20th November 2020

Dear Julie Marson, MP for Hertford and Stortford,

Thank you finally for your reply to my previous letters on 19th October 2020. There were many issues that I raised that you did not address but I will reserve comment on those until a later date as I would like to raise an even more pressing concern.

I have analysed the empirical mortality and clinical data that relates to SARS-CoV-2 / COVID-19 and find that it paints a very different picture than the one portrayed by government based on SAGE modelling.

Please could you enquire, as a matter of urgency, what analysis of empirical data has been undertaken by SAGE or other government advisors and bodies, what conclusions have been drawn and how they reconcile with current government policies and interventions?

For reference, I include my own analysis which I would like you to present as context for my question and ask that you seek to refute any conclusions that I draw from it, which are indeed in stark contrast to the current government position. In summary, they show that the epidemic was over in Spring, that COVID mortality now is a residue of the Spring epidemic and not a second wave, which means it cannot surpass the first in terms of demand on the healthcare system and overall death.

As such, any interventions that are now in place serve no benefit and should be lifted immediately as the significant damage they are causing is unmitigated.

I should add the caveat that my analysis may not be perfect as much of the useful information is not readily available to the public but I am certain that government should be able to access it without issue.

Regards,

Joel Smalley

Encls.

Analysis for Review

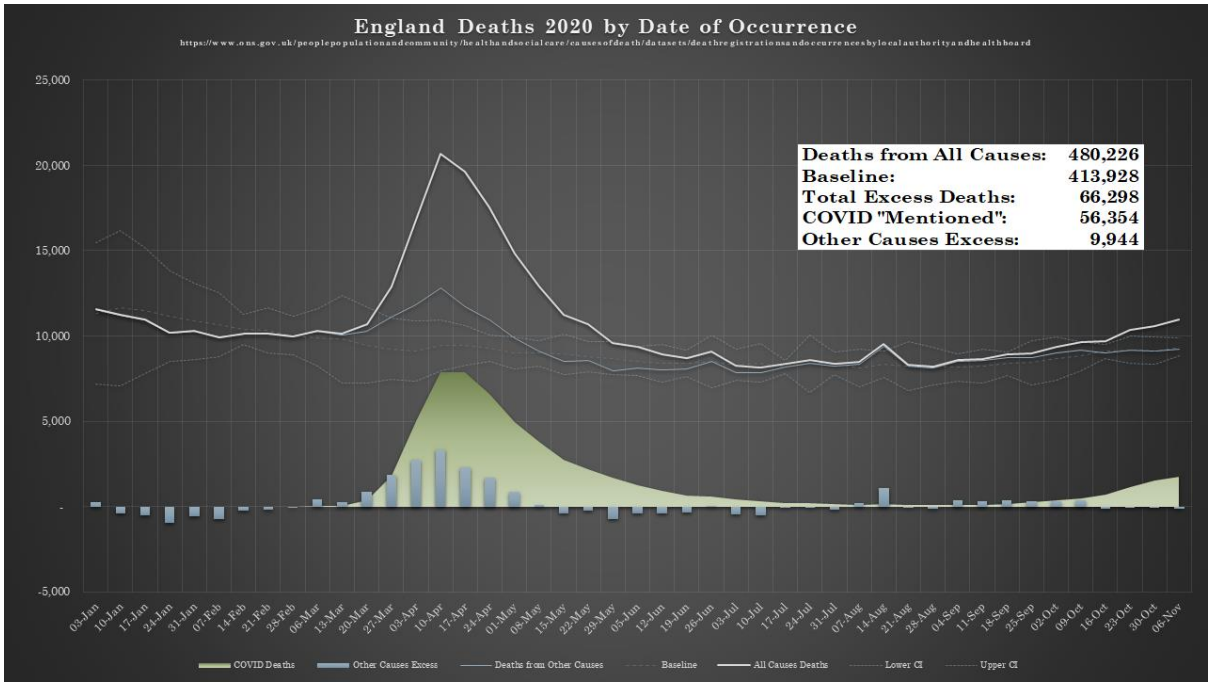

Figure 1

