

Covid Death Reality vs Covid Death Myths for Australia

or

Is it time health experts and advisers are replaced with a new breed of real-world scientists?

Due to the length of this article, which many may not have time to read, the summary and conclusion is placed at the beginning, followed by a pre-amble and the finally the Introduction and report.

Summary and Conclusion

Applying hybrid control charts to doctor certified deaths in Australia from 2015 to 28th of August 2021 showed the approximately 939 covid blamed deaths resulted in **NO CHANGE** on total doctor certified deaths published by the Australian Bureau of Statistics. Even the approximately 800 deaths reported in Victoria (mostly in nursing homes) concentrated during July – October 2020, did **NOT** have any effect on total doctor certified deaths during this period.

However, the flu in 2017 with approximately 1206 deaths in 2017 compared with 854 covid assigned deaths in 2019 **DID** influence total doctor certified deaths. The extra 352 flu deaths over the whole year are not responsible for the excess deaths. Furthermore, excess deaths for the flu were shown during its peak period. The difference in number of deaths during the flu peak period and covid peak period is only 90 deaths. That difference cannot cause excess deaths for the flu and not covid. Additionally, the peak maximum is higher for covid but had no effect.

The conclusion is that the flu did result in excess deaths but covid did not.

Similarly control charts showed deaths attributed to covid had **NO** effect on total doctor registered deaths for various age groups in Australia, **INCLUDING** those above 85. This **contradicts** all the reports that covid deaths mostly targeted the very old and frail in Australia. (What is really going on?)

Doctor Certified Respiratory Deaths almost conclusively showed that the practice of deeming a covid death, only because a patient tested positively, distorted the deadliness of Covid in Australia. The reported deaths cannot all have been **caused** by covid (SARS-COV-02 variant).

Caveats

There are some limitations to the analysis.

The conclusions are based on the available data provide by the Australian Bureau of Statistics and hence are only as good as the data integrity.

Data provided by the Australian Bureau of Statistics was provisional. Based on our previous analysis containing some provisional data, once data is non-provisional the effect has never been noticeable. Others may have different experiences.

Deaths were during lockdowns, social distancing, and use of face masks. This is irrelevant to the conclusions drawn. Covid deaths that were alleged to have occurred in the last two years had no effect on doctor certified deaths and when combined with analysis of respiratory deaths we can be reasonably certain that the covid deaths distorted reality and it was not covid that caused deaths but normal random causes of deaths. One can argue, if deaths were the basis of national emergency, that there never was an emergency, other than that built in people's imagination out of fear, fed by mainstream media and unrealistic models.

The Australian experience applies only to Australia. The facts that Europe and the Americas do have high excess deaths is indisputable. The cause of the excess deaths however is disputable and will be addressed by further research.

Just as the Victorian Premier has many times made it clear that Victoria is not NSW (yet ironically believed Victoria was like Europe and the USA), Australia is not Europe and the Americas. Work has now commenced to identify why some of these countries have such high excess deaths. The high excess deaths do not mean the covid is only deadly overseas but harmless in Australia. Factors such pollution, excessive panic, incompetent treatment, inadequate health systems need to be factored in.

We should not conclude that covid is harmless based on this analysis. The above only considers deaths during the lockdown period and does not consider what would have happened had we had no lockdowns. There are far more considerations than excess deaths. Nor can we conclude that there were no covid caused deaths. These could have been compensated for by a reduction in other deaths. However, if this is the case, then we are covid obsessive because if there has been no effect on total annual deaths what is the issue?

Concluding Remarks

Australia's political leaders have shown many times that the driving factor in the response is to be better than the rest of the world. On a personal level this is disappointing. It shows our leaders have lost touch with what matters – people lives.

In Australia the science behind the pandemic has been touted as the best possible science, yet no basis of such a statement has ever been provided. When asked for information on what science was used to justify responses a stonewall was encountered. What was there to hide?

Our political leaders prior to the pandemic were all different people. They were human, albeit imperfect. What happened? Were their minds distorted with misinformation due to the application of bad academic science that has no place in the real world? Did this misinformation bring out the worst in them because they truly believed they were saving lives? Sadly, these leaders, who like us

are human, are now hated by many, because their decisions made no sense to intelligent people who could see the bad science.

It took the Australian Prime Minister two years (ironically coinciding with election time) to realize something real-world experts knew March 2020 when Australia locked down.

"But we're not going back to lockdowns, we're not going back to shutting down people's lives – we're going forward to live with this virus with common sense and responsibility."

