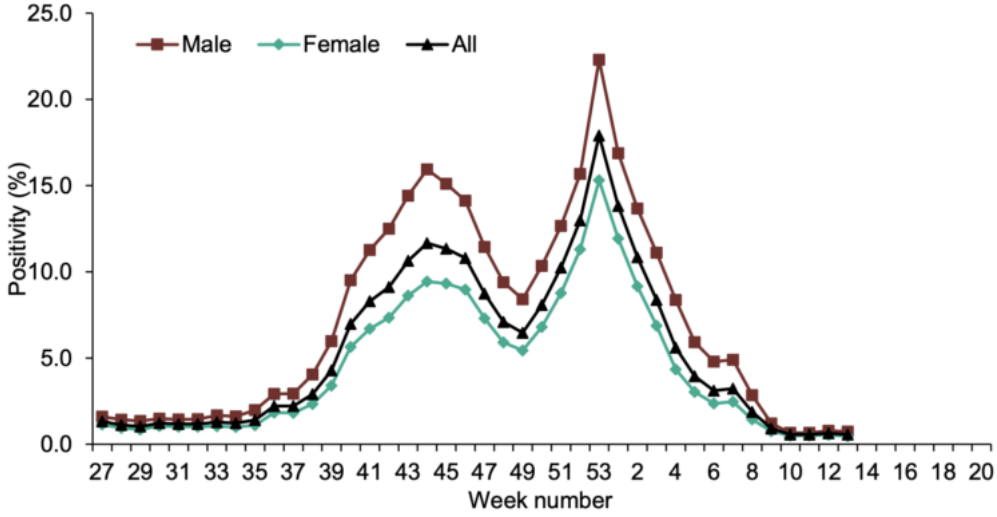
COVID-19 Weekly Bulletin

16 April 2021

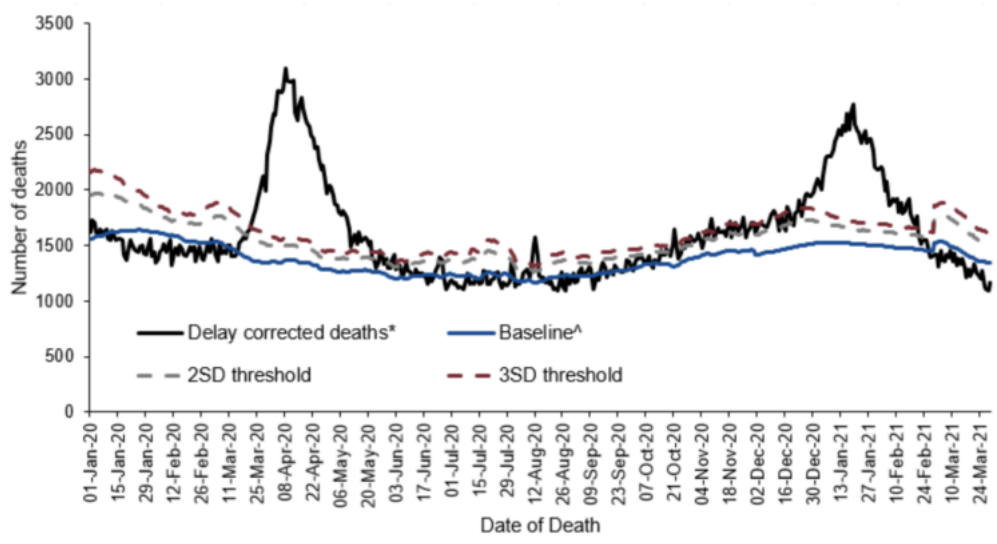
Restrictions pose more of a threat than COVID-19

After several weeks of no cases being found in the community and weekly deaths below normal levels we are still locked down. Lockdown costs us about £500m (https://www.dailymail.co.uk/news/article-9386907/The-521m-DAY-hit-economy-Thats-cost-lockdown-British-businesses.html) a day and every day brings more businesses to the brink. Over 4.7 million people are now waiting for NHS operations (https://www.bbc.co.uk/news/health-56752599). Between March 2020 and January 2021 there were 350,000 fewer cancer referrals to hospitals than expected (https://www.thetimes.co.uk/article/shocking-rise-in-cancer-patients-not-being-treated-due-to-covid-19-concerns-nhs-england-data-shows-bj50db80d?fbclid=IwAR11BCL7GIlESvuel7kO4PrUSUBy6gjSD5hj6NS6UUKxt16e0QEEuXzfND0), a shortfall which is still growing. Education is still being interrupted with universities not returning to face-to-face teaching until 17 May.



Percentage of positives per test done in the community, PHE

(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977003/Weekly_I -19_report_w14.pdf)



Daily deaths in England, all ages, PHE

(https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977003/Weekly_I

-19_report_w14.pdf)

Vaccine certification

The opposition to 'Covid status certificates' continues to grow this week, with the news that over 1,000 Christian leaders (https://vaccinepassportletter.wordpress.com/) and counting have signed an open letter to the Prime Minister detailing their concerns. The Telegraph (https://www.telegraph.co.uk/politics/2021/04/13/exclusive-wont-make-customers-show-covid-passports-hospitality/) reported this week on a new charter for licensed premises and events, Open For All (https://www.openforall.co.uk/), in which over 60 hospitality owners commit to never forcing patrons to show health status documentation.

The Equality and Human Rights Commission has also advised that any such scheme could lead to unlawful indirect discrimination and risks creating a 'two-tier society'. In particular, it could further exclude disadvantaged groups from accessing services and employment. You can read more here (https://www.theguardian.com/world/2021/apr/14/covid-status-certificates-may-cause-unlawful-discrimination-warns-ehrc).

HART continues to have grave concerns about the adoption of domestic or international vaccine passports. Certification of any kind would be highly coercive and would go against the UK's strong record of public health measures by consent. The Yellow Fever certificate is not a legitimate comparison, as that disease has a 30% mortality and has a well-established vaccine that gives lifelong protection. COVID-19 vaccination has now been offered to all the top 9 categories and accepted by the vast majority. This was promised as the road to freedom and the government now needs to deliver on this.

The government is currently running a consultation on making COVID-19 vaccination a legal requirement for all care workers (https://www.gov.uk/government/consultations/making-vaccination-a-condition-of-deployment-in-older-adult-care-homes). This is concerning, against international law and could further erode informed consent. The Royal College of Nursing published a statement yesterday detailing 'serious concerns around mandating vaccines' and stated they 'do not support staff being made or coerced into having the vaccine'. You can read the full statement, here (https://www.rcn.org.uk/about-us/our-influencing-work/position-statements/rcn-position-on-mandating-vaccination-for-health-and-social-care-staff). This policy is difficult to justify when the most vulnerable have been offered both doses of vaccine, which could reduce the risk of hospitalisation by up to 94% according to Scottish data on the Oxford-AstraZeneca vaccine (https://www.telegraph.co.uk/news/2021/02/22/vaccines-reduce-covid-hospital-admissions-94pc-study-shows/). HART will be responding to the government's call for views and we hope you will do the same. The deadline is 21 May 2021.

Conflicts of interest

Many individuals advising the government have financial conflicts of interest which they have declared. Even after being honest about such conflicts, it is not unreasonable to assume some subconscious bias affecting people. The reason for declaring conflicts is to allow policy makers to take account of such biases when considering the advice given. It is therefore the responsibility of policy makers and parliamentarians to be aware of such financial incentives that may cause biases, both at an individual and organisational level. So far £271 billion (https://www.nao.org.uk/covid-19/cost-tracker/) has been committed to the COVID-19 response. That is almost twice (https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget#:~:text=Planned%20spending%20for%20the%20Department,150.4%20billion%20in%202019%2F20.&text=The%20majority%20of%20this%20budget,for%20spending%20on%20health%20services.) the entire NHS budget for 2019/20. With so much money at stake, personal and organisational gains may well be biasing advice.

Vaccine pause

Denmark (https://www.reuters.com/article/us-health-coronavirus-denmark-vaccine/denmark-to-permanently-discontinue-use-of-astrazeneca-vaccine-tv2-idUSKBN2C118T) has totally halted use of the AstraZeneca vaccine, and on 15 April Norway (https://www.ft.com/content/fcc50938-4190-43c8-b8f9-d011b5f840e1) announced an extension of its pause pending further analysis. The US has paused (https://www.bbc.co.uk/news/world-europe-56744474) rollout of the Johnson & Johnson vaccine and South Africa has halted (https://www.aa.com.tr/en/africa/south-africa-

halts-rollout-of-johnson-johnson-vaccine/2208115) it. Meanwhile, the British Society of Haematologists has produced formal guidance for managing VITT, Vaccine Induced Thrombosis and Thrombocytopenia (https://b-s-h.org.uk/media/19530/guidance-version-13-on-mngmt-of-thrombosis-with-thrombocytopenia-occurring-after-c-19-vaccine_20210407.pdf), in which it points out that this can occur in any age or gender, up to 28 days after vaccination, and is not limited to one particular type of vaccination. Young adults at low risk from SARS-CoV-2 should be permitted the autonomy to judge their own risk-benefit balance and not be coerced into receiving vaccination.

Many media outlets have reported on the fact that clotting is a bigger risk for those who have COVID-19 than those being vaccinated against it. The paper (https://osf.io/a9jdq/) being reported included only COVID-19 cases that had been diagnosed and we know that cases were under-diagnosed in spring. If they had included all cases defined as those that developed antibodies then the risk would be 2 to 2.5 per million, or half the risk from the vaccine. This misses the critical point that someone being vaccinated gets all of that risk and possibly further risk from further doses if, as is already being discussed (https://news.sky.com/story/people-will-likely-need-to-have-a-third-dose-of-a-covid-jab-within-12-months-pfizer-boss-says-12276745), they are required as early as this year. The risk from COVID-19 must be coupled with the risk of developing COVID-19, which is far lower than 100%.

