What the UK Covid Inquiry did not hear

Presentation to the All-Party Parliamentary Group on Pandemic Response and Recovery

Thank you for the invitation.

I was asked to speak today about what the Covid Inquiry did not say.

But I think we need to distinguish two quite different types of omission.

The **first category** is what the Inquiry did not hear at all:

- relevant witnesses were not called,
- relevant questions were not asked,
- relevant answers were shut down;
- the remit was drawn so narrowly that entire topics were ruled out.

The **second category** is what the Inquiry *did* hear - but which was simply not reflected in the conclusions of the first report - and likely will not be in the conclusions of future reports.

They both matter.

I am going to cover - **lockdowns, care homes, the Infection Fatality Rate and vaccines**

But it is helpful to begin by comparing the UK Inquiry with the **Scottish** Inquiry.

The two inquiries were structured in opposite ways.

The **Scottish Inquiry** took the scientifically correct approach. It began by asking:

> **"What actually happened? What were the outcomes? Then it will turn to how the decisions were made."**

This is the correct order.
How can you judge a decision before understanding its consequences?

The **UK Inquiry** reversed this sequence.

It began with decision-making and processes and has reached conclusions about those decisions and processes *before* hearing the evidence on what those decisions caused.

Now that the report has concluded that the decisions were sound or even not harsh *enough*, it will be almost impossible to properly reflect the actual harms the decisions caused into the final report.

The inquiry, just like the government in 2020, has decided in advance that the harms caused by the decisions were **worth it for a greater good.**

Everything from now on will be supplementary to that point.

LOCKDOWNS

I know you are aware that huge numbers of papers have been written on the failure of lockdowns to affect the virus trajectory and I won't reiterate those basic points.

There were some embarrassing tensions in the conclusion.

The Inquiry concluded:

1. Lockdowns were *harmful* but should have started *earlier*.
2. Modelling should not be *used to justify* major policy but simultaneously proved that 23,000 lives would have been saved by locking down earlier.

Professor Carl Heneghan, Director for the Centre for Evidence Based Medicine in Oxford was called to give evidence in the module on the decision making. He had tried to explain that expert synthesis of evidence, in good faith, and placing that evidence in its appropriate context and within existing scientific paradigms (without which it cannot be understood properly) itself qualifies as pertinent evidence. Lady Hallett cut him off with the extraordinary line:

> ***"Not in my world it doesn't, I'm afraid. Well, not in a court of law it doesn't."***

And then she concluded by saying:

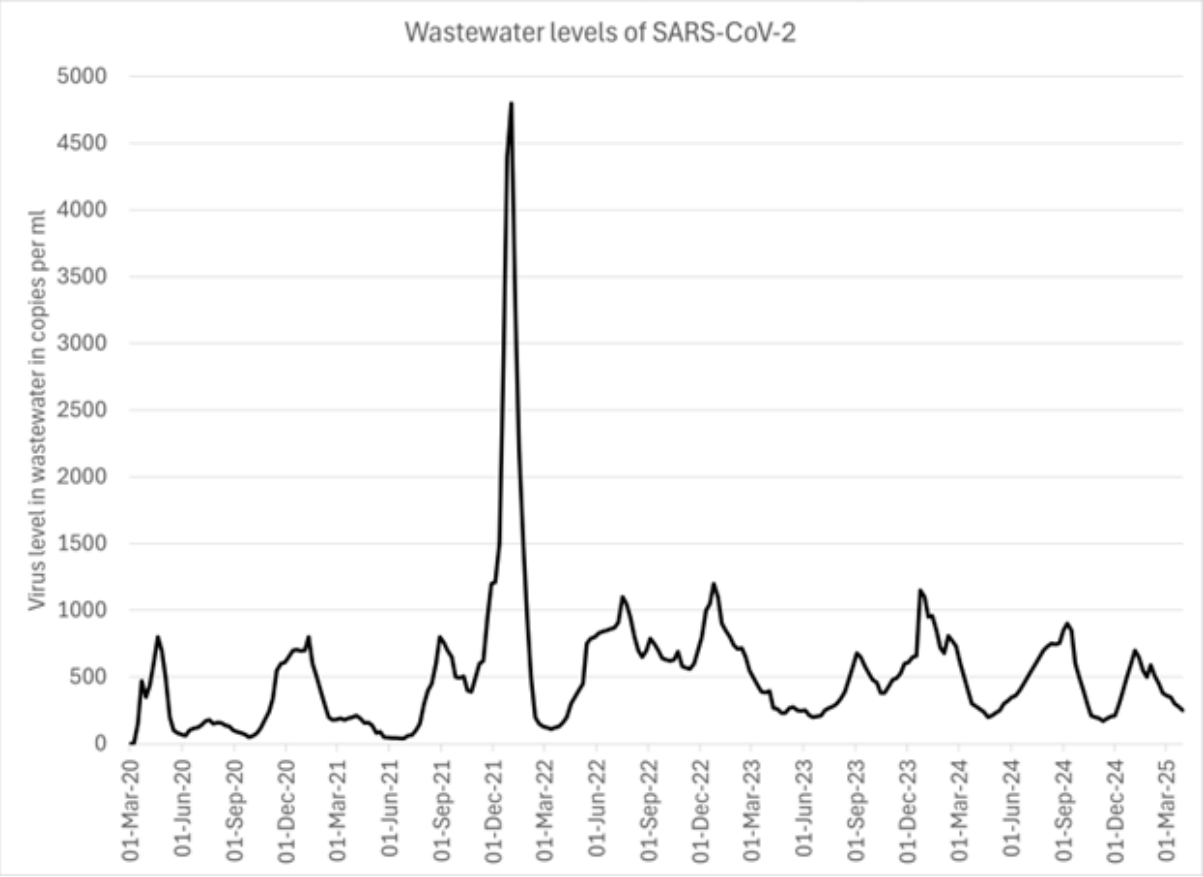
“If there is anything further, please submit it in writing.”

