A series of unfortunate events, or something else?

Key points

- In April 2020 there was a push to use Opioids and Midazolam extensively in the UK
- Were these drugs used inappropriately and if so, why was this? Inexperience or something else?
- Were people's deaths hastened as a result of this drug combination?
- Why has there not been a public enquiry or police investigation? I myself made a report to the police in 2020 and last year as part of a wider investigation.
- What professional bodies are culpable, if any?
- Was there end of life pathways in place. Did this amount to euthanasia?
- Why have best interests procedures not been followed and cheap anti virals not been used?

Midazolam and Morphine

Appropriate care for the dying, or misguided misuse of drugs which ended lives prematurely?

Dr Bryan Ardis and Clare Wills Harrison

13th January 2022

Critical thinking questions to ask, which arise from this presentation

1. Was fraudulent testing used to drive cases, and were midazolam and other drugs used inappropriately in the UK on those that could have survived, with the effect that these drugs hastened deaths, all to fit a narrative? Did this happen elsewhere?
2. Was the narrative mentioned at (1) crafted to move us to MRNA jabs, (they are not vaccines), which given adverse event figures, are extremely dangerous in both the long and short term?
3. Are the jabs an attempt to move us to a totalitarian digital, tracked and traced, enslaved world?
4. If the above is true, what can we learn from this?

Writers answer/thoughts

I think at the most basic level we need to learn and accept that we cannot trust government and much of main stream science, we cannot trust the media who are funded by pharma and others, and that there are a small group of financially motivated people with no empathy, that are insistent on attempting to push the population of the world in a direction that they feel is most beneficial to them, NOT us.

The good news is that due to the attempts of a small group of people, many people are now waking up to the statements at 1-4 above.

There is much more to this story, and other pieces of the puzzle. This presentation focuses on only one small part . Research around it, and look at other elements including amongst other things the financial situation of the world and how that is also controlled.

Do also consider the spiritual aspect of things, i.e., the evolution of humanity's consciousness and why a small group of people may wish to stop this. Do the MRNA jabs assist in this ?

What is Midazolam?

Key points

- It is a Benzodiazepine which works by slowing activity in the brain to allow relaxation and decreased consciousness
- In the US Midazolam is used in lethal injection executions for sedation (along with other drugs).
- Importantly, Midazolam is a sedative, not a barbiturate. Even at extremely high doses, midazolam does not have the properties to render a person insensate — immune to pain.
- Midazolam is also used for the reasons stated opposite.
- More info on Midazolam here: https://medlineplus.gov/druginfo/meds/a609014.html

1. Midazolam injection is used before medical procedures and surgery to cause drowsiness, relieve anxiety, and prevent any memory of the event. In the hands of a competent anaesthesiologist, Midazolam is used appropriately.
2. Midazolam is also sometimes given as part of the anaesthesia during surgery to produce a loss of consciousness.
3. Midazolam injection is also used to cause a state of decreased consciousness in seriously ill people in intensive care units (ICU) who are breathing with the help of a machine.
4. In the UK, Midazolam is also used for epilepsy as it is thought that any convulsive seizure lasting longer than five minutes leads to an increased risk of neuronal compromise. Midazolam, is therefore used to abort ongoing seizures and avoid the complications of prolonged status epilepticus.
5. Midazolam is widely used in the UK for palliative care, but in the hands of an inexperienced practitioner can be misused and lead to deaths. Example of NHS palliative care guidelines here:

Nice guidance published 3rd April 2020

Key points

- Opioids and Benzodiazepines are to be considered to manage breathlessness and agitation at “end of life”
- How easy is it to tell if someone is at end of life? Some people are classed as end of life and go on to live for many many months, even years
- Opioids and Benzodiazepines did NOT have a UK marketing authorisation for this indication in April 2020
- Midazolam up to 60mg over 24 hours via syringe driver is in addition to Midazolam 2.5mg subcutaneously “as required”. A huge amount. 10mg could sedate someone depending on their size, so can a lower dose, but sometimes a higher dose would be needed. Patient, age and weight appropriate. Is 2.5mg as a starting dose too high?
- Is this document why the UK govt ordered so much midazolam?
- Remember countries in Europe, ie Italy had declared a national emergency in Jan 2020, so the UK had weeks of data to rely on to compile advice. Hydroxychloroquine had already been mentioned as an early treatment by now

