Excess Deaths in the United Kingdom: Midazolam and Euthanasia in the COVID-19 Pandemic

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Excess Deaths in the United Kingdom: Midazolam and Euthanasia in the COVID-19 Pandemic

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Abstract

Macro-data during the COVID-19 pandemic in the United Kingdom (UK) are shown to have significant data anomalies and inconsistencies with existing explanations. This paper shows that the UK spike in deaths, wrongly attributed to COVID-19 in April 2020, was not due to SARS-CoV-2 virus, which was largely absent, but was due to the widespread use of Midazolam injections which were statistically very highly correlated (coefficient over 90 percent) with excess deaths in all regions of England during 2020. Importantly, excess deaths remained elevated following mass vaccination in 2021, but were statistically uncorrelated to COVID vaccination, while remaining significantly correlated to Midazolam injections. The widespread and persistent use of Midazolam in UK suggests a possible policy of systemic euthanasia. Unlike Australia, where assessing the statistical impact of COVID vaccination on excess deaths is relatively straightforward, UK excess deaths were closely associated with the use of Midazolam and other medical intervention. The iatrogenic pandemic in the UK was caused by euthanasia deaths from Midazolam and also, likely caused by COVID vaccination, but their relative impacts are difficult to measure from the data, due to causal proximity of euthanasia. Global investigations of COVID-19 epidemiology, based only on the relative impacts of COVID disease and vaccination, may be inaccurate, due to the neglect of significant confounding factors in some countries.

Introduction

In a recent paper [1], it was shown that COVID injections are causally predictive of Australian excess deaths, suggesting the Australian pandemic is iatrogenic [2]. Believing that the iatrogenesis by COVID injections may be universally relevant, we studied closely the case of United Kingdom, because its Office for National Statistics (ONS) is reputed to have some of the most accurate and detailed statistics on the COVID-19 pandemic in UK. Obviously, comparing the statistics of the "vaccinated" versus "unvaccinated" is the most straightforward method to assess the risks and benefits of vaccination, but only if the data were accurate, being free from data entry errors. Many data errors originated from the flawed PCR test, which does not detect presence of the SARS-CoV-2 virus [3, 4]. The extensive analysis [5] of detailed ONS statistics based on vaccination status and their relationships with COVID cases and mortality has shown inconsistencies, which appear to have originated from flawed definitions of vaccination status and erroneous data entry.

This aspect of ONS data corruption appears universal, as it also occurs with Australian data [6] which have originated from the flawed data entry and reporting convention [7] from the Centers for Disease Control and Prevention (CDC), which may have recorded status lagging actual status by at least 14 days. Essentially, the death of a recently injected person may not be recorded in the database of deaths of the "vaccinated" [8]. This simple omission makes comparison of deaths by vaccination status a data misdirection inflating "unvaccinated" deaths which are calculated by subtracting "vaccinated" deaths from all deaths of the population [9].

Despite advances in modern information technology, the accuracy of data collection has not advanced in the United Kingdom for over 150 years, because the same problems of erroneous data entry found then are still found now in the COVID pandemic, not only in the UK but all over the world. We have independently discovered [6] the same UK data problem and solution for assessing COVID-19 vaccination as Alfred Russel Wallace [10] had 150 years ago in investigating the consequences of Vaccination Acts starting in 1840 on smallpox:

"Having thus cleared away the mass of ***doubtful or erroneous statistics depending on comparisons of the vaccinated and unvaccinated in limited areas or selected groups of patients,*** we turn to the only really important evidence, those 'masses of national experience'..."

Emphasis added. The entry of incorrect data for vaccination status, over 150 years ago as now [10], cannot be solved by technology, but by better data management. Just as did Alfred Wallace, an eminent peer and friend of Charles Darwin, the method we have used (the "Wallace Method") to overcome the lack of accurate detailed vaccination data is to use accurate macro-data such as all-cause mortality ('masses of national experience') and doses of COVID vaccination, to perform detailed statistical analysis to draw broad and robust epidemiological conclusions.

This paper follows the Wallace Method by examining the "masses of national experience" of the pandemic which are the all-cause and excess mortality data over time and across the regions of England.

Many published statistical findings, based on data misdirection, are internally inconsistent and are contradicted by macro-data of the Wallace Method, as shown here for UK. These factual contradictions show up as data anomalies, which are mortality data facts which cannot be explained by data misdirection. Two main data anomalies in April 2020 and January 2021 are discussed in detail below in successive sections.

Another important data anomaly is the absence, since 2021, of any statistically significant relationship between vaccination and mortality, even when mortality data are variously lagged relative to the vaccination data. Therefore, apparently there is no correlation statistically, positive or negative, between vaccination and mortality.

This counter-intuitive absence of a relationship between vaccination and excess deaths and other anomalies are resolved in this paper by showing the existence of a strong confounding factor, which is a strong positive correlation between Midazolam use and excess mortality data in England, across all regions throughout the COVID-19 pandemic, particularly before mass vaccination.

The rest of the paper is devoted to a detailed discussion of the implications of the findings on how UK health policy has led to the observed outcomes of euthanasia and iatrogenic geronticide. The UK findings raise strong doubt about many epidemiological findings worldwide regarding the evidence of positive or negative impact of vaccination on mortality in the COVID-19 pandemic.

UK Macro-Data

The macro-data include official UK all-cause mortality published by ONS [11]. The data collated from 2015 to July 2023 are shown in Figure 1.

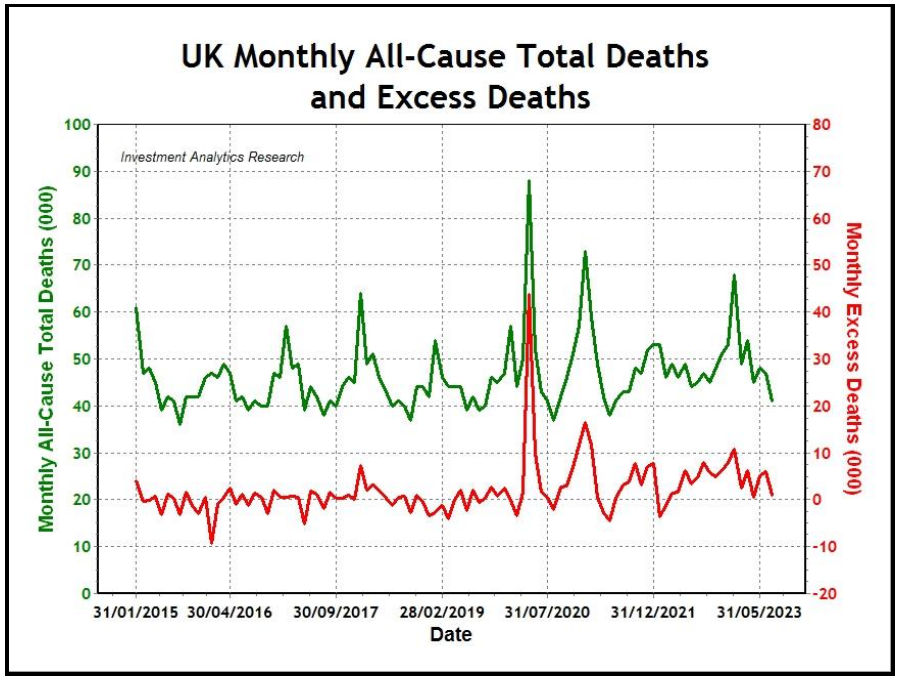

Figure 1: UK Monthly All- Cause Total Deaths and Excess Deaths.

The green curve with the left-axis, represents monthly raw death counts of all causes for United Kingdom from 2015 to July 2023, the latest monthly ONS data. Most data analysts (e.g. Australian Bureau of Statistics), would simply overlay the green curve with the baseline (as expectation), with seasonal fluctuations, and a one standard deviation band around the baseline, to show the significance of all-cause mortality outside the expected band (see an example below). However, seasonal fluctuations make the relative significance of excess deaths visually harder to discern, obscuring statistical significance.

For greater clarity, seasonal fluctuations are removed by displaying excess deaths directly where excess mortality is calculated as deviations from the baseline, which is defined by the pre-pandemic

period using 2015-2019 monthly averages. The average baseline UK mortality is about 44,000 monthly and 532,000 annually. The purpose of the baseline is to serve as a benchmark for assessing whether pandemic excess deaths since 2020 are statistically significant.

The red curve with the right axis shows the excess mortality death counts. The average baseline excess deaths is zero (by definition) and the standard deviation (sigma) is 2,470 monthly. It is now clearly evident that excess deaths in UK are statistically significant for most periods in the COVID-19 pandemic since the enormous spike in 2020.

Note that the ONS includes 2017-2019 and 2021, but excludes 2020 in its calculation of the 2022 baseline and therefore ONS excess deaths for 2022 differ from ours as will be discussed below. Since the pandemic starting in 2020, there have been persistent elevation of excess mortality, characterized sometimes by sharp spikes. The red curve for monthly excess deaths as percentage of the baseline shows nevertheless a trend decline from 2020 before vaccination to after 2021 onwards, suggesting (misleadingly as discussed below) a beneficial effect of vaccination.

Many studies published in 2022 found negative correlations between excess deaths and mass vaccination [12], and suggested mitigation effects by the COVID injections. However, these casual observations of causation are shown below to be another example of Simpson's Paradox, where confounding factors were overlooked and the correlations were invalid [12].

Specifically as indicated [13], a common error of those studies comes from data selection bias, where early studies, with synchronous correlation, occurring only in a selected subset of the data, implied that vaccinations had immediate beneficial impact on reducing deaths, which is medically highly unlikely [2], given the vaccinology of how mRNA injections take significant time to affect the immune system.

The errors of earlier studies [12] can be understood, if those results were placed in the broader contexts of other epidemiological variables and in hindsight, with fuller sets of available data. Illustrated here are many anomalies and inconsistencies of UK data which have led to inferences of erroneous conclusions and to harmful policies.

Anomaly of April 2020

To establish even more clearly the statistical significance of the excess deaths, they are measured as percentages of the baseline, as well as units of standard deviation (sigma) of the monthly fluctuations of the baseline, as shown in Figure 2.

