June 2021 newsletter

Introduction

Hi to all of you and thank you for reading this June edition of my newsletter.

I have to apologise at the outset if you did not directly receive this, even though you have signed up for them. I am trying to work out why only around 60% of my mailing list gets these newsletters and the online provider does not seem to give me the information I keep asking for. So if you are not directly getting them, please try subscribing again via my contact page on www.roryduff.com

We are in June again so that means we have a gathering coming up. This time the day before the solstice when the harmony begins is the Sunday 20th and I will be heading down to Burrow Mump in Somerset – another wonderful site where the St Michael and St Mary lines cross over at the top of a small hill with a ruined church on top.

https://www.google.com/maps/@51.070913,-2.9143327,3a,55.1y,236.95h,92.6t/data=!3m8!1e1!3m6!1sAF1QipPDQXX57pDRAIvdssnoSF_ygoAxRmNoW2s2NR4I!2e10!3e11!6shttps:%2F%2Flh5.googleusercontent.com%2Fp%2FAF1QipPDQXX57pDRAIvdssnoSF_ygoAxRmNoW2s2NR4I%3Dw203-h100-k-no-pi-0-ya170.3144-ro-0-fo100!7i5300!8i2650

If you can join me there for a 12.00 midday meditation, that would be lovely, if not please do join in at your nearest sacred site at your midday wherever you are in the World. We are making a major positive difference doing this and our numbers are growing. *(Positive vibes are needed in the run up to this from everyone as the last three solar quarter days, we have been placed under lockdown conditions in the UK – it's as though they don't want us to gather on these particular days ☺& there is talk of another lockdown (b)looming from the E'epa)*

This time, the duration of the harmony time looks like it will be 11-12 days. Things are getting interesting as they say.

As for what I hope you find interesting, in this newsletter I have started with an article on 'When a Ley is a Ley or not a Ley?' What I have done is work you through an example to show how mistakes can easily be made and how these can be avoided when working remotely. The latter is shown with my own experience tracking an alignment across a few states in the USA last month.

The books section follows this up nicely with a book that took 15 years to research and write. I have to say this really is a great piece of work and if you liked reading the book 'The Sun and the Serpent', you will enjoy this one.

The science section describes the galactic current sheet in as much detail as is known at the moment and what we can expect as we pass into it and through it. There are also hints on what we can do. This is revealed in a historical way looking back at it all, with us having gone it through it already. I hope you will permit me this small poetic license here.

This month's image that you can see at the start of this newsletter is discussed in the social media section. In May I wrote about some of Salvador Dali's work, its connection to geometry and spirituality and now here, there is a connection to what we might expect to find happening in the future. It seems the Dali, just as Jung too discovered, was able to get glimpses of the future, via his subconscious mind, through the symbolism that emerged from that and into his art. I make an early attempt to analyse this in this section of the newsletter – see what you think and yes, there is a connection to the content in the science section.

I now have to apologise again this month for my newsletter being large *(albeit that my section on only 25 pages).* I had not intended this but then my colleague Mr John Dee, one of the World's leading statisticians, just kept blowing me away with what he was discovering and I had no real choice but to add his work to the last section of this newsletter. So if you have not been keeping up with his work on his social media sites, it has all been compiled into 50 pages at the end. Please take your time to read this.

If, though, his work is new to you though, I would advise reading his reports in my May 2021 newsletter which can be found online at my website www.roryduff.com

*(In short summary, yes we have seasonal flu and **coronavuris** problems which unfortunately have a fairly regular fatality rate, but we have also been experiencing short sporadic doses of gamma ray radiation – particularly in February & March 2020. This caused a serious increase in lung inflammation and breathing problems and a spike in the fatality rate. We have since been dealing with the reaction to that in the World with the roll out of all kinds of control systems and experimental treatments – all with disastrous consequences).*

You may notice that some words in this newsletter have been spelt wrongly. This is deliberate so as to not draw attention to any online 'bots' that might try and restrict the sharing of this document.

What I can promise you about Mr Dee's work this last May is that it is truly astounding. If you would like to subscribe directly to see his ongoing daily statistical analysis here is the link https://www.facebook.com/groups/johndee333 But please no long questions to him, he just cannot cope with the increasing number of subscribers 10 to 2000 in two months is pretty good going.

Having looked at the European database (EudroVigilance) with its adverse reactions and fatalities following vaccination, he now takes an in depth look the VAERS database – the American version. There he found thousands of incidents with report dates that don't yet exist! Some nefarious group of people have clearly been fudging things.

In addition to that he shows from this data just how more dangerous the civod viccanes are when compared to the flu viccanes. A hint here – this is hundreds of times more dangerous.

He then delves deeper into finding the age at which you have an increased chance of dying from the vaccination rather than the vuris with a statement saying that the viccane is more likely to kill you if you are under this age. OMG.

As for whether vaccinations are responsible for the increase in deaths – well the answer is in no doubt when you see the percentage who die within the first two days.

All in all, he comes to the conclusion that what we have been experiencing is nothing like a pandemic, it's not even a 'casedemic' but instead a 'testdemic'.

At the very end of his work in May he was astonished to find that the vaccination program is increasing the prevalence of the vuris – absolutely contrary to what the government has been telling us about how effective their viccane program had been. He goes further here though to show how the government has not even bothered to check the bias in their own statistics & figures. When you learn what that bias is, you will see just how easy it is to engineer a crisis and then make it look like you have come up with the right solution to sort out the problem.

We have clearly all been subject to a massive global fraud that has been manipulated at the highest levels for nothing more than greed, money and power. In the last couple of sections he shows just how they are doing this.

There is still so much more though and both he and I have still stayed away from projecting any figures that might arise from the possible medium to long term effects of having the experimental treatment. When this was trialled in the past on animals it led to antibody-dependent enhancement (ADE). The only thing to say here is that inflammation is the number one problem and anything that helps reduce that inflammation, like fasting, is critical. *(Invermectin, Hydroxychloroquine are two successful drugs that have been used very successfully recently in India to combat the sudden increase in inflammation in that country – seasonal illnesses like flu and coronavuris occur during the winter months so their last bout of problems was far more likely to have come from some more sporadic gamma ray radiation.)*

Please remember, you are free to share this newsletter with anyone you think might appreciate its information. It has to be said that some people, might not appreciate this and I do not wish to offend or upset them.

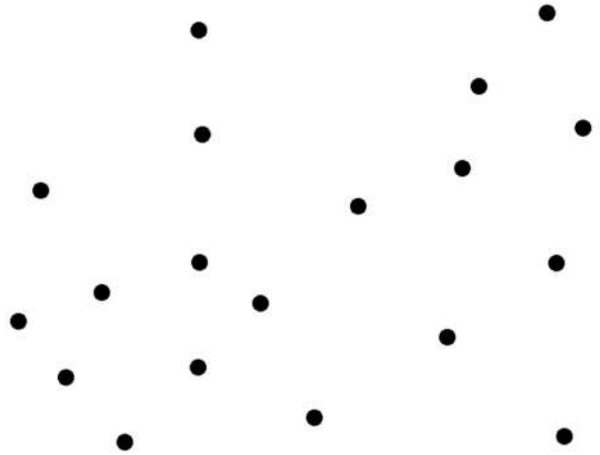
That may be for another time though. For now, please enjoy the rest of this newsletter.

Earth energies

I have been mapping earth energies now in earnest since around 2005. Many lessons have been learnt since then and mistakes rectified. My teacher is undoubtedly the energies themselves. The snake is the instructor as the Gnostics would say.

One of the biggest lessons was the discovery of different types of energy lines based on their frequencies and energy signatures with their side to side movement. Just this understanding helped me overcome the first problem that I have now set for you in this section of the newsletter.

What you can see below are a random arrangement of dots. You can consider them as a variety of different landmarks like tumuli, holy wells, churches, standing stones, stone circles and passage mounds - in other words possible sacred sites.



If you look at these dots, you can see possible lines or alignments in several directions. Indeed many different straight lines could be drawn between them all.

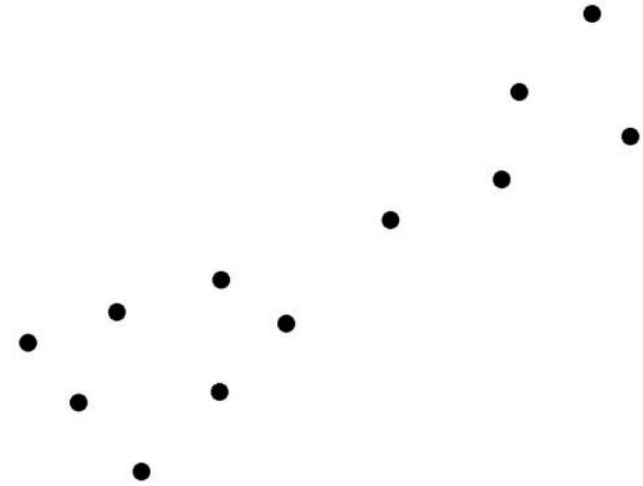
Alfred Watkins, in his book 'The Old Straight Track', wrote that he noticed that these sorts of sites all seemed to run in straight alignments across the countryside. He rightly wondered why this might be the case. He called these alignments Leys. John Michell, writer of 'The new view over Atlantis' went on to suggest that there was some ancient energetic significance with one of these alignments. He identified this as the St Michael alignment which ran through Cornwall in the South West of the UK up through to East Anglia on the East coast.

This became much a more well-known feature when Hamish Miller and Paul Broadhurst discovered a pair of Earth Energy lines running alongside this alignment - which was now becoming more commonly known as a Ley line.

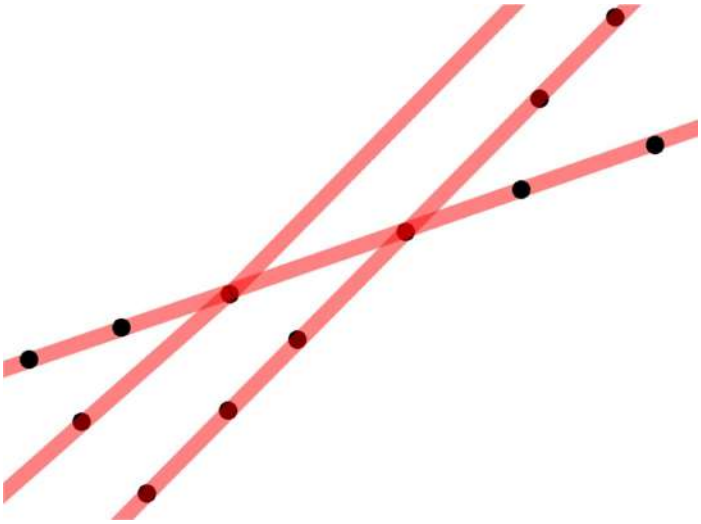
When looking at these dots on the above image though, if we were told that there was one strong powerful alignment here with a pair of energy lines, we could not sure exactly where this alignment would run and through which sites it would pass though.

Indeed this was one of the main criticisms from scientists when confronted with the idea of Leylines and earth energies. They rightly point to the fact that there could be straight lines anywhere and many different places for there to be intersections between all of these lines. Some would even say 'Why do we not see sacred sites at every intersection?'

One way that we might perhaps try to answer this is to be selective with the sites. We could perhaps just pick out the stone circles and the standing stones. There is no scientific method behind this though.

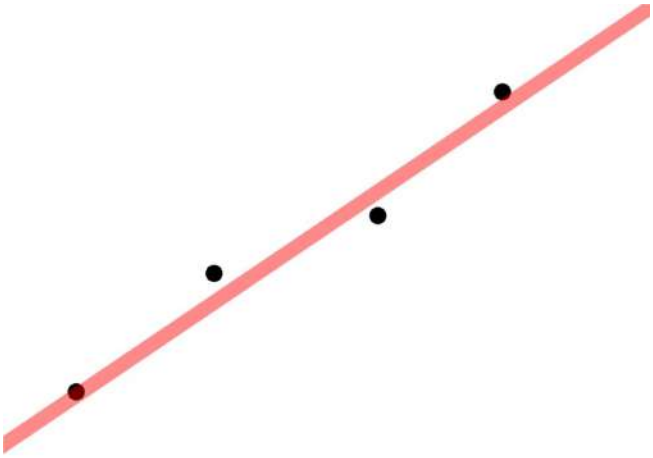


For example, you could consider the above image is what we might be left with if we selected key sites. But we are still left with wondering where the straight alignments might be.



For example, in the above image, there are three possible straight alignments that could be drawn here between all these lines. Would this be right though and how could we check.

You see finding alignments running across a country could be extremely helpful, as long as we had a way of checking to see if they were significant and correct.



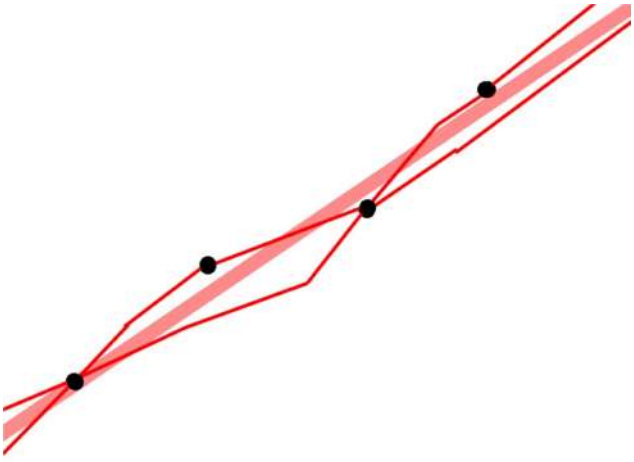
Would it now surprise you if I told you this was the right answer to the question posed above?

You may well ask ‘How could this be proved?’ Indeed you might even ask ‘Why are these special sites not sitting exactly on the alignment?’

Well a closer look at the St Michael alignment, and the work done by Hamish Miller, and you will see that the many St Michael and St Mary churches found along the alignment did not actually fall precisely on the straight line. He told many people about this and even wrote about it. Some of them were definitely found to the side sometimes by over a kilometre away.

The feedback, that helps you establish whether you have a significant alignment or not, is all about finding the pair of earth energy lines that are associated with that alignment.

It is not until you get into the field and make observations, in the way that Hamish Miller did, do you find out exactly where the two energy lines are found and where they intersect each other. The image below shows this.



The thicker line is the straight alignment – the Ley or the Leyline depending on what you prefer to call them. The thinner lines are the two Earth energy lines.

This is all very well but we still have many other sacred sites in the above example. If you remember the first image with all the dots, we must consider if they too have any relevance? Are they special places? Did our ancestors think they were? Are there even any energy centres at these places? Are there other alignments in this region – ones with other pairs of energy lines?

This is where the discovery of the different types of energy line came in and it massively helped our understanding in these areas.

If you look at the image above again you can see that two of the dots are where the two *(thinner red lines)* energy lines cross over each other. Each of these two dots would be where an earth energy node would be found. But at this stage we cannot tell whether one of the two is more significant that the other. If we could tell the difference, we would be able to turn around to the 'dismissive' scientists and explain why there were not sacred sites found at all the possible straight line intersections.

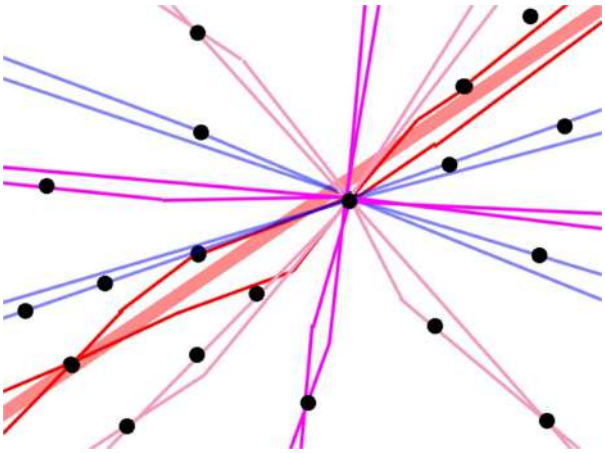
Fortunately, now that we can differentiate between all the groupings of the energy lines, an answer emerges.

When you are mapping a large area, many different energy lines can be found. These differ in several ways. There are a few that are wider and which exhibit much lower frequencies. But there are others which are much narrower, with higher frequencies, and these are much more numerous.

The frequencies are identifiable by their side to side movement away from the intersections. In the UK the lowest frequency lines take 18hrs to go one way and 18hrs to move back the other way. The faster, higher frequency lines do this every 6 hrs. *(It is when all the lines move at the same frequency – four times a year – that are the times we have our group meditation gatherings as it is these times that the special energy shapes occur at the intersections.)*

When we map a large area to see where all these energy lines are found, we find that the major intersections are were where the rarer low frequency lines crossed over. We also find that at these places, there is a concentration of many more of the higher frequency energy lines. It is as though the crossing of the lower frequency lines attract many more of the smaller higher frequency lines.

In the example we are using, we can draw in some smaller Earth energy lines to demonstrate this. As you can see a bigger picture emerges – one that now shows that one of these dots is much more significant in terms of energy than all the other special sites.



In doing my sacred site searches for people all around the World, one of the important lessons here is that we can look for straight alignments but not to be too strict in regards to the special sites we find on the ground.

Firstly, it is because these sites may be to the side of the alignment. Secondly, it is because at the outset of looking at new area, we cannot know where the major energy lines are found.

In other words, these alignments make a useful starting place to find these energy lines but something else is needed to be able to provide feedback that supports it being a true alignment with a pair of powerful low frequency energy lines. In the field, this feedback is easy to do with colleagues checking your work independently and in a double blind way.

When doing these searched remotely though, this is not possible. It is simply not possible to travel everywhere. There are several ways we can still get this feedback and I wanted to discuss one of these in this newsletter.

In many discussions with people about these energy lines, we know that people build up a familiarity with the frequencies of these lines – especially if you live or work on them for long periods of time.

However this familiarity seems to run deeper than this. I have met several people who have had significant moments in their life that have occurred when they lived in other areas of the country. What they have found strange is that the locations of these events have fallen on a straight line. It is also fund that very often it is the one that they are still living on. It is as though they are drawn to these places/energies for some reason.

One of the reasons I like Gary Biltcliffe and Caroline Hoare's book 'The Spine of Albion' *(This is covered this month in the book section)* is that it shows this familiarity with these lines

goes into a deeper level still. They discovered that families over time had been drawn to places along this energy line. This alignment has a pair of type 1 energy lines running alongside it. These are fairly common lines but this particular line has been shown to have been remembered over time by the people living on it making it much more special than all the other type 1 lines. The reason for this is that sacredness is about the location and the people interacting through meditation and prayer on these locations. If lines and sacred sites are forgotten, then those locations need finding and reactivation through prayer and meditation and this is the main reason why I do the sacred site searches.

Many powerful energy alignments as well as many less powerful ones have been lost over time and it is work like Gary and Caroline's that help us learn more about these energy systems.

It is now this link with people and these energy lines and their sacred sites and their connection to the universal consciousness that can be shown to work on several other levels as well.

Indeed it is one of these that can provide us with feedback that then indicates we are not making things up when we do remote searches. What I am talking about here is synchronicity and staying in the flow.

When you are working in the flow, following a vocational path, synchronicity keeps on appearing. For example, as you are probably aware I have embarked on a project to map all the type 4 alignments that cross over the USA. This has already taken me around 18 months and I am still not finished. There are many of these lines and many intersections and some of these lines cross over each other at narrow angles. A real problem that has to be overcome is tracking one alignment, only to find you are now deviating and following another one that has crossed your original one at a narrow angle.

Of course, if this happens, after a while you end up a long way away from your original alignment. When trying to find out how this happens in the first place, it is often down to one's own desire to get the work done, rather than going with the flow.

I had been tracking one particular type 4 alignment that ran through a place called Mount Diablo, just to the East of San Francisco. *(Regular readers will know this from an earlier newsletter and a dragon Kite).* This line was heading up in a North Easterly direction but work on it had stopped several months ago as I was busy on other things. However this month, I was sent a link to an online book about energy lines.

It was written by a chap called David Alan Ritchie and it is called 'We the Skythians' *(This refers to the people from the Isle of Skye)*. Here is a link for you.
https://archive.org/details/skythians/mode/2up

It is a beautifully colourful book with lovely images that is unfortunately now out of print. At the time it came out in 2012, it was quite ground breaking and there is much in it that still holds today. However, just as there is much in it I like, there are some parts that I disagree with – mainly because research into Earth energies is still a young science and learning since 2012 has progressed rapidly. There is of course nothing wrong in disagreeing with someone else – this is how we progress to get closer to the truth. My own books and research may even be updated by others in the future when new observations have been made.

What got my attention with this book though were the several similarities to my own life. David Alan Ritchie lived on the Isle of Skye, an island off the West coast of Scotland, in a place called Sleat. This immediately got my attention as this was where my own ancestors came from – my tartan is even called 'Macdonald of Sleat'. He had started by learning to dowse for water – so had I. He was fascinated with Energy lines Sound and Resonance and so am I. He also had a strong gold mining connection *(mentioned in his book)* – so did I *(I worked as a geologist on the Gold mines in Southern Africa)*. He had also been to several very special sites around the UK that I have also been to and that I had also recognised were extremely significant – Roseberry Topping for example.

So as you can imagine, I was eager to explore this book further to see if there were any secondary events that might show some current synchronicity and also to find the nuggets of truth it contained.

I did not have to look far as he described where he used to live in the USA. It was here that he began mentioning significant places that were exactly where I was about to start working on for a sacred site search for a lady in Nevada.

This search was in the Lake Tahoe region and the mountain he had mentioned was Pyramid Peak (Just over the state border in California). This was now right on the alignment I had been tracking from Mount Diablo.

This alone might have been enough feedback to think I was still following the same alignment but there was more. Another earlier sacred site search, two weeks before, had thrown up some significance with the Grand Tetons in Wyoming and this too now was on this same alignment.

At this stage it looked as though this SW/NE alignment was going to cross over another type 4 alignment that I had found three months ago running in a NW to SE direction and which ran through the Big Horn medicine Wheel.

It is easy to self suggest where an intersection between two lines might be found as this sort of mind game will result in finding what you expect to find. In this case, it looked as though the node might be at the medicine wheel.

The trick to being successful though is to know how not to fall prey to self-suggestion. *(If you would like to know more about these, just book up on my dowsing courses).* With that in mind, I parked my own conscious desire to see where this node might be found.

A week later, I had another enquiry about a search in the sacred grounds region of Southern Montana – an area just to the North of the Big Horn wheel and I now had a wonderful influx of uncertainty as to where these two great alignments were not going to intersect. It could be at Big Horn medicine wheel or at some location in these sacred grounds, or indeed somewhere in between. The point was that now when the time come to do the search my conscious mind will play no part.

I feel very fortunate to being guided this way to do this work.

So, with several concurrent, independent, informational prompts all connected along this one type 4 alignment within 4 weeks of each other, it provided me with good, synchronistic feedback that this alignment I had been tracking was indeed a very real one and that it had a pair of type 4 earth energy lines running along its length.

In other words synchronicity helps verify the remote tracking and mapping of these powerful energy lines. Whilst this is good news, it also means that the pace of the project is not up to me.

One final point here, one that you might have come to see for yourself, is that the Leys (Leylines/Alignments), are not what are most important. It is all about the energy lines and where they intersect one another. The Leys do help us find them though.

If you would like to know more about these different energy lines, nodes and vortexes, I have a **guide book** but **please do not buy it** at the moment.

I am in the middle of a large update to it and a 2nd edition. Hopefully this will be available to buy in July so I would suggest waiting until then. The last three years, since I wrote the first edition, has brought forth some very valid observations that have necessitated this new edition as well as it being able to be massively expanded in its informational content.

Science

What is the nature of the Galactic current sheet? What are its different zones widths? What can we expect when our solar system passes through it? And perhaps more importantly – why do we need to know this information?

The Voyager 1 space probe exited the solar system *(an area defined by the extent of the Sun's Heliosphere)* several years ago now and immediately began to make new discoveries. One of the first was that our solar system was in a **local interstellar magnetic field**.

It went on to find that, within this, there was a **large scale density gradient in the plasma** (ionised gas) that was found there.

Then, in 2017, a weak narrowband plasma wave emission was found which has persisted ever since then. Details of this can be read in a paper in Nature titled **'**Persistent plasma waves in interstellar space detected by Voyager 1'.

(A link to this paper here https://www.nature.com/articles/s41550-021-01363-70)

By **2020 Voyager 1**, was still moving through the interstellar medium and it had now **found three shocks and one pressure front within this field.**

In a paper in the Astrophysical journal titled 'Magnetic Field and Plasma Density Observations of a Pressure Front by Voyager 1 during 2020 in the Very Local Interstellar Medium' it said that a relatively **large increase in the magnetic field strength** appeared to be associated with a **compressive wave**. (Think of a high pressure wave here).

(A link to this paper here https://iopscience.iop.org/article/10.3847/1538-4357/abeb6a)

It now appears that **in 2017 a magnetic pressure wave was found by Voyager 1** and this has not stopped building since then and **in May 2020 another wave was detected**.

