

THE COVID-19 “PANDEMIC”

An Independent Investigation

CHALLENGING THE NARRATIVE, RECLAIMING OUR FUTURE

By Andrew Johnson

(A concerned Citizen)

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TABLE OF CONTENTS

1. INTRODUCTION	3
1.1 COVID-19 Assumptions and Claims	3
2. CLAIMS, EVIDENCE AND ANALYSIS	4
2.1 Claim 1 – Novel Virus	4
2.2 Claim 2 – Deaths, Death Rates and Reporting	5
2.3 Deaths Incorrectly Attributed in the Media	8
2.4 Claim 3 - COVID-19 Infectiousness	9
2.5 Claim 4 – Virus is Dangerous/Can Be Fatal	10
3. THE PAST	11
3.1 The 2009 Swine Flu “Pandemic”	11
3.2 “Event 201” – 18 Oct 2019 (Note the Date Carefully!)	11
3.3 Dr Anthony Fauci Predicts the Future	12
3.4 Declaration of COVID-19 Pandemic	12
4. THE FUTURE	13
4.1 Lockdown Effects	13
4.2 Immunisation and Tracking	13
5. CONCLUSIONS	16
5.1 The Case for COVID-19	16
5.2 A Call For Reversal Of Measures	16
5.3 Who is Responsible for the Deception? Who is Accountable?	17
6. APPENDIX - FURTHER LINKS AND INFORMATION	18
6.1 Additional Quotes from Skeptical Doctors	18
6.2 Do the Mainstream Media Stories Make Sense?	18
6.3 Facts about COVID-19	19
6.4 What Really Makes You Ill?	19
6.5 References/Hyperlinks	20

About the Author

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1. Introduction

In this report, claims, assumptions, facts and evidence relating to the alleged COVID-19 Pandemic will be critically analysed and reviewed. The rationale for doing this is to illustrate that current measures are inappropriate – even illegal – and should be lifted immediately.

1.1 COVID-19 Assumptions and Claims

Now let us apply some logic to the current situation. The claim is that an assumed-to-be deadly infectious virus has spread across the world, from Wuhan, China and we need to take steps to stop the effects and prevent the spread of the disease.

1. It is alleged, a test can detect the infectious “novel virus” – COVID-19. This claim is based on the use of a “PCR test.”
2. This novel virus has killed tens of thousands of (or more) people worldwide.
3. The COVID-19 virus highly infectious.
4. The COVID-19 virus is therefore dangerous - even fatal - and so extreme measures must be taken to deal with the threat.

Logic dictates that if we were to call into question any or all of these claims, we must also call into question the claims of a pandemic. Further, if the pandemic claims are unfounded, governments must withdraw/reverse measures which are claimed to mitigate the effects or magnitude of the alleged pandemic.

Please now study carefully and objectively the evidence herein, without prejudice or assumption. Please do not make the simple mistake of starting with a question such as “What would be the motive for governments, officials or groups to mistakenly or falsely identify, promote or support claims of a pandemic if it was not real?” This report is not intended to establish motives for any actions – it is meant to illustrate and inform readers of facts and issues rarely or never discussed or shown by “mainstream” sources.

1.1.1 Keeping Up To Date

Please note, some parts of this report may become outdated quite quickly and as an independent researcher, working on a voluntary basis, I probably won't have time to update this report. I will be attempting to post updates and new information at www.cvpandemicinvestigation.com, as people from around the world send me links etc.

2. Claims, Evidence and Analysis

2.1 Claim 1 – Novel Virus

This claim is based on the results of one or more tests – and it seems that it is mainly the results of a PCR (Polymerase Chain Reaction) test that is being used to support this “Novel Virus” claim. In March 2020, this claim was called into question in a paper by [GH Zhuang](#)¹ et al (although this paper is listed as “withdrawn”). Additionally, the commonly used test for COVID-19 isn’t a “gold standard” – it is a surrogate test ([where an effect of the virus is tested for, not the virus itself](#)²). Further, the COVID-19 virus has never been purified and identified by itself and none of the tests appear to be very reliable. In a video of [Dr Wolfgang Wodarg](#)³, a German physician specializing in Pulmonology, he states:

“Politicians are being courted by scientists...scientists who want to be important to get money for their institutions. Scientists who just swim along in the mainstream and want their part of it [...] And what is missing right now is a rational way of looking at things. We should be asking questions like ‘How did you find out this virus was dangerous?’ ‘How was it before?’ ‘Didn’t we have the same thing last year?’ ‘Is it even something new?’”

Wodarg goes on to outline how the COVID-19 test was developed and compares that to similar tests.

(In 2009 Wodarg called for an inquiry into alleged conflicts of interest surrounding the EU response to the alleged Swine Flu pandemic – there is more information related to this later in this document.)

A [BBC story from 13 Feb 2020](#)⁴ raised concerns that the COVID-19 test generates too many negative results, not false positives – but the basic concern should be the accuracy of the test.

A [story from RT on 9 Apr 2020](#) also raises questions about the reliability of the test⁵. The headline reads “Unbeatable virus or false positive? Doctors alarmed after some COVID-19 patients test positive after recovering.”

If, as Dr Wodarg says, it is not really clear if this is a new Corona Virus and that the test was unreliable, it would explain the circumstances described in both these articles – i.e. the virus is not being correctly identified – and it can therefore be found in people who have never been to China or may never have had any contact with sources of infection - or, the reverse can be true and people who express symptoms test negative for COVID-19 and then health workers think they have misdiagnosed the patient!

(This then brings up an associated possibility in that diagnoses become so oriented towards COVID-19 that other more serious problems a patient has could be overlooked or missed.)

