Toward a New York City Hypothesis

Jessica Hockett, PhD | Presentation for PANDA Open Science

This is an enhanced transcript of two-part presentation for PANDA Open Session, delivered virtually on 23 May 2023 and 25 July 2023. https://pandata.org/toward-a-new-york-city-hypothesis/ https://rumble.com/v37r0gc-toward-a-new-york-city-hypothesis-dr-jessica-hockett.html Some of the points made in the first half of the presentation were repeated in the second part (which occurred on a different day), to account for participants who didn't attend the first session. Most of the participant questions were removed and the videos for both sessions were edited.

At this point in 2023, I was asserting there was no pandemic and seriously doubting sudden spread of a novel coronavirus but wasn't yet claiming outright that COVID-19 was a fraudulent disease. I've inserted bracketed notes to clarify certain points or make a connection to something I wrote or learned later that changed my thinking. Later presentations via I-PAK and to Senator Ron Johnson's staff included updated and revised material. "Eleven Sets of Serious Problems with the New York City Mass Casualty Event of Spring 2020" is a summary of findings as of September 2024. "New York City Spring 2020: An unsubstantiated mass casualty event that appears fraudulent and staged" is a personalized narrative that includes my perspective on NYC as an intentionally activated simulation.

The November 2023 PANDA article, "Does New York City 2020 make any sense?" (Verduyn, Hockett, Engler, Kenyon, & Neil), followed this presentation and was a collaborative effort among analysts in the PANDA Slack channel to distill and flag key data anomalies surrounding the New York City 2020 event.

Session 1: 23 May 2023

Background

Good morning, everybody. My name is Dr. Jessica Hockett. You can take a look in the Slack description for details of my bio. I live in Chicagoland and I'm new to the PANDA group but not new to advocacy and writing about data and things that went on during the alleged global pandemic.

Ever since I came back from my Twitter ban, I've been very, very focused on just a few topics, from January onward or so. One of those has been New York City and the mass casualty event that occurred there in 2020.

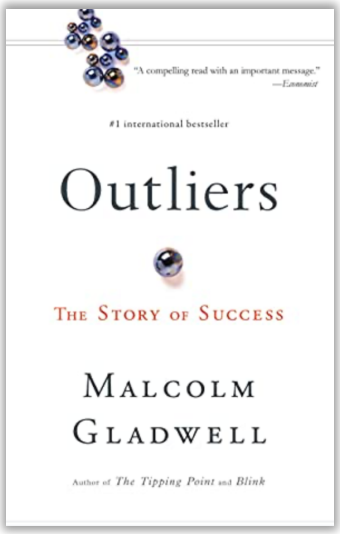
I've long been interested in it. In 2020, Todd Kenyon probably remembers when I was like, "Hey everyone! What happened in New York City? Can we talk about this?" And people would say "ventilators" or "nursing home policy." But that never really seemed

to fully explain things for me, and I was never really convinced or intellectually satisfied -- and I'm still not – that there was sudden spread of a novel respiratory pathogen that killed 20,000 people in 11 weeks in New York.

I've spent a lot of my personal time, nobody's funding this work – this is just me and my hobby. I've spent a lot of time gathering data, getting data through public records requests and directly from researchers. Some of that work is going to be in here. If you have a really burning question while I'm more formally presenting, please interject. I grew up in a family of interjectors. Some people would call us 'interrupters," but it's interjectors. So, I'm more than comfortable with that.

Approach to investigation: Study the outliers - exceptions prove the rules.

I want to start by giving you a metaphor. If you've ever read the book *Outliers* by Malcolm Gladwell, you know that the basic premise is that, when you look at outliers, you look at extremes – extreme stories of success, in his book – and you say, "What is it that makes this 'outlier' successful, and what could we learn from it?"



And I think that's true for New York, except I would call it a story of systemic *failure*. **[JAH: I later came to see the event as a simulation with real patients and people that was pulled off very successfully.]**

But I think that it's an exception in such a huge regard that we can look at it and say, "Does the exception prove the rules?"

I believe that in-depth study of what occurred there can generate some rules that apply to the entire pandemic. That's why my focus has been on a very specific time period and sequence of events.

This morning, my questions that I framed the presentation with – well, first just a statement: I hope we can all agree that New York City experienced a near-peerless mass casualty event in spring 2020. What the heck happened? This has been a burning question for me for a long time.

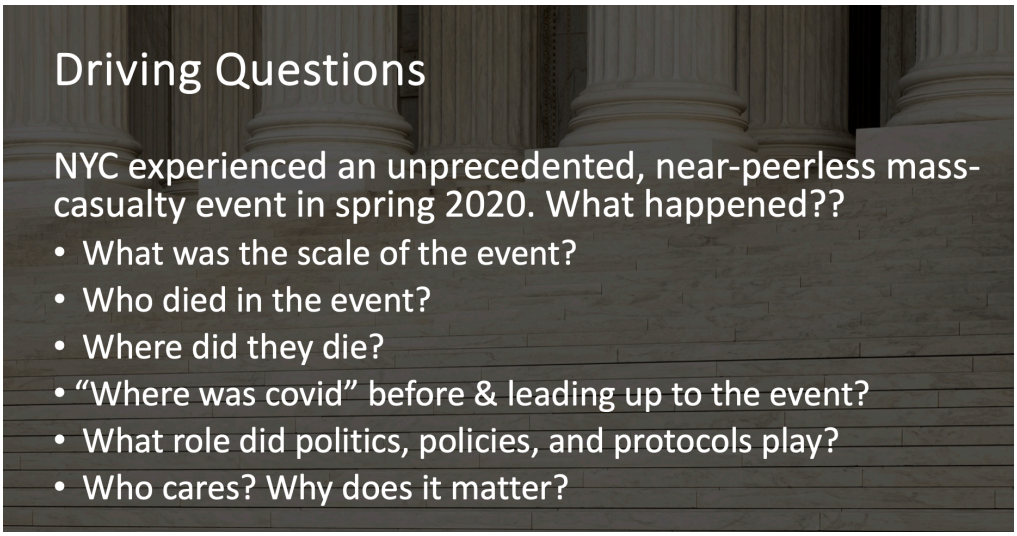
Driving/Ongoing Questions

I'm going to present aspect of the scale of the event, to give us all a sense of the scale. Some elements about who died – although, I have to tell you, this is such a burning question for me: who the heck *were* these people? Not just gender and age and cultural background or racial background, yes, but who were these people? Where did they die? How did they get to the hospital, for example, if they died in the hospital?

Place of death data is very thorough in the United States and has been often neglected by researchers – and the CDC, which is very interesting to me.

I'll also show you some things around this question of "where was covid?" before and leading up to this mass casualty event. Was it "silently seeding"? How can we see it? Where does it show up in data? Are there some clues?

Then I'll also touch on the role of – maybe not touch on it, maybe this is enveloping the whole thing – but what did role politics and protocols and policies play? And who cares? Why does it matter?



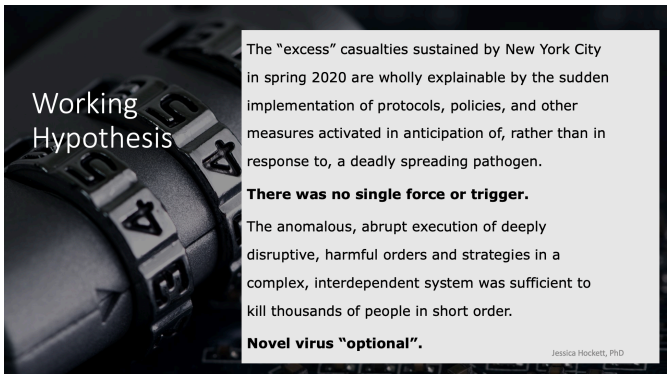
I get that a lot, from my colleagues, or some of them are former colleagues now, but on Twitter: "Why do you care about this? Why are we looking back on this?" I get that from New Yorkers a lot. "So what? The virus was bad. People died. We could've done better." I'll address that toward the end.

This group is really smart. I'm presenting to a group of people that are far beyond my expertise in pretty much every arena, but I just want to let you know that this [presentation] is a little graph heavy, the content that I'm going to present. But because this was a mass casualty event, and an *incident*, timeseries data, especially, has been so critical to me, and I think is critical to *any* examination of looking at what happened in New York City.

Working Hypothesis

This [below] is my **working hypothesis**, which it's a hypothesis that I know some of you share too, just in general about what happened with the global pandemic.

> The "excess" casualties sustained by New York City in spring 2020 are wholly explainable by the sudden implementation of protocols, policies, and other measures activated in anticipation of, rather than in response to, a deadly spreading pathogen.
> **There was no single force or trigger.**
> The anomalous, abrupt execution of deeply disruptive, harmful orders and strategies in a complex, interdependent system was sufficient to kill thousands of people in short order.
> **Novel virus "optional".**



Operating from "the Null"

I'm operating more or less from "the null" – not because the null is *necessarily* 100% true – in other words, null hypothesis ***Sudden spread of a novel respiratory pathogen is not responsible for ANY of the excess deaths in 2020*** -- that may or may not be the case in the final analysis, but I think we get closer to the truth by operating from the null than operating from the assumption that it was mostly COVID.

I hope to be able to show you today just a glimpse of the reasons why I believe, look, 27,000 extra people died in eleven weeks. It's astounding. It's incredible. But I think that enough happened from the human intervention side that does explain, that can explain the casualties that occurred. Does that mean I don't think there's a virus? No. **I don't really care if there's a virus, in some ways.**

I'm less concerned with that than I am with investigation of the non-natural forces that were acting upon a city of 8.8 million people.

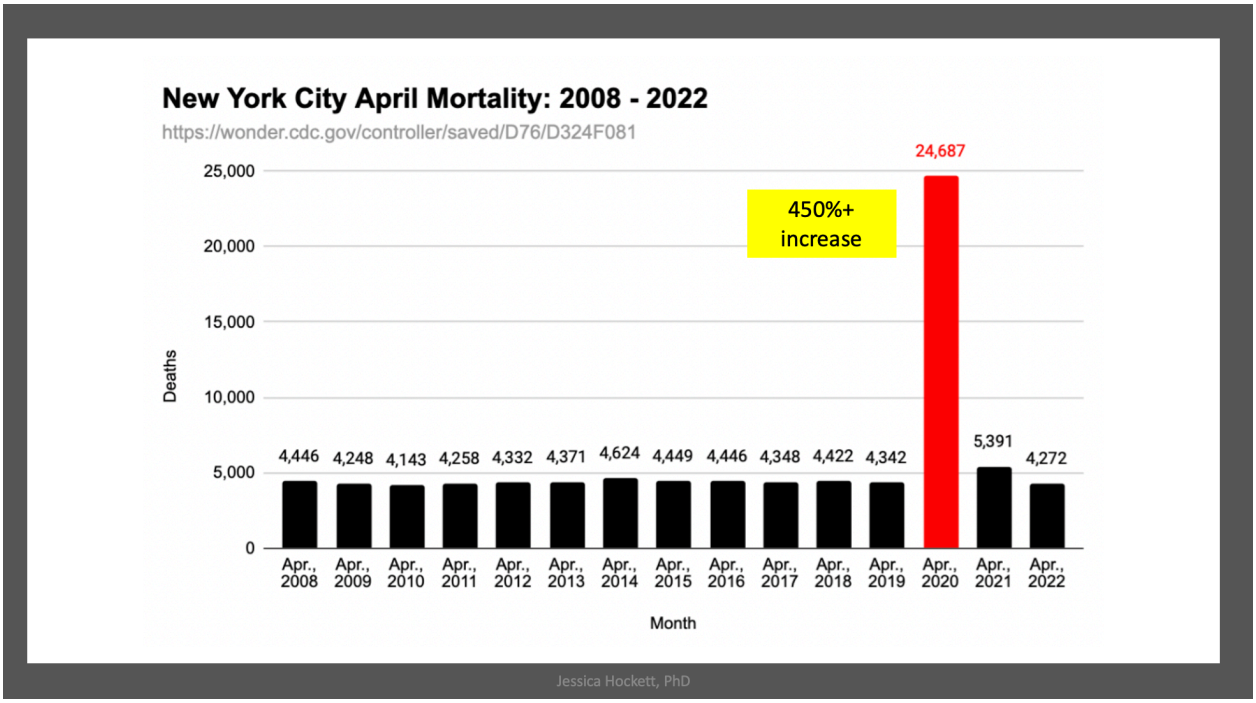
Scale of the Event

Let's look at the scale of the event. I know this group is aware of some of these details already.

It's always interesting to me to frame for people, I did this a few months ago on Twitter, to try to keep getting at the scale of the event, because I feel like a lot of people don't understand. Back in February, I said, "Say there's a city that normally experiences 4,000 deaths or so in a month. If that number jumped to 25,000, what would you think had happened there?"

The responses were pretty funny. Some people were like "Climate change!" Other people said "vaccines," which was an interesting response to me as well. And other people were like, "Where did that happen? Did that happen?"

Yes, it did happen. To quote T.S. Eliot: "April was the cruelest month," in New York City, in a very, very, very long time. **[JAH: Here, I was also invoking the title of an article I wrote in October 2022, critiquing Michael Senger's iatrogenic death estimate for New York City.]** The scale there is just incredible.



I think people believe, "Okay, 8.8 million people live in New York City. So, 27,000 extra people in 11 weeks isn't that much."

It **is** a lot. It's a city that experiences about 150 deaths a day, give or take, about 4,500 in an average month. They had an astounding number of bodies – no disrespect to the dead – an astounding number of casualties occurred.

Are the casualties real?

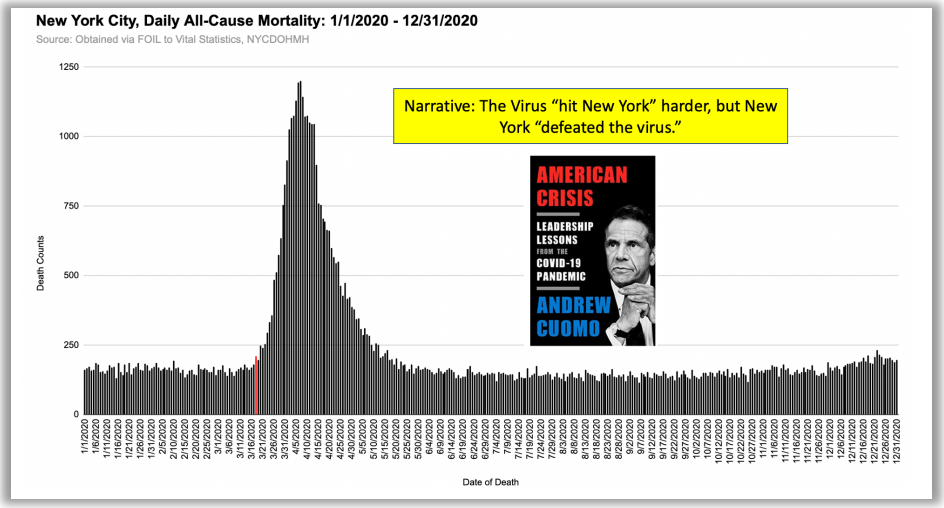
I do assume that those casualties did occur. People ask me, "Do you think it's fraud? Do you think they made stuff up?" Anything is possible, but I do operate from the assumption that those are actual people who died. **[By the second session, in July, later in this transcript, I was saying that I thought data fraud was in the mix and the spike not entirely real.]**

A four hundred fifty percent (450%) increase [in April 2020 versus baseline Aprils]. Pretty much unmatched around the world at that time, maybe with the exception of Bergamo. Jonathan Engler maybe could speak to that better than I could. **[JAH: I later took an interest in the Bergamo event and wrote this, this, and other articles related to the daily death curve, which I regard as fraudulent.]**

I was able to obtain daily death data. I tend to focus a lot on all-cause mortality, so I'm a little like Denis Rancourt in that regard. Dead is dead, right?[1] Unless we're talking about excess mortality, it doesn't necessarily matter what people die of, when we're talking natural death.

If we take a look at the daily data, you can see that I have a red bar there. It's not anything statistical. I'm showing where exactly mortality kind of starts to move. That's on March 18th, 2020. But it's astounding to me that we don't have anything going on in all-cause mortality leading up to mid-March. And then perhaps even *more* striking is that daily all-cause mortality (and weekly and monthly) *dropped like a rock.* It actually went below baseline and doesn't rise again until December, late December, which is during the advent of the mass vaccination campaign.

I think that's incredible. Very, very few places around the world – excuse me, in the United States – look exactly like this. New Orleans, actually, comes pretty close, insofar as the drama of the rise and then the fall and it doesn't come back up until late December.[2] So, a lot of people in a very, very short time.



[1] h/t Mary Pat Campbell, life actuary, for this phrase

The New York Story

The prevailing narrative that I would say most New Yorkers, most Americans, still believe is that **"the virus hit New York harder"** and then "**New York defeated the virus"** And there couldn't be a more American narrative than that, right?

This was basically the narrative of Andrew Cuomo's book – fascinating read, by the way, if you don't mind spending the $5. It's fascinating. And that was Trump's narrative too, about it. That's New Yorkers' narrative.

> ***The virus "hit harder" but New York defeated it. New York hospitals figured out what to do with the virus and showed the rest of the world, and then the rest of the world wanted to avoid being New York. And thank you, New York, for doing this for us!***

Participant: I have a quick question. Do you have this timescale showing when they first did the massive lockdown of some part of the city? Because I was *in* New York when they said, "Oh my God! We gotta stop right now! This part of the locale has been blocked off. We've got guards at the gate – that kind of crap."

Hockett: In New Rochelle, right? The National Guard came in…

Participant: Exactly! "Oh my lord, we've gotta get home!" I was kind of struck by the fear. I kind of got – bought into it. "Oh my God! I gotta get the train like right now!"

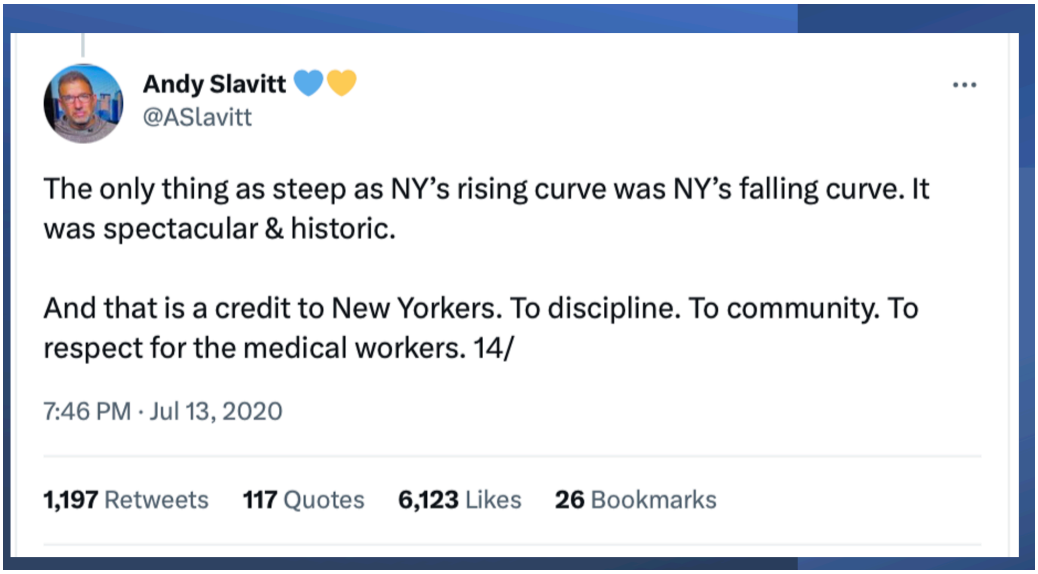
Hockett: Yeah. And to your point – and I'll come back to this too – and I live in Chicagoland, I used to live in the city, in Chicago. I was in Cook County when this all went down, but I know New York very well. My husband's there all the time. I used to go all the time too. A lot of people don't understand: there's an inherent tenseness to New York anyway. And being in the city, any city, when panic starts to grip it, you can feel it.

People in New York City live in these postage-stamp sized apartments. Even some wealthy people in Manhattan live in 700 square feet. It's very enclosed. So, when you talk about shutting down a city like New York and telling people to stay home, it's a very different thing than telling people in L.A. Because in New York, your life is very much outside of your apartment, and around people, right? You go to the deli. You go to the park and play checkers. You go to the theatre. Nobody lives in New York because

their apartment is so great. If you picture "stay in your apartment," the fear would grip in New York, I think, like no place else. I think it is exceptional in many regards.

So, I will get to that kind of timeline very soon because that is important. The sequence of events really matters in this event.

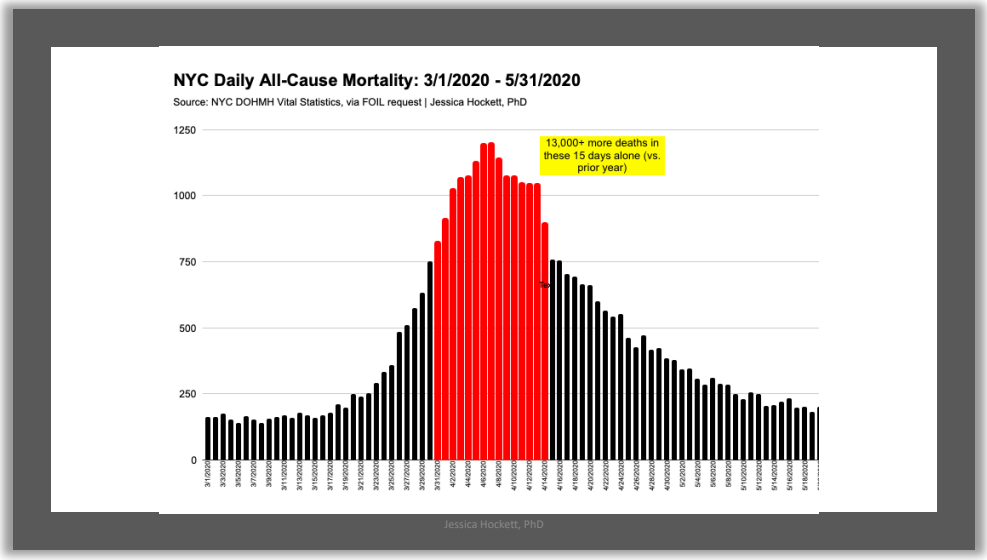
Here's another example, I don't know if some of you know Andy Slavitt. If you don't, it's probably for the best. This is what he tweeted back in July after this initial event occurred.



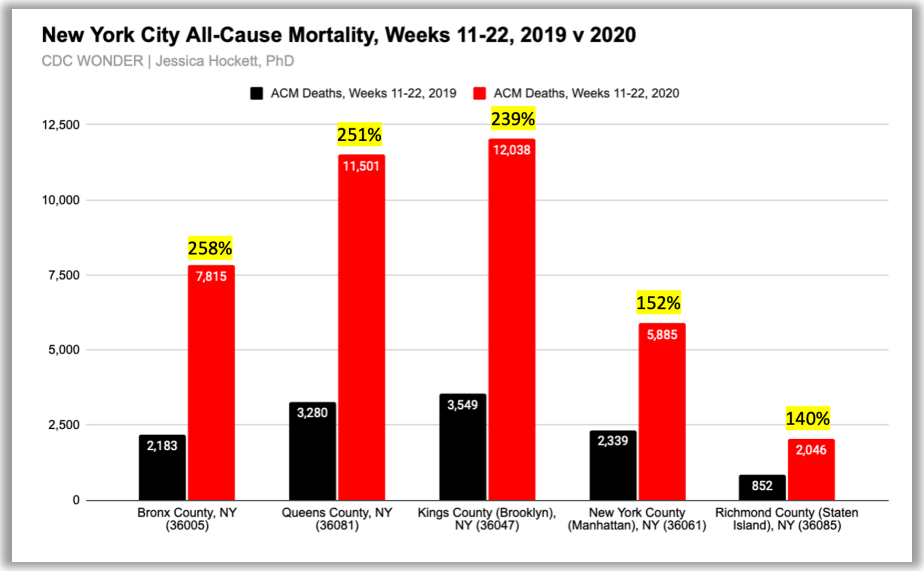
It was like, "Yay New Yorkers! You did it! Healthcare Heroes!" I would say this narrative persists to this day and it's going to be hard to undo.

Event magnitude: Density, World Trade Center disaster comparison, borough differential

Another sense of scale: Most of the deaths, ironically, the bulk of the deaths occurred in 15 days. "15 days to slow the spread!" 13,000 more deaths occurred in 15 days – the mortality equivalent of four and a half times the 9/11 event, just to give perspective to New Yorkers. It's astounding to me that people are like, "Yeah well, the virus. The virus hit us." That's what people say.



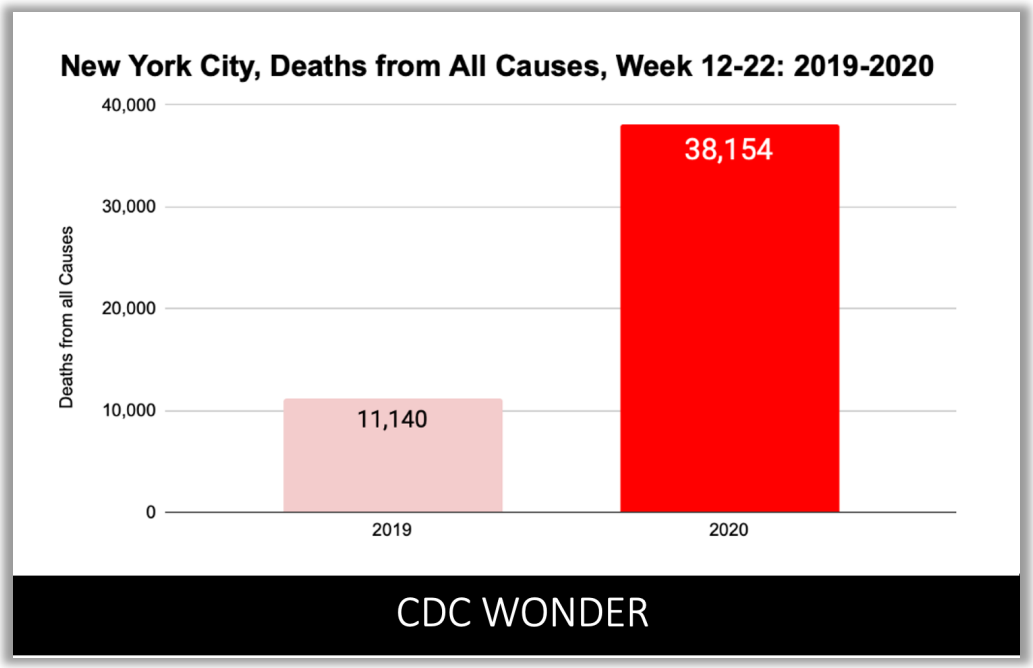
Another fascinating point about sense of scale is New York City is comprised of five boroughs, five counties. Some boroughs have the same name as the county, some don't. It's interesting that New York County (Manhattan) and Staten Island saw a lower increase in mortality.



The CDC's explanation for Manhattan is that people fled Manhattan, and I do think that's true, that a lot of the rich fled to their place in the Hamptons or Cape Cod or what have you. So, the emptying out of Manhattan could explain some of that, because I would say there are fewer people that went to the hospital, so that I can explain. Staten Island, people have told me that there's a different vibe there among some different

groups of people. I'm not going to get into all of the possibilities, but apparently – I've joked that apparently water is protective. We've got the two island boroughs that the virus didn't strike as hard. The differences are fascinating when you're looking at that kind of comparison.

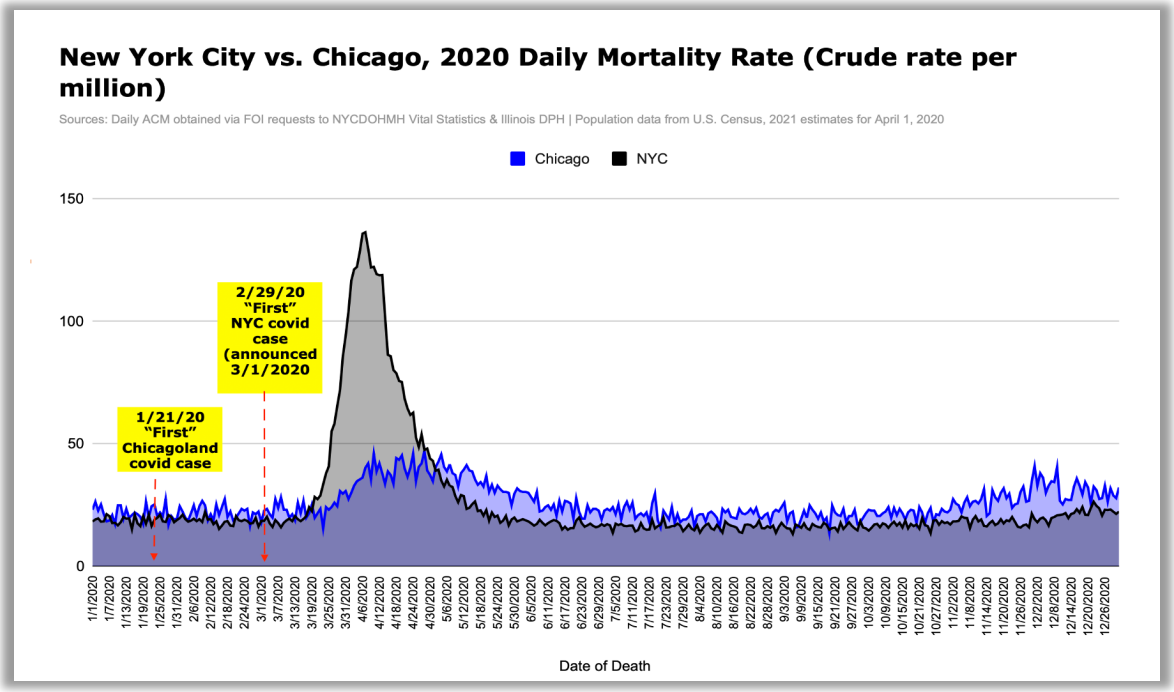
This is just another view, just a bar graph comparison of the 27,000 [increase].



New York versus Chicago

A great comparison for me, probably because I live in Chicagoland *is* Chicago. When you scale for the population, when you adjust for population, we see that New York City, *yes,* it is bigger by far in terms of population; *yes*, it's denser. But it is head and shoulders above Chicago, which also experienced pretty severe mortality during that time.

