia or hypoxia.

**Moderate disease**

● Pneumonia – Adolescent or adult with clinical signs of pneumonia (fever, cough, dyspnoea, fast breathing) but no signs of severe pneumonia.

● Child with clinical signs of non-severe pneumonia (cough or difficulty breathing + fast breathing and/or chest indrawing) and no signs of severe pneumonia.

**Severe disease**

● Severe pneumonia

Adolescent or adult with clinical signs of pneumonia (fever, cough, dyspnoea, fast breathing) plus one of the following: respiratory rate > 30 breaths/min; severe respiratory distress; or SpO2 < 90% on room air.

Child with clinical signs of pneumonia (cough or difficulty in breathing)+ at least one of the following:

● Central cyanosis; severe respiratory distress (e.g. fast breathing, grunting, very severe chest indrawing); general danger

sign: inability to breastfeed or drink, lethargy or unconsciousness, or convulsions.

**Critical disease**

- Acute respiratory distress syndrome (ARDS)
- Sepsis
- Septic shock[182]

# 7. Diamond Princess & USS Theodore Roosevelt Were Covid-19 Petri Dishes

A ship is a small floating island that can function as a Petri-dish for understanding the transmission and effects of a respiratory virus such as COVID-19. A ship is a closed environment in which it can be expected that when there are infected persons onboard, everyone is exposed multiple times to the virus. The people onboard have maximum exposure to the virus and the virus has maximum opportunity to infect every susceptible person. Due to the isolation and the period during which the virus spreads to ever more people on the ship, it is likely that all people onboard have the chance to become infected with the virus, such as COVID-19. It isn't a situation of Kevin Bacon's six-degrees of separation, but likely no degree of separation.

The Diamond Princess cruise ship and the USS Theodore Roosevelt aircraft carrier were two perfect Petri-dishes to understand the spread and effect of COVID-19 in a closed system. Both ships had COVID-19 infections spread with the opportunity to infect everyone onboard, and everyone onboard both ships was tested.

The disease outbreaks on both ships were particularly important because the age and health demographics of those onboard were very different.

It was found that 21.8% of everyone onboard both ships tested positive for COVID-19.

It was also found that the death rate was 0.09% (less than 1 in a 1,000) of everyone onboard.

The hospitalization rate was 0.5% of everyone onboard.

It was also found a very high percentage of people on both ships were asymptomatic who tested positive, and there was a large percentage of people who had antibodies.

The findings of the COVID-19 outbreak on the cruise ship Grand Princess were similar, but not quite as complete because testing wasn't conducted on all crew members and passengers.

## I – Diamond Princess

COVID-19 spread through the Diamond Princess cruise ship unchecked for two weeks in late January-early February 2020, and then for the two weeks it was quarantined in Tokyo Bay. The experience of what happened to the passengers and crew on the Diamond Princess cruise ship during those four weeks provides a worst case scenario for the virus: 58% of the people on the ship were 60 or older, and 33% were 70 and older, which are much

higher percentages than the U.S. population as a whole. It is known COVID-19 is much more severe in people 60 and over. Thus, the outbreak on the Diamond Princess can be expected to be much worse than what would occur in the general population.

Several key facts are known to the world from the events that occurred on the Diamond Princess:

- A significant majority of people of all age groups have natural immunity to COVID-19;
- In an environment of universal exposure to COVID-19 infections peak within several weeks and then rapidly fall to zero or near zero;
- COVID-19 has zero or close to zero lethality for healthy people under 70, and a very low lethality rate for healthy people over 70.

On January 20, 2020 the Diamond Princess left Yokohama, Japan for a 14-day cruise to China, Vietnam, and Taiwan, then back to Japan.

On January 23 there were news reports that to stop the spread of a new coronavirus, China had blocked all travel from and within Wuhan, a city of 11 million.

On February 2, the captain of the Diamond Princess was informed a passenger in his eighties who disembarked from the ship in Hong Kong on January 25 had tested positive for the coronavirus. The passenger had the onset of symptoms on January 19, a day before boarding the ship. The captain was ordered to take the ship from Okinawa to Tokyo Bay, so the passengers and crew could be tested.

On February 3, in Tokyo Bay health workers boarded the ship and went through the ship asking passengers and crew if they were feverish or coughing, taking temperatures and swabbing throats.[183]

There were 3,711 people on the ship: 2,666 passengers and 1,045 crew members. The average age of crew members was 36, and passengers was 69.[184] Seventy-five percent of the passengers were over 62, while 75% of the crew were 43 or younger.[185] The passengers and crew were from more than 48 countries.

Everyone on board the Diamond Princess was administered a PCR test for COVID-19. 712 people tested positive: 567 passengers and 145 crew members.

Thirty-seven people were hospitalized due to COVID-19.[186] There were seven deaths, all of a person 70 or older. The elderly also had dramatically higher infection rates than young and middle-aged people.

80% of the people testing positive "showed mild symptoms or none at all, according to a report compiled by the Self-Defense Forces Central Hospital."[187] 46.5% of everyone who tested positive showed no symptoms whatsoever: they were asymptomatic.[188]

The lower proportion of crew members who tested positive could be due to them being much younger and likely healthier than the passenger demographic. Crew members were 28% of the ship's population, but accounted for 20% of the positive tests, and zero deaths.

An important statistic is that with virtual 100% exposure to COVID-19, 81% of all people on the Diamond Princess tested negative, and 90% of people under 60 tested negative. The most reasonable explanation is those people had natural immunity to infection by COVID-19 from exposure to a previous coronavirus.

After an onboard 14-day health observation period, passengers began disembarking on February 19, 2020.[189] All passenger and crew had disembarked by March 1, with those still testing positive quarantined in a hospital – even if they were asymptomatic or didn't require medical attention or hospitalization to treat their COVID-19.

Anti-body tests were later developed to identify people who tested negative, but the virus had been in their system at some previous time. Given the immediacy of the testing of the Diamond Princess passengers, it seems reasonable that few of the people who tested negative would test positive for antibodies from an infection that had passed.

In the closed environment of the ship it is reasonable that everyone was exposed to the virus, and perhaps multiple times. After the ship anchored in Tokyo Bay, on February 5 the passengers were generally confined to their cabins, however many left their cabins to eat at buffets and get exercise, and passengers came into contact with staff members who freely moved throughout the ship. Kentaro Iwata, an infectious disease specialist at Kobe University, visited the ship and described: "There was no distinction between the green zone, which is free of infection, and the red zone, which is potentially contaminated by virus." [190] The universal exposure suggests those who weren't infected had a natural immunity to infection by COVID-19.

| Age Range | People on ship | Symptomatic cases | Asymptomatic Cases | Deaths |
|---|---|---|---|---|
| 0-9 | 16 | 0 | 1 | 0 |
| 10-19 | 23 | 2 | 3 | 0 |
| 20-29 | 347 | 25 | 9 | 0 |
| 30-39 | 428 | 27 | 11 | 0 |
| 40-49 | 334 | 19 | 8 | 0 |
| 50-59 | 398 | 28 | 31 | 0 |
| 60-69 | 923 | 76 | 101 | 0 |
| 70-79 | 1015 | 95 | 139 | 3 |
| 80-89 | 216 | 32 | 25 | 4 |
| 90-99 | 11 | 2 | 0 | 0 |
| Total | 3711 | 306 | 328 | 7 |

The accompanying chart is of Diamond Princess passengers, ages, cases, and deaths:[191]

All the deaths were between February 20 and March 1. The first death was 15 days after passengers were quarantined in their cabin, and the last was 25 days.

The average age of the deceased was about 81. Since everyone who died

was 70 or over, it is very possible some or all the fatalities were of people with one or more serious underlying health conditions that compromised their immune system. Elderly people with serious health conditions that aren't yet completely debilitating go on cruises. The death rate was 0.98% of all people testing positive, and 0.189% of all people.

The positive tests peaked on February 17 – 12 days after quarantine – and by Feb 21 – 16 days after quarantine – they dropped to 1 or 2. There was an aberrational spike on February 23 – 18 days after quarantine – that the next day dropped to a handful.[192]

As its own self-contained island, the Diamond Princess provides data to make basic predictions about infections and deaths for different age groups in an environment in which 100% of the people have multiple exposures to the virus. That is the perfect environment to determine maximum symptomatic and asymptomatic infection rates, and the maximum death rate for people of each age group. That is important because the rates vary significantly for different age groups.

The Diamond Princess also provides important data about the extent of natural population immunity (aka herd immunity) to exposure to COVID-19 – which is a member of the coronavirus family that humanity has been exposed to on multiple occasions.

| Age Range | % Sympto | % Asympto | % Total positives | % Deaths all persons | % Deaths positive |
|---|---|---|---|---|---|
| 0-9 | 0.0% | 6.3% | 6.3% | 0.0% | 0.0% |
| 10-19 | 8.7% | 13.0% | 21.7% | 0.0% | 0.0% |
| 20-29 | 7.2% | 0.9% | 8.1% | 0.0% | 0.0% |
| 30-39 | 6.3% | 1.6% | 8.0% | 0.0% | 0.0% |
| 40-49 | 5.7% | 2.4% | 8.1% | 0.0% | 0.0% |
| 50-59 | 7.0% | 7.8% | 14.8% | 0.0% | 0.0% |
| 60-69 | 8.2% | 10.9% | 19.1% | 0.0% | 0.0% |
| 70-79 | 9.4% | 13.7% | 23.1% | 0.3% | 1.3% |
| 80-89 | 13.4% | 11.6% | 25.0% | 1.9% | 7.4% |
| 90-99 | 18.3% | 0.00% | 18.3% | 0.0% | 1.0% |
| Avg. | 8.1% | 8.6% | 16.7% | 0.19% | 0.98% |

The chart above shows the percentage of cases and deaths of Diamond Princess passengers and crew by age.[193]

The chart to the right shows the percentage of cases and deaths for combined age groups.

| Age Range | % Sympto | % Asympto | % Total positives | % Deaths all persons | % Deaths positive |
|---|---|---|---|---|---|
| 0-19 | 5.1% | 10.3% | 15.4% | 0.0% | 0.0% |
| 0-49 | 6.4% | 1.9% | 8.3% | 0.0% | 0.0% |
| 0-59 | 6.5% | 3.4% | 10.0% | 0.0% | 0.0% |
| 0-69 | 7.2% | 6.2% | 13.4% | 0.0% | 0.0% |
| 60-99 | 9.3% | 12.3% | 21.6% | 0.3% | 1.5% |
| 70-99 | 10.1% | 13.3% | 23.4% | 0.6% | 2.4% |
| Avg. | 8.1% | 8.6% | 16.7% | 0.19% | 0.98% |

The Diamond Princess provides real-world data that can be applied to generally predicting a worst case scenario of the number of infections and deaths from COVID-19 in the general population. Those

predictions can expect to be overstated because the ship's population was heavily weighted to elderly people, but they may be somewhat accurate for anticipating deaths in elder care facilities, and hospitals with a preponderance of elderly patients.

To summarize the Diamond Princess:

- 3,711 onboard
- 37 known hospitalizations (1% of everyone)
- 8 deaths. (0.2% of everyone)
- 712 passengers and crew tested positive (19.2% of everyone)
- 2,999 passengers and crew tested negative (80.8% of everyone)
- Herd immunity existed on the Diamond Princess because about 81% of the passengers and crew were immune to COVID-19 (i.e., they tested negative). "Herd immunity" has been identified to exist when 68% or more of a population exhibits immunity to an infection.[194]

## II – Professor John P. A. Ioannidis' analysis of the Diamond Princess

One analysis of the Diamond Princess data was by Stanford University Professor John P. A. Ioannidis, published on March 17.[195] Ioannidis wrote:

> "The one situation where an entire, closed population was tested was the Diamond Princess cruise ship and its quarantine passengers. The case fatality rate there was 1.0%, but this was a largely elderly population, in which the death rate from Covid-19 is much higher.
>
> Projecting the Diamond Princess mortality rate onto the age structure of the U.S. population, the death rate among people infected with Covid-19 would be 0.125%. But since this estimate is based on extremely thin data — there were just seven deaths among the 700 infected passengers and crew — the real death rate could stretch from five times lower (0.025%) to five times higher (0.625%). It is also possible that some of the passengers who were infected might die later, and that tourists may have different frequencies of chronic diseases — a risk factor for worse outcomes with SARS-CoV-2 infection — than the general population. Adding these extra sources of uncertainty, reasonable estimates for the case fatality ratio in the general U.S. population vary from 0.05% to 1%.
>
> That huge range markedly affects how severe the pandemic is and what should be done. A population-wide case fatality rate of 0.05% is lower than seasonal influenza. If that is the true rate, locking down the world with potentially tremendous social and financial consequences may be totally irrational. It's like an elephant

being attacked by a house cat. Frustrated and trying to avoid the cat, the elephant accidentally jumps off a cliff and dies.

Could the Covid-19 case fatality rate be that low? No, some say, pointing to the high rate in elderly people. However, even some so-called mild or common-cold-type coronaviruses that have been known for decades can have case fatality rates as high as 8% when they infect elderly people in nursing homes. In fact, such "mild" coronaviruses infect tens of millions of people every year, and account for 3% to 11% of those hospitalized in the U.S. with lower respiratory infections each winter.

These "mild" coronaviruses may be implicated in several thousands of deaths every year worldwide, though the vast majority of them are not documented with precise testing. Instead, they are lost as noise among 60 million deaths from various causes every year.

Although successful surveillance systems have long existed for influenza, the disease is confirmed by a laboratory in a tiny minority of cases. In the U.S., for example, so far this season 1,073,976 specimens have been tested and 222,552 (20.7%) have tested positive for influenza. In the same period, the estimated number of influenza-like illnesses is between 36,000,000 and 51,000,000, with an estimated 22,000 to 55,000 flu deaths. …

If we assume that case fatality rate among individuals infected by SARS-CoV-2 is 0.3% in the general population — a mid-range guess from my Diamond Princess analysis — and that 1% of the U.S. population gets infected (about 3.3 million people), this would translate to about 10,000 deaths. …

In the absence of data, prepare-for-the-worst reasoning leads to extreme measures of social distancing and lockdowns. Unfortunately, we do not know if these measures work. School closures, for example, may reduce transmission rates. But they may also backfire if children socialize anyhow, if school closure leads children to spend more time with susceptible elderly family members, if children at home disrupt their parent's ability to work, and more. School closures may also diminish the chances of developing herd immunity in an age group that is spared serious disease. …

Flattening the curve to avoid overwhelming the health system is conceptually sound — in theory. …

Yet if the health system does become overwhelmed, the majority of the extra deaths may not be due to coronavirus but to other

common diseases and conditions such as heart attacks, strokes, trauma, bleeding, and the like that are not adequately treated. …

One of the bottom lines is that we don't know how long social distancing measures and lockdowns can be maintained without major consequences to the economy, society, and mental health. Unpredictable evolutions may ensue, including financial crisis, unrest, civil strife, war, and a meltdown of the social fabric. At a minimum, we need unbiased prevalence and incidence data for the evolving infectious load to guide decision-making. …

One can only hope that, much like in 1918, life will continue. Conversely, with lockdowns of months, if not years, life largely stops, short-term and long-term consequences are entirely unknown, and billions, not just millions, of lives may be eventually at stake. If we decide to jump off the cliff, we need some data to inform us about the rationale of such an action and the chances of landing somewhere safe."[196]

While Ioannidis determined that "Projecting the Diamond Princess mortality rate onto the age structure of the U.S. population, the death rate among people infected with Covid-19 would be 0.125%," he settles on a rate of 0.3% as "a mid-range guess from my Diamond Princess analysis."[197]

## III – USS Theodore Roosevelt Aircraft Carrier

The USS Theodore Roosevelt was also a perfect petri dish for COVID-19, with its entire crew of 4,865 likely exposed to the virus, and everyone onboard was tested.

On January 17, 2020 the USS Theodore Roosevelt departed San Diego Naval Base for deployment to the western Pacific region.[198]

On February 7 the Roosevelt arrived in Guam.

On March 5 the Roosevelt arrived in Da Nang, Vietnam. It was the second carrier to visit Da Nang since the Vietnam War. Sailors visited the city on leave. At that time there had been 16 positive COVID-19 tests in Vietnam.[199]

On March 8 two British tourists in Da Nang were among new COVID-19 cases in Vietnam.

On March 9 the Roosevelt left Da Nang.

On March 22 the first Roosevelt sailor is diagnosed with COVID-19.[200]

By March 25, seven sailors had been diagnosed with COVID-19.[201]

On March 26 the Roosevelt begins testing its entire crew.

On March 27 the Roosevelt docked in Guam.

On March 28 eight sailors were sent to the Naval Hospital Guam for treatment of COVID-19.[202]

On March 30 the Roosevelt's Capt. Brett Crozier sent an unclassified memo to 20 or 30 Navy people that he wanted approval of his superiors and help in executing his proposal to remove all but 10 percent of the crew from the ship. Crozier wrote: "The spread of the disease is ongoing and accelerating. Decisive action is required."[203]

As of April 1, 93 sailors had tested positive for COVID-19 out of 1,273 tested.

On April 2 Crozier was relieved of command by Acting Navy Secretary Thomas Modly because he "demonstrated extremely poor judgment in the midst of a crisis" by sending the March 31 letter to people outside as well as inside his chain of command.[204]

As of April 3, 137 sailors had tested positive for COVID-19 and 95 were symptomatic.

As of April 6, 172 crew members, plus Crozier, had tested positive for COVID-19.

As of April 11, 550 crew members had tested positive for COVID-19.

On April 13 a 42-year-old sailor died of COVID-19. He was the Roosevelt's only fatality.[205]

As of May 5, 1,156 crew member had tested positive, and the Navy didn't announce additional further cases.[206]

To summarize the Roosevelt:

- 4,865 crew members
- 8 known hospitalizations (0.16% of crew)
- 1 death of a 42 year old sailor. (0.02% of crew)
- 1,156 sailors tested positive (23.8% of crew)
- 3,709 sailors tested negative (76.2% of crew)
- Herd immunity existed on the USS Roosevelt because 76% of the sailors were immune to COVID-19 (i.e., they tested negative). "Herd immunity" has been identified to exist when 68% or more of a population exhibits immunity to an infection.[207]

Sixty percent of the carrier crew – 2,909 crew members – had coronavirus antibodies according to U.S. Navy tests. [208] So 1,753 crew members – 36% of the crew – had effectively fought a COVID-19 infection by their body making antibodies against it without testing positive.[209]

## IV – Combined data from Diamond Princess and USS Roosevelt

Combining the two Petri-dish ships shows the following data:

- 8,576 aboard both ships:
- 1,868 tested positive (21.8% of passengers and crew)

• 6,708 tested negative (78.2% of everyone)
• 45 hospitalizations (0.5% of everyone)
• 8 deaths (0.09% of everyone and 0.4% of positive cases)
• 60% of the Theodore Roosevelt's crew members had coronavirus antibodies, so it can reasonably be assumed the same was true for the Diamond Princess.
• 46.5% of people on the Diamond Princess who tested positive were asymptomatic, so it can reasonably be assumed the same was true for the Theodore Roosevelt.

## V – Grand Princess

There was also a COVID-19 outbreak among passengers on the Grand Princess cruise ship. The ship had 3,571 onboard, 2,460 passengers and 1,111 crew members. Testing was voluntary and conducted on 22.4% of those onboard. So it doesn't provide as complete a picture as the Diamond Princess and the USS Theodore Roosevelt on which everyone was tested.

The age demographics was virtually identical to the Diamond Princess. The crew members average age was 36 and the passengers average age was 68. Seventy-five percent of crew members were 43 and younger, and 75% of passengers were 61 and over.[210]

The ship left San Francisco on February 21, and as it returned it was reported that several passengers who had been on a previous voyage to Mexico had contracted COVID-19. It was scheduled to dock on March 7, but it was quarantined offshore in San Francisco Bay while voluntary testing was conducted onboard. As of March 6, 21 people had tested positive. On March 9 passengers were allowed to disembark at the Port of Oakland. Passengers were sent to quarantine at military bases in California, Texas and Georgia, and Canadian citizens were sent to a military base in Ontario, Canada.[211]

With voluntary testing, 802 tests are known to have been conducted: 103 positive tests and 699 negative tests. Seven passengers died from COVID-19.[212]

To summarize the Grand Princess:

• 3,571 onboard
• 7 deaths. (0.2% of everyone on board)
• 802 passenger and crew tested (22.4% of everyone)
• 103 positive tests (12.8% of those tested, 2.8% of everyone)
• 699 negative tests (87.2% of those tested, 19.6% of everyone)
• Herd immunity existed on the Grand Princess because more than 87% of the passengers and crew were immune to COVID-19 (i.e., they tested negative). "Herd immunity" has been identified to exist when 68% or more of a population exhibits immunity to an infection.[213]

# 8. Computer Medical Models Are Guesstimates, Not Reality

It is now known that the lockdowns imposed in the U.S., the U.K., and other countries was made on catastrophically flawed computer modeling that over-predicted the lethality of COVID-19 by a factor of around 20.

The first known use of mathematics to predict the spread of a disease was in 1760. Swiss mathematician and physicist Daniel Bernoulli used smallpox morbidity and mortality data to estimate the efficacy of inoculating people against smallpox. His calculations predicted that universal inoculation could increase life expectancy at birth by 3 years and 2 months.[214]

Mathematical models that described the relationship between the susceptible, infected and immune people in a population were developed in the 1920s.[215]

The computational speed of a computer allowed for the development of more sophisticated infectious disease predictive models.

However, a model predicting the number and distribution of persons infected by a disease as it is circulates through a population during a period of time is not reality. It is a guess. The reliability of that guess depends on the quality of the data inputted and the degree to which the computer program analyzing that data accurately mimics the real-world.

Garbage in, garbage out is 100% applicable to infectious disease modeling. Incorrect or poor quality input will always produce faulty output. A model based on sketchy or outright flawed mathematical equations and/or poor programming practices will produce unreliable or even nonsensical results. It is guaranteed. The hallmark of the scientific method is reproducibility. A process is not scientific if it cannot be repeated and produce the same result without fail.

The ultimate test of the reliability of an infectious disease model is if its prediction is validated in the real world. Validation is determined by whether the model's prediction matches reality (or at the very worst approximates it within an acceptable range).[216] If it doesn't the model's "input" is flawed and its "output" cannot be relied on, and certainly not to make any life impacting decisions.

## I – Imperial College COVID-19 model predicted catastrophe

U.K. Prime Minister Boris Johnson initially implemented a "herd immunity" COVID-19 policy patterned after Sweden's non-lockdown

strategy. To enable the natural process of population inoculation through infection as COVID-19 worked its way through the population, businesses remained open and people could travel to work, for shopping, and recreation: with the government's encouragement that they stay home when possible.

### Imperial College Report 9 released March 16, 2020

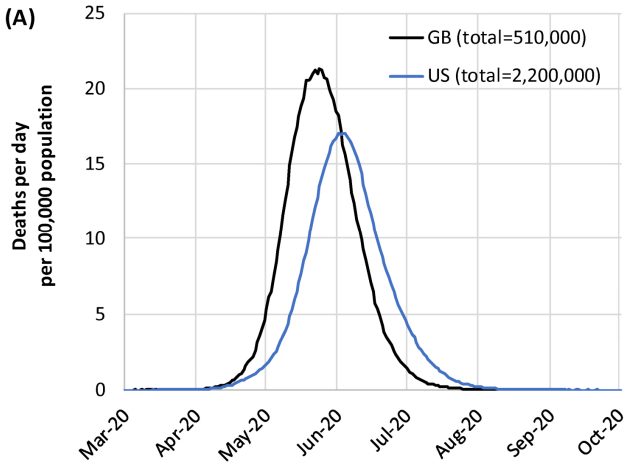
Then on March 16, 2020 the Imperial College COVID-19 Response Team headed by Neil Ferguson, issued its *Report 9: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand*.[217] Report 9 was an internal report that had not been peer-reviewed or externally reviewed at all.[218]

Report 9 detailed that 40-50% of people who tested positive for COVID-19 were asymptomatic or its effects were too mild for them to know they were infected.[219] It also estimated that 81% of the population would become infected over a 2-year period of time if nothing was done.

Imperial College's Report 9 of March 16, 2020 stated:

> The global impact of COVID-19 has been profound, and the public health threat it represents is the most serious seen in a respiratory virus since the 1918 H1N1 influenza pandemic. Here we present the results of epidemiological modelling which has informed policymaking in the UK and other countries in recent weeks.[220]
>
> In the (unlikely) absence of any control measures or spontaneous changes in individual behaviour, we would expect a peak in mortality (daily deaths) to occur after approximately 3 months (Figure 1A). In such scenarios … we predict 81% of the GB and US populations would be infected over the course of the epidemic. … The epidemic is predicted to be broader in the US than in GB and to peak slightly later. This is due to the larger geographic scale of the US, resulting in more distinct localised epidemics across states than seen across GB. The higher peak in mortality in GB is due to the smaller size of the country and its older population compared with the US.[221]
>
> "In total, *in an unmitigated epidemic*, we would predict approximately *510,000 deaths in GB and 2.2 million in the US*, not accounting for the potential negative effects of health systems being overwhelmed on mortality."[222] (underlining added to original)

Figure 1A showed that Report 9 predicted daily deaths in the U.K. would peak about June 10 at about 22 per 100k, and in the U.S. about June 25 at about 17 per 100k population.




Report 9 also made predictions about hospital bed capacities:

> For an uncontrolled epidemic, we predict critical care bed capacity would be exceeded as early as the second week in April, with an eventual peak in ICU or critical care bed demand that is *over 30 times greater* than the maximum supply in both countries (Figure 2).[223]

Then the Report explained the importance of "flattening the curve" to reduce strain on the health care system:

> The aim of mitigation is to reduce the impact of an epidemic by flattening the curve, reducing peak incidence and overall deaths (Figure 2). Since the aim of mitigation is to minimise mortality, the interventions need to remain in place for as much of the epidemic period as possible. Introducing such interventions too early risks allowing transmission to return once they are lifted (if insufficient herd immunity has developed…"[224]

After presenting its doomsday scenarios of deaths and an overwhelmed health care system if nothing was done, Report 9 stated its recommendation:

> Given that mitigation is unlikely to be a viable option without overwhelming healthcare systems, suppression is likely necessary in countries able to implement the intensive controls required. Our projections show that to be able to reduce R to close to 1 or below, a combination of case isolation, social distancing of the entire population and either household quarantine or school and university closure are required []. Measures are assumed to be in place for a 5-month duration."[225]

The Report predicted that if all its recommendations for – case isolation, home quarantine, social distancing, and school/university closure – were implemented, the total U.K. deaths would be reduced to a maximum of 39,000 from 510,000 over a two-year period. It also predicted that maximum demand for hospital beds would be reduced by almost 37 times from 180,000 to 4,900.[226]

The Report also predicted that if isolating patients, quarantining those in contact with them, and keeping the most vulnerable people apart from others for three months, could cut the predicted death toll by half.

The Report also discussed a "second wave": "To avoid a rebound in transmission, these policies will need to be maintained until large stocks of vaccine are available to immunize the population – which could be 18 months or more."[227]

Regarding the societal impact of its recommendations being implemented, the Report stated: "no public health intervention with such disruptive effects on society has been previously attempted for such a long duration of time. How populations and societies will respond remains unclear."[228]

### Boris Johnson responds to Report 9

Politically, the key part of Imperial College's Report 9 was the predictions of 510,000 deaths and an overwhelmed health system in Great Britain from COVID-19 unless its health impact was mitigated with radical government intervention. PM Johnson heavily relied on Imperial College's prediction and the recommendation of the U.K.'s Scientific Advisory Group for Emergencies in announcing a lockdown of the U.K. on March 23, 2020.[229] At the time the WHO reported 281 deaths COVID-19 in the U.K. out of a population of 67.9 million. Johnson stated in his nationwide televised address:

> "Good evening,
>
> The coronavirus is the biggest threat this country has faced for decades - and this country is not alone.
>
> All over the world we are seeing the devastating impact of this invisible killer. …
>
> Without a huge national effort to halt the growth of this virus, there will come a moment when no health service in the world could possibly cope; because there won't be enough ventilators, enough intensive care beds, enough doctors and nurses. …
>
> So it's vital to slow the spread of the disease.
>
> And that's why we have been asking people to stay at home during this pandemic.

And though huge numbers are complying - and I thank you all - the time has now come for us all to do more.

From this evening I must give the British people a very simple instruction - you must stay at home.

Because the critical thing we must do is stop the disease spreading between households.

That is why people will only be allowed to leave their home for the following very limited purposes:

- Shopping for basic necessities, as infrequently as possible
- One form of exercise a day – for example a run, walk, or cycle - alone or with members of your household;
- Any medical need, to provide care or to help a vulnerable person; and
- Travelling to and from work, but only where this is absolutely necessary and cannot be done from home.

That's all – these are the only reasons you should leave your home. …

To ensure compliance with the government's instruction to stay at home, we will immediately:

- Close all shops selling non-essential goods, including clothing and electronic stores and other premises including libraries, playgrounds and outdoor gyms, and places of worship
- We will stop all gatherings of more than two people in public – excluding people you live with
- And we'll stop all social events, including weddings, baptisms and other ceremonies, but excluding funerals

Parks will remain open for exercise but gatherings will be dispersed. …

I know the damage that this disruption is doing and will do to people's lives, to their businesses and to their jobs.

And that's why we have produced a huge and unprecedented programme of support both for workers and for business.

And I can assure you that we will keep these restrictions under constant review. We will look again in three weeks, and relax them if the evidence shows we are able to. …

But in this fight we can be in no doubt that each and every one of us is directly enlisted. Each and every one of us is now obliged to join together.

To halt the spread of this disease. To protect our NHS and to save many many thousands of lives. …

We will beat the coronavirus and we will beat it together and therefore I urge you at this moment of national emergency to stay at home, protect our NHS and save lives.

Thank you."[230]

Businesses deemed non-essential were closed, people stayed home, and 80% of their normal wages was paid by the government to people laid off from their job due to Johnson's decree. (On October 26 the Welsh government banned the sale of "non-essential" products in response to increased positive C-19 test results – with no increase in deaths.)[231]

## Less than 20,000 could die Ferguson testifies after Johnson's decree

Two days after Johnson's decree Ferguson testified to the British Parliament's Science and Technology Committee the COVID-19 death toll could be "substantially less" than 20,000.[232] Ferguson's testimony "caused shock waves," given Imperial College's 510,000 death estimate was behind Johnson abandoning a *de facto* herd immunity strategy for the U.K.[233]

## U.S. responds to Report 9

Report 9 had a shock wave effect in the U.S. with its prediction of 2.2 million deaths if nothing was done.

President Donald Trump had issued his declaration of a COVID-19 National Emergency on March 13, 2020, but Report 9 emboldened the presidential COVID-19 Task Force to recommend that Americans avoid groups of more than 10 people, work from home, avoid unnecessary shopping trips, and refrain from eating in restaurants.[234] Dr. Deborah Birx, one of the task force leaders, told reporters at the White House briefing on March 16: "What had the biggest impact in the [Imperial College] model is social distancing, small groups, not going in public in large groups. The most important thing was if one person in the household became infected, the whole household self-quarantined for 14 days. Because that stops 100 percent of the transmission outside of the household."[235]

State governors and the heads of state health departments began issuing lock down regimes that included harsh limitations on business and social interaction. Modeling was specifically cited in some of those orders as a justification for imposing draconian measures to try and "flatten the curve." of COVID-19 impact on the health care system. For example, Washington Governor Jay Inslee stated in his Emergency Proclamation issued March 23, 2020:

"**WHEREAS,** *models predict* that many hospitals in Washington State will reach capacity or become overwhelmed with COVID-19 patients within the next several weeks unless we substantially slow down the spread of COVID-19 throughout the state;"[236]

## II – Imperial College has history of unreliable modeling

Ferguson and his Imperial College colleagues have a sketchy 20 year history of making radically erroneous predictions.

In 2001, Ferguson and his Imperial College colleagues were behind the unverified modeling that sparked the mass slaughter in the U.K. of an estimated 10 million animals: 6.5 million sheep and cattle, and 3.5 million "still-suckling lambs, calves and pigs" during an outbreak of foot-and-mouth disease.[237] There was "public disgust with the magnitude of the slaughter, and political resolve to adopt alternative options … to control any future epidemics." [238] Charlotte Reid, a farmer's neighbor, recalls: "I remember that appalling time. Sheep were left starving in fields near us. Then came the open air slaughter. The poor animals were panic stricken. It was one of the worst things I've witnessed. And all based on a model — if's but's and maybe's."[239] The estimated cost to the UK economy was £10 billion.

In 2002, Ferguson predicted that by 2080 up to 150,000 people could die from exposure to BSE (mad cow disease) in beef. In the U.K., there were 177 deaths from BSE. [240]

In 2005, Ferguson predicted up to 200 million people could be killed from bird flu. In the end, 282 people died worldwide from the disease between 2003 and 2009.[241]

In 2009, the government relied on Ferguson's analysis that a "reasonable worst-case scenario" was the swine flu would lead to 65,000 British deaths. [242] Ferguson also predicted: "It is likely to spread around the world in the next six to nine months, and when it does so, it will affect about one-third of the world's population. To put that into context, normal seasonal flu probably affects around 10% of the world's population every year, so we are heading for a flu season which is perhaps three times worse than usual – not allowing for whether this virus is more severe than normal seasonal flu viruses."[243] In the end, swine flu killed 457 people in the U.K. [244] Ferguson prediction was the most likely mortality rate was 0.4% of those infected, when it was actually 0.026%.[245]

## III – Imperial College Report 9's modeling exposed as unreliable

Ferguson's track record was so spotty that a key question is why anyone in any position of responsibility would have relied on recommendations based on his modeling predictions. And certainly not without rock-solid confidence in his predictions – especially catastrophic ones.

A tip off that something was amiss in Imperial College's March 16 report was its Table 1 showed the known Infection Fatality Ratio of people under 20 was extremely low – 1 out of 50,000 for ages 0 to 9 and 1 out of 16,667 for ages 10 to 19 with 81% of the population infected.[246] Accepted at face value, 124 people under 20 would die in the U.K. from COVID-19 over a two-year period of time, if 25% of people under 20 were infected.[247] That is a very small number in a country with more than 66 million people.

Table 1 also showed the known percentage of *symptomatic cases* requiring hospitalization for people under 20 was extremely low – 1 out of 1,000 for ages 0 to 9 and 1 out of 333 for ages 10 to 19.[248]

**Table 1: Current estimates of the severity of cases. The IFR estimates from Verity et al.[12] have been adjusted to account for a non-uniform attack rate giving an overall IFR of 0.9% (95% credible interval 0.4%-1.4%). Hospitalisation estimates from Verity et al.[12] were also adjusted in this way and scaled to match expected rates in the oldest age-group (80+ years) in a GB/US context. These estimates will be updated as more data accrue.**

| Age-group (years) | % symptomatic cases requiring hospitalisation | % hospitalised cases requiring critical care | Infection Fatality Ratio |
|---|---|---|---|
| 0 to 9 | 0.1% | 5.0% | 0.002% |
| 10 to 19 | 0.3% | 5.0% | 0.006% |
| 20 to 29 | 1.2% | 5.0% | 0.03% |
| 30 to 39 | 3.2% | 5.0% | 0.08% |
| 40 to 49 | 4.9% | 6.3% | 0.15% |
| 50 to 59 | 10.2% | 12.2% | 0.60% |
| 60 to 69 | 16.6% | 27.4% | 2.2% |
| 70 to 79 | 24.3% | 43.2% | 5.1% |
| 80+ | 27.3% | 70.9% | 9.3% |

Yet, with those small numbers of deaths and hospitalizations one of Ferguson's key recommendations was closing schools and universities. It was subsequently learned from data reported from additional countries that Ferguson *significantly over-predicted* the Infection Fatality Ratio of people under 20. However, even without the new data his predictions were so low that there was no justification to close educational facilities. Table 1 shows the IFR and hospitalization rates significantly increase beginning at age 60.

Ferguson and his Imperial College colleagues were under considerable pressure to release the code that produced the COVID-19 fatality predictions relied on to shut down the schools, the economy, and the social life of the U.K. and the U.S. In early May a heavily modified derivative of the code Ferguson relied on to produce Report 9 was released on Github.[249] The code had been worked on for a month by a team from Microsoft and others.[250] So it would be expected to be an improvement over the code that produced the results published in Report 9.

After it was released to the public the code was analyzed by many computer experts. It is an indication of the problems with Ferguson's code that Microsoft couldn't mask its problems: "In our commercial reality, we would fire anyone for developing code like this and any business that relied on it to produce software for sale would likely go bust," was the evaluation of David Richards, co-founder of British data technology company WANdisco.[251] Richards also said "it is a "buggy mess that looks more like a bowl of angel hair pasta than a finely tuned piece of programming."[252]

The problems revealed after the code was publicly released were suggested by Ferguson's Twitter posts on March 22, 2020:

> neil_ferguson, @neil_ferguson, Mar 22
> I'm conscious that lots of people would like to see and run the pandemic simulation code we are using to model control measures against COVID-19. To explain the background - I wrote the code (thousands of lines of undocumented C) 13+ years ago to model flu pandemics.."

And,

> neil_ferguson, @neil_ferguson, Mar 22
> Replying to @neil_ferguson
> I am happy to say that @Microsoft and @GitHub are working with @Imperial_JIDEA and MRC_Outbreak to document, refactor and extend the code to allow others to use without the multiple days training it would currently require (and which we don't have time to give)...

A computer expert reported after analyzing the code:

> "It attempts to simulate households, schools, offices, people and their movements, etc.
>
> Due to bugs, the code can produce very different results given identical inputs. They routinely act as if this is unimportant.
>
> This problem makes the code unusable for scientific purposes, given that a key part of the scientific method is the ability to replicate results. Without replication, the findings might not be real at all – as the field of psychology has been finding out to its cost. Even if their original code was released, it's apparent that the same numbers as in Report 9 might not come out of it.
>
> Non-deterministic outputs may take some explanation, as it's not something anyone previously floated as a possibility. …
>
> Clearly, the documentation wants us to think that, given a starting seed, the model will always produce the same results.

> Investigation reveals the truth: the code produces critically different results, even for identical starting seeds and parameters. …
>
> I'll illustrate with a few bugs. In issue 116 a UK "red team" at Edinburgh University reports that they tried to use a mode that stores data tables in a more efficient format for faster loading, and discovered – to their surprise – that the resulting predictions varied by around 80,000 deaths after 80 days:…
>
> Neil Ferguson [] is well aware that the code is filled with bugs that create random results. …
>
> Imperial are trying to have their cake and eat it. Reports of random results are dismissed with responses like "that's not a problem, just run it a lot of times and take the average", but at the same time, they're fixing such bugs when they find them. They know their code can't withstand scrutiny, so they hid it until professionals had a chance to fix it, but the damage from over a decade of amateur hobby programming is so extensive that even Microsoft was unable to make it run right.…
>
> Conclusions. All papers based on this code should be retracted immediately. Imperial's modelling efforts should be reset with a new team that isn't under Professor Ferguson, and which has a commitment to replicable results with published code from day one.
>
> On a personal level, I'd go further and suggest that all academic epidemiology be defunded. This sort of work is best done by the insurance sector. Insurers employ modellers and data scientists, but also employ managers whose job is to decide whether a model is accurate enough for real world usage and professional software engineers to ensure model software is properly tested, understandable and so on. Academic efforts don't have these people, and the results speak for themselves."[253]

The author was politely saying that Ferguson and his Imperial College colleagues are amateurs who don't know enough to be trusted with engaging in predictive modeling.

It was even suggested by the head of a top software firm that Imperial College's COVID-19 modeling could be most devastating software error in history.[254]

# IV – Oxford Study That 50% of UK's Population Exposed to COVID-19

Half or more of the U.K.'s population could have already been infected with COVID-19 by mid-March 2020, according to modeling by the Oxford's Evolutionary Ecology of Infectious Disease group, which is headed by Professor Sunetra Gupta.[255]

The report released on March 24, shows that COVID-19 reached the UK no later than mid-January and spread unchecked through the population before the first official case was reported in late February and the first death on March 5, 2020.

The vast majority of infected people with COVID-19 develop very mild symptoms or none at all, with the hospitalization rate only one in a thousand infections.[256] The health care system would not be overwhelmed with that rate of hospitalization, unlike the doomsday scenario set-forth in Imperial College's Report 9.

Gupta told the *Financial Times*: "I am surprised that there has been such unqualified acceptance of the Imperial model."[257] The Report states:

> "The spread of a novel pathogenic infectious agent eliciting protective immunity is typically characterised by three distinct phases: (I) an initial phase of slow accumulation of new infections (often undetectable), (II) a second phase of rapid growth in cases of infection, disease and death, and (III) an eventual slow down of transmission due to the depletion of susceptible individuals, typically leading to the termination of the (first) epidemic wave. Before the implementation of control measures (e.g. social distancing, travel bans, etc) and under the assumption that infection elicits protective immunity, epidemiological theory indicates that the ongoing epidemic of SARS-CoV-2 will conform to this pattern."[258]

In other words, the announced U.K. lock-down declared by Johnson scheduled to go into effect on March 26 was unnecessary. Unbeknownst to medical experts the U.K. had silently experienced the benefits of "herd immunity."

In early June Gupta told *The Guardian*: "It's becoming clear that a lot of people have been exposed to the virus and that the death rate in people under 65 is not something you would lock down the economy for. We can't just think about those who are vulnerable to the disease. We have to think about those who are vulnerable to lockdown too. The costs of lockdown are too high at this point. … My primary concern is that the lockdown is affecting a lot of people very adversely and it is causing deaths and will cause more deaths."[259]

# V – Swedish COVID-19 model exaggerated deaths by 17 times

A computer model based on Sweden's minimal COVID-19 mitigation strategy predicted that deaths in Sweden would peak at about 85,500 on July 1, 2020.[260] The model's prediction was off by more than 1,600%. That is not surprising because it was "based on work by Ferguson et al," which radically over-predicted virus deaths in the U.K.

The accompanying chart shows the computer based prediction compared with Sweden's actual deaths.

| Date | Deaths Predicted | Deaths Actual | % Diff. Proj/Actual |
|---|---|---|---|
| March 15 | 3 | 3 | 0 |
| April 1 | 250 | 180 | 139% |
| April 15 | 2,000 | 1,033 | 194% |
| May 1 | 13,000 | 2,586 | 503% |
| May 15 | 50,000 | 3,529 | 1,417% |
| June 1 | 82,000 | 4,395 | 1,866% |
| June 15 | 85,000 | 4,874 | 1,744% |
| July 1 | 85,500 | 5,333 | 1,603% |

The computer model also predicted that by immediately imposing a full lockdown – closure of businesses, all schools, and mandated social distancing – Sweden's death toll by July 1 could be reduced to 26,700. Sweden's actual death toll was less than 20% of that prediction, without adopting those harsh measures.

The report published by Uppsala University's Science for Life Laboratory stated in part:

> Most European countries have enacted strict suppression measures including lockdown, school closures, enforced social distancing; while Sweden has chosen a different strategy of milder mitigation…
>
> … Healthcare needs are expected to substantially exceed pre-pandemic capacity even if the most aggressive interventions considered were implemented in the coming weeks. …
>
> … Sweden is the most prominent example of mitigation—limiting the extent of social distancing and economically disruptive interventions while still aiming to slow the spread sufficiently to allow for an effective medical response. Studying the Swedish strategy and its health implications thus yields important lessons for global public health policy.
>
> COVID-19 is spreading globally because of a lack of prior immunity combined with relatively high infectiousness …
>
> … Predictive models for COVID-19 have been used to assess the impact of the pandemic and guide national policy. …
>
> We employed an individual agent-based model based on work

by Ferguson et al. Individual-based models are increasingly used to model epidemic spread with explicit representation of demographic and spatial factors such as population distribution, workplace data, school data, and mobility.

Transmission between individuals occurs through contact at each individual's workplace or school, within their household, and in their communities. Infectiousness is thus an additive property dependent on contacts from household members, school/workplace members and community members with a probability based on household distances. …

Public-health interventions are introduced to reduce the spread of transmission. These interventions can be required for all individuals, i.e. for school closures, or have a compliance rate associated to account for individuals who do not follow the mandate. The following interventions were tested and analysed.

Current Swedish policy: This intervention emulates Swedish government policy through at least 10 April 2020. In this intervention, high schools and universities are closed, people aged 70 and above are advised to practice social distancing, and symptomatic people are advised to practice home quarantine. All students in high school or college (aged 15-22 years old) do not attend school as implemented by the Swedish authorities …

Since the COVID-19 pandemic is still ongoing and rapidly spreading in Sweden, the results will be of high importance to the Swedish public; and will be disseminated broadly to the general public and the Swedish authorities. …

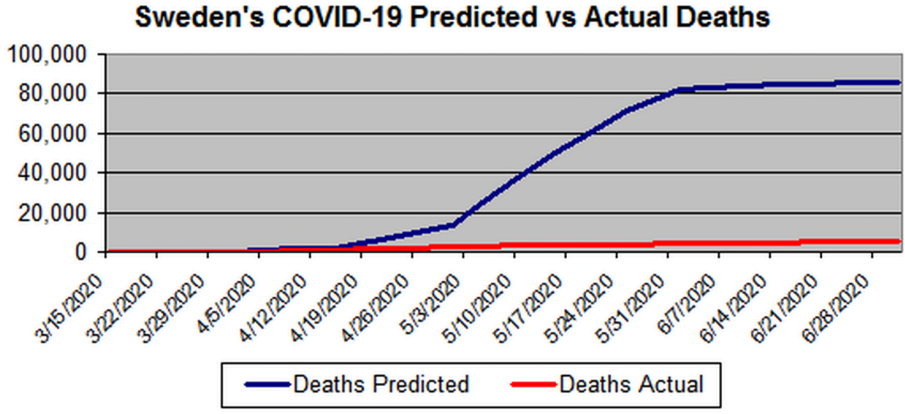
This individual-based modelling project predicts that with the current mitigation approach … At the peak period (early May), the need for ICU beds will be at least 40-fold higher than the pre-pandemic ICU-bed capacity, not considering ICU admissions for other conditions. …

Sweden is selecting a public-health strategy for COVID-19 different from that of most other industrialized countries, A number of epidemiological models have suggested that the current strategy could have dire consequences, but one persistent criticism has been whether those models take into account the social and demographic structure of Sweden. …

Our results predict that Sweden's healthcare capacity (both for COVID-19 patients and for others) will be rapidly overwhelmed under the current strategy, both through the need to care for COVID-19 patients and because healthcare workers will themselves become

ill and unable to work. Intensive care capacity is projected to become a particular bottleneck, as shown in other countries. … The projected mortality from COVID-19 may cause a Swedish all-cause mortality in 2020 exceeding that of 1918, which was the greatest absolute mortality in Sweden in the 20th century. The COVID-19 pandemic and associated public-health measures will also impact non-COVID-19 related healthcare and mortality, as well the country's economy. …

… The results of Sweden's public-health policy will inform the world's knowledge of COVID-19 and the efficacy of suppressive measures or lack thereof."[261]




Sweden's minimalist approach worked without resulting in the doomsday scenario predicted by the computer model. Sweden's 0.58 deaths per 1,000 people from COVID-19 were less than 10% of the 5.9 deaths per 1,000 people caused by the Spanish Flu in 1918.[262]

## VI – University of Washington COVID-19 model

There were COVID-19 modelers in the U.S., with the Institute for Health Metrics and Evaluation at the University of Washington (IHME) one of the most prominent.[263]

### Washington's governor relied on unreliable model to shut down the state

Washington Gov. Jay Inslee issued a "Stay-Home" Proclamation on March 23 that ordered all "non-essential" businesses to close effective March 25. One justification for the order cited by Inslee was:

**"WHEREAS,** models predict that many hospitals in Washington State will reach capacity or become overwhelmed with COVID-19 patients within the next several weeks unless we substantially slow

down the spread of COVID-19 throughout the state;"

On March 25 the IHME issued modeling that projected that April 23, 2020 would be the height of the outbreak and a maximum of 5,546 hospital beds would be needed for COVID-19 patients in Washington.[264] In fact, on April 23 a total of 34 COVID-19 patients were admitted in Washington, and as of July 1, 2020 the total number of COVID-19 patients hospitalized in Washington was 4,402.[265] So the IHME model for April 23 model was off by *a factor of 163* for hospitalizations, and it predicted 25% more people would be hospitalized *on that day* than the total COVID-19 hospitalizations in Washington for the almost 5-1/2 months from January 20 to July 1, 2020. The March 25 model predicted a maximum of 181 hospitalizations on June 30, and there were 10 – so it was only off by a factor of 18.[266]

Washington's hospitals were never going to be overwhelmed, because if the IHME's predicted worst case scenario of 5,546 beds being needed on April 23 had come true –only 54% capacity of the 10,322 hospital beds available in Washington state would have been need for COVID-19 cases. There are 5,745 hospital beds in the Seattle metro area, so even with an outbreak concentrated there, it had enough beds to handle all cases expected in the entire state. The IHME's predicted (mean) of 2,874 beds being needed on April 23 was only was only 28% of capacity in Washington. [267]

Furthermore, the model was so disconnected from reality that the peak for hospitalizations had already passed when the IHME issued its March 25 modeling projection: the peak was two days earlier on March 23 with 89 hospitalizations in all of Washington state.[268] The peak of COVID-19 had also passed already passed when the IHME issued its modeling projection: it was also on March 23 with 34 deaths in all of Washington state.[269]

The problem is Gov. Inslee and the governors of other states issued orders for people to stay home and for non-essential businesses to close based on IHME's modeling predictions that had no relationship to the reality of actual COVID-19 deaths and hospitalizations.

The IHME modeling was so wrong that deaths and hospitalizations in Washington had already peaked and were declining when the governor's order went into effect on March 25. Two days before that – on March 23 – COVID-19 deaths peaked at 33, and hospitalizations peaked at 88 in Washington.[270]

### IHME COVID-19 model is inherently unreliable

IHME's modeling predictions were not just used by state governments to formulate COVID-19 policies, but the Trump administration relied on them in developing national guidelines.[271] However, IHME's predictions excitedly reported in the media changed so often – even weekly – that many

epidemiologists rejected them as too flawed and misleading to be relied on by the public, medical personnel, and government officials – state and federal.

Epidemiologist Marc Lipsitch of the Harvard T.H. Chan School of Public Health told reporters in April 2020, "It's not a model that most of us in the infectious disease epidemiology field think is well suited" to projecting Covid-19 deaths.[272]

Epidemiologist Ruth Etzioni of the Fred Hutchinson Cancer Center in Seattle was much more direct in asserting it shouldn't be used: "That the IHME model keeps changing is evidence of its lack of reliability as a predictive tool. That it is being used for policy decisions and its results interpreted wrongly is a travesty unfolding before our eyes."[273] Etzioni elaborated that "the fact that they overshot will be used to suggest that the government response prevented an even greater catastrophe, when in fact the predictions were shaky in the first place."[274]

The IHME defends its vacillating predictions on its: "As data continue to come in, our estimates may change. Specifically, new death data … have changed our projections."[275]

Lipsitch explains "The fundamental concept of infectious disease epidemiology is that infections spread when there are two things: infected people and susceptible people."[276] But the IHME model doesn't follow that concept. The IHME model takes data from the U.S. and puts it on a graph of the path the COVID-19 outbreak took in other countries, such as China, Italy, and Spain, based on the assumption the virus will follow the same pattern in U.S. states and nationally, and even in other countries. There is no individuation for circumstances specific to a particular state, or the U.S. as a whole.

Researchers at both the London School of Hygiene & Tropical Medicine and Imperial College London published a critique in April 2020 that the IHME predictions were based "*on a statistical model with no epidemiologic basis*." They described that the IHME "statistical model" is nothing more than putting U.S. data onto the graph of other countries' outbreak.[277]

The IHME's model is so unreliable that it even fails at predicting the number of deaths that will occur in a geographical region the next day within an acceptable range. Statistician Sally Cripps of the University of Sydney says of the IHME model: "It performs poorly even when it predicts the number of next-day deaths: The true number of next-day deaths has been outside the 95% intervals 70% of the time."[278]

Nevertheless, the IHME's modelling continues to be influential in influencing the policy of the federal government and some states.

# VII – Conclusion

"All models are wrong, but some are useful," statistician George Box supposedly once said.[279]

The COVID-19 models upon which the U.S., the U.K., and other countries based their shut-down went beyond being wrong, they had no usefulness whatsoever: They have an infamous legacy for contributing to an almost endless depth of psychological pain, social destruction, medical neglect, and financial catastrophe.

The lesson to be learned from the COVID-19 fiasco is in the future no sane society should even consider limiting its social and economic activity based on a computer model of what a purported dangerous virus or bacteria might possibly do.

Even in the worst case scenario of the Spanish Flu outbreak of 1918/19, there was far less harm to society from that virus running its natural course, than if governments had interfered and ruptured the very fabric of society – like they did in 2020 – with the mandatory closure of businesses, schools, churches, and other social activities. The people alive in 1918 can only be thankful there were no computer models to influence governors and other government officials to radically act contrary to the interests of the population and preserving society.

# 9. Reasoned Analysis Of COVID-19 Outbreak Were Ignored

The federal and state governments in the U.S., and other governments around the world went off half-cocked when faced with what was described by the world-health organization as a world-wide COVID-19 pandemic. A reasonable approach to dealing with a purported crises requires a reasoned analysis of the situation based on reliable information. The adage garbage-in-garbage-out applies to all decision making: What you decide to do is no more grounded in reality than the information is grounded in reality upon which it is based.

## I – Knut Wittkowski, PhD

"There is nothing to be scared about. This is a flu epidemic like every other flu."[280]

"If the government, if there had been no intervention, the epidemic would have been over, like every other respiratory disease epidemic."[281]

There were extremely knowledgeable people whose reasonable analysis of COVID-19 was ignored. One was epidemiologist Knut Wittkowski, PhD. For 20 years he was head of the Department of Biostatistics, Epidemiology, and Research Design at The Rockefeller University, New York. He also worked for 15 years with Klaus Dietz, one of the leading epidemiologists in the world, at German's Eberhard Karls University.

Wittkowski gave several interviews in March and April 2020 that presented his opinion COVID-19 should be allowed to run its course like every other respiratory virus, and government mandated shutdowns would be counter-productive by prolonging the life-cycle of the virus in society.

Wittkowski observed in one article the U.S. was hit by three epidemics in 2019-2020 – influenza epidemics in late December, 2019 and early February, 2020, and COVID-19 in 2020. He included a chart (Fig. 18, see below) showing both flu outbreaks resulted in a greater percentage of hospitalizations than COVID-19.[282] Hospitalizations were also greater in two other recent flu outbreaks – in 2009-10, and in 2017-18. The chart also shows COVID-19 hospitalizations peaked the week of March 18 – which was before state lockdowns across the country began. Wittkowski writes, "the hospital systems in most affected countries have shown to be able to handle the COVID-19 epidemic."[283] Certainly so in the U.S. where hospitalizations for it were less than the two flu epidemics in 2019-2020.

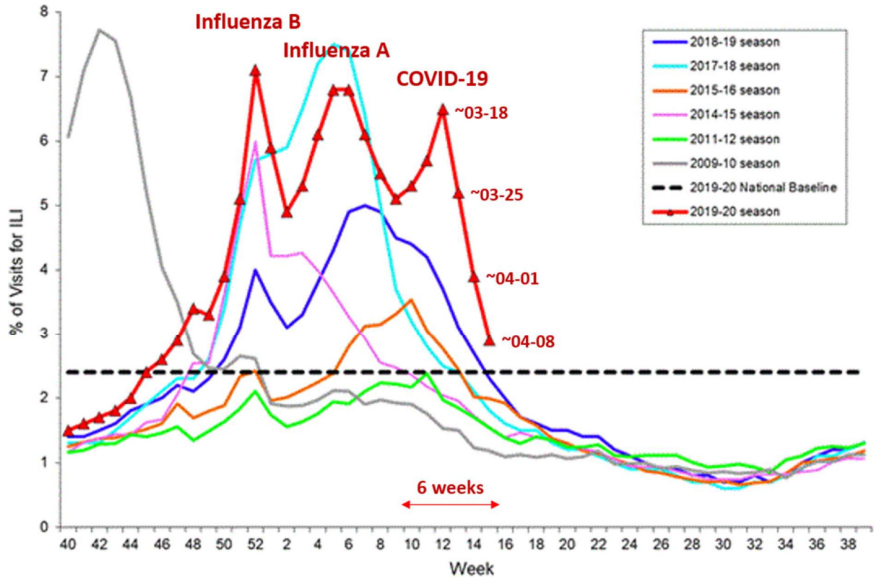



**Fig 18: Percentage of US Hospital Visits of Influenza-like Illness (ILI).** Reported by the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet). Weekly national Summary, 2019-2020 and Selected Previous Seasons. The 3rd peak of the 2019-20 season (03-16..22) reflects hospital utilization by COVID-19 patients.(https://www.cdc.gov/flu/weekly/index.htm, https://www.cdc.gov/flu/weekly/weeklyarchives2019-2020/images/ILI15_small.gif , accessed 2020-04-17f

Wittkowski brought to attention that in the U.S. there were four flu outbreaks in the last ten years that resulted in more hospitalizations than COVID-19 – and nothing unusual was done in the functioning of society for any of them. There was no media induced panic in the general population or by state and federal politicians. The outbreaks ran their course and died out. COVID-19 had reached its peak in the U.S. and was on the way to dying out when the lockdowns of schools, businesses, churches, social activities, sports and other activities were instituted in late March.

Wittkowski displayed a chart of data during an interview on April 1 that showed the same dynamic that the intensity of the COVID-19 outbreak peaking in late March in the U.S. was also true in Europe:

> "Interviewer: Okay, so, what does this graph tell you, in general?
>
> Wittkowski: It tells us that there are no—the numbers in Europe are not increasing anymore, of cases. The deaths follow it by about a week, and that's normal because people die after they develop the disease. But the important thing is that the numbers of infections peaked around a week ago [about March 23] and is already on the decline."[284]

During that interview Wittkowski described that achieving "herd immunity" is what stops every respiratory disease:

"With all respiratory diseases, the only thing that stops the disease is herd immunity. About 80% of the people need to have had contact with the virus, and the majority of them won't even have recognized that they were infected, or they had very, very mild symptoms, especially if they are children. So, it's very important to keep the schools open and kids mingling to spread the virus to get herd immunity as fast as possible, and then the elderly people, who should be separated, and the nursing homes should be closed during that time, can come back and meet their children and grandchildren after about 4 weeks when the virus has been exterminated."[285]

Wittkowski identified the importance of allowing children to be exposed to COVID-19:

"As with every respiratory disease, we should protect the elderly and fragile because when they get pneumonia, they have a high risk of dying of the pneumonia. So that is one of the key issues that we should keep in mind. On the other hand, *children do very well with these diseases. They're evolutionarily designed to be exposed to all sorts of viruses during their lifetime, and so they should keep going to school and infecting each other. Then, that contributes to herd immunity.*"[286] (emphasis added)

Regarding "herd immunity" Wittkowski said:

"If 80% of people are immune and somebody has a virus and is infectious, it will be very difficult for that infectious person to find somebody who is still susceptible, not immune. And therefore, this person will not infect anybody else and therefore we won't have the disease spreading. That is herd immunity.[287]

*If we had herd immunity now, there couldn't be a second wave in autumn*. Herd immunity lasts for a couple of years, typically … *However, if we are preventing herd immunity from developing, it is almost guaranteed that we have a second wave as soon as either we stop the social distancing or the climate changes with winter coming* or something like that."[288] And, "*Unfortunately, it seems that in western countries* where the story of China was already known, *people started with social distancing, as imperfect as it is, before the epidemic could reach the level that is needed to develop herd immunity*.[289] … *The second wave is a direct consequence of social distancing*."[290] (emphasis added)

An interviewer asked Wittkowski about using lockdown strategies to combat COVID-19:

"And so, what do you make of the policy that was enacted in the United States and England and most places throughout the world, this policy of containment, shelter-in-place, etc.? What's your opinion of it?[291]

Wittkowski responded: "Well, what people are trying to do is flatten the curve. *I don't really know why*. But, what happens is if you flatten the curve, you also prolong, to widen it, and it takes more time. And *I don't see a good reason for a respiratory disease to stay in the population longer than necessary*."[292] (emphasis added)

In response to a question about COVID-19 being a new virus, he said: "It's not the first coronavirus that comes out, and it won't be the last. And *for all respiratory diseases, we have the same type of an epidemic. If you leave it alone, it comes for two weeks, it peaks, and it goes for two weeks and it's gone*."[293] (emphasis added)

Wittkowski also noted the "containment" strategies of most European countries and the U.S. had flattened the normal bell curve pattern of a flu outbreak, "and prolonged the epidemic."[294] He added: "We already know that the social distancing cost the US taxpayer 2 trillion dollars, in addition to everything else that it costs, but it also has severe consequences for our social life, and depression is definitely something that we will be researching. I can say for myself, walking through New York City right now is depressing.[295]

Regarding vaccines he said: "We don't have a vaccine against the common cold. We don't have—we have some vaccines against flu, but they are not that effective."[296]

He expressed calm about COVID-19 because: "There is nothing to be scared about. *This is a flu epidemic like every other flu*. Maybe a bit more severe, but nothing that is fundamentally different from the flu that we see in other years."[297] …"For some reason that we haven't fully understood yet, humankind has survived all sorts of respiratory diseases. Nature has a way of making sure that we survive."[298]

Wittkowski was asked by one of the interviewers: "Why are we suddenly so much more panicked and having shut the world down? What do you think is going on?"[299] He responded: "*I think at least one factor is the internet. People are using the internet now much more often, and so news, wrong or false, is spreading the globe within hours, if not minutes*. And so, let's say 50 years ago, we would read in the paper that about a week ago there was an epidemic of flu in the United States or in China or somewhere else, and at that time, it was already over. So, people would say, "Okay, that happens all the time." Now, what we read is, "Oh! There were 785 cases in the Vatican for two days" Eh, maybe not. And *even if it was a reporting error, these stories are circulating the world and contributing to chaos and people being afraid of things they shouldn't be afraid of*."[300] (emphasis added)

Commenting about what should be done to counter the virus, Wittkowski said: "*One thing we definitely need to do, and that would be safe and effective, is opening schools.* Let the children spread the virus among themselves, which is a necessity to get herd immunity. *That was probably one of the most destructive actions the government has done*. We should focus on the elderly and separating them from the population where the virus is circulating. *We should not prevent the virus from circulating among school children*, which is the fastest way to create herd immunity."[301] He also said about being pro-active: "***Going outdoors is what stops every respiratory disease***."

Wittkowski bluntly stated why he can say things contrary to the accepted narrative: "*I'm not paid by the government, so I'm entitled to actually do science. If the government, if there had been no intervention, the epidemic would have been over, like every other respiratory disease epidemic*."[302] (emphasis added)

**The first three months of the COVID-19 epidemic**

Wittkowski's research paper – *The first three months of the COVID-19 epidemic* – was posted online April 29, 2020. The abstract stated:

> "About one month after the COVID-19 epidemic peaked in Mainland China and SARS-CoV-2 migrated to Europe and then the U.S., the epidemiological data begin to provide important insights into the risks associated with the disease and the effectiveness of intervention strategies such as travel restrictions and lockdowns ("social distancing"). Respiratory diseases, including the 2003 SARS epidemic, remain only about two months in any given population, although peak incidence and lethality can vary. Containment of high-risk people, like the elderly, and reducing disease severity, either by vaccination or by early treatment of complications, is the best strategy against a respiratory virus disease.."[303]

Excerpts from the article follow:

> "China initially (on 01-23) only closed means of transportation in Wuhan and other Hubei cities, causing 100,000s to leave the city before, in the afternoon, closing major highways. … non-essential companies were shut down on 02-13, and schools were closed on 02-20, two and three weeks, respectively, after the turning point, when interventions are not effective anymore. South Korea controlled the epidemic without imposing a lockdown on its people. and without shutting down its economy … On 02-22, (a day before the peak of the main wave, or only three days after the turning point), the KCDC issued a nation-wide recommendation for "social distancing." Still,

the recommended "social distancing" may have prevented herd immunity from developing, as suggested by the continuing low number of cases becoming infected (including some deaths).[304] …

The SARS-C0V-2 data also suggest that it takes at least a month from the first case entering the country (typically followed by others) for the epidemic to be detected, about three weeks for the number of cases to peak and a month for the epidemic to "resolve."[305] [Author's note: Thus a COVID-19 outbreak lasts about three months from beginning to end.] …

SARS-CoV-2 has arrived in the U.S. almost a week after it arrived in Europe and incidence of COVID-19 in Europe peaked around 04-04. … U.S. lethality is similar to that of Europe as a whole. Hence, there is no evidence for a high lethality strain dominating the epidemic in the U.S., with the possible exception of NYC."[306]

Regarding the government's response to COVID-19 Wittkowski said: "This is not the first, and likely not the last time, that well-intentioned public health policies are inconsistent with our understanding of how epidemics spread. For instance, during much of the HIV epidemic, there was widespread fear that HIV could establish itself in the population as a whole, even though the data and models contradicted this fear.[307] …

A major problem with respiratory diseases is that one cannot stop all chains of infections within families, friends, neighbors, … . Even after a couple of weeks of "lockdown" there will be a few infectious persons, and as long as there are enough susceptible people in the society, this is enough to re-start the epidemic until there are enough immune people in the society to create "herd immunity". Hence, one would expect the cases to appear in waves (Fig 15, the period of the "lockdown" corresponds to March to May, 2020 in the U.S.). Such waves of cases have been seen in different countries and the longer than expected duration of the epidemic supports the hypothesis that the social distancing / lockdown interventions had some effect…[308]

The epidemic of Oceania, together with those of China, South Korea, and Iran are consistent with the model results suggesting that a natural COVID-19 epidemic peaks two weeks after the first cases are seen, and then declines with financial and medical assistance from the government to prevent deaths to reduce the burden on the health system and damage to the economy.

The data from Scandinavia (Fig 9) also does not support the

effectiveness of social distancing. The epidemic curves of Sweden and the surrounding Norway, Denmark, and Finland do not indicate that imposed "social distancing" rules in the latter countries, but not in Sweden, had a major impact. Iceland, which, like Sweden, did also not impose a lockdown on its citizens had a particularly mild epidemic.[309]

… A substantial increase in the duration of the epidemic by preventing immunity to develop among the young, however, might make effective containment of the elderly more difficult and, thus, increase the number of deaths among the elderly.[310]

Aside from separating susceptible populations (elderly and high-risk subjects, e.g., in nursing homes) from the epidemic, which is effective as long as virus is circulating, public health intervention aiming to contain a respiratory disease need to start within a narrow window of opportunity starting when or a week after the curve of the new cases changes from increasing faster to increasing more slowly. Only if stopping the epidemic from generating a sufficient number of immune people is avoided can containment efforts stop after about a month or two (depending on late or early start, respectively), when the ratio of infectious vs immune people is low enough for preventing the disease from rebounding. When the window of opportunity has been missed, any type of containment has only limited impact on the course of the epidemic, but high impact on economy and society.

So far, the hospital systems in most affected countries have shown to be able to handle the COVID-19 epidemic. …"[311]

## II – Professor John P. A. Ioannidis

Stanford University Professor John P. A. Ioannidis published a thoughtful article four days after President Trump declared a COVID-19 National Emergency on March 13, 2020, and before the states began issuing lockdown/stay at home orders. His article was titled: *A fiasco in the making? As the coronavirus pandemic takes hold, we are making decisions without reliable data*, in which he wrote in part:

"The data collected so far on how many people are infected and how the epidemic is evolving are utterly unreliable. Given the limited testing to date, some deaths and probably the vast majority of infections due to SARS-CoV-2 are being missed. We don't know if we are failing to capture infections by a factor of three or 300. Three months after the outbreak emerged, most countries, including the U.S., lack the ability to test a large number of people and no

countries have reliable data on the prevalence of the virus in a representative random sample of the general population.

This evidence fiasco creates tremendous uncertainty about the risk of dying from Covid-19. Reported case fatality rates, like the official 3.4% rate from the World Health Organization, cause horror — and are meaningless. Patients who have been tested for SARS-CoV-2 are disproportionately those with severe symptoms and bad outcomes. As most health systems have limited testing capacity, selection bias may even worsen in the near future.

The one situation where an entire, closed population was tested was the Diamond Princess cruise ship and its quarantine passengers. The case fatality rate there was 1.0%, but this was a largely elderly population, in which the death rate from Covid-19 is much higher.

Projecting the Diamond Princess mortality rate onto the age structure of the U.S. population, the death rate among people infected with Covid-19 would be 0.125%. But since this estimate is based on extremely thin data — there were just seven deaths among the 700 infected passengers and crew — the real death rate could stretch from five times lower (0.025%) to five times higher (0.625%). It is also possible that some of the passengers who were infected might die later, and that tourists may have different frequencies of chronic diseases — a risk factor for worse outcomes with SARS-CoV-2 infection — than the general population. Adding these extra sources of uncertainty, reasonable estimates for the case fatality ratio in the general U.S. population vary from 0.05% to 1%.

That huge range markedly affects how severe the pandemic is and what should be done. A population-wide case fatality rate of 0.05% is lower than seasonal influenza. If that is the true rate, locking down the world with potentially tremendous social and financial consequences may be totally irrational. It's like an elephant being attacked by a house cat. Frustrated and trying to avoid the cat, the elephant accidentally jumps off a cliff and dies.

Could the Covid-19 case fatality rate be that low? … In fact, such "mild" coronaviruses infect tens of millions of people every year, and account for 3% to 11% of those hospitalized in the U.S. with lower respiratory infections each winter.

In the U.S., for example, so far this season … the estimated number of influenza-like illnesses is between 36,000,000 and 51,000,000, with an estimated 22,000 to 55,000 flu deaths.

Note the uncertainty about influenza-like illness deaths: a 2.5-fold range, corresponding to tens of thousands of deaths. Every year,

some of these deaths are due to influenza and some to other viruses, like common-cold coronaviruses.

… In some people who die from viral respiratory pathogens, more than one virus is found upon autopsy and bacteria are often superimposed. A positive test for coronavirus does not mean necessarily that this virus is always primarily responsible for a patient's demise."[312]

Ioannidis' description of an "evidence fiasco" due to "tremendous uncertainty about the risk of dying from Covid-19" was proven more than apt in the wake of the data that became known shortly after he wrote his article. While the WHO was projecting a 3.4% case fatality rate – Ioannidis estimated in mid-March 2020 it was more than *11 times less* than that at 0.3% based on the data known from the outbreak on the Diamond Princess.

On May 20, 2020 the CDC released its "COVID-19 Pandemic Planning Scenarios" that estimated the COVID-19 fatality rate based on five scenarios. Scenario 5: *Current Best Estimate* was the "Symptomatic Case Fatality Ratio was 0.4% (for all ages combined) with an asymptomatic case rate of 35%, which *brought the total CFR to 0.26%*. That was *lower* than the 0.3% Ioannidis was mocked for estimating more than two months earlier. However, the CDC did attach the proviso to its estimate: "The scenarios are intended to advance public health preparedness and planning**.** They are not predictions or estimates of the expected impact of COVID-19."[313] Nevertheless, the CDC was sending the direct message that COVID-19 was not a doomsday virus. The CDC paper also importantly listed the Symptomatic CFR for combined ages 0-49 was 26 times less than age 65+, and for ages 50-64 it was 6.5 times less than age 65+.[314] It was apparent to the CDC the at risk age group was 65+ – but that didn't jibe with their public pronouncements that all of society was at eminent risk of infection and death.

## III – Drs. Dan Erickson & Artin Massihi Compare COVID-19 To Flu

On April 22, 2020 Dr. Dan Erickson and Dr. Artin Massihi gave a press conference to ABC Channel 23 in Bakersfield, California during which they presented their evidence that the death rate of COVID-19 is similar to the flu.[315] They are co-owners of five Accelerated Urgent Care clinics in Kern County.

Erickson and Massihi acknowledged California's Gov. Newsome was relying on imperfect information when he mandated a shut down. However, based on the results of 5,213 COVID-19 tests they conducted at their clinics and a walk-in testing site for people complaining of symptoms, they found a small percentage of people tested positive and it is no more deadly than the

flu. Erickson said, "Now that we have the facts. It's time to get back to work."[316]

Erickson also explained their findings were consistent with data from U.S. states, including New York that had the worst outbreak in the U.S., and other countries: "Millions of cases, small amount of deaths."[317] He also said mitigation strategies were imposed and states shut down based on computer models that were unreliable because they projected enormous numbers of COVID-19 deaths that was not supported by actual data.