Excessive harm from vaccination is a serious concern and we urge further investigation into the issue. We would also recommend that the same consideration and scrutiny of collateral damage is extended to lockdowns and other non-pharmaceutical interventions.

'Lockdowns work' – not according to the evidence

On Tuesday 13 April the Prime Minister claimed that lockdowns had caused the fall in cases after the third wave, not vaccination. The ONS reported that estimated total cases nationally started falling at the end of December which was a week before lockdown. At this point only 25% of over 80-year-olds and a few healthcare workers had been vaccinated so it was too early for this to have had an effect. It feels intuitive that lockdowns ***should*** work but that is because our assumptions about disease spread are oversimplified. The evidence is conclusive that even when we try to prevent spread, while it works for some infections like norovirus, it does not work for SARS-CoV-2.

It has been well established previously that lockdowns do not work for respiratory infections and that is why they (together with mandated face-coverings and mass testing of asymptomatic individuals) were explicitly excluded before 2020 from influenza pandemic plans across the globe for all grades of severity (https://www.who.int/influenza/publications/public_health_measures/publication/en/). Transmission has mainly occurred in hospitals and care homes (as was the case for SARS1 and MERS (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7290630/pdf/atm-08-10-629.pdf) too) and to people within households. Lockdowns would have no effect on these transmission settings. A new paper (https://onlinelibrary.wiley.com/doi/10.1111/biom.13462) was published this week, again showing that lockdowns were not responsible for the decline in cases in the UK. This adds to the growing evidence (https://www.hartgroup.org/lockdowns-do-they-work/) base of more than 30 scientific publications (https://www.hartgroup.org/wp-content/uploads/2021/04/Lockdown_Efficacy_Studies.pdf) that shows that lockdowns don't work. Cases peaked simultaneously (https://app.powerbi.com/view?r=eyJrIjoiMGVjYjhkMjMtMzhjMy00OWRkLWJlNWItNjM0NzI0NjhiNTlkIiwidCI6IjlkZWYwNTBlLTExMDUtNDk1ZC1iNzUzLWRhOGRiZTc5MGVmNyJ9)on four continents in early January indicating that there were other factors at play unrelated to vaccination or lockdowns.

Legal challenges update

A number of legal challenges are being mounted around the world:

On 8 April the Weimar Family Court in Germany prohibited with immediate effect two Weimar schools from requiring pupils to wear face coverings of any kind, from imposing social distancing and from testing pupils. An English translation of the judgment can be found here (http://www.fuzzydemocracy.eu/francais/rubrique1.html).

On 1 April The Vienna Administrative Court lifted the ban on gatherings (https://www.anwalt.de/rechtstipps/verwaltungsgericht-wien-hebt-versammlungsverbot-auf-und-haelt-pcr-tests-fuer-nicht-aussagekraeftig-187224.html) and held that it considers PCR tests to be insufficient to prove an infection, stating that an "actual illness can only be determined by a doctor".

Objections to PCR testing being used as the sole determinant of infectiousness have in fact been upheld in the courts as long ago as November 2020 in Portugal (https://www.portugalresident.com/judges-in-portugal-highlight-more-than-debatable-reliability-of-covid-tests/).

On 31 March the Brussels court of first instance (https://www.politico.eu/article/belgian-court-slaps-down-covid-19-measures-reports/) ruled that the Belgian government did not have a legal basis for coronavirus restrictions.

Closer to home, a number of legal actions are underway in the UK:

- A test case on masks is being pursued against a school (https://www.crowdjustice.com/case/stop-masks-in-schools/) on the basis of no proper risk / benefit assessments for pupils (the H&S expert report (https://drive.google.com/file/d/106AfuBg3qslWwEiMtV-hnyXc2Dcc-RC1/view) on this makes salutary reading).
- Some big names from hospitality are formally challenging (https://www.bighospitality.co.uk/Article/2021/04/07/Government-stalling-tactics-fail-as-Sacha-Lord-s-High-Court-case-against-delayed-reopening-of-hospitality-expediated) the disparity between their reopening timetable compared to retail's (despite government delaying tactics this will be heard on 19 April (https://twitter.com/Sacha_Lord/status/1379450241540366338?s=20)).
- Staff are challenging (https://www.crowdjustice.com/case/stop-coerced-vaccination/) the legality of a "no jab, no job" policy soon to be adopted by one of the UK's largest care home chains.
- The requirement that care home residents be forced to self-isolate (https://www.dailymail.co.uk/news/article-9476607/Rule-insists-care-home-residents-isolate-day-abuse-human-rights.html) for 14 days after any time out of their homes is also currently subject to legal action.
- A legal challenge (https://www.crowdjustice.com/case/abingdon-health/?utm_source=CrowdJustice&utm_campaign=500612606a-ABHEALAPR2021&utm_medium=email&utm_term=0_7304756a43-500612606a-169749093) has been mounted to the award of contracts for lateral flow testing.

Behaviour hubs

Last week, a press release (https://bit.ly/3a8m7zh) from Education Secretary, Gavin Williamson, announced a £10 million 'Behaviour Hubs' programme aimed at improving discipline in our schools. From the start of the summer term, heads and 'behaviour leads' from high-performing schools will act as mentors and trainers for low-performing ones that are struggling to manage high levels of pupil disobedience. One part of the trainers' remit will be to offer advice on 'systematic approaches to maintaining order'.

While supportive of psychological approaches to nurture a positive learning environment in classrooms, HART is concerned about both the methods and goals of the Behaviour-Hub initiative. The record of the Government's behavioural scientists throughout the pandemic is an ignominious one. From the outset they have recommended the use of covert psychological 'nudges' (https://thecritic.co.uk/a-year-of-fear/), that have strategically used fear inflation, shame and scapegoating to increase compliance with contentious and unprecedented coronavirus restrictions, an ethically dubious approach that is likely to have been responsible for much 'collateral' damage. Given this track record, it is reasonable to be concerned that Behaviour Hub experts may deploy similar tactics with school pupils, to embed in their minds the dominant – but increasingly disputed – coronavirus narrative. Any move to promote adherence with the school mask mandate, an unnecessary restriction on our children that is doing more harm than good, should be resisted. You can read more on that topic, here (https://uploads-ssl.webflow.com/5fa5866942937a4d73918723/602e6afd2d5e00dbe4cfd228_UKMFA_Open_Letter_Face_Mask_Mandates.pdf).

Children have been disproportionately affected with the sacrifices of lockdown and school closures, and have suffered a significant increase in mental health problems (https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2020-wave-1-follow-up). While academic achievement is important, our kids now require a nurturing and supportive school environment to emotionally stabilise, relearn how to socialise with peers and to have fun. A strict disciplinary regime, informed by the often unethical interventions of behavioural science, may not be the appropriate milieu to achieve these aims.

8 April 2021

Child vaccine trials paused

The trial of the Oxford-AstraZeneca Covid vaccine in children has been paused (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=ac670f4ac9&e=31ecf78ece) while a possible link with blood clots in adults is investigated. Given that the phase 3 adult vaccine trials to establish long-term safety data are on-going and are not due to conclude until late 2022/early 2023, the question remains why were trials in children ever started? The risks to children from COVID-19 remain extremely low and any suggestion that children should be vaccinated to protect adults is ethically highly questionable.

HART's position remains that it is unnecessary, unethical and should be strongly discouraged until long-term safety data in adults are complete. HART would also remind regulators, the media and politicians that these are experimental vaccines, without full regulatory approval but issued under emergency waivers. It is vital that data is collected and rigorous scrutiny of vaccine effects is completed and letters such as this one in The BMJ (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=2351405d78&e=31ecf78ece) must surely be followed up as a matter of urgency.

Vaccine certification

Boris Johnson has confirmed that the government is investigating the use of 'Covid status certificates' which could be introduced in May. HART's position has not changed on this topic. HART strongly contends that any vaccine certification or passport is highly coercive, threatening the loss of livelihood and the loss of freedom of movement, violates informed consent and instead represents unwarranted and considerable duress. It is welcome news that the Liberal Democrats and Labour (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=5d0a25e253&e=31ecf78ece) are poised to vote against such measures in Parliament. Many businesses have also joined the wave of opposition, most notably the UK Cinema Association (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=e08edcd742&e=31ecf78ece). Over the weekend, Michael Gove asked readers of The Daily Telegraph (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=e3bfbfd57f&e=31ecf78ece) to share their views on the issue. Over 8,000 comments were forthcoming with the overwhelming majority strongly against the idea. As is argued by this article in The Critic (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=ab96b798b6&e=31ecf78ece), we must not remove the rights of the individual to assess risk and prioritise the quality of their own life.

Do we need the vaccine to protect others?

Putting aside the obvious breach of moral standards that domestic vaccine passports represent, how sound is the logic of the scheme? The premise of the idea, which has been welcomed by certain members of the press and public, is that the healthy population needs to be vaccinated in order to protect the vulnerable, who have themselves been vaccinated. The bottom line is, if an unvaccinated person poses a threat to a vaccinated person, then the vaccine does not work.

Fortunately, this is not true; the vaccine's efficacy is undeniable. It is being reported that the AZ vaccine is 94% effective (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=a0cf4c16f9&e=31ecf78ece) at preventing severe illness after just a single dose. ^ With over 5 million people now fully-vaccinated, the most clinically vulnerable members of society are even less likely to die as a result of exposure to SARS-CoV-2. Vaccine passports are a redundant concept.

For context, a 65-year-old male with Type 2 diabetes has a 0.2% chance of hospitalisation from Covid (according to the QCovid risk assessment (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=9cf945b81e&e=31ecf78ece)). Vaccination reduces this 0.2% risk by 94% to 0.01%.

