Before Covid, four types of pneumonia added together were the highest cause of death in the UK. In a newly implemented Medical Examiner System to certify deaths, the Medical Examiner was certifying all types of pneumonia deaths as covid-19 deaths, a former Director of End-of-Life Care has said.

On Saturday, Sai, a former NHS Director of End-of-Life Care, wrote a Twitter thread which, amongst other things, gave a personal account of the changes to the system of reporting deaths implemented in the NHS:

“When four different diseases [are] grouped and now being called covid-19, you will inevitably see covid-19 with a huge death rate. The mainstream media was reporting on this huge increase in covid-19 deaths due to the Medical Examiner System being in place.

“Patients being admitted and dying with very common conditions such as old age, myocardial infarctions, end-stage kidney failure, haemorrhages, strokes, COPD and cancer etc. were all now being certified as covid-19 via the Medical Examiner System.

“Hospitals were switching to and from the Medical Examiner System and the pre-pandemic system as [and] when they pleased. When covid-19 deaths needed to be increased, the hospital would switch to the Medical Examiner System.”

In addition, “hospitals were incentivised to report covid-19 deaths over normal deaths, as the government was paying hospitals additional money for every covid-19 death that was being reported,” Sai said. “I have no doubt in my mind, that the Government has planned the entire pandemic since 2016 when they first proposed the change to medical death certification.”

You can read Sai’s thread on Twitter or Thread Reader App. In the event it is removed from Twitter we have copied the thread below and attached a pdf copy at the end of this article. In the following, the number at the beginning of a paragraph relates to the number of the tweet within the thread.

1. The truth about the covid-19 pandemic from within the NHS (ex-Director of End-of-Life Care at one of the largest hospital trusts in the UK)

2. In 2016, the British government proposed and piloted a change to the process of how deaths were certified across all hospitals in the UK. I have attached a link to this Department of Health (“DoH”) document below:

Reforming death certification: Introducing scrutiny by Medical Examiners, Department of Health, May 2016

3 & 4. The DoH document proposed a switch to the “Medical Examiner” (“ME”) System and was sent to a number of different audiences for feedback and consultation. The ME System was already being piloted at two hospitals up north. The results of the consultation are below:

Introduction of Medical Examiners and Reforms to Death Certification in England and Wales: Government response to consultation, Department of Health & Social Care, June 2018

5. Prior to the covid-19 pandemic, the death certification process involved treating doctors of a patient to attend Bereavement Services/Patient Affairs to discuss the death and either: a) refer the death to the Coroner or b) write a Medical Certificate of Cause of Death (“MCCD”).

6. The MCCD states the cause of death. Whereby a direct cause (1a) or contributing causes (1b) (1c) (1d) are stated along with co-morbidities (not directly causing the death) being written in (2) on the MCCD. The MCCD is only ever a probable cause of death, it is not definitive.

7. The only definitive way of determining an accurate and plausible cause of death is to refer the deceased patient to HM Coroner (if certain criteria are met), for HM Coroner to accept and take on the case, resulting in a Post Mortem ("PM") being conducted by a Histopathologist.

8. When a death is seen as natural and there is nothing untoward, the MCCD is written by the treating doctor of a deceased patient. Usually, this is an F1, F2, SHO or Registrar that attends. It is rare for a treating Consultant to attend, but they will finalise the cause of death.

9. A strict hospital hierarchy exists within the NHS for doctors. It is as follows – from lowest to highest rank: Foundation Year 1 (FY1), Foundation Year 2 (FY2), Senior House Officer (SHO), Registrar (Reg), Consultant, Clinical Lead, Medical Director.

10. Junior doctors will very rarely speak up or challenge their seniors. A senior decision is seen as final and it will be carried out and executed without any hesitance or questioning.

11. In my 5.5 years of experience in End-of-Life Care, I have only ever seen one junior doctor disagree with a proposed cause of death and challenge their consultant.

12. With the number of deaths that occur in a hospital, as you can imagine, there is a great deal of variation with regards to causes of death, as we have numerous different doctors writing an MCCD and coming up with various different potential diseases in different orders.

13. The proposed ME system would change this, as the government would now hire and pay one Medical Examiner, to sit in every hospital and write all MCCDs for all deceased patients. This would effectively eliminate any variation in causes of death.

14. In 2016, when I heard of this proposal, I worked as a Bereavement Officer at a hospital in Central London. My mentor/line manager at the time was a former Chief Nurse who managed Bereavement Services and all hospital deaths would be controlled by her and the department.

15. We essentially carried a huge amount of power with regard to decision-making, as we would go through all patient notes following the death of a patient, and essentially guide and advise doctors on what would need to be written with regards to an MCCD or Coroners Referral.