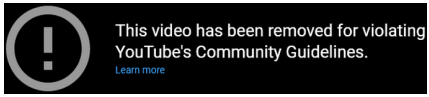
Erickson not only advocated for reopening society, schools, and businesses, but he said staying home could be worse for a person's health than resuming normal life: "we understand microbiology, we understand immunology and we want strong immune systems." I don't want to stay in my home and develop a weak immune system and then come out and get a disease."[318]

There was immediate backlash against Erickson and Massihi for presenting their testing and death data, the actual data from U.S. states and other countries, and making observations about it. One critic, Dr. George Rutherford of UC San Francisco claimed Erickson was wrong because COVID-19's mortality rate could be 30 times worse than the flu. Rutherford said on April 27, "The early [computer] projections were that there would be 44,000 deaths in the Bay Area."[319]

Rutherford has been proven radically wrong to have relied on computer models instead of the actual data Erickson was relying on. As of October 21 – 6 months after Rutherford made his comments – a total of 1,704 people had died in the Bay area from COVID-19.[320] That is *26 times less* than the 44,000 deaths Rutherford said computer modeling projected.

The American College of Emergency Physicians and the American Academy of Emergency Medicine publicly declared they "emphatically condemn the recent opinions released by Dr. Daniel Erickson and Dr. Artin Massihi. These reckless and untested musings do not speak for medical societies and are inconsistent with current science and epidemiology regarding COVID-19."[321] The Academy was as wrong as Rutherford and for the same reason, the actual death data in April supported Erickson's conclusions, and six months later it still does.

The video of Erickson and Massihi's press conference went viral after it was posted on ABC Channel 23's YouTube page. In a matter of days it garnered 5.46 million views and Elon Musk had tweeted about it to his 33 million followers.




The next day YouTube removed the press conference video, and informed ABC23 that it violated "our Community Guidelines, including content that explicitly disputes the efficacy of local healthy authority recommended guidance on social distancing that may lead others to act against that guidance." ABC23 made the full video available on their website.[322]

The irony of the video's removal is their presentation was based on the actual data at the time, which has been confirmed by data from around the world in the six months after their press conference. In contrast, their critics were wrong at the time and even more wrong as time goes by, because they were relying on computer models making guesstimates, and not reality like Erickson and Massihi were.

## IV – Economist Sanjeev Sabhlok

Economist Sanjeev Sabhlok resigned from the Victorian Treasury in protest against what he described as the "Police State" imposed on the Australian State of Victoria by Premier Daniel Andrews. Sabhlok immigrated to Australia from India in 2001. In Sabhlok's September 10, 2020 resignation letter to Andrews he wrote:

> Dear Dan,
>
> I served your government as an economist till 10 September 2020 but have resigned to protest your Police State.
>
> I did not come to Australia to be a slave of whimsical government. You have not implemented risk-based management, no evidence-based policy, no cost-benefit analysis. No justification. Just whimsy.
>
> You must reset Victoria's policies right now.
>
> But if you won't, then go!
>
> Sanjeev Sabhlok[323]

A week later he wrote an article published in the *Financial Review* explaining "Why I quit rather than be silenced" that stated in part:

> "Last week I quit my job as an economist in the Victorian Department of Finance and Treasury so that I would be free to speak out against the state's management of the COVID-19 infection.
>
> I had made a number of criticisms of the state government on social media. The head of human relations at Treasury asked me to remove them. I considered deleting the few direct criticisms, but they wanted all indirect criticism removed too. I resigned on the same day, the only honourable course for a free citizen of Australia.

The pandemic policies being pursued in Australia – particularly in Victoria – are the most heavy-handed possible, a sledgehammer to kill a swarm of flies. These policies are having hugely adverse economic, social and health effects, with the poorer sections of the community that don't have the ability to work from home suffering the most.

Australia is signalling to the world that it is closed for business and doesn't care for human freedoms. …

*The whole thing hinges on the scare created by politicians and health professionals*. For instance, Victoria's Chief Health Officer Brett Sutton claims this is the "greatest public health challenge since the Spanish flu".

But this is no Spanish flu – we can verify that easily.

The Spanish flu killed at least 50 million people worldwide in 1918 when the global population was 1.8 billion. Proportionately, to be as lethal as Spanish flu, a virus would have to kill at least 210 million people today. Instead, only around 0.9 million have died so far. …

*But even if the pandemic had been as big as the Spanish flu, lockdowns could never have been justified. There are strong scientific arguments against lockdowns too*.

The need for good policy process does not disappear just because we face a public health crisis. In fact, it gets even more urgent.

The Victorian Guide to Regulation notes that "It is not possible for governments to provide a completely 'risk free' society, or to prevent every possible event that might cause harm". …

*Governments back in February needed to commission a cost-benefit analysis of alternative policy options that took into account different scenarios* (such as with and without a vaccine). Thereafter, the best option had to be picked given the uncertainty, but consistent also with the need to intrude minimally into human freedoms. This cost-benefit analysis and policies needed then to be updated as new information emerged. …

Governments should have also realised at the outset that they are hostage to chronic groupthink and actively sought alternative advice. I attempted repeatedly to raise my voice within my public sector role, but my attempts were rebuffed. The bureaucracy has clamped down on frank and fearless, impartial advice, in a misplaced determination to support whatever the government decides …

So what happens now? Billions of dollars in income and wealth have been wiped out in the name of a virus that is no worse than the Asian flu …

The problem for politicians now is to reverse course without losing their job. …"[324]

## V – Belgian doctors protest there is no COVID-19 emergency

> If we compare the waves of infection in countries with strict lockdown policies to countries that did not impose lockdowns (Sweden, Iceland …), we see similar curves. So there is no link between the imposed lockdown and the course of the infection. *Lockdown has not led to a lower mortality rate*.[325]

More than 2,000 Belgian medical doctors and medically trained health professionals signed an open letter dated September 5, 2020 in which point by point they challenged the medical basis for continuation of emergency COVID-19 restrictions on society.[326] The letter states in part:

> **"We, Belgian doctors and health professionals, wish to express our serious concern about the evolution of the situation in the recent months surrounding the outbreak of the SARS-CoV-2 virus. We call on politicians to be independently and critically informed in the decision-making process and in the compulsory implementation of corona-measures. We ask for an open debate, where all experts are represented without any form of censorship. After the initial panic surrounding covid-19, the objective facts now show a completely different picture – there is no medical justification for any emergency policy anymore.**
>
> **The current crisis management has become totally disproportionate and causes more damage than it does any good.**
>
> **We call for an end to all measures and ask for an immediate restoration of our normal democratic governance and legal structures and of all our civil liberties.** (Bold in original)
>
> 'A cure must not be worse than the problem' is a thesis that is more relevant than ever in the current situation. We note, however, that the collateral damage now being caused to the population will have a greater impact in the short and long term on all sections of the population than the number of people now being safeguarded from corona.

In our opinion, the current corona measures and the strict penalties for non-compliance with them are contrary to the values formulated by the Belgian Supreme Health Council, which, until recently, as the health authority, has always ensured quality medicine in our country: "Science – Expertise – Quality – Impartiality – Independence – Transparency".

**The concept of health**

Health … is a broad concept that goes beyond the physical and also relates to the emotional and social well-being of the individual. …

The current global measures taken to combat SARS-CoV-2 violate to a large extent this view of health and human rights. Measures include compulsory wearing of a mask … physical distancing, social isolation, compulsory quarantine for some groups and hygiene measures.

**The predicted pandemic with millions of deaths**

… The WHO originally predicted a pandemic that would claim 3.4% victims, in other words millions of deaths, and a highly contagious virus for which no treatment or vaccine was available. This would put unprecedented pressure on the intensive care units (ICUs) of our hospitals.

This led to a global alarm situation, never seen in the history of mankind: "flatten the curve" was represented by a lockdown that shut down the entire society and economy and quarantined healthy people. …

**The facts about covid-19**

*The course of covid-19 followed the course of a normal wave of infection similar to a flu season*. As every year, we see a mix of flu viruses following the curve: first the rhinoviruses, then the influenza A and B viruses, followed by the coronaviruses. There is nothing different from what we normally see.

The use of the non-specific PCR test, which produces many false positives, showed an exponential picture. …

The test does not measure how many viruses are present in the sample. … If someone tests positive, this does not mean that that person is actually clinically infected, is ill or is going to become ill. …

*Since a positive PCR test does not automatically indicate active infection or infectivity, this does not justify the social measures taken, which are based solely on these tests*.

**Lockdown**

If we compare the waves of infection in countries with strict lockdown policies to countries that did not impose lockdowns (Sweden, Iceland …), we see similar curves. So there is no link between the imposed lockdown and the course of the infection. *Lockdown has not led to a lower mortality rate*.

*If we look at the date of application of the imposed lockdowns we see that the lockdowns were set after the peak was already over and the number of cases decreasing. The drop was therefore not the result of the taken measures*.

As every year, it seems that climatic conditions (weather, temperature and humidity) and growing immunity are more likely to reduce the wave of infection.

**Our immune system**

For thousands of years, the human body has been exposed daily to moisture and droplets containing infectious microorganisms (viruses, bacteria and fungi).

The penetration of these microorganisms is prevented by an advanced defence mechanism – the immune system. A strong immune system relies on normal daily exposure to these microbial influences. Overly hygienic measures have a detrimental effect on our immunity. *Only people with a weak or faulty immune system should be protected by extensive hygiene or social distancing*. …

*It appears that most people already have a congenital or general immunity to e.g. influenza and other viruses*. This is confirmed by the findings on the cruise ship Diamond Princess, which was quarantined because of a few passengers who died of Covid-19. Most of the passengers were elderly and were in an ideal situation of transmission on the ship. However, 75% did not appear to be infected. *So even in this high-risk group, the majority are resistant to the virus*. …

Most people therefore already have a congenital or cross-immunity because they were already in contact with variants of the same virus. …

Most people who test positive (PCR) have no complaints. Their immune system is strong enough. Strengthening natural immunity is a much more logical approach. Prevention is an important, insufficiently highlighted pillar: healthy, full-fledged nutrition, exercise in fresh air, without a mask, stress reduction and nourishing emotional and social contacts.

**Consequences of social isolation on physical and mental health**

Social isolation and economic damage led to an increase in depression, anxiety, suicides, intra-family violence and child abuse.

Studies have shown that the more social and emotional commitments people have, the more resistant they are to viruses. It is much more likely that isolation and quarantine have fatal consequences.

The isolation measures have also led to physical inactivity in many older people due to their being forced to stay indoors. However, sufficient exercise has a positive effect on cognitive functioning, reducing depressive complaints and anxiety and improving physical health, energy levels, well-being and, in general, quality of life.

Fear, persistent stress and loneliness induced by social distancing have a proven negative influence on psychological and general health.

**A highly contagious virus with millions of deaths without any treatment?**

*Mortality turned out to be many times lower than expected and close to that of a normal seasonal flu* (0.2%).

*The number of registered corona deaths therefore still seems to be overestimated.*

*There is a difference between death by corona and death with corona.* … Taking into account the fact that most people who developed serious symptoms suffered from additional pathology, one cannot simply conclude that the corona-infection was the cause of death. *This was mostly not taken into account in the statistics*.

The most vulnerable groups can be clearly identified. … *The vast majority of infected persons (>98%) did not or hardly became ill or recovered spontaneously*.

Meanwhile, *there is an affordable, safe and efficient therapy* available for those who do show severe symptoms of disease in the form of *HCQ (hydroxychloroquine), zinc and azithromycin*. Rapidly applied this therapy leads to recovery and often prevents hospitalisation. Hardly anyone has to die now.

This effective therapy has been confirmed by the clinical experience of colleagues in the field with impressive results. …

It is therefore not a killer virus, but a well-treatable condition.

**Propagation**

Spreading occurs by drip infection (only for patients who cough or sneeze) and aerosols in closed, unventilated rooms. *Contamination is therefore not possible in the open air*. Contact

tracing and epidemiological studies show that *healthy people (or positively tested asymptomatic carriers) are virtually unable to transmit the virus. Healthy people therefore do not put each other at risk*. …

*All this seriously calls into question the whole policy of social distancing and compulsory mouth masks for healthy people – there is no scientific basis for this*.

**Masks**

Oral masks belong in contexts where contacts with proven at-risk groups or people with upper respiratory complaints take place, and in a medical context/hospital-retirement home setting. They reduce the risk of droplet infection by sneezing or coughing. *Oral masks in healthy individuals are ineffective against the spread of viral infections*.

*Wearing a mask is not without side effects. Oxygen deficiency* (headache, nausea, fatigue, loss of concentration) *occurs fairly quickly, an effect similar to altitude sickness*. … In addition, the accumulated CO2 leads to a toxic acidification of the organism which affects our immunity. …

…Our Labour Code (Codex 6) refers to a CO2 content (ventilation in workplaces) of 900 ppm, maximum 1200 ppm in special circumstances. After wearing a mask for one minute, this toxic limit is considerably exceeded to values that are three to four times higher than these maximum values. *Anyone who wears a mask is therefore in an extreme poorly ventilated room*. …

Hospitals have a sterile environment in their operating rooms where staff wear masks and there is precise regulation of humidity / temperature with appropriately monitored oxygen flow to compensate for this, thus meeting strict safety standards. …

**The Hippocratic Oath**

As a doctor, we took the Hippocratic Oath:

"I will above all care for my patients, promote their health and alleviate their suffering".

"I will inform my patients correctly."

"Even under pressure, I will not use my medical knowledge for practices that are against humanity."

The current measures force us to act against this oath.

Other health professionals have a similar code.

The '*primum non nocere*', which every doctor and health professional assumes, is also undermined by the current measures

and by the prospect of the possible introduction of a generalised vaccine, which is not subject to extensive prior testing.

**Vaccine**

… Vaccinating our elderly appears to be inefficient. *Over 75 years of age, the efficacy is almost non-existent*.

Due to the continuous natural mutation of viruses, as we also see every year in the case of the influenza virus, a vaccine is at most a temporary solution, which requires new vaccines each time afterwards. An untested vaccine, which is implemented by emergency procedure and for which the manufacturers have already obtained legal immunity from possible harm, raises serious questions. *We do not wish to use our patients as guinea pigs*.

*On a global scale, 700 000 cases of damage or death are expected as a result of the vaccine*.

*If 95% of people experience Covid-19 virtually symptom-free, the risk of exposure to an untested vaccine is irresponsible*.

**The role of the media and the official communication plan**

Over the past few months, newspaper, radio and TV makers seemed to stand almost uncritically behind the panel of experts and the government, there, where it is precisely the press that should be critical and prevent one-sided governmental communication. *This has led to a public communication in our news media, that was more like propaganda than objective reporting*. …

The official story that a lockdown was necessary, that this was the only possible solution, and that everyone stood behind this lockdown, made it difficult for people with a different view, as well as experts, to express a different opinion.

*Alternative opinions were ignored or ridiculed. We have not seen open debates in the media, where different views could be expressed*.

*We were also surprised by the many videos and articles by many scientific experts and authorities, which were and are still being removed from social media.* We feel that this does not fit in with a free, democratic constitutional state, all the more so as it leads to tunnel vision. This policy also has a paralysing effect and feeds fear and concern in society. In this context, we reject the intention of censorship of dissidents in the European Union!

The way in which Covid-19 has been portrayed by politicians and the media has not done the situation any good either. … *There has often been mention of a 'war' with an 'invisible enemy' who has to be 'defeated'*. … as has the idea that we are globally dealing with a 'killer virus'.

The relentless bombardment with figures … without comparing them to flu deaths in other years, without comparing them to deaths from other causes, has induced a real psychosis of fear in the population. *This is not information, this is manipulation*.

*We deplore the role of the WHO in this, which has called for the infodemic* (i.e. all divergent opinions from the official discourse, including by experts with different views) *to be silenced by an unprecedented media censorship*. …

We demand an open debate in which all experts are heard.

**Emergency law versus Human Rights**

The measures currently taken concern interference in the exercise of, among other things, the right to respect of private and family life, freedom of thought, conscience and religion, freedom of expression and freedom of assembly and association, the right to education, etc., and must therefore comply with fundamental rights as protected by the European Convention on Human Rights (ECHR).

…For example, in accordance with Article 8(2) of the ECHR, interference with the right to private and family life is permissible only if the measures are necessary in the interests of national security, public safety … and the … the protection of health…

The predicted pandemic of millions of deaths seemed to respond to these crisis conditions, leading to the establishment of an emergency government. *Now that the objective facts show something completely different*, the condition of inability to act otherwise … (…an emergency) is no longer in place. *Covid-19 is not a cold virus, but a well treatable condition with a mortality rate comparable to the seasonal flu.* …

*There is no state of emergency.*

**Immense damage caused by the current policies**

An open discussion on corona measures means that, in addition to the years of life gained by corona patients, we must also take into account other factors affecting the health of the entire population. These include damage in the psychosocial domain (increase in depression, anxiety, suicides, intra-family violence and child abuse) and economic damage.

*If we take this collateral damage into account, the current policy is out of all proportion, the proverbial use of a sledgehammer to crack a nut*.

*We find it shocking that the government is invoking health as a reason for the emergency law*.

As doctors and health professionals, *in the face of a virus which, in terms of its harmfulness, mortality and transmissibility, approaches the seasonal influenza, we can only reject these extremely disproportionate measures*.

- *We therefore demand an immediate end to all measures.*
- *We are questioning the legitimacy of the current advisory experts, who meet behind closed doors*.
- Following on from ACU 2020 – https://acu2020.org/nederlandse-versie/ – *we call for an in-depth examination of the role of the WHO and the possible influence of conflicts of interest in this organisation*. It was also at the heart of the fight against the "infodemic", i.e. the systematic censorship of all dissenting opinions in the media. This is unacceptable for a democratic state governed by the rule of law.

**Distribution of this letter**

We would like to make a public appeal to our professional associations and fellow carers to give their opinion on the current measures.

We draw attention to and call for an open discussion in which carers can and dare to speak out.

With this open letter, we send out the signal that progress on the same footing does more harm than good, and call on politicians to inform themselves independently and critically about the available evidence – including that from experts with different views, as long as it is based on sound science – when rolling out a policy, with the aim of promoting optimum health. ….[327]

## VI – Professor Dolores Cahill

Professor Dolores Cahill is an expert in pathogenic viruses and vaccines. She received her degree in Molecular Genetics from Trinity College Dublin (1989) and her PhD in Immunology from Dublin City University in 1994. She was group leader of the Protein Technology Group in the Max-Planck-Institute of Molecular Genetics, Berlin, Germany (1996-2003) She co-founded a biotechnology company, Protagen AG in Dortmund to commercialize this technology. Beginning in 2005 she was Professor of Translational Science at the UCD School of Medicine and Medical Sciences.

Cahill had first-hand experience with COVID-19 because she was infected with it in January-February 2020. She has said it gave her a dry cough and she was short of breath for several days, but then it went away.[328]

Cahill spoke at a COVID-19 rally in Dublin on July 25, 2020. The following are excerpts from her talk:[329]

"Thank you for waiting around for the last speaker. I would like to thank all of you for your support and I won't keep too much time.

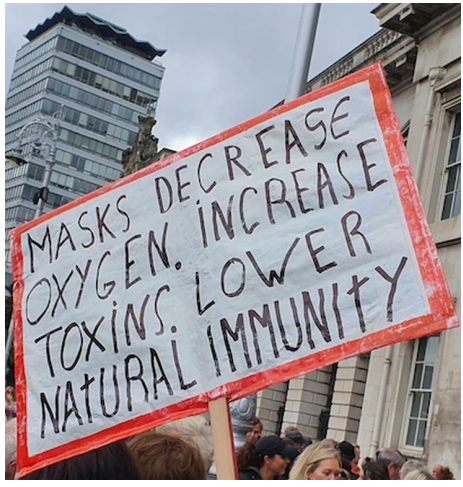
The theme I'm just going to say is that out duty in life is to live it and not be afraid. So don't be afraid. … So that the opposite of fear is love. And so what we have to do is to figure out what's going on and I will just give you some information about this virus.

So when they called the pandemic there are 7,800 million people in the world and the World Health Organization called the pandemic on the 11th of March. And guess how many people – now all deaths are tragic – but guess how many people had died of SARS-CoV-2: 4,200. So you had a 1.1 in 1.8 million chance of dying. …

… [S]o when they talk about a second spike, there wasn't a first one.

So the World Health Organization came out with figures on the 9th of March for how many people died: 3,000 of TB every day; 1,000 of influenza; 56 for SARS-CoV-2. So there was no need to call a pandemic. There was no need in Ireland or anywhere in the world to shut down the economy. Absolutely no need. And that is the fundamental, that is the fundamental issue. If there was no death or illness relatively from the virus then all of the other consequences are legally, ethically, societally, not necessary. … And I would say in everything in life it's the harm versus the benefit.

If you wear a mask it reduces your oxygen supply and the OSHA standards in the United States say if your oxygen level is below 19.5 per cent that you can't work and you can't function. And once you put on any mask it goes down under 18%. So you should not be wearing a mask. It's bad for your health, it suppresses your immune system and I would say the government and the health agencies have to face the consequences of recommending employers and restaurants and bus drivers or anyone who is driving a vehicle to be wearing a mask that reduces their oxygen supply and increases their carbon dioxide to above



dangerous levels. So it is wrong. So we have to stand up and say to the government, "How dare you. How dare you."

… So I suppose my two things today about the motto is: Don't be afraid we are on this Earth to live life, we have a duty to live life not to be afraid. Don't be afraid.. We have to speak the truth and we have to value our freedoms. … I will go against 10 people or 20 people from the HSE, any doctor, any immunologist … that they need to provide the evidence for why they are mandating masks. And why they are mandating social distance. I can honestly say it was never necessary. Never necessary.

So the other thing that is which is not good, is that in May 2020 Switzerland did a study of the harm due to the lockdown. So a lot of the evidence is known that for every one percent increase in unemployment you get so many ill health effects, cancers and suicide. So Bloomberg did a study in May 2020 and guess which country is going … to have the worst outcomes from … lockdown in Europe? Ireland. So our unemployment rate has gone from 5.6% in February to 26% in June. …

So I know this is not good news, but what we've been waiting for and what I've been waiting for is some honesty in the conversation about Ireland. …


… So in Ireland a thousand one hundred people died out of nearly five million from COVID-19. In Japan less than a thousand people died out of 120 million. Okay, but in Ireland we had the same deaths. 62% of the deaths are in the care homes. The largest number of deaths in Europe.

Thank you for coming out today, and those vaccines should not be mandatory. I support the heath freedom of Ireland. I support them 100%. We have inalienable rights to bodily integrity. Freedom of speech, to assemble. Freedom to practice religion. Freedom to Travel. All of our inalienable freedoms that cannot be taken away are being attacked by a virus that causes death that's much less than the influenza virus. You don't need masks. You don't need social distancing. Children should be in school."[330]

Cahill has also been a vocal advocate for people to boost their immune system against COVID-19 by taking vitamin D, vitamin C, zinc, and hydroxychloroquine tablets. Hydroxychloroquine is a widely used

inexpensive anti-malaria treatment. She asserts those self-treatments are an effective prophylactic to shield a person from COVID-19.[331]

The many proponents of vitamin D as a COVID-19 preventative were provided with additional evidentiary support by the report in late October 2020 that a study found 82% of COVID-19 patients hospitalized in Spain suffered from vitamin D deficiency.[332] Vitamin D is known to strengthen immune system function: it is naturally produced when a person's body is exposed to sunlight, and it can also be obtained from eating fatty fish, egg yolks, mushrooms and cheese.[333]

## VII – Pamela Popper

Pamela Popper is president of Wellness Forum Health (WFH) in Ohio, which specializes in assisting people in informed medical decision making.[334]

In the spring of 2020 Popper began producing YouTube videos and publishing articles in the WFH newsletter – *Get InforMED Weekly* –that examined issues related to COVID-19.[335] Her videos and articles were from an investigated perspective. She sought to find the truth behind the headlines, political speeches, social media posts, and government policies relying on the narrative of the CDC and the WHO that COVID-19 is a grave medical threat that can only be countered with draconian interference in the economic and social life of people around the world.

Titles of Popper's videos shows the breadth of her inquisitiveness:

- Which New Normal Do You Want?
- A UK Doctor Analyzes COVID Data
- Data from CDC, WHO, State of Ohio and British Columbia Minister of Health
- Consequences: How Can People Do This To Children?
- Restrictions and Lockdowns: Good News and Bad News From States
- Another Testing Debacle
- The Real Cost of COVID Restrictions and Some Good News
- And dozens more.[336]

Popper's ongoing investigation resulted in her expressing skepticism about the truthfulness of what the public was being told by the media, government officials, the CDC and WHO, and others, about COVID-19. Popper's doubts about the official COVID-19 narrative is encapsulated in an excerpt from her September 14, 2020 article – "Here's Why I Am Worried and Why You Should Be Too!":

> For several months I've been warning people that there is no pandemic, and that using the pandemic as an excuse, our government has been overthrown by criminals. Every few weeks, the disconnect between COVID-19 data and actions taken by our criminal rulers

becomes bigger and bigger. There is good news and bad news here. The bad news is obvious – lunatics are in charge of many states, like Ohio where I live. Here's the good news. The decisions and orders are so insane and arbitrary that more and more people are starting to wake up and realize what is really going on, and that we all must take action before it is too late.[337]

Popper also started a grassroots organization to promote citizen involvement in restoring life in the United States as it had been before March 2020 called – Make Americans Free Again.[338]

## VIII – Professor Harvey Risch & hydroxychloroquine

The use of hydroxychloroquine was endorsed in a July 23, 2020 *Newsweek* magazine feature article by Harvey A. Risch, MD, PhD, Professor of Epidemiology, Yale School of Public Health. [339] Risch wrote:

> "I am fighting for a treatment that the data fully support but which, for reasons having nothing to do with a correct understanding of the science, has been pushed to the sidelines. As a result, tens of thousands of patients with COVID-19 are dying unnecessarily. …
>
> I am referring, of course, to the medication hydroxychloroquine. When this inexpensive oral medication is given very early in the course of illness, before the virus has had time to multiply beyond control, it has shown to be highly effective, especially when given in combination with the antibiotics azithromycin or doxycycline and the nutritional supplement zinc."
>
> On May 27, I published an article in the American Journal of Epidemiology (AJE) entitled, "Early Outpatient Treatment of Symptomatic, High-Risk COVID-19 Patients that Should be Ramped-Up Immediately as Key to the Pandemic Crisis."[340] That article, published in the world's leading epidemiology journal, analyzed five studies, demonstrating clear-cut and significant benefits to treated patients, plus other very large studies that showed the medication safety.
>
> …
>
> Since publication of my May 27 article, seven more studies have demonstrated similar benefit. …These seven studies include: an additional 400 high-risk patients treated by Dr. Vladimir Zelenko, with zero deaths; four studies totaling almost 500 high-risk patients treated in nursing homes and clinics across the U.S., with no deaths; a controlled trial of more than 700 high-risk patients in Brazil, with

significantly reduced risk of hospitalization and two deaths among 334 patients treated with hydroxychloroquine…"

Why has hydroxychloroquine been disregarded?

First, as all know, the medication has become highly politicized. …We must judge this medication strictly on the science. When doctors graduate from medical school, they formally promise to make the health and life of the patient their first consideration …

Second, the drug has not been used properly in many studies. Hydroxychloroquine has shown major success when used early in high-risk people but, as one would expect for an antiviral, much less success when used late in the disease course. …

In fact, as inexpensive, oral and widely available medications, and a nutritional supplement, the combination of hydroxychloroquine, azithromycin or doxycycline, and zinc are well-suited for early treatment in the outpatient setting. The combination should be prescribed in high-risk patients immediately upon clinical suspicion of COVID-19 disease …

Third, concerns have been raised by the FDA and others about risks of cardiac arrhythmia …This reporting system captured up to a thousand cases of arrhythmias attributed to hydroxychloroquine use. … But what the FDA did not announce is that these adverse events were generated from tens of millions of patient uses of hydroxychloroquine for long periods of time, often for the chronic treatment of lupus or rheumatoid arthritis. …This fact is proven by an Oxford University study of more than 320,000 older patients taking both hydroxychloroquine and azithromycin, who had arrhythmia excess death rates of less than 9/100,000 users …

In the future, I believe this misbegotten episode regarding hydroxychloroquine will be studied by sociologists of medicine as a classic example of how extra-scientific factors overrode clear-cut medical evidence. …"[341]

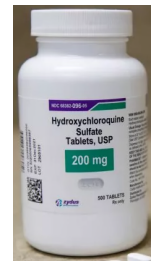
Dr. Risch's position on the effectiveness of low-cost and readily available hydroxychloroquine (HCQ) to treat COVID-19 was much criticized by the medical establishment and advocates of universal inoculation of people with an expensive vaccine developed and distributed by pharmaceutical companies. Risch publicly accused White House coronavirus task force member Dr. Anthony Fauci of waging a "misinformation campaign" against hydroxychloroquine.[342] Fauci's position was contrary to President Trump endorsing responsible use of hydroxychloroquine.

# IX – Dr. Peter Breggin & hydroxychloroquine

Hydroxychloroquine, which is sold under an number of brand names, has long been used to treat malaria as well as other illnesses such as arthritis and lupus. The World Health Organization lists HCQ as an essential medicine, and around five million Americans hold prescriptions for it.[343]

Dr. Peter Breggin is a Harvard trained psychiatrist and a former Consultant at NIMH. His work provides the foundation for modern criticism of psychiatric diagnoses and drugs. His research and educational projects have brought about major changes in the FDA-approved Full Prescribing Information or labels for dozens of antipsychotic and antidepressant drugs. He is a long-time advocate of responsible and appropriate use of drugs on adults and children.[344]

On March 20, 2020 President Trump publicly expressed enthusiasm about using hydroxychloroquine as a preventative for coronavirus.[345] Anthony Fauci disagreed by saying "No" when asked during that White House press briefing if hydroxychloroquine was effective at preventing coronavirus.




On April 22, 2020 Breggin responded to news reports that a study of 368 coronavirus patients in U.S. veterans hospitals that claimed to show hydroxychloroquine by itself and in combination with azithromycin had no benefit compared with versus standard care.[346] Breggin has been evaluating drug studies since the early 1990s. He identified the study itself exposed why its results were skewed: "However, hydroxychloroquine, with or without azithromycin, *was more likely to be prescribed to patients with more severe disease*, as assessed by baseline ventilatory status and metabolic and hematologic parameters. Thus, *as expected, increased mortality was observed in patients treated with hydroxychloroquine*, both with and without azithromycin."[347] Breggin wrote in response to this:

> "It was expected that more patients would die while taking the drugs because they were being given to much sicker patients! …
>
> Furthermore, there is strong evidence that the combination of hydroxychloroquine and azithromycin was saving lives. There was "no significant difference" in the death rates from any cause for the patients on the drug combination compared to the patients on no drugs (p. 11). In other words, although the patients taking the drug combination of hydroxychloroquine and azithromycin were probably the sickest of the sick, there was no significant increase in deaths among them compared to the much less sick patients who received

no drug treatment. This suggests that the drug combination had a lifesaving impact."[348]

On May 19, 2020 Breggin wrote about the media's accusation President Trump was killing people for "announcing that he has been taking hydroxychloroquine (HCQ) for two weeks to prevent the occurrence of COVID-19."[349] Breggin also wrote:

> "Has Trump gone overboard, taking hydroxychloroquine, and promoting it? Hydroxychloroquine is the most widely used drug worldwide to treat COVID-19, with many doctors reporting it is the best drug available. A March 27, 2020 worldwide survey headlined, "Doctors Rate Hydroxychloroquine Most Effective Therapy for Coronavirus Infection." India found hydroxychloroquine so essential to saving the lives of its citizens that for a time it stopped exporting it and more recently has been sending it to Africa in the "war against the coronavirus."
>
> The US lags behind many other nations in using HCQ because of the politically-driven negative PR in this country, but its use remains extensive. *Reuters* reported, "Doctors and pharmacists from more than half a dozen large healthcare systems in New York, Louisiana, Massachusetts, Ohio, Washington and California told *Reuters* they are routinely using hydroxychloroquine on patients hospitalized with COVID-19."[350]

In August 2020 Breggin published an article about hydroxychloroquine: *Scientific Study—Or Megadose Mass Murder?* in which he wrote:

> From *The New York Times* to the *Journal of the American Medical Association* (*JAMA*), partisans have been promoting a "scientific study" that supposedly proves that chloroquine, and by association, hydroxychloroquine, are too dangerous to use in treating COVID-19 patients. The [Brazilian] study gave such megadoses of chloroquine to such frail and ill patients that many were bound to die of drug toxicity. … <u>It may also be an extraordinary example of politically motivated mass murder under the guise of scientific research</u>.
>
> When science becomes politicized, as during the current COVID-19 pandemic, it becomes especially subject to human corruption. Still, we are shocked at the extremes to which scientists in Brazil and media and medical authorities in the US will go to stifle use of hydroxychloroquine. …
>
> The Brazil study used enormous repeated doses of chloroquine: 1200 mg daily for 10 days. This dose is so large that the authors

could not cite a single other clinical study that approximated this megadose range. …

As already noted, all the patients were very ill with COVID-19, some were elderly, and many had comorbid disease, including heart disease. The lethal dose for them would be considerably below 30 mg/kg. It is no exaggeration to observe that, given their physical condition and frailties, all the patients in this study were at risk of death from the megadoses of chloroquine administered to them. …

Many of the patients were probably too ill to properly metabolize or break down the drug, increasing the size of dose in terms of its concentration in the blood and hence its lethality. …

When the death rate in the high dose group reached 39%, the megadose arm of the study was ended. …

Those who planned the clinical trial created a no-win study to demonstrate that the highly politicized treatment known as "Trump's drug" was too dangerous to treat COVID-19 patients. They administered the medications in potentially lethal doses with no other discernable goal than to discredit hydroxychloroquine and President Trump, along with their own Brazilian President, Jair Bolsonaro, a supporter of both Trump and hydroxychloroquine."[351]

# 10. Media Hunger For Hits, Clicks and Viewers Fueled COVID-19 Hysteria

It was known from the experience of China, Thailand, Japan, South Korea, and Taiwan and other countries that had COVID-19 cases beginning in January 2020 that it was not a serious threat to society. It was known it was a flu-like respiratory illness that was an out of normal danger to only one specific group of people: those with one or more serious underlying health conditions. Predictably, that group is primarily comprised of frail and sickly elderly people. Data from Italy which had the first major outbreak in Europe showed more than 85% of COVID-19 related fatalities were aged 70 or over, 59% were aged 80 or over, and the average age was 80.[352] Of the fatalities 99.2% had one or more pre-existing serious diseases.[353]

The plain truth that COVID-19 is less dangerous for society as a whole than the seasonal flu doesn't get people's blood flowing or sell advertising. Pushing the narrative COVID-19 is a virus that can be lethal for sick people and at worst like the seasonal flu for healthy else wouldn't feed the legacy media's endless hunger for hits, clicks and views of its programs, websites, and Twitter and Facebook posts to generate advertising revenue. If it bleeds it leads is also true to generate readers and sell advertising for the remaining legacy media print publications. The narrative coronavirus is an uncontrolled killer likewise provides hysteria fodder to fuel hits, clicks, views, likes, and retweets for the online content of social media users.

The legacy media's laser like focus on pushing the coronavirus as a lurking menace and its symbiotic relationship with social media was driven home by Bari Weiss' resignation from her position as a writer and editor for *The New York Times'* opinion department on July 14, 2020. In her letter she said Twitter had become the "ultimate editor" of the *Times*:

> "… a new consensus has emerged in the press, but perhaps especially at this paper: that truth isn't a process of collective discovery, but an orthodoxy already known to an enlightened few whose job is to inform everyone else.
>
> Twitter is not on the masthead of *The New York Times*. But Twitter has become its ultimate editor. As the ethics and mores of that platform have become those of the paper, the paper itself has increasingly become a kind of performance space. Stories are chosen and told in a way to satisfy the narrowest of audiences, rather than to allow a curious public to read about the world and then draw their own conclusions. I was always taught that journalists were charged

with writing the first rough draft of history. Now, history itself is one more ephemeral thing molded to fit the needs of a predetermined narrative. …

Part of me wishes I could say that my experience was unique. But the truth is that intellectual curiosity—let alone risk-taking—is now a liability at *The Times*. Why edit something challenging to our readers, or write something bold only to go through the numbing process of making it ideologically kosher, when we can assure ourselves of job security (and clicks) by publishing our 4,000th op-ed arguing that Donald Trump is a unique danger to the country and the world? And so self-censorship has become the norm."[354]

The legacy media's focus on ratings was spotlighted less than two weeks later when Ariana Pekary resigned from her position as a producer for MSNBC's program, "The Last Word with Lawrence O'Donnell." Pekary's July 24, 2020 resignation letter said among other things, "the networks have incentive to amplify fringe voices and events, at the expense of others… all because it pumps up the ratings." Her letter also said in part:

"It's possible that I'm more sensitive to the editorial process due to my background in public radio, where no decision I ever witnessed was predicated on how a topic or guest would "rate." The longer I was at MSNBC, the more I saw such choices — it's practically baked in to the editorial process – and those decisions affect news content every day. Likewise, it's taboo to discuss how the ratings scheme distorts content, or it's simply taken for granted …

"We are a cancer and there is no cure," a successful and insightful TV veteran said to me. …

As it is, this cancer stokes national division, even in the middle of a civil rights crisis. The model blocks diversity of thought and content because the networks have incentive to amplify fringe voices and events, at the expense of others… all because it pumps up the ratings. …

This cancer risks our democracy, even in the middle of a presidential election. Any discussion about the election usually focuses on Donald Trump, not Joe Biden, a repeat offense from 2016. …

… They could contemplate more creative methods for captivating an audience. Just about anything would improve the current process, which can be pretty rudimentary (think basing

today's content on whatever rated well yesterday, or look to see what's trending online today).

… Due to the simple structure of the industry – the desire to charge more money for commercials, as well as the ratings bonuses that top-tier decision-makers earn – they always relapse into their old profitable programming habits." [355]

A vivid example of what Weiss and Pekary were talking about is what happened after President Trump was acquitted by the Senate on February 5. RussiaGate appeared to be waning as a way to attract an audience. The legacy media and the social media mob needed something to take its place. They found that issue in COVID-19.

The media's campaign to fuel chaos about COVID-19 as a driver for hits, clicks and views was exposed on March 9, 2020 by Trish Regan on her Fox Business program: *Trish Regan Primetime*. She said during her opening monologue:

"We've reached a tipping point. The chorus of hate being leveled at the president is nearing a crescendo as Democrats blame him, and only him, for a virus that originated halfway around the world. This is yet another attempt to impeach the president. Sadly, it seems they care very little for any of the destruction they are leaving in their wake. … The hate is boiling over. The liberal media using, and I mean using, coronavirus in an attempt to demonize and destroy the president. … This is impeachment all over again."[356]


Regan was placed on "indefinite hiatus" after that program, and Fox significantly increased its coronavirus coverage. Regan didn't appear on Fox again. On March 27 Fox announced it had "parted ways" with Regan.[357]

The legacy media and social media kept the COVID-19 drumbeat going because it proved to attract eyeballs and it had very long legs. A July 20, 2020 Google search on "COVID-19" returned 5.85 *billion* results, and 1.17 *billion* news stories. Three weeks later, an August 11 search on "COVID-19" returned 15.32 *billion* results, and 1.57 *billion* news stories.

# 11. Aleksandr Lukashenko Directed Belarus' Rational COVID-19 Response

Belarus President Aleksandr Lukashenko was one the world's few leaders to direct a rational national response to COVID-19. From the beginning of the outbreak Lukashenko said it was no more serious of a health threat than the flu, and political and health officials around the world were wildly over-reacting to it as a danger.

On March 18 – five days after President Trump declared a COVID-19 national emergency in the U.S. – Lukashenko was reported as saying in an interview:

> "Despite some criticism on my part, I call this coronavirus nothing other than a psychosis, and I will never deny that, because I've gone through many situations of psychosis together with you, and we know what the results were.
>
> Coronavirus is yet another psychosis, which will benefit some people and will harm others.
>
> But we're living in a specific situation, and naturally, we should proceed from the situation not only in our country, but also outside our country. Why am I behaving this way? Because I am absolutely convinced that panic can hurt us more than the virus itself. That's what concerns me the most."[358]

Those comments mirrored what he said two days earlier in urging local government officials to keep their head cool over coronavirus:

> "You see that the world has gone crazy over coronavirus or maybe over the speculations related to coronavirus. But for us it is not the main and most terrible thing. We have survived viruses before. There were more complicated viruses: swine flue, bird flue, and atypical pneumonia. …Belarusians are doing everything right. Except for one thing: Please, do not run around pharmacies buying masks, uniforms or some medicines."[359]

Belarus did not lockdown, or mandate social distancing or mask wearing.. Life was able to go on as normal with stores, restaurants, schools, churches and sporting venues remaining open. Belarus kept its border open, but everyone entering the country quarantined for 14 days, after which if they tested negative they could freely travel about the country. While he kept his country open Lukashenko said "The civilized world is going nuts,"[360] and he described the restrictions imposed in other countries as "coronapsychosis."

Most other countries locked down and crashed their economy.

Lukashenko was regularly seen in public and he even played with his ice hockey team. Lukashenko told a ONT-TV journalist: "It is better to die on your feet than to live on your knees."[361] Belarus benefited financially from its hockey league continuing to play, while other leagues in the world had stopped. India, Israel, Russia and other countries bought rights to televise their games.[362] It was also the only European country to continue playing soccer, with the Belarusian Premier League beginning its 2020 season in March.

The largest celebration of the year in Belarus and other eastern European countries is Victory Day to commemorate the end of World War II. On May 9 Belarus held its annual parade in the capital of Minsk. Russia had decided to delay its parade, but Lukashenko said it was unthinkable: "In this insane, disoriented world there will be people who will condemn us. Do not rush to draw conclusions, let alone condemn us, the heirs of the victory, the Belarusians ... We simply could not act differently, we had no other choice."[363]

Tens of thousands of spectators lined the parade route. Very few people wore face coverings or other protective measures. One spectator who watched the parade with his wife and eight-year-old son without masks told a reporter: "I don't feel danger, I don't give in to psychosis. There is no fear."[364]


Belarus reaped considerable benefits from continuing to function as normal, while neighboring Russia shut-down as many other countries had done. It was reported in May: "The Belarussian ruble has strengthened 10 percent against the dollar since March, while the Russian ruble has fallen by more than 20 percent. Unemployment in Belarus still stands at just 4 percent, while more than 1 million Russians have lost their jobs in the last two months. Experts predict that Russia might lose almost 10 million jobs because of the coronavirus crisis. And while the Kremlin has earmarked more than 2 trillion rubles ($27 billion) to support the Russian economy, economists say that's just a drop in an ocean of economic suffering."[365]

It was reported on August 17, 2020 that from January-July 2020 the Belarus' GDP declined by 1.6% from the same period in 2019.[366] That was

much less than the GDP decline by its neighboring states that imposed economic shutdowns in panic over COVID-19. Belarus' Prime Minister Roman Golovchenko said at a meeting of officials on July 23, 2020 that "Timely decisions amid the pandemic helped preserve the country's economy."[367]

Belarus' strategy has proven successful, with its number of cases and deaths per 100k population comparable to the countries it borders: Russia; Ukraine; Poland; Latvia; and, Lithuania. While Belarus didn't shut down its economy, society, and schools, it did institute widespread testing, isolated vulnerable elderly people, and mandated 14-day quarantining for everyone coming into the country. It was reported on July 23, 2020 the countries COVID-19 measures cost the country about US$196 million.[368]

Lukashenko revealed during a visit to a military base in Minsk on July 28, 2020 that he "had coronavirus without knowing about it as I showed no symptoms." Lukashenko said: "This is the conclusion that the doctors made yesterday. It was an asymptomatic case. As I have said earlier, 97% of the Belarusians who contract the virus recover without showing any symptoms. Thank heavens, I was one of the asymptomatic ones,"[369]

During an interview with Ukrainian journalist Dmitry Gordon, Lukashenko said: "We have never denied that coronavirus existed. This is the way mass media has presented it. How can we deny what is really here." Lukashenko said he tried to prevent panic among: "If you panic, you lose. The world was going into psychosis, the media was aggravating it by showing reports of excavators being used to dig graves, providing horrendous comments. People in Belarus have been watching it. Then an economic pandemic with oil prices followed and later a political one with the election." [370]

The president explained that he supervised the operation of the healthcare system in dealing with the coronavirus, and that since the end of the Soviet Union: "We have preserved the infectious disease hospitals, we have preserved specialists, education. We have taught such things in universities."[371]

Lukashenko gave a speech on August 7, 2020 to members of Belarus' healthcare system workers during which he said coronavirus involves "political and economic warfare," and is not just a disease outbreak.[372] He knew about the "warfare" first-hand from the pressure put on him by WHO, the IMF, and other international organizations and politicians for Belarus to shut-down like other countries. Lukashenko had expressed similar thoughts on May 29 at the Minsk Tractor Works where he told workers: "The disease is only a half of the coronavirus pandemic, the other half is politics."[373]

Acknowledgment must be given to Aleksandr Lukashenko for having the strength of character to publicly identify the wildly exaggerated reaction to COVID-19 as a psychosis, and providing an oasis of rationality in Belarus from coronavirus insanity that gripped most of the world.

(Lukashenko giving speech on August 7, 2020 that coronavirus isn't just a disease, but "political and economic warfare.")

Lukashenko has been president of Belarus since 1994. He was reelected to another six year term on August 9, 2020.

# 12. Zombie Culture Has Fueled Apocalyptic Coronavirus COVID-19 Hysteria

Fear of COVID-19 circled around the world faster than the virus. Fear of the virus, and not the virus itself drives coronavirus phobia and fact-deficient public policies. Reality is much different than coronavirus fear. That is because for the large majority of people COVID-19 is a phantom virus: it is in the realm of man bites dog stories – you've heard of it but never seen or experienced it. A very small minority of people in the U.S. and other countries personally know a person who has died from COVID-19 or anyone ill enough to have required hospitalization[374] – or even a person ill enough to have missed a day of work. That is because the large majority of people infected with COVID-19 don't know it, and of those that do, the majority are symptom free.

Various horror themes have been a staple of movies since the earliest days of cinema. One of the first horror films was 1896's *House of the Devil* about demonic entities in a castle.[375] Transmogrified human villains include Dracula, Frankenstein, the mummy, werewolves, and zombies.[376] Initially all were portrayed as solitary creatures – but the portrayal of zombies eventually had a unique evolution into a viral worldwide threat to humanity.

*White Zombie* released in 1932 is cited as the first full-length zombie movie. Its theme is a young woman in Haiti dies after drinking a potion, which then acts to bring her back to life by transforming her into a zombie. The movie had a happy ending because after the man behind her drugging died, the heroine was released from her zombie trance and reawakened as a human being.[377]

The zombie as a lone figure was essentially unchanged for 36 years. Then in 1968 George Romero's *Night of the Living Dead* was released. For the first time zombies were portrayed as pack hunters of live human flesh. The trigger for the undead to come back to life from funeral parlors, morgues and cemeteries was radiation from a space probe returning from Venus that exploded in the Earth's atmosphere.

Film critic Roger Ebert wrote in his review after watching *Night of the Living Dead* for the first time during a Saturday matinee: "I don't think the younger kids really knew what hit them. … This was ghouls eating people up – and you could actually see what they were eating. This was little girls killing their mothers. … I felt real terror in that neighborhood theater …. I

saw kids who had no resources they could draw upon to protect themselves from the dread and fear they felt."[378]

The portrayal of zombies as insatiable slow moving fiends persisted for almost 20 years. *The Return of the Living Dead* in 1985 was the first movie that portrayed zombies as predators who can run to capture victims, and not just shuffle around and overwhelm their prey with numbers. In the movie people turn into zombies after becoming infected with a virus that first gives them the symptoms of a cold. They get muscular pain, start shivering, die, and are then reanimated as walking dead hungering to eat human brain.

However, the idea of fast zombies didn't take off until the release in 2002 of *28 Days Later*. Great Britain is ravaged by a hyper-contagious virus that leaves its victims in a state of uncontrollable homicidal rage.

The virus was spread to humans by infected chimpanzees freed from a laboratory in Cambridge by animal liberation activists. Infected animals and even birds can transmit the virus to humans. The zombies are not just fast, but *very* fast.


The idea of a zombie infection outbreak was taken to the next level in 2013 in the big budget *World War Z* starring Brad Pitt. Becoming infected by a single zombie bite in moments transforms a healthy person into a non-human feral, vicious, unthinking beast. The zombies ravenous urge to attack the healthy was aided by their lightening-fast speed. In an interconnected world the zombie virus spread unchecked as civilized society collapsed like a house of cards. Isolated pockets of humans trying to survive. *World War Z* presented the scenario of a planet Earth zombie apocalypse.

While the zombie's power to ravish humankind is terrifying, they have a weakness: they ignore people unsuitable as hosts for viral reproduction, which includes the seriously injured or terminally ill. Discovery of that weakness (by Brad Pitt's character) leads to development of a vaccine from deadly pathogens that shields healthy people from attack by tricking the zombies into sensing they are deathly ill.

*World War Z* was an international box office hit, grossing $202.4 million in North America, and $337.6 million in other countries. With lower admission prices in other countries, many more people outside of North America saw the movie, than inside. Its total gross of over $540 million far exceeding its reported $190 million budget.[379]

The review on RogerEbert.com describes *World War Z* as: "…a globetrotting medical mystery that just happens to feature zombies, with Lane and various helpers, some military and others scientific, trying to figure out what sparked the disease and counter it before the undead overrun everything. It's "Contagion" or "The Andromeda Strain," but with zombies, and without much panache."[380]

The comparison of *World War Z* to *Contagion* – released in 2011 – and *The Andromeda Strain* – released in 1971 – is apropos because they both involve highly contagious deadly viruses and the efforts to identify and contain them. The deadly respiratory virus in *Contagion* originated in bats and was transmitted to humans in Hong Kong. While the microscopic organism causing death from nearly instantaneous blood clotting in *The Andromeda Strain* was extraterrestrial in origin and brought to earth in a research satellite that crashed after being struck by a meteor carrying the microbe. (Somewhat echoing what triggered the zombie outbreak in *Night of the Living Dead.*)

A 2003 publication by the Infectious Diseases Society of America noted *The Andromeda Strain* is the "most significant, scientifically accurate, and prototypic of all films of this [killer virus] genre ... it accurately details the appearance of a deadly agent, its impact, and the efforts at containing it, and, finally, the work-up on its identification and clarification on why certain persons are immune to it."[381]

*Contagion* presented a scenario that has some similarities to what evolved with COVID-19 just nine years later. It involved a contagious virus that was a hybrid of two real-life infections: influenza and NIPAH – which can cause acute respiratory symptoms. The film's hypothetical virus quickly encircled the globe and WHO led the effort to counteract it. *Contagion* had a Hollywood ending of the virus being contained without the survival of humanity being threatened.[382]

Outbreak scenarios of people needing to deal with their fear of a lack of control over a lethal human or non-human threat are a quasi-staple of movies, with the danger heightened by porous borders and rapid worldwide travel. The idea of a zombie apocalypse became so widespread that it became associated with the need for national disaster preparedness.

Dr. Johannes Fehrle wrote in his 2016 article: *Zombies Don't Recognize Borders*:

> In early 2013, Winnipeg Center MP Pat Martin rose in the Canadian House of Commons to inquire of Foreign Affairs Minister John Baird whether the government had any plans in store for a zombie attack. As Martin reminded his fellow parliamentarians, "zombies don't recognize borders," and therefore "a zombie invasion in the United States could easily turn into a *continent-wide pandemic* if it's not contained." … The background behind this exchange is the use of disaster plans in Quebec and the United States that take mock zombie attacks as stand-ins for a variety of disaster scenarios in order to teach preparedness. As part of this strategy, the U.S. Centers for Disease Control and Prevention provides the info comic *Preparedness 101: Zombie Pandemic*, which uses a zombie invasion to inform a younger audience about preparations for natural disasters."
>
> … In a growing number of non-fictional texts, from preparedness brochures to journalistic accounts to scientific papers about simulations of mass panic scenarios, zombies become stand-ins for and personifications of dangers ranging from viral diseases via storms and floods to radiation and panic caused by any variety of factors[]. … Since the zombie genre is so centrally concerned with questions of borders, boundaries, and the attempt to prohibit the movement of infected people into certain areas, it can be brought to resonate in an increasingly globalized world in which a paradox exists between the attempt to minimize the restrictions imposed on the movement of goods through free trade agreements on the one hand, and the regulation of the mobility of people, on the other …
>
> In an age of globalization, outbreak scenarios—regardless of whether the threat is a real disease or the spread of zombification—develop anxieties about a loss of control over the human and non-human environment, which are underlying in older catastrophe narratives, into a realization of the increasing instability of borders, be they national, physical, or social. … As such, these narratives can be read as artistically negotiating concerns about the uncontrolled and ultimately uncontrollable movement across borders of both human and non-human agents. …"[383]

The degree to which the worldwide popularity of the 'respects no borders' zombie narrative overlaps with the 'respects no borders' viral outbreak narrative in the minds of moviegoers is reflected in the response worldwide to COVID-19. Countries around the world tried to isolate

themselves from possibly infected people entering by closing their border. The idea being that stopping infected international travelers from entering would limit the number of people infected within the country. However, the lesson of *World War Z* is the only hope that strategy has of working is if the border is sealed before any infected person enters. One infected person can rapidly lead to hordes of people spreading the infection unchecked.

Many people have internalized fear of COVID-19 as a foreign invader to the degree that they are fanatics about wearing face coverings or social distancing when there is no scientific evidence those things actually provide meaningful protection. They are essentially like Pig Pen's dirty blanket that he tots around to make him feel secure while he sucks his thumb.

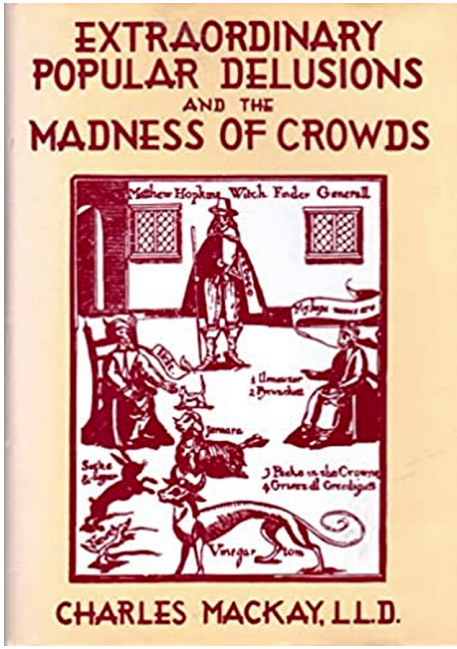
As a meme the coronavirus is so powerful because true believers mentally equate it with the zombie apocalypse depicted in *World War Z*, or a viral contagion such as in *Contagion* or *The Andromeda Strain*. That idea was accepted to a degree that it caused catastrophic human suffering and brought some of the world's largest economies to their knees. People viewed others with suspicion and become alarmed if they got to close to someone they didn't live with. COVID-19 brought to life "public service pronouncements" and attitudes about protecting oneself from the virus as if it was the zombies in George Romero's 2005 zombie movie *Land of the Dead*, which begins with the following dialogue as if it is from a news cast:

> "Unburied human corpses are coming to life and feeding on the living. (man #2)
> *Stay inside*. (woman #2)
> *Do not try to leave your homes*. (man #3)
> They seem to survive by eating human flesh. (man #4)
> Everyone who dies will become one of them. (woman #3)
> If you are bitten, you will just become one of them that much sooner. (woman #3)
> *They're not your neighbors and friends anymore*. (man #5)
> "My wife had a heart attack. Got up and came after me like a banshee from hell." (man #6)
> "I put a curling iron through her head." (man #6)
> "…the head …" (women #4)
> "… the brain …" (man #7)
> "They must be destroyed as quickly as possible. There's no time for funeral arrangements." (woman #4)
> "There no time to dig up holes so you can drop these things in the ground." (man #8)
> "As long as we're alive they ain't never gonna run out of food. They day they do, it'll mean only one thing: We're all dead." (man #9)

"*This is not only a local or a regional phenomenon*." (man #10)
"*Cities are under siege*." (woman #5)[384]

Untold numbers of people literally mentally equated COVID-19 with the spread of a zombie virus after which nothing would be the same – there would be a new normal.

## I – COVID-19 is new chapter for *Extraordinary Popular Delusions*




*Extraordinary Popular Delusions and the Madness of Crowds* is one of the 19th century's most enduringly relevant books. The book published in 1841 is a chronicle of the susceptibility of the public to act on their acceptance of a folly and delusion as real.

The book's most well-known episode is the Dutch tulip mania that peaked in the winter of 1637. Mackay wrote: "Nobles, citizens, farmers, mechanics, seamen, footmen, maidservants, even chimney sweeps and old clotheswomen, dabbled in tulips."[385] The common belief was tulip bulbs are so intrinsically valuable they would continue to increase in price. At the peak a single bulb could sell for the equivalent of up to 15 years of wages for a skilled worker.

Of course, the bubble eventually burst. After peaking on February 3, 1637, within three months the price of tulips declined by more than 99.99%.[386]

Mackay wrote in his Preface:

> "In reading the history of nations, we find that, like individuals, they have their whims and their peculiarities; their seasons of excitement and recklessness, when they care not what they do. We find that whole communities suddenly fix their minds upon one object, and go mad in its pursuit; that millions of people become simultaneously impressed with one delusion, and run after it, till their attention is caught by some new folly more captivating than the first."

> Popular delusions began so early, spread so widely, and have lasted so long, that instead of two or three volumes, fifty would scarcely suffice to detail their history. The present may be considered more of a miscellany of delusions than a history—a chapter only in the great and awful book of human folly which yet remains to be written, and which Person once jestingly said he would write in five hundred volumes!"[387]

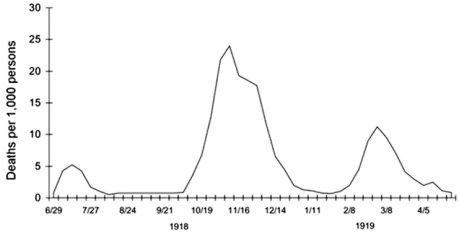
A worthy addition to Mackay's book would be the COVID-19 episode during which enormous numbers of people throughout the world have seemingly been infected with a contagion and gone mad with fear of a virus that substantive evidence proves is less of a threat for healthy people than the seasonal flu. The coronavirus episode shows the raw destructive power of people internalizing the zombie narrative and being induced to project it onto what is in fact a relatively normal real life event.

# 13. Flattening The Curve Was Bogus Argument — Hospital Beds Galore

Flattening the curve became a widely used phrase in March 2020 by media pundits and personalities when discussing COVID-19, and by politicians and government health care officials to justify policy decisions regarding COVID-19. Flattening the curve referred to slowing down the incidence of the population contracting COVID-19 so the health care system – and specifically hospitals, wouldn't become overwhelmed.

Flattening the curve was not presented as a method to reduce the overall number of people becoming infected with COVID-19 or dying from it. Its proponents acknowledged the total number of infected people and deaths before the virus ran its course would not be reduced. It was asserted that flattening the curve would be an effective strategy to extend the period of time over which people would become infected so the number of people needing hospitalization at any one time was reduced to a point hospitals wouldn't exceed their capacity of beds for severely ill COVID-19 patients.

Infection outbreaks of respiratory illnesses such as coronavirus and influenza follow a bell curve: infections, hospitalizations, and deaths go up at a rate of progression and after reaching their maximum they go down at approximately the same rate. The normal infection period is 30 to 60 days for a coronavirus/flu virus outbreak. The bell curve follow the same pattern for each outbreak: the only difference is how many people are infected. Flattening the curve was promoted as a method to reduce the peak of the bell curve and extend the total infections to some months from the normal 30 to 60 days. Even the three waves of the most severe flu pandemic in history – the Spanish flu – followed a bell curve pattern.



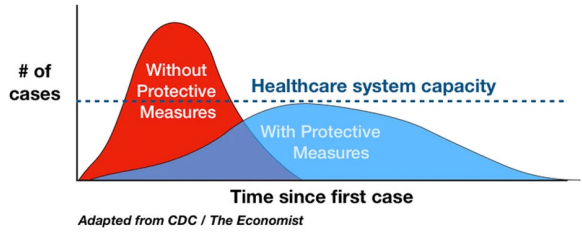

The Spanish Flu (1918-1919) graph (by Jeffery K. Taubenberger & David Morens) shows the bell curve pattern of the three outbreaks.

Mobile or temporary hospitals were set up in several cities, and non-essential medical procedures were delayed/cancelled to increase the number of available hospital beds, based on dire pronouncements about the impending catastrophe that would occur during the peak of the COVID-19 outbreak. However, there was a huge problem with relying on the idea of flattening the curve to hastily make policy decisions: It was an idea without real-world justification. It was based

on non-peer reviewed guesstimate computer models that prophesized catastrophic numbers of hospitalizations and deaths from COVID-19 that didn't reflect reality. (See the chapter: *Computer Medical Models Are Guesstimates, Not Reality*.)

## I – Flattening The Curve Was Mantra For Lockdowns

"Flattening the curve" became the mantra relied on as the medical justification for lockdowns of society instituted by states in the United States, and by many countries around the world. The following graphic illustrates the idea underlying "flattening the curve": reduce the rate of ill people requiring hospitalization to what can be handled by the available facilities:




The Proclamation by Washington Governor Jay Inslee on March 23, 2020 is representative of those made around the country by states wanting to "flatten the curve" by limiting personal activities and commercial and government activity. The policies were driven by fear of inadequate hospital facilities to care for COVID-19 patients. Inslee's Proclamation stated in part:

> "**WHEREAS,** models predict that many hospitals in Washington State will reach capacity or become overwhelmed with COVID-19 patients within the next several weeks unless we substantially slow down the spread of COVID-19 throughout the state; and
>
> **WHEREAS,** hospitalizations for COVID-19 like illnesses are significantly elevated in all adults, and a sharply increasing trend in COVID-19 like illness hospitalizations has been observed for the past three (3) weeks; and
>
> …
>
> **NOW, THEREFORE**, I, Jay Inslee, Governor of the state of Washington, as a result of the above-noted situation, and under Chapters 38.08, 38.52 and 43.06 RCW, do hereby proclaim: that a State of Emergency continues to exist in all counties of Washington State; that Proclamation 20-05 and all amendments thereto remain in effect as otherwise amended; and that Proclamations 20-05, 20-07, 20-11, 20-13, and 20-14 are amended and superseded by this Proclamation to impose a Stay Home – Stay Healthy Order throughout Washington State by prohibiting all people in

Washington State from leaving their homes or participating in social, spiritual and recreational gatherings of any kind regardless of the number of participants, and all non-essential businesses in Washington State from conducting business, within the limitations provided herein."[388]

President Donald Trump's March 13, 2020 "Proclamation On Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak" stated in part:

> The spread of COVID-19 within our Nation's communities threatens to strain our Nation's healthcare systems. As of March 12, 2020, 1,645 people from 47 States have been infected with the virus that causes COVID-19. It is incumbent on hospitals and medical facilities throughout the country to assess their preparedness posture and be prepared to surge capacity and capability. (underlining added)[389]

Flattening the curve was integral to the state and federal strategy to ensure there was sufficient medical facilities for the number of COVID-19 patients predicted by computer models.

## II – COVID-19 Hospitalizations Were Minimal In U.S.

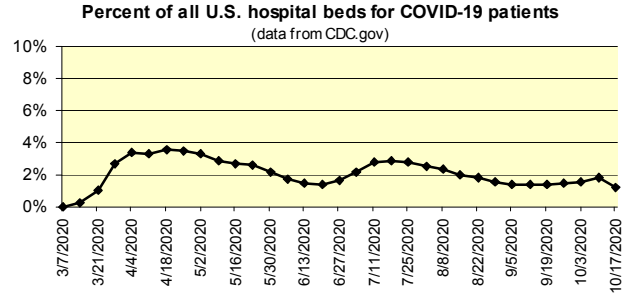
There were 635,800 total COVID-19 hospitalizations nationwide in the U.S. for the almost nine months from January 2020 to October 17, 2020.[390]

Hospitalizations peaked the week ending April 18, 2020, with 33,152.[391]

There are 924,107 staffed hospital beds in the U.S. according to the American Hospital Directory.[392]

Hospitals would be at *only 68% of their bed capacity* if every COVID patient since the first confirmed case in January to mid-October was hospitalized *at ONE time*.

Hospitals were at *only 3.6% of their bed capacity* when the peak of COVID-19 hospitalizations occurred the week ending April 18, 2020. So overall hospitals nationwide were virtually empty of coronavirus patients – and have remained empty of them.




There were up to 740,000 influenza hospitalizations in U.S. for 2019/2020 according to the CDC website.[393] Therefore during the first nine months of the

COVID-19 outbreak, about as many people were hospitalized for COVID as were hospitalized in the U.S. for influenza during the flu season that only lasted a few months. Although the flu was evidently more virulent and much more concentrated in its effect on the population than COVID-19, the CDC has not suggested there was a flu pandemic, because there wasn't – it was a normal flu season.

The abundance of hospital beds available nationally but not needed for COVID-19 is true for the individual states. You can pick a state at random to illustrate the abundance of hospital beds.

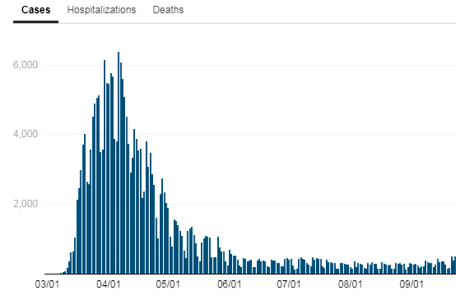
Washington had 7,477 total COVID hospitalizations (through September) and 10,259 hospital beds.[394] 73% of Washington's beds would be used if all COVID patients from January 2020 to the end of September were hospitalized at one time. There were 540,898 discharges from Washington hospitals in 2019, so COVID-19 patients have been 1.4% of that.

Oregon had 2,558 total COVID hospitalization (through September) s and 6,111 hospital beds.[395] 42% of Oregon beds would be used if all COVID patients from January 2020 to the end of September were hospitalized at one time. There were 320,118 discharges from Oregon hospitals in 2019, so COVID-19 patients have been 0.8% of that.

Ohio had 15,516 total COVID hospitalizations (through September) and 27,064 hospital beds.[396] 57% of Ohio's beds would be used if all COVID patients from January 2020 to the end of September were hospitalized at one time.

Florida had the second highest reported positive case rate in the U.S. from January 2020 to the end of September. It had a total of 44,355 COVID-19 hospitalizations (through September), while it has 56,158 hospital beds.[397] 79% of Florida's beds would be used if all COVID patients from January 2020 to the end of September were hospitalized at one time. There were 2,580,636 discharges from Florida hospitals in 2019, so COVID-19 patients have been 1.7% of that.

New York City had the worst COVID-19 outbreak in the country. In New York City the number of cases per day peaked on April 6 and began rapidly falling – 6,366 cases on April 6 and 3,313 seven days later (4-13) (See chart at right).[398] Yet, in the entire run-up to the peak on April 6 fewer people were hospitalized in New York City for COVID-19 *in total* than there were hospital beds in the city: 15,333 *total* hospitalizations and 22,967 hospital



beds.[399] 67% of NYC's beds would have been used if all COVID-19 patients up to the April 6 peak had been hospitalized at one time. The number of COVID-19 hospitalizations at any one time didn't come close to the bed capacity in NYC. That is why –as detailed in the chart below – there were temporary field hospitals set-up in New York City that were *dismantled without having a single patient*.

## III – Emergency Field Hospitals Were Not Necessary

The Army Corps of Engineers contracted with private companies to create emergency field hospitals to handle the overflow of COVID-19 patients that regular hospitals couldn't handle. The following is a chart of field hospitals that shows their location, their cost, the maximum beds, and the total patients served:

| Facility name | Location | Contractor | Total cost | Max beds | Total patients |
|---|---|---|---|---|---|
| SUNY Stony Brook[400] | Stony Brook, NY | Turner Const. Co. | $155,500,000 | 1,038 | 0 |
| SUNY Old Westbury | Old Westbury, NY | AECOM Technical Services Inc. | $118,504,737 | 1,022 | 0 |
| McCormick Place | Chicago | Metro Pier & Expo Authority | $65,526,533 | 3,000 | 37 |
| Westchester County Center | White Plains, NY | Haugland Energy Group LLC | $46,971,895 | 120 | 0 |
| Colorado Conv Center | Denver | ECC Environmental LLC | $34,609,792 | 2,000 | 0 |
| Walter Washington Conv Center | Washington, D.C. | Hensel Phelps Const Co. | $31,793,893 | 443 | 0 |
| Commercial Appeal Building | Memphis, Tenn. | AECOM Technical Services Inc. | $26,134,527 | 40 | 0 |
| Miami Beach Conv Center | Miami Beach, Fla. | The Robins & Morton Group | $25,925,692 | 450 | 0 |
| Sherman Hospital | Elgin, Ill. | Turner Const Co. | $18,255,251 | 283 | 0 |
| Westlake Hospital | Melrose Park, Ill. | Bulley & Andrews | $16,391,366 | 314 | 0 |
| MetroSouth Medical Center | Blue Island, Ill. | Clark Construction Group LLC | $14,989,955 | 350 | 0 |
| Wisconsin State Fair Expo Center | West Allis, Wis. | Gilbane Inc. | $14,912,326 | 530 | 0 |

| Facility name | Location | Contractor | Total cost | Max beds | Total patients |
|---|---|---|---|---|---|
| The Ranch Events Complex | Loveland, Colo. | AECOM Technical Services Inc. | $13,331,415 | 1,007 | 0 |
| Suburban Collection Showplace | Novi, Mich. | Gilbane Federal | $11,754,262 | 1,100 | 6 |
| Javits Center | New York City | NY Conv Ctr Operating Corp | $11,364,953 | 1,900 | 1,095 |
| East Orange General Hospital | East Orange, N.J. | Cutting Edge Group LLC | $10,993,404 | 250 | 0 |
| TCF Center | Detroit | Gilbane Inc. | $9,452,813 | 1,000 | 39 |
| Brooklyn Cruise Terminal[401] | New York City | SLSCO | $21,000,000 | 670 | 0 |
| Billie Jean King Tennis Center[402] | New York City | SLSCO | $19,800,000 | 470 | 79 |
| USNS Comfort[403] | New York City | U S Navy | | 1,000 | 182 |
| CenturyLink Field[404] | Seattle | | | 250 | 0 |
| Soccer Field[405] | Shoreline, WA | | | 200 | 0 |
| Astria Regional Medical Center[406] | Yakima, WA | State leased closed hospital | $1,500,000 | 250 | 0 |
| | | | | | |
| **Total** | | | **$668,712,814** | **17,687** | **1,438** |

It is readily apparent the emergency hospitals were an unnecessary over-reaction. The only ones that had any reasonable number of patients were in New York City, where the hospital system handled the number of COVID patients with no problem. The emergency hospitals in NYC were only used because they were there – with the presence of the Navy hospital ship USNS Comfort described as "irrelevant."[407]

The chart shows the cost of the emergency hospitals was well in excess of $465,030 per patient.

There was no a shortage of beds for COVID-19 patients in New York City at the peak of its outbreak, or anywhere in the United States.

# 14. Case And Death Counts

The unreliability of case, death, and even hospitalization totals is one of the most certain features of the COVID-19 phenomena. There are powerful professional, psychological, and financial incentives to inflate or otherwise pad totals.

## I – Diagnostic and Antibody Testing

Reliable counting of COVID-19 cases depends on the reliability of the tests used to determine if someone has an active infection. Likewise, reliable counting of deaths from COVID-19 depends on accurately determining if it directly contributed to a person's death, and wasn't merely present.

The CDC explains two kinds of tests are available for COVID-19: a diagnostic viral test to detect if a person is currently infected; and an antibody test to detect if a person had a past infection. [408]

There are two types of diagnostic tests: a molecular (RT-PCR) test that detects the virus' genetic material; and, an antigen test that detects specific proteins on the surface of the virus. Samples for PCR and antigen tests are typically collected from a nasal or throat swab. Results can be known from the same day to up to a week later for the molecular PCR test, and within an hour or less for the antigen test.[409] However a CDC instruction guide for PCR testing expresses strong caveats about relying on the accuracy of a PCR test to determine if a person testing positive actually has a COVID-19 infection:

> • Detection of viral RNA may not indicate the presence of infectious virus or that 2019-nCoV is the causative agent for clinical symptoms.
> • The performance of this test has not been established for monitoring treatment of 2019-nCoV infection.
> • The performance of this test has not been established for screening of blood or blood products for the presence of 2019-nCoV.
> • This test cannot rule out diseases caused by other bacterial or viral pathogens.[410]

An antibody test detects antibodies that are made by a person's immune system in response to a threat such as the SARS-CoV-2 virus. A blood sample for an antibody test is typically obtained from a finger stick or a blood draw. Antibodies can take between several days to several weeks to develop after a person develops an infection. They can stay in a person's blood for several weeks or more after recovery. The FDA cautions that "because of this, antibody tests should not be used to diagnose an active coronavirus infection."[411] Having antibodies to the virus that causes COVID-19 may provide protection from getting infected with the virus again.

