IN THE HIGH COURT OF JUSTICE **CLAIM NO.**
ADMINISTRATIVE COURT

between:-

THE QUEEN on the application of MR ROBIN CLARKE

Claimant

and

THE GOVERNMENT OF THE UK*

Defendant

INDEX

* Including: The Secretary of State for Health and Social Care, The Secretary of State for the Home Department, The Secretary of State for Business, Energy, and Industrial Strategy, Parliamentary Under-Secretary of State at the DHSC, Parliamentary Under-Secretary of State at the Dept for Business, Energy, and Industrial Strategy.

Judicial Review
Application for urgent consideration

This form must be completed by the Claimant or the Claimant's advocate if exceptional urgency is being claimed and the application needs to be determined within a certain time scale.

The claimant, or the claimant's solicitors must serve this form on the defendant(s) and any interested parties with the N461 Judicial review claim form.

To the Defendant(s) and Interested Party(ies)
Representations as to the urgency of the claim may be made by defendants or interested parties to the relevant Administrative Court Office by fax or email:-

For cases proceeding in

In the High Court of Justice **Administrative Court**	
Claim No.	
Claimant(s) *(including ref.)*	Robin Clarke
Defendant(s)	Government of the UK
Interested Party(ies)	

London	**Fax:** 020 7947 6802 **email:** administrativecourtoffice.generaloffice@hmcts.x.gsi.gov.uk
Birmingham	**Fax:** 0121 250 6730 **email:** administrativecourtoffice.birmingham@hmcts.x.gsi.gov.uk
Cardiff	**Fax:** 02920 376461 **email:** administrativecourtoffice.cardiff@hmcts.x.gsi.gov.uk
Leeds	**Fax:** 0113 306 2581 **email:** administrativecourtoffice.leeds@hmcts.x.gsi.gov.uk
Manchester	**Fax:** 0161 240 5315 **email:** administrativecourtoffice.manchester@hmcts.x.gsi.gov.uk

You must complete sections 1 to 5 and attach a draft order.

SECTION 1 Reasons for urgency

This case relates to the regulations imposed in respect of the Covid-19 pandemic, which are widely condemned by competent people around the world, and have no defensible evidential justification.

In view of the harms being caused from every further day of these regulations, the Claimant requests that they be suspended by an injunction, and their enforcement prohibited, until such time as a sound defensible scientific basis for them has been published and not found clearly wanting by any significant number of scientific experts.

The evidence cited in the Claimant's Statement of Facts and Grounds makes clear that there is no credible scientific basis for the regulations, and that there is clear evidential basis for rejecting them as lacking in any benefit. The Defendants' Letter of Response contained only a reference to a document which actually finds fault with their tests rather than justifies them (as per SFG para 44). And the official document supposedly of evidence for a new lockdown contains no real evidence.

The data indicated in paragraphs 20 and 22 of the Statement of Facts and Grounds suffices by itself to make clear that there is no scientific justification for these regulations.

2

SECTION 2 Proposed timetable

2.1 How quickly do you require the application (Form N463) to be considered?
This will determine the timeframe within which your application is referred for consideration.

a)	☐ Immediately **(within 3 days)** – indicate in hours (eg. 2 hours, 24 hours etc.)		Hours
b)	☑ Urgently **(over 3 days)** – indicate in days (eg. 4 days, 6 days etc.)	4	Days

2.2 Please specify the nature and timeframe of consideration sought.

a)	☑ **Interim relief** is sought and the application for such relief should be considered within	4 days	Hours/Days
b)	☐ **Abridgement of time for AOS** is sought and should be considered with		Hours/Days
c)	☐ **The N461 application for permission** should be considered within		Hours/Days
d)	☐ **If permission for judicial review is granted,** a substantive hearing is sought by		Date

SECTION 3 Justification for request for immediate consideration

Date and time when it was first appreciated that an immediate application might be necessary.

Date | Time

Please provide reasons for any delay in making the application.

What efforts have been made to put the defendant and any interested party on notice of the application?

3

SECTION 4 Interim relief *(state what interim relief is sought and why in the box below)*

A draft order must be attached.

The Claimant requests that the the various Covid-related regulations be suspended by an injunction and their enforcement prohibited, until such time as a sound scientific basis for them has been published and not found clearly wanting by any significant number of scientific experts. The relevant regulations include (but may not be limited to) those listed at https://www.legislation.gov.uk/coronavirus

In view of the great harms being caused from every further day of these regulations, the Claimant requests that they be suspended by an injunction, and their enforcement prohibited, until such time as a defensible scientific basis for them has been published and not found clearly wanting by any significant number of scientific experts.

SECTION 5 Service

A copy of this form of application was served on the defendant(s) and interested parties as follows:

Defendant

☐ by fax machine to — time sent

Fax no. | time

☐ by handing it to or leaving it with

name

☑ by e-mail to

e-mail address: Daniel.Emery@governmentlegal.gov.uk

Date served

Date: 13/11/2020

Interested party

☐ by fax machine to — time sent

Fax no. | time

☐ by handing it to or leaving it with

name

☐ by e-mail to

e-mail address

Date served

Date

I confirm that all relevant facts have been disclosed in this application

Name of claimant's advocate

name: Robin Clarke

Claimant (claimant's advocate)

Signed: Robin Clarke 4

IN THE HIGH COURT OF JUSTICE **CLAIM NO.**

ADMINISTRATIVE COURT

between:-

THE QUEEN on the application of MR ROBIN CLARKE

Claimant

and

THE GOVERNMENT OF THE UK*

Defendant

ORDER FOR INTERIM RELIEF

UPON the consideration on the papers of the Claimant's application for urgent consideration and interim relief, and the Defendant's submissions in response,

IT IS ORDERED that:

Until the date of final judgment of this Claim, the Defendant must not enforce any of the regulations controlling business operations and public conduct, specifically relating to the pandemic of Covid-19 virus, and most particularly in respect of imposing of "lockdown" regulations, prohibiting certain forms of gatherings and movements, and imposing requirements of "social distancing" and wearing of face masks with penalties for non-compliance, including but not limited to those arising from:

- The Health Protection (Coronavirus, Restrictions) (England) (No. 4) Regulations 2020 (S.I. 2020/1200)
- The Health Protection (Coronavirus, Restrictions) (No. 3) (England) Regulations 2020 (S.I. 2020/750)
- The Health Protection (Coronavirus, Restrictions) (No. 2) (England) Regulations 2020 (S.I. 2020/684)

* Including: The Secretary of State for Health and Social Care, The Secretary of State for the Home Department, The Secretary of State for Business, Energy and Industrial Strategy, Parliamentary Under-Secretary of State at the DHSC, Parliamentary Under-Secretary of State at the Dept for Business, Energy, and Industrial Strategy.

- The Health Protection (Coronavirus, International Travel) (England) Regulations 2020 (S.I. 2020/568)
- The Health Protection (Coronavirus, Wearing of Face Coverings in a Relevant Place) (England) Regulations 2020 (S.I. 2020/791)
- The Health Protection (Coronavirus, Collection of Contact Details etc. and Related Requirements) Regulations 2020 (S.I. 2020/1005)
- The Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 (S.I. 2020/1045)
- The Health Protection (Coronavirus, Local COVID-19 Alert Level) (Medium) (England) Regulations 2020 (S.I. 2020/1103)
- The Health Protection (Coronavirus, Local COVID-19 Alert Level) (High) (England) Regulations 2020 (S.I. 2020/1104)
- The Health Protection (Coronavirus, Local COVID-19 Alert Level) (Very High) (England) Regulations 2020 (S.I. 2020/1105)

and any others currently or in future listed at https://www.legislation.gov.uk/coronavirus.

Signed:

Print form Reset form

Judicial Review
Claim Form

Notes for guidance are available which explain how to complete the judicial review claim form. Please read them carefully before you complete the form.

In the High Court of Justice
Administrative Court

Help with Fees - Ref no. (if applicable) H W F – – –

For Court use only	
Administrative Court Reference No.	
Date filed	

Seal

Is your claim in respect of refusal of an application for fee remission? ☐ Yes ☑ No

SECTION 1 Details of the claimant(s) and defendant(s)

Claimant(s) name and address(es)

name
Robin Clarke

address

Telephone no. **Fax no.**

E-mail address
r@rpcc.info

Claimant's or claimant's legal representatives' address to which documents should be sent.

name
~~~

address

Telephone no. **Fax no.**

E-mail address

Claimant's Counsel's details

name
~~~

address

Telephone no. **Fax no.**

E-mail address

1st Defendant

name
Government of the UK (incl SoS Dept of Health, et al.)

Defendant's or (where known) Defendant's legal representatives' address to which documents should be sent.

name
Daniel Emery

address
Z2011208/DFE/HO17
Litigation Group
102 Petty France
Westmister London SW1H 9GL

Telephone no.
020 7210 3000

Fax no.

E-mail address
Daniel.Emery@governmentlegal.gov.uk

2nd Defendant

name
~~~

Defendant's or (where known) Defendant's legal representatives' address to which documents should be sent.

name
~~~

address

Telephone no. **Fax no.**

E-mail address

SECTION 2 Details of other interested parties

Include name and address and, if appropriate, details of DX, telephone or fax numbers and e-mail

name
~~~

address

Telephone no.

Fax no.

E-mail address

name

address

Telephone no.

Fax no.

E-mail address

SECTION 3 Details of the decision to be judicially reviewed

Decision:
The various ongoing regulations relating to the Covid-19 pandemic, and most particularly in respect of “lockdown” regulations, prohibiting certain gatherings and movements, and imposing masks and "social distancing".

Date of decision:
Ongoing

Name and address of the court, tribunal, person or body who made the decision to be reviewed.

name
Government of the UK

address
10 Downing Street
London
SW1A 2AA

SECTION 4 Permission to proceed with a claim for judicial review

I am seeking permission to proceed with my claim for Judicial Review.

Is this application being made under the terms of Section 18 Practice Direction 54 (Challenging removal)? ☐ Yes ☑ No

Are you making any other applications? If Yes, complete Section 8. ☐ Yes ☑ No

Is the claimant in receipt of a Civil Legal Aid Certificate? ☐ Yes ☑ No

Are you claiming exceptional urgency, or do you need this application determined within a certain time scale? If Yes, complete Form N463 and file this with your application. ☑ Yes ☐ No

Have you complied with the pre-action protocol? If No, give reasons for non-compliance in the box below. ☑ Yes ☐ No

Have you issued this claim in the region with which you have the closest connection? (Give any additional reasons for wanting it to be dealt with in this region in the box below). If No, give reasons in the box below. ☑ Yes ☐ No

8
~~~

Does the claim include any issues arising from the Human Rights Act 1998?
If Yes, state the articles which you contend have been breached in the box below. ☑ Yes ☐ No

Article 8
Article 9
Article 10
Article 11
Article 3 of First Protocol

SECTION 5 Detailed statement of grounds

☐ set out below ☑ attached

SECTION 6 Aarhus Convention claim

I contend that this claim is an Aarhus Convention claim ☐ Yes ☑ No

If Yes, indicate in the following box if you do not wish the costs limits under CPR 45.43 to apply.

If you have indicated that the claim is an Aarhus claim set out the grounds below, including (if relevant) reasons why you want to vary the limit on costs recoverable from a party.

SECTION 7 Details of remedy (including any interim remedy) being sought

A) Quashing of the regulations (lockdowns, distancing, mask-wearing) ostensibly serving to address a health crisis caused by the Covid-19 pandemic.
B) Prohibiting the issuing or enforcement of any further such regulations until such time as a defensible scientific basis for them has been published, and subject to proper public and expert consultation, and not found clearly wanting by significant numbers of competent experts.
C) A declaration that there is no evidence of any health-protective benefit from the lockdowns, distancing, and masks, and that on the contrary the evidence clearly shows no benefit, and also no exceptional health crisis of a “second wave”, but instead to the contrary, and accordingly that there is no rational basis for continued enforcement of these regulations.
Interim): Prohibiting enforcement of these regulations pending final outcome of this case.

SECTION 8 Other applications

I wish to make an application for:-

9

SECTION 9 Statement of facts relied on

Please see attached Statement of Facts and Grounds.

Statement of Truth

~~I believe~~ (The claimant believes) that the facts stated in this claim form are true.

Full name Robin Clarke

~~Name of claimant's solicitor's firm~~

Signed Robin Clarke

Claimant (~~'s solicitor~~)

Position or office held

(if signing on behalf of firm or company)

10

SECTION 10 Supporting documents

If you do not have a document that you intend to use to support your claim, identify it, give the date when you expect it to be available and give reasons why it is not currently available in the box below.

Please tick the papers you are filing with this claim form and any you will be filing later.

☑ Statement of grounds	☐ included	☑ attached
☑ Statement of the facts relied on	☐ included	☑ attached
☐ Application to extend the time limit for filing the claim form	☐ included	☐ attached
☐ Application for directions	☐ included	☐ attached
☐ Any written evidence in support of the claim or application to extend time		
☐ Where the claim for judicial review relates to a decision of a court or tribunal, an approved copy of the reasons for reaching that decision		
☑ Copies of any documents on which the claimant proposes to rely		
☐ A copy of the legal aid or Civil Legal Aid Certificate *(if legally represented)*		
☐ Copies of any relevant statutory material		
☐ A list of essential documents for advance reading by the court *(with page references to the passages relied upon)*		
☐ Where a claim relates to an Aarhus Convention claim, a schedule of the claimant's significant assets, liabilities, income and expenditure.	☐ included	☐ attached

If Section 18 Practice Direction 54 applies, please tick the relevant box(es) below to indicate which papers you are filing with this claim form:

☐ a copy of the removal directions and the decision to which the application relates	☐ included	☐ attached
☐ a copy of the documents served with the removal directions including any documents which contains the Immigration and Nationality Directorate's factual summary of the case	☐ included	☐ attached
☐ a detailed statement of the grounds	☐ included	☐ attached

Reasons why you have not supplied a document and date when you expect it to be available:-

Signed _____ Claimant (’s Solicitor)_____

IN THE HIGH COURT OF JUSTICE **CLAIM NO.**

ADMINISTRATIVE COURT

between:-

THE QUEEN on the application of MR ROBIN CLARKE

Claimant

and

THE GOVERNMENT OF THE UK*

Defendant

STATEMENT OF FACTS AND GROUNDS
(In respect of alleged crisis of COVID-19)

(not page numbers)

* Including: The Secretary of State for Health and Social Care, The Secretary of State for the Home Department, The Secretary of State for Business, Energy, and Industrial Strategy, Parliamentary Under-Secretary of State at the DHSC, Parliamentary Under-Secretary of State at the Dept for Business, Energy, and Industrial Strategy.

Introduction and outline

1. The Claimant seeks permission to apply for judicial review of the various ongoing regulations relating to the pandemic of Covid-19 virus, and most particularly in respect of imposing of "lockdown" regulations, prohibiting certain forms of gatherings and movements, and imposing requirements of "social distancing" and wearing of face masks with penalties for non-compliance.

2. **Important Note: This Claim does not request the Court to make expert judgments of balance of scientific evidence. Rather is it a matter of distinguishing plainly untrue assertions from not particularly complex actual facts.**

3. **Note re the Dolan and Corbett cases:** This Claim differs majorly from those of Mr Dolan and Mr Corbett. It presents much more substantial scientific evidence, refuting the whole notion that the regulations could have effectiveness for protecting health, and thereby its ambit is not limited to the legality of only some of the existing Covid-related regulations.

4. The Claim is brought on the grounds that:

   (1) there is a failure to take account of the proof that the regulatory measures have had no beneficial effect, while causing major adverse consequences including increased morbidity and mortality;

   (2) there is a failure to take into account the evidence that there is not a particularly exceptional health crisis currently, relative to most other years;

   (3) there is a failure to take into account the evidence that there is no defensible scientific basis in justification of these regulations;

   (4) there is a lack of defensible scientific basis for the regulations, such that no reasonable or rational decisionmaker would make such decisions;

   (5) consequently there is no proper aim and necessity that can justify these regulations being considered compliant with the Articles of the Human Rights Act.

5. The present Claimant contends as follows.

6. The various anti-Covid regulations, including closing of businesses, restrictions on meetings and movements, social distancing rules, and enforcement of mask-wearing, are of an extreme nature, and such as to majorly violate natural norms of normal behaviour as well as infringe on human rights not least of assembly and political protest, and such as to cause major harm not only economically but also psychologically and to the social fabric of communities, and even in increased mortality from other causes.

7. Such extreme measures can only be justified by presentation of defensible evidence of significant usefulness in addressing some sort of problem.

8. But there is no such defensible evidence. And indeed on the contrary the evidence shows that these regulations do not provide any health-protective benefits (not least as shown in paragraphs 20 and 22).

9. The government have now had months in which to prepare and present a credible eveidential case for their policies. And yet no such evidential case has been issued, let alone discussed or debated or consulted on.

10. The regulations can thereby be understood to be illegal, firstly in terms of their failure to take into account the absence of evidence in support and the weight of evidence against, secondly in terms of *Wednesbury* unreasonableness/irrationality, and thirdly in terms of unjustified breaches of the HRA.

11. The government might wish to characterise this situation as one in which they are entitled to just continue with the extreme directives until such time as the Claimant proves a case that they should be stopped. But a more proper understanding is that it is for the government to first show its case for justifying the directives to continue, in absence of which they cannot hold any legal validity. The entire majorly harmful "anti-Covid" measures should be urgently suspended until such time as the government does show at least a plausible scientific case, such as would not be rejected by so many notable experts in relevant fields such as Professors Sunetra Gupta, Jay Bhattacharya, Martin Kuldorff, Carl Heneghan, Karol Sikora, Michael Levitt, John Ioannidis, David Spiegelhalter, Francois Balloux, Karl Friston, Johan Giesecke, and many other experts.

12. But the evidence such as presented herein shows that no such defensible evidentialc case can be forthcoming, and meanwhile that the evidential case *against* the measures is beyond hope of refutation.

13. Judges may be wary of setting themselves up as judges of scientific controversy, yet there is good reason why that is sometimes appropriate. Indeed Prof Bauer's book (below) concludes that there needs to be a "science court" to enable important controversies to be properly resolved. Undoubtedly there are some fields of expertise where the evidence is too complex and dependent on substantial experience to be credibly dismissed by a judge. But this matter is not one such. The facts here are not particularly complex, and those facts can speak far louder than any number of putative experts seeking to rationalise them away.

Factual background

Important principles when considering the credibility of medical expertise

14. There are strong incentives towards promoting products and methods as being effective and valuable, and telling others that there is a serious problem they are needed for to solve. And meanwhile strong incentives against challenging such products and methods and alleged urgencies. No-one has ever got rich by advising others not to do or change anything. But many have done so from indeed advising change. And while the vast majority of academics aspire to tell the truth, they are very wary of speaking out against ideological bandwagons heavily promoted by wealthy profit-making organisations.

15. These facts should be seen as the necessary context of the constant assertions that there is an important "search for a vaccine" to save us from the alleged Covid crisis. For pharmaceutical corporations, a million dollars is peanuts, and yet even just one of those "peanuts" can fund an enormous amount of contrived "research", publicity, and distorting incentives. Meanwhile those who express dissenting views can find such million-dollar "peanuts" being deployed *against* them in character-assassination operations, while they have almost no funding for the defence of themselves or the evidential positions they try to advance.

16. For these reasons, when looking at alleged scientific evidence from experts, one should be **very wary** of those arguing in favour of products (vaccines, masks, etc.) and methods ("tests" for Covid), and insisting there are serious problems needing those solutions, and conversely **considerably more trusting** of those putting their careers at risk to argue against those products and methods and alleged serious problems. That is not to say that one should automatically dismiss the former and accept the latter, but should still require a solidly defensible case from the former.

17. (Though the supposed evidence in favour of the Defendants' regulations is so vacuous that that warning may not have been really necessary.)

Scientific evidence relating to the pandemic

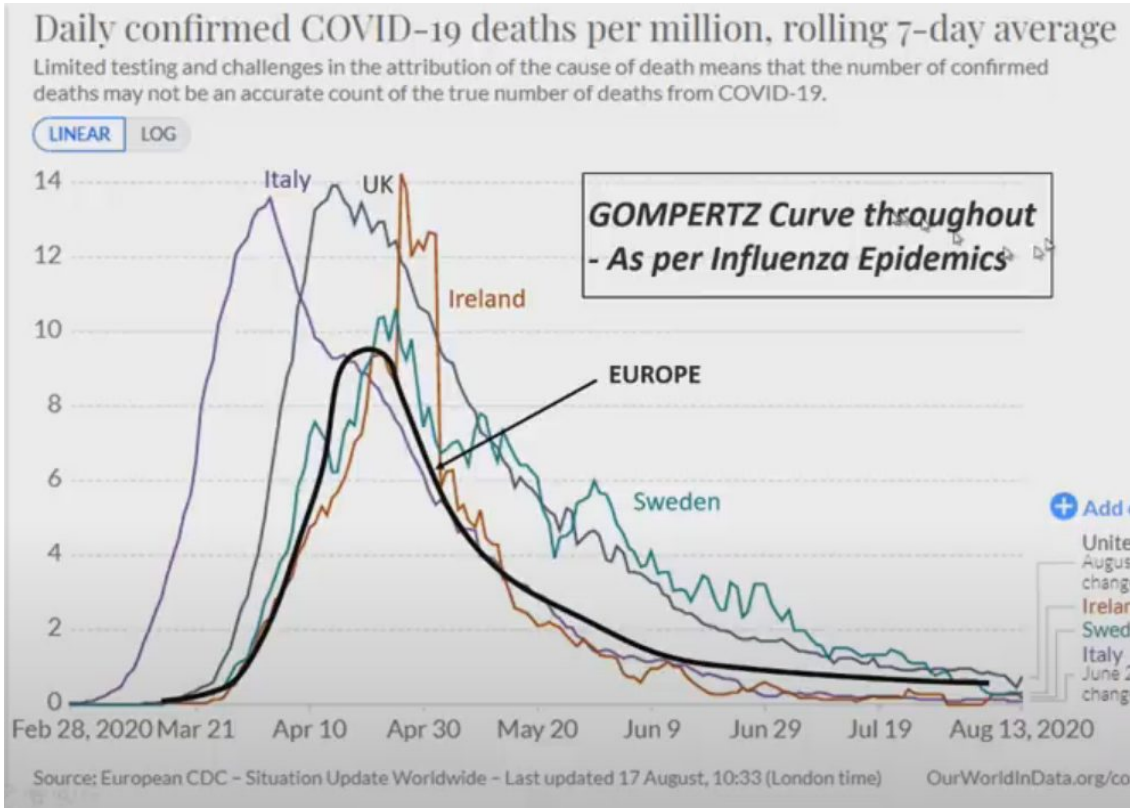
18. Many words have been written about the false science being used to justify the "anti-Covid" policies. But for purposes of this case it should suffice to consider just three issues. Namely:
    (i) the complete lack of effectiveness of the lockdown measures,
    (ii) the false use of tests, and
    (iii) the various pieces of evidence showing that there is not some exceptional crisis (in any country let alone just the UK), and certainly not such as could ever justify such harmful policies (even if they did have useful effect – which they don't).

Whether lockdowns, distancing, and masks do anything useful

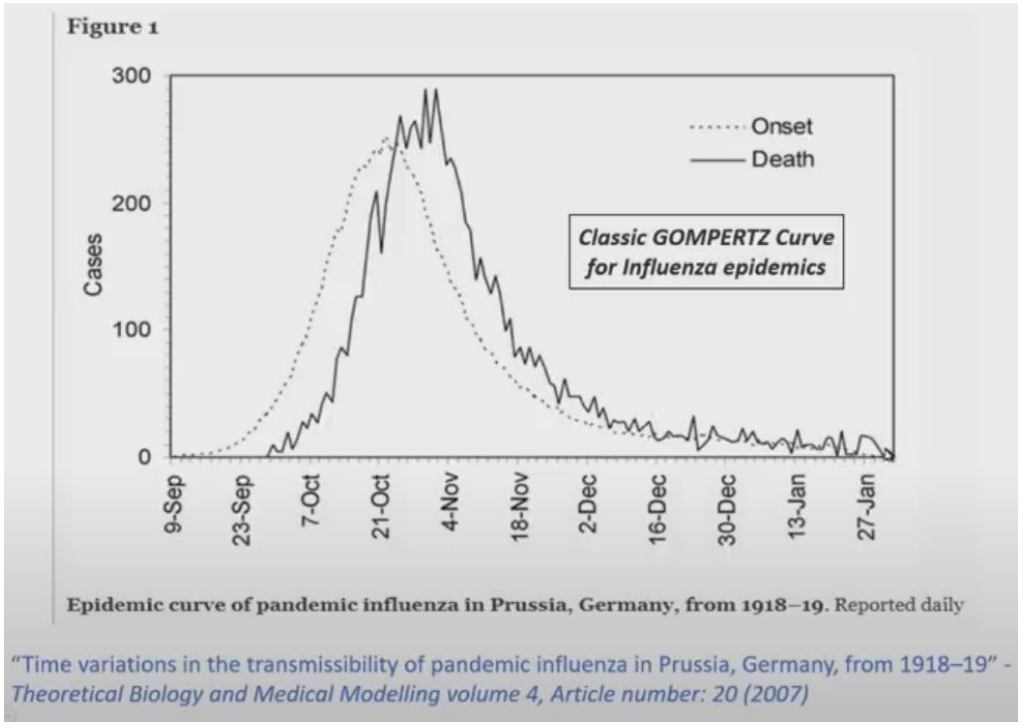
19. The clearest problem with the case for the regulations is the evidence that they have produced no benefit in terms of reduced illness. Useful for demonstrating this evidence is a youtube video, packed with well-presented information, compiled by Ivor Cummins https://www.youtube.com/watch?v=8UvFhIFzaac, titled "Viral Issue Crucial Update Sept 8th: the Science, Logic and Data Explained" (It should be noted that Ivor Cummins does not have a g in his name unlike a famous other person.)
    The Cummins video lacks a transcript so the Claimant has compiled some notes of its contents, as follows here (on a separate page after paragraph 30).

20. In that video the following evidence particularly testifies to the worthlessness of the various regulations, with reference to the indicated time-points in the video.

1.00 The time-series of cases and deaths just follow the Gompertz curve in all European countries, with no impact of the policy measures. (Note: Small areas such as Ireland have narrow peaks, large areas such as Europe have blunter ones.)

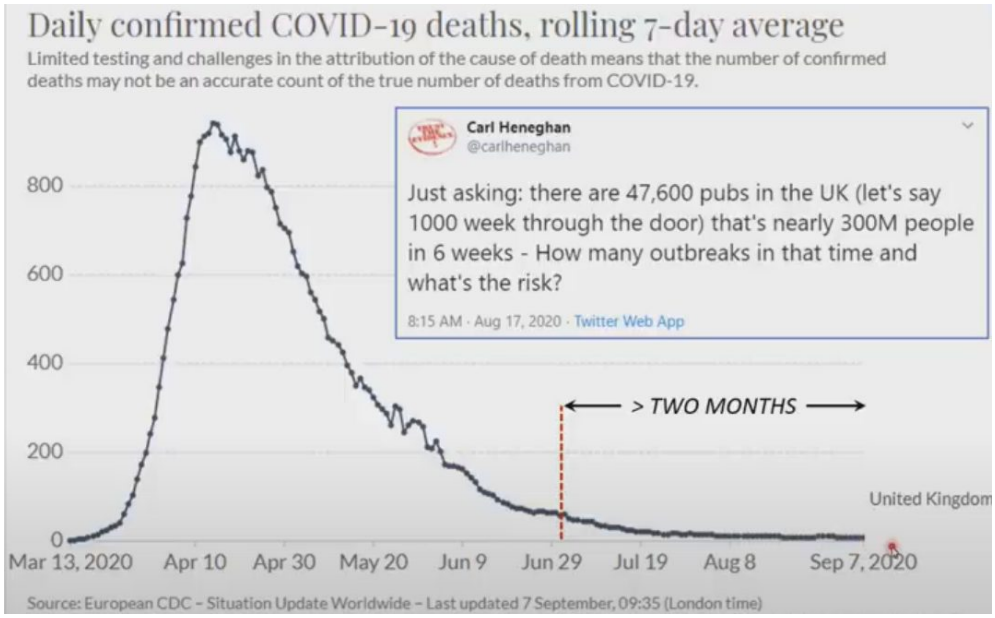


1918 Spanish Flu epidemic in Prussia:

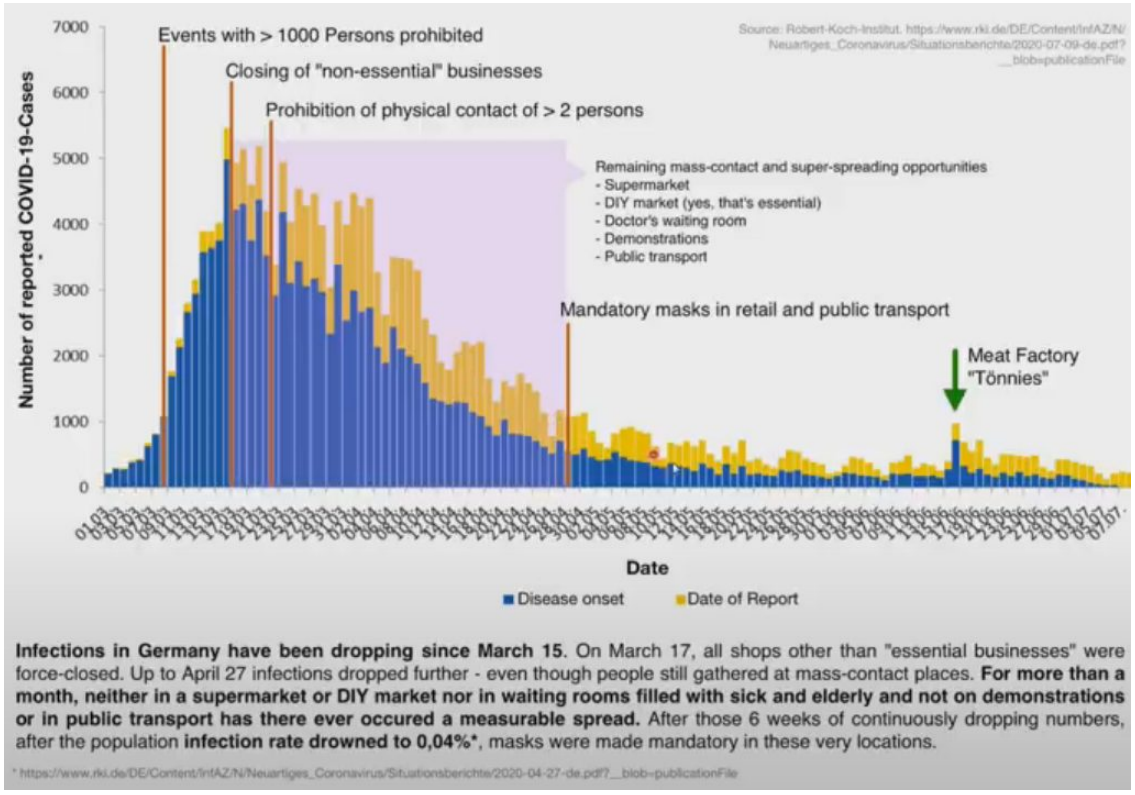


10.40 Lockdown is shown to be the least important of 16 factors in "16 Possible Factors for Sweden's High COVID Death Rate among the Nordics" https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3674138

11.20 Prof Carl Heneghan - Pubs reopening should have caused a major increase, but instead there was only a continuing decrease, as this graph shows.

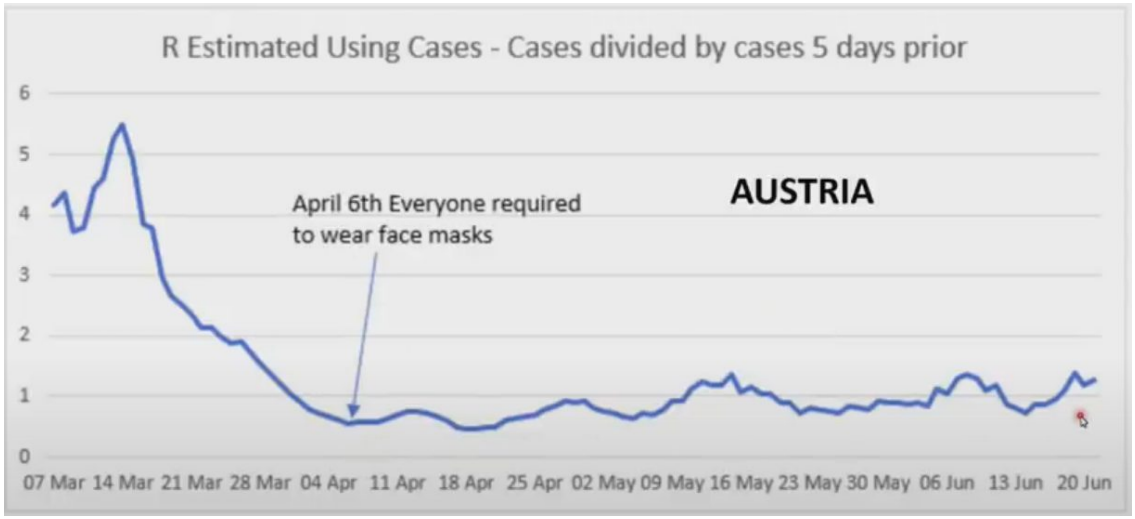


15.20 Millions of grocery workers were "exposed" but with no associated consequences. And ends of lockdowns made no difference either.



"Three big supermarket chains operating in Ireland have reported low levels of the coronavirus among staff, despite staying open throughout the pandemic."
https://www.thetimes.co.uk/edition/ireland/supermarket-staff-largely-evade-virus-in-ireland-zs2wbb9xr

17.30 Numerous graphs show zero effect of masks policy.



21. **Even just these facts above should suffice to prove that the various regulations are indefensible on any scientific basis.**

The regulations give no benefit because the virus particles just float everywhere in the air just like water vapour or pollen dust does and are too small to be blocked by masks.

22. Meanwhile the government's "evidence" for the alleged usefulness of the new lockdown was presented in the "summary" linked here: https://www.gov.uk/government/publications/summary-of-the-effectiveness-and-harms-of-different-non-pharmaceutical-interventions-16-september-2020.
The nearest thing to actual evidence therein is the notion that the lockdown from 23rd March caused a reduction in the R-number. But in reality, as can be seen at the start of the Cummins video (and first graph herein), all that happened was the UK data coming to the natural peak of its Gompertz curve around 10th April, exactly as had happened everywhere else and always does. In other words the government's key document of "evidence" shows not one jot of real evidence to justify these majorly harmful impositions.

23. A study by Prof Isaac Ben-Israel also agrees with the uselessness of the lockdowns: Titled "The end of exponential growth: The decline in the spread of coronavirus" https://www.timesofisrael.com/the-end-of-exponential-growth-the-decline-in-the-spread-of-coronavirus/ :

> It turns out that a similar pattern – rapid increase in infections that reaches a peak in the sixth week and declines from the eighth week – is common to all countries in which the disease was discovered, regardless of their response policies: some imposed a severe and immediate lockdown that included not only "social distancing" and banning crowding, but also shutout of economy (like Israel); some "ignored" the infection and continued almost a normal life (such as Taiwan, Korea or Sweden), and some initially adopted a lenient policy but soon reversed to a complete lockdown (such as Italy or the State of New York). **Nonetheless, the data shows similar time constants amongst all these countries in regard to the initial rapid growth and the decline of the disease.**

24. From these facts it is clear that not only is there a lack of sound science to justify the policies, but also there is sound science that refutes any rationale for them. In face of this evidence, there can be no justification for the continuation of the harmful policies for a moment longer. If these policies were a drug, they would be required to undergo extensive testing of safety and efficacy. The government has not made any attempt at either category of testing. And yet we can see that these "non-pharmaceutical measures" have failed both the test of safety and of efficacy.

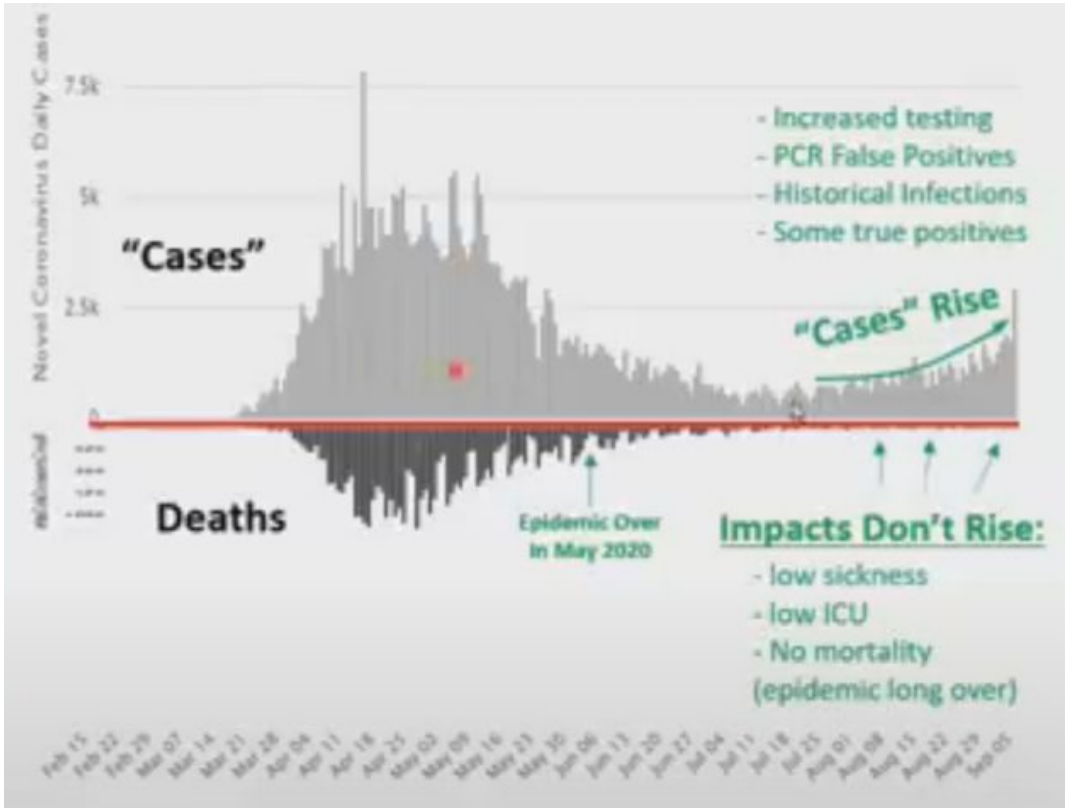
Whether or not there is a particularly concerning "second wave"

25. An article published by Prof Heneghan on 2nd August argued that any increase of "cases" was in reality just due to increase of testing, herewith included as **Exhibit RC01**: https://www.cebm.net/covid-19/covid-cases-in-england-arent-rising-heres-why/.

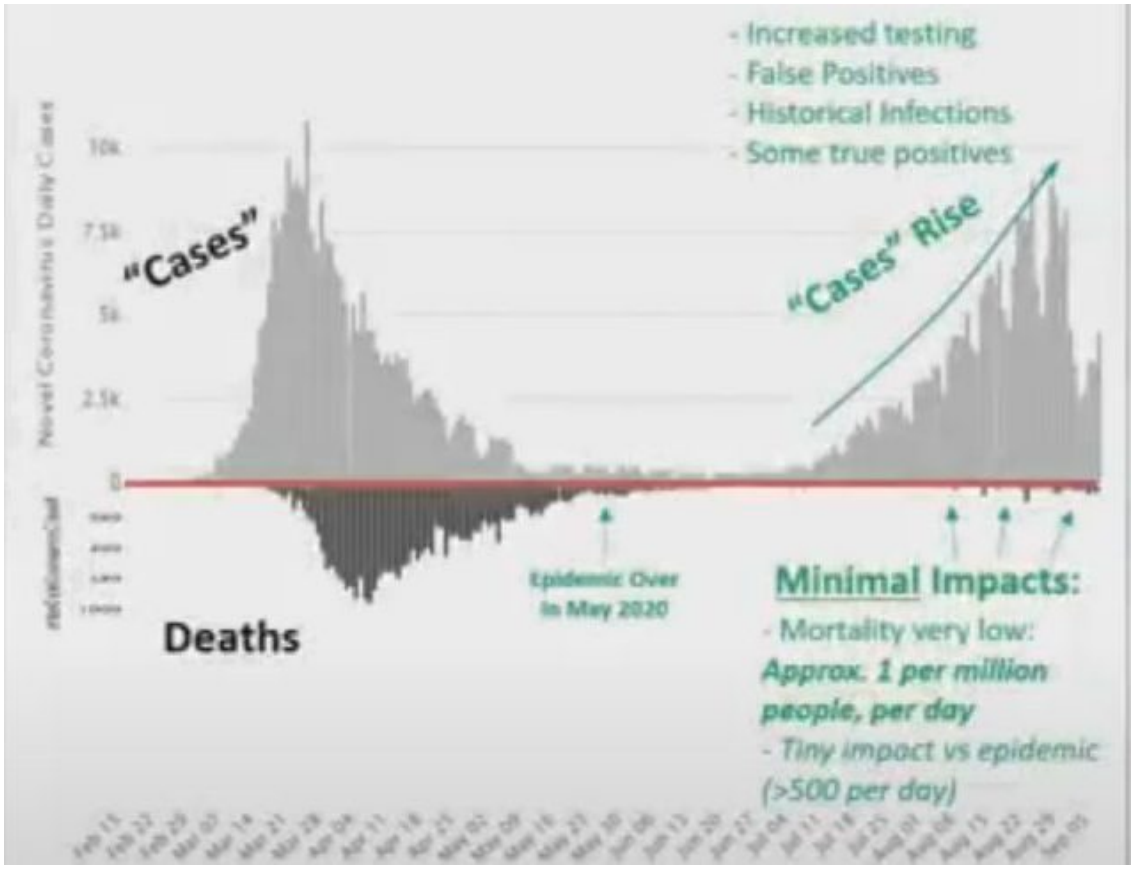
26. Since then, much more data of this supposed second wave has become available, along with more time for people to learn and think about it. Many people have been writing and vlogging about this subject, but it is suggested that there is proof enough of the pseudoscientific nature of the government's position to be seen in the same youtube video of Ivor Cummins

27. In particular, from the 24th minute of the video, Cummins explains how the data of numerous countries can be properly understood in terms of mere "Casedemics" of positive test results, with no real illness or infection involved, just false positives from a testing system using unsound testing methods.

