

# Midazolam and Euthanasia

notes on the work of Wilson Sy

by Craig Paardekooper

## KEY POINTS

### INVOLUNTARY

1. End of life drugs were prescribed immediately with the beginning of lockdown
2. These drugs were administered by injection in hospitals / care-homes to a captive population – elderly and sick.

### DRUG-DEATH CORRELATION

3. There is a consistent 1 month lag between peaks of Midazolam medication and peaks of excess death.
4. The size of the peaks of medication are directly proportional to the size of the peaks of excess death.
5. There is a 1 : 1 correspondence between the number of Midazolam injections and the number of excess deaths
6. In 2020, the correlation between Midazolam medication and excess death is 99%.

### MECHANISM

7. Midazolam and Morphine have the highest incidence for depressing respiration.
8. The dosages given match the Guideline and those required for effective euthanasia

### POLICY

9. The NICE Guideline states that the intended use of Midazolam and Morphine was end-of-life care.
10. Do Not Resuscitate orders were applied
11. Effective treatments were withheld and discouraged
12. Liability was removed.

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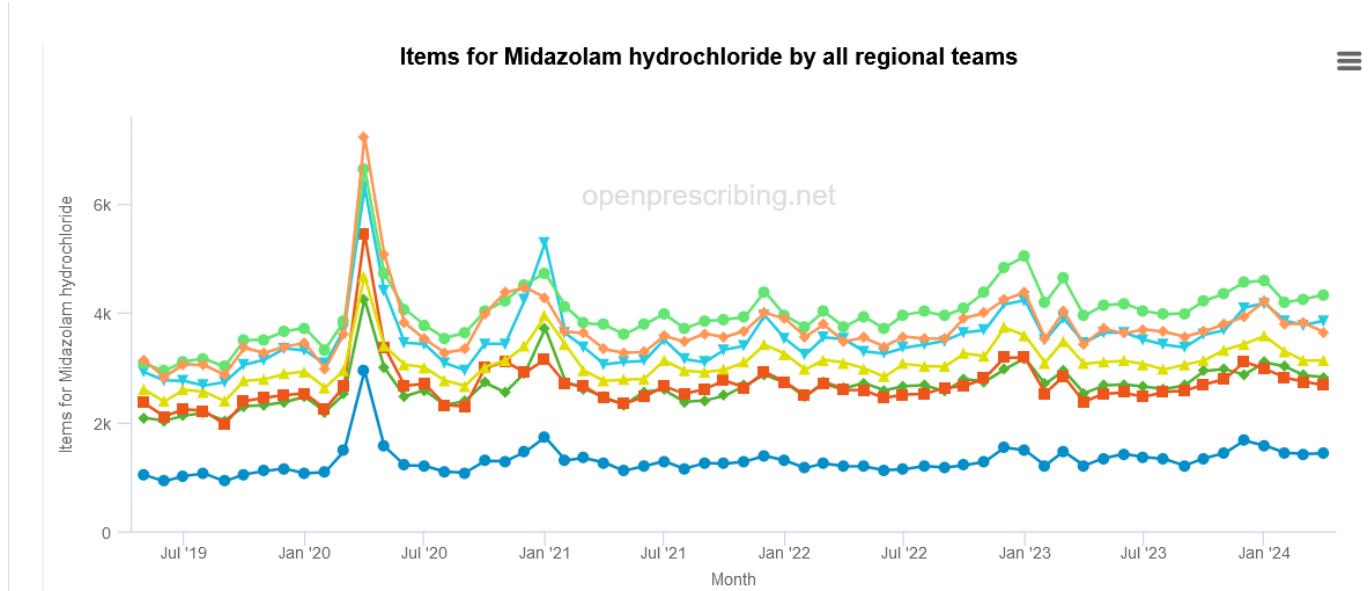
### Conclusion

### Anti-Retro-Viral Drugs

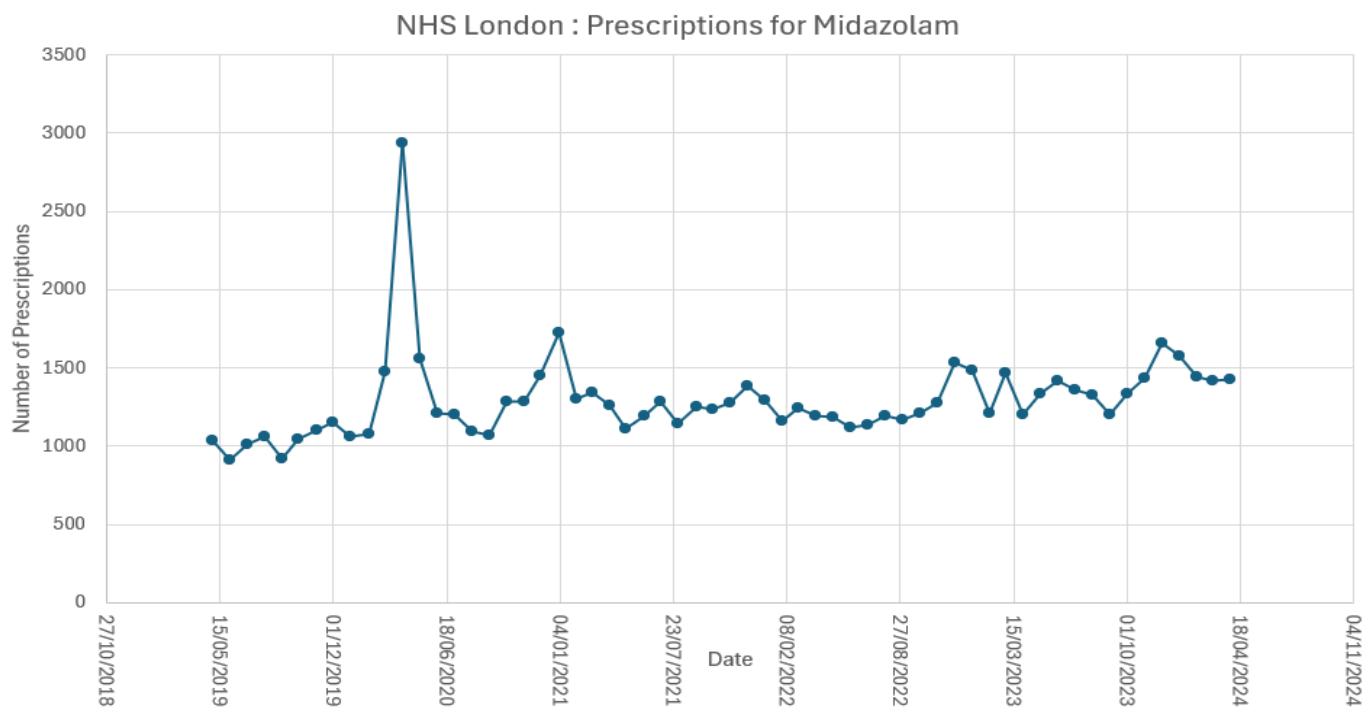
[Paxlovid](#)

[Tamiflu](#)

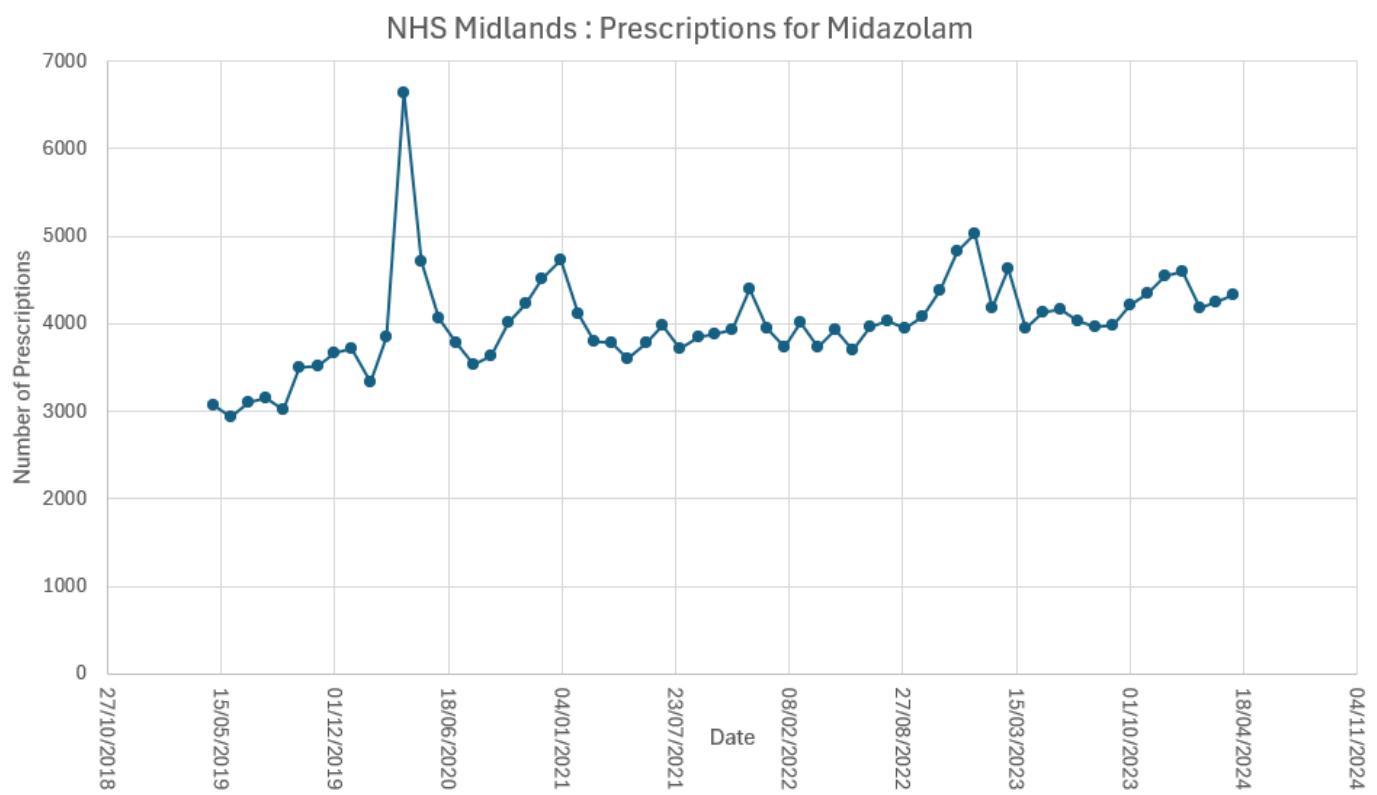
Midazolam prescriptions increased during the COVID-19 pandemic. Data from the English Prescribing Dataset, shows a jump in prescriptions of midazolam for “sedative or analgesic” purposes in April 2020. Ref : [Openprescribing.net](https://www.openprescribing.net)