Antibody test results can be known from the same day to up to three days later.[412] Antibody testing has been used to estimate the percentage of a population that has been infected with a virus – such as COVID-19.[413] However, the FDA acknowledges an antibody test for COVID-19 can also detect antibodies from diseases such as the common cold, so their accuracy is poor at best.[414]

| Topic | PCR (DNA) Test | Antigen Test | Antibody (Serology) Test |
|---|---|---|---|
| Why test used? | PCR tests look for fragments of SARS-CoV-2. | Antigen tests look for fragments of SARS CoV-2 virus proteins. | Serology looks for antibodies against SARS-CoV-2. |
| How test performed? | Nasal/throat swab. | Nasal/throat swab. | Blood sample. |
| What positive test means? | Positive PCR test can mean COVID-19 infection. | Positive antigen test can mean COVID-19 infection. | Positive antibody test can mean antibodies from a past COVID-19 infection are present..[415] |

The accuracy of diagnostic and antibody tests is a key issue.

A diagnostic test may have a false-negative result in a person who is infected but not yet symptomatic, as well as a person whose symptoms are waning.[416] Conversely a false positive can result from a diagnostic (PCR) test of a person previously infected with a coronavirus – even years earlier – by the detection of fragments of dead virus.[417]

False positive antibody tests can be more difficult to identify because they are only intended to identify a person's immunity from a prior infection.[418]

The FDA effectively abandoned its role as a gatekeeper of testing accuracy, by issuing an Emergency Use Authorization that allowed laboratories to market a COVID-19 test without going through normal FDA oversight to ensure it worked. An EUA can be issued by the FDA "in as little as a day, which it has done repeatedly."[419] At least 230 test developers have or are expected to submit EUA's, and more than 110 laboratories have begun using their own tests.[420] The FDA created a loosey-goosey environment that was a breeding ground for the marketing and use of unreliable tests that yield unreliable results.

It wasn't a surprise when the FDA issued an alert in May 2020 concerning the accuracy of the Abbot Labs Rapid ID Now [PCR COVID-19] Test. Researchers found it was inaccurate between one-third and fifty percent of the time – particularly in returning false negatives.[421] There are likely many more tests as inaccurate as the Abbot Labs test.

## Viral load predicts COVID-19 mortality

In March 2020 the Centre for Evidence-Based Medicine published the article "SARS-CoV-2 viral load and the severity of COVID-19." The article states:

> "The initial dose of virus and the amount of virus an individual has at any one time might worsen the severity of COVID 19 disease. Viral load is a measure of the number of viral particles present in an individual. Higher SARS-CoV-2 viral loads. might worsen outcomes, and data from China suggests the viral load is higher in patients with more severe disease. The amount of virus exposure at the start of infection – the infectious dose – may increase the severity of the illness and is also linked to a higher viral load.
>
> The evidence suggests an association of viral dose with the severity of the disease. However, the evidence of the relationship is limited by the poor quality of many of the studies, the retrospective nature of the studies, small sample sizes and the potential problem with selection bias."[422]

The questions concerning sample, size, selection bias, etc. were addressed five months later in an article published in *The Lancet* concerning the relationship between mortality risk and a person's viral load.

In August 2020 *The Lancet* published the first report detailing that a person's viral load of the SARS-CoV-2 virus at the time of diagnosis is a predictor of their mortality risk. Viral load is a measure of the number of viral particles present in an individual. The finding that viral load can predict mortality risk is not surprising because it is "associated with transmission risk and disease severity in other viral illnesses."[423] The study only involved symptomatic hospitalized patients who tested positive. Only patients who were either discharged or died were included in the study. Adjusting for age, sex, race, and pre-existing medical conditions "revealed a significant difference in survival probability between those with high viral load [] and those with low viral load."[424] The study also found that with factors being approximately equal in patients, the survival probability of a person with a low viral load significantly increased over time, compared with a person with a high viral load.

The predicted survival difference over time is substantial:

- 33% higher survival probability 20 days after diagnosis.
- 40% higher survival probability 40 days after diagnosis.
- 62% higher survival probability 60 days after diagnosis.[425]

There is evidence a positive test needs to be accompanied by a viral load analysis for a meaningful evaluation of the seriousness of a person's

infection. Particularly in high risk persons the viral load can suggest the level of care they should be afforded: a low viral load indicates a much less serious infection and a lower level of necessary care, while a high viral load suggests a much higher mortality risk and thus a higher level of care is required.

## II – COVID-19 Death Counting

There are irregularities related to the counting of deaths attributed to COVID-19 in countries and states. Those irregularities are to be expected considering the guidelines of both WHO and the CDC for attributing a death to COVID-19.

### WHO guidelines

The WHO's guidelines allow for certifying COVID-19 as a cause of death when it isn't known if the virus was the cause, or even if it is only believed to have contributed to the death and not actually caused it. The WHO's "International Guidelines For Certification And Classification (Coding) Of COVID-19 As Cause Of Death" states:

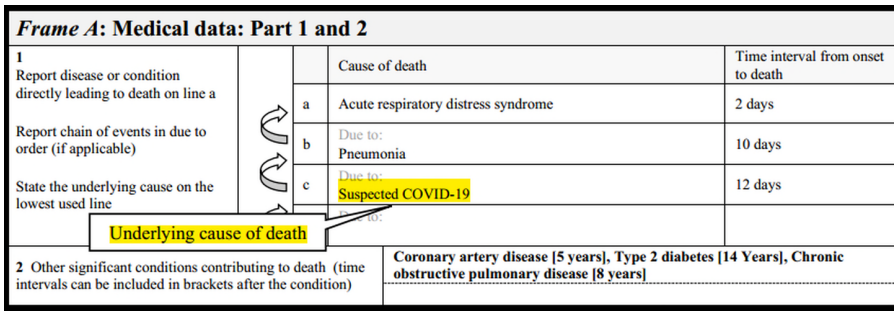
> 2. Definition For Deaths Due To COVID-19
>
> A death due to COVID-19 is defined for surveillance purposes as a death resulting from a clinically compatible illness, *in a probable or confirmed COVID-19 case*, unless there is a clear alternative cause of death that cannot be related to COVID disease (e.g. trauma).
>
> …
>
> A death due to COVID-19 may not be attributed to another disease (e.g. cancer) and should be counted independently of preexisting conditions that are suspected of triggering a severe course of COVID-19.
>
> 3. Guidelines For Certifying COVID-19 As A Cause Of Death
>
> In view of COVID-19 it is important to record and report deaths due to COVID-19 in a uniform way.
>
> A- Recording COVID-19 On The Medical Certificate Of Cause Of Death
>
> COVID-19 should be recorded on the medical certificate of cause of death for ALL decedents where the disease caused*, or is assumed to have caused, or contributed to death*.[426]

That definition leaves the door open for significant inflation of the number of reported deaths by countries all over the world, because it allows for inclusion of people assumed to have died from COVID-19 or may have merely contributed to their death.

Thus, if a person has a pre-existing serious heart condition, then acquires

COVID-19 and later dies, under WHO guidelines it would be classified as a COVID-19 death. The same for diabetes, a respiratory illnesses like pneumonia, or any other serious underlying health condition.

The guidelines also illustrate how to list COVID-19 as a "Cause of death" when it is merely "suspected" of causing a death. As shown in the screenshot below, the WHO guidelines detail how to list "Suspected COVID-19" as the *underlying cause of death* on the "International Form of Medical Certificate of Cause of Death" – when a person was also suffering from *five comorbidities*: Pneumonia; Acute respiratory distress syndrome; Coronary artery disease; Type 2 diabetes; and, Chronic obstructive pulmonary disease.[427] That type of person on death's door from multiple serious medical conditions is counted as a COVID-19 death on the WHO's Internet COVID-19 Dashboard. With that kind of definition inflation it is no wonder the WHO's COVID-19 death toll has exceeded one million.



***Frame A*: Medical data: Part 1 and 2**

| | | Cause of death | Time interval from onset to death |
|---|---|---|---|
| 1 Report disease or condition directly leading to death on line a | a | Acute respiratory distress syndrome | 2 days |
| Report chain of events in due to order (if applicable) | b | Due to: Pneumonia | 10 days |
| State the underlying cause on the lowest used line | c | Due to: Suspected COVID-19 | 12 days |
| Underlying cause of death | | | |
| 2 Other significant conditions contributing to death (time intervals can be included in brackets after the condition) | | **Coronary artery disease [5 years], Type 2 diabetes [14 Years], Chronic obstructive pulmonary disease [8 years]** | |

To its credit, the WHO guidelines do state that a person who person who tested positive for COVID-19 but died in a "Motor vehicle accident" or died from "Myocardial infarction: (heart attack)" should not be classified as a COVID-19 death.[428]

## CDC guidelines

President Trump declared a COVID-19 national emergency on March 13, 2020. Eleven days later, on March 24, the CDC adopted new data collection and fatality reporting guidelines unique to COVID-19 that went into effect immediately. The new death certificate ICD for COVID-19 was U07.1. It was ordered for COVID-19 to be coded on a death certificate as a cause of death when without confirmation it was "*assumed* to have caused or contributed to death."[429] Furthermore, it was ordered that "If the death certificate reports terms such as "probable COVID-19" or "likely COVID-19," these terms would be assigned the new ICD code."[430] Thus that death would be classified as a COVID-19 fatality. It was acknowledged the new guidelines would significantly increase the number of deaths attributed to COVID-19: "the rules for coding and selection of the underlying cause of

death are expected to result in COVID-19 being the underlying cause more often than not."[431]

The March 24 guidelines were important because it made attributing a death to COVID-19 different than for all other causes of death: Assigning a cause of death is based on the 2003 CDC's *Medical Examiners' & Coroners' Handbook on Death Registration and Fetal Death Reporting*,[432] and the CDC's *Physicians' Handbook on Medical Certification of Death*.[433]

Under the new CDC guidelines States were specifically directed to report as a COVID-19 death:

- People whose cause of death is reported as COVID-19;
- People whose "presumed" cause of death is COVID-19;
- People whose "probable" cause of death is COVID-19;
- People can be reported as a COVID-19 death with or without laboratory confirmation.[434]

Those guidelines predictably inflates the number of reported deaths since it ensures an unknown number of people will be included whose death wasn't caused by COVID-19. Deborah Brix said at a White House meeting in May 2020 she was concerned the CDC's reported deaths were up to 25% too high. She told CDC Director Robert Redfield: "There is nothing from the CDC that I can trust."[435]

Brix said during a previous task force meeting: "There are other countries that if you had a pre-existing condition, and let's say the virus caused you to go to the ICU [intensive care unit] and then you have a heart or kidney problem. Some countries are recording that as a heart issue or a kidney issue and not a COVID-19 death."[436]

### CDC reported COVID-19 deaths

The CDC reports 7,096 people in the U.S. have died solely because of COVID-19 as of October 21, 2020. Those people had no known serious life-threatening underlying health issue.[437]

The CDC also reports 196,639 deaths of people with an average of 2.6 serious underlying medical conditions, in addition to testing positive for COVID-19.[438]

With 2,150,188 deaths in the U.S. from all causes to date in 2020, COVID-19 isn't even in the top 15 as a sole cause of death[439]

### CDC reporting policies overinflate COVID-19 deaths by 1,000%

The CDC adopted new death certificate guidelines in March and April 2020 that are estimated to have inflated COVID-19 deaths by about 1,000%. A July 2020 paper states: "Had the CDC used its industry standard, *Medical Examiners' and Coroners' Handbook on Death Registration and Fetal Death Reporting Revision 2003,* as it has for all other causes of death for the last 17

years, the COVID-19 fatality count would be approximately 90.2% lower than it currently is."[440]

Somewhat mysteriously the new death reporting guidelines were adopted in private without input by qualified professionals. The author's state in their paper: "On March 9, 2020 CNBC reported on comments by a CDC director: "This seems to be a disease that affects adults and most seriously older adults. Starting at age 60, there is an increasing risk of disease and the risk increases with age. People with diabetes, heart disease, lung disease and other serious underlying conditions are more likely to develop "serious outcomes, including death."[441]

The author's wonder aloud: "The CDC knew in early March that the vast majority of fatalities would be in people over 60 with comorbidities… Why would the CDC adopt new rules for reporting fatalities when they already had successful guidelines?"[442]

The authors state that if the standard death reporting guidelines had been applied, thus reducing COVID-19 fatalities by 90.2%, "questions would be non-existent regarding schools reopening and whether or not Americans should be allowed to work."[443]

The paper's authors applied the death reporting standard used for all other causes of death to the only seven states then publishing comorbidity data.[444] Regarding the irregularities used to inflate COVID-19 deaths they state: "Without the March 24th NVSS guidelines or the April 14th CSTE position paper adoption, COVID-19 would NOT be allowed to be listed on a death certificate at all WITHOUT A POSITIVE LAB TEST or confirmatory pathologic autopsy findings."[445]

There were approximately 14,763 actual COVID-19 deaths at the time the authors paper was published on July 24, based on their estimate the 150,640 deaths the CDC reported was overstated by 90.2%.[446]

There were approx. 18,739 actual COVID-19 deaths as of September 30 – instead of the CDC's reported 191,211 – based on the analysis the CDC inflated the death total by more than 1,000% by putting its foot on the mortality scale.[447]

Based on 18.7k deaths, COVID-19 isn't even in the top 15 causes of death in the U.S. – and it doesn't remotely qualify as an epidemic, much less a pandemic.

Ironically, the authors of that paper may have actually *over-stated* that 9.8% of people reported to have died from COVID-19 died from the virus. The CDC COVID-19 Comorbidities webpage states: "For *6%* of the deaths, COVID-19 was the only cause mentioned." [448] Thus, with no comorbidity their identifiable cause of death is the virus. The CDC reports that the unhealthy 94% who died testing positive for COVID-19 had an average of

2.6 comorbidities.[449] So it is possible that 14,473 people died because of COVID-19 as of September 30 – and not the 191,211 reported on the CDC website who died *with the virus*. However, that may even be an overstatement of COVID-19 deaths, because the CDC's table of deaths with comorbidities shows that only 6,402 deaths were absent any comorbidity.[450] That is just 0.003% of all U.S. deaths.

### United Kingdom

On July 17, 2020 the British government put a hold on releasing daily COVID-19 death updates after questions were raised about the way Public Health England counts those deaths. The hold was announced on the UK government's website that stated: "Currently, the daily deaths measure counts all people who have tested positive for coronavirus and since died, with no cut-off between time of testing and date of death. There have been claims that the lack of cut-off may distort the current daily deaths number. We are therefore pausing the publication of the daily figure while this is resolved."[451]

After that the government's coronavirus daily update webpage acknowledged that people had been reported as a COVID-19 death, when it is not known if they died from the virus:

> "Coronavirus deaths and cases give a sense of the spread of the epidemic. Deaths are counted where a lab-confirmed positive coronavirus test result is reported in any setting. This means that not all deaths reported here are caused by coronavirus. Further information is available in the 'Notes on deaths figures' section.
>
> The Office for National Statistics (ONS) publishes further statistics of deaths with breakdowns. This covers death registrations where coronavirus was mentioned, so will include deaths where a person did not have a lab-confirmed positive result."[452]

On August 12, 2020 the U.K. government announced that following a review by Public Health England, the methodology used to calculate the daily data on COVID-19 deaths would change and apply to reporting across the U.K. The new standard is "Deaths in people with COVID-19 that occurred within 28 days of testing positive will be published daily."[453]

An analysis of data in England found that 88% of deaths that had been attributed to COVID-19 occurred within 28 days of a positive test. That resulted in a reduction of the U.K.'s deaths reported to WHO by 5,459, to 41,329 as of August 12.[454]

The government also announced two other changes: A new weekly set of figures would be published showing the number of deaths occurring within 60 days of a positive test; and, Deaths occurring after 60 days would be

added to that total if COVID-19 appears on the death certificate. That additional death total would provide an additional measure of COVID-19's impact over time.[455]

### Czech Republic

Sixty percent of deaths recorded in Czech Republic (Czechia) coronavirus statistics are of people whose death was not primarily due to COVID-19, according to Institute of Health Information and Statistics (ÚZIS) director Ladislav Dušek.[456]

Dušek told attendees of a conference at the University of Prague that most people who died with COVID-19 had other very serious chronic diseases that include heart disease, respiratory system issues, diabetes, and digestive system problems.

Dušek's comments came at a time when coronavirus death figures were being questioned by people around the world as erroneously including deaths of people who actually died from one or more comorbidities. That was suggested by people whose death was attributed to COVID-19 were of an age when underlying health conditions are common: One-third of all deaths in Czechia were of people over 85 years of age; more than a third were in the 75 to 84 age group; and almost a quarter were 65 to 74 years old. Only one deceased person was under 34.[457]

The question of how many deaths are actually attributable to COVID-19 is important to determining when lockdowns in many countries should end.

### Russia

It can be surmised that Russia enforces stricter protocols of what it classifies as a COVID-19 death than the U.S., simply from the fact that compared with the U.S., Russia has had less than one-quarter the number of deaths per 100k people. Russia has widespread testing, yet it has less than 2/5 the number of positive tests per 100k people as the U.S. (As of October 10, 2020):

- Russia – 14.4 deaths per 100k people
- U.S. – 63.8 deaths per 100k people

- Russia – 881 cases per 100k people
- U.S. – 2,274 cases per 100k people[458]

Yelena Malinnikova, Russia's Health Ministry's chief of infectious diseases, has said the relatively low mortality was due to testing and quick detection.[459]

### New York State

In mid-April New York City added 3,778 deaths of people who had never tested positive for COVID-19, but were presumed to have had it. That

increased the number of deaths in NYC from 6,589 to 10,367.[460] At the same time, New York City's Health Department announced said it will now count any fatality deemed a "probable" coronavirus death, defined as a victim whose "death certificate lists as a cause of death 'COVID-19' or an equivalent."

Listing people as dying from COVID-19 is also compromised by the extreme percentage of people who died with COVID-19 who had a life-threatening comorbidity. Data shows 99.3% of people in New York City who died with COVID-19 had one or more serious comorbidities.[461] Those comorbidities included: "lung disease, asthma, heart disease, a weakened immune system, obesity, diabetes, kidney disease, liver disease and cancer."[462] So regardless of whether a person's death was caused by COVID-19 or they just happened to have it at the time of their death, it is listed as a COVID-19 death.

### Washington State

Inflation of COVID-19 deaths by the Washington State Department of Health (DOH) was exposed on May 18, 2020 by the Washington Freedom Foundation.[463] It published a report on its website that documents obtained by public records requests revealed the DOH was counting in its COVID-19 death total persons who tested positive for the virus but were known to have died from other causes. Only 82% of the states reported deaths had COVID-19 listed it as a cause of death on a person's death certificate – 681 of 828 reported deaths.[464] Five percent of the reported deaths (41) were of people whose death certificate listed COVID-19 as a "significant condition contributing to death," but not the cause. Thirteen percent of the deaths (106) were of people who didn't have COVID-19 listed anywhere on the death certificate.[465] Included were persons who died from gunshot wounds.

It was also disclosed the DOH intended to inflate the number of COVID-19 deaths even more by counting suspected but unconfirmed COVID deaths in its total.

During a press conference Governor Jay Inslee called the Freedom Foundation exposure of the death over-counting as "dangerous," "disgusting" and "malarkey." He also accused the Freedom Foundation of "fanning these conspiracy claims from the planet Pluto" and not caring about the death of people from COVID-19.[466]

On May 21, 2020 the Washington DOH confirmed the state was counting every death of a person who tests positive for COVID-19 as a COVID-19 death – even when the person's cause of death is plainly from something else such as a gunshot to the head, suicide off a building, drowning, etc.[467] The DOH also said it doesn't really know how many deaths are due to COVID-19.

The DOH confirmed it plans to begin counting "probable" deaths from COVID-19 when presence of the virus has "not been confirmed by a lab test."[468]

On July 13 the DOH changed its policy from classifying everyone who dies with the virus and a person who "probably" had it to classifying deaths into five categories: Confirmed; probable; pending; suspect; and non-COVID-19-related.[469] Of the five categories, only one – "confirmed" – is of a person identified as having the virus at the time of their death. Following the change the DOH began removing some deaths from its COVID-19 total: removing at least 44 as of July 15.[470]

### Colorado

After news reports disclosed it had been inflating the number of COVID-19 deaths, on May 15, 2020 the Colorado Department of Health and Environment announced it would begin only counting people whose death was thought to be contributed to by the virus. Just as in Washington and other states, Colorado had been reporting on its website every death by a person who tested positive as a COVID-19 death. The DOH reduced its number of COVID-19 deaths by almost 300 – from 1,150 to 878 – after going back and changing how it had coded deaths.[471]

Governor Jared Polis' office issued a statement: "The Governor applauds efforts to ensure that we are as transparent as possible with our reporting and therefore fully supports efforts by CDPHE to specify how many deaths are specifically due to COVID-19 and not just specific to CDC guidelines that include people who died with Coronavirus but not necessarily from it."[472]

## III – COVID-19 Case Counting

There are multiple ways COVID-19 case counts can be inaccurate. Those include:

- False positives;
- False negatives;
- Over-counting negative cases;
- Over-counting positive cases;
- Counting "probable" or "suspected" untested cases as infectious positives.

The last one – probable or suspected untested cases – was fueled with nitroglycerin by the CDC's adoption on April 14, 2020 of the Council of State and Territorial Epidemiologists (CSTE)'s unique COVID-19 data collection guidelines that allows reporting of "probable" cases, hospitalizations, and fatalities.[473] The guidelines allow for the classification of a COVID-19 case:

- *without* a confirmatory laboratory test;
- based on evidence as minimal as a *single cough*, or shortness of breath, or difficulty breathing;
- based on evidence of *being within 6 feet of a "probable" infected person* for 10 minutes or more;
- based on evidence of traveling in an area with an infection outbreak (even of people "probably" infected).[474]

Furthermore, the guidelines don't prevent the same person from being counted multiple times as a "new" COVID-19 case based on being tested multiple times (E.g., a person testing positive upon admittance to a hospital can be counted as a new COVID-19 case after retesting everyday and until their discharge.).

### U.S. COVID-19 case guidelines

CDC guidelines state "A COVID-19 case includes confirmed and probable cases and deaths."[475] The CDC defines a probable case or death as:

- A person meeting clinical criteria AND epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19;
- A person meeting presumptive laboratory evidence AND either clinical criteria OR epidemiologic evidence;
- A person meeting vital records criteria with no confirmatory laboratory testing performed for COVID-19.[476]

That definition was consistent with an interim COVID-19 position statement issued by the Council of State and Territorial Epidemiologists on April 5, 2020. That position statement included a case definition and made COVID-19 a nationally notifiable disease.[477] The CSTE's Clinical Criteria for a probable case are:

• At least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)
OR
• At least one of the following symptoms: *cough*, shortness of breath, or difficulty breathing
OR
• Severe respiratory illness with at least one of the following:
Clinical or radiographic evidence of pneumonia, OR
Acute respiratory distress syndrome (ARDS).
AND
• No alternative more likely diagnosis.[478]

Thus CDC guidelines permit the counting of a COVID-19 case that is not laboratory confirmed, and merely presumed. The inexactness of the process is one justification for Deborah Brix expression of concern during a White House meeting in May 2020 that the CDC's reported cases were up to 25% too high.[479]

### WHO case counting

WHO guidelines state: "All suspect cases should be tested to determine if they are a *confirmed* case. Until proven negative, all suspected cases should remain in the COVID-19 care pathway. If testing is not available, the person becomes a probable case (based on clinical suspicions)."[480]

Unlike the CDC, the WHO's policy is to only report cases confirmed by testing. The WHO's online Coronavirus Disease (COVID-19) Dashboard only includes confirmed cases in its country totals. Of course, the accuracy of the reported numbers depends on the accuracy of the testing.

### Multiple counting of same positive hospital patient

It has been reported that repeated tests of a person are counted as through they are from separate persons. There have also been reports that hospital patients tested multiple times have had each test counted as they from a separate person. A guest on *The Ingraham Angle* stated on the July 15 program:

> "We have this huge discontinuity in the data around June 10 where you can just see the number of positives and the number of tests take off everywhere in the country. And, you know, states were told to do this. The panic purveyors [were saying] that you have to test everyone: 'Mass testing is the greatest'. Then we start seeing these huge numbers of tests, including huge numbers of positives. And it's 'Oh, my God, panic. Shut everything down again based on those numbers.' But a lot of the tests are repeat tests."[481]

### Uncounted cases

CDC Director Robert Redfield stated during a news conference that it is estimated the actual number of COVID-19 infections is "likely 10 times the number of reported cases."[482] With 7.96 million cases reported as of October 16, 2020, that would mean the actual number of cases has been approximately 79.6 million – which is about 24% of the U.S. population.[483] Presumably those are uncounted cases because the infected person was asymptomatic or had such mild symptoms they thought they had a cold.

## People miscounted as positive cases due to oversensitive PCR tests

In late August 2020 it was reported that data from New York, Nevada, and Massachusetts shows binary (positive or negative) COVID-19 PCR tests are so sensitive that up to 90% of people who test positive should actually be considered negative because they have such a tiny amount of genetic material that they are both asymptomatic and not contagious. Thus they are counted as positive even though they pose no risk to others and have no need to be isolated.[484]

A person can test positive with a PCR test for presence of the SARS-CoV-2 virus in their DNA, but be negative for the COVID-19 disease because it is not active and they do not have any symptoms– and thus that person is not a real case.

The situation of very large numbers of healthy being classified as positive for COVID-19 was created by increasing the sensitivity of PCR (Polymerase chain reaction) tests. "Most testing companies have chosen the outrageously high sensitivity limit of 40 PCR cycles – meaning that the DNA in a sample is exponentially increased 40 times in order to amplify its signal."[485] That degree of sensitivity allows very faint traces of a dead virus, or even leftovers from previous infections that are no longer contagious, to register as a positive test result. "Professor Juliet Morrison, a University of California virologist, said that even a limit of 35 PCR cycles is too high, let alone 40. She said she was "shocked that people would think that 40 could represent a positive."[486] In other words the PCR test identifies the presence of genetic material in a person that could be an artifact many years old, and not the presence of a live active virus.

The coronavirus testing companies have been, and are continuing to put both feet on the scale to inflate the number of positive tests. As Morrison alluded to, there is nothing accidental about the inflation of positive test results, it was done by design.

The hyper-sensitive PCR binary tests are effectively worthless for diagnostic purposes because they not only provide no information about a person's COVID-19 contagiousness, but they only detect the presence of DNA and not the SARS-CoV-2 virus. Consequently, the PCR tests unnecessarily lump the overwhelming majority of people who test positive but pose no danger to anyone – including themselves – in with people who could in fact become ill or possibly infect others.[487]

Thus media reports about a significant rise in cases – which are in fact overwhelmingly harmless –mislead the public and sustain support for medically unnecessary and economically harmful government mitigation policies. Because such large numbers of harmless and healthy people are

misleadingly being reported as positive, the scale of the COVID-19 outbreak is dramatically less than what people around the world have been led to believe. Cutting the number of reported cases by 90% or more to reflect the relatively small number of actual cases, shows there was no medical justification for the mass coronavirus scare and draconian government suspension of rights, imposition of lockdowns and quarantines, or even mass testing and proposed vaccinations.[488]

The magnitude of the damage caused by the egregiously misleading testing and inflated case numbers is immense. Because of it "the might of the world's scientific establishment is trained with the zeal of a Witchfinder General on one particular microscopic particle. Not even one that's most likely to kill you; the latest data show it is the eighth most common cause of death in England, and it doesn't make the top ten in Wales."[489]

### PCR test inappropriate to use as virus diagnostic tool

The inarticulateness of the PCR test as a diagnostic tool was explained in the April 2020 article *Was the Was the COVID-19 Test Meant to Detect a Virus?*: "The reason is that the intended use of the PCR was, and still is, to apply it as a manufacturing technique, being able to replicate DNA sequences millions and billions of times, and not as a diagnostic tool to detect viruses."[490]

Kary Mullis invented the PCR test in 1983. Mullis passed away in 2019 so he was unable to comment directly on the use of PCR as a world-wide tool for coronavirus testing. However, it is likely he would have had extreme misgivings, if not outright opposition, because the PCR test was not intended to identify a person was ill with a virus. Mullis explained this in commenting about HIV: "PCR made it easier to see that certain people are infected with HIV, and some of those people came down with symptoms of AIDS. But that doesn't begin even to answer the question, 'Does HIV cause it?'"[491]

Mullis also had opinions about viruses in general that were counter to orthodox thought: "Human beings are full of retroviruses. We don't know if it is hundreds or thousands or hundreds of thousands. We've only recently started to look for them. But they've never killed anybody before. People have always survived retroviruses."[492] Mullis said about HIV – which equally applies to COVID-19: "The mystery of that damn virus has been generated by the $2 billion a year they spend on it. You take any other virus, and you spend $2 billion, and you can make up some great mysteries about it too."[493]

### Tanzania – goat and paw paw fruit test positive for COVID-19

Tanzania's President John Magufuli has a doctorate in chemistry. He described imported coronavirus testing kits as faulty after they returned positive test results for multiple different non-human samples. Magufuli had

been alerted tests provided by the World Health Organization (WHO) might be inaccurate. To determine their accuracy, he had security forces submit random samples from a goat, a sheep, a papaya, a pawpaw, and vehicle oil to Tanzania's National Referral Laboratory for blind tests. The technicians were not aware Magufuli was behind the tests or they were non-human samples. The samples were given human names and ages to ensure they would be treated the same as any other sample submitted for coronavirus testing. The goat, papaya, and the pawpaw (fruit in photo) samples came back positive for coronavirus.[494] Magufuli then suspended the head of the laboratory.

After receiving the test results, Magufuli blamed a spike in coronavirus positive cases on the faulty test kits.[495]

Magufuli also ordered the WHO's representative out of the country.[496] Tanzania has not reported any Coronavirus data to the WHO since May 9, 2020.[497]

### Florida – 100% COVID-19 positive tests reported

In mid-July 2020 it was publicly reported that since mid-March the Florida Department of Health had been listing multiple laboratories in the state as having 100% positive test results for COVID-19. The Florida DOH's daily coronavirus summary on March 16 included results from 42 labs with 29 listed as either reporting 100% positive or 100% negative tests.[498]

The Lee Health hospital system disputed the state's reporting that 100% of its tests were positive, and publicly disclosed its laboratory testing had actually shown a positive rate of about 18%. The DOH blamed the problem on laboratories failing to report the number of negative results, and "began working with those labs to ensure that all results were being reported in order to provide comprehensive and transparent data."[499]

A broadcast report by OANN reporter Pierson Sharp on July 22, 2020 stated:

> "Reports are coming in that hospitals are intentionally inflating their numbers of COVID-19 patients. An investigation of hospitals in Florida reveals that health authorities were misreporting the number of positive patients all over the state. Hospitals were reporting a 100% positivity rate in infections and numerous labs claimed every single patient that came in was testing positive for coronavirus. On Friday alone, 98 different labs reported 100% positivity rates and experts say that's very concerning and means the results are likely inaccurate, and cannot be trusted. One testing site CentraCare reported 83 people were tested and all 83 were positive for Coronavirus. Something health officials say is extremely unlikely.

Yet, when investigators contacted hospitals like Orlando Health which was reporting a 98% positivity rate, the hospital admitted there were errors in their report. The actual positivity rate wasn't 98% as they had claimed, but just 9%. And at the Orlando Veterans Medical Center 76% of patients were testing positive, but it turns out that was an error as well, and in reality just 6% were positive. Most absurdly, last week even a man killed in a motorcycle accident in Florida's Orange County was reported as dying from Coronavirus. When questioned about it, health officials wouldn't reveal whether the man's death was removed from the overall Coronavirus death count in the state. According to the Florida Department of Health, although labs are required to report negative results, many haven't been and these are now being investigated. But Florida's not alone, and similar cases are popping in other states as well." [500]

### Connecticut – people without COVID-19 test positive

OANN reported on July 22, 2020: "In Connecticut a state lab found that 90 patients who tested positive for Coronavirus last week actually didn't have the virus. The state Department of Health revealed there was a flaw in the testing leading to false positives. This is especially concerning since the testing method is from a widely used process the state adopted in June. Meaning there are likely many other cases of virus-free patients testing positive." [501]

### Rhode Island – false positives for people without COVID-19

OANN reported on July 22, 2020: "And in Rhode Island another 113 patients without any Coronavirus at all tested positive at a private lab based in New York. Health officials say the patients received false positives results and the testing method is being investigated. Based on these examples alone, it's clear that testing facilities and hospitals are likely significantly inflating Coronavirus cases. That means despite the dramatic reports from the mainstream media, the true number of cases is likely much lower than what's being reported. Pearson Sharp, One American News."[502]

### False positive COVID-19 tests jeopardize pro sports events

The plague of false positives also infects pro sports. The Indianapolis Colts NFL team closed its practice facility on the morning of Friday, October 16, 2020, after four individuals tested positive for COVID-19. Practice stopped for the game on Sunday against Cincinnati stopped. The positive results were found to be erroneous when the four samples were retested in the afternoon and confirmed to be negative. The Colts' issued a statement: "…the team will open the practice facility this afternoon under the league's intensive protocol and will continue preparation for Sunday's game against Cincinnati."[503]

# 15. Masks, Social Distancing, Societal Quarantines And Other Mitigation Strategies Are Ineffective To Retard COVID-19 Deaths

A 2006 article on mitigation measures to control an epidemic virus outbreak cautioned:

> "Experience has shown that communities faced with epidemics or other adverse events respond best and with the least anxiety when the normal social functioning of the community is least disrupted. Strong political and public health leadership to provide reassurance and to ensure that needed medical care services are provided are critical elements. If either is seen to be less than optimal, a manageable epidemic could move toward catastrophe."[504]

There is no scientific consensus that wearing masks, social distancing, surface cleaning, hand washing, closing non-essential businesses, limiting business hours, and other mitigation strategies are efficacious in reducing COVID-19 deaths. Even more to the point is there is an absence of compelling scientific data establishing they are effective to retard contracting or transmitting the virus. There is no scientific basis for anyone to have confidence that, for example, wearing a mask is going to protect them from contracting an influenza-like respiratory virus such as COVID-19.

## I – Face Masks

"Seriously people – STOP BUYING MASKS!
They are NOT effective in preventing general public from catching #Coronavirus."
Tweet by U.S. Surgeon General Jerome M. Adams on February 29, 2020

The idea of wearing a face mask to protect against infecting someone with COVID-19, or to prevent oneself from being infected is a surprisingly contentious issue. It is surprising because the science is clear that face masks are ineffective to prevent the transmission or reception of an airborne respiratory virus such a COVID-19. Neither the wearer or people they come into contact with is protected. Face masks are derisively called face diapers or nappies.

Masks are most obviously unnecessary outside because the viral load due to quick dispersal in the open air is too low to be expected in the most extreme situation to infect a person. For the same reason the carbon dioxide

humans exhale doesn't cause the death of people standing next to them because it quickly disperses to an insignificant concentration.[505]

### 2020 review found no reduction in flu transmission with face masks

The May 2020 issue of the CDC's peer reviewed publication *Emerging Infectious Diseases* published an article by seven researchers that states regarding face masks:

> "In our systematic review, we identified 10 [randomized controlled trials] that reported estimates of the effectiveness of face masks in reducing laboratory-confirmed influenza virus infections in the community from literature published during 1946–July 27, 2018. *In pooled analysis, we found no significant reduction in influenza transmission with the use of face masks*. … One study evaluated the use of masks among pilgrims from Australia during the Hajj pilgrimage … Two studies in university settings assessed the effectiveness of face masks for primary protection by monitoring the incidence of laboratory-confirmed influenza among student hall residents for 5 months. *The overall reduction in [Influenza Like Illness] or laboratory-confirmed influenza cases in the face mask group was not significant in either studies*. Study designs in the 7 household studies were slightly different: 1 study provided face masks and P2 respirators for household contacts only, another study evaluated face mask use as a source control for infected persons only, and the remaining studies provided masks for the infected persons as well as their close contacts. *None of the household studies reported a significant reduction in secondary laboratory-confirmed influenza virus infections in the face mask group*.
>
> Disposable medical masks (also known as surgical masks) are loose-fitting devices that were designed to be worn by medical personnel to protect accidental contamination of patient wounds, and to protect the wearer against splashes or sprays of bodily fluids. … *Our systematic review found no significant effect of face masks on transmission of laboratory confirmed influenza*.
>
> We did not consider the use of respirators in the community. Respirators are tight-fitting masks that can protect the wearer from fine particles and should provide better protection against influenza virus exposures when properly worn because of higher filtration efficiency. However, respirators, such as N95 and P2 masks, work best when they are fit-tested. …
>
> *We did not find evidence that surgical-type face masks are*

*effective in reducing laboratory-confirmed influenza transmission, either when worn by infected persons (source control) or by persons in the general community to reduce their susceptibility*." [506]

### 2016 investigation of "Why Face Masks Don't Work"

The 2020 research that found the transmission of influenza is not retarded by the wearing of face masks is consistent with what was reported in a 2016 review of the scientific literature of "Why Face Masks Don't Work."[507] That 4,200 word article was written about the use of face masks by dentists as protective equipment because they have constant close exposure to the respiratory excretions of patients. The article details research related to transmission of airborne pathogens including SARS, MERS, Ebola, tuberculosis, and influenza.

The following are important excerpts from "Why Face Masks Don't Work: A Revealing Review" by John Hardie:

**Trends in Infection Control**

For the past three decades there has been minimal opposition to what have become seemingly established and accepted infection control recommendations. … [In 2009] while commenting on guidelines for face masks, Dr. M. Rupp of the Society for Healthcare Epidemiology of America noted that some of the practices relating to infection control that have been in place for decades, "haven't been subjected to the same strenuous investigation that, for instance, a new medicine might be subjected."[508] ... Dr. R. MacIntyre, a prolific investigator of face masks … noted that most studies on face masks have been based on laboratory simulated tests which quite simply have limited clinical applicability as they cannot account for such human factors as compliance, coughing and talking.[509]

Covering the nose and mouth for infection control started in the early 1900s when the German physician Carl Flugge discovered that exhaled droplets could transmit tuberculosis.[510] … Modern studies are employing sensitive instruments and interpretative techniques to better understand the size and distribution of potentially infectious aerosol particles.[511] … Nevertheless, it is the historical understanding of droplet and airborne transmission that has driven the longstanding and continuing tradition of mask wearing among health professionals.

… In her 2014 article, "Germs and the Pseudoscience of Quality Improvement", Dr. K Sibert, an anaesthetist with an interest in infection control, is of the opinion that many infection control rules are indeed arbitrary, not justified by the available evidence … devised, often under pressure, to give the appearance of doing something.[512]

The above illustrate the developing concerns that many infection control measures have been adopted with minimal supporting evidence. … Dr. R. MacIntyre … has used her research findings to boldly state that, "it would not seem justifiable to ask healthcare workers to wear surgical masks."[513] …

**Airborne Transmissions**

Early studies of airborne transmissions were hampered by the fact that the investigators were not able to detect small particles (less than 5 microns) near an infectious person.[514] ... This became known as "droplet infection", and 5 microns or greater became established as the size of large particles and the traditional belief that such particles could, in theory, be trapped by a face mask.[515] ... any small particles would be transmitted via air currents, dispersed over long distances, remain infective over time and might be inhaled by persons who never had any close contact with the host.[516] This became known as "airborne transmission" against which a face mask would be of little use.[517]

Through the use of highly sensitive instruments it is now appreciated that the aerosols transmitted from the respiratory tract due to coughing, sneezing, talking, exhalation[518] … potentially contain bacteria averaging in size from 1-10 microns and viruses ranging in size from 0.004 to 0.1 microns.[519] … upon their emission large "droplets" will undergo evaporation producing a concentration of readily inhalable small particles surrounding the aerosol source.[520]

… Aerosol transmission has been defined as "person –to – person transmission of pathogens through air by means of inhalation of infectious particles."[521] **…**

Traditionally face masks have been recommended to protect the mouth and nose from the "droplet" route of infection, presumably because they will prevent the inhalation of relatively large particles.[522] Their efficacy must be re-examined in light of the fact that aerosols contain particles many times smaller than 5 microns. …

**Respiratory System Defences**

… coughing, sneezing, nasal hairs, respiratory tract cilia, mucous producing lining cells and the phagocytic activity of alveolar macrophages provide protection against inhaled foreign bodies including fungi, bacteria and viruses.[523] Indeed, the pathogen laden aerosols produced by everyday talking and eating would have the potential to cause significant disease if it were not for these effective respiratory tract defences.

… A pertinent demonstration of the respiratory tract's ability to resist disease is the finding that- compared to controls – dentists had

significantly elevated levels of antibodies to influenza A and B and the respiratory syncytial virus.[524] Thus, while dentists had greater than normal exposure to these aerosol transmissible pathogens, their potential to cause disease was resisted by respiratory immunologic responses. Interestingly, the wearing of masks and eye glasses did not lessen the production of antibodies, thus reducing their significance as personal protective barriers.[525] … The ability of a face mask to prevent the infectious risk potentially inherent in sprays of blood and saliva reaching the wearers mouth and nose is questionable since, before the advent of mask use, dentists were no more likely to die of infectious diseases than the general population.[526]

The respiratory tract has efficient defence mechanisms. Unless face masks have the ability to either enhance or lessen the need for such natural defences, their use as protection against airborne pathogens must be questioned. (underlining added to original)

**Face Masks**

*History:* Cloth or cotton gauze masks have been used since the late 19th century to protect sterile fields from spit and mucous generated by the wearer.[527] A secondary function was to protect the mouth and nose of the wearer from the sprays and splashes of blood and body fluids created during surgery.[528] … Indeed, most current dental infection control recommendations insist that a face mask be worn, "as a key component of personal protection against airborne pathogens".[529]

Literature reviews have confirmed that wearing a mask during surgery has no impact whatsoever on wound infection rates during clean surgery.[530] A recent 2014 report states categorically that no clinical trials have ever shown that wearing a mask prevents contamination of surgical sites.[531] ...

***Structure and Fit:*** … No matter how well a mask conforms to the shape of a person's face, it is not designed to create an air tight seal around the face. Masks will always fit fairly loosely with considerable gaps along the cheeks, around the bridge of the nose and along the bottom edge of the mask below the chin.[532] These gaps do not provide adequate protection as they permit the passage of air and aerosols when the wearer inhales.[533] It is important to appreciate that if masks contained filters capable of trapping viruses, the peripheral gaps around the masks would continue to permit the inhalation of unfiltered air and aerosols.[534]

***Filtering Capacity:*** The filters in masks do not act as sieves by trapping particles greater than a specific size while allowing smaller particles to pass through.[535] ... a study of eight brands of face masks found that they did not filter out 20-100% of particles varying in size

from 0.1 to 4.0 microns.[536] … A further study found that masks were incapable of filtering out 80-85% of particles varying in size from 0.3 to 2.0 microns.[537] A 2008 investigation identified the poor filtering performance of dental masks.[538] It should be concluded from these and similar studies that the filter material of face masks does not retain or filter out viruses or other submicron particles.[539] When this understanding is combined with the poor fit of masks, it is readily appreciated that neither the filter performance nor the facial fit characteristics of face masks qualify them as being devices which protect against respiratory infections.[540] …

***Performance Standards:*** Face masks are not subject to any regulations.[541] … To obtain the necessary approval to sell masks all that a manufacturer need do is satisfy the FDA that any new device is substantially the same as any mask currently available for sale.[542] ... Nor does the FDA conduct or sponsor testing of surgical masks."[543] Although the FDA recommends two filter efficiency tests … it does not stipulate a minimum level of filter performance for these tests.[544] The PFE test … does not assess the effectiveness of a mask in preventing the ingress of potentially harmful particles nor can it be used to characterize the protective nature of a mask.[545] The BFE test is a measure of a mask's ability to provide protection from large particles expelled by the wearer. It does not provide an assessment of a mask's ability to protect the wearer.[546] ... Failure to appreciate the limitations of these tests … "created an environment in which health care workers think they are more protected than they actually are."[547] **…**

**The Inadequacies**

Between 2004 and 2016 at least a dozen research or review articles have been published on the inadequacies of face masks.[548] All agree that the poor facial fit and limited filtration characteristics of face masks make them unable to prevent the wearer inhaling airborne particles. … "facemasks will not protect against the inhalation of aerosols."[549] **…** "There is a lack of substantiated evidence to support claims that facemasks protect either patient or surgeon from infectious contamination."[550] ... randomized controlled trials of facemasks failed to prove their efficacy.[551] In August 2016 responding to a question on the protection from facemasks the Canadian Centre for Occupational Health and Safety replied:

- The filter material of surgical masks does not retain or filter out submicron particles;
- Surgical masks are not designed to eliminate air leakage around the edges;

• Surgical masks do not protect the wearer from inhaling small particles that can remain airborne for long periods of time.[552]

… "Health care workers have long relied heavily on surgical masks to provide protection against influenza and other infections. Yet there are no convincing scientific data that support the effectiveness of masks for respiratory protection. The masks we use are not designed for such purposes …"[553]

Face masks do not satisfy the criteria for effectiveness as described by Drs. Landefeld and Shojania in their NEJM article, "The Tension between Needing to Improve Care and Knowing How to Do It.[554] ... A significant inadequacy of face masks is that they were mandated as an intervention based on an assumption rather than on appropriate testing.

**Conclusions**

The primary reason for mandating the wearing of face masks is to protect dental personnel from airborne pathogens. This review has established that face masks are incapable of providing such a level of protection. … Professional associations and governing bodies must ensure the clinical efficacy of quality improvement procedures prior to them being mandated. … In 1910, Dr. C. Chapin, a public health pioneer, summarized this idea by stating, "We should not be ashamed to change our methods; rather, we should be ashamed not to do so."[555]... as this review has revealed, dentists have nothing to fear by unmasking.

### Hospital study comparing cloth masks and medical masks

A randomized clinic trial (RCT) of the effectiveness of cloth masks and medical masks was conducted following the 2009 influenza outbreak and with emerging infectious diseases such as avian influenza.[556] The trial by eight researchers involved 1607 full-time nurses and doctors in 14 hospitals in Hanoi, Vietnam.

People excluded from the trial were those with "Beards, long moustaches or long facial hair stubble," and anyone with a "Current respiratory illness, rhinitis and/or allergy."[557] Participants wore the mask on every shift for four consecutive weeks. Mask wearing was measured and documented for all participants. Results of the study were published in the *BMJ Open* medical journal in 2015. Excerpts of that study follow:

Historically, various types of cloth/cotton masks (referred to here after as 'cloth masks') have been used to protect HCWs. Disposable medical/surgical masks (referred to here after as 'medical masks') were introduced into healthcare in the mid 19th century, followed later by respirators. Compared with other parts of the world, the use of face masks is more prevalent in Asian countries, such as China and Vietnam.

[558] …

Despite widespread use, cloth masks are rarely mentioned in policy documents, and have never been tested for efficacy in a RCT. Very few studies have been conducted around the clinical effectiveness of cloth masks, and most available studies are observational or in vitro. Emerging infectious diseases are not constrained within geographical borders, so it is important for global disease control that use of cloth masks be underpinned by evidence. The aim of this study was to determine the efficacy of cloth masks compared with medical masks in HCWs working in high-risk hospital wards, against the prevention of respiratory infections.[559] …

The laboratory results were blinded and laboratory testing was conducted in a blinded fashion.[560] …

Adverse events associated with facemask use were reported in 40.4% of HCWs in the medical mask arm and 42.6% in the cloth mask arm. General discomfort (35.1%) and breathing problems (18.3%,) were the most frequently reported adverse events.[561]

Laboratory tests showed the penetration of particles through the cloth masks to be very high (97%) compared with medical masks (44%) (used in trial) and 3M 9320 N95, 3M Vflex 9105 N95.

We have provided the first clinical efficacy data of cloth masks, which suggest HCWs should not use cloth masks as protection against respiratory infection. Cloth masks resulted in significantly higher rates of infection than medical masks… . When we analysed all mask-wearers … the higher risk of cloth masks was seen for laboratory-confirmed respiratory viral infection.[562]

… cloth masks should not be recommended. We also recommend that infection control guidelines be updated about cloth mask use to protect the occupational health and safety of HCWs.[563]

## Swiss report concludes masks don't reduce COVID-19 infection rate

A study published in September 2020 comparing Swiss cantons that required mask wearing in public with cantons that didn't found any identifiable difference between the two in COVID-19 infection rates.[564]

The study was conducted by the Swiss Consumer Information and Protection Association, which publishes *Ktipp*, a magazine similar to Consumer Reports in the U.S.

The title of the article in *Ktipp's* September 29, 2020 issue reporting on the study revealed what it found: "The rate of infection is mostly falling — with or without a mask."[565]

The rate of positive COVID-19 tests in cantons that required masks

was found to have been falling in August before the mask wearing mandate was instituted. Likewise, the rate of positive COVID-19 tests in the seven cantons that did not require masks in public followed an almost identical pattern.[566]

"A mask requirement when shopping has no demonstrable influence on the number of infections with the coronavirus" – was the *Ktipp* article's conclusion:

The mask mandate was ineffective because: "According to data from canton doctors, most infections occur in one's own household and when traveling abroad. There is very little evidence in the data of infection in shops."[567]

That is consistent with studies around the world that have found most COVID-19 transmission occurs inside a household.

## Masks Don't Work – Technical Report by Denis G. Rancourt PhD

> "individuals should know that there is no known benefit arising from wearing a mask in a viral respiratory illness epidemic"[568]

Denis G. Rancourt is a researcher at the Ontario Civil Liberties Association (OCLA.ca) and is formerly a tenured professor at the University of Ottawa, Canada. In April 2020 he wrote a technical report for the OCLA: *Masks Don't Work: A Review of Science Relevant to COVID-19 Social Policy*. Excerpts from that report follow:

### Conclusion Regarding That Masks Do Not Work

No RCT study with verified outcome shows a benefit for HCW or community members in households to wearing a mask or respirator. …

Likewise, no study exists that shows a benefit from a broad policy to wear masks in public …

Furthermore, if there were any benefit to wearing a mask, because of the blocking power against droplets and aerosol particles, then there should be more benefit from wearing a respirator (N95) compared to a surgical mask, yet several large meta-analyses, and all the RCT, prove that there is no such relative benefit.

Masks and respirators do not work.

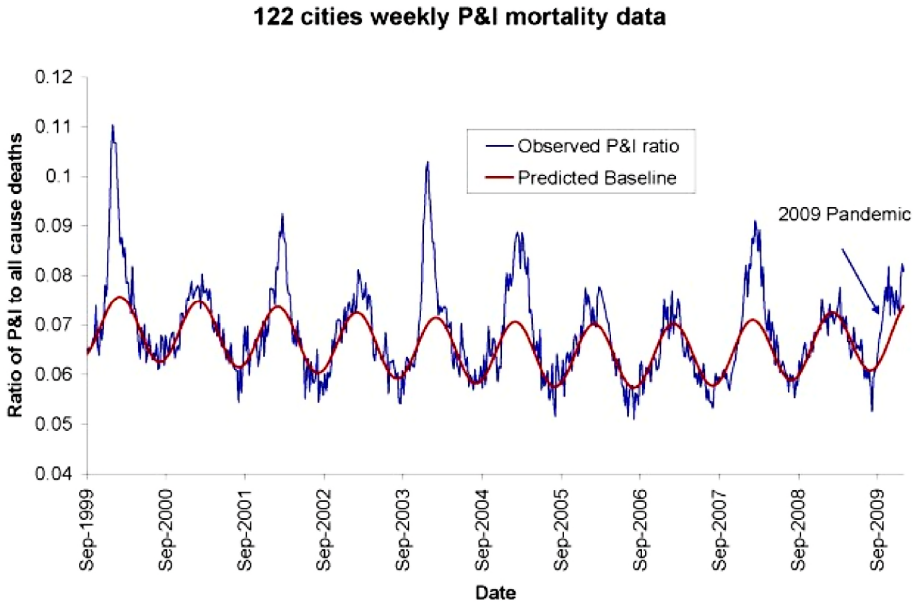
### Precautionary Principle Turned on Its Head with Masks

In light of the medical research, therefore, it is difficult to understand why public-health authorities are not consistently adamant about this established scientific result, since the distributed psychological, economic, and environmental harm from a broad recommendation to wear masks is significant, not to mention the unknown potential harm from concentration and distribution of pathogens on and from used masks. In this case, public authorities would be turning the precautionary principle on its head.[569]

**Physics and Biology of Viral Respiratory Disease and of Why Masks Do Not Work**

In order to understand why masks cannot possibly work, we must review established knowledge about viral respiratory diseases, the mechanism of seasonal variation of excess deaths from pneumonia and influenza, the aerosol mechanism of infectious disease transmission, the physics and chemistry of aerosols, and the mechanism of the so-called minimum-infective-dose.

"Weekly time series of the ratio of deaths from pneumonia and influenza to all deaths, based on the 122 cities surveillance in the US (blue line). The red line represents the expected baseline ratio in the absence of influenza activity,"[570]




In a landmark study, Shaman et al. (2010) showed that the seasonal pattern of extra respiratory-disease mortality can be explained quantitatively on the sole basis of absolute humidity, and its direct controlling impact on transmission of airborne pathogens.[571] …

… pathogen-laden aerosol particles or droplets are neutralized within a half-life that monotonically and significantly decreases with increasing ambient humidity. … Harper [1961] experimentally showed that viral-pathogen-carrying droplets were inactivated within shorter and shorter times, as ambient humidity was increased. …

Shaman's work necessarily implies … the epidemic's basic reproduction number (R0) is highly or predominantly dependent on ambient absolute humidity. … the seasonal infectious viral respiratory diseases that plague

temperate latitudes every year go from being intrinsically mildly contagious to virulently contagious, due simply to the bio-physical mode of transmission controlled by atmospheric humidity, irrespective of any other consideration.[572] …

Therefore, all the epidemiological mathematical modelling of the benefits of mediating policies (*such as social distancing*), which assumes humidity-independent R0 values, *has a large likelihood of being of little value, on this basis alone*.[573]

To put it simply, *the "second wave" of an epidemic is not a consequence of human sin regarding mask wearing and hand shaking*. Rather, the "second wave" is an inescapable consequence of an air-dryness-driven many-fold increase in disease contagiousness, in a population that has not yet attained immunity.

… Shaman's work further necessarily implies that the dryness-driven high transmissibility (large R0) arises from small aerosol particles fluidly suspended in the air; as opposed to large droplets that are quickly gravitationally removed from the air.

Such small aerosol particles fluidly suspended in air, of biological origin, are of every variety and are everywhere, including down to virion-sizes … *It is not entirely unlikely that viruses can thereby be physically transported over inter-continental distances* …

More to the point, indoor airborne virus concentrations have been shown to exist (in day-care facilities, health centres, and onboard airplanes) primarily as aerosol particles of diameters smaller than 2.5 μm …

"…On average, 64 per cent of the viral genome copies were associated with fine particles smaller than 2.5 μm, which can remain suspended for hours. …These results provide quantitative support for the idea that the aerosol route could be an important mode of influenza transmission."

Such small particles (< 2.5 μm) are part of air fluidity, are not subject to gravitational sedimentation … This means that the slightest (even momentary) facial misfit of a mask or respirator renders the design filtration norm of the mask or respirator entirely irrelevant. In any case, the filtration material itself of N95 … does not block virion penetration, not to mention surgical masks.[574]

…

- …if the MID (minimal infective virus dose) is amply surpassed by the virions carried in a single aerosol particle able to evade mask-capture, then the mask is of no practical utility, which is the case. …
- …it is believed that a single virion can be enough to induce illness in the host.

• …the 50%-probability MID easily fits into a single (one) aerolized droplet.

…

All of this to say that: if anything gets through (and it always does, irrespective of the mask), then you are going to be infected. *Masks cannot possibly work.* …[575]

Therefore, the studies that show partial stopping power of masks, or that show that masks can capture many large droplets produced by a sneezing or coughing mask-wearer … are irrelevant.[576]

**Unknown Aspects of Mask Wearing**

Many potential harms may arise from broad public policies to wear masks, and the following unanswered questions arise:

• Do used and loaded masks become sources of enhanced transmission, for the wearer and others?

• Do masks become collectors and retainers of pathogens that the mask wearer would otherwise avoid when breathing without a mask?

• Are large droplets captured by a mask atomized or aerolized into breathable components? Can virions escape an evaporating droplet stuck to a mask fiber?

• What are the dangers of bacterial growth on a used and loaded mask?

• How do pathogen-laden droplets interact with environmental dust and aerosols captured on the mask?

• What are long-term health effects on HCW, such as headaches, arising from impeded breathing?

**Conclusion**

By making mask-wearing recommendations and policies for the general public, or by expressly condoning the practice, governments have both ignored the scientific evidence and done the opposite of following the precautionary principle.

In an absence of knowledge, governments should not make policies that have a hypothetical potential to cause harm. The government has an onus barrier before it instigates a broad social engineering intervention, or allows corporations to exploit fear-based sentiments.

Furthermore, *individuals should know that there is no known benefit arising from wearing a mask in a viral respiratory illness epidemic*, and that scientific studies have shown that any benefit must be residually small, compared to other and determinative factors.

Otherwise, what is the point of publicly funded science?

*The present paper about masks illustrates the degree to which governments, the mainstream media, and institutional propagandists can decide to operate in a science vacuum, or select only incomplete science that*

*serves their interests*. Such recklessness is also certainly the case with the current global lockdown of over 1 billion people, an unprecedented experiment in medical and political history.[577]

### Dr. Scott Jenson statement regarding masks

The ineffectiveness of masks to protect the wearer against becoming infected with a virus such as COVID-19 is well known in the medical profession. Minnesota State Senator Scott Jenson, who is a medical doctor, stated regarding masks:

> "When it comes to masks, this much is about a meter, this much is about a millimeter, when we talk about a mask we have to talk about microns. And typically if you look at an N-95 mask what that does is it filters out 95% of particulate matter larger than .3 microns. Well the question then is how big is the COVID particle. And a COVID particle is about .1 micron. So we know that even an N-95 mask has tremendous limitations. Yes it does help some because COVID particles will coalesce and coagulate almost as they come into the magnetized or electrified field of the N-95 mask. But the bottom line is a surgical mask or a cloth mask are really designed only for particulate matter greater than 5 microns. Typical bacteria are 1 to 20 microns. So when we wear surgical masks in surgery, we're simply trying to make sure that if we sneeze or cough we're not spraying a lot of bacteria into the place we're doing surgery. But this idea of people thinking that they are doing something particularly useful with a cotton mask or a handkerchief or a homemade mask or a surgical mask is just Looney tunes."[578]

### Anders Tegnell interviewed about lack of mask use in Sweden

Anders Tegnell is chief epidemiologist at Sweden's Public Health Agency. During an interview in July 2020 he was asked about the lack of mask use in Sweden compared to other countries:

> Question by interviewer: "I was in Stockholm the other day and pretty much no one is wearing masks. The restaurants are quite full. It seems a lot more like a normal city than other European cities. Why are not you encouraging or requiring people to wear masks?
>
> Anders Tegnell: "For a number of reasons. One reason is that the evidence base for using masks in society is still very weak. Even if more and more countries are now enforcing them in different ways. … We haven't seen any new evidence coming up, which is a little bit surprising. So that is one reason. The other reason is everything tells us that keeping social distances is a much better way of controlling this disease than putting masks on people. And we are worried, and we get at least tales from other countries, that people put on masks and then they believe they

can go around in society being close to each other, even going around in society being sick. And that, in our view, would definitely produce higher spreads than we have right now." [579]

In August 2020 Tegnell gave an interview to the *Financial Times* in which he said that it is "very dangerous" for people to wear face masks thinking it would stop the spread of coronavirus: "It is very dangerous to believe face masks would change the game when it comes to COVID-19." [580] Tegnell mentioned infection rates were rising in countries that had high rates of compliance with strict mask wearing requirements such as Spain and Belgium.

In an interview with *The Times* (of London) Tegnell rejected the idea of mandating mask wearing in Sweden, saying: "we see no point in wearing a face mask in Sweden, not even on public transport."[581] Tegnell also emphasized the effectiveness of face masks to protect a person from contracting or transmitting a respiratory virus like COVID-19 is "astonishingly weak." He also said, "I'm surprised that we don't have more or better studies showing what effect masks actually have."

### Mask wearing by general public is ineffective according to doctors

An article in the *New England Journal of Medicine* explained that mask wearing by the general public is ineffective against becoming infected by COVID-19, and "the desire for widespread masking is a reflexive reaction to anxiety over the pandemic." The article by five doctors states:

> "We know that wearing a mask outside health care facilities offers little, if any, protection from infection. Public health authorities define a significant exposure to Covid-19 as face-to-face contact within 6 feet with a patient with symptomatic Covid-19 that is sustained for at least a few minutes (and some say more than 10 minutes or even 30 minutes). The chance of catching Covid-19 from a passing interaction in a public space is therefore minimal. In many cases, the desire for widespread masking is a reflexive reaction to anxiety over the pandemic."[582]

### Dr. Judy Mikovits questions mask effectiveness to limit virus spread

In *The Case Against Masks*, former federal research scientist Dr. Judy Mikovits and co-author Kent Heckenlively summarize some of their concerns about masks: "The more effective a mask is at blocking normal air flow, the greater the problem with decreased oxygen and increased carbon dioxide a person is likely to have. The less effective a mask is at blocking normal airflow, the less of a case can be made for using it. And we haven't

really dealt with what seems to be the main way that the virus spreads, through coughing and sneezing which spreads respiratory droplets."[583]

### CDC mask wearing recommendations are unstable

In 2017 the CDC released its current "Community Mitigation Guidelines to Prevent Pandemic Influenza."[584] They do not mandate the wearing of a face mask under any circumstances by an ill person – or recommend it under any circumstance by a well-person. For a severe, very severe, or extreme outbreak it stated: "CDC might recommend use of face masks by ill persons when crowded community settings cannot be avoided."[585]

It was the official position of the CDC when Trump declared a COVID-19 National Emergency on March 13, 2020 that the wearing of a face mask by a well-person was not recommended under any circumstance.

On March 28, 2020 the CDC's Coronavirus Disease 2019 (COVID-19) – Know How it Spreads webpage stated:

Wear a facemask if you are sick:

- If you are sick: You should wear a facemask when you are around other people (e.g., sharing a room or vehicle) and before you enter a healthcare provider's office. If you are not able to wear a facemask (for example, because it causes trouble breathing), then you should do your best to cover your coughs and sneezes, and people who are caring for you should wear a facemask if they enter your room.
- *If you are NOT sick: You do not need to wear a facemask unless you are caring for someone who is sick* (and they are not able to wear a facemask).[586]

On April 4, 2020 the CDC radically changed its recommendation regarding facemasks – by assuming everyone was infected with COVID-19:

Cover your mouth and nose with a close face cover when around others:

- You could spread COVID-19 to others even if you do not feel sick.
- Everyone should wear a cloth face cover when they have to go out in public, for example to the grocery store or to pick up other necessities.
- *The cloth face cover is meant to protect other people in case you are infected*.
- Do NOT use a facemask meant for a healthcare worker.[587]

On July 2, 2020 the CDC again changed its recommendation regarding facemasks to include wearing them in your home when a non-resident is present:

Cover your mouth and nose with a close face cover when around others:

- You could spread COVID-19 to others even if you do not feel sick.

- Everyone should wear a cloth face cover in public settings *and when around people who don't live in your household*, especially when other social distancing measures are difficult to maintain.
- The cloth face cover is meant to protect other people in case you are infected.
- Do NOT use a facemask meant for a healthcare worker.[588]

There was no new compelling scientific data supporting the revisions of the CDC's facemask position from March 13 to July 2, 2020. It stiffened as the case fatality rate fell – precisely the circumstance when that wouldn't be expected unless it was driven by political motivations.

## WHO recognizes no evidence masks prevent COVID-19 infections

On January 29, 2020 the World Health Organization issued its "Advice on the use of masks the community, during home care and in health care settings in the context of the novel coronavirus (2019-nCoV) outbreak." The WHO recommended: "Individuals without respiratory symptoms … – a medical mask is not required, as no evidence is available on its usefulness to protect non-sick persons." However, for "Individuals with respiratory symptoms should: – wear a medical mask and seek medical care if experiencing fever, cough and difficulty breathing …"[589]

Two months later executive director of the WHO health emergencies program stated at a March media briefing in Geneva, Switzerland: "There is no specific evidence to suggest that the wearing of masks by the mass population has any potential benefit. In fact, there's some evidence to suggest the opposite in the misuse of wearing a mask properly or fitting it properly."[590]

> Another two months later , on June 5, the WHO reaffirmed the ineffectiveness of mask use by the general public: "*At the present time, the widespread use of masks by healthy people in the community setting is not yet supported by high quality or direct scientific evidence*." [591] In spite of acknowledging the lack of scientific evidence supporting the efficacy of mask use by people who are not sick or caring for someone who is sick, the WHO announced it "has updated its guidance to advise that to prevent COVID-19 transmission effectively in areas of community transmission, governments should encourage the general public to wear masks in specific situations and settings."[592]

## Netherlands and Sweden among countries rejecting public mask wearing

Beginning in late spring 2020 some U.S. states and nations disregarded the absence of evidence that face masks are effective to retard the

transmission or contraction of COVID-19, and mandated them being worn in certain public settings. As of August 10, 2020, 34 states had various forms of a mask wearing mandate.[593]

Several countries mandating the wearing of a mask in public. On July 29 the Dutch government announced "it will not advise the public to wear masks to slow the spread of coronavirus, asserting that their effectiveness has not been proven."[594] After a review by the Netherland's National Institute for Health (RIVM), Minister for Medical Care Tamara van Ark said at a press conference in The Hague: "Because from a medical perspective there is no proven effectiveness of masks, the Cabinet has decided that there will be no national obligation for wearing non-medical masks."[595]

In July 2020 Sweden's chief epidemiologist Anders Tegnell said face masks are pointless, even on public transport. Tegnell said, "With numbers diminishing very quickly in Sweden, we see no point in wearing a face mask in Sweden, not even on public transport."[596]

Diners at cafe in Amsterdam, Netherlands in June 2020 (Reuters - Eva Plevier)

## Unvaccinated nurses win case freeing them from forced mask wearing

Nurses in Ontario, Canada were prevented from being forced to wear a facemask when they did not have an influenza vaccine, after they won a court case in 2018.

In 2014 St. Michael's Hospital in Toronto (and several other hospitals) instituted a Vaccine or Mask Policy (VOM). "Under the VOM policy, Health Care Workers and that group, of course, includes nurses, who have not received the annual influenza vaccine, must, during all or most of the flu season, wear a surgical or procedural mask in areas where patients are present and/or patient care is delivered.[597]

The Ontario Nurses' Association filed a grievance of the VOM policy in every hospital where it was introduced. They argued their was scant scientific evidence mask wearing reduced transmission of the influenza virus. An arbitration hearing began in October 2014 and ended in July 2015. On September 8, 2015 Arbitrator James K. A. Hayes ruled in favor of the nurses, finding the Sault Area Hospital's VOM policy was inconsistent with the collective agreement and unreasonable because its intent was to coerce vaccination of nurses and there was insufficient scientific evidence mask

wearing increased patient safety. Hayes' ruling stated in part:

> "*I find that the Policy was introduced at SAH for the purpose of driving up vaccination rates*. *I also find that the weight of scientific evidence said to support the VOM Policy on patient safety grounds is insufficient to warrant the imposition of a mask-wearing requirement* for up to six months every year. Absent adequate support for the freestanding patient safety purpose alleged, *I conclude that the Policy operates to coerce influenza immunization* and, thereby, undermines the collective agreement right of employees to refuse vaccination. [598]

The hospitals didn't want to abide by Hayes' ruling and after legal maneuvering, another case began an arbitration hearing in 2016. The policy and legal issues were the same as in the earlier case.

On September 6, 2018 Arbitrator William Kaplan ruled in favor of the nurses and barred them from being compelled to wear a facemask if unvaccinated. The hospitals case was largely based on the TAHSN report prepared by a working group from 13 Toronto area teaching hospitals. Kaplan's ruling stated in part:

> "The THASN report mad it clear that voluntary efforts to increase influenza immunization [by nurses] had failed – 40% to 60% uptake "despite robust influenza education campaigns" – and that steps were necessary to address that failure … The report recommended that VOM policies "be part of a comprehensive prevention and control program aimed at preventing hospital-acquired influenza…." This recommendation was made *in the admitted absence of direct evidence that mask wearing HCWs protected patients from influenza*…"[599]

Kaplan wrote: "The only fair words to describe *the evidence advanced in support of the masking component* of the VOM policy in the THASN report, and in this proceeding, *are insufficient, inadequate, and completely unpersuasive*."[600]

Kaplan's ruling stated:

> "…the question to be answered is whether the evidence supports the conclusion that the use of surgical or procedural masks, worn by unvaccinated HCWs for some or all of the flu season, actually results in reduction of harm to patients? Does it prevent the transmission of illness? Does it save lives? …[601]
>
> … The evidentiary record is extensive: … numerous expert reports, more than one hundred and fifty exhibits and thousands of pages of transcript.[602] …

**Masking – Not a Solution**

There is no persuasive evidence establishing a conclusive relationship between the use of surgical and procedural masks and protection against influenza transmission.

… the preponderance of the masking evidence is compelling – surgical and procedural masks are extremely limited in terms of source control: they do not prevent the transmission of the influenza virus. The two masks introduced into evidence clearly demonstrate why that would be the case. What protection they provide is self-evidently limited by their construction and how they sit on a human face. …

The bin-Reza systemic review concluded as follows: "None of the studies established a conclusive relationship between mask/respirator use and protection against influenza transmission." Dr. Gardam agreed: "The use of surgical or procedural masks is neither a viable nor scientifically supported alternative." …

Yet another study observed: "there is a lack of substantial evidence to support clams that face-masks protect either patient or surgeon from infectious contamination." The CDC is categorical: "No studies have definitively shown that mask use by either infectious patients or health-care personnel prevents influenza transmission." As the CDC also stated, "while a facemask may be effective in blocking splashes and large-particle droplets, a facemask, by design, does not filter or block very small particles in the air that may be transmitted by coughs, sneezes or certain medical procedures."

… because of "leakage," surgical masks do not exhibit "adequate filter performance and facial fit characteristics to be considered respiratory protection devices."

… I cannot conclude that the evidence comes even close to establishing that masking may be as "effective as vaccine in protecting patients from influenza." …

**Asymptomatic Transmission Overstated**

The argument was advanced by St. Michael's that masking was especially important to reduce the risk of nosocomial influenza by asymptomatic or pre-symptomatic HCWs. At best, the evidence indicates that asymptomatic transmission is not asignificant factor in nosocomial influenza. …

… Dr. Eleni Patrozou concluded following her systemic review: "*Based on the available literature, we found that there is scant, if any, evidence that asymptomatic or pre-symptomatic individuals play an important role in influenza transmission*." …

On balance, I am persuaded by the evidence and accept the conclusion of the experts that there is, indeed, scant evidence of asymptomatic nosocomial influenza transmission. It is unlikely to be of clinical significance. Accordingly, requiring unvaccinated HCWs to wear surgical or procedural masks – notwithstanding the inherent illogicality of it all – is unreasonable, and so, therefore, is the policy compelling it." …

**Conclusion**

It was noted at the outset that this case was, in large measure, a repeat of the one put before Arbitrator Hayes. It is not, therefore, surprising that there is an identical outcome. Ultimately, I agree with Arbitrator Hayes: "There is scant scientific evidence concerning asymptomatic transmission, and, also, scant scientific evidence of the use of masks in reducing the transmission of the virus to patients" (at para. 329) …

… I find St. Michael's VOM policy contrary to the collective agreement and unreasonable. St. Michael's is required, immediately, to rescind its VOM policy." [603]

## Public hypocrites don't believe their BS masks stop COVID-19


Oregon Governor Kate Brown was photographed on August 2, 2020 disregarding her own mask wearing mandate while out walking with her three Oregon State Trooper bodyguards – who were also maskless. Brown issued an executive order in mid-July requiring masks to be worn *outside* by everyone in the State of Oregon unless social-distancing and minimum six-foot distances could be maintained. [604]

Dr. Anthony Fauci wearing his mask below his nose when he testified before a Congressional committee in Washington D.C.

## Sweden has dramatically lower infection rate than mask mandating Israel

A Twitter post by Ian Miller on September 29, 2020 included a chart comparing the positive COVID-19 infection rate of Israel – which had a hard mask wearing mandate – with that of Sweden, which only had voluntary mask wearing, with a low percentage of people choosing to wear one.[605] It is particularly interesting that the chart shows the infection rate of the two countries was comparable or Israel even had a lower positive rate until late June when disregard for mask wearing ended with an increase in fines for non-compliance. Positive rates increased significantly in Israel with the imposition of additional restrictions in early July – while positive rates in Sweden decreased to a very low level and stayed there. The positive infection rate in Israel skyrocketed with the imposition of a second lockdown in mid-September 2020 – while they remained relatively flat in Sweden which had no lockdown. The Twitter post including the chart follows:


*The Washington Post* published an article on April 2, 2020 that detailed the ineffectiveness of mandatory mask wearing during the Spanish Flu outbreak in the U.S.[606]

### Masks are neither effective nor safe: A summary of the science

Colleen Huber, NMD, published a review on July 6, 2020 of the science related to mask wearing, titled: "Are masks effective at preventing transmission of respiratory pathogens?"[607] Excerpts of that review follow:

"… The public has been instructed by media and their governments that one's use of masks, even if not sick, may prevent others from being infected with SARS-CoV-2, the infectious agent of COVID-19.

