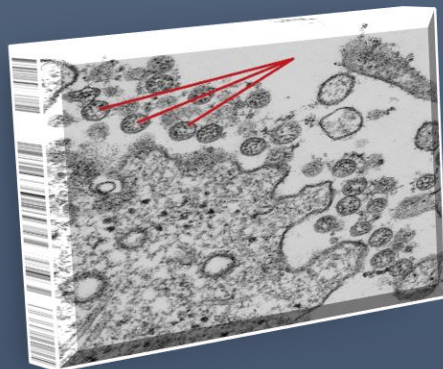# Flawed Science applied to the management of the Covid-19 Pandemic

Current as at 2020-12-31

Please note although the report is now out of date the conclusions are timeless.

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Veracity check: Professor Zhaobo Bob Wang, BS, MS, MBA, PhD, Fairleigh Dickinson University New Jersey; Lecturer in Business Analytics and Statistical Data Analysis in Business

Structure of this report

Section 1 Contains

- A listing of conflicts of interest
- Apologies
- Disclaimers
- Author Information

Section 2 Contains the Executive Summary

Section 3 Contains the Introduction

Section 4 Contains the Summary

Section 5 Compares Saving Lives with Destroying Lives and questions the rationale behind living taking second place to Saving Lives, instead of the two going hand in hand.

Section 6 Virus propganda, and how it can result in mishandling of the virus.

Section 7 Covers the flaws in modeling and the faulty ratioanle of using models to make decisions that have destoyed the global economy and lives

Section 8 Is about cases, in particular how case reporting distorts fact when incidences depend on test size. Jumping to conclusions is covered as is heterogenity of the cases between countries. A case Study for Australia and Victoria is included.

Section 9 Covers the observed effectiveness of containment action.

Section 10 Covers deaths. Here we discuss 'acceptable' and 'unacceptable' deaths; perspective next to the flu; deadliness of the virus; the unscientific reliance on case deaths to determine the deadliness of the virus; gross bias in assigning cause of death; discreprencies between countries (throwing doubts on the deadliess); and effect on total death registrations

Section 11 Discussses possible reasons for high excess deaths in some countries and not others.

Section 12 Sweden

Section 13 Conclusion

Appendix

Audience for the Report

This report is target for a global audience. Some content may be around Australia and Victoria, but the content applies to all countries. Europe and the USA are covered.

Section 1 Preliminary Information

1.1 Conflict of Interest

My Company

I manage a company which over the years has given hope to many people at home and in underdeveloped countries.
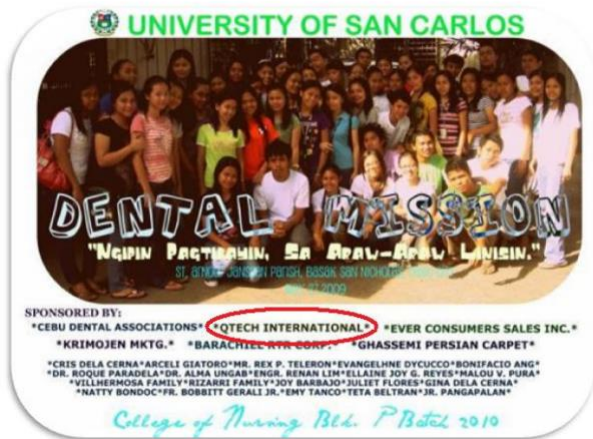
I am driven to restore the viability of my company so that we can continue to give hope to people and provide jobs.

My Family

I have multi-cultural grandchildren. They give hope that the world can one day live together, instead of following the example leaders are setting with their chest beating and sabre rattling, instead of developing relationships and living by example.

I am driven to give these children and all the children in the world a life worth living for. If this precedence continues and we keep locking down every time cases are evident, there will be nothing worth living for them.

My Dad has recently died in a nursing home, which he and his fellow residents called jail. In the little time he had left he needed to see his children and grandchildren to give him something worth living for. If he were isolated in the name of saving his life for the remaining 6 months of his life, it would have been the ultimate cruelty.

I am driven to wake politicians up to give all the people in age-care a few remaining months where they can be with their loved ones before their time comes instead of being locked up in the equivalent of a maximum-security prison.

1.2 Disclaimers

Due to the dynamic nature of the pandemic facts kept changing rapidly. It was not always possible to update this report. It is strongly recommended that the open letter, recommendations to the **Independent Panel for Pandemic Preparedness & Response** and appended recommendations is read for further insights

https://www.covidmedicalnetwork.com/Recommendations.aspx

https://www.covidmedicalnetwork.com/AmmendedRecommendations.aspx

https://www.covidmedicalnetwork.com/OverView.aspx

- The data is continuously changing. Whatever conclusions were made at the time of writing the report or at the date mentioned, may no longer apply in the future. But the overall theme remains.
- Although professional due care was exercised, and an independent veracity check was performed no guarantee is given to the accuracy reported here in.
- Data integrity is unreliable. It is impossible to know how much doctoring and manipulation occurs throughout different countries. It is impossible to know how many short cuts were taken. It is impossible to know how many deaths and cases were not recorded. The report is as good as the data.
- Considerable information came from our sources and experts in Wuhan and Australia which included virologists and medical professionals, who have different viewpoints to their peers. The report is dependent on the reliability of these sources and publicly available information.
- The statistics reported are valid at the time only. As time passes the statistics need to be revised. The reader is advised to check calculations with latest data, which may change perspective and conclusions.
- We are not virologists and make no attempt to. But we are real world data and situation analysts with over 3 decades experience. We do know about data integrity, modelling, the futility of over testing, testing errors, jumping to conclusions and ways to extract information not recognized by others.
- We are not medical experts but have worked with hospitals, and medical practitioners for many years. We are not academics but have academic university backgrounds.
- No guarantee is given to the correct use of terminology. Pandemic and Epidemic is used interchangeably. The reader needs to know that epidemic refers to many people within a population and pandemic over multiple countries.

  Sometimes the word rate is used, such as death rate. Rate refers to time, but the term is used extensively by other experts and so has been used in here also.

  SARS-CoV-2 is the virus and Covid-19 the lung related disease, not necessarily new complications reported. Sometimes these two are used interchangeably.

- It is not possible to be hundred percent politically correct. Some conclusions may seem general, but common-sense must dictate that there are exceptions.

- This report is about the science used to manage the virus. There are many other science applications for viruses which are not covered because these fall outside our area of expertise.
- Several conclusions have been drawn. There is no guarantee that the conclusion is correct. Readers need to draw their own conclusion.
- The opinions are those of the author and may not be shared by others in his company and the COVIDMEDICALNETWORK members whose website this report was downloaded from.

1.3 Apology

The analysis was performed of 7 months at no cost to any third party. Although due care was taken in the analysis and reporting, the standard of writing is not that of a professionally written report as we simply could not afford the extra time to do so. We apologize for the standard if it is not up to expected standards. If clarifications are need contact us on the provided email address.

Nothing in the report is meant to offend.

The period was an emotional period for all of us and emotion may have unintentionally entered the report. I apologize to anyone who may have been offended by the occasional wrong tone.

Those families who have lost their loved ones I can relate too because I too have lost loved ones. My heart is with them. This is about better pandemic management. It is not about stopping frightened people protecting themselves. It is about the right for people to live and take their own risks. It is about minimizing damage not foolishly and hypocritically destroying lives in the name of saving lives. I apologize if I seem callous.

I apologize to anyone who is affected by my comments.

I apologise to countries for comments that may contradict that their containment efforts may not have been as effective as they believe. I can only report the results of the analysis truthfully. Of course, they should be proud of what they have done because every little bit helps.

Someone must think of the millions who have lost their jobs, the mums, and dads whose businesses have been destroyed after risking so much and creating so many jobs. I am thinking of the people who have starved in the Philippines and possibly elsewhere. I am thinking of the grandparents, like me, who could not hug their grandchildren. Someone must bring the world back to its senses. I cannot apologise for that.

I cannot apologize for trying to prevent a recurrence of the human cost with future pandemics.

1.4 Veracity

The report is not an academic paper that is refereed by peers. This is not about reporting on new technology or a scientific break-though. This report is about the science behind Covid-19, and the damage caused by propaganda tactics and hysteria.

The report has been checked for correctness by several scientists in our company. However, the information is dependent on the reliability of the information sources. Links have been given throughout for the reader to verify the contents.

An independent veracity check was performed by Professor Zhaobo Bob Wang, BS, MS, MBA, PhD, Fairleigh Dickinson University New Jersey; Lecturer in Business Analytics and Statistical Data Analysis in Business

There has been no use of models made to prove points. Readers can download their own data from the data sources listed and perform their own analysis and interpretation to verify statements and conclusions.

Many charts use our own technology to display underlying trends and scatter. The technology itself, has been used for over a decade in industry. More information on the technology can be obtained on www.bisnetanalyst.com and www.bisnetanalyst.com/knowledge-center.

The technology however is not important to verify because the reader can see how the points hug around the trends. The reader can also use their own charting tools with the same data.

1.5 The Author

1.5.1 Academic Qualifications

- Certificate in Applied Chemistry
- Degree in Applied Science with Distinction, majoring in Statistics and Operations Research as top student in Statistics, Operations Research and second top in Pure Mathematics.
- Master's in Economics (Operations Research) with High Distinctions in every subject.
- PhD in Computer modelling and algorithms.

1.5.2 Academic Work Experience

- Lectured in the faculty of Computing and Information technology on subjects of data analysis and computer modelling and quality and reliability.
- Ran many training courses and seminars with my University.

1.5.3 Publications and Seminars

123 papers for Quality Organizations in Australia, United Kingdom, and India on new analysis technology.

Ran new technology seminars throughout the world.

1.5.4 Industrial Experience

- 18 Years as a statistician and operations researcher in management roles.
- Saved employers millions of dollars with AI and ML algorithms.
- Founded own company which provides data analysis solutions which have been used in companies in over 40 countries.

  My work has seen me help businesses and Organizations such as Coca-Cola, Kuwait Airways, Singapore Aerospace technologies, Top-Gun USA, Australian Defence Industries. Ran seminars on technology in 30 countries, including the USA and Russia. Introduced statistical quality control and data analysis for industry to the Chinese government with my Chinese partner in preparation for acceptance into the WTO. Developed campaign analysis software for politicians.

1.5.5 Modeling Experience

Developed highly complex AI models to make process adjustments, forecast drying times, sales, micro and infestation contamination in the food industry.

Wrote over 5 million lines of code for mathematical models, analytics, AI and ML algorithms for my company's software and bespoke customer software.

1.6 Data Sources

https://ourworldindata.org/coronavirus-testing

https://www.bdm.vic.gov.au/research-and-family-history/research-and-data-services/death-statistics

http://data.un.org/Data.aspx?d=POP&f=tableCode%3A65

https://covidlive.com.au/vic

https://www.aihw.gov.au/reports/heart-stroke-vascular-diseases/cardiovascular-health-compendium/contents/deaths-from-cardiovascular-disease

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales

https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

https://coronavirus.jhu.edu/

https://ec.europa.eu/eurostat/web/population-demography-migration-projections/data/database

1.7 Apps used for the analysis.

Apps were downloaded from https://www.bisnetanalyst.com

Technology information can be found on https://www.bisnetanalyst.com/knowledge-center

Section 2 Executive Summary and Assertions

Summary

Covid-19 science has distorted reality and lost perspective. We hear daily how deadly the virus is and how it attacks not only the old but the young and that it can leave permanent scars. We hear that it is far deadlier than the flu.

The sciences applied during the pandemic are soft sciences. Although soft science follows a scientific process, it is virtually impossible to draw reliable predictive conclusions from soft science research and experiments because there are too many variables.

The global mitigation response was reducing cases through border closures, contact tracing, use of face masks, social distancing, quarantining including complete lockdown. This has resulted in the destruction of the economy, job losses, consequential deaths, depression, and damaging education and if not stopped from happening again, risks a second great depression.

Mitigating is about making something less severe, but the world made matters far more severe through the consequences of mitigation and bad management and science.

The justification, for accepting the consequences, was based on modeling and overseas experience.

A five months, situation and data analysis showed that every model investigated was highly flawed based on too many assumptions. Every model grossly overexaggerated the situation. Models are always wrong, but they can be useful.

There was conclusion jumping throughout the pandemic by assuming that certain mitigation steps were successful just because they corresponded to lower-than-normal cases instead of searching of alternative possibilities for the lower-than-normal cases. This has added to the mishandling of the virus. South Koreas', Japan's, and Singapore's successes were short lived. Victoria jumped to conclusions by thinking its Lockdown Stage 4 bought down the cases. Flawed mathematics was used to prove that it did.

The global end of year cases is no more severe than the annual flu cases and the common cold. The annual flu has far more annual global cases. But there are estimation errors, and both may be the same.

The fact that cases are many times in the millions (based on prevalence estimates) contradicts the conclusion that the virus is so harmful. A harmful virus would affect not only the elderly with co morbidities, but everyone and thus with millions of cases we would expect far more overwhelming of hospitals and far more deaths than are estimated.

There was no evidence that the mitigation methods used had a conclusive effect. This does not mean that the methods used are ineffective under ideal and controlled conditions, it means that in the real world with real people it is impossible to control a virus with these methods.

Although PCR and and Serology antibody tests are being used extensively, we have no confidence in their reliability based on three decades of experience in measurement system analysis. Until we see a formal MSA performed on these tests we have no confidence in both positive and negative test results.

Both cases and deaths are heterogeneously distributed from country to country. Only a small percentage of countries have much higher-than-average cases and deaths. Countries who assumed they would follow those with high rates have most likely self-destructed for no scientific reason. They had the opportunity to grow in strength during the period but missed out due to the bad science.

The global deadliness of the virus is out of proportion with other forms of deaths which are far greater. There is no evidence that Covid-19 has far greater deaths than the flu. Other forms of deaths are much higher. There is no evidence based on countries that did not exercise lockdown such as Sweden, Taiwan, and South Korea that there would be run-away deaths of the magnitude implied by Covid-19 propaganda.

It is acknowledged that some countries, especially the USA has higher than normal deaths and currently reports are stating the Covid-19 deaths have become the highest cause of death. But the extra deaths are still only one thousand of the population size. Total deaths are approximately 1%. Does this justify ruining lives and the economy.

Case deaths are used to prove that the virus is far deadlier than the flu. The comparisons are invalid and have been based on wrong data. Current evidence is that case deaths are less than 0.1%.

Cases deaths have no credibility because many countries classify a Covid-19 death as one where if a patient who has died had Covid-19 the death is a Covid-19 death. The most reliable way of determining if a pandemic is having an effect is to use distribution optimized control chart methods applied to registered deaths. Excess deaths do not place perspective on registered deaths and have a component of error due to the use of models.

Most countries were in control. Countries such as Italy, Spain, the UK, and the USA have had out-of-control deaths, but these are glitches according to what is common in life. The flu also caused glitches in some countries. Out-of-control points need to be investigated to identify causes not used as basis of concluding the virus is so deadly. Why has the USA so many deaths and others so few? What is it about the USA needs to be investigated instead of concluding the virus is a killer of all of mankind!

The USA has major health system and health issues. It has an extremely high prevalence of obesity, heart, and lung diseases and hence the USA cannot be considered representative. It is little wonder that the USA has such high number of deaths. The virus may have simply exasperated the health problems which are the underlying cause. If we are genuine about saving lives why not spent the money, we spend destroying the economy on improving health so that we become more robust to viruses, including the flu.

There is no proof that the out-of-control points are due to Covid-19. There are other possibilities and there is strong evidence that they could be due to panic and fear induced deaths. There is some evidence, but not conclusive that some countries may have had much higher deaths because of extreme pollution which compromised health even before Covid-19.

The current second wave in Europe and the USA is mainly due to increased testing numbers not due to prevalence increases, though that has contributed to some extent. Deaths are following proportions not cases showing that proportions are the correct way of reporting, not cases. If there are hospitalizations, then panic by a fearful public is a likely cause and that can be handled with panic management.

There is evidence that cases and deaths were coming down on their own. Sweden had a death peak of the same relative magnitude as Italy and came down as fast. Italy had lockdown and Sweden did not. Australia was already coming down when it locked down.

Contrary to the virus propaganda total registered deaths analysis for all European counties and most US States showed that people below 50 had no extra registered deaths. The virus is not the deadly virus that kills young and old.

The worst examples of bad science are the use of case reporting not factoring in test numbers. **There is currently considerable 'Angst' over new strains in the UK and South Africa which has already 'panicked' countries such as Australia, who without question believe the science that has concluded the new strains are much more contagious. There is no evidence of this. The high cases numbers can be related to increased testing numbers.**

Though it is not disputed that some countries have higher than normal deaths, It is not universally deadly, and we assert that many deaths were caused by mismanagement especially not managing treatment, fear, and panic. We also assert that the false assumption that the deaths attained in some countries, such as Italy and the USA would be attained in all countries has resulted in unnecessary destruction in countries that do not have the same health problems. We assert that decisions were driven by fear and not calm rational thinking. The difference between fear imagined in the mind and real danger was not understood.

Assertions

We assert that hospital overwhelming, a likely major cause for deaths, was mismanaged. The science suggested that by spreading the curve hospitals would be less overwhelmed and hence less deaths. Instead of spreading the curve, which is what destroyed the economy and lives, a fraction of the damage that was caused would have occurred if we expanded capacity by building temporary hospitals. If there were human resource shortages sharing of resources would have been an alternative. We do the same in Bushfire seasons. **By spreading the curve over time, we also bought time for the virus to mutate into a more dangerous form.**

We assert a high degree of scientific bias to making this virus deadlier than it is. There have been recent reports of 33 people dying after been given the Phizer vaccine in Norway. The argument used is that people were already sick and over the age of 80. Hence the vaccine is not to blame. However, this same reasoning does not apply to the corona virus. Why?

We assert that science failed us because it was unable to offer constrained solutions. Constrained solutions are the norm in other sciences such as Operations Research, where we minimize (maximize) subject to constraints. Science has been unable to minimize deaths subject to not restrict movement and quarantining. Restricting movement has human costs that are immeasurable. The WHO before it became embroiled with US politics was against freedom of movement and quarantining and clearly stated in 2018 that these forms of containment measures are unacceptable today. Science has failed badly.

We assert that the fundamental error in the general approach taken by world health authorities to the Covid-19 phenomenon in 2020 was a failure to understand the difference between soft science and hard science. [i]

We assert that there has been a failure to understand that 'Soft sciences' cannot convert uncertainty to certainty with its tools or theories. Soft science complements but cannot replace human wisdom and judgement. Instincts is what nature has given living creatures to deal with uncertainty. We must not discard this fundamental survival tool.

We assert that pandemics must not rely on science alone. In this uncertain world, science is not the answer to all situations especially ones with high levels of uncertainty. We will never dispute the scientific process, but we will dispute blind faith in science because human beings make mistakes and scientific conceit, and incompetence is a human reality that cannot be ignored. Blindly accepting soft science conclusions has resulted in an unprecedented economical and human costs.

Because soft science conclusions cannot be relied on soft science conclusions must be confirmed with an independent and competent data analysis. This part of the scientific process was irresponsibly missing and the reason we performed it instead. It is irresponsible to make decisions based on theories, even if supported by research, that destroy lives because soft science cannot be relied on. A responsible process would have included an extensive data analysis to confirm the conclusions before reacting the way the world did.

It is hoped that by seeing how deficient the science used to determine the prevalence, contagiousness, infectiousness, spread, virulence and deadliness and anything related is, that leaders will rectify the deficiencies and more humanly and intelligently manage future epidemics.

The world cannot afford a repeat of this precedence. Scientists need to be more responsible when asserting deadliness by basing assertions on indisputable facts. Currently facts can be disputed. Experts need to be more compassionate when recommending lock down whilst their jobs are secure.

We have not followed the WHO's advice. We have used a slash and burn self-destructive strategy.

"Thus, we are recognizing that the complexity of 21st century epidemics and their prevention and control require not just new technologies and techniques, but new skills and new attitudes all across the public health community."

Executive Conclusion

The science was so bad that it is not possible to make a statement on the contagiousness, infectiousness, spread, virulence and deadliness and anything related to SARS-CoV-2 either way.

All we can conclude is the statements made by experts were wrong.

It is not possible to manage pandemics with the old-fashioned science that was applied. It is impossible to manage a pandemic by treating soft science as hard science. It is impossible to manage pandemics with current attitudes, skills, and technology. Models, Artificial Intelligence, Machine Learning and Predictive Analytics all failed. We destroyed the economy and lives and even caused deaths and yet the deaths were nowhere near levels that justified the draconian actions, many which were just kneejerk reactions. The science failed.

We need new technologies and skills and attitudes to permanently restore hope. The technology exists and it does not rely on AI, ML and PA. However, a different breed of openminded scientists and experts are required for this from multiple disciplines. This breed is capable of minimizing deaths subject to not destroying lives and not taking away human rights to choose one's own risks in life, whist protecting those who need protection. It just requires the will.

Recommendations

Breaking Release

The following has been replaced with a set of recommendations has been replaced with a set of recommendations submitted to the **Independent Panel for Pandemic Preparedness & Response**

Please follow this link

https://www.covidmedicalnetwork.com/AmmendedRecommendations.aspx

What this has shown though is that we were not prepared in 2020. What this has shown is that the science is lacking. We now have an opportunity using competent science to give back hope to the world by setting up a global pandemic system that can cope with future pandemics without destroying the economy and lives.

As the WHO said in 2018, we need new technologies, new attitudes, and skills where quarantining is no longer part of the solution. There is so much new technology available not reliant on hyped AI, ML and PA. Outside these hyped technologies there is so much more that is possible. A global integrated international virus tsunami warning system can be developed that uses real science. A risk analysis is now possible that can determine factors that exasperate deaths, so that we can focus on protecting the vulnerable with real risks instead of isolating broad groups. A fingerprint analysis is needed to observe changes with other causes of death. A globally integrated information system can be developed that combined with new technology, that is available will provide accurate information, not propaganda statements, that will let human beings decide what risks take, instead of removing their freedom to choose their own risks over and life and death.

An open discussion is urgently needed with the Independent Panel for Pandemic Preparedness & Response, politicians, the media, and a representative cross section of experts from a variety of fields.

We can organize an international event with our team, possibly in Wuhan which includes visiting the wet market and with selected competent international experts and start a process beginning with an open discussion to give hope for the world with new technologies, attitudes, and skills so this never happens again. Interest in such an event can be expressed here.
https://www.covidmedicalnetwork.com/Registerforevent.aspx

Opportunities for Research:

The psychological aspect was not considered sufficiently. It is known that stress can result in immune system breakdown. How many deaths were caused through fear of certain death? How many

doctors were influenced in their treatment only because they were convinced the virus is a killer. Would they have used ECMO or ventilators if they did not believe the presence of the virus is deadly? What effect did hysteria have. Hysteria does manifest itself physically. Hysteria has caused big disruptions E.g., Y2K bug. What about the copycat syndrome?

The following is only food for thought and no more. This all started in Wuhan when 3 atypical pneumonia cases were associated with SARS CoV-2 and one person died. SARS CoV-2 was seen as deadly. Respectfully, that is unscientific, and such conclusion jumping has become part of modern science. Of course, the conclusion may have been right, but there could have been other reasons for the atypical pneumonia, such as Wuhan's acid rain, which could have damaged lungs.

When the whistle blower went public, assume the Chinese government panicked after the world's condemnation to its SARS reaction. To impress the world, it locked up Wuhan. (This is just a supposition, because we do not know why the government reacted the way it did). Panic now started locally and globally. Why would China have locked down a city and more after, if the virus were not so deadly? Then everyone copied the response, panic and hysteria set in causing deaths, not because of the virus per se, but due to panic, fear, and fear based overwhelming of hospitals etc.

These are psychological factors behind the decisions which need to be researched.

Another area of research is the reluctance by human beings to accept that they may be wrong. When observations support our theories, we tend to refuse to acknowledge that we may be wrong. Denial goes both ways. We seem to want to believe the virus is the deadliest virus since the dawn of time. Hence, we shut off from reality.

There is so much opportunity for researching psychological factors that were part of the pandemic which can help dealing with pandemics better in the future.

Contents

Section 3 Introduction

In March 2020, the most extraordinary thing that ever happened in human history occurred. The world has shut down the economy, destroying lives and taking away civil liberties in the name of saving lives.

Throughout history a small number of people, who are supposed to lead people have destroyed the lives of millions with wars fueled by propaganda. Now a war has been declared on a tiny invisible virus, that is part of nature and again millions of lives have been destroyed again fueled with propaganda. The basic human right to choose risks over one's own life has been taken by democratic countries who once prided themselves for respecting and standing up for human rights all because of a fear of the virus. Wars are no way to manage pandemics and yet many leaders, convinced by the science, have openly declared war on the virus, ignoring the human cost as is the norm in wars.

No country listened to the WHO's and managed its response accordingly. Prior to Covid-19 the WHO said regarding the next pandemic -

"But we can say, with a high degree of certainty, that when it comes, there will be (a) an initial delay in recognising it; (b) a serious impact on travel and trade; (c) a public reaction that includes anxiety, or even panic and confusion, and (d) this will be aided and abetted by media coverage."

*"**In addition, the fear generated by the emergence of a previously-unknown infection may be greatly out of proportion to its real public health impact**. Fear often generates inadequate decisions or inappropriate behaviours, including stigma of certain at-risk populations. The impact on travel and trade and on economies can be disproportionate, as it has been seen in the Republic of Korea during the MERS epidemic. To a certain extent, global health security also encompasses economic and human security."*

*"We have also seen that many traditional containment measures are no longer efficient. **They should therefore be re-examined in the light of people's expectations of more freedom, including freedom of movement**. Measures such as quarantine, for example, once regarded as a matter of fact, would be unacceptable to many populations today."*

*"A proliferation of web-based "experts" with diverse and often contradictory views can generate confusion, anxiety and even panic in times of serious infectious outbreaks. **False or misleading information is dangerous"***

"Thus, we are recognizing that the complexity of 21st century epidemics and their prevention and control require not just new technologies techniques, but new skills and new attitudes all across the public health community."

https://www.who.int/emergencies/diseases/managing-epidemics-interactive.pdf

The predictions were ominously correct in every way!

The analysis was performed to establish whether the global self-destruction of the economy and harming of human lives was justified noting that the science used as the basis of the decisions was highly flawed according to our 30 years global experience in data science and analytics.

The objective of this report is hence not to prove or disprove the deadliness of the virus. (A scientist does not set to prove or disprove a theory. A scientist is unbiased and interested only in obtaining an insight into reality)

The objective is not to blame anyone. We had to learn.

It is hoped that the report will show how deficient the science used to determine the prevalence, contagiousness, infectiousness, spread, virulence and deadliness and anything related is and was in the hope that this will lead to a better way of managing pandemics in the future in accord with the statement made by the World Health Organization in 2018.

Section 4 Summary

4.1 Factors that contributed to mismanaging Covid-19 and the damage caused.

DECLARATION OF WAR ON A VIRUS

    COVID-19 PROPGANDA

    HUMAN BEINGS SEEN AS COLLATERAL DAMAGE

    SLASH AND BURN MENTALITY

EDUCATION ISSUES

    INCOMPETENCY

    ACADEMIC THINKING AS OPPOSED TO REAL-WORLD THINKING

    DETERIORATED EDUCATION

    INEXPERIENCED REAL-WORLD SCIENTISTS

    INABILITY TO THINK CLEARLY

HUMAN FACTORS

    CONCEIT

    LACK OF EMPHATHY

    INABILITY TO ACCEPT DEATH AS PART OF THE BALANCE TO LIVE ON A FINITE SIZED EARTH

    TRYING TO FIGHT NATURE MAINTAINING ITS BALANCES

    LACK OF VALUE JUDGEMENT

    THE NEED TO DRAMATIZE

    FEAR

POLITICAL FACTORS

    DICTATOR MENTALITY

    LACK OF COURAGE BY POLITICANS

    COPYCAT SYNDROME BY POLITICIANS – COPY CHINA

    BLINDNESS TO HUMAN SUFFERING – THE BACKBONE OF THE ECCONOMY SUFFERED

    INABILITY OF POLITICIANS TO STEP OUTSIDE THEIR REALITY

    POLITIZING THE SITUATION THAT DESTROYED LIVES

    FURTHER DESTRUCTION OF THE ECONOMY BY DESTABLING RELATIONSHIPS WITH TRADNG PARTNERS BY BLAMING, SABRE RATTLING AND CHEST BEATING.

    INABILITY TO SEE THE HUMAN DAMAGE

BAD SCIENCE

NOT BEING ABLE TO DEIFERENTIAT EBETWEEN SOF AND HARD SCIENCE

OBESSION WITH MODELS AND HYPED TECHNOLOGY

BIASED OBSESSION WITH PROVING DEADLINESS INSTEAD OF HARMLESSNESS

CONCLUSION JUMPING

DELUSIONAL OBSESSION WANTING TO SAVE THE WORLD FROM VIRUSES

BLINDNESS TO PERSPECTIVE

INABILITY TO DIFFERENTIATE BETWEEN SUPPORTIVE EVIDENCE AND EMPERICAL EVIDENCE

CASE REPORTING

UNCOORDINATED SCIENTIFIC REPORTING

DIRTY DATA

LACK OF PERSPECTIVE

LACK OF STATISTICAL THINKING

LACK OF REAL-WORLD DATA SCIENCE

TEST TUBE THINKING APPLIED TO REAL-WORLD PROBLEMS

SOLUTIONS WITHOUT MULTIPLE OBJECTIVES

SOLUTIONS WITHOUT CONSTRAINTS - HUMAN RIGHTS MUST NEVER BE DESTROYED

FALSE OBJECTIVES

IRRATIONAL DECISIONS

EXTREME BIAS - MAKE VIRUS DEADLIER THAN IT IS

Bad Technology

Models

Hyped Technologies such as Artificial Analysis, Machine Learning and Predictive Analytics

Global Unpreparedness

Knee jerk reactions
Inadequate real-world technologies that exclude perspective and multi-objectives
No integration
Wrong mix of experts.
No warning system and flawed reporting system

4.2 Summary list

- The human damage that has been caused to save lives, without regard to protecting quality of life is far greater than those responsible can comprehend because they are not affected by it.
- Business owners, who have risked so much, salary sacrificed and have worked so hard all their lives have been devastated.
- Mum and dad business owners who are the backbone of employment feel they have been stabbed in the back for their risks and sacrifices and contribution to employment.
- Those who have lost their jobs and careers they loved must start again in a career that is not their calling.
- Those responsible who remain in their jobs cannot comprehend the feeling of helplessness, not knowing what the future holds.
- Age care residents who have little left in their lives who consider nursing homes a jail have been forced to live the last few months of their lives in what can only be considered maximum security jail.
- Mental Patients are expected to feel better knowing money has been injected into helplines and can receive hollow counselling by counselors who have no understanding of the anguish they go through.
- WHO's predictions with regards to the next emerging virus was born out exactly. The WHO warned that the fear generated by the emergence of a previously unknown infection may be greatly out of proportion to its real public health impact.
- Flawed models have been used extensively to justify flattening of the economy by proving how many lives were saved.
- All models are wrong, which has been first proposed by George E. Box considered to be one "one of the greatest statistical minds of the 20th century".
- Every model's output studied was wrong. Predictions of thousands of deaths in Victoria Australia, if its physical distancing measure were not introduced, were not borne out by countries who did not rely on the same measures.
- The mathematics behind the models studied was flawed and based on too many assumptions. To use models which are always wrong to justify flattening the curve is unscientific. Empirical methods need to be used instead.
- A perspective of COVID-19 cases was provided by comparing with global flu cases. For all of 2020 the total COVID-19 cases were 85 million. Global flu cases have been estimated between 225 million to **1.1 billion**.
- Considering unreliable data, testing errors, flu injections and other factors there is no rational evidence that COVID-19 has more infections than the flu, with or without lockdown.
- Case reporting was found to have no scientific basis and provides a misleading picture of current trends. The obsession with unscientific case reporting has destroyed our lives.
- Because cases are dependent on test numbers proportion of cases relative to test numbers should be used instead.
- There are no reliable prevalence estimates because sampling is based on biased test sampling.
- Currently in Europe it appears that infections are approaching or are beyond the first wave. Proportion reporting shows a different picture because test numbers have increased so much.

- Cases in the second wave increased because testing increased. Death rates have not followed cases. Death rates are following prevalence estimates as would be expected.
- Based on prevalence estimates using test proportions, even though test samples are not designed for population estimates, one can have reasonable confidence that actual symptomatic cases are not in the low thousands but for many countries in the millions.
- Because medical clinic presentations do not reflect the millions of cases that must be present in the population one can only conclude that virus is not perceived as bad as we think.
- Throughout the pandemic experts have jumped to conclusions. That was very evident with the early touted success stories for Singapore, South Korea, Japan, Taiwan, and Vietnam. The conclusions were premature because the pandemic had not yet reached final prevalence. There is nothing these countries did that others did not.
- Rapid early reaction was given as a reason but after considering what every other country did there is no evidence that this caused the low case numbers. Japan's, Taiwan's, and Vietnam's all had tiny test numbers which may better explain the low cases, though not conclusively.
- **Without aggressive actions Taiwan had only SEVEN deaths**. **With aggressive action Victoria (Au) had 820 deaths** with a population size of 6 million compared to Taiwan's 24 million.
- A heterogeneity study on cases and percentage of cases showed that there is too much variability from country to country to justify the propaganda statements that imply without drastic containment actions we would have had thousands and thousands of cases and thousands of deaths.
- A Case Study for Australia and Victoria showed that Australia started lockdown after cases already came down begging the question why?
- Victoria, Australia whose population is going through great stress was at the brunt of bad science. Moving averages of 14 have been used to convince the public that Stage 4 lockdown made a big difference. Moving averages lag. In fact, there is no evidence that both Lock Down 3 and 4 made a difference. Cases were already coming down when lockdown 4 was implemented.
- A study was performed to determine if Facemasks, Testing or Contact Tracing and Quarantining, Lockdown has worked. This study did not rely on models, because models are never correct. Instead, the study relied on data evidence.
- There was no evidence that Facemasks had an effect. Some will conclude the reason is because they were not used diligently, but then neither must hospitals because hospitals have not managed to stop infections.
- There was no evidence that the extensive testing programs have had any effect on the number of infections, and the time it takes to flatten the curve. However, testing distorts infection rate because cases are dependent on test numbers. As expected, Taiwan, Vietnam, Cambodia, and Laos report very few cases but also have no extensive test program.
- Many countries including the above mentioned make claim that their fast actions made the difference. No evidence was found to support these statements.
- There was no evidence that lockdown worked effectively. This is maybe because lockdown was not managed effectively or is impossible to manage effectively.
- Some waves came down by themselves. Sweden's deaths came down by themselves. Australian cases started coming down by themselves. This is not a shock. The common cold comes and goes.

- The WHO has prior to COVID-19 implied that quarantining and lockdowns today are not workable in today's world.
- After placing perspective relative to other causes of deaths the fear and reaction to Covid-19 deaths is irrational. Even with pessimistic forecasting other causes of deaths still outnumber Covid-19.
- If we are serious about saving lives then we need to stop all private transport, make homosexuality and prostitution illegal again, remain in permanent lockdown to stop seven million global deaths due to other viruses.
- Private transport not only kills people of the same order of magnitude but also maims people.
- If we stopped private transport, then there will be 15 million job losses. The reaction to Covid-19 has destroyed hundreds of millions of full-time jobs and 1.6 billion workers in the informal sector.
- The world is getting larger. According to the United Nations in 4 more years there will be six more million deaths. We need to accept death and not let it destroy us. The world cannot sustain an ever-growing population. Nature must take its course and we must accept it with dignity by not cowering in-front of death.
- In Victoria/ Australia even two deaths are now unacceptable per day even though people die every day and even though weakly deaths have no impact on total deaths. We are destroying lives with a fear-based war on a virus.
- Experts have gone out of their way to convince us that the flu is less deadly then Covid-19 deaths. Case percentages are used as evidence. The science behind the comparisons is incompetent. Flu deaths are unreliable because they are not accurately recorded. Case deaths are too variable and biased and not representative. Variation in both flu and Covid-19 cases has not been scientifically considered when comparing.
- The 1918 pandemic is not the only one with high flu deaths. The 1968 Hong Kong flue caused an estimated 700,000 to 1 million deaths world-wide. The flu cannot be trusted.
- Although experts are going to great length to convince us that Covid-19 is just as deadly for young people Covid-19 targets old and frail people with comorbidities. The flu targets young people. Which is more deadly a virus that targets those with reduced life expectancy or one that targets young people?
- If we quarantine old people for Covid-19 should we not quarantine the young population with the flu
- There is no correlation between cases and deaths. There is too much variation from country to country, and within countries over time. Globally case deaths have dropped from around 10% to 2 %. Individual countries varied between less than 0.1% to 14%
- Case deaths are dramatically reducing.
- Case death percentages have all been based on cases. but cases are influenced by test numbers. When using prevalence estimates of cases and estimating number of cases in the population % case deaths are a fraction of calculated values based on reported cases.
- **Although cases have been underestimated by millions, it means that % case deaths are very low.**
- Flu case fatalities are oversimplified when comparing Covid-19 with the flu. For the 2009 pandemic case percentages varied between 0.001 and 10%, which is no different to Covid-19 case fatality heterogeneity.
- Proportion of deaths relative to the population are tiny. 30% of countries had less than 0.001% deaths. Countries such as Belgium, Brazil, Chile, Italy, Mexico, Peru, Spain, United

Kingdom, United States are in the top 5% of death percentages which vary between .06 to .12 percent. The black death was estimated to have killed between 30% to 60% of the European population. This is not the black death.

- Deaths relative to total deaths are low. 60% of countries fall below 1% of total deaths. 90% of countries fall below 5% of the total deaths recorded in 2017
- There is great bias in assigning cause of death to Covid-19. This is a common problem which has been reported on by the BBC. **Reported** deaths may have been inflated by a factor of ten if previous years' experience is used as a guide.
- An analysis based on distribution optimized SPC BIS.Net Hybrid charts shows that deaths during the high death rate period are all with reasonable limits. For many countries there was no effect on normal total deaths at all. Some did have glitches, but glitches are also part of life. Several countries had higher flu glitches which did not concern anyone.
- Similar analysis used models to compare with previous equivalent periods. The objective of the distribution optimized analysis was not to estimate excess amounts but to place perspective on the total registered deaths relative to what is normal in life.
- Some cities such as NYC and Wuhan certainly had high excess deaths which fall outside normal variation. These cities can be related to unusual pollution which may have comprised the respiratory system of the elderly. For example according to commentators, for NYC the concrete/metal dust and toxic plumes that covered NYC 20 years ago, when the twin towers collapsed has been a ticking time bomb ever since, in terms of respiratory health as NY residents have aged since. Wuhan's Iron and Steel factory used to pollute the air with acid rain. London's smog years are not that long ago and could have compromised the respiratory system of the now elderly. Lombardy has a major pollution problem that has affected health. However, that is no evidence that pollution caused the high rates because France with clean air also had high deaths.
- The effect of panic on excess deaths cannot be ignored. People have out of fear of catching the virus not checked themselves into hospitals leaving treatment too late. Others overwhelmed the system causing deaths in countries where panic was more than in others. Fear of death by those infected may have contributed to lowering of the immune system and will to live.
- Reported deaths follow proportions more closely than cases showing that proportions are a better measure than cases.
- Contrary to the virus propaganda total registered deaths analysis for all European countries and US States showed that people below 50 had no effect on registered deaths. The virus is not the deadly virus that kills young and old.
- The current spike of cases in the UK is attributed to a new strain. That is conclusion jumping and the conclusion is once again based on models. The majority of the increase is related to test number increases and possibly colder weather.

There is a reasonable possibility that it was panic and fear that caused the problems in the high death countries. Panic and fear results in overwhelming, not thought out treatment, etc. Every European country with high deaths extensively reported by the media had very little lag between case reporting and death reporting. Germany, Austria, Norway all had large lags, implying, but not proving, the issue is human not virus

The current wave of cases in Europe has been distorted by testing. When cases are based on testing it is unscientific to report test cases. Proportions need to be reported.

It has been observed that deaths are now much lower. Although many reasons have been suggested the reason may be due to the incorrect reporting of cases. When plotting proportions deaths follows a similar pattern, which would be expected if there was no change in case fatalities.

A 2017 study has shown that the common cold was deadlier than the flu amongst elderly patients studied. Covid-19 may be a common cold virus all along! What if we use the same biased cause of death method that was used for Covid-19. What if we report case after case? What if we used fear generating propaganda to cause deaths?

Section 5 Saving lives versus Damage Caused to Lives

Is the price we paid for saving lives worth it. Can we sustain it each time there is a new virus?

We assert that science failed us because it was unable to offer constrained solutions. Constrained solutions are the norm in other sciences such as Operations Research, where we minimize (maximize) subject to constraints. Science has been unable to minimize deaths subject to not restrict movement and quarantining an ideal expressed by the WHO. The WHO before it became embroiled with US politics was against freedom of movement and quarantining and clearly stated in 2018 that these forms of containment measures are unacceptable today.

It is thus appropriate to remind of the human damage caused by declaring war on the virus to save lives.

5.1 Saving Lives.

The global rhetoric is that COVID-19 is a rampant deadly virus and that we must stop at nothing to save lives. However, there is a price to pay, which is examined in Section 5.2

Are we perhaps trying to do the impossible? Death is inevitable and necessary for life to be livable in a finite sized earth. To just let someone, die when we can save that person's life is unquestionably immoral. But is saving the world without regard to living moral?

One cannot help but notice the irrationality over what has happened. We seem to be only interested in saving Corona Virus related deaths. We must ask ourselves, why are other deaths of even far greater magnitude not important.

We send our boys to war to fight and die to protect our way of life and human rights. That means we used to value living over saving lives because we were willing to send our boys to wars to die for our way of life. Now living is no longer important. Saving lives has taken over even though we all die and all we are doing is saving a small period for those with comorbidities or elderly whilst destroying people's lives.

Should this not be constrained minimization problem, solved with new science and a different way of thinking to what we are used to, in line with *"Thus, we are recognizing that the complexity of 21st century epidemics and their prevention and control require not just new technologies techniques, but new skills and new attitudes all across the public health community."*

Should the objective not be 'minimize deaths constrained by not destroying the way we live and our human rights'?

CASE STUDY

My father died in a nursing home middle of 2019. Six months before admission he would look forward to having coffee inside a mall and watching people walk by. He believed everyone had a story to tell. If he were alive now, he would not appreciate having to be locked up and prevented from watching people walk by in the last few months of his life.

He hated every minute of his nursing home. It was a 'jail' and he could not handle the atmosphere of moaning people around him and the stench of urine. He wanted to die and told his priest he wanted to take his life. He died 3 months later. He would not have thanked anyone for saving his life, but that's my Dad, and he would not want to speak on behalf of others.

There is no point in saving lives of the elderly if you destroy the little life (6 to 12 months on average) they have left. If you prevent the elderly in age care from seeing their family with so little time left, you have already taken their life.

5.2 Damage Caused to Lives

The damage caused is well documented, but as is often the case, those who recommended and implemented the actions that have caused the damage, may say that they understand the hardship and sympathize, but because they are not affected by their decisions really have no idea what they have done. That is human nature. Unless we go through something ourselves, we have no idea what it feels like. One can only ask would those responsible for the damage have resigned from their jobs to go through this with those who have lost everything and run the country without salary as a sacrifice. Perhaps our leaders, who serve us, feel they are above us and are working hard and thus should not make such a sacrifice?

This report is about opening eyes to the possibility that a terrible mistake was made, caused by bad science.

First, we need to open eyes to the damage done.

5.2.1 Loss of Human Rights

The world's democratic countries have long frowned upon totalitarian governments.

When we were put on this earth, we were born free. In principle no human being has the right to take away someone's birth given freedom as long as that freedom does not take away someone else's freedom.

Our freedom to choose the risk we take with our lives has been taken away. Where will it stop? Will be asked to stop taking the risk of driving a car to save our lives. It is our risk and no one else to decide – provided we do not risk someone else's life.

When a democratically elected government can lock up its people in the name of saving lives, without perspective, without regard to the cruelty caused, other than what sounds like hollow words, 'we are in it together', from those who lose nothing, then respect for human rights and democracy are gone.

Who is the selfish one? The person who can self-isolate if they are vulnerable, or feel they are vulnerable but expect others to do the same, or the person who wants to go on living, and take risks that

LOSS OF CONFIDENCE

How can businesspeople have confidence to once again risk everything knowing any day there will be a reversal? That has already happened where restaurants once again had to close for a deadly rampant virus which to date has killed 'only' 2 in 10000 people (which maybe exaggerated worldwide and mostly old people many in age care and people with comorbidities, who have limited lives left anyway.

How can business owners have confidence in the future knowing virologists are now trying to save the world by using new technology which will identify viruses that have probably always been around, but now that they will be found, may cause for more future panic.

We need to give business owners confidence that this precedence will never be repeated.

affect no one else and keep the economy alive so we can afford welfare. Life is about taking risks. It is the risk takers that have achieved everything that humanity has achieved. The human rights of these people have been taken away because of fear of death possibly based on false perspective and science.

5.2.2 Destruction of Front-Line Workers

There are two types of frontline workers. Doctors, nurses, paramedics, age care workers etc. They always risk their lives with catching viruses and there can be no denial, we are grateful to them.

But there is another set of frontline workers who have never been given the recognition they deserve, many of whom have had their lives and dreams cruelly destroyed. These are the business owners and entrepreneurs and investors, who make living worth it and give hope to the world by creating jobs and opportunities. What about airline pilots who risk their lives daily and have now lost their jobs for years to come? These, few people with courage carry the world. They are frontline workers of the economy without whom the economy cannot afford hospitals and free medical care. These people who have few holidays typically work 70-80 hours a week, have invested their time, money and taken risks not many can ever understand. The stress business owners and investors endure can cause heart attacks, broken marriages, and strokes and health problems which reduce life expectancy.

 Now they were the first of the collateral damage and are told they must find ways to rebuild. What has happened to them is cruel. To think the economy will suddenly rebound is naïve. No doubt there will be lots of propaganda statements made to convince the economy is flourishing again, but lives have been destroyed and things will never return to normal until our leaders restore their sanity and are driven by real experts.

5.2.3 Destruction of Careers

We all have callings. Some of us are good with our hands, some of us are good with our minds. We are all different. We choose careers that make us happy, just as advisers and politicians have chosen their career paths. To have to work in a job that is not our calling is soul destroying. Would advisers work in any job? How many have lost the jobs or careers that they love? How many are now expected to take on casual construction jobs, that have been created to boost the economy? Some people will be happy, but we are all different.

5.2.4 Mental Health

Mental Health problems have risen. Money keeps being allocated to alleviate mental health problems caused by isolation, showing how out-of-touch politicians are. How can money alleviate anguish and despair? Will it even reach the sufferer?

Has any expert with someone in the family suffering with mental health issues ever tried to ring one of the many helplines to see what really happens? The lip service advice provided, does not make

the pain of depression go away. Only those with family members suffering with mental health problems understand the futility of the help lines.

My brother believes birds dropped his mother's bones in his garden and that he sees Ned Kelly at the mall. My other brother must pay his expenses out of his own pension because the system will not allow him to get guardianship. The help lines provided him with nothing but run arounds. The advice by counselors who have had no personal mental health issue, and hence no understanding, had little value.

Our reactions to the virus, has caused more mental health issues and made suffering far worse. Mental health is not a disease. It is anguish and not being able to cope in a cruel world. It cannot be treated with money, only the removal of the factors that cause depression and loss of hope. Now we have added to these factors for what reason? To save lives when we have never cared before.

Quotes from real people

"I am being refused medical care in Sydney! I cannot wear a face mask due to multiple medical conditions which are well documented and I am on a Disability Support Pension because of. I have been trying to get a potentially cancerous growth behind my left ear seen to for over 2 weeks but every single medical centre I contact has said that they won't let me enter without a face mask and have even threatened to call the Police on me and threatened me with $200 fines! The Manager from Enmore Medical Centre called me up to just abuse me and refuse me medical care this morning. I couldn't get a single word in and when I tried to speak she just hung up on me! I had to call 000 Ambulance but the young woman who came in to see me refused to even look at my ear and told me that I would have to present to a hospital but would have to wear a face mask! She suggested I just get dosed up on a very high level of anti-anxiety drugs which have severe side-effects (which she didn't even mention) so that she could force a mask on to me even though I cannot breath in a face mask due to my many well documented medical issues including asthma and anxiety so I just refused and asked her to leave! I literally cannot get any medical care in Australia at all. At this stage I have just given up and am hoping that I die from cancer as it would be better than continuing to live in Australia and I am against suicide due to my Christianity!" sic

"My mother died during lockdown & we couldnt have a funeral or a family get-together.... & our family still under great stress from this inhumane rule." sic

5.2.5 Relationships

The greatest stress was not being able to see family and friends and going to church. When was the last time we could go to church in Australia? Being able to hug your grandchildren is therapeutic, but that was been taken away. That has been taken away.