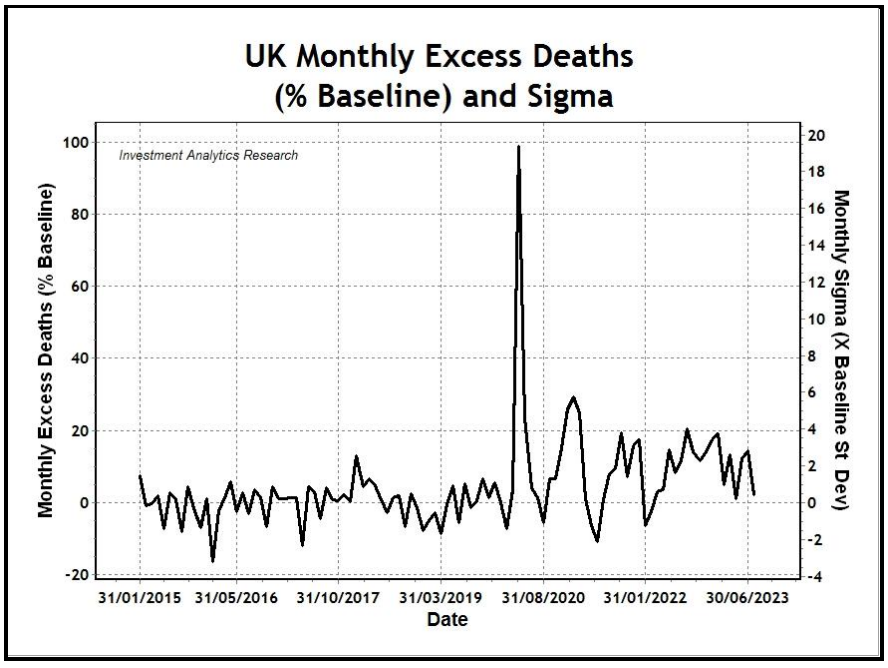

Figure 2: UK Monthly Excess Deaths (%Baseline) and Sigma.

The left axis shows excess deaths as percentages of the baseline. Note that the huge spike in April 2020 reached 100 percent of the baseline. Since the monthly standard deviation of excess deaths as a percentage the 2015-2019 baseline is 5.1 percent ("one sigma"), the huge spike was a 20-sigma event, shown on the right axis. This event has received relatively little attention or analysis, as the ONS simply stated as a matter of fact, in an early version of its latest release [14]:

"The months with the highest number of total excess deaths were April 2020 (43,796 excess deaths, a 98.8% increase) and January 2021 (16,546 excess deaths, a 29.2% increase)."

Doubling normal death rate in April 2020, ("a 98.8% increase")

had received no special comment by the ONS, and has been removed in recent releases. A sudden surge of 44,000 deaths cannot be explained by population growth or changes in life expectancy. The official narrative was that the SARS-CoV-2 virus was very deadly to have caused the huge spike in COVID deaths. This interpretation, which is disputable (see below), justified politically the declaration of emergency and all public health measures, including masking, lockdowns, etc.

However, the UK Health Security Agency declared [15] "*As of 19 March 2020, COVID-19 is no longer considered to be an HCID in the UK. There are many diseases which can cause serious illness which are not classified as HCIDs."* That is, COVID-19 was officially not considered a high consequence infectious disease (HCID) – no pandemic. This declaration was in stark contradiction to 44,000 excess deaths, mostly attributed to COVID-19, which represented a doubling of all-cause mortality in April 2020. As confirmed by empirical data below, the UK Health Security Agency was correct: there was no pandemic caused by a HCID.

If this interpretation of the huge spike being due to the COVID virus were really correct (shown not to be correct below) then it is obvious apparently from Figure 2, that COVID injections may have saved lives, because with mass vaccination since 2021 the rates of excess deaths have decreased systematically, as Table 1 confirms – vaccination was associated apparently, but misleadingly, with fewer excess deaths over time.

	2020	2021	2022	2022 (ONS)	2020-2022 Av	2023 (to July)
Baseline (000)	532	532	532	611	532	320
Actual (000)	608	586	577	577	590	352
Excess (000)	76	54	45	34	58	32
% Excess	14.3	10.2	8.5	5.6	11.0	10.0
Sigma (Mo Av)	2.8	1.9	1.8	1.1	2.2	2

Table 1: UK Annual All-Cause and Excess Mortality.

All numbers in this paper are expressed, at most, to three significant figures for ease of reading. On an annual basis, Table 1 shows that both all-cause mortality and excess mortality have consistently declined (columns 2 to 4) from 2020 to 2022. From this perspective, COVID vaccinations in the years 2021 and 2022, with 54,000 and 45,000 excess deaths respectively, would have been interpreted erroneously as effective in reducing excess deaths of 76,000 in 2020.

The apparent effectiveness was even more pronounced in 2022, if the baseline were calculated using the method used by ONS (see column 5), where one sigma deviation in 2022 was hardly statistically significant for UK excess deaths. This evidence of "vaccine effectiveness" was illusory, as shown below, due to incorrect attribution of the 2020 death spike.

Like the Australian Bureau of Statistics (ABS), the Office for National Statistics (ONS) also excluded 2020 in its calculation of the 2022 baseline, but for diametrically opposite reasons. For Australia [16], 2020 was a low mortality year, exclusion of which leads to higher baseline and lower calculated excess mortality. On the other hand for UK, 2020 was a high mortality year, exclusion of which leads to lower baseline and higher calculated excess mortality.

Had 2020 been included in the 2022 calculation, the UK baseline would have been raised by about 19,000 and 2022 excess mortality would have dropped correspondingly even further, astonishingly giving about three percent excess deaths above baseline. This represents a "normalization" of the pandemic, so that excess deaths no longer provide any statistical signal. This "too good to be true" statistic would be unbelievable and may attract undesirable criticism to its methodology.

By the UK officially assigning the April 2020 death spike to mostly COVID deaths, the role of other causes of excess deaths have been substantially reduced [14]:

"When deaths due to COVID-19 were subtracted from the analysis, April 2020 remained the month with the highest number of excess deaths (14,361 excess deaths, a 32.4% increase on the five-year average for deaths due to all causes)."

However, this questionable assignment of 67.6 percent of the deaths to COVID in March/April 2020 is inconsistent with the number of COVID cases in that period, as shown in Figure 3.

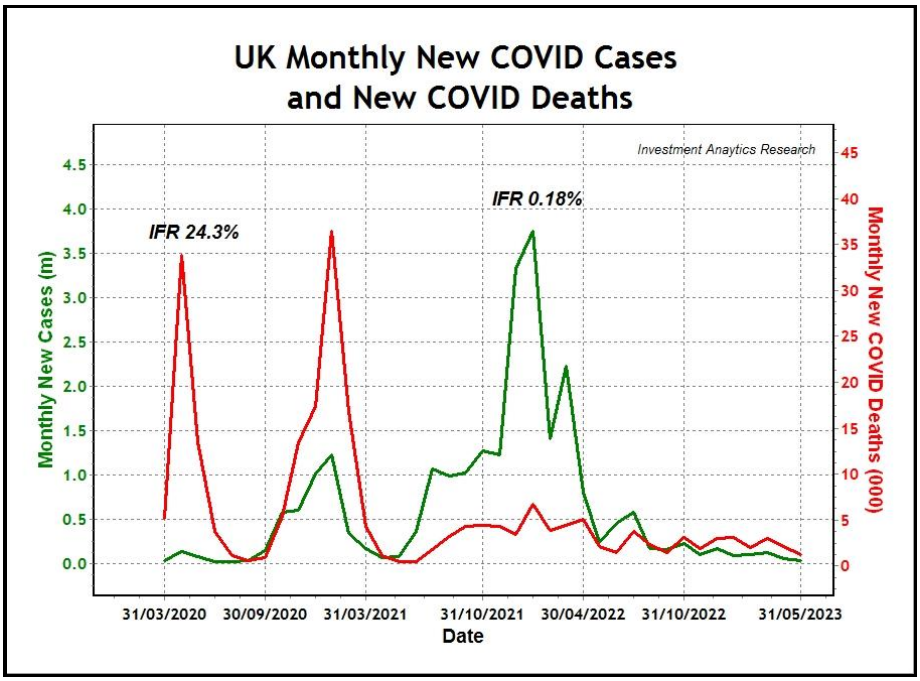

Figure 3: UK Monthly New Covid cases and New Covid Deaths.

Figure 3 shows inconsistent correlation between COVID cases (green line) and COVID deaths (red line), except for early 2021 when mass "vaccination" was first rolled out. The most glaring anomaly is in early 2020 when relatively few cases led to a disproportionate number of alleged COVID deaths such that the infection fatality rate (or more accurately case fatality rate) was very high at 24.3 percent, if the data are taken on their face values.

On 11 March 2020, the World Health Organization (WHO) declared the global pandemic based on 4,291 deaths worldwide. In April 2020, the UK data showed 35,000 new COVID deaths which represent an extraordinary increase in a very short time, particularly when there were only 139,000 new COVID cases in April 2020, moreover, the UK cumulative total cases did not exceed 500,000 (less than one percent of the population) until after September that year.

While there were suggestions that UK may have had a shortage of PCR tests available early in the pandemic which may explain the relatively small number of COVID cases, but this explanation does not resolve the inconsistency. If there were a shortage of tests, then the registration of the large number of COVID deaths could not have been verified by PCR tests and therefore they were arbitrarily assigned.

Given the data of Figure 3, the UK case fatality rate (CFR) of SARS-CoV-2 would have been an extreme 24.3 percent, compared to later CFR from the Omicron variant of 0.18 percent. The high fatality rate was inconsistent with published research findings [17] that early in the pandemic the "*new coronavirus SARS-CoV-2 is less deadly but far more transmissible than MERS-CoV or SARS-CoV.*"

The enormous April 2020 spike in UK excess deaths may have required fewer cases of infection to cause the deaths if transmission were localized to limited numbers of regions; otherwise unbelievably fast spreading across a wide geographic area was needed. The data on excess deaths show the spikes in excess deaths occurred simultaneously across a wide area in all major regions of the UK, as Table 2 shows.

Region	April Baseline	All-cause Deaths	Excess Deaths	Excess (% Baseline)
London	4,140	12,200	8,030	194
East	4,840	9,510	4,670	97
North West	5,960	12,400	6,390	107
South West	4,720	7,600	2,880	61
South East	6,840	12,800	5,980	87
North East (& Yorkshire)	6,610	12,300	5,730	87
Midlands	8,310	16,700	8,390	101
England	41,400	83,500	42,100	102
UK (& Wales)	44,300	88,100	43,800	99

Table 2: UK Regions Excess Mortality April 2020.