2.1.1 Implications of an Inaccurate Test that Gives Too Many False-Positives

If accurate identification and testing so difficult or questionable, how could any measures developed to deal with the virus be deemed appropriate, if it is not even known, reliably, whether it is a “Novel Virus”? What if, as some say, the truth is that *the majority of the people already have the corona virus in their system* ([as seems to be the case with some bacteria and viruses generally](#)). Doesn’t this then mean that the more that people are tested for COVID-19, the greater the number of “positive” results we will see? The “Pandemic” will then seem to be worse and worse and won’t the restrictions therefore increase or be kept in place for longer?

2.1.2 Symptoms

As is commonly stated, COVID-19 has [no particularly unusual symptoms](#)⁶ - just a high temperature and a persistent “dry cough” – so COVID-19 cannot be directly identified from its symptoms. Some people have (unsurprisingly) reported experiencing COVID-19 symptoms in the winter (2019)

months before the alleged outbreak - which is perfectly in line with the normal pattern of flu-like illnesses increasing in frequency during the winter and early spring months.

2.1.3 What if Nearly Everyone Already Has the Virus?

Dr Andy Kaufman, who is a psychiatrist with a B.S. (from M.I.T.) in Molecular Biology⁷, is one of several doctors who argues that the virus has been misidentified – which would also explain why the test is unreliable. In an online presentation he gave in late March 2020, Kaufman suggests that the virus may actually be an exosome⁸. Exosomes – which most people have in their bodies - are produced as a result of cellular damage⁹. Cellular damage can be caused by the ingestion of toxins, physical trauma and from other effects. If Kaufman is correct, then the implications for the detection of viruses are enormous.

2.2 Claim 2 – Deaths, Death Rates and Reporting

Since early 2020, it has often been claimed or implied that COVID-19 is killing and will kill lots of people – and that is one of the main reasons for imposing such severe measures. However, this claim can also be called into question by considering reported death numbers and how those deaths are classified.

2.2.1 Models and Projections

The UK government has based a lot of its decision-making on the models and estimates created by Imperial College London¹⁰. Any model or estimate is only as accurate as the data being used to create it. The data for these models is taken from the “European Centre of Disease Control”¹¹ which in turn takes its data from a number of different sources, but is based on causes of death noted on death certificates. We can also note that Imperial College has greatly reduced the initial estimations of deaths that would be caused by COVID-19 infection from 500,000 to 20,000¹².

In the next few sections, we will consider the recording of deaths and their causes.

2.2.2 COVID-19 Death Reports Reviewed in Italy

A Bloomberg Headline, dated 18 Mar 2020 reads¹³ “99% of Those Who Died From Virus Had Other Illness, Italy Says”

The Rome-based institute has examined medical records of about 18% of the country’s corona virus fatalities, finding that just three victims, or 0.8% of the total, had no previous pathology. Almost half of the victims suffered from at least three prior illnesses and about a fourth had either one or two previous conditions.

Similarly, a Daily Telegraph Article from 23 Mar 2020 reads¹⁴:

“The way in which we code deaths in our country is very generous in the sense that all the people who die in hospitals with the corona virus are deemed to be dying of the corona virus.”

2.2.3 UK Deaths in 2018, 2019 and Early 2020

Using data from the UK Office of National Statistics¹⁵, I have compiled the following table of the total deaths in England and Wales in the first 3 months of the years 2017, 2018, 2019 and 2020¹⁶.

2017	2018	2019	2020
153,538	164,238	143,283	154,190

These results, so far, do not strongly support the conclusion that COVID-19 is an epidemic/pandemic. It seems to be a similar story with death figures from other countries.

Claims, Evidence and Analysis

The image displays three screenshots of Excel spreadsheets, each showing a table of death statistics by area of usual residence for a specific year. The tables are structured as follows:

Area of usual residence	Jan-17	Feb-17	Mar-17
K04000001, J99000001 ENGLAND, WALES AND ELSEWHERE ¹	57,368	47,766	48,664
K04000001 ENGLAND AND WALES	57,266	47,695	48,577
Total	153,538		

Area of usual residence	Jan-18	Feb-18	Mar-18
K04000001, J99000001 ENGLAND, WALES AND ELSEWHERE ¹	64,154	49,177	51,229
K04000001 ENGLAND AND WALES	64,020	49,087	51,131
Total	164,238		

Area of usual residence	Jan-19 ³	Feb-19 ³	Mar-19 ³
K04000001, J99000001 ENGLAND, WALES AND ELSEWHERE ¹	53,910	45,796	43,946
K04000001 ENGLAND AND WALES	53,772	45,696	43,815
Total	143,283		

The fourth spreadsheet on the right shows a weekly breakdown of deaths, with a total of 154,190 deaths for a specific period.

2.2.4 Drs Lee and Wittkowski

These two Doctors are part of a larger group who don't agree with the "pandemic" label.

Dr John Lee is a recently retired professor of pathology and a former NHS consultant pathologist. In a "Spectator" article dated 28 Mar 2020 he writes¹⁷:

We have yet to see any statistical evidence for excess deaths, in any part of the world'.

Professor Knut Wittkowski of the Department of Biostatistics, Epidemiology, and Research Design at The Rockefeller University, New York was interviewed in a YouTube interview/video in Apr 2020, when he stated¹⁸:

There are no indications that this flu is fundamentally different from a regular flu – [it] may be one that is a bit worse than other flu's.

Knutt also argued, looking at, for example, South Korea, that Social Distancing made things worse¹⁹ – with new cases appearing over a longer period than where the social distancing did not take place. He also argues there can be no vaccine – because there is no vaccine for the common cold.