16. In my personal opinion, our role was to sit on the fence and act in the best interests of a deceased patient (and their families), but also protect the hospital and our doctors from any potential negligence.

17. As you can imagine many battles were fought over decisions about a cause of death of a patient or a referral to the coroner with a vast [number] of doctors over the years.

18. F2s and SHOs were particularly the worst with regards to carrying an arrogance of knowing what should be written on an MCCD or stating that a patient didn't need to be referred to the Coroner (often stating that their Consultant had given them instructions).

19. It is worth noting that Consultants are also only human and can be incorrect at times too. We have to remember that they are succeeded in hierarchy by a Clinical Lead and beyond that a Medical Director. Who have far more experience and knowledge.

20. When I asked my mentor in 2016, how the ME system would change things, I was told that Bereavement Services/Patient Affairs would become purely administrative and that the clinical judgement would fall to the Medical Examiner.

21. The power and decision-making with regards to MCCD/Coroners Referrals was being taken away not only from treating doctors but also from Bereavement Services/Patient Affairs/Bereavement Officers/Bereavement Service Managers/Directors of End-of-Life Care.

22. This decision-making power was being handed solely to the Medical Examiner, who has not been involved in the treatment of a patient during an admission.

I took all this information in at the time and acquired as much knowledge as I could from my mentor/line manager.

23. In 2016, I also happened to make a move and take up an opportunity to manage my own Bereavement Services at one of the largest hospital trusts in the whole of the UK. On average, I would oversee MCCD/Coroner Referrals for approximately 1,750 deaths on an annual basis.

24. I developed a very close working relationship and friendship with one of the Medical Directors (a doctor with the highest ranking in a hospital). This was especially helpful when having to challenge doctors with regard to MCCDs/Coroners Referrals.

25. Progressing to Director of End-of-Life Care, I became involved with the reporting of mortality rates, conducting mortality reviews and writing hospital policies. I had also developed an excellent working relationship with the HM Coroner who oversaw our Trust.

26. HM Coroner holds the power to investigate any hospital or trust with regard to a death or a number of deaths. A slight problem may arise, in that HM Coroner has an allegiance to the Crown and the Government.

27. When a death is reported to the Coroner, this was previously reported via [a] telephone call by the treating doctor. A discussion was had with the Coroner's Office and a direct outcome and instruction would come from the Coroner's Office, by way of HM Coroner (via a phone call).

28. There is a fundamental flaw [in] this system, as there is no documentation of the decision and instruction from the Coroner. It comes via word of mouth. There is always room for error without any electronic documentation.

29. Every Hospital/Trust and HM Coroner will have a different system of reporting deaths. I personally made a decision to safeguard my hospital and the Trust, by developing an electronic coroners referral form, which I proposed to our Coroner and developed after their agreement.

30. We now had documentation of every death being reported and every outcome.

When reporting a death, the Coroner will look at a proposed cause of death and accept it, or reject the cause of death and take on the case (death of the patient), leading to an Inquest or a PM.

31. In 2019, our Medical Director, came into my office one morning and stated that the Board of Directors at the Hospital had made a decision to switch to the Medical Examiner System.

Hearing the words "ME System" was a massive case of Déjà vu (conversation with my mentor in 2016)

32. I knew exactly what the ME System was, but I chose instead, to play the fool and enquire what exactly the ME System was and what it meant for our service, my staff and our roles. Everything the Medical Director mentioned to me that day was a carbon copy of what I already knew.

33. I knew that my time in End-of-Life Care had come to an end. I'd reached the top and there was no more progress for me. Losing all power and decision-making to any ME coming into the hospital did not appeal to me. I'd already made up my mind that I needed to leave.

34. Seeking a new challenge and experience, I made a move in 2019 to another major hospital in Central London, this time side-tracking into operational management. I was in charge of the operational management of Nephrology, Rheumatology, Dermatology and Diabetes & Endocrinology.

35. In Jan 2020, I remember hearing about the first case of covid-19 at our hospital, with a patient arriving from China and walking into our A&E. A&E was shut down and steam cleaned that day, I recollect the moment I heard about this.

36. In my mind, I saw the reporting of covid-19 in the media as nothing more than Bird Flu or Ebola, which had caused panic but yet passed. I wasn't worried in the slightest bit.

Things began to escalate around in Feb 2020, around the time I was going on holiday.

37. Due to the reporting by the media, I bought N95 masks as a precaution for my trip and to give to my parents and younger sister. I was blessed to have had an opportunity to spend a few days in Sri Lanka for a wedding and then nearly a whole month in Australia (March 2020).

38. I watched as the narrative of a deadly infectious disease continued to grow with every day that passed. I made a decision to cut my holiday short by a couple of days so that I could make sure I got back to my family and [did] not end up being stranded in Australia.

