Our grave concerns about the handling of the COVID pandemic by Governments of the Nations of the UK

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Ms Nicola Sturgeon, First Minister for Scotland
Mr Mark Drakeford, First Minister for Wales
Mr Paul Givan, First Minister for Northern Ireland
Mr Sajid Javid, Health Secretary
Dr Chris Whitty, Chief Medical Officer
Dr Patrick Vallance, Chief Scientific Officer

22 August 2021

Dear Sirs and Madam,

Our grave concerns about the handling of the COVID pandemic by Governments of the Nations of the UK.

We write as concerned doctors, nurses, and other allied healthcare professionals with no vested interest in doing so. To the contrary, we face personal risk in relation to our employment for doing so and / or the risk of being personally "smeared" by those who inevitably will not like us speaking out.

We are taking the step of writing this public letter because it has become apparent to us that:

- The Government (by which we mean the UK government and three devolved governments/administrations and associated government advisors and agencies such as the CMOs, CSA, SAGE, MHRA, JCVI, Public Health services, Ofcom etc, hereinafter "you" or the "Government") have based the handling of the COVID pandemic on flawed assumptions.
- These have been pointed out to you by numerous individuals and organisations.
- You have failed to engage in dialogue and show no signs of doing so. You have removed from people fundamental rights and altered the fabric of society with little debate in Parliament. No minister responsible for policy has ever appeared in a proper debate with anyone with opposing views on any mainstream media channel.
- Despite being aware of alternative medical and scientific viewpoints you have failed to ensure an open and full discussion of the pros and cons of alternative ways of managing the pandemic.
- The pandemic response policies implemented have caused massive, permanent and unnecessary harm to our nation, and must never be repeated.
- Only by revealing the complete lack of widespread approval among healthcare professionals of your policies will a wider debate be demanded by the public.

In relation to the above, we wish to draw attention to the following points. Supporting references can be provided upon request.

1. No attempt to measure the harms of lockdown policies

The evidence of disastrous effects of lockdowns on the physical and mental health of the population is there for all to see. The harms are massive, widespread, and long lasting. In particular, the psychological impact on a generation of developing children could be lifelong.
It is for this reason that lockdown policies were never part of any pandemic preparedness plans prior to 2020. In fact, they were expressly not recommended in WHO documents, even for severe respiratory viral pathogens and for that matter neither were border closures, face coverings, and testing of asymptomatic individuals. There has been such an inexplicable absence of consideration of the harms caused by lockdown policy it is difficult to avoid the suspicion that this is willful avoidance.
The introduction of such policies was never accompanied by any sort of risk/benefit analysis. As bad as that is, it is even worse that after the event when plenty of data became available by which the harms could be measured, only perfunctory attention to this aspect of pandemic planning has been afforded. Eminent professionals have repeatedly called for discourse on these health impacts in press-conferences but have been universally ignored.
What is so odd, is that the policies being pursued before mid-March 2020 (self-isolation of the ill and protection of the vulnerable, while otherwise society continued close to normality) were balanced, sensible and reflected the approach established by consensus prior to 2020. No cogent reason was given then for the abrupt change of direction from mid-March 2020 and strikingly none has been put forward at any time since.

2. Institutional nature of COVID

It was actually clear early on from Italian data that COVID (the disease – as opposed to SARS-Cov-2 infection or exposure) was largely a disease of institutions. Care home residents comprised around half of all deaths, despite making up less than 1% of the population. Hospital infections are the major driver of transmission rates as was the case for both SARS1 and MERS. Transmission was associated with hospital contact in up to 40% of cases in the first wave in Spring 2020 and in 64% in winter 2020/2021.
Severe illness among healthy people below 70 years old did occur (as seen with flu pandemics) but was extremely rare.
Despite this, no early, aggressive and targeted measures were taken to protect care homes; to the contrary, patients were discharged without testing to homes where staff had inadequate PPE, training and information. Many unnecessary deaths were caused as a result.
Preparations for this coming winter, including ensuring sufficient capacity and preventative measures such as ventilation solutions, have not been prioritised.