Note that UK statistics are mostly represented by those in England (and Wales), which is sometimes loosely referred, in the following discussions, as UK. The seven regions in Table 2 are geographically identified in Figure 4, where they are amalgamated into four major regions.

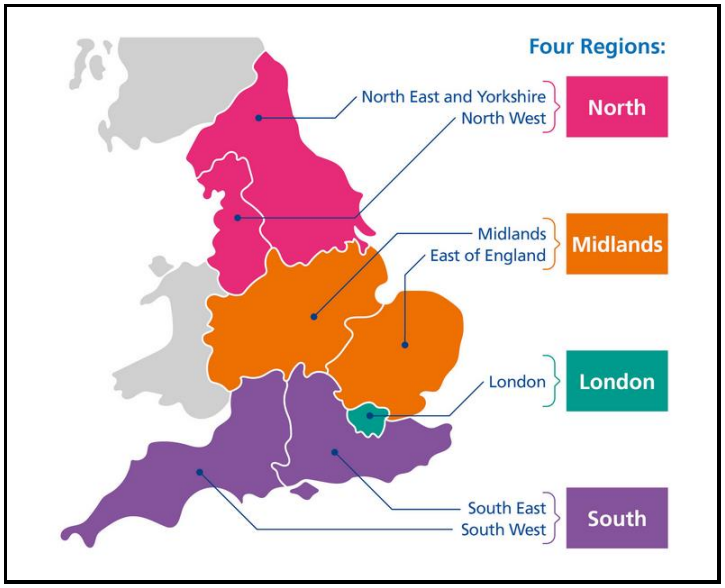

Figure 4: UK Regions of ONS Data.

Unsurprisingly, the small area of London had one of the highest excess deaths, less expected is the near tripling (3X) of all-cause mortality compared to the baseline with 194 percent excess deaths. All other regions also had very high excess deaths, the South West region having the lowest 61 percent excess deaths, which is still highly statistically significant.

If COVID-19 were the commonly accepted explanation for the April 2020 data, then the wide geographical spread of high excess deaths in all regions within a very short period would require the SARS-CoV-2 virus to be transmitted very rapidly and be very lethal at the same time, which is biologically unlikely. The data anomaly contradicts the COVID-19 hypothesis and the unfounded popular belief that most elderly who died early were evidence that the elderly were particularly vulnerable to COVID-19, which was unlikely, not being prevalent.

In conclusion, the UK data anomaly of April 2020, where the data on COVID cases and deaths are inconsistent, most likely indicated that the huge spike in death may not have been due to SARS-CoV-2 virus. This possible misattribution to COVID-19 was confirmed by the UK Health Security Agency [15], mentioned earlier, which declared that as of 19 March 2020, COVID-19 was not a "high consequence infectious disease". Therefore, this data anomaly leaves the huge spike in the non-COVID excess deaths yet to be explained, before mass vaccination or any other factors were available, as discussed below.

Anomaly of January 2021

A similar anomaly occurred in January 2021 suggesting also a misclassification of non-COVID deaths to COVID deaths. That is, unvaccinated individuals who died of non-COVID causes, may have been misclassified as COVID deaths. This type of data flaw has occurred in the history of UK data as Alfred Wallace wrote [10] (p. 28, p. 30) on smallpox:

*"…whereas the other result, of a **greatly increased fatality in the unvaccinated so exactly balanced by an alleged greatly diminished fatality in the vaccinated is not explicable**,…the two classes of facts taken together thus render it almost certain that vaccination has never saved a single human life."*

Emphasis added. That is, during the smallpox epidemic of the second half of the 19th century, the justification of compulsory smallpox vaccination in UK was due to the same type of data flaw of confusing vaccinated with unvaccinated as in 2020. The likely confusion also between COVID deaths and non-COVID excess deaths [11,14] in January 2021 is evident in Figure 5.

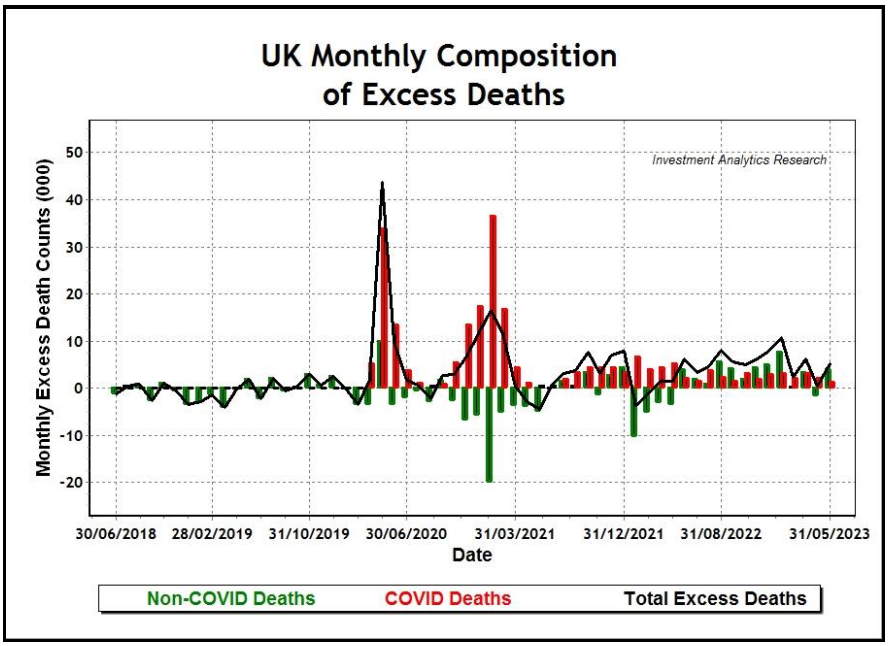

Figure 5: UK Monthly Composition of Excess Deaths.

With 2020 COVID data, paraphrasing Alfred Wallace's observations for smallpox data in UK 150 years ago [10], we observe for the UK pandemic in January 2021: *…a greatly increased fatality in the **COVID deaths** so exactly balanced by an alleged greatly diminished fatality in **non-COVID deaths** is not explicable…*

The words in bold were substituted in the above quote of Alfred Wallace [10]. Why was there a spike in COVID deaths and a compensating plunge in the non-COVID deaths? The spike in COVID deaths in January 2021 was slightly higher than that of April 2020, but was incongruous with total excess deaths which were substantially lower in January 2021 compared to the first spike in April 2020. This meant that for the numbers to tally, non-COVID deaths had to plunge deeply below expectation, which is inexplicable.

In January 2021, new COVID cases were still relatively too subdued to explain the spike in COVID deaths and there was no apparent reason for the plunge in non-COVID deaths. The data were apparently not explicable, suggesting errors in recording COVID deaths, which are clear evidence confirming the unreliability of COVID data generally [5, 6].

To analyze the data confusion between COVID deaths and non-COVID deaths, we summarize the data in Figure 4 with Table 3.

	COVID-19	Non-COVID	Total Excess
Mar-Dec 2020	95,000	(15,700)	79,300
2021	81,000	(26,800)	54,200
2022	39,300	5,770	45,100
Jan-May 2023	11,500	13,600	25,100
Mar 2020-May 2023	227,000	(23,100)	204,000

Table 3: Decomposition of UK Excess Deaths.

Evidently (columns 2 and 4), both COVID-19 deaths and total excess deaths have been falling annually from 2020 to 2022, but non-COVID deaths have been rising generally, except for 2021 due to the strange anomaly in January 2021, when the 26,800 plunge in non-COVID excess deaths (see the yellow cell in the third column) was inexplicable. The spike in claimed COVID deaths, as high as that in April 2020, would have conveniently persuaded the public to accept vaccination, just as it was being rolled out in January 2021.

By now, it should be well-known that data on COVID cases and deaths are unreliable, because they are based on flawed PCR tests which do not reliably detect the presence of the SARS-CoV-2 virus and often produced false positives. This fundamental flaw facilitated the inconsistent attribution of COVID cases and deaths. In conclusion, in 2020 and early 2021, spikes in UK COVID deaths were likely misclassification of non-COVID deaths, which begs the question: what caused the surges in non-COVID deaths early in the pandemic? If the beginning of the UK pandemic was not largely related to the SARS-CoV-2 virus, what was it related to?

Vaccination and Excess Deaths

Before addressing the enigma of excess deaths in 2020, consider the Australian explanation in vaccination causality [1,2]. It was predicted that mass vaccination reaching population herd immunity would end the UK pandemic, but this did not happen. Instead, COVID deaths and non-COVID excess deaths remained elevated. In Australia, the excess deaths since 2021 were shown likely to have been caused by COVID injections, where deaths followed consistently and predictably after injections five-months later [1,2]. On average, normally it takes some time in a multistage process for the injections to cause the generation of antibodies in response to antigenic cellular production of toxic spike proteins which are potentially pathogenic, possibly causing death. The corresponding relationship of COVID injections and five-month lagged excess deaths for UK data is shown in Figure 6.

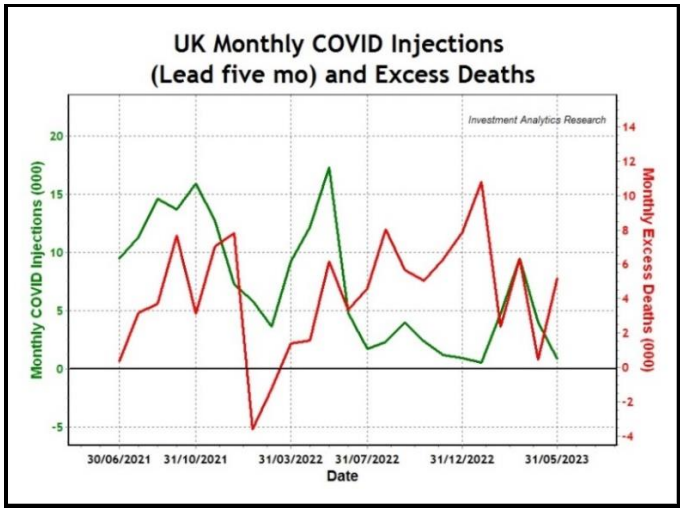

Figure 6: UK Monthly COVID Injections (Lead five mo) and Excess Deaths.