GMC statement on NICE guidance published 14th April 2020

Key points

- “Entirely appropriate to follow NICE guidelines and the GMC had “no concerns” despite opioids and benzodiazepines not having a UK marketing licence for use in treating breathlessness”
- Clearly states that sedation and opioid use “should not be withheld for fear of causing respiratory depression” . Is this good advice?
- Covid is a respiratory depressing disease supposedly?
- What went wrong here, if anything?

BMJ issue guidelines of their own in support of NICE guidelines

Key points

- Published 20th April 2020
- States has been prepared with input from NHS England.
- Reiterates the guidance from Nice about concomitant use of Opioids and Benzodiazepines. Makes no referral to other drugs or, crucially, NG31 (see next slide)
- States again that Opioids and Benzodiazepines did not have a UK marketing licence for treating breathlessness at date of article, but that they should not be withheld for fear of causing respiratory depression

Doctors were concerned about NICE and BMJ guidance and GMC statement

Key points

- Article published 20th April 2020
- States - under 'General advice for managing COVID-19 symptoms', recommended: " When managing key symptoms of COVID 19 in the last hours and days of life, follow the relevant parts of NICE guideline [NG31] on care of dying adults in the last days of life.
- The earlier NICE guideline NG31 (2015) for symptom management at the end of life was based on studies carried out in people who were mostly in the advanced stages of cancer. However, in NG31 the evidence base was so poor that it did not publish detailed recommendations for drugs and doses. We are unaware of more recent high-quality research evidence that NICE could have used to produce such specific drug and dosing recommendations now for COVID-19 patients.

Cont'd….

- NG31 aimed at care of people who were likely to die in the coming hours and days - usually from advanced diseases, from which recovery was deemed most improbable. **Many people in the UK suspected of having COVID-19 will not have advanced cancer or be dying from another existing terminal condition**. The accumulating global evidence shows that the case fatality rate reaches >50% **in those needing mechanical ventilation, over 80 years and with serious underlying health conditions including congestive heart failure, chronic kidney disease and lung cancer**..
- **So it is worrying that while the NICE guidance states that "Note that symptoms can change, and patients can deteriorate rapidly in a few hours or less", there is no counterpoint that most patients without the preconditions above will eventually recover**. In contrast, NICE guideline NG31 emphasised the importance of how to recognise whether someone was dying, but also to keep open the possibility for recovery by '**monitoring for further changes at least every 24 hours'.(5)**
- Compared with advanced cancer, COVID-19 is a condition that very few practitioners will have sufficient confidence to prognosticate on. For no doubt good intention to provide ease from distress, **patients may be started by inexperienced practitioners on potent medications with detailed advice on how to escalate doses, but not on monitoring daily or more frequently, and how to wean off medication if the patient stabilises and recovery becomes possible**.
- **The combination of opioid, benzodiazepine and/or neuroleptic is used in specialist palliative care settings for symptom control and for 'palliative sedation' to reduce agitation at the end of life. It takes great skill and experience to use palliative sedation proportionately so that extreme physical and existential distress are palliated, but death is not primarily accelerated.** Nice guidance states: "Sedation and opioid use should not be withheld because of a fear of causing respiratory depression**." If COVID-19 infection were uniformly fatal, this would be an acceptable statement. But for people not previously known to be at the end of life, there is potential risk of unintended serious harm, if these medications are used incorrectly and without the benefit of specialist palliative care advice.**

House of Commons – Health and Social Care Committee

Key points

- Meeting took place via Zoom 17th April 2020
- Questions 376 (page 39) to 379 (page 40) allude to a large order of medicines by UK govt, including morphine and midazolam, along with syringe drives
- Q377 – what is a good death? Dr Luke Evans states that “a good death needs”…. Morphine, midazolam and syringe drivers. If a good death happens a syringe drive and midazolam is not needed
- Is this just good planning?