1. Analysis of deaths from all causes in 2020 by date of occurrence (Figure 1) shows significant excess between 13th March and 19th June. This period coincides with the undisputed period of the epidemic and in lasting 14 weeks is consistent with expectations for a respiratory infection epidemic.
2. The analysis also reveals a rather less significant but moderately steady increase in excess death beginning in the first week of September until the last week of available data (6th Nov). This period also coincides with evidence of increased activity of COVID.
3. It is quite apparent that the second period of COVID is so distinct in character from the first that it cannot by any stretch of the imagination be considered a second epidemic. The more plausible explanation is that it is the residue of the main outbreak in Spring.
4. If this is the case then it completely refutes the assertions made by government on the advice of SAGE that this “second wave” could exceed the damage of the first.

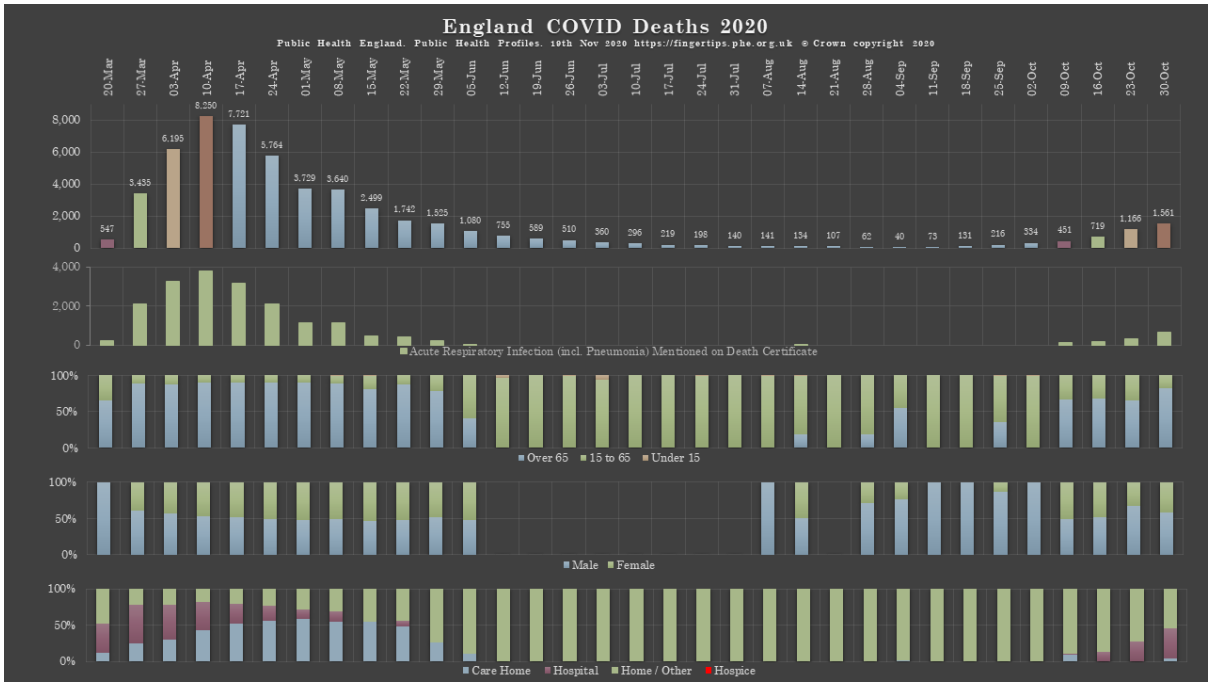

Figure 2

5. This hypothesis can be easily tested by observing the mortality profiles of all those that have died this year (Figure 2).
6. It is evident by looking at the epidemic period that the characteristics of COVID death include the mention of acute respiratory infection (including pneumonia) on the death certificate, a high ratio of over 65s dying relative to other age groups, an equal mix of male and females, and a higher proportion of deaths in care homes and hospitals.
7. According to these observations, it is confirmed that the period of COVID mortality ended by 19th June and reoccurred week ending 16th October, albeit with weaker overall signal. This supports the hypothesis that Autumn COVID is not as significant as Spring COVID.