39. Upon returning to the UK in late March 2020. One of the immediate things that struck me was the lack of any temperature monitoring or questioning at Heathrow Airport. This seemed odd for a potentially deadly infectious disease that was spreading around the world.

40. This was especially odd, as Sri Lanka and Australia had questioned me/checked temperatures upon arrival, with even Singapore monitoring temperatures during transit.

41. My mother had just recovered from cancer, my father was over 70 and my younger sister was born with Down's Syndrome alongside having multiple other conditions. I had three high risk individuals to covid-19 in my family and I was scared/fearful of giving them covid-19.

42. I asked my hospital to allow me to work from home. They refused. I wasn't deemed high risk, although I lived with my parents at the time. I needed to help my mum and my sister. The hospital held no regard for the safety of its employees. They forced me to come into work.

43. I spent two months isolating in my bedroom, I barely came out of my room, for fear of spreading an infectious disease. Never once did I think about the situation or my prior experience or knowledge, I was just reacting to the media frenzy. I was full of panic and stress.

44. The first irregularity I noticed, was the government and media stating that covid-19 was an infectious disease. However just before the first lockdown was implemented, I noted that the government had downgraded the status of covid-19 stating it was no longer infectious.

45. This made no sense to me. Why would we need to isolate if they downgraded the status? My circle of friends contained many medics and dentists. They were all panicking at the time, saying they had inadequate surgical masks and that they needed N95 masks.

46. N95 masks were seen as the only way to prevent medical professionals from becoming infected with covid-19.

The public being asked to wear surgical masks made no sense to me. The virus would be able to go straight through. Something didn't seem right.

47. I ended up meeting and dating an FY1 doctor (my ex-[girl friend]) around October 2020. We clicked because she was different from every other doctor I had previously spoken to about covid-19. She also had her suspicions and believed it wasn't as infectious as it was made out to be.

48. We both started to slowly realise that covid-19 was a real disease (as it was showing up on X-rays in patients) but that it wasn't infectious at all, despite all the reporting in the media.

49. I needed to experience working in a covid-19 hotspot and see all the action for myself. In March 2021, I quit my job at the hospital in Central London and took up an opportunity to manage A&E and AMU (Acute Medical Unit) at a hospital in South London.

50. The 6 months that I spent working in A&E/AMU confirmed all my suspicions and culminated in my decision to end my career in the NHS.

51. [For] the entire 6 months, I was not tested once with a PCR Test, despite walking into wards full of covid-19 positive patients on a daily basis. Yet we were required to test multiple times when visiting another country.

52. The PCR test that the NHS was using to test patients, is known to have false-positive results. This is shown in numerous studies which can be found online, an example of which is: Are you infectious if you have a positive PCR test result for COVID-19? – The Centre for Evidence-Based Medicine, The Centre for Evidence-Based Medicine, 5 August 2020

53. If a patient tests positive for Covid-19 with a PCR Test, this doesn't mean they are infected. If tested again, they may well turn out with a negative test. However, in the NHS, patients are only tested once and this stays on their record throughout their admission.

54. Hospital policies were changed alongside the implementation of the Medical Examiner System, to ensure that any patient who died within 30 days of a positive test, would have to have covid-19 as their primary cause of death. This was regulated by the Medical Examiner.

55. The highest cause of death at every hospital per annum pre covid-19 is Pneumonia. Pneumonia is a respiratory disease like covid-19.

56. Pneumonia can be broken down into 4 different causes of death: Bronchopneumonia, Aspiration Pneumonia, Community-Acquired Pneumonia and Hospital Acquired Pneumonia. These four causes when added together kill the largest number of people on an annual basis prior to the pandemic.

57. The Medical Examiner (one individual in each hospital), was certifying all these pneumonia deaths as covid-19 deaths. When four different diseases [are] grouped and now being called covid-19, you will inevitably see covid-19 with a huge death rate.

58. The mainstream media was reporting on this huge increase in covid-19 deaths due to the Medical Examiner System being in place.

59. Patients being admitted and dying with very common conditions such as old age, myocardial infarctions, end-stage kidney failure, haemorrhages, strokes, COPD and cancer etc. were all now being certified as covid-19 via the Medical Examiner System.

60. Hospitals were switching to and from the Medical Examiner System and the pre-pandemic system as [and] when they pleased. When covid-19 deaths needed to be increased, the hospital would switch to the Medical Examiner System.

61. Doctors were one week being told they needed to complete an MCCD, to then be told the following week that they weren't required to fill out an MCCD, as the Medical Examiner was handling this.

62. Hospitals were incentivised to report covid-19 deaths over normal deaths, as the government was paying hospitals additional money for every covid-19 death that was being reported. The Medical Examiner system ensured that covid-19 was being put down as the cause of death.