I find that pretty fascinating from a "spread theory" perspective, because in Chicago we had the first cases announced in January, the third week of January or so. New York City didn't announce its first case until March 1st.



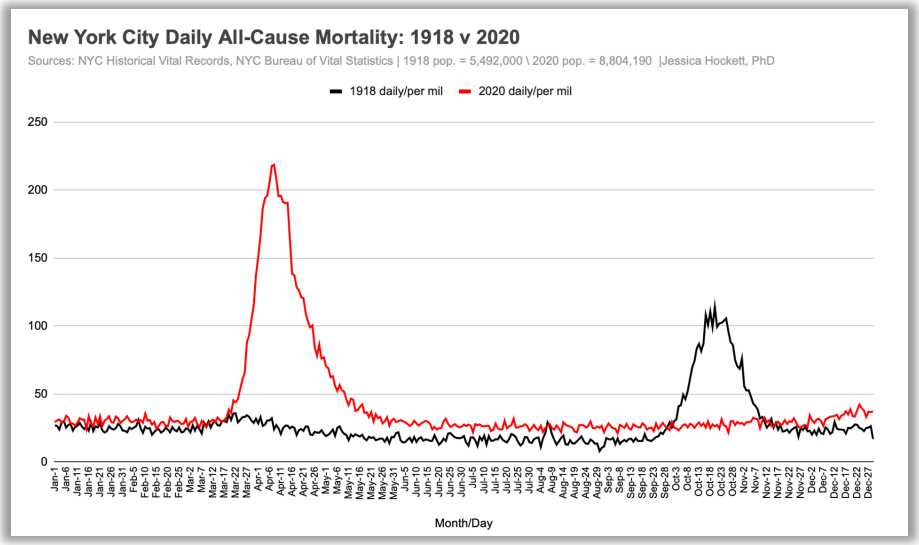
But in neither city, in daily all-cause mortality, do you see anything that looks like *oh the virus is spreading, the virus is spreading, the virus is spreading*. In both cases, it happens after so-to-speak lockdown orders and other interventions.

New York Spring 2020 versus New York 1918

One more point, this is my final point about scale. People talk about 1918. I went and looked. New York City has every death certificate digitized from 1850-1949, and they have some line-item data associated as well.

When I take 1918 daily all-cause mortality versus 2020, 2020 exceeds that period that I would call it "panic period." **[JAH: I no longer use the term 'panic' as freely as a descriptor as I once did because I find it imprecise, inaccurate, and (ultimately) beneficial to the government officials and purveyors of pandemic mythologies.]**

I think I would also call 1918 a panic driven as well, based on how fast the mortality went up and how fast it went back down. But right now, the New York City Department of Health, Bureau of Vital Statistics, still tells everybody that 2020 wasn't like 1918. It was close. If you look at just the event itself, it's higher, which I find hard to believe. So we're saying that 'COVID' was more deadly than the 'historic' 1918 flu pandemic. Really? I find that really fascinating.



Who died? The working-age adult conundrum

Who died in New York? is a key question that we don't have, really, a lot of answers, but I do think it's worth showing you some quick things about age.

The age profile of deaths – and I'll get to COVID deaths later – but the age profile, if we just break it up into 20-69, and then 70+, insofar as percent increase, these two age groups were very similar, almost equal. **[JAH - The reason for choosing these groups relates to age bands described in Pezzullo et al (2023), which reported COVID IFR's through age 69.]**

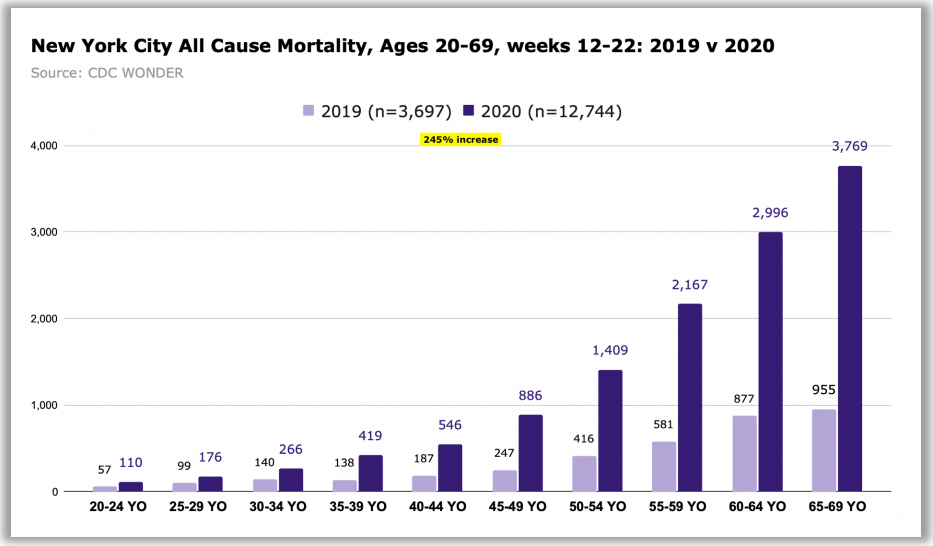
New York City, pop. 8.8 million			
MMWR Week	2019 All-Cause Deaths (20-69)	2020 All-Cause Deaths (20-69)	% Increase
Week 12	323	445	38%
Week 13	341	961	182%
Week 14	354	2,192	519%
Week 15	380	2,541	569%
Week 16	321	1,896	491%
Week 17	321	1,325	313%
Week 18	336	996	196%
Week 19	336	813	142%
Week 20	344	588	71%
Week 21	330	540	64%
Week 22	311	447	44%
TOTALS	3,697	12,744	245%
Source: CDC WONDER			

New York City, pop. 8.8 million			
MMWR Week	2019 All-Cause Deaths (70+)	2020 All-Cause Deaths (70+)	% Increase
Week 12	676	942	39%
Week 13	742	1,831	147%
Week 14	665	4,186	529%
Week 15	689	5,474	694%
Week 16	629	4,193	567%
Week 17	609	2,838	366%
Week 18	645	1,939	201%
Week 19	687	1,320	92%
Week 20	683	1,043	53%
Week 21	701	806	15%
Week 22	567	718	27%
TOTALS	7,293	25,290	247%
Source: CDC WONDER			

Jessica Hockett, PhD

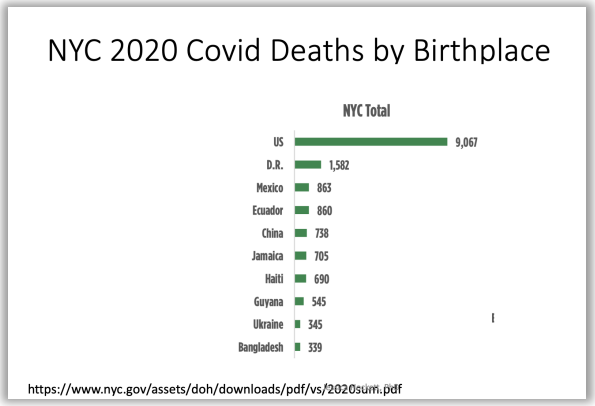
We had a ton of younger people dying, people in age groups that we know are not susceptible to death-by-SARS-CoV-2-infection and things that might result from that. So, again, New York is an outlier in this regard.

This is just a different view of the same data [of the 20-69 data broken up into age groups]. Again, keep in mind, this is just over 11 weeks. It's not even a full year that this occurred.



Who Died: Undocumented Immigrants?

One thing that people have asked me is **do I think that there's a lot of undocumented immigrants, so to speak, that died.** I don't know, but the New York City mortality, their 2020 mortality report (which was just finally released last month, by the way), they did include some COVID deaths by where people were born.

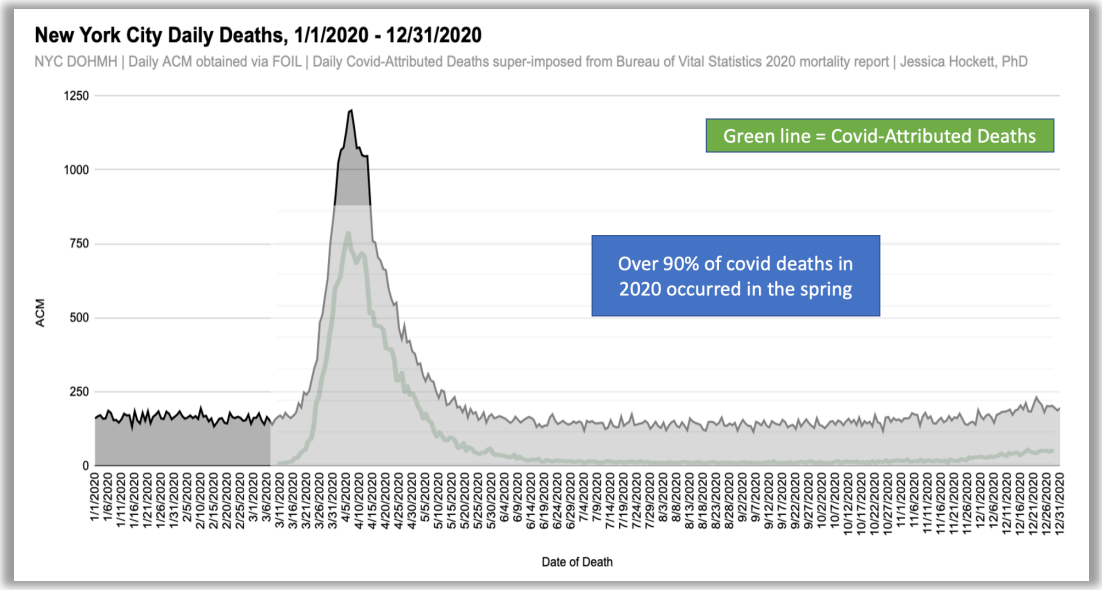


The overwhelming majority is in the U.S., but there are a number that were born elsewhere, so that could be a starting point for thinking about who died and whether it was people that there's no record of them being here. In this case, this [data] would be people that there's record of, but I think that's an interesting line of inquiry.

Looking for signals: Daily ACM vs Daily Covid-blamed

Let's take a look at "where" we see, or don't see, signals or signs of COVID.

Here's that same daily death graph. I've superimposed the line from the vital statistics report for daily COVID deaths so you can see what they're saying. **[JAH: I did this because I hadn't yet received a response to my FOIL to NYC DOH for daily COVID deaths]**



Right now, New York City says that around 20,000 people died from COVID during that period. I've lined up the timeline [dates]. Over 90% of COVID deaths in 2020 occurred in that timeframe, and I think it's 93% or 90% of excess *for the year* also occurred in that timeframe.

The implication here is *Look, COVID struck New York City like a series of bombs going off, and then it left the city alone*. **[JAH: The bomb metaphor is one I kept returning to – and still use. Chris Waldburger framed our Septemeber 2023 Twitter Space with it, accessible here: https://x.com/i/spaces/1MYxNglPgMOKw/peek]**

I don't understand quite how people rationalize that. I guess if you're in the "spread theory" mindset, it's like, *oh look: it picked off the most vulnerable and then left everybody alone because the general population gained immunity.*

I don't know all the ins and outs of that, which actually kind of helps me, because then I can ask stupid questions. I can be that kid in class, like, "Hey, how does that work? Because there's a lot of vulnerable people still left in New York City, right? What happened there?"

I find that view fascinating because it raises questions about SARS-CoV-2 in general, in my mind.

Young COVID Deaths raise questions about all COVID deaths.

If we look at the specific age ranges insofar as COVID deaths, you can see that these mortality increases from 2019 to 2020 in these groups, in some cases, are effectively being blamed on COVID.

Five-Year Age Groups	NYC ACM, Weeks 12-22, 2019	NYC ACM, Weeks 12-22, 2020	Increase	% Increase	Deaths with Covid-19 on Death Certicate	% Increase with Covid on DC
20-24 YO	57	110	53	*93%*	26	49%
25-29 YO	99	176	77	*78%*	57	74%
30-34 YO	140	266	126	*90%*	108	86%
35-39 YO	138	419	281	*204%*	208	74%
40-44 YO	187	546	359	*192%*	301	84%
45-49 YO	247	886	639	*259%*	527	82%
50-54 YO	416	1,409	993	*239%*	827	83%
55-59 YO	581	2,167	1,586	*273%*	1,325	84%
60-64 YO	877	2,996	2,119	*242%*	1,850	87%
65-69 YO	955	3,769	2,814	*295%*	2,348	83%
Totals	**3,697**	**12,744**	**9,047**	***245%***	**7,593**	**84%**
Source: CDC WONDER						

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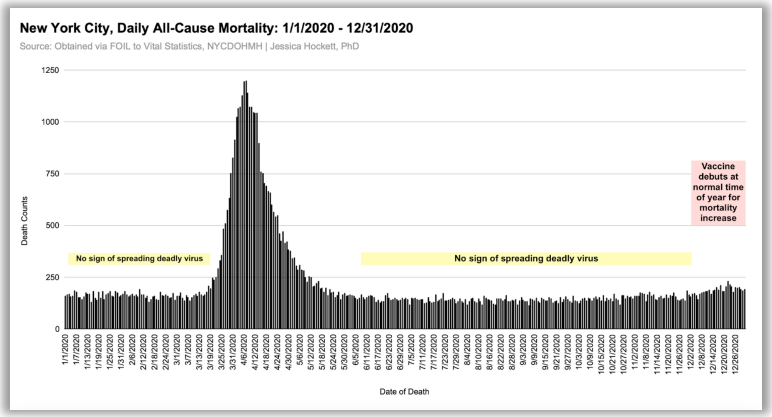
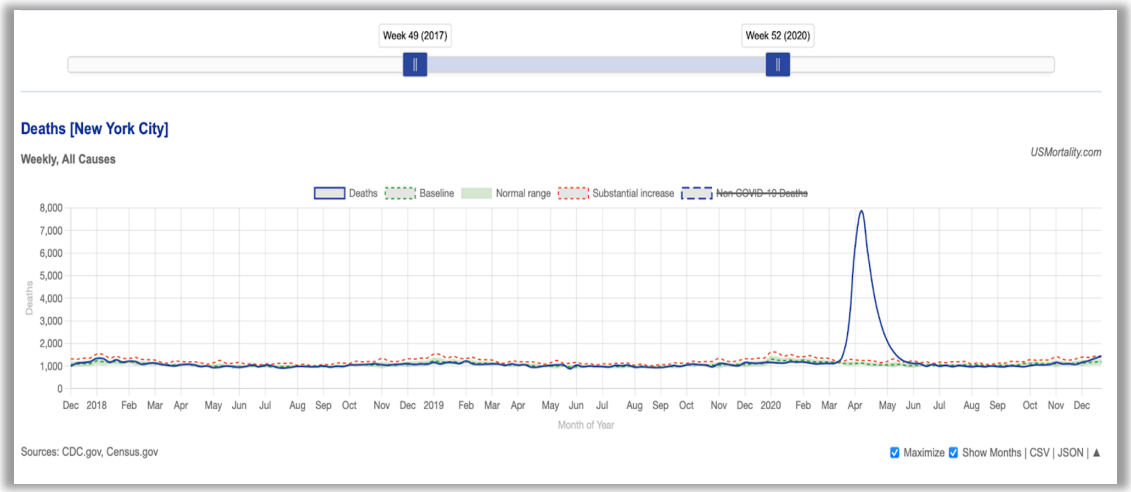
COVID is being used to explain, or potentially explain in some way, for example, 827 of the 993 "extra" deaths among people ages 50-54. Looking back, these statistics defy what we "know" about this virus and raise a lot of different questions. **[JAH: "Young people are at risk too" and "Young people are dying" was a theme of the spring 2020 propaganda and script. See Hockett, J. (2024, June 1). "Message: The young and healthy are at risk from COVID-19." *Wood House 76*.]**

Looking for signals: Longer timeline and cause of death categories

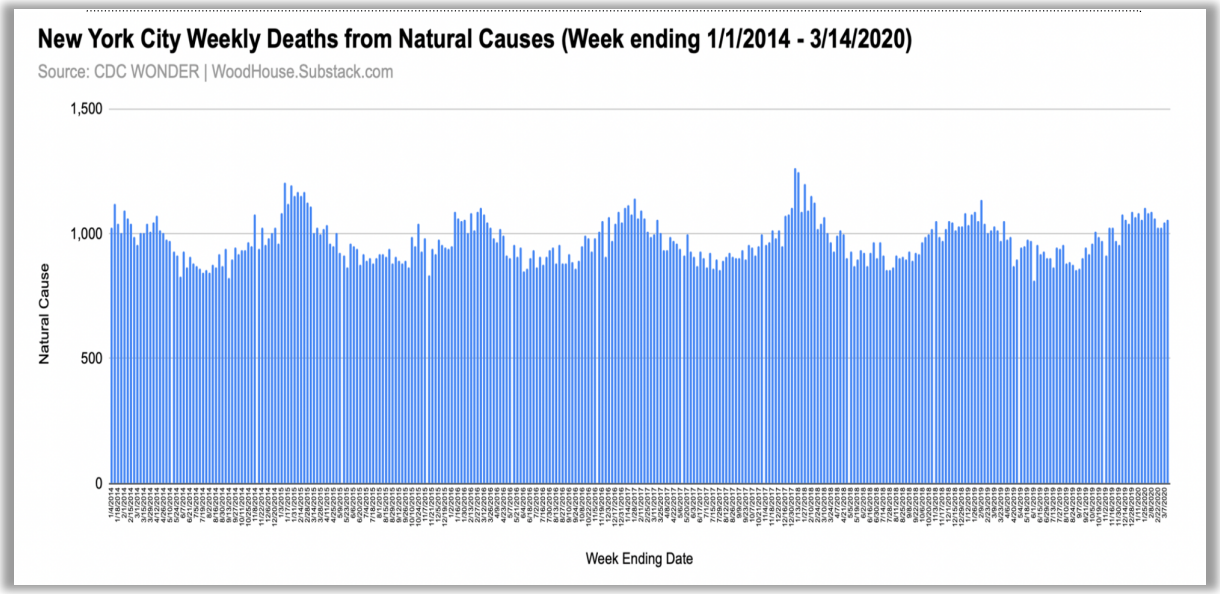
In all cause-mortality, we don't see "sign of spreading deadly virus" -- either before or after.



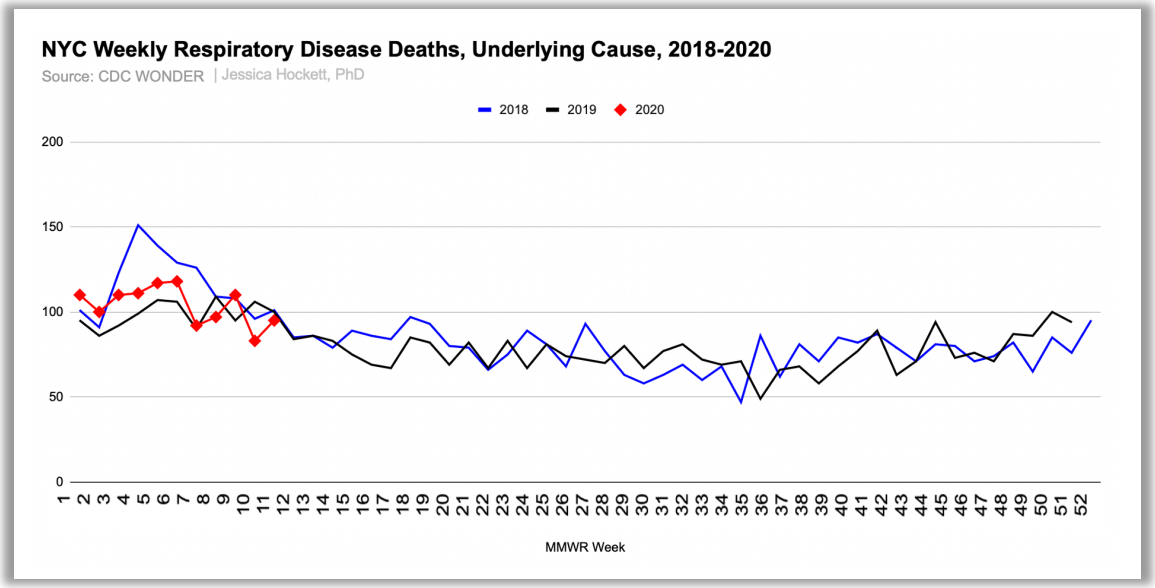
This is Ben Marten's view (US Mortality.com). Looking all the way back, there's nothing happening there whatsoever. So when I look at a spike like this, I think, "That's an event. If I didn't know about a virus, I would think something very cataclysmic happened. To go **up** and then go all the way back down below baseline.



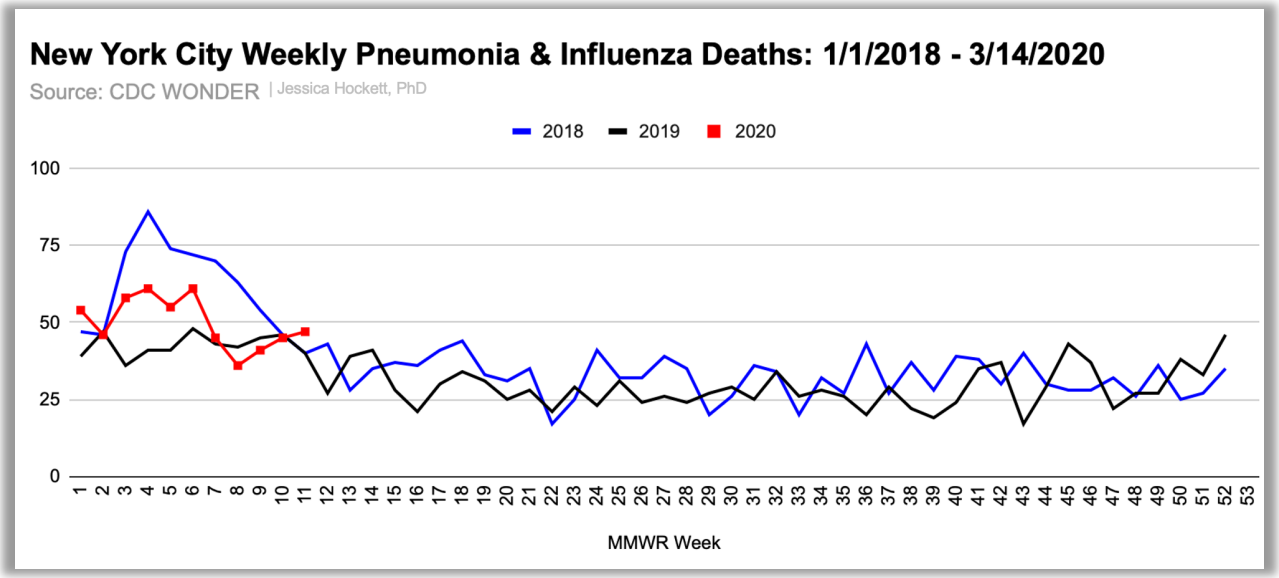
We also don't see anything in **natural cause deaths.** This [graph] going all the way back to 2014. There are no real signals, when you take out non-natural causes.



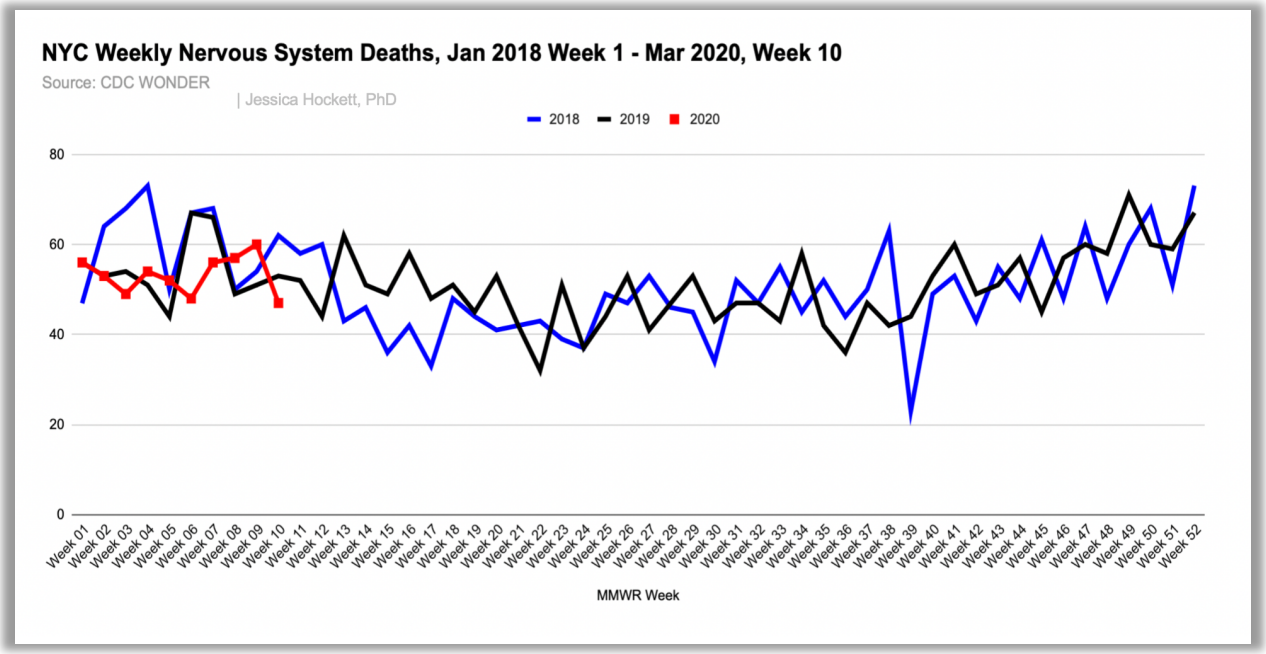
If I look at just **respiratory disease**, I don't see much going on there. Certainly not compared to 2018. I don't remember anybody closing schools at freaking out in 2018. Don't think you do either.



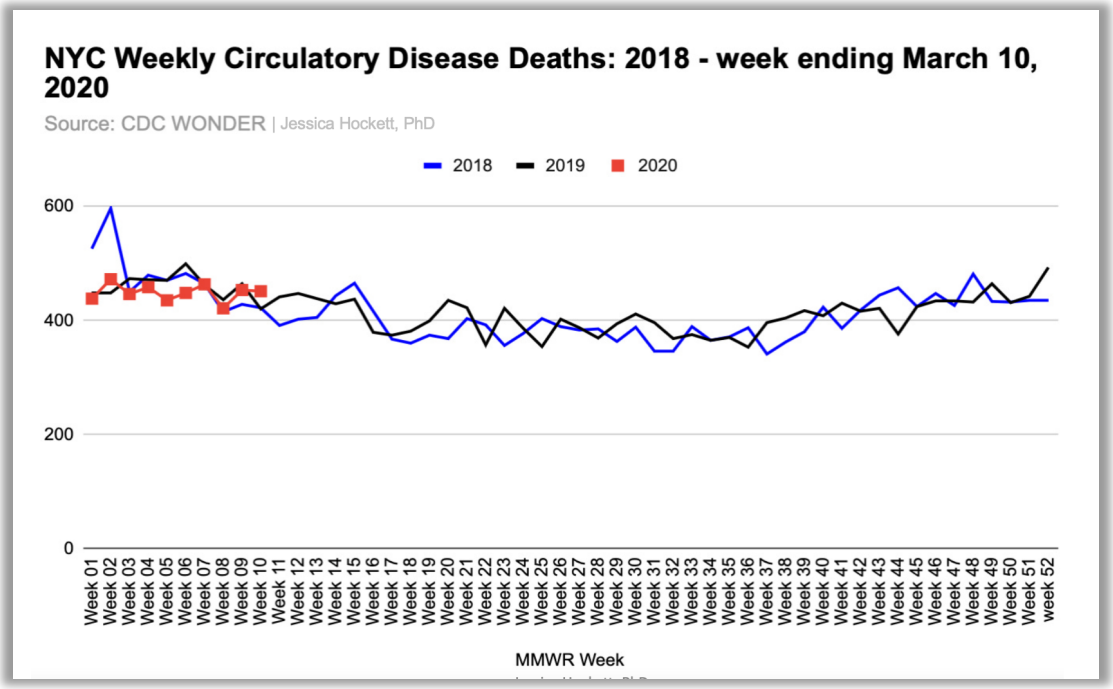
If I take out the **P&I, [pneumonia and influenza]**, we have some elevated P&I in those earlier weeks. It's not really anything to write home about and it's *low* right before the cataclysm.



What about **Alzheimer's** deaths? Do we see anything there? Not really. This is the general category of nervous system deaths, but not too much going on there.



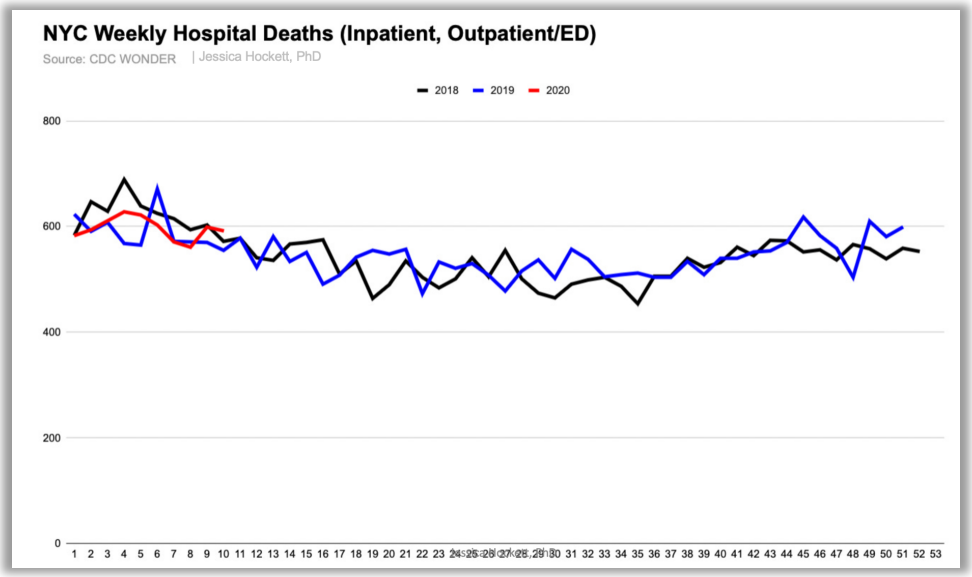
What about **heart-related** deaths? Again, this is just the big category, but I'm not seeing much there either. 2018, yes. Not so much in 2020 in those early months.