To him, this confirmed that she had forgotten or not engaged with the substantial written material he had already provided to the Inquiry.

Inconvenient truths, such as those painstakingly explained to the Inquiry by a Professor of Evidence Based Medicine were not welcome at the Inquiry.

The failure of interventions to impact infections and slow the trajectory is most clearly seen by looking at the US data on levels of virus in the wastewater. (There is no equivalent UK dataset).

Graph 1: Virus levels in wastewater in USA



You can see the waves coming, peaking and going with the same time course from 2020 onwards. It continues today. Peaks happen at predictable times of year with a minimum each spring.

We were promised that interventions would help in squashing the

sombrero, delaying the peak and flattening the curve to spread it all out. There is zero evidence of that effect. Anywhere. Globally.
The reason the curves are almost all the same size is because only a fraction of the population are susceptible in any one wave.
We know this because of two measures.

First, the test and trace data showed that when covid began in a household only 8.5% of household contacts would later develop symptomatic covid.

Variant	**Peak deaths**	**Susceptible population based on PCR estimate of % of household catching covid and equivalent estimate by antigen testing**
Wuhan	April 2020	11% by PCR ~8.5% symptomatic by antigen testing
Autumn unnamed	October 2020	11 % by PCR ~8.5% symptomatic by antigen testing
Vaccine rollout begins		
Alpha	January 2021	10.2% by PCR ~7.9% symptomatic by antigen testing
Delta	October 2021	10.9% by PCR ~8.4% symptomatic by antigen testing
Omicron 1	January 2022	~13.9% by PCR 10.7% symptomatic on antigen testing

Subsequent Omicron waves	Spring 2022 onwards	No data because contact tracing stopped.

PHE and UKHSA also tested blood donors for antibodies. After every wave around 6% acquired antibodies - this is likely lower because the test was not as sensitive.

This shows that everyone who could have had it, in any one wave, had it. There was no escape from a pervasive airborne virus.

We will come to the taller 2022 wave shortly.

It is hard to believe we are still arguing with people who believe lockdowns saved lives - but seeing as we are - I find this useful even if it is a flawed collectivist model.

An actuary friend of mine asked people:

> **"How many months of your life would you trade to prevent a another year like 2020-2021 with lockdown?"**

Some had had a terrible time and would sacrifice years and for others they did not mind and the answer was zero but the average answer was **two months of life**.

Scaled to the UK population, this implies 120 million life-months - or about **10 million life-years** - that people would willingly sacrifice to avoid repeating what they experienced.

This is way higher than even the most exaggerated claims of life years at risk in the first place.

I don't want to spend too long on the harms of lockdowns from the economy to the awful effects on children but I will tell you more about the effects on non-covid healthcare.

Emergency attendances and admissions fell by around half in lockdowns.

People with heart attacks, strokes, and sepsis stayed home because the official government messaging told them to *"protect the NHS".*

Even people with painful, life threatening surgical emergencies, appendicitis and abscesses did not attend hospital when they should have

Some who were trying to access healthcare were denied it because they had a fever or a cough and were told they should isolate. Oxford pathologists showed that some of those people died as a consequence.

The other issue that was not heard was the effect of fear. Just as a placebo effect can make people better, a negative expectation, called a nocebo effect can make people far worse - it can even kill. The fear propaganda would have had a direct mortality rate.

It is interesting to note that the factor that best predicted covid death after age and learning difficulties was anxiety. Hyperventilation alone can drop oxygen levels to around 80% or even 70% and would have triggered ventilation for patients in hospital which itself can be harmful.

Beyond the stress of a covid diagnosis, decades of data show that acute fear and social disruption increase cardiovascular events. The collapse of the USSR and natural disasters all show this. Young to middle aged men started dying in excess numbers, not in spring 2020 with covid, but that summer - after the lockdown.

CARE HOMES

Now let us turn to what happened in care homes.

The Inquiry heard detailed and often distressing testimony about care homes. But it did not draw the conclusions that follow from that testimony.

The headlines of a ***"generational slaughter"*** were attributed to discharging patients early from hospitals - but this does not stand up to scrutiny. The susceptible fraction of the population *all* ended up infected both inside and outside care homes because *everyone* was exposed to

the airborne, ubiquitous virus.

In Cambridge, genetic sequencing showed that every lineage circulating in the community was present inside 'locked-down' care homes *at the same time*.

It is simply not true that every transmission chain was recklessly brought in by staff.

It is because the virus spreads in the air and locking the doors and windows and excluding family does *nothing* to prevent that.

GPs issued blanket do not resuscitate orders to people on their list who were frail and over 65 years old or, perhaps most shockingly, had learning difficulties. At the same time, hospitals refused to admit anyone with such an order. At the inquiry, families described **blanket DNACPR notices** placed without consultation or even with forged signatures.

A relative told the Inquiry:

> ***"paramedics were called out but, because [a DNACPR] notice was in place, they were not admitted to hospital".***

One extreme example was of a woman in her twenties who was in care for her epilepsy,

> ***they wouldn't pin her collarbone when she broke it. And I just thought this is yet another example of the NHS seeing her as a second class citizen and although she has human rights under the Human Rights Act, these have been disregarded really. And you know, she was a healthy young woman in her twenties, apart from the epilepsy. And at that time, she was in better health than the rest of us. And I didn't see why I should agree to a DNA CPR for a healthy young woman in her twenties.***

Care home managers said the following:

> ***"Our GP, I did a lot of video calls with them, it was hard to get them to come out… As soon as the Covid hit and we went into lockdown, we really struggled to get any doctors… They quickly started giving instructions over the phone and giving us more and more responsibilities in terms of how we needed to manage the residents."***

Another reported how she was told,

> ***"we don't take covid positive residents to hospital – order the end of life pack."***

Instead of antibiotics (which were denied to all covid patients for years) numerous residents were sent these **end-of-life medication packs**. I am all for palliative care drugs in the context of terminal cancer or heart failure - but it is a little known fact that such drugs have a disturbing side effect which is that they depress the drive to breathe so giving them for a respiratory infection - where that drive means survival - is reckless if not downright negligent.

