



O'Malley Clan Association Monthly Newsletter

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Listen to the Authorities and We'll get through this!

Greetings to all you out there from Chieftain Tom O'Malley, and all of us in The O'Malley Clan Association! Depending on where you are around the world the restrictions on travel etc are slowly lifting to various degrees. Remember to heed the advice of the authorities and lets do whatever is necessary to make Covid 19 a thing of the past!

Say a prayer for all those Doctors, Nurses, and everyone else involved in the battle against the virus and We'll get through this in the end!



Get in touch and share your O'Malley Heritage!

Have you got an article or old photographs that you'd like to submit for future editions of "Ó Máille" The O'Malley Clan Association Newsletter.

We'd love to hear from you wherever you're based around the world. Old photographs and stories to go with them, old letters, family trees or just an article

that you'd like to share with the rest of the clan. Drop us a line and We'll get right to it!



A letter to Grandad

Letter to grandad who died from Covid-19: 'I'm proud of my future because I can be like you'



Christy O'Malley (83) died from coronavirus on March 30th

Christy O'Malley (83) was a family man. He visited each of his children and grandchildren at least once a week, was fond of a family sing-song and organised word games to entertain the adults and children at gatherings.

But when he died from coronavirus on March 30th in Connolly Hospital, Blanchardstown, Dublin, his family couldn't be with him, they couldn't attend his funeral ceremony a day later, and instead had to view it through a livestream.

Devastated that she was unable to say goodbye in person, his eldest grandchild Rachel (17) wrote a letter, which was read out during the ceremony.

"I am almost glad the last time I saw you I didn't know what was going to happen because I did not yet know the pain of your absence, only the joy of your presence. I remember the last time I was in your house you showed me how to use the tools for the garden and an alarm you had built for your shed," the letter said.

'Utter admiration'

"I remember standing there in utter admiration of someone who was so smart – but would never brag about it, someone who could have been in pain but would never have moaned and someone who put other people's feelings above his own."

She added: "You make me proud of my past because you are what I came from and proud of my future because I can be like you."

A letter to Grandad

Mr O'Malley didn't have the typical coronavirus symptoms. He lost his sense of taste and was more tired than usual, his family said.

Having had cancer in the past, his daughter Patricia brought him to the hospital to undergo various tests. While there, he developed a temperature and tested positive for the virus, before suddenly deteriorating.

Dara Keogh, his son-in-law, said while there is awareness the virus causes death, its impact on grief is often overlooked.

"You're attending a virtual funeral, it's not the same. The grieving process hasn't started yet. It's not the way we do funerals or do grief at all. It's like it's happened but it hasn't happened, and so it's very difficult to process and move forward," Mr Keogh said.

"You can't come together, you're forced apart and rightly so. Having seen the outcome, the worst-case outcome, you wouldn't want anybody else to go through it."

His wife Patricia has had to isolate for 14 days because she brought her father to the hospital.

"She is now in a bedroom, and she can't go out, and we can't go in, and she had to take the news on her own and could only speak through a doorway. She hasn't seen her brother or sister or any other member of the family since he died."

He said that despite the difficulties this brings, there is a sense of solidarity within the community, as people try to help one another through the loss and devastation.

'A thorough gentleman'

"One lovely thing our neighbours did was on Monday night, they all gathered outside the house, with social distancing in mind. They gathered for a minute's silence, all holding candles," Mr Keogh added.

"They put a little arrangement of flowers together and then each of them put their candle down by the flowers in a little jar. Then they all stood back and they sang The Rose, and wished us well."

Mr O'Malley, who was born and raised in Crumlin, Co Dublin, before moving to Palmerstown in 1962, was an avid reader and was an active member of Our Lady's Choral Society until 2015.

"He had books that he would read upstairs and books that he would read downstairs. He could have six or seven books on the go at once," Mr Keogh said.

"He was just a thorough gentleman. He was a man who engaged with people in a very loving way. Behind the [fatality] figures are real people. There's a human consequence to this."