5.3 Damaging our Children's Education.

Education has already taken a hit over many years such as through a reduction of standards in universities who are driven to have pass mark quotas to ensure export earnings. Modern teaching methods leave a lot to desire. Now education for the current generation has taken a further hit. Remote learning is no education.

We now have the situation, at least in Australia, where parents have given up their jobs, to take over the role of teachers who continue to get paid for doing nothing.

Quotes from Christopher Ude a Parent. Full letter to education department is in Appendix A.4

> Is this fair for parents who have been forced to work from home and must do their jobs otherwise face unemployment? How does this affect the children's learning when parents are shattered and stressed?

> I completely support SAFETY for our children and teachers during COVID-19. But don't we need to EQUALLY SAFEGUARD our children's education? Remote learning is not cutting it! I see groups of primary children congregating unattended in parks. Doesn't this go against the reason why we are home schooling in the first place

> Is this fair for children to receive teaching from parents who are not qualified teachers hence struggle in conveying proper explanations? How about children of different ethnic backgrounds, whose parents struggle with the English language?

Working at home parents are struggling. We have pressures from our bosses, which in these unprecedented times, are higher than ever due to uncertainties. If we do not do our jobs, we join the unemployment line. Is this something the government would want?

I have noted that socializing or wellbeing seems to be more of the focus, but not so much teaching. Every day, my 8 year daughter is involved in a game such as 'connect 4', 'paper, rock and scissors'. How can this be good for our children's education

Everybody is stressed and tired. Moods are in overdrive and the children are sometimes the ones who bear the brunt. Children themselves are tired, stressed and sometimes unmanageable where tantrums are even thrown at an attempt to refuse their schooling simply because they are at home!

5.4 Saving Lives versus

Protecting our Lives.

We live in an age where the world is becoming over-populated. This causes resource problems, poverty, more disease, more conflict and starvation and welfare issues. Countries are raising pension age to cope with welfare. As the world is growing so MUST the deaths. In 5 years according to UN projections we can expect an extra 5 million deaths world-wide. We must accept deaths whether we like it or not.

https://ourworldindata.org/grapher/births-and-deaths-projected-to-2100

Counterproductively we are trying to save lives which will only add to more deaths and more problems making living even harder.

Of course, that sounds callous, and it is callous, if this is saying we are all going to die, the world is over-populated, so do not bother to prevent deaths.

That is not what is meant. What is meant is that saving lives is not the only priority. If we destroy lives, there is no point in living. Saving lives only has value if living is not compromised. We have taken the easy way out by having a singular objective, instead of a risk based constrained objective, which is to minimize deaths constrained by not destroying those things that mean a lot to us like our jobs, hugging grandchildren, going to church, giving our respects to those who have left us and not forsaking the elderly in age care. There is no perfect solution. Risks will always exist which is what life is about.

New scientific thinking is required to ensure that for future pandemics we are capable to move from singular objectives to constrained objectives where we accept risks, just as we accept the risk of a car accident each time we hop in a car.

Section 6 Propaganda

This report is about the science used during the pandemic. Propaganda may seem to fall outside this scope, but it does not. Part of science is factual communication. There is no point in following a scientific process if the results of the process are miscommunicated.

Propaganda is often associated with Nazi-Germanys war time propaganda to deceive its citizens and hence is a word that can offend if not understood.

Propaganda is not just used during war time. It used extensively today by marketers to sell products and concepts.

Propaganda "is communication that is used primarily to influence an audience and further an agenda, which may not be objective and may be presenting facts selectively to encourage a particular synthesis or perception, or using loaded language to produce an emotional rather than a rational response to the information".

https://en.wikipedia.org/wiki/Propaganda#:~:text=Propaganda%20is%20communication%20that%20is,rational%20response%20to%20the%20information

That is exactly what has been happening with COVID-19. Statements such as below and general rhetoric, have been used continuously all over the world to influence the public to accept the harsh containment actions because leaders believed the virus is deadly and using non-emotive communication would not be understood by the general public.

Is it right in today's age to resort to propaganda to get the message across, especially when the statements have not been objectively substantiated?

""We are talking about people dying because of decisions people are making, because they want to have a birthday party." That has not been proven and is pure propaganda meant to scare. Children at primary school were told if they do not sanitise, they may die. Registered deaths for those below 50 were not affected by covid-19.

There is no argument that whilst rules are in place, we must follow them, even if we do not agree. But how many deaths have in that case have been caused by essential workers not following 'rules'? I have seen many who have broken social distancing rules and did not wear masks when they thought they were not being observed.

Other examples of propaganda.

"The alternative, as we know only too well, is many thousands of people dying, in some of the horrific scenes that we've seen in other parts of the world.". Who has seen it? Who is we?

"It can be deadly, and it has been deadly here and around the world in people of all age groups and, indeed, people that are in otherwise good health"

The last statement is misleading because it implies the virus will indiscriminately kill young or old, making it seem much deadlier than it is. A more truthful statement would have been -

"The virus has been associated with some deaths, predominantly the elderly but the overall death rates is very low, though some countries have had unusually high deaths, mainly for the elderly."

Switzerland is just one example where we can see how far from the truth these influencing statements are. Figure 6 shows a glitch of registered deaths for those above 65 years old and **not one glitch for those below 65 years**. The glitch is not much higher than for flu years and not as wide.

In fact, for every state European Country there were no glitches for anyone below 50. Some reports have concluded that deaths for healthy people below 70 are infinitesimal.
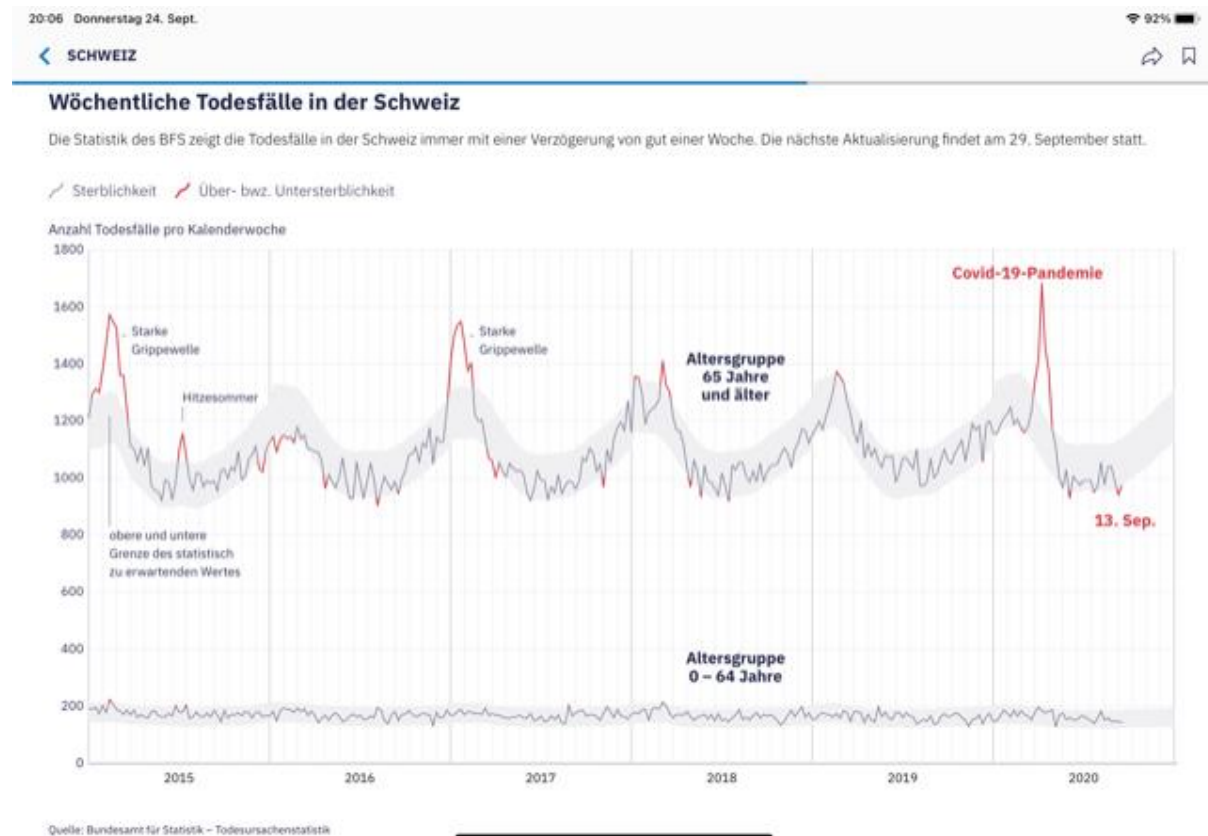
Figure 6 Registered deaths in Switzerland separated by above and below 65 years of age.

Propaganda, because it does not provide an honest perspective, causes destruction by rallying people to follow something they do not understand. World War II shows the extent of the damage such emotional rallying causes.

Section 7 Models

Children play with model airplanes. Adults fly airplanes.

7.1 Models are always wrong.

Artificial Intelligence (AI), Machine Learning (ML), Predictive Analytics (PA) and especially Models have been used throughout the pandemic by experts to convince politicians how rampant and deadly the virus is. In turn politicians have used these to justify their actions which have destroyed so many lives.

Models, AI, ML and PA have their purpose. For example, they can provide an academic insight into the effect of different mitigation actions which is not practical by direct experimentation. Outside COVID-19 they can be very useful for forecasting, provided the models can be tweaked until the desired results are obtained.

Models, AI, ML and PA do have limitations which make them unsuitable for life changing decisions. They should only be used for academic insights into possible scenarios not for decision making that destroys lives.

Models are no more than a mathematical attempt to represent reality in manageable format for various uses, such as above. They depend on the model developer's ability to reflect life or data mathematically and algorithmically. Some are better than others. Models depend on the application and how easy it is to represent life mathematically, without assumptions.

Because life cannot be represented mathematically models are always wrong. This has been accepted by the science community.

George E. Box, who has been called "one of the great statistical minds of the 20th century" famously said, "All models are wrong", although they can be useful.

https://en.wikipedia.org/wiki/George_E._P._Box

If all models are wrong, which they are, then they cannot be used as evidence to convince the public how many lives have been saved through containment actions.

7.2 Examples of how wrong models can be.

7.2.1 Victoria Australia

"The alternative, as we know only too well, is many thousands of people dying, in some of the horrific scenes that we've seen in other parts of the world."

"Theoretical modelling shows some 36,000 people would have died from coronavirus in Victoria if physical-distancing restrictions were not put into place, "

"The modelling shows 650 people could have died each day at the state's coronavirus peak without physical-distancing measures"

The facts show that modelling cannot be used to estimate deaths. There are too many factors involved. Every country is unique. None of the countries without the drastic physical distancing measures had Victoria's predicted deaths during its peak period.

Many countries with physical distancing measures such as Italy had higher death rates. Of course, one can argue that they did not do it right, and certainly the USA only had halfhearted physical distancing. But can one really say that only we got it right and no one else is able to?

7.2.2 Hype as part of Covid-19 propaganda.

Facts in numbers

Based on the period that Victoria's model predictions were made.

- Sweden **without lockdown** averaged 44 deaths per day. When adjusted for Victoria's size **20 deaths** per day, nowhere near 650 people per day.
- Japan without lockdown during a peak death period averaged 17 deaths per day. When adjusted for Victoria's size **1 death** per day, nowhere near 650 people per day.
- South Korea which has controlled its first wave without major physical distancing, but contact tracing, has during its peak death period averaged around 7 deaths per day. When adjusted for Victoria's size less than **1 death per day.**

For comparison, the Covid-19 statement about thousands of people dying, (without physical distancing) referred to countries such as Italy and the USA. Here are their statistics.

- The United States averaged 1900 deaths per day during the period of high deaths. When adjusted for Victoria's population size **37 deaths** per day, nowhere near 650 people per day.
- Italy averaged 668 deaths per day at peak. When adjusted to Victoria's population size **70 deaths** per day, nowhere near 650 people per day.

Referring to models has been a strategy consistently used as part of the Covid-19 propaganda program.

Models, AI, ML, PA are common hyped technologies used to convince the public of the deadliness of the virus.

Just because the term modelling is used does not mean the use of superior technology able to provide magical solutions.

For example –

From above, "*Theoretical modelling shows some 36,000 people would have died from coronavirus in Victoria if physical-distancing restrictions were not put into place,* "

How would the 36000 have been derived? What model would have been used? How sophisticated is the model?

The mathematical model is not sophisticated at all, just a simple multiplicative equation.

Deaths = Population of Victoria * proportion of infected * proportion of deaths within the infected.

Victoria has an approximate population of 6 million. An often-assumed infection rate was 60%. The typical assumed death rate at the time of the statement, is 1% (much higher values are also reported). Thus Deaths = 6m*.6*.1=**36000**.

The problem lies in the model's parameters. 60% infection rate is not unusual, such as for the common cold. The assumption that 1% of those 60% will die is flawed. The 1% is based on case deaths. It is a worst-case assumption that does not take asymptomatic cases into account.

As will be shown later in the report % cases deaths provide no realistic estimate of the deadliness of the virus.

7.2.3 Sophisticated Models

Sophisticated models are more than just simple mathematical questions, such as the above one. These models may try an emulate human behaviour such as going to the shops, visiting friends, and interacting with humans. They normally involve simulation of random numbers and use of probability distributions such as the time to death, the time for symptoms to appear, the length of human interaction time. They rely on many assumptions, such as human behaviour.

Quotation from George Box

"Since all models are wrong the scientist cannot obtain a "correct" one by excessive elaboration. On the contrary following William of Occam he should seek an economical description of natural phenomena. 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."

https://en.wikipedia.org/wiki/All_models_are_wrong

It is however hard to define over-parametrization. In theory a complex world requires a complicated model. In practice the more complicated the more the model is prone to error.

Some models, such as reported in "Modelling transmission and control of the COVID-19 pandemic in Australia" and "Report 13: Estimating the number of infections and the impact of non-pharmaceutical interventions on COVID-19 in 11 European countries" were notably complex and hence more prone to significant output errors.

https://arxiv.org/abs/2003.10218

These sophisticated models assume academic distributions which are not real in this pandemic. Almost every country had different distributions, and none followed the neat academic distributions typically assumed in models, such as an exponential curve or logistic curve, or a negative binomial distribution. None considered the effect of test size on cases. All made too many assumptions about case deaths percentages.

The UK's new strain has been said to be 40 times as contagious as the previous one. This was based on models. Actual performance data shows no difference.

7.2.4 Case Study - Modelling used to justify Victoria/Australia's Stage 3 lockdown

Victoria had the harshest lockdown in Australia and yet once lockdown finished had a resurgence in cases which led to further hardship and flattening the economy even further.

As has become the norm throughout the world, modelling was used to justify the action.

The headline read.

"Victoria's stage three lockdown in July averted up to 37,000 coronavirus cases and saved 1,258 lives, research finds"

A 'model' based on an assumption of exponential growth was used by the xxx (we wish to respect the institute by not openly disclosing its name in public) Institute, Melbourne Victoria to draw the above conclusion. We decided to analyse the basis of the conclusion ourselves.

We cannot agree with the model's conclusion for reasons now explained.

Data used was obtained from the Victorian Health and Human Services as per the paper.

Figure 7.0 shows three trends identified using our technology applied to the actual cases using the same data used by the xxx Institute. Whatever technology we used is irrelevant because it is easy to visually see how the actual points hug the lines. The increase in variability is expected for the random process of case occurrence.
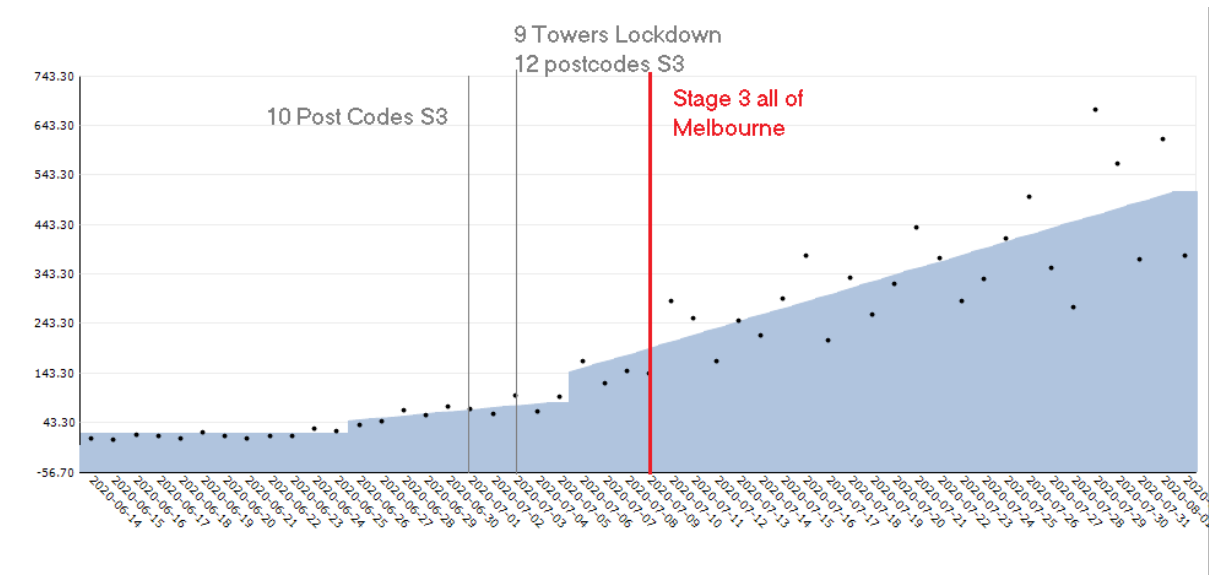
Figure 7.0 Trend identification technology applied to Victoria's cases between June 14th and August the second.

Actual data, in Figure 7.0 showed no evidence that Stage 3 slowed down the daily increase in reported cases. Even after 3 weeks the trend shows no discontinuation of the slope, which would have been expected.

The model used to justify lockdown assumed exponential growth. There was **no exponential growth** as shown in Figure 7.1., shown especially in Section 3. Exponential growth can occur in the classroom under perfect scenarios, but Victoria is not a classroom.
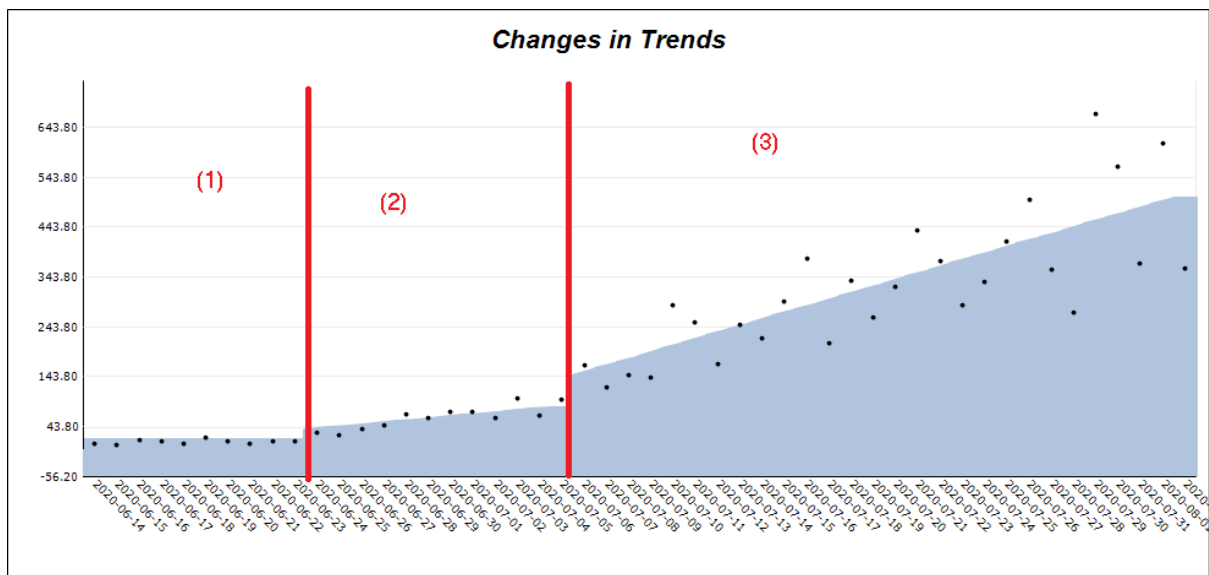
Figure 7.1 linear segments. No exponential growth.

One can stretch the imagination and approximate section 1 and 2 with an exponential curve as shown in Figure 7.2, but stretching the imagination is not a scientific process.
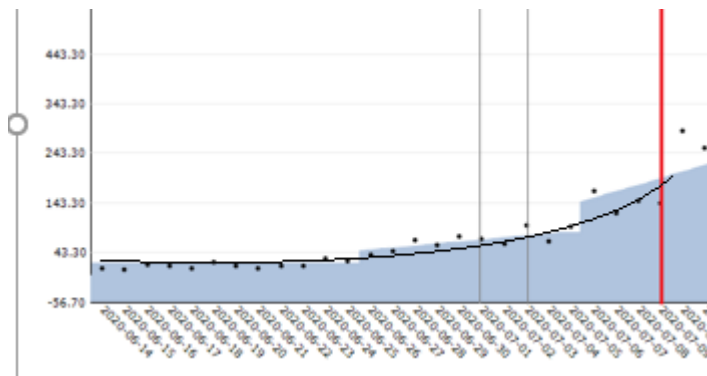
Figure 7.2. A fitted exponential curve.

If we extrapolate the curve in Figure 7.2 it will appear that we would have had far greater cases and deaths to follow. But that is not reality.

The xxx Institute assuming an exponential curve plotted the logarithms to base 10 and obtained a chart like that in Figure 7.3.
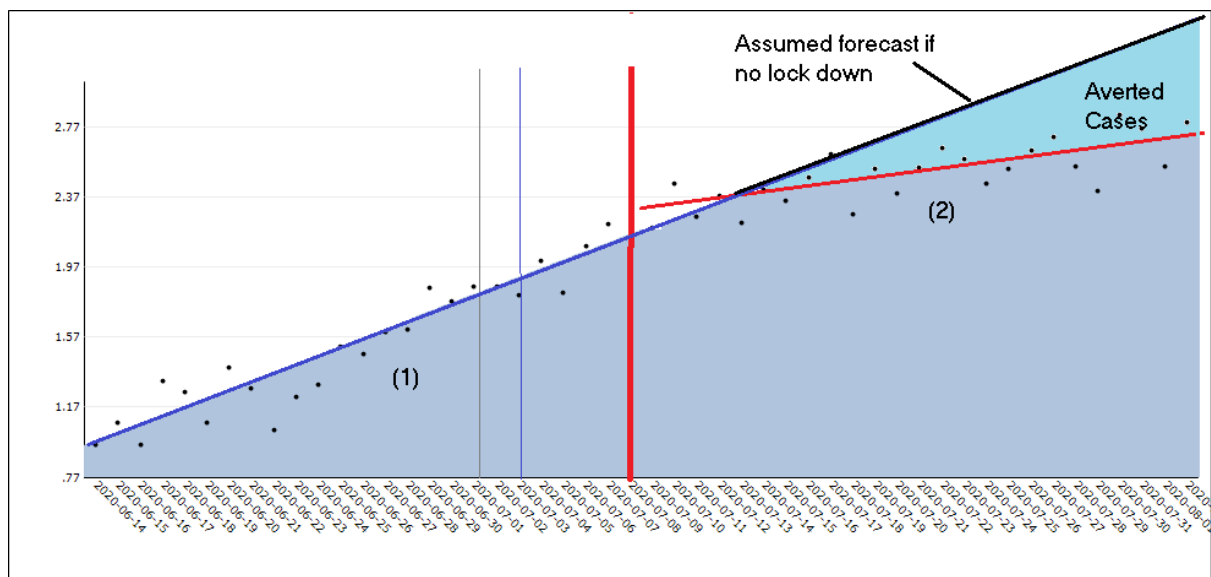
Figure 7.3 A plot of the logarithm of reported daily cases.

Referring to Figure 7.3, one will observe two sections. One with a blue slope and one with a red slope. Because the slopes of the logarithms are linear xxx Institute assumed two exponential growth curves. One prior to lockdown and the other post lockdown.

Appendix A.3 shows that linear logarithmic transformed lines does not prove exponential growth.

The institute then used this misinformation to calculate averted cases and concluded that

Victoria's stage three lockdown in July averted up to 37,000 coronavirus cases and saved 1,258 lives, research finds.

However, as Section 8.5 will show stage 3 lockdown had no proven effect. The model was wrong and incorrectly assumed an exponential equation.

Section 8 Cases

Cases are confirmed positive results and hence do not include all infections in the population.

The world has become focused on cases more so than on deaths. It is reasoned that by controlling cases we are controlling deaths. It makes theoretical sense. The more cases the more deaths. Practically the situation is not so simple. Deaths and Cases do not correlate well. Case fatality percentages are depending on many things, such as the state of general health within the community and bias in assigning cause of death.

8.1 Perspective on COVID-19 Cases

Since it has been accepted that COVID-19 is a rampant deadly virus, far deadlier and more contagious than the flu it is prudent to first obtain a global perspective by reviewing the global data.

As of the 31st of December 2020, there are 85 **million reported cases worldwide.** The trend is shown in Figure 8.1. There was a jump and now the trend seems to be increasing again, as rapidly as at the beginning. The curve is linear segmented and does not follow the theoretical distributions used in models. There is no exponential curve.
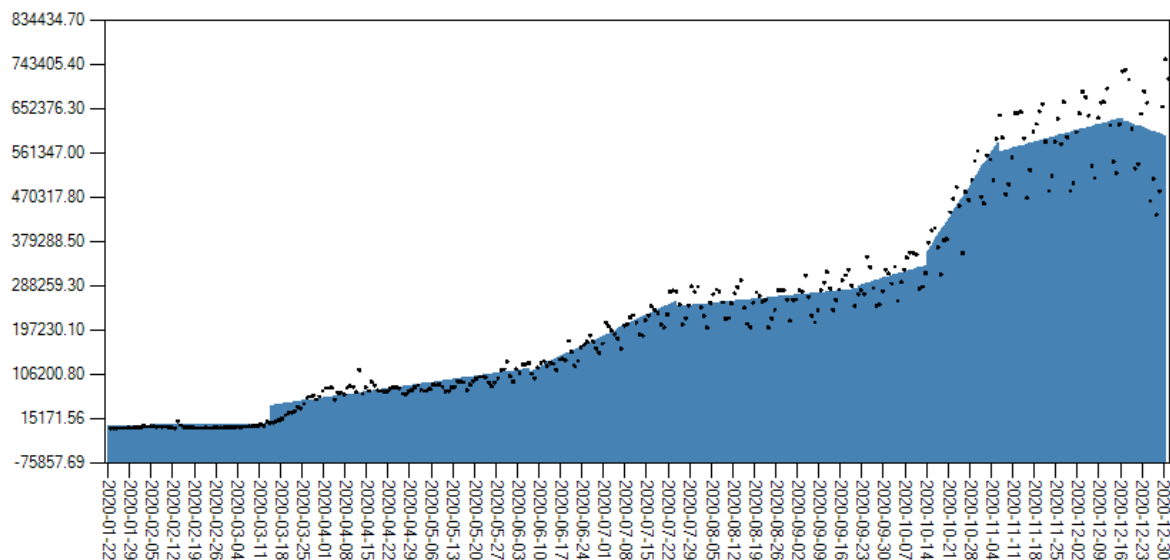
Figure 8.1 Daily total cases as of the 31st of December 2020

What is reported are numbers and nothing else. They are not the actual total infections in the world. We do not know what these are and never will. We only know the numbers that appear on the daily reports. These depend on diligence in reporting, testing sizes, accuracy of tests, stage of infection, and much more. All of these are unreliable.

Let us put some perspective on what appears to be 'huge' numbers and are causing panic.

The USA according to the CDC estimates 9 to 45 million illnesses due to the flu virus annually and the USA is 4% of the world's population. These are symptomatic cases because they are illnesses.

https://www.cdc.gov/flu/about/burden/index.html

If the global infections are proportional to population size, then one can say that the total annual global flu infections are 225 million to **1.1 billion**. Of course, the global infections are unlikely to be directly proportional to the USA infections, and hence the estimate is only an insight, not a precise fact.

Another estimate can be obtained as follows. According to https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278149/ Influenza is a highly contagious respiratory illness that is responsible for significant morbidity and mortality. Approximately 9% (702,000,00) of the world's population is affected annually, with up to 1 billion infections. This supports the basic naïve calculation based on projecting the US case infections.

The world does not go paranoid over 0.7 to 1 billion flu infections each year and yet has daily nervous breakdowns, over infections which 85 million for 2020.   There are other diseases also. In 2018 there were 228 million cases of malaria. 272000 children died of Malaria in 2018 according to the WHO. These are children under 5 years old.

https://www.who.int/news-room/fact-sheets/detail/malaria

The common cold infects over 62 million people in the USA each year and far more globally. 85 million for Covid-19 is not unusual, especially when considering that SARS-CoV-2 is of the same family as some common cold viruses.

We can argue that the COVID figures are under lockdown and strong social distancing and without it there would be far greater infections and cases. To counter this one may say that we have a flu vaccine if comparing with the flu, which is just a different form of containment.

Lockdown was never designed to reduce infections only to flatten the curve over a long time periods for hospitals to cope.

Just as lockdown is not 100% reliable so flu injections are not 100% reliable. According to some estimates the vaccination rate is 38%. Just as not everyone receives a flu injection, not everyone locked own.

Currently we are counting on vaccination but contrary to experts we cannot be sure that vaccinations will be successful. It is not possible to reliably determine how effective vaccination will be. There are too many factors which cannot be tested for.

The paranoia over cases is not scientifically based. It is based on assumed exaggerated deadliness.

8.2 Living in a fool's paradise.

Section 8.1 placed perspective on the numbers. But these numbers mean nothing. They may be inflated or underestimated. We may be living in a fool's paradise with much greater numbers matching the flu, the common cold and malaria infections (though malaria is not a virus, but a parasite)

8.2.1 Incidence rate

These are the new cases of a disease in a time interval. The daily reporting of cases is an example of incidence rate reporting. Here, the interval is day. In theory this information can be used to see how fast the virus is spreading and help predict whether hospitals will become overwhelmed and if deaths become out-of-control.

In practice this type of reporting is only valid for situations where the reported incidences are the total incidences in the reference population. For example, when members of the public **without influence** present themselves to clinics due to a new viral disease, daily reporting of cases makes sense. The cases will allow us to see how extensive the new disease is, how fast it is growing and where. The statistic is the number of people who presented themselves in the population. If there were 1000 cases reported then we know that 1000 people, no more and no less, in the population felt enough symptoms to present themselves to a medical clinic.

Another type of situation that incident rate reporting is valid for is deaths.

Case reporting as is done is only applicable if the positive cases are all the people in the population as in the last example. That is unrealistic. It would mean that every person with a Covid-19 symptom gets tested voluntarily on the day of testing. If that were the case, then governments would not need to drive testing because people with Covid-19 symptoms all get tested voluntarily. But they do not know they have Covid-19!

With current test programs where test numbers are a result of influencing covid19-cases will depend on the test numbers. At a particular point in time there will be so many infected people in the population and out of this population a certain number of people will get tested. The number of positive cases will be proportional to test numbers, following normal sampling laws.

To explain. If tests are taken in a region and in that region, there were say 1000 cases and the population size were 100,000 then in that region we have 1% of cases. If we took 100 tests with some degree of random selection, we would expect on average to obtain 1 case, plus or minus a random sampling error component. If we took 200 tests, we would on average obtain 2 cases, plus or minus a random sampling component. This of course assumes random sampling which is not the case with influenced sampling.

Case reporting is the worst case of scientific incompetence identified and makes no sense if cases come from extensive testing. Proportions need to be monitored instead because incidence rate cases depend on test numbers.

Test proportions can be used to crudely estimate prevalence if we treat the test samples as random sample. The estimate is crude because there is no scientific random sampling applied for Covid-19. There will be people that are too scared to get quarantined over mild symptoms. At the other extreme there will be people who panic. There is bias towards testing people with symptoms. More

people with symptoms may present themselves at the beginning for fear of leaving testing too late. The opposite can also happen.

The effect of incorrect case reporting can be seen with Europe today where there is considerable panic over a second wave.

Table 8 shows how case reporting has distorted the estimated prevalence (recognising these only provide an insight). Column 2 shows the trend in cases by plotting daily case numbers and Column 3 shows the trend by plotting proportions.

The data source was https://ourworldindata.org/coronavirus-testing

Table 8 Comparing Cases Reporting with Proportion of Tests Reporting as of October the 8ᵗʰ 2020

Country	Case Reporting	Proportion Reporting
Belgium		
Italy		
France		
Germany		
United Kingdom		

United States		
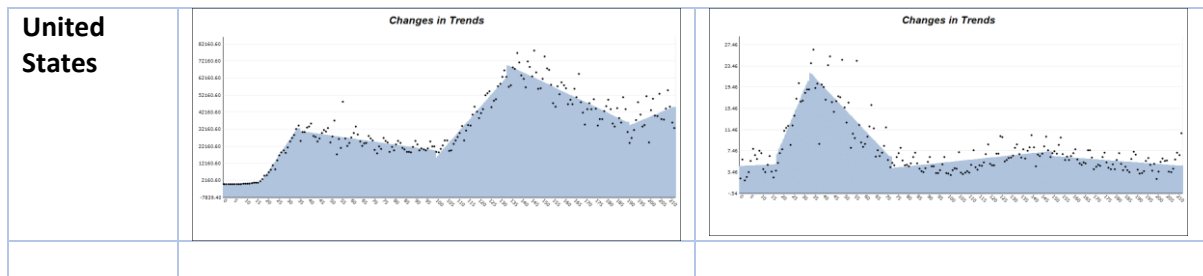
Table 8 shows that case reporting provides a misleading picture. Most of Europe is panicking because the cases have gone up but so has testing. The prevalence estimate based on testing percentage shows that prevalence is not going up dramatically as case reporting implies. The USA's prevalence at the time of writing this report is going down not up. The reason is increased testing.

There are no big second wave increases of the same magnitude shown by the cases that are causing lockdowns. Of course, this does not mean that prevalence will not increase, later. France in Table 8 is showing an increase and end of year figures do have an increase as reported later.

The above figures are as at October the 8th. A reanalysis as at end of 2020 draws similar conclusions.

Later in Section 100 it will be shown that reported deaths correlate much better with proportions than cases, supporting the fact that proportions are a better estimate of infections.

There are caveats to the above

- Testing results are not reliable. Different countries use different test methods. Some countries report number of tests carried out, others report people tested and other samples taken.
- Delays between testing and results vary.
- There is more to the data which will become apparent below.
- Testing data was not available early in the pandemic and hence data on the left side is incomplete.
- Using case percentages relative to tests is not a reliable way of estimating prevalence due to biased sampling.

Section 12 discussing Europe's current crisis has more updated charts.

The fact that test numbers of effect cases has been acknowledged as early ago as May, e.g.

As you can see, the number of confirmed cases provides a good snapshot of the outbreak across countries, but it is heavily dependent on how many tests a country is doing: if you don't test for coronavirus, you can't find it.

https://www.abc.net.au/news/2020-05-13/coronavirus-numbers-worldwide-data-tracking-charts/12107500?nw=0

The question that must be asked is if you need to test for it to find it how dangerous is the virus? If the virus were so dangerous people would feel sick with it and check themselves into a medical centre. It is hard to conceive a bi-polar virus that either kills or has no other effect that justifies checking into a medical centre. The only explanation is that the virus itself is harmless with healthy people. Appendix A 5 reports that the chance of death for anyone below 70 without comorbidity is close to zero. We have however not confirmed this independently.

8.2.2 Fools in paradise.

If samples are taken from the population (as they are for testing purposes) those samples provide a loose estimate of the symptomatic cases in the population, because positive test results are obtained mainly from symptomatic patients. To be strictly correct, we can say that testing samples provide an estimate of case equivalents in the population.

Consider the UK. The same arguments apply to other countries. Now the UK would have around 5% symptomatic cases, the equivalent of 3.4 million cases compared to approximately 5000 currently reported.

Unfortunately test samples are not taken to estimate prevalence but are used for contact tracing and quarantining. So, the estimates are only a ball-park figure and must not be treated as absolute fact.

So, are these estimates realistic? The reality is we do not know because the science behind case reporting is so bad.

But, to provide some perspective, in Australia over 50% of the population catch the common cold in Winter and 25% in spring. People working in hospitals catch it six to twelve times a year.

https://lungfoundation.com.au/patients-carers/living-with-a-lung-disease/other-lung-conditions/the-common-cold/

Thus, in Australia between 13 million and 17 million people are infected with a common cold virus every year.

The numbers are thus not impossible. Until we get used to that fact that the case numbers reported grossly underestimate the real numbers, the sooner we can accept case numbers in the millions and use more rational science to determine if there is a threat to humanity.

The question must be begged. If the reality is that there were and/or are thousands and even millions of case equivalents in the population, why do we ne not have thousands and millions of people presenting themselves to medical clinics if the virus is so bad?

8.3 Jumping to Conclusions.

Jumping to conclusions and accepting conclusions by others without question is a major problem that we have noticed over the years with experts. One cannot effectively manage a virus by jumping to conclusions.

Anyone that has participated in day trading on the stock market will know how experts jump to conclusions by associating market events with price fluctuations. As dismayed traders know, none of the reasons ever have repeatable responses.

This section will review the alleged successes of Singapore, Japan, South Korea, Taiwan, and Vietnam to see if these countries were as successful with their alternative strategies. If they were then the question must be asked why did countries flatten their economy and destroyed lives when they could have just followed the same strategies as the 5 countries listed? If they were not so successful after all, then why have countries added to the stress and loss of civil liberties by following strategies that have not been proven to work.

8.3.1 Singapore

These were the headlines around March 05, 2020

5 things we can learn from how Singapore has managed the Coronavirus crisis

Singapore contained Coronavirus. Could other countries learn from its approach?

Singapore's cases as at March 04, 2020 the cases are shown in Figure 8.2
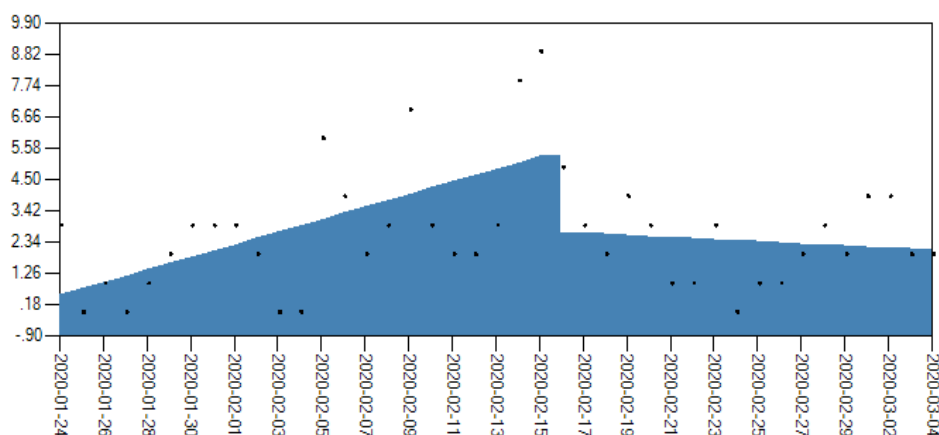
Figure 8.2 Singapore cases as of 4th of March 2020.

The conclusion was that Singapore was highly successful keeping its cases below those experienced by European countries.

The suggested reasons

- a top-notch health system
- tracing and containment measures
- a small population that is largely accepting of government's expansive orders.
- Use of an app tracing system
- Strict hospital and home quarantining

We should never assume that all countries follow the same pattern as other countries. Just because some European countries experienced rapid infection rates at the beginning should not have resulted in the belief that Singapore would follow an equally fast path. As those who travel extensively know, every country is different, even neighbouring. This mistake resulted in the belief that Singapore beat the pandemic with many countries trying to emulate Singapore without success.

The second mistake, which is the norm today, is to search for reasons of success and then believe them. This does not mean that the suggested reasons were not the reason. The mistake is to blindly believe what may just be coincidence and then follow actions based on unproven facts. If the conclusions were wrong a lot of resources could have been wasted and a lot of stress could have been caused unnecessarily.

The reality for Singapore is shown in Figure 8.3
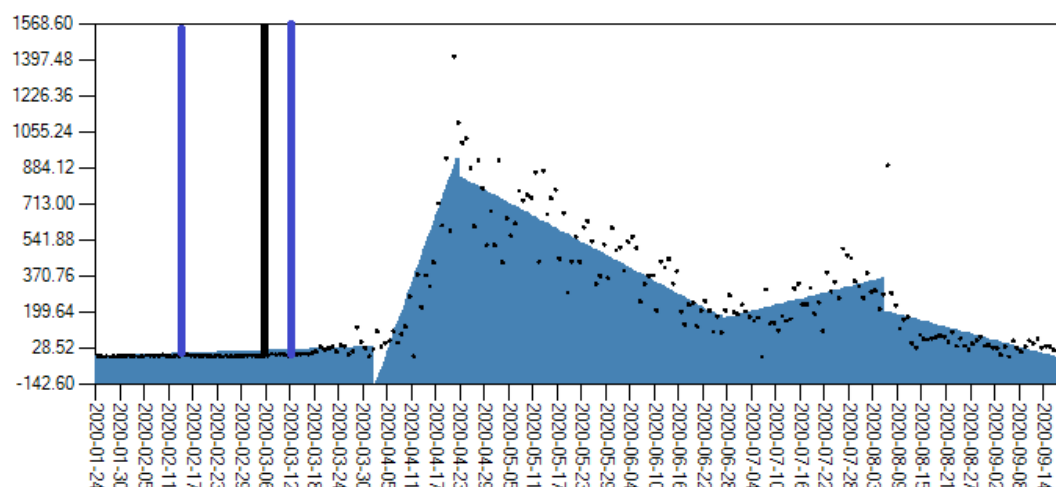
Figure 8.3 Singapore cases as of 30th September 2020

The blue lines show where WHO complimented Singapore for its success. The black line is March the 5th around which time the world was 'mesmerized' by Singapore's success. The period displayed in Figure 8.2 had such tiny cases that it does not even appear as a glitch in Figure 8.3.

The data shows that Singapore's top-notch health system, tracing and containment measures, small population, quarantining did not stop the cases. There was no success story. None of the reasons are unique to Singapore. Italy has a top-notch health system. Most countries had strict quarantining. None made a proven difference as will be shown later in this report.

8.3.2 South Korea

South Korea it is said flattened the curve quickly, without closing business, stay at home orders. Instead, its success was attributed rapid action, to its high testing frequency, contact tracing, and ensuring its health system met the demand.

Figure 8.4 shows South Korea's case performance as of the 31st of December 2020
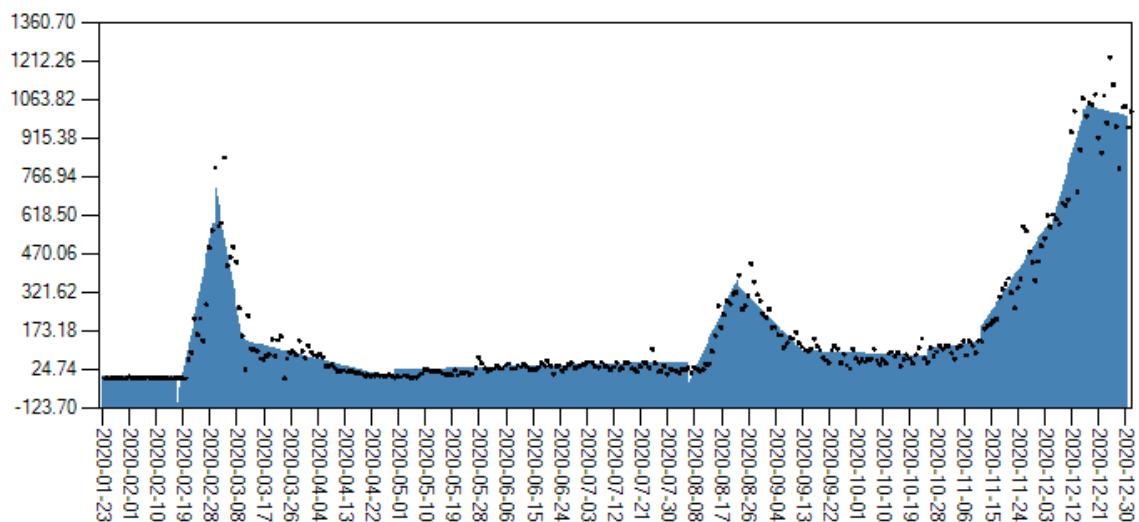
Figure 8.4 South Korea's case performance as of the 1st of October 2020

The facts are that South Korea took a long time (over two months) to reduce its cases to levels that existed at the commencement of the curve. Its system did not stop a second wave from recurring and definitely not a third wave.

As will be reported later many countries, such as the USA and Italy had higher tests per million than South Korea and still had more cases per million. Countries without a high-test frequency flattened the curve much faster.

There is nothing that South Korea did that has not been done in other countries. It is foolish to jump to conclusions by concluding that South Korea's strategies are responsible for its perceived success. It is foolish to assume that other countries could not do it as well as South Korea, This, does not mean the strategies made no difference. They must have to a degree. It means that there is no magical cure all.

South Korea has now has a third wave, showing that the world jumped to conclusions. Its testing and tracing program was not so effective. Tracing can work at the beginning but one a virus takes hold it becomes impossible. We have talked to several people involved in tracing and behind the scenes the situation differs to what is said in public.

As with Europe test numbers have exaggerated the severity of the problem.

8.3.3 Japan's Success Story

Nothing that Japan has done has not been done by anyone else. But notably it has not tested extensively at the beginning at least.

The world first reported on Japans success story late March. At that time, the situation was as shown in Figure 8.5.
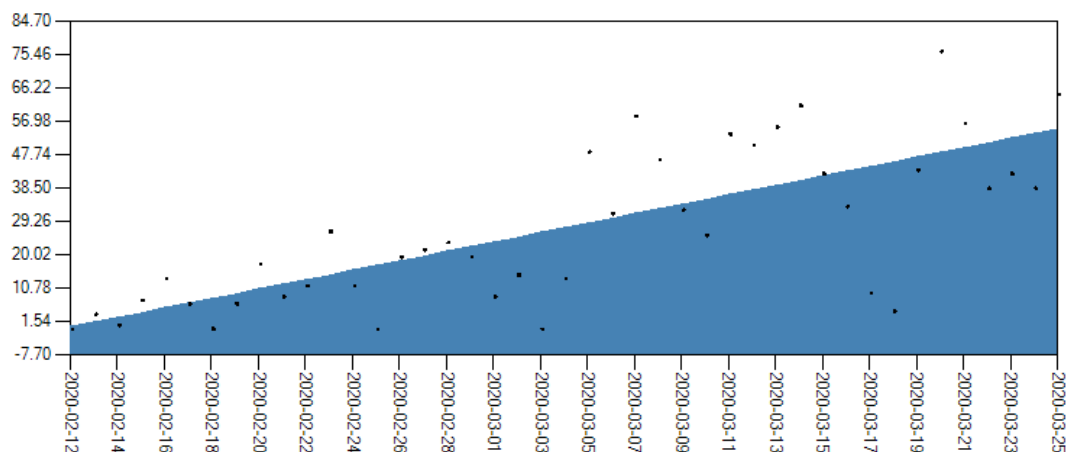
Figure 8.5 Japan's case history as of March 5th, 2020

It is difficult to comprehend how with an upward slope it was concluded that Japan was successful. Perhaps a basic bar chart was fitted a classroom technology curve which concluded flattening. Figure 8.6 shows such a possible fit which would have resulted in drawing the wrong conclusion that Japan flattened the curve.

Perhaps the conclusion was based on the low cases.
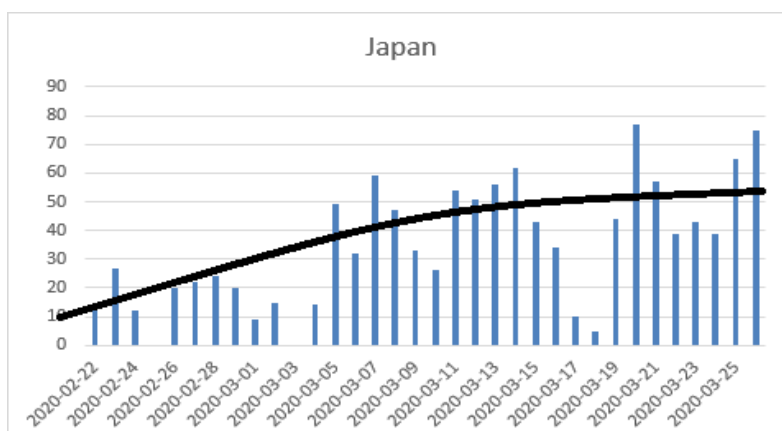
Figure 8.6 fitting of a classroom curve to the data.

