Covid-19 – Points

Notes:

All dates refer to 2020 unless otherwise stated.

GB (Great Britain) and UK (United Kingdom) are used interchangeably.

Part A

A.0 In which we set out the contents of this document and any notes which may increase the understanding of the purpose and nature of this document including its limitations deliberately imposed to ensure a more readable experience for non-mathematicians and statisticians.

A.1 This document is set out in various parts according to the purpose of each part.

A.1.1 This part A is intended to be an introduction and preparation for the reader so that they may understand and better appreciate and use the document in the main.

A.1.2 Part B provides a summary of the points covered in each section

A.1.3 Part C addresses the actions in particular of Professor Ferguson (PF) of Imperial College (IC) and his Imperial College Covid-19 Response Team (ICCRT) Report 9 (ICCRT R9).

A.1.4 Part D addresses the Covid-19 contagion in its broader context

A.1.4.1 It includes UK government actions and narrative

A.1.4.2 It includes worldwide comparisons actions and narrative

A.1.5 Part E addresses the arithmetic of contagions

Part B

B.0 In which we set out the contents of this document and the major points covered in each part

B.1 We summarise the contents of Part C

B.1.1 Part C addresses the actions of Professor Ferguson (PF) of Imperial College (IC) and his Imperial College Covid-19 Response Team (ICCRT) Report 9 (ICCRT R9).

B.1.2 We use the numbering associated with Part C.

C.1.0 We claim that Professor Ferguson (PF) of Imperial College (IC) knowingly published a fraudulent document in support of government measures which would inevitably cause damage and hardship.

C.2.0 Parameters and Output of the PF Model

C.3.0 Our claims in regard to ICCRT R9

C.4.0 Demonstration of Claims

36.0 Normal Life Far More Dangerous Than Covid-19

36.1 If we do not end society for normal life risks why then should we end it for a threat that is less dangerous than normal life?

36.1.1 There is no age group or condition (having pre-existing conditions or not having them) where Covid-19 presents a greater threat than normal life.

36.2 We examine the Covid-19 deaths in England and Wales between March and June where the primary contagion was at its height.

36.2.1 In this period Covid-19 had the greatest opportunity to pose a temporary threat greater than normal life and yet it failed to do so in every age group wither we include sick people with pre-existing conditions or exclude them.

36.3.1 The data is contained in referencetables.xlsx Table 2

36.3.1.1 This is available at
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsinvolvingcovid19englandandwales

36.3.1.2 Comorbidity percentages are obtained from Table 6a of the same publication

36.3.1.3 Deaths by year of age 2018 are available in deathsyoauk2018.xlsx

36.3.1.3.1 This is available from
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathregistrationssummarytablesenglandandwalesdeathsbysingleyearofagetables

36.3.2 Covid deaths age range is in 5 year intervals from 5-9 onwards with <1 and 1-4 for the first interval and 90+ beyond 90.

36.3.2.1 Comorbidity classification 'No pre-existing condition' is available for 5 year ranges from 45-49 onwards to 90+ with an initial interval of 0-44.

36.3.2.1.1 We therefore apply the 0-44 for all intervals covered by that larger interval.

36.3.2.2 Deaths in 2018 by single year of age are grouped into the <1, 1-4 and subsequent 5 year intervals

36.4 We derive two key figures

36.4.1 By comparing deaths in the same interval in 2018 to Covid deaths in 2020 we arrive at a figure for each age-band for how many times normal life is more dangerous overall disregarding pre-existing conditions

36.4.1.1 With 1 death < 1 attributed to covid we have that normal life was 857 times more dangerous than covid for <1 which is hardly a surprise given the significant risk of death at age <1.

36.4.1.2 With zero deaths attributed to covid up to age 9 we have that normal life was infinitely more dangerous which we represent simply as 9999 times more dangerous

36.4.1.3 From age 10 to age 90+ normal life starts at 52 times more dangerous and declines to 3 times more dangerous between 80 and 89 and rises to 4 times more dangerous for 90+.

36.4.1.4 Even in the most vulnerable category of all the old including old and sick normal life is still overwhelmingly the greater risk despite everything the government did to increase risk to the elderly with mandated Do Not Resuscitate orders and sending sick people into care homes.

36.4.2 By factoring in the deaths to ordinary people without pre-existing conditions we arrive at a figure for each age-band for how many times normal life is more dangerous for ordinary people without pre-existing conditions

36.4.2.1 Applying the 18.6% no-pre-existing conditions percentage 0-44 to all sub-intervals we have that for <1 year of age normal life was 4608 times more dangerous.

36.4.2.2 With zero covid deaths age 1 to 9 normal life remained infinitely more dangerous in that age band which we represent as 9999 times more dangerous.

36.4.2.3 From age 10 to age 24 applying the 18.6% no pre-existing condition percentage we get that normal life was 277 times more dangerous at age 10 declining to 122 times more dangerous by age 24.

36.4.2.3.1 As such the proposition that children should not be at school or young people at university due to Covid is preposterous.

36.4.2.3.2 If children and young people can bear the risk of normal life without concern for continuing their education then the idea that it should be curtailed for ordinary children for something 100 times less dangerous even at its height is absurd.

36.4.2.3.3 It is hardly difficult to recognise a pre-existing condition and the health service have clearly done so.

36.4.2.3.4 Restricting school and disseminating misinformation or lack of information to raise this as an issue is consistent only with exaggerating the threat and not with responsible risk analysis.

36.4.2.3.5 The government yet again demonstrates its determination to promote the agenda regardless of the impact on education, on young people's mental health, and on the mental well-being of parents of children.

36.4.2.3.6 The only advantage of not attending school is that the schools themselves have become propaganda arms of the government promoting pro-agenda pro-Covid-risk material and imprinting minds which are vulnerable and absorbent with false representations as to life, risk and covid.

36.4.2.3.7 This aspect is perhaps one of the most damning in demonstrating the government's willingness to disregard all decent and moral behaviour in pursuit of its objective.

36.4.2.4 From age 25 to 90+ normal life declines from being 70 times more dangerous than Covid-19 to being 42 times more dangerous than Covid-19 for 90+.

36.4.2.4.1 In regard to OAPs if you weren't already sick then life was far more likely to get you than Covid, and if you were already sick then life was indeed also far more likely to get you than Covid but Covid-19 would get the credit.

36.4.2.4.2 In regard to the working and normal adult population to be afraid of Covid-19 was to be afraid of something dozens of times less dangerous than walking out of your door or getting on with your life.

36.4.2.4.2.1 As it happens the absolute highest risk was at age 45-49 when normal life was only 35 times more dangerous.

36.4.2.4.2.2 Another way of stating that is that normal life was at its lowest likelihood of killing you relative to covid.

36.4.2.4.2.2.1 After the significant risk of being less than one year of age life risk drops precipitously to age 4 at which point you're essentially the safest you'll ever be in life.

36.4.2.4.2.2.3 Death risk increases essentially exponentially doubling every decade in terms of deaths until the diminishing OAP population finally results in a precipitous fall in death numbers.

36.4.2.4.2.2.4 We're not overly concerned with mortality analysis but we simply make the observation that normal life is an ever-increasing risk with age until it's managed to kill so many of us that absolute deaths finally drop off but of course the percentage of risk of dying at that age no doubt is at a maximum.

36.4.2.4.2.2.5 This is the great untold story of Covid-19 that for all of CW and Vallance's apparent determination to be fair and reasonable they have utterly omitted the most critical context of all: that life kills and covid is not only just a part of that, but it's a very minor part of that.

36.4.2.4.2.2.6 And by likewise omitting the simply demonstrated failure of lockdown they get to persist in lockdowns through the end of the year and into the new year of 2021 as we write this.

36.4.2.4.2.2.7 A minor risk compared to real life and a strategy that doesn't work but neither of those facts is either disseminated to the public nor does it affect the strategy which is one of society shut down and ceaseless exhortation as to the latest news of the vaccine.

36.4.2.4.2.2.8 It is the single most fraudulent and destructive forced-sale pitch in history.

36.5 If normal life isn't a good reason to shut down society then a threat that is at worst 35 times less dangerous than normal life is no reason at all.

36.5.1 For parents to injure their children mentally, emotionally and academically for a threat 122 and 277 times less dangerous than normal life is criminal and the parents cannot absolve themselves from responsibility for some part of that.

36.5.1.1 It is not difficult to download the data files we have downloaded.

36.5.1.1.1 It is not difficult to cast one's eye over the figures even if one has little experience in arithmetic.

36.5.1.1.2 And even if someone uses the excuse that they're not good at maths there are millions of people who've passed maths O level or A level or their modern equivalent who have no such excuse.

36.5.1.1.3 The damage done to children and society has not been done because of Covid-19.

36.5.1.1.4 It has been done because the mass of the adult population hasn't lifted a finger to inform themselves using the government's own published data.

36.5.1.1.5 It is the biggest failure of citizenship in our nation's history and removes any right such people have to be considered responsible citizens.

36.5.1.1.5.1 Ignorance and laziness are poor qualities in a democracy.

36.5.1.1.5.2 Wilful and determined compliance with the government at all costs is a godsend to totalitarian regimes.

36.5.1.1.5.3 The tragedy is that the people of the United Kingdom have by their complacency, laziness and blind obedience seen this nation transformed from democracy to totalitarian and there is at this point no indication that the situation will ever be reversed.

36.6 Our summary table is below

36.6.1 Table

F1	F2	F3	F4	F5	F6	F7	F8	
<1	1	2,571	857	857	18.6%	0	4,608	
01-04	0	379	126	9,999	18.6%	0	9,999	
05-09	0	270	90	9,999	18.6%	0	9,999	
10-14	2	310	103	52	18.6%	0	277	
15-19	8	831	277	35	18.6%	1	186	
20-24	20	1,359	453	23	18.6%	4	122	
25-29	47	1,823	608	13	18.6%	9	70	
30-34	76	2,534	845	11	18.6%	14	60	
35-39	116	3,607	1,202	10	18.6%	22	56	
40-44	216	5,020	1,673	8	18.6%	40	42	
45-49	412	8,705	2,902	7	19.9%	82	35	
50-54	772	12,964	4,321	6	14.5%	112	39	
55-59	1,329	18,180	6,060	5	15.6%	207	29	
60-64	1,929	24,305	8,102	4	11.1%	214	38	
65-69	2,551	35,848	11,949	5	10.5%	268	45	
70-74	4,258	54,180	18,060	4	8.8%	375	48	
75-79	6,189	65,236	21,745	4	7.8%	483	45	
80-84	8,910	86,686	28,895	3	7.3%	650	44	
85-89	9,605	99,610	33,203	3	7.8%	749	44	
90+	10,295	117,171		39,057	4	9.0%	927	42

36.6.2 The fields F1 to F8 represent the following

36.6.2.1 F1 Age - Age range in question

36.6.2.2 F2 CV.4m.Dth – aka: Covid deaths in the 4 months March to June 2020

36.6.2.3 F3 2018.Dth – aka Total deaths in 2018

36.6.2.4 F4 18.4m.Dth – 2018 deaths for the 4 month period in question

36.6.2.4.1 These are full-year deaths divided by 3.

36.6.2.4.2 A separate analysis found that these are very close to the actual deaths recorded so we have left them as the benchmark in the table.

36.6.2.5 F5 18.4m.vs.Cv – aka the 4 month 2018 deaths figure divided by the 4 month covid deaths figure without taking into account comorbidities

36.6.2.5.1 This is the first key figure representing the number of times normal life was more dangerous than covid without factoring in comorbidities

36.6.2.6 F6 NoPreCon – aka the percentage of covid deaths in that age group that had no pre-existing conditions

36.6.2.7 F7 NoPre.Dth – aka the Covid deaths that had no pre-existing conditions by the percentage in F6

36.6.2.8 F8 No.Pre.Life.Risk – aka normal life deaths divided by covid no-pre-existing conditions deaths

36.6.2.8.1 This is the second key figure and ultimately the most important figure in understanding whether or not it was reasonable to shut down society for Covid-19

36.7 If the population can ignore that normal life is dangerous and get on with their lives then they can and should certainly ignore something that is far less dangerous than normal life.

36.7.1 To do otherwise is contrary to reason and if the government insists on that they insist on something contrary to reason

36.7.1.1 If the government insists on something contrary to reason it is reasonable to look at the motivation for doing so and as is traditional in all crime we must consider the two most likely objectives being money and power

36.7.1.1.1 There is no question that certain powerful commercial and financial interests have gained a great deal of money and stand to gain a great deal of money from the covid narrative

36.7.1.1.1.1 At least one of these TP has publicly supported the narrative with interviews and presentations and publicly supported Imperial College with an abnormally large donation in the precise month that the critical marketing piece for Covid-19 was released

36.7.1.1.2 There is no question that the government has appropriated powers to itself which would be inconceivable in peacetime thus highlighting that we are in effect in a state of war with ourselves or with Covid-19 or with the government.

36.7.1.1.2.1 There is no question that the government has declared an agenda inimical to democracy and without discussion or media consideration all of which remain moot as rational discussion has been eliminated and suppressed while the Covid-19 agenda is in play.

36.8 All of this disregards that the UK has already managed to be hit 100 times worse than the Far East and Africa.

36.8.1 Notwithstanding such an absurd discrepancy the government has still not succeeded in achieving a threat that is greater than normal life with Covid-19.

36.8.2 Indeed the UK government data shows that at the worst possible age relative to normal life 45-49 year olds are still 35 times more likely to die from ordinary life than Covid-19.

36.8.3 The absolute risk to OAPs might be higher not least courtesy of government policy but normal life is still by far the greater threat by a factor of around 45 times.

36.8.3.1 That is hardly a trivial difference.

36.8.4 We have long said that you have to be old-and-sick to die of Covid as the figures reveal.

36.8.4.1 Even so and even if you start out not old and sick it is still the case that normal life will prove a greater risk by a factor of 3 to 4 times.

36.8.4.1.1 Thus being old you can become sick and die or being old you can become sick and die and credit will be given to Covid-19.

36.8.4.1.2 OAPs overall are still more vulnerable to life than Covid-19.

36.8.4.1.3 OAPs who are not already sick from other illnesses are massively more at risk from life than Covid-19.

36.9 Whatever age group whatever condition normal life is overwhelmingly the greater risk to the population.

36.9.1 Whatever age group if you do not have a pre-existing condition normal life is even more egregiously dangerous than Covid-19.

36.9.2 If you're going to ban children playing on stairs while doing nothing about them playing in traffic we would call that absurd and irresponsible.

36.9.3 The logic is entirely the same for shutting down society for Covid-19 but not for everyday life.

36.9.4 There is only one question: what will you or the court do about it?

--- End of Draft --

Part C

C.0 In which we address the particular actions of Professor Ferguson (PF) of Imperial College (IC) and his Imperial College Covid-19 Response Team (ICCRT) Report 9.

1.0 We claim that Professor Ferguson (PF) of Imperial College (IC) knowingly published a fraudulent document in support of government measures which would inevitably cause damage and hardship.

1.0.1 We claim that PF is thereby guilty of the commission of criminal fraud.

1.0.2 We claim that Figure 1A of the Imperial College Covid-19 Response Team Report 9 (ICCRT R9) and the associated figures of 510,000 UK deaths and 2.2 million US deaths are fraudulent.

1.0.2.1 We claim that lead author of ICCRT R9 Professor Ferguson (PF) of Imperial College (IC) chose figures to grossly exaggerate the threat of Covid-19.

1.0.2.2 The grossly exaggerated threat implied by the chosen figures facilitated the acceptance of lockdown one week later on March 23rd.

1.0.2.3 The damage associated with lockdown including 15,000 excess non-covid deaths by government figures, the financial hardship and loss of income, the emotional distress and increased suicides, the massive damage to the economy and fundamental loss of freedom in a democracy were all facilitated by PF's publication ICCRT R9.

1.0.3 Our wider case includes one against the UK government and advisers for its actions in regard to Covid-19.

1.0.4 This case focuses on the specific fraud committed knowingly and intentionally by PF.

1.1 We claim that Figure 1A of the Imperial College Covid-19 Response Team Report 9 (ICCRT R9) and the associated figures of 510,000 UK deaths and 2.2 million US deaths are fraudulent.

1.1.1 We claim that Figure 1A and the associated 510,000 UK and 2.2 million US deaths are not connected with the containing document ICCRT R9.

1.1.2 Not being connected with ICCRT R9 the lead author Professor Ferguson (PF) of Imperial College London (IC) was free to choose any chart and figures and insert them into the report.

1.1.3 The chart and figures do not reflect the description and parameters provided by PF in ICCRT R9 whence 1.1.1

1.1.4 The chart and figures do not reflect the real-world data available to PF on Covid-19 at the time of writing the report.

1.1.5 The chart and figures grossly exaggerate the real-world data on Covid-19 available at the time of writing of the report.

1.1.6 The chart and figures grossly exaggerate the real-world data on Covid-19 available since that time.

1.1.7 Being free by 1.1.2 to choose any chart and figures PF chose to insert a chart and figures grossly exaggerating the real-world threat of Covid-19.

1.2 On 16th March 2020, Professor Ferguson (PF) of Imperial College London (IC) published a paper "Report 9: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand" under the auspices of the 'Imperial College COVID-19 Response Team' (ICCRT). We refer to the paper as ICCRT R9.

1.2.1 In ICCRT R9 under 'Results' on pages 6 and 7 he states "In the (unlikely) absence of any control measures or spontaneous changes in individual behaviour, we would expect a peak in mortality (daily deaths) to occur after approximately 3 months (Figure 1A). In such scenarios, given an estimated R0 of 2.4, we predict 81% of the GB and US populations would be infected over the course of the epidemic. Epidemic timings are approximate given the limitations of surveillance data in both countries: The epidemic is predicted to be broader in the US than in GB and to peak slightly later. This is due to the larger geographic scale of the US, resulting in more distinct localised epidemics across states (Figure 1B) than seen across GB. The higher peak in mortality in GB is due to the smaller size of the country and its older population compared with the US. In total, in an unmitigated epidemic, we would predict approximately 510,000 deaths in GB and 2.2 million in the US, not accounting for the potential negative effects of health systems being overwhelmed on mortality."

1.3 The key figures in ICCRT R9 are 81% infected for both GB and the US and 510,000 deaths in GB, 2.2 million deaths in the US.

1.4 These figures echo the figures published in the media following the government's March 3rd briefing of 80% infected, 530,000 deaths (1% of 80% of 66.25 million where the UK population was thereby deemed by the media to be 66.25 million).

1.5 In the absence of alternate publications and given the similarity in the figures we assume that the source of the March 3rd briefing data was also PF.

1.5 On the basis of the threat indicated by these figures Prime Minister Boris Johnson announced a UK lockdown on 23rd March 2020.

1.6 That the lockdown has had a negative effect on the UK in terms of loss of freedom, loss of business, impact on the economy, the emotional impact of being told that we are under threat, the requirements of social distancing and mask wearing, we consider to be self-evident.

2.0 Parameters and Output of the PF Model

2.1 The output of the model is derived from the nature of the model and the key parameters.

2.1.1 PF states in ICCRT R9 ('Methods, Transmission Model') Infection was assumed to be seeded in each country at an exponentially growing rate (with a doubling time of 5 days) from early January 2020, with the rate of seeding being calibrated to give local epidemics which reproduced the observed cumulative number of deaths in GB or the US seen by 14th March 2020."

2.2 A key parameter is that "Infection was assumed to be seeded in each country at an exponentially growing rate (with a doubling time of 5 days) from early January 2020"

2.3 A key parameter is that "with the rate of seeding being calibrated to give local epidemics which reproduced the observed cumulative number of deaths in GB or the US seen by 14th March 2020."

2.4 The output of the model is displayed in Figure 1A "Figure 1: Unmitigated epidemic scenarios for GB and the US. (A) Projected deaths per day per 100,000 population in GB and US."

2.5 The output of the model (Figure 1A) will therefore reflect being "seeded in each country at an exponentially growing rate (with a doubling time of 5 days) from early January 2020"

2.6 The output of the model (Figure 1A) will therefore "reproduce(d) the observed cumulative number of deaths in GB or the US seen by 14th March 2020."

3.0 Our claims in regard to ICCRT R9

3.1 The document represents an article of pure invention not intended to reflect reality.

3.1.1 The document ignores the reality officially documented at the time.

3.1.2 The figures cited (81%, 510,000, 2.2 million) are pure invention and do not reflect the reality at that time or since.

3.1.3 The chart (Figure 1a) which includes the figures 510,000 (UK) and 2.2 million (US) is an article of pure invention.

3.1.4 The chart does not reflect the claimed parameters in the report.

3.1.5 The chart does not reflect the claim in the report that "Infection was assumed to be seeded in each country at an exponentially growing rate (with a doubling time of 5 days) from early January

2020, with the rate of seeding being calibrated to give local epidemics which reproduced the observed cumulative number of deaths in GB or the US seen by 14th March 2020."

3.1.6 The chart does not reflect a contagion with "an exponentially growing rate (with a doubling time of 5 days) from early January 2020"

3.1.7 The chart does not "reproduce(d) the observed cumulative number of deaths in GB or the US seen by 14th March 2020."

3.1.8 The chart does not reflect the observed cumulative number of deaths in the US seen by 14th March 2020.

3.1.9 The chart (Figure 1A) does not reflect the two explicit parametrisations declared by PF in ICCRT R9.

3.1.10 The chart constitutes an independent entity with form and magnitude independent of the claimed parameters.

3.1.10.1 The chart being an independent entity, PF was free to choose any form and any magnitude for the claimed 'output'.

3.1.10.2 The chart being an independent entity, PF chose massively exaggerating the existing real-world reports of Covid-19.

3.1.10.2.1 PF exaggerated the only legitimate real-world 'worst case' scenario at the time of the report (Hubei, China) by a factor of 148 times (147.8).

3.1.10.2.1 PF exaggerated the only near-complete land-based contagion outside China by a factor of [1700] times (South Korea).

3.1.11 The chart (Figure 1A) and associated deaths (510,000 UK, 2.2 million US) being independent of the claimed parameters the chart and figures were a choice by PF.

3.1.12. The chart (Figure 1A) and associated deaths (510,000 UK, 2.2 million US) being independent of the claimed parameters, PF chose to exaggerate the only completed and near completed land-based contagions of Hubei 148 times and South Korea 1700 times.

3.1.12. The chart (Figure 1A) and associated deaths (510,000 UK, 2.2 million US) being independent of the claimed parameters, the chart is a fiction invented by PF.

3.1.12. The chart (Figure 1A) and associated deaths (510,000 UK, 2.2 million US) being independent of the claimed parameters, the chart is designed to massively exaggerate the real-world experience of Covid-19

3.1.12. The chart (Figure 1A) and associated deaths (510,000 UK, 2.2 million US) being independent of the claimed parameters, and being the key output of ICCRT R9, the report is designed to massively exaggerate the real-world experience of Covid-19.

3.1.13 PF is the named and leading author of ICCRT R9

3.1.14 PF is the only author of note for ICCRT R9 with other named co-authors typically being employees or members of PF's team in IC including students.

3.1.15 PF chose to author and publish a report designed to massively exaggerate the real-world experience of Covid-19.

3.1.16 PF chose to author and publish a report designed to massively exaggerate the real-world experience of Covid-19 whose results were the likely source already underpinning the government position from March 3rd 2020.

3.1.17. PF chose to author and publish a report designed to massively exaggerate the real-world experience which report became the basis for the UK, US and other countries to present the case for a massive threat from an unmitigated contagion.

3.1.18 PF chose to author and publish a report designed to massively exaggerate the real-world experience which report became the basis for the UK, US and other countries to impose lockdown and other measures on the previously free peoples of their nations, with effects that have been readily apparent.

3.1.19 PF chose to author and publish a report designed to massively exaggerate the real-world experience which report became the basis for the UK, US and other countries policies and by that exaggeration ensured that people believing that report to be authentic would comply with all such measures imposed even at the cost of their freedom and their lives.

3.1.20 PF bears the singular responsibility for providing the basis for measures which have caused suffering, hardship and deaths at the hands of policies which were instituted in the name of the Covid-19 threat posed by his report.

3.1.21 PF has thereby committed a criminal fraud by misrepresenting Covid-19 by an invented outcome not related to the reality of Covid-19 and thereby providing the basis and justification for the measures which resulted in harm including loss of freedom, emotional distress, financial distress and loss of life.

4.0 Demonstration of Claims

4.1 Declared Parameters and Actual Data

4.1.1 In regard to 2.2 'A key parameter is that "Infection was assumed to be seeded in each country at an exponentially growing rate (with a doubling time of 5 days) from early January 2020"' we observe the following.

4.1.1.1 A date is not specified so for the purpose of exposition we will choose 5th January as a starting date. We might choose the 7th or 9th or another date, but within the first week would seem to be consistent with 'early January'.

4.1.1.2 We will start with a single case, since fractional cases make no sense. Doubling every five days, we have 2 cases by the 10th January, 4 by the 15th, 8 by the 20th, 16 by the 25th. This is PF setting the model to reflect the reality that he is modelling.

4.1.1.3 The first case was a pair on January 29th as reported in Metro when "when two Chinese nationals fell ill at the Staycity Aparthotel in York." PF would be about to hit 32 cases on the 30th, and in fact the real Covid-19 contagion has only just entered Britain. No Briton has been infected as yet, but PF already has his model up to 32 cases (30th, using our arbitrary date).

https://metro.co.uk/2020/04/19/first-case-coronavirus-uk-covid-19-diagnosis-12578061

4.1.1.4 We note that we have used a constant rate of doubling (exponential) for convenience. This is in fact an egregious error in formal analysis of contagions, since no recorded contagion has ever

been exponential. That has not stopped the UK government embracing the 'exponential virus' but Ferguson only stated that it would be 'seeded' at an exponentially growing rate. We do not therefore accuse PF of the same fraud as perpetrated by those who claim that an entire contagion can be exponential.

4.1.1.5 PF has however made an explicit claim as to the start date for his model which makes absolutely no sense. At the time that he claimed to begin his model, there were zero cases, nor would be any cases until the 29th, which were foreigners visiting Britain, patient zero in theory therefore.

4.1.1.6 It is the most basic parameter (along with the doubling time and one other factor – the rate of change of the growth rate – which we will describe anon) and incredibly difficult to get wrong by accident. There are only three (two for 'exponential') parameters. How can one state a nonsensical start date by accident?

4.1.1.7 Our case does not hang on this point, but it illustrates an issue that will recur: that the text of the document in no way reflects either the real world data (as here) or the output of his model.

4.1.1.8 In order to make the following points we need to determine PF's model for cases in regard to its output. Rather than attempting to decode the released code for his claimed model, we consider only the output as published, Figure 1A, for deaths.

4.1.1.8.1 In order to reverse deaths back to cases we observe that 81% of the UK are claimed to become infected in the unmitigated scenario (53.6625 million), that 510,000 deaths are projected (0.51 million), that PF references two-thirds as 'self-isolating' based on an estimate of half of China's infections being unreported, so take a 'case' (someone ill enough to be noticed) to be one third of the infected total (17.885 million) giving a case-fatality-ratio of 0.51 / 17.885 or 2.8% nominally in use by the model.

4.1.1.8.2 Typical CFR in the Far East were 4.5%, but it will not be material to the point we will be making.

4.1.1.8.3 In order to generate a chart equivalent to the death-output chart (Figure 1A) we need two parameters: the CFR (as noted) so that we multiply deaths by 35 (1 / 2.8%). We also need the lag between cases diagnosed and deaths.

4.1.1.8.4 By an arcane analysis and comparison between Figure 1A (deaths) and Figure 1B (cases, US trajectories) we estimate that the overall peak of cases from the cloud of different trajectories would be 2nd June. We estimate that the peak of the deaths was 22nd June. Thus it appears the PF expects a 20 day delay between onset of a case and death, which is generous (14 days seems to be more accurate in countries like Germany and Austria) but it is not an absurd figure, and so we use the 20 day delay as appearing to represent PF's case-to-death lag.

4.1.1.8.5 With the peak in deaths occurring June 11th 2020 in the model, that puts the peak of cases on the 22nd of May, and given the 35 to 1 (2.8%) ratio, we anticipate that PF's model would have indicated 744 cases against the 21 deaths (per 100k) that would be occurring 20 days later.

4.1.1.8.6 It may appear that we are hypothesizing as to what PF's model may have said, which is accurate, but it is a reasonable and necessary conclusion that deaths should follow cases at a consistent rate at some consistent delay.

4.1.1.8.7 Our observation to follow will not depend on the precision of that estimate. We are merely observing that PF must have had a cases profile that reflected the deaths profile, with an

appropriate precession (anticipating deaths) and CFR ratio. What that cases profile must have displayed will be clear and stated in a moment.

4.1.1.8.8 Translating the published Figure 1A back 20 days and magnifying 35 times to generate the presumed cases chart, we find that the first case occurred on 4th April, there was greater than ½ a case on the 2nd April, greater than 0.1 of a case per 100,000 on the 28th March, and greater than 0.01 of a case on the 21st March and fittingly, greater than 0.001 of a case (one thousandth of a case) on the 15th March 2020.

4.1.1.8.9 That series of dates and expected cases (4.1.1.8.8) is implied by the deaths profile published as the official output recorded in ICCRT R9 which deaths profile (and figure of 510,000 UK deaths) was the prime cause for the UK government taking us into lockdown. There was no other candidate suggesting such a massively threatening scenario. Indeed, other scenarios existed but were overruled, but our case does not depend on those.

4.1.1.8.10 Per 2.2 'A key parameter is that "Infection was assumed to be seeded in each country at an exponentially growing rate (with a doubling time of 5 days) from early January 2020".

4.1.1.8.11 With a population of 66.25 million (which appears to be the figure total population used to arrive at the original 530,000 deaths figure based on 80% infected and 1% deaths), 1 case per 66.25 million Is equivalent to 1/662.5 cases per 100,000 (there being 662.5 '100,000' in 66.25 million).

4.1.1.8.12 As such, when the first case is created in the model, it will represent 1/662.5 per 100,000 or 0.001509 cases (approximately one and a half thousandths' of a case).

4.1.1.8.13 We noted that the reversed 'cases' curve from the 'deaths' curve (Figure 1A) transitioned to greater than one thousandth of a case on the 15th March 2020.

4.1.1.8.14 Yet PF claims (2.2) to have "seeded in each country at an exponentially growing rate (with a doubling time of 5 days) from early January 2020".

4.1.1.8.15 In ICCRT R9 text PF claims that the first case (seeding, must be at least one person infected) was used to set up the model, and yet the first case according to the output was 15th March.

4.1.1.8.16 One final excuse might be that 'infected' is not a case, and so by the 'only one third of infected are cases' rule that PF appears to create in the text, we need to drop our threshold from 0.001509 to 0.000503.

4.1.1.8.16 0.000503 cases per 100,000 is exceeded on the 13th March, which would represent 1/3rd of a 'real' case or 1 infected person in 66.25 million. So the absolute earliest that the output suggests the first person would be infected would be 13th March.

4.1.1.8.17 With the output suggesting the first person would be infected on or about the 13th March, and PF declaring that the first person was infected (the model 'seeded') in early January, the output does not agree with the input.

4.1.1.8.18 This is not a trivial error. To put this in context: if you ask how much money you will earn, depositing £10,000 at 3.5% interest and the model says that on day 1 you deposit £1,000, that output is nonsense. You have already specified that you were depositing £10,000 not £1000.

4.1.1.8.19 This discrepancy illustrates that the output presented in the ICCRT R9 as Figure 1A is not in fact connected with the scenario presented by PF in his declaration 2.2 "Infection was assumed to

be seeded in each country at an exponentially growing rate (with a doubling time of 5 days) from early January 2020"

4.1.1.8.20 It is perfectly reasonable to suggest that a model COULD have used such a parameter. What we have demonstrated is that the CLAIMED output does not match the CLAIMED input. The two are not connected.

4.1.1.8.21 The output (Figure 1A) with its estimate of massive deaths (510,000 UK, 2.2 million US) is demonstrated to be independent of the claimed and apparently impressive theoretical scenario that PF is expounding to back up that output.

4.1.1.8.22 In simple terms, ICCRT R9 may be an overwhelmingly academic paper, but the media do not report the details of academic papers, themselves being no doubt overwhelmed. The media reports the key figures and the key figures (510,000 UK deaths, 2.2 million US deaths) as annotated on Figure 1A are not connected with any of the detailed exposition which lends ICCRT R9 its gravitas.

4.1.1.8.23 In the simplest terms of all, PF could have chosen to put any figures and any chart into ICCRT R9 Figure 1A and they would have been equally valid by comparison to the actual Figure 1A.

4.1.1.8.24 The question arises: why did PF choose those particular figures? Given the massive exaggeration vs the real-world data which was ignored, we suggest that it is perfectly reasonable to state that the intention was precisely to create a massively exaggerated threat.

4.1.1.8.25 That massively exaggerated threat would be used to cow the public into lockdown.

4.1.1.8.26 That and subsequent government behaviour, continuing 8 months on at the time of writing, has from the start (April 5th and thereafter) been explicitly and publicly declared to be in support of one goal, one mantra: no normal till the vaccine.

4.1.1.8.27 ICCRT R9 was a report written by an expert and it was written intentionally. It is not a cup of coffee spilled by accident. It was an extensive effort which must have taken considerable work. However all that work is window dressing if the critical chart and the critical numbers that are all the media would focus upon are independent of the report itself. ICCRT R9 is the cushion. 510,000 UK deaths is the pearl sitting on the cushion, wrapped in Figure 1A.

4.1.1.8.28 The intentional creation of a document with the critical figure an independent, chosen, invented figure not connected to the container document is a deliberate act. It is a deliberate act of deception. It is a deliberate act of fraud. The consequences for this country and many other countries which relied upon this document have been disastrous. It is perhaps the single greatest criminal act – outside of war – in history.

4.1.1.8.29 It is an act carried out by PF in full possession of his faculties and indeed reinforced by a subsequent claim that 'lockdown saved 470,000 lives', by the simple expedient of subtracting the actual deaths (40,000) from the proposed deaths (510,000).

4.1.1.8.30 It is an act betrayed by the failure to finesse the report so that the rationale provided and the output generated are consistent.

4.1.1.8.31 Had the two been consistent however, then either the absurdity of the parameters might have been noticed or the output would have had to have reflected reality, at a far lower level, and as such it would not have served its purpose.

4.1.1.8.32 Overall, we suggest that the risk was taken (if it was recognised) to leave the document and the figure inconsistent, because who, after all, is ever going to bother to read the fine print? And indeed, in the 8 months since publication, nobody in the mainstream it seems has troubled to do so.

4.1.1.8.33 As such, we rely on the integrity of the court to recognise the significance of this discrepancy in indicating that Figure 1A with its critical estimate was a choice independent of the claimed parameters and it was a choice made with an intent, an intent that it is not difficult to discern, which is to provide the UK government with the scientific rationale to impose lockdown and to promote an agenda of control and fear until the vaccine becomes available.

4.2 In regard to 2.3 'A key parameter is that "with the rate of seeding being calibrated to give local epidemics which reproduced the observed cumulative number of deaths in GB or the US seen by 14th March 2020."'

4.2.1 PF is claiming to have calibrated the model to reflect the number of deaths in GB to 14th March.

4.3 We use a best fit of a normal curve to Figure 1A with a mean (peak) of 11th June, a standard deviation of 13.2 days for the curve to peak, and a scaling factor of 465,000 total deaths or 701.89 total deaths per 100,000.

4.3.1 The first death in GB on scales of per 100,000 is 1/662.5 = 0.001509 deaths. In our fit to the PF model to peak, this is passed on 15th April. The first death per 100,000 is passed on 10th May.

4.3.2 At the extremely low early values our fit to the PF is out by a small but significant amount for the accuracy required understating PF model by approximately 0.2 deaths per 100,000.

4.4 We therefore use PF Figure 1A directly scaled to a maximum of 5 deaths per day to zoom in to the critical early days.

4.4.1.1 The first black dot on PF Figure 1A is discernible at approximately 0.1 deaths per day equivalent to 66.25 deaths per day in the GB. The first black dot is in line with the actual data at 76 deaths reported on the 24th March.

4.4.2 There are no discernible values in Figure 1A prior to the 24th March. The date at which 'first death' (0.001509 deaths per 100,000) occurs in Figure 1A cannot be determined.

4.4.3 Figure 1A therefore does not offer any information as to the accuracy or appropriateness of PF's 'fit to the 14th March'.

4.4.4 Since the first black dot in Figure 1A is in line with actual data a generous interpretation would be that PF did indeed 'fit to the 14th March'.

4.4.5 However another perspective is to consider precisely what it meant to fit to the 14th March. We consider this shortly.

4.5 That first black dot is also the last data point that accurately reflects what happened thereafter.

4.5.1 The first data point on Figure 1A is the only data point which reflected reality.

4.5.2 By coincidence it was also the data point for March 24th, the first day of lockdown (which could not have an effect until the incubation period had elapsed though that is not material).

4.5.3 Having implemented lockdown exactly one week after publication of ICCRT R9 the UK government eliminated any opportunity to discover whether Figure 1A was accurate and representative.

4.5.4 Any 'discrepancy' between Figure 1A and actual events could now be put down to 'error' or 'lockdown effect'.

4.5.5 By acting so precipitously, the UK government had the effect of granting PF the opportunity to be 'wrong' not 'fraudulent'.

4.5.6 As soon as it became clear that PF was 'wrong' (if not fraudulent) then the UK government had the opportunity to cancel the 'massive threat' scenario and lockdown.

4.5.7 Far from doing so, the UK government has insisted that the 'massive threat' scenario is accurate and re-iterated the 530,000 original deaths figure when PM BJ extended the lockdown on [x].

4.5.8 That constitutes a claim against the UK government not against PF.

4.6 Just how wrong PF and Figure 1A got it would shortly become apparent.

4.6.1 Despite lockdown the UK continued with the real contagion rapidly rising to peak deaths over the 8th to 11th April. 'Without mitigation' the supposedly more aggressive unmitigated contagion remains at its March 24th level of approximately 0.1 deaths per day per 100,000 until 24th April when it ticks up to 0.2 deaths per day per 100,000 equivalent to around 133 deaths per day in the GB actual.

4.6.2 Where PF's model Figure 1A has just begun to move on the 24th April, the UK has in fact already had and survived its crisis, having peaked on 11th and 12th April.

4.6.3 In the real contagion, GB climbs rapidly from 76 deaths on the 24th March to 1105, 1030, 1116 and 1122 deaths on the 8th to 11th April. The equivalent in GB deaths per 100,000 is 1.67, 1.55, 1.68 and 1.69.

4.6.4 That is the peak in GB deaths and the contagion is over, beginning an inexorable decline from that point.

4..6.5 Figure 1A GB will not attain 1.67 until approximately 6th May.

4.6.6 Our fit to Figure 1A GB which from early May (3rd May) to peak at 11th June is excellent attains 1.67 on the 7th May with Figure 1A GB having a slight kink to the left giving rise to our stated estimate of 6th May for Figure 1A.

4.7 Despite any 'moderating' effect that the court may imagine lockdown to have had, the actual contagion had surged ahead of the 'unmoderated' contagion predicted by PF in Figure 1A.

4.7.1 PF Figure 1A turned out therefore not to reflect reality very well at all.

4.7.2 Getting it wrong however is not a criminal offence.

4.7.3 That the UK government had the opportunity to recognise that the model was getting it very wrong and did nothing about that is a matter we will address in a separate document. It does not directly impinge upon our case against PF.

4.8 The absence of data discernible in Figure 1A makes it ineffective to determining the appropriateness or accuracy of PF's claim to fit to the March 14th data.

4.8.1 That does not mean that we cannot examine that claim from other directions.

4.8.2 One such direction is this: given the paucity of data, how on earth was the UK government already convinced of the 530,000 deaths figure by 3rd March?

4.8.3 We will examine that shortly.

4.8.4 Another direction is precisely to examine that paucity of data.

4.9 Per 2.3 PF is going to 'manufacture' with his model "local epidemics which reproduced the observed cumulative number of deaths in GB or the US seen by 14th March 2020."

4.9.1 That sounds very rational and professional.

4.9.2 What did it mean in practice.

4.9.10 PF was going to guess ('model') the next number in this series: 1, 1, 0, 1, 4, 0, 2, 1.

4.9.11 We invite the court as an exercise to put themselves in PF's shoes and to 'estimate' or 'guess' or 'model' the next number in that series. They are the deaths reported to the WHO for the 3rd March (1st reported death) to the 14th March.

4.9.12 The fate of 66 million people hangs on the accuracy of the court's assessment. What will the next figure be? And the next after that? And the next after that? A further 90 guesses or so till PF Figure 1A peak in mid June, 90 till the end of the actual UK contagion in mid to late July, 120 to Figure 1A ending in August.

4.9.13 Would the court have guessed 19? That is the figure reported on the 15th to bring total UK deaths to 29.

4.9.14 Metro (UK newspaper) declared on the 15th March that UK deaths had reached 35, suggesting that reporting to the WHO was a day late, and the 35 is equivalent to the 29 deaths actually reported (and perhaps subsequently revised down from 35 to 29).

4.9.15 So by PF's declaration his intention was to 'model' the series 1, 1, 0, 1, 4, 0, 2, 1, 19 or 1, 1, 0, 1, 4, 0, 2, 1, 25 if we accept the Metro figure.

4.9.16 The discrepancy between 19 and 25 is already 25% out, an 'error' factor of 1.25, on the very first figure to 'break out' from the low single figures series. Project that out by compounding an 'exponential' virus and that error alone would be massive.

4.9.17 Nine figures and the extrapolation from them would determine the fate of not only 66 million Britons, but the hundreds of millions of Americans, and hundreds of millions or billions of people in other nations who took this guessing game seriously.

4.9.18 And what growth rate would the court assign to a contagion that jumps from an average of 1.25 deaths a day to 19 or 25 on the very next day? That isn't 'doubling every five days' that is going up 16 times in one day.

4.9.19 From a contagion which for the first 8 days doesn't increase at all, to one that goes up 16 times in one day, PF had an absurd range of growth factors to choose from. 'Fitting' to that series as

he declares he did is meaningless. Extrapolating from that series to determine the fate of hundreds of millions of people is an act of statistical insanity.

4.9.20 And yet that is a key declared methodology of the PF 510,000 GB deaths figure.

4.9.21 Had the court held the fate of the British people in their hands, would they have considered those 9 figures to be sufficient to guide them to estimate a final death toll? Or even the death toll for the coming week, or month?

4.9.22 We would not.

4.10 Let us step back to March 3rd.

4.10.1 On that day, the UK government briefed the press and the headline figures were for 530,000 deaths. That is not PF's ICCRT R9 figure of 510,000 but we are not aware of any alternate candidate also offering a similar figure and so we conjecture that PF was either behind the 530,000 figure also, or alternatively that he duly chose the 510,000 figure for his report to reflect that initial 530,000 figure.

4.10.2 When was the first UK death from Covid-19?

4.10.3 According to Metro "The first death in the UK came one week later, on March 5, when a woman in her seventies was confirmed to have died from the virus."

https://metro.co.uk/2020/04/19/first-case-coronavirus-uk-covid-19-diagnosis-12578061/

4.10.4 The first death reported by WHO for the UK was for the 7th March, a delay of two days. The March 5th date for first death appears reasonable.

4.10.5 Before a single death had occurred in the UK, the UK government felt confident enough to announce a figure in deaths at around 83% of a projected 634,000 deaths projecting the 2018 figure of 616,000 deaths and 2017 figure of 607,000 up 9,000 per annum.

4.10.6 Not one death had occurred in Britain from Covid-19, and yet the government felt confident that the Covid-19 threat would account either for almost all deaths in Britain this year, or that deaths in Britain would nearly double, with 530,000 extra deaths.

4.10.7 Announcing such a figure generated a very predictable sense of panic, but to do so when Covid-19 had yet to claim a single life in Britain?

4.10.8 What kind of model can effectively extrapolate from 0 to get 530,000?

4.10.9 There is no such model. Multiply zero by infinity, and you get a philosophical debate as to the result. Multiply zero by any number less than infinity (a finite number) and you get zero.

4.10.10 PF on March 16th claimed to fit his model to 9 numbers, mostly 1's and 0's, and managed to come up with 510,000.

4.10.11 The UK government (based on PF?) managed to generate a figure of 530,000 deaths from zero numbers, zero deaths.

4.10.12 There is one simple method to generate such numbers: invention.

4.10.13 The court (and defendants) may imagine others as we can.

4.10.13.1 One might look at other contagions with other diseases (cf: seasonal flu, a natural choice, or SARS, or Ebola, or 1918 flu).

4.10.13.2 One might look at completed contagions (Hubei, China) and the Diamond Princess (ship) or near-complete contagions such as South Korea.

4.10.13.3 One might look at contagions in progress round the world, of which as PF notes in ICCRT R9 "with 146 countries now having reported at least one case."

4.10.13.4 One might look at cases not deaths to examine the trajectories of actual contagions and then apply a CFR (case fatality ratio).

4.10.14 All of the above strategies are perfectly reasonable. Any or all of them could have been applied by the UK government.

4.10.14.1 We ourselves made significant use of 4.10.13.2, 3 and 4 immediately we began publishing on Peerless Reads or shortly thereafter, and can readily provide figures for 4.10.13.1.

4.10.14.2 PF explicitly did not avail himself of any of those. The court will search in vain for any data or reference to existing real-world contagions in ICCRT R9.

4.10.14.3 We cannot comment on what the UK government did or did not do, except to note its reported claim of 530,000 deaths (a figure derived from the announcement and in line with Ferguson's later 510,000 UK deaths).

4.10.13.4 What we can state is that by PF's own declaration 2.3 "with the rate of seeding being calibrated to give local epidemics which reproduced the observed cumulative number of deaths in GB or the US seen by 14th March 2020."

4.10.13.5 PF explicitly chose to promote a scenario based on the analysis of 9 figures, mostly 1's and 0's, basing therefore his figure which provided the basis for the UK, US and other lockdown on the least possible data and giving himself by a 'magic wand' of his model the opportunity to essentially invent any figure he chose. There is no rational means to extrapolate those 9 figures reliably.

4.10.13.6 There is even less any rational means to extrapolate zero figures to 530,000 deaths.

4.10.13.7 Yet PF and the UK government chose those strategies instead of the utterly rational strategies of looking at the real-world data that was available for over a hundred countries, including two completed contagions (Hubei and Diamond Princess), a near complete contagion (South Korea) and dozens of countries reporting the critically important fact: the shape of the contagion's curve.

4.10.13.8 It is akin to guessing a 500 piece jigsaw puzzle from 9 pieces… when two complete puzzles and a near complete puzzle are available right next to you.

4.10.13.9 Who could possibly regard 'guessing' a completed puzzle from 9 pieces to be sane and rational with two complete and one near complete puzzles readily available?

4.10.13.10 Who, with the fate of hundreds of millions of people in their hands, would refuse to pay attention to the completed and near complete puzzles, and the hundred puzzles sufficiently developed to confirm what the completed and near complete puzzles are already telling us?

4.10.13.11 It is impossible to regard such a strategy as responsible.

4.10.14 There is however one scenario in which such a strategy is rational, even mandatory.

4.10.14.1 It is where the completed puzzle, the near complete puzzle, and the hundreds of other partially complete puzzles contradict the story that you are determined to tell.

4.10.14.2 Generating a figure reported as 530,000 deaths from UK data when there was not a single UK death makes the 530,000 deaths a pure invention.

4.10.14.3 Generating a figure of 510,000 deaths from 9 figures mostly 1's and 0's again marks the 510,000 figure as one of pure invention.

4.10.14.4 Comparing those figures to the real-world data already available to the UK government on PF on the 15th March, and the UK government on the 22nd March, the day before the UK committed to lockdown, makes clear the magnitude of the exaggeration declared in that invention.

4.10.15 PF made a choice to ignore the real-world and to generate a chart contradicted by his own declarations in ICCRT R9, contradicted by the real-world data available on 15th March, but consistent with the UK government's claim of 530,000 deaths from zero deaths.

4.10.15.1 PF therefore presumably satisfied his own agenda or motive in doing so.

4.10.15.2 Dressed in ICCRT R9 PF then passed off this figure as 'scientific', 'modelled', and so gave the UK government the legitimacy it needed for lockdown and its earlier 530,000 figure.

4.10.15.3 PF made a deliberate choice to ignore the real world and to ignore even his own declared parameters and to produce a chart and deaths figures independent of all of those.

4.10.15.4 PF provided that figure intentionally emphasising that it was the penalty for no action. PF made clear that action (lockdown) would be the most effective response. [check]

4.10.15.5 PF thereby provided a 'scientific' marketing piece for lockdown and authored it knowing and intending its use by the UK government.

4.10.15.6. PF provided the means by which the government could implement lockdown.

4.10.15.7 By providing the means for the government to implement lockdown, a strategy PF recommended, PF bears responsibility jointly with the UK government for the harmful consequences of that lockdown.

4.10.15.8 By providing the means based on a chart and figures independent of the real-world data and independent even of his own claimed parameters PF provided a means of his own choice and massively exaggerating real-world comparisons and independent of his own declared parameters.

4.11 PF made a choice to exaggerate the threat of Covid-19 to a huge degree to promote lockdown.

4.11.1 PF engaged in conscious misrepresentation and deception.

4.11.2 The consequences of that deception have been to impose massive harm on the British people and on peoples around the world.

4.11.3 That constitutes in our view at least culpability in regard to criminal fraud.

4.11.4 In that the UK government has declared 15,000 excess deaths non-covid during the contagion we may declare that to be the cost of lockdown and government measures.

4.11.5 The emotional distress was immediately and obviously going to be such as to drive people to despair as they lost their businesses and were unable to pay the bills.

4.11.6 Such despair would inevitably lead to suicide.

4.11.7 Suicides have duly been reported as being significantly higher.

4.11.8 PF in his deliberate actions to promote lockdown bears a share of the responsibility for causing those 15,000 excess deaths and suicides also.

4.12 The UK government and its officers and scientists reporting to and for the UK government have engaged in fraud and misrepresentation to promote the Covid-19 agenda.

4.12.1 While not the purpose of this case to pursue the UK government per se the damage done as a result of the Covid-19 agenda and that fraud would not have been possible without the 'scientific' basis for the 'massive threat' of Covid-19

4.12.1 PF by facilitating the Covid-19 agenda and providing a 'scientific' basis for it bears some responsibility for the UK government's actions, frauds, misrepresentations and harm done in pursuing the Covid-19 agenda.

4.13 The UK government and its officers have managed by their choices and actions to generate a contagion which was marked as being the world's second worst national contagion by deaths per million behind only the EU HQ Belgium.

4.13.1 It is notable that the Belgium itself managed to be eclipsed by the world's leading western power centre, the US (New York State and New York City) so that the world's richest and most powerful centres were also the worst hit by Covid-19

4.13.2 The magnitude of this 'misfortune' is staggering and yet has gone unremarked in the media. As of June 24th at the end of the primary contagion, NY ranked at nearly [500] times worse than the Far East, Belgium at [133] times, and the UK at [122] times.

4.13.3 It is not possible to conceive that the world's richest and most powerful nations can be hit hundreds of times worse than the Far East by the same virus, following the same policies, and indeed insisting on the most stringent 'controlling' practices.

4.13.4 What is possible and is demonstrated by the government's own data is that the richest and most powerful governments including the UK can engineer reports and events so as to seem to create a massive crisis where the Far East, Africa and rest of the world have a very different experience.

4.13.5 While the UK government's actions and fraud are generally beyond the scope of this case we again note that in facilitating this fraud PF shares some responsibility for the outcome.

5.0 Architect Of A Crisis

5.1 We hold PF to be accountable for preparing a fraudulent document which facilitated the Covid-19 declared agenda.

5.1.1 That agenda as publicly declared by the UK governments and other governments may be stated as:

a) massive threat (530,000 deaths)

b) ‘proven’ (scientific) 510,000 UK deaths (2.2 million US deaths)

c) lockdown

d) wait for the vaccine (no normal till the vaccine)

and more recently

e) Great Reset

5.2 PF was critical and instrumental in providing b) the scientific basis for taking the ‘massive threat’ seriously

5.3 However the Covid-19 crisis is worldwide.

5.4 The response of the leading western nations contrasts strongly with the Far East and non-aligned nations.

5.4 We do not suggest that PF provided the leadership, guidance or co-ordination to allow common messages and themes to be indicative of the western response.

5.4.1 Any ‘leadership’ in the Covid-19 situation would come from another party or parties.

5.4.2 PF’s action was to author a report.

5.4.3 The critical nature of providing a ‘scientific’ basis for the threat is such that any such ‘leadership’ would have an incentive to provide that basis.

5.4.3.1 If such leadership existed and it took action to generate the scientific support it required for lockdown it would be expected to be commissioned discreetly.

