COVID-Status Certification Review – Call for Evidence

Sent by email to: certification.cfe@cabinetoffice.gov.uk

Friday, 26 March 2021

To Whom It May Concern:

Thank you for providing this 14-day period for concerned members of the British public to inform you with evidence that you should consider in your COVID-status certification review. You will no doubt receive submissions from stakeholders who stand to benefit from implementation of the proposed scheme. Those submissions need to be read in context. By contrast, ***only*** submissions from informed members of the public (including medical and legal experts), who have nothing to gain from a COVID-status certification scheme, can be viewed as truly unbiased and unfettered. These submissions should be taken most seriously.

My submission is below.

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Question 1

I respond to this call for evidence as an **individual**. I hold a postgraduate law degree, as well as a psychology degree. I run my own business and am a wife and mother.

Question 2

In my view, the key considerations, including opportunities and risks, associated with a potential COVID-status certification scheme are as follows:

*[NB: '**PCR**' in this document refers to the various **RT-PCR** tests being employed to detect SARS-CoV-2, and may at times include other forms of testing, such as Lateral Flow Tests (**LFT**). The term 'PCR' is used for simplicity and readability.]*

a) Clinical / medical considerations

The brief for this 'request for evidence' states,

> *"COVID-status certification refers to the use of testing or vaccination data to **confirm** in different settings that individuals have a lower risk of getting sick with or transmitting COVID-19 to others." [my emphasis]*

There is a fundamental issue here. "*COVID-status certification*" based on "*testing or vaccination data*" **CANNOT "*confirm* ... *that individuals have a lower risk of getting sick with or transmitting COVID-19 to others*."** This is because:

(i) A positive PCR result is NOT a reliable indication that someone is *infected* with active virus, nor *infectious* to others.
(ii) The PCR test CANNOT diagnose any illness or disease, including COVID-19.
(iii) COVID-19 vaccines are NOT shown to reduce risk of contracting or transmitting the SARS-CoV-2 virus, nor the COVID-19 disease.

I elaborate on the above points in the following paragraphs, dealing with each of the three points in turn.

(i) A positive PCR result is NOT a reliable indication that someone is *infected* with active virus, nor *infectious* to others.

The Public Health England (**PHE**) document, "*Understanding cycle threshold (Ct) in SARS-CoV-2 RT-PCR – A guide for health protection teams*,"[1] (**the PHE document**) states:

> *"RT-PCR detects presence of viral genetic material in a sample but is **not able to distinguish whether infectious virus is present**." [their emphasis] (p6)*

This is supported by numerous clinical studies.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/926410/Understanding_Cycle_Threshold__Ct__in_SARS-CoV-2_RT-PCR_.pdf.

An article in the British Medical Journal (**BMJ**), published 21 December 2020[2] (**the BMJ article**) reviewed evidence from many peer-reviewed, published studies. It addressed two key questions relating to mass testing: How infectious are people who test positive but have no symptoms? And, what is their contribution to transmission of live virus? The article states:

> *"The only test for live virus is viral culture. PCR and lateral flow tests do not distinguish live virus. No test of infection or infectiousness is currently available for routine use…* ***a person who tests positive with any kind of test may or may not have an active infection with live virus, and may or may not be infectious****." [my emphasis]*

The article cites many authoritative sources, all of which should be reviewed carefully if the present *'request for evidence'* is a serious undertaking and ***not merely a rubber-stamping exercise***.

A positive PCR result means that fragments of genetic material have been detected by the test. The more 'cycles' the test is run for, the more sensitive it becomes to minute and inconsequential fragments. The Cycle Threshold (**Ct**) value denotes the number of cycles that an individual test was run, before a positive result was returned. Thus, a person may have a negative result at 27 cycles but a positive result at 35 cycles.

Regarding cycle thresholds, the **PHE** document states:

> *"The clinical significance of positive results with high Ct are difficult to interpret in the absence of clinical history and context." (p7)*

It is widely accepted that PCR positive results with Ct values over 35 are meaningless. Dr Anthony Fauci (director of the U.S. National Institute of Allergy and Infectious Diseases (NIAID) and chief medical advisor to the U.S. President) confirmed this in an interview in December 2020.[3] In fact, a systematic review of 29 studies found that "*A cut-off RT-PCR* ***Ct > 30 was associated with non-infectious samples***."[4] **This suggests that anybody who tests positive result with a Ct above 30 would essentially be a 'false positive' for the purposes of COVID-status certification, if such certification was designed to reduce risk in the community**.