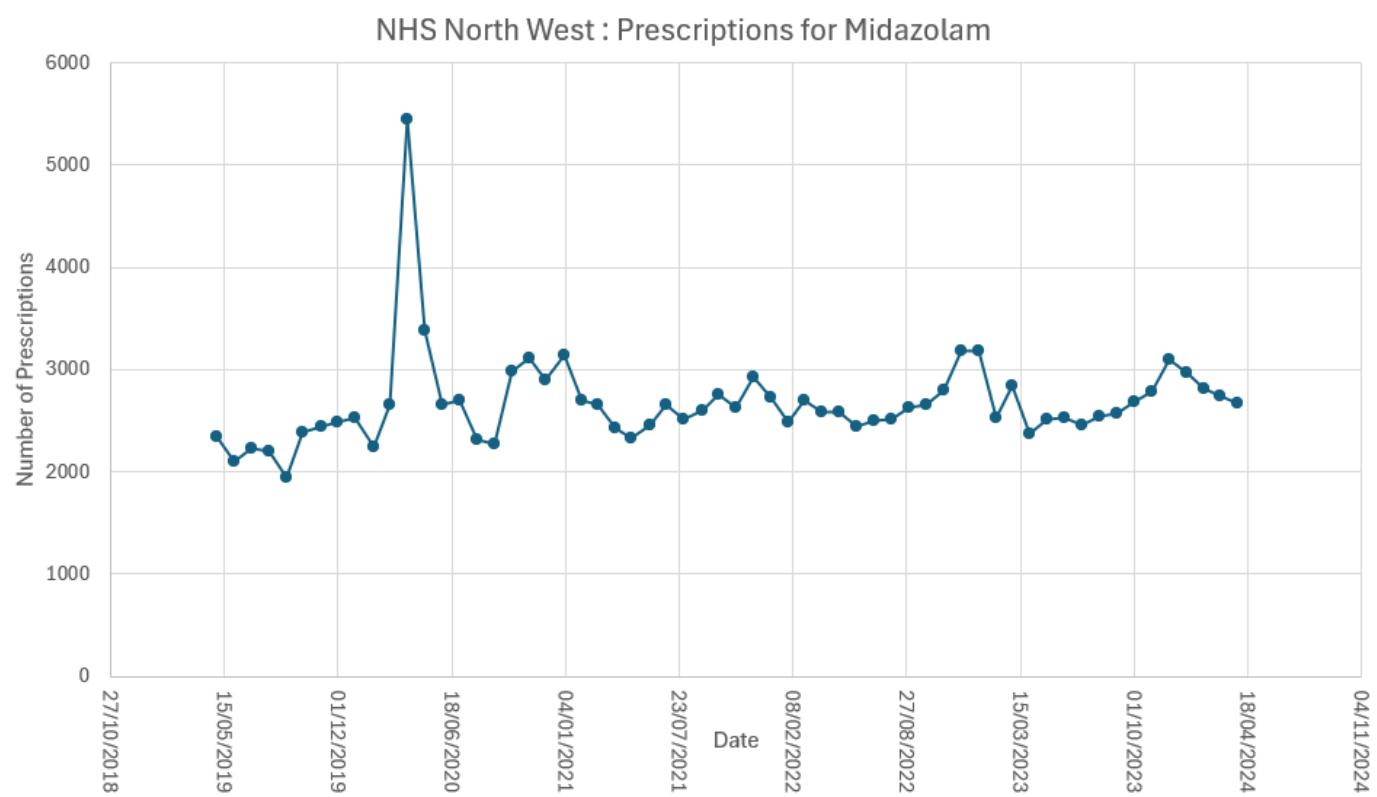
Here are the values for NHS in London –



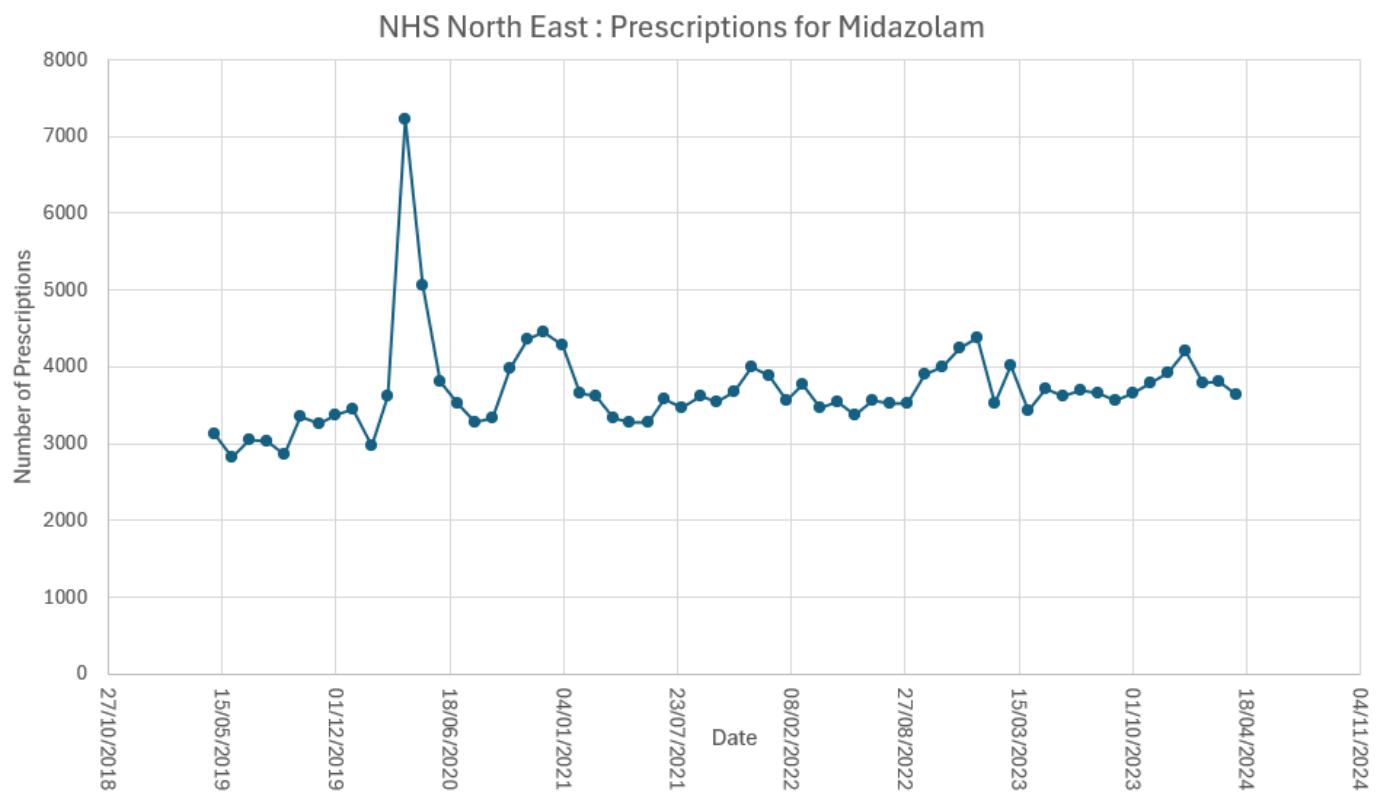
Here are the values for NHS in the Midlands



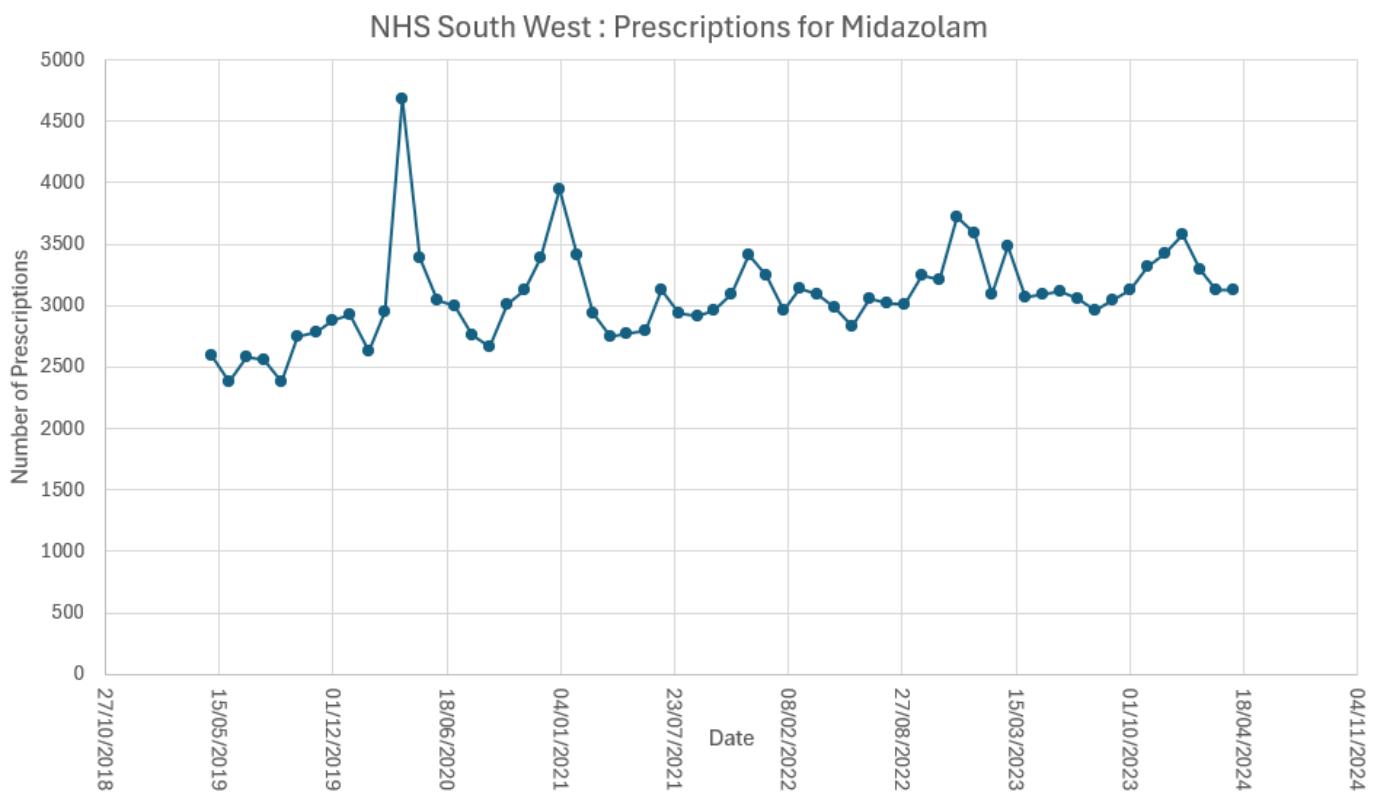
Here are the values for NHS in the North West Region UK