Accounting for the fact that these figures were based on the prevalence of SARS-CoV-2 in the spring 2020 peak, and test positivity rates in England are now just 4% of that level, we should correct the risk to take this into account. The vaccinated 65-year-old now has a hospitalisation risk of 0.0004%.

The vaccine is reported to reduce transmissions by 70%, which seems like a high number on paper. However, once you have taken into account the low chance of a vaccinated person contracting the disease, we are talking about applying a 70% reduction to a starting risk of 0.0004% (roughly 1 in 250,000).

Given the efficacy of the vaccine and the huge uptake of the vaccine in the healthy population, the chance of a vaccinated person dying as a result of contact with an unvaccinated person is close to zero. We are risking widespread social division in order to alleviate a risk that barely exists.

SAGE modelling – approach with caution

On Monday 6 April, SAGE published their latest forecast, predicting spikes, surges and epidemic peaks if we venture from our homes in June. They say that 'while the vaccines prevent the vast majority of people from falling ill and dying from coronavirus, they are not good enough to see all curbs lifted without a big epidemic.'

This shift in strategy has also been noted in tweets from Health Secretary Matt Hancock who on 3 April said: "The vaccine is our route to normal". But just two days later on 5 April, he tweeted: "Reclaiming our lost freedoms and getting back to normal hinges on us all getting tested regularly."

The SAGE model in question ignores real world data. Why should the UK, with one of the biggest vaccination roll-outs and high disease incidence over the past year expect 'epidemic' proportions of this disease, particularly when it did not occur last summer when fewer people in the population had been exposed to the virus and none had been vaccinated? This seems even more unlikely with the news that we will pass the herd immunity threshold (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=f1afc7b29e&e=31ecf78ece) next week. We also note in the same article that the Government is unhappy with the 'pessimistic tone set by models produced by SPI-M' and is asking other groups to critique the work. We look forward to reading these critiques and will be publishing our own in due course.

Value for money?

Boris Johnson has announced a further rollout for mass-testing the entire population as part of his return to normal. Twice weekly nose and throat swabs are far from 'normal' and certainly not scientifically valid or cost effective. Indeed the proposal for 10 million Lateral Flow tests at £10 per kit will cost £200 million per week.

By the government's own calculation of 0.3% false positives (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=e62161e612&e=31ecf78ece), that will generate 60,000 false positives per week. These will all require tracing and offering a confirmatory PCR test at £100 each adding a further £6 million to the bill. Then NHS Test and Trace, already struggling with its current work-load, will be required to contact not only these 60,000 people but their 600,000 or more contacts. At present, deaths from COVID-19 are at a low level with a total of 227 deaths in the 7-days to 31 March. Even assuming that all these deaths were preventable, then this proposal would cost £907,489 per life saved, with no account of the staffing costs of the scheme.

NICE guidance (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=01f55863c2&e=31ecf78ece) for public health measures, define £20,000 per quality-adjusted life year (QALY) as cost effective. So for £206 million to be cost effective, it assumes those whose deaths were prevented still had an average of 45 years of quality life ahead of them (unlikely given the average age of

COVID-19 deaths is 82.4). This money could provide proper care for those who are symptomatic and yet not self-isolating fully, while still leaving well over £200 million pounds to be spent on dealing with cancer waiting lists, mental health, a struggling economy or even a new communication strategy of hope.

Asthma remedy may reduce hospitalisation by 90%

One of the successes of the UK's pandemic response has been mobilising the NHS to run clinical trials of new treatments for COVID-19 as part of the "RECOVERY" trial. It is through this trial that the benefits of a cheap, and widely available steroid drug, dexamethasone, when given to the seriously ill in hospital were discovered (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=768b17f3e8&e=31ecf78ece), and it seems likely that thousands of people's lives have been saved worldwide as a result.

A group in Oxford, observing the benefits of dexamethasone reported above, and also noticing that asthma patients taking inhaled steroids seemed (surprisingly) to be under-represented as COVID-19 inpatients, embarked on a trial of budesonide – a cheap, widely available drug taken via inhaler by millions of asthma patients – started within 7 days of the onset of symptoms. 146 patients were recruited and half received budesonide.

As reported here (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=99038e71e0&e=31ecf78ece), the results are impressive – the steroid inhaler reduced the relative risk of requiring urgent care or hospitalisation by 90% over the 28-day study period. The paper for the trial can be found here (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=24fe995ddc&e=31ecf78ece) and is, according to the author (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=c7b9c9d253&e=31ecf78ece), soon to be published in the Lancet Respiratory Medicine Journal.

Given that these results were published 2 months ago, it seems surprising that this trial has not attracted more interest, since many would quite rightly regard a safe, cheap and widely available treatment that could be given in early disease to prevent progression and the need for hospitalisation as a "game-changer", with the potential to alter our entire attitude to COVID-19 management. For example, it could recalibrate the risk-benefit ratio of vaccination, especially relevant this week with the news (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=5249c894c3&e=31ecf78ece) of the clotting problems related to the AstraZeneca vaccine being confirmed by several authorities.

Texas back to normal

Followers of social media will have seen astonishing video clips (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=edd85dd028&e=31ecf78ece) of the jam-packed Texas Rangers stadium hosting a baseball game on Monday. Horrified observers in states maintaining restrictions (albeit lighter than those in the UK) argued that this will lead to massive spikes in infections.

But, they claimed the same when Texas State Governor Abbot ended the mask mandate and business restrictions (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=bee6a5b256&e=31ecf78ece) over a month ago.

Did a disaster come to pass? No, in fact, over the past month Texas has seen substantial and sustained declines in cases, hospitalisations and deaths (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=e662132a6b&e=31ecf78ece). This is despite only 16% of Texans being fully vaccinated even now (this was at 6.7% on 1 March). The state Governor has now announced a ban on (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=cb7d7ed3af&e=31ecf78ece) vaccine passports in common with Florida, and the White House has also ruled them out (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=a57b38cf70&e=31ecf78ece) at a Federal level, stating that "citizens' privacy and rights should be protected".

Masks in the classroom

The Prime Minister did not even mention children in Monday's press conference on the road map, despite the promised review of face coverings in class introduced on 8 March. It took a tweet from the Department of Education (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=8cc22877d5&e=31ecf78ece) yesterday to announce that this measure was to continue, with no risk-assessment provided. This is now 10 weeks of increased restrictions on school children despite the continuing fall in hospitalisations and deaths and the almost complete rollout of the vaccination programme to the top 9 risk categories. What does this say about how our society values its children?

31 March 2021

HART vs SAGE

HART Pathology Lead Dr John Lee appeared on Good Morning Britain (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=bedf384f11&e=31ecf78ece) this week (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=4d4ba7214d&e=31ecf78ece) alongside Professor Susan Michie who sits on SAGE and the Scientific Pandemic Insights Group on Behaviours (SPI-B).

Dr Lee noted the lack of evidence for asymptomatic spread of SARS-CoV-2 and also pointed out the absence of diverse scientific discussion in the media. Susanna Reid denied this, stating that the other side was being heard on social media and in the papers. However, these avenues are not the same as trusted mainstream TV programmes and the void of diverse thinking here has no doubt hampered the public's understanding of 'the science'.

Reid went on to say that '***we know from the evidence that lockdown does work***'. This is simply not true. Increasingly, the body of evidence points to the exact opposite as can be seen here (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=5f32fac06c&e=31ecf78ece) and in dozens of published peer-reviewed papers, in stark contrast to the absence of evidence demonstrating significant benefits from lockdown when examining the real-world (as opposed to modelled) evidence. In addition, these models neglect to adequately assess the collateral harms.

Reid highlighted the figure of 126,000 COVID-19 deaths. However, there is a serious issue with excess, mainly non-Covid deaths at home which have reached over 50,000 in total (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=20f0673478&e=31ecf78ece). Here in the UK this figure currently sits at roughly 1,000 people each week. Perhaps many of these people would not have been put off seeking medical treatment had Michie, and her behavioural science colleagues, not terrified them into 'staying at home'. A review of these covert, ethically questionable, psychological strategies was recently published by a member of HART here (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=66266b1fcf&e=31ecf78ece).

Michie also talked about mutant variants and how many people it is or is not 'safe' to interact with. It is a shame that these questions were addressed to a psychologist, rather than to a pathologist with medical training. No mention was made of the inevitable seasonal decline of the virus and Michie mentioned several thousand new cases a day, neglecting to outline how these figures relate to hospital statistics (currently at September levels (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=2e2b80a581&e=31ecf78ece)).

Patients admitted to hospital in the UK

In fact, we know from numerous studies that there will be a significant number of post infectious positives at this stage with patients admitted to hospital for other reasons, incidentally testing positive. In the community, the expected surge in cases in the secondary school population has not materialised and the results of testing show that there is no active SARS-CoV-2 in that population. Overall, there is minimal evidence of residual coronavirus in the community. Mitchie went on to say cases are rising in Scotland. Again, this simply is not true (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=72e44c5506&e=31ecf78ece).

Cases in Scotland

Michie then described the possibility of exponential growth if we remove measures too quickly, which shows a misunderstanding of the current immunity status of the population. With so many now having antibodies (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=8c988e8a37&e=31ecf78ece) through natural infection or vaccination, it seems highly unlikely that this virus could now spread in an epidemic fashion. A transition into an endemic phase, as with seasonal flu in which there may be localised outbreaks, mainly in specific institutionalised settings, is much more likely.

The problems with Michie's thesis are underpinned by the false assumption that asymptomatic spread (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=49201e903f&e=31ecf78ece) is a major driver of transmission. There is no robust evidence (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=4b9d44f8ee&e=31ecf78ece) for this phenomenon, and it would go against decades of understanding of respiratory viruses and how they are transmitted. By continuing to disseminate this questionable hypothesis to the British public, she is continuing to spread unnecessary fear. A far more balanced approach would be to focus on:

1. The viral season rapidly waning
2. The huge percentages of vaccinated people & those with acquired or innate immunity
3. The fact that children are not a significant driver of the disease
4. The fact that clinical symptoms are the driver of transmission of respiratory viruses

We need to stop 'acting like we've got it' and start living what is left of our finite lives.

