(The following is a draft translation of the summons by Jeroen Pols and Willem de Engel seeking an immediate end to the lockdown measures. Pol and de Engel are part of the group Viruswaanzin)

Introduction

1. On 27 February 2020, the first contamination of COVID-19 was detected in the Netherlands. After the WHO classified the outbreak as a pandemic on 11 March 2020, all countries worldwide proceeded to take drastic measures on an unprecedented scale in modern history. In the Netherlands, the outbreak led to strict measures whereby social traffic was virtually shut down due to the closure of schools, universities, libraries, museums, cinemas, restaurants, cafes, gyms, and barbershops. In addition, heavy restrictions have been placed on the freedom of movement of the population, which means that even the non-closed part of society is limited to a very small number of people and can only function to a limited extent. The use of emergency ordinances has been used to enforce these social restrictions and everyone has been urged to stay at home as much as possible. Recreational areas and sports facilities have also been closed or made inaccessible.After more than two months of measures, the official death toll in the Netherlands is 5,830 (persons who died with COVID-19, up until 25 May 2020). Although the actual number that have died with COVID-19 is significantly higher, it has now been established that the virus has only contributed substantially to the cause of death in a few cases. The elderly with underlying health conditions were particularly susceptible to the virus. The damage caused as a result of such drastic measures is barely comprehensible. The government estimates this year's best-case scenario budget deficit to be in the region of EUR 92 billion. In addition, the death toll as a result of the enforced measures has far exceeded the number of victims of COVID-19, while the expected psychological consequences are still incalculable. The functioning of the democratic rule of law has been severely curtailed and measures broadly denying citizens' fundamental rights have been put into effect. For the time being, most of the measures are still in force, and the damage is increasing daily. Plaintiffs believe that, regardless of whether the initial measures taken at that time were justifiable or unjustifiable, the continuation of this situation in the current circumstances and with the evolving scientific understanding of COVID-19, is unacceptable. Plaintiffs claim in this preliminary injunction an immediate prohibition on the extension of the

lockdown, and immediate removal of the measures currently in force. This preliminary injunction will first give an overview of the facts, followed by a legal analysis of the measures and the assessment framework of the European Court of Human Rights for exceptional situations of this kind. The decision-making process, the purpose and the effectiveness of the measures will be analysed on the basis of these criteria. This is followed by an analysis of the dangers represented by COVID-19 and a description of the consequences of the measures. On the basis of these consequences, we will establish in our conclusion whether the measures were proportionate.

Facts

Proclamation of a pandemic by the WHO

2. In 2005, the World Health Organisation (WHO) member states adopted the amended International Health Regulations (IHR), and this entered into force in 2007. The Convention regulates cooperation between the 196 Member States in order to combat the international spread of disease and other health risks, and so as to avoid unnecessary disruption of international traffic of goods and people.

3. In the event of an incident in a Member State involving the outbreak of a virus, the IHR requires that this be reported to the WHO. Article 12 of the IHR empowers the Director-General of the WHO to determine whether a reported case is a Public Health Emergency of International Concern (PHEIC). The IHR defines a PHEIC as “an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response”. This is the case if there is a serious and unusual situation which has implications for health beyond the borders of the State concerned, and which may require immediate and international action. The Director-General of the WHO has declared a PHEIC five times since 2007:

2009 H1N1 influenza pandemic;
2014 setbacks in polio global eradication efforts;
2014 West Africa Ebola epidemic;
2016 Zika virus outbreak;
2018-'19 Kivu Ebola epidemic.

4. On 22 and 23 January 2020, in response to the COVID-19 outbreak in China, a meeting of the Emergency Committee, headed by the Director-General, took place. At this meeting there was insufficient support to allow the outbreak to be categorised as a PHEIC. According to data from China, in 25% of infections, the virus would lead to serious complications with a fatality rate of 4%. The transferability of the virus from human to human and an estimated transmission ratio R0 of 1.4 to 2.5 was considered alarming. However, the countries of the European Union believed it was too early to escalate to a PHEIC. During a follow-up meeting of the Emergency Committee on January 30th however, these countries agreed to adopt the COVID-19 measures and to support the declaration of a PHEIC. This meant that in accordance with Article 49 of the IHR, the WHO was to inform all Member States and make recommendations as to the measures to be taken. (Appendix 1: Statement by Emergency Committee 23 January 2020)

5. In a press conference on 11 March 2020, the Director-General of WHO declared the outbreak of COVID-19 to be a pandemic. According to the Director General, at the time 4,291 people had died worldwide with COVID-19. In unprecedented ferocious terms the Director-General directed the Member States to take "urgent and aggressive action". In accordance with Article 49 the IHR made recommendations to Member States with regard to the measures to be taken. According to the definition of a pandemic, amended in 2009 for reasons unknown, a pandemic is the worldwide spread of a new disease. The harmfulness of a virus is no longer a criterion for declaring a pandemic. (Appendix 2: explanation by the Director-General, 11 March 2020)

The response in the Netherlands to the WHO call

6. An Outbreak Management Team (OMT) was convened on 24 January 2020. This team was composed of experts from the National Institute for Public Health and the Environment (RIVM) and would advise the Ministry of Health on the virus and, if necessary, take measures. By ministerial decree of 28 January 2020 the novel coronavirus (2019-nCoV) was classed as belonging to group A, as referred to in Article 1(e) of the Public Administration Act (Public Health Law). This decision was published in the Government Gazette on 31 January 2020. (Appendix 3: Ministerial Decree 28 January 2020)

7. In a letter dated 14 February 2020, the Minister for Medical Care announced that there were as yet no infections detected in the Netherlands. The aim of the current policy was to prevent the spread within the Netherlands were an incidental introduction of the virus to occur. (Appendix 4: letter 14 February 2020)

8. In a letter from the Minister for Medical Care to the Lower House of Parliament dated 6 March 2020, the people in North Brabant with symptoms of illness were told to stay at home as much as possible and to stay away from other people. (Appendix 5: letter 6 March 2020)

9. Letter dd 13 March 2020 wherein the Minister of Justice and Security informed the House of Representatives that a national crisis structure had been put into place to deal with broad societal challenges when faced with the consequences of the COVID-19 (coronavirus) outbreak. This action was in accordance with the Institutional Decree of the Ministerial Commission for Crisis Management 2016 (Official Gazette 2016, No 48258) and the National Handbook on Crisis Decisions. (Appendix 6: letter to the Chamber dd 13 March 2020)

10. On 9 March 2020, after an increase in the number of infections, the Prime Minister held a press conference where he advised everyone to comply with hygiene measures and as far as possible to work from home. From March 11, 2020, meetings of over 1,000 people in the province of Brabant were forbidden. In a press conference by the Prime Minister on 12 March 2020 further measures are announced, including a ban on events with more than 100 people. This prohibition also applied to activities in the cultural sector such as concerts, cinemas and music events. On 15 March 2020, a Sunday, the limit of 1,000 deaths due to COVID-19 was exceeded. The OMT required *additional measures for the whole of the Netherlands to be adhered to with the aim of maintaining good quality of care for those seriously ill and people from groups vulnerable to coronavirus infections*. The OMT did not recommend closing schools. On the same day, at about half past five in the afternoon, the government announced that all eating and drinking establishments (except those in hotels), sports and fitness clubs, saunas, sex clubs and coffee shops had to close from 6 p.m. that day. (Appendix 7: advice OMT 15 March 2020)

11. The Cabinet declared that from 16 March 2020 onwards, all schools

and day-care centres would be closed. This affected schools in primary and secondary education and secondary vocational education (MBO). Children of persons in what were called "crucial professions", such as those in health care, police, public transport and fire brigade would still receive lessons in order for their parents to work. Everyone was required to strictly observe a distance of 1.5 meters from each other. The next day, some of the rules were relaxed. For example, take-away restaurants could remain open, as well as coffeeshops, as long as customers left immediately after collecting the order. The stated objective of the policy was the achievement of 'group immunity'. (Appendix 8: Prime Minister's speech 16 March 2020)

12. On 17 March 2020, the OMT issued an additional opinion containing further recommendations. There were currently 6,507 reported deaths from COVID-19 in Europe. The epidemiological developments *suggested* that the numbers of infected persons and hospitalizations *could* rise further. In that case, care *would* come under pressure. There was not enough test capacity available so only selective testing among healthcare personnel would be carried out. Testing of patients with an increased risk of fatal consequences from Covid-19 did not have any added value for the assessment of follow-up treatment, according to the OMT. The OMT further advised that data on the numbers of people who have been treated with COVID-19, or admitted to a hospital or intensive care unit (IC), as well as the number of discharges and deceased patients should be collected from the hospital boards on a daily basis. (Appendix 9: OMT advice 17 March 2020)

13. In an OMT opinion of 23 March 2020, the following measures were added to those currently in force. The OMT advised, among other things, that all events until June 2020, regardless of the number of participants, should be cancelled . On the basis of this opinion, the Prime Minister announced further measures to remedy the situation and referred to these as an 'intelligent lockdown'. The basis for these measures had not yet been laid down in emergency ordinances. The following measures would be implemented:
1. Events with a permit and notification requirement would be prohibited until 1 June 2020.
(The measures set out in points 2 to 7 should be reconsidered by 6 April 2020 at the latest.)

2. All other meetings would be prohibited, with some exceptions e.g:
a. statutory meetings , such as meetings of the City Council as well as the States General(max 100 persons)
b. Meetings necessary for the continuation of the daily activities of institutions, companies and other organisations (max 100 persons);
c. funerals and weddings (max 30 persons);
d. religious or philosophical gatherings (max 30 persons);
(These gatherings could only take place if all hygiene measures to control the corona virus were observed, and everyone stayed 1.5 meters away from each other.
3. Casinos, amusement arcades and similar establishments would be closed. Professions like barbershops and nail salons, where there was physical contact, would also have to close their doors.
4. The exercise of all forms of contact professions was prohibited to the extent that the 1.5m rule could not be observed. This included hairdressers, nail stylists, escort services and driving instructors. There would be an exception made for the treatment of (para)medical professions, provided that an individual could show a medical indication for treatment and the practitioner observed all the hygiene requirements.
5. Shops, markets were to be closed and public transport would be discontinued if there was no or insufficient compliance with the hygiene measures in force, and with the 1.5 m distance requirement.
6. Locations such as holiday parks, campsites, parks, nature reserves and beaches were to be closed if there was no or insufficient compliance with the hygiene measures in force and the 1.5 m distance, or if there was the risk of this happening.
7. Group formation (accidental or otherwise) in the public space would be prohibited. The Cabinet determined a sanctioned group to be three or more persons who do not observe the 1.5m distance rule. There is no question of group formation when it comes to persons forming a joint household. There is also no question of group formation if children up to 12 years of age play together under the supervision of one or more parents or guardians, provided that the parents and/or guardians keep a distance of 1.5 m between each other. (Appendix 10: advice OMT 23 March 2020, appendix 11: additional measures news item 23 March 2020, appendix 12: Minister's answers to parliamentary questions 30 March 2020)

14. As a result of the measures announced, security for all regions was scaled up to GRIP 4. On the basis of article 39 of the Security Regions

Act, several of the mayor's powers were given exclusively to the President of the Security Regions. Following this, on 17 March 2020, the Emergency Ordinance for Covid-19 was adopted by each security region. (Appendix 13: letter to security regions dd 24 March 2020, appendix 14: sample emergency ordinance security regions dd 17 March 2020)

15. On 6 April 2020, a bill with temporary provisions was submitted to the Second Chamber of Parliament. With the bill, temporary provisions would be made for preliminary proceedings in the case of rendering delegated legislation relating to COVID-19 inoperative. This includes skipping the grounds for advice and consultation prescribed by general administrative measures and ministerial regulations. The members of the States General or one of the Houses were also deprived of the opportunity to demand that certain subjects are regulated by law. Furthermore, the option of holding court hearings through telecommunications links was created. (Appendix 15: legislative proposal and opinion of the Council of State dd 6 April 2020)

16. The OMT issued an additional opinion on 6 April 2020. The purpose of this opinion was to limit the spread of the virus and reduce pressure on ICUs. There *should* be a flattening of new hospital admissions. The peak of new admissions to ICUs *seemed* to have been reached. Due to the delayed outflow, the peak of full occupation of the ICUs *had not yet* occurred. The reporting delay also created uncertainty in the calculation of the desired reproduction number (R0). The OMT did not expect the measures to be downscaled. The transition strategy was based on three pillars:
a. Determining an acceptable burden on the ICUs and long-term hospital care;
b. Optimizing the recognition of coronavirus infections through contact detection and contact notification and
c. Protection of vulnerable groups in society.

17. The OMT advised focusing the control policy on limiting the number of people that get sick, or that need to be hospitalized in ICUs, and limiting deaths from the virus. To do this, the R0 number should remain below 1. The OMT stated that the measures could be downscaled if:
a. The R0, measured by hospital admissions, has been less than 1 for a significant period of time;

b. The healthcare system, including ICUs, was no longer under pressure and had had a chance to recover;
c. There was sufficient test capacity and sufficient source and contact tracing available, including the capacity to analyze large data streams at regional level;
c. Measuring instruments that quickly assess the effects of the transition, such as a sufficiently sensitive virological sentinel surveillance, were developed.

18. Furthermore, the OMT recommended immediate investigation of options for supporting contact sources using mobile applications. The OMT considered this necessary for the future phase. According to the OMT, the 1.5-meter rule would remain important and could only be downscaled if the virus circulation had been definitely suppressed and quick recognition of those infected and their contacts could be guaranteed. (Appendix 16: advice OMT April 6, 2020)

19. The Dutch Health Authority warned that research showed a reservoir of over 361,000 patients who have gone untreated since the start of the measures. (Appendix 17: Analysis of the consequences of covid-19 for regular healthcare)

20. On 20 April 2020, the OMT produced a follow-up advisory on what would be an acceptable burden for the healthcare services in which both COVID-19 patients and regular patients could be treated. In addition, vulnerable people in society were to be protected and insight into the development of the spread of the virus should be developed. The effective reproduction number (Reff) had been lower than 1 since 16 March, which according to the OMT was an indicator that the measures were working. A reliable estimate was, according to the OMT, not possible to deliver due to the reporting delay in registrations. The expectation of The OMT was that the ICU occupation of 700 COVID-19 beds would be established around 1 May. The OMT recommended establishing the goals of the transition strategy as follows:
a. Prevent the virus from spreading to vulnerable people so as to limit the number of seriously ill patients;
b. Prevent the healthcare system from being overloaded. The ICU occupation should be reduced to 700 beds by May 1, 2020;
c. Minimise the harmful effects of measures on the population and society;

d. Maintain broad support among the population.

21. The OMT emphasised that there was a lot of uncertainty about the effect of the measures to prevent spread. Knowledge that was necessary for a scientific substantiation of interventions was largely lacking. *It is not possible to use scientific evidence to work out a strategy to reopen society without this leading to a possible uncontrollable spread of the virus.* (Appendix 18: OMT advice April 20, 2020)

22. In a letter dd 21 April 2020, the House was informed about the state of affairs. The minister concluded that the measures were effective and the figures from the ICUs were hopeful. According to the minister, the Netherlands was only at the beginning of the next phase in combating the virus. The virus *could* only continue to go down if measures and advice were followed. The minister also reported that there were 3,206 beds nationwide creating sufficient care capacity for vulnerable patients outside the hospital. In addition, 3,832 beds that could be used in the short term were made available with a total capacity of 7,038 beds.

23. A press conference on 21 April 2020 announced that the measures introduced on 13 March 2020 and due to expire on April 28, 2020, would be extended to May 19, 2020. The measures regarding events would be extended until September 1, 2020. In this news conference the prime minister stressed that after downscaling the situation would not return to how it was before the measures. There was talk of "the new normal". Health remained the all-determining criterion. The development of an exit strategy would mainly take into account the future possibility of spread or revival of the virus. The success of this strategy was partly dependent on a preventive vaccine. It would be some time before this became available. (Appendix 19: Letter from the safety region to municipalities dd 22 April 2020, appendix 20: Model Regulation COVID-19, April 24, 2020)

24. What is noticeable is the enthusiastic efforts being made to research and develop a vaccine. In fact, a vaccine has become a prerequisite for removing the virus from the world. For this purpose, 50 million euros has been made available to the Coalition on Epidemic Preparedness despite the fact that to this date, a vaccine has never resolved a crisis. It is a preparatory medium and by definition cannot be used during an epidemic.