Scientists now think **we will get many more of these as we head deeper into the galactic reversal zone in the galactic current sheet**.

Before we get to this galactic reversal zone, it should be remember that back in 2017 we found all the earth's energy lines all suddenly doubled in their widths and shortly after that we had the arrival of thee more Emperor dragon type 5 energy lines. It is now considered most likely that the source energy for these is galactic and that the centre of our own galaxy is almost certainly one of these sources.

What we are looking at here is the very real possibility that these energy lines are connected to the events, magnetic fields, plasma & cosmic waves now being encountered as our solar system enters this galactic current sheet.

Changes to these energy lines will therefore potentially give us some advance information about these coming changing conditions out beyond our Heliosphere and quite probably information well before we get any more data from Voyager 1.

The galactic current sheet is an electric field that ripples out from the centre of our Milky Way galaxy. We have a fairly good understanding of just what this is like because our own Sun has its own Heliospheric **current sheet** and our Earth passes through it every 8-10 days.

The only difference between the two current sheets seems to be that the galactic one has a lot of dust travelling with it, whereas space in our own solar system is a lot cleaner.

Because we know the Sun's current sheet affects our atmosphere and leads to Earthquakes, we know that the galactic one will also do this but perhaps on a bigger scale.

One of the recent findings on studying the type 3 energy lines is that these come into harmony every 8-10 days at the same times the Earth passes through the Sun's current sheet for 2 mins every 8-10 days.

This now suggests that when we pass into the galactic current sheet, all the energy lines are going to come into harmony – possibly for a lot longer than 200 years – which is the time our solar system takes to pass through this sheet.

The implications of 1000 years living with one energetic vibrational frequency will be incredible.

In the central area of the galactic current sheet, which we won't immediately pass into until we have been in it for a few years, we find **the reversal zone**. This is an interface between two different magnetic regions. These are opposite and yet parallel electric flows which, along with the spin of the galaxy, lead to the ripple like effect that has been observed.

These two magnetic regions have one clockwise motion and the other counter clockwise. **The reversal zone is the interface between these two different magnetic regions.**

As we move through this area of space, we move through these ripples one after the other. At our distance from the galactic centre, we move through it roughly every 12000 years.

As our solar system heads towards this reversal zone, we will get more pressure waves and the Earth's magnetic field will continue to lower in strength.

More information about this can be read in the paper titled 'Three-dimensional structure of the magnetic field in the disk of the Milky Way' in the Astronomy and Astrophysics journal

(A link to this paper here https://www.aanda.org/articles/aa/full_html/2017/07/aa30740-17/aa30740-17.html)

The question on everyone's minds who knows about this, and we talking about a very small percentage of the World's population *(probably only a few hundred thousand people out of 7.8 billion)* is **what will happen to us?**

This question to me is **the single biggest and most important question facing mankind right now** and it's not even being discussed in the mainstream media. Forget climate change, forget any vuris, it is these changing space conditions that are in the driving seat.

If you read my last newsletter, you will see that this is also responsible for the increasing gamma ray radiation and the effects we are finding from that.

As I see it at the moment, we are going to go through **four different stages** as we head to the centre of the sheet and then again as we exit the sheet.

The following is not really something that should really come under the science section of this newsletter as they are thoughts on what we might expect to experience.

It is also written in a historic perspective as though we are looking back at having come through it all – I just felt that this would help you stay positive during your reading as I have the firm belief mankind will endure and live though it:-

1. Entering the presence of the galactic sheet
2. Fully entering the galactic sheet
3. Entering the reversal zone region
4. Passing through the central boundary between the two different magnetic regions

Entering the presence of the galactic sheet

This began back in 2017 when we experienced the first magnetic pressure wave and when all the energy lines doubled in width and, in particular, the central band of these energy lines widened far more than the other bands. This was the one that correlated with the Sun's energy.

The North South type 5 line meridians appeared at the end of that year and this was linked to the Hopi prophecy about the arrival of the twins – the god of the North pole and the god of the South pole. *(More about the universal prophecy in my book Grail Bound).* This indicated to us that this was the start of the 7 year countdown before we entered the actual galactic sheet.

Since then we were getting extended harmony times. What was less than half a day long four times a year became 9 days long. These extended durations continued until they were 96 days long and all year round and year in year out, with one continual single vibrational frequency. The timing fitted perfectly with the 7 year prophecy.

Back in 2017 what also started was chain of increasing physical & mental effects in the World. Sensitive people all felt something had shifted energetically and psychically. Empathy, telepathy, synchronicity and lucid dreaming all began to increase for people.

Unfortunately too the effect on the human mind was not helpful for some and a rise of extremist thinking began as did a rise in mental ill health for those unsure of what was going on. Their minds, with the thoughts and visions that they were inexplicably experiencing, were deeply concerning to them and they found it all far too hard to handle. Friends and family and even professional helpers around them were at a loss, and without explanation back then, for how they could help.

Independent thinking also grew stronger as people began to resent the control structures that the 'would-be' rulers of the World had put up. They in turn sensed the tidal change in public thinking and took steps to put further controls on their populations.

Physically, what had actually begun very slowly many years before, was the gradual declining strength of the Earth's magnetic field. Since 2017 though, this field strength loss dramatically increased and the North and South magnetic poles started moving much faster towards each other. Back then it was thought to be either the start of a magnetic incursion, where the poles would stop heading towards each other and go back again, or the start of a full magnetic pole shift. We didn't know the answer then.

With the magnetic field strength decreasing, more cosmic rays were getting through to our atmosphere. These, we knew, were evolutionary in that they could mutate cells, but we also knew they could kill human cells. The thinking back then was that they could also reactivate dormant cells in our hearts and minds. This began to explain the increase in psychic abilities.

It was at this stage that a few people in the World, who had known this event was coming, and who had prepared for this, began to put their plans in place. On the one side there were the enlightened few but on the side there were those who wanted to stop this coming evolutionary shift in global consciousness.

All sorts of dastardly, evil actions and plans were put in place by some of these humans – ones who we now know were being influenced from demonic sources.

The increasing cosmic energy led to the natural increase in gamma ray radiation & this led to a large rise in lung inflammation. This restricted the oxygen intake into the blood and many people died as a result – especially in the areas where the magnetic field strength was drastically lower. Fortunately common medicines were found that could reduce this inflammation and fatality numbers started to reduce.

Some of the more enlightened and informed people started fasting and taking in more vitamin D from the sun. They started being even more careful with their food and drink intake in order to maintain a strong immune system. They knew there was both a positive and negative effect to these energies and that they would soon be coming in waves with greater and greater strength.

Their only way to survive, and thrive, was to build up their body's and their mind's ability to cope with these increasing energetic changes to their environment.

They knew had to stay extremely positive and to begin to work in groups and form strong local communities.

Fully entering the galactic sheet – The expected timing for this was December 2024 to January 2025. As it happened, it hit us just after the Winter solstice when hundreds of thousands of people had gathered on sacred sites all around the World. Groups were now taking it in turns to ensure continuous meditation and chanting at these sites was going on throughout the following weeks. The energetic wave effect they generated all around the World was felt by everyone and it lifted people's hearts to feel a brief sense of enlightenment. It became known as the time of ecstacy and there were all sorts of reports afterwards of amazing phenomena being witnessed during those moments.

It was at this point in time that it was expected that we would have fully entered the current sheet. This would now dominate all the other energy arriving at our iron nickel inner core to the extent it would override all the frequencies to produce just one extremely low vibrational signal.

This one frequency was the 72 hour 'side to side and back again' frequency which we had already experienced as an incredibly different delicate almost divine feminine energy.

Just having one frequency then allowed us to learn how to connect with our subconscious mind more precisely. Chanting/ musical instruments/ vibrational generators were far more easily tuned to achieve resonance with this frequency.

The wave of energy that brought the whole population a feeling of ecstasy and enlightenment was brief but it was enough to make people realise the truth and this was when the real learning began. Many people now wanted to make the World a beautiful place and to experience that feeling again.

The motivation to do this was because we knew about what good felt and looked and sounded like. Many of us to though has also been given insights into all the challenges that were to come and they knew that more had to be learnt in order to overcome these but they also knew that it was well within mankind's ability to do so.

The one thing we were unsure of back then though was when the next event would happen. When would this next challenge come along? There was a calm urgency to everything like the peacefulness in the middle of a storm going on all around us.

Going with the flow, staying connected, was what we knew would lead us to the right result.

Nature provided both action and reaction. All we had to do was to work in groups to discover how to put up the protective electromagnetic energy grids in the areas where we lived. Doing this would deflect and shield us from most of the coming shockwave.

That was also the beginning of the time when communications with the 'Beings' on the other Worlds of spirit became much easier and clearer.

Our ‘conscious mind to subconscious mind’ communications skills grew with practice and we were able to develop much greater abilities and skill in Empathy, Telepathy, Clairvoyance. All beings were experiencing these same effects on their matter frequency Worlds as they were in exactly the same area of Space as we were – on their version of Earth – on their frequency of matter, just as we were on ours.

All of these new abilities we were feeling soon felt very natural – we just had to train to accept them and not become completely overwhelmed by them *(Our success with the decentralisation and the local support networks that were connected to the sacred sites led to a dramatic decrease in mental ill health)*

In regards to the physical effects that we were experiencing, we were finding increasing earthquakes storms and climate chaos. With our protective magnetic field lowering even faster, we were experiencing times when Earth facing solar flares were taking down large electrical generators and we had no electricity for several weeks as these were repaired. Fortunately most of us had built up reserves of food and water and these were shared with those who were less unfortunate. Many of us had stored more than enough for ourselves just to be able to do that as we were no feeling each other’s hunger with the increased empathy.

The economies around the World began to suffer and greater travel restrictions were put in place to stop the flow of people moving from areas where it was harder to live in, to where it was easier. The successful areas were the ones who had built strong communities which were then able to trade successfully with other growing communities. The move to decentralisation increased quickly despite the authorities trying to stop this.

More and more people however lost their fears and instead felt the beautiful loving support that was now emerging from out of the centres of these communities – their sacred sites.

Back then we were at a crucial time in our learning, We had to develop our skills enough so we could learn how we can protect ourselves from the worst of what nature could send at us.

Just when we would fully enter the galactic sheet’s reversal zone, we were not sure about at all. All we could do back then was to use our growing awareness and connection with the subconscious to help give us some timely information.

We were therefore unsure how long we would have – it could have been for months or several years or even a decade or two. It seemed that the ‘beings’ on the other Worlds were also trying to work it out or had been told they were not allowed to tell us as it was part of our learning curve.

Entering the reversal zone region

As it was, as it always is, we found we had just the right amount of time to learn, prepare and practice what we had to do. Why would the universe do it any differently? The first signs given to us came in dreams & visions and these were shared throughout all the different inter connected communities.

We then knew what to do.

The first signs were seen by the teams of scientists who had eventually been allowed to focus all of their attentions on the changes happening on the outer planets in our solar system and in our galaxy.

The first part of the zone to arrive ahead of the rest was the wave of dust. This was recognised because the scientists had detected small amounts of it arriving in advance and had noticed the slight darkening effect it had on our Sun.

When the full dust storm hit the surface of the Sun it went dark. We knew we had moments before it would turn red and seem to explode in all directions. During the darkness, many people went underground. The of us few us that knew what they had to do next stayed on the surface – just as the Hopi had drawn on their rocks so many centuries before.

The electromagnetic earth grids were moved into their protective positions and the hundreds of thousands of the more 'gifted and skilled' stood in circular group meditation on the key sites around the World.

As they saw the red light, they drifted into the realm of Universal consciousness with the magnitude of the force of love entering every cell in their body where they carried out their practiced individual functions within the group.

A few days later, the Earth was hit by storms of tiny beads of glass that contained all sorts of rare isotopic elements that could only have been made under nearby solar conditions. The storm caused superficial damage and some fires in the areas in most Sun facing areas of the Earth, but fortunately most of it fell onto our great oceans. The protective shield that had been erected by those in meditation helped reduce much of the damage from the unseen energies.

The build-up in earthquake activity had been continual and most people had moved out of living near or in high rise buildings. The earth tremors now rapid increased and that was when the tsunami's began. We knew this would happen though and we also knew that with foreknowledge death and destruction could be massively limited. Tales of 1000 feet high waves were just that, instead there was just lowland flooding in most parts of the World. Earths past catastrophic mile high Tsunami's had come from asteroid impacts, not solar eruptions or magnetic incursions.

Within days people began to return above ground and, where necessary, they began to rebuild their community infrastructure. The fact that so little destruction was found raised spirits to high levels.

We knew that it was not all over though and that the reversal zone would have one more hurdle for us to cross.

Passing through the central boundary between the two different magnetic regions

The earth's magnetic field was now down to 30% of what it used to be and the magnetic poles were about to switch. The Old North and South pole were about to meet just off the coast of the island of Java in Indonesia and a new opposite pole was now forming above Brazil.

Electronic communications had been patchy for the last few years building up to the Black Sun /Red Sun predictions. Fortunately enough of us were working well telepathically. The problem we faced now was with all of the electronic equipment. Much work had been done designing Faraday cages that could protect as much of it as we could, but sustaining constant power generation was always going to be a problem – even in renewable ways.

With the magnetic field changing as we passed through the centre of the reversal zone, it slowly began to build up to full strength again.

This time the new North pole was formed over the island of Java and the new South pole was found over Brazil. It was many years before these two poles began their slow journey back to the old polar regions and it was not until we were out of the reversal zone did the movement begin to speed up.

In the meantime all the climate patterns had changed. With all the electrical changes on the Sun also going on, the Earth's global electric circuit – the key driver for climate on the Earth, was also changing.

Cyclones and Anticyclones were not where they used to be. Rainfall fell in different areas than before. The regular winds had completely changed and short term meteorological prediction was so chaotic with the old measuring systems, it was down to the local seers to decide when and where to grow food.

We knew we were going to have challenges with crops and food production but we also knew that, where places were once barren dry deserts, they would become new places where life and vegetation would return.

The Sahara had already started becoming green again. It was just a matter of rearranging where we worked and lived.

Fortunately this whole process of change was occurring slowly and surely and our seers had given us advance knowledge of when and where to migrate and what to grow. Indeed we had returned to what humans had been doing 12000 years beforehand – only now we were also able to do this with the benefit of technology and all that we had learnt in the meantime.

We knew it would be hard work, but we were in a state of continual bliss so we hardly recognised it as work.

And besides, we could now see our unseen help.

This historical perspective of course is just made up, but hopefully for now, it is a best fit possible visualisation of what may likely come and how we might come together to face our challenges and overcome them and to become better people in the process.

For a brief overview of the scientific areas, you might like to watch this short video by Suspicious Observers. It will hopefully add to your understanding of the nature of the current sheet here. It is titled Galactic Electric Field & Solar Micronova https://www.youtube.com/watch?v=7W-OQT4pWaA

After the first 4min 30s, it goes into the micro nova section which to me can be positioned in a much more positive light when you factor in the human capacity to evolve and learn to adapt, cope and thrive under the new energetic environmental conditions.

Social media

My last couple of social media posts have been on Salvador Dali's paintings and how he might have been influenced and, besides the material World, what intrigued him.

https://www.facebook.com/RoryDuffGeobiologist

https://www.instagram.com/thegeobiologist/

I have essentially been exploring how the underlying geometry, that helps guide and construct the material world we see around us, might change over time (See post 365 for the latest on this). Understanding these changes might then help us begin to understand the sort of changes we are about to go through and offer us clues that will help us safely navigate our way through them.

What Dali seems to have been exploring is some understanding of the concept of spiritual levitation – something he had read about that St Theresa of Avila had been said to do.

It has been said that Dali used to use the lucid moments of time between sleeping and awakening to obtain answers to his questions but it is also undoubtedly true that all artists can

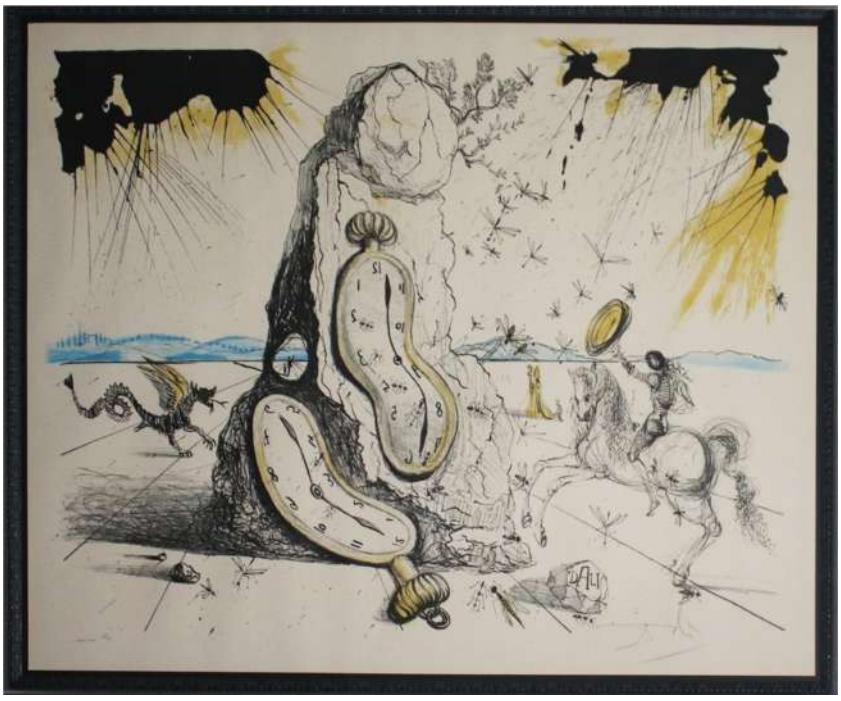
reach the same connection between their conscious and subconscious mind during their most creative moments when they work.

Either way, Dali was clearly tapping into his own subconscious mind for information. I explore this more in the spiritual discussion group modules that I run and one of the areas we look at closely is Jung's red book images. Jung too had become good at bridging this gap and on several occasions he seemed to get glimpses of the future. Indeed it was his final recognition that this was happening, and that he was not going mad, that made him continue with his experimentation.

So now when we look at the image at the start of this newsletter, we can see one of Dali's lesser known works. It is colour lithograph published in 1965 titled '*Cosmic Rays Resuscitating Soft Watches'.*

For all of Dali's ego, madness, opulence & extravagance, it probably helped him maintain some kind of balance in his life with his inner explorations within his art. In this image he was almost certainly receiving information about the future, just as Jung also had.

So when we look at the detail he has included in it, we can perhaps begin to see some clues as to what now lies ahead for us.



Just examining the title we must ask what Dali was really conveying here. He is known for his soft watches and they appear in much of his work, but here, in this one, there is a difference – the numbers have been deliberately reversed into a mirror image. The title also offers us a connection here between this reversal of time with cosmic rays, the latter of which are appearing from black clouds and spreading down to the ground in many directions. Just what this connection is we are left to wonder and its possible that even Dali was unclear about this

and it is highly likely he started painting without knowing where he was heading, hoping to learn more. The last thing he did was probably to find a title for it.

For regular readers of my newsletters, you will immediately see what drew me to this lithograph. On the left there is a dragon and we have to wonder why this universal symbol has made a presence in this work.

Dali though was thoroughly absorbed with dragons and he had a history doing St George and the Dragon sculptures and drawings that, to him, represented the duality of good and evil. But we have to ask here is whether this was exactly the same trap that Jung also fell into when he too came across serpents and dragons and associated them with evil.

To me, in both cases, this was the early indoctrination and programming of their early religious experience. So when these symbols appeared creatively to them both, an immediate conscious connection was made with what their minds had been programmed to think.

Instead we find the dragon drawn on top of lines of perspective coming to a point that has been clearly shown to us through a rather unnatural looking hole in the large rock in the centre of the picture. What we are being directed to look at the other side of this hole is an image of an adult and a child. Could we possibly being seeing here a symbol of people meditating on a node?

There is a sense of movement in this piece of art and yet, at the same time, it is also showing that it is capturing a moment in time – a moment that is perhaps particularly meaningful to mankind.

To try and find out more about this moment, we are drawn to the right side of the drawing and the white horse with the unidentified rider holding what looks like a shield high into the air.

Is this the moment in time just before St George duelled with the dragon, or is this some future time this dual will happen again and, if it is, how does this now connect with the implications in the title that link time itself to some great cosmic energy event.

But if we look more closely we see no sword and no lance. Will there be no dual this time around and if not why not?

Of course if St George has now recognised the good intentions of the approaching dragon a different story can begin to emerge. The shield being held up high seems to indicate the threat from above rather than from the ground below. Are the Dragon and the Saint now here to help mankind in its hour of need?

What now should we make of the flies and possibly a bee or two? Are they attacking or are they gathering to help us too? Much of course depends on our own perspective but that may be the very point here. We have a choice – we can choose to think of those around us are gathering to be helpful or we can think of them as adversaries we need to overcome. We can think too of the cosmic rays as damaging or helpful to us as well.

Are we left a final clue with his final act of writing the title? The word ‘resuscitating’ applied to time might well now suggest we hold the future in our own hands. Are we destined to repeat our great karmic cycle all over again or will we learn from our mistakes this time progress onwards for a change.

Do we choose conflict with our aggressors or do we instead choose to come together?

Yes flies and bees could be seen to be torturing us & stinging us, but nature provides us with both action and reaction, both problem and solution.

Yes, these coming cosmic rays can be destructive but they can be beneficial too – they can both kill and mutate cells. Yes, these dragon energies can cause us emotional issues as they enhance all our emotions, but they also teach us and show us the way.

We can wait and see or we can take action to ensure that most people know about this choice and wish to make the right decision.

It is these sorts of things that we discuss in the group discussion modules as the group learns techniques to connect and discover what comes through from their subconscious minds. If you are interested, new groups will start later in the year. Just keep a watch out on my website and future newsletters.

Books

An appropriate book, mentioned earlier, that I would draw you attention to in this newsletter is ‘The Spine of Albion’ by Gary Biltcliffe and Caroline Hoare.

If you liked reading Hamish Miller and Paul Broadhurst’s book ‘The Sun and the Serpent’, you will enjoy reading this one. Whilst Hamish and Paul followed the St Michael alignment and its St Michael & St. Mary earth energy lines, Gary and Caroline followed the ‘Belinus’ alignment and its two energy lines they called the Elen and Belinus serpents.

Their book is not just a well-researched odyssey following a roughly North to South alignment up through the UK (which they call ‘The Spine of Albion’), it also really starts to show the human connection to this alignment over more recent times. I know this too because I have met and spoken with them and listened to a couple of talks that they gave.

It took them 15 years to complete so they have really put their life into this work and the reader is rewarded for this by receiving some beautiful images and some wonderful information about some of the lesser well known areas of the UK.

Just as with the ‘Sun and the Serpent’ the book comes with maps of these lines as they take you on a journey Northwards from the Isle of Wight. This allows you to visit these same places and find these lines where they did – which is only a short distance for anyone living close to the

central part of the UK. Anything that encourages more people to get out and experience these energy lines has to additionally be a good thing.

More about this book, and others of theirs, can be found on their website www.belinusline.com

Other

In this final section, I have added the work done by Mr Dee on his analysis of the Coronavuris and the vaccinations with all the publically available data. It is truly ground breaking and revelatory – so much so that you really need to know just a bit about this retired independent scientist.

Mr Dee is a former Principal/G7 UK government scientist, NHS consultant analyst and statistician with experience in a variety of applied fields including accident causation, law enforcement, driver behaviour, cardiac surgery, cardiac anaesthesia, cardiology, cardiac rehabilitation, thoracic surgery and public health. He served as policy adviser and analyst to a number of organisations including the Department of the Environment, Transport and the Regions (DETR), Home Office, Cabinet Office, House of Lords, & the Office for National Statistics (ONS).

The following are all Mr Dee's own written words. I have only highlighted certain areas and added colours to assist your reading in these areas as this is detailed information that is being presented to us here.

May 1st

EudraVigilance Latest
As at 1st May April 2021 the EudraVigilance European database for suspected adverse drug reaction reports indicated 9,627 deaths amongst 384,178 individuals for whom adverse reaction reports for the four CIVOD-19 biological products under trial have been filed, this representing a report fatal outcome rate of 2.5%.

Over the same time frame a total of 3,120 adverse individual reactions to standard 'flu shots were reported across Europe of which just 13 were fatal, this giving us report fatal outcome of 0.42%.

The difference between these two rates is highly statistically significant ($p<0.001$), with the likelihood of a fatal outcome report following use of CIVOD-19 biological products being 6.0 times higher than that for 'flu shots.

The 384,178 individuals reporting adverse effects following vaccination with CIVOD-19 biological products generated 483,501 non-serious and 513,688 serious reactions, making a total of 997,189 registered adverse reactions between them, this equating to a mean reporting rate of 2.6 adverse reactions per individual.

In terms of ranked adverse incident rate (percentage of individuals reporting out of those treated) by product we find the following: AstraZeneca (0.75%), Pfizer (0.22%), Moderna (0.21%), Janssen (0.13%).

