

Vaccination of Children for Covid-19

Doing more of something because it is not working?

A discussion of the situation in the UK, using scientific literature, as of September 16th 2021

Researched by a team of methodologists concerned about misinformation in the mass media.

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Introduction

This document synthesizes relevant scientific literature on the extent of the danger to children in the United Kingdom posed both by Covid-19 and the responses to it. No substantive claim is made which is not referenced to a scientific paper that is either published or under review after submission from professional scientists. The situation in UK is worth analyzing closely not only for the health of its own citizens, but also because it was hit hard by Covid-19, began vaccinating its adult population with two novel forms of vaccines faster than most other countries, and produces regular statistics on the pandemic, with details on vaccination status and variants of concern.

Many media stories on topics related to Covid-19 ignore the information in this document, or quote one study, scientist or medical officer to promote a particular perspective on hazards or responses. In this paper, by contrast, we adopt a careful scientific approach by focusing on the weight of scientific evidence on the topic under consideration. That does not mean that all scientific papers are correct by definition, and we critique some scientific studies in this paper. However, by focusing exclusively on scientific papers, the aim is to enable a more informed and rigorous scrutiny of policy options, that transcends the current habit of accepting or rejecting information on the basis of assumptions about agendas and characters – a habit which is itself risky for undermining intelligently

informed sense-making and decision-making. That is why the researchers involved in producing this review of relevant science have, for now, chosen to remain anonymous.

A key conclusion of the research analysis in this paper is that if all British children are vaccinated against Covid-19 then they could be nearly 20 times more likely to die from the vaccine than from the disease itself. Moreover, that calculation is *prior to* including any assessments of possibilities of medium- or long-term ill-effects from Covid-19 vaccinations.

Another key finding is that the well-documented declining effectiveness of novel vaccines for Covid-19 means that a new agenda that focuses more systemic and empowering approaches is urgently needed to prevent and respond to any future waves of Covid-19 or any other infectious disease. Recommendations are offered for the latter, with a focus on children's health.

Facts Suggest that Vaccinating Children for Covid-19 Does More Harm than Good

Child death rates from Covid-19 are so low, that vaccinating them is not for their own protection. Some calculations of the overall Infection Death Rate (IFR) for Covid-19 for all age groups show that it is slightly higher than influenza at 0.15% globally,¹ but that the death rate varies greatly due to age. The disease becomes more dangerous into middle age, with one comprehensive study finding an IFR of 0.4% at age 55, 1.4% at age 65, 4.6% at age 75, and a far more dangerous 15% at age 85. However, for children around 12 years old, the study found the IFR to be around 0.002%, or 1 death per 50,000 children.²

The calculation of IFRs can be done in various ways, and each study needs to be interrogated by other scientists and compared to other IFR studies.³ That is the normal process in science. However, media discussion of the dangers of Covid-19 has focused on Case Fatality Rate, not Infection Fatality Rate (which requires assessment of the exposure of a whole population), and has involved blanket statements without emphasis on age differences. Indeed, such media coverage has even demonized leading epidemiologists to imply that their IFR calculations means they do not care about addressing Covid-19. Despite that, IFR studies from a range of different epidemiologists in recent months do tend to agree that IFRs of Covid-19 for children (under 18) are not only low, but even lower than they are for influenza.⁴

As there were about 15 million children in the UK in 2020,⁵ then if every single child became infected, in the absence of efforts towards improved immunity, then the total deaths will be about 300 extremely unfortunate child deaths from Covid-19 per year. That statistic is higher than what has been found to be the case from research on actual deaths that was done by NHS experts and top British epidemiologists. They found that only 25 children under the age of 18-years-old died of Covid-19 from the start of the pandemic until the end of February 2021. They also provided important context by reporting that during the same time-period, there were 124 child suicides.⁶

It is important to note that the most recent data from Public Health England (end of August 2021) indicates that while the Delta variant is more infectious, it is *less* deadly than previous variants and is the dominant variant in the UK. Data from 1 February to 16 August 2021 shows that of the 226,732 people testing positive for the Alpha variant, sadly 4,323 people died; while of the far higher 386,852 people testing positive for the Delta variant in that time period, fortunately a much lower number of people passed away – 1,192. That means a 0.3% Case Fatality Rate for Delta which is thankfully

almost four times lower than the 1.1% CFR for Alpha.⁷ However, that is a slight rise in Delta death rates since June, which will require continued vigilance to see why that might be occurring.