25. What is also striking is the emphasis on research into using mobile applications to support source and contact data collection. The development of a COVID-19 app followed a recommendation from the European Commission (2) although this was not communicated to the public. In a manual, the European Commission gave the criteria with which such an app must comply. (3) The minister gave a step-by-step plan for arriving at a functional track-and-trace app.

26. In the NRC of 7 April 2020, professor of epidemiology and infectious diseases at Harvard University, Jaap Goudsmit discussed the premise that "Testing for antibodies was now essential" (4). This led to questions in the Second Chamber on how a representative sample would be established in order to provide a basis for the policy being pursued. The Minister replied, without further explanation, that in the Pienter-Covid study a broader sample was being implemented. (Appendix 21: Parliamentary questions 6 May 2020, Hijink and Van Gerven)

27. On 1 May 2020, the Prime Minister held a press conference following the Council of Ministers' meeting which made it clear that with regard to the scaling-down of the measures, nothing could be promised with any certainty. On the question of whether a reduction in occupied ICU-beds could lead to downscaling of the measures, the Prime Minister replied that this was not a consideration. According to him, the whole of the healthcare system was now being looked into. It was also important to ensure that the reproduction digit R0 remained below 1. According to the Prime Minister, no decisions on opening sectors could be taken until all figures on how the virus is 'raging through society' were available. At the moment the reproduction rate is below 1. The Prime Minister was further surprised at the criticism that the OMT operated as if it were an inaccessible stronghold. The consultation of experts should according to him, take place in confidence in order to arrive at a well-considered assessment. There was still too little known about the virus. 'A recommendation to open sectors could only be given with very accurate information on the spread of the virus and current data is not yet positive enough for us to predict that right now. We are now only looking at the possibility if, for example, it continues to go well for two weeks that a plan is made to reopen in blocks of four or six weeks. As soon as the figures give reason for a positive perspective, that will happen,' says Rutte.

(2)https://ec.europa.eu/info/sites/info/files/recommendation_on_apps_for_contact_tracing_4.pdf
(3)https://ec.europa.eu/info/sites/info/files/5_en_act_part1_v3.pdf
(4)NRC, 7 April 2020, 'Testing for antibodies now essential'.

28. On the question of which figures would give reason for a positive perspective, the Prime Minister replied that the rate of reproduction must really be below 1. (Appendix 22: literal text from press conference with Prime Minister, 1 May 2020)

29. The OMT produced an additional opinion on 4 May 2020. According to the OMT, the current situation is that the reproduction number *R0 has been below 1 since 16 March 2020.* According to one estimate, the number of people with an active infection in the Netherlands on 13 April 2020 was around 25,000. The prognosis for the ICUs was that there would be just under 700 COVID-19 patients on 1 May 2020. This satisfied the condition for relaxation of the lockdown measures. The OMT expected that by 11 May 2020, fewer than 500 IC beds would be occupied by COVID-19 patients. A general easing of measures could only take effect - irrespective of the additional hygiene and one and a half meter rule – when the incidence of infections was low. The conditions for easing were, according to the OMT, sufficient testing and collection capacity and a maximum scaling up of public health infrastructure for source and contact tracing. As soon as it was technically possible, virological surveillance should be complemented by serological surveillance so that an image of group immunity could be created. As to the efficacy of facial masks the OMT would not comment one way or the other as there was an ambiguous picture as to their usefulness. (Appendix 23: advice OMT 4 May 2020)

30. In response to the OMT recommendation, the Minister sent a letter to the House of Representatives on 6 May 2020 with an update on the state of play. According to the minister, since March good results have been achieved and the number of new infections and hospital and ICU admissions is tapering off. According to the minister, 'we're only at the beginning of the next phase in combating the outbreak in which a step-by-step approach is being in the control phase. This should be done in a responsible manner because there is the real chance of a second outbreak if you're not careful enough.' According to the minister, this was a communal quest for a responsible approach *'until we have an effective vaccine'*.

31. In the control phase, three anchor points will be maintained, namely to ensure that care is taken in the protection of the vulnerable in society and in order to ensure even more visibility and insight into the spread of the virus. In order to be well prepared in this transitional phase for, according to the Minister, the next phase of 'the new normal' clear frameworks from government and good agreements with society are needed. Only then, according to the minister, would it be possible to eliminate the measures taken step by step, and society could restart economic activities as much as possible.

32. As a first step towards the "new normal", some sectors would be given the opportunity to start up again, opening subject to numerous restrictions. For example, a number of contact professions could go back to work as long as work was done by appointment and the one and a half meter distance could be guaranteed. Swimming pools could partially open but the showers had to stay closed. The conditions for these 'openings' were that:
a.The RIVM guidelines were implemented;
b.Strict hygiene measures were applied;
c.The contact professions had to work in accordance with the assessment framework established by the OMT;
d.The contact professions mentioned in the assessment framework should work on the basis of appointments and triage; and
e.Vulnerable groups should be discouraged from using the services of contact professions. This did not apply to necessary contacts with medical professionals.

33. In addition, education would be reopened on a small scale, also observing many restrictions. Public transport could be used again provided that a mouth shield was worn and the 1.5m distance was maintained.

34. The testing policy would be adjusted so that from now on everyone with flu symptoms could be tested. Further source and contact research would take place. Regular healthcare would also slowly restart. (Appendix 24: letter 6 May 2020 from the Minister of Medical Care to the Chamber)

35. On 18 May 2020, the OMT issued a new advisory report, which was converted by the Minister into policy. According to the OMT, the three pillars of the transition policy were as follows:

a.an acceptable load-bearing capacity for healthcare - hospitals should be able to offer quality care to both COVID-19 patients and regular care patients whose procedures had been delayed due to the virus, and this care should be resumed in the short term;
c.protecting vulnerable people in society;
d.monitoring and understanding the spread of the virus.

36. At that point a total of 5,590 persons with a confirmed SARS-CoV-2 infection had died. The OMT reported that on 14 May 2020, 373 COVID-19 patients had been admitted and that this number would fall to 200 IC beds by 1 June 2020. The effective reproduction number (Rt) of the epidemic had been calculated on the basis of the first day of illness of admitted patients, had been below 1 since March 16 and has remained just below 1 since then.

37. The OMT advised a (limited) opening of catering establishments. Restaurants, cafés, cinemas, cultural institutions could open from 1 June with a maximum of 30 people, including staff. This under the condition that a reservation is made in advance, there is medical assistance, hygiene measures are implemented on site and the 1.5m rule is observed.
a.Terraces could reopen under two conditions: all guests have a seat and people keep a meter and a half away from each other.
b.Museums (including monuments) could also reopen on 1 June, subject to prior reservation, medical assistance on site, hygiene measures are implemented on site and the 1.5m rule is enforced.
c.The (partial) opening up of secondary education. This under the provision that hygiene measures are implemented on site and the 1.5m rule is observed.

38. The OMT once again stressed the importance of maintaining general recommendations such as maintaining the 1.5m distance between people, advice on hand hygiene, and staying home with the slightest respiratory complaint. Strict adherence to this advice was a conditio sine qua non for further monitoring of COVID-19, and potentiall relaxation of the measures, according to the OMT. (Appendix 25: opinion 18 May 2020)

39. In a letter dated 3 June 2020, the Minister informed the House of Representatives about an initiative of the European Parliament. The Commission wanted to accelerate the availability of a COVID-19 vaccine.

Together with Germany, France and Italy, the Netherlands took the initiative and set up the "Inclusive Vaccine Alliance" on 2 June 2020. With this move, the Netherlands is looking for alliances with a number of international leading European partners who, like the Netherlands, have the capacity to significantly contribute to vaccine development and production for Europe and beyond (Appendix 26: letter 3 June 2020 to the Chamber)

40. On 13 June 2020, the Minister informed the House that the Netherlands, France, Germany and Italy had concluded an agreement with the pharmaceutical company AstraZeneca for the supply of 300 million euros worth of corona vaccines. In addition, there was the option of purchasing another 100 million doses. In this way, the government was investing in the large-scale production of an important potential vaccine such as that developed by Oxford University. The Minister foresaw an initial quantity of vaccine available by the end of 2020.

41. The value of the agreement is potentially in excess of one billion euros. (5) Since 2003, AstraZeneca has been regularly involved in criminal investigations and since 2016, the company has paid more than one billion euros in settlements. (6) In 2003, in a criminal prosecution for fraud against US health insurance funds, the company agreed to a penalty of 355 million euros. (7) No explanation was given by the Minister as to whether prior to the tender the company had been screened for integrity or conduct compliance in accordance with the European Directives. (8) (Appendix 27: letter 13 June 2020 to the Chamber)

(5) https://nypost.com/2020/06/04/astrazeneca-doubles-coronavirus-vaccine-production-capacity/
(6) https://wikispooks.com/wiki/AstraZeneca
(7) https://www.nu.nl/economie/164554/astrazeneca-koopt-klacht-af-voor-355-miljoen-dollar.html
(8) Directive 2004/18/EC of the European Parliament and of the Council of the European Union of 31 March 2004 on the harmonisation of the laws of the Member States relating to turnover taxes coordination of procedures for the award of public works contracts, public supply contracts and public service contracts (OJEU 2004 L 134)

The whole world in lockdown

42. A frequently asked question is how was it possible for the whole world to almost simultaneously go into lockdown? In order to place Dutch policy in an international context, it is important to further analyse this aspect.

43. On 15 June 2007 International Humanitarian Law (IHL) entered into force for 194 countries including the Netherlands. (9) Each state was obliged to transpose this regulation into law. In the Netherlands this took the form of the Public Health Act (Wpg) and the guidelines and royal decrees based thereon. (10) The IHR provides for protective measures to be followed worldwide to safeguard public health, including in the area of international travel. These IHR measures enter into force in the event of "*a public health emergency of international concern"* and the decision-making power as to which measures should be adopted and what form these should take, lies exclusively with the WHO (See above 2 ff.). (11)

(9) WHO, International Health Regulations (2005), Trb. 2007, 34
(10) Zie Wet Publieke Gezondheid (Public Health Act), Kamerstukken II 2007-2008, 31 316
(11) Artikel 15.3 jo 49 lid 5 IHR

44. The government is obliged, even if it has other views, to follow the WHO's decisions and to act in accordance with the guidelines imposed for the "pandemic" scenario. (12) As long as the pandemic status persists, the WHO can intervene at any time it deems necessary and take health measures which must be acted on by the Member States. The government stated that these are only guidelines which a state does not have to follow. It is however unclear whether this is the case for all measures. (13)

(12) Zie MvT, Kamerstukken Nr, 3, 31 316, Bepalingen over de zorg voor de Publieke Gezondheid, p. 5
(13) Zie artikel 15 jo 18 lid 1, jo 31 lid 2 ten aanzien van specifie

45. This means that if the WHO - rightly or wrongly - declares pandemic status, the government may restrict fundamental human rights, whether or not such restrictions are recommended by the WHO. Rights may be restricted on the grounds of the Public Health Act (Wpg) and/or at the behest of the WHO. The constitutional safeguards within Member States

are thus set aside, being automatically overridden by the declaration of a pandemic, and opening the door to far-reaching infringements of fundamental human rights. Additionally, affected individuals are denied the right of appeal against these infringements.

46. Declaring the outbreak of the COVID-19 virus to be a global pandemic on March 12, 2020 caused a chain reaction of worldwide lockdowns as member states implemented contingency plans. This syncronisation was made possible by the standardisation of national legislation with regard to the implementation of the IHL (2007).

47. The government cannot however justify the continuation of the measures by referring to the IHL treaty provisions or to WHO guidelines. Article 2 After all, the ECHR (EVRM) holds that the government is obliged to safeguard the right to health and life. This is a right that cannot be derogated, not even in a state of emergency. Other treaty provisions also oblige governments to take measures to ensure the best possible physical and mental health of the population. (14) It goes without saying that in the actions of the government, the best interests of the population do not always prevail.

(14) Artikel 12, lid 1 en 2, Internationaal Verdrag inzake economische, sociale en culturele rechten

Information provision regarding the COVID-19 pandemic

48. The media as the “fourth estate” play an essential role in a democratic constitutional state. It acts as a public watchdog and helps citizens to improve their position by contributing to their understanding of the current political and social landscape. The media also promotes informed participation in public life. The right to provide and obtain information is one of the fundamental democratic core values that underpin the European Union.

49. The way in which information and reporting by the mainstream media, including other sources of digital information such as YouTube, Facebook, WhatsApp, Google, Twitter and *influencers* has taken place, has played an important role in the course of the COVID-19 crisis. The provision of information is characterized by a monopolisation of government talking

points in which the COVID-19 virus is portrayed as a *killer virus*.

50. This media campaign was strictly directed by the WHO, who had devised a plan for this purpose namely the Risk Communication and Community Engagement plan (RCCE). The RCCE provided an *Action Plan Guidance* manual. The starting point of this media strategy was a scary collaboration between governments and the entire mainstream media, and including reporting via *influencers*. Parliamentary questions have shown that the deployed *influencers* have received significant payments for their services. Fighting "Misinformation" is an important aspect of this strategy (p.5):

“Set up and implement a rumor tracking system to closely watch misinformation and report to relevant partners/sectors. Make sure to respond to rumors and misinformation with evidence-based guidance so that all rumors can be effectively refuted. Adapt materials, messages and methodologies accordingly with help of the relevant technical group. ” (Appendix 28: WHO RCCE Action Plan Guidance)

51. Part of the RCCE is the provision of information from the WHO which should be communicated to the public in a monopolized manner. In an emergency, it is conceivable that the independent provision of information would be limited temporarily to enable minimal communication with the public. During the COVID-19 crisis however, this strategy led to a situation in which there was little room for dissenting voices or for questions about the policy being pursued. The public therefore had limited access to diverse information that would have contributed to the formation of balanced opinion.

Legislation

52. There follows a brief description of the legal structures of competences currently in force in the fight against the COVID-19 virus.

53. The basis for the measures in force can be found in the Public Health Act (Wpg). CoV-19 was designated by ministerial decree of January 28, 2020 as belonging to group A, as referred to in Article 1 (e) of the Public Health Act. Group A also includes Middle East respiratory syndrome coronavirus (MERS-CoV), smallpox, polio, severe acute respiratory

syndrome (SARS) and viral haemorrhagic fever.

54. The chairman of the security region shall deal with an epidemic of an infectious disease belonging to group A, or with the direct threat thereof, with the exclusive authority to apply Article 34, paragraphs 4, 47, 51, 54, 55 or 56. This article includes the powers to impose periodic penalties in cases where isolation is necessary. This article also grants the authority to check buildings, means of transport or goods for the presence of infection; to disinfect these, to close or prohibit use of such and to enforce fines and penalties.

55. Article 7, paragraph 1, of the Wpg stipulates that the Minister of Health, Welfare and Sport (the Minister) is in charge of the control of an infectious disease belonging to group A. The minister has the power to instruct the president of the security region on how to combat the virus, including ordering the application of the abovementioned measures.

56. The minister is assisted by the Center for Infectious Diseases (CIb) of the RIVM. The centre for National Coordination of Infectious Disease Control (LCI) is part of the CIb and is responsible for substantive advice to the government and professionals on how best to control the outbreak and for the implementation of national policy in the case of an outbreak of infectious disease. To this end, an Outbreak Management Team (OMT) of (medical) professionals will be convened. Before the advice of the OMT is applied, the minister must first consult the Administrative Coordination Group (BAO). The BAO is chaired by the Director General of Public Health. Officials of the ministries concerned, representatives of the Association of Dutch Municipalities (VNG), GGD, GHOR Nederland, the Inspectorate Healthcare and Youth (IGJ), the Dutch Food and Consumer Product Safety Authority (NVWA), the director CJb are all represented in the OMT sessions. The minister ultimately tasks the chairmen of the security regions with implementation of the measures he has decided on.

57. The presidents of the security regions must ensure the measures are binding. Emergency powers with regard to public policy on municipal law are granted to mayors, (section 175 and 176 are relevant). The power to declare a GRIP 4 situation is vested in the president of the security regions under Article 39 of the Security Regions Act. This is exclusively for use in the case of an (imminent) disaster or crisis of more than local significance

whereby the life and health of persons are seriously affected, harmed or threatened. According to Article 1 WVR, a crisis is a situation in which vital harm threatens the interests of society.