The remarks signal the Morrison government's intent to move from "a culture of mandates to a culture of responsibility".

A Royal Commission is badly needed, run not by fulltime university based academic experts, but a carefully selected panel of highly qualified experts who have been successful in the real-world. The objective must be not to start a witch hunt to hold people accountable which will achieve nothing.

The objective must be to determine

- The scientific basis of Australia's pandemic decisions.
- The flaws in the science used.
- The damage caused by the human element through negligence, self-interest, incompetency, and irresponsibility by media reporting
- The damage cause by not allowing highly qualified and real-world experienced scientists to question the academic responses.

Hopefully this will prevent a recurrence of the mismanagement of pandemics through scientific misinformation caused by experts not understanding the difference between hard core science and soft science.

The time has come for politicians with a conscience to get their facts by meeting with those real-world experts, censored and rubbished by mainstream media, who have had the courage to speak out against the narrative.

Hopefully this will lead to Australia truly becoming great, not by destabilizing the world with tough talk, but offering something to the world that everyone nation needs – an alternative to academic driven responses to pandemics with new technologies, attitudes and skills that never before existed.

Preamble

This section can be skipped but was written to raise the issues with blind faith in science and our academic intuitions where smart is synonymous with complexity instead of simplicity being synonymous with smart.

William of Occam "Just as the ability to devise simple but evocative models is the signature of the great scientist so over-elaboration and overparameterization is often the mark of mediocrity."

From the onset of the pandemic in 2020 global leaders, through health advisers, have based their pandemic responses on what they believed was science. The quality of the science is however a matter of opinion. The Australian Prime Minister often said that Australia used the best scientific advice and was the envy of the world in its pandemic management. Others, such as the author concluded that the science was appalling.

Applying science (the study of knowledge) alone should not give confidence in our pandemic response, because of the human factor. It shows naivety by those politicians who have blind faith in science. Scientists are human beings. Not every scientist is competent. George E. Box, arguably one of the greatest statistical minds of the twentieth century, once told attendees at an Australian Statistical Society meeting that in a class of 100 university students there would only be one bright student who understands the material taught. The rest have no clue and simply apply what they learn parrot fashion in the real world. Some of these we can argue are the experts today. How can we be sure that the health advisers have the necessary competence? The evidence based on data, contradicting almost all statements made by the advisers, demonstrates either incompetence, or negligence.

Qualifications mean little. Having a qualification in a particular subject, even to PhD level, does not mean the scientist understands the real world. Australian university standards have dropped over the years to maximize revenue to ensure a high overseas student intake. Epidemiologists who are relied on in pandemic management may have performed some academic studies in statistics/biostatistics but that does not automatically mean that the epidemiologists truly understand the statistical and data side of pandemics, which are crucial when formulating a response. Reading academic papers on pandemics it is clear that statistics applied by experts was often applied in parrot fashion, without the author really understanding the statistics.

It appears most health advisers, are academia based. After all universities are supposed to be our foundation for knowledge, but that is naïve thinking which ignores the human element. Academia certainly plays an important role in life, which is preparing students for the real-world and performing research. But barring exceptions, they do work in a protected environment focusing on intellectual singular objectives without true perspective to overall human needs. Their thought processes occur in the mind, which bypasses reality and instead relies on models and assumptions and imagination.

At the risk of overgeneralizing, academic experts tend to be judged for competence based on the number of peer-reviewed academic papers that have been published. These tend to be focused on demonstrating intellectual know how which results in unnecessary complicated jargon (waffle) and use of models and functions that do not reflect reality. Life does not follow formulae academics have developed to simplify analysis because they cannot handle the complexity.

Of course, there are thousands of highly competent academic experts with a real-world background, but they don't seem to be the ones who have driven the responses. Many of the issues with academic based scientists apply also to real-world based scientists, such as incompetence and self-interest driven bias, however these were not discussed because governments focused on academia for its source of advisers.

Listening to Australian Senate hearings questioning the health advisers and the TGA, to some trained and experienced scientists it appears that the advisers do not really understand their responses, relying on overseas experiences and experts. They do not offer any demonstrable scientific basis for their decisions, relying only on citing overseas studies. What we need is to see the data and science that was used to determine strategies.

Introduction

Experts and advisers have convinced political leaders that covid has caused hundreds of thousands of deaths and if there had been no lockdowns these numbers would have been far higher. The Australian Prime Minister, to justify Australia's response, has many times said that Australia's response has saved 30000 deaths, without providing any evidence.