GPs stopped visiting many homes. Routine examinations ceased. People who needed oxygen, fluids, antibiotics, or simple observation were managed by telephone.

The consequence was denial of healthcare and careless use of respiratory depressant drugs to those most at risk of dying. It is quite unsurprising to see excess death waves as a result. We do not know what proportion of covid-ascribed deaths were in fact caused by this systemic gross negligence.

Denying visitors access and scaring staff such that staffing plummeted also comes with a mortality rate. Residents with dementia were left

- dehydrated
- sometimes malnourished
- and with no advocates - essential for recognising disease
- and prolonged isolation - with well known negative effects

It is crucial to recognised that these factors cause their own mortality rate in a frail population.

It is important we note the 3.7 fold **excess deaths (compared to those with similar age and health profiles) among those with learning disabilities** who were also given DNA CPR orders and consequently denied care.

Even after adjusting for age and comorbidities, mortality remained disproportionately high at 70% above expected levels.

Viruses do not discriminate by cognitive capacity. People do. This ought to be a gigantic scandal on its own.

Now what happens if too many people die and those deaths are blamed on a virus?

That affects the infection fatality rate.

INFECTION FATALITY RATE

The infection fatality rate is a fraction - the deaths divided by the total number of infections.

There has been a fair amount of debate about the (in)accuracy of the denominator but not enough about the numerator.

Too many covid deaths resulted partly from overdiagnosis with mass testing but also because of denial of healthcare to people with a community pneumonia and over use of end of life drugs.

This inflated the claimed IFR for covid. This in turn created fear. Fear justified lockdowns and other policies that caused unnecessary deaths. Those deaths were ascribed to covid. This increased the perceived IFR. And so on.

There was thus a dangerous, nay lethal, feedback loop where deaths were being caused by policies that were then used to justify further and harder versions of those same policies.

None of this was examined by the Hallett Inquiry.

VACCINES

Lastly, I want to focus on the vaccines.

All of this - fear, propaganda, misattributed deaths, inflated IFR, the fear of another lockdown and its harms - created the narrative foundation to claim we needed vaccines.

We then had the trials. The trials were large but the disease so mild that the authorisations for billions of doses were, Pfizer, Moderna and AstraZeneca, all based on only a *single* claimed placebo covid death in the trial evidence used for authorisations. This is science by cowboys.

Tens of millions are being spent on the lawyers for this inquiry who let this pass without the slightest challenge.

Two key questions were not asked:

1. **Were the vaccines capable of doing what was claimed?**
2. **Did they in fact do what was claimed?**

These questions should have been central to the Inquiry.

Instead, they were avoided.

Vaccine efficacy was deliberately and explicitly omitted from the remit.

Hugo Keith KC, lead counsel, said,

> ***"The exercise of pronouncing the last word on the efficacy and safety of specific vaccines may prove to serve little purpose."***

He then talked about *"entirely effective"* vaccines which were *"undoubted successes"* with *"lifesaving benefits . . . which . . . vastly outweighed the very rare risk of a serious side effect."* Adding *"without any doubt",* he even went as far as saying they offered *"the promised land".*

Would he say that about any other novel pharmaceutical products, let alone novel ones?

Other participants repeatedly claimed the vaccines were *"undoubtedly"* beneficial, *"an extraordinary achievement", "world-beating"* and *"saved millions of lives".*

The evidence to support or undermine these claims was not even *heard let alone weighed and assessed* - it was not even in the *remit*.

Why the vaccines could not achieve the claims made for them

Long before Covid, the immunology and virology communities already knew a critical fact about respiratory viruses.

This was not controversial.

This basic fact has been explained many times over decades in the context of influenza.

1. In 2000, the US National Institutes of Health commissioned investigations into the future of vaccine development and concluded that, although injections

> ***"induce protective immune responses, they rarely, if ever, induce mucosal immune responses that may prevent infection".***

2. In January 2021, during the vaccine rollout, Anthony Fauci co-authored a paper saying,

> ***"[giving injected] vaccines alone typically does not result in potent mucosal immunity that might interrupt infection or transmission… our current understanding of these vaccines is very likely to change over the coming months."***

3. In January 2023, Fauci and colleagues distinguished between detection of viral RNA in blood and the presence of intact virus which they did not observe. They explained that SARS-CoV-2 and influenza

> ***“do not significantly encounter the systemic immune***

> ***system…***
>
> ***"It is not surprising that none of the predominantly mucosal respiratory viruses have ever been effectively controlled by vaccines....***
>
> ***This observation raises a question of fundamental importance: if natural mucosal respiratory virus infections do not elicit complete and long term protective immunity against reinfection, how can we expect vaccines, especially systemically administered non-replicating vaccines to do so?"***

This argument would not apply to measles as it travels through the blood and replicates in lymph nodes.

This is basic biology.

Had the Inquiry asked even a single mucosal immunology expert, this limitation would have been made clear.

But it did not ask.

