Testimony of Jack Windsor
Support of House Bill 624
State and Local Government
June 2, 2020

Chairman Wiggam, Vice-chair Stephens, Ranking Member Kelly and Honorable Members of the Ohio House State and Local Government Committee thank you for allowing me to speak today about why I support House Bill 624.

My name is Jack Windsor I am an independent investigative reporter working with WMFD-TV in Mansfield, Ohio.

On May 28, 2020, Representative Grendell stated in her sponsor testimony:

> *"The major problems with the reporting of data concerning COVID-19 by the Ohio Department of Health are that the reporting has been one-sided and woefully incomplete. Only the data that promotes fear and despair – confirmed cases, hospitalizations, deaths – has been reported by the Ohio Department of Health. What has not been publicly reported is the other half of the story:*
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> - *The number of confirmed cases that did not require any medical care;*
> - *The number of patients who were treated and released from the hospital;*
> - *The number of individuals who tested negative;*
> - *The number of deaths that did not involve nursing home residents or prison inmates.*
> - *Number of individuals with contributing factors such as:*
>   - *Diabetes*
>   - *Heart Disease*
>   - *High Blood Pressure*
>   - *Pulmonary Issues"*

Why is this important? Data matters.

When stay-at-home orders were issued on March 23, Ohioans were charged with flattening the curve and buying time for hospitals to ramp capacity.

As we enter our 11th week since the statewide lockout started, many Ohioans still ask: are the hospitals in danger of being overrun? Are we going to see a spike in the curve? And there is a spike, how bad will it be?

Information shared daily by the Governor's staff on social media reports the cumulative number of the following: positive cases, hospitalizations, ICU visits and deaths. Unless mention is made during the Governor's press conference, important information such as whether our hospitals are in danger and if the virus outbreak is spiking, is not clearly reported and not easily understood.

I praise the Ohio Department of Health and Governor DeWine and his staff for their devotion to collecting significant amounts of data. Compared to other states around the country, Ohio has been one of the best at collecting information. Collection and use are different.

The true value of accurate and timely data is derived when that data are applied to accurate and timely decisions.

Information out of Italy[1] revealed the following critical factors DeWine and Acton could have used to laser-focus their response to Coronavirus:
1) People aged 79 and older with other diseases are most at risk for serious health outcomes, especially death;
2) More than 75% had high blood pressure;
3) About 35% had diabetes and;
4) A third suffered from heart disease.

Information out of Italy and China was available before Ohio Department of Health (ODH) Director Amy Acton signed the first stay-at-home order. The perils of economic fallout and sheltering-in-place were also documented for consideration as the administration formed policies. After the first SARS outbreak, Studies on the secondary impact to mental health[2] showed serious distress among those quarantined, causing PTSD and depression when the sick were quarantined for just two weeks or less. The 2008 financial crisis spiked suicides due to unemployment[3]: rates were four-times higher; a 1% increase in unemployment resulted in a 1% increase in suicides among males. Instead of using a scalpel to carve-out policies to target the most vulnerable, alleviate economic impact and spare the uninfected from sheltering, DeWine, Acton and Husted did the opposite—they swung a wrecking ball.

What we know today about COVID-19, we knew in March. Regardless, measures were implemented and then defended by pointing to data and case studies from the Spanish Flu pandemic, which happened over 100 years earlier.

Hospital capacity, ICU capacity and positive cases never came close to inaccurate projections. The health system we set out to save by flattening the curve has actually been negatively impacted—the broad cancellation of all elective procedures (including things like cancer screenings) has led to furloughs, layoffs and loss of healthcare capacity due to the economic consequence of not having enough patients—COVID or otherwise. Plus, there is a broader

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[1] Ebhardt, T., Remondini, C., & Marco, M. (2020, March 18). 99% of Those Who Died From Virus Had Other Illness, Italy Says. Retrieved May 31, 2020, from https://www.msn.com/en-us/news/world/99-25-of-those-who-died-from-virus-had-other-illness-italy-says/ar-BB11mr4X

[2] Hawryluck, L., Gold, W. L., Robinson, S., Pogorski, S., Galea, S., & Styra, R. (2004). SARS Control and Psychological Effects of Quarantine, Toronto, Canada. *Emerging Infectious Diseases, 10*(7), 1206-1212. doi:10.3201/eid1007.030703

[3] Carey, B. (2012, November 05). Increase Seen in U.S. Suicide Rate Since Recession. Retrieved May 31, 2020, from https://www.nytimes.com/2012/11/05/health/us-suicide-rate-rose-during-recession-study-finds.html

health consequence to the mental, emotional and physical outcomes of Ohioans that we are just now beginning to understand.