Robert E O'Malley Medal Of Honour Winner leads the tributes

VIETNAM VETERANS HONORED AT MEMORIAL DAY SERVICE



Brownwood News – The Central Texas Veterans Memorial organization observed Memorial Day by honoring Vietnam War veterans from Central Texas. A stone monument was recently placed in the Central Texas Veterans Memorial Park, inscribed with the names of eleven Central Texas men who made the ultimate sacrifice, giving up their lives, in service to their country while serving in Vietnam. The eleven men are:

Raymond Rodriguez Delgado, Eddie Lee Ephraim, James T. Griffin, Jr., J.D. Harrell, Phillip Hease Holmes, Arthur Earl Keesee, Brit P. Lemmons, Willard Alton Perry, Jr., Michael Autrey Teague, Nelson Payne Tuttle, Kenneth Wayne Wheeler.

Guest of Honor was Sgt. Robert E. O'Malley USMC, of Goldthwaite, who served in Vietnam in 1965, and received the Congressional Medal of Honor for bravery and valor.

Robert E O'Malley Medal Of Honour Winner leads the tributes

According to the Congressional Medal of Honor Society, the CMOH is “the highest award for valor in action against an enemy force which can be bestowed upon an individual serving in the Armed Forces of the United States.” O'Malley is one of only 71 living recipients of the award.

A plaque was recently placed in the Veterans Memorial Park in honor of O'Malley. It tells the story of O'Malley's actions which earned him the Medal of Honor:

“For conspicuous gallantry and intrepidity in action against the Communist (Viet Cong) forces at the risk of his life above and beyond the call of duty while serving as a squad leader in Company “I”, Third Battalion, Third Marines, Third Marine Division (Reinforced) near An Cu'ong 2, South Vietnam, on 18 August 1965. While leading his squad in the assault against a strongly entrenched enemy force, his unit came under intense small arms fire. With complete disregard for his personal safety, Corporal O'Malley raced across an open rice paddy to a trench line where the enemy forces were located. Jumping into the trench, he attacked the Viet Cong with his rifle and grenades, and singly killed eight of the enemy. He then led his squad to the assistance of an adjacent Marine unit which was suffering heavy casualties. Continuing to press forward, he reloaded his weapon and fired with telling effect into the enemy emplacement. He personally assisted in the evacuation of several wounded Marines, and again regrouping the remnants of his squad, he returned to the point of the heaviest fighting. Ordered to an evacuation point by an officer, Corporal O'Malley gathered his besieged and badly wounded squad, and boldly led them under fire to a helicopter for withdrawal. Although three times wounded in this encounter, and facing imminent death from a fanatic and determined enemy, he steadfastly refused evacuation and continued to cover his squad's boarding of heli



Robert E O'Malley Medal Of Honour Winner leads the tributes

copters while, from an exposed position, he delivered fire against the enemy until his wounded men were evacuated. Only then, with his last mission accomplished, did he permit himself to be removed from the battlefield. By his valor, leadership, and courageous efforts in behalf of his comrades, he served as an inspiration to all who observed him, and reflected the highest credit upon the Marine Corps and the United States Naval Service.”



O'Malley was presented the Congressional Medal of Honor by President Lyndon B. Johnson on December 6, 1966, in Austin Texas.

The Central Texas Veterans Memorial Park is located in the Camp Bowie area, across the street from Brownwood Regional Medical Center. It features monuments and plaques in honor of all men and women from Central Texas who served the United States in military service. Also on display are a restored Willys Jeep from World War II, and a restored Huey helicopter from the Vietnam War.

Robert E O'Malley Medal Of Honour Winner leads the tributes



This Vietnam era Huey helicopter is on display at the Central Texas Veterans Memorial Park



Robert E O'Malley's Medal of Honour

The Emperor has no clothes



Eri Mountbatten-O'Malley (FHEA)

The Government has been criticised for doing 'too little, too late'. Proposals to suspend duties in the Care Act, 2014, have led Disability Rights to complain that there is 'a real and present danger to the lives of Disabled people... effectively rolling back 30 years of progress for Disabled people'. Other regressive actions are taking place with citizens being tracked through their phones, fined for shopping for 'inessential items', and being watched by drones with even further restrictions promised if the public fail to adhere to Government stipulations. There is also an increasing concern about the rise of Police power with #PoliceState trending last week alongside #COVID1984. In some parts of the world citizens are being beaten with rods and in the Philippines there is live footage of President Rodrigo Duterte threatening citizens that he will order police to 'shoot them dead' if they fail to adhere to Government quarantine policy. Curfew is being enforced with tear gas in Kenya to disperse the crowds. The pattern is similar across the world.