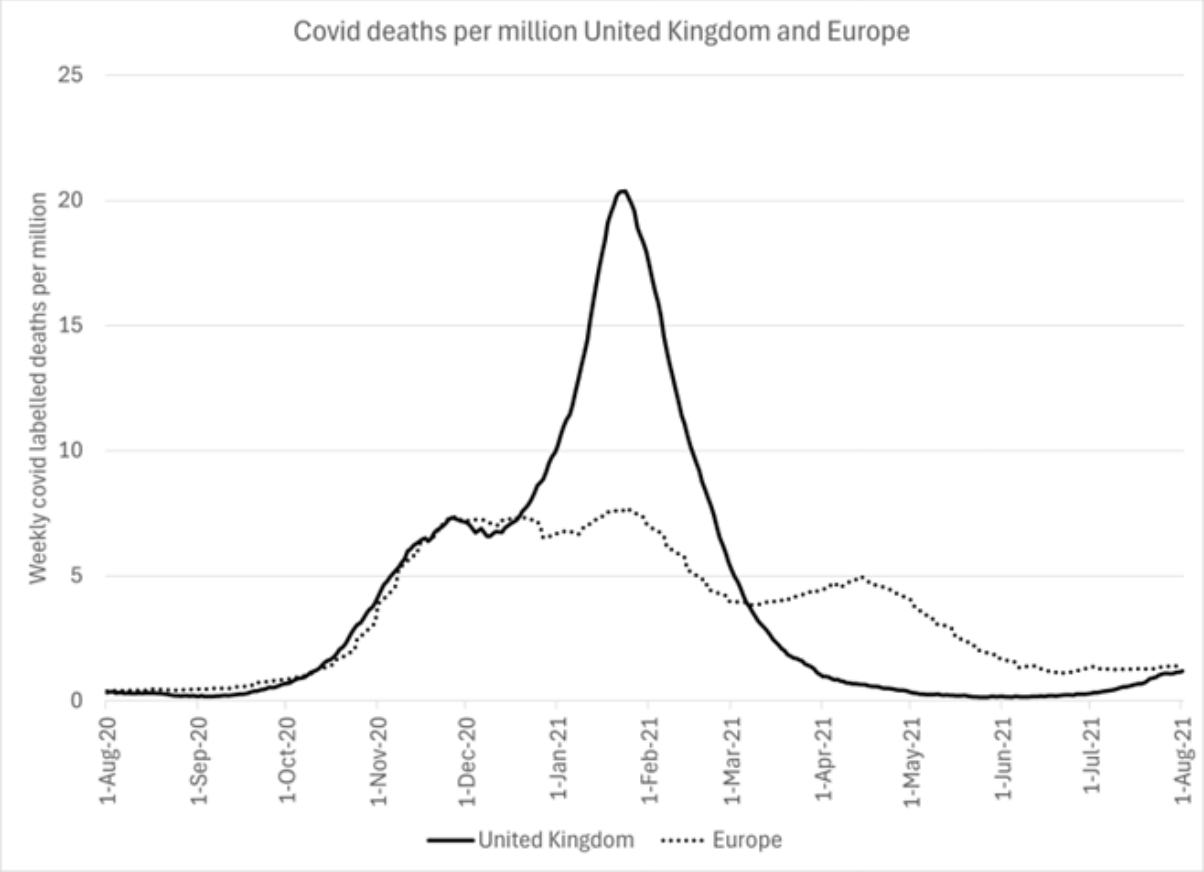
Why did they avoid such a key question?

Next we need to talk about what happens in the first 2 weeks post-vaccination.

The first two weeks were a critical time because numerous cells are making foreign spike protein and immune cells are actively killing the cells affected. The levels of immune cells in the blood plummeted and people were left with a consequential immune suppression. Covid and other virus infections were more common in that two week period - shingles, cytomegalovirus, herpes simplex virus, Epstein Barr virus etc. This period of increased susceptibility had serious consequences especially for vaccinated people infected earlier and with less immune reserve.

Look at graph 2 - we can see total mortality for UK and all of Europe.

Graph 2: UK mortality vs Europe mortality



The area under the lines tells you how many died in total and the trajectory tells you when. Over the whole graph 13% more died in the UK - but the deaths were clearly earlier. In Europe they were more spread out.

Giving immune suppressive vaccines which cause infections will result in more infections (in the unvaccinated as well as the vaccinated). This is not a good idea if trying to avoid overwhelming the health service.

Every period had outliers for covid and summer 2021 saw the UK, Portugal and Ireland as outliers - all three had exceptional peaks in Jan 2021 and then a longer drawn out flatter wave later in the year. The total hospitalisations, intensive care admissions and deaths over 6 months was the same however. These places all had exceptional hospitalisation and deaths in January 2021 so a reduction in the number of frail people meant there was no peak that summer as there was elsewhere.

Now we come to the statistical 'cheap trick' (a phrase coined by Martin Neil and Norman Fenton to describe a phenomenon many of us have been trying to bring to public attention for years.)

The illusion of benefit:

Over the course of a wave the evidence indicates that the vaccinated had the same rate of infections as the unvaccinated overall. At best, the vaccine had no more effect than a placebo. In fact, overall it had negative effects on outcomes for patients infected with covid. This claim takes some explaining:

- Only around 8.5% of people are susceptible to symptomatic covid in each wave.
- The vaccine suppressed immunity for two weeks, triggering infections earlier and sometimes more severely in those who were anyway susceptible and destined to be infected at some point in that wave.
- The two-week window after vaccination is also problematic. People who had been vaccinated were classified as 'unvaccinated' for at least 14 days or more after the jab. This was deeply misleading.
- It made it look as if the vaccine worked because after two weeks the newly vaccinated were either not susceptible in that wave anyway or had acquired immunity from early infection, thus skewing later figures.
- This made the vaccinated look like they were less likely to die in comparison with the unvaccinated
- This was a statistical illusion - it was false. Any immuno-suppressive drug would have resulted in identical outcomes without any benefit in terms of rate of infections. Thereafter, the unvaccinated continued to be infected along a natural trajectory but those who had been vaccinated and thus infected early were no longer becoming infected when they would have done. This again skewed the statistics.
- When the next wave arrived – weeks or months later – a new tranche of 8.5% susceptible. The evidence is that vaccinated and unvaccinated segments of that new tranche of 8.5% were infected at the identical rate as each other. The vaccine conferred no benefit.
- The phenomenon of identical rates of infection was explained away by the novel claim that the immunisation was only effective

