An Open Letter on the science used to manage the corona virus pandemic.

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About Us: Our companies have over 30 years industrial experience providing solutions in data analysis, data science, statistics, data modeling and operations research. This experience was gained in over 40 countries including Russia and the USA. We have developed commercial analytical software products used by thousands of users throughout these countries. We understand cause and effect, sampling, testing, the scientific process, and empirical evidence. We also understand modeling, having developed many models ourselves. The same applies to Artificial Intelligence and Machine Learning. We have been involved in analytics for manufacturing, health, and well-being for many years. We have experience in infestation and bacterial control in the food industry which has similarities with this pandemic. Further information and customer lists can be obtained from our websites above and https://www.bisnetanalyst.com

Most disturbing is recently acquired anecdotal evidence by members of the public, confirmed by at least one Nursing Home General Medical Practitioner, that nursing homes in Victoria, Australia have administered morphine to patients with the virus, who then died. Since most deaths were from the frail and elderly, how many excess deaths were caused by this practice? Without this practice how deadly would the virus have been. An urgent enquiry is required to get facts. We make no assertion on the facts, and are only reporting on the feedback.

To All,

There have been several open letters on the corona virus pandemic written by Doctors, Lawyers, and some members from the police. Some of Australia's open letters are displayed on the https://www.covidmedicalnetwork.com website. What is missing is an Open Letter on the science that was used to respond to the corona virus.

This Open Letter is based on an unbiased 40000+ word report using the results of a data analysis performed over the last seven months of 2020. The report can be accessed from the Covid Medical Network Ltd (CMN) website by following this link (https://www.covidmedicalnetwork.com/COVID19Analysis.aspx).

We recommend that this report is downloaded and that the Disclaimers, Apologies and Executive Summary are read.

This letter is not about wishing to discredit the virus. That would be disrespecting those who have lost loved ones. This letter is about restoring hope to humanity, by reestablishing reality that was lost through errors in science to restore hope to humanity. The human cost has been highly underestimated. Just as lives have been lost, people's lives have been destroyed and it is time that conscience not science alone factors into decisions.

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

To provide a brief history, in September 2020 Qtech International approached the Australian Covid Medical Network offering to help the network achieve its objectives through Qtech's statistical and analytical expertise. The CMN (htttps://www.covidmedicalnetwork.com) were the first group of Doctors in Australia with the courage to openly voice their concerns and dissidence with the response to the pandemic. The CMN then commissioned a report on the analysis to confirm their concerns, which it did.

Realistically there is little that can be done about Covid-19 at this stage. The fear is too entrenched. What is now important is to learn from the mistakes to prevent this precedence from happening again. As part of this learning process this letter in its Appendix, highlights the flaws in the science used to manage the pandemic. This has led into a set of recommendations that has been forwarded to the Independent Panel for Pandemic Preparedness & Response. The recommendations can be accessed below.

The worst examples of bad science are the use of case reporting not factoring in test numbers and treating dying with the virus the same as dying from the virus. There is currently considerable 'Angst' over new strains in the UK (Kent) 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 at the date of this letter. The high cases numbers are due to increased testing numbers.

Though it is not disputed that some countries have higher than normal deaths, the virus is not universally deadly, and we assert that many deaths were caused by mismanagement especially not managing treatment, fear, and panic. A recent study by SAGE, UK, documented here Has lockdowns caused more deaths than actual Covid-19 deaths? (covidmedicalnetwork.com) has confirmed this.

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, health system, wealth, and other 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.

We assert that hospital overwhelming, a likely major cause for deaths, was mismanaged, also confirmed by SAGE who admitted non corona virus deaths, which includes hospital overwhelming may have doubled deaths. We go as far as saying, tripled, because Sage used reported deaths which died with, not from the Corona Virus.

Most disturbing is recently acquired anecdotal evidence by members of the public, confirmed by at least one Nursing Home General Medical Practitioner that nursing homes have administered morphine to patients with the virus, who then died. Since most deaths were from the frail, elderly, how many excess deaths were caused by this practice? An urgent enquiry is required to establish the extent.

We reluctantly conclude we probably caused far more deaths than the virus did directly.

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. These can also be used for quarantining. We do the same in Bushfire seasons. **By spreading the curve over time, we bought time for the virus to mutate into a more dangerous form. This may have happened.**

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 restricting movement and quarantining. Restricting movement has human costs that are immeasurable. The World Health Organization before it became embroiled with US politics was against restricting 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 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. Hence, the reason we performed such a data analysis, which started as early as the commencement of the Wuhan outbreak.

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 humanely and intelligently manage future epidemics.

A summary of the full report is listed in the appendix.

The details of the analysis with fact supporting links can be obtained by following this link (https://www.covidmedicalnetwork.com/Covid19Analysis.aspx).

This 40,000 word report is comprehensive and includes disclaimers, limitations, caveats, and apologies.

You can also download a pdf containing information snippets where you decide whether a terrible mistake was made through highly flawed science. All facts can be verified independently.

https://www.covidmedicalnetwork.com/coronavirus-facts/statistical-and-data-evidence/truthbehindthescience.aspx

Alternatively visit https://www.covidmedicalnetwork.com/coronavirus-facts/statistical-and-data-evidence/overview.aspx to view the information from the CovidMedicalNetwork website.