28. "Casedemic" in UK: :



"Casedemic" in Spain:



The video also includes almost identical graphs in respect of Ireland, Germany, Switzerland, France, Netherlands, and also the 2008-9 H1N1 ("swine flu") epidemic. (France closely resembles the Spain graph, and the others closely resemble the UK one.)

29. Yet more confirming information can be found in a newer video from Ivor Cummins: "November 7th Crucial Update: Ireland and UK Lockdown - the WHY?" https://www.youtube.com/watch?v=PuZ0WmC8uP0

30. The next page here contains the Claimant's notes of Ivor Cummins' longer video "Viral Issue Crucial Update Sept 8th: the Science, Logic and Data Explained" (the one with those various graphs above). And thereafter is some commentary on it.

Ivor Cummins Covid-19 Video – Notes by Robin Clarke
"Viral Issue Crucial Update Sept 8th: the Science, Logic and Data Explained"
The video is currently at https://www.youtube.com/watch?v=8UvFhIFzaac
The Claimant also has a copy as MP4 file.

1.00 Gompertz curve, is the standard time series of infections. Rapid rise to about 20% population, then abrupt turn downwards, and then sloping off. **It will be seen that the time series just follow the Gompertz curve in all countries, with no effect of the political policy measures.** (The US has a second peak due to the North-South explained further on)

2.00 Spain showing Gompertz curve.
-All-cause deaths (total mortality) - this is the most valid data as death is not usually mistaken for something else.

5.00 Modelling was hugely inaccurate

6.00 Sweden Gompertz curve, and mostly co-morbid

7.00 **Graph of spikes in each year - big spike in 1918, tiny one in 2020.**

8.30 **Effect of prior season. (Low prior season causes high later.) Explains Sweden, Norway, Finland.**

10.20 Prof David Spiegelhalter's correlation of the same prior season effect.

10.40 **Lockdown is least important of 16 factors**

11.20 **Prof Carl Heneghan - Pubs reopening had no outbreak consequences**

13 **Baizuo graphs - no effect on flu curves**

15.20 **Millions of grocery workers exposed but no associated consequences**
And end of lockdowns makes no difference

16.30 Masks study, 40 years science shows no value of masks ("Non-pharmaceutical measures...")

17.30 **Numerous graphs show no effect of masks policy**

19 **Well-established seasonality of corona and flu viruses**

20.40 Edgar Hope Simspon 1992 book (including the seasonality data)

22 US combination of North and South causes "double" peak effect.

24.15 **"Casedemics"**

25 Search for "CEMB PCR" "Are you infectious if you have a positive PCR test result?" [More up-to-date documents are now cited in this statement here.]

25.50 Casedemics in Ireland, UK, Germany, Switzerland, Spain.

28 Netherlands, France, US (North+South).

29 H1N1 2008-9.

30 Search "Spiegel Swine Flu"

30.40 Germany Casedemic

31 Spain Casedemic (now supposedly in a "state of emergency")

End

31. The Claimant sought out critical commentary on the Cummins video, but found only this one article by Jeffrey S Morris: https://www.covid-datascience.com/post/ivor-cummins-evaluating-some-european-unconventional-doubter-denier-viewpoints, here attached as **Exhibit RC02** (with the Claimant's marginal annotation numbers).

32. And that commentary is hopelessly defective in its criticisms, as will be explained here with reference to the marginal annotations. It repeatedly alleges that Cummins was "cherry-picking", but never shows or even cites what contradicting data was omitted. Indeed the commentary never points to any specific data, but only asserts at multiple points that there is a large amount (or "a mountain") of evidence about x or y which Cummins has allegedly overlooked. Another of the objections is that Cummins concentrates on deaths. But that is with good reason because they are not so readily invalidly assumed to be something else. Whereas "cases" can be shown to mean in reality just positive test results (usually false). With reference to the annotations on the commentary:

(1) "He has no control group with which to compare" — but he compares before/after in the various time-series, none of which show any beneficial impact of the policies.

(2) "we have learned in rigorous studies how this virus spreads" — namely what studies?

(3) "his analysis did not even attempt to use the tools of causal inference" — but he most certainly used the tools of common sense inference.

(4) "There is a mountain of data...." — but none of it shown or cited in the commentary, and in any case it is trumped by the actual data of this particular pandemic.

(5) "masks don't work — yet....." — but see Rancourt **[Exhibit RC07]** and graphs in paragraph 20 here, which is in no way refuted by this commentary.

(6) "Since masks are easy and harmless to wear..." — with which many would disagree. And others have shown reason to believe masks are actually harmful. They certainly function as a psychological equivalent of the Hitler Salute, intimidating people into fear and conformity.

(7) This paragraph contains at best some contentious assertions.

(8) This is perhaps a fair point about the US data, but the commentary does not show or cite the alleged contradicting evidence.
(9) "The counterfactual necessary for his analysis..." — entirely by chance the Claimant was yesterday chatting with a lady recently come from Romania, and she volunteered the information that people over there were not bothering with all these measures, and yet with nothing much by way of consequences. And today visited a Polish/international supermarket, which was *very* crowded and yet where the mask-wearers were outnumbered 20-to-one, and everyone was considering the masks to be nonsense, probably because these foreigners are well aware of what is happening and not happening in their countries of origin. And that store should be a catastrophe epicentre by now due to lack of masks and "social distancing".
(10) "in NYC... we saw how bad that went" — but note the book *Undercover Epicenter Nurse* (paragraph 48 below) which is specifically about the people being murdered in an NYC hospital and pretended to be deaths due to Covid.
(11) "the voluminous scientific literature [of infections]" — again no showing or citations of this "voluminous literature", but more to the point we have the actual information about this specific pandemic itself.

33. And none of the other content undermines the conclusions reached in Cummins' video. Nowhere are those key points really refuted.

34. Also attached herewith is an article by Prof Paul Kirkham et al., *"How likely is a second wave?"* **[Exhibit RC03]** which reinforces the points made by Cummins of a mere "casedemic", and about the misuse of PCR tests that underlies that false epidemiology. Particularly informative parts are indicated by side-linings on the exhibit and or boxing of the specific sentences.

Whether the PCR testing is useful or instead misleading

35. By far the main test used for "diagnosing" alleged "cases" of Covid "infection" is the PCR test. PCR tests are the very basis on which we are being constantly told that there is a worrying increase of "cases" of Covid. Indeed, judging by this graph below being constantly published by the Guardian, one would have to assume that the Covid pandemic is now four times greater than in April, and rapidly getting even worse.

36. PCR is a technique which was invented by Nobel Prizewinner Kary Mullis. He has repeatedly insisted that PCR cannot be used to "diagnose" or "test" whether a person is ill or infected or is a "case". You can see him speaking on this point in this video titled "We are being lied to. Here is how". https://www.youtube.com/watch?v=Ljxah4NrYKU.

    Mullis speaks at 2.00. At 5.00 he says "It doesn't tell you that you are sick. It doesn't tell you that the thing you ended up with is going to hurt you." From 6.30 to 12..45 you can see the contrast between the conscientious genuine scientist Mullis and the charlatan Montagnier – as always these charlatans cannot answer the most basic question from a genuine scientist. 13.00: Mullis comment about Fauci. 14:15: Supposedly "confirmed cases". 16.20: More details about the PCR process and why it cannot be a test.

37. The Claimant sought to understand why the PCR test was being used despite Kary Mullis's declarations. He encountered a short considerably vague paper by Dr Christian Drosten, which apparently was supposed to establish its validity. At which the Claimant emailed to Dr Drosten to ask what had changed to make Mullis's position no longer correct. He has not received any reply to the email. (The Claimant only later learned of allegations that Dr Drosten had a central role in promoting a Covid hoax, as per sources in paragraphs 60-61 below.)

38. Meanwhile, numerous notable people have published their reasons for considering the PCR tests to be either worthless, or at best of unascertained validity.

39. A useful introduction to the "denier" side of this matter may be found in the excerpt from a recent book by Dr Karina Reiss, *Corona False Alarm* (translated from German), pages 17-27, which is here-appended as **Exhibit RC04**.

40. And note for instance this paper authored by three scientists of the Centre for Evidence-Based Medicine, University of Oxford:

https://www.cebm.net/covid-19/when-is-covid-covid/ . In their article they state:

> The methodology [of the UK] for counting cases states the following:
>
> > "If a person has both a negative and a positive test, then only their positive test will be counted. If a person is tested as positive under both pillar 1 and pillar 2, then only the first positive case is counted."
>
> An asymptomatic person who tested positive could have two confirmatory negative tests, but would still count as a confirmed case.
>
> **We deduce that a reported "case" is most probably simply the result of a positive PCR test. The new guidance is meaningless unless it provides a clear threshold for the limits of detection.**
>
> Currently, any person meeting the laboratory criteria is a confirmed case. Yet, a case definition should be a set of standard criteria for classifying whether a person has a certain disease, syndrome, or other health condition (Centers for Disease Control and Prevention).
>
> The PCR test positivity counts should include a standardized threshold level of detection, and at a minimum, the recording of the presence or absence of symptoms. As a disease, the COVID-19 case definition should constitute a disorder that produces a specific set of symptoms and signs. The in-hospital case definition should, therefore, record the CT lung findings and associated blood tests.
>
> Only when an international standard is agreed upon will we be able to make comparisons, and answer the question of *When is Covid, Covid?*.

41. Another paper, authored by researchers in Norway, is

https://www.cebm.net/covid-19/pcr-positives-what-do-they-mean/,

in which they write:

> Ultimately, this means PCR positives cannot be used to tell if the pandemic is advancing if for that we understand that deaths are to increase or decrease. This agrees with the interpretation of CEBM above.
>
> Finally, we want to point out that the same can be said for all countries we have examined, i.e. other than Spain. For example, in the months of July to September positive cases in Europe are said to have risen, but we find no evidence of excess deaths in the countries in Europe reported by euromomo.eu (Figure 10).

42. Another commentary, published 20th September, was by Dr Michael Yeadon, the former CSO and VP, Allergy and Respiratory Research Head with Pfizer Global R&D and co-Founder of Ziarco Pharma Ltd. https://lockdownsceptics.org/lies-damned-lies-and-health-statistics-the-deadly-danger-of-false-positives/

[Exhibit RC05] Therein he stated as follows.

> This test is fatally flawed and MUST immediately be withdrawn and never used again in this setting unless shown to be fixed.
> The likelihood of an apparently positive case being a false positive is between 89-94%, or near-certainty.

43. From the Defendants' Letter of Response it is clear that they do not have any sensible rebuttal of these criticisms of their PCR tests. Their LoR paragraph 20 asserts that:

> **"On PCR testing specifically, RT-PCR tests are <u>universally recognised as the gold standard</u> for testing."**

But by way of evidence for that notion (quite apart from ignoring the many experts who do not concur with this "universally recognised") they cite only a document of theirs which states the exact opposite, namely

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/898437/Evaluation__of_sensitivity_and_specificity_of_4_commercially_available_SARS-CoV-2_antibody_immunoassays.pdf .

of which page 6 states that:

> Of note, **<u>there is no clear gold standard</u>** against which to evaluate these antibody tests; PCR-positivity is a proxy for the expected presence of antibody....

Spot the difference

And furthermore their LoR paragraph 20 would have us believe that that document shows that the PCR tests "should never show more than 5% false positives or 5% false negatives". But it does not state that. What that page 6 of their document *actually* says is about <u>target specifications</u> for the antibody tests:

> The .... MHRA has recently released a "<u>Target</u> Product Profile...."
> .... <u>specifying</u> ..... ≥98% .... ≥98%...

From these facts it is difficult to avoid the conclusion that the Defendants have no real basis for dismissing the criticisms of their use of PCR tests to discern "cases". And on the contrary, the actual facts are against them here. The point about this case not being some matter of expert judgement should be now clear to the reader.

44. And furthermore, Mayers and Baker *"Impact of false positives...."*
(**one of the Government's own advisory input documents**, dated 3rd June 2020)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/895843/S0519_Impact_of_false_positives_and_negatives.pdf
states:

> The diagnostic sensitivity and diagnostic specificity of a test **can only be measured in operational conditions**." "**The UK operational false positive rate is unknown. There are no published studies on the operational false positive rate of any national COVID-19 testing program.**

45. Meanwhile a 13th July 2020 publication of the US Centers for Disease Control (CDC) https://www.fda.gov/media/134922/download states on its page 38:

> Detection of viral RNA may not indicate the presence of infectious virus or that 2019-nCoV is the causative agent for clinical symptoms.
> This test cannot rule out diseases caused by other bacterial or viral pathogens.

46. There are many other published commentaries highly critical of the use of PCR tests for supposedly identifying Covid-19 cases. But the point is surely sufficiently made already here that this is not defensible science, but instead is unsound science. Furthermore, the credibility of PCR testing takes an even heavier bashing via the earlier section showing the fallaciousness of the "second wave" which this testing is alleged to be showing us.

Some "Frequently Asked Questions"

47. In response to the evidence stated above here, some "challenging" questions may be raised, such as might be supposed to cast doubt on the thesis of a non-crisis. But it should first be pointed out that it would anyway be logically impossible for any such answers to rebut the reality already shown in the graphs in paragraphs 20-28.

48. Firstly: **But what about the increasing numbers of deaths occurring currently (late October 2020)?** In fact this is not at all surprising in the context of a non-crisis. People are dying of respiratory conditions all the time. Pneumonia has long been a very common "cause of death". If you combine that with a large increase of "cases" there will inevitably be a large increase of those "cases" dying of respiratory conditions. One should also be mindful of the secretiveness and dishonesty in the NHS as indicated below at paragraph 58. Also relevant here is the undercover video made by a nurse in New York, https://www.youtube.com/watch?v=UIDsKdeFOmQ (Perspectives on the Pandemic | The (Undercover) Epicenter Nurse | Episode Nine) and her book *Undercover Epicenter Nurse* https://www.amazon.co.uk/dp/151076366X which includes basically the same content as the video. That undercover video indicates that many "Covid deaths" could be more accurately characterised as murder by medical malpractice.

49. Secondly: **But what about the reports now emerging of cases of chronic illness, being called "Long Covid"?** But people have been developing chronic problems for many years before now anyway. There have been extensive assertions about for instance chronic fatigue, "ME", "MS", and other chronic conditions being caused by, allegedly, Lyme Disease, or yeast infection, some toxicants, or as a follow-on from a viral infection. Determining the true causes of such cases is far from easy. But now that a great many people are being "diagnosed" as "cases" of Covid, it follows that something like an equal proportion of the "Covid cases" are going to develop long-term problems. It does not follow that the long-term problems are something specially significantly related to the Covid, let alone caused by this alleged virus.

50. Thirdly: **But what about the reports that hospitals are again at risk of being overwhelmed with Covid cases?** Well, firstly, the same principle of false diagnoses applies, in the context that the NHS is a secretive and dishonest organisation (as per paragraph 58 below). An organisation that can steadfastly pretend that several million people have not been poisoned by their dental amalgams (www.pseudoexpertise.com/ch-3.pdf) would be quite capable of also pretending that thousands of people need to be in hospital just because they are coughing and hyperventilating with anxiety. Secondly, the lockdowns will have had major negative effects on peoples' health, from lack of exercise, lack of sunlight (for vitamin D), lack of the normal social interactions, poor nutrition due to lack of money, and huge stress from impoverishment and uncertainty. Such policies would be very much expected to result in deterioration in peoples' health, such that many more would indeed become more ill from flu and therefrom find themselves in hospital. Strongly in line with this, it is notable that Liverpool, which has been particularly stressed by the impoverishing effects of lockdowns, is notably reporting high hospital usage. And furthermore, there was already talk of strained hospitals capacity before Covid-19 arose. Meanwhile here are the words of Prof Karol Sikora: "I've been a doctor for decades, this is no different to a normal year." "People with comorbidites always come at winter, ever since I've been a medical student." And of Prof Heneghan: "This is completely in line with what is normally available at this time of year." https://www.dailymail.co.uk/femail/article-8916871/Whistleblower-NHS-worker-reveals-whats-REALLY-going-NHS-hospitals.html

51. Fourthly: **Are we seriously to believe that there is a huge conspiracy, of all the media and governments, all around the world, to impose some pseudoscience scam on us all? The notion is patently absurd.** Well, it should firstly be noted that conspiracies of major significance do sometimes occur in reality, one such being the famous "Watergate Conspiracy". There have also been many smaller conspiracies, such as Volkswagen's conspiracy to trick the systems for measuring pollution, and the many abuses by big pharmaceutical corporations as documented in Prof Gotzsche's book *Deadly Medicines and Organised Crime*. Another example in the medical field is that of the false attribution of the book *Let's Stay Healthy*, falsely attributed as being the "last book" by the famous nutritionist Adelle

Davis despite contradicting everything she had written in the books she had actually written herself. This very Claimant encountered that book on its publication and wrote about it to Dr Bernard Rimland, who turned out to be a member of the Adelle Davis Foundation and who replied to agree that there was no way that Adelle Davis would have endorsed the views supposedly authorised by her in that book. Here attached are a surviving part of the letter sent by the Claimant and a letter of reply from Dr Rimland **[Exhibit RC06]**. These should give some measure of the extent of elaborate conspiracy which Big Pharma crooks do indeed actually get into.

52. And in respect of the present case, we do not need to suppose that many thousands around the world are "in" on some "conspiracy" to trick the rest of us. It only requires a relatively small number of conspiring deceivers who can rely on the trust naively placed in their "expertise" and reputation for integrity. The "very busy" journalists can be relied on to just go along with their disinformations. And likewise politicians are also just about always too "busy" to actually stop and think about what they are being told and believing. And add to that the heavy intimidation from speaking out, to the extent that even the distinguished Great Barrington Declaration authors got sneered at as "fringe" "extremists".

Additional evidence about the science

53. It is the Claimant's reckoning that the evidence presented above here (and not least the video from Ivor Cummings) should suffice as proof of his claims about the science. However, there will be here appended some further documents by way of evidence:

a) Rancourt *"Masks Don't Work"*, herewith **Exhibit RC07**. This clearly genuinely scientific article was deleted from the ResearchGate server on the patently unsound excuse that:

> "Our Terms of Service prohibit the posting of non-scientific content on the platform. Given its questionable scientific basis and controversial subject matter, the content you posted is a violation of our Terms."

b) JB Handley's Preface to the *Undercover Epicenter Nurse* book, sections relating to lockdown 'science', Professor Neil Ferguson, and lack of effect of measures, **Exhibit RC08**.

c) Belgian letter https://docs4opendebate.be/en/open-letter/ **Exhibit RC09**

54. Mention should also be made of the abundant long-established evidence of the powerful impact of vitamin C in preventing and curing all sorts of viral infections, key information which has peculiarly been ignored and suppressed in the context of the constant noisy going-on about "the search for a vaccine", when no such dubious technology would even be needed anyway (and no vaccine for any coronavirus has ever been made to date). A summary of such evidence about vitamin C can be found in the book by Thomas Levy MD, *"Primal Panacea"*, pages 32-3, 95-6, 214, 220, 222-5, 232, 235-6, 255, 260, 265, and references list 328-333.

Credibility of the institutions, experts, and decisionmakers involved

55. It may also be useful to consider the level of credibility of the various sources of opinion, data, and policymaking which have been and continue to be involved.

56. Numerous books have been written about the failure of modern science. For instance from Prof HH Bauer the tellingly titled *"Science is not what you think: Why it has changed, Why you cannot trust it"* (2017). From Prof Peter Gotzsche the tellingly titled *"Deadly Medicines and Organised Crime"* (2013). And yet more major malfunctioning of medical science is documented in this Claimant's own book *"Experts Catastrophe",* which ironically he wrote before this present crisis. Prof Bauer has compiled a substantial list of books and other documents about this "crisis of science" which just about never gets mentioned in the media, and probably even less mentioned by allegedly expert witnesses in courtrooms.

57. It is in this context of unreliability of medical "expertise" that the guiding principles explained in paragraphs 14-16 should be invaluable.

Credibility of the NHS

58. Some hint of the secretiveness and dishonesty within the NHS may be gained from how it treats whistleblowers (and indeed from the fact that there need to be whistleblowers anyway). This Claimant enquired in 2019 of his MP as to (a) how many whistleblowers had been reinstated to their posts, and (b) how many of the crooks secretly blacklisting the whistleblowers had been dismissed. He got no reply so asked again two weeks later. He again got no reply so asked a third time another two weeks later. Untimately he never got any answer. But the basic fact here is that – just about no whistleblowers ever get their jobs back, and none of the crooked blacklisters ever lose theirs. And so as a source of truth, the NHS has no credibility whatsoever. Some of its extensive secrecy and dishonesty is documented in Chapters 3 and 8 of the Claimant's book *Experts Catastrophe*.

Credibility of the Great Barrington Declaration

59. The Great Barrington Declaration, issued in October 2020, calls for the abandonment of the current lockdown policies. It was authored by three considerably senior professors, specifically of epidemiology, from three of the most prestigious universities (Oxford, Harvard, and Stanford). And, in view of the principles outlined earlier, because they were speaking against rather than for the promotion of a "crisis" narrative, some credibility would be properly given to their opinions. The Declaration has since been signed by many other notable medical experts. Note also the many signatories of the Belgian letter (paragraph 53(c)).

Credibility of organisations more widely (internationally).

60. There is certainly not anything like a global consensus about the lockdown policies. A huge legal challenge, for tort against millions, is being prepared and supported by an international collaboration headed in Germany by the German Corona Investigative Committee (Außerparlamentarischer Corona Untersuchungsausschuss), as described in the following webpages: https://corona-ausschuss.de/ https://articles.mercola.com/sites/articles/archive/2020/10/17/coronavirus-fraud-biggest-crime-against-humanity.aspx (attached as **Exhibit RC10**) https://www.ageofautism.com/2020/10/reiner-fuellmich-crimes-against-humanity-transcript.html

    Dr Fuellmich's video has been removed from Youtube as part of their operation to remove "misinformation". Perhaps the courts should adopt a similar system, refusing to allow defendants to speak in their hearings. Meanwhile the video can be viewed at http://mediathek.rechtsanwalt-fuellmich.de/money_talks_v_en.m4v

61. A detailed recent email from Dr Fuellmich is attached as **Exhibit RC11**

The regulations here challenged

62. This Claim seeks the review of all the ongoing regulations intended (ostensibly) for combatting the alleged crisis of the Covid pandemic. This includes all the current S.I.s listed at https://www.legislation.gov.uk/coronavirus. In respect of England these include (as links to the texts here):

    The Health Protection (Coronavirus, Restrictions) (England) (No. 4) Regulations 2020 (S.I. 2020/1200)
    The Health Protection (Coronavirus, Restrictions) (No. 3) (England) Regulations 2020 (S.I. 2020/750)
    The Health Protection (Coronavirus, Restrictions) (No. 2) (England) Regulations 2020 (S.I. 2020/684)
    The Health Protection (Coronavirus, International Travel) (England) Regulations 2020 (S.I. 2020/568)
    The Health Protection (Coronavirus, Wearing of Face Coverings in a Relevant Place) (England) Regulations 2020 (S.I. 2020/791)
    The Health Protection (Coronavirus, Collection of Contact Details etc. and Related Requirements) Regulations 2020 (S.I. 2020/1005)
    The Health Protection (Coronavirus, Restrictions) (Self-Isolation) (England) Regulations 2020 (S.I. 2020/1045)
    The Health Protection (Coronavirus, Local COVID-19 Alert Level) (Medium) (England) Regulations 2020 (S.I. 2020/1103)

The Health Protection (Coronavirus, Local COVID-19 Alert Level) (High) (England) Regulations 2020 (S.I. 2020/1104)
The Health Protection (Coronavirus, Local COVID-19 Alert Level) (Very High) (England) Regulations 2020 (S.I. 2020/1105)

Though as the Claimant (and all the other usual residents of England) would normally be considered to have citizenship of the whole UK area, this case also has extensive relevance to the regulations relating specifically to Scotland, Wales, and Northern Ireland. A useful account of the facts of many of these various regulations is given in the opening pages of the Statement of Facts and Grounds for Mr Dolan's second Covid-related Claim, here attached as **Exhibit RC12**.

63. And the Claim is also intended in respect of any such regulations as may arise concurrently or subsequent to its filing, insofar as they would be founded on the same indefensible scientific basis of a supposed great health crisis.

Grounds of review

Ground 1. There is a failure to take account of the proof that the regulatory measures have had no beneficial effect, while causing major adverse consequences including increased morbidity and mortality;.

Ground 2. There is a failure to take into account the proof that there is not a particularly exceptional health crisis currently, relative to most other years.

Ground 3. There is a failure to take into account the evidence that there is no defensible scientific basis in justification of these regulations.

Ground 4. There is a lack of defensible scientific basis for the regulations, such that no reasonable or rational decisionmaker would make such decisions.

Ground 5. Consequently there is no proper aim and necessity that can justify these measures being considered to be not in breach of Articles of the Human Rights Act. In particular:

- In respect of **HRA Article 8**, the "right to respect for his private and family life, his home and his correspondence" is interfered with insofar as ability to maintain that private life and home is undermined by regulations interfering with the conduct of a chosen occupation or mode of business.

- In respect of **Article 9**, the "freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance" is breached by the regulations prohibiting such assemblies and by those regulations prohibiting travelling to them..

- In respect of **Article 10**, the right to "freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers" is breached by the regulations restricting movements outside the home and by regulations obliging "social distancing" and prohibiting gathering in numbers above a certain level.

- In respect of **Article 11**, the "right to freedom of peaceful assembly and to freedom of association with others" is breached by those regulations which prohibit gatherings beyond certain specifications, and those regulations which prohibit leaving the home or travelling except for specified purposes (which do not include such assembly or association).

- In respect of **Article 3 of the First Protocol**, the undertaking "to hold free elections at reasonable intervals by secret ballot" has already been breached in respect of the May 2020 elections, and there remains a threat of continuation or recurrence until such time as this supposed health crisis is officially declared to be ended (which could be never).

And in respect **all these Articles**, none of the regulations are "necessary [....] for the protection of health", because (a) they do not reduce illness and (b) the alleged extraordinary health crisis does not actually exist. Otherwise these rights would have to be curtailed during every annual recurrence of the "winter flu".

Pre-action Protocol and Standing of the Claimant

64. The Claimant's *Letter before Claim*, the Defendants' *Letter of Response*, and the Claimant's comments thereon are herewith attached, **after** Exhibit RC12.

65. The Claimant has standing in this matter in that he is a resident of Birmingham, and more widely of the UK, and consequently inevitably has been and will be substantially affected by these regulations in obvious ways. He also brings this Claim on behalf of many thousands who have been devastated thereby.

Timing and Expedition

66. The cause of action in this case arises not from any specific event or decision or enactment at any specific time, but rather arises in the context of a progressive continuum of change, both in terms of accumulating facts of the science, and of continuing application (varying or otherwise) of the various regulations. There has thus not been any particular date at which the cause of this action has binarily switched from not existing to indeed existing, but instead there has been a gradual increase of the level of absurdity and indefensibility of the policies, till at some point in October it was clear that there was no longer any scientifically defensible rationality justifying the policies. Though the Defendants will insist that such a point has still not been reached.

67. Meanwhile the major harms being caused by these regulations need no evidencing from this Claimant. Every day that they are allowed to continue brings us so much nearer to so much more disaster. Accordingly it is respectfully suggested that the hearing of this Claim should be expedited.

Remedies sought

68. The Claimant seeks an order for the following:

a) Quashing of these various regulations ostensibly serving to address a health crisis caused by the Covid-19 pandemic.

b) Prohibiting of the issuing or enforcement of any further such regulations, until such time as a defensible scientific basis for them has been published, and subject to public and expert consultation, and not found wanting by such a significant number of competent experts.

c) A declaration that there is no evidence of any health-protective benefit from the lockdowns, distancing, and masks, and that on the contrary the evidence clearly shows no benefit, and also no exceptional health crisis of a “second wave”, but instead to the contrary, and accordingly that there is no rational basis for the continued enforcement of these regulations.

Request for urgent interim injunction

69. In view of the major harms being caused from every further day of these regulations, the Claimant requests that they be suspended by an injunction and their enforcement prohibited, until such time as a defensible scientific basis for them has been published and not found wanting by any significant number of scientific experts**.**

STATEMENT OF TRUTH

I believe that the facts stated in this Statement of Facts and Grounds are true.

Robin Clarke

Robin Clarke, Claimant

Dated November 2020 r[at]rpcc[dot]info 0121 456 4274

EXHIBIT RC01

CEBM
The Centre for Evidence-Based Medicine develops, promotes and disseminates better evidence for healthcare.
CEBM UNIVERSITY OF OXFORD

COVID cases in England aren't rising: here's why

August 2, 2020

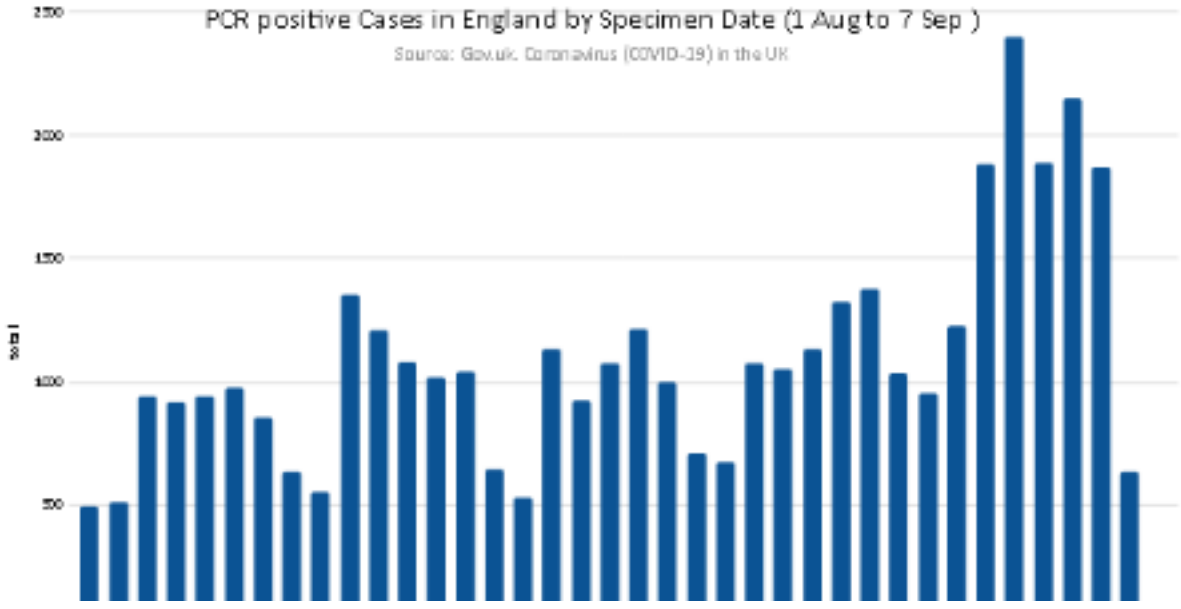
Carl Heneghan

The government has restricted movements on millions of people in England: COVID is apparently on the rise. But what happens when you start digging into the data.

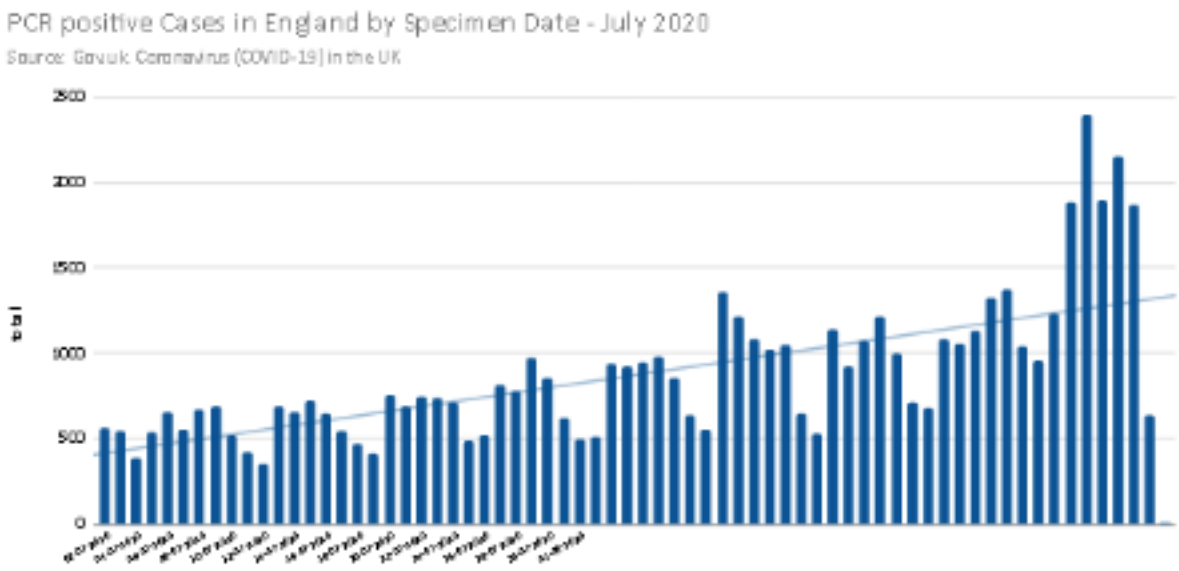
I have used the following data sets to piece together the number of tests, cases and results for Pillar 1* (done in healthcare settings) and Pillar 2* (tests are done in the community).

- Coronavirus cases in the UK: daily updated statistics [https://www.gov.uk/guidance/coronavirus-covid-19-information-for-the-public#time-series-documents]
- https://coronavirus-staging.data.gov.uk/healthcare [https://coronavirus-staging.data.gov.uk/healthcare]

Looking at the data for July, by the date the PCR test to detect the virus SARs-CoV-2 is reported, shows a trend for an increased number of cases detected – (from about 500 to nearly 750 a day)



If you look at the data by the date the specimen is taken the trend is still apparent (the number of cases varies when assessed by specimen date compared to the date of the reported test)

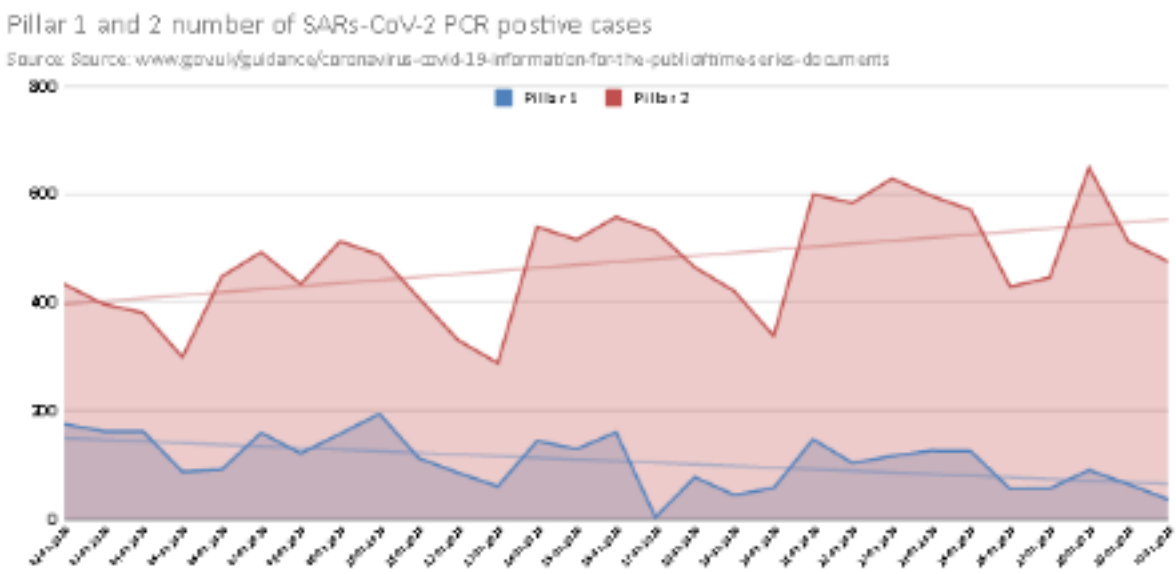


Now all things being equal, the increase in cases is about 250 per day over a month – not an exponential rise, and no sudden jump. But is this a real increase or could it be down to something else – can an increase in testing explain the rise?

See a time series of positive cases by specimen date: 31 July 2020 [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/905965/2020-07-31_COVID-19_UK_positive_cases_time_series_by_specimen_date.csv] to look at the Pillar 1, 2 cases detected.

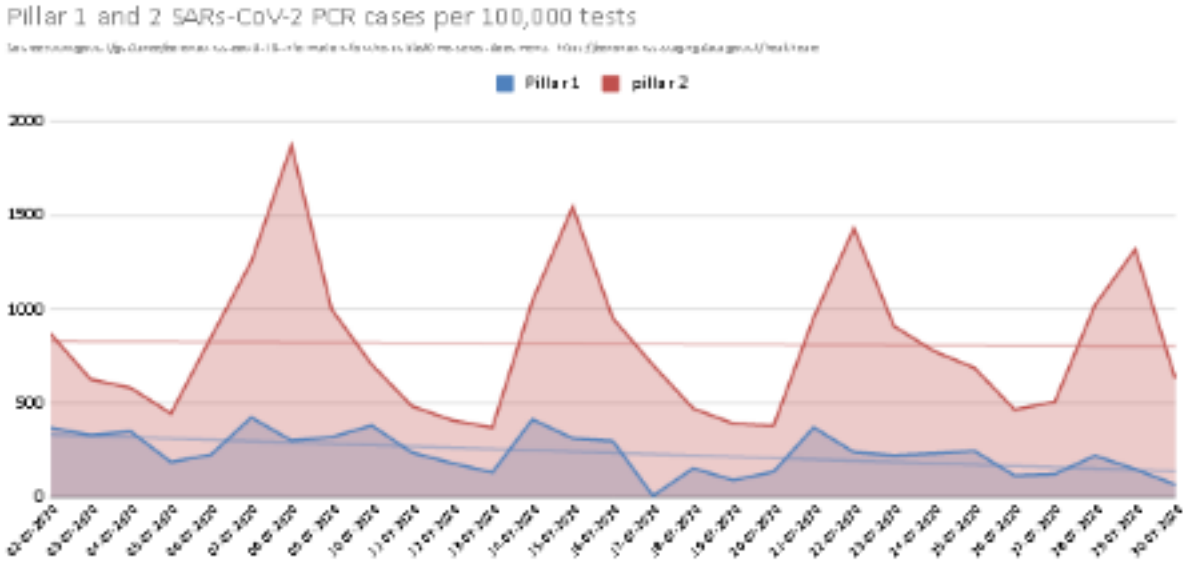
On the 28th of July in England, Pillar 1 reported 64 cases, and Pillar 2 reports 512 cases (576 in total). Yet www.gov.site [http://www.gov.site] reports on the same-day fewer cases – 547 of the two combined. Which one is, therefore right? This inaccuracy makes it difficult to make judgements as to what is happening on the ground.

On first glance it looks like the number of cases in Pillar 2 is trending up and Pillar 1 is trending down. This would suggest that the increase in hospitals – in the sickest (Pillar 1) – is staying the same; while in the community Pillar 2 testing is picking up milder asymptomatic disease.



However, what happens if you adjust for any change in testing over time? On the 1st of July – the seven day moving average of testing was 41,109 for Pillar 1 and 43,161 in Pillar 2. By the 31st July, the Pillar, 1 seven day average for testing had increased to 49,543 (a 20% increase); while the Pillar 2 had risen by much more – by 82% to 78,522 tests.

The next graph shows what happens when you adjust for the number of tests done and then standardise to per 100,000 tests. Pillar 1 is seen to be still trending down, but Pillar 2 is now flatlining. The increase in the number of cases detected, therefore, is likely due to the increase in testing in Pillar 2.



It is essential to adjust for the number of tests being done. Leicester and Oldham have seen significant increases in testing in a short time. Leicester, for example in the first two weeks of July did more tests than anywhere else in England: 15,122 tests

[https://mcusercontent.com/ab3c575ef029741145cc68979/files/ea2ed527-a57c-46f6-926e-d5aa50d7b3ba/COVID19_Presentation_15_July_2020_1_.pdf] completed in the two weeks up to 13th July.

The potential for false-positives (those people without the disease who test positive) to drive the increase in community (Pillar 2) cases is substantial, particularly because the accuracy of the test and the detection of viable viruses within a community setting is unclear.

Standardising cases per tests done, and aligning the counts in different datasets to provide the same numbers will allow a better understanding of whether cases are going up or down.

Inaccuracies in the data and poor interpretation will often lead to errors in decisions about imposing restrictions, particularly if these decisions are done in haste and the interpretation does not account for fluctuations in the rates of testing. The current reporting of the data with its inconsistencies also makes it difficult to provide accurate estimates of the case rates per tests done.