There were clear positive correlations in selected periods (e.g. first half of 2022), but the whole dataset, without selection bias, shows a negative correlation of -12 percent, but the relationship is not statistically significant with a *p-value* of 0.587. Therefore, the causal relationship observed in Australia, of COVID injections being sources of harm, cannot be similarly established for UK. On the other hand, these data also show no indication that vaccination had any beneficial effects on UK excess deaths.

Further statistical investigation of the correlation spectrum, with different leads and lags of the two time-series, produced no significant relations, suggesting no detectable causality. Therefore, statistically, the unclear impact of COVID injections on UK excess deaths remains a puzzle, and the whole UK pandemic has remained a statistical mystery.

Midazolam and Excess Deaths

The doubling of all-cause mortality in April 2020 was unlikely explicable by the SARS-CoV-2 virus, because there were low levels of infection at that time and there was low lethality of the SARS-CoV-2 virus [15]. This puzzle in April 2020 and the puzzle of lack of statistical relationships between excess deaths and COVID injections later in the pandemic, suggest alternative explanations are required for the UK pandemic.

In 2020, since most medical treatments for COVID-19 infection such as Ivermectin, Hydroxychloroquine, etc. were forbidden or not recommended in many countries, except for selected medicines such as Remdesivir in the US and Midazolam in the UK, we investigate the possible role of Midazolam in the UK pandemic.

Midazolam is a Benzodiazepine, which enhances the effects of gamma-aminobutyric acid (GABA), a naturally occurring inhibitor of brain activity. Midazolam is on the World Health Organization (WHO) list of essential medicine [21] for preoperative short-term sedation, for palliative care and for diseases of the nervous system. For each function, there are usually several other pharmaceutical alternatives; for example, for sedation and palliative care, UK alternatives include Lorazepam and Diazepam [21,22].

Used orally, Midazolam is not normally lethal to healthy people. However, given intravenously in large doses continuously, often with opioids, to the elderly with comorbidities, particularly those who are terminally ill, it could be lethal. According to the US National Library of Medicine [23]: *"Midazolam injection may cause serious or life-threatening breathing problems such as shallow, slowed, or temporarily stopped breathing that may lead to permanent brain injury or death."* Midazolam is used in US executions.

From an observational study [24] in a French hospital, 60 mg could cause death in 24 hours and at that rate few survive more than five days, and in that hospital only one third of the 54 palliative sedations had patient consent, suggesting both voluntary and nonvoluntary euthanasia which will be discussed below.

The possible widespread use of Midazolam in the pandemic was suggested early by anecdotes of UK funeral directors [18] and more recently by statistical observations [19]. Indeed, the Bennett Institute for Applied Data Science publishes a raw English Prescribing Dataset [20], which includes, by English regions (as shown in Table 2 above), prescriptions of Midazolam 10 mg/2 ml solution for injection ampoules, as shown in Figure 7.

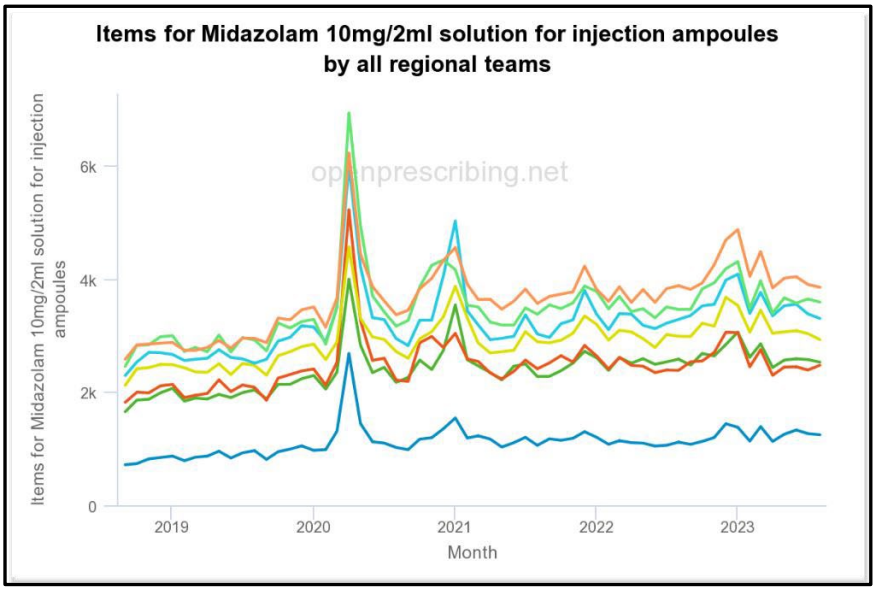

Figure 7: Items for Midazolam 10 mg/2 ml solution for injection ampoules by all reagions.

As noted in several blog posts on the internet [19], doses of Midazolam injections show visually remarkable correlation with excess deaths for UK. In Figure 8, excess deaths for various regions in England have been calculated individually and attempted colour matched to Figure 7.

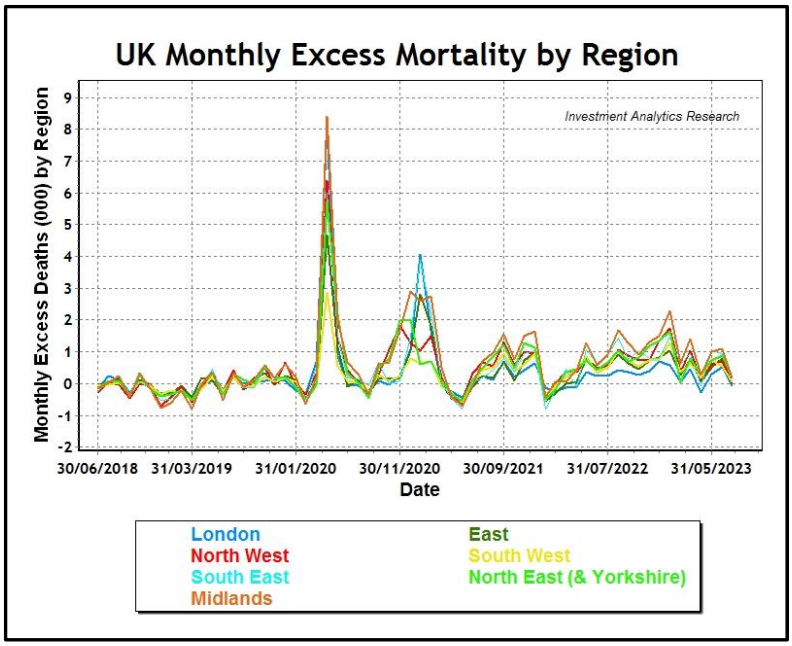

Figure 8: UK Monthly Excess Mortality by Region.

Visually, Figures 7 and 8 suggest a high correlation between Midazolam injections and excess deaths across all regions in England. Figure 8 also shows similar regional numerical distribution of excess deaths, particularly in April 2020, as though by deliberate allocation.

Midazolam Correlation

Aggregating over English regions, the time series relationship between Midazolam injections and excess deaths in England is shown in Figure 9.

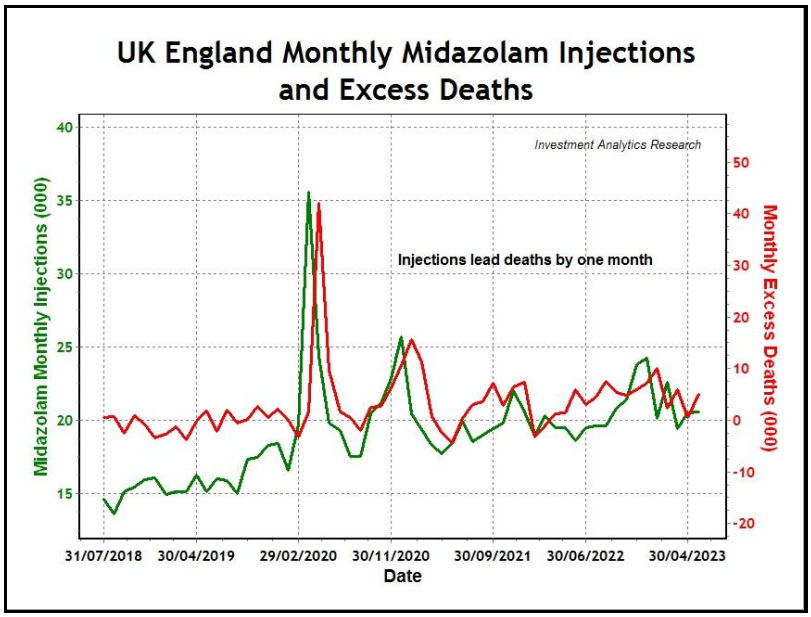

Figure 9: UK Engliand Monthly Midazolam Injections and Excess Deaths

Clearly, Midazolam injections and excess deaths in England are highly correlated, but not synchronously, because medication generally does not have instantaneous impact and also reporting of dosages used and registration of deaths may lag. Shifting the time series for Midazolam injections one-month forward, very high correlation is seen in Figure 10.

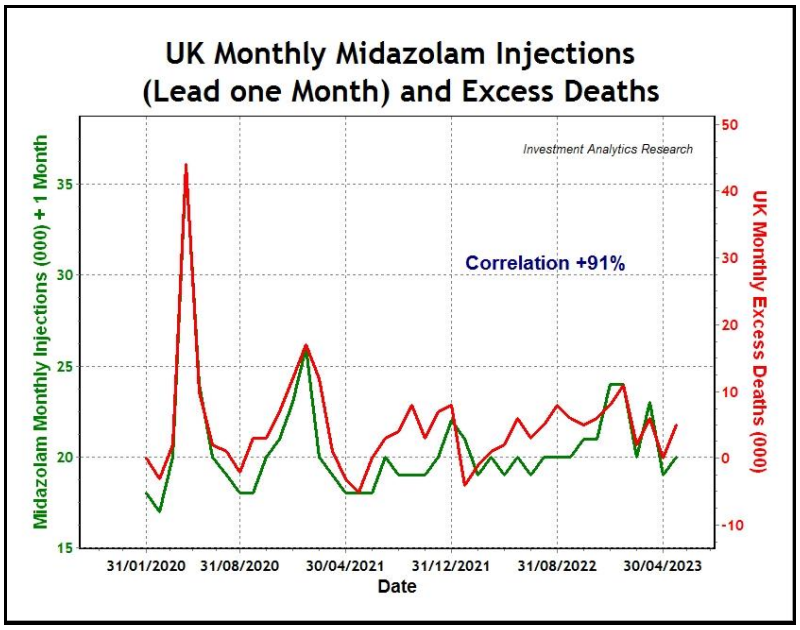

Figure 10: UK Monthly Midazolam Injections (Lead One Month) and Excess Deaths.