Recommendations submitted to the Independent Panel for Pandemic Preparedness & Response can be accessed here.

https://www.covidmedicalnetwork.com/coronavirus-facts/statistical-and-data-evidence/Recommendations.aspx

an appended recommendation can be accessed here. (Highly recommended)

https://www.covidmedicalnetwork.com/coronavirus-facts/statistical-and-data-evidence/AppendedRecommendations.aspx

Dr. Juergen Ude and Luo Fucheng

Comments, Opportunities for further Research

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

What we will state is that we do not concur with the firm statements made about the prevalence, infectiousness, contagiousness, spread, virulence and deadliness and anything related to SARS CoV-2. It is unscientific to make firm statements based on soft science analysis.

What we do assert is that the science was highly flawed and incompetent, resulting in exaggerated 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. Observing the reactions, this virus was mismanaged badly.

Unfortunately, when we believe soft science conclusions are concrete, we risk distorting reality in our minds. The world has taken the easy way out and accepts everything it reads and hears about the virus as indisputable fact. Denial does not just apply to the perceived harmfulness of the virus, but also to reality. Reality is now filtered through censorship of information and alternative views by high qualified people. What have we become?

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 paranoia 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. Reported death statistics cannot even be trusted because they are based on the definition of having died with the virus, not from the virus. If we define a pimple death as having died with a pimple how many pimple deaths would there be?

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.

Though not perfect the best criteria to measure deadliness is total death registrations. There were certainly higher than normal deaths in some countries. 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. Europe at this stage would normally start developing peaks. The onset will have been distorted by interference caused though our responses. This is normal though out life. Interferences causes a reaction.

Because of our interference to natural variation, we cannot be certain whether increases in registered deaths are due to the virus itself, or due to the virus in conjunction with comorbidities, or part of the natural cycles, or human factors.

The science was so incompetent that it was unable to consider country peculiarities, age groups, wealth, health, health systems etc. with response strategies. Instead of a burn and slash strategy a more intelligent approach would have been targeted strategies tailored for each country and situation. 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.

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. Already reports of new dangerous viruses are 'popping up', as predicted.

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 health 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.

Would advisers recommend life destroying decisions if they lost their careers and life's work? It is so easy to destroy lives if it is other people's lives that are destroyed because we cannot feel the pain.

Values and Priorities

We believe that saving lives, though certainly a priority, is not the only priority. Living, freedom and freedom of movement is what we are fighting for, whilst of course also saving lives. The World Health Organization also believes freedom and freedom of movement need to be protected.

Russian men have an average life expectancy of only 65 years, 15 years less than many other countries. The reason – Vodka. They can extend their lives but choose Vodka. We may not agree with it, but it is their choice. Of course, if we can convince them to make better choices that would be better. Animals in captivity live much longer, but would they choose captivity over freedom at the expense of living less. Cockatoos can live for many years in a cage, but eventually pluck their own feathers. Would they choose freedom over long life if they were smart enough to choose? Many of us are' plucking our feathers' now.

Ironically, we have fought wars sacrificing millions of lives over freedom, now we sacrifice freedom over a few deaths. 2 in 10000 people have globally died in 2020. There are many other sources of deaths with higher numbers, that we could do something about, but we accept it.

Many of those whose lives we were trying to protect were in urine stenched age care facilities with limited time left. Based on our own experiences with our loved ones, residents see nursing homes as jails and do not wish to have their lives extended. Have we really thought of them when we disallowed their only source of happiness, which is seeing family?

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?

Hysteria and fear will result in hospital overwhelming and exaggerated display of symptoms, not unlike the exaggeration expressed when trying to get an emergency medical appointment or requesting a sickie.

According to the SAGE report, approximately 50% of deaths were caused by factors other than the virus itself. That did not even factor in death possibly caused by stressing out a patient through fear.

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.

Appendix

Summary of the full report

The following is a highly condensed summary of the full report to show the flaws in the science used.

- **Methodology:**

Only reproducible and easy to understand, visual statistically based analytics were used. No models were used. No black box AI, ML technology was used, which make it impossible to argue for or against conclusions. Instead, our own developed technology was used to visually display the data that anyone can interpret using common sense.

The technology can be reviewed on our knowledge-centre.

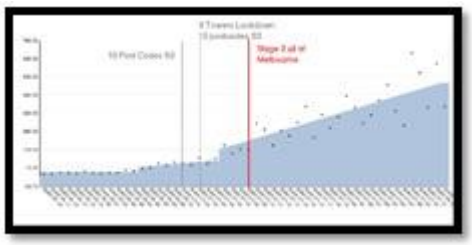
Hybrid SPC Charts | Statistical Process Control (bisnetanalyst.com)

Change Analysis | Alternative to Shewhart Charts (bisnetanalyst.com)

https://www.bisnetanalyst.com/quality-assurance/knowledge-center/articles/change-analysis/manhattan-control.aspx

- **Computer Models**

Models were the driving force behind the justification of actions that some argue destroyed lives and the economy. The science community has acknowledged models are always wrong. It is hence illogical to use models that cannot be right to prove how rampant and deadly the virus is. Pandemic models have a history of unrealistic predictions due to wrong assumptions. Every model researched, simple or complex, was excessively 'academic' and highly flawed with invalidating assumptions. One Victorian model used to justify Victoria's harsh lockdown assumed an exponential growth curve when the growth was clearly linear. This resulted in an exaggeration of reality. Overseas countries without lockdown had far less deaths than predicted by Victoria's models. Victoria was supposed to have 650 deaths per day without physical distancing. In comparison Sweden, without draconian lockdown averaged 20 deaths per day, at its peak death period, when adjusted for Victoria's size. Japan 1 death per day.



The above Bis.Net Change Analysis chart represents the growth of the virus in Victoria. As you can see there was no exponential growth.