Most if not all countries have classified a covid death as being a death if the patient died with covid, which does not mean that the patient died from covid. This practice is an academic practice that ensures we do not miss any death due to covid, but at the same time it means there will be a lot of false alarms and unnecessary panic. It is believed that the false alarm of reporting a covid death when the person did not die of covid is of far less importance than falsely concluding the person did not die of covid when he or she did. Placing such importance on not missing a real covid caused deaths shows that the pandemic management was influenced by hysterical fear which must not be a way to manage pandemics in the future.

Does the lack of science, bias, and self-interest mean that covid is just a mild flu and the whole world succumbed to hysteria? Maybe, and maybe not. Australia's disproportionate fear-based response points towards 'yes', but the high excess deaths in many European countries and the America's points towards a 'No'. What if there are reasons for the high excess deaths overseas, that has nothing to do with deadliness of Sars-Cov-02? Until a thorough coordinated international study is performed by proven real-world unbiased scientists we will never know.

To obtain some feel for the real situation the writer's team, consisting of highly qualified data scientists, whose career is applying data science, not teaching it, has started a process of reviewing the vast amount of data that is now available.

The following is the first report of a series of independent analysis that we are conducting to get to the truth, without any bias.

All analysis are transparent and can **AND SHOULD** be confirmed by others independently

Australian Doctor Certified Deaths

We commence with reviewing Australian Covid Deaths using clearly understood technology.

The concept of using clearly understood technology was first introduced by Dr. [W. Edwards Deming - Wikipedia](#) resulting in industries transformation late last century and it worked. Dr Deming knew that excessively complicated tools would fail, and they did. The transformation movement attempted to involve academia but there was little interest shown because the concepts were too 'simple' for universities.

This meant that the quality and efficiency of today's industry is the result of Dr. Deming's vision, not academic research. We need a similar long-overdue over-hall in medical science, especially pandemic management where new attitudes, skills and technologies are applied, just as the W.H.O. suggested in 2018.

The following data sources were used

[Provisional Mortality Statistics, Jan 2020 - Aug 2021 | Australian Bureau of Statistics \(abs.gov.au\)](#)

Includes Doctor Certified Deaths prior to 2020

[3303.0 - Causes of Death, Australia, 2017 \(abs.gov.au\)](#)

[Causes of Death, Australia, 2020 | Australian Bureau of Statistics \(abs.gov.au\)](#)

Refer to links to learn about limitations in the data.

The approach of calculating excess deaths used by Australian Bureau of Statistics was discarded as it is based on out-of-date science that does not realistically display variation. Dr. Deming taught industry how to better understand and measure variation.

Instead of using a model approach where this period deaths are compared with modelling of say the average of the last 5 years, we will use a simple hybrid control chart that display limits of unusual variation and changes in trends which give a realistic perspective of deaths.

Total Deaths from all Causes

Covid deaths numbers have little credibility because they were rarely based on autopsies and instead a death was deemed a covid death only because the patient tested positive to covid, using an unreliable test method. Additionally, even if autopsies were performed, it is very difficult for a doctor to determine the cause of death, especially when there are multiple comorbidities involved. Concluding a cause of death is therefore often unreliable and amounts to no more than a learned opinion.

Instead of attempting the impossible, which is counting of covid deaths without knowing when covid caused a death we try and establish if there has been a change to the natural overall variation in total deaths. If there is no change then this does not mean covid did not cause deaths, because they could have been compensated by less deaths from other causes. What it means is that in the overall scheme of things 'the process is in control' a term taken from Quality Control. Industry, thanks to Dr. Deming, and others such as Walter Shewhart, was taught that **it is futile to react to common cause variation** until an 'engineering overhaul' reduced these. Only special causes should be reacted to. These are statistically determined with control charts.

Figure 1 shows doctor certified covid deaths. These do not necessarily mean the patient really died of covid. All it means is that the patient who died tested positively with covid. There is no direct causal relationship with Covid.

Figure 2 shows a modern hybrid weekly based control chart augmented with a trend shifting detection algorithm to map statistically significant changes in trends of total deaths from all causes. The horizontal lines are control limits used to detect unusual variation in individual deaths. The red rectangle shows the bounds of the covid period of 2020 to week 34 2021 (Aug 23-29). Further information is currently not available.

Figure 3 shows influenza deaths for the same period, determined by subtracting the Australian Bureau of Statistics data from 'Pneumonia Only' from 'Pneumonia plus Influenza.'