58. The minister has followed this path, but does not himself have any regulatory powers. The emergency ordinance power of Article 175 of the Municipalities Act gives the chairman of the security regions the power to deviate from regulations other than those laid down by the Constitution. This does however mean that the President has no authority to limit citizens' fundamental rights. Acting in violation of the provisions laid down by the emergency ordinance is punishable under Article 443 Sr. The chairmen have no discretion as to policy and must follow the instructions of the minister.

59. The emergency ordinances issued by the safety regions on the basis of which the current measures are being implemented are based on the Model Emergency Regulation COVID-19 of 26 May 2020. Although the Minister has submitted a bill under the Extraordinary Powers Act to give legal basis to specific emergency provisions, to date this is not yet in force. This legislative proposal will be discussed below. The law allows separate emergency provisions to be triggered without declaring a general or limited state of emergency. However, on the basis of this power, fundamental rights may be restricted as set out in Article 103(2) of the Constitution, if the conditions set for this have been met. (Appendix 29: Model emergency regulation COVID-19 designation of 26 May 2020)

60. The relevant emergency ordinance with all measures taken is in the original .pdf in Dutch on pages 13 to 19, in italics.

Assessment framework for violations of the ECHR and fundamental rights

61. The measures included in the emergency ordinance constitute far-reaching restrictions on the exercise of numerous freedoms and rights contained in human rights treaties and the Constitution. For example, church services were limited in terms of numbers, but the right to association, meeting and demonstration was also severely limited. Here the question of which criteria must be met in order to deviate from these fundamental rights in an exceptional situation will be addressed.

62. According to the presidents of the security regions, the measures were also to apply in domestic situations. Practice showed that even in private and domestic situations, the injunction against social interaction was enforced. This is an outright violation of the constitutionally protected right to privacy and house law. Other fundamental rights affected by the emergency ordinances are the freedom to enjoy one's property undisturbed. The right to education is guaranteed, inter alia, in the First Protocol to the ECHR of 20 March 1952. The right to work and to exercise a liberal profession is protected in Article 12 of the ECHR and the European Charter and this right has been severely restricted by the measures.

63. In view of the unclear drafting of the provisions in the Regulations, the principle of legality set out in Article 16 of the Constitution and Article 7 of the ECHR, has also been violated. (15)

(15). A.J. Wierenga en J.G. Brouwer: “Coronacrisis en het Recht”: Centrum voor openbare Orde en Veiligheid: 2020

64. It is problematic that the restrictions are currently regulated by emergency regulations issued by the chairmen of the security regions. Article 176 of the Municipalities Act stipulates that only rules other than those laid down in the Constitution may be deviated from. Article 103 paragraph 2 of the Constitution determines which fundamental rights can be deviated from in an exceptional situation. The right to association and demonstration, for example, may not be waived. The Constitution requires a fully elaborated basis for such deviation from Parliament. Certainly now that the enforcement of the measures has been extended, these restrictions should be regulated by emergency law on the basis of the Act Extraordinary Powers of Civil Authority (Wbbbg). (16)

(16) A.J. Wierenga en J.G. Brouwer: “Coronacrisis en het Recht”: Centrum voor openbare Orde en Veiligheid: 2020

65. In situations where there is conflict with constitutional rights, it may be defensible to consider that the protection of the population outweighs these rights. This is a trade-off which can only be made in specific disaster situations where the life and health of many persons have been seriously harmed or threatened. However, the European Court of Human Rights

offers some leeway: “It falls in the first place to each Contracting State, with its responsibility for "the life of [its] nation", to determine whether that life is threatened by a "public emergency" and, if so, how far it is necessary to go in attempting to overcome the emergency. By reason of their direct and continuous contact with the pressing needs of the moment, the national authorities are in principle in a better position than the international judge to decide both on the presence of such an emergency and on the nature and scope of derogations necessary to avert it. In this matter Article 15 § 1 (...) leaves those authorities a *wide margin of appreciation*.” (17)

(17) Ireland v.UK Judgment of 18.01.1978, Series A No 25, para 207.

66. The ECHR does however set very strict parameters to this *margin of appreciation.* Any curtailment of the rights guaranteed by the treaty under Article 15 of the ECHR *must have a clear basis in domestic law in order to protect against arbitrariness and must be strictly necessary to combat the public emergency*. The ECHR further states the following restrictions: The main purpose of the state of emergency regime (or similar) is to contain the development of the crisis and *return, as quickly as possible, to normality*. (18) The principle of necessity requires that emergency measures *must be capable of achieving their purpose with minimal alteration of normal rules and procedures of democratic decision-making.* (19)

(18) Experience shows that “the longer the emergency regime lasts, the further the state is likely to move away from the objective criteria that may have validated the use of emergency powers in the first place. The longer the situation persists, the lesser justification there is for treating a situation as exceptional in nature with the consequence that it cannot be addressed by application of normal legal tools.” - The Venice Commission, Turkey - Opinion on Emergency Decree Laws N°s667-676 adopted following the failed coup of 15 July 2016, CDLAD (2016) 037, para. 41
(19) The principle of necessity is not referred directly in the context of the institutional emergency measures, but may be derived from the requirement of proportionality and necessity of the emergency measures in the field of human rights

67. The use of measures to limit fundamental rights can therefore only take

place in the case of very exceptional circumstances and where this is strictly necessary to maintain external or internal safety. Exceptional circumstances exist when there are actual events that necessitate the application of emergency powers but the law that these powers require is lacking.

68. To determine whether the measures in force can withstand the test of the ECHR, the following questions should be answered:
a.How does decision-making take place?
b.What is the purpose of the measures?
c.Are the measures suitable for achieving the goal?
d.Are there less drastic means available to achieve this goal?
e.Are the measures proportional or is the remedy worse than the disease?

Poor decision-making

Preface
69. The decision-making process has been so flawed that, given the grave consequences of its policy, unlawful conduct has occurred. Not only does the policy offer no prospect of an end to this exceptional situation but decisions are also currently being taken by the OMT and not by those designated for the task. Furthermore, the lack of transparency in the decision-making process is of major concern. Due to the lack of an open scientific debate and the reliance on experts rather than on a 'science-driven' approach, it is questionable whether the policy is based on the best advice and information. The OMT has also based some of its decisions on questionable studies, models, data and inappropriate PCR tests such that it is currently not even possible to determine whether the virus is still in the Netherlands. Finally, there is a lack of culpability where the lessons learned during the 2009 Mexican flu appear to have disappeared from memory. The main characters who were responsible at the time for major policy errors, have repeated these superlatively. As will be seen below, this policy is so flawed that in the interest of the population this situation should be terminated immediately.

The policy is open-ended
70. In a situation where the freedom and rights of millions of citizens have been seriously curtailed, every effort should be made to bring this situation to an end as soon as possible. This is a longstanding condition in the case

law of the ECHR which this policy does not seem prepared to do.

71. What is noticeable about the statements by the Prime Minister is that he gives no indication as to when this disastrous situation could end. Reading the transcript of the press conferences, his announcements are filled with open-ended uncertainties. The rationale for these decisions is limited to the statement that *the experts here have looked very carefully at the situation and there is really no other way to act*. There is no clear prospect of an end to the policy, and no clear criteria on how to achieve this.

72. Insofar as criteria are mentioned, they are not permanent either. With every successive advisory, the criteria are changed, supplemented or modified without further explanation. For some time now, the Dutch population has been told that the reproduction number R0 should be below 1 before the measures could be lifted. In retrospect, it turned out that this number had already been achieved on March 16. Nevertheless, the measures have not been lifted. After that, the number of occupied IC beds had to drop below 700 before the measures could be lifted. At the moment this number is below 50, but no prospects are given for an end to an unsustainable situation that is destroying the Dutch economy at a terrifying pace.

73. Additionally, completely unrealistic criteria that have no place in a situation which must be terminated urgently, have been set. The OMT has repeatedly stated that first there must be an app. The minister and the OMT have repeatedly stated that a vaccine has to be available before there could be any normality. These are criteria which allow an unlimited continuation of this situation.

74. Minister De Jonge submitted the Temporary Act on Covid-19 Measures to the Second Chamber. This Act gives the Minister of Health powers to substantially curtail fundamental rights in order to combat the virus. The "New Normal" law will enter into force in July 2020. The law aims to give the COVID-19 measures laid down in emergency ordinances a legal basis and a more definite character. The law is as yet valid for one year, but offers the possibility of extending this by two months. It is therefore clear that the minister wishes to turn an exceptional situation into a permanent normality which is contrary to the criteria formulated by the

ECHR. (Appendix 30: Bill Temporary Act COVID-19)

OMT rules the country
A second essential flaw in decision-making is that the government has blindly followed the advice of the OMT. The OMT is a group of physicians and virologists without democratic legitimation. Virologists can make predictions with models, but the onus is on politicians to make a balanced assessment of which an expert opinion forms but one part. A doctor or a virologist will weigh things up completely differently to how a policymaker would. For example, a doctor would use the policy to immediately prohibit motorcycles as a means of transport. A policymaker must consider the consequences of such a decision and to weigh up efficiency, proportionality and subsidiarity. A manager cannot hide the decision-making process behind expert opinion. The country is currently being governed by the OMT where policymakers are no longer accountable for their decisions.

Lack of transparency
Another major issue is the lack of transparency in the advisory statements produced by the OMT. The models and data used by the OMT are kept secret. This means that decision-making cannot be confirmed. Within the scientific community, there are major objections to this lack of transparency. These scientists would like to test the statistical models used to justify the policy and according to them, there is no scientific basis for any of the measures taken. There are no footnotes to the advisory statements indicating any scientific basis. There is also criticism of the way in which and the basis on which the experts of the OMT were selected. The public outcry of despair by scientists has so far been ignored. Scientists are also appalled at the lack of discussion of these shortcomings in decision making by the media. According to Eric Jan Wagenmakers, professor of methodology at the University of Amsterdam, the OMT does not do science but politics. (Appendix 31: article Nieuwsuur 8 May 2020, “Scientists criticize the lack of openness in corona advice”, appendix 32: NRC Opinion April 9, 2020, "Use us to ward off the crisis")

Not science-driven but agenda-driven
75. The Prime Minister regularly states that his decisions are science-driven, that they are based on the result of scientific data. According to Cees Hemeling, emeritus professor of Communications Science at the

University of Amsterdam, science and political policy making are two different worlds. Where politics asks for quick answers, science is seldom unambiguous. The current policy is according to him based on advice from experts who may have academic degrees or have university positions, but are not scientists. Experts operate in a grey area between politics and science. According to him, experts are not kept awake by the expected death toll, based on the Imperial College model, dropping from 500,000 to 1,600 within a month. This would cause a scientist sleepless nights however. Decision-making is therefore not science-driven. (Appendix 33: de Volkskrant "Do not abuse science for corona politics")

Lack of scientific debate

Not only is there no scientific debate due to the lack of transparency but more seriously, a debate has been made impossible due to the views of the OMT monopolising any debate. Scientists asking legitimate questions on the policiy barely get exposure in the mainstream media. When they do get noticed, they become the target of defamation campaigns and public scorn. This is a direct consequence of the WHO-coordinated approach to *misinformation*. Opinions which deviate from that of the WHO are defused with *counter information*. This has led to an atmosphere of fear in which an openly critical question can lead to character assassination. It is understandable that many scientists prefer to keep a low profile.

Questions about reliability of models

76. Furthermore, it appears that the estimates of the OMT are based on models with significant statistical inaccuracy, as a result of which it is not possible to determine the magnitude of the problem or whether the measures are useful or necessary at all.

77. The estimates by Neil Ferguson of Imperial College London that launched the draconian measures in many countries, are illustrative of this statistical failure. Armageddon was predicted by Ferguson if governments did not adopt far-reaching measures. For example, the death toll in the United Kingdom would reach 500,000 and the United States should expect more than 2.3 million victims. Shortly after, Ferguson corrected his estimates, adjusting the number of deaths for the UK to 20,000 by the end of the year, half of which would have died by the end of the year without COVID-19. Ferguson has since left his position at Imperial College.

78. It is also striking that nowhere in the advice is there an evaluation of what an alternative scenario, without these measures would look like. How many more deaths are to be expected as a result of COVID-19 if the measures are terminated? Which *infection fatality rate* (IFR) is assumed by the OMT? Nobody knows. The comments in the opinion of 20 April 2020 leave much to be desired in this regard: "*There is still much uncertainty about the characteristics of the coronavirus and the effect of the measures to prevent the spread. Knowledge necessary for scientific support for the interventions is largely lacking. It is not possible to draw up a strategy based on scientific evidence to reopen society without this leading to a possibly uncontrollable spread of the virus.*"

79. This passage actually states that the OMT is a pilot trying to fly a plane with a blindfold on and with the politicians responsible as passengers. It becomes quite obvious that policymakers are using the incorrect starting point for their decision-making. If there is no scientific evidence for the effectiveness of the measures taken, there is no justification for the prolonging of the measures. This statement makes it clear that, on the contrary, there is no justification for the measures. This is the world turned upside down. It is not just the lifting of measures which requires scientific substantiation but the *measures* themselves.

80. This is all the more relevant in those countries where little to no action was taken, yet the predicted disaster failed to arrive. The strongest evidence of the inaccuracy of the models used is in the case of Sweden. H. Sjödin of the Umea University predicted that the demand for IC capacity in Sweden would exceed the available IC capacity by a factor of 30. (20) Researcher J. Gardner of Uppsala University made an even more dramatic prediction that the situation in Sweden would get completely out of hand in early May with demand for IC capacity higher than availability by a factor of 40. (21) The Swedish government however kept a cool head and refused to act on international pressure to change its policy. Swedish society did not shut down.

(20)https://www.researchgate.net/publication/340060554_COVID19_healthcare_demand_and_mortality_in_Sweden_in_response_to_non-pharmaceutical_NPIs_mitigation_and_suppression_scenarios
(21)https://www.researchgate.net/publication/340060554_COVID19_healthcare_demand_and_mortality_in_Sweden_in_response_to_non-

pharmaceutical_NPIs_mitigation_and_suppression_scenarios

81. The media warning that Sweden would now be penalised for this policy lacked any factual basis. This reluctant choice appears to have been the only correct one and is now praised as exemplary by WHO. The 82,000 predicted deaths have failed to materialize. In fact, mortality rates in Sweden are no higher than European countries where draconian lockdown measures applied. (Appendix 34: Article The Spectator May 12, 2020: “Can we trust Covid modelling? More evidence from Sweden”, appendix 35: WHO Official: Sweden's Policy of Individual Responsibility “a Model” for the Rest of the World)

82. Sweden limited its measures to avoiding large gatherings. For the rest, daily life has continued. Nothing indicates that the OMT has taken note of these incorrect assessments and practical experience. On the contrary, the OMT has used the inaccuracy of predictions to argue for the extension of the restrictions on the grounds that *it is too early to remove the infection prevention measures*. "Hold on" is the message while the Netherlands and the rest of Europe are plunged into an unprecedented humanitarian and economic crisis on the grounds of yet-to-materialise doomsday scenarios. If a decision to restrict freedom is not properly substantiated with scientific evidence, it is unlawful.

Underlying OMT recommendations are unreliable and incomplete
83. Another major shortcoming is the lack of data in support of the policy. In order to determine whether and which measures are necessary, the situation must first be assessed with regard to the degree of distribution among the population. This is only possible with representative serology samples to determine the percentage of the population that has developed antibodies against the virus.

84. Representative sampling should have been carried out. This did not happen which makes the OMT advice by definition unusable. (22) This view is shared by leading scientists such as Prof. John P.A. Ioannidis from Stanford University. On March 17, 2020 - a day after the measures took effect - he already warned in an article that this was a fiasco in the making. According to him, there was insufficient evidence to decide on rigid measures. (23)

(22) Wolfgang Knut Wittkowski, Head, Biostatistics, Epidemiology, and Research Design, Center for Clinical & Translational Science, KenFM 29 april 2020
(23) John P.A. Ioannidis, March 17, 2020, “A Fiasco in the Making? As the coronavirus pandemic has taken hold, we are making decisions without reliable data”

85. As will be explained in detail below, according to renowned scientists it is only on the basis of reliable data that an impression can be obtained of the actual IFR and the number of IC places required. Despite an announcement on the 6 April 2020 that a capacity of 30 to 50,000 tests per day was available, nothing further on that front has been heard. Neither the OMT nor the policymakers have shown any intention of creating a foundation in the shortest possible term for the necessity of the measures that have now been in force for months.