2.2.5 Changes in the Way Cause of Death is being Recorded - USA

We now have clear evidence from the USA that those recording deaths are encouraged to attribute them to COVID-19 infection. [From a CDC document](#)²⁰, in use in at least Minnesota (emphasis added):

*An accurate count of the number of deaths due to COVID–19 infection, which depends in part on proper death certification, is critical to ongoing public health surveillance and response. When a death is due to COVID–19, it is likely the UCOD and thus, it should be reported on the lowest line used in Part I of the death certificate. **Ideally, testing for COVID–19 should be conducted, but it is acceptable to report COVID–19 on a death certificate without this confirmation if the circumstances are compelling within a reasonable degree of certainty.***

2.2.6 UK Deaths Recording and Reporting

A UK Government document “Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales (For Use During The Emergency Period Only)” explains in section 4.1²¹(emphasis added) :

*“The MCCD is set out in two parts, in accordance with World Health Organisation (WHO) recommendations in the International Statistical Classification of Diseases and Related Health Problems (ICD). You are asked to start with the immediate, direct cause of death on line 1a, then to go back through the sequence of events or conditions that led to death on subsequent lines, until you reach the one that started the fatal sequence. **If the certificate has been completed properly, the condition on the lowest completed line of part I will have caused all of the conditions on the lines above it. This initiating condition, on the lowest line of part I will usually be selected as the underlying cause of death, following the ICD coding rules.** WHO defines the underlying cause of death as “a)the disease or injury which initiated the train of morbid events leading directly to death, or b) the circumstances of the accident or violence which produced the fatal injury”. From a public health point of view, preventing this first disease or injury will result in the greatest health gain.”*

They also state

“You should also enter any other diseases, injuries, conditions, or events that contributed to the death, but were not part of the direct sequence, in part two of the certificate. The conditions mentioned in part two must be known or suspected to have contributed to the death, not merely be other conditions which were present at the time.”

It then goes on to show some example death certificates with the first one being COVID-19 as the underlying cause as it is mentioned in the “lowest completed line”. So that particular example would be a death caused by COVID-19 and this would most likely be used in the COVID-19 death rate as per section 4.1

“Most routine mortality statistics are based on the underlying cause. Underlying cause statistics are widely used to determine priorities for health service and public health programmes and for resource allocation. Remember that the underlying cause may be a longstanding, chronic disease or disorder that predisposed the patient to later fatal complications.”

However a spreadsheet on ONS’s website states²² (emphasis added):

*Because of the corona virus (COVID-19) pandemic, our regular weekly deaths release now provides a separate breakdown of the numbers of deaths involving COVID-19. **That is, where COVID-19 or suspected COVID-19 was mentioned anywhere on the death certificate, including in combination with other health conditions.** Previously, the number of deaths with an underlying cause of respiratory disease was published a week behind the current week. These will now be published for the current week and revised the following week."*

We can also see a change in the way UK deaths are counted, thus:

From 31 March 2020 these figures also show the number of deaths involving corona virus (COVID-19), based on any mention of COVID-19 on the death certificate."

Further [information on a page "Deaths involving COVID-19, England and Wales: deaths occurring in March 2020"](#) on the ONS website is worth considering, when assessing the figures²³:

"Between 1 and 31 March 2020, there were 47,358 deaths that occurred in England and Wales and were registered by 6 April 2020. Of these, 8% involved the coronavirus (COVID-19) (3,912 deaths). The doctor certifying a death can list all causes in the chain of events that led to the death and pre-existing conditions that may have contributed to the death. Using this information, we determine an underlying cause of death. More information on this process can be found in our user guide. In the majority of cases (3,372 deaths, 86%) when COVID-19 was mentioned on the death certificate, it was found to be the underlying cause of death.

*Our definition of COVID-19 includes some cases where the certifying doctor **suspected** the death involved COVID-19 but was not certain, for example, because no test was done. Of the 3,372 deaths with an underlying cause of COVID-19, 38 (1%) were classified as "suspected" COVID-19. Looking at all mentions, "suspected" COVID-19 was recorded on 1% of all deaths involving COVID-19."*

In section 6 they state the following (bold parts emphasised added):

"Of the 3,912 deaths that occurred in March 2020 involving COVID-19, 3,563 (91%) had at least one pre-existing condition, while 349 (9%) had none. The mean number of pre-existing conditions was 2.7.

*The most common main pre-existing condition was **ischaemic heart diseases, with 541 deaths (14% of all deaths involving COVID-19). This may in part explain the decrease in deaths resulting from ischaemic heart diseases in March 2020, but this requires further analysis.** Pneumonia, dementia and chronic obstructive pulmonary disease (COPD) were all in the top five most common pre-existing conditions."*

In the final emboldened sentence above, it seems the ONS has acknowledged the anomalies in the data that question the validity of COVID-19 as the underlying cause.

It is likely, then, that from April 2020, deaths alleged to be caused by COVID-19 could rise substantially, but closer attention should be paid to the *total* number of mortalities compared to previous years.

2.3 Deaths Incorrectly Attributed in the Media

We can also highlight two cases of death wrongly attributed (by mainstream sources) to COVID-19 – those of 21-year old [Chloe Middleton](#)²⁴ (who died of a heart attack) and 45-year old [Craig Ruston, who had Motor Neurone Disease](#). He was also reported as COVID-19 death by the UK Daily Express.²⁵

2.3.1 Hospitals Not Overwhelmed

I have received reports from about 5 different people (and seen twice as many online videos) of [non-busy hospitals around the world](#)²⁶ – with all but urgent cases turned away.

Operations have been cancelled or delayed, so is it any wonder that ICU's are overwhelmed with people who have fallen ill at home and have received no care?

What is having an effect, and against which measures need to be taken, are the “lockdown measures” – which will cause stress, anxiety and resulting physical and mental illnesses. How many more people are either dying or become severely ill at home or and then “filling up” ICU wards? (It would be very difficult indeed to measure this figure.)

2.4 Claim 3 - COVID-19 Infectiousness

In most cases, when people have shown symptoms or “tested positive” for a particular bug/illness, it is *then* that they are put into isolation. However, with the current alleged pandemic, this situation is reversed! That is, people have been instructed to “self- isolate” even they have not shown any symptoms of the illness!