The very high correlation (coefficient 91 percent) between excess deaths lagged one month after Midazolam injections is largely due to the first two enormous spikes to early 2021. From April 2021 onwards to May 2023, the same correlation dropped to 59 percent, but still statistically significant with *p-valu*e at 0.0007. The misclassification of COVID deaths, possibly deliberate, also led to their high correlation with Midazolam injections as seen Figure 11.

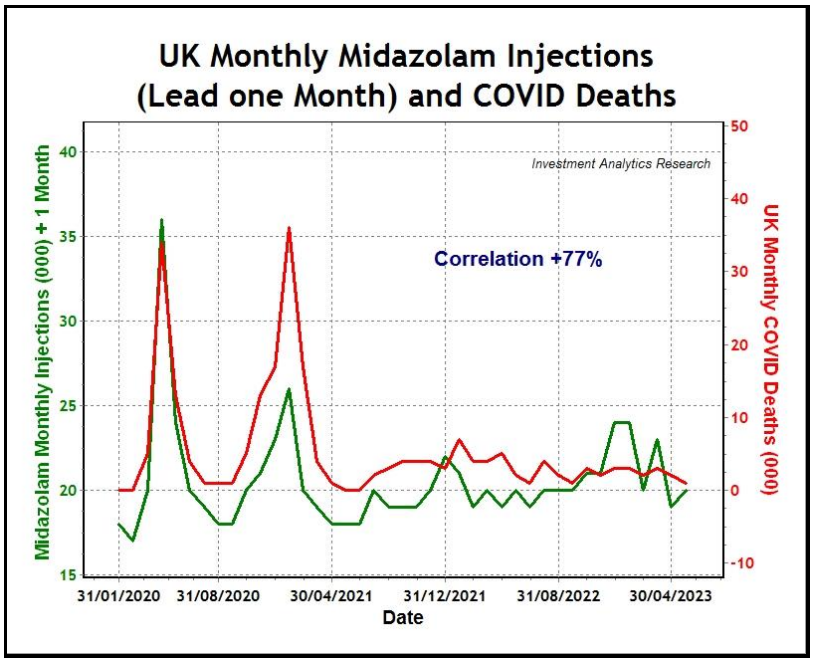

Figure 11: UK Monthly Midazolam Injections (Lead One Month) and COVID Deaths.

The high correlation (77 percent) between COVID deaths lagged one month after Midazolam injections is largely due to the first two enormous spikes to early 2021. From April 2021 onwards to May 2023, there was no significant correlation (with any lags), implying that Midazolam had no statistical relationship to COVID deaths, suggesting a change in assignment policy.

The temporal separation between Midazolam cause and excess deaths effect was consistently one month for the whole pandemic since 2020, indicating palliative use for assisted dying or other euthanasia. Midazolam was the proximate, if not the primary, cause of excess deaths in the UK. Statistically, correlations improve substantially when Midazolam injections lead excess deaths by one month for all regions in England, as illustrated by Figure 12.

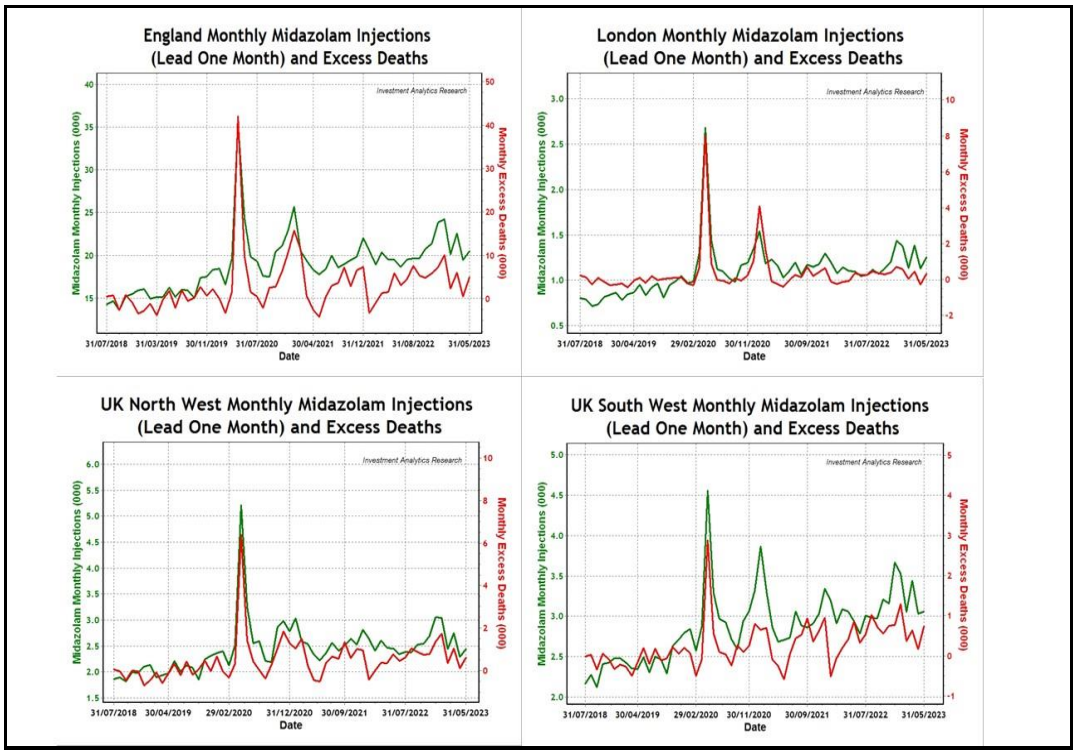

Figure 12: Midazolam Injections Lead Excess Deaths (Lead One Month) for All Regions in England.

For the rest of this paper, unless stated otherwise, correlations between Midazolam injections and excess deaths imply lags of one-month have been applied to excess deaths. Before the pandemic, the correlations were mostly moderate with low statistical significance.

Midazolam in the 2020 Death Spike

The extraordinary death spike in April 2020 caused by Midazolam has attracted disproportionally little attention. Table 4 shows that in that month 35,600 doses of Midazolam were associated with 42,000 excess deaths, which is virtually an average of one dose per death.

Region	Midazolam Doses	Excess Deaths	Dose per Death (Rank)	Excess % Baseline (rank)
London	2,680	8,030	0.33 (7)	194 (1)
East	3,990	4,680	0.85 (4)	96.6 (4)
North West	5,210	6,390	0.82 (5)	107 (2)
South West	4,560	2,880	1.58 (1)	61 (7)
South East	6,000	5,980	1 (3)	87.4 (5)
North East (& Yorkshire)	6,920	5,730	1.21 (2)	86.6 (6)
Midlands	6,210	8,390	0.74 (6)	101 (3)

Table 4: Midazolam Injections and Regional Excess Deaths for March/April 2020.

Compared to regional baselines calculated from 2015-2019 monthly averages (see Table 2), London region had tripled (300 percent) its expected all-cause mortality, while most other regions had approximately doubled (200 percent) their respective expected all-cause mortality. Such rapid, temporally concentrated and uniformly distributed deaths across England were unlikely to be caused naturally by an infectious disease.

Indeed, the Midazolam dose-to-death relationships were very similar across all regions, further supporting the supposed role of Midazolam in a UK systemic policy of euthanasia.

Some regions such as London, East, North West and Midlands had less than one dose per excess death, which suggests that Midazolam was not uniformly applied in all cases and that Midazolam was not the only sedative used in the euthanasia, particularly in the London region. For example, along with many other drugs, Levomepromazine hydrochloride which is a sedative as well as an anti-psychotic drug, also had a surge in usage in UK [25] at about same time.

Another possible reason for why the London region had relatively high excess deaths compared to the registered doses of Midazolam may be due to selection bias by sick patients. It is possible that many sick patients from other regions may have sought specialist treatment from major London hospitals and clinics, which may have to use other sedatives due to limited supplies of Midazolam. The London outlier statistics may be another example of Simpson's Paradox where a subpopulation may have confounding factors including selection bias, violating a statistical property which is valid only for the whole population or for other subpopulations.

Midazolam in the Pandemic

The deliberate use of Midazolam during the COVID-19 pandemic in causing deaths can be seen from a more normal use of Midazolam before the pandemic in 2020, as seen in Table 5 below.

Region	Pre-pandemic June 1918 -2020 Correlation % (*p-value*)	Pandemic since 2020 Correlation %	2020 Pre-vaccination Correlation %	Pandemic Post-vaccination Correlation %
London	33 (0.09)	92	99	66
East	25 (0.16)	89	99	75
North West	48 (0.02)	92	98	62
South West	51 (0.01)	77	97	48
South East	39 (0.06)	87	96	74
North East (& Yorkshire)	49 (0.02)	91	98	57
Midlands	60 (0)	88	98	63
England	48 (0.02)	91	98	70

Table 5: Correlation of Midazolam Injections and Regional Excess Deaths (*p-values* < 0.001 or zero unless specified in **brackets).**

While the pre-pandemic correlations (second column) between Midazolam injections and excess deaths are statistically significant to *p-value* < 0.05, for North West, South West, North East (& Yorkshire) and Midlands, the correlation coefficient for the whole of England was only 48 percent.

For 2020, the correlation coefficient (fourth column) for the whole of England spiked to 98 percent, leaving little doubt about Midazolam's role in UK excess deaths in 2020. The overall correlation coefficient (third column) for the whole pandemic was 91 percent, contributed substantially by 2020 data. Importantly, even after 2020, in the vaccination era, the correlation coefficient (last column) was still highly statistically significant at 70 percent. Regardless of other factors, such as COVID-19 disease and vaccination, Midazolam was an important confounding factor in explaining excess deaths, competing with other possible factors.