Total tests until the 25th of March were around 40 per million people with total cases of around 9 cases per million.

For the same time-period Malaysia performed 589 tests per million with around 50 cases per million

It has already been said in Section 8.2.1 that case reporting is unscientific and flawed because cases depend on number of tests performed. Malaysia performed many more tests and found more cases as expected.

It is thus possible, though not guaranteed, had Japan tested as extensively as Malaysia it could have had 16000 cases getting to European standards.

Figure 8.7 shows what happened to Japan's cases since the initial euphoria. The trend in Figure 8.6 did continue, unlike the flattening conclusion. Eventually it came down by 'itself'.
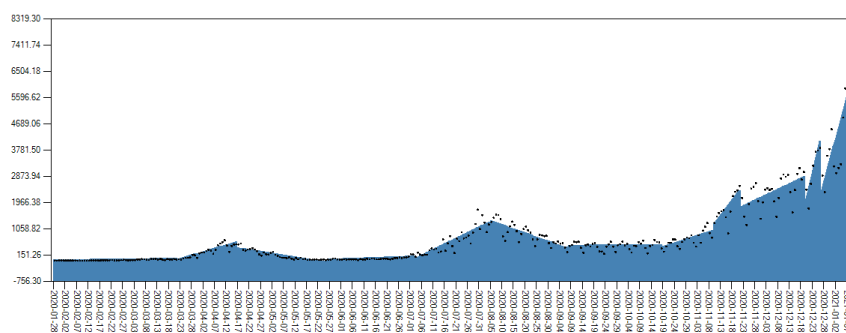
Figure 8.8 Japan's cases as of 31st December 2020

As currently with the second waves in Europe the cases have been exaggerated by test number changes.

There is now a third wave which has been grossly overexaggerated by testing. When plotting proportions (case positivity) there is no third wave, however the test numbers are 'dirty' and cannot be relied on and hence no conclusion will be made.

8.3.4 Taiwan's success story

Victoria, Australia has used its success as a basis for justifying its lock-down based on Taiwan's aggressive strategy.

The reality, without wishing to discredit Taiwan, based on reports seen (perhaps there are others), is that Taiwan has hardly done anything, other than travel restrictions, hand sanitizers and other things most other countries have already done. Of course, this is a matter of opinion, but if there were compelling evidence that Taiwan did something that caused its low cases and deaths there would be no opinion, just unanimous agreement.

"Why Taiwan Has Just 42 Coronavirus Cases while Neighbours Report Hundreds or Thousands"

https://www.voanews.com/science-health/coronavirus-outbreak/why-taiwan-has-just-42-coronavirus-cases-while-neighbors-report

There **may** be an obvious reason for its low cases which was not seen because of the failure to recognise that case reporting is unscientific when cases depend on test numbers.

First, Taiwan is a small island. If borders are quickly closed then as with other islands, such as Australia controlling the virus is much easier than for European Countries.

Taiwan only had tiny testing numbers. When you have tiny testing numbers you will not find cases. Applying percentages Taiwan's situation is like Australia's. Taiwan may thus have had many more cases but was not aware of them. Its test numbers were only a few hundred per day. Its cases are statistically consistent with such a small test number.

Of course, if prevalence is low than increasing test numbers will not compensate for the low cases. The estimated prevalence was no lower than Victoria, Australia's which has higher case numbers in proportion to higher test numbers. This implies that Taiwan's success story is partially, if not completely explained because it did not test much.

This also shows how harmless the virus maybe from one perspective. If extensive testing is required to identify cases symptoms must be negligible for most of the population. It is hard to accept that a deadly virus has no symptoms worth presenting to medical clinic without influence for most of the population.

Without aggressive actions Taiwan had only SEVEN deaths.

8.3.5 Vietnam's success story

The same conclusion is obtained for Vietnam's low case numbers.

Vietnam has prided itself with taking early action. For example, when the first virus case was confirmed an emergency plan was put into place. Others may have been slower but did other things. Experts noted Vietnams low obesity rate. We found no relationship between obesity, age and infections and deaths.

Nothing that Vietnam did, was not done by others. Unfortunately, it is impossible to disprove statements for reasons of success, but neither is it possible to prove them. If we are to manage the virus scientifically it must be based on reasonable evidence. Unfortunately, reasonable is subjective.

One factor attributed to Vietnam's success is that as of the 29th April it performed more tests per case than any other country. All that means is that the proportion of cases was very low. In fact, 0.1%. That only means that the virus may not have spread, or Vietnam did not look hard enough because its tests per capita are low.

Cambodia and Laos also have low cases and low deaths. They were not as prepared as Vietnam. They too had low tests per capita. If you look for trouble you will find trouble.

8.4 Case heterogeneity between countries

Science has been used extensively as the basis for containment actions. This section is meant to demonstrate that there is no science in assuming that without aggressive containment action we would have reached Italy's and other high case numbers. There is too much variation from country to country. Each country is different.

Figure 8.8 is a histogram of total cases per million people as of October 1, 2020. It shows that the distribution is highly skewed meaning that the most countries are not at extreme levels. However, we must not forget that cases are misleading because cases depend on test numbers.
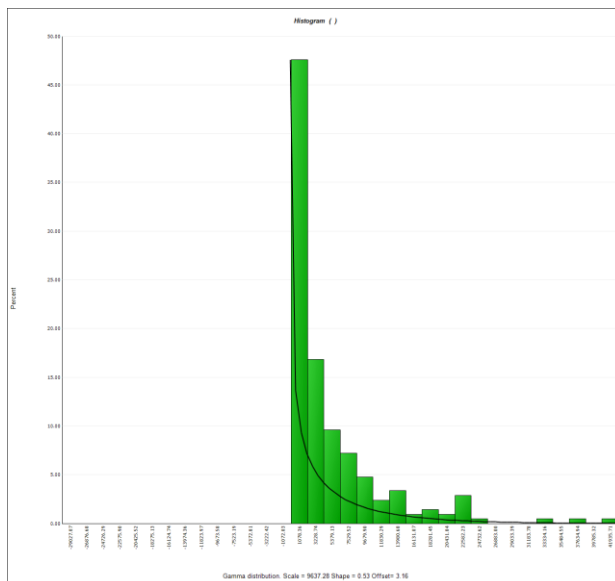
Figure 8.8 Histogram for cases of all countries monitoring Covid-19.

Cases vary between 3 to 43000 per million (Qatar).

Perhaps Qatar's nose rubbing greeting social habit is the cause for the large number of cases!

Yet Qatar' total deaths count is 245. In Qatar, the virus can hardly be called deadly.

Figure 8.9 is the histogram for proportions. These are based on number of tests.
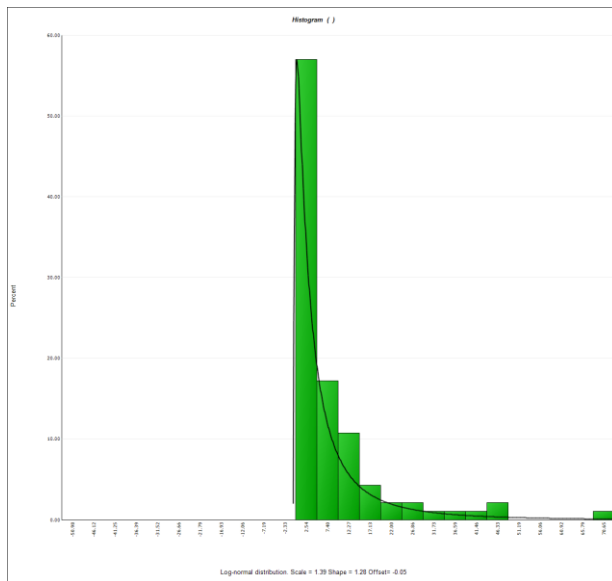
Figure 8.9 Histogram for percent proportions of all countries monitoring Covid-19.

The conclusion is the same. There is too much variation from country to country to make decisions based on a few outlying countries.

8.5 Case Study for Australia and Victoria

8.5.1 Australia

Australia has prided itself as being the envy of the world, that we have done better than other countries. As of 31st August 2020, 35% of the world's countries had a lower number of cases per million than Australia. This included Egypt, Indonesia (just), Sri Lanka, Yemen and countries that did much less to mitigate the virus, such as Japan.

A study reported on the 28th of January 2021 differed by reporting that Australia ranked 8th in the world according to a study which used 14 day moving averages to base their rankings.

[Australia's COVID response ranked eighth best in the world, behind Rwanda and Iceland | 7NEWS.com.au](#)

There are scientific flaws with this type of analysis. Using tests per thousand people is not a valid criterion, for determining effectiveness of the response. It is just a response mechanism, which is not the same as effectiveness. Use of moving averages is fraught with problems.

Our own analysis does not concur with the conclusions. Australia did not perform anywhere near as well. Many countries had better performance. Scientific mediocracy has been demonstrated with such a simple comparison. Australia and New Zealand (low population) being islands have little problems containing a virus when compared with countries such European countries where boarder control is not so easy. It is thus not correct to conclude who are the better performers with taking all factors into account.

In fact, Australia was the only country, that started lockdown after its first peak had reached. Cases were on the way down as shown in Figure 8.10. This can hardly be called responsive.

If anything, lockdown slowed down the rate of decrease in cases.
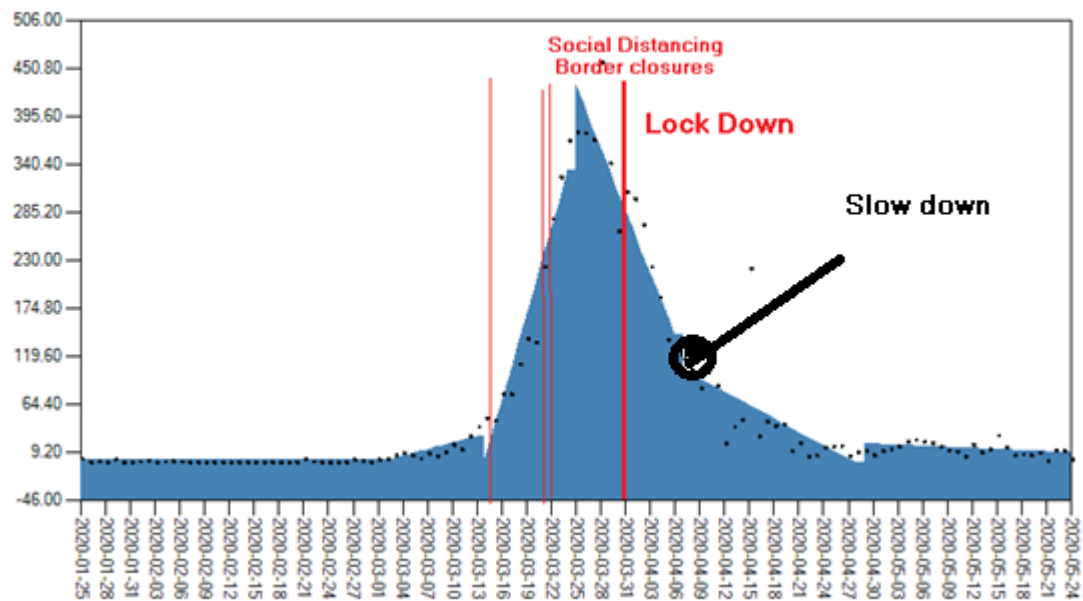
Figure 8.10 Australia implementing lock down, after the peak had already been reached.

Other countries started at the beginning of the infection rise, such as Italy, France, and Spain. Figure 8.11 shows examples. Please note a slowdown kink like Australia's.
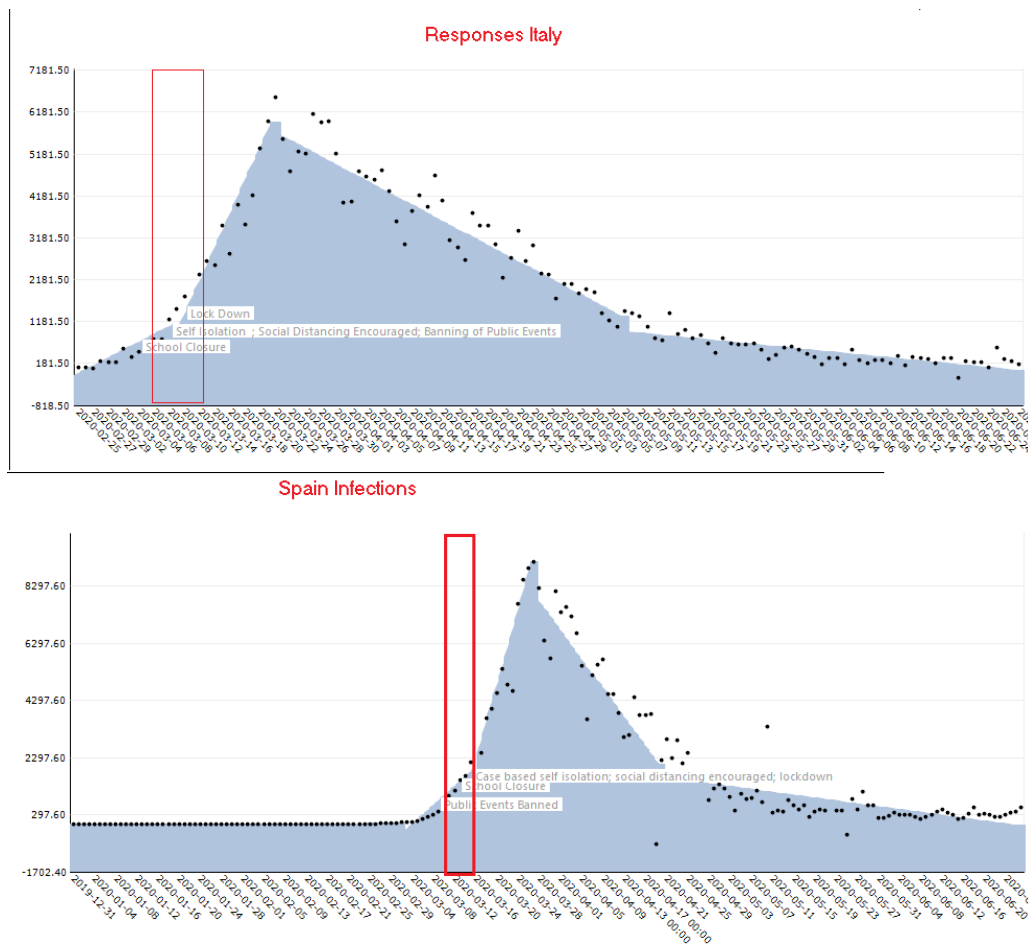
Figure 8.11 Infection polygons for Italy and Spain.

The first side of the rectangle is when some minor mitigation efforts were put in place and the second full lockdown.

8.5.2 The folly of using incidence rate in Australia's case

The above used incidence rate reporting because that is all that Australia and other countries is currently able to understand.

When applying incidence rate reporting to all of Australia's data we obtain the chart shown in Figure 8.12. The large cases increases are due mainly to Victoria.
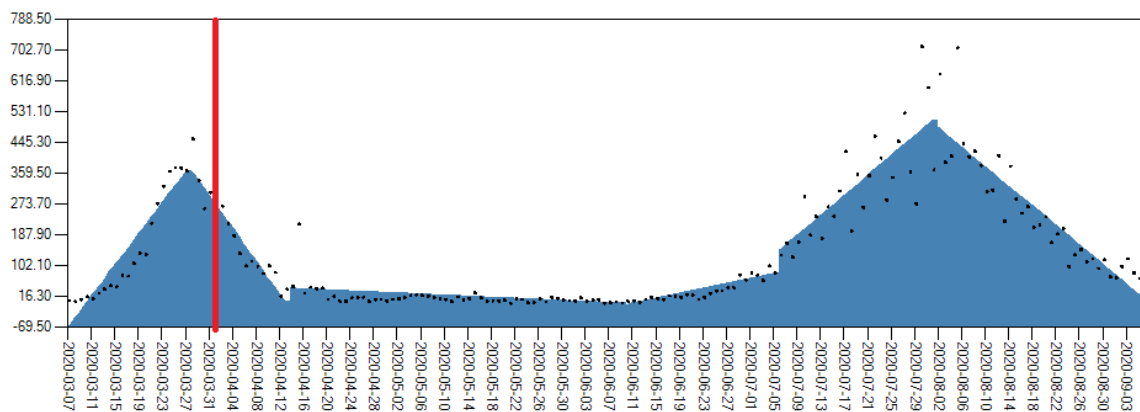
Figure 8.12 Cases for Australia

When applying proportions to Australian data we obtained a different picture as shown in Figure 8.12
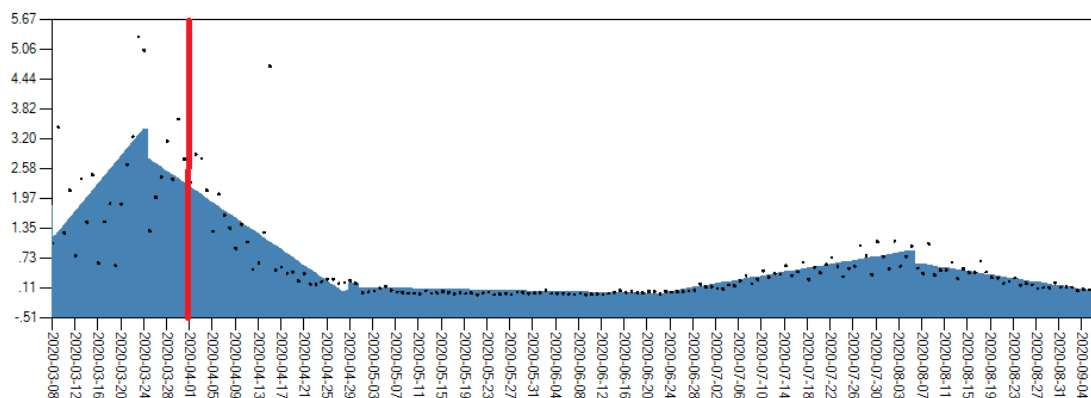
Figure 8.13 Proportion of cases in test 'samples' for Australia (considering delays between testing and release of results)

Plotting proportions shows that the actual symptomatic infections in the population has not deteriorated as much as cases imply. They also show that lockdown was too late and most likely unnecessary because proportions were already coming down by themselves. This is not uncommon. Colds and seasonal flus also come down by themselves.

The proportions at the two peaks were 3.2% and .7% respectively. This means the current infections are .21 times those at the first wave. Suddenly the situation is not as grim. However, prevalence estimates during the first wave were more unreliable due to lower test numbers.

The numbers will not be pleasant to Australia's politicians. If the estimates based on test size are reliable estimators (which they are not) of Australia's population then at our first peak, we had 832, 000 infections (small next to the common cold numbers of 12 million+-). At the second peak we had 175000 infections across Australia at the peak and end of September 15000.
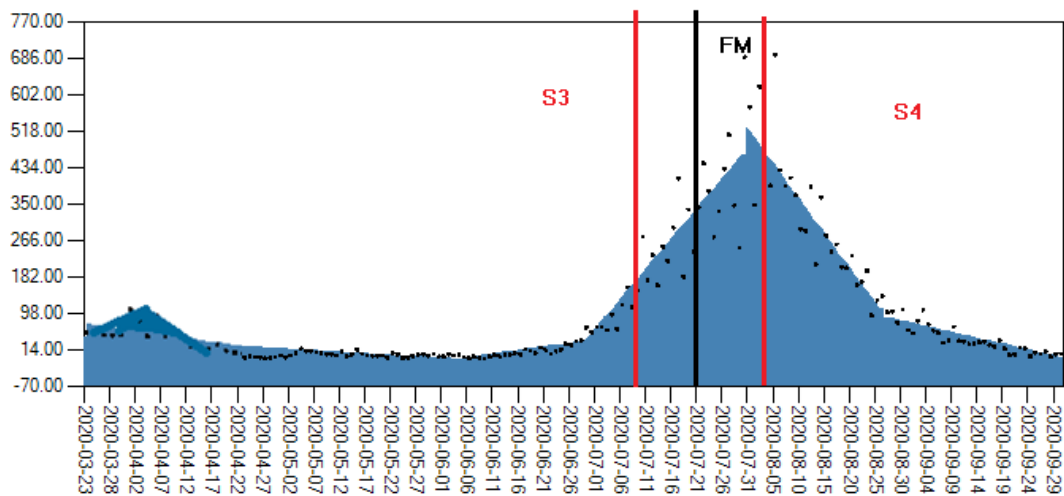
Figure 8.14 Cases for Victoria 23rd of March to 1st of October

"An urgent health warning has been issued for five suburbs in Melbourne's north after a primary school student who should have been isolating sparked the new outbreak that has been linked to two schools and a public housing block."

https://www.msn.com/en-au/news/melbourne/victoria-records-five-new-coronavirus-cases/ar-BB1agRhu?ocid=msedgdhp

No country can manage a virus if it fears the virus so much.

Referring to Figure 8.14, If we consider cases only, we will conclude Stage 3 made NO difference. The time between commencement and downturn is 3 weeks. Something should have happened within 7 days according to many scholars. Stage 4 made no difference because cases were coming down immediately, if not earlier.

Facemasks may have made a difference. But, analysis, on effectiveness of face masks in other countries, has shown no effect. It is possible that face masks plus Stage 3 made a difference, but there is no evidence. The effect of face masks will be covered later in this report.

Interestingly Victoria used bad science, shown in Figure 8.15, to convince the public that Lockdown 4 was effective. It was not.

The introduction of Stage 4 restrictions helped us speed things up, and cases are now halving every 18 days: more than twice as fast.

Keeping Stage 4 restrictions until case numbers are low enough to safely reopen will enable all Victorians to get back to COVID-normal, faster.

Victorian 14-day new case average. *(Supplied: Victorian Government)*
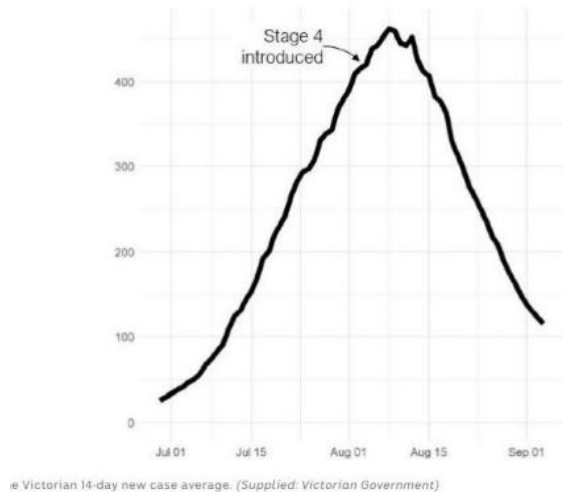
Figure 8.15 Effect of Lockdown 'proved' with a moving average of 14.

The science is bad because moving averages always lag. To demonstrate the point Figure 8.16 shows two linear lines with a change at point 30
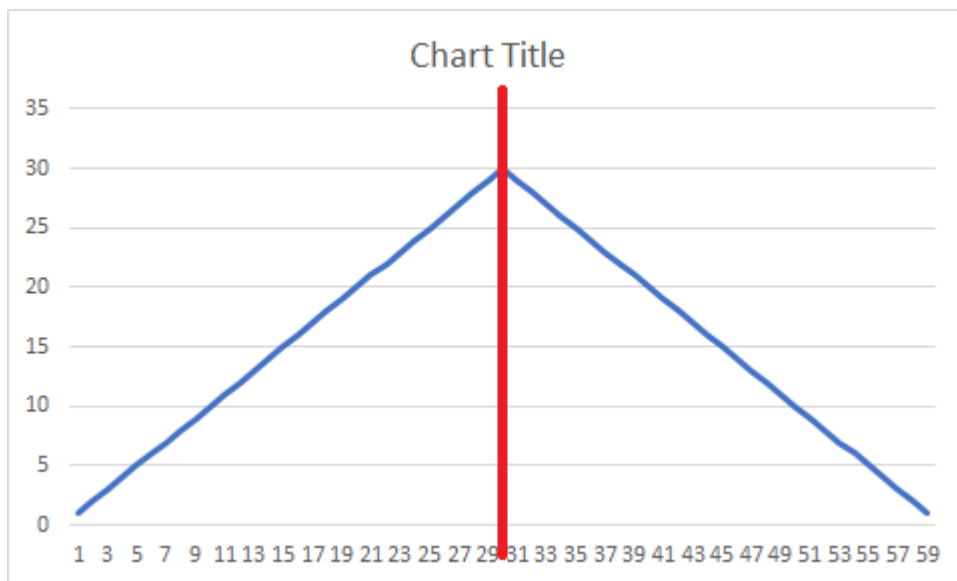
Figure 8.16 Base data to demonstrate the lag of moving averages.

Figure 8.17 shows the data with a moving average of 14 applied.
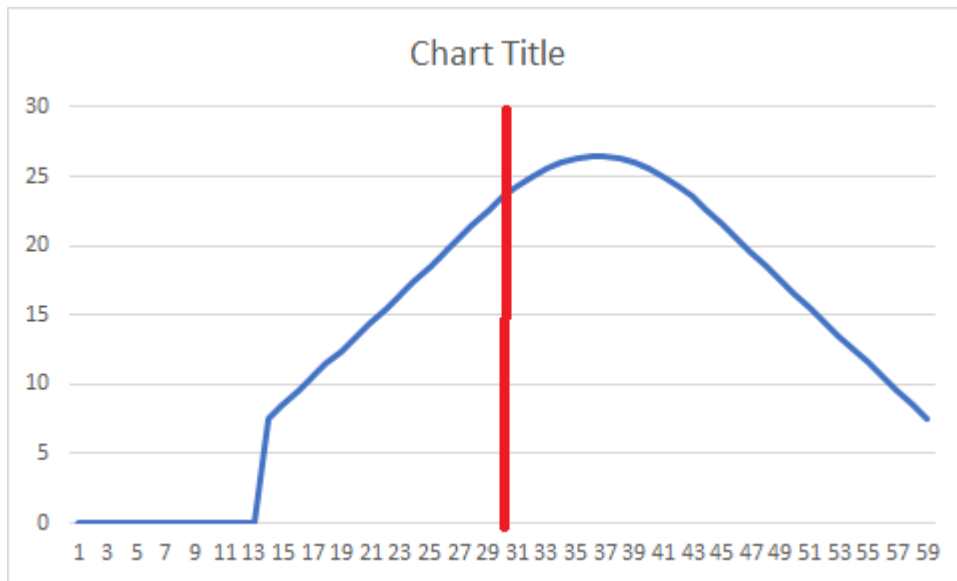
Figure 8.17 Applying a moving average of 14 to the data used in Figure 8.16

The zeros at the beginning are space holders because no 14-day average can be calculated since less than 14 days

The change occurred 7 days after the known change (because the average age is 7 days for the moving average). Just like for VIC

One can argue that had we not had lockdown cases would have gone up, such shown by the orange curve in Figure 8.18
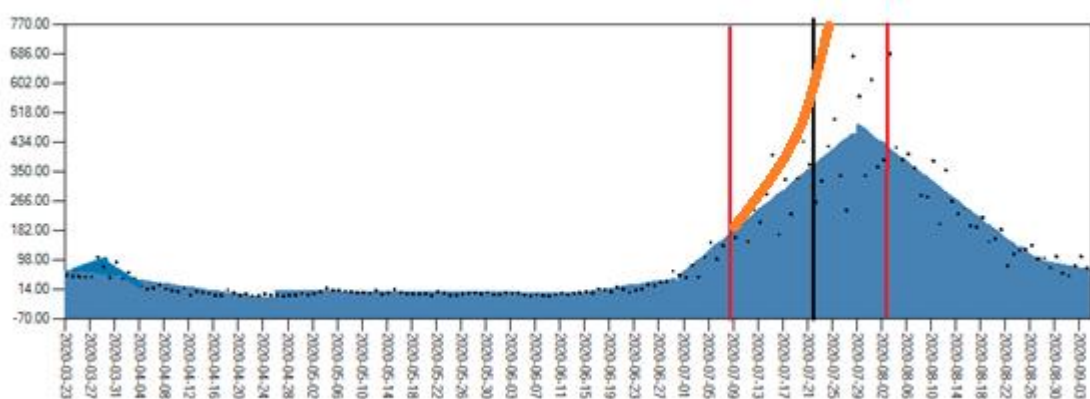
Figure 8.18 Cases for Victoria with an imagined increase.

Arguments such as these are common because it is impossible to disprove the possibility. But it is also not possible to prove the possibility and hence no further time is wasted on hypothetical unscientific conjecture.

Figure 8.19 shows the proportion of cases relative to test sample size - the correct way.
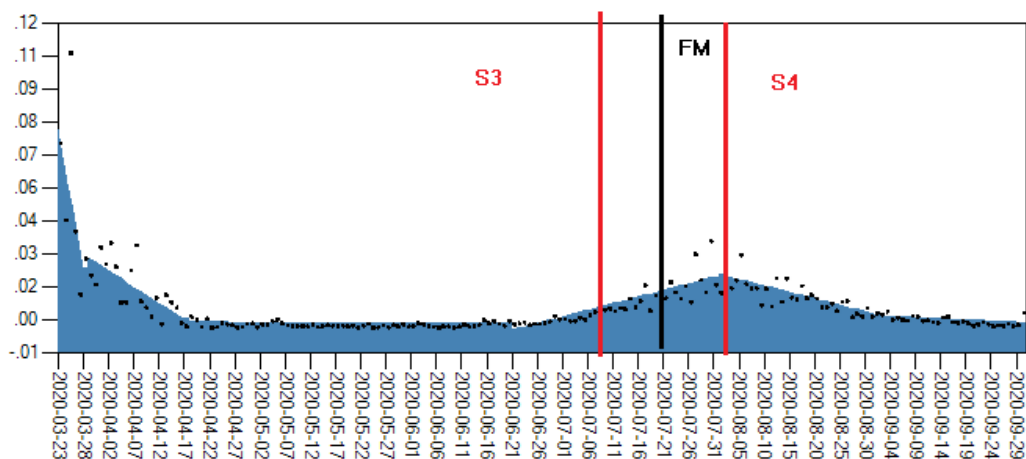
Figure 8.19 Proportion of cases for Victoria 23rd as of March to 1st of October

Now the second wave is much less severe. The relative magnitude between the two crests has reversed. This is the real situation, not the one implied by case reporting.

There is still no evidence that lockdowns made a difference. Stage 4 **was implemented on the peak.** Given that it takes around 7 days before an impact of mitigation is noticed Stage 4 had no impact. Infections were already coming down. One can again argue that Facemasks caused the reduction on the 3rd of August, but that is only speculative. What is certain is that Stage 3 and stage 4 alone are not responsible for the down- turn. The downturn may have happened without intervention. This is not abnormal.

Our analysis has shown similar effects in other countries. For example, Japan, shown in Figure 8.20 had a peak which came down seemingly by itself.
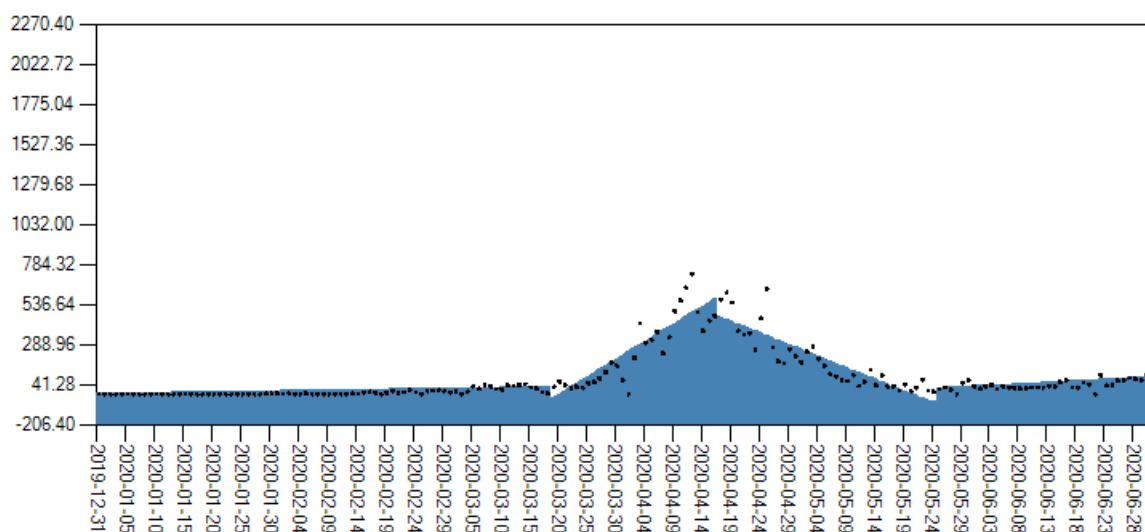
Figure 8.20 Cases for Japan 13rd of December 2019 to 28th of June 2020

Japan did nothing that could have an effect during this period. The reader can refer to https://en.wikipedia.org/wiki/COVID-19_pandemic_in_Japan to determine what little Japan did during that period, yet infections came down. (They are now going up again)

8.5.3.1 Victoria's justification for lockdown
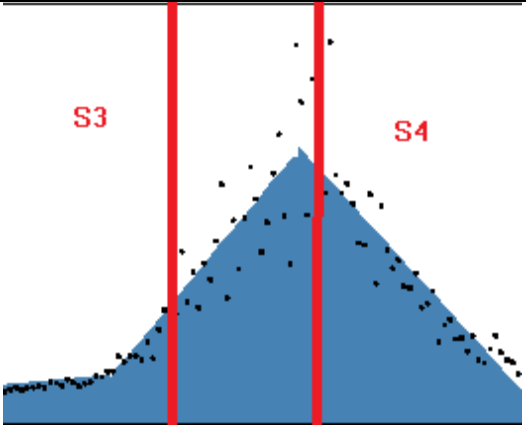
The Victorian Governments Modelling Report extracted on the 10th of September 2020

https://mobile.abc.net.au/news/2020-09-06/victoria-coronavirus-covid-19-lockdown-restrictions-modelling/12633906

The report was meant to justify lockdowns. Table 8.1 below will list the elements in column 1 and make comment in the second column based at the time of the report. Some numbers have since changed but the conclusions remain.

Table 8.1 Victoria's modelling report

Around the world, countries are struggling with the pandemic. Some have never emerged from their first wave	Countries are struggling NOT because of the virus, but its reactions. This is a statement that has no perspective. We have viral waves every year. Every year the common cold infects over half of Australia's population.
COVID-19 has caused 26 million global infections and 1 million deaths **Many countries have never emerged from their first wave**	Yes, and by end of year it was 85 million. The USA according to the CDC estimates up to 8 to 45, million illnesses due to the flu virus annually and the USA is 4% of the world's population. Up to one billion flu infections are found in the world each year.
Almost a million have died.	Global road Injury deaths are 1.24 million each year. If the number of deaths is a justification for lockdown then we must now ban all cars.
In many countries the virus was allowed to spread for weeks, or even months, before containment measures were put in place.	Many countries that did not put significant or any containment action in place did not have run away deaths. Taiwan is an example. Those that did had many deaths, such as Italy.
In Victoria, cases peaked at just 104, of which 48 were acquired through local community transmission.	This statement is irrelevant to justifying lockdown. We did not just have 104 cases. 104 was what we found using small sample sizes. We did not test every Victorian. At the time of the initial peak the estimated proportion was about 4 %. Dependent on the population representativeness of the tests, Vic may have had 240000 cases. Because we used no data science, we now wonder why there are still so many infections. Everyone is infected with viruses throughout the year. In Victoria approximately 3 million adults +- are infected with the common cold each tear
Some of these people will live with permanent disability arising from COVID-19. 20 lives were tragically lost.	All deaths are tragic but life without death is impossible. Car accidents result in far more horrific disabilities. Are unproven COVID

	disabilities worse. What can be worse than paralysis, or loss of limbs?
	20 lives is a tiny amount compared to all losses of lives.
Modelling published in April showed the much more catastrophic outcome that would have happened in the absence of intervention.	Models are always wrong. Every model this year has grossly over predicted deaths. The models used by the government were highly flawed. Models have no place in a 'court of law'. They are not evidence just a reflection of how the mathematician imagines the real world. Data driven science shows that there is no evidence that the interventions made a difference. Indeed, Victoria had the most aggressive strategy, but highest reported infections and deaths.
Outside Australia, New Zealand, and Taiwan, which have pursued aggressive suppression and elimination strategies, these (second waves) have been common.	New Zealand declared a public emergency with zero deaths. No further comment will be made other than what hope is there if we destroy economies before there is evidence of an impending disaster. Taiwan has not had an aggressive strategy. No lockdown which is most aggressive. Taiwan is an island which is easier to control. The number of people it tested are very low. It had 3 waves. Taiwan had very small test numbers, mostly around 150 people per day. If you look for trouble, you will find trouble. Taiwan did not look and thus only had a few cases.
Stage 3 restrictions helped slow the growth of coronavirus cases, but even with masks, cases were taking 49 days to halve. **The introduction of Stage 4 restrictions helped us speed things up, and cases are now halving every 18 days: more than twice as fast.**	 Stage 3 cases NEVER halved. There was no reduction. Cases after stage 4 were already coming down. Stage 4 cannot be concluded to be responsible for the reduction.

Spain's hospitals are reaching capacity again	Probably because of panic. Overwhelming of hospitals is common during flu seasons but we all accept it. https://www.abc.net.au/news/2020-02-11/early-outbreaks-to-blame-for-worst-flu-season-on-record/11949320 According to the above ABC report "More than **310,000** people presented to Australian health services with influenza in 2019, marking the country's worst flu season on record" "Hospital beds full and staff sick Queensland Health Minister, Stephen Miles, said the intense season put a major strain on hospital and health services nationwide, which would have to incorporate early outbreaks into future planning." Spain at end of 2020 has not had changes in registered deaths

Many epidemiologists have warned that we need to accept that the virus is here to stay and probably everyone will get it. But they were accused of being outrageous and sensationalists.

Outrageous is destroying lives to save lives.

8.6 Community infections and hotspots

The science behind community infections and hotspots is missing. Victoria, Australia has had the longest lockdown and one reason given is that we have had the most community transmission. That has not been proven. There is another problem which has been overlooked and that is one of sparse distribution combined with low testing numbers.

Hotspots are areas where there are more concentrated amounts of infections than normal for the whole population. The concept of hotspot is not new. Chocolate manufacturers must contend with hot spots in chocolate weevils and cigarette makers with tobacco beetle infestation. These are usually distributed throughout a few pallets of batches. To the naïve control is easy, just destroy the offending pallets. Destroying only these pallets gives a false sense of security. Invariably small numbers have reached other pallets and in a matter of time these suddenly become new hotspots. It is no different with the Cobid-19 hotspot strategy where we focus on what we think is a hotspot and then feel we have beaten the virus.

There seems to be little understanding of sampling theory. Based on tests some cases will be identified in some Victorian Local Government Areas (LGAs) and not others. Just because we did not find cases in some does not mean the infection rate was less. The number of tests is too low to draw conclusions in the various LGAs. For example, the number of daily tests on average in each Metropolitan Melbourne LGA is around 321 tests as of October the 5th.

https://www.dhhs.vic.gov.au/coronavirus-testing-data-local-government-area

The estimate of prevalence in Victoria as of October the 5th is 0.1%. Thus, on average we will get less than 1 confirmed case per LGA. But because of sampling variation sometimes it will be 2, but rarely, not often. That is exactly what the reported statistics are showing.

For regional Victoria it is even worse. The average tests per day per LGA are only 35. It will be rare to have a positive case. Hence, we think Regional Victoria is a doing a better job when it is not.

Then, when by chance, we do get 1 or 2 in a LGA there is a fear of a cluster, and more restrictions, whereas the situation is no different than for other LGAs where due to low sampling we found nothing.

Section 9 Effectiveness of Containment Actions

The world destroyed itself out of fear of the virus through its containment actions. This section will examine how effective and consistently effective the actions were from country to country. If we can prove beyond doubt that some containment actions worked and some not then this may lead to more rational actions in future, instead of the slash and destroy strategy used by many countries.

There are some considerations that need to be explained now. The only way to be sure that a strategy works is through empirical experimentation where we knowingly infect a population. That is unethical. Even if we can, we can never be sure if the results of the experiment can be projected to future situations or other countries because the world changes continuously.

The only way we can be sure that a strategy worked for a country (even if not for others) is NOT through models, but empirical data analysis.

Containment actions included

- Closing borders
- Closing schools
- Isolating hot spots
- Social distancing
- Declaration of national emergencies
- Lock down
- Closing non-essential businesses
- Use of Face marks
- Testing and Contact Tracing
- Quarantining
- Public education

In this section we will examine the effectiveness of facemasks, testing/ contact tracing and lockdown.

The following is about evidence on whether the containment actions worked in practice. It is not about whether they work theoretically. If we live in a dome then it is clear we can not spread the virus, but we will suffocate unless we have an opening. Nothing is perfect.

Theoretically, all containment actions should work. The problem is the world consists of people, who are not perfect and have their own agendas and universe around them. Although somethings should work does not mean they will work in practice unless we destroy the fabric of our lives. Sometimes we need to accept reality, or we have no lives worth living for. This section is about whether containment action worked in the real world, consisting of human beings.

9.1 Effectiveness of Face Masks

The use of face masks is based on the belief that it will reduce the transfer of the virus. After researching the mandates issued by various countries, it seems that face masks were tried as an additional or last resort.

At the onset of the outbreak experts made it clear that face masks are ineffective. Initially, depending on the report read, only one type was recommended- N95. World opinion has now changed, and even face shields were approved by some countries as an option to reduce transmission.

After initial hesitation, experts are now convinced that face masks are an effective tool in preventing the spread of COVID-19.

"It is now abundantly clear that face masks are an important and effective tool in preventing the spread of COVID-19."

https://www.aljazeera.com/news/2020/04/countries-wearing-face-masks-compulsory-200423094510867.html

The fact that face masks can help in certain settings, is not disputed. Hospitals are on example. Even there one can argue if they are effective then why do hospitals have so many infection outbreaks?

Intuitively, in the perfect world, face masks will stop infectious droplets from spreading when a wearer is speaking, coughing, and sneezing. Clearly, we no longer believe that distancing rules will stop these droplets from spreading. The concept of diminishing return on investment is not understood. 1.5 m social distancing + face masks will not be twice as effective as either alone. Can we as human beings put fellow human beings through such requirements when one would be sufficient and the second only add a small extra benefit? One can respond by saying no single containment method works, so we must use all.

There are disadvantages in using facemasks

- Rebreathing our own air with Carbon Dioxide.
   How many health issues have been caused by elderly people having to breathe in less oxygen? Maybe none!
- Rebreathing the corona virus, or other viruses by people who are infected. According to our research, every time we breathe out a virus, it is mutated. Are we increasing the speed of dangerous mutation now by rebreathing? Will an infected person who keeps rebreathing a mutated virus increase their chance of dangerous symptoms?
- Bacterial infections due to unhygienic use of masks.
- If the virus spreads like the flu, through the air, it can still be transferred because masks are not that snug, or at least not worn snuggly.
- It is very stressful to have to breathe, through masks for long periods of time, even when no one is around.
- Loss of dignity. Many people think it looks wimpy to walk round as if there is virus lurking round the corner. They cannot 'lurk' because they do not even live.

"More than 50 countries require people to cover their faces when they leave home."

In this section we will report on whether there is any evidence that these countries have seen a reduction in infections after mandate.

Interestingly -
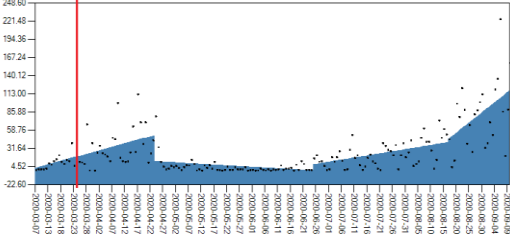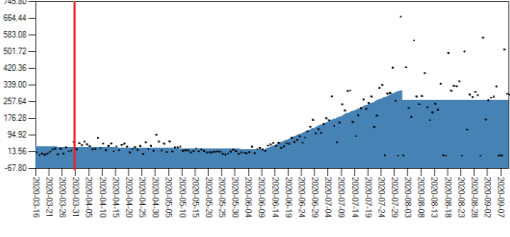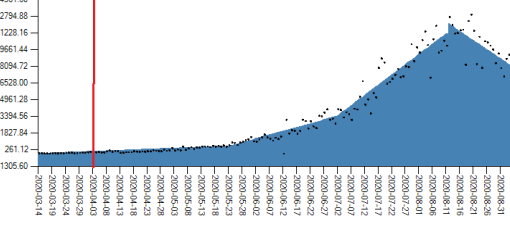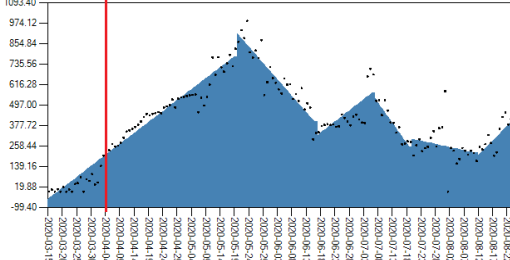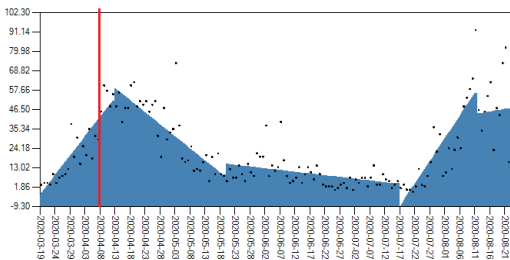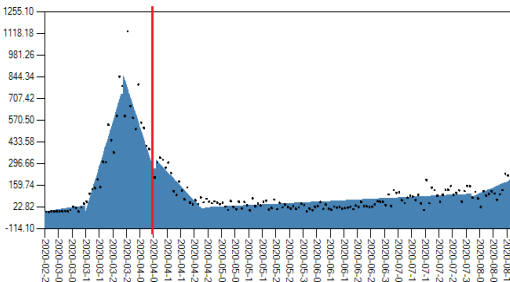
"The Robert Koch Institute (RKI) said despite there being **no evidence for self-protection**, covering the mouth and nose can trap infectious droplets that are expelled when the wearer is speaking, coughing, or sneezing. That is, face masks are designed to protect people from the wearer."
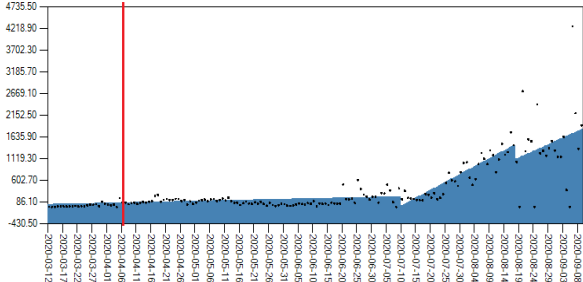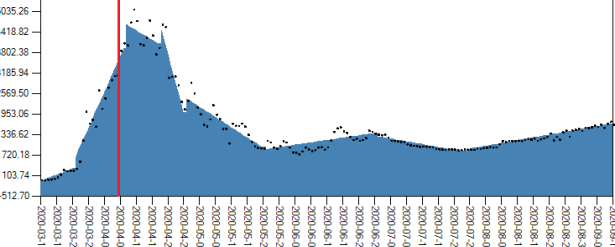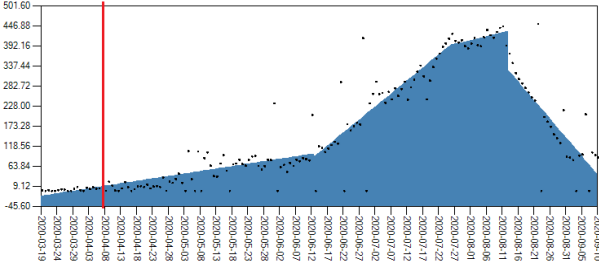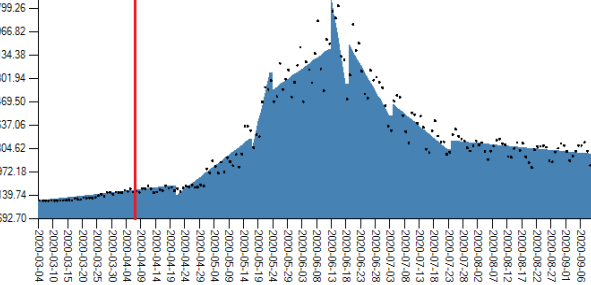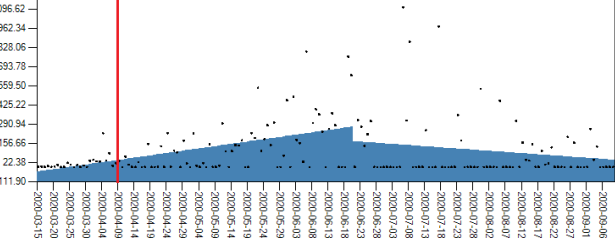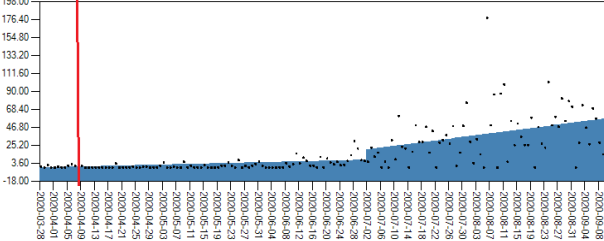
Table 9.1 visually shows the effect of face coverings for countries that have mandated its use.