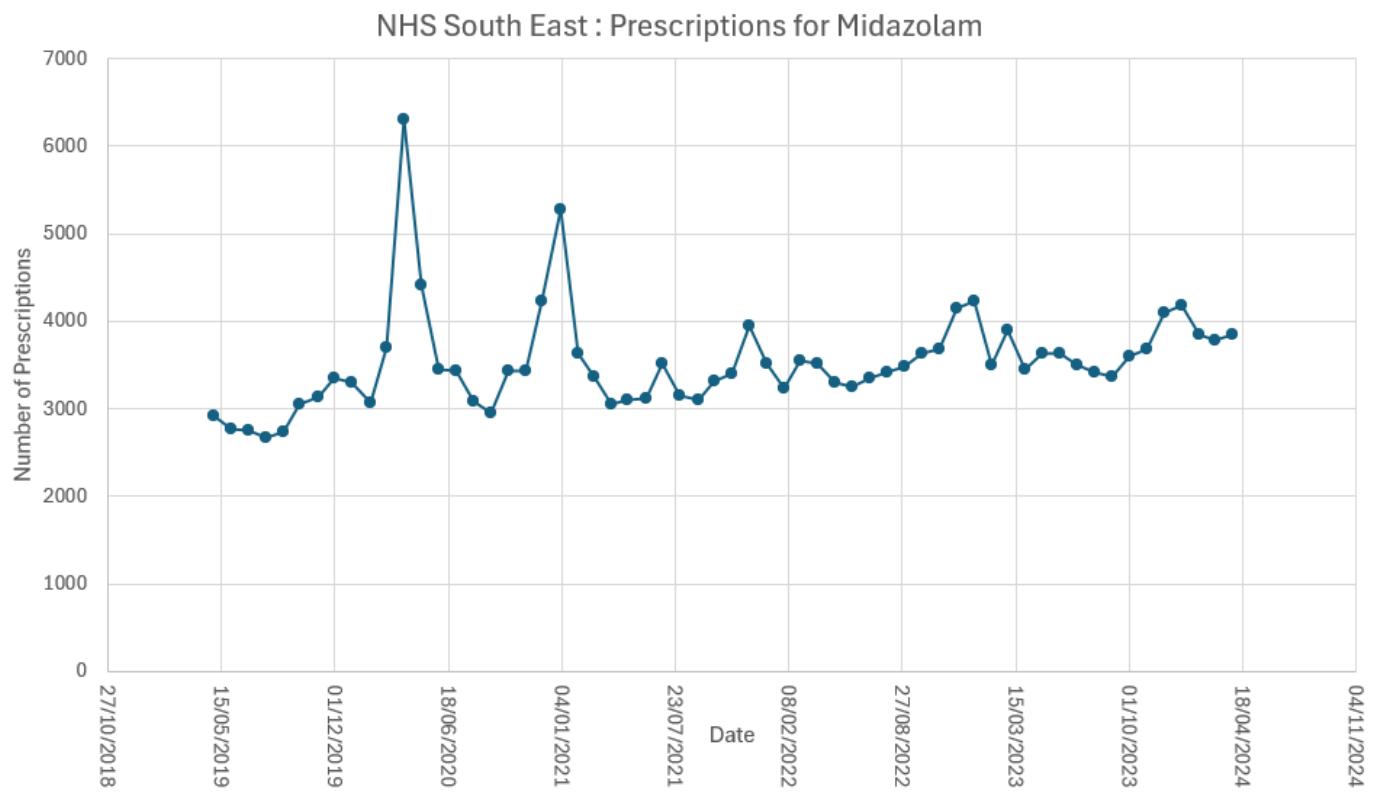
Here are the values for NHS in the North East Region UK



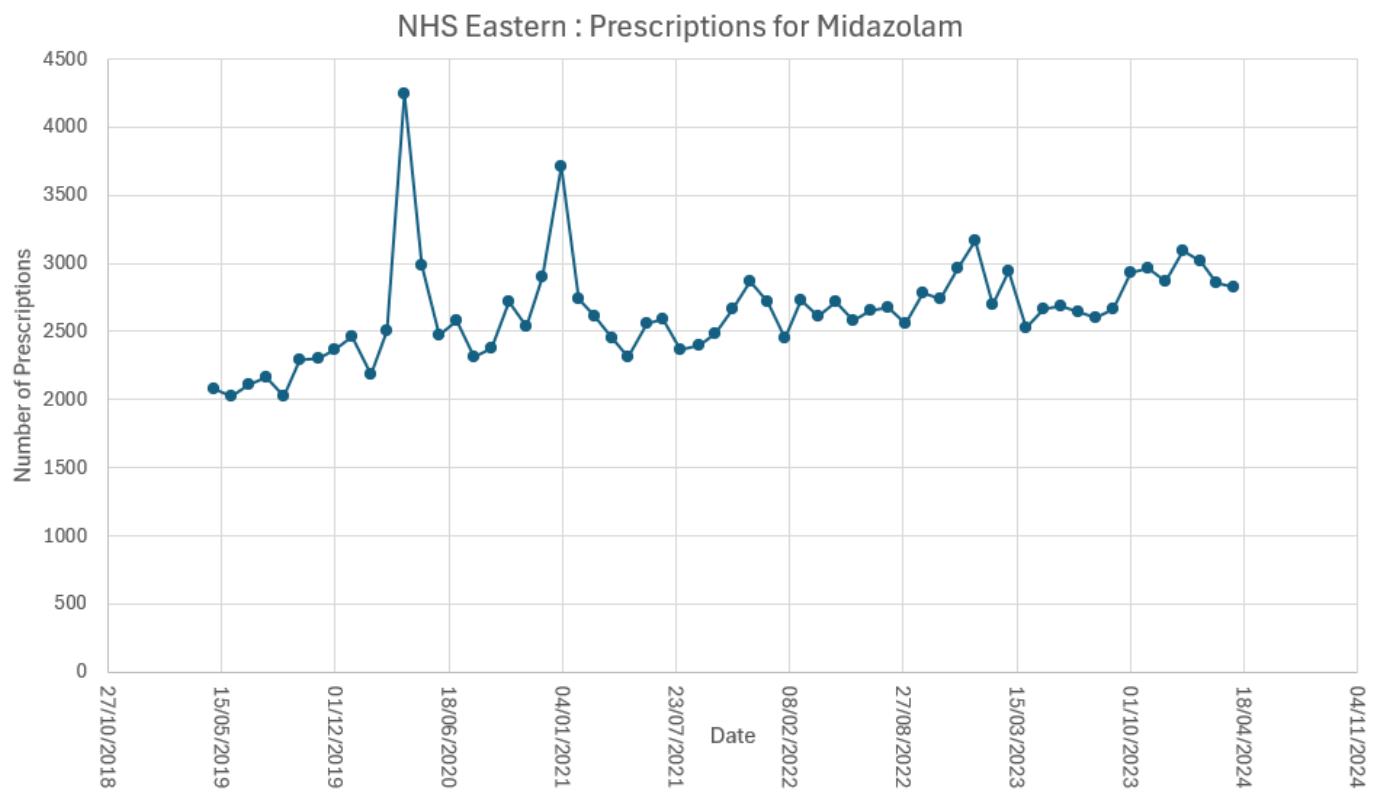
Here are the values for NHS in the South West Region UK



Here are the values for NHS in the South East Region UK

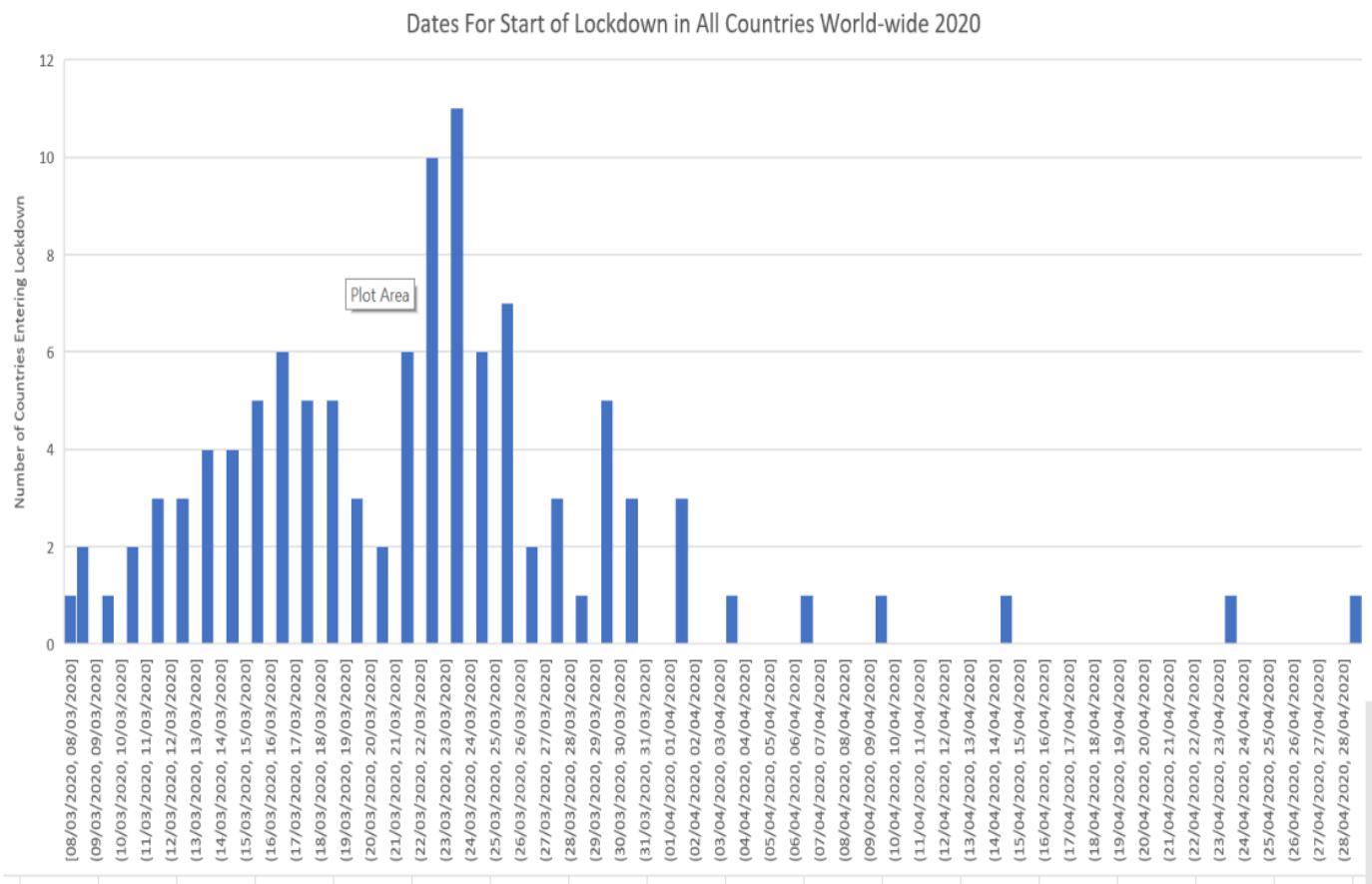


Here are the values for NHS in the Eastern Region UK



## WHEN DID THE LOCKDOWNS BEGIN ? [contents](#)

Lockdown began on March 3<sup>rd</sup> 2020 and were complete in almost all countries by March 31<sup>st</sup> 2020.