During each press conference, Amy Acton will review the Ohio COVID-19 dashboard. You may note that Acton reports deaths as "deaths reported in the last 24 hours." Deaths reported in the last 24 hours are different than the actual number of deaths in the last 24 hours. The number reported includes deaths over several days, perhaps as far back as January. The practice of using "reported" data causes the public to perceive more cases and more deaths than are occurring in the present. The practice is confusing the press, the public and at times even the Governor and Dr. Acton seem confused.

For example, On May 23, the Ohio Department of Health indicated there were 84 reported deaths over the past 24 hours. However, the real number of deaths as originally displayed on the CSV file available on the coronavirus.ohio.gov site was seven (7), that number later went up to 9. As of June 1, that number is 27. The day the number was first reported, the difference between the number of deaths reported and the date of the incidence of death was 77. This information is found by doing some digging manipulating the spreadsheet file.

Inflated and inaccurate data gets picked up and reported by unsuspecting news outlets. That, in fact, happened on May 23 when an Ohio media outlet reported the 84 deaths under the headline: "*Deaths more than double the previous 24-hour period*"[4]. During a press conference on April 14 Governor DeWine repeatedly claimed 50[5] people died over the previous 24 hours. The actual number of reported deaths was five (5). When confronted with the disparity, DeWine deferred to Amy Acton who said, "I think it might be a reporting lag."

Total deaths includes confirmed deaths (a test confirmed the presence of COVID-19) and suspected cases (not confirmed by a positive test). Daily, the number prominently displayed and most discussed is total deaths. On June 1, Ohio reported 2,206 deaths; 1,193 of those deaths were confirmed. The difference between total deaths and confirmed deaths is 213 deaths, a difference of over 10%.
In March, the original testing methodology was more strict than at present. Early on, a patient had to be sick enough to appeal to the judgment of someone in the health system who judged whether the person was symptomatic enough to get a test because tests were rationed, then a test was administered and the result rendered.

Presently, a positive test and onset date includes a mix of scenarios and data sets: lab confirmed tests, probable cases and antibody tests. Determining the actual number of newly,

[4] Zachariah, H. (2020, May 23). Coronavirus in Ohio: Deaths more than double the previous 24-hour period. Retrieved May 31, 2020, from https://www.cincinnati.com/story/news/2020/05/23/coronavirus-cincinnati-columbus-cleveland-ohio-deaths-more-than-double-previous-24-hour-period/5250810002/
[5] Staff, N. (2020, April 14). Did 50 people die of coronavirus in Ohio in the last 24 hours? Here's what today's data says. Retrieved May 31, 2020, from https://www.wkbn.com/news/coronavirus/did-50-people-die-of-coronavirus-in-ohio-in-the-last-24-hours-heres-what-todays-data-says/

test confirmed positive cases is difficult. The methodology changed and that change has not been clearly explained and the data trendlines include these data points.

The r-naught factor is a number indicating viral infectiousness. The r-naught (often expressed as R0) tells you how many people will, on average, be infected by one infected person. For example: if COVID-19 had an R0 of four, one infected person would, on average, infect four other people.

One solid first step to making the r-naught more meaningful requires carving-out congregate living data sets. Congregate living includes facilities such as nursing homes and prisons. Extracting, measuring and independently dealing with people who live in these close quarters will produce not only an r-naught that more accurately represents community spread, it will also produce policies that save lives inside prisons, nursing homes and long term care facilities.

Mixing congregate living with statistics from the general population skews how infectious the virus may be to the general population. A spike in congregate living settings could equal a clampdown on the general population—it would be like punishing the entire class if one child is acting out. Continuing to report and create policy with mixed data sets breeds misinformation and, frankly, panics people.

Common sense can derive that if the current r-naught is 1:1 with mixed data sets, the general population is experiencing a contagiousness that is a fraction of the r-naught in congregate settings. What may be discovered once the congregate living numbers are backed out is that the r-naught is likely significantly lower in our communities than the current 1:1 .Understanding the difference between the r-naught in congregate settings versus the r-naught in the general population should drive more on-target mitigation and policy decisions.