In terms of eliciting reports following dosing the AstraZeneca product clearly stands out from the rest, being **5.6 times more likely to elicit an adverse report** than the Janssen product ($p<0.001$, Poisson Means Test). Overall, the adverse reporting rate for all four licensed products is 0.350% i.e. 1 in every 286 treated people will develop symptoms sufficient to trigger an adverse incident report.

In terms of ranked fatal outcome rate (percentage of fatal outcomes reported for those treated) by product we find the following: Moderna (0.027%), Janssen (0.012%), Pfizer (0.007%), AstraZeneca (0.007%).

In terms of associated **fatal outcomes** following dosing the Moderna product clearly stands out from the rest, being **3.8 times more likely to be associated with a fatal outcome report** than the AstraZeneca product ($p<0.001$, Poisson Means Test). Overall, the fatal outcome rate for all four licensed products is 0.009% i.e. 1 in every 11,111 treated people will return a fatal outcome following vaccination.

In terms of ranked ratio of serious to non-serious adverse reaction for the four products under licence we find the following: Janssen (1.68), AstraZeneca (1.46), Moderna (1.26), Pfizer (0.65). Only Pfizer's product is generating more non-serious adverse reactions than serious. In terms of ranked report fatality rate (percentage of fatal outcome reports to total reports) by product we find the following: Moderna (12.9%), Janssen (9.2%), Pfizer (3.1%), AstraZeneca (0.9%). It is somewhat puzzling that the Moderna product is yielding 14.1 times the fatal report likelihood than the AstraZeneca product.

According to OECD data 'flu vaccination rates for the primary target population of 65+ years has been running at 40% uptake across Europe, on average, for the last three years. In comparison, the European Centre for Disease Prevention and Control (ECDC) report a mean uptake of 64% for CIVOD-19 biological products for the age group 60+ years.

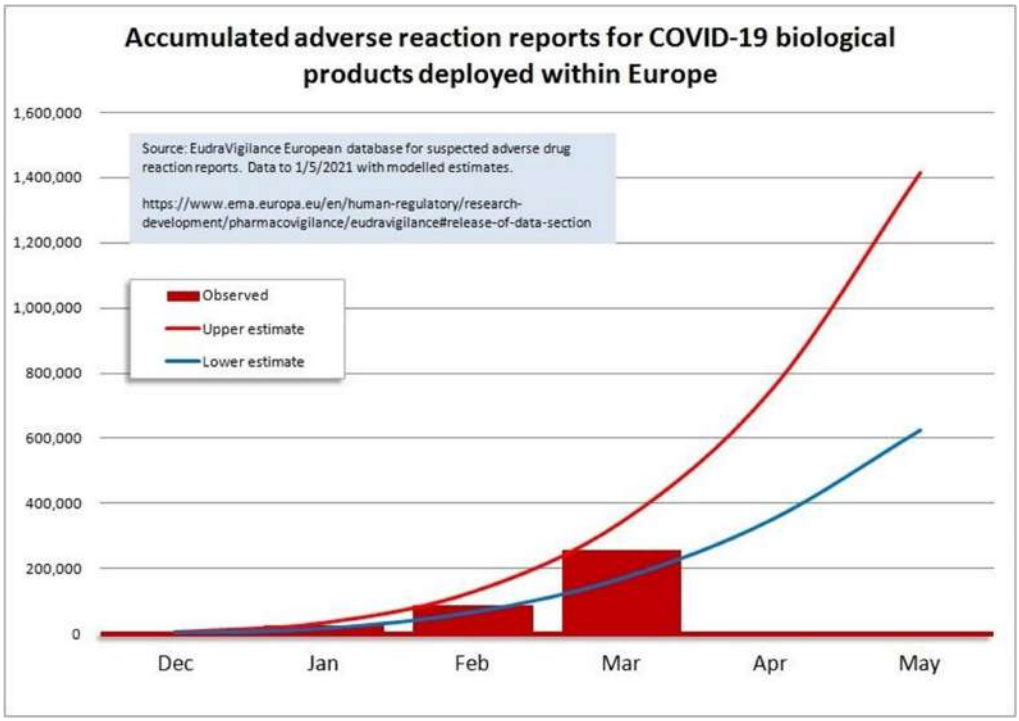
We may thus expect adverse incident reports for CIVOD-19 biological products to be running at around 1.6 times that for standard 'flu shots. **Incredibly, we find 123 times more adverse reports following vaccination with CIVOD-19 biological products and 741 times more reports of fatalities.** Whilst this is astonishing and alarming in equal measure the problem doesn't end here.

Statistical modelling of accumulated adverse reports for the months of December 2020 through to March 2021 reveals the number of affected individuals is growing as a power series of the order 3.3 (R-square = 0.999, $p<0.001$).

If this trend continues then we may expect Just **over 1.5 million adversely affected individuals** across Europe come **June** and as many as **12.5 million affected individuals come December**.

If this modelled scenario holds true in months to come (see slide) it is highly likely that many, if not all European healthcare systems will collapse under the weight of sheer numbers.

https://www.ema.europa.eu/en/human-regulatory/research-development/pharmacovigilance/eudravigilance#release-of-data-section



Risk Comparison

In my last post I churned out a whole bunch of figures derived from the EudraVigilance European database for suspected adverse drug reaction reports combined with dose data provided by the European Centre for Disease Prevention and Control. In this post I am going to turn these into one easy-to-understand slide.

Before this we need to have a word about **prevalence,** which is the term used to denote the proportion of the population that are carrying the vuris. This is not easy to determine because our blood and our bodies carry our viral history. Anybody going for a RT-PCR test this morning might test positive not because they are carrying the live vuris but because they are carrying evidence of a historic infection. Seroprevalence studies (studies that look for antibodies in blood samples) are very much historical studies since it takes weeks to build sufficient antibodies, which we then may carry for a lifetime.

Thus, when we hear experts claiming 1 in 3 households in Britain are infected with CIVOD (e.g. REACT trial results) that doesn't mean to say that is the situation on the ground at this moment in time. All it means is that at least one person in a household was, at some point since January 2020, carrying the vuris in sufficient quantities to produce antibodies that we have now detected a while later. The public, being sensible, automatically assume that experts talk about the disease as it exists within the population this very morning (a.k.a point prevalence) but that is never the case!

Ward et al (SARS-CoV-2 antibody prevalence in England following the first peak of the pandemic. Nature Communications 12, Article number 905. 2021) did as good a job as any in trying to determine what is called the point prevalence and estimated it to be 6% during the peak of the UK pandemic.

Thus, at any one time no more than 6 in every 100 people were actually carrying any vuris. Over time this point prevalence builds into the historic prevalence that gives us that 1 in 3 estimate as the vuris spreads.

This is an important concept to grasp because if you want to assess your individual risk you have to know the point prevalence for the environment in which you work, rest and play.

During the initial UK peak of 2020 this was estimated at 6% but it is now going to be much, much less. Let us suppose it has sunk from 6% to 0.6%, what then? Well, I can now pull down estimates of the infection fatality rate from O'Driscoll et al (Age-specific mortality and immunity patterns of SARS-CoV-2." Nature. DOI: 10.1038/s41586-020-2918-0 (2020)) and factor these by the estimated point prevalence of 0.6% to obtain the estimated the risk of death from CIVOD, then compare this with risk of death following vaccination in that single slide.

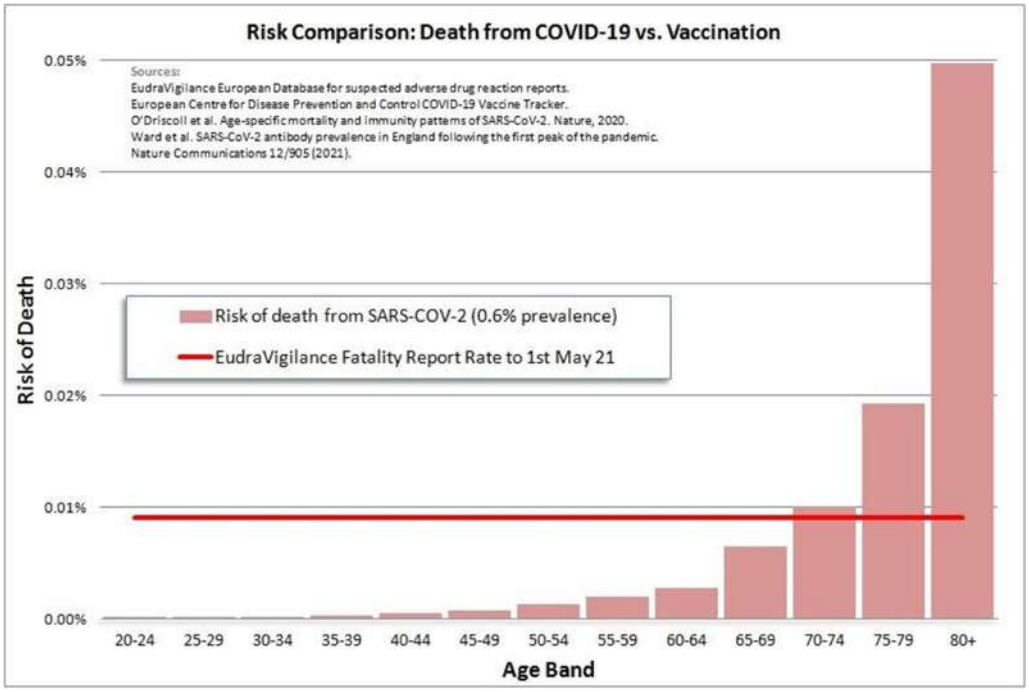
We now see that, for a point prevalence of 0.6%, outcomes following vaccination with CIVOD-19 biological products are less favourable than outcomes for viral infection for anybody under 70 years of age.

In plain English, the viccane is more likely to kill you if you are under 70!

The only clear benefit would seem to lie with those aged 75 and older. However, it is somewhat sobering to realise that, with a point prevalence of 0.06% (6 in 10,000 infected), then the risk of death from the viccane far outweighs the risk from the vuris for all age groups.

A major assumption underpinning this analysis here is that (voluntary) adverse incident reporting across Europe offers 100% data capture but we know it does not. In the States an audit of the (voluntary) VAERS system revealed only 1% of reactions get registered and I've heard rumours of it being no greater than 10% for EudraVigilance. Multiply that 0.009% red line by 10 to get 0.09% and we now see risk of death following vaccination outstripping the risk from the vuris by a long way.

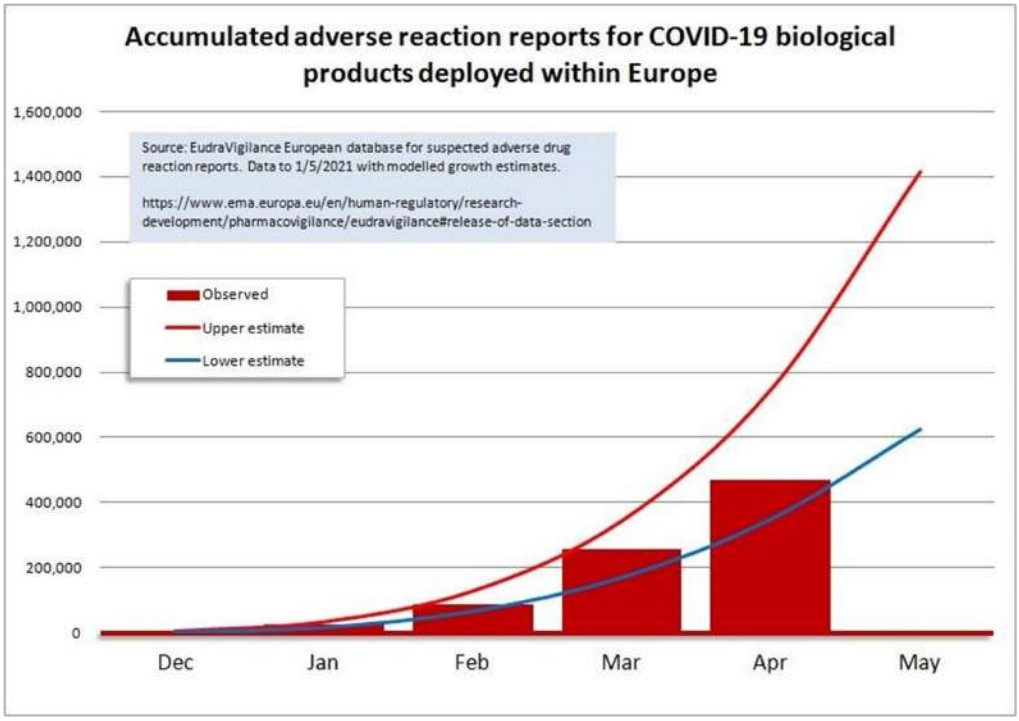
Medical authorities wave all this away suggesting there is no causal link. In the final analysis there may not be but we simply don't know that as yet. People are gambling with their lives in a situation of nil knowledge and unprecedented expertism.



April Data

In my post EudraVigilance Latest, dated 5th May 2021 I put out a chart with figures for accumulated adverse reaction reports for December 2020 through to March 2021. I had hoped EudraVigilance bods would have released the all important April data but we're now a week into May with still nothing showing. Since I've been taking snapshots of the data I realised I could derive these myself by taking declared March figures away from the new totals – simples!

Here is the updated chart showing the April data, which is pretty much sitting slap bang in the middle of my growth prediction using the December – March figures. Consequently, I ran statistical modelling again and this confirmed the growth in numbers is following a power series of the order 3.3 (R-square = 0.999, $p<0.001$). If this trend continues our health services will need to brace themselves for handling 12.5 million adverse reactions across Europe come next December.



Spike Proteins, Shedding & Haddock

There's a lot of confusion about viccanes, transmission and shedding right now. As far as my knowledge takes me the mRNA viccane encodes the spike protein, and the spike protein is what permits viral binding to ACE2 sites, particularly in the lungs, these being rich with these receptors.

The spike protein is thus the grappling hook-cum-crowbar for the health thief to gain entry and is not the method of transmission. Whatever the precise transmission method is hasn't changed one jot as a result of vaccination. Anybody mumbling on about viccanes reducing transmission needs to be hit with wet haddock until they come to their senses.

VAERS Analysis III

Back on 28 Jan 2021 I reported the results of a VAERS mini-project with three posts imaginatively entitled VAERS Mini Project: Result 1, VAERS Mini Project: Result 2 and VAERS Mini Project: Result 3.

On 7 Mar 2021 I ran an updated analysis, results of which may be found under... wait for it... VAERS Analysis.

This morning I have been downloading and processing the very latest VAERS data and will be reporting on this when I can. The raw data are not in the best of shape so I need to run quality checks before I get to the juicy stuff.

What I can reveal right now is that I'm sitting on 157,099 incident reports since folk first starting jabbing Americans with emergency use products. This is an awful lot of reports by any standards and this is without addressing the audit finding that VAERS only captures 1% of data!

Will The Real Vuris Please Stand Up!

The problem with claims of shedding and of viral infection in general is that they rely on reliable testing and we simply don't have that. The RT-PCT test, as used, doesn't reveal much of value when we consider real world sensitivity and specificity. Antibody tests fare little better, since sequences for these were also not calibrated against purified viral isolate (no lab has, as yet, purified the vuris). The latter also reveal viral history and cannot be held to be a reliable indicator for current infection status in test result alone, though it's clear that some authorities are doing just that.

Qualified assessment of symptoms and sound medical judgement are where we traditionally should start, this being aided by testing but we've gone and cut the GP from that task and jumped straight for number generation.

RT-PCR run strictly at Cq <30 will give an indication of viral loading of sorts but primer sequences for this are based on un-purified, ultra-centrifuged culture supernatants in which anything including the kitchen sink is floating. This is why I state 'loading of sorts' rather than SARS-COV-2.

A useful exposé of the sorry state of affairs can be found within the attached article, in which we learn that the base sequences used for test primers are not unique to SARS-COV-2. My own bit of digging reveals the construction of the SARS-COV-2 genome upon which all rests is also highly suspect, which is why I'd like the real vuris to stand up.

In short, as far as I can able to tell, we don't precisely know what we are shedding and we don't know what we are precisely being infected with in the first instance, but it is clear something peculiar is going on within the population.

Needless to say we don't precisely know what some are being vaccinated with, since the spike protein base sequence is therefore also open to question. All in all, a mighty strange state of affairs.

https://principia-scientific.com/confirmed-pcr-tests-cannot-detect-sars-cov-2-cause-of-civod19/

Bad Smell In The Closet

I have spent 12 hours grappling with VAERS data today ensuring it is clean enough to perform analysis. Around 1 hour ago I swore until the air was blue because **I was finding thousands of incidents with report dates that don't yet exist** - 4th December 2021 is taking the piss somewhat.

I'm aware that Americans are fond of mm/dd/yyyy encoding but that wasn't the problem. The problem is that UK dd/mm/yyyy encoding had been embedded within US mm/dd/yyyy encoding thus making a pig's ear of the entire dataset. How come UK coding is scattered throughout the VAERS database?

I've been able to identify great blocks of mis-coding which makes sense but what doesn't make sense are little runs of mis-coded data from Jan 2021 onward. In contrast, the 2020 dataset is clean as a whistle.

But here's the thing... when I sort the data by the primary key (VAERS ID) I'd expect to see this corruption start at, say, entry 919807 and continue to the end. This is not what we find - the corruption is scattered throughout, which means incorrect dates have been sporadically entered as registrations have rolled in.

But here's the other thing... it is the system that allocates a date to an ID, so we've got instances of low value IDs with dates that do exist and low value IDs with dates that do not exist as yet!

If you want to corrupt counts over time I cannot think of a finer way to go about it.

VAERS III Progress

After getting up at 4am and putting pedal to metal I can confirm I am in possession of 157,099 cleaned VAERS records. The main headache was date entry, with a mixed bag of UK and US formats and a whole load of typos (e.g. 2012 entered instead of 2021), including dates of birth entered for vaccination date and everything else higgledy-piggledy that you can possibly imagine, like forgetting 1st Jan 2021 is the year 2021 and not 2020! Classic stuff really, and I've seen it all before more times than I'd care to imagine.

To give you a concrete example of why fastidiousness counts, according to VAERS the maximum duration from vaccination to symptom onset is 36,896 days with a mean onset of 20.56 days. I think not for this would mean a CIVOD vaccination back on 24th April 1920! After cleaning dates this simmered down to a modest 114 days maximum with a mean onset of 2.61 days i.e. folk get to know pretty darn quickly.

I now need some fresh air, a good book and a decent cuppa so will start to turn the handle on the stats tomorrow morning - stay tuned!

Pooh-Poohing

Smart folk are very fond of pooh-poohing adverse reaction data. Some like to point out that this is just a large number of suspected reactions with no evidential basis for causality. Though this is entirely correct it misses the point, for VAERS, EudraVigilance, Yellow Card and other **systems were designed to act as an early warning system just in case something is amiss with distribution of a licensed product.**

Other very smart folk like to dismiss the data entirely, pointing out that counting adverse reactions in a product that is designed to generate a reaction is utterly meaningless. All depends on the reaction. Whilst counting 'flu-like symptoms will be fairly pointless I'm pretty sure counting death is not pointless and neither is counting permanent disability or requirement for hospitalisation. In fact, counting anything that serves to burden healthcare systems isn't pointless even if that condition is mild and recoverable.

Given the sheer volume of reactions recorded in Europe and America (and bearing in mind only 1% - 10% of reactions are captured) then those bells should be ringing, and smart folk like this need to understand the bigger picture of health provision.

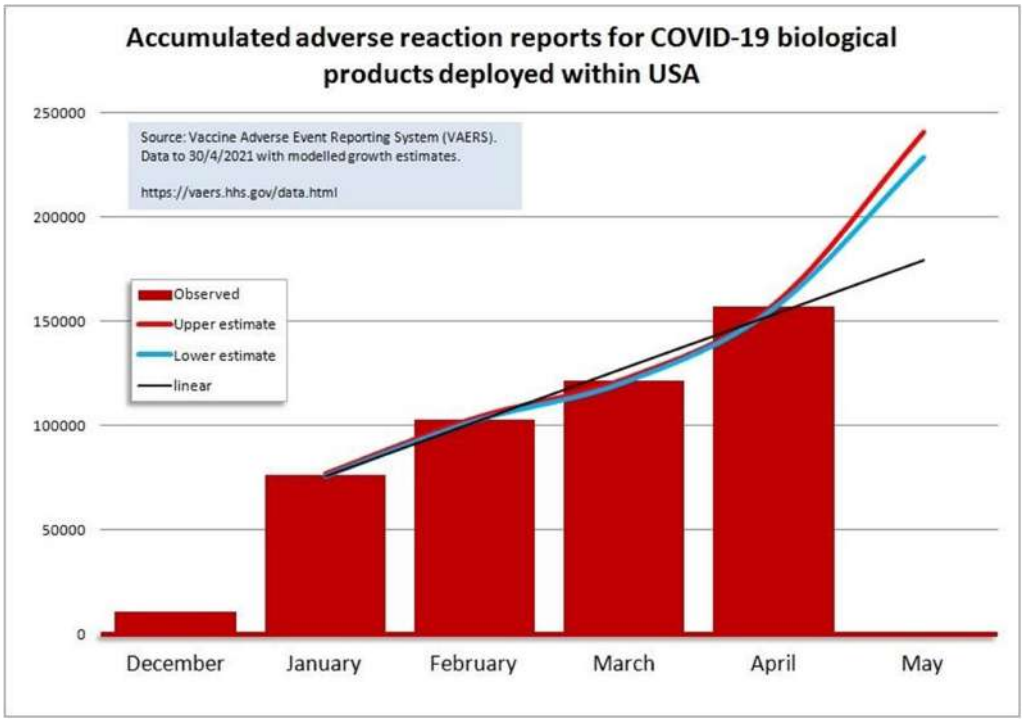
VAERS III: Growth Curve

I attach a slide of monthly accumulated adverse reaction reports for CIVOD-19 biological products in use across all US territories as retrieved from VAERS for the period 15th December 2020 – 30th April 2021. People understandably want to know where we could be going with this so I opted to model counts two different ways – simple and fancy. December is only a part month so we need to ignore this and look at January – April. Four data points is not a lot to analyse, so everything I'm about to reveal needs to be taken with huge pinch of salt.

If we assume things are progressing in a linear manner then that black line points the way for May, with an estimated 178,908 events. At this steady rate of progression we may expect to see between 319,570 and 399,515 events come next December

What may look like a steady linear progression from January – April actually hides an extraordinary secret in that a cubic model is absolute perfect fit to the data (R-square = 1.000, p<0.001). **I've never had a perfect fit like this in 37 years of crunching so I'm somewhat befuddled at what appears to be an extraordinary coincidence.**

A cubic model is a bendy affair and predictions using this start to look a little more scary, with May's figure predicted to be up at 234,599. If this model proves to be appropriate over the next few months then we may see as many as 3,628,011 to 4,459,707 adverse events come next December, which is a chilling prospect. **Let us hope my fancy modelling of just four points is sheer nonsense**.



VAERS III: Clinical Outcomes

For the period 15th December 2020 – 30th April 2021 VAERS reports the following event totals, for which I have calculated percentages of the grand total of 157,099 events:

Life threatening event following vaccination – 3,274 (2.1%)
Permanent disability following vaccination – 2,277 (1.4%)
Death following vaccination – 3,700 (2.4%)
Death or disablement following vaccination – 5,959 (3.8%)
Death, disablement or life threatening event – 8,662 (5.5%)
Required hospitalisation – 10,692 (6.8%)
Required a prolonged hospital stay – 150 (0.1%)
Required emergency department – 21,573 (13.7%)
Required in-hospital care – 27,234 (17.3%)
All significant clinical outcomes – 30,981 (19.7%)

Aside from the startling figure of 5.5% of events involving death, disablement or a life-threatening condition, another figure we need to pay close attention to is the 17.3% of cases requiring hospital services. If the growth trend continues US healthcare services are going to get swamped, with the obvious knock-on effects for all other acute conditions.

A final note concerns the VAERS definition of 'life threatening' – I discovered that 3,586 entries classified as not life threatening were for folk who died. Bizarrely, the data reveals 3,586 out of 3,700 deaths were not life threatening (96.9%). **Make of that what you will – these are bizarre times!**

VAERS III: Hospital Stays & Symptom Onset

For the period 15th December 2020 – 30th April 2021 VAERS holds a grand total of 157,099 adverse events. Herewith a summary of hospital stay and onset data:

Mean time between vaccination and onset of symptoms – 2.94 days (St.Dev 6.74 days, n=137,416)
Median time between vaccination and onset of symptoms – 1 day
Mean time between onset of symptoms and registration in VAERS – 13.26 days (St.Dev 21.58 days, n=150,186)
Median time between onset of symptoms and registration in VAERS – 4 days
Mean duration of hospital stay – 4.11 days (St.Dev 4.64 days, n=7,138)
Median duration of hospital stay – 3 days
Total hospital stay – 29,491 days

We may conclude that the **adverse reactions reported happened pretty quickly**, with a reasonably prompt turnaround by VAERS. Hospital stays are thankfully short but even a short stay will require precious resources. Most folk concern themselves with the impact of the vuris but that is only one side of the coin. Adverse reactions whether deadly, serious or mild are also going to take their toll and I see little or no planning for this by the authorities nor much understanding by the public of the greater problem faced by health professionals whenever mass vaccination kicks in.