- *Pillar 1: swab (antigen) testing in Public Health England labs and NHS hospitals for those with a clinical need and health and care workers
- *Pillar 2: swab (antigen) testing for the wider population

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View questions under review

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EXHIBIT RC02

Jeffrey S Morris Reply to Ivor Cummins video
Jeffrey S Morris, 9th Sept
https://www.covid-datascience.com/post/ivor-cummins-evaluating-some-european-unconventional-doubter-denier-viewpoints

Ivor Cummins: Evaluating some European unconventional doubter/denier viewpoints

Annotation numbers below

Updated: Oct 7

This video by Ivor Cummins describes some of his unconventional viewpoints. He supports the position that mandatory lockdowns were not needed, and has a hypothesis that viral deaths are cyclic suggesting that countries that were hit hard by flu before 2020 did not have as many deaths from COVID-19 while those with low flu death rates in 2019 had higher COVID-19 deaths.

This was forwarded to my by a friend so I watched and gave my thoughts to him, and since I was so detailed thought I would turn it into a blog post since his ideas highlight several important points about our society and this pandemic, and the doubter/denier vs. worrier/alarmist ends of the continuum on COVID-19.

1. He highlights some real facts that for some reason don't seem to register with many individuals in our society or the media -- these are facts that people on the doubter/denier end of the spectrum focus on. Some of these are real facts, and need to be acknowledged and understood if we are to have full knowledge of what is going on in the pandemic and to construct the best mitigation and management strategies. Some of these facts are not acknowledged by many who tend towards the alarmist end of the continuum. Ignoring these facts feeds the denial/doubter perspective.

2. While acknowledging these facts and bringing some interesting ideas to the discussion, he seems to ignore other facts and data, effectively cherry picking information to support his thesis. I will point out some of these problems with his argument and what information he is not taking into account.

First, I will highlight his points that I agree with:

1. The media has misrepresented the strategy and outcomes in Sweden -- they never really were seeking herd immunity -- i.e. they did not try to speed viral spread through society to reach immunity. Rather, their strategy was to avoid government mandated lockdowns, instead focusing on providing guidance to the public about targeted mitigation strategies and trusting them to follow them, which they largely have, much better than the USA has since reopening after lockdowns. He rightly points out that Sweden's death rate is far lower than what was predicted, and lower or comparable to many other European nations including UK, Spain, and Belgium, or the USA. Here is the comparison that shows that even with their controversial strategy, they are in better shape than the USA.

(See graph at end here)

This is not to say I agree with their strategy -- I don't -- but it does bother me that they are such a media punching bag, and their approach and results are not accurately represented. I agree with this point that he makes.

2. People are obsessed with following numbers of cases and don't look enough at hospitalizations, deaths, and long term morbidity induced by the virus. When you look at those you get perspective on the virus, and can have a realistic sense of the risk of the virus to each infected person, which is important to have a complete picture of the effects of the virus.

3. It is important to consider the collateral damage caused by strict mitigation strategies, in terms of lives, public health, mental health, education, and the economy. These don't seem to be explicitly considered in people's discussions about strategies for viral control -- ideally policymakers would bring together multidisciplinary teams including infectious disease experts, but also other professionals including mental health professionals, educators, economists, and data scientists to try to pull together all of this information in a meaningful and explicit cost-benefit analysis.

4. I agree that there may be a subset of the population that have some T-cell memory from previous coronavirus infections from strains that are part of the common cold, and these may confer immunity or mild disease on these people. I am working on a blog post discussing key points from the literature about what we know and don't know about this phenomenon. It is largely ignored by many people in society, especially those leaning towards the alarmist side, and overemphasized, exaggerated and misrepresented by many leaning towards the doubter/denier side.

5. I agree there may be reasons why cases in the summer are more mild than the ones we will see in the fall and winter. There are many good reasons for that, the most convincing which involves lower viral loads -- high enough to lead to infection but not high enough to have as high a risk of severe infection as in the winter/spring time. The flip side of this is that all of the low death and hospitalization rates relative to April may increase greatly as the weather turns in the fall (which is another reason why I think getting viral levels under control right now is of paramount importance).

6. He mentions that places that had high death rates from COVID-19 strongly tended to have very low death rates for the 2019 flu season, suggesting this provided a population of vulnerable people. This is an interesting hypothesis, and he shows some plots -- would be better to see more rigorous study to be sure the effect is not cherry-picked from certain locations where it fits while ignoring other locations for which it does not.

In spite of my agreement with some of these points that I think are under appreciated by many and underreported in the media, I see a number of speculative arguments he makes without support, untested assumptions, and cherry picking science and representing himself like "he knows the real science" and studies he doesn't mention are somehow more flawed than the ones he chooses to focus on. I will give examples below. But first I will mention the key feature of his argument -- He ONLY looks at deaths, not cases, testing, hospitalizations, long term side effects from infection, with a few cherry picked exceptions to support specific points ...

I agree that deaths are ultimately most important from a human perspective, but they are not the only important thing, and they are the least reliable measure of epidemic viral spread. He does not mention potential long term complications for infected, which I will mention below could be a major issue and sufficient reason alone for caution. Deaths lag cases by a month or more, so during the early days of a surge we don't immediately see the deaths -- given the surges take a month or so until the cases are really high this means the correponding deaths will manifest maybe 2 months into

the surge. This cuts into a lot of his argument that the European uptick in late summer will not produce a corresponding uptick in deaths like the Southern/Western USA summer surge did, instead speculating these cases do not indicate a true surge but rather speculating they are due to "false positive tests", "detecting nonactive virus", and "over-testing". Why is the surge happening now and not in June or July then? He never presents any plots overlaying testing to provide support for this -- in the Spanish pandemic, testing has steadily increased since May, yet cases stayed flat through August and then started a sharp uptick that is faster than the increase in testing. His argument here, that (a) the increase is artifact of testing and (b) it is not real because deaths haven't increased (much), is eerily similar to the specious argument made in Texas and Florida during their surges, where deaths predictably sharply increased after the usual delay. He never considers that the uptick in Spain and other European countries might not be a meaningless seasonal effect, but might be the beginning of a surge induced by people getting sick of staying at home and getting together indoor in crowds and starting a surge like happened in the summer in the southern USA -- that seems like Occam's razor (the most parsimonious explanation) to me. To understand this pandemic, it is necessary to look at all the data together -- including tests, cases, hospitalizations, severe disease rates, and deaths so an analysis based only on deaths misses insights into the dynamics of viral spread, which paint a lot more clear picture into what the pandemic is doing at a particular location.

Some of his speculative assumptions without support:

1. He blithely states that about 20% of populations were infected and then the death numbers came down predictably because 80% have T-cell immunity from "one of the many" other coronaviruses. First, only in the most highly surging places is it possible 20% were infected (Texas, Phoenix, Florida and NY in USA, Italy and Spain in Europe, e.g.). Second, assuming that all of those not infected in the first wave have "T cell immunity" is major speculation and implausible. For one thing, almost all these places locked down so many people were never exposed, especially vulnerable populations, and second, there is no evidence that 80% of the population has T-cell immunity. Third, the "many" coronaviruses he refers to are 3 that are part of the common cold, plus SARS/MERS that are rare in Europe or USA. Fourth, there are small studies that show evidence that 20-50% of the population have some T cell memory pre-SARS-CoV-2 and it is true that these may confer immune advantages to these individuals. Whether it confers actual immunity or just predisposes them to more mild disease is not clear, but there is no evidence this number is 80%.

2. He assumes the lockdowns, mask wearing, and physical distancing had no effect when he has little basis for doing so -- almost the entire world locked down for a time and after opening have had major physical distancing guidelines and most places have closed places with large indoor gatherings. He has no control group to which to compare in order to make this inference. From what we have learned in rigorous studies about how this virus spreads, it is clear that mitigation strategies like avoiding crowded indoor settings, physical distancing when indoors, and mask wearing make a clear difference in suppressing viral spread. Looking only at deaths before/after directives were made is not helpful in the least bit -- deaths depend on so many other factors and there is confounding of viral levels and time -- that make causal inference on these factors extremely difficult -- and his analysis did not even attempt to use the tools of causal inference in addressing this question, but cites a handful of selected studies and makes an argument about plots before/after directives were put into place.

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3. He invents several concepts and terms without defining them or supporting them in scientific literature.

3a. He says that the "virome does what it does", meaning that cases wax and wane with humidity, UV and seasonal immune cycles and ignores human intervention. What is virome and where is his support for this claim? There is a mountain of data showing viral spread is linked to societal behavior in terms of gathering indoors and physical distancing. This idea of the virus spreading based on season and not human behavior is antithetical to the principles of infectious disease.

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3b. He says that by trying to limit the spread of the virus in the summer, we have interfered with the "ancestral/evolutionary safe summer spread immunity", of course without precisely defining or citing articles about this concept. He then claims that "there will NOT be a surge of deaths in the winter since any deaths will be what would have happened because of seasonal flu" and then out of the other side of his mouth claims "any extra deaths will be due to the summer mitigation strategies interfering with this natural evolutionary protection". Pretty slick, he can claim he was right whether there is a surge of deaths or not. This is perhaps the most transparently weak part of his argument.

4. He argues that "40 years of science" show masks don't work -- yet those were done for flu and other respiratory viruses that don't spread asymptomatically. It is clear from what we have learned that one of the key characteristics of SARS-CoV-2 is that it spreads predominantly from asymptomatic/presymptomatic infected which is what makes it so hard to get its spread under control. This is precisely why masks are recommended in this case but not for flu. There is ample evidence from designed mechanistic experiments that even cloth masks block a high % of the particles exhaled by infected individuals, and given most spread is from respiratory particles it stands to reason that this would slow (not completely prevent) spread. And there is epidemiological evidence to support it has an effect although as above difficult to show causally. Since masks are easy and harmless to wear, especially when indoors around other people, it is staggering to me why some people have such an aversion to them as a basic mitigation strategy.

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5. Throughout he equates flu to SARS-CoV-2, and it is clear this is his ideological perspective that "this is no more than a flu that has been overhyped". This is fundamentally wrong, as there are numerous features of SARS-CoV-2 far more problematic than flu -- from its proclivity to super-spread and spread from asymptomatics to the broad immune system/inflammatory disregulation it can induce that leads to severe cases and deaths. These problems also lead to post-infection inflammatory syndomes ,in some children, and apparent serious lasting side effects from infection such as the documented myocarditis that has been found in a sizable % of recovered people, especially young people, and including many people with asymptotic and mild symptom disease. If the numbers from this and other similar studies are representative, and if this is long-lasting, this could be a life-changing and major life-shortening after effect of the infection and a game changer that justifies extreme caution. We need to learn more, but this is the problem -- he is presuming there are no such effects or problem when all he looks at is deaths, and this virus works in freaky ways like nothing I've ever seen, and until we can confirm there are not major long term repercussions like this it is prudent to restrict infectious spread as much as possible, which he would dismiss as unnecessary or even harmful.

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6. He presumes that all the death curves can be explained by natural seasonal variation like flu. This is convenient since most early surges happened in north in late winter which fit the timing. But the southern/western USA surge doesn't fit that at all -- and he blithely reclassifies this as "Mexico-like" and lumps this pattern in with Mexico and South America like it is a normal pattern. Yet he never shows from previous years that flu has this pattern in the southern USA because .... it does not. The easier and empirically supported explanation is that the southern/western USA surge happened later because (1) the initial surge was focused in NYC and didn't hit the south right away and (2) the south quickly and rather recklessly reopened putting lots of people together in crowded indoor settings and without masks, because these regions reject mask wearing, during the hot summer when people are indoors in AC to avoid the heat. This is much better explanation than his "virome" or "flu seasonal pattern" hocus pocus, and far more empirically supported from the data.

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7. He simultaneously argues that the death curves from this covid-19 surge, which has been met with near universal lockdowns followed by physical distancing and mask wearing upon opening, has been "not that bad" comparing it to a usual flu season while simultaneously arguing that "lockdowns, masks and physical distancing don't work" without having a valid control or counterfactual against which to compare it. Sweden does not provide a valid counterfactual since, while they did not lock down, they closed secondary schools and recommended major physical distancing practices and encouraged outdoor gatherings, where it is beautiful weather in the summer so conducive to being outdoors. Sweden practiced what he called "smart distancing", and which I call "targeted mitigation". The counterfactual necessary for his analysis would be a society plowing through life ignoring the pandemic, not having lockdowns or mask wearing or closing anything, but also with people not taking any individual precautions like staying at home more, gathering outside instead of inside, practicing better hand hygiene and physical distancing, which would be like a typical flu season. The best simile to that is NYC in April and we saw how bad that went. If some place did THAT and the deaths were like flu, I might buy it, but all over the world we took all of these precautions and still saw these numbers of deaths. I believe had this counterfactual been followed the deaths and severe cases would have FAR dwarfed any flu season. He never acknowledges this potential bias because he conveniently and with very little evidence dismisses that any of these measures suppressed spread, while ignoring the volumnous scientific literature and entire infectious disease community and what they have learned about infectious disease throughout history. By ignoring the potential that death rates would have been much much higher without mitigation strategies, he can spin the relatively low death rates as nothing more than a "typical flu season". If his presupposition that mitigatoin has NO effect on cases and deaths is not true, then his whole analysis that the deaths are nothing more than a typical flu season also go out the window with it. It is appropriate that he ends his video with a diagram of a train of dominos, since if you push one domino of his untested assumptions over much of his argument goes along with it.

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In conclusion, I'd say that he has some good points that need to be heard, but he goes too far trying to squeeze the data and pandemic into his preconceived explanations, which he presents in a condescending "I know what real science is" way, and makes speculative unsupported points, ignores data and studies that don't suit him, and does not even attempt to link the other data types into his analysis which is convenient because it is easier to spin his narrative using just the death data.

It makes me sad, because some of his key points I believe are valid and NEED to be heard -- the media and others DO have a blind spot that tends to push them towards the alarmist side, discounting evidence that paints the virus as not so foreboding and also skewing discussion of points like low mortality rate for most groups of people, the potential of T-cell memory assisting immune response for many people, and and honest assessment of Swedish strategy of experience and its lessons. But by going too far into speculation and cherry picking to tell a clean, compelling narrative (which he does well), he lowers himself to be nothing more than a partisan feeding the denier/doubter side, likely to be dismissed by people leaning towards the alarmist side or people in the middle.

Conversely, I think the failure to acknowledge some of these points mentioned above, perhaps driven by fear of somehow providing justification for the doubter/denier perspective, backfires and contributes to out inability to come together as a society and agree on a set of common facts that could serve as the basis for a unified strategy.

This is a shame because what we need is people illuminating some of the points he has made in a balanced way while acknowledging (1) how fast this virus spreads (2) that it does nasty things beyond a common flu, and we don't fully know all it does, (3) that mitigation strategies do slow viral spread, and thus suggesting that we should take some steps to slow its spread, but finding a middle ground that provides the best viral suppression possible while also minimizing collateral damage to society. If he made that balanced argument I think he'd be more influential to the people who don't already agree with him before they see his video podcast.

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Graph below.

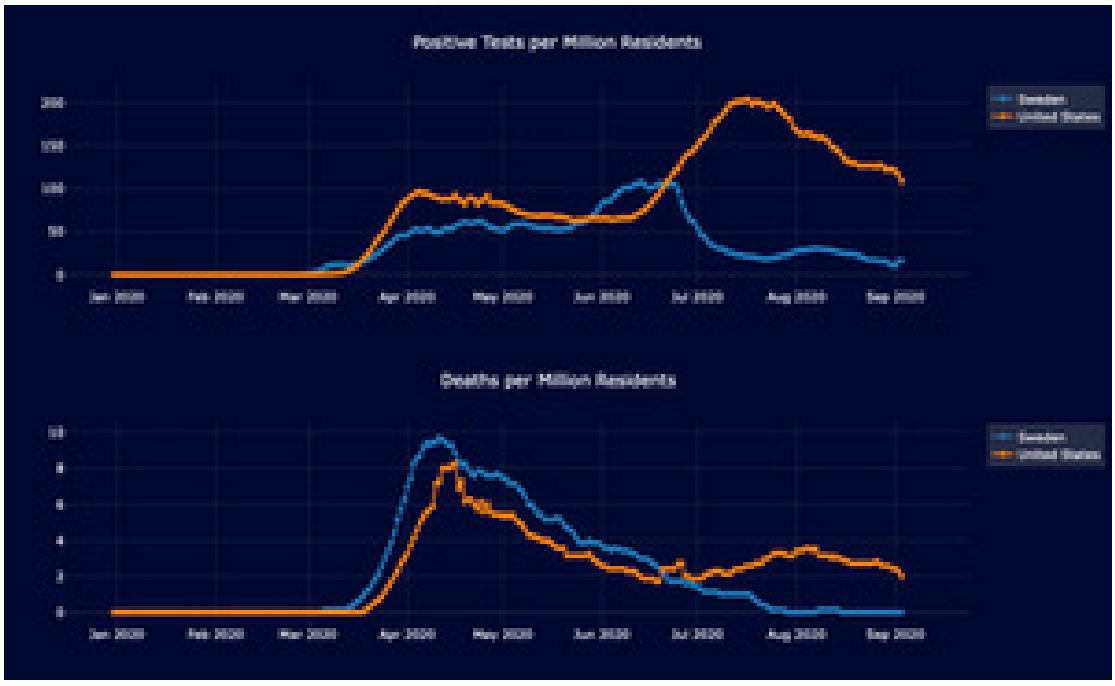
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EXHIBIT RC03

LOCKDOWN SCEPTICS

STAY SCEPTICAL. CONTROL THE HYSTERIA. SAVE LIVES.

How Likely is a Second wave?

7 September 2020. Updated 8 September 2020.

Paul Kirkham, Professor of cell Biology and Head of Respiratory Disease Research Group at Wolverhampton University

Dr Mike Yeadon, former CSO and VP, Allergy and Respiratory Research Head with Pfizer Global R&D and co-Founder of Ziarco Pharma Ltd

Barry Thomas, Epidemiologist

Contents

Executive Summary

Evidence presented in this paper indicates that the severe acute respiratory syndrome coronavirus 2 pandemic as an event in the UK is essentially complete, with ongoing and anticipated challenges well within the capacity of a normalised NHS to cope. The virus infection has passed through the bulk of the population as a result of wholly natural processes and evidence indicates that in the UK and other heavily infected European countries the spread of the virus has been all but halted by a substantial reduction in the susceptible population. This has occurred because the level of infection required to introduce enough immunity into the population to reduce the reproduction number (R) permanently below 1 occurred at markedly lower infection rates and loss of life than had been initially anticipated. The evidence presented in this paper indicates that there should be no expectation of a large scale 'second wave' with smaller localised outbreaks when the virus contacts pockets of previously uninfected populations.

Current mass testing using the PCR test is inappropriate in its current form. If it is to continue, then results and reporting should be refined to meet the gold standard of testing methodology to give clinicians improved information so that they are able to make appropriate clinical decisions. Positive tests should be confirmed by testing a second sample and all positive tests should be reported along with the Cycle Threshold (Ct) obtained during the test to aid assessment of a patient's viral load.

It is recommended that a greater focus be placed on evidence-based medicine rather than highly sensitive theoretical modelling based on assumptions and unknowns. Current evidence allows for a greatly improved understanding of positive infectious patients and using the evidence to improve measurements

and understanding can lead to sensitive measurements of active cases to give a more accurate warning of escalating cases and potential issues and outbreaks.

Background

Based upon guidance from NHS England, our primary and secondary care service across the country are currently following protocols to limit access to care due to the dangers of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 or COVID-19) pandemic. Whilst work has begun to restore NHS services (the "restoration"), there remains a strong focus on preparing for a second wave as implied by the Imperial College epidemiological model designed by Professor Neil Ferguson and his team. While this model may have had some limited value when we were faced with a novel virus outbreak, the evidence that has emerged over recent months along with detailed analysis of previous outbreaks implies that the model that is still being followed is unreliable and not consistent with both previously measured systems and current evidence. This paper outlines the evidence and data we have gathered to support a change in focus to further expedite the return of both primary and secondary care to full capacity.

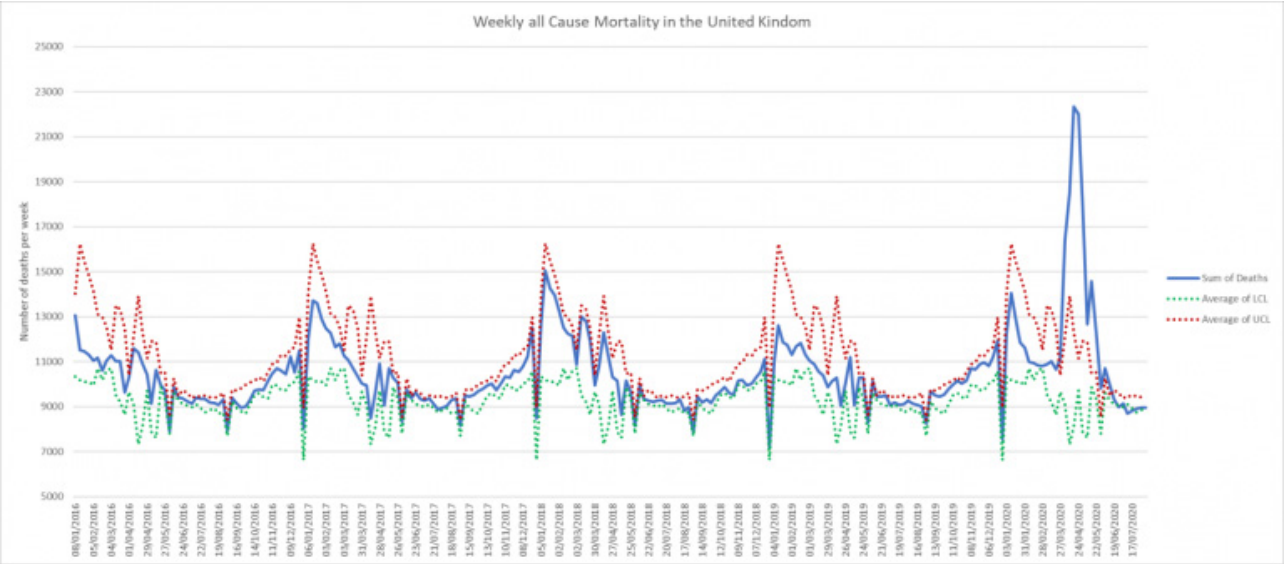
The COVID-19 pandemic has undoubtedly allowed for some very positive and rapid changes within NHS pathways, protocols and services which should be maintained. However, the current reduction in delivered primary care activity, referrals and elective care gives concern as to the degree of 'collateral damage' being caused in patients not receiving the diagnostic and ensuing care they should be receiving at the earliest possible stage of intervention. While there has been a very specific focus on the cancer and cardiology services, similar negative impacts can be seen across most services with, for example, neurological, dermatological and renal patients all presenting with more severe disease due to delays in receiving both diagnosis and treatment.

Mortality and Critical Care

National weekly mortality data is useful for looking at the effect of the COVID-19 pandemic. The past four years data were used for comparison purposes and to calculate upper and lower control limits (based on two standard deviations).

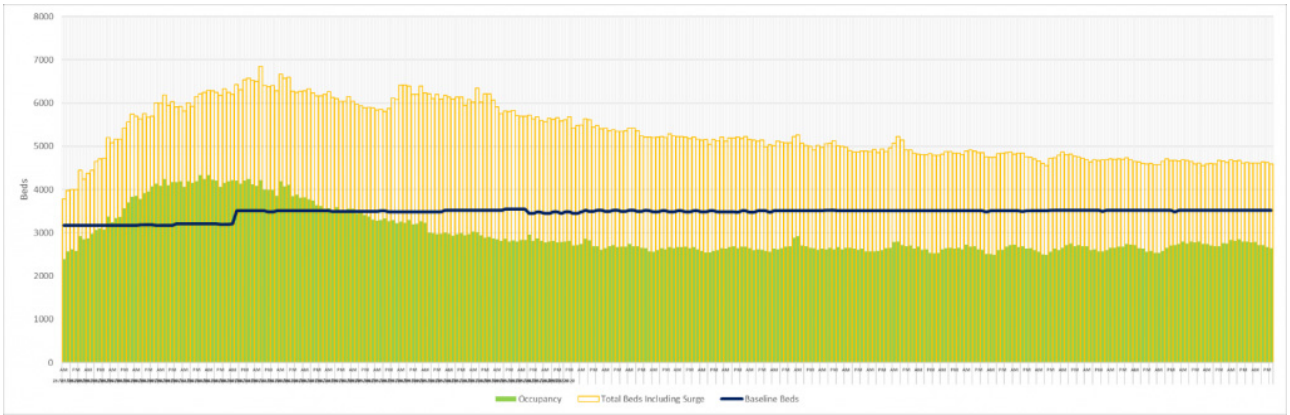
This shows that in the pandemic peak (April 17th to 30th) more than twice the number of seasonal average deaths occurred, with the number of deaths above the upper control limit from March 27th through to June 12th, totalling 44,895 excess deaths. Since June 26th the number of weekly deaths has

now fallen so it is not only below the weekly average but has regularly dropped below the lower control limit, showing that we are now at the lowest number of weekly deaths recorded in many years.



Over the last three months since lockdown measures started easing on the May 10th there has been no increase in weekly deaths. On the contrary, these have continued to fall.

Another useful measure of disease impact is the Adult Critical Care Bed Occupancy which showed a peak in bed demand between April 7th and 23rd with the number of patients occupying critical care beds significantly higher than our national baseline capacity. However, by the end of May the occupancy had dropped back to pre-COVID-19 levels, well below the national baseline capacity and has shown no statistical change since.



Restrictions have been progressively eased across the country for over three months. A continuation of the virus would be expected to manifest itself as an increase in both Critical Care bed occupancy and national All-Causes Mortality statistics. This has not been the case in either critical indicator.

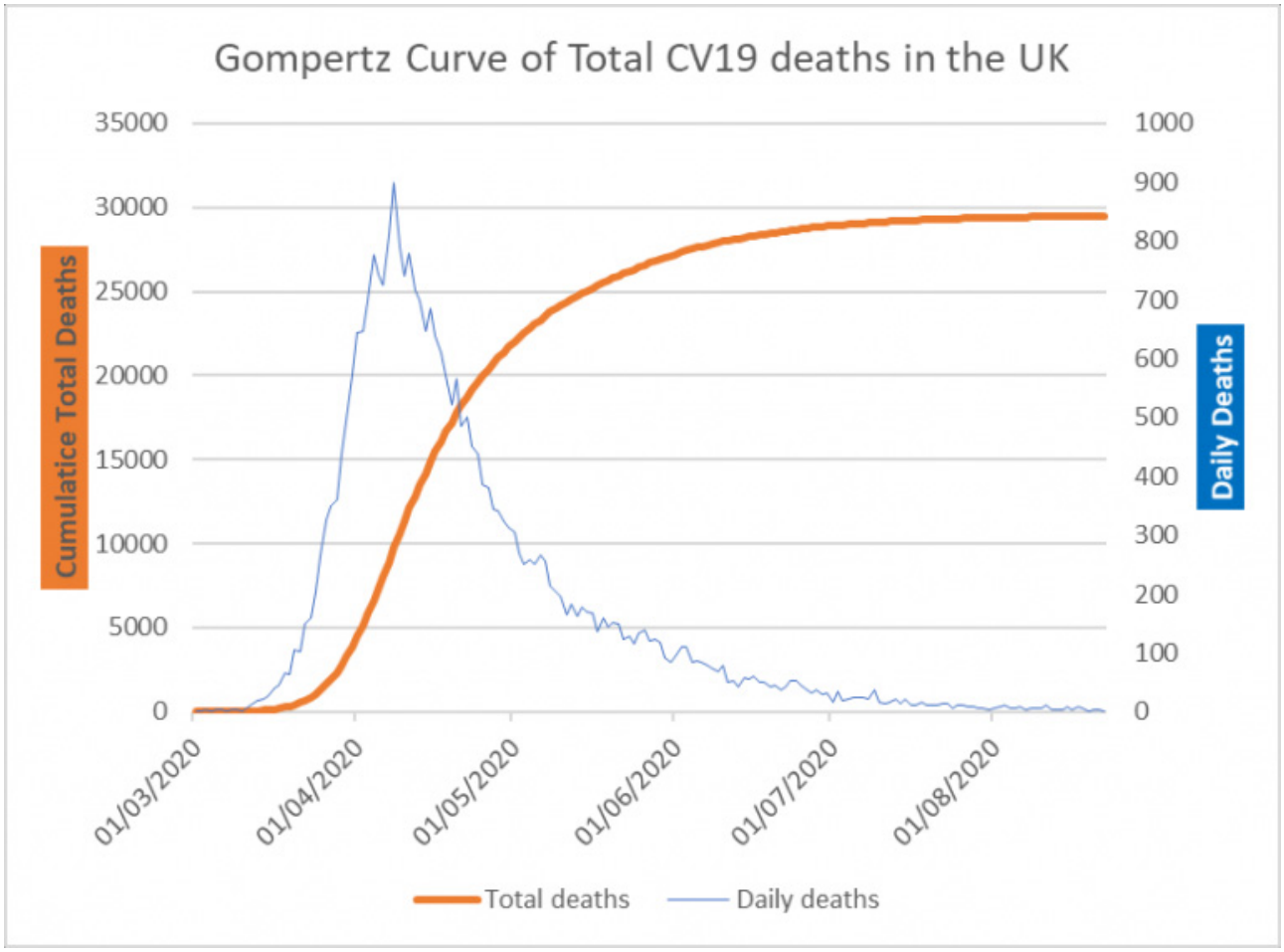
A Complete Event of the Pandemic

There are very good reasons to believe that the population of the UK and of many heavily infected countries have arrived at a position where the prevalence of the virus is low and probably falling further because the reproduction number (R) has been below 1 for several months. We understand the term 'herd immunity' can raise hackles in some quarters of the media. However, it might be more acceptably expressed by stating that the proportion remaining of the population who are susceptible to the virus has fallen sufficiently far that a sustained and growing outbreak of disease is no longer supported. This end state is not at all new or, in our view, controversial. It is how mammals – specifically jawed vertebrates – learned to live with the thousands of viruses that infect every living organism on the planet, not just us, but even plants, fungi and bacteria.

We are of the view that a continued focus primarily on the virus flows from responding to what we are concerned is a seriously flawed transmission model. We are told that only seven per cent of the population have antibodies to the virus and it is implied that this represents the proportion of the population who have so far been infected. The model assumes that we started with 100% susceptibility, because the virus is new, therefore the virus hasn't gone away and must sooner or later return. This is the basis of all the second wave fears we hear about.

However, we do not believe the model is correct and our assertions and inferences are based upon recently published science, some in highly eminent journals and some by researchers in pre-review online servers which have this year become crucial in keeping pace with emerging science.

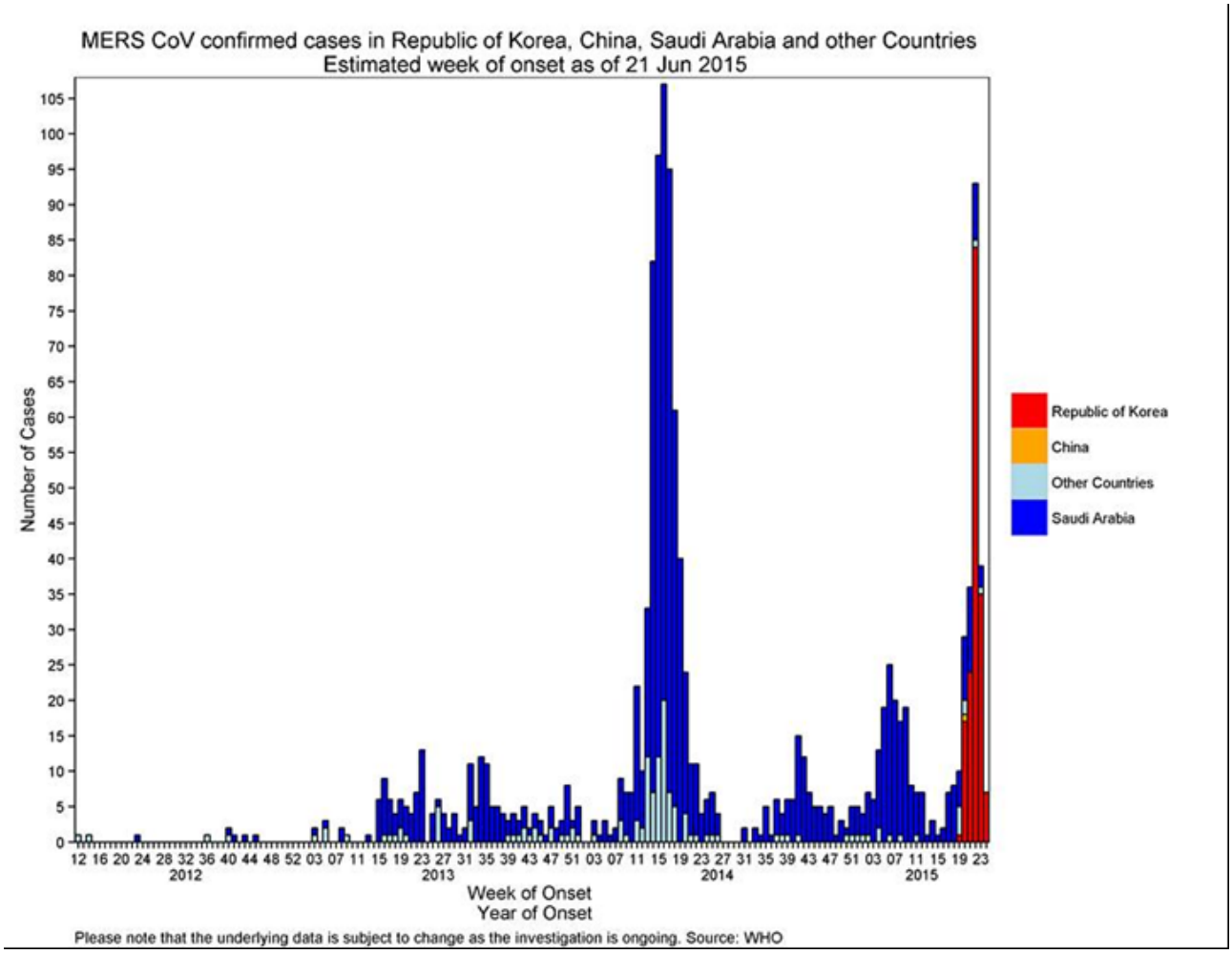
While published data on deaths 'with' COVID-19 is dependent on testing regimes and therefore liable to inaccuracy due to missing information – for example undetected asymptomatic patients – the data does allow a sound approximation of the flow of the outbreak. Inspecting the daily COVID-19 deaths vs. time curve for the UK we see a Gompertz-type curve (Rypdal and Rypdal, 2020) which are typical of natural, biological phenomena, well documented in biomedical scientific papers over the last 40 years. Note the lack of discontinuities in the curve, suggesting no effective interventions have interrupted its development.

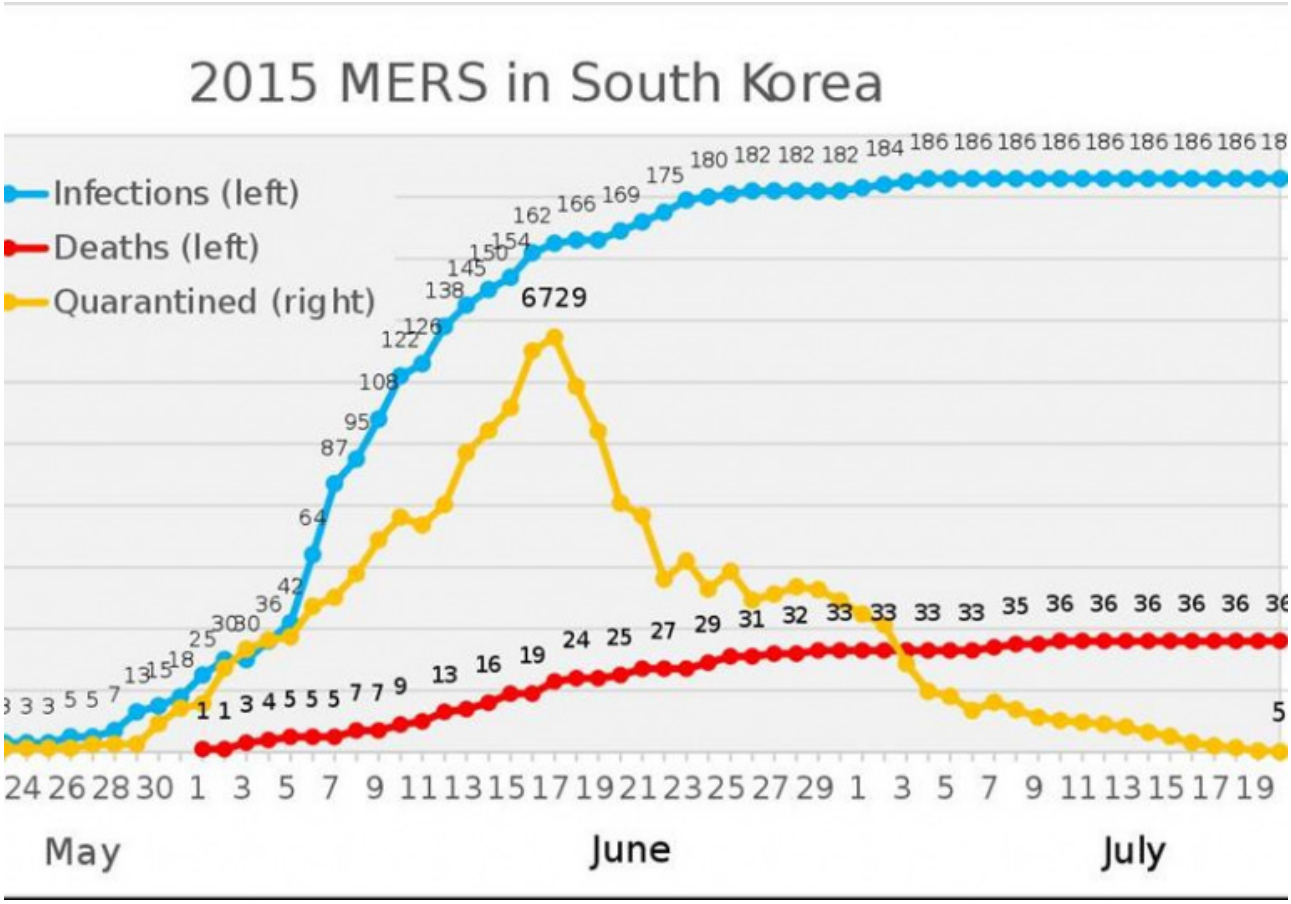


Epidemic Outbreaks

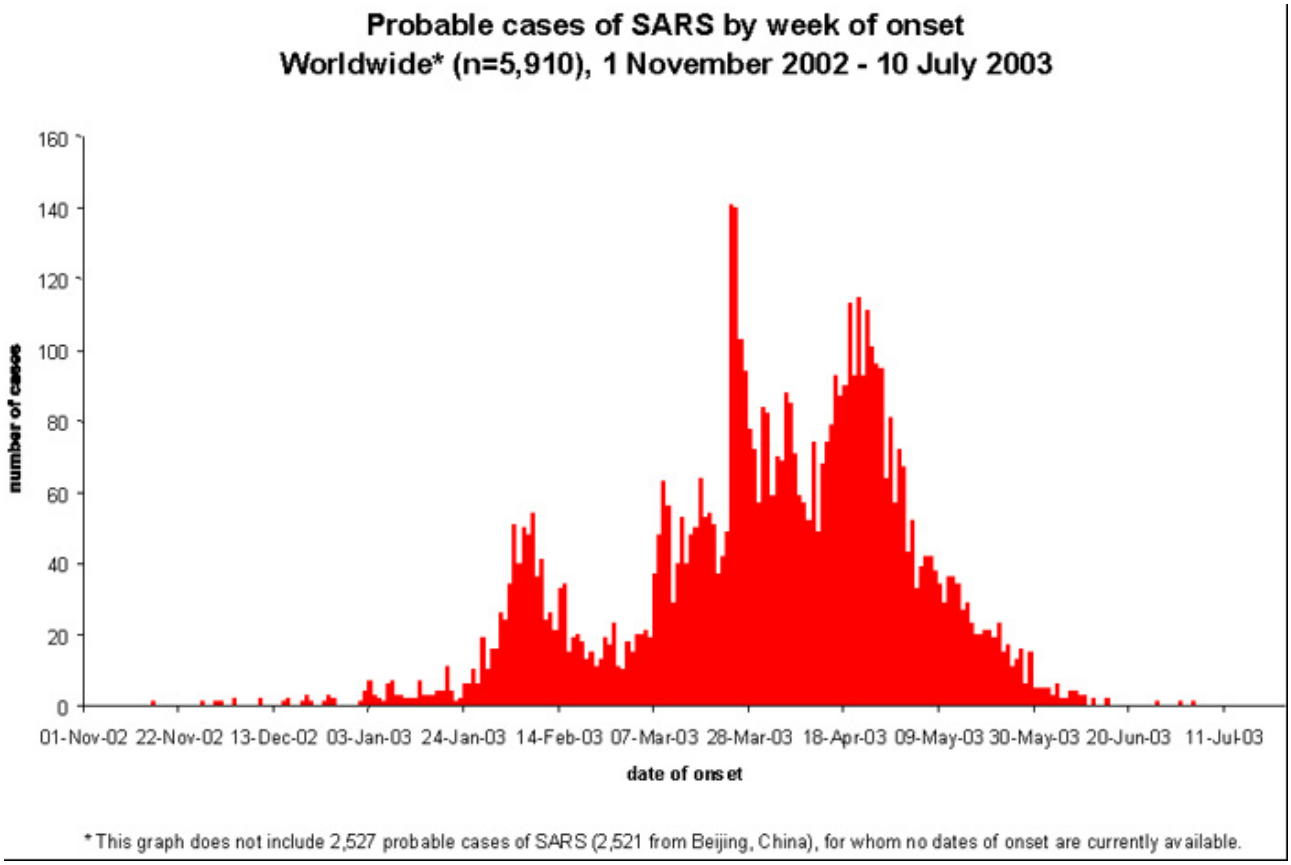
The Gompertz-type plot seen above, which is formed by a single surge in activity, often followed by smaller minor upturns as the disease reaches new populations is typical of previous virus outbreaks that have been well documented, none of which have demonstrated a significant second wave even though control methods were used to prevent the spread of disease in each case.