House of Commons Oral Evidence.pdf

Accord order by UK Govt

Key points

- A spokesperson from Accord, (Accord – UK Ltd) told *The Pharmaceutical Journal* on 11 May 2020 that it was out of stock of midazolam injection after the NHS requested it "place all of its stock of midazolam — equivalent to around two year's forecasted supply — into its wholesale partners", even though the manufacturer "does not currently have any NHS contracts in England" to supply the drug. Article here Supplies of sedative used for COVID-19 patients diverted from France to avoid potential shortages - The Pharmaceutical Journal (pharmaceutical-journal.com)
- The MHRA gave the manufacturer approval "for some French label stock — another 22,000 packs — to be sold into the NHS and they were currently waiting for the MHRA's direction on where to place the stock".
- The manufacturer said the French stock only included midazolam at the strength of 1mg/mL in 5mL, while the initial supply in March 2020 contained a variety of four different strengths.
- Was this extra order as a result of the NICE guidelines and GMC statement?

Accord_French_Midazolam[22068].pdf

Midazolam prescribing UK April 2020 and others

Key points

- In April 2020 out of hospital Midazolam prescribing increased by over 100%
- Out of hospital prescribing means that the Midazolam was dispensed into care homes, hospices and the community. The Midazolam was not therefore used for sedation, operations, ventilators etc
- The key question is – “Did this prescribing lead to the hastening of deaths?”

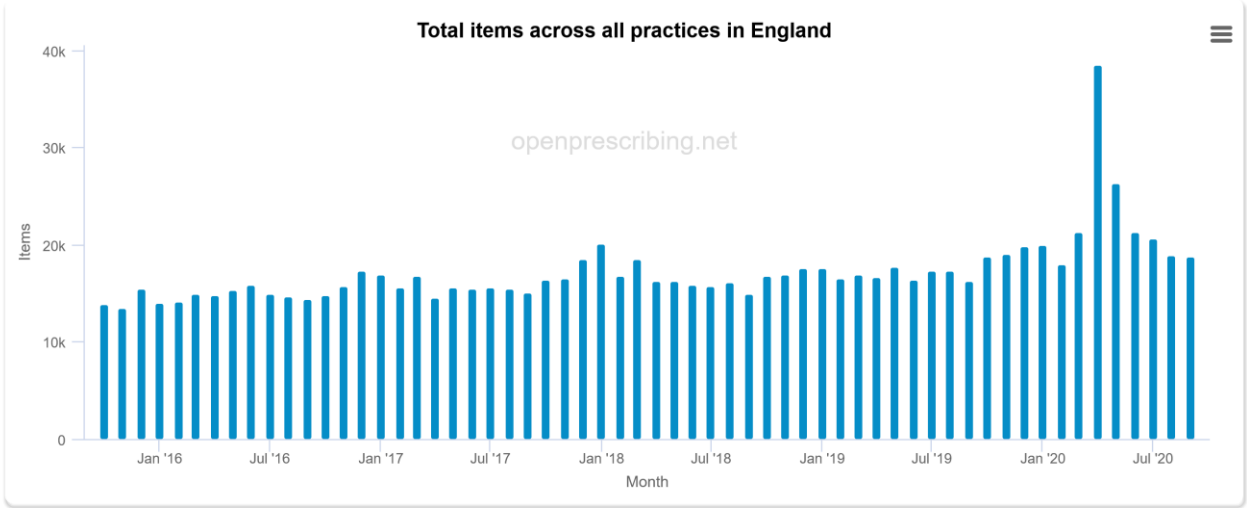
Midazolam Hydrochloride (1501041T0)

Part of chapter 15 Anaesthesia, section 15.1 General anaesthesia, paragraph 15.1.4 Sedative and analgesic peri-operative drgs

High-level prescribing trends for Midazolam Hydrochloride (BNF code 1501041T0) across all GP practices in NHS England for the last five years. You can see which CCGs prescribe most of this chemical relative to its class, or learn more about this site.

