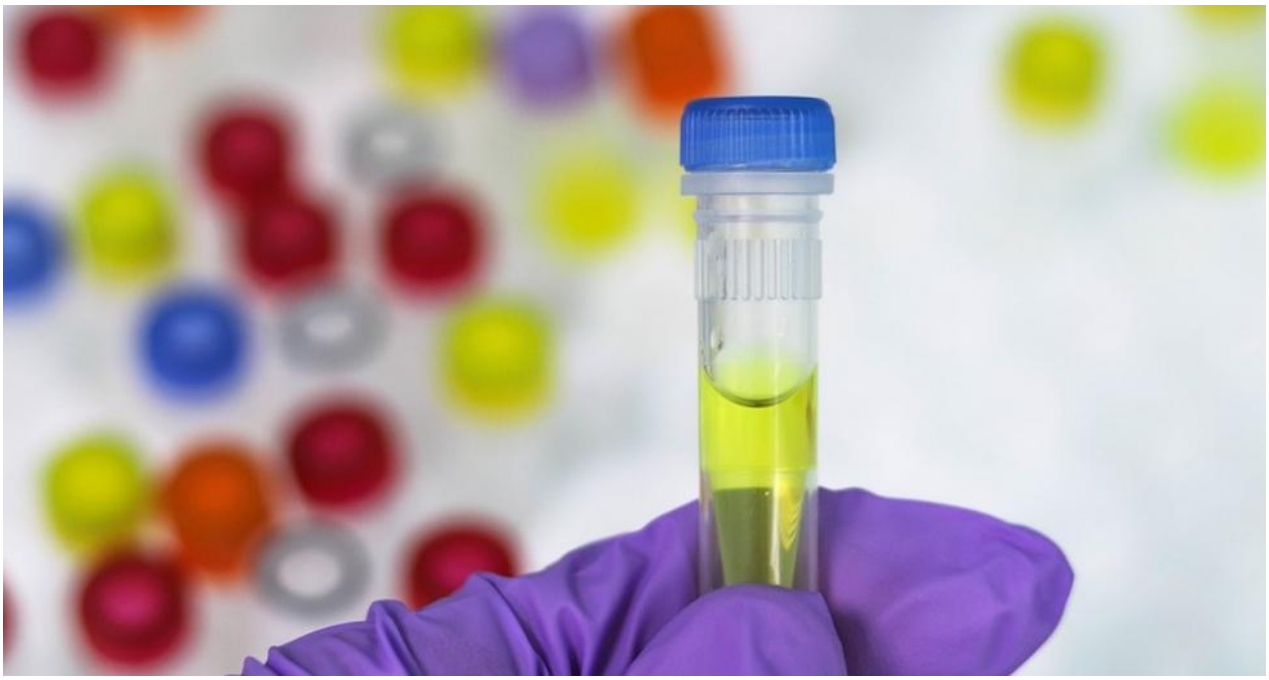
Coronavirus

COVID-19 — Everything And Nothing



by Iain Davis

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COVID-19 is the respiratory disease that some patients suffer following infection with the SARS-CoV-2 virus. The question is how many?

A disease can be clearly defined. It has a specific cause, a defined set of symptoms and observable physical effects. Scientific evidence indicates that there is a novel viral respiratory disease called COVID-19. The problem is that we have no idea how many people are affected by it.

Office of National Statistics figures show that just 9% of people who were said to have died from COVID-19 had no other underlying health condition. Similar figures have been reported by other nations, including Italy and the U.S. These are the minority of people whose deaths can be most clearly attributed to COVID-19. For the remaining, significant majority the evidence that they died *of* COVID-19 is far less certain.

Mortality caused by COVID-19 seems to be primarily from lung damage. Tiny blood clots (microthrombi) appear to form in the lungs, reducing oxygen intake. It is possible for these tiny clots to migrate to other organs causing wider organ damage. However, post mortems reveal that it is not possible to clearly ascertain the direct impact of COVID-19 on other organs.