The widespread perception of risk to life is of course driving public fears which has led to some of 'the most momentous peace time restrictions on the liberty in peacetime, the Coronavirus Act 2020.

Yet there appears to be widespread support for the quarantine measures. There is evidence in increases in social shaming as well and for example on twitter #COVIDIOTS is regularly trending. Some police forces are inundated with calls from diligent neighbourhood informants reminiscent of the breakdown of social fabric during long gone periods of autocratic European political history. The expansion of police and administrative powers is simply unprecedented and the social and economic fallout and ensuing human cost is unfathomable.

Although the Government must rightly do everything it can to protect the public, it must do so in ways that are proportionate to the risk. It must strike the right balance between respect for civil liberties and the legitimate aims for the protection of public health. Government justifications for the introduction of a wave of emergency powers however seems to have been predicated on misleading mortality statistics and poor methodological practices, contributing to what I term as a perfect sensationalist storm of error. This cannot be the basis for Government policy if we are to safeguard a healthy democracy.

The Emperor has no clothes

A death, is a death, is a death... right?

The crude mortality rate in the UK (CMR) is the broadest measure of the total number of deaths from all causes in a given population, over a specific time period and is defined as total deaths per 1,000 population. Alternatively, the case fatality rate (CFR) is most often cited. Various subsets can be made using either age, gender or causal variables. In the context of an epidemic, the 'case fatality rate' (CFR) measures death rates in a population among *diagnosed* cases. This is important because CFR offers a picture of useful data for preparation of *responsive* services such as acute emergency care services. Importantly however, the infection fatality rate (IFR, also known as 'true case fatality rate', *tCFR*) is much more useful. This is because it helps to account for *all* cases of infection, including asymptomatic infections, in the wider population. The World Health Organisation (WHO) tends to publish its fatality estimates using CFR; however, as shown, this is method of measurement that targets those who seek emergency assistance and have been tested as a result of seeking emergency care. Thus, in countries where widespread testing is *not* instituted, such as the UK, CFR is misleading. This clearly amounts to a form of 'selection bias'.

Unaccountable coding & risk projections

The two most influential studies in the UK to date, certainly in terms of Government policy, appear to be Verity et al (2020), for China, and Ferguson et al (2020) from Imperial College. Verity et al use the broader CFR measure whereas Ferguson et al at Imperial College use IFR. However, Imperial use their own mathematical coding and modelling for estimating IFR. The trouble is that the 'shocking' Imperial College study released on 16th suggested that fatalities could be in the region of 500,000, in the UK and over 2,000,000 in the US. This study has almost single-handedly been responsible for the UK Government U-turn and a misleading characterisation of risk to public health. These figures have recently been revised down to around 20,000 of mitigated deaths. Understandably, experts keen to peer-review the coding have since raised a number of questions about the coding practices used to arrive at those figures. In response, Ferguson has tried to explain himself on twitter saying that he 'wrote the code (thousands of lines of undocumented C) 13+ years ago to model flu pandemics'; this is far from satisfactory. Part of the problem is that the Imperial College model used projections from China and Italy to predict the rates of infection in the UK. Those are nations with significantly disparate social conditions to the UK. This was clearly a flawed standard to begin with.

Co-morbidities & *post hoc* fallacies

Relatedly, there is the issue of dubious death certification practices and new procedural guidance which seems to conflate COVID-19 deaths with other co-morbidities with a serious blurring of correlation and causation. There are a number of serious issues with both the revised methods of recording of COVID-19 deaths, as much as with the reporting of those fatalities. Both are having a misleading effect on the advertised numbers.

For example, guidance in the UK has recently been revised to account for COVID-19 as a notifiable disease. COVID-19 is now attributable as a 'direct or underlying' cause of death. However, in a note on the approach to mortality statistics, ONS stated that in publishing the figures, 'it will not always be the main cause of death, but may be a contributory factor' mentioned 'somewhere on the death certificate'.