View all matching dm+d items.

Trends Items Spending



Daily Mail Article dated 12th July 2020

Key points

- "The number of prescriptions for a powerful sedative that can kill the frail doubled at the height of the pandemic, raising fears it was used to control elderly residents in stretched care homes – or even to hasten their deaths"
- "Out-of-hospital prescribing of the drug midazolam increased by more than 100 per cent in April 2020 compared to previous months.". See chart in previous slide.
- Anti-euthanasia campaigner said he suspected that the spike was evidence that many people had been put on end-of-life protocols or 'pathways'
- Whistleblowers claim to have witnessed misuse of sedative, with staff told to give it to dementia patients to stop them wandering the corridors – matches with what whistleblowers have told me
- Professor Patrick Pullicino, who was instrumental in raising concerns a decade ago that the Liverpool Care Pathway was bringing forward patients' deaths, believes the jump indicated something similar had happened. He said: 'Midazolam depresses respiration and it hastens death. It changes end-of-life care into euthanasia.'
- Prof Pullicino also claimed that an official flow-chart intended to help health workers decide if people sick with Covid-19 were suitable for intensive care wrongly consigned those deemed too frail to end-of-life care. Was this chart based on the NICE guidelines of April 2020 and the GMC/BMJ statement of April 2020?
- Pullicino suggested that some people were not taken to hospital even though they could have been helped by doing so.

Article here:

https://www.dailymail.co.uk/news/article-8514081/Number-prescriptions-drug-midazolam-doubled-height-pandemic.html

Blanket DNAR's found to have been placed on care home residents

Key points

- In March and April 2020 there were reports that some GPs had applied "do not attempt resuscitation" (DNAR) notices to groups of care home residents that meant people would not be taken to hospital for potentially life-saving care.
- This was being done without residents consent or with little information to allow them to make informed decisions.
- The CQC launched an investigation.
- DNARs being made for patients in a blanket fashion, is unlawful. There was also no communication or explanation to patients or their loved ones in many cases, despite this being a legal requirement.
- More than 18,000 people died from confirmed or **suspected** Covid-19 in UK care homes in the first phase of the "pandemic". (Next slide – 25,000 were discharged from hospital to care homes in March 2020)

Article here:

https://www.theguardian.com/world/2020/oct/12/inquiry-begins-into-blanket-use-in-england-of-covid-do-not-resuscitate-orders

Further article here:

https://compassionindying.org.uk/compassion-in-dying-joins-calls-for-inquiry-into-blanket-dnr-orders-during-pandemic/

CQC interim report here:

CQC interim report DNRs.pdf

"There is evidence of unacceptable and inappropriate DNACPRs being made at the start of the pandemic. Through our review, we will aim to establish the scale of national concern."

CQC final report here:

https://www.cqc.org.uk/publications/themed-work/protect-respect-connect-decisions-about-living-dying-well-during-covid-19

"From the beginning of the COVID-19 pandemic, there were concerns that 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions were being made without involving people, or their families and/or carers if so wished, and were being applied to groups of people, rather than taking into account each person's individual circumstances."

