Rt. Hon. Mr Sajid Javid,
Secretary of State,
Department of Health and Social Care
39 Victoria Street
London SW1H 0EU

Also by email to: sajid.javid.mp@parliament.uk

Date 16th August 2021

Dear Mr Javid,

Please ensure that this document and all its questions are circulated to all of the following for full answers, namely:

- Matt Hancock and all staff who worked for him during the time- period January 2020 to 26th June 2021
- Duncan Selbie - Chief Executive, Public Health England.
- Professor Stephen H Powis - National Medical Director of NHS England
- Sir Simon Stevens - former NHS chief executive
- Amanda Pritchard - current NHS Chief Executive
- June Raine – CEO MHRA
- Neil Ferguson
- Patrick Vallance - Government Chief Scientific Adviser
- Chris Whitty - Chief Medical Officer

NOTICE OF INTENDED PRIVATE CRIMINAL PROSECUTION

MASS MURDER BY GOVERNMENT POLICY

1. According to the World Health Organisation (WHO), "Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus". However, the genome sequence for SARS-COV-2, released in January 2020, proved that the test to identify its presence was created in the absence of virus samples[1]. We therefore contend that no virus isolate of SARS COV 2 exists, and that a disease called Covid 19 has not caused excess deaths in the UK.

[1] Eurosurveillance | Detection of 2019 novel coronavirus (2019-nCoV) by real-time RT-PCR

2. Our assertion is supported by public documents confirming that no pure isolate of the virus exists[2]. Furthermore, publicly available death data proves that the so called "first wave of COVID", and excess deaths in England, only occurred ONCE the pandemic was announced and lockdowns commenced on 23rd March 2020, and that a “virus” which was not a HCID, may have been in circulation as early as October 2019.[3]

3. On 3rd March 2020, the UK Government scientific advisor echoed the Prime Minister, when he said: "Let me be absolutely clear that for the overwhelming majority of people who contract the "virus", this will be a mild disease from which they will speedily and fully recover as we’ve already seen". In line with this, on 13/03/2020, the threat from the virus was officially downgraded from a HCID to a NOID by the UK Government and the details on the same published on the UK Government website.[4].

Advisory Committee on Dangerous Pathogens

Professor Jonathan Van Tam
Deputy Chief Medical Officer
Department of Health and Social Care

ACDP Secretariat
Public Health England
61 Colindale Avenue
London NW9 5EQ

Email: acdp@phe.org.uk

13 March 2020

Dear Jonathan,

Classification of COVID-19 as a HCID

I am writing as Chair of the Advisory Committee on Dangerous Pathogens (ACDP). The committee discussed today the classification of COVID-19 as a high consequence infectious disease. The unanimous view of the committee was that this infection should NOT be classified as a HCID.

Best wishes

Yours sincerely,

[redacted]

Professor Tom Evans
Chair

[2] FOIs reveal that health/science institutions around the world have no record of SARS-COV-2 isolation/purification, anywhere, ever – Fluoride Free Peel

[3] 'Plausible' evidence that Covid may have been circulating in Italy in October 2019 (telegraph.co.uk)

[4] High consequence infectious diseases (HCID) - GOV.UK (www.gov.uk)

4. However, this decision to downgrade from HCID to NOID was highly controversial because of the WHO's declaration of a worldwide High Consequence Infectious Disease [HCID] two days previously on 11/03/2020, upon the advice of Neil Ferguson of Imperial College. In other words, the downgrading is an implicit contradiction of Ferguson's triggering of a worldwide health emergency.

5. Remarkably, following the private announcement of the downgrading on 13th Match 2020, and the subsequent public announcement of the downgrading on 19/03/2020, there appears to have been a premeditated decision to use this unproven 'pandemic' as justification to impose measures and medication which went on to kill people. This in turn justified the lockdown measures, which themselves were one of the driving forces of the deaths they claimed to be trying to avoid. This premedication to cause deaths of course amounts to murder by government policy.

6. There is support for this argument when we look at government policy decisions, which simply put, make no sense. On 17th March 2020, 4 days after the private downgrading mentioned above, the NHS wrote to all hospitals asking them to free-up the maximum possible number of beds by urgently discharging any patients they could[5].

7. Many of these patients were discharged to care homes, some of which were given ultimatums forcing them to take more patients than they were equipped to provide care for. In addition, the NHS cancelled all 'non-urgent' treatments.