Data not dates

It was reported (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=f1fce9fe41&e=31ecf78ece) this week that the weekly COVID-19-related death toll has fallen to the lowest rate since October. However, in a scenario of ever-decreasing death rates and diminishing prevalence of the virus, a comparison to the COVID mortality rate at the beginning of the winter wave seems somewhat arbitrary and of no relevance to the current situation. Once deaths reach minimal levels, this indicates that cases must have been minimal 18 days earlier.

A far more sensible metric for comparison would be the current test positivity rate. Since 21 March the PCR positivity rate has been only 2.1% i.e. only 1% higher than the baseline positivity rate we saw in summer. Including all testing, only 0.43% of 1.2 million tests were positive on 29 March. To put this in perspective, 9,957 people tested negative out of every 10,000 tests done. Remaining locked down under these circumstances indicates that the Government has adopted a "Zero Covid" strategy, despite their own admission of the futility and harm that would be caused by attempting this policy. Patrick Vallance himself said (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=af08fbbe46&e=31ecf78ece): "I think the chance of eradication, true eradication – ie zero – are in themselves close to zero."

Tracking the success of the vaccine and maintaining confidence

Last week, Sir Christopher Chope MP and William Wragg MP raised important questions in the House of Commons (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=1dd91dbe6d&e=31ecf78ece) regarding COVID-19 deaths following coronavirus vaccination. Health Secretary Matt Hancock responded 'I think we do have it'. Hancock also referred to the SIREN study (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=ab24a2d76e&e=31ecf78ece) but this only covers healthcare workers and therefore does not provide the complete information required for monitoring adverse effects, safety and efficacy. HART would urge active data capture, including a simple vaccine history taken at every unscheduled attendance at a hospital.

We must not forget that these are experimental vaccines, without full regulatory approval but issued under emergency waivers. It would be concerning in the extreme if data were not being collected or if the level of scrutiny of vaccine effects was not sufficient. The availability and rapid access to this data is vital in maintaining the public's confidence in the vaccination programme.

US states continuing to open up

Governors across the US are continuing to open up their states (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=07cfb4c9d8&e=31ecf78ece) and remove COVID-19 restrictions. Earlier this month, Mississippi and Texas both announced the end of business restrictions and mask mandates, while North Dakota went a step further and implemented legislation to make mask mandates illegal. In Florida, Governor DeSantis is to forbid vaccine passports (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=0fe82f6b47&e=31ecf78ece) with an executive order.

In Texas, COVID-19 cases and hospitalisations carry on their downward trajectory (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=ae1b52fbf2&e=31ecf78ece) despite their removal of measures being described variously as: "absolutely reckless" by California Governor Gavin Newsom, "it just is inexplicable why you would want to pull back now" by Dr Fauci and "neanderthal thinking" by President Joe Biden.

Essential viewing

Nick Hudson, co-founder of the international group Pandemics ~ Data & Analytics (PANDA), has given a keynote address at the inaugural BizNews Investment Conference in South Africa. In his speech, Hudson gives a comprehensive overview of the COVID-19 pandemic and explores how instead of helping to slow the spread of the virus, lockdowns have led to infant mortality, poverty, starvation, joblessness and a major upsurge of psychological disorders. Well worth taking 30 minutes to watch in full, here (https://odysee.com/@PANDA:3b/TimeToReopenSociety:7). This video is currently being viewed by several thousand people per hour.

24 March 2021

There is no emergency

COVID-19 cases are low and all-cause deaths are now back to normal pre-pandemic rates and falling. All vulnerable groups have been offered a vaccination. There are no longer any justifiable or ethical reasons for prolonging Covid-related statutory 'emergency powers'.

It is anticipated that all phase 1 priority groups (approximately 32 million people) will have been offered a vaccine by 15 April, a group accounting for 99% of the deaths last spring. This will be an amazing achievement. The virus is now endemic and will circulate at very low levels this summer and is then likely to join the range of respiratory viruses circulating each winter. Talk of continuing social distancing and masks for several years is therefore unnecessary and unhelpful. We urgently need to reduce fear and increase hope as we recover from this crisis.

It is vital that we harness the benefits of the rapid vaccine rollout by acknowledging we are no longer in an emergency. We can and must reopen society. Government and SAGE will need to undo the negative messaging, after a year in restrictions many people will still be fearful to pick up their lives again. News that a £2m Government contract (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=62b4a3c6b4&e=31ecf78ece) has just been awarded for a COVID Public Information Campaign over the next two years is concerning. The repeal of the coronavirus emergency legislation would give a very positive message of confidence and hope to the British public. Therefore, HART continues to urge all MPs to vote against the renewal of the Coronavirus Act this week in Parliament.

No evidence of SARS-CoV-2 in schools

HART predicted 24,000 false positive results in children in the first week of mass testing based on 4 million children being tested twice. In the week of 4 March, only 2.7 million tests (https://www.gov.uk/government/publications/weekly-statistics-for-nhs-test-and-trace-england-4-march-to-10-march-2021) were carried out on secondary school children and 0.05% of them were positive. Our previous prediction was based on the estimated false positive rate for the adult population of 0.3% (https://www.ox.ac.uk/news/2020-11-11-oxford-university-and-phe-confirm-lateral-flow-tests-show-high-specificity-and-are). Testing of university students prior to Christmas showed a very low false positive rate of at or below 0.06% including Newcastle (https://www.chroniclelive.co.uk/news/north-east-news/only-quite-small-proportion-newcastle-19457664), Hull (https://www.hulldailymail.co.uk/news/hull-east-yorkshire-news/positive-covid-19-result-tests-4778823), Exeter (https://www.radioexe.co.uk/news-and-features/local-news/just-two-exeter-university-students-test-positive/) and Birmingham (https://twitter.com/deeksj/status/1340975390412685312?s=20). Testing among school children is demonstrating a similar rate. The good news is that these numbers are so low that no-one can be left in any doubt that they represent only false positive results and that there is no SARS-CoV-2 at present in the secondary school population. The ONS (https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/bulletins/coronaviruscovid19infectionsurveypilot/19march2021) estimated that there would be SARS-CoV-2 in 0.4% (1 in 250) 12-24 year olds, so this is another instance of failed testing with PCR. With no virus in schools, there is now no justification for the mask mandate or mass testing.

Is mask wearing benign?

This week, Dr Mary Ramsay from Public Health England told the BBC (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=4b1bd1cbd7&e=31ecf78ece) that face coverings were a 'lower level restriction' that 'people can live with' and they should continue to be worn 'for a few years'. Her words are similar to those used by politicians to justify the introduction of the mask mandate in summer 2020, when it was portrayed as an extra layer of protection, a precautionary measure, a nothing-to-lose restriction.

While there is no evidence that masks significantly reduce transmission when worn routinely in real-world settings (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=6e93b93424&e=31ecf78ece), there is recognition that they may constitute an infection hazard, particularly when used incorrectly (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=4bc1a4fb72&e=31ecf78ece). Masks potentially cause physical harms, while the social and psychological cost of concealing our faces from other people is considerable. Face coverings impair all forms of communication and human connection, make lip-reading impossible for the deaf and constitute a gross impediment to children's social development (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=140948adb1&e=31ecf78ece).

A highly visible reminder that danger is supposedly all around, face coverings are fuelling widespread, irrational fear at a time when the current viral threat is very low and the vulnerable have been vaccinated. As we look to re-activate the economy and reopen our society, this mask-induced fear will act as a major obstacle. HART believes the Government should now lift the mandate and allow people to decide for themselves whether to wear one. It is time to trust the public with their own personal risk-based decision making.

The futility of border closures

Summer holidays are in doubt again, with the news that a £5,000 fine will come into force for anyone trying to travel abroad without a 'reasonable excuse'. Matt Hancock has said the restrictions are to 'guard against (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=0b0dbde7af&e=31ecf78ece)' new variants that might put the vaccine rollout at risk. Professor Neil Ferguson was also quoted as saying we 'should be planning on summer holidays in the UK not overseas (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=b07d09a71e&e=31ecf78ece)'. Closing international borders to keep out 'foreign mutants' of an already endemic virus is neither useful nor possible. It is worth noting that mutant variants from abroad pose no extra threat compared with any homegrown variants and are likely to have very similar sequences. Mutant variants, emerging overseas or domestically, are an inevitable biological reality once a virus is in the population, as is the case in the UK. The virus will mutate slowly over time, irrespective of borders.

Mandatory vaccination for care home workers

The news that the government is considering making COVID-19 vaccination a legal requirement for all care workers (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=7deb9809f7&e=31ecf78ece) is concerning and against international law. This would create a precedent of eroding informed consent, and is difficult to justify when the vulnerable population have themselves already been offered at least one dose of vaccine, especially in the light of Scottish data that suggests the Oxford-AstraZeneca vaccine reduces risk of hospitalisation (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=ffb304f7e3&e=31ecf78ece) by up to 94%. If this is case, would it be better to prioritise second doses for all vulnerable groups, thus rendering the vaccination of our younger, healthy population unnecessary?

And some good news...

The number of patients admitted per day to intensive care units is now close to normal, pre-pandemic levels for the time of year. It appears we are well beyond the risk of overwhelming the NHS – further highlighting that now is the time to lift restrictions and allow the NHS to begin rapidly addressing the backlog of postponed appointments and operations. There is no sign of a virus resurgence in American states such as Florida (https://hartgroup.us7.list-

manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=798d03d1bc&e=31ecf78ece) and Texas (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=b9336283e8&e=31ecf78ece) which have lifted restrictions.