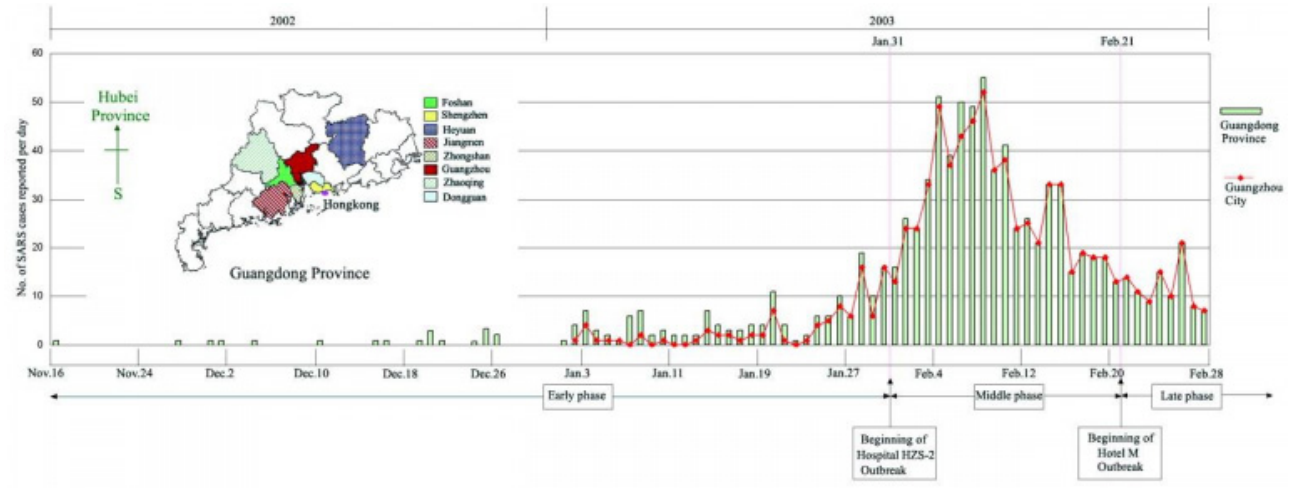
For example, below we see in the MERS CoV outbreak of 2015 what appears to be a significant double wave. However, it is actually multiple single waves affecting geographically distinct populations at different times as the disease spreads. In this case the first major peak was seen in Saudi Arabia with a second peak some months later in the Republic of Korea. Analysed individually, each area followed a typical single event Gompertz curve.


MERS CoV confirmed cases in Republic of Korea, China, Saudi Arabia and other Countries
Estimated week of onset as of 21 Jun 2015
Number of Cases
Week of Onset
Year of Onset
2012
2013
2014
2015
Republic of Korea
China
Other Countries
Saudi Arabia
Please note that the underlying data is subject to change as the investigation is ongoing. Source: WHO



Similarly, when we look at the SARS outbreak of 2003 the initial identification of an apparent double wave when looking at world wide data is actually multiple single events or waves in disparate locations each following the typical Gompertz-type curve.





Population Susceptibility

It is now established that at least 30% of our population already had immunological recognition of this new virus, before it even arrived (Le Bert *et al*, 2020; Braun *et al*, 2020; Grifoni *et al*, 2020). COVID-19 is new, but coronaviruses are not. There are at least four well characterised family members (229E, NL63, OC43 and HKU1) which are endemic and cause some of the common colds we experience, especially in winter. They all have striking sequence similarity to the new coronavirus. A major component our immune systems is the group of white blood cells called T-cells whose job it is to

memorise a short piece of whatever virus we were infected with so the right cell types can multiply rapidly and protect us if we get a related infection. Responses to COVID-19 have been shown in dozens of blood samples taken from donors before the new virus arrived. The most recent paper by Mateus *et al* (2020) was published in the journal *Science* in August and supports the previous findings of Le Bert *et al* (2020). Importantly, only Mateus performed detailed epitope mapping and found that epitopes present in each of the known endemic coronaviruses share sequence homology or close similarity to those in the new virus. Prior to this, three other groups including immunologists in Germany, Sweden and the USA each independently published similar findings (refs as above and discussed in Sewell, 2020). These papers showed this pre-immunity is geographically widespread and prevalent within each population studied, but it was only the Mateus paper that gave us the understanding as to why and how. It had previously been suggested that pre-pandemic immune responses in circulating T-cells might have occurred following exposure to one or more of the endemic coronaviruses. Mateus, by using parts of these endemic coronaviruses which also exist within COVID-19 confirmed this.

We understand that objections might be raised about the clinical correlates of this T-cell recognition. While that is a fair challenge, it would be unreasonable to dismiss it and assume is has no relevance. This is because this is how T-cell memory works (for example, Ling *et al*, 2020 show that convalescent COVID-19 patients analogously display exactly these T-cell responses) and more importantly because we have solid evidence in the case of SARS that those expressing T-cell recognition of that coronavirus were resistant to it. In a study of 23 people who survived SARS in 2003, every single one had memory T-cells that recognised the SARS virus 17 years later. (Le Bert *et al*, 2020). The T-cell response was consistent with measurements taken after vaccination with approved vaccines for other viruses. As important, these T-cell responses also develop even in recovering patients infected with the new virus but who were asymptomatic (Sekine *et al*, 2020).

In conclusion, we believe it is reasonable to take from this body of work that those displaying vigorous T-cell responses to this family of coronaviruses are resistant to or immune from infection. They are distinct from the others in the population who do not have these T-cell responses and are therefore susceptible to a new virus.

Immunity Threshold

Transmission models, such as the one used by the Imperial team, are highly sensitive to the input parameters they are based on and we argue that a modification of the current model should be applied with, at most, 70% initial population susceptibility. This is a conservative value since current literature

finds that between 20% and 50% of the population display this pre-pandemic T-cell responsiveness, meaning we could adopt an initially susceptible population value from 80% to 50%. The lower the real initial susceptibility, the more secure we are in our contention that a herd immunity threshold (HIT) has been reached.

However, our concerns with the Imperial model are not limited solely to T-cell memory mediated reduction in initial susceptibility. This is because there are factors other than T-cell mechanisms which alter a person's susceptibility to the virus. We now know that children, especially young children, appear harder to infect and/or they are less affected by the virus. To do us harm, viruses need to get inside our cells. To do that, they exploit as 'grappling hooks' receptors on the outside of those cells – in the case of the new virus, and at high speed, scientists determined it is an enzyme called ACE2. It turns out that the levels of ACE2 are highest in adults and much lower in children, becoming progressively lower the younger they are (Lingappan *et al*, 2020). That is a fortunate finding indeed, and goes some way in explaining why children have been relatively spared. In addition, other groups have shown that infectivity is significantly reduced in individuals with the O-blood group (Wu *et al*, 2020; Ellinghaus *et al*, 2020). There are approximately eight million children aged 0-10 in the UK and 12.7 million aged 0-15. These cohorts represent approximately 11.9% and 19% of the UK population, respectively

Taking this into account it is, in total, at least 35%, and likely to be significantly more of the population who are resistant or immune to the virus, meaning that they will neither get ill nor participate significantly in viral transmission (Lee, 2020). This is crucial to understanding where we are with respect to the epidemic in the UK and the potential for a second wave of infections.

The proportion of the population that need to be resistant to an infection, in order to stop it spreading, depends on the proportion who were originally susceptible and the initial reproduction number, or R0. If 100% truly were susceptible, then epidemiology suggests that 65% would have to be infected for the herd immunity threshold to be reached, given the initial estimates of R0. That would have resulted in very many more deaths than have been measured. But if, as we are now reasonably sure, a much lower initial percentage was susceptible, it takes far fewer people to catch the virus before there are too few susceptible people remaining within the population for the virus to be able to find the next person to infect.

Recent seroprevalence studies, which measure the proportion of the population displaying antibodies to the novel virus, are widely assumed to show the proportion of the population which has been infected. However, the observation that, for example, only 17% of Londoners have antibodies is not the same as

saying only 17% have been infected (though the media often wrongly assumes it does). It is important to appreciate that much of the early serological studies were conducted on hospitalised patients who, by definition, are the most ill cohort. In such patients the majority do seroconvert (eg Theel *et al*, 2020). In mildly symptomatic and asymptomatic patients, a lower proportion seroconvert (Long *et al*, 2020). This is because the antibody system is but one of several tools our immunology has to defend us. There have been a number of papers illustrating this important principle. Long *et al* (2020) find that almost half of previously infected individuals are no longer seropositive a few months later. Gallais (2020) shows that none of the familial contacts of those testing positive to SARS-CoV-2 went onto to develop antibodies.

A reasonable hypothesis is that the lower intensity of immunological challenges tends to rely less on the generation of antibodies and more on innate and cellular responses. This means that a factor of two-fold and possibly higher would need to be applied to population serology data in order to better approximate the infected population. If 7% is the mean for UK, then perhaps 14-21% of the population has actually been infected (which would imply, very approximately, 9-14 million people infected). The authors recognise that the exact number in this example is speculative, but conversations with immunologists indicate that this principle is widely accepted as reasonable for community infection where viral load varies widely and contrasts markedly with seroconversion after vaccination, where the goal is close to 100%.

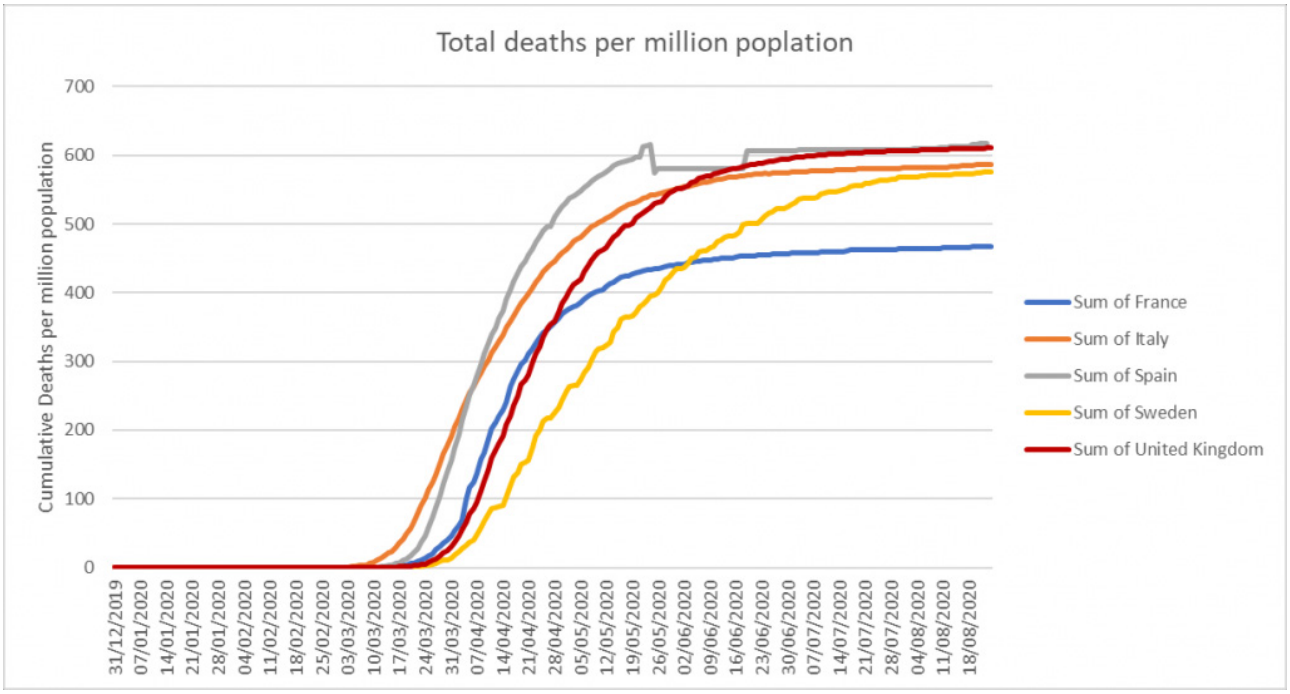
Interestingly, this question of what percentage of the population have been infected can be approached using a different methodology. Numerous estimates have been made of the infection fatality ratio (IFR) for this new virus. Naturally, it varies depending on the population under study as well as the methodology used and, accordingly, researchers have arrived at a wide range of estimates for IFR. The Centre for Evidence-Based Medicine has done much work in this area and their current estimate is 0.1-0.4% (Oke and Heneghan, 2020). Let us take a midpoint value, especially as for months the US CDC displayed a value for IFR of 0.26% on their website. This implies that for every death from COVID-19, there were a preceding 100/0.26 or ~400 infections. The UK has suffered approximately 42,000 such deaths which, to a first approximation using IFR, implies 16.8million infections, or 25% of the population having been infected.

Consequently, two different and independent analytical approaches provide estimates that are at least in the same range for total population having been infected (overlapping at approximately 20%), and this is crucial in the argument put forward here. Other, theoretical epidemiological studies show that, with the extent of prior immunity that we can now reasonably assume to be the case, only 15-25% of the population being infected is sufficient to bring the spread of the virus to a halt (Lourenco, 2020; Gomez *et*

al, 2020). Importantly, we emphasise there are additional schools of epidemiological work which show that variation in likelihood of becoming infected itself can greatly reduce the so-called herd immunity threshold and that this can be reached at even lower proportions of the population having been infected (e.g. Aguas, 2020).

We saw early on in the pandemic that the number of daily deaths rapidly soar and at that time did we not know where and when it would stop rising. It has been evidenced previously that the most easily infected people got infected earliest (see Gomez *et al*, 2020). Humans vary hugely, not only in our responses to viruses, but also in the ease or difficulty the virus experiences as it tries to invade us. The most susceptible were those already elderly and/or ill, some very ill, and so we saw very high death rates initially. Once that super-susceptible group were removed from the pool of susceptible individuals by the virus, it began a slower march through everyone else, slowing all the time, as the remaining population's susceptibility fell continually towards the herd immunity threshold. That is where our evidence indicates we are now and why the virus is disappearing from the environment.

It is important to see this document in light of information available elsewhere in the world. It has widely been observed that in all heavily infected countries in Europe and several of the US states likewise, that the shape of the daily deaths vs. time curves is similar to ours in the UK. Many of these curves are not just similar, but almost super imposable. Italy, France, Spain, Sweden and the UK, for example (OWID, 2020). The shape of the deaths vs. time curve implies a natural process and not one resulting mainly from human interventions, given the widely varying non-pharmaceutical interventions in those countries. Taking this and applying it more widely, the very strong similarities of UK data with that of nearby countries which employed different responses yields another conclusion – that none of the interventions altered the broad course of the pandemic event. Further, it is reasonable to conclude that the pandemic event has ended in those countries, too. Famously, Sweden has adopted an almost *laissez faire* approach, with qualified advice given, but no generalised lockdowns. Yet its profile and that of the UK's is very similar. The officials in Sweden appear to be of the view that their population has closely approached or in some places reached what they term herd immunity, with R persistently lower than 1.

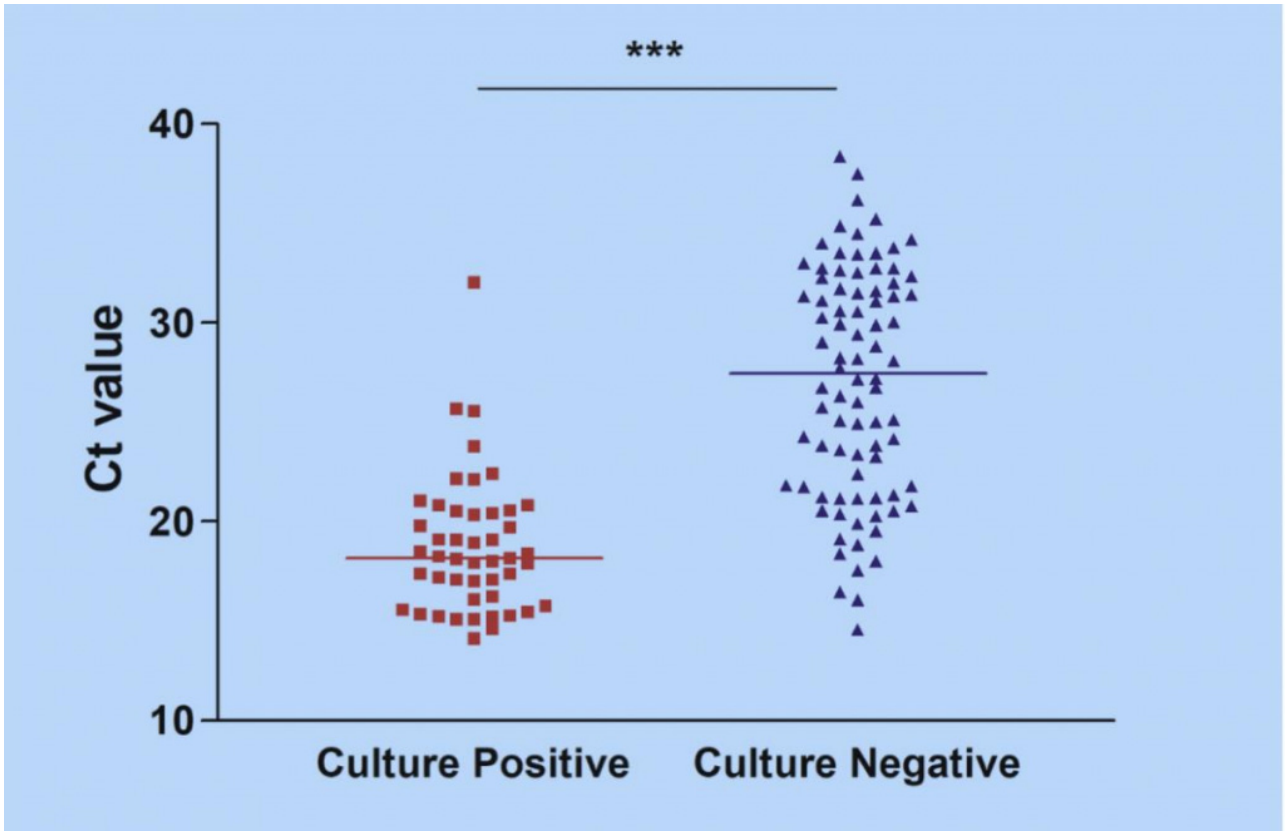


The PCR Test

The PCR test for the virus is good enough to confirm infection in someone with symptoms. "Is it flu or is it COVID-19?" is a question easily answered. What it is very poor at, however, is what is being asked of it now, namely estimating the percentage of people who are currently infectious in the community. We do not know exactly what the false positive rate is, but it is widely believed to be greater than the actual, remaining prevalence of the virus (Heneghan, 2020), which is around 1:2000, or 0.05%. (ONS prevalence survey Aug 14th 2020). The result of continuing to use this test alone on a massive widescale screening program is inevitably to generate a high proportion of false positives. The problem of using any assay to conduct surveillance on a low prevalence virus with a PCR test has been widely discussed (Heneghan, 2020). Under present parameters, even accepting an unlikely 0.1% False Positive rate and a prevalence of 0.1%, more than half of the positives are likely to be false, potentially all of them. It is the opinion of the authors that the false positive rate is higher and the prevalence lower than this. Consequently, it is impossible for the positives to be much other than false. A recent letter to the *British Medical Journal* (Healy, 2020) exemplifies the extent of harm that actually arose in a setting in which all but one of the positives ended up being false positives. This resulted not only in considerable time and money wasted by surgeries, but also other medical issues being delayed. It is not rational and may even be dangerous to use these results to drive policy. Note that recent so-called 'spikes' were never accompanied or followed by people getting ill, going to hospital and dying in elevated numbers. Consequently, it is possible that most of the positives from mass testing are either false positives or 'cold positives' (fragments of real virus which are not intact and incapable of replication or of causing disease or infecting others) and therefore begs the

question of whether mass testing of patients without symptoms is in fact helpful or misleading? It may be of relevance to note that, on August 24th the US CDC changed its guidance on when PCR testing is appropriate. They now recommend not testing people with no symptoms who are not contacts in a contact-tracing activity.

There are practical alternatives to mass testing. For example, calls to the NHS111 service captures all reports of what is termed 'influenza-like illness'. Change in this parameter is likely to be a much more sensitive measure of the presence of increasing prevalence of SARS-CoV-2 infection than flawed PCR testing without modifications. Obviously, and perhaps it has already happened, there is the potential for emerging influenza to complicate the picture. A modification to the strategy involving PCR testing which would easily resolve any uncertainty is this: every positive test result is followed up as quickly as possible, ideally within 24 hours of the positive result, and every one is retested. If this is done, almost all the false positives will be removed. We predict there would be few genuine positive results remaining. But even here, it is important to recall what it is that the PCR test measures, and it is simply the presence of partial RNA sequences present in the intact virus. This means that even a true positive does not necessarily indicate the presence of viable virus. In limited studies to date, many researchers have shown that some subjects remain PCR-positive long after the ability to culture virus from swabs has disappeared. We term this a 'cold positive' (to distinguish it from a 'hot positive', someone actually infected with intact virus). The key point about 'cold positives' is that they are not ill, not symptomatic, not going to become symptomatic and, furthermore, are unable to infect others. As each PCR test that is carried out returns the Cycle Threshold (Ct) used to obtain a positive result, it is important that this Ct is reported with every positive result. The Ct gives strong evidence of the viral load and aids clinicians in determining if a patient has a "hot" infectious positive result or a "cold" non-infectious positive result. Gniazdowski *et al* (2020) studied 161 positive PCR test samples with a Ct value below 23 that yielded 91.5% of virus isolates and the study showed a strong correlation between recovery of SARS-CoV-2 infectious virus on cell culture and Ct values. Ct values above 30 returned negative cultures in all except one case.



Expectations of a Second Wave

Daily deaths from and with COVID-19 have almost ceased, having fallen over 99% from peak. All the numbers monitored carefully fall like this, too: the numbers being hospitalised, numbers in hospital, number in intensive care – all are falling in synchrony from the April peak. Viral evidence historically tells us that you don't generally get infected by the exact same virus twice, certainly not within a short period of time. It'd be a poor immune system which lets that happen and we'd probably not have made it as a species into the 21st century if that's how it worked. So there's an expectation of some duration of immunity. It needs studying, but our experience and evidence for coronaviruses (Le Bert *et al*, 2020) suggests that if you have memory T-cells, durability can be very long lasting. This study showed that people still had robust T-cell responses in 2020, 17 years after the first SARS outbreak back in 2003. The concerns people have expressed about falling antibody levels underscores a lack of knowledge about acquired immunity. It is not efficient nor required for immunity to maintain high levels of antibodies to everything to which you are immune. Instead, cellular memory enables very rapid re-generation of antibodies upon re-encounter with the antigen, if that is required to defend the host. Alternatively, innate and cellular memory responses can be sufficient.

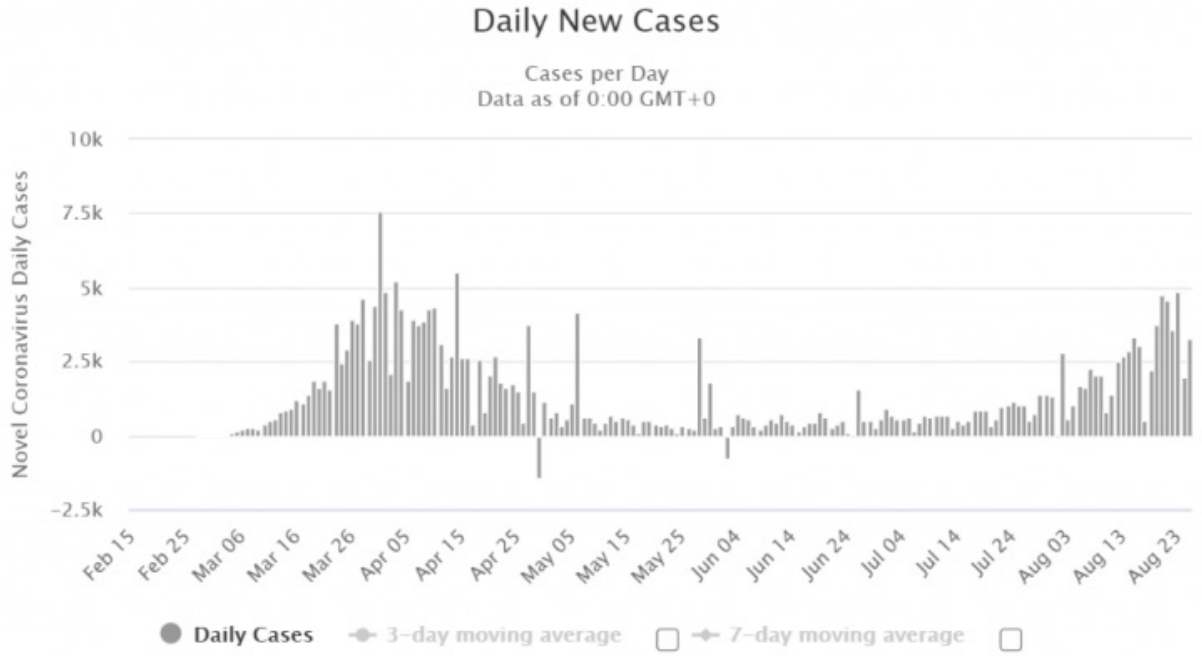
The NHS currently remains 'COVID-19 ready' in preparation for an expected second wave, a highly

unlikely scenario based upon an initial model with highly sensitive input variables that we already know to be inaccurate. The evidence we've presented leads us to believe there is unlikely to be a second wave and that while there have been apparent multi-'wave' respiratory viruses in the past, notably 1918-20, in many cases it became clear that this was either different populations being infected at different times or in some cases multiple different organisms involved. There is no biological principle that leads us to expect a second wave based on the accumulation of data over the past six months. Instead, it is likely there will be local, small and self-limiting mini-outbreaks as areas previously unexposed come into contact with the virus.

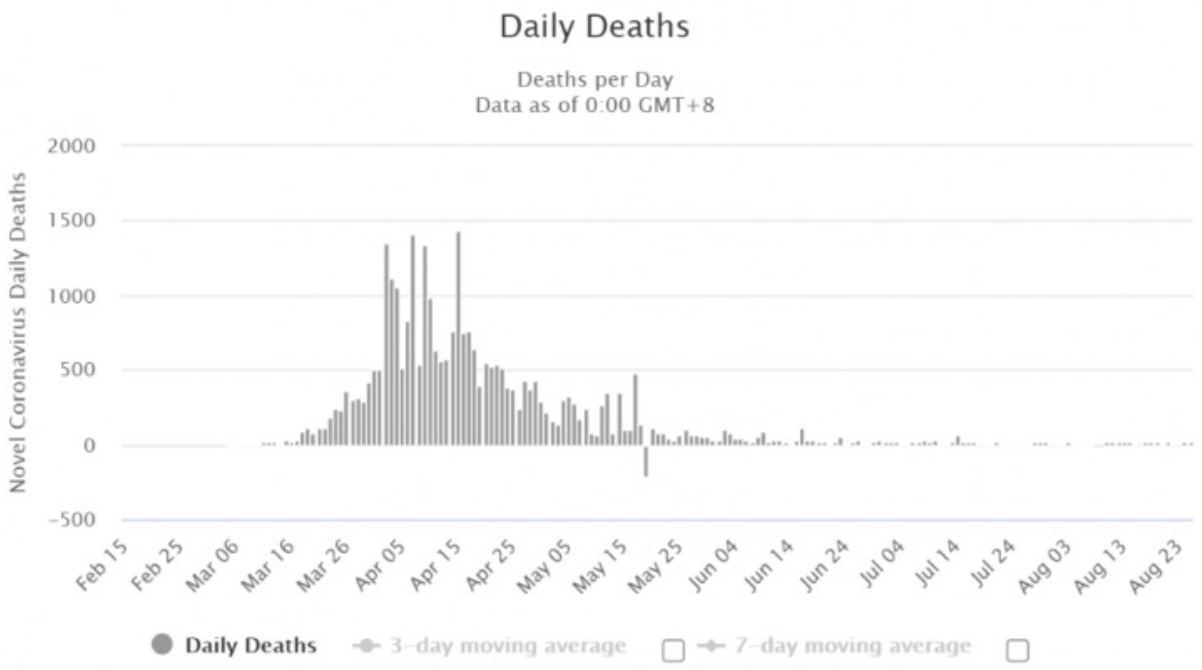
Spain and France

So what is happening in terms of second wave concerns in France and Spain? As the rate of hospitalisations, ICU utilisation and the daily death rate from COVID-19 all decayed steadily, it appears that several but not all countries have greatly expanded their testing capacity in the broader population of people who are not showing any symptoms of infection. We contend that the many claims in the media for outbreaks, spikes and second waves are all artefacts of amplified rates of testing. It should be noted that illness, hospitalisations and deaths have not reversed in any clear and sustained manner. Specifically, careful examination of the weekly all-causes mortality data in France is completely clear. Six weeks into an apparent surge of cases, the number of deaths remain completely flat and normal, in all age bands (as of mid-August when this document was written).

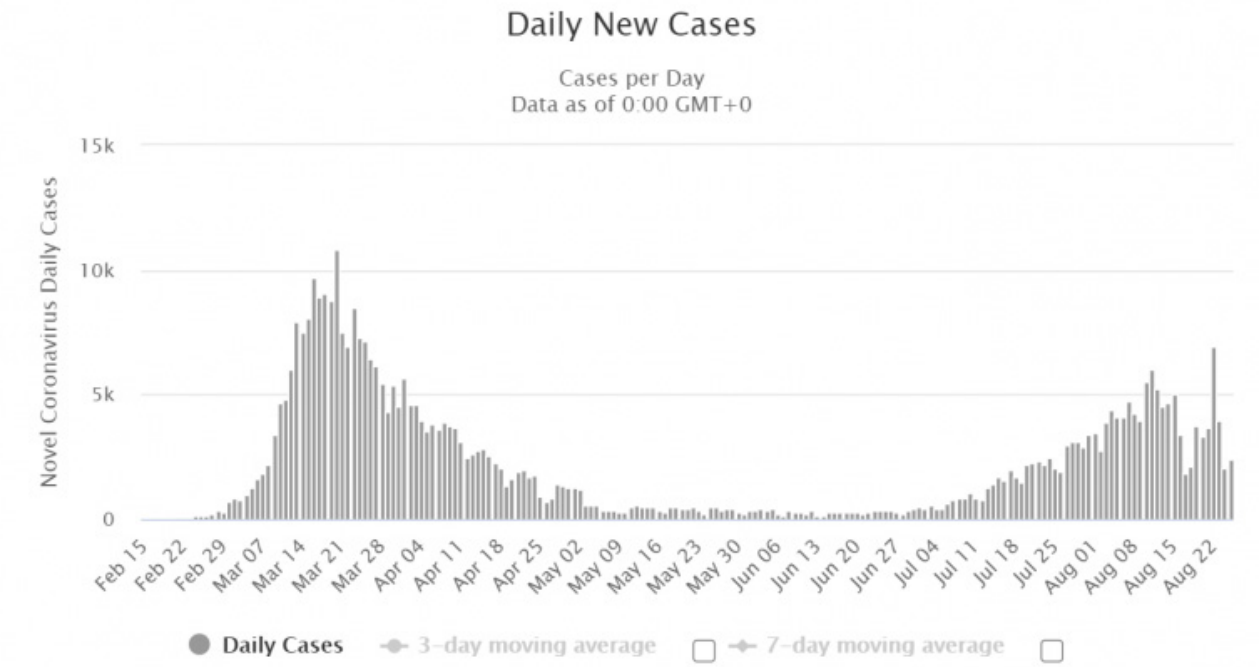
Daily New Cases in France



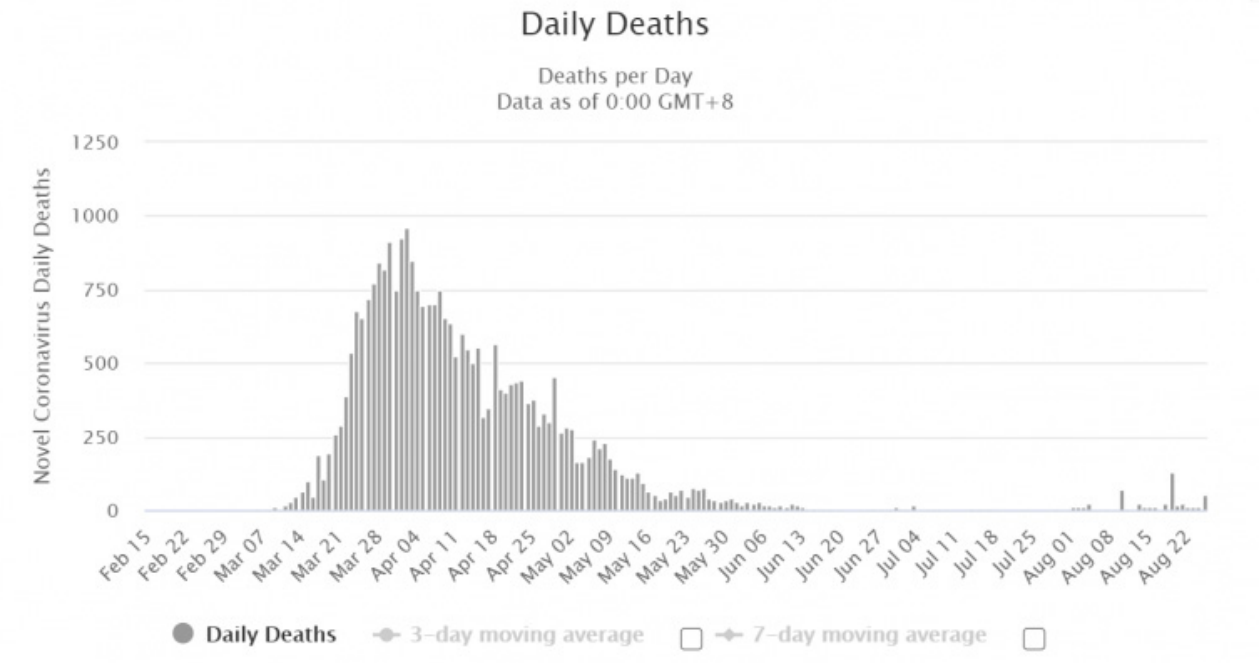
Daily New Deaths in France

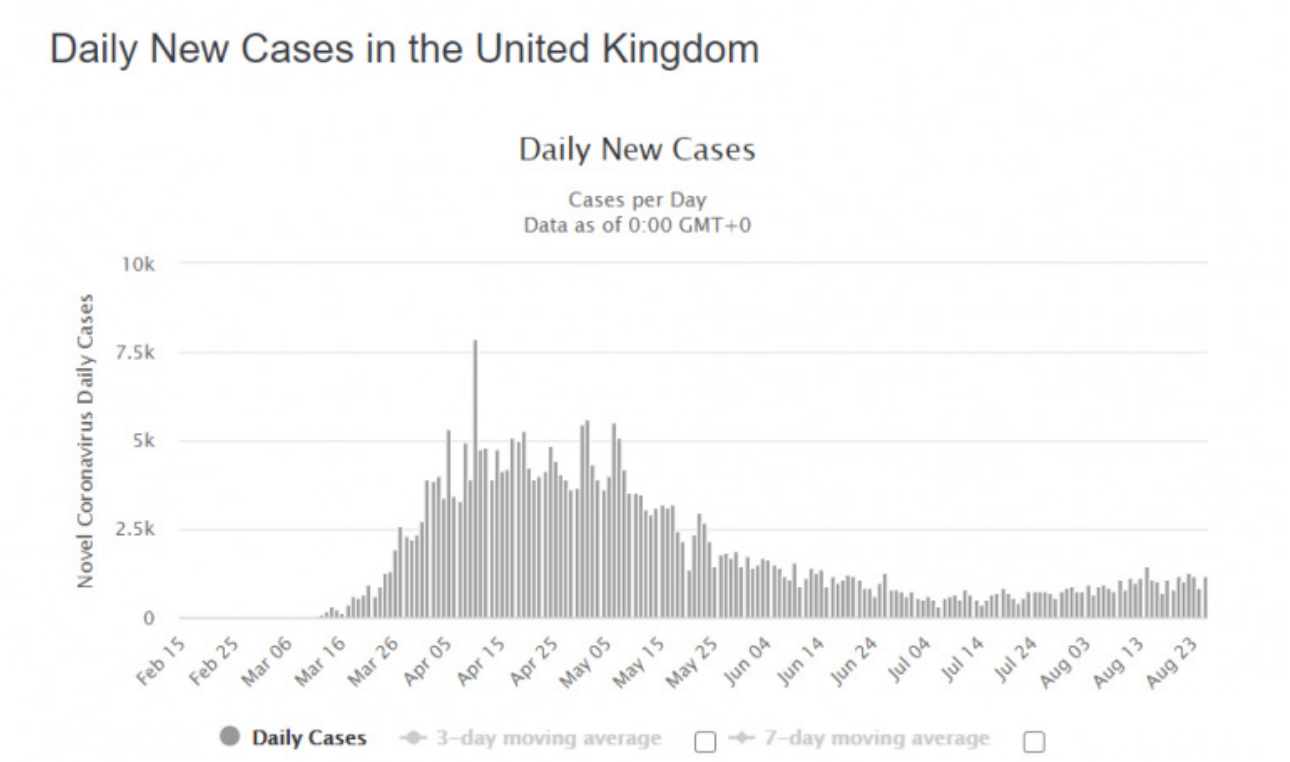


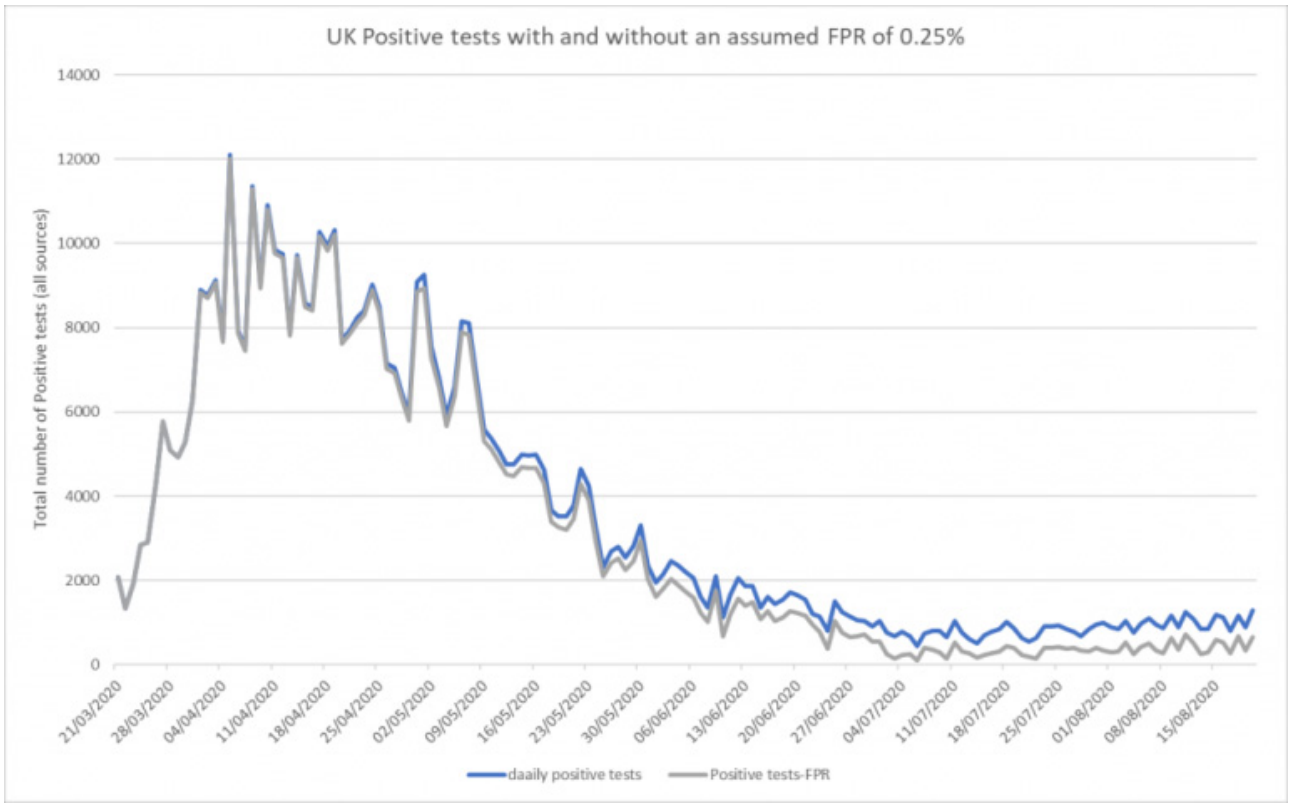
Daily New Cases in Spain



Daily New Deaths in Spain




Daily New Cases in the United Kingdom
Daily New Cases
Cases per Day
Data as of 0:00 GMT+0
Novel Coronavirus Daily Cases
10k
7.5k
5k
2.5k
0
Feb 15
Feb 25
Mar 06
Mar 16
Mar 26
Apr 05
Apr 15
Apr 25
May 05
May 15
May 25
Jun 04
Jun 14
Jun 24
Jul 04
Jul 14
Jul 24
Aug 03
Aug 13
Aug 23
Daily Cases
3-day moving average
7-day moving average


UK Positive tests with and without an assumed FPR of 0.25%
Total number of Positive tests (all sources)
14000
12000
10000
8000
6000
4000
2000
0
21/03/2020
28/03/2020
04/04/2020
11/04/2020
18/04/2020
25/04/2020
02/05/2020
09/05/2020
16/05/2020
23/05/2020
30/05/2020
06/06/2020
13/06/2020
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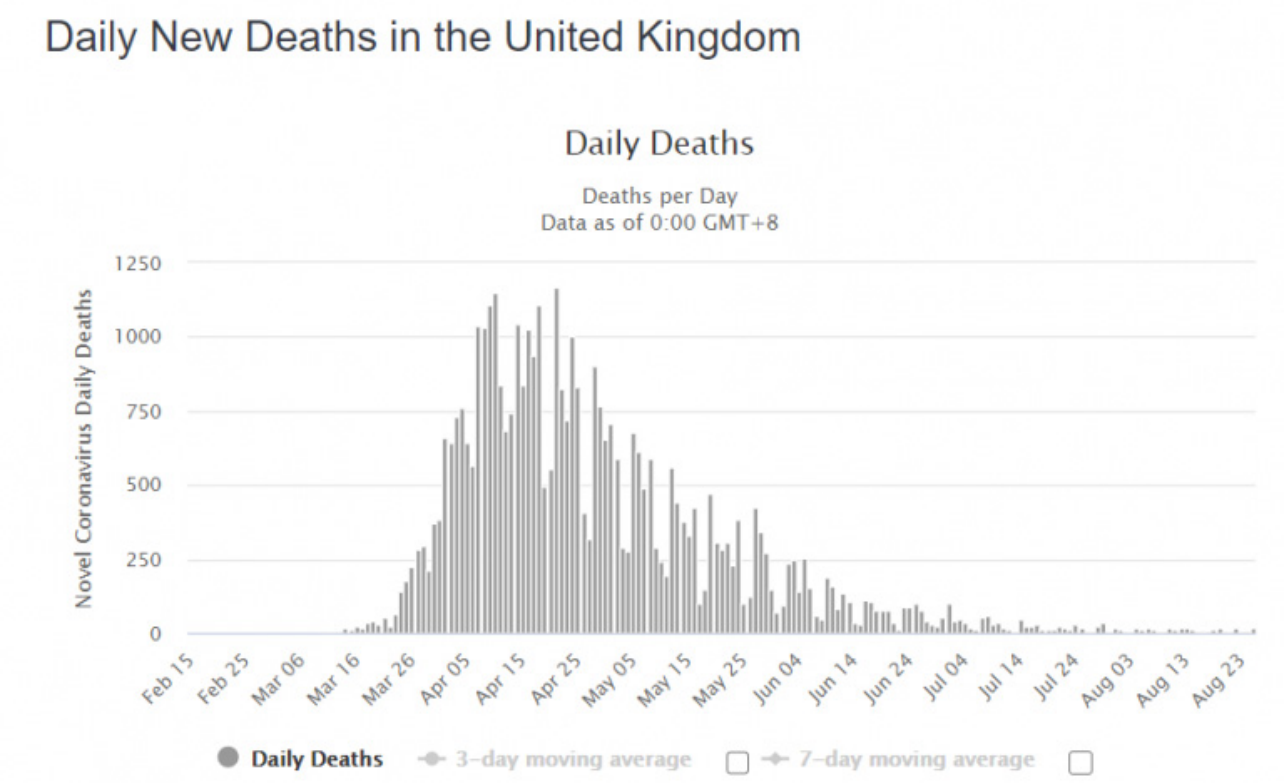
Positive tests-FPR



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(CONTINUATION OF REFERENCES CUT OUT HERE)

71

Regarding the number of deaths

How can the aforementioned be reconciled with the official reports of the horrifying number of COVID-19 deaths? Two numbers must be known if the danger of a virus is to be assessed:

the number of infections and the number of deaths.