[5] 20200317-NHS-COVID-letter-FINAL.pdf (england.nhs.uk)

8. Why was this policy invented at all given scientific advice on 3rd March, and why was it not reversed, given the downgrading on 13/03/2020 by the Advisory Committee on Dangerous Pathogens?

9. It is our contention that the excess deaths in the first wave occurred AS A RESULT of the relentless implementation of this policy, which was coupled with the inappropriate use of respiratory depressing medications such as Midazolam during the same period. This is how the excess deaths occurred. They were NOT because of a novel virus, isolation of which, according to long held standards, has never occurred.

10. Our extrapolated data on community Midazolam prescribing supports the above theory, along with the data on how and where deaths during this time period occurred.

11. Following the letter of 17th March from the NHS, bed occupancy in England reduced from the usual 90% to an average of 63% in the spring quarter of 2020. In addition, there was no influx of 'large numbers of inpatients requiring respiratory support'. Accident and emergency (A&E) departments saw a huge decrease in attendances and overall admitted patient care decreased significantly during the same period.

12. Of those patients who were admitted to hospital and residents who were discharged to care homes, the outcomes can only be described as devastating. We assert that those outcomes were engineered. When we look at mortality, figures

show that hospital and care home death ratios increased during the "first wave" lockdown period[6].

13. The excess death ratio in private homes also exceeded that of hospitals in the first wave and has remained in excess every week since the announcement that a "new virus" was circulating. This is not in line with where deaths would occur if there were indeed a novel virus killing thousands of people. The fact is that hospitals WOULD be overwhelmed, and the majority of deaths would occur therein. The data is clear, this is NOT the case.

14. Shockingly, 6 out of 10 "with COVID" deaths during the first lockdown were of people with any sort of disability[7]. It is impossible for a 'virus' to discriminate in such a manner, and therefore we contend these deaths must have been as a result of very nefarious policies. These policies were blanket DNRs and mandatory prescribed medications, two factors which have contributed to most other “non disability" deaths during the first lockdown period.

15. Data proves that up to 13th May 2020, deaths in care homes from all causes were 159% higher than at the start of “the COVID-19 outbreak”[8]. In April 2020, the ratio of excess deaths in English care homes was almost three times that of the prior five years’ average. It is not a mere coincidence that during the same month, prescribing of Midazolam increased by more than 100%[9]. There is a clear correlation between policy, prescribing of Midazolam and deaths, which simply cannot be overlooked.

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[6] Excess mortality in England, week ending 03 July 2020 (phe.org.uk)
[7] 6 out of 10 people who have died from COVID-19 are disabled | The Health Foundation
[8] Care homes have seen the biggest increase in deaths since the start of the outbreak | The Health Foundation
[9] Number of prescriptions for the drug midazolam doubled during height of the pandemic | Daily Mail Online

16. Further, during the period 2 March to 12 June 2020, 18,562 residents of care homes in England died, supposedly "with COVID-19", including 18,168 people aged 65 and over. This represented almost 40% of all deaths involving "COVID-19" in England during this period [10]

17. In addition to the above, during the first lockdown there was an unbelievable policy change in care homes[11]. The change restricted access for residents' families. This removed crucial oversight of treatment along with safeguards. Also, support services such as SALT, chiropody, physiotherapy and in house GP visits, were removed.

18. Simply put, care homes and their residents were thrown to the wolves. Staffing levels dropped due to a policy of self-isolation for anything akin to a sniffle, and this further pressured care homes who then had a ratio of staff to patients that was unworkable.

19. We contend this was not an accident, and instead was by design. Only a fool, or perhaps a madman, would implement such policies and not realise the consequences. Only a fool or a madman would say they were necessary after the down grading of Covid 19 from an HCID to a NOID on 13th March 2020.

20. As we have already stated, we assert that the above were premeditated policies, to cause excess deaths in care homes, (as well as in the community generally). It is without doubt that family surveillance in care homes, at a time when staff limits were stretched, could have stopped avoidable deaths. Furthermore, had

[10] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto12june2020andregisteredupto20june2020provisional/relateddata

[11] Care homes: Visiting restrictions during the covid-19 pandemic (parliament.uk)

support services been available, we very much doubt that the over prescribing of respiratory depressing medication would have been either necessary, or allowed.

