

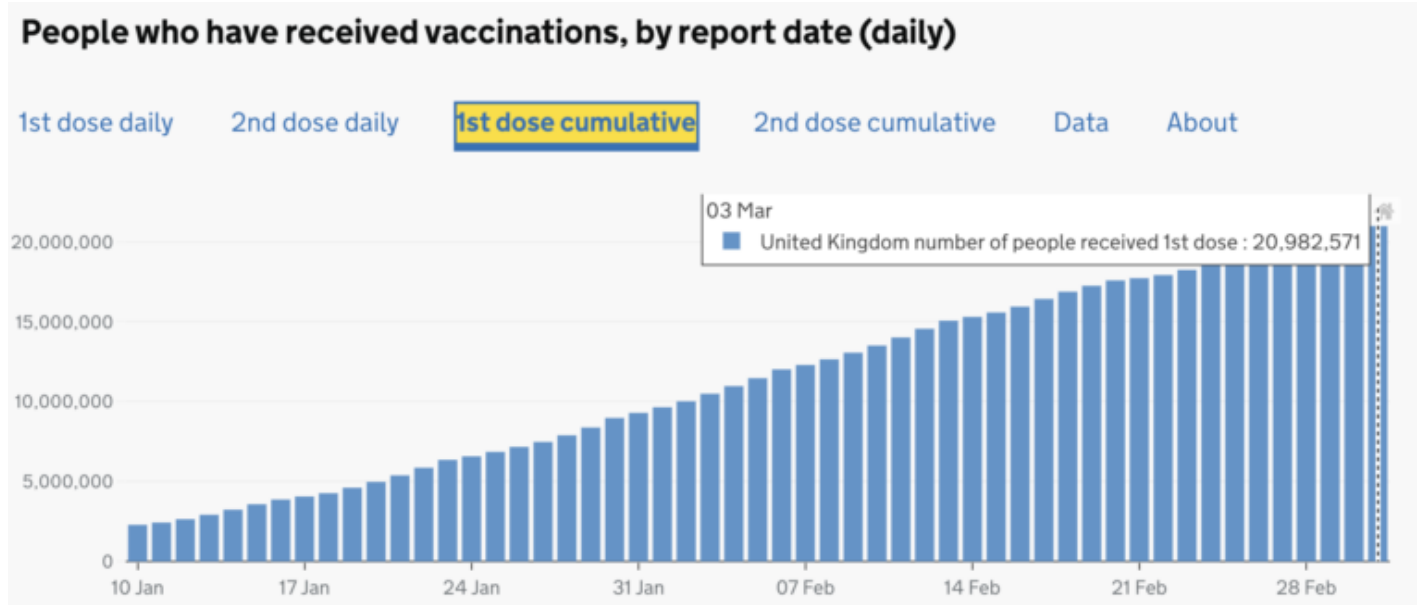
# COVID-19 Weekly Bulletin

5 March 2021

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## **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'

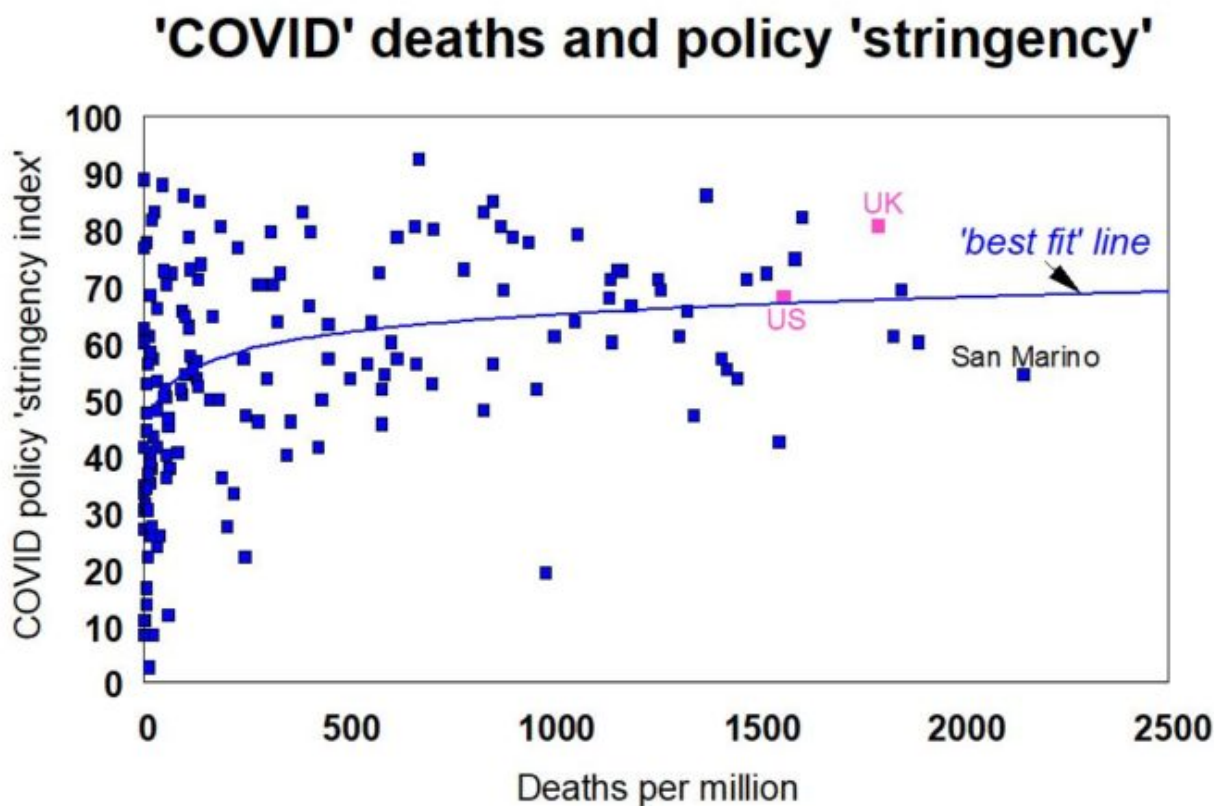
Vaccination proceeds at pace, with the UK the second most prolific vaccinator worldwide behind Israel. Over 20 million people have now had their first dose and everyone in the first four priority groups – those aged 70 and over, care home residents, healthcare workers and people required to shield – 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).