By contrast, UK laboratories are routinely reporting PCR results as 'positive' with cycle thresholds of 40 and above. And they do not qualify the result by providing the subject with his/her Ct value. The Department of Health and Social Care (**DHSC**) has confirmed that "*it is for the test manufacturer to determine whether more than 40 cycles is appropriate for their test. Determination of the absolute number of cycles is […] not for PHE or Government.*"[5] In other words, neither the

[2] Asymptomatic transmission of covid-19, Allyson M Pollock, professor of public health, James Lancaster, independent researcher, https://www.bmj.com/content/371/bmj.m4851.
[3] Dr Fauci explains the significance of cycle thresholds in PCR tests: https://youtu.be/m7vls-tA1Rw
[4] https://www.medrxiv.org/content/10.1101/2020.08.04.20167932v4
[5] Freedom of Information Request Reference FOI-1296715, dated 29 January 2021.

DHSC nor Public Health England (**PHE**) can prescribe or monitor the maximum Ct values used in any UK laboratory.

A recent Portuguese case of unlawful quarantine[6] confirmed the clinical / medical position on PCR results from a legal standpoint. The Lisbon Court of Appeal cited an article published in *Clinical Infectious Diseases* (September 2020),[7] and concluded that:

> *"if someone is tested by PCR as positive when a cycle threshold (Ct) of 35 cycles or higher is used… **"the probability that said person is infected is <3%, and the probability that said result is a false positive is 97%."**"*

This means that, unless Ct value is routinely provided with each and every positive test result, nobody can know whether they are truly infected, or whether their result was a false positive. **If their Ct value were 35 or more, they would know there is a 97% chance they are not a risk to society**. Denying COVID-status certification based on a 3% risk of infection ***would not only be an appalling injustice***, given that they would be denied certain services and privileges; ***it would also contribute to the ongoing collapse of the economy***, through lost hours, days, weeks and months of work by the healthy 97%, who would be forced to stay at home and/or home school their children, who would be denied their education. Also note that ***'infection' does not mean 'infectious.' i.e., even the 3% 'true positives' could be non-infectious, even if the test found their sample to be 'infected.'*** So, it is possible that 100% of those tests were in fact 'false positives' for the purposes of COVID-status certification (to reduce risk in society).

If the government or PHE could prescribe a maximum Ct for various tests and/or laboratories, then *theoretically* a balance could be struck between the "risk" of infectious individuals in society and the risk of mass unlawful quarantine of healthy individuals.

But it is not just high Ct values that are the problem. The **BMJ** article also notes,

> *"no study was able to culture live virus from symptomatic participants after the ninth day of illness, despite persistently high viral loads in quantitative PCR diagnostic tests. However, cycle threshold (C_t) values from PCR tests are not direct measures of viral load and are subject to error."*

This means that a person could have recovered from *infection*, and no longer be *infectious*, yet still trigger a PCR positive result at a low Ct value. The low Ct value would be taken to mean that he had a high viral load; but, if the virus cannot be cultured, then there is no risk to others. In other words, a denial of COVID-status certification based on this test result would be **incorrect, unjust, and economically unsound**. It should therefore be advised that no one take a PCR test after the ninth day of illness. They should assume they are not infectious, although they could *choose* to

[6] A summary of the case can be found here: https://lockdownsceptics.org/2020/11/16/#portuguese-appeals-court-deems-pcr-tests-unreliable. The full English translation of the November 2020 court judgment can be read here: https://translate.google.com/translate?hl=&sl=pt&tl=en&u=http%3A%2F%2Fwww.dgsi.pt%2Fjtrl.nsf%2F33182fc732316039802565fa00497eec%2F79d6ba338dcbe5e28025861f003e7b30 .
[7] Jaafar et. al., https://academic.oup.com/cid/advance-article/doi/10.1093/cid/ciaa1491/5912603

continue to isolate or shield, if they wish. A PCR test would be meaningless for them because, whether positive or negative, the scientific evidence suggests no viral replication would be possible at this time. *(And it goes without saying that fresh air and pleasant company are likely to be conducive to their recovery from illness).*

A possible solution to avoid ***unfair denial of COVID-status certification***, would be to ONLY deny certification to those individuals who test positive with Ct values of, say, 30 or less; AND who are symptomatic with COVID-19. This could be deemed reasonable, because 'asymptomatic spread' has been shown to be non-existent.[8] However, before pursuing this avenue, it is imperative one considers the inherent limitations of laboratory tests…

(ii) The PCR test CANNOT diagnose any illness or disease, including COVID-19.