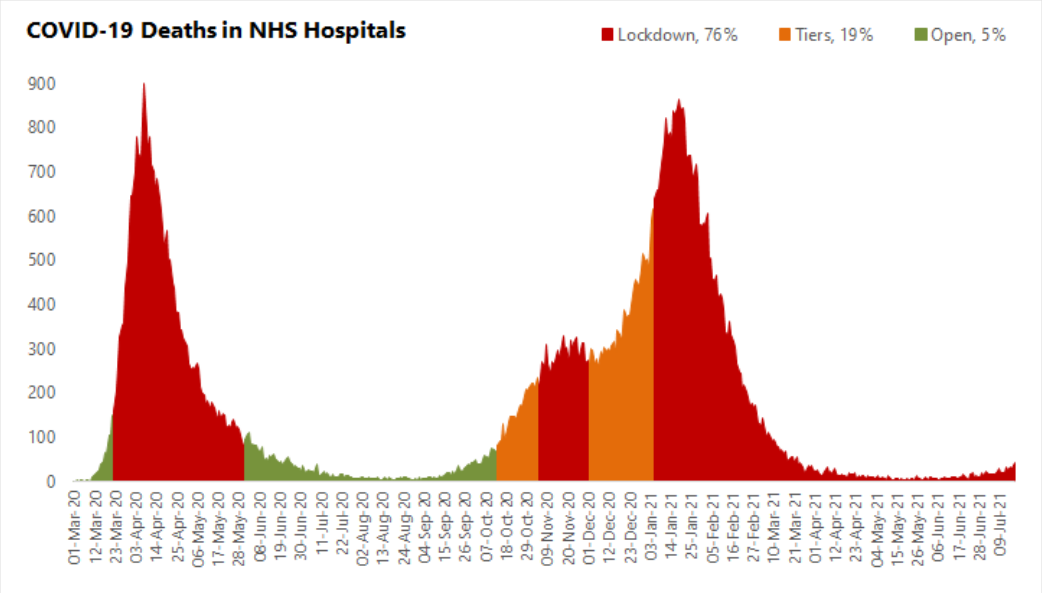
21. Bizarrely, in addition to the above, all official inspections were suspended during the first lockdown, leading to less and less oversight. Very worryingly the use of blanket DNRs,[12] (now an acknowledged fact by Matt Hancock), as well as do not admit to hospital orders, were imposed, and undoubtedly led to countless avoidable deaths.

22. Lockdown restrictions eased at the start of June 2020 and up to the start of the second national lockdown, there was NEGATIVE excess deaths in care homes (a ratio of 0.96 versus expected levels). This fall in deaths occurred in the absence of any vaccines or alternative treatment for so called Covid 19.

23. We therefore contend that the initial wave of deaths during the first lockdown were driven by policy decisions by this government and Midazolam prescribing. These deaths were in fact accelerated deaths, rather than excess deaths, and these accelerated deaths were created for political and policy gain, to feed a narrative of a deadly pandemic which simply did not, and still does not, exist.

24. Jay Bhattacharya, a Stanford professor, has labelled lockdowns "the single biggest public health mistake in history"[13]. 95% of hospital COVID-labelled deaths occurred DURING lockdown. How is this possible if lockdowns save lives?

[12] Third of UK hospital Covid patients had 'do not resuscitate' order in first wave | Coronavirus | The Guardian
[13] Lockdowns are 'the single biggest public health mistake in history', says top scientist (telegraph.co.uk)



25. We contend that lockdowns kill, but moreover that they are designed to do so. However, lockdowns alone do not provide the significant number of deaths needed to create the illusion of a pandemic. This is the primary reason we have looked at Midazolam prescribing during this period.

26. It is a well-known fact that Midazolam is a respiratory depressing drug[14]. It creates the very respiratory symptoms of so called "COVID-19". Used in copious amounts in conjunction with lockdowns, Midazolam led to premature deaths. The data we have extrapolated on community Midazolam prescribing supports this, along with the pertinent observations above, about *where* and *how* excess deaths occurred.

27. Given our assertions that government policy and Midazolam prescribing have created deaths, and our assertion that this was designed and premeditated by

[14] https://pubmed.ncbi.nlm.nih.gov/7457966/

certain individuals within and advising this government, we have some questions that we wish to put to you.