5.4.3.2 Nevertheless the presence of such leadership if it existed might be discernible.

5.4.3.3 Any connection between such leadership and the PF ICCRT R9 report would be of interest

5.4.3.4 If such a connection was demonstrated then PF should be questioned properly to determine if indeed he was guided, instructed, coerced into creating his report

5.4.3.5 If such a connection was demonstrated then PF should be questioned properly to determine if he was rewarded or promised reward or was fulfilling an agreement in creating his report

5.4.4 Any such connection in creating a fraudulent report would both reinforce the case against PF

5.4.5 Any such connection in creating a fraudulent report would create a case against the leadership

6.0 Philanthropy and Covid-19

6 ‘Philanthropy’ sounds like the innocuous and generous charitable donation of a party incidental to the main purpose of that party and incidental to the main business of eg: healthcare.

6.1 The role of ‘philanthropy’ in the medical, medical-scientific and medical-pharmaceutical realms is far from incidental

6.1.1 E. Richard Brown in “Rockefeller Medicine Men: Medicine and Capitalism in America” © 1979 makes clear that ‘philanthropy’ was an intentional and intensive strategy to transform medicine from ‘homeopathic’ to ‘allopathic’ (scientific, based on ‘physical causes’)

6.1.1.1 Bing (Oxford Dictionaries) defines ‘allopathic’ as “the treatment of disease by conventional means, i.e., with drugs having opposite effects to the symptoms. Often contrasted with homeopathy.”

6.1.1.2 In practice the strategy was the creation of ‘scientific’ medicine with formal training, qualifications, research into treatments and funding thereof, medical schools (typically associated with universities), and a proliferation of technology and pharmacology to support the same

6.1.1.3 It is no exaggeration that ‘philanthropy’ created and controlled the development of the ‘modern’ scientific healthcare strategy

6.1.1.4 ‘Philanthropy’ is not therefore incidental to modern healthcare. It is the guiding force and financier of the directions that ‘modern’ scientific healthcare should take

6.2 During Covid-19, the role of ‘medical philanthropist’ has been most evident in a singular individual and his associated foundation

6.2.1 The ‘leader’ of the Covid-19 response worldwide particularly in the west has not been the ‘leader’ of the free world, the US president

6.2.2 As Center For Health Security states: “Event 201 was a 3.5-hour pandemic tabletop exercise that simulated a series of dramatic, scenario-based facilitated discussions, confronting difficult, true-to-life dilemmas associated with response to a hypothetical, but scientifically plausible, pandemic.”

https://www.centerforhealthsecurity.org/event201/about

6.2.2.1 How fortuitous that such an event should be held October 18th 2019 in New York barely three months before a ‘devastating’ pandemic should unfold in January 2020.

6.2.2.1.1 It was introduce by Anita Cicero (AC) Deputy Director of the Johns Hopkins (JH) Center for Health Security (CHS).

6.2.2.1.2 Johns Hopkins is a globally prestigious university and medical centre whose history is described in E. Richard Brown’s book. It is also the promoter of blatantly and absurdly fraudulent memes regarding ‘flattening the curve’.

6.2.2.1.3 In her intro (Segment 1 video) AC immediately introduces their partners: World Economic Forum (WEF) and the Bill and Melinda Gates Foundation (BAMGF)

6.2.2.1.3.1 Bill Gates, The Philanthropist (TP).

6.2.2.1.3.2 Outcome: “The Johns Hopkins Center for Health Security, World Economic Forum, and Bill & Melinda Gates Foundation jointly propose” a strategy.

https://www.centerforhealthsecurity.org/event201/recommendations.html

6.2.3 On April 5th TP gave an interview on Fox News with Chris Wallace (CW).

6.2.3.1 The interview started with CW gushing at TP’s prescience in ‘predicting’ a massive global killer pandemic in 2015.

6.2.3.1 The interview proceeds with TP misrepresenting the facts of pandemics and Covid-19 26 times in the first 2 minutes and 30 seconds.

6.2.3.1.1 We document this in a video on Peerless Reads YouTube Channel

6.2.3.2 TP makes a key statement: “It’s, it is fair to say things won’t go back to truly normal until we have a vaccine that we’ve gotten out to basically the entire world.”

6.2.3.2.1 Note the phrasing “ (no)… normal… until… vaccine”

6.2.3.2.2 April 7th USA

“Dr. Fauci Says We’re Not Going Back To Normal Without A Vaccine Or Treatment”

https://www.yahoo.com/lifestyle/dr-fauci-says-not-going-080828192.html

6.2.3.2.3 April 7th UK Daily Mail

“Nouri says normal life cannot resume until a vaccine against coronavirus is in circulation, which could take over a year to produce “

https://www.dailymail.co.uk/news/article-8196473/Normal-life-wont-resume-2021-says-scientist-pandemic-preparedness.html

6.2.3.2.3.1 April 10th UK, Daily Mail

“Normal life will stay on hold until a virus vaccine becomes available in about 18 months, officials have said”

https://www.dailymail.co.uk/news/article-8209347/UK-live-restrictions-coronavirus-vaccine-developed-say-officials.html

6.2.3.2.4 April 9th Canada

“Trudeau says no return to ‘normal’ without vaccine”,

“No return to ‘normality’ until coronavirus vaccine is available, Trudeau says”

(Sources)

https://www.lifesitenews.com/news/trudeau-says-no-return-to-normal-without-vaccine-could-take-12-to-18-months

https://globalnews.ca/news/6799110/coronavirus-covid-19-vaccine-return-to-normality-trudeau/

6.2.3.2.5 Search for no normal till the vaccine before April 5th and only one notable result comes up:

6.2.3.2.5.1 March 22nd: “But life's never going to be perfectly normal till we get to a vaccine.”

6.2.3.2.5.1.1 Scott Gottlieb, former FMA Commissioner

6.2.3.2.5.1.1.1 The US, Canada and UK did not make official statements echoing this within days.

6.2.3.2.6 TP makes an announcement on Fox News, April 5th and within two days it is the official statement and policy of the US government, within 4 days it is official in Canada, five days and it’s official in the UK

6.2.3.2.6.1 That speed of take-up of TP's position is faster even than the UK government's take-up of PF's ICCRT R9 to announce lockdown.

6.2.3.2.6 UK, October 14th

"NINE MORE MONTHS Oxford vaccine head says UK has no hope of normality until JULY with face masks and social distancing until next summer" (Emphasis in original)

https://www.thesun.co.uk/news/12923961/oxford-vaccine-no-normality-july-face-masks/

6.2.3.2.6.1 The agenda rolls on, six months after the April declarations, it is re-iterated and reinforced.

6.2.4 TP meets with UK leaders and officials

6.2.4.1 19th May

"The Prime Minister spoke to Bill and Melinda Gates today via video call. He was joined by Kate Bingham, Chair of the UK's Vaccine Taskforce."

https://www.gov.uk/government/news/pm-call-with-bill-and-melinda-gates-19-may-2020

6.2.4.2 4th June

"Bill Gates-backed vaccine alliance raises $8.8 billion from world leaders and businesses"

https://www.cnbc.com/2020/06/04/bill-gates-backed-vaccine-alliance-looks-to-raise-7point4-billion.html

6.2.4.5 10th November

"OPEN THE GATES Boris Johnson to meet Bill Gates to plan national vaccine rollout with pharma giants"

https://www.thesun.co.uk/news/politics/13159687/boris-bill-gates-national-vaccine/

"Boris Johnson meets Bill Gates to discuss plans to prevent future pandemics"

https://www.msn.com/en-gb/news/uknews/boris-johnson-meets-bill-gates-to-discuss-plans-to-prevent-future-pandemics/ar-BB1aSZdB?pfr=1

6.2.5 October 2018

Not a pandemic in sight. Fifteen months before Covid, twelve months before the Covid rehearsal, BAMG visit the UK Prime Minister.

It would be fascinating to know what was discussed.

"Bill and Melinda Gates Visit Downing Street"

6.2.6 A person with the recorded participation of TP is not an incidental player.

6.2.6.1 A person who co-creates a pandemic rehearsal three months before the 'real' pandemic is not a bit player.

6.2.6.2 A person who announces a key policy meme taken up days later by three governments is not a bit player.

6.2.6.3 A person who co-creates a Vaccine Alliance and has the UK Prime Minister attend and host that is not a bit player.

6.2.6.4 A person who liaises with the UK Prime Minister to plan a mass vaccine rollout is not a bit player.

6.3 TP with BAMGF exerts massive financial influence.

6.4 The strange case of Malaria

6.4.1 Malaria is an ancient disease

6.4.1.1 Malaria has existed since pre-historic times

6.4.1.2 The first effective treatment was introduced to Europe from South America around 1640

6.4.1.2.1 The treatment centres around the bark of the Cinchona tree whence Quinine

6.4.1.2.2 Quinine first successfully extracted 1820

6.4.1.2.3 Quinine water a tonic against Malaria was made palatable with gin

6.4.1.3 A modern treatment of Malaria is hydroxychloroquine (HCQ)

6.4.1.3.1 "Quinine was first recognized as a potent antimalarial agent hundreds of years ago. Since then, the beneficial effects of quinine and its more advanced synthetic forms, chloroquine and hydroxychloroquine, have been increasingly recognized in a myriad of other diseases in addition to malaria."

https://pubmed.ncbi.nlm.nih.gov/21221847/

6.4.1.4 HCQ has been actively suppressed in the west as a possible remedy for Covid-19

6.4.1.4.1 The availability of a long-established safe drug as a treatment would obviate the need for a vaccine

6.4.1.4.2 Just as the lack of a massive threat from Covid-19 would obviate the need for a vaccine

6.4.1.4.3 'By May 27, Dr. Harvey Risch, Professor of Epidemiology at the Yale Schools of Public Health and Medicine, had confronted this disaster. He issued an urgent call through the top-ranked American Journal of Epidemiology for hydroxychloroquine + azithromycin "to be widely available and promoted immediately for physicians to prescribe."

"Five studies," he wrote from Yale, "including two controlled clinical trials, had demonstrated significant major outpatient treatment efficacy." Incredibly, this call for immediate action published in America's top epidemiology journal did not appear in the mainstream news.[v]

Instead, the opposite occurred. Although international protest drove the Lancet to retract its fraudulent May 22 article on June 4, the retraction made few headlines. In those two short weeks the U.S. media, with one voice, established HCQ as "controversial," "anecdotal," and even "dangerous" when paired with Gilead Science's highly publicized golden goose, remdesivir.'

https://www.globalresearch.ca/hydroxychloroquine-efficacy-suppression/5718676

6.5 A Missing Link

6.5.1 What is the connection between Malaria and Covid-19

6.5.1.1 We have that HCQ is a synthetic derivative of Quinine

6.5.1.2 We have that Quinine is an effective treatment of Malaria

6.5.1.3 We have that HCQ is a suppressed drug effective against Covid-19

6.5.2 What is the declared agenda by western governments for Covid-19

6.5.2.1 a) massive threat b) lockdown c) wait for the vaccine

6.5.3 Who is the beneficiary of a massive vaccine rollout?

6.5.3.1 Pharmaceutical companies

6.5.4 What could threaten that massive vaccine rollout?

6.5.4.1 An effective alternate treatment (HCQ)

6.5.4.2 Not a massive threat after all

6.5.5 Who created the 'massive threat' as a plausible scenario?

6.5.5.1 PF with ICCRT R9

6.5.6 Who is co-ordinating the 'global rollout' and 'mass rollout' of the vaccine?

6.5.6.1 TP

6.6 A Possible Connection

6.6.1 We have PF creating a document which is fraudulent by our assertions

6.6.1.1 That document provides the 'scientific basis' for massive threat

6.6.1.2 Without that 'scientific basis' and 510,000 death meme the agenda would fail

6.6.1.3 Without the 'massive threat' there is no need for the vaccine

6.6.1.4 Without the 'massive threat' TP's GAVI has nothing to do

6.6.1.5 Without the 'massive threat' pharma misses out on billions, hundreds of billions of dollars

6.6.1.6 Without the 'massive threat' TP's 'no normal without the vaccine' disappears

6.6.1.7 Without the 'massive threat' the new normal is all politicians in jail (and TP)

6.6.2 The 'massive threat' ICCRT R9 is critical to the agenda as declared by TP

6.6.3 Malaria has been around since prehistory

6.6.4 TP chooses March 2020 to grant PF's Imperial College $79m 'for malaria'

6.6.5 PF authors a fraudulent document and the covid-19 agenda is off and running

6.6.6 10th November TP and PM BJ meet to plan the mass vaccine rollout

6.6.6.1 (of all the perfect numbering, entirely coincidental, note 6.6.6 above)

6.6.6.2 Without PF and ICCRT R9 there would be no vaccine rollout

6.6.6.2 You don’t need a massive vaccine rollout for a miniscule threat

6.6.6.2.1 Somehow the mainstream hasn’t noticed that only the western power centres and their close allies (and South America, for reasons unknown) are being badly hit

6.6.6.2.2 Even then, covid has approximately the lethality of a bad flu season

6.6.6.2.3 In the Far East, it’s a hundred times less threatening

6.6.6.2.4 And no, lockdown had zero effect

6.7 Why Malaria? Why now?

6.7.1 In the month that a leading Imperial College scientist, renowned for getting it wrong with exaggerated claims, yet again publishes a report ‘getting it wrong’ and massively exaggerating the threat of Covid-19, the Bill and Melinda Gates Foundation grants Imperial College $76 million.

https://www.gatesfoundation.org/How-We-Work/Quick-Links/Grants-Database/Grants/2020/03/OPP1210755

6.7.2 I’m sure that Imperial College were grateful.

6.7.3 I’m sure that TP was grateful too

6.7.4 Like (dark) comedy: it’s all about the timing.

6.7.4.1 BAMG was founded according to its website around 1997.

6.7.4.2 Malaria has been around since pre-history

6.7.4.3 BAMG routinely hands out grants for a few hundred thousand dollars to a few million

6.7.5 In the same month that covid is going to become a crisis courtesy of PF’s ICCRT R9, BAMG provides a grant that dwarfs the previous two years’ grants to Imperial College and all but a very few grants ever for eg: Malaria. Large (tens of millions) grants seem to be associated rationally enough with capital intensive projects.

6.7.6 If this was an episode of NCIS it wouldn’t be difficult for the investigators to consider that there might possibly be a connection. It’s not an accusation. It’s not a conspiracy theory. Follow the money or Qui Bono is an ancient predicate for how and why people do things, even bad things.

6.8 Criminal Fraud with Questions To Ask

6.8.1 That the ICCRT R9 Figure 1A bears no relation to the real-world covid19 or even with PF’s declared parameters within ICCRT RT is readily and easily proven.

6.8.2 As such PF has introduced into the ‘nest’ of ICCRT R9 a cuckoo’s egg, a chart and stated figures massively exaggerating the Covid-19 threat as the WHO data of the past nine months has readily shown, regardless of the mythical effectiveness of lockdown.

6.8.3 Professors do not write papers ‘by accident’. What PF did was a choice. It was a choice that supported an agenda he himself declared to take action rather than leaving Covid-19 ‘unmitigated’.

6.8.4 The consequences of those actions (lockdown) have been incredibly damaging personally, financially, emotionally, and to the economy, including substantial loss of life.

6.8.5 PF chose to create a fraudulent document designed to promote a massive threat and to promote reaction to that threat with damaging consequences for this UK and other nations.

6.8.6 That to us constitutes fraud knowing or intending measures which would cause harm to others. That to us is criminal fraud.

7.0 Government as Victim or Agent

7.1 We are not suggesting that as a result of PF ICCRT R9 that the government was misled and would have managed the contagion very differently without that estimate.

7.1.1 We hold that the PF ICCRT R9 was created entirely consistent with the government's stance on Covid-19 as set out in the March 3rd Press Conference.

7.1.2 What was a 'worst case' set out by Whitty and Valance became normalised as the expected outcome in ICCRT R9.

7.1.2.1 As such ICCRT R9 was consistent with the government position but had three effects on the government narrative

7.1.2.1.1 Firstly it supported the government narrative by re-iterating the estimates set out on March 3rd

7.1.2.1.1.1 The figures were slightly modified between press reporting of March 3rd and ICCRT R9 March 16th but this discrepancy can be considered to have supported the independence of the report rather than detracting from its apparent validity

7.1.2.1.1.1.1 Where [Whitty] referenced 80% infection as a 'worst case' PF ICCRT R9 cited 81%

7.1.2.1.1.1.2 Where [Whitty] referenced 1% deaths interpreted by the press as 530,000 deaths based therefore on an implied UK population of 66.25 million and 80% infected PF ICCRT R9 referenced 510,000 UK deaths and 2.2 million US deaths.

7.1.2.1.2 Secondly it escalated the government's position without the government having to explain why it had gone from a 'worst case' of 530,000 deaths to an 'expectation' of 510,000 deaths without mitigation

7.1.2.1.2.1 The escalation is not the figure but in the shift from 'worst case' to 'expectation'

7.1.2.1.2.1.1 On any given day a 'worst case' scenario is that we leave our home, and are struck and killed by a runaway lorry, mauled by an escaped tiger, struck down by a mugger intent on stealing our wallet, all of which happen to people around the world and as such are legitimate worst cases.

7.1.2.1.2.1.2 That the worst case can and does happen does not make it the 'expected' case which corresponds to the mean, average or typical outcome

7.1.2.1.2.1.3 The mean, average or typical outcome when we leave our home is rather more mundane. We shop, we go to work, we meet people. Or we did before Covid-19 and the government's agenda.

7.1.2.1.2.1.4 Anyone suggesting we should not leave home because we could be hit by a runaway truck, mauled by an escaped tiger, or struck down by a mugger would be dismissed as a hysterical crank.

7.1.2.1.2.1.5 If the government made such an announcement it would be derided and shortly thereafter we might hope relieved of responsibility for being the government.

7.1.2.1.2.2 Yet because people are not statisticians and because the government did not formally announce the escalation as such, the government achieved a declaration equally as absurd and outrageous as our example but without the slightest criticism or even understanding by the media and the populace.

7.1.2.1.2.3 What had been an 'extremely unlikely' event (worst case) was now the expected outcome and the scene was set to implement draconian measures to handle this 'expected' outcome.

7.1.2.1.2.4 Naturally what the virus had managed to do in the real world which was entirely well-known to the government by virtue of the official reports out of China and South Korea was never disclosed to the public.

7.1.2.1.2.4.1 Had the government told the British people that in fact the virus hadn't managed to kill more than 3085 people in Hubei home to Wuhan out of 59.17 million people so that a reasonable estimate for the UK was 3454 deaths not 510,000 deaths or 530,000 deaths it's unlikely the people would have been so devastated by the threat.

7.1.2.1.2.4.1.1 For want of a nail or in this instance an honest statement of the real-world 'worst case' experienced so far the British people were led down a path of 510,000 deaths which would only be avoided by a severe lockdown.

7.1.2.1.2.4.1.2 When the 'expected' deaths did not materialise this was of course put down to the effectiveness of lockdown and thus the severity of the threat and the severity of the response were both legitimised

7.1.2.1.2.4.1.3 The government has never declared that the real-world worst-cases was 3454 deaths UK equivalent and never declared that lockdown failed to affect the trajectory of the contagion in the slightest

7.1.2.1.2.4.1.4 And so the government has knowingly and intentionally supported a myth massively exaggerating the reality of the threat despite having all the data and simple arithmetical tools to allow a simple direct and honest statement regarding the actual threat posed by Covid-19

7.1.2.1.2.4.1.5 As such the government was not misled by an tragically incompetent scientist PF.

7.1.2.1.2.4.1.6 Rather the perfectly competent scientist PF provided the government with the gloss of legitimacy consistent with the government's desire and intent to portray Covid-19 as a massive threat as it had already indicated on March 3rd and which position it would not rescind even when outcomes in the UK and the rest of the world utterly contradicted its claimed position.

7.1.2.1.3 Thus thirdly ICCRT R9 provided scientific support more properly described as the veneer of scientific support for this now escalated estimate.

7.1.2.1.3.1 That the government was comfortable with this escalation is evidenced by the following.

7.1.2.1.3.1.1 It did not censure the media for focusing on the 'worst case' and citing it as 530,000 deaths.

7.1.2.1.3.1.2 It did not censure PF for escalating a 'worst case' to an expected scenario without mitigation

7.1.2.1.3.1.3 It did not inform the public that the worst case in the real world had been shown to be 3085 deaths in 59.17m people equivalent to 3454 deaths in the UK.

7.1.2.1.3.1.4 It did not inform the public that already South Korea was demonstrating that the worst case of 3085 deaths greatly exceeded the potential for far lower deaths at less than [x] for [50m] people

7.1.2.1.4 The UK government was not a victim. It was a willing determined and competent agent of the narrative of the 'massive threat' of Covid-19.

7.2.1 The UK in common with leading western nations has experienced a very different Covid-19 contagion to that half of the world most distant from the west the Far East and Africa.

7.2.2 There is a bizarre characteristic of Covid-19: it attacks a nation exponentially more aggressively according to its proximity to a western power centre.

7.2.2.1 As of June 24th the end approximately of the primary contagion the worst hit nations were not impoverished and disease ridden Africa, but the UK at [122 times] worse hit than the Far East, Belgium [133 times] worse hit than the Far East, and the US with New York City hit an astonishing 500 times worse than the Far East.

7.2.2.1.1 This is not down to genetics. Australia and New Zealand are Anglo nations with similar populations to the UK and Europe.

7.2.2.1.2 This is not down to pollution. Pollution does not decide to strike in the weeks of March and April 2020 and I suggest the Bangkok, Thailand is rather more polluted than the West.

7.2.2.1.3 This is not down to GDP. A plot of GDP against deaths per 100 million reveals that GDP is evenly spread from the hardest hit to the least hit.

7.2.2.1.4 This is not down to lockdown which saw lockdown nations being the worst hit and the least badly hit.

7.2.2.1.5 This is not down to avoiding lockdown which saw no-lockdown nations among the worst hit and the least badly hit.

8.0 Independence of UK Government and PF culpability

8.1 We are not required to investigate and demonstrate the behaviour of the UK government in detail to demonstrate the fraudulent nature of ICCRT R9 and the fraud of PF.

8.1.0 The material in this section 8 is intended largely to provide a context within which to understand that the actions of PF were only one part of a much larger fraudulent endeavour.

8.1.1 It is appropriate to put the actions of PF into the context of the behaviour of the UK government, western governments and parties advising western governments including TP.

8.1.1.1 It is particularly appropriate to demonstrate that the statements and actions of the UK government have been misleading or outright fraudulent.

8.1.1.2 It is particularly appropriate to demonstrate that the reported contagion has features which render it apparently artificial rather than natural.

8.1.1.3 It is particularly appropriate to emphasise that the government does not respond to Covid-19. It responds to its own reports of Covid-19.

8.1.2 It is appropriate to highlight that every arm of the state has been engaged to promote a massive and unique threat to the people of this nation.

8.1.2.1 The government is the primary arm of the state and the gives the lead to the country's handling of Covid-19

8.1.2.1.1 The government in particular BJ, CW, PV have put on solemn faces as they announce absurd exaggerations, inventions and misrepresentations but reassure us that things will likely be not nearly so bad.

8.1.2.1.2 The government omits salient facts and analysis that would restore some sanity to the Covid-19 situation.

8.1.2.2 The mainstream media (BBC, ITN, Daily Mail, Daily Telegraph, Guardian as examples) have overwhelmingly supported the narrative created by the government.

8.1.2.2.1 Objections to the governments actions and criticism never proceeds deeply enough to highlight actions or statements that are fraudulent, mendacious, or which support an agenda contrary to the interest of the British people.

8.1.2.2.2 The mainstream media are at pains to highlight the risk of 'fake news' or false information on social media.

8.1.2.2.2.1 The mainstream media do not take such pains to avoid presenting their own 'fake news' or false information.

8.1.2.3.1 Social media titans such as Google, YouTube (Google), Facebook, Amazon (less so) have been strongly supportive of the Covid-19 narrative and aggressively address any source critical of the narrative.

8.1.2.3.1.1 Government announcements and sources supportive of the agenda are promoted regardless of their accuracy.

8.1.2.3.1.2 The same agents shut down any popular channel contradicting or challenging the accuracy of the government claims also regardless of their accuracy.

8.1.2.3.1.2.1 An example from personal experience is the channel of the appropriately named Amazing Polly whose deep research into the connections behind the players in Covid-19 was astonishing.

8.1.2.3.1.2.1.1 Apparently revealing such connections was not appreciated by YouTube. Her channel was cancelled.

8.1.2.3.1.2.1.2 The court may care to note that highlighting government fraud is very much in the public interest.

8.1.2.3.1.2.1.3 The court may ask therefore what interest is served by suppressing channels revealing such fraud.

8.1.2.3.2 We have experienced this censorship ourselves.

8.1.2.3.2.1 Our immediate response to the UK actions was to create an entirely factual and analytical book on Covid-19.

8.1.2.3.2.1.1 It was blocked and prevented from being published on Amazon Kindle.

8.1.2.3.2.1.2 In response we set up the Peerless Reads YouTube Channel and presented essentially the same material in a YouTube Video.

8.1.2.3.2.1.2.1 To their credit YouTube left that video and over [90] other videos removing only one a satirical version of Johnson's announcement.

8.1.2.3.2.1.2.2 In an attempt to protect ourselves each video and accompanying slides carries the following notice immediately after the title: "NOTE TO CENSORS: We use only government data. If you have a problem with the results speak to the government."

8.1.2.3.2.1.2.3 Needless to say in a society of free speech we would not feel the need to place such a warning in our work nor would we see YouTube researchers and personalities removed when they get too popular.

8.1.2.3.1.2 A regular conversation on Social Media is where to go: where to go when inevitably our work is denounced as fake news while the fake news of governments is promoted.

8.1.2.4 The combination of government and television has been exploited in a manner such that this item alone should result in criminal action.

8.1.2.4.1 The government aired repeatedly every few minutes a government notice that we consider to be shameful in the extreme.

8.1.2.4.1.1 The warning to ["Stay Home, Save The NHS"] in yellow and black would be more appropriate to a nuclear attack warning such was its intensity and frequency.

9.0 Scale of the Covid-19 Experience and Our Analysis

9.1 A note on scale

9.1.1 The Covid-19 experience is global.

9.1.2.Like a World War it is beyond the capacity of one person or one case or one book to detail every aspect of that experience effectively.

9.1.2.1 To attempt to provide irrefutable evidence for every point made would expand the case beyond any convoluted fraud case and would take up the court's time for months or years.

9.1.2.1.2 We do not possess the resources to pursue a case of that magnitude.

9.1.2.1.2.1 As such much of what we disclose or claim is anecdotal in the sense that it does not directly impinge on the actions of PF and we do not propose to provide evidence of all such claims.

9.1.2.1.2.2 Nevertheless if challenged we could do the necessary work to provide the research and evidence to support such claims.

9.1.2.1.2.3 We do not consider doing so to be supportive of the case or necessary.

9. 2 Our focus in analytical.

9. 2.1 With a background in finance, technology and mathematics we have focused on the published reports of government particularly cases and deaths as reported by over 200 countries to WHO and available as a download from their Covid-19 Dashboard.

9.2.1.1 The dashboard is available at https://covid19.who.int/

9.2.1.2 That data is more than sufficient to highlight anomalies and discrepancies which reveal a very unnatural state of affairs for the different reported contagions around the world.

9.2.1.3 That data is more than sufficient to highlight anomalies and discrepancies which are key indicators of fraud by the UK government.

9.2.2 We are also able to analyse the statements of government officers in particular those of CW and PV for their factual basis.

9.2.2.1 We have found CW and PV to make statements which are irresponsible, misrepresentative and outright fraudulent to the detriment of the British people.

9.2.3 We are also able to analyse reports such as ICCRT R9 whence this case.

9.2.4 We are also able to analyse NHS and ONS data publications which further reveal anomalies, discrepancies and disturbing facts about the supposed Covid-19 contagion.

9.3 A single anomaly may not be enough to convict a particular individual but it can be enough to show that an issue exists which should be investigated with a view to possible criminal charges.

9.3.1 With the entire state operating in support of the Covid-19 narrative in collusion with other states we do not expect that any such investigation can or will occur or would be pursued with integrity if it did occur.

9.3.1.1 As such the role of such anomalies is to illustrate that there are reasons to doubt the integrity of the government's message and narrative regarding Covid-19.

9.3.1.1.1 That PF might innocently or inadvertently 'get it wrong' would be an excuse to avoid the criminal nature of creating a fraudulent document for the use of the government which would then go on to promote a fraudulent strategy.

9.3.1.1.2 That the government officers have themselves been shown to misrepresent the facts in pursuit of a fraudulent strategy would weaken the case for an 'innocent' mistake.

9.3.1.1.3 That the UK contagion in common with other western contagions appears to be artificial when the reported cases and deaths and other data are examined supported the risk that the UK contagion as reported is fraudulent.

9.3.1.1.4 Thus our analysis of the UK contagion not only supports a potential case against the UK government it also removes the grounds for believing in an 'innocent' error.

9.3.1.1.5 ICCRT R9 was consistent with a pre-announced position of the 3rd March by the government as revealed by the Press Briefing by BJ, CW, PV on that date.

9.3.1.1.6 A document supporting the government position so neatly is not therefore an 'errror'. It was designed and scripted to do so or else the government's position was defined by that document.

9.3.1.1.7 In either case PF enjoyed the trust and support of the UK government and other governments worldwide including in particular the US and ICCRT R9 became the widely publicised document which transformed the US position and ensured that the government had a scientific basis for implementing lockdown one week later.

9.3.1.1.8 ICCRT R9 and PF as author are therefore inextricably entwined with the UK government's actions and whether one or other was the source of the declared position is immaterial. Clearly the two were in lockstep on the scenario to be presented.

9.3.1.1.9 The key provisions of the 3rd March Press Briefing were 80% infected as a worst case and 1% deaths cited as 530,000 deaths. ICCRT R9 cites 81% infected as a ['likely'] unmitigated scenario and 510,000 deaths.

9.3.1.1.9.1 It should be noted that while CW and PV dutifully emphasised that they expected it to be a lot better than this.

9.3.1.1.9.1.1 Did the media pay attention to their assurance or did the media do what the media does and print the most dramatic headlines?

9.3.1.1.9.1.1.1 It would be disingenuous of the officers to suggest that they are not responsible for the media.

9.3.1.1.9.1.1.1.1 A responsible politician knows not to say something which might be quoted out of context and give an erroneous impression.

9.3.1.1.9.1.1.1.2 At no point did the government censure the press for being alarmist and for mis-representing their statement.

10.3.1.1.9.1.1.1.3 When ICCRT R9 was published it stated " in an unmitigated epidemic, we would predict approximately 510,000 deaths in GB and 2.2 million in the US".

10.3.1.1.9.1.1.1.4 What had been a worst case and it would be much better than that according to CW and PV had a fortnight later been transformed into the expected case.

10.3.1.1.9.1.1.1.5 At no point did the government censure PF for his alarmist position or remind the public that they considered such an outcome extremely unlikely.

10.3.1.1.9.1.1.1.6 Thus the government allowed a figure to be promoted from an alarming worst case but not really to be expected to one that is the publicly declared unmitigated case.

10.0 Lies, Damned Lies and Government Data

10.1 The fall of science, truth and integrity during Covid-19 has been extraordinary and heart-breaking.

10.1.1 The actions of PF are no less abhorrent for being only one piece in a far larger mosaic of scientific fraud and uncritical media reporting or ignoring of that fraud.

10.2 The UK Government Embraces Fraud

10.2 As early as May 11th BJ and the British Government officially embraced the fraudulent exponential meme.

10.2.1 In his press briefing of May 11th PM BJ stated "Throughout the period of lockdown which started on March 23rd we have been at Level 4 – meaning a Covid19 epidemic is in general circulation, and transmission is high or rising exponentially."

10.2.1.1. It is difficult to adequately express our astonishment and indignation at such a statement.

10.2.1.2 If the PM BJ had announced "there's no question that the sun rises in the west and anyone claiming otherwise will be punishable with a fine" then it could not have been more outrageous.

10.2.1.3 The fraudulent exponential meme is one of the primary memes of the Covid-19 agenda.

10.2.1.4 The maths of exponential and contagions and the associated fraud is dealt with separately.

10.3 Science and Medical Science Embrace Fraud

10.3.1 That we are presenting a case against PF of Imperial College makes our opinion of that organisation as to its trustworthiness obvious.

10.3.2 Perhaps we should turn to the US and a world-leading medical establishment and university Johns Hopkins.

10.3.2.1 Johns Hopkins makes statements on its Covid-19 data page that leave us in the same state of astonished shock as the PM's use of the 'exponential' virus.

10.3.2.1.1 They make statement regarding 'flattening the curve' which are so egregiously false that a school-leaver should spot them, and yet those statements are still in place months later, and nobody notices or challenges them.

10.3.2.1.2 We will go into detail as we go through the fraudulent memes of Covid-19 in a separate section.

11.0 What is a Normal Contagion?

11.1. Given that governments, scientists and even the mainstream sources (or especially the mainstream sources) are unreliable and flagrantly mis-representing contagions we must caution the court against any presumption that they know anything about contagions and contagious diseases and in particular about Covid-19 based on what they have read or been told elsewhere.

11.1.1 That may seem an arrogant statement to make for a simple citizen with a Maths degree, but the concepts involved are indeed arithmetical and a very basic arithmetic at that.

11.1.2 It is deeply disturbing that even reputable published statements and resources such as Wikipedia are not immune to the disease of inaccuracy.

11.1.3 Nor is it an issue of just nit-picking. We are dealing with core issues which go the heart of the selling of the Covid-19 agenda.

11.2 We list a number of the core memes which have been misused and mis-represented.

11.2.1 The single most fraudulent meme is the exponential meme.

11.2.1.1 This meme represents the unmitigated growth of the Covid-19 contagion to be exponential.

11.2.1.2 Search on 'Covid-19 exponential'

11.2.1.3 With regard to the UK government we have heard and found that each of the PM BJ, CW, PV, the Joint Statement of 25th September all refer to the 'exponential' growth of the virus.

11.2.1.4 No virus whose progress has been recorded (which takes us back to 1840) has ever been exponential in nature.

11.2.1.5 This is the simplest thing of all to check and can be checked at a glance from a chart or graph or by arithmetic based on the data.

11.2.1.6 To suggest that the scientists and experts advising the government are incapable of doing such basic arithmetic is absurd.

11.2.1.7 To suggest that the scientists and experts advising the government are unaware of the definition of exponential is absurd.

11.2.1.8 To suggest that the scientists and experts advising the government have never seen a chart of a contagion is absurd.

11.2.1.9 Thus the conclusion has to be either that they really are that incompetent and so should not be in charge of a kindergarten math class let alone a nation during a pandemic or that they are knowingly misrepresenting the contagion.

11.2.1.10 If they are knowingly misrepresenting the Covid-19 contagion then it presumably is not because they are wilful capricious individuals.

11.2.1.11 If they are knowingly misrepresenting the Covid-19 contagion it presumably is because it suits them and it supports their agenda.

11.2.1.12 Their agenda is publicly declared and has been rammed home since April: no normal till the vaccine.

11.2.1.13 It is hardly a challenging issue to answer 'Qui Bono' if this entire agenda hinges on entire populations being persuaded or coerced or mandated to take a vaccine.

11.2.1.14 That government experts and scientists around the world are mis-representing Covid-19 in the most fundamental way is barely even arithmetic. A glance at a chart suffices.

11.2.1.15 As such the only question becomes: why personally did those authorities choose to pursue this agenda including to the point where they knowingly mis-represented the most basic facts?

11.2.1.16 We do not offer an answer. The traditional ones are money, power, patronage and we have no doubt they will have been involved. However that is for a separate criminal case against those individuals as we or others may pursue.

11.2.1.17 The issue applies only tangentially to PF. He has not to our knowledge mis-represented the principles of contagion or the basic nature of contagion as regards for example exponential growth. He states that he 'seeds' the model with exponential, but that is arguably limited to the initial stage, and so we make no claim to the contrary.

11.2.1.18 The issue with PF is that he presented on the nature of it 'good' science, correct science theoretically, but then substituted a result which is inconsistent with his own parameters, inconsistent with the real-world data on Covid-19 and inconsistent with any historical contagion.

11.2.1.19 Indeed the irony is that his charts are anything but exponential. They are precisely of a reasonable form for a contagion except in terms of magnitude. They are essentially normal as in normally-distributed.

12.0 Understanding the Covid Experience

12.1 The Covid-19 experience is simple

12.1.1 A nation's Covid-19 experience depends on its location

12.1.2 We will reference the primary contagion ending approximately June 24th

12.1.3 If you are in the West including the UK in proximity to a globally dominant pharmaceutical company your country experienced typically between [x] and [x] deaths per million

12.1.3 If you are not in the West such as for example in the Far East or Africa your country experienced typically between [x] and [x] deaths per million

12.1.4 That discrepancy is an order of [100] times and cannot be explained by such factors as genetics, pollution, 5G, GDP

12.2.1 The publicly declared agenda for the UK and western governments is a) massive threat b) 510,000 deaths UK, 2.2 million deaths US c) lockdown d) wait for the vaccine and more recently The Great Reset

12.2.2 In the Far East and Africa mortality from Covid-19 is so slight as to render a vaccine unnecessary

12.2.2.1 That does not mean that countries won't take a vaccine. It simply means that Covid-19 is a very slight influence on the country's overall deaths per annum

12.2.3 In the West the vaccine has been sold as the saviour from Covid-19

12.2.3.1 Flu vaccines have been around apparently since the 1940s

12.2.3.2 Flu is still around

12.2.3.3 Flu is still a significant killer and in the UK and US typically kills the same order of magnitude of people as Covid-19

12.2.3.4 Yet the government is marketing a Covid-19 vaccine as an immediate solution or at least as the great step necessary to fight Covid-19

12.2.3.5 For it to be necessary there has to be a massive threat and substantial deaths

12.2.3.5.1 For there to be a massive threat there have to be declarations from government advisers and scientific reports demonstrating that threat

12.2.3.5.1.1 In that context ICCRT R9 is the dodgy dossier of Covid-19

12.2.3.5.1.2 The dodgy dossier was a report rapidly proven to be fraudulent that backed up the government's claim of WMD in Iraq

12.2.3.5.1.3 The dodgy dossier and WMD provided the rationale for the otherwise illegal and unnecessary war against Iraq

12.2.3.5.1.4 The dodgy dossier of Covid-19, the massive threat of Covid-19 as promoted by the government and engineered substantial reported deaths in the west provide the rationale for the otherwise unnecessary vaccine

12.2.3.6 Western government declarations and actions including in particular those of the UK have by their own declaration a primary goal of massive uptake including possible or likely mandatory uptake of a Covid-19 vaccine

12.2.3.6 Western government declarations and actions including in particular those of the UK have by their own declaration a secondary goal of The Great Reset an opportunity to build again from the ashes of the Covid-19 experience

12.2.3.6 The nations in the Far East and Africa have no such need as there has been no substantial deaths from Covid-19

12.2.4 The distinction is simple and clear by their own reported statements and figures that the West has experienced a very different Covid-19 to the Far East and Africa and that the West intends by that different experience to promote the uptake of vaccines and The Great Reset having broken their economies with lockdown and other measures which will require and has already required massive borrowing from Central Banks and the people who own them.

12.2.5 Thus it is not a theory but a simple statement of fact that Covid-19 in the west is a massive win for those who a) sell medical intervention and vaccines b) desire a reshaping of the nature of western society c) enjoy a position as the world's wealthiest individuals who enrich themselves by lending money to governments.

12.2.6 It is not a theory but a simple statement of fact that Covid-19 in the west is a massive loss for those who a) work in or manage or own physical commercial enterprises or small to medium businesses b) hoped and believed they live in a free society where they determine their movements and actions c) hoped and believed they live in a free society where they can rely on their children being educated and their own persons being sacrosanct and free of coercion d) hoped and believed they live in a free society where they can make a free and informed choice as to whether to take medication including vaccines e) have lost a family member due to government measures such as lockdown or by suicide or who are undergoing violence and threat while confined to their homes.

12.2.7 It is not a theory but a simple statement of fact therefore that Covid-19 as practiced in the west is a massive win for the wealthiest corporations and individuals in the world and individuals who cherish the opportunity to remodel societies as they see fit.

12.2.8 It is not a theory but a simple statement of fact therefore that Covid-19 as practiced in the west is massive loss for ordinary people and for people who believe in democracies and people who believe in putting the people first and politics and global design second.

12.3.1 Governments in the west in particular the UK and including their supporting arms politicians, scientists, the media and the health services have promoted and taken action to ensure a massive threat against the people of their respective nations sufficient to justify arguably the greatest loss of liberty in those nations' histories.

12.3.1.1 It is the position of the government that individuals must act in compliance with the government for the safety of all.

12.3.1.2 It is our position that the government must be removed and put in jail for the safety of all.

12.3.1.3 The lies and fraud of Covid-19 in the west are simple and rely on simple arithmetic and often less than that to observe and prove them.

12.3.1.1.1 The failure of scientists, the media, politicians to reveal and highlight these lies and fraud is testament either to their lack of integrity from a desire to keep their jobs or their complicity in the lies and fraud.

12.3.1.1.2 The lies and fraud are not matters of opinion. They are simple fact at the level of the basic arithmetic as stated.

12.3.1.1.3 The lies and fraud have been relentlessly promoted by governments including in particular the UK and in particular BJ, PV, CW and PF.

12.4.1 The nature of true Covid-19 crisis is simple: either we lose the politicians and the fraud or we lose the society that our fathers and grandfathers and great-grandfathers gave their lives to protect.

12.5.1 It is a slim hope that the legal system supports integrity, justice and a society of the people.

12.5.1.1 Every other government arm and associated arm has acted against integrity, justice and the people.

12.5.1.2 The legal system has also acted in support of the agenda and therefore against integrity, justice and the people.

12.5.1.3 Thus our hope relies not on the legal system entire but on finding one individual within it with integrity who will promote justice and support the people.

12.5.1.4 It is a testament to the true massive threat of Covid-19 to our society that the future of that society and its status as a free nation with a free people hinges on finding one person of integrity in the legal system.

12.5.1.5 It is a sad postscript or epitaph for a history of thousands of years of struggle from a fair and just society to a fair and just society with many interventions and unfair and unjust societies in between that we cannot take for granted that we will find such an individual.

13.0 Topics Not Covered

13.1 There are a vast number of topics which we could cover but the essence of the UK and western Covid-19 fraud is simple and requires only a small subset to be considered.

13.1.1 We could assess the following legitimate topics but we choose not to.

13.1.1.1 A great deal of information has been gathered by other people on these topics.

13.1.1.1.1 This material is available online typically on social media.

13.1.1.1.2 Naturally it is not covered by the mainstream media.

13.1.1.1.2.1 The exception to this is if the mainstream media makes an effort to dismiss, ridicule or otherwise suppress the material.

13.1.1.1.2.2 And instance of this would be the [x of doctors] highlighting the effectiveness of Hydroxychloroquine (HCQ).

13.1.1.1.2.1.1 It is an extraordinary a scenario where it is reasonable to discredit individuals with a professional background and expertise

13.1.1.1.2.1.2 It is less extraordinary if the media are owned by and compliant to people who are supporting or instigating the western Covid-19 agenda.

13.1.1.1.2.1.3 That is not a theory. That is a simple observation.

13.1.1.1.3 Naturally it is generally suppressed by the social media titans such as YouTube and Facebook.

14.0 Memes, False Memes and Deception

14.1 A number of memes have been promoted which co-operate to reinforce the message that a nation such as the UK is under massive threat and would have experienced massive deaths without severe government intervention.

14.1.1 The media do not report the UK relative to the world and so the discrepancy that we have already experienced massive death by comparison to the rest of the world in particular the Far East and Africa is a fact of which the mass of the people are oblivious.

14.2 The principle memes and their roles are as follows.

14.2.1 The virus grows exponentially without intervention.

14.2.1.1 This is the most egregious falsehood of the Covid-19 experience.

14.2.1.2 No contagion in history whose data has been recorded shows an exponential curve (a climbing straight line on log scales) for either its daily or cumulative data.

14.2.1.2.1 An exponential curve is somewhat unique in that its daily (or periodic) reports and its cumulative (total) reports are both exponential.

14.2.1.2.1.1. Strictly the total is fractionally off exponential but by so small an amount that it is indiscernible on a chart.

14.2.1.2.1.2 The daily and cumulative lines appear parallel and straight on log scales both climbing remorselessly to infinity.

14.2.1.2.2 In the real world it is trite to say that the virus or a contagion must run out of people eventually long before infinity.

14.2.1.2.2.1 This is pertinent to official epidemiological models such as SI, SIR, SEIR which have a built in exponential which is only moderated close to peak at which point the contagion promptly reverses itself and declines similarly exponentially.

14.2.1.2.2.2 This in no way reflects the real world of contagions but will be dealt with in a section on these models.

14.2.1.3 The key distinguishing feature of exponential is that it is a constant growth rate.

14.2.1.3.1 If the contagion daily cases increase 15% today they will increase 15% tomorrow and the next day and the next ad infinitum.

14.2.1.3.2 PV used the constant rate terminology in the 21st September Press Briefing.

14.2.1.3.2.1 CW used the exponential term explicitly demonstrating that both CW and PV were consciously using the exponential meme to describe the virus.

14.2.1.3.2.2 PM BJ used the exponential meme in his briefing of the [x] [at which he extended the period of lockdown].

14.2.1.3.2.3 The UK Joint Statement of 25th September explicitly referenced the exponential meme.

14.2.1.3.2.4 Thus the use of 'exponential' to describe the growth of the virus is long-standing and not a singular accidental reference.

14.2.1.3.2.5 Despite its use for months not one scientist or analyst or professor has come forward to contradict the government's use of this meme.

14.2.1.3.2.5.1 That failure is not due to the exponential meme being right or justified. It is simple arithmetic to demonstrate the utter fraud of the meme.

14.2.1.3.2.5.2 As such we have to consider that not only is the government willing to promote an egregious falsehood but that the media, universities, government institutions such as the NHS and corporations are all willing to participate in these fraudulent claims or are unwilling to contradict their sponsor.

14.2.1.3.3 On either linear scales or log scales if we plot the growth rate and it is constant then it is a horizontal line.

14.2.1.3.3.1 No contagion including Covid-19 reports from over 200 countries shows a horizontal line for its growth rate.

14.2.1.3.4 A chart plotted on log scales of either the daily or cumulative data is not exponential if it diverges from a straight climbing line.

14.2.1.3.4.1 The inevitable randomness of reported cases or deaths would cause some divergence but in a random manner.

14.2.1.3.4.1.1 Despite which an exponential virus would still climb generally and clearly in a straight climbing line on log scales.

14.2.1.3.5 A search on 'contagion data stats' or 'pandemic data charts' or similar readily brings up dozens of plots of typical contagions including those for Covid-19 but also for Ebola, Sars, Influenza (1918), Seasonal Flu as well as infographics for Covid-19.

14.2.1.3.5.1 ICCRT R9 despite the fraudulent nature of the magnitude and timing of the chart Figure 1A is also pertinent as an example of what PF considers to be a 'normal' contagion.

14.2.1.3.5.2 All these charts without exception if they are for daily or weekly (periodic) reports share a consistent feature.

14.2.1.3.5.2.1 All these charts are humped and demonstrate a clear similarity to a formal Normal Distribution or Bell Curve. We will refer to such a distribution simply as 'normal'.

14.2.1.3.5.2.2 William Farr in 1840 observed that contagions followed a roughly normal curve.

14.2.1.3.5.2.2.1 His observations on such became known as Farr's laws.

14.2.1.3.5.2.2.2 Wikipedia: William Farr. References

"On p. 97, Farr stated that during a recent smallpox epidemic, the number of deaths versus time followed a roughly normal curve:"

William Farr - Wikipedia

14.2.1.3.5.2.3 We observed early on that the data for Hubei, China, looked normal and when fitted with a normal curve it was a very reasonable fit.

14.2.1.3.5.2.3.1 A viewer referred us to Farr's Law and we are indebted.

14.2.1.3.5.2.4 Even if someone might quibble as to the relative perfection or accuracy as to the normal curve as a model of contagions there is no possible doubt in a sane world that the charts for Ebola, Sars, 1918 Influenza, Seasonal Flu, Covid-19, Covid-19 infographics, ICCRT R9 Figure 1A are all humped, much as a normal distribution is also humped in its probability form vs cumulative form.

14.2.1.3.5.2.5 In its cumulative form contagions and humped curves show on linear scales what is known as an S curve or sigmoid curve which resembles approaching and climbing a hill.

14.2.1.3.5.2.5.1 In such a curve the initial approach is gently climbing and then the real climb begins as the curve curls upwards at which point the climb becomes established until close to the peak the climb levels off and after crossing the peak the sequence reverses with an increasing rate of descent then a sharp decline and finally a lessening descent to level.

14.2.1.3.5.2.5.2 Farr observed this and described it thus: "It appears probable, however, that the small-pox increases at an accelerated and then a retarded rate; that it declines first at a slightly accelerated, and at a rapidly accelerated, and lastly at a retarded rate, until the disease attains the minimum intensity, and remains stationary."

William Farr - Wikipedia

14.2.1.3.5.2.5.2.1 We do not cite Farr's description for formal evidence but simply to acknowledge the man's contribution which Wiki remarks makes him the father of epidemiology.

14.2.1.3.5.2.5.2.2 The very least we can say is that he was rather more accurate than our politicians and advisers some 180 years later.

14.2.1.3.5.4 It is evident that none of these curves and none of their associated contagions are climbing to heaven as we put it.

14.2.1.3.5.4.1 Formally we state as self-evident that published curves for epidemics and pandemics do not show graphs with the characteristic exponential accelerating climb on linear scales or linear constant rate of climb on log scales.

14.2.1.3.5.4.1.1 We refer to the charts in their entirety.

14.2.1.3.5.4.1.1.1 It is not sufficient to say that the chart has the characteristic accelerating climb on linear scales for a few days to make it exponential moving forward and in its entirety.

14.2.1.3.5.4.1.1.2 It is not even accurate to describe contagions as being exponential even during that initial 'accelerating' climb.

14.2.1.3.5.4.1.1.2.1 The ‘accelerating’ (curling up) portion of a normal curve or a contagion is a misleading artefact of linear scales.

14.2.1.3.5.4.1.1.2.1.1 The growth rate is neither increasing (beyond exponential) nor constant (exponential) but decreasing.

14.2.1.3.5..4.1.1.2.1.2 The growth rate of a normal curve is decreasing from the very beginning no matter how far back one plots the curve.

14.2.1.3.5.4.1.1.2.1.2.1 This is a signature characteristic of the normal distribution but in fact we can be even more strict.

14.2.1.3.5.4.1.1.2.1.2.2 The growth rate of a normal curve is declining at a constant rate throughout the curve.

14.2.1.3.5.4.1.1.2.1.2.2.1 This is a defining feature of the normal curve.

14.2.1.3.5.4.1.1.2.1.2.2.2 Contagions including Covid-19 including charts for the UK also evince this constant rate of growth decline demonstrating that they are indeed properly normal curves not ‘somewhat’ normal.

14.2.1.3.5.4.1.1.2.1.2.2.3 The random nature of data does show imperfections but so slight in many cases as to make it impossible to reject the observation that by the constant rate of growth decline the contagion followed a normal path during its primary contagion.

14.2.1.3.5.4.1.1.2.1.2.2.4 A normal distribution has the advantage of fractional values. A contagion deals with integral cases starting at 0 and then there is the first case or death.

14.2.1.3.5.4.1.1.2.1.2.2.4.1 The growth rate from 0 to 1 is infinite. The growth rate from 1 to 2 is 100%. The early reports may leap from 1 to 13 to 37 as imperfect information comes in and these growth rates may be relatively huge involving rates of growth of hundreds of percent per day.

14.2.1.3.5.4.1.1.2.1.2.2.4.1.1 There is a certain irony here that the scientists with R0 offer very timid and modest rates of growth such as ICCRT R9 2.4 and doubling every five days (1.15 factor per day) or PV September 21st doubling every seven days [(1.104 factor per day)].

14.2.1.3.5.4.1.1.2.1.2.2.4.1.2 The reality is that in the early days contagions can show accelerating growth (climbing when plotted) which makes them far more threatening than exponential.

14.2.1.3.5.4.1.1.2.1.2.2.4.1.2 What the scientists fail to mention however is that after the first few days and it is only a matter of a few days the chart settles into the characteristic feature of contagions and normal curves and the growth rate declines at a consistent and constant rate.

14.2.1.3.5.4.1.1.2.1.2.2.4.1.3 This is not chance or happenstance. It is impossible to have a humped curve without the decline in growth rate. Where the decline is at a constant rate that is the signature of specifically a normal curve. Other humped curves will have varying rates of decline but the growth rate must decline.

14.2.1.3.5.4.1.1.2.1.2.2.4.1.3.1 This is most simply demonstrated by considering peak which must exist on a humped curve.

14.2.1.3.5.4.1.1.2.1.2.2.4.1.3.2 At peak yesterday’s cases equals today’s cases by definition. The curve on either linear or log scales is horizontal for a brief moment. The growth rate is zero.