… The purpose of this paper is to examine data regarding the effectiveness of facemasks, as well as safety data. … a risk-benefit analysis is necessary to guide decisions on if and when to wear a mask.

**Are masks effective at preventing transmission of respiratory pathogens?**

In this [2020] meta-analysis, face masks were found to have no detectable effect against transmission of viral infections. It found: "Compared to no masks, there was no reduction of influenza-like illness cases or influenza for masks in the general population, nor in healthcare workers."

This 2020 meta-analysis found that evidence from randomized controlled trials of face masks did not support a substantial effect on transmission of laboratory-confirmed influenza, either when worn by infected persons (source control) or by persons in the general community to reduce their susceptibility.

Another recent review found that masks had no effect specifically against Covid-19 …

This 2019 study … showed that both N95 respirators and surgical masks "resulted in no significant difference in the incidence of laboratory confirmed influenza."

This 2016 meta-analysis found that both randomized controlled trials and observational studies of N95 respirators and surgical masks used by healthcare workers did not show benefit against transmission of acute respiratory infections. …

A 2011 meta-analysis of 17 studies regarding masks and effect on

transmission of influenza found that "none of the studies established a conclusive relationship between mask/respirator use and protection against influenza infection." …

**Airflow around masks**

Masks have been assumed to be effective in obstructing forward travel of viral particles. Considering those positioned next to or behind a mask wearer, there have been farther transmission of virus-laden fluid particles from masked individuals than from unmasked individuals, by means of "several leakage jets, including intense backward and downwards jets that may present major hazards," and a "potentially dangerous leakage jet of up to several meters." …Schlieren imaging showed that both surgical masks and cloth masks had farther brow jets (unfiltered upward airflow past eyebrows) than not wearing any mask at all … vs none discernible with no mask. Backward unfiltered airflow was found to be strong with all masks compared to not masking.…

**Penetration through masks**

A study of 44 mask brands found mean 35.6% penetration (+ 34.7%). … The study found that "Medical masks, general masks, and handkerchiefs were found to provide little protection against respiratory aerosols." (10)

… In respiration, the relevant aerosol is the suspension of bacterial or viral particles in inhaled or exhaled breath.

In another study, penetration of cloth masks by particles was almost 97% and medical masks 44%.

**N95 respirators**

… N95 respirators are so named, because 95% of particles having a diameter of 0.3 microns are filtered by the mask forward of the wearer … Coronaviruses are approximately 0.125 microns in diameter.

This meta-analysis found that N95 respirators did not provide superior protection to facemasks against viral infections or influenza-like infections. …

**Surgical masks**

This study found that surgical masks offered no protection at all against influenza. …

Use of masks in surgery were found to slightly increase incidence of infection over not masking in a study of 3,088 surgeries. [] The surgeons' masks were found to give no protective effect to the patients.

This study found that "there is a lack of substantial evidence to support claims that facemasks protect either patient or surgeon from infectious contamination." [] …

Specifically, are surgical masks effective in stopping human transmission

of coronaviruses? Both experimental and control groups, masked and unmasked respectively, were found to "not shed detectable virus in respiratory droplets or aerosols." [] In that study, they "did not confirm the infectivity of coronavirus" as found in exhaled breath. …

In another study, that observed subjects while coughing, "neither surgical nor cotton masks effectively filtered SARS-CoV-2 during coughs by infected patients." And more viral particles were found on the outside than on the inside of masks tested. []

**Cloth masks**

Cloth masks were found to have low efficiency for blocking particles of 0.3 microns and smaller. …

Healthcare workers wearing cloth masks were found to have 13 times the risk of influenza-like illness than those wearing medical masks. []

This 1920 analysis of cloth mask use during the 1918 pandemic examines the failure of masks to impede or stop flu transmission at that time …

**Masks against Covid-19**

The *New England Journal of Medicine* editorial on the topic of mask use versus Covid-19 assesses the matter as follows:

> "We know that wearing a mask outside health care facilities offers little, if any, protection from infection. Public health authorities define a significant exposure to Covid-19 as face-to-face contact within 6 feet with a patient with symptomatic Covid-19 that is sustained for at least a few minutes (and some say more than 10 minutes or even 20 minutes). The chance of catching Covid-19 from a passing interaction in a public space is therefore minimal. In many cases, the desire for widespread masking is a reflexive reaction to anxiety over the pandemic."[608]

**<u>Are masks safe?</u>**

**During walking or other exercise**

Surgical mask wearers had significantly increased dyspnea after a 6-minute walk than non-mask wearers.[]

Researchers are concerned about possible burden of facemasks during physical activity on pulmonary, circulatory and immune systems, due to oxygen reduction and air trapping reducing substantial carbon dioxide exchange. As a result of hypercapnia, there may be cardiac overload, renal overload, and a shift to metabolic acidosis.[]

**Risks of N95 respirators**

Pregnant healthcare workers were found to have a loss in volume of oxygen consumption by 13.8% compared to controls when wearing N95

respirators. 17.7% less carbon dioxide was exhaled. …

Healthcare workers' N95 respirators were measured by personal bioaerosol samplers to harbor influenza virus. …

**Risks of surgical masks**

Healthcare workers' surgical masks also were measured by personal bioaerosol samplers to harbor for influenza virus.[]

Various respiratory pathogens were found on the outer surface of used medical masks, which could result in self-contamination. The risk was found to be higher with longer duration of mask use.[]

Surgical masks were also found to be a repository of bacterial contamination. …The source of the bacteria was determined to be the body surface of the surgeons … laypeople generally have even more exposed body surface to serve as a source for bacteria to collect on their masks.

**Risks of cloth masks**

Healthcare workers wearing cloth masks had significantly higher rates of influenza-like illness after four weeks of continuous on-the-job use, when compared to controls. []

The increased rate of infection in mask-wearers may be due to a weakening of immune function during mask use. Surgeons have been found to have lower oxygen saturation after surgeries even as short as 30 minutes…

**Weighing risks versus benefits of mask use**

In the summer of 2020 the United States is experiencing a surge of popular mask use, which is frequently promoted by the media, political leaders and celebrities. …The use of face masks, whether cloth, surgical or N95, creates a poor obstacle to aerosolized pathogens as we can see from the meta-analyses and other studies in this paper, allowing both transmission of aerosolized pathogens to others in various directions, as well as self-contamination.

It must also be considered that masks impede the necessary volume of air intake required for adequate oxygen exchange, which results in observed physiological effects that may be undesirable. Even 6- minute walks, let alone more strenuous activity, resulted in dyspnea. …

The foregoing data show that masks serve more as instruments of obstruction of normal breathing, rather than as effective barriers to pathogens. Therefore, masks should not be used by the general public, either by adults or children, and their limitations as prophylaxis against pathogens should also be considered in medical settings."[609]

## II – Isolation Social Distancing

There is no clear scientific evidence that a strategy of social distancing

by isolation/quarantining provides protection for a person to not be infected by some who carries an active COVID-19 virus. The isolation social distancing regime practiced by countries around the world is based on wishful thinking.

### 2006 study casts doubt on efficacy of virus mitigation strategies

*Biosecurity and Bioterrorism* magazine published an article in 2006 that explored the efficacy of virus mitigation strategies: "Disease Mitigation Measures in the Control of Pandemic Influenza." That article states in part:

> "*There are no historical observations or scientific studies that support the confinement by quarantine of groups of possibly infected people for extended periods in order to slow the spread of influenza*. A World Health Organization (WHO) Writing Group, after reviewing the literature and considering contemporary international experience, concluded that "*forced isolation and quarantine are ineffective and impractical*. Despite this recommendation by experts, mandatory large-scale quarantine continues to be considered as an option by some authorities and government officials."[610]
>
> The threat of an influenza pandemic caused by some variant of the highly pathogenic, especially H5N1 avian strains, has alarmed countries around the world.
>
> …
>
> Accordingly, there has been interest in a range of disease mitigation measures. Possible measures that have been proposed include: isolation of sick people in hospital or at home, use of antiviral medications, hand-washing and respiratory etiquette, large-scale or home quarantine of people believed to have been exposed, travel restrictions, prohibition of social gatherings, school closures, maintaining personal distance, and the use of masks. Thus, we must ask whether any or all of the proposed measures are epidemiologically sound, logistically feasible, and politically viable. It is also critically important to consider possible secondary social and economic impacts of various mitigation measures.
>
> …Other studies have suggested that, except in the most extreme applications, disease mitigation measures have not had a significant impact on altering the course of an influenza pandemic.[611]
>
> **Epidemiologic Expectations**
>
> *Historically, it has been all but impossible to prevent influenza from being imported into a country or political jurisdiction, and there has been little evidence that any particular disease mitigation measure has significantly slowed the spread of flu*. The clinical and

epidemiologic characteristics of influenza explain why:

• The influenza virus is known to spread rapidly from one person to the next …

• Some flu-infected individuals may be asymptomatic and so would not be recognized as being infected. In seasonal flu outbreaks, this group may represent a significant proportion of infected people. …

• Many patients who are symptomatic are not readily diagnosed because their symptoms differ little from individuals with other respiratory illnesses or allergies.

**Epidemiologic Assessment: Do available data or experience suggest the measure will work?**

Such models consist of computer simulations of disease outbreaks that are developed from very limited data regarding the epidemiological and biological characteristics of influenza and a series of assumptions about the likely compliance of the population, the feasibility of applying various interventions, and so on. *The predictions provided by such models can vary widely depending on the assumptions that are made in their construction.*

…

No model, no matter how accurate its epidemiologic assumptions, can illuminate or predict the secondary and tertiary effects of particular disease mitigation measures. …

**Isolation of Sick People in Hospitals**

Beyond widespread vaccination, isolating symptomatic influenza patients, either at home or in the hospital, is probably the most important measure that could be taken to reduce the transmission and slow the spread of illness within a community. The sickest (and presumably most contagious) patients are most likely to seek hospital care.

**Home Isolation of Sick People**

In light of the expected shortages of medical beds and personnel, home isolation of non–critically ill influenza patients would be necessary in a major pandemic. A policy that persuades sick individuals to voluntarily stay at home unless they are critically ill would allow hospitals to focus efforts on those most seriously threatened.

**Hand-Washing and Respiratory Etiquette**

The influenza virus actually survives on the hands for less than 5 minutes, but regular hand-washing is a commonsense action that

should be widely followed. It has been shown to reduce the transmission of respiratory illness in a military trainee setting, although there are no data to demonstrate that hand-washing deters the spread of influenza within a community.

General respiratory hygiene, such as covering one's mouth when coughing and using disposable paper tissues, is widely believed to be of some value in diminishing spread, *even though there is no hard evidence that this is so*.

**Large-Scale Quarantine Measures**

There are no historical observations or scientific studies that support the confinement by quarantine of groups of possibly infected people for extended periods in order to slow the spread of influenza. A World Health Organization (WHO) Writing Group, after reviewing the literature and considering contemporary international experience, *concluded that "forced isolation and quarantine are ineffective and impractical*."

*The interest in quarantine reflects the views and conditions prevalent more than 50 years ago*, when much less was known about the epidemiology of infectious diseases and when there was far less international and domestic travel in a less densely populated world. *It is difficult to identify circumstances in the past half-century when large-scale quarantine has been effectively used in the control of any disease*.

**Home Quarantine**

Voluntary home quarantine would be requested of individuals who are asymptomatic but who have had substantial contact with a person who has influenza—primarily household members. The aim of voluntary home quarantine is to keep possibly contagious, but still asymptomatic, people out of circulation. This sounds logical, but this measure raises significant practical and ethical issues.

**Travel Restrictions**

*Travel restrictions, such as closing airports and screening travelers at borders, have historically been ineffective.* The World Health Organization Writing Group concluded that "*screening and quarantining entering travelers at international borders did not substantially delay virus introduction in past pandemics . . . and will likely be even less effective in the modern era*."

**Prohibition of Social Gatherings**

During seasonal influenza epidemics, public events with an expected large attendance have sometimes been cancelled or

postponed, the rationale being to decrease the number of contacts with those who might be contagious. *There are, however, no certain indications that these actions have had any definitive effect on the severity or duration of an epidemic*. … It might mean closing theaters, restaurants, malls, large stores, and bars. Implementing *such measures would have seriously disruptive consequences for a community if extended through the 8-week period of an epidemic in a municipal area* … But a policy calling for communitywide cancellation of public events seems inadvisable.

**School Closures**

In previous influenza epidemics, the impact of school closings on illness rates has been mixed. … when schools closed for a winter holiday during the 1918 pandemic in Chicago, "*more influenza cases developed among pupils . . . than when schools were in session*."

Schools are often closed for 1–2 weeks early in the development of seasonal community outbreaks of influenza primarily because of high absentee rates, especially in elementary schools, and because of illness among teachers. This would seem reasonable on practical grounds. However, to close schools for longer periods is not only impracticable but carries the possibility of a serious adverse outcome. … A portion of America's workforce would be unable to go to work as long as children were out of schools.

**Maintaining Personal Distance**

It has been recommended that individuals maintain a distance of 3 feet or more during a pandemic so as to diminish the number of contacts with people who may be infected. The efficacy of this measure is unknown. …

**Use of Masks and Personal Protective Equipment**

… *studies have shown that the ordinary surgical mask does little to prevent inhalation of small droplets bearing influenza virus*. The pores in the mask become blocked by moisture from breathing, and the air stream simply diverts around the mask. There are few data available to support the efficacy of N95 or surgical masks outside a healthcare setting. N95 masks need to be fit-tested to be efficacious and are uncomfortable to wear for more than an hour or two.

**Community Response To A Pandemic: A Summary Of Possible Actions**

There is no question but that another influenza pandemic will occur … Influenza is unlike any other disease epidemic in the rapidity with which it spreads and, as it emerges, the number of

illnesses that it can cause over a period of a few months. … The world has weathered three pandemics during the past century and will certainly surmount the next one. …

Everyone should be encouraged to wash their hands after coming in contact with people who are ill and to cover their mouths when coughing or sneezing.

… Recognizing that the spread of influenza is primarily by person-to-person contact, any one individual, even in a large gathering, would have only a limited number of such close encounters with infected people. Thus, cancelling or postponing large meetings would not be likely to have any significant effect on the development of the epidemic. …

As experience shows, *there is no basis for recommending quarantine either of groups or individuals*.

Screening passengers at borders or closing air or rail hubs. Experience has shown that these actions are not effective …

***An overriding principle. Experience has shown that communities faced with epidemics or other adverse events respond best and with the least anxiety when the normal social functioning of the community is least disrupted***. Strong political and public health leadership to provide reassurance and to ensure that needed medical care services are provided are critical elements. If either is seen to be less than optimal, a manageable epidemic could move toward catastrophe.[612]

## Girl's school project is foundation of isolation social distancing policy

While isolating/quarantining groups of possibly infected people is not supported by "historical observations or scientific studies," it is supported by a school science project begun in 2005 by 14-year-old Laura M. Glass in Albuquerque, New Mexico. In a May 2020 article about Glass' project the *Albuquerque Journal* wrote:

Person-to-person contact is the most common way infectious diseases are spread. Laura, with some guidance from her dad, devised a computer simulation that showed how people – family members, co-workers, students in schools, people in social situations – interact.

What she discovered was that school kids come in contact with about 140 people a day, more than any other group.

Based on that finding, her program showed that in a hypothetical town of 10,000 people, 5,000 would be infected during a pandemic if

no measures were taken, but only 500 would be infected if the schools were closed.[613]

Glass' dad Robert worked with the National Infrastructure Simulation and Analysis Center (NISAC) at Sandia in Albuquerque. He worked on complex systems modeling, where a person would be put on a grid and moved around to find out who they would come into contact with. Glass used that idea to model how an infectious disease would spread through personal contact. The *Albuquerque Journal* quotes Robert Glass: "On Halloween 2005, NISAC received a call. Could we prepare a brief for Secretary (Michael) Chertoff of the U.S. Department of Homeland Security?"[614]

The Bush administration wanted to develop a plan for dealing with a contagious disease outbreak. The NISAC brief was to be presented at a Cabinet-level meeting at the White House. The question to be answered in the brief was what could be done to avert disaster if no vaccine and limited antiviral supplies were available to counteract an outbreak? Robert Glass said: "I thought, 'That's exactly what Laura is working on.'" He talked about it with his daughter, and she told him: "Why don't you close the schools?"[615] Her program showed it would slow the spread of a virus through society.

Robert Glass analyzed the premise of Laura's study with the computers at Sandia. The computer modeling suggested in a widespread outbreak that schools should be closed, public and workplace social interactions should be limited, and people *de facto* quarantined at home to limit human interaction. He incorporated that research into the brief he sent to Washington. He says now: "It looked like a solution if we could get people to prepare for it."[616] Fifteen-year-old Laura Glass was listed as one of four authors of that brief: "Targeted Social Distancing Designs for Pandemic Influenza" (Nov. 2006).[617] Imperial College's Neil Ferguson was one of the people acknowledged in the brief for their "discussions and suggestions" related to it.[618]

That brief stated in part:

> At the start of an influenza pandemic, effective vaccine and antiviral drugs may not be available to the general population. If the accompanying illness and death rates of the virus strain are high, how might a community respond to protect itself?… However, within a community, influenza spreads from person to person through the social contact network. … We describe how social contact network–focused mitigation can be designed. At the foundation of the design process is a network-based simulation model for the spread of influenza. We apply this model to a community of 10,000 persons connected within an overlapping, stylized, social network representative of a small US town.[619]

…

The backbone of infectious contact networks is formed primarily of children and teenagers with infectious transmissions mostly in the household, neighborhood, and schools.[620]

…

To find effective targeted social distancing strategy combinations across the range of disease infectivity and infectious contact networks, we formulated 5 strategies and applied them individually and in combination:

1) school closure where the contact frequency within schools was reduced 90% and children and teenagers household contacts were doubled;

2) children and teenagers social distancing where their contact frequencies in all non-household and nonschool groups were reduced 90% and their household contacts doubled;

3) adult and older adult social distancing, where their contact frequencies in all non-household and non-work groups were reduced 90% and household contacts doubled;

4) liberal leave, where all children and teenagers and 90% of adults withdraw to the home when symptomatic; and

5) work social distancing where the contact frequency within work groups was reduced 50%.[621]

…

**Discussion**

*Results for our stylized small town suggest that targeted social distancing strategies can be designed to effectively mitigate the local progression of pandemic influenza without the use of vaccine or antiviral drugs*. … However, given uncertainty in the infectivity of the influenza strain, underlying social contact network, or relative infectivity/susceptibility of the young versus adults, planning to implement strategies that also target adults and the work environment is prudent. …[622]

Implementation of social distancing strategies is challenging. They likely must be imposed *for the duration of the local epidemic* … If compliance with the strategy is high over this period, an epidemic within a community can be averted. However, if neighboring communities do not also use these interventions, infected neighbors will continue to introduce influenza and prolong the local epidemic, albeit at a depressed level more easily accommodated by healthcare systems."[623]

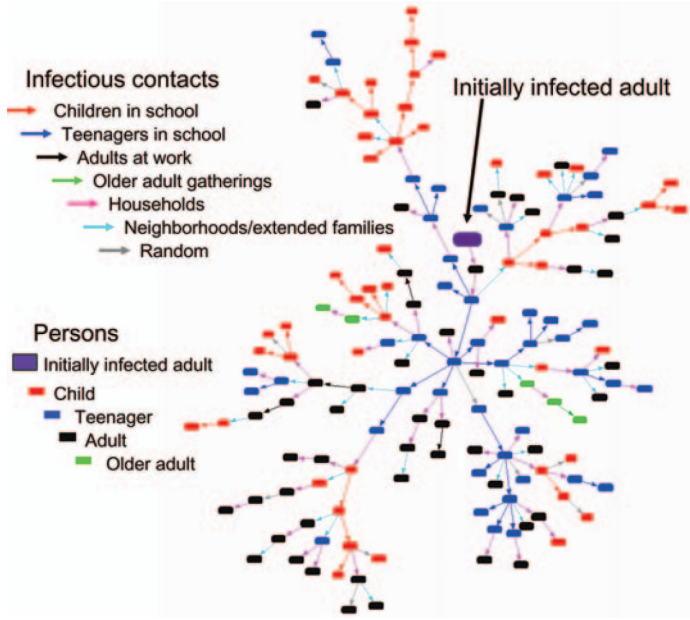


Figure 4 shows spider web of social interactions

The brief specifically argued for using social distancing strategies within a local community to minimize an outbreak – not countywide, much less statewide, or nationally. It also argued that those strategies would alleviate an outbreak "without the use of vaccine or antiviral drugs." There was no recommendation for the closure or limiting of any business activity even in the most severe pandemic as a strategy – although it did indicate unspecified social distancing stratagems could be used to reduce "contact frequency within work groups."[624]

There was opposition to the brief's ideas of isolating school children at home and limiting social interactions in the workplace to control an infectious outbreak, because it was considered unnecessary and would cause economic and social upheaval. Dr. Howard Markel was present when Glass' idea was first brought up to government public health experts: "*People could not believe that the strategy would be effective or even feasible*."[625]

## 2007 CDC guidelines

Glass' basic idea of widespread isolation social distancing was incorporated into the CDC's February 2007 document: "Interim pre-pandemic planning guidance: Community strategy for pandemic influenza mitigation in the United States."[626] Glass' idea was one of the CDC's strategies called Non-Pharmaceutical Interventions.

The document's Introduction outlined the strategy we now call "flattening the curve": "A severe pandemic could overwhelm acute care

services in the United States and challenge our nation's healthcare system. … Delaying a rapid upswing of cases and lowering the epidemic peak to the extent possible would allow a better match between the number of ill persons requiring hospitalization and the nation's capacity to provide medical care for such people."[627]

The 2007 document had a Severity Index rating a novel influenza outbreak on a scale with 1 the least, and 5 the most severe:

- Category 1 was seasonal flu with deaths of up to 90,000 in a year (CFR <0 .1%)
- Category 2 was deaths between 90,000-<450,000 (CFR 0.1-<0.5%)
- Category 3 was deaths between 450,000-<900,000 (CFR 0.5-<1.0%)
- Category 4 was deaths between 900,000-<1.8 million) (CFR 1.0-<2.0%)
- Category 5 was deaths between >1.8 mil. (CFR (>2.0%) (Deaths based on 2006 U.S. population)[628]

Quarantine/Social Distancing recommendations were based on the outbreak severity:

- Categories 1, 2 and 3: "Voluntary isolation of ill at home."
- Categories 4 and 5: "Voluntary isolation of ill at home;
  Voluntary quarantine of household member in homes with ill persons;
  Child social distancing -- Dismissal of students from schools and school based activities; reduce out-of-school social contacts.
  Adult social distancing – Decrease number of social contacts; increase distance between persons; modify, postpone, or cancel selected public gatherings; modify work place schedules and practices.[629]

The CDC's planning guide did not include any mention of closing or limiting business activity as a recommendation under even a category 4 or 5 outbreak. It only mentioned that some workplaces might be disrupted by employee absenteeism due to illness or child minding.[630]

For the next ten years – until April 2017 – the 2007 document was unchanged as the CDC's official strategy for dealing with an influenza outbreak.

### 2017 CDC guidelines

In 2017 "Community Mitigation Guidelines" replaced the CDC's 2007 planning guide.[631] Many general recommendations related to responding to a virus outbreak were unchanged. However, one significant change was the 5-level Severity Index was replaced with a 7-level Pandemic Severity Assessment Framework (PSAF). The PSAF significantly reduced the severity of an outbreak to CFR >1.0% for it to be classified at the highest

category of 7 – whereas it was CFR >2.0% in 2007.[632] The new standards lowered the CFR of all categories so that even the seasonal flu would be classified as at least a category 3 and possibly 4 – whereas in 2007 it was classified as the benchmark for category 1.

Thus, the normal seasonal flu would be considered a much more severe health threat and could elicit more of a response by government health agencies under the 2017 guidelines than under the 2007 guidelines.

The PSAF is somewhat subjective because it doesn't rely on a quantifiable number like the CFR, but on a mixture of factors to determine if a novel virus outbreak is:

- Low to medium severity and transmissibility.
- High transmissibility and low to medium severity.
- High to very high transmissibility and severity.[633]

The maximum social distancing/quarantining recommendations by the CDC during the most severe novel virus outbreak are:

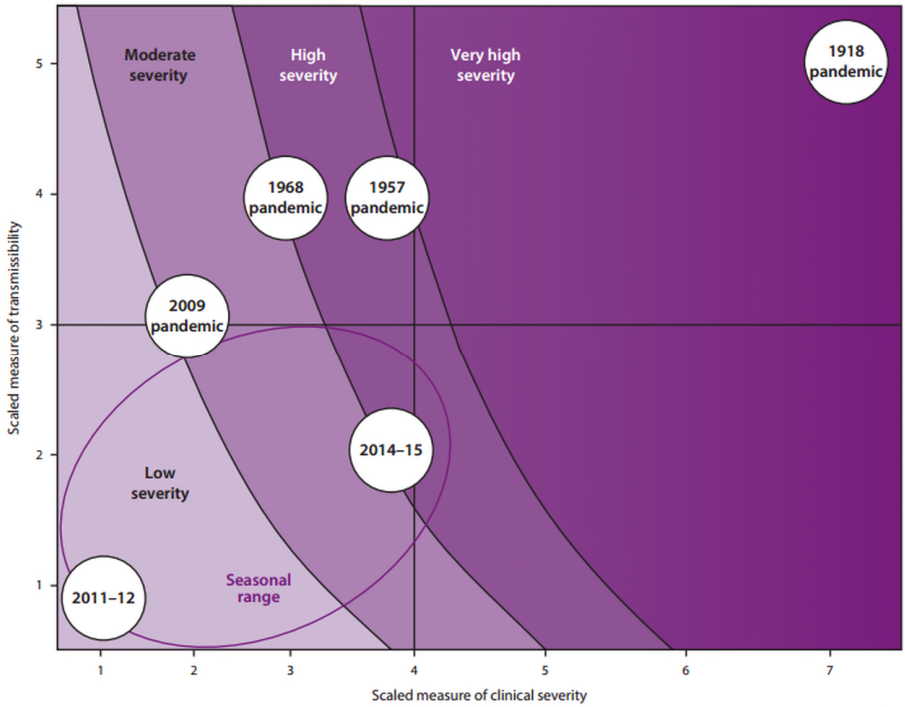
*Personal*

- Voluntary home quarantine (household members of ill persons stay home for up to 3 days and then remain home if they become ill)
- Face mask use by ill persons for source control (Community)
- School closures and dismissals
- Mass gathering modifications/postponements/cancellations
- Other social distancing measures (e.g., telecommuting in workplaces or seating students further apart in classrooms [if schools aren't closed])[634]

The general murkiness of determining the severity level of a virus outbreak and inflating the recommended response gives health officials and state and national leaders enormous leeway in escalating a response compared to the 2007 guidelines, which established clear-cut parameters and the corresponding response. We have seen the mushiness of the 2017 guidelines by the response at the state and federal level to COVID-19 in imposing the most severe mitigation strategies on every level.

That response would have been unthinkable under the 2007 guidelines, because the COVID-19 outbreak only rates as a mid-level Category 2 (out of 5) outbreak. The maximum recommended CDC response up to 2017 would have been: "Voluntary isolation of ill at home." (See above sub-chapter: 2007 CDC Guidelines.) That measured response would have been consistent with how previous severe respiratory illnesses outbreaks were handled in the U.S.

FIGURE 6. U.S. Department of Health and Human Services pandemic planning scenarios based on the Pandemic Severity Assessment Framework




Source: Adapted from: Reed C, Biggerstaff M, Finelli L, et al. Novel framework for assessing epidemiologic effects of influenza epidemics and pandemics. Emerg Infec Dis 2013;19:85–91.

In the 2017 guidelines There is no recommendation for the closure or limiting of any business activity even in the most severe pandemic as a strategy to mitigate the outbreak. The word non-essential is not in the document anywhere.

One thing the guidelines caution about is to consider the cost of a Non-Pharmaceutical Intervention (NPI) to mitigate an outbreak versus the societal costs:

> **Balancing Public Health Benefits and Social Costs.** *It is especially important for planners to consider, in advance, how their communities might balance the public health benefits of NPIs – in terms of reduced illness and death – against the economic and social costs associated with different pandemic scenarios*.
>
> …
>
> Depending on local resources and preferences, different communities may reach different conclusions about the degree of pandemic severity required before (for example) schools dismiss students and businesses start encouraging workers to telecommute.[635]

Unfortunately, every state that imposed severe mitigation measures outlined in the 2017 guidelines failed to exercise the caution of only doing so after "balanc[ing] the public health benefits of NPIs – in terms of reduced illness and death – against the economic and social costs associated with different pandemic scenarios."[636] State governors and health officials dove in head first without any consideration of the predictably severe consequences.

## USC Professor Joel Hay

USC Professor Joel Hay, PhD. stated during an interview on April 22, 2020:

> "In fact there's no basis, there's no scientific evidence to support social distancing with this particular virus C-19. Social distancing is for viruses that are very lethal but not that contagious and transmissible. This is probably the most contagious virus we've ever seen. I mean it leaped around the world in a matter of weeks or months. Probably was in Los Angeles and California generally last year. I mean keep in mind this is the Covid-19 virus. It is from last year and its been around for a long time and that is what a lot of the serology data is now starting to show. We just had a big study in LA County showing that about 70 times more people are positive for C-19 than their tests were showing. When you go out and test asymptomatic people out in the community … They are C-19 positive and it's not affecting them.
>
> …
>
> What has not been 100% effective is the idea of social closure. They said that if we reduced office work. If we shut down restaurants and non-essential businesses. If we cut transportation. If we shut down the schools. That we would reduce viral transmissions to zero. Guess what. None of that happened… <u>They're based their entire intervention of social distancing on no evidence</u>. So we now have plenty of evidence that the virus has been out there for a long time and we got to open up. [637]

## Conclusion

Even though quarantining and severe social distancing regimes have been integral to the CDC's written plans to control a virus outbreak – and they were instituted in the most extreme way imaginable related to COVID-19 – there is no evidence they are effective:

> "It is difficult to identify circumstances in the past half-century when large-scale quarantine has been effectively used in the control of any disease. The negative consequences of large-scale quarantine are so extreme … that this mitigation measure should be eliminated from serious consideration."[638]

Beginning in March 2020 an experiment was begun in the U.S. (and other countries) to test Laura Glass' basic premise that a virus epidemic could seriously be mitigated by social distancing and targeted quarantines. However, her idea was taken to a level far beyond what she had suggested: social and economic life was largely shut-down statewide (and nationwide in some countries) and all schools were closed; people were isolated at home and social distancing rules were imposed for when they weren't at home. All without any evidence it was an effective strategy to reduce COVID-19 deaths. Those action presupposed COVID-19 was a virus so deadly that it would decimate the world if it spread unchecked through the population – which was itself not backed by any scientific evidence.

We now know one fundamental flaw in Laura Glass' study was it focused on overall transmission, and it didn't take into account the people who actually need to be socially distanced/isolated in an infectious outbreak are the people most at risk from serious illness and death from contracting it. It is unnecessary overkill to socially distance/quarantine low-risk people, who in the case of COVID-19 is virtually every reasonably healthy person under 80 – and especially healthy people under 50.

## III – Public Social Distancing

There is no clear scientific evidence that public social distancing by maintaining a 3 foot or 6 foot (1 to 2 meters) physical separation between strangers is an effective strategy to reduce COVID-19 infections. It is advanced as a non-pharmaceutical intervention to prevent the spread of COVID-19.

### UK's politically inspired two-meter rule is "conjured out of nowhere"

It is known the United Kingdom's two-meter (6') rule was "conjured out of nowhere." Government advisor Robert Dingwall stated in an interview on England's Radio 4 in late April 2020: "I think it will be much harder to get compliance with some of the measures that really do not have an evidence base. I mean *the two-metre rule was conjured up out of nowhere. There's never been a scientific basis for two metres*, it's kind of a rule of thumb. But it's not like there is a whole kind of rigorous scientific literature that it is founded upon."[639] Dingwall further said: "We cannot sustain [social distancing measures] without causing serious damage to society, to the economy and to the physical and mental health of the population."[640]

The UK's COVID-19 lockdown rules announced on March 23 included forced public social distancing: "If you meet others when you are outdoors (for example, on a walk) ensure that you stay at least 2 metres away."[641]

After Dingwall's interview that undermined the need to stay two-meters apart, a spokesperson for Public Health England said: "It is absolutely vital that people continue to follow social distancing guidance to protect the NHS and save lives. This includes staying at home, only going outside for food, health reasons or work - and if you go out, stay two metres away from other people at all times."[642]

The political nature the two-meter rule is devoid of any scientific basis is reflected in the public disclosure that Boris Johnson's most powerful political aide and chief adviser Dominic Cummings sat in on the March 18 meeting of the Scientific Advisory Group for Emergencies that made the lockdown recommendations to the government.[643] Multiple people involved in the meeting said Cummings "pressed the U.K.'s independent scientific advisers to recommend lockdown measures," and he wanted the restrictions imposed quickly.[644] Cummings told the SAGE advisory group "pubs and restaurants should be closed within two days." After Cummings' (representing Boris Johnson) direct involvement in the lockdown decision making process was made public, the Labour Party's Shadow Health Secretary Jonathan Ashworth asked in an interview why he was allowed to attend: "The concern is that political advisers have influenced the debate."[645]

### CDC six foot recommendation

The CDC recommends:

> "To practice social or physical distancing, stay at least 6 feet (about 2 arms' length) from other people who are not from your household in both indoor and outdoor spaces. … COVID-19 spreads mainly among people who are in close contact (within about 6 feet) for a prolonged period. Spread happens when an infected person coughs, sneezes, or talks, and droplets from their mouth or nose are launched into the air and land in the mouths or noses of people nearby. The droplets can also be inhaled into the lungs."[646]

The CDC does not cite any study supporting the effectiveness of its 6 feet social distancing recommendation.

### WHO's one meter (3') recommendation

The WHO recommends:

> "Maintain at least 1 metre (3 feet) distance between yourself and others. Why? When someone coughs, sneezes, or speaks they spray small liquid droplets from their nose or mouth which may contain virus. If you are too close, you can breathe in the droplets, including the COVID-19 virus if the person has the disease."[647]

The WHO does not cite any study supporting the effectiveness of its 3 feet social distancing recommendation.

During the 2009 Swine flu outbreak, the WHO described social distancing as "keeping at least an arm's length distance from others."[648] But again there was no scientific basis for making that recommendation. In 2009 the WHO also recommended: "minimizing gatherings, respiratory etiquette (covering coughs and sneezes), hand hygiene, and household ventilation, are likely to be the most effective public health measures and are highly recommended."[649]

### 1930s study

Scientists at the UNSW Sydney and Massachusetts Institute of Technology reviewed available literature on the horizontal distance travelled by respiratory droplets. They found the 1 to 2 meter rule is based on no contemporary research. What they found was in the 1930s scientists believed large droplets emitted from symptomatic patients did not travel more than 2 meters.[650]

### Current studies of droplet exhalations

Studies of droplets from different types of exhalations by a person are known to travel up to 8 meters (26-1/4 feet). Studies of COVID-19 have found traces of the virus in air vents of a person's room and up to 4 meters (13-1/8 feet) from them.[651]

### Conclusion

There is not only no scientific support for the 3' or 6' social distancing recommendations, but they are undermined by research supporting that the COVID-19 virus may possibly travel up to 26' from the exhalations of an infected person. But that doesn't address the infectability of a person subject to those exhalations. At this point in time public social distancing is a political concept so it is less reliable than junk science. The 3-feet or 6-feet social distancing rule imposed by governments around the world to purportedly stop the spread of COVID-19 is literally made up, and medical and government officials have blindly adopted it in knee-jerk fashion.

## IV – Hand Washing

The May 2020 issue of the CDC's peer reviewed publication *Emerging Infectious Diseases* published an article by seven researchers that states regarding hand washing:

> The effect of hand hygiene combined with face masks on laboratory-confirmed influenza was not statistically significant….

… results from our meta-analysis on RCTs did not provide evidence to support a protective effect of hand hygiene against transmission of laboratory-confirmed influenza. …

Hand hygiene is also effective in preventing other infectious diseases, including diarrheal diseases and some respiratory diseases. The need for hand hygiene in disease prevention is well recognized among most communities. There are few adverse effects of hand hygiene except for skin irritation caused by some hand hygiene products.

Hand hygiene is a widely used intervention and has been shown to effectively reduce the transmission of gastrointestinal infections and respiratory infections. However, in our systematic review …*we did not find evidence of a major effect of hand hygiene on laboratory-confirmed influenza virus transmission*.[652]

## V – Surface and Object Cleaning

The May 2020 issue of the CDC's peer reviewed publication *Emerging Infectious Diseases* published an article by seven researchers that states regarding sanitizing surfaces:

"Although we found no evidence that surface and object cleaning could reduce influenza transmission, this measure does have an established impact on prevention of other infectious diseases.

There was a limited amount of evidence suggesting that surface and object cleaning does not have a substantial effect on influenza transmission."[653]

While surface and object cleaning isn't likely to prevent contracting a respiratory flu-like virus, the studies indicate it could reduce the likelihood of contracting something else.

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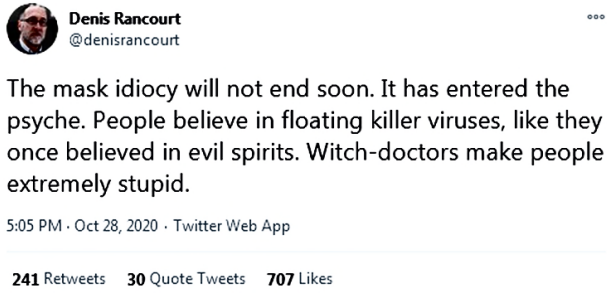


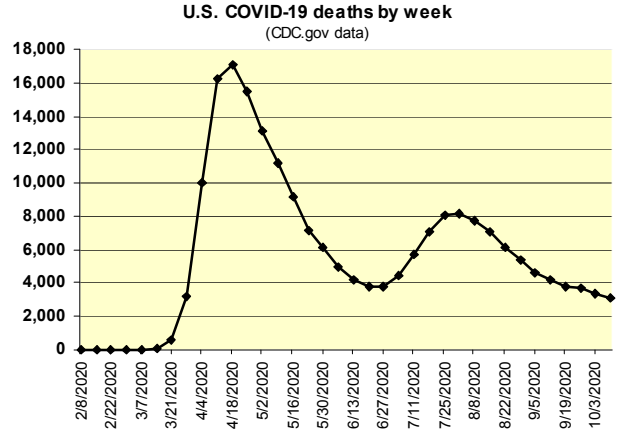
# 16. COVID-19 Peaked In Potency When Lockdowns Were Imposed

In the U.S. state imposed lockdowns occurred in the last week in March. With a 14-day quarantine period as the accepted norm to determine a person was not asymptomatic, infections contracted prior to imposition of the lockdowns would have likely appeared by mid-April. As the following charts show, COVID-19 deaths peaked in the U.S. the week ending April 18. Tracking that exactly, hospitalizations also peaked the week-ending April 18. There was no curve to flatten because the severity of the COVID-19 outbreak peaked nationally at the very time the lockdowns were imposed. The death and hospitalization data proves the lockdowns had no effect on the falling rate of deaths and hospitalizations from the peak.

The most accurate barometer of the COVID-19 outbreak are deaths caused by the virus. Mere counting of positive test results is unreliable at gauging the severity of a case, because it is known a large majority of people who test positive are asymptomatic, they were infected with a virus that is no longer active, or they had a false positive. Counting people who test positive for COVID-19 anti-bodies but who don't test positive for the virus is even less of a reliable barometer for gauging severe cases – because those people are asymptomatic plus.

## I – U.S. deaths and hospitalizations peaked April 18

The accompanying chart shows the weekly deaths in the U.S. from February 1, 2020 to October 10, 2020. Deaths peaked at 17,057 the week ending April 18, 2020.

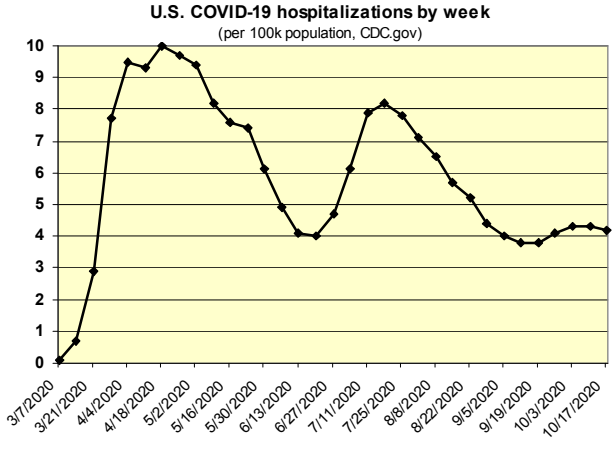



Counting people who are hospitalized can be a general barometer of serious cases. People mildly affected are not going to seek hospitalization. However, there are significant financial incentives for a hospital to code an admittance as a COVID case without a

positive test being conducted, when a person merely shows a symptom such as sniffles or a cough – when the reason they went to the hospital is a different ailment. Thus hospitalization is less of a precise measure than deaths, but they are nevertheless a mathematical measure that can be used to generally track the increase and decrease of the outbreak.

The hospitalization chart shows the number of COVID-19 patients peaked at 10 per 100k population the week ending April 18, 2020.

The chart also shows one of the biggest false claims in U.S. history was there was going to be a shortage of hospital beds for COVID-19 patients. At the outbreak's peak, 1 person was hospitalized for every 10,000 people in the U.S.




There are a total of 924,107 staffed beds in all U.S. hospitals.[654]

A total of 635,800 people were hospitalized for COVID-19 in the U.S. during the seven months from the first week of March to the first week of October.[655] So if *all* COVID-19 patients *for the first nine months* of the outbreak had been hospitalized at the same time, *68%* of all hospital beds in the U.S. would have been needed.

Shutdowns were instituted by the governors in 42 states based on their alleged fear hospitals would be overwhelmed by COVID-19 patients. That fear had no basis in reality.

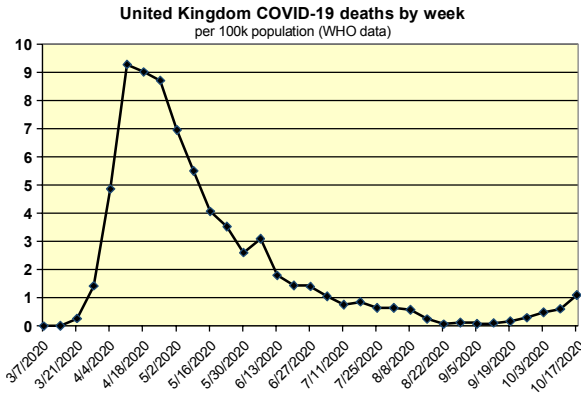
## II – U.K. deaths peaked April 11

Deaths in the United Kingdom followed a similar pattern as those in the U.S. Prime Minister Boris Johnson announced a very hard lockdown effective March 23. Deaths peaked the week ending April 11 at 9.28 per 100k population. That was a week before deaths peaked in the U.S.

The U.K. continued its hard lockdown even after deaths declined in early-July to less than 1 per 100k people.

Based solely on a rise in infection rates – and with a very low death rate – on September 14 the U.K. government imposed the "rule of six" that prohibited any indoor or outdoor social gathering of more than six people. The police were authorized to disperse any such gatherings and fine the

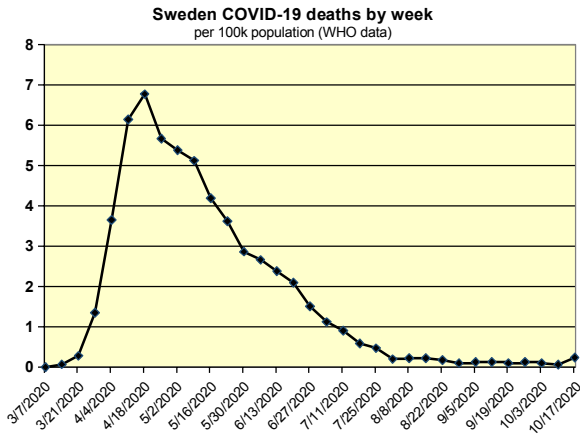
individuals involved £100. The fines could double for each subsequent violation up to a maximum of £3,200.[656]




On September 22 the U.K. government issued new restrictions: "Pubs, bars and restaurants will have to close early at 10:00pm local time from Thursday, while face coverings will be made compulsory for staff in retail, as well as in taxis."[657] People who violate quarantine and social distancing rules would face heavy fines.

Several British cities imposed local lockdowns on September 25 in response to the rise in infections, with people in many communities no longer able to socialize with other households.[658]

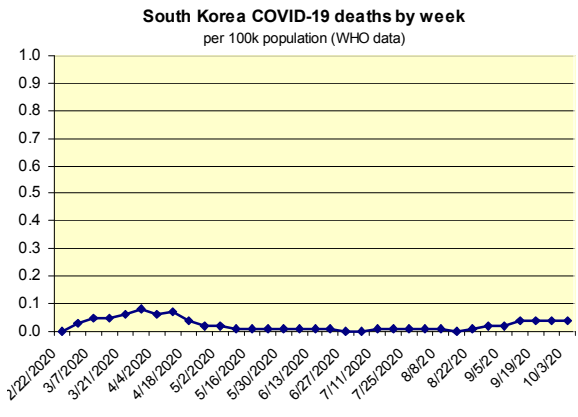
## III – Sweden deaths peaked April 18




Deaths in Sweden peaked the week ending April 18 at 6.77 per 100k population. That was the same week deaths peaked in the U.S. Sweden's national government didn't mandate a hard lockdown like most U.S. states and other countries. In Sweden businesses and elementary schools remained open, while public gatherings were limited to no more than 50 people and secondary schools and universities were closed. Masks were not mandatory, while voluntary social distancing was encouraged.

# IV – South Korea deaths peaked March 28

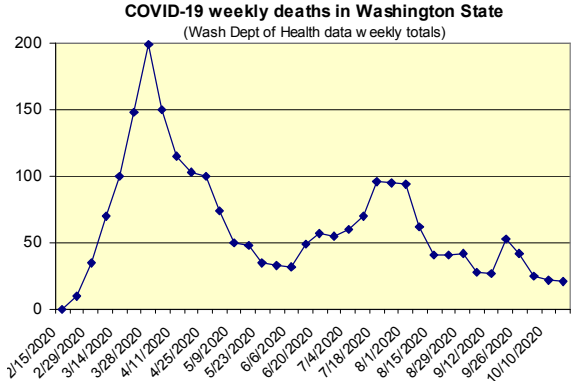
Deaths in South Korea peaked the week ending March 28 at .08 per 100k population. That is 1/116th the U.K.'s peak rate.




South Korea's national government didn't mandate a lockdown, but voluntary social distancing was encouraged. There were weeks in the following months in which there were zero COVID-19 deaths in South Korea.

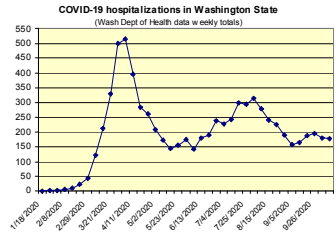
# V – Washington State deaths and hospitalizations peaked March 23

The first confirmed case of COVID-19 in the United States was in Washington state on January 20, 2020. The first large outbreak was at an elderly care facility in neighboring King County. So Washington has particular value for understanding the progression of the virus in the U.S.




On March 23 Governor Jay Inslee proclaimed a statewide stay at home order and the closure of non-essential businesses. The proclamation's stated purpose was to flatten the curve to prevent hospitals from becoming overwhelmed with COVID-19 patients.[659]

Less than two weeks after that – the incubation period of an existing infection – COVID-19 related deaths, hospitalizations, and the percentage of positive confirmed tests all peaked in Washington – and began declining.[660]

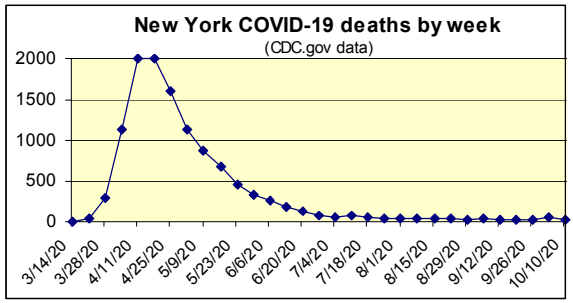



Inslee's Proclamation was thus completely

unnecessary and could have immediately been rescinded because there was no curve to flatten – the COVID-19 outbreak was following the same downward trajectory of all influenza like illnesses and naturally dying out.

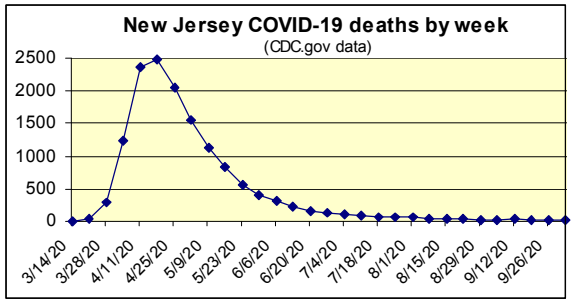
The patterns of deaths and hospitalizations somewhat match each other.

## VI – New York state deaths



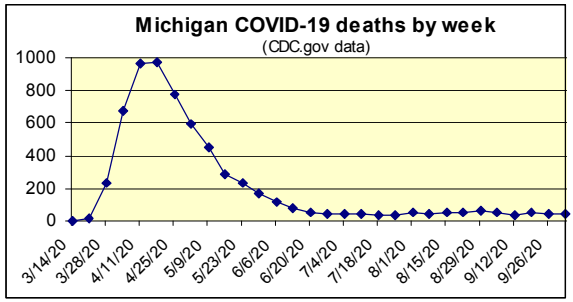

COVID-19 deaths in New York peaked on April 11, 2020.[661] The accompanying chart shows the deaths somewhat followed a bell curve similar to Pennsylvania, Michigan and New Jersey that likewise required long-term care facilities to take COVID-19 positive patients from hospitals. With widespread infection of the most vulnerable people which occurs during a flu outbreak, mortality in those states followed a relatively normal bell curve with a peak, and then a drop to a very low level.

## VII – New Jersey deaths




COVID-19 deaths in New Jersey peaked on April 18, 2020.[662] The chart shows N.J. deaths somewhat followed a bell curve like other states that required long-term care facilities to take COVID-19 patients from hospitals.

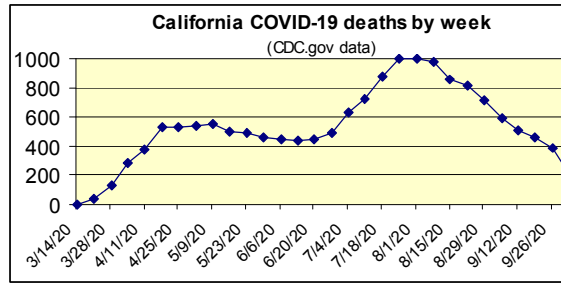
## VIII – Michigan deaths




COVID-19 deaths in Michigan peaked on April 18, 2020.[663]

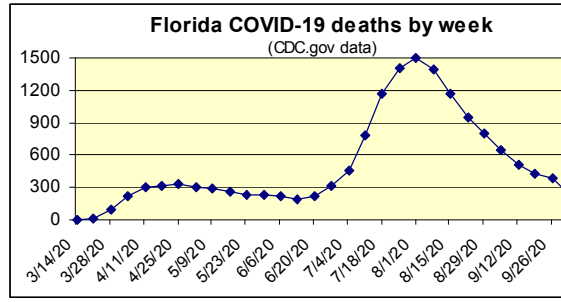
## IX – California deaths

Unlike states across the northern U.S., COVID-19 deaths in states across the southern U.S. peaked in mid-summer. California peaked during the week ending August 1, 2020.[664] Other states in the southern U.S. followed a similar pattern.



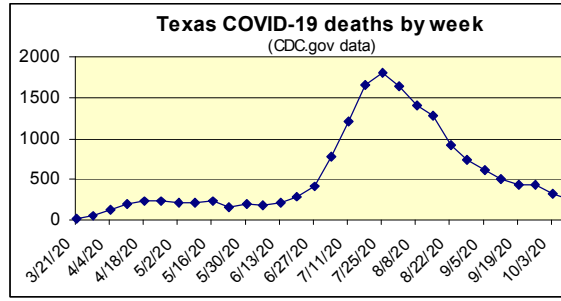

## X – Florida deaths

COVID-19 deaths in Florida peaked during the week ending August 1, 2020.[665]




## XI – Texas deaths

COVID-19 deaths in Texas peaked on July 25, 2020.[666]



# 17. Seriously Unhealthy People Are Demographic At Risk From COVID-19

It has been known since shortly after the COVID-19 outbreak began in Wuhan, China that the people most vulnerable to it are unhealthy people of any age with one or more serious underlying health problem, and frail elderly people. It has also been known that for healthy people of any age, and particularly those under 30, it can be less serious than the seasonal flu.

The Council of State and Territorial Epidemiologists issue a COVID-19 position statement on April 5, 2020 that stated in part:

> "Based on epidemiologic reports of the outbreak in China, those at highest risk for severe disease and death include people aged over 60 years and those with underlying conditions such as hypertension, diabetes, cardiovascular disease, chronic respiratory disease, and cancer. Disease in children appears to be relatively mild, and growing evidence that a significant proportion of infections across all age groups are asymptomatic."[667]

Dr. Steven Shapiro, chief medical and scientific officer of the University of Pennsylvania Medical Center stated during a roundtable convened by U.S. Senator Pat Toomey (R-Pa):

> "Our outcomes are similar to the state of Pennsylvania, where the median age of death from COVID-19 is 84 years old. The few younger patients who died all had significant preexisting conditions. Very few children were infected and none died. … In sum, this is a disease of the elderly, sick and poor. …
>
> COVID-19 is a disease that ravages those with preexisting conditions – whether it be immunosenescence of aging or the social determinants of health. We can manage society in the presence of this pathogen if we focus on these preexisting conditions."[668]

The CDC identifies two groups of people at increased risk for severe illness from COVID-19:

- Older adults, with the greatest risk among those aged 85 and older.[669]
- People with underlying medical conditions that are known to include:
  - Chronic kidney disease
  - COPD (chronic obstructive pulmonary disease)
  - Immunocompromised state (weakened immune system) from solid organ transplant
  - Obesity (body mass index [BMI] of 30 or higher)

Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
Sickle cell disease
Type 2 diabetes mellitus[670]

## I – Isolation is best mitigation for at risk people

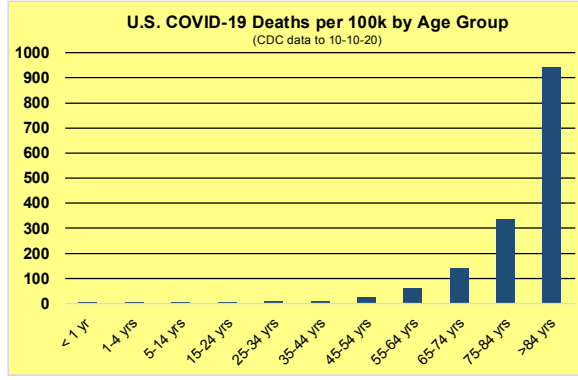
It known that isolation of symptomatic flu patients is the most effective way to prevent them from transmitting it in the absence of a vaccine:

Isolating symptomatic people with a respiratory illness, either at home or in the hospital, is probably the most important measure that can be taken to reduce the transmission and slow the spread of illness within a community. The sickest (and presumably most contagious) patients are most likely to seek hospital care.[671]

However, not everyone who is ill needs to be in a hospital: "A policy that persuades sick individuals to voluntarily stay at home unless they are critically ill would allow hospitals to focus efforts on those most seriously threatened."[672]

Isolation is temporary state until the danger period is past: "What we cannot do, is extended social isolation. Humans are social beings, and we are already seeing the adverse mental health consequences of loneliness, and that is before the much greater effects of economic devastation take hold on the human condition." [673]

## II – COVID-19 kills elderly at 10,500 times rate of children




The fact that almost 10,500 people 85 or older die from COVID-19 for every school aged child shows how much more vulnerable elderly people are than the young. The accompanying chart shows deaths per 100k by age group.

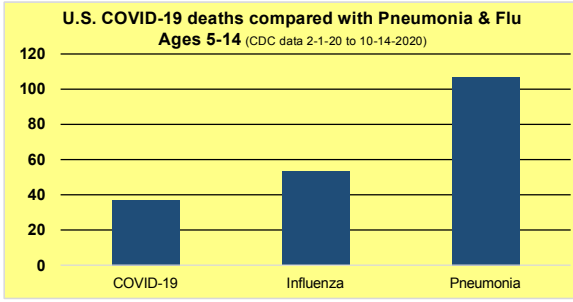
The actual numbers are 944 deaths per 100k ages 85 and up, and 0.09 deaths per 100k (1 in 1.1 million) in children 5 to 14.[674] School aged children are almost twice as likely to be the victim of a lightning strike than to die from COVID-19.[675]

# 18. Closing Of Schools Was Unjustified: Young People Don't Spread COVID-19 And Are Minimally Affected

It was known at the time schools were closed in the U.S. and countries around the world in the late Winter/early Spring 2020 from the data out of Asia, the preliminary data from Italy, and the Diamond Princess cruise ship that COVID-19 minimally affected children who had it, with deaths almost non-existent.

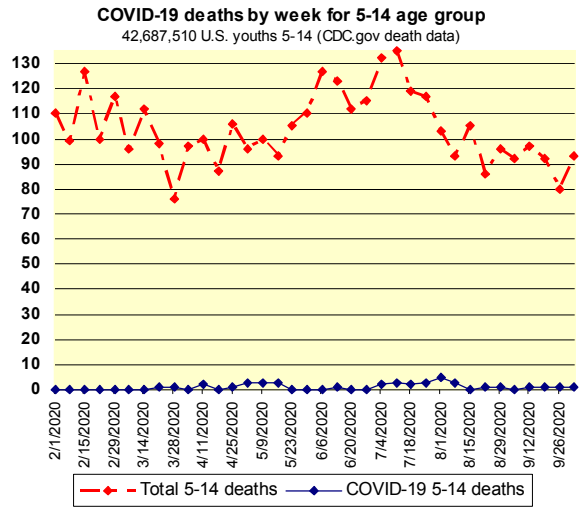
It has since been established that the R value for children is 0 or as close to zero as you can get without it being zero. (R value is the average number of people infected by a single infectious person)

In June 2020, Mark Woolhouse, a professor of infectious disease epidemiology at Edinburgh University acknowledged that in the UK people over-75 are 10,000 times more likely to die from Covid-19 than people under-15. He said: "That is a massive, massive difference. When you see something like that as a public health scientist, you don't think of a blanket lockdown. This disease is massively concentrated in the older age group. We need to concentrate efforts where they are needed most and where we really need attention is in the care homes."[676]




It is a fact the flu and pneumonia are both significantly more deadly for children than COVID-19. The flu killed 50% more children 5-14, and pneumonia killed 300% more children 5-14, than COVID-19 during the almost nine months from Feb. 1 to Oct. 14.[677] (See chart) There is no record of anyone suggesting any school should have been closed for even one day due to the flu or pneumonia during those eight months. Yet on account of the much less lethal COVID-19, schools in the U.S. and other countries were closed in March, and inexplicably, many continue to be closed or have limited in-person attendance when for most weeks there is zero or close to zero fatalities among the almost 43 million children aged 5 to 14.

Less than 1% of all deaths by 5 to 14 year olds was by COVID-19 during those eight months, with no more than four in any week.[678] That is less than 1 death per 10.5 million children. (See chart) So it is known with 100% certainty COVID-19 was never a mortality menace to school children.




That the risk of harm to children from missing school is greater than Covid-19 is understood by the U.K.'s former Prime Minister Tony Blair: "You have to explain to people, yes, there is nothing we are going to do in this situation that doesn't carry some risk. But you have got to measure that risk against the risk of an entire group of young children, usually the most socially deprived or most economically distressed young people, not getting the education they need."[679]

COVID-19's health effect on school aged children was insignificant in the U.S. An important but ignored aspect of closing schools is it not only does nothing to protect students from COVID-19, but it was predicted by Imperial College's Report 9 to increase the number of deaths by the elderly and other seriously unhealthy people.[680]

## I – Saxony Student and Teacher Study

The minimal effect of COVID-19 on school-aged kids and its almost non-existent transmission in schools by either students or teachers was demonstrated by a study published on July 16, 2020 that involved blood analysis of 1,538 grades 8-11 students and 507 teachers (30 to 66 years-old) in 13 secondary schools in three districts in Saxony, Germany. Those schools were selected because they had reopened with full class sizes in May, so the students and teachers had weeks to interact with each other prior to being tested. In Saxony the total infection rate as of July 13 had been 139 per 100k inhabitants.[681]

The study found COVID-19 antibodies in 12 of those who took part – 11 students and one teacher – and none were ill. There was no evidence they became infected within their school. Twenty-three participants testing seronegative had a household member who tested positive for COVID-19,

while one had antibodies, indicating transmission within families is infrequent. The study concluded:

> "Students and teachers do not play a crucial role in driving the SARS-CoV-2 pandemic in a low prevalence setting. Transmission in families occurs very infrequently, and the number of unreported cases is low in this age group, making school closures not appear appropriate as a strategy in this low prevalence settings."[682]

That was supported by an Australian study cited in the Saxony study: "In addition, a recent report from Australia could only identify a very limited spread of COVID-19 in primary schools, with no evidence of children infecting teachers."[683]

## II – Remote Online Learning Didn't Work During Lockdown

All public and private schools in the U.S. were temporarily closed for in-person teaching in March 2020 by the edict of governors, who then made the closure permanent by extending it through the end of the school year.[684] Online remote learning was instituted around the country after the closures were made permanent.

In June 2020 *The New York Times* published an article only a week from the end of the school year that stated in part:

> "New research suggests that by September, most students will have fallen behind where they would have been if they had stayed in classrooms, with some losing the equivalent of a full school year's worth of academic gains.
>
> The harm to students could grow if schools continue to teach fully or partly online in the fall, or if they reopen with significant budget cuts because of the economic downturn. High school dropout rates could increase, researchers say, while younger children could miss out on foundational concepts in phonics and fractions that prepare them for a lifetime of learning and working. …
>
> "We know this isn't a good way to teach," [Aurora, Colo. Seventh-grade social studies teacher Clint] Silva said. "We want to hold kids accountable. We want to see their progress, be in the classroom with them and see them struggle and overcome that. Instead, we are logging in for an hour a day, and kids are turning their cameras off and staying quiet and not talking to us."
>
> Research can now estimate the size of the learning loss students have experienced under such conditions. Because regular standardized testing has been suspended, some of the research uses

past disruptions to learning — such as natural disasters or even summer break — to project the potential impact of the current crisis. Other studies look at schools that used online learning software before the coronavirus shutdown, and check to see how students performed using the same programs from home.

The average student could begin the next school year having lost as much as a third of the expected progress from the previous year in reading and half of the expected progress in math, according to a working paper from NWEA, a nonprofit organization, and scholars at Brown University and the University of Virginia.

A separate analysis of 800,000 students from researchers at Brown and Harvard looked at how Zearn, an online math program, was used both before and after schools closed in March. It found that through late April, student progress in math decreased by about half in classrooms located in low-income ZIP codes, by a third in classrooms in middle-income ZIP codes and not at all in classrooms in high-income ZIP codes.

When all of the impacts are taken into account, the average student could fall seven months behind academically, while black and Hispanic students could experience even greater learning losses, equivalent to 10 months for black children and nine months for Latinos ….

… Schools with many poor students sometimes chose to relax instructional expectations on teachers because they knew families did not have reliable access to home computers or internet connections able to stream video.

The disparities in educational progress do not appear to be caused by any lack of effort on the part of families. The poorest parents spent about the same amount of time during school closures assisting their children with learning — 13 hours per week — as those making over $200,000 per year, according to a May Census Bureau survey of households with children."[685]

A *Wall Street Journal* article similarly stated:

"This spring, America took an involuntary crash course in remote learning. With the school year now winding down, the grade from students, teachers, parents and administrators is already in: It was a failure. School districts closed campuses in March in response to the coronavirus pandemic and, with practically no time at all for planning or training, launched a grand experiment to educate more than 50 million students from kindergarten through 12th grade using technology. The problems began piling up almost immediately.

> There were students with no computers or internet access. Teachers had no experience with remote learning. And many parents weren't available to help. In many places, lots of students simply didn't show up online, and administrators had no good way to find out why not. Soon many districts weren't requiring students to do any work at all, increasing the risk that millions of students would have big gaps in their learning." [686]

This wasn't just the case in the U.S. A World Bank report "foresees significant learning loss in the Western Balkans countries following the coronavirus outbreak, with more students falling back into functional illiteracy and dropping out of school."[687] The report stated: "All Western Balkan countries have responded to the disruption in education delivery by introducing various remote teaching modalities. … The current school closures are expected to result in considerable learning loss. Not attending school has two impacts: students do not learn anything new, and they forget what they had already learned. … In 2014 severe flooding in 2014 closed schools in Thailand for up to a month and reduced student achievement, depending on the subject and level, by 7 to 25 percent. … using data from over half a million students in grades 2–9 in a southern U.S. state (in 2008–12), a study found that over the summer, students on average lost 25–30 percent of their school-year learning—about 3 months of learning. The study also establishes that historically disadvantaged students lose more learning than the rest. The current school closures and resulting learning loss will take months or years to recover from, which will necessitate immediate policy responses to mitigate the impact, especially for those who suffered the most during school closures."[688]

Forcing every school aged child in the U.S. out of in-person schooling and into remote learning over the Internet didn't work. Ninety-one percent of the world's school children were affected by a school closure. The research suggests closing the schools put most students significantly behind where they would have been if they had stayed in classrooms, with some losing the equivalent of a full school year's worth of education.

## III – Washington Governor Inslee Requested To Reopen Schools

Washington Governor Jay Inslee issued an executive Proclamation on March 12, 2020 that due to the threat of COVID-19 he was ordering the prohibition of public school districts, charter schools, and private schools in three counties in the greater Seattle area from conducting in-person educational, recreational, and other K-12 school programs in their school facilities until April 24, 2020.[689] The order took effect on March 17 and

affected King County (where Seattle is), Snohomish County, and Pierce County. Those are the three most populous counties in Washington, and with about 4 million residents they have 55% of the state's population.

On March 13, 2020 Inslee issue a Proclamation ordering the closure of all schools in the state effective March 17, until April 24. On April 6 Inslee issued a Proclamation ordering the continued closure of all schools until June 19 – which was the last scheduled day of school in Washington state.

During the months of March, April and May significant data and studies became available documenting both the minimal impact of COVID-19 on the health of children, and that they neither transmit it to each other or adults, or if they do it is in insignificant numbers.

However, Governor Inslee didn't respond to that new information by rescinding his Executive order of April 6, and ordering the immediate reopening of Washington's schools.

Since it was known Washington's schools were remaining closed for no valid health related reason, the author composed a two-page letter to Inslee supported by nine-pages of information requesting that he order the immediate reopening of the schools. The letter that was physically mailed on May 23 to Inslee, and it was also emailed to him. The Governor's Office acknowledged receiving the letter, but Inslee did not directly respond to it. Inslee did not order the reopening of Washington's schools prior to the end of the school year.

It is positively known there is no valid health related reason for all K-12 and higher education schools to not open in the fall of 2020 and operate exactly as they did prior to being closed in March 2020. There is no health related justification to impose any COVID-19 restrictions on school operations.

The letter sent to Gov. Inslee follows:

**Hans Sherrer**

**_____**

**_____, WA**

May 23, 2020

Governor Jay Inslee
Office of the Governor
PO Box 40002
Olympia, Washington 98504-0002

RE: Reopening Washington's schools

Dear Governor Inslee,

I am requesting that you order the immediate reopening and resumption

of normal in-person activities in all K-12 public school districts, charter schools, and private schools in Washington State.

There was meager data regarding children and COVID-19 when you made your proclamations on March 13 and April 6 closing all Washington schools. That is no longer true. There is very extensive research supporting that children either do not transmit COVID-19 to other children or to adults, or if they do it is in insignificant numbers. It is also now known that the seasonal flu is more dangerous for K-12 children than COVID-19, which can have symptoms so mild or undetectable that it can be less of a nuisance for children than the common cold.

It is now positively known from data in Washington, the rest of the United States, and countries around the world that the probability of a K-12 child dying from COVID-19 is less than their probability of being struck by lightning or dying in a traffic accident. Zero children have died from COVID-19 in Washington, Oregon, or California, and only a handful of children have died world-wide.

It is also positively known that far fewer K-12 children have been hospitalized in Washington for COVID-19 than for the seasonal flu. The flu or a lingering common cold can be expected to cause more health difficulties for a K-12 child than COVID-19.

Not only are schools around the world reopening – including 22 EU countries – because it is now known it is safe to do so, but the schools in Sweden, Iceland and Belarus didn't close. If Washington had followed the lead of those countries and remained open it is now known there would have been no ill-effects for students and teachers – while life would have gone on as normal with no interruption.

In support of my above statements attached to this letter is a Statement of Information Supporting The Reopening Of Washington's Schools that includes real-world data, scientific evidence, and relevant facts related to the following:

- Death and hospitalization regarding COVID-19 and school aged children;
- Transmission and infection regarding COVID-19 and school aged children;
- Mental health of children has been harmed by school closures;
- Schools are safely open and reopening world-wide;
- Reopening schools will be painless because new procedures are not necessary;
- Summary.

The essence of what the information in the Statement of Information establishes was expressed in a May 3, 2020 statement by the Australian

Government's Deputy Chief Medical Officer, Nick Coatsworth, supporting the reopening of Australia's schools for face-to-face teaching:

> "When school closures were initially proposed to control an epidemic, planners had influenza in mind. Flu spreading within schools and children are the main source for transmission in the community. But COVID-19 is not the flu.
>
> Far fewer children are affected by COVID-19, and the number of transmissions from children to children and children to adults is far less. … As an infectious diseases specialist, I have examined all of the available evidence from within Australia and around the world and, as it stands, it does not support avoiding classroom learning as a means to control COVID-19."[690]

Consequently, it is now known the rationale doesn't exist for the statewide emergency first set forth more than two months ago in your Proclamation closing the schools. We now know:

- K-12 children have an insignificant role in transmitting COVID-19;
- COVID-19 is not an abnormal threat to the life and health of K-12 children;
- There is no public disaster affecting life, health, property or the public peace to justify the continued closure of schools in Washington due to COVID-19.

There is no emergency necessitating continued closure of the schools. The fire drill is over.

We know you take your elected position seriously and wouldn't have given any consideration to issuing your Proclamations closing schools statewide if what is known now about COVID-19 was known in March and early April. It is now known the school closures have no scientific basis, serve no identifiable health purpose, do not protect children, and have triggered significant negative mental health consequences.

For all the reasons set-forth in this letter and the accompanying Statement of Information, I am requesting that you order the prompt reopening and resumption of normal in-person activities in all K-12 public school districts, charter schools, and private schools in Washington.

The schools were closed with four days notice to comply. There is every reason to think that with that same notice all of Washington's schools can be open and operating normally the week of June 1, 2020.

Thank you for your prompt attention to this urgent matter of putting the mental health and welfare of the children of Washington first, and not delaying the reopening of their schools due to any political pressures or political considerations to keep them closed, or legacy media and social

media fueled hysteria. In the immortal words of President Franklin D. Roosevelt, we now know that regarding children and COVID-19 the "Only thing we have to fear is fear itself."

If you have any questions you can contact me by mail or email at hanss@forejustice.org.

Sincerely,
Hans Sherrer

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## Information Supporting The Reopening Of Washington's Schools May 23, 2020

### Introduction

Governor Jay Inslee's March 13, 2020 emergency Proclamation 20-09 – "Statewide K-12 School Closures" – stated as a key reason for ordering the prohibition of public school districts, charter schools, and private schools from conducting in-person educational, recreational, and other K-12 school programs in their school facilities until April 24, 2020, was:

> "WHEREAS, while we do not fully understand the role children have in transmitting the virus, we do know they have a significant role in transmitting other respiratory viruses; and …"

That Proclamation also cited general concerns regarding the transmission and health risk of COVID-19, based on the limited information known at that time.

Governor Inslee's April 6, 2020 emergency Proclamation 20-09.1 – "Statewide K-12 School Closures" – extended the emergency Proclamation 20-09 until June 19, 2020. It stated a key reason for doing so was:

> "WHEREAS, to curtail the spread of COVID-19 in Washington State, protect our people from its effects, and reduce the impact on our health care system, it is necessary to continue stringent social distancing and sanitation requirements, restrictions on gatherings and personal interactions, and closure of our K-12 schools statewide; and…"

That Proclamation also cited general concerns regarding the transmission and health risk of COVID-19, based on the limited information known at that time.