The **BMJ** article states:

> *"**Unusually** in disease management, a positive test result is the **sole criterion** for a covid-19 case. Normally, a test is a **support** for clinical diagnosis, **not a substitute**." [my emphasis]*

This indicates an understanding within the scientific and medical community that a PCR (or any other) test is NOT meant to diagnose illness or disease, including COVID-19.

The **PHE** document supports this view. It states:

> *"A single Ct value **in the absence of clinical context** cannot be relied upon for decision making about a person's infectivity." [my emphasis] (p3)*

This means that a positive PCR result cannot be taken to mean an individual is infected, or infectious, without additional clinical diagnosis by a trained professional.

This medical position was also confirmed by the Lisbon Court of Appeal.[9] The court stated:

> *"… prescription and diagnosis are medical acts, the sole responsibility of a doctor…*
>
> *"Thus, the prescription of auxiliary diagnostic methods (such as tests for the detection of viral infection), as well as the diagnosis of the existence of a disease, in relation to any and all people, is a matter that cannot be carried out by law,*

[8] Asymptomatic spread non-existent, based on PCR screening of nearly 10,000,000 people: https://www.nature.com/articles/s41467-020-19802-w

[9] The English translation of the judgment can be read here: https://translate.google.com/translate?hl=&sl=pt&tl=en&u=http%3A%2F%2Fwww.dgsi.pt%2Fjtrl.nsf%2F33182fc732316039802565fa00497eec%2F79d6ba338dcbe5e28025861f003e7b30 .

> *Resolution, Decree, Regulation or any other normative way, as these are acts that our legal system reserves to the exclusive competence of a doctor, being sure that, in advising his patient, he should always try to obtain his informed consent (1 of article 6 of the Universal Declaration on Bioethics and Human Rights).”*

The UK's legal and medical systems are bound to similar constraints and standards, when it comes to who may be authorised to give a clinical diagnosis. **There is no precedent or justification to warrant the substitution of a full clinical diagnosis, with valid informed consent of the subject, with a single laboratory test**.

In summary:

Testing data from a PCR or any other test CANNOT "*confirm in different settings that individuals have a lower risk of getting sick with or transmitting COVID-19 to others*" for the purposes of COVID-status certification.

At the very best, a prescribed upper limit on maximum Ct could indicate that an individual ***might*** be infected or infectious with SARS-CoV-2 (and laboratories should be mandated to provide each individual the Ct value for their positive test). But there can be no confirmation that the person is suffering from COVID-19, or any other deadly disease, without a traditional clinical diagnosis by a trained physician. Therefore, to grant or deny COVID-status certification based on testing data alone is without doubt unlawful, as well as clinically and medically wrong.

'Asymptomatic spread' of COVID-19 (or, more correctly, SARS-CoV-2, since a disease cannot exist without symptoms) has been shown to be non-existent. Therefore, denying services or access to anyone without symptoms of infection is medically and legally wrong. Thus, COVID-status certification would serve no purpose for asymptomatic individuals.

Implementation of COVID-status certification when it serves no purpose would be a phenomenal abuse of taxpayer money, running the country further and further into hundreds of billions of pounds of debt.

Those who are symptomatic may produce a true positive PCR test result. But they would still need to be ***clinically assessed*** before they can be correctly diagnosed as suffering from COVID-19. In such cases, denial of COVID-status certification *may* be justified, ***if*** these individuals pose a real risk to society (but see below, under 'legal considerations').

(iii) COVID-19 vaccines are NOT shown to reduce risk of contracting or transmitting the SARS-CoV-2 virus, nor the COVID-19 disease.

There is no scientific evidence that COVID-19 vaccines prevent either infection with, or transmission of, SARS-CoV-2.[10] Therefore, COVID-status certification based on vaccination is completely unreliable. If the purpose of certification is to prevent infection in the community, and infection is likely to lead to death from COVID-19, then certification based on vaccination would be dangerous and reckless.

[10] https://www.bmj.com/content/371/bmj.m4037.