Damage appears to occur for a number of reasons. There is evidence of the direct impact of the disease, but also damage from an immune response (cytokine storm), damage from comorbidity (blood clotting due to obesity etc), indirect damage from oxygen depletion and the toxic effect of treatments.

Clearly attributing death to COVID-19 is far from straightforward. Many of the claimed symptoms of COVID-19, such as loss of taste and smell are also attributable to other diseases.

As a result, the COVID-19 narrative is largely based upon statistical analysis, rather than medical science. However, the systems created to gather that data are questionable. The reliability of data, the validity of tests and, in particular, the manner of the reporting of the statistics, often misleads the public.

Such as it is, the data indicates an Infection Mortality Rate (IFR) somewhere between 0.1 - 0.5%. This is comparable to a relatively severe, but not population threatening, influenza outbreak.

Death rates seem to be in the range of a bad influenza season and there is little to no evidence that 'lockdown' measures have any impact on COVID-19 mortality. If anything, it appears lockdown increased the mortality risk for the wider population.

Most people develop only mild or no symptoms and the hospitalisation rate is again similar to influenza. In western democratic nations the median age of mortality is over 80 yrs. For example, in Sweden the median mortality age is 84 yrs. The U.S. is the exception with an apparent median mortality of just 79 yrs.

In Italy, fewer than 5% of those who have had their deaths attributed to COVID-19 had no serious comorbidities. On average, across western democracies, up to two thirds of mortality occurred in care settings. Reports of young people dying *"of COVID-19"* have been consistently false. There is no appreciable risk for people of working age. Save for the tiny minority of immunosuppressed people who are vulnerable to all viruses and diseases.

COVID-19 mortality risks increase with age, as nearly all mortality risks do. Mortality distribution is practically indistinguishable from normal mortality.

COVID-19 is consistently reported to the public as if it presents a significant threat to the population, yet right from the beginning of the 'pandemic', it was determined

not to be a High Impact Infectious Disease (HCID), as overall mortality is low.

Claimed disease prevalence is being used by governments to continue the process of social, economic, political and cultural transformation. The objective seems to be to create a global surveillance, biosecurity State; a new global society where every aspect of our lives will be controlled by our biosecurity or *immunity* status. In order to deal with this allegedly *severe threat,* the governments are forcing our behaviour change.

What is the evidence to support this claim that COVID-19 is a major threat? Does the scale of the problem warrant the total restructuring of society?

What Is COVID-19?

According to the World Health Organisation (WHO) COVID-19 is the **CO**rona**VI**rus **D**isease, discovered in 2019. It is distinct from the SARS-CoV-2 virus, said to commonly cause it.

A disease has three unique features:

- There is an established biological cause behind the condition.
- A defined group of symptoms exists, characterising the disease.
- A consistent change in anatomy, due to the disease, can be observed.

Therefore, in classifying COVID-19 as a disease, the WHO claims it meets these criteria. As we will discuss, COVID-19 possesses the characteristics of a disease. However, the list of symptoms used to diagnose COVID-19 "cases" is ambiguous and the common test used to allegedly find them in the community is fundamentally flawed.

Instead of accurate and robust diagnostic and testing procedures we have a vague range of symptoms and a testing program seemingly designed to hugely inflate the alleged public health impact of COVID-19. The reported claims about the level of disease in the population are doubtful.

It is not that COVID-19 cannot be accurately identified, but rather that governments and corporate run testing facilities are reporting nearly everything as COVID-19 without justification.

The frequency with which SARS-CoV-2 causes COVID-19 is far from certain. While SARS-CoV-2 *may* be a common virus it does not mean that COVID-19 is anything more than a rare disease.

What Is A COVID-19 Case?

Presently, the UK government and the UK mainstream media (MSM) are among many organisations around the world claiming that a positive test for SARS-CoV-2 constitutes *a case*. Stories of rising cases are common.