This Statement of Information includes real-world data, scientific evidence and relevant facts supporting that the immediate reopening of Washington's schools is the only logical and sensible course of action based on the extensive information that is now known about COVID-19. Unlike when Governor Inslee issued his school closure Proclamations, it is now

known that children have a negligible role in transmitting COVID-19; the infection rate of children is very low and when infected they are generally asymptomatic or show mild cold like symptoms; the death rate of children from COVID-19 is nil; and the hospitalization rate is insignificant. It is also known the mental health of children has been harmed by school closures.

**Death and hospitalization regarding COVID-19 and school aged children**

Not a single person under the age of 20 has died in Washington State from COVID-19, according to the Washington State Department of Health COVID-19 Data Dashboard.[691]

One person under 20 was admitted to a hospital for COVID-19 out of 158 in the entire state during the week ending 5-17-20.[692] That is consistent with the 2 out of 159 in the previous week (5-10), the 1 out of 168 in the week before that (5-3), and the 2 out of 148 in the week before that (4-26). In the last four weeks there have been a total of 6 COVID-19 hospital admissions for people under 20. That is less than 1% of the 633 people of all ages hospitalized in Washington during that time.

According to U.S. Census Bureau data there are at least 1,839,468 people under 20 in Washington.[693] Therefore, the current COVID-19 hospitalization rate for children is about 1 in 1.84 million.

It is known that this winter and spring about three times more K-12 children have been hospitalized for the seasonal flu than for COVID-19.[694]

There were 107,807 persons under 18 discharged from all Washington hospitals in 2017 – the most recent year data is available on the Washington DOH's website.[695] That is an average of more than 2,000 per week for all causes. So for 1 or 2 COVID-19 patients a week under age 20 to be admitted is miniscule.[696]

Washington's experience is consistent with Oregon where not a single person under the age of 40 has died from COVID-19 according to the Oregon Health Authority's COVID-19 Updates webpage, and only eight people under 20 have ever been hospitalized in Oregon for COVID-19.[697]

Washington's experience is also consistent with Idaho where not a single person under the age of 50 has died from COVID-19 according to the Idaho Department of Health and Welfare's COVID-19 webpage. While it doesn't breakdown hospitalizations by age, only five people in the entire state of Idaho were hospitalized for COVID-19 in the week ending 5-20.[698]

Washington's experience is consistent with California where not a single person under the age of 18 has died from COVID-19 according to the California Department of Public Health's COVID-19 webpage.[699] It is possible no one 18 or 19 has died but California doesn't provide that breakdown. California provides no breakdown of hospitalization by age.

The CDC reports that nationally there are currently 0.17 COVID-19 hospitalizations per 100,000 school age children 5 to 17 – that is 1 hospitalization nationally for every 588,000 children.[700] The CDC breakdowns the age of COVID-19 deaths by 5 to 14 and 15 to 24, with a total of 7 deaths in the entire United States for kids aged 5 to 14 and 76 for young adults aged 15 to 24 from February 1, 2020 to May 16, 2020.[701] In contrast, during that period of time nationally 43 kids aged 5 to 14 died from pneumonia and 44 died from seasonal flu, and 173 young adults 15 to 24 died from pneumonia and 46 from the seasonal flu.[702] So a 5 to 14 year old is *12 times* more likely to die from the flu or pneumonia as from COVID-19. In the most recent week reported – the week ending May 17 – a total of 23 children 5 to 14 died from all causes, with zero from COVID-19, and a total of 192 young adults 15 to 24 died from all causes, with two from COVID-19.[703]

The CDC reports 1,335 kids aged 5 to 14 died from all causes from February 1, 2020 to May 16, 2020. Seven died from COVID-19 – so for every child who died from COVID-19, 191 children died from another cause. There are at least 41,075,169 school aged children 5 to 14 in the U.S.[704] – so with 7 deaths about 1 child died from COVID-19 for every 5,867,881 children: a death rate of 0.00001704%.

Thus, a child in the U.S. is ten times more likely to be struck by lightning than die from COVID-19, according to the National Geographic that reports the odds of being the victim of lightning in any one year is 1 in 700,000.[705]

The complete absence of deaths of school aged children in Washington, and the vanishingly small number in the United States as a whole – 0.00% of all U.S. COVID-19 deaths – is important because it demonstrates that during the height of COVID-19's presence a child has less than ½ of 1 percent chance of dying from it nationally compared to every other cause of death, such as a motor vehicle crash, pneumonia, flu, fire, heart disease, drowning, suffocation, suicide, etc.[706]

The miniscule number of school aged kids in the U.S. who have died is consistent with Sweden, which has reported the death of only one person under the age of 20 from COVID-19.[707] Sweden kept its schools open after COVID-19 cases began being reported.

Iceland and Belarus also kept their schools open, and there is no reported death of a school aged child from COVID-19 in either country. Iceland and Belarus are also safe for adults: World Health Organization data shows Iceland and Belarus have among the lowest death rates per confirmed COVID-19 case in the world: .00555 in Iceland[708] and 0.00554% in Belarus.[709] In contrast the U.S. death rate is more than ten times greater at 0.060%, and Washington's is ten times greater at 0.055% (all adults).[710]

A summary published on May 19, 2020 of data from multiple countries on the UK website fullfact.org, details evidence that "Death from Covid-19 is very rare among young people."[711]

There have only been two deaths of children aged 0 to 14 in England and Wales.[712] That is two child deaths out of a population of 10,674,532 youths.[713] One child death from COVID-19 for every 5,337,266 children is a death rate of 0.00001874% –almost as low as the U.S. The U.K.'s leading statistician, Professor Sir David Spiegelhalter, has said the COVID-19 risk for young people is "staggeringly low."[714]

A review of 155 world-wide studies found that: "To date, deaths remain extremely rare in children from COVID-19, with only a handful of cases reported."[715] World-wide.

In conjunction with the zero death rate in Washington (and miniscule in the U.S. and the rest of the world), the extremely low rate of COVID-19 hospitalizations for school aged children is important because it demonstrates that overall it is not a serious illness for them. Someone's hospitalization would likely involve a serious case.

**Transmission and infection regarding COVID-19 and school aged children**

An Icelandic study found there was not a single case of a child testing positive for COVID-19 passed it to an adult. The study was conducted by Iceland's Directorate of Health and the National University Hospital, in conjunction with deCODE genetics, whose CEO Kari Stefansson said "few children suffer any [COVID-19] symptoms, and are less likely to cough, [which] is an important factor."[716] The study found one child testing positive for COVID-19 didn't pass it to any of the 170 children he is known to have come into contact with, while he did pass on the flu and a cold to his siblings.[717] Iceland is well-suited for analyzing COVID-19 because more than 12% of the population has been tested.[718]

Another recent Icelandic study found no evidence that children transmit COVID-19 to relatives/adults.[719]

A Chinese contact-tracing study published in the journal *Science* found that children have a low susceptibility to COVID-19 infections.[720]

An Australian study of 15 schools found there was not a single case of a child (or adult) testing positive for COVID-19 passing it to an adult. The study was conducted by Australia's National Centre for Immunisation Research and Surveillance with the support of the New South Wales Ministry of Health and the New South Wales Department of Education.[721] The study included 735 students and 128 school staff members from 15 schools who had close contact at school with nine students and nine staff members who had tested positive, and who had the opportunity to transmit it to everyone

around them. None of the 128 teachers or staff members contracted COVID-19. It couldn't be confirmed where one primary school student and one high school student who later tested positive contracted it. Both of those students had a positive antibody test about four weeks after their exposure at school, so they had been infected somewhere and recovered without any symptoms (asymptomatic).[722] So the rate of the 863 students and staff getting ill from COVID-19 was zero.

A summary published on May 19, 2020 of data from multiple countries on the UK website fullfact.org, details evidence "children seem to be less prone to catching the virus"; "children have a limited role in spreading the virus."[723]

A review of 155 world-wide studies summarized infection of children with COVID-19:

> "Following the initial epidemiological data released from China, it appeared children were significantly less affected by infection with SARS-CoV-2 than their adult counterparts. This was reflected both in total case numbers, but also severity, with very few cases in young children and no deaths in children under 10yrs in the initial report. This finding has been reproduced in subsequent data from other countries. Low numbers of childhood cases have been seen in the rest of Europe, as well as the USA, where 1/3 of childhood cases are in late adolescence. … data from South Korea and subsequently Iceland which have undertaken widespread community testing, have also demonstrated significantly lower case numbers in children. This has also been seen in the Italian town of Vo, which screening 70% of its population and found 0 children <10 years positive, despite a 2.6% positive rate in the general population." [724]

The review of 155 studies also found that: "A significant proportion of children with COVID-19 do not appear to develop any symptoms, or have subclinical symptoms. … Clinical features in symptomatic children are somewhat different to adults. Children tend to have more mild illness. … There appears to be little in the way of clinical signs in children to differentiate COVID-19 from other childhood respiratory virus infections."[725]

The review of 155 studies also summarized transmission of COVID-19 by children. It explained about studies in Japan and four studies in China: "These have all demonstrated a significantly lower attack rate in children. This, coupled with low case numbers would suggest at least that children are less likely to acquire the disease. … Notably, the China/WHO joint commission could not recall episodes during contact tracing where transmission occurred from a child to an adult. Studies of multiple family clusters have revealed children were unlikely to be the index case, in

Guangzhou, China, and internationally. A SARS-CoV2 positive child in a cluster in the French alps did not transmit to anyone else, despite exposure to over 100 people."[726]

Regarding symptoms of infection, the CDC states on its website: "The symptoms of COVID-19 are similar in children and adults. However, children with confirmed COVID-19 have generally presented with mild symptoms. Reported symptoms in children include cold-like symptoms, such as fever, runny nose, and cough. Vomiting and diarrhea have also been reported."[727] Those symptoms are not unusual or indicative of a serious illness, because the CDC also lists fever, vomiting, and diarrhea as symptoms of food poisoning.[728]

**Mental health of children has been harmed by school closures**

The closing of schools for more than two months has been a mental health catastrophe for children. NPR published a report that stated:

> "Nightmares. Tantrums. Regressions. Grief. Violent outbursts. Exaggerated fear of strangers. Even suicidal thoughts. In response to a call on social media, parents across the country shared with NPR that the mental health of their young children appears to be suffering as the weeks of lockdown drag on."[729]

NPR's report states regarding the comment by "Sen. Rand Paul, Republican of Kentucky: "I think it's a huge mistake not sending our kids back to school." Dr. Dimitri Christakis, one of the nation's most prominent pediatricians, agrees with Paul, who is a physician by training. Christakis, who directs the Center for Child Health, Behavior and Development at Seattle Children's Hospital, is the editor-in-chief of the journal *JAMA Pediatrics*." NPR describes how children being kept from school are talking about how they don't care if they die. Christakis argues the mental health and social-emotional development of keeping children out of school hasn't been discussed: "The social-emotional needs of children to connect with other children in real time and space, whether it's for physical activity, unstructured play or structured play, this is immensely important for young children in particular."[730]

An article in *The Lancet*: "Mental Health Effects of School Closures During COVID-19 states:

> "For children and adolescents with mental health needs, such closures mean a lack of access to the resources they usually have through schools. In a survey by the mental health charity YoungMinds, which included 2,111 participants up to age 25 years with a mental illness history in the UK, 83% said the pandemic had made their conditions worse. 26% said they were unable to access

mental health support; peer support groups and face-to-face services have been cancelled, and support by phone or online can be challenging for some young people."

School routines are important coping mechanisms for young people with mental health issues. When schools are closed, they lose an anchor in life and their symptoms could relapse. "Going to school had been a struggle for [some children with depression] prior to the pandemic, but at least they had school routines to stick with", said Zanonia Chiu, a registered clinical psychologist working with children and adolescents in Hong Kong, where schools have been closed since Feb 3. "Now that schools are closed, some lock themselves up inside their rooms for weeks, refusing to take showers, eat, or leave their beds." For some children with depression, there will be considerable difficulties adjusting back to normal life when school resumes.

Children with special education needs, such as those with autism spectrum disorder, are also at risk. They can become frustrated and short-tempered when their daily routines are disrupted." [731]

High school juniors and seniors are also being severely mentally impacted by the school closure. Juniors can expect to be highly stressed because of interference with preparations for their senior year and possibly college beyond, while seniors are being deprived of the once in a lifetime experience of their last months after 12 years in school – senior prom, graduation, getting their yearbook signed by teachers and classmates, etc. Seniors are being unjustifiably robbed of those experiences and memories with no regard for how it affects them.

It is inexplicable how protecting the mental health of K-12 students is being disregarded and shunted off to the side like it is unimportant. The negative consequences to children from the closing of the schools for the extended time they have been shuttered could possible be considered child abuse under RCW 26-44-020 if it was caused by an individual.[732] Adults may think that kids are happy they don't have to get up early in the morning and go to school, but as the foregoing information illustrates, that attitude shows an absence of empathy and a lack of understanding reality.

**Schools are safely open and reopening world-wide**

Schools in a number of countries that includes Switzerland, Australia, South Korea, Japan, Singapore, Iceland and *22* European Union countries have reopened after being closed following the initial COVID-19 confusion.[733]

Singapore reopened its schools on March 23 after a temporary closure.[734]

Sweden, Iceland and Belarus are countries where all or most schools

remained open after the presence of COVID-19 became known.[735] Children in Belarus are not required to wear masks or engage in social distancing.[736] In Sweden children are not required to wear masks – and they are not recommended – because the position of the Swedish Public Health Agency is "Face masks in public spaces do not provide any greater protection to the population."[737] Kindergarten and primary school never closed in Iceland and those students are not required to wear masks or engage in any social distancing, while students in high school (secondary) which reopened May 4, do not wear masks but are recommended to maintain social distancing.[738]

Twenty-two EU countries have reopened their schools and there has not been a spike in COVID-19 cases. The evidence from reopening schools in those almost two dozen countries "suggests little or no risk to pupils, teachers or families."[739] Those countries have instituted varying student and staff requirements. Croatia's education minister recently said, "We haven't heard anything negative about the reopening of schools."[740]

WA's Premier Mark McGowan showed a can-do attitude in his public statement prior to school attendance becoming mandatory on May 18: "it's time for all West Australian students to go back to school and go back to the classroom."[741]

The Australian Health Protection Principal Committee (AHPPC) "advises of a relatively low risk of COVID-19 transmission in schools,"[742] and in their official statement regarding the reopening of schools, recognizes that "… the greatest risk of transmission in the school environment is between adults."[743]

The Australian Government's Deputy Chief Medical Officer, Nick Coatsworth, issued a statement on May 3, 2020 supporting the reopening of schools for face-to-face teaching:

> "When school closures were initially proposed to control an epidemic, planners had influenza in mind. Flu spreading within schools and children are the main source for transmission in the community. But COVID-19 is not the flu.
>
> Far fewer children are affected by COVID-19, and the number of transmissions from children to children and children to adults is far less. … As an infectious diseases specialist, I have examined all of the available evidence from within Australia and around the world and, as it stands, it does not support avoiding classroom learning as a means to control COVID-19."[744]

The reopening of schools around the world is based on an awareness children are safe in school. World-wide research is clear that children do not transmit COVID-19 either at all to each other or adults, or at a rate so much less than adults that it is not a health hazard for them to intermingle face-to-

face with each other and teachers in a school setting.

Since there is evidence children don't pass on COVID-19, with possibly rare exceptions, there is no any need to enforce any social distancing between students in a school setting. If they get it the evidence is they are either asymptomatic or exhibit mild symptoms. It is now known that by many orders of magnitude school age children are more at risk of being harmed travelling to school than from being harmed by contact with a student at school who is positive for COVID-19.

**Reopening schools will be painless because new procedures are not necessary**

The reopening the schools would not require any special measures. They could reopen under the same basic framework as when they were ordered closed on March 13, 2020. The old normal works.

Social distancing for students wouldn't be necessary because it is now known that the susceptibility of a student to contract COVID-19 from another student is close to nil.

It would be easy to test all teachers and other school personal, with those testing negative good to go to begin teaching. No social distancing would be required for staff because they wouldn't transmit COVID-19 to students and the students wouldn't be expected to transmit it to them.

In addition to social distancing not being necessary, face masks, hand washing, and surface and object cleaning of surfaces are unnecessary because they are ineffective to retard COVID-19 infections. An article by seven researchers published in the May 2020 issue of the CDC's peer reviewed publication *Emerging Infectious Diseases* explains:

- "We did not find evidence that surgical-type face masks are effective in reducing laboratory-confirmed influenza transmission, either when worn by infected persons (source control) or by persons in the general community to reduce their susceptibility."
- "we found no evidence that surface and object cleaning could reduce influenza transmission"
- "we did not find evidence of a major effect of hand hygiene on laboratory-confirmed influenza virus transmission"[745]

Consequently, reopening the schools will not require any new fundamental operating procedures. Teachers could simply be tested, and teachers, students, and parents could be made aware to be on the look-out for symptoms. That self-monitoring wouldn't involve any intrusive action by the state or school.

**Summary**

The closure of schools was an unnecessary action, and K-12 children would be much better off if their schools had remained open.

The damage inflicted on K-12 children is by the school closures, not by COVID-19. The information related above only scratches the surface of evidence supporting that COVID-19 hasn't and isn't capable of inflicting meaningful harm on the school aged population. We now know the seasonal flu is more dangerous for K-12 children than COVID-19, which typically is so mild that it is less of a nuisance for children than the common cold (Children know when they have a cold, while most COVID-19 cases are asymptomatic.)

Acting promptly to ensure the mental health and vibrancy of children is the overriding concern because COVID-19 is not a substantive peril to their physical health or safety.

Data and research from around the world now establishes that COVID-19 is insignificantly transmitted through society by children personally interacting with other children or with adults – or not at all. That is different than the seasonal flu, cold virus, and other respiratory ailments that are easily be spread by children. Schools are not closed statewide for months because of a localized outbreak of the seasonal flu, colds, or other respiratory ailments in a few counties. There is no evidence of a debilitating localized outbreak of COVID-19 among school aged children anywhere in the world – and of course there have been none in Washington.

Governor Inslee does not need the approval of any political coalition, public action committee, public employee union, or any other pressure group to reopen Washington's schools. Some of them could whine and cry, but their approval isn't needed for the governor to order resumption of normal school operation. When an order to immediately reopen is issued all affected people can be expected to act professionally to make it happen expeditiously: that is their job.

Washington state and the U.S. is on the edge of becoming an outlier by international standards with its schools remaining closed. Schools in more than two-dozen countries have reopened with no problems for students, teachers, or parents. Governor Inslee has the opportunity to show uncommon leadership in this country by ordering the immediate reopening of public schools, charter schools, and private schools. Governors in other states may be afraid to take the first step, but they can be expected to follow genuine leadership that is based on data, evidence and common sense.

Governors throughout the country can be expected to take advantage of the opportunity to rectify the increasingly obvious situation that their state's schools were closed based on doomsday scenarios and legacy media and social media fueled hysteria about the supposed danger of COVID-19 to

children that wasn't based on any actual evidence – and which is now positively known to be false.

Sincerely,
Hans Sherrer

**********

Governor Inslee's office acknowledged receiving the letter, and then on June 18, 2020 responded to it in an email that stated in part:

Dear Hans:

Thank you for contacting the Office of Governor Inslee. We appreciate the opportunity to respond to your concerns regarding the 2019 Novel Coronavirus (COVID-19) pandemic. Unfortunately, due to the incredibly high volume of messages we are receiving at this time, we are unable to respond to each question directly, but please know that your comments are being read and shared with the appropriate staff.

We have compiled the following list of resources in an effort to help answer any possible questions you might have. Additionally, a comprehensive website that is regularly updated has been created to provide you with as much virus-related information in one location as possible. Please visit the state's Coronavirus Website, at *coronavirus.wa.gov*, for more information. If your question is not answered below, *coronavirus.wa.gov* could have more specific information tailored to your needs.

**For Families with Students:**

The Office of the Superintendent of Public Instruction (OSPI) has released health and safety guidelines for the return of K-12 Public Instruction. Click here to review the Reopening Washington Schools 2020 District Planning Guide. Additional information may also be found on the OSPI website here

…

Finally, please note that this is a rapidly developing situation and we are attempting to be as dynamic and responsive to concerns as possible. As clarifications and new orders are issued, the best place to find updated information is the Governor's website, specifically our News Release Archive, and our list of Emergency Actions.

Our priority now is to slow the spread of COVID-19. Our health care professionals say that the easiest way to do that is to practice good hygiene – wash your hands for at least 20 seconds, sanitize frequently touched surfaces, stay home when you are sick, and wear a mask in public spaces. Preventing future cases will require the work of all of us.

In the Governor's words, "This is a time to take common-sense, proactive measures to ensure the health and safety of those who live in Washington State. Our state agency directors have been actively preparing since the nation's first case appeared in Snohomish County. Washingtonians can be assured we've taken this threat seriously and have been working in collaboration with our health care partners to develop plans and procedures to prepare for what could likely be a world-wide pandemic."

Again, thank you for your message.

Sincerely,
Constituent Services
Office of Governor Jay Inslee

## IV – College Students Not Hospitalized Or Dying From COVID-19

University aged students are relatively unaffected by COVID-19 as K-12 students. The virus doesn't seriously harm them – unless they are obese.[746] There is no rational health related reason for in-person university level classes to be limited by the possibility some students may test positive for COVID-19. This is clearly shown in a chart by Andrew Bostom recording COVID-19 Case (reported infections), Hospitalization, and Death data for 37 U.S. colleges from August to September 22, 2020.[747] The data shows 48,199 reported positive tests ("Cases"), two hospitalizations, and zero deaths. At least one of the hospitalizations was of an obese student. The chart published on Twitter, follows:

**9/22/20 update on C19 among students on campus since August, from 37 U.S. universities: Despite ~48,300 "+ C19 tests" near absence of reported C19 hospitalizations, and zero reported deaths**

| University | Reported C19+, "Cases" (N)* | Reported Hospitalizations (N)** | Reported C19 Deaths (N)*** |
|---|---|---|---|
| (1) U of Alabama sys | 2729 | 0 | 0 |
| (2) U of Georgia | 2901 | 0 | 0 |
| (3) U of Kentucky | 1645 | 0 | 0 |
| (4) Ohio State U | 2638 | 0 | 0 |
| (5) U of Dayton | 1242 | 0 | 0 |
| (6) Miami U of OH | 1372 | 0 | 0 |
| (7) Illinois State U | 1334 | 0 | 0 |
| (8) U of Iowa | 1908 | 0 | 0 |
| (9) Missouri State U | 960 | 0 | 0 |
| (10) U of Kansas | 882 | 0 | 0 |
| (11) Kansas State U | 707 | 0 | 0 |
| (12) Penn State U | 1182 | 0 | 0 |
| (13) U of Wisconsin | 2684 | 1 | 0 |
| (14) U of Miami | 394 | 0 | 0 |
| (15) U of S Carolina | 2256 | 0 | 0 |
| (16) U of Arizona | 2137 | 0 | 0 |
| (17) Notre Dame U | 688 | 0 | 0 |
| (18) Temple University | 448 | 0 | 0 |
| (19) James Madison U | 1465 | 0 | 0 |
| (20) Texas Tech U | 1332 | 0 | 0 |
| (21) U of Texas | 955 | 0 | 0 |
| (22) Texas Christian U | 917 | 0 | 0 |
| (23) Texas A & M U | 1330 | 0 | 0 |
| (24) U of Illinois | 2138 | 0 | 0 |
| (25) Iowa State U | 1021 | 0 | 0 |
| (26) East Carolina U | 889 | 0 | 0 |
| (27) U of N Carolina | 1085 | 0 | 0 |
| (28) N Carolina State U | 957 | 0 | 0 |
| (29) Auburn U | 1654 | 0 | 0 |
| (30) Arizona State U | 807 | 0 | 0 |
| (31) San Diego State U | 845 | 1 | 0 |
| (32) Ball State U | 965 | 0 | 0 |
| (33) U of N. Dakota | 712 | 0 | 0 |
| (34) U of Cent Florida | 895 | 0 | 0 |
| (35) U of Florida | 653 | 0 | 0 |
| (36) Oklahoma State U | 892 | 0 | 0 |
| (37) SUNY-Oneonta | 680 | 0 | 0 |
| **Totals (N)** | **48,299** | **2**** | **0** |

***As of data accessed 9/22/20; ostensibly** by reverse transcriptase polymerase chain reaction amplification & detection of C19 viral RNA, or C19 nucleocapsid protein antigen detection by immunofluorescent assay(s); ****As originally noted here:** https://twitter.com/andrewbostom/status/1302438825063591936; https://bit.ly/3mHD3Be "Kansas college student hospitalized with suspected case of multisystem inflammatory syndrome", but the KS college was unidentified; However 1 of the now 845 C19+ students at SDSU was hospitalized "1st SDSU Student Among COVID-19 Surge Hospitalized as Cases Reach 440." https://www.nbcsandiego.com/news/investigations/1st-sdsu-student-among-covid-19-surge-hospitalized-as-cases-reach-440/2402332/ and 1 U-Wisc-Madison student was hospitalized out of 2684 C19+ https://wkow.com/2020/09/16/first-known-uw-madison-student-hospitalized-with-covid-19/

# 19. Countries & States Weren't Hurt By No Shutdown

A large majority of countries around the world instituted the policy of trying to contain the spread of COVID-19 by locking down society and issuing stay at home orders. That was done by limiting retail commerce to businesses classified as "essential," barring religious gatherings, closing public parks and in-person school attendance, and limiting or barring other forms of social interaction. Social distancing was encouraged world-wide when people were in public, the WHO recommended a one meter separation, and the CDC and the U.K. government recommended two meters.

In the U.S. the governor or other official of a state issued orders that to varying degrees limited retail commerce to businesses classified as "essential," barred religious gatherings, closed public parks and in-person school attendance, and imposed other limitations.

At least twelve countries did not have a policy of trying to contain the spread of COVID-19 by locking down their society by closing all but "essential businesses" and religious services, and limiting other forms of social interaction.

## I – Eight states didn't issue Stay-At-Home orders

Eight state governments did not issue a stay at home order for residents to refrain from leaving home except to engage in an "essential activity." Those states were: Arkansas, Iowa, Nebraska, North Dakota, South Dakota, Oklahoma, Utah, and Wyoming.[748]

The accompanying chart shows how COVID-19 cases and deaths in those eight states compare to the rest of the U.S. according to CDC data.

| State | Deaths[749] (2-1 to 10-3-20) | Population | Deaths (per 100k) | Confirmed Cases (per 100k[750]) | Expected Deaths |
|---|---|---|---|---|---|
| **Arkansas** | 1,315 | 3,038,999 | 43.3 | 2,966 | 110% |
| **Iowa** | 1,399 | 3,179,849 | 44.0 | 3,026 | 106% |
| **Nebraska** | 504 | 1,952,570 | 25.8 | 2,564 | 103% |
| **North Dakota** | 238 | 761,723 | 31.2 | 3,419 | 100% |
| **Oklahoma** | 1,189 | 3,954,821 | 30.1 | 2,282 | 101% |
| **South Dakota** | 277 | 903,027 | 30.7 | 2,928 | 102% |
| **Utah** | 483 | 3,282,115 | 14.7 | 2,497 | 109% |
| **Wyoming** | 41 | 567,025 | 7.2 | 1,064 | 110% |
| **Total** | 5,446 | 17,640,129 | 30.9 | 2,648 | 105.2% |
| **Rest of U.S.** | 195,053 | 313,678,863 | 62.2 | 2,269 | 112.3% |

The data clearly shows that nationwide the states with Stay-At-Home orders had *more than double* the deaths per 100k people, and a *7% higher* rate of expected deaths based on historical norms, than states win no Stay-At-Home order.

The eight non-Stay-At-Home states had an average death rate of 30.9 per 100k people – less than half the average of 62.2 per 100k people for the other 42 states. Wyoming's rate of 7.2 is particularly low.

The eight non-Stay-At-Home states had an expected death rate 7.1% less than the 42 other states. That suggests about 129,900 fewer people would have died nationwide of COVID-19 if there had been no stay-at-home orders.[751] The rate of expected deaths in the eight states that didn't have stay-at-home orders was too much lower for too long a period of time for it to be an anomaly. It appears the Stay-At-Home orders were counter-productive and deadly.

Stay-At-Home social limiting orders were not just ineffective – they were catastrophic for the health of the public.

Widespread public interaction was better for generally healthy people as a whole, than being confined to their residence. The Stay-At-Home orders turned people's homes into State mandated infection cesspools.

One important thing learned from the eight states without a Stay-At-Home order is the lack of a direct relationship between virus testing and the severity of cases in general. Those eight states had confirmed case totals per 100k *17% higher* than the other 42 states – yet their deaths per 100k people was more than *50% less*. Utah's cases per 100k was *10% greater* than the 42 states with Orders – but its deaths per 100k was *420% less*. Likewise, North Dakota's cases per 100k was *51% greater*, but its deaths were *200% less*.

## II – Belarus

Population: 9,449,323 (2020)
First COVID-19 case February 27, 2020.

Government policy: There was no domestic restriction on personal, commercial, religious, religious, sporting, or political activities within the country. There was no government requirement for social distancing or wearing a face mask. Schools remained open. There was 14-day quarantining of anyone entering Belarus from an infected country.

Belarus' President Aleksandr Lukashenko said in March 2020: "Coronavirus is yet another psychosis, which will benefit some people and will harm others. … I am absolutely convinced that panic can hurt us more than the virus itself. That's what concerns me the most."[752] In another interview he expressed similar sentiments: "You see that the world has gone crazy over coronavirus or maybe over the speculations related to coronavirus.

… We have survived viruses before. There were more complicated viruses: swine flue, bird flue, and atypical pneumonia."[753]

Lukashenko's unwavering calm and resolve was in sharp contrast to the hysterical knee-jerk legacy media and social media driven responses by political leaders in the large majority of countries.

Belarus is bordered by five countries. The following chart shows how COVID-19 death in Belarus compare to its five neighbors[754]:

| **Country** (WHO data per 100k) | **Deaths** (to 10-18-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.)[755] |
|---|---|---|---|
| **Belarus** | 9.7 | 914 | -6.0% |
| Latvia | 2.2 | 170 | -8.6% |
| Lithuania | 4.1 | 259 | -8.1% |
| Poland | 9.1 | 416 | -4.6% |
| Russia | 16.4 | 949 | -5.5% |
| Ukraine | 12.6 | 671 | -7.7% |
| World avg | 14.2 | 505 | -4.9% |

Belarus' death rate is 1/3rd less than the world average, and comparable to the overall death rate of its five neighboring countries. Belarus has vigorous COVID-19 testing, so it has recorded more confirmed cases per 100k than the world average.

It is also significant that Belarus' economy over-all faired comparable to its neighbors and only slightly less than the world overall during the 2020 COVID-19 panic.

## III – Burundi

Population: 11,890,784 (2020)
First COVID-19 case April 1, 2020.

COVID-19 measures: No domestic restriction on personal, commercial, religious, religious or political activities. No government requirement for social distancing or wearing a face mask. 14-day quarantining of anyone entering Burundi from an infected country imposed on March 12, 2020.[756]

On June 8, 2020 President Pierre Nkurunziza died of a heart attack. COVID-19 proponents tried to push the narrative Nkurunziza died from the virus, without any evidence he did so.[757] At the time of Nkurunziza's death there was one reported COVID-19 death in Burundi.

Burundi is bordered by three countries. The accompanying chart shows how COVID-19 cases and death in Burundi compare to its three neighbors[758]:

| **Country** (WHO data per 100k) | **Deaths** (to 10-18-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.) |
|---|---|---|---|
| **Burundi** | 0.0 | 5.0 | -5.5% |
| Congo (DRC) | 0.3 | 12 | -2.2% |
| Rwanda | 0.3 | 38 | 3.5% |
| Tanzania | 0.0 | 0.9 | 2.0% |
| World avg | 14.2 | 505 | -4.9% |

Burundi 0.0 deaths per 100k people is less than 1% of the worldwide average, and its confirmed cases rate of 4.0 per 100k is less than 1% of the worldwide average. Burundi's death rate is roughly comparable to its three neighboring countries, who have death rates of 0.0, 0.2, and 0.3 per 100k.

# IV – Iceland

Population: 341,243 (2020)
First COVID-19 case February 28, 2020.

COVID-19 measures: On March 24 the government limited groups in public to no more than 20 people, and swimming pools, museums, libraries and bars were closed. Social distancing in a business of 2 meters was also imposed.[759] Elementary schools and preschools were not closed, but universities and secondary schools were closed for four weeks from mid-March until mid-April. Those with symptoms of COVID-19 were asked to avoid health care centers and hospitals. While masks were not required, it was recommended that "If you cannot avoid contact with other people … cover the nose and mouth with tissue when coughing or sneezing and pay careful attention to hygiene."[760]

Iceland participated in the EU travel ban along with other Schengen states, and travelers from outside the Schengen area we no longer granted access into the country. Effective March 2, 2020, all travelers entering Iceland, including Icelandic citizens and residents, were required to self-quarantine for 14 days. The maximum sanction for violating the quarantine was three months in prison.[761]

On June 15 Iceland reopened its borders to Schengen states (26 European countries), and two days later the country celebrated its national day. Life was back to normal: Bars and restaurants were full, there was no government mandated social distancing or mask use. A CNN article said: "Anyone visiting Iceland right now could be forgiven for thinking they've arrived in a parallel universe where the coronavirus never happened."[762] The country was to be open to travelers from non-Schengen states on July 1.[763]

| **Country** (WHO data per 100k) | **Deaths** (to 10-18-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.) |
|---|---|---|---|
| **Iceland** | 3.2 | 1,151 | -7.2% |
| Faroe Islands | 0.0 | 921 | |
| Greenland | 0.0 | 28 | |
| World avg | 14.2 | 505 | -4.9% |

Iceland is an island so it doesn't physically border any countries. The accompanying chart compares Iceland with its two closest countries/independent territories[764]:

Iceland's death rate is not only less than 1/3 the world average, but its two closest neighbors have even lower death rates. (Iceland and its two closest neighbors are all islands.) Iceland has widespread COVID-19 testing so it has recorded more confirmed cases per 100k than the world average – but its rate of 1 death for every 301 confirmed cases is more than 900% *less than* the worldwide average of 1 death per 34 confirmed cases.

# V – Japan

Population: 126,476,461 (2020)
First COVID-19 case January 14, 2020.

COVID-19 measures: On April 7, Prime Minister Shinzo Abe declared a partial state of emergency and expanded it nationwide on April 16. The national and local governments promoted the "the idea of avoiding the "three Cs": (1) closed spaces, (2) crowded places, and (3) close-contact settings. In addition to avoiding the three Cs, Japanese citizens continued their long-held practice of wearing masks and other cleanliness practices. There is little resistance to this behavior since hay fever is very common, and washing hands and taking off shoes are built into Japanese culture. The high consciousness of proper sanitation surely contributed to the mitigation strategy."[765]

Japanese law doesn't empower the government to impose or enforce a lockdown of businesses, so it was left to each business to voluntarily limit their business practices and enforce the three Cs.

Businesses, restaurants, and transportation were kept open, and public life continued relatively normally.

Japanese researchers found from examining data collected in China and on the cruise ship Diamond Princess, "that the transmission of the disease happens through only 20 percent of patients, but these patients will then infect many others at once and create a cluster. So, they found that it is possible to mitigate the spread of disease by focusing on the cluster with aggressive contact tracing."[766]

PM Abe announced May 14 the state of emergency would be lifted except for eight local areas that included Tokyo. He encouraged avoiding the "three C's". Nationwide the state of emergency ended May 25.[767]

Japan is an island so it doesn't physically border any countries. The accompanying chart shows how COVID-19 deaths in Japan compare to its neighbors[768]:

| **Country** (WHO data per 100k) | **Deaths** (to 10-18-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.) |
|---|---|---|---|
| **Japan** | 1.3 | 73 | -5.8% |
| China | 0.3 | 6 | 1.0% |
| South Korea | 0.9 | 49 | -2.1% |
| Taiwan | 0.0 | 2.0 | -4.0% |
| World avg | 14.2 | 505 | -4.9% |

Japan's death rate is 10% of the world average. Japan is an island, but three neighboring countries do not have higher death rates. Japan's rate of confirmed cases is not only *15%* of the worldwide average – and those three neighboring also have very low rates of confirmed cases.

# VI – Nicaragua

Population: 6,624,554 (2020)
First COVID-19 case March 20, 2020.

Government policy: There was no domestic restriction on personal, commercial, religious, religious, sporting, or political activities within the country. Schools remained open. There was no government requirement for social distancing or wearing a face mask. The government did not discourage large-scale public events. Nicaragua did not impose any domestic travel restrictions. International travelers from active transmission regions to had to self-quarantine for 14 days.[769]

The government instituted tracing contacts of confirmed cases. The government had public sector employees and party members conduct in-person home visits across the country to inform people about the virus and recommend preventative measures such as hand-washing. National universities instituted a rotating class schedule to reduce crowding in classrooms and on campuses.[770]

In response to criticism of the government's approach to the coronavirus, President Daniel Ortega said on April 30 that "he was against public campaigns that urged people to stay at home, and called those who encouraged such measures "radicals" and "extremists" who "only want to see the country destroyed."[771]

| **Country** (WHO data per 100k) | **Deaths** (to 10-18-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.) |
|---|---|---|---|
| **Nicaragua** | 2.3 | 66 | -6.0% |
| Costa Rica | 22.8 | 1,829 | -3.3% |
| Honduras | 25.8 | 869 | -2.4% |
| World avg | 14.2 | 505 | -4.9% |

Nicaragua is bordered by two countries. The accompanying chart shows how COVID-19 deaths in Nicaragua compare to its neighbors[772]

Nicaragua's death rate is not only less than 1/5 the world average, it is much less than its two neighboring countries. Its rate of confirmed cases is also less than 1/5 the world average, and also much less than its two neighbors.

# VII – South Korea

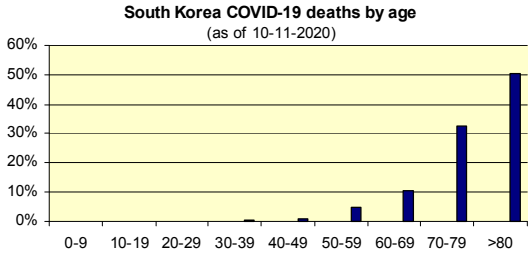
Population: 51,269,185 (2020)
First COVID-19 case January 19, 2020.

"South Korea – which in February had the largest outbreak outside of China – used a combination of widespread testing, aggressive contact tracing, stern public health measures and digital technology to contain the coronavirus without having to impose a widespread lockdown. It also maintained a strict quarantine regime for travelers coming into the country.

Thanks to these measures, newly diagnosed cases have slowed to a trickle …according to its Centers for Disease Control and Prevention.

Against that backdrop, the South Korean government relaxed its social distancing rules, imposed on March 22, in line with a set of guidelines referred to as the "distancing in daily life" policy. Life essentially went on as normal with people attending amusement parks and engaging in other social activities. (Above is April 2020 photo of people at an amusement park.(Reuters))

According to these guidelines, people should stay at home if they become sick with suspected Covid-19 symptoms, continue to keep a distance of 2 meters (6 feet) from others, wash their hands for 30 seconds and keep rooms well ventilated and disinfected regularly. Those aged over 65 and in high-risk groups should continue to stay home and avoid enclosed and crowded spaces."[773]




South Korea age data shows the vulnerable population was people over 60 who had 95% of deaths. That age group is predictably vulnerable due to age related ill-health or being afflicted with one or more serious life-threatening illnesses such as heart disease, diabetes, and cancer that are known to exacerbate the effects of a respiratory influenza type virus. There were zero deaths in South Korea of anyone under the age of 30. Information about COVID-19's target age group was known by western countries prior to them imposing strict lockdowns of their entire society and closing schools.[774]

South Korea borders China, and North Korea (for which there is no data). The accompanying chart shows how COVID-19 deaths in South Korea compare to China[775]:

| **Country** (WHO data per 100k) | **Deaths** (to 10-18-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.) |
|---|---|---|---|
| **South Korea** | 0.9 | 49 | -2.1% |
| China | 0.3 | 6 | 1.0% |
| World avg | 14.2 | 505 | -4.9% |

South Korea's death rate is 1/16 the world average, and its rate of confirmed cases is about 1/9 the world average. The death and case rates of neighboring China are also much lower than the worldwide average.

# VIII – Sweden

Population: 10,099,264 (2020)
First COVID-19 case, January 31, 2020.

Sweden's national government adopted a minimalist mitigation policy in which "high schools and universities are closed, public gatherings are limited to 50 people, people aged 70 and above are advised to practice social distancing, and symptomatic people are advised to practice home quarantine. All students in high school or college (aged 15-22 years old) do not attend school as implemented by the Swedish authorities, effective 13 March 2020."[776]

An April 2020 article in *Vanity Fair* described the situation in Sweden:

> "To start with, it's a myth that Sweden is doing nothing about the virus. … Schools for older kids are closed, as are universities. People are working from home, when they can, and the elderly are being urged to keep to themselves. Gatherings of over 50 people are prohibited, and ski resorts are closed. Restaurants and bars are allowing table service only, and grocery stores are installing glass dividers between customers and cashiers. People who go to Stockholm may be stunned to see bars and cafés with customers …
>
> … Sweden has pumped the brakes instead of slamming on them. You close school for older kids, but you keep grade school going, because evidence so far suggests that younger children are not a major cause of transmission for the novel coronavirus. … You prohibit standing room and shoulder-to-shoulder seating in popular bars and restaurants, but you allow them to keep operating with greater space between tables and customers. You encourage people to keep a physical distance among one another, but you don't command it."[777]

Anders Tegnell is the state epidemiologist of Sweden who devised the country's COVID-19 program. In a July 22, 2020 interview Tegnell said regarding future coronavirus outbreaks that he thought Sweden had an edge over countries that had COVID-19 lockdowns because a higher percentage of Sweden's population had been exposed to the virus and developed an immunity to it. He said: "I think it is likely that those kind of resurgence, those kind of outbreaks will be easier to limit in Sweden because there is an immunity in the population. All our experience with measles and other diseases shows that … we are going to have outbreaks and we know that with large immunity … in a population it is much easier to control the outbreak than if you don't have an immunity in the population. And most likely that would also apply to this disease. [778] Tegnell conceded Sweden had

more than expected deaths: "The failure has of course been the death toll … that has been very much related to the long-term care facilities in Sweden. Now that has improved, we see a lot less cases in those facilities."[779]

| Age Range | Sweden[780] | Norway[781] | Finland[782] |
|---|---|---|---|
| <10 | 0.0% | | |
| 20-29 | 0.2% | | 0.3% |
| 30-39 | 0.3% | | 0.6% |
| 40-49 | 0.8% | 2.0% | 0.9% |
| 50-59 | 2.8% | 2.3% | 3.3% |
| 60-69 | 6.9% | 8.6% | 8.1% |
| 70-79 | 21.6% | 23.4% | 19.8% |
| 80-90 | 41.5% | 34.4% | 41.1% |
| >90 | 26.1% | 29.3% | 25.8% |

Almost half of Sweden's COVID-19 deaths were in a health care facility, so Tegnell's inference was those deaths – and Sweden's overall death rate – would have been significantly lower if the country had gotten its health care facility situation under control sooner.

Sweden is an anomaly because it has noticeably higher infection and death rates than its neighbors, unlike all other countries that didn't have a major lockdown. The most logical explanation is as Tegnell said, Swedish authorities failed to expeditiously isolate nursing homes and care facilities where the most vulnerable people lived.

Sweden is bordered by two countries and connected to Denmark by the Øresund Bridge across the Øresund strait.

The Age Range chart shows the age demographic of the people who died in Sweden, Norway and Finland was very similar: 89% of Sweden's COVID-19 fatalities were people 70 and older, and 68% were 80 or older. In Norway 87% of fatalities were people 70 and older, and 64% were 80 and older. In Finland 87% of fatalities were people 70 and older, and 67% were 80 and older. Fatality rate for people under 50 was 1.3% in Sweden, 2.0% in Norway, and 1.8% in Finland.

| Country (WHO data per 100k) | Deaths (to 10-18-20) | Confirmed Cases | Real GDP growth 2020 (IMF est.) |
|---|---|---|---|
| **Sweden** | 58.6 | 1,022 | -6.8% |
| Denmark | 11.7 | 595 | -6.5% |
| Finland | 6.3 | 237 | -6.0% |
| Norway | 5.1 | 298 | -6.3% |
| World avg | 14.2 | 505 | -4.9% |

The accompanying chart shows how the rate per 100k people of COVID-19 deaths and confirmed cases in Sweden compares to its neighbors[783]:

As shown above, the percentage of people who died in different age groups in Sweden, Finland, and Norway was very similar. One explanation for Sweden's significantly higher death rate is that about half of all COVID-19 Swedish deaths occurred in a long-term care facility. Many elderly people who became ill with COVID-19 were never transported to a hospital – they simply died in the facility. Sweden's Prime Minister Stefan Löfven admitted the breakdown in elderly care: "We did not manage to

protect the most vulnerable people, the most elderly, despite our best intentions."[784]

Given the experience of the other countries that did not have a lockdown, there is no reason to think the greater personal freedom Swedes were allowed by the government had anything to do with Sweden's higher death and confirmed case rate. If the elderly had adequately been cared for, it can be expected Sweden's death rate would have been comparable to its neighbors.

This chart shows the COVID-19 cases and deaths were most concentrated in Stockholm, where almost 25% of Sweden's population lives. The death rate in Stockholm was 2.3 times the rest of the country, and its confirmed case infection rate was 33% higher than the rest of the country.

| **Sweden** (Data per 100k)[785] | **Deaths** (to 8-18-20) | **Confirmed Cases** |
|---|---|---|
| **Stockholm** | 100.6 | 1,017 |
| Rest of Sweden | 43.0 | 769 |

## IX – Taiwan

Population: 23,816,775 (2020)
First COVID-19 case January 19, 2020.

It was announced in early June the government's minimal COVID-19 social distancing measures were to be removed. Those included limiting the number of people allowed at public gatherings, including cultural and leisure events, and social distancing seating arrangements on trains, cinemas, concert halls, and baseball stadiums were also to be removed.[786] People were requested to wear masks in public.

Starting March 19 foreign nationals were barred from entering Taiwan, with those qualifying for an exception required to complete a 14-day quarantine.[787]

Taiwan is an island so it doesn't physically border any countries. The accompanying chart compares Taiwan's COVID-19 deaths with three relatively close countries[788]

| **Country** (WHO data per 100k) | **Deaths** (to 10-18-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.) |
|---|---|---|---|
| **Taiwan** | 0.0 | 2.0 | -4.0% |
| China | 0.3 | 6 | 1.0% |
| Japan | 1.3 | 73 | -5.8% |
| South Korea | 0.9 | 49 | -2.1% |
| World avg | 14.2 | 505 | -4.9% |

Taiwan's COVID-19 death rate of 0.0% is as low as any country in the world. Taiwan is an island. Three neighboring countries have death rates higher than Taiwan, but their rates are still less than 10% of the worldwide average. Taiwan's rate of confirmed cases is less than *1%* of the worldwide average – and those three neighboring countries have higher case rates than Taiwan, but they are also much less than the worldwide average.

# X – Tajikistan

Population: 9,537,645 (2020)
First COVID-19 confirmed case April 30, 2020

COVID-19 measures: Tajik citizens and foreign nationals arriving from foreign countries were put in quarantine for 14 days, beginning February 1. At the same time entry was blocked by nationals from 35 countries. The number of restricted countries was later reduced.

| Country (WHO data per 100k) | Deaths (to 10-18-20) | Confirmed Cases | Real GDP growth 2020 (IMF est.) |
|---|---|---|---|
| **Tajikistan** | 0.8 | 105 | 1.0% |
| Afghanistan | 3.8 | 103 | -3.0% |
| China | 0.3 | 6 | 1.0% |
| Kyrgyzstan | 17.0 | 789 | -4.0% |
| Uzbekistan | 1.6 | 188 | 1.8% |
| World avg | 14.2 | 505 | -4.9% |

No domestic restriction on personal, commercial, religious, religious, sporting, or political activities within the country. No government requirement for social distancing, but wearing a face mask was required by local regulation.[789] President Emomali Rahmon was photographed participating in large public gatherings in late March.[790]

Tajikistan is bordered by four countries. The accompanying chart shows how COVID-19 deaths in Tajikistan compares to its neighbors.[791]

Tajikistan's death rate of is less than 10% of the worldwide average, and its confirmed cases rate less than 1/4$^{th}$ of the worldwide average. Tajikistan's death rate is lower than three of its neighboring countries, but higher than China.

# XI – Tanzania

Population: 59,734,218 (2020)
First COVID-19 case Not known.

April 29 was the last day that Tanzania reported data to the WHO: it had a total of 509 cases and 21 deaths.

COVID-19 measures: No domestic restriction on personal, commercial, religious, religious or political activities, other than a ban on mass public gatherings. Schools and universities were closed.[792] No government requirement for social distancing or wearing a face mask.

14-day quarantining of anyone entering Burundi from a high risk country imposed on March 12, 2020.

On June 7, 2020 Tanzania's President John Magufuli declared the country was "coronavirus free"[793] The week before Magufuli told reporters that Tanzania had only four people hospitalized with COVID-19.

Tanzania is bordered by eight countries. The accompanying chart shows how COVID-19 deaths in Tanzania compares to its neighbors[794]:

| Country (WHO data per 100k) | Deaths (to 10-18-20) | Confirmed Cases | Real GDP growth 2020 (IMF est.) |
|---|---|---|---|
| **Tanzania** | 0.0 | 0.9 | 2.0% |
| Burundi | 0.0 | 5.0 | -5.5% |
| Congo | 0.3 | 12 | -2.3% |
| Kenya | 1.5 | 81 | 1.0% |
| Malawi | 0.9 | 31 | 1.0% |
| Mozambique | 0.2 | 34 | 2.2% |
| Rwanda | 0.3 | 38 | 3.5% |
| Uganda | 0.2 | 23 | 3.5% |
| Zambia | 1.9 | 85 | -3.5% |
| World avg | 14.2 | 505 | -4.9% |

Tanzania's current death and confirmed case rates are not known because it no longer reports them to the WHO. However, based on what those rates were when it suspended cooperation with the WHO, and that no abnormal health crisis has been reported in Tanzania, it can be expected those rates are no more than its eight neighboring countries – all of which have death and confirmed case rates significantly below worldwide averages.

## XII – Turkmenistan

Population: 6,031,200 (2020)
First COVID-19 case Not known

Turkmenistan is one of the few countries in the world with no reported cases of the disease as of now. While flights from Beijing and Bangkok and later all international flights were suspended during the disease outbreak and the country began to lift its citizens from other countries in February-end, no lockdown measures have been imposed in the country as such. Even so, there are checkpoints to enter big cities and towns where passengers' body temperatures are checked and traffic has been restricted between different provinces.

On April 25 and 26, thousands of spectators gathered in stadiums to celebrate Horse Day, a local holiday, where President Gurbanguly Berdymukhamedov's horse was declared as the most beautiful by the judges.

But there is skepticism about the claim of having no cases of the disease as the country is believed to have one of the most repressive and secretive governments in Central Asia. On April 28, Radio Free Europe Radio Liberty (RFE/RL) reported that ahead of a visit to the country by WHO's experts, authorities were clearing out hundreds of people from quarantine zones in an attempt to hide suspected cases of coronavirus. Foreign Minister Rashid Meredov, however, maintains they are not hiding anything.

A couple removes temporarily protective face masks that they wear to avoid the spread of the coronavirus disease (COVID-19), as they take a picture at an amusement park in Seoul, South Korea.

In fact, some news reports have claimed that the country "banned" the use of the word "coronavirus" by media outlets and arrested people if they were found discussing it. One report in RFE/RL said the state media was treating it as if the disease never existed as they are not saying anything about the effects of coronavirus, "and the word has even been removed from health information brochures distributed in schools, hospitals and workplaces, according to Turkmenistan Chronicles, one of the few sources of independent news, whose site is blocked within the country," the report said.

An article in *The Diplomat* said, "The Turkmen government is … taking the coronavirus seriously — just not as a public health threat."[795]

Turkmenistan is bordered by four countries: The accompanying chart shows how COVID-19 deaths in Turkmenistan compares to its neighbors.[796]

| **Country** (WHO data per 100k) | **Deaths** (to 10-18-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.) |
|---|---|---|---|
| **Turkmenistan** | ?? | ?? | 1.8% |
| Afghanistan | 3.8 | 103 | -3.0% |
| Iran | 35.6 | 622 | -6.0% |
| Kazakhstan | 11.4 | 772 | -2.5% |
| Uzbekistan | 1.6 | 188 | 1.8% |
| World avg | 14.2 | 505 | -4.9% |

Turkmenistan's current death and confirmed case rates are not known because it does not report them to the WHO. However, the overall average death and confirmed case rate of its four neighboring countries is less than the worldwide average. There have been no reports from Turkmenistan of an abnormal health crisis that would indicate its death and confirmed case rates are higher than its neighboring countries.

## XIII – Uruguay

Population: 3,473,730 (2020)
First COVID-19 case March 13, 2020.

COVID-19 measures: Rather than shut down the economy, the government relied on voluntary responsible behavior, with widespread testing (only South Korea had more tests as a percentage of confirmed cases), and limited quarantining of those who had Covid-19. The external borders were shut, but internally the country was kept open.[797]

Uruguay's health care system was never taxed, and there were always sufficient hospital beds available.

Citing Uruguay's measured response, epidemiologist Julio Vignolo said in May 2020 that the outbreak "is currently under control."[798]

Uruguay's reproduction number – the rate of infection – was 0.74 in mid-May, according to a model developed by engineer Andres Ferragut and mathematician Ernesto Mordecki, who are working with the government as advisors. With an R less than 1 the infection was diminishing.

In mid-May President Luis Lacalle Pou announced schools will resume classes in June, saying "we are convinced that the risk is minimal."[799]

| **Country** (WHO data per 100k) | **Deaths** (to 10-18-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.) |
|---|---|---|---|
| **Uruguay** | 1.5 | 70 | -3.0% |
| Argentina | 56.1 | 2,100 | -9.9% |
| Brazil | 71.7 | 2,432 | -9.1% |
| World avg | 14.2 | 505 | -4.9% |

Uruguay is bordered by two countries. The accompanying chart shows how COVID-19 deaths and confirmed cases in Uruguay compares to its neighbors.[800]

Uruguay's death rate per 100k people is about 10% of the worldwide average, and its confirmed cases rate per 100k is about 1/7th of the worldwide average. Both of those rates are very significantly less than its neighboring countries Brazil and Argentina who both have death and case rates far in excess of worldwide averages.

# 20. Lockdowns Were Unnecessary To Control COVID-19 Outbreak

One of the most troubling aspects of the COVID-19 outbreak was that numerous countries hastily imposed lockdowns of businesses and society in general to varying degrees. It is now known those lockdowns were imposed without due consideration of the data that was available at the time from the experience of China, South Korea, Japan, Taiwan and other countries that had the largest initial experience with the virus. It is also now known those hysteria driven lockdowns were unnecessary to control the COVID-19 outbreak or reduce deaths.

## I – Lockdowns were ineffective to minimize COVID-19 harm

Lockdowns in the U.K. and the U.S. that included closure of "non-essential" businesses, schools, churches, and social activities, were largely based on the claim by Neil Ferguson's COVID-19 Response Team at Imperial College that 510,000 people in the U.K. and 2.2 million in the U.S. would die if a societal lockdown wasn't instituted to prevent overburdening of the health care system.[801] Imperial College's Report 9 released on March 16, 2020 stated:

> "In total, *in an unmitigated epidemic*, we would predict approximately *510,000 deaths in GB and 2.2 million in the US*, not accounting for the potential negative effects of health systems being overwhelmed on mortality."[802]

Countries around the world also instituted a lockdown of businesses, schools, and society in general.

The irony of relying on Report 9 to justify school and university closures and to institute strict social distancing measures is the report included tables predicting those measures would actually increase the overall number of deaths caused by the COVID-19 outbreak[803] Report 9 recognized the flattening the curve mitigation strategy would simply postpone when people most susceptible to the virus would contract it, and result in more of them dying than if nothing was done because artificially reducing "herd immunity" limited spread of the disease through society to provide a natural protective shield for the vulnerable.[804] Those important aspects of Report 9 were ignored by government policy makers responsible for the lockdowns.

## Sweden's non-intervention was as effective as U.K.'s total lockdown

Ferguson resigned his role on the government's Scientific Advisory Group for Emergencies (Sage) on May 5, 2020, after it was reported he had broken England's social distancing guidelines by having multiple liaisons with his married lover who travelled to his home.[805] The first time was on March 30 – only seven days after Johnson ordered a nationwide lockdown – and the second time was on April 8. Ferguson's flaunting of the physical distancing guidelines suggested he discounted their importance. It was particularly embarrassing because Ferguson was known in the U.K. as Professor Lockdown. Ferguson ascribed his actions to an "error of judgment."[806]

Then on June 2, 2020 Ferguson testified before the House of Lords' science and technology committee that Sweden had achieved similar suppression of COVID-19 as the U.K. The U.K.'s harsh lockdown of businesses and society had not been more successful in suppressing the virus than Sweden's reliance on voluntary social distancing. Ferguson told the committee the Swedish authorities had "*got a long way to the same effect*" as the U.K. [807]

Regarding the Swedes decision to keep their society relatively open and rely on herd immunity to end the outbreak, Ferguson said: "*They [Swedish scientists] came to a different policy conclusion based really on quite similar science. ... scientifically they're not far from scientists in any part of the world."*[808]

The British media downplayed Ferguson's testimony. It wasn't featured on the front-page of any major newspaper, but instead was buried on the inside of print editions. The *Daily Telegraph* published its story on page seven, but it didn't try to hide the substance of the story with its subheading: *"Professor admits radical Scandinavian policy worked as well as British policy of shutting down."*[809]

Ferguson didn't actually give the Swedes largely voluntary policy enough credit, because it actually had better results than Britain's hard shut-down policy. As of the day of his testimony on June 2 the U.K. had a death rate of 57.5 per 100k population, while Sweden's rate of 43.6 was 32% less. The U.K.'s confirmed cases was 407.1 per 100k population, while Sweden's rate of 374.4 was 9% less.[810] Thus, Sweden's CIFR was 21% less than the U.K.

## Nobel Prize Winner Michael Levitt asserts lockdowns were ineffective

Stanford Professor Michael Levitt shared the 2013 Nobel Prize for chemistry. In a June 2020 interview with the RT news network he expressed the opinion, "the lockdown measures that have been implemented across many countries worldwide were actually not that effective. The vast majority of the disease transmissions actually occurred before the lockdowns went into force – and in many countries the people were not that eager to abide by the rules, making the restrictions even more useless." [811]

Levitt also said he thinks the best strategy for governments would have been to focus on protecting the people known to be vulnerable to the virus, such as the elderly, while letting others move freely. He observed about COVID-19: "*What happened is that the virus is most infectious and most dangerous before you actually know it's there."*[812]

While Sweden was harshly criticized for primarily relying on voluntary social distancing, its deaths were less than other countries such as the U.K. and Belgium that had hard lockdowns. Levitt noted: *"The predicted number for Sweden was around 60,000 [deaths]. Sweden looks like it's going to stop at 6,000 at the most."*[813]

Levitt made the observation: "*This virus really does seem to be limiting. It gets to about 500 to 1,000 fatalities per million people and then it stops. And this we've seen at so many places. I don't think that Northern Italy practiced wonderful social distancing, I don't think that social distancing was practiced wonderfully in New York City."*[814]

Levitt also said he didn't doubt China's official COVID-19 data because it corresponded with the dynamics observed in other countries: "What happened in China outside of Hubei is exactly the same dynamics of the curve as what happened in New Zealand. If China is forging statistics, they must have a time machine. And if they have the time machine, they would've beaten us in any competition anyway."[815]

Those comments largely echoed an interview Levitt gave to *The Telegraph* in late May in which he said the lockdown caused more deaths than it saved. Levitt also said he sent messages to Neil Ferguson in March after Imperial Colleges Report 9 was released that estimated up to 510,000 deaths in the U.K. He told Ferguson that he had over-estimated the potential death toll of COVID-19 by "10 or 12 times." [816] The release of Imperial College's report caused what Levitt called an unnecessary "panic virus" among global political leaders, and abandonment of the U.K.'s then *de facto* herd immunity policy that was aligned with Sweden's policy.

## Lockdowns didn't reduce cases or mortality according to Canadian study

> "… full lockdowns and wide-spread COVID-19 testing were not associated with reductions in the number of critical cases or overall mortality."

The COVID-19 mortality rate of a country was "not associated" with whether or not that country locked down, according to a study by researchers from the University of Toronto and University of Texas. Instead, the study found that obesity, diabetes, smoking, and the vulnerabilities of old age played a large role.[817]

The researchers examined mortality rates and cases for the top 50 countries ranked by number of cases. They used a mathematical model to compare the impact of each country's response on cases and deaths with demographic factors such as smoking, obesity and age. They found that shutting down society did not translate into a significant reduction in a country's deaths: "*Government actions such as border closures, full lockdowns, and a high rate of Covid-19 testing were not associated with statistically significant reductions in the number of critical cases or overall mortality*."[818]

The study, published in *The Lancet* online journal EClinicalMedicine on July 21, 2020, stated: "Consistent with reported Covid-19 outcome data from Europe, the United States, and China, higher caseloads and overall mortality were associated with comorbidities such as obesity and advanced population age."[819] The study also found that an increased scale of national testing was not associated with the number of critical cases, or deaths per million."[820]

One interesting finding was: "Countries with a higher per capita GDP had an increased number of reported critical cases and deaths per million population. This may reflect more widespread testing in those countries, greater transparency with reporting and better national surveillance systems. Other potential putative reasons for the association might include increase accessibility to air travel and international holidays in wealthier countries, as travel was identified as an important factor contributing to international viral spread."[821]

Regarding the closure of borders, the researchers found: "Additionally, the relative difference in the number of cases in neighboring countries is likely to have a significant impact on whether border closures are effective. Two countries with similar epidemiologic curves and effective social distancing policies may not see a major impact from border closures, whereas two countries with very disparate epidemiologic curves may be more likely to see a significant impact from travel restrictions."[822]

The study found what other studies have also found regarding a positive correlation between smoking and lower COVID-19 infection rates: "The final unexpected finding was the lower frequency of critical cases and deaths in countries with a higher smoking prevalence. This finding requires further investigation, as the literature is inconsistent. However, there was an interesting observation from a recently published paper describing 393 critical patients with COVID-19 admitted to two hospitals in New York City. The analysis revealed that only 5.1% of the patient sample were current smokers, compared to the 15.6% smoking incidence in United States reported by the CDC."[823]

And regarding smoking: "A potential protective effect of smoking was identified in a recent evaluation of 17 million adult patients within the National Health Service of the United Kingdom, with 5,683 COVID related deaths. In their analysis, current smokers were associated with a reduced risk of COVID-19 related mortality."[824]

The authors wrote about their findings: "The findings of this country level analysis on COVID-19 related health outcomes suggest that low levels of national preparedness, scale of testing, as well as population characteristics such as obesity, advanced age and higher per capita GDP are associated with increased national case load and mortality."[825]

A key conclusion of the study was: "However, *in our analysis, full lockdowns and wide-spread COVID-19 testing were not associated with reductions in the number of critical cases or overall mortality*."[826]

## Japanese study found asymptomatic people with COVID-19 antibodies

A Japanese study found that over three months in the summer of 2020 people testing positive for COVID-19 antibodies increased *over 800%* – from 5.8% to 46.8%.[827] Yet, not a single one of the 41% who tested seropositive after three months was hospitalized or died. While a high percentage of people became "infected" with COVID-19 during the test period, almost all were asymptomatic.

The test period was May 26 to August 25, 2020 and involved 615 people. The participants were recruited from 11 disparate locations across Tokyo. They worked for the same large company, but had limited contact with each other. The participants ranged from 19 to 69 years old, and 54% were male and 46% were female. No one was selected to participate if they had a fever, cough, or shortness of breath, or were otherwise not considered to be healthy.[828]

Tokyo is an ideal place to study the spread of a virus like COVID-19, "given its remarkably high population density, tightspacing, the widespread

use of public transportation, and no implementation of a "lockdown"."[829]

The authors write about the discovery a high percentage of people became infected during the three months: "These findings should also take into context the epidemiological dynamics seen during this COVID-19 wave. Japan took the atypical step of not instituting a mandatory lockdown. During this time, businesses, restaurants, and transportation were kept open, and public life continued relatively unabated." [830]

They also observed: "With the rise in SPR nearing 50% within our cohort, matching the time when COVID-19 cases waned, *the possibility of herd immunity should be considered, particularly in the highly-dense urban scenario like Tokyo*. … Much like our cohort which had no reported hospitalizations, clinical severity in Tokyo was low. During the second surge, only 31 fatal cases (observed between June 22 and August 25) were reported in Tokyo … Assuming an infection rate of 40% within the Tokyo urban population (14 million), the infection fatality rate (IFR) during this period could potentially be as low as 0.0006%, which is as low as the lowest IFR observed among teens in Switzerland."[831]

Although the authors didn't mention it, the study is important because it shows COVID-19 is just like the seasonal flu: the overwhelming majority of people exposed to the virus develop antibodies to it without becoming ill.

## Criticism of Lockdowns & Social Distancing by Denis G. Rancourt

> "This is not a major killer that would warrant a military style lockdown. This is nothing like that."[832]

Denis G. Rancourt is a researcher at the Ontario Civil Liberties Association (OCLA.ca) and is formerly a tenured professor at the University of Ottawa, Canada. In April 2020 he wrote a technical report for the OCLA regarding the lockdown of Canadian society related to COVID-19: *OCLA Report 2020-1: Criticism of Government Response to COVID-19 in Canada*. Excerpts from that report follow:[833]

### I. Absence of an evidentiary basis to support general-population lockdown

### General-population lockdown has previously not been attempted in modern medical history

1. Intervention during an epidemic of a viral respiratory disease by lengthy large-scale (regional, provincial, national) general-population lockdown to individual homes and institutions has not been attempted in modern medical history …and has not been studied in field research.

2. …General-population lockdown measures intended to "flatten the curve" were not applied in the 2013-2016 Ebola outbreak or in the 2003 SARS epidemic…

3. The authoritative critical assessment by Ferguson et al. (2006) of the expected array of mitigation strategies for viral respiratory-disease pandemics did not even consider general-population lockdowns …

**Health liabilities of general-population lockdown during an epidemic are not known from empirical studies**

4. Both effectiveness and potential liabilities of general-population lockdown (and social distancing) strategies are unknown, although critical warnings have recently been expressed in the leading scientific literature …

**The epidemiological effectiveness (R0 reduction) of lockdown is entirely hypothetical**

5. There are no studies that reliably measure reduction in the epidemiological basic reproduction number (R0), relative to its value in the absence of government intervention, induced by specific lockdown measures in a real urban society. The assumed benefit from the intervention, in limited regard to R0, is entirely hypothetical. …

**II. Scientific expert reports: lockdown causes significantly more cumulative COVID-19 deaths**

**Any temporary advantage from mitigation comes at the expense of lower population immunity and higher cumulative deaths**

6. In social circumstances in which R0 would be reduced by lockdown measures, this is necessarily achieved at the expense of a resulting lower population immunity (measured as the ratio of the numbers of immune and susceptible individuals), which leaves the population more vulnerable to the same virus, or a similar strain, than if no lockdown or social distancing had been applied … *The cumulative number of infections is thereby increased substantially, compared to no government intervention*…

7. …"For simulations with seasonal forcing, *the post-intervention resurgent peak could exceed the size of the unconstrained epidemic, both in terms of peak prevalence and in terms of total number infected*. Strong social distancing maintained a high proportion of susceptible individuals in the population, *leading to an intense epidemic when R0 rises in the late autumn and winter*. … The observation that strong, temporary social distancing can lead to

especially large resurgences agrees with data from the 1918 influenza pandemic in the United States, in which the size of the autumn 1918 peak of infection was inversely associated with that of a subsequent winter peak after interventions were no longer in place."

**Any flattening of the infection peak does not itself save lives in the initial (first wave) epidemic**

8. … the net number of lives saved by lockdown in the initial epidemic, under theoretically optimal conditions, is usually small…
9. The only recognized goal of social-distancing or lockdown is solely to reduce peak intensity of the epidemic ("flatten the curve"), in order to avoid overwhelming the health system … yet the government did not provide evidence that any life-saving treatment would be denied to anyone in Canada, and there are many ad hoc reports of emptied hospitals …
10. The context is one in which the coronavirus is deadly almost exclusively to elderly people having comorbidity conditions … and where the most severe cases do not survive irrespective of any medical intervention (49.0 % of hospitalized cases classified as "critical" are fatal) …

**"Flattening the curve" extends the period of confinement, while suppressing the attainment of societal immunity, and thus increases the cumulative deaths among the segregated elderly**

14. As such, the governments have acted in diametrical opposition to the precautionary principle: "government shall not act with insufficient scientific knowledge, if the action has any likelihood of causing more harm than good"
15. The governments are playing Russian roulette with the lives of the most vulnerable members of society, regarding death from the coronavirus itself, both in the initial (first wave) and artificially-prolonged epidemic, and in subsequent waves of infection, in the following years.
16. Regarding extended confinement of the segregated elderly, there are already several media reports of deaths being caused by the lockdown conditions themselves …

**III. Justification for the early panic-response is not corroborated**

17. *Recent studies converge in showing that COVID-19 is not particularly virulent, nor unusually contagious, compared to the baseline of seasonal influenza and influenza-like illnesses*:

• The work of **Silverman et al. (2020)** shows that the overall (all ages included) infection fatality-ratio is likely to be 0.1 % (typical of average seasonal influenza),
• The deaths for COVID-19 are virtually exclusive to susceptible individuals >65 years of age, and there is no reasonable justification for a general-population lockdown of all individuals versus a policy of vigilant protection specifically of those at risk. …

> "People <65 years old and not having any underlying predisposing conditions accounted for only 0.3%, 0.7%, and 1.8% of all COVID-19 deaths in Netherlands, Italy, and New York City. …Strategies focusing specifically on protecting high-risk elderly individuals should be considered in managing the pandemic."

18. Thus, *there is no objective reason to believe the coronavirus is significantly more contagious or more virulent than seasonal influenza or influenza-like-illness*…

**IV. Faith in epidemic-modeling of catastrophe-scenarios and mitigation strategies is not justified**

19. *A panicked response can be incited by mere computer simulations performed with dubious input assumptions, tentative input parameters, and an unrealistic model architecture. Such a model … may have played a role in China's response in Wuhan.*

…

22. There is no need to rely on these models because the similarities with the 2003 SARS epidemic are compelling. …

23. *The general-population global lockdown saga, incited by incorrect model simulations, should not have occurred. The epidemic would be over, and societal immunity would be achieved, in the regions of high transmission, without government intervention other than facilitating specific measures to protect vulnerable persons*.

**V. The Canadian government's forecast of deaths is questionable**

24. Canada has made dramatic pronouncements regarding potential deaths:

> Even in that best-case scenario, the federal public health agency projects that 4,400 to 44,000 Canadians could die of COVID-19 in the coming months.

26. The epidemic curve is following the same pattern as with the 2003 SARS epidemic…

27. There is no compelling reason to conclude that the general-

population lockdown measures …had a detectable effect in Canada.

28. Even if Canada — with its publicly funded health sector, its pristine air, its relatively uncrowded living conditions, and its regular seasonal natural immunizations to every form of viral respiratory illness — were to suffer the same COVID-19 fatality rate as Italy, then this would translate … to 13,500 Canadian deaths, which (in a year) corresponds to 4% of the Canadian death rate per year from all causes, and is comparable to historic non-pandemic influenza-associated excess mortality in the USA…

In a technical report about the ineffectiveness of masks to prevent the spread of COVID-19, Rancourt said about lockdowns:

> The present paper about masks illustrates the degree to which governments, the mainstream media, and institutional propagandists can decide to operate in a science vacuum, or select only incomplete science that serves their interests. *Such recklessness is also certainly the case with the current global lockdown of over 1 billion people, an unprecedented experiment in medical and political history*.[834]

## Australian doctors critical of harsh lockdown in Victoria

Victoria, Australia's Premier Daniel Andrews imposed very strict COVID-19 lockdown measures that in addition to closure of businesses, schools, churches, and other social activities, imposed curfews, limited how far a person could travel from their home, and mandated mask wearing in public.[835] Andrews measures for Victoria were the harshest of any Australian state.

A group of doctors in Victoria began speaking out against the negative physical and mental health consequences of Andrews' policies. They organized the Covid Medical Network and set-up a website.[836] The organization's Statement reads in part:

> "*The Victorian government's response to the SARS-CoV-2 virus is now doing more harm than good. These measures will cause more deaths and result in far more negative health effects than the virus itself*. Left unchecked, the Victorian government risks creating the state's worst ever public health crisis.
>
> Many Australian doctors and other health professionals consider the lockdown measures to be disproportionate, unscientific, excessively authoritarian and the cause of widespread suffering for many Victorians.
>
> Thereby, we Australian Doctors and Health Professionals, in solidarity with thousands of international doctors, call for the cessation of all disproportionate measures that contravene the

International Siracusa Principles.