11 March 2021

Vaccine passports: the debate

Parliament is due to debate vaccine passports on 15th March, triggered by an online petition. After consideration of the arguments for and against below, HART strongly contends that any vaccine certification or passport would create a precedent of **eroding informed consent**. An independent group, the UK Medical Freedom Alliance, has prepared a detailed open letter (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=15fa1a7e56&e=31ecf78ece) on the topic, which is well worth reading.

For	Against

– The vaccine is the way out of lockdowns.	– The vaccine rollout to all vulnerable groups has been very efficient. These groups account for 99% of those at risk of dying, thus transmission by younger unvaccinated people becomes irrelevant.
– Other countries might do it and it will be the only way to restart the tourist industry.	– Although 30% of people testing positive for SARS-CoV-2 may be asymptomatic, that does not mean that 30% of transmission comes from this group. Proven asymptomatic transfer is very rare (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=41fe3fa47e&e=31ecf78ece).
– The hospitality industry and performing arts could quickly abandon social distancing which has such an impact on profit margins and business viability.	– The UK has a strong record of public health measures by consent; vaccination has never been mandatory.
– It is necessary, in case unvaccinated people cause asymptomatic transmission.	– Vaccine passports would have a coercive effect on informed consent which is contrary to UNESCO's "Universal Declaration on Bioethics and Human Rights (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=6bb16874ac&e=31ecf78ece)" (2005).
	– Any inducement is especially inappropriate given these vaccines are still in a period of temporary licence pending publication of long-term safety data.
	– Vaccine passports would create a two-tier society, in which those who remain unvaccinated for whatever reason are deprived of their basic freedoms of travel, association and employment.
	– The WHO does not support vaccine passports (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=942b3a2faf&e=31ecf78ece).
	– The flu vaccine is given to high risk members of society and those who choose not to have it do not suffer any restrictions. Given COVID-19 is now endemic, the vaccination programme should follow this previously well-established protocol.

Variants no cause for concern

Variants arise spontaneously due to the error-prone replication of SARS-CoV-2. Compared with influenza, however, the rate of variation is slow. Despite the exaggerated news on this front, in over a year, the most-changed variant (Brazilian P1) of SARS-CoV-2 is just 0.2% different from the Wuhan sequence. So far, none of the observed differences in any variant has been particularly important functionally, with the expected trend towards modestly increased ease of transmission. Reassuringly, it has recently been shown that the vaccinated and those recovering from natural infection all possess a broad repertoire of T-cell responses (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=0d6b1f7b43&e=31ecf78ece) entirely capable of recognising all the most noted variants. As mentioned before, immune escape is considered by the most qualified immunologists to be implausible (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=f0d473a421&e=31ecf78ece). We are therefore perplexed by the concept of 'Red List Countries' and border restrictions. It is simply not true that variants are more likely to arise in unvaccinated people. It is an immunologically unsound concept and arguably the converse is more likely.

Back to school

As we reported last week, after conducting 1.9 million tests in secondary schools (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=bff67b968a&e=31ecf78ece) throughout January and February, the results have shown no genuine COVID-19. Given that the children attending schools in those months were mostly the children of key workers and therefore most at risk of COVID-19, this is a wonderful result that should be celebrated.

Despite having established that there is no COVID-19 in the asymptomatic (or healthy) school population, we are about to embark on mass testing. Even if the positive rate stays at the current record-breaking low there will be tens of thousands of false positive results before Easter, resulting in more education being missed. All mass testing (such as cancer screening), treats the initial result as an indication of a higher risk of diagnosis. Only a confirmatory test can make the diagnosis. By ignoring this basic principle the Government risks undermining faith in their ability to correctly diagnose COVID-19.

Even though we have both low prevalence and mass testing, most children are now having to wear masks. Boris Johnson called this approach "nonsensical (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=7e7052cbdb&e=31ecf78ece)" in August. Masks have been introduced without assessment of the potential harms they cause nor any evidence that they have a benefit. The UsforThem (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=6259c78057&e=31ecf78ece) open letter opposing mask wearing in schools has attracted support from hundreds of professionals.

Children have been disproportionately affected with the sacrifices of lockdown resulting in an epidemic of mental health issues (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=118ebd52da&e=31ecf78ece). Gavin Williamson has promised no child's prospects should be "blighted by the pandemic". Consequently there are plans to address academic achievement. However, there is a failure to understand that academic success will be severely hampered for those struggling with mental health problems and for many children these need to be addressed before efforts at catching up academically will succeed.

US states are opening up

The situation in the USA is changing rapidly. North and South Dakota are well matched across many key metrics so make an ideal comparison. Neither state instituted spring lockdowns, but, in November, in response to rising case numbers, North Dakota imposed stringent policies of mandatory face covering and lockdowns, whereas South Dakota did not. No difference in case counts was observed.

Initially, Florida followed the established policy line. Later, however, as reported here (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=cc0801d06e&e=31ecf78ece), Gov. Ron DeSantis shifted policy towards focused protection of the vulnerable, while allowing the remainder of society to continue living life near to normal. The disaster predicted by many advocating lockdowns did not come to pass. In fact, the opposite happened. Florida has had a lower age-adjusted mortality than most other states, yet the economy and tourism are in comparatively good shape. COVID-19 deaths per million are, in fact, similar to California's, which has instituted one of the toughest lockdown and mask mandate regimes in the US.

Over the past week Texas, Mississippi, Tennessee, West Virginia, Arizona, Wyoming and Connecticut have also announced the restoration of freedoms to their citizens, either by ending mask mandates, reducing restrictions on business, or both. This is despite having a vaccination program dramatically behind the UK's in terms of percentage vaccinated.

Covert 'nudges' – is it ethical?

Throughout the pandemic, the Government's behavioural scientists have used covert psychological strategies – 'nudges' – as an effective way of increasing compliance with restrictions (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=41caf4da11&e=31ecf78ece). Several interventions of this type have been woven into the intensive communication campaign, including: fear (strategically inflating perceived threat levels); shaming (framing compliance as akin to being a virtuous person); and peer pressure (portraying non-compliers as a deviant minority). Contrary to the traditional tools of persuasion, such as information provision and rational argument, these 'nudges' largely work subconsciously and raise important ethical questions.

The same covert strategies are now being used to promote the uptake of COVID-19 vaccines. A recent NHS England document (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=bf61852eb7&e=31ecf78ece) recommends, for example, that healthcare staff "leverage anticipated regret" on the over-65s by asking them "how will you feel if you do not get vaccinated and end up with COVID-19?". For young people, who are at vanishingly small risk of suffering serious illness, one recommendation is that they should be told "normality can only return, for you and others, with your vaccination". Obtaining informed consent before administering an intervention should be a vital part of medical practice. To ensure ethical integrity, healthcare staff should be encouraging each individual to, consciously and rationally, weigh up the pros and cons to themselves of accepting a vaccine rather than covertly "nudging" them towards compliance.

The ethical dilemmas of using covert methods have long been recognised; in 2010, prominent figures in the discipline stated (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=48ed5dd7b9&e=31ecf78ece) (pg 74), "Policy makers wishing to use these tools... need the approval of the public to do so". No such consent has been sought or granted. HART believes that an open debate about the ethical integrity of these approaches, and the collateral damage associated with them, is now urgently required.

Quicker reopening could help boost vaccine immunity

This winter, levels of many common seasonal infections – such as flu (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=e1a7f88311&e=31ecf78ece) – remain extremely low due to a combination (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=258c690886&e=31ecf78ece) of lockdown measures, reduced global travel and high flu vaccination uptake. HART scientists are concerned that this may result in waning immunity (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=41ee1da2b1&e=31ecf78ece) to flu and other respiratory pathogens, following a year where the population has had very little exposure. Evidence for this is already emerging in Australia, where a sharp increase in Respiratory Syncytial Virus infections (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=a66206e5ec&e=31ecf78ece) in young children has been observed at an unusual time of year. A child's immune system is not fully developed until the age of 6-7 years old, and exposure to pathogens during those early years helps shape an individual's ability to deal with common pathogens circulating within the population. HART's view is that this demonstrates yet another potential harm of prolonged lockdowns and social distancing measures that has not been properly evaluated. The longer populations remain unexposed to common pathogens, the greater the risk this poses (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=13d0917d7b&e=31ecf78ece).

It is worth noting that as vulnerable groups are vaccinated against COVID-19, opening up society swiftly would allow natural boosting of vaccine-induced immunity at a point when the population is most protected (https://hartgroup.us7.list-manage.com/track/click?u=a1fa0a6b6b9bcb501d631b376&id=96214228eb&e=31ecf78ece). The vulnerable will thereby be exposed at a point when their antibody levels are highest and they are best able to defend themselves, and their immunity will be strengthened by this exposure.

Being overly cautious in lifting lockdown is not a cost-free option, and risks not building on the advantages that have been gained by the rapid rollout of vaccines. We could end up in a vicious circle of reduced immunity caused by lockdowns leading to worse respiratory illness and deaths the next season, with calls for more lockdowns to deal with the resulting healthcare crisis. Now is the time to open up society, to prevent this decline in public health and immunity.

And some good news...

All measures of COVID-19 prevalence and harm are currently low and falling. The most important measure, excess deaths, now shows that **deaths are below normal levels for the time of year**. As there is a 23 day window between contracting infection and death, this shows that transmission levels have been essentially zero for nearly a month now.