Another significant contradiction has arisen in March 2020 with statements by [Dr Michael Ryan Executive, Director, WHO Health Emergencies Programme](#)²⁷, [apparently discussing the situation in India](#)²⁸:

“Most of the transmission that’s actually happening in many countries now is happening in the household at family level. In some senses, transmission has been taken off the streets and pushed back into family units. Now we need to go and look in families to find those people who may be sick and remove them and isolate them in a safe and dignified manner.”

So, should we self-isolate, or not? In a similar vein, 2 papers [[1](#)²⁹][[2](#)³⁰] I identified relating to the effectiveness of social distancing are both based on numerical modelling, not “real world data”. Also, what Dr Ryan proposes would be a contravention of human rights.

Since February 2020, worrying developments have been reported in relation to proposed [UK legislation such as on the House of Lords Library website](#)³¹:

*The Government has introduced emergency regulations to prevent the further spread of corona virus. The Health Protection (Corona virus) Regulations 2020 were laid before Parliament on 10 February 2020. They give health professionals the power to detain patients with COVID-19 for the specific purposes of screening and assessment, or to isolate them for a period of time. **The regulations also empower police constables to detain people suspected of having the virus. The Government has stated that the regulations are intended to apply to people who attempt to “leave supported isolation before the current quarantine period of 14 days is complete”.***

A [WHO report about COVID-19 “Modes of transmission” dated](#)³² 29 Mar 2020 concludes:

It is important to note that the detection of RNA in environmental samples based on PCR-based assays is not indicative of viable virus that could be transmissible. Further studies are needed to determine whether it is possible to detect COVID-19 virus in air samples from patient rooms where no procedures or support treatments that generate aerosols are ongoing. As evidence emerges, it is important to know whether viable virus is found and what role it may play in transmission.

This means that even one of the WHO's own reports does not clearly state that COVID-19 can be transmitted in a manner which would be positively or negatively influenced by “Social Distancing.”

2.4.1 Further Contradictory Advice

The [UK Government has stated people should self-isolate and stay indoors](#)³³ – yet they are encouraged to “go outside” at suggested times and “[clap and cheer](#)” in support of the NHS and their [staff](#)³⁴, which then goes against the government's own recommendations. The “cheering for health workers” suggestion/recommendation is one which has [been disseminated in other places e.g. India, Spain and Italy](#)³⁵.

2.4.2 Police not worried about “Spreading the Virus”

In a [letter I wrote to Derbyshire Police on 28 Mar 2020](#)³⁶, I pointed out that officers/staff operating drones to check on walkers in the Derbyshire Peak District didn't seem to be worried about “spreading the virus.” Also, a [report I received from a man in Scotland](#)³⁷, who was stopped and fined for being outside “without good reason” showed that officers/staff seemed unconcerned “about spreading the virus.” [A number of videos have been posted on YouTube and elsewhere showing similar scenarios](#)³⁸, [where police seem to be acting against the government's own advice!](#)

2.4.3 Other Countries not in “Lockdown”

It can also be noted that countries such as [Japan](#)³⁹ and [Sweden](#)⁴⁰ have no “lockdown” measures, yet it can be argued they don't have a significantly worse “COVID-19 problem.”

2.5 Claim 4 – Virus is Dangerous/Can Be Fatal

This claim can also be called into question – even based on a 19 Mar 2020 posting on [Gov.UK](#)⁴¹, [which reads as follows](#):

As of 19 March 2020, COVID-19 is no longer considered to be a high consequence infectious diseases (HCID) in the UK. Now that more is known about COVID-19, the public health bodies in the UK have reviewed the most up to date information about COVID-19 against the UK HCID criteria. They have determined that several features have now changed; in particular, more information is available about mortality rates (low overall), and there is now greater clinical awareness and a specific and sensitive laboratory test, the availability of which continues to increase.
The Advisory Committee on Dangerous Pathogens (ACDP) is also of the opinion that COVID-19 should no longer be classified as an HCID.

The fact that Dr. Anthony Fauci, a “pandemic advisor” to the US Trump Administration has been quoted, in an article/paper in [“The New England Journal of Medicine” \(re-published 26 Mar\)](#)⁴²:

*“If one assumes that the number of asymptomatic or minimally symptomatic cases is several times as high as the number of reported cases, the case fatality rate may be considerably less than 1%. This suggests that the overall clinical consequences of COVID-19 **may ultimately be more akin to those of a severe seasonal influenza** (which has a case fatality rate of approximately 0.1%) or a pandemic influenza (similar to those in 1957 and 1968)...”*

Of course those “pandemic influenza seasons” of 1957 and 1968 did NOT result in any lockdowns or similar reactions or anything approaching a mass hysteria, for example.

In the UK, both [Prince Charles \(Windsor or Sax-Coburg\)](#)⁴³ - himself now in the “vulnerable” over 70's age group - and [UK Prime Minister Boris Johnson](#)⁴⁴ have recovered from their COVID-19 infections. Johnson did not have a lengthy stay in hospital, was never on a ventilator and [is reported to have gone to his residence, not into isolation](#)⁴⁵. While on the subject of politicians, we can note that [Scottish Health Chief Catherine Calderwood, decided to travel to her holiday home and not stay in “self-isolation” in early April 2020](#)⁴⁶.

Another high-profile “victim,” Hollywood Actor [Tom Hanks](#)⁴⁷ was “not even sick”. In a [14 Mar 2020 Daily Mail story, Arsenal football boss, Mikel Arteta](#)⁴⁸, who self-isolated after testing positive for COVID-19 was described by his wife thus: “Some temperatures, some headaches but that's it. That's his experience. My kids and I are perfectly well.” His symptoms were therefore no different to ordinary flu.