VAERS III: Age & Gender Profile

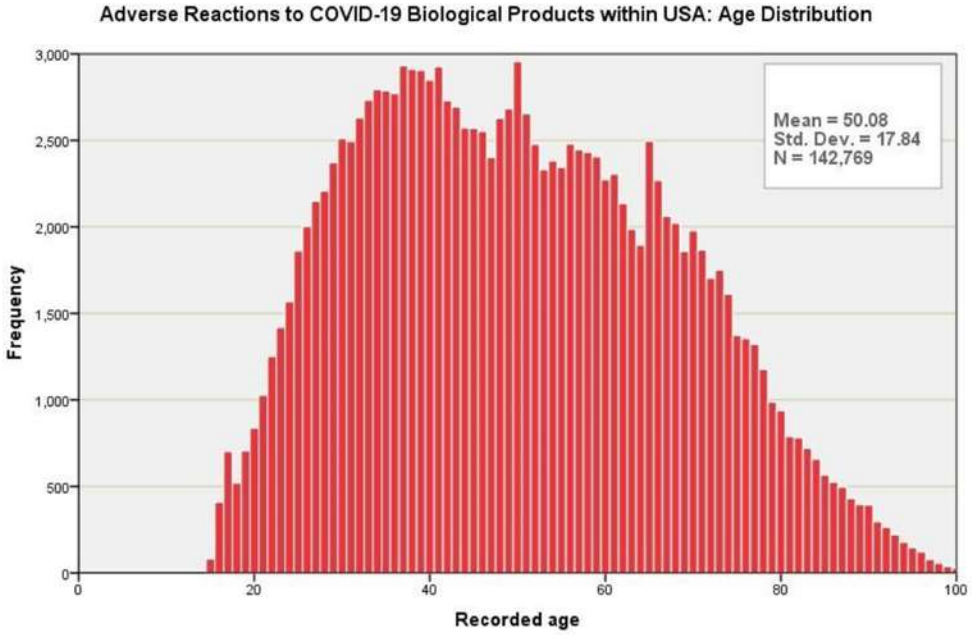
There are a couple of surprises in store as regards the age and gender profile of those reporting adverse symptoms. Firstly, we see the majority (75.4%) of entries are made by women. Secondly, we see that women reporting adverse events tend to be younger than men, on average, by 3.9 years, this difference being highly statistically significant ($p<0.001$; ANOVA). I am not sure whether this is due to a tendency for women to report their health status more readily than men or whether they are suffering a greater range of more severe symptoms.

Gender differences like this are definitely something to chase, and a factor may be unequal distribution of viccane makes within the data sample. Johnson & Johnson's Janssen jab features in reports for 31.2% of males (8,618/27,599), whereas Moderna's product only features in reports for 22.2% of males (14,452/65,174) with Pfizer's product sitting in the middle at 24.0% (13,947/58,089). The potential impact of this inequality will be investigated as I turn the handle.

I was somewhat surprised to learn the average age of reporting individuals across the US to be as low as 50.1 years, especially given the initial thrust of the inoculation drive to have been toward the elderly and vulnerable. That being said the elderly will not be fully represented in the sample for many reasons - many may well be neglected in terms of healthcare, many may not in a position to report problems or even desire to do so, and others sadly may no longer be alive. We need to remind ourselves that VAERS only captures 1% of problems that exist in the real world and failure to register reactions in care homes is going to be part of that reality.

	Frequency	Valid Percent
Females	114,154	75.4%
Males	37,168	24.6%
Unknown	5,777	
Total	157,099	

Mean age females	49.2 years
Mean age males	53.0 years
Difference	3.9 (p<0.001; ANOVA)
Mean age (all)	50.1 years



Source: Vaccine Adverse Event Reporting System 15/12/20 - 30/4/21

VAERS III: Gender Effects

For the period 15th December 2020 – 30th April 2021 VAERS holds a grand total of 157,099 adverse events. Following on from my post entitled VAERS III: Age & Gender Profile I now attach a screenshot of a top-line summary of investigations into gender differences.

We now see that, although the majority of VAERS entries are from women (75.4%) and that these women tend to be slightly younger than men by 3.9 years on average, it is men in general who are suffering the most unpleasant side-effects with elevated stays and greater risk of serious or fatal outcome.

In terms of all significant outcome (hospital stay, emergency department visit, life threatening event, disablement or death) then men are 1.46 times more likely to feature in VAERS than women and 3.86 times more likely to feature as a fatality. What kind of viccane can discriminate on the basis of gender?

VAERS reporting period 15 Dec 2020 - 30 Apr 21 (n=157,099)	Females	Males	*Factor*
Life threatening event	1.7%	3.5%	2.06
Permanently disabled	1.2%	2.4%	2.00
Died	1.4%	5.4%	3.86
Died or permanently disabled	2.6%	7.8%	3.00
Died, disabled or life threatening event	4.0%	10.5%	2.63
Required hospitalisation	5.3%	12.3%	2.32
Required a prolonged hospital stay	0.1%	0.2%	2.00
Required Emergency Department	13.8%	15.1%	1.09
Required in-hospital care	16.5%	21.8%	1.32
All significant clinical outcomes	18.2%	26.5%	1.46
Mean duration of hospital stay (days)	3.89	4.41	
Mean vaccination to symptom onset (days)	2.75	3.39	
Mean symptom onset to VAERS registration (days)	12.61	14.06	
Median duration of hospital stay (days)	3	3	
Median vaccination to symptom onset (days)	1	1	
Median symptom onset to VAERS registration (days)	4	4	

VAERS III: Onset Of Symptoms & Death

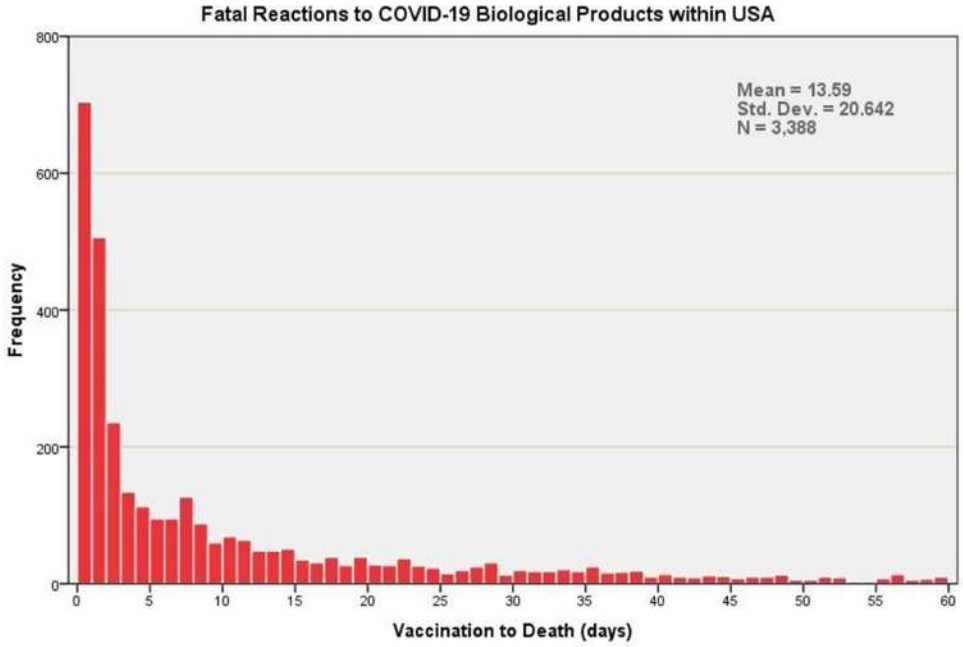
For the period 15th December 2020 – 30th April 2021 VAERS reports a grand total of 157,099 adverse events. This is an awful lot by any standards and the reaction of folk to this – especially those who ought to know better - is downright bizarre. In this post I thought we ought to take a look at how quickly these adverse symptoms set in, and to determine how quickly people are dying following vaccination.

The answer is very quickly indeed. Out of a total of 137,416 records possessing full date information we find 64,008 reports from folk suffering adverse symptoms the same day (46.6%) with a further 32,401 reporting symptoms the very next day (23.6%). Thus **the great majority (70.2%) suffer symptoms sufficient to trigger a report within the first 24 - 48 hours after vaccination.**

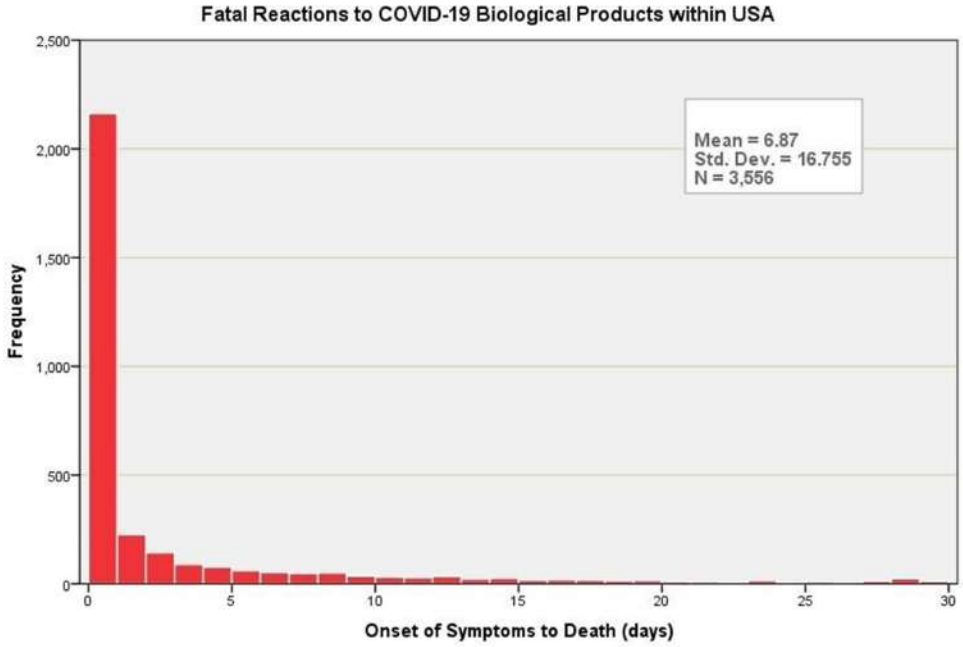
As regards death following vaccination we find 704 reports out of a total of 3,388 records possessing full date information indicating same day fatal outcome (20.8%) and a further 506 reports indicating next day fatal outcome (14.9%). Thus an astonishing 35.7% of people – just over a third - are dying with 24 - 48 hours of vaccination.

Of those whose initial symptoms were not reported as fatal, but who later died, we find no less than **2,390 records out of a total of 3,556 (67.2%) indicating death within the space of just two days of symptom onset**.

And we are supposed to believe there is no causal connection, with these being coincidental reactions the authorities can safely ignore.



Source: Vaccine Adverse Event Reporting System 15/12/20 - 30/4/21



Source: Vaccine Adverse Event Reporting System 15/12/20 - 30/4/21

VAERS III: Viccane Reaction & Gender

In my post entitled VAERS III: Gender Effects we saw just that and asked why adverse reaction reports for males were turning out to be more severe in nature. There is, of course, the old argument that men, being macho, will hold back until their leg has fallen off before admitting to problems and that women are more in touch with their bodies. I'm not keen on wrangling with political correctness and have no published research to hand to tell me whether this is a possibility so I decided to let the data speak for itself.

Generalised Linear Modelling (GLIM) was used to investigate significant correlations between clinical course factors in the prediction of gender and a couple of surprises popped out.

Firstly, death as a sole clinical outcome wasn't a useful predictor of gender (p=0.269), neither was disablement (p=0.905), which suggests gender parity on these matters following vaccination. What did turn out to be statistically significant were age (p<0.001), length of hospital stay (p=0.001) and an interaction between life threatening events and death (p=0.002). The latter wrinkle comes about because VAERS does not always consider death as a life threatening event! So far so good and all pretty much as expected – now comes the second and somewhat significant surprise…

It turns out that viccane make is a statistically significant predictor of gender (p=0.029), and this despite accounting for age, length of stay and death/life threatening conditions! The bottom line output from GLIM is a table of something called estimated marginal means and a screenshot is attached. In the top section of this (estimates) we see Johnson & Johnson's jab being represented by 41.37% of males, the Moderna shot by 41.62% of males and the Pfizer/BioNtech product by 38.38% of males. In the bottom section (Pairwise Comparisons) we get to see that there is just one statistically significant difference of 3.2% and that is between the Moderna and Pfizer/BioNtech mRNA jabs (p=0.011).

In plain English this means **there is an unexpected difference in the male response to what are supposed to be two identical mRNA shots**, with the Moderna shot yielding slightly more adverse reactions in males than the Pfizer/BioNtech competitor. Nothing in this sorry business is ever what it seems!

Estimated Marginal Means 2: Manufacturer

Estimates

Manufacturer	Mean	Std. Error	95% Wald Confidence Interval	
			Lower	Upper
JOHNSON&JOHNSON	.4137	.025	.37	.46
MODERNA	.4162	.021	.38	.46
PFIZER\BIONTECH	.3838	.020	.35	.42

Covariates appearing in the model are fixed at the following values: Recorded age=62.50; Days in hospital=4.10

Pairwise Comparisons

(I) Manufacturer	(J) Manufacturer	Mean Difference (I-J)	Std. Error	df	Sig.	95% Wald Confidence Interval for Difference	
						Lower	Upper
JOHNSON&JOHNSON	MODERNA	-.0025	.020	1	.898	-.0409	.0359
	PFIZER\BIONTECH	.0299	.019	1	.123	-.0081	.0679
MODERNA	JOHNSON&JOHNSON	.0025	.020	1	.898	-.0359	.0409
	PFIZER\BIONTECH	.0324[a]	.013	1	.011	.0075	.0573
PFIZER\BIONTECH	MODERNA	-.0324[a]	.013	1	.011	-.0573	-.0075
	JOHNSON&JOHNSON	-.0299	.019	1	.123	-.0679	.0081

Pairwise comparisons of estimated marginal means based on the original scale of dependent variable Gender

a. The mean difference is significant at the .05 level.

VAERS III: Viccane Risk Profile

For the period 15th December 2020 – 30th April 2021 VAERS holds a grand total of 157,099 adverse events. Raw counts by manufacturer will reflect doses issued more so than safety, these being Johnson & Johnson – 29,278 (18.6%), Moderna – 67,739 (43.1%), Pfizer/BioNtech – 59,575 (37.9%) and Unknown – 507 (0.3%).

It is tempting to ask which viccane is safest. Whilst we can't directly answer that without dosing data for each product what we can do is be sneaky and analyse relative clinical outcome to see if there is a preponderance of, say, death reports for one viccane when compared to another, the assumption being the reporting rate for death should be equal across products if they are equally as safe.

Comparison is tricky because we've already noted a gender inequality in report distribution, and we can be certain that both gender and age will impact on clinical outcome, so what we have to do is take account of all of these factors all at the same time using something called Generalised Linear Modelling (GLIM). This is a powerful statistical technique that enables us to see the genuine impact of a viccane once confounding factors like gender and age are accounted for. I'll spare the gory technical detail behind this weighty analytical run and wade straight in with a summary slide of the bottom line results.

The first thing to note about these results is that they are adjusted for age, gender and product distribution across gender. For example, without any adjustment the incidence of death within the sample of 157,099 reports is 2.39% (3,700 deaths in 157,099 reports).

Once we make adjustments for these three factors we find that the overall estimate for incidence of death drops to 0.82%, which is effectively an estimate of the risk of death for somebody at the sample average age of 50.1 years with a balanced number of males and females. This may sound crazy but until we make these critical adjustments using GLIM we cannot compare products since it is unlikely that age and gender profiles for recipients were identical across products – we must remember this is a retrospective observational study and not a clinical trial! Another way to think of this fiddling is that these adjustments will turn the raw and warty data into what we may expect from a clinical trial based on equal numbers of males and females, with equal representation for all age groups.

With that understanding under our belt we now see Pfizer/BioNtech's product is not faring at all well when compared to the others and leads the way in every single adverse clinical outcome. Those cells shaded pink are where the rate for Pfizer/BioNtech's product is statistically significantly different from the next nearest competitor at the 99.9% level of confidence ($p<0.001$) – this usually being Moderna's offering.

In contrast Johnson & Johnson's Janssen jab fares best in six of the eight categories, and significantly so in five of these at the 99.9% level of confidence ($p<0.001$), these being shaded green. This may sound like a big fat plug for vector viccanes but I am sure they'll have their own problems somewhere down the line. For one thing this is an analysis of relative risk within an adverse report database – we have no idea of what absolute risk within the population looks like until we obtain dose data. Again it is worth asking why two supposedly identical mRNA jabs are giving rise to such different results.

VAERS reporting period 15 Dec 2020 - 30 Apr 21 (n=157,099)

Clinical Outcome	*All products*	*Johnson & Johnson*	*Moderna*	*Pfizer/BioNtech*
Death	0.82%	0.62%	0.91%	0.98%
Life threatening reaction	2.22%	2.07%	1.94%	2.72%
Hospitalisation	6.15%	5.32%	5.93%	7.53%
Permanently disabled	1.44%	1.08%	1.35%	2.04%
Required Emergency Department	14.90%	13.74%	13.02%	18.38%
Death, disablement or life threatening reaction	4.53%	3.53%	4.52%	5.80%
Required in-hospital care	18.86%	17.03%	17.33%	22.60%
Any significant clinical outcome	21.27%	18.38%	20.08%	25.84%

Report rate adjusted for age, gender and product distribution across gender

VAERS III: Serious Outcome Report Likelihood – all products

For the period 15th December 2020 – 30th April 2021 VAERS holds a grand total of 157,099 adverse events, 8,662 of which were classified as life threatening, causing permanent disability and/or death (5.5%). I have now managed to develop logistic regression models for such serious outcomes to establish the impact of age, gender and product. Logistic regression sounds all fancy but it is simply a statistical method for predicting a yes/no outcome among people, being a most valuable tool in medical science.

The rather technical output of logistic regression modelling can be turned into rather colourful plots that most folk will find intuitive, so let's start with out very first plot. For this I have lumped all CIVOD-19 biological products together and separated the effects of age and gender. These two curves reveal the likelihood finding serious outcome reports within our sample of 157,099 adverse incident reports. This isn't the same as measuring risk of serious outcome within the population at large but may be considered a rough proxy.

A key thing to grasp here is that we are looking at the probability of serious outcomes being registered with an entirely voluntary database for which an audit revealed a 1% response rate from the public. Whomsoever desires to hand reports in is going to bias the results like crazy, and this may well explain some of the gender differences. We should ask why we live in a world that doesn't have mandatory and rigorous follow-up for all medications by the various authorities. It can certainly be done because I was the project lead for one of the world's most comprehensive databases for tracking cardiac surgery outcomes (please ask if you want to see annual audit reports).

That's enough ranting... as we may see from the attach plot likelihood of a serious report rises rapidly with age, with males associated with a greater likelihood of reporting than females at all ages, though there is little difference down in the 20 – 30 age band. This underpins previous findings of gender differences.

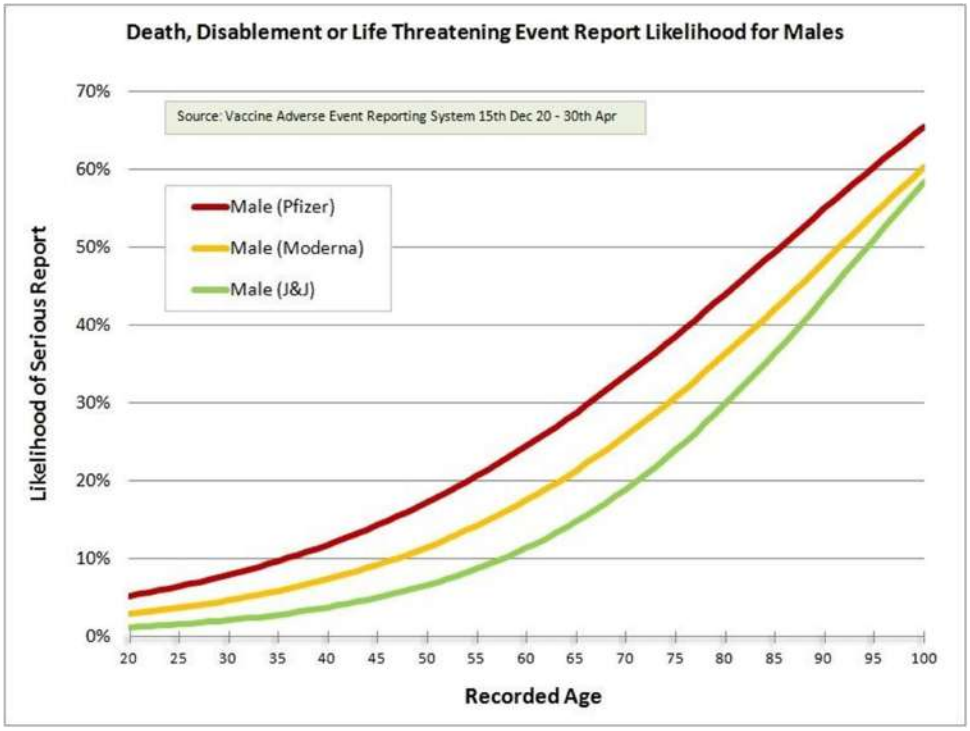
VAERS III: Serious Outcome Report Likelihood – gender & product effects

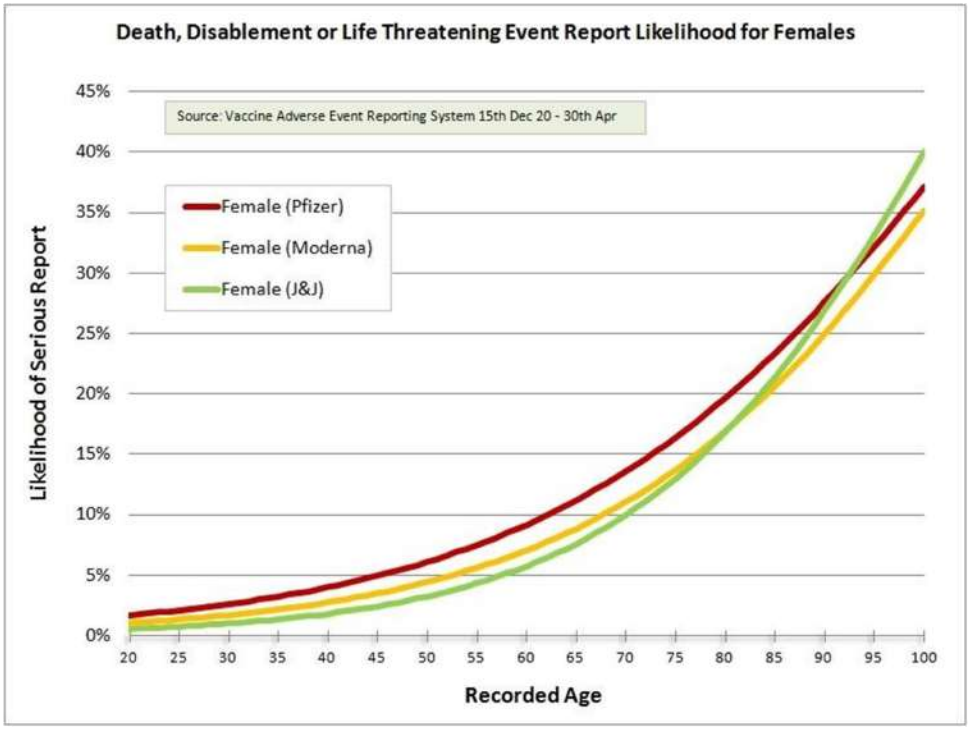
For the period 15th December 2020 – 30th April 2021 VAERS holds a grand total of 157,099 adverse events, 8,662 of which were classified as life threatening, causing permanent disability and/or death (5.5%). In my previous post entitled VAERS III: Serious Outcome Report Likelihood – all products we saw the results of logistic regression modelling that revealed how likelihood of serious outcome

reporting rises sharply with age, with males exhibiting a greater reporting likelihood than females. In this post I am going to repeat the process but this time we shall take a look at the impact of product.

In this first slide for males we see the Pfizer/BioNtech product faring badly in comparison to others, as discussed in my post entitled VAERS III: Viccane Risk Profile. Interestingly, the greatest absolute difference between likelihood of reporting occurs in the 50 – 70 age band, with the gap narrowing as we approach the nonagenarians. Johnson & Johnson, with their vector viccane, would no doubt be chuffed to see this but, of course, we are barely scratching the surface of viccane safety even with 157,099 records within VAERS!