28. Our allegations described above are of the most serious kind. In the absence of any appropriate answers, or indeed in the absence of satisfactory answers from you to our questions and given the supporting evidence we are presenting with this letter, we wish to make clear that we will assume you cannot prove beyond reasonable doubt, that what we have asserted about a government premeditated policy of murder is false.

29. Let us be clear, this is your chance to answer the questions posed and give proof that our allegations and assertions are wrong. If you can do that by bringing evidence to the contrary of ours, we will accept that we have perhaps misinterpreted our evidence.

30. However, you will need to produce sufficient material evidence to rebut our assertions, and in the absence of the same, we will pursue a private criminal prosecution based on the allegations made herein.

Questions

31. According to an article from The Pharmaceutical Journal, dated 19th May 2020,[15] Accord healthcare sold its entire 2-year stock of Midazolam injection ampoules to "wholesalers" at "the request of the NHS in March 2020".

32. With the above in mind, please answer the following questions: -

    a. Who in the NHS requested the order?

    b. Was it in fact the DHSC that requested it, and if it was, which minister signed off the order?

    c. What was the cost of the 2 year order?

    d. What was the rationale for ordering 2 years' worth of Midazolam injection ampoules? Was it discussed and considered what the purpose was? In other words, was the order deemed to be necessary for hospitals, community prescribing, or both. If the latter, in what proportions was it envisaged that each sector would need extra stock? 50/50, 75/25 etc. Please be specific for each sector.

    e. Which wholesalers in the UK was the 2-year order supplied to, and if more than one, in what quantities?

    f. What proportion 10mg 2 mL Midazolam hydrochloride injection ampoules made up the 2-year order in March 2020?

    g. What proportion 1mg/mL in 5mL Midazolam hydrochloride ampoules made up the 2-year order in March 2020?

[15] https://pharmaceutical-journal.com/article/news/supplies-of-sedative-used-for-covid-19-patients-diverted-from-france-to-avoid-potential-shortages

h. Before the 2-year order, how much stock of 10mg 2 mL Midazolam hydrochloride ampoules were held in the UK, and by what wholesalers?

i. Before the 2-year order, how much stock of 1mg 5 mL Midazolam hydrochloride ampoules were held in the UK, and by what wholesalers?

j. How much stock of 10mg 2 mL Midazolam hydrochloride ampoules is, in an average year, held in the UK in Spring quarter, summer quarter, autumn quarter and winter quarter?

k. How much stock of 1mg 5 mL Midazolam hydrochloride ampoules is, in an average year, held in the UK in Spring quarter, summer quarter, autumn quarter and winter quarter?

l. How many items of 10mg 2 mL Midazolam hydrochloride ampoules are, in an average year, prescribed, where is it prescribed to, and in what proportions? For instance, 500 items to hospitals, and 400 items to the community. Please be specific about numbers and sector.

m. How many items of 1mg 5 mL Midazolam hydrochloride ampoules are, in an average year, prescribed, where is it prescribed to, and in what proportions? For instance, 500 items to hospitals, and 400 items to the community. Please be specific about numbers and sector.

n. What does 1 item of 10mg 2 mL Midazolam hydrochloride ampoules on a prescription constitute? Is it one ampoule or one box of 10 ampoules? Please answer the same for 1mg 5 mL Midazolam hydrochloride.

33. Following the order of 2 years' worth of Midazolam in March 2020, a further request of Accord was made to divert supplies from France. The Medicines and Healthcare products Regulatory Agency (MHRA) had given the manufacturer

approval “for some French label stock — another 22,000 packs — to be sold into the NHS". This was at 1mg in 5mL injection ampoules.

34. Given the above please answer the following:-

    a. How much 1mg 5mL Midazolam Hydrochloride ampoules were used in England between March and May 2020?

    b. Of 1mg in 5mL Midazolam Hydrochloride ampoules used between March and May 2020, where were they prescribed, and in what proportion, i.e. what went into the community, and what went into hospitals?

    c. What was the UK stock of 1mg 5ml Midazolam Hydrochloride ampoules held for the months October 2019, November 2019, December 2019, January 2020 and February 2020

    d. How much 1mg 5ml Midazolam Hydrochloride ampoules were left in the UK in October 2020?

    e. What was the UK stock of 10mg 2ml Midazolam in the months October 2019, November 2019, December 2019, January 2020 and February 2020?

    f How much 10mg 2ml Midazolam Hydrochloride ampoules were left in the UK in October 2020?

    g. Who ordered the 22,000 extra packs in May 2020? Was it the DHSC, and if so, which minister signed off the order? If it was not the DHSC please specify who it was.

    h. What was the cost of the order of the 22,000 packs?