- **Perspective and comparisons:**

(Science without perspective is no science.)

There was no perspective placed on Covid-19 infections and deaths. Annual flu cases (up to 1.2 billion) exceed the total reported SARS-CoV-2 cases of 83 million in 2020 **by up to a factor of 14.**

Comparisons with flu deadliness have according to our standards been unscientific and biased.

There is in fact no evidence that the flu has lower mortality rates than SARS-CoV-2 and its related Covid-19 illness. This is especially so when considering Quality Adjusted Life Years (QALYs). Many strains of Influenza affect predominantly younger people, in stark contrast to the predominant mortality impacts of the current SARS-Cov-2 on the elderly and the aged with multiple with comorbidities.

Relative to other causes of deaths, Covid-19 reported deaths **in all of 2020** are high, but less than 1/3 of all respiratory diseases in 2017, and around half of virus-related respiratory diseases. The number is likely lower if only deaths caused specifically and with reasonable certainty by SARS-CoV-2 were considered, instead of as per definitions used by public health authorities.

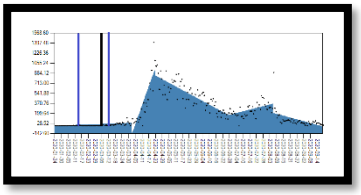
The global deaths attributed to Covid-19 in all of 2020 is 2 per 10000 of the world's population, nowhere near black death percentages of 30% to 60% of Europe's population. Similarly, as above, the number is likely lower if only deaths caused specifically and with reasonable certainty by SARS-CoV-2 were considered instead of as per definitions used by public health authorities.

- **Problems with Hasty Judgements and an inadequate review process:**

Lockdown and social distancing measures were introduced as unprecedented measures following the examples of other countries that appeared to have early success with such measures. However, many of the examples were misleading. Experts were in fact 'jumping to conclusions', arriving at decisions too early and without the proper processes to review such decisions in a timely, well-prepared and organised manner. It was a matter of attributing causation to what was at best an appearance of association or correlation of variables.

There were many examples throughout the pandemic where public health experts jumped to conclusions. Examples include the widespread lauding of Singapore, South Korea and Japan for the early successes of their approaches only to find them struggling with rising 'cases' later. Taiwan and Vietnam had relatively reduced testing programs. If you do not test you will not find problems. Vietnams neighbors, Laos and Cambodia also had low cases.

The graph below demonstrates the Singapore experience illustrating how timing is important when examining the success or failure of various public health strategies and the difficulty of attributing causation to the various measures employed.



The black line is when Singapore's performance mesmerized the world. The blue lines are when the WHO complimented Singapore for its success.

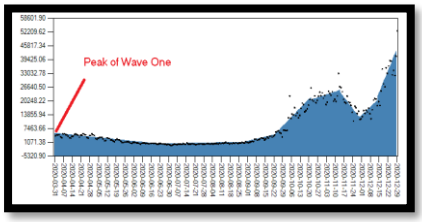
How much time, money and effort were wasted and how much hardship was caused because of conclusion jumping?

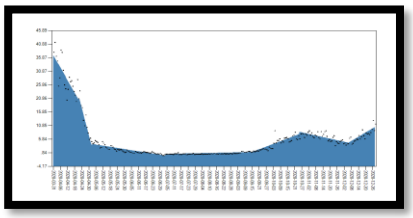
- **Case Reporting**

Case reporting is without offence intended the worst scientific incompetence that was identified. Cases are dependent on test numbers and hence have no meaning. For a given prevalence the more you test the more cases are obtained. For most European countries, as at the date of this report, the explosion in cases is nowhere near as bad as case reporting implies. Proportions, aka case positivity, are the correct way to show the changing degree of infections by taking testing size into account. Many second waves have mostly been the result of increased testing numbers not increased infections in the population.

The 2 charts below are for the UK. The first chart plots 'cases only' with no regard to testing numbers. As you can see, there is a dramatic increase which resulted in new lockdowns. The second chart plots 'proportions' which factors in the testing numbers, thereby better representing infections in a 'population'. The proportions do not show such a dramatic increase of the virus in the population.

The first chart shows why it is now believed that the new strain is 70% more infectious. There is a greater than previous sharp increase in cases, but that is mostly the consequence of increasing test numbers, not the new strain. When factoring in test numbers the increase is a fraction of case increases. The smaller third increase is expected due to the colder weather, which also results in more registered deaths at this time.





A crude estimate of prevalence for the UK using proportions is 5%. On this basis, based on the last 28 days the fatality rate for Covid-19 is 0.4%. Since the case positivity is biased towards symptomatic cases the fatality rate can be expected to be much lower. The virus is not as deadly as it has been portrayed from this perspective. Furthermore, using this prevalence the UK would over the last month have had over three million cases.

This should not be surprising. SARS-CoV-2 is a member of the common cold virus and the common cold is the most prevalent virus. 5% is a low percentage for common colds. In Australia over 50% of people get infected each year. If there were 3 million cases, why has there not been far greater hospital overwhelming. The virus cannot be so harmful if the symptoms are so mild for most that people do not need to present themselves to a medical clinic.

Interesting China is accused of withholding case numbers because antibody residuals in the population imply higher cases than were reported. If we use this argument, is the UK withholding case numbers since reported case numbers are much lower than the estimate of 3 million cases at around this time?