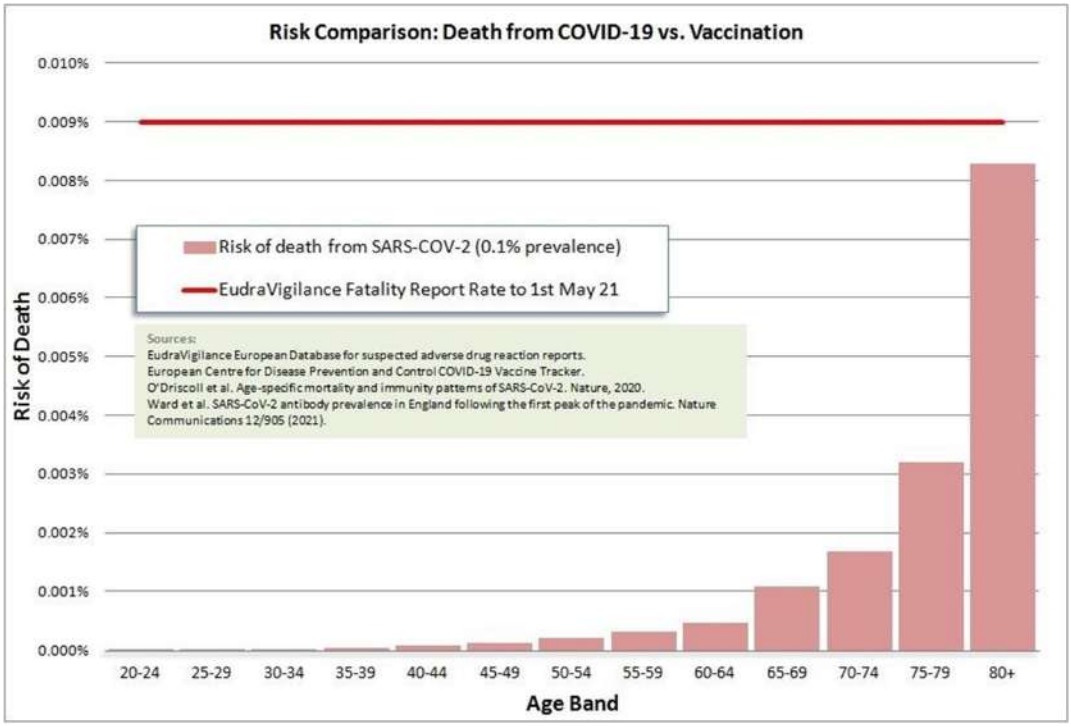
In this second slide for females something kinky and unexpected happens. Firstly, there is little difference between all three products and secondly, the Johnson & Johnson Janssen jab twists across the others to become the leader among nonagenarians. Whatever women are doing report-wise, and whatever is happening to them sure looks different to what men are doing. All very curious.





Chani's Chart

A member of John Dee's almanac has been quick to note that, with the declaration of an official viral prevalence of 0.1% (1 in 1,000 people) by the UK government yesterday, we can re-draw the chart presented on 6th Mar 21 (under a post conservatively entitled 'Risk Comparison') and see how risk of death from SARS-COV-2 viral infection under a national prevalance of 0.1% across age groups compares with the flat rate of 0.009% obtained from EudraVigilance and ECDC data. I'm not sure I need to say anything other than henceforth this shall be known as Chani's chart. Well done Chani for being as sharp as razors, as my old mate used to say!



The Morris Oracle

I've had some cracking discussions with a GP called Mr Morris regarding nominal test sensitivity, specificity, disease prevalence, bench-marking and gold standards (lack thereof) and decided to treat everyone to a single slide that summarises everything we need to understand about false positives.

In plain English a false positive is when we tell somebody they are infected with a disease when they are not. All diagnostic tests have their limits and the RT-PCR test is no exception, but what governments and their expert advisors are doing is completely ignoring this basic fact and assuming everybody who tests positive is either sick with CIVOD symptoms, infectious or carrying the SARS-COV-2 vuris. Nothing could be further from the truth, as you are about to see for yourselves.

For this analysis I've set test sensitivity at a nominal 80% (a figure supplied by the Centre for Evidence Based Medicine at Oxford University). This figure tells us how good the test is at detecting presence of the vuris in infected people and an 80% sensitivity means that the test will detect 8 out of every 10 infected people, thus 2 people will go home being told they don't have the vuris when they do.

RT-PCR test specificity is a most controversial subject, with initial nominal estimates set at 99.9%. This figure is essentially a guess based on previous research, bench studies and hand waving, with experts arguing over what the real figure is. Specificity tells us how good the test is at detecting absence of the vuris in uninfected people, and 99.9% specificity means that the test will accidentally yield 1 infected case out of every 1000 uninfected cases, thus this person will be told they are carrying the vuris when they are not.

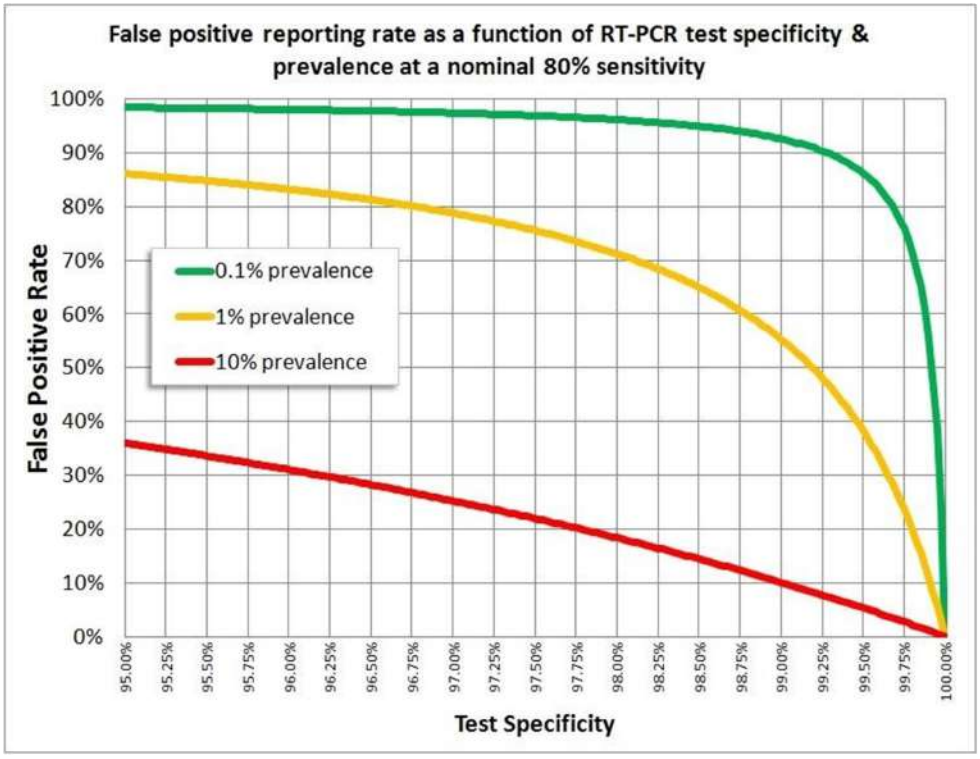
What complicates matters is how much disease there is in the population. We call this prevalence and 1% prevalence means 1 in every 100 people are carrying the vuris (SARS-COV-2) that causes the disease we call CIVOD-19. When a viral infection is highly prevalent diagnostic tests work well, but when prevalence starts to wane diagnostic tests start to produce nonsensical results.

Prevalence is another of those controversial guesstimates because it is hard to measure reliably and yet the latest UK government report suggests this may now be down to 0.1% (1 in every 1,000 people).

This chart – dubbed the Morris Oracle after Mr Morris – enables you to see just how false positive cases are being generated for differing levels of test specificity for three levels of prevalence for an assumed nominal sensitivity of 80%. The first thing to notice is how low the red line is compared to the others. This reminds us that few false positives are generated when the vuris is rampant at 10% prevalence.

With UK government estimates now down at 0.1% prevalence (green line) we can see that false positives are going to rocket at anything below the nominal 99.9% specificity. Since operational specificity (real world specificity) is likely down at 97% or even 95% we now see that virtually every positive test result the government is counting as a 'case' is almost certainly a false positive.

With estimate of prevalence down at just 6% for England even during the peak of the outbreak (Ward et al Nature Communications 12, Article number 905. 2021) and operational prevalence likely lying somewhere between 95% and 97%, then we can safely assume that lockdown, mandatory masks, social distancing, closure of health services, destruction of businesses, damage to the economy and all the rest of the shit shovelled upon us has been built on nothing more than a gigantic fiction so huge and so fraudulent that the public cannot even see it. Perhaps they dare not see it for the price of listening to a few alleged experts has been great and terrible.



Age Analysis

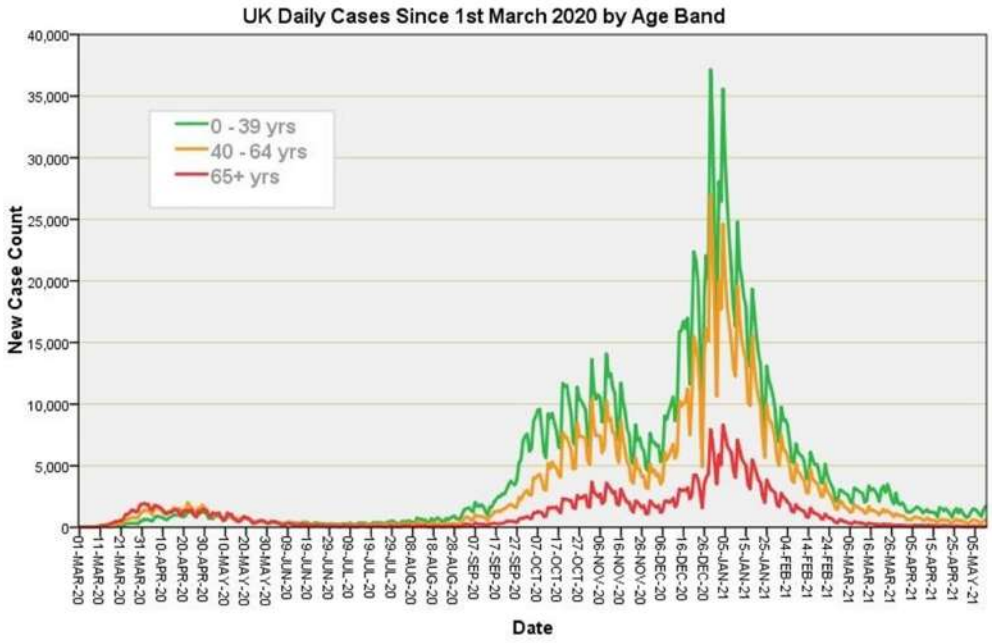
Public Health England (PHE) put out a colourful chart every week revealing case count per 100k population by age band. Every time I see this I make a comment to the effect that it is garbage since comparison rests on the assumption that test rates across age groups are equal.

For example, if we stopped testing everyone under 15 then the curve for this age group would fall to zero! This is because what is being called a 'case' isn't a genuine clinical case as such and is merely a positive test result; more results mean more 'cases'. Surprisingly, a large slice of the public don't understand this basic logic and some get rather unpleasant when I criticise PHE's efforts.

This morning I tried to obtain data from UK GOV to see what PHE's chart should look like if we make adjustments for differing numbers of tests across age bands. It will come as no surprise to folk here that I cannot obtain the data I need. In the process I discovered 3 flaws in UK GOV data tabulation that I've grumbled on about in an email to the project lead. I did eventually manage to produce a spreadsheet with nationwide daily case counts by age band and total daily numbers of tests (sadly not by age band) and discovered something rather unexpected.

In the slide below I present daily case counts grouped by three age bands for the period 1st March 2020 – 10th May 2021. Though hard to see because of the scaling the pandemic starts off with the most elderly group dominating the count, as we may expect. From September 2020 onward we see a rather strange inversion, with the youngest age group now dominating the case count. Bizarrely, the most vulnerable and at risk age group didn't really feature much in the so-called "second wave" – what kind of disease starts out hammering old folk then switches to hammering young folk?

My guess is that this second wave of young things last winter is merely a function of the national test strategy. We could call it the poking disease. We poked lots of younger people up the nose with lateral flow tests for one thing (many employers were keen on deploying kits), and then we decided to poke kids up the nose at least twice a week (as if double maths isn't bad enough). All that poking with lateral flow kits resulted in greater PCR follow-through, and this brought heaps of positives, and false ones at that.



Source: https://coronavirus.data.gov.uk/

Age Analysis II

Regulars will realise by now that I'm going to reach for a spanner in my bag called Generalised Linear Modelling (GLIM). This is a mighty powerful tool and I've gone and I shall be using it this afternoon to see how well I can predict the number of cases in each six age bands (0 – 14, 15 -29, 30 – 44, 45- 59, 60-74, 75+) using just test counts alone. The problem with daily data series is that they are often subject to peaks and troughs brought about by weekends and bank holidays. On top of this there are time lags between declared positive case counts (defined by earliest specimen date) and declared numbers of tests (defined by publication date), so I decided to derive 7-day rolling counts for cases and 7-day rolling counts for tests to iron out some of these wrinkles.

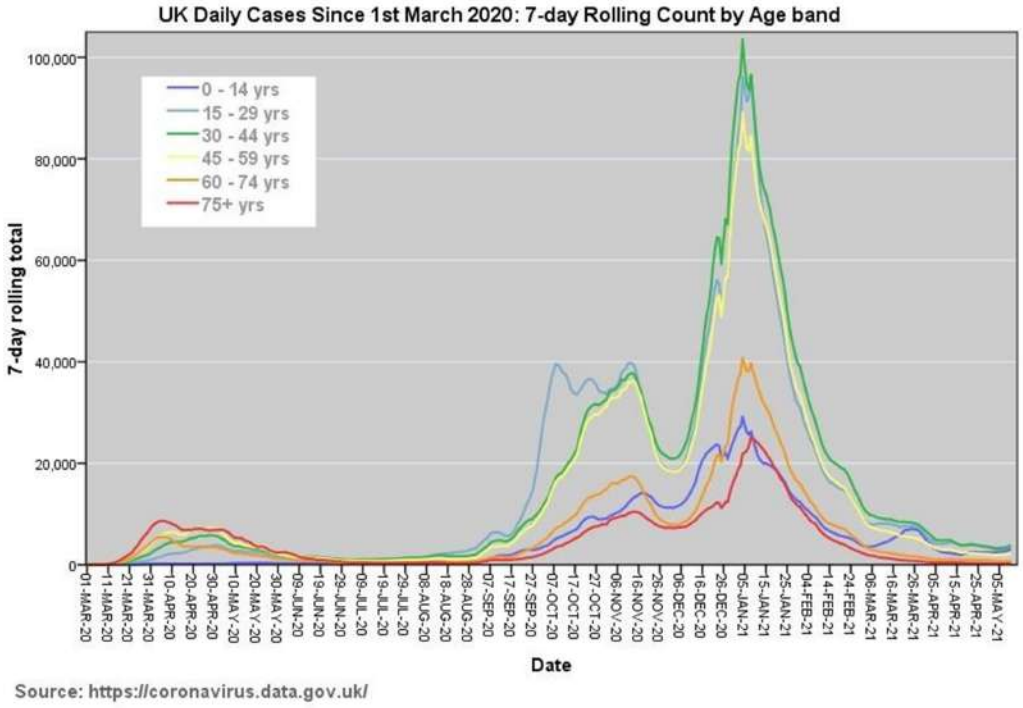
Just to check everything had gone fine I decided to plot the case counts by age and came face to face with another bizarre finding. In the attached slide you'll see a remarkable leap in the 7-day case counts for the 15 – 29 year age group just after 17th September 2020 that is not matched by other age groups. I presume this was caused by mass testing of older children as they returned to school and is further proof of a 'testdemic'.

With a so-called "second wave" on the way during October of last year we may ask just why cases across all age groups abruptly declined toward the end of November and into early December. Could

it be testing was relaxed in both volume and cycle threshold in order to permit the illusion of a winter peak? Perhaps SARS-COV-2 took an early vacation.

We now come to the great winter peak of 2020/21, where we magically shift from 20,000 cases per rolling week to just over 100,000 cases per rolling week in the space of just one month despite people being masked and locked down. How is this possible and how is it possible that the peak should disappear again so rapidly? What stands out for me most about this strange peak is that it is predominantly the 15 – 29, 30 – 44 and 45 – 59 year age groups, and nigh on identical counts at that! Bizarrely, the two groups normally clobbered by influenza, being the very young and very old fared rather well last winter.

We must either conclude that SARS-COV-2 can tell your age or the majority of positive cases are arising from a PCR test that is not fit for purpose.



Age Analysis III: GLIM

I've reached for that spanner in my bag called Generalised Linear Modelling (GLIM) and I've used it to see how well I can predict the number of 7-day rolling cases in each of six age bands (0 – 14, 15 - 29, 30 – 44, 45- 59, 60-74, 75+) using numbers of tests alone. What I have discovered has totally blown my mind.

In fiddling about with GLIM all three types of test stood out as key to the prediction of 7-day rolling case counts by age, these being the number of RT-PCR tests, the number of lateral flow tests, the number of antibody tests plus interactions between lateral flow and antibody tests and between PCR tests and antibody tests.

I'll spare the gory details of the models and report that Pearson bivariate correlations between observed daily counts and predicted daily counts within each age band ranged between an

astonishing r=0.906 for the 60 -74 years group (p<0.001, n=195) to a gobsmacking r=0.926 for the oldest group of 75+ years (p<0.001, n=195). In plain English this means using just the number of different tests and only the number of tests we can explain 82% - 86% of the variation we see in 7-day rolling case counts. **This is utterly mind blowing and is evidence of what some are calling a casedemic (though it really is a testdemic).**

The first slide reveals just how well we can predict positive cases from a consideration of the number of tests alone for the oldest age band of 75+ years. Striking isn't it? We may note that the first predicted peak between 20th December and 30th December seems to flag up a modelling discrepancy but this coincides with the Christmas holiday which means cases would not have been processed as usual, with declarations made much later than normal.

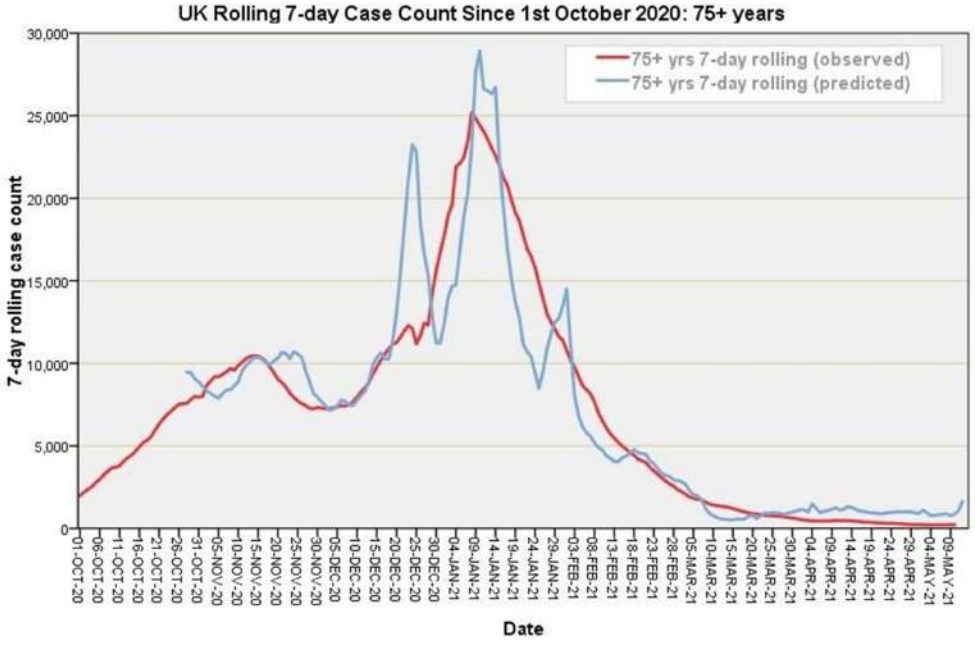
Declaration of case and specimen dates is another of those 'funny business' areas in which we find data authorities playing musical chairs with dates (please see my compiled PDF file for 2020 for examples of death date shuffling). One thing the authorities cannot afford, of course, is to have an inexplicable double-peak with trough slap bang in the festive season. I would also suggest the third test peak of early February has possibly been discreetly smoothed in this manner.

Sticking with the same age group of 75+ years we can now do something sneaky and that is to calculate the ratio of observed to predicted values. In this second slide we see this ratio bobbing about the unity value of 1.0, which suggests 7-day rolling case counts are simply following the test numbers as the GLIM model predicts. There is a notable departure around 15th March which could either be a genuine vuris doing a genuine thing or a decision to hike the RT-PCR cycle threshold to generate a fresh batch of cases. This particularly sharp peak is not very viral-like in dynamic and is rather more indicative of short-term laboratory policy changes.

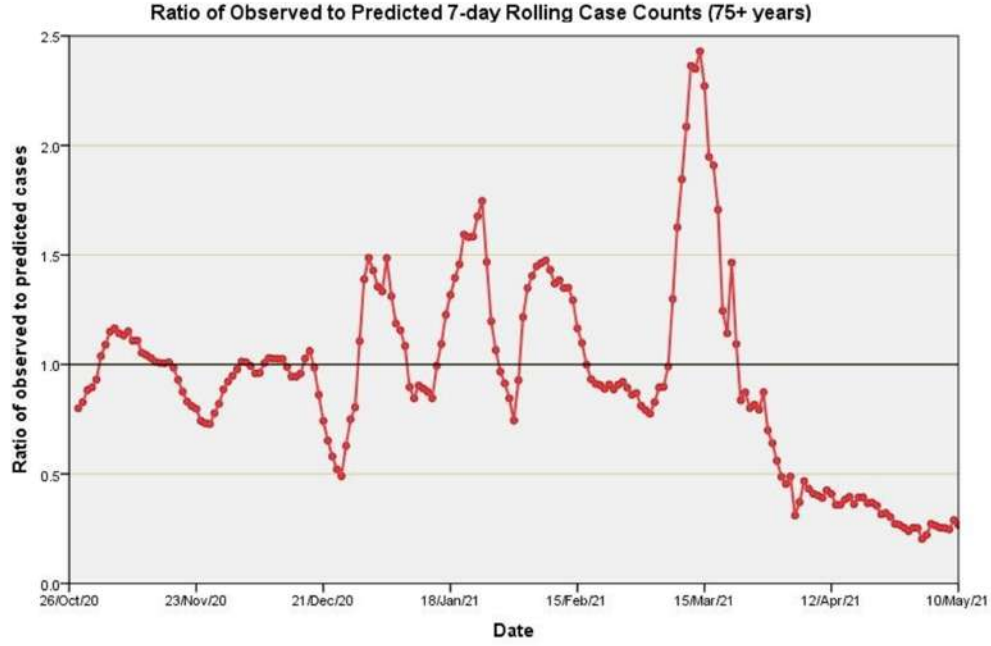
At some point the government will want evidence that the viccanes are working and the easiest way to obtain this is to start lowering the RT-PCR cycle threshold to reduce the number of false positives per test over time. My well-fitting GLIM model doesn't realise this, of course, and so will start over-predicting positive cases in a systematic manner once the policy decision has been taken.

This is precisely what we see happening after that mid-March peak, with a steady decline in the ratio to well below 0.5.

Either a genuine vuris is in genuine decline as a result of seasonality and/or effective viccane rollout or RT-PCR cycle threshold is being lowered – the choice is yours!



Source: https://coronavirus.data.gov.uk/



Source: https://coronavirus.data.gov.uk/

Negative People!
An extract of an email I have just fired off to the coronavuris tracker bods at UK GOV....

Morning!
Assuming a 7-day rolling summation I have now translated the data held in - uniquePeopleTestedBySpecimenDateRollingSum - back to daily counts and have cross-checked calculations. In doing so I have discovered errors in the this field and attach a screenshot of a section of my spreadsheet revealing some of these.

You will see that on 18/01/2021 a negative daily count of -36,046 unique people tested is required to reach a rolling 7-day summation of 2,072,001 from the previous 7-day count data (I can email my spreadsheet if this would help). In total some 18 daily instances of negative count error summing to 5,044,326 negative counts of unique people tested are present in this field (and presumably the source data used to derive the field).

This presents a considerable problem for anybody trying to perform analyses because we're either 5,044,326 people missing or there are glitches in the system that have gone unnoticed. I would therefore appreciate somebody getting back to me on the matter.

Kind regards,

...I am waiting to hear back on how they've managed to misplace 5,044,036 folk who were tested but are not showing up in the statistics. Here's a screenshot of all negative daily counts of folk going for tests. There's no way you'd discover this by looking at the summed data they provide. I wonder how many other 'errors' are lurking?