Amnesty report - devastating findings

Key points

- Highlights the UK Government's failure to protect older people in care homes
- Picks up on the discharge of 25,000 elderly from hospital into under prepared care homes. Did lack of staff and more residents lead to DNARs? Did it also lead to use of Midazolam – see Daily Mail article
- A series of "shockingly irresponsible" Government decisions put tens of thousands of older people's lives at risk and led to multiple violations of care home residents' human rights
- The report's conclusion is that the human rights of staff and residents in care homes were ignored and violated. This includes the right to life and health together with the right to non-discrimination (by age).
- What we must also realise is that during this time visiting was suspended as were almost all in home GP visits (switched to remote), all physio, chiropdy etc. Absolutely no oversight or help

Report here:

Amnesty Care Homes Report.pdf

Amnesty International received a number of reports and has seen documentary evidence that Durham County Council made funding for coronavirus-related costs conditional on **care homes accepting patients discharged from hospital untested or COVID-19 positive. On the 19th April, the government announced £1.6bn un-ringfenced funding for local authorities to support COVID-19-related costs. On the same day £1.3bn was also allocated to the NHS to help discharge patients from hospitals, including to pay for patients' stay in care home or other social care services. In allocating funding at local level, Durham County Council wrote to 98 local homes offering a 10% additional COVID-19 temporary funding to care homes who agreed to accept "new referrals; either from hospital discharge / community, or inclusive of people who have had a diagnosis of / are recovering from COVID-19**."

Amnesty International received multiple reports of care home residents' right to NHS services, including access to general medical services (GMS) and hospital admission, being denied during the pandemic, violating their right to health and potentially their right to life, as well as their right to non-discrimination. Care home managers have pointed out that such reluctance or refusal to admit older care home residents to hospital could not be explained by need, as hospital bed capacity was never reached.

Care home managers and staff and relatives of care home residents in different parts of the country told Amnesty International how, in their experience, sending residents to hospital was discouraged or outright refused by hospitals, ambulance teams, and GPs. A manager in Yorkshire said: "We were heavily discouraged from sending residents to hospital. We talked about it in meetings; we were all aware of this."

The problem was widely reported early on, and was seemingly exacerbated by guidelines **published by NHS England on its website on 10 April advising that some care home residents "should not ordinarily be conveyed to hospital unless authorised by a senior colleague**." The guidelines caused a controversy and were withdrawn a few days later but the damage lingered. **Hospitals, CCGs and GP surgeries continued to discourage or deny hospitalisation of care home residents, a perception developed among care home staff that hospitalisation was not generally an option. With the problem seemingly persisting, the CQC felt it necessary to issue a statement in August 2020 addressing the issue.**

Official figures show admissions to hospital for care home residents decreased substantially during the pandemic, with 11,800 fewer admissions during March and April compared to previous years. The Health Foundation has noted that while there may have been a number of reasons for reduced admissions, "the data suggest that there may be unmet need for health care among care home residents as a result of COVID19." The Joint [Parliamentary] Committee on Human rights expressed concern that "decision-making relating to admission to hospital, in particular critical care, for adults with Covid-19 has **discriminated against older and disabled people."**

Best Interests – What does it mean

Key points

- A Best Interests decision is a decision made by applying the Best Interest principle, as set out in the Mental Capacity Act 2005.
- A Best Interests decision is a decision made for and on behalf of a person who lacks capacity to make their own decision.
- A Best Interest decision can only be made when the matter to be decided is a matter that it would normally be within the person's power to decide (and not something that would normally be outside of their control).
- A Best Interests decision should, wherever possible reflect the decision that the person lacking capacity would make for themselves.

Best interests checklist:

- Consider your wishes and feelings: both your current wishes and those you expressed before losing capacity to make the decision, as well as any beliefs and values that are important to you.
- Consider all the circumstances relevant to you, like: the type of mental health problem **or physical illness you have**, how long it is going to last, your age, whether you would normally take this decision yourself, whether you are likely to recover capacity in the near future and who has cared or is caring for you.
- Consider whether you will have capacity to make the decision in future and whether the decision can be put off in the short-term. If you are experiencing severe mental distress, for example, will your distress ease in the near future enough to let you make your own decisions?
- Support your involvement in acts done for you and decisions affecting you.
- **Consider the views of your carers, family, or people who may have an interest in your welfare, or people you have appointed to act for you.**

We need to ask if the best interests procedure should have included discussions about cheap anti virals, hydroxychloroquine and/or other protocols (i.e. Zelenko protocol), rather than just relying on a midazolam and morphine prescribing base.