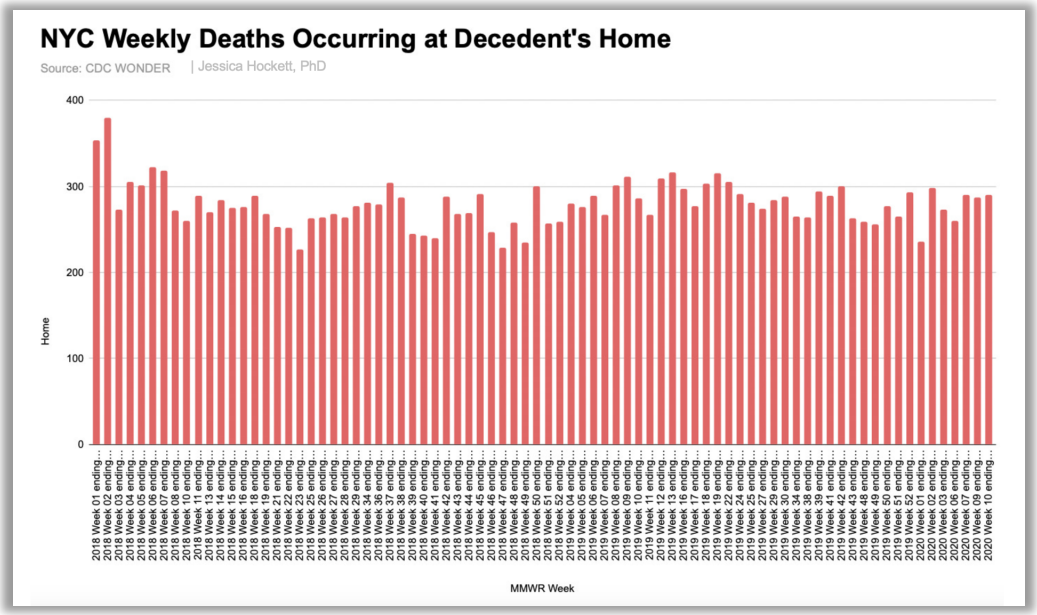
Looking for signals in "place of death"

What about place of death?

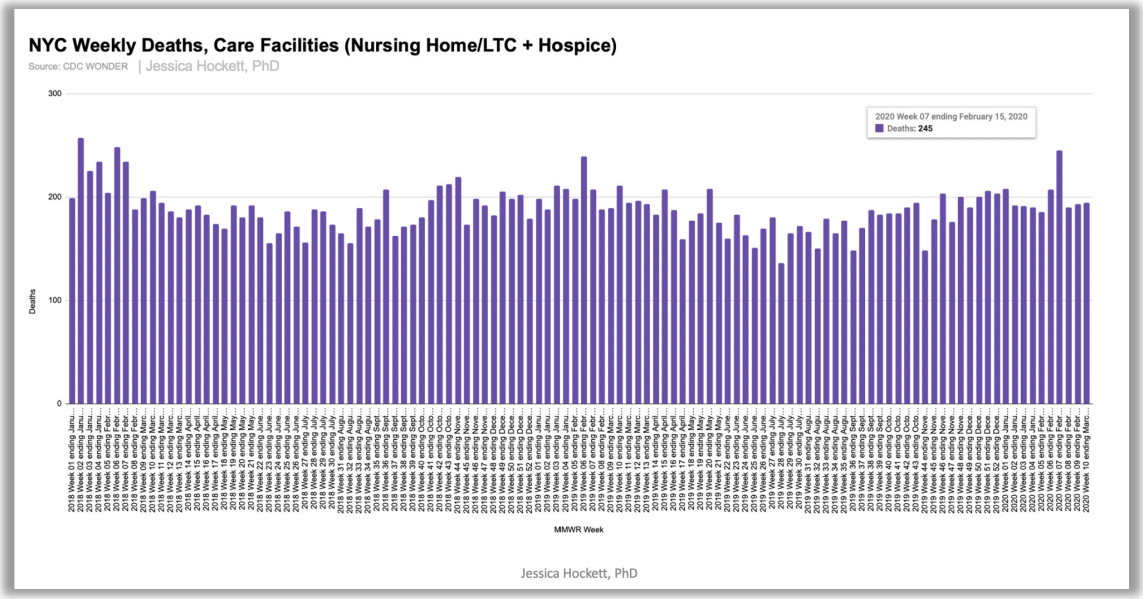
If there's some new virus that's adding risk of mortality, you would expect hospital deaths to be going up. I don't see it there.



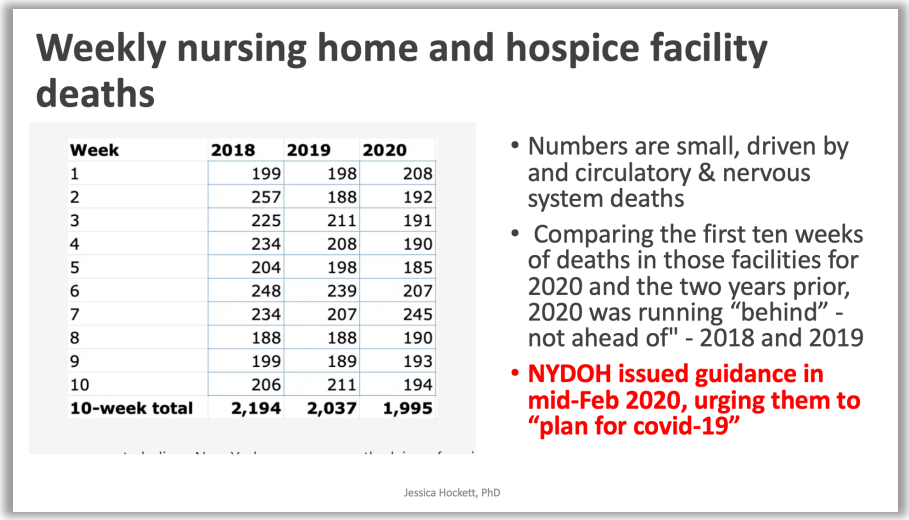
This switches to a bar graph view. Somebody's **home** – were there more people dying at home in any appreciable way, right before "it hit"? I don't see that.



When I look at nursing home and hospice [combined] we *do* see a rise right before, in February, excuse me. Something I think is notable is about that – and I'm not dismissing it outright as some kind of potential something – but I do think some points about that are notable.



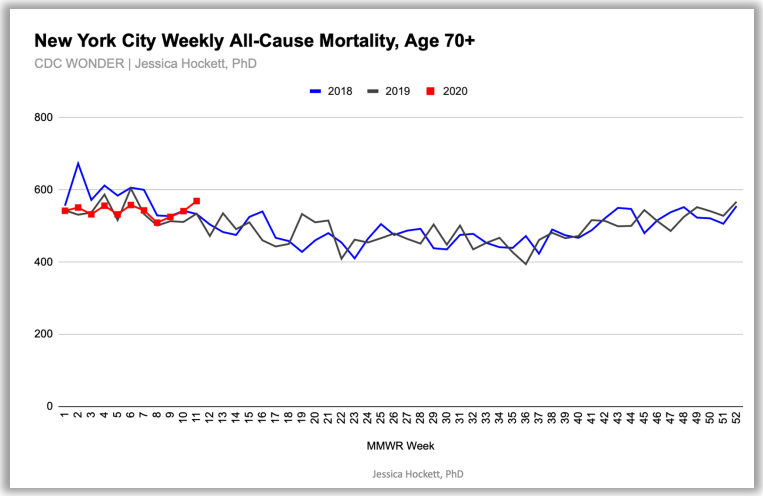
The numbers are small, overall, and they're driven by circulatory and nervous system deaths in those places. The other point is when I look at the 10-week totals, it's running "behind" these prior years, not ahead of.



And then, really importantly, mid-February 2020, the New York City Department of Health issued an alert to nursing homes, telling them to plan for COVID-19. So, I don't know what people did or didn't do in that time, but I think that's interesting – that that is the time we see a rise, a bit of a rise, in those deaths.

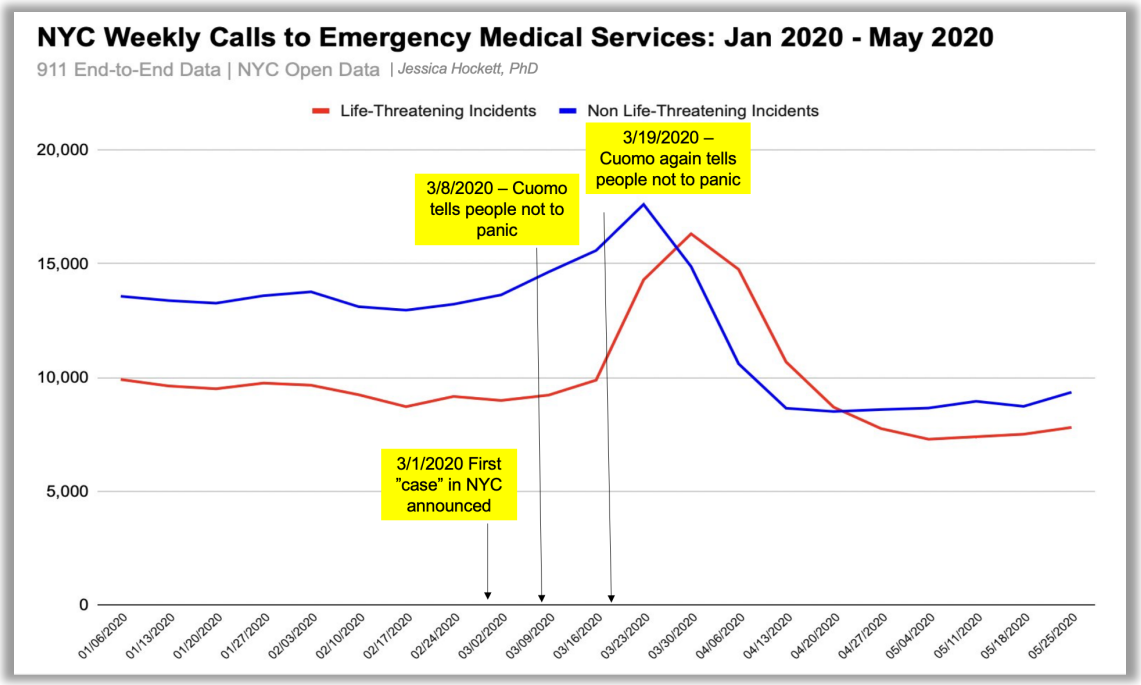
If we look at older groups [weekly timeseries], age 70+, we see a little bit of a bump, but I don't know that statistically I would call that a signal.

Looking for signals in elderly deaths, EMS calls, ILI visits, and ED visits

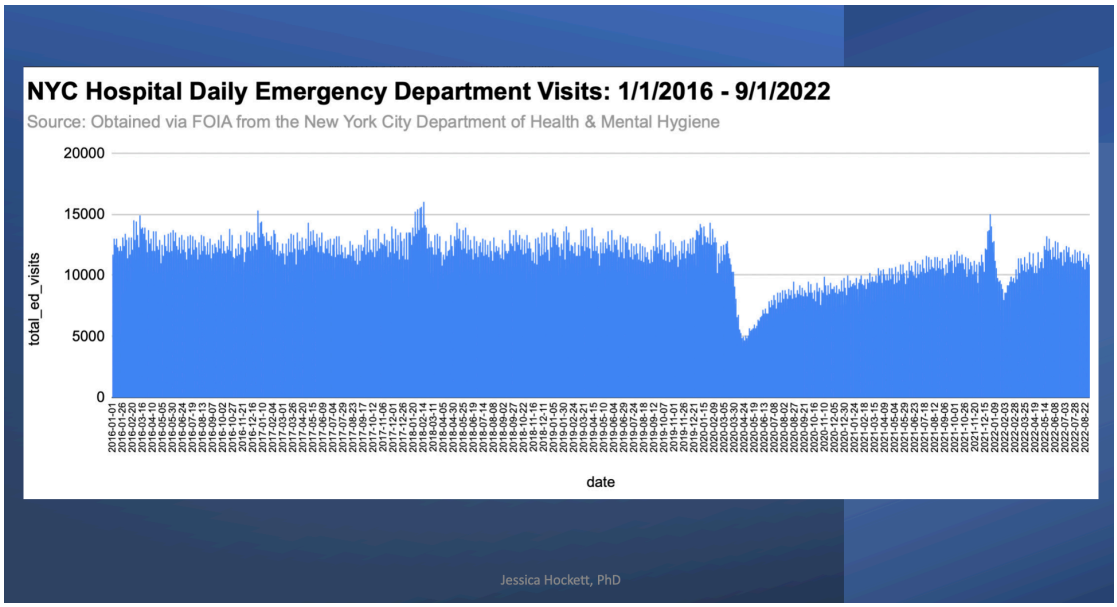


Other sources of data are fascinating to look at and say, "Do we see signs of COVID in, for example, people calling for an ambulance?"

This timeline is fascinating. We see the non life-threatening calls start to go up when the first case is announced. A few days later, Cuomo is on the news. They are telling people not to panic. *Don't panic, people. This is fine. Everything is going to be fine.*



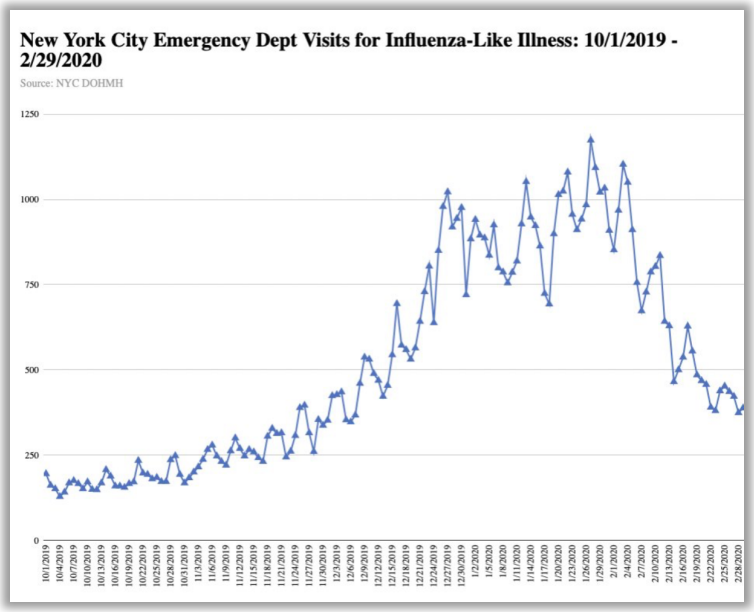
People are still panicking. The 16th at the bottom there, I should have put this on there. The 15th, I think, was the 15 Days to Slow the Spread, the federal notice. Or maybe that was the 16th. A couple days later, he's telling people not to panic, but there is some degree of panic going on. The question obviously is, *is it just panic, is there spread of something going on, what kinds of health issues are going on there?* A lot of these calls for life threatening were people reporting that they couldn't breathe -- and heart issues was a big one during that time. **[JAH: I dug more deeply into this data later and saw things differently than I did when I gave this presentation. Call redirections, not "people panicking" is a big part of what we see in the blue and red lines above.]**



Emergency department visits plummeted, which is counter-narrative because the narrative was that we have to save the hospitals, New York hospitals are becoming overwhelmed. There was a little bit of a constant, I don't want to call it a surge, but there's some indications in systemwide data and when I look at individual hospitals that, after the shutdown was announced, people started going to the emergency room for every little cough that they had. But overall the *volume* of people go to the emergency department and the *intake* of the hospitals was down. This is true nationwide as well, although not quite as dramatic as a plummet as there was in New York City. **[JAH: This is another dataset that I came to interpret differently, based on what I learned later. See https://woodhouse76.wpcomstaging.com/2026/01/06/overdue-records-request-to-the-fire-department-of-new-york-fdny-for-telemedicine-calls-and-a-possible-reason-ed-visits-there-and-elsewhere-show-a-huge-drop/]**

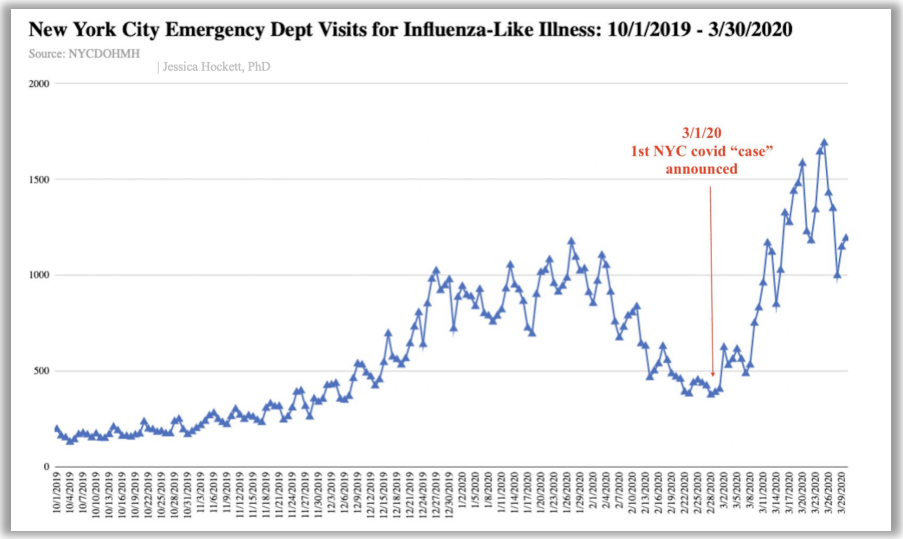
I find this really interesting too. I've learned how – in studying all of this – I've just become more aware of how much what people do when it comes to their sickness is maybe influenced by choices that they're making [and] things they're hearing on the news. **[JAH: I wouldn't call this nocebo effect, exactly, but rather a *behavioral choice in response to external stimuli*. To the extent that people make a bigger deal about something they are already experiencing due to what someone else tells them or what they themselves perceive, I would characterize it as *aggrandizement of symptoms*. See ideas in this interview and article: https://woodhouse76.wpcomstaging.com/wp-content/uploads/2025/11/enigma-of-rapid-mortality-surge-5.pdf]**

This is emergency department visits for ILI [influenza-like illness]. Typically, in the United States, ILI is fever of 100 or more, and/or sore throat, and/or cough.

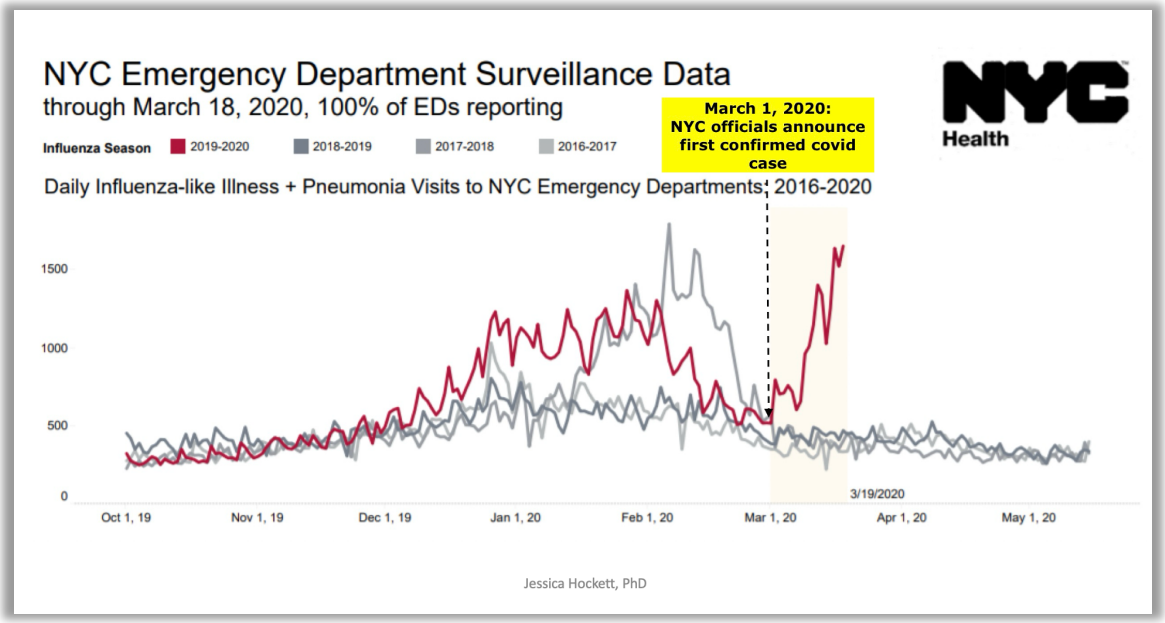


Not a hugely remarkable season here. There are some elevated visits in late January, early part of February. My own belief is that that is somewhat fueled by hearing about 'the China virus,' as Trump was calling it back then. But we have a decrease, it falls down pretty normally, as you would expect, that time of year, until the case is announced.

Case is announced on March 1st and then we see the ILI visits go back up. I'm really struck by that. I'm really struck by the influence of – or the association, I should say – between what people are hearing, and then what they have a tendency to go and do.



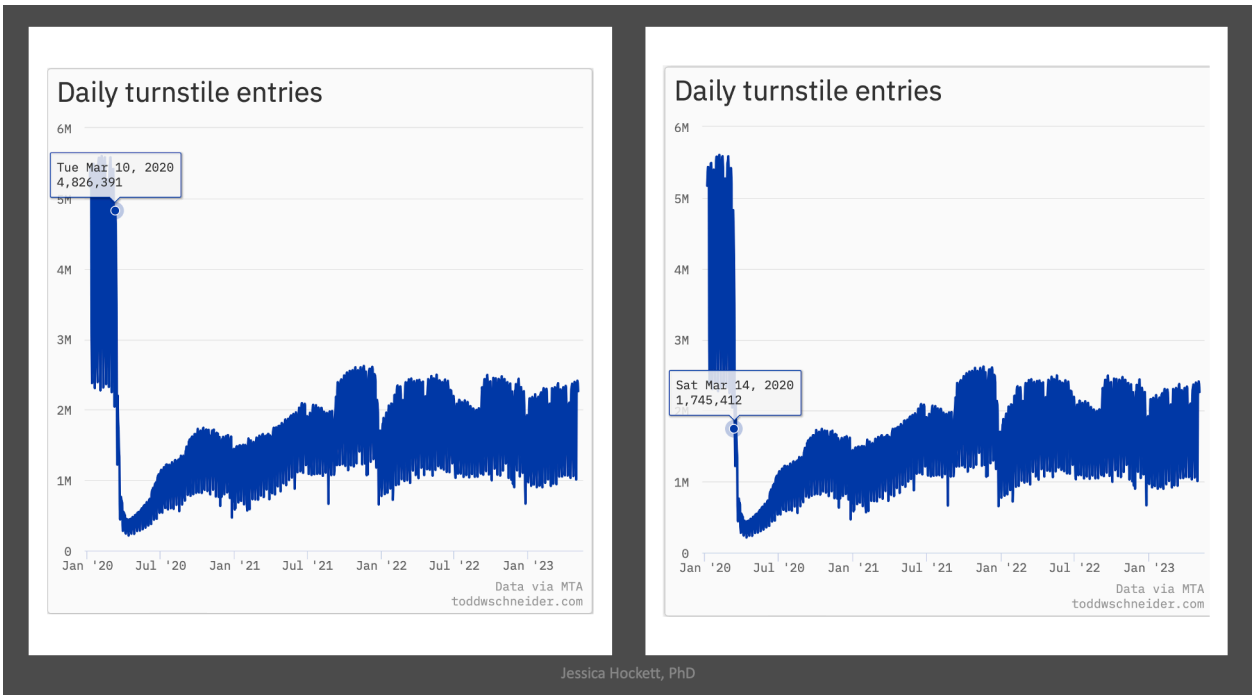
This is directly from a health bulletin that hospitals got from the New York City health department.



What I find interesting about this view is they're not giving healthcare workers or hospital administrators a sense of what's happening with emergency department visits overall. This just shows ILI, so it's like, "Hey, a virus is here. Look, it's coming," and I think this is help induced panic – one of many things that was inducing panic among healthcare workers. **[JAH: I've come to see the question *"Were healthcare workers panicking?"* differently than I did when I gave this presentation. I haven't written about it at length in a single article. In this overview I explained why I now view many of the elevated or "showcased" physician and nurse voices coming out of New York as curated—selected, approved, and amplified. In that sense, even the panic appears less spontaneous than performed.]**

Subways as a vehicle for spread?

A lot of people say, or have said early on, that the subways are responsible for "the spread." I take issue with that theory, but I do thinking it's interesting to look at what the actual subway data was.



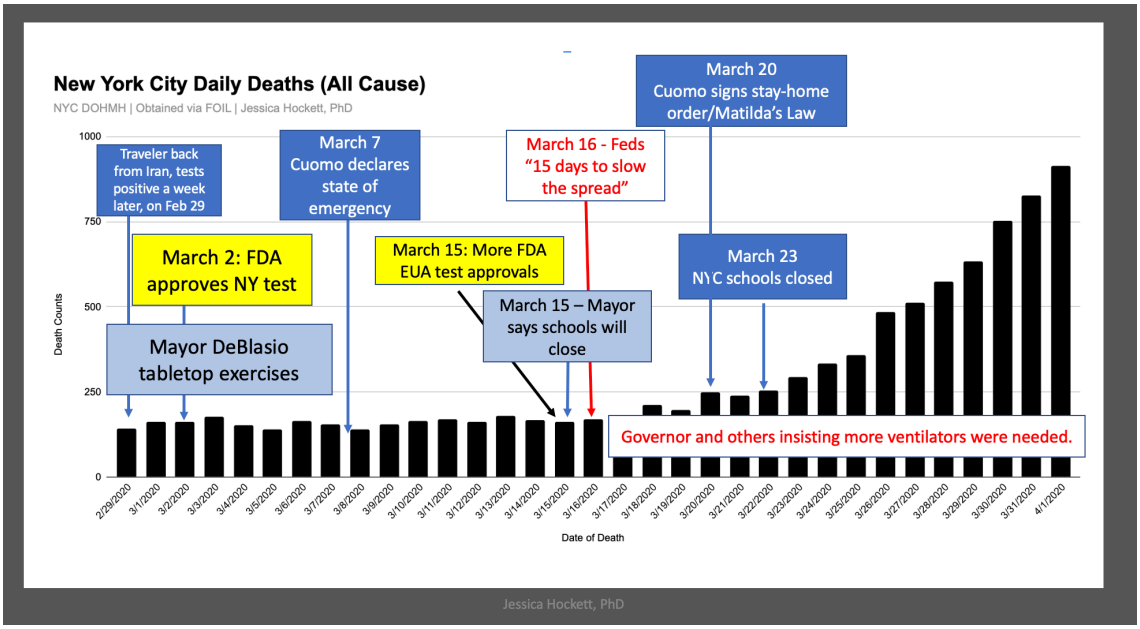
People were beginning to stop using the subway before the official shutdown order was issued. So whatever you believe about the subways, I think the actual data on subway use is worth considering.

Sequence of Events: Federal "15 Days" as the trigger or hinge point

Let's look at the timeline of events that somebody brought up earlier.

- [March 1st] We've got the first case, a 37-year-old woman, back from Iran. Not hospitalized, perfectly fine.
- We have the FDA approval, EUA [emergency use authorization], for New York's test that their Wadsworth Lab was using. I think I'm getting the detail right on that.
- We had Mayor DeBlasio doing a series of tabletop exercises around the emergency plans that might have to be put into place.
- On March 7th, Cuomo declared the state of emergency for the whole state.
- March 15th was a big day because it was the day that hospitals and other labs were cleared to do their tests. So that's really when we see the advent of mass testing. "Big COVID" is what I call it on March 15th. That day, the Mayor said that schools were going to close.
- The following day, Trump saying "15 days to slow the spread".

- March 20th is when Cuomo signed his official stay home lawyer and something else called Matilda's Law. It wasn't a law at all; it was probably illegal. I'll show you that in a second. That's the official shut-down date, but all before here, New Yorkers are staying home. Things are shutting down. It's not like there was all this bustle going on in the city and then people stopped March 20th.
- March 23rd was the first official day of schools being closed, that was the day after a weekend.



And just notice: by the time "15 days to slow the spread" is coming to a close – [aside] it was *never* going to be 15 days to slow the spread, I can tell you that – mortality was *very* high in New York. Very, very high. So I tell people, "Look, no matter what, it was never going to be 15 days because New York was off the charts already."

In that time, too, we had a political battle going on: The Blue-State Governors versus Trump, with Cuomo leading the charge for the Blue State governors and saying, "We need a federal response! We need these things from the federal government! We need leadership!" and there was a huge battle that heated up between those two.

"Focused Protection" via Matilda's Law: Harmful (and illegal?)