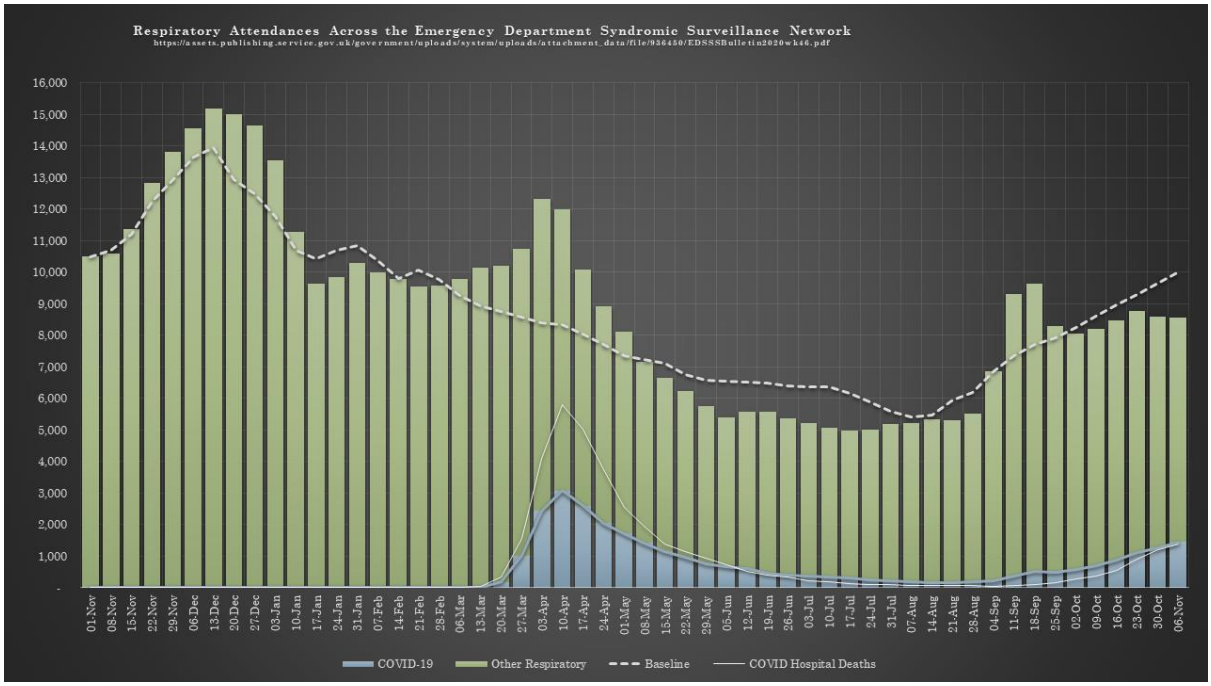

Figure 3

8. These mortality profile data are also supported by other clinical data. Respiratory attendances for respiratory emergencies at the Emergency Department (where it is understood the majority of real, serious COVID admissions would present) show significant excess between 8th March and 10th May (Figure 3). This is consistent with Spring COVID mortality between 13th March and 19th June. There is a second period of excess attendance, albeit much smaller than the first, between 6th Sept and 4th October, again consistent with Autumn COVID mortality occurring 16th Oct to now.