> for a few weeks.They called this **waning.** It wasn't waning. It was evidence. For example, the claimed time to 'waning' was two months for Japan but a full six months for Belgium. The difference was simply due to the timing of their rollout. All we were seeing was *the exposure of a statistical illusion.*

One tragic example was Peter Rossiter. He was 39 – a teacher and pianist. Four days after his second dose, he fell ill with covid. This is the danger period. The immune system is suppressed by the vaccine in this period so people become more susceptible to infection.

His mother said at the Inquiry,

> ***"his white blood count was almost zero . . . he very sadly fell very seriously ill very quickly."***

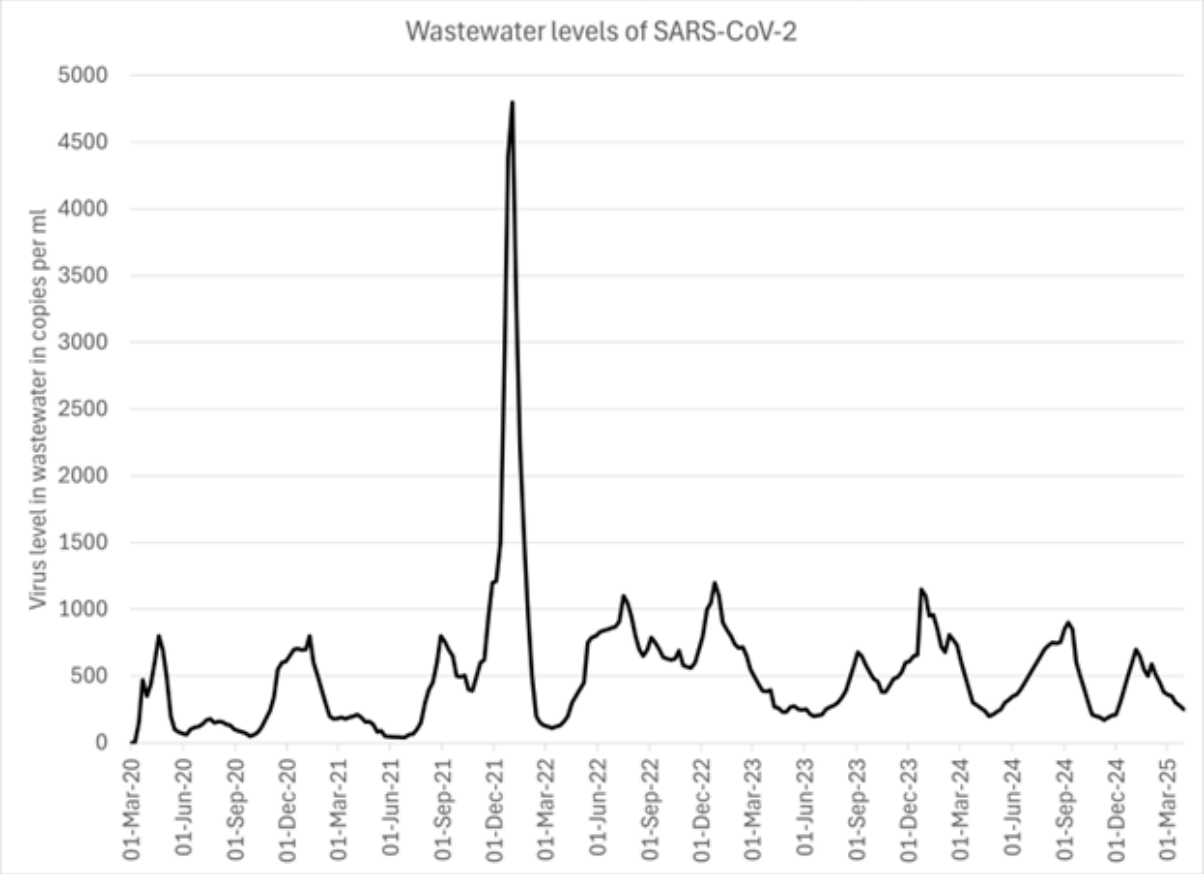
Pfizer said:

> ***"He wasn't fully protected."***

Pfizer knew the two-week period was risky. But instead of admitting it they used these cases to prop up the illusion of benefit. Shameful.

If we consider graph one again, it shows that the vaccines did not affect the virus waves in the USA in the second half of 2021.

Graph 1: Virus levels in wastewater in USA



OMICRON

In 2022, there was a huge spike in viral load in USA wastewater after the booster doses caused a further immune problem when Omicron arrived. The third dose of mRNA caused a problem with the immune response - except in those previously infected or those who had had an AstraZeneca vaccine. It is important that the immune system does not mount an attack when met with food or pollen despite these being foreign bodies. However, after a third and subsequent doses of mRNA there was an ever increasing risk that the virus would be treated by the immune system in the same way as food or pollen. When the virus was encountered subsequently, a full response was therefore not possible. That is why on graph 1 you see the massive rapid spike for Omicron and why the periods in between waves never return to baseline again.

It is clear from the evidence that vaccines did not and could not prevent transmission.