This recent official data, in raw form, appears to override and negate the widely publicized study that processed data from before 23 May 2021, from the first two months of the appearance of Delta in the UK, to argue it is a more dangerous variant than Alpha.⁸ The more recent data, without any subjective and opaque statistical adjustments, indicates that future IFRs will likely be lower unless a new variant emerges, or vaccination proves to be counterproductive (see below). This means that the total future deaths of children could be less than either the 300 projected on the basis of an existing IFR study, or the 25 reported to have died so far.

What is the risk to children of near-term death and other adverse reaction to the Covid-19 vaccines? The vaccines have not been used on children extensively in countries with good systems for reporting immediate adverse reactions. Therefore, we must extrapolate from the situation with adults. The UK yellow card system for reporting adverse reactions after vaccines reports (in August 2021) 1,517 deaths and 1,102,228 adverse reactions soon after Covid-19 vaccines.⁹ Some of the deaths will not be due to the vaccine, but given that reporting a death in this way requires involvement of a medical professional, the possibility that they are all due to the vaccine cannot be ruled out until coroners' reports state otherwise. (Any 'fact checking' websites debunking this data would therefore be premature, as well as disrespectful and hurtful to relatives of the deceased.)

As 47 million people have received at least the first vaccination in the UK,¹⁰ assuming all suspected vaccination-related deaths have been reported to the yellow card scheme, at most the death rate from those vaccinations is 0.003227%. If that repeats in children and all 15 million children are vaccinated in a year in the UK, then about 484 might die from Covid-19 vaccination. That is nearly 20 times more than the number of children who have died from Covid-19 in the UK since the pandemic began. It is also higher than the number of deaths projected from IFR assessments. Even if we assumed 100 percent effectiveness of the vaccinations in preventing deaths, one could justifiably make the shocking yet factual statement that children are now more at risk of death from the actions of adults than from Covid-19. And this is before considering the potential long-term counter-productiveness and/or long-term dangers of novel vaccines for which we have no multi-year data – an issue we return to below.

Lasting negative health impacts from Covid-19 symptomatic infection in children, sometimes called 'long-Covid', are important to address, and this would likely be achieved with greater provision of early treatment advice and resources for every household. This includes a range of micro-nutrients which are known, through extensive peer-reviewed research – and in some cases clinical trials – to boost the immune system against viruses. These are listed in a discussion of smarter options on children and health during the pandemic, below. In the longer term, the underlying causes of poor nutrition in children need addressing in order to develop a coherent approach to public health, including chronic post-viral conditions like long-Covid.¹¹

The UK Covid-19 infection and mortality data confirm that the vaccination of children has nothing to do with their own health and wellbeing, but rather exposes them to danger. The only argument for vaccination is therefore to risk children's health to seek to protect vulnerable people, who themselves have access to the vaccine and various measures for their protection. That is unprecedented in the history of medical interventions, and is likely to lead to legal contestation. Unfortunately, the risk that children are being exposed to could be far worse than currently agreed by government scientists, which is important to state clearly.

The process of Antibody Dependent Enhancement (ADE) of diseases by vaccines that disturb the immune response, so that it is suboptimal when a new infection occurs, is a well-known phenomenon, and has been studied in relation to past coronavirus diseases.¹² Such viruses are known to mutate rapidly and are thus candidates for ADE,¹³ whereby the immune response to a new variant stimulated by a vaccine administered for an old variant interferes with the body's ability to combat the virus with its naturally produced antibodies. Research on the Covid-19 virus was published in October 2020 that proposed the likelihood of ADE.¹⁴ It is important to note here that ADE can occur naturally, but is rare. It is also important to note that ADE can increase the mortality of a disease by multiple times: if this effect occurs, then suddenly Covid-19 could be far more dangerous than 0.15% IFR, and a disease that is not dangerous to young and healthy adults could become so due to them being vaccinated.

Research released in August 2021 indicates that the Delta variant can lead to ADE.¹⁵ Only after many people have been vaccinated and some months have passed could we see evidence of whether this effect is occurring in the population. The first indicator that this process might be happening in people would be the hospitalization and death of people who have been fully vaccinated.