A few weeks ago Amy Acton estimated death rates in nursing homes comprised just over 20% of the Ohio death toll. As reporters and citizen journalists investigated that claim, it was discovered that confirmed deaths were double Acton's estimate. That number was based only on numbers reported since April 15. Further investigation found the percentage to be even higher. Continued digging reveals that, as of May 21, confirmed deaths in nursing homes[6] total 79% of the state total.

The errors in reporting and the disproportionate deaths in long term care facilities seems to stem from mixing data sets, slow responses and an overall lack of focus on critical information. Mixing data sets from congregate settings for reporting and consideration may have been a fatal error. The state has reported data broken-out by senior congregate living and prisons, but did decision makers dig into the data well enough, particularly pertaining to nursing homes, to see the magnitude of the problem?

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[6] Kasler, K. (2020, May 21). Huge Percentage Of Ohio COVID-19 Deaths Come From Nursing Homes. Retrieved May 31, 2020, from https://www.statenews.org/post/huge-percentage-ohio-covid-19-deaths-come-nursing-homes

The administration was void of understanding on the total number of deaths from nursing homes. This seems to signal a lack of tight focus on our senior living facilities. Consequently, was it this lack of focus that drove the less aggressive, non-compulsory tactics that could have been deployed? What if the state had not only segregated the data sets, but taken strong, aggressive and compulsory action? In the elderly population, the time from COVID-19 onset to death is an estimated 14 days. The nursing home crisis is condensed to less than one percent of our population. Residents in nursing homes are the most immobile in our communities, they are easily identified and reached.

The slow response to directives can best be seen in the delay in DeWine's response to a directive from Vice President Mike Pence that called on all governors to perform testing in all their long term care facilities—all nursing home staff and patients. Pence announced the directive on May 12. On May 19, a week later, Governor DeWine took steps to ramp testing in nursing homes—saying that he would be deploying the national guard to aid in testing[7]. However, during his press conference on May 28 Governor DeWine said the be dispatched to nursing homes the week of June 1st.

During press conferences from March through May, Acton has stated the average age of cases. That number was around 50—most recently dipping to 46. Has she stated publicly that the median age of death is 81? And if not, why? The fact is, after approximately five months of the Coronavirus circulating in the population, approximately 327 Ohioans have died outside of prisons and nursing homes, as of May 31, 78% of those deaths occurred in people aged 70 and older, and 92% of deaths occurring in people 60 years of age and older--according to the coronavirus.ohio.gov.

Nearly a week before the stay-at-home order was issued, Imperial College epidemiologist Neil Ferguson modeled[8] the COVID-19 outbreak. Ferguson's model became the point of reference for leaders across the globe, influencing lockouts and sheltering policies. Ferguson himself backtracked on his model's accuracy just weeks later after the projections tanked. The swing and miss on COVID-19 is not Ferguson's first projection whiff. Ferguson predicted 200 million would die from the bird flu in 2005--deaths totaled 455. In 2009 Ferguson predicted 65,000 people would die in the U.K. from swine flu—the death toll was 392.

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[7] Seewer, J., Welsh-Huggins, A., & Associated Press. (2020, May 20). Ohio governor calls on National Guard to help nursing homes. Retrieved May 31, 2020, from https://www.militarytimes.com/news/coronavirus/2020/05/20/ohio-governor-calls-on-national-guard-to-help-nursing-homes/

[8] Ferguson, N. M. et al.; (2020, March 16). Report 9: Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand. Retrieved May 31, 2020, from https://www.msn.com/en-us/news/world/99-25-of-those-who-died-from-virus-had-other-illness-italy-says/ar-BB11mr4X

Ohio Department of Health (ODH) Director Amy Acton delivered early projections and modeling based on Ferguson's wildly inaccurate Imperial College model. Acton guessed 100,000 Ohioans were already infected when she introduced her modeling. She also projected the COVID outbreak would: peak in April, overwhelm hospitals, unmitigated would produce 62,000 new cases a day and infect 40% to 70% of Ohioans. Like Ferguson's model, Acton's projections were exponentially inaccurate.

The ODH model was revised twice, alongside researchers at The Ohio State University. According to the Affidavit from Michael S. Wilson presented in the Rock House Fitness Inc et.al. v. Amy Acton et.al.[9]:

"The Ohio State model projections dated 3/28/2020 cited a peak of about 10,000 new cases/day on April 25th with strict social distancing mitigation measures in place. These projections were revised on 4/5/2020 to project a peak of about 1,600 new cases/day on 4/19/2020 with the same mitigation measures in place. Both revisions presented a projection for an unmitigated peak of 62,000 cases per day on 3/22/2020.