- **Prevalence:**

Prevalence is needed to determine deadliness; location of clusters and hotspots; optimization of and confirmation of effectiveness of containment efforts. Yet the science needed for prevalence estimates is non-existent. There has been no science applied in every country that we investigated, including Australia. A pandemic cannot be controlled without ruining lives and the economy if we do not have an accurate estimate of prevalence and its distribution throughout a country?

Current sampling is designed for contact tracing, not prevalence estimates and hence is biased and influenced, making prevalence estimates unreliable. The absence of prevalence estimates throughout a country means hotspot and cluster conclusions are meaningless. A sudden appearance of cases in a region does not necessarily mean a hotspot just 'unlucky sampling'**.**

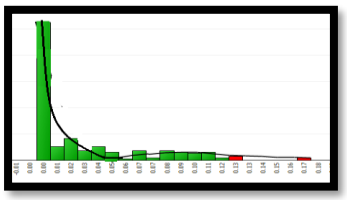
If we find new cases in one area, not in another, we are living in a 'fool's paradise' believing that the virus is located only in the area where a case was found.

We then disproportionally allocate testing resources giving the virus a chance to multiply in areas not focused on. Until this aspect is dealt with by competent experts, we will continue to chase our tails and affect lives longer than necessary.

- **Conflating homogeneity with heterogeneity:**

The distributions of deaths and prevalence amongst different countries is heterogeneous, not homogeneous. This Is not unexpected with soft science subjects where nothing is predictable and simple. This means we should not have drawn the conclusion that we will all reach Italy's high levels.

Many countries only have a small percentage of deaths and even **without lockdown or halfhearted lockdown**. Singapore with 59000 infections only had 29 deaths in 2020. 80% of countries had less than 0.05% of deaths. Italy is amongst the top 3% of countries. There were two groups of countries, possibly three with notably different deaths.



It is unscientific to treat heterogeneity as homogeneity, instead of scientifically trying to establish why the differences so that tailored responses can be established.

For example, Lombardi is an area known to have serious health problems due to pollution. In the UK someone dies of lung related problems every five minutes which is not related to Covid-19. 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 simply exasperated the health problems which are the underlying cause.

The question is begged - is it right to 'punish' the whole world because some people did not care about their health, or some governments failed to address pollution, or some countries have poor health systems preventing everyone to get adequate and timely treatment? Since we are forcing people to social distance why do we not force people to exercise daily, make smoking

illegal, control food servings in restaurants, and save far more lives, at a fraction of the cost that was spent destroying the economy.

- **The Lack of Evidence for the implementation of novel Non-Pharmacological Interventions in controlling the Pandemic:**

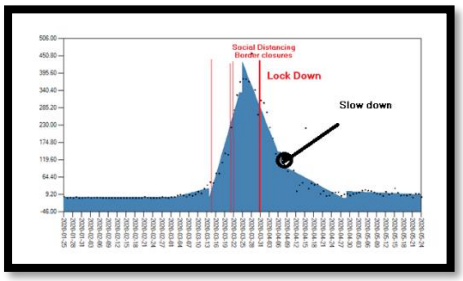
Academically lockdowns, face masks, social distancing, quarantining, and testing all make a difference. If we live under a dome it is impossible to spread diseases, but the price is suffocation. Lockdowns result in mental and economical suffocation. Even the WHO in 2018 suggested that quarantining and restricting movement is no longer acceptable and other ways need to be found.

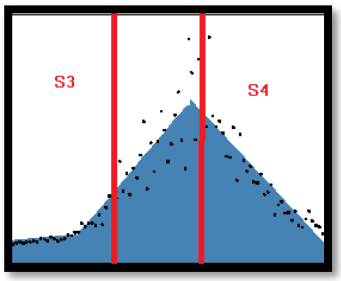
This is soft science. What may have been found in an academic controlled research study means nothing in practice and what makes sense intellectually means nothing. This is the real world consisting of human beings who are not perfect. We have studied every country and the conclusion was that there was no evidence that lockdown and other containment measures, such as face masks **and testing** made an **observable consistent predictable** difference.

Details of our study with charts and complete references can be found in our full report.

- **Curves coming down independently of interventions:**

It was noted that curves came down by themselves for various countries. This is not unexpected and will be covered later under registered deaths. The seasonal flu and common colds come and go in all but tropical countries. Australia who thought it was the envy of the world with its rapid response (left chart below) was the only country which started lockdown after cases were already coming down on their own. This can hardly be called a rapid response because other countries started lockdown at the left foot of the curve.





Similarly, Victoria (second chart) should have been patient. We may not have needed lockdown 4. Cases already came down. But Victoria used a moving average of 14 to prove lockdown 4 worked, and we were thus subjected to the longest lockdown in the world. People suffered because of it. **The moving averages did not prove lockdown 4 worked because they lag real changes.**

- **PCR Testing:**

The key to controlling the pandemic is believed to be testing. We cannot concur based on our analysis and commonsense is enough to conclude the futility of the huge amount of testing conducted once a virus has taken a foot hold. Earlier in a pandemic maybe.

One modern PCR 'machine' under ideal conditions can provide 300+ tests in 24 hours. Someone must prepare the samples. That is a tedious job. As unpalatable as it may sound, it would be naïve to believe that short cuts were not taken by those who must perform this mundane job. We have seen it too many times even when laboratories made it clear, "we take our testing integrity very serious and have checks in place that prevent this".

Do we have enough PCR machines to perform tens of thousands of tests a day? Do we fall back on less reliable methods as some countries do?

Testing relies on measurements and yet no scientific measurement system analysis results could be located, at least according to our standards. This does not mean that there were no validations performed. We located a number, but they all used highly dubious science.

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.