I mentioned Matilda's Law. Just really quick…this was effectively, in my opinion, an illegal quarantine order issued for the elderly. In other words, like, "Stay home." Matilda was Cuomo's mom, so he couched it as "I'm protecting the elderly. **[JAH: I**

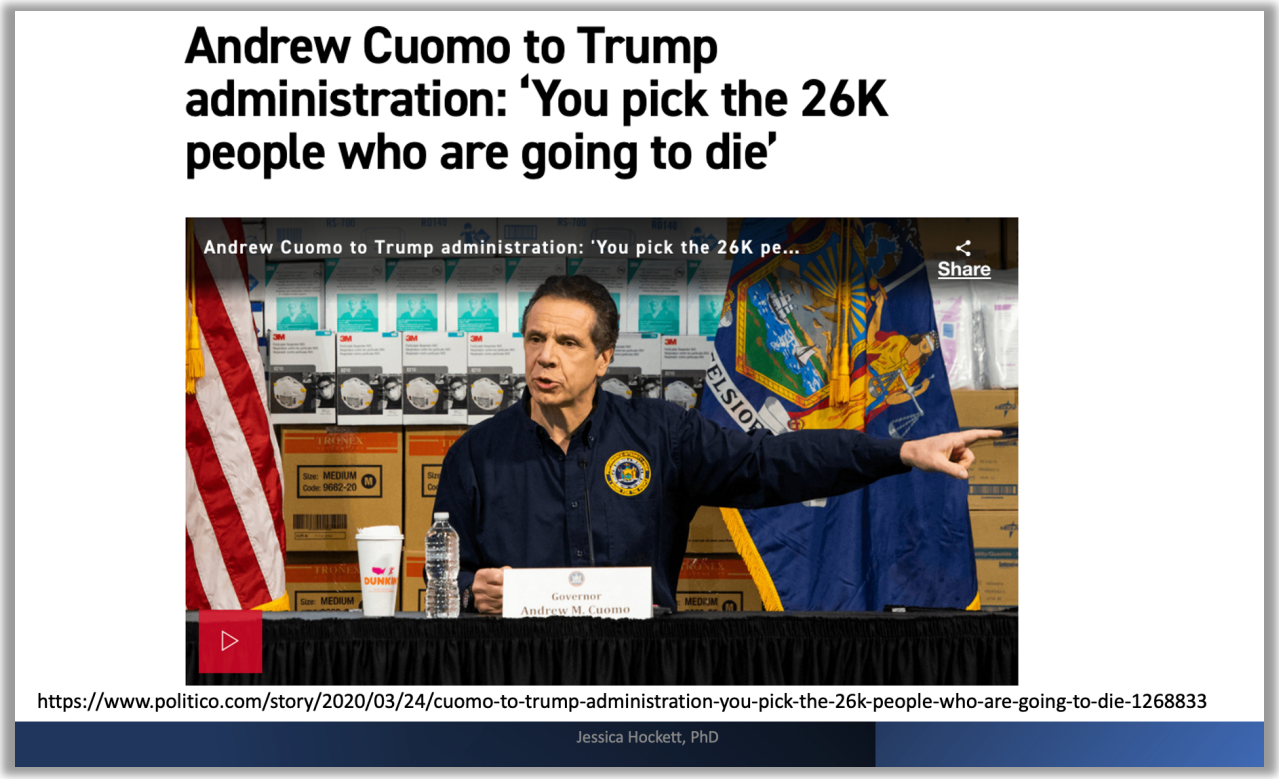
would be interested in a legal opinion on the legality of this directive. It appears to violate state law on quarantine orders.]

I don't know if 'focused protection' advocates would call this focused protection. I don't. You think about – I'm just going to make a person up: Ernie Goldstein who lives in a rent-controlled apartment on the Upper East Side. He's got his routines every day. He's 75 years old. He's in okay health.

You tell that guy that he's about to die and he can't go out and, you know, go to his synagogue or be with his friends. That person's chances of dying, virus or no virus, are very high. So, when we look at home deaths, Matilda's Law or the general shutdown order plays a different kind of role in a city like New York than in other players.

The Ventilators

There's been a lot of talk lately about ventilators. I've been talking about ventilators for a long time. But I think it's interesting to go back and listen to what Cuomo was saying about the ventilators. Hopefully, you can hear this. This is an example of the political battle heating up. https://www.politico.com/story/2020/03/24/cuomo-to-trump-administration-you-pick-the-26k-people-who-are-going-to-die-1268833



Cuomo: *Where are the ventilators? Where are the gowns? Where's the PPEs? Where are the masks? Where are they? Where are they, if they're doing it? When we went to war, we didn't say, 'Uh, any company out there want to build a battleship? Who wants to build a battleship?' That's not how you did it. The President said it's a war. It is a war! Then act like it's a war!*

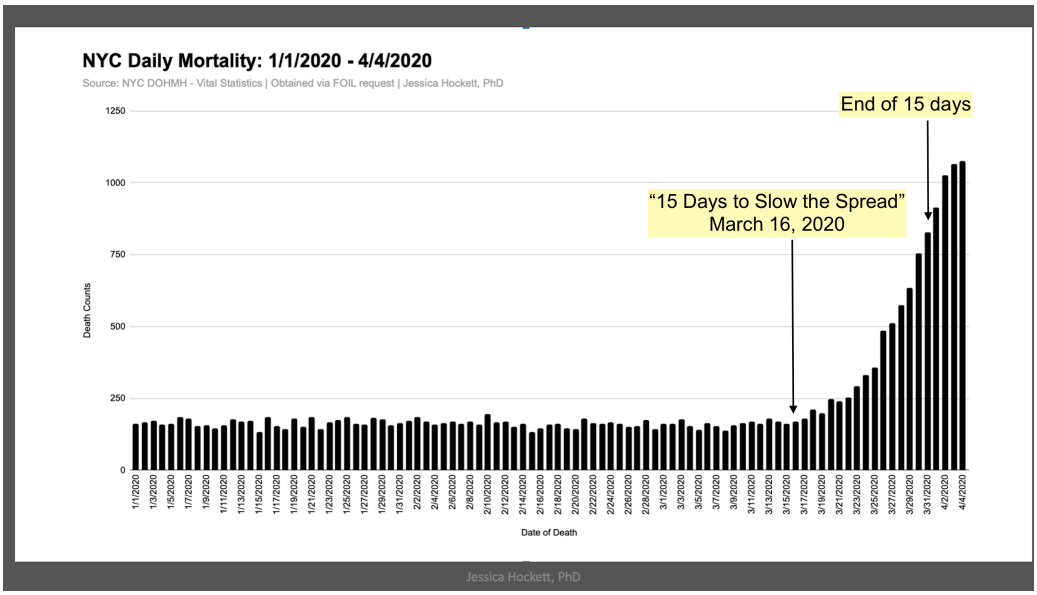
It's not 'anti-business'. We have been working around the clock, scouring the globe. We've procured about 7,000 ventilators. We need, at a minimum, an additional 30,000 ventilators. You cannot buy them. You cannot find them. Every state is trying to get them. Other countries are trying to get them. The capacity is limited. They're technical pieces of equipment. They're not manufactured in two days or four days or seven days or ten days. So, this is a critical and desperate need for ventilators.

I'll stop it there. His press conferences were hugely entertaining for sure, if nothing else.

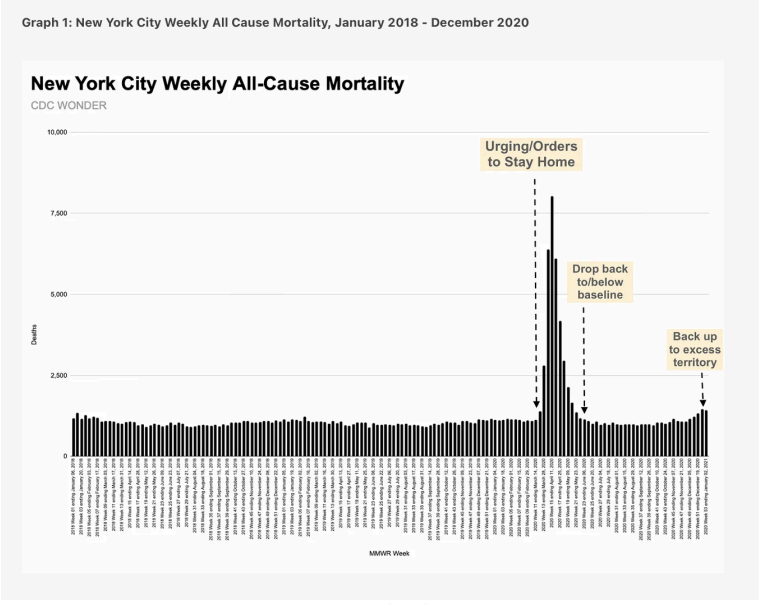
What's ironic, and tragic, about Cuomo saying, "You pick the 26,000 who are going to die!" is that 27,000 extra people *did* die in 11 weeks. And I would say it's *because of* the interventions. A ton of them. Not just one thing, not just ventilators, not just the stay home orders – which I'll get to a little later. But this was the narrative: *It was a* ***war****. There was an* ***unseen enemy.*** *Trump* ***wasn't doing enough****. The Blue State governors needed more*

ventilators to fight this ***unseen enemy.*** That's the political narrative that was driving a lot of this.

So, by the end of the "15 days" and beyond, the mortality keeps going up and up and up. The damage was done is what I tell people. It was too late and no matter if it was a virus or not, people were dead.

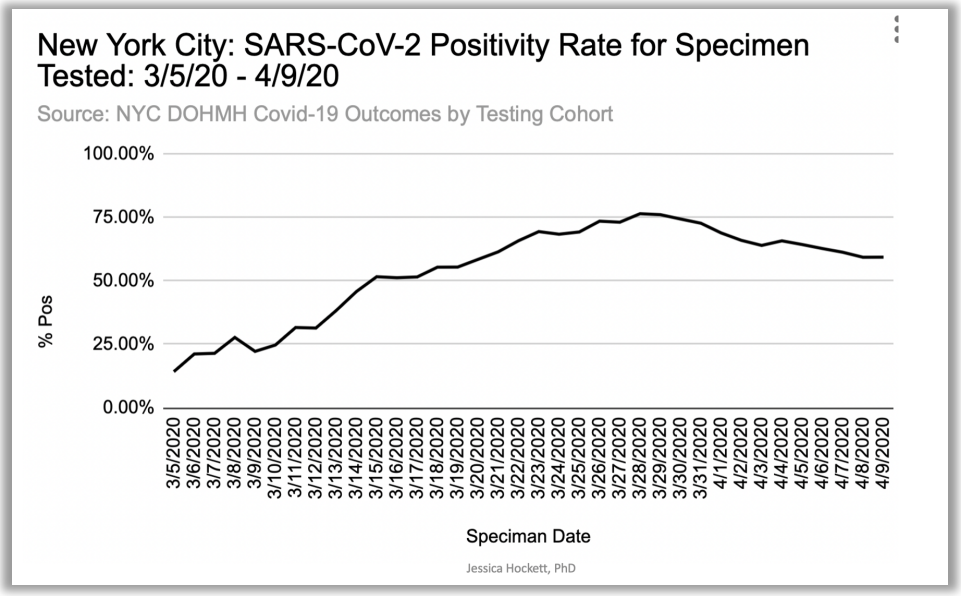


This is just a weekly view. This is a distilled…there was an urging to stay home, there were stay-at-home orders. That's when the mortality starts to go up. It plummets back to baseline, starts to get up to excess territory by the end of the year.



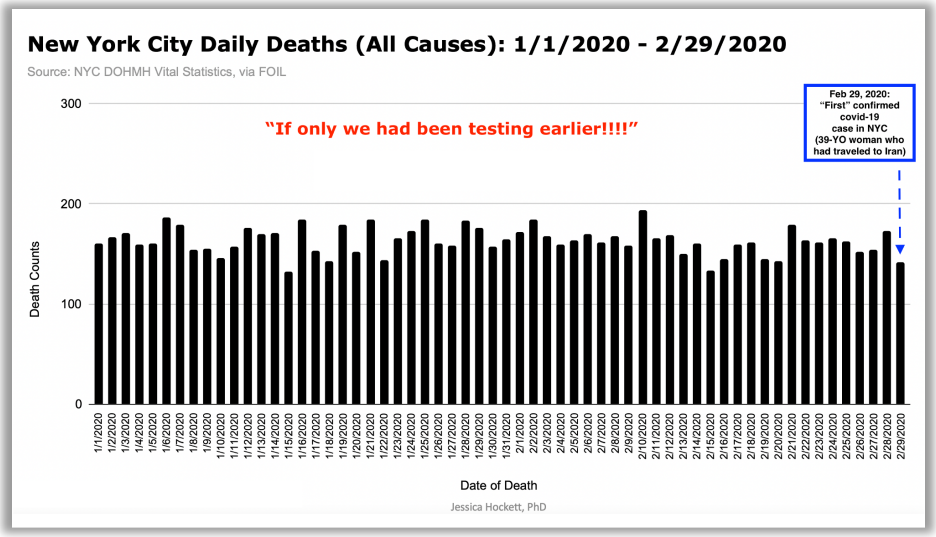
Plenty of tests showing high prevalence and remarkably high positivity rates.

When we're talking about *Where was COVID?* or *Where was SARS-CoV-2?* – and I know people have different views on what that is – percent positivity was **high**, *really* high. And I've had a lot of scientists and doctors try to 'explain' this to me.

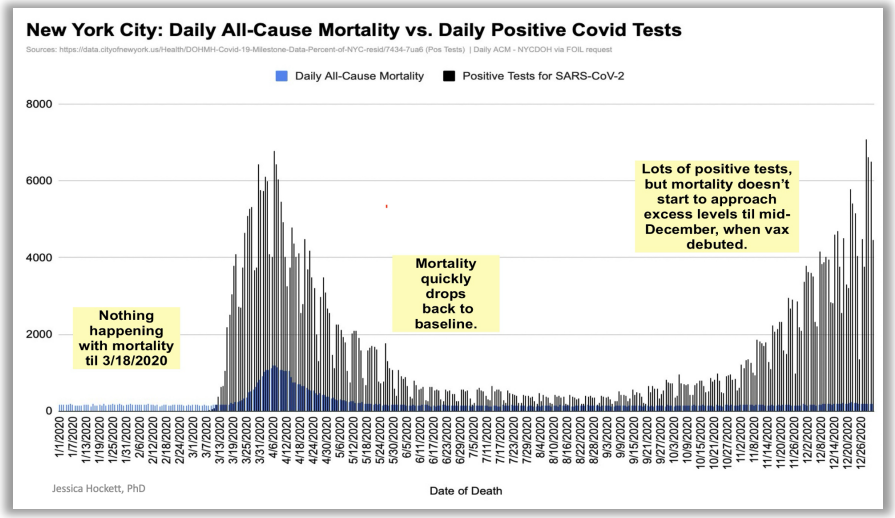


Seventy-five percent (75%) coming back positive when you're giving *thousands* of tests a day, that raises a *lot* of questions for me, as a layperson. I'm like, "So this thing was already here. Whatever is being tested. Or something is wrong with the test." But I'm told I have an immature view and I don't really know what I'm talking about because I don't know PCR tests. For me this is a red flag.

People will say to me, "We needed more tests. We needed them earlier." And I say, "For what? To tell what?" Nothing was going on with mortality. To tell you that people were dying of something that wasn't killing people in any huge, appreciable way?" I don't understand that.



Here's a different view: Just the daily positive COVID tests against the daily all-cause mortality. It's really easy to see here.



And, again, I know people have different views, but if people are dying for a lot of different reasons, and many of them in the hospital and nursing homes, and you have a test that's coming back at a really high rate, that positive allows you to cover up a multitude of sins – especially when you pretty much define a COVID death as somebody who tests positive on that test and then dies 30 or 60 days later.

There's an early study from group of researchers from Northwell Health, which is one of the bigger healthcare systems in the New York metro area that I don't think got the attention that it should [have].

Clin Infect Dis. 2020 Dec 15; 71(12): 3204–3213. Published online 2020 Jul 9.
doi: 10.1093/cid/ciaa922

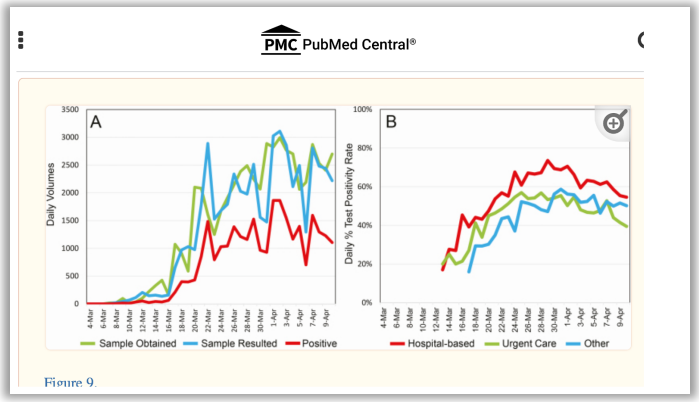
PMCID: PMC7454448 | PMID: 32640030

Rapid Emergence of SARS-CoV-2 in the Greater New York Metropolitan Area: Geolocation, Demographics, Positivity Rates, and Hospitalization for 46 793 Persons Tested by Northwell Health

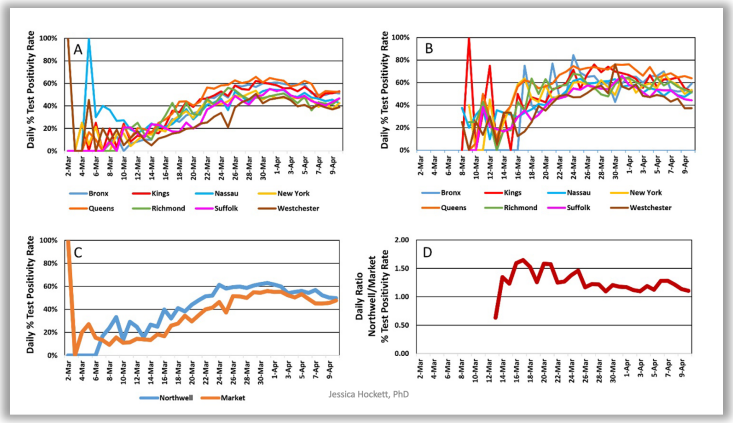
Samuel B Reichberg,[1,2,3] Partha P Mitra,[1,4] Aya Haghamad,[2,3] Girish Ramrattan,[3] James M Crawford,[1,2,3] Northwell COVID-19 Research Consortium, Gregory J Berry,[2,3] Karina W Davidson,[1] Alex Drach,[2] Scott Duong,[2,3] Stefan Juretschko,[2,3] Naomi I Maria,[5] Yihe Yang,[2] and Yonah C Ziemba[2]

Feedback

Northwell Health is 17 hospitals and they also had some other labs that were testing as well, in other settings. I mean, this is straight from their study at the time.

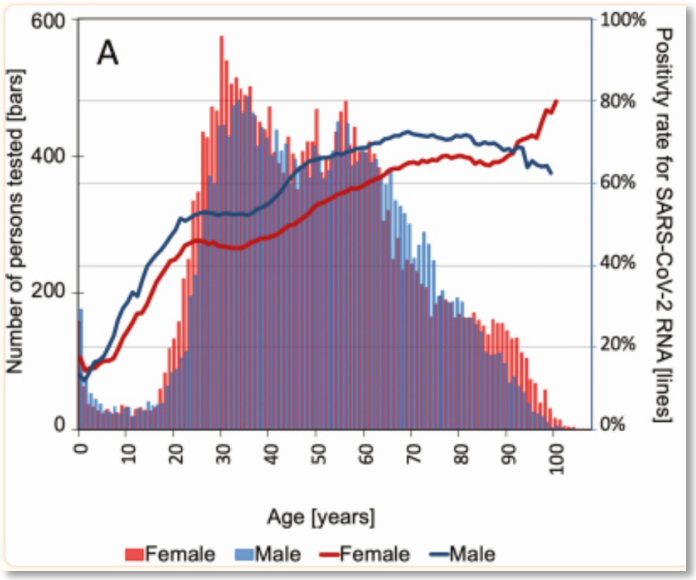


You can see, not only in hospitals, but in urgent care and other settings like nursing homes they had a huge percent positive coming back.



Breaking it down by borough or region, I mean, approaching 80 percent of tests, of thousands of tests coming back? Something was going on there.

I love this graph from the study. It breaks it down by gender.



You can see *number of persons* tested is on the side. The positivity rate is out of control on the other side. But notice how it's labeled: positivity rate for SARS-CoV-2 RNA. That's what it was. It's detecting for the RNA. So, I appreciate the specificity about what was coming back positivity. This wasn't necessarily sick people or people who need to be tested.

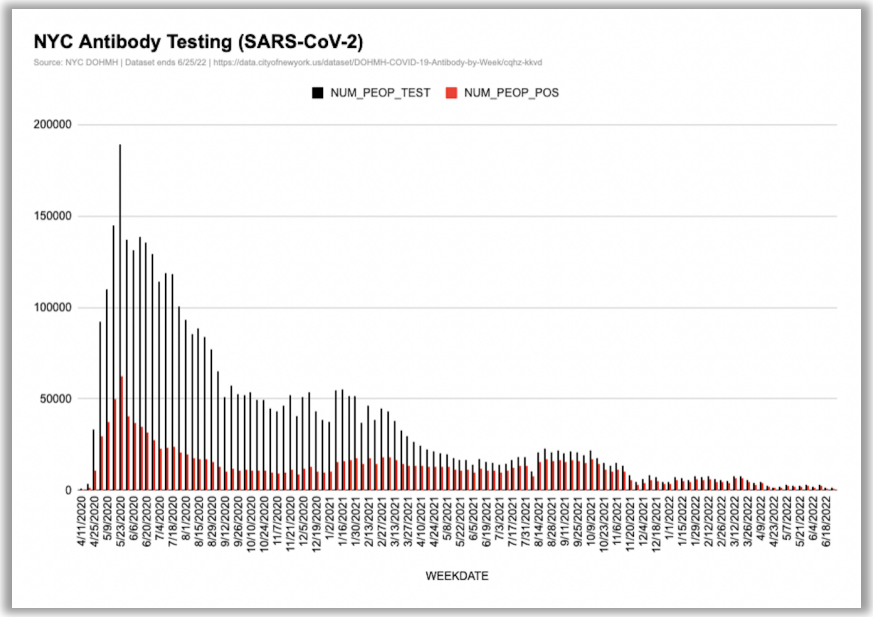
This line from the study is funny to me:

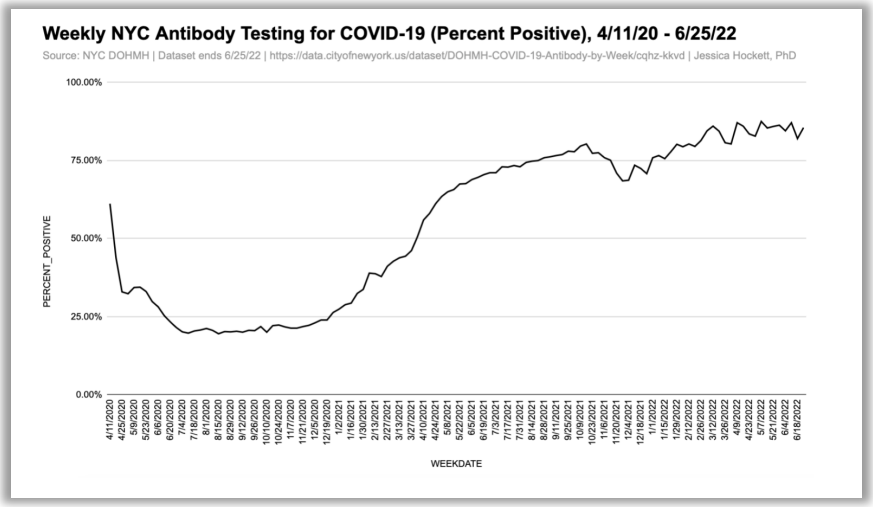
> "Our [testing] data reveal that SARS-CoV-2 incidence emerged rapidly and almost simultaneously across a broad demographic population in the region. These findings support the premise that SARS-CoV-2 infection was widely distributed prior to virus testing availability." [3]

I ***completely agree*** with what those authors are saying. The punchline is, it was everywhere, but it wasn't resulting in excess mortality.

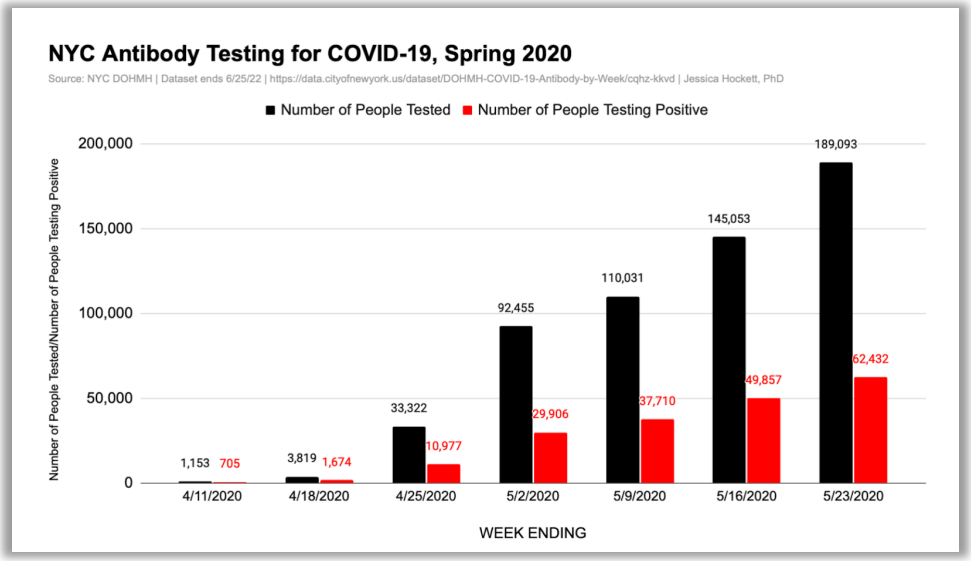
New York City also engaged in antibody testing very early on. I don't know *a lot* about antibody testing, being a layperson, but again, these rates, even early on -- I know the sample sizes were small. We don't have information about how the samples were taken, if it was done in any kind of random or systematic way. But right away, the rate was

really high, then it dips low with more tests that they're giving, but we don't have the information about who all was being tested.





What I see there, honestly – and maybe this is 'tin foil hat' – I see, "Oh shoot! There's a really high prevalence of this thing. Let's give more tests so we can get that rate down so people don't know that it was already here." Maybe I'm wrong, but I think the antibody testing data should get more attention. **[JAH: Articles I co-authored later speak to the antibody testing issue, beyond New York's results. See "Novelty and immunity: Why were we so blind to the obvious?" (Engler & Hockett, 2025) and "The Fallacy of Trust: Revisiting the Reliability of SARS-CoV-2 Antigen Testing Methods" (Neil, Engler, Fenton, & Hockett, 2025].**



Where People Died

When I think about what happened in New York – and actually this goes for any country, and anywhere throughout the United States – I think that the number one question that people don't ask that there's plenty of data for is *where did people die?* And *what does where people died tell us about how people died – or how people* ***couldn't*** *have died,* ***because of*** *where they died.*

So, let's take a look at New York City.

New York City, Weeks 12-22, 2020

Place of Death	2019 Deaths from All Causes	2020 Deaths from All Causes	All Cause Increase/ Decrease (2019/2020)	Percent Change from 2019	Percent of Total Increase/ Decrease
Hospital Inpatient	4,837	19,827	14,990	310%	55.5%
Outpatient/Emergency Department	1,026	2,697	1,671	163%	6.2%
Nursing Home/LTC Facilty	1,762	6,642	4,880	277%	18.1%
Hospice Facility	267	231	-36	-13%	-0.1%
Decedent's Home	2,906	8,215	5,309	183%	19.7%
Dead on Arrival (to Hospital)	122	139	17	14%	0.1%
Other	220	403	183	83%	0.7%
Totals	**11,140**	**38,154**	**27,014**	**242%**	**100%**

"Toward a New York City Hypothesis" PANDA Open Science presentation | Jessica Hockett | CDC WONDER

Every death certificate in the United States has options for one of seven places of death: hospital inpatient, outpatient or emergency department -- which really is all [at the]

hospital, for all intents and purposes, especially in the spring period). Nursing homes or long-term care facilities. Hospice facilities – so not home hospice care but facilities. The person's home or apartment or residents. DOA to the hospital or Other. Other can be a little bit of a catch-all category. Some kinds of adult care homes *can be* in Other. It just depends on the guidance states give. But Other would also include on the street or in your car, in a car accident. So, this is literally where you died.

The normal year I'm using here, in these weeks, in 2019.

Let's look at 2020. You see the 2020 amount, followed by the increase or decrease, the percent change, and the percent of the total increase or decrease for that category.

Hospitals v Nursing Homes

The majority of deaths that occurred in this time – there's no getting around it –were in hospitals, or healthcare settings if you want to include nursing homes. There were a lot of deaths in nursing homes. We don't know how many, after all the 'nursing home policy' craziness, we still don't know all-cause mortality or how many nursing home residents died in the hospitals. New York state says that about 2,000 COVID-attributed nursing home deaths occurred in hospitals. That still leaves us with 12,000-13,000 'extra' people where I'm like, "Who were these people that died in the hospitals?"

When we're talking about ventilators per se, the hospital numbers would be the starting point – although I would also like to know how many people who died in nursing homes and at home had been in a hospital and were discharged – and had been on a ventilator. That would be something to think about. Or had had certain kinds of treatment.

The "Nursing Home Policy" Controversy

Participant question: Did you try to tease out -- along the way, trying to hide his bumbling of the long-term care home facility handling, Cuomo changed the tracking methodology so that a person who was in a LTC and died on the way to the hospital got counted as a hospital deaths versus an LTC death. I'm not sure that I'm saying it right, but I know he did some hand-waving.

Hockett: I'm actually going to defend Cuomo for a second here. When the state--

Participant: Okay, I'm out. Bye [laughing].

Hockett: No, just listen. First of all, this is CDC data. CDC place of death data was always publicly reported. Always. So when people are like, "Oh, somebody's hiding this or that," even during the time I remember this. I was like, "Where people died is right here." But what we didn't know is how many nursing home residents died in the hospitals. What Cuomo said at the time was, "Who cares where people died? They died." Which, so on one hand I understand what he's saying, and I almost hear it now as a defense of the hospitals. If 6,000 – I'm just making a number – if 6,000 of those hospital inpatient deaths are nursing home residents, well now I have questions about the treatment they received at the hospital, or why they were sent to the hospital at all.

But he did – other states were reporting their total [COVID] nursing home resident deaths, regardless of where they died – and he wasn't doing that, and then tried to cover it up. But we had the reverse in Illinois: 70% of nursing home resident COVID deaths in spring 2020 occurred in the hospitals. And *most* of the deaths in the hospitals were nursing home residents. **[JAH: This is my estimate, inferred from state and federal data.]**

That's why when people are like, "Well, the nursing home policy," I'm like "I don't know – that still doesn't answer what was going on in the hospitals." Does that make sense?

Participant: Good point. Excellent nuance. Super.

Hockett: Insofar as COVID, I mean, look, this is just outrageous to me.

New York City, Weeks 12-22, 2020

Place of Death	2019 Deaths from All Causes	2020 Deaths from All Causes	All Cause Increase/ Decrease (2019/2020)	2020, Deaths Listing Covid as Underlying Cause	% of total Covid Deaths
Hospital Inpatient	4,837	19,827	14,990	14,704	76.1%
Outpatient/Emergency Department	1,026	2,697	1,671	1,271	6.6%
Nursing Home/LTC Facilty	1,762	6,642	4,880	1,797	9.3%
Hospice Facility	267	231	-36	57	0.3%
Decedent's Home	2,906	8,215	5,309	1,426	7.4%
Dead on Arrival (to Hospital)	122	139	17	25	0.1%
Other	220	403	183	43	0.2%
Totals	**11,140**	**38,154**	**27014**	**19,323**	**100.0%**

"Toward a New York City Hypothesis" PANDA Open Science presentation | Jessica Hockett | CDC WONDER

COVID deaths in hospitals vs. at home

And *yes* we had incentives in the United States. Yes, hospitals got a bigger payout if COVID was on the death certificate. That's not a conspiracy theory; that's what the CARES Act provided for. These statistics, most of the COVID deaths by far were in hospitals, *not* in nursing homes. We had a whole lot of excess in nursing homes for other reasons, but it's not where most of the COVID deaths were.