How many were infected by the new virus?

Attempts to answer this question were beset by three problems:

1. How reliable was the test for virus detection?

The virus is present in the nasopharynx for approximately two weeks, during which time it can be detected. How is this done? Viral RNA is transcribed into DNA and quantified by the so-called polymerase chain reaction (PCR). The first assay for the new coronavirus was developed under guidance of Professor Christian Drosten, Head of the Institute for Virology at the Charité Berlin. This test was used worldwide in the initial months of the outbreak (19). Tests from other laboratories followed (20).

Diagnostic PCR tests must normally undergo stringent quality assessment and be approved by regulatory agencies before use. This is important because no laboratory test can ever give 100% correct results. The quality control requirements were essentially shelved in

the case of SARS-CoV-2 because of declared international urgency. Consequently, nothing was really known regarding test reliability, specificity and sensitivity. In essence, these parameters give an indication of how many false-positive or false-negative results should be expected. The test protocol from the Drosten laboratory were used worldwide, and test results played a key role in political decision-making. Yet, data interpretation was often largely a matter of belief. What did Drosten himself say on Twitter (21)?

> Sure: Towards the end of the illness the PCR is sometimes positive and sometimes negative. Here, chance plays a role. When you test a patient twice as negative and discharge him as cured, it is indeed possible that you can have positive test results again at home. But this is still far from being a re-infection.

Several physician colleagues have informed us of similar haphazard results with patients who had been tested repeatedly during their hospitalisation. Is it particularly surprising that goats and papayas tested positive for the virus in Tanzania? The criticism by the President of Tanzania regarding the unreliability of the test kits was of course immediately dismissed by the WHO (22).

But today it is perfectly clear that the test result is error-prone, as is every PCR (23, 24). How much so, and whether there are significant differences among the presently available tests, cannot be determined because of lack of data.

So let us assume that the PCR test is incredibly good and produces 99.5% correct results. That sounds, and

would indeed be, exceptional – it means that one can expect only 0.5% false-positives. Now take the cruise ship "Mein Schiff 3". After a crew member had tested positive for the virus, almost 2,900 people from 73 countries were forced into "ship quarantine". Many had been on board for nine months. Complaints reached the outside world about the "prison-like" conditions, psychological problems abounded and nerves were frayed (25).

Nine positive cases were reported after testing was completed. One person who tested positive had a cough, the other eight were without symptoms. Might they have belonged to the 0.5% false-positive cases, as perhaps the very first case had been? Where were the true-positives that must theoretically have been there? Were they possibly tested as false-negatives or were all positive tests false?

In the context of false results, we should consider the following: when the epidemic subsided (in Germany, in mid-April,) PCR testing became a dangerous source of misinformation because numbers of new cases were derived from the "background noise" of false-positive results. When all 7,500 employees of the Charité Berlin (one of Europe's largest university hospitals) were tested from April 7 to April 21, 0.33% were positive (26). True or false?

When positive test rates drop below a certain limit, it is senseless to continue mass screening for the virus in non-symptomatic individuals. And use of numbers acquired under these circumstances as a reason for implementing any measures should not be tolerated.

2. Selective or representative? Who was tested?

There is only one way to approximate how many people are infected during an epidemic with an agent that causes high numbers of unnoticed infections: at sites of an outbreak, the population must be tested as extensively as possible. But scientists who called for this during the coronavirus epidemic (27, 28) were ignored.

Instead, the Robert Koch Institute (RKI), the German federal government agency and research institute for disease control, stipulated at the beginning that only selective testing should be carried out – exactly the opposite of what should have happened. And as the epidemic ran its course, the RKI stepwise altered the testing strategy – always in the diametrically wrong direction (29).

At first, only people who had been in a high-risk area and/or had been in contact with an infected person and also presented with flu-like symptoms were to be tested. At the end of March, the RKI then changed the recommended test criteria to: flu-like symptoms and, at the same time, contact with an infected person. At the beginning of May, the President of the RKI, Professor Lothar Wieler, announced people with even "the slightest symptoms" should be tested (29).

The responsibility for translating these dubious decisions into action lay entirely within the hands of the local health authorities. A co-worker at our lab was a typical example: the coach of her handball team was coronavirus positive. The players – all from different administrative districts – were sent home on 14-

day quarantine. One player developed symptoms with coughing and hoarseness and wanted to get tested but was refused on the grounds that she had no fever. A player from a neighbouring district had no symptoms but the local health authority ordered a test despite this fact.

This resulted in chaos, caused by the appalling ineptitude of the authorities from top to bottom. What would have been urgently needed instead were scientifically sound studies to clarify basic issues of virus dissemination. As many as possible should have been tested in outbreak areas. Antibody responses in those that had tested positively could have subsequently been assessed.

Only a single such study addressing these questions was undertaken in Germany: the Heinsberg investigation conducted by Professor Hendrik Streeck, Director of the Institute for Virology at the University of Bonn. Aware of the importance of the preliminary data, these were presented at a press conference – where Streeck was torn apart by the disbelieving media (30, 31). The fatality rate was ridiculed as being impossible because it was ten times lower than what acknowledged experts and the WHO had been spreading as established facts. After completion of the study, final results essentially confirming the preliminary report were again presented, and again deemed by the media to be flawed and inconclusive. But the results of the study spoke for themselves (32) – and they contradicted the panic propaganda of the media.

3. The number of conducted tests directly influences infection statistics

A third factor added to the statistical mess. Imagine that you wanted to count the number of a migratory bird species in a large lake district. There are hundreds of thousands but your counting device can only count 5,000 per day. Next day, you ask a colleague to help, and together you arrive at 10,000 counts. The day after that, two more colleagues join in and 20,000 birds are counted. In short, the higher the testing capacity/ number of tests, the higher the numbers – as long as innumerable unidentified cases abound, as with SARS-CoV-2 (16, 32–36). The more tests are performed, the more COVID-19 cases are found during the epidemic. This is the essence of a "laboratory-created pandemic".

Now recall that the test has neither 100% specificity nor 100% sensitivity – meaning that occasionally you would mistake a log for a bird. Therefore, even after all our birds have long since moved on, you would still "find" many by just performing a sufficient number of tests.

In conclusion, no reliable data existed regarding the true numbers of infection at any stage of the epidemic in this country. At the peak of the epidemic, the official numbers must have been gross underestimates – in the order of 10 or even more. At its wane at the end of April in Germany, the numbers must also have been gross overestimates.

Basing any political decisions on official numbers at any stage was fallacy.

How many deaths did SARS-CoV-2 infections claim?
Here, again, we have the dilemma of definition: what is a "coronavirus death"?

If I drive to the hospital to be tested and later have a fatal car accident – just as my positive test results are returned – I become a coronavirus death. If I am diagnosed positive for coronavirus and jump off the balcony in shock, I also become a coronavirus death. The same is true for a sudden stroke, etc. As openly declared by RKI president Wieler, every individual with a positive test result at the time of death is entered into the statistics. The first "coronavirus death" in the northernmost state of Germany, Schleswig-Holstein, occurred in a palliative ward, where a patient with terminal oesophageal cancer was seeking peace before embarking on his last journey. A swab was taken just before his demise that was returned positive – after his death (37). He might equally well have been positive for other viruses such as rhino-, adeno- or influenza virus – if they had been tested for.

This particular case did not need more testing or a post-mortem to determine the actual cause of death.

However, with the emergence of a new and possibly dangerous infectious disease, autopsies should be undertaken in cases of doubt to clarify the actual cause of death. Only one pathologist ventured to fulfil this task in Germany. Against the specific advice of the RKI, Professor Klaus Püschel, Director of the Institute of Forensic Medicine, Hamburg University, performed autopsies on all "coronavirus victims" and found that not one had been healthy (38). Most had suffered from

several pre-existing conditions. One in two suffered from coronary heart disease. Other frequent ailments were hypertension, atherosclerosis, obesity, diabetes, cancer, lung and kidney disease and liver cirrhosis (39).

The same occurred elsewhere. Swiss pathologist Professor Alexander Tzankov reported that many victims had suffered from hypertension, most were overweight, two thirds had heart problems and one third had diabetes (40). The Italian Ministry of Health reported that 96% of COVID-19 hospital deaths had been patients with at least one severe underlying illness. Almost 50% had three or more pre-existing conditions (41).

Interestingly, Püschel found lung embolisms in every third patient (39). Pulmonary embolisms usually arise through detachment of blood clots in deep veins of the leg that are swept into the lungs. Clots typically form when blood flow sags in the legs, as when the elderly spend the day seated and inactive. A high frequency of lung embolisms was already described in deceased influenza patients 50 years ago (42). Thus, we are not on the verge of discovering a unique property of SARS-Cov-2 that would heighten its threat, but we do bear witness to the absurd situation where the elderly seek to protect themselves by obeying the chant that sounds around the world: "Stay at home". Physical inactivity is pre-programmed, thromboses included? Swedish epidemiologist Professor Johann Giesecke recommended exactly the opposite: As much fresh air and activity as possible. The man knows his job!

The number of genuine COVID-19 fatalities remained unknown outside Hamburg. The situation was

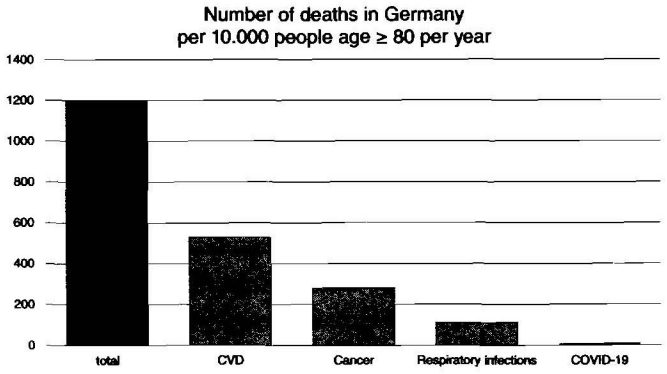
no better in other countries. Professor Walter Riccardi, adviser to the Italian Ministry of Health, stated in a March interview with "The Telegraph" that 88% of the Italian "coronavirus deaths" had not been due to the virus (43).

The problem with coronavirus death counts is such that the numbers can be viewed as nothing other than gross overestimates (44). In Belgium, not only fatalities with a positive COVID-19 test entered the ranks but also those where COVID-19 was simply suspected (45).

Scientific competence did not seem to rule the agenda of Germany's RKI. Fortunately, there are scientists who stand out in contrast. Stanford Professor John Ioannidis is one of the eminent epidemiologists of our times. When it became clear that the epidemic in Europe was nearing its end, he showed how the officially reported numbers of "coronavirus deaths" could be used to calculate the absolute risk of dying from COVID-19 (46).

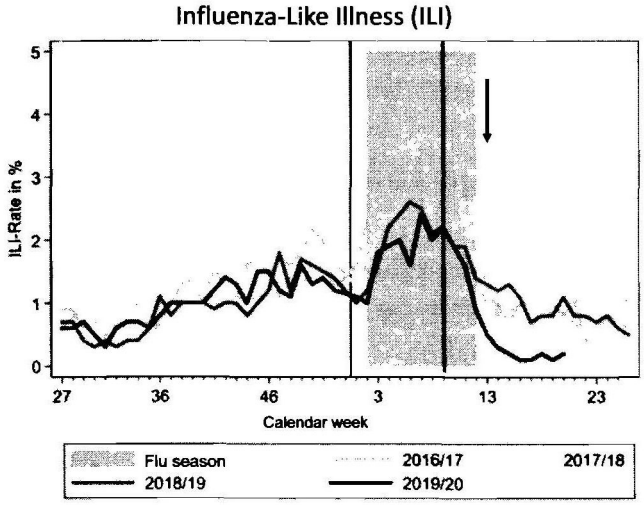
The risk for a person under 65 years in Germany was about as high as a daily drive of 24 kilometres. The risk was low even for the elderly ≥ 80 with 10 "coronavirus deaths" per 10,000 ≥ 80-year olds in Germany (column at the far right).

Calculation of this number is simple. About 8.5 million citizens are ≥ 80 years in Germany. About 8,500 "coronavirus deaths" were recorded in this age group. This leads to an absolute risk of coronavirus death of 10 per 10,000 ≥ 80 year-olds. Now realise that every year about 1,200 of 10,000 ≥ 80-year olds die in Germany (black column, data from the Federal Office of



Statistics). Nearly half of them due to cardiovascular diseases (CVD), almost a third from cancer and around 10% (over 100) owing to respiratory infections. The latter have always been caused by a multitude of pathogens including the coronavirus family. It is obvious that a new member has now joined the club, and that SARS-CoV-2 cannot be assigned any special role as a "killer virus".

This is underlined by another observation. Severe respiratory infections are registered by the RKI in the context of influenza surveillance. The vertical line marks the time when documentation of SARS-CoV-2 infections was started. Was there ever any indication for an increase in the number of respiratory infections (47)? No, the 2019/20 winter peak is followed by typical seasonal decline. And note that the lockdown (black arrow) was implemented when the curve had almost reached base level.



Source: Homepage RKI (Fig. 1), https://grippeweb.rki.de/

How does the new coronavirus compare with influenza viruses?

The WHO warned the world that the COVID-19 virus was much more infectious, that the illness could take a very serious course, and that no vaccine or medication was available.

The WHO abstained from explaining that truly effective medication hardly exists against any viral disease and that vaccination against seasonal flu is increasingly recognised as being ineffective or even counterproductive. Furthermore, the WHO disregarded two

https://lockdownsceptics.org/lies-damned-lies-and-health-statistics-the-deadly-danger-of-false-positives/

Lies, Damned Lies and Health Statistics – – the Deadly Danger of False Positives

20 September 2020 by Dr Michael Yeadon

I never expected to be writing something like this. I am an ordinary person, recently semi-retired from a career in the pharmaceutical industry and biotech, where I spent over 30 years trying to solve problems of disease understanding and seek new treatments for allergic and inflammatory disorders of lung and skin. I've always been interested in problem solving, so when anything biological comes along, my attention is drawn to it. Come 2020, came SARS-CoV-2. I've written about the pandemic as objectively as I could. The scientific method never leaves a person who trained and worked as a professional scientist. Please do read that piece. My co-authors & I will submit it to the normal rigours of peer review, but that process is slow and many pieces of new science this year have come to attention through pre-print servers and other less conventional outlets.

While paying close attention to data, we all initially focused on the sad matter of deaths. I found it remarkable that, in discussing the COVID-19 related deaths, most people I spoke to had no idea of large numbers. Asked approximately how many people a year die in the UK in the ordinary course of events, each a personal tragedy, They usually didn't know. I had to inform them it is around 620,000, sometimes less if we had a mild winter, sometimes quite a bit higher if we had a severe 'flu season. I mention this number because we know that around 42,000 people have died with or of COVID-19. While it's a huge number of people, its 'only' 0.06% of the UK population. Its not a coincidence that this is almost the same proportion who have died with or of COVID-19 in each of the heavily infected European countries – for example, Sweden. The annual all-causes mortality of 620,000 amounts to 1,700 per day, lower in summer and higher in winter. That has always been the lot of humans in the temperate zones. So for context, 42,000 is about ~24 days worth of normal mortality. Please know I am not minimising it, just trying to get some perspective on it. Deaths of this magnitude are not uncommon, and can occur in the more severe flu seasons. Flu vaccines help a little, but on only three occasions in the last decade did vaccination reach 50% effectiveness. They're good, but they've never been magic bullets for respiratory viruses. Instead, we have learned to live with such viruses, ranging from numerous common colds all the way to pneumonias which can kill. Medicines and human caring do their best.

So, to this article. Its about the testing we do with something called PCR, an amplification technique, better known to biologists as a research tool used in our labs, when trying to unpick mechanisms of disease. I was frankly astonished to realise they're sometimes used in population screening for diseases – astonished because it is a very exacting technique, prone to invisible errors and it's quite a tall order to get reliable information out of it, especially because of the prodigious amounts of amplification involved in attempting to pick up a strand of viral genetic code. The test cannot distinguish between a living virus and a short strand of RNA from a virus which broke into pieces weeks or months ago.

I believe I have identified a serious, really a fatal flaw in the PCR test used in what is called by the UK Government the Pillar 2 screening – that is, testing many people out in their communities. I'm going to go through this with care and in detail because I'm a scientist and dislike where this investigation takes me. I'm not particularly political and my preference is for competent, honest administration over the actual policies chosen. We're a reasonable lot in UK and not much given to extremes. What I'm particularly reluctant about is that, by following the evidence, I have no choice but to show that the Health Secretary, Matt Hancock, misled the House of Commons and also made misleading statements in a radio interview. Those are serious accusations. I know that. I'm not a ruthless person. But I'm writing this anyway, because what I have uncovered is of monumental importance to the health and wellbeing of all the people living in the nation I have always called home.

Back to the story, and then to the evidence. When the first (and I think, only) wave of COVID-19 hit the UK, I was with almost everyone else in being very afraid. I'm 60 and in reasonable health, but on learning that I had about a 1% additional risk of perishing if I caught the virus, I discovered I was far from ready to go. So, I wasn't surprised or angry when the first lockdown arrived. It must have been a very difficult thing to decide. However, before the first three-week period was over, I'd begun to develop an understanding of what was happening. The rate of infection, which has been calculated to have infected well over 100,000 new people every day around the peak, began to fall, and was declining before lockdown. Infection continued to spread out, at an ever-reducing rate and we saw this in the turning point of daily deaths, at a grim press conference each afternoon. We now know that lockdown made no difference at all to the spread of the virus. We can tell this because the interval between catching the virus and, in those who don't make it, their death is longer than the interval between lockdown and peak daily deaths. There isn't any controversy about this fact, easily demonstrated, but I'm aware some people like to pretend it was lockdown that turned the pandemic, perhaps to justify the extraordinary price we have all paid to do it. That price wasn't just economic. It involved avoidable deaths from diseases other than COVID-19, as medical services were restricted, in order to focus on the virus. Some say that lockdown, directly and indirectly, killed as many as the virus. I don't know. Its not something I've sought to learn. But I mention because interventions in all our lives should not be made lightly. Its not only inconvenience, but real suffering, loss of livelihoods, friendships, anchors of huge importance to us all, that are severed by such acts. We need to be certain that the prize is worth the price. While it is uncertain it was, even for the first lockdown, I too supported it, because we did not know what we faced, and frankly, almost everyone else did it, except Sweden. I am now resolutely against further interventions in what I have become convinced is a fruitless attempt to 'control the virus'. We are, in my opinion – shared by others, some of whom are well placed to assess the situation – closer to the end of the pandemic in terms of deaths, than we are to its middle. I believe we should provide the best protection we can for any vulnerable people, and otherwise cautiously get on with our lives. I think we are all going to get a little more Swedish over time.

In recent weeks, though, it cannot have escaped anyone's attention that there has been a drum beat which feels for all the world like a prelude to yet more fruitless and damaging restrictions. Think back to mid-summer. We were newly out of lockdown and despite concerns for crowded beaches, large demonstrations, opening of shops and pubs, the main item on the news in relation to COVID-19 was the reassuring and relentless fall in daily deaths. I noticed that, as compared to the slopes of the declining death tolls in many nearby countries, that our slope was too flat. I even mentioned to scientist friends that inferred the presence of some fixed signal that was being mixed up with genuine COVID-19 deaths. Imagine how gratifying it was when the definition of a COVID-19 death was changed to line up with that in other countries and in a heartbeat our declining death toll line became matched with that elsewhere. I was sure it would: what we have experienced and witnessed is a terrible kind of equilibrium. A virus that kills few, then leaves survivors who are almost certainly immune – a virus to which perhaps 30-50% were already immune because it has relatives and some of us have already encountered them – accounts for the whole terrible but also fascinating biological process. There was a very interesting piece in the *BMJ* in recent days that offers potential support for this contention.

Now we have learned some of the unusual characteristics of the new virus, better treatments (anti-inflammatory steroids, anti-coagulants and in particular, oxygen masks and not ventilators in the main) the 'case fatality rate' even for the most hard-hit individuals is far lower now than it was six months ago.
As there is no foundational, medical or scientific literature which tells us to expect a 'second wave', I began to pay more attention to the phrase as it appeared on TV, radio and print media – all on the same day – and has been relentlessly repeated ever since. I was interviewed recently by Julia Hartley-Brewer on her talkRADIO show and on that occasion I called on the Government to disclose to us the evidence upon which they were relying to predict this second wave. Surely they have some evidence? I don't think they do. I searched and am very qualified to do so, drawing on academic friends, and we were all surprised to find that there is nothing at all. The last two novel coronaviruses, Sar (2003) and MERS (2012), were of one wave each. Even the WW1 flu 'waves' were almost certainly a series of single waves involving more than one virus. I believe any second wave talk is pure speculation. Or perhaps it is in a model somewhere, disconnected from the world of evidence to me? It would be reasonable to expect some limited 'resurgence' of a virus given we don't mix like cordial in a glass of water, but in a more lumpy, human fashion. You're most in contact with family, friends and workmates and they are the people with whom you generally exchange colds.

A long period of imposed restrictions, in addition to those of our ordinary lives did prevent the final few percent of virus mixing with the population. With the movements of holidays, new jobs, visiting distant relatives, starting new terms at universities and schools, that final mixing is under way. It should not be a terrifying process. It happens with every new virus, flu included. It's just that we've never before in our history chased it around the countryside with a technique more suited to the biology lab than to a supermarket car park.

A very long prelude, but necessary. Part of the 'project fear' that is rather too obvious, involving second waves, has been the daily count of 'cases'. Its important to understand that, according to the infectious disease specialists I've spoken to, the word 'case' has to mean more than merely the presence of some foreign organism. It must present signs (things medics notice) and symptoms (things you notice). And in most so-called cases, those testing positive had no signs or symptoms of illness at all. There was much talk of asymptomatic spreading, and as a biologist this surprised me. In almost every case, a person is symptomatic because they have a high viral load and either it is attacking their body or their immune system is fighting it, generally a mix. I don't doubt there have been some cases of asymptomatic transmission, but I'm confident it is not important.

That all said, Government decided to call a person a 'case' if their swab sample was positive for viral RNA, which is what is measured in PCR. A person's sample can be positive if they have the virus, and so it should. They can also be positive if they've had the virus some weeks or months ago and recovered. It's faintly possible that high loads of related, but different coronaviruses, which can cause some of the common colds we get, might also react in the PCR test, though it's unclear to me if it does.

But there's a final setting in which a person can be positive and that's a random process. This may have multiple causes, such as the amplification technique not being perfect and so amplifying the 'bait' sequences placed in with the sample, with the aim of marrying up with related SARS-CoV-2 viral RNA. There will be many other contributions to such positives. These are what are called false positives.

Think of any diagnostic test a doctor might use on you. The ideal diagnostic test correctly confirms all who have the disease and never wrongly indicates that healthy people have the disease. There is no such test. All tests have some degree of weakness in generating false positives. The important thing is to know how often this happens, and this is called the false positive rate. If 1 in 100 disease-free samples are wrongly coming up positive, the disease is not present, we call that a 1% false positive rate. The actual or operational false positive rate differs, sometimes substantially, under different settings, technical operators, detection methods and equipment. I'm focusing solely on the false positive rate in Pillar 2, because most people do not have the virus (recently around 1 in 1000 people and earlier in summer it was around 1 in 2000 people). It is when the amount of disease, its so-called prevalence, is low that any amount of a false positive rate can be a major problem. This problem can be so severe that unless changes are made, the test is hopelessly unsuitable to the job asked of it. In this case, the test in Pillar 2 was and remains charged with the job of identifying people with the virus, yet as I will show, it is unable to do so.

Because of the high false positive rate and the low prevalence, almost every positive test, a so-called case, identified by Pillar 2 since May of this year has been a FALSE POSITIVE. Not just a few percent. Not a quarter or even a half of the positives are FALSE, but around 90% of them. Put simply, the number of people Mr Hancock sombrely tells us about is an overestimate by a factor of about ten-fold. Earlier in the summer, it was an overestimate by about 20-fold.

Let me take you through this, though if you're able to read Prof Carl Heneghan's clearly written piece first, I'm more confident that I'll be successful in explaining this dramatic conclusion to you. (Here is a link to the record of numbers of tests, combining Pillar 1 (hospital) and Pillar 2 (community).)

Imagine 10,000 people getting tested using those swabs you see on TV. We have a good estimate of the general prevalence of the virus from the ONS, who are wholly independent (from Pillar 2 testing) and are testing only a few people a day, around one per cent of the numbers recently tested in Pillar 2. It is reasonable to assume that most of the time, those being tested do not have symptoms. People were asked to only seek a test if they have symptoms. However, we know from TV news and stories on social media from sampling staff, from stern guidance from the Health Minister and the surprising fact that in numerous locations around the country, the local council is leafleting people's houses, street by street to come and get tested.

The bottom line is that it is reasonable to expect the prevalence of the virus to be close to the number found by ONS, because they sample randomly, and would pick up symptomatic and asymptomatic people in proportion to their presence in the community. As of the most recent ONS survey, to a first approximation, the virus was found in 1 in every 1000 people. This can also be written as 0.1%. So when all these 10,000 people are tested in Pillar 2, you'd expect 10 true positives to be found (false negatives can be an issue when the virus is very common, but in this community setting, it is statistically unimportant and so I have chosen to ignore it, better to focus only on false positives).

So, what is the false positive rate of testing in Pillar 2? For months, this has been a concern. It appears that it isn't known, even though as I've mentioned, you absolutely need to know it in order to work out whether the diagnostic test has any value! What do we know about the false positive rate? Well, we do know that the Government's own scientists were very concerned about it, and a report on this problem was sent to SAGE dated June 3rd 2020. I quote: "Unless we understand the operational false positive rate of the UK's RT-PCR testing system, we risk over-estimating the COVID-19 incidence, the demand on track and trace and the extent of asymptomatic infection". In that same report, the authors helpfully listed the lowest to highest false positive rate of dozens of tests using the same technology. The lowest value for false positive rate was 0.8%.

Allow me to explain the impact of a false positive rate of 0.8% on Pillar 2. We return to our 10,000 people who've volunteered to get tested, and the expected ten with virus (0.1% prevalence or 1:1000) have been identified by the PCR test. But now we've to calculate how many false positives are to accompanying them. The shocking answer is 80. 80 is 0.8% of 10,000. That's how many false positives you'd get every time you were to use a Pillar 2 test on a group of that size.

The effect of this is, in this example, where 10,000 people have been tested in Pillar 2, could be summarised in a headline like this: "90 new cases were identified today" (10 real positive cases and 80 false positives). But we know this is wildly incorrect. Unknown to the poor technician, there were in this example, only 10 real cases. 80 did not even have a piece of viral RNA in their sample. They are really false positives.

I'm going to explain how bad this is another way, back to diagnostics. If you'd submitted to a test and it was positive, you'd expect the doctor to tell you that you had a disease, whatever it was testing for. Usually, though, they'll answer a slightly different question: "If the patient is positive in this test, what is the probability they have the disease?" Typically, for a good diagnostic test, the doctor will be able to say something like 95% and you and they can live with that. You might take a different, confirmatory test, if the result was very serious, like cancer. But in our Pillar 2 example, what is the probability a person testing positive in Pillar 2 actually has

COVID-19? The awful answer is 11% (10 divided by 80 + 10). The test exaggerates the number of covid-19 cases by almost ten-fold (90 divided by 10). Scared yet? That daily picture they show you, with the 'cases' climbing up on the right-hand side? Its horribly exaggerated. Its not a mistake, as I shall show.

Earlier in the summer, the ONS showed the virus prevalence was a little lower, 1 in 2000 or 0.05%. That doesn't sound much of a difference, but it is. Now the Pillar 2 test will find half as many real cases from our notional 10,000 volunteers, so 5 real cases. But the flaw in the test means it will still find 80 false positives (0.8% of 10,000). So its even worse. The headline would be "85 new cases identified today". But now the probability a person testing positive has the virus is an absurdly low 6% (5 divided by 80 + 5). Earlier in the summer, this same test exaggerated the number of COVID-19 cases by 17-fold (85 divided by 5). Its so easy to generate an apparently large epidemic this way. Just ignore the problem of false positives. Pretend its zero. But it is never zero.

This test is fatally flawed and MUST immediately be withdrawn and never used again in this setting unless shown to be fixed. The examples I gave are very close to what is actually happening every day as you read this.

I'm bound to ask, did Mr Hancock know of this fatal flaw? Did he know of the effect it would inevitably have, and is still having, not only on the reported case load, but the nation's state of anxiety. I'd love to believe it is all an innocent mistake. If it was, though, he'd have to resign over sheer incompetence. But is it? We know that internal scientists wrote to SAGE, in terms, and, surely, this short but shocking warning document would have been drawn to the Health Secretary's attention? If that was the only bit of evidence, you might be inclined to give him the benefit of the doubt. But the evidence grows more damning.

Recently, I published with my co-authors a short Position Paper. I don't think by then, a month ago or so, the penny had quite dropped with me. And I'm an experienced biomedical research scientist, used to dealing with complex datasets and probabilities.

On September 11th 2020, I was a guest on Julia Hartley-Brewer's talkRADIO show. Among other things, I called upon Mr Hancock to release the evidence underscoring his confidence in and planning for 'the second wave'. This evidence has not yet been shown to the public by anyone. I also demanded he disclose the operational false positive rate in Pillar 2 testing.

On September 16th, I was back on Julia's show and this time focused on the false positive rate issue (1m 45s – 2min 30s). I had read Carl Heneghan's analysis showing that even if the false positive rate was as low as 0.1%, 8 times lower than any similar test, it still yields a majority of false positives. So, my critique doesn't fall if the actual false positive rate is lower than my assumed 0.8%.

On September 18th, Mr Hancock again appeared, as often he does, on Julia Hartley-Brewer's show. Julia asked him directly (1min 50s – on) what the false positive rate in Pillar 2 is. Mr Hancock said "It's under 1%". Julia again asked him exactly what it was, and did he even know it? He didn't answer that, but then said "it means that, for all the positive cases, the likelihood of one being a false positive is very small".

That is a seriously misleading statement as it is incorrect. The likelihood of an apparently positive case being a false positive is between 89-94%, or near-certainty. Of note, even when ONS was recording its lowest-ever prevalence, the positive rate in Pillar 2 testing never fell below 0.8%.

It gets worse for the Health Secretary. On September the 17th, I believe, Mr Hancock took a question from Sir Desmond Swayne about false positives. It is clear that Sir Desmond is asking about Pillar 2.

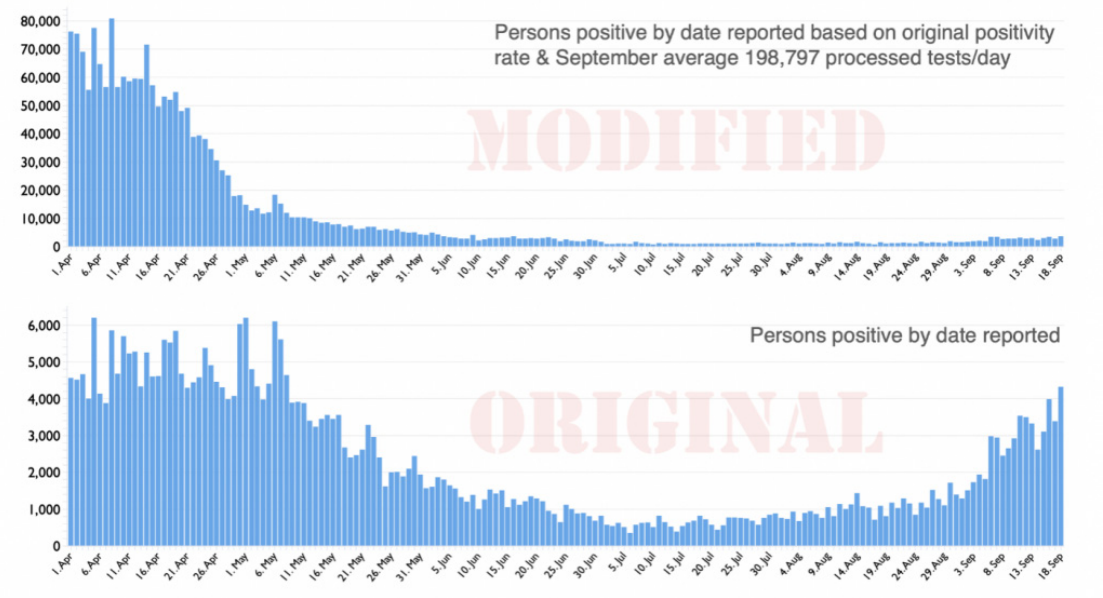
Mr Hancock replied: "I like my right honourable friend very much and I wish it were true. The reason we have surveillance testing, done by ONS, is to ensure that we're constantly looking at a nationally representative sample at what the case rate is. The latest ONS survey, published on Friday, does show a rise consummate (sic) with the increased number of tests that have come back positive."

He did not answer Sir Desmond's question, but instead answered a question of his choosing. Did the Health Secretary knowingly mislead the House? By referring only to ONS and not even mentioning the false positive rate of the test in Pillar 2 he was, as it were, stealing the garb of ONS's more careful work which has a lower false positive rate, in order to smuggle through the hidden and very much higher, false positive rate in Pillar 2. The reader will have to decide for themselves.

Pillar 2 testing has been ongoing since May but it's only in recent weeks that it has reached several hundreds of thousands of tests per day. The effect of the day by day climb in the number of people that are being described as 'cases' cannot be overstated. I know it is inducing fear, anxiety and concern for the possibility of new and unjustified restrictions, including lockdowns. I have no idea what Mr Hancock's motivations are. But he has and continues to use the hugely inflated output from a fatally flawed Pillar 2 test and appears often on media, gravely intoning the need for additional interventions (none of which, I repeat, are proven to be effective).

You will be very familiar with the cases plot which is shown on most TV broadcasts at the moment. It purports to show the numbers of cases which rose then fell in the spring, and the recent rise in cases. This graph is always accompanied by the headline that "so many thousands of new cases were detected in the last 24 hours".

You should know that there are two major deceptions, in that picture, which combined are very likely both to mislead and to induce anxiety. Its ubiquity indicates that it is a deliberate choice.



Firstly, it is very misleading in relation to the spring peak of cases. This is because we had no community screening capacity at that time. A colleague has adjusted the plot to show the number of cases we would have detected, had there been a well-behaved community test capability available. The effect is to greatly increase the size of the spring cases peak, because there are very many cases for each hospitalisation and many hospitalisations for every death.

Secondly, as I hope I have shown and persuaded you, the cases in summer and at present, generated by seriously flawed Pillar 2 tests, should be corrected downwards by around ten-fold.

I do believe genuine cases are rising somewhat. This is, however, also true for flu, which we neither measure daily nor report on every news bulletin. If we did, you would appreciate that, going forward, it is quite likely that flu is a greater risk to public health than COVID-19. The corrected cases plot (above) does, I believe, put the recent rises in incidence of COVID-19 in a much more reasonable context. I thought you should see that difference before arriving at your own verdict on this sorry tale.

There are very serious consequences arising from grotesque over-estimation of so-called cases in Pillar 2 community testing, which I believe was put in place knowingly. Perhaps Mr Hancock believes his own copy about the level of risk now faced by the general public? Its not for me to deduce. What this huge over-estimation has done is to have slowed the normalisation of the NHS. We are all aware that access to medical services is, to varying degrees, restricted. Many specialities were greatly curtailed in spring and after some recovery, some are still between a third and a half below their normal capacities. This has led both to continuing delays and growth of waiting lists for numerous operations and treatments. I am not qualified to assess the damage to the nation's and individuals' health as a direct consequence of this extended wait for a second wave. Going into winter with this configuration will, on top of the already restricted access for six months, lead inevitably to a large number of avoidable, non-Covid deaths. That is already a serious enough charge. Less obvious but, in aggregate, additional impacts arise from fear of the virus, inappropriately heightened in my view, which include: damage to or even destruction of large numbers of businesses, especially small businesses, with attendant loss of livelihoods, loss of educational opportunities, strains on family relationships, eating disorders, increasing alcoholism and domestic abuse and even suicides, to name but a few.

In closing, I wish to note that in the last 40 years alone the UK has had seven official epidemics/pandemics; AIDS, Swine flu, CJD, SARS, MERS, Bird flu as well as annual, seasonal flu. All were very worrying but schools remained open and the NHS treated everybody and most of the population were unaffected. The country would rarely have been open if it had been shut down every time.

I have explained how a hopelessly-performing diagnostic test has been, and continues to be used, not for diagnosis of disease but, it seems, solely to create fear.

This misuse of power must cease. All the above costs are on the ledger, too, when weighing up the residual risks to society from COVID-19 and the appropriate actions to take, if any. Whatever else happens, the test used in Pillar 2 must be immediately withdrawn as it provides no useful information. In the absence of vastly inflated case numbers arising from this test, the pandemic would be seen and felt to be almost over.

Dr Mike Yeadon is the former CSO and VP, Allergy and Respiratory Research Head with Pfizer Global R&D and co-Founder of Ziarco Pharma Ltd.