These Siracusa Principles are part of the International Covenant on Civil and Political Rights, to which Australia is a signatory, and are recommended by the World Health Organisation. They require all public health management policies to meet standards of legality, evidence-based necessity and proportionality, and that they recognise our basic, universal and non-derogable human rights.

Children and adolescents are suffering and being needlessly harmed by the denial of normal social interactions such as play, schooling and relationships with family and friends, particularly as the virus poses an almost negligible risk. These effects on child and adolescent health will impact their future wellbeing for many years to come.

*The ambition for 'viral elimination' and the intent of achieving "zero cases for a period of time", is both irrational and unachievable*, according to the best local and international evidence.

…

The Victorian government's measures are 'anti-health' and deny the principles of good medical practice. They constitute a disproportionate approach which relies on a fear-based media narrative as well as inadequate and misleading information. This must cease as soon as possible.

These policies seriously compromise the health of individuals and the wider community … These policies are contrary to common-sense …

The fear and societal anxiety caused by these policies has delayed presentations of many serious medical conditions, including cancers and heart disease. … The interruption and closure of businesses has created significant financial and relationship strain for many families and further impacted the mental stress and negative health impacts we are witnessing

Evidence does not support these measures. *The limited virulence of the SARS-CoV-2 virus for the vast majority of the population is now well established from the latest international data sets*. …

It is incumbent on all of us to examine the bigger picture and assess the significant harms being inflicted on our society in the pursuit of a very narrow concept of 'health'. We must re-establish the importance of our basic rights and freedoms and reflect deeply on what kind of society we wish to live in."[837]

The magnitude of what the people of Victoria, Australia have to deal with is Premier Andrews is basing his harsh measures on the assumption that

COVID-19 is a health menace even if there are zero cases. Part 2—Amendment of the Public Health and Wellbeing Act 2008. Definitions: Section 2 states: "…*COVID-19 may pose a material risk of substantial injury or prejudice to health* of human beings *even when* the rate of community transmission of COVID-19 in Victoria is low or *there have been no cases of COVID-19 in Victoria for a period of time*."[838]

## Epidemiologists and public health scientists advocate Focused Protection

Infectious disease epidemiologists and public health scientists around the world who are critical of the harmful economic, medical and psychological effects of government lockdown strategies set-up a website to host their petition "The Great Barrington Declaration."[839] The Declaration states in part:

> "As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection.
>
> … Current lockdown policies are producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden. Keeping students out of school is a grave injustice. …
>
> Fortunately, our understanding of the virus is growing. *We know that vulnerability to death from COVID-19 is more than a thousand-fold higher in the old and infirm than the young*. *Indeed, for children, COVID-19 is less dangerous than many other harms, including influenza*.
>
> As immunity builds in the population, the risk of infection to all – including the vulnerable – falls. We know that all populations will eventually reach herd immunity – i.e. the point at which the rate of new infections is stable … Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.
>
> *The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection*, while better protecting those who are at highest risk. We call this Focused Protection.

> Adopting measures to protect the vulnerable should be the central aim of public health responses to COVID-19. By way of example, nursing homes should use staff with acquired immunity and perform frequent PCR testing of other staff and all visitors. Staff rotation should be minimized. Retired people living at home should have groceries and other essentials delivered to their home. When possible, they should meet family members outside rather than inside. …
>
> *Those who are not vulnerable should immediately be allowed to resume life as normal*. Simple hygiene measures, such as hand washing and staying home when sick should be practiced by everyone to reduce the herd immunity threshold. Schools and universities should be open for in-person teaching. Extracurricular activities, such as sports, should be resumed. Young low-risk adults should work normally, rather than from home. Restaurants and other businesses should open. Arts, music, sport and other cultural activities should resume. People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity."[840]

The Declaration was authored and signed on October 4, 2020 by Dr. Sunetra Gupta, Dr. Martin Kulldorff, and Dr. Jay Bhattacharya. Thirty-five esteemed professionals co-signed the Declaration. It was posted for signing by the public, and in the two weeks it had 515,366 signatures.[841]

### WHO advises against lockdowns due to negative effects

Dr. David Nabarro – The WHO's special envoy on COVID-19 – stated during an interview with the Spectator (UK) in October 2020: "We in the World Health Organization do not advocate lockdowns as the primary means of control of this virus." He also said: "*We really do appeal to all world leaders, stop using lockdown as your primary control method*. Lockdowns have just one consequence that you must never ever belittle, and that is making poor people an awful lot poorer." He also said lockdowns have a devastating impact on small countries whose economy relies on tourism, and "Too many restrictions damage people's livelihoods and provoke resentment." Nabarro emphasized lockdowns are not helpful as the primary means to control COVID-19, suggesting a middle path which means keeping the economy and social life going while taking common sense precautions.[842]

## II – Asymptomatic people don't drive COVID-19 outbreak

Asymptomatic people don't drive a respiratory virus outbreak according to Dr. Anthony Fauci, director of the National Institute for Allergy and Infectious Diseases. Fauci was specifically referring to COVID-19 when during a press conference on January 28, 2020 he stated:

> "But the one thing that people need to realize, that even if there is some asymptomatic transmission. In all the history of respiratory borne viruses of any type, asymptomatic transmission has never been the driver of outbreaks. The driver of outbreaks is always a symptomatic person. Even if there is a rare asymptomatic person that might transmit, an epidemic is not driven by asymptomatic carriers."[843]

The transmission of COVID-19 by someone who is infected but not showing symptoms is rare according to Maria Van Kerkhove, the World Health Organization's technical lead for coronavirus response and head of the emerging diseases and zoonoses unit. Kerkhove said during a media briefing in Geneva on June 8, 2020: "From the data we have, it still seems to be rare that an asymptomatic person actually transmits onward to a secondary individual."[844]

A June 5 WHO document states about asymptomatic transmission of COVID-19:

> Comprehensive studies on transmission from asymptomatic individuals are difficult to conduct, but the available evidence from contact tracing reported by Member States suggests that asymptomatically-infected individuals are much less likely to transmit the virus than those who develop symptoms. Among the available published studies, some have described occurrences of transmission from people who did not have symptoms. For example, among 63 asymptomatically-infected individuals studied in China, there was evidence that 9 (14%) infected another person. Furthermore, among two studies which carefully investigated secondary transmission from cases to contacts, one found no secondary transmission among 91 contacts of 9 asymptomatic cases, while the other reported that 6.4% of cases were attributable to pre-symptomatic transmission.[845]

Another aspect of asymptomatic people is the majority of them had no symptoms when they tested positive for COVID-19. In England the Office of National Statistics reported: "Only 22% of people testing positive for

coronavirus reported having symptoms on the day of their test."[846] An extreme example of this is a 20-year-old woman in Quebec, Canada who tested positive eight times with no symptoms over four months from May to August 2020. Epidemiologist Dr. Sumon Chakrabarti told *Global News* the woman is likely testing positive for dead and inactive viral particles: "There are still little bits of genetic material being detected. But I suspect if you take her swabs and look at how much of the virus is actually there, it would be below the level that we consider infectious."[847] Thus the woman is not only asymptomatic but non-infectious.

The U.K.'s 78% asymptomatic rate is consistent with research from the village at the epicenter of the outbreak in Italy: 50% to 75% of people who tested positive were asymptomatic. [848] It is also in line with a large-scale test in Iceland that found "about half [50%] of those who tested positive are non-symptomatic. The other half displays very moderate cold-like symptoms."[849] In other words, a small percentage of people in Iceland who tested positive had symptoms more severe than those of a moderate cold.

Also consistent with those findings is a WHO report that, "For COVID-19, data to date suggest that 80% of infections are mild or asymptomatic, 15% are severe infection, … and 5% are critical infections…"[850] That report doesn't specify what percentage are asymptomatic, but the mild cases are not serious enough to require hospitalization.

# 21. Lockdowns Didn't Reduce Deaths

The rationale of states and entire countries imposing a COVID-19 inspired lock down of society was to "flatten the curve" to relieve over-burdening of the health care system and reduce deaths.

If the number of deaths wasn't reduced – but actually increased by lock-downs, then the rationale for them had no medical basis in reality.

## I – Influenza-like illness outbreaks follow a bell curve pattern

Influenza outbreaks are known to follow a bell curve shape. Approximately an equal shape to the rise and the fall of the impact of the virus: in cases, hospitalizations, and deaths. The following chart shows this for a cousin of COVID-19, the SARS coronavirus. In a population of 10 million, infections (orange) total about 2 million with a steep rise to a peak and then a steep fall, cases (yellow) total about 200,000 with a steep rise to a peak and then a steep fall, and deaths (grey) total 597 with a rise to peak and then a fall. The infections, cases and deaths all follow the pattern of a symmetrical bell curve. The chart is based on a transmission rate of R=2.2, and the outbreak lasts about 90 days from beginning to end.[851]

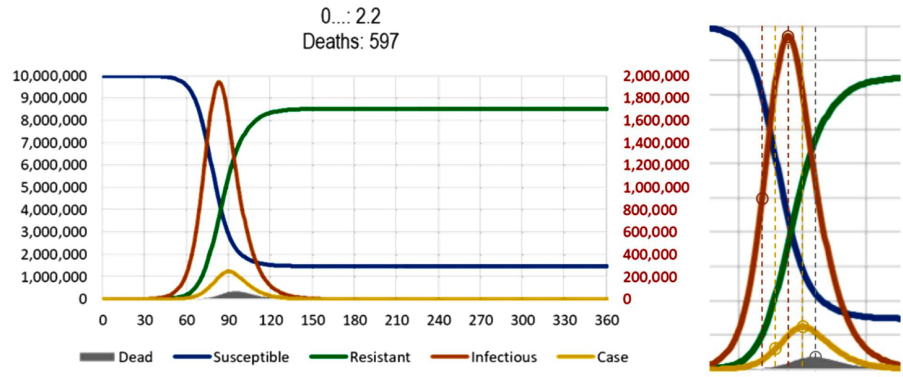



**Fig 3: SIR Model of SARS.** Number of susceptible (blue), infectious (red), resistant (green), case (orange) and dead (gray) people after a population of 10,000,000 susceptible people is exposed to 20 subjects infected carrying a novel virus. Assumptions: $R_0$ = 2.2, infectious period = 7 days,(available from https://app.box.com/s/pa446z1csxcvfksgi13oohjm3bjg86ql )

The lockdown of society imposed by the leaders of many countries was ostensibly to "flatten the curve" of COVID-19 – which means to disrupt the natural bell-shaped progression of the virus. It is logically impossible to "flatten the curve" to diminish the severity of an outbreak after its peak has been reached, and it is on a downward trajectory. Yet, that is exactly what countries around the world and U.S. states did, with predictably catastrophic results.

## II – Washington State Deaths Quadrupled After Lockdown

On March 23, 2020 the number of COVID-19 deaths per day peaked in Washington and – and total deaths was 420. The first death was five weeks earlier on February 17.[852] Based on a bell curve of the rise, it could be expected that deaths from virus would approach zero approximately five weeks after they began falling March 24 – which would be the first or second week of May. That pattern was exhibited perfectly for two weeks after the peak as deaths fell at the same rate they had increased (See chart below). Then the fall to zero was interrupted.

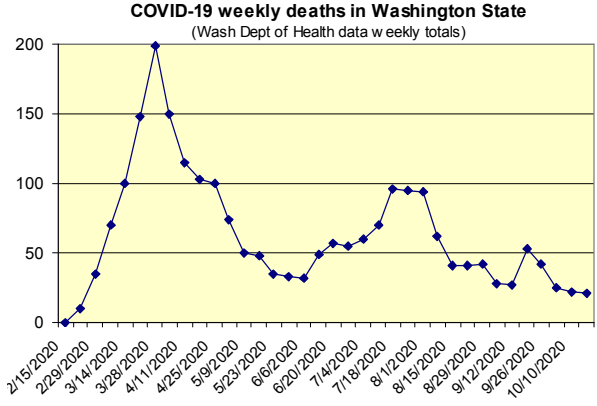
What had happened?

On March 23, 2020 Washington State Governor Jay Inslee proclaimed a statewide lockdown. People were instructed to stay home unless they had to leave for an urgent reason, and businesses the state classified as non-essential were required to close.

Inslee's Proclamation couldn't have been more ill-timed, or unnecessary, because it was issued the same day COVID-19 deaths peaked, and the next day they began falling naturally as the outbreak dissipated.

The effects of Inslee's lockdown interfering with normal economic and social interaction could be expected to kick in after about two weeks, based on what was known about transmission and infectability from the virus. That would have been at the beginning of the second week in February. So for several weeks after Inslee's proclamation it would be expected that deaths (and hospitalizations) would fall precipitously. That is exactly what happened.

The accompanying chart shows that after hitting their peak on March 23, COVID-19 deaths in Washington state fell rapidly for two weeks at virtually the same rate they had risen. Then the breaks were put on when Inslee's interference took effect slowing the natural dissipation of the virus. The dramatic decrease in the number of deaths was slowed, and the virus predictably continued to wreak havoc for much longer than mid-May at the latest. As of October 16, 2020, 2,296 deaths have been attributed to COVID-19 in Washington state.[853] That exceeds by more than 250% the approximately 840



deaths total that would be expected considering the 420 deaths that had occurred by the peak on March 23. The number of deaths in Washington at the beginning of October was still in excess of what would have been expected five months earlier – in May – if Inslee had not issued his Proclamation.

The additional people who died as a result of Inslee extending the COVID-19 outbreak with his Proclamation of March 23 were not collateral damage – they were the predictable consequence of him interfering with the natural fall of deaths from their peak to zero. There is a substantial basis to conclude those excess deaths were avoidable except for Inslee's action that artificially extended the life cycle of the virus in Washington state. If Inslee had conscious knowledge that his action would result in additional deaths then charges against him for murder could be considered because intent could be shown. Without proof he had knowledge (i.e., intent) his action would predictably result in unnecessary deaths, state charges against him for second-degree manslaughter can be considered because his negligence in the deaths for issuing his proclamation is what needs to be proved:

- Manslaughter in the Second Degree: "with criminal negligence, he or she causes the death of another person." (Wash Crim. Code §9A.32.070). Maximum penalty of $20,000 fine and 10 years in prison.[854]

The Washington Supreme Court has ruled: "Manslaughter in the second degree is committed when someone with criminal negligence causes another's death. Criminal negligence occurs when a reasonable person would realize the presence of a substantial risk of harm." (*Washington v. Hughes*, 106 Wn.2d 176, 721 P.2d 902 (1986)).

Inslee can be expected to "realize the presence of a substantial risk of harm" caused by his Proclamation because the COVID-19 outbreak in Washington peaked *the week he issued it*. COVID-19 deaths and hospitalizations fell like a rock after March 23. *There was no health emergency*. There was zero possibility hospital and other medical resources would be taxed by COVID-19 beyond their normal ability to provide services. Inslee can be expected to know that because he had ready access to information from the Washington Department of Health that the COVID-19 outbreak began dying out the week of his Proclamation, and was rapidly disappearing. (See the chart above.) The measures instituted by Inslee resulted in the bumpy pattern of deaths shown on the chart.

Washington state's hasty and counterfactual response wasn't unique. An examination can be made of other state's death evidence and the interference of their governor when deaths were naturally declining.

# III – U.S., Canada & Mexico had high world death rates with lockdowns

| Country (all data is per 100k) | Deaths (to 10-17-20) | Confirmed Cases (to 10-17-20) | Real GDP growth 2020 (IMF est.) |
|---|---|---|---|
| **United States** | 65.3 | 2,386 | -8.0% |
| Canada | 25.7 | 508 | -8.4% |
| Mexico | 66.1 | 648 | -10.5% |
| World avg | 14.2 | 505 | -4.9% |

Lockdowns were instituted in the U.S., Canada and Mexico. They all had death and confirmed case rates in excess of worldwide averages. The United States' death rate and its confirmed cases rate were both almost 500% greater than the world average.[855] The high cases rate can be attributed to widespread testing in the U.S.

All three countries had greater reductions in their GDP for 2020 as projected by the IMF than the world-wide average, ranging from -8.0% (U.S.) to 10.5% (Mexico).

### New York City had hard lockdown and highest U.S. death rate

New York City had a dual distinction. It had perhaps the hardest lockdown in the U.S., and it had the highest death rate of any major city in the country. New York is comprised of five counties. The death rate of those counties is in the accompanying chart.

| County | Deaths (per 100k) (as of 9-22-20) | U.S. Rank (Counties over 475k pop.) |
|---|---|---|
| Bronx | 348.5 | 1 |
| Queens | 321.4 | 2 |
| Kings | 285.9 | 3 |
| Richmond | 227.9 | 7 |
| New York | 194.8 | 10 |
| NYC total | 285.0 | |
| NY outside NYC | 80.1 | |
| NY State avg | 168.0 | |
| U.S. Avg | 61.2 | |

New York City five counties all ranked in the top 10 for deaths per 100k people among the 147 counties in the U.S. with a population over 475,000. Three of those five counties ranked 1, 2 and 3 in deaths per 100k, with the other two ranking 7th and 10th . New York City's overall death rate of 285.0 per 100k ranked #1 among all U.S. cities with a population over 475,000. The second highest was Newark, New Jersey in Essex County – across the Hudson River from NYC – with a rate of 266.1 per 100k. New Jersey also had a hard lockdown.

It is notable the death rate in New York state was 72% lower than in NYC – 80 deaths per 100k outside NYC and 285 in NYC.

It is also notable that while a lot of media attention was given to Italy's Lombardy region, its death rate of 167.7 per 100k[856] was more than 40% lower than NYC's 285 per 100k population.

# IV – European countries had very high death rates with lockdowns

Every European country had a COVID-19 mortality rate higher than the worldwide average. Germany had the lowest death rate, and Belgium the highest. Luxembourg had the third lowest death rate, but by far the highest rate of confirmed cases, suggesting it conducted more testing.[858]

A lot of press coverage was given to the high death rates in the U.K., Spain, and Italy. They were higher than all European countries except Belgium, and much higher than Germany, Luxembourg, Portugal, and Switzerland. One anomaly is Spain's death rate was more then three times higher than Portugal, when they are both on the Iberian Peninsula and they implemented comparable lockdown strategies – albeit Spain's first reported case was more than a month before one was reported in Portugal.

| **Country** (all data is per 100k) | **Deaths** (to 10-17-20) | **Confirmed Cases** | **Real GDP Growth 2020** (IMF est.)[857] |
|---|---|---|---|
| United Kingdom | 64.0 | 1,015 | -10.2% |
| Belgium | 89.4 | 1,743 | -6.9% |
| France | 50.6 | 1,234 | -12.5% |
| Germany | 11.7 | 425 | -7.8% |
| Ireland | 37.3 | 961 | -6.8% |
| Italy | 60.2 | 648 | -12.8% |
| Luxembourg | 21.2 | 1,673 | -4.9% |
| Netherlands | 39.1 | 1,235 | -7.7% |
| Portugal | 21.1 | 941 | -8.0% |
| Spain | 72.2 | 2,003 | -12.8% |
| Switzerland | 21.1 | 858 | -6.0% |
| World avg. | 14.2 | 505 | -4.9% |

## Northern Italy had high fatality rate compared to rest of Italy

| **Region** | **Deaths** per 100k (to 9-1-20)[859] | **Population** |
|---|---|---|
| North | 107.4 | 28,267,004 |
| Central | 26.7 | 13,327,589 |
| South | 8.1 | 19,285,844 |
| Total | 58.3 | 60,880,437 |

Italy illustrates the dramatic difference in the COVID-19 mortality rate between a country's regions. News reports about Italy's serious coronavirus outbreak concerned the country's North, and particularly the Lombardy region. Northern Italy's death rate of 107.4 deaths per 100k was *seven times* that of the rest of the country, and Lombardy's death rate of 167.7 deaths per 100k was more than *4.6 times* the rest of Italy combined.[860]

Four factors in particular have been suggested as the reason for Lombardy's especially high rate: a large number of tourists from Wuhan in January and February 2020; a large population of Chinese migrants from Wuhan working in factories; very bad air quality

| **Pop. Rank** | **City** | **Region** | **Area** | **Deaths** (per 100k) (to 9-1-20)[861] |
|---|---|---|---|---|
| 1 | Rome | Lazio | Central | 14.9 |
| 2 | Milan | Lombardy | North | 167.7 |
| 3 | Naples | Campania | South | 7.7 |
| 4 | Turin | Piedmont | North | 95.2 |
| 5 | Palermo | Sicily | South | 5.7 |

that could cause people to have weakened respiratory systems; and a large population of retired persons.

The accompanying table of Italy's five largest cities shows the COVID-19 death rate had nothing to do with the size of a city. Palermo is in Sicily whose death rate was 3.3% that of the Lombardy region where Milan is located. Rome is in the Lazio region whose death rate was 4.5% that of Lombardy.

## V – Non-lockdown countries had death rate 1/4 of lockdown countries

Non-lockdown countries had a COVID-19 mortality rate *almost 1/5* the death rate of lockdown countries. Their rate of confirmed cases was also *about 1/5* that of lockdown countries.[862]

Economically not locking down was overall beneficial. Six of the twelve non-lockdown countries had IMF projected GDP growth rates equal to or higher than the worldwide average, with three countries having positive projected growth rates. The overall average was slightly better than the worldwide average.

| **Country** (WHO data per 100k) | **Deaths** (to 10-17-20) | **Confirmed Cases** | **Real GDP growth 2020** (IMF est.) |
|---|---|---|---|
| Belarus | 9.7 | 914 | -6% |
| Burundi | 0.0 | 4.5 | -5.5% |
| Iceland | 3.2 | 1,151 | -7.2% |
| Japan | 1.3 | 73 | -5.8% |
| Nicaragua | 2.3 | 65 | -6.0% |
| South Korea | 0.9 | 49 | -6% |
| Sweden | 58.6 | 1,022 | -6.8% |
| Taiwan | 0.0 | 2.2 | -4.0% |
| Tajikistan | 0.8 | 109 | 1.0% |
| Tanzania | 0.0 | 0.9 | 2.0% |
| Turkmenistan | ?? | ?? | 1.8% |
| Uruguay | 1.5 | 70 | -3.0% |
| 12 country avg. | 3.0 | 105 | |
| | | | |
| Lockdown countries | 14.7 | 522 | |
| | | | |
| World avg | 14.2 | 505 | -4.9% |

The very low death and case rates of the non-lockdown countries is representative of conditions around the world because those countries were in Europe, South America, Africa, the Middle East, and Asia. It is reasonable to surmise other countries would have had similar low death and case rates if they had not imposed a lockdown.

## VI – Sweden's death rate was lower than U.K. that had hard lockdown

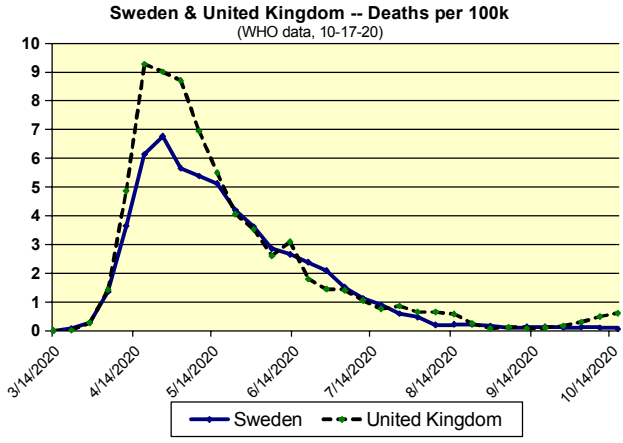
Sweden's COVID-19 mortality rate was lower than the United Kingdom from February to mid-October 2020: Sweden had 58.6 deaths per 100k while the U.K. had 64.0.

The effect of COVID-19 on the two countries is a case study because the

| Date | Sweden | U.K. |
|---|---|---|
| March 23, 2020 | 0.2 | 0.4 |
| October 17, 2020 | 58.6 | 64.0 |

U.K. initially had a containment strategy similar to Sweden, before radically changing course on March 23, 2020. On March 23 they had similar total deaths per 100k – Sweden 0.2 and the U.K. 0.4.

Sweden's national government adopted a minimalist mitigation policy in which high schools and universities were closed, public gatherings were limited to 50 people, people aged 70 and above were advised to practice social distancing, and symptomatic people were advised to practice home quarantine.[863]




Until the United Kingdom instituted a nationwide hard lockdown on March 23, 2020, it had effectively followed Sweden's minimalist strategy,. The U.K.'s hard lockdown included a mandatory stay-at-home order; the closing of churches, schools, social activities, and "non-essential" businesses; the banning of more than two strangers in public. The U.K. also mandated 2-meter social distancing from strangers in public. While some of the restrictions were eased with time, mask wearing on public transportation and indoors in public was added as a mandate. On September 14, 2020 the U.K. also added the "Rule of Six" that legally limited gatherings in public to no more than six people. The police were able to disperse gatherings and fine individuals £100, that could double for each repeat offense up to a maximum £3,200 fine.[864]

The U.K.'s abandonment of Sweden's minimalist strategy and adoption of a radical invasive containment strategy didn't pay off: its death rate was almost 10% greater than Sweden's as of October 2020. An unanswered question is if the U.K.'s death rate would have been the same, or possibly less, if it had continued with Sweden's minimalist strategy.

The possible futility of England's hard lockdown strategy is suggested by the fact deaths per 100k in both countries followed roughly the same course, as shown in the accompanying chart. Although after the U.K. imposed the "Rule of Six" deaths *increased* in five weeks by more than 500%, while during that time in Sweden they *decreased* by more than 50%. Sweden didn't even have a mask wearing requirement.

## VII – U.S. had higher rate of COVID-19 deaths in states that had lockdown

There were high rates of COVID-19 deaths in the states with hard lockdowns and intransigent governors unwilling to return society to normal by surrendering the emergency powers they used to impose restrictions in the name of fighting the virus. The lockdown states had an overall death rate more than three times greater than the eight states that did not issue statewide stay-at-home orders.

The chart shows how the states with the highest rate of COVID-19 deaths compared to the eight states that didn't impose statewide Stay-At-Home orders according to CDC data.[865]

| State | COVID-19 Deaths (2-1 to 9-30-20) | Population | Deaths (per 100k) | Confirmed Cases (per 100k) | Expected Deaths |
|---|---|---|---|---|---|
| New Jersey | 16,121 | 8,936,574 | 181.5 | 2,307 | 133% |
| New York | 32,756 | 19,440,469 | 168.4 | 2,358 | 145% |
| Massachusetts | 9,451 | 6,976,597 | 137.1 | 1,994 | 118% |
| Connecticut | 4,508 | 3,563,077 | 126.4 | 1,610 | 109% |
| Louisiana | 5,321 | 4,645,184 | 114.5 | 3,567 | 117% |
| Rhode Island | 1,092 | 1,056,161 | 103.1 | 2,142 | 109% |
| Mississippi | 2,968 | 2,989,260 | 99.7 | 3,299 | 118% |
| Arizona | 1,369 | 3,017,804 | 77.6 | 3,002 | 125% |
| Michigan | 6,999 | 9,986,857 | 70.1 | 1,322 | 114% |
| Illinois | 8,671 | 12,671,821 | 68.4 | 2,313 | 116% |
| **All stay at home states** | 195,053 | 313,678,863 | 62.2 | 2,269 | 112.3% |
| **No stay at home states** | 5,446 | 17,640,129 | 30.9 | 2,648 | 105.2% |

Eight of the states/regions with the highest death rates were on the east coast, with only Louisiana and Mississippi breaking into the top ten, at 7th and 8th, respectively.

The data shows the COVID-19 policies of states imposing lockdowns were less effective at reducing death and cases than those of states that didn't issue Stay-At-Home orders That same dynamic occurred in countries that didn't lockdown fairing better than countries that did.

## VIII – Almost million more have died globally than been saved by lockdowns

Directly applying the average of 3.0 deaths per 100k people in the countries that did not lockdown to all other countries whose average death rate was 14.7 – a difference of 490% – would suggest that all things being equal not locking down would have reduced COVID-19 deaths worldwide by more than 910,000 people.[866] It is difficult to characterize the lockdowns as driven by concern by officials for the health of the people within the area affected.

WHO reported 1,152,064 deaths as of October 26, 2020, and the non-lockdown countries overall have had a death rate 20.4% of the lockdown countries. A reasonable conclusion is the politically endorsed idea to lockdown regions, states, and entire countries was at best a catastrophic public policy failure. Influenza like respiratory illnesses follow a predictable bell curve trajectory that was interrupted by the lockdowns. The lockdowns extended the seriousness of the COVID-19 outbreak for months longer than it otherwise would have lasted.

## IX – Global study found lockdowns & masks don't reduce COVID-19 deaths

A study of 25 countries and 23 states that had more than 1,000 cumulative deaths attributed to COVID-19 found the lockdowns of businesses, schools, churches, etc., and social distancing, mask wearing, travel restrictions, curfews, stay-home orders, and quarantines had no effect on reducing COVID-19 deaths.[867] The study was by the National Bureau of Economic Research in Cambridge, Massachusetts.

The study examined death data and found:

> "Relatively slow growth or even shrinkage of daily deaths from the disease was observed in every location that we study 20-30 days after that location first experienced 25 cumulative deaths, and the dispersion in growth rates of daily deaths across locations fell even more rapidly.
>
> …
>
> This finding of a rapid decline in the transmission of COVID-19 within the first 30 days of the progression of the pandemic in widely heterogeneous countries worldwide and the persistence of these low transmission rates over the past few months has important implications for studies of the impact of policy interventions on the progression of this epidemic.
>
> …
>
> COVID-19 is not the first epidemic for which transmission rates have fallen faster than would be predicted by simple epidemiological models. Chowell *et al*. (2016) and Eksin *et al*. (2019) are two of many studies indicating that this rapid drop in transmission rates is a pervasive feature of human epidemics. These studies and many others point to two hypotheses as to why transmission rates for human epidemics might fall rapidly that we argue deserve further study when applied to COVID-19.
>
> The first of these hypotheses is that humans spontaneously take action to avoid disease transmission once an epidemic breaks out. …

The second of these hypothesis is that the network structure of human interactions naturally leads to a slowdown in disease transmission …

Finally, we must consider the possibility that unexplained natural forces might account for the observed decline in transmission rates for COVID-19. … of eight major influenza pandemics that have occurred since the early 1700's (including the Spanish Flu of 1918-19), *seven had an early peak that disappeared over the course of a few months without significant human intervention*.[868]

…

Findings.

Our estimation results yield the following four stylized facts about the COVID-19 epidemic.

**Fact 1.** *The growth rate of daily deaths from COVID-19 fell rapidly everywhere within the first 30 days after each region reached 25 cumulative deaths*.

**Fact 2.** *After this first period of rapid decline, the growth rate of daily deaths in all regions has hovered around zero or slightly below.*

**Fact 3.** *The cross-regional standard deviation of growth rates of deaths fell rapidly in the first 10 days of the epidemic and has, subsequently, remained low relative to its initial level.*

**Fact 4.** *When interpreted through a range of epidemiological models, Facts 1 – 3 imply that both the effective reproduction numbers and transmission rates of COVID-19 fell rapidly from widely dispersed initial levels during the 30 days after cumulative deaths reached 25. After this initial period of rapid decline, the effective reproduction number has hovered around one everywhere in the world."*[869]

…

One of the central policy questions regarding the COVID-19 pandemic is the question of which non-pharmeceutical interventions governments might use to influence the transmission of the disease. … The facts that we document in this paper cast doubt on this premise. Our finding in Fact 1 that early declines in the transmission rate of COVID-19 were nearly universal worldwide suggest that the role of region-specific NPI's implemented in this early phase of the pandemic is likely overstated. …

Our findings in Fact 2 and Fact 3 further raise doubt about the importance in NPI's (lockdown policies in particular) in accounting for the evolution of COVID-19 transmission rates over time and

> across locations. … effective reproduction numbers in all regions have continued to remain low relative to initial levels indicating that the removal of lockdown policies has had little effect on transmission rates."[870]

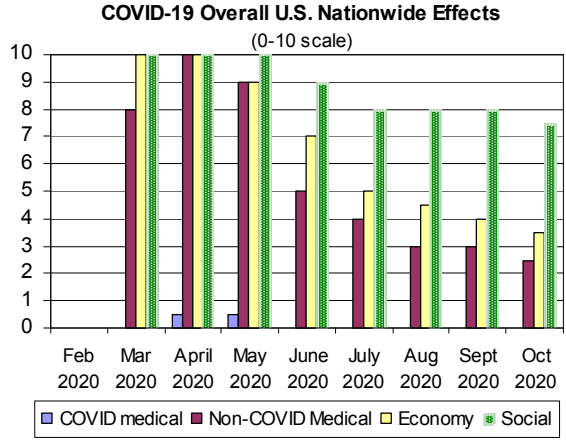
The essence of the study is the number of COVID-19 deaths would not have increased in countries and states that had lockdowns, social distancing, and other non-pharmaceutical interventions if they had let the virus run its natural course like is done for the flu, common cold, and other viruses.

While it isn't mentioned in the study, Belarus in particular proves the study's finding. Belarus had no lockdown and no mandated social distancing or mask wearing, etc. Schools, businesses, churches, sports, and social activities continued as normal throughout the outbreak, while most other countries imposed varying degrees of lockdowns and other restrictions. Yet, Belarus has a COVID-19 death rate about 1/7th of the U.S. and a positive test rate almost 1/3 of the U.S.[871]

# 22. COVID-19 Was Global False Alarm That Governments Turned Into An Economic And Societal Catastrophe

That COVID-19 was a global false alarm is now known to the same scientific certainty as the Earth revolving around the sun.

It is also known the reaction of governments world-wide to COVID-19 was wildly disproportionate to its possible danger. That resulted in catastrophic harm to the economies, medical services, and social fabric of cities, regions, and entire countries. The accompanying chart shows on a scale of 1 to 10 the author's estimate of the medical effect of COVID-19 nationwide in the U.S.; and the effect of government policies on non-COVID-19 medical services; the economy, and social life as a whole by month from March to September 2020. (There was zero effects in all categories in February.)[872] The worst effects were in April and May, but not because of the virus that had minimal effect, but because the economy, social life, and basic medical services were ravaged by state and federal government COVID-19 policies. The chart visualizes the harm in the U.S. wasn't caused by the virus, but by the cavalcade of effects triggered by the government's disproportionately hysterical response to it. In fact, the effect of COVID-19 itself was so negligible in the U.S. that the only months when it even rose to having a nationwide effect of 1 on a sale of 10 was in April and May 2020. The abnormal medical effects of COVID-19 have been close to zero in the U.S. since May.




## I – Soviet style lockdowns were imposed in western countries

The commandeering of state and national economies by government officials is an affirmation of why the Soviet Union's top-down economy was so much less dynamic than that in western countries.

Government officials in countries around the world reacted to their fear of COVID-19 by dictating what businesses they considered to be non-essential and thus must close their doors to customers until permitted to do so – at an undetermined time in the future.

The closures were justified by the claim that preventing personal interactions in those businesses would limit the spread of COVID-19. Yet, large retail businesses such as Wal-Mart, Target, Safeway, etc. were classified by government officials as essential and allowed to remain open, with very large number of people freely intermingling in them, and with store clerks and other store workers. Tellingly, the COVID-19 death rate was *less than 1/2* for grocery store clerks – who came into contact with hundreds of people daily – and other members of the United Food and Commercial Workers International Union (UFCW) than it was for the general population in the U.S.[873]

As with all Soviet style top-down economic policies, the decisions bureaucrats made under the guise of protecting the public from COVID-19 were not reality based in who was pegged as a winner by being allowed to remain open (large box stores, supermarkets, etc.) and those chosen to be a loser (typically small family owned businesses, that even included bowling alleys.). The totally arbitrary authoritarian nature of the lockdowns is demonstrated by the fact there is no scientific evidence that closing or limiting the operation of ANY of the affected businesses affected – or reasonably could have been expected – to have an actual effect on reducing deaths attributable to COVID-19. They were 100% arbitrary political decisions. That is shown by the fact that retail workers exposed to large numbers of strangers every work day had a significantly lower COVID-19 death rate than the general population.

### Non-essential businesses are determined by lack of customers

A market economy is driven by bottom-up decision making. Customers determine what businesses are essential. Businesses that are essential are those that attract sufficient customers to meet their overhead and provide enough profit for the owners to think it is worthwhile to continue operating. A business that doesn't attract enough customers to meet its overhead is likely destined for a short life – because the marketplace has deemed it to be non-essential at meeting the needs of a sufficient number of customers to continue operating. There is no government intervention in the process that is entirely driven by bottom-up individual decision making.

## II – "It's Just the Flu" says Russia's Coronavirus Czar

Dr. Alexander Myasnikov was appointed in April 2020 to inform Russians about coronavirus treatment and prevention methods, and to

provide honest information about COVID-19. He was Russia's equivalent of Anthony Fauci and Dr. Deborah Birx in the U.S.

In a May 2020 interview by Ksenia Sobchak, Myasnikov said that in most COVID-19 cases there are several contributors to a person's 'cause of death' because most have serious underlying health conditions that would be fatal without the virus.

Myasnikov also said COVID-19 is not nearly as dangerous as people think, and because of misplaced anxiety the many authorities in the world have over-reacted. He also insisted the number of deaths in the West were significantly over-counted. However, he said that like any virus vulnerable people will die, but it is a "Russian miracle" the country's death rate is so low.

(Alexander Myasnikov (Ksenia Sobchak)

Myasnikov further said "It's all bullsh*t. It's all exaggerated. It's an acute respiratory disease with minimal mortality. Why has the whole world been destroyed? That I don't know."[874]

Myasnikov had given a prior interview to *The Moscow Times* in which he said his duties included informing the public about COVID-19 treatment and prevention methods, and to combat "fake news" about the virus. He also said: "The infection will still take its toll and we'll all get it. Those meant to die will die. Everyone dies." But he cautioned Russians not to panic over potential symptoms: "Even if it's coronavirus, so what? "Of course you need to get a test to avoid infecting others, but you do understand it's an illusion. We'll run out of tests if everyone runs out to check after every sneeze." [875]

After his comments were reported by the Russian press, Myasnikov wrote on his social media page that he wanted to reassure people feeling "uncertainty and fear of tomorrow. There's no need to waste energy and destroy your psyche with panic. We're all mortal by dint of our existence. The fact that a person is mortal shouldn't darken the days of our, alas, fleeting life. We should just live and enjoy this life."[876]

Before Myasnikov was assigned his post, in the last days of March and first days of April stay-at-home "self-isolation regimes" were imposed in some Russian republics and many Russian cities, including Moscow.[877] On June 9, 2020 Moscow ended its restrictions and people were able to freely use public transportation and travel around the city.[878] Myasnikov's words of optimism are warranted by Russia's COVID-19 experience of a death rate of 15.3 per 100k people – ranked 60th in the world by the WHO, and a known positive infection rate of 872 per 100k people – ranked 54th in the world by the WHO as of October 9, 2020. Those are both significantly lower than the U.S.' ranking of 10th in death rate at 63.5 and 13th ranked positive infection rate of 2,257.[879]

# III – COVID-19 Menace Was Exaggerated To Justify Lockdowns

Learned people recognized the threat of COVID-19 was exaggerated before a lockdown was imposed in any U.S. state, before President Trump declared a national emergency on March 13, and before many countries imposed lockdowns of various severities,. Within weeks of those lockdowns there were analyses that confirmed there was a minimal or non-existent risk of death or even serious illness from COVID-19 for basically everyone but the frail elderly, the obese, and people with grave underlying health conditions.

### March 2020 analysis COVID-19's death rate was vastly exaggerated

One clear reasoned analysis of COVID-19's exaggeration as a health threat was on March 4 by Jeremy Samuel Faust, a physician at Brigham and Women's Hospital in Boston:

> "There are many compelling reasons to conclude that SARS-CoV-2, the virus that causes COVID-19, is not nearly as deadly as is currently feared. But COVID-19 panic has set in nonetheless. … The public is behaving as if this epidemic is the next Spanish flu, which is frankly understandable given that initial reports have staked COVID-19 mortality at about 2–3 percent, quite similar to the 1918 pandemic that killed tens of millions of people.
>
> Allow me to be the bearer of good news. These frightening numbers are unlikely to hold. The true case fatality rate, known as CFR, of this virus is likely to be far lower than current reports suggest. Even some lower estimates, such as the 1 percent death rate recently mentioned by the directors of the National Institutes of Health and the Centers for Disease Control and Prevention, likely substantially overstate the case.
>
> We shouldn't be surprised that the CFR numbers are inflated. In past epidemics, initial CFRs were floridly exaggerated. For example, in the 2009 H1N1 pandemic some early estimates were significantly greater than the eventual CFR, of 0.02-0.03 percent. … As testing begins to include more asymptomatic and mild cases, more realistic numbers are starting to surface. …
>
> But the most straightforward and compelling evidence that the true case fatality rate of SARS-CoV-2 is well under 1 percent comes not from statistical trends and methodological massage, but from data from the Diamond Princess cruise outbreak and subsequent quarantine off the coast of Japan.

A quarantined boat is an ideal—if unfortunate—natural laboratory to study a virus. Many variables normally impossible to control are controlled. We know that all but one patient boarded the boat without the virus. We know that the other passengers were healthy enough to travel. We know their whereabouts and exposures. …

Here's the problem with looking at mortality numbers in a general setting: In China, 9 million people die per year, which comes out to 25,000 people every single day … During the peak of the outbreak in China in January and early February, around 25 patients per day were dying with SARS-CoV-2. Most were older patients in whom the chronic diseases listed above are prevalent. … What we need to know is how many excess deaths this virus causes.

This is where the *Diamond Princess* data provides important insight. Of the 3,711 people on board, at least 705 have tested positive for the virus (which, considering the confines, conditions, and how contagious this virus appears to be, is surprisingly low). Of those, more than half are asymptomatic … This alone suggests a halving of the virus's true fatality rate.

On the *Diamond Princess*, seven deaths have occurred among the passengers, constituting a case fatality rate of 0.99 percent. … we can assume that these are excess fatalities—they wouldn't have occurred but for SARS-CoV-2. The most important insight is that all seven fatalities occurred in patients who are more than 70 years old. …

…But there's another thing that's worth remembering: These patients [on *Diamond Princess*] were likely exposed repeatedly to concentrated viral loads (which can cause worse illness). Some treatments were delayed. So even the lower CFR found on the *Diamond Princess* could have been even lower, with proper protocols. …

<u>This all suggests that COVID-19 is a relatively benign disease for most young people, and a potentially devastating one for the old and chronically ill, albeit not nearly as risky as reported</u>. Given the low mortality rate among younger patients with coronavirus—zero in children 10 or younger among hundreds of cases in China, and 0.2-0.4 percent in most healthy nongeriatric adults (and this is still before accounting for what is likely to be a high number of undetected asymptomatic cases)—<u>we need to divert our focus away from worrying about preventing systemic spread among healthy people</u>—which is likely either inevitable, or out of our control—<u>and commit</u>

most if not all of our resources toward protecting those truly at risk of developing critical illness and even death: everyone over 70, and people who are already at higher risk from this kind of virus.

This still largely comes down to hygiene and isolation. But in particular, we need to focus on the right people and the right places. Nursing homes, not schools. Hospitals, not planes. …

Yes, this disease is real. And, yes, there truly do appear to be vulnerable patients among us, those far more likely to develop critical illness from it. And that relatively small subset, if infected in high numbers, could add up to a tragically high number of fatalities if we fail to adequately protect them.

The good news is that we have huge advantages to leverage: We already know all of this and have learned it remarkably quickly. We know how this virus spreads. We know how long people are contagious. We know who the most vulnerable patients are likely to be, and where they are.

… When [] efforts are not directly in service of protecting the right people, not only do they miss the point of everything we have learned so far, they may actually unwittingly be squandering what have suddenly become precious and limited resources.[880] (underlining added to original)

### COVID-19 mortality rate was vastly overestimated

A month later, on April 4, the *World Economic Forum* published the article "We could be vastly overestimating the death rate for COVID-19. Here's why." That article stated in part:

Public health epidemiology is the science of counting to prevent disease and promote health. We count the number of new cases of a particular disease; this is the incidence. Then we count how much a disease has spread in a population; this is the prevalence.

Using patient data from China, public health officials initially estimated that 80% of COVID-19 cases are either asymptomatic or have mild disease. … The people who do not feel seriously ill stay home, recover quietly, and are never counted. This matters because they do not appear in any of the official statistics.

Take, for example, a New Yorker who is mildly sick. … Only if she becomes ill enough to be admitted to the hospital, or is tested, is she counted as a COVID-19 case. If she dies, she is counted as a COVID-19 death. If she survives, she will not be counted at all.

Once the number of infections is determined, this eventually becomes the denominator in our public health calculation. The number of deaths is our numerator.

*Numerator (number of deaths) divided by the denominator (number of people infected) x 100 = the infection fatality rate.*

We understand that the virus spreads very fast once it is introduced into a population. That means many of us in the general population may be or have already been infected with the virus - whether or not we have symptoms.

However, instead of counting everyone who has been infected in the denominator, in many countries – including the US – only people sick enough to go to the hospital are counted. This is known as selection bias, as people who are sick enough to go to the hospital are more likely to need critical care than patients with mild symptoms.

Further, even when we are testing, depending on the type of tests used and how we are using them, we may only be counting people who are actively infected. This again will lead to an underestimate of the denominator.

What does it mean? It means that the denominator (number of infections) is smaller than it should be, so the numerator (number of deaths) has a lot of power. In this case, the result is that the infection fatality rate (numerator divided by denominator) reported is higher than it should be.

In other words … we are overestimating the percentage of infected people who die of COVID-19. It's a dangerous message that is causing fear - and it is all driven by a false denominator.

… While recognizing the tragedy of every life lost to COVID-19 and other diseases, it will seem as if a higher percentage of COVID-infected people are dying than is actually the case.

… *The majority of us will be infected, survive, and remain unaware that we carried the virus or were contagious*. …

And at some point, we will return to and rebuild our daily routines, with the new addition of attending to the mental health crisis caused by weeks of fear, isolation and anxiety – much of which could have been palliated by an accurate and clear definition of the denominator."[881] (underlining added to orginal)

## Fauci inflating COVID-19 death rate by 10 times fueled lockdown fever

Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, first wrote about what came to be known as COVID-19

in a January 23, 2020 *JAMA* article: "Human coronaviruses (HCoVs) have long been considered inconsequential pathogens, causing the "common cold" in otherwise healthy people. … In December 2019, yet another pathogenic HCoV, 2019 novel coronavirus (2019-nCoV), was recognized in Wuhan, China, and has caused serious illness and death. The ultimate scope and effect of this outbreak is unclear at present as the situation is rapidly evolving."[882]

A month later, Fauci wrote in a February 28 editorial for *The New England Journal of Medicine*:

> "In their *Journal* article, Li and colleagues provide a detailed clinical and epidemiologic description of the first 425 cases reported in the epicenter of the outbreak: the city of Wuhan in Hubei province, China. … a degree of clarity is emerging from this report. The median age of the patients was 59 years, with higher morbidity and mortality among the elderly and among those with coexisting conditions (similar to the situation with influenza) … Of note, *there were no cases in children younger than 15 years of age*. *Either children are less likely to become infected ... or their symptoms were so mild that their infection escaped detection*…"
>
> …
>
> If one assumes that the number of asymptomatic or minimally symptomatic cases is several times as high as the number of reported cases, the case fatality rate may be considerably less than 1%. *This suggests that the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately 0.1%*) or a pandemic influenza (similar to those in 1957 and 1968) …"[883]

On March 11, less than two weeks after declaring in writing he expected COVID-19 to have a case fatality rate of 0.1%, Fauci testified in the U.S. Congress to the House Oversight and Reform Committee, it "*is 10 times more lethal than the seasonal flu*" – which would be about 1 percent.[884] Fauci's testimony about a 1% mortality rate was widely publicized by legacy and social media – while his 0.1% estimate to academics that was 10 times less was ignored. Fauci's testimony heaped nitroglycerine on the coronavirus hysteria building among politicians and the general public throughout the U.S.

Two days after Fauci's testimony President Trump declared a national COVID-19 emergency on March 13, and state governors and officials began ordering business and organization lockdowns, school and church closures, stay-at-home/shelter-in-place orders, and social distancing requirements. It seems unlikely Trump would have declared a national emergency or that

state officials would have ordered any closures and other measures if Fauci had truthfully testified to Congress that COVID-19's expected mortality rate was the 0.1% that he freely communicated to his medical colleagues – but that is a matter for historians to debate.[885]

### Hasty and irresponsible COVID-19 related decisions were made

There were many exaggerations and misconceptions that contributed to the hasty political decisions to institute COVID-19 inspired lockdowns in the U.S. and other countries. John P.A. Ioannidis examined 12 of those issues in a paper published on March 12 – the day before President Trump declared a coronavirus national emergency. The following are excerpts from Ioannidis paper:

**1. Fake news and withdrawn papers**

Based on Altmetric scores, the most discussed and most visible scientific paper across all 20+ million papers published in the last 8 years across all science is a preprint claiming that the new coronavirus' spike protein bears "uncanny similarity" with HIV-1 proteins. … The paper was rapidly criticized as highly flawed, and the authors withdrew it within days. Regardless, major harm was already done. …

The first report documenting transmission by an asymptomatic individual was published in the *New England Journal of Medicine* on January 30. However, *the specific patient did have symptoms*, but researchers had not asked. …

*Lancet* published on February 24 an account from two Chinese nurses of their front-line experience fighting coronavirus. The authors soon retracted the paper admitting it was not a first-hand account.

These examples show how sensationalism affects even top scientific venues. Moreover, peer review may malfunction when there is little evidence and strong opinions. … As outlined below, for the main features of the epidemic and the response to it, circulating estimates are often exaggerated, even when they come from otherwise excellent scientists.

**2. Exaggerated pandemic estimates**

An early speculation that 40%-70% of the global population will be infected went viral. … The originator of the "40%-70% of the population" estimate tweeted on March 3 a revised estimate of "20%-60% of adults," but this is probably still substantially exaggerated. …

**3. Exaggerated case fatality rate (CFR)**

Early reported CFR figures also seem exaggerated. The most widely quoted CFR has been 3.4%, reported by WHO dividing the number of deaths by documented cases in early March. … The most complete data come from Diamond Princess passengers … CFR may be much lower than 1% in the general population, probably higher than seasonal flu (CFR = 0.1%), but not much so. …

**4. Exaggerated exponential community spread**

At face value, the epidemic curve of new cases outside China since late February is compatible with exponential community spread. … Part of the growth of documented cases could reflect rapid increases in numbers of coronavirus tests performed. …

**5. Extreme measures**

Under alarming circumstances, extreme measures of unknown effectiveness are adopted. … School closures, cancellation of social events, air travel curtailment and restrictions, entry control measures and border closure are applied by various countries. …

Evidence is lacking for the most aggressive measures. …A systematic review on measures to prevent the spread of respiratory viruses found insufficient evidence for … social distancing in reducing epidemic spreading. *Plain hygienic measures have the strongest evidence*.

**6. Harms from non evidence based measures**

Given the uncertainties, one may opt for abundant caution and implement the most severe containment measures. …

This reasoning ignores possible harms. Impulsive actions can indeed cause major harm. One clear example is the panic shopping which depleted supplies of face masks … Masks [] are clearly needed for medical personnel… Conversely, they are meaningless for the uninfected general population. …

**7. Misallocation of resources**

Policymakers feel pressure from opponents who lambast inaction. Also, adoption of measures in one institution, jurisdiction or country creates pressure for taking similar measures elsewhere under fear of being accused of negligence. …

…For example, undoubtedly research on coronavirus vaccines and potential treatments must be accelerated. …

… For patients without severe symptoms, hospitalizations offer no benefit and may only infect health workers causing shortage of much-needed personnel. Even for severe cases, effectiveness of intensive supportive care is unknown. …

**8. Lockdowns—for how long?**

An argument in favour of lockdowns is that postponing the epidemic wave ("flattening the curve") gains time to develop vaccines and reduces strain on the health system. … Maintaining lockdowns for many months may have even worse consequences than an epidemic wave that runs an acute course. …

**9. Economic and social disruption**

The potential consequences on the global economy are already tangible. Moreover, some political decisions may be confounded with alternative motives. Lockdowns weaponized by suppressive regimes can create a precedent for easy adoption in the future. … Regardless, even in the strongest economies, disruption of social life, travel, work and school education may have major adverse consequences.

The eventual cost of such disruption is notoriously difficult to project. … Much depends on the duration of the anomaly. … The global economy and society is already getting a major blow from an epidemic that … that kills almost exclusively people with relatively low life expectancy.

**10. Claims for once in a century pandemic**

Leading figures insist that the current situation is a once-in-a-century pandemic. A corollary might be that any reaction to it, no matter how extreme, is justified.

This year's coronavirus outbreak is clearly unprecedented in amount of attention received. … Conversely, "influenza" attracted 30- to 60-fold less attention although this season it has caused so far more deaths globally than coronavirus.

Different coronaviruses actually infect millions of people every year, and they are common especially in the elderly and in hospitalized patients with respiratory illness in the winter. … However, it is only this year that every single case and every single death gets red alert broadcasting in the news.

**11. Comparisons with 1918**

Some fear an analogy to the 1918 influenza pandemic that killed 20-40 million people. Retrospective data from that pandemic suggest … total deaths were eventually little affected by early social distancing: *people just died several weeks later*. Importantly, this year we are dealing with thousands, not tens of millions deaths.

**12. Learning from COVID-19**

… Exaggeration and overreaction may seriously damage the

reputation of science, public health, media and policymakers. It may foster disbelief that will jeopardize the prospects of an appropriately strong response if and when a more major pandemic strikes in the future.[886] (underlining added to original)

### Data and biological principles didn't support COVID-19 panic

Dr. Scott Atlas wrote an article in late-April 2020: "The data is in — stop the panic and end the total isolation."[887] It was about a month after lockdowns were instituted in 80% of U.S. states. Atlas stated in part:

> The tragedy of the COVID-19 pandemic appears to be entering the containment phase. … Americans are now desperate for sensible policymakers who have the courage to ignore the panic and rely on facts. Leaders must examine accumulated data to see what has actually happened, rather than keep emphasizing hypothetical projections …
>
> Five key facts are being ignored by those calling for continuing the near-total lockdown.
>
> **Fact 1:** The overwhelming majority of people do not have any significant risk of dying from COVID-19.
>
> The recent Stanford University antibody study now estimates that the fatality rate if infected is likely 0.1 to 0.2 percent … [the rate estimated by Fauci in late February] …
>
> … If you do not already have an underlying chronic condition, your chances of dying are small, regardless of age. And young adults and children in normal health have almost no risk of any serious illness from COVID-19.
>
> **Fact 2:** Protecting older, at-risk people eliminates hospital overcrowding.
>
> **Fact 3:** Vital population immunity is prevented by total isolation policies, prolonging the problem.
>
> We know from decades of medical science that infection itself allows people to generate an immune response — antibodies — so that the infection is controlled throughout the population by "herd immunity." … In this virus, we know that medical care is not even necessary for the vast majority of people who are infected. … Extending whole-population isolation would directly prevent that widespread [herd] immunity from developing.
>
> **Fact 4:** People are dying because other medical care is not getting done due to hypothetical projections.
>
> Critical health care for millions of Americans is being ignored and people are dying to accommodate "potential" COVID-19

patients and for fear of spreading the disease. Most states and many hospitals abruptly stopped "nonessential" procedures and surgery. … Treatments, including emergency care, for the most serious illnesses were also missed. Cancer patients deferred chemotherapy. … Acute stroke and heart attack patients missed their only chances for treatment, some dying and many now facing permanent disability.

**Fact 5:** We have a clearly defined population at risk who can be protected with targeted measures.

The overwhelming evidence all over the world consistently shows that a clearly defined group — older people and others with underlying conditions — is more likely to have a serious illness requiring hospitalization and more likely to die from COVID-19. Knowing that, it is a commonsense, achievable goal to target isolation policy to that group ….

Scott concluded by stating "Facts matter," and suggested a reliance on "empirical evidence" instead of "hypothetical models." He recommended strategies that would "would allow the essential socializing to generate immunity among those with minimal risk of serious consequence … and limiting the enormous harms compounded by continued total isolation."[888]

## IV – German report identified COVID-19 as "a global false alarm"

In early May 2020 a German official leaked to the press an Interior Ministry report that identified the threat posed by COVID-19 had been overblown by the government and the media, and it was "a global false alarm."[889]

The 93-pages report titled "Analysis of the Crisis Management" was produced by Germany's Interior Ministry Department KM4 that was charged with the "Protection of critical infrastructures." The report was authored by a panel of ten external scientists and medical experts from several German universities who were appointed by the Interior Ministry.[890]

The report was leaked to the media by Stephen Kohn, who worked in KM4.

On May 10, the German government publicly dismissed the report as the individual opinion of a disgruntled employee, Kohn, who was suspended.

On May 11 the doctors and scientists who authored the report issued a Press Release in which they said they were astonished by the government's dishonest reaction to the report.[891]

Key passages in the report are:

- The dangerousness of Covid-19 was overestimated: probably *at no point did the danger posed by the new virus go beyond the normal level*.
- *The people who die from coronavirus are essentially those who would statistically die this year, because they have reached the end of their lives* and their weakened bodies can no longer cope with any random everyday stress (including the approximately 150 viruses currently in circulation).
- The danger is obviously no greater than that of many other viruses. *There is no evidence that this was more than a false alarm*.
- A reproach could go along these lines: During the coronavirus crisis the State has proved itself as one of the biggest producers of Fake News.[892]

The report is important enough that its entire Short Version is reprinted below:

KM 4 - 51000/29 # 2

**KM4 Analysis of Crisis Management** (Short Version) [893]

Preliminary note: The task and goal of crisis teams and any crisis management is to identify special dangers and to combat them until the normal state is reached again. So a normal state cannot be a crisis.

**Summary of analysis results**

1. In the past (unfortunately contrary to better institutional knowledge), crisis management has not developed adequate instruments for hazard analysis and assessment. The status reports, in which all information relevant to decision-making would have to be summarized, only deal with a small section of the threatening range of risks in the current crisis. On the basis of incomplete and unsuitable information in the situation pictures, an assessment of the danger is fundamentally not possible. Without a correctly assessed risk assessment, there can be no appropriate and effective planning of measures. The methodological deficit affects every level at a higher level; Up until now, politics has had a greatly reduced chance of making the factually correct decisions.
2. The observable effects and effects of COVID-19 does not provide sufficient evidence that – in terms of health effects on society as a whole – it is more than a false alarm. The new virus presumably did not at any time pose a risk to the population that exceeded the normal level (comparative figure is the usual death rate in DEU). Corona essentially kills the people who statistically die this year because they have reached the end of their lives and their weakened bodies

can no longer cope with any random everyday stress (including the approximately 150 viruses currently in circulation). The dangerousness of Covid-19 was overestimated. (No more than 250,000 deaths from Covid-19 worldwide in a quarter of a year, compared to 1.5 million Dead during the 2017/18 influenza wave). The risk is obviously no greater than that of many other viruses. We are most likely dealing with a global false alarm that has remained undetected for a long time. – This analysis result has been checked by KM 4 for scientific plausibility and essentially does not contradict the data and risk assessments submitted by the RKI.

3. The fact that the alleged false alarm remained undetected for weeks is largely due to the fact that the applicable framework for action by the crisis team and crisis management in a pandemic does not contain suitable detection instruments that automatically trigger an alarm and initiate the immediate termination of measures as soon as they occur either a pandemic warning was identified as a false alarm or it is foreseeable that the collateral damage - and in particular parts that destroy human life - are threatening to become greater than the health and in particular the fatal potential of the disease under consideration.
4. The collateral damage is now higher than the apparent benefit. This determination is not based on a comparison of material damage with personal injury (human life)! A comparison of previous deaths due to the virus with deaths due to the state-ordered protective measures (both without a secure database) confirms the finding. An overview-like compilation of health-related collateral damage (including deaths) checked by scientists for plausibility is attached below.
5. The (completely pointless) collateral damage caused by the corona crisis has now become gigantic. Much of this damage will only manifest itself in the near and distant future. This can no longer be prevented, but only limited.
6. Critical infrastructures are the vital lifelines of modern societies. With the critical infrastructures, the current security of supply is no longer given as usual as a result of the protective measures (previously a gradual reduction in the basic security of supply, which can be reflected in upcoming stress situations, for example). The resilience of the highly complex and strongly interdependent overall system of critical infrastructures has decreased. Our society is now living with increased vulnerability and higher default risks of vital infrastructures. This can have fatal consequences if a really dangerous pandemic or other threat arises at the now reduced

resilience level of KRITIS.

UN Secretary General António Guterres raised a fundamental risk four weeks ago. Guterres said (according to a daily news report dated April 10, 2020): "The weaknesses and inadequate preparation that have been exposed by this pandemic provide insight into what a bioterrorist attack could look like -- and [these weaknesses] may increase the risk of it." Our analyzes are a serious deficiency in DEU the lack of an adequate hazard analysis and assessment system in crisis situations (see above).

7. The state-ordered protective measures, as well as the diverse social activities and initiatives that originally caused the collateral damage but have now lost all meaning, are still largely in force. It is strongly recommended that they be lifted completely in the short term in order to avert damage to the population -- especially unnecessary additional deaths -- and to stabilize the potentially precarious situation in the critical infrastructure.
8. The deficits and failures in crisis management have consequently led to the communication of incorrect information and thus triggered disinformation among the population. (An accusation could be: The state has proven itself to be one of the largest fake news producers in the corona crisis.)

**The following results from these findings:**

a) The proportionality of interference in the rights of, for example, citizens is currently not given, since the state has not adequately weighed up the consequences. The BVerfG requires an appropriate weighing of measures with negative consequences (PSPP judgment of May 5, 2020).

b) The situation reports of the BMI-BMG crisis team and the federal state reports to the federal states must therefore be sent immediately
   - carry out an appropriate hazard analysis and assessment.
   - contain an additional department with meaningful data on collateral damage (see e.g. explanations in the long version)
   - Relieved of superfluous data and information that are not necessary for the risk assessment because they make it difficult to keep an overview.
   - Key figures would have to be formed and placed in front.

c) An appropriate hazard analysis and assessment must be carried out immediately. Otherwise the state could be liable for any damage incurred

**Explanations for a better understanding of the causal relationships in a pandemic**

A severe pandemic is very rare and therefore a major challenge. The responsible authorities have to deal with a crisis situation for which there is no experience.

Emergency departments, pandemic plans and other organizational and legal frameworks for combating pandemics are regularly developed in the BMI department of the BMI and in the BBK (together with other authorities such as the RKI, partly under the leadership of the cooperation partner). In the past, studies were occasionally carried out on the scenario of a pandemic, less extensive exercises were carried out and more in-depth risk analyzes were conducted less frequently. But all of this work could offer little more than a rough framework in the current crisis. Because good, smoothly running crisis management requires above all a lot of experience with similar crisis and exercise situations and the constant improvement of framework conditions. In the area of fire brigades and rescue services, this has been continuously optimized over the years. In the event of a pandemic, no routine can be built on, which means that most of those involved will be poorly prepared and overwhelmed, and that crisis management will make mistakes.

The starting point of a crisis intervention is always the existence of a special risk situation.

**Identification of a special danger situation (pandemic)**

The determination of a particular danger situation does not necessarily presuppose that damage has already occurred. In the event of a suspected pandemic, an assessment is made of possible damage that would probably occur without protective measures. This estimate has to be continuously updated in the course of a pandemic because it is initially only a plausible guess. If this plausibility no longer exists, or if an opposing assessment appears to be more plausible, or if the extent of the damage does not reach an extraordinary level within a reasonable period of time, there is no longer any particular danger.

**Protective measures as a separate source of danger - occurrence of a multi-hazard situation**

Protective measures cannot be used as a preventive measure because they also have the potential to cause extraordinary damage. In a pandemic, there are always at least two dangers that crisis management must keep in mind: damage to health from a pathogen, collateral damage from side effects of the protective measures or (as a special case) a false alarm.

Because of this dualism, the likelihood of extraordinary damage occurring and the expected amount of damage arising for all existing

hazards must be continuously tracked in the course of a pandemic. The evaluation of data on the occurrence of infection and the number of deaths is far from sufficient. A systematic multi-hazard analysis is suitable for this (the long version contains criteria for a multi-hazard analysis).

**Importance of collateral damage**

A key finding from all previous studies, exercises and risk analyzes is that combating a pandemic always results in collateral damage (as an effect of those taken Protective measures), and that this collateral damage caused by a pandemic can be significantly greater than the damage that can be caused by the pathogen.

Collateral damage that can always be accepted has the best cost-benefit ratio if it is not greater than is at least necessary to achieve a protection goal.

It has the worst possible cost-benefit ratio if the original warning about an unknown virus turns out to be exaggerated or, in extreme cases, even a false alarm, because then the overall damage to the pandemic consists exclusively of the completely unintended collateral damage.

**Perspective**

It makes little sense and you won't get any closer to a solution if you just try to understand the precise stages of the crisis management's failure. Remedial action will only be possible if there is an active examination of those systemic effects which, in their overall dynamic in the corona crisis, can lead to existential damage to the community and also to the state order.

Crisis management and the entire state are in a precarious situation. If you look closely, there can be no more reasonable doubt that:

- the corona warning was a false alarm,
- crisis management has underperformed security work and made mistakes that have done great damage and continue to cause (including fatalities) every day on which the measures are not canceled without replacement.

Since the crisis management team and the entire crisis management, including politics, have largely acted in accordance with the legal, organizational and other framework requirements, there initially appears to be little reason for them to make any changes. The findings elaborated in this analysis alone will not be sufficient, even if the results are factually correct and a reorientation is urgently needed in the interest of the country and its people. Already a coordination of the present analysis with all relevant departments of the ministerial administration would, due

to the heterogeneous interests and responsibilities of the numerous participants involved, probably or based on experience, lead to a leveling (or sorting out) of their content.

Actually, a new crisis should now be identified and crisis management set up to combat the dangers of an automated and thus out of control pandemic crisis management. That would be appropriate. If the executive does not manage this on its own, there would basically be possibilities for correction in a state with a separation of powers:

a) Legislative power (the parliaments of the federal and state governments) could change the legal framework and thus induce (force) the executive to operate crisis management differently than before. The legislature has proven in recent weeks that it can take decisions at short notice.

b) The case law could intervene. The constitutional courts of the federal and state governments have considered the government's order to impose extreme restrictions on elementary and constitutional rights in DEU due to an alleged extraordinary threat from a dangerous virus. You have denied the legality and legitimacy of every basic complaint, lawsuit and opposition. So far they have been doing this without one to carry out an in-depth plausibility check. As I have shown, this is possible and would expose the error.

c) In principle, the large electronic mass media and the national supra-regional media could also be a corrective. The fact that this does not actually happen has to provoke two considerations: The general conditions for the media are suboptimal, they obviously actually complicate the originally intended variety of opinions in our country. The relative uniformity that emerges is not based on oppositional opinions and directions (this could theoretically have a slightly system-destabilizing effect indirectly) but on established political directions, in particular on the intentions of governments (this would indirectly stabilize existing governments and shield them from an opposition, too) in the event that there is concrete government action, e.g. due to a factual error against the existential interests of the country). The leading media and above all the public law apparently seem to see themselves predominantly as transmitters of the basic positions of the dominant political direction, which are viewed as common, to the population.

**Overview of the health effects (damage) of the measures and restrictions imposed by the state in the Corona Crisis 2020** (As of May 7, 2020 fin)

Methodological preliminary remarks

Risks are listed that were considered by 10 high-ranking experts /

scientists of the respective disciplines to be fundamentally plausible. The experts were selected at random, so the result cannot be representative.

It is important for the future systematic recording of collateral damage in the health of the pandemic to consult at least specialists from the scientific disciplines involved. Otherwise, a realistic overall inventory is not possible.

1. **Deaths**

a) Due to limitation in clinical availability (and Treatment options) **postponed or canceled operations**:

Overall, we had a total of around 17 million inpatients with surgery in 2018. That is an average of 1.4 million patients per month. In March and April 90% of all necessary surgeries were postponed or not carried out. That means 2.5 million people were not cared for as a result of the government measures. So 2.5 million patients were not operated on in March and April 2020, although this would have been natural. The expected death rate cannot be assessed seriously; Experts assume that there are numbers between 5,000 and up to 125,000 patients who will die / have already died due to the postponed surgery.

b) Due to limitations in clinic availability (and Treatment options) postponed or canceled **follow-up treatments** from (e.g. cancer, stroke or heart attack) sufferers:

The negative effects of interrupted care structures in tumor patients, whether cancer follow-up or interrupted cancer prevention programs, such as breast cancer, are obvious, because these measures have proven their usefulness in long studies and have been established on this basis.

Here, too, it can be assumed that the number of treatments will be in the millions every year. In some cases, the availability restrictions of the clinics will also lead to the premature death of patients. It is difficult to predict this effect. Experts who commented on this went from up to several thousand additional deaths were expected in March and April 2020 or will continue to die.

c) In the case of care for those in need of care (a total of 3.5 million people in DEU), the level of care and the quality of care (in care facilities, in outpatient care services as well as in private / family care) decreases due to restrictions imposed by the state. As it has been proven that the good level of care in DEU protects many people from premature death (which is why so much money is spent on this), the drop in levels enforced in March and April 2020 will have led to premature deaths. For 3.5 million people in need of care, an additional death rate of one tenth of a percent would result in an additional 3,500 deaths. In the absence of more precise estimates, it is not known whether there are more or fewer.

d) Increases in suicides (previously an average of 9,000 per year); Reasons for the increase in suicides: long-lasting significant impairment of all living conditions, which can become critical for mentally unstable personalities; but numerous suicides as a reaction to the economic destruction of livelihoods can also be expected; Various professional groups that do not feel able to cope with the burden of social and personal changes and their personal (joint) responsibility.

e) Additional deaths from **heart attacks** and **strokes:**

Over the past years and decades, integrated concepts have been developed that have successfully influenced morbidity and mortality and are based on the fact that care is provided as early as possible (in the course of the disease), as quickly as possible (time to care) and as magically as possible. These inter-sectoral / -disciplinary chains are damaged in many ways (outpatient care, deprivation of resources) and also suffer from the fact that due to one-sided and exaggerated information policy, those affected unjustifiably fear Corona more than these diseases and suppress warning signs and also fear with these diseases not being treated well in the current corona fixation in the hospital. As a consequence, many affected people are not / too late to see a doctor, which means increased morbidity, worsened rehabilitation and increased mortality in these diseases.

2. **Other damage to health** (associated with suffering for those affected and high cost effects for the social security systems, the health system and the labor market)

a) Particularly in their contacts, elderly people / people in need of care are affected by the measures and often suffer severely from them. The measures taken (border closings, quarantine regulations, bans on contacts, etc.) adversely affect the previously critical outpatient / inpatient care situation (thus also optimal care in relation to corona)

b) (serious) Psychoses requiring treatment, Neuroses (anxiety, compulsive starvation, ..) due to long-lasting considerable impairment of all living conditions, which will cause illnesses for psychologically unstable personalities; Long-term medical treatments and rehabilitation services are necessary to compensate for these impairments, and there are health-related lost days. 1 to 2% of the total German salvage experience one at least once in a lifetime Psychosis. If there is a disposition or vulnerability, there is an increased likelihood that this will manifest itself in the framework of the corona crisis.

c) more disputes and body injuries as a result of strong contact restrictions and contact bans; Domestic violence, child abuse

d) widespread communication starters (through psychological effects,

see above, and also, for example, through the compulsion to wear face masks, through which gestures and facial expressions are severely restricted as a means of communication (leads to misunderstandings, mistrust, ...)

b) (depending on the economic / economic development :) loss of:

**Life expectancy**.

In the long term, this is likely to cause major damage to the crisis. Since the 1950s, DEU has seen a significant increase in life expectancy due to positive economic development (average life span 13 to 14 years longer). The steadily increasing level of prosperity made it possible, among other things, to increasingly implement costly health care and care. With a strongly negative economic development and a corresponding reduction in the level of prosperity, the development goes in the opposite direction: life expectancy will decrease. (The RKI has shown that high unemployment lowers life expectancy.) With over 80 million inhabitants, government protection measures (not the virus) can have destroyed a correspondingly high volume of population life years.

Most of the above-mentioned effects have in common that even after the restrictions have been lifted, it will take a long time for these measures and treatments to return to the previous level, since all interlocking links must be functional again, the resources must be (re) allocated and patient confidence also needs to be restored. In addition, there may be contradictory, at first glance, paradoxical reactions, so the damage phase is likely to last much longer than the actual interruption. If life expectancy is shortened in the future, the damage will only start in the future.

Since, in theory, at least partially, opposing effects must also be expected - that is, reactions that appear paradoxical at first glance - precise numerical estimates of expected damage events have not been made. The above-mentioned numbers are used to show dimensions of trench.