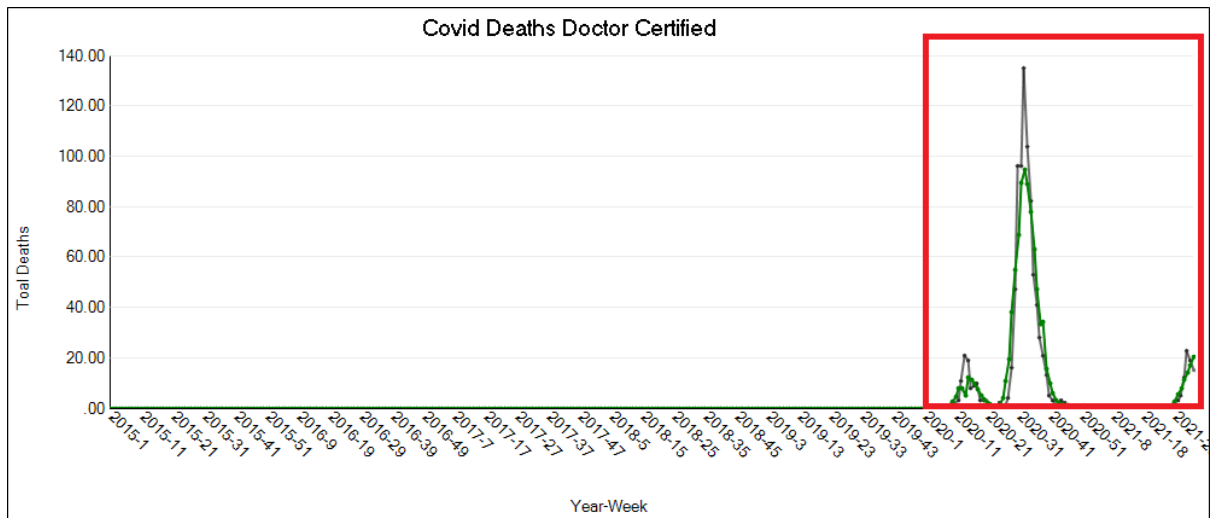


Figure 1 Doctor Certified Covid Deaths Period 2015 to week 34 2021.

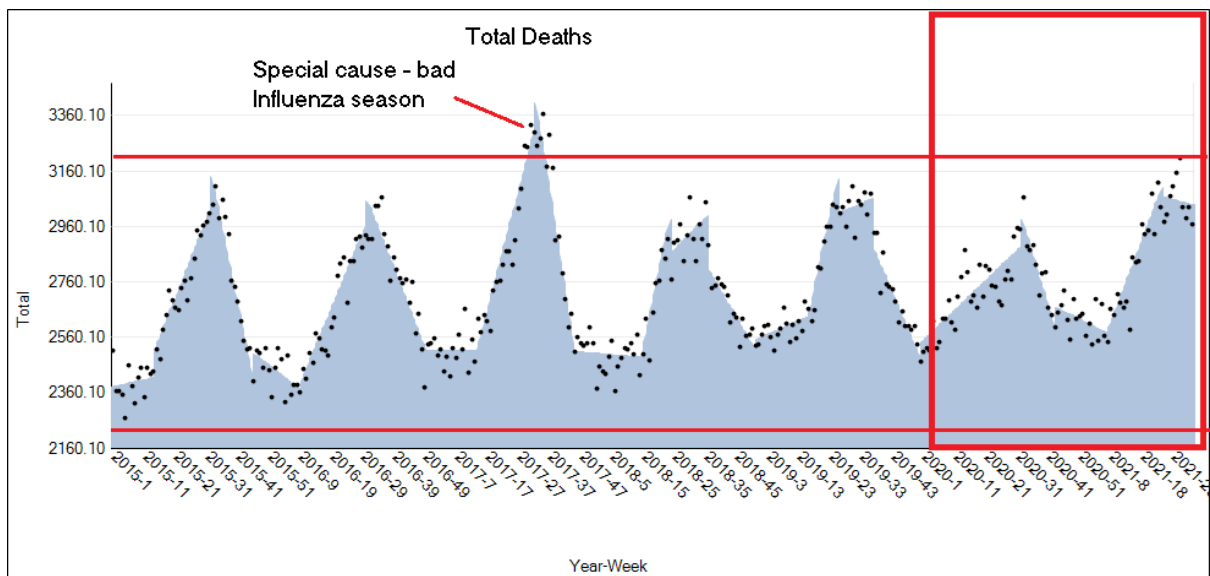


Figure 2 Total Deaths from all causes as recorded in the above sources. This includes alleged Covid caused deaths. Period 2015 to week 34 2021.