14.2.1.3.5.4.1.1.2.1.2.2.4.1.3.3 From zero cases the contagion cannot exist unless zero cases becomes 1 cases and proceeds to peak. Thus there must be growth greater than zero. Yet at peak the growth rate is zero. Thus the contagion must proceed from a positive growth rate to a zero growth rate. The decline of the growth rate in a humped curve is inevitable and necessary for the curve to be humped in the first place.

14.2.1.3.5.4.1.1.2.1.2.2.4.1.3.4 The rate and form by which the growth rate declines will be dependent on the nature of the curve which might be Sigmoid, Richards, Lognormal, Normal, Logistic, Gompertz or even Sine all of which are humped (having a flat top at maximum and then declining).

14.2.1.3.5.4.1.1.2.1.2.2.4.1.3.5 It is an apparently remarkable coincidence that the curve which most resembles a typical contagion is indeed the normal curve most commonly associated with probability distributions and not one of the more arcane variations.

14.2.1.3.5.4.1.1.2.1.2.2.4.1.3.5 It is an apparently remarkable coincidence that the Normal Curve has such a convenient tell in that it has a constant rate of growth decline which is easily discerned as a descending straight line when plotted on log scales.

14.2.1.3.5.4.1.1.2.1.2.2.4.1.3.5 The coincidence and its convenience may not be coincidence at all.

14.2.1.3.5.4.1.1 We accept that individual contagions when plotted may differ from a perfect normal curve.

14.2.1.3.5.4.1.1.1 No cookie or biscuit is ever perfectly round but it does not make it unreasonable to describe cookies or biscuits as round.

14.2.1.3.5.4.1.1.2 As a spirit-level or set-square provides a reference or template by which to assess the gradient of a surface or accuracy of a right-angle so we use the normal curve as a reference or template to highlight the nature of a plotted contagion curve.

14.2.1.3.5.4.1.1.3 There are some specific examples of contagion curves such as Covid-19 South Korea or Ebola Sierra Leone which are so perfect as normal or lognormal curves that we consider them to be an art form.

14.2.1.3.5.4.1.1.3.1 The South Korea curve is almost perfectly normal but can be even more accurately fitted with a lognormal curve. The difference is slight but the fit is truly remarkable for a ‘real world’ contagion.

14.2.1.3.5.4.1.1.3.2 South Korea was the first land contagion outside China to be completed.

14.2.1.3.5.4.1.1.3.2.1 We typically refer only to land contagions. The experience of cruise ships is of a specialist and distinct nature not pertinent to general discussion. They are of particular interest in setting maxima for infection and death rates based on their role as compact perfect incubators.

14.2.1.3.5.4.1.1.3.2.2 That the first land contagion outside China to be completed should have evolved as a perfect normal curve cannot have escaped the attention of the UK government advisors PV CW and the author PF.

14.2.1.3.5.4.1.1.3.2.3 By 14th March the date cited by PF for fitting his data South Korea had peaked and was showing a downturn.

14.2.1.3.5.4.1.1.3.2.4 By 22nd March the day before BJ instituted lockdown South Korea was essentially complete, the rate of new cases declined to around [20%] of peak, the cumulative (total) chart was near horizontal. It was clear that South Korea was all but over.

14.2.1.3.5.4.1.1.3.2.5 South Korea by 22nd March had reported 98 deaths or 187 deaths per 100 million and it was all but over. As of 19th November it has reported 473 deaths despite a population of 50 million. The UK is reporting 100 times that, almost perfectly, at 47,366.

14.2.1.3.5.4.1.1.3.2.6 Even if UK and western politicians had been utterly honest and sincere they would still have been incompetent to oversee a death count 100 times that of the Far East or here South Korea.

14.2.1.3.5.4.1.1.3.2.7 They have not been utterly honest.

14.2.1.3.5.4.1.1.3.2.8 To be exact and fair in normalised population terms South Korea was reporting 908 deaths per 100 million population and the UK 70,211 so the UK has managed to fare worse by a factor of 77 times.

14.2.1.3.5.4.1.1.3.2.9 The experience of South Korea is not unique. It is typical of Far Eastern or African experiences of Covid-19.

14.2.1.3.5.4.1.1.3.2.10 Somehow the western nations with all their science and money have managed to experience a contagion around a hundred times worse than the Far East and Africa.

14.2.1.3.5.4.1.1.3.2.11 How fortunate that as the nations who dominate the world in pharmaceutical corporations we have ready access to a vaccine.

14.2.1.3.5.4.1.1.3.2.12 How fortunate for the pharmaceutical corporations that the massive deaths in the west by comparison to the Far East and Africa make the need for the vaccine so apparent.

14.2.1.3.5.4.1.1.3.2.13 Only one thing is not fortunate: that the 'exponential' meme used to sell the threat of the virus is utterly contradicted by humped curves for Hubei, South Korea, and now all Covid-19 curves [with any exceptions?] as well as all recorded curves in history for other contagions and including infographics for Covid-19 and even ICCRT R9 Figure 1A.

14.2.1.3.5.4.1.1.3.2.14 Covid-19 was never exponential. It's two earliest land contagions told the politicians and scientists all they needed to know including assuring them that it was not exponential.

14.2.1.3.5.4.1.1.3.2.15 Yet as recently as the September 21st briefing and September 25th joint statement and no doubt far more recently still the government is still selling Covid-19 as exponential.

14.2.1.3.5.4.1.1.3.2.16 If the court has not yet understood that a humped curve cannot be and never is exponential we need to move on to a simple absolute test of growth decline.

14.2.1.4 Plotting the growth rate on either linear or log scales will readily and immediately demonstrate whether the virus contagion is exponential.

14.2.1.4.1 Exponential is defined as a constant rate of growth.

14.2.1.4.2 A constant when plotted on either linear or log-scales is horizontal.

14.2.1.4.3 An observer need only decide whether during the primary contagion the growth rate line so plotted is in fact horizontal.

14.2.1.4.4 Time and again where the data allows a proper calculation of rate to be plotted it shows an initial spike up which is inevitable when proceeding from zero for the first few days and then the contagion settles into a declining growth rate.

14.2.1.4.5 With over 200 countries to choose from there is not one which shows a horizontal growth rate.

14.2.1.4.5.1 It would be impossible for them to do so because their associated charts would be increasing rapidly and remorselessly to infinity both on linear and log scales and in a straight climbing line on log scales.

14.2.1.4.5.2 There are no such exponential charts in Covid-19 nor in Ebola or Sars or Influenza or any historical chart.

14.2.1.4.5.3 Yet the government and other sources persist in using the exponential meme.

14.2.1.4.5.4. By comparison to actual contagion paths the exponential egregiously exaggerates them yet the government persists in using the exponential meme.

14.2.1.4.5.5 The exponential meme is utterly contradicted by the simplest humped curve of which the most famous is ICCRT R9 Figure 1A and yet the government persists in using the exponential meme.

14.2.1.4.5.6 Exponential is the simplest concept and has been widely sold by not just the UK government as expressing the threat of Covid-19 but such a simple concept is also most easily contradicted by the evidence and yet mysteriously nobody speaks up to contradict the government.

14.2.1.4.5.7 Exponential is the most bizarre and damaging example of The Emperor's New Clothes in history and the only question is why those speaking up are silent.

14.2.1.4.5.8 There is not mystery as to why the government is selling an exponential virus. It massively exaggerates the threat. And the media is overwhelmed with the answer to that threat: the vaccine. And under discussion is whether that vaccine is optional and should be sold to us as beneficial or whether it is mandatory so it doesn't matter if we believe it's beneficial or not because the government and agenda says that it is.

14.2.1.4.5.9 Exponential sells the threat. Exponential sells the vaccine. And government sells exponential and the vaccine.

14.2.1.4.5.10 If the government were employed by pharmaceutical companies they could not have done a better job.

14.2.1.4.5.10.1 Indeed if the government were employed by pharmaceutical companies and not in government they could not have done this job.

14.2.1.4.5.10.2 Only because the government has the power to decide the agenda have they been able to sell exponential and the vaccine as effectively as they have done based on a contagion 70 times worse than South Korea, a hundred times worse than the Far East and Africa, a contagion they have overseen.

14.2.1.4.5.10.3 That order of magnitude is not natural. So the only question is how the people selling the exponential virus and the vaccine engineered the contagion that is so extreme by Far East and African levels.

14.2.1.4.5.10.3.1 Given that such a differential is not natural the question arises whether the government has attained the figures reported solely by false reporting which would be a criminal fraud of historic proportions.

14.2.1.4.5.10.3.2 Or were the deaths as reported also real in which case the government has also succeeded in accelerating or causing death which makes them culpable of massive homicide in the count of tens of thousands.

14.2.1.4.5.10.3.3 That the contagion is unnatural is evidenced elsewhere in detail but the two-orders-of-magnitude difference between 'natural' Covid-19 in the Far East and Africa and 'unnatural' Covid-19 in the Western Pharmaceutical Nations is a key indicator of the fraud.

14.2.1.4.5.10.3.3.1 Anyone doubting that this is about the vaccine at this point must truly have seen nothing, heard nothing and done nothing in the last nine months.

14.2.1.4.5.10.3.3.2 It became official policy in a series of international (US, UK and Canada) announcement only a day or so after TP announced the policy in his Apr 5th interview with Chris Wallace on Fox News.

14.2.1.4.5.10.3.3.2.1 No normal till the vaccine.

14.2.1.4.5.10.3.3.2.2 A vaccine that isn't required unless there's a threat.

14.2.1.4.5.10.3.3.2.3 A threat that sounds so much more threatening if it's exponential.

14.2.1.4.5.10.3.3.2.4 Even if no contagion in history has ever been exponential

14.2.1.4.5.10.3.3.2.5 Not even or especially Covid-19.

14.3 The first victim of war is the truth.

14.3.1 "In 1918 US Senator Hiram Warren Johnson is purported to have said: The first casualty when war comes is truth. However, this was not recorded. In 1928 Arthur Ponsonby's wrote: The 'When war is declared, truth is the first casualty'. (Falsehood in Wartime) Samuel Johnson seems to have had the first word: 'Among the calamities of war may be jointly numbered the diminution of the love of truth, by the falsehoods which interest dictates and credulity encourages.' (from The Idler, 1758)"

Peter Brooke, Mewmachar Scotland

https://www.theguardian.com/notesandqueries/query/0,5753,-21510,00.html

15.0 Growth-Decline Analysis

15.1 Growth-decline analysis is a simple and highly effective method of assessing the growth rate and trajectory of a contagion

15.2 We do not use R-analysis (R-nought, R numbers)

15.2.1 The discussion of R-nought and the R number is something of a red herring in contagion and Covid-19 analysis.

15.2.2 In that it avoids a simple, practical and highly effective measure it can be argued to be misleading and distracting and thereby adding to the confusion of people about Covid-19.

15.2.3 We will touch on R-nought in depth separately.

15.3 The simple and practical method is obvious and already familiar to the court from interest payments which we assume are sufficiently common and well understood to be essentially universal.

15.3.1 If a sum of £100 grows to £110 then £10 interest has been earned and the growth is 10% which is 10/100 = 0.1 = 10%.

15.3.1.1 The growth from £100 to £110 can be expressed as a factor 1.1 = 110 / 100.

15.3.1.2 Growth quoted over one time period can be converted to an equivalent rate in a second time period.

15.3.1.2.1 If interest is earned at 1% per month it can be scaled up to an Annual Percentage Rate (APR) by raising (1 + 1%) to the power 12 and subtracting one. This gives

15.3.1.2.2 The conversion expresses a constant rate of growth which is therefore exponential.

15.3.1.2.3 Although contagions do not grow exponentially the conversion between eg: doubling every week to a daily rate is convenient and sufficient.

15.3.1.3 The use of an ‘exponential’ conversion does not vindicate an ‘exponential’ virus.

15.3.1.2.5 On the contrary the conversion is most commonly used to translate declarations from officials to the daily rate demonstrated by the data to contrast the two.

15.3.1.2.6 The alternative is to retain the rate as stated and do the growth calculation based on that time interval.

15.3.1.2.7 The results are equivalent and equally damning where false rates have been used.

15.3.1.3 A more extensive introduction to the arithmetic of growth will be covered separately.

15.4 In the context of Covid-19 the term being analysed is typically that of cases or deaths though hospitalizations would be an obvious further candidate.

15.4.1 In the early day to approximately June deaths were understood to be somewhat fraudulent and so we focused on cases.

15.4.1.1 With the advent of testing cases have become fraudulent and so we included deaths data.

15.4.1.2 From approximately July reporting-testing-as-cases has utterly erased the original meaning of cases and all but eliminated the utility of reported cases except to highlight fraud in the declarations of governments and officials notably PV and CW.

15.5 We will refer to ‘cases’ as the generic context and will specify deaths if particularly required.

15.6 For two data points of 12 then 18 cases the growth between 12 and 18 is 18 / 12 as a factor or 1.5 = 50% as a ‘rate’.

15.6.1 A rate requires a time period. If the interval between 12 and 18 was 1 day it would be a daily rate. If it was 7 days it would be weekly and so on.

15.6.2. A rate may be based on any interval but Covid-19 is reported daily by the WHO and so typically we refer to daily rates.

15.6.2 The general calculation is that if Cn is the Cases figure on Day n then the following day will be Cn+1 (subscript not addition) and we calculate the growth factor as Cn+1 / Cn.

15.6.2.1 In other words, to get the growth ‘today’ we divide today’s cases by yesterday’s cases.

15.6.2.2 The result is a factor which we can convert to a percentage rate by subtracting one.

15.6.2.3 In growth arithmetic the factor is convenient and we rarely convert to a percentage expect for the purposes of eg: exposition or stating a result akin to “doubling every five days”.

15.7 It is clear that calculating growth in this manner is trivial.

15.7.1 WHO reports over 200 countries with 9 months data as of 3rd December for around 270 data points therefore per country for each of four measures – cases daily, cases total, deaths daily and deaths total – and we have around 300 columns each calculating something pertinent in our standard analysis for a country.

15.7.1.1 Thus we routinely make over 16 million calculations to cover a single update of the world Covid-19 situation as reported by WHO.

15.7.1.2 This is all handled on an Excel spreadsheet.

15.7.1.3 The spreadsheet is becoming cumbersome as the contagion or agenda is prolonged but still workable.

15.7.1.4 And yet it all hinges on this incredibly simple concept: growth calculated by taking today’s cases and dividing by yesterday’s cases.

15.7.1.5 We invite the court to consider if they could do that on a calculator or phone and thereby acquire the title Covid-19 analyst.

15.7.1.5.1 We believe they could.

15.7.1.5.2 We invite the court to offer us their calculated R-nought for Covid-19.

15.7.1.5.3 We doubt that they could.

15.7.1.5.4 Nor could we.

15.7.2 Tracking the growth of the Covid-19 contagion is simple to the point of being trivial.

15.7.2.1 Yet the chosen R-0 methodology is not even a growth rate which requires a formal time component.

15.7.2.2 An R-0 of 2.4 if we understand Wikipedia and other sources correctly implies that one person will infect 2.4 other people.

15.7.2.2.1 If they infect those 2.4 people in one day the UK would be overwhelmed in three weeks.

15.7.2.2.1.1 We have seen not dissimilar claims in the early days as people sought to maximise the fear and alarm even non-government and non-media personages.

15.7.2.2.2 If they infect those 2.4 people in twelve years then one person infecting one person every five years is not exactly a crisis.

15.7.2.2.3. We note that we do not consider ourselves experts in R-0.

15.7.2.2.3.1 We rely on Wikipedia and other publicly available sources.

15.7.2.2.4 Wikipedia states “ Also, it is important to note that is a dimensionless number and not a rate, which would have units of time−1,[24] or units of time like doubling time.”

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

15.7.2.2.4.1 Without a unit of time the R-0 is useless as a measure of the aggressiveness or rate of growth of the contagion.

15.7.2.2.4.2 To be useful it has to be converted to a doubling time when PF “doubling every five days” or PV “doubling every week”.

15.7.2.2.4.3 The “doubling every five days” or “doubling every week” phrasing is both misleading and useless because even if the data had been correctly evaluated or a true first week it would not be true of the second week.

15.7.2.2.4.3.1 We revert to the false exponential meme.

15.7.2.2.4.3.2 Contagions are not exponential which is defined as constant growth so that the growth the second week will not be the same as the first week and once the contagion is established will be markedly slower.

15.7.3 Thus we use a simple to calculate immediately useful growth familiar to anyone who has ever calculated interest on their bank account.

15.7.3.1 By contrast the government uses a measure which is arcane.

15.7.3.1.1 R-0 has to be measured by experts.

15.7.3.1.2 There is no single formula for R-0.

15.7.3.1.3 It is not a growth rate since it lacks a time component.

15.7.3.1.4 In short it is a number that can’t readily be checked by the public and which lacking a time component can only effectively say one thing being whether the contagion is growing or declining.

15.7.3.1.4.1 It is like turning to a druid to find out if it’s raining.

15.7.3.1.4.2 Why not just look out the window?

15.7.3.1.4.3 Or in the case of Covid-19 look at a chart?

15.7.3.1.4.4 The R-0 or R number which has formed the centrepiece of government communication as to the growth of the contagion requires the oracle of government experts to tell us something that any member of the public could tell just by looking at a chart.

15.7.3.1.4.5 That defines futility and can have no utility beyond perhaps reinforcing that only the government experts know what’s going on.

15.7.4 Whereas we use a measure which can be replicated by any school-leaver or younger capable of looking something up on the internet and doing basic division.

15.7.4.1 The resulting measure is more effective than R-0 or the R number because it naturally has a proper time component.

15.7.4.2 It is equivalent to the “doubling every x days” which government officials have to resort to when translating R-0 to something useful.

15.7.4.3 It supports further analytics including the critical growth-decline analysis.

15.7.5 There are two possibilities in regard to the government’s use of R-0.

15.7.5.1 Either they genuinely believe that a near-meaningless number is useful which suggests incompetence.

15.7.5.1.1 This is contradicted by their use of “doubling every x days” which demonstrates that they understand that they need a more practical and useful measure.

15.7.5.2 Or they persist with a near-meaningless number because it is useful in its lack of usefulness.

15.7.5.2.1 A measure which does not inform the public leaves the public uninformed.

15.7.5.2.2 An uninformed public needs to turn to the media and government for information.

15.7.5.2.3 Government and media announcements no matter how absurd will be accepted as fact by an uninformed public.

15.7.5.2.4 In that light and in that light alone R-0 and the R number as the centrepiece of government analysis of Covid-19 make perfect sense.

15.8 We use the same concept of growth rate as is familiar from interest rates, vehicle acceleration, and any other context where growth rate is measured naturally as a percentage or factor over time.

15.8.1 The government also uses the same concept of growth rate when it states “doubling every”.

15.8.2 The core distinction between our use and the government’s use is that the government references it as a constant or exponential rate of growth.

15.8.3 We do the basic arithmetic from government data to show that it is never constant and instead is constantly declining through a contagion and as such is perfectly normal as in matches a normal curve.

15.8.3.1 There is no requirement that a contagion match a normal curve.

15.8.3.2 We simply observe that it consistently does and thereby the curve may reflect a mechanism intrinsic to contagions.

15.8.3.3 Growth-decline analysis does not require any such fit.

15.8.3.4 Growth-decline analysis simply reflects what is so.

15.8.3.5 What is so in Covid-19 for the UK and other nations is that it is blatantly not exponential.

15.8.3.6 Calculate the growth rate and plot it on a chart and after an uptick of a few days the contagion settles into a declining growth rate and the chart takes on its characteristic humped form.

15.8.3.6.1 That is the reality of Covid-19.

15.8.3.6.2 That is the reality of every recorded contagion.

15.8.3.6.3 That is the reality of the Covid-19 infographics.

15.8.3.6.4 That is the reality observed by Farr.

15.8.3.6.5 That is the reality illustrated in ICCRT R9.

15.8.3.6.6 That is the reality of a normal (typical and typically Normal Curve) contagion

15.8.3.6.7 That is not an exponential reality

15.8.3.6.8 Yet the exponential myth which greatly exaggerates the threat of Covid-19 has consistently and repeatedly been states as official policy.

15.8.3.6.9 That is fraud and for the policies it has enabled and supported and for the damage that has been done on that basis it is criminal fraud.

15.8.3.6.10 By enabling and promoting the 'massive threat' meme of Covid-19 the exponential meme has demonstrated the true massive threat of government actions against individuals, the economy and society.

15.8.3.6.11 Use of and promoting the exponential meme should be a criminal offence.

15.8.3.6.11.1 If the court wishes to moderate that then it should be a criminal offence to use the exponential meme in regard to a contagion in particular Covid-19 so as to promote or facilitate a policy or action that would otherwise be questionable or beyond the normal action of a government or official.

15.8.3.6.11.2 It is by no means the only questionable or fraudulent action of government officials but it is transparent given the clear simple and formal definition of exponential and the contrast with the equally clear and simple reality of humped or normal contagions.

15.8.3.6.11.2.1 As such it requires the least effort by the court to determine whether an official has acted fraudulently.

15.8.3.6.11.2.2 Given the convenience of speeding as a justification for punishment regardless of the facts we would be delighted to see a summary punishment based on abuse of the exponential meme.

15.8.3.6.11.2.2.1 It would be a summary punishment commensurate with actual fraud.

16.0 Case-Death Lag

16.1 Case-Death Lag is a key fraud indicator for Covid-19 Reporting.

16.2 You're not supposed to die the day you enter hospital.

16.2.1 We use a 14-day case-to-death lag for reasons which will become clear.

16.3 Governments do not appear to publish this statistic the delay from diagnosis to death on average but we can discern the lag from reported cases and deaths in the early months when cases actually falling ill and being confirmed as Covid-19.

16.4 Consider a simple pyramid contagion that goes straight up (diagonally) and straight down for simplicity.

16.4.1 On log scales that would be a contagion for example of 10, 100, 1000, 100, 10 cases and with a 10% CFR case fatality ratio 1, 10, 100, 10, 1 deaths 14 days later. We'll say the intervals are one week to avoid variability in timing of death and say that for our purposes there is non for convenience.

16.4.1.1 Plot those on log scales on separate axes such that the two peaks are the same height which will scale the death up 10 times which is 1 divided by 10%.

16.4.1.2 There will be two adjacent overlapping pyramids.

16.4.1.3 On linear scales a similar pyramid would be achieved with 100, 200, 300, 200, 100 cases and 10,20,30,20,10 deaths.

16.4.1.4 The peaks will be 14 days apart.

16.4.1.5 Each of the case-death pairs (10,1; 100,10; 1000,100; 100,10; 10,1) will be 14 days apart.

16.4.1.6 By scaling the deaths to match the peak in cases the case-death pairs will be on the same horizontal level.

16.4.2 We can reverse the process and given two such adjacent pyramids we can assume that the difference in peaks indicates the case-death lag.

16.4.2.1 Likewise if we scale deaths to match the peak of cases we can assume that the horizontal gap from cases to deaths represents the case-death lag.

16.4.2.2 If it is claimed that the case-death lag in our example is actually seven days then the CFR will oscillate wildly.

16.4.2.2.1 Instead of 10 mapping to 1 death, 100 to 10 deaths, 1000 to 100 deaths, two pyramids separated by 14 days but claimed to have seven days case-death lag then 10 maps to zero or null data, 100 maps to 1 death, 1000 to 10 deaths, 100 to 100 deaths, 10 to 10 and a null data point no cases maps to 1 death.

16.4.2.2.2 The CFRs would be 0%, 1%, 1%, 100%, 100%, infinite or error.

16.4.2.2.3 That does not look reasonable.

16.4.2.3 The reverse applies similarly if the claimed lag is 21 days not 14.

16.4.2.3.1 Now nothing maps to the first 1, 10 maps to 10, 100 to 100, 1000 to 10, 100 to 1 and 10 maps to nothing.

16.4.2.3.2 The CFRs would be error, 100%, 100%, 1%, 1%, 0%

16.4.2.3.3 Again the CFR's indicate that the postulated lag is absurd.

16.4.3 Barring extraordinary circumstances which would need to be clearly understood the rational case-death lag is one that leads to a near-uniform CFR.

16.4.4 Likewise if it is known that patients are typically dying after 14 days then the CFR on that basis by lagging deaths back to 14 days prior should be rational.

16.5 We choose a 14 day lag because Germany has perhaps the most orderly charts of the over 200 countries WHO publish which we thereby track.

16.5.1 It has two well-defined normal contagions with a 14 day separation.

16.5.2 This is not absurdly inconsistent with an article we recall for the UK that mentioned 19 day stays for Covid-19 patients.

16.5.3 Our choice of 14 days is arbitrary but it is a reasonable figure given the charts we have seen.

16.5.4 It seems reasonable that a modern society should be able to keep someone alive for 14 days.

16.5.4.1 As the time shortens it becomes more unreasonable.

16.5.4.2 A number of apparently reasonable countries or charts show seven days case-death lag.

16.5.4.2.1 it surprises us that patients are dying so fast and it is a yellow flag. Caution.

16.5.4.3 A number of countries report 3 days case-death lag.

16.5.4.3.1 That seems absurd that a modern hospital can't keep patients alive for 3 days.

16.5.4.3.2 That country gets a red flag for suspicious activity.

16.5.4.4 A number of countries report less than a day or zero days or even have deaths peak before cases.

16.5.4.4.1 To state that patients die the day they are diagnosed or before as a matter of course seems absurd in the extreme.

16.5.4.4.2 That country gets a black flag for fraud.

16.5.4.4.3 Unless some exceptional evidence came to light we would consider that country's reported deaths to be fraudulent.

16.5.4.4.4 The UK is a black-flag country by its peak data.

16.5.5 The UK is a red flag country by its 3-day average but black flag by the actual peak raw data.

16.5.5.1 UK cases in the primary contagion exceeded [x] between the [8th and 10th April].

16.5.5.2 UK deaths in the primary contagion exceeded [x] between the [8th and 11th April].

16.5.5.3 Centring the two periods the cases peak was midday 9th April and the deaths peak was midnight 9th April.

16.5.5.4 According to the UK government reported cases and deaths Covid-19 victims died at the height of the contagion within 12 hours of being diagnosed.

16.5.5.4.1 That is either an egregiously poor state of critical health care or an egregiously absurd reporting of figures.

16.5.5.4.2 The problem becomes that you cannot simply reduce the reported deaths.

16.5.5.4.2.1 By our observations on scaling the two charts, reducing the deaths by admitting fraud or error would not change the lag for the chart.

16.5.5.4.2.2 In other words a fraudulent lag renders the entire chart fraudulent.

16.5.5.4.2.3 The government cannot say "oh well we just reported their deaths 14 days early."

16.5.5.4.2.3.1 I trust we're right in saying that.

16.5.5.4.2.3.1 Given what the government does say and gets away with we can't even exclude the possibility that the government could state that and get away with it.

16.6 A similar problem arises with the rebranding of ordinary deaths by old and sick people as Covid-19 deaths.

16.6.1 The government has reported a massive spike in excess deaths in March, April, [and May], the period of the prime contagion.

16.6.2 The government cannot just say that they rebranded those deaths and they're sorry.

16.6.2.1 That surge in excess deaths is real in the sense that it is reported.

16.6.2.2 There is no reason other than Covid-19 for those excess deaths by which we include the excess deaths from lockdown and government policy.

16.6.2.3 Thus either those deaths really occurred in which case the government has to explain how it managed to kill people at 100 times the rate of the Far East and Africa by its negligence or intentional actions.

16.6.2.4 Or the government has to admit that it caused the NHS, the ONS to both fabricate figures and create a fictitious contagion because no one extra died.

16.6.2.5 Either the UK government is responsible for the excess deaths of tens of thousands of Britons by its negligence or intentional actions or it lied about tens of thousands of Britons dying from Covid-19 and corrupted the ONS and NHS in the process.

16.6.2.6 Either way the Government is overdue for a long stretch in Broadmoor.

16.6.2.7 That is slightly off-topic for case-death lag but both have severe consequences for what some may wish to pass off as simply 'data error'.

16.6.2.7.1 If reported figures betray a claimed reality that is absurd then either the absurd reality is real and has to be explained as such or the reported figures are not real and causing them to be published as real is fraud.

16.6.2.7.2 The consequences of that fraud are the destruction of freedom, lives and the economy and the imminent likely compulsory or coerced mass vaccination program.

16.6.2.7.3 If this story was been relayed about National Socialist Germany or East Germany after World War II we would shake our heads at such behaviour and abuse of the people.

16.6.2.7.4 Yet this is real and we are living it in what were claimed to be 'free' societies.

16.6.2.7.5 Discrepancies in numbers revealing fraudulent claims are not trivial.

16.6.2.7.6 The entire policy of the government relies on these figures and has become a staple of the mainstream media.

16.7 Just this evening 3rd December 2020 we were in our local garage and heard the radio announcing that we had passed 50,000 deaths and were the first European country to do so.

16.7.1 That sounds like a large number and indeed it is but not for the implied reasons.

16.7.2 The radio broadcast supported the message of the severity the crisis.

16.7.3 We find that broadcast depressing because it indicates the severity of the misrepresentation.

16.8 The issues we highlight are not trivial.

16.8.1 Selling a crisis and exaggerating a crisis to coerce the people is not a trivial act.

16.8.2 Many of us recall WMD and the dodgy dossier.

16.8.3 We are used to the relatively minor endemic fraud eg: speeding law.

16.8.4 The magnitude of what we are currently experience is beyond any historical event in Britain.

16.8.5 It exceeds even Orwell and Orwell's 1984 was taken for granted as a 'couldn't happen here'.

16.8.6 It is happening here right now and has been since March 3rd and the PM Press Briefing.

16.9 Having an authority recognise the legitimacy of our observations is our last hope.

16.9.1 Misrepresentation and fraud has been endemic since March.

16.9.2 The mainstream media has managed not to notice any of it.

16.9.3 The people thereby have managed not to notice any of it.

16.9.4 It can therefore only be ended if a sufficient independent authority with integrity recognises it and ends it.

16.9.5 It can end therefore only if the law is superior to the fraud and excises it.

16.9.6 We have no great hope that that can happen.

16.9.7 Nevertheless we present our material in the hope that it may.

17.0 Mortality

17.1 Intellectually if you ask people I'm sure that they will admit that yes people die that humans are mortal.

17.2 Emotionally the awareness of death and integrating death into their understanding of life has been driven from people's consciousness.

17.3 It has been replaced with a single source of death in the public arena: Covid-19.

17.3.1 What is remarkable is the coincidence that death from Covid-19 looks a lot like death from ordinary life.

17.3.1.1 530,000 people will die from Covid-1in in a worst case scenario, CW March 3rd. 510,000 people will die from Covid-19 not in a worst-case but a most-likely prediction, PF March 16th. 616,000 died in 2018. Increasing at 9k to 10k per annum 634,000 would have died in 2020.

17.3.1.2 Risk of death increases near exponentially by age band for both life and Covid-19.

17.3.1.2.1 China CDC published the first CFR Case Fatality Rate which we used in our March 24th first Peerless Reads Video.

17.3.1.2.1.1 Age 10-39: 0.2% risk of death, 40+: 0.4%, 50+: 1.3%, 60+: 3.6%, 70+: 8.0%, 80+: 14.8%

17.3.1.2.1.2 In that same video we used figures from France having difficulty getting UK mortality figures.

17.3.1.2.1.2.1 Risk of death from normal life: age 18, 0.02%, 45 0.2%, 75 2%.

17.3.1.2.1.2.2 Those figures are as published and it is notable that they are not so far apart in terms of order of magnitude.

17.3.1.2.1.2.3 Life kills. Covid-19 kills. The difference is that you actually have to catch Covid-19 for Covid-19 to be relevant.

17.3.1.2.1.2.4 Factoring in the risk of becoming a Covid-19 case.

17.3.1.2.1.2.4.1 In the same presentation we used the published figures from WHO on Hubei the worst hit province in China which was 0.11% or 67,000 out of 59 million people.

17.3.1.2.1.2.4.2 These figures are available from WHO Daily Situation Reports March 15th the last day the China regional breakdown was provided as China's contagion was now essentially over and has remained over ever since.

17.3.1.2.1.2.4.2.1 That stands in stark contrast with the UK where the threat of Covid-19 has been sold aggressively now for 9 months with no end in sight

17.3.1.2.1.2.4.2.2 Naturally government figures back up the threat.

17.3.1.2.1.2.4.2.2.1 The government sets the policy for Covid-19

17.3.1.2.1.2.4.2.2.2 The government reports the figures for Covid-19

17.3.1.2.1.2.4.2.2.3 The government decides our future with Covid-19

17.3.1.2.1.2.4.2.2.4 In short, the government decides what happens, decides what to report on what happens, decides what to do about what it reports about what happens and then tells how we're going to live our lives based on that agenda or policy.

17.3.1.2.1.2.4.2.2.5 There is no possible risk of abuse where one agent controls the facts and the policy is there?

17.3.1.2.1.2.4.3 Factoring in the risk of actually becoming a Covid-19 case the risk of dying from Covid-19 reduced to: age 18 0.0002%, 45 0.0005% 75 0.0092% making normal life 91 times more deadly for 18 year olds, 444 times more deadly for 45 year olds, and 218 times more deadly for 75 year olds.

17.3.1.2.1.2.4.4 We don't shut down our lives for normal life.

17.3.1.2.1.2.4.4.1 The very conception of doing so is absurd.

17.3.1.2.1.2.4.4.1 Yet the PM BJ had just shut down Britain for a threat far less deadly than normal life.

17.3.1.2.1.2.4.4.1 And that calculation was without factoring in comorbidities.

17.4 It turns out that it is not enough for you to be old for Covid-19 to be a material threat.

17.4.1 You have to be old and sick and at risk of dying.

17.4.2 At which point the presence or absence of Covid-19 is not exactly going to change the outcome.

17.4.3 This is the massive emotional and logical fraud that the government is honest about but doesn't tell people

17.4.4 To be at risk of dying from Covid-19 you have to be at risk of dying from life anyway

17.4.5 There are exceptions but they are so few that they are not a material factor for ordinary people even the elderly

17.4.6 Which reinforces the point. Covid-19 is not a material factor for ordinary people.

17.4.7 We will not use the term not a material risk for ‘healthy’ people because who is really healthy in modern Britain?

17.4.8 This is the relevance and impact of the comorbidity analysis and statistics published by the government.

17.4.9 Even if we take the UK figures at face value despite being 100 times what the rest of the world notably the Far East and Africa experience, they still do not represent a material threat to life

17.4.10 Yet they are presented to the public via the media relentlessly as a massive threat, the only threat that people should be focused upon, the threat that justifies shutting down life, restricting it, and contemplating continuing it only when vaccinated and if you choose not to vaccinate, we may have to protect other people from you and limit your right to work, to travel, to have a life.

17.4.11 To their credit no politician has outright proposed euthanasia but then we don’t know what’s in the vaccine, the government has already admitted to killing 15,000 excess non-covid deaths, even the sleepy public are aware of increased suicides.

17.4.12 Not only has the government engineered via its policies and reporting a contagion 100 times worse than the Far East and Africa but it has also killed a similar order of magnitude of people by its own policy to save us – lockdown

17.4.13 A policy that has not avoided a single case or saved a single life as we show in a separate section

17.5 Putting Covid-19 into proper context with ordinary mortality removes the threat

17.6 Removing the proper context allows the government to massively exaggerate the threat not only logically and intellectually but emotionally

17.7 The remorseless prosecution of that threat as witnessed over the past nine months from March to December is a separate and abhorrent crime against humanity in our view

17.7.1 We have never witnessed nor imagined we could witness such a relentless propaganda campaign against the British people by the government

17.7.2 Supporters will argue that it was necessary because of the massive threat

17.7.3 It becomes a self-fulfilling agenda: we tell you there’s a massive threat, so we have to sell the massive threat, because there’s a massive threat, because we’ve told you there’s a massive threat.

17.7.4 And all along when you put Covid-19 into context with ordinary life there is no massive threat

17.8 Covid-19 barely figures on mortality round the world particularly the Far East

17.8.1 By which we mean that mortality with Covid-19 is commonly around 1% or even 0% of a country’s overall mortality.

17.8.1.1 A figure of 0% means that it is less than 0.5% eg 0.49%.

17.8.2 Even the worst hit nation on the planet for most of the contagion and still so today Belgium has only achieved an overall mortality of [x] of the normal mortality.

17.8.3 New York City under Cuomo with the Cuomovirus 500 times more deadly than Covid-19 has only achieved an overall mortality of [x] of their normal mortality.

17.8.4 We use a standard 9 per 1000 mortality for such calculations.

17.8.4.1 This figure is not unreasonable for a western nation and it is easier to apply a standard reference than to first obtain and then explain figures based on individual nations mortality.

17.8.4.2 To our surprise poor nations seem to have lower normal mortality which makes no sense to use often seeing 7 per 1000 cited vs 9 for western nations.

17.8.4.2.1 A lower ordinary mortality would make covid-19 seem more dangerous in those countries.

17.8.4.2.2 It would not change the overall picture of massive numbers for the West (and South America which is following its own bizarre path) and slight numbers for the Far East and Africa

17.8.5 By June 24th the UK had achieved a rate of [x] of normal mortality. That figure has since [reduced] to [x] as of [19th November].

17.8.6 No matter how hard governments try in the West, they just can't get Covid-19 to be a threat commensurate with normal life.

17.8.7 So they omit normal life from their reporting and focus on Covid-19 exclusively.

17.8.8 That is misrepresenting the threat to the public.

17.8.9 It is WMD all over again.

18.0 Lockdown

18.1 Lockdown is the signature strategy of the west

18.2 Lockdown is one of the three key elements of the western and UK narrative

18.3 Massive threat, lockdown, wait for the vaccine

18.4 If real-world data shows that PF ICCRT R9 figures were massively exaggerated then no we escaped that because of lockdown

18.4.1 PF himself asserts that argument in claiming 470,000 lives saved in the UK from lockdown which is essentially his 510,000 figure less 40,000 deaths.

18.5 At no point has the government proposed a simple sensible test for whether lockdown actually worked

18.5.1 Indeed at no point has the government provided any useful or in-depth analysis of the contagion and its measures at all

18.5.2 We contrast that with our own work which is extensive and has received plaudits from professors and grateful thanks from viewers for sustaining their sanity.

18.5.3 We emphasise that our work is simple arithmetic and highly revealing yet it has been utterly avoided by the government.

18.5.4 The only figures we've noted the government using are the R-0 or R figure and the "doubling time" (doubling every five days, Ferguson, ICCRT R9 and doubling every seven days, PV, Sep 21st).

18.5.4.1 These doubling figures were both fraudulent and contradicted by actual data.

18.5.5 Fortunately the government along with other governments world wide do support the public disclosure of a wide range of covid-relevant data as they do on other topics.

18.5.6 It is an irony that the government's fraud is most easily proven by using the government's own data

18.5.7 The sad part is that the government's message is promoted by mainstream media so that the public absorbs it without critical review whereas what the data is actually saying never reaches mainstream media so that the public remain unaware of it.

18.6 A first test of lockdown effectiveness

18.6.1 Early on we projected the cumulative totals of cases on log scales based on their curves.

18.6.2 A straight line projects as a continuing straight line eg: the mythical exponential on log scales.

18.6.3 A curve can be projected by continuing the curve with a smooth curvature.

18.6.4 Other nations curves were calculated on the last available data.

18.6.5 The UK curve was locked with the 26th March datapoint being the last on the curve.

18.6.5.1 Given the incubation period of lockdown the 26th March datapoint cannot have been affected by lockdown

18.6.5.2 Given that the projection continues the curve as a whole the last datapoint does not define the curve but is merely the last datapoint on that curve.

18.6.5.3 Thus the projection was a reasonable statement of what the no-lockdown contagion would have continued as.

18.6.5.4 We expected to have to measure a decline in the curve with a relatively sharp initial deviation after incubation followed by a curve below that of the no-lockdown projection.

18.6.5.5 Yet the UK reported cases continued to track the no-lockdown curve perfectly.

18.6.5.5.1 They did so with such accuracy that we could not eliminated the possibility that a civil-servant was tracking our work and using our data. We admitted as such in an update.

18.6.6 Incubation was over approximately the 30th or 31st March yet the curve continued to track our no-lockdown projection.

18.6.7 Three weeks later on the 22nd April our chart showed cases still tracking our no-lockdown projection perfectly with the slightest hint of a breakout to the upside. That is to say that far from reducing cases there was a slight excess of cases vs the no-lockdown projection.

18.6.8 Six days later on our 28th April update the breakout was pronounced. Not only had lockdown had zero effect but cases were continuing higher in a clear breakaway from a rational normal contagion.

18.6.8.1 On linear scales which we rarely use except to highlight an absurdity the projection was curling over to flat but the cases had been increasing arithmetically in a straight line neither normal nor the mythical exponential since around March 10th or 11th.

18.6.8 Not only had lockdown had zero effect but the contagion had now increased beyond the rational projection and was going off on an adventure of its own.

18.6.8.1 We will revisit this as we look at the autofit normal for the climb to peak and the avoided peak.

18.7 A second test of lockdown effectiveness.

18.7.1 Although the projection was rational and the results shocking we were aware that pro-government loyalists would find the slightest reason to quibble with the evidence so we sought a second more definitive means to test lockdown.

18.7.2 This turned out to be the invaluable concept of growth-decline which has proven to be the single most powerful concept in contagion analysis.

18.7.2.1 It is unsurprising perhaps that such a simple concept familiar from interest rates and vehicle acceleration has been completely avoided by both epidemiology and the government.

18.7.2.2 It is far too useful and effective in revealing the frauds of both epidemiology and the government.

18.7.3 We plotted the growth of the cases in multiple forms on the same chart including various permutations of average-of-growth calculated on average-of-cases. Thus the actual cases can be plotted as actual daily (or 3 day if we were using 3 day data points) or 3-day average of daily or 5-day average of daily and so on. Then a growth rate can be calculated (today's cases over yesterday's cases for example, simple arithmetic) on any of those series, and an average of those growth rates can be calculated as a 3-day or 5-day average of growth rates.

18.7.3.1 As such a final curve might be a 3-day average of the growth rates calculated from 5-day average of cases.

18.7.3.2 The longer the average in either case the smoother the line.

18.7.3.3 The goal was to tame the data into some trend without losing the information from the raw data to which end we tried a number of measures and plotted them on the same chart.

18.7.3.4 There was a clear descending channel and we plotted inner and outer bands for that channel.

18.7.3.5 Finally we took the slope of that channel and centred it to get a trend line for the growth.

18.7.3.6 Thus at no point did we make an assumption as to the 'correct' shape of the curve, whether it was normal or lognormal, or make any assumptions of that nature.

18.7.3.7 This was pure discovery, plotting the growth to see what was occurring.

18.7.3.7.1 It was obvious that growth was descending and had been descending since very early on.

18.7.3.7.2 It was also clear that the descent had in no way been moderated by lockdown.

18.7.3.7.3 Bear in mind that this does not rely on any projection on our part either. We are merely measuring the growth of the reported contagion and plotting it.

18.7.3.7.4 At the time we were approaching and then passing through peak and we watched with bated breath to see what would happen.

18.7.3.7.4.1 Peak by growth-decline analysis occurs when the growth factor hits unity. Today's cases are the same as yesterday's cases. As the growth rate continues to descend to less than unity, today's cases will be less than yesterday's. The contagion is declining.

18.7.3.7.4.2 Notice that this is very simple arithmetic that could be done by any school leaver with a maths O or A level or modern equivalent.

18.7.3.7.4.3 Yet the government persists with the R number which is not even a rate (has no time component), has no single definitive formula, and is in the hand of government experts much as the Word of God is in the hands of authorities of the Church.

18.7.3.7.4.4 Why would the government avoid such a simple and effective tool and prefer a rather more arcane measure that only they and their authorised advisers can determine?

18.7.3.7.4.4.1 That question rather answers itself.

18.7.3.7.5 Peak by this analysis occurred on the 11th or 12th April.

18.7.3.7.5.1 The Telegraph it transpired had predicted just such a peak which is greatly to its credit.

18.7.3.7.5.1.1 Sadly that would turn out to be a rare occurrence by which a mainstream media demonstrated the capacity for independent analysis.

18.7.3.7.5.1.2 Their capacity for analysis sadly also never extended to calling the fraud on the many issues or anomalies that we highlight in this testimony.

18.7.3.7.5.2 We watched this day by day, reporting every 3 days initially from March 24th, then every 6 days as the contagion continued.

18.7.3.7.5.2.1 We continued to publish updates at gradually extending intervals as the contagion or more accurately the agenda showed no signs of diminishing.

18.7.3.7.5.2.2 By September we had had enough. We had tracked this agenda since March 24th essentially 24/7. Seven months constant effort took its toll. We ceased updates at that point as a regular intentional service.

18.7.3.7.5.2.3 We did publish an update no the 19th November to see how the promoted (and fraudulent) second wave was coming along.

18.7.3.7.5.2.4 Whether we publish any further standard updates will depend entirely on circumstances.

18.7.3.7.5.3 As of April 11th and through April the jury was out: was the government going to allow us a normal contagion.

18.7.3.7.5.4 Eventually it became clear that they were not. The agenda had overridden any pretence at normal or rational.

18.7.3.7.5.5 Since then our focus has been on highlighting the abnormal.

18.7.3.7.6 At this time we were not thinking in terms of global systemic fraud or regional systemic fraud.

18.7.3.7.6.1 We started on March 24th tracking 6 countries manually every three days.

18.7.3.7.6.2 We assessed and charted cases.

18.7.3.7.6.2 Over time we grew to tracking 50 countries every three days and extended the coverage [to deaths] with separate research or pieces on items of interest.

18.7.3.7.6.3 It was only when we switched to downloading the WHO data download from the Covid dashboard containing data for over 200 countries that we were finally able to do a comprehensive analysis per country and a world summary analysis and ranking.

18.7.3.7.6.4 At that point with the governments determined to prolong the contagion and push the agenda the devastating nature of the discrepancy between western Covid-19 and Far Eastern and African Covid-19 became apparent.

18.7.3.7.7 As we watched and every few days updated the chart the breakout of cases to the upside became clear. The UK was no longer behaving 'normally'. The first evidence of fraud was becoming apparent.

18.7.3.7.7.1 Over time and now the growth rate which should have continued to decline in a normal contagion was blatantly going horizontal maintaining an artificially high level so that cases continued horizontal before declining slowly while deaths declined slowly.

18.7.3.7.7.2 Because of the artificial horizontal cases, the slow deaths decline actually anticipates the slow cases decline which is absurd. Deaths follow cases.

18.8 The mapping of growth and its decline had been highly effective in demonstrating the lack of effect of lockdown and the artificial nature of our denied-peak and subsequent horizontal excess cases and slow (delayed) decline in cases and deaths.

18.8.1 The clear linear (on log scales) constant rate of decline of growth seen in the chart and the excellent fit of the normal to peak and its own characteristic decline finally were connected.

18.8.2 The characteristic constant rate of growth-decline of the normal and the excellent fit of the normal became part of the same story and examination of other charts in particular with the use of the autofit normal became an invaluable tool in examining countries for the 'normality' of its contagion.

18.8.3 Countries with ab-normal contagions deserved particular attention.

18.8.3.1 The UK remains perhaps the most blatant and unique ab-normal chart as befits its ranking as world #2 to June 24th.

18.8.3.2 South America with its own ab-normal charts recently usurped the UK from its #2 slot but left Belgium in the #1 slot as of 19th November.

18.8.3.3 Having an ab-normal chart is not sufficient to prove fraud.

18.8.3.3.1 However in conjunction with other measures and analysis it puts the viewer on notice that the government is likely committing fraud.

18.8.3.3.2 In conjunction with simple clear and explicit examples of fraud such as misrepresentations as to growth rates PF and PV of note it builds a picture of systematic fraud against the people of the nation here the UK.

18.9 Overall the maths is simple and unequivocable.

18.10 Lockdown had no effect on the progress of the contagion.

18.10.1 Lockdown did not save a single case or life.

18.10.2 Claims to the contrary are readily seen to be fraudulent.

19.0 International Lockdown

19.1 No Rescue from International Lockdowns

19.1.1 Wikipedia lists [70] lockdowns by nation and timing of lockdown start and finish

19.1.1.1 For all the criticism of Wikipedia it is still a reasonable source

19.1.1.2 The research required to assess over 200 countries for their particular response to Covid-19 would be exhausting and time consuming for a team to properly implement

19.1.1.3 That would be required before we could even begin to measure lockdown effectiveness

19.1.1.4 As an individual researcher we therefore take the Wikipedia information to be reasonable.

19.1.1.5 If an error is pointed out in their data or timing we will happily reflect that as required

19.1.2 WHO provides a daily download of reported cases and deaths on its Covid-19 Dashboard

19.1.3 Growth decline analysis gives us our expected consistent rate of decline

19.1.4 If lockdown is to have an effect it has to accelerate that decline so that cases fall faster

19.1.5 This utterly failed to occur in the UK but how did it fare internationally?

19.1.5.1 We studied 72 lockdowns based on the Wiki list and a couple of others requested

19.1.5.2 We found definitive consistent lack of response to lockdown in 52 cases

19.1.5.3 In 18 cases the lockdown was out of synch with the contagion or one or both was too short to assess.

19.1.5.3.1 If the contagion was too short to assess that should be a hint that Covid-19 was not a threat in that country

19.1.5.4 In two countries reported as locked-down WHO doesn't provide data

19.2 In not one country of the 72 tested did the virus diverge post lockdown and incubation

19.2.1 In 52 countries is definitively did not

19.2.2 In 18 countries the test could not be applied due to short lockdown, contagion, or out of synch lockdown and contagion or sporadic data

19.2.3 In 2 countries there was no data available from WHO

19.3 In not one country out of 72 did lockdown demonstrably prove effective and in 52 out of 72 it definitively did not

19.4 Lockdown is a failed strategy having no effect on the contagion

19.4.1 Claims to the contrary are fraudulent and are easily seen to be fraudulent

19.4.1.1 They typically claim "lockdown is working, the growth rate is reducing2

19.4.1.1.1 That totally ignores that growth rate reduces in every contagion regardless of lockdown

19.4.1.1.2 It is a necessary condition for any humped curve

19.4.1.1.3 That contagions consistently show humped curves and reducing growth rates makes it a normal feature of a contagion and not a consequence of lockdown

19.4.1.1.4 For lockdown to have an effect it would have to accelerate the normal condition and show divergence from the normal trajectory

19.4.1.1.5 We can test that by observing the trajectory before lockdown, between lockdown and lockdown plus incubation and post incubation

19.4.1.1.6 If the trajectory continues without steepening markedly to indicates accelerated decline then lockdown has had zero effect

19.4.1.1.7 What is being observed is the mere normal decline and progress of any normal contagion

19.5 Not only does lockdown have zero effect but governments and scientists are determined to claim that it does have an effect

19.5.1 None of them recognise the normal and necessary characteristics of a humped contagion

19.5.2 Instead the normal characteristic is taken as evidence of lockdown effectiveness

19.5.3 Notice that if the scientists did recognise the normal and necessary characteristics of a humped contagion they wouldn't also be able to claim it as proof of lockdown effectiveness

19.5.4 Thus either governments and their scientists are ignorant and incompetent in regard to the most basic geometry of a contagion

19.5.5 Or they choose to leave the public ignorant and unaware of the most basic geometry of a contagion

19.5.5.1 They then exploit that lack of awareness by stating falsehoods that are readily observed by the a mathematician with school leaver arithmetic

19.5.5.2 And yet none of the professors or analysts in the country or others with better than school-leaver qualifications in mathematics notices these egregious mis-statements

19.5.5.2.1 It is the biggest failure in integrity in the history of this nation

19.5.5.2.2 It is our view that to fund such lack of integrity with public money is an outrageous waste of public money when it is now being used against the British people and without the slightest objection from the people who are paid for in their ivory towers by the British people

19.5.5.2.3 Universities have remained silent and oblivious to these egregious errors mis-statements and misrepresentations

19.5.5.2.4 Universities have failed the British people and have done so utterly and without the slightest excuse

19.5.5.2.5 Nothing less than the dissolution of these institutions to cut out this cancer of indifference to truth and cowardice or self-serving avoidance of fact will suffice but that is of course merely our opinion

19.5.5.2.6 Sadly the millions of Britons supposedly educated by these institutions remain also mentally and emotionally incompetent and incapable of noticing the same egregious and basic arithmetic fraudulent claims

19.5.5.2.7 It isn't difficult. It is basic arithmetic and observation.

19.5.5.2.8 And yet nobody notices.

20.0 Spread Of The Contagion

20.1 A virus in particular a respiratory virus is supposed to spread by contact or proximity to another human being.

20.1.1 We do not intend to examine clinical data or pretend to a knowledge of contagion characteristics and different means of spread or distribution beyond observing this most basic idea that the viral spread is supposed to be by proximity to another human being.

20.1.1.1 This perspective is supported by the emphasis on lockdown and wearing masks and social distancing.

20.1.2 The natural expected pattern of contagion would be similar to what might be observed in a petri-dish also that the contagion spreads quickly and intensely in a local area because that is where people are concentrated close to the patient-zero.