86. The only representative serological study is the Pienter Corona study in which 6,000 people participated. On April 22, 2020, Jaap van Dissel gave an extensive briefing on the course of the COVID-19 epidemic on behalf of RIVM. (24) This information was the basis for the decision to extend the disastrous measures for another month. Van Dissel informed the House that the RIVM's Pienter Corona investigation had shown that the spread of the virus in the population is 3.6%. This statistic is debatable.

(24)https://www.tweedekamer.nl/sites/default/files/atoms/files/20200422_technische_briefing_jaap_van_dissel_rivm_22_april.pdf

87. An important yardstick for the course of an epidemic is the development of immunity in the population. In his briefings to the House of Representatives, Van Dissel regularly emphasised that this information was of great importance in determining how long the measures should remain in effect. Serological research – ie the testing of blood samples - can determine the proportion of the population that has been infected with the virus.

88. According to Van Dissel, an investigation by the RIVM, the Pienter Corona investigation, has examined 2,096 blood samples since 17 April. (25) The RIVM website claims that this is a representative sample of the Dutch population. The study showed that 3.6% of the population had

antibodies in the blood. (26) This was striking because the serological research carried out by the Sanquin blood bank on the basis of samples taken between 1 and 15 April came to an identical result. This case, however, was not a representative sample because all donors with symptoms were excluded from the study.

(25) https://www.rivm.nl/en/news/rivm-launches-study-on-coronavirus-herd-immunity
(26) https://nos.nl/collectie/13824/artikel/2329623-eerste-onderdelen-over-opbouw-immuniteit-tegen-corona-komst-weken-verwacht

89. Despite the difference in sample composition, it is of course entirely possible that both studies generated an identical result, but this is not plausible. Or has Van Dissel perhaps presented the results of the Sanquin study as the results of the Pienter Corona study? In that case, the House would have been misinformed or possibly even misled. However, RIVM has so far refused to publish the Pienter Corona survey, so that this suspicion cannot be confirmed. (27)

(27)https://www.sanquin.nl/over-sanquin/nieuws/2020/04/sanquin-ongeveer-3-van-donors-heeft-corona-antistoffen

90. The focus on the daily numbers of infected persons is also misleading, as shown in the graph below. The table suggests a momentum to the virus which is not actually present.

(Please see original document for table on number of persons testing positive in week 19 2020, page 25)

91. The daily reports of the numbers of people testing positive do not contain any indication of the *total number of tests performed*. The intensity of testing directly determines the number of positive tests, which gives no indication about the actual course of the epidemic. The mainstream media are in lockstep, with every headline focusing only on the number of newly confirmed infected persons.

92. In addition, the OMT has amended the testing policy so many times that the course of the epidemic can no longer be followed. Where previously only individuals who were hospitalised were tested, this was

later extended to include everyone who had flu-like symptoms. This resulted in a sudden increase in positive test results while in fact the rate of infection was decreasing.

The PCR test used is unreliable
93. The presence of the virus is determined by the PCR test. The tests used are however, unreliable and only suitable as a screening tool for the population and not for individual diagnosis. Various scientific studies previously warned against this inaccuracy. These studies have clearly shown that in about 3% of cases the PCR test *produces a false positive.* (28, 29, 30)

(28)https://www.medrxiv.org/content/10.1101/2020.04.26.20080911v2.article-info
(29)https://www.mta-dialog.de/artikel/warnung-vor-so-genannten-schnelltests-zum-nachweis-des-coronavirus.html
(30) coronavirus.htmlhttps: //www.youtube.com/watch? V = xy6VLvnl-LE & feature = youtu.be

94. In the meantime, an extensive study has recently been published by the Deutsche Akkreditierungsstelle, which is comparable to the TNO in the Netherlands. The reliability of a variety of PCR tests, from a large number of manufacturers, was analysed. The numbers we are showered with each day come from this research. The RIVM counts every positive test as an infection with the virus. But according to the renowned German research institute, the PCR gives *a false positive* result for harmless cold viruses.

95. In this study, in addition to actual COVID-19 samples, two harmless coronaviruses and a placebo were added to the sample. The result is shocking. One of the harmless cold viruses tested positive for COVID-19 in 7.6% of cases. The placebo samples gave a positive test result in 1.4% of cases. The test kits were from different manufacturers. The reliability appears to be very variable. The test kits from one manufacturer even gave up to 50% false positive test results.

96. Since RIVM considers each positive test as a new infection case of COVID-19, there is no room for reservations in the daily reporting on new infections. The Netherlands is testing more people than ever before, so it seems as if the rate of infection is increasing by 150 to 250 daily. If this is

offset against the average of 9,000 tests per day, these numbers are well within the margins of error established by the German researchers.

97. By publishing these test results without analysis of the results, the RIVM is practising deception. In reality, RIVM simply cannot prove that the COVID-19 virus is still currently in the Netherlands at all and as a consequence there is no justification for any of the measures taken. (Appendix 36: Research PRC test Deutsche Akkreditierungsstelle, appendix 37: explanation of the consequences of the reliability of the test "Testing, testing, testing")

No learning from previous experience

98. Learning from previous experience is integral to sound decision-making. Policy errors are evaluated and form part of decision-making strategy. In this crisis, however, previous experiences seems forgotten or deleted from history. The parallels with the Mexican flu of more than ten years ago are truly shocking. The progress of the virus, the decisions taken at various points, the main players and the role of the media are virtually identical. Even the focus on only one possible solution, namely a vaccine, repeats the same policy applied to the Mexican flu, a policy which today is regarded as failed policy. In this collection of newspaper articles it becomes clear just how similar the situation was to the COVID19 crisis of today. (Appendix 38: newspaper articles 2009 ff.)

99. After the initial phase of the Mexican flu, the WHO declared the outbreak of the virus to be a pandemic on 11 July 2009. This was possible because in April 2009 for reasons unknown, the definition of "pandemic" was changed. Mortality, the most obvious criterion for determining whether a virus was dangerous, had been deleted without any explanation. Since this change to the definition in 2009, *the rate at which a virus spreads, known as its 'virility'*, is sufficient to declare a pandemic. The declaration of a pandemic caused consternation, concern and general panic then and the same is happening today. The VPRO radio program Argos devoted a series of broadcasts to the striking course of events surrounding the Mexican flu. (31)

(31) https://www.vpro.nl/argos/speel~POMS_VPRO_345446~osterhaus-of-osterhype-argos~.html

100. These broadcasts have repeatedly led to parliamentary questions that in the light of the present situation deserve extra attention: (32) *"Questions from the member Gerbrands (PVV) to the Minister of Public Health, Welfare and Sport on the sponsored swine flu pandemic (submitted November 22, 2010).*

Answer given by Minister Schippers (Health, Welfare and Sport) (received December 17 2010).

Question 1: Are you familiar with the message "The sponsored swine flu pandemic"? Answer 1: Yes.

Question 2 and 3: What is your response to the fact that the pandemic definition was changed by WHO shortly before the outbreak of swine flu? Do you share the observation that without the change of that definition there would be no pandemic and that the Netherlands could have sufficed with purchasing far fewer vaccines?
Answer 2 and 3: The 2005 International Health Regulations (IHR) are currently being evaluated. The outbreak of swine flu is the most important case. The results of this evaluation will be reported to the World Health Assembly (WHA) in May 2011. The Evaluation will also address the confusion that has arisen around the definition as well as the effect of the use of the term pandemic on public image.
The fact that the WHO declared phase 6 was not the direct reason for the Netherlands to take the decision to purchase vaccines. When the decision to purchase the vaccine was made, there was an uncertain situation where action had to be taken quickly. On May 8, 2009 the Health Council had issued an opinion on vaccination against swine flu. The Health Council found that there was insufficient data for a full evaluation of the epidemiological situation. In addition, there was still a risk that the virus, while perhaps still mild at the time, would mutate to a more pathogenic strain as it spread throughout the world. If we had waited longer, the vaccines would probably have been delivered late, or an order would no longer be possible at all. This was due to the required production time and the expected large global demand for this vaccine. It was therefore necessary to act on the basis of a risk assessment, knowing that there was a real chance that the vaccines would not have to be used other than for the known risk groups.

Question 4 Do you share the opinion that experts whose interests coincide with those of the pharmaceutical industry should not participate in the development of definitions and guidelines?
Answer 4: This must be assessed on a case-by-case basis. Having interests does not automatically mean a conflict of interest. Full industry independence is not possible and to my opinion also undesirable. There are areas in which public research funding is not appropriate yet excellent research is well-supported in these areas. It would be unwise not to use the knowledge of relevant top scientists. I think it is important that full transparency is exercised. In addition, it is important that an organisation responsible for the definitions and guidelines, applies procedures to guarantee independent advice. For example, the Health Council has a comprehensive set of safeguards to avoid conflicts of interest in its Committees (see also the answer to question 5).”

(32) Parliamentary Papers 2010/2011, acts Appendix 845

101. Policy-makers wanted to vaccinate the entire population as soon as possible and ordered two doses per inhabitant to be on the safe side. These hasty orders followed after the current protagonists Jaap van Dissel, Ab Osterhaus, but also current OMT member Marion Koopmans, took every opportunity to emphasize in the media *that the virus was dangerous and would never leave.* A vaccine was according to these experts necessary because *the virus mutated in such a way that the population was unable to produce antibodies.* These are identical claims that are also being made daily in the COVID-19 crisis by the same protagonists as in 2009.

102. In Europe, more than two billion euros in public money has been spent on useless vaccines. Although the then health minister Ad Klink emphasised that at the time the vaccine was completely safe, serious side effects were subsequently reported. In 2018, two years ago, after years of litigation, the government reached a settlement with the victims of the vaccine.

103. The media's role in the outbreak of Mexican flu was investigated by WODC. (33) Here too, the parallels with the COVID-19 crisis are so interesting that an extensive quote is appropriate: “*(...) but with regard to the social mission of journalism, the media have fallen far short of fulfilling this responsibility. In the first phase, people allowed themselves*

to be carried away in what could be called excitement brought about by the catastrophic of a pandemic which had been warned about for years. As the study shows, Ab Osterhaus was quite dominant in the media with a very disturbing story which emphasised the elevated risk of a very disruptive pandemic. Osterhaus did not speak on behalf of the government although the television viewer may have got that impression. As a scientist, he did not have to answer to anyone for his statements. That the media chose the best known virologist in the Netherlands is understandable, but it does mean that he shaped public perception. The question is whether, from the government's perspective, this was the desired message or were there other options available whereby the government maintained control of the narrative

But then the mood suddenly changed: the reason for this was the "Osterhaus affair" in which Osterhaus was accused of spreading panic and having conflict of interest. After first being given free rein, for months, aside from a single critical interview, he suddenly ended up in the dock despite none of the allegations being substantiated. The affair blew over quickly, although it did cause the media to investigate the links between science and the pharmaceutical industry more thoroughly. For example, the VPRO television programme 'Argos15', broadcast in April 2010, explored the theory that the industry had influenced changes to what constituted a pandemic. That some experts who advised the WHO on the pandemic also worked for pharmaceutical companies and had not done independent research, was later confirmed by British investigative journalists in association with the British Medical Journal (16). In addition, the government lowered the risk estimate for the flu in August, which of course had a de-escalating effect. The question is whether the government took the measures in June as a result of being influenced by the alarming media reports about the upcoming pandemic. In a statement to the British House of Commons(March 2, 2011), the Science and Technology Committee (17) declared that the worst-case scenarios, although of interest to organizations that need to prepare for emergencies, lead to sensationalist media coverage and to unnecessary distress for the population. The committee therefore argued for an emphasis on communicating the most probable scenario. Moreover, the committee recommended that a new virus should be assessed in the context of the annual flu and should not be treated as a pandemic."

(33) https://www.wodc.nl/binaries/volledige-tekst_tcm28-71937.pdf, p.47

104. In retrospect, despite the presence of the Mexican flu virus, it was a very mild flu season with the lowest number of flu deaths in years. In the Netherlands 56 people died. The question is how it is possible that the errors made in the 2009 Mexican flu crisis, errors made by the same experts and partly the same ministers have been repeated with even more gusto? Whether this is about political incompetence or whether there is another explanation, is irrelevant for the conclusion. Ignoring previous experiences with the Mexican flu has resulted in flawed decision-making and on these grounds alone, all lockdown measures should be terminated forthwith.

One-sided focus on physical health

105. Policy makers have unambiguously communicated from the outset that the decision-making primarily focuses on public health. All measures have but one goal, which is to prevent infections. Based on government statements society as a whole has been disrupted for the sole purpose of physical health. This policy choice is the result of a misconception. The concept of health has been modified and adapted by WHO since the 1950s. In 1972 the article *Quantitative Approach to the World Health Organization Definition of Health: Physical, Mental and Social Well-being* was published. The concept of health is described as an inseparable trinity of physical, mental and social health:

"Our concept and measurement of health has generally focused on ill health. This focus on pathology probably arose from the fact that for most of human existence the health challenge facing society, and medicine in particular, has been overcoming disease. By mid-twentieth century, however, already for some of mankind and hopefully soon for the rest, the health picture had changed — people as a whole were not disease-ridden and ideas of so-called positive health emerged. This emboldened the WHO to define health in a new way as "physical, mental and social well-being, not merely the absence of disease or infirmity". (34)

(34) International Journal of Epidemiology, Volume 1, Issue 4, WINTER 1972, Pages 347–355, https://doi.org/10.1093/ije/1.4.347

106. A policy that focuses exclusively on physical health, especially if this

has been going on for months, raises serious ethical concerns with regard to the disastrous consequences that are slowly becoming visible. The measures to prevent infections, such as *social distancing*, isolation, prohibiting group formation, forced detention in nursing homes and large-scale closures of schools, businesses and other establishments have caused serious damage to the social and mental well-being of the population. The policy choice is therefore not justifiable.

Conclusion

107. It follows from the above that the decision-making regarding the measures is unsound: Policy makers hide behind their advice so that the OMT has effectively taken over the government of the country;
The decision-making is opaque and uncontrollable;
Scientific debate is lacking due to a lack of transparency and unilateral media reporting so that decisions are taken with one-sided lighting;
The decision-making is not science-driven;
The recommendations of the OMT are not verifiable, unsubstantiated and unreliable;
Underlying figures in support of the OMT advisory were unreliable and incomplete;
There was no scientific basis for the measures;
Past experience of an identical situation with the Mexican flu in 2009 were excluded from decision making;
The PCR test used is unreliable so policies are being made without being able to prove that the virus is still present;
The policy focuses on the physical aspect of health and ignores mental and social health.

108. Apparently a curious dynamic has arisen in which arbitrary measures from the grab bag are used, without being substantiated, to determine policy. The answer to the question about what knowledge policymakers had when announcing the measures on 16 March 2020, and whether this course of action was justified at the time, falls outside the scope of this indictment. Such questions can be addressed at a later time in a parliamentary inquiry and possibly a criminal investigation. This indictment is only interested, given the knowledge currently available, in the fact that the continuation of the measures cannot be justified and that these must be terminated immediately.

109. Now that it appears that the decision-making process is unsustainable in law, we will discuss in more detail below the other three conditions set by the ECHR, namely the purpose, effectiveness of the resources used and proportionality.

What is the purpose of the measures?

110. The objectives behind the measures have been adjusted or changed several times without further explanation over the course of the lockdown. In the advisory of March 15, 2020, *maintenance of good care for the seriously ill, for people with coronavirus infections and for other vulnerable groups* was the aim of the measures. In the Prime Minister's first speech the gradual achievement of group immunity was given as justification for the measures.

111. On 3 April 2020, a three-pillar transition strategy was presented, namely the determination of an acceptable burden on the ICs and hospital care over a longer period, optimizing the detection of coronavirus infections from contact detection and contact notification and protection of vulnerable groups in society. With these goals no concrete criteria have been set.