I'm really suspicious of all those COVID blamed deaths at home. I have a lot of questions about that. But I'd like to know how many people had been in the hospital and were discharged. These stats, I mean, New York City hospitals would have us believe that nothing else that was going on caused an extra death. That it was all because of COVID. That, to me, is outrageous, that we'd have near-100% of the increase attributed to COVID. It doesn't make sense.

This is a swim-lane table, but we see a shift in where deaths occur. Yes, most deaths do take place in the hospital. But we saw that even more deaths took place in the hospital in 2020. That's a huge shift to me. I don't study place of death for a living but that sets off my spidey senses there.

Change in Relative Proportion for Place of Death in New York City, Weeks 12-22: 2019 vs 2020

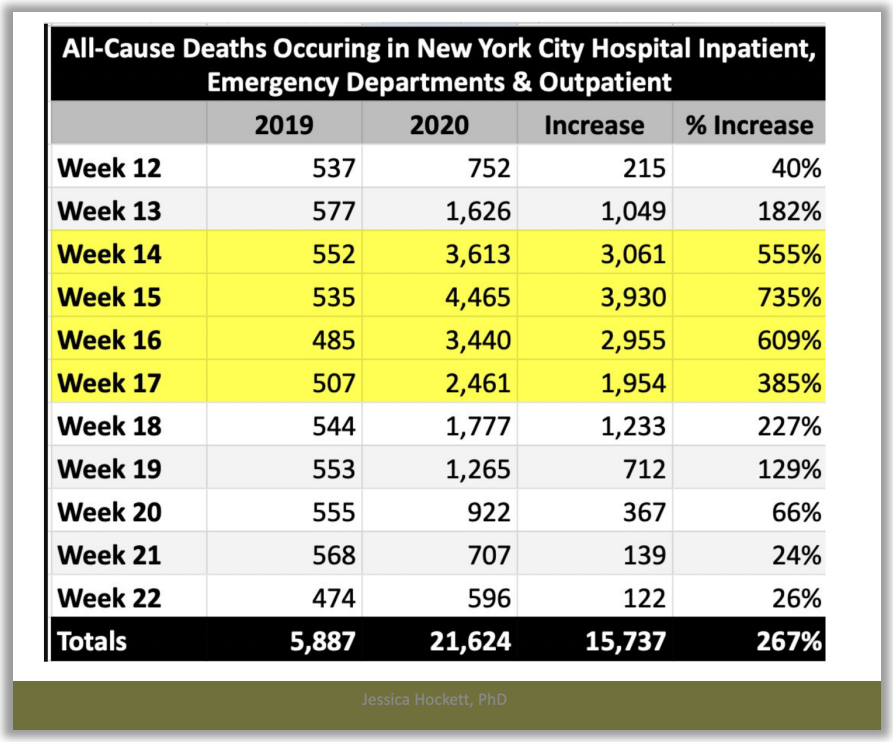
Place of Death	Percent of Total 2019 ACM	Percent of Total 2020 ACM	Change from 2019-2020
Hospital Inpatient	43.42%	51.97%	8.55%
Outpatient/Emergency Department	9.21%	7.07%	-2.14%
Nursing Home/LTC Facilty	15.82%	17.41%	1.59%
Hospice Facility	2.40%	0.61%	-1.79%
Decedent's Home	26.09%	21.53%	-4.56%
Dead on Arrival (to Hospital)	1.10%	0.36%	-0.73%
Other	1.97%	1.06%	-0.92%

"Toward a New York City Hypothesis" PANDA Open Science presentation | Jessica Hockett | CDC WONDER

Deaths in nursing home facilities actually didn't change all that much, at least not in manner commensurate with the narrative around it. Those shifts are fascinating to me.

A question of body-management feasibility

If you look weekly, week by week, those of you who have ever worked in a hospital, maybe you can speak to this, I don't know. That is *so many bodies*. Look at the increases in this 4-week event.



All-Cause Deaths Occuring in New York City Hospital Inpatient, Emergency Departments & Outpatient				
	2019	2020	Increase	% Increase
Week 12	537	752	215	40%
Week 13	577	1,626	1,049	182%
Week 14	552	3,613	3,061	555%
Week 15	535	4,465	3,930	735%
Week 16	485	3,440	2,955	609%
Week 17	507	2,461	1,954	385%
Week 18	544	1,777	1,233	227%
Week 19	553	1,265	712	129%
Week 20	555	922	367	66%
Week 21	568	707	139	24%
Week 22	474	596	122	26%
Totals	5,887	21,624	15,737	267%

Jessica Hockett, PhD

The morgue trucks were on the news. I believe it. If these things actually, if this happened, there was a lot of bodies that had to be handled in a very, very short period of time.

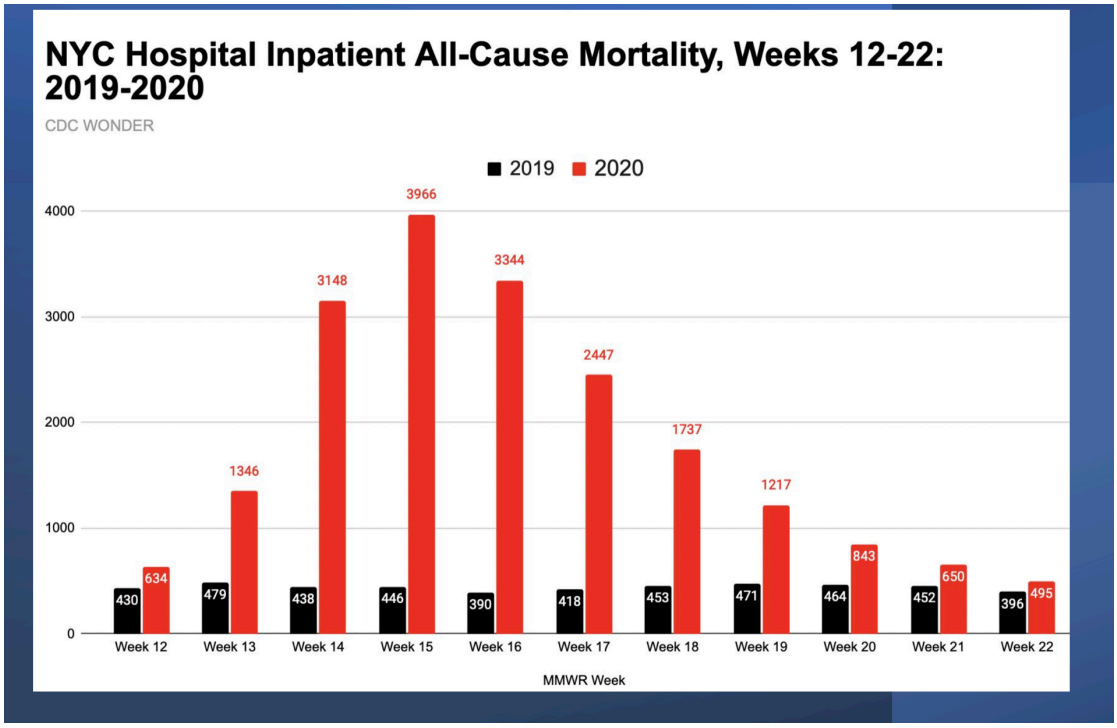
The other thing to note is that if you look at the increase for the whole U.S. in those weeks, New York City was a substantial – New York went first, I say.

U.S. Hospital Inpatient Deaths (CDC WONDER)					
MMWR Week	2019	2020	Increase	Increase from NYC alone	% of Increase from NYC alone
Week 12	16,766	16,781	15	204	1360.00%
Week 13	16,486	17,739	1,253	867	69.19%
Week 14	16,387	22,357	5,970	2,710	45.39%
Week 15	16,011	24,784	8,773	3,520	40.12%
Week 16	15,608	24,179	8,571	2,954	34.47%
Week 17	15,518	22,718	7,200	2,029	28.18%
Week 18	15,558	20,961	5,403	1,284	23.76%
Week 19	15,407	19,576	4,169	746	17.89%
Week 20	15,284	18,452	3,168	379	11.96%
Week 21	15,294	17,347	2,053	198	9.64%
Week 22	15,096	16,586	1,490	99	6.64%
TOTALS	173,415	221,480	48,065	14,990	31.19%

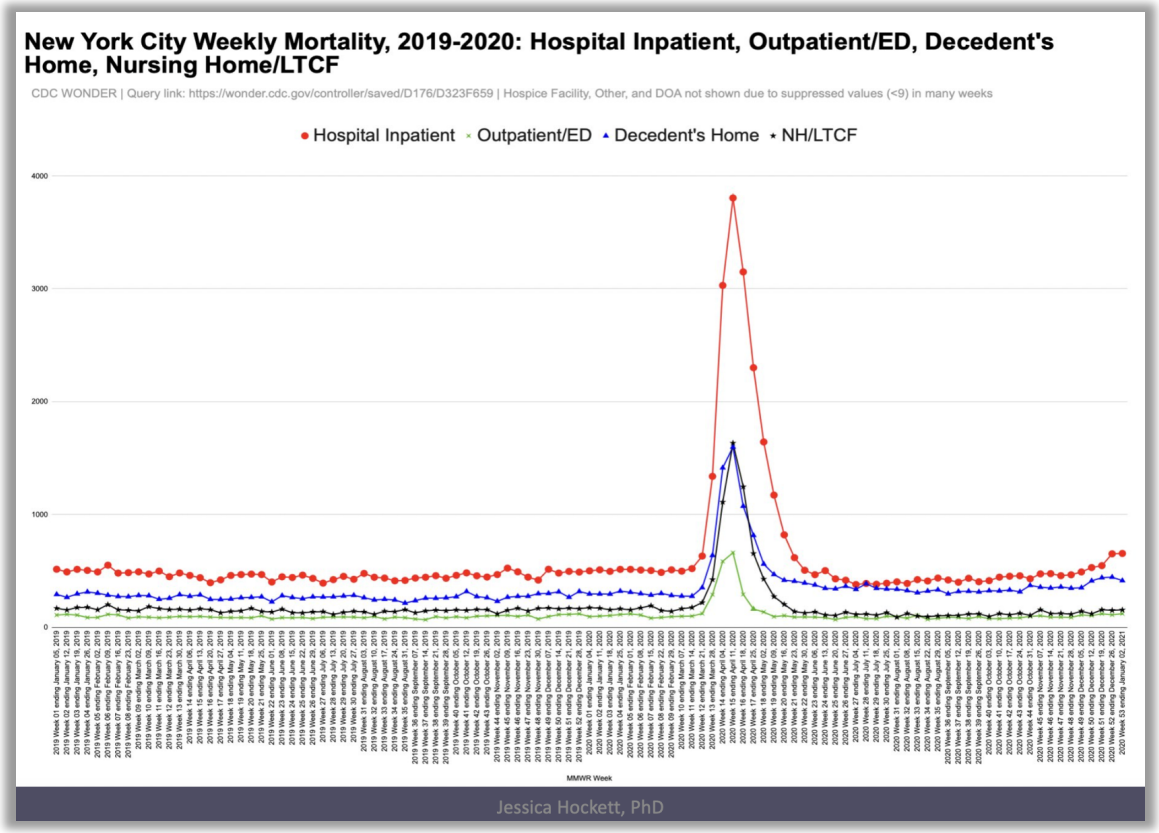
Jessica Hockett, PhD

New York City constituted a massive proportion of increases in [U.S.] hospital inpatient deaths. This alone should trigger an investigation of every single hospital, but we don't see anything like that.

Here's the week-to-week view. This is inpatient only. It's absolutely astounding.



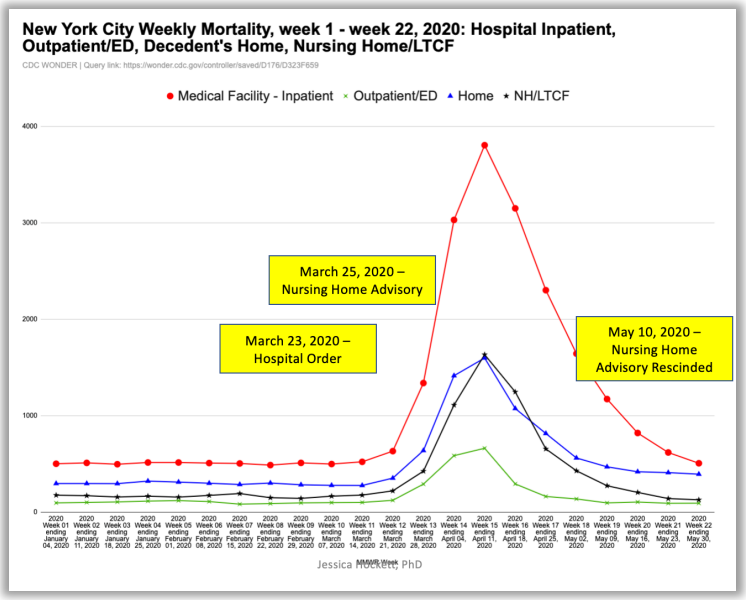
This graph is a nice view because it shows in time-series what was occurring.



The deaths in hospitals went up first, then nursing homes and decedent's home.

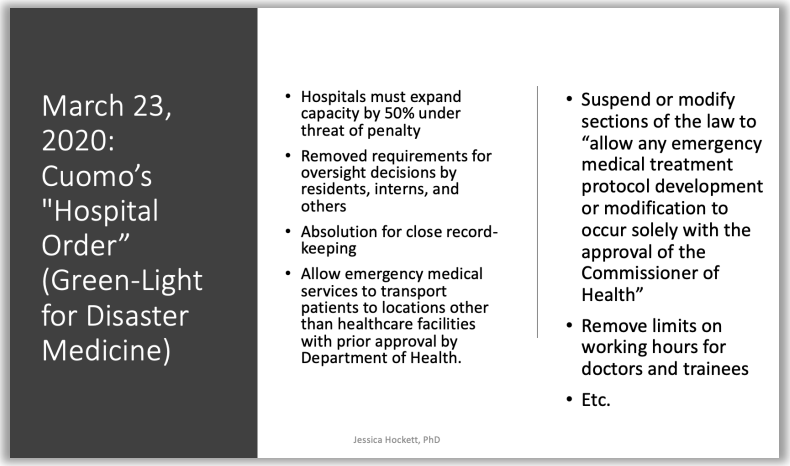
Hospital orders vs Nursing Home advisory

Cuomo's hospital order, in many ways, was actually *more* deadly than the nursing home advisory. The nursing home advisory was just simply – I don't mean to minimize it, exactly – but it's just like "Hey, nursing homes, you can't reject somebody on the basis of COVID status." COVID was already in the nursing homes. It didn't get introduced by people coming back from the hospital who were persistently positive and would've tested positive probably for weeks after. So just the timeline here defies the nursing home narrative as well. Again, people did die in nursing homes, but you can see where the real issue was.



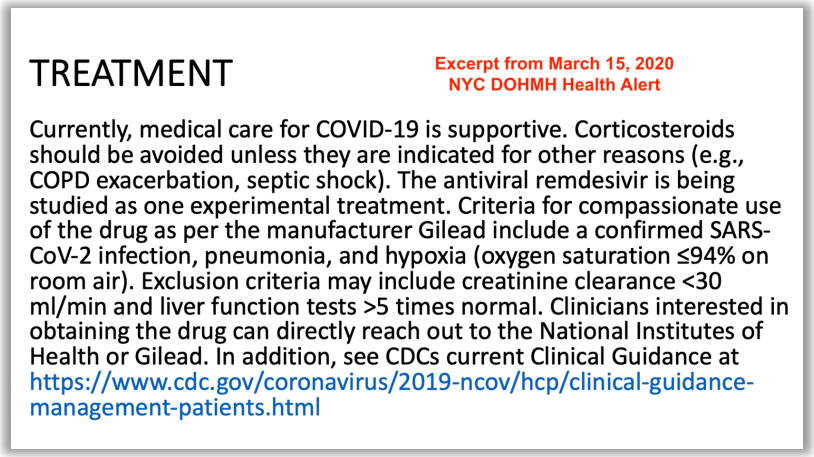
The hospital order that Cuomo issued did a few things. It told hospitals – even though in the data I've seen, I don't see that they needed to do this – but he ordered hospitals to increase their capacity by 50%. **[JAH: There is no indication that hospitals did this or would have been able to do this. State data show that the appearance of 50% more capacity was done via field hospital/USS Comfort beds.]**

He removed oversight for decisions that were made by residents and other staff. He absolved people of close record-keeping…and did a host of other things that were essentially a green-light for disaster medicine. Not disaster medicine like "something is happening" like Hurricane Katrina just came through and now we have to do something. It was for *an anticipated disaster*, which is really interesting, and I think it ended up creating death.



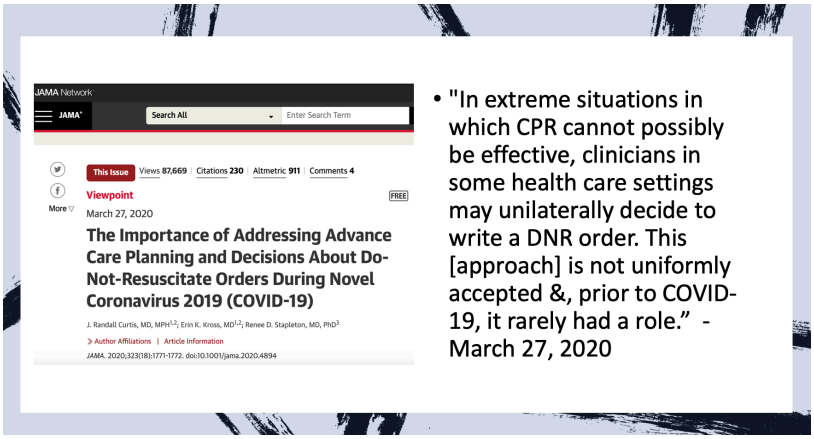
Some things doctors were told

Insofar as what doctors and nurses were told, this is just one example of a health alert that went out.

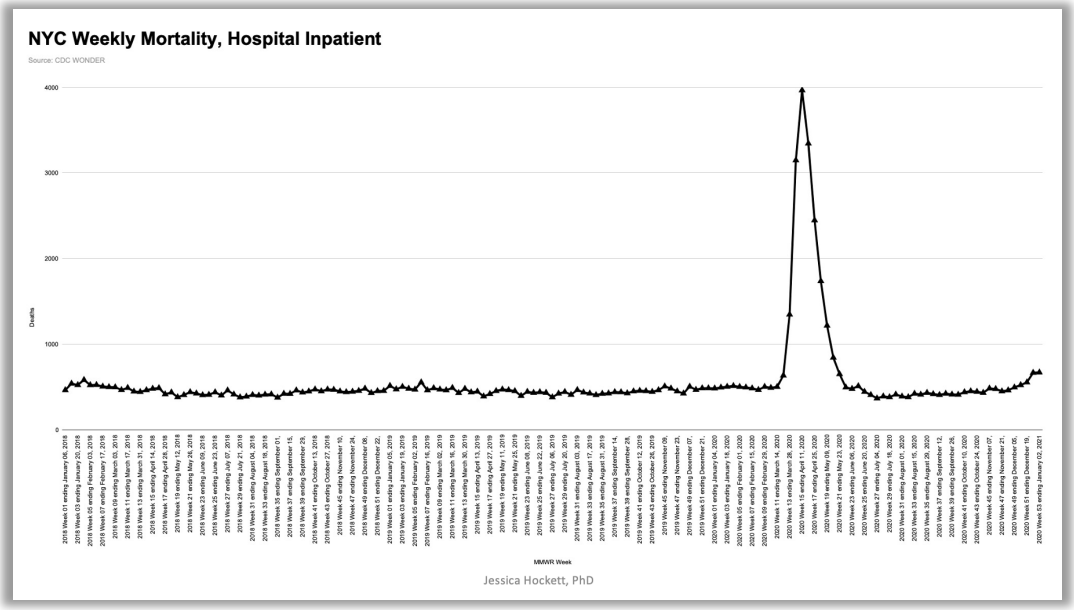


Some things that they were told to do, not to do, and use or not to use. I think that oxygen saturation is a little bit on the – I don't know about that for a definition of hypoxia. There *was* encouragement to use remdesivir, whatever you think about that. I don't have strong feelings about that either way. It's not a topic that I know a lot about. But even just that first line of "Currently, medical care for COVID is supportive". In other words, *we can't really do anything for this.* That's the message that was being sent. And I would say they *had* being doing stuff for whatever manifestation the virus had *for months* – before it had a name.

There was also a lot of encouragement from professional organizations and other sources to not give CPR, to issue unilateral DNRs. This was everywhere.

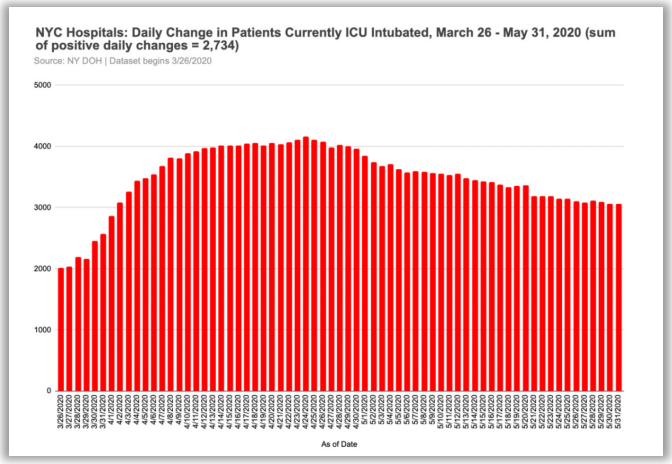


And so, doctors and nurses, whatever you think about their ethical and moral responsibilities in the end, they were being told that this was a virus that was new and they couldn't really do all the old stuff for it, and *when somebody tells positive, here's what you have to do* – under a lot of duress. I think this hospital inpatient toll is because of what people were being told.



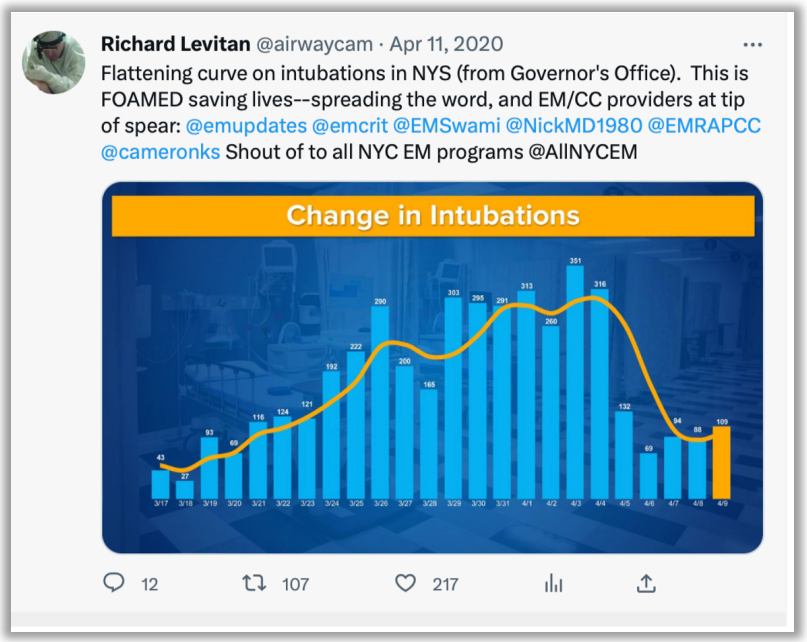
Ventilator Data

We unfortunately don't have the ventilator data that we would like to have. This is as good as it gets. This is patients currently ICU-intubated from March 26 – May 31. I have the data beyond this too, but the dataset starts the 26th.



We have change in intubations, actually, I have a graph of that somewhere too.

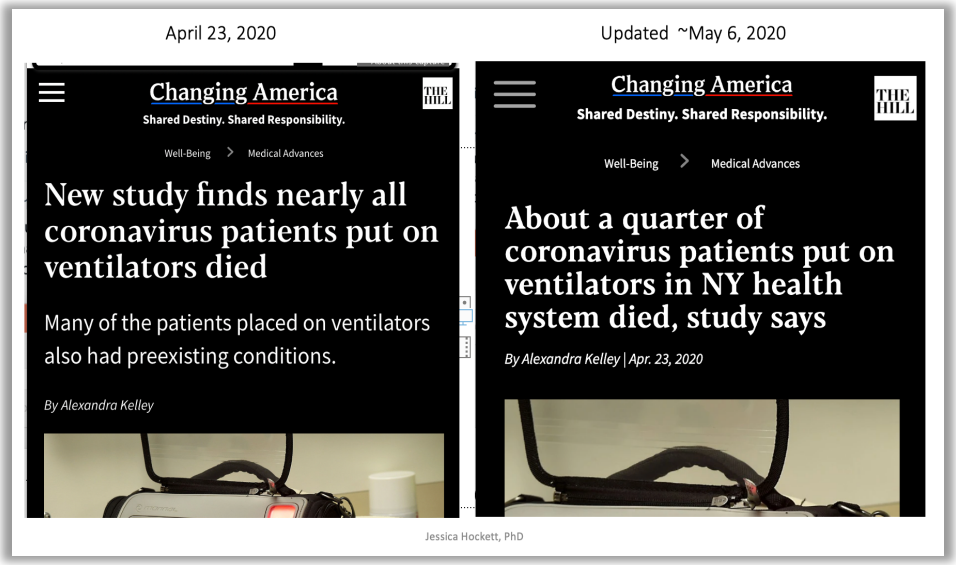
This guy – Richard Levitan (I hope he's not on the call). He developed some kind of device for airway intubation, some of you might know what it is. But he was really prominent in the beginning about hypoxia and people being able to talk with having low oxygen.



I've tried to engage with him but he blocked me. There's something going on there where they were intubating everyone and then started to stop. That's what I see in all of the data that I've looked at. **[JAH: Levitan later deleted his account after Jonathan Engler attempted to engage him here.]**

The Northwell Study

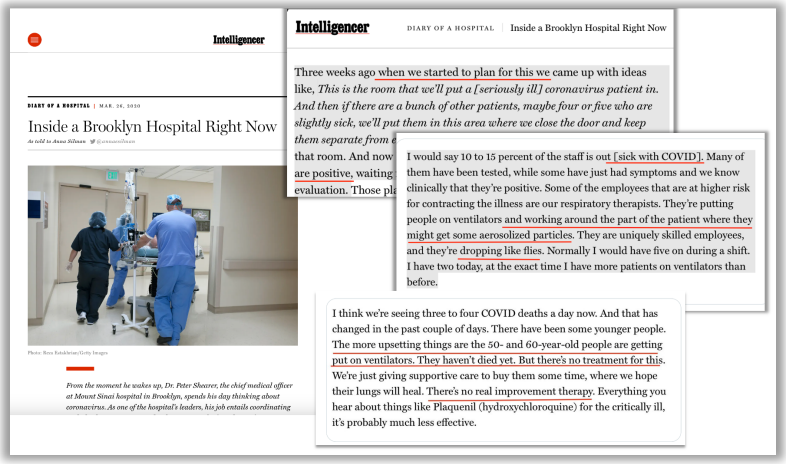
There was a study that came out from the Northwell hospital system early on. I think it was published the 20th of April or thereafter. The study endpoint went to April 6th. That data came out and said, "Hey, 88% of people placed on ventilators in this study died. 97% of people aged 65 and over." So that study came out and very quickly the narrative around that study changed.



The authors [issued a clarifying note or two in the study](). I think it was known that the ventilators, among other things, were killing people, but nobody want to say what exactly was going on. **[JAH: I later came to see the ventilators – both the "push" for more and the sudden announcement that there were being over-used/incorrectly used as part of the staging.]**

Authentic Doctor Experience?

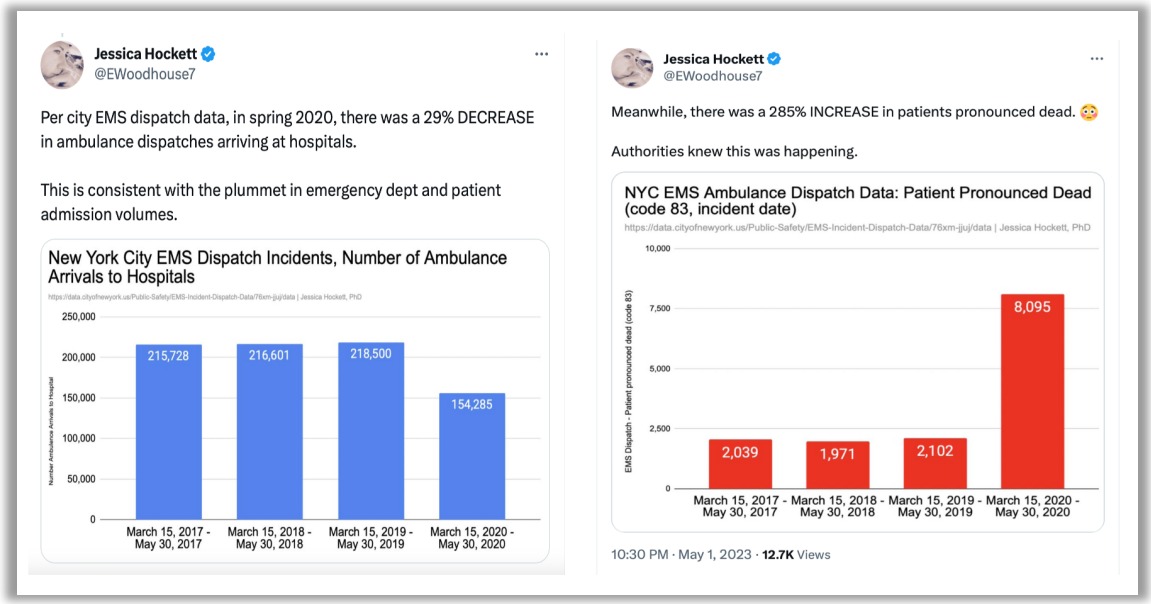
Let me show one thing for now. There's a great real-time account from a New York City doctor, Mount Sinai, and it's told in the first person. I think this is, for me, one of the best examples **of what somebody was experiencing, assuming it's authentic**. He's basically panicked. He's like, "Okay, we planned for this. I've got people in the emergency department that are positive and they need a bed." I don't know why they needed a bed, right? But he's like "they're positive so they need a bed." "There's other people under evaluation." "People are dropping like flies" "50- and 60- year-olds are being intubated." "There's no real improvement therapy."