	A	B	C	D	E	F	G	H	I
1	areaCode	areaName	areaType	date	uniquePeopleTestedBySpecimenDateRollingSum	prev6count	dailycount	Rolling7sumcheck	Comment
326	E92000001	England	nation	28/12/2020	1704459	1776410	-71951	1704459	what?
347	E92000001	England	nation	18/01/2021	2072001	2108047	-36046	2072001	what?
354	E92000001	England	nation	25/01/2021	1819616	1922384	-102768	1819616	what?
361	E92000001	England	nation	01/02/2021	1699801	1836474	-136673	1699801	what?
368	E92000001	England	nation	08/02/2021	1671109	1837916	-166807	1671109	what?
375	E92000001	England	nation	15/02/2021	1572007	1765034	-193027	1572007	what?
382	E92000001	England	nation	22/02/2021	1510805	1723668	-212863	1510805	what?
389	E92000001	England	nation	01/03/2021	1428917	1667652	-238735	1428917	what?
396	E92000001	England	nation	08/03/2021	1433294	1702116	-268822	1433294	what?
403	E92000001	England	nation	15/03/2021	1423918	1694335	-270417	1423918	what?
410	E92000001	England	nation	22/03/2021	1540625	1819617	-278992	1540625	what?
417	E92000001	England	nation	29/03/2021	1510322	1830667	-320345	1510322	what?
424	E92000001	England	nation	05/04/2021	1187582	1643272	-455690	1187582	what?
431	E92000001	England	nation	12/04/2021	1417798	1826224	-408426	1417798	what?
438	E92000001	England	nation	19/04/2021	1476037	1877810	-401773	1476037	what?
445	E92000001	England	nation	26/04/2021	1495307	1922972	-427665	1495307	what?
452	E92000001	England	nation	03/05/2021	1308115	1859938	-551823	1308115	what?
459	E92000001	England	nation	10/05/2021	1471126	1972629	-501503	1471126	what?

UK Big Picture
I've been up since 5am putting together an automated batch file system to enable me to pull down data from UK GOV at the touch of a few buttons. In doing so I've unearthed a few glitches and I'm now in correspondence with the coronavuris dashboard team. To test batch processing out for all four nations making up the UK (Scotland, Ireland, Wales & England) I knocked out a few UK-wide charts and thought this one might go down a treat, being everything folk like to know in one colourful display.

New cases (specimen date) are positive PCR test results and nothing more. We shouldn't be calling them cases and we shouldn't be using a test that is not fit for purpose, but there you go. These are

counted according to the date of the earliest swab rather than the date on which the authorities decided to announce the results (publication date). We should note that many folk will be tested more than once and so will be counted more than once.

New admissions sure sounds like the number of folk sick with CIVOD going to hospital for treatment but this is far from the case. Admission may be for any reason whatsoever – so long as the admitting patient tests positive then they'll count as a CIVOD case. Testing positive does not mean they are sick with CIVOD or carrying any vuris (false positive). An admission need not lead to a bed stay, whether day bed or overnight bed and can be self-admission.

CIVOD Hospital Cases sounds the business but it is not. These folk are in-patients who test positive during their stay; they are not necessarily in hospital because of CIVOD. Somebody in hospital for a hip operation will count as a case if they happen to test positive. Testing positive does not mean they are sick with CIVOD nor carrying any vuris (false positive).

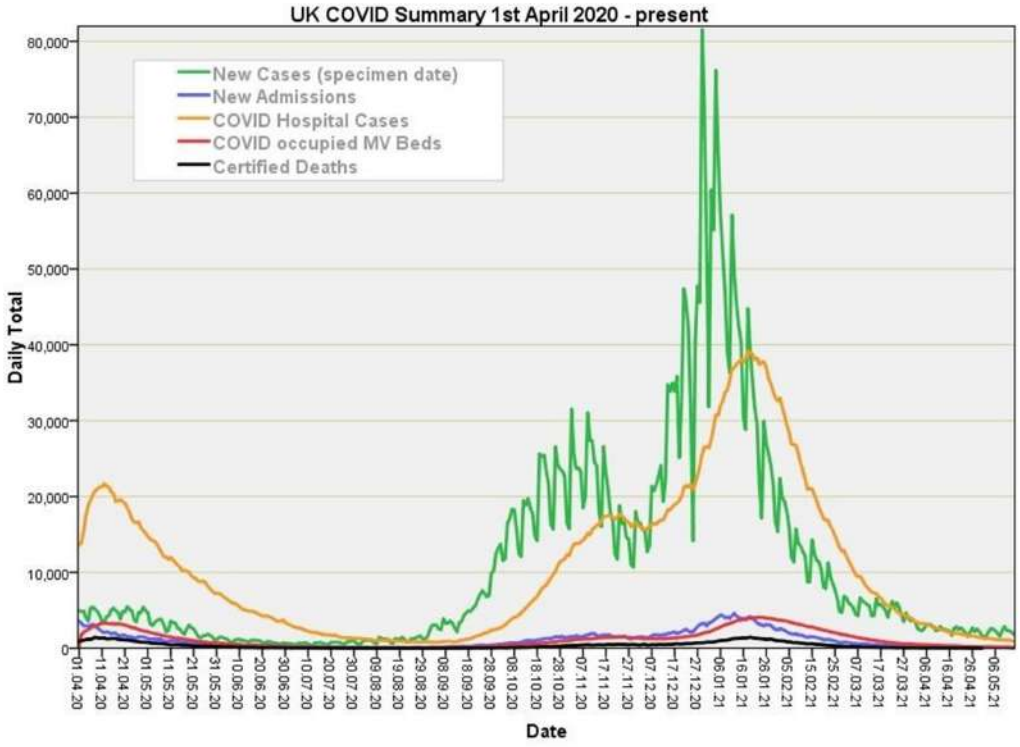
CIVOD occupied MV Beds sounds serious business. It is indeed, but it is not necessarily serious CIVOD business. Patients with both acute and chronic respiratory conditions (a major killer in the UK) will continue to require high-end treatment, but if they happen to test positive they'll be counted as a CIVOD case even if they are not carrying any vuris (false positive).

Certified Deaths sounds like genuine CIVOD business but again it is not. If certifying physicians rely on PCR test results then false positives are also going to land on the death certificate. Certified doesn't necessarily mean causal since it can refer to CIVOD as a co-morbidity (section II certification). On top of this the automated cause of death software known as MUSE (Multicausal and Unicausal Selection Engine) will override anything written by the certifying physician to ensure WHO guidelines are followed rather than the medical reality.

With that understanding in place let us have a look at some peculiar features, starting with the big orange hump back in April – June 2020 that tells us the initial outbreak was largely among existing inpatients already in hospital for something else other than CIVOD. Inpatients don't tend to commute or go partying **so how did a nation of inpatients suddenly get sick all at once?** Are we talking an army of well-meaning super-spreaders bearing grapes and contaminated cheap magazines… **or perhaps a test that generated a heap of false positives?**

We also see an autumnal mini-wave of new cases that didn't translate into MV bed use or deaths. **Did the vuris suddenly lose its nerve?** Bizarrely, this mini-wave of new cases converted into inpatients directly without an attendant rise in new admissions. **What we have, then, is a vuris without sufficient potency to get folk coming in through the doors that somehow bumped numbers of folk already in hospital**. If the PCR test produced nothing but false positives yet was used extensively in healthcare settings as the NHS opened its doors again then this phantom orange rise is what I'd expect to see. Ditto the classic winter peak

No doubt there's more bizarreness to figure but right now I need a cold beer. The best explanation I can muster is that there isn't a vuris, merely a test that purports to show a vuris but I shall continue to dig!



Unique People Tested

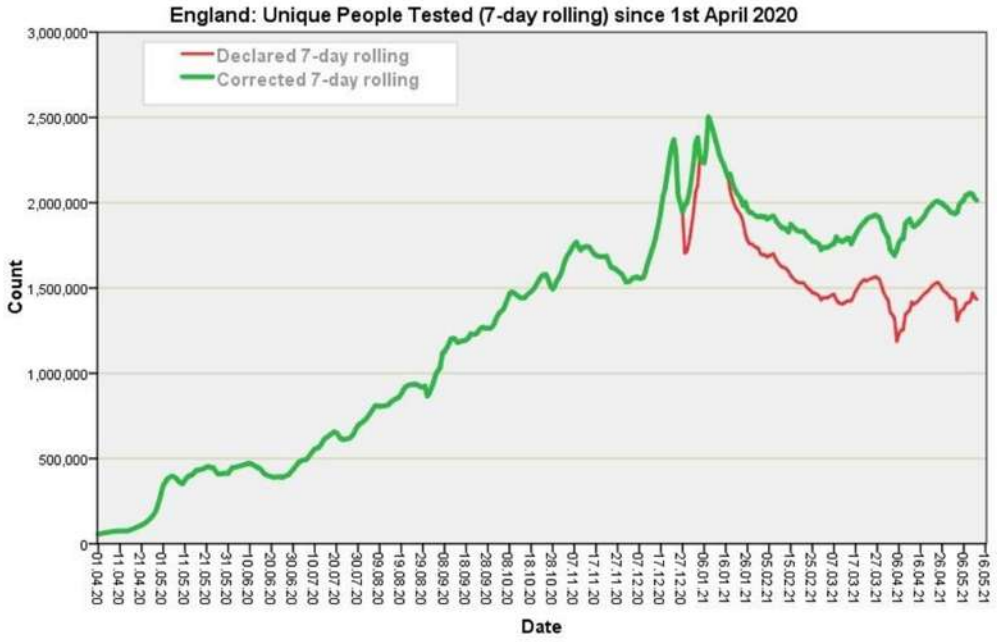
We get to hear a lot about the zillions of tests being undertaken and the millions of positive test outcomes that governments prefer to call a 'case' these days, even though its only a swab result with a high probability of being in error. I have mentioned that folk being tested more than once get counted as a 'case' more than once if they return a positive test, so it's pretty important to know just **how much double, triple and quadruple counting is going on** so we may better judge what is exactly happening as opposed to what the media and authorities claim is happening.

A while back I undertook a mini-project on bed occupancy using data provided by the NHS and discovered that hospital admissions were being multiply counted. This would occur, for example, with somebody going for dialysis or chemotherapy on a regular basis - if they tested positive at any point then a course of 13 visits for that patient would count as 13 CIVOD admissions. Across the 315 service providers of NHS England I calculated a median admission bias factor of 2.3x; thus each patient, on average, is generating 2.3 so-called 'admissions'. I wondered if the same bias factor applied to testing and so set about pulling down data for the unique number of people tested from UK GOV.

This is where the fun and games began for I discovered that for the official 7-day rolling summation data to hold its numerical course then negative entries totalling some 5,044,326 unique persons must have been entered onto the system. This isn't just about missing data; this is about negative values being entered into the system! I alerted group members to this nonsense in a post entitled 'Negative People!' and since then I have been able to use statistical techniques to remove the 18 negative person counts and replace them with robust estimates of what the true count should have

been. As a result I have been able to derive what the true 7-day rolling summation for unique people being tested should be for England.

This result should speak for itself - that is some serious discrepancy isn't it? The knock-on effect will be elevation of any rate estimates made using the number of people tested. In plain English, the outbreak will look worse than it is if we try to calculate infection rates (positive tests per person).



Source: https://coronavirus.data.gov.uk/

Test Application Rate

In my previous post entitled Negative People! we got to learn how official data sitting on UK GOV servers contains negative numbers of people being tested – **some 5,044,326 negative people to be precise**. I wrote to the project lead pointing out the ghastly flaw in a most friendly manner but I haven't had a reply as yet. Consequently, I went and replaced 18 sets of negative numbers with something far more sensible derived from statistical modelling of the remaining data, the impact being summarised in my post entitled Unique People Tested.

This morning we are going to see why counting the actual number of individuals involved is rather important, but **some of you no doubt have already realised the government's game and that is to use a single individual to generate many cases and many admissions to hospital**.

We shall start by looking at the number of times a person gets swabbed or poked. To generate this slide I derived 7-day rolling summations of vuris tests undertaken (both PCR and lateral flow varieties), 7-day rolling summations of PCR tests alone and 7-day summations of the number of individuals subjected to testing.

If the phrase 7-day rolling summations hurts the brain think of it as a weekly total, with each week progressively starting on a new day. The reason we flip to using 7-day summations is because weekends play havoc with data processing, with weekend counts often being dumped onto Monday. Such a summation usefully irons out administrative issues and stabilises the numbers. Once we have

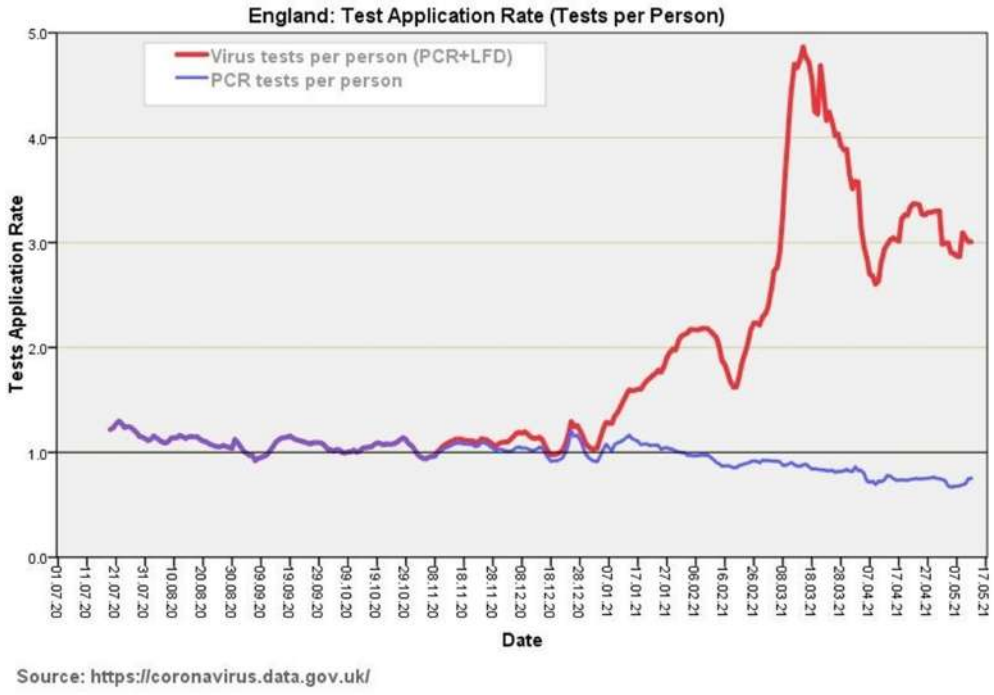
7-day summation data for tests and people tested we simply divide one by the other to see how many times individuals are being swabbed, on average.

In the attached slide it is abundantly clear that 1 swab up 1 nose was pretty much the norm from the beginning of data collection right up until January 2021. We also see it was the PCR test that ruled the roost back then**. After January 2021 everything changed. Not only did PCR testing give way to lateral flow but we went crazy and started poking people up the nose as if there was no tomorrow**.

Nose poking reached a peak pretty much close to 5 pokes per person in mid March 2021, after which some employers and some headmasters may well have seen sense to bring it down to a slightly less idiotic 3 pokes per person.

The number of false positives we are going to be generating from this is breathtaking. Assuming an overall operational test sensitivity of 80%, a somewhat generous combined test specificity of 95% and an officially declared prevalence of 0.1% then my calculator indicates a grim test reality that is generating 98.4% false positives. We are poking folk for nothing!

In pursuing mass testing we are flushing serious amounts of money down the drain at a time when the economy is likely broken and beyond repair. **We are subjecting citizens to repeated invasive procedures that have absolutely no clinical value,** and we are pursuing this worthless goal with increasing vigour; in effect our employer and our school have now become our physician. No doubt sadists and shareholders will be equally pleased.



Source: https://coronavirus.data.gov.uk/

Impact of vaccination on household transmission of SARS-COV-2 in England

This is the title of a report prepared by Public Health England (PHE) that came out last April, causing quite a stir. I say 'came out' because it didn't manage to receive peer review nor did it appear in a quality journal, it effectively being an internal document issued as a PDF. A great gift to the media, government, experts, authorities and manufacturers alike, this report appeared to provide the first solid evidence that vaccination reduces transmission, with the conclusion:

These results show that the likelihood of household transmission is 40-50% lower for households in which the index cases are vaccinated 21 days or more prior to testing positive (compared to no vaccination), with similar effects for both ChAdOx1 nCoV-19 and BNT162b2 viccanes.

A hard copy has been sitting in my in-tray for a week and I've tried to muster the desire to wade through yet another turgid government report to ensure it passes muster. I've now had a chance to give it some consideration and, once again, it doesn't pass muster! In fact, it doesn't pass muster in a rather glaring way; I shall explain in four bullet points.

1). The entire premise of the study rests on the assumption that members of households only interact with each other in terms of SARS-COV-2 transmission. The idea behind the study is a good one in theory – determine if other people within a household are infected 2 – 14 days after an index carrier and establish if vaccination prevents this – but a poor one in practice since we have no idea what household members will have been doing with their lives.

2). The study ignores likely behavioural differences between households. Members of households keen on vaccination are likely to behave differently to members of households not keen on vaccination. These behaviours will lead to differing levels of exposure, for which no compensation was made.

3). The study start date for indexed (primary) cases was 4th January 2021 but since a 21 day window post-vaccination was required for vaccinated index cases then the earliest start date for these was 25th January 2021. This introduces a significant bias whereby data for un-vaccinated households from 4th January onward during a period of higher background rate of infection (prevalence) were compared with data for vaccinated households from 25th January onward during a period of lower background rate of infection. Variation in case counts for England over this time period reveals a 51.5% reduction, of which PHE estimated a 40%-50% reduction allegedly due to vaccination.

4). Propensity adjustment was not undertaken in order to account for variation in disease prevalence both spatially and temporally. Whilst PHE analysts opted for region and calendar week indicator variables these are no substitute for regional and weekly infection rates. Propensity adjustment in retrospective observational clinical studies is a fundamental prerequisite and failure to incorporate this into modelling represents a major study weakness. It is likely that the results obtained stem from this singular oversight.

My conclusion is that PHE undertook an impressive study involving 552,984 households and 1,449,427 contacts, that was backed by extensive multivariate logistic modelling but which failed to account for changes in actual exposure to SARS-COV-2 of those contacts across regions and over time. The study also rests on the thin premise that household members only reacted with each other over a span of 70 days, which stretches incredulity somewhat.

On this basis folk are being convinced by authorities and the media alike that vaccination reduces transmission when in all likelihood it does not (the spike protein is not the means of transmission).

I am tempted to place a FOI to obtain the dataset and expose the methodological flaw by re-running PHE's logistic regressions using propensity score adjustment to take account of variations in disease prevalence. Ironically, last time I did this I helped bail one of Bayer's products (please ask if you want to see my Lancet paper).

BOMBSHELL: Connecticut govt. secretly tells health care workers civod viccanes are DEADLY, but withholds the same information from the public

https://www.naturalnews.com/2021-05-18-connecticut-govt-secretly-tells-health-care-workers-civod-viccanes-are-deadly.html

Two Slides You Won't See

One glaring thing that sticks out for me above all other things (and there's a truck load of many glaring things) is that the authorities and organisations producing all these fancy slides for consumption by the public fail to consider the humble rate. We see lots of case counts, lots of admission counts, lots of hospital bed counts, lots of death counts and lots of test counts **but nowhere is the humble rate graph to be seen.**

Public Health England (PHE) manage a feeble cases per 100k population by age band and by region forgetting that this means nothing until we adjust for different numbers of tests within each age band and region. This is akin to buying a 1kg bag of carrots and putting it in the dining room, then buying a 5kg bag of carrots and putting it in the kitchen then declaring the kitchen has more carrots and is thus a tastier place. In the following two slides I am going to buy the same amount of carrots on a day-by-day basis so we may actually see what has been happening over time despite varying levels of test activity.

In the first slide we get to see what I am calling the case detection rate, being positive 'cases' per 100 people tested. **That monster early peak of April 2020 sure gives some perspective to the so-called "second wave" and represents a time when we decided to test people who were actually sick rather than attending college**.

The second wave now peaks at just 15 – 20 positive cases per 100 but **we must remember that this will include all those false positives**.

If we assume a nominal test sensitivity of 80%, a nominal specificity of 99.9% and the recently declared prevalence of 0.1% then we find PCR testing would have yielded 55.5% false positives i.e. just over half of the data are utter nonsense. Yet these are nominal estimates; if we assume an operational specificity of 97% then the false positive rate rises to a breathtaking 97.4%, which means most of what we are seeing is an illusion; even more so when we realise that positive test results can be made to come and go simply by choosing a different cycle threshold. In this regard we may note

no laboratory publishes a weekly SOP so we may see what they are doing, and no authority publishes historic cycle threshold data even though they're sitting on piles of this.

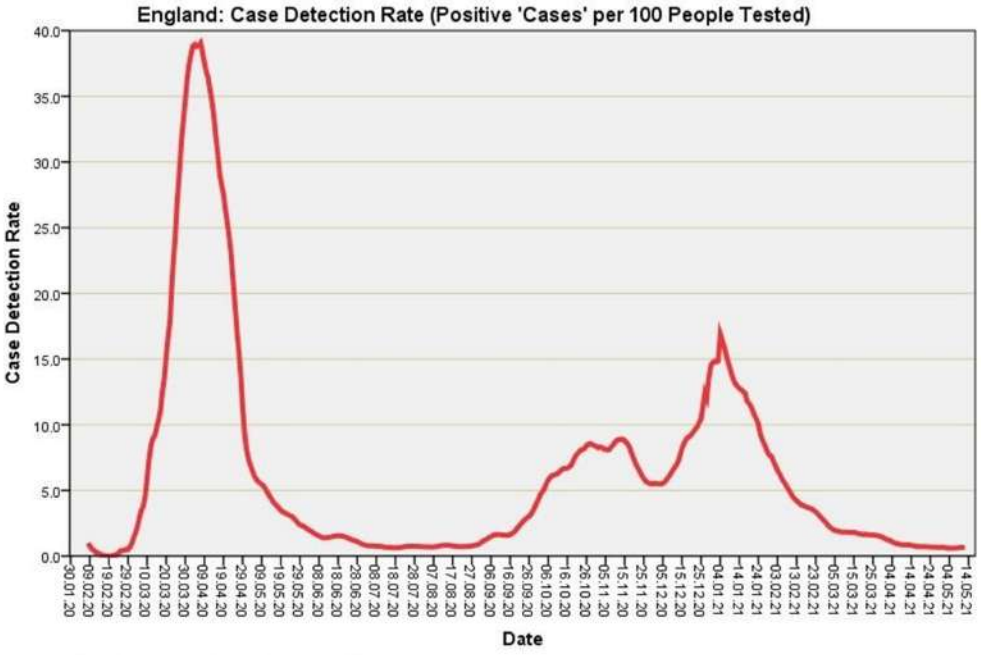
In the second slide I do my carrot trick on hospital admission rate (admissions per 100 new cases). To most folk the word 'admission' will mean the number of folk sick with CIVOD going to hospital for treatment for CIVOD but this is not what the word admissions means in GOVSPEAK.

In GOVSPEAK admission may be for any reason whatsoever – so long as the admitting patient tests positive then they'll count as a CIVOD case. Testing positive does not mean they are sick with CIVOD or carrying any vuris (false positive). An admission need not lead to a bed stay, whether day bed or overnight bed and can be self-admission.

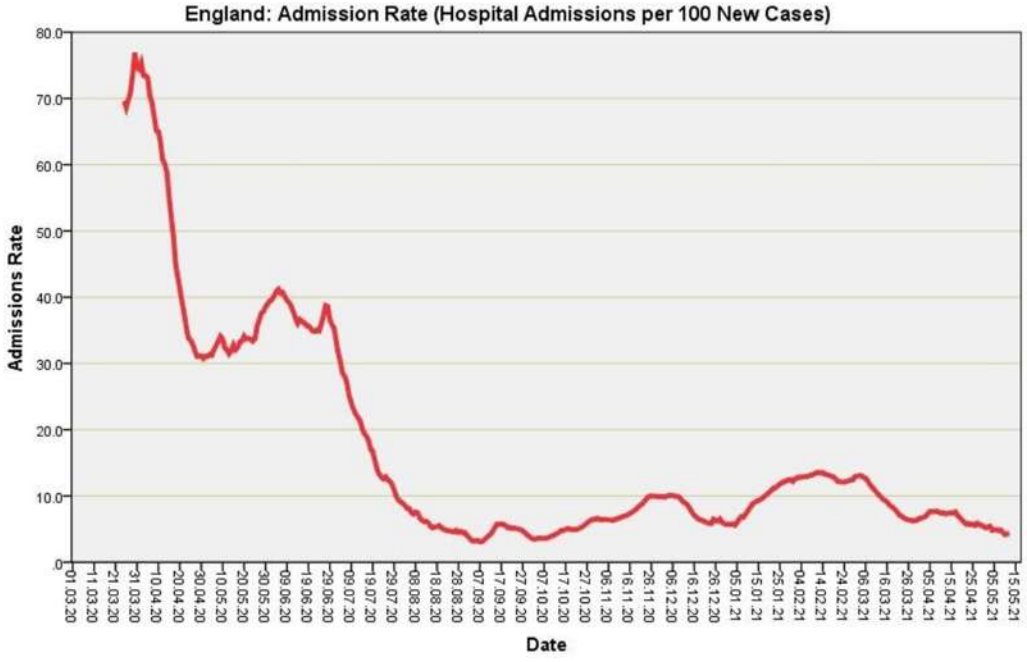
An admission need not be to a unit that even treats CIVOD! Thus, a rather healthy pregnant woman being admitted to a gynaecology unit to give birth to a healthy bouncing baby will be counted as a CIVOD admission if she happens to receive one of the many false positive test results. The same goes for hip replacements, those needing dialysis, the many with cancer or heart conditions and whipper-snappers coming a cropper in road accidents. If we could set aside the thousands of false positive test results it would be pretty much business as usual, with seasonal respiratory conditions doing the seasonal thing.