EXHIBIT RC06

Institute for Child Behavior Research

4157 Adams Avenue
San Diego, California 92116

BERNARD RIMLAND, Ph.D., *Director*

(714) 281-7165

October 14, 1982

Mr. William Jovanovich
Harcourt Brace Jovanovich
600 B St.
San Diego, CA 92101

Dear Mr. Jovanovich,

[my pseudonym]

I am enclosing a copy of a letter I have just received from Mr. A.K. Heath of Birmingham, England. You may have already seen the original of this letter, which was addressed to Harcourt Brace Jovanovich in New York City.

I do not know how Mr. Heath got my name, but he is right on target, since I had been a friend of Adelle Davis for many years, and am on the board of the Adelle Davis Foundation. I have not yet had an opportunity to see the book published by H.B.J., with which Mr. Heath's letter is concerned, Let's Stay Healthy, which purports to be the last book by Adelle Davis. I had been dimly aware that "Adelle Davis' last book" was being prepared for publication by someone, who I assumed was a friend and aid to Adelle. I was astounded and appalled on reading the quotations from Ann Gildroy's version of Let's Stay Healthy. There is no way in the world that Adelle would have agreed with, much less stated, the ideas that are apparently attributed to her in Let's Stay Healthy.

I have read segments of Mr. Heath's letter to several of Adelle's other friends, and they were as shocked and dismayed as I was to find that this monstrous slander of Adelle's work had gotten into print. They all agreed that there was no possible way in which Adelle would have endorsed the statements that Ann Gildroy attributes to her.

I am sure that Harcourt Brace Jovanovich is not trembling in its boots as a result of Mr. Heath's threat to boycott your publications. I do agree with him, however that the book should be retracted immediately, as a matter of ethics.

Publishing Let's Stay Healthy with Adelle Davis' name on it is very much like posthumously publishing a book purportedly written by the Pope in which atheism or satanism is advocated.

Who is Ann Gildroy, and what evidence has she presented that her claim to represent Adelle Davis is authentic? I do hope that you will look into this matter and speedily withdraw Let's Stay Healthy from publication. If Ann Gildroy wishes to publish it under her own name, but under the name Adelle Davis? Heaven forbid!

I will look forward to hearing from you.

Very sincerely,

Bernard Rimland, Ph.D.
Director

BRmo
enc.
cc: A.K. Heath, 37 Church Rd., Moseley, Birmingham, England B13 9ED

The details that follow can readily be checked on by means of the extensive indexing and sectioning of the three books. Page numbers are as in Allen & Unwin (LSH), and Unwin paperback 5⅛"x7¾" (others) editions.

Observe the cursory dismissal - within two pages - in LSH of pantothenate, cholin, inositol, and PABA. Compare with in LGW and LERTKF the extensive index references, and whole chapters on the role of cholin, inositol and lecithin in cholesterol control and heart attack prevention. Lecithin is not even mentioned in LSH, and nor is the value of cholin in preventing and curing kidney failure. According to LSH p156 "there has been no positive proof that vitamin C works to prevent infection..". Compare with the extensive coverage in the other books of vitamin C overcoming and preventing infections. Vitamin C requirements: LERTKF: 50,000-100,000 mg short term, 10,000- 15,000 long term; LSH: 30-60 mg, with implication that more than 60 mg causes kidney stones, which LERTKF discounts, and LGW also describes cures for kidney stones, ignored in LSH.

In LGW there is a whole chapter on prevention and cure of allergies, of which LSH says nothing. Likewise LSH overlooks the references in LERTKF to deficiencies of magnesium and niacin being major causes of nervousness and depression respectively. There is no mention of the observation in LERTKF that 99% of epilepsy can be cured by magnesium or B6.

In LSH p240 (vitamin supplements: do we need them?): "If the diet is carefully planned there should be no trouble in aligning our actual daily intake with the desired daily intake shown in the tables." In LERTKF p203 (lets not be part-smart): "If wholesome foods were available. supplements would rarely be needed except for vitamin D." In LERTKF same page: "By wholesomeness I mean.. naturally composted.. untouched by.. chemical fertilizers and poison sprays.". There is no mention of any of this in LSH.

LSH p148:"Cultivate a taste for liver.. sweetbreads.. and use them more frequently." Same book, p288 "liver.. (sweetbreads).. these are not for you". Same page: "Buy a book on low-cholesterol cooking." LERTKF: "..eggs, liver.. supply the very nutrients needed to reduce cholesterol. Furthermore, when no cholesterol is obtained from the diet, the body produces cholesterol far more rapidly.."

LSH: "10 mg of.. vitamin E per day.. is thought to be adequate for most people." LERTKF: ".. an adult usually needs 140 to 210 units (= mg) daily but requires 100 additional units.." There is no mention in LSH of the other books' observations of scar prevention with vitamin E.

LERTKF p56: 20,000 units of vitamin A are recommended, 100,000 on p52. LSH: No mention of more than 4000 units except implication of danger of more, which is discredited in LERTKF, p55.

I have not remotely exhausted the list of such contradictions, but you should have got the point by now. If you havent you should study this letter and the books more carefully.

Yours sincerely,

A K Heath

A. K. Heath.

EXHIBIT RC07

Masks Don't Work

A review of science relevant to COVID-19 social policy

Denis G. Rancourt, PhD
Researcher, Ontario Civil Liberties Association (ocla.ca)
Prior publishing-attempt history of this article:
https://archive.org/details/covid-censorship-at-research-gate-2/
April 2020

Summary / Abstract

Masks and respirators do not work.

There have been extensive randomized controlled trial (RCT) studies, and meta-analysis reviews of RCT studies, which all show that masks and respirators do not work to prevent respiratory influenza-like illnesses, or respiratory illnesses believed to be transmitted by droplets and aerosol particles.

Furthermore, the relevant known physics and biology, which I review, are such that masks and respirators should not work. It would be a paradox if masks and respirators worked, given what we know about viral respiratory diseases: The main transmission path is long-residence-time aerosol particles (< 2.5 μm), which are too fine to be blocked, and the minimum-infective-dose is smaller than one aerosol particle.

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.

Review of the Medical Literature

Here are key anchor points to the extensive scientific literature that establishes that wearing surgical masks and respirators (e.g., "N95") does not reduce the risk of contracting a verified illness:

Jacobs, J. L. et al. (2009) "Use of surgical face masks to reduce the incidence of the common cold among health care workers in Japan: A randomized controlled trial", *American Journal of Infection Control*, Volume 37, Issue 5, 417 - 419.
https://www.ncbi.nlm.nih.gov/pubmed/19216002
N95-masked health-care workers (HCW) were significantly more likely to experience headaches. Face mask use in HCW was not demonstrated to provide benefit in terms of cold symptoms or getting colds.

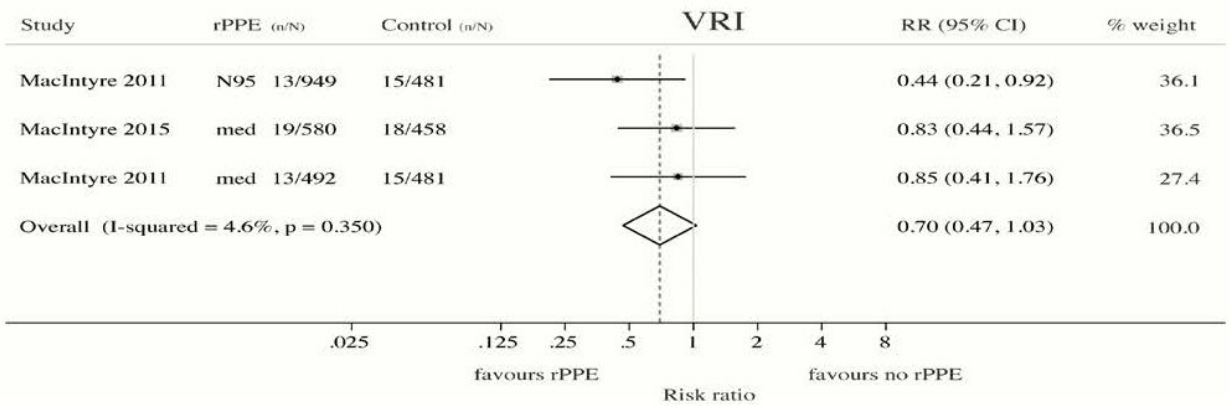
Cowling, B. et al. (2010) "Face masks to prevent transmission of influenza virus: A systematic review", *Epidemiology and Infection*, 138(4), 449-456. doi:10.1017/S0950268809991658
https://www.cambridge.org/core/journals/epidemiology-and-infection/article/face-masks-to-prevent-transmission-of-influenza-virus-a-systematic-review/64D368496EBDE0AFCC6639CCC9D8BC05

None of the studies reviewed showed a benefit from wearing a mask, in either HCW or community members in households (H). See summary Tables 1 and 2 therein.

bin-Reza et al. (2012) "The use of masks and respirators to prevent transmission of influenza: a systematic review of the scientific evidence", *Influenza and Other Respiratory Viruses* 6(4), 257–267. https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1750-2659.2011.00307.x
"There were 17 eligible studies. … None of the studies established a conclusive relationship between mask/respirator use and protection against influenza infection."

Smith, J.D. et al. (2016) "Effectiveness of N95 respirators versus surgical masks in protecting health care workers from acute respiratory infection: a systematic review and meta-analysis", *CMAJ* Mar 2016, cmaj.150835; DOI: 10.1503/cmaj.150835
https://www.cmaj.ca/content/188/8/567
"We identified 6 clinical studies ... In the meta-analysis of the clinical studies, we found no significant difference between N95 respirators and surgical masks in associated risk of (a) laboratory-confirmed respiratory infection, (b) influenza-like illness, or (c) reported work-place absenteeism."

Offeddu, V. et al. (2017) "Effectiveness of Masks and Respirators Against Respiratory Infections in Healthcare Workers: A Systematic Review and Meta-Analysis", *Clinical Infectious Diseases*, Volume 65, Issue 11, 1 December 2017, Pages 1934–1942, https://doi.org/10.1093/cid/cix681
https://academic.oup.com/cid/article/65/11/1934/4068747
"Self-reported assessment of clinical outcomes was prone to bias. Evidence of a protective effect of masks or respirators against verified respiratory infection (VRI) was not statistically significant"; as per Fig. 2c therein:



Radonovich, L.J. et al. (2019) "N95 Respirators vs Medical Masks for Preventing Influenza Among Health Care Personnel: A Randomized Clinical Trial", *JAMA*. 2019; 322(9): 824–833. doi:10.1001/jama.2019.11645
https://jamanetwork.com/journals/jama/fullarticle/2749214
"Among 2862 randomized participants, 2371 completed the study and accounted for 5180 HCW-seasons. … Among outpatient health care personnel, N95 respirators vs medical masks as worn by participants in this trial resulted in no significant difference in the incidence of laboratory-confirmed influenza."

Long, Y. et al. (2020) "Effectiveness of N95 respirators versus surgical masks against influenza: A systematic review and meta-analysis", *J Evid Based Med.* 2020; 1- 9.
https://doi.org/10.1111/jebm.12381
https://onlinelibrary.wiley.com/doi/epdf/10.1111/jebm.12381
"A total of six RCTs involving 9 171 participants were included. There were no statistically significant differences in preventing laboratory-confirmed influenza, laboratory-confirmed respiratory viral infections, laboratory-confirmed respiratory infection and influenza-like illness using N95 respirators and surgical masks. Meta-analysis indicated a protective effect of N95 respirators against laboratory-confirmed bacterial colonization (RR = 0.58, 95% CI 0.43-0.78). The use of N95 respirators compared with surgical masks is not associated with a lower risk of laboratory-confirmed influenza."

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. There is no such study. There are no exceptions.

Likewise, no study exists that shows a benefit from a broad policy to wear masks in public (more on this below).

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

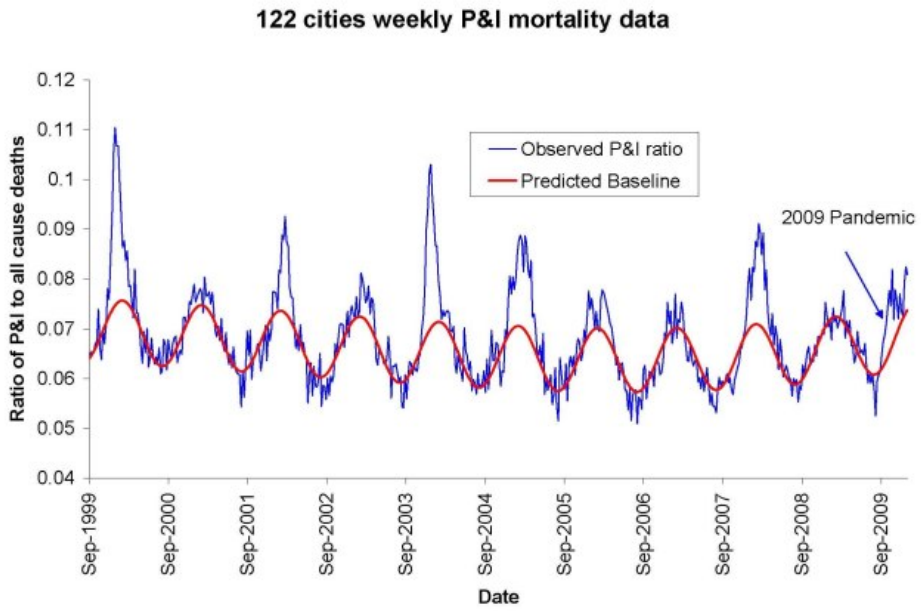
In light of the medical research, therefore, it is difficult to understand why public-health authorities are not consistently adamant about this established scientific result, since the distributed psychological, economic and environmental harm from a broad recommendation to wear masks is significant, 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 (see below).

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.

In addition to pandemics that can occur anytime, in the temperate latitudes there is an extra burden of respiratory-disease mortality that is seasonal, and that is caused by viruses. For example, see the review of influenza by Paules and Subbarao (2017). This has been known for a long time, and the seasonal pattern is exceedingly regular.

For example, see Figure 1 of Viboud (2010), which has "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," here:



The seasonality of the phenomenon was largely not understood until a decade ago. Until recently, it was debated whether the pattern arose primarily because of seasonal change in virulence of the pathogens, or because of seasonal change in susceptibility of the host (such as from dry air causing tissue irritation, or diminished daylight causing vitamin deficiency or hormonal stress). For example, see Dowell (2001).

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.

Lowen et al. (2007) demonstrated the phenomenon of humidity-dependent airborne-virus virulence in actual disease transmission between guinea pigs, and discussed potential underlying mechanisms for the measured controlling effect of humidity.

The underlying mechanism is that the pathogen-laden aerosol particles or droplets are neutralized within a half-life that monotonically and significantly decreases with increasing ambient humidity. This is based on the seminal work of Harper (1961). Harper experimentally showed that viral-pathogen-carrying droplets were inactivated within shorter and shorter times, as ambient humidity was increased.

Harper argued that the viruses themselves were made inoperative by the humidity ("viable decay"), however, he admitted that the effect could be from humidity-enhanced physical removal or sedimentation of the droplets ("physical loss"): "Aerosol viabilities reported in this paper are based on the ratio of virus titre to radioactive count in suspension and cloud samples, and can be criticized on the ground that test and tracer materials were not physically identical."

The latter ("physical loss") seems more plausible to me, since humidity would have a universal physical effect of causing particle / droplet growth and sedimentation, and all tested viral pathogens have essentially the same humidity-driven "decay". Furthermore, it is difficult to understand how a virion (of all virus types) in a droplet would be molecularly or structurally attacked or damaged by an increase in ambient humidity. A "virion" is the complete, infective form of a virus outside a host cell, with a core of RNA or DNA and a capsid. The actual mechanism of such humidity-driven intra-droplet "viable decay" of a virion has not been explained or studied.

In any case, the explanation and model of Shaman et al. (2010) is not dependent on the particular mechanism of the humidity-driven decay of virions in aerosol / droplets. Shaman's quantitatively demonstrated model of seasonal regional viral epidemiology is valid for either mechanism (or combination of mechanisms), whether "viable decay" or "physical loss".

The breakthrough achieved by Shaman et al. is not merely some academic point. Rather, it has profound health-policy implications, which have been entirely ignored or overlooked in the current coronavirus pandemic.

In particular, Shaman's work necessarily implies that, rather than being a fixed number (dependent solely on the spatial-temporal structure of social interactions in a completely susceptible population, and on the viral strain), the epidemic's **basic reproduction number** (R0) is highly or predominantly dependent on ambient absolute humidity.

For a definition of R0, see HealthKnowlege-UK (2020): R0 is "the average number of secondary infections produced by a typical case of an infection in a population where everyone is susceptible." The average R0 for influenza is said to be 1.28 (1.19–1.37); see the comprehensive review by Biggerstaff et al. (2014).

In fact, Shaman et al. showed that R0 must be understood to seasonally vary between humid-summer values of just larger than "1" and dry-winter values typically as large as "4" (for example, see their Table 2). In other words, 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.

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. For studies about modelling and regarding mediation effects on the effective reproduction number, see Coburn (2009) and Tracht (2010).

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.

If my view of the mechanism is correct (i.e., "physical loss"), then 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 (Despres, 2012). It is not entirely unlikely that viruses can thereby be physically transported over inter-continental distances (e.g., Hammond, 1989).

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, such as in the work of Yang et al. (2011):

"Half of the 16 samples were positive, and their total virus concentrations ranged from 5800 to 37 000 genome copies m^{-3}. 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. Modelling of virus concentrations indoors suggested a source strength of $1.6 \pm 1.2 \times 10^5$ genome copies m^{-3} air h^{-1} and a deposition flux onto surfaces of 13 ± 7 genome copies m^{-2} h^{-1} by Brownian motion. Over 1 hour, the inhalation dose was estimated to be 30 ± 18 median tissue culture infectious dose ($TCID_{50}$), adequate to induce infection. 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, and would not be stopped by long-range inertial impact. 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 (average pore size ~0.3−0.5 μm) does not block virion penetration, not to mention surgical masks. For example, see Balazy et al. (2006).

Mask stoppage efficiency and host inhalation are only half of the equation, however, because the minimal infective dose (MID) must also be considered. For example, if a large number of pathogen-laden particles must be delivered to the lung within a certain time for the illness to take hold, then partial blocking by any mask or cloth can be enough to make a significant difference.

On the other hand, if the MID 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.

Yezli and Otter (2011), in their review of the MID, point out relevant features:

• most respiratory viruses are as infective in humans as in tissue culture having optimal laboratory susceptibility

• it is believed that a single virion can be enough to induce illness in the host

• the 50%-probability MID ("$TCID_{50}$") has variably been found to be in the range 100−1000 virions

• there are typically 10^3−10^7 virions per aerolized influenza droplet with diameter 1 μm − 10 μm

• the 50%-probability MID easily fits into a single (one) aerolized droplet

For further background:

• A classic description of dose-response assessment is provided by Haas (1993).

• Zwart et al. (2009) provided the first laboratory proof, in a virus-insect system, that the action of a single virion can be sufficient to cause disease.

• Baccam et al. (2006) calculated from empirical data that, with influenza A in humans, "we estimate that after a delay of ~6 h, infected cells begin producing influenza virus and continue to do so for ~5 h. The average lifetime of infected cells is ~11 h, and the half-life of free infectious virus is ~3 h. We calculated the [in-body] basic reproductive number, R_0, which indicated that a single infected cell could produce ~22 new productive infections."

• Brooke et al. (2013) showed that, contrary to prior modeling assumptions, although not all influenza-A-infected cells in the human body produce infectious progeny (virions), nonetheless, 90% of infected cell are significantly impacted, rather than simply surviving unharmed.

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. It is not surprising, therefore, that no bias-free study has ever found a benefit from wearing a mask or respirator in this application.

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, in light of the above-described features of the problem, are irrelevant. For example, such studies as these: Leung (2020), Davies (2013), Lai (2012), and Sande (2008).

Why There Can Never Be an Empirical Test of a Nation-Wide Mask-Wearing Policy

As mentioned above, no study exists that shows a benefit from a broad policy to wear masks in public. There is good reason for this. It would be impossible to obtain unambiguous and bias-free results:

• Any benefit from mask-wearing would have to be a small effect, since undetected in controlled experiments, which would be swamped by the larger effects, notably the large effect from changing atmospheric humidity.

• Mask compliance and mask adjustment habits would be unknown.

• Mask-wearing is associated (correlated) with several other health behaviours; see Wada (2012).

• The results would not be transferable, because of differing cultural habits.

• Compliance is achieved by fear, and individuals can habituate to fear-based propaganda, and can have disparate basic responses.

• Monitoring and compliance measurement are near-impossible, and subject to large errors.
• Self-reporting (such as in surveys) is notoriously biased, because individuals have the self-interested belief that their efforts are useful.
• Progression of the epidemic is not verified with reliable tests on large population samples, and generally relies on non-representative hospital visits or admissions.
• Several different pathogens (viruses and strains of viruses) causing respiratory illness generally act together, in the same population and/or in individuals, and are not resolved, while having different epidemiological characteristics.

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?
• Are there negative social consequences to a masked society?
• Are there negative psychological consequences to wearing a mask, as a fear-based behavioural modification?
• What are the environmental consequences of mask manufacturing and disposal?
• Do the masks shed fibres or substances that are harmful when inhaled?

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.

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Fact #8: The idea of locking down an entire society had never been done and has no supportable science, only theoretical modeling.

In fact, the first time the idea was ever raised to lock down everyone was in 2006, in a paper titled "Targeted Social Distancing Designs for Pandemic Influenza."[30] The paper detailed "how social contact network-focused mitigation can be designed" and modeled various outcomes based on how people behaved. At the time, cooler heads prevailed and dismissed the ideas in the paper, as represented this critique from Dr. D.A. Henderson, the man who led the public effort to eradicate smallpox. According to the *New York Times*, "Dr. Henderson was convinced that it made no sense to force schools to close or public gatherings to stop. Teenagers would escape their homes to hang out at the mall. School lunch programs would close, and impoverished children would not have enough to eat. Hospital staffs would have a hard time going to work if their children were at home."

The shutdown measures would "result in significant disruption of the social functioning of communities and result in possibly serious economic problems," Dr. Henderson wrote in his own academic paper responding to their ideas. The answer, he insisted, was to tough it out: Let the pandemic spread, treat people who get sick, and work quickly to develop a vaccine to prevent it from coming back.

Soon after, Dr. Henderson and several other prescient colleagues penned an important paper encapsulating many of these ideas, "Disease Mitigation Measures in the Control of Pandemic Influenza," including this astonishing conclusion:[31]

> 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.
>
> The interest in quarantine reflects the views and conditions prevalent more than fifty 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.

They ended with a sentence so important, it deserves its own call-out: *The negative consequences of large-scale quarantine are so extreme (forced confinement of sick people with the well; complete restriction of movement of large populations; difficulty in getting critical supplies, medicines, and food to people inside the quarantine zone) that this mitigation measure should be eliminated from serious consideration.*

Indeed, as late as 2019, the World Health Organization DIDN'T EVEN LIST the idea of a total lockdown in their report titled "Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza."[32]

Obvious question: If there was no science to support a lockdown, we'd never actually done one before, and many in public health said it would be a terrible idea, why did it happen? There are really two answers as best I can tell: The first answer is that the WHO, early on in the pandemic, chose to praise the Chinese response of locking down Hubei Province, which effectively served to legitimize the practice, despite the extreme limitations of data available to anyone about the Chinese lockdown's actual effectiveness.

What changed the WHO's mind and prompted it to praise the response of the Chinese authorities in Hubei province, which included the virtual incarceration of sixty million people? It was this, more than anything else, that persuaded governments across the world to lock down their citizens.

The second answer is that newly created disease models scared the living

30 Robert J. Glass et al., "Targeted Social Distancing Designs for Pandemic Influenza," *Emerging Infectious Diseases*, November, 2006, https://wwwnc.cdc.gov/eid/article/12/11/06-0255_article.

31 Thomas V. Inglesby et al., "Disease Mitigation Measures in the Control of Pandemic Influenza," *Biosecurity and Bioterrorism*, 2006, http://www.upmc-biosecurity.org/website/resources/publications/2006/2006-09-15-diseasemitigationcontrolpandemicflu.html.

32 https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf?ua=1

daylights out of world leaders, and the modelers stood ready to offer a simple solution to their made-up numbers: lock everything down, NOW!

Fact #9: The epidemic models of COVID-19 have been disastrously wrong, and both the practice of modeling and the people behind it have a terrible history.

While many disease models have been used during the COVID-19 pandemic, two have been particularly influential in the public policy of lockdowns: that of Imperial College (UK) and that of the IHME (Institute for Health Metrics and Evaluation, Washington, USA). They've both proven to be unmitigated disasters.

It's safe to say that the reason the United States locked down, and the reason the White House extended their lockdowns, was almost exclusively due to the models created by Imperial College Professor Neil Ferguson. As the *Washington Post* explained, "Officials have said the Imperial College's eye-popping 2.2 million death projection convinced Trump to stop dismissing the outbreak and take it more seriously. Similarly, officials said, the new projection of one hundred thousand to two hundred and forty thousand deaths is what convinced Trump to extend restrictions for thirty days and abandon his push to reopen parts of the country by Easter, which many health experts believe could have worsened the outbreak."

Oddly, Professor Ferguson has a history of massive overestimation of pandemics, but apparently no one bothered to consider that in taking his advice. The *Spectator* spelled out his incredibly bad calls on three previous emerging diseases.[33] (He actually has more terrible calls. I'm just highlighting three.)

2002, Mad Cow Disease:

In 2002, Ferguson predicted that between fifty and fifty thousand people would likely die from exposure to BSE (mad cow disease) in beef. He also predicted that number could rise to one hundred and fifty thousand if there was a sheep epidemic, as well.[34] In the UK, there have only been one hundred and seventy-seven deaths from BSE.

33 "Six questions that Neil Ferguson should be asked," *The Spectator*, April 16, 2020, https://www.spectator.co.uk/article/six-questions-that-neil-ferguson-should-be-asked.

34 Lee Elliot Major, "BSE-Infected sheep a 'greater risk' to humans," *The Guardian*, January 9, 2002, https://www.theguardian.com/education/2002/jan/09/research.highereducation.

2005, Bird Flu:

In 2005, Ferguson said that up to two hundred million people could be killed from bird flu.[35] He told the Guardian that "around forty million people died in 1918 Spanish flu outbreak. . . . There are six times more people on the planet now, so you could scale it up to around two hundred million people, probably." In the end, only two hundred and eighty-two people died worldwide from the disease between 2003 and 2009.

2009, Swine Flu:

In 2009, Ferguson and his Imperial team predicted that swine flu had a case fatality rate 0.3 percent to 1.5 percent. His most likely estimate was that the mortality rate was 0.4 percent.[36] A government estimate, based on Ferguson's advice, said a "reasonable worst-case scenario" was that the disease would lead to sixty-five thousand UK deaths. In the end swine flu killed four hundred and fifty-seven people in the UK and had a death rate of just 0.026 percent in those infected.[37]

Don't you think that history should have mattered more before relying on his model to lock down our entire country? It actually gets worse. The *National Review* reported, "Johan Giesecke, the former chief scientist for the European Center for Disease Control and Prevention, has called Ferguson's model 'the most influential scientific paper' in memory. He also says it was, sadly, 'one of the most wrong.'"[38]

Indeed, Ferguson's Imperial College model for COVID-19 already has been proven wildly inaccurate.[39] To cite just one example, Ferguson foresaw Sweden

35 James Sturcke, "Bird flu pandemic 'could kill 150m'," *The Guardian*, September 30, 2005, https://www.theguardian.com/world/2005/sep/30/birdflu.jamessturcke.

36 "Swine flu: early findings about pandemic potential reported in new study," Imperial College of London, May 12, 2009, https://www.imperial.ac.uk/news/66374/swine-early-findings-about-pandemic-potential/.

37 Nick Triggle, "Swine flue less lethal than feared," *BBC News*, December 10, 2009, http://news.bbc.co.uk/2/hi/health/8406723.stm.

38 John Fund, "Professor Lockdown Modeler Resigns in Disgrace," *National Review*, May 6, 2020, https://www.nationalreview.com/corner/professor-lockdown-modeler-resigns-in-disgrace/.

39 John Cochrane, "An SIR model with behavior," *The Grumpy Economist*, May 4, 2020, https://johnhcochrane.blogspot.com/2020/05/an-sir-model-with-behavior.html.

paying a huge price for no lockdown, with forty thousand COVID deaths by May 1, and one hundred thousand by June. As of late May, Sweden had under three thousand deaths. As Fraser Nelson, editor of Britain's *Spectator*, wrote, "Imperial College's model is wrong by an order of magnitude."

Indeed, Ferguson has been wrong so often that some of his fellow modelers call him "The Master of Disaster."

You can decide if this is relevant or not, but Professor Ferguson recently resigned from his position. According to the U.K.'s *Telegraph*, "he broke social distancing rules to meet his married lover."[40]

If the Imperial College model was really the motivation for President Trump, Boris Johnson, and then many other world leaders to lockdown, the IHME models have almost always been the "science" state governors cite to demonstrate how many lives their lockdowns are saving. It's a nice plan, really: Find a model that massively overestimates the deaths in your state, lock it down, and then have the modelers show you how many lives you have saved.

Luckily, other scientists have been watching, and the IHME model has received one of the most ferocious beatdowns I have ever seen in the scientific literature from professors at the University of Sydney, Northwestern, and UTEP. Titled "Learning as We Go—An Examination of the Statistical Accuracy of COVID-19 Daily Death Count Predictions" and released last week, the study says that the IHME model is dangerously inaccurate.[41]

The authors write, "Specifically, the true number of next day deaths fell outside the IHME prediction intervals as much as seventy-six percent of the time, in comparison to the expected value of five percent. Regarding the updated models, our analyses indicate that the April models show little, if any, improvement in the accuracy of the point estimate predictions."

And then they land the big punch: "Our analysis calls into question the usefulness of the predictions to drive policy making and resource allocation."

In English? The IHME models are so bad at forecasting, they shouldn't be relied upon for anything. Need more? *National Review*'s Andrew McCarthy

40 Anna Mikhailova et al., "Government scientist Neil Ferguson resigns after breaking lockdown rules to meet his married lover," May 5, 2020, https://www.telegraph.co.uk/news/2020/05/05/exclusive-government-scientist-neil-ferguson-resigns-breaking/.

41 Roman Marchant et al., "Learning As We Go—An Examination of the Statistical Accuracy of COVID-19 Daily Death Count Predictions," May 24, 2020, https://arxiv.org/pdf/2004.04734.pdf.

was very eloquent all the way back on April 9 in criticizing the IMHE models' inaccuracy and uselessness, writing, "The model on which the government is relying is simply unreliable. It is not that social distancing has changed the equation; it is that the equation's fundamental assumptions are so dead wrong, they cannot remain reasonably stable for just seventy-two hours. And mind you, when we observe that the government is relying on the models, we mean reliance for the purpose of making policy, including the policy of completely closing down American businesses and attempting to confine people to their homes because, it is said, no lesser measures will do."[42]

How does Mr. McCarthy, a senior fellow at the National Review Institute, think these models have performed? He wrote, "To describe as 'stunning' the collapse of a key model the government has used to alarm the nation about the catastrophic threat of the coronavirus would not do this development justice."

How should we proceed? Michael Fumento wrote an excellent article for *Issues and Insights* arguing that "After Repeated Failures, It's Time to Permanently Dump Epidemic Models."[43] He explained:

> The models essentially have three purposes:
>
> 1) To satisfy the public's need for a number, any number;
> 2) To bring media attention for the modeler; and
> 3) To scare the crap out of people to get them to "do the right thing."
>
> That can be defined as "flattening the curve" so health care systems aren't overridden, or encouraging people to become sheeple and accept restrictions on liberties never even imposed during wars. Like Ferguson, all the modelers know that no matter what the low end, headlines will always reflect the high end. Assuming it's possible to model an epidemic at all, any that the mainstream press relays will have been designed to promote panic.

42 Andrew McCarthy, "COVID-19 Projection Models Are Proving to Be Unreliable," *National Review*, April 9, 2020, https://www.nationalreview.com/corner/coronavirus-pandemic-projection-models-proving-unreliable/.

43 Michael Fumento, "After Repeated Failures, It's Time to Permanently Dump Epidemic Models," *Issues & Insights*, April 18, 2020, https://issuesinsights.com/2020/04/18/after-repeated-failures-its-time-to-permanently-dump-epidemic-models/.

Fact #10: The data show that lockdowns have NOT had an impact on the course of the disease.

This is certainly the fact that people will have the hardest time with: Who wants to believe that all this suffering and isolation was for no reason? However, there are more than enough states and countries that didn't lock down, or locked down for a much shorter time, or in a much different manner, to provide sufficient data. Perhaps the simplest explanation for why lockdowns have been ineffective is the easiest: COVID-19 was in wide circulation much earlier than experts thought.[44] This alone would explain why lockdowns have been so ineffective, but whatever the final explanation, let's see what the data say.

I'm going to start with a source that you might consider unusual: the global bank JP Morgan. Of all the facts I have covered, this one about the ineffectiveness of lockdowns has become the most politicized, because it's being used to play the blame game. JP Morgan, on the other hand, creates their analysis to do something very nonpartisan: make money. Their analysts crunch data to see which economies are likely to restart first, and you shouldn't be surprised at this point to discover three things: 1) the least damaged economies are the ones that did the least onerous lockdowns, 2) lifting lockdowns has had no negative impact on deaths or hospitalizations, and 3) lifting lockdowns had not increased viral transmission.

Reading the JP Morgan conclusions is profoundly depressing, because here in the US many communities are STILL being put through many different lockdown mandates, despite overwhelming evidence to their ineffectiveness.

JP Morgan strategist and paper author Marko Kolanovic is pretty much my hero because he says everything I wish many other people were saying when he writes, "Unlike rigorous testing of new drugs, lockdowns were administered with little consideration that they might not only cause economic devastation, but potentially more deaths than Covid-19 itself."[45]

Kolanovic and his team also show that transmissibility of the virus has

44 Kashmira Gander, "Some Scientists Think COVID-19 May Have Been Spreading Far Earlier Than Previously Thought," *Newsweek*, May 6, 2020, https://www.newsweek.com/covid-19-spreading-earlier-thought-scientists-1502077.

45 Tim Stickings, "Lockdowns failed to alter course of pandemic and are now destroying millions of livelihoods worldwide, JP Morgan claims," *Daily Mail*, May 22, 2020, https://www.dailymail.co.uk/news/article-8347635/Lockdowns-failed-alter-course-pandemic-JP-Morgan-study-claims.html.

actually DECREASED after lockdowns have been lifted in US states after lockdowns were ended.

T. J. Rogers, the founder of Cypress Semiconductor, and a team of his engineers also analyzed the data and published their results in an article in the *Wall Street Journal* titled "Do Lockdowns Save Many Lives? In Most Places, the Data Say No."[46] They explain: "We ran a simple one-variable correlation of deaths per million and days to shutdown, which ranged from minus-ten days (some states shut down before any sign of Covid-19) to thirty-five days for South Dakota, one of seven states with limited or no shutdown. The correlation coefficient was five point five percent—so low that the engineers I used to employ would have summarized it as 'no correlation' and moved on to find the real cause of the problem."

Translation: something other than lockdowns must explain the course of the virus. (See Fact #14). Thomas A. J. Meunier of the Woods Hole Oceanographic Institution released this report in early May titled "Full lockdown policies in Western Europe countries have no evident impacts on the COVID-19 epidemic."[47] Like JP Morgan's report, his conclusion is depressing:

"Our results show a general decay trend in the growth rates and reproduction numbers two to three weeks before the full lockdown policies would be expected to have visible effects. Comparison of pre- and post-lockdown observations reveals a counterintuitive slowdown in the decay of the epidemic after lockdown."

And, the clincher: "Estimates of daily and total deaths numbers using pre-lockdown trends suggest that no lives were saved by this strategy, in comparison with pre-lockdown, less restrictive, social distancing policies."

Bloomberg's Elain He and colleagues also analyzed the data an article titled, "The Results of Europe's Lockdown Experiment Are In."[48] Their conclusion is unlikely to surprise you. They wrote that "there's little correlation

46 T.J. Rodgers, "Do Lockdowns Save Lives? In Most Places, the Data Say No," *Wall Street Journal*, April 26, 2020, https://www.wsj.com/articles/do-lockdowns-save-many-lives-is-most-places-the-data-say-no-11587930911.

47 Thomas Meunier, "Full lockdown policies in Western Europe countries have no evident impacts on COVID-19 epidemic," Woods Hole Oceanographic Institute, April 24, 2020, https://www.medrxiv.org/content/10.1101/2020.04.24.20078717v1.full.pdf.

48 Elaine He, "The Results of Europe's Lockdown Experiment Are In," *Bloomberg*, May 29, 2020, https://www.bloomberg.com/graphics/2020-opinion-coronavirus-europe-lockdown-excess-deaths-recession/.

between the severity of a nation's restrictions and whether it managed to curb excess fatalities—a measure that looks at the overall number of deaths compared with normal trends."

Speaking of Europe, we should all thank God for Sweden. By choosing NOT to lock down, the Swedes have proven that society can survive without a strict lockdown, and hopefully their results will prevent lockdowns from ever happening again. If you have followed this story closely, you know that naysayers were predicting doom for Sweden (and for Florida and Georgia; more on them in a moment), and none of that has ever come to pass.

Conveniently, the World Health Organization went from praising the response of the Chinese lockdown in Wuhan—which likely ignited the lockdown mania—to holding up Sweden as the model for how to combat an epidemic.[49]

Fact #11: Florida locked down late, opened early, and is doing fine, despite predictions of doom.

The best article I have read about Florida's Governor Ron DeSantis comes from the *National Review* on May 20.[50] I was pleasantly surprised by what a rational student of history Governor DeSantis was, as he explained, "One of the things that bothered me throughout this whole time was, I researched the 1918 pandemic, '57, '68, and there were some mitigation efforts done in May 1918, but never just a national-shutdown type deal. There was really no observed experience about what the negative impacts would be on that."

Unlike many of his peers, Governor DeSantis and his administration found doomsday models to be unhelpful. "We kind of lost confidence very early on in models," a Florida health official said. "We look at them closely, but how can you rely on something when it says you're peaking in a week and then the next day you've already peaked?" Instead, they explained, "we started really focusing on just what we saw."

That approach included a rifle-shot approach on the citizens most at risk:

49 Elena Pavlovska, "WHO reverses course, praises lockdown-ignoring Sweden," *NewEurope*, May 2020, https://www.neweurope.eu/article/who-reverses-course-praises-lockdown-ignoring-sweden/.

50 Rich Lowry, "Where Does Ron DeSantis Go to Get His Apology?," *National Review*, May 20, 2020, https://www.nationalreview.com/2020/05/coronavirus-crisis-ron-desantis-florida-covid-19-strategy/.

nursing home residents, of which Florida has the most in the nation. Inspectors and assessment teams visited nursing homes. The state focused on facilities that had previously been cited for infection control issues, to make sure that they were properly educated on how to prevent an outbreak.

Florida, DeSantis noted, "required all staff and any worker that entered to be screened for COVID illness, temperature checks. Anybody that's symptomatic would just simply not be allowed to go in."

In addition, they required staff to wear PPE (Personal Protective Equipment). "We put our money where our mouth is," DeSantis continued. "We recognized that a lot of these facilities were just not prepared to deal with something like this. So we ended up sending a total of ten million masks just to our long-term-care facilities, a million gloves, half a million face shields."

Florida fortified the hospitals with PPE, too, but DeSantis realized that it wouldn't do the hospitals any good if infection in the nursing homes ran out of control: "If I can send PPE to the nursing homes, and they can prevent an outbreak there, that's going to do more to lower the burden on hospitals than me just sending them another 500,000 N95 masks," he explained.

It's impossible to overstate the importance of this insight, and how much it drove Florida's approach, counter to the policies of New York and other states. ("I don't want to cast aspersions on others, but it is incredible to me, it's shocking," said the Florida health official, "that Governor Cuomo [and others] are able to kind of just avoid real questions about their policies early on to actually send individuals into the nursing home, which is completely counter to the real data.")

That brings us to New York, the state that every other governor who locked their people down pointed to, saying something to the effect of, "by locking down early, we avoided being New York." Is that really true?

There are MANY other states—and countries—with data similar to Florida's, including Georgia, Texas, Arkansas, Utah, Japan, and of course, Sweden, to name just a few. In ALL cases, the media predicted doom, and early numbers proved the pundits wrong.

Fact #12: New York's above-average death rate appears to be driven by a fatal policy error combined with aggressive intubations.

This brings us to the crux of Erin's incredible investigation. The evidence you

are about to review is irrefutable. Even if you don't believe her at first, others are reaching similar conclusions.

Massive deaths of elderly individuals in nursing homes, nosocomial infections, and overwhelmed hospitals may explain the very high fatality seen in specific locations in Northern Italy, New York, and New Jersey. A very unfortunate decision of the governors in New York and New Jersey was to have COVID-19 patients sent to nursing homes.

Dr. Ioannidis of Stanford also mentioned the choice by medical personnel in New York to quickly put patients on ventilators, which doctors now realize likely does more harm than good.

The *New York Post* was particularly harsh in criticizing New York's nursing home policy,[51] with a reporter writing:

> The carnage started in March, when hospitals inundated with COVID-19 patients insisted on clearing out elderly patients, even if they were still infected, and sending them to whatever nursing homes had empty beds. To swing that, they had to get rid of a safety regulation requiring patients to test negative twice for COVID-19 before being placed in a home. The state Health Department willingly complied.
>
> On March 25, Gov. Cuomo's Health Department mandated that nursing homes had to accept COVID patients and barred requiring any COVID tests for admission. Facilities like Newfane had to fly blind, not knowing which incoming patients had it.
>
> The American Health Care Association called it a "recipe for disaster." The Committee to Reduce Infection Deaths urged Cuomo to change course. . . . Bottom line: 11,000 to 12,000 nursing-home and assisted-living residents have died from COVID-19, half of all the virus deaths statewide. . . . That awful death toll didn't have to happen. It's six times the number of nursing-home fatalities as in Florida or California, both more populous states.