20.1.2.1 Patient-zero is the supposed first contactee of the virus in its human-infecting form.

20.1.2.2 Patient-zero is supposed to infect others and they infect others in sequence.

20.1.3 The virus in this model can only break out of the local zone by an infected person breaking out of the original area and travelling to another area

20.1.3.1 In this second area this new arrival is patient-zero for that area and the process repeats itself

20.1.4 Courtesy of air-travel an infected person can travel to another country and become patient-zero in that country

20.1.4.1 Thus in the UK the first reported Covid-19 cases were in [x] on the [x].

20.1.4.1.1 In theory therefore the UK would have expected a local contagion in [x].

20.1.4.1.2 In due course as people mingled and travelled that initial zone would widen.

20.1.4.1.3 Given the incubation period of around a week, a week after patient zero arrived, further people contacted by patient-zero would begin to fall ill

20.1.4.1.3.1 Somehow those few people that they managed to infect would then fall ill a week after that

20.1.4.1.3.2 As such given the incubation period and this theory of spreading by contact it is clear that you expect a local contagion to develop that will in due course spread by the travel of a sick person to a new area

20.1.4.1.3.2.1 Most people do not feel like travelling when they are sick

20.1.4.1.3.2.2 They are even less likely to travel when they are warned about the risk of Covid-19

20.1.4.1.3.2.3 They are even less likely to travel when they are locked down

20.1.5 So the idea that infected people will make a special effort to go to new areas to ensure that they are infected as soon as possible is absurd.

20.1.5.1 The dominant contagion will be local.

20.1.5.2 The contagion will or may spread to a larger area by transport of an infected person.

20.1.5.3 The contagion will then develop in that larger area.

20.1.5.4 The contagion may then extend its spread by the movement again of an infected person.

20.1.5.5 Thus the process is iterative and repeats.

20.1.5.5.1 A local contagion develops rapidly.

20.1.5.5.2 A locally infected person has to move to a new area to spread the contagion.

20.1.5.5.3 Given the incubation period there will be a delay of at least the incubation period before a local contagion begins in the new area.

20.2 Spread by contact or proximity is the model of contagion spread is the one that is being sold to us by the government and the media.

20.2.1 Spread by contact or proximity is the model that justifies lockdown, social-distancing and masks.

20.2.2 Spread by contact or proximity has a characteristic pattern of local contagion plus risk of seeding non-local contagions which will develop with at least the delay of incubation.

20.2.3 Spread by contact or proximity will therefore demonstrate a sequence of geographic concentration at the original source diminishing outward at any given time

20.2.4 Spread by contact or proximity will therefore demonstrate a sequence of delay between the original contagion and subsequent contagions

20.3 All of that is natural common sense and the inevitable consequence of the concept of spread by contact or proximity.

20.4 What would be unnatural if spread by contact or proximity was accurate would be for the contagion to develop simultaneously in multiple sites independent of the local patient zero.

20.4.1 Simultaneous development of contagions in widely separated areas would not be consistent with the spread by contact or proximity model that we have been sold.

20.5.1 Simultaneous development of contagions would be consistent with an act of policy.

20.5.1.1 Such an act of policy might be by respect of instruction to find or report Covid-19 regardless of fact.

20.5.1.2 Such an act of policy might be by respect of instruction to distribute infected persons by act of policy.

20.5.1.2.1 Such an act or policy was widely reported when the government sent infected people into care homes.

20.5.1.3 Such an act or policy might be by respect of distribution of the virus by artificial means

20.5.1.3.1 This might be akin to sending contaminated materials or sending supplies of a Covid-19 agent to separate areas to be made use of

20.5.1.3.1.1 We do not assert that this occurred.

20.5.1.3.1.2 We simply include it as it is a historically proven threat to send contaminated packages through the mail.

20.5.2 Other non-policy solutions are unlikely but would include for example coincidental travel of multiple infected patients-zero to multiple areas

20.5.3 Overall we regard simultaneous development of contagions to be unnatural and contradicting the strongly reinforced story of spread by contact or proximity as promoted by the government and evidenced by related policies of lockdown, social-distancing and mask wearing

20.5.3.1 We regard simultaneous development of contagions to be indicative of an act of policy

20.5.3.1.1 As noted at least one widely publicised such act or policy is recognised

20.5.3.1.2 The distribution of infected people to care homes has been widely publicised and criticised

20.5.4 The UK demonstrates simultaneous development of contagions

20.5.1 The regional breakdown of Covid-19 death by England, Wales, Scotland and Northern Ireland shows simultaneous development of contagions

20.5.1.1 ONS publication on weekly deaths publishedweek472020.xlsx in its tab 'UK – Covid-19 - Weekly Reg' lists deaths by week for England Wales Scotland and Northern Ireland.

20.5.1.2 England as the largest country shows 5 deaths in week 11. Wales, Scotland and Northern Ireland all follow a week later.

20.5.1.3 When normalised to a standard 100m population our standard benchmark the charts of the contagion proceed essentially identically.

20.5.1.4 In the developing contagion England, Wales, Scotland and Northern Ireland all show a characteristic rises on the 20th March and sharp rise on the 27th March.

20.5.1.5 To 3rd April Scotland shows a delay of one day, Wales two days. Northern Ireland participates more slowly and so our focus continues with England, Wales and Northern Ireland.

20.5.1.6 As of the 10th April the day before the peak by growth decline analysis Scotland has closed the gap and has identical deaths per 100m (DPCM) at around 11,000 on around the 10th April. Wales has proceeded in parallel reaching the slightly lower 9,000 DPCM.

20.5.1.7 England Wales and Scotland proceed to an actual peak (England), near peak (Wales and Scotland) on the 17th April (week containing the 11th Peak by Growth Decline analysis).

20.5.1.7.1 England peaks at 15,0i00 DPCM, Wales at a little under 13,000 and Scotland and slightly below 12,000.

20.5.1.8 Northern Ireland has a more subdued path from 3rd April but has the first two signature upticks of the 20th March and 27th March.

20.5.1.9 More refined analysis requires daily data however the chart derived from this ONS report makes the point entirely clearly.

20.5.1.10 Despite being centred hundreds of miles apart (London-Cardiff 152 miles; London-Edinburgh 416 miles; Cardiff-Edinburgh 426 miles) and despite being separated by the Irish Sea (Dublin) and with Wales and Scotland sharing no common border, the four nations initiated their contagions essentially simultaneously, developed them simultaneously in the first weeks, and three of those nations peaked simultaneously with not massively dissimilar rates of death after which the three nations England Scotland and Wales declined simultaneous at similar rates and levels per normalised population.

20.5.1.10.1 That isn't a natural contagion spread by proximity or contact.

20.5.1.10.2 That is an act of policy.

20.6. [second wave]

21.0 Spread Magnitude and Blockade

21.1 China experienced a very different Covid-19 to the UK with beneficial results in China which the UK managed not to emulate.

21.1.1 An elegant demonstration of how epidemics are focused by epicentres of the contagion is given by the hierarchy of Wuhan a city in Hubei a province in China.

21.1.1.1 Wuhan has a population of 11m (11 million) in a province Hubei with a population of 59m in China a country with a population of 1.4bn (1400 million).

21.1.1.2 Wuhan is commonly treated as the origin of the Covid-19 virus and contagion

21.1.1.2.1 Studies showing Covid-19 presence in the west before January 2020 rather complicate matters

21.1.1.2.1. The issue is not material to our demonstration.

21.1.1.2.2 We are focusing on the severity of a contagion as it might be experienced at it epicentre and in its expanded regions of its province and of its country

21.1.1.2.3 We are not claiming any particular epidemic expertise.

21.1.1.2.4 We are merely pointing out what actually happened in the real world and in a particularly significant location given its position in the Covid-19 story

21.1.1.3 As of March 15th WHO reported 67,794 cases and 3085 deaths for Hubei the province containing Wuhan.

21.1.2.3.1 It was the last such report as the China contagion was essentially over so a regional provincial breakdown was presumably deemed not material

21.1.2.3.2 There were 34 such provinces listed with a total cases and deaths March 15 of 81,048 and 3,204 respectively.

21.1.2.3.2 Thus Hubei represented 80% of China's cases and 97% of China's deaths.

21.1.2.3.2.1 That doesn't actually convey the severe difference between risk in Hubei vs risk elsewhere

21.1.2.3.2.2 We can adjust for population or calculate the deaths and cases as a percentage of the population. Either method will assist. We choose the percentage of the population method.

21.1.2.3.2.3 Hubei cases and deaths represented 0.115% and 0.005% of the population respectively.

21.1.2.3.2.4 Being outside Hubei represented 0.001% of the population in cases and 0.00001% in deaths.

21.1.2.3.2.5 Thus being inside Hubei was 118 times riskier in cases and 600 times risker in terms of deaths.

21.1.2.3.2.5.1 We note that we're citing figures from our spreadsheet and doing to at conveniently readable levels of accuracy. Attempting to do the same calculations with our stated figures may give different factors as a result of the rounding for presentation purposes.

21.1.1.4 Wikipedia presents data for Hubei and Wuhan for 4th June 2020.

21.1.1.4.1 Little had changed between March 15th and June 4th with 341 further cases but 1427 further deaths.

21.1.1.4.1.1 Early figures in China and Hubei included cases by medical diagnosis rather than confirmed cases when such confirmation was not yet possible.

21.1.1.4.1.2 341 cases cannot generate 1427 deaths and so we treat the vast majority of that figure as being retroactive classification of deaths as the new confirmation process was available.

21.1.1.4.1.3 It does not materially affect the percentages for our purposes.

21.1.1.4.2 The Wikipedia June 4th data notes 50,340 cases and 3,869 deaths for Wuhan population 11,081,000. The same table by adding up the non-Wuhan regions or subtracting Wuhan from the total provides 17,795 cases and 643 deaths for a population of 48,091,662.

21.1.1.4.2.1 Thus the risk for Wuhan in cases and deaths was 0.454% in cases and 0.0349% in deaths.

21.1.1.4.2.2 The risk for non-Wuhan in Hubei was 0.037% and 0.0013% in cases and deaths respectively.

21.1.1.4.2.3 Thus being in Wuhan was 12 times riskier than being in Hubei but not Wuhan for cases and 26 times riskier for deaths.

21.1.1.4.2.4 Recall that being in Hubei was 118 times riskier in cases and 600 times riskier in deaths than being in China but not Hubei.

21.1.1.4.2.5 Being at the epicentre of the contagion Wuhan was 1453 times riskier in cases than being in China outside Hubei and 15,664 times riskier in deaths.

21.1.1.4.2.6 You didn't want to be in Hubei while Covid-19 was active and you definitely didn't want to be in Wuhan.

21.2 Thus in China there was a strong distinction between the origin of the contagion Wuhan and its surrounding province Hubei, and then a further strong distinction between the origin province Hubei and its containing country China.

21.2.1 We observed no such distinction in the UK with the four nations enjoying simultaneous contagions with the three mainland nations of England, Wales and Scotland having not merely simultaneous contagions but contagions which were of similar magnitude as a percentage of the population.

21.2.1.1 The contrast with China could not be stronger.

21.2.1.1.1 The UK experienced a very strange contagion if it was supposed to be natural.

21.2.1.1.2 The UK experienced a contagion inconsistent with an epicentre and spread but consistent with a policy directive.

22.0 China vs Select Countries

22.1 We put the hierarchy of Wuhan, Hubei and China in perspective with other key countries

22.2 We will use our standard Normalised to 100m Population for convenience.

22.2.1 Thus at 66.25m (million) people for the UK, a raw figure of 10,000 will be expressed as 15,000

22.2.2 This allows us to compare magnitudes of cases and deaths across very different contexts

22.2.3 The figures are equivalent to eg: deaths per million or deaths as a percentage of the population

22.2.4 We chose the 100m benchmark as a convenient fit between the UK and USA

22.3 For non-China and China the nation we use numbers to 24th June roughly the end of the primary contagion for western nations

22.3.1 China was long over by this point so the figures are comparable

22.4.1 Wuhan to 4th June experienced 3869 deaths or 34,916 deaths per hundred million (DPCM).

22.4.1.1 We refer to normalised population cases and deaths as NP cases and deaths

22.4.1.2 Once we declare we are using normalised figures all figures are normalised unless otherwise stated

22.4.1.3 For narrative purposes to focus on the essentials we will round declared figures to two sig figures

22.4.1.4 Thus Wuhan experienced 35k (35,000) normalised deaths per hundred million

22.4.2 Hubei ex-Wuhan experienced 1300 deaths DPCM so fared nearly 30 times better

22.4.2.1 China ex-Hubei experienced 10 DPCM so 130 times better than Hubei-ex Wuhan

22.4.2.2 At 10 DPCM China ex-Hubei was 3500 times better than the epicentre Wuhan

22.4.2.3 Overall Hubei reported 5200 DPCM as of March 15th 7600 post adjustment 4th June

22.4.2.4 Overall China reported 224 DPCM to March 15th 325 DPCM post adjustment

22.5 It should be noted just how significant geographic spread and its containment were in China

22.5.1 These figures were all available March 15th before PF published and a full week before PM BJ sent us into lockdown

22.5.2 Blockade, not lockdown, was highly effective.

22.5.2.1 Either that or the virus was extremely reluctant to spread geographically

22.5.2.2 Lockdown can hardly be argued to have spared Wuhan relative to Hubei or Hubei relative to China

22.5.2.2.1 Lockdown's subsequent failure can hardly be considered a surprise

22.5.2.2.2 Yet Lockdown was the government's primary initiative

22.5.2.2.3 No attempt at blockade to separate regions, counties or nations was implemented

22.5.2.2.4 Instead those nations experienced a highly unusual simultaneous contagion

22.6 Now consider the severity of the select nations.

22.6.1 The USA experienced 36,000 deaths to 24th June DPCM as all figures in this context will be quoted.

22.6.1.1 The Continental USA, 331 million people, 50 states, countless cities, massive rural and desert areas, managed to exceed the severity of the very epicentre of Covid-19, a compact densely populated city of 11 million people.

22.6.1.2 That's quite an achievement.

22.6.1.3 The entire USA was hit five times harder than the epicentre province in China

22.6.1.4 The entire USA was hit 100 times harder than the entire of China.

22.6.1.5 The USA was a prime candidate for blockade between states and isolating cities

22.6.1.5.1 As far as we're aware no effective attempt was made to institute such

22.6.1.5.2 The single most blatantly obvious conclusion from looking at WHO's Daily Situation Reports and their breakdown by province was utterly ignored by the west and as far as we know every other nation on the planet

22.6.1.5.3 We find that astonishing to say the least

22.6.2 The UK trumped the USA with 65,000 deaths to June 24th DPCM.

22.6.2.1 The UK managed to nearly double (1.9 times) the Covid-19 epicentre of Wuhan across the entire nation

22.6.2.2 It did so with simultaneous contagions in its core nations

22.6.2.3 It did so despite being a massive widely diversified nation across dozens of cities and major towns, widely dispersed in a characterised by greenery and countryside.

22.6.2.4 Yet the UK government managed to oversee a contagion twice as severe as the epicentre of Covid-19.

22.6.2.5 It was nearly nine times more severe than the comparable province of Hubei at 59m people even after the June 4th adjustment substantially increasing the Wuhan/Hubei/China death count.

22.6.2.6 In our first video presentation of 24th March we did the simple arithmetic to translate Hubei to the UK, 3085 x 66.25 / 59.17 = 3454 deaths (actual not DPCM).

22.6.2.6.1 That is equivalent to a DPCM figure of 5213 deaths.

22.6.2.6.2 That remains a rational comparison and suggested estimate and yet the UK managed to experience a contagion over 12 times worse.

22.6.2.6.3 The UK managed to exceed the China nation figures 290 times using the March 15th figures, 200 times post adjustment.

22.6.2.6.3.1 That is an absurdity.

22.6.2.6.3.2 Yes China is a massive continent enjoying a huge natural impediment to geographic spread.

22.6.2.6.3.3 Yet China is far from alone in having achieved low numbers as a nation as we'll see.

22.6.3 The only good thing that can be said about the UK contagion the second worst in the world at the time as a nation is that we weren't Belgium.

22.6.3.1 Notice that the UK is still considered a Global Player, a leading centre of finance, power, technology, and yes, science and pharmaceuticals.

22.6.3.1.1 Belgium is the headquarters of the EU, a Global Player, more significant arguably than the UK which I admit only reluctantly as a loyal Briton.

22.6.3.1.2 Belgium is not impoverished, disease-ridden Africa and yet here it is leading the world as the world's worst hit nation.

22.6.3.1.3 And Belgium does so with 83,000 deaths DPCM dwarfing Wuhan's 35,000 deaths.

22.6.3.1.4 Wuhan, the very epicentre of Covid-19 is outshone and outperformed by Belgium, home of the EU headquarters.

22.6.3.1.4.1 Rotten luck or extremely convenient?

22.6.3.1.4.1.1 The EU has always had plans for Europe.

22.6.3.1.4.1.2 Arguably that's its job.

22.6.3.1.4.1.3 Grand plans including the eradication of nations.

22.6.3.1.4.1.4 That's not its job.

22.6.3.1.4.1.5 Covid-19 and The Great Reset is official and embraced even in the UK.

22.6.3.1.4.1.6 How fortunate that Covid-19 hit so massively in the very nations where compliance is needed.

22.6.3.1.4.1.7 How fortunate that Covid-19 hit so massively in the very nations that are the world's leading global pharma nations.

22.6.3.1.4.1.8 How sad for the leading nations and how fortunate for the Central Bankers that they'll be extending massively profitable loans to the core western nations.

22.6.3.1.4.1.9 Qui Bono? Covid-19 is a massive win for Big Pharma, People who want to restructure our society, and Central Bankers and the people who own them.

22.6.3.1.4.1.10 And there are people who vociferously refuse to contemplate that the government could act against them and that Covid-19 in the West is anything but natural

22.6.3.1.4.1.11 Even when it's a hundred times more aggressive and deadly than the Far East

22.6.3.1.4.1.12 Even when there is simple and blatant misrepresentation and fraud

22.6.4 But at least Belgians could be grateful they weren't New York

22.6.4.1 New York under Governor Cuomo experienced a virus so insane we dubbed it the Cuomovirus.

22.6.4.2 New York City under Cuomo devastated Wuhan's status as the epicentre of Covid-19 with an overwhelming 221,000 deaths DPCM over 6 times Wuhan's total.

22.6.4.2.1 Apologists who wish to treat that as real should look to Singapore another City-State.

22.6.4.2.2 So while the USA was content to merely outdo Wuhan at 36,000 DPCM the financial Power Centre of the US and arguably the world would not be content with such a modest achievement.

22.6.4.2.3 Thus the triad of worst hit centres of the world were not the continents of impoverished, disease ridden Africa or the strange and massively crowded Far East, home to cheap labour and crowded conditions.

22.6.4.2.4 No the triad of worst hit centres were the three most powerful and richest power centres on the planet, western aligned at least.

22.6.4.2.5 Wealth, power, technology, science and home to pharmaceutical powerhouses was not enough to save USA/New York, UK and EU HQ Belgium from Covid-19.

22.6.4.2.6 Or perhaps we have that the wrong way round and it was never about wealth, power and Big Pharma saving the west at all.

22.7 The west, its governments and media and to a large extent its people are myopically focused on the narrative of the disaster and threat of Covid-19.

22.7.1 How strange that the rest of the world particularly the Far East and Africa have not shared that experience.

22.7.1.1 There is a simple and clear rule of thumb evident in the data.

22.7.1.2 The aggressiveness of Covid-19 increases dramatically almost exponentially the closer you get to a western power centre.

22.7.1.3 That isn't a virus.

22.7.2 Let us progress in the other direction and show a few illustrative results from the Far East.

22.7.2.1 China overall experienced 224 deaths DPCM by March 15th adjusted to 325 deaths DPCM by June 4th.

22.7.2.1.2 Note that the substantial increase in deaths had only a fraction of a matching increase in cases.

22.7.2.1.3 It was an adjustment we believe as better information became available on the original clinical-diagnoses.

22.7.2.1.4 But China is a massive continent (or sub-continent essentially) benefiting from a huge natural barrier to geographic spread.

22.7.2.1.5 Yet its results were closely matched by other countries as we'll see in a world review in a separate section.

22.7.2.1.6 Here we focus on just a few Far Eastern nations to highlight the difference from the west.

22.7.2.2 Korea (Republic of, South) experienced 539 DPCM against Hubei at 5214 March 15th and 7625 adjusted so doing ten to fifteen times better than Hubei.

22.7.2.2.1 At 539 DPCM that was 64 times better than Wuhan, 10 (March 15th) to 14 (June 04) times better than Hubei, 66 times better than the USA, 120 and 154 times better than the UK and Belgium, 410 times better than New York and an astonishing 1427 times better than UK Ferguson.

22.7.2.2.2 Korea didn't lock down.

22.7.2.2.3 It was also well on the way to completion, the first non-China country to do so, as Ferguson published and PM BJ took us into lockdown.

22.7.2.2.4 Did the UK government ever care to ask how they'd done it?

22.7.2.2.4.4.1 We suspect that the British people would have appreciated having only 360 deaths instead of 40,000+ deaths.

22.7.2.2.5 At 539 deaths DPCM vs China at 325 it was a very respectable result without the massive advantage of being 1.4 billion people spread out over a landmass that was a continent or sub-continent in its own right by any reasonable measure.

22.7.2.3 A complete contrast to China and even Korea, Singapore is a City-State with only 5.7m people and it managed 456 deaths DPCM.

22.7.2.3.1 Singapore at 456 deaths DPCM is a bit of a contrast with New York City at 221,000 DPCM.

22.7.2.3.1.1 We wonder how New Yorkers would have felt if someone had pointed out they could have 480 times fewer deaths, if only they weren't led by Cuomo or could transport themselves to Singapore.

22.7.2.4 New Zealand, larger in landmass but not in population enjoyed 439 DPCM.

22.7.2.4.1 New Zealand is a recognised Anglo nation.

22.7.2.4.1.1 If there was a genetic bias to Covid-19 against the west it wasn't evident in NZ.

22.7.2.5 Australia another Anglo nation enjoyed 396 DPCM a result not far off China's 325 DPCM

22.7.2.5.1 Did anyone notice that you had to be in the west near a western power centre to be so massively hit?

22.7.2.5.1.1 The media certainly didn't notice how two entire continents or regions – the Far East and Africa – were brushing off the virus with ease.

22.7.2.5.1.2 An occasional article might surface with a tone of surprise as to how well a singular nation was doing: Japan, it must be masks. Korea, social obedience.

22.7.2.5.1.2.1 Somehow in an excruciating display of allegiance to the agenda the mainstream media managed to make these massive counter-examples to the threat of Covid-19 into socially-responsible messages for compliance.

22.7.2.5.1.2.2 What they never pointed out was that Japan wasn't an anomaly. Korea wasn't an anomaly. With the entire Far East and Africa brushing off the virus it was we the western power centres who were the anomaly.

22.8 What were we doing wrong?

22.8.1 Wrong is a relative term depending on the perspective of the viewer.

22.8.1.1 It might be argued that sending sick people into care homes was wrong.

22.8.1.1.1 Unless it wasn't.

22.8.1.2 It might be argued that having the worst contagions in the world was terrible.

22.8.1.2.1 Unless it wasn't.

22.8.1.3 We'd been told from the outset (April 5th Fox News TP) that there would be no normal till the vaccine, a statement which became US, UK and Canadian public policy days later.

22.8.1.3.1 Massively hit western nations certainly helped that message along.

22.8.1.3.2 We doubt that the Far East or Africa will be as hungry for the vaccine.

22.8.1.3.3 In a strange counterpoint that makes the point Australia and New Zealand escaped with excellent results just like the rest of the Far East.

22.8.1.3.3.1 Yet as Anglo nations they have been subjected to the same indeed the worst and most exaggerated forms of the aggressive message against the people and for control and the vaccine.

22.8.1.3.3.2 With their results they should be celebrating and freeing us from the fraud and the agenda.

22.8.1.3.3.3 Instead they have been subjected to a barrage of programming that has been just as effective but for a threat 150 times less.

22.8.1.3.3.4 That statement alone should be enough to show that the message isn't determined by the threat.

22.8.1.3.3.5 The message is determined by policy.

22.8.1.3.3.6 And that policy is fraud.

23.0 Massive Threat – Not by Mortality

23.1 Any reasonable person experiencing the last nine months in the UK would reasonably conclude that Covid-19 was a serious threat indeed a massive threat to society.

23.1.1 Personal freedom, earnings, lives have been lost with massive damage to the economy and a correspondingly large massive increase in national debt to pay for testing, to pay for vaccines, to pay for recovery, to ring fence the public sector jobs vital to our safety

23.1.1.1 All of which will eventually have to be paid by the private sector shut down by the government

23.1.1.2 Covid-19 is the biggest win for centralising authority, work and the economy overturning all pretence at progress towards honouring the people who actually pay for the nation the private sector.

23.1.1.3 An alien vampire zombie invasion apocalypse might make such a transformation worthwhile or inevitable.

23.1.1.3.1 A virus shrugged off by the Far East and Africa and of only mild impact in the west does not.

23.1.1.3.2 Mild impact? Surely Covid-19 has been devastating in terms of mortality?

23.1.1.3.2.1 Actually not. A closely related calculation to those already illustrated as deaths per hundred million allows us to assess the impact of Covid-19 in terms or ordinary mortality.

23.1.1.3.2.2 People die and have continued to die as they have done throughout history.

23.1.1.3.2.3 And they die for all the usual reasons except apparently of the flu which is unusually mild this year by all accounts. Strange that.

23.1.1.3.2.4 We represent this mortality by a standard rate of 9 per 1000 reasonable for a western nation and apply it to our standard 100 million population for a rate of 900,000 per annum or 2464 per day.

23.1.1.3.2.5 We consider the period from the first death in a country to the end date being analysed.

23.1.1.3.2.5.1 Covid-19 deaths will be as reported.

23.1.1.3.2.5.2 Standard deaths as a benchmark are the day count from first death times 2464.

23.1.1.3.2.4.1 That is how many people nominally would have been expected to die during the period.

23.1.1.3.2.4.2 We are not attempting to adjust for winter, seasons, flu, national mortality figures or any such minor improvement.

23.1.1.3.2.4.3 We are looking to provide an order-of-magnitude measure indicative of the seriousness of Covid-19 vs normal life.

23.1.1.3.3 Covid-19 in Hubei our benchmark for a nation's experience represented 3.3% to 15th March 2.1% to 4th June.

23.1.1.3.3.1 A devastating virus that shut the world down and yet which represented only 2 to 3 percent of normal life's risk?

23.1.1.3.3.1.1 That would have been considered an absurdity and is considered an absurdity by anyone not programmed by the fear-generating messages from government.

23.1.1.3.4 Wuhan the very epicentre of Covid-19 experienced 10% of normal mortality specifically due to Covid-19.

23.1.1.3.4.1 So for five months, a city experienced a 10% boost in mortality, and that so panicked the world that it shut down?

23.1.1.3.4.1.1 Except the world didn't shut down.

23.1.1.3.4.1.2 A third of the world did including the UK and the US.

23.1.1.3.4.1.3 And it didn't change a thing.

23.1.1.3.4.1.4 But it did do massive damage.

23.1.1.3.4.1.5 And justify The Great Reset and the vaccine.

23.1.1.3.5 The USA experienced a 13% boost in mortality.

23.1.1.3.5.1 Given that the flu season boosts mortality [x] we're not sure that's adequate to justify the response.

23.1.1.3.5.1.1 But the response wasn't based on reality was it?

23.1.1.3.5.1.2 It was based on PF ICCRT R9.

23.1.1.3.6 The UK experienced a 23% boost in mortality.

23.1.1.3.6.1 Flu and winter in the UK generate a [x] boost in mortality.

23.1.1.3.6.2 Even with all the UK government could do to ensure we ended up as the 2nd worst hit nation on the planet Covid-19 never came close to replacing ordinary life as the biggest threat.

23.1.1.3.6.2.1 And of course 92% of those 'Covid-19' deaths were indeed down to ordinary life.

23.1.1.3.6.2.2 Comorbidities represented 92% of UK Covid-19 deaths

23.1.1.3.6.2.3 But Covid-19 got the credit

23.1.1.3.6.3 So Covid-19 was never close to usurping ordinary life as the major threat to life

23.1.1.3.6.3.1 Strangely neither the government nor mainstream media ever pointed this out

23.1.1.3.6.3.2 Instead we were being saved from PF ICCRT R9 by Lockdown

23.1.1.3.6.3.3 A lockdown that had had zero effect on cases and deaths

23.1.1.3.7 Belgium managed 32% of normal mortality and only New York came close in the real world to a claimed threat close to but still below ordinary life at 83%.

23.1.1.3.7.1 Even a threat 500 times exaggerated vs the Far East wasn't enough to break the grip of normal life as the prime and only serious source of death

23.1.1.3.7.1.1 Did any mainstream source or politician offer this calming and rational perspective?

23.1.1.3.7.1.1.1 They did not

23.1.1.3.7.1.1.2 We did as one of the first things we pointed out in our first presentation March 24th Peerless Reads YouTube

23.1.1.3.7.1.1.3 As a result of that video and over 90 others we have had countless thank you's for keeping people sane by their own estimation.

23.1.1.3.7.1.1.4 The overwhelming message of the government and mainstream media has not been sane, calm, balanced or in context.

23.1.1.3.7.1.1.4.1 The message has focused single-mindedly on Covid-19 the threat and the hope that has been offered has been the vaccine

23.1.1.3.7.1.1.4.2 It is the biggest and most vile sales pitch in history

23.1.1.3.8 There is only one obvious candidate beyond New York's absurdity and that is Ferguson's ICCRT R9 510,000 UK deaths, 2.2 million US deaths which represented 250% of normal mortality, essentially double.

23.1.1.3.8.1 ICCRT R9 Figure 1A suggests a first death around 20th April and last death around 20th August.

23.1.1.3.9 While Ferguson was offering over double mortality, the Far East of course was experiencing figures in an entirely different realm.

23.1.1.3.9.1 The Far East was commonly reporting figures around 0.1% of mortality with a number showing 0.0% which means less than 0.05% mortality.

23.1.1.3.9.1.1 The real world was showing results 2500 times better than Ferguson and yet he still has the temerity to emerge and declare that lockdown saved 470,000 lives in the UK.

23.2 Reality has quite literally been usurped by a government and advisers determined that we should not encounter reality but should only encounter the massive threat.

23.3 How else to sell the vaccine?

24.0 The Strange Case of The Care-borne Virus

24.1 The two primary sources for UK based local analysis are the ONS and the NHS national sites

24.1 It is unfortunate that in the name of giving 'national identity' to the regions we do not have a single integrated data source for NHS specific data

24.1.1 The only slight compensation is that with the data provision not being uniform sometimes one service will prove to be more helpful with additional information

24.1.2 This does not in our view compensate for the loss of a uniform data source across the UK

24.1.3 By default we therefore first work with NHS England as the largest population component and only work with Scotland, Wales and N. Ireland when a particular need arises

24.1.3.1 One such need is to demonstrate that unusual phenomena in England are not England specific

24.1.3.2 Another such need is to support national communities in social media who have a natural focus on their own region and who seem reluctant to consider that an observation in England can apply to them also

24.1.4 The particularly useful sources for this section are the NHS hospitalisation data and the ONS weekly deaths data

24.1.4.1 The NHS Hospitalisation data for England is published as eg: 'Covid-Publication-12-11-2020_v4-CB.xlsx' from https://www.england.nhs.uk/statistics/wp-

content/uploads/sites/2/2020/11/Covid-Publication-12-11-2020_v4-CB.xlsx available at https://www.england.nhs.uk/statistics/statistical-work-areas/covid-19-hospital-activity/

24.1.4.2 Our analysis used the earlier August 'Covid-Publication-13-08-2020.xlsx'

24.1.4.2.1 Having been doing and publishing analysis since Mar 24th we do not feel obliged to bring each piece of research up to date with the latest source

24.1.4.2.2 Given that barring the need to cover testing and second wave we are focused on the unusual and fraudulent features of the early and primary contagion there is no merit to using later data sources when the early data sources and analysis have already been used and performed

24.1.4.3 The ONS Deaths data for the UK is published as eg: 'publishedweek472020.xlsx' from https://www.ons.gov.uk/file?uri=%2fpeoplepopulationandcommunity%2fbirthsdeathsandmarriages%2fdeaths%2fdatasets%2fweeklyprovisionalfiguresondeathsregisteredinenglandandwales%2f2020/publishedweek472020.xlsx available at https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales

24.1.4.3 As with the NHS national issue this too is England-and-Wales rather than an integrated data source for the UK

24.1.4.3.1 We work with what we've got and it is sufficient to show anomalies in one nation particularly when that nation is England and contains and is represented by Westminster the overall government of the UK

24.2 Within the NHS 'Covid-publication' there are two tabs of particular interest in this context.

24.2.1 The 'Admissions Total' tab is described as 'Provider Level Data - Admissions - Number of patients admitted with COVID-19 (Last 24hrs)' in a title above the data.

24.2.1.1 The 'Diagnoses Total' tab is described as 'Provider Level Data - Diagnoses - Total number of inpatients diagnosed with COVID (Last 24hrs)'

24.2.1.2 Notice the key distinctions 'patients admitted with COVID-19' vs 'inpatients diagnosed with COVID'.

24.2.1.2.1 That seems to be a clear distinction between "we are receiving a Covid-19 victim" and "we have an existing patient and have discovered that they have Covid"

24.2.1.2.2 Thus the inference is that the latter were admitted for reasons other than Covid-19

24.2.1.2.3 Had they been admitted by reason of Covid-19 then they would have been included as an Admission tab entry rather than a Diagnosis of inpatient tab entry

24.2.1.2.4 An important test would be to prove that the two tabs are discreet and independent so that you cannot both be an 'Admitted with Covid' and 'Inpatient diagnosed as Covid'

24.2.1.2.4.1 Recent versions of the data include an further tab 'Reported Admissions and Diagnoses'.

24.2.1.2.4.2 This is described as 'Provider Level Data - Total reported admissions to hospital and diagnoses in hospital'

24.2.1.2.4.3 The figures in this series [agree with/closely agree with] the sum of the two tabs for Admissions with Covid and Inpatients diagnosed with Covid.

24.2.1.2.4.2 Thus the two categories do appear to be independent and to comprise the total NHS covid diagnoses

24.3 What we appear to have here is two very different scenarios for infection with Covid-19

24.3.1 We have people external to the NHS patient population who enter the NHS as patients because they have contracted covid and we have a second group of people already in the NHS patient population for reasons other than covid who are then diagnosed as having covid

24.3.1.1 It is not unreasonable to suggest that since covid is supposedly a transmissible disease not an intrinsic risk or condition of being human that if someone admitted for non-covid reasons subsequently turns out to have covid then that new condition of Covid-19 infection occurred while they were in the NHS as an inpatient

24.3.1.1.1 That is after all the label on the tab 'inpatients diagnosed with COVID'

24.3.1.1.2 We belabour this point because this is going to be a rather dramatic figure that emerges

24.3.2 Thus we have external Admissions being the general public (including potentially OAPs from Care Homes) who are the same people being sold the massive risk, lockdown, be responsible, save lives, save the NHS mantra

24.3.2.1 That latter "Save the NHS" is going to be particularly ironic as will be seen shortly

24.3.2.2 And we have the internal Diagnoses being the existing patients in the NHS care who sadly and unfortunately managed to get infected with Covid-19 while in the care of the NHS

24.3.2.2.1 Already notice that this doesn't seem exactly encouraging.

24.3.2.2.1.1 If the professionals of the NHS cannot manage the spread (or non-spread) of viral infections within their hospitals, what does that say about their professionalism and procedures?

24.3.2.2.1.2 We recall the twerking videos which the NHS thought funny enough to share with us while they were supposedly being overstressed and overwhelmed with Covid-19

24.3.2.2.1.3 Given the government measures which have overstressed and overwhelmed the people of this nation, their lives and freedoms, their financial capacity, their jobs and the economy, no, we didn't find that display particularly funny at all

24.3.2.2.1.4 Nor since we mention displays did we particularly enjoy the macabre scenario supposedly to entertain us at the opening of the [2012] Olympics.

24.3.2.2.1.4.1 Frankly looking back it looks like a remarkably prescient piece for the scary story of Covid-19 and a far stretch from the traditional nurse as gentle angel of healing

24.3.2.2.1.4.2 Nevertheless suffice it to say that Covid-19 spreading in and through hospitals doesn't sound very encouraging

24.3.2.3 Catching Covid-19 while in hospital for other reasons has already made the news

24.3.2.3.1 It was referenced in an early in contagion terms article in [March] in the [Guardian] as

[x]

24.3.2.3.1.1 The article disclosed a government admission that [as much as 20% of covid victims [admitted to the NHS] were by internal transmission within the NHS.

24.3.2.3.1.1.1 That again is already a disturbing number.

24.3.2.3.1.1.2 The two populations are extremely dissimilar in size with 66 million people not patients of the NHS and around [100k] patients within the NHS for England and Wales which comprises the overwhelming majority of the UK population

24.3.2.3.1.1.3 In fact presumably due to the emptying of hospitals in anticipation of Covid the patient figures in NHS England and Wales were far lower at [50k] initially in March rising to [x] by June

24.3.2.3.1.1.3 With a ratio of [660 to 1 at capacity, 1320 to 1 at the start of Covid and [x] on average over the course of the primary contagion, the expected proportion without other factors is between 0.15% and [0.075%] of patients internally infected.

24.3.2.3.1.1.4 For 20% to be infected is therefore [is a minimum two hundred times worse] within the NHS.

24.3.2.3.1.1.5 Again, this does not sound encouraging as regards the professionalism and procedures of the NHS

24.3.2.3.1.1.6 However that was merely a publicly declared and admitted figure at 20%.

24.3.3 Now we examine that same scenario using the data in the two tabs

24.3.3.1 We do so with the November 'Covid-Publication-12-11-2020_v4-CB.xlsx' version of the NHS England and Wales Covid publication

24.3.3.2 Our interest is examining the primary contagion

24.3.3.2.1 We deal with the 'second wave' separately

24.3.3.2.2 Cases reached a minimum for England at 533 per week on 1st July

24.3.3.2.2.1 The date is convenient so we will treat the primary contagion as being from first case through to June 30th

24.3.3.2.2.2 We habitually also use 24th June as a significant date as we developed a world ranking analysis published on that date

24.3.3.2.2.3 For purposes of analysis the two are essentially interchangeable. The primary contagion was over in either case.

24.3.3.2.2.4 Deaths at the end of June were running at around 35 per week.

24.3.3.2.2.4.1 Deaths would continue to decline to a minimum of 6 per week at the end of August

24.3.3.2.2.4.2 Considering that around 1360 people die every day in Britain neither of those figures is significant.

24.3.3.2.2.4.3 Indeed on 8th April Covid achieved its peak lethality at 975 deaths that day and so not even at its worst did it manage to exceed three-quarters of a normal day's deaths.

24.3.3.2.2.4.3.1 Factor in comorbidities at over 90% and Covid-19 without comorbidities managed on its worst day to reflect no more than around 7% of a normal days deaths

24.3.3.2.2.4.3.2 It's difficult with those sorts of numbers to envisage a government imposing such a massive degree of harm

24.3.3.2.2.4.3.3 And devastating to recall that these figures are 100 times worse than the Far East and Africa

24.3.3.2.2.4.3.4 Nevertheless we revert to the assessment

24.3.4 We will examine the primary contagion.

24.3.4.1 All figures are for England

24.3.4.1.1 All figures are quoted to 30th June

24.3.4.2 Total 'Admissions with Covid-19' were 23,546.

24.3.4.2.1 Total 'Inpatients diagnosed with Covid' were 85,649.

24.3.4.2.1.1 Total diagnoses (admissions and inpatients) were therefore 109,195.

24.3.4.2.1.2 Inpatients diagnosed with covid represented 78% of the total diagnoses

24.3.4.2.1.3 Admissions with covid represented only 22% of the total diagnoses

24.3.5 We belaboured our earlier discussion as to the meaning of 'Inpatients diagnosed with Covid' for a very good reason

24.3.5.1 If an inpatient diagnosed with covid is an admitted not for covid but diagnosed as covid then there are two scenarios

24.3.5.1.1 They were admitted for some other trauma or condition and as part of the admissions process they were tested and found to be covid positive

24.3.5.1.1.1 The deadly virus had struck again and the medical reason for admission was now incidental

24.3.5.1.2 Our immediate problem with that is that wouldn't they then count as an Admission not an Inpatient diagnosis?

24.3.5.1.2.1 It will require the government to clarify the definition and defend against the scenario these figures seem to present

24.3.5.1.2 The other scenario is that the patient was as described an inpatient a patient already existing and admitted for non-Covid reasons who subsequently got infected with covid

24.3.5.1.2.1 That is certainly what the wording suggests

24.3.5.1.2.2 It is what creating it as a distinct category from Admissions suggests

24.3.5.1.2.2.1 Else why not simply recognise that anyone 'coming in' might be Covid-positive and upon testing it turned out they were

24.3.5.1.2.2.2 Or are we to believe that at the height of the contagion the NHS was 'surprised' to find that covid had been lurking among its patients unnoticed for weeks or months?

24.3.5.1.2.2.3 It would be easy for the government to come up with a definition that excused the result and the interpretation

24.3.5.1.2.2.4 It will be far less easy for us to find an excuse to be plausible

24.3.5.1.2.2.4.1 This will be even more clear when we consider the charts and what they tell us

24.3.6 Barring extraordinary re-interpretation the likely scenario being presented by the data is that 78% of England's NHS Covid cases were internally generated.

24.3.6.1 The mantra was 'Save the NHS'

24.3.6.1.1 Did the government really mean Save the NHS from Itself?

24.3.6.1.2 Or worse, did an NHS responsible for 78% of its Covid cases suit the narrative?

24.3.7 Consider that the government has made clear from the beginning the massive threat of Covid

24.3.7.1 Then consider the further message that is both expressed explicitly and signalled by the measures implemented by the government

24.3.7.2 We are the threat.

24.3.7.2.1 We the public are the threat

24.3.7.2.1.1 We the public need to be locked down

24.3.7.2.1.1.1 We the public need to socially distance

24.3.7.2.1.1.2 We the public need to wear masks

24.3.7.2.1.1.3 We the public need to obey and be responsible

24.3.7.2.1.1.4 Just for a short while

24.3.7.2.1.1.4.1 A few weeks to Save the NHS from being overwhelmed

24.3.7.2.1.1.4.2 Nine months later the message and agenda continues full strength

24.3.7.2.2.1.4.3 With the second wave finally upon us we now must prepare for a third wave

24.3.7.2.2.1.4.4 Measures into 2021 are being discussed

24.3.7.2.2.1.4.5 Measures into 2022 even are being discussed

24.3.7.2.2.1.4.6 Airlines won't fly you without a positively negative test.

24.3.7.2.2.1.4.6.1 It's not enough to not feel ill or not be in a vulnerable category

24.3.7.2.2.1.4.6.2 You have to be positively absolutely tested and confirmed as negative for Covid.

24.3.7.2.3 Because you are the threat

24.3.7.2.3.1 You are the threat to your fellow citizens

24.3.7.2.3.2 You are the threat to society

24.3.7.2.3.3 You are the threat to the NHS

24.3.7.2.4 When all along it seems the NHS was the threat to the NHS

24.3.7.2.4.1 The NHS was the threat to society

24.3.7.2.4.2 It was used deliberately and shamelessly to control the people

24.3.7.2.4.3 And all along it was the main source of Covid infection

24.3.7.2.4.3.1 Our context is the NHS but consider that patients with Covid were sent back to their care homes

24.3.7.2.4.3.1.1 It is not much of a stretch to say that the NHS caused or contributed to the Care Home Cull as many regard it

24.3.7.2.4.3.1.2 And between the NHS deaths overall and Care Home deaths you have the vast majority of Covid deaths

24.3.7.2.4.3.1.2.1 That's simple numbers.

24.3.7.2.4.3.1.2.2 Of course people overwhelmingly died in hospital. Where else would they?

24.3.7.2.4.3.1.2.3 Except It wasn't quite overwhelming. 63 percent, two thirds, in hospitals with 30 percent in Care Homes.

24.3.7.2.4.3.1.2.3 But it wasn't supposed to be two thirds in hospitals with over three-quarters of those being internal infection.

24.3.8 Taking 78% internal infection and multiplying by 63% and you get 49%.

24.3.8.1 Do that accurately using the actual figures and it's 50% (49.65%).

24.3.8.2. That's a very nice round number. It would look good in a headline.

24.3.8.3 "HALF OF COVID DEATHS DUE TO INTERNAL NHS INFECTION"

24.3.8.4 Add in Care Home deaths and you get another nice number 80% (79.62%).

24.3.8.5 "80% OF COVID DEATHS IN MANAGED CARE"

24.3.8.6 If the Mainstream Media (MSM) wasn't so fully behind the agenda they might actually do the research and print those headlines.

24.3.8.7 Those headlines are legitimate until the government proves otherwise.

24.3.8.7.1 To have caused 30% of Covid deaths by deaths in Care Homes should have been enough to bring down the government

24.3.8.7.1.1 The government made a particular point that the important thing was to protect the vulnerable

24.3.8.7.1.2 Yet it seems the populace just wants to be saved.

24.3.8.7.1.2.1 Holding the government to account appears to be beyond them.

24.3.8.7.1.2.2 Doing the research seems to be beyond them.

24.3.8.7.1.2.3 Noticing what's happening or not happening in the rest of the world seems to be beyond them.

24.3.8.7.1.2.4 It is hardly surprising that social media discusses the hypnosis of the people, the Stockholm Syndrome, the sheep or the sheeple.

24.3.8.7.1.2.5 It is left to the court to apply justice and sanity where democracy the government and the people are failing to do so.

24.3.8.8 The government may have escaped the Care Home issue

24.3.8.8.1 It may escape this particular issue of internal infection

24.3.8.8.1.1 It may do so by clarifying the definition

24.3.8.8.1.2 It may escape simply because the people have no interest or power

24.3.8.8.1.2.1 This was clearly demonstrated in the matter of WMD

24.3.8.8.1.2.2 It is not enough to know the government has lied if we have no power to remove them

24.3.8.8.1.2.3 We are doing our best to remove them

24.3.8.8.1.2.3.1 It is our civic duty and obligation if we are to live under a just government

24.3.8.8.1.2.3.2 A just government doesn't lie in pursuit of an agenda

24.3.8.8.1.2.3.3 A just government doesn't do harm in pursuit of an agenda

24.3.8.8.1.2.3.4 WMD arguably clearly did both though largely the harm was not to the British people

24.3.8.8.1.2.3.5 This time with Covid the lies and harm are present but the harm is overwhelmingly done to the British people

24.3.8.8.1.2.3.6 Saving us or just saving us for the vaccine?

24.3.8.8.1.2.3.6.1 That's a rhetorical question. The answer is already plain.

24.3.8.8.1.2.3.6.2 The vaccine is being trumpeted as we write this.

24.3.8.8.1.2.3.6.2.1 The Pfizer indemnity is in place.

24.3.8.8.1.2.3.6.2.2 The disclaimers that it hasn't been tested for its effect on fertility are in place.

24.3.8.8.1.2.3.6.2.3 NHS staff appear not to keen to get the vaccine and so won't be a priority on rollout after all

24.3.8.8.1.2.3.6.2.4 And at a hundred times fewer deaths in the Far East and Africa, they won't have to worry about the vaccine's safety

24.3.8.8.1.2.3.6.2.5 Unless like Australia and New Zealand their governments are pushing the massive threat and overwhelming fear agenda despite results which to us should look miraculous

24.3.8.8.1.2.3.6.2.6 But no one notices. Not in the mainstream. Not the public.

24.3.9 The headlines again.

24.3.9.1 "HALF OF COVID DEATHS DUE TO INTERNAL NHS INFECTION"

24.3.9.2 "80% OF COVID DEATHS IN MANAGED CARE"

24.3.9.3 Those numbers are what the NHS England and ONS England data are saying.

24.3.9.4 The only question is whether the NHS when it says "inpatients diagnosed with Covid" means 'inpatients diagnosed with covid because if you're an inpatient you were admitted and if you were admitted with covid you'd be in Admissions with Covid so you weren't admitted with covid.

24.3.9.5 Which means the inpatient contracted it while at hospital.

24.3.9.6 It's difficult to see how that can be wrong or inaccurate.

24.3.9.7 As such the headlines stand until the government proves otherwise.

24.4 It would be useful if we had an independent means of checking this interpretation.

24.4.1 A test. Wouldn't it be nice if we could test this?

24.4.1.1 Testing is after all a topical topic.

24.4.2 There is indeed an analysis that sheds some light on the matter and which corroborates our conjecture that 'inpatients diagnosed with covid' means 'infected with covid in hospital'.

24.4.2.1 By peak analysis as we've already seen in Case-Death lag we can observe a timeline by the dates on which peaks of a condition occurred.

24.4.2.1.1 In Case-Death lag we observed that if the cases peaked on 11th April and patients were supposed to survive 14 days on average between diagnosis and death then you'd expect the peak for deaths to be on the 25th April.

24.4.2.1.1.1 In fact the UK peak occurs almost simultaneously in the raw WHO data and within 3 days using a [3 day] average.

24.4.2.1.1.2 Neither of those is an encouraging figure.

24.4.2.1.1.2.1 Either you were diagnosed and dead within three days.

24.4.2.1.1.2.2 Or the figures are fraudulent.

24.4.2.1.1.2.3 It will take a (criminal) investigation to distinguish which is accurate if not both.

24.4.2.2 If you attempt to disregard the time between peaks and assign a different interval then the ratio eg: Case-Death ratio or CFR becomes wildly oscillating

24.4.2.2.1 That is a very useful fraud indicator eg: our Lag 14 for deaths CFR number.

24.4.2.3 Thus we can extend the peak analysis to examine multiple contexts

24.4.2.3.1 We can review the WHO data using the ONS data for the UK and for England

24.4.2.3.2 We can examine the peak data for Admissions vs Inpatient diagnoses

24.4.2.3.3 We can examine the timing of NHS diagnoses vs ONS cases vs ONS deaths

24.4.2.3.4 We have done each of these

24.4.2.4 A summary of the results is as follows

24.4.2.4.1 WHO data lags in cases by 2 days and in deaths by 4 days

24.4.2.4.1.1 This is done by lagging back WHO vs ONS data on a chart until they overlap

24.4.2.4.1.2 Notice that this would make deaths 2 days earlier vs cases than is currently apparent in WHO data

24.4.2.4.1.3 This would take the UK Case-Death lag to minus 1.5 days (deaths peak prior to cases peak) in raw data and 1 day Case-to-death lag based on the 3-day average

24.4.2.4.1.3.1 In other words they would make an already strong fraud indicator into a fraud indicator flashing ‘absurd’ – blatant fraud.

24.4.2.4.1.3.2 Or ‘outrageous error’ but seriously are politicians going to get away with ‘mistakes were made’ yet again?

24.4.2.4.1.4 As it happens the ONS current data looks remarkably smooth and gets the WHO data off the hook

24.4.2.4.1.4.1 We do wonder how the ONS has managed to finally put together such a tidy data series when its original and ‘honest’ reporting provided a chaotic time series

24.4.2.4.1.4.2 No doubt the government has had time in the intervening months to ‘get it right’

24.4.2.4.1.5 However either the government doesn’t understand the significance of case-death lag or it doesn’t care or it simply cannot be seen to change the data enough at this late stage

24.4.2.4.1.6 Because the case death lag using date of death and the official ONS data for the UK shows two very tidy peaks 3 days apart.

24.4.2.4.1.6.1 We can nudge them even to 4 days apart and the two resulting lagged curves for deaths bracket the cases curve to peak almost perfectly.

24.4.2.4.1.6.2 So the official case-death lag for the UK and for England appears to be 3 days or 3.5 days

24.4.2.4.1.6.2.1 That corroborates the original average-based delay in WHO data despite the difference in lag-matches between ONS and WHO

24.4.2.4.1.6.2.1 It still isn’t very long. To say that you were diagnosed and dead within three days does not seem very encouraging.

24.4.2.4.1.6.2.1.1 It also contradicts eg: Germany and other countries where the peaks are a very reasonable 14 days apart as previously noted.

24.4.2.4.1.6.2.1.2 And it isn’t as bad as Spain where you die the same day you’re diagnosed.

24.4.2.4.1.6.2.1.2.1 Case-death lag in Spain is zero days

24.4.2.4.1.6.2.1.2.2 The curves sit on top of one another.

24.4.2.4.1.6.2.1.2.3 It is an outcome so absurd that it highlights that the UK is not alone in this agenda.

24.4.2.4.1.6.2.1.2.4 Nor is it alone in being willing to perpetrate fraud or worse in pursuit of that agenda.

24.4.2.4.2 We examined the peaks for Admissions with Covid vs Inpatients diagnosed with Covid

24.4.2.4.2.1 If the public caused internal infections by being admitted with covid then there should be a one week lag between peaks due to incubation period of Covid-19.