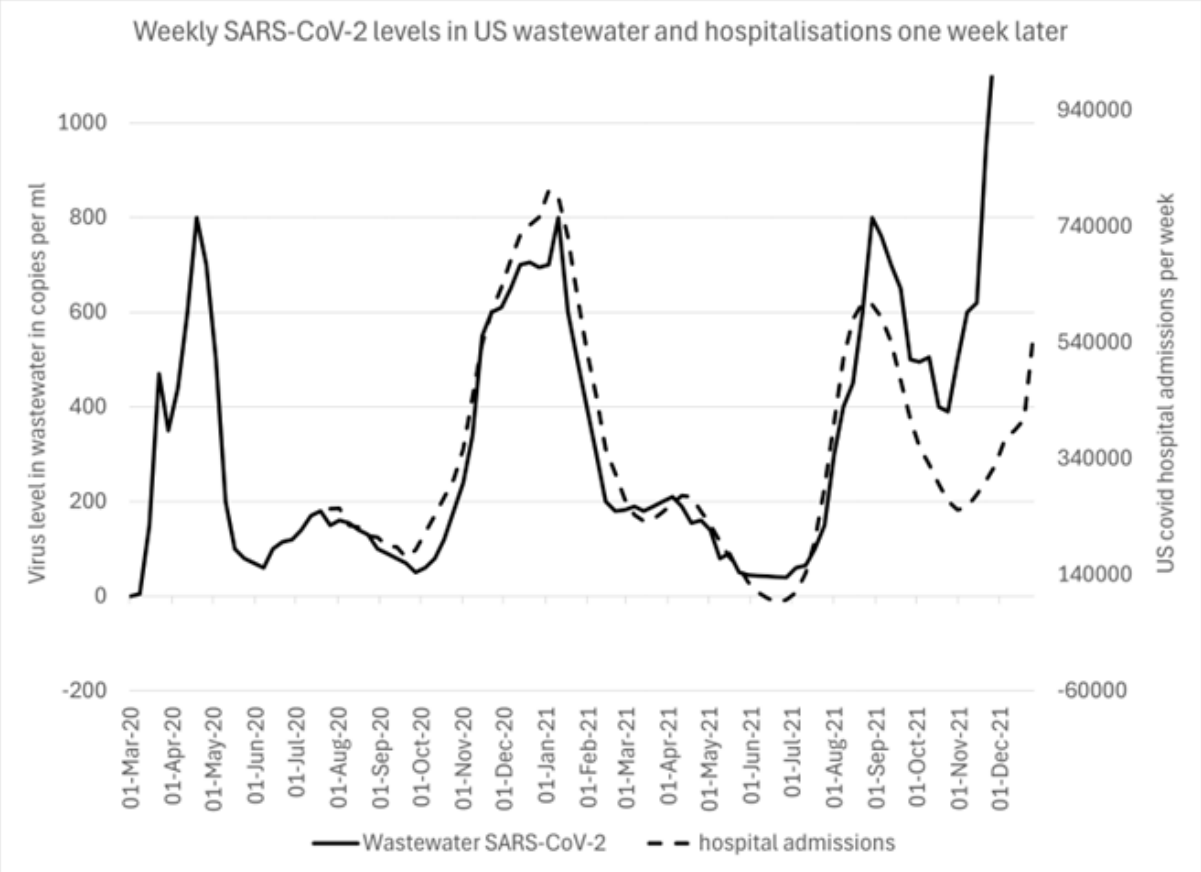
But what about deaths?

Lord James Bethell, the government minister who signed the vaccine authorisations, said in his evidence to the Inquiry:

> ***"The vaccination programme had delivered, for most of the population, a really good protection, certainly from severe disease and death. It didn't stop transmission, it didn't stop long covid, it didn't work for absolutely everyone."***

The third graph shows USA excess mortality against their wastewater data.

Graph 3: US excess deaths plotted against virus in wastewater in 2020-2021



The curves only separate after the arrival of omicron.

The only mention of Omicron's severity in oral evidence was from

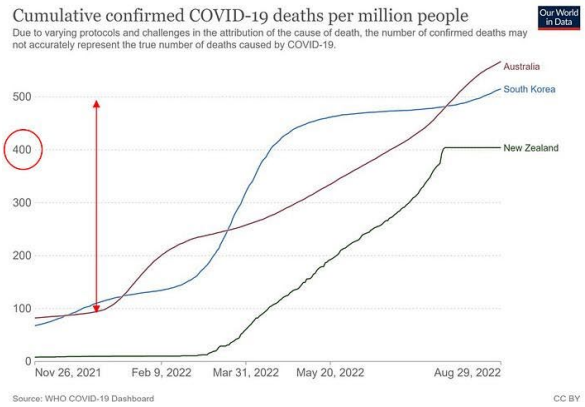
Sajid Javid who farcically got the evidence – as a former Health Secretary, no less – completely wrong, saying,

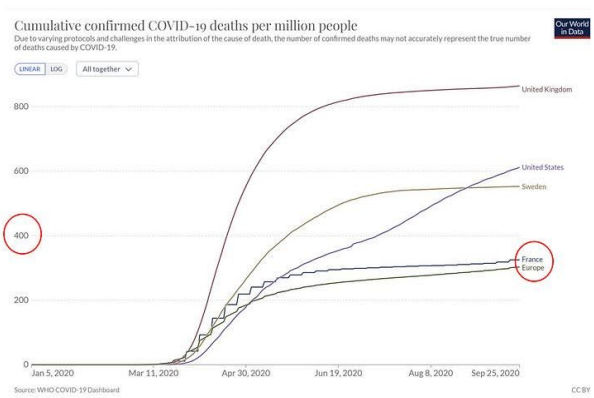
"We knew Omicron was a lot more severe".

Omicron was said to be a third as deadly by the ONS in the UK - but remember the numerator was skewed by preventable policy-related deaths.