When your governor tries to tell you that their destructive decision to lock

51 Betsy McCaughey, "New York's nursing home horrors are even worse than you think," *New York Post*, May 29, 2020, https://nypost.com/2020/05/29/new-yorks-nursing-home-horrors-are-even-worse-than-you-think/.

everyone down saved you from being New York, remember Florida and Sweden. Oh, and don't forget the country no doomsday folks want to even discuss: Japan.

Science reported, "On May 25, Japan declared at least a temporary victory in its battle with COVID-19, and it triumphed by following its own playbook. It drove down the number of daily new cases to near target levels of 0.5 per one hundred thousand people with voluntary and not very restrictive social distancing and without large-scale testing. The dwindling numbers of new cases led the government to start to lift the state of emergency for much of Japan on May 14, ahead of the intended May 31 schedule."[52]

Fact #13: Public health officials and disease epidemiologists do NOT consider the other negative societal consequences of lockdowns.

If you asked me for a suggestion for how to lose a few pounds and I said, "Stop eating or drinking anything," would you take my advice? It would work to achieve your goals, but you may not like the side effects. That's basically what has happened here. Rather than being ONE input on policy, public health officials were handed the keys to the convertible without their license, and off they sped!

Consider what Dr. Anthony Fauci said to Congress earlier this month: "I'm a scientist, a physician, and a public health official. I give advice, according to the best scientific evidence. There are a number of other people who come into that and give advice that are more related to the things that you spoke about, the need to get the country back open again, and economically. I don't give advice about economic things. I don't give advice about anything other than public health."

The *Wall Street Journal* actively criticized this single-dimensional thinking by American public health officials, noting, "Dr. Fauci is clear on the fact that Americans should not rely on him to conduct cost-benefit analysis of the policies he is recommending."[53] This excellent critique of the Imperial College model from the *Times of India* makes a similar point: "The Imperial College

52 Dennis Normile, "Japan Ends Its COVID-19 State of Emergency," *Science*, May 26, 2020, https://www.sciencemag.org/news/2020/05/japan-ends-its-covid-19-state-emergency.

53 James Freeman, "The Limits of Anthony Fauci's Expertise," *Wall Street Journal*, May 13, 2020, https://www.wsj.com/articles/the-limits-of-anthony-faucis-expertise-11589392347

EXHIBIT RC09

Belgian Letter
https://docs4opendebate.be/en/open-letter/ https://docs4opendebate.be/en/signatories/
Open letter from medical doctors and health professionals to all Belgian authorities and all Belgian media. September 5th 2020

Signed by 666 medical doctors, 2175 medically trained health professionals, 16637 citizens

We, 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.

'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". 1

We believe that the policy has introduced mandatory measures that are not sufficiently scientifically based, unilaterally directed, and that there is not enough space in the media for an open debate in which different views and opinions are heard. In addition, each municipality and province now has the authorisation to add its own measures, whether well-founded or not.

Moreover, the strict repressive policy on corona strongly contrasts with the government's minimal policy when it comes to disease prevention, strengthening our own immune system through a healthy lifestyle, optimal care with attention for the individual and investment in care personnel.2

The concept of health

In 1948, the WHO defined health as follows: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or other physical impairment'.3

Health, therefore, is a broad concept that goes beyond the physical and also relates to the emotional and social well-being of the individual. Belgium also has a duty, from the point of view of subscribing to fundamental human rights, to include these human rights in its decision-making when it comes to measures taken in the context of public health. 4

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 (also in open air and during sporting activities, and in some municipalities even when there are no other people in the vicinity), physical distancing, social isolation, compulsory quarantine for some groups and hygiene measures.

The predicted pandemic with millions of deaths

At the beginning of the pandemic, the measures were understandable and widely supported, even if there were differences in implementation in the countries around us. The WHO originally reported in March that the death rate among the registered covid-19 cases was 3.4%. Millions of deaths were thus foreseen, and an extremely 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. Social distancing became the new normal in anticipation of a rescue vaccine.

The facts about covid-19

Gradually, the alarm bell was sounded from many sources: the objective facts showed a completely different reality.5 6

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. This test was rushed through with an emergency procedure and was never seriously self-tested. The creator expressly warned that this test was intended for research and not for diagnostics.7
The PCR test works with cycles of amplification of genetic material – a piece of genome is amplified each time. Any contamination (e.g. other viruses, debris from old virus genomes) can possibly result in false positives.8

The test does not measure how many viruses are present in the sample. A real viral infection means a massive presence of viruses, the so-called virus load. If someone tests positive, this does not mean that that person is actually clinically infected, is ill or is going to become ill. Koch's postulate was not fulfilled ("The pure agent found in a patient with complaints can provoke the same complaints in a healthy person").

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. 9 10

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 of the virus replication rate was already over and

decreasing. The drop was therefore not the result of the taken measures. 11
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. 12 13Only people with a weak or faulty immune system should be protected by extensive hygiene or social distancing.

Influenza will re-emerge in the autumn (in combination with covid-19) and a possible decrease in natural resilience may lead to further casualties.

Our immune system consists of two parts: a congenital, non-specific immune system and an adaptive immune system.

The non-specific immune system forms a first barrier: skin, saliva, gastric juice, intestinal mucus, vibratory hair cells, commensal flora, … and prevents the attachment of micro-organisms to tissue.

If they do attach, macrophages can cause the microorganisms to be encapsulated and destroyed.

The adaptive immune system consists of mucosal immunity (IgA antibodies, mainly produced by cells in the intestines and lung epithelium), cellular immunity (T-cell activation), which can be generated in contact with foreign substances or microorganisms, and humoral immunity (IgM and IgG antibodies produced by the B cells).

Recent research shows that both systems are highly entangled.

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.

A study in the journal Cell shows that most people neutralise the coronavirus by mucosal (IgA) and cellular immunity (T-cells), while experiencing few or no symptoms 14.

Researchers found up to 60% SARS-Cov-2 reactivity with CD4+T cells in a non-infected population, suggesting cross-reactivity with other cold (corona) viruses.15

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

The antibody formation (IgM and IgG) by B-cells only occupies a relatively small part of our immune system. This may explain why, with an antibody percentage of 5-10%, there may be a group immunity anyway. The efficacy of vaccines is assessed precisely on the basis of whether or not we have these antibodies. This is a misrepresentation.

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.16

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. 17

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.18

Fear, persistent stress and loneliness induced by social distancing have a proven negative influence on psychological and general health. 19

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 (0.1-0.5%). 20
The number of registered corona deaths therefore still seems to be overestimated. There is a difference between death by corona and death with corona. Humans are often carriers of multiple viruses and potentially pathogenic bacteria at the same time. 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 deceased patients were 80 years of age or older. The majority (70%) of the deceased, younger than 70 years, had an underlying disorder, such as cardiovascular suffering, diabetes mellitus, chronic lung disease or obesity. 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. This contrasts sharply with the theoretical criticism (insufficient substantiation by double-blind studies) which in some countries (e.g. the Netherlands) has even led to a ban on this therapy. A meta-analysis in The Lancet, which could not demonstrate an effect of HCQ, was withdrawn. The primary data sources used proved to be unreliable and 2 out of 3 authors were in conflict of interest. However, most of the guidelines based on this study remained unchanged … 48 49

We have serious questions about this state of affairs. In the US, a group of doctors in the field, who see patients on a daily basis, united in "America's Frontline Doctors" and gave a press conference which has been watched millions of times.21 51
French Prof Didier Raoult of the Institut d'Infectiologie de Marseille (IHU) also presented this promising combination therapy as early as April. Dutch GP Rob Elens, who cured several patients in his practice with HCQ and zinc, called on colleagues in a petition for freedom of therapy.22

The definitive evidence comes from the epidemiological follow-up in Switzerland: mortality rates compared with and without this therapy.23

From the distressing media images of ARDS (acute respiratory distress syndrome) where people were suffocating and given artificial respiration in agony, we now know that this was caused by an exaggerated immune response with intravascular coagulation in the pulmonary blood vessels. The administration of blood thinners and dexamethasone and the avoidance of artificial ventilation, which was found to cause additional damage to lung tissue, means that this dreaded complication, too, is virtually not fatal anymore. 47

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. 24 25

Transfer via objects (e.g. money, shopping or shopping trolleys) has not been scientifically proven.26 27 28

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. 29 30 31

Wearing a mask is not without side effects. 32 33 Oxygen deficiency (headache, nausea, fatigue, loss of concentration) occurs fairly quickly, an effect similar to altitude sickness. Every day we now see patients complaining of headaches, sinus problems, respiratory problems and hyperventilation due to wearing masks. In addition, the accumulated CO2 leads to a toxic acidification of the organism which affects our immunity. Some experts even warn of an increased transmission of the virus in case of inappropriate use of the mask.34

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. 35

Inappropriate use of masks without a comprehensive medical cardio-pulmonary test file is therefore not recommended by recognised safety specialists for workers. 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. 36

A second corona wave?

A second wave is now being discussed in Belgium, with a further tightening of the measures as a result. However, closer examination of Sciensano's figures37 shows that, although there has been an increase in the number of infections since mid-July, there was no increase in hospital admissions or deaths at that time. It is therefore not a second wave of corona, but a so-called "case chemistry" due to an increased number of tests. 50
The number of hospital admissions or deaths showed a shortlasting minimal increase in recent weeks, but in interpreting it, we must take into account the recent heatwave. In addition, the vast majority of the victims are still in the population group >75 years. This indicates that the proportion of the measures taken in relation to the working population and young people is disproportionate to the intended objectives.
The vast majority of the positively tested "infected" persons are in the age group of the active population, which does not develop any or merely limited symptoms, due to a well-functioning immune system. So nothing has changed – the peak is over.

Strengthening a prevention policy

The corona measures form a striking contrast to the minimal policy pursued by the government until now, when it comes to well-founded measures with proven health benefits such as the sugar tax, the ban on (e-)cigarettes and making healthy food, exercise and social support networks financially attractive and widely accessible. It is a missed opportunity for a better prevention policy that could have brought about a change in mentality in all sections of the population with clear results in terms of public health. At present, only 3% of the health care budget goes to prevention. 2

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

Survey studies on influenza vaccinations show that in 10 years we have only succeeded three times in developing a vaccine with an efficiency rate of more than 50%. Vaccinating our elderly appears to be inefficient. Over 75 years of age, the efficacy is almost non-existent.38

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. 39 40 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.41 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.

In our opinion, it is the task of journalism to bring news as objectively and neutrally as possible, aimed at finding the truth and critically controlling power, with dissenting experts also being given a forum in which to express themselves.

This view is supported by the journalistic codes of ethics.42

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! 43

The way in which Covid-19 has been portrayed by politicians and the media has not done the situation any good either. War terms were popular and warlike language was not lacking. There has often been mention of a ‘war’ with an ‘invisible enemy’ who has to be ‘defeated’. The use in the media of phrases such as ‘care heroes in the front line’ and ‘corona victims’ has further fuelled fear, as has the idea that we are globally dealing with a ‘killer virus’.

The relentless bombardment with figures, that were unleashed on the population day after day, hour after hour, without interpreting those 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.43 44
We urgently call on the media to take their responsibilities here!

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

Emergency law versus Human Rights

The general principle of good governance calls for the proportionality of government decisions to be weighed up in the light of the Higher Legal Standards: any interference by government must comply with the fundamental rights as protected in the European Convention on Human Rights (ECHR). Interference by public authorities is only permitted in crisis situations. In other words, discretionary decisions must be proportionate to an absolute necessity.

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, the economic well-being of the country, the protection of public order and the prevention of criminal offences, the protection of health or the protection of the rights and freedoms of others, the regulatory text on which the interference is based must be sufficiently clear, foreseeable and proportionate to the objectives pursued.45

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 (no time to evaluate thoroughly if there is an emergency) is no longer in place. Covid-19 is not a killervirus, but a well treatable condition with a mortality rate comparable to the seasonal flu. In other words, there is no longer an insurmountable obstacle to public health.

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)16 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 46 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.43**

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.

This letter was originally intended for Belgian doctors and health professionals/Belgian citizens.

More and more foreign colleagues reacted as well and wanted to sign the open letter. The objectively substantiated facts and our demand for an immediate end to all further measures appear to have crossed all borders. We decided therefore at one point to definitively open the letter to all doctors – anywhere in the world – who agree with its content.

This way, the open letter becomes an internationally supported document that aims to openly expose the fake pandemic, which is being perpetuated by the media and governments all over the world.

With concern, hope and in a personal capacity.

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EXHIBIT RC10

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Coronavirus Fraud Scandal — The Biggest Fight Has Just Begun

Analysis by Dr. Joseph Mercola October 17, 2020

STORY AT-A-GLANCE

- The German Corona Extra-Parliamentary Inquiry Committee (Außerparlamentarischer Corona Untersuchungsausschuss), launched July 10, 2020, was founded by four trial attorneys to investigate and prosecute those responsible for implementing the economically devastating lockdowns around the world, as well as using fraudulent testing to engineer the appearance of a dangerous pandemic
- The Corona Extra-Parliamentary Inquiry Committee will be working with an international network of lawyers to argue the most massive tort case ever — a case described as "probably the greatest crime against humanity ever committed"
- They argue that pandemic measures were intended to sow panic so that the pharmaceutical and tech industries can generate huge profits from the sale of PCR tests, antigen and antibody tests and vaccines, and the harvesting of our genetic fingerprints
- Lockdowns were unnecessary, and any claim to the contrary is wrong, the Inquiry Committee insists. The virus was already in retreat and infection rates were starting to decline when lockdowns were imposed; scientific evidence shows a majority of people already have built-in protection against the virus due to cross-reactive T cell immunity, and the PCR test cannot be used to identify an active infection with SARS-CoV-2 or any other virus
- While mortality statistics during the pandemic have been within the norms of any given year, meaning the pandemic has not resulted in an excess number of deaths or a death toll higher than normal, the collateral damage from pandemic response measures is nearly incalculable

The video announcement[1,2,3,4] above* by Dr. Reiner Fuellmich[5] is long* [49 minutes], but I strongly recommend listening to it in its entirety. Fuellmich has been a consumer protection trial lawyer in California and Germany[6] for 26 years and is one of four founding members of the German Corona Extra-Parliamentary Inquiry Committee (Außerparlamentarischer Corona Untersuchungsausschuss[7]),[8,9] launched July 10, 2020.

The other three founding members, all lawyers, are Viviane Fischer, Antonia Fischer and Justus P. Hoffmann, Ph.D.[10] Fuellmich is heading up the committee's corona crisis tort case. All meetings are live-streamed and available on the Committee's YouTube channel[11] (at least for now).

* The video was deleted by Youtube as part of its policy against "misinformation", but made viewable again at http://mediathek.rechtsanwalt-fuellmich.de/money_talks_v_en.m4v

According to Fuellmich, an international class-action lawsuit will be filed against those responsible for implementing the economically devastating lockdowns around the world, as well as using fraudulent testing to engineer the appearance of a dangerous pandemic.

This includes everyone from local policy makers all the way to the World Health Organization and drug companies. He claims more than 50 other countries will be following suit.

> "I have been practicing law primarily as a trial lawyer against fraudulent corporations such as Deutsche Bank, formerly one of the world's largest and most respected banks, today one of the most toxic criminal organizations in the world;"
>
> "VW, one of the world's largest and most respected car manufacturers, today notorious for its giant diesel fraud; and Cunard and Niagara the world's largest shipping company. We're suing them in a multi-million-dollar bribery case," Fuellmich say*s*.
>
> "All the above-mentioned cases of corruption and fraud committed by the German corporations pale in comparison in view of the extent of the damage that the corona crisis has caused and continues to cause. This corona crisis, according to all we know today, must be renamed a corona scandal; and those responsible for it must be criminally prosecuted and sued for civil damages."

Exposing Corrupt Agendas

Fuellmich stresses that, on a political level, all-out efforts must be made to ensure "that no one will ever again be in a position of such power as to be able to defraud humanity, or to attempt to manipulate us with their corrupt agendas."

To that end, the Corona Extra-Parliamentary Inquiry Committee will be working with an international network of lawyers to argue the most massive tort case ever — a case Fuellmich describes as "probably the greatest crime against humanity ever committed."

As explained by Fuellmich, crimes against humanity, first defined during the Nuremberg trials following World War II, are today regulated in Section 7 of the International Criminal Code. The three questions the committee seeks to answer through judicial means are:

1. Is there a COVID-19 pandemic or is there only a polymerase chain reaction (PCR) test pandemic?

Specifically, does a positive PCR test result mean that the individual is infected with SARS-CoV-2 and has COVID-19, or does it mean absolutely nothing in connection with the COVID-19 infection?

2. Do pandemic response measures such as lockdowns, mask mandates, social distancing and quarantine regulations serve to protect the world's population from COVID-19, or do these measures serve only to make people panic?

Are these measures intended to sow "panic in order to make people believe, without asking any questions, that their lives are in danger, so that the pharmaceutical and tech industries can generate huge profits from the sale of PCR tests, antigen and antibody tests and vaccines, as well as the harvesting of our genetic fingerprints?"

3. Is it true that the German government was massively lobbied — more so than any other country — by the chief protagonists of this COVID-19 pandemic?

According to Fuellmich, Germany "is known as a particularly disciplined country and was therefore to become a role model for the rest of the world for its strict and, of course, successful adherence" to pandemic measures.

Answers to these questions are urgently needed, he says, because SARS-CoV-2, which is touted as one of the most serious threats to life in modern history, "has not caused any excess mortality anywhere in the world."

Pandemic measures, on the other hand, have "caused the loss of innumerable human lives, and have destroyed the economic existence of countless companies and individuals worldwide," Fuellmich says.

He points out that in Australia, residents are now thrown into prison if they do not comply with mask rules, and in the Philippines, people can be shot dead if they defy lockdown orders or don't wear a mask.[12,13] During the first week of April 2020, Philippine President Rodrigo Duterte announced he would "not hesitate" to kill anyone challenging his pandemic restrictions:[14,15]

> "I will not hesitate. My orders are to the police and military, as well as village officials, if there is any trouble, or occasions where there's violence and your lives are in danger, shoot them dead.
>
> Is that understood? Dead. Instead of causing trouble, I will bury you. Do not intimidate the government. Do not challenge the government. You will lose," Duterte said.

This hardly seems to be a strategy aimed at preserving life. Fuellmich goes on to present "the facts as they present themselves," based on expert testimony collected by the committee so far.

The German Congress on Global Health

According to Fuellmich, in May 2019, and again in early 2020, the Christian Democratic Union (CDU) of Germany held a congress on global health. In addition to political leaders, including Mr. Tedros Adhanom, head of the WHO, and German health officials, speeches were also given by chief lobbyists of the Bill and Melinda Gates Foundation and the Wellcome Trust.

> "Less than a year later these very people called the shots in the proclamation of the worldwide corona pandemic, made sure that mass PCR tests were used to prove mass infections with COVID-19 all over the world, and are now pushing for vaccines to be invented and sold worldwide," Fuellmich says.
>
> "These infections, or rather the positive test results that the PCR tests delivered, in turn became the justification for worldwide lockdowns, social distancing and mandatory face masks."

He also points out that the very definition of "pandemic" was altered 12 years ago. Originally, a pandemic was defined as a disease that spread worldwide, resulting in widespread serious illness and deaths. Twelve years ago, the definition was changed to reflect a disease that spreads worldwide only. "Many serious illnesses and many deaths were not required anymore, to announce a pandemic," he says.

The Swine Flu Pandemic That Wasn't

This change to the definition of a pandemic is what allowed the WHO to declare the swine flu a pandemic in June 2009,[16] which resulted in the sale of many millions of dollars of fast-tracked swine flu vaccines. Within months, cases of disability and death from the H1N1 vaccine were reported in various parts of the world.
In the aftermath, the Council of Europe Parliamentary Assembly (PACE) questioned the WHO's handling of the pandemic. In June 2010, PACE concluded "the handling of the pandemic by the World Health Organization (WHO), EU health agencies and national governments led to a 'waste of large sums of public money, and unjustified scares and fears about the health risks faced by the European public.'"[17]

Specifically, PACE concluded there was "overwhelming evidence that the seriousness of the pandemic was vastly overrated by WHO," and that the drug industry had influenced the organization's decision-making.

A joint investigation by the British Medical Journal and the Bureau of Investigative Journalism (BIJ) also uncovered serious conflicts of interest between the WHO — which promoted the global vaccination agenda — and the drug companies that created those vaccines.[18] As noted by Fuellmich:

> "These vaccines proved to be completely unnecessary because the swine flu eventually turned out to be a mild flu and never became the horrific plague that the pharmaceutical industry and its affiliated universities kept announcing it would turn into, with millions of deaths certain to happen, if people didn't get vaccinated.
>
> These vaccines also led to serious health problems: about 700 children in Europe fell incurably ill with narcolepsy and are now forever severely disabled. The vaccines bought with millions of taxpayers' money had to be destroyed, with even more taxpayers' money."

The Virologist Responsible for Germany's Lockdown Orders

One of the characters that drummed up panic in 2009 with his doomsday prophesies was German virologist Christian Drosten, head of the Institute of Virology at the University of Bonn Medical Centre, best known for developing the first diagnostic test for SARS in 2003. He also developed a diagnostic test for the swine flu.[19]

Drosten spoke at the 2019 CDU congress on global health, and according to Fuellmich, when it came time to decide on a response for COVID-19, the German government relied on the opinion of Drosten alone.

> "In an outrageous violation of the universally accepted principle audiator at ultra parse, which means that one must also hear the other side, the only person they listened to was Mr. Drosten, that is, the very person whose horrific panic-inducing prognosis had proved to be catastrophically false 12 years earlier," Fuellmich says.

Meanwhile, many "highly renowned scientists" painted a completely different picture of the COVID-19 pandemic. Among them, professor John Ioannidis of Stanford University in California; professor Michael Levitt, a biophysicist at Stanford University and Nobel prize winner for chemistry; German professors Karin Mulling, Sucharit Bhakdi, Klud Wittkowski and Stefan Homburg.

Dr. Mike Yeadon, former vice president and scientific director of Pfizer, is also on this list. Yeadon recently went on record stating "there is no science to suggest a second wave should happen," and that false positive results from unreliable PCR tests are being used to "manufacture a 'second wave' based on 'new cases.'"[20]

> "They assumed, and still do assume, that there was no disease that went beyond the gravity of the seasonal flu; that the population had already acquired cross or T-cell immunity against this allegedly new virus; and that there was therefore no reason for any special measures and certainly not for vaccinations," Fuellmich says.

He also quotes[21] from a scientific paper published in September 2020 by Yeadon and colleagues, in which they state:

> "We're basing our government policy, our economic policy and the policy of restricting fundamental rights presumably on completely wrong data and assumptions about the coronavirus. If it weren't for the test results that are constantly reported in the media, the pandemic would be over, because nothing really happened."

Situational Analysis

Commenting on "the current, actual situation regarding the virus's danger; the complete uselessness of PCR tests for the detection of infections; and the lockdowns based on nonexistent infections," Fuellmich states:

> "We know that the health care systems were never in danger of becoming overwhelmed by COVID-19. On the contrary, many hospitals remain empty to this day and some are now facing bankruptcy. The hospital ship Comfort which anchored in New York at the time, and could have accommodated a thousand patients, never accommodated more than some 20 patients.
>
> Nowhere was there any excess mortality. Studies carried out by Professor Ioannidis and others have shown that the mortality of corona is equivalent to that of the seasonal flu; even the pictures from Bergamo and New York that were used to demonstrate to the world that panic was in order proved to be deliberately misleading.
>
> Then, the so-called 'panic paper' was leaked which was written by the German Department of the Interior. Its classified content shows beyond a shadow of a doubt that in fact the population was deliberately driven to panic by politicians and mainstream media.
>
> The accompanying irresponsible statements of the head of the RKI, remember the CDC, Mr. Wieler who repeatedly and excitedly announced that the corona measures must be followed unconditionally by the population, without them asking any question shows that he followed the script verbatim.
>
> In his public statements, he kept announcing that the situation was very grave and threatening although the figures compiled by his own institute proved the exact opposite. Among other things, the panic paper calls for children to be made to feel responsible, and I quote, 'for the painful tortured death of their parents and grandparents if they do not follow the corona rules.'"

Fuellmich goes on to cite data showing that in Bergamo, Italy, 94% of deaths were not the result of COVID-19 infection spreading wild but, rather, the consequence of the government's decision to transfer sick patients from hospitals to nursing homes, where they spread infection — colds, flu and SARS-CoV-2 — among the old and frail.

This was also done by New York Governor Andrew Cuomo,[22] in direct violation of federal guidelines,[23] as well as in Minnesota, Ohio,[24] Pennsylvania, New Jersey, Michigan and California.[25] Fuellmich also points out the routine malpractice that occurred in some New York hospitals, where all suspected COVID-19 patients were placed on mechanical ventilation, which turned out to be a death sentence.

> "Again, to clarify, COVID-19 .... is a dangerous disease, just like the seasonal flu is a dangerous disease, and of course COVID-19, just like the seasonal flu, may sometimes take a severe clinical course and will sometimes kill patients," *Fuellmich says.*
>
> "However, as autopsies have shown, which were carried out in Germany, in particular by the forensic scientist Professor Klaus Püschel in Hamburg, the fatalities he examined had almost all been caused by serious pre-existing conditions and almost all of the people who had died, had died at a very old age, just like in Italy, meaning they had lived beyond their average life expectancy.
>
> In this context, the following should also be mentioned: the German RKI, that is again the equivalent of the CDC, had initially, strangely enough, recommended that no autopsies be performed and there are numerous credible reports that doctors and hospitals worldwide had been paid money for declaring a deceased person a victim of COVID-19 rather than writing down the true cause of death on the death certificate, for example a heart attack or a gunshot wound.
>
> Without the autopsies, we would never know that the overwhelming majority of the alleged COVID-19 victims had died of completely different diseases but not of COVID-19.*"*

Lockdowns Were and Are Unnecessary

Based on the expert testimony collected so far by Fuellmich and his colleagues, lockdowns were unnecessary, and any claim to the contrary is wrong. The three reasons for this are:

Lockdowns were imposed at a time when the virus was already in retreat and infection rates were starting to decline

Scientific evidence shows a majority of people already have built-in protection against the virus due to cross-reactive T cell immunity from exposure to cold and flu viruses[26,27,28,29,30,31,32,33,34,35]

The PCR test — which is being used as a gauge of infection rates and a justification for restrictive measures — "do not give any indication of an infection with any virus let alone an infection with SARS-CoV-2"

The PCR Test Fraud

First of all, the PCR test have not been approved for diagnostic purposes. Its inventor, Kary Mullis, has repeatedly yet unsuccessfully stressed that this test should not be used as a diagnostic tool. As noted by Fuellmich:

> "[PCR tests] are simply incapable of diagnosing any disease ... A positive PCR test result does not mean that an infection is present. If someone tests positive, it does not mean that they're infected with anything, let alone with the contagious SARS-CoV-2 virus. Even the United States CDC ... agrees with this and I quote directly from page 38 of one of its publications on the coronavirus and the PCR tests dated July 13 2020:36
>
> - 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.
> - This test cannot rule out diseases caused by other bacterial or viral pathogens.
>
> The PCR swabs take one or two sequences of a molecule that are invisible to the human eye and therefore need to be amplified in many cycles to make it visible. Everything over 35 cycles is .... considered completely unreliable and scientifically unjustifiable.
>
> However, the Drosten test as well as the WHO recommended tests ....are set to 45 cycles. Can that be because of the desire to produce as many positive results as possible and thereby provide the basis for the false assumption that a large number of infections have been detected?"

Equally important is the fact that PCR tests cannot distinguish between inactive viruses and "live" or reproductive ones. As a result, they may pick up dead debris or inactive viral particles that pose no risk whatsoever to the patient and others. What's more, the test can pick up the presence of other coronaviruses, so a positive result may simply indicate that you've recuperated from a common cold in the past.

> "Even Drosten himself declared in an interview with a German business magazine in 2014 .... that these PCR tests are so highly sensitive that even very healthy and non-infectious people may test positive," Fuellmich notes.
>
> "In my view, it is completely implausible that [Drosten] forgot in 2020 what he knew about the PCR tests and told the business magazine in 2014. In short, this test cannot detect any infection, contrary to all false claims stating that it can.
>
> An infection, a so-called hot infection, requires that the virus ... penetrates into the cells, replicates there and causes symptoms such as headaches or a sore throat. Only then is a person really infected, in the sense of a hot infection; because only then is a person contagious, that is, able to infect others.

> Until then it is completely harmless for both the host and all other people that the host comes into contact with ...a number of highly respected scientists worldwide assume that there has never been a corona pandemic but only a PCR test pandemic ... .Dr. Yeadon, in agreement with the professors of immunology, Camera from Germany, Capel from the Netherlands and Cahill from Ireland as well as a microbiologist, Dr. Harvey from Austria, all of whom testified before the German corona committee, explicitly points out that a positive test does not mean that an intact virus has been found."

In the September 20, 2020 article[37] "Lies, Damned Lies and Health Statistics — The Deadly Danger of False Positives," Yeadon details the problems with basing our pandemic response on positive PCR tests.

In summary, the PCR test simply measures the presence of partial DNA sequences that are present in a virus, but it cannot tell us whether that virus is active or inactive. Chances are, if you have no symptoms, a positive test simply means it has detected inactive viral DNA in your body. This would also mean that you are not contagious.

Collateral Damage

While mortality statistics during the pandemic have been within the norms of any given year,[38,39] meaning the pandemic has not resulted in an excess number of deaths or a death toll higher than normal, the collateral damage from pandemic response measures is nearly incalculable. Public health, both physical and mental, as well as the global economy, have all suffered tremendous blows.

Fuellmich cites yet another leaked document written by a German official in the Department of the Interior, dubbed "the False Alarm paper,"[40,41] which concludes that there's no evidence to suggest SARS-CoV-2 posed a serious health risk for the population, at least the danger is no greater than that of many other viruses, while pandemic measures have "manifold" and "grave" consequences.

> "This, he concludes, will lead to very high claims for damages, which the government will be held responsible for. This has now become reality but the paper's author was suspended," Fuellmich says.
>
> "More and more scientists, but also lawyers, recognize that as a result of the deliberate panic-mongering and the corona measures enabled by this panic, democracy is in great danger of being replaced by fascist totalitarian models ...
>
> According to psychologists and psychotherapists who testified before the corona committee, children are traumatized en masse, with the worst psychological consequences yet to be expected in the medium and long term.
>
> In Germany alone, 500,000 to 800,000 bankruptcies are expected in the fall to strike small and medium-sized businesses which form the backbone of the economy. This will result in incalculable tax losses and incalculably high and long-term social security money transfers for, among other things, unemployment benefits."

Legal Consequences

In closing, Fuellmich reviews the legal consequences that are currently underway. This includes looking at the constitutionality of the measures. He notes:

> "Very recently, a judge, Torsten Schleife ... declared publicly that the German judiciary, just like the general public has been so panic-stricken that it was no longer able to administer justice properly. He says that the courts of law, and I quote:
>
> 'Have all too quickly waved through coercive measures which for millions of people all over Germany represent massive suspensions of their constitutional rights.' He points out that German citizens, again I quote:
>
> 'Are currently experiencing the most serious encroachment on their constitutional rights since the founding of the Federal Republic of Germany in 1949. In order to contain the corona pandemic federal and state governments have intervened,' he says, 'massively and in part threatening the very existence of the country, as it is guaranteed by the constitutional rights of the people.'"

Then there are the issues of fraud, intentional infliction of damage and crimes against humanity. According to Fuellmich, there's evidence showing a range of falsehoods and misrepresentations of facts have purposely been circulated, such that, based on the rules of criminal law, "it can only be assessed as fraud," and "based on the rules of civil tort law, this translates into intentional infliction of damage."

> "The German professor of civil law, Martin Schwab, supports this finding in public interviews in a comprehensive legal opinion of around 180 pages. He has familiarized himself with the subject matter like no other legal scholar has done thus far and in particular has provided a detailed account of the complete failure of the mainstream media to report on the true facts of this so-called pandemic," *Fuellmich says*.
>
> "Under the rules of civil tort law, all those who have been harmed by these PCR tests, PCR tests induced lockdowns are entitled to receive full compensation for their losses. In particular, there is a duty to compensate, that is, a duty to pay damages, for the loss of profits suffered by companies and self-employed persons as a result of the lockdown, and other measures.
>
> In the meantime, however, the anti-corona measures have caused and continue to cause such devastating damage to the world's population's health and economy that the crimes committed by Messrs Drosten, Wieler and the WHO must be legally qualified as actual crimes against humanity, as defined in Section 7 of the International Criminal Code."

To address these grievances, the German Corona Extra-Parliamentary Inquiry Committee is prepared to file a class-action lawsuit — a legal remedy available in the U.S. and Canada — against the responsible parties.

> "It should be emphasized that nobody must join the class action, but every injured party can join the class action," *Fuellmich explains*. "The advantage of the class action is that only one trial is needed, namely, to try the complaint of a representative plaintiff who is affected in a manner typical of everyone else in the class."

Such a lawsuit would also open the door to pretrial discovery, which requires all relevant evidence to be presented to the other party. Destruction or withholding evidence has serious consequences, as "the party withholding or … destroying evidence loses the case under these evidence rules."

In Germany, a group of tort lawyers have already started the process of disseminating information and legal forms, and estimating damages among German plaintiffs. Fuellmich concludes his announcement explaining how the lawsuit will proceed from here:

> "Initially, this group of lawyers had considered to also collect and manage the claims for damages of other non-German plaintiffs but this proved to be unmanageable.
>
> However, through an international lawyers' network, which is growing larger by the day, the German group of attorneys provides to all of their colleagues, in all other countries, free of charge, all relevant information, including expert opinions and testimonies of experts showing that the PCR tests cannot detect infections and they also provide them with all relevant information as to how they can prepare and bundle the claims for damages of their clients so that they too can assert their clients claims for damages either in their home countries, courts of law, or within the framework of the class action as explained above ...
>
> To the politicians, who believe those corrupt people, these facts are hereby offered as a lifeline, that can help you readjust your course of action and start the long overdue public scientific discussion and not go down with those charlatans and criminals."

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EXHIBIT RC11

Email from Dr. Reiner Fuellmich, LL.M., attorney at law
28 October 2020 19:57
Collaboration - Law Suits/ Corona - Class Action

Sehr geehrte Kollegen, Dear colleagues,

You can find the English version of the following text underneath the German one.

Sie wollen bei der juristischen Aufarbeitung des Corona-Skandals mitwirken, und wir wollen möglichst viele Menschen, insbesondere Juristen in die Lage versetzen, dies zu tun. Dazu müssen Sie zunächst die wichtigsten Fakten kennen. Nach unserer Einschätzung, welche auf den Aussagen von Experten insbesondere aus Wissenschaft, Medizin, Wirtschaft und Psychologie beruhen, die wir seit dem 10.07.2020 im Rahmen des Berliner Corona-Ausschusses angehört haben, haben wir es bei der angeblichen Corona-Pandemie mit einer inszenierten Pandemie zu tun:

I.
D.h.: Lobbyisten für die Tech- und die Pharmazeutische Industrie und derjenigen Personen, die in diese Industrien sehr viel Geld investiert haben, haben seit 10 Jahren zu verschiedenen, immer wiederkehrenden Gelegenheiten (z.B. im Rahmen der jährlich stattfindenden Veranstaltungen des Weltwirtschaftsforums und des Weltwährungsfonds, zweier nicht staatlicher, Organisationen) massiv erfolgreich auf die bei diesen Veranstaltungen anwesenden Spitzenpolitiker der nationalen Politik eingewirkt. Das Ergebnis dieser Vermischung von Politik und Konzerninteressen ist, daß weite Teile der Politik immer mehr von Konzerninteressen bestimmt werden, ja sogar zentrale hoheitliche Aufgaben inzwischen von Konzernen wahrgenommen werden. Wichtigste Beispiel ist insoweit die Tatsache, daß das zentrale, für die Demokratie entscheidende Grundrecht der Meinungsfreiheit inzwischen faktisch von den globalen Akteuren der sozialen Medien, wie FaceBook, YouTube u.a. nach Belieben außer Kraft gesetzt wird, nicht mehr von den dafür eigentlich zuständigen Hoheitsträgern der Staaten.
Noch im Herbst des vergangenen Jahres gab es mit dem Event 201 eine von vielen „Übungen“ der sogenannten Eliten von Politik und Wirtschaft, einberufen vom Weltwirtschaftsforum, dem Johns Hopkins Center for Health Security und der Bill & Melinda Gates Foundation, im Rahmen derer die dann wenige Monate später inszenierte Corona-Pandemie durchgespielt wurde. Deutschland war offenbar von Anfang an wegen der weltweit bekannten Disziplin der Deutschen als weltweites role model ausgewählt worden, damit alle anderen Länder anhand des deutschen Beispiels erkennen können würden, wie wichtig es ist, den lockdown, die Maskenpflicht, social distancing usw. zu befolgen. Deshalb hatte noch im Mai 2019 im Rahmen einer Veranstaltung der Regierungspartei CDU zu „Global Health“ die Lobbyisten der Pharma- und der Tech Industrie, sowie deren Investoren (der inzwischen hoch umstrittene Prof. Dr. Drosten vom Berliner Charité Krankenhaus, Prof. Wieler, Tierarzt und Leiter des RKI, sowie der ebenfalls hoch umstrittene angebliche Philosoph Tedros, Leiter des WHO, sowie die Cheflobbyisten der Bill & Melinda Gates Foundation und des Wellcome Trust) massiv auf die deutsche Bundesregierung eingewirkt. Anfang 2020 waren es dann genau diese Personen, welche die Pandemie verkündeten.

II.
Inzwischen hat die WHO unter dem Eindruck insbesondere der Arbeit des weltweit meistzitierten Wissenschaftlers Prof. John Ioannidis zugestehen müssen, daß die Mortalität, d.h.: die Gefährlichkeit des angeblich neuen Virus derjenigen einer normalen Grippe entspricht, und das amerikanische CDC hat offengelegt, daß das angeblich neue Wuhan-Virus bislang von niemandem in wissenschaftlich korrekter Weise isoliert wurde. Gleichzeitig ist unübersehbar geworden, daß die Corona-Maßnahmen weltweit zu einer nie dagewesenen Welle der Zerstörung von Gesundheit und Wirtschaft geführt haben. Das heißt: Das einzige Mittel, mit welchem die Bevölkerungen davon abgehalten werden können, nachzudenken und Fragen zu stellen, ist die nach wie vor von Teilen der Politik und ihren Helfern geschürte Panik. Und diese Panik kann nur noch anknüpfen an die mit Hilfe von PCR-Tests angeblich festgestellten Infektionszahlen. Denn daß die Horrorbilder aus Bergamo und New York fast nichts mit einem Corona-Virus, dafür aber fast alles mit der Panikmache und medizinischer Falschbehandlung zu tun haben, haben uns die angehörten Experten aus Italien und den USA berichtet.

Tatsächlich aber können und dürfen PCR-Tests nicht zu diagnostischen Zwecken eingesetzt werden. Dies hat der Erfinder des PCR-Tests, der Nobelpreisträger Kary Mullis wiederholt mit sehr deutlichen Worten erklärt: Ein positiver PCR-Test bedeutet rein gar nichts betreffend eine Infektion. Dies umso weniger, wenn die Vergrößerung-Zyklen, mit deren Hilfe man die für das menschliche Auge unsichtbaren Fragmente von Molekülen, die mit dem Abstrich genommen werden, höher als 35 liegen, denn dann „erkennt“ der Test nicht mehr den Unterschied zwischen lebenden und toten Fragmenten, wobei die toten Fragmente auch Reste des Kampfes des körpereigenen Immunsystems gegen eine Erkältung sein können, dann erkennt der PCR-Tests auch Papayas, Ziegen und Chicken Wings als positiv. Der sogenannte „Drosten“-Test, welcher von Drosten und der WHO weltweit zur Erkennung von Infektionen mit dem Wuhan-Virus vermarktet wurde, ist auf 45 Zyklen eingestellt. Der ehemalige Chief Science Officer und Vizepräsident von Pfizer Dr. Mike Yeadon hat dringend dazu aufgefordert, diesen Test sofort einzustellen, der einziger Zweck dieser Tests sei die Verursachung von Panik, um die Bevölkerung unter Kontrolle zu behalten. Genauso sehen das alle wissenschaftlichen experten, welche der Corona-Ausschuß angehört hat.

III.
Die Anwaltsgruppe, welche hier in Deutschland haftungsrechtlich gegen die Verantwortlichen für diese Panik vorgeht, wird auch in Deutschland in diesen Tagen Klagen einreichen, und zwar insbesondere wegen der PCR-Tests, damit gerichtlich mit Hilfe von Sachverständigen geklärt wird, daß die Behauptungen der Herre Drosten, Wieler und der WHO betreffend die PCR-Tests als Wasserstandsmelder für Infektionen vorsätzlich falsch sind. Denn: Ohne PCR-Tests gibt es keine Pandemie, bzw.: Es gibt keine Corona-Pandemie, sondern nur eine PCR-Test-Pandemie.