**Closing remarks**

There are two important reasons why this information is sent directly without first consulting other relevant agencies:

1. There is imminent danger! Alleged protective measures are currently causing further serious damage every day, from material and health to a large number of avoidable deaths. These deaths are triggered by the action of the crisis management and are responsible for it as soon as the knowledge about the matters dealt with in the analysis submitted is available - also from the sender of this information, which is part of the crisis management. Remedial action is only possible if the existing

knowledge is passed on and noted. All possibilities of upstream intervention were exhausted by the sender.

2. In view of the factual findings of the present analysis and the political decisions in contrast to them, injured outsiders may fear that the defining protection goal of national crisis management is no longer the safety and health of the population, but the credibility and acceptance of government parties and government officials. Such perceptions, which are not irrational per se, can give rise to an unfavorable dynamic in a community based on cohesion, which can be well limited, especially with rational follow-up decisions by crisis management and politics – based on complete analyzes.[894]

# 23. Shutdowns Were More Deadly Than COVID-19

The total economic, medical, and human costs of shutting down society was not taken into consideration by the politicians who imposed shutdowns under the guise of protecting the public from COVID-19. The shutdowns resulted in dramatically more years of life lost than from the virus, and they caused massive economic and societal damage.

## I – Health consequences

The health consequences of the government mandated shutdowns to ostensibly "flatten the curve" by slowing the spread of COVID-19 are not known to have been seriously considered by any politician imposing them in the U.S. (or the rest of the world). Those consequences are not just far more severe than the virus, but data is available indicating the devastating effect the shutdowns have had on the total health of people.

One measurement of those consequences is years of lost life. That "is an analysis that calculates the number of years of life lost when someone dies due to an incident, compared with that person's remaining life expectancy at the point of death."[895]

### COVID-19 lockdowns cost Americans millions of years of life

In May 2020 – two months after the shutdowns began – Dr. Scott Atlas and two co-authors wrote about the shutdowns in the U.S., that "using numerous National Institutes of Health Public Access publications, Centers for Disease Control and Prevention (CDC) and Bureau of Labor Statistics data, and various actuarial tables, we calculate *these policies will cause devastating non-economic consequences that will total millions of accumulated years of life lost in the United States, far beyond what the virus itself has caused*."[896] Highlights of that article are:

- "If we only consider unemployment-related fatalities from the economic shutdown, that would total at least an additional 7,200 lives per month. Assuming these deaths occur proportionally across the ages of current U.S. mortality data … this amounts to *more than 200,000 lost years of life for each month of the economic shutdown*."
- "…lives also are lost due to delayed or foregone health care imposed by the shutdown … These unintended consequences of missed health care *amount to more than 500,000 lost years of life per month*, not including all the other known skipped care."[897]

- "COVID-19 fatalities have fallen disproportionately on the elderly, particularly in nursing homes, and those with co-morbidities. Based on the expected remaining lifetimes of these COVID-19 patients, and given that 40 percent of deaths are in nursing homes, the disease has been responsible for *800,000 lost years of life so far*."
- "Considering only the losses of life from missed health care and unemployment … the national lockdown is responsible for at least 700,000 lost years of life every month, or about *1.5 million so far — already far surpassing the COVID-19 total*."

The suggestion health and unemployment consequences are double COVID-19 related deaths significantly understates the actual mortality differential is much greater than that for two reasons: First, the authors likely overinflated the years of life lost from COVID-19 considering the average age of deceased persons is within a few years of the average life expectancy in the U.S. (and worldwide); and second, it doesn't include that "many small business owners are near financial collapse, creating lost wealth that results in mortality increases of 50 percent. With an average estimate of one additional lost life per $17 million income loss, that would translate to 65,000 lives lost in the U.S. for each month because of the economic shutdown."[898]

The article concluded with the recommendation: "*To end the loss of life from the economic lockdown*, businesses as well as K-12 schools, public transportation, parks and beaches *should smartly reopen* with enhanced hygiene and science-based protection warnings for any in the high-risk population. For most of the country, *that reopening should occur now, without any unnecessary fear-based restrictions, many of which repeat the error of disregarding the evidence*. By following a thoughtful analysis that finally recognizes all available actions and their consequences, we can save millions of years of American life. When the next pandemic inevitably arises, *we need to remember these lessons and follow policies that consider the lives of all Americans from the outset*."[899]

That this study very significantly understated the shutdown health consequences was emphasized by the findings of a study published three months later in August 2020.

### U.S. lockdowns are ten times deadlier than COVID-19

*Revolver News* published a study in late August 2020 that found "*the lockdowns will end up costing Americans over 10 times as many years of life as they will save from the virus itself*."[900]

The study quantifies the net damage of the lockdowns in terms of a metric known as "life-years." The study examined "the health effects of

unemployment to calculate an estimate of how many years of life will have been lost due to the lockdowns in the United States," which was weighed "against an estimate of how many years of life will have been saved by the lockdowns."[901]

The study gauged the impact of COVID-19 by analyzing the life-years lost. The normal way of reviewing the number of deaths by age is misleading to politicians and the public because COVID-19 is disproportionately fatal for the elderly, while lockdowns disproportionately cause economic harm to the younger working population, who have much longer life expectancies.

The study estimated over 18.7 million life years will be lost just due to long-term effect of the economic conditions created by the lockdowns in the U.S. That was based on analysis of three primary groups of workers:

Those 18.7 million lost life-years directly attributable to the economic effects of the lockdowns were almost *eight times* the 2,285,735 life-years lost from COVID-19 deaths.[902]

| Group | Est. life-years lost |
|---|---|
| 2020 Displaced Workers | 8,071,000 |
| New Workforce Entrants | 8,180,000 |
| Recent Graduates | 2,453,000 |
| Total | 18,704,000 |

The studies most important finding is how much better off the U.S. would have been if it had adopted Sweden's minimalist strategy of zero business closures, 100% voluntary social distancing, no mandatory mask wearing, only closing secondary (high) schools and universities; and limiting public gatherings to 50 or less.

The U.S. lockdowns and mandatory social distancing saved less than 1/4 million life years compared with Sweden that had no economic shutdown and voluntary social distancing.[903]

Sweden though, had zero life-years lost due to an economic shutdown unlike the 18.7 million lost life-years in the U.S.

The following chart shows by age group the projected life years the U.S. lost by not adopting Sweden's open economic strategy, and the life-years saved by implementing a lockdown strategy (in 42 states)[904]:

| Life-Years lost due to U.S. economic lockdowns & lives saved in U.S. compared to Sweden | | | | | | |
|---|---|---|---|---|---|---|
| **Age** | **15-24** | **25-34** | **35-44** | **45-54** | **55+** | **Totals** |
| **U.S. life-years lost with economic lockdowns** | -8,180,000 | -5,240,193 | -1,821,935 | -1,640,944 | -1,836,793 | -18,719,865 |
| **U.S. life-years saved compared to Swedish model[905]** | 1,811 | 7,230 | 15,026 | 31,019 | 188,834 | 243,920 |
| **Net life-years lost** | -8,178,189 | -5,232,963 | -1,806,909 | -1,609,925 | -1,647,959 | -18,475,945 |

The U.S. *lost 18.5 million life-years* by not following Sweden's strategy of keeping its businesses and society open. That doesn't even take into consideration the lost life-years from dramatically reduced medical services provided non-COVID-19 patients, increased suicides, etc. that are directly

attributable to the lockdowns, but which the Revolver study did not attempt to quantify.

## South Africa's lockdown can cost 30X more years of life lost than saved

South Africa's lockdown can be expected to cost *thirty times more years of life lost* than it can be expected to prevent, according to the report "Quantifying Years of Lost Life in South Africa Due to COVID-19."[906] The report was prepared by Pandemics – Data & Analysis (PANDA). PANDA is a collective of actuaries, economists, data scientists, statisticians, medical professionals, lawyers, engineers and businesspeople working together to replace bad science with good science.

The report stated: "*It would be no exaggeration to say that each week of continuing lockdown will, in the long run, result in more loss of life than the virus itself*. In the face of this, *economically restrictive lockdown measures should be discontinued immediately*."[907]

The reports conclusion is very conservative, because with their methodology they could have arrived at a negative consequence of over 100 times more years lost instead of 30:

> "We estimate years of life lost owing to economic contraction caused by South Africa's lockdown to conservatively be approximately 14 million years. In contrast, we estimate the years of life lost to avoidable overburdening of health resources to lie in the range of 25,335 to 445,901. (The latter should not be confused with the number of COVID-19 *deaths* expected, which is much lower.) We derive our 30x multiple above by taking the low point of the economic contraction effect and dividing by the high point of the overburdening effect. Under a less conservative view, this multiple would be substantially higher."[908]

The report states regarding the implications of a lockdown:

> "Decisions made by governments in relation to COVID-19 should ... should balance the loss of life from COVID-19 overburdening their health systems with the loss of life expectancy flowing from the long-term economic impact of lower incomes that result from restrictive lockdown measures. Middle-income nations need to tread particularly carefully, as a substantial portion of their populations are separated from poverty by the slimmest of margins. Their governments are also far more constrained fiscally and administratively to compensate for adverse economic situations. Consequently, even small changes in incomes can have a big impact on life expectancies. Countries where the economic impact on life-years of a full lockdown would be much larger than that of the virus should devise different strategies:

● A smarter form of lockdown is advised, incorporating measures to protect the very old and very sick.

● Restrictions on economic activities should be limited to mild policies, such as bans on large gatherings.

● Children should stay at school."[909]

…

"The economic impact in South Africa from the lockdown is severe and will have effects that last well beyond 2020.

We estimate that the impact of lockdown on the economy will be considerably greater than a no-lockdown policy in the presence of COVID-19, voluntary social distancing, and offshore lockdowns."[910]

…

"Even if you disagree with our methods or our parameter choices, what our work surely highlights is the need for policymakers to assess trade-offs amid the current crisis. Advisors to government are ethically bound to include estimation of harms from the economic contraction. Our work proposes proceeding by taking a 'years of life lost' approach. We estimate that continuation of lockdown in its current form entails harms that outweigh benefits by a factor of at least 30x. In light of this, continuing with such a restrictive and economically damaging lockdown would be a moral outrage."[911]

## Lockdown countries had 33% more excess deaths than caused by COVID-19

A study of the deaths in 21 industrialized countries from mid-February to the end of May 2020 determined there were a total of 206,000 deaths beyond the norm (excess deaths) of what would be expected in those countries for that period of time.[912]

WHO recorded a total of 154,500 COVID-19 deaths during that period of time for those 21 countries.[913]

The difference between the total excess deaths and coronavirus deaths was 51,500: one-third of the COVID-19 total.

The authors recognized excess deaths could not just be due to COVID-19, but also deaths resulting from "indirect effects … and responses to it, acting through social, economic, environmental and healthcare pathways, can also be substantial. Indirect effects include denied or delayed disease prevention and medical procedures for acute and chronic conditions; loss of jobs and income; disruption of social networks; increases in self-harm and crime, especially domestic abuse; changes in quantity and quality of food and the use of tobacco, alcohol and other drugs; and changes in other infectious diseases, road traffic crashes, other injuries and air pollution resulting from changes in social

contacts, mobility and transportation."[914]

The study was important for discovering there is about a 3 to 1 ratio of COVID-19 deaths compared to deaths directly caused in real-time by a government's response to COVID-19. Those 1/3rd additional excess deaths are related to the economic, medical, mental and social consequences of a shutdown.

There were about 363,000 government caused non-COVID deaths extrapolating the study's finding to the 1,089,047 COVID-19 deaths WHO reported as of October 15, 2020.

## II – Economic destruction in U.S. & other countries

The shutdown of states and the federal government in the U.S. and of other countries has resulted in trillions of dollars in lost economic activity.

The IMF estimated in June 2020 contraction of the world's economy by 4.9% in 2020.[915] The worsening worldwide economic situation is indicated by the fact that estimate was 1.9% below the April forecast (-3%) – just two months earlier. Global GDP was $142.005 trillion at the end of 2019.[916] A 4.9% drop would be $135.047 trillion – a world-wide loss of $6.958 trillion.

The U.S.'s GDP was projected to decline by 8% in 2020. The U.S. GDP was $21.73 trillion at the end of 2020. [917] An 8% drop would be 19.99 trillion – a loss of $1.74 trillion, or about $5,300 for every person in the U.S..

In 2019 the U.S. GDP increased by 2.3%, and the IMF projects it will increase by 4.8% from 2020 to 2021 – so the U.S. economy at the end of 2021 is still projected to be significantly smaller than it was at the end of 2019.[918]

The unemployment caused by the shutdowns in the U.S. is reflected in the non-payment of housing payments (rent and mortgage payments) on time and in full across the country: 31% in May; 30% in June; 32% in July;[919] and, 34% (est.) in August.[920] Business affected by the economic shutdowns, and particularly those closed as "non-essential", have also been slow in making rent and lease payments. Consequently, the state and federal governments instituted payment moratoriums barring landlords from evicting non-payers, and mortgage holders from foreclosing for the duration of the moratorium. The 120-day federal moratorium included in the CARES Act for renters participating in a federal housing assistance program and a federally backed mortgages expired July 24 – allowing landlords and mortgage holders to issue 30 day notices to vacate.[921] Many states, and even counties, imposed moratoriums covering their jurisdiction.

In their May 2020 article, Dr. Scott Atlas and his co-authors wrote: "… the lockdown was imposed without consideration of its consequences beyond those directly from the pandemic. The policies have created the greatest

global economic disruption in history, with trillions of dollars of lost economic output."[922]

All of that economic destruction was entirely due to the political decision to shutdown the economy – without any consideration of the human and economic consequences.

## COVID-19 estimated to cost U.S. $16 trillion

The total economic and health cost of COVID-19 in the U.S. is estimated to exceed $16 trillion according to an analysis published by the JAMA Network on October 12, 2020.[923]

The analysis aggregates mortality, morbidity, mental health conditions, and direct economic losses, and makes the assumption the negative effect of COVID-19 will substantially end by fall 2021.

Job losses resulted in 60 million unemployment insurance claims filed from March to late September. The article explains: "Recessions feed on themselves. Workers not at work have less to spend, and thus subsequent business revenue declines. … But the virus is ongoing, and thus full recovery is not expected until well into the future. The Congressional Budget Office projects a total of $7.6 trillion in lost output during the next decade."[924]

**Table. Estimated Economic Cost of the COVID-19 Crisis**

| Category | Cost (billions), US$ |
|---|---|
| Lost GDP | 7592 |
| Health loss | |
| Premature death | 4375 |
| Long-term health impairment | 2572 |
| Mental health impairment | 1581 |
| Total | 16 121 |
| Total for a family of 4 | 196 475 |
| % of annual GDP | 90 |

Abbreviation: GDP, gross domestic product.

The authors explain: "… if the current trajectories continue, an estimated 625,000 cumulative deaths associated with the pandemic will occur through next year in the US. … economists have developed the technique of valuing "statistical lives"; measuring how much it is worth to people to reduce their risk of mortality or morbidity. … Although no single number is universally accepted, ranges are often used. In environmental and health policy, for example, a statistical life is assumed to be worth $10 million. With a more conservative value of $7 million per life, the economic cost of premature deaths expected through the next year is estimated at $4.4 trillion." [925]

The authors also explain: "Some individuals who survive COVID-19 are likely to have significant long-term complications, including respiratory, cardiac, and mental health disorders, and may have an increased risk of premature death. … Assuming a total reduction in quality-adjusted life expectancy, including length as well as quality of life, of 35% and taking into

consideration the assumed value of a year of life yields an estimated loss from long-term complications of $2.6 trillion for cases forecast through the next year."[926]

The authors further explain: "Even individuals who do not develop COVID-19 are affected by the virus. Loss of life among friends and loved ones, fear of contracting the virus, concern about economic security, and the effects of isolation and loneliness have all taken a toll on the mental health of the population. The proportion of US adults who report symptoms of depression or anxiety has averaged approximately 40% since April 2020; the comparable figure in early 2019 was 11.0%. These data translate to an estimated 80 million additional individuals with these mental health conditions related to COVID-19. If, in line with prevailing estimates, the cost of these conditions is valued at about $20 000 per person per year and the mental health symptoms last for only 1 year, the valuation of these losses could reach approximately $1.6 trillion."[927]

The article summarizes the findings: "The estimated cumulative financial costs of the COVID-19 pandemic related to the lost output and health reduction are … estimated at more than $16 trillion, or approximately 90% of the annual gross domestic product of the US. For a family of 4, the estimated loss would be nearly $200,000."[928]

The direct and indirect economic consequences of the economic and social shutdowns imposed by the federal and state governments is enormous. Beyond the economic impact on businesses and individuals is the long-term effect of ballooning revenue declines for federal and state governments.

It beggars comprehension that no economic cost-benefit analysis was conducted by the federal government or any state prior to imposing its shutdown policies. It is sobering there is no evidence those shutdown policies saved a single person from dying of COVID-19 – while there is indisputable evidence they directly caused or contributed to untold thousands of deaths.

## III – Divorce increased

Divorce rates in the U.S. were noticeably increasing just three weeks after the lockdowns began. Spending 24 hours a day 7 days a week with a spouse that one typically had a breather from for at least the time at work, was compounded by the additional stresses of "quarantine conditions, unemployment, financial strain, death of loved ones, illness, homeschooling children, mental illnesses, and more."[929]

The phenomena isn't limited to the U.S., but surfaced in China, and could be expected to affect all lockdown countries to some degree. In China a woman in her 30s said she and her husband had agreed to divorce because of the stress on their relationship caused by two months of quarantine: not

enough money, too much time watching television/videos, uneven child care, and just getting on each others nerves. In March 2020 there were record high numbers of divorce filings in many Chinese cities. The registration director of Miluo, in Hunan Province, said "Trivial matters in life led to the escalation of conflicts, and poor communication has caused everyone to be disappointed in marriage and make the decision to divorce."[930] A Shanghai divorce lawyer said his cases had increased 25% when the city's lockdown eased. He said people had spent too much time together without respite, "People need space. Not just for couples – this applies to everybody."[931]

The same dynamic applied to the U.S. A survey found that 31% of all couples reported the quarantine had been irreparably damaging to their relationship. The LegalTemplates.net website reported that it saw a 34% increase in sales of its divorce agreement over the same period in 2019.[932] It also found a month after the quarantines began divorce agreement sales had increased 57% compared to a month before it began.

The two hardest hit groups were couples married less than five years and couples with children under 18, with respectively 58% and 45% of the divorces sought in those groups.[933]

## IV – Drug use increased

Illicit drug use increased significantly in the United States in the four months after President Trump declared a national COVID-19 emergency on March 13, 2020 compared to the four previous months.

A study was conducted of drug tests ordered by health care professionals nationwide as part of a comprehensive treatment plan between November 14, 2019, and July 10, 2020. The study used definitive test results performed for cocaine, fentanyl, heroin, and methamphetamine. Patients were excluded who were reported to have been prescribed cocaine, fentanyl, or methamphetamine. 75,000 urine drug test specimens were randomly selected for the four months (November 14, 2019, to March 12, 2020) before President Trump declared a COVID-19 national emergency on March 13, 2020, and the four months after (March 13, 2020, to July 10, 2020). [934]

The study discovered substance abuse increased dramatically for the following four drugs:

- Cocaine use increased 33%;
- Fentanyl use increased 92%;
- Heroin use increased 62%;
- Methamphetamine use increased 39%.[935]

Other changes were the average age of users decreased to 46 from 49, and percentage of males increased to 48.5% from 46%.[936] Women are the majority of illicit drug users in the U.S.

No census region saw a significant decrease in drug use. The authors of the study – *The Opioid Epidemic During the COVID-19 Pandemic* – concluded: "This study demonstrated that urine drug test positivity in a population diagnosed with or at risk of substance use disorders increased significantly for illicit cocaine, fentanyl, heroin, and methamphetamine from the 4 months before the COVID-19 emergency declaration to the 4 months after the COVID-19 declaration."[937]

## V – Suicide increased

An increase in suicides was a predictable consequence of the COVID-19 inspired lockdowns from when they were first instituted.

Tens of millions of people in the U.S. – plus hundreds of millions more worldwide – were suddenly unemployed. Research from the 2008 recession found that every 1% rise in unemployment resulted in approximately a 1% rise in the suicide rate.[938] The 2008 recession resulted in at least 4,750 additional "economic" related suicides in the U.S. and it was much less severe than unemployment and economic hardship caused by the COVID-19 shutdowns.[939] The U.S. unemployment rate was 3.6% in April 2019, and in April 2020 it was officially 14.7%.[940] That was an increase of 11.1%. With 48,344 suicide deaths in 2018 (latest year data is available), the long-term effect of the COVID shutdown is suicides could increase by more than 5,300.

### Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm?

*Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm?* was published in JAMA on April 10. The authors wrote: "Remarkable social distancing interventions have been implemented to fundamentally reduce human contact. … the potential for adverse outcomes on suicide risk is high. … It is important to consider changes in a variety of economic, psychosocial, and health-associated risk factors."[941] The authors detailed the following risk factors:

- **Economic Stress** – Economic downturns are usually associated with higher suicide rates compared with periods of relative prosperity. … Research suggests sustained economic stress is associated with higher US suicide rates in the future.
- **Social Isolation** – It is known that social connections play a significant role in suicides.

It is unlikely mental health professionals were consulted – or if so that their concerns were given serious consideration – before most governments imposed social distancing regimes.

- **Decreased Access to Community and Religious Support** –

Disruption in the routine of many tens of millions of Americans to regularly attend community or religious activities can cause significant psychological distress. Thus, the social isolation caused by closing churches and suspending community activities can be expected to result in a significant increase in suicides.

● **Barriers to Mental Health Treatment** – Entry to mental health facilities can be conditional on satisfying COVID-19 screening questions. Those actions, and others, can create barriers to mental health treatment.

● **Illness and Medical Problems** – There could be increased risk for suicide by people plagued by physical health problems – which are associated with increased probability of suicide. Those problems are most prevalent among the elderly.

● **Media Induced Anxiety** – The 24/7 negative end-of-the-world COVID-19 coverage by the legacy media and parroted by social media is an additional stressor on psychologically vulnerable people. Particularly people with preexisting mental health issues are subject to depression, anxiety, and substance abuse by the media inflamed psychosis.

● **Health Care Professional Suicide Rates** – Elevated suicide rates among medical professionals is documented in many studies. These are the people subject to the stress of providing care for what the media has trumpeted for many months is the greatest threat to mankind since the Spanish Flu. The media hype can elevate concerns by health related workers "about infection, exposure of family members, sick colleagues, shortages of necessary personal protective equipment, overwhelmed facilities, and work stress."[942]

● **Firearm Sales** – Firearms are the most common method of suicide in the U.S. firearm purchases in the U.S. during the COVID-19 are the highest on record.[943] Access and unsafe storage are associated with an increased suicide risk.[944] With the factors related to COVID-19 contributing to psychological imbalance, it can be expected there will be an increase in firearm suicides.

● **Seasonal Variation in Rates** – Suicides generally peak in the northern hemisphere in late spring and early summer – a period during which the COVID-19 outbreak occurred. This could result in more suicides being recorded as they are tallied for the year.

### 11% of U.S. adults considered suicide in spring 2020

The CDC reported that 40.9% of adults surveyed in the U.S. reported having a negative mental or behavioral health condition from April to June 2020. Those problems included: symptoms of anxiety disorder or depressive disorder (30.9%); traumatic or stressor-related disorder symptoms related to COVID-19 (26.3%); starting or increased substance use to cope with stress

or emotions related to COVID-19 (13.3%); and seriously considering suicide in the preceding 30 days (10.7%).[945] Contemplating suicide was highest among young adults 18-24 – 25.5%.

All of those rates of mental conditions were dramatically higher in 2020 than 2019:

- symptoms of anxiety disorder – *up 315%*.
- symptoms of depressive disorder – *up 374%*.
- contemplating suicide – *up 250%*.

The increases were caused by COVID-19 hysteria in 2020.

### More people driven to suicide by shutdown than killed by COVID-19

More people died by suicide than COVID-19 during California's shutdown according to doctors at the John Muir Medical Center in Contra Costa County. The head of the hospital's trauma team, Dr. Mike deBoisblanc, told San Francisco's KGO-TV during an interview in late May 2020: "We've never seen numbers like this, in such a short period of time. I mean we've seen a year's worth of suicide attempts in the last four weeks." [946]

He said the mental health of people was being harmed so much by California's shelter-in-place order that it needed to end: "Personally I think it's time. I think, originally, this (the shelter-in-place order) was put in place to flatten the curve and to make sure hospitals have the resources to take care of COVID patients. We have the current resources to do that and our other community health is suffering."[947]

A trauma nurse with 33 years experience at the hospital, Kacey Hansen, told KGO, that they were not only seeing many more suicide attempts, but they were serious attempts so they were not able to save as many people as usual: "What I have seen recently, I have never seen before. I have never seen so much intentional injury." She said of the people attempting suicide: "They intend to die. Sometimes, people will make what we call a 'gesture'. It's a cry for help. We're just seeing something a little different than that right now. It's upsetting." [948] Because of that she said a focus on mental health is very important.

Both Hansen and deBoisblanc said a high percentage of the suicide attempts are by young adults. They speculated that isolation and job loss were driving people to despair.

# 24. Health Care Debacles Related To COVID-19

As with any disease, there are varying problems with the treatment of persons ill with COVID-19. The following are some of those problems.

## I – COVID-19 in long-term care facilities

The people most vulnerable to serious illness or death from COVID-19 are the elderly with one or more underlying health conditions. That is precisely the clientele of a long-term care facility.

| **Care Home High Death Rate** Share of all C-19 deaths[949] | |
|---|---|
| **Country** | **Deaths** |
| Canada | 85.1% |
| Slovenia | 81.0% |
| New Zealand | 72.7% |
| Belgium | 64.1% |
| Ireland | 63.2% |
| Norway | 59.0% |
| France | 48.5% |
| Sweden | 47.4% |
| Finland | 45.0% |
| Israel | 44.6% |
| **Care Home Low Death Rate** | |
| Hong Kong | 0.0% |
| Singapore | 7.7% |
| Hungary | 23.9% |
| Australia | 28.4% |
| South Korea | 34.0% |

There are serious problems related to COVID-19 and care facilities. Some of those problems relate to lack of qualified staff. Others relate to care facilities being given financial incentives to take COVID-19 patients. Others relate to insufficient oversight. Others relate to care facilities being compelled by state authorities to take coronavirus patients.

Consequently it is to be expected that in some countries a significant percentage of COVID-19 deaths are of people living in a care facility.

However, there are factors that can artificially increase the number of fatalities. One of those factors is placing known infected persons in a care facility, where it can spread like wildfire. Another is to delay treatment when a vulnerable person begins displaying symptoms.

In the U.S. about 43% of deaths over-all are of a person living in a long-term care facility,[950] and in Canada it is 85%.[951]

### Ontario, Canada investigates long-term care facility deaths

The Ontario, Canada government has launched an independent commission to investigate the adequacy of efforts to prevent the spread of COVID-19 in long-term care facilities.

Sixty-seven percent of all deaths in Ontario attributed to COVID-19 have been in long-term care facilities: 1,852 out of 2,772 total deaths, as of August 1, 2020.[952]

In some care facilities more than 25% of the residents tested positive for coronavirus.

Ontario's government issued a press release stating the three-person

commission will investigate "how COVID-19 spread within long-term care homes, how residents, staff, and families were impacted, and the adequacy of measures taken by the province and other parties to prevent, isolate and contain the virus. The commission will also provide the government with guidance on how to better protect long-term care home residents and staff from any future outbreaks." The commission's powers include "compelling persons to give or produce evidence, issuing summons, and holding public meetings."[953]

Some officials think the commission's mandate is too limited, and should include investigating the conditions between non-profit and for-profit long-term care facilities. "A recent report from McMaster University found that nearly a quarter of residents in for-profit homes where COVID-19 outbreaks occurred became infected, compared with 17 per cent in non-profit homes and seven percent in municipally owned facilities. The study determined that the difference stemmed primarily from the design of the buildings, and that more for-profit homes use an older design standard that permits up to four residents per room."[954]

### COVID-19 positive patients sent to New York long-term care facilities

There was an inordinate number of COVID-19 infections and deaths in New York nursing homes after elderly patients released from hospitals who had tested positive for COVID-19 were ordered to be accepted and housed in them. A New York Health Department directive issued March 25, 2020 prohibited nursing homes from refusing to take in patients because they had or may have had COVID-19.[955]

It was reported in July 2020 that more than 6,300 recovering coronavirus patients were transferred to nursing homes during the height of the outbreak. As of June there were more than 6,400 deaths attributed to COVID-19 in New York's nursing home and long-term care-facilities.[956]

On May 10 Governor Andrew Cuomo reversed the directive, but he claimed the nursing home deaths weren't due to his policy of warehousing infected elderly people in nursing homes, but that they were caused by around 20,000 infected home staffers in March and April. Cuomo acknowledged coronavirus spread through the nursing homes like a "fire through dry grass."[957]

Daniel Arbeeny said of the directive, which prompted him to remove his 88-year-old father out of a Brooklyn nursing home where more than 50 people had died. "It was the single dumbest decision anyone could make if they wanted to kill people. This isn't rocket science. We knew the most vulnerable – the elderly and compromised – are in nursing homes and rehab centers." Arbeeny's father later died of COVID-19 at home.[958]

Forty-seven residents of the 460-bed Gurwin Jewish nursing home on

Long Island died after 58 coronavirus positive patients were transferred there from local hospitals.[959] Gurwin's CEO Stuart Almer said the State's order "put staff and residents at great risk. We can't draw a straight line from bringing in someone positive to someone catching the disease, but we're talking about elderly, fragile and vulnerable residents."[960]

On August 26, 2020 the U.S. Justice Department announced it had ordered the governments of New York, New Jersey, Michigan, and Pennsylvania to turn over data to the Civil Rights Division related to Covid-19 and nursing homes. The DOJ is evaluating whether to pursue an investigation of those states for possibly violating the Civil Rights of Institutionalized Persons Act (CRIPA) for mandating the admittance of COVID-19 positive clients to long-term state run care facilities.[961]

New York's 32,430 deaths as of October 5, 2020 are the most of any state.[962]

### COVID-19 positive patients sent to New Jersey long-term care facilities

In late March 2020 New Jersey Health Commissioner Judy Persichilli ordered that nursing homes cannot bar coronavirus patients from being admitted into their facilities. Persichilli issued the order because care facilities were refusing to allow residents who tested positive to return after going to the hospital for coronavirus treatment. She said the order was justified because "this is that resident's home. We keep forgetting that. They should be accepted back with the appropriate precautions." [963] Persichilli said whether a COVID-19 patient was returning to the home from the hospital or entering the facility for the first time, they could go only to a facility that was already keeping infected or recovering patients on a segregated wing or floor.

Families of residents were adamantly opposed to the policy of forcibly housing coronavirus infected patients with elderly people in a care facility. A daughter of a resident said about Persichilli's directive: "It's putting my mother at enormous risk."[964] She was alarmed because the directive provides the opportunity for COVID-19 to infect one of the most at-risk populations.

New Jersey's 14,339 COVID-19 deaths as of October 5, 2020 are the third most of any state.

### COVID-19 positive patients sent to Pennsylvania care facilities

On March 19, 2020 Pennsylvania's Department of Health instructed that "Nursing care facilities must continue to accept new admissions and receive readmissions for current residents who have been discharged from the hospital … This may include stable patients who have had the COVID-19 virus."[965]

U.S. Rep. Steve Scalise (R-La.) and other Republican leaders sent a letter on June 15 to Governor Tom Wolf that stated regarding the placing of

COVID-19 patients in care facilities: "This decision likely contributed to the thousands of elderly deaths in Pennsylvania."[966] On June 30 Scalise and other members of a House committee stated they wanted to know "the science and information" Wolf relied on to require care facilities to accept people who had been hospitalized for COVID-19 or exposed to the virus. Scalise said Pennsylvania "forced the nursing homes to take seniors who are COVID positive from the hospital back into the nursing home, even knowing they couldn't properly take care of them. It was a death sentence for thousands of Pennsylvania seniors."[967]

Pennsylvania's 8,341 COVID-19 deaths as of October 5, 2020 are the seventh most of any state.

### COVID-19 positive patients sent to Michigan long-term care facilities

U.S. Rep. Steve Scalise (R-La.) and other Republican leaders sent a letter on June 15 to Michigan Governor Gretchen Whitmer that stated:

> "On April 15, 2020, you issued an Executive Order mandating nursing homes accept patients regardless of COVID-19 status.4 The Order said that nursing homes must accept COVID-19 positive patients stating, "[a] long-term care facility *must not prohibit* admission or readmission of a resident based on COVID-19 testing requirements or results…"[968]

Michigan State Democratic Representative Leslie Love criticized Whitmer's order calling it "an epic fail."

Scalise's letter also said: "You have yet to rescind this controversial order. According to the most recently available data, Michigan has suffered 2,297 nursing home deaths related to COVID-19. That is more than 41% of the State's total COVID-19 deaths and more than 3% of the State's entire nursing home population. … we call on you to protect those most vulnerable – the elderly – and rescind your mandate on nursing homes."[969]

Michigan's 6,236 COVID-19 deaths as of October 5, 2020 are the eighth most of any state.

### COVID-19 positive patients sent to California long-term care facilities

"On March 30, 2020, the California Department of Public Health issued guidance mandating nursing homes not use COVID-19 positivity as a reason to block admission. The guidance mandated nursing homes accept COVID-19 positive patients stating, "[nursing homes] shall not refuse to admit or readmit a resident based on their status as a suspected or confirmed COVID-19 case." The Calif. DPH offered the financial incentive to nursing homes of $1,000 per day per COVID-19 positive patient a facility took in.[970]

The California Association of Long-Term Care Medicine said the entire program of housing COVID-19 patients in nursing homes where the virus could spread like wildfire "ma[de] no sense."

U.S. Rep. Steve Scalise (R-La.) and other Republican leaders sent a letter on June 15 to Governor Gavin Newsom that was critical of his "lethal decision" to place COVID-19 patients in long-care facilities, and the fact that "more than 50% of the State's total COVID-19 deaths and 1% of the State's entire nursing home population" had died from the virus."[971]

An attorney at California Advocates for Nursing Home Reform described the situation was:. "The places hospitals want to send these Covid-positive patients turn out to be the places least equipped to take them, places that are already the most dangerous facilities in the United States. These are places that have serious infection control issues, terrible understaffing issues."[972]

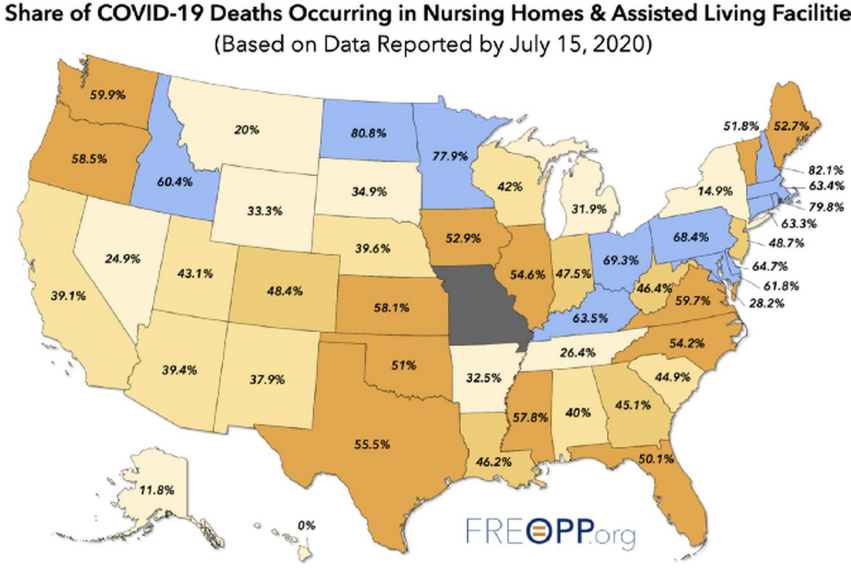
California's 15,270 COVID-19 deaths as of October 5, 2020 are the second most of any state.

### COVID-19 positive patients sent to Massachusetts care facilities

Massachusetts was one of a number of states that provided financial incentives to take COVID-19 patients that could double the money they were paid by the state for other patients. Massachusetts' 8,086 COVID-19 deaths as of October 5, 2020 are the sixth most of any state.

### Map of COVID-19 deaths by state in long-term care facilities

The following is a map of the percentage of deaths in each state of people in a long-term care facility. Overall, about 45% of COVID-19 deaths in the U.S. are of persons in a long-term care facility.



## II – U.S. CARES Act was pork-barrel give-away to hospitals

The CARES Act (Coronavirus Aid, Relief, and Economic Security Act) passed by the U.S. Congress and signed into law by President Trump on March 27, 2020, included $175 billion for payments to hospitals and health systems. The emergency federal grants were distributed based on "eligible providers' share of net patient revenue."

Three hospitals received over $100 million: Dignity Health ($180,264,488); the Cleveland Clinic ($103,289,897); Stanford Health Care ($102,405,229). Eleven other medical organizations received between $50 and $100 million. Sixteen medical systems received between $40 to $50 million. Twenty-five received between $30 to $40 million. Fifty-five hospitals received over $30 million.[973] They received a total of more than $2.7 billion.

In addition a number of health systems received significant payments. The four largest recipients were: HCA Healthcare – $700 million; Tenet – $345 million; Community Health Systems –$245 million; and Universal Health Services – $195 million.[974]

The CARES Act payments were not equally distributed to hospitals around the country. Hospitals in Minnesota, Nebraska, and Montana received more than $300,000 per reported COVID-19 case, while Florida hospitals received $132,000.[975]

The reason payments were not the same for every state is the federal government gave hospitals and doctors money based on their historical share of revenue from the Medicare program for seniors — not according to their number of coronavirus patients. Thus hospitals that had fewer COVID-19 patients would effectively receive more money for each of those patients than hospitals that proportionately had more coronavirus patients.[976]

## III – Germans denied critical care as health system focused on COVID-19

In early May 2020 a German official leaked to the press an Interior Ministry report that identified the harm caused to Germans from the denial or postponement of critical care while the health system focused on COVID-19.[977] The report identified the following serious problems:

- In just March and April 2020, 90% of an average of 1.4 million surgeries per month were not performed – for a total of 2.5 million. "Experts assume that there are numbers between 5,000 and up to 125,000 patients who will die / have already died due to the postponed surgery."[978]

- Postponed or canceled follow-up treatments from cancer, stroke, heart attack and other health conditions had the consequence of "up to several thousand additional deaths were expected in March and April 2020 or will continue to die [as lack of treatment continues]."[979]
- Level of care "in care facilities, in outpatient care services as well as in private / family care") decreases due to restrictions imposed by the state. … the drop in levels enforced in March and April 2020 will have led to premature deaths. For 3.5 million people in need of care, an additional death rate of one tenth of a percent would result in an additional 3,500 deaths."[980]
- Increases in suicides that historically are "an average of 9,000 per year. Reasons for the increase in suicides: long-lasting significant impairment of all living conditions, which can become critical for mentally unstable personalities; but numerous suicides as a reaction to the economic destruction of livelihoods can also be expected."[981]
- Additional deaths from heart attacks and strokes. "Over the past years and decades, integrated concepts have been developed that have successfully influenced morbidity and mortality and are based on the fact that care is provided as early as possible [], as quickly as possible []and as intensively as possible. …due to the current corona fixation … many affected people are not, or are too late to see a doctor, which means increased morbidity, worsened rehabilitation and increased mortality in these diseases."[982]

So the Report identified a minimum of 10,500 and possibly over 130,000 additional deaths – were directly caused by the German government's coronavirus response, during just the *two months* of March and April 2020. And that number doesn't include an unknown number of suicides, and heart attacks and strokes attributable to government coronavirus policies. There would be more additional deaths in May and beyond until the repeal of all government coronavirus policies and harmful private policies inspired by them.

9,534 COVID-19 deaths are reported by the WHO (as of October 5, 2020). So more people (10,500 minimum) died in two months (March and April) as a result of the German government's COVID-19 restrictions than died from the virus in the eight months from February to early October. The actual number of COVID-19 restriction caused deaths could be well in excess of 400% more than deaths from the virus.

Other damage to health the Report identified are:

- Elderly people were damaged particularly by measures such as quarantine regulations, bans on contacts, etc.

- Serious mental illnesses requiring long-term medical treatment will be caused in psychologically unstable personalities by the government's coronavirus response.
- Domestic violence and child abuse will increase and there will be more body injuries as a result of the government's coronavirus contact restrictions and contact bans.
- Widespread communication problems "through psychological effects …and also, for example, through the compulsion to wear face masks, through which gestures and facial expressions are severely restricted as a means of communication (leads to misunderstandings, mistrust ...)"[983]

Another serious problem the Report identified was loss of life expectancy in Germany. "Since the 1950s, DEU has seen a significant increase in life expectancy due to positive economic development (average life span 13 to 14 years longer). … With a strongly negative economic development and a corresponding reduction in the level of prosperity … life expectancy will decrease. … (The RKI has shown that high unemployment lowers life expectancy.) With over 80 million inhabitants, government protection measures (not the virus) can have destroyed a correspondingly high volume of population life years."[984]

The Report stated in its Closing Remarks:

> "*Alleged protective measures are currently causing further serious damage every day, from material and health to a large number of avoidable deaths. These deaths are triggered by the action of the crisis management* and are responsible for it as soon as the knowledge about the matters dealt with in the analysis submitted is available. … In view of the factual findings of the present analysis and the political decisions in contrast to them, injured outsiders may fear that the defining protection goal of national crisis management is no longer the safety and health of the population, but the credibility and acceptance of government parties and government officials."[985]

## IV – Brits denied critical care while health system focused on COVID-19

A study by academics at Essex University found that in the U.K. almost two-thirds of people with life-threatening conditions were denied health care due to the suspension of non-coronavirus procedures by National Health Service (NHS). The study found that "huge numbers of people with health issues could not undergo surgery, diagnostic tests or outpatient

appointments." Professor Michaela Benzeval headed the study that showed 53 percent of cancer patients have been unable to access treatment in the normal way, and, 70 percent of diabetics; 65 percent of people with high blood pressure; and 64 percent of people with breathing problems have had care canceled by the NHS across the U.K. from March to early June 2020. [986]

A number of NHS leaders and senior doctors have confirmed a large majority of patients have been too scared to come into a hospital for critical treatment. "A little over one in five of those who regularly receive NHS help for a long-term condition were able to complete planned treatment in April."[987]

Another study, determined there could be more than "17,900 extra cancer deaths within a year, including 6,270 fatal cases in newly diagnosed cancer patients," because health resources were diverted to COVID-19 and people avoided seeking medical care. The joint study by University College London (UCL) and the Health Data Research Hub for Cancer (DATA-CAN) analyzed data from more than 3.5 million patients.[988]

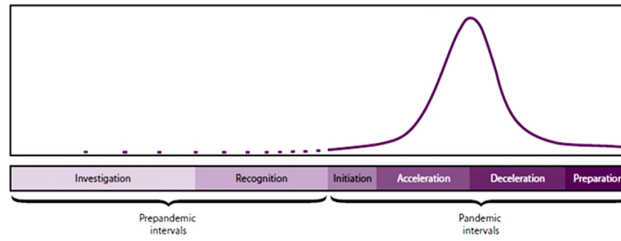
The study found the average drop in early cancer diagnosis referrals had amounted to 76 percent, and chemotherapy attendance had fallen by 60 percent in the U.K.[989]

Polling has shown that a large number of people are reluctant to contact a doctor or go to a medical facility out of fear of contracting coronavirus, even if they have some possible symptoms. One poll found that 10 percent of people would not contact their doctor even if they had a lump or a new mole that didn't disappear after a week.[990]

# 25. Vaccine Mania

Outbreaks of an influenza like respiratory disease follow a predictable bell curve: A gradual upgrade as the virus begins to spread through the population; Then a sharp rise in hospitalizations and possibly deaths for several weeks as the vulnerable succumb to effects of being infected; Then an equally sharp decline as the number of weak people for the virus to take advantage of is exhausted; then a gradual downgrade. It is not uncommon for there to be a "second" or even a "third" wave as a new stock of vulnerable people becomes available for infection with serious consequences.

So the pattern of an influenza like respiratory disease outbreak is known, and while vulnerable people are affected, everyone else is a veritable bystander. A typical influenza outbreak bell curve is shown in the accompanying graphic (Dena et al 2010)




Because the pattern of a viral outbreak is so well known to be of limited duration, and that it attacks the vulnerable, there is limited reason to develop a vaccine.

## I – COVID-19 vaccine

After 17 years of effort there is no vaccine for the SARS-CoV coronavirus that has been shown to be both safe and effective in humans, even though it has been a priority for governments and public health agencies around the world since it was first identified in 2003.

There is also no proven vaccine against the MERS-CoV coronavirus. When MERS became prevalent in 2012, it was thought existing SARS research could provide useful groundwork for developing a vaccine against a MERS infection. No vaccine had been marketed, however there are clinical trials in humans in progress.

There is also no vaccine against the common cold that is an offshoot of four different coronaviruses. Yearly hundreds of millions of people, and possibly over a billion people get a cold. The CDC's webpage titled Common Human Coronavirus states: "Common human coronaviruses, including types 229E, NL63, OC43, and HKU1, usually cause mild to moderate upper-respiratory tract illnesses, like the common cold. Most people get infected with one or more of these viruses at some point in their lives."[991]

Human coronaviruses can sometimes cause lower-respiratory tract illnesses, such as pneumonia, bronchitis, and the common cold. This is more common in people with cardiopulmonary disease, people with weakened immune systems, infants, and older adults.[992]

The CDC's webpage also states:

> "Symptoms of common human coronaviruses: runny nose; sore throat; headache; fever; cough; general feeling of being unwell."[993]

Those are also reported as COVID-19 symptoms, so an otherwise healthy person could easily mistake a common cold for a COVID-19 infection.

Additional research is necessary to confirm the possibility there are very large numbers of people with a level of immunity to COVID-19 (SARS-CoV-2) from their exposure to SARS, MERS, and the common cold, since they are all members of the coronavirus family that share some commonalities. This pre-existing coronavirus immunity may be why the percentage of asymptomatic people is in the 80%+ range for people who test positive for COVID-19. The possibility of pre-existing immunity is supported by the identification of coronavirus SARS T-cells in persons 17 years after they were infected in 2003. It was reported in a research article published in *Nature* magazine, "these T cells displayed robust cross-reactivity to the N protein of SARS-CoV-2. We also detected SARS-CoV-2-specific T cells in individuals with no history of SARS, COVID-19 or contact with individuals who had SARS and/or COVID-19."[994] The research found there could be a link to presence of the T cells and the 'common cold': "Thus, infection with betacoronaviruses induces multi-specific and long-lasting T cell immunity against the structural N protein [of SARS-CoV-2]."[995]

Although COVID-19 is in fact far less disruptive to society than the seasonal flu because it targets the least productive people – the seriously ill, the frail and sick elderly, and obese people of all ages – there was a herculean world-wide rush by laboratories around the world to develop a vaccine for the SARS-CoV-2 virus. In February 2020 the World Health Organization said it did not expect a vaccine to become available in less than 18 months.

Billionaire Bill Gates is the world's most visible spokesman for universal COVID-19 vaccination. That follows Gates promoting development of a universal flu vaccine in 2018, and $12 million in seed money was offered to laboratories by the Bill and Melinda Gates Foundation. Gates said in an interview before announcing the funding: "We think a universal flu vaccine would not only eliminate the pandemic risk, but would have significant health benefits."[996]

In January 2020 *Forbes* magazine published an article about the effort, partially funded by the Gates Foundation, to develop a universal flu vaccine. The effort to find the vaccine is monumental because the influenza virus "affects not only humans, but billions of chickens, pigs, wildfowl and more animals besides." Complicating the problem, according to Professor Munir Iqbal of the Pirbright Institute, is "influenza viruses can mutate and evolve at a rapid rate. The result is that frequent, often annual update of vaccine strains in humans is required to protect against prospective seasonal influenza viruses."[997]

Skepticism about the safety of vaccines has resulted in a reduction of vaccination rates in the world since 2010, particularly among the elderly that are most vulnerable to the flu virus. That is why Gates has said the "final hurdle" when a COVID-19 vaccine is developed is getting people to take it, because "You'll have a choice of whether you take the vaccine or not."[998]

Gates doesn't think everyone will need the vaccine, because he says "herd immunity" will be achieved if 70% to 80% of the population takes it.[999] That seems excessive, considering there are estimates that in some areas more than 50% of people already have COVID-19 immunity – so vaccination of a low percentage of people would achieve his projected "herd immunity."

There is good reason for people to be concerned about rushed development and inadequate testing of a COVID-19 vaccine. Rushed development and deployment of a Swine Flu vaccine in 1976 by the administration of President Gerald Ford resulted in more than 500 inoculated people in the U.S. developing Guillain-Barre syndrome. 25 died from the vaccine. The federal government wound up paying millions of dollars in damages to people harmed by the poison vaccine or their families. The vaccine was pulled from the market within two months of its deployment. [1000]

The irony of the push to put a COVID-19 vaccine on the market is it is known its potential value is only for the unhealthy segment of the population who already have one or more serious comorbidities. Healthy people of all ages do not need a COVID-19 vaccine any more than they need one for the common cold – for which no vaccine exists.

## II – Russia announces first COVID-19 vaccine in August 2020

The Russian Health Ministry announced on August 15, 2020 that production had begun of the world's first registered COVID-19 vaccine. Russia has received applications for more than one billion doses from 20 countries. It is expected to be produced in Russia and Brazil. The vaccine is expected to go into general circulation in January 2021.[1001]

Named Sputnik V after the space satellite launched by the U.S.S.R. in

1957. the registration of the vaccine had been announced by President Vladimir Putin on August 11. Putin said the vaccine developed by Moscow's Gamaleya National Research Center was completely safe, and one of his daughters had taken it as a volunteer with no side-effect.[1002] The vaccine is administered in two doses.

A week later Russia's 'Vector' virology center in Novosibirsk announced the second stage of clinical trials were underway on a different vaccine. It was reported by the lab: "Those who received the vaccine have not shown any adverse reactions, and there is not even the slightest reddening at the injection site."[1003] The Vector research facility is one of the world's leading virology and biotechnology facilities.

## III – Bill Gates lied to promote vaccines & oppose hydroxychloroquine

One of the oddest stories of the COVID-19 episode is high profile billionaire Bill Gates promoting the development of a costly vaccine for the virus, and the universal administration of it to everyone in the world. The Bill and Melinda Gates Foundation is the world's largest individual financial supporter of vaccine development outside of governments.

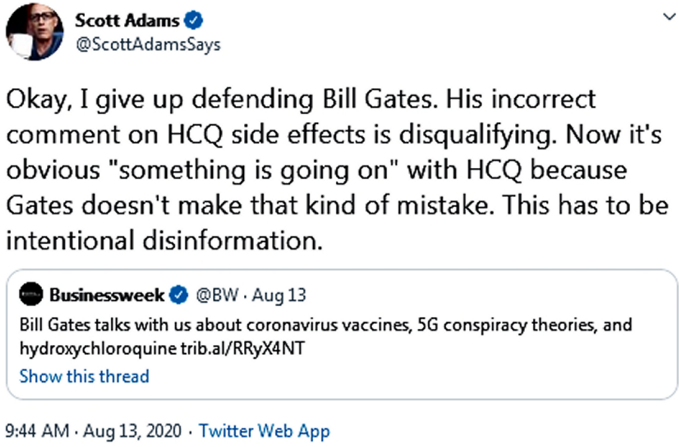
Concomitant with promoting vaccination is Gates' opposition to anything that could reduce or eliminate the need for a high-priced vaccine, including less expensive pharmaceutical alternatives. Hydroxychloroquine is the most widely discussed non-vaccine COVID-19 treatment. Hydroxychloroquine is a low cost prescription drug (in the U.S.) that is widely used around the world to treat malaria, rheumatoid arthritis, and other ailments. Hydroxychloroquine is readily available and costs about 37¢ each for a supply of 100 tablets.[1004]

Predictably Gates is rabidly opposed to the use of hydroxychloroquine. In August 2020 Gates' hyperbole against hydroxychloroquine reached a crescendo when he said it shouldn't be used because it has "severe side effects."[1005] At the same time Gates argued medical officials should continue pursuing the "good therapeutic drugs", i.e., expensive vaccines that would be sold by pharmaceutical companies.

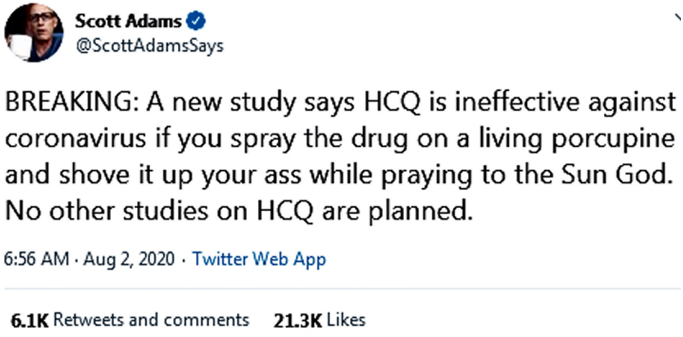
Yet, there is no evidence of "severe side effects" by COVID-19 patients who take hydroxychloroquine: the majority of reported negative side effects are relatively mild.[1006] Even a study published in the *New England Journal of Medicine* in August that wasn't favorable towards hydroxychloroquine as a COVID-19 treatment, acknowledged there were "no serious intervention-related adverse reactions or cardiac arrhythmias" reported by participants.[1007] The side-effects included nausea, loose stools and abdominal discomfort. Studies in England and France likewise found mild side-effects among

participants.[1008]

Gates dishonesty in using his position to falsely promote the idea hydroxychloroquine has dangerous side-effects resulted in at least one popular blogger, Scott Adams, to comment.




Adams also wrote about the blind opposition by Gates and the medical establishment to hydroxychloroquine:



# 26. U.S. Government Has Long History Of Perpetrating False Narratives To Exaggerate Or Fabricate An Event

The United States government is infamous for perpetrating a fake crisis, creating a "crisis" by its own actions, over-blowing an event to make it appear much worse than it is, or creating a fake narrative to justify a radical action. The following are how the federal government took the necessary actions to involve the U.S. in the Vietnam War; the 1991 Gulf War; the invasion of Afghanistan; the invasion of Iraq; and failed to disclose the truth about 9/11. The same PR machine that sold these false narratives to the American people is now being used to "sell" COVID-19 as a killer menace people can only be protected from by surrendering their constitutional rights to due process, freedom of religion and assembly, freedom from illegal search and seizure, freedom to a speedy trial and a jury trial, and others.

## I – 1964 – Vietnam War

The trigger for escalation of U.S. military involvement in Vietnam were alleged incidents in the Gulf of Tonkin on August 2 and 4, 1964. At the time the U.S. was providing military support – but not fighting troops – for the South Vietnamese government in its war with North Vietnam (which was militarily aided by China). The South Vietnamese Government was near collapse.

On August 2, three North Vietnamese Navy torpedo boats came within 10,000 yards (almost 6 miles) of the destroyer *USS Maddox*. The *Maddox* fired three warning shots. The torpedo boats responded with torpedoes and machine gun fire, and the *Maddox* returned fire. The three torpedo boats were damaged and four sailors were killed. The *Maddox's* only damage was a single bullet hole from a Vietnamese machine gun.[1009]

On August 4 the administration of President Lyndon Johnson alleged that another skirmish occurred.

Johnson used those incidents described as unprovoked attacks on the *Maddox* to secure passage on August 7 of the Gulf of Tonkin Resolution by the U.S. Congress. That Resolution granted Johnson authority to assist a Southeast Asian country considered to be jeopardized by "communist aggression." Johnson relied on the resolution to deploy U.S. military forces to Vietnam and their engagement in combat against North Vietnam.[1010]

Former Secretary of Defense Robert McNamara admitted in the 2003 documentary *The Fog of War* that there was no August 4 attack on the

*Maddox*. That was confirmed by NSA documents released in 2005 and 2006.[1011]

Forty years after the Gulf of Tonkin the truth was known that U.S. government officials distorted facts and deceived the American public – with the enthusiastic assistance of its willing accomplices in the media – to contrive a justification for the U.S. to become an active military participant in the Vietnam War with the consequence of over 58,000 dead U.S. service members and hundreds of billions of dollars spent. For nothing. In 1975 the U.S. hurriedly evacuated Saigon when the city was entered by North Vietnamese troops, and South Vietnam's government immediately collapsed.

It can safely be suggested the reunification of North and South Vietnam would have occurred ten years earlier if the U.S. had not justified its military intervention by fabrication of the narrative used to trick Congress into passing the Gulf of Tonkin Resolution.

## II – 1991 – Gulf War

The 1991 Gulf War was based on a non-existent lie perpetrated on the American people by the U.S. government. The primary justification for the Gulf War – codenamed Operation Desert Shield – was the Iraqi army was allegedly on the border with Saudi Arabia poised for an imminent invasion. The U.S. government claimed that such an event would endanger the national interest of the U.S. by potentially affecting Saudi Arabia's supply of oil to this country. To sell the idea that Iraq was prepared to attack Saudi Arabia, the U.S. government, under President George H.W. Bush, claimed that "classified satellite images showed that up to 250,000 Iraqi troops and 1,500 tanks had amassed on the border of Saudi Arabia."[1012] At the time Saddam Hussein denied he was preparing to attack Saudi Arabia. Today the alleged planned attack of Saudi is generally overlooked as the justification for the Gulf War, and the entire reason is alleged to have been Iraq's invasion of Kuwait in August 1990 – which did not endanger U.S. national security.

The *St. Petersburg Times* obtained two Soviet commercial satellite images of the area between Iraq and Saudi Arabia taken at the time the U.S. classified photos allegedly showed Iraq's army poised for an attack. The commercial photos show an empty desert. The *Times* reporter who in 2002 broke the story about the satellite images said, "That [Iraqi buildup] was the whole justification for Bush sending troops in there, and it just didn't exist."[1013] Lee Hamilton was a U.S. Representative (D Indiana) in 1991 and served on foreign affairs and intelligence committees. Discovery of the satellite images was news to Hamilton: "My concern in these situations, always, is that the intelligence that you get is driven by the policy, rather than the policy being driven by the intelligence."[1014]

The 1991 Gulf War was based on a fabrication by the U.S. government that was perpetrated on the American people as the truth by the Bush administration, and duly reported by its unquestioning accomplices in the news media.

## III – 2001 – 9/11

The events of September 11, 2001 are shrouded in mystery because there has been virtually zero transparency by the federal government regarding what happened. The official story is 19 foreign nationals hijacked four airliners on the morning of September 11, with one airliner crashing into the Pentagon, separate airliners crashing into both Twin Towers in New York City, and one airliner crashing into the ground in Pennsylvania.

President George Bush did not want an official investigation of 9/11. However, Bush and Republican leaders in Congress caved to unrelenting pressure by families of people who died on September 11, and agreed to create a commission to investigate the events leading up to and on September 11.[1015]

There was extreme dissatisfaction with the commission's final report. One description of that report is:

> "Books and articles have been written detailing the *9/11 Commission Report* issued on July 22, 2004 has more holes than Swiss Cheese in its explanation of what happened regarding the four airliners and the events concerning them in New York, Pennsylvania, and Washington D.C.[1016]
>
> Prior to 9/11 no high rise office building in the world had simply fallen down from a non-natural event or fire – and none has fallen down since.[1017]
>
> Entire websites are devoted to debunking the 9/11 Commission Report. Esteemed engineers and even physicists have become involved in questioning the official narrative of how the 110 story Twin Towers and the 47 story Building 7 – which wasn't even hit by an airliner – fell down.
>
> Enormous investigative resources have been devoted to exposing the inadequacy of the official explanation regarding why the Twin Towers and WTC Building 7 fell down. Building 7 was 370 feet south of the Twin Towers and fell down about seven hours after they did.[1018] A person who didn't know they were watching a video of Building 7 falling down would think they were watching the controlled demotion of the building. That simple fact has not been reasonably explained."[1019]

The mystery of Building 7 intensified in March 2020 when the

University of Alaska Fairbanks, Institute of Northern Engineering released its final report after a four year study: "A Structural Reevaluation of the Collapse of World Trade Center 7."[1020] The two key findings in that Report are:

> **"Fire Did Not Cause the Collapse of WTC 7**
>
> The principal conclusion of our study is that fire did not cause the collapse of WTC 7 on 9/11, contrary to the conclusions of NIST and private engineering firms that studied the collapse.
>
> **Near-Simultaneous Failure of Every Column Explains the Collapse**
>
> The secondary conclusion of our study is that the collapse of WTC 7 was a global failure involving the near-simultaneous failure of every column in the building."[1021]

The report turned the official story pushed by the 9/11 Commission Report on its head that Building 7 collapsed due to fire. The University of Alaska Report was prepared for Architects & Engineers for 9/11 Truth, an organization of professional members who rely on evidence to challenge the official narrative of the events of 9/11.[1022] Many of the professionals associated with AE911Truth also doubt the official story that the airliners crashing into the Twin Towers caused their collapse.

There is also significant evidence the official story as detailed in the 9/11 Commission Report that American Airlines Flight 77 crashed into the Pentagon is not just wrong, but a fabrication.[1023]

Needless to say, the American people have not been told the truth about the events of 9/11 that were used as a pretext to start the war on terror that resulted in the U.S. led invasions of Afghanistan and Iraq, and the military's continued significant involvement in the middle east.

## IV – 2001 – Invasion of Afghanistan

President George Bush accused Osama bin Laden and al-Qaeda as responsible for the events of September 11, 2001. The Taliban controlled the area of Afghanistan where Bin Laden was believed to be, and the U.S. demanded that he be turned over. The Taliban refused to hand over bin Laden unless they were provided evidence of his involvement in 9/11, which the U.S. refused to provide.[1024] The U.S. military responded by leading the invasion of Afghanistan on October 7, 2001. As of October 2020 – 19 years later – the U.S. military is still actively engaged in Afghanistan. It is the U.S.' longest war.

It is now known the reason the reason the Taliban wasn't provided evidence bin Laden was responsible for 9/11 is because the U.S. didn't have any. Bin Laden was never indicted by the U.S. government for any crime

related to 9/11, and he never publicly stated he and/or al-Qaeda was involved, while he repeatedly publicly denied involvement. The FBI's biographical webpage for Usama (Osama) bin Laden does not contain a single word alleging any involvement in 9/11.[1025]

In June 1998 bin Laden was indicted by a federal grand jury in New York City on one count of "Conspiracy to Attack Defense Utilities of the United States."[1026] The only act of violence alleged in his indictment was:

> "l. On October 3 and 4, 1993, members of al-Qaeda participated with Somali tribesmen in an attack on United States military personnel serving in Somalia as part of Operation Restore Hope, which attack killed a total of 18 United States soldiers and wounded 73 others in Mogadishu;"[1027]

The indictment was dismissed on June 17, 2011, based on evidence bin Laden was killed on May 1, 2011 in Afghanistan. The dismissals were in response to a *nolle prosequi* motion filed by the U.S. Attorney's Office in Manhattan.[1028] The indictments were the only pending criminal charges against bin Laden.

Obama was never charged with any crime related to 9/11. The story sold to the American people by the legacy media and the government that Afghanistan needed to be invaded to fight terrorism because bin Laden was responsible for 9/11 was an outlandish lie. Unfortunately that lie resulted in the U.S. becoming enmeshed in an quagmire that has been ongoing for almost two decades.

## V – 2003 – Second Gulf War

On March 20, 2003 the U.S. led an invasion of Iraq that was joined by the United Kingdom, Australia, Spain, and Poland. Within a month the Iraqi government collapsed, and on May 1, 2003 President George Bush announced the end of combat operations.[1029]

There was no suggestion by the Bush administration that Iraq was involved in 9/11. The invasion of Iraq was justified by the administration's assertion the Iraqi government had weapons of mass destruction – even though U.N. weapons inspectors in Iraq maintained their inspections were unable to find that any such weapons existed.[1030] The Bush administration also asserted the Iraqi government was seeking to develop nuclear weapons – which claim Secretary of State Colin Powell made in a speech to the U.N. The administration and Powell offered no credible evidence that claim was true – even though the mainstream media reported it as if it was true.[1031]

The Bush Administration offered only rhetoric that wasn't back up by substantive evidence, that Iraq had weapons of mass destruction and was attempting to build an atomic weapon. Yet the media in the U.S. was so

incurious about the truth that 97% supported the 2003 invasion that they were cheerleaders for.[1032]

The U.S. media belatedly admitted long after the invasion, that it had reported erroneous information that influenced the public to support it. In 2004 *The New York Times* publicly acknowledged a September 8, 2002 article titled "U.S. Says Hussein Intensifies Quest for A-Bomb Parts" – was based on discredited information.[1033]

So the war was based on the whole cloth of fabrications by the U.S. government that Iraq had weapons of mass destruction and that it was trying to develop a nuclear weapon.

Although the U.S. ended direct military involvement in 2011, more than 17 years after the invasion the U.S. maintains a significant military presence in Iraq to provide support for the Iraqi government, with no end in sight.

## VI – Conclusion

History teaches us government agencies and officials routinely lie to the American people about the most important thing imaginable: the pretext for the U.S. to actively become involved in a war. It did so to get the U.S. into the Vietnam War in 1964; the 1991 Gulf War; the 2001 invasion of Afghanistan; and the 2003 invasion of Iraq. It is almost self-evident the official version of 9/11 that was used to involve the U.S. in the war on terror is riddled with almost mind-numbing outrageous lies.

The lies to justify U.S. military action don't even begin to stop there. Franklin Roosevelt blatantly lied during the 1940 presidential election that he didn't want the U.S. to get involved in war with either Japan or the German axis in World War II; President Woodrow Wilson lied that he didn't want the U.S. to become involved as a combatant in World War I; the U.S. became involved in the Spanish-American War based on the fabrication the Spanish attacked the battleship Oregon; and Abraham Lincoln was itching for the North to become embroiled in a war with the South.

Most recently, there is compelling evidence U.S. missile attacks on Syria were based on fabricated allegations the Syrian military used chemical weapons on civilians. [1034]

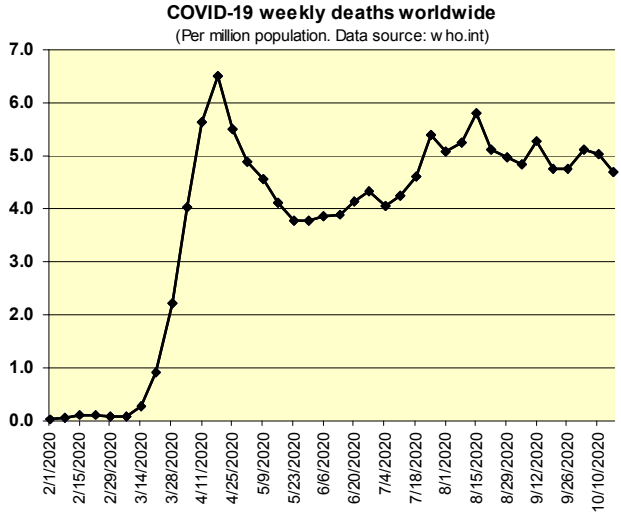
The idea COVID-19 hysteria in the U.S. is attributable to misinformation at best, and outright lies at worst, trumpeted by government officials and medical experts linked to the government, is consistent with its longstanding behavior to dishonestly maximize exploitation of a situation.

# 27. Data From The U.S. And Worldwide

The following is various data and charts related to COVID-19 in the United States and countries worldwide.

## I – Worldwide weekly COVID-19 deaths

The following graph shows the weekly number of deaths worldwide. Deaths peaked the week ending April 18, 2020, the same week they peaked in the United States.




The worldwide peak of deaths was 6.5 per million the week of April 18. That is significant because the medical and political establishment, and the legacy and social media were promoting the narrative COVID-19 is a killer virus that is a menace to all mankind – and it is known the death total was inflated (See sub-chapter: "COVID-19 Death Counting – WHO guidelines"). In October about 5 deaths per million per week were credited to COVID-19. That is about 3.5% of all deaths, which is relatively insignificant compared to the 96.5% of deaths attributed to other causes.[1035]

## II – Top 10 countries with most deaths & cases per 100k people by month

The number of confirmed cases is a weak indicator of the prevalence of COVID-19 in a country because the more widespread the testing the more likely there will be a large number of positives. However, a significant percentage of cases with a relatively small number of deaths can be indicative of an actually low CFR rate.

There is controversy regarding the reporting of deaths related to COVID-19, but the number of deaths a country reports to the WHO is the best measure currently available of the number of people who have died in a

country. It would be most accurate if countries were required to break down their death reports by the number of people who had no comorbidities, one comorbidity, two comorbidities, three comorbidities, four comorbidities, etc. However, that isn't done.