The effect is not determined with mathematical models but actual data.
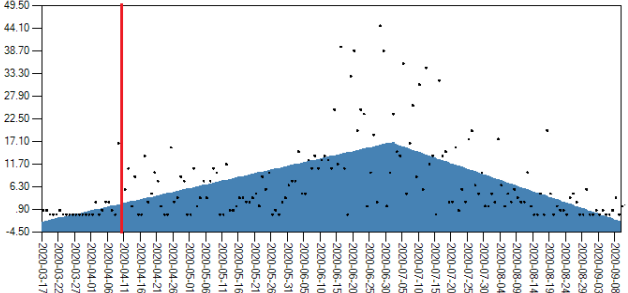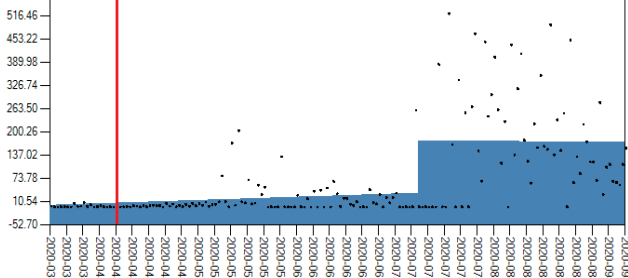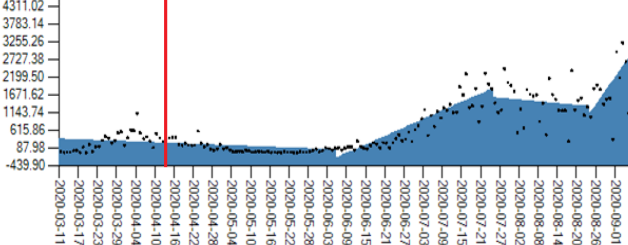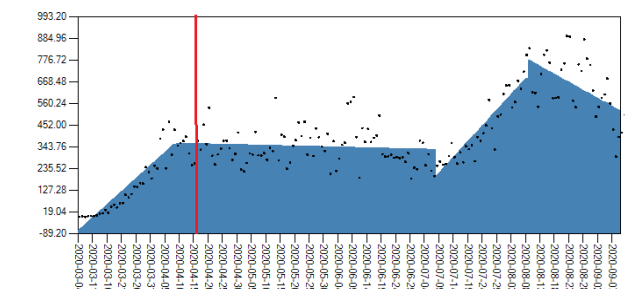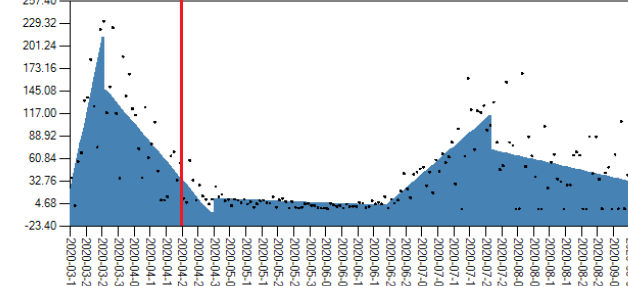
Table 9.1 Visual display of effect of face covering
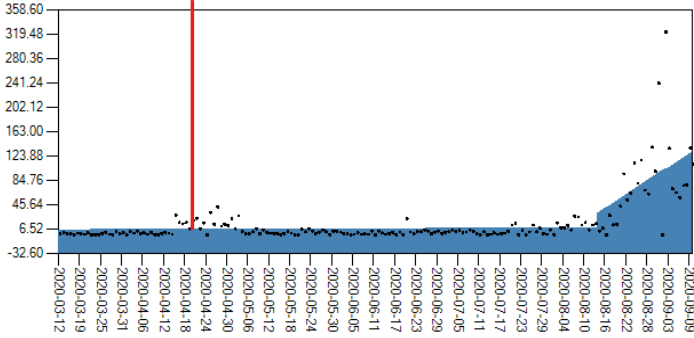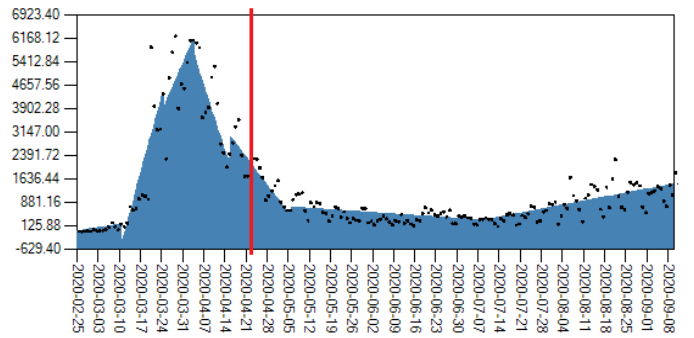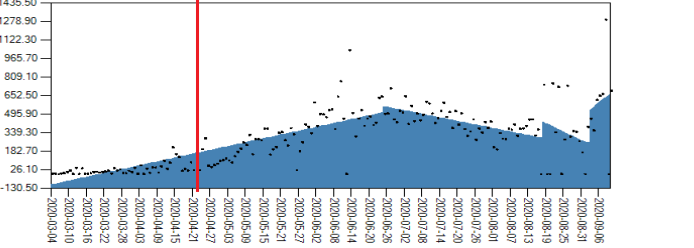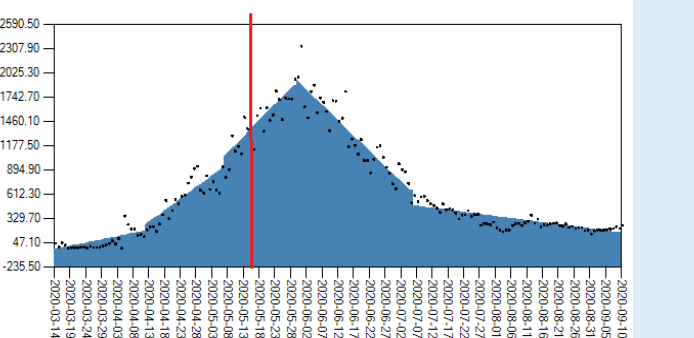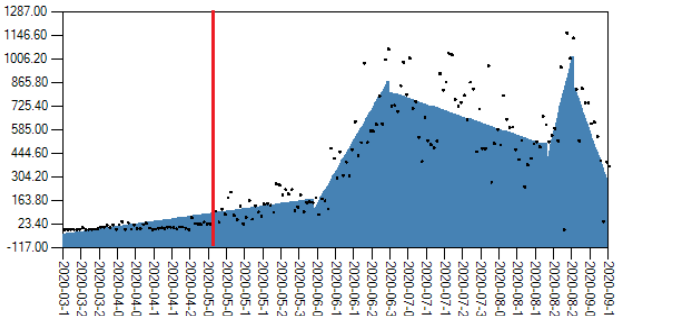
Country and date of mandate	Visual	Comment
Venezuela March		No visual effect. Did not stop June onward wave
Vietnam March 16th		Sudden drop after 2 weeks. It seems impossible for face masks to result in such a drop for one country but not others. Did not stope second wave.
Czech Republic March 18th		A change occurred after 14 days. 7 days is the accepted norm for changes to come through. Face masks have not stopped the increase after May.
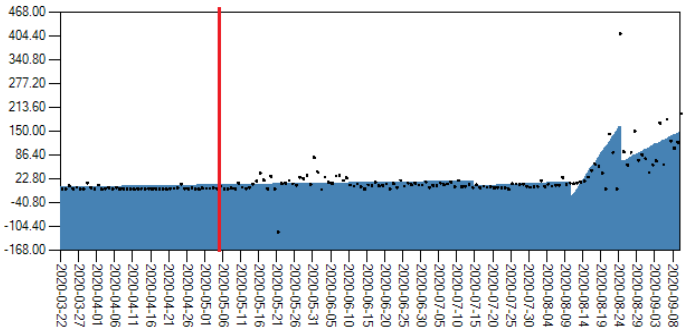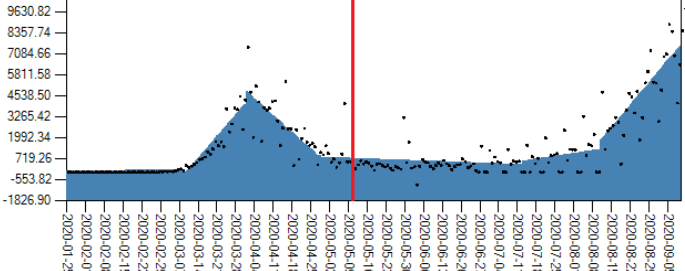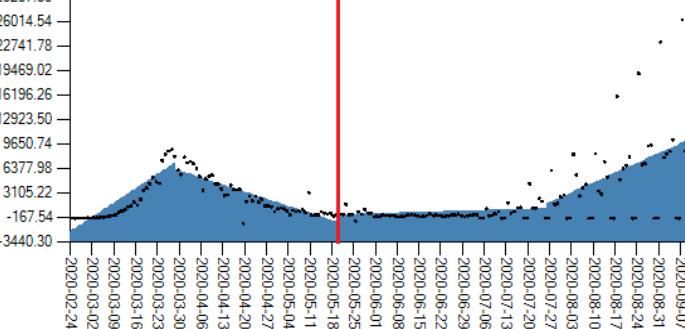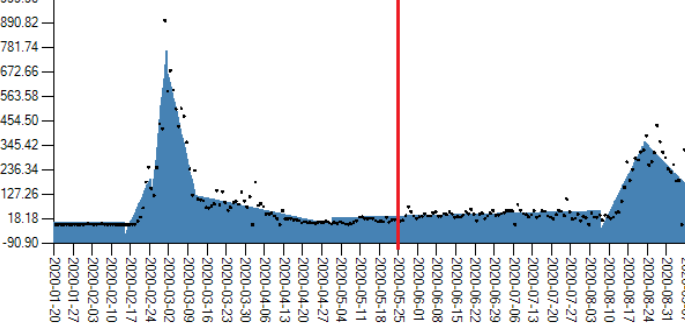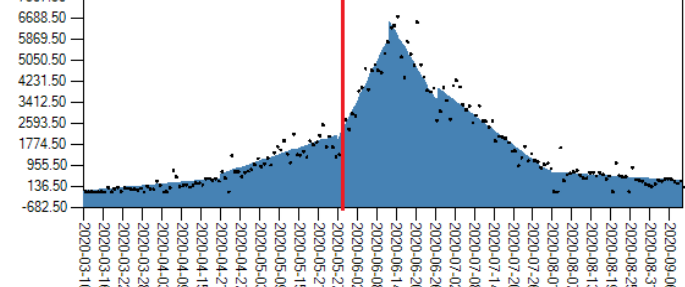
Slovakia March 25		A sudden drop occurred one month after. No stopping of new wave.
Bosnia and Herzegovia March 29		No change. Did not stop new increase
Colombia April 4		No effect. Did not prevent new increase.
UAE April 4		No effect. Did not stop three waves.
Cuba April 6		A possible drop but because it did not stop a new increase ineffective
Austria April 6		Did not prevent new increase.

Morocco April 7		No change. Did not prevent increase after June. No effect
Turkey April 7		Possible effect
El Salvador April 8		Cases kept increasing. No effect
Chile April 8		No effect. Cases keep going up
Cameroon April 9		No effect
Angola April 9+		No effect

Benin April 9 +			No effect
Burkina Farso April 9_			No effect. Drop already started and did not stop new rise
Equatorial Guinea April 9 +			N effect
Gabon April 9 +			No effect
Guinea April 9 +			No effect
Kenya April 9+			No effect
Liberia April 9 +			

Sierra Leone April 9+		No effect
Zambia April 9+		No effect
Israel April 14		No effect. Did not stop increase
Poland April 16		No effect. Did not stop increase
Luxembourg April 20		Impossible to determine effect because already near the bottom of the curve. Did not stop new wave

Jamaica April 21		No effect Did not stop rise
Germany April 22		No effect on already existent trend. Is not stopping current upward trend
Bahrain April 22		No effect.
Qatar April 26 and May 17		A possible effect but probably coincidence
Honduras May 3		No effect

Uganda May 5		No effect
France May 10		No effect No prevention
Spain May 20		No effect No prevention
South Korea May 26		No effect No prevention
Pakistan May 30		No effect unless imagination is stretched

Italy August 16		No effect. Wave keeps increasing
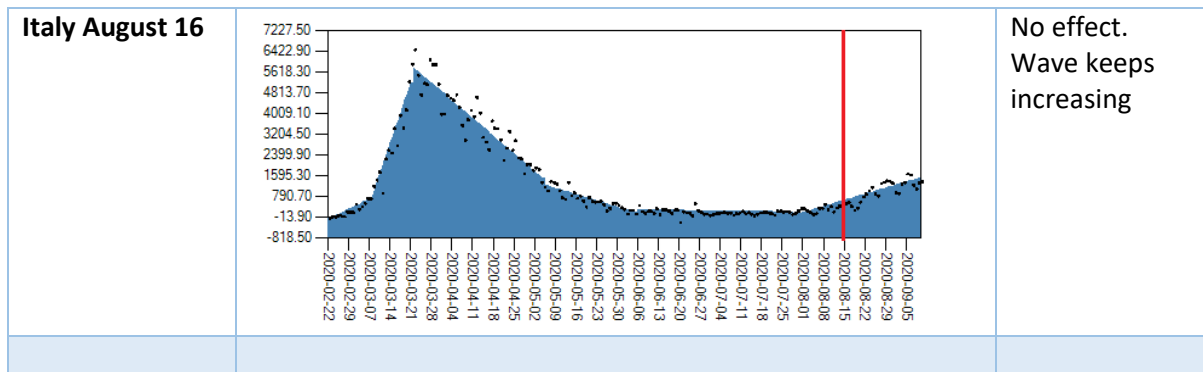
The above list is dependent on the accuracy in https://www.aljazeera.com/news/2020/04/countries-wearing-face-masks-compulsory-200423094510867.html

There is no evidence that face masked made a difference. This Is not to say that Facemasks if worn properly, without other mitigation methods, other than hand washing do not have an effect. However, with the social distancing rule where people do not get close enough to breathe in droplets, one must question the rationale.

It is of course possible that use of face masks did not stop the second wave because some countries stopped using face masks. We do not have that information. However, the point remains there is no evidence that face masks worked and they can be dangerous if they result in rebreathing the virus giving it a chance to further mutate.

Our data-analysis was consistent with the long-held understanding of medical authorities, as well as recent observational studies of the current pandemic, that there is **NO EVIDENCE** that mandated masks arrest or reduce respiratory viral transmission or case prevalence of the SARS-CoV-2 virus. For example, even the **US CDC** found recently that 85% of people infected with the new coronavirus reported wearing a mask "always" (70.6%) or "often" (14.4%). Compared to the control group of uninfected people, 'always wearing a mask' did not reduce the risk of infection.

The previous universally accepted and well-evidenced position of medical authorities was based on extensive observational data and an abundance of medical literature[ii].

Although there have been several new recent studies that support the use of face marks, we found **no robust new evidence to support the recent change of position** by experts to now endorse face-mask mandates.

Who is right and wrong under academically controlled research conditions is not important! What is important is that in practice there is no consistent and conclusive evidence that face masks worked.

9.2 Testing for Contact Tracing and Quarantining infected people.

"Across the United States, governors are weighing the difficult question of when, and how, to begin to lift lockdown restrictions. Without federal coordination, some are looking abroad to see what has worked in countries like New Zealand, Australia, and South Korea, which have effectively controlled the spread of the virus. The answer? Widespread testing."

The State of Testing

Rigorous testing has been key to reopening economies in Asia. So why is the U.S. lagging behind?

https://www.nytimes.com/2020/04/28/podcasts/the-daily/coronavirus-testing.html

April 28th, 2020

Many countries have embarked on an extensive testing program in the belief that the outbreak can be controlled by a combination of contact tracing and quarantining infected people. In the classroom this belief makes sense. When someone has been confirmed with Covid-19 by effectively quarantining that person, the person cannot further spread the virus. By tracing those people that have been in contact with the infected person these people can be tested and if infected also quarantined to prevent further spreading of the virus.

Outside the classroom there are real-world practical issues. Not everyone will be truthful in recalling the people contacted, because they do not wish to be the cause for quarantining friends and family. It will not be possible to identify strangers that have been contacted in locations such as supermarkets. By the time that a person has been case confirmed, if the virus is rampant, others will have been infected. Those with negative test results can be infected after the test.

Based on our feedback from people involved in tracing, irrespective of what is said publicly, behind the scenes effective tracing is virtually impossible and a nightmare for those involved.

9.2.1 Disadvantages of testing

- Causing fear-based stress for those who are tested positive because they have been convinced the virus will kill them.
- Distorting the true state of infections through biased sampling and unscientific case reporting, compounded by lack of clarity of whether test results are per person tested, or number of tests, which includes multiple tests on the same person, and samples tested.
- Potential overwhelming of hospitals by virtue of finding more cases which may then be referred to hospitals, just to be sure, if symptoms are present.
- Potential increase of deaths if hospitals are overwhelmed due to the above.
- Preventing the population to go on with its lives by constant blow by blow test result reporting.

9.2.2 Proof in the pudding is in the eating.

With all the hype around testing, it is difficult to make an objective decision on whether testing causes more harm than good. This section will only attempt to place some perspective on whether testing does make a difference.

9.2.3 Prevention of second 'waves'

If testing is so powerful for containing the virus then there would be no second waves. The problem is not the concept, but practicality.

Many of the countries who have had extensive testing, including Australia, reported a second wave. One can argue that perhaps testing reduced after the first wave, but the data does not support this. Australia for example increased testing after its first wave. The testing did not stop the second wave.

(Actually, testing is the dominant cause for the second wave in many countries. Because test numbers increased, cases increased even though there was no change in the underlying population)

Countries that were once praised for having beaten the pandemic with tracing and quarantining are no longer successful. Some countries such as Japan and South Korea now have extensive third waves. Recall how South Korea was lauded for its testing.

9.2.4 Reducing infections.

Testing is supposed to reduce infections.

If testing reduced infections, then the data should show a reasonable negative correlation between tests per million and cases for all countries with testing programs. The more tests per capita the lower the cases. This was not found. Figure 9.1 shows the scatter diagram for Cases per Million versus Tests Per Million of all countries with testing programs.
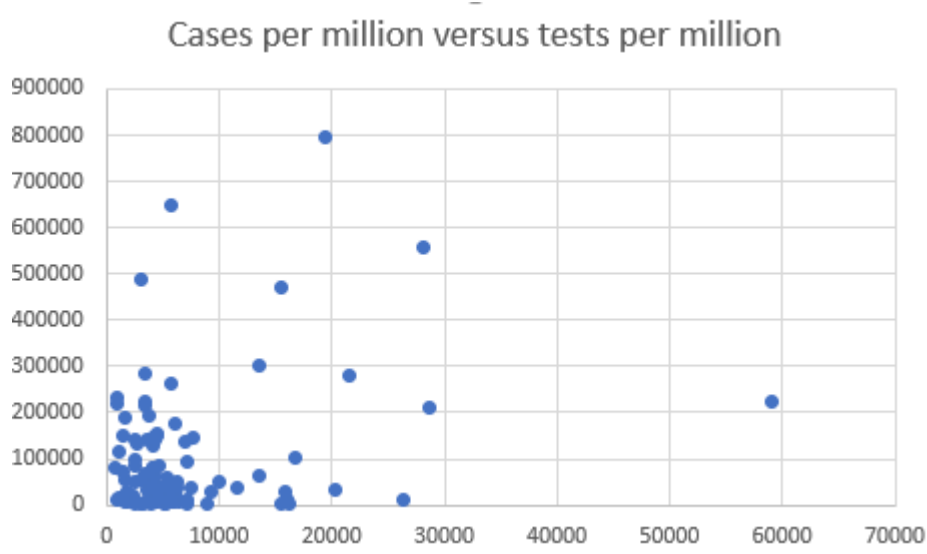
Figure 9.1 Correlation matrix of cases per million versus tests per million.

Noteworthy is that Australia with its flouted high testing regime has performed roughly 318000 tests per million and reached a total of 1053 cases per million as at 19th of October 2020

South Korea, who was praised for its successful testing program has tested around 48000 people per million and reached a total of 491 cases per million. In other words, Australia tested 7 times es extensive as South Korea and yet had around 2 times as high infections per million.

Because cases are dependent on test size a similar analysis was performed using proportion of infections. The conclusion was the same. There is no relationship between infections and contact tracing testing.

Caveat

Because different countries record different information some degree of flexible thinking must be applied. For example, South Korea reports people tested, which is a much better statistic than number of tests performed. Number of tests performed can include repeat tests on the same person. If Australia takes 2 test per person then Australia tests 3.5 times as much as South Korea.

The problem is we do not know what countries do.

For this reason, a similar analysis was performed using the same testing units (people tested, tests performed, samples tested). The conclusion remained.

9.2.5 Average tests per million versus flattening the case positive curve.

Another measure for testing effectiveness of testing is the time it took to flatten the curve.

The following table was obtained by counting the number of days to restore infection levels for representative countries which conducted significant testing. Levels were based on total counts, the naive way because that is what experts currently understand. The number of days is bounded by the black rectangle.
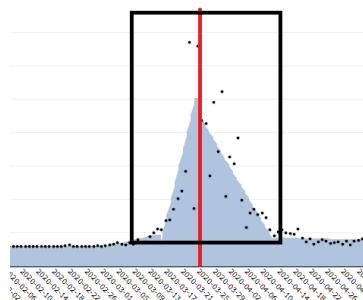
Country	Average tests per million during bounded period	Days
Japan	31	52
Malaysia	189	100
South Korea	212	90
Norway	365	68
Austria	547	40
New Zealand	483	28
Belgium	572	68
Italy	625	120

Visually one can see that testing frequency had no effect on 'flattening' the curve.

Caveat

Some guess work was required to estimate the number of days and average tests because the 'curves' are not clearly defined (contrary to the assumed model curves). Different scholars may thus obtain different values. However, the relative differences were conclusive. There is no relationship between testing and time it takes to flattening the curve.

It is possible to argue that without testing cases would have been a lot higher. That cannot be proven or disproven. The above shows that there is no evidence that countries with high testing rates performed better than those without. In fact, countries with little testing, such as Taiwan, Vietnam had very low cases. As has already been shown, testing increases reported cases.

9.2.6 Testing Errors

There are two types of testing errors. One is false negatives and the other is false positives. Due to the fear-based bias with the virus the focus is on false negatives. Yet false positives are just as important. We should not be biased to finding positive results and yet we are. In Wuhan patients were often tested up to 10 times to be sure they are found positive. This is a common but damaging problem in industry. What if the positive was false and we scared the patient to 'death' with the positive result?

All the tests are indirect. The only direct test is with an Electron Microscope and that too can result in false identification of the virus. In Wuhan where CT scans were often used as a basis to declare a case there were many false alarms because the expertise of interpreting the images was lacking.

Currently there are two main types of tests used. These are PCR tests and Serology antibody tests. Because we are not virologists, we cannot comment on either directly. However, we are forefront experts on testing error and have developed new Measurement System Analysis (MSA) technology.

In all our years' experience, testing error is a major problem and it needs to be quantified. We have never come across reliable indirect methods of testing, for example the use of refractive index to measure sugar content.

It would seem like a 'miracle' that there are no significant sources of error with the complicated viral technology. DNA/RNA testing is not 100% reliable according to our sources.

Some virologists we know pointed out that the PCR test was never designed for the purpose it is used now and that they expect it to be unreliable. Many of these tests were developed in a hurry. It is possible that there are many false positives and negatives and that the true number of reported infected cases are much less.

How can we be so confident that the technology is so advanced that we are not at times detecting genetic material from a different related harmless corona virus, or indeed other viruses, which react similarly to the primers.

Has the resolution power of the tests been established? What if similar viruses give COVID-19 positives? Indeed, common cold antibodies can cause false antibodies in some Covid antibodies tests according to

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2095096/

Although the above report is not about Covid-19 it shows how unreliable tests are.

So, when we conclude that a patient has COVID-19 can we really be sure? Based on 30 years' experience with testing in the real world, our confidence is low.

We have not to this date found any information on scientific Measurement System Analysis (MSA) tests to provide the confidence that positives are all due to COVID-19. Too many short cuts have been taken.

Until a MSA is performed which also includes tester variation we can have no statistical confidence in the test results.

Although it is highly unlikely that the frequency of false positive will be excessive high, the point being made is that if we are to effectively manage this and other viruses we need to 'up our game' and become more scientific so that we have greater confidence in the results.

There is a very real risk that when we have corona virus common colds we will see new waves of SARS-CoV-2 and do not know it.

9.3 The effect of Lockdown

9.3.1 Reducing infections.

This section investigates whether lockdown really is effective in controlling a virus.

One does not need rocket science to deduce that if we are locked a under a dome then we cannot spread the virus. The problem with lockdown in the real world is that it not possible to lockdown under dome conditions. The virus will find a way. Essential workers are human beings and can spread the virus.

One must however ask - What happens when we are released again? Some scientists seem to assume that the virus dies. That is not a given. Asymptomatic people have no symptoms so why should the body try and remove the virus? There may thus be a risk that after lockdown in a matter of time new waves will appear. (This begs the question why not get it over and done with, instead of prolonging the damage caused by lockdown?)

According to some, China, notably Wuhan did the best lock down job worldwide. The whole city was even fumigated. It took about three to 4 months to remove all lockdowns in China and Wuhan and China are now back to normal as the pictures below show. (This may of course change in the future)
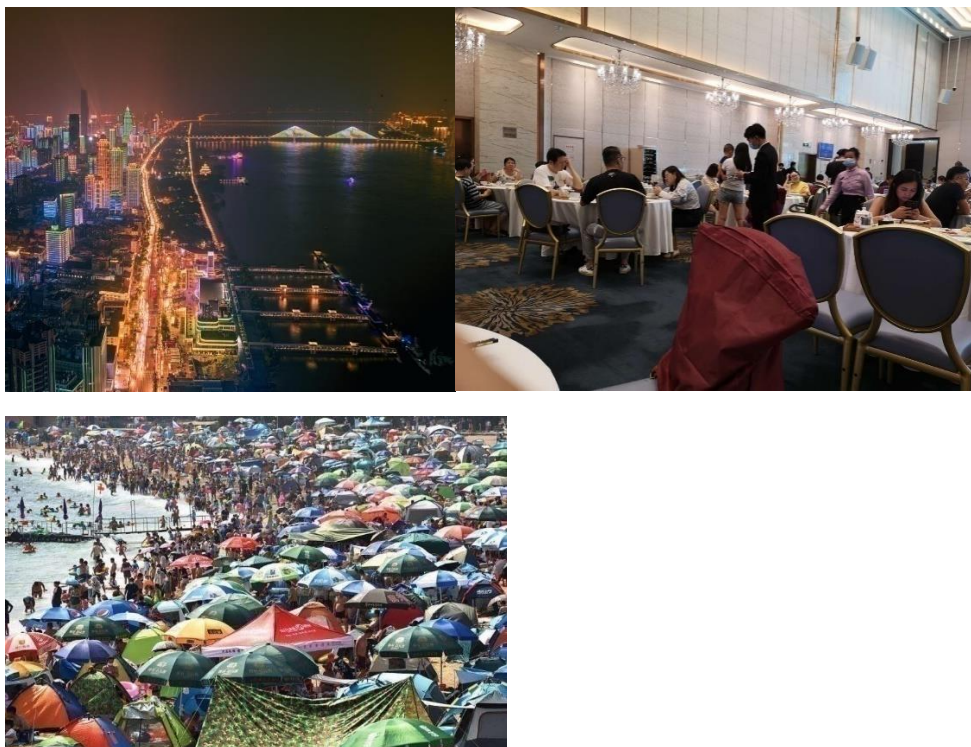
China did fear a second wave in Beijing but did not respond with the same severity as Wuhan did and Victoria/Australia for its second wave in comparison.

https://theconversation.com/coronavirus-beijing-outbreak-shows-chinas-plan-for-preventing-a-second-wave-141159

Notably according to our sources China is now listening less to its experts and no longer has extensive testing programs. Only when there is a case reported does it conduct localised tests. Its

people are now living a normal life whilst the rest of the world remains in a panic further destroying lives and the economy. (Again, this may change overnight. According to recent reports local areas have been locked down but not with the same intensity as previously. China is reluctant to further damage its economy.)

9.3.2 Analysis of effect of lockdown

Unfortunately, it is impossible to determine how diligently the lockdown has been applied in the various countries. Countries such as the Philippines and India with people living in slums cannot possibly have a successful lock down.
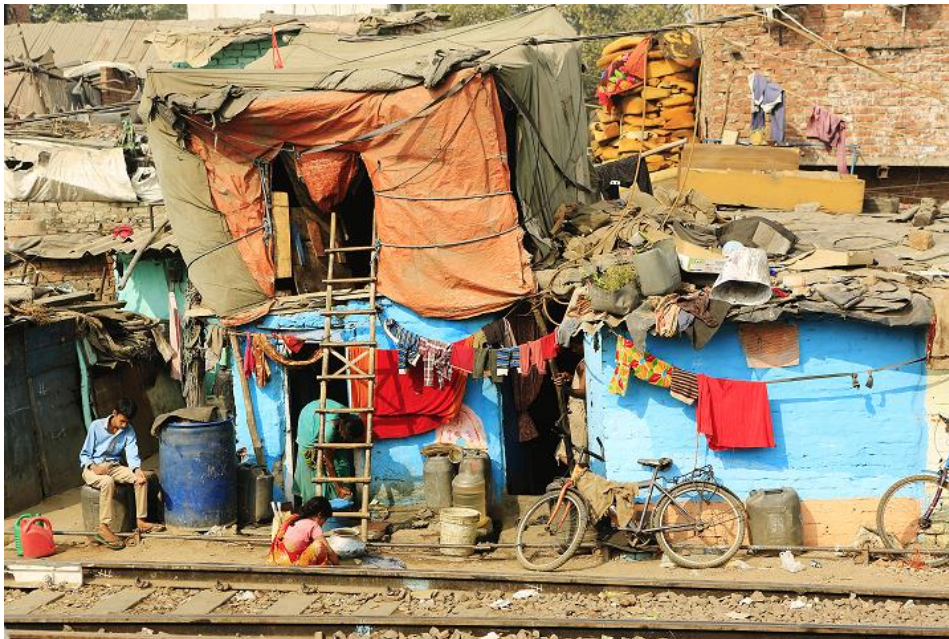
(It is a surprise that deaths in these environments are not at the predicted levels.)

Models have been used to determine the effectiveness. The flaw in this approach is that it assumes the models accurately reflect what happens in the real world, which with over 30 years modelling experience, we know is impossible.

The best that can be done is to simply look at visualization of the cases as is done below.

Because of the unreliability of COVID data all we can do is obtain an insight into how effective lock down is,

The problem is how to measure effectiveness. Measures can include

- Time for the effect of lockdown to be visual.
- The time to revert to a manageable level. (depends on definition of manageable)
- The maximum of the peak.

Every country was analysed, but only the following are displayed here which are thought to be representative. Countries are from all over the globe and include countries that did not perform lock down with peaks that came down without any notable intervention.

The statistics are not precise and often rounded. Precision is unrealistic because there is no precision.

Table 9.2 is used to visually determine if lockdown had an effect when the first waves appeared. One would expect a reduction in cases 7 days after lockdown. Table 9.2 also reports the minimum percent reached based on test proportion. It is not the current proportion. This provides a feel for what the residual infection rate in the population is. It is only a feel because the data is unreliable, the testing samples are not based on statistical designs whose objective is to draw reliable inferences about the population.

Residual is a term used for remaining infections which may never disappear. Only time will tell, but for that we need to test the population over a long time.
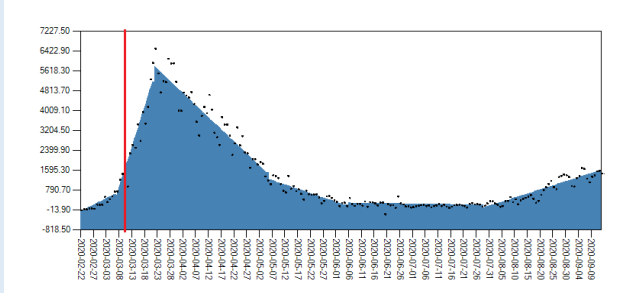
The estimate of the residual infections (number not proportion) is based on the minimum percent reached and population size. These also only provide a feel. The estimates are unreliable for the same reason as above.

The shaded areas are based on linear segments sections fitted with a special algorithm that can detect statistically significant changes. They should only be used for visualization. All Academic models that we have studied, have assumed theoretical curves, such as the exponential or logistics curve for cases. These are classroom science tools, but not real-world science tools. Most curves are indeed linear because the cases are dependent on test sample size which in many cases changed linearly as countries reacted to out breaks. It is acknowledged that some curves can be broken into linear segments. This did not happen often and has no effect on visualization as used below.

The analysis should have been performed on proportions, but daily test sample size was not available for many countries or contained considerable errors. Where appropriate and where possible a count and proportion visualization were provided.

For the countries that had no clearly defined lockdown it was difficult to determine exactly, what was done.

Table 9.2 Effect of Lockdown

Country	Visual
Italy 11th of March	
	Reversal commenced 11 days after lockdown Duration to reach manageable level 3 months Minimum % reached .5% Estimate of Residual Infections 302000

France
17th March
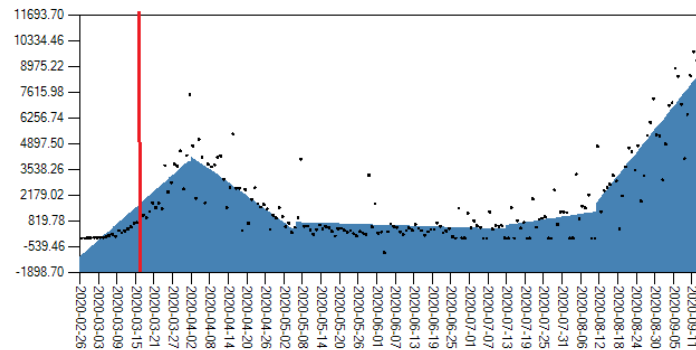
Reversal commenced 14 days after lockdown
Duration to reach manageable level 50 days
Minimum % Reached 1.5%
Estimate of residual infections 975000

Spain
14th March
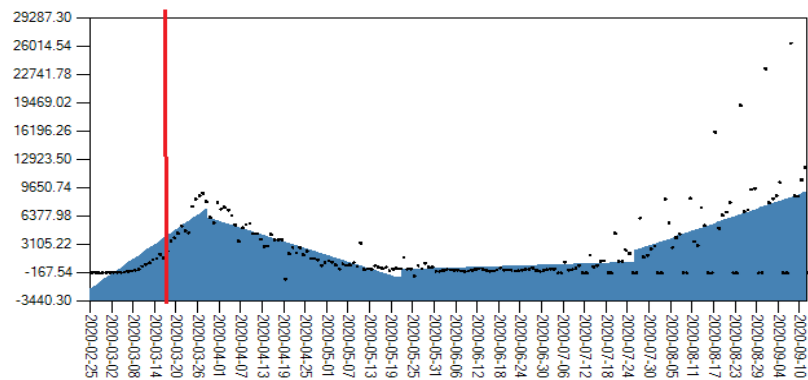
Reversal commenced 10 days after lockdown
Duration to reach manageable levels took 2 months
Minimum % reached .9%
Estimate of residual infections = 414000

Germany
22nd March
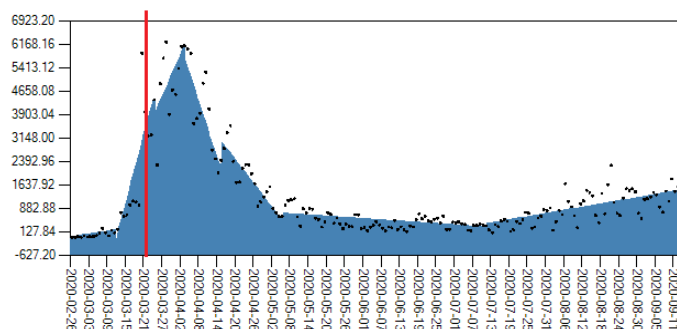
Reversal commenced 14 days after lockdown
Duration to reach manageable level = 2 to 3 months
Minimum % reached = 0.5%
Estimate of residual infections = 415000

Qatar
11ᵗʰ of March
Partial
Lockdown
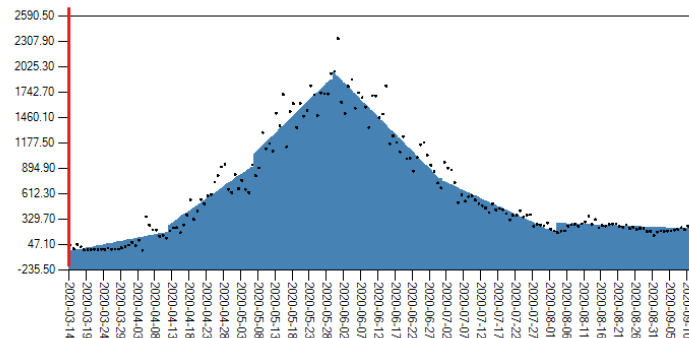
Reversal Commenced 1.5 months later
Duration to reach manageable level 4 months
Minimum percent reached = 4.5%
Estimate of residual infections 130000
Dropped on its own

Turkey
No full
lockdown
-face masks
-closure of cities
-tracing
-no coffee shop
visits
-lockdown of
<20 and > 60
year old
-border closure
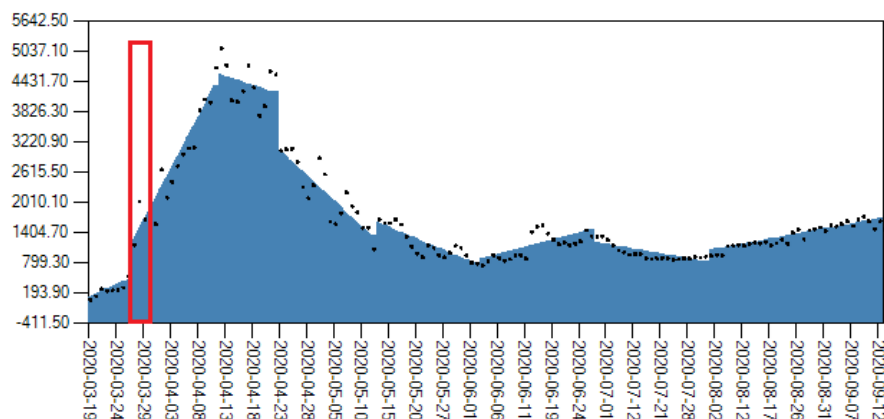
Red rectangle
most
containment

Without lockdown Turkey flattened the curve but still had high number of cases over 1500 per day. But these are misleading because of distortion of infections by increasing test numbers.

True picture, considering test size, shows continuous decrease in infections.
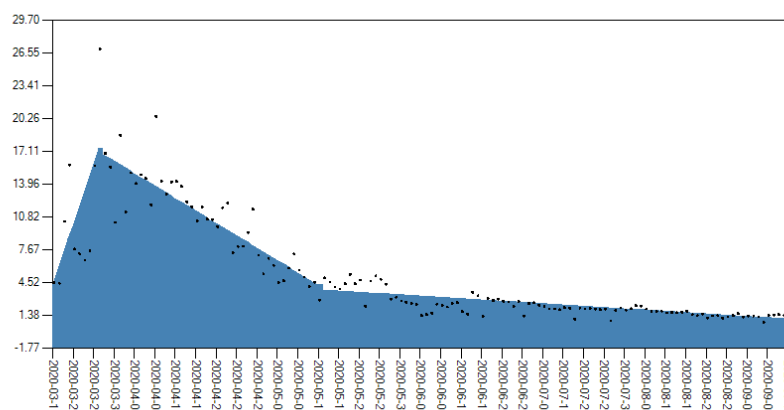
Minimum percent reached = 1.5%
Estimate of residual infection = 1.26 million

Chile

No national lockdown

But some cities were quarantined
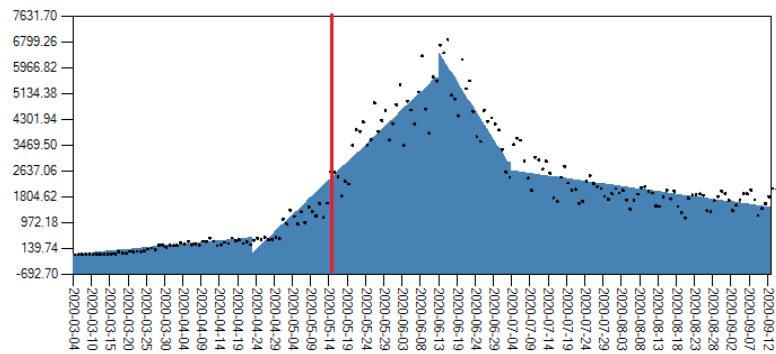
As for Turkey the cases are misleading due to test sample size variation
The true picture is shown below indicating a much greater drop in infections.
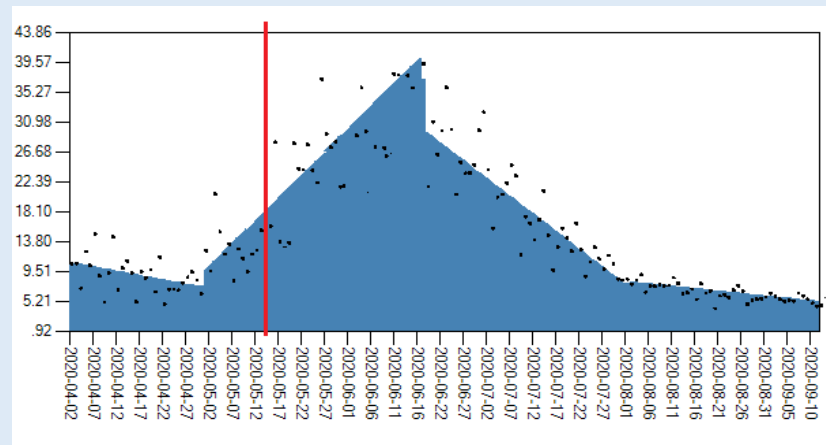
Estimate of minimum percent reached = 5%
Estimate of residual infections = 950 000

Cuba
No national lockdown

Early April Havana Quarantined Curfews Public Transportation suspended 4th -10th April
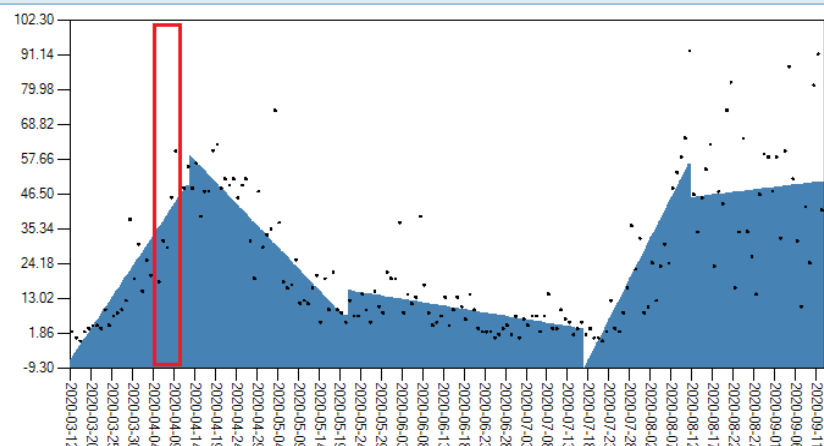
The cases are misleading due to test sample variation.
The true picture is shown below indicating a much different situation.
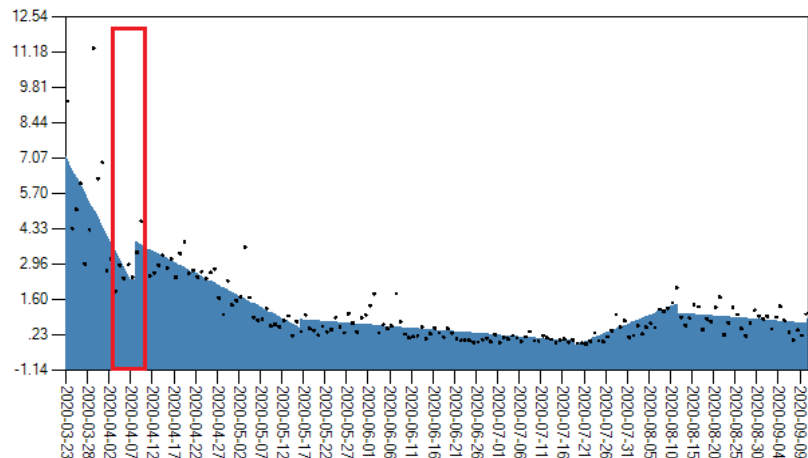
Infections were already coming down. There was no need to again reinstate quarantine August 8th. The problem is increasing daily tests.

Estimate of minimum percent reached = 0.5%
Estimate of residual infections = 55000

United Kingdom Lock Down 25th of March	
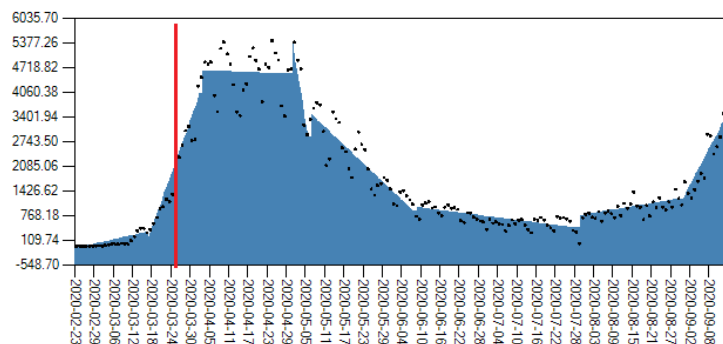
Slowing down commenced after 11 days. Reversal commenced 40 days after lockdown.
Duration to reach manageable level 4 months
Minimum % reached = 1 %
Estimate of residual infections = 680000

The cases are grossly misleading due to not considering daily test size. The true picture is shown below by using proportion of infections.
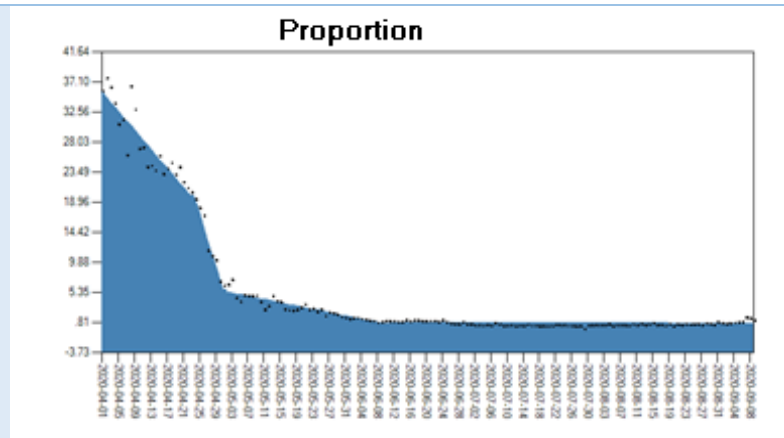
Since test numbers were not made available from first of April the chart below is provided starting from the 1st of April for comparison
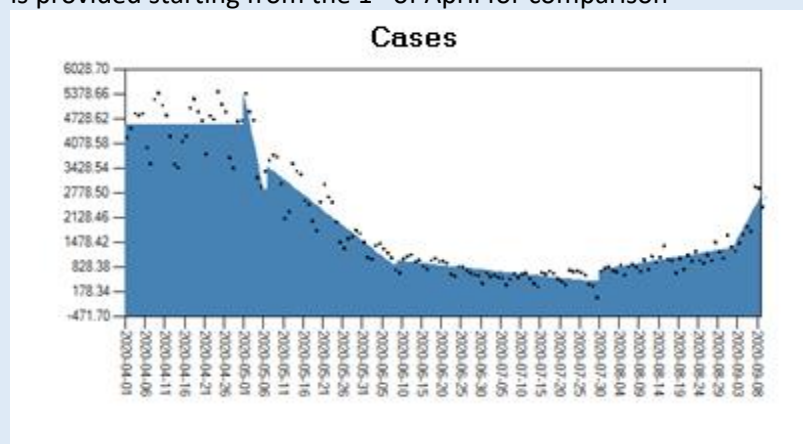
The infection trends are nowhere near as bad as the UK believes and it could have avoided the recent panic.