[https://en.wikipedia.org/wiki/COVID-19\\_lockdowns](https://en.wikipedia.org/wiki/COVID-19_lockdowns)

It seems anomalous that Midazolam would be prescribed so heavily immediately following the beginning of lockdown.

1. **IMMEDIATE** : Lockdowns began globally on March 3<sup>rd</sup> 2020 and were completed by March 31<sup>st</sup> 2020 for almost all countries. A huge spike in excess prescriptions for Midazolam began in April 2020, the month IMMEDIATELY following, but then resumed a more gentle increase. This suggests that the policy of prescribing Midazolam was part and parcel of the policy of lockdowns. With the start of lockdown large numbers of people were immediately administered Midazolam.

Mass administration would only be possible if the recipients were under the care and control of the drug administrator. This would suggest a sick or elderly population – in hospitals or care homes.

The association with lockdown (loss of freedom of movement) suggests that the recipients were administered this drug whilst in a state of captivity, isolation- which suggests that the administration was involuntary – perhaps as a condition of their freedom.

Mass administration also suggests that it was done regardless of personal state of health – by a one size fits all policy.

2. **NATIONAL** : Midazolam was used simultaneously in all 7 NHS regions. This suggests that individual NHS regions or health workers within those regions were not left to decide for themselves upon the use of Midazolam, but rather this decision was made centrally (by government).

The sudden national use of midazolam is anomalous because there were few cases of Covid at this time, and also because viruses would not spread instantaneously and uniformly to all regions of the UK in this manner. And finally because in March 2020 Covid had been declared to be a low fatality virus, so it is anomalous that so many would suddenly need end of life care.

3. **NOT OUTSIDE ENGLAND** : The April 2020 Midazolam peak only occurred in England. It was absent in Scotland, Wales and Northern Ireland.

Once again, this is anomalous. If a virus spread so fast and uniformly that it required the mass use of end of life medications in all 7 NHS regions simultaneously, then we would have expected it to cross borders into Wales, Scotland and Northern Ireland such that they too would need to prescribe end of life medications.

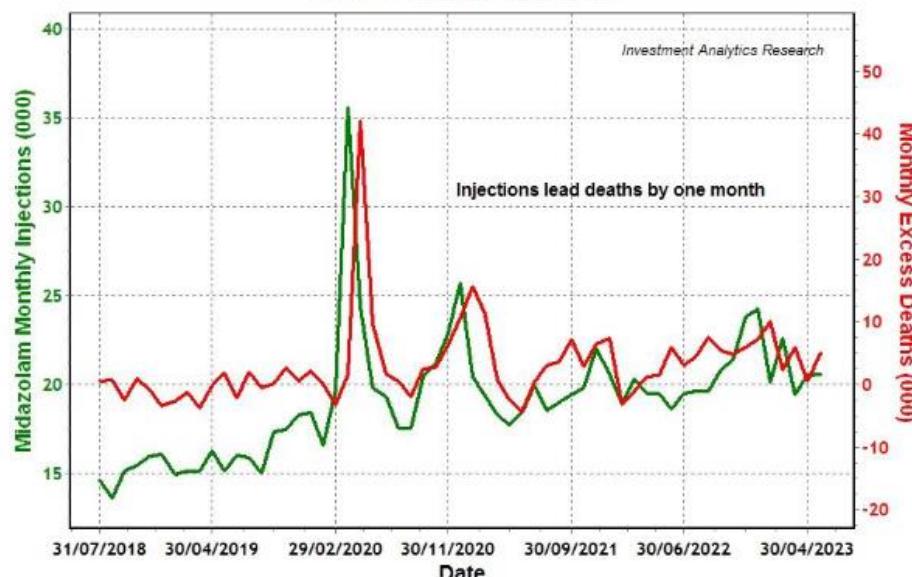
4. **GRADUAL INCREASE THEREAFTER** : Besides the massive peaks of usage in April 2020 and January 2021, all graphs show a gradual escalation of usage over the 3 year period of the “pandemic”

The openprescription.net downloaded data also provides the prescription costs. Prescription cost analysis of monthly administrative data for April 2020 also shows a similar level of prescribing.

1. There is a consistent 1 month lag between peaks of Midazolam medication and peaks of excess death.
2. The size of the peaks of medication are directly proportional to the size of the peaks of excess death.
3. There is an approximate 1 : 1 correspondence between the number of Midazolam injections and the number of excess deaths.

This degree of correlation is extraordinary !

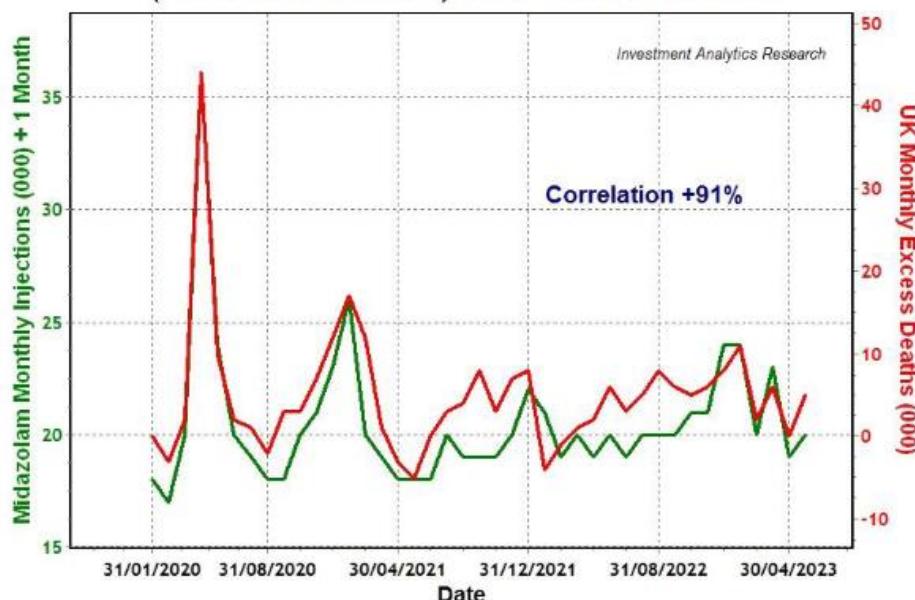
### UK England Monthly Midazolam Injections and Excess Deaths



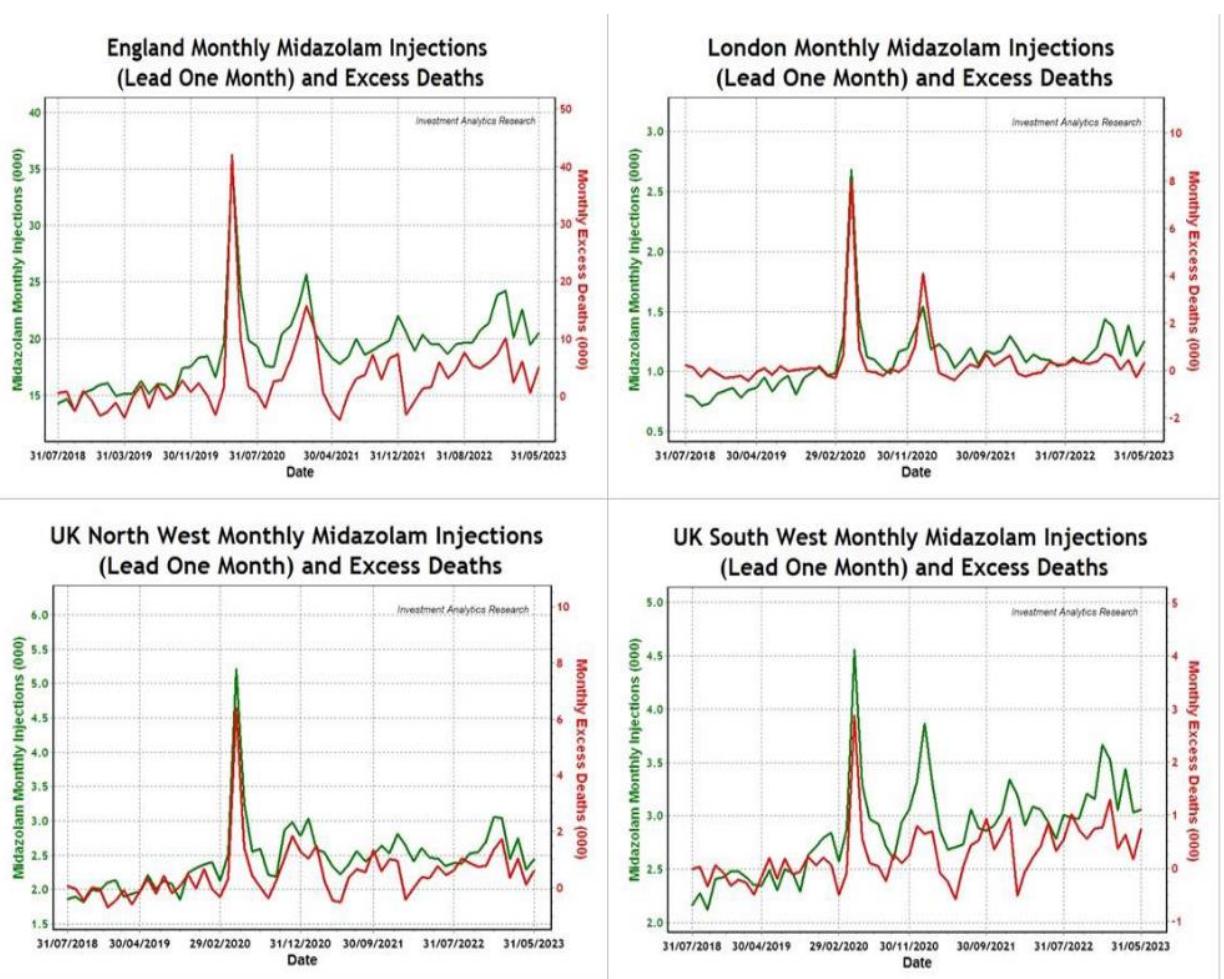
Source : Excess Deaths in the United Kingdom: Midazolam and Euthanasia in the COVID-19

Clearly, Midazolam injections and excess deaths in England are highly correlated, but not synchronously, because medication generally does not have instantaneous impact and also reporting of dosages used and registration of deaths may lag. Shifting the time series for Midazolam injections one-month forward, very high correlation is seen.