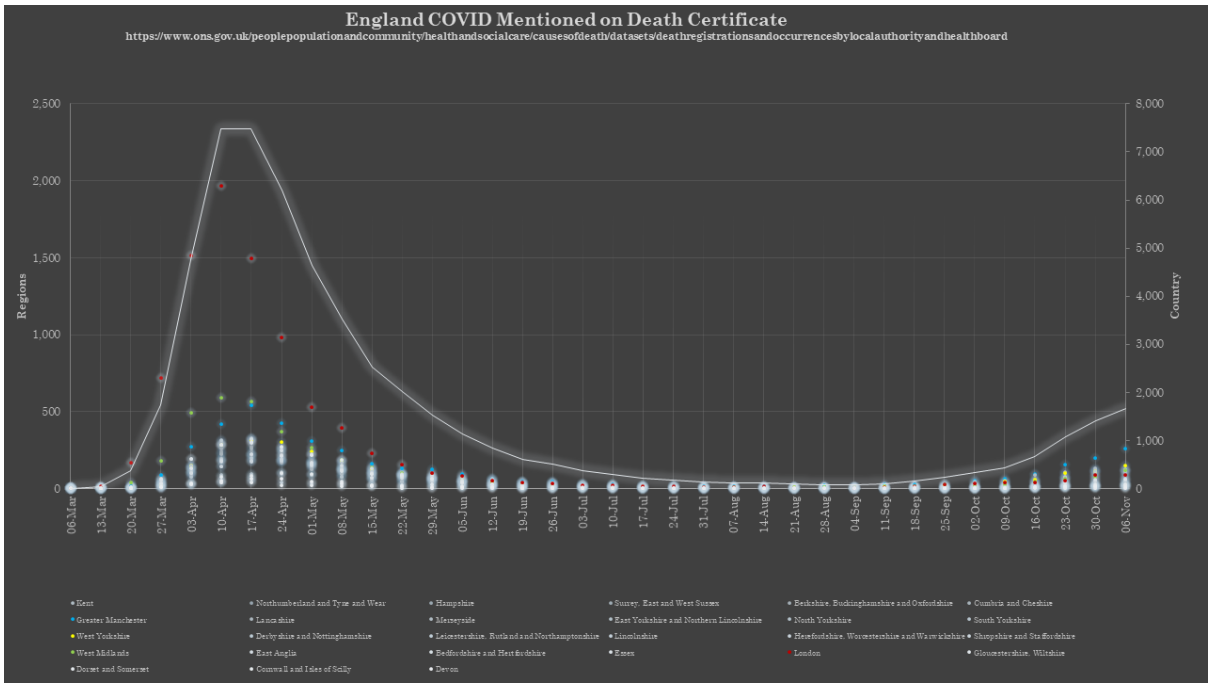

Figure 4

9. The decline in Emergency Department attendance (which is now below baseline) would suggest a decline in Autumn COVID mortality should also occur. We have evidence of this and clear indications of community immunity being responsible for suppression of the virus by careful examination of the mortality data at regional level (Figure 4).
10. London was the clear driver of Spring COVID activity but not Autumn COVID activity. If this were a "second wave", we should plausibly expect London to be the driver again whereas it is the North West and Yorkshire that are responsible for Autumn COVID deaths with London hardly registering.