Current estimates of asymptomatic rates for SARS-CoV-2 are up to 80%. This means that up to 80% of the people who are genuinely infected with SARS-CoV-2 don't have COVID-19 and may not go on to develop COVID-19.

Research shows that those infected with SARS-Cov-2, symptomatic or not, can shed RNA for up to three months. It is highly likely, then, that a positive RT-PCR test does not show that anyone currently has COVID-19.

Similarly, a review of the available science by the Oxford Centre For Evidence Based Medicine found that the mere detection of SARS-CoV-2 RNA does not necessarily indicate the presence of any disease. They found:

> A binary Yes/No approach to the interpretation RT-PCR unvalidated against viral culture will result in false positives with segregation of large numbers of people who are no longer infectious and hence not a threat to public health.

In the UK, the government's own research found that negative and false positive rates for RT-PCR test results (many analysed and recorded by pharmaceutical corporations) are not reported. While RT-PCR in the laboratory is extremely sensitive to RNA detection, when used in community settings controls are far less stringent.

The risk of contamination, sample degradation or other sources of error are relatively high. Researchers stated:

> We have been unable to find any data on the operational false positive and false negative rates in the UK COVID-19 RT-PCR testing programme. DHSC figures show that 100,664 tests were carried out on 31 May 2020...1,570 of those tests were positive for SARS-CoV-2 (1.6%). The majority of people tested on that day did not have SARS-CoV-2 (98.4% of tests are negative)..... If the operational false positive rate was 0.4%, 400 of the 1,570 positive tests would be false positives.

An RT-PCR test can detect fragments of RNA, but not that the RNA is part of an active virus, capable of causing illness. A positive test is not evidence of an infectious *disease*. It is not a *"case."*

There is no evidence that draconian lockdowns or other measures, such as the wearing of face masks, reduce the spread of COVID-19. However, irrespective of this fact, the widespread reporting of supposed *"cases"* to justify further lockdowns have no basis in medical science.

When Is A Case Not A Case?

In early August, to coincide neatly with the shift towards MSM reporting of nothing but alleged *cases*, the WHO decided to change their definition of COVID-19.

Previously, the WHO Case definition for a *suspected case,* though ludicrously broad, did at least suggest that someone with acute respiratory illness needed to have some related respiratory symptoms.

The WHO announced that a *probable case*, which was presumably supposed to be more conclusive than a *suspected case*, was simply a *suspected case* without any positive test for COVID-19. Quite what that added to degrees of certainty about the alleged prevalence of a disease is difficult to say.

With their changed definition, the WHO decided to do away with respiratory symptoms for a *suspected case*. Those feeling a little depressed, who have a headache or feel bit run down, as long as they live in or have recently visited an area of *"community transmission,"* or have been *contact traced* to someone else who has, can be diagnosed as a *suspected* COVID-19 *case*.

In the UK, as elsewhere, an area of *"community transmission,"* more recently re-branded as an *"area of intervention,"* is an arbitrary declaration by the government based upon extremely dubious data. For example, Leicester was recently deemed to be a *community transmission* area as a result of the UK government's *Pillar 2* test data.

This data is provided to the UK government by pharmaceutical corporations like Astrazeneca and GlaxoSmithKline. Far from the only fundamental conflict of financial interest that pervades the government response.

Office of National Statistic (ONS) data, combined with a calculated minimum false positive rate of 0.8%, led researcher Dr. Michael Yeadon to conclude that approximately 90% of the Pillar 2 positive test results, widely disseminated by the MSM to support the second wave narrative, are false. There is no detection of any SARS-CoV-2 RNA in the vast majority of these alleged *cases*.

So poor is the Pillar 2 data, the government had to suspend the reporting of it in May 2020. The chair of the UK Statistics Authority, David Norgrove, wrote to the Health Secretary on 3rd June complaining that Pillar 2 data was practically useless. For the WHO to use *community transmission areas* as a criteria for clinical diagnoses of a disease is scientific gibberish.