The main Bradford Hill criteria of medical causality have been satisfied with strong correlation, consistency over time and geography, specificity of effect and consistent temporality of one-month lag in excess deaths following Midazolam injections. Other Bradford Hill aspects, such as biological gradient or dose-response relationships, follow naturally from consideration of the pharmaceutics of Midazolam.

In summary, Midazolam was strongly and causally associated with UK excess deaths, particularly in 2020. It was clearly the proximate cause of excess mortality in UK, but it was unlikely to be the primary cause in the chain of causality for deaths, because Midazolam was used mostly for accelerated or assisted dying in euthanasia often to alleviate possible suffering in end-of-life protocols. Midazolam's role based on its pharmaceutics is circumscribed in health policy guidelines.

Biological Gradient

Clearly the close association of UK excess deaths following Midazolam injections suggests significant involvement of sedatives with euthanasia in the UK pandemic. A systemic policy of euthanasia may be evident from the pharmaceutics of Midazolam applied across time and across the various regions during the pandemic. Figure 13 shows the dose-response relationships for England over three separate periods.

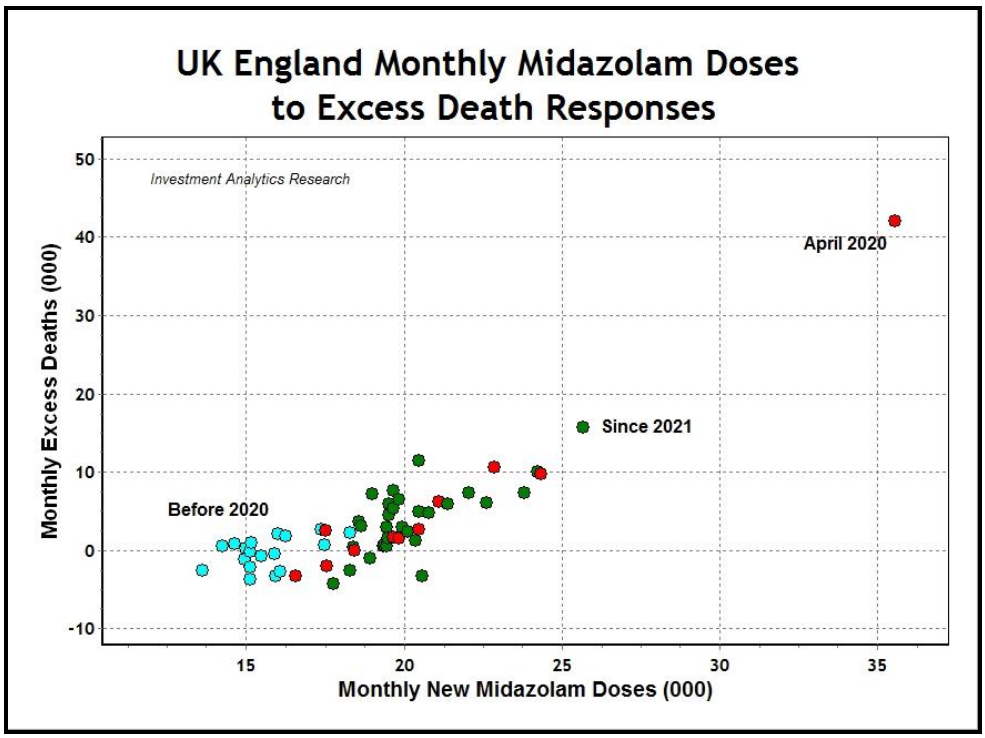

Figure 13: UK England Monthly Midazolam doses to Excess Deaths Responses.

The data points in aqua refer to the pre-pandemic period from July 2018 to 2020, the points in red refer to 2020, the first pandemic period before mass vaccination, while the green data points refer to the pandemic period post vaccination. The statistics of the dose-response relationships in the three distinct periods are shown in Table 5.

Period	Sample	Intercept (000)	Slope	Correlation (%)	*p-value*
Pre-Pandemic to 2020	18	-12.9	0.803	47	0.0465
2020 Pre-Vaccination	12	-43.6	2.35	98	0
2021 to May 2023	29	-29.9	1.67	70	0

Table 5: Regression of Midazolam Injections and Excess Deaths (England: Three Periods to May 2023).

In the April 2020 spike, 35,000 doses of Midazolam were associated with 38,700 excess deaths. The statistical analysis shows that in England before the pandemic, the dose-response relationship between Midazolam injections and excess deaths was weak and only marginally significant. In 2020 of the pandemic, before vaccination, the impact of Midazolam injections was very strong and highly significant statistically, while the impact of Midazolam later moderated undoubtedly due to the competing influence of vaccination, but it remained highly statistically significant.

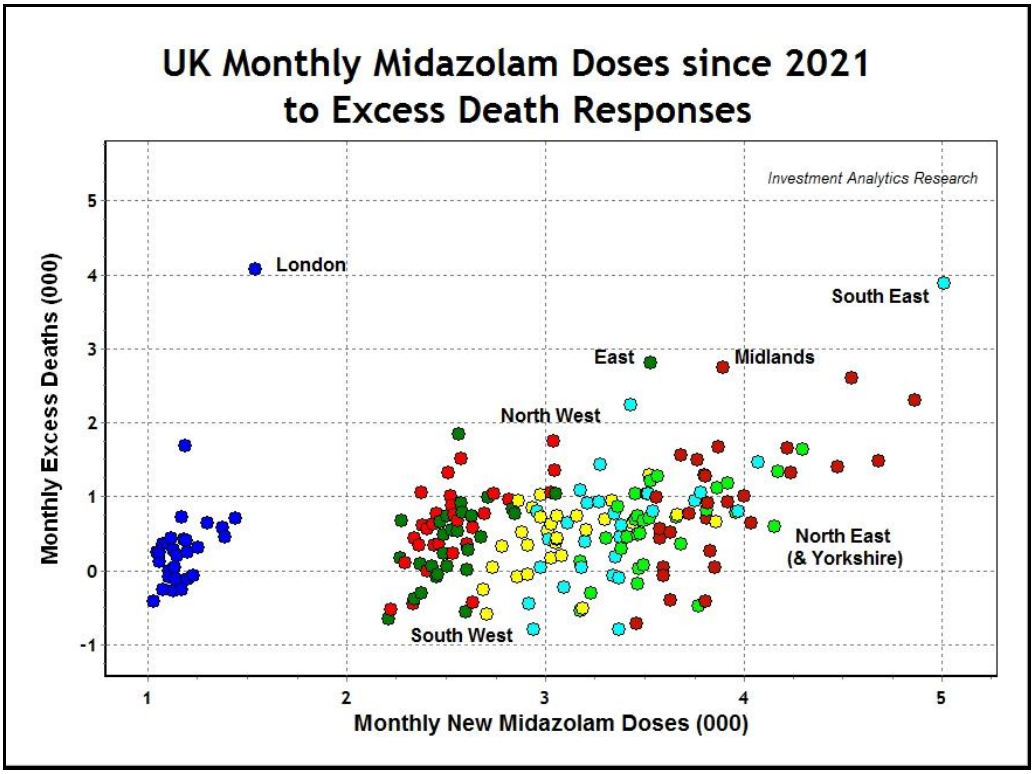

Figure 14: UK England Monthly Midazolam doses since 2021 to Excess Deaths Responses.

Note that the London region is a statistical outlier in the use of Midazolam, suggesting the additional use of other similar sedatives which might be even more powerful than Midazolam for euthanasia, as suggested by the comparisons in Table 6.

Region	Intercept	Slope	Correlation (%)	*p-value*
London	-4.81	4.39	66	0.0001
East	-4.76	2.03	75	0
North West	-3.43	1.59	62	0.0004
South West	-1.94	0.776	48	0.0078
South East	-4.73	1.59	74	0
North East (& Yorkshire)	-3.30	0.669	57	0.0012
Midlands	-5.08	1.54	63	0.0002

Table 6: Regression of Midazolam Injections and Regional Excess Deaths (Post Mass Vaccination since 2021).

Note that all regional subpopulations have consistently positive correlations, avoiding Simpson's Paradox and suggesting the absence of significant confounding factors in the statistical relationships. That is, even though the mathematical details of the regressions may differ quantitatively (due to other minor confounding factors), the firm conclusion prevails that Midazolam injections have significant causal impact on excess deaths in England.

Pandemic Euthanasia

With dire predictions from SAGE computer modelling early in 2020, an atmosphere of panic prevailed in the UK. After 30 years of cutbacks [26], NHS hospital beds in England were halved from 299,000 in 1987/88 to 141,000 in 2019/20. Shortages of hospital beds were already felt before the pandemic. Therefore, there was apprehension that UK hospitals could not cope with the anticipated surge in COVID-19 cases.

It is clear that the highest priority of UK public health policy, early in the pandemic, was to avoid hospitals being overwhelmed, like those sensationally reported in northern Italy around that time. The NHS created new guidelines in March 2020 [27] to facilitate discharges from hospitals, stating *"Unless required to be in hospital (see Annex B), patients must not remain in an NHS bed"*.

In a move which was later judged irrational [28], many elderly were discharged from hospital and died in care homes across England as shown from an ONS report [29] in Figure 15.

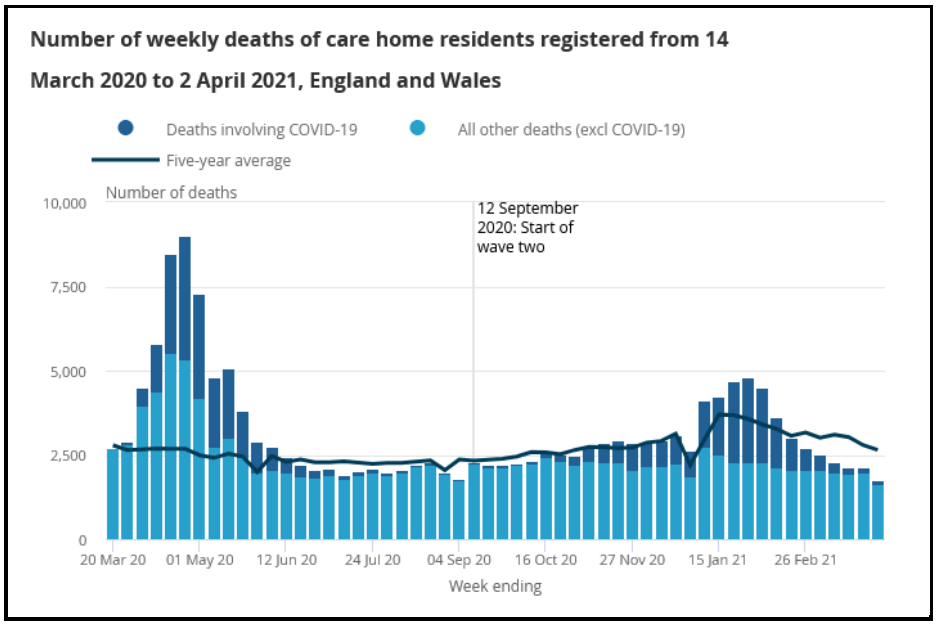

Figure 15: Number of weekly deaths of care Home residents registered from 14 March 2020 50 2 April, England and Wales.