Actual new cases/day as reported by the Ohio Department of Health were below the mitigated projections of the OSU model dated 4/5/2020 for each day between 4/5/2020 and 4/15/2020. The model projected a total of 803 new cases on 4/5/2020, yet the actual new cases on that day were 250.

Even using the data set available on 4/5/2020 that matches the release of the revised Ohio State model, it should have been obvious that the projected model peak would not occur. My analysis of the new cases/day utilized a least squares linear regression over the previous two-week period to determine the growth rate in new cases/day for any given day in the data set. I then calculated a seven-day moving average to determine if the growth rate was increasing or decreasing on a given day. Using the data set available on 4/5/2020, the two-week growth rate was barely positive with a negative trend in the growth rate showing that the growth rate was likely to decrease in the future.

This analysis proved accurate as revised current data shows that the two-week growth rate reached a minimum on 4/5/2020 before increased availability of testing and targeted testing of hot spots caused a secular increase in detected cases that were asymptomatic or less sick than previously detected cases.

During a conference call to provide an update on modeling projections that I participated in on 4/17/2020, Drs. Elisabeth Root and Michael Oglesbee of Ohio State admitted that they were not able to exactly quantify the impact of the state enacted mitigation measures and that they had underestimated the impact of social distancing measures taken independently by private individuals.

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[9] Wilson Aff. ¶ 11, May 17, 2020.

Using similar mathematical methods as described above, the growth rate of new cases/day in Ohio began to decelerate on 3/15/2020 and begin to decline on 3/19/2020.

Because the deceleration in the growth rate began on 3/15 before the enactment of most state-enacted mitigation measures, including closure of gyms, I conclude that it is not possible to attribute the reduction in new cases/day to these measures.

Additionally, the model projections of Ohio State dated 3/28/2020 and 4/5/2020 are unreliable for determining the impact of mitigation measures through their predictive failures and through the obvious inaccuracy easily determined by an independent data analyst using data available on the day of the 4/5 model release and as admitted by their own authors.

Therefore, I conclude Director Acton relied upon obviously inaccurate data in creating her mitigation orders while neglecting the impact of private measures to slow the spread of COVID-19."

The affidavit indicates that the Ohio State modelers cannot quantify the impact of the state's mitigation efforts. My conversation with Michael Wilson on Sunday, May 31 uncovered that his modeling not only shows a deceleration beginning in March, it also indicates a maximum peak in cases of 400 a day. These important findings, which may instill hope, have not been shared by the administration with Ohioans. The state coronavirus website still shows an unmitigated curve peak of 62,000 cases a day and a mitigated peak of nearly 2,000 new cases a day. The information presented to the public, again, seems to be disconnected with realt-time data.

Another important piece of information that has been partially presented is the preliminary injunction issued by Eugene Lucci out of Lake County Ohio. This injunction came through, again, the Rock House Fitness Inc et.al. v. Amy Acton, et.al. case. In issuing the injunction, Judge Eugene Lucci. Lucci said:

> *"The director [Acton] has no statutory authority to close all businesses, including the plaintiffs' gyms...she has acted in an impermissibly arbitrary, unreasonable, and oppressive manner without any procedural safeguards."*

Governor DeWine, when questioned about the ruling at a press conference on May 21 said, essentially, all the case did was shorten the existing orders by six days.

Where Acton erred on projections, Ohioans extended grace because COVID-19 was pitched as a novel virus without clear data on contagiousness, how it spreads, who is at risk and how many people would need hospital and intensive care. Up-front information did exist—information directly related to COVID-19, and studies related to the secondary impact of shut-it-all-down policies.

The administration has engaged in the practice of intentional selection of data to present to Ohioans. Citizens were promised data transparency and policies based on the best science. The results: nearly 1 million unemployed, more than 1,589 nursing home deaths, a startling

number of businesses that will never re-open, and—if history repeats—a 16%-and-counting increase in suicide.

Again, as we enter our 11th week since the statewide lockout started, many Ohioans still ask: are the hospitals in danger of being overrun? Are we going to see a spike in the curve? And there is a spike, how bad will it be?

We have the answers to these questions. Please support HB624 so Ohioans can finally get the answers to their pressing questions and the promised data transparency they deserve. Thank you for your time and I will be happy to answer any questions.