On the other hand, the estimated number of infections in the population is far greater than case reporting implies (up to 680000 against 3000).

| South Korea
No lockdown
Relied mainly on
contact tracing | |
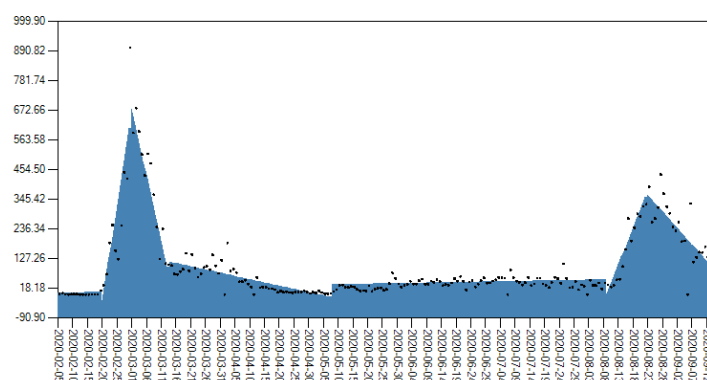
Even though no lockdown cases came down. There has been no evidence of contact tracing working and it has not prevented the new wave.

Duration of first wave = 3 months consistent with duration of first wave for countries using lockdown.

	South Korea did not frantically keep increasing its testing rate and hence the infection pattern of proportions is like that of cases and thus not shown below Estimate of Current % minimum = 1% Estimate of current infections in population = 510000
Japan No Lockdown Contact tracing Urging of population to social distance, relocation of patients	 Nothing was done during the first wave that can be considered to have had an impact of such magnitude to have flattened the first wave. Estimate of Current % minimum = 3% Estimate of current infections in population = 3,780,000
Philippines Lockdowns of varying strictness was implemented since March.	 Philippines lockdown efforts made no difference. This is to be expected with slums. Estimate of Current % minimum = 3.5% Estimate of current infections in population = 3,850,000
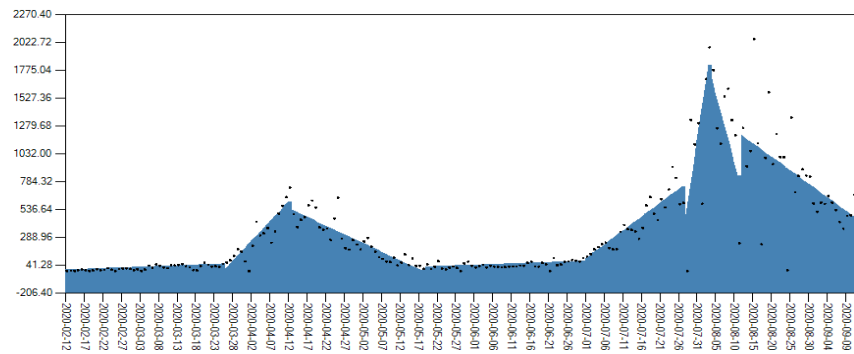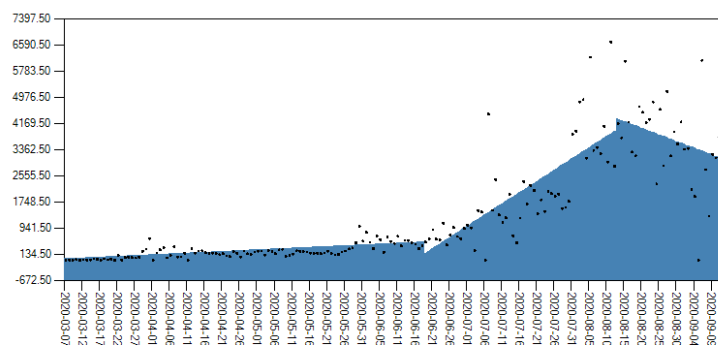
Other studies have been performed to establish whether lockdown had an effect.

For example, the study reported below concludes that lockdown had an effect.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7293850/

The conclusion was based on a correlation analysis of cumulative cases and lockdown days. Correlation was established using transformed data which is highly risky. The analysis is flawed

because it assumes that cases are only due to lockdown. Cases are dependent on a large range of factors, a notable one being testing and population size.

Recall that Victoria falsely proved that lockdown worked using mathematically deceptive moving averages and false modelling assumptions.

Vietnam had very low cases without lockdown as did Thailand. If these countries had lockdown the analysis would have been falsely influenced to conclude lockdown made a difference.

The best way to determine how effective lockdown was is not mathematically, but visually as above.

Please note that some countries have had new waves since the above analysis, but the conclusions remain.

9.3.3 Comment

The fact that lockdown will reduce spread is not disputed. Otherwise, why have less common cold and flu cases been reported during the lockdowns. The issue is how effective was it, would the peak have reduced anyway, are other forms of containment equally effective.

There is nothing conclusive about the effect of lockdown based on the visual inspection of the charts in Table 9.2 If we assume that an effect will take 7 days to start showing, as has been suggested by some scholars, then there is no evidence that lockdown worked. But we can of course not be sure how long it takes for effects to come through. If we assume that it does take ten to 14 days then it is possible that lockdown had an effect for a small number of countries, but all indications are that the effect is temporary in most cases.

The infections may have also come down for other reasons. There are several countries where this has happened. Japan, South Korea, Cuba, Chile are examples where cases came down without hard lockdown.

Lock downs have not stopped second and third waves, but some waves were not real waves, and just a reflection of continuously increased testing numbers. Some politicians allege that the lock downs were not long enough. The assumption is that the virus will die out. Viruses do not die because they are not alive. The immune system can get rid of them but as previously mentioned above, for asymptomatic cases it is not impossible for the immune system not to remove them, it is then a matter of time before the next wave. As we are not virologists this possibility needs to be discussed with qualified virologists.

Lock down has not shown to have influenced registered deaths.

Section 10.0 Deaths

10.1 Setting the scene with trivia.

The pandemic has made the world paranoid with viral infections, even though everyone has viruses in their body, even though every year people get sick with viruses. The human virome has 340 trillion viruses. The world is full of viruses which are just molecules of acids that we now, have turned into living monsters without any perspective.

Of course, viruses can kill, as can cars. If we are to have any hope of not letting the virus affect how we live we must stop glorifying it and get on with living instead of worrying about case after case. This does not mean we foolishly ignore its deadliness, but first we need to see how deadly it really is by ignoring the Covid-19 propaganda and bringing back perspective and looking at all facts and possibilities.

To show our mentality, instead of searching for evidence that the virus may not be so deadly, we search for evidence that the virus is far deadlier than it is.

We draw pretty pictures of COVID-19, such as shown in Figure 10, which only serve to keep the virus alive in our minds, preventing us from thinking about living.
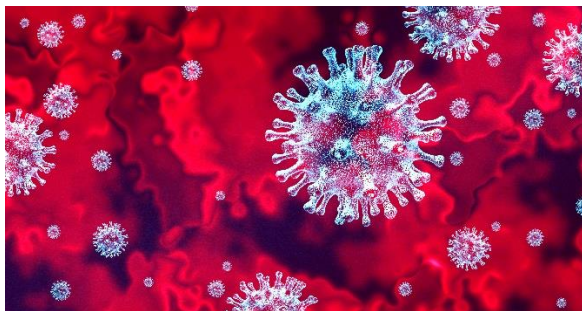
Figure 10 A 'glorified' human created illustration of COVID-19

Do we really know what viruses look like beyond electron microscope images?

Figure 10.1 is an image from the first U.S. Case to show what the virus really looks like. How can we deduce, other than theoretically, that the virus looks like the artists impression? The artist's impression only increases fear and makes the virus look deadlier.
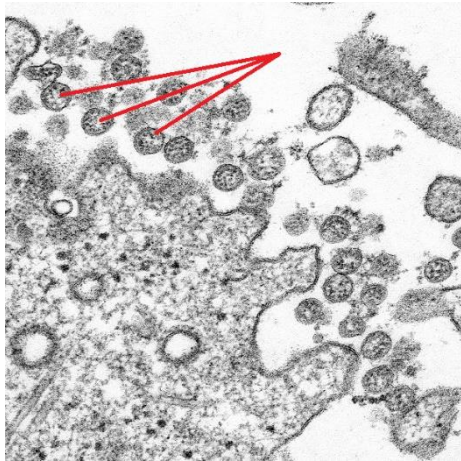
Figure 10.1 A public domain image of a transmission electron microscopic image of an isolate from the first U.S. case of COVID-19

https://www.cdc.gov/media/subtopic/images.htm

The real images just show flat little circles with dots. For perspective Figure 10.2 shows another virus, the Bourbon virus. The shape is slightly different, not as circular, more like an ellipse, but there are also dots. There is nothing special and glorious about the COVID-19 images. It does not mean it is not deadly, but we should not automatically assume this either. The virus is still a part of the family of common cold viruses, though we must acknowledge that a cat and tiger are of the Felidae family, where one is harmless and the other is not.
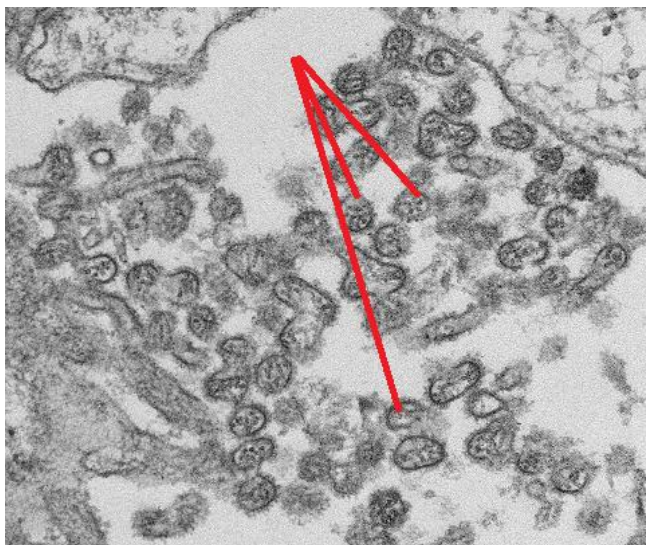
Figure 10.2 Bourbon virus particles

The world has more viruses than the stars in the universe and yet life goes on and the world's population of human beings is exploding. We have never in the known history of mankind had a virus that we know has killed the number of people that modelling predicted COVID-19 has killed, if we had not taken the action that destroyed lives for so many. This does not mean that there have not been deadly viruses e.g. The Aids Virus.

The black death, though not a virus, allegedly has killed up to 20% to 60% of the European population. But, not having lived in that time, can we really be sure of the numbers? Did we have accurate census then. Did we have a database that stored all the plague deaths so we could get an

accurate report or was it a case of experts grossly over exaggerating. This is not to say the plague was trivial, it was serious but how much of Europe and the rest of the world were really annihilated? We can only imagine, hypothesize with models, but we do not truly know because we did not live at the time. Even then a reliable estimate would allude us.

Now scientists have identified a virus that has not been previously identified, which does not mean it has never been around before. It may have just been one of those viruses that are blamed when we had the sniffles. But we do not know either way. Chances are that it was not because of the high deaths in some countries. On the other hand, maybe it did not reach those countries before. We do not know either way. Everything is possible!

10.2 Perspective with other deaths.

Science without perspective is no science.
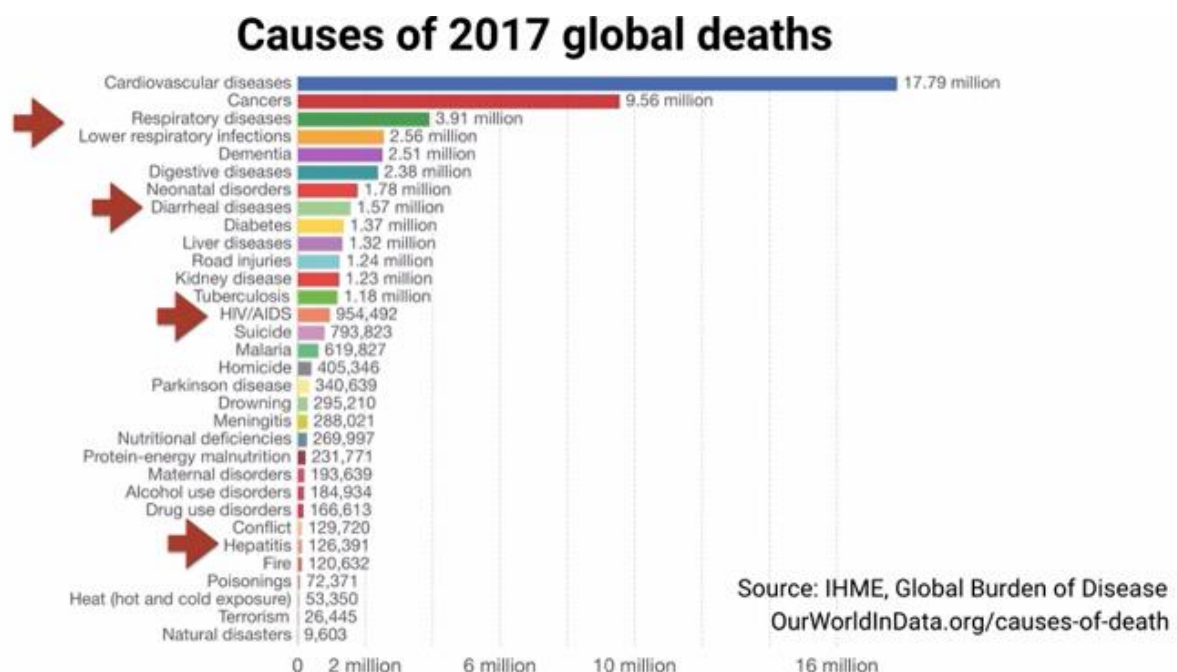
Figure 10.3 Global deaths in 2017

If we are to conclude that the virus is deadly, then it must be with perspective. If car accidents kill far more and cause far more long-lasting damage if death is not the outcome, then treating the virus more deadly to the extent of destroying lives something is not right.

Currently as of December 31st global deaths are 1.8 million.

Before continuing it needs to be emphasized that these are reported deaths. They may not be the real numbers. Reported deaths can be exaggerated or underestimated and even manipulated for political reasons. We do not know!

Figure 10.3 shows deaths caused by viruses marked with an arrow. The total is 6.6 million for 2017. This begs the question, should we not also introduce global containment action to eliminate these viruses, which total far more deaths than Covid-19. Why do we accept almost 7 million deaths which

we could reduce by locking down the world permanently? A- Because we must accept death because death is inevitable and if we destroy living, life is not worth it.

It is ironical that governments are increasing age pension age and are concerned about an aging population, yet we do not let nature, which has balancing constraints, take its course, acting, as if we have the black death on our hands. (This is not meant to be misinterpreted as saying do not try to save lives, but it must be without obsession manifesting itself in ignoring the most important part of life and that is living.)

Road injuries are 1.24 million in 2017. That is .6 million less than Covid-19deaths, which is not much. We do not need to lockdown cities to remove this source of death. All we need to do is replace private transport with public transport. Why don't we? Because this will destroy the car industry and result in 15 million job losses globally.

But that is a fraction of the jobs lost due to the reaction to the Corona Virus. Perhaps the difference is because we foolishly believe COVID-19 is a one in a hundred-year event. Are we so sure?

"Hundreds of millions of people worldwide have lost their jobs as a result of the coronavirus pandemic. But what about the 1.6 billion workers in the "informal sector" – half the global workforce – who didn't have a steady job to start with?"

https://www.csmonitor.com/World/2020/0506/No-jobs-so-what-future-Half-the-world-s-workforce-on-the-edge

Aids has resulted in close to one million deaths (admittedly most in Africa). That is at the Corona Virus level. Should we make homo sexuality and prostitution illegal again to save these lives. Of course not.

The statistics are shown to demonstrate how irrational the world has become to a virus that has been pulled out of all proportion relative to other deaths.

Perhaps we are we saying that we cannot have more deaths on top of the others? Then why do we send our boys to unnecessary wars? COVID-19 will not necessarily add directly to the death numbers in the medium term. Deaths that would have been caused by other factors, such as by the flu, may no longer occur so there will be a balancing factor. Over time the total deaths will not change because we all die. Since most of the unfortunate people already had ailments or already were frail one can imagine they would have lived perhaps another 6 months to twelve months more. Do these people wish for their lives to be extended, if they are suffering knowing their time has come? I cannot speak for others, but my Dad would not.

As the world gets larger there will be far more deaths. According to United Nations predictions in just 4 more years deaths will be six million more. Again, if that is acceptable, what is so special about COVID-19 deaths that make those deaths unacceptable, even though they are less. Is it because we think we have the black death on hand?

On the one hand we worry about an aging population, we worry about dwindling resources due to an excessive global population, we worry about congestion, encroaching on wild life, pollution, diseases and the very thing that will reduce it, nature trying to maintain a healthy balance, we fight without rational thinking and terrible science. Perhaps this is callous but destroying lives is cruel.

What is more callous, knowingly destroying lives, or accepting that nature does its job and instead balance nature by doing what we can to save lives without destroying lives.

10.3 What are unacceptable deaths?

How do we decide what is an unacceptable number of deaths?

The Victorian Premier from Australia has made it clear that the current level of deaths, mainly from age care are unacceptable.

In August there were 449 Victorian deaths, which are considered unacceptable by the Victorian Government. Of course, all deaths are unwanted, but all deaths must be accepted per se because we cannot stop death. It is understood that if we can avoid premature death then we must try, but without perspective? Many people in age care want their lives to end. So, why we are prolonging their suffering with the rhetoric, "We must save lives" when they may not want their lives saved.

Figure 10.5 is a Hybrid SPC Chart for total registered monthly deaths in Victoria. The chart shows underlying changes in the current average and outliers.
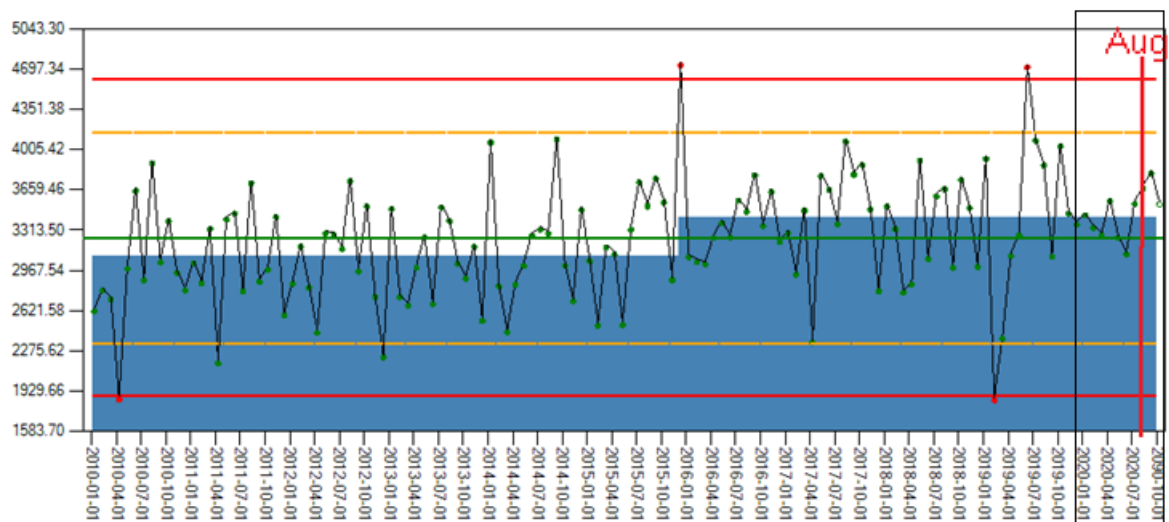
Figure 10.5 Hybrid SPC Chart for Victorian Registered deaths by month till end of October

The black rectangle covers year 2020

Victoria's deaths have not influenced monthly registered deaths.

August had the worst month with approx. 450 reported Covid deaths. Not even a glitch crossing the distribution optimized control limits.

The Hybrid SPC chart also shows that from 2016 onwards there have been an extra 400 deaths monthly. Why was this increase not deemed unacceptable and why was this not investigated?

10.4 Perspective next to Flu deaths

We cannot compare because the flu is grossly under reported, which is compensated for with model predictions, which cannot be trusted because all models are wrong.

https://www.cdc.gov/flu/about/burden/faq.htm#deaths

"Seasonal influenza may lead to death from other causes, such as pneumonia, congestive heart failure, or chronic obstructive pulmonary disease. It has been recognized for many years that influenza is underreported on death certificates and patients aren't always tested for seasonal influenza infection, particularly the elderly who are at greatest risk of seasonal influenza complications and death. Some deaths – particularly among the elderly – are associated with secondary complications of influenza (including bacterial pneumonias). Influenza virus infection may not be identified in many instances because influenza virus is only detectable for a short period of time and/or many people don't seek medical care until after the first few days of acute illness. For these and other reasons, statistical modelling strategies have been used to estimate seasonal flu-related deaths for many decades. Only counting deaths where influenza was included on a death certificate would be a gross underestimation of seasonal influenza's true impact."

The following are some historic estimates of **flu pandemics** which did not result in the destruction of the global economy to the same extent as now.

According to https://www.medscape.com/answers/219557-3460/what-are-the-mortality-rates-associated-with-influenza

***The 1918 H1N1 influenza pandemic caused 500,000-700,000 deaths in the United States—almost 200,000 of them in October 1918 alone—and an estimated 30-40 million deaths worldwide, mostly among people aged 15-35 years. If we had that damage, why don't we take precautions and lock down with any new swine flu? The initial wave was not that harmful, but the second was. We cannot be sure that the next swine flu will not kill that many again. Vaccines are not that reliable.

The 1957 H2N2 influenza pandemic (Asian flu) caused an estimated 70,000 deaths in the United States and 1-2 million fatalities worldwide

The 1968 H3N2 influenza pandemic (Hong Kong flu) caused an estimated 34,000 deaths in the United States and 700,000 to 1 million fatalities worldwide.

In 2009 – 2010 the swine flu resulted in attributable excess mortality world-wide of 100,000 to 400000. Children and young people were predominantly affected. This begs the question, which is the deadlier a virus that predominantly kills the older generation (In Australia 76% above 80, most from age care, with comorbidities, or a virus which attacks young people who are healthy without comorbidities? Some countries have taken away liberties of those over 65. Should we not also take away liberties of 20 to 35-year-olds each time there is a swine flu outbreak. We cannot be sure it will not be deadly.

The numbers do not support the statement that the virus is deadlier than the flu. Although the annual WHO estimate is lower than the current COVID-19 deaths, there have been periods where deaths were much more, and an estimate is an estimate only.

10.6 Is the common cold harmless?

A study reported in 2017 throws doubt on the harmlessness of the common cold.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5343795/

As would be expected it can be deadly for the frail and elderly. The study found that the rhinovirus for the patients in the study was more deadly than the regular seasonal flu. "The 30-day mortality for frail elderly people admitted to hospital due to a rhinovirus infection was 10%. For frail elderly people admitted to hospital due to influenza, 30-day mortality was 7%."

https://sebastianrushworth.com/2020/10/24/how-deadly-is-covid-19/

The problem is that we have only a fraction of the data available for the common cold and the flu relative to Covid-19. We are not able to yet draw conclusions.

10.7 How deadly is the virus really?

Unless we can run unethical cause and effect experiments on patients, we will never know the answer.

What we can do is try and get an insight into reality from different perspectives.

In the previous section we have learned that there is no solid evidence that COVID-19 is deadlier than the flu, taking all things into account. The flu's deadliness varies over time. Just as it has been deadly before it can be deadly again. Realistically we do not know either way. Models cannot be relied on because they are always wrong.

10.7.1 Case Deaths

10.7.1.1 Unreliability of Case Death comparisons

Covid19's deadliness compared to the flu has in part been based on case deaths which has led to panic and we will later suggest helped increase death numbers. Case percentages have been used as input for modeling, which has contributed to the gross modeling errors.

Allegedly the case death rate of the seasonal flu is only 0.2%, some estimates are 0.1% and depending on which report one reads, 3% to 5% for COVID-19.

The 0.2% is a meaningless statistic for comparison. One must consider variability and error in variability. The flu case deaths vary.

The estimated case fatality for the 1918 Spanish Flu was 2 to 3%.

Case deaths depend on too many factors to be deemed as reliable. Estimated deaths for COVID have been based on influenced statistics which grossly bias the figures. Influencing statistics is achieved by searching for cases with high probability of an infection, convincing the public to test which would otherwise not test. Bias is caused by focusing on those with symptoms. Case deaths depend on the period in the pandemic. For example, at the beginning there may be more people with comorbidities inflating the deaths.

Consider the case deaths for the avian flu reported to WHO during 2003 and 2018. The case deaths were **55%** (fifty five percent), far greater than COVID.

https://www.who.int/emergencies/diseases/managing-epidemics-interactive.pdf

And these cases were not influenced as much as COVID-19 cases are. These were based on small case numbers but nevertheless were high.

10.7.1.2 Variability in Case Deaths from country to country.

The crude case percentages for all the countries in the world do not hover around one value but are skewed following a log-normal distribution.

Figure 10.7 shows the distribution for case deaths.
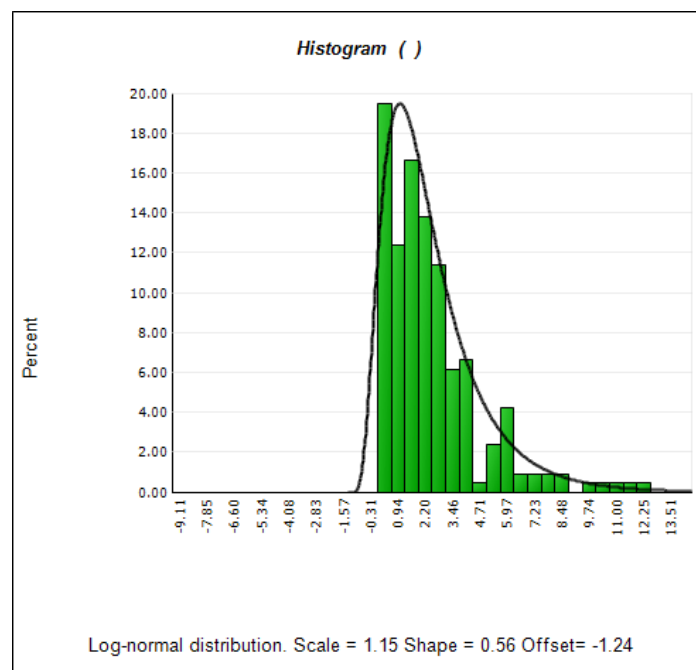
Figure 10.7 Global case percentages for all countries following a log-normal distribution

The case percentages were based on all data from the beginning to the current date. It is a crude estimate because it is impossible to accurately reflect the time between case detection and death. Nevertheless, it is accurate enough to show the variability.

The case death variation displayed in Figure 10.6 shows that the deadliness varies if we use case statistics as measure of deadliness. Case percentages vary from **below** .1% to 14%.

Due to the variation and unreliability in case deaths, case deaths cannot be used to determine the deadliness of Covid-19 in comparison with the flu.

There are too many unknown factors currently influencing Covid-19 case deaths to enable a reliable comparison.

10.7.2 Case Numbers

Case numbers can be used to obtain an insight into the deadliness.

In Australia between 13 million and 17 million people are infected with a common cold virus every year. In comparison, the number of coronavirus cases for Australia is 27113 as at 3rd of October 2020. Why are there not more cases? The population percent of total cases reached in Australia is only 0.1 % nowhere near Common Cold and Flu percentages. Does this mean the rest were asymptomatic, if so, how can we call the virus deadly? Do we call cars deadly just because some people get killed?

Alternatively, if we estimate the symptomatic cases, from test numbers, the estimated proportion of symptomatic cases over the whole Covid-19 period is 0.35% for Australia. There should have been around 90000 cases. Why did these cases not come forward? The symptoms could not have been that bad, no more than common cold. The same applies to other countries.

Although the estimate is unreliable due to bias, testing and sampling distortions it does provide an insight. We would have expected more people presenting themselves voluntarily to medical clinics if the symptoms were that bad.

The reported cases are mostly influenced cases, not cases with people presenting themselves because they felt ill.

"More than **310,000** people presented to Australian health services with influenza in 2019.

https://www.abc.net.au/news/2020-02-11/early-outbreaks-to-blame-for-worst-flu-season-on-record/11949320

These are flu cases, without the influence that Covid-19 cases receive through testing programs and daily government encouragement. This is around 1% of the population. This does not even reflect the masses of people that have flu symptoms but do not check themselves in.

The effect of lockdown is a possible reason for the low numbers, but in Australia lockdown started after the peak so this may not be the explanation. Furthermore, the flu has a vaccine which is more effective than a lock down.

Japan has had no lockdown and only has 0.07% cases as of October the 4th.

Sweden which has had no lock down and no extensive testing program and has had 0.9% cases less than the 1% reported for the flu in Australia above.

As of the 18th of September, the Philippines reported 88% of its cases are mild or asymptomatic.

Can such a virus be called deadly? The propaganda makes it seem that anyone who catches the virus will die.

10.7.3 Proportion of reported deaths

Another way to measure the deadliness of COVID-19 is with proportion of reported deaths in the population.

Proportion of deaths are not dependent on testing and influencing. However, they are dependent on correct assigning of death to COVID-19. They are dependent on treatment competency. They are

dependent on overwhelming of hospitals. They are dependent on comorbidities. They may be dependent on fear of COVID-19 which may destroy the immune system, contributing to death. Thus, proportion of reported deaths is also not a perfect measure.

Proportion of deaths can be expressed several ways. To obtain a better perspective of deaths in the population percent is chosen here as the measure of proportion. Those that wish can multiply these by 10,000 to convert proportion to number of deaths per million.

As of 20th September 2020, the distribution of the percentage of REPORTED deaths for all countries due to COVID-19 are shown in Figure 10.8. This includes countries in full lock down, no lock down and partial lockdown.
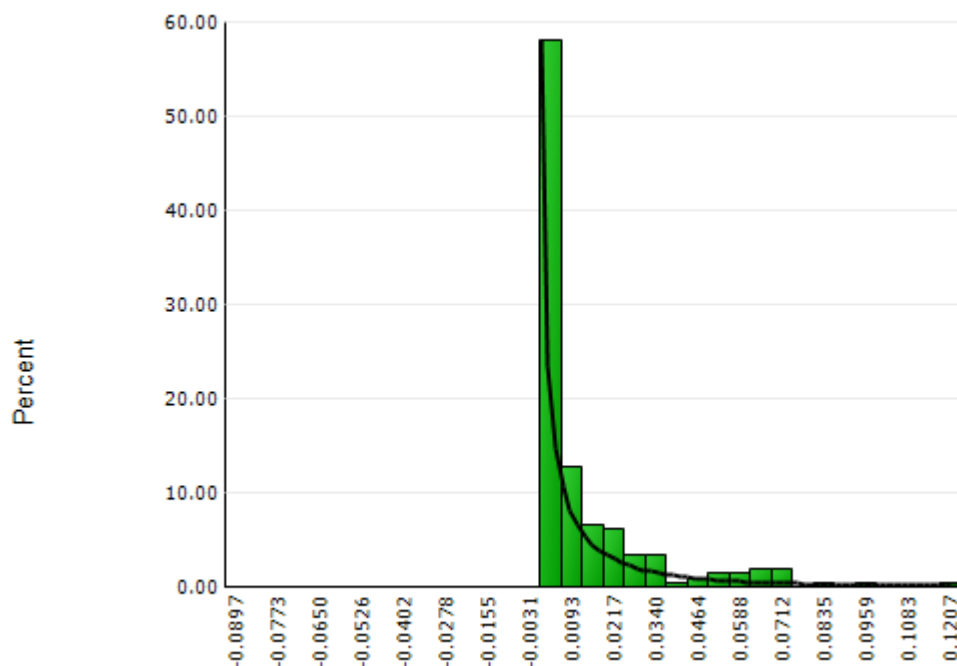
Figure 10.8 Distribution for percent reported population deaths.

The distribution is a Weibull curve, though Log-normal can also be fitted.

Belgium, Brazil, Chile, Italy, Mexico, Peru, Spain, United Kingdom, United States are in the top 5% of death percentages which vary between .06 to .12 percent. The black death was estimated to have killed between 30% to 60% of the European population. These percentages are small in comparison.

Sweden without any drastic containment had 0.056% of deaths by 2nd October 2020. 30% of countries had less than 0.001 % of deaths which includes countries such as Taiwan and South Korea who had no draconian lockdown. 90% of countries had less than 0.045 % of deaths in the population.

10.7.4 Percent of deaths relative to Total Deaths by country

These statistics put additional perspective on deaths.

Figure 10.9 shows the distribution of Covid-19 deaths for all countries relative to total deaths in 2017. The outlying countries were the European countries mentioned above. The maximum percent relative to total deaths is 11% i.e. the countries with the maximum (Panama, Bolivia, and Mexico) deaths relative to total deaths were 11%
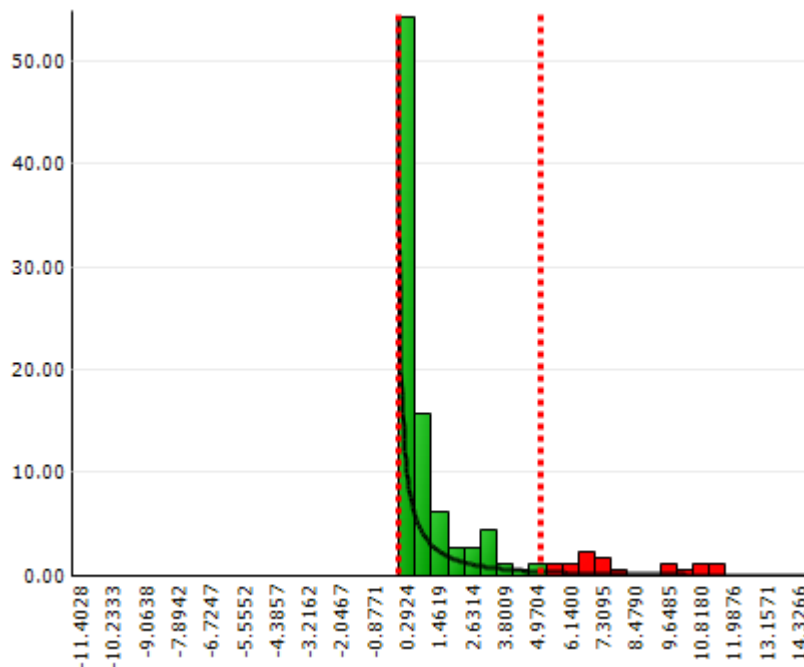
Figure 10.9 Distribution of Covid-19 deaths as of October 10th 2020 for all countries relative to total deaths in 2017

90% of countries have a death rate below 5% of total normal deaths based on 2017 data.

The 10% of countries above 5% include

Saudi Arabia, Colombia, France, Italy, Iraq, Bahrain, Iran, Sweden, Spain, United States, United Kingdom, Ecuador, Kuwait, Belgium, Andorra, Brazil, Chile, Mexico, Bolivia, Panama, Peru In that order.

65% of countries fall below 1 percent.

These numbers include countries with and without lock down. Perhaps with lockdown there would be much more deaths. But there is no evidence of that.

Sweden one of the countries that did not participate in self destruction had a lower percent than the United States, United Kingdom and Belgium who had some form of lockdown.

Taiwan without lockdown has a percent of 0.003%, South Korea 0.06%, Japan 0.1%. The variation between countries that have had lockdown, such as Australia and Belgium are significant!

The fact that there is so much variation, and the fact that a known distribution is followed, without outliers means that no country should base its decisions on propaganda statements such as, "We all

know that we would have same death as European Countries if we did not have social distancing". That is not the case. Each country is different with its own reasons.

10.7.5 Assigning Cause of Death

The above applied to reported numbers of deaths. Reported numbers of deaths do not mean that the deaths are caused by Covid-19. This needs to be understood. The above figures may have been grossly inflated due to human nature which tends to take short cuts. This is not a statement of fact but a possibility that cannot be ignored and needs to be investigated when all this is over. One does not need to be a Medical Doctor, to know how difficult it can be to assign cause of death in many cases. For road trauma, cancers, homicide the task is relatively straight forward. For elderly suffering with organ failure it may not be that easy. The problem arises when a patient with a comorbidity also has COVID-19. What is the cause-ofdeath? Many countries, especially those with high deaths have openly admitted of recording a Covid-19 death if the patient had COVID-19, even though Covid-19 may not have caused the death.

I refer the reader to the following. 1. UK BBC https://www.bbc.com/future/article/20200401-coronavirus-why-death-andmortality-ratesdiffer "During an epidemic, doctors are more likely to attribute a death with complex causes as being caused by the disease in question – a trait known as ascertainment bias. "We know, during an epidemic, people will call every death as though it's related to Covid-19. But that is not the case," says Heneghan. "Always, when people look back at the case notes and assign causation, they realise they will have overestimated the case fatality in relation to the disease." The reason for the bias is that "there's a tendency to focus on the worst-case scenario", says Heneghan. "That's the only message that gets out there." One example is the H1N1 pandemic of 2009, known as swine flu. Early case fatality rate estimates were inflated by a factor of more than 10. Even 10 weeks into the epidemic, estimates varied widely between countries, coming in between 0.1% and 5.1%. When medics later had a chance to go through case documents and evaluate cases, the actual H1N1 case death rate was far lower, at 0.02%." Please note the similarity in case percentage variation for COVID-19. If the variation was .1% to 5.1% the average was likely to be 1.5 and hence there was an inflation of 1.5/.01 = 150 which seems far-fetched. For practical purposes inflation of 10 to 20 times is possible by some of those countries. What this means is that although there were many deaths, they may not have been anywhere near as much as the numbers say. USA deaths may thus only be 20000 or less, in line with less severe flu seasons. Little else makes sense when countries like Singapore only have 27 deaths to date.

2. United States https://www.bbc.com/future/article/20200401-coronavirus-why-death-andmortality-ratesdiffer "At present in the US, any death of a Covid-19 patient, no matter what the physician believes to be the direct cause, is counted for public reporting as a Covid-19 death." https://www.nytimes.com/2020/04/14/nyregion/new-york-coronavirus-deaths.html New York City, already a world epicenter of the coronavirus outbreak, sharply increased its death toll by more than 3,700 victims on Tuesday, after officials said they were now including people who had never tested positive for the virus but were presumed to have died of it. 3. Italy According to Prof Walter Ricciardi, scientific advisor to Italy's minister of health the high rates are due to demographics and the manner in which the nation records deaths. "The way in which we code deaths in our country is very generous in the sense that all the people who die in hospitals with the coronavirus are deemed to be dying of the coronavirus" 51 https://www.telegraph.co.uk/globalhealth/science-and-disease/have-many-coronaviruspatients-died-italy/ 4. UK Peter Hitchens https://www.youtube.com/watch?v=e66-8_JXq6o 5. Belgium "And that includes deaths suspected

to be from COVID but not actually tested. More of those deaths are in care homes. Dr De Keersmaecker said: "If we think the people are dying of COVID, we count it."

10.7.6 Death Registrations

Arguably the best alternative to see if there is a problem is by analysing the registered death numbers. These figures are deaths and not effected by bias in assigning cause of death. **Although registered deaths do not prove Covid-19 was the cause for the excess deaths, we can say if there are no excess deaths then COVID-19 has not had a significant effect and may not been so deadly.**

As with all data the data is not necessarily 100% reliable because it depends on how diligently the registration process was carried out by the chain involved in the registration process.

There have already been several analyses performed on excess deaths, in Europe and in the USA. These all concluded a bleak picture. For example, Figure 9.10 extracted from

https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Weekly_death_statistics&stable#Dramatic_rise_in_deaths_in_early_spring

shows a disturbing increase in total deaths during the Covid-19 period that must not be ignored.

Figure 1: Weekly deaths in 24 European countries, 2020 and average 2016-2019 (deaths)

Source: Eurostat (demo_r_mwk_ts)
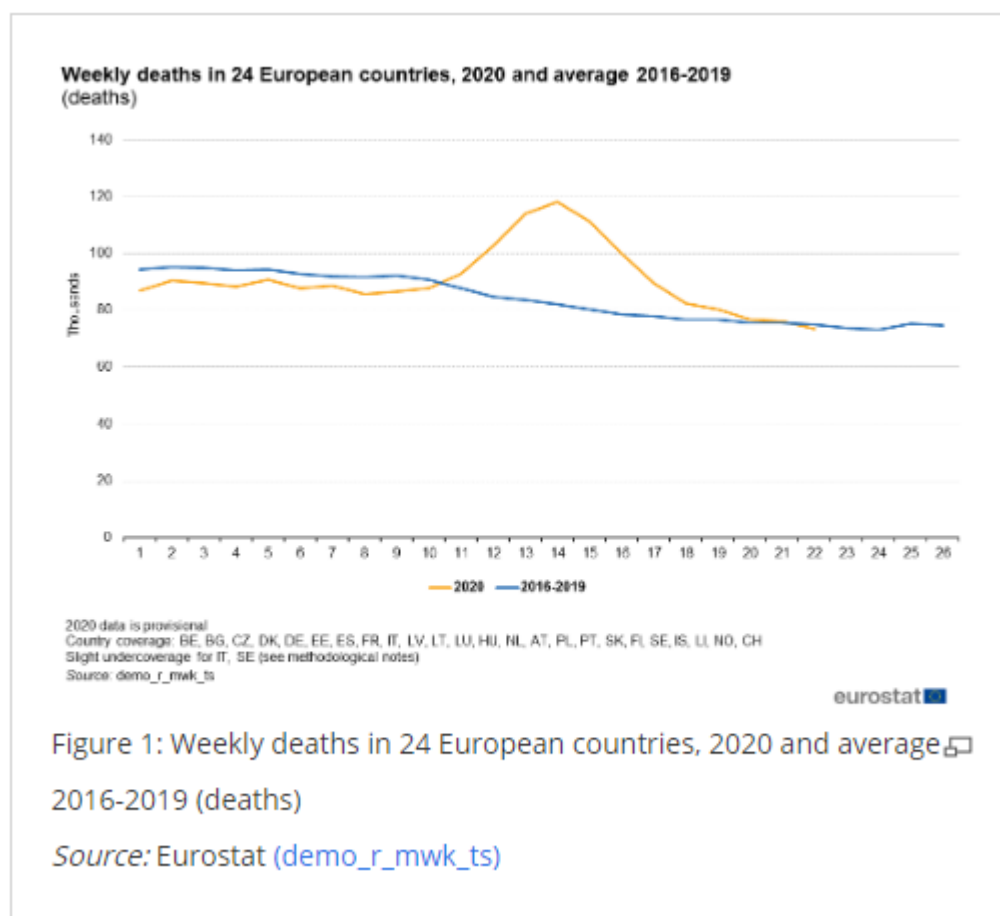
Figure 10.10 Weekly deaths in 24 European Countries compared with the average of 2016-2019 deaths.

Throughout the Covid-19 pandemic there has been a tendency towards reporting in a manner that amplifies the severity of the virus, instead of attempting to obtain a long-term perspective to obtain a better insight into the severity. For example, though not useless by any means, the analysis in the above link gives no real perspective over time and instead compares performance with the average of the previous three years for the same time-period. That assumes that the same time-period has a similar number of deaths which should not be assumed.

To provide perspective 'distribution optimized Hybrid SPC charts' are drawn. Statistical Process Control (SPC) charts have been used in Manufacturing for process control for decades to ensure that operators do not overreact to natural variation in the process. Reacting to natural variation causes more harm than good, which may have happened with Covid-19.

Control limits for normal SPC charts are based on a theoretical probability distribution which does not apply to deaths. Hence distribution optimized charts are used which determine control limits from the actual distribution found for the deaths.

Figure 10.11 shows two different distributions for total deaths over time for two different countries.
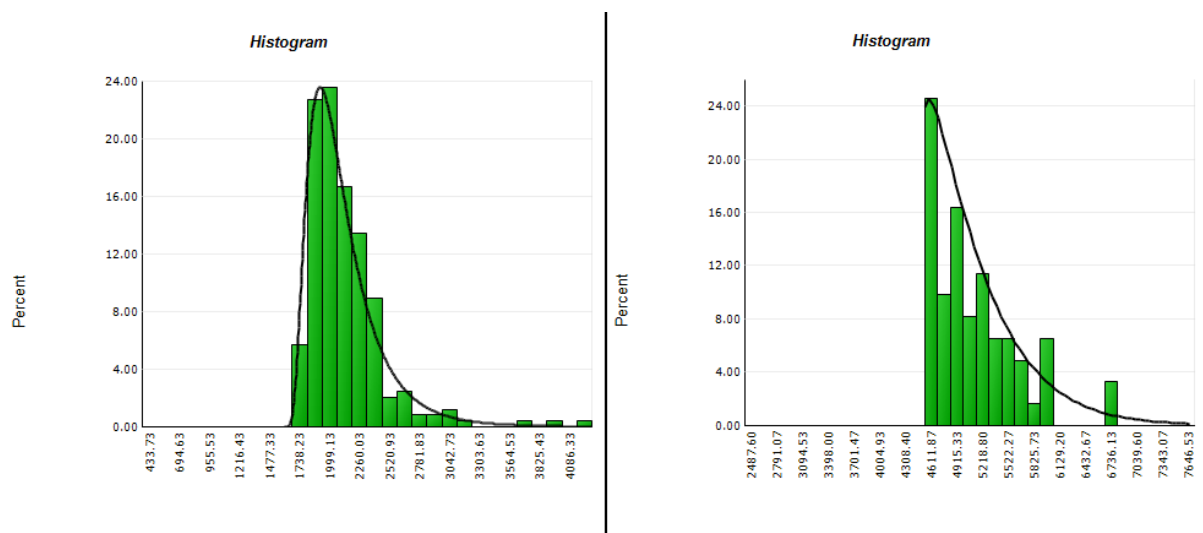
Figure 10.11 Two distributions for total deaths over time from two different countries.

(Figure 10.11 shows the futility in assuming one distribution for all countries which has unfortunately been assumed during many model simulations.)

The extremes are used to determine the red control limits. Any total death falling outside these limits means that the number is unusual. Unusual does not mean unacceptable. Unacceptable should not be based of statistical theory, or any theory. No death is unacceptable because death is part of life. We must accept deaths. What is unacceptable is unnecessary premature death that is not part of the natural cycle of life. But we must consider the price of preventing unacceptable pre-mature death.

Not too much should be made of the red limits in terms of the exact value. They should be used as **a guide** only to obtain perspective from.

10.7.6.1 Europe

Table 10 shows Hybrid SPC charts for 18 European countries with a wide variety of death rates.

The rectangles are the region within which deaths were reported with case data.

Data was obtained from https://ec.europa.eu/eurostat/web/population-demography-migration-projections/data/database

Table 10 Hybrid SPC Charts for selected European Countries as at 20th December with currently available data.

Austria
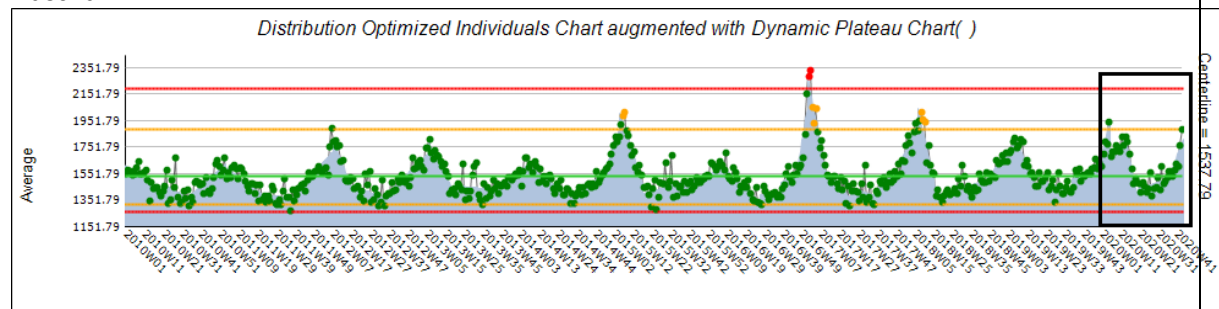
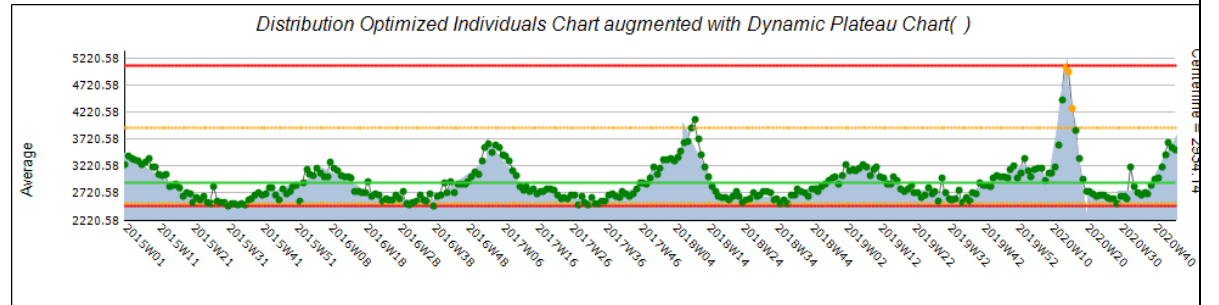SARS-CoV-2 had no effect on death registrations. There were significant excess deaths at other periods (flu?).