Israel has led the way in rapid mass vaccination, so evidence from there is important. Data from August 2021 shows a rapid rise in hospitalizations and death of fully vaccinated people. That is leading to more scrutiny of the original claims of pharmaceutical companies and their regulators that some of the vaccines delivered over 95 percent effectiveness.¹⁶ The data is not yet conclusive that ADE will occur some months after vaccination, but provides further evidence for caution on the use of novel vaccines, without multi-year data on effects. As children are not at risk of Covid-19 there is no argument for taking the risk of making them more vulnerable to a future variant. This is further supported by new research on the comprehensiveness and likely long-lasting quality of natural immunity to covid-19.¹⁷ Therefore, the best protection against a potentially more virulent and dangerous future variant of Covid-19 could be contracting the least virulent of the variants, which is the one now dominant in the UK.

The vaccines being used against Covid-19 were all given emergency use authorization so they could be used prior to completion of Stage 3 trials. Stage 3 trials typically span some years to test for whether the vaccine's effectiveness lasts, and whether there are any of the typical counterproductive effects (such as those discussed below).¹⁸ At present, their widespread use is in the absence of multi-year data to rule out any potential damaging side-effects from novel types of vaccination (either mRNA or adenovirus technologies). Just as critics of Covid-19 mass vaccination cannot yet point to long-term effects other than through speculation on the basis of theories and small data studies, so their proponents of mass vaccination cannot yet point to any long-term data on their safety. The emergence of new understanding about the pathogenesis of the virus, such as the way the spike proteins of the virus cause damage to cells, reveals the potentially critical nature of limited knowledge on the virus.¹⁹ Such spike proteins are also produced in smaller amounts by the novel vaccine technologies (but not by Covid-19 vaccines using traditional methods, such as Sinovac or Sinopharm).

Aside from the disproportionate risks to children of Covid-19 vaccination, there is also the question of whether it might be counterproductive for wider public health to vaccinate people who are not at risk to the disease. That is because mass vaccination can increase the evolutionary pressure on the virus such that mutations lead to variants that evade the vaccine and therefore could lead to higher mortality rates. Whereas the evolution of vaccine resistance is less of a concern than the evolution of drug resistance, there is consensus within the field of Immunology that it exists.²⁰ The key evidence for that process comes from veterinary science, due to the widespread use of vaccinations

on whole populations.²¹ What is important is not whether natural evolution of the virus occurs without vaccines – of course it does – but whether vaccines influence that process so that the vaccines rapidly lose effectiveness.

Because less than a year has passed since the mass roll-out of Covid-19 vaccinations began, there are varying opinions about the potential for vaccines to drive harmful evolution of the virus. Some scientists argue against it existing for Covid-19²² whereas others argue that because it might exist we need to vaccinate everyone quickly with the aim of seeking to eliminate the virus entirely from the world.²³ The latter aim of zero-Covid is now widely dismissed due to the rapid evolution of the virus to evade vaccines and the fact that it can exist in animals and then reappear as a new variant in humans.²⁴

In addition, and unfortunately, whether vaccinated or not, immunocompromised people are likely to host the virus over time, produce more variants and also remain infectious to others.²⁵ The problem of evolutionary pressure on the virus is now recognised by the scientific advisory group SAGE, who state: *'The combination of high prevalence and high levels of vaccination creates the conditions in which an immune escape variant is most likely to emerge'*.²⁶ The latest evidence from Israel, where mRNA vaccines were used first and widest, indicates that evolutionary pressure may be occurring, leading to the new AY3 coronavirus strain. It is based on the Delta variant, from which a number of further mutations have been found, including several considered more virulent.²⁷ Therefore, we need to have far higher vigilance about the potential impact of mass vaccination on viral mutation, and avoid vaccinating people who do not benefit from it until we know much more about the impacts of the vaccines on the virus. The implication is that contrary to the falsehood that a vaccinated child *protects* their Grandma, by getting vaccinated a child might be more likely to incubate a new variant that could *kill* Grandma. Therefore, there is a strong argument that it is unethical for anyone to accept Covid-19 vaccination if one is not at risk of death from the disease.