3. The exaggerated nature of the threat

Policy appears to have been directed at systematic exaggeration of the number of deaths which can be attributed to COVID. Testing was designed to find every possible ‘case’

rather than focusing on clinically diagnosed infections and the resulting exaggerated case numbers fed through to the death data with large numbers of people dying 'with COVID' and not 'of COVID' where the disease was the underlying cause of death.
The policy of publishing a daily death figure meant the figure was based entirely on the PCR test result with no input from treating clinicians. By including all deaths within a time period after a positive test, incidental deaths, with but not due to COVID, were not excluded thereby exaggerating the nature of the threat.
Moreover, in headlines reporting the number of deaths, a categorisation by age was not included. The average age of a COVID-labelled death is 81 for men and 84 for women, higher than the average life expectancy when these people were born. This is a highly relevant fact in assessing the societal impact of the pandemic. Death in old age is a natural phenomenon. It cannot be said that a disease primarily affecting the elderly is the same as one which affects all ages, and yet the government's messaging appears designed to make the public think that everyone is at equal risk.
Doctors were asked to complete death certificates in the knowledge that the deceased's death had already been recorded as a COVID death by the Government. Since it would be virtually impossible to find evidence categorically ruling out COVID as a contributory factor to death, once recorded as a "COVID death" by the government, it was inevitable that it would be included as a cause on the death certificate. Diagnosing the cause of death is always difficult and the reduction in post mortems will have inevitably resulted in increased inaccuracy. The fact that deaths due to non-COVID causes actually moved into a substantial deficit (compared to average) as COVID-labelled deaths rose (and this was reversed as COVID-labelled deaths fell) is striking evidence of over-attribution of deaths to COVID.
The overall all-cause mortality rate from 2015-2019 was unusually low and yet these figures have been used to compare to 2020 and 2021 mortality figures which has made the increased mortality appear unprecedented. Comparisons with data from earlier years would have demonstrated that the 2020 mortality rate was exceeded in every year prior to 2003 and is unexceptional as a result.
Even now COVID cases and deaths continue to be added to the existing total without proper rigour such that overall totals grow ever larger and exaggerate the threat. No effort has been made to count totals in each winter season separately which is standard practice for every other disease.
You have continued to adopt high-frequency advertising through publishing and broadcast media outlets to add to the impact of "fear messaging". The cost of this has not been widely published, but government procurement websites reveal it to be immense – hundreds of millions of pounds.
The media and government rhetoric is now moving onto the idea that "Long Covid" is going to cause major morbidity in all age groups including children, without having a discussion of the normality of postviral fatigue which lasts upwards of 6 months. This adds to the public fear of the disease, encouraging vaccination amongst those who are highly unlikely to suffer any adverse effects from COVID.

4. Active suppression of discussion of early treatment using protocols being successfully deployed elsewhere.

The harm caused by COVID and our response to it should have meant that advances in prophylaxis and therapeutics for COVID were embraced. However, evidence on

successful treatments has been ignored or even actively suppressed. For example, a study in Oxford published in February 2021 demonstrated that inhaled Budesonide could reduce hospitalisations by 90% in low risk patients and a publication in April 2021 showed that recovery was faster for high risk patients too. However, this important intervention has not been promoted.
Dr. Tess Lawrie, of the Evidence Based Medical Consultancy in Bath, presented a thorough analysis of the prophylactic and therapeutic benefits of Ivermectin to the government in January 2021. More than 24 randomised trials with 3,400 people have demonstrated a 79-91% reduction in infections and a 27-81% reduction in deaths with Ivermectin.
Many doctors are understandably cautious about possible over-interpretation of the available data for the drugs mentioned above and other treatments, although it is to be noted that no such caution seems to have been applied in relation to the treatment of data around the government's interventions (eg the effectiveness of lockdowns or masks) when used in support of the government's agenda.
Whatever one's view on the merits of these repurposed drugs, it is totally unacceptable that doctors who have attempted to merely open discussion about the potential benefits of early treatments for COVID have been heavily and inexplicably censored. Knowing that early treatments which could reduce the risk of requiring hospitalisation might be available would alter the entire view held by many professionals and lay people alike about the threat posed by COVID, and therefore the risk / benefit ratio for vaccination, especially in younger groups.