5 March 2021

Mass testing in schools

From next week, secondary pupils across England will be asked to take rapid lateral flow tests to help identify anyone who might be infectious. According to PHE and the University of Oxford, lateral flow tests have a false positive rate of around 0.3% (https://www.ox.ac.uk/news/2020-11-11-oxford-university-and-phe-confirm-lateral-flow-tests-show-high-specificity-and-are), which in a clinical setting would be acceptable, but when testing 4 million (https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics) healthy, asymptomatic schoolchildren twice a week will mean 24,000 false positive tests. When you add in their contacts this could see up to 700,000 children out of the classroom every week (based on classes in quarantine rather than whole year groups). This clearly undermines the "national priority (https://www.bbc.com/news/education-55810468)" of ensuring British schoolchildren have the education that they deserve. It is also important to note that after conducting 1.9 million tests in secondary schools (https://twitter.com/deeksj/status/1366517953848573952?s=21) throughout January and February, the results have shown no genuine COVID-19.

UK's data is progressing faster than the 'Road Map'

Vaccination proceeds at pace, with the UK the second most prolific vaccinator worldwide behind Israel. Over 20 million people have now had their first dose and everyone in the first four priority groups – those aged 70 and over, care home residents, healthcare workers and people required to shield – were offered a jab by mid-February. The foresight in securing supplies from multiple manufacturers appears to be paying off and may enable the UK to assist other countries once our greatest priorities have been met. Regardless of the inconclusive debates about why it is happening, the following numbers (https://coronavirus.data.gov.uk/) continue to fall and are to be celebrated:

	Numbers	% reduction over last 7 days

Cases	6573 (as of 4 March)	-34.4%
Hospitalisations	757 (as of 28 Feb)	-29%
Deaths	242 (as of 4 March)	-33.6%

Do COVID-19 restrictions work?

When the relationship between lockdown stringency (as measured by Oxford University Blavatnik School's index (https://www.bsg.ox.ac.uk/research/research-projects/covid-19-government-response-tracker)) and COVID-19 deaths (from Worldometer (https://www.worldometers.info/coronavirus/)) is examined, there is a striking lack of any suggestion whatsoever that the more severe the lockdown, the lower the COVID-19 mortality, and in fact, if anything, the data suggests the opposite may be true. This is also apparent from studies in the USA which have shown that COVID-19 mortality is not linked to lockdown stringency (or mask usage).

This should be investigated as a priority, because the costs of lockdown are truly large, in every possible dimension. A number of groups have, throughout the pandemic, estimated that the negative impacts of lockdown have or will exceed the anticipated lives saved or deaths delayed – read more here (https://www.frontiersin.org/articles/10.3389/fpubh.2021.625778/full).

Modelled predictions by definition rely on assumptions and these assumptions might be wrong. Only by correcting models in light of real life data can errors be avoided. Real world data should always trump modelled data as it is not based on potentially false assumptions. Instead, the modelers appear to have "doubled down" on their position, creating ever more frightening projections which have never actually come to pass, but which have been used to frighten the population into compliance with the restrictions.
There have not been many assessments of whether the theoretical expectations of lockdown match up with the reality and accordingly, a member of HART recently published this review in The Critic (https://thecritic.co.uk/mutant-variations-and-the-danger-of-lockdowns/) which was endorsed by a member of NERVTAG (https://twitter.com/rwjdingwall/status/1367052428621791237?s=20). In brief, it is conceivable that, by altering the evolutionary pressures on the virus, our measures may inadvertently be making the situation worse.

Avoiding harm to children

As it stands, COVID-19 vaccines will not be offered to children and indeed all the original trials specifically excluded them. It is worth noting that phase 3 of the vaccine trials to establish long-term safety data are on-going and not due to conclude until late 2022/early 2023. It is concerning to hear scientists continue to call for COVID-19 vaccines to be

rolled out to this age group. Some have expressed concerns that a very small number of children may develop 'long Covid', a post-viral syndrome; however given the unknown risks of adverse events from blanket vaccination, this is not a reason to proceed. None of the trials have specifically looked at whether the vaccines could reduce 'long Covid' – so this is a hypothesis that must first be investigated and substantiated.

Any suggestion that children should be vaccinated to prevent spread to older people is surely questionable on two grounds: (1) the ethics of children having an unknown long-term risk imposed on them for no matching benefit – given their extremely low COVID-19 risks – and (2) if vaccination is available for those vulnerable persons who desire it, such a need is surely absent. We encourage you to read this fully-referenced letter (https://uploads-ssl.webflow.com/5fa5866942937a4d73918723/60379523f61260115203f392_UKMFA%20_Covid-19_Vaccine_in_Children.pdf) on the ethical concerns over COVID-19 vaccine use in children.

Assessing asymptomatic transmission's role in the pandemic

As SARS-CoV-2 is transmitted from person to person, measures intended to reduce the number of daily contacts for each person should reduce transmission and ultimately deaths – as concluded in this Imperial College London paper (https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf). However, the underlying assumption is that all contacts are approximately of equal weight in terms of the probability of infecting others and that the prevalence of the infected individuals are similar, wherever one looks.

Prior to 2020 the default assumption was that only symptomatic individuals are at high risk of infecting others with a respiratory pathogen, as droplet secretion expulsion is the major mode of transmission. Early in the COVID-19 pandemic however, based on very limited evidence (a mere 6 case studies involving just 7 people), it was claimed that asymptomatic transmission was a very important driver of the pandemic (although Dr. Maria Van Kerkhove of the WHO is quoted as saying it is 'very rare (https://www.forbes.com/sites/mattperez/2020/06/08/who-says-asymptomatic-spread-of-coronavirus-very-rare-but-experts-raise-questions/?sh=6f53cd1a43d0)'). The entire rationale for mask wearing and mass testing is based on the assumption of the importance of asymptomatic transmission being correct. However, when the source data was reviewed (https://www.bmj.com/content/371/bmj.m4436/rr-10) this assumption was called into question. Empirical data show that transmission risk is very variable and is much greater in those displaying symptoms than from those who test positive for the virus, yet show no symptoms. For example, in this household infection survey (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2776908), those with symptoms had a surprisingly low transmission rate of 17% probability of infecting another householder while those who had not yet developed symptoms led to another householder turning positive in just 0.7% of cases.

By contrast, it is clear that a high proportion of infections have been acquired in institutions.In spring 2020, up to 40% of infections were hospital acquired (https://www.telegraph.co.uk/news/2021/02/12/40-per-cent-first-wave-covid-cases-could-have-caught-hospitals/) (which are attended by large numbers of people, even in lockdowns) and 40% of deaths were in care homes (https://news.sky.com/story/coronavirus-40-of-recent-covid-19-deaths-in-england-and-wales-occurred-in-care-homes-ons-11986899). It seems plausible therefore that COVID-19 may be well on its way to becoming predominantly a disease of institutional spread, as was the case with prior novel coronaviruses (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7290630/pdf/atm-08-10-629.pdf). HART recommends urgently undertaking a detailed, multi-disciplinary review of the effectiveness of non-pharmaceutical interventions in community and institutional settings.

SARS-CoV-2 or COVID-19?

It is very important to avoid conflating the virus and the disease. SARS CoV-2 is a respiratory virus. If you contract that virus, you will likely have mild symptoms. In rarer cases, SARS CoV-2 can lead to a more severe collection of symptoms, characterising a disease we call COVID-19. This is not a problem of semantics, it is a public mental health issue. By referring to the virus and the disease interchangeably, we end up with unnecessary panic. Headlines where experts describe COVID-19 as "the worst illness I've ever had" (https://www.rnz.co.nz/news/world/422019/covid-19-the-worst-illness-i-ve-ever-had-medical-expert-says) do not sit well alongside announcements that imply "60,000

people [are] catching Covid each day (https://www.mirror.co.uk/news/uk-news/interactive-map-shows-60000-people-23358144)". By failing to grasp the difference between the disease (severe illness) and the virus (usually mild or no symptoms) the public are inferring an exaggerated risk to their own health, resulting in increased anxiety and widespread fear of germs that could have long-term implications for mental health.

More good news from the NHS

Not only are suspected COVID-19 attendances continuing to decrease nationally and across all age groups and regions, but people coming to A&E with an acute respiratory infection is **almost as low as the summer minimum and well below normal for the time of year**. This would suggest that any pressure the NHS is experiencing is not related to community spread of SARS-CoV-2.

25 February 2021

Welcome to our latest weekly bulletin.

Good news from the NHS

COVID-19 like symptom triages through 999 and 111 (https://digital.nhs.uk/dashboards/nhs-pathways) calls dipped this week to 3,734 – the lowest since the 8th August, when few non-pharmaceutical interventions were in place.

UK restrictions among strictest in the world

It may be a surprise to learn that, compared with all other nations for which a stringency index of NPIs was calculable, the UK ranks fifth most severe behind only Cuba, Eritrea, Honduras and Lebanon. See the Oxford COVID-19 Government Response Tracker (https://www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker#data) for their methodology.

It is HART's position that, in combating novel diseases such as SARS-CoV-2, all possible tools to achieve protection must be evaluated for benefits, taking account of all impacts on wider society over the short, medium and long-term and not solely focusing on the immediate threat. These tools include well-targeted NPIs and also the use of experimental treatments (especially "drug repurposing") as well as vaccination where available, subject to the benefits of any medical interventions being shown to be greater than the risks, in accordance with accepted norms of medical practice.

Avoiding harm to children and young adults

Masks have been widely used during this pandemic in an attempt to reduce transmission, but with no accompanying quantification of benefit or published risk assessment of harms (physical, psychological, educational or societal). The assumptions that face coverings reduce transmission and cause no harms is not borne out by the published science. A recent large randomised controlled trial (https://www.acpjournals.org/doi/10.7326/M20-6817) found no significant protection from SARS-CoV-2 infection for mask-wearers, which is consistent with findings in previous investigations (https://wwwnc.cdc.gov/eid/article/26/5/19-0994_article) of protection from other respiratory viruses. Furthermore, there are documented harms from prolonged use, particularly in children and young adults, both physiological and psychological (https://reaction.life/making-pupils-wear-masks-is-pointless-and-cruel/).