Another major concern from the approach being taken by medical authorities until now is the impact of questionable (and perhaps impulsive) policies on Covid-19 vaccination on general public sentiment towards medical professionals and vaccines in general. Research has shown an unprecedented decline in vaccination rates for diseases posing far more serious threats to child health, and where the vaccines do have long-term safety and effectiveness data. The implications for future disease burden and death are unclear but not positive.²⁸

Unfortunately, when the decisions were taken in early 2020 to prioritise vaccinations as the method to address Covid-19, the mainstream immunological knowledge on viral evolution and declining vaccine effectiveness, or ADE and potential vaccine counter-productiveness, and therefore the necessity for Stage 3 trials and multi-year safety data for any vaccine, were not aired in mainstream media or acknowledged as important considerations by government scientists. One possible side-effect is that other approaches to protecting our health have not yet been given the attention they deserve, as we will now explore.

Healthy Policies and Initiatives for Children during the Pandemic

In a generation the UK has gone from providing free milk at school for all children to help them all to be healthy, to offering nothing nutritional for free for all children, but instead coercing vaccinations for the possibility they might help elderly people be safer – all of whom have the option of vaccination.

Just as evidence of the ineffectiveness of vaccines in providing long-lasting immunity to variants of Covid-19 has become available²⁹, the extension of the vaccination programme to children appears to fit with the famous definition of madness – i.e. to do more of the same thing while expecting a different result. If not insanity, then it may indicate a panicked response from governments who do not know what else to do. Therefore, it is worth considering what other approaches could address the problems that are purported to be addressed by the child vaccination programme. Just three of the possibilities are listed here:

- Micro-nutrition support for every household
- Advice for household interactions between the young and the vulnerable
- Support for school staff to self-certify when symptomatic and not face problems with employment or income

Micro-nutrition support for every household

There are a range of ways that nutrition could be better supported, in general, that would mean children are less at risk of damaging effects of any kind of disease. Focusing on early treatment options that involve better nutrition should not be a distraction from the underlying situation of the health of children, especially those living in poverty and experiencing poor nutrition as a result. However, in relation to Covid-19, the following are particularly relevant: Zinc, Vitamin D3, Vitamin C.

- Zinc is known as an essential micro-nutrient for the body to fight viruses, and many people are deficient in it, so for decades it has been widely used to help people against all kinds of viruses (e.g. herpes zoster).³⁰ It is being used against Covid-19 by many people, and many clinical trials underway about its role in both prevention and treatment of Covid-19.³¹
- Vitamin D3 is also known an essential micro-nutrient for the immune system.³² Early data on death rates from Covid-19 indicated that a deficiency in D3 might be a reason for higher hospitalisations³³ and mortality³⁴ in some populations. One clinical trial on the regular provision of Vitamin D3 to Covid-19 patients found a significant benefit, and recommends its medical use.³⁵ (Unfortunately some irrelevant and distracting studies have been done using one-off single doses in Brazil, which have been cited in order to debunk the focus on this vitamin,³⁶ but fortunately there are many other studies providing reputable scientific insight.)³⁷
- Vitamin C is known to be important in the immune system's function.³⁸ Low levels of vitamin C have been found to be correlated with the severity of Covid-19 symptoms, with some explanation about how some people are more at risk of that vulnerability than others.³⁹ Unfortunately it appears that political, commercial, institutional or career interests may well be influencing the design and analysis of some clinical trials for these various micro-nutrients. A re-analysis of one clinical trial of Vitamin C, for example, found that it demonstrated quite different results from the initial report, concluding that the vitamin may increase the recovery rate of outpatient cases of SARS-CoV-2 infection by 70%.⁴⁰

Effective alternative or complementary therapies

In addition to micro-nutrients there are many plants around the world that have been widely known for decades, or even centuries, to be helpful against disease, and where recent research supports that customary community health knowledge. These include garlic and sambiloto.

- Allicin, found in garlic, is known around the world as being able to support the immune system when it is dealing with pathogens, and peer-reviewed research confirms this traditional knowledge.⁴¹ Despite such research reaching even the mainstream media over the past decades,⁴² it has been largely ignored by the medical profession in the UK.
- Sambiloto is a bitter herb used for centuries in Asia against viral fevers, like malaria and dengue, with peer-reviewed research confirming its effectiveness in reducing symptoms and saving lives.⁴³ Recent government clinical trials in both Thailand and Indonesia have concluded that it has a significant positive effect on the treatment of Covid-19.⁴⁴ Until now the WHO has ignored this information from the research and policies of these governments. It is somewhat tragic how 'global Britain' has been so insular that it only listens to carefully selected specialists from the UK, USA and the WHO. These government-funded clinical trials on Sambiloto suggest that less people would have died if Britain had not been so insular and limited in its consideration of how to respond to Covid-19.