But you would not know that looking at South East Asia and Oceania.

Graph 4: South East Asia and Oceania mortality per million first wave in 2022 vs Europe in 2020





Look at the graph 4 - these places were all heavily vaccinated before 2022. But by the end of their first wave they had similar mortality to France or Europe as a whole after their first wave. Where was the benefit? Indeed, the fatality rate was similar despite Omicron being agreed to be milder - 400 deaths per million. So what caused the milder variant to have similar death rates?

In Hong Kong, for example, there was a plan to isolate anyone with covid in hospital. The hospitals were soon overwhelmed with the worried well and the genuinely sick were left dying in corridors. It was a similar story of a collapsed healthcare system that caused the real mortality.

What about claims of benefit?

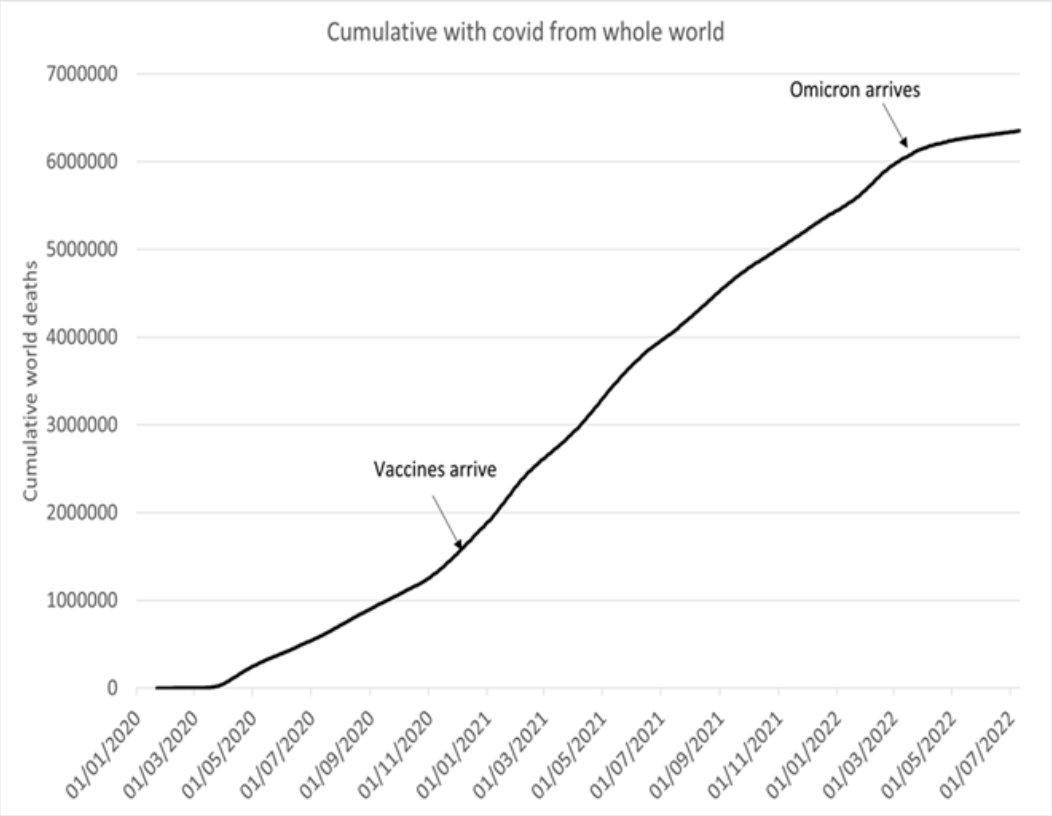
There were three ways in which a vaccine benefit was claimed:

1. Using modelling

Graph 5 shows cumulative actual global deaths over time (the only

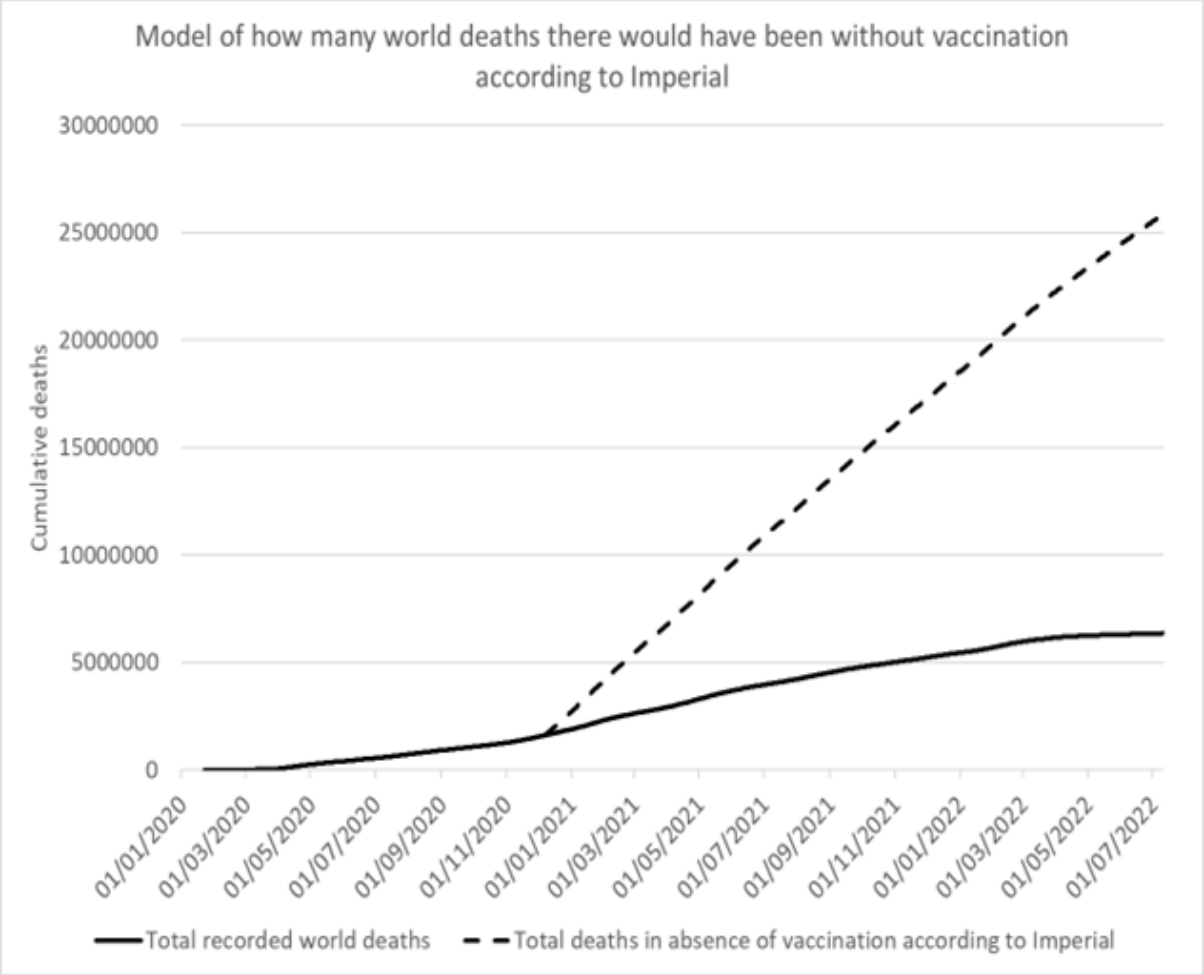
change in gradient happened with the arrival of Omicron). Note the gradient slightly *worsens* when the vaccine arrived.