24.4.2.4.2.2 Instead Inpatient diagnoses peaks on the 3rd April. Admissions peaks on the 5th April.

24.4.2.4.2.3 Thus far from corroborating the ‘innocent’ interpretation that everything was normal, the public just came in and infected us, the data contradicts that.

24.4.2.4.2.4 Even had we not examined the ratio and percentages of Admissions to Inpatient diagnoses this would still be an issue.

24.4.2.4.2.5 Just as you're not supposed to die of covid before you're diagnosed with covid or die the same day or die even within three days so you're not supposed to have the hospitals leading the way in being infected.

24.4.2.4.2.6 But maybe diagnosed doesn't mean infected.

24.4.2.4.2.6.1 That of course is a massive issue in the second wave and testing.

24.4.2.4.2.6.2 In the primary contagion things almost made sense even when they didn't.

24.4.2.4.2.6.3 Hospitals leading the way in infections doesn't make sense in the narrative of Save the NHS.

24.4.2.4.2.6.3.1 Save Us From The NHS would be more appropriate.

24.4.2.4.2.6.4 But hospitals leading the way in infections does make sense if infections, cases, deaths are advantageous to your position and you happen to be both paymaster and controller of the NHS.

24.4.2.4.2.6.4.1 And the NHS cases and deaths have sold the vaccine, no question.

24.4.2.4.2.6.4.2 It's just that by leading the way as cause rather than victim, it rather changes the narrative from Nightingale to Nightmare.

24.4.2.4.2.6.4.2.1 Maybe the Olympics ceremony was trying to tell us something after all.

24.4.2.4.2.7 Thus even if the ratios between Admissions with covid and Inpatients diagnosed with Covid had been different we would still have had this issue.

24.4.2.4.2.7.1 Whether we'd have troubled to do the analysis without the disturbing ratios is a moot point

24.4.2.4.2.7.2 With 78% of NHS diagnoses being inpatient diagnoses the peak analysis supports the picture of the NHS as an independent source of infections because it manages to peak before the Admissions and long before the Admissions peak plus seven-day or so incubation

24.4.2.4.3 NHS Diagnoses ONS Cases and ONS Deaths by Date of Death

24.4.2.4.3.1 Again by peak analysis we look at the timing and sequence of the three elements of an NHS diagnosis, declaration as an ONS case and declaration of a death by date of death.

24.4.2.4.3.1.1 That it is by date of death is important. As such there is no delay in the date.

24.4.2.4.3.1.2 We can therefore consider any derived case-death lag to be accurate at least as regards the date of death

24.4.2.4.3.1.3 If the ONS case declaration is by date of sample that two will be within a matter of a day or few days depending on the performance of the lab or procedure

24.4.2.4.3.1.4 We have no specific data to address that particular lag

24.4.2.4.3.2 Again using England data for convenience we see three peaks for the primary contagion for NHS diagnoses, ONS cases and ONS deaths respectively and in that order.

24.4.2.4.3.2.1 NHS Diagnoses peak on the 3rd April, ONS cases two days later on the 5th and ONS deaths 4 days later on the 9th.

24.4.2.4.3.2.1.1 There is a slight uptick to the 10th but the 9th is more consistent with the curvature of a peak and so we use that.

24.4.2.4.3.2.1 A simple interpretation of that would be that you are diagnosed with Covid on the 3rd which gets reported on the 5th and you're dead on the 9th.

24.4.2.4.3.2.2 That extends the ONS case-death lag from 4 days to an NHS-ONS diagnosis-death lag of 6 days.

24.4.2.4.3.2.2.1 That still doesn't seem very long to be keeping someone alive with modern medicine.

24.4.2.4.3.2.2.1.1 ONS case death lag at 4 days is markedly shorter than eg: Germany and other nations at 14 days

24.4.2.4.3.3 Notice the sequence.

24.4.2.4.3.3.1 It is not fell ill, went to a doctor, got tested, came back positive, taken to hospital.

24.4.2.4.3.3.1.1 The ONS case does not precede the hospital diagnosis upon admission or within the hospital for an inpatient.

24.4.2.4.3.3.1.2 Rather the hospital leads with its diagnosis and the ONS case then follows.

24.4.2.4.3.3.1.3 Within the hospital we know that inpatients dominate vs admissions.

24.4.2.4.3.3.1.4 The hospital leads the case discovery and inpatients dominate as the class of case.

24.4.2.4.3.3.1.5 We would not say that this is definitive in and of itself.

24.4.2.4.3.3.1.5.1 It is sufficient to draw attention to the role of the hospital as a leading candidate for being the source of the infection.

24.4.2.4.3.3.1.5.1.1 It is up to the government or NHS or investigators to demonstrate how that sequence is consistent with the narrative of a massive surge of public infections and illness sweeping the nation.

24.5 Overall the NHS data on Admissions with Covid vs Inpatients diagnosed with covid clearly shows that Inpatient diagnoses dominated at 78% of diagnoses in the primary contagion period.

24.5.1 They cannot have been admitted with covid else they would be recognised in that category instead.

24.5.1.1 NHS covid diagnoses appear to be the sum of these two independent categories by comparison of the sum with the new category of all diagnoses admissions and inpatients.

24.5.2 If they weren't admitted with covid then they were admitted as non-covid.

24.5.3 That implies that if subsequently diagnosed with covid then they got that infection in the hospital.

24.5.4 That implies that 78% of NHS covid diagnoses were from internal infection.

24.5.5 With hospitals accounting for 63% of covid deaths then 78% x 63% equals 50% of covid deaths were by internal infection.

24.5.6 Add the 30% of covid deaths in Care Homes where the government is already censured for its actions and you have that 80% of covid deaths are in managed care.

24.6 Even if the government should break that chain of logic they have already admitted to 20% of NHS diagnoses being from internal infections

24.6.1 In that case the calculation would be 20% of 63% or 12.5% plus 30% for a total of 42% of covid deaths being in managed care.

24.6.2 Even at that lower figure having over 40% of covid deaths being as a result of being infected while in managed care looks literally care-less and contrary to the governments claimed priority of protecting the vulnerable.

24.7 At 42% of covid deaths being due to infection while in managed care there is a severe issue.

24.7.1 At 80% of covid deaths being due to infection while in managed care it demolishes the claim that there was a contagion among the public which was caused by the public.

24.8 Consider that the declarations available on social media from NHS staff are inimical to open debate and transparency as to the facts of Covid in the NHS

24.8.1 I have personally received an email from an NHS nurse who recorded how a doctor came round when her father had just died and the doctor was very keen to record him as covid

24.8.2 I am personally aware of instructions to follow the government guidelines else there will be disciplinary action

24.8.3 Other reports speak of prohibitions from speaking to the media which naturally are not an issue provided the speaker is pro-agenda

24.8.4 Other reports speak of empty hospitals and the dismantling of the Nightingale hospitals for want of patients to attend to

24.8.4 Other reports speak of NHS staff handling supposedly dangerously infectious patients positively diagnosed with covid without the slightest concern or masks or precautions

24.8.5 While all these reports are anecdotal and circumstantial that does not make them without merit

24.9 When the NHS and ONS data make a plausible case for a minimum 42% of covid deaths and possible 80% of covid deaths being attributed to infection while in managed care we believe that merits being taken most seriously.

24.9.1 If the figure remained at the low end it would be a scandal except that it seems that the massive-threat mantra has so cowed people that apparently the saviour government can get away with anything.

24.9.2 If the figure is proved by investigation to be at the high end then it is beyond scandal and becomes a criminal action.

24.9.2.1 That scenario at 80% of deaths by infection in managed facilities cannot be considered a natural event.

24.9.2.2 We cannot prove wrongdoing without investigation but if eight people die in a fire an investigation seems the minimum sensible action.

24.9.2.2.1 Of the 40,000 deaths to end of June in the primary contagion the possibility declared by the government's own data is that 32,000 of those were in managed care by internal infection.

24.9.2.2.2 That would not be a contagion.

24.9.2.2.2.1 That would be massive wrongful death or as it is considered online a cull of the elderly.

24.9.3 Sadly we cannot trust the government or NHS or any body taking orders from the government to investigate the very actions of the government.

24.9.3.1 We do not need another WMD.

24.9.3.2 We do not have an answer as to who could be trusted with such an investigation.

24.9.3.3 We merely highlight what the numbers say.

24.9.3.4 And until the government or NHS proves otherwise they seem to be declaring that 80% of covid deaths were in managed care.

25.0 Understanding the Scope, Relevance and Importance of Our Work

25.1 We began our presentations March 24th in the early hours of the morning after hearing Johnson's misguided and inappropriate lockdown call.

25.1.1 Our first action even as he was speaking was to get up, put on a coat and drive to 10 Downing Street to point out that he'd been badly misinformed and had made a bad decions

25.1.1.1 By the time we reached Westminster an hour or so later from Kent we realised several things.

25.1.1.1.1 We realised that this was not a casual decision

25.1.1.1.2 We realised that he was unlikely to change that decision because one old guy thought he'd made a fundamental mistake

25.1.1.1.3 We realised that we'd be advertising ourselves as an opponent at a time when there really were no obvious opponents

25.1.1.1.4 Recalling Dr Kelly we decided that discretion was the better move

25.1.1.1.5 We began our presentations on reaching home

25.1.1.1.6 The first was published on Peerless Reads YouTube on March 24th

25.1.1.1.7 As an aside we had written an e-book with essentially the same material

25.1.1.1.7.1 It was blocked by Amazon

25.1.1.1.8 Remarkably and probably due to our lack of significant viewer count we have not been blocked on YouTube

25.1.1.1.8.1 Our first video garnered 300,000 views. Our recent videos might reach 1000.

25.1.1.1.8.1.1 Against which the loyalty and respect for our work from viewers on YouTube and Facebook is heartwarming

25.1.1.1.8.1.2 We are recognised as and regularly recommended as one of the leading figures online when it comes to analysis of covid

25.1.1.1.8.1.3 We also have been repeatedly thanked for in the viewers' words "keeping us sane"

25.2 Our reports have evolved from a simple tracking and demonstration of non-exponential normal growth in the contagions with manual data tracking every three days to coverage of all covid-affected nations with daily data courtesy of the WHO dashboard data download.

25.2.1 Our standard chart is actually six charts and a data and statistics section

25.2.1.1 Our primary chart shows cases and deaths, daily and cumulative, with Hubei for reference on log scales and a standard daily mortality level with both raw data and averages.

25.2.1.2 Our secondary charts show specific aspects of a country's contagion

25.2.1.2.1 We show a cases autofit and daily growth rate

25.2.1.2.1.1 This needs to be modified with tests now distorting 'true' cases away from the primary contagion

25.2.1.2.1.2 This illustrates the declining growth rate of the contagion not exponential

25.2.1.2.2 We show a deaths autofit and daily growth rate

25.2.1.2.2.1 This similarly demonstrates the declining growth rate of the contagion not exponential

25.2.1.2.3 We show a cases-deaths lag (cases and deaths to same scale to show overlap) which is an indicator of the naturalness or lack thereof of the get-sick-die-later interval.

25.2.1.2.4 We show a percent of standard mortality chart

25.2.1.2.4.1 This shows the daily deaths as a percent of standard daily deaths (2464 per 100 million standard population that we use) which therefore mirrors the daily deaths but scaled to standard mortality

25.2.1.2.4.1 We scale the chart from zero to 100% where 100% means deaths from covid are equal to the normal standard deaths in that country on that day

25.2.1.2.4.1.1 The only nation to have achieved that is Belgium on precisely two days achieving 2790 and 2617 vs standard 2464.

25.2.1.2.4.1.2 Thus in the entire world with over 200 countries only one country which managed to exaggerate the deaths by 133 times vs the Far East managed even for a day to reach normal death risk from life and did so for precisely two days and exceeded the normal death rate on those two days by a minimal amount.

25.2.1.2.4.1.3 That same country managed and overall mortality rate to July 11th of 23% of normal deaths

25.2.1.2.4.1.3.1 The worst hit nation in the entire world did not manage to exceed a quarter of the deaths from normal life

25.2.1.2.4.1.3.1.1 We don't shut down our economies and do immense harm for normal life

25.2.1.2.4.1.3.1.1.1 Apologists will say that was only because of lockdown

25.2.1.2.4.1.3.1.1.2 We've shown that definitively lockdown had zero effect on reducing the rate of growth of the contagion

25.2.1.2.4.1.3.1.1.3 The rate of growth is always and was already declining in a normal contagion including covid

25.2.1.2.4.1.3.1.1.4 The harm of lockdown is clear and well publicised in terms of loss of freedom, loss of earnings, emotional distress, increased harm, increased deaths including suicides and a devastating hit on the economy with an equally devastating uptake of debt to 'cope' with covid.

25.2.1.2.4.1.3.1.1.4.1 The issue of lockdown itself should be sufficient to see politicians in jail for their fraudulent and heinously damaging policy of same

133 times worse hit than the Far East and disregarding that comorbidities were over 90% (UK, US and Italy, Belgium presumably similar) and that the death risk from Covid was essentially identical to the normal risk from life (14% risk per annum for age 80 appears reasonable) and t

25.2.1.2.4.1.3.1.2 Belgium's 23% overall mortality to 11th July ignores factors which reduce the significance of the figure still further

25.2.1.2.4.1.3.1.2.1 It ignores comorbidities where in excess of 90% of covid deaths had at least one and typically two pre-existing conditions (US, UK and Italy figures, Belgium likely similar)

25.2.1.2.4.1.3.1.2.2 It ignores that the average age of death was over 80 years of age

25.2.1.2.4.1.3.1.2.2.1 At this age the natural mortality is around [14%] per annum

25.2.1.2.4.1.3.1.2.2.2 That is coincidentally or not similar to the covid death rate of 14%

25.2.1.2.4.1.3.1.2.2.3 However for the covid death rate of 14% you actually have to have the disease

25.2.1.2.4.1.3.1.2.2.4 Factor in the risk that you actually catch covid and the actual risk becomes miniscule

25.2.1.2.4.1.3.1.2.2.4.1 Unless of course the government manages to make you a target by virtue of being in the NHS or in a Care Home.

25.2.1.2.4.2 Ultimately covid-19 never came close to matching normal life overall in any nation and in most nations especially in the Far East and Africa it barely registered.

25.2.1.2.4.2.1 PF of course at 510,000 deaths was proposing a real risk of 81% of a normal year

25.2.1.2.4.2.1.1 We do not consider Sweden to be entirely trustworthy but even no-lockdown Sweden did not manage more than 15% of normal mortality overall to 11th July and did not exceed 72% even on its worst day.

25.2.1.2.4.2.1.1 Thus PF predicted 81% infected and 81% of a normal year's deaths many times higher than even the egregiously exaggerated and disproportionate deaths in the west.

25.2.1.2.4.2.1.1.1 Compared to figures available for the rest of the world particularly the Far East and Africa his figures are an absurd exaggeration of the order of 80 times with typical Far East overall mortality commonly at around 1% of normal mortality.

25.2.1.2.4.2.1.1.2 And courtesy of China in-depth and as it turns out perfectly reasonable and therefore presumably accurate reporting by comparison to other world nations Ferguson knew that at the time.

25.2.1.2.4.2.1.1.3 The Hubei level of cases was 0.11%.

25.2.1.2.4.2.1.1.3.1 Even tripling that to allow for asymptomatic infected that's an infection rate of 0.33% vs 81% for an exaggeration of the order of 240 times.

25.2.1.2.4.2.1.1.3.2 But ICCRT R9 was effective.

25.2.1.2.4.2.1.1.3.2.1 It sold the threat

25.2.1.2.4.2.1.1.3.2.2 It sold lockdown

25.2.1.2.4.2.1.1.3.2.3 It sold the massive UK deaths total as being saved when we were the second worst hit nation in the world and 122 times worse hit than the Far East

25.2.1.2.4.2.1.1.3.2.4 It sold the vaccine

25.2.1.2.4.2.1.1.3.2.5 And TP said thank you with a $79 million grant in that same month to Imperial College for 'Malaria' a grant totally disproportionate to the few grants in the previous two years and yet no doubt massively appropriate by coincidence when an Imperial College report fully supports and indeed effectively triggers the agenda and sequence rehearsed in TP's supported Event 201 and described in detail in TP's April 5th Fox News interview.

25.2.1.2.4.2.1.1.3.2.5.1 No doubt the people of Africa who've brushed off Covid will greatly appreciate Imperial College's work on the centuries (millennia) old issue of Malaria if Imperial College isn't too distracted by Covid.

25.2.1.2.4.3 Thus yes we include a percent of standard mortality chart as a useful sub-chart.

25.2.1.2.5 Finally as a sub-chart we include the daily death rate and overall death rate as a CFR Case Fatality Ratio

25.2.1.2.5.1 We present an overall death rate as a constant which is therefore a horizontal line

25.2.1.2.5.2 We also present simple and lagged death rates on daily data

25.2.1.2.5.2.1 You're not supposed to die the day you're diagnosed

25.2.1.2.5.2.2 Lagging the death data to cases sometime earlier is therefore theoretically more accurate

25.2.1.2.5.2.2.1 Unless the reports are fraudulent in which case in the rising contagion the death rates are going to show absurd levels prior to peak as high deaths are mapped back to low cases

25.2.1.2.5.2.2.2 We treat a 14-day Case-Death lag as typical and responsible based essentially on the fact that Germany shows perhaps the most responsible charts in the entire world and has a well-defined 14-day Case-death lag

25.2.1.2.5.2.2.2.1 It also seems a not unreasonable figure though lacking clinical data it is difficult to find a definitive case-death lag from public information

25.2.1.2.5.2.2.2.2 At the very least we suggest that a week seems a rather poor effort at keeping someone alive

25.2.1.2.5.2.2.2.2.1 Three days seems very poor and same day death as diagnosis is absurd

25.2.1.2.5.2.2.2.2.2 Yet three days is the UK figure and same-day is the Spanish lack of lag

25.2.1.2.5.2.3 The gradient of the lagged death rate is also instructive.

25.2.1.2.5.2.3.1 A lag that exceeds the country's reported case death lag will show high initial values descending as the contagion progresses

25.2.1.2.5.2.3.2 A lag that is too short will show low initial values rising as the contagion progresses

25.2.1.2.5.2.3.2.1 This is recognised with for example today's deaths over today's cases since it is widely understood that you get sick then later you die not both on the same day.

25.2.1.2.5.2.3.2 A lag that is just right will be horizontal with slight variation so that eg: if people are cases today and die 12 days later then a 12-day lag will accurately capture the ratio between them as being near constant for a plausible constant CFR.

25.2.1.2.5.3 As such the death-rates sub-chart is an excellent fraud indicator.

25.2.1.2.6 It should be noted that each chart in its own way is a fraud indicator

25.2.1.2.6.1 The main chart on log scales reveals the fraud of exponential as data curls over

25.2.1.2.6.1.1 It also reveals the fraud of exaggeration by reference to Hubei

25.2.1.2.6.2 The autofit cases and deaths reveal the fraud of exponential due declining growth rates

25.2.1.2.6.2.1 They also reveal the common normal contagion and charts with are literally ab-normal

25.2.1.2.6.2.2 In principle they also show the failure of lockdown with the constantly and already declining growth rates but in practice this is best shown on a larger scale independent chart

25.2.1.2.6.3 The cases-deaths lag reveals the fraud of people dying far too early to be appropriate

25.2.1.2.6.4 The mortality sub-chart reveals multiple fraud indicators

25.2.1.2.6.4.1 Overall mortality shows the absurdly high deaths in the West vs the Far East

25.2.1.2.6.4.1.1 Technically there are multiple charts and data that show this same issue

25.2.1.2.6.4.2 Overall mortality shows the fraud of the massive threat meme

25.2.1.2.6.4.2.1 It never approaches normal life even in the west and in the Far East and Africa it's typically 0.1% or 1000 times less risky than normal life and that's without regard for comorbidities and age risk.

25.2.1.2.6.4.2.1.1 Factor comorbidities in alone and that's a 10 times reduction (90% comorbidities) taking Covid to 10,000 times less risky than normal life in the Far East and Africa.

25.2.1.2.6.4.2.1.1.1 We'd have to confirm Far East and African comorbidities to be definitive and we're using the US and European figures.

25.2.1.2.6.4.2.1.1.2 Nevertheless it makes the point that even those few deaths were overwhelmingly of the old and already sick. Harsh but true.

25.2.1.2.6.4.2 2 Peak daily mortality and the daily line shows the same points but most evocatively that for eg: the Far East and Africa covid was flatlined and never a material issue and that even in the

west it managed to look like an issue for only a short time and never was a material threat exceeding normal life barring those two days for Belgium.

25.2.1.2.7 In short our charts contained as a dashboard style panel are more than enough to flag whether a country appears responsible or fraudulent.

25.2.1.2.7.1 The non-nation that shows such flags to a degree that is so absurd as to be darkly entertaining is New York City

25.2.1.2.7.1.1 Although not a WHO nation we can included local independent data sets by appending them to the WHO data and including them thereby as regions to be mapped.

25.2.1.2.7.1.2 We applied this based on local or special interest and in practice that has meant the following occasional inclusions.

25.2.1.2.7.1.2.1 Hubei as the origin of the contagion though that is now contested

25.2.1.2.7.1.2.2 New York City for its macabre display of the absurd and its relevance to the USA

25.2.1.2.7.1.2.3 Scotland for its interest in its own data not that of England or the UK overall

25.2.1.2.7.2 Where on June 24th Belgium had managed 133 times the Far East and the UK 122 times the Far East, New York City had managed an astonishing [500] times.

25.2.1.2.7.2.1 At 100 times the Far East, that isn't Covid.

25.2.1.2.7.2.1.1 At 500 times the Far East that is theatre deserving its own name.

25.2.1.2.7.2.1.2 Thus we dubbed the New York experience the Cuomovirus.

25.2.1.2.7.2.1.2.1 Cuomo's video appearance crying out for more ventilators remains a burning image of the Covid-19 experience worldwide.

25.2.1.3 Adjacent to the charts we have a data section

25.2.1.3.1 This section lists over 60 data points or statistics often the figures associated with key conditions in the charts such as peak daily percent mortality or overall percent mortality

25.2.1.3.2 Overall mortality as a note is counted from the first covid death in that country to the date of the chart.

25.2.1.3.2.1 Thus at 2464 deaths a day then for 100 days that Is 246,400 deaths from normal life.

25.2.1.3.2.2 If actual covid deaths were around 120,000 then that is just under half so that would represent a figure of just under 50% of normal daily mortality

25.2.1.3.2.3 The actual figure would be 120,000 / 246,400 or 48.7% essentially 49%.

25.2.1.3.2.3.1 The spreadsheet obviously works to exact figures so that even 2464 is not 2464 but 900,000 / 365.25 the 9 per 1000 for our 100 million population divided by 365.25 days to get an exact figure of 2464.0657 to four decimal places.

25.2.1.3.2.3.2 Being concerned about such accuracy is spurious.

25.2.1.3.2.3.2.1 Had PF been wrong by a fraction of a percent it would have been truly a miracle of science.

25.2.1.3.2.3.2.2 Being wrong even by 100% would have been perfectly acceptable for an estimate.

25.2.1.3.2.3.2.3 Exaggerating by 8000% or 13,700% is not acceptable especially when the real world is right there to give you reasonable data.

25.2.1.3.2.3.2.4 These are decision support tools and whether the UK is 122 times or 97 times the Far East doesn't really matter.

25.2.1.3.2.3.2.4.1 What matters is that either way it's around 100 times worse than the Far East

25.2.1.3.2.3.2.4.2 How on earth did the UK, Belgium, USA and core EU nations manage that?

25.2.1.3.2.3.2.4.2.1 Because that achievement was entirely optional as the rest of the world's data clearly shows.

26.0 What we don't do

26.1 It's worth re-iterating that our natural interest and ability is around translating data into statistics and statistics into observations especially where the statistics contradict official stories.

26.2 There is a whole world of research that is being done on other areas that highlights the agenda and fraud of covid-19 worldwide and in the UK.

26.3 Our primary concern is to catch lies and compare the reality as disclosed by government data and contrast it with the story being promoted by government

26.4 It is ironic that we use government data to discredit the government's statements but that is also it's strength

26.4.1 If we are accused of lying then it's the government's data that's doing the lying

26.4.1.1 So the government is lying

26.4.2 If the data shows the government is lying then the government is lying

26.4.2.1 So the government is lying

26.4.3 Either way when our analysis discredits the government's story then the government is lying

26.4.3.1 And yes we strongly warn against 'mistakes were made'.

26.4.3.2 Nobody writes a report by mistake

26.4.3.3 Nobody gets basic arithmetic so wrong especially not a group that styles itself SAGE

26.5 What we don't do therefore tends to be topics that are not so clear cut

26.6 We also tend not to do topics that are adequately covered elsewhere

26.6.1 Research into the strange case of the disappearing flu in 2020 is an example of such

27.0 Local Geographic Spread

27.1 We've touched on the simultaneous contagions with almost identical profiles (N. Ireland lower peak) contradicting the 'community spread' or 'outbreak' models of a virus contagion.

27.2 We can also look at the localised spread of the infection within UK nations.

27.3 Consider the nature of everyday life, socializing and interaction.

27.3.1 How many trips of over 100 miles to you make by comparison to trips of over 10 miles and under ten miles?

27.3.1.1 Barring travelling salesmen and long-distance lorry drivers we suggest that most people's lives centre around their homes, their schools, their local village and nearest town or mall.

27.3.1.1. Their nearest town is likely to be the one they live in or one within a very few miles.

27.3.1.2 We live in a highly urbanised society. The greatest concentration of social proximity occurs in towns and cities.

27.3.1.2.1 We note that the rural population is harder to infect than the urban population by empirical observation.

27.3.2 Is there any claimed psychoactive component to Covid-19 that gives infected people a compulsion to travel widely to spread the virus?

27.3.2.1 When people feel sick and come down with symptoms of a cold or virus do they feel more compelled to travel widely to ensure everyone experiences their misfortune?

27.3.2.2 Or do sick people tend to want to stay home, in bed preferably, and definitely avoid work?

27.3.3 Thus we live in a highly concentrated environment of towns and cities, with the bulk of our lives spent locally, and if we get sick we get even more insular and tend to hide.

27.3.3.1 What would the natural interpretation of a 'contact' or 'proximity' contagion look like in that environment?

27.3.3.1.1 The people most at risk are those close to you.

27.3.3.1.1.1 The strangers most at risk are those in your local shopping mall or school.

27.3.3.1.1.2 There is a dense and populous target environment for the spread of a virus and it's right next to the sick person, in their home, within a mile or so at their local school or shopping centre, and if they are not already in a town or city, it is in the mall or local town perhaps once a week.

27.3.3.1.1.3 This is entirely consistent with the message threat and policy of lockdown, social distancing, masks, one-way systems in shops.

27.4 What does a viral contagion particularly one with the characteristics of Covid-19 look like in that environment?

27.4.1 Covid-19 has an incubation period reportedly of the order of 7 days and 5 to 10 days would be a reasonable period.

27.4.1.1 The CDC references 2 to 14 days as the incubation period.

27.4.1.2 What at least seems to be agreed upon is that there is at least a delay of some days before you will show symptoms.

27.4.1.3 It is suggested in media and is plausible that the most dangerous time as a spreader is the 24-48 hour window post latency and prior to the end of incubation when you will finally show symptoms.

27.4.1.3.1 In that short window, the individual doesn't know they're infected but they're infectious and shortly will discover that they're infected, at which point by dint of social awareness or simply feeling poorly, they would automatically bias towards self-isolation, regardless of the illness and regardless of the government's mandate.

27.4.1.3.1.2 Pulling a sickie is an enthusiastic pastime for those without illness. With an illness we are even less inclined to work or go to school.

27.4.1.3.2 We will leave science to debate the nature of infectiousness but the observation that an infected individual will become infectious a few days later and may spread it in a window before they become aware that they're infectious seems reasonable, and that they can continue to be infectious for around 14 days also seems reasonable.

27.4.1.3.3 The key principle is that people are not instantly infectious.

27.4.1.3.3.1 There is a delay of a few days.

27.4.2 From our simple perspective as to concentrated society, the target environment for an infected person to infect others is focused locally.

27.4.2.1 As more people become infected, this concentration increases.

27.4.2.1.1 That is to say that as a law of mathematics, while one person can be an 'outlier' and behave essentially randomly, travelling perhaps to Scotland from Dorset that very day, the behaviour of larger groups rapidly conforms with expectation.

27.4.2.1.2 That means that one person may infect three others in their immediate local environment.

27.4.2.1.2.1 A few days later, they too become infectious apparently before they're even aware of symptoms and so they too go about their local life, overwhelmingly exposing themselves to local people within a mile or a few miles at the local town or shopping mall.

27.4.2.1.2.1 The exponential meme may be fraudulent when extended to the path of the contagion but it is compelling because over very short time periods the growth is approximately exponential, with a divergence that follows a triangle progression, rapidly degrading the 'constant growth' of a true exponential.

27.4.2.1.2.2 Thus those locals going about their lives locally are infecting others in a near-exponential manner, or at least that's what's supposed to happen.

27.4.2.1.2.2.1 What they are not doing is suddenly becoming possessed to travel long distances to ensure that the next county enjoys the benefit of Covid-19 instead of their local community.

27.4.2.1.2.2.1.1 Whether one thinks petri dish or fire or Chinese whispers, things which spread by contact or local transmission are concentrated locally first, and spread by the borders of that localised phenomenon contacting previously untouched matter.

27.4.2.1.2.2.1.1.1 Yes we have air-travel but we do not translate mass-communities or entire villages by air to and from infected regions.

27.4.2.1.2.2.1.1.1.1 An infected traveller may arrive in Britain, but they are even more vulnerable to the localised phenomenon.

27.4.2.1.2.2.1.1.1.1.1 They're likely to be getting sick especially with a nominally aggressive virus like Covid-19.

27.4.2.1.2.2.1.1.1.1.2 They're easily monitored and tracked by dint of the formalised nature of international travel documentation.

27.4.2.1.2.2.1.1.1.1.2.1 Indeed as we should address elsewhere, the time for Track and Trace is not at the end of a contagion to keep the fear going, but right at the start with less than a handful of cases to follow up on.

27.4.2.1.2.2.1.1.1.2 We've also heard a 'skiers brought it back from holiday' in regard to Scotland and the Shetlands

27.4.2.1.2.2.1.1.1.2.1 This brings up a second issue in regard to travellers especially 'skiers'

27.4.2.1.2.2.1.1.1.2.1.1 Skiing is an active pastime in fresh air at high altitude

27.4.2.1.2.2.1.1.1.2.1.2 Skiing is an invigorating pastime pursued by overwhelmingly fit and healthy individuals at an altitude that encourages or requires high blood oxygen.

27.4.2.1.2.2.1.1.1.2.1.3 Covid is nominally a debilitating illness thriving on low blood oxygen either by creating that or taking advantage of that and overwhelmingly attacking and killing those already old and sick

27.4.2.1.2.2.1.1.1.2.1.4 How many old and sick people do you notice in ski resorts?

27.4.2.1.2.2.1.1.1.2.1.5 And where would you naturally look to find old and sick people?

27.4.2.1.2.2.1.1.1.2.1.5.1 Care Homes and Hospitals.

27.4.2.1.2.2.1.1.1.2.1.5.2 And where do the diagnoses and deaths overwhelmingly occur?

27.4.2.1.2.2.1.1.1.2.1.5.2.1 Care Homes and Hospitals

27.4.2.1.2.2.1.1.1.2.1.5.2.2 The idea that Jimmy can come home from school and infect grandpa is a great meme for social conditioning.

27.4.2.1.2.2.1.1.1.2.1.5.2.1.1 The people who are actually around old and sick people however are hospital and care home staff.

27.4.2.1.2.2.1.1.1.2.1.5.2.1.1.1 The government admits to 16% internal infection.

27.4.2.1.2.2.1.1.1.2.1.5.2.1.1.2 With a co-ordinated simultaneous contagion overwhelmingly led by inpatient diagnoses claiming the old and sick we know two things:

27.4.2.1.2.2.1.1.1.2.1.5.2.1.1.2.1 The skiing holiday meme is a distractor.

27.4.2.1.2.2.1.1.1.2.1.5.2.1.1.2.2 The NHS is the prime suspect in how Covid 'spread' or didn't.

27.5 Examining England and Scotland data contradicts the 'community spread' or 'outbreak' model that is being touted as responsible for the UK contagion.

27.5.1 As we've seen the community spread or outbreak models are perfectly reasonable and plausible.

27.5.1.1 It's just that they aren't what happened.

27.5.2 We look at England with its regions London, Midlands, North East (and Yorkshire), North West, South West, South East and East.

27.5.2.1 As with the nations (England, Wales, Scotland, Northern Ireland), the regions experienced remarkably synchronous contagions for a virus that's supposed to spread, not jump or coordinate.

27.5.2.2 Looking at the Inpatients Diagnosed With Covid by the NHS which dominate (78%) Covid diagnoses (vs Admissions with Covid) we see a remarkably synchronous and well-ordered set of contagions across the regions of the UK.

27.5.2.2.1 Bear in mind that Ferguson et al suggest a figure of 3:1 or so for infected to symptoms.

27.5.2.2.1.1 We use a ready-reckoner of 10:10:10 infected to cases (serious enough for treatment) to deaths.

27.5.2.2.1.1.1 Actual figures will vary by country.

27.5.2.2.1.1.1.1 The UK has a Case Fatality Ratio (CFR) of anywhere between 13% and 100% depending on the context so using 10% is forgiving and generous in the case of the UK.

27.5.2.2.2 We expect the individual who became the first case to be part of a local contagion that will rapidly spread and come to the notice of the NHS and government.

27.5.2.2.2.1 This is the ideal time to track and trace and nip the contagion in the bud.

27.5.2.2.2.1.1 Remarkably the government showed no interest in such an action which had reduced South Korea's contagion to one tenth that of Hubei, home to Wuhan and the worst hit province in China.

27.5.2.2.2.2 Unhindered the contagion grows locally and sooner or later one of those infected will have a trip to make to a neighbouring county. Eventually someone will make a trip unfortunately to an entirely new region.

27.5.2.2.2.2.1 The new county will potentially start a new contagion, days later from the odds of an infected person choosing to travel, and further delayed by the latency period before the local residents in the new county themselves start to infect others.

27.5.2.2.2.2.2 The new county will likely be in the same region so it will show up as a contributor to the stats in the same region as the original contagion.

27.5.2.2.2.2.2.1 Trips further afield to new regions will be rarer. Empirically we suggest that people make trips of over 100 miles perhaps once a month if actively having a reason, more like once every six months for most families we would suggest.

27.5.2.2.2.2.2.2 Regardless of that exact travel profiles and percentages it is clear that overwhelmingly we are local people, a local society first, and that the greater the distance, the less frequent the journey and the far smaller the percentage of social contacts and opportunity to spread disease.

27.5.2.2.2.2.2.3 Thus while the contagion rapidly gains a foothold in the original town and county, and may spread within a relatively short time (a matter of a week perhaps or two weeks) to start a new contagion, the disparity between the too should be obvious and significant.

27.5.2.2.2.2.2.4 That difference will be even more marked in neighbouring and then distant regions.

27.5.2.2.2.2.2.4.1 Tracked on a chart of cases per region we'd expect two key features.

27.5.2.2.2.2.2.4.1.1 We'd expect a gradient of severity as the original region surges ahead.

27.5.2.2.2.2.2.4.1.2 We'd expect a timeline of delayed starts, easily a week, likely weeks to a month before the contagion took hold in distant regions.

27.5.2.2.2.2.2.4.1.2.1 This is even more reasonable given the dramatic and disturbing emphasis given to Covid by the government.

27.5.2.3 That is not what we see.

27.5.2.3.1 What we see instead is near simultaneous contagions.

27.5.2.3.1.1 There are two methodologies for examining their timing.

27.5.2.3.1.1.1 We can examine their onset and early spread.

27.5.2.3.1.1.1.1 This is not possible with England data that we've found since the first case data is available from March 19th by which time the early contagions are already established in all regions.

27.5.2.3.1.1.2 We can examine their peaks and contagion profiles.

27.5.2.3.1.1.2.1 Since the England regional contagions show well-defined and smooth contagions we believe that similarly to case-death lag the comparison of the timing of the contagions by peaks is very reasonable.

27.5.2.3.1.1.2.2 London, Midlands and the North West all peaked on the 3rd April.

27.5.2.3.1.1.2.2.1 On the 5th April, the North East and South East both peaked

27.5.2.3.1.1.2.2.2 On the 6th April, the East and South West both peaked.

27.5.2.3.1.1.2.3 What happened to a virus 'spreading'?

27.5.2.3.1.1.2.3.1 If these were charts of a vaccine programme being rolled out nationwide, then such a consistency would be unremarkable and indeed if there were any significant delay to eg: the North West the Guardian would be publishing articles about the nefarious actions of the Tories.

27.5.2.3.1.1.2.3.2 This isn't a vaccination programme. It's supposed to be the Chinese Whispers spread by personal contact of a virus from somewhere (itself a good question, unanswerable without the early data), developing locally, then regrettably spreading after the government ignores the opportunity to contain the local infection.

27.5.2.3.1.1.2.3.2.1 Pick any region, even the most central one – Midlands – and expect it to develop there, fail to be contained, and sadly someone travels so while the Midlands rages on, a new centre develops, and then since the government manages not to contain that either, someone travels and a new centre develops, maybe a week or two later in each case, and as it gets to a centre outside the region, a new region starts up.

27.5.2.3.1.1.2.3.2.2 What we don't expect is a contagion so well co-ordinated or a virus so well-travelled that every region is covered, active, and peaked within three days of each other.

27.5.2.3.1.1.2.3.2.3 It wasn't a vaccine rollout, but it certainly looks like a co-ordinated program across the entire nation rather than the natural progress of a virus.

27.5.2.3.2 Bearing in mind that these were Inpatient Diagnoses and that we have yet to have the sending-infected-into-Care-Homes scandal, what of Admissions with Covid?

27.5.2.3.2.1 Inpatient Diagnoses were for patients in the care of and under the control of the NHS who are under the control of the government.

27.5.2.3.2.1.1 The government may 'take advice' but it mandates policy.

27.5.2.3.2.1.2 'Admissions with Covid' have the potential to be slightly different.

27.5.2.3.2.1.2.1 Someone admitted with Covid has presumably seen their GP or some such and has been tested and confirmed positive and Is deemed sufficiently unwell that a hospital stay is required.

27.5.2.3.2.1.2.2 Thus they have come in from the outside world, been diagnosed by the outside world, and are accepted into the NHS.

27.5.2.3.2.1.2.2.1 The NHS in an email to me were as ever entirely helpful in highlighting scenarios other than internal infection for 'Inpatient diagnosed with covid' particularly highlighting 'suspected covid' (illness untested for covid) and 'unsuspected covid' (significant illness but unwittingly a covid carrier).

27.5.2.3.2.1.2.2.2 Thus we accept those scenarios and therefore highlight a range of 16% (government figures) to 78% (inpatient diagnoses as a percentage of all diagnoses) for 'internal infection'.

27.5.2.3.2.1.2.2.3 What we cannot know are the details of the NHS actions and policies in regard to originating vs responding to infection.

27.5.2.3.2.1.2.2.4 What we can know is the reports from whistleblowers, nurses, doctors, visitors, patients, relatives, and simple observers of eg: the Nightingale hospitals.

27.5.2.3.2.1.2.2.4.1 Staff twerking in 'crisis hit' hospitals

27.5.2.3.2.1.2.2.4.2 Empty hospitals

27.5.2.3.2.1.2.2.4.3 Doctors coming round to claim a non-covid death as covid

27.5.2.3.2.1.2.2.4.3.1 I have personally received an angry email to that effect from an NHS nurse whose father died in hospital

27.5.2.3.2.1.2.2.4.4 Staff being instructed not to speak to media or social media

27.5.2.3.2.1.2.2.4.5 Staff being instructed that they will face disciplinary action if they don't comply with government guidelines

27.5.2.3.2.1.2.2.4.5.1 Again I have personal direct experience of such from a close contact

27.5.2.3.2.1.2.2.5 When the reported data causes concern and the external reports cause concern we consider it reasonable to be concerned.

27.5.2.3.2.1.2.2.5.1 We consider the concern sufficient to be cause for independent investigation

27.5.2.3.2.1.2.2.5.2 We consider the concern sufficient to mistrust internal NHS claims and policy

27.5.2.3.2.1.3 As such it is not unreasonable to consider that there may be an interesting difference in quality or nature between the 'external, public' diagnoses reflected in Admissions with Covid and the 'internal, NHS elected' diagnoses reflected in Inpatients Diagnosed with Covid

27.5.2.3.2.1.3.1 Note that we in no way question the integrity of staff in the data centres or responsible for data within the NHS

27.5.2.3.2.1.3.1.1 In common with other data departments in the UK and worldwide we find their work to be critical and fundamental to our analysis

27.5.2.3.2.1.3.1.2 Simply put without the data that governments provide we could not demonstrate the fraudulent statements and outright lies of the government ministers and spokesmen and associated authorities such as advisors and scientists.

27.5.2.4 We compare and contrast the Inpatient diagnoses and Admissions with covid by region within England

27.5.2.4.1 England.

27.5.2.4.1.1 Overall the inpatient and admissions diagnoses are perfectly in synch with a 5th April peak.

27.5.2.4.1.1.1 Inpatient diagnoses dominate at [78%] of diagnoses.

27.5.2.4.1.1.2 The synchronicity argues against the 'public admissions came in and infected our patients'

27.5.2.4.2 London

27.5.2.4.2.1 London inpatient diagnoses had an early peak the 28th March, admissions the 30th March, inpatients a formal twin peak on the 3rd and 5th April in line with England of which it is the major component.

27.5.2.4.2.2 Overall if we ignored the flattened calderas of both sets of diagnoses and look at the two humped curves, they are both in line with a 4th April or 5th April peak.

27.5.2.4.3 Midlands

27.5.2.4.3.1 The Midlands has the most perfect and normal looking curves for both inpatients and admissions.

27.5.2.4.3.1.1 Either the contagions were actually natural and reasonable or the individuals responsible for managing the reports knew what a contagion should look like

27.5.2.4.3.1.2 Inpatients peak the 2nd April and admissions the 4th April.

27.5.2.4.3.1.3 Inpatients dominate in scale and certainly do not lag admissions

27.5.2.4.4 North East and Yorkshire

27.5.2.4.4.1 Inpatients peak with a rather amusing spike on 5th April, perfectly in synch with England overall but admissions don't peak till weeks later on the 25th April.

27.5.2.4.4.2 Where the NHS diagnoses perfectly reflect the synchronised contagion and peak of 5th April, the public admissions seem positively laggardly.

27.5.2.4.4.2.1 The first intermediate peak – a slight levelling off and decline of a very flat curve – for admissions occurs on the 10th, when the NHS diagnoses are already in sharp decline.

27.5.2.4.4.2.2 By the time of the proper peak – again a gentle levelling off and decline – on the 25th April, NHS admissions are down to half their peak levels and the contagion is well on the way to being over.

27.5.2.4.4.2.2.1 This is an intriguing contrast between an aggressive and narrative-consistent contagion by NHS diagnoses and a reluctant and nondescript contagion being only reluctantly recognised or present in the external public domain.

27.5.2.4.4.2.2.2 Perhaps in that contrast we are seeing exactly the nature of Covid in the UK

27.5.2.4.4.2.2.2.1 The government has promoted an aggressive and deadly contagion that rapidly dominated to peak on the 11th April by growth-decline analysis

27.5.2.4.4.2.2.2.2 Care homes lagged the NHS, two entirely separate phenomena and again those are both locations identified by their role not by geographic spread

27.5.2.4.4.2.2.2.3 Meantime the public contagion has been barely evident

27.5.2.4.4.2.2.2.3.1 The government has been so far pushed to emphasise that Covid is real that it has had to resort to posters telling the public it's real because look at this case

27.5.2.4.4.2.2.2.3.1.1 A public with family members and community members dying in droves from a plague or contagion wouldn't need to be told there was a plague or contagion

27.5.2.4.4.2.2.2.3.1.1.1 Nor would they need to be told to stay at home to protect the NHS and save lives

27.5.2.4.4.2.2.2.3.1.1.1.1 They'd be barricading their homes to keep strangers and the plague out

27.5.2.4.4.2.2.2.3.1.1.1.2 Instead they're shrugging, getting on with their lives, shopping, or railing at the government as to when these measures are going to end

27.5.2.4.4.2.2.2.3.1.1.1.3 That sounds less a population that is the victim of a plague and more a population that is a victim of the government

27.5.2.4.5 North West

27.5.2.4.5.1 An almost normal chart but as ever with inpatient diagnoses dominant and in the lead

27.5.2.4.5.2 NHS diagnoses peak on the 3rd April. Public admissions peak on the 6th April.

27.5.2.4.6 South East

27.5.2.4.6.1 Similar to the North West in looking normal but with NHS in the lead and dominant

27.5.2.4.6.2 NHS (inpatient) diagnoses peak on the 5th April. Public admissions on the 6th.

27.5.2.4.6.3 What stands out in this rather bland chart is that with the exception of the initial rise and slight hump in early April, the entire of the public admissions looks more like a long-drawn-out phenomenon

27.5.2.4.6.3.1 True contagions are classically humped, normal.

27.5.2.4.6.3.1.1 Seasonal flu for example, or Ebola, or Sars, or even Covid outside the UK

27.5.2.4.6.3.1.2 Day to day phenomena tend to be flat.

27.5.2.4.6.3.1.3 In the South East (where we live) Covid it seems has in the public population been a day-to-day affair with only the slightest decline as the weeks passed.

27.5.2.4.6.3.1.4 One might almost dub it the 'me too' virus and indeed we've noted that people seem to experience a certain pride and joy that they've finally been diagnosed with covid.

27.5.2.4.7 South West

27.5.2.4.7.1 Again the usual dominance by the NHS but here the lag is marked

27.5.2.4.7.1.1 the NHS (inpatient diagnoses) peak on the 6th April in line with the narrative and England overall but the public diagnoses (Admissions with covid) lag severely peaking only on the 19th April.

27.5.2.4.7.1.2 Public admissions show an early surge in line with NHS diagnoses but quickly get bored and tail off from the 25th March.

27.5.2.4.7.1.2.1 Lockdown working?

27.5.2.4.7.1.2.1.1 Firstly it's two early, since lockdown can only have an effect post latency or incubation

27.5.2.4.7.1.2.1.2 Secondly other regions don't show the same effect

27.5.2.4.7.1.2.1.3 Third, growth-decline analysis for the UK and England show that the overall growth of the virus was unfazed by lockdown

27.5.2.4.7.1.2.1.4 It did show a marked move in the wrong direction by sustaining peak when cases should have been declining

27.5.2.4.7.1.2.1.5 Overall we'd be inclined to shoot down anyone suggesting this was proof of lockdown working

27.5.2.4.7.1.2.2 Instead similarly to the South East we enter a long slow climb and then have a long and barely noticeable descent

27.5.2.4.7.1.2.2.1 That doesn't look like an outbreak or contagion. It looks like a day-to-day phenomenon.

27.5.2.4.8 East

27.5.2.4.8.1 The East of England provides the most bizarre of the comparison charts for several reasons

27.5.2.4.8.2 NHS inpatients peak on the 6th April on schedule but the public contagion doesn't peak until the 27th April, shortly before the NHS engages in an unusual second surge not seen on other charts creating a local peak on the 1st May.

27.5.2.4.8.3 Admissions have an earlier peak on the 11th April, still significantly lagging the NHS diagnoses.

27.5.2.4.8.4 The public contagion is climbing slowly to 27th April even though the NHS inpatient diagnoses have long peaked on the 6th and are in substantial decline.

27.5.2.4.9 Whether ill, tested, and sent to hospital (Admissions with covid) or ill, sent to hospital and tested (Inpatient diagnoses) we should be seeing the same picture

27.5.2.4.9.1 It is after all supposed to be the same contagion

27.5.2.4.9.2 That some regions support the rational perspective with extremely smooth charts while others are extremely contradictory is an anomaly

27.5.2.4.9.3 Overall the NHS was very much on-message with contagion-like surges to peak as expected

27.5.2.4.9.3.1 What is not normal is the long slow decline

27.5.2.4.9.3.1.1 That is a feature unique to a select few countries

27.5.2.4.9.3.1.2. When a contagion fails to act normally we consider that an indicator of potential fraud

27.5.2.4.9.3.1.3 When the virus ignores lockdown but delays reducing its cases that is a double magnification of the reported case

27.5.2.4.9.3.1.4 Two abnormal features both magnifying the supposed threat of the virus Is a disturbing coincidence

27.5.2.4.9.3.1.5 The NHS controlled by the government supporting the narrative while the public contagion is a minor player and out of synch with the narrative is a disturbing anomaly

27.5.2.4.9.3.1.6 Synchronous contagions across the regions of England is a disturbing anomaly

27.5.2.4.9.3.1.7 Synchronous contagions across the nations of England is a disturbing anomaly

27.5.2.4.9.3.1.8 That this is only one aspect of the UK covid story to be disturbing is disturbing

27.5.2.4.9.3.1.9 Overall the England regional charts do not reassure us that the England contagion was natural

27.5.2.4.9.3.1.10 Overall the England regional charts reinforce the sense of an NHS obedient to orders to support a massive-threat narrative rather than the honest victim of a contagion doing its best to get through this ‘crisis’.

27.5.2.5 Scotland NHS Boards

27.5.2.5.1 We performed a similar exercise with NHS boards in Scotland

27.5.2.5.2 Unlike England, we found a dataset with precise case counts for each board going back to the very first case in each board by day.

27.5.2.5.3 This allows us to track how severely the contagion spread in one region before it escaped and spread to a typically adjacent region.

27.5.2.5.3.1 A series of stepped contagions would be our expectation for a virus spreading by ‘community transmission’ ie: person to person, predominantly locally.

27.5.2.5.3.2 What actually happened was rather different.

27.5.2.5.3.3 The virus didn’t even manage to spread locally before other boards were infected and had their first case.

27.5.2.5.3.3.1 Scotland was essentially covered before the first contagions had even got started.

27.5.2.5.3.3.1.1 That is an absurdity and makes a mockery of the ‘community transmission’ model.

27.5.2.5.3.3.1.2 What is the point of locking down, masking up, socially distancing, when before there's even a second case in Tayside (the first board) the virus can jump straight from Tayside to Forth, Grampian and Ayrshire?

27.5.2.5.3.3.1.3 That was days 3 and 4, and on day 5 the virus jumped to Glasgow and Clyde with no board having more than 2 cases.

27.5.2.5.3.3.1.3 On days 6 to 8, with no board having more than 4 cases, the virus jumped to Lothian (Edinburgh), Fife, Lanarkshire and Shetland.

27.5.2.5.3.3.1.3.1 These are entire health boards, regions of Scotland, and nine regions have had their first case in eight days, before any region has managed to get more than 4 cases.

27.5.2.5.3.3.1.3.1.1 There are a grand total of 21 cases in Scotland, but the virus has managed to bypass community transmission entirely and reach nine regions, an average of barely two cases per board.

27.5.2.5.3.3.1.3.2 Only Amazon could ship a virus faster to these health boards than they seem to have managed by themselves.

27.5.2.5.3.3.1.3.3 Three quarters of mainland Scottish health boards are now 'covid engaged' with at least one case, by day eight, with 21 cases split between 9 boards, at most 4 cases per board.

27.5.2.5.3.3.1.3.4 That isn't 'community transmission'. That is mass transit.

27.5.2.5.3.3.1.3.4.1 And no, even if the virus caused a psychosis that said "get on a train and infect other regions" there would be a necessary delay not only for the transport but also for the latency and incubation, a delay of several days for each region in sequence.

27.5.2.5.3.3.1.3.4.2 We have observed the extreme determination of pro-agenda loyalists to explain away every anomaly, every inconsistency.

27.5.2.5.3.3.1.3.4.2.1 New York City attacked 500 times more aggressively? 5G. Pollution. It's a city.

27.5.2.5.3.3.1.3.4.2.1.1 Singapore is also a city and escaped like the rest of the Far East with a few hundred deaths per hundred million population.

27.5.2.5.3.3.1.3.4.2.2 Three-quarters of Scotland infected with boards active before the first board has more than 4 cases? Skiing trip.

27.5.2.5.3.3.1.3.4.3 At some point we have to remind the court and other people that WMD happened. Iran-Contra happened. Watergate happened.

27.5.2.5.3.3.1.3.4.3.1 And they are simply the more memorable of the government frauds.

27.5.2.5.3.3.1.3.4.3.2 To put politicians and scientists in jail because some numbers don't add up or make sense might be too much of a stretch, even if we could rely on the integrity of the police and the courts.

27.5.2.5.3.3.1.3.4.3.3 Not to recognise that there is reasonable cause for an independent criminal investigation would be something else.

27.5.2.5.3.3.1.3.4.3.4 There is a very simple issue at stake here.

27.5.2.5.3.3.1.3.4.3.4.1 Either the government and its sponsors can do and say anything they like and the public will absorb every absurdity and do nothing.