Effective drug treatments

The potential for repurposing drugs to treat diseases is a normal practice in medicine, and there have been many drugs tried with Covid-19, with varying effects. One of the most promising of all these is the generic drug Ivermectin, as it has been found through many studies to have a helpful effect in both prevention and therapy,⁴⁵ with well-researched theories to explain this effect from a drug not created for that purpose,⁴⁶ and past experience of its effectiveness against malaria.⁴⁷ A comprehensive review of studies, that did not include any withdrawn studies, published in a scientific journal in August 2021 concluded:

*Moderate-certainty evidence finds that large reductions in COVID-19 deaths are possible using ivermectin. Using ivermectin early in the clinical course may reduce numbers progressing to severe disease. The apparent safety and low cost suggest that ivermectin is likely to have a significant impact on the SARS-CoV-2 pandemic globally.*⁴⁸

The matter of the use of Ivermectin has been made controversial, and it has become like a football in the 'kick about' between, on the one hand, people who see vaccines as the main answer to Covid-19 and any discussion of alternatives as counterproductive, and on the other, people who prefer that we consider alternatives to vaccinations. However, in the past year the drug has been used as an adjunct to vaccination in dozens of countries, and the most recent overview finds strong evidence that it is beneficial. That helps to explain the decision of the US Biden administration to back the originator of Ivermectin to produce a new patentable version with a focus on usage for Covid-19.⁴⁹

The mainstream media has misled the public by referring to ivermectin as a 'horse dewormer', when the same 'logic' would mean they should refer to antibiotics as 'cattle debuggers', as there is widespread usage of antibiotics in the livestock sector. The actual scientific basis for journalists to debunk the potential benefit of Ivermectin is typically a review of studies from April 2021, then updated in July.⁵⁰ That study was part-funded by the Foreign Ministry of the UK, did not go through blind peer review, and was not published by a medical journal but by an organization which seeks to inform governments in the Global South what they need to know about science. While it may be a

useful contribution to the scientific discussion on Ivermectin, the context and nature of the publication means that from a scientific viewpoint, it should not be taken as the final factual word on the matter, especially given the many other reviews.

As of March 2021, the WHO does not support Ivermectin because, it says, there are no peer-reviewed clinical trials at the scale required to be accepted as medical fact.⁵¹ There are two significant problems with that stance. First, it means ignoring the plethora of studies by clinicians around the world on the effectiveness of Ivermectin and the peer reviewed paper I cited above. Second, it involves hypocritical double standards, as the WHO accepted vaccines to be used for Covid-19 without the same criteria – i.e. published peer-reviewed papers on the completion of all stages of clinical trials. Unlike the Covid-19 vaccines, Ivermectin has years of multi-year data on its safety, and therefore there are very low risks from an emergency use authorisation. Private ‘off the record’ correspondence with WHO officials has revealed to one of the authors of this paper that they are resistant to exploring new evidence, which suggests they are concerned with how acceptance of the utility of Ivermectin might undermine their wider policy approach and open them up to criticism for the health and mortality effects of the stance they have taken on the drug, and how that was then policed online by tech platforms. Therefore, the organisation may require some ‘encouragement’ from its board members – i.e. national governments. As one such member and a significant donor to the WHO, Britain should urgently ask the WHO not to uphold double standards and not be resistant to changing its advice, as that not only undermines global confidence in the organisation at a time when such confidence is important, but is fundamentally ‘anti-science’. A more reasonable position from the WHO would be to report on the evidence for and against ivermectin, and, if it still believes that Covid-19 requires emergency approaches that mean swift action rather than delaying until completion of all studies, then supporting people using Ivermectin under medical supervision.

By mentioning ivermectin here we do not suggest that it is the only or the best readily available drug for either prophylaxis or therapy for Covid-19. Many other drugs are being tried around the world, with promising data on their effects. For this pandemic and the next, a better system for assessing drug effectiveness than has occurred in the past 18 months might help save lives in future.