Stringency Index: <https://www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker>

'COVID' deaths: <https://www.worldometers.info/coronavirus/>

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\_UK MFA%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-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

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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](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\\_UK\\_MFA\\_Open\\_Letter\\_Face\\_Mask\\_Mandates.pdf](https://uploads-ssl.webflow.com/5fa5866942937a4d73918723/602e6afd2d5e00dbe4cfd228_UK_MFA_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](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\\_XqToapRIyxV2lsl8](https://pace.coe.int/en/files/29004/html?fbclid=IwAR1HrpB1giQFPm0mMsLcswGzeePH2AcHq6I4Ef6Chk_XqToapRIyxV2lsl8)) (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](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](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.

19 February 2021

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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](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.



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

### **Unemployment rises, GDP falls**

Devastating economic impacts are now manifest, with unemployment rising to a record 10.4% ([https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandunemployment/unemployment](https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandunemployment/employment/unemployment)) and GDP falling 2.1% in February (<https://www.ons.gov.uk/economy/grossdomesticproductgdp/bulletins/gdpmom>) compared to the EU average of 4.8% ([https://ec.europa.eu/eurostat/documents/portlet\\_file\\_entry](https://ec.europa.eu/eurostat/documents/portlet_file_entry)). These figures would point to the economic restrictions being untenable going forwards. Rising unemployment is a major concern for the NHS and all services.

It seems likely that the restrictions will result in large parts of the hospitality, travel and retail sectors being closed for years to come. (<https://www.ukhospitality.org.uk/page/EconomicContributionoftheUKHospitalitySector>) and (<https://www.ukhospitality.org.uk/news/551801/New-GDP-figures-highlight-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 anxiety. A recent journal-of-psychiatry/article/mental-health-and-wellbeing-during-the-covid-19-pandemic (https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-and-wellbeing-during-the-covid-19-pandemic) found that loneliness is a major problem, many for the first time. By winter, 1 in 4 young people felt unable to cope with depression (https://bmjopen.bmj.com/content/10/9/e040620) during the first lockdown (https://www.bbc.com/health/psychology/2020/12/loneliness-mental-health-covid-19-usual-during-the-pandemic). Loneliness is likely to have evoked mental defeat and despair. The evidence of the mental health costs of restrictions has emerged with reports of a sharp rise in disabling tic disorders in children (https://www.telegraph.co.uk/news/2020/12/15/children-tic-disorders-covid-19/).

Due to the psychological characteristics underpinning their difficulties, people are often fearful of contamination and the protection of others; panic attacks, often driven by recurring thoughts about the future. The psychological impact of constant testing is also something to be aware of.

## **COVID-19 in hospitals and care homes**

The low prevalence of the virus in the community and the increasing levels of immunity are making it difficult to manage the residual cases. When the R-value is estimated, it is not a quantity that justifies a dominant role, it now seems needlessly destructive to maintain restrictions in the long term.

It has been estimated that up to 40% of infections in the spring 2020 (https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/covid-19-deaths-in-spring-2020) were in care homes.

(https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/covid-19-deaths-in-spring-2020)

It has been estimated that, during the growth phase of an outbreak, the R number is around 1.5 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/534447/covid-19-estimating-r-number-15-202003.pdf). Yet decisions have been made to close schools based on a potential for a second wave (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/534447/covid-19-estimating-r-number-15-202003.pdf).

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

It is not necessary nor likely possible at an acceptable social or economic cost to eliminate the virus (https://inews.co.uk/news/politics/operation-moonshot-boris-johnson-mass-testing-covid-19-comes-to-dominate-the-results). At very low prevalence, with mass testing of those at risk, a strategy of 'unremarkable COVID-19' is in sight.

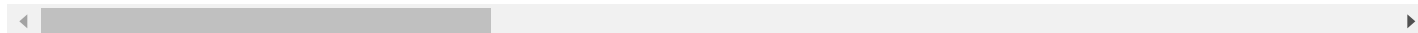
Given the backdrop of vaccines, natural immunity and novel, effective treatment options, a strategy of 'unremarkable COVID-19' is in sight. A solution and one which lines up with public health strategy on numerous other infectious diseases.

## **Computer modelling – handle with care**

In contemplating the consequences of emerging from lockdown, it is concerning that computer modelling (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/534447/covid-19-estimating-r-number-15-202003.pdf) is often used to justify continued restrictions.

([https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/91222/2022](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/91222/2022)). However, an undergraduate student of mathematics spotted a serious error in the model, which highlighted the strongly seasonal nature of virus transmission. Due caution is strongly encouraged.

One of the best examples of modelling failure is Sweden. In the below, the orange line shows the predicted number of deaths in Sweden. Sweden didn't institute a stringent lockdown similar to the UK. In the event, Sweden's actual number of deaths was clearly not remotely close to the disaster predicted.



### Sources:

<https://www.medrxiv.org/content/10.1101/2020.04.11.20062133v1.full.pdf>

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([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

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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.

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## **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](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>).



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