I don't think we have murderers on our hands here. I think we have some people who were being subjected to some psychological duress by the messages they were being told. **[JAH: I later came to see accounts like these as part of a staged event/simulation with live patients. They are contrived. The writer may be experiencing something but as a crisis actor or persuaded victim.]**

Ambulance dispatches: hospital arrivals down, pronounced dead up

More data that I think is relevant: We don't see an increase in the number of ambulances that are going to the New York City hospitals. We do see an increase in the number of dispatches though. That's why people heard ambulances, but they were going to people's homes and other places where people were dead or could not be saved. I mean, really, the whole New York incident can be summed up in those two graphs.



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END EDITED RECORDING FOR SESSION 1. SESSION CONTINUED AND INCLUDED Q&A.

Session 2 – 25 July 2023

Introduction/Re-Cap

I'm Jessica Hockett. I'm going to be sharing some data and questions and answers to questions I have to "what the heck happened?" in New York City in spring 2020. New York City experienced an almost unfathomable mass casualty event at that time. I've been involved in an **ongoing personal inquiry** about what was the scale of this event, who died, how do we know, how can we tell?

I think people forget that **New York City was really key to convincing not only Americans but the world that this was a really serious virus that we needed to do something about.** That we needed to disrupt everything that we were doing and try to stop or slow the spread of this deadly pathogen.

Answering questions about New York City, which have *not* been sufficiently answered by anyone, I think, is key to getting at the heart of what occurred with this whole 'global viral pandemic declaration.'

Moreover, the mandates that were implemented in the name of slowing the spread – including vax passport mandates like the one New York City implemented – they were the first one to do so in the United States, I believe. Could've been San Francisco first. They have not been declared illegal. They could come back. Yesterday, the second circuit the Key to New York vax passport measure, noting that it was an effective way to combat 'spread' of COVID-19. **I don't see any evidence of sudden spread of a deadly pathogen in New York City, so that would probably be my case against that mandate, but I want to show you, in part, why I think that.**

My hypothesis at this point is that **the excess casualties that New York City experienced are wholly, or mostly, could be explained by the things that were implemented all at once, in anticipation of, not in reaction to, an actual emergency that was occurred.**

There wasn't a single force or trigger as far as I can tell.

A lot of people want to say it was ventilators and remdesivir. That is in the mix, but that is not just one thing, and I think that's really obvious especially when you look at WHERE people died. That is, whether they died in the hospital, nursing home, at their own home, etc. We'll take a look at that again.

SARS-CoV-2 as a virus

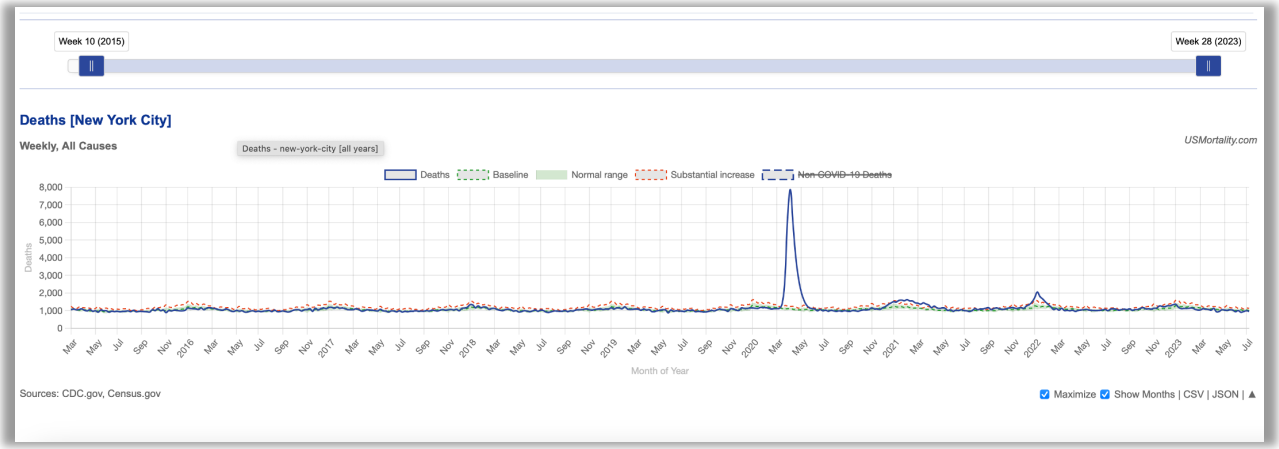
Insofar as a novel virus, it's not that I don't believe in viruses, or that I believe SARS-CoV-2 is not a thing. That's fine. I accept that it is, for now. But I don't think you need it to explain, or start to explain, what occurred.

Data Fraud

I do think fraud could be involved in New York City, possibly elsewhere too. But in New York City I see some signals, have some questions, have some concerns that do suggest that fraud could be involved. So I'll talk about that a little bit later. **[JAH – I wrote about the NYC curve being fraudulent, and offered possible mechanisms for curve distortion, in "The F Word".]**

Event Scale

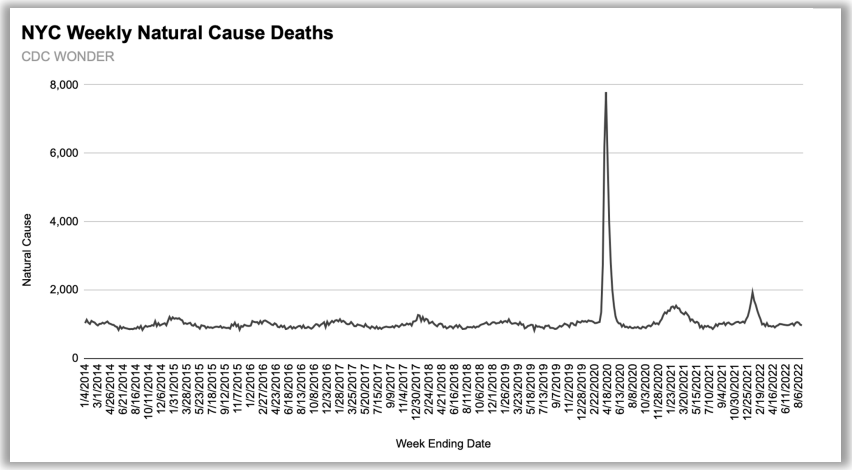
Just to remind everyone about the scale of the event. This is weekly all-cause mortality. We have that massive, massive spike.



I think only Northern Italy comes close so far as magnitude. An extra 27,000 deaths in 11 weeks. New York City usually experiences around 1,500 deaths a week; at the peak in early April, it was around 8,000 that occurred that week. It's just, when we think about the increase in the number of bodies, it's just incredible to think about. Dwarfs 9/11 by a long shot.

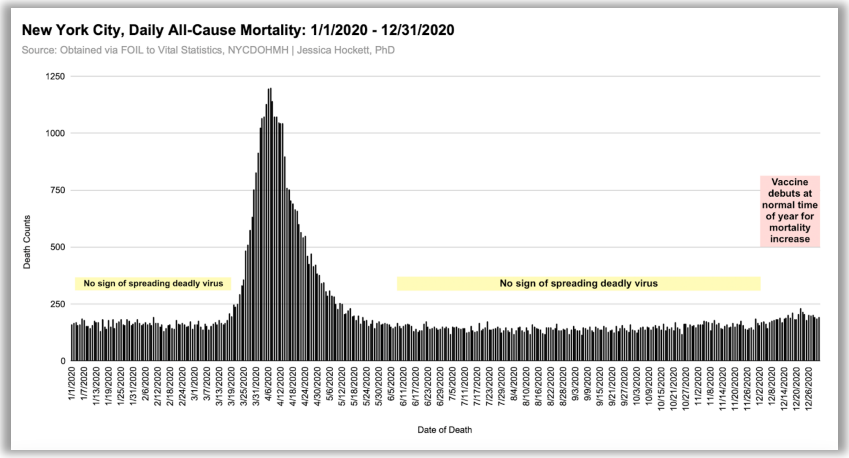
Perhaps just as shocking is the drop, back down to baseline, where it stayed – even a little bit below baseline in some places of death, until mid to late December.

Even just taking out -- there *were* some non-natural cause deaths in that rise – but this is natural cause deaths only. And you can see that dramatic rise, dramatic fall. Stays down and doesn't start to creep back up into excess territory…and even then it doesn't get super high compared to 2017 and 2018.



So, I would say that kind of spike, on its face, should raise a lot of questions. It's the kind of thing you would see in an earthquake with aftershocks. It's not something – **a virus isn't a bomb, I like to say.** If you just looked at that spike and you were an alien visitor from another planet, and you didn't know what happened, probably would not be disease. They, again, would be non-natural causes or phenomenon like a tidal wave enveloping the city.

This is daily all-cause mortality.



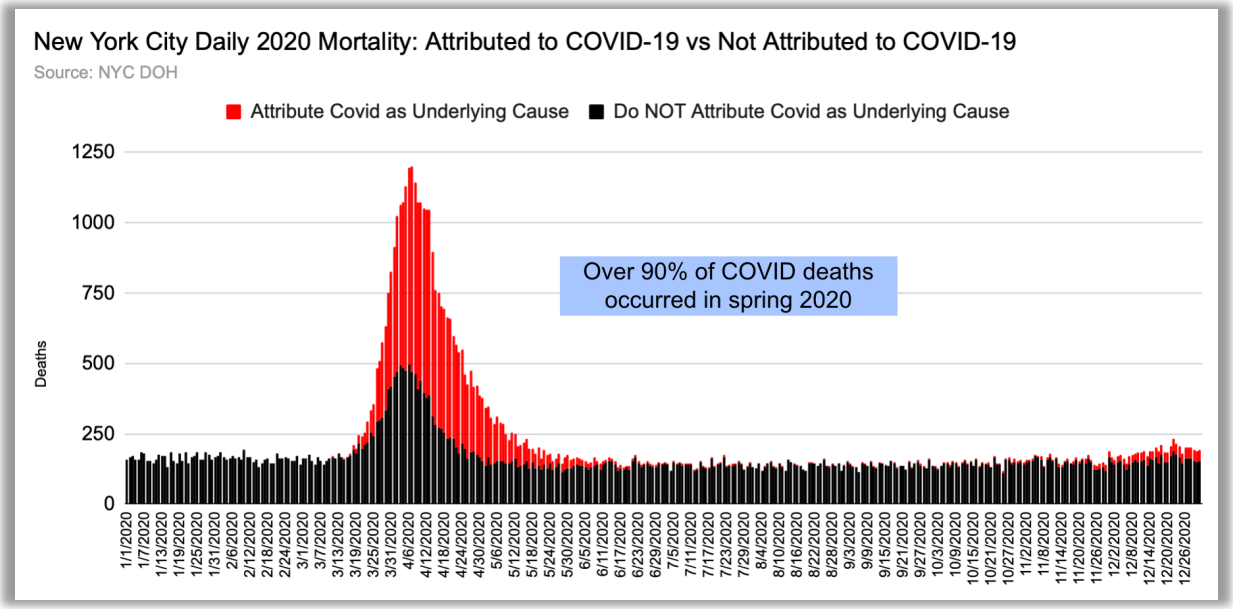
I like this view because I think of spring 2020, not only in New York but in other locations, as a *discrete event*. So, from almost a historian's perspective, you have to say,

"Okay, when I'm looking at an event that happened over a very short period, I want to see *day to day to day* what was occurring to try to get to the bottom of this."

Deborah Birx, in her book, she talks about – and actually a lot of American officials talk about this – the "silent spread of COVID." That it was "silently seeding". *Hiding in the flu*, for example, is one thing that people say.

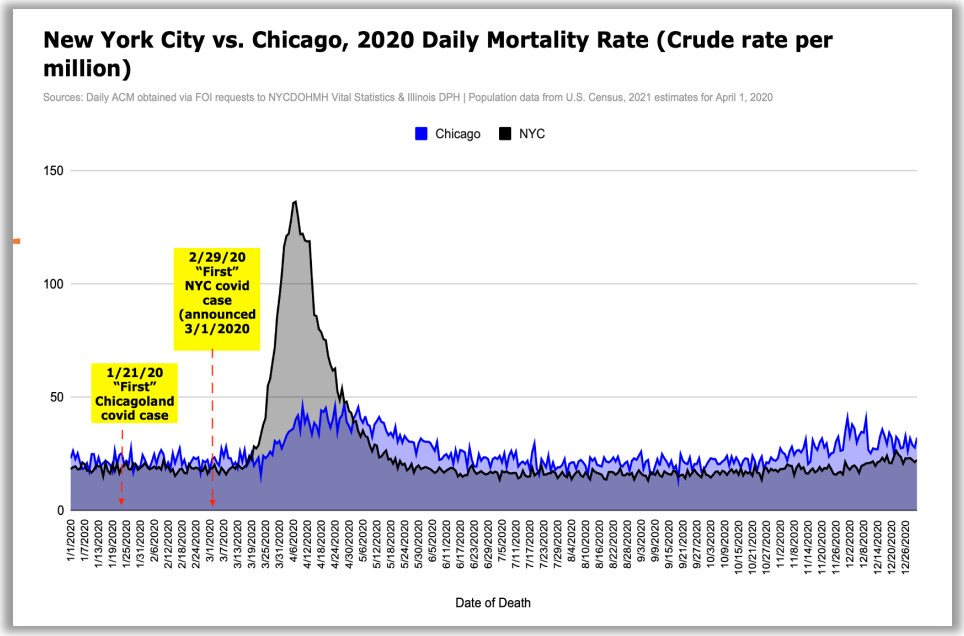
Last time I showed you that I've looked in multiple places: flu data, circulatory disease deaths, different age groupings. I do not see *anywhere, any impact* of a novel deadly pathogen on mortality. I just don't see it. So, no sign of spread. Drops back down. The pathogen seemingly disappears or does not have an impact on mortality until maybe later on.

And it's not that deaths weren't still being attributed to the virus. They did have some of that. But over 90% of deaths attributed to COVID in New York City occurred in the spring. So, again, you can see why I call it an event. Something happened. What happened there?



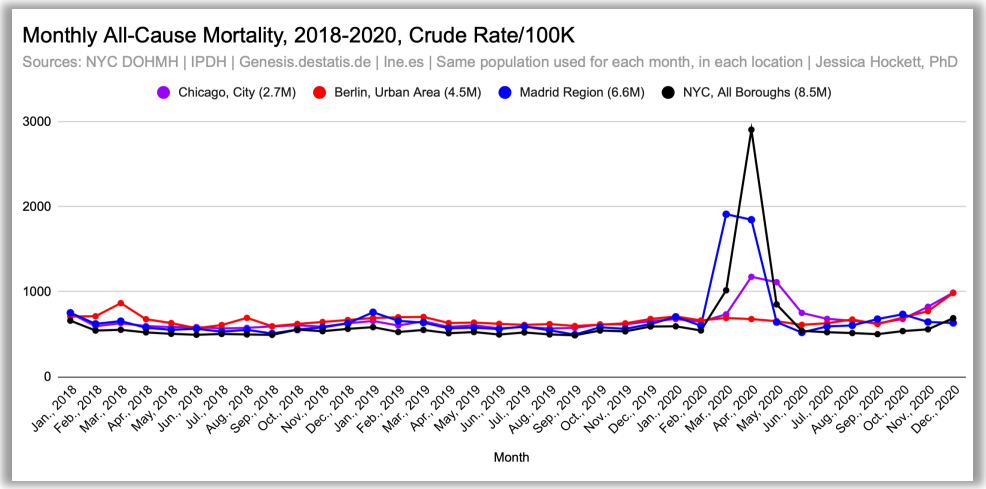
If we compare it to Chicago, it's many, many magnitudes higher. Chicago reported its first cases of COVID much earlier than New York City did. Actually, even New York state reported its first COVID cases sooner than New York City did. New York City's first case was announced on the 1st of March. It was a woman returning from Iran. She was 38 or so. Not hospitalized. Not a severe case. With Chicago, New York – and this is true, I think, in most places around the world, we see mortality go up *not gradually*, not

rising. But we see it *dramatically* go up after the advent of mass testing and other government interventions.



New York and Chicago vs Berlin and Madrid

This is a comparison of New York with some cities around the world. I'm always looking for this kind of data for any city, all cause. Daily is my favorite but if you have weekly or monthly, it'll do. But New York City is head and shoulders above Madrid, again, far above Chicago.

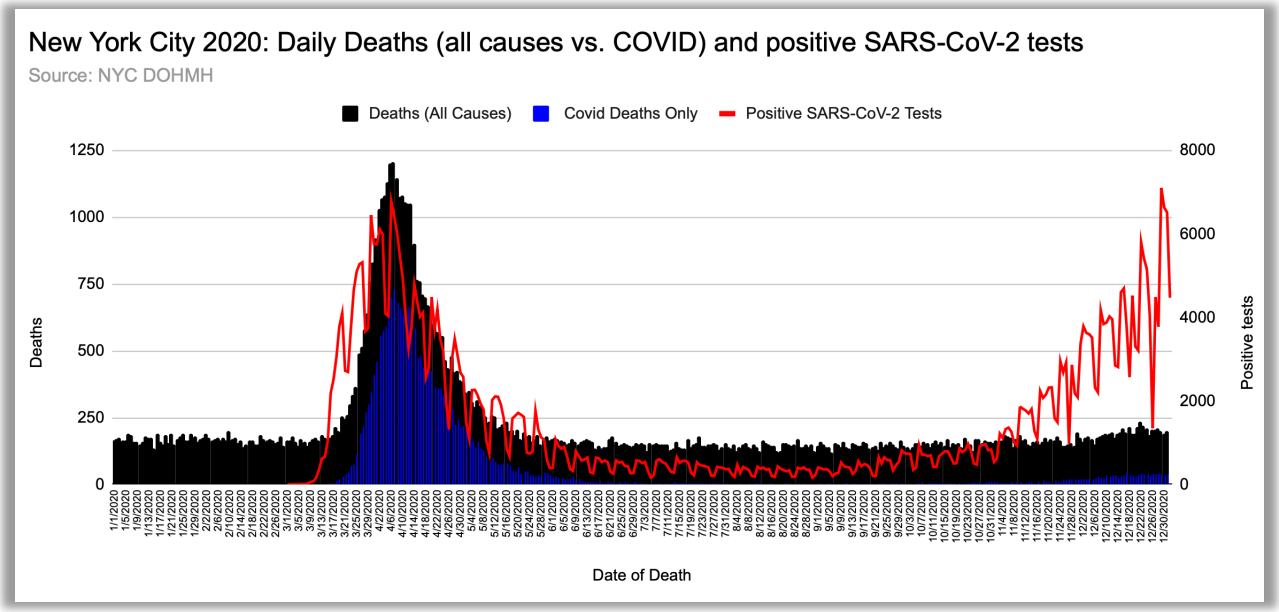


I have a lot of questions about **Berlin.** [Sarcastically] They apparently did not experience any spread or any *impact* of this deadly pathogen. I guess there could be many reasons for that, but I had not realized before I did this that Berlin, or that Germany in general, really did not experience excess at that time.

I noticed too that **Madrid**, which was another place besides Italy and Iran that was used to scare Americans and scare the world. It's interesting that their event came sooner. You also have the dramatic peak and dramatic fall. That, to me, strongly suggests non-natural factors at work.

Testing Trigger

I find this look at what happened pretty interesting. We see the mortality, all causes, and then just COVID – like a bomb, goes off. But we had a really high, unusually high percent positivity rate in New York City.

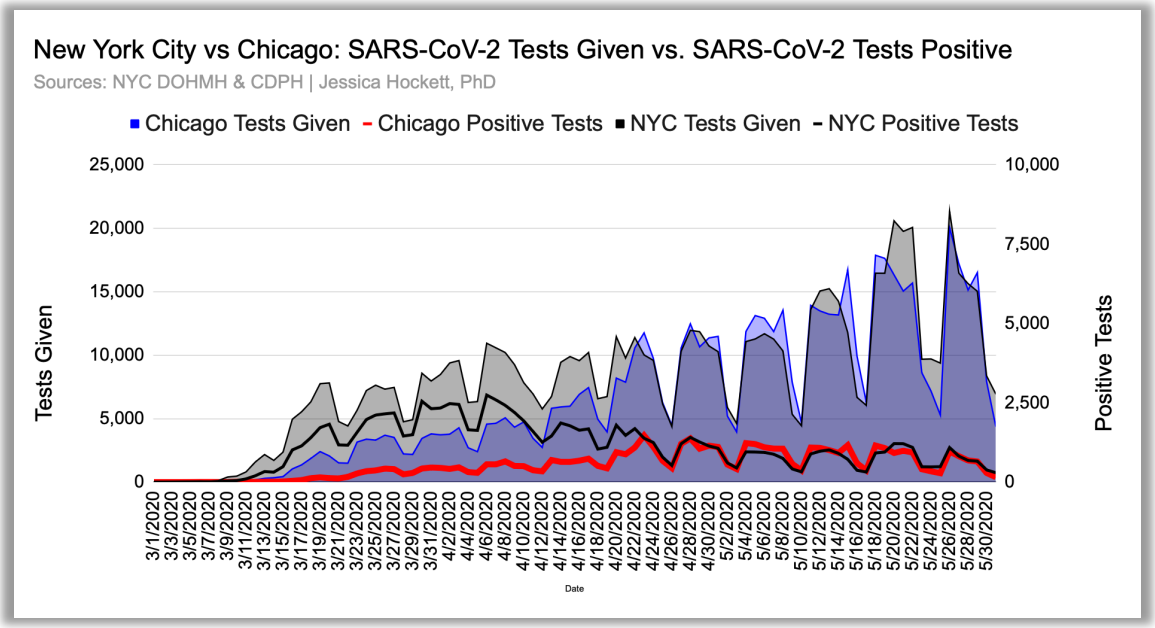


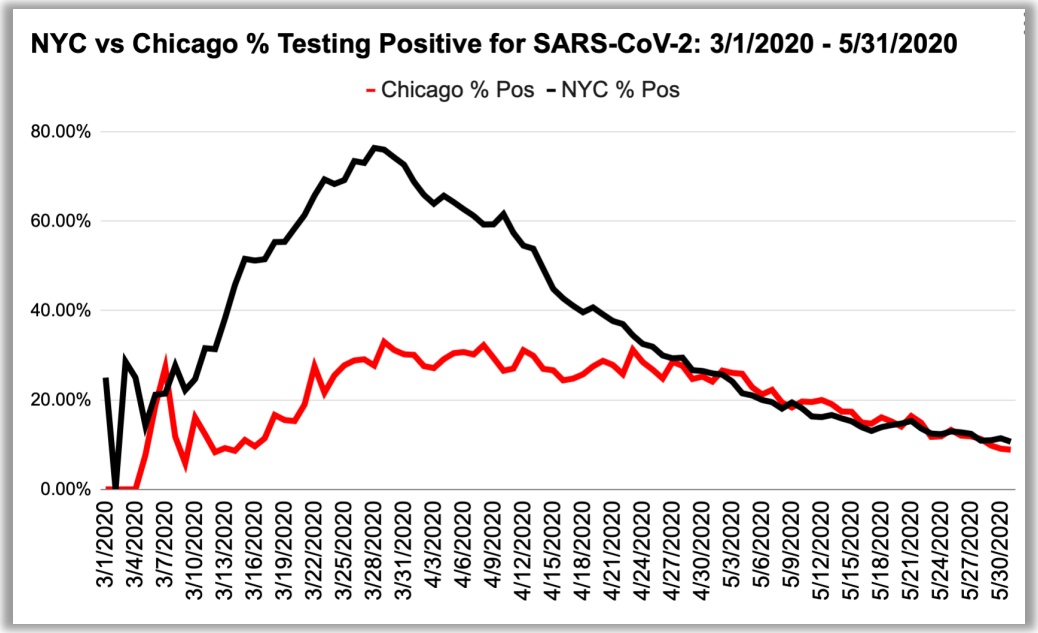
It is *not* true that they had no tests. In fact, the "case" reports that Americans were hearing every day, New York City comprised a huge portion of those cases *because of* all the testing they were doing. Not only in their hospitals, but in urgent care centers, and in nursing homes as well. They had tests. In fact, they were *re*-testing people in the hospital. There's evidence that they suddenly tested everybody who was *in* the hospital, pretty much right away in early March. So, it's interesting that when you look at that percent positivity that it pre-dates, timing wise, it precedes the mass casualty.

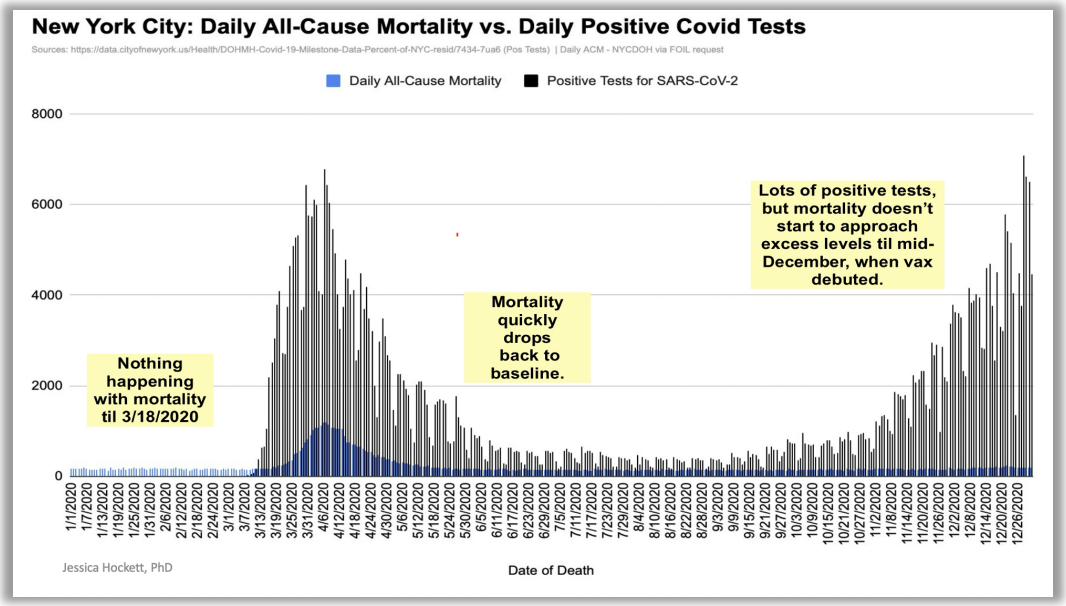
Then it *drops,* and then it doesn't back get up even over 10% later on. It's not because they weren't giving tests. They *were* giving tests. Some tests were coming back positive. Apparently, New York City had figured out how to *defeat the virus*. That was the narrative at the time. I remember it well. Andrew Cuomo, it's the kind of thing that he was saying. ***The virus hit New York harder. Then we learned how to handle it. And we showed everybody how it was done.*** There was an incentive there: **to show the world that New York had conquered the virus.**

I don't know why they didn't tell Los Angeles. Los Angeles experienced a huge increase in COVID-blamed death and all-cause mortality [in late 2020, early 2021], including in their hospitals. I don't know why New York City hospitals wouldn't tell L.A. hospitals how to do it – how to handle it -- but apparently they had figured it out. **[JAH: See Hockett, J. (2025, March 8) "LOL La La Land." *Wood House 76*]**

If we compare that positivity rate to Chicago, back in 2020, Chicago also had tests, but their push began after New York's – about two weeks after New York's. It's interesting, how you see the positivity rate, it's very different. Chicago's never gets over 30%, which is still too high in my opinion and raise questions about the test and what was going on. **[JAH: Correction: Chicago's peak that spring was 33%.]** New York's starts out massively high. Notice with this view that many tests are still being given in the fall and winter but mortality never starts to approach the same levels.



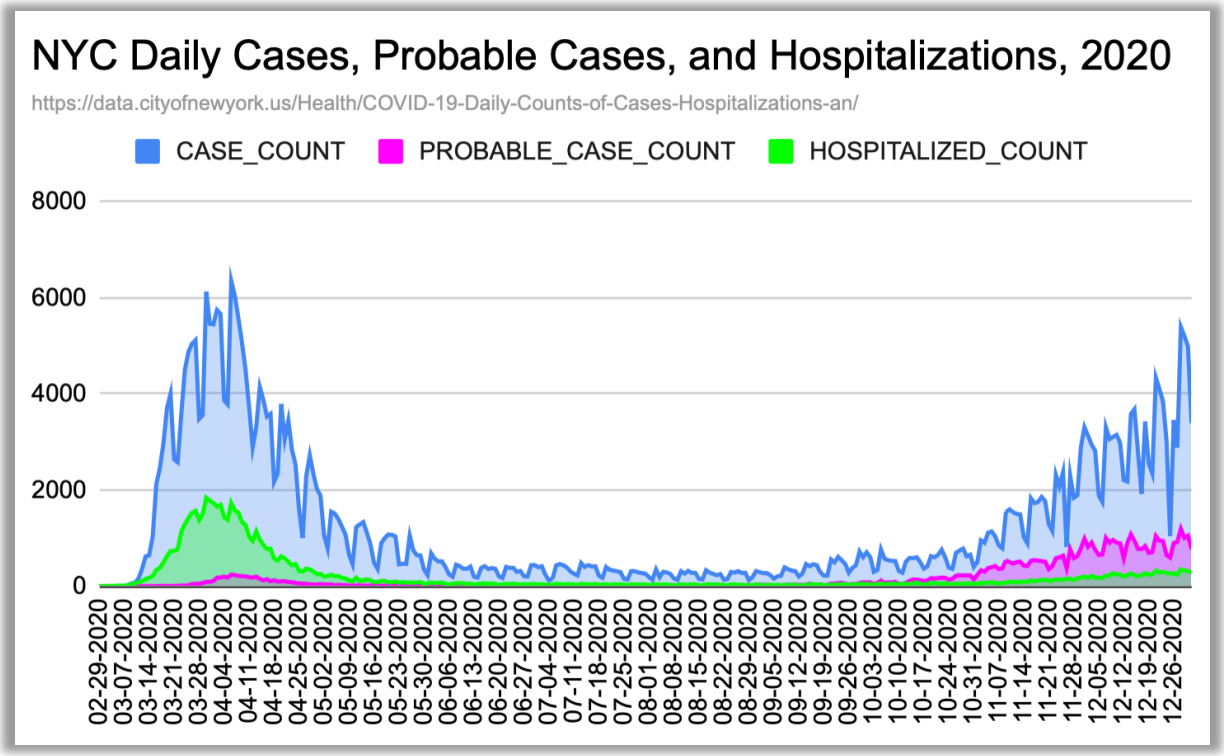




My guess is that hospitals stopped mass testing [of inpatients], and that nursing homes did as well, and that the of most of those tests came from other places. Other facilities, like pharmacies. But, again, somehow New York had "learned how to manage the virus."