Following reinstatement on July the 14th, Pillar 2 test data has been used to report the vast majority of recent alleged *"cases"* in the UK. There is no evidence that the problems have been fixed.

This deceptive use of statistics has enabled the UK government to use meaningless claims of COVID-19 *cases* to instigate more lockdowns. Lockdown policies are not *"led by the science"* at all. Nor is there any sign of this situation improving.

COVID-19 - Initial Reasons To Question Its Prevalence?

The WHO definition for a COVID-19 *confirmed case* (as opposed to a probable case as discussed above) is:

> A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

A confirmed case relies solely upon the WHO's Laboratory testing guidance. It doesn't matter if you have any symptoms or not. The Laboratory guidance states:

> The etiologic agent [causation for the disease] responsible for the cluster of pneumonia cases in Wuhan has been identified as a novel betacoronavirus, (in the same family as SARS-CoV and MERS-CoV).

To be clear about the WHO's claim: they are firmly stating that SARS-CoV-2 *causes* the *disease* of COVID-19. This is crucial to the definition of any disease as it must have an *established biological cause*.

The WHO criteria for a *confirmed case* also infers that the detected presence of SARS-CoV-2, regardless of viral load, proves that the tested individual has COVID-19. For the WHO, and western democratic governments, an RT-PCR test is the ultimate diagnosis of COVID-19.

There appears to be a rudimentary *error* in the WHO's definition of a COVID-19. It assumes that the detection of SARS-CoV-2 equates to the diagnosis of COVID-19. This is not true. Yet governments too have ostensibly accepted this false premise.

When the virus was first discovered it was called 2019-nCoV and was subsequently renamed SARS-CoV-2 by the WHO. In the WHO's Novel Coronavirus 2019-nCov Situation Report 1, they stated:

> The Chinese authorities identified a new type of coronavirus, which was isolated on 7 January 2020……On 12 January 2020, China shared the genetic sequence of the novel coronavirus for countries to use in developing specific diagnostic kits.

Again, clarity is important. The WHO unequivocally state the virus was *isolated*.

MN908947.1 was the first full SARS-CoV-2 genome published by the Wuhan Center for Disease Control and Prevention, working in collaboration with the Shanghai Public Health Clinical Centre. This reported genome has been updated many times.

This was the first scientific description of the *etiologic agent* (SARS-CoV-2). It is the basis for all subsequent genetic sequences and all tests are calibrated to it. In their paper discussing the possible origins of what we now call SARS-CoV-2, the scientists from the Wuhan CDC explained what their claim of *isolating* the virus meant.

They took blood and skin cell samples (swab tests) from seven suspected COVID-19 patients, living in Wuhan.

After filtering out the human genome, 5 of these samples then underwent metagenomic analysis using next-generation sequencing (NGS). They found an 87.1% match with known SARS coronavirus. From these they used targeted PCR (more on this shortly) and *isolated* nearly 30,000 base pairs CoV genome that shared 79.6% sequence identity to known SARS-CoV.

The Wuhan researchers stated:

> The culture supernatant was examined for the presence of virus by qRT-PCR methods developed in this study.....For qPCR analysis, primers based on the S gene of 2019-nCoV were designed.....Amplification was performed as follows: 50 °C for 3 min, 95 °C for 30 s followed by 40 cycles consisting of 95 °C for 10 s and 60 °C for 30 s.

SARS-CoV-2 is a positive strand RNA virus. They only posses RNA (ribonucleic acid) but, in order to assemble (sequence) the genetic code, the trace fragments of RNA need to be amplified many times using cycles of Polymerase Chain Reaction (PCR). However, PCR can only amplify DNA (deoxyribonucleic acid). So the RNA is first transcribed, using a viral enzyme known as reverse transcriptase (RT), effectively reversing normal cellular transcription. The transcription of the RNA produces cDNA (complimentary DNA) which can then be amplified using PCR.