In addition it does not appear that the bests interest procedure has been followed in many cases, as family, friends and carers have not been included in decision making. This is a failure of legal systems in place to protect people.

Where are we now in the UK?

Key points

- Estimated 60,000 care workers could have lost their jobs due to mandatory vaccination policy
- At least 42,000 social care staff have already left sector since April
- In December, UK hotels were being turned into temporary care facilities staffed with workers flown in from Spain and Greece to relieve pressure on NHS
- Three hotels in the south of England were being used
- At least three other health authorities were considering the move, which was partly driven by the severe shortage of domiciliary care workers
- On 10th January, a UK council appealed for volunteers among its 30,000-strong workforce to help out in its 23 care homes amid staff shortages. Looking for "vaccinated and boosted employees" to take on duties such as catering and laundry.

More:

We have historically had a shortage of staff in the care sector. It is now severely compounded by the no jab no job policy

Articles on hotels and council workers:-

https://www.theguardian.com/society/2021/dec/13/hotels-being-used-as-care-facilities-to-relieve-pressure-on-nhs

https://www.localgov.co.uk/Council-staff-asked-to-provide-care-services-amid-workforce-crisis-/53526

Our NHS workers face the same rule as of 1st April 2021. It is estimated that 126k will lose their jobs or leave as a result. The NHS is likely to collapse.

A House of Lords committee raised several concerns about the proposed legislation to make vaccination for all NHS staff in England, particularly whether the benefits of vaccinating the remaining 8% of NHS workers were proportionate and how the NHS would cope with losing the 5.4% who don't want to be vaccinated. The Secondary Legislation Scrutiny Committee said that the government's plans had not been thoroughly thought through, leaving the House of Lords unable to scrutinise the proposed legislation.

A report published on 30 November 2021 stated that of the 208k NHS staff who weren't currently vaccinated 54 000 (26%) would take up the vaccine under the law and 126 000 (61%) would leave their jobs.

The committee said that the benefit of increasing the protection from vaccinating staff who had not yet taken up offers of the jab "may be marginal" and that the UK government had failed to publish any contingency plans on how it would cope with the loss of staff who do not want the vaccine.

Article on report https://www.bmj.com/content/375/bmj.n2957

Recent article regarding ICU doctor https://www.dailymail.co.uk/news/article-10381709/Doctors-warn-no-jab-no-job-rule-make-NHS-staff-shortages-worse.html

Where are we now in the UK cont'd?

Key points

- Amid all of the issues noted on slide 14 and this slide, the UK govt put out a tender for further midazolam which closed in December 2021 https://bidstats.uk/tenders/2021/W49/764543450
- "The Authority seeks to top up the Stockpile holdings of Midazolam 50mg/10ml …… in preparations for further waves of Covid 19 in Winter 2021/ Spring 2022".
- Why are we doing this when we have alternative solutions such as ivermectin, Zelenko protocol etc?

More:

Check what stock was held in the UK for Midazolam, Morphine, Fentanyl etc in October 2019 and October 2020. Midazolam, despite the two year supply, and further Accord order, on top of what we already held, had run out.

https://questions-statements.parliament.uk/written-questions/detail/2020-10-01/98182

Midazolam is one of a number of drugs that can not be exported from the UK since March 2020

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1042790/restricted-medicines-list-december-2021-v3.csv/preview

We are now ordering more. Why?

You can find, follow and subscribe to us here:-

Telegram for Lawyers of Light https://t.me/lawyersoflight

Sister website www.awakenedworld.co.uk

The Expose Telegram link https://t.me/dailyexpose

Interview for further background info
https://open.spotify.com/episode/1kOBFyD2YV5Zf8zZHKg0HQ