112. It is noteworthy that the OMT has included the second point in its advice. With that,the continuation of the measures was made conditional on the availability of a suitable app. OMT then issued follow-up advice on 20 April 2020. The objective now is also to prevent the virus from spreading among vulnerable persons and to prevent the healthcare system from being overloaded. The IC occupation was expected to be reduced to 700 beds around 1 May 2020. In addition, the harmful effects of the measures for the population and society must be limited as much as possible and there should be broad support among the population.

113. On the basis of the advice of 4 May 2020, the Minister would send a letter to the Chamber with an update on the state of affairs. According to the minister, there have been good results achieved since March and the number of new infections and hospital admissions was tapering off. However, according to the minister, we are only at the beginning of the next phase in combating the outbreak in which work is progressively

progressed to the control phase. This must be done, according to the minister, in a responsible way because the chance of a second outbreak is real is we don't act carefully enough. According to the minister, this is a joint search for a responsible path *until we have an effective vaccine.*

114. The control phase is anchored on three principles, namely ensuring that the healthcare system can manage, that the vulnerable in society are protected and gaining more insight into the spread of the virus. To be well prepared for the next phase, "the new normal", there will be clear frameworks from the government, according to the Minister, and good agreements with society are needed. Only then will it be possible, according to the minister, to lift the measures step by step, and for social and economic activities to restart as much as possible.

115. What is striking about the stated goals is that the removal of fundamental human rights is not a priority. There is talk of a transition phase in which the freedom restrictions will remain in force. In this phase, the entire population will be intensively monitored with a comprehensive surveillance system. The minister describes this in a comprehensive letter. (35) Such a system would have been unthinkable three months ago. That the implementation of such a system is now a reality is a major cause for concern.

(35)https://www.rijksoverheid.nl/documenten/kameronderdelen/2020/05/20/kamerbrief-stand-van-zaken-covid-19

116. What is also striking is that none of the stated goals is directly aimed at preventing deaths. Preventing overloading of care implies this, but there are no estimates of the number of lives that could be saved with the meanwhile hundreds of billions of measures. It seems that preventing the overloading of the healthcare system has become a goal in itself. This while every year the system is completely overloaded by a flu epidemic.

117. Professor of virology Hendrik Streeck, director of the leading Institute for Virology and HIV research at the Medical Faculty of Bonn, also finds it striking that the capacity in health care is "*now suddenly the main issue. No such measures have ever been taken with other infections.*" (36) In Germany, the same argument was used to justify custodial measures while at the height of the epidemic 10,000 IC beds were unused

(sic!). Similarly, during the flu wave in 2017/18, no such measures were taken. The website of the RIVM states the following on the flu wave of 2017/2018: (37) "*In the winter of 2017/2018, the flu epidemic lasted 18 weeks. That is longer than the average of the past 20 years (nine weeks). In total between October 2017 and May 2018, approximately 900,000 people fell ill with the flu virus. An estimated 340,000 people visited the GP with flu-like complaints. In addition, hospitals were temporarily overloaded by the many patients who were there because of complications from flu (usually pneumonia) and had to be included, estimated at over 16,000. 9,500 more people died during the epidemic than was usual in the flu season (October to May)*."

(36) Virologist Streeck: Marcus Lanz on April 1, 2020, https://www.youtube.com/watch?v=VP7La2bkOMo
(37) https://www.rivm.nl/publicaties/annual-report-surveillance-of-influenza-and-other-respiratory-infections-winter

118. With regard to the influenza mortality in 2017/2018, it should also be noted that the excess mortality was not 9,500 but 12,000. The former excess mortality concerns the excess mortality *compared to the annual normal influenza mortality of 2,500*. The hospital admissions and deaths connected to corona, mostly with complications like pneumonia, are significantly lower than reported in the 15-week COVID-19 pandemic (as of May 25, 2020): (38)

Hospital admissions 11,492
Deceased persons 5,830

(38) https://www.rivm.nl/coronavirus-covid-19/actueel

119. Prominent epidemiologist Wolfgang Knut Wittkowski, head of *Biostatistics, Epidemiology, and Research Design, Center for Clinical & Translational Science*, wonders whether hospitals were actually overloaded during the COVID-19 pandemic. According to him, there may have been local bottlenecks which the media paid disproportionate attention to. Even the hospitals in New York – the residence of Wittkowski - have not been full. This while in the media only a one-sided image of disaster has been brought out. Staff have even been sent home in New York because there

was no work.

120. This has also been the case in Germany, where hospitals have a maximum of 60% occupation. For COVID-19 it is characteristic that there is a high peak and the virus thereafter disappears. This is the case with all *respiratory viruses*. Humanity has survived this according to Wittkowski for the last hundred thousand years.

121. Also in the Netherlands, IC staff and scientists do not recognize themselves in the message from the media and politics that hospitals have been more heavily burdened than during the annual flu wave. Erwin Kompanje, medical philosopher, clinical ethicist and associate professor at the Erasmus Medical Center said the following: (39)
"*What we saw in the hospital, in the last two months without exception, was a whole selection of the ones we actually saw before with influenza. I have a lot of interns and intensive care nurses and they said: these are the same patients who we see with flu every year, every winter. And this is actually exact the same."*

(39) https://www.youtube.com/watch?v=RKaT69GNBzA

122. It is striking that the experiences of the people working on the ICs do not match the message of politicians and the media. The need for draconian measures so that the healthcare system is not overloaded, is not borne out by the figures.

123. Based on the figures, the COVID-19 epidemic can be classified as *mild to moderate*. This is taken from the National Security Profile 2016 which gives this category 40 to 50,000 hospitalisations and 14,000 deaths. The current pandemic falls within the scope of the basic scenario outlined, which assumes 18,000 hospital admissions and 7,000 deaths. In the national security profile, the Spanish Flu in 1918-1919 is with 20,000 deaths cited as an example of a pandemic. The estimated cost in the case of a serious epidemic is up to EUR 5 billion. The budget deficit due to the current pandemic is according to cautious estimates 92 billion euros but this is widely expected to be higher. This is not counting the economic and social damage that is almost incalculable. Even if this were a serious pandemic, the current measures are not justified. (Appendix 38: National Security Profile 2016)

124. The policy strives at all costs to avoid a (possible) overload of the healthcare system, but compared to the price to be paid, this is a monstrous endeavor with surrealistic features. This also applies to the link made by the OMT and various policymakers between the availability of a vaccination and a working tracking app for the entire population and ending the measures. These two conditions suggest that the policy pursued is not the result of one's own considerations, but that a WHO guideline has been meticulously ticked off.

125. The objectives and formulations in the OMT's recommendations correspond to the scenario recommended in the policy document for the transition phase "*Strengthening and adjusting public health measures throughout the COVID-19 transition phase*", which was released on 24 April 2020. The following is on p. 6:

"*Managing the transition phase effectively will depend on finding the best equilibrium between modulating restrictive large-scale public health interventions, such as identifying, isolation, testing and caring for all cases, and tracing and quarantining all contacts together with personal protective measures (hand hygiene and respitory etiquette) and individual physical distancing (> 1 meter distance). (...)*

Measures must be eased in an incremental, step-wise manner leaving sufficient time (around 2 weeks) to elapse for the true impact of the easing becomes visible. The time interval between relaxation of two measures depends largely on the quality of the surveillance system and capacity to measure the effect.

Transition is likely to be a bidirectional process and countries must be ready to constantly monitor, adjust, move forward and quickly reverse processes depending on the disease transmission patterns and how they change as a result of the shifts in restrictive measures as well the manner in which people react to the easing of the restrictions. It is extremely important to emphasize that in practice, risk will depend very much on people's interaction, behavior and cultural or living arrangements.

Due consideration should be given to progressive easing. When deciding which measures should be reversed first, modelling suggests that lower

risk activities could include use of public spaces and people allowed of their home but still keeping distance (> 1 meter distance) while higher risk activities could include opening restaurants, schools, non-essential retail and some small gatherings.

Until a vaccine is made available, individual physical distancing (e.g.> 1 meter distance), hand hygiene measures must continue to play an important role, even as large-scale restrictive measures are adjusted." (Appendix 39: "Strengthening and adjusting public health measures throughout the COVID19 transition phase")

126. The OMT has clearly been following the transition strategy outlined by the WHO. This strategy describes a situation where the measures continue until a vaccine for the population as a whole is available. The government should constantly threaten the citizen with "bad behaviour will mean an extension of the lockdown". This is the "new normal" about which both policymakers and the media constantly remind us.

127. Preventing bottlenecks in the healthcare system as the main goal for the continuation of the freedom restrictions and the curtailment of other fundamental rights is not strictly necessary to manage an emergency, according to the ECHR. This policy has resulted in restrictions on the right to live a life without unnecessary government interference. The goals previously set for fewer than 700 IC beds have been met and the predicted armageddon has not been forthcoming. The earlier projections of 1,900 required IC beds by the middle of May were also realised. Currently, hardly any IC beds are occupied by patients with COVID-19. Nevertheless, there is no real perspective offered on lifting the state of emergency.

128. As stated, the efforts of policy makers to maintain this situation until the availability of a vaccine and a surveillance app for the entire population is grotesque and lacks democratic legitimacy. There are serious questions regarding the current obsession with developing a vaccine. All the more concerning given the cautionary experience of the past. For example, when the WHO declared the Mexican flu to be a pandemic (40), a global panic situation arose which bears a striking resemblance to the current COVID-19 situation. (41) As described above, the Dutch government hastily purchased 36 million units of a vaccine without going

through a process of checks and balances. (42) Billions were spent, Europe-wide, on this vaccine. All had to be destroyed unused because the vaccine was more dangerous than the virus itself. In the Netherlands, 54 people eventually passed away as a result of the Mexican flu.

(40)https://www.who.int/mediacentre/news/statements/2009/h1n1_20090425/en/
(41)https://www.who.int/mediacentre/news/statements/2009/h1n1_20090429/en/
(42) https://www.rtlnieuws.nl/nieuws/artikel/3073921/mexican-griep-kostte-onnodig-144-miljoen

129. Wittkowski, himself not an opponent of vaccination, provided it is *necessary and effective*, wonders "*why governments engage with experts who know nothing about virology*". (43) Wittkowski argues that there is no scientific evidence that a vaccine would contribute to the fight against COVID-19. "*It is in fact completely absurd to bet on a vaccine*," said Wittkowski. Epidemiology and Public Health Professor at Stanford John Loannidis University believes it is unlikely that after the outbreak of COVID-19 there would be repeat infections. "The virus is comparable to the influenza virus. A repeat infection is only possible after the virus has mutated. That can take two years. Normal life should be resumed as soon as possible," said Loannidis. (44) Vaccines according to him are also among the successes of science, but that does not mean that *this* vaccine will also be a success. Previous attempts to develop corona vaccines have in any case *failed* and have caused many problems due to extreme physical reactions and sometimes death. Ioannidis: "By waiting 18 months we will destroy ourselves. It takes a decade to determine if a vaccine is actually safe."

(43) Interview KenFM, April 29, 2020
(44) Dr. Ioannidis on Results of Coronavirus Studies April 30, 2020, https://www.youtube.com/watch?v=T-saAuXaPok

Pandemic is over
130. The main objective of the measures was to prevent overloading of the healthcare system, and in particular to prevent the IC capacity from becoming overloaded. The measures only make sense if the threat of such an overload was still present. In the absence of the problem the pursued

objective has no justification. In addition, official figures show that the pandemic was already past its peak at the start of the measures on 16 March 2020.

131. The course of the pandemic has been identical to any other annually recurring viral infection. On the basis of the official figures, Professor Dr. Stefan Homburg, Director of the Public Finance Institute of the University of Hanover, came to the conclusion that the measures taken were utterly meaningless and have had no influence on the course of the pandemic. (45) In countries where there was no *lockdown*, the curve has been identical. This applies to both Sweden and South Korea. By March 23, 2020, the pandemic was already over in Germany. Homburg calls the pandemic "a lie." From the data of the RKI it can be deduced that the peak of the epidemic was on March 21, 2020. Since this date the reproduction factor R0 has been below 1. The underlying dynamic revealed by the official figures can only be explained by a changed test policy. The situation in Germany with regard to the course of the virus is no different to the Netherlands. The OMT has confirmed that the reproduction number R0 has been under 1 since March 16, 2020. (Appendix 40: Homburg: "Statistik widerspricht Lockdown", Panorama April 27, 2020)

(45) „Es ist eine Lüge“ Punkt PRERADOVIC mit Prof Dr Stefan Homburg April 28, 2020: https://www.youtube.com/watch?v=y-6Wlsm2Cso
(46) Reference missing

132. Wittkowski also supports this view. (47) In his view, the epidemic is over. The numbers are falling everywhere. There are no indications that the consequences have been worse than the usual wave of flu. When the measures were taken, the worst was already over. Closing the economy, he says, is "*madness*." (48) Ioannidis also agrees with this view. Homburg also points out that in Germany the *lockdown* by policymakers was justified with the threat of 1.2 million deaths. This armageddon has not manifested, the measures aside. Based on these figures, the Federal Government already knew in March 2020 that the danger had been greatly exaggerated. (49)

(47) Wolfgang Knut Wittkowski, Head, Biostatistics, Epidemiology, and Research Design, Center for Clinical & Translational Science, April 29,

2020: KenFM
(48) Dr. Ioannidis on Results of Coronavirus Studies April 30, 2020, https://www.youtube.com/watch?v=T-saAuXaPok
(49) Standpoint: Dirk Ginzel, Bundesregierung wusste schon im März, dass Gefahr übertrieben dargestellt wird, KENFM, 7 May 2020

133. Judging by the number of positive PCR tests, the RIVM can no longer demonstrate that the virus is still present in the Netherlands. As explained above, the percentage of positive tests falls well within the range of *false positives*. If it cannot be determined that the virus is still in the Netherlands, then there is no need for any of the measures.

134. The argument that the measures are necessary because there may be a second wave of infections is not valid either. According to Wittkowski, a second wave rarely appears. The only example he knows of is the Spanish Flu. In addition, the second wave is usually milder than the first. "The worst thing that can happen is a mild second wave. Nothing shocking will happen," said Wittkowski.

135. The conclusion is that the goals set by the OMT and other policy makers do not provide any grounds for a continuation of the state of emergency.

Are the measures suitable for achieving the goal?

136. The next question to be answered is whether the measures imposed are suitable for achieving the goal. The following should be noted. The starting point for the imposition of restrictions on freedom imposed by the government can be deemed to be unlawful and can be considered arbitrary *if these restrictions lack sound scientific justification*.

137. At present there appears to be a situation where the citizens must demonstrate that the measure is not effective in order to have their fundamental rights restored. Obviously, this is an upside-down world. The Netherlands is not an open institution where the management can remove or redistribute, at its discretion, the freedoms of residents. It goes without saying that any restriction of freedom must be strictly necessary and proven to be effective. To date there is no sound scientific justification for the restriction of freedom. The restrictions on freedom are therefore

unlawful.

138. In addition, the measures taken are not effective and lack any rationale. This is first evidenced by a comparison with countries where mandatory measures were dispensed with. Hardly any measures were taken in Sweden and Japan. Those who follow the media in the Netherlands could get the impression that Sweden made a big mistake by not implementing a full lockdown, and that the death toll is rising uncontrollably. However, here too, the figures do not support the harsh criticism of the media. Sweden's mortality rate of 3,674 deaths out of 10.23 million residents comes to 0.039%. The Dutch figure is 0.033%. In Belgium, with one of the strictest *lockdowns* in Europe, there is a mortality rate double that of Sweden, at 0.076%. France too has a higher mortality rate at 0.041% as well as Spain with 0.048%. These numbers are significantly higher than Sweden while the populations of these countries have been literally detained in their homes for months.