35. Moving on to the Health and Social Care Committee. Oral evidence: Preparations for Coronavirus, HC 36, Friday 17 April 2020, ordered by the House of Commons

to be published on 17 April 2020 [16], and more specifically: Q376 to Q379 inclusive.

a. What does Dr Luke Evans mean when he says, “a good death”? Does he mean euthanasia which this term commonly refers to? Assuming he does mean this, why did Dr Luke Evans openly discuss government policy of assisting people on 'the end-of-life pathway' to “a good death”, when to do so is tantamount to an implicit confession of mass murder by design? Euthanasia and assisted suicide are both illegal under English Law. Assisted suicide is illegal under the terms of the Suicide Act (1961) and punishable by up to 14 years' imprisonment. Depending on the circumstances, euthanasia is regarded as either manslaughter or murder.

b. Are Dr Luke Evans’ remarks as a result of the Confidential Pandemic Influenza (CPI) briefing paper dated 8th September 2017[17], which states, and we quote “There is significant discussion in the paper about ceasing or changing care to patients in the HRG categories; however a decision may more appropriately be taken to treat patients in the listed HRG groups rather than influenza patients, dependent upon likelihood of survival…… Total excess death rate would be in excess of 7,806 per week of the peak of the pandemic if all these services were stopped. So, in the peak six weeks of a pandemic (recognising the typical profile of increasing and decreasing case numbers either side of the peak weeks), 46,836 excess deaths could be expected. On the one hand, this is likely to be an underestimate as it only considers the top 14 HRG codes and it does not

[16] Unrevised (parliament.uk)
[17] Pandemic-Influenza-Briefing-Paper-NHS-Surge-and-Triage.pdf(Shared)- Adobe Document Cloud

consider additional deaths occurring particularly in the elderly and frail across primary care where HRGs are not coded."

c. Give the CPI and Dr Luke Evans' remarks, is there a culture within government, Public Health England and indeed the NHS to enact the supposedly defunct Liverpool Care Pathway, to end lives at the behest of the treating doctor, which of course is illegal as described above?

d. If the answer to (c) above is "no", can you please explain why the NHS drew up the CPI and included within it plans to withdraw hospital care from people in nursing homes in the event of a pandemic, which also included refusal to treat those in their 70s and instead offer "support" to use so-called "end of life pathways".

e. The CPI states that the "Health Secretary (at the time) could authorise medics to prioritise some patients over others and even stop providing critical care altogether. Was such a decision taken by the Health Secretary at the time, (Matt Hancock), in relation to care home, hospital and community residents over a certain age?

f. Government ministers have repeatedly insisted that care homes were not abandoned by the NHS during the coronavirus crisis, despite more than 42,000 residents in England and Wales dying during the "pandemic". Given this, what is your proof that this was not because of decisions made by the DHSC, and/or PHE and NHS chiefs, which then resulted in thousands of needless deaths?

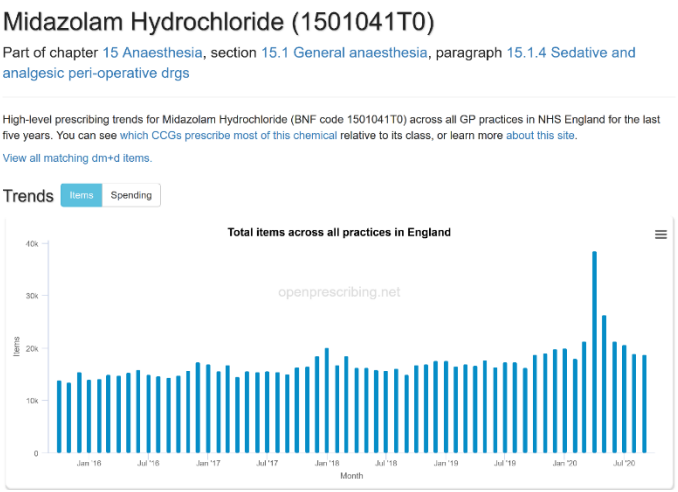
g. Care homes were asked by NHS managers and GPs to place DNR's on all residents at the height of the "pandemic" to keep hospital beds free – in breach of

guidelines[18]. Blanket DNR's were also imposed on people with learning disabilities "who were not near the end of their lives", showing a concerning disregard for disabled people. Who made the decision to ask care homes to do this, and were these decisions taken because of the CPI?