It is not scientific to assume a high resolution without running properly designed experiments. **Can we even be sure that in the past common cold out breaks were not sometimes due to SARS-CoV-2 when we did not test as extensively as now?**

Until thorough studies have been performed and published and written in manner that is understood there can be no confidence in the test results.

- **Definition of Covid-19 Deaths:**

Without a proper definition of a 'Covid-19 death', the official reported death numbers are meaningless.

"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."

"Belgium, for instance, attributes deaths to Covid-19 if the disease is a suspected cause, even if no test has been carried out."

How can Covid-19 deaths be taken serious by anyone with intelligence?

How can governments talk about thousands of deaths when reporting Covid-19 deaths when there is no scientific basis for ascertaining that the death was caused by the virus?

The same situation existed for SARS. SARS initially was diagnosed just based on symptoms being consistent with SARS. That is not science. This invalidates many of the SARS conclusions that were made.

To show how nonsensical this ascertainment bias is, consider a death to be deemed a pimple death if the person that has died had a pimple. Pimples will suddenly become deadly.

This is no different to defining a 'Covid-19 death' based on a positive test for SARS CoV-2, reported on prior to their death.

The medical industry has never considered the presence of a cold at time of death to be the cause of death unless that cold has resulted in a severe respiratory infection and illness. This is so regardless of whether the 'cold-causing-virus' could be detected by a laboratory test.

To conflate 'dying from and dying with the SARS CoV-2 virus, is unscientific and misleading.

Such an approach goes against the common understanding of medical science and good medical practice and risks many unforeseen and unintended negative consequences.

- **Registered Deaths instead of Cause of Death:**

To attempt to overcome the distortions resulting from the misapplied causation of deaths, we examined registered deaths as a more reliable way of determining the virulence or deadliness of the SARS CoV-2 virus. However, even with this approach we found the data science to be lacking in rigour and quality. This approach also does not establish causality. It only shows whether there were more deaths during the period. There may be factors correlating with the pandemic that are causal, not the virus. For example, overwhelming of hospitals.

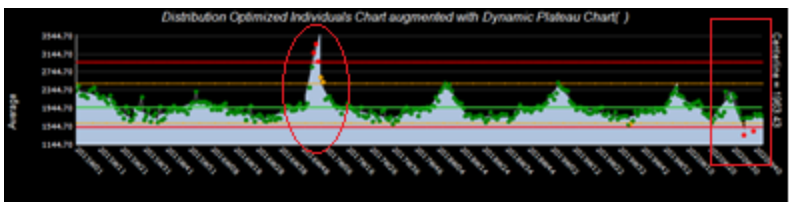
(Overwhelming of hospitals is a complex subject. Current reports imply that overwhelming has never been a problem, but it has. In Australia during some flu seasons over 300,000 people presented themselves to hospitals causing overwhelming. In Sweden, the virus is currently being accused of causing 100% utilization of hospital beds, but this is normal every year at this time according to reports.)

Experts use excess deaths, and these are based on expected values using models, or the average of the last n years, both of which add a component of error. There will always be periods of excess deaths. When do we draw the line? What is needed is a tool that tells us when something abnormal is happening, that is beyond nature's way of maintaining a balance between life and death.

A tool that tells us when something abnormal is happening is a control chart.

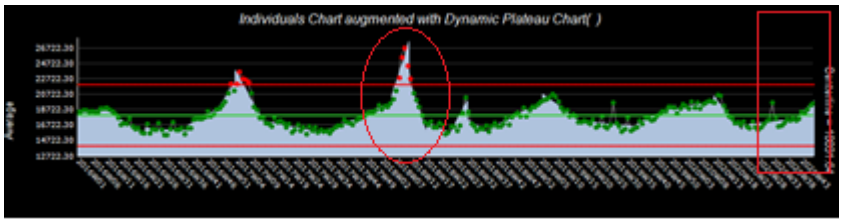
Industry has for over a hundred years successfully used control charts to determine if there is unnatural variation. Natural variation should not be reacted to because that makes matters worse. Points falling outside control limits are due to unnatural causes, but this does not automatically mean that industry closes in response. Industry would try to find causes to prevent recurrence of the outlying points or accept them if occurrence of such rare events is also part of natural variation.

Occasional unusual deaths are normal. They are part of life. The image for Serbia below shows a large spike (circle) beginning of 2017, but nothing **spectacular** in 2020 (rectangle) during the covid-19 period. The spike is of comparable size to spikes experienced in the USA, Italy, UK, but there was no public health emergency instituted.



Bis.Net Hybrid Chart for Serbia

Similarly, Germany below shows a large spike in deaths 2018, no different that Covid-19 spikes.



Bis.Net Hybrid Chart for Germany

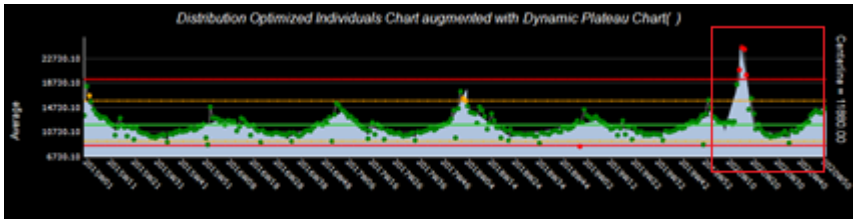
- **Registered Deaths Analysis:**

We applied distribution optimized BIS.Net Hybrid SPC charts to 36 European Countries in the European Union and every state of the USA and South Korea and Taiwan.

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 for the first wave.

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.