The Chinese team amplified the cDNA through 40 qPCR cycles. While this is quite normal for qPCR experiments, in doing so they also amplified all dilution errors. That is, they amplified all contaminants too. According to the MIQE standards for qPCR, 40 cycles is the absolute limit of reliability and anything above 35 cycles would indicate that the quantity of the target RNA cannot be known.

The inventor of PCR Karry Mullis, speaking about the use of qPCR to detect HIV, another retrovirus, stated:

> Quantitative PCR [qPCR)] is an oxymoron.' PCR is intended to identify substances qualitatively, but by its very nature is unsuited for estimating numbers (viral load) ... These tests cannot detect free, infectious viruses at all ... The tests can detect genetic sequences of viruses, but not viruses themselves.

Writing for the Infectious Diseases Society of America, researchers considered the minimum cycle threshold (Ct or Cq) for effectively identifying the presence of SARS-CoV-2. They found that anything above 34 cycles would indicate that the test subject did not have any *"meaningful or transmissible disease."* The WHO's standard for RT-PCR to identify alleged COVID-19 *"cases"* recommends 50 cycles of amplification.

SARS-CoV-2 was *isolated* based upon the sequencing of an unknown quantity of viral RNA segments from in 5 patients. Because the quantity of the RNA was unknown, there was no indication that the sequenced RNA fragments caused any illness in the 5 test subjects.

A causal link between SARS-CoV-2 and COVID-19 disease was not established in the RT-qPCR experiment which is the foundation of all subsequent tests and claims. Nor is the link between viral load and the subsequent onset of COVID-19 clearly understood.

While the SARS-CoV-2 genome may have been sequenced, given a Ct of 40 cycles, there is poor evidence that it commonly causes a *"meaningful or transmissible disease."* Nor does the WHO's recommended practice of 50 cycles of PCR, commonly used to determine COVID-19 *cases*, allow for any identification of any transmissible disease.

The *established biological cause* of COVID-19 was proven, but the frequency with which it causes disease was not. RT-PCR tests used to identify SARS-CoV-2 do not evidence the presence of COVID 19 and tell us little about its prevalence. The WHO's assertion that they do is false.

COVID-19 - Further Reason To Question Its Prevalence

The viral *isolation* of 2019-nCoV (SARS-CoV-2) does not mean *"isolated"* in the accepted etymological sense, which is:

> Chemistry Biology: - Obtain or extract (a compound, microorganism, etc.) in a pure form.....Biology - A culture of microorganisms isolated for study.

Instead researchers have provided electron-microscope images of something they claim to be SARS-CoV-2 virions. However, these protein structures are not unique in their appearance. Other intracellular groups of round vesicles, such as endocytic vesicles and exosomes, look the same.

Furthermore, while RT-PCR is extremely sensitive to possible detection of RNA, it does not identify where those fragments originated. Even if images of alleged virions are as described, it doesn't mean the sequenced RNA came from them.

When German investigative journalists Torsten Engelbrecht and Konstantin Demeter asked a number of scientists, who had published images of alleged virions, to confirm that these showed the isolated, purified, SARS-CoV-2 virus, none of them could. RT-qPCR (and RT-PCR) allows only for the sequencing of RNA. This alone does not prove causation of any claimed, subsequent disease.

Numerous claims by scientists, that they have *isolated* the virus, are not what they seem. Like the word *"case,"* bandied about the MSM, the word *"isolated,"* in the mouths of some scientists, is not being used as most of us would understand it.

For example, in Australia in January 2020 Dr Mike Catton and Dr Julian Druse, representing the Doherty Institute, announced that they had *isolated* the SARS-CoV-2 virus. When asked to clarify Dr Druse said:

> We have short (RNA) sequences from the diagnostic test that can be used in the diagnostic tests....it's an exact match to the sequences from China....it tells you that your test method is spot on.