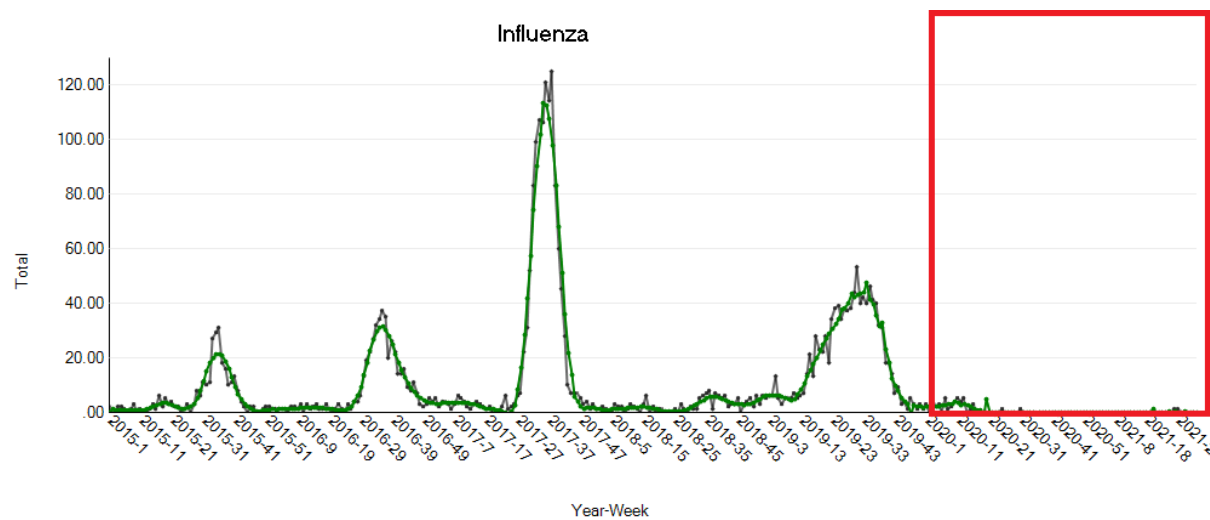


Figure 3 Influenza Deaths

Figure 1 and Figure 3 show that the Covid death peak was higher than the flu peak in 2017. The flu peak clearly effected total deaths from all causes. However, covid deaths, **with a higher peak**, had no effect on total deaths. The comparison is valid. 2017 there were no covid deaths and in 2020 – there were no significant flu deaths. We thus can't use the reason we had no flu deaths to explain why no excess deaths with covid. The flu caused excess deaths without covid.

Flu deaths, as with covid deaths also usually involve other comorbidities according to [3303.0 - Causes of Death, Australia, 2017 \(abs.gov.au\)](#). The implication is that the flu, at least in 2017, made the effect of comorbidities worse and hence increased total deaths beyond what is normal variability in deaths and hence is a special cause according to Dr Deming. Covid however, because it did not have any effect on total deaths, is not a special cause.

According to the link above in 2017 there were 251,142 laboratory confirmed influenza notifications, i.e., 251,142 cases. In 2020 the time of the high death peak there were only 28,408 covid cases in Australia according to [Daily Confirmed Cases - COVID Live](#). What justifies the panic and what justifies the Victorian CHO's comments below?

Of course, this makes covid case fatality far worse than influenza case fatality, but cases fatality is a flawed measure of deadliness. The bottom line is that covid deaths have not had any effect on doctor certified deaths, implying that deadliness is small compared to the flu in 2017.

Mr Sutton, Victorian CHO, may have to conduct further research to realize that he may be wrong with his response in

[Brett Sutton mocks article calling Aussies 'bedwetters' over Covid \(msn.com\)](#)

Hildebrand wrote that Australians should 'accept that eventually most of us will get Covid' and highlights a quote from Chief Medical Officer Paul Kelly that compares Covid to the flu.

'We have to accept we will continue to see cases of Covid-19 in Australia, and that some people with increased vulnerability may suffer significant illness or even death. That happens every year with other infectious diseases like influenza.'

Mr Sutton had a blunt response to the common comparison.

'For the millionth time - COVID is not a "little flu",' he wrote.

Specific Causes of Death reported by the Australian Bureau of Statistics

Cerebrovascular, Dementia, Diabetes, Ischaemic Heart Diseases show no notable change in deaths within the covid period.