Even worse, a COVID-status certification scheme would encourage members of the public to have a vaccine even if they prefer to decline it, at least until further information is available. Many people are rightly "hesitant" about the COVID-19 vaccines for the following reasons:

- The vaccines are still in trial phase until 2023. There is limited short-term safety data and NO long-term safety data to rule out late onset side-effects such as autoimmune diseases, neurological conditions, infertility, or cancers.

- Some of the vaccines use novel technology (mRNA), which has never previously been approved for vaccines. It is known to be cytotoxic (kills cells), which is why it has previously been used in cancer therapy.[11]

- There are many thousands of reports of serious adverse events and deaths to the VAERS Database in the US,[12] the Eudravigilance Database in Europe[13] and the MHRA in the UK.[14] It should be noted that only a small minority of all adverse events are officially reported. The UK Medical Freedom Alliance has collated a database of various sources of information about adverse events relating to COVID-19 vaccines.[15]

- COVID-19 vaccines carry a real risk of antibody-dependent enhancement (**ADE**).[16] This means that "*COVID-19 vaccines could worsen disease upon exposure to challenge or circulating virus*." Sufficient literature exists to warrant the disclosure of this risk to trial participants and to all potential vaccinees post-approval of these experimental vaccines. But disclosure has not been given in either case. Only those diligent individuals who conduct their own research have discovered these risks.

Conversely, there is evidence of long-term natural immunity after contracting SARS-CoV-2. This immunity, which is based on memory B cells, is also protective against mutations of the virus.[17] Therefore, a person who has natural immunity would have no reason to take a COVID-19 vaccination. If that person were then denied COVID-status certification, because they were not vaccinated, it would be clinically and medically wrong, as well as unjust and unlawful.

In summary:

Vaccination data CANNOT "*confirm in different settings that individuals have a lower risk of getting sick with or transmitting COVID-19 to others*" for the purposes of COVID-status certification.

So, **COVID-status certification based on vaccination data will not achieve the stated aims of reducing risk and improving safety. It would be dangerous and reckless to implement or allow such a scheme in the UK**.

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[11] https://www.ukmedfreedom.org/resources/covid-19-vaccine-info#Vaccine-Analysis.
[12] https://medalerts.org/vaersdb/findfield.php?TABLE=ON&GROUP1=AGE&EVENTS=ON&VAX=COVID19&DIED=Yes.
[13] https://reseauinternational.net/la-base-de-donnees-europeenne-des-rapports-deffets-indesirables-indique-que-le-vaccin-pfizer-pourrait-avoir-cause-438-deces-a-ce-jour-en-europe/.
[14] https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions.
[15] https://www.ukmedfreedom.org/resources/covid-19-vaccine-info#Adverse-Reactions.
[16] https://www.onlinelibrary.wiley.com/doi/epdf/10.1111/ijcp.13795.
[17] Evolution of antibody immunity to SARS-CoV-2, https://www.nature.com/articles/s41586-021-03207-w.

It would also be ***coercive***. People would accept vaccination simply for the 'reward' of certification. They would be accepting a trial product, which has serious, but undisclosed, risks, under ***undue influence***. Without the required standard of patient comprehension for informed consent, there can be liability for injuries resulting from vaccination conducted in these circumstances.

b) Legal considerations

Deprivation of liberty for the prevention of the spreading of infectious diseases

Article 5 § 1(e) (Right to liberty and security) of the European Convention on Human Rights (**the Convention**) provides that an individual's liberty can be restricted "for the prevention of the spreading of infectious diseases." But the case of ***Enhorn v Sweden*** (2005)[18] established that such restriction of liberty depends on:

(1) whether the spreading of the infectious disease is dangerous to public health or safety; and
(2) whether detention of the person infected is the last resort in order to prevent the spreading of the disease, because less severe measures have been considered and found to be insufficient to safeguard the public interest.

When these criteria are no longer fulfilled, the basis for the deprivation of liberty ceases to exist (*Enhorn v Sweden*, § 44).

COVID-status certification constitutes a restriction of liberty and 'detention' of the person, insofar as the person is prevented from moving and acting freely in society. Therefore, to ascertain whether COVID-status certification can be legally justified, the above two criteria need to be fulfilled.

Enhorn v Sweden condition (1) – assessing the danger

We can only answer this question on the medical and scientific facts. A wealth of data now exists, which has been collated from the past 12 months and more, both from the UK and around the world.