5. Inappropriate and unethical use of behavioural science to generate unwarranted fear.

Propagation of a deliberate fear narrative (confirmed through publicly accessible government documentation) has been disproportionate, harmful and counterproductive. We request that it should cease forthwith.

To give just one example, the government's face covering policies seem to have been driven by behavioural psychology advice in relation to generating a level of fear necessary for compliance with other policies. Those policies do not appear to have been driven by reason of infection control, because there is no robust evidence showing that wearing a face covering (particularly cloth or standard surgical masks) is effective against transmission of airborne respiratory pathogens such as SARS-Cov-2. Several high profile institutions and individuals are aware of this and have advocated against face coverings during this pandemic only inexplicably to reverse their advice on the basis of no scientific justification of which we are aware. On the other hand there is plenty of evidence suggesting that mask wearing can cause multiple harms, both physical and mental. This has been particularly distressing for the nation's school children who have been encouraged by government policy and their schools to wear masks for long periods at school.
Finally, the use of face coverings is highly symbolic and thus counterproductive in making people feel safe. Prolonged wearing risks becoming an ingrained safety behaviour, actually preventing people from getting back to normal because they erroneously attribute their safety to the act of mask wearing rather than to the remote risk, for the vast majority of healthy people under 70 years old, of catching the virus and becoming seriously unwell with COVID.

6. Misunderstanding of the ubiquitous nature of mutations of newly emergent viruses.

The mutation of any novel virus into newer strains – especially when under selection pressure from abnormal restrictions on mixing and vaccination – is normal, unavoidable and not something to be concerned about. Hundreds of thousands of mutations of the original Wuhan strain have already been identified. Chasing down every new emergent variant is counterproductive, harmful and totally unnecessary and there is no convincing evidence that any newly identified variant is any more deadly than the original strain. Mutant strains appear simultaneously in different countries (by way of 'convergent evolution') and the closing of national borders in attempts to prevent variants travelling from one country to another serves no significant infection control purpose and should be abandoned.

7. Misunderstanding of asymptomatic spread and its use to promote public compliance with restrictions.

It is well-established that asymptomatic spread has never been a major driver of a respiratory disease pandemic and we object to your constant messaging implying this, which should cease forthwith. Never before have we perverted the centuries-old practice of isolating the ill by instead isolating the healthy. Repeated mandates to healthy, asymptomatic people to self-isolate, especially school children, serves no useful purpose and has only contributed to the widespread harms of such policies. In the vast majority of cases healthy people are healthy and cannot transmit the virus and only sick people with symptoms should be isolated.

The government's claim that one in three people could have the virus has been shown to be mutually inconsistent with the ONS data on prevalence of disease in society, and the sole effect of this messaging appears to have been to generate fear and promote compliance with government restrictions. The government's messaging to 'act as if you have the virus' has also been unnecessarily fear-inducing given that healthy people are extremely unlikely to transmit the virus to others.

The PCR test, widely used to determine the existence of 'cases', is now indisputably acknowledged to be unable reliably to detect infectiousness. The test cannot discriminate between those in whom the presence of fragments of genetic material partially matching the virus is either incidental (perhaps because of past infection), or is representative of active infection, or is indicative of infectiousness. Yet, it has been used almost universally without qualification or clinical diagnosis to justify lockdown policies and to quarantine millions of people needlessly at enormous cost to health and well-being and to the country's economy.

Countries that have removed community restrictions have seen no negative consequences which can be attributed to the easing. Empirical data from many countries demonstrates that the rise and fall in infections is seasonal and not due to restrictions or face coverings. The reason for reduced impact of each successive wave is that: (1) most people have some level of immunity either through prior immunity or immunity acquired through exposure; (2) as is usual with emergent new viruses, mutation of the virus towards strains causing milder disease appears to have occurred. Vaccination may also contribute to this although its durability and level of protection against variants is unclear.