The special case of respiratory (upper and lower) deaths

It is interesting to note that the Australian Bureau of Statistics included the flu as a respiratory death but not covid. Covid was treated separately.

Figure 7 for respiratory deaths shows conspicuous plateau that makes no sense

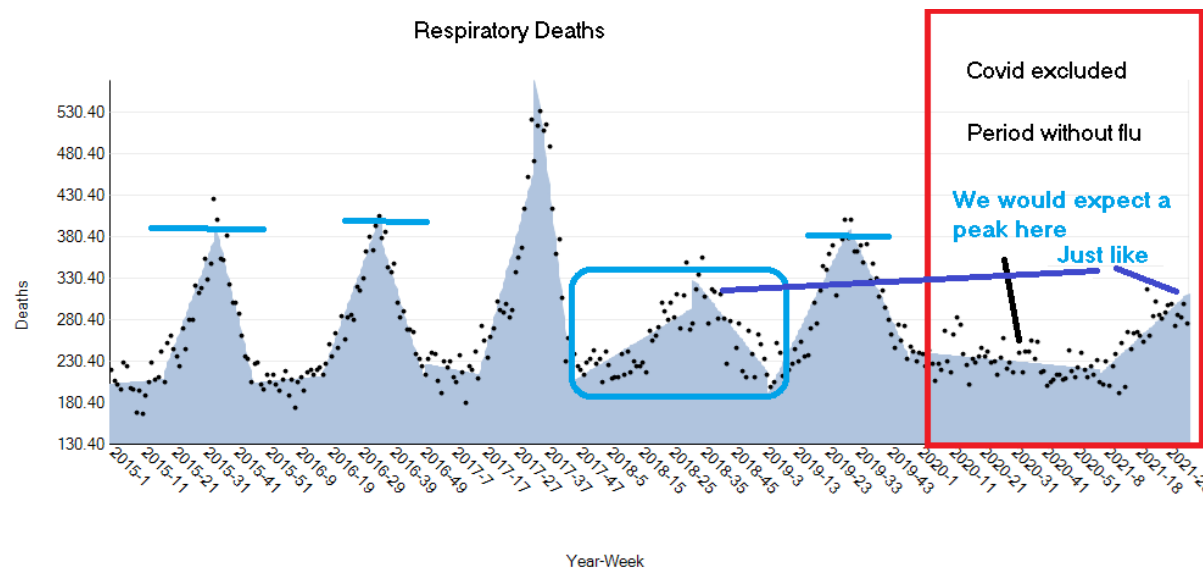


Figure 7 Respiratory Deaths

The flat period, pointed to with a black arrow is highly suspect and cannot be attributed to absence of the flu. Referring to Figure 3 in 2018 there were also hardly any flu deaths, yet there was a significant peak circled in Figure 7. The peak was less than the 3 blue marked peaks but that is explained by the reduction in the flu in 2018 compared to 2005, 2016 and 2019. We should have still had a respiratory death peak in 2020. As expected, a peak is starting after week 8 in 2021 at which time there was also no flu. But in 2020 there was no peak. Why?

We should have expected a peak at around week 31-35 whether there was a flu or not. Suspiciously this period corresponds to the very high 'covid' death period shown in Figure 1, which was predominantly due to Victoria. Because covid was not treated as a respiratory disease by the Australian Bureau of Statistics there is one possible explanation that comes to mind. The explanation is that deaths were classified as covid deaths only because the patient was tested positive, **taking away from respiratory deaths** shown in Figure 7. We expect that taking away from other deaths also occurred for other causes of deaths. In other words, in Australia covid does not appear deadly. We made it deadly by classifying deaths as covid deaths merely based on a patient having been unfortunate enough to have tested positively. There exists considerable anecdotal evidence that supports this from Age Care Doctors.

Total Deaths by Age Group

Appendix A shows that in Australia Covid has not affected doctor certified deaths for all age groups. All the death statistics have been based on deaths simply because the patient had a positive test at time of death. Disturbing is that **there is no evidence that covid was much more deadly for old people**. This contradicts the government reported numbers based on deaths deemed to be due to covid. The older the people the higher the number of deaths. Since more older people die than younger people and since covid reached age care residences of course deeming will make it appear covid is deadlier for old people. The reality is that according to the data released by the Australian Bureau of Statistics covid has had no effect on total deaths. Are reported deaths caused by covid a myth?

Appendix A

Total deaths by Age