And Dr Catton added:

> In answer to your question - what's the virus doing - the segments are too short to shed light on the properties of the virus.

In other words, the properties of the virus are not evident from either the RNA sequencing nor the electron-microscope imagery. The Australian team had calibrated their tests to the most recent update of MN908947.1 and had sequenced

corresponding RNA fragments. They had confirmed a test for the presence of a virus. They had not *isolated* the virus itself nor demonstrated that it commonly caused a disease.

This explains why the Australian government state:

> The reliability of COVID-19 tests is uncertain due to the limited evidence base...The extent to which a positive PCR result correlates with the infectious state of an individual is still being determined..... There is limited evidence available to assess the accuracy and clinical utility of available COVID-19 tests.

The Australian government are not alone in being unable to verify the accuracy of their own tests. Neither, it seems, can any other government. Nor can any demonstrate that the SARS-CoV-2 virus has been isolated, purified and can be proven to commonly cause COVID-19.

Canadian researcher Christine Massey made a freedom of information request, asking the Canadian government a simple question. She asked if they could provide her with their records of the isolation of a SARS-COV-2 virus.

She requested that this be from a sample taken from a *diseased* patient, where the sample was not first combined with any other source of genetic material. To which the Canadian government replied:

> Having completed a thorough search, we regret to inform you that we were unable to locate any records responsive to your request.

When UK researcher Andrew Johnson asked Public Health England (PHE) the same question they responded:

> PHE can confirm it does not hold information in the way suggested by your request.

Similarly in the U.S. the Centre For Disease Control (CDC) RT-PCR Diagnostic Panel state:

> ...No quantified virus isolates of the 2019-nCoV are currently available.....Detection of viral RNA may not indicate the presence of infectious virus or that 2019-nCoV is the causative agent for clinical symptoms.

The CDC diagnostic panel last updated their guidance on 13th July 2020. Therefore, as of that date, there were no SARS-CoV-2 isolates. There has been no subsequent

update. This indicates that, as yet, no pure viral sample has ever been obtained from any patient said to have the disease of COVID-19.

COVID-19 - Everything and Nothing

To diagnose a disease it must also be possible to observe consistent, resultant changes in anatomy. Once more, these observed changes are not unique to COVID-19.

Computer tomography (CT) scans of alleged COVID-19 patients show a *"ground glass"* shadow in the lungs. However, the American College of Radiology (ACR) are among those who caution against using CT scans as diagnoses for COVID-19. This is because CT imagery of COVID-19 lacks any clear distinction between a range of other respiratory illnesses. They state:

> Chest imaging in COVID-19 are not specific, and overlap with other infections, including influenza, H1N1, SARS and MERS. Being in the midst of the current flu season with a much higher prevalence of influenza in the U.S. than COVID-19, further limits the specificity of CT.

It is proposed in the UK that future *"diagnosis"* of COVID-19 infection will be based upon serological (blood) tests for the presence of disease antibodies. The initial roll out of these tests was also halted after a series of errors, inaccuracies and faults were found.

The Royal College of Pathologists were compelled to commission a study highlighting the numerous inadequacies of COVID-19 antibody testing. A systemic meta-analysis, by an international team of researchers, also found that the tests were unreliable with commercially available tests being of poor quality. They concluded:

> Currently, available evidence does not support the continued use of existing point-of-care serological tests.

In addition, there is scientific evidence that a large proportion of the population already have T-Cell immunity to SARS-CoV-2. Further evidence shows that the point at which SARS-CoV-2 loses virulence (its possible capacity to cause illness) occurs when a little as 20% of the community, or even less, are infected with the virus.

The initial identification of the SARS-CoV-2 demonstrated that the virus caused cell mutation (cytopathogenic effects) and it was seen to bind to ACE2 receptors, in cell

cultures, as other SARS betacoronavirus strains do. It had a high degree of similarity to the known SARS genome.