Other media reports claim some celebrities have died, but these accounts would need studying more closely to find out if, as with cases mentioned earlier in this report, the victims had other health issues.

3. The Past

In the 1980s, claims were made that AIDS would decimate the population - this never happened. Between 2002 and 2004, governments/health agencies claimed that the SARS virus posed a significant threat to public health. This threat never materialised. In 2006, similar claims were made about the H5N1 virus – Bird Flu – which also had no significant or lasting effect on the general population.

3.1 The 2009 Swine Flu “Pandemic”

In early 2009, it was alleged the UK was – or would be – in the grip of a Swine Flu Pandemic. At the time, I was not convinced of the claims being made and carried out a similar process of research and investigation to the one included in this report. [I wrote to the UK Department of Health in August 2009 and they couldn’t satisfactorily answer a number of the questions I asked them](#)⁴⁹. Of course, there was no obvious “mass death outbreak” during that pandemic either, as the [figures on the ONS site clearly show](#)⁵⁰. (Negative figures show when 2009 deaths were fewer than in 2008 or 2010.)

ENGLAND & WALES	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2008	51,951	42,257	41,928	45,929	39,134	37,741	39,961	34,878	39,095	42,061	39,406	53,488	507,829
2009	54,938	41,348	42,302	40,209	36,500	38,755	37,877	33,516	39,013	40,090	40,030	45,669	490,247
2010	48,269	40,984	45,071	40,507	36,439	40,080	36,799	35,979	39,317	38,540	42,038	48,191	492,214
’09 – ’08	2,987	-909	374	-5,720	-2,634	1,014	-2,084	-1,362	-82	-1,971	624	-7,819	-17,582
’09 – ’10	6,669	364	-2,769	-298	61	-1,325	1,078	-2,463	-304	1,550	-2,008	-2,522	-1,967

Neither the yearly nor monthly figure comparisons shown above seem consistent with claims of a Swine Flu pandemic having been in progress during 2009 as fewer people actually died in 2009 than in 2008 and 2010!

3.2 “Event 201” – 18 Oct 2019 (Note the Date Carefully!)

It is easy to find information about a [“Pandemic tabletop exercise hosted by The Johns Hopkins Center for Health Security](#)⁵¹ in partnership with the World Economic Forum and the [Bill and Melinda Gates Foundation](#) on [October 18, 2019](#), in New York, NY.” [This related to “Corona Virus.”](#)⁵²

[In the introduction of the video “highlights”](#)⁵³ of the event, posted on Nov 4, 2019 we can hear the following words:

It began in healthy looking pigs, months perhaps years ago - a new corona virus, spread silently within herds. Gradually, farmers started getting sick. Infected people got a respiratory illness with symptoms ranging from mild flu-like signs to severe pneumonia. The sickest required intensive care, many died. Experts agree unless it is quickly controlled, it could lead to a severe pandemic - an outbreak that circles the globe and affects people everywhere.

[On their website](#)⁵⁴, we can read:

*About the Event 201 exercise
Event 201 was a 3.5-hour pandemic tabletop exercise that simulated a series of dramatic, scenario-based facilitated discussions, confronting difficult, true-to-life dilemmas associated with response to a hypothetical, but scientifically plausible, pandemic. 15 global business, government, and public health leaders were players in the simulation exercise that highlighted unresolved real-world policy and economic issues that could be solved with sufficient political will, financial investment, and attention now and in the future.*

The exercise consisted of pre-recorded news broadcasts, live “staff” briefings, and moderated discussions on specific topics. These issues were carefully designed in a compelling narrative that educated the participants and the audience.

About 6 weeks later, in early December 2019, the first COVID-19 case was allegedly diagnosed in the polluted city of Wuhan, China⁵⁵.

3.3 Dr Anthony Fauci Predicts the Future

Dr Anthony Fauci (mentioned earlier in this report), is the U.S. government’s “pandemic advisor” and head of the National Institute of Allergy and Infectious Diseases (NIAID). In a speech titled “Pandemic Preparedness in the Next Administration” at Georgetown University Medical Center⁵⁶, delivered just days before Trump was inaugurated on Jan. 20, 2017, Fauci stated:

*“There is **no question** that there will be a challenge to the coming administration in the arena of infectious diseases,”*



A number of people have noted Fauci’s connection to the afore-mentioned Bill and Melinda Gates Foundation,⁵⁷ which contributes funds to many health-related organisations, such as WHO,⁵⁸ CDC⁵⁹ and the NIH⁶⁰.

3.4 Declaration of COVID-19 Pandemic

In 2005, an unelected group of World Health Organisation (WHO) officials produced a document containing guidelines for signatory states entitled “WHO checklist for influenza pandemic preparedness planning”⁶¹ (Ref: WHO/CDS/CSR/GIP/2005.4) In Section 1.5, we find

*During a pandemic, it may be necessary to **overrule existing legislation or (individual) human rights. Examples are the enforcement of quarantine** (overruling individual freedom of movement), use of privately owned buildings for hospitals, off-license use of drugs, compulsory vaccination or implementation of emergency shifts in essential services. These decisions need a legal framework to ensure transparent assessment and justification of the measures that are being considered, and to ensure coherence with international legislation (International Health Regulations).”*

WHO chief Tedros Adhanom declared the COVID-19 Pandemic on 11 Mar 2020⁶². Yet Adhanom does not have a medical degree⁶³ and was strongly connected to cases of Human Rights abuses in his home country of Ethiopia⁶⁴. From an article on “The Burning Platform” website, we can find that:

The head of the WHO was the 3rd most powerful person in the TPLF, a Communist Revolutionary Party in Ethiopia that was listed as a terrorist organization in the 90s and, as a political arm of a minority ethnic group (6%), reportedly conducted systematic discrimination and human rights abuses against the majority ethnic group.