### UK Monthly Midazolam Injections (Lead one Month) and Excess Deaths



The very high correlation (coefficient **91 percent**) between excess deaths lagged one month after Midazolam injections is largely due to the first two enormous spikes to early 2021. From April 2021 onwards to May 2023, the same correlation dropped to 59 percent, but still statistically significant with p-value at 0.0007.



Source : [Excess Deaths in the United Kingdom: Midazolam and Euthanasia in the COVID-19](#)

Graphs show that correlation between excess deaths and Midazolam improves substantially when Midazolam injections lead excess deaths by 1 month. This high correlation is consistent for all NHS regions of England.

The correlation is greatest in 2020 prior to vaccination, when it reached 99%. The lower correlation after vaccination rollout may be due to the contributing factor of vaccination to fatal outcomes.

Region	Pre-pandemic June 1918 -2020 Correlation % (p-value)	Pandemic since 2020 Correlation %	2020 Pre-vaccination Correlation %	Pandemic Post-vaccination Correlation %
London	33 (0.09)	92	99	66
East	25 (0.16)	89	99	75
North West	48 (0.02)	92	98	62
South West	51 (0.01)	77	97	48
South East	39 (0.06)	87	96	74
North East (& Yorkshire)	49 (0.02)	91	98	57
Midlands	60 (0)	88	98	63
England	48 (0.02)	91	98	70

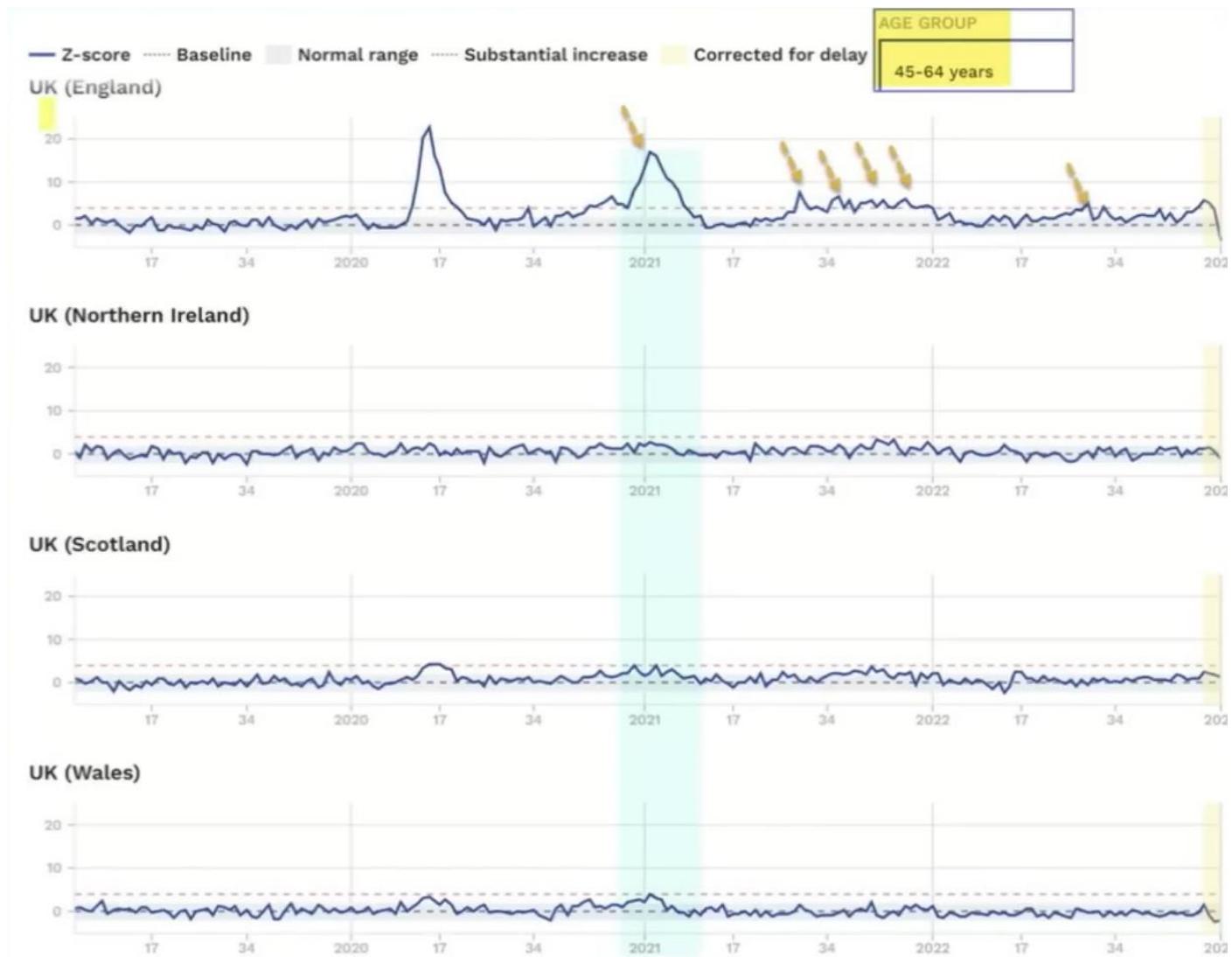
Table 5: Correlation of Midazolam Injections and Regional Excess Deaths (p-values < 0.001 or zero unless specified in brackets).

Source : [Excess Deaths in the United Kingdom: Midazolam and Euthanasia in the COVID-19](#)

The two peaks of excess death, occurring in 2020 in England and in early 2021 in England, are completely missing from the data for Wales, Scotland and Northern Ireland.

The peak of excess deaths in England in 2020 is seen in the data for all 7 NHS regions, but is absent in the data for Scotland, Wales and Ireland. If this peak was caused by a virus spreading rapidly throughout the 7 regions of England then we would not expect it to stop at national boundaries.

Policy however does stop at national boundaries, so we should see if England had a unique policy of treating Covid patients with end-of-life medications such as Midazolam which the other countries did not have.



Source : Dr Chris Martenson, toxicologist, - [Dr Chris Martenson - video](#) : (see @ 37 min 52 secs)

The simultaneous administration of Midazolam in April 2020 in all 7 NHS regions suggests a national policy was implemented immediately after the start of lockdowns.

We find this policy in the new guidelines published on April 3<sup>rd</sup> 2020 by the National Institute for Health and Care Excellence (NICE) for managing COVID-19 symptoms, including those at the end-of-life.

## COVID-19 rapid guideline: managing symptoms (including at the end of life) in the community

NICE guideline  
Published: 3 April 2020  
[www.nice.org.uk/guidance/ng163](http://www.nice.org.uk/guidance/ng163)

NICE has taken down the original guideline, but it can be found on the wayback machine here – [Way Back Link](#)

It is also available here – [How Bad Link](#)

The NICE rapid guidelines on treatments in the last days and last hours of life for managing breathlessness for adult patients are found in Table 5 – shown below

Table 5 Treatments in the last days and hours of life for managing breathlessness for patients aged 18 years and over

Treatment	Dosage
Opioid	Morphine sulfate 10 mg over 24 hours via a syringe driver, increasing stepwise to morphine sulfate 30 mg over 24 hours as required
Benzodiazepine if required in addition to opioid	Midazolam 10 mg over 24 hours via the syringe driver, increasing stepwise to midazolam 60 mg over 24 hours as required
Add parenteralmorphine or midazolam if required	Morphine sulfate 2.5 mg to 5 mg subcutaneously as required Midazolam 2.5 mg subcutaneously as required. (See <a href="#">BNF</a> for more details on dosages).
	Special considerations Consider concomitant use of an antiemetic (such as haloperidol) and a regular stimulant laxative (such as senna). Continue with non-pharmacological strategies for managing breathlessness when starting an opioid. Sedation and opioid use should not be withheld because of an inappropriate fear of causing respiratory depression.

### Conditions for use

1. Person at end of life
2. Moderate breathlessness
3. Person distressed

**Note : Their method of managing breathlessness is to induce MORE breathlessness, since both Midazolam and Morphine depress respiration.**

**Note : They advise “Sedation and opioid use should not be withheld because of fear of causing respiratory depression.”**

Notes: At the time of publication (April 2020), opioids and benzodiazepines did not have a UK marketing authorisation for this indication or route of administration (see [General Medical Council's guidance on prescribing unlicensed medicines](#) for further information).

Using <https://openprescribing.net> we can see which dosages of Midazolam have a peak in April 2020 –

Drug dosage and concentration of Midazolam	Max Doses per region
• 10mg in 2ml of solution	6918
• 10mg in 5ml of solution	87
• 2mg in 2ml of solution	75
• 50mg in 10ml of solution	2
• 5mg in 2ml of solution	1
• 5mg in 5ml of solution	250

The dosage of Midazolam used most in April 2020 was 10mg in 2ml of solution for injection ampoules. This is precisely the dosage outlined in the NICE Guideline to be used for euthanasia and end-of-life care.

Drug dosage and concentration of Morphine Sulphate	Max Doses per region
• 5mg in 5ml of solution	25
• 60mg in 2ml of solution	23
• 5mg in 1ml of solution	0
• 5mg in 10ml of solution	0
• 50mg in 5ml of solution	1
• 4mg in 10ml of solution	0
• 30mg in 1 ml of solution	133
• 300mg in 10ml of solution	0
• 2mg in 5ml of solution	0
• 2mg in 10ml of solution	0
• 2.5mg in 5ml of solution	0
• 20mg in 2ml of solution	0
• 20mg in 1ml of solution	79
• 1mg in 1ml of solution	6
• 15mg in 1ml of solution	49
• 10mg in 2ml of solution	1
• 10mg in 1ml of solution	5710

The dosage of Morphine sulphate used most in April 2020 was 10mg in 1ml of solution for injection ampoules.