Belgium
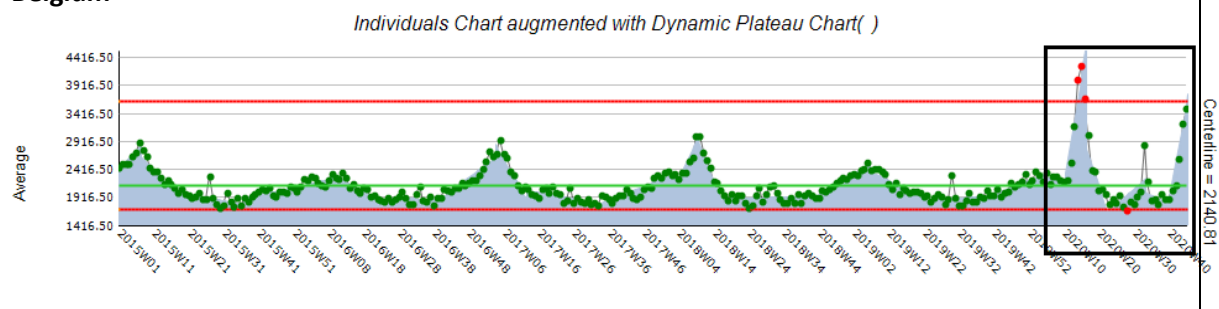
Belgium is the only country that is having a problem with the first and second wave.

Bulgaria
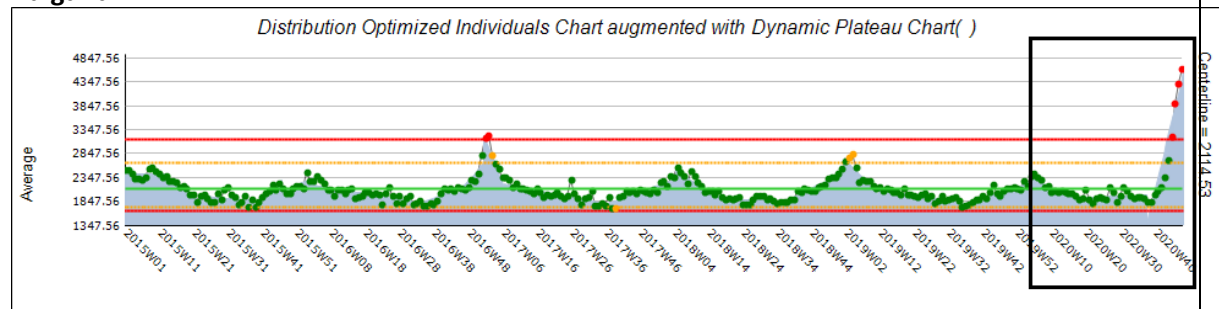
SARS-CoV-2 had no effect on death registrations during Europe's first wave but is now.

Czechia
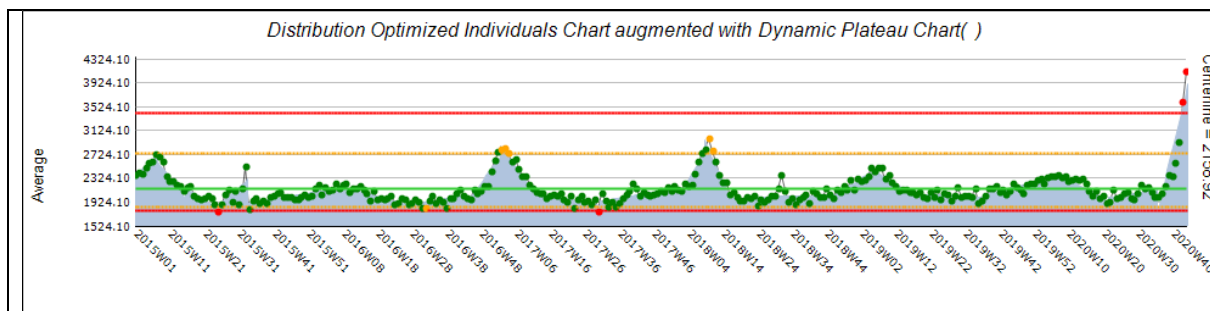
SARS-CoV-2 had no effect on death registrations during Europe's first wave but is now.

France
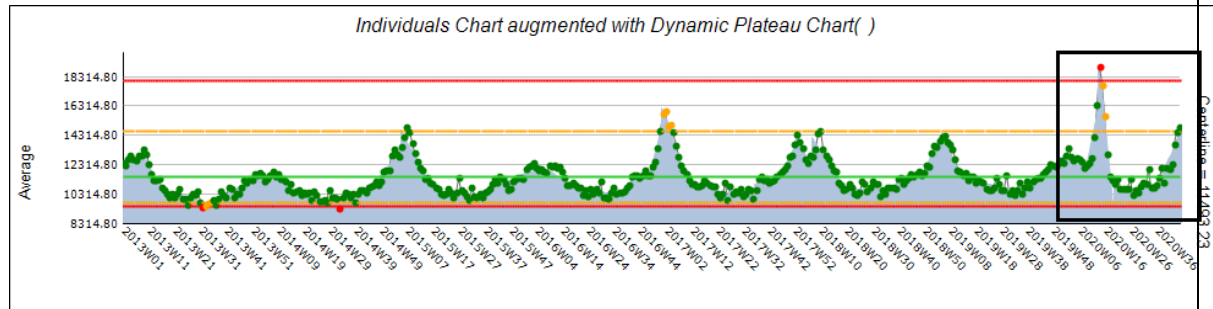
SARS-CoV-2 had an effect during the first wave but at this stage does not seem to have a serious impact. This may of course change

Germany
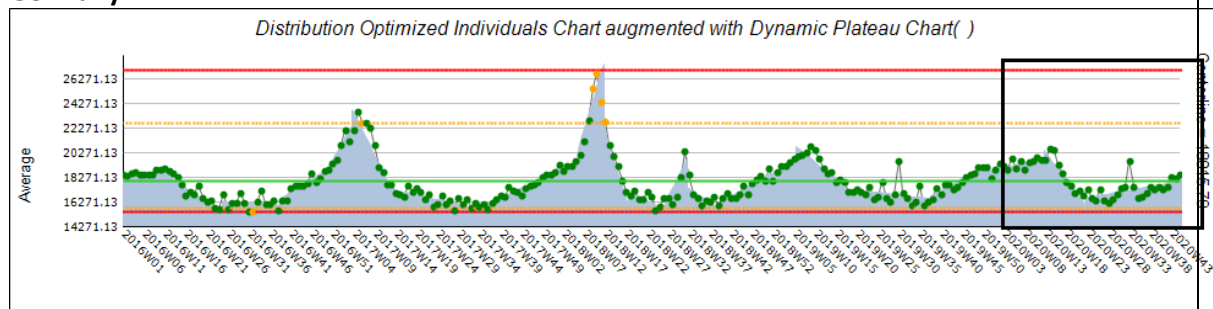
SARS-CoV-2 had no effect on death registrations. There were significant excess deaths at other periods (flu?).

Hungary
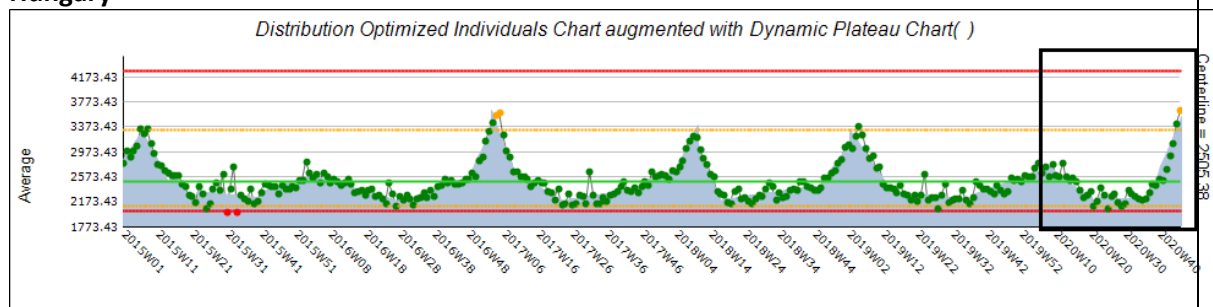
SARS-CoV-2 had no effect on death registrations

Italy
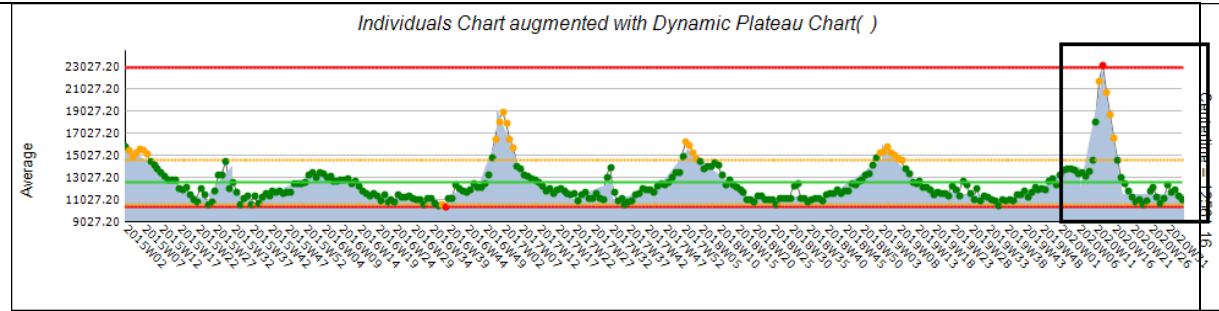
SARS-CoV-2 influenced death registrations during the first wave

Netherland

SARS-CoV-2 had an effect during the first wave but at this stage does not seem to have a serious impact. This may of course change

Norway
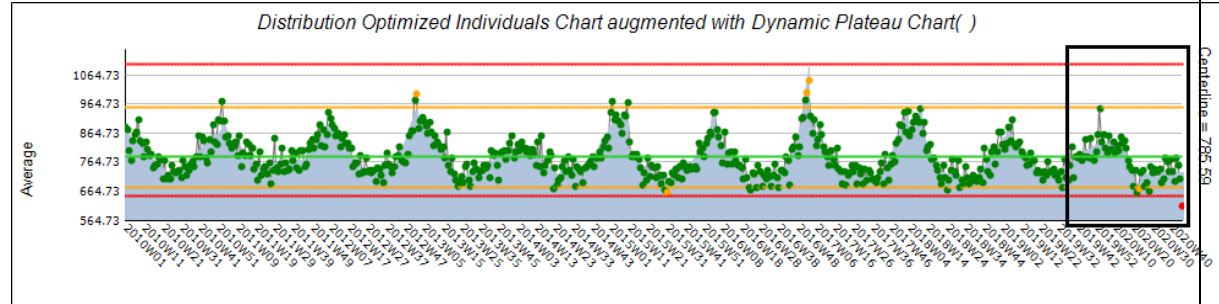
SARS-CoV-2 had no effect on death registrations

Poland
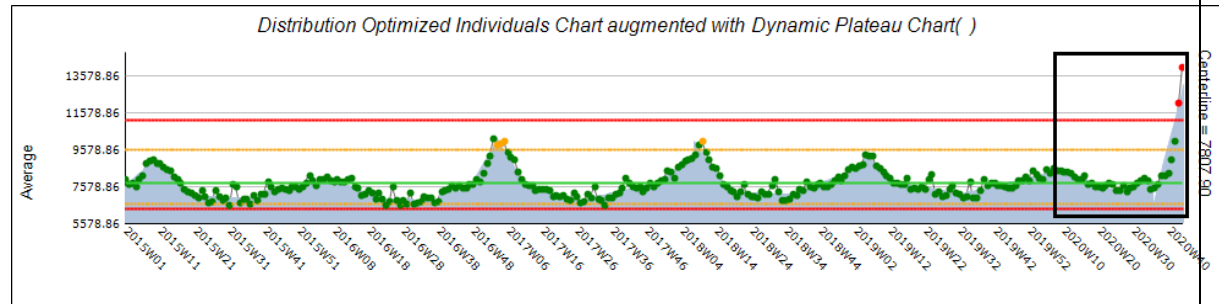
SARS-CoV-2 had no effect on death registrations during Europe's first wave but is now.

Portugal
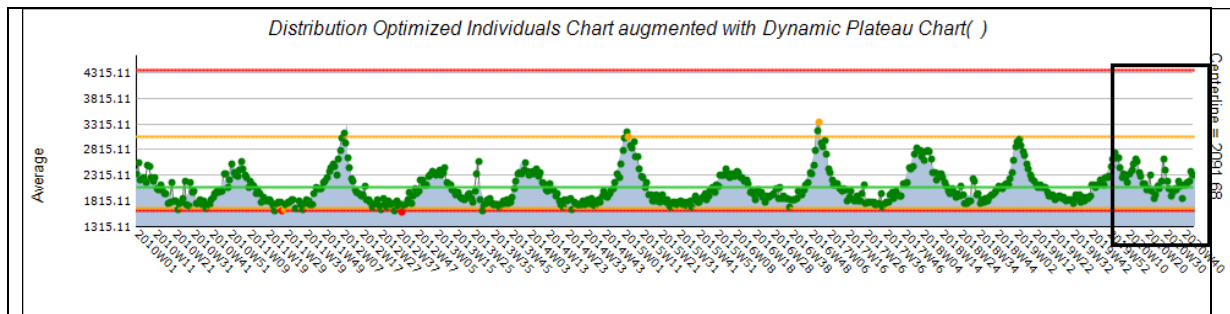
SARS-CoV-2 had no effect on death registrations

Serbia
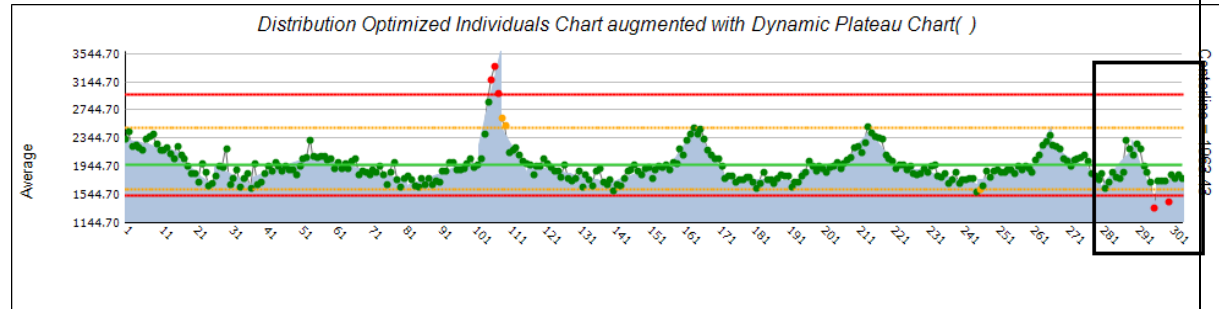
SARS-CoV-2 had no effect on death registrations

Spain
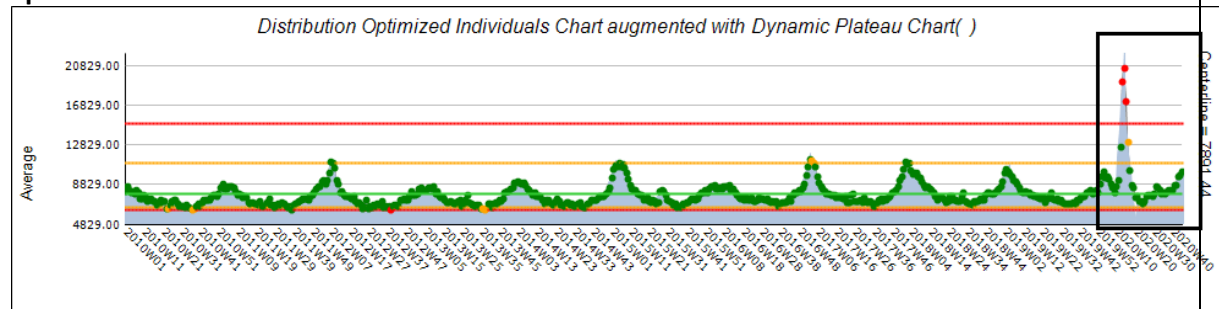
SARS-CoV-2 influenced death registrations during the first wave

Sweden
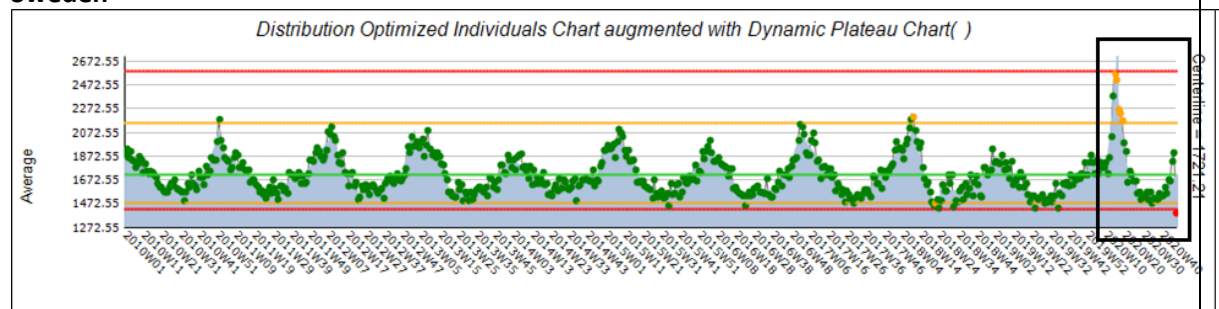
SARS-CoV-2 influenced death registrations during the first wave

Switzerland
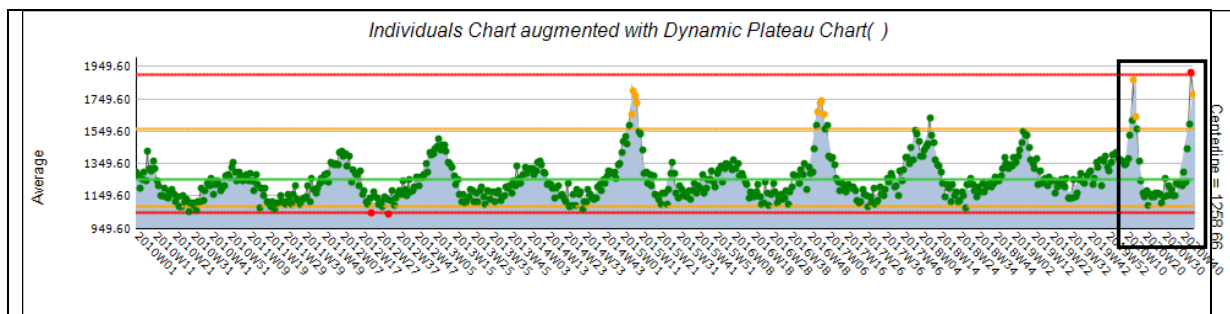
SARS-CoV-2 influenced death registrations during both waves

United Kingdom
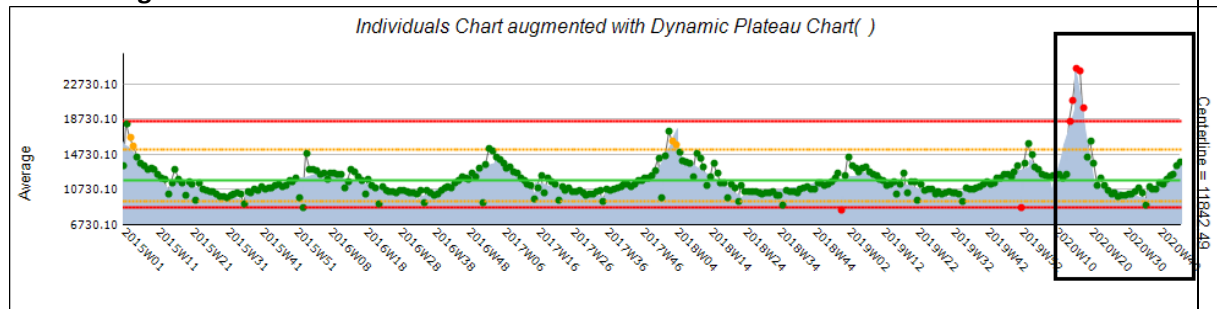
SARS-CoV-2 influenced death registrations during the first wave

Estonia, Croatia, Latvia, Slovakia, Serbia, Lithuania, Romania, Slovenia at the time of writing this report were all not impacted by SARS-CoV-2.

At the time of this report out of the 36 European countries analyzed only the UK, Italy, Spain, Belgium, Netherlands, France, Sweden (7 countries) had registered deaths that fall outside normal variation.

Sweden who only had some abnormal deaths (and there may be reasons) earlier in the year, now has no unusual deaths. Sweden did not ignore its people's right to freedom and is coming out on top.

For some countries there were times when the flu had the same magnitude of excessive deaths, but there was no panic, just acceptance. European countries and US states have a strong seasonal death effect. If our motive of saving lives is genuine why could we not have put money into reducing the seasonal effect, such as possibly better heating for the elderly, instead of destroying the economy. The total deaths saved would be far greater than those blamed on Covid-19.

For the second wave at this stage only Bulgaria, Czechoslovakia, Hungary, Belgium, Poland, Austria, and Switzerland have out-of-control deaths out of the 36 countries. All but Belgium had no unusual number of reported deaths in the first wave, because the first wave was a fraction of the second wave.

Although these numbers are provisional or estimates, experience has shown that final confirmed number are statistically similar. The fact that only some countries had high registered deaths, there was no justification to bring the world to its knees and cruelly ruining people lives. Considering that it is normal to have spikes the frequency of the unusual countries is also normal, based on our years' experience with data. There must be acceptance that sometimes there will be more deaths and we must deal with this non-destructively.

For all the European countries analyzed there were no unusual, registered deaths for those below 50 years of age. If there is no impact on total registered deaths for those below 50 years, how can we say that the virus kills young and old? How can teachers have been so irresponsible to scare little children by telling they will die if they do not wash their hands. How can we coerce all age groups to vaccinate? Why not save the vaccination costs by not vaccinating those that clearly are not in danger?

If we used real science, we would have focused on finding out why a few countries had such a high number of deaths. Was it due to panic mismanagement causing overwhelming, or patients too scared to go to hospital? Was it due to excessive pollution? Lombardy has a health problem with its pollution. According to some reports, in the UK one person dies every 5 minutes with a lung problem. That is 105,000 each year.

Nothing unusual does not mean that some countries did not experience extreme difficulties, but when it comes to perspective it is hard to justify flattening of the world economy based on the deaths from Europe. It may have been cheaper to build more field hospitals or temporary hospitals if overwhelming was the issue.

10.7.6.1 USA

The data source we used was from the CDC
https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm

The CDC acknowledged limitations in the data. Our analysis found discrepancies when cross checking for validation that made no sense. It was hard to determine what the data meant, for example in the downloaded spreadsheets a column may say Observed number, but elsewhere the same column is called predicted total counts.

For the sake of completeness, we proceeded to re-analyse the publicly available data on the website and compared conclusions.

Figure 10.12 shows Total Deaths for United States as obtained from the above link
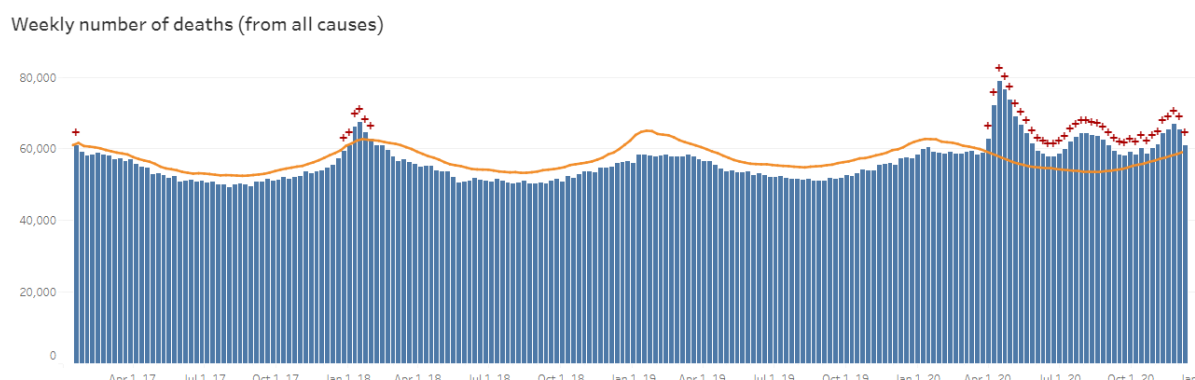
Figure 10.12 Weekly Total Deaths for United States CDC chart

Using the same data the chart shown in Figure 10.13 was obtained.
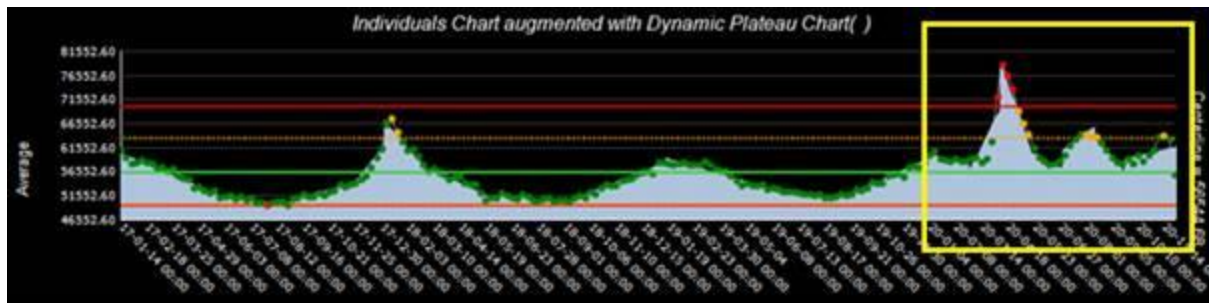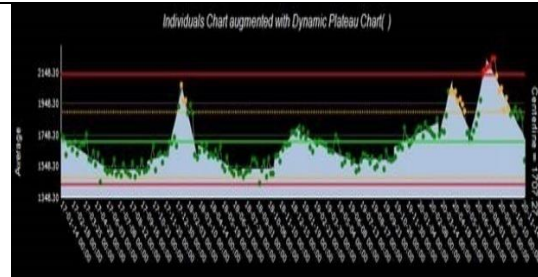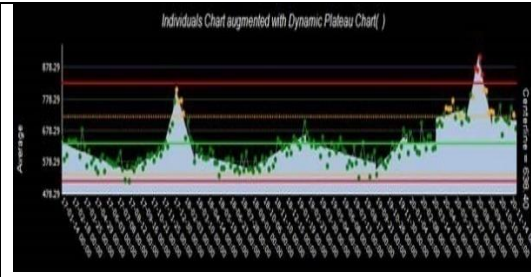
Figure 10.13 US weekly total deaths Hybrid SPC chart

The same analysis was performed for all the States of the United States of America.

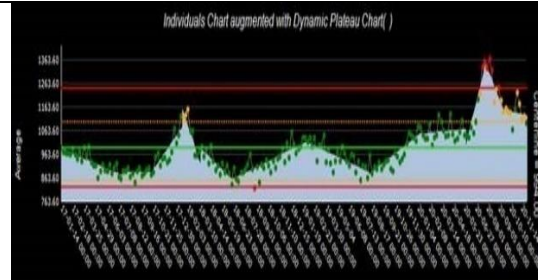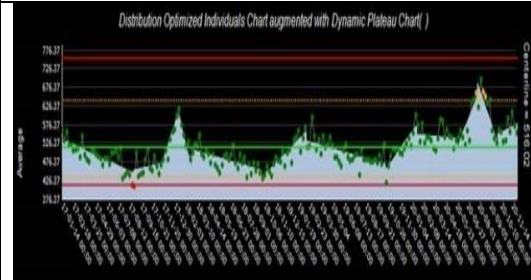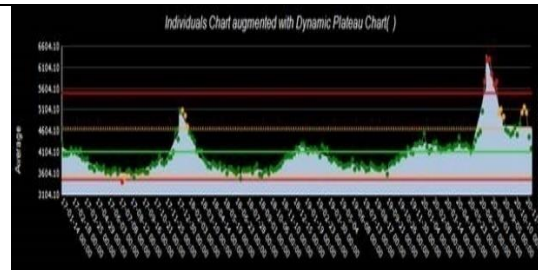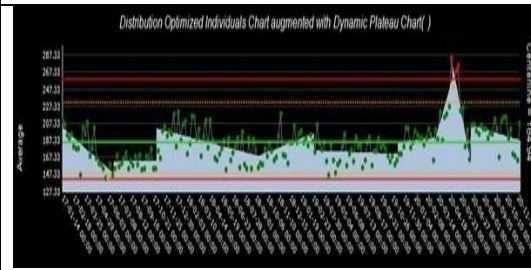New York State

Connecticut

Massachusetts

New Jersey

Alabama

Arizona

Florida
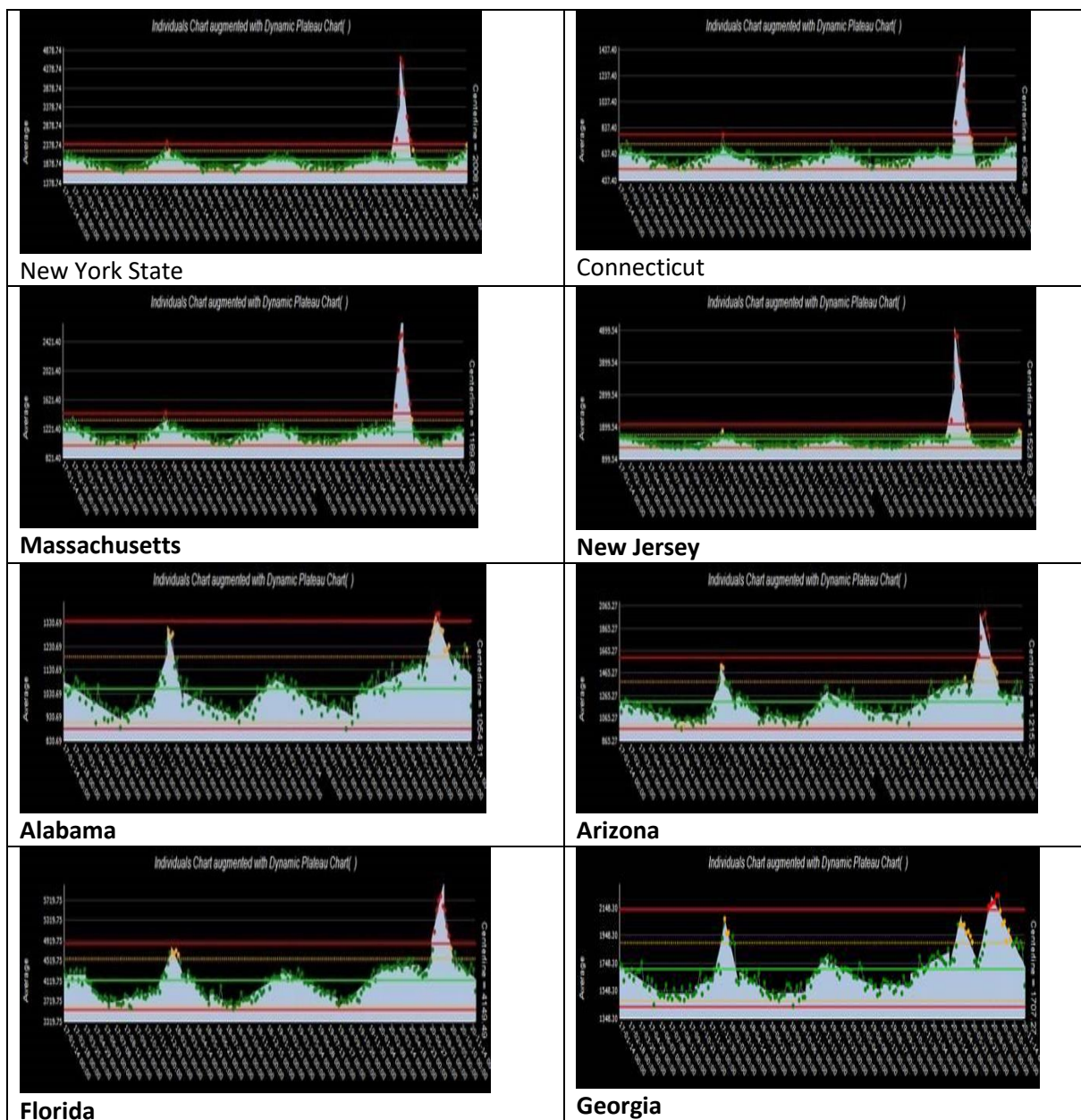
Georgia

Georgia	**Mississippi**
South Carolina	**Nevada**
Texas	**Delaware**
Colorado	**Illinois**
Indiana	**Michigan**
Minnesota	**Maryland**
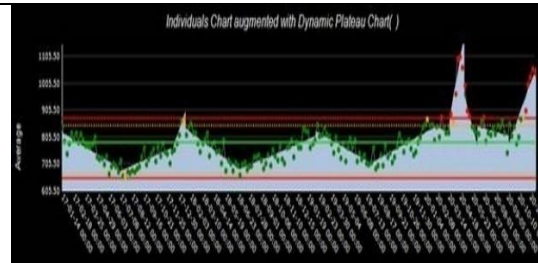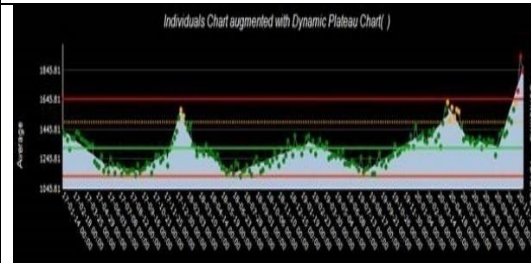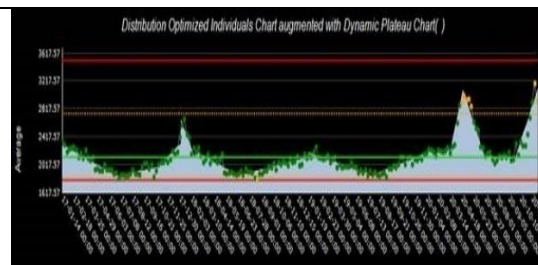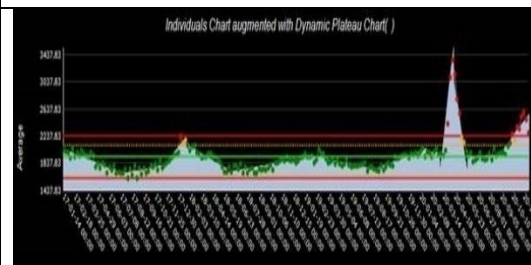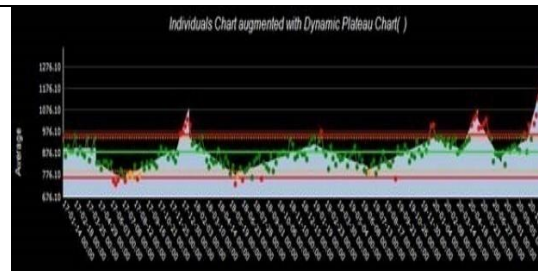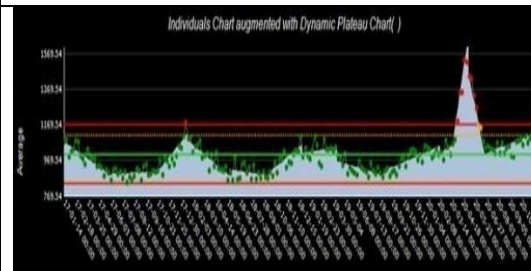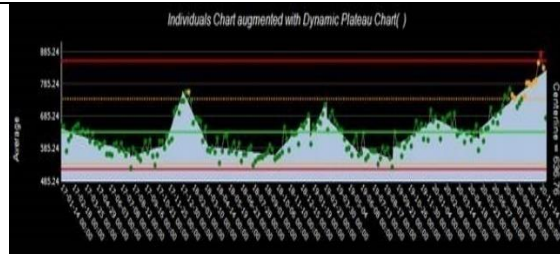
Arkansas
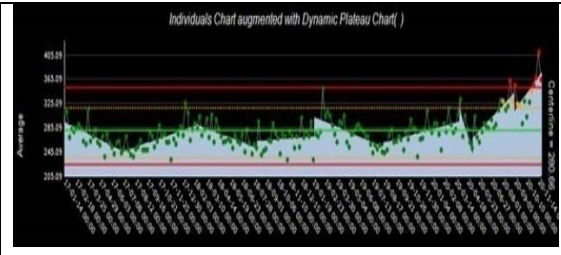
Idaho
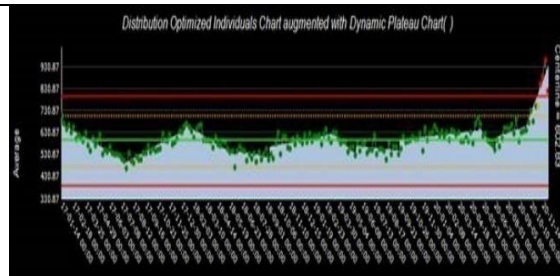
Iowa
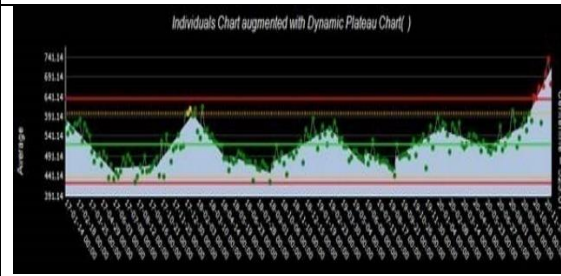
Kansas
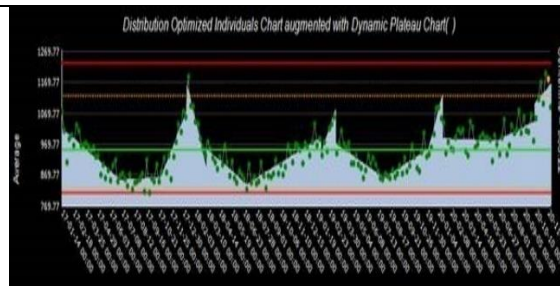
Kentucky
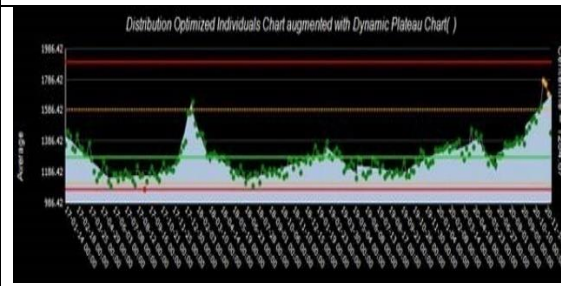
Missouri
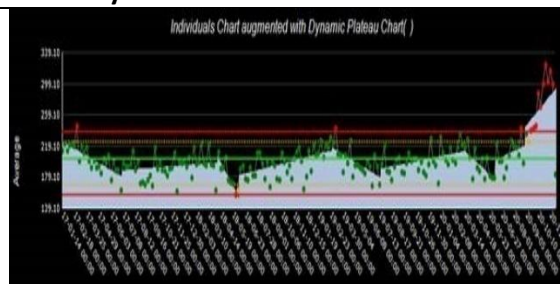
Montana
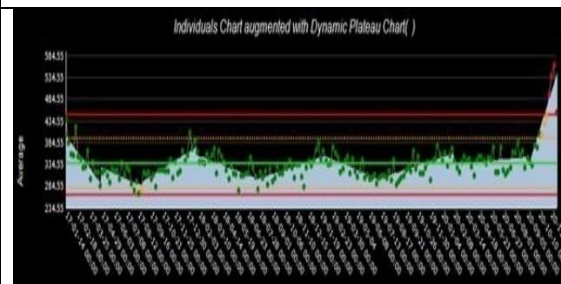
Nebraska

North Dakota

Ohio

115
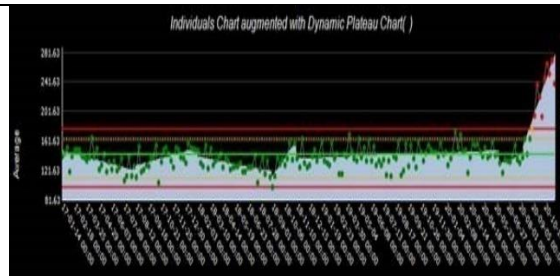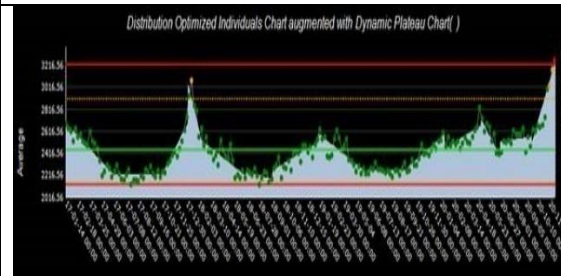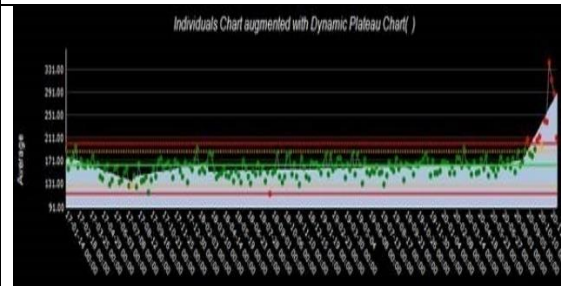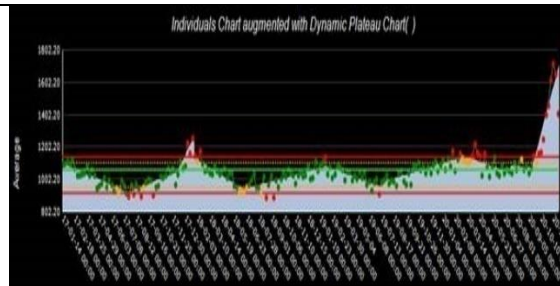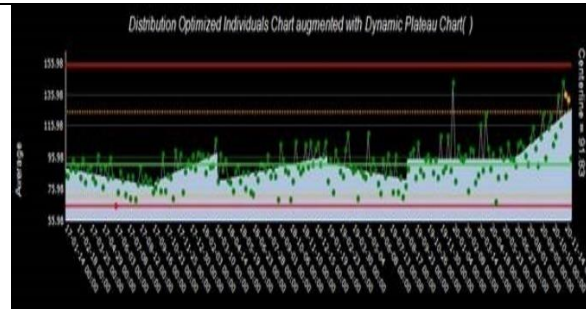
Wisconsin	South Dakota
Wyoming	Alaska
California	Hawaii
New Hampshire	Oregon
North Carolina	West Virginia
Maine	Oklahoma
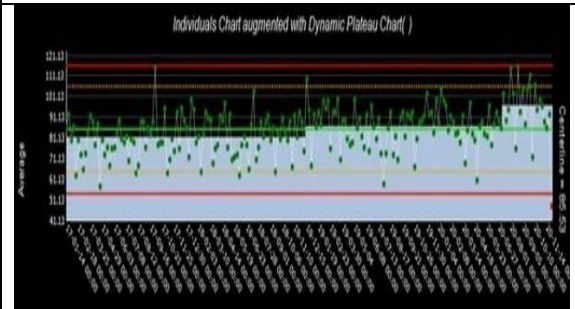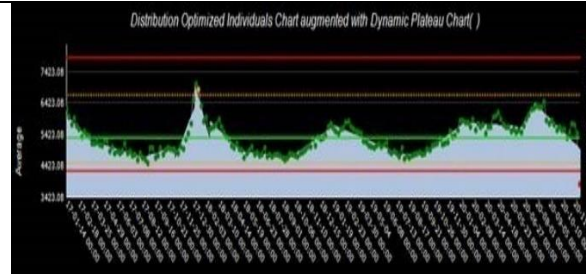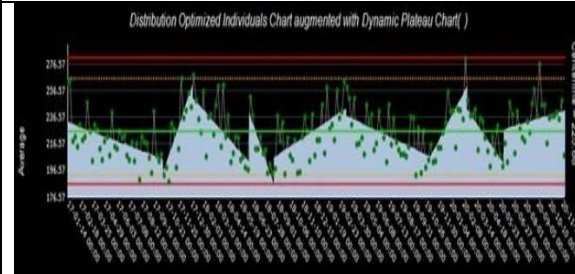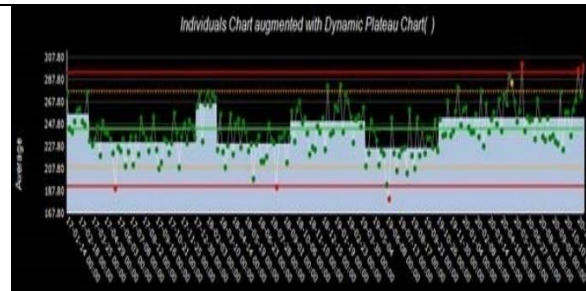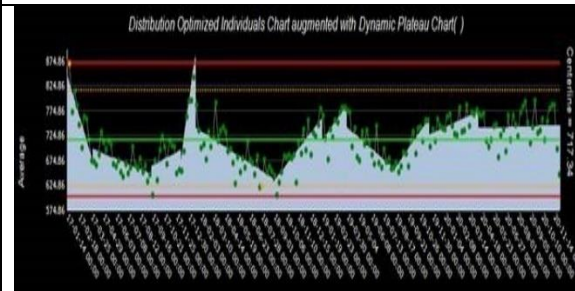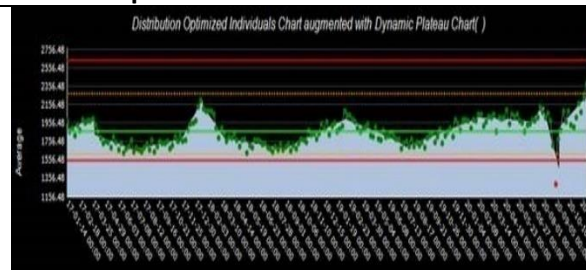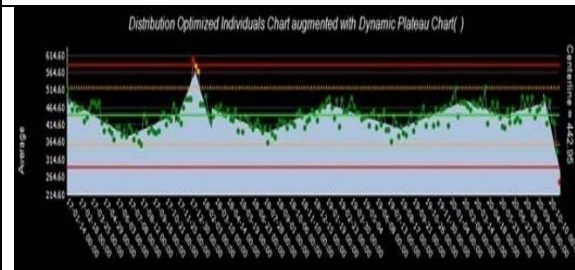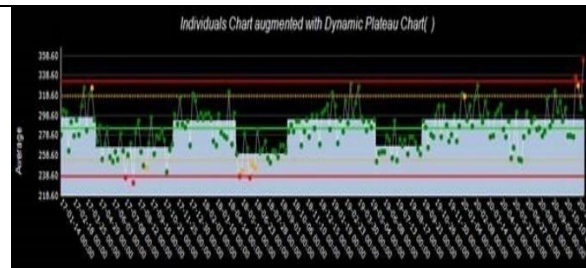
Louisiana

Pennsylvania

New Mexico

Tennessee

Utah

Virginia

Washington
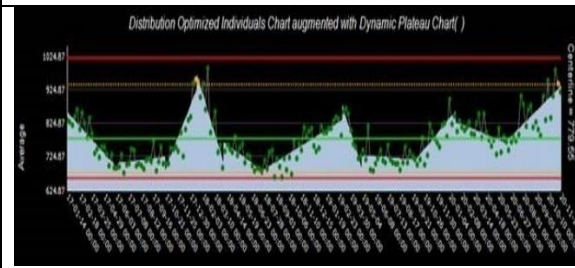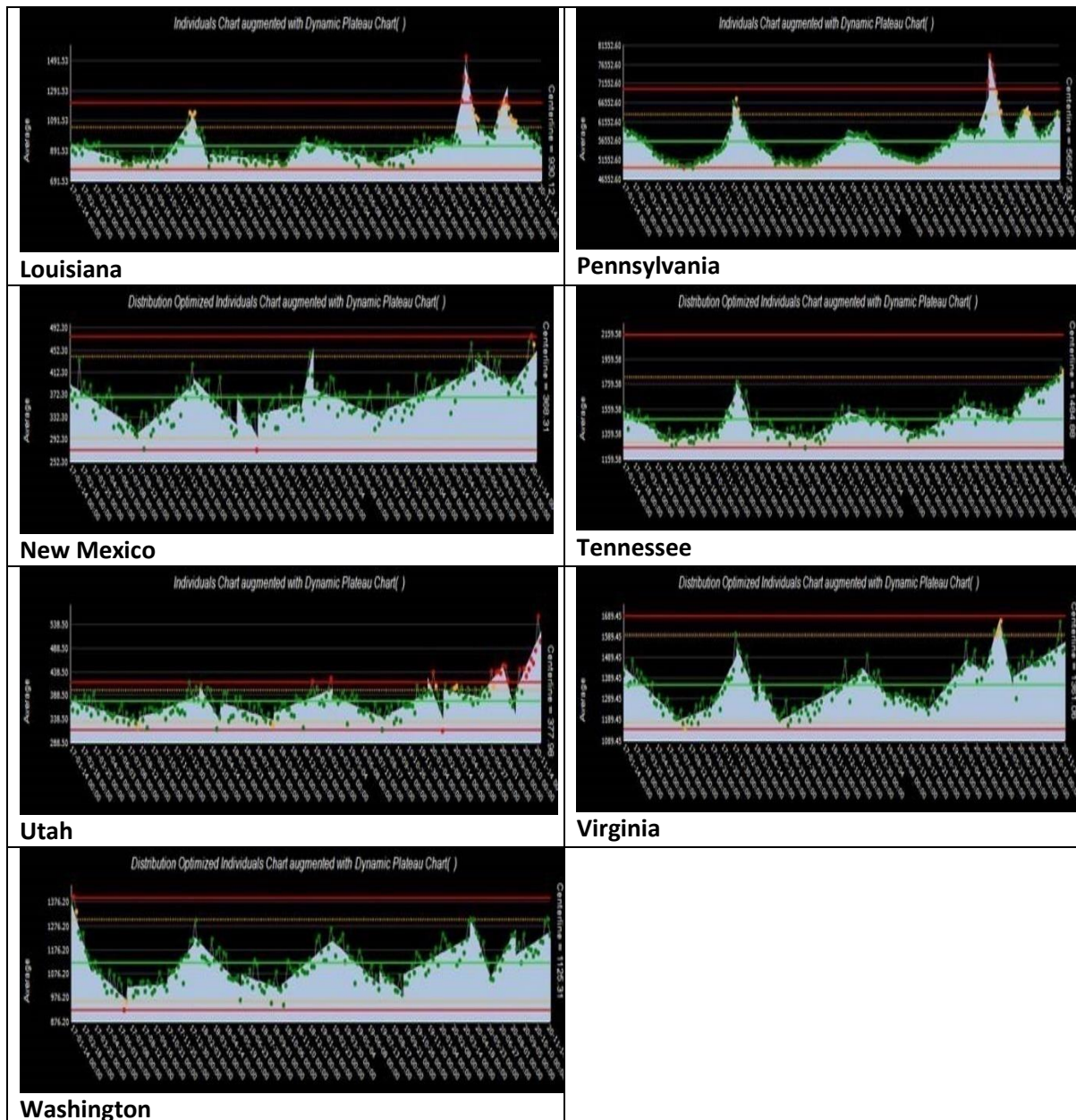
Different states have different death waves. Some states who have had high deaths during the first wave have had no new waves. Others who have had no initial waves have had high second or third waves. Some states only had high second waves. No first wave and no third wave.