Weil nur dass angloamerikanische Rechtssystem über class actions verfügt, und dort außerdem das in der Praxis sehr gut funktionierende Beweisrecht mit der sogenannten pre trial discovery existiert, sammeln wir außerdem hier in Deutschland alle Ansprüche von Unternehmern, die wegen der PCR-Test basierten Lockdowns Schäden erlitten haben. Dafür nehmen wir die Namen, Adressen und den Geschäftszweck der Unternehmen oder des Unternehmers auf.

Dasselbe raten wir allen Kollegen im Ausland: Organisieren Sie sich, und nehmen Sie die Schadensersatzansprüche ihrer durch die Lockdowns geschädigten Unternehmer auf; am Einfachsten ist ein Vergleich der Umsätze, bzw. des Gewinns 2019 von März bis Juni mit den Umsätzen, bzw. Gewinnen in 2020. Von uns bekommen Sie die Informationen darüber, wann die Klage in den USA konkret losgeht, in welche dann alle in gleicher Weise durch die weltweiten Lockdowns Geschädigten eintreten können. Von uns bekommen Sie auch auch die Gutachten, die Sie benötigen, um in Ihrem eigenen Land oder in Deutschland zu klagen wegen
der Maskenpflicht (die Masken sind nicht nur ungeeignet zum Schutz vor Viren, sondern hochgefährlich, insbesondere für Kinder),
der PCR-Tests (Sie können entweder hier in Deutschland, aber auch in ihrem eigenen Land Drosten und die WHO wegen der falschen Tatsachenbehauptungen betreffend die PCR-Tests auf Schadensersatz verklagen

Wir arbeiten sehr eng mit einer Reihe von hoch kompetenten und schlagkräftigen Kollegen und Organisationen in den USA und Kanada zusammen, damit dort schnellstmöglich eine – allerdings sehr gut vorbereitete – Klage eines US- oder kanadischen Geschädigten eingereicht werden kann gegen die Verantwortlichen für die PCR-Test-Täuschung, und diese Klage dann als Sammelklage zugelassen wird. Wenn Sie in Ihrem Land Mandanten die Teilnahme an der geplanten class action ermöglichen wollen, können wir Sie auch über unsere Website direkt mit den internationalen Rechtsanwaltskanzleien verlinken. Wir erhalten täglich aus vielen Teilen der Welt Anfragen nach Anwälten in den jeweiligen Ländern und möchten diese Informationen über unsere Website publizieren.

Bei Interesse antworten Sie bitte auf die E-Mail lawyer@corona-schadensersatzklage.de
Geben Sie bitte Ihren zur Veröffentlichung bestimmten Namen, den Namen der Kanzlei und Ihre Website-URL oder E-Mail-Adresse an.

Auf unserer Website werden wir auch auf internationale Zoom-Konferenzen hinweisen, die für Sie von Interesse sein könnten.

Mit den besten Grüßen
Dr. Reiner Fuellmich, LL.M.

Dear Colleagues,

You have written us because you want to be part of the international fight aimed at saving democracy and resolve the Corona scandal peacefully in the courts of law of our countries. And we – The Berlin Corona Committee and the group of tort lawyers supporting this committee and its work - want to enable as many people as possible, especially lawyers, to participate in this undertaking. To do this, it is crucial that you know the facts, especially the fact that the tool for stirring up worldwide panic, the PCR test, contrary to the false statements made by e.g. Prof. Drosten and others do not tell us anything about infections… Only if we have the facts straight can we then analyze them correctly in our countries´ legal systems. Based on the statements of experts from the fields of science, medicine, business and psychology, whom the Berlin Corona Committee has been interviewing since July 10, 2020, we have assessed that the alleged corona pandemic is a staged pandemic on the basis of which Crimes against Humanity are being committed, and which gives rise to claims for damages for Malicious Infliction of Harm according to sec 826 of the German Civil Code (BGB):

I.

Lobbyists for the tech and pharmaceutical industries and those persons who have invested a lot of money in these industries (e.g. Bill Gates of Microsoft and Klaus Schwab, the founder and CEO of the World Economic Forum WEF) have for at least 10 years massively and successfully influenced the top national politicians on various recurring occasions , e.g. within the framework of the events of the World Economic Forum. The result of this long-running collusion between politics and corporate interests is that much of global politics are more and more determined by corporate interests, and even central sovereign tasks are now decided and carried out by corporations. The most important example of this is the fact that the central, fundamental right of freedom of speech, which is the corner stone of democracy, has now been supplanted and subverted by Big Tech, Big Pharma and social media (e.g. Facebook, YouTube, Google etc). usurping the power of sovereign authorities.

As recently as last fall, the “Event 201”was one of many "exercises" of the so-called, self appointed elites of politics and business. It was convened by the World Economic Forum, the Johns Hopkins Center for Health Security and the Bill & Melinda Gates Foundation. In this “exercise“, a hypothetical corona pandemic was staged which then played out in the real world a few months later in March 2020. Apparently, Germany was chosen as the role model from the very beginning because of the globally known discipline of the Germans, so that all other countries would recognize, based on the German example, how important it is to follow the lockdown, the mandatory masks, social distancing, etc.

A few months before this “Event 201”, in May of 2019, lobbyists from the pharmaceutical and tech industries had a meeting with the CDU (the governing party in Germany) on "Global Health." Present were Prof. Dr. Drosten, as Germany´s national virologist, who´s doctoral dissertation has been found out to be a fake, Prof. Dr. Wieler a veterinarian who is the leader of the German equivalent of the CDC, the RKI, and Dr. Tedros, a philosopher who is the head of the WHO. Present also were the chief lobbyists of the Bill & Melinda Gates Foundation and the Wellcome Trust. This, of course, was a massive lobbying approach, which translates into an attack on the German government. At the beginning of 2020, it was precisely these people who announced the pandemic.

II.
In the meantime, based on the expertise of the world's most cited scientist, Prof. John Ioannidis, the WHO has admitted that the lethality or danger of the allegedly new virus corresponds to that of the seasonal influenza, and there are still doubts whether this new virus has ever been isolated in a scientifically correct way, and where it came from. At the same time, it has become obvious that the Corona measures have led to an unprecedented wave of catastrophic devastation of global health and economies. In a published sermon, a German cleric describes these events and the resulting havoc as a Third World War.

As there was and is, however, no excess mortality, at least not in Germany, no overwhelmed hospitals, etc. the only way to prevent the population from questioning this false narrative about the governmental panic messages being received daily through the mainstream media (which the same players, who invested heavily in the pharmaceutical and tech industries, invested a lot of money into) was through more fear and government mandated controls on personal freedoms. A leaked paper from the German Secretary of the Interior includes explicitly making children feel responsible for the “tortured death” of their parents and/or grandparents if they don´t adhere to social distancing, orders to wear masks, etc. The experts from Italy and the USA have told us that the horror pictures from Bergamo and New York were not due to a corona virus, but almost entirely due to the panic-mongering and medical malpractice that ensued.

The controls which the government/the above alluded to corporations and private institutions like the WEF are now tightening to an even greater degree than at the beginning of this fake pandemic use the wholly unreliable PCR tests as its most important tool to induce fear and panic.

In reality, however, PCR tests cannot and must not be used for diagnostic purposes. The inventor of the PCR test, Nobel Prize winner Kary Mullis, has repeatedly explained this in very clear terms. The videos available on this subject are impressive: a positive PCR test means absolutely nothing concerning an infection, and even less than nothing concerning an illness, Mullis states over and over again. This is even more true if the amplification cycles with which the fragments of molecules taken with the swab, invisible to the human eye, are magnified are higher than 35, because then the test no longer "recognizes" the difference between living and dead fragments. The dead fragments found by the test may very simply be remnants of the body's own immune system's fight against a common cold. The PCR test also recognizes papayas, goats and chicken wings as positive according to tests caried out at the behest of the President of Tanzania, a chemist, by his country´s laboratories.

The so-called "Drosten test” is set to 45 cycles. It was marketed worldwide by Drosten and the WHO for the detection of infections with the Wuhan virus. The former Chief Science Officer and Vice President of Pfizer, Dr. Mike Yeadon, has urged that this test be stopped immediately, stating that the sole purpose of these tests is to cause panic in order to keep the population under control. This is the view of all international scientific experts whom the Corona Committee has consulted.

III.
The group of lawyers taking legal action against those responsible for this panic here in Germany will be filing lawsuits in Germany in the next few days, with a focus on the PCR tests. (Another law suit will focus on studies that show that the masks are not only useless for protection against a virus, but highly dangerous, in particular for children). It will be clarified in court with the help of experts that the claims of Mr. Drosten, Mr. Wieler and the WHO concerning the PCR tests as an indicator for infections are intentionally wrong. The crux of the issue is this: Without PCR tests there is no pandemic, or, phrased differently: There is no corona pandemic, only a PCR test pandemic.

Given that only the Anglo-American legal system has class actions and a special law of evidence with the so-called pre trial discovery, we are also cooperating very closely with American and Canadian colleagues in order to file a class action in one or both of those countries. If the court agrees to allow the case to go forward as a class action suit, this may make it possible for any person or corporation from anywhere in the world who suffered damages due to the PCR test based lockdowns to join the class. For this purpose, we will record the names, addresses and the business purpose of the companies or the entrepreneur and the damages they have suffered thus far. It must be stressed that anyone who suffered and is suffering harm as a result of the PCR test based lockdowns and other measures (mandatory mask wearing, for example) has a claim for damages; for now, we concentrate on businesses only for one reason: It is simpler for them to come up with an amount of damages.

The same advice is given to all colleagues abroad: Organize yourselves and record the claims for damages of the companies or individuals damaged by the lockdowns. The easiest way is to compare the sales or profits from March-June 2019 with the sales or profits during the same period in 2020. We will publish on our websites all relevant information on how our German cases are progressing, as well as cases everywhere else in the world, in particular in the US and Canada. We will also publish the expert opinions and witness statements we have obtained that you will need to proceed with prosecution in your own country, so that you may:
revoke the mandates to wear masks (masks are not only unsuitable for protection against viruses, but are highly dangerous, especially for children),
legally invalidate the reliability of PCR tests (you can sue Drosten and Wieler for damages either here in Germany or in your own country because of the false and non factual claims concerning the PCR tests)

The Corona Committee also works very closely with highly competent and effective colleagues and organizations in the USA and Canada to ensure that a very well prepared lawsuit by a US or Canadian plaintiff can be filed there as quickly as possible, and that this lawsuit is then admitted as a class action.

We are also currently building up a list of international attorneys who are contacting us from individual countries, so that you can also network with each other in this way. On our website we will also point out international Zoom conferences that might be of interest to you.

If you are interested, please reply to the e-mail lawyer@corona-schadensersatzklage.de

Please include your name intended for publication, the name of the law firm and your website URL or e-mail address.

As my English language video on this planned pandemic "Crimes against Humanity" was taken down by YouTube (we are currently attacking this in a German court), we have provided a new link to the video which is now secure: http://mediathek.rechtsanwalt-fuellmich.de/money_talks_v_en.m4v

Dr. Reiner Fuellmich, LL.M.
- attorney at law -

EXHIBIT RC12

HIGH COURT OF JUSTICE **Claim No.:**

QUEEN'S BENCH DIVISION

THE ADMINISTRATIVE COURT

AND IN THE MATTER OF THE PUBLIC HEALTH (CONTROL OF DISEASE) ACT 1984;

B E T W E E N :

THE QUEEN

(On the application of
(1) SIMON DOLAN

(2) CRIPPS BARN GROUP LIMITED
and
(3) LAUREN MONKS)

Claimants

- and –

1) THE SECRETARY OF STATE FOR HEALTH & SOCIAL CARE

(2) THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

(3) THE SECRETARY OF STATE FOR BUSINESS, ENERGY AND INDUSTRIAL STRATEGY

(4) PARLIAMENTARY UNDER SECRETARY OF STATE AT THE DEPARTMENT OF HEALTH AND SOCIAL CARE (MINISTER FOR INNOVATION)

(5) PARLIAMENTARY UNDER SECRETARY OF STATE AT THE DEPARTMENT FOR BUSINESS, ENERGY AND INDUSTRIAL STRATEGY (MINISTER FOR BUSINESS AND INDUSTRY)

Defendants

STATEMENT OF FACTS AND GROUNDS
AND WRITTEN SUBMISSIONS OF THE CLAIMANTS

INTRODUCTION

Factual background

1 This claim challenges restrictions on the ability of individuals to meet and socialise with their family and friends, to attend political protests save in limited defined circumstances; and which reduce the ability of businesses to trade profitably and so deprive them of much of the value of their property. They impose restrictions on the day to day life and society of individuals and communities more onerous than perhaps any that have ever been imposed before March of this year.

2 As Daniel Kelly J found in relation to similar restrictions imposed in the State of Wisconsin:

> '*The power to confine law-abiding individuals to their homes, commandeer their businesses, forbid private gatherings… and dictate their personal behavior cannot, in any imaginable universe, be considered a "detail." This comprehensive claim to control virtually every aspect of a person's life is something we normally associate with a prison, not a free society governed by the rule of law*.'[1]

3 The restrictions challenged in this claim, purportedly made in response to the SARS-CoV-2 epidemic ('**the coronavirus**'; '**the virus**'), were made on 3.7.2020, 26.8.20, 13.9.2020, 17.9.20 and 23.9.20 and each came into force only hours or even minutes after they were published. Aside from their effect on cherished fundamental human rights, they will, individually and collectively, have a devastating effect on businesses throughout the hospitality industry and (through the collateral effects) more widely. They were made without impact assessments, in the absence of any empirical scientific evidence that they would affect the transmission of the virus and after death rates from the virus had dropped below 1 % of total deaths. They have been justified using 'positive' test results, many of which – perhaps even the majority – represent individuals who present no risk of transmitting the virus. And the restrictions were made using the 'emergency' procedure but in the absence of circumstances that could possibly be described as necessary due to "urgency".

4 While many people have died from the virus in the last seven months, only just over 300 of those were under 60 with no pre-existing conditions The average age of death from the virus is over 80 years old.

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[1] *Wisconsin Legislature v. Secretary-Designee Andrea Palm* [2020] WI 42, Wisconsin Supreme Court, at para 113

5 On 13.9.2020, the Secretary of State for the Home Department made regulations that imposed a limit on gatherings of six persons, save where exceptions applied; and applied a statutory maximum of 30 to weddings, funerals and other 'significant events'. These and all other Regulations were made under Part 2A of the Public Health (Control of Disease) Act 1984, as amended ('**the 1984 Act**') These regulations (the Health Protection (Coronavirus, Restrictions) (England) (No 2) (Amendment No. 4) Regulations 2020, '**the Rule of Six Regulations**') were an amendment to the Health Protection (Coronavirus, Restrictions) (England) (No 2) Regulations 2020 ('**the No. 2 Regulations**'[2]), which were made by the Secretary of State for Health on 3.7.2020. The No. 2 Regulations replaced, in turn, the Health Protection (Coronavirus, Restrictions) (England) Regulations 2020, ('**the Restriction Regulations**'), which were made on 26.3.2020 and which imposed the most fundamental restrictions on fundamental rights in the modern era.

6 On 24.9.2020 the Parliamentary Under Secretary of State for Business & Industry, Department for Business, Energy and Industrial Strategy, Nadim Zahawi MP, made The Health Protection (Coronavirus, Restrictions) (Obligations of Hospitality Undertakings) (England) Regulations 2020 No.1008 ("**the Booking Regulations**") were made on 17 September. These regulations were again made using the emergency procedure and certified as urgent and came into force on 18.9.2020. The Booking Regulations imposed obligations on pubs, cafes and any establishment providing food or drink for consumption on its premises not to take bookings for groups of more than 6 (unless falling within exemptions). But they went further and imposed obligations on the venue to "take all reasonable measures" to prevent "mingling" by one group with another and to ensure persons remain seated whilst consuming food or drink.

7 The No. 2 Regulations had previously been amended by the Health Protection (Coronavirus) (Restrictions on Holding of Gatherings and Amendment) (England) Regulations 2020 ('**the Holding of Gatherings Regulations**'), made on 28.8.2020, which increased the fixed penalty notice on those holding gatherings of over 30 to £10,000. These were made under the emergency procedure.

8 Before subsequent Regulations were made, the government's Chief Medical Officer, Professor Chris Whitty, and its Chief Scientific Officer, Sir Patrick Vallence, made a presentation on 21.9.2020. This presented selective data on the rise in positive test results that it described as 'cases' (despite those including non-symptomatic individuals). Very little information was given about the extremely low rate of deaths of patients with positive tests for the virus. A

[2] This term is used to refer to the No. 2 Regulations as originally enacted, not as amended by the Rule of Six Regulations.

graph was presented that purported to be a 'reasonable worst case scenario', which showed exponential growth of the virus. In the ten days since that presentation, cases have risen at a much slower rate. The officers failed to refer to the effect of the false positive rate on testing data (which suggests that a large proportion of tests show false positive readings at this level) and suggested that all but 8% of the population were susceptible to the virus (which is contrary to growing evidence about the existence of pre-existing T-cell immunity). They also failed to mention the relative risk to different age groups of the virus.

9 On 22.9.2020 the Prime Minister made a statement to the House of Commons followed by a broadcast that evening. In each, he asserted the supposed 'need' for further restrictions with no acknowledgment of any of the above factors and barely any of their grave effect on fundamental rights.

10 On 23.9.2020, the Parliamentary Under Secretary of State for Health, Lord Bethell, made the Health Protection (Coronavirus, Restrictions) (England) (No 2) (Amendment No. 5) Regulations 2020 ('**the Opening Hours Regulations**'). These imposed additional restrictions, including reducing the number of persons that could attend weddings to 15, restricting pubs and restaurants from serving food or drink save where customers were seated and prohibiting those premises from opening after 10 pm. They were made under the emergency procedure.

11 Separate statutory instruments extending the compulsory wearing of face coverings were made through the Health Protection (Coronavirus, Wearing of Face Coverings in a Relevant Place and on Public Transport) (England) (Amendment) (No. 3) Regulations 2020 No.1026 ('**the Mask Regulations**'). The Mask Regulations were signed by the Secretary of State for Health and Social Care on 23 September and came into force on 24 September. They were again introduced using the emergency procedure.

12 Prior to the re-opening of pubs, cafés and restaurants on 4.7.2020, the UK Government issued 'the COVID-19 Guidance on Pubs, Bars, Restaurants, and Takeaway Services' ('**the Hospitality Guidance**'),[3] The Covid-19 Guidance on Wedding Receptions[4] ('**the Wedding Reception Guidance**') and Guidance for Small Marriages and Civil Partnerships[5] ('**the Marriage Guidance**') ('**the Guidance**' when referred to collectively). Regulation 5(5G) gives the latter Regulations direct statutory effect by requiring the organiser of a marriage or wedding

[3] https://assets.publishing.service.gov.uk/media/5eb96e8e86650c278b077616/working-safely-during-covid-19-restaurants-pubs-takeaways-240920.pdf
[4] https://www.gov.uk/government/publications/covid-19-guidance-for-small-marriages-and-civil-partnerships/covid-19-guidance-for-wedding-and-civil-partnership-receptions-and-celebrations
[5] https://www.gov.uk/government/publications/covid-19-guidance-for-small-marriages-and-civil-partnerships/covid-19-guidance-for-small-marriages-and-civil-partnerships#enforcement

reception to undertake a risk assessment that takes account of government guidance about the spread of the virus.

13 Before the Restriction Regulations were replaced by the No. 2 Regulations and restrictions on the fundamental rights of the entire population considerably relaxed, the First Secretary of State announced on 16.4.2020 a policy to guide the relaxation and possible tightening of restrictions. This policy was only to relax restrictions if each one of five tests ('the Five Tests') were met; and to tighten restrictions if any one of the tests were no longer met. Each of those tests related to the virus and none of them to any other considerations. The Five Tests were later reiterated by the Health Secretary and the Prime Minister and were set out in published guidance.

14 Very recently, on 23.9.2020, the UK Government, the Northern Ireland Executive, the Scottish Government, and the Welsh Government announced a policy that they 'must' reduce the reproduction rate of the virus below 1; and that they were collectively committed 'to suppressing the virus to the lowest possible level and keeping it there, while we strive to return life to as normal as possible for as many people as possible. We agree that our policy decisions should be consistent with **this** objective.'[6] This statement failed to state that measures to 'suppress' the virus must be proportionate to the harms they will cause. Indeed, the UK government has turned its face against acting proportionately or rationally in a narrow-minded focus on one potential harm that is unprecedented in modern history outside wartime and is, in its impact on fundamental rights, irrational and disproportionate.

15 The Claimant relies, in support of this claim, on evidence contained in the witness statements of:

(1) Michael Gardner, solicitor to the Claimants;
(2) Mark Henriques, managing director of Cripps;
(3) Simon Keeling, financial director of Cripps.
(4) Lauren Monks, the Third Claimant and
(5) Simon Dolan the First Claimant

Together with the documentary evidence, which is mostly in the public domain, exhibited by Michael Gardner as MG1.

The Claimants

[6] https://www.gov.uk/government/publications/joint-statement-on-covid-19/joint-statement-on-coronavirus-covid-19

Robin P Clarke

Email: r@rpcc.info

Tel:

Government Legal Department
102 Petty France, Westminster, London SW1H 9GL
By email to newproceedings@governmentlegal.gov.uk

15th October 2020

Letter before Claim
re Covid-19 policies

1. Proposed claim for judicial review

To The Government of the United Kingdom.

2 The claimant

Mr Robin Clarke,

3 The defendant's reference details

None currently available, though the matter is highly prominent anyway.

4 The details of the claimants' legal advisers, if any, dealing with this claim

None as yet.

5 The details of the matter being challenged

The Claimant seeks permission to apply for judicial review of the various ongoing decisions and policies relating to control of the pandemic of Covid-19 virus, and most particularly in respect of imposing of "lockdown" regulations, prohibiting certain forms of gatherings and movements, and imposing requirements of "social distancing" and wearing of face masks with penalties for non-compliance.

6 The details of any Interested Parties

(Thousands of small businesses, non-profit, and voluntary organisations interested, but cannot practically be listed here.)

7 The issue

The Claim is envisaged to be brought on the grounds that:

(1) there is a failure to take into account the considerable evidence that there is no credible scientific basis in justification of these policies;

(2) there is a failure to take account of the considerable evidence that these policies are causing and will continue to cause massive adverse consequences, including increased morbidity and mortality, such as to considerably outweigh any benefits;

(3) there is a lack of credible coherent scientific basis for the policies, such that no reasonable or rational decisionmaker would make such decisions.

In particular:

There is no basis for assuming that the PCR tests have validity for diagnosing cases or infections, and much reason for concluding that they do not.

There is no good reason to believe that there is currently a concerningly high level of cases or infections, or rapid increase of cases or infections.

There is no basis for assuming that a pandemic would become excessively harmful in absence of the socially-oppressive policies and or use of quack vaccine technologies.

8 The details of the action that the defendant is expected to take

Unless there be demonstrated a credibly sound scientific basis, and be established properly uncensored and public corrective debate both within and without the "scientific community", to cease and desist from the oppressive policies of lockdown and imposing of "social distancing" and requiring of wearing of face-masks.

9 ADR proposals

None proposed at this point.

10 The details of any information sought

None specifically identified at this stage.

11 The details of any documents that are considered relevant and necessary

None specifically identified at this stage.

12 The address for reply and service of court documents

115 Salisbury Tower, Birmingham B18 7DB

13 Proposed reply date

Within 14 days of receipt of this letter, though preferably earlier in view of the urgency of this matter.

Sincerely,

Robin P Clarke

Government
Legal Department

Mr Robin Clarke

By email only: r@rpcc.info

Litigation Group
102 Petty France
Westminster
London
SW1H 9GL

T 020 7210 3000

DX 123243, Westminster 12 www.gov.uk/gld

Your ref: None given
Our ref: Z2011208/DFE/HOI7

29 October 2020

WITH ANNOTATIONS BY ROBIN CLARKE

Dear Sir

R (Clarke) v Secretary of State for Health and Social Care and Others – Response to pre-action protocol letter before claim

1. This is a letter of response to your Pre-action Protocol Letter dated 15 October 2020, received by the Government Legal Department on 15 October 2020. We are instructed by the Secretary of State for Health and Social Care.

2. The Secretary of State does not accept that he has acted unlawfully, in any of the matters you complain of.

The Proposed Claimant

3. The details in your letter are noted.

The Defendant

4. You do not identify a specific defendant. As noted, we act for the Secretary of State for Health and Social Care, who we consider to be the appropriate defendant to the proposed claim.

Reference details

5. Our reference for this matter is listed at the top of this letter. The solicitor with conduct of this matter is Daniel Emery, of the Government Legal Department. His email address is Daniel.Emery@governmentlegal.gov.uk.

6. Due to the current circumstances, any correspondence or service of documents should be sent via email to the address above, to limit the handling of materials by post.

The details of the matter being challenged

7. You have stated that you intend to challenge "v*arious ongoing decisions and policies relating to control of the pandemic of Covid-19 virus, and most particularly in respect of imposing of "lockdown" regulations, prohibiting certain forms of gathering and movements, and imposing requirements of "social distancing" and wearing of face masks with penalties for non-compliance*."

8. You state that your claim is brought on the grounds that: (a) there is a failure to take into account "*considerable evidence that there is no credible scientific basis*" to justify these decisions and policies; (b) there is a failure to take into account "*considerable evidence that these policies are causing and will continue to cause massive adverse consequences*" and (c) there is a lack of "*credible coherent scientific basis for the policies, such that no reasonable or rational decision maker would make such decisions*."

9. You add that: (a) there is no basis for assuming that PCR tests are valid for the purposes of diagnosis, and "*much reason for concluding that they do not*"; (b) there is no good reason to believe that there is a "*concerningly high level of cases or infections, or rapid increase of cases or infections*"; and (c) there is no basis for assuming that the pandemic would become "*excessively harmful"* in the absence of what you describe as the "*socially-oppressive policies*" and/or use of "*quack vaccine technologies*."

Response to the proposed claim

1

10. Your claim fails to identify which decisions or policies you propose to challenge, making only a vague reference to "various ongoing decisions and policies" concerning the broad matters you identify. You refer to evidence which you allege the Secretary of State has failed to take into account, but fail to identify: (a) in respect of which specific decisions the Secretary of State is alleged to have failed to do so; (b) any proper reasons as to why you allege this; and (c) the evidence upon which you rely. The only real basis you identify for the bringing of the proposed claim is that the (unspecified) decisions and policies are irrational, but you have failed to provide any explanation whatsoever as to the basis upon which you assert that the Secretary of State has acted irrationally.

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11. The approach that you have adopted is inconsistent with the requirements and purpose of the pre-action protocol for judicial review claims. The pre-action protocol requires a letter before claim to set out "the date and details of the decision, act or omission being challenged, a clear summary of the facts and the legal basis for the claim" (see paragraph 16 of the protocol). Your letter clearly does not meet this requirement, in terms of the claim proposed to be brought. Further, the purpose of the protocol is to enable parties, *inter alia*, to understand and identify the issues in dispute, and avoid unnecessary expense and costs (see paragraph 3 of the protocol). The approach in your letter defeats both these purposes: you have wholly failed to identify the issues in dispute in relation to your targets in this claim. It is not for the Secretary of State to guess at what your claims may be.

12. In the circumstances, we have addressed your proposed claim briefly only, and we have not addressed each and every allegation or assertion you make. We also make clear that the content of this letter is without prejudice to any further point which the Secretary of State may make in response to any properly particularised claim which you choose to issue (or any further proposed claim which you intimate), such as in relation to standing, delay or otherwise. Given the lack of detail in your letter as to the matters you are challenging, the Secretary of State does not address such matters in this reply.

13. To be clear, it is the Secretary of State's position that your proposed claim is wholly without merit.

5

6

14. Broadly, your case appears to be that there is no proper basis upon which any Secretary of State, acting rationally, could take measures such as restricting movement, or requiring the wearing of face-masks, and that the pandemic does not pose a sufficient risk to justify preventative measures being taken. Both contentions are hopeless, and bound to fail.

15. The nature of the threat presented by coronavirus, and the rationale behind underlying measures taken to reduce its incidence, were considered in the case of *R (Hussain) v Secretary of State for Health and Social* Care [2020] EWHC 1392 (Admin), where Swift J held at para 19:

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> "*The Covid-19 pandemic presents truly exceptional circumstances, the like of which has not been experienced in the United Kingdom for more than half a century. Over 30,000 people have died in the United Kingdom. Many, many more are likely to have been infected with the Covid-19 virus. That virus is a genuine and present danger to the health and well-being of the general population. I fully accept that the maintenance of public health is a very important objective pursued in the public interest. The restrictions contained in regulations 5 to 7, the regulations in issue in this case, are directed to the threat from the Covid-19 virus. The Secretary of State describes the "basic principle" underlying the restrictions as being to reduce the degree to which people gather and mix with others not of the same household and, in particular, reducing and preventing such mixing in indoor spaces. I accept that this is the premise of the restrictions in the 2020 Regulations, and I accept that this premise is rationally connected to the objective of protecting public health. It rests on scientific advice acted on by the Secretary of State to the effect that the Covid-19 virus is highly contagious and particularly easily spread in gatherings of people indoors, including, for present purposes, gatherings in mosques, churches, synagogues, temples and so on for communal prayer*."

16. In *Christian Concern v Secretary of State for Health and Social Care* [2020] EWCA 1239, the Court of Appeal repeatedly described the situation caused by the emergence of a novel coronavirus as a "public health emergency": see [19], [48], [56].

17. In *R (Shaw) v Secretary of State for Education* [2020] EWHC Civ 2216 (Admin), Kerr J described the situation as follows, at [27]:

> *"There is currently a pandemic in this country and many other parts of the world. The disruption, upheaval, suffering and deaths caused by the coronavirus pandemic are too well known to need further elaboration …*"

18. The Government is advised by expert scientific advisors, who are constantly reviewing and updating their advice in the light of the developing evidence and wider scientific thinking. The measures put in place, including enforcement of self-isolation and social distancing, are believed to be effective in reducing the transmission of COVID-19 by reducing contact within the population. COVID-19 is a highly-transmittable, infectious disease that can have fatal consequences for a small percentage of the people infected, and its longer term effects remain unknown. The entirety of the United Kingdom is affected in different ways by the public health pandemic caused by the virus. The extremely serious risk to life and health posed by the virus has obliged the Government to take unprecedented, vital steps to limit the ability of the virus to spread. These aims seek to protect and reduce the risk to the lives of the population, in circumstances in which tens of thousands of people in England have died having tested positive for the virus.

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19. As to the wearing of face coverings, social distancing is difficult to manage consistently and at all times in shops and other public indoor spaces, including hospitality and leisure settings, as well as on public transport and in transport hubs, including inside vehicles, at pinch points on stations (e.g. entrances and exits) and during times of disruption. On 21 April 2020, Scientific Advisory Group for Emergencies ('SAGE') advised that, on balance, there is enough evidence to support a recommendation of community use of face coverings, for short periods in enclosed spaces where social distancing is not possible. Mandating the use of face coverings therefore offers a reasonable protective measure to reduce the risk of transmitting the infection to others, when used alongside other measures, social distancing and handwashing.

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20. Your letter questions whether PCR tests can diagnose infections, and you assert that there is no real reason for concern about the current level of infections, or the coronavirus more generally. You have not set out any credible basis for making those assertions, which are manifestly wrong. The risk posed by the coronavirus is widely and globally recognised. The Government has also published extensive documentation relating to the advice provided by SAGE concerning the pandemic at: https://www.gov.uk/government/groups/scientific-advisory-group-for-emergencies-

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sage-coronavirus-covid-19-response, as well as statistics about the current level of cases: https://coronavirus.data.gov.uk/. On PCR testing specifically, RT-PCR tests are universally recognised as the gold standard for testing. The RT-PCR assays used for the UK's COVID-19 testing programme have been verified by Public Health England. They show over 95% sensitivity and specificity. This means that under laboratory conditions, these RT-PCR tests should never show more than 5% false positives or 5% false negatives: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/898437/Evaluation__of_sensitivity_and_specificity_of_4_commercially_available_SARS-CoV-2_antibody_immunoassays.pdf. To suggest that there is no reason to be concerned about the coronavirus is absurd. It is a proposition which, as is clear from the extracts from the case-law set out above, a court would simply not entertain.

21. As the case-law also makes clear, the fact that scientists, and others, might take different views as to the right approach for dealing with the virus and the public health emergency it has caused, is simply not to the point. To contend that the existence of different scientific views renders the Secretary of State's actions irrational as a matter of law is manifestly unarguable. That there is not uniformity in every respect in relation to the pandemic is not surprising, and nor does it begin to demonstrate illegality.

22. This can be seen from paras 53 – 56 of *R (Dolan and Monks) v Secretary of State for Health and Social Care and Others* [2020] EWHC 1786 (Admin), where the Court held as follows:

> *"Was there a failure to have regard to relevant considerations?*
>
> *53. The claimants refer in their grounds to a failure to have regard to the uncertainty of scientific evidence, the effect of the restrictions on public health generally (including non-Covid-19 deaths), the increased incidence of domestic violence, the economic effects of the restrictions, the medium and long-term consequences of the restrictions and whether less restrictive measures could have been adopted.*
>
> *54. It is clear from the evidence, read fairly, that all of those matters have been considered in the decision-making process and continue to be taken into account in the reviews. There has been no failure to take those matters into account. The ultimate decision on how to respond, given the spread of coronavirus and the consequences of the restrictions, is a matter of difficult health, social, and economic choice. People may legitimately disagree on where the balance should be struck. But, as a matter of law, it cannot be argued that the government has not had regard to those considerations in reaching its decision on where the balance should be struck.*
>
> *Was the decision to make and maintain the regulations irrational?*
>
> *55. There is no arguable basis for concluding that the decision to make the Regulations or to maintain them in force, with amendments, was irrational. The claimants refer to the risks of mortality to those under 60, and to children and young persons. They point to alleged anomalies in the operation of the Regulations.*
>
> *56. The basic point, however, is that the measures adopted are intended to reduce the risk of transmission between humans of a disease which is infectious, and can cause death or serious ill health, and where the scientific understanding of the disease is limited. The focus on the death rates of particular groups does not make it irrational to take steps to reduce opportunities for transmission from persons in those groups to others. The fact that not all situations where contact, and potentially transmission, may occur are subject to restrictions does not make it irrational to adopt a set of measures which are intended to bear down on the risk of transmission by prohibiting other contacts. Given the complexities of modern life and social interaction, there may be situations where contact between persons can occur which are not covered by the Regulations. Such differences, or anomalies, do not render the decision to make or maintain the Regulations irrational."*

23. Earlier, the Court said this, at [7]:

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"[7] The role of the court in judicial review is concerned with resolving questions of law. The court is not responsible for making political, social, or economic choices. The court is not responsible for determining how best to respond to the risks to public health posed by the emergence of a novel coronavirus. Those decisions, and those choices, are ones that Parliament has entrusted to ministers and other public bodies."

24. The Divisional Court also explained the role of the courts in *R (Detention Action) v Secretary of State for the Home Department* [2020] EWHC 732 (Admin) at para 27:

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"*we must emphasise that it is the role of the court to assess the legality of the Secretary of State's actions, not to second-guess legitimate operational choices. The circumstances presented by the COVID-19 pandemic are unprecedented and are unfolding hour by hour and day by day. Within sensible bounds the Secretary of State must be permitted to anticipate such events as she considers appropriate and respond to events as they unfold. As matters stand, it does seem to us that she has taken and will no doubt continue to take prudent measures, both precautionary and reactive.*"

25. The Government is acutely aware of the degree of interference of certain measures which have been taken to address the Covid-19 pandemic, and of the obvious economic, health, equalities and social impacts engaged by such unprecedented action. It is actively monitoring those impacts. The suggestion that Government has brought in these measures without recognising that there would be a significant economic impact, or that the restrictions would not make life for some more difficult in a variety of ways, is absurd. The Government has had regard to such matters at all times. However, it is a matter for the Government alone, subject only to rationality review, to decide what considerations are relevant and what weight to attribute to them: *R (Khatun) v Newham LBC* [2004] EWCA Civ 55; [2005] QB 37. For all of the reasons set out, any rationality challenge along the lines you intimate is clearly unarguable.

26. In short, the Government's approach has been consistently to seek to strike the most appropriate balance possible, having regard to: the risks posed by the virus; the ease of its spread; the need to reduce the risk of subsequent surges in infection and mortality; and the adverse economic and social impacts which will or might follow from the restrictions imposed. In all the circumstances, any challenge along the lines asserted in your letter is bound to fail.

27. We would draw to your attention the fact that the normal rule in judicial review challenges is that the losing party pays the successful party's costs. If you choose to bring a challenge, we will seek the costs of defending your claim.

Action to be taken

28. Your letter requests that the Secretary of State cease and desist from the "*oppressive policies of lockdown and imposing of "social distancing" and requiring of wearing of face-masks*." It follows from the above that the Secretary of State will not be taking the action you request in your letter.

Details of any other Interested Parties

29. You have not identified any Interested Parties, although you observe that thousands of small businesses and organisations would be interested in your proposed claim. Such bodies are not Interested Parties for the purposes of a judicial review claim.

ADR proposals

30. You make no proposals for ADR. We agree that ADR is not appropriate for the type of challenge you have brought.

Information and documents sought

31. You do not seek any information or documents.

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Address for service of court documents

32. As above, any further correspondence or service of documents should be sent via email to Daniel.Emery@governmentlegal.gov.uk.

Yours sincerely

Daniel Emery
For the Treasury Solicitor

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Claimant's Commentary on Letter of Response

In summary, the Letter of Response has nothing sensible to say by way of rebuttal, and indeed scores an own goal instead. And still nowhere is there any presentation of the Defendants' scientific case for these extraordinary regulations.

With reference to the annotation numbers on the herewith copy of the Letter of Response.

1. The lawyers of the Department of Health here appear to be suggesting they are unsure what regulations are meant by the "various ongoing decisions and policies relating to control of the pandemic of Covid-19". Do they really need to be told, considering there is this list: https://www.legislation.gov.uk/coronavirus ?

2. *"The date and details of the decision, act or omission being challenged"* is clearly-enough indicated by the LbC's section 5, and further expanded in the Statement of Facts and Grounds.

3. The relevant facts and legal basis were made clear enough in the LbC's section 7, which is why the continuation of the LoR was capable of attempting to respond to them.

4. *"Wholly failed to identify the issues in dispute"* — So the LoR must have been written by mind-readers considering it then goes on to comment on exactly those issues.

5. No, the Claimant's case does not allege that *"there is no proper basis upon which any Secretary of State, acting rationally, could take measures such as restricting movement [etc.]"*.

6. Yes, the Claimant's case does contend that *"the pandemic does not pose a sufficient risk to justify [these particular] preventative measures"*.

7. The cited cases of *R (Hussain)*, *Christian Concern*, and *R (Shaw)* were brought on different evidence, at a materially different time, and with different arguments from those of the present claim. For that reason they are irrelevant, just as someone being found guilty of murder last year does not make everyone accused this year also guilty.

8. *"The extremely serious risk to life and health...."* Here (and at other points) the LoR merely *presumes* the truth of what is very much shown not to be true by the present claim.

9. The regulations requiring wearing masks are not the main concern of this claim, but the scientific evidence is also firmly against them too, as explained in the Statement of Facts.

10. "The risk posed by the coronavirus is widely and globally recognised." Actually it is the lack of any exceptional risk that is widely and globally recognised, as shown by the evidence presented in the Claim.

11. **"RT-PCR tests are universally recognised as the gold standard for testing"**. Really, on what evidence? The *very next sentence* asserts that there is a linked document in support, and yet page 6 of that document indicates exactly the opposite: **"Of note, there is no clear gold standard** against which to evaluate these antibody tests; PCR-positivity is a proxy for the expected presence of antibody...."
The Statement of Facts shows extensive evidence that the PCR tests are incapable of being anything remotely like a gold standard. Indeed, as indicated next.

12. The LoR would have us believe that the document linked here shows that the PCR tests would never show more than 5% false positives or 5% false negatives. But in reality that document states nothing of the sort. What page 6 of their document *actually* says is "The .... MHRA has recently released a "Target Product Profile...." .... specifying ..... 98% .... 98%..."
Those numbers are mere "targets" and not even targets for PCR tests.

So here we see the Defendants putting forth this one document in their supposed defence of PCR, which actually serves to support the Claimant's case instead (not that it is not solid enough already anyway). Basically the Defendants do not have any sensible defence for use of the PCR tests.

13. *"To suggest that there is no reason to be concerned .... is absurd."*
Again, the Defendants merely assert (with unsound information such as the above in support), whereas the Claimant shows clear evidence to the contrary.

14. *"the fact that scientists ... might take different views ... is simply not to the point."*
Indeed, and it is not any part of the Claimant's claim.
"To contend that the existence of different scientific views renders the SoS's actions irrational .... is manifestly unarguable." Indeed, which is why the Claimant has never reckoned to argue it.

15. The Dolan cases were brought on different evidence with different arguments and different grounds. For that reason they are irrelevant here.

16. *"The court is not responsible for making political, social, or economic choices. The court is not responsible for determining how best to respond to the risks to public health...."*. Indeed. That is why this Claim does not allege that they are. What it *does* allege can be learned from (a) the Letter Before Claim, and (b) the Statement of Facts and Grounds.

17. *"It is the role of the court to assess the legality ....not to second-guess legitimate operational choices"*. Indeed. That is why this Claim does not presume that the court does have that second-guessing role.

Interested Parties — The many thousands of devastated businesses and community groups do indeed have proper status as Interested Parties. Just it is not practical for them to be so designated here. The Claimant brings this claim also on behalf of those many thousands of unheard voices.