The second most frequently used was 30mg in 1ml of solution. This is precisely the dosage outlined in the NICE Guideline to be used for euthanasia and end-of-life care.

At these dosages, Midazolam and Morphine Sulphate have the dual effect of pacifying the recipient whilst hastening death – especially in those suffering from acute respiratory infection who are breathless to begin with. Both Opioids and Midazolam depress respiration further.

Breathlessness is a common symptom of a respiratory infection. **Their method of managing breathlessness for patients 18 years old and older is to induce MORE breathlessness, since both Midazolam and Morphine depress respiration.**

## WHAT ARE THE DRUGS AND DOSAGES FOR ASSISTED DYING ? [contents](#)

These can be found here - [Efficacy and Safety of Drugs Used for Assisted Dying](#)

### For Assisted Dying :

- A dosage of 10mg of Midazolam
- A dosage of 15mg to 3g of Morphine

### For Euthanasia :

- A dosage of 2mg to 120mg of Midazolam
- A dosage of 16mg to 480mg of Morphine

Sedatives	Chloral Hydrate	20 g	Sedatives	Propofol	1000–2000 mg
	Amitriptyline	Not reported		Vesparax	Not reported
	<b>Barbiturates</b>			Chloral Hydrate	35–40 mg
	Pentobarbital	9–15 g		<b>Benzodiazepines</b>	
	Phenobarbital	20 g		Diazepam	10–120 mg
	Secobarbital	9–15 g		Lorazepam	1.5–5 mg
	Brallobarbital	Not reported		Midazolam	2–120 mg
	Sodium Thiopental	Not reported		<b>Barbiturates</b>	
	<b>Benzodiazepines</b>			Pentobarbital	1–15 g
	Diazepam	1 g		Thiopental	1–2 g
	Lorazepam	0.25–2 mg		Secobarbital	9 g
	Midazolam	10 mg		Phenobarbital	3000 mg
Analgesics	<b>Opioids</b>		Analgesics	<b>Opioids</b>	
	Morphine	15 mg–3 g		Morphine	16–480 mg
	Detropropoxyphene	Not reported		Fentanyl	25–1500 µg
Cardiotoxic	Digoxin	50 mg	Neuromuscular blockers	Mivacurium	Not reported50–100 mg45 g
	Propranolol	2 g		Pancuronium	18–20 mg
Antiemetics	Metoclopramide			Rocuronium	50–300 mg
	Ondansetron			Cisatracurium	30–40 mg
	Haloperidol			Vecuronium	10–60 mg
			Cardiotoxic	Curare	Not reported
				Potassium chloride	Not reported
				Bupivacaine	400 mg

See also [https://www.jpsmjournal.com/article/S0885-3924\(18\)30339-7/fulltext](https://www.jpsmjournal.com/article/S0885-3924(18)30339-7/fulltext)

**Data source :**

Eudra-vigilance data for all medicines, substances, products and vaccines between 2017 and 2024. [500 Mb compressed].

Note : The single-line datafile is case-sensitive. Each symptom should be converted to lower case.

**Download link -**

<https://www.dropbox.com/scl/fi/phs3y74e3fytluuv7otx/eudra.zip?rlkey=5hwm09juhwp7cmks6qx8uw17a&st=1hie7ev0&dl=0>

**Method 1**

1. The multi-line data file was used.
2. All records where the REACTION is null were removed.
3. All records where the DRUG is null were removed.
4. All report records for Midazolam where selected from the Eudra-vigilance data.
5. The frequency of each unique symptom in the filtered records was counted.
6. Each symptom count was divided by the total number of symptoms (10698) to give the percentage of all symptoms for Midazolam.

**Results**

**Table 1 : Incidence of each symptom for Midazolam**

REACTION	FREQ	%
Empty	522	4.88
Anaphylactic shock	337	3.15
Anaphylactic reaction	282	2.64
Drug ineffective	193	1.80
Respiratory depression	168	1.57
Anaesthetic complication neurological	151	1.41
Hypotension	114	1.07
Respiratory arrest	100	0.93
Death	88	0.82
Seizure	83	0.78
Hypotension ,Off label use	78	0.73
Cardiac arrest	69	0.64
Anaphylactoid reaction	64	0.60
Apnoea	57	0.53
Oxygen saturation decreased	55	0.51
Urticaria	54	0.50
Withdrawal syndrome	52	0.49
Overdose	50	0.47
Delirium	49	0.46
Off label use ,Respiratory depression	48	0.45
Rash	48	0.45
Delayed recovery from anaesthesia	46	0.43
Depressed level of consciousness	44	0.41
Sedation complication	41	0.38

It can be seen that almost all of the most common symptoms have to do with respiratory arrest or respiratory depression – meaning less oxygen is carried by the blood, and consciousness is depressed. One of the symptoms – apnoea – is where the breathing reflex stops during sleep !.

So we can see that the most dominant symptoms of Midazolam is depression of respiration.

But how does this level of respiratory depression compare with all the other 25,000 drugs in Eudra-vigilance? To answer this I took one symptom – “respiratory depression” – and counted the frequency of this symptom in all other drugs.

Midazolam had the highest rank out of all of these drugs. Morphine is a very close third.

Table 2 : Incidence of “Respiratory Depression” for all drugs in Eudra-vigilance

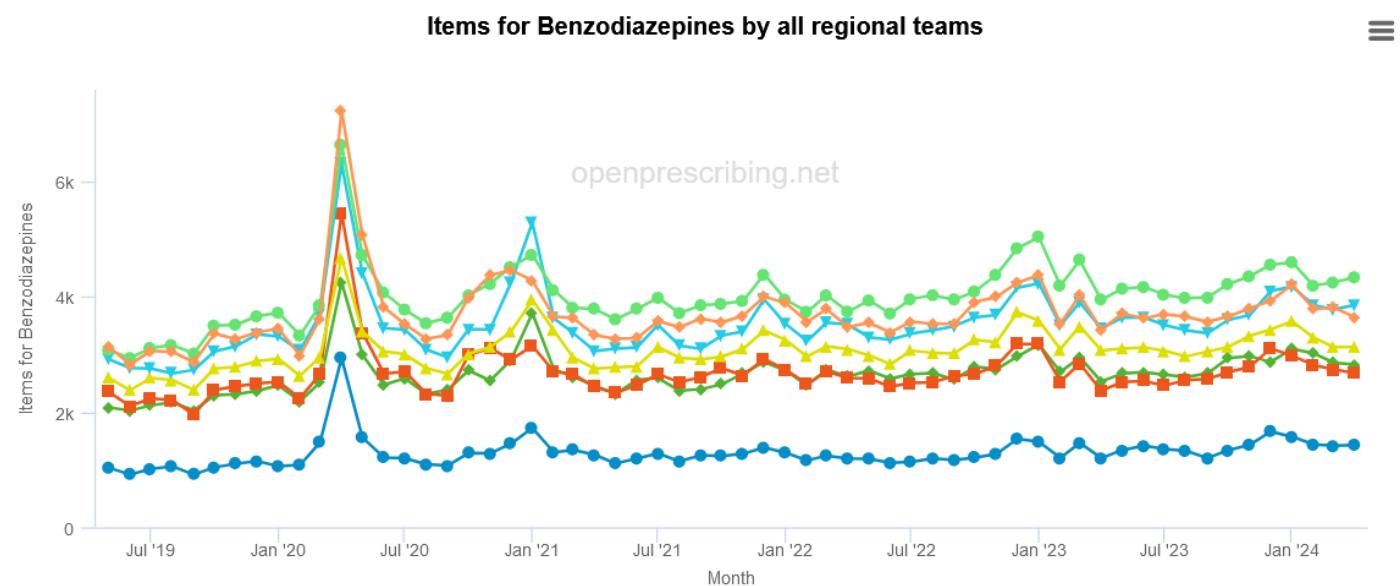
DRUG	FREQ	TOT	%
[MIDAZOLAM HYDROCHLORIDE]	68	483	14.08
[PIRITRAMIDE]	31	222	13.96
[MORPHINE]	19	145	13.10
[REMIFENTANIL HYDROCHLORIDE]	14	157	8.92
[REMIFENTANIL, REMIFENTANIL HYDROCHLORIDE]	38	494	7.69
[MIDAZOLAM, MIDAZOLAM HYDROCHLORIDE, MIDAZOLAM MALEATE]	104	1398	7.44
RISPERIDONE [RISPERIDONE]	91	1297	7.02
NALOXONE [NALOXONE, NALOXONE HYDROCHLORIDE, NALOXONE HYDROCHLORIDE DIHYDRATE]	18	261	6.90
[REMIFENTANIL]	28	436	6.42
[FENTANYL]	72	1156	6.23
[MORPHINE HYDROCHLORIDE]	44	895	4.92
[MORPHINE, MORPHINE HYDROCHLORIDE]	142	3192	4.45
[PETHIDINE, PETHIDINE HYDROCHLORIDE]	10	231	4.33
[PETHIDINE HYDROCHLORIDE]	20	470	4.26
GLUCAGON [GLUCAGON, GLUCAGON HYDROCHLORIDE]	20	504	3.97
[MORPHINE SULFATE, MORPHINE SULFATE PENTAHYDRATE]	41	1036	3.96
DEXMEDETOMIDINE [DEXMEDETOMIDINE]	27	715	3.78
[VECURONIUM BROMIDE]	13	349	3.72
[BENZATROPINE]	19	524	3.63
[DIHYDROCODEINE, DIHYDROCODEINE TARTRATE BP]	10	286	3.50
[BUPRENORPHINE HYDROCHLORIDE]	38	1125	3.38
[FLUNITRAZEPAM]	11	341	3.23
FENTANYL CITRATE [FENTANYL CITRATE]	92	2894	3.18
[METHADONE HYDROCHLORIDE]	35	1113	3.14

## Summary

- When we look at Midazolam on its own, the most frequent symptoms are all to do with respiratory depression
- When we compare Midazolam with all other drugs for the symptom of respiratory depression, we find that Midazolam occupies the highest rank – it has the greatest incidence of all drugs for this symptom..