The Emperor has no clothes

Further, *Post hoc* fallacies have been systematized as part of a wider certification policy-framework in numerous countries with revised reporting guidance in Italy, the US, UK and even Germany. Here in the UK, COVID-19 deaths are partly based on *testing* and the rather loose definition of a deceased person having ‘tested positive’ for the virus having then died irrespective of the actual cause of death. In an early report from the Italian National Institute of Health, one advisor to the Italian Government raised this as an issue there as well:

“The way in which we code deaths in our country is very generous in the sense that all the people who die in hospitals with the coronavirus are deemed to be dying of the coronavirus... On re-evaluation by the National Institute of Health, only 12 per cent of death certificates have shown a direct causality from coronavirus, while 88 per cent of patients who have died have at least one pre-morbidity – many had two or three,”

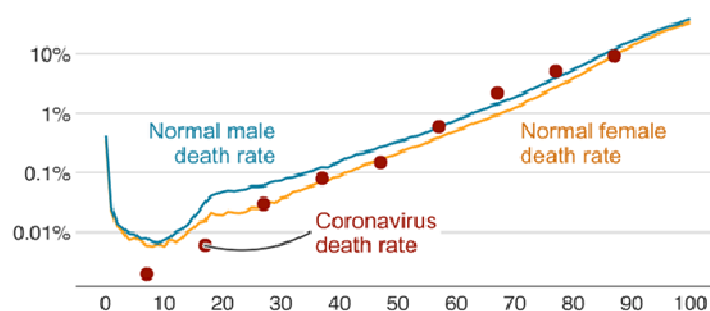
The other certification approach is based on *symptoms*. Guidance from NHS clarifies that if the test result has ‘not been received’ it would be satisfactory to give ‘COVID-19’ as the cause of death based on symptoms alone. However, we’ve also known for some time that COVID-19 is very similar to influenza so it’s unreliable to rely on presenting symptoms alone.

We therefore have a collection of errors from two extremes. On the one hand, the mere presence of COVID-19 through *testing* is enough to certify it as a cause of death (*post hoc*). On the other extreme, a clinical assessment based on *symptoms* is seen as sufficient ‘[w]ithout diagnostic proof’. The death certification and publication process is quite simply rife, layer upon layer, with confounding and misleading interpretation and representation of data.

If we look at the Government published figures for COVID-19 as of 26th April the total is now 20,319. The seasonal flu deaths for a similar week period (using 5 year averages up to week 15) is 12,982. On the surface that seems like almost a doubling of fatalities, but once we factor that there is a two-week lag in flu statistics (only so far being published up to 10th April) compared with the figures for COVID-19 which are more or less live, we can estimate a further 4,000 in the flu back log. This would bring estimated flu deaths to at least 16,000 or more, not far off the published COVID-19 fatality figures. So, if we accept the published figures there is little difference between them over the first 15 week period of this year. In terms of overall deaths, these may well balance out with little or no excess deaths (excluding deaths indirectly related to the quarantine measures such as suicide). The BBC chart right helps to illustrate the anticipated risks overall a bit further as the pattern more or less tracks the same as if COVID-19 had not appeared:

Chances of dying from coronavirus v normal annual risk

Risk of dying each year by age (GB)



Log scale used to see differences in rates at younger ages

Source: Prof. Sir David Spiegelhalter, ONS, Imperial College London

BBC

The Emperor has no clothes

Dr. William Schaffner, a vaccine expert at Vanderbilt University Medical Centre in Nashville, Tennessee (USA) has suggested that ‘When we think about the relative danger of this new coronavirus and influenza, there’s just no comparison... The risk is trivial’. It is suggested by at least one other a collaborative pre-review study out this week, including researchers from Stanford, suggests that the virus is likely ‘widespread’. Dr. Jay Bhattacharya, one of the researchers on that project, discussed the study in a recent interview where he suggests that the initial WHO forecast fatality rate of 1-3% was hugely out of step. Due to populational prevalence of COVID-19 (largely mild or asymptomatic), the actual fatality rates for COVID-19 is likely to be up to 10 times less severe than initially projected – closer to 0.1-0.3%. Even Fauci et al (2020) recently arrived at a similar conclusion:

“ ...the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately 0.1%) or a pandemic influenza”