This emulates Europe. For all states those below 50 were unaffected by SARS-CoV-2.

Although it is acknowledged that during the Covid-19 period the US and some European countries had higher than normal deaths whether these justify destroying lives and resetting the economy is debatable.

Section 11 Possible Reasons for High Excess Deaths in some countries and cities and low numbers in most others.

11.1 Different strains of the virus

Only virologists are qualified to comment on this possibility.

11.2 Demographic factors

No obvious factors have been found at this stage. However, a more thorough study may find demographic factors by considering interaction effects. Such a study may be performed in the future.

11.3 Pollution

Wuhan's Iron and Steel Factory emitted pollution that resulted in Acid Rain which can be expected to have caused respiratory health problems.

Lombardy in Italy's extremely high pollution is known to have caused serious Health Problems

London, once the city of smog, is highly polluted, although recent improvements have been made. 10000 people are diagnosed with a new lung disease every week. Someone dies from lung disease in the UK every 5 minutes

.
(https://statistics.blf.org.uk/?cmp_id=1486843417&adg_id=63798229194&kwd=%2Bhealth%20%2B
pollution&device=c&gclid=CjwKCAjw_Y_8BRBiEiwA5MCBJrEBHxkX_d2Z7YAy5QjV-
A7ggRePUa_ALIGv6LFarUF7Oc1OEO7SxoCo-UQAvD_BwE)

Quito, Ecuador according to reports had "bodies abandoned on sidewalks, slumped on wheelchairs, packed in cardboard coffins and stacked by hundreds in morgues"
https://www.nytimes.com/2020/04/23/world/americas/ecuador-deaths-coronavirus.html

How much of these reports involving staging for publicity is hard to determine.

However, Quito is a city with respiratory illness problems due to severe air pollution emitted by manufacturing plants as well as motor vehicles. JURADO, J., & SOUTHGATE, D. (1999). Dealing with air pollution in Latin America: The case of Quito, Ecuador. Environment and Development Economics, 4(3), 375-388. doi:10.1017/S1355770X99000248

There seems to be an obvious common denominator to the high death variation. EXTREME POLLUTION.

Unfortunately, there are also many inconsistencies. Beijing has high pollution but much lower deaths per million. France is in the top 10 cleanest countries. This however does not mean pollution is not a factor, because there may be other interacting factors.

Excessive pollution makes sense though. If over the years, the respiratory system has been compromised then Covid-19, or any virus which attacks the respiratory system is likely to exasperate symptoms, including causing more deaths.

Research needs to be conducted in this area.

11.4 Fear of death and panic caused by hysteria fed propaganda.

11.4.1 Did the world succumb to panic and fear?

Only a few countries had significant spikes and there are reasons for that which advisers should have investigated. Instead, the virus was treated as equally deadly in every country.

The human response to the idea of a deadly airborne respiratory virus may have had significant effects. Deaths may have been caused, not by the virus, but the unavailability of hospital beds because elective surgeries had been cancelled. Many people refused to check themselves into hospitals for fear of the virus which resulted in deaths. What about the fear of death? To be told one may have contracted a very deadly virus may be a terrible shock for many. How many people died or became sick because they believed death was near or even certain? Did we consider the impact of fear on human health? Was this even considered? This is an area that needs more research.

We need to accept that human failures in terms of non-rational responses and general incompetence occur in all professions and may have impacted the course of the pandemic and influenced the outcomes, including in terms of negative health outcomes and deaths. Decisions by doctors and public health advisors may have been inadvertently causal for death due to inadequate scientific information or understanding. Such circumstances may have varied between countries. When doctors are convinced of the deadliness of a respiratory airborne virus, is it not possible that their responses and treatments may cause more problems than the actual harm of the virus itself?

We need to accept that many people may have died due to our responses, both personal and government led, to the SARS-CoV-2 phenomenon and may have contributed to the unusual high deaths in some countries.

Referring to the table below we noted that for the first European wave those European countries with unusual, registered deaths had lags between case peaks and death peaks much less than expected 21+ or so days. Those that did not have high deaths had the expected lag. That implies that many people died because they checked themselves in too late, possibly through reluctance to go to hospital or overwhelming. If the latter, then we needed to merely increase temporary capacity and shared medical resources instead of destroying lives.

According to the following source and others it takes around 3 weeks +/- to die once catching the disease and 5 days less from diagnosis as it takes on average 5 days for symptoms to appear.

https://www.dailymail.co.uk/news/article-8192993/The-coronavirus-death-lag-explained-weeks-fatality-recorded.html

Table 11 provides a visual perspective of the time lag between reporting positive cases and deaths for countries. These happen to be the USA and European countries extensively reported in the media.

The red bars are for deaths. Because death numbers were so high the scale for deaths was increased to make the bars visible.

Table 11.1 Comparing Countries with excess deaths and without excess deaths from the list that received extensive coverage by the media.

Countries with Excess Deaths	Countries without Excess Deaths
Belgium	Australia
Italy	Austria
Spain	Germany

Netherlands	Norway
United Kingdom	
USA	
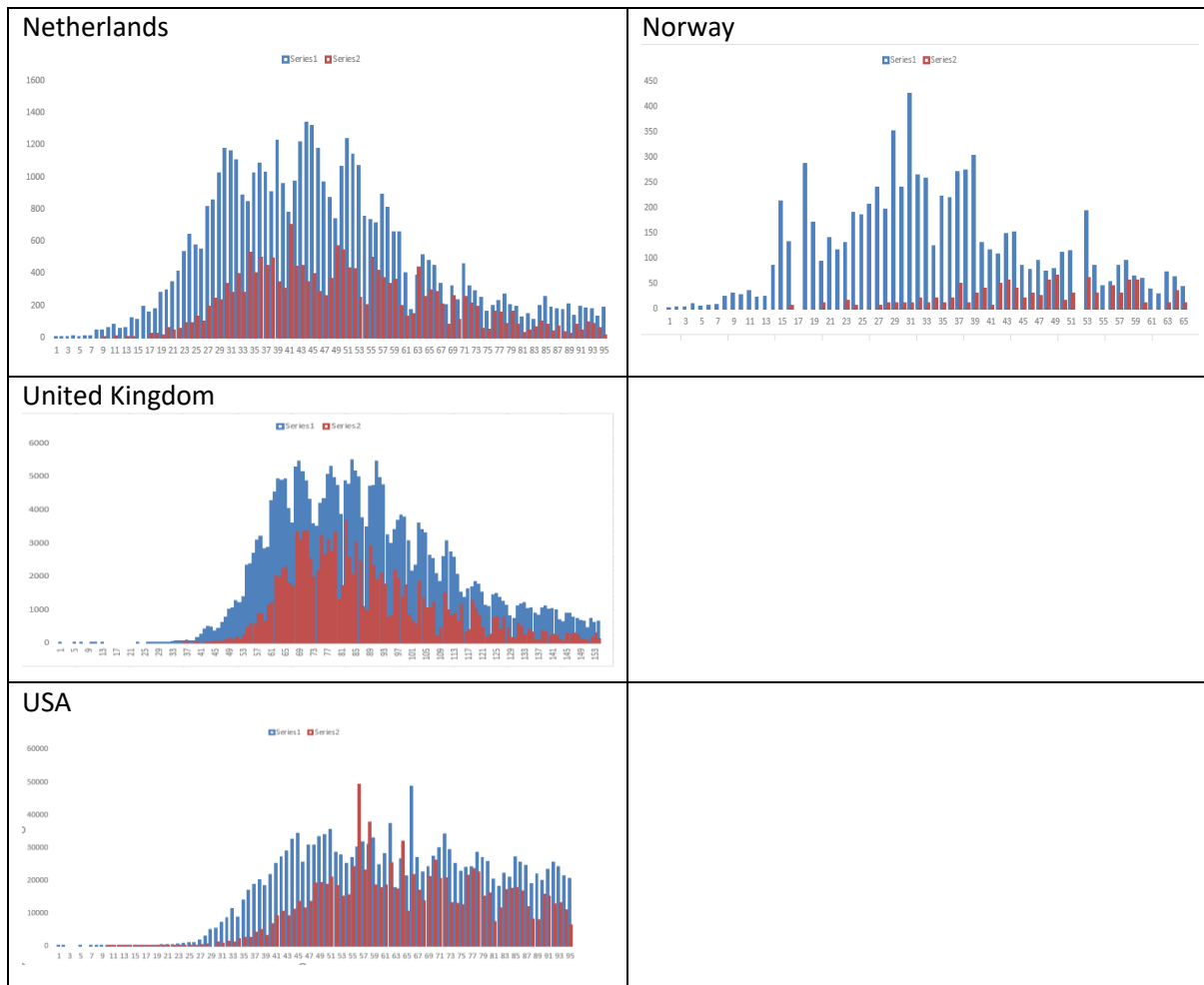
Table 11.1 conclusively shows that there is a highly significant difference in lags between cases and deaths for the European countries that have received considerable media coverage. The first column shows the case and death peaks have much smaller differences than the second column.

There is no modeling used. Anyone with access to the data can perform the same analysis.

"There is a highly significant difference in lags between cases and deaths for the European countries that have received considerable media coverage."

It is these countries that were used to justify shutting down the economy and destroying lives.

The difference in lag is conclusive and panic and fear caused by covid-19 propaganda cannot be excluded. It does seem that we may have caused the excess deaths for no reason but mismanaging fear and panic and indeed fueling fear and panic with Covid-19 propaganda.

Covid-9 propaganda inspired Fear and Panic seems to be a strong possibility to explain why countries in the left column had excess deaths. But why these countries?

Section 12 The second wave in Europe

The second wave in Europe is now causing considerable 'Angst' and several European countries are reinstating some containment actions. It has been noticed that the number of deaths is considerably lower that than during the first wave. This has resulted in experts suggesting a wide range of reasons, such as a different strain in the virus and better treatment, having learned from the first wave.

The most important factor has been overlooked, and that is the testing factor. Testing has increased exponentially and distorted the case numbers in the population. Case numbers have increased mostly because of testing having increased. For a given prevalence the more tests we take the more cases. It is the 'case equivalent' numbers in the population that effect deaths, not test samples. (If deaths only incur in test samples the solution to stop deaths is by stopping testing)

12.1 A global perspective

Figure 12.1 shows how the world as at 25th October 2020 global cases are increasing faster than at any time of the pandemic.
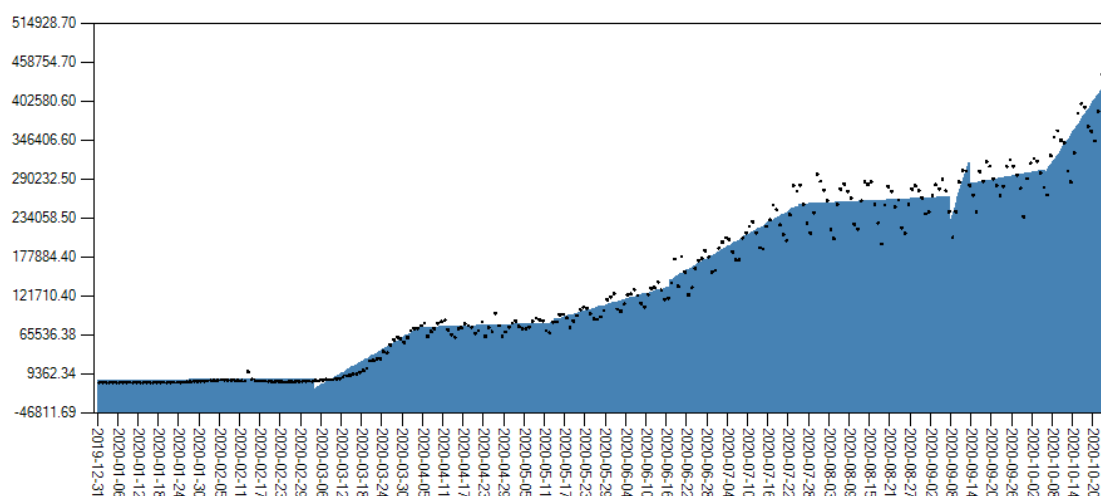
Figure 12.1 Global cases growing faster than ever before

However, reported deaths are not growing in proportion implying that the case fatality percent is reducing. These are shown in Figure 12.2
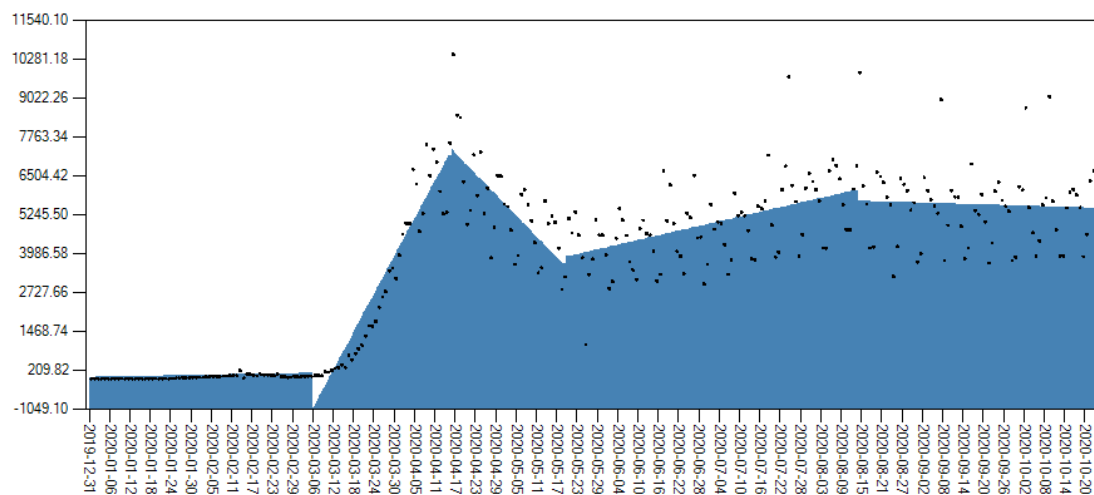
Figure 12.2 Global Deaths which are reducing

Figure 12.3 shows that testing has increased dramatically which is the major reason cases have increased. The more tests the more cases.
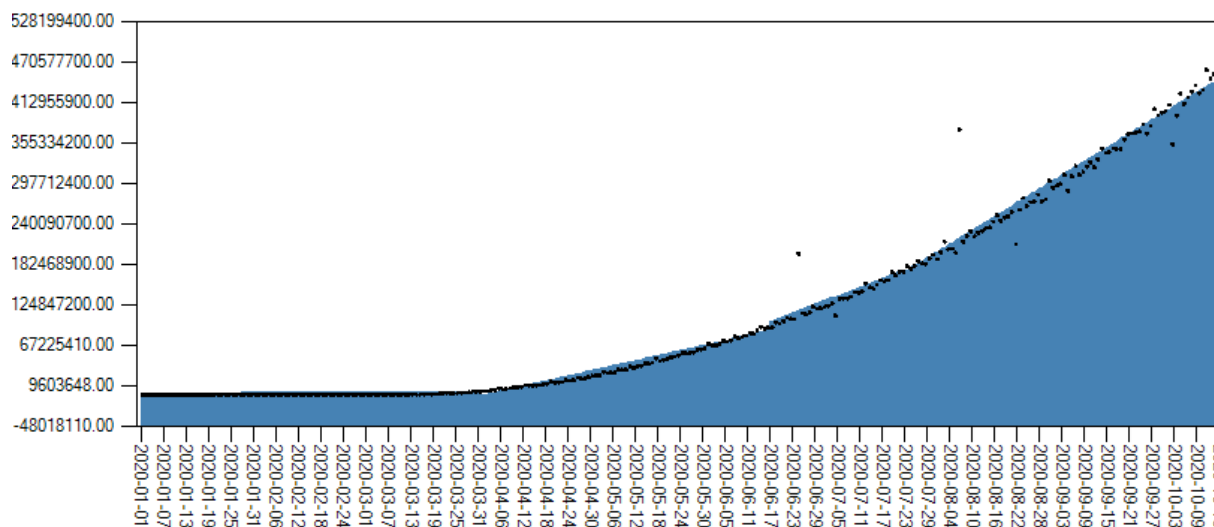
Figure 12.3 Total tests per day

Figure 12.4 shows that proportion of cases relative to test numbers is decreasing as at the 19th October. Figure 12.4 is as of the 24th of May 2020 because prior to that period test numbers were less than cases reported. It seems that many countries prior did not rely on testing as much as now
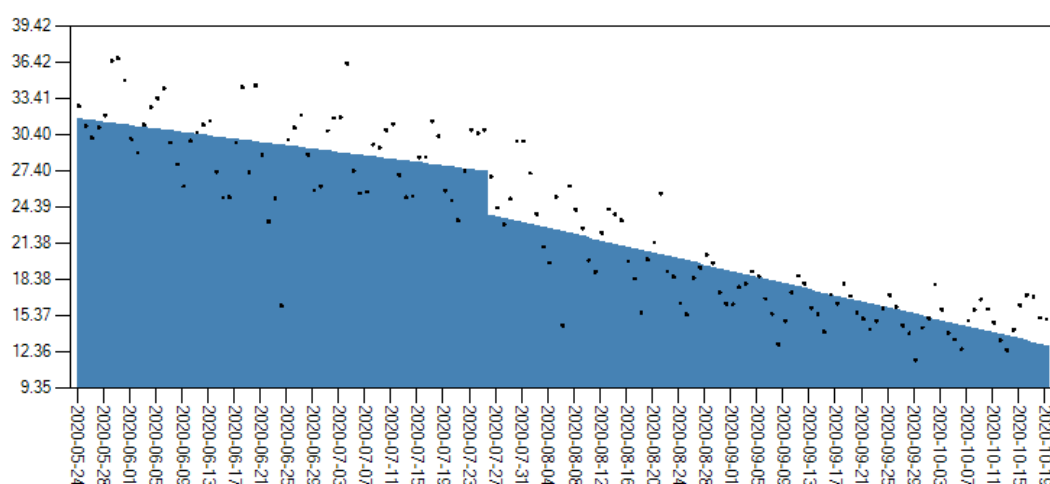
Figure 12.4 Case proportions relative to tests

Middle of October case proportions are running at around 15% over the last month. If we use this value as an estimate of population infections, then 15% of the world's population is currently infected with the virus. That means the true number of cases is equal to 1.17 billion. These are 'case equivalents', i.e. the type of cases found positive, which are mainly symptomatic. Recall annual flu infections can also be over 1 billion globally and possibly a lot more because we do not test for the flu as extensively.

The above conclusion does not incorporate variability. Individual countries will be more or less infected.

If this number is correct, then based on the last month where total deaths were around 173305 then case fatalities are equal to only 0.015% and probably less if all unknown asymptomatic cases are included.

Unfortunately, that is only an insight and should not be used as a factual estimate. Testing is focused around contact tracing, not prevalence estimation, and we do not know the false positive rate because an MSA has not been performed by the various countries (to the best of our knowledge) and reported deaths are highly biased.

2.2 Second wave in France as at 1st[th] at end of 2020

Figure 12. 5 shows the second wave from a case only perspective. Cases have increased dramatically causing 'Angst' once again.
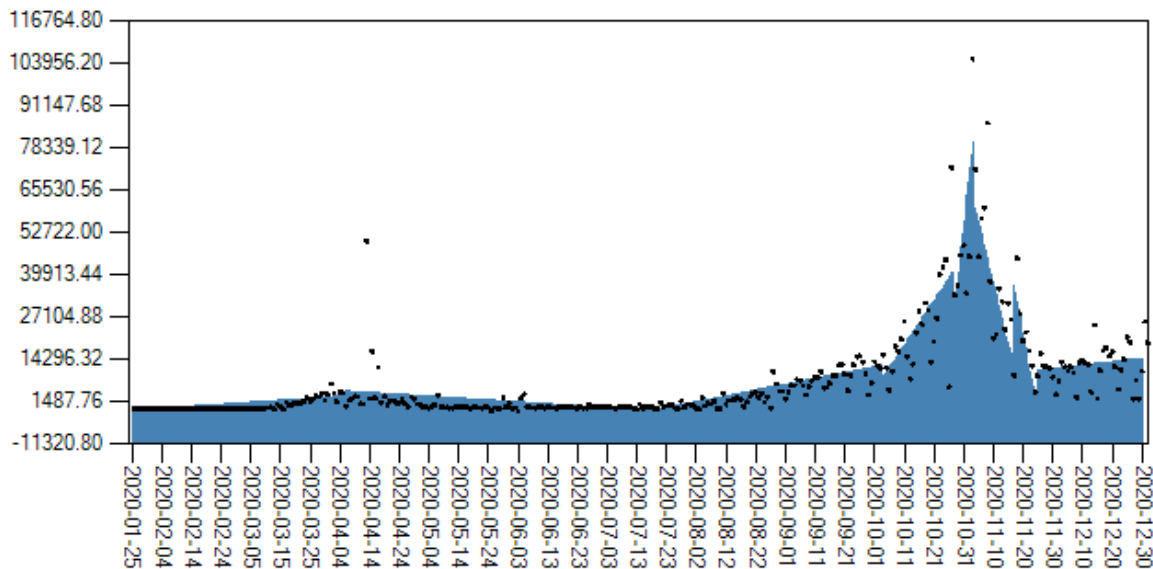
Figure 12.5 Cases in France showing a large increase in cases

Yet, figure 12.6 shows deaths have not gone up in the same proportion. Is the virus less deadly now. Then why the 'Angst' with the new strain? The peak lags make no sense. Are causes of deaths due to another cause, recalling the pimple death phenomenon.
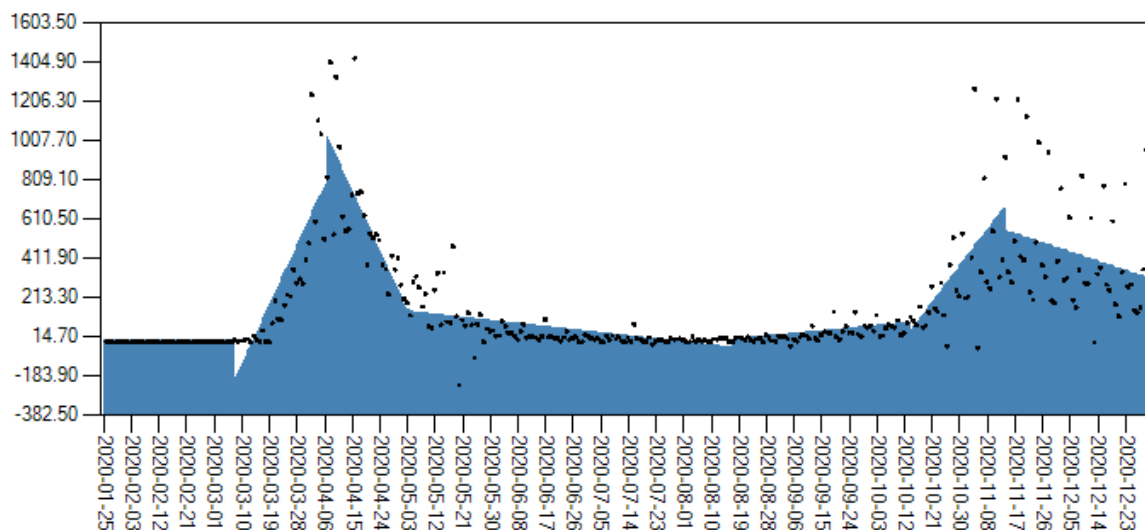
Figure 12.6 Reported Deaths for France which remain low compared to previous deaths.

Case Proportions- France's data was too dirty to calculate Case Proportions. Maybe the prevalence is much less, and case increases are only due to test number increases.

Figure 12.7 shows Hybrid SPC chart for France until Week 52
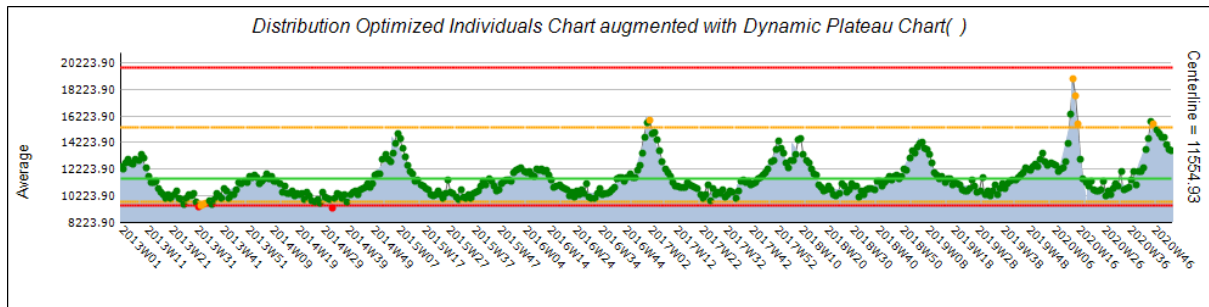
Figure 12.7 Registered deaths up until week 52 2020 show no sign of second wave reported deaths
affecting registered deaths.

As at week 52, considering variation in cycles, registered deaths are not significantly affected
contradicting reported death numbers. Perhaps the reported deaths are inflated due to biased
assigning of cause of death and hence there have been no extra deaths due to Covi-19 itself.

This explains why reported deaths did not make sense next to cases. We have a pimple death issue.
The deaths were due to normal factors expected due to cycling, taking into account that the
containment actions interfered a little with cyscles.

12.3 Second wave in Spain as at end of 2020

Figure 12.8 Shows cases for Spain as of week 52. The data was too dirty for proportion analysis. We
have noticed unusual amount of dirty data for several countries with high reported deaths. How
reliable is information from these countries?
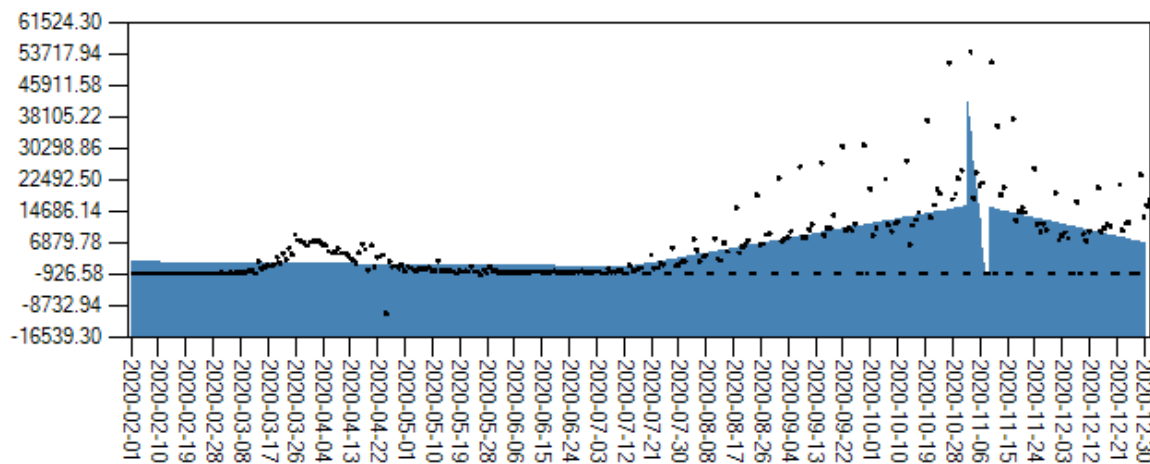
Figure 12.8 showing cases for Spain.

Figure 12.9 shows reported deaths for Spain as at week52
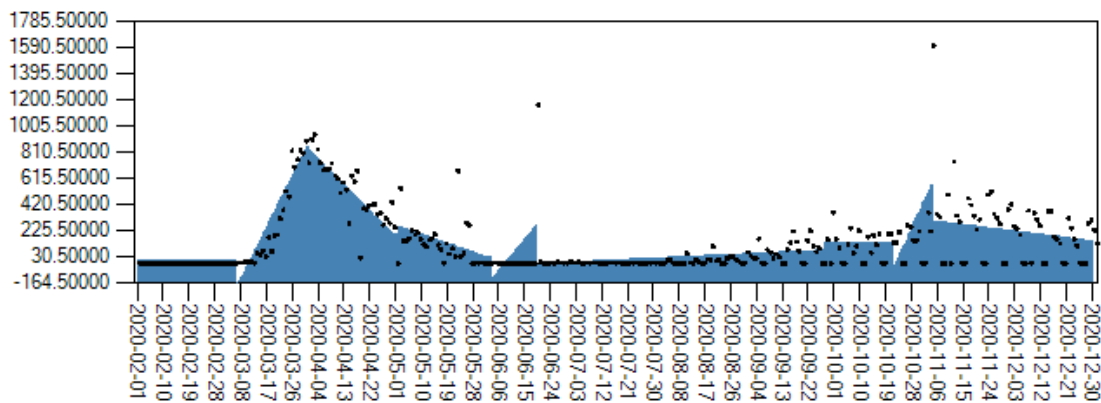
Figure 12.9 showing reported deaths for Spain as at week 52

Again, the deaths do not reflect the cases. Is the virus less deadly? If so, why the panic with the new strain. Or the deaths part of the natural cycle which have nothing to do with Covid-19. The reported deaths are simply due to the pimple factor.

Figure 12.11 shows Hybrid SPC chart for France until Week 52

Distribution Optimized Individuals Chart augmented with Dynamic Plateau Chart( )
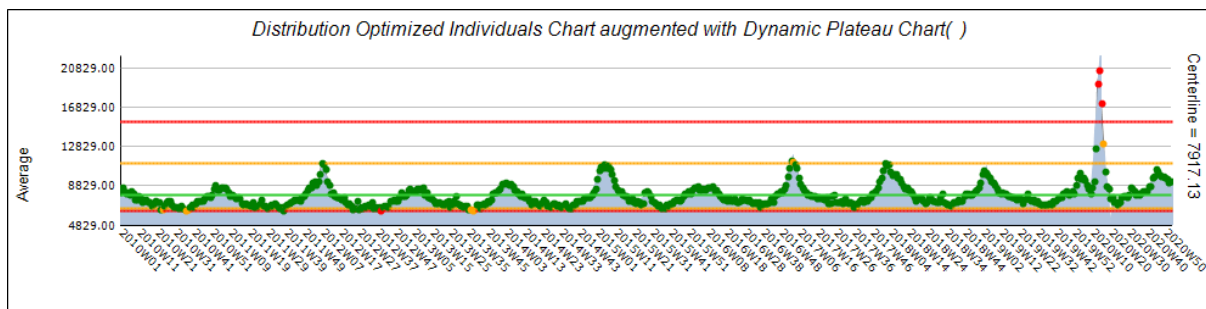
Figure 12.11 Registered deaths up until week 52 2020 show no sign of second wave reported deaths affecting registered deaths.

Registered deaths are not affected by the current wave. Increase in deaths are consistent with natura cycles. This supports the assortment about pimple deaths. The virus is blamed when the virus is not the cause.

12.4 Second Wave in Italy as at end of 2020

Insufficient registered death data was available and hence no analysis was performed for Italy.

12.5 Second Wave in Belgium as at end of 2020

Figure 12.15 shows the raw cases for Belgium as at 1st of November 2020
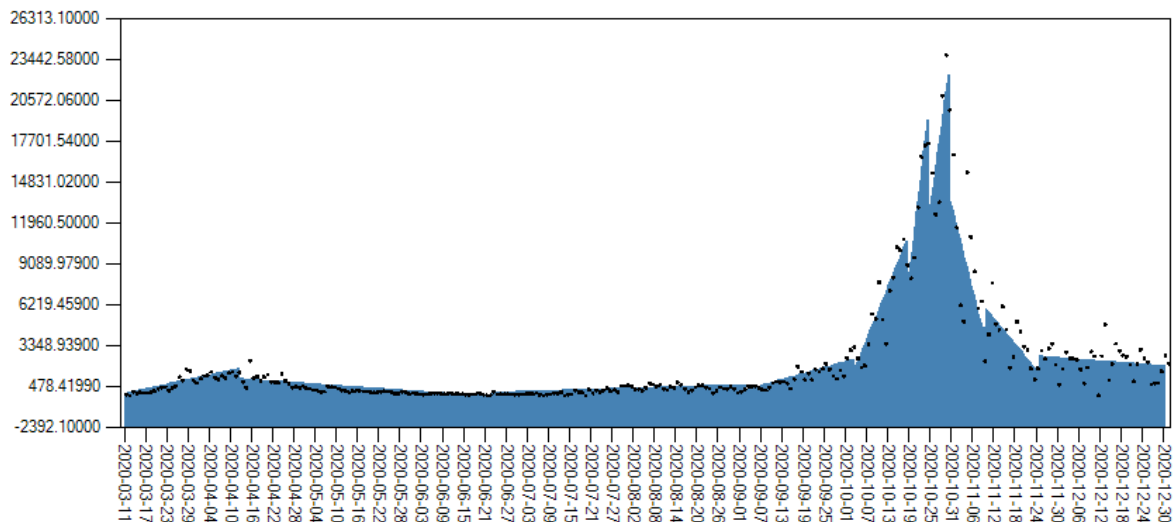
Figure 12.15 Cases for Belgium as at end of 2020

Figure 12.16 shows the reported deaths for Belgium as at end of 2020. The latest deaths are not in proportion to the large increase in cases.
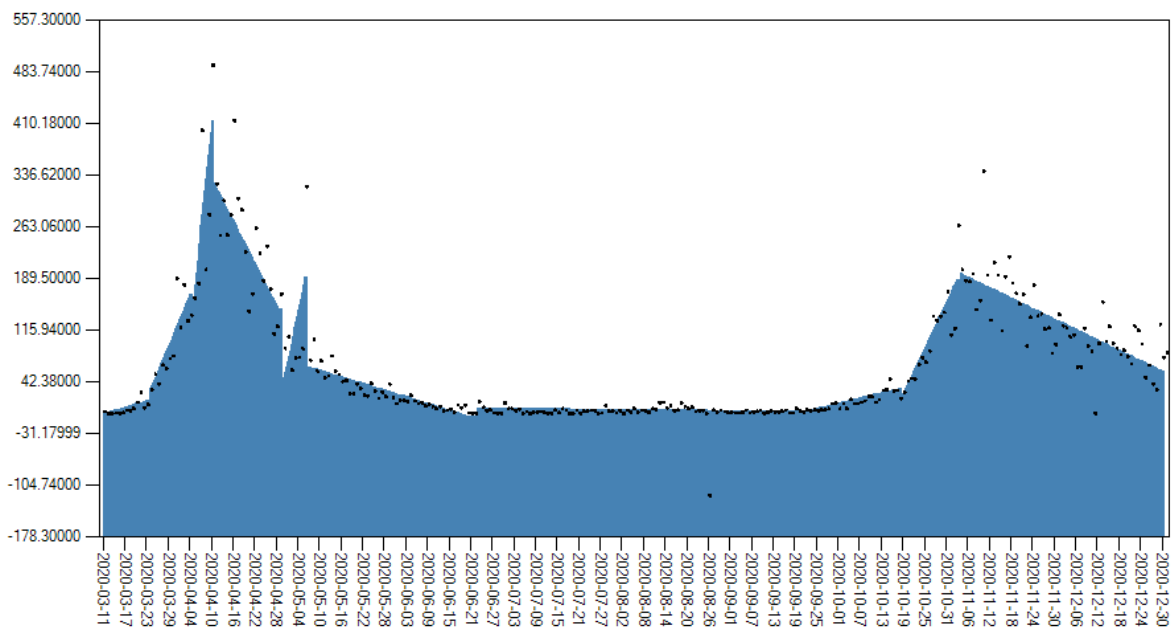
Figure 12.16 Reported deaths for Belgium as at 1st of November 2020

Figure 12.18 shows a Hybrid SPC chart which at end of 2020 shows no statistically abnormal change in registered deaths. Part of the visual increase is part of the natural cycles.
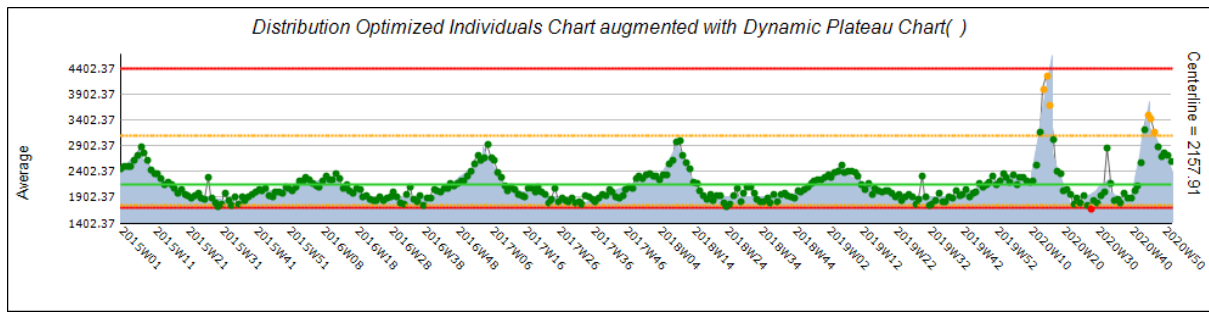
Figure 12.18 Hybrid SPC chart for Belgium as at end of 2020

Although a little higher than normal the current rise in deaths is consistent with natural cycles

12.6 Second Wave in the UK as of end of 2020

Figure 12.19 shows the raw cases for the UK as at 1st of November 2020, Cases are 3 times as high as for the first wave generating 'Angst' and new lockdown.
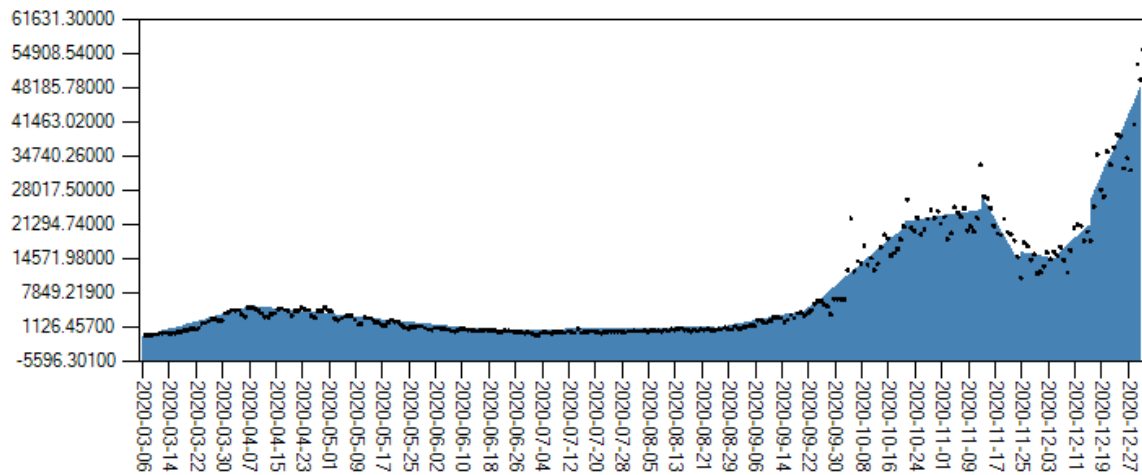
Figure 12.19 Cases the UK as at end of 2020
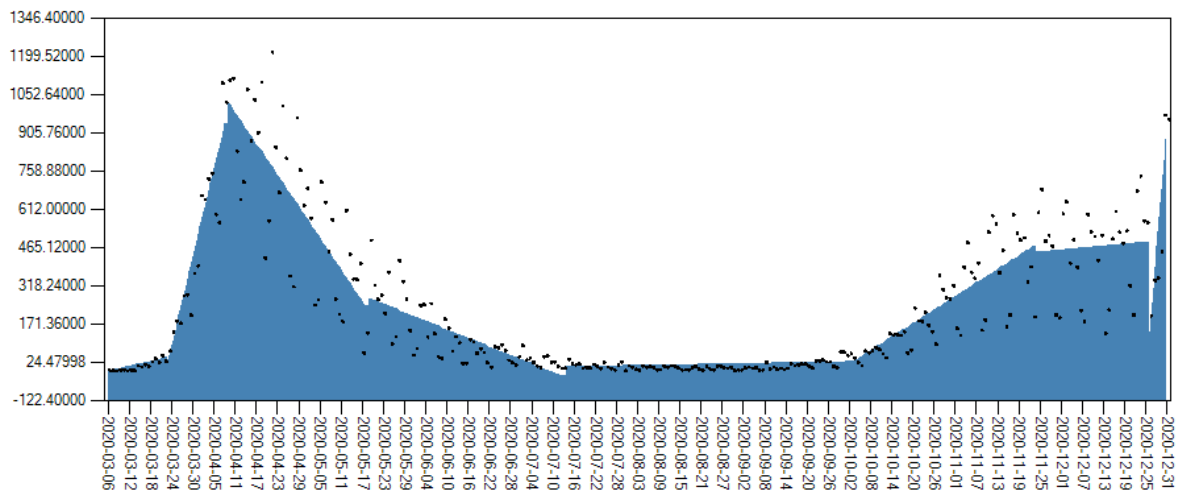
Figure 12.20 Reported deaths for the UK as at 1st of November 2020

Deaths shown in Figure 12.20 are a fraction of the previous peak even though cases have increased over 3-fold.

Figure 12.21 shows the proportion of cases relative to tests for the UK as at end of 2020.
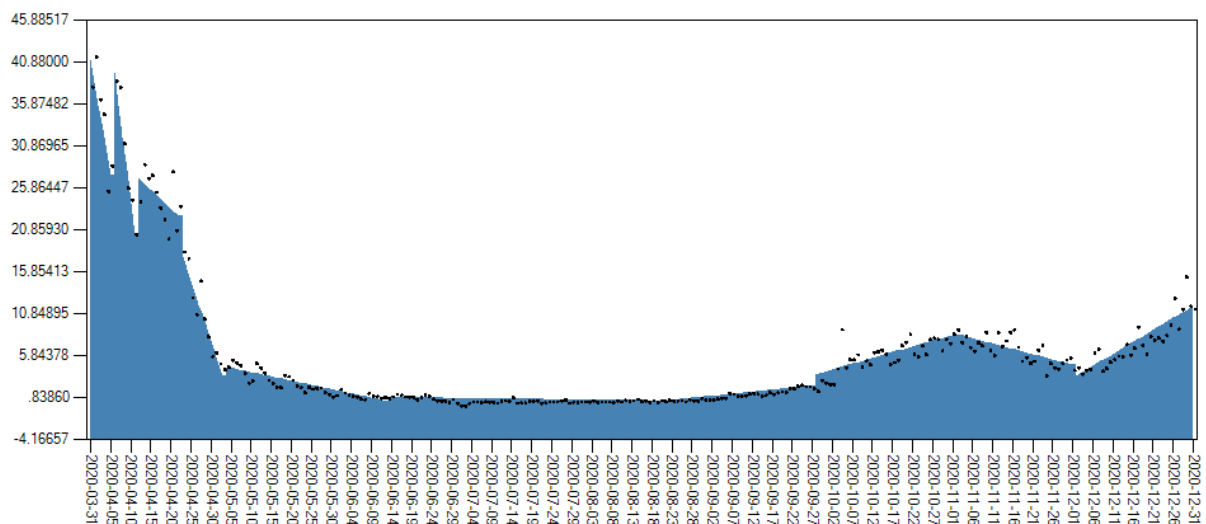
Figure 12.21 Proportion of cases relative to tests for the UK as at end of 2020

By comparing with deaths, deaths follow proportions much closer than cases. The first wave deaths are the highest. There is currently there is a new increase which appears to be consistent with expected increases at this time of the year, taking variation in cycles into account.

At the end of 2020 there is no statistical change in registered deaths for the UK and hence the current wave made no difference. The increase as suspected is consistent with the natural cycles.

Distribution Optimized Individuals Chart augmented with Dynamic Plateau Chart( )
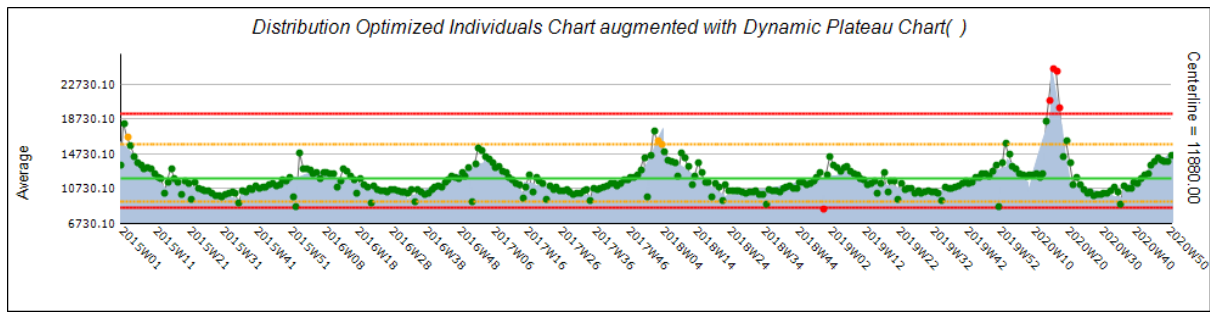
12.7 Conclusion

The current second wave cases have been mostly exaggerated by test numbers. Current deaths are not related to increased cased, but natural cycles. It appears due to bad science that failed to separate covid-19 deaths from natural deaths at this time countries caused further self-destruction for no reason. People suffered again for nothing.

Section 13 Sweden

Sweden has stood out from other European countries in that it did not impose lockdown, keeping large parts of Sweden open. Its constitution does not permit lockdown because it protects freedom of movement. Sweden did pass legislation, following its Public Health Agency's advice to limit freedom of assembly by banning gatherings of large number of people, banning people from visiting nursing homes, and closing secondary and tertiary institutions.

Sweden's response has generally been viewed critically by experts who pointed out that its cases and deaths were more than that of neighboring countries and that had it locked down many people would not have lost their lives.

An alternative viewpoint is that Sweden, through the Public Health Agency's Anders Tegnell, had courage and thanks to that courage the world has a reference to determine what would happen without lockdown.