COVID-19 is ***NOT*** a high consequence infectious disease (HCID) in the UK.[19] This is partly owing to its ***low mortality rate***.[20] The Infection Fatality Rate (IFR) for SARS-CoV-2, for those under 70 is less than 0.05%.[21] This is comparable with seasonal flu, which was *underdiagnosed* in 2020 to the same extent that COVID-19 was diagnosed as the 'main cause of death.'

Further, the Secretary of State for Health, Matt Hancock, revealed in a press conference in early 2020 that having COVID-19 on one's death certificate did not necessarily mean that the individual died ***of***, or even ***with*** COVID-19. An official 'COVID-19 death' is any death from any cause within 28 days of a positive PCR test. It became policy in 2020 that physicians and other healthcare workers could 'assume' that a person died ***of or with*** COVID-19. And, for the first time in medical history, no autopsies were to be carried out to confirm that COVID-19 was the cause of death.

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[18] http://hudoc.echr.coe.int/eng?i=001-68077.
[19] https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid.
[20] https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid.
[21] https://www.who.int/bulletin/online_first/BLT.20.265892.pdf.

Fortunately, there are ongoing independent investigations about the true and direct cause of death in all cases where the death was attributed to COVID-19.[22] These investigations will help to address the question of "*whether the spreading of the infectious disease is dangerous to public health or safety.*"

The ***vast majority*** of people who test positive for the SARS-CoV-2 virus are ***either asymptomatic or have mild symptoms***. Of those who sadly die after testing positive, the vast majority have one or more co-morbidities, are very old and/or frail in health. In other words, these people would be likely to die from their underlying health issues after contracting *any* virus, such as another coronavirus or influenza. Since an unusual and unprecedented DNR policy also expedited many deaths in 2020, even the overall excess death rate must be read in context. Additionally, many of the deaths in 2020 (which may have been certified as 'Covid deaths') were not related to the virus at all but were "deaths from the negative impacts of the measures themselves," as described by the Chief Medical Officer, Professor Chris Whitty. And there are now concerns that the COVID-19 vaccines themselves are expediting deaths in care homes around the world, following numerous reports of mass deaths following vaccinations[23] (*see notes on ADE under Question 2, a)(iii) above*). So, death figures, Case Fatality Rate (**CFR**) and IFR must be adjusted once the facts have been established about these concerns.

The above are just a few of the reasons to suggest that the "spreading of infectious disease" in the case of COVID-19 may not be as dangerous to public health and safety than the official statistics would appear to suggest. It may even be comparable to the risks from other circulating viruses, such as flu. We cannot know the reality until all the relevant audits have been done. What is clear is that the government has to prove that "*the spreading of the infectious disease is dangerous to public health or safety*" as one of the two conditions before justifying the deprivation of anybody's liberty by denying them COVID-status certification, especially given the clinical / medical considerations outlined above.

Enhorn v Sweden (2) – less severe measures

The *Enhorn v Sweden* case related to a man who was infected with the HIV virus and had infected a 15-year-old boy with HIV, albeit 4 years prior to discovering he himself was infected. The applicant was placed under strict prohibitory injunctions pursuant to Sweden's Infectious Diseases Act 1988 and later detained for 3 months in a hospital. The reasoning for the restraint on his liberty was that the applicant was said to be promiscuous and somewhat reckless in his sexual relations, thereby posing a real risk of spreading a deadly disease.

However, even in these circumstances, the European Court of Human Rights found that detention could NOT be considered the "last resort" to prevent the spreading of the disease, and that the Swedish Government did not provide "*any examples of less severe measures which might have been considered… but were apparently found to be insufficient to safeguard the public interest*" (§ 49). The court also found "*no indication that the applicant transmitted the HIV virus to the young man as a result of intent or gross neglect, which in many of the Contracting States, including Sweden, would have been considered a criminal offence*" (§ 54).

Hence, the Swedish government was found have acted in contravention of Article 5 of the Convention.

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[22] https://www.covid19assembly.org/covid-deaths-audit/.
[23] Beneath a short article, there is a log of news reports from around the world, including the UK, of care home deaths following vaccination, throughout January and February 2021: https://australianvoice.livejournal.com/47277.html.

It is clear from the court's judgment that the onus was on the Swedish Government to prove that a) it had considered less severe measures and found those measures to be insufficient to safeguard the public interest; and b) the applicant was likely to infect others intentionally or neglectfully with a deadly virus. The ***legal presumption***, then, was that the applicant was ***not*** prone to infecting other individuals intentionally or neglectfully.