In the coming weeks, all eyes will be on countries like Sweden who followed a policy comparable with the UK prior to the release of the Imperial College report on 16th March. So far, they have seen incomparably fewer deaths without any enforced quarantine. Indeed, some of the pre-review evidence from the notable Professor Wittkowski, former chief biostatistician and epidemiologist at Rockefeller University Hospital, suggests that our interventions may well have damaged our chances of reaching already herd immunity, increasing the likelihood of a second ‘rebound’. In the UK we likely peaked a week before the lockdown was even instituted, calling into question the whole efficacy of the policy. The list of dissidents against the *status quo* is growing day by day. Once we factor in the substantive issues raised here already, an honest assessment of the final fatality figures for COVID-19 deaths will likely be massively, not marginally, less fatal than flu.

The diminishing case for proportionality

Guidance from the WHO regulations (2005), specifically, Article 12 suggests that advice given to states should be based on ‘scientific principles’ regarding ‘assessment of the risk to human health’. As Benatar & Brock (2015: 93) aver, lockdowns should only be mandated ‘as a last resort’. Public health measures must be proportionate and should pay attention to the overall ‘net pay-off’ for mandated measures taking into account the potential harm on society. The maximal promotion of public health, no matter how conceived, should not become the ‘sole goal’ of an ethical public health policy. What this means is that for wide sweeping liberty-infringing measures to be ‘permissible’, the stakes need to be ‘very high’.

The problems I have raised here include the use of generalised CFRs infused with selection bias and flawed, unaccountable coding projections based on nations with considerably disparate socio-economic conditions. These issues have been compounded by government policies across the world which systematised *post hoc* fallacies. This is in defiance of well-established scientific, epidemiological and statistical best practice. Together these have contributed to creating a ***perfect sensationalist storm of error***.

The Emperor has no clothes

The Council of Europe advised that ‘the challenge for governments in this crisis is the ability to respond to this crisis effectively, whilst ensuring that the measures they take do not undermine our genuine long-term interest in safeguarding Europe’s founding values of democracy, rule of law and human rights’. Although, the quarantine measures seem to have met the ‘general interest of the community’ test early on, it is likely that this case is weaker by the day, particularly as the weight of evidence mounts and awareness increases against the prevalent (mis)conceptions of risk. We now have a reasonable understanding of this virus emerging from the crisis and we are slowly arriving at a consensus: that although particular groups are at risk, we are experiencing broadly similar levels of risk as standard influenza, with similar symptoms as well. I’d suggest that the stakes and the risk are therefore not at all high enough to warrant such sweeping Government measures. This is an issue that has also been recently raised by Francis Hoar QC who has undertaken a timely analysis of the relevant evidential grounds for lockdown and the ‘questionable’ scientific basis for lockdown. We need an honest assessment by the Government if we are to truly navigate out of this crisis.

The challenge for any government is to develop an approach to political decision-making that reflects an appropriate level of responsiveness to an emerging threat (apparent or actual), whilst also remaining sensitive to the need for proportionality under changing circumstances. This is a continual process. However, the UK Government response has been marked by a serious lack of transparency, regarding both the scientific basis for lockdown and the decision-making framework for easing of restrictions.

Decision-makers have the responsibility to respond to expert advice in the context of scientific best practice and legal principle with weighty (even paramount) consideration given for the very real needs and concerns of the populations they govern. If policy is based on scientific evidence, then as the evidence changes, we should see a change of both narrative and political decision-making. For some reason, this is not happening.

Final remarks

The consequences of prolonged lockdown are serious and I have absolutely no doubt that the human cost of these measures across the world will be so immense as to completely overshadow any perceived and debatable benefits of enforced lockdown. As Dr John Lee has suggested, ‘the moral debate is not lives vs money. It is lives vs lives’.

As a society, we must remain aware of the ever-present dangers and risks of being led by small groups of influential scientists. Laski once said, ‘we must ceaselessly remember that no body of experts is wise enough, or good enough to be charged with the destiny of mankind’. Scientific understanding is not the sole possession of a single individual or set of individuals; it is distributed, and its ‘locus is at the population level’. This ‘locus’ is a non-negotiable principle of any democracy worth its salt and we would do well to remember it.