27.5.2.5.3.3.1.3.4.3.4.2 Or the government can be held to account with it has demonstrably lied, misrepresented the facts, imposed an agenda and harmed the people of this nation.

27.5.2.5.3.3.1.3.4.3.4.3 We are well aware that the former is the typical modus-operandi of the government and indeed governments around the world.

27.5.2.5.3.3.1.3.4.3.4.4 Given the extreme harm done by the government's statements and policies in pursuit of their published agenda it would be nice if for once the court ruled on the side of the people.

27.5.2.5.3.3.1.3.4.3.4.5 That the government has lied and misrepresented the facts is simply shown.

27.5.2.5.3.3.1.3.4.3.4.6 That the government has harmed the people of this nation is simply shown.

27.5.2.5.3.3.1.3.4.3.4.7 So this case is incredibly simple: the government has lied and done harm.

27.5.2.5.3.3.1.3.4.3.4.8 The only test is not of the government but of the courts.

27.5.2.5.3.3.1.3.4.3.4.8.1 Will a court stand up for the rights of the people.

27.5.2.5.3.3.1.3.4.3.4.8.2 Or will it represent and protect the interests of the government.

27.5.2.5.3.3.1.3.5 Scotland enjoys a two day respite before Borders and Highland join on the day 11 and 12.

27.5.2.5.3.3.1.3.5.1 It is less than two weeks since the first case.

27.5.2.5.3.3.1.3.5.2 The entire of mainland Scotland how has Covid cases in its boards barring Dumfries and it has even reached Shetland.

27.5.2.5.3.3.1.3.5.2.1 This is an infamous 'skier' apparently.

27.5.2.5.3.3.1.3.5.3 Not one board has more than 12 cases and there are no more than 67 in the entire of Scotland.

27.5.2.5.3.3.1.3.5.4 It is day 12. At 11 boards, the virus has added a board a day, close enough. By contrast each board has added a case a day, reaching a maximum of 12 cases per board.

27.5.2.5.3.3.1.3.5.4.1 That is the definition of insanity believing that the virus can jump to a new region faster or as fast as it can add one case in an existing region.

27.5.2.5.3.3.1.3.5.4.2 Is it easier to go to the local Mall or to drive from Edinburgh to Glasgow?

27.5.2.5.3.3.1.3.5.4.3 At what point does the tipping point come and the absurdity is recognised as likely fraud and the chances of it being legitimate are consigned to that of a UFO materialising in a courtroom?

27.5.2.5.3.3.1.3.5.4.3 This virus finds it easier to go from Tayside to Highland than it does to nip down to the local shops and infect a neighbour.

27.5.2.5.3.3.1.3.5.4.4 And there's no pesky delay for latency, incubation.

27.5.2.5.3.3.1.3.5.4.4.1 Next day case, no problem, which means the newly infected person in the new region has progressed through latency and incubation to full symptoms serious enough to warrant medical attention by a GP and hospitalisation.

27.5.2.5.3.3.1.3.5.4.4.2 In a day, one a day for the first 12 days.

27.5.2.5.3.3.1.3.5.4.4.3 What kind of impossible does it take before someone actually notices?

27.5.2.5.3.3.1.4 Dumfries (Dumfries and Galloway) joins on day 17 and at least Western Isles and Orkney have the decency to wait till day 28 and day 30.

27.5.2.5.4 If the court wants to test the viability of the reported contagions it can do so very simply.

27.5.2.5.4.1 Chinese Whispers shares the essential character of 'community transmission' of a virus

27.5.2.5.4.1.1 Close proximity of individuals (vs the 'safe' social distancing)

27.5.2.5.4.1.2 Easy transmission of something (which in covid would be the virus)

27.5.2.5.4.2 If the court wishes to test whether it really is possible to get a virus to nine boards in eight days or 11 boards in 12 days, then simply arrange a monitored experiment with Chinese Whispers.

27.5.2.5.4.2.1 Bear in mind that Chinese Whispers has zero latency or incubation time.

27.5.2.5.4.2.2 Even so, I think the virus would give Chinese Whispers a run for its money.

27.5.2.5.4.2.3 Build in a two day latency for each Whisper and the virus will win hands down

27.5.2.5.4.2.4 And if the virus can beat something as simple and direct as Chinese whispers it isn't a virus.

27.5.2.5.4.2.4.1 It's a policy directive.

28.0 Wales Geographic Spread

28.1 We have an analysis of Wales for local geographic spread and then one for England which is rather compelling.

28.1.1 Note that we have touched on England by region. A different dataset allows a more detailed analysis and from the very first case.

28.2. Here we focus on Wales.

28.2.1 We are working with the 'Rapid COVID-19 Surveillance Data.xlsx' data set.

28.2.1.1 This was downloaded from [x]

28.2.1.1.1 The particular release contained data from 3rd March to 14th December

28.2.1.1.1.1 The later data post primary contagion (approx to 30th June) is of no interest in this context and so the currency of the release is not pertinent.

28.2.1.1.1.2 As the (fictional) Princess Irulan put it: "A beginning is a very delicate time."

28.2.1.1.1.2.1 Never were truer words spoken by a fictional character.

28.2.1.1.1.2.2 What the government and other governments have disregarded is that a contagion is founded on an interconnected and very clear chain of events.

28.2.1.1.1.2.2.1 You come into contact with the virus, the virus infects you, it incubates, there is a latency period before you become infectious, you end up asymptomatic or symptomatic, you get sick, you are hospitalised or not, you recover after some time or you die

28.2.1.1.1.2.2.1.1 Each of those connections and relations has associated data and associated statistics and rates

28.2.1.1.1.2.2.1.1.1 CFR (Case Fatality Rate) is just one possible statistic.

28.2.1.1.1.2.2.1.1.1.1 Divide deaths on a day by the cases on that day and you get a rough or simple CFR

28.2.1.1.1.2.2.1.1.1.2 But you're not supposed to die the day you're diagnosed

28.2.1.1.1.2.2.1.1.1.3 Lag the deaths back to cases some days earlier and you get a different CFR

28.2.1.1.1.2.2.1.1.1.4 Lag the UK deaths back 14 days and you get 100% death rate.

28.2.1.1.1.2.2.1.1.1.4.1 That does not seem very encouraging or representative of NHS 'care'.

28.2.1.1.1.2.2.1.1.1.4.2 So either the reported data is wrong or the 'care' is wrong.

28.2.1.1.1.2.2.1.1.1.5 Thus the connected data reveals implied realities are that are not consistent with our understanding of actual reality.

28.2.1.1.1.2.2.1.1.1.5.1 When that occurs then one of only three things must be true

28.2.1.1.1.2.2.1.1.1.5.1.1 The original data is wrong

28.2.1.1.1.2.2.1.1.1.5.1.2 The analysis is wrong

28.2.1.1.1.2.2.1.1.1.5.1.3 Our understanding of reality is wrong

28.2.1.1.1.2.2.1.1.1.6 The data is the official data of the government and is the prime resource backing the narrative and policies of the government.

28.2.1.1.1.2.2.1.1.1.6.1 If that is wrong then the narrative and policies are wrong

28.2.1.1.1.2.2.1.1.1.6.1.1 That immediately invalidates the narrative and policies

28.2.1.1.1.2.2.1.1.1.6.1.2 It also gives rise to an enquiry as to how come the government data is wrong.

28.2.1.1.1.2.2.1.1.1.6.1.3 As ever we are confronted with the core issue: with something so important it challenges common sense for something so fundamental to be a mistake

28.2.1.1.1.2.2.1.1.1.6.1.4 Running over a child and killing them might be a mistake on the part of the child or the driver

28.2.1.1.1.2.2.1.1.1.6.1.4.1 If the slightest blame or irresponsibility can be attributed to the driver they will go to jail

28.2.1.1.1.2.2.1.1.1.6.1.5 With the government so ready to be harsh to drivers regardless of the pedestrian's failure for a single death what should be our judgement of a government whose failure has caused 15,000 excess deaths not from covid but in addition to covid deaths?

28.2.1.1.1.2.2.1.1.1.6.1.6 If the government has made the slightest mistake or failed to be competent even for a moment then like the driver we hold it accountable.

28.2.1.1.1.2.2.1.1.1.6.1.6.1 The mistakes and failures have not been for a moment have not been minor or trivial and are not conceivable as rational for people who are or who are informed by leading scientific advisors and medical experts.

28.2.1.1.1.2.2.1.1.1.6.1.6.2 To put it another way if an aging financier, techie and maths graduate can spot and highlight the inconsistences with simple arithmetic it is beyond reason to suggest that an entire government staffed with and with access to the nation's and world's leading experts cannot do the same simple arithmetic.

28.2.1.1.1.2.2.1.1.1.6.1.6.3 As such the choice to avoid or avoid publishing or reporting these facts is a deliberate choice.

28.2.1.1.1.2.2.1.1.1.6.1.6.4 The choice to report the contagion its data or observations on the data are a deliberate choice.

28.2.1.1.1.2.2.1.1.1.6.1.6.5 The choice to misrepresent covid and the contagion is a deliberate choice.

28.2.1.1.1.2.2.1.1.1.6.1.6.6 To misrepresent covid and the contagion as a deliberate choice is fraudulent.

28.2.1.1.1.2.2.1.1.1.6.1.6.7 To cause harm by that misrepresentation is criminal.

28.2.1.1.1.2.2.1.1.1.6.1.6.8 This UK government has participated in criminal fraud as a deliberate choice for the full duration of the contagion which we take to mean since the March 3rd Press Conference with PM BJ and advisers CW and PV.

28.2.1.1.1.2.2.1.1.1.6.1.6.9 It's not difficult. It's simple arithmetic.

28.2.1.1.2 The data comprised 22 regions plus two categories 'outside Wales' and 'unknown'

28.2.1.1.2.1 Outside Wales comprised 4% of the cases and Unknown comprised 1%

28.2.1.1.2.1.1 Our analysis focuses on what happened inside Wales by known locations

28.2.1.1.2.1.2 As such we exclude 'Outside Wales' and 'Unknown' from our analysis

28.2.1.1.2.1.2.1 The exclusion is not material to the analysis

28.2.1.2 The data comprises 22 regions in Wales which we understand to be LHB's which we further take to be 'Local Health Boards'.

28.2.1.2.1 Apparently these have been re-organised into a new strata of 7 regions but fortunately the data was provided for the pre-existing 22 LHB's which gives us a finer granularity and therefore a more detailed image.

28.2.1.2.1.1 "Wales got sick" may be (somewhat) accurate but it doesn't tell us much.

28.2.1.2.1.2 The more fine-grained the data the clearer the picture.

28.2.1.2.1.2.1 The clearest picture (and the most challenging to analyse from a data perspective) would be clinical records.

28.2.1.2.1.2.1.1 Naturally clinical records are not public domain.

28.2.1.2.1.2.1.2 Nor necessarily would they be helpful.

28.2.1.2.1.2.1.2.1 We are not forensic investigators or prosecutors. We have no team or funding (which is a bit of a sore point when we're fighting an entire nation's government-backed agenda).

28.2.1.2.1.2.1.2.2 We are an individual examining and sharing the government's own data.

28.2.1.2.1.2.1.2.3 That the government made a bad call on March 23rd was obvious but a personal opinion based on a reaction to the (lack of) death risk by age published by China CDC.

28.2.1.2.1.2.1.2.4 That bad call (lockdown) didn't start to look strange, then fraudulent until April 12th and beyond when the UK cases ceased to respect a normal contagion and went walkabout remaining at a high level when we should have been in the clear over peak and exiting the crisis.

28.2.1.2.1.2.1.2.4.1 Thus we had no vindictive agenda at the outset nor are we vindictive now.

28.2.1.2.1.2.1.2.4.2 What we are is shocked and angry that the UK government, UK scientists have along with other (western) governments and scientists engaged in long-term systematic mis-representation and outright lies regarding Covid-19 and contagions and have off the back of that not allowed us to escape and recover from the original contagion but have reinforced the fear and increased the damage done by their policies all nominally to keep us safe or compliant until the vaccine.

28.2.1.2.1.2.1.2.4.3 We are fortunate that the UK government along with the US government and others do indeed public so much very useful data.

28.2.1.2.1.2.1.2.4.4 It is inevitable as with financial fraud that if the agenda reports and actions of the government are indeed fraudulent that there will be traces in the data.

28.2.1.2.1.2.1.2.4.4 It turns out such traces are not hard to find. Sadly they are in fact so blinding and obvious that the real tragedy is the disregard the mainstream media has for the obvious flaws.

28.2.1.2.1.2.1.2.4.4.1 There is a point beyond which an anomaly becomes untenable as a mistake and has to be recognised as a deliberate action.

28.2.1.2.1.2.1.2.4.4.2 The simpler and more fundamental the anomaly the harder it is to consider its being ignored as a mistake and the sooner the evidence speaks to deliberate fraud on the people who are otherwise regarded as experts and so more than capable of recognising the anomaly.

28.2.1.3 The data was organised into a table comprising a row of the 22 regions (LHB's) for each date from 3rd March onwards (to 14th December though the latter is not material).

28.2.1.3.1 Thus one row gives a total of all the cases in Wales (barring 'outside Wales' and 'unknown' which qualification we will henceforth not restate)

28.2.1.3.2 We derive two companion tables for convenience and several simple arithmetic totals or figures as appropriate and convenient

28.2.1.3.2.1 The first table asks whether a region has been triggered by which we mean had its first case.

28.2.1.3.2.1.1 Once 'triggered' a region remains 'infected'.

28.2.1.3.2.1.1.1 Having a case means there are infected people about one of whom has progressed to symptomatic illness noticeable or severe enough to warrant attention and confirmation as a case.

28.2.1.3.2.2 The second table is simply the cumulative total of cases for each region over time.

28.2.1.3.2.2.1 This is the prior day's total plus today's new cases which may be zero.

28.2.1.3.2.3 Thus we can derive totals such as cases in Wales per day, cases per region over a period or in total.

28.2.1.3.2.4 We then track a few key indicators.

28.2.1.3.2.4.1 These are 'Total Boards', 'New Boards', 'Cases per Board Max – Daily', 'Cases Per Board Max – Total' and 'Wales Cases Total'

28.2.1.3.2.4.1.1 Having just done the Scottish analysis we tended to think of the regions as 'boards'. Strictly we understand them to be LHB's or Local Health Boards.

28.2.1.3.2.4.1.1.1 Their designation is not material to the analysis

28.2.1.3.2.4.2 'Total Boards' is the number of boards (out of 22) that are now 'infected' 'joined' or 'triggered' having had their first case.

28.2.1.3.2.4.2.1 'New Boards' is the number of boards joining or triggered that day

28.2.1.3.2.4.2.2 'Cases per Board' is the data for one specific board.

28.2.1.3.2.4.2.2.1 'Cases per Board Max' is the largest case count across all the boards (which by definition is the same as the largest case count across all the triggered boards as non-triggered boards have case count zero).

28.2.1.3.2.4.2.2.2 'Cases per Board Max' can be daily or in total (cumulative)

28.2.1.3.2.4.2.2.2.1 'Cases per Board Max' is the highest number of cases reported that day by a single board

28.2.1.3.2.4.2.2.2.2 'Cases per Board Max Total' is the highest number of cases reported so far by a single board (since 3rd Feb on which no cases were reported).

28.2.1.3.2.4.2.3 'Wales Cases Total' is the sum across all boards (excluding outside Wales and Unknown) to that date

28.2.1.3.2.5 We then track the timeline summarised by these numbers.

28.2.1.3.2.5.1 Thus Swansea was triggered on the 27th Feb with a single case.

28.2.1.3.2.5.1.1 Cardiff followed on the 4th March with a single case with no further cases from Swansea to date.

28.2.1.3.2.5.1.2 At this point then on 4th March 'Total Boards' was 2, 'New Boards' was 1 (Cardiff), Cases Per Board Max was 1 for daily and 1 for total, and Wales had had 2 cases.

28.2.1.3.2.5.1.3 Between 7th March and 14th March 17 boards were triggered.

28.2.1.3.2.5.1.3.1 As of the 14th 'Total Boards' was 19, 'New Boards' that day was 1 (Vale of Glamorgan), 'Cases Per Board Max' were 4 daily (that day) and 15 total (cases to date in the worst hit region). Wales had 103 cases in total.

28.2.1.3.2.5.1.4 On the 16th March two further boards joined (were triggered) and on the 21st March the final board joined bringing the total boards triggered (infected, with cases) to 22.

28.2.1.3.2.6 All that is simple observation based on trivial arithmetic and the official data.

28.2.1.3.2.6.1 The question is: what does it mean?

28.2.1.3.2.6.1.1 On the face of it we have evidence of a contagion spreading across Wales and developing in each area which is of course what the narrative tells us: Wales got hit with covid.

28.2.1.3.2.6.1.2 The question is: what does that data present as a reality and how does it compare with the narrative and our understanding of a contagion?

28.2.1.3.2.6.1.2.1 We suggest that the narrative nature of a contagion and the Covid-19 contagion in particular is clear from government pronouncements and a relentless campaign of posters, informercials, announcements, orders for lockdown, mask wearing, social distancing, one-way systems in shops.

28.2.1.3.2.6.1.2.1.1 We spread the virus.

28.2.1.3.2.6.1.2.1.1.1 An infected person unwittingly or recklessly goes about their day and a person in close proximity to them sadly picks up a virus particle which wouldn't happen if they weren't in close proximity and obviously if the first person wasn't infected.

28.2.1.3.2.6.1.2.1.1.1.1 There are subtleties in that a newly infected person is not immediately infectious, that there is a latency period (to infectiousness), an incubation period (to symptomatic), and that latency can precede incubation by 24-48 hours by our understanding, and then that the disease will play out in approximately 14 days.

28.2.1.3.2.6.1.2.1.1.1.2 None of that is material to our analysis which is both strange and convenient.

28.2.1.3.2.6.1.2.1.1.1.3 We are going to examine the local spread within the community (region) and compare it to the geographic spread (triggering new regions).

28.2.1.3.2.6.1.2.1.1.1.4 We know that if there is a case then there is a group of infected in a reasonably consistent average once we're dealing with a statistically significant sample population.

28.2.1.3.2.6.1.2.1.1.1.4.1 Putting it simply the bigger the sample the more data we have the more reliable and consistent our numbers become.

28.2.1.3.2.6.1.2.1.1.1.4.2 The 'super spreader' meme is going around and while we have not paid attention we have no doubt its real purpose is to spread fear and alarm.

28.2.1.3.2.6.1.2.1.1.1.4.2.1 We are comfortable stating that on zero evidence because it's not based on zero evidence.

28.2.1.3.2.6.1.2.1.1.1.4.2.2 This very analysis shows the fraudulent or unbelievable or absurd nature of the claimed 'spreading' of the virus.

28.2.1.3.2.6.1.2.1.1.1.4.2.3 As such it is hardly a stretch to anticipate that the 'super spreader' meme will be equally fraudulent.

28.2.1.3.2.6.1.2.1.1.1.4.3 We know that if there's a case, there's at least one infected and likely a group consistent with a common ratio observed overall at all scales of the data from a Wales LHB to UK to other countries comparable data and back to China of course.

28.2.1.3.2.6.1.2.1.1.1.4.3.1 We don't need to know the ratio and that ratio will vary according to the definition of a case.

28.2.1.3.2.6.1.2.1.1.1.4.3.1.1 We don't need to know the ratio only that it is reasonably consistent.

28.2.1.3.2.6.1.2.1.1.1.4.3.1.2 Sadly the definition of a case has been corrupted and as ever it plays to the massive threat narrative as testing has reduced case from ‘ill-and-confirmed-covid’ to ‘not-ill-lets-test-97%-false-positive-hey-you’re-covid’.

28.2.1.3.2.6.1.2.1.1.1.4.3.1.2.1 The corruption of the case definition alone and the testing fraud in regard to misrepresentation of ‘cases’ should be enough to ensure criminal charges and jail terms even had the government done not one other thing wrong or fraudulently

28.2.1.3.2.6.1.2.1.1.1.4.3.1.2.2 It is a massive persistent and alarming narrative leveraging the ‘case’ meme of the original contagion (to June 30th approx) and pretending without clarification that somehow the massively increased figures reported as ‘cases’ still represent a similar ‘massive threat’.

28.2.1.3.2.6.1.2.1.1.1.4.3.1.2.3 The original threat wasn’t massive.

28.2.1.3.2.6.1.2.1.1.1.4.3.1.2.3.1 If that is not already apparent we will be touching on comorbidities and that will make it even clearer.

28.2.1.3.2.6.1.2.1.1.1.4.3.1.2.3 The new threat under ‘cases redefined’ is even less so but even more misrepresented by re-using a reasonable ‘ill-confirmed-covid’ to describe ‘not-ill-97%-false-positive-hey-you’re-covid’.

28.2.1.3.2.6.1.2.1.1.1.5 As long as the ratio of infected to cases whatever cases means on that date is consistent then trends and events reflected in cases can be deemed to correspond to an implied and matching group of infecteds.

28.2.1.3.2.6.1.2.1.1.1.5.1 Thus we don’t need to add complexity by attempting to reverse engineer an implied infected distribution.

28.2.1.3.2.6.1.2.1.1.1.5.2 We and the government also don’t need to attempt to second-guess or divine an ‘R’ number for infecteds and their capacity to infect others.

28.2.1.3.2.6.1.2.1.1.1.5.2.1 We have a simple direct and well-documented time-series of cases for hundreds of nations and hundreds of sub-divisions within those nations and we have that worldwide for essentially the entire contagion

28.2.1.3.2.6.1.2.1.1.1.5.2.2 We do not need divination by robed sages to pronounce on the matter

28.2.1.3.2.6.1.2.1.1.1.5.2.3 We definitely don’t need an ‘R’ number that doesn’t even have a time component associated with it so that it has to be restated by PV or CW as a ‘doubling every’ number.

28.2.1.3.2.6.1.2.1.1.1.5.2.3.1 The Gutenberg Bible and Printing Press freed the masses from the authority and control of the Church

28.2.1.3.2.6.1.2.1.1.1.5.2.3.2 The government has enjoyed the advantages of mysticism in similar authority over the ‘R’ number

28.2.1.3.2.6.1.2.1.1.1.5.2.3.3 A far more practical and useful measure based on simple arithmetic the growth in cases or growth in deaths as a percentage daily or over a period frees us from such false and mystical practices as tracking the ‘R’ number

28.2.1.3.2.6.1.2.1.1.1.5.2.3.4 Unfortunately and perhaps inevitably it is that same clarity and ease of analysis that reveals the fraud of the government's narrative claims and reports in essentially every aspect of Covid-19.

28.2.1.3.2.6.1.2.1.1.1.5.3 So the simple outcome is that we need only track cases and take for granted that yes there will be a potentially or inevitably larger group of infecteds by some broadly consistent ratio.

28.2.1.3.2.6.1.2.1.1.1.5.3.1 The ratio doesn't matter because if it takes 10 infecteds to create a case then fine next time there's a case we know there's 10 infecteds out there.

28.2.1.3.2.6.1.2.1.1.1.5.3.2 If someone says no the ratio is 5 then fine next time there's a case we know there's five infecteds out there.

28.2.1.3.2.6.1.2.1.1.1.5.3.3 Whatever it takes to create a case we know is out there and a case won't materialise on average until that level of infecteds is out there.

28.2.1.3.2.6.1.2.1.1.1.5.3.4 Either there's a broad consistency as to what it takes to get a case from a group of infecteds or there isn't.

28.2.1.3.2.6.1.2.1.1.1.5.3.4.1 The government has been quoting ratios of infection to fatality from the very beginning March 3rd where CW cited 80% infected and 1% mortality from that.

28.2.1.3.2.6.1.2.1.1.1.5.3.4.2 Thus the government's position is that yes there is consistency in rates else stating such rates is an exercise in futility or misdirection or misrepresentation and we doubt the government would like to sustain that argument so yes there is consistency in rates according to the government.

28.2.1.3.2.6.1.2.1.1.1.5.3.4.3 We also affirm that by 'infecteds' we refer to a group of people infected by something here the Covid-19 virus.

28.2.1.3.2.6.1.2.1.2 So we spread the virus. We do. Not drones or the CIA or UFO's or 5G or pollution or storms or God or anyone else. Us. We do. We the people.

28.2.1.3.2.6.1.2.1.2.1 It is not spontaneous infection. We spread it.

28.2.1.3.2.6.1.2.1.2.1.1 No one gets the virus without an infected person in proximity.

28.2.1.3.2.6.1.2.1.2.1.2 Strictly no one gets the virus without coming into contact or close proximity with an object or presence with Covid-19 particles present.

28.2.1.3.2.6.1.2.1.2.1.3 That presence could be the miasma of a person's breath, a toilet seat they touched or a door handle. The memes warning us of where and how we can find and contact the virus are extensive and merely be coincidence the proliferation of such memes only enhances and prolongs the fear of the virus.

28.2.1.3.2.6.1.2.1.2.1.4 But the door handle wasn't touched by God (though we infer no inability on God to do so). It was touched by us. People. Ordinary people. The community. The person next to you. The person behind you in a queue. The person on a train with you. Us. We are the threat. We are the infecteds. We the people.

28.2.1.3.2.6.1.2.1.2.1.4.1 The short and pithy term to describe this in daily WHO data is 'community transmission'.

28.2.1.3.2.6.1.2.1.2.1.4.2 So let's look at 'community transmission'

28.2.1.3.2.6.1.2.1.3 If we spread the virus then the virus spread must reflect us.

28.2.1.3.2.6.1.2.1.3.1 It must reflect our movements and actions including the locations we move ourselves into and the actions we take in such locations.

28.2.1.3.2.6.1.2.1.3.1.1 Whence lockdown (stay in one location, your home), social distancing (do not move close to another), masks (do not allow the miasma of your breath containing Covid-19 particles to waft into another's face), one-way in shops (so you can stay 2m behind someone and have no intersection and undesirable close proximity), bubbles (so the people you've already infected or not infected are the only people you've already infected or not infected).

28.2.1.3.2.6.1.2.1.3.1.2 It's safe to say that the government has made clear that they represent that our movements and actions including the locations where we move to and from and the actions we take in those locations are at the core of government 'management' of covid

28.2.1.3.2.6.1.2.1.3.1.3 Whether if manages covid or not (and government data shows that lockdown at least is totally fraudulent in having zero effect) it certainly manages the people causes massive disruption, distress, financial duress, and has seen a spike in suicide and 15,000 excess non-covid deaths.

28.2.1.3.2.6.1.2.1.3.1.4 So managing our movements and actions is a concrete affirmation that our movements and actions – our belonging to we the people us – are the government's declared cause giving rise to the spread of the virus.

28.2.1.3.2.6.1.2.1.3.1.5 The government is therefore a strong proponent of the 'community transmission' model which of course we could easily verify because that's the nature of covid in the UK as reported to WHO.

28.2.1.3.2.6.1.2.1.4 We emphasise this to the point of extreme repetition and absurdity because when the outcome of the analysis is recognised we do not want a palliative excuse.

28.2.1.3.2.6.1.2.1.4.1 We are the cause of the spread

28.2.1.3.2.6.1.2.1.4.2 As such the spread must reflect human nature and behaviour

28.2.1.3.2.6.1.2.1.4.2.1 If the government claimed that the virus spread because super-spreaders super-villains flew down chimneys to infect children and parents we would hope that the public would recognise that as absurd

28.2.1.3.2.6.1.2.1.4.2.1.1 We cannot even be sure of that. The degree of complacency among the population as to what the government is saying and doing is truly remarkable to the point of being terrifying in its own right.

28.2.1.3.2.6.1.2.1.4.2.1.2 It is interesting that the government has in fact engaged the meme of a super-spreader flying down chimneys only in the natural and frankly despicable double-speak of the expert propagandists in the employ of the government the resulting meme is one designed to instil fear even terror and certainly guilt into the most innocent sector of our society

28.2.1.3.2.6.1.2.1.4.2.1.2.1 We cannot adequately describe our disgust that the government should knowingly and intentionally target children with its propaganda and should do so with the clear intent not to reassure and calm to but instil fear and alarm

28.2.1.3.2.6.1.2.1.4.2.1.2.2 There is a figure who does indeed fly down chimneys every year and who normally spreads cheer and presents

28.2.1.3.2.6.1.2.1.4.2.1.2.2.1 At least that's the narrative we tell our children and that they sincerely believe until they're old enough to realise it's just a tale but the presents are real

28.2.1.3.2.6.1.2.1.4.2.1.2.2.2 Nevertheless Santa is one of the world's most enduring images not far removed from that of a religious figure or icon such as the Christ or Buddha and that is hardly a coincidence.

28.2.1.3.2.6.1.2.1.4.2.1.2.2.2.1 Santa may have been reduced to a figure of marketing and 'harmless' fiction but his roots go back to our pagan days and what the government is doing by showing Santa in hospital 'sickened' by a family with Covid is despicable.

28.2.1.3.2.6.1.2.1.4.2.1.2.2.2.2 For that harm and advert alone we would happily see the government in jail.

28.2.1.3.2.6.1.2.1.4.2.2 So the government is in fact more than happy to engage the meme of people flying down chimneys and if not infecting with the virus which would cause outrage then likewise Santa being infected with the virus causes genuine horror and fear in children.

28.2.1.3.2.6.1.2.1.4.2.2.1 This isn't Doctor WHO. There's no harmless or vicarious thrill. This is not entertainment. That is a deliberate and malicious attack on the most vulnerable minds in our society, those of children.

28.2.1.3.2.6.1.2.1.4.2.2.2 The government has attacked or utterly neglected those with the most vulnerable bodies and garnered massive deaths to bolster its massive threat narrative.

28.2.1.3.2.6.1.2.1.4.2.2.3 The government has attacked those with the most vulnerable minds to bolster its massive threat narrative.

28.2.1.3.2.6.1.2.1.4.2.2.4 A government willing to act in such away against the old with the most vulnerable bodies and the young with the most vulnerable minds is one that if it wasn't happening in the UK but was happening in for example Russia or China we would call evil.

28.2.1.3.2.6.1.2.1.4.2.2.5 Is it ok because we're not Russia, not China?

28.2.1.3.2.6.1.2.1.4.2.2.6 Or is it ok because honestly there's a virus?

28.2.1.3.2.6.1.2.1.4.2.2.7 Or is it ok because of the threat of community transmission?

28.2.1.3.2.6.1.2.1.4.2.2.8 Which by coincidence is what we're looking at.

28.2.1.3.2.6.1.2.1.4.2.2 So we being the problem with our movements actions and locations, what is the defining nature of our movements, actions and locations?

28.2.1.3.2.6.1.2.1.4.2.2.1 It is in fact very simple.

28.2.1.3.2.6.1.2.1.4.2.2.1.1 Humans are social animals.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.1 Humans are pack animals

28.2.1.3.2.6.1.2.1.4.2.2.1.1.2 Humans are herd animals

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3 Independent humans are rare and indeed it is almost impossible for a human to survive individually and they certainly won't give rise to a continuing race on their own.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.1 The quality of life of an independent human being with zero support on an arbitrary plot of land will be survival at best if they're lucky with the basics perhaps of a hut or shelter, and limited tools or implements.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.2 An individual human reduces themselves to the level at or below that of the caveman who could at least hunt in a pack.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3 It is not hard therefore to say that we need each other.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.1 And what has this government done but isolate us from each other?

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.2 That should be borne in mind when considering the government's actions that it has violated the most fundamental principle of human society: we need each other.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3 Humans congregate by choice.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.1 The most basic unit for survival of the species is the heterosexual couple and derived children. That's biology and all the science in the world won't change that if one day the electricity fails. Political agendas that attempt to violate reality create massive disturbance and disruption and that in no way obviates the right and opportunity for two people to choose partners of whatever persuasion and gender.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.1.1 Humans may think or believe what they like but nature and reality dictate that barring artificial actions and interventions the heterosexual couple and derived family are critical to the human race. Every other variant from priesthood to isolation to homosexual relationship and interaction is a variant that is optional. Heterosexual union is vital. It's as simple as that. If we want to survive. Unless we want to go full-blown Aldous Huxley and perhaps the people leading this Brave New World and Great Reset would be happy with that.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.1.2 We can only observe that it isn't natural in nature and it isn't natural in humans nor has been ever. That is not to make relatively uncommon choices wrong but it is equally wrong to ignore what is necessary and natural for humans and human society to have survived thus far and to have reached a relative pinnacle in science and society.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2 Humans congregate and where do they congregate?

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1 Are you reading this in a nation that you have never visited before in a room that you have been in less than one hour and in which you have no intention of spending the night?

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1 It is essentially impossible for a human being to avoid two things which are to be somewhere familiar and to be somewhere close by.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1.1 Unless you are a strange alien being teleporting randomly around the world or universe you spend most of the time in one place.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1.2 That place may change slightly and temporarily and then stabilise once more. We call it movement. Getting up to get a drink of water. Going out for a walk. Going down to the shops. Going to the local mall. Going to school. Going to work.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1.3 Measured on the scale of the planet let alone the galaxy or universe you really don't change position much.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1.4 And if we track humans changing position it's clear they overwhelmingly stay local.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1.4.1 Go on vacation even thousands of miles away and then what happens: you are then local to that vacation spot.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1.4.2 How many people go on vacation to one resort, check in, drop the bags, get in a taxi, go to the airport, get on a plane to a different country, check in, with no bags and get in a taxi to go to a third resort, check in… and that's only three resorts, a risible number.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1.4.3 The reality is even when we travel a long distance it's to stay there and become local once more, even if it's only for a few days.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1.4.4 Travel for your job even as an airline pilot and you'll come home to wherever home is. And your other destinations are limited and local. A meeting 5000 miles away means you'll be local to that meeting for a day or so and then come home or go to another place and stay local to that place.

28.2.1.3.2.6.1.2.1.4.2.2.1.1.3.3.3.2.1.4.5 We simply are not bizarre alien creatures randomly teleporting from place to place. We are stuck and stick to local areas overwhelmingly the vast majority of the time and even when we temporarily move it is to be temporarily local to that new area overwhelmingly.

28.2.1.3.2.6.1.2.1.4.2.2.2 So does anyone seriously wish to challenge the following proposition?

28.2.1.3.2.6.1.2.1.4.2.2.3 The further a location is away from us the less likely we are to visit it and the less likely we are to spend substantial time there.

28.2.1.3.2.6.1.2.1.4.2.2.3.1 How many people randomly pick a country and move there permanently every day?

28.2.1.3.2.6.1.2.1.4.2.2.3.2 How many people do that even once in their lifetime?

28.2.1.3.2.6.1.2.1.4.2.2.3.3 How many homes do we have in a single lifetime overwhelmingly in the same country we grew up in?

28.2.1.3.2.6.1.2.1.4.2.2.4 And what possible relevance does this massively extended stating of the obvious have to do with the geographic spread of covid?

28.2.1.3.2.6.1.2.1.4.2.2.4.1 If we stay local, the virus stays local.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1 "We had one case in March, a visitor who'd been to China, and they went on a tour of every county in England, Wales, Scotland and Northern Ireland and sadly it turns out they were infected with Covid and that's why every county in England, Scotland, Wales and Northern Ireland has Covid-19".

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1.1 Would you buy that?

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1.1.1 Sadly if the government announced that it would explain everything and so the government would be off the hook. Sally Jones, intrepid explorer from Wandsworth and charity-worker has sadly and inadvertently ensured that every county in the United Kingdom has covid. No further explanation required. Sadly, Sally Jones died, so we can't interview her or prosecute her. We can't even find records for her because of course we made her up.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1.1.2 It is quite remarkable what we've heard to explain Covid and the 100 times worse results the Western governments have achieved vs the Far East.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1.1.2.1 Super-spreaders like our fictional 'Sally Jones' excuse everything. We've all got it. How sad. Now we just need to control it so stay at home, wear a mask, forget your job, we'll do our best to indoctrinate your children with fear and the narrative and above all stay safe, protect the NHS and wait for the vaccine.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1.1.2.2 But if there's a super-spreader like "Sally Jones" then why are we locked down? She's going to do the damage anyway… let us out. No, because we are still the threat, or a threat, a massive threat because there's 66.25 million of us.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1.1.2.2.1 At some point we might wonder if 66.25 million people are a threat to themselves or a threat to people with more wealth and power than we can imagine but that is beyond the scope of this testament.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1.1.2.2.2 We're still the threat. How do we know this? Because we're locked down, wearing masks, socially distancing, waiting for the vaccine.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1.1.2.2.3 So super-spreaders aren't material to the threat we present.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.1.1.2.2.4 As such let's take super-spreaders out of the equation and look at the threat we present and the claimed progress of the virus in the light of that threat.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.2 If we stay local, the virus stays local.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.2.1 Obvious? It should be. It's the whole point of lockdown, shutting down transport, air-travel, entire regions as China did. Isolating cities or counties, as 'local lockdowns' are supposed to do.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.2.2 If staying local doesn't keep it local then those actions are pointless. It would mean that virus doesn't depend on our staying local so there's no point in our staying local. No point to lockdown. But the government is plainly determined to enforce lockdowns currently via its tier system.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.2.3 So clearly the government adheres to the "If we stay local, the virus stays local" logic.

28.2.1.3.2.6.1.2.1.4.2.2.4.1.2.3.1 "Stay Home, Save Lives" or "Stay Home, Save the NHS"

28.2.1.3.2.6.1.2.1.4.2.2.4.1.2.3.2 Don't move. Don't travel. No unnecessary journeys.

28.2.1.4 If we stay local, the virus stays local.

28.2.1.4.1 That's beyond contest at this point or at least the entire of nine months government policy reinforces it and is invalidated if the government challenges that premise so yes we'll treat that premise as beyond challenge: if we stay local the virus stays local.

28.2.1.4.1.1 Ultra super-strictly that statement should be: if we stay local we don't spread the virus beyond local.

28.2.1.4.1.2 If a virus arrives in a community previously untouched it is not spontaneous.

28.2.1.4.1.2.1 A visitor arrived. They didn't stay local so they came to us and now we have the virus.

28.2.1.4.1.2.1.1 The only exception to that is Patient Zero and the bat that visited them.

28.2.1.4.1.2.1.1.1 Except Covid-19 has been found since back in 2019 at least so that shoots down the bat and the weapons lab but that' snot material to our analysis.

28.2.1.4.1.3 Believe it or not that's all we need.

28.2.1.4.1.3.1 The virus or Covid-19 'illness' does not arise spontaneously.

28.2.1.4.1.3.1.1 Some may argue with that even as to whether Covid-19 exists but we are stating the government's position. No one 'just gets Covid'. You are infected. It's a contagious disease spread by a virus. You need to be infected to get sick with Covid.

28.2.1.4.1.3.2 The virus spreads by community transmission.

28.2.1.4.1.3.2.1 We spread the virus.

28.2.1.4.1.3.2.2 If we stay local we don't spread the virus beyond local.

28.2.1.4.1.3.3 Two statements, two conditions and we need both of them.

28.2.1.4.1.3.3.1 If we stay local and another community has zero infecteds and zero visitors and it still gets a new infected then that infection arose spontaneously with zero contact with pre-existing infecteds.

28.2.1.4.1.3.3.2 Everyone stayed local but still an infection materialised in a non-infected community.

28.2.1.4.1.3.3.3 That infection must therefore be spontaneous.

28.2.1.4.1.3.3.4 Do we or the government allow that?

28.2.1.4.1.3.3.4.1 We've certainly not heard the government theorize as to the risk of spontaneous self-infection with covid. Perhaps it's only a matter of time.

28.2.1.4.1.3.3.4.1.1 If you can just 'get' Covid, a bit like a cold, or cancer maybe, then maybe worrying about someone else 'infecting' you is a bit pointless.

28.2.1.4.1.3.3.4.1.2 Does it seem like the government encourages the perception that you can just 'get' covid?

28.2.1.4.1.3.3.4.1.2.1 We would say no.

28.2.1.4.1.3.3.4.1.2.2 We would suggest that by its silence on a topic never even verbalised to our knowledge the government's position is clear.

28.2.1.4.1.3.3.4.1.2.3 Spontaneous self-infection like spontaneous self-pregnancy and unlike spontaneous self-combustion (which does appear to occur) people don't just get Covid or don't just get pregnant.

28.2.1.4.1.3.3.4.1.2.3.1 The virus is necessary for infection by Covid to occur.

28.2.1.4.1.3.3.4.1.2.3.2 Presence and union of sperm and ovum are necessary for pregnancy to occur

28.2.1.4.1.3.3.4.1.2.3.3 We have no intention or need to dispute where babies come from but for the purpose of this analysis we hold as self-evident that the government position is that the virus is necessary for Covid-19 infection to occur.

28.2.1.5 So we have two things about Covid-19 and one thing about humans.

28.2.1.5.1 The first of two things about covid is that spontaneous self-infection doesn't occur. If someone is infected it is because someone else deposited the virus close enough for the newly infected person to come in contact that that means actual physical contact or within around 2 metres to judge by social distancing rules. A mile is safe. No one has seriously suggested you can get it from a mile away from an infected person.

28.2.1.5.1.1 The second is that if we stay local we don't spread the virus.

28.2.1.5.1.2 Corollaries are that a pristine uninfected region cannot become infected without a visitor who is themselves infected.

28.2.1.5.1.2.1 Someone didn't stay local.

28.2.1.5.2 The one thing we know about humans is: we stay local.

28.2.1.5.2.1 Mathematically that means that if we plot our position over time it will be overwhelmingly concentrated on a very few locations: home, work, school, mall, and that of those home and work will dominate.

28.2.1.5.2.1.1 Where we are not is overwhelmingly not in our home country or not in our home county.

28.2.1.5.2.1.1 The exceptions such as travelling salesmen or adventurers are so rare that they are not mathematically material.

28.2.1.5.3 We're local. If we spread the virus it will be locally. Overwhelmingly we're going to be spreading it in local work, local school, local shops, local churches, local bars, local restaurants.

28.2.1.5.3.1 That's why restaurants are closed or takeaway only.

28.2.1.5.3.2 We know this. Why are we belabouring this point to the point beyond ad nauseam?

28.2.1.5.3.3 Because nine months of covid debate tells us one thing

28.2.1.5.3.3.1 When confronted with facts which contradict the narrative of the believers, the believers dismiss the facts not their faith.

28.2.1.5.3.3.1.1 Covid-19 is or has become faith

28.2.1.5.3.3.1.2 That is hardly surprising since it is promoted by the parent government with all the resources at its disposal.

28.2.1.5.3.3.1.3 So when we show the data or evidence the believer will reject it and try to find an explanation even though they would agree we hope with everything we've discussed.

28.2.1.5.3.3.1.4 When it comes to faith it's easier to reject reality fact and science than give up a cherished and indeed emotionally critical belief.

28.2.1.5.3.3.1.5 What is deeply disturbing is that the government has succeeded in making Covid-19 and its threat a cherished and emotionally critical belief.

28.2.1.5.3.3.1.6 It is hardly surprising given nine months of relentless propaganda from the government and media.

28.2.1.5.3.3.1.7 And we're sure that the government having no experience in communications or the delivery of information or the nuances of public opinion or reaction would be utterly shocked to

imagine that people now BELIEVE Covid-19 to be a massive threat as an article of faith as a result of the government's actions.

28.2.1.5.3.3.1.8 Shocking indeed but true.

28.3 So we're local, we spread the virus locally. What's the big deal?

28.3.1 The big deal is the virus doesn't spread locally. it's a jumper. At least according to the government. Here we're talking Wales. We've seen England and Scotland. And we'll revisit England in due course.

28.3.2 We're the threat. We spread the virus. We spread the virus locally.

28.3.2.1 But the virus doesn't spread locally according to the Welsh government et al.

28.3.2.2 Sure, it tells us it does implicitly by dint of lockdown, social distancing, masks, travel restrictions, restaurant closure.

28.3.2.3 Explicitly in its data it doesn't. It says the opposite or at least something very different that contradicts the local-spread condition of Covid-19.

28.3.2.4 In local spread the vast majority of cases accumulate locally before sadly an occasional wanderer takes it out of region and a new contagion starts if the locals haven't magically but very responsibly contained the virus in its new home.

28.3.2.4.1 If there's 100 people spreading it in your local town and 1 person goes another fifty miles away to an untouched town, then the 100 people spreading it in your local town are going to be accelerating the contagion far faster than the 1 person in the distant town.

28.3.2.4.1.1 To have got to 100 people means the contagion is already well established. And now those 100 people will infect a proportion (no it's not exponential) and that proportion is going to be a lot more than the 1 person in a different town.

28.3.2.4.1.2 It's called an outbreak. And when the people in the outbreak wander off to infect others that's community transmission. Or at least that would be my common sense observation.

28.3.2.4.1.3 The maths doesn't change. We're local. We infect locally. We infect within a mile more than within ten miles, within ten miles more than within 100 miles, and it's extremely unlikely we'll be getting on a plane to infect 1000 miles away. A few might. 99.9% will be at home infecting within their home county, their home country, but overwhelmingly local.

28.3.2.4.1.4 Yet Covid as a 'pandemic' hasn't bothered to be local. It's whipped around the world and spread with ease… only we don't get to see the real covid. We get to see reported covid.

28.3.2.4.1.4.1 And reported covid can indeed spread with ease.

28.3.2.4.1.4.2 It's just a shame if it violates physical reality and the nature of human society is a reality. It is physical. It is observable. It is inescapable.

28.3.2.4.1.4.3 And it utterly violates what the government of Wales is claiming.

28.3.2.4.1.5 The UK government as with other governments regionally and internationally insist that transmission is local by proximity of humans,

28.3.2.4.1.5.1 The data says that Covid-19 spreads non-locally preferring to infect a new region before it even escalates the first region. An impatient traveller that never settles.

28.3.2.4.1.5.1.1 That's not community transmission.

28.3.2.4.1.5.1.2 That's not local.

28.3.2.4.1.5.1.3 And that's only possible if we're not local.

28.3.2.4.1.5.1.4 So either human beings do not tend to form communities and operate with a bias to local environs or covid does not spread by human carriers or the data reported by the government here Wales is false.

28.3.2.4.1.5.1.4.1 Well humans do form communities and spend their lives locally not randomly remotely. Even a non-random remote (move somewhere) is just a shift to a new local. Literally moving to a new locale.

28.3.2.4.1.5.1.4.2 If covid is indeed real then whether bacterial, viral, whatever, it is indeed if infectious then likely carried by human carriers.

28.3.2.4.1.5.1.4.3 So if we do form communities and do operate locally and covid does spread via human carriers then only one possibility is left: the data is false.

28.3.2.4.1.5.1.4.4 Now why would the government want to give the false impression of a massive threat and have we seen this before?

28.3.2.4.1.5.1.4.4.1 PF gave the false impression of a massive threat with ICCRT R9.

28.3.2.4.1.5.1.4.4.2 CW gave the false impression of a massive threat with 80% infected 1% of those dead.

28.3.2.4.1.5.1.4.4.3 The govt gave the false impression of a massive threat with 'lockdown is working' when it hadn't saved a single case or single life.

28.3.2.4.1.5.1.4.4.4 CW PV and the government give the impression of a massive threat with the false meme of an 'exponential' virus.

28.3.2.4.1.5.1.4.4.5 Is there in fact any arm or aspect of the government that has emphasised anything but the massive threat of the virus?

28.3.2.4.1.5.1.4.4.6 Not really.

28.3.2.4.1.5.1.4.4.7 So why should we be surprised that Wales turns out to be reporting figures that give the impression of a massive threat but which turn out to contradict a fundamental and critical requirement for being real: that the virus spreads locally?

28.3.2.4.1.5.1.4.4.8 The virus in Wales shows non-local spread, a preference for not spreading locally but spreading elsewhere in a new region.

28.3.2.4.1.5.1.4.4.9 And since it has to be carried by people, that means people are preferring to spend their time anywhere but their home county.

28.3.2.4.1.5.1.4.4.10 That simply isn't practical, possible, or in any way consistent with reality.

28.3.2.4.1.5.1.4.4.11 So the Welsh reported cases are fraudulent. It's as simple as that.

28.4 What do we mean by Wales spreading non-locally?

28.4.1 We mean a preference for not spreading locally but spreading elsewhere in a new region.

28.4.2 Where do we see that in the data?

28.4.2.1 Believe it or not we already gave you that information a long time ago.

28.4.2.1.1 Swansea was triggered on the 27th Feb with a single case.

28.4.2.1.1.1 Cardiff followed on the 4th March with a single case with no further cases from Swansea to date.

28.4.2.1.1.2 At this point then on 4th March 'Total Boards' was 2, 'New Boards' was 1 (Cardiff), Cases Per Board Max was 1 for daily and 1 for total, and Wales had had 2 cases.

28.4.2.1.1.3 Between 7th March and 14th March 17 boards were triggered.

28.4.2.1.1.3.1 As of the 14th 'Total Boards' was 19, 'New Boards' that day was 1 (Vale of Glamorgan), 'Cases Per Board Max' were 4 daily (that day) and 15 total (cases to date in the worst hit region). Wales had 103 cases in total.

28.4.2.1.1.3.2 On the 16th March two further boards joined (were triggered) and on the 21st March the final board joined bringing the total boards triggered (infected, with cases) to 22.

28.4.2.1.1.3.3 In 8 days 17 boards (new regions) were triggered.

28.4.2.1.1.3.3.1 At the start of that period the first new region was hit when maximum cases per day in any region was 1, maximum cases per region was 1, and Wales had 3 cases… yet they had sufficient 'infecteds' to go out to 17 new regions and (five days earlier) infect each one to ensure a massive surge of 17 regions in the next 7 days.

28.4.2.1.1.3.3.1.1 At cases as 'symptomatic' the ratio of infecteds to cases is around 3 to 1 maybe. At cases as 'ill' it's more like 10 to 1. So between 10 and 30 people suddenly rose up and rushed out to those 17 new regions to infect them. Does that sound plausible?

28.4.2.1.1.3.3.2 At the end of the 8 day period, maximum cases per day was 4, the worst hit board had 15 cases, and there were a total of 87 cases in Wales across 19 boards, averaging around 4 cases per board.

28.4.2.1.1.3.3.2.1 The 'local' contagions had barely started yet the infecteds had rushed out to cover all but 3 of the 20 uninfected boards. Is covid a mind-altering virus that compels people to find uninfected regions and travel to them?

28.4.2.1.1.3.3.2.2 The virus infected more regions in that 8 day period than there were cases in the worst hit region by the end of the period.

28.4.2.1.1.3.3.2.3 The virus infected seventeen times as many regions in that 8 day period than there were cases in the worst hit region in the beginning of that period.

28.4.2.1.1.3.3.2.4 That isn't a virus staying local and infecting local people. Not even close.

28.5 If an apologist for the virus or government narrative wants a plausible explanation for how those regions became infected we'd have to look at an external factor like a planeload with maybe a rugby team or choir returning from Wuhan infected and rushing to their seventeen uninfected home regions.

28.5.1 Does that sound plausible?

28.5.1.1 Maybe the government will claim that's exactly what happened.

28.5.1.2 Until then the Wales data says that no, the virus didn't build locally and then 'shed' the occasional wandering infected person.

28.5.1.3 It says the councils surged and rushed to get their first covid case.

28.5.1.3.1 How they did so would require an in-depth investigation by investigators independent of the government and with integrity

28.5.1.3.1.1 So it's not going to happen

28.5.1.3.1.2 Instead the data is going to remain just another indicator of the abnormal nature of the UK virus and an indicator of fraud

28.5.1.3.1.3 It's up to the court whether an indication of fraud gives rise to the kind of investigation that leads to the proof of fraud sufficient for criminal charges

29.0 England Local Authority Data

29.1 We were fortunate to find a dataset previously alluded to for England being 'comparison_of_geographic_allocation_methodologies.xlsx' from [x].

29.1.1 Our previous sources for England (NHS data) started on March 19th by which time the contagion was already well established.

29.1.1.1 As such the opportunity to do a Wales or Scotland style day-1 analysis was not available.

29.1.1.2 The new dataset had case data back to the very first case in York on 30th Jan.

29.1.1.2.1 That seems early but we trust that the data is indeed covid and is indeed accurate.

29.1.1.2.1.1 We can test by the following.

29.1.1.2.1.2 On 30th June approximately the end of the primary contagion the England Local Authority data reports 236,210 cases. The UK reports 283,545 to the WHO on that date. The England data represents 83% of the WHO figure for the UK. England at 55 million people represents 83% of the UK 66.25 million people that we use based on the original Whitty 80% infected 1% deaths and 530,000 deaths reported in the media.

29.1.1.2.1.3 Thus the local authority data is exactly proportional in terms of a fraction of the entire UK population both being at 83%.

29.1.1.2.1.4 As such we consider that the data is indeed Covid and accurate at least in the sense that it represents the governments reported cases for England at that time.

29.1.1.3 In regard to local authorities which escaped covid, Wikipedia references 339 principal councils in multiple tiers. That is at least of the same order as the 315 for which data is supplied but we would not draw any further conclusion nor need to.