139. Secondly, it can be established on the basis of previous WHO recommendations that the rationale behind the measures in the Netherlands is missing. In October 2019, the WHO issued a comprehensive study on the effectiveness of non-pharmaceutical agents that could be used to contain an influenza virus (hereinafter referred to as “the WHO study”). These recommendations are also applicable to the COVID-19 virus. A Taiwanese study showed that the influenza virus was up to four times more contagious than COVID-19. (50)

(50) MedRxiv 19 maart 2020, High transmissibility of COVID-19 near symptom onset Hao-Yuan Cheng, Shu-Wan Jian, Ding-Ping Liu, View ORCID ProfileTa-Chou Ng, Wan-Ting Huang, Taiwan COVID-19 outbreak investigation team, View ORCID Profile Hsien-Ho Lin doi: https://doi.org/10.1101/2020.03.18.20034561

140. The measures that the Dutch public are currently subject to were analysed in terms of effectiveness, impact and suitability in the WHO study. A distinction was made between a medium, severe and extraordinarily severe pandemic. The COVID-19 pandemic will here be considered to be a “moderate” pandemic since COVID-19 is no heavier than an average influenza wave (as will be shown below). Which measures does the WHO advise in the event of a pandemic such as this? (Appendix

41: Non-pharmaceutical public health measures for mitigation the risk and impact or epidemic and pandemic influenza)

141. The only measures that the WHO study advises in times of a pandemic like this include: hand hygiene, no coughing in the hand, face masks for persons with symptoms of the disease, surface hygiene, ventilation, quarantine of sick persons and travel advice. In an average pandemic, such as COVID-19, the cancellation of major events could be a supplementary measure. The measures that currently apply in the Netherlands are discouraged by the WHO and are only to be recommended in the event of a very serious pandemic. In the current situation, *the measures lack proportionality*.

142. Indeed, a meta-analysis shows that there is no evidence that wearing mouth masks is effective in limiting the transmission of viruses (p.6 of the WHO study). Incidentally, the OMT has never advised making the wearing of masks mandatory. The current obligation to wear face masks in public transport serves no apparent purpose. On the contrary, the wearing of mouth masks by people without symptoms is not recommended. Microbiologist and epidemiologist Emeritus Professor Sucharit Bhakdi from Johannes Gutenberg University Mainz strongly advises against wearing mouth masks and points to the damage to health damage that would occur. He called it "*a disgrace*" to force older people to wear a mask. (51)

(51) https://www.youtube.com/watch?v=Y6W-JIMCfmo

143. Home quarantine for non-infected persons is also not recommended. There are serious ethical objections to this measure. Because people are trapped together, the perfect circumstances for transfer of the virus are created. Ioannidis supports the conclusion of the WHO study. According to this, quarantine measures do not usually have a positive effect on the spread because people live too close together. People are in fact actually *forced to be infected* by being locked up together. (52)

(52) Dr. Ioannidis on Results of Coronavirus Studies April 30, 2020, https://www.youtube.com/watch?v=T-saAuXaPok

144. Closing schools and other establishments *could* contribute to a

reduction in the spread of the virus. At the same time, there are significant drawbacks to this measure, with a particularly negative effect on those with low incomes. For example, there is a loss of income because parents have to stay at home and children fall behind in their education. The WHO study recommended this measure only in the case of a major pandemic (p. 53 WHO study).

145. Evidence that closing the workplace contributed to the control of the virus spread is thin on the ground. There are only studies of simulations. Large-scale closures may have delayed the epidemic peak for a week according to this study, but appear to have had a modest influence on the course of the outbreak. The full impact of this measure, on the other hand, has been devastating. The self-employed and those on low incomes have been hardest hit. In addition these measures have resulted in major disruption to the economy. The closing of the workplace can be considered as an *extreme social distancing measure,* only to be considered in an extremely severe pandemic. This is not the case here.

146. The use of *contact tracing* by means of an app (which may or may not be compulsory to install) and which involves both the European Commission and national policymakers, has been heavily invested in despite there being no circumstances in which the WHO recommends the use of an app. Studies show the effectiveness of *contact tracing* is very much limited. Only one study measured a very limited positive effect in combination with quarantine measures. This means an app can only be used in specific conditions with a very small number of infections. With a virus like COVID-19, which has similar properties to the influenza virus, the use of such an app would result in a nationwide quarantine in no time. According to the WHO, the ethical considerations of the app outweighed the so-called benefits. The WHO study advised against the use of contact tracing in all cases. Also according to Ionnaidis, use of the app was only possible where there few infections and would not be appropriate in most countries. As 30% of the population are infected, 70% of the population comes into contact with them. The whole population would be quarantined in no time. Even with an infection rate of 5% it would be almost impossible to contain the spread with an app.

147. The conclusion is unambiguous: Both from the comparison with countries that were not forced to take lockdown measures and with the

WHO study, it follows that there is no rationale behind the measures. This makes the continuation of the measures illegal.

Has the subsidiarity principle been respected?

148. The next question to be answered was whether the same result could have been achieved with less drastic measures. The measures are presented by policymakers as the only possible route, without any alternatives. In particular the example of Sweden points to the contrary. Sweden actually followed the recommendations of the WHO report, limiting the measures to behavioral advice and the cancellation of major events. Daily life has continued without the government using repressive measures. Despite this, death rates in Sweden are not higher than average in Europe and are even lower than the countries with the hardest *lockdowns*.

149. The argument put forward against this point by politicians and media is that the case of Sweden would be incomparable because the population density is much lower. This argument is not valid. Ioannidis points out the number of contacts in Sweden may be lower than in many countries, but it is comparable to a country like Switzerland. In that country, the mortality rate is higher than in Sweden. According to him, there is no evidence that Sweden has done anything wrong. In addition, their health care system has not collapsed. (53)

(53) Dr. Ioannidis on Results of Coronavirus Studies 30 april 2020, https://www.youtube.com/watch?v=T-saAuXaPok 54 Wolfgang Knut Wittkowski, Head, Biostatistics, Epidemiology, and Research Design, Center for Clinical & Translational Science, 29 april 2020: KenFM

150. Wittkowski found the measures exaggerated. According to him, it was a tragedy that not the the elderly but the young were isolated. Isolating people who were not infected was, in his opinion, disastrous. According to him, it would have been much cheaper to isolate nursing homes - where the most fatalities occurred - rather than locking down the entire population. In addition, he wondered why we suddenly had to organize our whole lives differently for a virus to which we had been exposed for thousands of years. This epidemic was no different from other epidemics that visited us annually. There was no need for measures that normally would not be taken for example in the event of a flu epidemic. (54)

(54) Wolfgang Knut Wittkowski, Head, Biostatistics, Epidemiology, and Research Design, Center for Clinical & Translational Science, 29 april 2020: KenFM

151. Streeck is also critical of the way in which the measures were decided upon. 'The models used were highly speculative, "said Streeck. Based on these speculations, decisions were taken without first waiting for the effect of measures to be observed. There was insufficient research into the facts of the matter and Streeck was surprised that this was still the case. For example, the course of the epidemic should have been investigated with the analysis of large representative samples. As a consequence of not doing this, the need for rigid measures has not been established. For example, South Korea has undergone intensive testing to determine the course of the pandemic. Policy decisions were made on the basis of this. The Netherlands did as little testing as Germany.

152. There has also been no focus on preventive measures. For example, it turns out that most infections occur under specific circumstances, the so-called *super spread events*. (55, 56) There is now consensus about this and RIVM has through Van Dissel reluctantly admitted that these *super spreads* do indeed play a role. Even if the virus is still present, this measure can be implemented while everyday life continues as usual. Also, with the use of ionizers, the virus can be rendered harmless in close quarters. This was evident from the RIVM's own 2010 study. (57) The question is why RIVM has not focused on these resources? Schools, offices, churches and sports facilities restaurants could have been equipped with ionizers so that they could continue doing business. This would have prevented enormous social and economic damage.

(55) https://www.cafeweltschmerz.nl/%E2%80%AAstop-superspread-events-en-het-virus-verdwijnt-maurice-de-hond-en-pim-van-galen-%E2%80%AC/
(56) https://www.nytimes.com/2020/06/02/opinion/coronavirus-superspreaders.html
(57) https://www.rivm.nl/bibliotheek/rapporten/609330004.pdf

153. The use of a combination therapy with HCQ also appears to have a virus inhibiting effect. It is striking that in their communiques, RIVM

advised against using these scientifically proven remedies. A notorious article in the Lancet that supported the view of RIVM, had to be withdrawn. (58) Suffice it to say, there has been no investigation of prevention methods and neither have less invasive means of treatment been assessed.

(58) https://www.theguardian.com/world/2020/jun/04/covid-19-lancet-retracts-paper-that-halted-hydroxychloroquine-trials

154. It is concluded that the initial hygiene advice to the public was likely sufficient to limit the harmful effects of the virus. The example of Sweden illustrates this. The option of milder alternatives has not been sufficiently investigated. The decision-making therefore does not satisfy the subsidiarity principle.

Are the measures proportionate or is the remedy worse than the disease?

Preface (preamble?)
155. The impact of the measures cannot be underestimated. People see their existence slipping away from them through mass unemployment, poverty and bankruptcies. Demoralisation and mistrust are the result. The humanitarian consequences are also incalculable. The loss of life, health and wellbeing as a result of the measures could only be justified in a situation of acute life-threatening emergency. The extent of loss of life as a result of the measures far outweighs the extent of deaths caused by COVID-19 - even with the use of skewed statistics. The lockdown measures are irresponsible and should be lifted. There follows a review of the threat represented by COVID-19, and of the consequences for the economy, public health, well-being and the rule of law.

COVID-19: an indiscriminate killer virus?
156. The WHO is fully responsible for a media campaign that has frightened the public. This fear campaign reached an unprecedented peak when Bruce Aylward, the Deputy Director General of WHO and President of an International Mission to Wuhan, found that there was no evidence of mild cases of the new virus. (Appendix 43: Article STAT February 25, 2020: *New data from China buttress fears about high coronavirus fatality rate, WHO expert says*)

157. The WHO had previously based its alarming message on the fear of *high infection fatality rates* (IFRs). It was suggested that 2-4% of infected people would die while at the same time it was suggested that there would not be large numbers with a mild response. An IFR of 2.3%, based on Chinese research, was predicted by the WHO. This number was also mentioned in an official message about the outbreak in China. (59) The fear campaign was subsequently given new impulse with the situation in Italy, as a result of which WHO reports have for some time been quoting an IFR of up to 10%. (60)

(59) Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China, Summary of a Report of 72314 Cases From the Chinese Center for Disease Control and Prevention)
(60) www.who.int COVID-19 situation reports

158. After a protracted worldwide *lockdown*, lasting almost five months, the damage to the economy and to humanity has been catastrophic. Despite these consequences, it is striking that the WHO is not making any efforts to induce member states to investigate the actual IFR using serology. On the contrary, it is remarkable how the WHO has actively maintained the myths surrounding the COVID-19 virus and has encouraged its member states to keep its residents in a possibly years-long exceptional situation until a vaccine is available. The WHO's approach wrongly gives the impression that it is engaged in saving humanity from a calamity.

159. A Q&A with extensive information on COVID-19 is available on the WHO website. Advice is given on hygiene rules, precautions, symptoms and lots of other information. However, whoever is looking for an answer to the most pressing question that arises in the Q&A, namely the chance of death, will be disappointed. This particular information is missing. For the commuication campaign *COVID-19 RCCE Action Plan Guidance* (See Appendix, p. 23), the WHO provided its member states with the *General information needed by most audiences about COVID 19*. Behind each question there is a web link with extensive answers to the most frequently asked questions, however the link for the question '*How severe is it*?' is missing.

160. Neither the mainstream media nor the OMT/politicians have provided

an answer to this question. The public is held in fear by anecdotal evidence from politicians and the media disseminate daily infection and death numbers without any context. Everyone is fully aware after endless repetition of the horrific images of coffins, corpses and panic seen in Wuhan, Northern Italy, Madrid, Barcelona, Paris and New York City. As explained below, however, the impact of COVID-19 is limited. 150,000 people die every day worldwide due to causes other than this virus. Despite the fact that a *killer virus* has been active for more than four months, the number of deaths is nowhere near this figure. For example, Germany in the first four months saw much lower excess mortality than predicted (Source: Robert Koch Institut):

2016	**290,641**
2017	**315,576**
2018	**330,152**
2019	**301,558**
2020	**304,354**

161. In Austria too, fewer people have died this year than in the same period last year. In fact, more people have died from the flu than from COVID-19. (61) 834 people died from the flu as opposed to 673 dying from COVID-19. The Netherlands is also not expected to see an increase in mortality. Statistics Netherlands has recently changed the basis for the death statistics. As a result, the figures are based on estimates and not on confirmed deaths. Incidentally, for a pandemic, it is noteworthy that there are no increased mortality rates.

(61) https://orf.at/stories/3169123/

162. Obviously, the answer to what degree COVID-19 poses a danger is central to deciding whether the effects of the measures are proportionate to the effects of the virus.

How dangerous is the virus?

163. Neil Ferguson's predictions from Imperial College were the impetus for a new high in the panic with the result that in no time, all of Europe was in lockdown. Ferguson predicted a death toll of 500,000 for the UK alone. Even Prime Minister Boris Johnson, who had been cynical until then, succumbed to the virus. Ferguson, on the QT, has since revised the estimated mortality to below 20,000. The WHO estimated 40 million

deaths worldwide.

164. The epidemic is now almost over. There are hardly any new cases or deaths. Nevertheless, restrictions on freedom remain in force and in fact, in the Netherlands, these restrictions have been laid down in temporary law. Analysis of the mortality rates worldwide shows that even on the basis of the skewed figures, COVID-19 hardly exceeds the danger of a regular influenza wave. Skewed statistics since these studies are based on officially published figures.

165. This is problematic since only the number of deaths with COVID-19 and not those from COVID-19 are being recorded. The WHO has drawn up guidelines on classifying deaths as COVID-19 on death certificates. (62) These guidelines explain why worldwide statistics are distorted by cases with COVID-19 as cause of death instead of from COVID-19. These guidelines resulted in over 99 percent of deaths recorded as due to COVID-19 while in reality death was due to other underlying conditions. It is unclear why each death with COVID-19 present at the time of death, was recorded as a COVID-19 death. This has led to a great deal of confusion. Italy is usually cited as an illustration of the dangers posed by COVID-19. The death toll of those with COVID-19 in Italy, for example, had risen slightly to 30,000 (as of May 7, 2020). Meanwhile Italian Prime Minister Giuseppe Conte admitted to Parliament that more than 99% of registered COVID-19 deaths had not died from the virus. (Appendix 44: Article March 18, 2020: “99% of those who died from virus had other illness, Italy says”)

(62)https://www.who.int/classifications/icd/Guidelines_Cause_of_Death_COVID-19-20200420-EN.pdf?ua=1

166. The majority of deaths had one or more accompanying comorbidities which contributed to death. (98.8% had at least one comorbidity while 48.6% had three or more) (63) The average age of those who died was 80 years and the average age of patients requiring ICU care was 67 years. Incidentally, mortality rates of those with COVID-19 are well above average life expectancy, worldwide:

Country	Age	Source
Austria	80+	EMS
UK	80+	NHS

France	84	SPF
Germany	82	RKI
Italy	81	ISS
Spain	~ 82	MDS
Sweden	86	FOHM
Switzerland	84	BAG
US	~ 80	CDC

(63) Characteristics of COVID-19 patients dying in Italy. Istituto Superiore di Sanità, https://www.epicentro.iss.it/en/coronavirus/sars-cov-2-analysis-of-deaths

167. Dr. John Ioannidis believes the high death toll in Italy, and in particular in the Bergamo region, was due to infection by hospital personnel. In addition, there were strategic errors made in Italy where patients with relatively mild symptoms were admitted to hospital while hospitals had already reached winter capacity with patients suffering from the annual influenza wave. Italy's relatively old population was also a factor. It is estimated that fewer than 300 people have died from COVID-19 in Italy. According to Ioannidis, COVID-19 was negligibly represented in the deaths ascribed to it. (64) (Appendix 45: John Ioannidis et al "What Other Countries Can Learn From Italy During the COVID-19 Pandemic")

(64) Perspectives on the Pandemic | Dr. John Ioannidis Update: 4.17.20 |, https://www.youtube.com/watch?v=cwPqmLoZA4s

168. Ioannidis' theory is supported by the observations of Klaus Püschel, forensic physician and director of the University Clinic Hamburg-Eppendorf (UKE) who went against the ban by the Robert Koch Institute on COVID-19 assessment at autopsy and carried out over 120 autopsies on patients who had died with COVID-19. "None of the deaths involved COVID-19 as the cause of death, "said Püschel. (65) The main cause of death was thrombosis and pulmonary embolism, often as a result of lack of exercise. Even the exceptional deaths of patients under fifty which were attributed to COVID-19 were found instead to be due to underlying conditions of which the patient was unaware.