The same presumption would be made for all members of the UK public: that **they are normal, sensible individuals who are able to comprehend signs and symptoms of sickness in their own bodies and are *not* prone to infecting others intentionally or neglectfully**.

And the UK Government is subject to the same standard of proof, in relation to article 5 of the Convention. That is, it needs to show that there is no less severe measure that could safeguard the public interest than a COVID-status certification scheme. To address this question, we can return to Sweden, who refrained from implementing harsh lockdown measures in response to COVID-19 in 2020. Perhaps Sweden had learned its lesson from the Enhorn case and decided it was safer NOT to deprive her people of their liberties, for the prevention of the spreading of infectious diseases. Instead, Sweden provided guidance and trusted the public to respond sensibly, using their own judgement and morals. Sweden's population density is similar to the UK's. Yet evidence shows that Sweden faired no worse than the UK, which adopted its 'suppression' strategy on 23 March last year. Thus, an alternative, less severe strategy than deprivation of liberty appears to have achieved the same result.

Sweden is not the only case to compare. An American report published in June 2020[24] compared all-cause mortality figures with the expected figures on a weekly basis, in each State. Of the five States who had NOT implemented a 'stay at home' order, all of them fell into the 'bottom half' of the chart (Figure 5, p4) and below average. Their figures for actual deaths in 2020 as a percentage of expected deaths ranged from 100% down to 80%, meaning that there were negative 'excess deaths' in these no-lockdown States. This is compelling evidence to suggest that the UK Government MUST consider alternatives to a COVID-status certification scheme, which would not work in practice anyway, for the reasons outlined under clinical / medical considerations.

Considering the above, if the UK government implemented, encouraged, or allowed COVID-status certification to be a condition of "access to settings," despite the availability of a less severe alternative, **it would be showing a callous disregard for the goodwill of each and every member of the UK population**. It would be assuming that the average member of society, when infectious, is disinclined to take sensible measures to protect the health of others, for instance, by voluntarily self-isolating.

Segregation, apartheid and crimes against humanity

If a COVID-status certification scheme is implemented in the UK, there will be a significant section of the population who will assert their legal rights and refuse to be tested and/or vaccinated. They will do this for valid reasons, none of which are selfish or reckless. Some of these reasons have been noted above. Some people may also, or alternatively, assert their legal right to refuse to wear a face covering, on grounds of reasonable excuse. If these people are then refused access or services, or made to wear lanyards or badges, or forced to seek and obtain some official 'exemption' (which may or may not be granted), or placed under *any other form of inconvenience*,

[24] https://www.cohealthchoice.org/wp-content/uploads/2020/06/Lessons-from-the-Lockdown-vF-6-17-20.pdf.

whether by the state, or by public or private bodies or entities, or by other individuals in society, this amounts to ***discrimination and unfair treatment of a particular group of people***.

That is how segregation starts. Segregation is the beginning of grave injustices based on a policy-led perception of inequality.

Segregation of a section of society based on its unwillingness to submit to arbitrary testing and vaccination is not just unlawful; it will be recognised as a crime against humanity, just as apartheid is listed as a crime against humanity in the Rome Statute of the International Criminal Court.[25] It took 25 years for apartheid to be recognised as a crime against humanity. In the current era of mass communication, it will not take that long for segregation based on COVID-status certification to be recognised as such. This is because there is already overwhelming evidence that "COVID-status" based on testing and/or vaccination data is practically arbitrary, and that an individual's bodily awareness is a better indication of sickness and/or infectivity.

If government decision-makers wish to proceed with a COVID-status certification scheme, despite the fact that it is unnecessary and would be practically useless, then **the government MUST widely advertise through all national media channels that such COVID-status certification is entirely voluntary and optional**; that nobody is obliged to be tested or vaccinated to prove their 'COVID status' to anybody else; that there can be no adverse consequences for those who choose not to be tested or vaccinated; and that any person who attempts to impose conditions of testing or vaccination, or place adverse consequences on someone for not being tested or vaccinated, will suffer a penalty.

This is the only way for government decision-makers to avoid liability for discrimination, in the short term, and for crimes against humanity in the long term.

f) Ethical considerations

Even if it were not legally wrong to implement this proposed COVID-status certification scheme, it would be completely unethical, for all the reasons outlined above.