This is another view that raises a lot of questions for me. This is case counts, which as we all know is positive tests – not necessarily associated with symptoms or even respiratory symptoms. New York and other cities here [in the U.S.] had these 'probable'

cases and 'probable' deaths for a time. I find it really interesting that probable cases go up when there's no shortage of tests. I'm not sure why probable cases went up later in the year but hospitalizations, meaning COVID-positive patients, are way down.



So, this is part of what leads me to believe that maybe there was a change in the tests that New York City was giving. Maybe their protocols for testing hospital patients and nursing home residents changed as well. It's hard to say.

Younger, Working-Age Adult Deaths

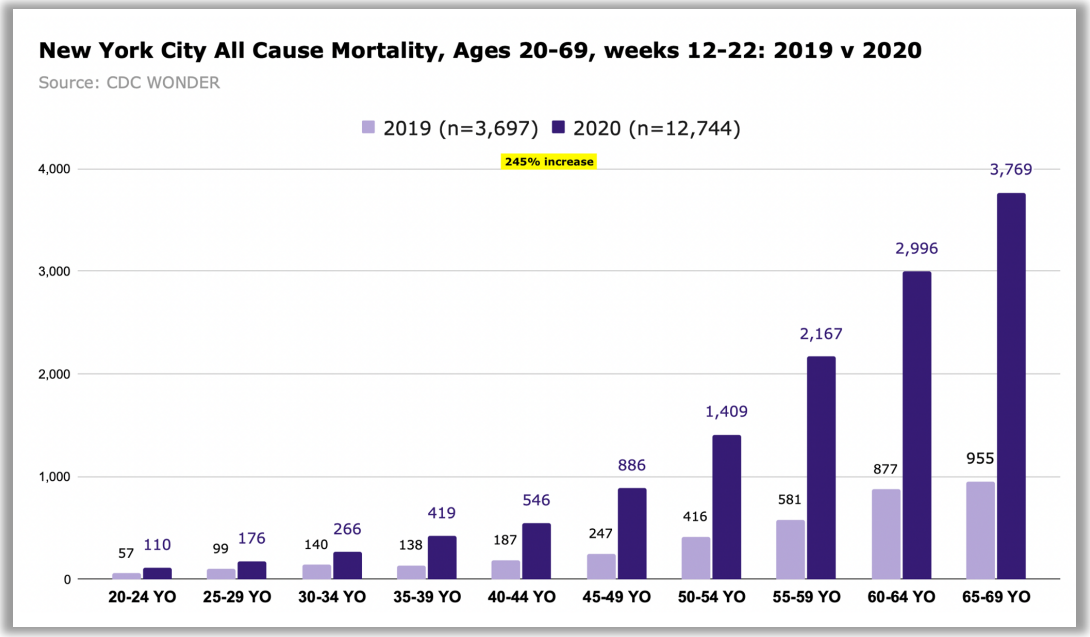
I mentioned this last time, but New York City is a global outlier as far as I can tell insofar as the number of younger people that died during this event. They had a massive loss of life years. This is a comparison of all cause deaths between ages 20-69, and then more elderly deaths over age 70. You'll see that one-third-ish of the excess (I say *increase;* I don't love the term *excess*) – increase in mortality was people under age 70. And pretty much right off the bat, too. So, when people say, "Well it's all those old people. The 'dry tinder.'" We had a lot of younger people too that died.

New York City, pop. 8.8 million			
MMWR Week	2019 All-Cause Deaths (20-69)	2020 All-Cause Deaths (20-69)	% Increase
Week 12	323	445	38%
Week 13	341	961	182%
Week 14	354	2,192	519%
Week 15	380	2,541	569%
Week 16	321	1,896	491%
Week 17	321	1,325	313%
Week 18	336	996	196%
Week 19	336	813	142%
Week 20	344	588	71%
Week 21	330	540	64%
Week 22	311	447	44%
TOTALS	3,697	12,744	245%
Source: CDC WONDER			

New York City, pop. 8.8 million			
MMWR Week	2019 All-Cause Deaths (70+)	2020 All-Cause Deaths (70+)	% Increase
Week 12	676	942	39%
Week 13	742	1,831	147%
Week 14	665	4,186	529%
Week 15	689	5,474	694%
Week 16	629	4,193	567%
Week 17	609	2,838	366%
Week 18	645	1,939	201%
Week 19	687	1,320	92%
Week 20	683	1,043	53%
Week 21	701	806	15%
Week 22	567	718	27%
TOTALS	7,293	25,290	247%
Source: CDC WONDER			

Jessica Hockett, PhD

Here's another view of the breakdown. Obviously, a greater proportion comes from the older group, closer to 69. I haven't seen this demographic profile anyplace else.



COVID as driver for younger adult deaths?

This is deaths with COVID-19 somewhere on the death certificate, whether as underlying cause or as contributing cause, in the smaller age groups, so you can see. The bottom line here is that New York City wants us to accept, especially for younger people, that COVID was really motivator of the excess. Which is contrary to what we

know to be true – or what we *believe* to be true at this point anyway – about the IFR of the pathogen.

Five-Year Age Groups	NYC ACM, Weeks 12-22, 2019	NYC ACM, Weeks 12-22, 2020	Increase	% Increase	Deaths with Covid-19 on Death Certicate	% Increase with Covid on DC
20-24 YO	57	110	53	*93%*	26	49%
25-29 YO	99	176	77	*78%*	57	74%
30-34 YO	140	266	126	*90%*	108	86%
35-39 YO	138	419	281	*204%*	208	74%
40-44 YO	187	546	359	*192%*	301	84%
45-49 YO	247	886	639	*259%*	527	82%
50-54 YO	416	1,409	993	*239%*	827	83%
55-59 YO	581	2,167	1,586	*273%*	1,325	84%
60-64 YO	877	2,996	2,119	*242%*	1,850	87%
65-69 YO	955	3,769	2,814	*295%*	2,348	83%
Totals	**3,697**	**12,744**	**9,047**	***245%***	**7,593**	**84%**
Source: CDC WONDER						

Where younger deaths occurred

One more view of the young deaths. **Where did they occur?** In the United States, we have seven places of death that are reported: medical facility inpatient, medical facility outpatient/ER, hospice facility (different from hospice care in a hospital or home), care homes are grouped separately from that. Then we have dead on arrival – that is, you were picked up alive from your home or your residence, could be from a care home, and you were en route to a hospital but you died before you got there. Your personal home, whether that's your apartment or town home, and then other places would be like a homeless shelter, the street, anything that falls outside of that.

NYC, ages 20-69, weeks 12-22, by Place of Death (2020 v 2019)						
Place of Death	ACM 2020	Covid on DC	No Covid on DC	ACM 2019	2020 vs 2019	% Change
Medical Facility - Inpatient	7,703	5,891	1,812	1,744	5,959	342%
Medical Facility - Outpatient or ER	1,095	517	578	498	597	120%
Hospice facility	53	<9	44	65	-12	-18%
Nursing home/long term care	798	248	550	243	555	228%
Medical Facility - Dead on Arrival	72	<9	63	67	5	7%
Decedent's home	2,767	885	1,882	933	1,834	197%
Other	256	23	233	147	109	74%
TOTALS	**12,744**	**7,564**	**5,162**	**3,697**	**9,047**	**245%**

Many of the working-age adult deaths were in hospitals.

Note that most of these younger deaths occurred in the hospital, among *inpatients*. These younger people were admitted and treated and there's COVID on the death certificate. The equivalent, pretty much, of all of that increase. For me, these younger deaths are a reason alone to *demand* – for every American, let alone New Yorkers – to demand that the death certificates for these individuals be released and an independent medical record review conducted in every New York City hospital. It's truly astounding.

Place of Death, All Ages (All Causes and COVID-attributed)

Looking at where people died regardless of their age, we can see that most of the increase was in hospitals.

New York City, Weeks 12-22, 2020					
Place of Death	2019 Deaths from All Causes	2020 Deaths from All Causes	All Cause Increase/ Decrease (2019/2020)	Percent Change from 2019	Percent of Total Increase/ Decrease
Hospital Inpatient	4,837	19,827	14,990	310%	55.5%
Outpatient/Emergency Department	1,026	2,697	1,671	163%	6.2%
Nursing Home/LTC Facilty	1,762	6,642	4,880	277%	18.1%
Hospice Facility	267	231	-36	-13%	-0.1%
Decedent's Home	2,906	8,215	5,309	183%	19.7%
Dead on Arrival (to Hospital)	122	139	17	14%	0.1%
Other	220	403	183	83%	0.7%
Totals	**11,140**	**38,154**	**27,014**	**242%**	**100%**

"Toward a New York City Hypothesis" PANDA Open Science presentation | Jessica Hockett | CDC WONDER

There was a lot of attention – still is a lot of attention – around what happened in nursing homes. I'll get to that again in a little bit. But, regardless, the bulk of the excess comes from hospitals. Really big chunk at home as well. I'll get at some of the forces that were at work there in a little bit.

Insofar as COVID being on the death certificate, again, we see that it's identified as not only a contributing cause but *underlying cause* in pretty much all of the hospital deaths – the equivalent of all of that increase. The implication is that "COVID caused this. Nobody died in the hospital, or no extra people, so to speak, for any other reason than sudden spread of a pathogen. That's the implication of these [hospital inpatient] data.

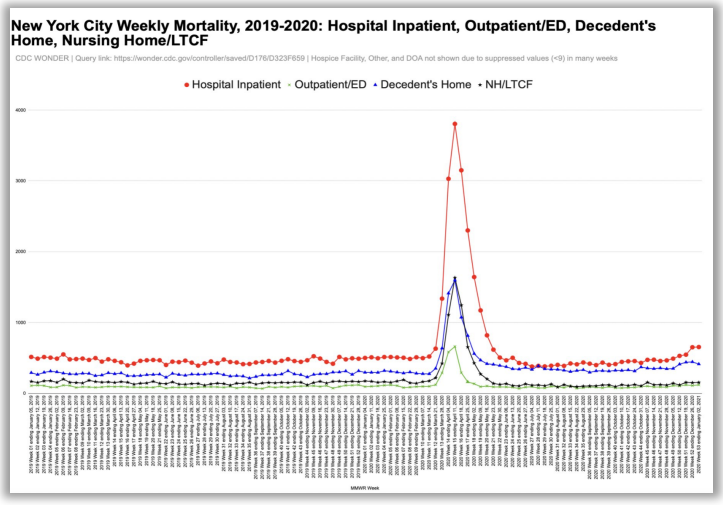
New York City, Weeks 12-22, 2020					
Place of Death	2019 Deaths from All Causes	2020 Deaths from All Causes	All Cause Increase/ Decrease (2019/2020)	2020, Deaths Listing Covid as Underlying Cause	% of total Covid Deaths
Hospital Inpatient	4,837	19,827	14,990	14,704	76.1%
Outpatient/Emergency Department	1,026	2,697	1,671	1,271	6.6%
Nursing Home/LTC Facilty	1,762	6,642	4,880	1,797	9.3%
Hospice Facility	267	231	-36	57	0.3%
Decedent's Home	2,906	8,215	5,309	1,426	7.4%
Dead on Arrival (to Hospital)	122	139	17	25	0.1%
Other	220	403	183	43	0.2%
Totals	**11,140**	**38,154**	**27014**	**19,323**	**100.0%**

"Toward a New York City Hypothesis" PANDA Open Science presentation | Jessica Hockett | CDC WONDER

Notice that in nursing homes, only 1700-1800 of those deaths have COVID as underlying cause. There was testing going in nursing homes, that's irrefutable with the testing data. So we had a lot of non-COVID death in nursing homes for various reasons. A lot of that is Alzheimer's – there's other kinds of deaths in there as well.

Massive number of deaths at home. I question the 1400 deaths that were attributed to COVID happening at home. I would really know how many of those people were discharged from the hospital. I'd really like to know how many people's bodies were just "swabbed" by the medical examiner. I question that attribution.

Insofar as the timing of the event, this is the main places of death for New York City. Hospital rose first by just a little bit [and] towers over the other places of death, especially if I added the green [ER] to the red [inpatient], that's at the hospital. And then you see nursing home and deaths at home as well.



This is another view of inpatient.

U.S. Hospital Inpatient Deaths (CDC WONDER)

MMWR Week	2019	2020	Increase	Increase from NYC alone	% of Increase from NYC alone
Week 12	16,766	16,781	15	204	1360.00%
Week 13	16,486	17,739	1,253	867	69.19%
Week 14	16,387	22,357	5,970	2,710	45.39%
Week 15	16,011	24,784	8,773	3,520	40.12%
Week 16	15,608	24,179	8,571	2,954	34.47%
Week 17	15,518	22,718	7,200	2,029	28.18%
Week 18	15,558	20,961	5,403	1,284	23.76%
Week 19	15,407	19,576	4,169	746	17.89%
Week 20	15,284	18,452	3,168	379	11.96%
Week 21	15,294	17,347	2,053	198	9.64%
Week 22	15,096	16,586	1,490	99	6.64%
TOTALS	173,415	221,480	48,065	14,990	31.19%

Jessica Hockett, PhD

At the time, New York City's hospital inpatient comprised the bulk of *all* deaths in the United States. That increase is astounding. The numbers that we were hearing every day in the United States, and that we were hearing from New York in particular, they were reporting at the time hospital numbers.

Very quickly, I have questions about that as well, but deaths that occur at home, those take longer to process. In normal times, they take longer to process. So the numbers we were hearing were hospital numbers. Huge, huge share of the national total. I'm not sure people realized that at the time. I know I didn't until later.

Cuomo's quote "nursing home order" got a lot of attention but he also issued other orders and other things also happened that impacted what was going on.

March 23, 2020: Cuomo's "Hospital Order" (Green-Light for Disaster Medicine)

- Hospitals must expand capacity by 50% under threat of penalty
- Removed requirements for oversight decisions by residents, interns, and others
- Absolution for close record-keeping
- Allow emergency medical services to transport patients to locations other than healthcare facilities with prior approval by Department of Health.
- Suspend or modify sections of the law to "allow any emergency medical treatment protocol development or modification to occur solely with the approval of the Commissioner of Health"
- Remove limits on working hours for doctors and trainees
- Etc.

What the hospitals were doing and what they were being told to do. I find it really interesting that hospitals were absolved of close record-keeping for patients. He removed requirements for oversights [of] residents and interns and others. He, this is very odd, he allowed EMS services to transport patients to locations other than healthcare facilities. That could've been because of anticipated field hospitals, right? Like the Javits Center or Center Park, the ship, the mercy ship that was sent. *Maybe* that was done in anticipation of that?

But there were a lot of things that were done or allowed in hospitals, including suspending visitors, right?

> There were no -- I call them **witnesses**.[3] There were no third-party witnesses. Not only in New York but that was true all around the county; in fact, in many places around the world. I would contend that removing visitors, removing advocates – that would increase the risk of mortality for everybody in the hospital. I'm not being disparaging to doctors. There are reasons that we have advocates there, and that wasn't the case.

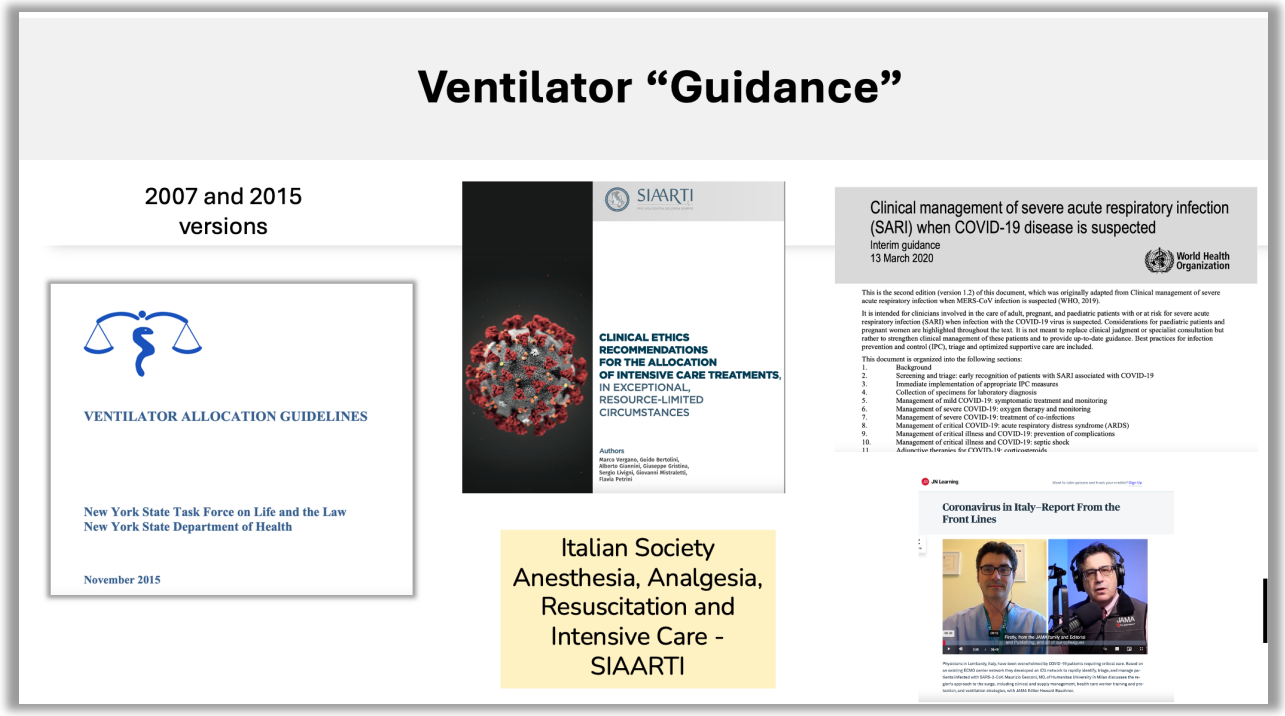
I think I mentioned last time that there was some general guidance from the city health department that was issued to hospitals on March 15th. They sort of said (I'm translating here), "We can't do anything for it," is how I interpret this. *Avoid the corticosteroids.* There was guidance to try remdesivir. There's what I would consider – I'm not a medical professional, but that hypoxia guideline seems a little high to me. I have questions about that. But that was the general treatment guidance that was given.

Ventilator "Guidance": Who's responsible?

I'm not going to get into all the specifics of this today, but insofar as ventilator guidance and where that came from, you remember the push for ventilators. "Where are the ventilators?" Cuomo said. There was a battle that developed between the President of

[3] Related article: Hockett, J. (2025, June 29). "Deadly medicine and missing witnesses." *Wood House 76*.

the United States and governors, including mine, JB Pritzker. Where did that push come from?



A lot of people talk about the WHO, the WHO guidance that was issued on March 13th and some advice or studies from China. I think that's true, I think that's part of it. But I've also seen some other things that played a role, based on some contemporaneous accounts at the time.

There was a group in Italy that issued a very ethically-questionable document in early March. It was controversial even in Italy, I've learned, about use of ventilators, ventilator allocation, how to – basically how to decide who's going to live and who's going to die.

There's also a really interesting interview and report that was put out by *JAMA* – the *Journal of the American Medical Association.* It was recorded on March 13th, published on March 16th, with a doctor – I think it's an anesthetist – in Italy about what he was seeing on the ground in, I think it was Milan, in Northern Italy. He's talking with the editor of *JAMA.* He emphasizes the use of ventilators as well. It's a fascinating interview to watch. I encourage you to do so if you're interested.

But also the state of New York had its own guidelines. And its deadlines were originally developed in 2007, then there was a new set that came out in November 2015. This was

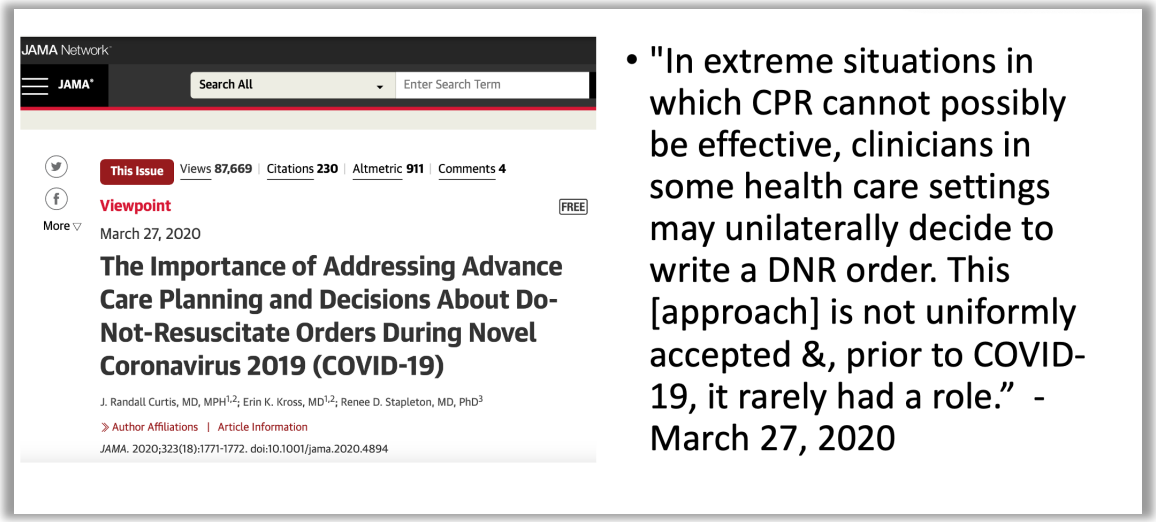
in anticipation of a flu pandemic, a global flu pandemic. The group that developed these met, they had an emergency call on, I think it was March 16th. Some heads of hospitals were involved in the call as well. And there was a look at these guidelines and how they would apply.

My understanding based on a *New Yorker* article on that meeting is that there weren't really concrete changes that came out of it and that hospitals felt like they were left to decide for themselves. I haven't been able to corroborate all of that yet.

All of that to say that I don't know we can blame China necessarily, or entirely, for the ventilator push. I think it was coming from other sources and had been anticipated already, years before addressing sudden spread of a virus, a flu virus at minimum. **[JAH: Question later addressed in "U.S. covid-19 ventilation policy: Made in China?" (Neil, Engler, & Hockett, 2023)]**

Moral permission for unilateral DNRs

JAMA also had put out – and other sources, other professional organizations had put out -- guidance to doctors about not using CPR, and about the moral permissibility of writing a unilateral DNR.[4]



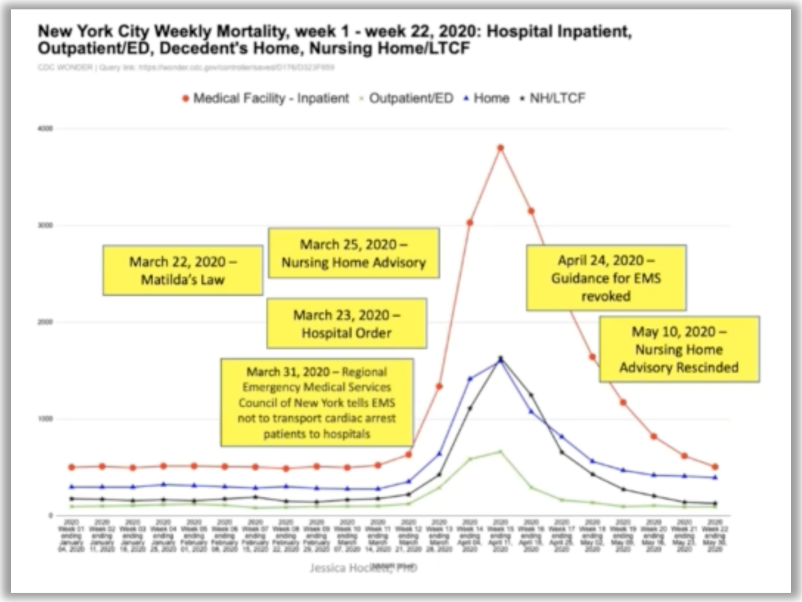
[4] Related articles: Hockett, J. (2025, February 26). "'Informed assent'? A DuPage County (IL) DNR in spring 2020." *Wood House 76*. | Hockett, J. (2025, March 4). "Follow-up on 'informed assent': More signs that spring 2020 was… not what it seemed to be." *Wood House 76*.

There's multiple accounts of that happening with the DNRs – sort of, not on a whim but maybe out of fear, certainly telling doctors not to administer CPR because it might spread the virus or they might put themselves at risk – all of these things contributed to the fear and probably the poor decision-making as well.

Other forces

If we look at some of the things that were issued besides that hospital order, we have different forces that seem to have contributed. These aren't the only things but they're some of the things that came along around this event.

We had the hospital order. We also had something called Matilda's Law, where basically Cuomo told old people to stay home – and that they shouldn't go out. It wasn't a law at all; it was an illegal order, in my opinion.



Inordinate attention on "the nursing home advisory"

The nursing home advisory is the one that's gotten so much attention. That said nursing homes could not reject a new admission or returning resident on the basis of COVID positivity. So people have said when nursing home residents came back from the hospital that were still COVID positive, they spread it to everybody in the nursing home, and that's what contributed to the toll in the nursing homes. I think there's reason to question that narrative, especially if you're somebody like who doesn't believe that there was a spreading, highly-contagious pathogen necessarily at play. But also COVID was already in the nursing homes – or I should say *COVID positivity* was

already in the nursing homes. So, the idea that the advisory – which was actually issued under pressure from the Greater New York Hospital Association who wanted to free up the beds -- but the idea that COVID positivity wasn't in nursing homes already is unsubstantiated by the timeline of events.

Orders to First Responders

Something else that people don't realize: the Fire Department of New York was asked to, ordered basically, to stand down from responding to medical emergency calls. There was still EMS, emergency medical services, but the Fire Department was told that they couldn't respond to some of these minor, they were ostensibly trying to keep them from answering minor calls because they had an influx of calls with people panicking. I showed that last time, with some data for that. Where people were starting to freak out after the first case was announced.

Topics › Coronavirus (COVID-19)

Email Print Comment

FDNY pulls firefighters back from potential coronavirus calls

The move angered EMS union leaders who say EMTs and paramedics in the city continue to be deprioritized

Mar 8, 2020

Ginger Adams Otis
New York Daily News

NEW YORK — The FDNY is pulling firefighters from answering medical calls that describe symptoms associated with coronavirus, the Daily News has learned.

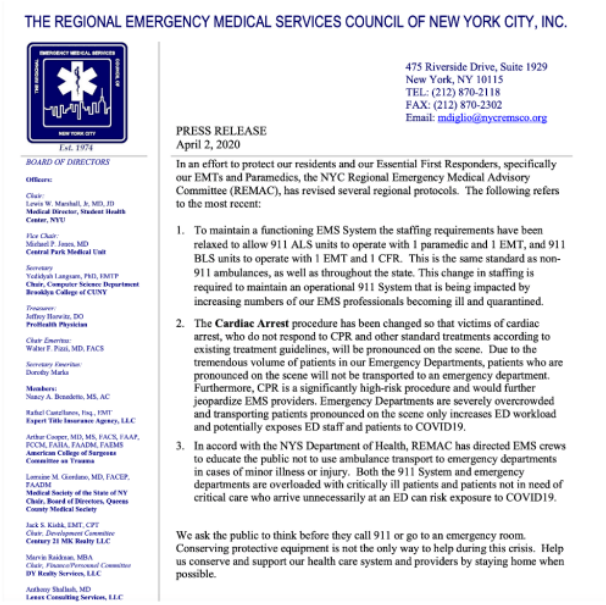
A department order issued Friday says 911 calls for asthma attacks, fever, coughs and difficult breathing will be handled by the Emergency Medical Service.

Fire companies with certified first responder training that would normally accompany ambulances are being to stand down, the order said.

But the other thing that happened was that guidance was issued to EMS that told EMS services not to transport cardiac arrest patients to hospitals. So, like, *if you arrive and the person doesn't have a pulse, you shouldn't try to save them.* And/or *if you have some reasonable attempts, you should not transport that person to the hospital, because you might spread the*

virus. The assumption was that the person might have the virus, and that that's what was causing the cardiac arrest. And so *you don't want to bring them into the hospital, because the hospitals are overwhelmed.*

[JAH - I can't speak to what was happening in cities in other countries, but regarding London and England, I have heard people essentially blame fear on the part of EMTs. If directives there or elsewhere sounded anything like those issued in New York City (2 April 2020 example below), then the responsibility lies not with the first responders and with those issuing the guidance.]



THE REGIONAL EMERGENCY MEDICAL SERVICES COUNCIL OF NEW YORK CITY, INC.

Est. 1974

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PRESS RELEASE
April 2, 2020

In an effort to protect our residents and our Essential First Responders, specifically our EMTs and Paramedics, the NYC Regional Emergency Medical Advisory Committee (REMAC), has revised several regional protocols. The following refers to the most recent:

1. To maintain a functioning EMS System the staffing requirements have been relaxed to allow 911 ALS units to operate with 1 paramedic and 1 EMT, and 911 BLS units to operate with 1 EMT and 1 CFR. This is the same standard as non-911 ambulances, as well as throughout the state. This change in staffing is required to maintain an operational 911 System that is being impacted by increasing numbers of our EMS professionals becoming ill and quarantined.
2. The **Cardiac Arrest** procedure has been changed so that victims of cardiac arrest, who do not respond to CPR and other standard treatments according to existing treatment guidelines, will be pronounced on the scene. Due to the tremendous volume of patients in our Emergency Departments, patients who are pronounced on the scene will not be transported to an emergency department. Furthermore, CPR is a significantly high-risk procedure and would further jeopardize EMS providers. Emergency Departments are severely overcrowded and transporting patients pronounced on the scene only increases ED workload and potentially exposes ED staff and patients to COVID19.
3. In accord with the NYS Department of Health, REMAC has directed EMS crews to educate the public not to use ambulance transport to emergency departments in cases of minor illness or injury. Both the 911 System and emergency departments are overloaded with critically ill patients and patients not in need of critical care who arrive unnecessarily at an ED can risk exposure to COVID19.