About 28,000 care home residents died in April 2020 across England, which represented about one third or 33.5 percent of all deaths in England. As there were about 375,000 care home residents (three quarters elderly, some with dementia, and the rest disabled) in an English population of 65 million, the mortality rates for that month were 7.5 percent and 0.128 percent respectively, implying an April 2020 death rate in care homes about sixty times (X60) that of the national average.

Many of the UK elderly with comorbidities or terminal illnesses have died with euthanasia in care homes, and not from COVID-19 due to few cases of infections early in 2020. The relative absence of COVID infections was corroborated by largely empty hospitals in early 2020 [30], as the overblown-feared spike in COVID hospitalization never eventuated. Even temporary "Nightingale" hospitals constructed for the expected emergency were empty [31]. The circumstances of euthanasia have led to the first common fallacy that the elderly were particularly vulnerable to COVID, whereas the elderly were vulnerable to the UK health care system which facilitated euthanasia in care homes [32]. A sudden surge in voluntary assisted dying was unlikely, but the extent of nonvoluntary euthanasia, suggesting iatrogenic geronticide in the UK has not been estimated.

A second fallacy has come from the fact that compared to the huge spike in 2020, fewer elderly deaths occurred after 2021 with mass vaccination, has led to the false conclusion that vaccination had saved many elderly lives, whereas Midazolam injections and other medication were significantly reduced after 2020. The benefit of vaccination for the elderly was illusory, but statistical evidence of vaccination causing deaths was also illusory, due to misleading data, as shown above in the section containing Figure 5.

UK Policy on Euthanasia

In its definitions, the UK National Health Service (NHS) [33] states "*Euthanasia is the act of deliberately ending a person's life to relieve suffering" and "Depending on the circumstances, euthanasia is regarded as either manslaughter or murder. The*

maximum penalty is life imprisonment." Even assisted suicide is illegal according to the Suicide Act (1961) and is punishable by up to 14 years' imprisonment, while suicide itself is not a criminal act. The above data analysis has shown clearly that most of the UK excess mortality during the pandemic was associated with Midazolam use in the euthanasia of the elderly, on a widespread and apparently coordinated scale. How was this possible when euthanasia was still strictly illegal in UK?

New guidelines were rapidly developed in early 2020 by the National Institute for Health and Care Excellence (NICE) for managing COVID-19 symptoms, including those at the end-of-life [22]. The rapidly developed new guidelines effectively opened the door to implement a policy of euthanasia in UK during the pandemic:

"NICE has developed these recommendations in direct response to the rapidly evolving situation and so could not follow the standard process for guidance development. The guideline has been developed using the interim process and methods for developing rapid guidelines on COVID-19."

The interim process for developing the guidelines includes the following caveats: "no public consultation on the scope", "there will be no systematic literature research", *"following WHO COVID-19 guidance", "there will be no formal risk of bias assessment of the evidence", "there will be no public consultation of the draft guidance", etc.*

Table 5 of the NICE rapid guidelines on treatments in the last days and last hours of life for managing breathlessness for adult patients include:
• Opioid: Morphine sulfate 10 mg over 24 hours via a syringe driver, increasing stepwise to morphine sulfate 30 mg over 24 hours as required.
• Benzodiazepine if required in addition to opioid: Midazolam 10 mg over 24 hours via the syringe driver, increasing stepwise to midazolam 60 mg over 24 hours as required.

There were changes in the guidelines [34] for anticipatory prescribing (AP) of injectable medications in advance of clinical needs in UK community palliative care.

Evidently, in an environment of rapidly changing guidelines, regular oversight procedures for care homes were suspended by the statutory regulating body, the Care Quality Commission (CQC), and the Local Government and Social Care Ombudsman.

Amnesty International UK published [35] a 2020 report titled: *"As if expendable: The UK government's failure to protect older people in care homes during the COVID-19 pandemic"* which stated:

"The UK government, national agencies, and local-level bodies have taken decisions and adopted policies during the COVID-19 pandemic that ***have directly violated the human rights of older residents of care homes in England—notably their right to life, their right to health, and their right to non-discrimination****. These decisions and policies have also impacted the rights of care home residents to private and family life, and may have violated their right not to be subjected to inhuman or degrading treatment."*

Emphasis added. Amnesty International was careful to avoid using the word: euthanasia, but instead used "violating human rights" – particularly right to life. De facto euthanasia in hospitals and care homes was made possible by loosening guidelines, lack of regulatory oversight and the blanket use of "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) notices or more simply "Do Not Attempt Resuscitation" (DNAR) notices.

The use of blanket DNAR notices in hospitals and care homes was a systemic policy of euthanasia, when it was not investigated or stopped by government regulators. From a joint investigation by the House of Commons and House of Lords, the UK Parliament admitted [36] in September 2020:

"Blanket use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notices in care homes constitutes a systematic violation of individuals' rights. The Government must ensure that their blanket use is not allowed."

Again, the UK government's response to COVID-19 was a systematic violation of human rights – the right to life, not euthanasia which is a criminal offence. Many cases were nonvoluntary euthanasia, which were different from voluntary assisted dying, as the UK Parliament reported [36]:

"We have received deeply troubling evidence from numerous sources that during the Covid-19 pandemic DNACPR notices have been applied in a blanket fashion to some categories of person by some care providers, without any involvement of the individuals or their families."

"The blanket imposition of DNACPR notices without proper patient involvement is unlawful. *The evidence suggests that the use of them in the context of the Covid-19 pandemic has been widespread."*

Emphasis added. The Care Quality Commission (CQC), which is an independent regulator funded from fees of hospitals and care homes to oversight them, was asked belatedly to review DNACPR decisions during the COVID-19 pandemic:

"It was prompted by concerns about the ***blanket application of DNACPR decisions, that is applying them to groups of people rather than on an assessment of each person's individual circumstances,*** *and about making decisions without involving the person concerned."*

Emphasis added. In its interim report released in November 2020, the CQC agreed with UK government investigation and observed

somewhat apologetically [37]:

"It is clear that there was confusion and miscommunication about the application of DNACPRs at the start of the pandemic, and a sense of providers being overwhelmed. There is evidence of unacceptable and inappropriate DNACPRs being made at the start of the pandemic."

Clearly, the "user-pays" regulator was the last to admit its own failure in regulation and merely repeated the findings of Amnesty International and the UK Government's report on human rights in the COVID-19 pandemic.

A systemic policy of euthanasia, which is illegal under UK laws, was couched merely as a violation of human rights–the right to life. There is much more to the euthanasia policy which appears to have discriminated according to vaccination status, with a bias against the "unvaccinated". The systemic policy has significant effect obscuring an understanding the impact of vaccination in the UK COVID-19 pandemic.

It is beyond the scope of this paper to discuss further how the systemic policy of euthanasia was carried out. The above discussion serves to explain that uniformity and consistency of the statistical data, throughout the pandemic and across all regions, relating Midazolam use to excess deaths.

Relative Impact of Vaccination

On explaining UK excess deaths, Midazolam injections have statistically significant correlation even post-vaccination, whereas COVID injections had no significant correlation (see Figure 6). Does vaccination have any impact in explaining any aspect of UK mortality data?

A comparison of relative impact of Midazolam injections and COVID injections on non-COVID excess deaths is shown in Figure 16.

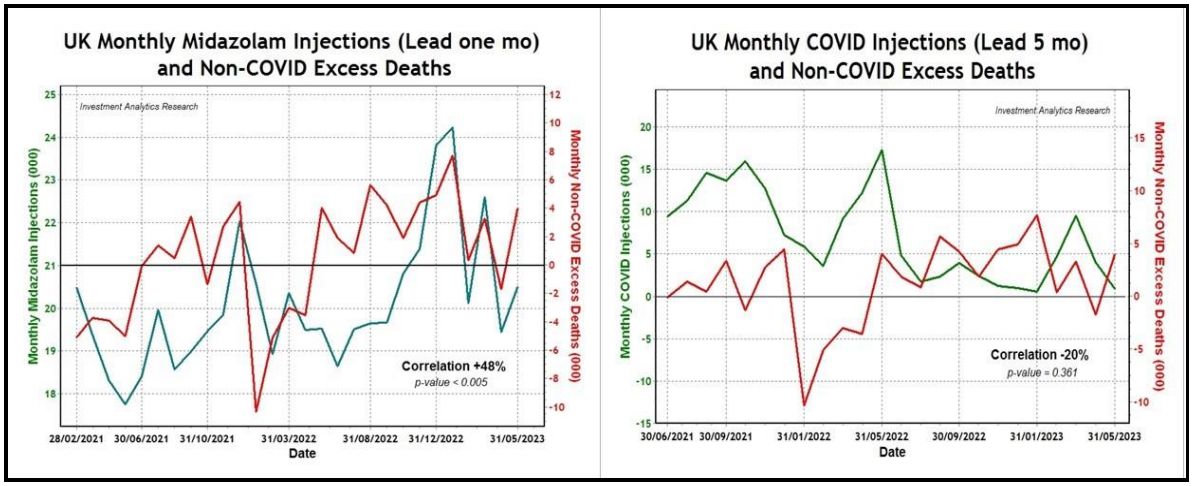

Figure 16: UK Monthly Midazolam injections and Non-COVID Excess Deaths.