What could have been virions were also observed. This suggests that a previously unknown strain of betacoronavirus exists. This is called SARS-CoV-2.

The binding of SARS-CoV-2 to ACE2 receptors has been seen in postmortem examinations. This caused the microthrombi which lead to respiratory distress and oxygen depletion. Evidence suggests, this physiological damage may be observed in about 37% of deceased patients who had postmortems. However, far more are *diagnosed* with COVID-19.

It is reasonable to say SARS-CoV-2 can cause a novel respiratory illness called COVID-19. However, we lack evidence which demonstrates that it commonly does so. Nor is the wider diagnosis of COVID-19 scientifically sound. We don't know how many claimed cases of COVID-19 actually are COVID-19.

There have been numerous reported accounts of people treated for respiratory symptoms. Medical professionals have also reported periods of intense activity, within the co called COVID wards, at the peak of the crisis. These testimonies strongly suggest the presence of a severe respiratory illness outbreak in a few regions. This was nothing new. It cannot reliably be attributed to COVID-19.

Just as the U.S *outbreak* was largely centred upon New York so, in the UK, this outbreak was most notable in London. However, in nearly every other part of the UK, at the height of the speculatively named *pandemic,* health services were experiencing a record low in patient numbers.

Scientists and governments acknowledge that the virus has neither been isolated nor purified. It cannot be shown that SARS-CoV-2 commonly causes the disease labeled as COVID-19. The list of symptoms attributed to it is so extensive that numerous other illnesses, and viral respiratory diseases, could easily be misdiagnosed as COVID-19.

We have a poor clinical diagnostic tests, incapable of determining the viral load (quantity of RNA) or its origins, and a meaningless set of symptoms which cannot clearly distinguish COVID-19. Genuine COVID-19 can cause mortality but we simply have no idea to what extent.

Any hospital admission or reported mortality from COVID-19 should be viewed in this context. If a patient presents to hospital with any respiratory symptoms, or even a range of non respiratory symptoms, a system exists which virtually guarantees they will be diagnosed with COVID-19.

Similarly, a positive RT-PCR or serological test, of someone who dies, will be sufficient categorise their passing as a COVID-19 death. We should treat all such claims with considerable scepticism.

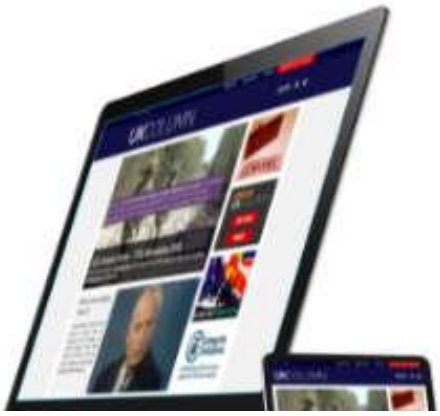
All that we have to substantiate the claim that COVID-19 is widespread are numerous MSM reports, anecdotes from patients, and accounts from a small number of doctors using a diagnostic process designed to identify practically everything as COVID-19.

Accurate diagnosis using the plethora of symptoms attributed to COVID 19 is impossible. Yet a system has been created to do precisely that. The commonly used RT-PCR test, used to identify so called COVID-19 *confirmed cases,* is not fit for purpose.

It is difficult to see how COVID-19 can legitimately be deemed a significant threat to public health. Its widespread prevalence has not been demonstrated and current evidence tends towards an assessment of relatively low risk. There is no evidence that it causes unprecedented illness or mortality. What we have instead is an apparent disconnect between the testing program, the diagnostic process and the genuine prevalence of a disease.

None of this appears to matter to the UK government as they, among many others, propose that our future freedoms will be restricted based upon extremely dubious claims and little else. Government lockdowns and other response measures are in no way *"led by the science"*.

The objective appears to be to change our behaviour and our society, in preparation for a Great Reset and to *"protect"* us all with a vaccine for a disease which does not seem to present a significant risk at all.



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