h. In making his remarks at the Health and Social Care Committee. Oral evidence: Preparations for Coronavirus, HC 36, Friday 17 April 2020, why did Dr Evans and indeed all those present, completely ignore the declassification of COVID-19 from an HCID to a NOID on 13/03/2020, meaning that such nefarious measures as those mentioned in the CPI were never necessary?

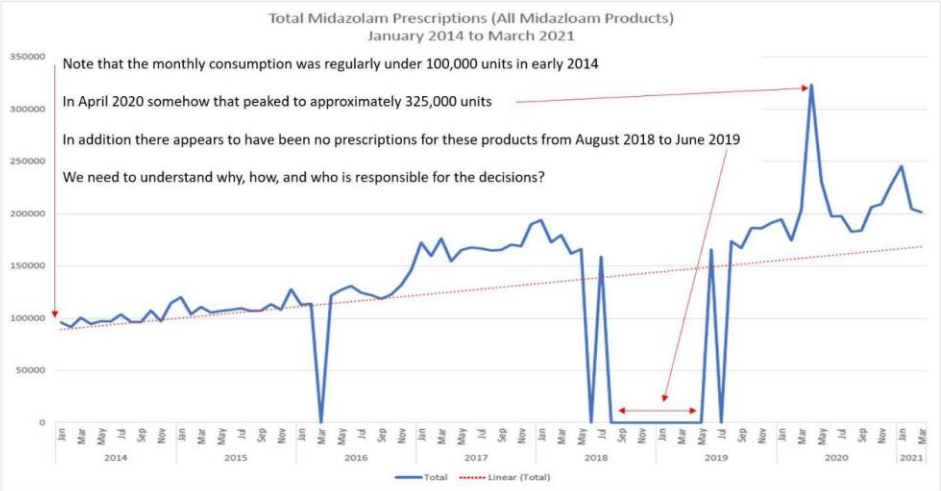
36 Moving on, we attach a selection of graphs regarding the prescribing of 10mg 2ml Midazolam hydrochloride ampoules for various years and months. Can you please explain:

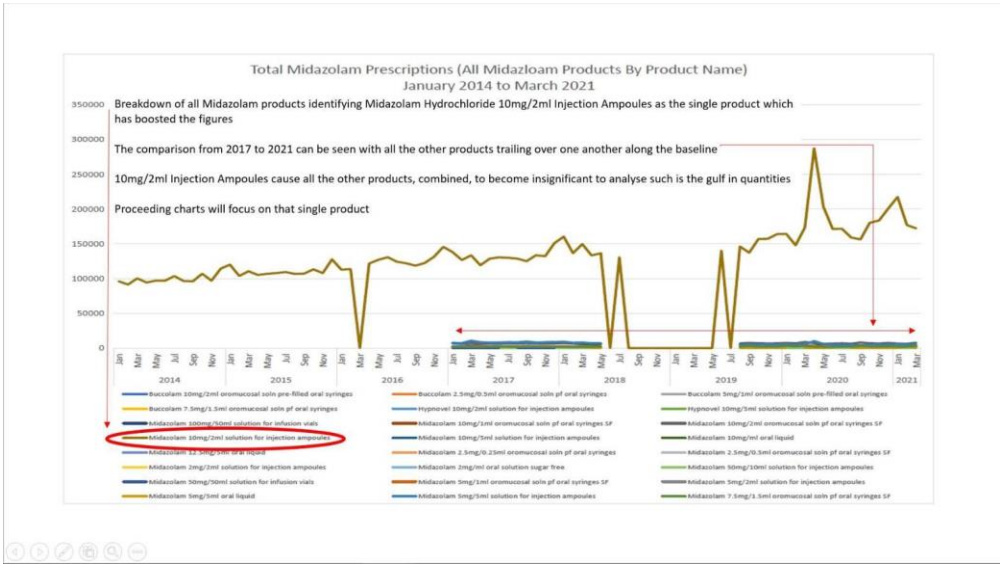
a. Why did the enormous increase in Midazolam prescriptions for 10mg 2ml Midazolam hydrochloride ampoules coincide with implementation of the UK Government's COVID-19 Battleplan in March 2020?