29.1.1.3.1 With the above calculation showing that we have case data in line with the UK WHO reported cases at June 30th we can consider the data to be complete in regard to England case data.

29.1.1.3.2 For the purpose of the analysis we will only be looking at the early segment but nevertheless we can consider the data to be a definitive report of England cases and so legitimate and definitive for our analysis.

29.2 We will be doing a similar analysis as for Wales and given the extensive treatment given to the issue of community spread and the nature of human society and behaviour we will not go over the same ground again

29.2.1 The core principles which we consider evident and pertinent are the following

29.2.1.1 The government has promoted community spread as its core narrative for cause of covid spread

29.2.1.1.1 That is evident from lockdown, social distancing, masks etc.

29.2.1.1.2 We are the threat.

29.2.1.1.2.1 Ordinary people going about their day not drones the water supply or any other factor.

29.2.1.1.2.2 We carry the virus as infected people and by proximity or leaving the virus on surfaces we put others at risk some of who duly get infected.

29.2.1.2 The virus has a globally accepted narrative of infection, latency (delay to infectiousness), incubation (delay to symptoms), infectious period, time to recovery or death.

29.2.1.2.1 The periods are not material to the analysis but appear to be of the order of 3 to 5 days for latency, 5 to 8 days for incubation, 14 days for recovery, self-isolation, or death though as our work shows the case-death lag is itself an issue.

29.2.1.2.2 By the law of large numbers the larger the sample the less the variation

29.2.1.2.2.1 Put another way the more people we're looking at the more likely they'll conform to averages and other statistical measure of normal or typical

29.2.1.2.3 We treat the proportion of infecteds to cases to be consistent in the short time period that we'll be studying

29.2.1.2.3.1 As such we do not need to attempt the reversing out of infecteds from case data

29.2.1.2.3.2 Case data will be proportional to infecteds

29.2.1.2.3.2.1 If there's a case there had to be at least one infected to turn into the case and presumably a group of infecteds in a ratio consistent with the number of infecteds necessary for a case to arise.

29.2.1.2.3.2.2 The meaning of a case as symptomatic or seriously ill again doesn't matter as long as it is consistent

29.2.1.2.3.2.2.1 We treat cases as homogenous. They can be homogenous identical or homogenous as a collection eg: ten cases might typically include 6 symptomatic, 3 seriously ill, 1 death.

29.2.1.2.3.2.2.2 We are making a statistical point over 315 local authorities. Variation in the significance of one individual case or a few cases will not affect the analysis.

29.2.1.2.3.2.2.3 If someone wishes to offer a more detailed analysis based on clinical records that would be fascinating but it is not material to the current analysis.

29.2.1.3 As the carriers of the virus the behaviour of the virus in terms of spread is determined by our behaviour.

29.2.1.3.1 Again demonstrated by the government's measures on lockdown, social distancing, mask wearing.

29.2.1.3.2 Our behaviour as humans is to compress into communities.

29.2.1.3.2.1 We are relatively speaking highly sophisticated technological pack or herd animals.

29.2.1.3.2.1.1 Nowhere is this more elegantly demonstrated than in the effectiveness of the governments messages on mainstream media which might as well be formal hypnosis given their effectiveness

29.2.1.3.2.1.2 For our purposes we are concerned with another aspect of this compressed community nature which is that we are overwhelmingly local.

29.2.1.3.2.1.2.1 That is to say that of course we can move as individuals and using cars and mass transit we can travel huge distances as individuals and via airplane travel to distant continents or even around the world.

29.2.1.3.2.1.2.2 But we don't.

29.2.1.3.2.1.2.2.1 Statistically the mass of humans is to be found at home or within a few miles of their home.

29.2.1.3.2.1.2.2.1.1 The exceptions prove the rule.

29.2.1.3.2.1.2.2.1.1.1 Some people travel the world as a lifestyle. It is a statistically insignificant number.

29.2.1.3.2.1.2.2.1.1.2 Some people commute to cities an hour or more away. The vast majority do not.

29.2.1.3.2.1.2.2.1.1.3 We may visit relatives hundreds of miles away. Such visits are typically rare and special occasions.

29.2.1.3.2.1.2.2.2 Overwhelmingly our lives can be defined by the humdrum.

29.2.1.3.2.1.2.2.2.1 Trips to work, to school, the village or town to shop, weekend trip to the mall and an annual vacation maybe or two.

29.2.1.3.3 As a mathematician then we can suggest with good reason that if we were to 'track and trace' a human we would typically find that the greater the distance from home the lower the chance of finding us there and likely the relationship is going to be exponential or similar.

29.2.1.3.3.1 It is the general principle which matters but for illustration we might find ourselves 90% of the time within a mile of a consistent location (our home or our work or split between the two), 9% of the time within 10 miles, 0.9% within a 100 miles, 0.09% within 1000 miles.

29.2.1.3.3.1.1 The accuracy of that model is not material.

29.2.1.3.3.1.2 As long as the reader recognises the phenomenon that we are creatures of habit tied to locations that will suffice.

29.2.1.3.4 A corollary of that is that any infecting we do will reflect that local compression by which we mean that our lives are compressed into a small number of locations from which we rarely stray.

29.2.1.3.4.1 Barring professional itinerants like lorry drivers who go long distance point to point and travelling salesmen therefore we will tend to stay within the domain of a single local authority or based on proximity to a second or a work location in a second perhaps two such authorities.

29.2.1.3.4.2 We have our local shops, local restaurants, local cinema, local mall, local town.

29.2.1.3.4.2.1 We are local creatures.

29.2.1.3.4.2.2 The virus then is a local creature.

29.2.1.3.4.2.2.1 Simply because it requires us to carry it.

29.2.1.3.4.2.2.2 The ability of the virus to spread so easily and rapidly around the world is an interesting counterpoint to that.

29.2.1.3.4.2.2.2.1 The narrative of infecteds on airplanes arriving home is plausible and may indeed have happened exactly as per the narrative.

29.2.1.3.4.2.2.2.2 However the aggressive ease with which a single or very few visitors took down entire nations is somewhat at odds with a local virus which is what covid has to be because we are local creatures.

29.2.1.3.4.2.2.2.3 This analysis rather reinforces that point and awakens a possibly line of further enquiry.

29.2.1.3.4.2.2.2.4 For the moment it suffices that the reader appreciates the limitation of a local virus.

29.2.1.3.4.2.2.2.4.1t can travel only if we travel.

29.2.1.3.4.2.2.2.4.1 Whence lockdown, social distancing, masks etc.

29.3 We are therefore going to apply a simple model to the case data

29.3.1 We do not include and present mapping data

29.3.2 We simply observe that a local virus carried by local humans will develop locally faster than it will spread and develop in new areas.

29.3.3 To compare the local vs new spread we apply some simple rules based on reasonable indeed necessary conclusions

29.3.3.1 The first case must be from an external source that is to say a visitor from an external area

29.3.3.1.1 Self-infection is not allowed.

29.3.3.1.1.1 Community spread says that we carry the virus and by proximity or shedding onto a person or surface a person in proximity to our position now or later picks up the virus

29.3.3.1.1.2 Overwhelmingly the government emphasises immediate proximity with lockdown, social-distancing, masks

29.3.3.1.2 As cases are proportional to infecteds we treat an area without cases as an area without infecteds.

29.3.3.1.2.1 The exception of a very small and contained group of infecteds who do not spread and do not develop into cases will be rare and not material

29.3.3.1.3 The external source might be a resident returning home infected or a visitor from abroad or a visitor from England

29.3.3.1.3.1 A visitor from England is possible only if they are from an infected area in England

29.3.3.1.4 As such we distinguish cases as follows.

29.3.3.1.4.1 The first case in a new area is attributed to an external source.

29.3.3.1.4.1.1 Every subsequent case in the area is attributed to local infection and is referred to as a local case

29.3.3.1.4.1.2 Until England has local cases the first cases arising in new areas are deemed to be from abroad

29.3.3.1.4.1.2.1 Once England has local cases the first cases in new areas are attributed to domestic spread

29.3.3.1.4.1.2.1.1 The domestic spread to a new area from another infected English area is referred to as a jumper

29.3.3.1.4.1.2.1.2 The virus has jumped from one infected English area to another previously uninfected area

29.3.3.1.4.1.2.1.3 Only the first case in a new area is attributed to jumpers

29.3.3.1.4.1.2.1.4 New cases are not attributed to jumpers until the first local case has occurred

29.3.3.1.5 Walking through the very first cases in England will illustrate the procedure

29.3.3.1.5.1 The first case in the data is attributed to York on 30th January

29.3.3.1.5.1.1 With no previous cases in England the source must be external

29.3.3.1.5.1.2 With no infected areas prior to this case the source must be foreign

29.3.3.1.5.1.2.1 Recall that we treat presence of cases and presence of infected as synonymous

29.3.3.1.5.1.2.1.1 We could reverse engineer and model infections from cases but it would add considerable complexity for no material gain

29.3.3.1.5.2 The second recorded case is in Brighton on the 5th February

29.3.3.1.5.2.1 At this time York has not experienced a second case which would be attributed to local spread and so with no local spread in England the first Brighton case is also attributed to external foreign as opposed to external domestic (jumper).

29.3.3.1.5.2.2 On the 8th February Brighton reports a second case. In fact it reports 3 cases on that day.

29.3.3.1.5.2.2.1 Since Brighton has already been triggered by the first case these three cases and all subsequent cases in Brighton will be deemed local

29.3.3.1.5.2.2.2 England has had its first case of local spread. Three of them.

29.3.3.1.5.2.2.2.1 England is now experiencing community spread in our terms.

29.3.3.1.5.2.2.3 Yes this is a model but it is based on actual cases and it is using rational and simple rules to allocate the nature of cases

29.3.3.1.5.2.2.3.1 The issue is not whether it is perfectly accurate but whether it is perfectly reasonable and reflects a reasonable interpretation of events

29.3.3.1.5.2.2.3.2 The model is generous to local infection and therefore likely to support local infection and a local virus and community spread

29.3.3.1.5.2.2.3.2.1 The external category only gets two cases

29.3.3.1.5.2.2.3.2.1.1 Now that England has had its first local case no further cases will be attributed to foreign visitors or residents returning home infected

29.3.3.1.5.2.2.3.2.1.2 That is certainly or plausibly inaccurate as air travel did not cease but even if an external visitor or resident returned infected they would randomly fall into a local infected or still uninfected region according to the relative density of the two classes of area

29.3.3.1.5.2.2.3.2.1.3 Without detailed information as to travellers and their infected state it is simpler and reasonable to their possible resulting infections as minor perturbations of the existing local or jumper categories

29.3.3.1.5.2.3 On the 8th Feb Cherwell also reports a case

29.3.3.1.5.2.3.1 This is Cherwell's first case so it is external as to source of the infection and since England has its first local infection in Brighton being Brighton's second case the Cherwell case is treated as domestic

29.3.3.1.5.2.3.1.1 As such Cherwell's first case is external domestic which we refer to as a jumper

29.3.3.1.5.2.3.1.1.1 The virus has jumped nominally from Brighton to Cherwell.

29.3.3.1.5.2.3.1.1.2 York has yet to experience a local case and so we would not say that the virus has jumped nominally from York to Cherwell as an alternative.

29.3.3.1.5.2.3.1.1.2.1 Super strictly we could allow that the foreign infector from York or the first case from York or an infected from York had travelled to Cherwell but we are not in fact concerned with the location of the source of the infection specifically and highlight the potential mechanics simply to illustrate the nature of the scenario we are developing.

29.3.3.1.5.2.3.1.1.2.2 As Brighton has already reported its first domestic case and we have 312 areas to go after York, Brighton and Cherwell, the issue of whether York should be given credit for Cherwell is moot. It is not material to what is about to unfold.

29.3.3.1.5.2.4 Brighton reports a 3rd case which is therefore a second local case on the 9th February.

29.3.3.1.5.2.4.1 This is encouraging for the narrative and is what we'd expect to see. One place developing cases now that it's been triggered (had its first case) while other areas remain untouched.

29.3.3.1.5.2.4.2 If this pattern continues with Brighton developing substantially and other areas developing only after a delay of some days or even weeks that would be evidence of a natural contagion with community spread.

29.3.3.1.5.2.4.2.1 This is reflected in the data for China with the province of Hubei which is home to Wuhan being overwhelmingly the province hit by covid and within Hubei it is Wuhan that is overwhelmingly the area hit within that province.

29.3.3.1.5.2.5 Gloucester and Lewisham each report a case on the 11th Feb and as their first cases that is two new areas triggered and the cases are allocated as jumpers not local.

29.3.3.1.5.2.6 A gap ensues of ten days until between the 21st Feb and 25th Feb 8 new areas are hit so that Gedling, Chiltern, Chichester, Lambeth, Ealing, High Peak, Southwark with two cases and Waverley have been triggered with their first case and these 9 cases are allocated to the jumper class.

29.3.3.1.5.2.6.1 Several things should begin to occur to the reader.

29.3.3.1.5.2.6.1.1 Brighton recorded its 3rd case on the 9th Feb and it is now the 25th over two weeks later and no new cases. That doesn't sound like a very aggressive virus, one that has managed to devastate the world by all reports at least if you pay attention to the media without critical thinking or analysis.

29.3.3.1.5.2.6.1.2 To infect these 8 new areas with 9 new cases there are only the 5 prior areas of York (we'll allow it), Brighton and Hove (which is quiet after five cases), Cherwell (with its single case), Gloucester and Lewisham (each likewise with a single case).

29.3.3.1.5.2.6.1.2.1 England has a grand total of 9 cases, 10 including one in the unallocated category which with no area specified is normally ignored. In this instance while there are so few cases we'll include it to be conservative.

29.3.3.1.5.2.6.1.2.2 And these 9 or 10 cases provided the pools of infecteds that implicitly travelled to 8 new areas to infect them.

29.3.3.1.5.2.6.1.2.2.1 If it takes a case-pool-of-infecteds to generate a case based on whatever the ratio is which we don't need to know, then 9 of the 10 case pools of infecteds available travelled to 8 new areas to provide the new areas with a case each and two for Southwark.

29.3.3.1.5.2.6.1.2.2.2 Had we not acknowledged the unknown then 100% of the case-pools-of-infecteds would have had to have travelled to new areas to seek out people to infect.

29.3.3.1.5.2.6.1.2.2.3 Nor are these new prior areas or new areas even approximately adjacent to one another as we might expect from community spread.

29.3.3.1.5.2.6.1.2.2.3.1 York, Brighton, Gloucester, Chichester, Lewisham. North, South East, South West, South something and London? That's the four corners of England pretty much covered plus London within the first 8 areas. That also doesn't sound like community spread.

29.3.3.1.5.2.6.1.2.2.3.1.1 It's early days and perhaps four independent travellers travelled to infected nations and started the ball rolling. We're creating a what-if and perhaps the reality was they were indeed external foreign as returning residents or visitors.

29.3.3.1.5.2.6.1.2.2.3.1.2 However it doesn't look like community spread and if it continues not looking like community spread over 315 local authorities then that's way beyond a statistically significant sample which is commonly held to begin at around 10 data points.

29.3.3.1.5.2.7 We've illustrated the process and supplied the first data points and already we're seeing surprising results that don't sound like community spread.

29.3.3.1.5.2.8 The three classes of case are foreign, jumper, and local.

29.3.3.1.5.2.8.1 Foreign contains two areas and two cases: York and its first case; and Brighton and its first case. York as England's first case had to be seeded externally to England. Brighton arguably could have been infected by York but since we want to look at local vs jumper ratios and York has yet to produce a local case we would end up dividing by zero so we treat Brighton as a second and the only other foreign external infection.

29.3.3.1.5.2.8.1.1 This penalises jumpers who are already under the disadvantage that they only get the first case for a new area. Local gets all the rest.

29.3.3.1.5.2.8.1.2 In total with 236,210 cases to 30th June and only 315 areas whose first cases can be attributed to jumpers, the rest going to local, it's inevitably going to be an easy win for local vs jumpers at 236,210 vs 315.

29.3.3.1.5.2.8.1.2.1 Except that York and Brighton being allocated to foreign not jumper it's going to be 236,210 vs 313. So we're certainly not doing jumpers any favours. If local cases dominate, then that's consistent with community spread and there's no case against the data or government in this context.

29.3.3.1.5.2.8.1.2.2 The problem is that the story has to remain consistent and as with case-death lag and lag-14 death rates in the words of Princess Irulan "A beginning is a delicate time."

29.3.3.1.5.2.8.1.2.2.1 In the beginning councils don't have to rush to be in on covid but if they do, there had better be plenty of contagion already going around else there's going to be a lot of jumpers and not much local action.

29.3.3.1.5.2.8.1.2.2.1.1 That is the very opposite of community spread.

29.3.3.1.5.2.8.1.2.2.1.2 As it turns out we're going to observe a very similar phenomenon to that of case-death lag and lagged death rates.

29.3.3.1.5.2.8.1.2.2.1.2.1 You cannot pump up death counts without also pumping up case counts 14 days earlier or so else the death rates look absurd when you translate them back to the cases to which they should apply.

29.3.3.1.5.2.8.1.2.2.1.2.2 Cases however have already been reported so if you're going to pump up death rates you have to anticipate and pump up case rates early and then be patient before finally declaring your pumped up death rates.

29.3.3.1.5.2.8.1.2.2.1.2.3 Governments in covid have not been patient.

29.3.3.1.5.2.8.1.2.2.1.2.4 The UK hits 100% death rate on a lag-14 basis. Spain hits 322%. That really doesn't look good when three people die of covid for every person reported to have covid.

29.3.3.1.5.2.8.1.2.2.2 So if the government and local authorities were going to be tempted to pump-up covid declarations of cases they would need to do so locally first and then introduce new areas as the local contagions shed as was to be expected.

29.3.3.1.5.2.8.1.2.2.2.1 Otherwise the end result would not look like community spread but a rush to invent and declare covid via spontaneous self-infection.

29.3.3.1.5.2.8.1.2.2.2.1.1 Because the infecteds simply wouldn't be there to make a plausible case for the spread unless the infecteds were rushing round the country instead of doing what humans generally do and staying local.

29.3.3.1.5.2.8.1.2.2.2.1.1.1 Especially when they have a cold that's a candidate for covid.

29.3.3.1.5.2.8.1.2.2.2.1.1.2 People are local overwhelmingly. Even more so when they're sick or down with a cold or fever. Even more so when the government is emphasising the scary nature of covid. But this is early days. Just the local and sick elements apply in February we'll allow.

29.3.3.1.6 How then did the contagions progress?

29.3.3.1.6.1 We last recounted 8 new councils in 5 days between the 21st Feb and 25th Feb.

29.3.3.1.6.2 The 26th Feb sees 4 councils reporting cases, the 27th 7 and the 28th 10 councils reporting cases.

29.3.3.1.6.2.1 Of those 4, 5 and 7, the significant majority (16 out of 21) are new councils.

29.3.3.1.6.2.1.1 That alone should be sending warning flags flying.

29.3.3.1.6.2.1.2 Unless of course the existing councils (by which we mean local authorities but common parlance is 'council') were reporting a slew of cases to balance these new councils.

29.3.3.1.6.2.1.2.1 By a generous figure we'd allow 10% of cases to be triggered externally by itinerant locals wandering astray. More realistically we'd expect around 1%.

29.3.3.1.6.2.1.2.2 At 10% existing councils need to have generated 10x (1/10%) the 16 new council cases to make the community spread narrative plausible and that means 160 cases reported.

29.3.3.1.6.2.1.2.3 At 1% existing councils need to have generated 100x (1/1%) the 16 new council cases to make the community spread narrative plausible and that means 1,600 cases reported.

29.3.3.1.6.2.1.2.4 Actual local cases reported (first case gets credited to external, as it has to be, after that everything's local) by the 28th is 9 cases vs 29 jumper cases.

29.3.3.1.6.2.1.2.4.1 The 9 local cases is a little short of the 160 needed to look plausible for community spread at 10% non-local spread, or 1600 for a more realistic 1% non-local spread we suspect.

29.3.3.1.6.2.1.2.4.2 To have 9 local cases supposedly explaining 29 non-local cases is in fact so absurd that we could end the analysis right there.

29.3.3.1.6.2.1.2.4.3 Nevertheless we continue.

29.3.3.1.6.2.1.2.4.4 In fact the government may be relieved to hear that we are already past the worst.

29.3.3.1.6.2.1.2.4.4.1 If we back up two days to the 26th there were 4 local cases and 16 jumper cases so that infecting new councils dominated the agenda of the virus to such an extent that it was sending out infecteds to new areas at four times the rate it was allowing them to stay behind and maintain local contagions and community spread.

29.3.3.1.6.2.1.2.4.4.1.1 Now can a virus have that kind of mind-altering effect to drive infecteds out to entirely new councils to infect them?

29.3.3.1.6.2.1.2.4.4.1.1.1 Perhaps, but that's pretty much in the realm of science-fiction.

29.3.3.1.6.2.1.2.4.4.1.1.2 Where as driving new councils to register covid cases just takes a memo if you're the government.

29.3.3.1.6.2.1.2.4.4.1.1.3 Which then stretches credulity less: a memo or a mind-altering virus with a very advanced and specific goal of dominating new councils.

29.3.3.1.6.2.1.2.4.4.1.1.4 We suggest the memo. The government might feel otherwise.

29.3.3.1.6.2.1.2.4.4 Jumpers will continue to dominate the new cases with jumpers overwhelming local cases until the 7th March when finally there are enough local cases now to match the jumper cases.

29.3.3.1.6.2.1.2.4.4.1 That still means that infecteds are under a bizarre compulsion to toss a coin and go 50:50 whether to stay local or go find a new council to infect which by this point might be hundreds of miles away.

29.3.3.1.6.2.1.2.4.4.2 If this sounds more like a plot for zombie apocalypse, it is.

29.3.3.1.6.2.1.2.4.4.2.1 There is no plausible scenario where half the people who are infected will seek out new councils to infect.

29.3.3.1.6.2.1.2.4.4.2.1.1 Not by accident. Not by design. And certainly not by mind-altering virus effects.

29.3.3.1.6.2.1.2.4.4.3 The only people who could have councils rush to find covid cases are people who want a rush in covid cases and who have the power to coerce councils into finding those cases.

29.3.3.1.6.2.1.2.4.4.3.1 That isn't the red cross and it isn't the public nor even the media for all their sins.

29.3.3.1.6.2.1.2.4.4.3.2 That's the government.

29.3.3.1.6.2.1.2.4.4.3.2.1 It doesn't matter how much someone objects to conspiracy theories or dislikes criticism of the narrative the government's own data makes entirely clear that new councils were being infected at an astonishing rate and as they weren't spontaneous self-infections (unless they were spontaneous fraudulent declarations) then they had to come from already infected places and cases.

29.3.3.1.6.2.1.2.4.4.3.2.2 It's simple arithmetic and the simple arithmetic says there weren't enough local cases to make it look plausibly like community spread.

29.3.3.1.6.2.1.2.4.4.3.2.2.1 We can phrase it as a ratio of non-local to local (4x) or non-local as a percentage of total (domestic, strictly, essentially identical) spread (80%, 4:1) or local as a percentage of total (20%, 1:4).

29.3.3.1.6.2.1.2.4.4.3.2.2.2 It's the same math however we express it. Infecteds were heading out to infect other councils at a rate greatly exceeding staying local from the 21st Feb to 7th March, from the 6th council to join (be hit) to the 155th council, just about perfectly 50% of all councils.

29.3.3.1.6.2.1.2.4.4.3.2.2.2.1 At this point on the 7th March with jumpers finally matched by local cases, jumpers represent 50% of cumulative total (domestic, but with only two assigned to foreign it's indistinguishable) cases down from 80% at peak.

29.3.3.1.6.2.1.2.4.4.3.2.2.3 For community spread to be plausible we need jumpers to be lower than 10% of cases in our view and personally we suspect the correct figure would be closer to 1% but we'd accept 10% as a reasonable figure at which to drop the issue.

29.3.3.1.6.2.1.2.4.4.3.2.2.3.1 However that doesn't mean that the community spread narrative becomes reasonable when jumpers drop to 10%. It means that jumpers should never have been above 10%. Humans don't wildly go out to infect new places just because it's covid.

29.3.3.1.6.2.1.2.4.4.3.2.2.3.2 We highlight the 10% to show by what degree jumpers have exceeded reasonable and contradicted community spread.

29.3.3.1.6.2.1.2.4.4.3.2.2.4 On the 7th March jumpers were finally matched by local cases making jumpers 50% of total (domestic) cases.

29.3.3.1.6.2.1.2.4.4.3.2.2.5 On the 12th March jumpers finally decline to 20% of covid cases by which time 265 of 315 councils have declared for covid representing 84% of councils.

29.3.3.1.6.2.1.2.4.4.3.2.2.5.1 It's still an absurdly high number but it's finally coming down to plausible territory as the local cases pick up.

29.3.3.1.6.2.1.2.4.4.3.2.2.5.2 Recall that jumpers could only ever claim 315 cases (313 with two foreign).

29.3.3.1.6.2.1.2.4.4.3.2.2.5.3 Local would go on to claim 236,210 (less 315) by 30th June and 1,174,856 by 15th December courtesy of testing.

29.3.3.1.6.2.1.2.4.4.3.2.2.5.4 All the government had to do was wait and it could have had a perfectly plausible case history showing the community spread that it claimed was the threat and which it declared to WHO as the nature of our covid experience.

29.3.3.1.6.2.1.2.4.4.3.2.2.5.5 Jumpers (non-local cases initiating new councils) didn't drop to 10% of traffic until 17th March by which time 301 or 96% of England councils (local authorities) had declared they'd found their first case.

29.3.3.1.6.2.1.2.4.4.3.2.2.5.6 The last council would join on 31st March at which point jumpers had been credited with their last possible and 313th case. By that point local cases at 31,365 were finally able to relegate jumpers to 1% our preferred threshold that had we seen that throughout, we'd have considered the contagion appropriately community spread.

29.3.3.1.6.2.1.2.4.4.3.2.2.5.7 Instead the councils rushed to join the covid agenda and declared themselves to have cases even though they'd be implying spontaneous self-infection because there simply weren't enough cases to warrant a 'spread' from local to the new areas.

29.3.3.1.6.3 When non-local new cases outnumber local cases 4 to 1, that's not community spread.

29.3.3.1.6.3.1 Impatient to push the massive threat and to support it with reportable figures England and hence the UK found covid spreading throughout the land.

29.3.3.1.6.3.2 Unfortunately while spreading throughout the land sounds like a classic epidemic or plague we do not live in such superstitious times that we have no concept of arithmetic or numbers or local vs non-local.

29.3.3.1.6.3.3 The government could have waited and had a contagion that looked consistent with its claimed community spread.

29.3.3.1.6.3.4 Instead it reported numbers that utterly violated the most basic premise of human society which is that we're creatures of habit tied to our homes and our workplace and are overwhelmingly local.

29.3.3.1.6.3.5 We don't go racing off to uninfected councils to infect them.

29.3.3.1.6.3.6 And as we are the carriers in the government's community spread threat and measures since we don't go neither does the virus which after all is the whole point of lockdown, social distancing and masks.

29.3.3.1.6.3.7 The problem is that the government may have used its power to control us but it failed to control itself.

29.3.3.1.6.3.8 Its own figures say the virus spread geographically far beyond the rate that local cases could plausibly support.

29.3.3.1.6.3.9 Humans didn't change their behaviour so if the humans didn't change then the scenario presented was in fact not supported by local cases which means that the reported cases so eagerly reported are fraudulent.

29.3.3.1.6.3.10 And since all cases were reported in areas which derived their covid status from this fraudulent rush that makes all such reported cases suspect as being reported by suspect fraudulent councils.

29.3.3.1.6.3.10.1 That is deep and disturbing indeed.

29.3.3.1.6.3.10.2 For now all we state is that the claimed rush of councils to report covid cases in England utterly violates the local nature of human communities and thus flags the reported cases as fraudulent and in need of investigation for possible criminal charges of fraud and harm derived from that fraud.

30.0 Second Wave World Comparison

30.1 The prominence given to the 'second wave' by the UK government requires that we pay attention to how the 'second wave' has been experienced worldwide.

30.2 Consistent with the primary contagion March to June the west had managed to experience a very different 'second wave' to the Far East and Africa.

30.2.1 Consistent with the primary contagion countries in an intermediate location tend to have intermediate results.

30.2.1.1 It is an absurdity to claim that a virus has a political bias against western nations focusing most significantly on the western power centres

30.2.1.2 At 74 times worse hit than the Western Pacific Region as WHO defines it that is not a discrepancy that can be attributed to Vitamin D or 5G or GDP or climate.

30.2.1.3 Such a discrepancy can only be explained as an act of policy and by its consistency across western nations and by region it is clear that the policies are shared in common to a great degree.

30.2.1.4 There is no inherent superiority in Far Eastern nations which include Anglo nations such as Australia and New Zealand.

30.2.1.5 We reject the excuse that ‘mistakes were made’ given the clear lies misrepresentations and egregious ignorance inconceivable in expert advisors.

30.2.1.6 If any such excuse were countenanced for the primary contagion it is eradicated by the eight or nine months delay before the ‘second wave’.

30.2.1.6.1 It does not take eight months to make a phone call to the nations that have brushed this virus aside to ask what they did right and to implement that.

30.2.1.6.1.1 The answer is not lockdown which is equally proven to have been ineffective in Australia and New Zealand as it was in the UK.

30.2.1.6.1.2 There are two components which can readily be considered to contribute to the difference in outcomes.

30.2.1.6.1.2.1 Policies designed to maximise the perceived threat and recorded deaths in the west

30.2.1.6.1.2.1.1 These may include a number of distinct policies.

30.2.1.6.1.2.1.1.1 Misrepresentation of the virus and contagion

30.2.1.6.1.2.1.1.2 Mis-reporting of the virus and contagion

30.2.1.6.1.2.1.1.2.1 This may include mis-reporting non-covid deaths as covid deaths

30.2.1.6.1.2.1.1.2.2 This may include manufacturing of covid cases and covid deaths

30.2.1.6.1.2.1.1.3 Suppression of effective treatment in covid cases

30.2.1.6.1.2.1.1.3.1 This may include implementation of involuntary DNR (Do Not Resuscitate) orders

30.2.1.6.1.2.1.1.3.2 This may include suppression of effective existing treatments

30.2.1.6.1.2.1.1.3.2.1 Such treatments include treatments suppressed and derided in the West despite doctors’ and scientific reports of their efficacy such as Zinc, Vitamin D, HCQ

30.2.1.6.1.2.1.1.3.2.1.1 We do not attempt clinical analysis preferring to leave that to those properly qualified in such fields. However the wide publicity given to the above make them worth noting for consideration in that category.

30.2.1.6.1.2.2 Policies designed to minimise the recorded deaths in the Far East and Africa

30.3 The second wave may reasonably be considered to have been optional and experienced based on the geographic location and political alignment of the country in question.

30.3.1 We report the 147 countries with greater than 1 million population and more than 1000 covid cases based on government data supplied to the WHO and downloaded from the WHO Covid dashboard.

30.3.1.1 The period analysed was 23rd November to 22nd December 30 days during which many countries experienced clear second-wave characteristics including peak deaths for that local phenomenon in time.

30.3.1.2 The WHO data categories countries into six regions being Americas (AMRO), Europe (EURO), Eastern Mediterranean (EMRO), South East Asia (SEARO), Africa (AFRO) and Western Pacific (WPRO).

30.3.1.2.1 Generally our common understanding of Far East reflects the WPRO region and some of the SEARO region excluding the more obviously Indian aligned nations such as India itself. The distinction is not material to the outcomes of the analysis.

30.3.1.3 The figures are standardised by normalising to 100 million population by multiplying by 100 and dividing by the population in millions. Thus a UK figure of 1000 with a population of 66.25 million would be reported here as 1500 (1509.206).

30.3.1.3.1 The only figure which we do not generally use as-is for a country is that of China.

30.3.1.3.1.1 We are aware that Hubei the province in China which contained Wuhan experienced [85%] of China's cases and [95%] of its deaths. Thus while we quote China figures per the WHO our preference is always to compare other nations to Hubei (population 59.17m).

30.3.1.3.1.1.1 This eliminates the arguments that 'China lied' or 'China was lucky' based on its extremely low figures.

30.3.1.3.1.1.2 Hubei's figures are not extremely low. They are approximately mid-ranked in the world as befitting a region containing ground-zero for the contagion in Wuhan.

30.3.1.3.1.1.2.1 The Wuhan as ground-zero for Covid-19 is of course contradicted by findings of Covid-19 prior to 2020 in other regions in Europe and America but the narrative does not affect the numbers of cases and deaths reported and so is not material.

30.3.2 Of the 147 countries with over 1m population and over 1000 cases versus the 2464 standard 9 per 1000 deaths per day or 2464 deaths per day:

30.3.2.1 There were 8 countries reporting less that 0.1 deaths per day of whom seven were zero deaths (Vietnam, Thailand, New Zealand, Lesotho, Gambia, Equatorial Guinea, Central African Republic) and China 0.05 deaths.

30.3.2.1.2 There were 21 countries reporting fewer than 1 deaths per day the 13 additional countries reporting between 0.1 deaths per day and less than 1 being Australia, Chad, Yemen, Benin, Malawi, Sierra Leone, Cote d'Ivoire, Singapore, Haiti, South Sudan, Liberia, Uzbekistan, Nigeria.

30.3.2.1.3 There were 39 countries reporting fewer than 5 deaths per day the 18 additional countries reporting between 1 and fewer than 5 being Tajikistan, Ghana, Madagascar, Togo, Burkina Faso, Guinea, Cuba, DR Congo, Cameroon, Niger, Guinea-Bissau, Nicaragua, Mozambique, Rwanda, Somalia, Zambia, Venezuela, Congo.

30.3.2.1.3.1 World NGOs like to post ads on Facebook highlighting the struggle to contain Covid in such nations of Africa. Perhaps they should have put more effort into containing Covid in the UK and the West given their evident success in Africa. Unless that is merely more PR for covid-control and to promote the myth of a world universally hit and suffering from Covid. The reported figures give the lie to that narrative.

30.3.2.1.4 There were 46 countries reporting fewer than 10 deaths per day the additional 7 being Uganda, Angola, Ethiopia, Gabon, Senegal, Qatar, Botswana.

30.3.2.1.4.1 Uganda was the topic of an NGO post to celebrate the 'International Day of Epidemic Preparedness (UN)'. Given its excellent results it's a pity that our government didn't seek the advice of this enlightened nation.

30.3.2.1.4.2 At 46 countries and 2.67 billion people that is over one third of the world experiencing fewer than 10 deaths per day per 100m population vs 2464 standard deaths per day.

30.3.2.1.4.2.1 At 10 deaths per day that upper bound is 0.4% of a standard day's deaths.

30.3.2.1.4.2.2 For one third of the world Covid without any adjustment for age or comorbidities Covid-19 was 250 (246.4) times less dangerous than ordinary life.

30.3.2.1.4.2.3 You will search in vain for any such recognition in the mainstream media that the contagion we are experiencing in the UK is not even remotely the contagion being experienced in the rest of the world in particular the Far East and Africa.

30.3.2.1.4.2.4 The actual average daily deaths per 100m population for these 46 countries one third of the world's population is 3.6 deaths per day vs 2464 standard deaths at 9 per 1000 mortality.

30.3.2.1.4.2.5 It is inconceivable and beyond irresponsible and into outright mendacity to treat a disease that is 700 (683.4) times less dangerous than ordinary daily life as a material threat to life and society.

30.3.2.1.4.2.6 That is the real Covid-19 threat as achieved and experienced by one third of the world.

30.3.2.1.4.2.6.1 If we have not experienced that threat or lack thereof it is not because we have experienced Covid-19 but because we have experienced the policies and agendas of the western nations including the UK.

30.3.2.1.5 There were 55 countries reporting fewer than 20 deaths per day the additional 9 being Malaysia, Zimbabwe, Mali, Republic of Korea (South Korea), Sri Lanka, Kenya, Egypt, Bangladesh, Sudan.

30.3.2.1.5.1 It is difficult not to realise that we should have prayed to be in an impoverished disease ridden nation to have the blessing of riding out Covid-19 with so little to fear.

30.3.2.1.5.1.1 If we have been made to fear Covid-19 it is not because of Covid-19.

30.3.2.1.6 There were 73 countries reporting fewer than 50 deaths per day the additional 18 being Dominican Republic, Trinidad and Tobago, Bahrain, Japan, Philippines, Pakistan, UAE, India, Algeria, Saudi Arabia, Afghanistan, Bolivia, Mauritania, Myanmar, Kuwait, Kazakhstan, Uruguay, Namibia.

30.3.2.1.6.1 That is now 69% of the world's population (strictly the 7.649 billion population of the 147 countries with > 1m population and > 1000 cases) who experienced covid and their worst experience was less than 50 deaths per day or 2% of normal mortality, with normal life 50 times more dangerous for the worst hit nation (Namibia).

30.3.2.1.6.2 Over two thirds of the world's population experienced fewer than 50 deaths per 100m population or 0.7% of a standard day's deaths so that normal life was 150 times more dangerous than Covid-19 and that is before taking into account risk that isolates the old-and-sick as the sole category of citizen at material risk of Covid-19.

30.3.2.1.6.2.1 The media likes to public stories about the 'unusual' escapee from Covid-19 who got excellent results. NGO's publish their 'doing our best in the pandemic' stories. Both market fear and Covid-19 to the West happily ignoring that two thirds of the world experienced a Covid-19 so unthreatening that normal life was 150 times more dangerous.

30.3.2.1.6.2.2 In being silent and blind to the real figures in this ‘global pandemic’ makes the western governments, western media, western corporations, western education and medical establishments and western analysts, scientists, reporters and politicians demonstrate a complicity in an agenda that suits their purpose notwithstanding the falsehood of the narrative of fear that is being promoted and soaked up by the mass of western citizens.

30.3.2.1.6.2.2.1 These are the real figures. They are published daily by the WHO and accumulate official government statistics from essentially all nations around the world.

30.3.2.1.6.2.2.2 It is impossible to believe that a government and all its advisers and all its commentators and all its education and medical establishments have no idea that the WHO is publishing this data to which they contribute as the UK and that they have no idea what the numbers show for the rest of the world.

30.3.2.1.6.2.2.3 It is entirely plausible that they choose to be ignorant because it is off-message but that does not excuse the ignorance or the mendacity in representing Covid-19 to the British people as a massive threat when for two thirds of the world it isn’t even a minor threat. It is a miniscule threat.

30.3.2.1.6.2.2.4 The guilt of the UK government, advisors, reporters, scientists, universities, medical establishments, mainstream media and social media is not in question in committing fraud and ignoring reality to promote a false message and suppress legitimate and accurate reporting.

30.3.2.1.6.2.2.4.1 What is in question is solely whether there is any person in authority or court which retains legitimacy and integrity and is thereby willing to recognise the obvious disparity between the western experience of covid including the narrative of covid and the reality as disclosed by the worldwide governments’ own figures reported to WHO.

30.3.2.1.6.2.2.4.1.1 At this point there are no grey areas. The facts are unequivocal and so the issue for any authority or any individual is simple: are you for the British people truth and freedom or are you against them?

30.3.2.1.6.2.2.4.1.2 The courts have so far supported the government thus making their allegiance clear.

30.3.2.1.6.2.2.4.1.3 Is there any court or individual left who could astonish us by acting in support of the British people and against the fraudulent and criminal activities of the government as clearly demonstrated by the absurd disparity between the narrative and the reality?

30.3.2.1.6.2.2.4.1.3.1 We frankly doubt it. But we must at least record our testimony and we must hope to put it before a court in due course. If we do not try our failure is certain. If we try we may fail but we will at least know that the courts are irrevocably against the British people.

30.3.2.1.6.2.2.4.1.3.1.1 That will hardly come as a surprise to us.

30.3.2.1.7 There were 87 countries reporting fewer than 100 deaths per day the additional 14 being Syria, Indonesia, Kyrgyzstan, Jamaica, Nepal, Honduras, Norway, Eswatini, Iraq, Oman, Finland, Belarus, Ireland, El Salvador

30.3.2.1.7.1 This category is notable therefore in finally including a few familiar names from Europe such as Ireland, Norway and Finland.

30.3.2.1.7.1.1 We remind that we are looking at 30-day period of the ‘second wave’ only and that Ireland was a loyal participant in the primary contagion. It seems that Ireland has decided to sit out the second-wave at least in its more egregious western form.

30.3.2.1.7.2 At 100 deaths per day maximum that is 4% of normal deaths per day or normal life is 25 times more dangerous.

30.3.2.1.7.2.1 This represents 74% of the world population a sliver under three-quarters of the world experiencing an average 31.8 deaths per day or 1.3% of standard deaths per day or normal life being 77.5 times more dangerous for three quarters of the world.

30.3.2.1.7.2.1.1 Again that still ignores the further refinement of risk to the old-and-sick.

30.3.2.1.7.2.1.2 Three quarters of the world including this time some countries from the west found normal life to 77.5 times more dangerous and the politicians, media, scientists, advisors didn’t notice?

30.3.2.1.7.2.1.3 It would be easier to believe that politicians were unaware that some cars to run on gasoline not electricity than it would be to believe that not one person in that list had noticed that the world was brushing off Covid-19.

30.3.2.1.7.2.1.3.1 Either there will be a long list of people exclaiming that they ‘tried to tell the Prime Minister’ or that they ‘tried to advise SAGE’ but they were ignored, over-ruled, side-lined which excuses we will find risible.

30.3.2.1.7.2.1.3.2 Or they are all culpable of knowledgeable and deliberate misrepresentation of the reality of Covid-19 world wide including keeping the UK population in ignorance by choice and distracting them by incessant messages of fear-inducing reports by choice.

30.3.2.1.8 There were 96 of 147 countries reporting fewer than 200 deaths per day the additional 9 being Guatemala, Israel, Cyprus, Libya, Ecuador, Denmark, Morocco, Peru, Lebanon.

30.3.2.1.8.1 We see Denmark and Cyprus joining from Europe and Israel, friend of America.

30.3.2.1.8.2 At between 100 and less than 200 deaths per day that is between 4.1% and less than 8.1% of standard daily deaths for these nine countries.

30.3.2.1.8.3 At this point we have covered 76% of the world’s population.

30.3.2.1.9 There were 120 of 147 countries reporting fewer than 500 deaths per day the additional 24 being Chile, Paraguay, South Africa, Turkey, Estonia, Costa Rica, Canada, Brazil, Netherlands, Spain, Russia, Colombia, Argentina, Azerbaijan, Iran, Puerto Rico, Tunisia, Sweden, Ukraine, Mexico, Jordan, Palestine, Albania, Panama.

30.3.2.1.9.1 We are approaching the upper range of deaths-per-day in the ‘second wave’ and have a significant group of western nations being Canada, Netherlands, Spain, Sweden (no-lockdown-Sweden).

30.3.2.1.9.2 This now represents 90% of the world population.

30.3.2.1.9.2.1 The upper limit of 500 deaths per day represents 20% of a day’s standard deaths the same sort of significance which we might attribute to Heart Disease for males in particular, Cancer or other leading causes of death.

30.3.2.1.9.2.2 The population bears the risk of cancer, heart disease, Alzheimer's stoically without the destruction of their lives, livelihoods, removal of freedoms, imposition of excess deaths due to political measures in the tens of thousands.

30.3.2.1.9.2.2.1 The actual risk factors of both other causes of death and Covid-19 reputed deaths are massively skewed to the old-and-sick. It is insufficient even to be merely old or merely sick for Covid-19 to be a material risk in an age group.

30.3.2.1.9.2.3 Now 6.8 billion people over 90% of the world's population (or the covid-impacted population for countries over 1m population and 1000 cases) have experienced an average 169 deaths per day from Covid vs 2464 deaths per day standard from normal life, so that Covid represents 6.9% of a day's deaths for 90% of the world on average, with normal life being 14.6 times more dangerous without taking into account comorbidities and age which further increase the disparity between covid and ordinary life for ordinary people.

30.3.2.1.9.2.3.1 The primary control mechanism of the UK government lockdown is simply proven to be fraudulent and a failure worldwide.

30.3.2.1.9.2.3.2 The massive threat of Covid-19 as presented by PF is simply and unequivocally shown to be fraudulent.

30.3.2.1.9.2.3.3 Almost the entire world is experiencing a Covid-19 experience in stark contrast to the reported deaths and risk in the UK.

30.3.2.1.9.2.3.4 At what point will a court rule that we are indeed trapped in an asylum where the managers of our predicament are determined to keep us hypnotised with false information until finally we can be drugged with a redundant and no doubt very expensive and profitable vaccine.

30.3.2.1.10 At over 500 and less than 1000 we finally meet the players still not quite the worst hit in this 'second wave' but the leaders and manufacturers of the figures and the fear in the primary contagion and the dominant players in the Covid-19 experience of the west.

30.3.2.1.10.1 There were 136 of 147 countries reporting up to 1000 deaths per day the additional 16 being Latvia, Germany, Slovakia, France, USA, UK, Kosovo, Serbia, Portugal, Romania, Armenia, Moldova, Belgium, Greece, Lithuania and Switzerland.

30.3.2.1.10.1.1 In this group you will find the world leaders as worst hit in the primary contagion being Belgium (#1) and the UK (#2) with the USA New York City outranking both of them and hit 500x harder than the Far East. That isn't a virus.

30.3.2.1.10.2 The 1000 deaths a day is now 40% (40.6%) of the standard 2464 deaths per day making Covid a 'leading cause of death' in the second wave. Naturally this is a 'leading cause of death' which overwhelmingly threatens the old-and-sick only.

30.3.2.1.11 There were finally 11 countries to complete the world's experience of Covid for the 147 countries with over 1m population and over 1000 cases being Georgia, Czechia, Poland, Italy, Austria, North Macedonia, Bosnia, Hungary, Croatia, Slovenia.

30.3.2.1.11.1 Barring Italy and Austria, these are exclusively Eastern European countries and Eastern Europe is notable for not having dominated the primary contagion.

30.3.2.1.11.1.1 What changed then in Eastern Europe?

30.3.2.1.11.1.1.1 Was it truly an astonishingly aggressive attack by Covid?

30.3.2.1.11.1.1.2 Or did the reported determination to bribe and coerce Eastern European nations as reported by the President of Belarus finally pay off?

30.3.2.1.11.1.1.3 If we are unlikely ever to see a true and independent investigation of what occurred in UK hospitals, local authorities and government that is even more the case in Eastern Europe.

30.4 The 'second wave' was as with the first wave an issue brushed off by the Far East and Africa and experienced progressively more aggressively as one approached the Western Power Centres with the slightly unusual feature of Eastern Europe actually trouncing the west in its reported deaths.

30.4.1 Politicians, the media, analysts, advisors all combine to ignore the picture presented by the WHO and governments around the world and focus solely on maximising the reported threat to the UK.

30.4.1.1 In so doing they misrepresent Covid-19 to the British people and mislead them as to the distinction between what Covid-19 is doing worldwide and what the government is achieving and reporting domestically within the UK.

30.4.1.2 Unaware that they are isolated in a narrative of massive threat not shared by the rest of the world the British people continue compliant solely because they have neither done the research nor been presented with the facts pertinent to a true and balanced perspective of Covid-19.

30.4.1.3 That misrepresentation by deliberate choice for else politicians are so ignorant as to be culpable by that ignorance supports the government's agenda of control and promulgation of fear.

30.4.1.4 That misrepresentation is fraudulent and consciously and deliberately chosen to be so and the harm resulting from it is therefore entirely due to that misrepresentation and fraud making the government its officers and advisers guilty of criminal fraud.

30.4.1.5 We may never find a court or jury to declare them so but the facts are transparently obvious.

30.4.1.6 This is not ultimately a trial of the accused but a trial of the legal system.

30.4.1.7 We have no hope that it will succeed but without trying it must fail so we try.

31.0 Quality of Data

31.1 We are about to enter a realm of complex and inter-related data regarding deaths, all deaths, deaths due to or with covid, comorbidities, deaths in previous periods where the quality of data materially impacts the quality of analysis.

31.1.1 Overall we are profoundly grateful at the quantity and quality of data published in particular by the UK ONS and NHS and by the USA CDC whose data is unquestionably the richest and most useful that we have found in the world.

31.1.2 We are also profoundly grateful to the simple but comprehensive worldwide data on cases and deaths supplied by the WHO and by the early detailed breakdown supplied to the WHO by China.

31.1.2 Without such data we would be subject to being informed solely by the government announcements and by the mainstream media and as all this other data shows, we would have remained in ignorance of the real story of Covid worldwide and in the UK.

31.2 Thus if the inconsistencies and discrepancies are frustrating on balance we are still far more grateful that the data is available than we are concerned at the inconsistencies.

31.2.1 The one slight niggle and exception to this rule is that we fail to understand why the NHS for England and Wales seems to have eliminated the history of deaths and replaced it with daily deaths only.

31.2.1.1 Such an action will not prevent a diligent researcher from compiling a history but it obviously impedes the process by creating an entirely unnecessary step.

31.2.1.2 Nevertheless we do not do more than highlight that somewhat retrograde step which is as noted the exception to the rule.

31.3 Anomalies and inconsistencies are of two particular forms of note.

31.3.1 It is frustrating that age ranges and breakdowns are not consistently provided.

33.3.1.1 The most useful ranges are 5 year ranges with the 0-year separated out in the first range (0-0 and 1-4 therefore).

33.3.1.2 Some age ranges have a very coarse initial range for the first younger range which is not in fact very young at all.

31.3.1.2.1 Some age breakdowns are as coarse as 0-69 and 70+ or 0-44 and then detailed age brackets beyond that.

31.3.1.2.1.1 Any age breakdown is useful but it should be clear that the experience of a 69 year old close to the OAPs who have been overwhelmingly the target of Covid-19 will be very different to a teenager.

31.3.1.2.1.2 A more detailed breakdown contrasting youth with near-OAPs would have been appreciated in tables where 0-69 or 0-44 was chosen as an aggregate of data pertinent to younger age groups.

31.3.1.2.1.3 This is an observation not a complaint. As ever, having the data is far better than not having it.

31.3.1.3 Some age ranges in different contexts are only broadly consistent so that we have to interpolate data from one source to match it to a second source.

31.3.1.3.1 Thus attempting to combine data from one source with an age range 18-64 with another source with an age range 60-70 for example requires us to split one or other and without attempting a complex and uncertain algorithm a simple linear interpolation is likely to be misleading.

31.3.1.3.2 Given the massive sensitivity to age for Covid-19 aggressiveness interpolating the 18-64 band linearly when data is likely to be clumped at the 64 end of the scale is very unlikely to be reasonable or accurate.

31.3.1.3.2.1 Where possible therefore we split the shortest age range and assign it to the longer age range breakdown.

31.3.1.3.2.2 This of course does not address the fact that the longer age breakdown is likely distorted towards the older end of the age range but we cannot address that.

31.3.1.3.2.2.1 As ever we work with what we've got and are grateful for what we do have.

31.3.1.3.2.2.1.1 The data may not be ideal but it is more than sufficient to highlight the conclusions and themes that we wish to address.

31.3.2 It is also noticeable that there are inconsistent totals reported across alternate ONS spreadsheets for nominally the same figures such as Covid-19 deaths March to June.

31.3.2.1 These inconsistencies can be quite marked with one source having only 70% or 80% of the figures reported in a second source.

31.3.2.2 Such inconsistencies weaken the certainty as to accuracy of our analytical conclusions but we can only work with the data as reported.

31.4 Overall we wish to state again that we are grateful for the work of statistical departments of the governments and similar organisations.

31.4.1 Their work is invaluable and has now three times highlighted the inconsistencies and outright representations between the official government narrative.

31.4.1.1 One such context is in Road Safety where the UK government data shows the speeding dogma to be entirely fraudulent and road safety explained very simply in terms of common sense.

31.4.1.1.1 Accidents and injuries show a near-perfect correlation with traffic density.

31.4.1.1.1.1 More cars, more accidents. What could be more natural?

31.4.1.1.2 Accidents and injuries show a near-perfect anti-correlation with speeding.

31.4.1.1.2.1 More cars, less speeding. What could be more natural?

31.4.1.1.3 As such, as speeding increases, accidents go down, because both are symptoms of traffic density.

31.4.1.1.3.1 The causative dogma of speeding causes accidents is entirely fraudulent.

31.4.1.1.3.1.1 As traffic density decreases, the traffic flow naturally eases and higher cruising speeds are possible in safer conditions.

31.4.1.1.3.1.2 As speeding increases, accidents decline.

31.4.1.1.3.1.2.1 That is not something you'll find road safety organisations promoting.

31.4.1.1.3.1.2.1.1 However road safety programmes similarly to Covid-19 are focused not on fact but on message and they have chosen a message that suits them rather than one that is based on fact.

31.4.1.2 The other context that we explored was entirely reasonably 9/11.

31.4.1.2.1 The US government provided comprehensive evidence of the attack on the Pentagon.

31.4.1.2.1.1 It is not difficult to show that the vehicle that struck the Pentagon did so from an angle contradicting the official story.