An independent group, the UK Medical Freedom Alliance, has prepared a detailed report (https://uploads-ssl.webflow.com/5fa5866942937a4d73918723/602e6afd2d5e00dbe4cfd228_UKMFA_Open_Letter_Face_Mask_Mandates.pdf) of the evidence, which we encourage you to read.

In light of this evidence, it is concerning to see in the Prime Minister's 'Roadmap' a recommendation that face masks should be worn by children all day (up to 8 hours) when they return to school. It is HART's position that this should be urgently reconsidered, given that the evidence suggests (https://publichealthscotland.scot/our-areas-of-work/covid-19/covid-19-data-and-intelligence/enhanced-surveillance-of-covid-19-in-education-settings/overview-of-enhanced-surveillance-of-covid-19-in-education-settings/) schools are among the safest places in relation to the virus, even without mass testing or face-coverings in classrooms, for pupils, teachers and families. For the same reason, repetitive testing for asymptomatic infection in schoolchildren is unlikely to result in useful benefits compared with the costs and burdens. Asymptomatic positives have not been found to be a significant driver (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774102) of transmission and the continued medicalising of children is a significant barrier to their recovery from a damaging year.

Society has a duty to protect and nurture the next generation by showing good judgement and putting their needs first. Children are rarely a source of onwards transmission of the virus and are extremely unlikely to become ill. It is therefore additionally concerning to hear scientists and others calling for COVID-19 vaccines to be rolled out to children (https://www.theguardian.com/world/2021/feb/22/vaccinating-children-could-be-key-to-stifling-covid-say-experts). HART's view is that this is unnecessary, unethical and should be strongly discouraged at least until long-term safety data is reported in 2023. For more information on this important topic, please read our briefing paper here (https://www.hartgroup.org/wp-content/uploads/2021/02/VACCINATION-IN-CHILREN.pdf).

Choosing the optimum response to a global threat

The SARS-CoV-2 global crisis – and most notably our responses to it – is an event without modern precedent. However, a year on, there remains no consensus regarding the best ways to respond in order to protect vulnerable citizens as well as wider society. Several countries and US states have chosen a 'light touch' approach, providing clear public health advice yet minimum compulsion (Sweden, Florida, South Dakota), others have elected to make extensive use of compulsion in non-pharmaceutical interventions (UK, California, New York).

Outcomes in terms of deaths, adjusted for population, are inconsistent with the notion that the available NPIs (such as 'lockdowns', face coverings and business closures) are any kind of magic bullet. Indeed, Professor Martin Kuldorff of Harvard Medical School has recently argued that NPIs are largely ineffective (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00193-8/fulltext?rss%253Dyes) yet disproportionately harmful. It is important to remain fact-based and, while there is no question that many mostly

elderly and already-ill people have died with COVID-19, its lethality is not as remarkable as often portrayed. It is not commonly known that there are already four, endemic coronaviruses (OC43, 229E, NL63 & HKU1) which cause around 20% of common colds. In the frail population, even infection by OC43 can cause fatalities at a similar rate to SAR-CoV-2 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2095096/).

Assessing risks from new-technology vaccines

The rapid development of COVID-19 vaccines has been a rare technical triumph in a very challenging year. The UK was extremely successful in securing a high volume of doses prior to availability, and the rapidity with which vaccination is proceeding should quickly be reducing the threat to the NHS and to vulnerable individuals. This is to be celebrated. However, the shorter than usual development period was made possible only through the use of technology which is new and for which there is no prior clinical experience. It is not appropriate to employ our usual assumptions on short- and long-term safety, for example.

With classical vaccines, all that changes each time is the 'immunogen', the material placed in the mixture to which a desirable immune response is sought. The COVID-19 mRNA vaccines use entirely novel technology. While the short-term safety profile appears acceptable, there is simply no safety database nor any validated methods at all which could guide us on the potential for unwanted effects in the mid to long-term, as summarised in this short review (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7521561/). Accordingly, it makes sense to move with caution once vaccination of the vulnerable has been accomplished and any form of mandated or pressurised adoption of the vaccines cannot be justified – including the adoption of domestic or international vaccine passports. This is, thankfully, being increasingly recognised, as seen in the Council of Europe's declaration on the matter (https://pace.coe.int/en/files/29004/html?fbclid=IwAR1HrpB1giQFPm0mMsLcswGzeePH2AcHq6I4Ef6Chk_XqT0apRIyxV2lsl8) (to which the UK remains a contracting party).

Treatments for COVID-19 beyond vaccination

While data from the vaccination trials suggest that these products can provide robust protection for those most vulnerable to severe outcomes, there are other good treatments being investigated and proven. A small randomised trial (137 people) (https://www.medrxiv.org/content/10.1101/2021.02.04.21251134v1) of the inhaled anti-inflammatory drug ***budesonide*** was conducted in early, mild COVID-19 cases, based on observations that asthmatics were underrepresented in COVID-19 deaths. A highly statistically significant 90% reduction in hospitalisation rates was observed. This drug is available as a low-cost generic and every GP is familiar with prescribing it because it is a safe and effective treatment for asthma.

There have also been strong clinical benefits following controlled trials with the generic anti-parasitic drug ***ivermectin (https://www.dailymail.co.uk/news/article-9297449/Drug-used-treat-lice-scabies-drug-cut-Covid-deaths-75-research-suggests.html)***. It is important to note that even "long COVID", a post-viral syndrome which, thus far, does not appear to be much more common or more severe than after influenza sequelae, is also successfully treated by some of these drugs, specifically ***ivermectin (https://www.researchgate.net/publication/344318845_POST-ACUTE_OR_PROLONGED_COVID-19_IVERMECTIN_TREATMENT_FOR_PATIENTS_WITH_PERSISTENT_SYMPTOMS_OR_POST-ACUTE)***. It is now reasonable to regard COVID-19 and its ongoing complications as largely treatable or even preventable.

It remains an enigma why high evidential bars are maintained, even for mere evaluation of existing drugs, whereas no such considerations appear to have been evident as regards the use of devastatingly harmful measures such as lockdowns.

The way forward – the importance of testing

Classically, a disease is diagnosed by a mixture of signs and symptoms which are consistent with the disorder suspected. Sometimes, additional tests are ordered to differentially diagnose illnesses which present with similar clinical pictures. Unusually, COVID-19 is primarily diagnosed by one test, largely the polymerase chain reaction (PCR) probing for genetic sequences characteristic of SARS-CoV-2. This alone places great weight on the reliability of the test

itself. There has been controversy in relation to the PCR test (https://probabilityandlaw.blogspot.com/2021/02/uk-lighthouse-laboratories-testing-for.html), which is extremely sensitive yet potentially subject to a number of interfering factors, which have not been fully investigated. 'False positives' or 'cold positives' are a particular concern, notably as prevalence of the virus falls further. Recently, additional tests, such as the 'rapid antigen' or lateral flow test, have become available. These have different characteristics and this is an advantage because it is common to have a range of testing techniques from which to choose, depending on the context (i.e hospitalised patients or healthy individuals in the community).

In order to minimise inappropriate focus on just one of forty or so respiratory viruses, HART recommends an in-depth review of testing followed by a revised testing strategy. The aim is to focus on reliable identification of those who are both clinically infected and infectious, because they represent the vulnerable from whom NHS burdens and also mortality risks emerge. Those who may be positive in certain circumstances but are not clinically infected or infectious are a distraction and also unhelpfully distort otherwise informative trends.

Accurate recording of deaths

Another area where COVID-19 testing inaccuracies can be problematic is death certificates. Normally a disease is defined by symptoms and testing is secondary. For COVID-19, a positive test result is the definition of disease and the clinical symptoms that have been associated with it are myriad. Where the specific symptoms are not present, a clinical diagnosis of the disease should be impossible. However, data on COVID-19 mortality is centred on all deaths within 28 days of a PCR positive. We rely on clinicians to determine the underlying cause of death and differentiate that cause from any possible contributing factors. HART's concern is that a front-line clinician certifying a death that has been recorded as a COVID-19 death in Government data will find it hard to overturn that decision in the absence of evidence that they did not have COVID-19. There is ample anecdotal evidence (https://www.dailymail.co.uk/news/article-9279767/BEL-MOONEY-dad-died-chronic-illness-hes-officially-Covid-victim.html?ito=amp__twitter__share-top) that deaths are being misattributed.

Regardless of the prevalence of false positives, the genuine presence of a respiratory virus does not necessarily implicate the virus in the patient's death. It is being assumed that where PCR positives indicate the presence of SARS-CoV-2, the virus has contributed in some way to the death. We have never adopted this system for any other virus. It is important to consider how many hospital deaths would be attributed to influenza in any given winter were we to employ a similar diagnostic strategy. Indeed, this Spanish study (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6038767/) demonstrates that respiratory viruses were present at death in 47% of elderly cases, while clinicians only diagnosed infection in 7% prior to death.

Perhaps the most useful measure available to us is all-cause mortality. When you look at the last 20 years, it certainly puts recent events in context.

Many of you found our first bulletin last week useful. We are pleased to circulate our second bulletin below.

COVID-19 in context

With every death comes personal tragedy, nevertheless it is important to remember:

– The median age of at death with COVID-19 (https://www.telegraph.co.uk/news/2020/11/12/public-wrongly-think-average-age-covid-death-65-poll-reveals/) (around 82 years) exceeds normal life expectancy.
– The majority of those who died with the virus also had two or more serious, chronic illnesses (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsinvolvingcovid19englandandwales).
– In 2020, there were 388 COVID-19 deaths (https://www.telegraph.co.uk/news/2020/12/28/60s-died-roads-last-year-no-underlying-conditions-coronavirus/) in those aged 60 and under with no prior illnesses.
– 99.9% of people under 70 years and with no underlying conditions (https://www.researchgate.net/publication/344229524_Predicted_COVID-19_fatality_rates_based_on_age_sex_comorbidities_and_health_system_capacity) survive the virus.