The following shows the Hybrid SPC chart to week 51 for the UK to see the effect of Covid-19 in the UK. The effect may not be desirable, but it is not at dooms day levels and countries such as Serbia (above) and Germany (see next page) had the same magnitude spikes (flu?) before Covid-19.

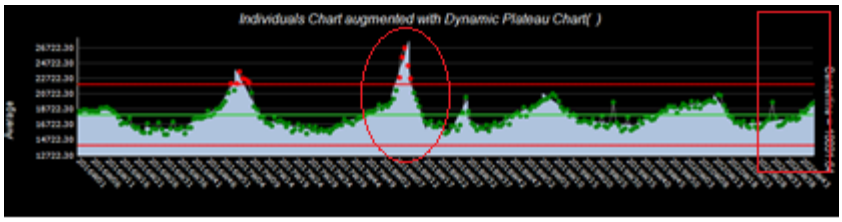


Bis.Net Hybrid Chart for the United Kingdom

The only unusual deaths occurred in March. **There have been reports about a new crisis,** overwhelming, more deaths due to the latest wave with a new highly infectious strain. However, there is no evidence at this stage that the strain is 70% more infections as claimed, and there are no unusual deaths at this stage. Overwhelming is normal for many countries at this stage of the year and can also be contributed by the paranoia with the high cases which have not factored in test numbers. The current increase taking variation in wavelength and amplitude into account is historically consistent. In fact, early 2015 there was a much bigger amplitude.

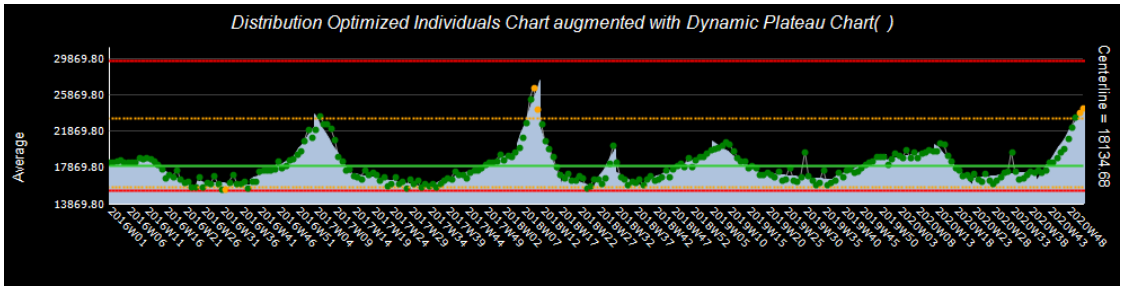
Once gain models were used to draw that conclusion, and already some countries such as Australia believed the science without question and the UK is implementing more lockdowns, even though as at week 51, there still has not been an effect on total registered deaths. Perhaps later there will!

Germany (see below) with 1.03 million cases and 16011 deaths at end of November has had no unusual deaths during the Covid-19 period (rectangle). [Australia panicked and destroyed its economy with a few thousand cases even though Germany had 1 million cases and no change on registered deaths. The reported deaths are meaningless being 'pimple' deaths.] But Germany did have an unusual number of deaths in 2017 and especially 2018 (circle) of a similar magnitude as the UK during the Corona Virus peak above. Why did that not result in destruction of lives Germany at the time? Why did the UK destroy lives with similar 'excess' deaths?



Bis.Net Hybrid Chart for Germany

The most recent registered deaths up to week 53 show that there is now an increase in deaths. However, it is still within natural cyclic variation as is shown below.



The most recent Bis.Net Hybrid Chart for Germany

We found no evidence that any of the recent containment actions made any difference. There seems to be another situation of conclusion jumping where the virus was blamed for the rise in deaths. Yet, peaks such as the current peak are natural and should thus not (at least at this stage) have resulted in further destruction of lives and the economy. There has been a larger peak in 2018. Although the current registered deaths are consistent with normal periodic variation it is also possible, though not proven, based on our analysis that the high cases have indirectly contributed to current deaths, not because of the virus directly, but human failures to be discussed below.

- **The Reality of the Virulence or 'Deadliness' of SARS CoV-2:**

For a few countries there was evidence of an unusual number of deaths, but in our opinion, the degree does not justify the world's reaction when considering the unprecedented damage to lives. Spikes are normal in industry and other sectors. For the USA extra deaths in 2020 were around 1/1000s of the US population. There are possible reasons why the USA is having problems and other countries do not. It may have nothing to do with ineffective lockdowns but all with its general health situation and national health systems as explained previously under

Heterogeneity and Homogeneity. Countries without lockdowns did not have similar deaths to the USA.

- **The Effects of fear and the Human Response to SARS CoV-2: A reflection on the complex issue of 'Cause of Death'.**

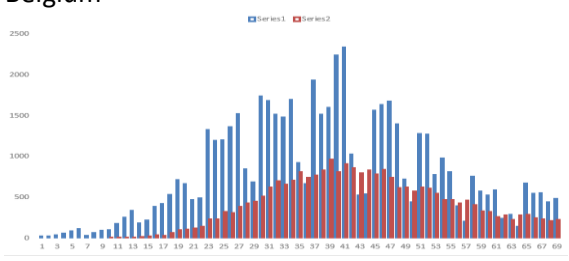
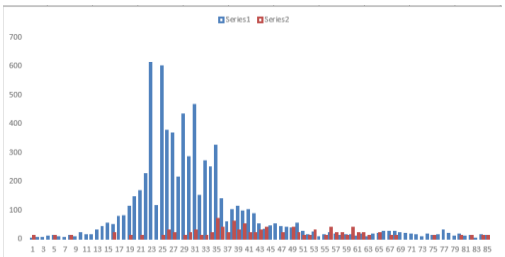
Only a few countries had significant spikes and there are reasons for that which advisers should have investigated. Instead, the virus was treated as equally deadly in every country.