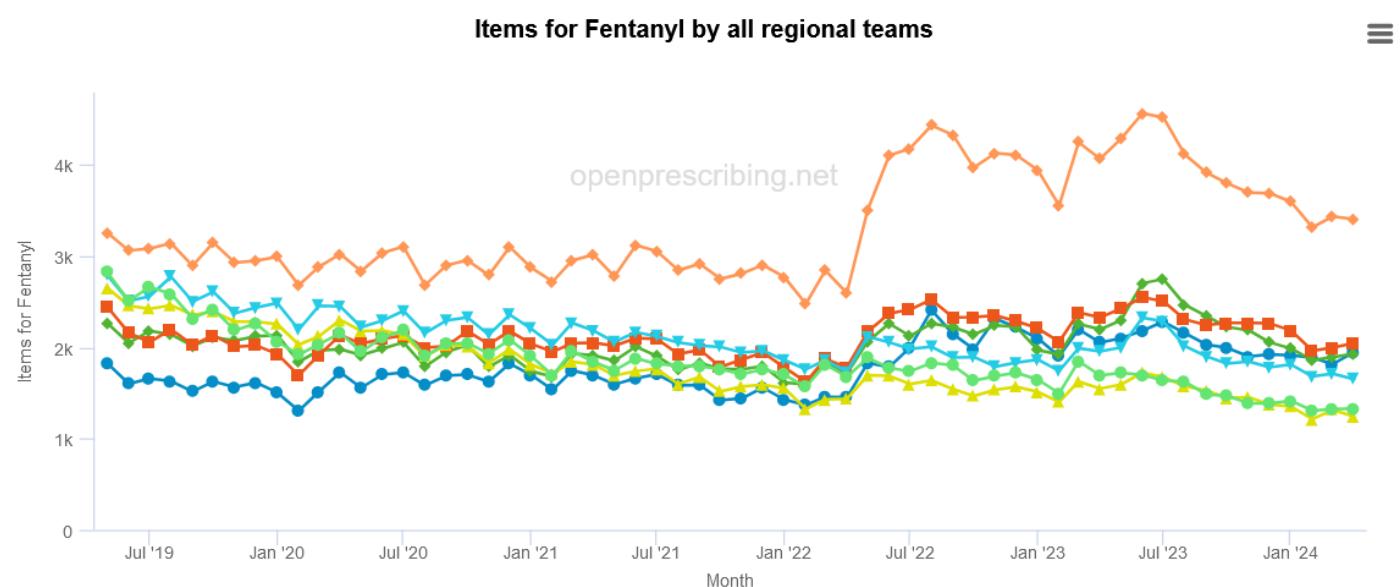
Medicines that can increase the risk of respiratory depression include benzodiazepines such as midazolam or diazepam, particularly when used in combination with other psychotropic medicines such as antidepressants, antipsychotics, anticonvulsants or sedatives such as phenobarbital.

## BENZODIAZEPINES



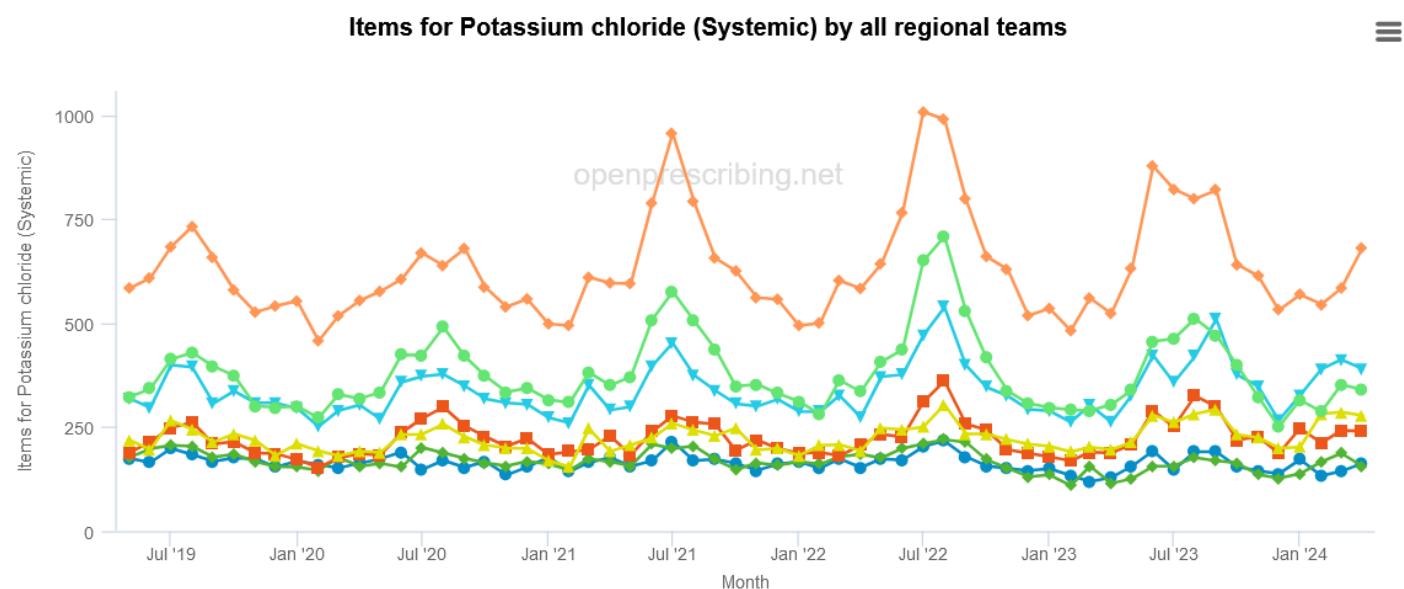
## FENTANYL

From April 2022 onwards there is a higher use of Fentanyl. Fentanyl is as powerful as Morphine for depressing respiration. This was used particularly in the Midlands NHS region.



## POTASSIUM CHLORIDE

In the context of euthanasia, potassium chloride is used to stop the heart. Shows peaks every July during the “pandemic”. This was used particularly in the Midlands NHS region.



## FURTHER RESEARCH

To get a full picture of changes in drug use in April 2020 and over the “pandemic” period, it will be necessary to download the openprescribing database in full, determine the frequency of all prescribed drugs in each month.

Eudra-vigilance data has the reports of adverse events for every drug by date. For any one drug this frequency will be proportional to the number of doses prescribed, so we can determine an increase in doses prescribed if number of reports increases.

The immediate implementation of this policy in April 2020 indicates that supplies had to be in place beforehand – supplies of –

- Midazolam and Morphine Sulphate solution ,
- Syringes
- Trained personnel willing to administer end of life medications

Obtaining supplies and organising training would have required months of preparation and pre-planning.

The focus of the dialog between Dr Evans and Mat Hancock was not on discussing or suggesting cures, but rather on assuming that death would be inevitable for many, and should therefore be assisted.

The interview feels like theatre, to create the impression that Mr Hancock was only doing what was necessary - that there was nothing odd in preparing for mass assisted dying.

Given what we now know about the low rate of death from COVID amongst unvaccinated populations, it does seem odd that they were purchasing all these end-of-life drugs in advance.

[Interview Link](#)

There is a general feeling that during the pandemic doctors and nurses abandoned their hypocritic oath by administering vaccines that caused significant observable harm. Well, many never took this oath to begin with.

And such an abandonment of the duty and standards of care is also evident in 2020, prior to the vaccination rollout –

## MEDICATION

1. Suspension of medicines that work – ivermectin, HCQ, vitamin D, antibiotics, steroids.
2. Use of medicines that hasten death – Remdesivir, Paxlovid, Tamiflu, Midazolam

## TREATMENT

3. Suspension of vital treatments and check-ups.
4. Do not resuscitate orders
5. Use of very harmful treatments such as ventilators.

## DIAGNOSIS

6. False diagnosis of infection. See
7. False attribution of death to Covid
8. False attribution of infection to healthy asymptomatic

Metaphorically, care-workers took off their white coats, relieved of their tiresome duty, and began to dance. It was as if the End had come, and concern for health no longer mattered.

Perhaps the clearest example of “withdrawal of care” is the imposition of “Do Not Resuscitate” orders

The use of blanket DNAR notices in hospitals and care homes was a systemic policy of euthanasia, when it was not investigated or stopped by government regulators. See [DNR](#)

## JOINT INVESTIGATION

From a joint investigation by the House of Commons and House of Lords, the UK Parliament admitted [36] in September 2020:

*“Blanket use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) notices in care homes constitutes a systematic violation of individuals’ rights. The Government must ensure that their blanket use is not allowed.”*

Again, the UK government’s response to COVID-19 was a systematic violation of human rights – the right to life, not euthanasia which is a criminal offence. Many cases were nonvoluntary euthanasia, which were different from voluntary assisted dying. The UK Parliament reported [36]:

*“We have received deeply troubling evidence from numerous sources that during the Covid-19 pandemic DNACPR notices have been applied in a blanket fashion to some categories of person by some care providers, without any involvement of the individuals or their families.”*

*“The blanket imposition of DNACPR notices without proper patient involvement is unlawful. The evidence suggests that the use of them in the context of the Covid-19 pandemic has been widespread.”*

## CARE QUALITY COMMISSION

The Care Quality Commission (CQC), which is an independent regulator funded from fees of hospitals and care homes to oversight them, was asked belatedly to review DNACPR decisions during the COVID-19 pandemic:

*“It was prompted by concerns about the blanket application of DNACPR decisions, that is applying them to groups of people rather than on an assessment of each person’s individual circumstances, and about making decisions without involving the person concerned.”*

Emphasis added. In its interim report released in November 2020, the CQC agreed with UK government investigation and observed somewhat apologetically [37]:

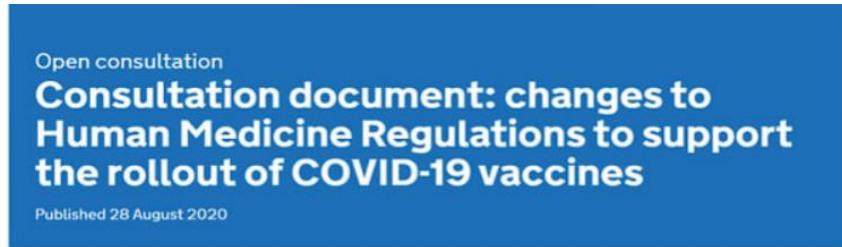
*“It is clear that there was confusion and miscommunication about the application of DNACPRs at the start of the pandemic, and a sense of providers being overwhelmed. There is evidence of unacceptable and inappropriate DNACPRs being made at the start of the pandemic.”*

Amnesty International UK published [35] a 2020 report titled: “As if expendable: The UK government’s failure to protect older people in care homes during the COVID-19 pandemic” which stated:

*“The UK government, national agencies, and local-level bodies have taken decisions and adopted policies during the COVID-19 pandemic that have directly violated the human rights of older residents of care homes in England—notably their right to life, their right to health, and their right to non-discrimination. These decisions and policies have also impacted the rights of care home residents to private and family life, and may have violated their right not to be subjected to inhuman or degrading treatment.”*

In August of 2020 the UK Government held an “open consultation” on changes to Human Medicine Regulations. The proposed changes were to exempt Pharma of any liability – removing any safe-guard against malpractice, any safeguard against the distribution of dangerous drugs.