[18] Care home residents put on 'do not resuscitate' orders without consent (telegraph.co.uk)

b. Why, when looking at average yearly prescriptions for 10mg 2ml Midazolam hydrochloride ampoules, were there no prescriptions for the same, from August 2018 to June 2019? Was this to create “dry tinder” and help to lead to excess deaths from March 23rd 2020?





c. Given there were no prescriptions for 10mg 2ml Midazolam hydrochloride ampoules, from August 2018 to June 2019, how could there have been a shortfall in the country leading to the need to order a 2-year supply?

d. How much 10mg 2ml Midazolam hydrochloride ampoules, were held in the UK in January 2020, and what wholesalers held them?

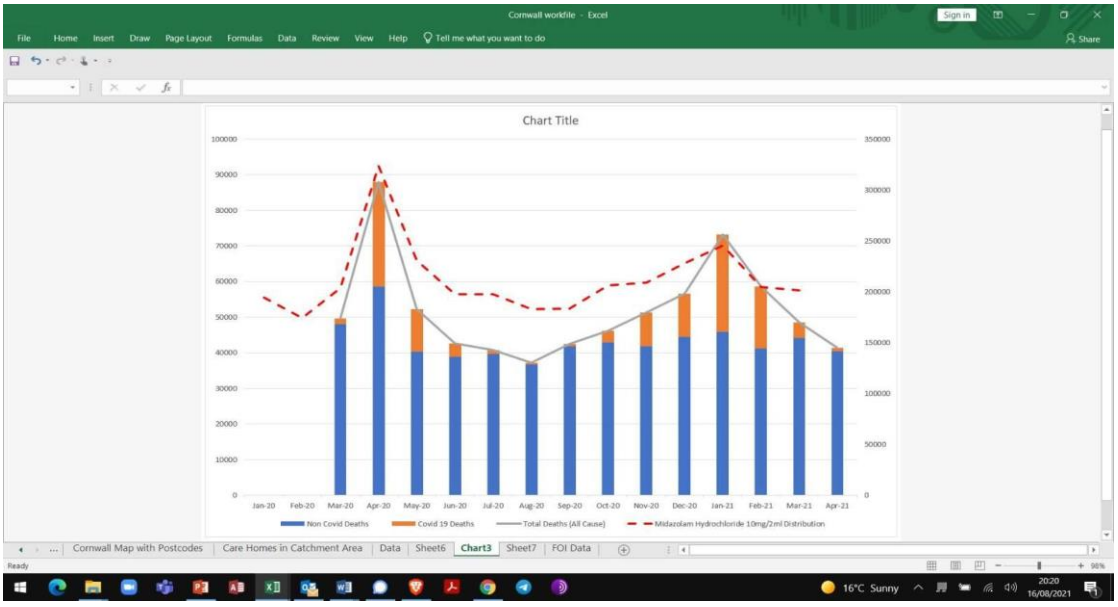
e. How does the DHSC, PHE and the NHS keep track of what stock it has of 10mg 2ml Midazolam hydrochloride ampoules, and indeed all other midazolam products?

37 We attach a final graph comparing all-cause mortality but distinguishing between NON "COVID-19" deaths and deaths "with COVID-19" for the period March 2020 to April 2021, compared to Midazolam prescribing for the same period.

Can you please explain: -

(i) why there is such a tight correlation between the "COVID-19" deaths in April 2020, and the prescribing of midazolam 10mg 2ml Midazolam hydrochloride ampoules?

(ii) As Midazolam is not a treatment for "COVID-19", and the prescribing in April is, in the main, into the community, and NOT hospitals, can you please answer if it is in fact the case that 10mg 2ml Midazolam hydrochloride ampoules were prescribed and used to end the lives of people in care that had a chance of surviving, and those deaths were then labelled as "COVID-19"?



For the avoidance of doubt, the appropriate answers to the above questions must be delivered without prevarication, obstruction, or unnecessary delays, whilst we reserve the right to lay this information in a criminal court without further notice, for the purposes of preventing any more harm being done to the people of the UK, by UK Government policy.

In sincerity and honour, without ill will, frivolity or vexation,

The Trustees of the People's Union of Britain