There were 17 countries with death rates of more than 50 per 100k people from January to the end of September 2020. However, there were also 83 countries with a death ate of 1.0 or less. Worldwide the average was 12.9 deaths per 100k – or about one death for every 7,750 people.

| January-September 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | San Marino | 123.8 | Qatar | 4,357 |
| 2 | Peru | 98.0 | Bahrain | 4.139 |
| 3 | Belgium | 86.4 | Aruba | 3,627 |
| 4 | Andorra | 68.6 | French Guiana | 3,324 |
| 5 | Spain | 67.9 | Palestine | 2,709 |
| 6 | Bolivia | 67.7 | Israel | 2,697 |
| 7 | Brazil | 66.8 | Panama | 2,579 |
| 8 | Chile | 66.6 | Andorra | 2,544 |
| 9 | Ecuador | 64.1 | Peru | 2,453 |
| 10 | United Kingdom | 62.0 | Kuwait | 2,449 |
| | World-wide | 12.9 | World-wide | 432 |

In January 2020 China was the only country with more than 23 COVID-19 cases and more than zero deaths, however, both its cases and deaths were 0.00 per 100k population. The outbreak did not start to become widespread until February 2020. In April deaths peaked at 2.4 per 100k population worldwide.

| February 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | South Korea | 0.42 | South Korea | 77.8 |
| 2 | China | 0.18 | San Marino | 14.7 |
| 3 | Iran | 0.05 | Monaco | 12.7 |
| 4 | Italy | 0.05 | China | 4.8 |
| 5 | | | Bahrain | 2.6 |
| 6 | | | Italy | 1.9 |
| 7 | | | Singapore | 1.5 |
| 8 | | | Kuwait | 1.1 |
| 9 | | | Iran | 0.7 |
| 10 | | | Switzerland | 0.6 |
| | World-wide | 0.04 | World-wide | 1.1 |

| March 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | San Marino | 73.7 | Holy See | 749 |
| 2 | Spain | 21.5 | San Marino | 663 |
| 3 | Italy | 19.1 | Andorra | 479 |
| 4 | Andorra | 10.4 | Faroe Islands | 321 |
| 5 | Belgium | 9.6 | Iceland | 318 |
| 6 | Switzerland | 5.5 | Luxembourg | 318 |
| 7 | Netherlands | 5.0 | Gibraltar | 205 |
| 8 | France | 4.6 | Switzerland | 197 |
| 9 | Luxembourg | 3.5 | Spain | 182 |
| 10 | Iran | 3.4 | Liechtenstein | 168 |
| | World-wide | 0.5 | World-wide | 8.8 |

| April 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | Belgium | 58.6 | San Marino | 981 |
| 2 | San Marino | 47.2 | Holy See | 499 |
| 3 | Andorra | 42.7 | Andorra | 484 |
| 4 | United Kingdom | 35.5 | Qatar | 441 |
| 5 | Spain | 32.5 | Falkland Islands | 374 |
| 6 | France | 32.2 | Ireland | 351 |
| 7 | St Maarten | 30.3 | Isle of Man | 314 |
| 8 | Italy | 26.6 | Guernsey | 301 |
| 9 | Isle of Man | 24.7 | Belgium | 298 |
| 10 | Ireland | 23.0 | Luxembourg | 285 |
| | World-wide | 2.4 | World-wide | 30 |

| May 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | Sweden | 19.1 | Qatar | 1,453 |
| 2 | United Kingdom | 18.8 | Kuwait | 519 |
| 3 | Ecuador | 13.9 | Mayotte | 470 |
| 4 | Belgium | 13.6 | Bahrain | 456 |
| 5 | United States | 13.6 | Chile | 418 |
| 6 | Andorra | 12.9 | San Marino | 365 |
| 7 | Canada | 10.8 | Peru | 355 |
| 8 | Brazil | 10.8 | Singapore | 320 |
| 9 | Peru | 10.2 | Belarus | 301 |
| 10 | Italy | 9.4 | Holy See | 250 |
| | World-wide | 1.9 | World-wide | 37 |

| June 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | Chile | 23.9 | Qatar | 1,383 |
| 2 | Peru | 15.0 | French Guiana | 1,118 |
| 3 | Brazil | 14.0 | Chile | 948 |
| 4 | Mexico | 13.4 | Bahrain | 908 |
| 5 | Armenia | 10.0 | Oman | 561 |
| 6 | Sweden | 9.1 | Armenia | 549 |
| 7 | North Macedonia | 8.0 | Kuwait | 453 |
| 8 | United States | 7.1 | Panama | 444 |
| 9 | United Kingdom | 6.9 | Brazil | 414 |
| 10 | Ecuador | 6.6 | Peru | 398 |
| | World-wide | 1.8 | World-wide | 55 |

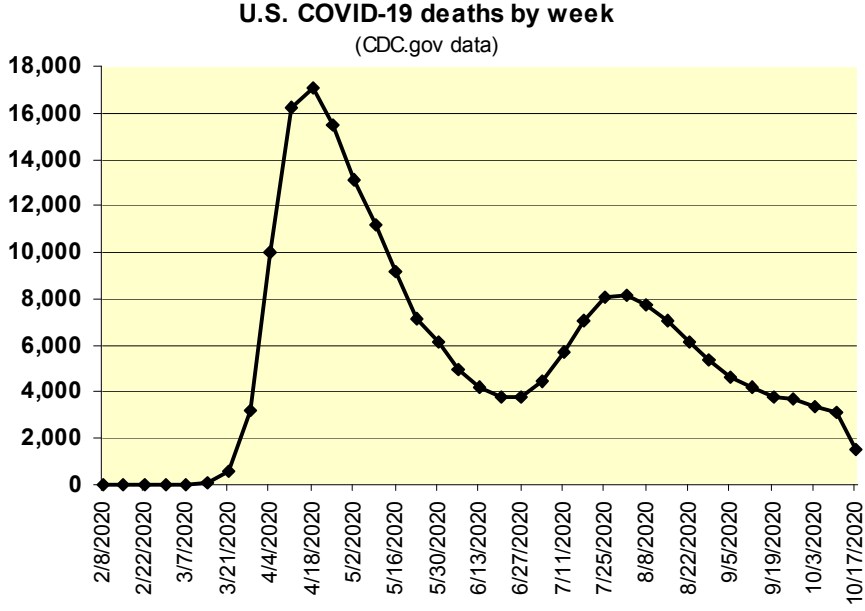
| July 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | Peru | 28.8 | French Guiana | 1,324 |
| 2 | Kyrgyzstan | 20.2 | Bahrain | 853 |
| 3 | Chile | 19.9 | Oman | 785 |
| 4 | Panama | 17.8 | Panama | 732 |
| 5 | Bolivia | 15.4 | South Africa | 570 |
| 6 | Brazil | 15.3 | Brazil | 568 |
| 7 | Mexico | 14.5 | United States | 559 |
| 8 | Colombia | 12.5 | Qatar | 533 |
| 9 | Armenia | 10.0 | Israel | 516 |
| 10 | French Guiana | 9.4 | Kuwait | 492 |
| | World-wide | 2.1 | World-wide | 90 |

| August 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | Peru | 29.7 | Aruba | 1,619 |
| 2 | Colombia | 18.9 | Turks & Caicos | 1,036 |
| 3 | Bolivia | 18.2 | Sint Maarten | 742 |
| 4 | Kosovo | 16.8 | Maldives | 730 |
| 5 | Mexico | 14.3 | Peru | 724 |
| 6 | Brazil | 14.3 | United States | 700 |
| 7 | Panama | 14.1 | Panama | 651 |
| 8 | Argentina | 11.3 | Colombia | 637 |
| 9 | South Africa | 10.5 | Bahrain | 636 |
| 10 | Chile | 9.8 | Brazil | 609 |
| | World-wide | 2.3 | World-wide | 104 |

| September 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | Ecuador | 27.0 | Aruba | 1,896 |
| 2 | Bolivia | 25.4 | Israel | 1,385 |
| 3 | Guam | 21.9 | Palestine | 1,138 |
| 4 | Argentina | 17.1 | Bahrain | 1,108 |
| 5 | Aruba | 15.9 | Andorra | 1,090 |
| 6 | Colombia | 12.9 | Montenegro | 1,057 |
| 7 | Bahamas | 12.2 | Guadeloupe | 952 |
| 8 | Saint Maarten | 11.7 | Argentina | 712 |
| 9 | Peru | 11.3 | Costa Rica | 668 |
| 10 | Montenegro | 11.1 | Guam | 654 |
| | World-wide | 2.1 | World-wide | 108 |

## III – U.S. weekly COVID-19 deaths

The following graph shows the weekly number of deaths in the U.S. Deaths peaked the week ending April 18, 2020, the same week they peaked worldwide.



# IV – Top 10 states with most deaths & cases per 100k population by month

In January and February 2020 COVID-19 confirmed cases and deaths were negligible in the U.S. The national confirmed case rate in both months was 0.0 per 100k people, and the national death rate was 0.0 per 100k people. They both began increasing in March.

From January to September 2020 four northeastern coastal states had by far the highest death rates. In contrast, eight states in the southern part of the U.S. were among the 10 states with the highest positive reported case rate.

| January-September 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | New Jersey | 181.5 | Louisiana | 3,567 |
| 2 | New York | 166.4 | Mississippi | 3,299 |
| 3 | Massachusetts | 137.1 | Florida | 3,281 |
| 4 | Connecticut | 125.4 | Alabama | 3,155 |
| 5 | Louisiana | 114.5 | Arizona | 3,002 |
| 6 | Rhode Island | 103.1 | South Carolina | 2,873 |
| 7 | Mississippi | 99.7 | North Dakota | 2,867 |
| 8 | Arizona | 77.6 | Georgia | 2,819 |
| 9 | Michigan | 70.1 | Iowa | 2,806 |
| 10 | Illinois | 68.4 | Tennessee | 2,784 |
| | U.S. | 62.8 | U.S. | 2,190 |

From March to June deaths the highest death rates were concentrated in states in the northern U.S. Beginning in July states in the southern U.S. began dominating with the highest death rates. The highest reported death rate for any state was New York in April with 110.9 per 100k population.

From March to May the highest positive reported case rates were concentrated in northern states. Beginning in June states in the southern U.S. began dominating with the highest case rates. The highest reported case rate for any state was Florida in July with 1,478 per 100k people, however, in July Florida only had the sixth highest death rate at 15.6 per 100k population.

| March 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | New York | 9.0 | New York | 383 |
| 2 | Louisiana | 5.0 | New Jersey | 169 |
| 3 | Washington | 2.9 | Louisiana | 112 |
| 4 | Michigan | 2.6 | Massachusetts | 91 |
| 5 | New Jersey | 2.3 | Connecticut | 86 |
| 6 | Connecticut | 1.9 | Michigan | 75 |
| 7 | Vermont | 1.3 | Washington | 69 |
| 8 | Massachusetts | 1.2 | Colorado | 49 |
| 9 | Colorado | 1.2 | Illinois | 47 |
| 10 | Georgia | 1.2 | Vermont | 45 |
| | U.S. | 1.2 | U.S. | 55 |

| April 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | New York | 110.9 | New York | 1,182 |
| 2 | New Jersey | 79.0 | New Jersey | 1,161 |
| 3 | Connecticut | 61.3 | Massachusetts | 805 |
| 4 | Massachusetts | 50.4 | Connecticut | 678 |
| 5 | Louisiana | 34.9 | Rhode Island | 672 |
| 6 | Michigan | 34.9 | Louisiana | 489 |
| 7 | Illinois | 17.8 | Delaware | 451 |
| 8 | Pennsylvania | 17.4 | Illinois | 367 |
| 9 | Maryland | 15.8 | Maryland | 332 |
| 10 | Delaware | 14.6 | Mississippi | 323 |
| | U.S. | 17.8 | U.S. | 267 |

| May 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | New Jersey | 50.3 | Illinois | 533 |
| 2 | Massachusetts | 47.6 | Rhode Island | 523 |
| 3 | Connecticut | 47.4 | Maryland | 512 |
| 4 | Rhode Island | 32.0 | Massachusetts | 506 |
| 5 | New York | 31.9 | Nebraska | 499 |
| 6 | Pennsylvania | 25.4 | Delaware | 487 |
| 7 | Illinois | 24.0 | New Jersey | 466 |
| 8 | Maryland | 23.1 | Connecticut | 413 |
| 9 | Delaware | 22.0 | Iowa | 392 |
| 10 | Louisiana | 17.7 | Minnesota | 348 |
| | U.S. | 12.6 | | 216 |

| June 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | New Jersey | 37.6 | Arizona | 812 |
| 2 | Massachusetts | 17.5 | South Carolina | 475 |
| 3 | Rhode Island | 17.3 | Florida | 448 |
| 4 | Delaware | 14.5 | Arkansas | 430 |
| 5 | Maryland | 13.1 | Alabama | 412 |
| 6 | Illinois | 12.1 | Utah | 406 |
| 7 | Mississippi | 11.4 | Mississippi | 395 |
| 8 | New York | 11.0 | Louisiana | 393 |
| 9 | Connecticut | 10.6 | North Carolina | 352 |
| 10 | Arizona | 9.9 | Texas | 330 |
| | U.S. | 7.0 | U.S. | 253 |

| July 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | Rhode Island | 29.5 | Florida | 1,478 |
| 2 | Arizona | 28.3 | Arizona | 1,303 |
| 3 | Mississippi | 18.5 | Louisiana | 1,251 |
| 4 | South Carolina | 17.7 | Mississippi | 1,058 |
| 5 | Louisiana | 15.6 | South Carolina | 1,014 |
| 6 | Florida | 15.6 | Alabama | 1,013 |
| 7 | Texas | 14.3 | Nevada | 981 |
| 8 | Alabama | 12.9 | Texas | 925 |
| 9 | Nevada | 10.5 | Georgia | 876 |
| 10 | New Jersey | 8.6 | Tennessee | 850 |
| | U.S. | 7.9 | U.S. | 573 |

| August 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | Mississippi | 28.5 | Mississippi | 813 |
| 2 | South Carolina | 20.9 | Alabama | 782 |
| 3 | Texas | 20.6 | Georgia | 779 |
| 4 | Louisiana | 20.5 | Florida | 711 |
| 5 | Florida | 20.2 | Tennessee | 707 |
| 6 | Arizona | 18.3 | North Dakota | 701 |
| 7 | Georgia | 17.2 | Nevada | 685 |
| 8 | Nevada | 15.3 | Louisiana | 682 |
| 9 | Alabama | 12.3 | Texas | 665 |
| 10 | Arkansas | 11.4 | Arkansas | 644 |
| | U.S. | 9.2 | U.S. | 438 |

| September 2020 | | | | |
|---|---|---|---|---|
| | **Deaths** | **Per 100k** | **Cases** | **Per 100k** |
| 1 | Arkansas | 19.0 | North Dakota | 1,317 |
| 2 | Mississippi | 16.6 | South Dakota | 1,004 |
| 3 | Florida | 14.5 | Wisconsin | 919 |
| 4 | North Dakota | 13.5 | Iowa | 756 |
| 5 | Georgia | 12.7 | Oklahoma | 721 |
| 6 | South Carolina | 12.7 | Arkansas | 711 |
| 7 | Louisiana | 11.5 | Missouri | 675 |
| 8 | Texas | 10.9 | Utah | 653 |
| 9 | Tennessee | 10.3 | Tennessee | 609 |
| 10 | Missouri | 9.7 | Kansas | 605 |
| | U.S. | 7.1 | U.S. | 363 |

# V – Top 10 states with fewest deaths & cases per 100k population by month

In January and February 2020 COVID-19 confirmed cases and deaths were negligible in the U.S. The national confirmed case rate in both months was 0.0 per 100k people, and the national death rate was 0.0 per 100k people. They both began increasing in March.

From January to September 2020 nine states in the northern part of the U.S. had the lowest cumulative death rates.

Likewise, nine northern states also had the lowest cumulative positive reported case rate. The only exception was Hawaii, which had the lowest death rate at 4.9 per 100k, and the 5th lowest case rate at 597 per 100k.

| January-September 2020 | | | | |
|---|---|---|---|---|
| | **Fewest Deaths** | **Per 100k** | **Fewest Cases** | **Per 100k** |
| 1 | Alaska | 7.7 | Vermont | 279 |
| 2 | Wyoming | 8.6 | Maine | 401 |
| 3 | Vermont | 9.3 | New Hampshire | 608 |
| 4 | Hawaii | 9.5 | Oregon | 794 |
| 5 | Maine | 10.5 | Hawaii | 874 |
| 6 | Oregon | 13.3 | West Virginia | 884 |
| 7 | Utah | 14.3 | Wyoming | 1,028 |
| 8 | Montana | 16.7 | Alaska | 1,069 |
| 9 | West Virginia | 19.5 | Washington | 1,145 |
| 10 | Kansas | 22.6 | Montana | 1,223 |
| | U.S. | 62.8 | U.S. | 2,190 |

The lowest death rates were concentrated in northern U.S. states from the beginning of the COVID-19 outbreak. The only southern state ranked in the lowest 10 death rates for a month was Texas in March when it was 9th, and April when it was 10th. Hawaii was ranked in the lowest 10 death rates for each month from March to July.

The lowest positive reported case rates were concentrated in northern U.S. states from the beginning of the COVID-19 outbreak. The only southern states ranked in the lowest 10 death rates for a month were Texas in March when it was 6th, and North Carolina which was 7th in March and 10th in April. Hawaii was ranked in the lowest 10 death rates for each month from March to June.

| March 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Fewest Deaths** | **Per 100k** | **Fewest Cases** | **Per 100k** |
| 1 | Wyoming | 0.0 | Nebraska | 8.6 |
| 2 | Rhode Island | 0.0 | West Virginia | 9.0 |
| 3 | West Virginia | 0.1 | Minnesota | 11.2 |
| 4 | Hawaii | 0.1 | South Dakota | 11.3 |
| 5 | North Carolina | 0.1 | Kentucky | 11.5 |
| 6 | South Dakota | 0.1 | Texas | 12.4 |
| 7 | Utah | 0.1 | North Carolina | 14.2 |
| 8 | Minnesota | 0.2 | Oklahoma | 14.3 |
| 9 | Texas | 0.2 | Virginia | 14.6 |
| 10 | Tennessee | 0.2 | Kansas | 14.7 |
| | U.S. | 1.2 | U.S. | 55 |

| April 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Fewest Deaths** | **Per 100k** | **Fewest Cases** | **Per 100k** |
| 1 | Alaska | 1.0 | Montana | 24 |
| 2 | Hawaii | 1.1 | Hawaii | 28 |
| 3 | Montana | 1.1 | Alaska | 30 |
| 4 | Wyoming | 1.2 | Oregon | 43 |
| 5 | Utah | 1.3 | Wyoming | 51 |
| 6 | South Dakota | 1.8 | West Virginia | 54 |
| 7 | Oregon | 2.0 | Maine | 61 |
| 8 | North Dakota | 2.1 | Oklahoma | 77 |
| 9 | West Virginia | 2.4 | Minnesota | 80 |
| 10 | Texas | 2.5 | North Carolina | 81 |
| | U.S. | 17.8 | U.S. | 267 |

| May 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Fewest Deaths** | **Per 100k** | **Fewest Cases** | **Per 100k** |
| 1 | Hawaii | 0.1 | Hawaii | 2 |
| 2 | Montana | 0.1 | Montana | 6 |
| 3 | Alaska | 0.1 | Alaska | 14 |
| 4 | Idaho | 1.1 | Vermont | 18 |
| 5 | Vermont | 1.1 | Oregon | 41 |
| 6 | Oregon | 1.2 | Idaho | 46 |
| 7 | Wyoming | 1.4 | West Virginia | 49 |
| 8 | West Virginia | 1.6 | Oklahoma | 71 |
| 9 | Utah | 1.9 | Wyoming | 84 |
| 10 | Tennessee | 2.4 | Maine | 91 |
| | U.S. | 12.6 | | 216 |

| June 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Fewest Deaths** | **Per 100k** | **Fewest Cases** | **Per 100k** |
| 1 | Hawaii | 0.1 | Hawaii | 18 |
| 2 | Vermont | 0.2 | Vermont | 36 |
| 3 | Alaska | 0.3 | Montana | 44 |
| 4 | Montana | 0.5 | West Virginia | 50 |
| 5 | Idaho | 0.6 | Alaska | 63 |
| 6 | Wyoming | 0.9 | Maine | 72 |
| 7 | West Virginia | 1.1 | New Hampshire | 84 |
| 8 | Maine | 1.2 | Wyoming | 101 |
| 9 | Oregon | 1.3 | Oregon | 105 |
| 10 | Oklahoma | 1.4 | Colorado | 110 |
| | U.S. | 7.0 | U.S. | 253 |

| July 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Fewest Deaths** | **Per 100k** | **Fewest Cases** | **Per 100k** |
| 1 | Vermont | 0.0 | Vermont | 33 |
| 2 | Hawaii | 0.5 | Maine | 46 |
| 3 | West Virginia | 0.6 | New Hampshire | 59 |
| 4 | Wyoming | 0.9 | Hawaii | 84 |
| 5 | Maine | 1.0 | Connecticut | 91 |
| 6 | Alaska | 1.1 | New York | 111 |
| 7 | Minnesota | 1.7 | New Jersey | 114 |
| 8 | Wisconsin | 1.9 | Massachusetts | 126 |
| 9 | Kansas | 1.9 | Rhode Island | 190 |
| 10 | Oregon | 1.9 | Maine | 199 |
| | U.S. | 7.9 | U.S. | 573 |

| August 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Fewest Deaths** | **Per 100k** | **Fewest Cases** | **Per 100k** |
| 1 | Vermont | 0.2 | Delaware | 10 |
| 2 | Maine | 0.7 | Vermont | 34 |
| 3 | Connecticut | 1.0 | Maine | 46 |
| 4 | New Hampshire | 1.3 | New Hampshire | 49 |
| 5 | New York | 1.4 | Connecticut | 90 |
| 6 | New Jersey | 1.6 | New York | 101 |
| 7 | Colorado | 1.9 | New Jersey | 119 |
| 8 | Alaska | 2.1 | Massachusetts | 140 |
| 9 | Wyoming | 2.1 | Pennsylvania | 172 |
| 10 | Delaware | 2.3 | Colorado | 184 |
| | U.S. | 9.2 | U.S. | 438 |

| September 2020 | | | | |
|---|---|---|---|---|
| **Rank** | **Fewest Deaths** | **Per 100k** | **Fewest Cases** | **Per 100k** |
| 1 | Vermont | 0.0 | Vermont | 21 |
| 2 | New Hampshire | 0.5 | Maine | 64 |
| 3 | Maine | 0.7 | New Hampshire | 74 |
| 4 | New York | 1.1 | New York | 123 |
| 5 | Connecticut | 1.2 | Connecticut | 130 |
| 6 | Utah | 1.7 | New Jersey | 150 |
| 7 | Colorado | 1.8 | Massachusetts | 152 |
| 8 | New Jersey | 2.0 | Oregon | 161 |
| 9 | Wyoming | 2.2 | Washington | 169 |
| 10 | Oregon | 2.4 | New Mexico | 192 |
| | U.S. | 7.1 | U.S. | 363 |

## VI – Top 10 U.S. counties with most deaths & positive tests by month

In February 2020 COVID-19 confirmed positive tests were minimal in the U.S. The national confirmed positive rate was 0.0 per 100k people. They began increasing in March. The county with the highest positive rate in the U.S. for each month illustrates this:

- March – Westchester County, New York has 967,506 people and it had 1,030 positives per 100k.
- April – Lincoln County, Arkansas has 13,024 people and it had 6,204 positives per 100k.
- May – Trousdale County, Tennessee has 7,816 people and it had 11,264 positives per 100k.
- June – Lee County, Arkansas has 8,985 people and it had 7,124 positives per 100k.
- July – La Salle County, Texas has 7,531 people and it had 4,561 positives per 100k.
- August – Lafayette County, Florida has 8,870 people and it had 13,085 positives per 100k.
- September– Woodward County, Oklahoma has 20,211 people and it had 4,968 positives per 100k.
- January to September – Lincoln County, Arkansas has 13,024 people and it had 15,548 positives per 100k.

A county with a relatively small population can show a high death rate per 100k because the death of a few people is statistically magnified. The county with the highest death rate in the U.S. for each month illustrates this:

- March – Toole County, Montana has 4,736 people and it had 3 deaths.
- April – Randolph County, Georgia has 6,778 people and it had 19 deaths.
- May – Hancock County, Georgia has 8,457 people and it had 22 deaths.
- June – Galax city, Virginia has 6,347 people and it had 13 deaths.
- July – Kenedy County, Texas has 404 people and it had 1 death.
- August – Knox County, Texas has 3,664 people and it had 8 deaths.
- September – Kenedy County, Texas has 404 people and it had 1 death.
- January to September – Hancock County, Georgia has 8,457 people and 496.6 deaths per 100k population.

| January-September 2020 | | | | |
|---|---|---|---|---|
| | **County** | **Deaths 100k** | **County** | **Positives 100k** |
| 1 | Hancock County, GA | 496.6 | Lincoln County, AR | 15,548 |
| 2 | Kenedy City, TX | 495.0 | Chattahoochee County, GA | 15,275 |
| 3 | Emporia city, VA | 486.3 | Trousdale County, TN | 14,844 |
| 4 | Galax city, VA | 472.7 | Lafayette County, FL | 14,640 |
| 5 | Randolph County, GA | 427.7 | Lake County, TN | 13,227 |
| 6 | East Feliciana Parish, LA | 376.3 | Lee County, AR | 12,024 |
| 7 | Terrell County, GA | 375.1 | Dakota County, NE | 11,185 |
| 8 | McKinley County, NM | 360.1 | Buena Vista County, IA | 10,214 |
| 9 | Neshoba County, MS | 357.2 | Chicot County, AR | 9,953 |
| 10 | Holmes County, MS | 352.7 | Nobles County, MN | 9,150 |
| 11 | Bronx County, NY | 349.2 | East Feliciana Parish, LA | 9,104 |
| 12 | Perkins County, NE | 345.8 | Wayne County, TN | 9,027 |
| 13 | Jenkins County, GA | 345.8 | Ford County, MS | 8,632 |
| 14 | Sharkey County, MS | 324.0 | Madison Parish, LA | 8,045 |
| 15 | Early County, GA | 323.8 | Issaquena County, MS | 7,988 |
| 16 | Queens County, NY | 321.8 | East Carroll Parish, LA | 7,987 |
| 17 | Brooks County, TX | 310.2 | Stewart County, GA | 7,899 |
| 18 | Clarke County, MS | 308.9 | Texas County, OK | 7,822 |
| 19 | Turner County, GA | 300.6 | Seward County, KS | 7,789 |
| 20 | Leflore County, MS | 291.0 | Colfax County, NE | 7,414 |
| | U.S Average | 62.8 | U.S. Average | 2,190 |

| March 2020 | | | | |
|---|---|---|---|---|
| | County | Deaths 100k | County | Positives 100k |
| 1 | Toole County, MT | 63.3 | Westchester County, NY | 1,030 |
| 2 | Oldham County, TX | 47.3 | Rockland County, NY | 879 |
| 3 | Baker County, GA | 32.9 | Blaine County, ID | 834 |
| 4 | Dougherty County, GA | 29.6 | Nassau County, NY | 630 |
| 5 | St. John the Baptist Parish, LA | 28.0 | Queens County, NY | 615 |
| 6 | Orleans Parish, LA | 25.9 | Bronx County, NY | 551 |
| 7 | Terrell County, GA | 23.4 | Dougherty County, GA | 530 |
| 8 | Lee County, GA | 23.3 | Richmond County, NY | 494 |
| 9 | Wilkinson County, MS | 23.2 | Orleans Parish, LA | 470 |
| 10 | St. James Parish, LA | 19.0 | Gunnison County, CO | 470 |

| April 2020 | | | | |
|---|---|---|---|---|
| | County | Deaths 100k | County | Positives 100k |
| 1 | Randolph County, GA | 280.3 | Lincoln County, AR | 6,204 |
| 2 | Bronx County, NY | 225.5 | Bledsoe County, TN | 3,930 |
| 3 | Queens County, NY | 206.6 | Nobles County, MN | 3,431 |
| 4 | Terrell County, GA | 199.3 | Marion County, OH | 3,361 |
| 5 | Kings County, NY | 194.0 | Dakota County, NE | 3,276 |
| 6 | Early County, GA | 186.5 | Cass County, IN | 3,086 |
| 7 | Essex County, NJ | 144.6 | Pickaway County, OH | 2,930 |
| 8 | Richmond County, NY | 137.1 | Rockland County, NY | 2,715 |
| 9 | St. John the Baptist Parish, LA | 133.1 | Louisa County, IA | 2,438 |
| 10 | Mitchell County, GA | 132.6 | Seward County, KS | 2,333 |

| May 2020 | | | | |
|---|---|---|---|---|
| | County | Deaths 100k | County | Positives 100k |
| 1 | Hancock County, GA | 260.1 | Trousdale County, TN | 11,264 |
| 2 | Northampton County, VA | 196.4 | Lake County, TN | 5,131 |
| 3 | Holmes County, MS | 135.2 | Colfax County, NE | 5,117 |
| 4 | McKinley County, NM | 127.5 | Dakota County, NE | 5,028 |
| 5 | Neshoba County, MS | 123.6 | Texas County, OK | 3,933 |
| 6 | Tama County, IA | 118.7 | Buena Vista County, IA | 3,823 |
| 7 | Tallapoosa County, AL | 116.4 | Nobles County, MN | 3,685 |
| 8 | Lowndes County, AL | 113.1 | Finney County, KS | 3,192 |
| 9 | Early County, GA | 107.9 | Ford County, KS | 3,162 |
| 10 | Carroll County, MS | 100.5 | Crawford County, IA | 2,949 |

| June 2020 | | | | |
|---|---|---|---|---|
| | County | Deaths 100k | County | Positives 100k |
| 1 | Galax city, VA | 204.8 | Lee County, AR | 7,124 |
| 2 | Emporia city, VA | 168.4 | Buena Vista County, IA | 4,796 |
| 3 | Crane County, TX | 125.1 | East Carroll Parish, LA | 4,256 |
| 4 | Gentry County, MO | 121.7 | Lake County, TN | 3,920 |
| 5 | Jenkins County, GA | 115.3 | Chattahoochee County, GA | 3,126 |
| 6 | Neshoba County, MS | 99.6 | Santa Cruz County, AZ | 3,099 |
| 7 | Hancock County, GA | 94.6 | Sevier County, AR | 2,881 |
| 8 | Claiborne County, MS | 89.0 | Buffalo County, SD | 2,752 |
| 9 | Randolph County, GA | 88.5 | Imperial County, CA | 2,543 |
| 10 | Parmer County, TX | 83.3 | Greensville County, VA | 2,523 |

| July 2020 | | | | |
|---|---|---|---|---|
| | County | Deaths 100k | County | Positives 100k |
| 1 | Kenedy County, TX | 247.5 | La Salle County, TX | 4,561 |
| 2 | Phillips County, KS | 152.8 | Madison County, TX | 4,306 |
| 3 | Jenkins County, GA | 126.8 | Crockett County, TX | 4,157 |
| 4 | Bamberg County, SC | 106.6 | Chicot County, AR | 3,677 |
| 5 | Buffalo County, SD | 101.9 | Perry County, AL | 3,418 |
| 6 | Walthall County, MS | 98.0 | Columbia County, FL | 3,054 |
| 7 | Galax City, VA | 94.5 | Miami-Dade County, FL | 3,005 |
| 8 | Culberson County, TX | 92.1 | Hot Spring County, AR | 2,991 |
| 9 | San Juan County, UT | 91.5 | Victoria County, TX | 2,957 |
| 10 | Pipestone County, MN | 87.7 | Allen Parish, LA | 2,856 |

| August 2020 | | | | |
|---|---|---|---|---|
| | County | Deaths 100k | County | Positives 100k |
| 1 | Knox County, TX | 218.3 | Lafayette County, FL | 13,085 |
| 2 | Brooks County, TX | 211.5 | Wayne County, TN | 6,436 |
| 3 | Perkins County, NE | 207.5 | Issaquena County, MS | 5,803 |
| 4 | Crenshaw County, AL | 167.0 | Chattahoochee County, GA | 5,116 |
| 5 | Sharkey County, MS | 162.0 | Chicot County, AR | 4,507 |
| 6 | Newton County, AR | 154.8 | Taylor County, FL | 4,034 |
| 7 | Issaquena County, MS | 150.7 | Franklin County, FL | 3,596 |
| 8 | Real County, TX | 144.8 | Gulf County, FL | 3,578 |
| 9 | Refugio County, TX | 143.9 | Bee County, FL | 3,399 |
| 10 | Montgomery County, MS | 143.2 | Lincoln County, AR | 3,371 |

| September 2020 | | | | |
|---|---|---|---|---|
| | **County** | **Deaths 100k** | **County** | **Positives 100k** |
| 1 | Kenedy County, TX | 247.5 | Woodward County, OK | 4,968 |
| 2 | Ness County, KS | 218.2 | Emmons County, ND | 4,906 |
| 3 | Rosebud County, MT | 190.2 | Chattahoochee County, GA | 4,713 |
| 4 | Emporia city, VA | 187.1 | Rosebud County, MT | 4,252 |
| 5 | Hooker County, NE | 146.6 | East Feliciana Parish, LA | 3,397 |
| 6 | East Feliciana Parish, LA | 141.1 | Pawnee County, KS | 3,336 |
| 7 | Sharkey County, MS | 138.9 | Lincoln County, AR | 3,232 |
| 8 | Pulaski County, GA | 134.7 | Roosevelt County, MT | 3,199 |
| 9 | McMullen County, TX | 134.6 | Logan County, ND | 3,135 |
| 10 | Eddy County, ND | 131.2 | Stark County, ND | 3,103 |

# 28. Lawsuit Alleges Ohio Took Advantage Of Overblowing COVID-19

A lawsuit filed in the U.S. District Court for the Western Division for the Northern District of Ohio in Toledo on August 31, 2020, alleged the constitutional rights of the seven defendants were being violated by COVID-19 related policies by the State of Ohio, Governor Michael DeWine, and State Health Director Lance Himes.[1036].The lawsuit *Renz v. Ohio* states in part:

"5. In recent months, entire states have been imprisoned without due process and with the clear threat to impose such lockdowns again, interstate travel has been severely restricted, privacy rights have been devastated, numerous business takings without compensation, and many regulations being implemented without statutory process requirements under the guise of a health emergency that is roughly as dangerous as a seasonal influenza outbreak.

7. Underlying all of this, and the foundation of this case is this question: if an emergency can be declared without the appropriate level of review based on the rights being limited, and under the guise of that emergency all rights are only subject to a rational basis review, how then do any previous judicial opinions or Constitutional principles have any meaning whatsoever? …

**Motions, Prayer for Relief, and Request for Trial by Jury:**

8. (1.) Grant a preliminary injunction against all current state actions and orders in Ohio issued under the COVID-19 Emergency Declaration and against the declaration itself until this case has been decided by the court. …

8. (2.) Grant a permanent injunction upon completion of this case against actions taken and orders under the guise of a public health emergency for an extended period without enabling action from the legislature in each event.

**Facts**

13. … It is indisputable that COVID-19 is roughly as dangerous as the seasonal flu (see below), less dangerous than many other infectious diseases that we have not taken such drastic steps to stop, and also that the reaction to COVID-19 is the definition of arbitrary and capricious. …

14. Injury occurred through the issuance of various orders and also promulgated under the emergency declaration …

**What Happened to the Curve?**

15. When COVID-19 first struck in the USA there was a tremendous amount of discussion related to flattening the curve. We were told that there was a very real danger that our healthcare system would be overrun, and people

could be dying in the streets. Because of this unprecedented danger, we were told that an emergency would be declared so that we could flatten the curve and that once it was flattened we could begin moving towards normalization.
16. The curve was a reference to the CDC's graph (model) that predicted a tremendous surge in the need for hospitalization around the country due to COVID-19. To deal with this potential crisis both the State of Ohio, other states around the country, and the federal government declared emergencies to allow for the bypass of laws and procedures that would have slowed their ability to create a mechanism to deal with this upcoming crisis. …
17. *Despite the substantial political noise made, the dreaded curve never happened*. The emergency supplies or hospitals were simply not needed and, to our knowledge, all of them have since been dismantled.
18. Another critical point to make regarding the curve is the fact that it was clearly stated, multiple times, while making the case for the emergency declaration that COVID-19 could not be stopped. … if the curve has been flattened enough to take down temporary hospitals and we have no alternative but to live with it, then why is there still a need for an emergency? …

**Deaths**

19. The reporting of deaths related to COVID-19 is so incredibly misleading that … At the time of this writing it is being claimed that there have been over 150,000 COVID-19 deaths in the United States. … the number of deaths primarily caused from COVID-19 is likely less than 50,000 and has been estimated in scientific studies to be closer to 20,000.
20. … the 150,000 number could be an accurate number of the people in the United States that have died *with* COVID-19 but instead has been presented as the number of people that have died *from* COVID-19.
21. During the early stages of dealing with the COVID-19 "crisis" the CDC changed the rules for counting deaths. … the changes allowed for unconfirmed cases of COVID-19 to be included in the death count contrary to … how every other disease death has been counted in the USA since 2003.
22. It is also critical to note the financial incentive to include deaths as COVID-19 deaths. In Ohio, according to Becker's Hospital Review, hospitals are being reimbursed an additional $180,000 per COVID-19 case and a death from COVID-19 requires no lab test but does qualify as a case.
23. All of this has led to absurd results with the entire count being thrown further off by epicenters for the disease, such as New York, putting the sick in nursing homes with others that are most at risk. … What we can say is that the death counts related to COVID-19 are misleading at best.
25. Excess deaths are calculated based on an estimate of how many people are expected to die during any given time period. …

26. We have demonstrated that the number of deaths from COVID-19 is nowhere near the number presented by the CDC, so how can we be experiencing so many excess deaths if they are not coming from COVID-19? The answer is frankly beyond disturbing and is answered in the next section.

**The Impact of Our Reaction to COVID-19**

27. The answer to the excess deaths question is the same as the answer to why is this case so critical. In both instances the answer is that the damage being done by the response to COVID- 19, whether to our rights, or the welfare of the general public, is beyond count. … … *the true danger to Ohioans and the American public stems not from COVID-19, but from the public health nightmare caused by the response to it*:

1. Impact on Hospitals & Patient Care

a. Loss of revenue due to the shutdown has closed a number of healthcare facilities and/or caused a number of hospital systems to consider further closures. …

b. Substantial evidence that patients are avoiding treatments that could prevent more severe conditions is accumulating. This has and will result in excess deaths because people fear getting the treatment they need.

c. As the lockdown has continued we are now seeing a surge in non-COVID patients and deaths (as would be expected given Points A and B). There were also reports of suicide hotlines seeing calls increase as much as 600% after the lockdown and one article references 600 physicians calling the lockdown a "mass casualty event".

2. Impact on Health

a. Lower levels of physical and mental health as well as weaker immune systems and other issues due to the lockdown and social distancing.

b. Substantial negative impacts on the wellbeing of mothers and children due to reductions in routine health services. It is estimated that the result will be a substantial increase in the number of maternal and child deaths.

c. Mask mouth (referring to dental problems resulting from wearing a mask) has the potential to be very dangerous. Some dentists are already reporting issues in as high as 50% of their patients.

d. Mental health is seeing a tremendous decline with depression, anxiety, and other impacts. Many of these seem to be particularly serious in children.

3. Impact on Substance Abuse, Violence, & Deaths of Despair

a. There has been a substantial spike in domestic violence.

b. Drug and alcohol usage has spiked and overdose deaths have surged to record levels. Addiction will increase resulting creating a long-term impact.

c. Suicide rates have increased dramatically – particularly in younger people.

d. Even motor vehicle fatalities have spiked by 23.5% in May due to reductions in enforcement and the assumption that empty roads mean there is no need to follow a speed limit.

e. One study estimated that there will be 75,000 additional "deaths of despair" due to the response to COVID-19.

4. Impacts on Human Trafficking

a. There was an estimated 40% increase in human trafficking during the statewide house arrest orders …

b. This has likely occurred because an estimated 75% of humanitarian operations worldwide stopped due to the COVID-19 response.

5. Impacts on Children

a. The economic impact on many families is likely to result in malnutrition for children.

b. In families that are food secure, many other children will be at risk for obesity as they are isolated and given fewer options for activity.

c. One study estimated that if actions continue there could be an additional 1.2 million child deaths and 56,700 maternal deaths around the world.

6. Impacts on the Economy

a. The economic shock brought on by the reaction to COVID-19 is greater than the 2008-2009 meltdown and likely more similar to the Great Depression.

b. Over 45 million Americans filed jobless claims as a result of the COVID-19 reaction.

c. Housing insecurity is at a crisis level …

7. Policies Related to Nursing Homes

a. More than 40% of US COVID-19 cases have been linked to nursing homes.

b. Nursing homes house the highest-risk population in regard to COVID-19

28. In short, *the plaintiffs do not doubt that there are substantial numbers of excess deaths occurring in the United States and in Ohio; in fact, we submit that the number will continue to increase. These increases, however, are not due to COVID-19* …

29. … *the fact that the policy is causing greater harm than the disease*, which again is roughly as dangerous as the seasonal flu, *clearly demonstrates that the policy is arbitrary and capricious*. The State simply cannot claim it is declaring an emergency to save life and then take actions to harm it. …

**Testing and Cases**

30. … According to CDC guidance … if a person has a cough whether they die or not, and that person lives in any of a majority of the cities in the

United States … then they can be counted as a COVID-19 case.
32. At this point, over 100 companies are manufacturing COVID-19 tests with approval from the FDA under emergency authorization. … This basically means that what qualifies as a case of COVID-19 in a test from one manufacturer may not qualify as a case in a test from another.
33. There are two main approaches to testing, a Poymerase Chain Reaction ("PCR") test and an antibody test. The antibody test can determine if a person has been infected but not whether they are infected … Further, the antibody testing can mistake antibodies from diseases such as the common cold for COVID-19 and so their accuracy is poor at best.
34. … PCR testing cannot detect how much of a virus exists in a person. Exposure of the existence of incomplete traces of a virus do not mean a person is infected with a disease which is part of the reason the PCR tests have an elevated rate of false positives.
37. When the Emergency was declared we heard a daily drumbeat about the danger and deaths related to COVID-19. Now that the case fatality rate has been shown to be roughly the same as the yearly flu those numbers are simply not scary to the public. As a result, *the State sees no impact from talking about fatalities and has instead begun testing more so they could tell us there are more cases*.

**Manipulation – the Psychological Approach to State/National Public Manipulation**

39. The idea of *using fear to manipulate the public is not new and is quite commonly used in public heal*th. …:

> "… behavior change can result by increasing people's perceived severity and perceived susceptibility of a health issue through heightened risk appraisal coupled by raising their self-efficacy and response-efficacy about a behavioral solution. In this model, *fear is used as the trigger to increase perceived susceptibility and severity*."

40. It is interesting to note that this article was specifically published to make the point that the use/continued use of fear appeals in response to COVID-19 was against the recommendation of the authors. The reason for the article stems from the well-known fact that fear based appeals are being used to manipulate the public …
41. It is difficult to argue that the State of Ohio is not intentionally manipulating the public.

**Masks**

42. The mask mandates that have been issued are the 21st century equivalent to the Tea Act that was a substantial factor in the Boston Tea Party. The main difference between the mask mandate and the Tea Act is that where the Tea Act raised money for a war the colonists were not involved in, the mask

mandate serves no purpose whatsoever and, in fact, creates a number of issues.

43. Attachment B discusses all that is wrong with the mask mandate in detail but an overview follows:

(1) The US Surgeon General, Dr. Fauci and many others have stated the public should not wear a mask in no uncertain terms.

(2) Healthy individuals cannot spread the disease.

(3) Facemasks do not stop the spread of COVID-19 making this a true case study in the arbitrary and capriciousness of this entire debacle.

(4) *The reason facemasks do not work is simple – the disease particles are smaller than the holes in the weave of facemasks so they simply pass through*.

(5) Even N95 respirators do not provide protection against COVID-19 or similar diseases.

(6) Surgical masks also provide little to no protection from COVID-19 …

(7) Cloth masks do almost nothing to prevent the spread of COVID-19.

(8) Wearing a mask can create result in dangerously low oxygen levels for people putting them at risk.

(9) The CO2 (Carbon Dioxide) levels caused by masks can actually lead to cognitive impairment.

(10) There are substantial psychological impacts to wearing masks that may have a particularly negative impact on children.

44. The collective data leaves us with an inexorable conclusion – there is no benefit to the use of a mask in protecting against COVID-19 …

**How Dangerous is COVID-19 Really?**

45 Given the above facts the natural reaction is to ask how dangerous COVID-19 really is. … The table below shows both the Case Fatality Rate ("CFR") and the Reproduction Rate of a number of well-known diseases.

46. …COVID-19 has a CFR of 0.26%. … The Spanish Flu, which COVID-19 is regularly compared to, had roughly nine times the CFR and was more contagious than the median reproduction rate from either Ohio or globally.

47. If we view the danger posed by this disease in terms of its potential to kill people infected with it and in

| Disease | Case Fatality Rate | Reproduction Rate |
|---|---|---|
| COVID-19 (Current) | 0.26% | 0.87% (Ohio)<br>0.7–1.9 (Global) |
| MERS (2012) | 34.3% | 2-5 |
| SARS-CoV (2002) | 9.6% | 2-5 |
| 2017-2018 Seasonal Flu | 0.14% | 1.53 |
| Ebola (2014) | 25% | 1.51 |
| 1957-1960 Flu Pandemic | 0.28% | 1.65 |
| 1918-1920 Flu Pandemic (Spanish Flu) | 2.25% | 1.8 |
| Tuberculosis | 12.3% | 0.24-4.3 |

conjunction with its level of contagiousness, then the answer to the question "how dangerous is COVID-19" is roughly the same as the yearly flu.

**A Final Summary of Facts**

49. The bottom line is this, there is no emergency.

50. The curve was never real … This is clearly demonstrated by the fact that the temporary facilities were never used and subsequently dismantled.

55. So minimal is this disease that the governor, ODH, CDC, and other such organizations had to use psychology, specifically motivational theory, to scare people into action. This is because *no rational person would do what the public health cabal would ask them to do if the true facts were shared*.

64. … While the Plaintiffs do not suppose to be in a position to prosecute such fraud *the facts seem to suggest that the State of Ohio and many others would have known that this disease is far less dangerous than it has been shown to be and that it knowingly concealed and covered up relevant data*.

**Law**

65. … we are asking the Court to grant our various prayers for relief and order the State to start over and reevaluate whether any emergency order is justified and, if so, to only issue orders that comply with the law.

**Conclusion**

121. *The emergency declaration and subsequent actions taken by the State of Ohio are not and have never had even a rational basis*. …

122. The evidence submitted and this complaint demonstrate, on their face, that the State's actions are based on false and misleading data and are wholly unconstitutional. …

124. We implore the Court to exercise its role as a coequal branch of the government and fulfill its duty to clarify the indisputable fact that the actions taken by the State of Ohio are unconstitutional. We humbly ask the Court to order that the emergency declaration and all actions taken subsequent to it in Ohio be declared void and order that no further actions against the rights of the people of Ohio be taken in violation of the letter and spirit of the Constitution.

# 29. Innocent People Arrested Worldwide For Social Distancing Violations

A consequence of shutdowns and social distancing requirements imposed by governments around the world is people going about their daily life being arrested for allegedly violating a rule. Individuals are arrested on beaches, walking on the street, in stores, and even in church. Large numbers of people are arrested at public gatherings – including rallies opposing shutdowns and social distancing rules. The following are a sampling of hundreds of news stories about these arrests:

● Police in Scotland have broken-up hundreds of house parties every week since they were granted new powers on August 28, 2020 to enforce social distancing rules. As of October 28 they had issued more than 420 fines and made 83 arrests.[1037]

● Five people were arrested during an anti-social distancing/vaccination rally in London on October 10, 2020. People not wearing masks were carrying signs that included: "I will not vaccinate"; "Freedom of speech is our right"; "Covid-19 is a hoax"; and "Curfews equal Nazification."[1038]

● Twelve citations were issued and four people arrested in Tuscaloosa, Alabama in mid-August after police were called because people going to bars in the city's Strip and downtown were not wearing masks or social distancing.[1039]

● A husband and wife were arrested in Tallahassee, Florida in July 2020 after a neighbor recorded him on her cellphone walking his dog. The man had been directed to quarantine and remain in his house after he tested positive for COVID-19.[1040]

● Hundreds of people have been arrested in Hawaii for violating the state's 14-day quarantine rule for people arriving on the islands – that applies whether a person tests negative or positive for COVID-19. A person is subject to a maximum of one year in jail and a $5,000 fine. A few examples follow. In July, 21 travelers were arrested on Oahu for breaking quarantine.[1041] Fourteen people were arrested on Kaua'i just between Oct. 15 and 24 – for violating quarantine.[1042] On Maui, 14 people were arrested from June 20 to August 19 for violating quarantine, with most released after posting $4,000 bail.[1043]

● Police in Melbourne, Australia fined 160 people and arrested seven people participating in a "Freedom Day" anti-lockdown rally on September 6, who were not wearing masks or social distancing.[1044]

● Eleven people arrested in Dublin, Ireland in October were participating

with hundreds of others in a protest opposing lockdown restrictions. The police ordered the large crowd of maskless people to disperse because they were "in breach of public health regulations."[1045]

● A woman in Perth, Australia was jailed for six months for violating a 14-day quarantine at a hotel, after returning from Victoria where she had been caring for a sick sister. The woman – who tested negative – instead self-quarantined at her partner's home, where she was arrested.[1046]

● Police in Puerto Escondido, Mexico arrested 233 people for not wearing a mask in the five days from October 16 to 21. People charged with not wearing a mask have three choices: six hours in jail; perform three hours community service; or pay a fine of 150 pesos (US $7.12).[1047]

● In the African country of Cameroon hundreds of people were arrested for not wearing a face mask in public and fined US$9. The police also impounded the motorcycle or vehicle operated by someone not wearing a mask.[1048]

● Police in Malaysia arrested 688 people in October for violating social distancing or inter-country traveling restrictions.[1049]

● In Orleans, France a police officer stomped on the head of a British man as he was being arrested at a train station for "not wearing a face mask" on September 15.[1050]

● In Turkey a woman was manhandled to the ground during her arrest for not wearing a face mask in early October.[1051]

However, some law enforcement officials refuse to enforce shutdown and/or social distancing requirements:

> "Don't be a sheep" was the message of Lewis County, Washington Sheriff Robert Snaza to a crowd of people after Washington Governor Jay Inslee announced a statewide mask wearing mandate.[1052] Snaza was wearing his uniform, but was without a mask as he used a megaphone to tell the crowd "In case you guys didn't hear, Gov. Inslee in his infinite wisdom has decided after over a hundred and some odd days that we should all wear face masks — inside and out."[1053] Snaza said Sheriff's deputies would focus on educating the public rather than issuing citations for not wearing a mask in a public place.

The common denominator of these cases is every person was arrested without even being accused of committing a crime against any person, property or disturbing public order –they simply weren't wearing a mask. In addition, mandatory mask wearing is by executive decree, not by the vote of a legislative body making it a crime or public offense. So executive officers are exercising what can accurately be described as dictatorial power – usually under the guise of a 'public health emergency'.

# 30. Insightful Observations About Coronavirus Mania

Fred Woodworth has written his insightful observations about current events and the evolvement of American society for more than fifty years in *The Match*, which he founded in 1969. It may be the oldest self-produced publication in the United States. Woodworth's 'From the Editor' column in the Spring 2020 issue –written in mid-March 2020 before most states shutdown – was largely devoted to his thoughts about COVID-19. Woodworth gave his permission for his column to be published.

## From the Editor

When governments act, fear more their acts than whatever it is they're acting against.

Beyond a doubt, they're going to be acting against YOU.

Readers, I'd often pondered the old engraving which I've now placed on the cover of this issue of *The Match*. I had a mental title for it: "Smoke and Mirrors", and again and again I resolved to use it (always Next Time); but for some reason, early this February, it seemed to me that that time was here. It said to me that everywhere I turned, gravely accepted Truths were bogus.

Then the current hysteria hit.

I would characterize it as the Coronavirus hysteria; but to do that is to okay the rigged house-game where the odds are tilted from the very instant when you start to play. Disease is all around us—all the time. Have you ever had a cold? The flu? Well, every time you did, it was a different one. You never had the same one twice, because each time it popped up, the affecting virus was a newly mutated version, not the one from last time which you were now immune to. They were, and are, all versions of fairly familiar respiratory afflictions which everybody knows what to do about: take it easy, drink lots of liquids, take vitamin-C or glug orange juice, and respect other people by staying out of their way so you won't give it to them.

Not this time, though. THIS time, government sprang to attention and started posturing and talking tough. Politicians and "authorities" began outdoing each other with calls for national emergencies and martial law. Doctors and hospitals eagerly chimed in, effectively pushing a dangerous new medical dictatorship which, if you've had the right experiences with these people, rings really hollow.

You easily could have died—and many people DID die—of those previous influenzas and even colds. Almost everyone has sometime had one

of those colds that went on and on, and after a while turned into bronchitis (that is, a cold affecting the bronchial tubes between the lungs and the throat), or a "chest cold", which is to say, essentially, a not-too-bad form of pneumonia. And at any time, it COULD have become the bad form, in which case you might have died, as many always have and always will.

But this time, government stepped in. With combat boots on. We had to destroy the village in order to save it— remember that old quote from Viet Nam?

The old engraving speaks to this bizarre syndrome and scene: An operator stands behind a curtain. He has some primitive apparatus in hand, and is projecting an image on a screen. On the other side of the screen there appears a gruesome spectre, leering with menace and deathly hand poised to blot out life. Shuddering and drawing back in horror, the unsophisticated onlookers, never having seen anything so horrible before, just cringe and gasp. From our own vantage point the terror is absurd; but you'd probably have a very hard time trying to convince THAT audience that they ought to sit back and smile.

This slideshow has been presented many times. Remember Reefer Madness? Crazy jazz musicians and other "negroes" "hopped up" on "dope"? Remember the fried egg in the skillet and "your brain on drugs"? Remember how every Japanese was an agent for Hirohito and needed to be brought in for house-arrest in a government project? Well, probably a handful of those Japanese Americans really WERE spies or even saboteurs; but hardly any. Probably somebody, somewhere, really thought he could fly, and stepped off the top of a building after smoking dope, grass, or godknowswhat. But not very many. Probably some jazz musician went nuts and stabbed somebody. But look what happened when these rumors and inculcated false beliefs turned into policies that then lasted for many decades.

OKAY: What's the deal with this drastic, vicious, planet-ranging new disease? Well, it probably did really originate—naturally—in China. Why? Because China is drastically overpopulated and people are crowded together in often-ghastly conditions. Millions of them are made to work in factories for brutally long hours with inadequate rest and substandard food. They're pushed and driven and have to breathe in incredibly toxic chemicals at the behest of a merciless Communist government that lacks the faintest concern for human rights. Under such conditions it would hardly be surprising if some advantage-seeking micro-microorganism would find a nice moist spot someplace in a nose or lung, and adapt its new self from an old guise.

Or then it could be—and I give this possibility only about a 10% likelihood, but I still have to mention it—that mercilessly murderous government COULD have been fooling around with viruses intentionally, in

the hope of finding something that would devastate the rest of the world. The government I speak of has gone on record as stating that it intended to conquer the entire planet by 2025, so with goals as hideous and megalomaniac as that it's certainly not impossible that they would have, or could have, engineered something that then escaped from the labs. But I favor the crowded unsanitary overpopulation model. …

But however it got started, the new flu soon came out of China, just the same way all the previous Chinese junk did—the formaldehyde-oozing drywall, the chemical-laced dogfood, the toxic baby formula, the lead-saturated toys, and a lot of other stuff that, while not exactly poisonous, was a consumer ripoff that didn't work or wore out in no-time. Buy a cordless drill or a scroll saw at Harbor Freight; look for the Made In China little label; then hit the button on your stopwatch. It won't be long before you're in the market for a new Whatsit—one that works.

Whether it arose through natural incompetent negligence and opportunism, or outright malevolence, the new disease triggered a bunch of "cures" that hold a very real threat of making life literally unlivable.

Cities and whole countries are being put under "lockdown"—a chillingly matter-of-fact prison term for real arrest and confinement and INDEFINITE-term detention. Frightening new phrases, seemingly worked up in well-funded Gray-Flannel-Suit "think tanks" are emerging daily with the glad connivance of the media: "Social Distancing" (goal: solitary confinement); "Shelter In Place" (go outside and the police will shoot you). Notice too that the smiling recent slogan of the "Census" is "Invitation"; you're INVITED to participate (translation: they ORDER you to hand over your info).

SO NOW the very possibility of an entire planet-wide civilization-collapse (in the worst sense because the structures of authority will NOT collapse even while everything else does) has arisen out of a misguided or outright contrivedly fraudulent aggrandizement mania of institutions and Great Leaders to STOP this latest in a long line of non-threatening to world culture, respiratory inconveniences or (rarely) fatal ailments.

What this insanity is going to mean:

Sources of livelihood for millions of persons, wiped out by fiat, leaving them with no way to live other than through doubtful charity, or crime. Remember the "government shutdown"? Here, breathless media reports featured employees of the Justice Department or PRISON industry who were "living paycheck to paycheck" and expressing great gratitude for free coffee at Buttfucks. Now, instead of hearing about these supported-via-taxation parasites, there are the unmentioned hordes of struggling workers in small businesses, now thrown into dire desperation when the cafe they work in or the movie theater or the thrift store closes down. Libraries are being ordered

closed, so the homeless people (and their numbers will soon burgeon) who have no other bathrooms to use will start taking a shit in the streets and alleys. This is a prescription for knocking out disease?

Drugs, prostitution, burglary, murder and looting will occur to the desperate as solutions to the gnawings of hunger and the fear and panic at having no place to sleep. Of course anonymous denunciations—that old reliable way of getting back at someone who has offered one a slight or an insult—will pour in to hotlines and cops will show up at the house where "that woman who coughs a lot" lives. Now police will be an even more elite Elite, with more than their usual powers of life-or-death since even BEING OUTSIDE is daily ramping up as a "crime". (When streets are empty—except of cop cars, of course—I think it would be insanely optimistic not to expect police to see themselves as even more godlike patrollers cruising about freely throughout an empty civilization where people resisting or without "papers" may be shot on sight. Or beaten, or arrested and immersed in an aptly-named jail "tank" where if "corona" isn't present, something just like it will be.)

Naturally, the POLICE will miraculously be immune, not only to the disease but to even the suggestion that they might NOT be immune. The cop-beloved further growth of records and permits and "fines" and prison time will linger long after corona itself subsides—if it ever does. (And why would it? The flu, pneumonia, and the common cold haven't; why would IT? People still die of tuberculosis.)

…

BUT you won't hear about any of these worse than corona side-effects of sentencing millions of people to house-arrest. The cheerleading/reassuring role of the media is right now, at least, going full blast. This morning a report from Italy, where people can only go outside their homes on specifically-approved errands while carrying a "paper' explicitly stating what that errand is, found (probably after considerable searching) some toothless Italian idiot who gloated that he was wearing either a lapel pin or a T-shirt, I couldn't tell which, that read: Resto In Casa—I stay at home. How proud he was. How proud and cheerful the reporter. How liltingly upbeat the announcer handing off to the on-site reporter! Can it be possible that there was NO person seething with rage at this intolerable commitment to what must be, in many cases, solitary confinement for an undefined period??

You WILL NOT hear of objections or domestic resistance except possibly in cases of very explicitly disgusting people's obviously slurred, mispronounced or obviously crazy overreactions and laughably false information.

...

The newspapers and broadcast media have clearly received orders about what to air, and it is relentlessly positive stuff about the draconian overreaction, and relentlessly negative stuff about the terrible, godawful horrific disease that has 'infected thousands around the world". (World population: over nine BILLION.)

Why wouldn't there be "thousands" of deaths from practically any cause you'd care to name, in a place where there are NINE BILLION inhabitants?

Of course, people right now are particularly accustomed to what once would have been almost unbelievable lapses of objectivity. It's now Standard Operating Procedure for news outlets to paint people blatantly as buffoons or criminals for no other reason than their having had a disagreement about policy with the reporter or paper on the spot.

CONTROL always has a HIGHER PURPOSE. That purpose outweighs any other consideration whatsoever. Ancient principles such as Habeas Corpus now don't apply; if cops war.: to seize you and toss you into a "tank" to "protect" you because you refused to conform to "social distancing"—and thereby crowd you in with no sanitation, food or legal redress, it's because SOCIETY has to be MADE SAFE. Not you—it's never YOU; it's `SOCIETY". If you need to be taken forcibly and subjected to outrages beyond number and stuck in a uniform and made to have your arms, legs, eyes, genitals, or whole body blown off in some country so distant that it couldn't possibly affect you even if tried, which it isn't, that's, as usual, okay.

This disease hysteria is as bad as the Black Plague madness of the Middle Ages—without the backup numbers. Every year 220,000 people in the United States die of sepsis, in hospitals, quietly, without politicians running back and forth screeching and laying about with the huge government axe, smashing livelihoods. Compare this orgy of destructiveness to the dire and awful consequences that are supposed to ensue any time someone suggests abolishing even one of the bloated government offices or agencies. But forcibly smashing hundreds of thousands of small businesses which are the only means of support of millions of ordinary working people, is just an inconvenient necessity. … How many suicides will there be? Is all this massacring of life serving a real net gain?

In France people had been ordered to stay home, and when they refused (the only positive sign I've seen in any of this insanity) the dictator of the country, having been sent photos of the populace enjoying sunny days in parks, became enraged and ordered even more incredible confinements, stating that persons who refused to stay indoors would be "arrested and punished". Who can doubt that somewhere soon there could be a new Stonewall incident, this time being one in which people refuse to "live on

their knees" and decide to die on their feet; they open up a cafe anyhow, and when the massive state force shows up surge out on the attack. They are then relentlessly gunned down by cops using live ammunition. That'll teach 'em not to let us save 'em. I look for this to happen. Soon. If it doesn't, the human race has lost its (yes) manhood.

Is mere "life"—existence—more important than quality of life.? "Give me liberty or give me death!" Is that forgotten?

Confined at home, what will people DO? They don't read anymore; most of them don't even have any books. So this is just the further push toward online "life" that was not needed just now. Hackers at home: How much damage will THEY be able to do? (A lot, I hope.)

There are of course millions of persons in this country alone who not only do not have computers, but have never used them at all.

Some who don't actually have computers use public libraries for internet access. For the "authorities" to unilaterally redefine life as "getting used to your kitchen and living room" and: overlook that whole communities' style of living is to mingle and interact directly with other human beings, is an outrageous yet not publicly addressed tyrannical act.

How insidious this is can be seen in the fact that warnings and predictions of even a permanent "lockdown" can and will be dismissed as "crazy paranoia", while a gargantuan effort to convince millions that every other human being is a grave danger who should be kept ten feet away at all times, is "reasonable".

Even if you disagree with some or all of my contentions here, and you think that this explosion of totalitarianism is only temporary and will pass when "the virus" does, please realize that the hysteria will leave behind a vast number of new powers, provisions, regulations, assumed-as-proper interventions, and a Sword of Damocles hanging from a thread that'll be even easier to break the next time. The Old Normal comprehensive control will at best be replaced by a much more sternly hammering iron fist of the New Normal.

Many people's lives are going to be destroyed by this thing—eventually probably more than the so-called disease of corona itself could have killed, especially in countries where sanitation and medical treatment are on a reasonably high level.

A serious warning I once heard needs to be repeated here: Don't go to crime-scene number two. This was the advice in a book about how to, if not stay alive, at least keep your suffering from being protracted or hideous. If you were being grabbed in a kidnapping or an attempted rape; don't march obediently to the car or van at point of a gun so that you can be taken to some other presumably private place where the assailant can operate more freely.

… There's not any advantage in going to Crime Scene #2; you may as well resist right where you are.

Be prepared to evade or resist any suggestion of your relocation to some "center" or "facility" "for your convenience". It's NOT your convenience but your management that they're looking to effect.

Likewise, do not on any account admit to any police officer or social worker visitant, census-taker, etc., that you possess a firearm. So far every single day that passes reveals the introduction of yet another facet of repression at a point where one has not yet even fully comprehended the previous day's almost unbelievable draconian orders. Thinking about cops coming around and seizing guns does seem like sheer imagination and paranoia; but in current circumstances, who knows. They seem to be trying to leave no stone unturned in their effort to inflict unopposable regimentation.

They have been pulling out all the stops, and the use of special new catchwords as I've already mentioned here—"social distancing", or "shelter-in-place"—should serve as sobering reminders that real, systematic, authoritarian thought is going into what may seem like a series of purely earnest and unpremeditated efforts. You can be absolutely sure, for example, that anyone stopped for being outside without a good reason is going to be run through the cop database to see about "outstanding warrants", "undocumented" status or anything else that might serve as a reason for full arrest.

Implied significance of phrases is mutating rapidly; being concerned about the health of "the elderly" is now quietly switching around to implying that persons over 60 are some kind of actual health danger themselves—to OTHERS. "Keep your children away from the elderly." This echoes some of the "stranger danger" warnings previously common, and is bound to be taken up by the recipients in a sense of there being disease danger TO children. Society is being relentlessly manipulated into grave worries about a practically endless number of disguised Typhoid Marys infiltrated everywhere in the manner of alien invaders.

NOW at last surely more people all over the Earth—more people than ever before—are having the real nature of The State made dramatically apparent. …

PLEASE NOTE THIS: As it says on the front page of *The Match*, this publication's official policy is "Criticism of, and resistance to, all statist laws and authoritarianism." The present orgy of totalitarian order-giving does not alter that by a single increment. For rulers and policing obsessed "experts", fifteen-minutes-of-fame media whores, this is a golden opportunity to herd

everyone more thickly into a new police state and the insidious digital corral. Those effects are worse than any disease.

Once in place, such stern, arrogant, and microscopically-particularizing rules and laws WILL NEVER GO AWAY.

**What I Think WILL Happen Soon**

First: A great surge in suicides. I've known three men who attempted it, two successfully. The reason may sometimes seem small and unimportant to other people; but it is quite important indeed to the person who has started to feel that he can't go on any farther.

Hundreds of thousands of people are now out of work because of this immense, insane overreaction by professional authoritarians. They are not likely to FIND work, either, because the whole gigantic ocean of labor and payment that these victims swam around in has suddenly drained off to only a few shallow natural puddles along with the horrifyingly numerous artificial pools which are the habitat of government office holders in ultimately non-productive jobs. It is unlikely that even a single one of the millions of food-service workers, for example, will be able to step into some federal or state sinecure. Abruptly confronted by a bank balance of zero, a maxing-out batch of credit cards, an asshole landlord barking at the front door, and Walgreen's on the phone wanting him to pick up that prescription with the $40 co-pay, it's an unusual man or woman whose thoughts don't range toward possible ways of ending it all, forever.

I do NOT think that you will hear about these suicides extremely soon; they will appear all at once, like the water in a flooded basement when you suddenly open the door. An extremely In Love With the New-Flu story will blank out reportage of suicide statistics until they climb to a no longer ignorable level.

Incidentally, government payouts to furloughed workers won't by any means forestall all suicides, since there is a whole underground economy of off-the-books or undocumented noncitizen workers for whom there is no official existence. Which brings me to:

Second: Soon there will be a lot more crime. Robbery, burglary, prostitution and shoplifting are going to become almost overnight the only options for thousands of people.

**What I Think Is Likely**

First, conflation of Old Flu numbers with New-Flu ones. At the time of this writing (March 19), the Old Flu numbers since last October are 36 million to 51 million who have been just ILL with that older disease, and 22 thousand to 55 thousand dead of it. About 400 thousand to 600 thousand people were hospitalized with it. Now you can see that there are great

tolerances in these numbers; they are not exact. But inevitably some parts of these slacknesses will get attached to the New Flu numbers—because the New Flu now has riding with IT the reputations and careers of a wide range of "experts" and politicians.

Incidentally, last year in the USA there were 47,123 known cases of suicide (tenth cause of death).

Second, I think it is likely that there could be compulsory universal testing for the Corona Virus. Perhaps a card will have to be carried (act of law) the way a Draft Card once was, to be presentable if asked for by any law enforcement officer.

Third: I would not be surprised to learn of cellphone tracking files being sorted through and arranged via computers in order to link Corona-Test positives with other nearby cellphones in the same short periods of time. This would result in the electronically-discovered persons later receiving a notice to go get tested. It should be noted that there are huge numbers of persons whose tests for Corona virus come back as Positive, who not only never get the disease, but don't even have any symptoms whatsoever.

Finally, I look for it to happen that some day, when someone is writing up a history of this time, a LARGE number of New Flu cases or hospitalizations or deaths (probably by conflating New Flu and Old Flu statistics) will be offered as justification for the murderous overblown authoritarian reaction. But if the statistics can't be jacked around to support the large number but, in fact, show a SMALL number, that will show how effective the authoritarian response was. The rigged statist game cannot be beaten![1054]

# 31. Final Thoughts

The insatiable hunger for clicks, hits and repostings on social media and views and advertising revenue by legacy media outlets, the obsession for 15 minutes of fame by medical talking heads, and knee-jerk reactions by politicians and bureaucrats to the media wave is responsible for a majority of the irrational world-wide hysteria about the coronavirus.

That is because COVID-19 has not in and of itself caused any significant harm in the U.S. or any other country in the world. It is the hysterical non-fact/non-data based response to a relatively normal virus outbreak that has caused very real economic damage, medical harm, and psychological anguish for effectively no obvious reason. Certainly no more reason than would be caused by the seasonal flu – which would provoke only routine health precautions by individuals.

It used to be that people preaching 'It is the end of the world' were laughed at and scorned as doomsayers. With COVID-19 they became respectable and were paid to spout emotion triggering 'world endangering pandemic' nonsense on mainstream media programs.

If someone had become comatose in December 2019 and they awakened in July or September 2020 they would think people associated with the legacy and social media, the medical establishment, and many of the world's political leaders had gone completely mad or been infected with an alien virus that caused lunacy. The magnitude of the epic coronavirus exaggeration that was egged on by legacy and social media and abetted by international organizations and leaders of their domestic medical and political structure may be the real legacy of 2020's COVID-19 hysteria.

Comparisons of COVID-19 with the Spanish Flu are particularly repugnant to this author because my grand uncle Walter Scherrer died of the Spanish Flu on October 2, 1918 at the Naval Hospital in Bremerton, Washington. He was 28, and being young and in good health, he would have had virtually a zero percent chance of getting seriously ill from COVID-19, much less dying from it.

The hysteria created over COVID-19 is an insult to the memory of everyone who died from the Spanish Flu, which was a real pandemic, and not a fake one pushed by the legacy and social media and self serving health officials and politicians feverishly trying to convince everyone that 2+2 really does equal 5, or maybe 7. Honest. Trust us. As their fingers are crossed behind their back and a smirk is on their face.

It can safely be said that if the disease's name Wuhan Flu hadn't been changed to COVID-19 it couldn't have been merchandised and sold as a

global menace. Wuhan Flu sounds normal and not scary because people are used to flu outbreaks every year, which often times are very severe. In contrast, COVID-19 is an exotic name people aren't used to, so it could be marketed in a Madison Avenue type campaign as a novel deadly new virus that will ravish mankind unless everyone cowers in their closet and obeys without question every dictatorial commandment of their political leaders and government bureaucrats.

Many conscientious doctors and other health professionals, researchers, writers, and interested lay persons have weathered considerable criticism and censoring by the legacy media and social media companies to present the actual data and reasoned alternate points of view regarding COVID-19 and encouraged people to consider that information and historical norms of influenza like respiratory diseases when evaluating how much weight to give the 'end of the world' pronouncements of government and public health organizations and officials. Those brave persons are too numerous to list, but they all are to be commended.

Repeal of the CDC's "Community Mitigation Guidelines" adopted in 2017 is absolutely essential to protect American society from another COVID-19 debacle. Those guidelines directly contributed to the objectively unnecessary and catastrophic overreaction by health officials across the country to support closing businesses, churches, schools, and social activities; restricting travel; and imposing social distancing, mask wearing, etc. None of those measures was objectively justifiable considering COVID-19's virtually non-existent effect on American society. It is effectively a phantom virus for over 99% of the population. The only crisis was the one created by the government directives.

Restoration of the 2007 CDC disease guidelines that were replaced in 2017 should be a top priority. Under the prior guidelines COVID-19 is classified as a mid-level Category 2 outbreak (out of 5), that would trigger only one recommended response: "Voluntary isolation of ill at home." If the CDC had simply recommended in March 2020 that people sick with COVID-19 stay home, and state health departments had followed it, COVID-19 would have been a blip on the radar of life in America, and forgotten by the public in a matter of months. No social, medical, and economic destruction was caused by COVID-19: it was caused by a contrived panic for what the CDC knew by early-March 2020 was a mild respiratory virus for almost everyone except people already knocking on death's door.

An existential victim of COVID-19 demonology is the illusion the U.S. is a land in which the rights of the people are protected by inviolate constitutional protections. Governors and health directors strutted around like the second coming of Nicolae Ceaușescu. They openly scorned the federal

and their state's constitution by issuing executive proclamations, orders and other directives that completely disregarded the right to freedom of religion, freedom of association, freedom to privacy, freedom from unjust takings, etc. These state officials assumed the persona of a tinpot dictator and issued commands based on their feelings and whim, while completely disregarding the incontrovertible fact COVID-19 is not a serious health problem and no more troubling for society than the seasonal flu.

A significant percentage of the population in the U.S. and other countries bear the shame of uncritically going along with the political theater that the alleged menace of COVID-19 justified the shutdown of society, and mandatory social distancing, mask wearing, etc. The government got away with their draconian actions by the majority of people blindly following.

COVID-19 was never a threat. For a month to six weeks after late January *the idea* of COVID-19 was troubling, but after early March it was known *the reality* of the virus was much less than had been feared. The COVID-19 catastrophe was caused by leaders of governments around the world neglecting to abide by a fundamental axiom: interfering with the inner-working of a human society can be a risky business that should never be undertaken lightly. The bigger the interference, the bigger the possible reaction.

The COVID-19 experience also provides additional evidence the major so-called social media companies work together to silence points of view they dislike, while promoting their approved positions. Facebook, Twitter, YouTube, etc. suppressed factual information the virus is not an indiscriminate killer stalking all of us .

A one sentence summary of the information in this book is: The most effective way to deal with COVID-19 is the same as for every other flu-like virus – sick people should stay home, while life goes on as normal for everyone else.

It is not known how 50 years, 100 years, or even a thousand years from now Wuhan Flu/COVID-19 hysteria will be remembered. It certainly deserves a chapter in an updated version of Charles Mackay's 1841 book: *Extraordinary Popular Delusions and the Madness of Crowds*. Hopefully, mankind will gain wisdom from the events of 2020 when the world went crazy over the flu.

# About the Author

Hans Sherrer is President of The Justice Institute that promotes awareness of issues related to wrongful convictions, and editor and publisher of *Justice Denied: the magazine for the wrongly convicted*. Hans created and maintains the Innocents Database, which is the only database that seeks to record every documentable wrongful conviction in the United States and worldwide.

Hans has conducted numerous investigations into the cases of wrongly convicted people. A typical feature of those cases is governmental and non-governmental actors jointly perpetrate a false narrative created to prop up the illusion the person committed a crime actually committed by someone else – or which didn't even occur.

This book is the result of Hans applying his skills and experience in unmasking the elaborate illusions of guilt involved in wrongful conviction cases, to investigating the official COVID-19 narrative promoted both by persons associated with governments and non-governmentally employed persons profiting financially, personally, professionally, or socially from the idea it is a novel killer virus that is a deadly menace to mankind.

# Endnotes

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SARS-CoV-2 is the name of the virus that causes the COVID-19 disease. The LOINC Component represents the analyte being tested for, which is why the Components include "SARS Coronavirus 2" rather than "COVID-19." See:

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The data in the charts was that known to the researchers at the time they prepared their paper. A preliminary version posted online on March 9, 2020 had the same data as the final version. The preliminary version was posted at, at https://doi.org/10.1101/2020.03.05.20031773. Subsequent data showed the total number of cases was 712 instead of the 619 cases documented in the paper, and the deaths attributable to COVID-19 remained at 7, although in later months some of the people who tested positive have died, but presumably from their serious underlying health condition.

Statistica.com published a chart showing March 15 was the last reported positive test from a Diamond Princess passenger, with a total of 712 and at least 410 asymptomatic. So of the additional 93 positive cases not documented in this chart, 92 were asymptomatic – which could account for why they were not detected until the tail end of testing, because they had no symptoms. See, "Cumulative number of coronavirus-positive (COVID-19) patients confirmed on Diamond Princess cruise ship docked in Japan as of April 16, 2020," https://www.statista.com/statistics/1099517/japan-coronavirus-patients-diamond-princess/ (last viewed June 15, 2020). This additional data changes the asymptomatic rate to 58% (410/712) from 51% (318/619).
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[743] https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-advice-on-reducing-the-potential-risk-of-covid-19-transmission-in-schools-24-april-2020 (last visited May 22, 2020)
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