We ask the public to think before they call 911 or go to an emergency room. Conserving protective equipment is not the only way to help during this crisis. Help us conserve and support our health care system and providers by staying home when possible.

- Reduced staffing
- "Due to the **tremendous volume of patients in our Emergency Departments,** patients who are pronounced on the scene will not be transported to an emergency department."
- "CPR is a significantly high-risk procedure and would further jeopardize EMS providers."
- "Both the **911 System and emergency departments are overloaded with critically ill patients and patients not in need of critical care who arrive unnecessarily at an ED can risk exposure to COVID19."**
- "We ask the public to think before they call 911 or go to an emergency room."

The hospitals were not overwhelmed. They were not overrun with patients; we know that from the data. But that order was issued. It was revoked in late April and the nursing home advisory was rescinded in May, early May. It's interesting to look at these orders around where people died.

Matilda's "Law" (illegal quarantine order)

Matilda's Law – not a law. Basically, "Hey, old people, stay home."

It was named after Cuomo's mother and issued as an act of caring, right? So it made it seem like a good thing. But telling elderly people in New York City to "stay home" is, I would say, that increases the risk of mortality right away. If you've ever been in a New York City apartment, they are not big. For most New Yorkers, their life is – and this is true in a lot of big cities – your life is outside of your apartment. You go to your deli, you go and play checkers in Central Park, you have your connections that you make. So, sitting at home, by yourself or even with others, watching the TV. This is all a recipe for disaster.

Unusual ambulance dispatch data

This is just one of the articles on that order to the EMTs:

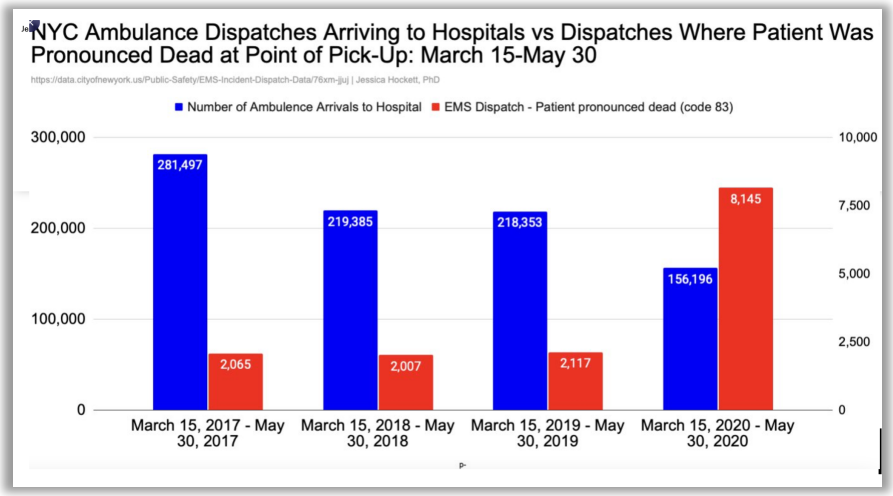

METRO

EMTs have stopped taking people in cardiac arrest to coronavirus-strained hospitals

By Susan Edelman and Jorge Fitz-Gibbon April 2, 2020 | 12:34am | Updated

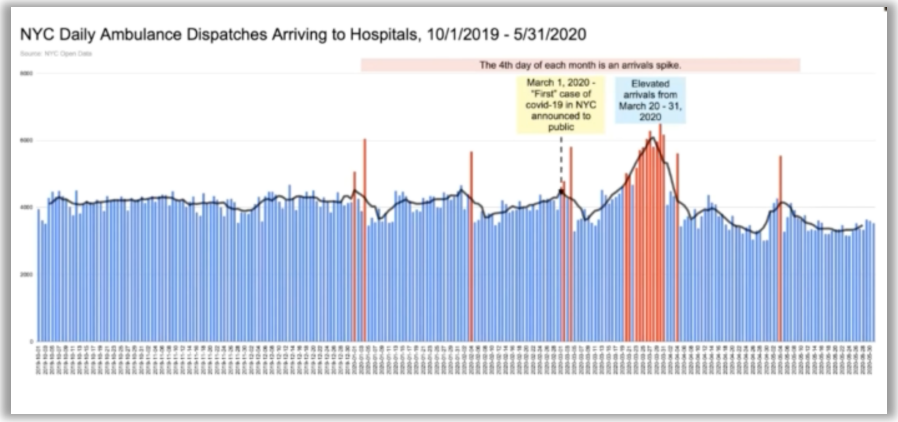
How did this play out in some of the other data? Is it corroborated, these deaths at home?

When I look at *ambulance dispatches, arriving to hospitals* in this period, we see a pretty dramatic decline. I have questions about the decline from this period in 2017 to 2018 too, but that's maybe for another time.



Look at the corresponding dramatic increase in *patient pronounced dead* at the scene. It makes sense given the deaths at home data.

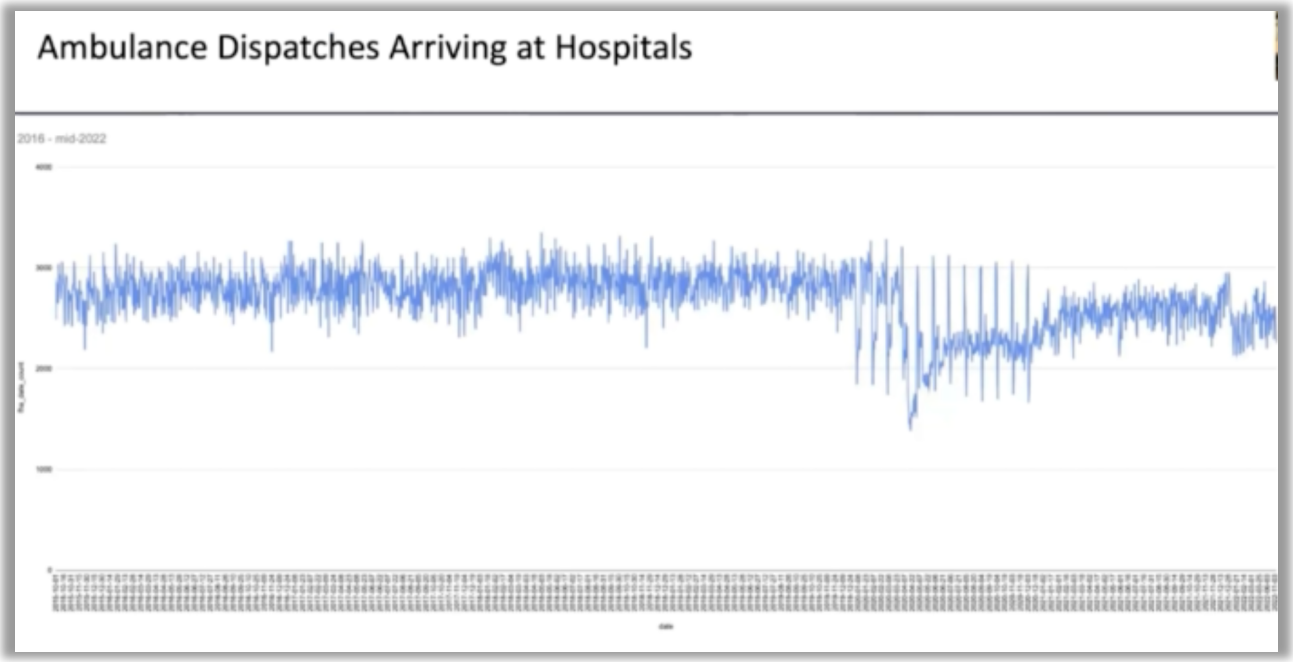
If we look a little more granular at ambulance dispatches arriving to hospital, so this is the daily view, this is one of those data points where if I were talking to somebody who could actually do something about this – like an official or Congressperson – I would express some concerns about what's going on here.



We see on the fourth each month, starting in January, we see a spike in the number of people being taken to hospitals. I find that pretty curious. Then we see a drop – we see a spike, then a drop when the first case is announced. Then we see a pretty concentrated stream of arrivals, but only for 11 days, and then a drop, and then we see the 4th. Oh look, April 4th. Oh look again, the 4th.

What do I think is going on here? Could it be that there's data backlog and then they stuck it on the 4th of every month? I guess. Could be a data fluke. But I also wonder whether this was long-term care facility residents being taken at certain times to the hospital. That would be my first – my first guess is data anomaly. My second one is there's a scheduled transport of people from particular places. I find that really curious.

If we look at a longer timeline, those spikes happen until the vaccine, basically, is rolled out. And then it normalizes again.



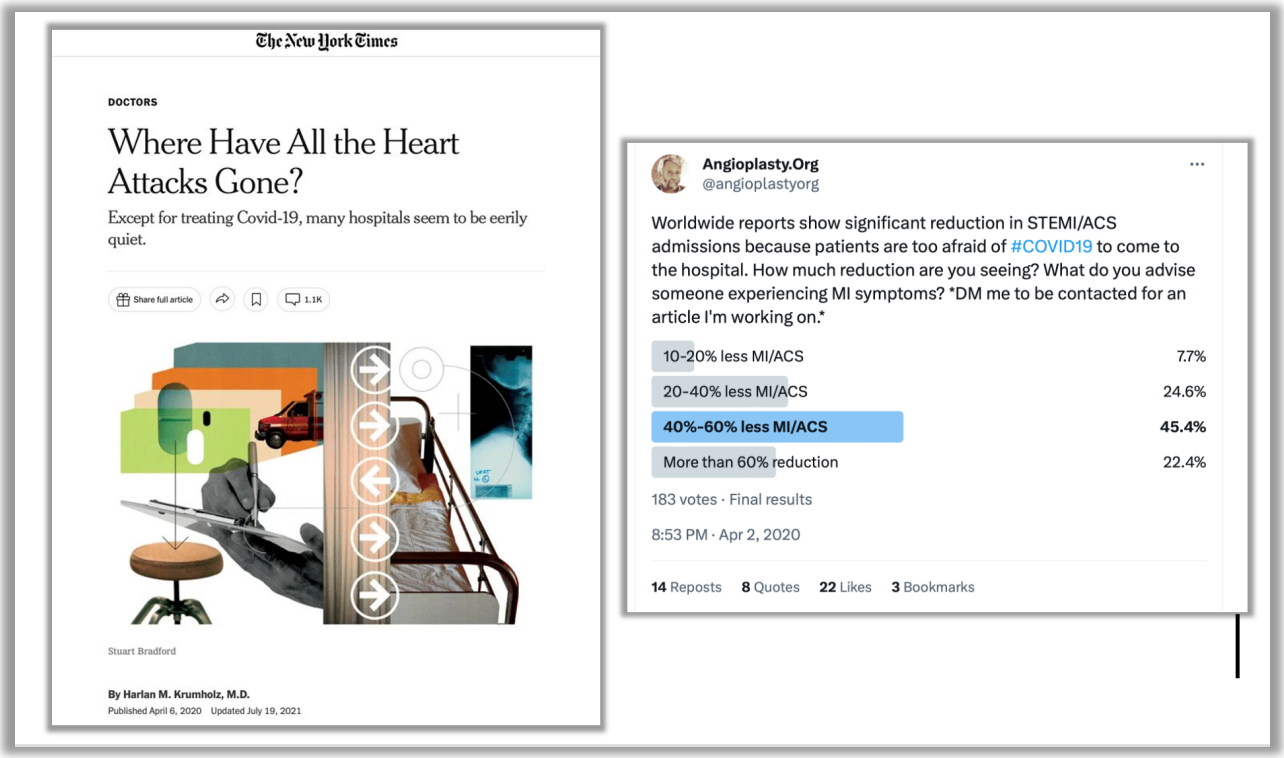
So, I would like New York City department of health and EMT to maybe answer some questions about this. I just posted this this week; I'm going to email them this week. What is going on there -- or what is *not* going on there? I find that interesting.

[JAH: An associate later exchanged emails with FDNY regarding the spikes in the data. Those anomalies were eventually "resolved" and attributed, she was told, to a software error in the way her program was reading the files. Based on the correspondence, however, there were reasons to suspect this explanation functioned

more as a dismissal than a true "diagnosis" — and that the spiky patterns reflected manipulation of the underlying data. Lacking definitive proof, we had to set the issue aside.]

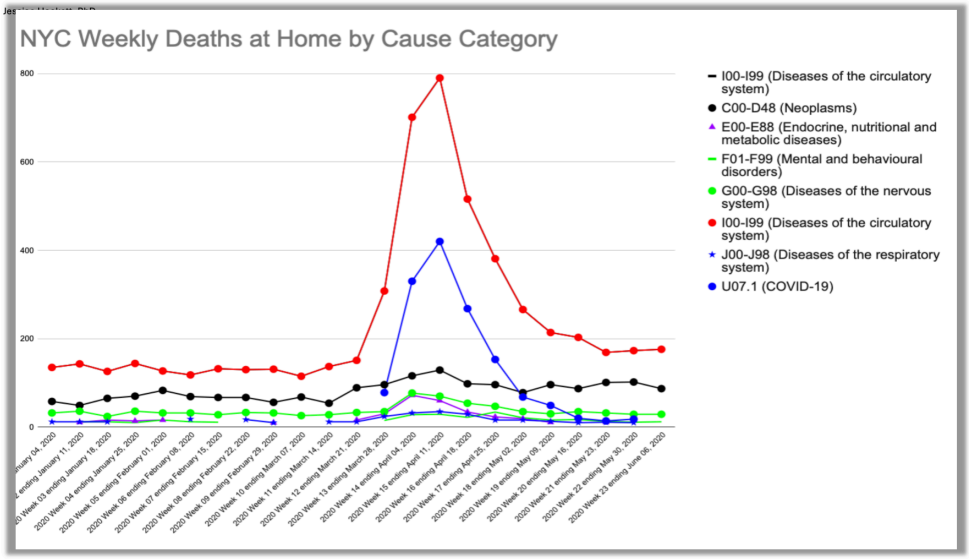
Deaths at Home

Doctors at the time *were* reporting that people were not showing up to the hospital. *Where's our heart attack patients?* People *were* afraid. I mean, just fear. People did show up at the hospital, or tend to show up at the hospital, if they had something that seemed like it could be the virus. Something respiratory. But everything else, or many other things, people were not brought. However, with the EMS order/guidance, you know, were people really afraid or were they just getting anxious? Somebody has a heart attack but then they're not saved.



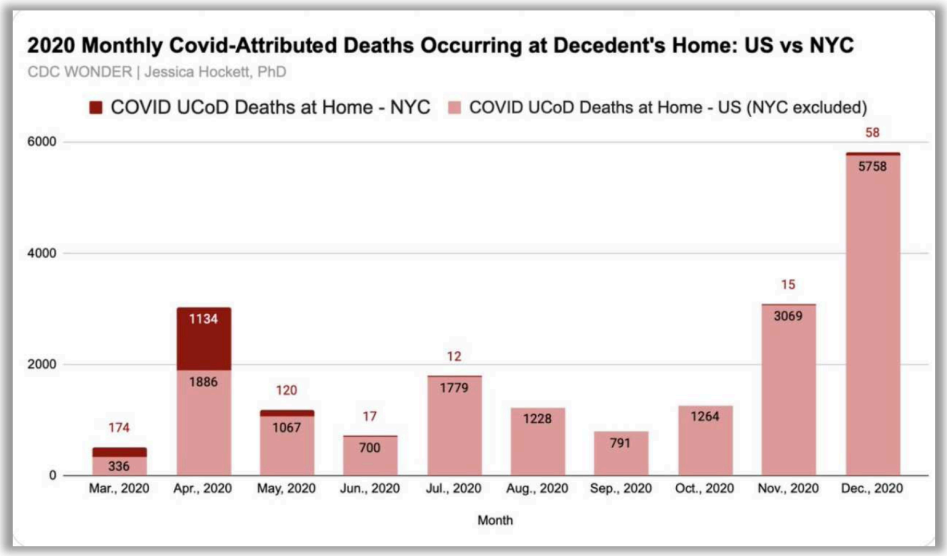
I think both were at play.

If we look at those deaths by home, they were primarily – or a good portion, I shouldn't say primarily – a huge number is heart-related. Then we have a suspiciously high number that has attributed underlying cause to COVID-19. Other respiratory, there is a little bit of an increase in other respiratory deaths at home.

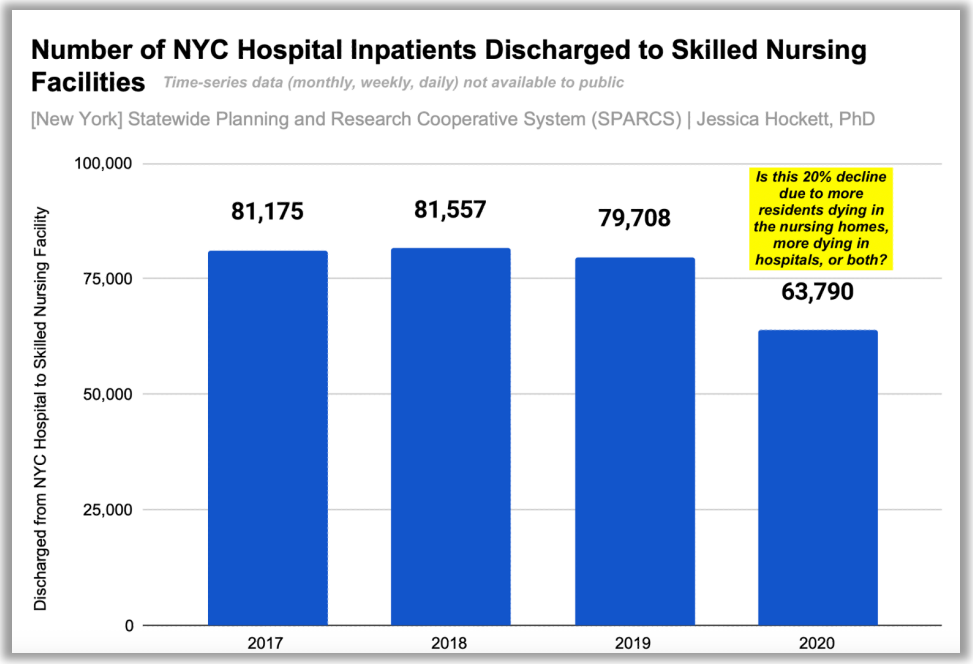


Then we see some cancer deaths at home. That could be people who were dying of cancer already and just chose to die at home or they came home from the hospital. So there's a lot of, obviously, sudden spread of cancer does not occur, but that's what the causes [at home] look like.

With those COVID deaths at home – the ones that were attributed – even though it's not an outsize portion of excess in this timeframe, it's very strange that 40% of all deaths attributed to COVID-19 that occurred in the decedent's home were in one city. I find that pretty crazy.



Going back for a second to the nursing home policy: I do not have this data by time-series. New York state says that I need to send in a research request to get it, which I might do. But there was a massive drop from hospital inpatient to skilled nursing facilities. A lot of this leads me to conclude that we had a lot of nursing home residents dying in the hospital and *that* true number is not being disclosed.



State data say at least 2,000 in the period were nursing home residents. But that's the ones that they say were COVID. We don't have an all-cause number of nursing home residents sent into hospitals who never left, but the data suggests that there were a good chunk of those people.

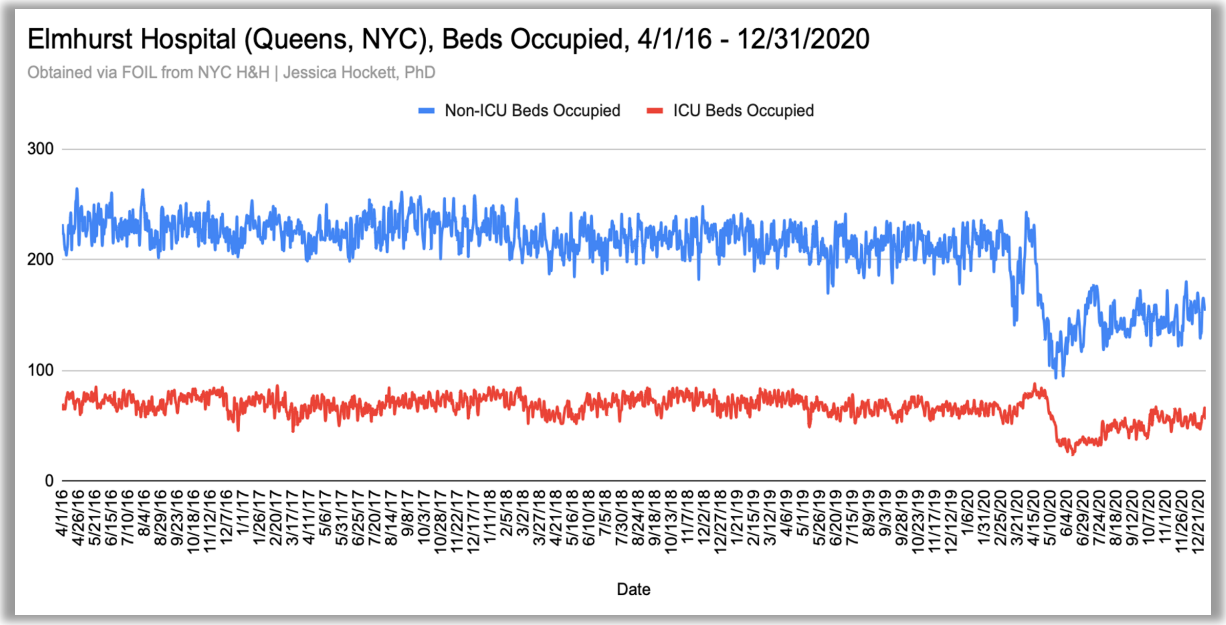
Data don't substantiate the overrun or "epicenter" hospital narratives.

The "overwhelmed hospital" narrative is a bunch of malarky, according to the data. *Overrun* I should say. Patient volumes were not high.

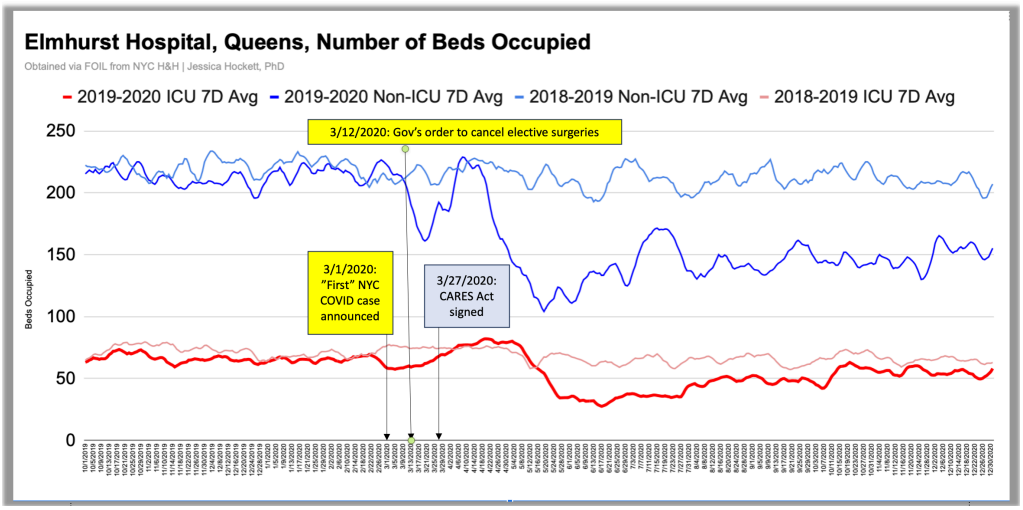
The purported epicenter, Elmhurst Center that got a lot of attention, they did not see their highest ever volumes. That didn't happen.

If we look more on the *daily* level – this is data I obtained via FOIL, it's not just "out there," although this should be out there. All of this data should be public; I shouldn't have to ask for it.

It's fascinating to look at the ICU and non-ICU beds alongside some other things that were done.



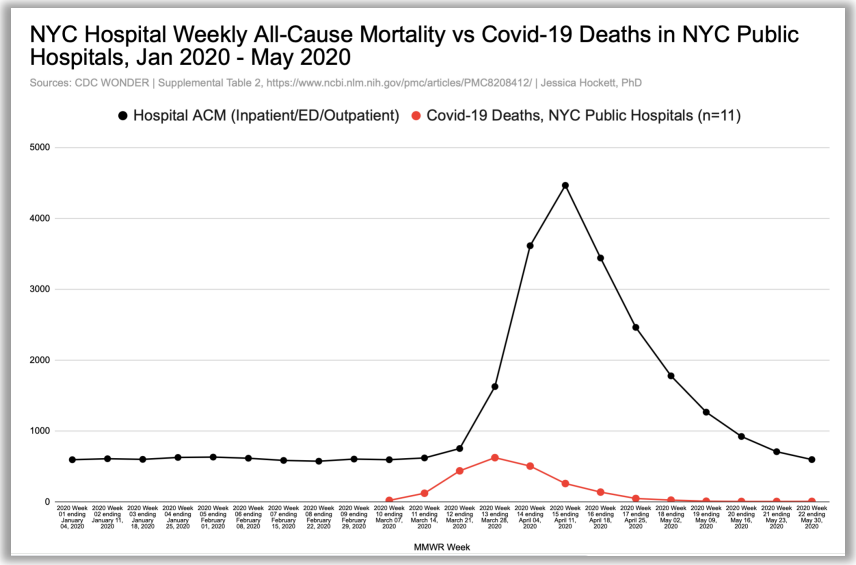
The canceling of elective surgeries, I think, has been minimized as a factor in people's death. People think, "Oh well, that's breast augmentation being canceled," and that's not the case. I just heard from a woman yesterday who said a friend who had been in a New York City hospital, was scheduled for an elective surgery – she didn't say what – and he died in the hospital two days later.



So, I really wonder about that [early March 2020] drop in the non-ICU and ICU beds. I wonder about deaths in those "pre-lockdown" days. That's pretty interesting, and this

is one of the potential fraud signals for me. I wonder if those deaths were moved forward, like they were post-dated. That would be pretty easy to do.

The other reason that I say that is because when I look at this occupancy data for Elmhurst – again, this is one hospital, a public hospital, and then I look at this other graph, that's data from CDC WONDER: All cause hospital inpatient deaths [weekly].



The red line is from the supplemental data in a study that was published in 2021 on ventilator use in the public hospitals. The COVID deaths reported in that study for those 11 hospitals, that curve pre-dates (comes before) the all-cause inpatient mortality curve. I don't understand that. It's almost like they're saying, or they're alleging, that some kind of event occurred in early March. So, I want to look more into that. That's something I just discovered recently, and I have a lot of questions about it. **[JAH: My subsequent attempts to resolve this discrepancy are described in "Still Attempting to Resolve NYC Hospital Data Discrepancy - Email to Austin Parish & John Ioannidis"]**

The U.S.'s "pinpoint pandemic"

Justin Hart, who some of you might know – [he] heads up Rational Ground – but early on in May 2020, he made a really, really good observation.

I tweeted about this this week. Martin Neil looked at this and called it a 'pinpoint pandemic'. I think that's a really, really good way of putting it.

We see, basically, a really high number reported COVID deaths being recorded as COVID at the time, which would've been mostly in hospitals. But we see them very concentrated in just a few areas: Detroit, Chicago, downstate Illinois – that's where East St Louis is. And then we have the tri-state area, we have Pittsburgh, and we have upstate New York.

So, I think that's pretty fascinating. Is this what we would expect from spread – a spreading virus?

I would *not*.

But what do some of these areas on here – and actually I'm surprised he doesn't have New Orleans. New Orleans had its rise and peak early. They peaked and fell earlier than New York, which is interesting.[5]

What do some of these areas have in common? I've put it this way on Twitter:

[5] Hockett, J. (2025, February 14). "New Orleans vs New York." *Wood House 76*

Lots of public housing. We've got a lot of residents who receive or rely on government aid. A lot of elderly living alone in smaller spaces. Lots of nursing homes. Some population groups with health issues, and I say that not because "more vulnerable to COVID" but just more vulnerable to disruption, especially in an urban area.

And with the exception of New Orleans, those other areas have colder climate in late winter. I think that's quote "ideal" in this situation, because those people are more likely to not go out [and to] stay home.

If you live in Hawaii, a shutdown order or a lockdown order is very different. It has a very different impact on your lifestyle than it does in a New York. And I think that's something people don't really think about or consider.

END EDITED RECORDING FOR SESSION 2. SESSION CONTINUED AND INCLUDED Q&A.

In my slide deck, I also had the following summary. I don't recall if I shared it during Q&A. I posted a version in tweets on X.

NYC "COVID" Disruptions by Place of Death (July 2023 draft, J. Hockett)

Place of Death	Examples of Sudden Disruption/Changes	Potential Roles in Increasing or Decreasing Mortality (Effects)
Healthcare (Hospital Inpatient, ED, Outpatient)	• Urging people to "protect the hospitals" by staying away • Disaster-medicine protocols (e.g., NYS ventilator guidance) • Compassionate use of Remdesivir • Banning visitors and advocates • Focused testing for SARS-CoV-2; reduced testing for others • Canceling elective procedures • Unilateral DNRs, avoiding CPR, withholding care • Messaging emphasizing HCW risk • Testing in public housing/NHs • Encouraging NH transfers to hospitals	• Dehumanized, stressful environment • No outside witnesses to decisions • Fear-based decision-making • Misdiagnosis • Non-treatment / mistreatment • Delayed care
Decedent's Home / Dead on Arrival	• Stay-home orders (incl. Matilda's Law) • Changes to 911 protocols • Cancellation of communal activities • COVID testing in public housing • Separation from non-household interactions	
Nursing Homes / LTC Facilities	• Transferring COVID+ residents into hospitals • Moving residents between facilities • Isolating residents • Canceling community activities • Messaging emphasizing HCW self-protection • Reduced staff contact • Dedicated COVID wards • Masking staff and residents • Banning visitors and advocates	
Other Places	• Restrictions on homeless populations/shelters • Use of hotels	
Hospice Facilities	• Reallocating hospice beds to inpatient beds • Patients dying in hospitals or at home instead of hospice	