I created a leaflet that was posted through doors in my neighbourhood and placed in shop windows –



The Government intends to –

1. allow the use of **UNLICENSED MEDICINES** for use as vaccines against Covid-19
2. allow non-medical personnel to administer these vaccines
3. exempt pharmaceuticals of **ANY** liability should the vaccine cause illness, maiming or death.

#### **Your Protection is Being Removed**

The only safeguard against malpractice, and the distribution of dangerous drugs is being removed.

#### **Why Remove Liability if its Safe?**

If the Government is so certain that the unlicensed medicines are safe, then why are they removing any liability for potential harms caused?

This consultation closes on 18<sup>th</sup> September 2020. Go online to speak out.

You wont be able to stop these laws going through. All you can do is tell your friends, your family, your community – those you love – warn them.

In his paper - [Excess Deaths in the United Kingdom: Midazolam and Euthanasia in the COVID-19](#) - Dr Wilson St concludes -

*"The COVID-19 pandemic in UK was iatrogenic (drug induced), as it did not originate from the SARS-CoV-2 virus, but originated from Midazolam use in euthanasia and then likely later from mass vaccination. The main findings supporting this conclusion are:*

- *There were relatively few cases of infections in early 2020, indicating the non-prevalence of the SARS-CoV-2 virus in the UK.*
- *The UK Health Security Agency declared on 19 March 2020, the absence of any "high consequence infectious disease", denying the existence of a pandemic.*
- *The enormous spike in excess deaths attributed to COVID-19 was inconsistent with the lack of prevalence of the SARS-CoV-2 virus, which was not verified, due to shortages and unreliability of PCR tests.*
- *NHS and Nightingale hospitals were mostly empty, confirming absence of a pandemic.*
- *The excess deaths were spread uniformly and simultaneously across all English regions, inconsistent with natural contagion.*
- *The spikes in excess deaths across all regions were strongly correlated with Midazolam injections, implicating euthanasia, particularly of the elderly in care homes.*
- *On investigation, the UK Government, Amnesty International and the Care Quality Commission have all acknowledged that "a systemic or structural dysfunction in hospital services" and the widespread blanket use of "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) notices in care homes have contributed to excess deaths in the UK"*

If the elderly and sick were targeted in this way, then what happened in the UK should serve as a warning to communities throughout the world.

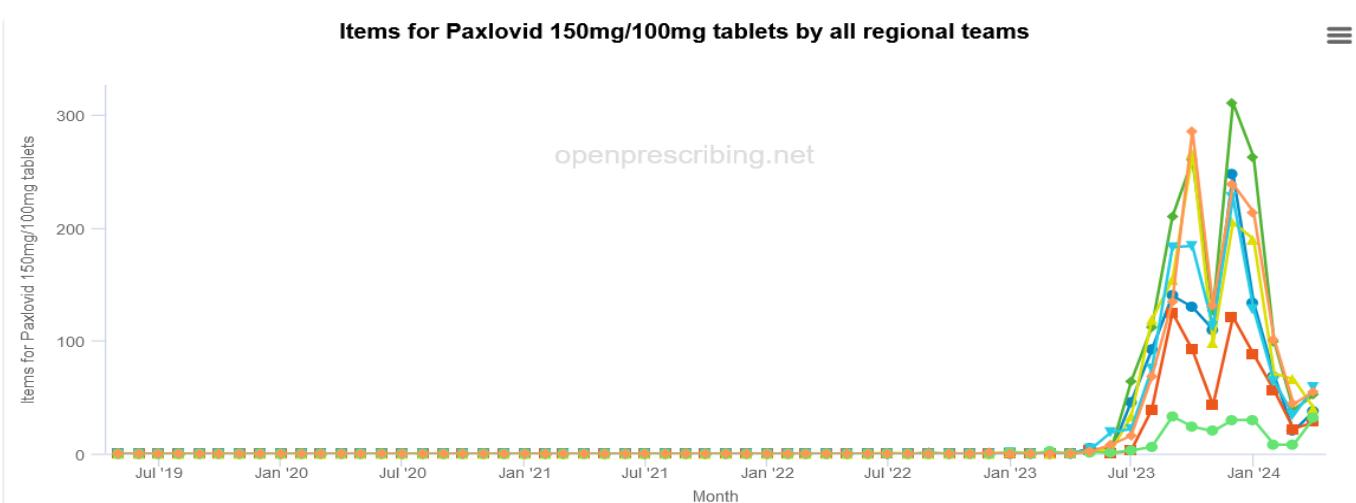
There is a malign intention towards the elderly that regards them as expendable – as unproductive and useless eaters – despite their years of service – and seeks to eliminate them prematurely. This threat is very real. Protect and care for your elderly and sick. Don't abandon them to institutional care.

There is a wolf is at the door.

Remdesivir was the anti-viral used in USA and Europe. The toxicity of Remdesivir is shown here – <https://howbad.info/rem2.pdf>. Remdesivir belongs to a family of drugs called “anti-retro-viral” drugs that cause kidney and liver injury. This family of drugs includes Paxlovid (Ritonavir), and Tamiflu.

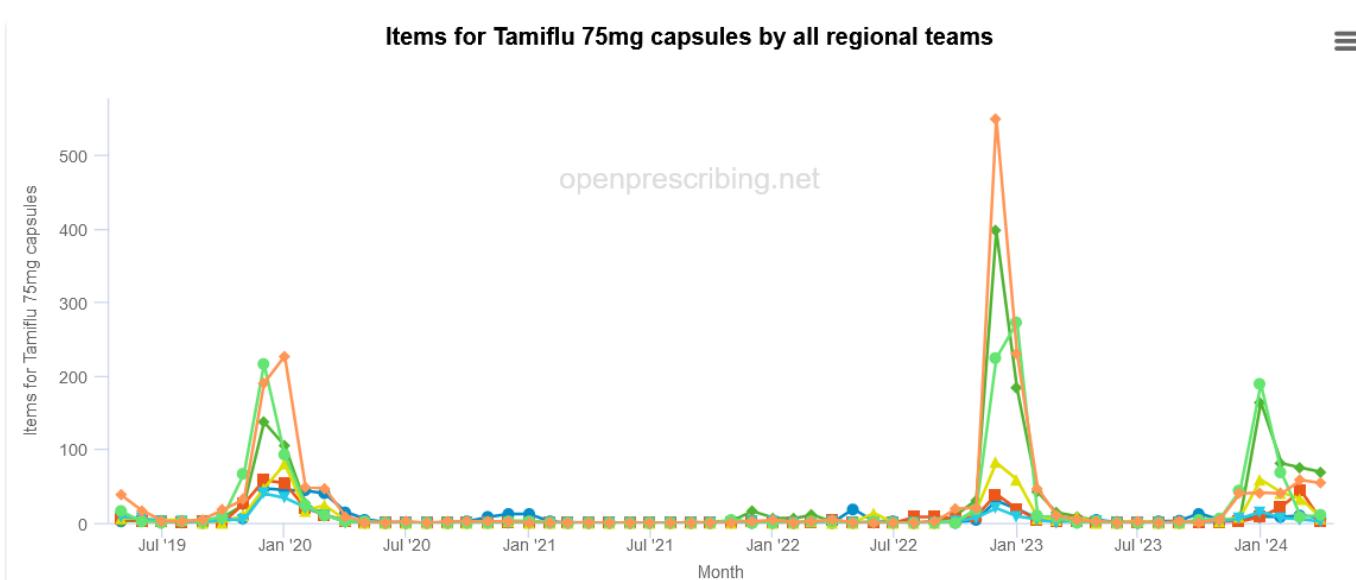
There are no records of prescriptions of either Remdesivir or Veklury in the openprescribing.net database. However Eudra-vigilance shows many records of adverse events for this drug in Europe from May 2020 onwards. The use of Remdesivir as an anti-viral in 2020 will have induced much toxicity through impairing liver and kidney functions.

After the Covid Pandemic ended in the UK in May 2023, Paxlovid began to be prescribed in England, and shows up in the openprescribing database from July 2023 onwards. In this post-pandemic phase, Paxlovid will have induced much toxicity through impairing liver and kidney function. See – [Link](#)



In December 2022, the MHRA approved the Covid vaccine for children aged 6 months to 4 years. Tamiflu was introduced in the UK during the flu season in the winter of 2022 and again in the winter of 2023, and targeted at children 1 year and older. See – [Link](#)

Prior to that it had been prescribed in the winter of 2019 and January 2020. The subsequent ill health of children, due to liver and kidney toxicity, may have served as a motivating factor at the start of the “pandemic”.



## Appendix : Python Code for Reading the Data [contents](#)

### 1. Getting frequency of each symptom of Midazolam

```
import pandas as pd
pd.set_option('display.max_rows', None)

Total = pd.read_csv(r"C:\Users\User\Downloads\drug-results\total-singleline-12-06-2024.csv")

Total.head()

Total = Total.fillna("Empty")

#Total["DRUG"] = Total["DRUG"].str.lower()

filtered = Total[Total["DRUGS"].str.contains("MIDAZOLAM")]
filtered.shape

result = filtered['REACTION'].value_counts().reset_index().rename(columns={"DRUG1": "Count", 0: "TOTAL RECORDS"})
result.head()

result.to_csv(r"C:\Users\User\Downloads\drug-results\midazolam.csv")
```

### 2. Comparing Midazolam with all other drugs for frequency of the symptom “respiratory depression”

```
import pandas as pd
pd.set_option('display.max_rows', None)

Total = pd.read_csv(r"C:\Users\User\Downloads\drug-results\total-singleline-12-06-2024.csv")

Total.head()

Total = Total.fillna("Empty")

Total["REACTION"] = Total["REACTION"].str.lower()

filtered = Total[Total["REACTION"].str.contains("respiratory depression")]
filtered.head(100)

filtered.shape

result = filtered['DRUGS'].value_counts().reset_index().rename(columns={"DRUG1": "Count", 0: "TOTAL RECORDS"})
result.head(100)

result.to_csv(r"C:\Users\User\Downloads\drug-results\respiratory-depression.csv")
```