63. The government sends out the annual NHS budget to Primary Care Trusts. This is split to fund Hospitals and GP Surgeries. A clinical coding team at each hospital will assign codes to each treatment or death, so that money is paid out to the hospitals.

63. Any doctor who argued against covid-19 as a cause of death was bullied and vilified. The General Medical Council ("GMC") maintains a register of all doctors within the UK. This ensures that there is a fear of being struck off for speaking out against an agenda.

64. The GMC effectively controls all doctors in the UK.

Even if a doctor realises what is going on and wants to speak out. They will think twice about talking, as they would be risking their entire career and everything that they've worked so hard for.

65. Doctors essentially have their hands tied, many have families, kids, mortgages and mouths to feed. If I was in their situation, I would think twice about speaking out, for fear of being struck off by the GMC and losing everything.

66. The NHS Track & Trace App, which was introduced to try and control the spread of the virus, did not apply to medical professionals. We were all asked to turn this off, as Doctors and staff isolating for 14 days disrupted patient flow, beds and the discharge of patients.

67. Any doctor that I spoke to regarding taking the covid-19 vaccine, were insistent that they were going to wait for a period of time, before taking it themselves, to ensure that it was safe.

How is it ethical to give a vaccine to your patients, but not want to take it yourself?

68. In my 12 years of NHS service, never has a doctor pushed or influenced the public to take a vaccine. Yet on social media, I was seeing close friends who were doctors, starting to post on social media that they have taken the vaccine and that the public should.

69. I wouldn't be surprised if doctors were being forced to promote the vaccine by their superiors or if they were receiving monetary gain in doing so.

70. I have no doubt in my mind, that the Government has planned the entire pandemic since 2016 when they first proposed the change to medical death certification.

71. Stress leads to disease and illness. Panic leads to people following whatever orders and instructions that are given to them by authority, such as prolonged mask use, which leads to an increase in admissions in to the NHS system due to hypoxia and bacterial pneumonia.

72. The NHS treatment pathway involved patients being placed onto ventilators. There is a 50% chance of death from this clinical decision alone. How many innocent people have died from the clinical decision to place them on a ventilator.

73. During board rounds (where every admitted patient is discussed), we were seeing patients on a daily basis being admitted due to suffering from adverse effects of taking the vaccine. Patients were blacking out after taking the vaccine or suffering from clots or strokes.

74. The NHS is all about money and making money. The safety of a patient didn't seem like the most important thing. It was more about: how do we make more beds available so that another patient can be treated?

75. Patients with no next of kin are discharged to nursing homes with care packages. I can't comment on what happened to these patients in nursing homes, during the pandemic, as I have no experience of their inner workings.

76. Patients are seen as money, even upon death, hospitals receive money for each death. Is there an actual concern for patient health and safety? I know numerous doctors who are driven primarily by money and monetary gain.

77. The reason why I left the NHS in 2021

56-year-old male, admitted into A&E with end stage kidney failure, has a previous history of regular dialysis treatment for this. No respiratory symptoms on admission and no temperature. However, when tested with a PCR Test…

He, unfortunately, tests positive. This stays on his record throughout his admission. Our hospital is relatively small in comparison to others I have worked at, we have no dialysis machine as a result. We urgently need to transfer this patient to another hospital otherwise this patient will die. Our treating doctor calls up larger hospitals with a dialysis machine to organise his transfer. All doctors pick up the phone and request the covid-19 status of the patient. A transfer is declined due to a covid-19 infection protocol. Our doctors again reiterate the point that this patient will die without dialysis. We are told there is nothing that can be done and that the patient cannot be accepted for transfer.

This gentleman ended up dying without dialysis. Now please tell me what goes on the MCCD … 1a) covid-19 2) End Stage Kidney Failure.

Not written by the treating doctor who disagreed with this cause of death but by a medical examiner, put in place by the government and the hospital.

When innocent people are being killed by a corrupt organisation and system, for pure monetary gain, I can't stand by and be part of this anymore. My conscious was clear and I no longer wanted to be a part of this anymore.

78. I am very blessed and lucky that I was in a position to walk away. I've been able to speak out, because my hands are not tied and I am not regulated by any organisation or governing body. I believe in speaking the truth and in doing so, I am only just an instrument for God.

79. I joined the NHS, 12 years ago because I had the desire to help those in need but the moment I realised that I was not doing this anymore, was the time for me to walk away.

80. I apologise to you all if the above thread is confusing with regard to terminology or if you cannot understand its contents. I'm hoping that at the very least, it can be understood by my fellow medical professionals or by journalists who would like to report the truth.

81. Would be very grateful if you could help spread this truth and raise awareness of what really went on within the NHS by reposting and tagging any relevant individuals who you think may help with spreading the truth.

Sai is currently the Creative Director at Trillionaire Gents Squad, a streetwear and lifestyle clothing brand established in 2021.