Graph 5: Global cumulative deaths - actual data



Graph 6 shows what Imperial modellers claimed would have happened without vaccines - this underpins their claim that 20 million lives were saved. The solid black line is the same as Graph 5 but on a necessarily different scale.

Graph 6: Imperial claim of what would have happened without vaccines



2. Researchers used **synthetic data** to claim that the vaccines conferred a benefit. This synthetic data is based on a model but was presented as if it was real.

3. They relied on papers with **extreme biases** in them.
Every paper accounted for age and comorbidities which made vaccines look safer but failed to account for socioeconomic and ethnic differences which explain higher mortality in the unvaccinated.

In fact, the same difference in mortality in vaccinated and unvaccinated regions seen in 2021 was evident in 2020 **before a single dose was given.**

HARM

The final area where the Inquiry's silence is most striking is vaccine harms. The Inquiry did hear some testimony from people whose health collapsed after vaccination: new neurological problems, cardiac issues,

autonomic dysfunction. These accounts were heard, but each time they were met with the same formula from counsel: *rare*, *very rare*, *extremely rare* - without presenting evidence to justify those categories, which have formal meanings in the literature.

But the most significant omissions are in what the Inquiry **did not** hear, because witnesses were **not permitted** to raise the central scientific and safety questions. A long list of key topics was ruled *"out of scope*" for oral evidence. These included:

- Lipid nanoparticle risks?
- Cardiac risks and sudden death?
- How much spike is produced, in which organs and for how long?
- Why Moderna doses of essentially the same product contained three times the dose as the Pfizer/ BioNTech product?
- Morphine and midazolam, antibiotics, vitamin D, budesonide?

These are not fringe issues. They are the basic scientific and regulatory questions any serious inquiry into vaccine safety would have to examine. Yet they were structurally excluded.

When Ruth O'Rafferty of the Scottish Vaccine Injured group brought up the critically important differences between the trial product in pristine laboratory conditions and the mass-produced product in the vats, Hugo Keith interrupted her saying,

> ***"I'm so sorry, I'm going to have to interrupt you there, we don't have the time or the wherewithal to be able to go into some of these areas in this sort of detail."***

When Ruth O'Rafferty also brought up regulatory failures at the Inquiry outlined in a 2005 parliamentary report, the recommendations of which have not been implemented, he said,

"All right. We're in danger of veering off."

When Charlet Crichton of UKCV Family mentioned participants being vaccine injured in the trials and their data being scrubbed from the reports he said,

> ***"All right, I'm going stop you there . . . We can't be looking at individual cases."***

That was a rule that did not apply to those with a covid label. Plenty of individual cases were considered in that context. Nor did Charlet in fact mention an individual case. She was talking about fundamental corruption in the only reliable measure we have of vaccine safety, and Counsel to the Inquiry simply did not want to know. Nor did the Chair intervene to find out more. She was not interested.

Once again, the pattern holds: the Inquiry heard enough to have been put on notice that there were issues, but it systematically avoided examining the questions that would have forced it to confront them.

There are two further stories you might have heard last week on what the inquiry did not hear - both a result of work of UsForThem.

A. The Telegraph revealed

The Moral and Ethical Advisory Group (MEAG) raised concerns about vaccinating children and Chris Whitty intervened to stop them discussing the topic.

The Inquiry did not examine this.

B. The Daily Mail revealed

SAGE members had **£200 million of undeclared Wellcome Trust grants** - despite Wellcome being the UK's largest private funder of pharmaceutical research.

The Inquiry did not examine this either.

These are central issues of independence and governance not discussed at the Inquiry.

A great deal of truth was placed before the Inquiry.
But it looked away from the parts that mattered most.

Whenever evidence supported the story the Inquiry wanted to tell, it was amplified. Whenever evidence challenged that story, it was set aside.

The truth will come out eventually - it always does.

Thank you.