Caveats aside we now see a rather serious looking disease outbreak back in March – June of last year, the likes of which we have not seen again. I would argue that the grumbling rate of around 10 admissions per 100 new cases from July 2020 onward is just background noise, being folk going to hospital clutching yet another false positive test result. Neither do we see any evidence of that highly political "second wave" in terms of admission rate.

n my book a second wave of something that doesn't impact on health service provision isn't really a wave. A wave of fear mongering maybe but not a wave of ill health.



Source: https://coronavirus.data.gov.uk/



Source: https://coronavirus.data.gov.uk/

Impact of vaccination on household transmission of SARS-COV-2 in England – further considerations

In my first post on this study of significance I provided four bullet points summarising design and methodological issues that would have been sufficient for it to fail proper peer review. Setting aside the fallacious assumption that household members remained in perfect isolation such that other

household members and only other household members were capable of infecting one another, we arrived at the tricky issue of background infection variability and household members' exposure to this. I noted that the time periods for vaccinated index and non-vaccinated index household members differed, with data for non-vaccinated index members starting 21 days earlier on 4th January 2021, as opposed to 25th January, and indicated this would greatly bias results owing to significant decline in disease prevalence over this time. This led to mention of the need for propensity adjustment in the statistical modelling of retrospective observational clinical studies and PHE's failure to do this. This morning I'd like to delve a little further...

In a well-designed clinical trial we balance our randomised samples across demographic, medical and other factors so that we can be confident in comparing groups under study. With data gathered from the public at large we don't have this luxury and must resort to using multivariate techniques to absorb variation due to age, gender, socio-economic group and so on before we can say anything about efficacy or safety of treatment.

Within a population the propensity for developing a medical condition is never equal even when age, gender, SEG etc have been taken into consideration, an example being increased likelihood of renal failure in cardiac patients presenting for surgery. If we don't adjust for this initial propensity we cannot say anything about the likely impact of a drug deemed to be causing renal failure during surgery.

In the matter of PHE's household study we find failure to account for the propensity of household members to be infected with SARS-COV-2 as disease prevalence changes over time. Turning to supplementary material S1 of the report we see a covariate called index case date (a factor variable representing a series of 8 weeks) yielding highly significant values of ($p<0.001$) for each and every week.

This is telling us that the passage of time is important in determining the odds ratio of a household contact becoming a secondary case. PHE interpret this as being due to progressive development of immunity of the vaccinated index (initial) household case, forgetting that exposure of that index case to SARS-COV-2 will also be varying over time as disease prevalence within the general population changes. Ideally PHE would have used weekly estimates of disease prevalence as a covariate to absorb this source of variation but failed to do so, this being an extraordinary oversight.

The same table provides statistical output for a covariate called Region (a factor variable representing 9 English regions). P-values range from $p=0.023$ down to $p<0.001$, revealing that there are statistically significant differences across regions. Why should this be so? Why should the odds ratio of a household contact becoming a secondary case depend on where they live during an extended period of lockdown? PHE do not address this peculiar finding but they should have because it is further evidence that regional differences may have arisen through regional variation in disease prevalence.

By way of worked example I have derived case detection rate (positive test results per 100 viral tests undertaken) for England using rolling 7-day data to provide a proxy for disease prevalence on a daily basis. The mean case detection rate for the period 4th January 2021 – 28th February 2021 (the period used for non-vaccinated index cases) was estimated at 4.98 cases per 100 tests. In comparison the mean case detection rate for the period 25th January 2021 – 28th February (the

period used for vaccinated index cases) was estimated at just 2.60 cases per 100 tests. We thus see that, in terms of national prevalence alone, there was a 47.8% decline in background likelihood of infection across England that PHE have gladly attributed to a 40%-50% saving arising from viccane immunity. I strongly suspect that using disease prevalence as a covariate in logistic modelling in an appropriate manner will completely change the study outcome.

I am hoping folk are following my argument here and understanding the need for propensity adjustment in studies such as PHE's but there is one other rather technical issue I should mention and that is failure of PHE's analysts to use staged multivariate logistic regression. What PHE have done is lump all covariates together, including the covariate of interest (Vaccination of Index – a 3 level factor variable indicating vaccination status).

In a study such as this it is considered good practice to undertake staged logistic regression whereby demographic and other general covariates are entered into the model at stage 1, with covariates of interest entered at stage 2. This is to ensure all the variability arising within the sample due to age, gender, SEG etc is absorbed within the covariance matrix before the variables of interest are considered. If you want to force an effect when there isn't one then bypassing the gold standard of staged multivariate logistic regression is the way to do it.

If you seriously want to produce an unbiased statistical model for estimating the odds ratio of a household contact becoming a secondary case then a proxy representing propensity of infection (prevalence) would be entered at stage 1, general covariates covering age, gender etc would be entered at stage 2, and then the critical vaccination of index would be entered at stage 3. This approach and only this approach will lead to appropriate results.

I cannot believe PHE's statisticians are not aware of this.

Before I brew my tea there is one final consideration – false positives! The validity of PHE's study also rests on the assumption that all PCR test results from all 1,449,427 contacts are going to be correct. If we assume a nominal test sensitivity of 80%, a nominal specificity of 99.9% and the recently declared prevalence of 0.1% then we find PCR testing would have yielded 55.5% false positives i.e. just over half of the data used by PHE are total and utter nonsense. Yet these are nominal estimates; if we assume an operational specificity of 97% then the false positive rate rises to a breathtaking 97.4%, which means PHE's study, in addition to the flaws and weaknesses mentioned, may well have been built on a house of cards.

Now if that sounds bad consider the impact of varying prevalence on false positive rates. In the decline of the outbreak following the late December peak national prevalence would have plummeted and the false positive rate would have rocketed, thus the data would have become more nonsensical as the study progressed. If PHE had any kahunas they would have estimated likely false positive rate during the course of the study and used this as a weighting factor in a propensity-adjusted staged multivariate logistic regression.

Real statisticians do it using weighted, propensity-adjusted, staged multivariate logistic regression – now that's a bumper sticker I must obtain!

Impact of vaccination on household transmission of SARS-COV-2 in England – Bombshell!
My professional response to this significant report is now contained in two lengthy posts and I'm hoping folk here are beginning to see the absurd assumption that underpins the study along with the poor methodology adopted. In jest I joked about a bumper sticker "Real statisticians do it using weighted, propensity-adjusted, staged multivariate logistic regression" and was planning on firing-off a FOI request to obtain the data so I could undertake the gold standard statistical work myself when I saw this depressing statement on page 24…

Data Availability Statement
The data underlying this article cannot be shared publicly due to the legal and policy controls placed on data used as part of the government's response to the Civod19 pandemic.

…after some thought and a decent lunch I realised I didn't need their precious source data – all I had to do was take the odds ratio information provided in figure 2 of PHE's report and subject this to propensity adjustment myself using my newly derived case detection rate series that I presented in my post entitled Two Slides You Won't See. It's taken a while to accurately re-create PHE's figure 2 but I have now done so and present this as the first slide. Please note that I've flipped the x-axis left-right to match how we are used to seeing time move from the origin and not toward the origin as per PHE's original slide.

This is the key slide of PHE's report and we see an apparent decrease in the odds ratio over time that PHE attribute to the benefits of vaccination through building immunity. If you are not used to odds ratios simply think of them as a factor such that a value of 1.0 means no change, 0.5 means halving of risk and 2.0 means doubling of risk. Halving and doubling of risk refers to the likelihood of other household members testing positive if the index member of the household (the person being tracked) gets vaccinated.

Right after vaccination we see odds ratios for both viccanes hovering about the unity value of 1.0 meaning vaccination had no initial impact, but over time we see the odds ratios fall below 1.0 which reveals it was less and less likely that secondary household members tested positive. **This sure looks convincing but it's a pile of junk for several reasons,** the chief reason being the analysts at PHE forgot to use variation in background disease prevalence as a covariate in logistic regression modelling by way of propensity adjustment.

At the start of PHE's study disease prevalence across England was running at an estimated 9.28 positive cases per 100 people tested. By the end of the study at day 60 this had dropped to just 1.83 cases per 100 people tested (these necessarily include false positives). We may expect this variation to find its way into the study since disease prevalence will ultimately determine the exposure of household members to SARS-COV-2 no matter what they were up to.

If we take the odds ratios PHE churned out in the first slide (figure 2a) and adjust them to account for background disease prevalence we arrive at the second slide.

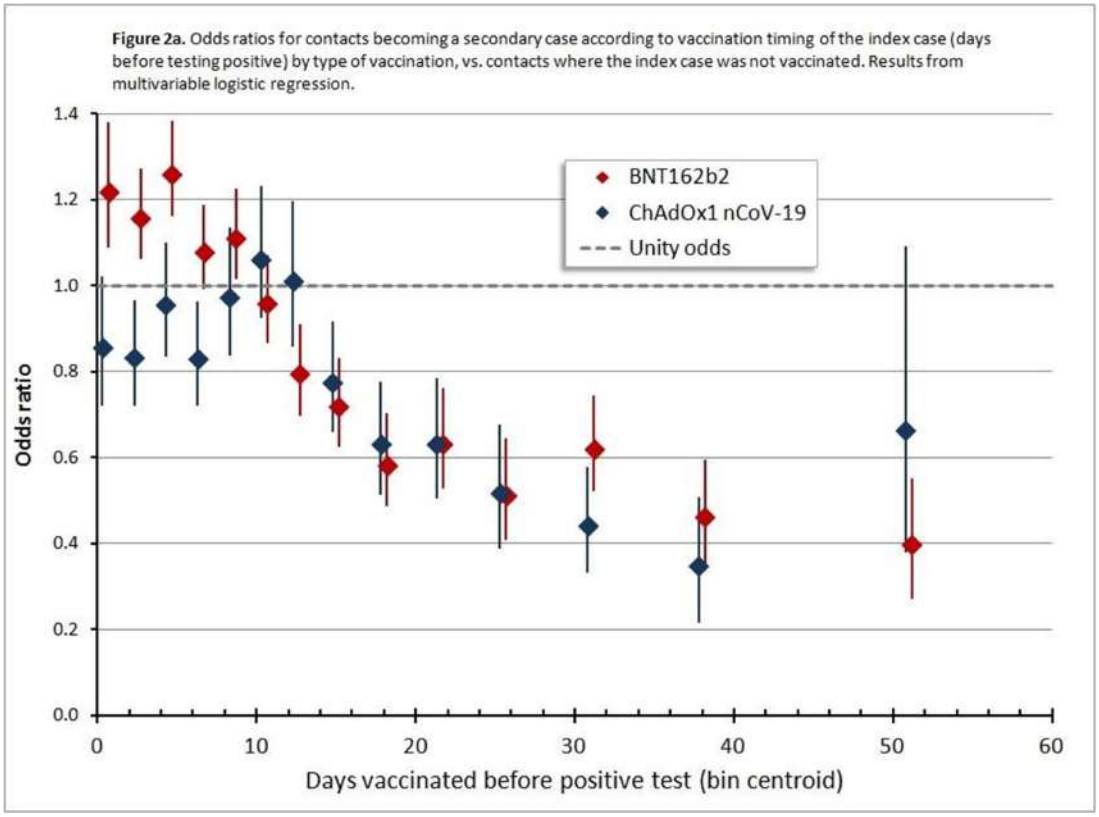
This is a veritable bombshell of a result for we now see the odds ratios climbing like crazy. This is only possible if vaccinated index members are transmitting some aspect of SARS-COV-2 to secondary (un-vaccinated) members. Incredibly, members of households where somebody got jabbed with Pfizer's BNT162b2 product are twice as likely to test positive at the 42 – 60 day mark, with

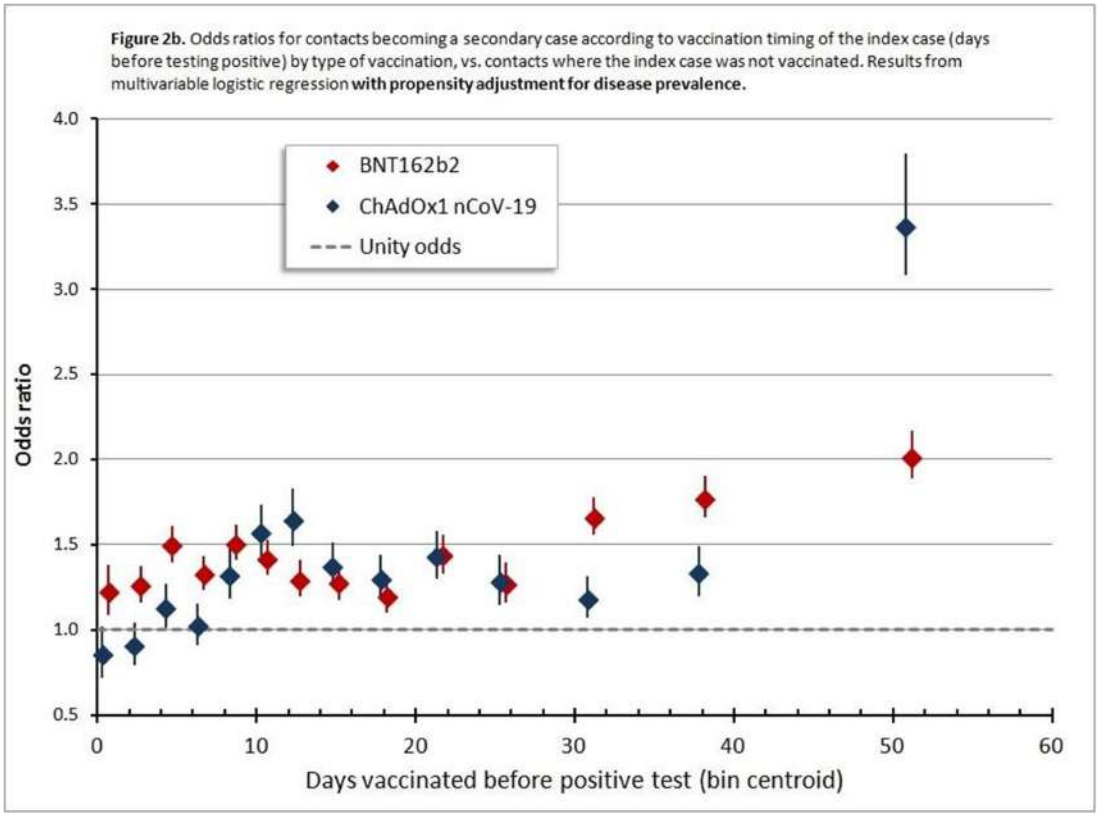
AstraZeneca's ChAdOx1 nCoV-19 concoction more than three times more likely to pass something unpleasant to others.

It is more than a little ironic that PHE's very own flagship study of 552,984 households reveals viccanes to be rather dangerous and ill-understood products if we take the trouble to apply appropriate and rigorous statistical methodology. **No wonder they don't want to release the data**.

The stable door is open, the milk spilled and Schrödinger's cat is mewing.

The biggest study in the land has just shot itself in the foot, dropped a clanger and stabbed big pharma in the back – all swords come double-edged.





Impact of vaccination on household transmission of SARS-COV-2 in England – an overpowered clinical study

This is one of those reports that keeps repeating on me like too many gherkins. This morning I realised there is another major flaw with their analysis and this is to do with sample size and test power. The final cohort settled at 1,018,842 secondary cases which is a rather big number. So big, in fact, that statistical analysis of any kind is going to declare all manner of minute difference that do not necessarily exist or have meaning in real life, with p-values going off the scale beyond $p<0.001$ due to the colossal statistical power of a sample that is a million strong.

To illustrate this I have synthesised two data series representing the height of male adults, the first series (group 'A') having a mean height of 180.000 cm with a standard deviation of 0.1cm, the second series (group 'B' having a mean height of 180.001cm with a standard deviation of 0.1cm.

If I take a random sample of just 100 males (50 from group 'A', 50 from group 'B') then a classic stats test (analysis of variance - ANOVA) tells me there is no statistically significant height difference between the two groups ($p=0.907$). If I take a random sample of 1,000 males (500 from group 'A', 500 from group 'B') then ANOVA tells me there is no statistically significant height difference between the two groups ($p=0.694$). Even if I take a somewhat healthy random sample of 10,000 males (5,000 from group 'A', 5,000 from group 'B') then ANOVA tells me there is still no statistically significant height difference between the two groups ($p=0.522$).

However, If I splash out the dosh on my clinical study and go for a sizeable random sample of 100,000 adult males I suddenly and rather magically obtain a statistically significant difference in height between the two groups ($p=0.016$).

If I now go extreme PHE-level and obtain a sample of 1,000,000 adult males the significance goes through the roof ($p<0.000000000001$). That utterly crazy p-value is a classic symptom of an overpowered clinical study in which we can detect any difference we want regardless of whether it has clinical value.

If we leave planet PHE and come back down to Earth for a moment we ought to ponder the issue of whether a difference of 0.001cm in adult male height has any meaning, this representing one hundredth of a millimetre – is there a real difference worth bothering about or have we immersed ourselves in statistical illusion brought about by over-sampling?

As it with continuous measures like height and age, so it is with discrete measures like positive test result, region, week, deprivation band and so on. Every variable - and I mean every variable in PHE's study - will be subject to the same statistical whimsy when samples of 1,018,842 are drawn from the population, yet I see no attempt by PHE analysts to draw attention to this major study weakness. If we turn to supplementary material S1 on pages 25 - 27 of the report we see a list of 46 p-values for various factor levels. Of these no less than 42 (91.3%) indicate $p<0.001$, which is a classic sign of a massively overpowered study.

To wrap up I attach a link to a paper by way of introduction to this tricky subject; we may like to consider the author's sobering conclusion…

Also very low p-values like $p<0.0001$ will be rarely encountered, because it would mean that the trial was overpowered and should have had a smaller sample size. It would seem appropriate, therefore, to require investigators to explain such results and to consider rejecting the research involved.

https://pubmed.ncbi.nlm.nih.gov/15080563/

Impact of vaccination on household transmission of SARS-COV-2 in England – propensity adjusted for prevalence & false positive reporting

Yesterday I produced two rather revealing slides, these being the original figure 2 of this significant report from PHE (reproduced rather cheekily as figure 2a) and the same slide but propensity adjusted for disease prevalence within the population that changed dramatically over the period of study (a factor that PHE analysts somehow overlooked). The issues with this gherkin of a report don't stop there for we also must realise that, as disease prevalence changes so does the false positive result rate.

What I've done this morning is to use my estimates of prevalence (as derived from the daily series of positive cases detected per 100 people tested) and used this to calculate the daily false positive reporting rate of a PCR test set at a likely real-world-working-lab value of 95% specificity. This rate was then converted to a scaling factor that was combined with the scaling factor for disease prevalence to arrive at a joint factor that offers propensity adjustment for both prevalence and test reliability – something PHE should have done if they were being serious!

I now present figure 2c in the series that reveals odds ratios bobbing along around the unity ratio of 1.0. This means the two biological products studied are generally neither conferring benefits in

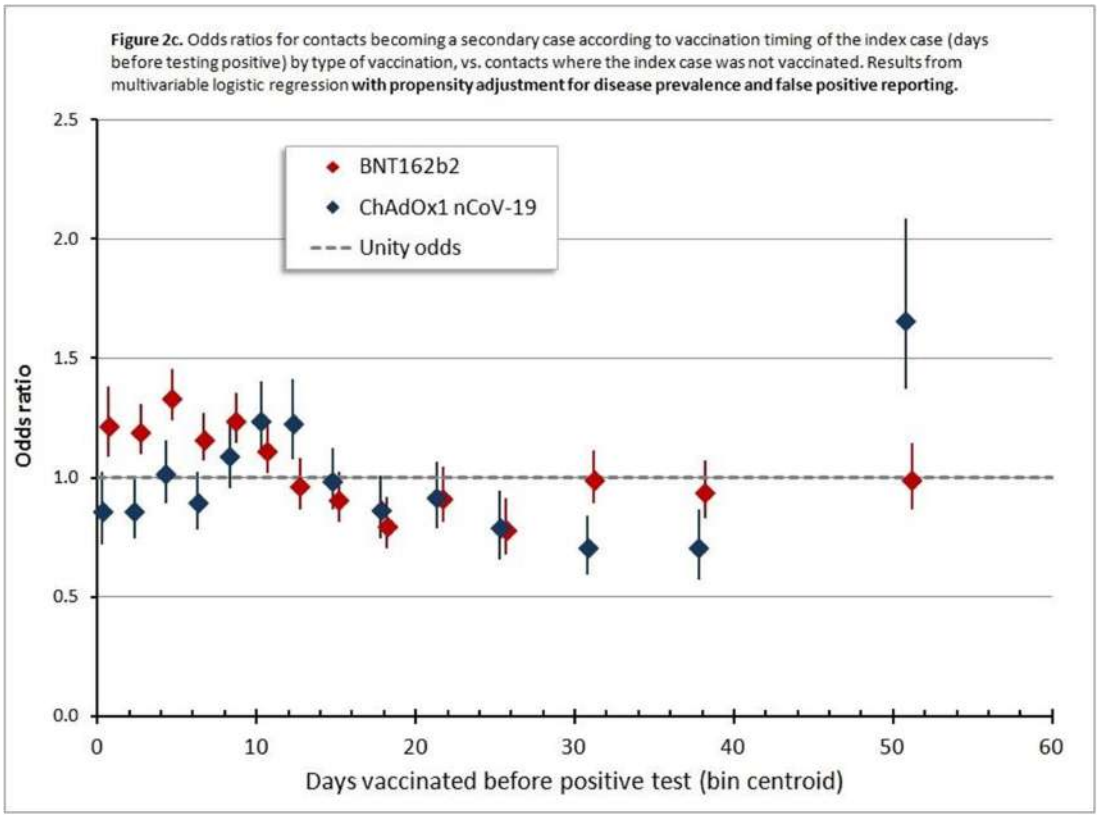
terms of reduced transmission nor are they elevating the risk of other household members testing positive through shedding whatever it is they are shedding as many folk fear.

Pfizer's BNT162b2 product does a darn good job of doing nothing for as far as the study stretches (60 days) and AstraZeneca's ChAdOx1 nCoV-19 product bizarrely seems to confer benefits at the 30 – 40 day mark that somehow finally reverse!

I've no idea how many indexed cases were vaccinated with ChAdOx1 nCoV-19 in the final weekly period of 22 Feb – 28 Feb but the sample total for both viccanes was 2,606, which should have been plenty to determine the odds ratio with sufficient accuracy. That final blue point sitting up at an odds ratio of 1.66 sits well clear of unity with no hint of the 95% confidence interval coming close to a value of 1.0.

I must conclude that, unlike Pfizer's mRNA product, AstraZeneca's adenovuris vector product is possibly shedding something beyond day 40 that is being transmitted to other household members sufficient to trigger a positive PCR test.

Whether or not this has any clinical implication I cannot be sure but one thing is for certain and that is the AZ jab is generating a circular paradigm.



PHE Household Study Design Bias

I've now spent a fair few hours and written 3,672 words on the absurdities, flaws, omissions and errors in this study by **Public Health England.** This morning I wanted to focus on just one aspect and make this as clear as possible, **this being failure of PHE's analysts** to account for variation in disease prevalence within the population as a whole. **This one omission renders the entire study useless.**

I shall start with a simple graph showing the decline in disease prevalence for England over the study period of 4th January 2021 – 14th March 2021 using official data obtained from the UK GOV coronavuris dashboard. Superimposed are the two sampling periods for unvaccinated and vaccinated index cases. PHE allowed a 21-day window for the development of immunity in vaccinated people which means the sampling frame for these cases started 25th January 2021 and not 4th January 2021 as with the unvaccinated index cases.

It should be abundantly clear that vaccinated index case data covers a later period with a lower rate of disease prevalence. We should not be surprised, therefore, to discover fewer positive cases among secondary household members during this period. This time difference in the sample frame is a significant source of study bias.