As mentioned, all COVID-19 vaccines currently in circulation are approved for emergency use ONLY. They are still in clinical trial stage until 2023. To invite someone to receive a trial product without providing them the opportunity to be fully informed with ALL the relevant facts is unethical, unlawful and a breach of the Nuremberg code for human experimentation. **To *require* anyone to receive a trial product as a condition of entry or access is not just unethical and unlawful; it is a wanton act of reckless disregard and could constitute manslaughter if someone dies from the vaccine, or battery if they suffer injury**.

g) Equalities considerations

As explained above, the proposed COVID-status certification scheme would create a separate group or 'class' of people who would be discriminated against. While not yet a 'protected group' under the Equalities Act 2010, there are far more serious consequences for a policy-led discriminatory agenda than simply a £9K maximum fine. The UK government needs to take proactive steps not only to avoid *creating* a discriminatory scheme, but to prevent any business, organisation or any other person from discriminating against people who choose to refuse

[25] https://legal.un.org/icc/statute/english/rome_statute(e).pdf.

medical interventions for any reason. Such discrimination would be in contravention of article 6 §1 of the UNESCO Universal Declaration on Bioethics and Human Rights,[26] which states:

> *"Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and* ***for any reason without disadvantage or prejudice****."*

Since the Cabinet Office is responsible for all COVID-related media communications, the **Cabinet Office should disseminate clear guidance and education to all UK entities who may consider using a certification scheme. This guidance and education should explain the law of informed consent and discrimination**. It should not incentivise segregational practices by, for example, "allowing" pubs to "drop social distancing" if they check customers' COVID status.[27]

h) Privacy considerations

Obviously, it is a violation of an individual's right to privacy to be forced to declare their 'COVID status' and have it accessible by any service provider or organisation.

If COVID-19 were proven to be so deadly as to have ***directly*** caused huge numbers of excess deaths, or the SARS-CoV-2 virus so virulent as to directly kill a significant proportion of its hosts, no matter their age or present state of health, then perhaps the British public could be asked to VOLUNTARILY disclose their disease status, or vaccination status *(assuming there was a vaccine that prevented transmission)* prior to entering a shop or an aeroplane. But this is not the case, as explained above.

Therefore, to disregard long-established privacy laws for the purposes of COVID-status certification is unjustified.

Question 3

Any other comments: there exists a wealth of evidence that unvaccinated children and adults are far healthier than their vaccinated counterparts. One excellent source of such information is The Control Group[28] website, which has produced information that was recently verified in a US Federal Court.[29] I recommend as a starting point, The Control Group's very clear graphical representation of the results from their 2020 Pilot Survey Data Comparison of vaccinated vs unvaccinated individuals, which you can download here.[30]

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[26] http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html.
[27] https://www.theguardian.com/world/2021/mar/24/pubs-should-decide-whether-to-demand-vaccine-passports-pm-says.
[28] https://www.thecontrolgroup.org/.
[29] https://informedconsentdefense.org/.
[30] https://cdn.website-editor.net/fbd2f2a8b1b04bdba97a21e6e5d356aa/files/uploaded/Pilot%2520Survey%2520Data%2520Graphs%2520--%2520October%25202020%2520%25283%2529.pdf.

Conclusion

There is no evidence to suggest that COVID-status certification can play a role in reopening the economy. It would go against medical and scientific evidence. Certification can only be effective in reducing risk to the extent that it would limit the number of people who are able to move freely in society. But such reduction in free movement would be arbitrary, and therefore unlawful.

Offering COVID-status certification would coerce individuals to accept medical intervention without giving valid consent. There will be liability for injury and death from medical interventions that were accepted without valid consent. Denial of certification would amount to false imprisonment of millions of individuals, who may be no less infectious than those awarded certification. There are less severe measures available to the UK Government, which could enable the safe reopening of the economy.

Under a COVID-status certification scheme, people asserting their right to refuse medical intervention would be outcast from society and subjected to a dangerous programme of segregation. Such segregation would be a crime against humanity, as there would be no lawful justification for the poor treatment and denial of civil liberties to this small section of society. **Thus, COVID-status certification would lead to UK Apartheid: an unlawful, immoral, unjust, unethical, cruel, discriminatory scheme that violates privacy and basic human rights**.

There is no place for the proposed scheme in any civilised society.

Thank you for your time in reviewing this submission. Should you have any questions, or require further information, please do not hesitate to contact me.

Yours faithfully

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