Support for school staff to self-certify when symptomatic and not face problems with employment or income

Both widespread vaccination and restricting the movement of healthy people are supported by the view that asymptomatic transmission of the disease is a significant concern. That means people are meant to consider it insufficient to be vigilant about symptoms in oneself or others. Focusing on asymptomatic transmission as significant therefore undermines the focus on people taking responsibility for their own and others’ health. However, the scientific basis for that perspective is, at best, extremely weak.

The first and largest-scale study on Covid-19 transmission, which investigated nearly 10 million people, found that asymptomatic transmission did not occur at all: *“There were no positive tests amongst 1,174 close contacts of asymptomatic cases.”*⁵² After the publication of such a massive study in November 2020, which appears to be the largest for any disease ever conducted, one might expect that the matter of asymptomatic transmission would be closed, and that a rethink of policies would occur. However, that has not happened. Since then, there have been studies which unhelpfully do not distinguish sufficiently between asymptomatic *infection* and asymptomatic *transmission*, often speculating that the former means that the latter must exist.⁵³

In addition, self-defined 'fact-checking' articles have misrepresented the issue in the same way.⁵⁴ One analysis that does not distinguish sufficiently, nevertheless concludes that asymptomatic Covid-19 infection exists in 1 in 6 people with a positive test result.⁵⁵ That estimate includes any false positives, which are known to be significant due to the nature of the tests used⁵⁶, and would inflate the total of people considered to be asymptomatic with Covid-19. One meta-analysis of transmission found that '*Among five transmission studies, 18 of 96 (18.8%) close contacts exposed to asymptomatic index patients were COVID-19 positive*'.⁵⁷ That means 1 in 5 asymptomatic people might infect close contacts, defined as co-inhabitants in most studies.

Although all these cited studies appear to be trying to make the case for asymptomatic transmission being a concern, what actually *is* the level of concern? If 1 in 6 are asymptomatic (based on imperfect testing) and of those, 1 in 5 can transmit to close contacts only, the probability of asymptomatic transmission to close contacts is no more than 1 in 30. That transmission rate is in the absence of an early stage and major public-education campaign on counter-measures relating to ventilation, nutrition and natural antivirals, as well as widespread advice on hygiene. If the massive study of nearly 10 million people is not enough to dismiss asymptomatic transmission as an important policy concern, then does the possibility of 1 in 30 make it a sufficient concern to justify focusing on policy measures affecting everyone, whether or not they have symptoms? Clearly not. Without that focus, a much more collaborative and respectful approach to disease control comes into view, and one that should be applied in the school sector immediately, given the potential for schools to transmit many diseases, not just Covid-19.

Currently, both the state of employment contracts and labour rights in the UK means that people typically go straight to work after going to bed or waking up with symptoms such as mild fever, sore throat, slight cough, headache, with no clear reason other than possible infection. Because of flexible work contracts, many people in the UK will not get paid if they are not at work. Since March 2020 this has been identified by a trade union in the UK as an unacceptable situation, as it undermines the ability of staff to do the right thing for their own health, that of fellow commuters, and their colleagues and customers at work.⁵⁸ Simply put – flexible contracts and poor labour rights help spread diseases, including Covid-19.

Therefore, the education sector urgently needs guidance that anyone on flexible contracts can self-certify that they have any symptoms and stay away from work, without losing income, and the organisation involved can apply for compensation if they incur costs as a result. In addition, if children have symptoms, there need to be systems (and trained staff) in place for them to recover at home, with support for families so the parents' work is not unduly disrupted. It is a great tragedy and indictment of the mainstream media and political elites that these simple ideas, based on solidarity with staff and parents, have not been championed and implemented. Instead of enabling our freedom to care for ourselves and each other, a different and toxic paradigm has been promoted that treats each other as a threat and passive recipient of instructions from authority and technology.