The government appears to be talking of "learning to live with COVID" while apparently practicing by stealth a "zero COVID" strategy which is futile and ultimately net-harmful.

8. Mass testing of healthy children

Repeated testing of children to find asymptomatic cases who are unlikely to spread virus, and treating them like some sort of biohazard is harmful, serves no public health purpose and must stop.
During Easter term, an amount equivalent to the cost of building one District General Hospital was spent weekly on testing schoolchildren to find a few thousand positive 'cases', none of which was serious as far as we are aware.
Lockdowns are in fact a far greater contributor to child health problems, with record levels of mental illness and soaring levels of non-COVID infections being seen, which some experts consider to be a result of distancing resulting in deconditioning of the immune system.

9. Vaccination of the entire adult population should never have been a prerequisite for ending restrictions.

Based merely on early "promising" vaccine data, it is clear that the Government decided in summer 2020 to pursue a policy of viral suppression within the entire population until vaccination was available (which was initially stated to be for the vulnerable only, then later changed – without proper debate or rigorous analysis – to the entire adult population).
This decision was taken despite massive harms consequent to continued lockdowns which were either known to you or ought to have been ascertained so as to be considered in the decision making process.
Moreover, a number of principles of good medical practice and previously unimpeachable ethical standards have been breached in relation to the vaccination campaign, meaning that in most cases, whether the consent obtained can be truly regarded as "fully informed" must be in serious doubt:

- The use of coercion supported by an unprecedented media campaign to persuade the public to be vaccinated, including threats of discrimination, either supported by the law or encouraged socially, for example in co-operation with social media platforms and dating apps.
- The omission of information permitting individuals to make a fully informed choice, especially in relation to the experimental nature of the vaccine agents, extremely low background COVID risk for most people, known occurrence of short-term side-effects and unknown long-term effects.

Finally, we note that the Government is seriously considering the possibility that these vaccines – which have no associated long-term safety data – could be administered to children on the basis that this might provide some degree of protection to adults. We find that notion an appalling and unethical inversion of the long-accepted duty falling on adults to protect children.

10. Over-reliance on modeling while ignoring real-world data

Throughout the pandemic, decisions seem to have been taken utilising unvalidated models produced by groups who have what can only be described as a woeful track record, massively overestimating the impact of several previous pandemics.
The decision-making teams appear to have very little clinical input and, as far as is ascertainable, no clinical immunology expertise.
Moreover, the assumptions underlying the modeling have never been adjusted to take into account real-world observations in the UK and other countries.
It is an astonishing admission that, when asked whether collateral harms had been considered by SAGE, the answer given was that it was not in their remit – they were simply asked to minimise COVID impact. That might be forgivable if some other advisory group was constantly studying the harms side of the ledger, yet this seems not to have been the case.

Conclusions

The UK's approach to COVID has palpably failed. In the apparent desire to protect one vulnerable group – the elderly – the implemented policies have caused widespread collateral and disproportionate harm to many other vulnerable groups, especially children. Moreover your policies have failed in any event to prevent the UK from notching up one of the highest reported death rates from COVID in the world.
Now, despite very high vaccination rates and the currently very low COVID death and hospitalisation rates, policy continues to be aimed at maintaining a population handicapped by extreme fear with restrictions on everyday life prolonging and deepening the policy-derived harms. To give just one example, NHS waiting lists now stand at 5.1m officially, with – according to the previous Health Secretary – a likely further 7m who will require treatment not yet presented. This is unacceptable and must be addressed urgently.

In short, there needs to be a sea change within the Government which must now pay proper attention to those esteemed experts outside its inner circle who are sounding these alarms. As those involved with healthcare, we are committed to our oath to "first do no harm", and we can no longer stand by in silence observing policies which have imposed a series of supposed "cures" which are in fact far worse than the disease they are supposed to address.
The signatories of this letter call on you, in Government, without further delay to widen the debate over policy, consult openly with groups of scientists, doctors, psychologists and others who share crucial, scientifically-valid and evidence-based alternative views and to do everything in your power to return the country as rapidly as possible to normality with the minimum of further damage to society.

Yours sincerely,

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COVID19
ASSEMBLY