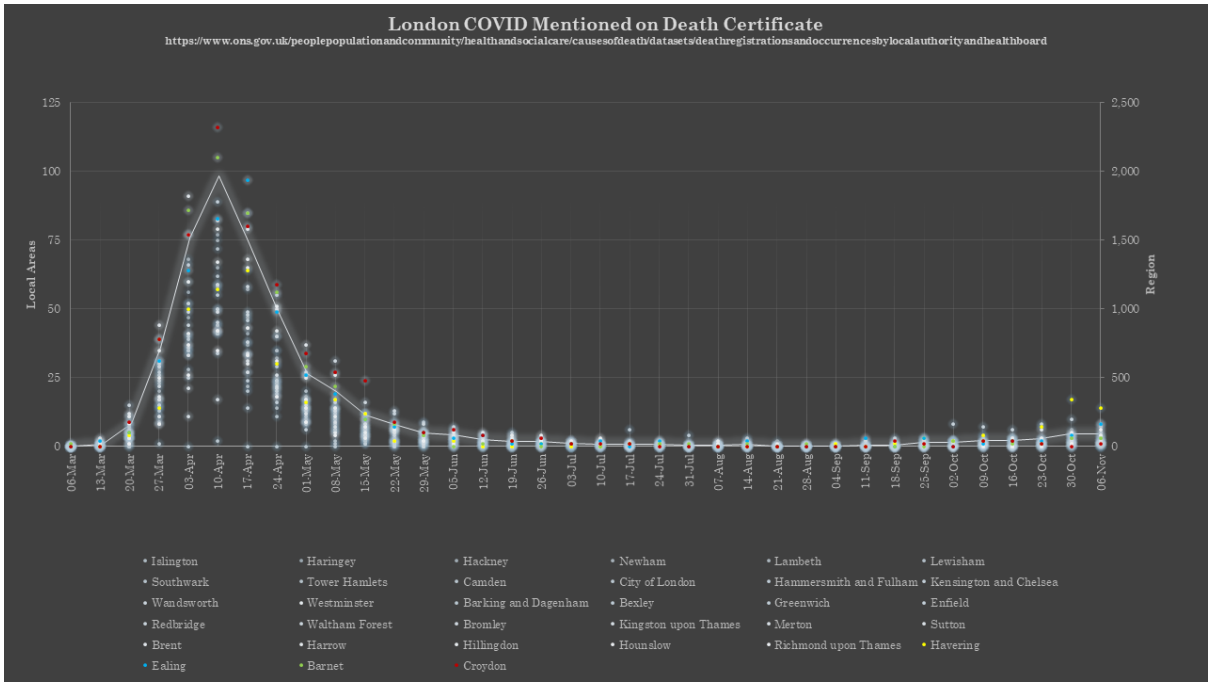

Figure 5

11. There is further confirmation of this by looking deeper still at the local authority level (Figure 5). Even within London, we can see that the only reason for even relatively modest Autumn COVID activity is due to isolated activity in the Havering area. Areas hit hardest in Spring like Croydon and Barnet, do not register at all in Autumn. There is no more plausible explanation for this than community immunity.