Although Sweden may have had more cases and deaths then neighboring countries, they are all within natural levels if we accept nature and life. The price countries other than Sweden paid to reduce deaths does not justify their unsustainable actions.

Irrespectively, comparing with neighbors is unscientific. If we compare France with its immediate neighbor, we must conclude France did something wrong because Germany its neighbor had no change on its registered deaths, whereas France did. Perhaps it did!

This section will briefly review Sweden's performance.

Figure 13 Shows the daily case history as at November the 3rd. There was a period where cases went up to around 1000 per day and then came down to about 80 per day. A second wave started in September. The Swedish government has since implemented stronger social distancing measures, but there is no evidence that it worked.
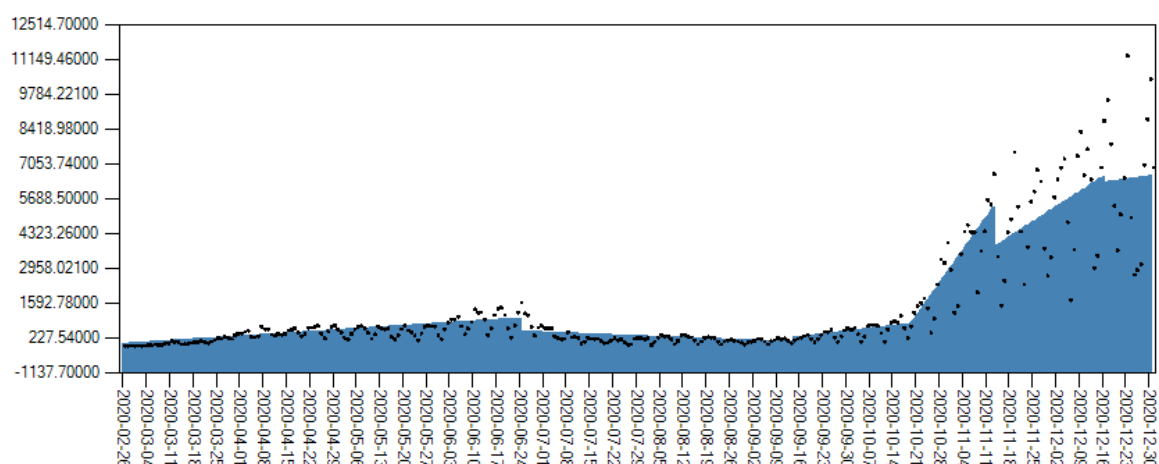
Figure 13 Daily Cases for Sweden as at end of 2020.

 Figure 13.1 Shows the reported Covid-19 deaths experienced by Sweden as at end of 2020.

There is NO relationship between cases and deaths
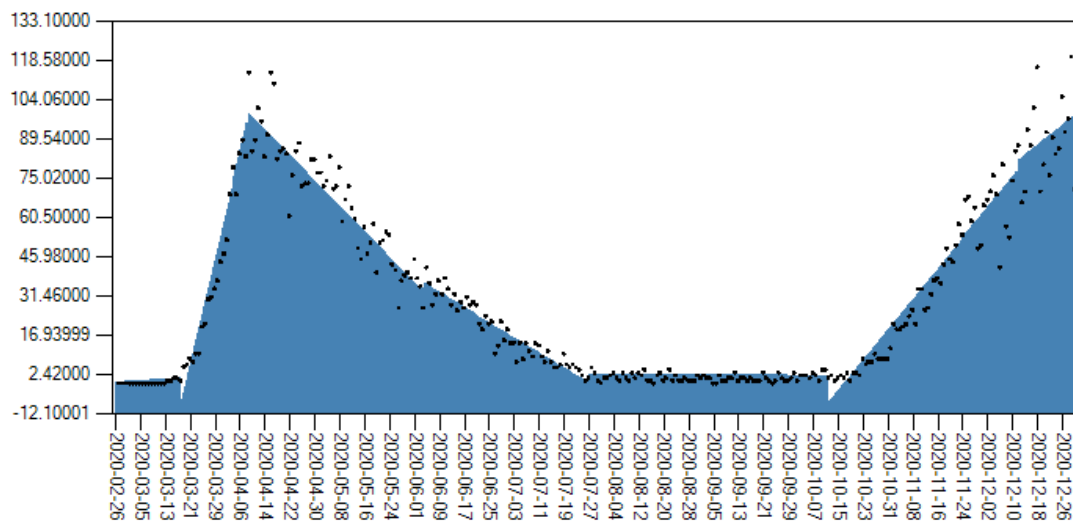
Figure 13.1 Daily reported deaths for Sweden as at end of 2020

Figure 13.3 shows a Hybrid SPC chart as at end of 2020.
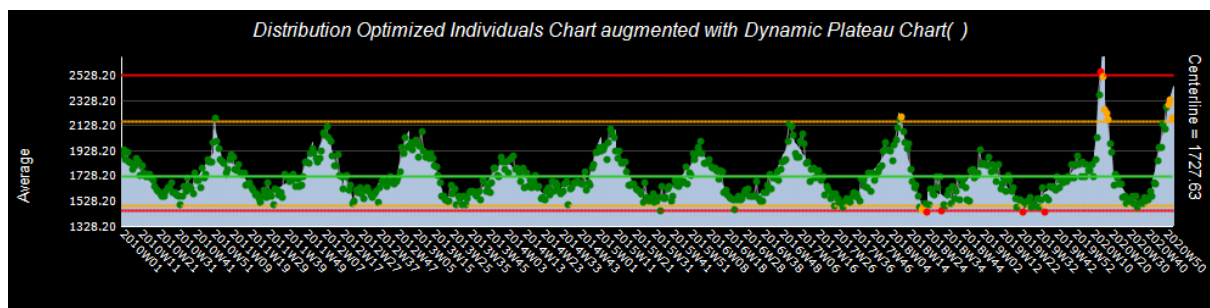
Figure 13.3 A distribution optimized Hybrid SPC chart for Sweden as at end of 2020

Note that the wave peaks in deaths are still within reasonable limits considering normal variation in registered deaths. The last peak also contains a component of natural cycle variation hence the increase cannot be completely attributed to Covid-19. Furthermore, the Swedish government has changed its tone, which one can argue may have resulted in more fear and panic, reflected in more deaths due to overreacting.

13.1 Italy versus Sweden

The chart below is for Italy.
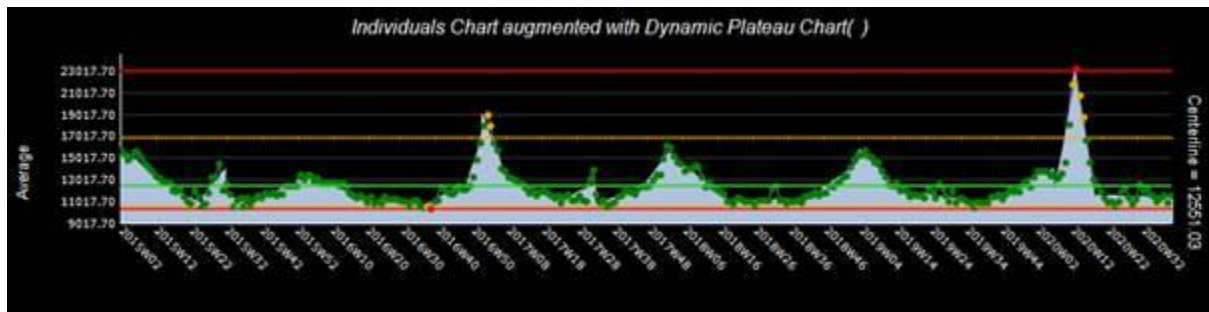
Total deaths though higher than normal, not really abnormal when considering what is natural variation. This time the peak may be due to SARS-CoV-2, sometime in the future it may be due to some other adverse event. If we start reacting to what is normal and random, we make matters worse, which we have. The occurrence of these events is random. We do not know when the next one will come. On average such an event if part of random process will appear every 100 years based on the control limits used. But there is also a standard deviation of average run lengths and such an event may recur sooner than later.

Many countries had larger out-of-control spikes. Out of control can also be randomly distributed with mother nature. Some latitude must hence be applied. We cannot just destroy lives and our way of living because there seems to be an unusual event.

It had a big peak well before Covid-19 of similar relative magnitude that Italy had.
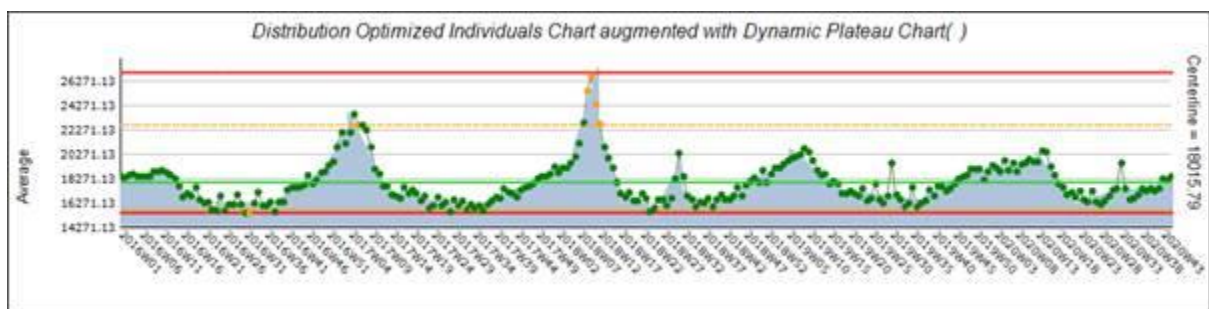
Now comes the eye opener. The following are total registered weekly deaths for Sweden for the same time period (prior to the current peak)

Note the similarity!

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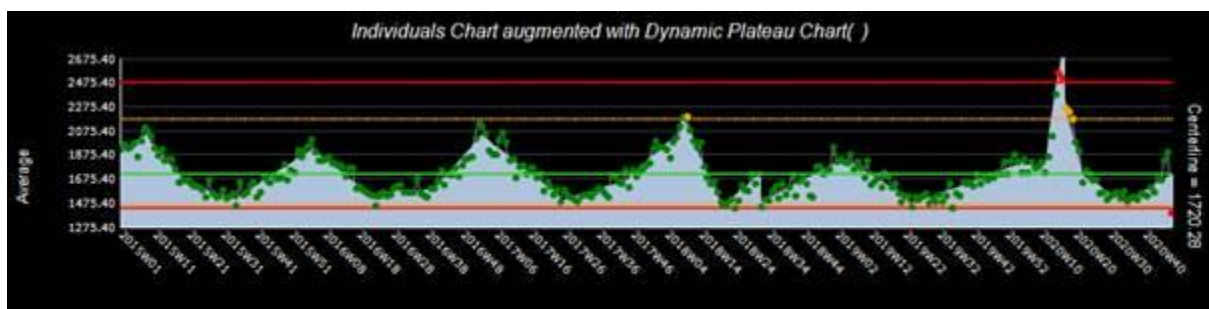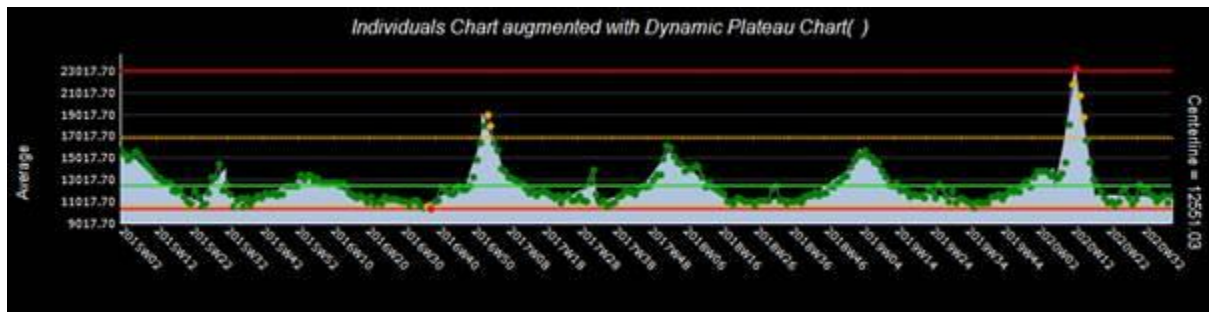
Sweden also had a high death peak at around the same time as Italy did. This is the amazing part. Italy started lockdown at the base of the peak. Sweden had no lockdown and did little. Italy destroyed lives by panicking but was no better off than Sweden, when taking population size into account. Another amazing thing. Sweden deaths came down by themselves. They are also coming down now by themselves as they always do.

Why should they not. The common cold comes down by itself, as does the seasonal flu. Australia was already coming down when it implemented lock down.

13 Conclusion

As scientists we are not biased. We do not make broad sweeping statements. Data Science and Statistics are also soft sciences. Today's conclusions may not be relevant tomorrow. Hence, we make no concrete statement about the virus or any virus, including the flu. There may be highly contagious and deadly strain of the flu 2021, as there may be of SARS CoV-2.

The science was so bad that it is not possible to make a statement on the contagiousness, infectiousness, spread, virulence and deadliness and anything related to SARS-CoV-2 either way.

All we can conclude is the statements made about the prevalence, infectiousness, contagiousness, spread, virulence and deadliness and anything related to SARS CoV-2 by experts were wrong.

What we do assert is that the science was highly flawed and incompetent, resulting in incorrect statements and hence unnecessary over reaction. The world did not have to destroy itself if the science were competent. It is not possible to manage an epidemic with the standard of science that was applied.

Unfortunately, when we believe soft science conclusions are concrete, we risk distorting reality in our minds. Once reality is distorted with false information 'insanity' takes over and we destroy ourselves having lost the ability to think rationally. This appears to have happened on a mass scale. Once we think irrationally anxiety takes over.

This has happened. Now we fear cases because we believe they mean certain death. The human virome has over 340 trillion viruses. No one dies because of it. We need to get real again and go on living side by side with viruses using common sense and science, not science alone.

Globally reported deaths are only 2 in ten thousand for 2020 and many may not have been caused by the virus, but by our reaction, incompetence, and our unhealthy lifestyle and the polluted environment we live in. Countries without draconian lockdown did not have runaway deaths. Many countries had low deaths, those with high deaths have other issues. The deaths had no perspective relative to other causes of deaths. Young and old are not equally affected. There is no evidence that the current wave in the UK is due to the new strain. Instead, there is evidence that case increases have been influenced by test numbers and possibly cold weather.

The best criteria to measure deadliness is total death registrations. There were certainly higher than normal deaths in some countries, nothing is denied. But do they justify destroying the world, especially since there is good reason to believe that there are human and environmental factors responsible for the higher deaths? Considering life's variability, using distribution optimized control charts we cannot concur that the spikes are any more abnormal than in other 'process of the world, which must be accepted or else make matters worse.

The science was so incompetent that it was unable to consider country peculiarities, age groups, health, health systems with response strategies. Intelligence was lacking. Instead of a burn and slash strategy a more intelligent approach would have been targeted strategies tailored for each country. This is a bad reflection on modern science. Instead of a 'dictator' approach a more humane way would have been for advisers to have suggested we react with common sense, report truthfully so that people can make their own informed choices. Facts were not reported truthfully. The flawed information science distorted facts.

Everyone would cooperate if there were black death numbers. If overwhelming is the issue, then why not have built more hospitals at a fraction of the costs. Why not have shared medical resources.

We have grave concerns for the future if 'science' as it has been practiced in relation to SARS CoV-2 continues unchecked into the future. Technology has found a way to detect new viruses through the Global Virome Project. The objective of this scientific project is to harness viruses for the good of mankind and to develop vaccines and other treatments to save lives. As more viruses are found, even though they may have always existed, scientists may conceptualize even greater 'deadliness' with their imaginations and theories, disconnected from the real-world. This will only cause more fear, panic, and the destruction of more lives. SARS CoV-2 was identified with the global virome technology.

Unless science in general is tempered with human wisdom our lives risk being transformed not for the better but for the worse. Unless this newfound obsession with viruses is put into perspective, we may be forced to live very different lives to our forebears with profound curtailments of our freedom and the undermining of what was until recently understood as a good and healthy life.

 Why was the relatively few deaths from Covd-19 singled out as reason to respond in such unprecedented and extreme ways to 'save lives'? Was it simply a failure of courage among our leaders and advisors in fear of the risk of being wrong and being blamed? What if deaths did rise to 'Black Death' levels? The backlash would have been significant, the careers of advisors put at risk. The cost of lockdowns is arguably harder to assess and harder to apportion blame.

There is little hope with this virus. The damage is done. Our minds have been clouded with bad science. No one will now have the courage to use common sense. But there is hope for the future if science gets its act together and stops being so conceited thinking that its clever use of models, that cannot be questioned by laymen, can adequately model life. There is more to life than just saving lives and that is protecting the quality of life whilst we are alive. We all must die so we need to focus on quality of life. We cannot stop death only 'spread' the death curve. In fact, spreading the curve can cause far more problems by giving viruses time to mutate into something far more deadly. What we can do is make life worth living.

Appendix

A.1 Inspiration

The report was partially inspired by experienced experts in virology and infectious diseases who were ridiculed for being outrageous and sensationalists, and yet their fears eventuated.

https://www.msn.com/en-au/news/world/someone-you-know-will-get-coronavirus-top-doctors-chilling-warning-as-he-claims-panic-buying-could-prove-disastrous/ar-BB10T4GY?ocid=spartanntp

A leading specialist on infectious diseases says people need to stop fearing what will happen if they get coronavirus and to instead 'expect' someone they know to come down with it.

'The fact is the virus itself will not likely do much harm when it arrives... but our own behaviours and "fight for yourself above all else" attitude could prove disastrous.'

I'm a doctor and an Infectious Diseases Specialist. I've been at this for more than 20 years seeing sick patients on a daily basis. I have worked in inner city hospitals and in the poorest slums of Africa. HIV-AIDS, Hepatitis,TB, SARS, Measles, Shingles, Whooping cough, Diphtheria...there is little I haven't been exposed to in my profession. And with notable exception of SARS, very little has left me feeling vulnerable, overwhelmed or downright scared.

I am not scared of Covid-19. I am concerned about the implications of a novel infectious agent that has spread the world over and continues to find new footholds in different soil. I am rightly concerned for the welfare of those who are elderly, in frail health or disenfranchised who stand to suffer mostly, and disproportionately, at the hands of this new scourge. But I am not scared of Covid-19.

What I am scared about is the loss of reason and wave of fear that has induced the masses of society into a spellbinding spiral of panic, stockpiling obscene quantities of anything that could fill a bomb shelter adequately in a post-apocalyptic world. I am scared of the N95 masks that are stolen from hospitals and urgent care clinics where they are actually needed for front line healthcare providers and instead are being donned in airports, malls, and coffee lounges, perpetuating even more fear and suspicion of others. I am scared that our hospitals will be overwhelmed with anyone who thinks they " probably don't have it but may as well get checked out no matter what because you just never know..." and those with heart failure, emphysema, pneumonia and strokes will pay the price for overfilled ER waiting rooms with only so many doctors and nurses to assess.

I am scared that travel restrictions will become so far reaching that weddings will be cancelled, graduations missed and family reunions will not materialize. And well, even that big party called the Olympic Games...that could be kyboshed too. Can you even imagine?

I'm scared those same epidemic fears will limit trade, harm partnerships in multiple sectors, business and otherwise and ultimately culminate in a global recession.

But mostly, I'm scared about what message we are telling our kids when faced with a threat. Instead of reason, rationality, openmindedness and altruism, we are telling them to panic, be fearful, suspicious, reactionary and self-interested.

A.2 Hysteria

Hysteria continues to be underestimated. We tend to recognise it years later, but never at the time. Hysteria is fear based and it succumbs almost everyone. Once people succumb to it, they can no longer see perspective and the damage they are causing. Instead the damage is just shrugged off.

A.2.1 Salem Witch Trials

The Salem With Trials were an example of hysteria where many innocent females were sentenced to death merely because a medical 'expert' blamed unexplained symptoms on two young girls on witchcraft. (just like a young doctor blamed an unexplained case of pneumonia on the corona virus). The public panicked and the judicial system was overwhelmed (just like hospitals), and many lost their lives, all because of fear. Today the hysteria is so obvious, but at the time it was not

A.2.2 The Y2K Bug

We have forgotten the Y2K bug where the share market was to crash, where planes were going to fall out of the sky and people stuck in elevators. Nothing happened. Had we not had the hysteria we would have had these events, some argued. What must be remembered is that the doomsday predictors said that planes were going to fall out the sky, they did not say they may fall out the sky if we do not act. They never fell out of the sky. The financial market did not crash.

As a refresher" "20 Years Ago, Y2K Hysteria Led to Emergency Bunkers and Cost the U.S. $100 Billion" "While many experts assured the public that they could celebrate the new year without any significant disruptions, there was increasing anxiety as the date approached. For some, "Y2K" had become synonymous with "doomsday." For its January 18, 1999 issue, Time magazine ran in the year with the words "The End of the World!?!" on its cover. Other publications would issue "Y2K Checklists," which advised people to have medicine, a few day's cash and up-to-date paper records of all financial transactions. Some families even went as far as setting up emergency bunkers in their basements to ride out the feared impending apocalypse. In the months leading up to January 2000, a California man filed a class-action lawsuit against six retailers, including Office Depot and the now-defunct Circuit City and CompUSA, 36 for failing to warn buyers about electronics that were not Y2K compliant.

Frustration was mounting across the country." "I'm waiting for disaster," Jay Wishner, a Manhattan internet consultant told the New York Daily News days before New Years 2000. "Do I have cases of food! … Cases of rice, containers of water, canned ham and vegetables. I am going to live better with or without Y2K."

A 12-year-old boy said his mother was stocking up on flashlights but had nothing to power them. "My mom keeps at least 17 blankets in the house, and we have 20 flashlights, but none with batteries," he told the newspaper. "We have a lot of leftover candles from Chanukah."

"But when the clock struck midnight on New Year's Eve, the lights stayed on and society remained intact." https://people.com/human-interest/y2k-millennium-bug-20-year-anniversary/

Will we ever learn? The Y2k Bug was real as is the virus. But the potential disaster was not real. Programmers knew about the problem and it was fixed.

A.2.3 2012 Sri Lankan Hysteria

The 2012 Sri Lankan Hysteria episode demonstrated that fear-based hysteria can manifest itself physically, in this instance through real rashes and diarrhea. How many people have died because

their system went into panic mode when they were told they had the virus? In Wuhan some of those who obtained treatment in the hospital had a higher death rate than those who were sent home to pass away in their own terms.

A.3 Linear logarithmic transformed lines do no prove exponential growth

Just because a logarithmic transformation results in two straight lines does not mean that there were two exponential growth curves.

As an example, consider Figure A.3.1 with two perfect linear trends
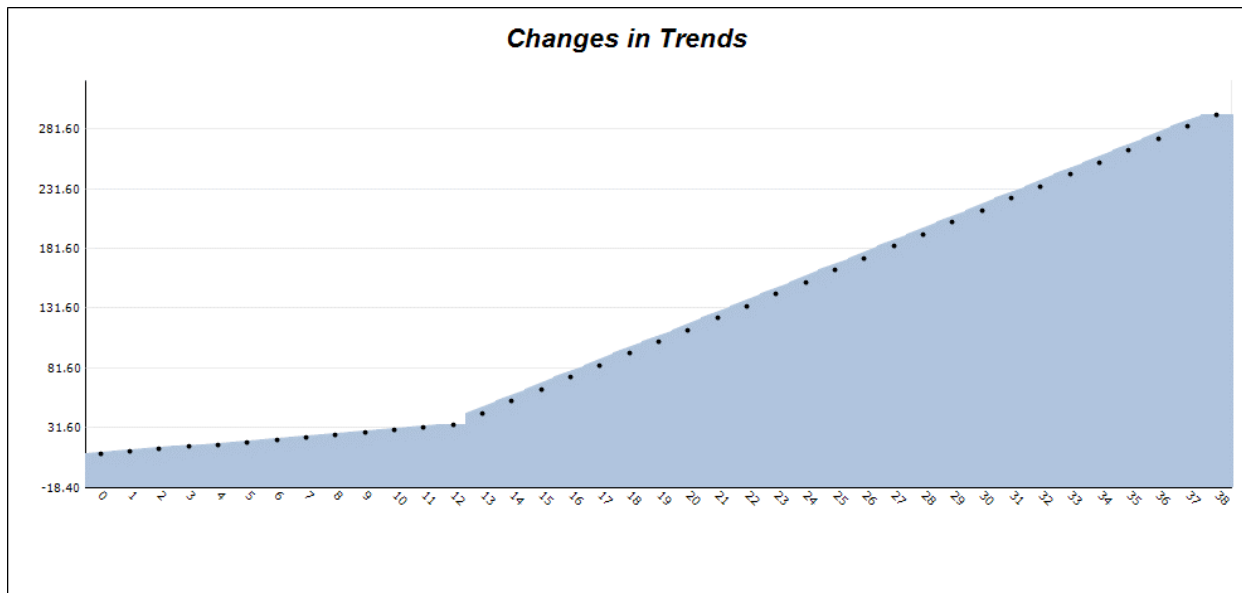
Figure A3.1 Two perfect Linear tends

After applying logarithms, we get the chart shown in Figure A3.2
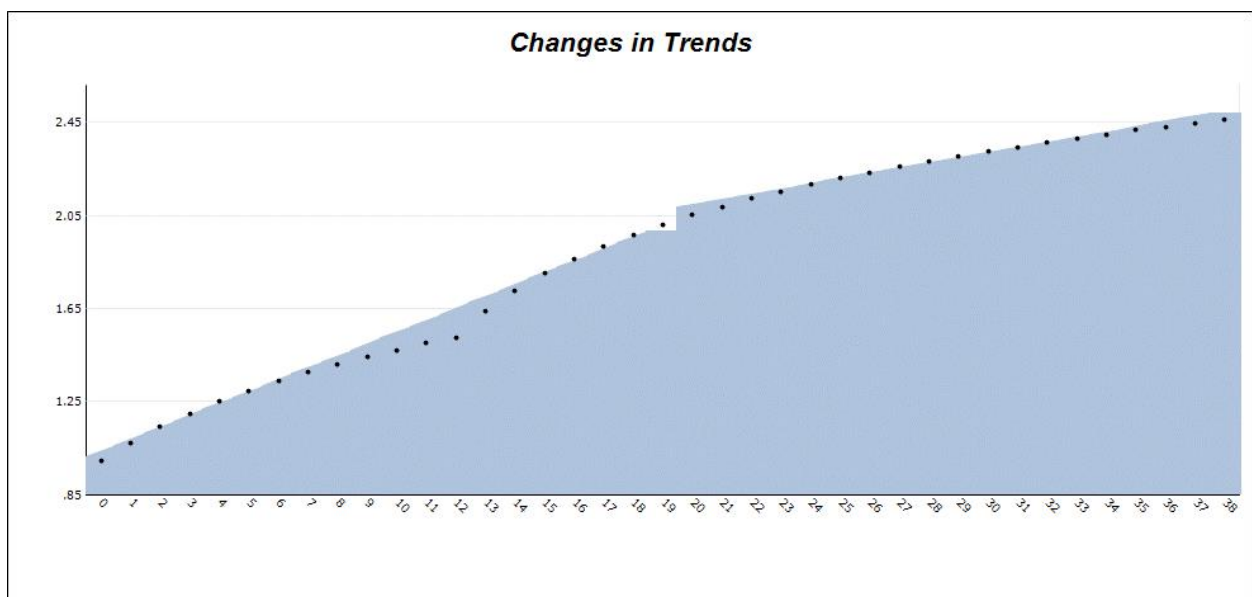
Figure A3.2 Logarithms applied to data used in Figure A3.1

The logarithms of two perfectly linear lines are also near linear. There is a little kink, but if you now add variation to the original data, we get something like what the xxx Institute obtained, shown in Figure A3.3

Note how the slopes reversed. The actual data in Figure A3.1 showed that cases increased faster in the second stage, but for the transformed data, shown in Figure A3.3, cases increased slower in the second half.
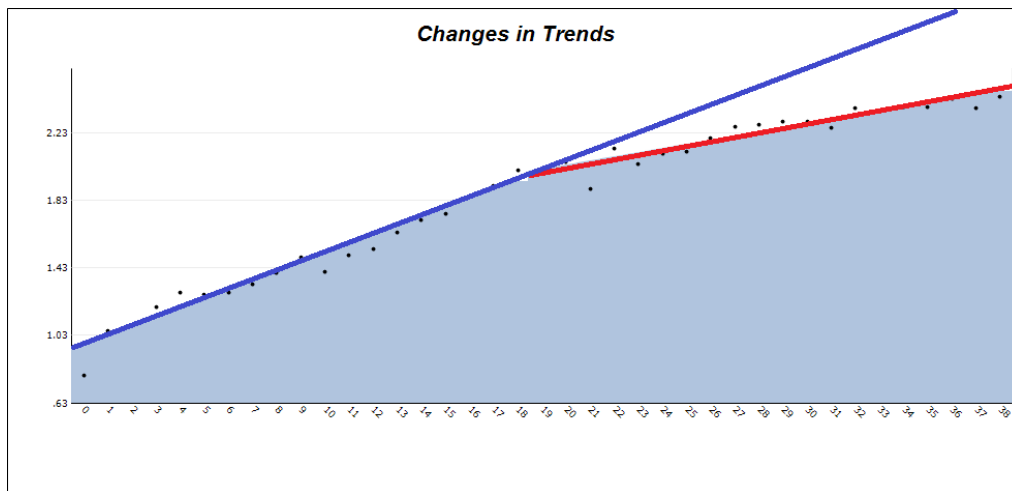
Figure A3.3 Some random variation added to the data in Figure A3.2

Concerns for Remote Learning at Primary School Level

We were forced into remote learning due to COVID-19 so education for our children can at least continue. Having provided remote learning to businesses around the world, I can say with experience that remote learning is not suitable for primary schools.

The following now elaborates on the concerns I have. Please know, the following is fact-based feedback on 'how remote learning is being carried out'. Though there will be variation in its delivery from school to school, the underlying issues nevertheless remain the same. It is interesting to note, that the following does support the research that has been conducted.

In short, parents are stressed! Children are subdued and want to come back to school! Teachers describe this as an 'unnatural way of learning'! Remote learning is unworkable. Effort should be focused on getting children back to classroom learning in a safe manner rather than investing more into remote learning which simply is doing our children's learning more harm than good.

With restrictions easing on May 11th 2020, it is only fair that as part of these restriction layoffs, parents are given back the CHOICE on how they wish for their children to be educated!

APOLOGY

The following may appear offensive, which if it does, I do apologise as this is not my intent. I am not blaming any education institute.

This is about remote learning, which in its current form is not working! Parents are struggling. There are those who need to work from home, those who come from a different ethnic background thus struggle with the English language, those who have lost their jobs and more.

The one thing, most parents all have in common, is we are not qualified teachers.

CONCERNS

Remote learning NOT SUITABLE for Primary Schools

Remote learning is essentially 'independent learning'. It is generally for industry professionals or students in higher education where reliance is on the individual to independently read the set material, comprehend it, and then complete tasks for assessment. Though teachers are available for Q&A, teacher/student interaction is limited.

Taking parents out of the equation, is this model suitable for primary level?

Primary school children, especially those from ages 6 to 9, are INCAPABLE of 'independent learning'. They are only just learning how to form words through recitation, spell, write, comprehend, and so

much more. They need constant interaction and guidance which only qualified teachers can provide. Additionally, remote learning assumes students possess confident navigational skills around PCs, IPADS, etc. Is it fair to assume that ALL primary school children should also have these skills?

How can remote learning really work for primary level? **The Parents!**

Too much reliance is on parents

It has been eluded that parents are only required for 'basic supervision'! How can this be? Just like in the classroom, children have questions, do not understand the set tasks, require explanations, etc? Children often look to their peers and observe what they are doing which only facilitates their learning. Without teachers or peers being present, parents are the only ones whom children can really turn to! This alone already goes beyond the scope of 'basic supervision'.

General questions are ok, but this has ballooned. *We have had to teach nouns; go over spelling and pronunciations; explain procedure/persuasive/predictive writing; teach a wide range of mathematics that include additions, multiplication, division, problem solving, etc; test for comprehension, and so much more.* **ESSENTIALLY, WE HAVE BECOME THE STAND-IN TEACHERS!**

Is this fair for parents who have been forced to work from home and must do their jobs otherwise face unemployment? How does this affect the children's learning when parents are scattered and stressed?

Is this fair for children to receive teaching from parents who are not qualified teachers hence struggle in conveying proper explanations? How about children of different ethnic backgrounds whose parents struggle with the English language?

What about the parents who now face unemployment thus are short-tempered? Volatility in families does not make for a good learning environment for children!

Working at home parents are struggling. We have pressures from our bosses, which in these unprecedented times, are higher than ever due to uncertainties. If we do not do our jobs, we join the unemployment line. I am not sure if the government would want to add to this already growing figure?

The more children you have, the more difficult it is. We have 2 children at different year levels, both requiring our time. In a typical day, we need to switch from teaching Grade 2 maths to Grade 5 literacy on-the-trot, and vice-versa. Then to have to do our actual jobs with mounting pressure from our bosses, followed by dealing with grumpy children, putting food on the table, etc, is just expecting too much.

Perhaps we are putting too much on ourselves! *Teachers supply the tasks but who is going to teach the material to the children when the teachers are not present? We do have WebEx meetings, but is this enough*?

WebEx meetings

Though grateful that teachers are interacting with our children using WebEx, a 30 minute once a day chat is NOT ENOUGH.

Sometimes the video chats fail. Friday, 23rd April 2020, we were unable to connect due to low internet connectivity. On Tuesday 28th April 2020, my son's video chat with his class teacher was changed to another time without us knowing. Please know, I do not hold the teacher accountable, but these things do happen, which means children only miss out. Few days ago, my son was unable to connect again due to an incorrect meeting number.

I have noted that socializing or wellbeing seems to be more of the focus (which is appreciated), but not so much teaching. Last week, my daughter's class was involved with a game of connect 4 and only on Friday a game of 'rock, paper, and scissors'.

I do respect teachers are trying to look after the wellbeing of the children. However, is this not the role of the parents whereas the role of the teacher is to provide learning? Have roles reversed? The focus on learning must not be lost! I understand it would be difficult to provide teaching through video chats. However, it is worth noting that gyms are providing online boot camps through zoom! Karate Dojos are offering online karate lessons! Businesses provide interactive lessons to their clients through webinars all the time! **Therefore, there is scope for teachers to consider.**

Teachers are busy with their family

I totally understand this! However, we are also investing in teachers thus not fair to parents on several grounds. Does this not also beg the question, is remote learning suitable for primary school children? Primary school children NEED THEIR TEACHERS for education! Without teachers, children's education will be compromised as parents are not skilled teachers or have the patience that comes with teaching.

Vulnerability

Children are all at different academic levels. Those already struggling will only fall behind further. With internet usage being so high, not all children will have access to the information when they need due to internet overload. We ourselves have already missed out on 3 video calls due to internet issues.

Every household has a different story. There are those suffering with serious financial hardships due to losing their jobs. There are those who are working from home and cannot provide their children with the time they require. There are also those parents who struggle with the English language thus are struggling. The playing learning field is no longer equal!

Everybody is stressed and tired. Moods are in overdrive and the children are sometimes the ones who bear the brunt. Children themselves are tired, stressed and sometimes unmanageable where tantrums are even thrown at an attempt to refuse their schooling simply because they are at home. Does this make for good learning? Teachers are using WebEx meetings to play games or socialize as an attempt to make children happy. Doesn't this only reinforce that there are concerns for children's wellbeing through remote learning?

Japanese, PE, Music, Art

Not to say these subjects are not important, but they are not core subjects, therefore due to parental struggles with teaching their children, we should **BE EXEMPT** from these subjects. Those who work from home need sufficient time during the day to concentrate on their jobs therefore to worry less about Japanese class or Art would ease the burden.

My son had a video call with his PE teacher on April 28th 2020 which only went for 10 minutes! I understand there may not be much to talk about, but then, why get us to do PE lessons when this could free our time to do our jobs? If the school is concerned about physical exercise, parents are already providing this through cycling, walking, running, etc through the Dandenong Creek.

FULL Term 2 Fees payable, yet we are doing the teaching

We are providing the teaching without pay, the children are in our care, we are unable to make use of the school facilities, there is no more classroom teaching, excursions and camps have been cancelled, and we can no longer concentrate on our jobs. Yet now we are expected to pay FULL TERM 2 FEES! This is NOT justifiable! We should be exempt or at least be given a significant discount.

REOPENING THE SCHOOL – Give parents the choice!

I completely support SAFETY for our children and teachers during COVID-19. But don't we need to EQUALLY SAFEGUARD our children's education? Remote learning is not cutting it! I see groups of primary children congregating unattended in parks. Doesn't this go against the reason why we are home schooling in the first place? Reopening of the school with safety measures should be the priority. With restrictions easing on May 11th 2020, it is only fair that as part of these restriction layoffs, parents are given back the CHOICE on how they wish for their children to be educated. If concerned about safety, few ideas could include:

- Open the school ONCE a week giving children the opportunity to go over their learning with their teachers
- Stagger opening/closing times
- Introduce temperature checking for children.

I do question why schools remained open in Term 1 whilst COVID-19 cases were rising, whereas now schools are in forced lockdown despite cases significantly dwindling to lower levels than in Term 1?

I also question why we in Victoria do not get the choice to send our children to school whereas other states offer the choice? Our cases of coronavirus are not any different to that of New South Wales for example.

Research which has been conducted locally and internationally reports that COVID-19 community transmission is low in schools. This has also been admitted by Mr Sutton himself. I understand the risk with parents and staff congregating. However, I believe the focus should be on how to minimize this risk so children can get back to school, rather than investing further into remote learning which truth be told is one big mess.

In conclusion, schools are critical to the delivery of education for children, providing the foundation blocks that will give students the best possible start in life. It needs to be delivered by professional teachers, not parents. Like health care, supermarkets, government, and police are all essential services, so are schools.

Teachers are essential. As supermarkets have implemented safety measures for workers, so must schools for their teachers.

With restrictions easing on May 11ᵗʰ 2020, it is only fair that as part of these restriction layoffs, parents are given back the CHOICE on how they wish for their children to be educated!

Department of Education and Training

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Christopher Ude
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Dear Mr Ude

Thank you for your correspondence of 6 May 2020, regarding remote learning in Victorian government schools during the coronavirus (COVID-19) pandemic.

I acknowledge that these last few weeks have been challenging for students, families and schools. Additionally, I wish to acknowledge your concerns and commend your desire to ensure the best possible educational outcome for all Victorian students

As you would be aware, the Victorian Government made the decision to transition government schools to remote and flexible learning from the beginning of Term 2 as part of efforts to slow the spread of coronavirus (COVID-19) based on advice from Victoria's Chief Health Officer. During this period schools have also provided an on-site supervision program for a small number of students who cannot learn from home.

Based on the success of Victoria's efforts to manage the spread of coronavirus to date and the continued low infection rates in the community, the Victorian Government has now put in place a plan for schools to return to on-site learning, consistent with the advice of Victoria's Chief Health Officer that it is safe to do so.

The Department is implementing a staged return to on-site learning plan which will involve:
- a Pupil Free Day on 25 May 2020 for school staff to plan and prepare for the return to face-to-face teaching
- a return to on-site learning on 26 May 2020 for students in Years Prep-2, 11 and 12 (including Year 10 students studying VCE subjects) and all students in specialist schools.
- the remaining Years 3-10 students returning to on-site learning on 9 June 2020.

Please note, students currently participating in the on-site supervision program will be able to continue to do so as required until their year level has returned to on-site learning.

Our aim is to maintain the health of our students, families and school staff and with instruction from the Chief Health Officer we will implement strategies including physical distancing between adults, ceasing the use of communal drinking fountains, minimising visitors to schools, staggering drop-off and pick-up/as well as recess/lunch breaks. Until further notice, school assemblies, camps and

VICTORIA State Government

excursions will not occur. Victorian government schools will be cleaned and disinfected daily, provided with personal protective equipment and supplied with hand sanitiser.

As the COVID-19 situation continues to evolve, the best place to get up-to-date information on what is happening is on the Departments website: www.coronavirus.vic.gov.au

I wish to advise that if you are not satisfied with my findings, further right of review is available through the Deputy Secretary, School and Regional Services, Department of Education and Training, on (03) 8688 7885 or by email: school.complaints@edumail.vic.gov.au

Yours sincerely

Anthony Raitman
Area Executive Director Outer East
North-Eastern Victoria Region

12 / 05 / 2020

Copy to: Kerrie Anderson, Senior Education Improvement Leader (LGA)

A.5 New post on Sebastian Rushworth M.D.
https://sebastianrushworth.com/?author=190027892

https://sebastianrushworth.com/2020/10/31/a-history-of-the-swedish-covid-response/

Update on the Swedish covid response

by Sebastian Rushworth, M.D.

Since my article at the end of October detailing exactly what had been happening in Sweden in relation to covid up to that point, I've been getting a lot of requests for a new update, detailing events in November and December. Here it is.

I ended my previous article by stating that there had been a slow increase in hospitalizations and deaths in October, and that the slope of the curve suggested that the peak would end up being significantly lower than in spring. That slow increase continued through most of November, and appears to have stabilized at a level of around 70 deaths per day at the beginning of December (as a reminder, in spring deaths peaked at 115 deaths per day in mid-April).

This makes Sweden similar to the UK and the Netherlands, two countries that Sweden has been tracking closely throughout the pandemic, with a second peak in deaths per day that is a little over half what was seen in spring.

Here in Stockholm, the number of people being treated in hospital for covid has been stable since late November, with around 800 people being treated simultaneously for covid in hospitals (in spring around 1,100 people were simultaneously being treated for covid in Stockholm at the peak).

Since the total number of hospital beds in Stockholm is around 3,850, it should be plain to everyone that the healthcare system has never been close to being overwhelmed, in spite of claims to the contrary in media. And while it is true that hospitals are currently at 100% capacity, it is false to claim that that situation is in any way unusual. Sweden has among the lowest number of hospital beds per 100,000 population in Europe, and the hospitals are always running at 100% capacity this time of year.

My feeling (shared by multiple colleagues I've spoken with) is also that we're being more generous with which covid patients we admit to the hospital than we were in spring, when we were more worried about the system being overwhelmed. In other words, if we had been as strict with admitting covid patients in autumn as we were in spring, the number of people in hospital in Stockholm with covid would not currently be 800, it would be quite a bit lower.

Other parts of Sweden, that were only hit lightly in spring, have however been hit harder the second time around. For example, Skåne, in the south, has been hit much harder in autumn than it was in spring. Parts of northern Sweden have also been hit harder.

One thing that I think is very interesting, that has received little mention in media, is that the proportion of people with antibodies has been rising by 2-3 percent every week. In Stockholm, 37% of those tested for antibodies in week 49 were positive (up from 20% six weeks earlier). That suggests that the level of immunity is rising very rapidly in the population, and makes it questionable whether the vaccine will arrive in time to have any meaningful impact on the course of covid-19 in Sweden, even if people start to get vaccinated shortly after Christmas, as is currently planned.

Overall, the situation is no more serious now than it was in spring, at least if you look at deaths, ICU-admissions, and hospitalizations. During the spring peak, 2,350 people were being treated simultaneously for covid in hospitals in Sweden as a whole. At present, 2,500 people are being treated in hospitals for covid, but, as mentioned, these 2,500 are on average less sick than the 2,350 being treated in spring, which is likely why deaths are lower even though hospitalizations are up a bit. Another data point in support of this is that at present, 290 people are being treated for covid in Intensive Care Units (where the very sickest people end up). In spring, that number was 550.

In the parts of Sweden that were hit hard in spring, like Stockholm, the situation is clearly less serious now than it was then. Of course, if you ignore hospitalizations, ICU-admissions, and deaths, and just look at cases, the situation looks a lot worse than in spring, but that is due to the fact that we're now testing ten times as many people per week as we were at the end of April.

Apart from that, we know a lot more about covid now than we did in spring. We now know that the overall fatality rate is less than 0,2%, and that the risk to healthy people under 70 years of age is infinitesimal. But if you see reporting in media, and if you look at the actions of the Swedish government, you get a very different picture. What follows is an update on all recommendations and restrictions coming from the Swedish state during November and December.

As I mentioned earlier, a decision was made in October by the Public Health Authority to start imposing recommendations on a local rather than national basis. This was followed by a tightening of recommendations in multiple counties over the next couple of weeks, so that by November 3rd (when tightened recommendations were imposed in Örebro, Halland, and Jönköping) fully 7 out of 10 Swedes were living in counties with tightened recommendations. On that day, the government also announced that people would be forbidden from gathering in groups of more than eight at the same table in restaurants. And it was reiterated that employers should allow employees to work from home, if possible.

On the 11th of November, the government announced that restaurants and bars would be forbidden from serving alcohol after ten pm, and would need to close at 22.30 at the latest.

On the 16th of November, the government announced that the number of people allowed at all public events (plays, demonstrations, lectures, sports events etc) was being decreased to eight, significantly lower than the previous lowest limit of 50.

On the 19th of November, the government authorized the Public Health Authority to make decisions to stop visits to nursing homes on a county by county basis (during spring and summer, all nursing homes in Sweden were closed to visitors, but this restriction was lifted at the beginning of October). On the 4th of December the Public Health Authority decided to make use of this measure, closing nursing homes to outside visitors in 32 Swedish municipalities (out of a total of 290).

On the 3rd of December, the government announced that high school students (ages 16-19) would return to distance learning, as had been the case during a period in spring. Initially, the plan is that this will apply until January 6th (this has later been extended to January 24th).

And then, on the 18th of December, the government went even further, imposing the most severe restrictions yet. Restaurants and bars are now ordered to stop serving alcohol at 20.00, and groups in restaurants are not allowed to number more than four. Shopping centers and other public venues like supermarkets and gyms are ordered to set a max number of visitors, so that crowding can't happen. All public venues that are run by the state, such as libraries, public swimming pools, and museums, are ordered to close, and stay closed at least until January 24th. The government has also recommended that people start wearing face masks in public transport during rush hour.

In total, this means that the restrictions and recommendations in place are now much more severe than the ones that were in place in spring. As I think is clear, the Swedish government has played a much more active role in autumn than it did in spring, when it was happy to let the Public Health Authority do most of the decision making.

The rhetoric from the Swedish government has also been more alarmist the second time around, with the Swedish Prime Minister, Stefan Löfven, delivering speeches that make it sound as if Sweden is going to war, for example telling people on November 16th to "do their duty".

The Health Minister, Lena Hallengren, said in a speech on November 16th "don't consider these measures voluntary", about the voluntary recommendations that the government is asking people to follow. To me, that's pretty clear evidence that the only reason Sweden hasn't followed other countries in imposing severe legally enforced restrictions is that the Swedish constitution has prohibited it.

In conclusion, the Swedish government has officially lost its mind. In the name of protecting public health, the government is doing its utmost to destroy public health. In spite of the fact that some of

the biggest risk factors for severe covid are obesity and lack of exercise, the government is seriously telling people to stop visiting swimming pools and gyms; in other words, to stop exercising.

Why the change in tone from the Swedish government during November and December?

If one were cynical, one might think it was due to the fact that the governing Social Democrats received a big boost to their opinion ratings in April and May, in the usual "rally around the flag" fashion seen when a nation faces some type of crisis, but since then they have been polling worse month on month. Maybe they saw their polling numbers, panicked, and hoped that they would get a boost in the polls if they could appear more assertive. Or maybe they've just capitulated to international pressure to "get in line".

You might also be interested in my article about why Sweden had more covid deaths than neighboring countries, or my article about whether lockdown is effective.

https://sebastianrushworth.com/2020/12/06/why-did-sweden-have-more-covid-deaths-than-its-neighbors/

Sebastian Rushworth, M.D. | 19 December, 2020 at 14:33 | Tags: covid-19, Sweden | Categories: Covid 19 | URL: https://wp.me/pcdgfy-BQ

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[i] Hard sciences have traditionally been natural or physical sciences such chemistry, physics, biology and physics and soft sciences psychology, sociology etc. But these categories, especially biology, are problematic relative to the core difference between soft science and hard science.

The core difference is that scientific investigations for hard science results in relatively concrete conclusions based on strictly measurable criteria. For soft sciences, these criteria are difficult to establish and conclusions are unreliable because there are too many interacting factors, many unknown. This results in a reliance on assumptions. It is thus virtually impossible to draw reliable real-world predictive conclusions from soft sciences, such as epidemiology.

[ii] -A systematic review published in July 2020 by the Oxford Centre for Evidence-Based Medicine found that there is no evidence for the effectiveness of cloth masks against virus infection or transmission. (Source)

-May 2020 - A meta-analysis study of previous influenza pandemics published by the US CDC found that face masks had no effect, neither as personal protective equipment nor as a source control in a community setting (Source)

-An April 2020 Cochrane review (preprint) found that face masks didn't reduce influenza-like illness (ILI) cases, neither in the general population nor in health care workers. (Source)