From the right Figure 16, vaccination had a negative correlation (-20 percent) impact on non-COVID deaths, suggesting benefit, but statistically insignificant. On the other hand, from 2021 onwards to May 2023, there was a significant 48 percent correlation (*p-value* <0.005) between Midazolam and non-COVID excess deaths (lagged one month), implying that Midazolam was likely involved in non-COVID deaths since 2021.

Relative impacts of Midazolam injections versus vaccination are compared for the period 30 June 2021 to 31 May 2023. The June start date of the comparison is due to a five-month lead in COVID injections, while Midazolam injections have only a one-month lead relative to the deaths. Table 7 shows only Midazolam injection had statistically significant correlation to excess deaths (highlighted in yellow) in the vaccination period.

Values	COVID deaths	Non-COVID deaths	Excess deaths
Midazolam correlation (%)	7	42	53
p-value	0.73	0.04	0.004
Vaccination correlation (%)	27	-20	-12
p-value	0.21	0.36	0.59

Table 7: Relative Impacts of Midazolam (lead one month) and Vaccination (lead five months) on UK Deaths

Neither Midazolam nor vaccination were statistically correlated with COVID deaths, which is not surprising given the unreliability of the data. Midazolam, shaded yellow in Table 7, was significantly correlated with both non-COVID deaths and excess deaths.

Vaccination had no significant statistical correlation with UK deaths with a five-month time lag or with any other time lag. Unlike in Australia, this lack of consistent correlation, suggests that COVID vaccination has no statistically provable impact on UK deaths: COVID deaths, non-COVID deaths or excess deaths. This lack of statistical evidence does not mean that vaccination may not be a primary cause which was likely masked by the causal proximity of euthanasia with Midazolam. Given the Australian research which proved "vaccination kills" [1], it is highly probable that the sustained elevation of the levels of UK excess deaths was not due to natural causes, but due to vaccination. However, for the epidemiology of the confounded situation in the UK, other approaches and methods are needed to establish the relationship between vaccination and excess deaths.

Implications for Epidemiology

The current study of excess deaths in the UK holds important lessons for the epidemiology of the COVID-19 pandemic globally, as it has demonstrated that in some countries, such as the UK, specific confounding factors should not be overlooked.

Attempting to attribute excess deaths solely to either COVID disease or COVID vaccination may be erroneous. Applying simplistic models globally to estimate how many millions lives vaccination has saved or how many million deaths vaccination has caused, without really understanding the actual facts of data limitations, has led to a confusion which prolonged bad policy decisions costing many lives.

A simple example may illustrate the prevailing fallacy. Figure 17 shows the pooled weekly total number of deaths for all ages in 27 data-providing EuroMOMO [38] partner countries and subnational regions, consisting of Austria, Belgium, Cyprus, Denmark, Estonia, Finland, France, Germany, Germany (Berlin), Germany (Hesse), Greece, Hungary, Ireland, Israel, Italy, Luxembourg, Malta, Netherlands, Portugal, Slovenia, Spain, Sweden, Switzerland, UK (England), UK (Northern Ireland), UK (Scotland), and UK (Wales).

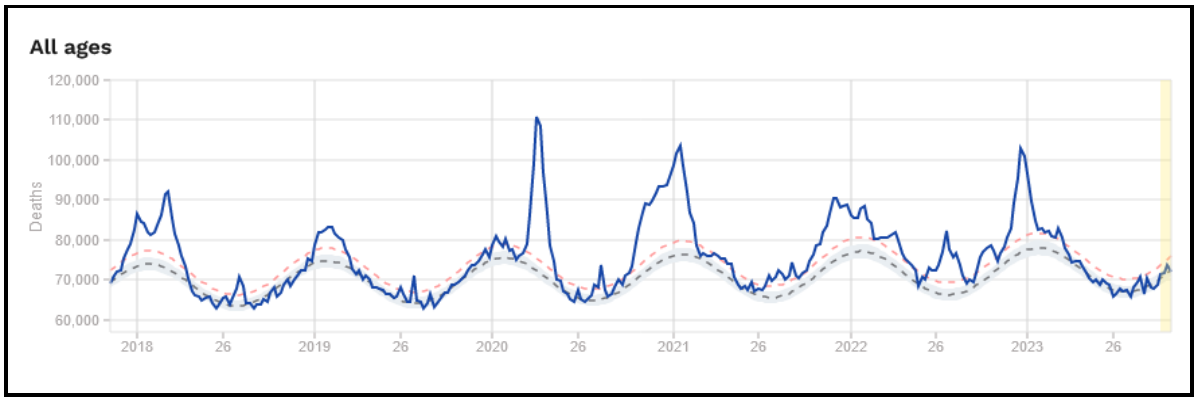

Figure 17: Weekly total number of deaths for all ages.

Ignoring confounding factors in individual countries, the pooled all-cause mortality (solid line) of 27 countries is shown above their baseline bands (dotted lines). Due to seasonal fluctuations and a slight rise in the baseline over time, Figure 17 is not the clearest way to compare excess deaths.

Evidently, comparing major all-cause mortality peaks, excess deaths in the European pandemic have never exceeded the peak of early 2020. The general observation has allowed European governments, with the help of flawed research based on flawed data, to claim that excess deaths are all explained by COVID virus and its variants. Our paper here has shown that the COVID virus had evidently little consistent impact on excess deaths in the UK.

Some governments, with pharmaceutical funding, have speculated with computer modelling that without vaccination excess deaths would have been much higher, saving millions of lives. Equally unjustified are the opposite claims that the data show that vaccination has cost millions of lives. This paper has shown that neither may be the case for UK, because currently available data may not be adequate for proving either case using existing methods.

This paper has shown that for global pandemic epidemiology, countries need to be classified at least into two groups: one group has members such as the US and UK which have intervened significantly with medical and clinical protocols early from the start of the pandemic. Another group has members such as Australia and New Zealand which apparently had no such medical intervention until the rollout of COVID vaccination. (Australia allowed voluntary assisted dying only recently in most states, except for Victoria which first allowed it in 2019, but also it happens to have the highest Australian COVID deaths in 2020.)

Summary of Findings

The COVID-19 pandemic in UK was iatrogenic, as it did not originate from the SARS-CoV-2 virus, but originated from Midazolam use in euthanasia and then likely later from mass vaccination. The main findings supporting this conclusion are:

• There were relatively few cases of infections in early 2020,

indicating the non-prevalence of the SARS-CoV-2 virus in the UK.
• The UK Health Security Agency declared on 19 March 2020, the absence of any "high consequence infectious disease", denying the existence of a pandemic.
• The enormous spike in excess deaths attributed to COVID-19 was inconsistent with the lack of prevalence of the SARS-CoV-2 virus, which was not verified, due to shortages and unreliability of PCR tests.
• NHS and Nightingale hospitals were mostly empty, confirming absence of a pandemic.
• The excess deaths were spread uniformly and simultaneously across all English regions, inconsistent with natural contagion.
• The spikes in excess deaths across all regions were strongly correlated with Midazolam injections, implicating euthanasia, particularly of the elderly in care homes.
• On investigation, the UK Government, Amnesty International and the Care Quality Commission have all acknowledged that *"a systemic or structural dysfunction in hospital services*" and the widespread blanket use of *"Do Not Attempt Cardiopulmonary Resuscitation"* (DNACPR) notices in care homes have contributed to excess deaths in the UK.

That "COVID vaccination kills" has been proven statistically using Australian macro-data, which should apply universally. However, this causality has not been confirmed for the UK, because the same method of proof is not available from UK macro-data due to the confounding effect of Midazolam use in UK euthanasia.

A major finding of this paper is that the very high excess deaths in 2020 in the UK were due to Midazolam intervention rather than SARS-CoV-2 infections, demonstrating the unreliability of COVID data as evidence of a SARS-CoV-2 pandemic, which was denied the status of a "High Consequence Infectious Disease" by UK Health Security Agency in March 2020.

Any claim that COVID vaccination saved lives has little merit, because few lives were threatened by the largely absent SARS-CoV-2 virus in the UK; the spike in so-called COVID deaths in 2020 was actually euthanasia deaths by Midazolam, which remains the dominant causal explanation of the pandemic, overwhelming other factors.

Midazolam injections were agnostic to vaccination status. Therefore, excess deaths caused by Midazolam were randomly related to vaccination status, confusing the raw data on "deaths by vaccination status" and thus invalidating most UK studies based on that flawed data.

The illusion that COVID vaccination was "safe and effective" was caused by Midazolam injections in UK being very high in 2020 and diminishing after vaccination, resulting in falling excess deaths over time, mistakenly credited to vaccination. This fallacy is material in justifying a continuation of vaccination policy in UK and Europe.

Most epidemiological studies of excess deaths in the COVID-19 pandemic have considered the relative impact of only two factors: COVID disease and COVID vaccination. Due to the presence of significant confounding factors, claims of observed correlation between deaths and vaccination for many countries are illusory.

Only those countries such as Australia, which were apparently free from euthanasia and other medical intervention, are suitable for the epidemiological study of the impact of vaccination on excess deaths.

Conclusion

The extraordinary spike in UK excess deaths in April 2020 was not due to the SARS-CoV-2 virus, because there were relatively few infections and there was no "high consequence infectious disease", as officially declared in March 2020.

The UK COVID-19 pandemic was iatrogenic, created with widespread and persistent use of Midazolam injections in all regions of England, particularly in care homes, under a systemic policy of euthanasia. The nature of the euthanasia needs further investigation.

Statistically, Midazolam injections were highly correlated with UK excess deaths throughout the pandemic, overwhelming COVID-19 disease or vaccination as other possible explanations for excess mortality.

Midazolam was the common proximal cause of excess deaths in the pandemic, but there were likely many other primary causes including comorbidities, infections and vaccination. The data available are not sufficient to measure the precise impact of vaccination on excess deaths.

Vaccination was unlikely to have saved many, if any, lives because the unreliable early data grossly exaggerated COVID deaths, inflating the extent of the SARS-CoV-2 threat which was subsequently assumed and projected in computer models which created illusory benefits.

Most global investigations of COVID-19 epidemiology, only based on the relative impacts of COVID disease and vaccination, are probably inaccurate, because their assumptions are generally false due to the significant presence of confounding factors in some countries, such as the UK.

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The author has no financial or political conflicts of interest and is not funded by external sources.

Acknowledgment

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