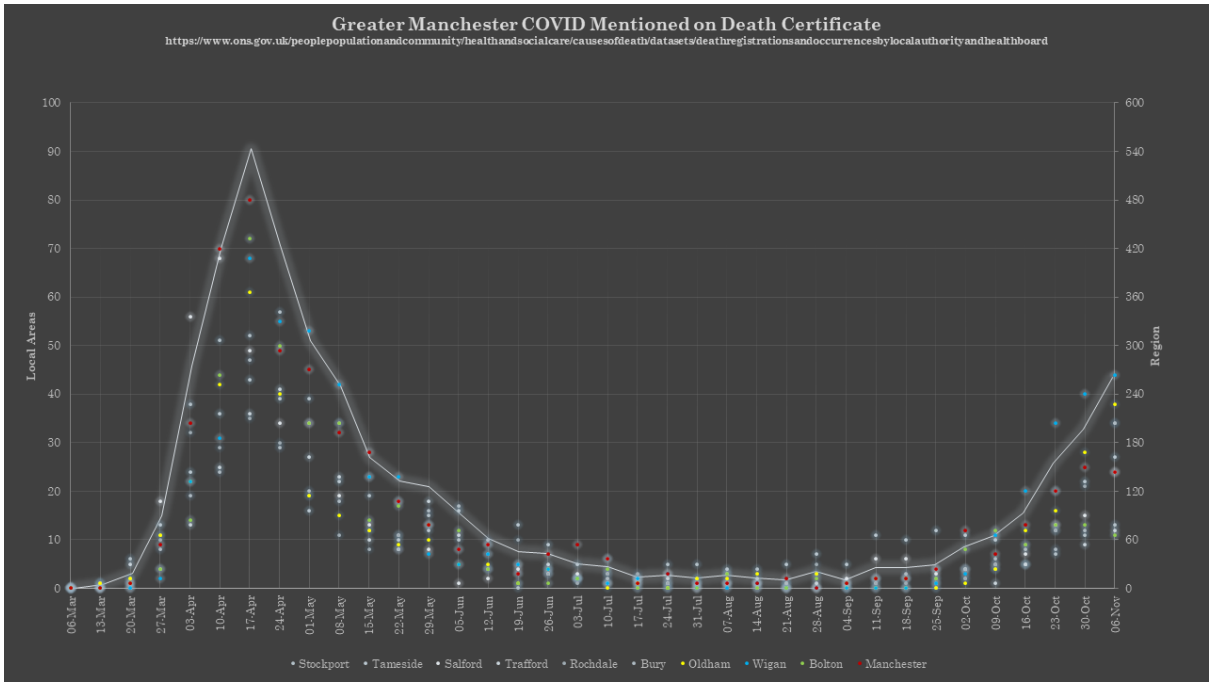

Figure 6

12. We see the same patterns in every other region of the country, including the North West (Figure 6). Evidently, Wigan and Oldham are the main areas of Autumn COVID mortality because they had softer Spring compared to Manchester which, like London, was nearly saturated, i.e. nearly attained community immunity threshold.

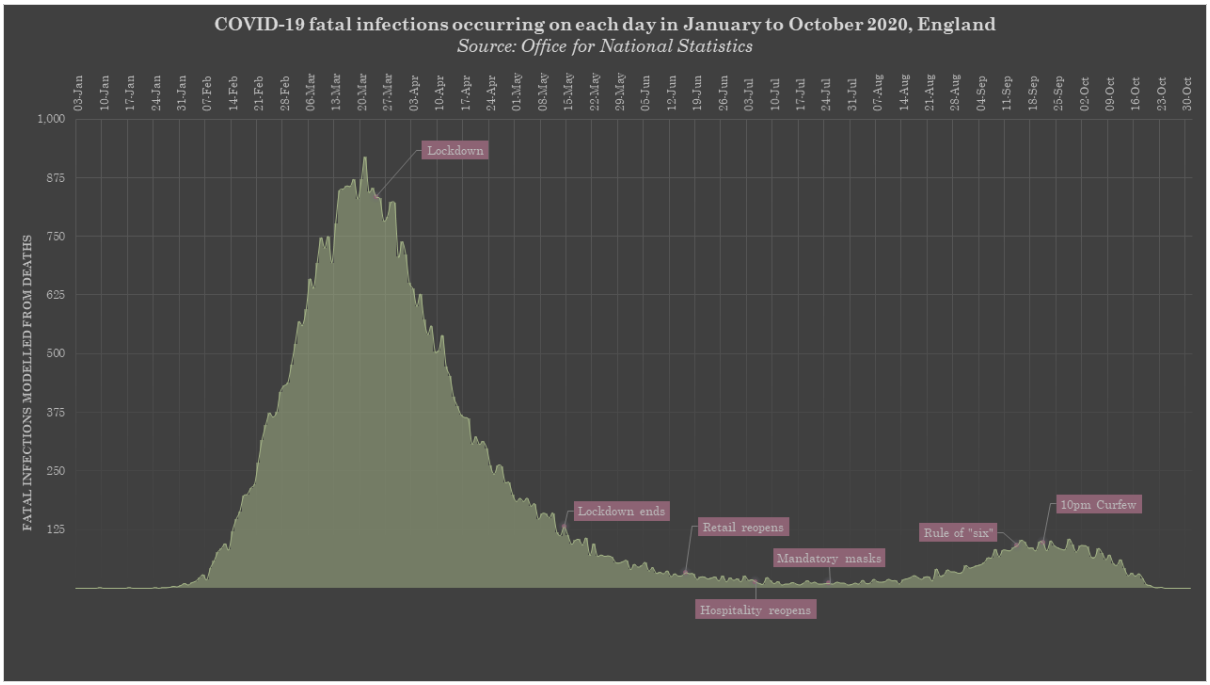

Figure 7

13. In case there is any lingering doubt that natural immunity is responsible for the waning of the virus, observation of the fatal infection curve with respect to the timing of interventions being imposed and lifted confirms that such interventions have made little discernible impact to the overall course of viral spread (Figure 7).