Dr Tedros Adhanom also appointed Robert Mugabe (another leader charged with many human rights abuses) as a WHO “Goodwill Ambassador” in 2017.⁶⁵

4. The Future

4.1 Lockdown Effects

4.1.1 Health Effects and Resulting Deaths From “Lockdown” Measures

We have already mentioned the effects of the lockdown on things like cancelled operations, but there are many less obvious effects which could cause substantial problems for mental health (even resulting in suicide), health treatments being suspended or limited (resulting in existing health conditions in some people worsening unnecessarily).

4.1.2 Economic Effects of “Lockdown”

We have already seen substantial effects on the British and Global economy due to lockdown measures – closed and bankrupted businesses, unemployment, shortage of supplies. It is difficult to predict what overall health impacts these, in turn, will create – but it’s likely they will be far more negative than positive.

4.2 Immunisation and Tracking

4.2.1 Vaccinations?

Now that the image (illusion?) of a global pandemic has been successfully created in the minds of many millions, the proposed solution to this is the development of a vaccine. One of the proponents of this solution is Bill Gates. In relation to this, Gates gave an interview on [BBC TV \(UK\) on 12 Apr 2020](#)⁶⁶. (Gates gave similar interviews on other channels around the world). **Remember, when reading the following that Mr Gates is co-founder of Microsoft and he has no medical qualifications – he is a billionaire who has made his fortune, primarily from sales of his company’s software and digital services.** The interviewer asked about the Vaccine development timescale (time code 7:50) and in response, Gates states:

*People like myself and **Tony Fauci** are saying 18 months. If everything went perfectly, we can do slightly better than that – but there will be a trade-off. **We’ll have less safety testing than we typically would have, so governments will have to decide - do they indemnify the companies and really say “let’s go out with this” when we just don’t have the time to do what we normally do.***

It is interesting to note, then, that Mr Gates does acknowledge vaccine safety problems, and talks about governments indemnifying the companies that make them. This issue will be briefly revisited in the next section.

At 11:10, Gates seems to reveal it’s just another business plan rather than an altruistic venture, to “save the planet from a deadly virus”:

You have to charge mostly a break-even price for things that are... helping out with a global crisis like this.

At 15:54 in the BBC interview, Gates suggests that *very large numbers* of people should be vaccinated and that people’s freedom of movement and gathering should be restricted until this has been done:

*Once you have a safe and effective vaccine and get that out to **almost all of the people on the planet** and build the preparatory systems for the next pandemic so you can nip it in the bud. We will go back to normal - and economies will recover but we have multiple stages to go through in terms of... until we have that, you know, how much can we open up... how do we*

The Future

help the developing countries, but the economy eventually will go back to where it was and innovation will help us not be at such a risk in the years after that...

His words also suggest this should then become a routine way of dealing with future pandemics.

4.2.2 ID2020

On a related issue, [on a Biotechnology Website \(Biohack.info\)](#), we can find a 19 Mar 2020 article titled [“Bill Gates will use microchip implants to fight corona virus.”](#)⁶⁷ The article states:

Microsoft co-founder Bill Gates will launch human-implantable capsules that have ‘digital certificates’ which can show who has been tested for the corona virus and who has been vaccinated against it.

The article suggests that “quantum dot tattoos” could be used. Later, in the article we can read:

The quantum-dot tattoos will likely be supplemented with Bill Gates’ other undertaking called ID2020, which is an ambitious project by Microsoft to solve the problem of over 1 billion people who live without an officially recognized identity. ID2020 is solving this through digital identity.

The article then notes:

As for ID2020, to see it through, Microsoft has formed an alliance with four other companies, namely; Accenture, IDEO, Gavi, and the Rockefeller Foundation. The project is supported by the United Nations and has been incorporated into the UN’s Sustainable Development Goals initiative.

4.2.3 Vaccine Safety and “Anti-Vaxers”

Whilst a detailed discussion of vaccination issues is beyond the scope of this report, it is worth noting the increasing likelihood of online censorship when questioning the safety or efficacy of vaccinations in general. For example, video sharing platform “Vimeo” writes into its guidelines that it will not allow [“...videos that make false or misleading claims about vaccination safety or claim that mass tragedies are hoaxes.”](#)⁶⁸

Some posters raising vaccine safety issues have also been censored or “shadow-banned” on [Facebook](#)⁶⁹.

It was also interesting to hear Boris Johnson’s views on the matter, when [he singled out “anti-vaxers” as being “anti-science” in his 24 Sep 2019 UN Address, thus](#)⁷⁰:

And there are today people today who are actually still anti-science. A whole movement called the anti-Vaxxers, who refuse to acknowledge the evidence that vaccinations have eradicated smallpox and who by their prejudices are actually endangering the very children they want to protect and I totally reject this anti-scientific pessimism.

In [1976 – the USA was told of a severe threat of swine flu infection and a vaccine campaign followed](#)⁷¹. Within a few months, claims totalling \$1.3 billion had been filed by victims who had suffered paralysis from the vaccine. The vaccine was also blamed for 25 deaths.

As mentioned earlier in this report, in 2009, I wrote to the UK Department of Health and asked about the Swine Flu issue – and the vaccine which had then been purchased by the Government. I asked:

Are drug companies in the UK immune (no pun intended) from prosecution by those people that experience any serious or debilitating side effects after having the vaccine? (As happened in 1976.)

They replied:

The Government signed the advance purchase agreements for the vaccines in June 2007 and accepted liability for their safety as a contingency. All governments signing up to an advance purchase agreement were expected to provide an indemnity for the vaccine, and neither manufacturer would sign the contracts without it. The Government's decision was based on the best procurement and legal advice. Accepting liability in this way is in line with Government accounting rules, and was cleared by the Public Accounts Committee at the time .