Already, all those in the first four groups of the vaccine rollout strategy (70+ and those considered clinically extremely vulnerable) have received at least one dose. Meanwhile, the numbers of daily deaths and the number of people severely ill in hospital continue to fall steadily. This is extremely encouraging.

It should also be noted that we have never previously counted deaths from a respiratory pathogen, season after season which to assess the current situation.

Unemployment rises, GDP falls

Devastating economic impacts are now manifest, with unemployment rising to a 4-year high of 5% in January (https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/ukla (https://www.ons.gov.uk/economy/grossdomesticproductgdp/bulletins/gdpmonthlyestimateuk/december2020). Swe EU average of 4.8% (https://ec.europa.eu/eurostat/documents/portlet_file_entry/2995521/2-02022021-AP-EN.pdf/0 would point to the economic restrictions being untenable going forwards. Rising debt, poor growth and a smaller econ available for the NHS and all services.

It seems likely that the restrictions will result in large parts of the hospitality, travel, tourism, events and arts sectors r (https://www.ukhospitality.org.uk/page/EconomicContributionoftheUKHospitalityIndustry2018) in the UK before the (https://www.ukhospitality.org.uk/news/551801/New-GDP-figures-highlight-damage-to-UKs-hospitality-sector-a consequences for years to come.

Evidence for increased psychiatric morbidity

A year of COVID-19 restrictions has led to unprecedented levels of loneliness, fear and uncertainty about the future. Th journal-of-psychiatry/article/mental-health-and-wellbeing-during-the-covid19-pandemic-longitudinal-analyses- (https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-peopl problem, many for the first time. By winter, 1 in 4 young people felt unable to cope (https://www.princes-trust.org.uk/ depression (https://bmjopen.bmj.com/content/10/9/e040620) during the first lockdown, and almost 1 in 3 people have usual-during-the-pandemic). Loneliness is likely to have evoked mental defeat in elderly people with dementia, often evidence of the mental health costs of restrictions has emerged with reports of significantly increased anxiety and dep rise in disabling tic disorders in children (https://www.telegraph.co.uk/news/2021/02/13/explosion-children-tics-tou

Due to the psychological characteristics underpinning their difficulties, people already struggling with these particular contamination and the protection of others; panic attacks, often driven by recurrent thoughts of imminent death; gene about the future.The psychological impact of constant testing is also something that needs to be urgently investigated,

COVID-19 in hospitals and care homes

The low prevalence of the virus in the community and the increasing levels of immunity in the population means this v managing the residual cases. When the R-value is estimated, it is not a quantity that's measured directly, but inferred dominant role, it now seems needlessly destructive to maintain restrictions in the community.

It has been estimated that up to 40% of infections in the spring 2020 (https://www.telegraph.co.uk/news/2021/02/12/ the COVID-19 deaths in spring 2020 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvin from care homes.

It has been estimated that, during the growth phase of an outbreak, the R number in hospitals may have been as high a hospitals/). Yet decisions have been made to close schools based on a potential reduction in R of 0.2 or less (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/925856/S0770_

A strategy of 'unremarkable COVID-19' is in sight

It is not necessary nor likely possible at an acceptable social or economic cost to reach "Zero Covid". Furthermore, the (https://inews.co.uk/news/politics/operation-moonshot-boris-johnson-mass-covid-testing-plan-642163) some tim comes to dominate the results. At very low prevalence, with mass testing of those without symptoms, it is unavoidable

Given the backdrop of vaccines, natural immunity and novel, effective treatments, it is HART's position that we can sa solution and one which lines up with public health strategy on numerous other infectious diseases.

Computer modelling – handle with care

In contemplating the consequences of emerging from lockdown, it is concerning that we continue to apply high weight (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/958913/S1024_ 2022. However, an undergraduate student of mathematics spotted a serious error in the assumptions in the model, as a strongly seasonal nature of virus transmission. Due caution is strongly encouraged when looking at modelling outputs

One of the best examples of modelling failure is Sweden. In the below, the orange bar represents the age and gender-ad Sweden didn't institute a stringent lockdown similar to the UK. In the event, Sweden did not adopt such measures; mor and clearly not remotely close to the disaster predicted.

Sources:
https://www.medrxiv.org/content/10.1101/2020.04.11.20062133v1.full.pdf
(https://www.medrxiv.org/content/10.1101/2020.04.11.20062133v1.full.pdf)
https://www.statista.com/statistics/525353/sweden-number-of-deaths/
(https://www.statista.com/statistics/525353/sweden-number-of-deaths/)
https://www.statistikdatabasen.scb.se/pxweb/en/ssd/START___BE___BE0101___BE0101I/Dodstal/
(https://www.statistikdatabasen.scb.se/pxweb/en/ssd/START___BE___BE0101___BE0101I/Dodstal/)

What are the risks of *not* lifting lockdown?
The evidence is clear that the longer these restrictions are in place, the greater the threat to our economy, livelihoods, mental and physical health and our children's future. Some businesses will no doubt bounce back in time, many unemployed people will find work again, but the chances of a full recovery are diminishing by the day. Our top priority, as always, should be the wellbeing of our children. Experts are calling for urgent action (https://www.express.co.uk/news/uk/1397594/UK-children-Covid-lockdown-task-force-10-years-children-mental-health). We need to act now to safeguard the potential of our most vulnerable young people and ensure that continuing restrictions do not derail their path to a happy and successful future.

It appears we are already beyond the risk of overwhelming the NHS, which is great news. HART believes now is the time to lift restrictions as we aspire to a world where COVID-19 is treated like other seasonal respiratory viruses, as explained by pathologist Dr John Lee in this newspaper piece (https://www.dailymail.co.uk/debate/article-9267781/What-point-vaccine-triumph-doomed-endless-curbs-asks-Dr-JOHN-LEE.html).

12 February 2021

Welcome to our first bulletin. HART has come together as a group of UK independent senior scientists, professors and doctors, clinical psychologists, economists and other representatives of relevant disciplines, with many years of experience in the NHS, private practice and academia.

Our aim is to find the common ground between the Government and groups that are concerned about COVID-19 restrictions. We want to bring all sides together and to widen the debate in order to formulate an exit strategy that benefits everyone in society. We hope you find this bulletin useful. We intend to be topical and cover matters as they occur and evolve.

Cases are falling
New cases per day appear to be falling rapidly across large parts of the world, regardless of lockdown policy, extent of vaccination and geography. It is not clear what is driving this change.

We suggest devoting more resources to understand this complex phenomenon. It is important to be aware of the risk of incorrect attribution, such as assuming it is due to particular interventions.

Re-opening schools

In the UK, the timing of and required steps for re-opening of schools continues to generate much debate.The inability of children to attend schools exacerbates an already clear educational catastrophe for the young. It is important to note that primary schools in Sweden have never been closed and those in Denmark only briefly. All junior and the majority of secondary schools are now open across France.

The published evidence is quite clear and has been for some time. Public Health England have already said (https://www.thetimes.co.uk/article/coronavirus-primary-schools-safe-to-open-soon-m9gv7jrhs) that it is safe for primary schools to reopen. Children are not at elevated risk from attending school and teachers as a professional group are at the lowest risk end of the range compared with almost all other occupations. Please see our HART summary on harms to children (https://www.hartgroup.org/wp-content/uploads/2021/02/HART-Harms-to-children.pdf) for further information.

Non-pharmaceutical interventions (NPIs)

UK policy, while awaiting vaccine rollouts, has rested heavily on NPIs, despite the bulk of them lacking good quality evidence supporting their effectiveness.

It is perhaps not widely known that a number of these NPIs including lockdowns and border closures were, as recently as 2019, explicitly not recommended by the WHO (https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf).They were also advised against in the Government's pandemic plan (https://www.theguardian.com/world/ng-interactive/2020/feb/27/what-are-the-uks-plans-for-dealing-with-a-pandemic-virus), which was prepared in 2011 and reaffirmed in March 2020.

Exploring the utility of existing medicine

In addition to vaccines and NPIs, the potential of existing medicines, approved for a variety of other medical conditions, should be explored rigorously. It is very common that medicines have utility in multiple disorders. The UK has seen encouraging signs that glucocorticoids could be useful when treating severe disease and HART would encourage more research in this area. Evidence has strengthened that population-wide use of Vitamin D (4000 i.u daily) could reduce illness and deaths from COVID-19 (https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0011088); we hope trials will continue so opportunities for cost-effective treatments and preventions are not missed.

Meanwhile, it is clear that inhaled steroid (budesonide) (https://www.ox.ac.uk/news/2021-02-09-common-asthma-treatment-reduces-need-hospitalisation-covid-19-patients-study), in the same dose and form as used for decades to treat chronic asthma, has substantial utility.

There is also now gathering evidence for clinical utility (https://swprs.org/wp-content/uploads/2021/01/andrew_hill_ivermectin_slides_december_2020.pdf) of the off-patent anti-parasitic agent ivermectin, which has shown benefit both as a preventative treatment as well as in patients already unwell with COVID-19 (https://www.researchsquare.com/article/rs-148845/v1). This is an avenue worth pursuing.

Understanding immunity

This week, Health Secretary Matt Hancock announced mandatory quarantines for travellers returning to the UK from 'hotspot countries'. HART believes that these measures and that of closing international borders will not stop new 'foreign mutants' of the virus circulating in the UK and represents a misunderstanding of immunity. As Patrick Vallance said at the press conference on 10 February 2021: "We are seeing the same variants popping up all over the world and that is what you would expect."

SARS-CoV-2 is a very slowly mutating virus, compared with influenza for example, which completely changes its outer coat inside a year. This virus has altered, at most, 0.2% of itself in a year. You can read more in our briefing paper (https://www.hartgroup.org/wp-content/uploads/2021/02/HART-Mutants-and-Borders.pdf).