PHE usefully provides positive case counts and sample sizes for vaccinated and unvaccinated cases in figure 1 of their report and this is presented as the second slide. I have taken the data for the two CIVOD biological products and combined this to produce the table you see in the third slide. To the right of the main table I've derived infection rates for secondary household members of both vaccinated and unvaccinated index cases by age band, with provision of grand totals and rates. The bottom line figures are 0.585% for vaccinated index cases and 0.975% for unvaccinated index cases, these giving us an unweighted grand odds ratio of 0.60. This estimate compares favourably with the multivariable modelled odds ratios of 0.52 (ChAdOx1 nCoV-19) and 0.54 (BNT162b2) presented in supplementary material S1 of the report.

Without further thought we may take this as evidence of viccanes reducing household transmission but we'd be **quite wrong to do so since we haven't taken account of the inherent design bias.**

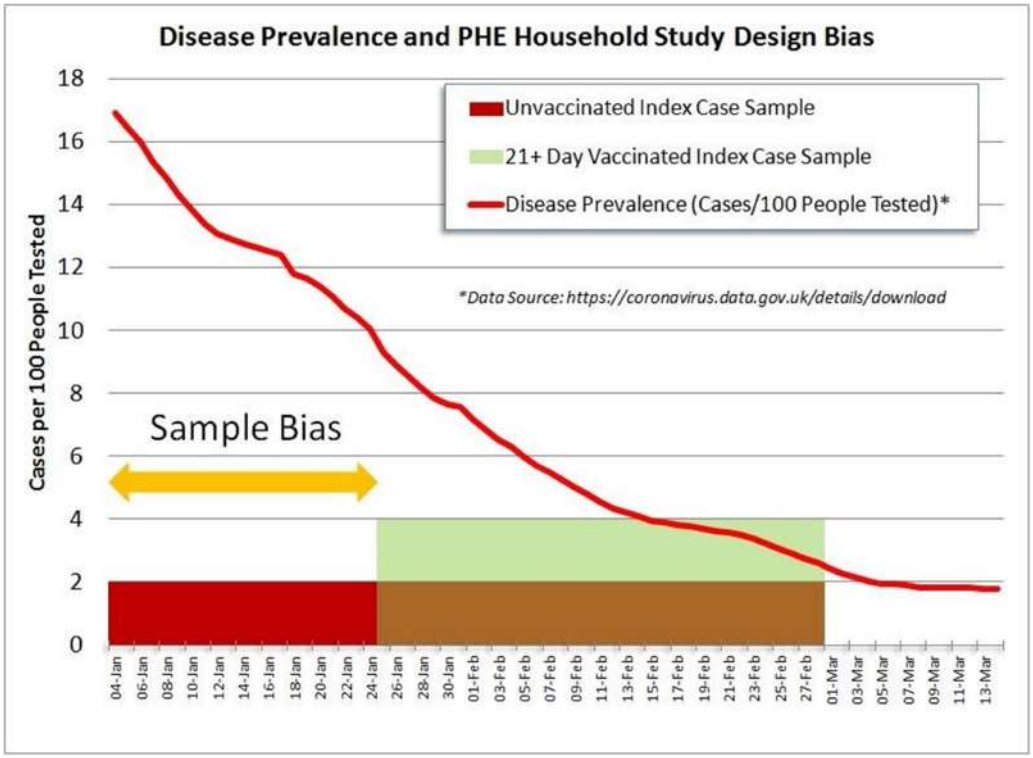
In table 2 of their report (characteristics of household contacts according to vaccination status of index case) PHE usefully provide counts of secondary household cases for each of the eight weeks starting 4th January 2021. This enabled me to derive mean weekly estimates of disease prevalence, which started at 15.38 cases per 100 people tested during w/b 4th January 2021 (15.38%), and ended at 3.05 cases per 100 people tested during w/b 22nd February 2021 (3.05%). It was then a simple matter to derive overall weighted estimates of prevalence for the vaccinated and unvaccinated index data series, these fetching-up at 4.26% and 11.22% respectively (see slide 3).

When applied as factor weightings to adjust for the study design bias **something remarkable happens** – we find **the infection rate for vaccinated index cases soaring to 1.540% compared to the 0.975% for unvaccinated cases**, this equating to a weight grand odds ratio of 1.58.

The primary study result has thus been stood on its head and **we find evidence of vaccinated individuals increasing the likelihood of SARS-COV-2 infection of other household members by 58%.**

PHE could easily correct this extraordinary statistical oversight either by using disease prevalence as a covariate in multivariable logistic regression modelling or by selecting unvaccinated index case

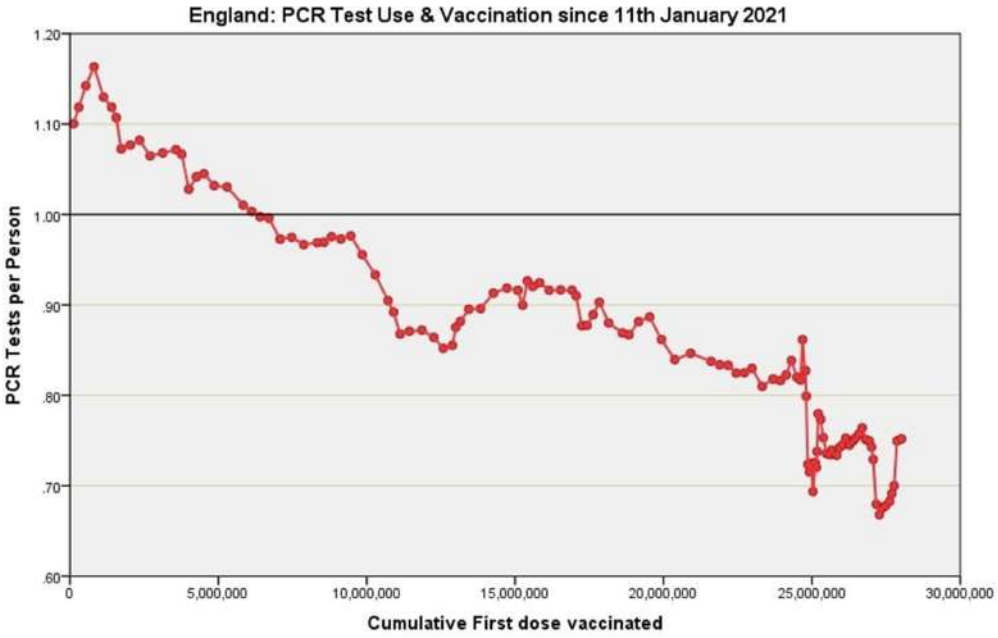
records from 25th January onward such that the sampling time frame matches. The former method is preferred since variation in weekly sample sizes still has the potential to bias the results; it would also offer an opportunity to adjust for regional variation in prevalence. Until this is done the study is as useful as finding a turd in your slipper.



PCR Test Bias & Vaccination

In preparing data for statistical modelling of the impact of vaccination on infection rates, admission rates and death rates I've come across a fly buzzing in the proverbial ointment. This is best explained by pulling up the attached slide, which reveals a distinct tendency to conduct less RT-PCR tests per person as the vaccination programme rolls along. Since PCR is currently the go to test for verification of SARS-COV-2 (positive lateral flow test results are verified using PCR) then less testing will mean decreased likelihood of detection. **In stats speak we call this sample bias, and there's plenty of it!**

In crude terms this slide reveals that the authorities have reduced likelihood of SARS-COV-2 detection by around 36% over a space of 17 weeks **by deciding to test less**. If nothing else this will be felt as a 36% reduction in new cases, which is most convenient for those spinning the narrative. Test less, get less and applaud the wonder of modern science – it couldn't be simpler!



Source: https://coronavirus.data.gov.uk/

Disease Prevalence & Vaccination

Over the next few posts I'm going to tackle a very big subject area and that is **analysis of the benefits of viccane rollout across England**. This is necessarily going to be a brain mangler requiring lots of fancy statistical techniques so I'll keep it as sweet and short as possible.

First up is the meaty question is vaccination rollout lowering disease prevalence within the population?

The answer is a big fat YES **if you fail** to undertake appropriate analyses

and

An enormous NO **if you actually bother to do it right**.

We'll start with the first slide that sure looks like it is telling us YES!

Here we see a measure of national disease prevalence for England (positive cases per 100 people tested, as derived from 7-day rolling case totals) plotted against cumulative figures for the 1st dose rollout.

The notion here is that rollout is going to reduce disease prevalence, so the more we jab folk, the lower disease prevalence becomes.

This is exactly what we see **but what we see is deceptive.** What we haven't done, for one thing, is **taken account of the bias introduced by testing folk less, as discussed in my previous post entitled 'PCR Test Bias & Vaccination'.**

If we test folk less using PCR then we are less likely to detect SARS-COV-2 within the population, which means cases are going to decline anyway.

The BIG question is whether this inclination to test less over time explains the reduction in disease prevalence we see in this first slide or whether there are benefits of vaccination despite this.

To answer this question we must turn to multivariable statistical modelling, and the powerful technique I have used is Generalised Linear Modelling (GLIM). We start by confirming the negative relationship of this first slide and then we run GLIM again but incorporating a variable that accounts for test use (rolling 7-day PCR tests per person). I provide the printout from my stats package for these two stages but all I want you to do is **look at the number in the green box and the number in the pink box.**

The number in the **green box** (-0.282) tells us that for every million first doses of viccane disease prevalence drops, on average, by 0.282% ($p<0.001$). That's a splendid benefit! Except it is an illusory benefit because **we haven't accounted for the bias introduced by testing people less with PCR**.

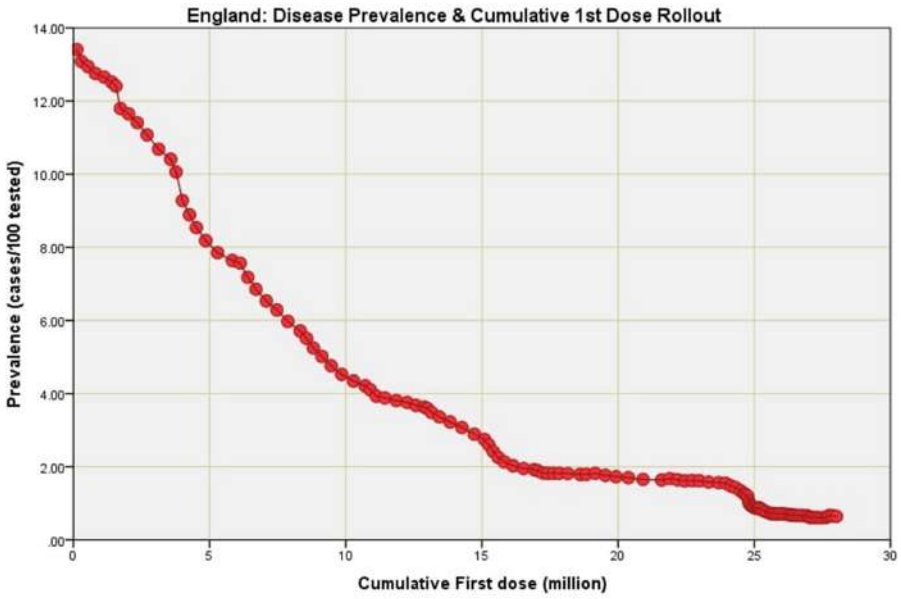
In the lower table I have done just this, and we find that rolling 7-day PCR tests per person is highly statistically significant ($p<0.001$), along with an interaction term ($p<0.001$) i.e. testing people less is having a tremendous impact on the national results.

Let us now look at the number in the **pink box** (0.690) – this tells us that **for every million first doses of viccane disease prevalence increases**, on average, by 0.690% ($p<0.001$) once we account for changes in the national test regime.

That is some result right there! Though there's a lot more modelling work still to be done here is the first empirical evidence that **vaccination rollout is increasing disease prevalence across England**.

This astonishing fact is being disguised because we're using PCR less and less frequently, and so the chances of detecting any vuris are lessening.

At this stage it would appear the viccanes are spreading the vuris rather than constraining it.



Source: https://coronavirus.data.gov.uk/ Data Period: 11th January - 12th May

Green box numbers and pink box numbers below

Parameter Estimates

Parameter	B	Std. Error	95% Wald Confidence Interval		Hypothesis Test		
			Lower	Upper	Wald Chi-Square	df	Sig.
(Intercept)	8.199	0.2865	7.637	8.761	818.813	1	0.000
Cumulative First dose (million)	-0.282	0.0111	-0.304	-0.260	643.287	1	0.000
(Scale)	.181[a]	0.0226	0.142	0.231			

Dependent Variable: Rolling 7-day Positive cases per 100 people tested
Model: (Intercept), Cumulative First dose (million)

a. Maximum likelihood estimate.

Parameter Estimates

Parameter	B	Std. Error	95% Wald Confidence Interval		Hypothesis Test		
			Lower	Upper	Wald Chi-Square	df	Sig.
(Intercept)	-18.072	1.6110	-21.229	-14.914	125.836	1	0.000
Cumulative First dose (million)	0.690	0.0545	0.583	0.796	160.230	1	0.000
Rolling 7-day PCR tests per person	27.027	1.6524	23.789	30.266	267.534	1	0.000
Rolling 7-day PCR tests per person * Cumulative First dose (million)	-0.993	0.0562	-1.103	-0.883	311.609	1	0.000
(Scale)	.044[a]	0.0056	0.034	0.056			

Dependent Variable: Rolling 7-day Positive cases per 100 people tested
Model: (Intercept), Cumulative First dose (million), Rolling 7-day PCR tests per person, Rolling 7-day PCR tests per person * Cumulative First dose (million)

a. Maximum likelihood estimate.

What Bias Is This I See Before Me?

There are many ways you can make pandemic look worse than it actually is. You can do more testing and get more cases. You can raise the cycle threshold for RT-PCR beyond the limits advised by MIQE guidelines *(Minimum Information for Publication of Quantitative Real-Time PCR Experiments)* and you can start testing people more often. The latter is a substantial but hidden source of bias that isn't that well known and is what I've been beefing on about in several posts now.

I hope the penny has dropped, if it hasn't drop another penny because that is what we are talking about.

If we test somebody just once *(whether symptomatic or not)* we have just once chance of obtaining a positive result *(whether true or false positive).* If we test them twice we have two chances of obtaining a positive result. Multiply these individual chances up to national level and we can shift the case count like crazy just by leaning slightly toward a more rigorous or more relaxed test policy over time.

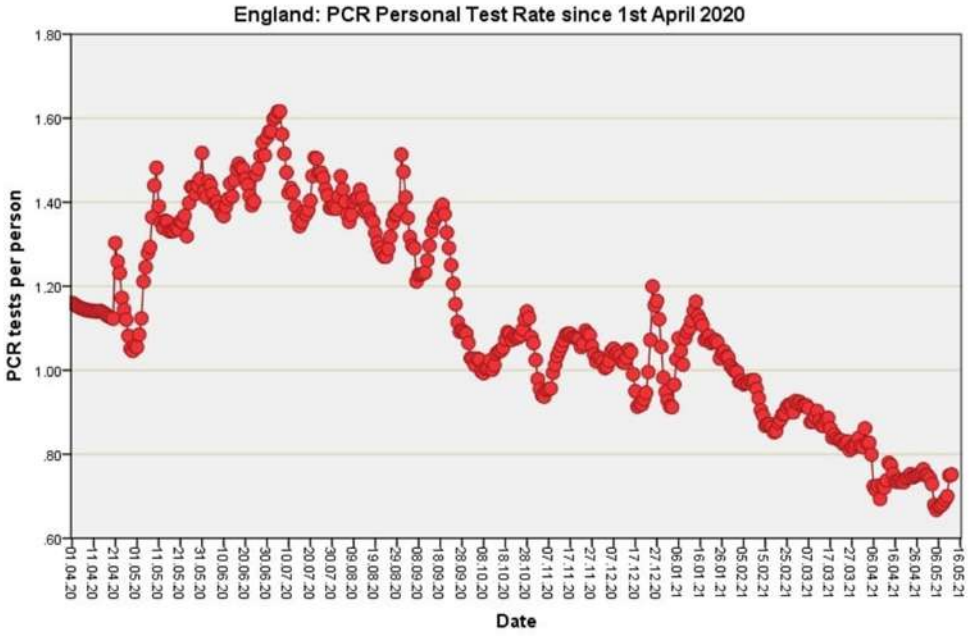
With that in mind I attach an expanded series for PCR tests per person showing just how much test rigour has changed since 1st April 2020. Bizarrely, **we see the greatest test rates occurring during the summer of 2020** at a time when the sun came out, folk ate ice cream in the fresh air and the disease had hit rock bottom. Anybody would think **they were trying to create cases to keep the pandemic alive in people's minds – surely not!**

Following viccane rollout commencing 8th December 2020 we find test rigour is now scraping an all time low and chances for obtaining a positive result evaporating.

Funny that. This all time post-viccane low isn't a new thing or a magical outcome of viccane benefit for **we can clearly see somebody decided to steadily cool the PCR testing regime way before viccanes came along.**

Instead of relying on eyeballs I can run a simple intervention analysis using Temporal Causal Modelling (TCM) and ask if the introduction of viccanes on 8th December 2020 is associated with a statistically significant reduction in the test rate over the period 1st October 2020 – 12th May 2021. Computer says no (p=0.813).

Facebook fact checkers are going to hate this. They'll respond with some statement that there is a decline in the test rate but only in "tests sent for sequencing". In plain English this means RT-PCR, which is precisely what I've analysed. So wise are the wise ones that they're admitting to what I've just shown; what they are not going to tell you is how this source of bias makes a mockery of the case counts and all the many analyses hanging off these (including some of my own!).



Source: https://coronavirus.data.gov.uk/ Data Period: 1st April 2020 - 12th May 2021

Do People Get Tested When Sick?

This is one of those seemingly simple questions that opens up a whole can of worms. Whilst people are obviously being tested when displaying symptoms, many more people are being tested when not displaying symptoms.

This is a most peculiar state of affairs and one in which we've somehow turned the concept of healthcare on its head. Everybody is now guilty of carrying a disease until proven innocent, and we prove that innocence using a test that is not fit for purpose. Right now, with a declared disease prevalence of 0.1%, a nominal PCR test sensitivity of 80% and likely real-world operational specificity of 97% at best, the PCR test is going to be churning out 97.4% false positives. On this basis we keep everyone locked up until vaccination prevails. **I wouldn't call this healthcare, I'd call it medical fascism.**

I'm surprised at just how many experts continue use the phrase 'asymptomatic case' when all they are talking about is a healthy person who happened to test positive with a test churning out garbage. There are indeed asymptomatic cases in medicine (asymptomatic/NYHA class I dyspnoea status pre surgery being an example of a condition I used to assess) but these are the real McCoy with people being genuinely sick with coronary heart disease with an elevated risk of early death. They weren't people who'd stuck a swab up their nose.

In the UK we have divided our test regime into four pillars.

Pillar 1 is testing folk at the sharp end in clinical settings, either because they're symptomatic or because they are working with symptomatic people.

Pillar 2 is testing folk in the wider community who may or may not be symptomatic and may or may not have come into contact with a symptomatic case. The emphasis placed on these is best

illustrated in the first slide where we see the symptomatic sharp end in blue trundling along, with community testing going wild, especially during recent months. What started out as valuable testing of sick folk and their carers has descended into testing anybody who breathes, whether this has clinical value or not.

Right now, we may pretty much assume testing of the UK population is a random affair giving a truck load of false positives, on which we base national policy.

With this in mind I'd now like to throw up a rather colourful slide that reveals the relationship between PCR test rate (PCR tests per person) and disease prevalence (cases per 100 people tested).

As discussed in my previous post entitled Clarification of Test Rate Issue, the number of times you decide to test somebody (whether symptomatic or not) is going to affect the number of cases you are going to count (an analogy with the rolling of a die was made).

This isn't a problem until you come to analyse historic data, for in doing so you assume standards, definitions and procedures haven't changed over time**. Except they have – and significantly so.**

In this second slide these shifting sands are markedly evident. It is noteworthy that the highest levels of disease prevalence were seen in the earliest stages during Jan – Jun 2020 (orange blobs on right), but in the lean summer months of Jul – Sep PCR testing went into hyperdrive despite extraordinary low prevalence.

This is the best way I can think of to generate a truck load of false positive results with which to scare people.

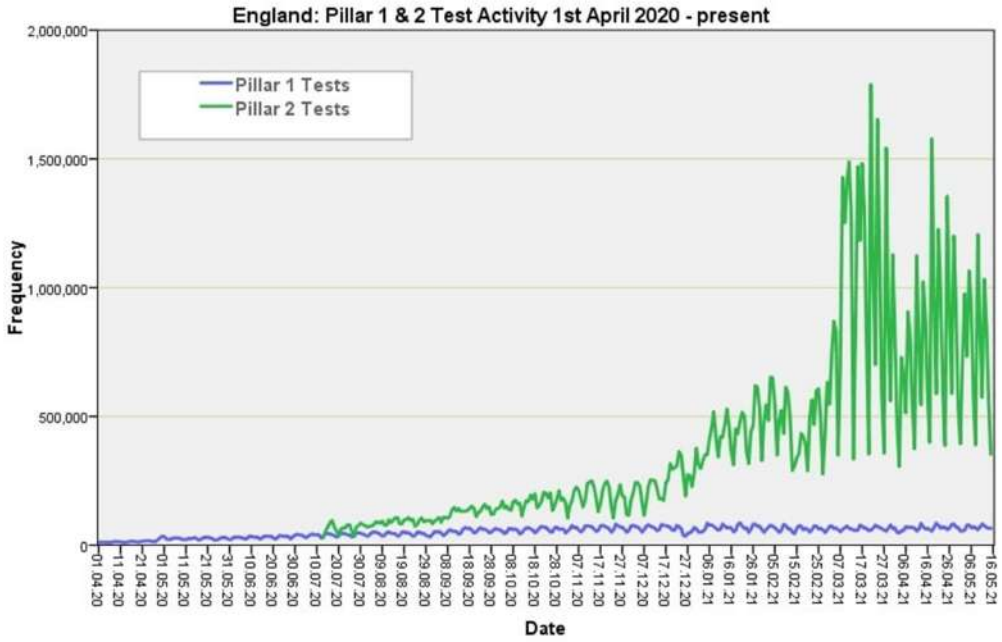
Another noteworthy finding is that our great and terrible second wave of Oct – Dec, that dwarfed the initial outbreak and wrecked Christmas, yielded rather modest disease prevalence. This brings us on to the most recent months where tests per person have hit rock bottom but disease prevalence is strung out.

The first word that comes into my head when looking at this colourful tangle is 'contrived'. The fact that our eyes can detect distinct clusters, patterns and strings is indicative of systematic policy changes.

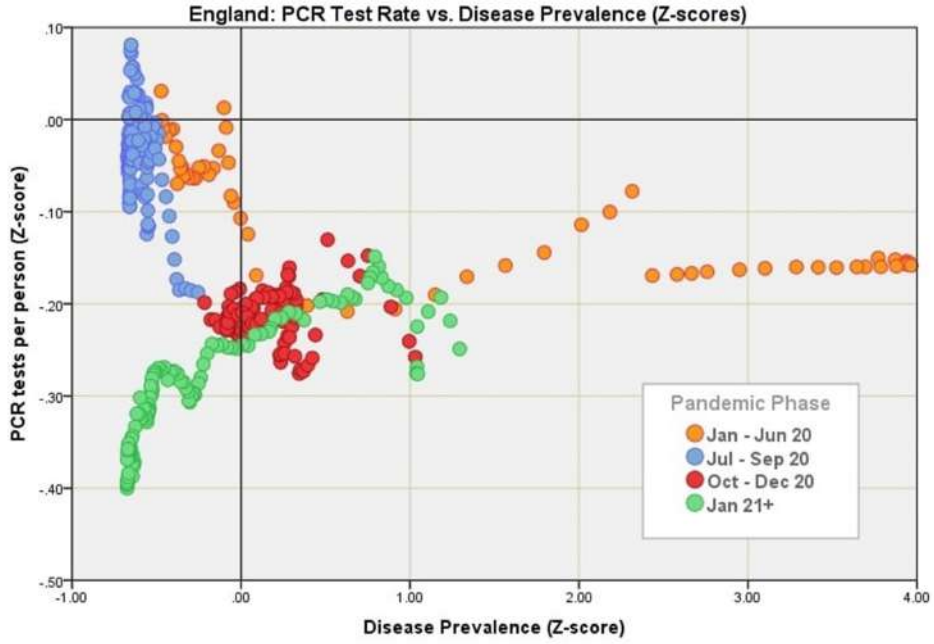
For example, they clearly decided to do extra tests on people during the summer holidays – the very time of year when risk is lowest. Since December 2020 they're not so keen on being rigorous. I wonder why.

I gather from some of you that facebook fact checkers aren't happy with my analyses revealing hidden test bias, with experts claiming "only sequenced tests are revealing a decline".

Well I have news for them – the PCR test is what they are calling a "sequenced test" and my analyses are all about the PCR test and nothing but the PCR test. **What kind of experts are they employing these days?**



Source: https://coronavirus.data.gov.uk/



Source: https://coronavirus.data.gov.uk/ Data Period: Apr 2020 - present

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