Unfortunately, both governmental and media attention to this matter is either non-existent, or exhibits gross oversight of the importance of enabling staff to make responsible choices. That was illustrated in an article in *The Observer* newspaper which discussed implications of a symptomatic sick teacher spreading Covid-19, and focused unscientifically on the case for child and teacher vaccination. It did not explore why that teacher went to work when sick, what obstacles there may have been for her to avoid work (perhaps absence of cover for class, peer pressure or contract insecurity), why she was not told to go home by management or colleagues (or even students, if properly trained and supported to express that), and what implications there are for policies and

support for wise decisions by teachers in future. Instead, the media appear to be promoting a negative attitude to staff and their ability to respond well if empowered, and instead promoting unproven impositions.⁵⁹

Advice for household interactions between the young and the vulnerable

Various approaches can be promoted for use in the home to help reduce the likelihood of the elderly not being infected by their grandchildren. These include better nutrition (as described above), better attention to ventilation, better attention to hygiene and better attention to symptoms and immediate counter-measures. More public education is needed, especially to undo the effect of existing campaigns from public and private media which may have undermined attention to personal responsibility when sick, or near someone who is sick. Fortunately, such advice is now being shared by some people in the health sector in the UK.⁶⁰

Politicians Can Accidentally Engage in Unethical and Criminal Behaviour, or Be Victims of It

Despite journalists' self-confessed coordinating of the manipulation of the British citizen's knowledge about Covid-19,⁶¹ it is important to note that the following information has been readily available, so should be known to officials and medical staff before the commencement of the child vaccination programme:

- evidence from various epidemiological experts since 2020 regarding the significant possibility of Antibody Dependent Enhancement (ADE) of Covid-19 by vaccines being used against a virus that was known to mutate rapidly and thus likely to evade vaccines
- the potential evolutionary pressure of vaccination on the rate and type of mutations of the coronavirus leading to variants that evade the vaccine and which could have higher mortality rates
- the absence of multi-year data to rule out any potential damaging side-effects from entirely novel types of vaccination (either mRNA or adenovirus technologies)
- the non-conclusion of Stage 3 trials of the novel vaccines

Given all this information, which can be traced back to the kind of scientific studies in this document that are either peer-reviewed or from professional scientists and in-review, it is very difficult to understand, and impossible to defend based on relevant science, why politicians and regulators are pursuing a child vaccination programme on Covid-19.

It is conceivable that some scientists, regulators and politicians are privy to confidential information about the probable trajectory of mutations of the novel coronavirus, and are concerned that it could mutate into a form that has an extremely high fatality rate, like FIP in cats which is near 100% fatal within one year.⁶² However, if that is the case, then they should share that information and allow people to make democratic and informed life choices on the basis of it.

Another possibility is that at least some politicians and regulators are simply not aware of the scientific information presented and analysed in this document. This could possibly be due to a

coordinated targeted manipulation of their online experience, something that is not without precedent. The first known case of a tech giant deliberately seeking to manipulate the online experience of politicians and regulators was the ride-booking company Uber. They created a tool called 'greyball' that would identify people who were definitely, or likely to be, politicians and regulators, and would render their Uber app incapable of seeing Uber drivers in their vicinity. The aim was to reduce regulator awareness of Uber activity, and thus reduce the likelihood of regulation.⁶³

Since then, moderation of the visibility of information to end-users by the big-tech platforms has grown and become well known as a concern for how it affects the political process in general.⁶⁴ Less discussed is how some platforms now have the capability to intentionally withhold information from the online experience of targeted politicians and regulators, if they were to choose to do so. Given the explicit public position of big-tech companies to try to manipulate people's access to information on the basis of their own (and 'fact checker') interpretations of governmental and intergovernmental positions on matters of public concern, it is at the very least worth investigating, as a matter of urgency, how that mandate is being implemented in relation to politicians and regulators in particular. For instance, a politician or regulator could compare what they are seeing online with what others see by using the accounts of someone who is not a friend, colleague or family member, on a device that is not in their house or place of work, and not currently geolocating at the same place as their own devices. (Note that the comparison cannot be done at the same time and location, due to geolocation-based 'greyballing'.)

Whether or not nefarious approaches to curating information have indeed been developed as far as greyballing politicians and regulators from important pandemic information, with the receipt of this document, linking to peer-reviewed scientific studies on all relevant claims being made, there becomes an additional record of this critical information being in the possession of policy makers. Therefore, if the result of the vaccination programme is counterproductive to the vaccinated children in any significant way, over any timescale, then future legal action could well involve criminal prosecutions against the relevant officials and health workers. Indeed, the potential nature of the damage and the scale of people affected might make it an extremely serious crime. Therefore, it is important that officials realise the situation in which they might be placing children, parents, themselves and the whole country through progressing with vaccinating children for Covid-19.