(65) WELT DOCUMENT: Corona Study - Viele Covid-19-Erkrankte sterben an Embolien, https://www.youtube.com/watch?v=VvH3mG-v0Ms

169. According to Ioannidis' findings (based on data from 11 European countries and twelve states in the US), the number of deaths under 65 is only 5-9% of the total. The risk to a person under 65 without life-threatening conditions of death by COVID-19 is the same as dying in a car accident. (66) Even in New York, where the CFR was significantly higher, the risk was comparable to a truck driver dying in a collision. Wittkowski confirms this picture: "In individual cases the virus has killed people younger than 65. These deaths are not however representative, yet they are disproportionately publicised by the media." (67)

(66) MedRxiv, Popoltion-level COVID-19 mortality risk for non*-elderly individuals without underlying diseases in pandemic epicenters, 5 april 2020
(67) Head, Bio-statistics, Epidemiology, and Research Design, Centre for Clinical & Translational Science 29 april KenFM

170. The Oxford COVID-19 Evidence Service conducted extensive research based on the official globally-published CFRs. The researchers arrived at an IFR of 0.36. This meant that 36 out of 10,000 individuals who became infected with the COVID-19 virus would die. This was in line with the results of the recent Heinsberg study conducted by the Institute of Virology at the University of Bonn in Germany. (68) In this study 919 residents of the town of Heinsberg, which had seen infection rates rise strongly after the carnival celebration, were serologically tested. From these results, the researchers arrived at an estimated IFR of 0.36. This was later adjusted to 0.278. (Appendix 46: Global Covid Case Fatality Rates Oxford COVID-19 Evidence Service)

(68) Infection fatality rate of SARS-CoV-2 infection in a German community with a super-spreading event, Hendrik Streeck et Institute of Virology, University Hospital, University of Bonn, Germany, and German Center for Infection Research (DZIF), partner site Bonn-Cologn

171. Recently, additional international serology-based studies have been published and they confirm this picture. In a study published on May 19, 2020, Ioannidis concluded that the IFR in most countries was <0.20. In COVID-19 hotspots in three countries, he found an IFR of <0.40. (69) A study published on May 1 2020 in Iran indicated an IFR <0.12. (70) A

study in Denmark, in collaboration with the blood bank, gave an IFR of 0.08. (71) Three studies in the United States also pointed to a comparable IFR: a study in Santa Clara <0.17 (72), Miami Dade County <0.1873 and a Los Angeles study from the University of Southern California <0.20.(74)

(69) MedRXiv 19.5.2020, Ioannidis 'The infection fatality rate of COVID-19 inferred from seroprevalence data'
(70)MedRXiv 1.5.202, Maryam Shakiba, "Seroprevalence of COVID-19 virus infection in Guilan province, Iran"
(71) MedRXiv, 24.4.2020, Christian Erikstrup et al, "Estimation of SARS-CoV-2 infection fatality rate by real-time antibody screening of blood donors"
(72) MedRXiv, 14.4.2020, Eran Bendavind, COVID-19 Antibody Seroprevalence in Santa Clara County, California
(73) Second round of COVID-19 community testing completed; Miami-Dade County and the University of Miami Miller School of Medicine announce initial findings
(74) https://pressroom.usc.edu/preliminary-results-of-usc-la-county-covid-19-study-released/

172. This is likely consistent with the results of the Pienter Corona survey that was carried out by RIVM in collaboration with Sanquin. (75) 2,096 samples of donated blood have been tested since 17 April. (76) Of the samples examined, 3.6% contained antibodies against COVID-19. For people over 20, this is 4.2%. Sanquin had the samples, apparently collected at the beginning of April, compared with archived samples of blood donors from before the onset of the epidemic. In cases where there was a double positive result, these were disregarded. This led to confusing results. Assuming the blood samples were taken in early April 2020, the IFR was estimated at 0.321.

(75)https://www.tweedekamer.nl/sites/default/files/atoms/files/20200422_technische_briefing_jaap_van_dissel_rivm_22_april.pdf
(Reference 76 is missing)

173. More and more countries no longer regard COVID-19 as a threatening disease. The United Kingdom and Denmark no longer classify COVID-19 as a threat to public health. The *Centers for Disease Control* (CDC), (the RIVM of the United States), the IFR have all been adjusted

downwards to 0.26. (77). This means that even with skewed statistics, it can be assumed that COVID-19 is no more deadly than the average flu.

(77) https://www.cdc.gov/coronavirus/2019-ncov/hcp/planning-scenarios.html

174. The IFR of Influenza is between 0.1 and 0.35. According to the RIVM figures on the 17th of May, a total of 5,680 people who had tested positive for COVID-19 had died. Only in 62 of cases was the chief cause of death COVID-19. This equates to an IFR of around 0.004. The remainder died *with* and not *from* COVID-19.

175. Excess mortality is used to establish the magnitude of influenza mortality during the flu season. In the first three months of 2020, fewer people died per day in the Netherlands than the average. The excess mortality measured over the first 17 weeks of 2020, shows an excess mortality of 8325 more than the average of the first 17 weeks of the years 2017-2019. (Based on CBS figures with a recently adjusted calculation method) It is not possible to determine how many of these died from the COVID-19 virus. The COVID-19 epidemic started in the middle of the annual influenza wave (which apparently ended abruptly). In addition, it is not unlikely that the measures themselves have caused significant excess mortality. The number of hospital admissions is far below the numbers seen, for example, two years ago during the influenza wave when 5,000 more people were treated in hospital.

176. It is also important to put the mortality figures in the right context. In recent months, the media and politicians have subjected the public to daily pronouncements of excess mortality due to COVID-19 without placing this in the context of mortality due to other causes. For example, in the first quarter of 2019, 112 people died daily from cardiovascular disease, 66 from mental disorders and diseases of the nervous system and 133 to cancer. People die in these numbers from these diseases day after day and year after year. Nevertheless, society is not fully devoted to measures to prevent these deaths neither have laws been passed or apps developed to monitor every detail of the entire population as to whether they are making sufficient efforts to prevent these diseases. Nor has the economy been plunged into the abyss. The entire COVID-19 epidemic lasted approximately 10 days where around 150 people died each day *with* the

virus. If the 8 o'clock news had quoted this statistic alongside the daily COVID-19 deaths, the Netherlands would have quickly been cured of its anxiety psychosis.

177. Whatever the case, even with the most flexible calculation method, the number of COVID-19 deaths is still well below the estimated influenza deaths from two years ago. In addition the victims are almost without exception older than 65 with multiple comorbidities. The victim group is identical to the victim group of the annual influenza wave. Wittkowski also comes to this conclusion. "This year there are statistically far fewer deaths from flu. This virus is competing with the annual flu," said Wittkowski. He therefore comes to the conclusion that COVID-19 is comparable to influenza. (78) Ioannidis also comes to a similar conclusion: it is a serious virus but not catastrophic. The risk group are not the elderly but older people with serious conditions. The virus does not form a risk for healthy elderly people. His question is therefore how the WHO could be so wrong. Science knew quite quickly that the first assumptions were incorrect. (79)

(78) Wolfgang Knut Wittkowski, Head, Biostatistics, Epidemiology, and Research Design, Center for Clinical & Translational Science, April 29 2020: KenFM
(79) Perspectives on the Pandemic | Dr. John Ioannidis Update: 4.17.20 |

The fatal consequences of the measures for the economy, public health, public welfare and the constitutional state

Preface
178. It follows from the foregoing that the virus itself poses a limited threat to public health. The consequences of the measures taken against the virus however, do indeed pose a threat despite being completely foreseeable. As explained in more detail here, the economic and humanitarian damage has been and is catastrophic. In addition, the fight against the virus has overshadowed the attack on the values of the constitutional state. Here follows an outline of the resultant damage.

Economic damage
179. The economic damage caused by the measures is almost incalculable. The IMF expects a global crisis that will outdo the *Great Depression* of

the 1920s in the previous century. (80) Public expenditure is exploding and as is to be expected, tax revenues are melting away. This year, the budget deficit has been estimated at a cautious 92 billion euros. Within a few months, policymakers have distributed an amount equivalent to 12% of GDP. It is expected that this amount will be adjusted upwards. This means that the national debt this year will be 25% greater than that of last year. This is an unprecedented increase in debt which burden future generations will bear.

(80) https://www.imf.org/en/About/FAQ/imf-response-to-covid-19

180. The Netherlands is also facing an unprecedented wave of bankruptcies. More than 22 percent of the smaller companies (employing 5 to 20 people) do not expect to survive the crisis. (81) This equates to around 300,000 companies. If the crisis lasts longer than six months, this percentage will rise to 56%. Hospitality entrepreneurs are even more pessimistic. 36% do not expect to survive the crisis. A further 33 per cent expect to fail if the crisis goes on for six months. Should the crisis last more than six months, a majority of entrepreneurs in the automotive industry, in construction, culture, sports and recreation would be in jeopardy of failing. In the retail industry, half of companies interviewed could not estimate how long their company would survive. The bankruptcy wave and decline in turnover will lead to mass layoffs with historically high rates of unemployment. Statistics Netherlands has never before seen such a large contraction in the consumption of goods. (82)

(81) https://www.cbs.nl/nl-nl/dossier/cbs-ijfers-coronacrisis/wat-zijn-de-economische-gevolgen-van-corona
(82) https://www.cbs.nl/nl-nl/ news / 2020/20 / largest-shrink-consumption-households-ever-measured

181. For months, macro-economist Kees de Kort, well-known for his daily talkshow on BNR-Radio, has been warning of the catastrophic impact on the economy. (83) As a consequence of the measures, the economy is contracting at a rate of 4 percent per month. He also warns that the financial system is in serious trouble. Rescue measures for this industry would cost hundreds of billions more. In addition, a quick recovery is not to be expected. Due to the failure of production chains, it is not possible to start at the point where we left off. Another danger, he says, is that the

high level of uncertainty has caused companies to forego investment for the time being, all the more since policymakers threaten daily with the prospect that this *lockdown* will return regularly if new virus cases crop up. Confidence in the future has disappeared among entrepreneurs. 'They have allowed themselves to be brought to their knees by this cabinet," as Kees de Kort put it.

83 https://www.bnr.nl/podcast/kees-de-kort

182. The extent of the economic damage will depend on many factors. The reality is that the lockdown measures have been responsible for the loss of hundreds of billions of euros.

Damage to health and well-being
183. According to policy makers, the measures were intended to save lives, however, it is abundantly clear that the damage to health and wellbeing is unprecedented. Ioaniddis has also warned of the consequences. (84) According to him, the population is in a state of shock and the people will not be able to just return to normal life. The consequences of this *lockdown* are catastrophic, he says.

(84) Perspectives on the Pandemic | Dr. John Ioannidis Update: 4.17.20

184. The effects of the lockdown on the well-being of the population of Italy are clearly beginning to show. A survey of 20,000 inhabitants showed that half of them were experiencing negative psychological effects. In addition, many more deaths are to be expected as a result of the deteriorating economy. (85)

(85) “The Dire effects of Italy's coronavirus lockdown”, Carl Heneghan, Oxford's Center for Evidence Based Medicine

Consequences of suspension of regular care:
185. 7.3 million people are treated in a hospital in the Netherlands every year. In the first three months of the year, 5.5 million patients are treated, 40% of whom need to be seen by a specialist within 30 days. (86) In 2020, starting from March which was the beginning of the corona crisis, care provided by Dutch hospitals has fallen considerably compared to previous years. (source: HD in the National Basic Register of Hospitals) Since

March, all emergency medical procedures and treatments in the Netherlands have been postponed. In total there were 650,000 fewer referrals or follow-up appointments.

(86) NZA, Analysis of the consequences of the corona crisis for regular care

186. According to estimates by cancer specialist Alexander Monro, in the coming years there will be 500 extra deaths due to breast cancer. (87) Studies have shown that since the start of the measures the number of patients with heart attacks has fallen by more than 40 percent. This is presumably not because there are fewer heart attacks, but the result of incorrect interpretation of complaints associated with COVID-19. What is more, people are avoiding healthcare facilities for fear of contracting the virus. (88) The National Health Service in the United Kingdom estimates that 20,000 deaths will be due to delay in treatments (as at April 25). This number will further increase by 2000 every week. (89) The Dutch Association of Cardiologists cautions that canceling and delaying cardiac care will result in the loss of between 65,000 and 100,000 life years. (100) It is expected that worldwide a million people will have perished as a direct result of COVID-19 measures. (90)

(87) “Over 500 additional breast cancer deaths due to impact corona in the coming years”, Eindhovens Dagblad June 7, 2020
(88) Decline of acute coronary syndrome since the outbreak of COVID-19: the pandemic response causes cardial collateral damage, Bernt metzler: European Heart Journal April 16, 2020
(89) The Telegraph April 25, 2020, Two new waves of deaths are about to break over the NHS
(90) ONE MILLION OR ONE HUNDRED MILLION CASUALTIES? - THE IMPACT OF THE COVID-19 CRISIS ON THE LEAST DEVELOPED AND DEVELOPING COUNTRIES, Dirk A. Zetzsche, Professor of Law, ADA Chair in Financial Law (Inclusive Finance), Faculty of Law, Economics and Finance, University of Luxembourg

187. For the Netherlands, a conservative estimate of 500 deaths per week as direct effect of the measures is not out of the question.

Reduced nursing care:
188. Due to the restrictions imposed, the care of dependent and elderly people has been much reduced. In Germany, it is estimated that the scaling back of care will result in 3,500 premature deaths. For the Netherlands this is likely to be 700 premature deaths resulting from the measures.

Increase in suicide:
189. The long-term negative effects on the living conditions of those who are mentally unstable has led to a critical situation. For a large portion of the population the loss of livelihood, security and future prospects has led to a significant increase in suicide rates.

Other measures causing health damage:
a. The elderly and those in need of care have been particularly badly affected by measures such as quarantine and contact restrictions;
b. The drastic change in living conditions has resulted in a significant increase in demand for psychiatric treatments for psychosis, obsessive-compulsive disorders and depression. This will lead to more people being unable to work;
c. Due to contact restrictions and other prohibitions, there has been a significant increase in domestic violence and child abuse.

Decrease in life expectancy
190. Life expectancy has grown enormously since the 1950s as a result of the increase in welfare. Due to this increase in prosperity, it was possible to significantly increase spending on health care. In the event of strongly negative economic developments and simultaneously, declining levels of prosperity, life expectancy could be significantly reduced. What is more, there is a strong correlation between unemployment and life expectancy.The measures will result in the destruction of a significant number of life years.

191. *Conclusion:* As a direct result of the measures, thousands of people have died or will die. In addition, the measures have caused incalculable human suffering.

Damage to the rule of law
192. Emergency Powers are to be used with the aim of saving lives. It is however inadmissible for fundamental rights to be abolished in the

process. The curtailment of fundamental rights and freedoms through emergency ordinances with an extremely weak legal basis is highly unusual. Using the motto “needs must” policy makers have made free with curtailment of rights. The rule of law must also be respected in exceptional situations. (91) The government should be the first to respect the limits of the rule of law. It appears that any obstacle to undermining fundamental rights has been removed for policymakers. With this attitude, the government is on slippery ground. It is no exaggeration to question whether the rule of law can continue to exist. To all intents and purposes, democracy has effectively been abolished.

(91) zie Venice Commission, Opinion on the protection of human rights in emergency situation, CDL-AD(2006)015), para. 13.

193.

194. As discussed above, emergency regulations have had far-reaching consequences as a result of the infringement of basic fundamental rights. There is no legal basis whatsoever for this infringement. In addition, the drafting of the Regulations is so unclear that it is a direct violation of the principle of legality. The lockdown measures have been rigorously enforced on the basis of provisions that are often not understood by the police and other enforcement services. This unclear situation which gives the impression that everything is forbidden causes transgressive behavior by government officials. For example, homes have been raided after neighbours tipped off the police about non-compliance with contact restrictions.