If the evidence for risk to life is as problematic as it appears, it follows that the case for enforced quarantine and lockdown is increasingly hard to justify. If needlessly maintained, it could be noted as one of the greatest errors of political judgement and decision-making in modern history.

The Emperor has no clothes

There is nothing virtuous in following a flawed narrative. It is deleterious to our national well-being and dangerous for the preservation of our British values, democratic norms and way of life. The question remains, who dares to doubt whether the emperor has any clothes?

Author's note:

This opinion piece was originally published via UKAJI (The UK Administrative Justice Institute) and is re-posted with permission and thanks. Data was correct at the time of original posting (28.04.20). The UK and other Gov'ts (including in the Republic of Ireland) have since begun to ease some of the restrictions, which is great news – not least for those in need of accessing healthcare, but also for the everyday citizen in need of social and emotional contact and some sense of normalcy.

It's fair to say that my article adopts a critical view of the lockdown. The international trend towards lockdown is an exceptional moment in public health policy with wide-reaching social, political and economic impacts. Consequently, my view is that the policy of national lockdown deserves very close scrutiny and critique. This is all the more important in the context of unfolding knowledge that many of the Gov't interventions appear to be driving fatalities rather than preventing them. For example, from at least 20th March 2020 (three days before national lockdown was mandated) the UK Gov't knew that the disease was being 'driven largely by nosocomial transmission' (i.e. hospital acquired), as opposed to community transmission. Further, that Covid-19 elderly patients were, as a matter of policy, being routinely sent from hospitals and into care homes, driving ICU beds, emergency healthcare and fatalities of the elderly. The same appears to be true for some of the infection hot spots in US too.

Despite what we now know, lockdown in the UK remains largely in place. It appears that although there are some tentative steps towards some form of acknowledgement, even today, few lessons are being learnt by politicians on the devastating impact of the policy or any hint of acknowledgement that the policy is failing. This seems largely to do with managing public perceptions and maintaining confidence in Gov't policy. You can read a long list of SAGE scientific advice and minutes as well as SPI behavioural science advice which has recently been made available to the public.

Most of you will already have widespread access to mainstream accounts and proponents for lockdown. So for alternative perspectives and for an up to date critical account of the ongoing UK Gov't handling of the Covid-19 crisis, please see the 'Lockdown lunacy' website or the 'Lockdown sceptics' website; both have lots of useful data, research and critique. You may wish to look back at some of their historical entries too. Further, I have already cited Francis Hoar QC in the main piece, but if you have a twitter account I'd recommend that you can follow him: @Francis_Hoar. You can also follow Alistair Haines, a professional statistician and well-known critic of lockdown on twitter: @AlistairHaines. I am sure there will be others more local to you as well.

Whatever your view of lockdown, it's important for citizens to stay informed and active during these unprecedented times of change. I appreciate that the issues raised here, and the resources, are from a UK policy perspective; but seeing as the issues are similar across nations I hope that you find the points raised here useful.



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The O'Malley Clan Association aims to reach out to O'Malleys from all around the world and foster links between the O'Malleys around the globe and the clan at home here in Ireland.

The Clan Association formed in 1953 has been connecting O'Malleys around the world in The US and Canada, Britain, Australia, South Africa, New Zealand, South America, and anywhere else you can think of for over 60 years now.

We hope with our new website, and newsletter, that We can go from strength to strength in our aim to connect all the O'Malleys around the world.

The O'Malley Clan DNA Project on Family Tree DNA

The most common queries we get at The O'Malley Clan Association are queries in relation to helping to trace peoples ancestors in Ireland. As we all know, written records can only take us so far, (if you're lucky you'll get back to the early 1800's or late 1700's).

Many of the Irish Census Records and other historic documents were destroyed during the early part of the 20th century and as a result it can be very hard to trace ancestors back beyond the 19th century. Church records are a help, but can be patchy at times.

One way of narrowing down the search is through DNA testing. The O'Malley Clan Association is involved in a project with Family Tree DNA to test as many O'Malleys as possible to try and expand our knowledge of our roots as much as we possibly can.

There's a specific page for the project on the Family Tree DNA website:

<https://www.familytreedna.com/groups/omalley/about>

Check it out, there's lots of info there, and administrators also for any questions.