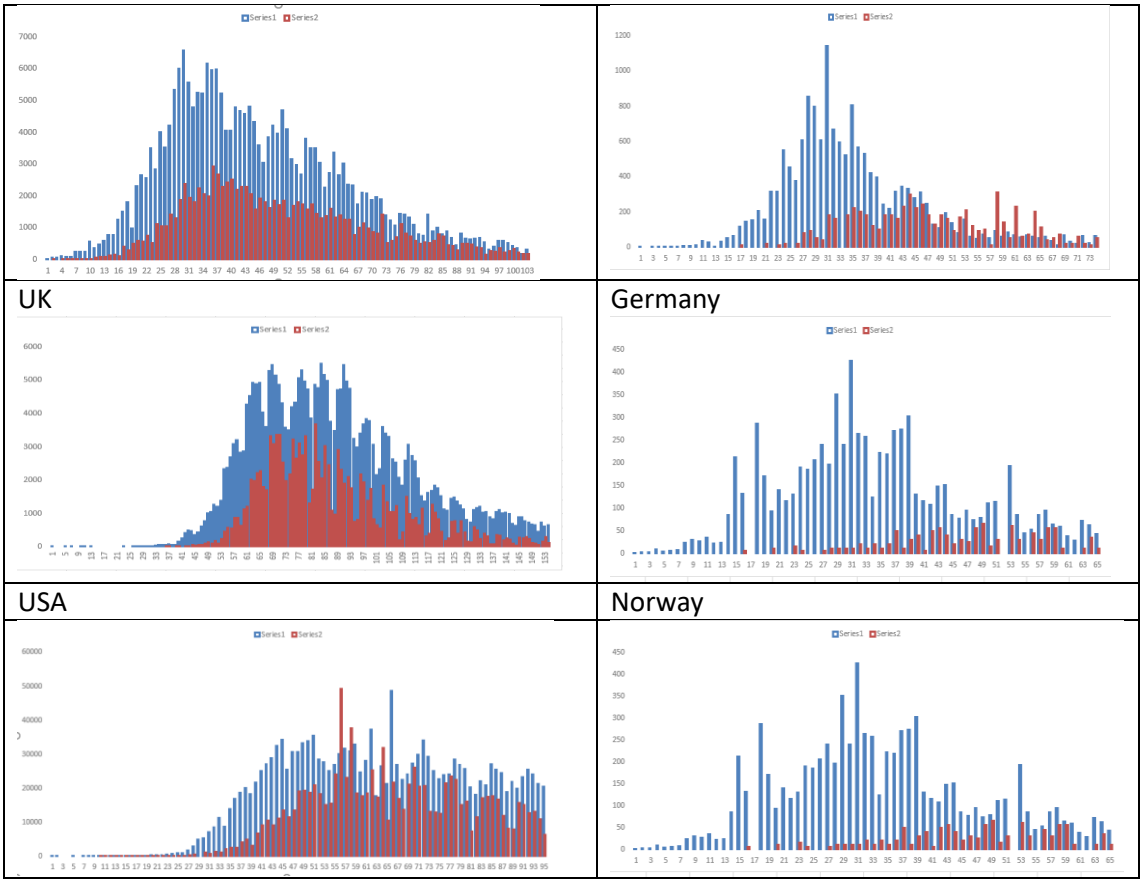
The human response to the idea of a deadly airborne respiratory virus may have had significant effects. Deaths may have been caused, not by the virus, but the unavailability of hospital beds because elective surgeries had been cancelled. Many people refused to check themselves into hospitals for fear 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 28+ 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.

Countries with higher-than-normal registered deaths	Countries without
Belgium 	Australia 
Italy	Austria



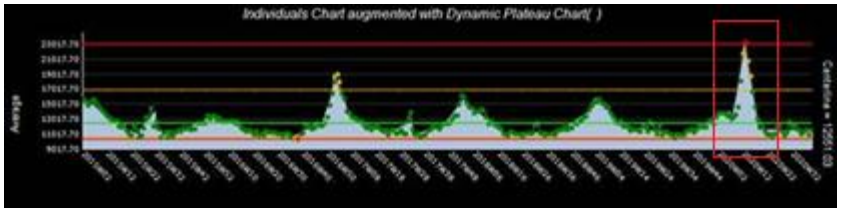
According to our analysis, without the underlying health issues and co-morbidities there was little impact on health outcomes and deaths by SARS CoV-2. In terms of causality, it raises the question whether it is the presence of a virus that we should be concerned about or whether our general health and old age should be our focus and the impetus for policies of healthcare management and resource allocation.

- **Evidence of natural reduction in deaths without intervention**

There has been an assumption that only containment actions will reduce deaths.

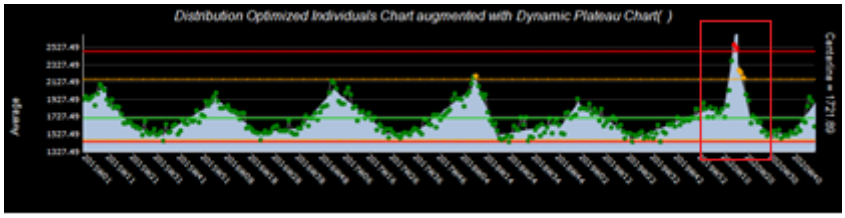
That is not true. Sweden is a perfect example that demonstrates that even when no draconian containment action is used deaths can come down by themselves and fast.