195. A micro-dictatorship has been created with the one and a half meter society. Children have been fined for failing to comply with the distance regulations or contact restrictions imposed in parks and playgrounds. Students have been fined for sitting out on a balcony together. Municipalities have set up hotlines so that neighbors can betray each other. Drones have been put into service to patrol beaches to catch those who might attempt to break the rules in private. In Rotterdam cars drive around scanning for 'wrongdoers'. Thousands of fines have been issued for completely absurd violations. Carefree outdoor living has thus become a thing of the past. This particular conduct shows little insight into the rule of law. It is such an infantile approach that the question may be asked

whether we are dealing here with the people's representative or with a strict father? Policy makers are playing Santa Claus with freedoms enshrined in the Constitution.

196. The right to demonstrate has also been seriously affected. Under the pretext of public health concerns, absurd restrictions lacking any legal basis have been enforced. So demonstrations were limited to, for example, a maximum of 15 people and the police would promptly intervene if the one and a half meter rule was not strictly observed. The Hague police went out of their way to enforce this during a demonstration on May 9, 2020 at the Malieveld in the Hague. Participants in a demonstration against the restrictions imposed were arrested en masse because there was not enough distance between them. They were then transported in full buses to the police station. This is the equivalent of a ban on the right to demonstrate.

197. In a democratic constitutional state, the media as the “fourth estate” plays an important role in controlling policymakers and informing citizens. The role played by the media during COVID-19 can be regarded as the final capitulation of a free and independent press. In a symbiosis between the media and policymakers, a campaign was launched during the COVID-19 crisis that made the population anxious and fearful. As Abraham Lincoln learned, a frightened people give up all their rights voluntarily. The fact that policymakers have in effect weaponised a fear driven by a lack of information in order to further restrict freedoms is highly alarming. The consent of a population which has been frightened and misinformed cannot serve to legitimate democracy.

198. The media have offensively monopolised the official view of COVID-19. There is hardly any room for dissenting opinions, as a result of which a full-fledged debate on legitimate questions has been disrupted. For example, journalist Jort Kelder raised the question of whether it was necessary to weigh up the costs and benefits of the measures. These kinds of questions were not desirable. After all, people were busy saving lives. Scientists were openly shamed for dissenting opinions. The media bears a lot of responsibility for the resulting damage. The right to free speech has been compromised.

199. Democracy has been largely deactivated. Emergency laws have been unanimously passed by both Chambers of Parliament without adequate

discussion. No answers to critical policy questions, fundamental rights violations, lack of accountability for far-reaching restrictions on fundamental rights or economic damage have been forthcoming. Instead, debates were held over masks.

200. The measures have also seriously affected the right to a fair trial. The Emergency Law COVID-19 Justice and Security has severely limited the public's access to justice. This is a violation of Article 121 of the Constitution. Arrangements for conducting criminal proceedings by telephone also infringe the right to a fair trial. The limited possibilities for oral treatment in civil and administrative proceedings has also seriously undermined the safeguards of Article 6 of the ECHR. In addition, preliminary procedures for delegated trials have been made inactive which further increases executive power.

201. The crisis has also been used to further restrict privacy regulations. RIVM has access to all metadata ostensibly to monitor citizens' movements. There will be an app that every Dutch person may have to install. There are plans to introduce vaccination passports without which it will no longer be possible to travel. And just like after the attack on the WTC in New York, the virus serves as a pretext to throw the privacy rules overboard. In the midst of the uproar, the government is trying to get extremely controversial legislation through the Chambers. In addition to the human suffering inflicted by the measures, confidence in the rule of law and in authority has been irreparably damaged. This could lead to a situation that is not in anyone's interests.

The bill “Emergency Covid-19 Law”

202. Minister De Jonge submitted the Bill on temporary measures for the Covid-19 outbreak to the House of Representatives. (92) This Act gives the Minister of Public Health powers to drastically limit fundamental rights in the fight against the virus. The "New Normal" law entered into force on July 1, 2020. The law aims to give a legal basis and a more definitive character to the COVID-19 measures. There is much criticism of the ambiguity of the emergency regulations. They also lack a legal foundation.

(92) https://www.raadsleden.nl/files/documenten/twm_covid-

19_consultatiemersie.pdf

203. With the proposed bill, the fundamental rights of the population have been curtailed in a way never seen before. For example, according to the bill one must keep a safe distance away from other people outside the home. Until now, this distance has been 1.5 meters, but the RIVM may adjust this distance at whim. People are also not allowed to gather in groups and large events are prohibited. The minister may further close establishments, prohibit professions, prescribe hygiene measures for sports and fitness professions at his own discretion. Even at home, citizens are no longer safe. The bill provides for the forcible removal of all visitors to a private home, apart from the residents themselves. The minister can also impose a ban on visitors for residents of care homes, prohibit or limit assisted care transport, education and childcare.

204. When these emergency bill rules are broken, both parties are punishable by law: both the person who is responsible for complying with the regulations (the resident, say) as well as the visitor (forcibly removed). The penalties proposed by the minister are hefty. Until now, offenders have been fined 390 euros. This will be increased to 435 with a maximum of 4,350 euros. One can also be detained for up to two months for violations of Covid-19 law. There are also special investigative officers designated for enforcement of the rules who, by the way, have just been armed with batons. After all, they are on the “front line”. The law is valid for a year and can be extended at any time. The irony, of course, is that if the virus was really dangerous, any coercion would be superfluous. In that case, the population would protect itself by staying indoors until the virus was gone.

205. In its advisory of 4 June 2020, the Netherlands Bar Association expressed strong criticism of the bill. The College for Human Rights and the Council of State came up with a “number of points for attention”. The law is such a gross curtailment of a full range of fundamental rights that it is no exaggeration to say that the rule of law has been abolished. It is hard to imagine seriously considering introducing this law. A government that submits such a bill in the full knowledge of this curtailment is not trying to fight a virus, but instead trying to abolish the democratic constitutional state.

Conclusion: the balance

206. Using completely arbitrary measures, policymakers have created a society which is utterly focused on fighting a phantom. An invisible enemy called COVID-19 was placed like a cuckoo's egg on the WPG's A-list of infectious diseases on January 28, 2020. The background for this decision, according to the explanatory memorandum, was that this would create an opportunity to *force suspected cases of Covid-19 into quarantine upon entering the country*. Meanwhile the entire population is groaning under the draconian restrictions on freedom.

207. Entrepreneurs have been forced to discontinue doing business while so-called easing of the measures has provided little relief. Resuming economic activities is subject to restrictive protocols which make it virtually impossible to continue doing business in a financially responsible manner. Catering establishments, hairdressers and the retail trade are often required to meet absurd and seemingly arbitrary conditions which severely limit sales capacity. The one and a half meter requirement leads to absurd situations in which only a very limited patronage can be served. The system seems to be devised to drive these entrepreneurs into bankruptcy.

208. Cultural life has come to a complete stop as a result of the measures. Musical performances are prohibited as are sporting events. Artists have been unemployed for months at home with the uncertainty of whether they will ever be able to practice their profession again. Sports clubs are on the brink of collapse. A quarter of museums are bankrupt. Young people have minimal access to education. Education will only be allowed to resume in terms of the “new normal” with its many limitations (strict hygiene, 1.5m social distancing, the list is long). Children over 12 can no longer hang out with each other without committing a criminal offense. The population is played against each other in an unacceptable manner. Policy makers urge the public to hold each other accountable for adhering to completely absurd rules and people are encouraged to betray each other under the motto "we have to do it together".

209. There is also a great deal of cognitive dissonance at play. On the one hand, the narrative of politicians and media is that we are in the midst of a catastrophic disaster. Alarming images of corpses, coffins, mass graves and panic situations in distant hospitals, saturated television and other

media, and yet this narrative cannot be reconciled with one's own observations. On the other hand, under the pretext of combating misinformation, reporting and information restrictions have made it impossible for the population to establish the facts behind the alarmism. Companies such as Google, Whatsapp, Facebook, Instagram and other platforms have removed information that does not correspond to what the WHO communicates about COVID-19.

210. The enormous damage to the economy, public health and the rule of law caused by the measures in the fight against a virus, is out of all proportion. It is a mystery why policymakers saw fit to cause billions of euros in damage to fight a virus which presents less of a threat than the annual flu outbreak.

211. The fact that the effects of the measures are completely disproportionate is an obvious consequence of the official policy documents. At the behest of the security regions, and in order to prevent or mitigate societal disruption in the event of a disaster, the Strategy for National Security and the National Security Profile were drawn up. The security regions also play an important role in the fight against a dangerous virus. In this way, the scenario for a pandemic outbreak is established. In a serious scenario such as an influenza epidemic, more than 14,000 deaths and 40 to 50 thousand hospital admissions are expected. The costs for this scenario have been estimated at 5 billion euros. 5,680 deaths have been officially attributed to COVID-19. The number of hospital admissions is less than a quarter of that expected in the serious flu outbreak scenario. The damage caused by the measures is at least EUR 150 billion. This is thirty times the estimated cost for a much more serious scenario. There is simply no justification for this.

212. Politics and the media justify their actions with ethical arguments. The only permitted truth is that human life is priceless and therefore any lifesaving measures are justified. In fact, spending hundreds of billions more is justified, even if this means a limited benefit in terms of life years. In an opinion piece in de Volkskrant Professor Ira Helsloot of the Radboud University concluded that every year of life the policymakers have saved through the measures has cost them 5 million euros. (93) Helsloot was publicly slaughtered in the media for this opinion. The opportunity was there to support Helsloot but politicians and policymakers decided not to.

(93) Volkrant 23 maart 2020, Een ongemakkelijke economische vraag tijdens de coronacrisis: hoeveel is een mensenleven waard

213. After all, making a trade-off between the burden of disease and cost-effectiveness is standard practice. This is important when apportioning resources fairly. The higher the burden of disease, the more we are willing to pay for health profits. Health profits are expressed in costs per '*Quality Adjusted Life Years*', or in other words: costs/QALY. The report "Cost-effectiveness in practice" describes how this happens, namely by giving three classes of disease a different reference value for cost-effectiveness and burden of disease.
Disease burden Reference value for the maximum additional costs (€/QALY)
From 0.1 to 0.4 Up to € 20,000 per QALY
From 0.41 to 0.7 Up to € 50,000 per QALY
From 0.71 to 1, 0 Up to € 80,000 per QALY

214. An extra year of life gained may therefore cost a maximum of between 20 and 80 thousand euros. Policy makers have so far spent up to 50 times as much. We appear to be extending death bed capacity rather than extending human lives. According to a study by Gupta Strategists, we would save 12,000 to 21,000 healthy life years (QALYs). This is evident from the report "COVID goes cuckoo" by Gupta Strategists. The number of healthy life years gained is very little compared with what the measures have cost: an estimated 100 thousand to 400 thousand healthy life years have been lost due to canceling and postponing regular care, such as care for people with cancer, heart failure, diabetes or intestinal diseases. (94) The qaly standard has been exceeded 70 to 100 times.

(94) https://gupta-strategists.nl/studies/het-koekoeksjong-dat-covid-heet

215. It is ironic that society has been plunged into this abyss under the pretext that this has been done to save the elderly in society. At the same time, the nursing of the elderly is kept to a minimum and non-emergency treatment has been suspended for months. Due to the draconian rules, the elderly have also been deprived of contact with family members for many months now. A large number of elderly people have consequently passed away prematurely.

216. When drawing up the balance sheet, the following picture emerges:
1. COVID-19 is no more dangerous than the annual flu and forms therefore no real threat of disruption to society and public health. This could well be a false alarm;
2. Decision-making has been flawed in every way. It has been opaque, arbitrary, not transparent, without democratic legitimation and would fail the test of the ECHR. Policy makers have reserved for themselves the right to extend the restrictions on freedom for days to come;
3. There have been far-reaching restrictions on fundamental rights and personal life implemented through emergency ordinances without legal foundation;
4. The goals set by the OMT and policy makers do not provide justification for a continuation of the state of emergency. Never before, not even in the 2017/18 epidemic which had significantly greater mortality, has the wellbeing of the whole of society been subjugated to the capacity of the health care system;
5. The subsidiarity principle has not been adhered to. Non-mandatory advice to the public would have sufficed;
6. Both from the comparison with countries which did not implement mandatory measures, and from the WHO study, it follows that there is no rationale behind the measures and the continuation of the measures is thereby unlawful;
7. The consequences for the economy, public health and society have been catastrophic and have no relation to the objectives pursued. It appears that more people have died as a result of the measures than from a COVID-19 infection.

217. It is possible that the initial decision on 15 March 2020 which was based on the information available at the time was indeed lawful. This will need to be further investigated. However, continuing to restrict freedoms when soon after this date it was established that COVID-19 did not pose a real threat, is in any case unlawful. All measures should be lifted immediately.

218. Policy makers justify continued restrictions on freedom with the argument that possible disasters are about to happen. Hundreds of thousands of people were supposed to die. This did not materialise. The public are now being terrorised with the threat of a second wave. It is unlikely that this catastrophe will take place based on current knowledge

of the virus. In addition, previous experience with the Mexican flu showed that the experts – who today also decide policy - were wrong. If possible disasters were to decide public policy, society would be permanently locked down. There is always the possibility that our country will be affected by disaster. But to keep the country locked down on the off-chance of something happening is unacceptable.

219. The fact remains that despite being fully aware of the financial and social consequences of *lockdown,* policymakers chose to focus all resources on the severe disaster scenario with the full lockdown that entailed, and which continues to be implemented to this day.

220. The media has made it impossible to have a balanced weighing up of interests. The political world should not be driven by emotion. Rather, they should take decisions in a legally responsible manner. The House of Representatives has also not been able to influence this process. This means that it is now the job of case law to correct this process with a debate about facts and an actual balancing of interests which should have been done by policymakers and politicians.

221. Incidentally, there are more judges worldwide who have intervened in this surreal situation. The Supreme Court of Wisconsin, for example, ruled on May 13, 2020 that all measures for the state of Wisconsin be waived. (95) Describing the situation succinctly, the verdict reads as follows: *"The rule of law, and therefore the true liberty of the people, is threatened no less by a tyrannical judiciary than by a tyrannical executive or legislature. Today's decision may or may not be good policy, but it is not grounded in the law."*

(95) https://law.justia.com/cases/wisconsin/supreme-court/2020/2020ap000765-oa.html

Conclusion: The measures must be lifted immediately and unconditionally.

Jurisdiction

222. The District Court of The Hague is, pursuant to Article 99 Rv. authorised to hear the dispute since the State of the Netherlands has its seat in The Hague.

Admissibility of claimants

223. Plaintiff sub 3 defends a general interest, on the basis of article 3: 305a BW according to its statutes. The requirements of Article 3: 305a BW have been met. He represents the interests at stake here, on the basis of adequate statutory provisions and he is active in the protection of fundamental rights and the rule of law. Plaintiff sub 3 has over 300 thousand statements by Dutch citizens and businesses in support of lifting the lockdown restrictions. These were digitally collected using the website's online form.

224. Plaintiffs have attempted to make amicable progress in these proceedings with their letter of 27 May 2020. However, in his letter of May 28, 2020, the defendant refused to consider in any way the stated disadvantages and objections to lockdown. (Appendix 47: Minister's letter May 28, 2020)

225. Claimants 1 and 2 each have an interest in the claims brought. Since they have Dutch nationality and reside in the Netherlands, they are confronted on a daily basis with serious infringements of their personal freedoms and other fundamental rights.

A matter of urgency

226. That this is a matter of urgency naturally follows from the aforementioned. The daily continuation of the measures has caused and is still causing extensive personal and social damage on an unprecedented scale.

Offer of Evidence

227. Without wishing to assume any burden of proof which does not legally rest on plaintiffs, they offer evidence of all their assertions by all legal means.

THEREFORE:

Plaintiffs ask, Your Honor, Lord/Lady Facility judge of the District Court of The Hague to order the defendants to immediately summon the directors of the security regions and to recommend that all emergency ordinances be withdrawn; to declare the prospective bill "Temporary Law Covid-19" null and void, or at least in good justice take a decision that will materially (in advance) lead to the non-application of this bill, or at least

this Act, with orders to pay the costs of the proceedings.

My appellants declare that they can set off turnover tax within the meaning of the Turnover Tax Act 1968 and furthermore, any disbursements made where necessary to carry out the present official act, and that I, bailiff, have no direct or indirect interest in the company that billed the costs.
The costs for me are bailiff, € 92.31 excl VAT