4.2.4 Vaccine Impact Modelling Group

Prof Neil Ferguson has been involved with generating projected figures of COVID-19 infection and mortality. [Ferguson is on the management team of the “Vaccine Impact Modelling Consortium.”](#) This group is overseen or even funded by the BMGF – The Bill and Melinda Gates Foundation⁷².

In the normal course of things, where experts are advising government on matters, conflicts of interest are meant to be disclosed. Gates has implied in a BBC interview that he treats mass vaccination, and possibly tracking to whom these vaccinations have been administered, as a “business interest.” It appears Professor Ferguson is also involved in this “interest.” I am therefore pointing this out as a possible serious “conflict of interest.” Further issues relating to conflicts of interest in relation to vaccination programmes and COVID-19 response plans were [discussed by Vanessa Beeley, Brian Gerrish and Mike Robinson in a 15 Apr 2020 independent “UK Column” news broadcast.](#)⁷³



© <https://www.imperial.ac.uk/people/neil.ferguson>

4.2.5 SAGE and Whitty – A Further Conflict of Interest?

[Prof. Chris Whitty is the UK’s Chief Medical Officer](#)⁷⁴ and a 4 Mar 2020 Guardian article titled [“Prof Chris Whitty: the expert we need in the corona virus crisis”](#)⁷⁵ reports:

In 2008, he was awarded \$40m (£31m) by the Bill and Melinda Gates Foundation for malaria research in Africa. A year later, Whitty, a doctor and epidemiologist (a scientist who studies the pattern of diseases), was appointed chief scientific adviser to the Department for International Development (DfID).



[Prof Whitty is also part of the UK’s SAGE \(Scientific Advisory Group for Emergencies\) Committee](#)⁷⁶ which has made recommendations about the duration of the UK’s “COVID-19” lockdown.

4.2.6 Vaccinations and Human Rights

“Noises” are now being made in various places about [mandatory vaccinations](#)⁷⁷ to deal with the COVID-19 (or future) similar “threats,” however, it should be noted that this would be a fundamental breach of human rights (as would some type of “implanted chip” to enable some type of tracking). It should be noted that mandatory vaccination would be in direct violation of The Nuremberg Code and a violation of article 6 of the [UNESCO 2005 Statement On Bioethics And Human Rights](#)⁷⁸.

Limiting peoples’ freedom to work, travel or access services based on some kind of [“immunity passport”](#)⁷⁹ has all kinds of Human Rights related implications - especially for those who don’t agree that vaccines are a safe or effective way of dealing with infectious diseases. For example, a friend of mine has stated that he would reject a vaccination and if this prevented him from travelling between two European countries, it would mean he would not be able to see his wife again. Just imagine, for a few minutes, other similar scenarios.

5. Conclusions

5.1 The Case for COVID-19

In this report, I have attempted to show evidence or point out that:

- The COVID-19 test is not reliable enough
- The COVID-19 virus is no more infectious or dangerous than other similar viruses
- Excess mortality rates for COVID-19 are low – or even non-existent
- Government/WHO advice is irrelevant, contradictory and in any case is not being consistently applied by the authorities themselves.
- Some group, which includes Bill Gates and his foundation appeared to have foreknowledge that a Pandemic would be declared.
- The same group appears to have some kind of “business interest” in a global vaccination programme which could be coupled with some kind of “biometric immunity passport” which may be used to dictate an individual’s freedom of travel and association.

If this does not cause whoever is reading this to consider deeper/wider investigation of the facts and evidence covered here, then the consequences for all of us could be extremely serious – not because of an exaggerated or even non-existent viral threat, but because of the “pandemic measures” so rapidly put into place by so many in authority, without the stories, accounts, backgrounds and history being studied carefully first.

Please note that any reported changes in number of deaths per week/month alleged to be from COVID-19 do not change the past, prior to the alleged outbreak of the virus. Nor do any changes in how those deaths are being recorded (as shown in the documentation linked in this report) change the historical facts presented earlier in this report.

5.1.1 Further Consideration

One can easily surmise that the virus story is a “smoke screen” and the measures have been put in place for other reasons – probably to do with the manipulation or control of the global financial system. Therefore, moving forward, readers might also consider research and investigation of these areas.

5.1.2 Protests and Response to Them?

[In some parts of the world, we are now seeing a few protests against lockdown measures](#)⁸⁰. This is not surprising due to the effects the measures (not the virus) are having on people and their livelihoods and wellbeing. It is my understanding that in the [UK, the Army are already on “standby” to “help out the NHS” if “things get bad.”](#)⁸¹ I therefore hope that this is the only way they are employed to “help.” As we have now demonstrated, the virus isn’t a real threat, so I hope the Army can be sent back to wherever they were before and carry on as they were doing – because they have no place on our streets.

5.2 A Call For Reversal Of Measures

The current measures contravene the basic human rights of freedom of movement and association. Having presented this evidence, analysis and information to you, I call for **all measures restricting the freedom of individuals in the UK (and elsewhere) immediately to be lifted and a restoration of “normal life” should take place soon after – not just in the UK, but globally. Any related legislation that has been put in place must also be repealed or reversed immediately.**

5.3 Who is Responsible for the Deception? Who is Accountable?

Whilst certain names have been mentioned in this report, it is not entirely clear what their role in the COVID-19 deception is motivated by or how it has all been coordinated. Clearly, it is a deception that has been carried off on a global scale – and so we must look to groups or organizations that have global influence if we want to find out how to protect ourselves and/or hold them accountable. Whether they could be held accountable depends on how many good, honest people are able to stand up to them. At this point, I am not optimistic in this area.

Once you have verified and understood the evidence in this report (and elsewhere), it is your duty as an honest, informed individual to prevent further removal of basic human rights, which has happened under the guise of the various world governments allegedly protecting their citizens against an unproven or invented threat.