Please note the first wave deaths for Italy in 2020 below



Bis.Net Hybrid Chart for Italy

And for Sweden below.



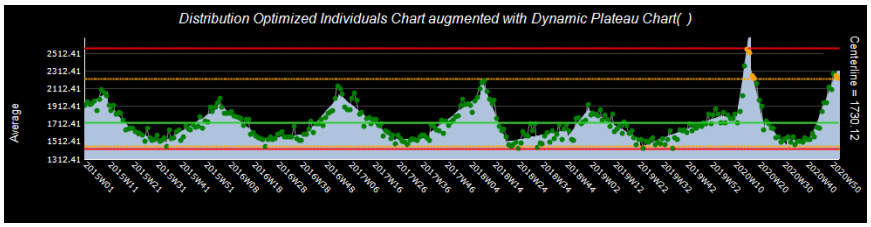
Bis.Net Hybrid Chart for Sweden

Where is the difference? Italy had draconian lockdowns. **Sweden did not.** Both deaths went up and down equally fast and both were out of control by similar amounts.

There is a strong possibility that without lockdown the deaths in Italy would have come down by themselves even if the cases did not, because once the virus has affected unhealthy people the remainder are healthy people, and less affected by the virus.

We will never know because unlike Sweden's Anders Tegnell, no one had the courage to deal with the virus using common sense, not theory based soft science.

A more recent update of the data shows that as at end of week 52/2020 there is another increase. The reason for that is that parts of Sweden that were not hit as bad in April are now being hit. However, a significant proportion of this increase is due to the natural cycle in deaths. Interestingly Sweden has taken more action to control the virus the second time round, but it has made no difference so far.



- **The Virus and Age-Based Mortality rates:**

The virus does not kill young and old alike. For all the European countries analysed there were no significantly unusual, registered deaths for those below 50 years of age.

For the USA, the situation is a little different. We found no unusual numbers of registered deaths for those below 25, confirming the virus does NOT kill young and old alike. 33 states also had no unusual, registered deaths for the 25–44-year-old age group. The rest had some. What this means is that there are interacting factor involved which are causing deaths. This does not have to be the virus. There could be health system issues, health issues and even treatment competency as unpalatable as this may sound. There is also an issue with data integrity in the USA which could distort numbers.

These are human factors that need to be identified to make more qualified statements, e.g., the virus kills some younger people with certain health problems. More honest scientific statements will result in more rational responses instead of the kneejerk responses we are used to.

Many victims have been from age care. To the best of my knowledge life expectancy in age care is a very short time. The quality of life in age care is very low and many residents feel they are in jail, wishing for their time to come. Does it make scientific sense to bring the world down to its knees when the probability of death is very low for those below 70 without comorbidities. Is it humane to save lives in age care when it means that the residents are prevented from seeing their loved ones in the last days of their lives? Is it human to extend life for those who have no quality of life left?

- **The Lack of Evidence for the Effect of Mandatory Masks:**

Our study of over 50 countries that have mandated the use of community face masks/face-coverings demonstrated that this measure had **NO EFFECT** on the transmission and prevalence of SARS-CoV-2.

Consistent with our findings with lockdown interventions and other recent studies **we noted that curves came down independently of mask mandate interventions for many of the various countries we studied.**

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].

Furthermore, we found **no robust new evidence to support the recent change of position** by experts to now endorse face-mask mandates.

Of greater concern, despite no evidence to support the effectiveness of masks, **there is robust evidence mandatory face-masks cause harm.**

Harms include; Increased susceptibility to respiratory infections[iii], psychological and emotional harm and negative learning and behavioural effects, especially among children and adolescents[iv]. Chronic hypoxia[v] (low oxygen levels in the blood) and hypercapnia (high CO2 levels in the blood).

Also, widespread, and improper mask use may increase viral transmission due to masks acting as a moist reservoir of microbiological contaminants, contamination with hands touching masks and decreased adherence to other protective measures, such as physical distancing and hand washing, due to mis-placed confidence in mask use.

End Notes

[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)

[iii] Australian Department Health Report by Infection Control Expert Group (ICEG) referenced a 2015 RCT study in the BMJ showing a 13-fold increase in respiratory illness and infection between mask use and non-mask use among 1600 Vietnamese health workers. "A cluster randomised trial of cloth masks compared with medical masks in healthcare workers. BMJ Open. 2015;5(4):e006577. 10.1136/bmjopen-2014- 006577

[iv] A recent German study, entitled 'Co-Ki was the first of its kind to survey parents of 25,930 children, Germany wide, regarding the impact of face-masks. It found: Impairments caused by wearing the mask were reported by 68% of the parents. These included irritability (60%), headache (53%), difficulty concentrating (50%), less happiness (49%), reluctance to go to school/kindergarten (44%), malaise (42%) impaired learning (38%) and drowsiness or fatigue (37%)

Reference: https://www.researchsquare.com/article/rs-124394/v1

[v] Preliminary report on surgical mask induced deoxygenation during major surgery" Journal of Neurology, 2008. A longitudinal and prospective observational study of 53 surgeons wearing surgical masks using a pulse oximeter pre and postoperatively, revealed a decrease in the oxygen saturation of arterial pulsations (SpO2), more prominent in the surgeons aged over 35. Reference: https://pubmed.ncbi.nlm.nih.gov/18500410/