Conclusion – Restoring a Culture of Scientific Scrutiny

On the issue of child vaccination for Covid-19 the medical establishment in the UK has descended into unscientific assessments of policy situations. For instance, in explaining her support for the decision of the UK government to vaccinate children for Covid-19, the President of the Royal College of Paediatrics and Child Health (RCPCH) explained to her members that "if vaccination means that 12-15 year olds can have a greater chance of attending school – and staying at school this winter, then we would support its use."⁶⁵ In other words, Covid-19 vaccinations for children are supported because of the threat of a potential future decision from government to close schools because the children are not vaccinated. That is purely circular reasoning – to vaccinate because government expects it. There is neither science, logic nor ethics in such circular reasoning, no matter how softened it might appear with statements of concern for children and parents.

The medical officers are neither trained, experienced nor mandated to make assessments about the kind of public policy agendas being responded to by the President of RCPCH and others. They are falling back on illogical arguments to comply with an existing vaccine-focused policy agenda which is failing to deliver on its promises. They are delaying the inevitable by not admitting mistakes in both process and strategy. To avoid the kind of accountability, introspection and innovation that such an admission would necessitate, members of the medical establishment are now going too far with implementing an ineffective and counterproductive policy approach. Vaccinating children for Covid-19 for no medical reason may one day be regarded both professionally and legally as an outcome of the vanity and hubris of an inflexible medical establishment.

The lack of accountability being exerted both on and by medical officers at present is indicative of how poor the discussions of the science of responding to Covid-19 have become. Discussions appear to have degenerated into being about affirming moral, political and intellectual identities, rather than understanding what is best for health and for society. This paper has focused on the scientific literature and official government data to arrive at conclusions which are contrary to the medical establishment and government policy in some countries, including the UK. We hope that many readers will not react to this paper with an instinct of identity-affirmation whereby they focus on their stories of whether or not we are within their moral, political and intellectual in-group. That is why we chose to be anonymous.

We can only hope and pray for the good fortune that the problems and risks listed above do not materialise, or at least not at scale. However, an uncompromised government in a society with means of effective scrutiny should not be needing prayer or luck to avoid dangerously counterproductive policies. For both this matter and other societal challenges, it is essential to restore a culture of scientific scrutiny of people, power and policy.

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<https://www.economist.com/graphic-detail/coronavirus-excess-deaths-estimates>

A discussion of the more subtle flaws and challenges of more professional IFR studies is here: Chen Shen,, Derrick VanGennep, Alexander F. Siegenfeld & Yaneer Bar-Yam, 'Unraveling the flaws of estimates of the infection fatality rate for COVID-19', *Journal of Travel Medicine*, 28 (2) (March), 2021, taaa239; DOI: <https://doi.org/10.1093/jtm/taaa239>. Available at <https://academic.oup.com/jtm/article/28/2/taaa239/6062388#228620183> (accessed 5 September 2021).

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The paper studies people with COVID-19 in England between 29 March and 23 May 2021. The Delta variant was first detected in England in March 2021, so the data include the early effect of a variant that, by being more infectious, managed to infect a wider scope of people, including those taking precautions, and thus the more vulnerable may have been more likely to be affected in the early months. The study found 196 (2.3%) patients with the delta variant versus 764 (2.2%) patients with the alpha variant were admitted to hospital within 14 days after the specimen was taken. That amounts to little difference, where the ratio of hazard between one and the other is 1.03 - not a statistically significant difference (see Table 2 in their paper). It is only after a ten different types of

adjustments (stratifications and regression manipulations), that the researchers produced a statistically significant hazard ratio between the variants. Neither in the paper nor in the supplementary material is the rationale for choices for making adjustments explained. In the main paper, instead of clarifying their subjective choices on those manipulations and the effects they had on the data, there are paragraphs on data sources for those manipulations. They explain they made an adjustment based on 'calendar week' that increased the hazard from Delta by 83%, which is most of the increased hazard. Exactly how and why that was done is not explained in the paper or in the supplementary information. That adjustment produces the result upon which the whole paper's argument is based (as it makes the difference of hazard statistically significant). That adjustment needs to be explained and open for scrutiny before this paper's arguments can be taken as a credible input into understanding risk. In any case, the official data on variants until mid-August 2021 show a very different situation, and given that we are in the middle of a pandemic, that new data could have led reviewers to consider this study too outdated to publish (aside from then being reported worldwide as a proof of greater risk).

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