This report (which may be updated) can be downloaded free from: www.cvpandemicinvestigation.com

6. APPENDIX - Further Links and Information

6.1 Additional Quotes from Skeptical Doctors

These paragraphs can be found in several places online, for example on [“The Burning Platform.”](#)⁸²

Dr Sucharit Bhakdi is a specialist in microbiology. He was a professor at the Johannes Gutenberg University in Mainz and head of the Institute for Medical Microbiology and Hygiene and one of the most cited research scientists in German history. On [Peter Hitchens' Blog](#)⁸³, he is quoted thus:

“We are afraid that 1 million infections with the new virus will lead to 30 deaths per day over the next 100 days. But we do not realize that 20, 30, 40 or 100 patients positive for normal Corona viruses are already dying every day. [The government's anti-COVID-19 measures] are grotesque, absurd and very dangerous [...] The life expectancy of millions is being shortened. The horrifying impact on the world economy threatens the existence of countless people. The consequences on medical care are profound. Already services to patients in need are reduced, operations canceled, practices empty, hospital personnel dwindling. All this will impact profoundly on our whole society. All these measures are leading to self-destruction and collective suicide based on nothing but a spook.”

Dr Peter Goetsche is Professor of Clinical Research Design and Analysis at the University of Copenhagen and founder of the Cochrane Medical Collaboration. He has written several books on corruption in the field of medicine and the power of big pharmaceutical companies.

“Our main problem is that no one will ever get in trouble for measures that are too draconian. They will only get in trouble if they do too little. So, our politicians and those working with public health do much more than they should do. No such draconian measures were applied during the 2009 influenza pandemic, and they obviously cannot be applied every winter, which is all year round, as it is always winter somewhere. We cannot close down the whole world permanently. Should it turn out that the epidemic wanes before long, there will be a queue of people wanting to take credit for this. And we can be damned sure draconian measures will be applied again next time. But remember the joke about tigers. “Why do you blow the horn?” “To keep the tigers away.” “But there are no tigers here.” “There you see!” “Corona: an epidemic of mass panic”, blog post on Deadly Medicines 21st March 2020

Dr John Ioannidis Professor of Medicine, of Health Research and Policy and of Biomedical Data Science, at Stanford University School of Medicine and a Professor of Statistics at Stanford University School of Humanities and Sciences. He is director of the Stanford Prevention Research Center, and co-director of the Meta-Research Innovation Center at Stanford (METRICS). He is also the editor-in-chief of the European Journal of Clinical Investigation. He was chairman at the Department of Hygiene and Epidemiology, University of Ioannina School of Medicine as well as adjunct professor at Tufts University School of Medicine. As a physician, scientist and author he has made contributions to evidence-based medicine, epidemiology, data science and clinical research. In addition, he pioneered the field of meta-research. He has shown that much of the published research does not meet good scientific standards of evidence.

“If we had not known about a new virus out there, and had not checked individuals with PCR tests, the number of total deaths due to ‘influenza-like illness’ would not seem unusual this year. At most, we might have casually noted that flu this season seems to be a bit worse than average.”

6.2 Do the Mainstream Media Stories Make Sense?

In the UK, stories in the Daily Mail have recently suggested that to [deal with the virus, “low level” prisoners should be released](#)⁸⁴. However new measures suggest that people should be put in prison or fined for breaking/going against guidelines about self-isolation. Does this make sense?

A story in the UK Daily Express (Mar 15, 2020) reads that "ISIS warns its terrorists to AVOID Europe over corona virus fears as infection spreads."⁸⁵ The obvious question to me is why would hard line terrorists be worried about a flu bug that doesn't seem to be a problem for younger, healthier people. Surely, with some cities almost devoid of people, it would be an ideal opportunity for certain clandestine activities...?

6.3 Facts about COVID-19

Below is a small selection from the "Swiss Propaganda Research" Website⁸⁶.

1. According to data from the best-studied countries such as South Korea⁸⁷, Iceland⁸⁸, Germany⁸⁹ and Denmark⁹⁰, the overall lethality of COVID-19 is in the lower *per mille* range and thus up to twenty times lower than initially assumed by the WHO.
2. A study in Nature Medicine comes to a similar conclusion⁹¹ even for the Chinese city of Wuhan. The initially significantly higher values for Wuhan were obtained because a many people with mild or no symptoms were not recorded.
3. 50% to 80% of test-positive individuals remain symptom-free⁹². Even among the 70 to 79 year old persons about 60%⁹³ remain symptom-free, many more show only mild symptoms.
4. The median age of the deceased in most countries (including Italy⁹⁴) is over 80 years and only about 1%⁹⁵ of the deceased had no serious previous illnesses. The age and risk profile of deaths thus essentially corresponds to normal mortality⁹⁶.
5. Many media reports of young and healthy people dying from COVID-19 have proven to be false upon closer inspection. Many of these people either did not die from COVID-19 or they in fact had serious preconditions⁹⁷ (such as undiagnosed leukaemia).

6.4 What Really Makes You Ill?

A recent comprehensive and lengthy book⁹⁸, the result of 10 years work by independent researchers David Parker and Dawn Lester re-examines the causes of illness and considers a wide array of evidence. The synopsis is included below:

"Doctors are men who prescribe medicines of which they know little, to cure diseases of which they know less, in human beings of whom they know nothing." Voltaire. The conventional approach adopted by most healthcare systems entails the use of 'medicine' to treat human disease. The idea encapsulated by the above quote attributed to Voltaire, the nom de plume of François-Marie Arouet (1694-1778), will no doubt be regarded by most people as inapplicable to 21st century healthcare, especially the system known as modern medicine. The reason that people would consider this idea to no longer be relevant is likely to be based on the assumption that 'medical science' has made significant advances since the 18th century and that 21st century doctors therefore possess a thorough, if not quite complete, knowledge of medicines, diseases and the human body. Unfortunately, however, this would be a mistaken assumption; as this book will demonstrate.

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