31.4.1.2.1.2 It is not difficult to show that the vehicle that struck the Pentagon was of a different size shape and orientation (approach path) to the official story.

31.4.1.2.1.2.1 It seems that the team that cleaned up the official evidence did not do quite the thorough job they should have done.

31.4.1.2.1.3 It is not difficult to show that a frame has been replaced with a patch of smoke superimposed on a clean background.

31.4.1.2.1.3.1 Falsifying evidence in a criminal trial is a criminal offence.

31.4.1.2.1.3.2 Naturally no successful legal initiative has ensued to prosecute the US government or US military for falsifying evidence.

31.5 Thus we are in familiar territory of being grateful for the government data that reveals the lies, fraud and misrepresentations of the government.

31.5.1 Whether this time we can indeed bring the government to account is another matter.

32.0 UK and England and Wales Deaths 2020 and Prior Years and Covid

32.1 ONS provides a comprehensive review of UK deaths and Covid-19 deaths by age and with pre-existing conditions in the spreadsheet referencetables.xlsx

32.1.1 The link to this table is available at
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsinvolvingcovid19englandandwales

32.1.2 To validate this data and compare it to a second source we use a second spreadsheet also referencetables.xlsx or specifically here referencetablescorrected.xlsx

32.1.2.1 This second source is available here
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/weeklyprovisionalfiguresondeathsregisteredinenglandandwales

32.2 Our goal is to look at data for March, April, May and June

32.2.1 The second source provides data by weeks which do not naturally align with month start and month end.

32.2.1.1 Interpolating by splitting the weeks which cross month boundaries we arrive at the following data from the second source.

32.2.1.1.1 The data provides the following items.

32.2.1.1.1.1 All deaths in England and Wales for 2020 in the relevant month

32.2.1.1.1.2 All deaths in the previous five year period in the relevant month

32.2.1.1.1.3 The excess deaths in 2020 by subtracting the five year previous average from the 2020 figures

32.2.1.1.1.4 The excess deaths in 2020 stated as a percentage of the previous average

32.2.1.1.1.5 The Covid-19 deaths in the relevant month

32.2.1.1.1.5.1 These are deemed to be responsible for a part of the excess

32.2.1.1.1.6 The non-Covid-19 excess deaths being the excess minus Covid-19

32.2.1.1.2 The data is summarised in the following table

Month	2020	5YrAvg	Excess	Exs.Pct	Cv-19	Non-CV
3	51508	47652	3856	8%	2633	1223
4	85275	44412	40863	92%	29870	10993
5	54967	42146	12821	30%	13467	-646
6	41166	40487	679	2%	3941	-3262

32.2.1.1.3 We would make the following observation on the data

32.2.1.1.3.1 We accept the data as accurate for the purposes of this analysis

32.2.1.1.3.1.1 That is to say in particular that we do not judge the veracity of the data or the actual causes in this local context

32.2.1.1.3.2 It is evident that the government reported one bad month with 40,863 or 92% excess deaths

32.2.1.1.3.2.1 The government further reported a notable uptick the month following of 12,821 excess deaths or 30% above the previous years' average.

32.2.1.1.3.2.2 Thus this country had a bad time for approximately five weeks if we allow 92% and 30% to reflect a five week period.

32.2.1.1.3.2.3 And then life and deaths returned to normal.

32.2.1.1.3.2.4 That was the entirety of the impact of Covid-19 except that it wasn't.

32.2.1.1.3.2.4.1 Covid-19 only explained 30,000 of the 41,000 excess deaths.

32.2.1.1.3.2.4.1.1 In a period dominated by lockdown, an extra 11,000 people lost their lives

32.2.1.1.3.2.4.1.2 Lockdown itself is mathematically proven to have had zero effect

32.2.1.1.3.2.4.1.3 The government's determination to implement a flawed policy cost 11,000 lives

32.2.1.1.3.2.5 The government, media and Ferguson would insist that lockdown saved us from being worse hit

32.2.1.1.3.2.5.1 The government, media and Ferguson conveniently ignored the failure of lockdown

32.2.1.1.3.2.5.2 The government, media and Ferguson conveniently ignored the dramatic contrast with the Far East, Africa and the rest of the world

32.2.1.1.3.2.5.3 An honest government could have admitted that lockdown had failed

32.2.1.1.3.2.5.4 An honest government could have acknowledged that the contagion was over

32.2.1.1.3.2.5.5 An honest government could have let us get on with our lives

32.2.1.1.3.2.5.6 Given its best shot and considerable government assistance Covid-19 had done no more than give us a bad month

32.2.1.1.3.2.5.7 Everything however hinges on a critical issue

32.2.1.1.3.2.5.7.1 Did the UK government want Covid-19 to be over?

32.2.1.1.3.2.5.7.1.1 It's determination to sell the fear, to extend the lockdown, to impose social distancing, mask wearing, a tiered system of lockdowns, to sell the second wave shows that it did not.

32.2.1.1.3.2.6 An interesting point is also revealed in the data

32.2.1.1.3.2.6.1 In June there were 3,941 reported Covid-19 deaths.

32.2.1.1.3.2.6.1.1 There was also a shortfall of 3,262 in expected non-covid deaths

32.2.1.1.3.2.6.1.2 Deaths had returned to normal but Covid-19 was still getting credit for ordinary deaths

32.2.1.1.3.2.6.1.2.1 We refer to this as rebranding

32.2.1.1.3.2.6.1.2.2 Rebranding also occurs when a doctor comes round to a newly deceased patient dead from other causes and seeks to list them as Covid-19

32.2.1.1.3.2.6.1.2.2.1 We have such a report from an NHS nurse whose father had just died and who emailed me to report this and was understandable extremely angry at the occurrence.

32.2.1.1.3.2.6.1.2.3 Rebranding also occurs when the NHS counts any death within 28 days of a positive test result as a Covid-19 death.

32.2.1.1.3.2.6.1.2.3.1 Being hit by a lorry in the following month is unfortunate but it's difficult to see that as Covid-19.

32.2.1.1.3.2.6.1.2.3.2 Having cancer and dying with your lungs destroyed is unfortunate but it's difficult to see that as Covid-19.

32.2.1.1.3.2.6.1.2.3.3 This brings us to the issue of comorbidities.

32.3 Yes the UK had a bad month.

32.3.1 Even that is inaccurate.

32.3.1.1 It is more accurate to state that the old-and-sick in managed care in hospitals and care homes had a very bad month.

32.3.1.1.1 That certainly played to the government narrative.

32.3.1.1.2 It rather contradicted the professed determination of the government to protect the vulnerable.

32.3.1.1.3 And it hid that for the mainstream population Covid-19 was barely an issue.

32.3.1.1.3.1 That is the topic of further related analysis as to a comparison between ordinary mortality and Covid-19 related deaths.

32.3.1.1.3.2 We have touched on mortality as revealed by WHO deaths reports around the world.

32.3.1.1.3.3 We will also be considering mortality as it specifically relates to the UK

32.4 The old-and-sick had a bad month and it was over.

32.4.1 Except that the UK government had no intention of allowing it to be over.

33.0 An Unexplained Anomaly In England & Wales Leading Causes of Death Mar-Jun 2020

33.1 Normally we understand what the data is telling us even or especially when it contradicts the narrative of the government

33.1.1 In this instance we have come across figures which make no sense to us

33.1.1.1 It is entirely possible that we have misunderstood the nature of the data or its presentation

33.1.1.2 Generally however we would say that we are sufficiently familiar with the data that that is not the case

33.1.1.3 Also by cross-referencing the multiple sources of data we can reassure ourselves that we're dealing with figures that are consistent across sources even if not a perfect match

33.1.1.4 In this instance we have diligently checked that we have not made a basic error but we simply cannot either eliminate or explain the magnitude of the anomaly we have found

33.1.1.5 Since we cannot offer a legitimate interpretation even one damning of the government we make no claim as to the cause or interpretation of this anomaly but merely record it until such time as clarity is available

33.2 We focus on the six leading causes of death England and Wales highlighted in the 2018 figures and in the 2020 March to June figures.

33.2.1 The six leading causes of death listed are

33.2.1.1 Cerebrovascular diseases (I60-I69)

33.2.1.2 Chronic lower respiratory diseases (J40-J47)

33.2.1.3 Dementia and Alzheimer disease (F01,F03,G30)

33.2.1.4 Influenza and pneumonia (J09-J18)

33.2.1.5 Ischaemic heart diseases (I20-I25)

33.2.1.6 Malignant neoplasm of trachea, bronchus and lung (C33-C34)

33.2.2 The 2018 figures are available in referencetablenewtab.xlsx at https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/leadingcausesofdeathuk

33.2.2.1 These list figures of 12,520, 14,973, 22,314, 12,446, 32,862 and 15,021 respectively for England and 901, 1,059, 1,428, 1,012, 2,399, 1,025

33.2.2.2 Summing these gives figures of 13421, 16032, 23742, 13458, 35261, 16046 for the groups listed above.

33.2.2.3 Since monthly or seasonal data isn't provided we use a simple linear interpolation to get two figures a period figure for the four months by dividing by three and a monthly figure for a single month by dividing by 12.

33.2.3 Reordering to suit our working table we end up with the following figures from 2018

33.2.3.1 The figures are 2018, 2018 divided by 3 and 2018.divided by 12

33.2.3.2 The table is as follows

Malignant neoplasm of trachea, bronchus and lung (C33-C34)	16046	5,349	1,337
Dementia and Alzheimer disease (F01,F03,G30)	23742	7,914	1,979
Ischaemic heart diseases (I20-I25)	35261	11,754	2,938
Cerebrovascular diseases (I60-I69)	13421	4,474	1,118
Influenza and pneumonia (J09-J18)	13458	4,486	1,122
Chronic lower respiratory diseases (J40-J47)	16032	5,344	1,336

33.2.4 For the March-to-June 2020 we use data from referencetables.xlsx available at

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsinvolvingcovid19englandandwales

33.2.4.1 Table 1 is 'Number of deaths by leading causes groupings and COVID-19, England and Wales, deaths occurring between March and June 2020'.

33.2.4.1.1 By selecting the same code groupings we extract the following data for deaths March to June 2020

33.2.4.1.1.1 The table lists the ICD-10 Code and Cause of Death groups

33.2.4.1.1.1.1 These are the codes and cause of death groups in order

C33-C34	Malignant neoplasm of trachea, bronchus and lung
F01, F03, G30	Dementia and Alzheimer disease
I20–I25	Ischaemic heart diseases
I60–I69	Cerebrovascular diseases
J09–J18	Influenza and pneumonia
J40–J47	Chronic lower respiratory diseases

33.2.4.1.1.2 The associated deaths for March to June with a Total and with the 2018 figures divided by 12 to give a monthly equivalent provides the following table.

March	April	May	June	Total	2018.Mth
2415	2394	2167	1948	8924	1,337
6806	10308	5725	3716	26555	1,979
4790	4786	4110	3136	16822	2,938
2709	2946	2336	1818	9809	1,118
2584	1914	1206	909	6613	1,122
3113	2831	1828	1416	9188	1,336

33.2.4.1.1.2.1 It is immediately apparent that the reported deaths by leading causes in March to June (particularly March and April) substantially exceed the 2018 figures.

33.2.4.1.1.2.2 Subtracting the 2018.Mth monthly figure from the declared deaths by leading cause in each month we get the following table for excess deaths due to each cause.

33.2.4.1.1.2.2.1 We sum the excess deaths to give a Total and the 2018 figure divided by 3 gives us a reference for 2018 deaths in a 4 month period to compare to the March-June total

March	April	May	June	Total	2018.By3
1,078	1,057	830	611	3,576	5349
4,827	8,329	3,746	1,737	18,639	7914
1,852	1,848	1,172	198	5,070	11754
1,591	1,828	1,218	700	5,337	4474
1,462	792	84	-213	2,125	4486
1,777	1,495	492	80	3,844	5344

33.2.4.1.1.2.2.2 Looking at the second row we note that for Dementia and Alzheimer's that is an excess of 18,639 vs a normal 4-month total of 7914. Total deaths reported in March to June 2020 were 26,555 or over three times the same period deaths in 2018.

33.2.4.1.1.2.2.2.1 For that to be the dominant aberration then clearly we're talking about OAPs and it's worth noting that even for 85+ Dementia is not supposed to be the leading cause of death

33.2.4.1.1.2.2.3 Notice that the excess is positive in all totals with only June for Influenza and Pneumonia showing a slight drop rather than an excess in reported deaths by cause.

33.2.4.1.1.2.2.3.1 The proportion of excess deaths is also substantial for each cause

33.2.4.1.1.2.2.3.2 The following are the factors of 2020 total period deaths divided by 2018 same period deaths nominally by dividing the 2018 total by 3.

33.2.4.1.1.2.2.3.2.1 This is the table of 2020 March-to-June vs 2018 divided by 3 by ICD-10 codes

C33-C34	167%
F01, F03, G30	336%
I20–I25	143%
I60–I69	219%
J09–J18	147%
J40–J47	172%

33.2.4.1.1.2.2.3.2.1.1 Translating 167% into ordinary language the reported deaths for C33-C34 were 1.67 times the equivalent 2018 figures or a 67% increase.

33.2.4.1.1.2.2.3.3 The total excess by month for all these leading causes nearly perfectly matches the entire deaths from 2018 for a 4 month period.

March	April	May	June	Total	2018.By3
12587	15349	7542	3113	38591	39321

33.2.4.1.1.2.2.3.3.1 At 77911 deaths reported March to June 2020 for these causes that was essentially double the 39,321 deaths for a similar 4 month period in 2018 dividing 2018 total figures for the year by 3.

33.3 The dilemma is: what do these figures mean?

33.3.1 What we can see is that a massive number of people almost certainly OAPs by the Alzheimer's total died in excess of expectations from 2018 figures.

33.3.2 We can also notice that the proportion of deaths by leading causes was completely unbalanced with regard to Dementia and Alzheimer's vs other leading causes.

33.3.2.1 We can examine leading causes of death by age by reference to the ONS 2019 publication finalreftables2019.xlsx

33.3.2.1.1 Table 10 is skewed with data out of alignment which we have reported to ONS

33.3.2.1.2 Nevertheless once corrected we can assemble a ranking of ICD groups and their relevance overall and to the 85+ age group

33.3.2.1.2.1 Given that most deaths involve old people the two rankings will be similar but they are not identical

33.3.2.1.2.2 Our particular interest is to see the ranking and relevance of Dementia and Alzheimer's

33.3.2.1.3 We derive the following table with our own caption for each code grouping

33.3.2.1.3.1 The ranking is as follows for 85+ and for All Ages

Code	aka/eg	85+	All Ages
C00-D48	Cancer	17%	29%
I00-I99	Heart, Cerebro	26%	24%
J00-J99	Resp, Flu, Pneu	15%	14%
F00-F99	Dementia	16%	9%
G00-G99	Alzheimer	8%	7%

33.3.2.1.3.2 Even summing Dementia and Alzheimer's we barely exceed J00-J99 respiratory at 16% vs 14% and we are substantially below I00-I99 Heart disease at 24% and C00-D48 Cancer at 29%.

33.3.2.1.3.2 Notice that 2018 monthly deaths vary by cause between 1100 (I-series and J-series, flu), 1300 (C-series cancer and J-series lower respiratory), 2000 (F- and G- Dementia and Alzheimer's) and finally 3000 (I series, Heart disease).

33.3.2.1.3.2.1 Combining the series to be consistent with the table above we can see that 2018 figures per series per month were: C-cancer, 1300; F-G-Dementia, Alzheimer's 2000; I-Heart, 4000; and J-Respiratory, 2500. Round figures will suffice to make our point.

33.3.2.1.3.2.1.1 So the F-G-Dementia, Alzheimer's is higher than C-cancer, matches J-respiratory close enough and is half of I-heart diseases.

33.3.2.1.3.2.1.2 Yet in March-June 2020, F-G-Dementia, Alzheimer's doubles relative to I-heart disease to match I-heart disease on 26,000 deaths each in the period, and in so doing F-G-Dementia-Alzheimer's goes from similar to and less than respiratory to 50% higher than J-respiratory.

33.3.2.1.3.2.1.3 The 2018 figures are consistent with the 2019 figures for all ages as we'd expect with Dementia and Alzheimer's summed to 16% which is likely overstating but similar to respiratory with I-series heart about 50% higher.

33.3.2.1.3.2.1.4 The 2020 figures however are inconsistent with the total figures but much more consistent with the 85+ figures with 24% Dementia and Alzheimer's matching the I-series at 26% and dominating respiratory at 15%.

33.3.2.1.3.2.1.5 In other words even if we didn't know this from other tables we can see that the excess deaths reported for March-June 2020 in these leading causes are consistent with an extremely old class of victim being 85+.

33.3.2.1.3.2.1.6 That can hardly be a surprise given the popularly understood impact on OAPs by covid and by the rest of the material in our report.

33.3.2.1.3.2.1.7 Nor is that the conundrum with confuses and disturbs us.

33.4 So we have that deaths in these leading causes doubled in March-June and that even if we didn't know or expect it from other tables they were OAPs at 85+ likely to be the victims.

33.4.1 That still isn't a surprise per se.

33.4.2 The problem is that there is no room for an excess 38,591 OAP deaths.

33.4.3 Either we've misunderstood the various tables or the tables don't make sense.

33.4.4 There are six possible interpretations of the Table 1 description " Number of deaths by leading causes groupings and COVID-19, England and Wales, deaths occurring between March and June 2020"

33.4.4.1 The six scenarios are a product of two and three possibilities.

33.4.4.1.1 The two possibilities in the first pair are

33.4.4.1.1.1 The first possibility is that a single code-death is assigned to a single death akin to the 'cause of death' whereby only a single cause of death is credited to each death

33.4.4.1.1.1.1 With covid regardless of comorbidities and courtesy of the 28 day rule covid was credited with being that single cause even if they were already critical with cancer or simply walked under a bus

33.4.4.1.1.1.1.1 Nevertheless we do not distract ourselves here with that issue

33.4.4.1.1.2 The second possibility is that multiple code-deaths are assigned to a single death akin to the practice in studying comorbidities

33.4.4.1.2 The three possibilities in the second triple are

33.4.4.1.2.1 The first possibility is that non-covid codes apply to non-covid deaths

33.4.4.1.2.2 The second possibility is that non-covid codes apply to all deaths in which case the annotation for covid deaths is superfluous and should not be included into a total of deaths as the non-covid codes have already been applied

33.4.4.1.2.3 The third possibility is that non-covid codes apply only to covid deaths and the table does not list codes for non-covid deaths

33.4.4.2 The six possibilities are obtained by combining each of the first two possibilities with each of the second three possibilities

33.4.4.2.1 The combination relying on these non-covid codes applying solely to covid deaths and in effect producing a table of comorbidities can be easily dismissed

33.4.4.2.1.1 The code-deaths in Table 1 can be totalled as follows

	March	April	May	June	Total
Total Covid	4,486	29,064	10,661	2,525	46,736
Total non Covid	42,703	46,258	34,202	26,920	150,083
Total inc Covid	47,189	75,322	44,863	29,445	196,819

33.4.4.2.1.2 If all the non-covid code deaths apply solely to covid deaths then 42,703 comorbidities were recorded for 4,486 covid deaths or approximately 10 comorbidities per covid death

33.4.4.2.1.2.1 ONS records an average of 1.7 to 2 typically comorbidities per covid death so a figure of 10 is absurd

33.4.4.2.1.2.2 The single code per covid death is contradicted by 42,703 single-code deaths vs 4,486 reported covid deaths

33.4.4.2.1.2.3 The multiple-code per covid death is contradicted by 10 codes per covid death in March vs an expected 1.7 to 2 non-covid codes per covid death

33.4.4.2.1.3 As such the premise that the table represents non-covid codes associated solely with covid deaths is dismissed

33.4.4.2.2 The combination relying on these non-covid codes applying to all deaths both covid and non-covid can also be dismissed

33.4.4.2.2.1 If the non-covid codes apply to all deaths then we can dismiss the covid-deaths annotations as superfluous and deal only with the non-covid codes

33.4.4.2.2.1.1 Drawing on publishedweek512020.xlsx weekly stats and adjusting to month ends we get the following for monthly deaths 2020 and monthly deaths based on the 5-year prior average.

	March	April	May	June	Total
20.D.All	51,508	85,275	54,967	41,166	232,916
5Y.D.All	47,652	44,412	42,146	40,487	174,697

33.4.4.2.2.1.2 As noted above Table 1 has non-covid codes for the following deaths by month plus total

Total non Covid	42,703	46,258	34,202	26,920	150,083

33.4.4.2.2.1.3 If Table 1 non-covid codes address all deaths and the covid-deaths annotation is superfluous then these non-covid totals represent all deaths

33.4.4.2.2.1.4 June would show 26,920 deaths vs weekly stats reporting 41,166 and a 5-yr prior average of 40,497

33.4.4.2.2.1.5 We doubt that anyone would argue that there were fewer deaths during the March-April contagion so this scenario is falsified

33.4.4.2.3 The last possibility then is the first we assumed which is that non-covid codes apply to non-covid deaths.

33.4.4.2.3.1 The issue arises as to whether it is a single code per death or multiple codes

33.4.4.2.3.1.1 The fit for 85+ percentages suggests strongly that it is single code per death

33.4.4.2.3.1.2 The Table 1 figures summing all codes including covid are

Total inc Covid 47,189 75,322 44,863 29,445 196,819

33.4.4.2.3.1.3 The ONS Weekly Stats figures aligned with months for 2020 and for the previous 5 year average are

20.D.All 51,508 85,275 54,967 41,166 232,916

5Y.D.All 47,652 44,412 42,146 40,487 174,697

33.4.4.2.3.1.3 The Table 1 figures are already below the weekly stats figures and above the 5 year average

33.4.4.2.3.1.4 Diluting the total deaths by allowing multiple codes per death would drop them significantly even lower than the 2020 weekly stats

33.4.4.2.3.1.5 The best fitting scenario therefore is that non-covid codes apply to non-covid deaths

33.5 Non-covid deaths can be represented as normal deaths per the 5 year average plus an excess or shortfall being the actual non-covid deaths minus the 5 year average

33.5.1 We can generate a table therefore showing the total deaths 2020 and previous 5 year average and create a total excess and then subtract from that the covid deaths to arrive at the non-covid excess

33.5.1.1 Given that the weekly stats cite different figures for covid deaths we show three sets of figures for covid deaths being the weekly stats covid, a second source whose origin we don't recollect offhand and which is not material but similar to the Table 1 covid deaths, and the Table 1 covid deaths

33.5.1.2 We present that table here

	March	April	May	June	Total
20.D.All	51,508	85,275	54,967	41,166	232,916
5Y.D.All	47,652	44,412	42,146	40,487	174,697
20.D.Exs	3,856	40,863	12,821	679	58,219
Exs.CV	2,633	29,870	13,467	3,941	49,911

Exs.NCv	1,223	10,993	-646	-3,262	8,308
Exs1.Cv	4,777	30,823	12,000	3,424	51,024
Exs1.NCv	-921	10,040	821	-2,745	7,195
Exs2.Cv	4,486	29,064	10,661	2,525	46,736
Exs2.NCv	-630	11,799	2,160	-1,846	11,483

33.5.1.2.1 Exs without a digit is the data from weekly stats.

33.5.1.2.1.1 Exs1 is the second source which we do not recollect offhand and which is not materially different from Table 1

33.5.1.2.1.2 Exs2 is the third source which is Table 1 data with its non-covid coded deaths

33.5.2 Notice that Table 1 implies a shortfall of non-covid deaths which we would describe as rebranding whereby covid gets the credit for a death already occurring

33.5.2.1 Note also that non-covid excess we label as lockdown penalty being the excess deaths occurring by dint of government policies and lockdown

33.5.2.1.1 At 11,799 in April alone that is a substantial price to pay for a policy which we've shown to have zero effect

33.5.3 Now consider the excess deaths reported by leading causes

33.5.3.1 These were briefly C-cancer, F-,G- dementia, Alzheimer's, I- heart and cerebrovascular, and J- flu, pneumonia and respiratory

33.5.3.1.1 The total excess across these six leading cause sub-groups are as follows

March	April	May	June	Total	18.Mth
12587	15349	7542	3113	38591	39321

33.5.3.1.2 These are supposed to explain the following excess deaths by weekly stats and Table 1

	March	April	May	June	Total
Exs.NCv	1,223	10,993	-646	-3,262	8,308
Exs2.NCv	-630	11,799	2,160	-1,846	11,483

33.5.3.1.2.1 So 39,321 excess deaths in Table 1 by leading causes are supposed to explain 8,308 excess non-covid deaths by weekly stats or 11,483 excess non-covid by Table 1

33.5.3.1.2.2 And 12,587 excess deaths by leading causes in Table 1 are supposed to explain 1,223 excess deaths by weekly stats or a shortfall of 630 non-covid deaths in Table 1

33.5.3.1.2.3 That is already absurd with nearly five times the excess non-covid deaths by leading causes than the excess non-covid deaths that need to be explained in weekly stats, over three times the excess non-covid deaths by Table 1 that need to be explained by the leading causes.

33.5.3.1.2.4 However the leading causes as we've seen only cover a percentage of deaths.

33.5.3.1.2.4.1 Thus if we take the excess deaths by leading causes and group the I- pair data and group the J-pair data we can apply the percentages from 2019 and by dividing by the prevalence in 2019 we get projected or implied totals of excess-deaths overall.

33.5.3.1.2.4.2. That table looks as follows

	March	April	May	June	Total	18.Mth		
	12587	15349	7542	3113	38591	39321		
	March	April	May	June	Total	18.Mth	Exp.Pct	Imp.Total
C33-C34	1078	1057	830	611	3576	5349	29%	12,538
F01, F03, G30	4827	8329	3746	1737	18639	7914	16%	116,494
I20–I25; I60–I69	3443	3676	2390	898	10407	16228	24%	43,363
J09–J18; J40–J47	3239	2287	576	-133	5969	9830	14%	42,636

33.5.3.1.2.4.3 The key figure here is the implied total on the right for implied total excess non-covid deaths.

33.5.3.1.2.4.3.1 The actual reported non-covid excess deaths by leading causes in Table 1 is 38,591 as seen in the top row

33.5.3.1.2.4.3.2 The expected deaths in period by 2018 annual deaths by leading causes divided by 3 is 39,321

33.5.3.1.2.4.3.2.1 Thus non-covid excess deaths nearly matched the normal deaths expected by these leading causes and the actual deaths by these leading causes was essentially double the normal

33.5.3.1.2.4.3.2.2 This is not covid. This is non-covid or what we refer to as lockdown penalty.

33.5.3.1.2.4.3.3 The implied totals for I-heart and J-respiratory are not unreasonable being 43k and 43k vs 39k in the actual reported non-covid-excess-deaths-by-leading-causes figure of 38,591.

33.5.3.1.2.4.3.3.1 That shows that our exercise is not unreasonable.

33.5.3.1.2.4.3.4 The figure for cancer at 12,538 is only a third of the 38,591 implying that somehow cancer ceases to kill or be responsible for the non-covid excess deaths March to June

33.5.3.1.2.4.3.5 Whereas the figure for Alzheimer's implies a total non-covid excess deaths of 116,494, an astronomical figure that dwarfs the Table 1 excess-non-covid deaths by leading causes at 38,591, is 14 times the 8,308 figure of actual excess non-covid deaths by weekly stats and 10 times the actual excess non-covid deaths by Table 1.

33.5.3.1.2.4.3.5.1 The raw figure of 18,639 excess Dementia and Alzheimer's deaths in period is already enough to dwarf the actual reported non-covid excess deaths at 8,308 by weekly stats and 11,483 by Table 1

33.5.3.1.2.4.3.5.2 The implied total excess non-covid deaths is little short of absurd

33.5.3.1.2.4.3.5.2.1 The most generous interpretation of the 116,494 figure is to forget other causes, Dementia and Alzheimer's ripped through the population (aka Care Homes and Hospitals) and a massive number (18,639 more than expected) suddenly died for this cause alone

33.5.3.1.2.4.3.5.2.2 We don't do clinical but believe we're on safe ground in saying that Dementia and Alzheimer's are degenerative diseases operating over the long term.

33.5.3.1.2.4.3.5.2.2.1 To suggest that they should suddenly surge in March to June, spiking in April, for no reason is like saying that air-pollution, a constant in our lives, suddenly caused a massive spike in deaths in March to June

33.5.3.1.2.4.3.5.2.2.2 Astonishing the latter is proposed by people who wish to explain the disparity between western deaths and Far Eastern and African deaths.

33.5.3.1.2.4.3.5.2.2.2.1 Mathematically it is a nonsense

33.5.3.1.2.4.3.5.2.3 Thus to claim Dementia and Alzheimer's as a clinical cause of death that spiked in March to April is absurd

33.5.3.1.2.4.3.5.2.3.1 More accurate and far more reasonable would be to say that those with Dementia and Alzheimer's were targeted by whatever did killed these people in excess in the period

33.5.3.1.2.4.3.5.2.3.2 That agent was not Covid-19 as these are all non-covid excess deaths in this scenario

33.5.3.1.2.4.3.5.2.3.3 Was that agent lockdown and did it target OAPs with Dementia and Alzheimer's particularly harshly?

33.5.3.1.2.4.3.5.2.3.3.1 Safe in their care homes or hospitals where they'd be unlikely to be mobile, it's difficult to support that hypothesis

33.5.3.1.2.4.3.5.2.3.4 Something targeted OAPs with Dementia and Alzheimer's in March-to-June.

33.5.3.1.2.4.3.5.2.3.4.1 The only agent drastically operating in March-to-June other than Covid-19 was the government nominally in response to Covid-19

33.5.3.1.2.4.3.5.2.3.4.2 How it caused these particular deaths we leave to others to investigate

33.5.3.1.2.4.3.5.2.3.4.3 That it is reasonable to investigate the government for causing these deaths is however entirely reasonable.

33.6 Overall we are faced with far too many OAP style deaths reported in Table 1 far exceeding the actual required non-covid excess deaths.

33.6.1 This can only be reconciled by saying that young people stopped dying to compensate for old people dying

33.6.1.1 Needless to say that is not a very plausible hypothesis

33.6.2 Treating Covid-19 deaths as double counting where the Table 1 non-covid codes already cover all deaths leads to a significant shortfall in deaths in March to June which renders that unlikely

33.6.3 Accepting the Table 1 deaths by non-covid codes leads to a massive overstatement of deaths by leading causes which renders that unlikely

33.6.4 Either way and by the scenarios we've considered Table 1 does not make sense

33.6.4.1 Either our understanding of what Table 1 is supposed to represent is flawed

33.6.4.2 Or the data in Table 1 and associated tables is flawed

33.7 We will write to the ONS to ask for clarification as to the nature of Table 1 to eliminate any misunderstanding as to its intended content

33.7.1 They may choose to address our rationale or they may not

33.7.2 This section will be extended and updated based on their reply

33.7.3 As things stand this remains a Table that cannot be reconciled with other available data

34.0 Comorbidity, Age and the Absence of Life Risk

34.1 The spreadsheet referencetables.xlsx allows us to consider comorbidity and covid.

34.1.1 It is available from
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsinvolvingcovid19englandandwales

34.1.1 The AllCond tab records under No pre-existing condition 756 male deaths 0-69 years and 309 female deaths 0-69 years for a total of 1,065 deaths below the age of 70.

34.1.1. For substantially fewer deaths than road deaths for people (mostly) below retirement age who were perfectly normal, getting on with their lives, we shut down the economy, ended lives and livelihoods, killed around 15,000 people with a strategy that didn't change a thing.

34.1.1 Total deaths March-June with no pre-existing condition was 4,476.

34.1.1.1 That represents less than 1% (about 0.8%) of the 530,000 deaths England and Wales experience every year.

34.1.1.1.1 Since people barely notice or actually don't notice at all over half a million deaths a year, the idea that we should end our lives and livelihoods for less than 1% of that is absurd.

34.1.1.1.2 That is in no way to disregard the threat to the old-and-sick.

34.1.1.1.2.1 On the contrary the government made clear that it was important to protect the vulnerable.

34.1.1.1.2.2 And then went on to farm the hospitals and care homes for the old and sick who duly succumbed to covid.

34.1.1.1.2.3 The government managed to end normal life for the below-retirement-age and ordinarily health for no reason that can possible be legitimately countenanced unless those 1000 people were truly the chosen ones whose lives were sacrosanct which I regret to suggest they were not.

34.1.1.1.2.4 And the government managed to do quite the opposite of protecting the vulnerable, the old and the sick, with hospitals in synch or leading the way in covid deaths and the government sending sick people into care homes.

34.1.1.1.2.5 The government could not have done a worse job of protecting the vulnerable or harming those who would brush off the disease even in this country 100 times harder hit than the Far East and Africa.

34.1.1.1.2.6 It is not ignorance when the government is that incompetent and acts so utterly contrary to what normal life mandates.

34.1.1.1.2.7 If ordinary people can go about their lives indifferent to 530,000 deaths a year they can certainly go about their lives indifferent to 1,065 deaths.

34.1.1.1.2.8 To suggest otherwise is absurd to the point of either insanity or fraud and in the case of the British government there is no doubt that they have committed fraud.

34.1.1.1.2.9 Knut Witkowski said it right at the beginning: protect the elderly, everyone else get on with their lives.

34.1.1.1.2.10 What did the British government do?

34.1.1.1.2.10.1 Shut down everyone else's lives.

34.1.1.1.2.10.2 Farm or utterly fail to protect the elderly.

34.1.1.1.2.10.3 That isn't even close to a mistake or incompetence by the 'wisest minds' of SAGE.

34.1.1.1.2.10.4 That is policy. Pure and simple.

34.1.1.1.2.10.5 When someone cries out "he's not breathing! Call a doctor!" while holding a hand over the victim's nose and mouth only an idiot will not recognise the fraud.

34.1.1.1.2.10.6 In Britain today sadly it seems we are overwhelmed by idiots.

34.1.1.1.2.10.6.1 Or people who are naïve.

34.1.1.1.2.10.6.2 Or brainwashed.

34.1.1.1.2.10.6.3 Or emotionally incapable of imagining their parent government to be peopled with humans who are entirely susceptible to greed, hunger for power, or suffer emotional issues such as lack of empathy, sociopathy.

34.1.1.1.2.10.6.4 Whatever term is used whether idiot or naïve the maths doesn't change.

34.1.1.1.2.10.6.5 We are in lockdown in December not because of Covid but because the mass of the British population has not lifted a finger to do the most basic research and is emotionally and intellectually incapable of critical thinking.

34.1.1.1.2.10.7 The maths is simple.

34.1.1.1.2.10.8 The capacity to recognise the import of the maths is utterly absent.

35.0 A single number dismantles the Covid-19 threat

35.1 An analysis of deaths involving covid by age and with causes and pre-existing conditions is published by ONS as referencetables.xlsx

35.1.1 It is available from
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsinvolvingcovid19englandandwales

35.1.1.1 It covers deaths in England and Wales approximately 59m people or just shy of 90% of the UK

35.1.1.1 It addresses deaths March to June 2020 and so essentially the entire primary contagion

35.1.2 In Table 6a it lists pre-existing conditions for Covid deaths by age range and pre-existing condition

35.1.2.1 The age ranges are 0-44, 5 year ranges from 45-49 onwards and a final 90+ range

35.1.2.2 A particular pre-existing condition is 'No pre-existing condition'

35.1.2.2.1 These are deaths where nominally a person had no recognised vulnerability and as such was an ordinary member of the public not already ill

35.1.2.2.1.1 This does not preclude the existence of vulnerabilities but we do nor need to consider that

35.2 Summing the deaths to age 59 with no pre-existing condition we find that in England and Wales 542 ordinary people died

35.2.1 If we extend to the traditional male retirement age of 65 the figure is 772

35.2.2 Thus 542 deaths represents a threat to life for ordinary people of less than 0.001%

35.2.2.1 This can also be phrases as a threat of less than 1 in 100,000

35.3 In 2019, 530,841 people died in England and Wales and nobody noticed

35.3.1 There were no calls to shut down society

35.3.1.1 There was no fear campaign pushed by the media

35.3.1.2 There were no emergency measures to shut down society

35.3.1.3 Ordinary people went about their lives oblivious

35.3.1.4 A little shy of 1500 people per day (1454) were dying every day

35.3.1.4.1 It didn't make the news

35.3.1.4.2 It didn't trigger alarm

35.3.1.4.3 It was just life

35.4 Yet 542 ordinary people dying was enough to end society

35.4.1 A massive fear campaign by the government and media were directed at the threat to ordinary people and from ordinary people

35.4.2 The priority of protecting the elderly and vulnerable was proven to be a sham

35.4.3 But it was the ordinary people who had their lives and livelihoods shut down in a narrative that said that they would not be safe until the vaccine

35.4.4 They would go about their lives oblivious to 530,000 deaths but these 542 deaths suddenly meant they were not safe, they were at risk and in the most abhorrent and loathsome piece the BBC

went further and said that anyone not recognising that risk and being obedient to the massive threat and measures to contain it had blood on their hands

35.4.4.1 Never mind the blood on the government's hands for a policy that changed nothing being lockdown

35.4.4.1.1 That policy cost 15,000 non-covid excess deaths in the primary contagion

35.4.4.2 Never mind the lies and deceptions of Ferguson, of an exponential virus, of Whitty and Vallance and an 80% infected, 1% deaths

35.4.4.3 Never mind a media translating that into 530,000 deaths in the UK, by coincidence or not the same as England and Wales deaths every year

35.5 No, we could ignore 530,000 deaths a year in England and Wales as ordinary life

35.5.1 But the government would not let us ignore 542 deaths as the real actual threat to ordinary people from Covid-19

35.6 Which of the following is more of a concern?

35.6.1 Falling from 30,000 feet or falling from 1 foot?

35.6.2 A 10 ton truck out of control and heading for you or a toy truck out of control and heading for you?

35.6.3 A fire consuming your entire house with your family inside or a fire in the lounge warming your family?

35.6.4 The risk of being one of 530,841 deaths a year or the risk of being one of 542 deaths a year?

35.7 It is not even a close decision. There is no decision. The disparity in risk is so massive that there can be no confusion or doubt.

35.7.1 Yet such is the power of the media and the sense of obedience and the lack of independent thinking by the people that the message of fear erased rational discourse.

35.7.2 That message of fear and threat was one deliberately chosen by people who had already been demonstrated to lie, misrepresent the facts even from the March 3rd Press Briefing, the March 16th publication of ICCRT R9, the March 23rd Lockdown announcement.

35.7.3 Even now in the first days of 2021 as we write this we are seeing posts from people literally exhorting people to listen and obey, don't think. Don't do research. Don't find out the facts for yourself. Just listen and obey.

35.7.3.1 Orwell could not have been more delighted or more horrified by the echoing of the scenes of blind obedience and the threats and propaganda against and suppression of people who actually do think and do check the facts and do research and analysis.

35.7.3.2 The very people who have the capacity to do that and who are paid to do that are paid by government money in universities and they remain overwhelmingly silent except to put out their pieces supporting the narrative of threat and fear and obedience.

35.7.3.3 It is left to independent people, amateurs or doctors or scientists to show the narrative that the government ignores.

35.7.3.4 The opposition in government who can normally be relied upon to challenge the government on principle regardless of merit are so silent as to be invisible.

35.7.3.5 The only opposing view is presented by independent people on social media and so we see the campaigns against ‘fake news’ against ‘tin-foil-hat conspiracy theorists’ and the blocking and closing of accounts and channels where someone attains a following and is being listened to.

35.7.3.6 The eradication of free speech is not a risk it is a massive endeavour already in play.

35.7.3.7 And it is all ultimately designed to ensure that the people cannot see or recognise one simple fact.

35.8 If the ordinary people of England and Wales can ignore 530,841 deaths a year they can certainly ignore 542 deaths a year.

35.8.1 They don’t need to be locked down

35.8.2 They don’t need to have their jobs taken away or forfeit

35.8.3 They don’t need to be deprived of income while the public sector enjoys its security

35.8.4 They don’t need to be subjected to an onslaught of misinformation, propaganda and exhortation to stay home save lives

35.8.5 They don’t need to be subjected to wave after wave of initiative from lockdown to mask-wearing to social-distancing to second-wave threats to a second wave not present or noticeable in the majority of the globe

35.9 Yet the government and every arm of the state subjects them to all of those and does so with one compelling narrative

35.9.1 No normal till the vaccine

35.10 When 530,841 deaths is perfectly normal and can be ignored but 542 deaths is a massive threat that cannot be ignored then that is an absurdity pushed by the government for the government’s own purposes

35.10.1 The government has granted itself emergency powers of control over society and violating the very integrity and security of the person

35.10.1.1 This eradicates the illusion that we are a free society and transforms us into a totalitarian society

35.10.2 The government has devastated the economy requiring financing by massive amounts of debt

35.10.2.1 This financing will be provided by central bankers and will earn them massive rewards for making a few entries in a database

35.10.3 The government has devastated the small and medium businesses of the private sector while ring-fencing the public sector and while online-titans reap the rewards of a people who locked in can only shop online

35.10.3.1 This decimates the tax-paying class who fund the government and who are financially independent of the government

35.10.3.2 Thus the only people who both pay for the nation and who are unlikely to support a totalitarian state are the very people targeted by the government measures

35.10.4 None of this is theory far less conspiracy theory

35.10.4.1 It is simply an observation of what the government has done

35.10.4.2 And it has done it to a people who can ignore 530,841 deaths per year but who were not allowed to ignore 542 deaths in four months.

35.10.4.3 The entire of Covid-19 is contained in that one statement.

35.10.4.4 This is not about a threat to the ordinary people of this nation from Covid-19.

35.10.4.5 This is about the treat to the ordinary people of this nation from the government.

35.10.4.6 Nor is the government in the slightest shy about advertising their agenda.

35.10.4.6.1 No normal till the vaccine.

35.10.4.6.2 Build Back Better

35.10.4.6.3 The Great Reset

35.10.4.6.4 A transformation of society from freedom to control in the name of protecting us.

35.11 There is quite literally no point to being alive if we are not free.

35.11.1 The government has implemented and continues to implement a program for the eradication of freedom.

35.11.1.1 That is not hyperbole. It is a simple statement of fact.

35.11.2 Scientists and opinion formers have been outspoken and entirely public about the need for and desirability of that loss of freedom.

35.11.2.1 As just one example without mentioning TP we can cite Gideon Lichfield (GL), MIT Technology Review, 'We're not going back to normal' which actually predates TP April 5th Fox News.

35.11.2.1.1 The article is available here
https://www.technologyreview.com/2020/03/17/905264/coronavirus-pandemic-social-distancing-18-months/

35.11.2.1.2 In the article GL states:

35.11.2.1.2.1 "This isn't a temporary disruption. It's the start of a completely different way of life."

35.11.2.1.2.2 "Ultimately, however, I predict that we'll restore the ability to socialize safely by developing more sophisticated ways to identify who is a disease risk and who isn't, and discriminating—legally—against those who are."

35.11.2.1.2.3 "But one can imagine a world in which, to get on a flight, perhaps you'll have to be signed up to a service that tracks your movements via your phone. The airline wouldn't be able to see where you'd gone, but it would get an alert if you'd been close to known infected people or disease hot spots. There'd be similar requirements at the entrance to large venues, government buildings, or public transport hubs. There would be temperature scanners everywhere, and your workplace might demand you wear a monitor that tracks your temperature or other vital signs.

Where nightclubs ask for proof of age, in future they might ask for proof of immunity—an identity card or some kind of digital verification via your phone, showing you've already recovered from or been vaccinated against the latest virus strains."

35.11.2.1.2.3 As TP et al have published, you won't be entitled to a job, to go shopping, to travel until you have your vaccine passport.

35.11.2.1.2.4 You will no longer be allowed an independent life.

35.11.2.1.2.5 You will comply or die.

35.11.2.1.3 Naturally this threatening scenario and eradication of freedom is backed up by science.

35.11.2.1.3.1 "In all scenarios without widespread social distancing, the number of Covid cases overwhelms the healthcare system. Imperial College Covid-19 Response Team."

35.11.2.1.3.2 The familiar science. The familiar source. Imperial College Covid-19 Response Team. Professor Ferguson. PF. The man – or college – that received $79m from TP the same month he/they released a fraudulent report that as illustrated here was immediately put to good use the very next day to set out the end of freedom agenda.

35.11.2.1.3.2.1 Dare we point out that MIT Technology Review and Gideon Lichfield were prompt in the extreme in being able to publish an in-depth article the very day after PF's publication.

35.11.2.1.3.2.2 We are fortunate that they had the intellectual capacity and the motivation to absorb that report in depth and put out such a far-reaching agenda in response.

35.11.2.1.3.2.3 To say that it was timely and a fast turnaround is an understatement.

35.11.2.1.3.2.4 Unless of course it was already prepared.

35.11.2.1.3.2.4.1 No one writes one report, one article, in isolation not in a media campaign.

35.11.2.1.3.2.4.2 There's a reason it's called a campaign.

35.11.2.1.3.2.4.3 A campaign is widespread, comprehensive, sustained.

35.11.2.1.3.2.4.4 The narrative of threat and response for Covid-19 has certainly been widespread, comprehensive and sustained.

35.11.2.1.3.2.4.5 And thus the agenda for loss of freedom was set out from the very beginning.

35.12 Yet at the end of the day it all hinges on 542.

35.12.1 The government claims that a people who can ignore 530,841 deaths a year should end their society for 542 deaths.

35.12.1.1 The people for their sins believed them because it was never stated that way.

35.12.1.2 That remains the fact however that the court must consider.

35.12.1.3 A society that can ignore 530,841 deaths a year cannot legitimately be ended because of 542 deaths in four months at the height of the contagion.

35.12.1.4 Such a society can only be ended or overthrown by deception and authority.

35.12.1.5 It can only be overthrown by deception by the sole authority the most powerful authority in the land determined not to act in accordance with 542 deaths vs 530,841 deaths but in

accordance with its own mission whose intent and consequences are publicly and stridently declared every day.

35.12.1.5.1 No normal till the vaccine.

35.12.1.5.2 Build Back Better

35.12.1.5.3 The Great Reset

35.12.2 None of this was desired by the ordinary people of this nation.

35.12.2.1 None of this was necessary for a people who could ignore 530,841 deaths a year.

35.12.2.2 It is only necessary and desired by the people who have chosen to implement their agenda in the name of 542 deaths a year.

35.12.2.3 A figure they studiously ignore presenting instead by charming coincidence the threat of 530,000 deaths a year or in ICCRT R9 510,000 UK deaths.

35.12.2.4 The Covid-19 530,000 deaths and 510,000 deaths are fraudulent as we've covered elsewhere.

35.12.2.5 The 542 deaths is real. it is the government's own data.

35.13 End this fraudulent tyranny before it ends three millennia of evolution from tribal societies enjoying some freedom through war invasion and tyranny ad nauseam until we enjoyed some illusion of freedom in the late 20th century.

35.13.1 Then came 9/11. Then came Covid-19.

35.13.2 There will be no free world to save us. We are the once free world. And our government has decided it is now possible and therefore timely to act directly against us.

35.13.3 And the submission of the people to the narrative proves the government right.

35.14 The only recourse now is the law beyond which we must hope for divine or alien intervention and as we have no hope for the latter two and no significant trust in the first we can as we have advised others do no more than breathe and eat for as long as we are allowed to breathe and eat.

35.14.1 To expect more or even to want more in a world where we can breathe and eat solely through our masks and solely if we can present evidence that we have been injected is absurd.

35.14.2 Death will quite literally be preferable to tyranny.

35.14.2.1 Many have shown that they will submit to any measure to stay alive and worse to stay believing in the parent government.

35.14.2.2 We are not among them.

36.0 Normal Life Far More Dangerous Than Covid-19

[x]. For England we are working with the data 'comparison_of_geographic_allocation_methodologies.xlsx' downloaded from [x]

[x]..1 Despite the name and coincidental similarity to our examination of geographic spread the purpose of the spreadsheet and its utility to us are only loosely connected.

[x]..1.1 The study apparently compares two extremely similar sources of counting cases by local authority. A typical difference might be two cases if there is any difference at all.

[x]..1.1.1 The only relevance that has for us is that we can use either of the contained columns without concern as to which is more accurate.

[x]..1.1.2 Far more useful is that the data table (in excess of 64k rows) contains or appears to contain every case individually recorded by every local authority in England with the associated date

[x]..1.1.2.1 The data lists 315 local authorities.

[x]..1.1.2.1.1 We have yet to check how many local authorities there actually are and so how many local authorities escaped covid but what we have here is a very comprehensive and detailed record of who did not and when each local authority was caught.

[x]..1.1.2.1.2 We also have yet to compare the recorded case count to discover whether this dataset is independent of and separate from the NHS dataset in the sense of a case recorded here not being a case recorded by the NHS or whether it is the same data seen from a different perspective.

[x]..1.1.2.1.3 Neither of these issues (completeness and identicality) are material to the analysis.

[x]..1.1.2.1.3.1 We have a record of 315 local authorities and their case histories for covid as reported by the government. That suffices for us to look at that picture regardless of whether some other local authorities escaped and whether the NHS was recording the same or another segment.

[x] Comorbidity

27.0 Formal World Rankings

26.0 Risk of Covid (including in the 80% scenario)

From our earlier observation that means that inpatients for non-covid reasons subsequently infected with Covid-19 represented [x] of NHS Covid-19 victims.

24.3.3.3.2 That means that people who entered hospital for non-covid reasons represented [x] of the England and Wales covid victims

24.3.3.3.2.1 We wonder how they and their families would have felt to know that going into the NHS for a non-covid reason was making them the prime target for Covid.

24.3.3.3.2.2 Many of those victims would not be emerging alive from the NHS

24.3.3.3.2.2.1 We turn to that now

24.4 ONS gives us a location for Covid-19 deaths in its Tab '[x]

--- sundry --

15.2.4.1 If the growth rate is known or declared it can be applied to a base figure.

15.2.4.1.1 Growth of the base can be calculated by adding a percentage to the base.

15.2.4.1.2 This is also equivalent to multiplying the base by one plus the interest rate.

15.2.4.2 A growth rate quoted per time period can be converted to a growth rate in a second time period.

15.2.4.2.1 The easiest way to do that is with eg: Excel Power function

15.2.4.2.2 Thus to convert a weekly rate into a daily rate we require the 7^{th} root of the weekly rate

15.2.4.2.3 This is expressed as =Power(R, 1/7) = S the new rate.

15.2.4.2.4 The conversion is such that S x S x S x S x S x S x S = R

15.2.4.2.5 As such the conversion expresses constant growth which is exponential growth.

15.2.4.2.6 Although contagions do not grow exponentially the conversion is simple and convenient for translating between eg: “doubling every week” to a daily rate.

25.3 Calculating an interest payment is simple.

25.3.1 First we illustrate an interest payment of 10% independent of time.

25.3.1.1 £100 at 10% interest yields £10 interest for a final total of £110.

25.3.1.2 10% is by definition 0.1.

25.3.1.3 The interest can be calculated as 100 x 0.1

25.3.1.4 The final sum can be calculated by multiplying by a factor.

25.3.1.5 The factor is 1 + 0.1 = 1.1

25.3.1.6 The final sum is therefore £110.

25.3.2 To calculate an interest payment at an annual rate for a different period we do the following.

25.3.2.1 APR is a common term

In which we address the mathematics and arithmetic.

20.1 Given the misinformation about Covid-19 and contagions we present an introduction to the essentials of contagion statistics and their typical nature.

20.1.1 Contrary

Part III

In which we provide evidence, statistics and statistical data

40.1

Don't Forget

Demonstration of Ferguson rates

World Rankings

Comorbidities

Risk vs Life

Geographic Spread –

England regional spread

Scotland health board spread

Optional (non-stats, avoided)

Disappearing flu

Vaccine

Govt contracts

Statements

BJ "And let me be absolutely clear that for the overwhelming majority of people who contract the virus, this will be a mild disease from which they will speedily and fully recover as we've already seen."

BJ “But at this stage, and with the exception of all of the points I have just mentioned, I want to stress that for the vast majority of the people of this country, we should be going about our business as usual.”

PV “and of course central to all of this is making sure that we protect the vulnerable”

3rd March Press Briefing

Coronavirus: Boris Johnson announces UK government's plan to tackle virus spread ITV News - YouTube

Throughout the period of lockdown which started on March 23rd we have been at Level 4 – meaning a Covid19 epidemic is in general circulation, and transmission is high or rising exponentially.

“The level will be primarily determined by the R value and the number of coronavirus cases”

“but crucially while avoiding what would be a disastrous second peak that overwhelms the NHS.”

11th May Press Briefing

Prime Minister's statement on coronavirus (COVID-19): 11 May 2020 - GOV.UK (www.gov.uk)

References

March 3rd Briefing

Coronavirus: Boris Johnson announces UK government's plan to tackle virus spread ITV News - YouTube

The shocking coronavirus study that rocked the UK and US | Financial Times (ft.com)

https://www.ft.com/content/16764a22-69ca-11ea-a3c9-1fe6fedcca75